Improvement Fund End of Project Impact Report

We have designed this form to be flexible so that you can evaluate your project in a way that is meaningful to you but that covers our needs as a funder too. We have provided prompts for the information we are looking for, with a particular emphasis on improvement tools and methodology, the impact made, and the role the improvement fund played in you project.

Project Details	
Project Title	Prevention/Multimorbidity: Anticipatory Care Planning (Phase 3)
Date of Report	17 May 2019
Project Start Date	01 April 2018
Project End Date	31 March 2019
Lead Organisation	Edinburgh Health & Social Care Partnership
Partner Organisations	VOCAL

What was the challenge? Guideline word count: 150

People in Scotland are living longer and long term conditions are increasingly common. In Edinburgh we estimate that 23% of people have at least one long term condition and 38% of these people have two or more long term conditions. People with multiple long term conditions often experience disjointed services and have a high 'burden of treatment' from the various professionals who support them to manage their conditions.

Anticipatory Care Planning (ACP) is a person-centred, proactive, 'thinking ahead' approach, with services and health and care professionals working with individuals, carers and their families to make informed choices about their care and support. It requires a supportive whole-system approach which puts individuals at the centre of decisions that affect them.

ACP enables individuals with chronic and complex conditions to understand their current health and wellbeing, whilst anticipating and proactively managing their health and care needs. Optimal outcomes and improving quality of life through ACP are helped by early intervention when people have complex needs or changing circumstances.

The challenge is to increase the use of Anticipatory Care Planning, carer support plans and Key Information Summaries so that people, and those who support and care for them, are better prepared to deal with health problems which may fluctuate or get worse over time.

What were your aims?

Building on the success of two initial tests of change (phase 1 and phase 2), Edinburgh Health and Social Care Partnership's Long Term Conditions programme supported delivery of two defined improvement aims for phase 3:

1. To reduce the number of avoidable hospital admissions by 10% within 18 care homes in Edinburgh Health and Social Care Partnership by March 2019.
2. To increase Anticipatory Care Planning and use of sharable Key Information Summaries by 30% in eight Health & Social Care Teams in Edinburgh Health and Social Care Partnership by March 2019.

What was your approach? Guideline word count: 500

- Develop, test and improve the ACP toolkit (7 steps to ACP for Care Homes), designed during phase 1 and 2.
- Develop and further improve the ACP pathway with care homes, GP practices, out of hours, and acute services.
- Provide guidance, teaching and support for care home staff in discussing and documenting care planning discussions with residents and families.
- Build confidence and skills to enable care home staff to access and act on the agreed escalation of care, wishes and preferences' as documented in ACP Key Information Summary (KIS).
- Facilitate reflective learning sessions and structure improvements through learning cycles, sharing learning and improvements in an end of project learning event.
- Support care homes to use real-time data to reflect on the impact of ACP changes made, come up with useful ideas for continuing to improve, and to see is these improvements were maintained.
- Establish a network of care home ACP champions to lead local improvements and provide peer support.
- Develop an ACP training plan to provide ACP training to health and social care teams and third sector partners
- Scope and take forward ACP tests of change with health and social care teams, acute care teams, and third sector partners.
- Establish an Edinburgh Health and Social Care Partnership ACP Stakeholder Group to provide guidance, share learning and improvements.
- Hold road shows to raise ACP awareness with general public and health and social care staff.

