

Edinburgh Health and Social Care Partnership Long Term Conditions Programme Improving ACP in Care Homes

A local story from Living Well in Communities

The challenge

Anticipatory care planning (ACP) improves care by enabling people with complex needs and the health and social care professionals who support them to 'think ahead'. This ensures that individuals are able to make informed choices about their care and support. However, many care home residents do not have an ACP in place, which means that staff can be unaware of their preferences for care. This can lead to unplanned hospital admissions.

Aims

Our project had the following aims:

1. Embed ACP and design reliable processes in 18 care homes in Edinburgh by March 2019.
2. Reduce the number of avoidable hospital admissions by 10% within 18 care homes in Edinburgh by March 2019.

Working with care homes and their aligned GP practices, we aimed to:

- train care home staff to develop ACP knowledge and skills
- implement reliable ACP processes, develop and improve the toolkit *7 steps to Anticipatory Care Planning* for care home staff
- facilitate reflective learning sessions and data for improvement over time, and
- share learning and provide peer support through a care home ACP champion network.

Background

With funding and support from Healthcare Improvement Scotland's (HIS) ihub Improvement Fund, the Long Term Conditions ACP team provided training to 20 care homes during 2018-19, and a framework to adopt a tailored care home ACP model.

Building on the success of testing Anticipatory Care Questions for care home residents with four care homes during 2016-2017, the approach was refined and an ACP pathway developed with a further 6 care homes during 2017-18.

Timeline

- Phase 1 (Jan-Jun 2017): Testing to improve ACP with four care homes.
- Phase 2 (Sep 2017-Apr 2018): Learning shared and improvements tested with a further six care homes.
- Phase 3 (Apr 2018-Mar 2019): ACP improvements scaled to 20 care homes.

How we did it



During phase 3 the ACP team recruited 20 care homes and their aligned GP practice teams, signing up to a partnership agreement setting out the ACP improvement approach. ACP training was designed and delivered to care home staff and support offered to GP practice teams. Each care home identified at least one ACP champion to provide local leadership, advice and peer support. 95 ACP care home champions joined a virtual network facilitated with support from St Columba's Hospice. Four learning sessions were held covering ACP topics.

Following an ACP Key Information Summary (KIS) audit to measure quantity and quality of KIS, care homes began to use the ACP toolkit, 7 steps to Anticipatory Care Planning for care home staff. The toolkit provides a tailored care home ACP process and accessible implementation tools to support care homes and GP practices to deliver a structured ACP approach. It also meets the requirements set out by the Care Inspectorate, Scottish Care and Healthcare Improvement Scotland.

The toolkit enables residents to discuss their current and future health and care and treatment preferences should they become very unwell. This approach supports residents to explore the three most common deterioration scenarios for which residents are most often unnecessarily admitted to hospital. Care home teams found this:

- leads to a shared understanding with residents and families, and the health teams involved in their care
- reduces stress in times of crisis, and
- gives the care home team the confidence to clearly communicate and act on individuals' wishes to improve their clinical and personal outcomes.



Reflective learning

Each participating care home and GP practice tested the ACP improvement approach over a 6-week period using the *7 steps to ACP* toolkit and ongoing support from the ACP team. During the 7th week the care home, GP and ACP team came together to reflect on what was going well, what was not going well, and to plan what could be done differently.

These changes were tested and improvements made during a series of learning cycles, shaping and embedding reliable ACP processes.