What was the impact? Guideline word count: 800

Improvement aim 1 qualitative outcomes:

Reflective learning sessions with care homes and GP practices provided rich qualitative information on the impact of implementing the 7 steps to ACP for care homes. Discussions were commonly around practicalities of implementing the ACP process/following the ACP pathway; having ACP discussions with residents and families; leadership and team working; improved care; and the impact on residents and families. Extracts from learning cycle summary reports include:

- Implementation of the 7 Steps to ACP has been an overwhelming success for the Care Home. In addition to the outstanding audit on KIS (100% of residents now have an up-to-date ACP-KIS), Care Home staff have adhered to the 7 steps to ACP on escalation of acute deterioration, ensuring appropriate care in an appropriate setting as per the residents' preferences.
- 'Death in hospital' data continues to be zero demonstrating the importance and benefits of the implementation of ACP.
- The implementation went well; ACP conversations helped family members to think ahead, and to plan ahead on future care. It was a relief to the family members having an ACP in place. ACP was discussed at all family meetings so that family members are familiarised with the process.
- If you want to enhance your practice you have to buy-in to this process. We are supporting person-centred care and this supports us from the very beginning. They're telling us what they want and we are here to facilitate that.

Please see ACP Improvement Programme Learning Report, Phase 3, Learning Cycles pp. 20-31, and Case Studies, Appendix 9.

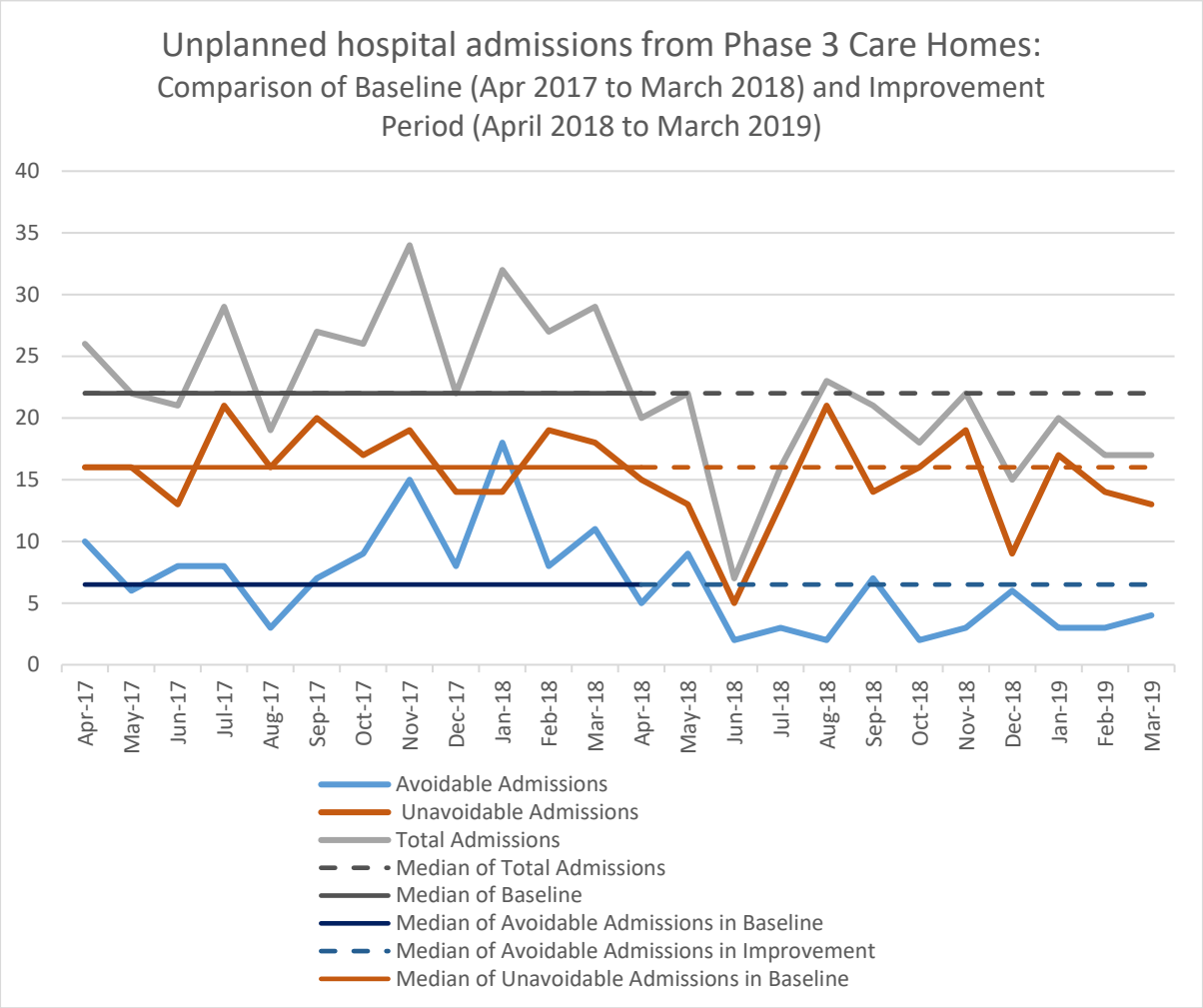
Quantitative data demonstrates that impact in relation to reducing avoidable admissions from the 20 care homes participating in phase 3. Using the Model for Improvement, the ACP team developed a measurement

plan to support care homes and GP practices to test if the changes made during learning cycles led to an improvement. Using real-time data enabled participants to reflect on the impact of ACP changes made, come up with useful ideas for continuing to improve, and to see is these improvements were maintained. The relationship between the improvement aims and changes to be tested were explored and made explicit through developing a driver diagram. This helped to determine what measures needed to be tracked to answer the Model for Improvement's second question "How will we know that a change is an improvement". The ACP team supported Care Homes to collect and review data throughout the learning cycles and reflective learning sessions.

Improvement aim 1 quantitative outcomes:

- Total A&E attendances decreased by 20% when comparing the baseline period (April 2017-March 2018) with the improvement period (March April 2019-March 2019).
- Of the attendances to A&E, the total number of unplanned admissions to hospital decreased by 96 admissions, a 31% reduction when comparing the baseline and improvement periods.
- The number of avoidable admissions decreased by 62 admissions, a 56% reduction. Avoidable admissions can be further broken down to:
    - avoidable if ACP-KIS included a plan for escalation of care
    - avoidable if ACP-KIS was followed
    - avoidable if ACP-KIS had a condition specific management plan
- Avoidable admissions to hospital due to the resident not having an ACP-KIS with a clear plan for escalation of care decreased by 49 admissions, a 53% when comparing baseline and improvement periods.

When examining the time series of all unplanned hospital admissions from the Phase 3 care home cohort, the median avoidable admissions dropped from 8 in the baseline period (April 2017 to March 2018) to 3 in the improvement period (April 2018 to March 2019). There is a statistically significant shift in avoidable admissions from October 18-March 19 (post-ACP training/7 steps to ACP implementation period) indicating that the reduction is likely to be attributable to the changes made to ACP through the improvement programme.



Please see ACP Improvement Programme Learning Report, Phase 3, Improvement measures, pp 32-39.

Improving ACP with unpaid carers

In partnership with Voices of Carers Across Lothian the ACP team aimed to raise awareness of the benefits of ACP with unpaid carers and develop a carer-GP ACP pathway. The ACP team delivered training to VOCAL staff, enabling VOCAL to hold ACP sessions as part of their established Power of Attorney surgeries. Working together carer ACP resources were produced: ACP information leaflet for carers; ACP carer document, to facilitate ACP discussions between carers and their GPs leading to the creation of an ACP-KIS; KIS fridge magnets and wallet cards, to prompt carers and those providing care and support at home to let emergency services know there is an ACP-KIS in place and to access it at points of deterioration. VOCAL plans to recruit a dedicated volunteer to explain ACP and book carers into the ACP sessions. VOCAL is integrating the approach to completing ACPs into existing workshops on future planning and emergency planning.

Learning from testing the ACP unpaid carer-GP pathway with VOCAL was shared with Edinburgh Health and Social Care Partnership's Edinburgh Carer Support Team. As part of its service the team carries out adult carer support assessments to provide carers with a plan to access council services that can support their caring role (eg respite services, carer's emergency card, benefits advice, arranging a needs assessment for the cared for person, etc). The Edinburgh Carer Support Team immediately recognised the value in including ACP for carers and is testing the unpaid carer-GP ACP pathway. As part of the adult carer support assessment the team has an ACP conversation with the carer, completes the Carer ACP Document providing the carer with a copy and forwarding a copy to the GP to update ACP-KIS. Working in partnership with the

ACP team a Quality Improvement (QI) approach[6] has been applied, testing the ACP change idea with 6 carers in the first learning cycle, with the aim of testing with an additional 25 carers during the second learning cycle by July 2019.

Improving ACP with acute care teams

The ACP team is working to improve ACP in partnership with Old Age Psychiatry teams at the Royal Edinburgh Hospital, Medicine of the Elderly and the Clinical Genetics Service at the Western General Hospital, and Medicine of the Elderly at the Royal Infirmary of Edinburgh.

Old Age Psychiatry at the Royal Edinburgh Hospital has designed and tested an inpatient ACP process, and is testing what ACP information to share with GPs when patients are discharged to upload to ACP-KISs. Similarly, Medicine of the Elderly at the Western General Hospital and Royal Infirmary continue to make ACP improvements for inpatients and are also testing what information to share with GPs when a patient is discharged. How the ACP information is included in the discharge letter, whether it is easily transferable to ACP-KIS, and if it is accessed to inform shared decision making, will be evaluated as part of this test of change.

The Clinical Genetics Service at the Western General Hospital identified key ACP information for Myotonic Dystrophy patients that is important to share with teams providing care and support in the event of an acute deterioration. In the first learning cycle 100% of Myotonic Dystrophy patients attending the clinic had the agreed ACP information/alert shared with their GP and uploaded to their ACP-KIS. The 2nd learning cycle will include providing a printed hard copy of ACP-KIS for patients to have at home, along with the ACP-KIS fridge magnet and wallet card. Spreading the ACP approach to include patients attending the clinic with different genetic conditions is being explored.

Different teams and professions can make assumptions about the level of ACP information that has been shared or can be accessed across the integrated system. Having an agreed ACP pathway across the service interface provides access to important information in the absence of integrated/accessible digital systems.

Improving ACP with health, and health & social care teams

The ACP team is working in partnership with community pharmacists, dieticians, community mental health teams, district nurses, and home care teams to improve ACP.

Dieticians are initially testing an ACP change idea with care homes. Sharing nutritional support information on the residents' ACP-KIS special notes ensures this information is available to acute care teams in the event of an unplanned hospital admission. It also facilitates appropriate nutritional support and treatment during a hospital stay. Pharmacists are also testing a change idea with care homes, with the intention to include a polypharmacy review for new care home residents as part of the 6-week ACP review.

Community Mental Health Teams are identifying information from mental health care plans to share across the integrated system to support mental health patients when they present at A&E or contact out of hours/emergency services. An ACP pathway is being developed to test effective and efficient mechanisms for transferring agreed ACP criteria from mental health care plans to ACP-KISs. Home care teams and district nurses are also beginning to identify ACP information to share across the integrated system and test systematic approaches to transferring to ACP-KISs. The benefits of people living at home having a hard copy of their ACP-KIS is also being tested.

People living with long term conditions or complex health needs at home may be in regular contact with multiple health and social care teams. Agreeing community care criteria to share in ACP-KISs provides immediate access to information that could improve care and treatment in the event of an acute deterioration. Taking forward tests of change will demonstrate if this approach to improving ACP can lead to improved personal and clinical outcomes and prevent unwanted or unnecessary hospital admissions.

Health and social care teams' capacity to design, test and evaluate ACP improvements can be limited due to demands of delivering services. Providing a structured QI approach and improvement support can help if the conditions are right within the service. If a service is working to capacity and/or is subject to service redesign or relocation as part of ongoing integration implementation then improvement initiatives can be challenging to start and/or sustain. Sharing learning from care home ACP improvements and initial tests of change with acute care and health & social care teams is starting to gain interest and build improvement momentum.

The ACP team will work towards achieving the 2nd improvement aim through partnership working during the next 12 months, changing the focus to developing and testing an ACP pathway across Edinburgh's community.

What went were the pros and cons?

Please see ACP Improvement Programme Learning Report, Phase 3, 2018-19.

What went well

- Enthusiasm and participation of care homes and GP practices. We had hoped to work with 18 care homes and had more care homes wanting to work with us than we had the capacity to support. We managed to support 20 care homes and their aligned GP practices through phase 3 of the ACP improvement programme.
- The care home ACP improvement approach was successful in enabling testing, reflection and evaluation with improvement outcomes that exceeded all our expectations.
- There is now a shared understanding of the importance of ACP for unpaid carers. The partnership's carer support team is taking forward ACP improvements.
- Acute care teams are keen to work together to improve ACP across the service interface (ongoing tests of changes re developing inpatient ACPs based on the care home model/testing ACP information provided at discharge and accessed on admission, etc).
- Interest from health and social care teams in developing and testing a structured approach to improving ACP has been more widespread than we'd anticipated, with a range of services now interested in working together to develop an ACP community pathway/improving ACP for people living at home with long term conditions.

Challenges

- Service capacity to design and test ACP improvements is an ongoing challenge. With care homes we had the advantage of two preceding improvement phases when the improvement approach was designed and tested with a few care homes. Learning from phase 1 and 2 informed a structured ACP improvement approach enabling us to work with 20 care homes, with the benefit of being able to predict and address challenges (staff turnover/different skills levels/communication across the interface/technical (digital systems) barriers etc)
- Phase 3 learning has started to inform the service capacity within the integrated health and social care setting and the particular challenges associated with taking forward a structured ACP improvement approach. There is now a clear will and shared aim to improve the ACP community pathway, the challenges experienced during phase 3 can inform future partnership working (eg QI capacity/competing integration priorities/understanding the benefits of ACP for all relevant patient and client groups, etc).

What learning will you share?

ACP stakeholder group

An Edinburgh Health and Social Care Partnership ACP Stakeholder group was formed, bringing together local teams from across Edinburgh's integrated service with representatives from national organisation, e.g. NHS 24, Scottish Ambulance Service, Scottish Care. The Stakeholder Group met 3 times between June 2018 and February 2019:

- providing input from a range of disciplines and sectors
- sharing and spreading ACP learning, and
- increasing the reach of collaborative approaches to ACP improvements.

Stakeholders contributed their expertise to developing a shared understanding of the barriers and enablers of effective ACP pathways, including improving the exchange of ACP information at the acute, primary, community and voluntary sector interface. Representatives from health and social care teams (Community Mental Health Teams, District Nurses, Multi-Agency Triage Teams, Community Pharmacists, Hub and Cluster Service Managers) translated shared learning into ACP improvements within their own settings. The ACP team is working in partnership with a range of health, integrated health and social care, and voluntary teams to test ACP improvements.

Learning event

To celebrate progress and share approaches to improving ACP, a learning event was held at the end of phase 3, bringing together care home teams, multidisciplinary health and social care teams, third sector partners, and carers involved in improving ACP across Edinburgh's community. The event was held on Wednesday 6 March 2019 and attended by more than 140 delegates.

The aim of the event was to:

- share the Long Term Conditions Programme and partners' activities designed to improve ACP across Edinburgh City
- recognise the involvement and achievements of the Phase 3 care home teams and care home ACP champions
- share ACP Improvements underway across community and acute services
- highlight why ACP matters from a national, out of hours, acute hospital, GP and health and social care locality perspective
- explore mechanisms that can support new and ongoing ACP improvements, and
- begin to scope a fourth phase of the Long Term Conditions ACP improvement programme.

An event report captures the content of the day, the presentations, discussions and suggestions for working together to improve ACP. Key themes included:

- roll out of ACP improvements across all care homes in Edinburgh
- continued support for the care homes that have participated in the ACP improvement programme to date
- spread ACP learning improvements to services supporting people living at home with long term conditions, and
- continuation of opportunities for reflective practice and for shared learning.

During the world cafe session delegates discussed with health, health & social care, and voluntary teams their approaches to improving ACP for people living with long term conditions in Edinburgh. The success of improving ACP with care homes/GP practices and the need to replicate similar improvements for people living at home with long term conditions was repeatedly discussed. Having a structured ACP approach with reliable processes that work across the integrated system emerged as a shared improvement aim. Some teams hosting tables shared progress with developing ACP discussions prompts (similar to the care homes Anticipatory Care Questions) and developing ACP pathways (similar to the care home-GP ACP pathway). The ACP team will support the development and testing of an ACP community pathway during the next 12-month period. Please refer to 'Anticipatory care planning improvements: celebrating success and sharing learning in Edinburgh, Post Event Report, March 2019.'

For a summary of learning points please see ACP Improvement Programme Learning Report, Phase 3, Appendix 3.

LWiC is creating a subpage of its online ACP section for the ACP team to share the ACP Improvement Programme Learning Report, the Post Event Report, and our improving ACP resources, eg talking heads video/carer support videos, etc.

What are the next steps? Guideline word count: 200

Recommendations made from the findings of phase 3 are:

1. Develop a care home ACP improvement and support package to support participating care homes to sustain improvements. With support from national partners (Healthcare Improvement Scotland, Care Inspectorate, Scottish Care) develop a scalable ACP improvement model which can be shared and tested across Scotland.

2. Undertake an economic evaluation of improving ACP with participating care homes to ascertain the cost saving of a 56% reduction in avoidable hospital admissions, and determine how the allocation of resources can achieve the greatest benefit.

3. Continue to work in partnership with health, health and social care, and voluntary teams to improve ACP for people living with long term conditions at home, improving the ACP community pathway.

4. Facilitate an ACP champions' network broadening out from care homes to include health and social care and voluntary teams involved in improving ACP.

5. Working with the Scottish Health Council review feedback from participating care homes' residents and families, and engage with citizens to understand the level of ACP awareness and utilisation among the general public. Co-produce resources to empower people to start ACP conversations early, enabling them to make informed choices about their care and support.

The care home ACP improvement and support package is being developed. This enhances the '7 steps to ACP for care homes' providing guidance for implementation and improvement tools (eg training resources, local measurement plan, etc).

EEvIT is taking forward an economic evaluation with us which will be important to inform a scalable care home ACP model.

Following the ACP Learning Event health and social care teams have asked for improvement support to improve ACP. We are considering the best approach to taking forward improvements without continued funding/ dedicated ACP improvement resources.

The Scottish Health Council is supporting our aim to engage with citizens to raise awareness and utilisation of ACP, we are in early discussions re partnership working.

We are keen to make best use of learning gained through the ACP improvement programme to develop and test:

- a scalable care home ACP improvement model which can be shared and tested across Scotland
- an ACP community pathway to improve ACP for people living with long term conditions at home
- an ACP network broadening out from care homes to include health and social care and voluntary teams involved in improving ACP.

We would welcome HIS' knowledge and expertise to support taking these actions forward.

What did the Improvement Fund support you with?
Support from HIS was provided through LWiC team, a particular note of thanks to Jo Thomson and Scott Purdie.

Other Guideline word count: 200
• Is there anything else you would like to add not covered in the other sections?

Please attach any supporting information as an appendix.

If you have any questions contact hcis.improvementfund@nhs.net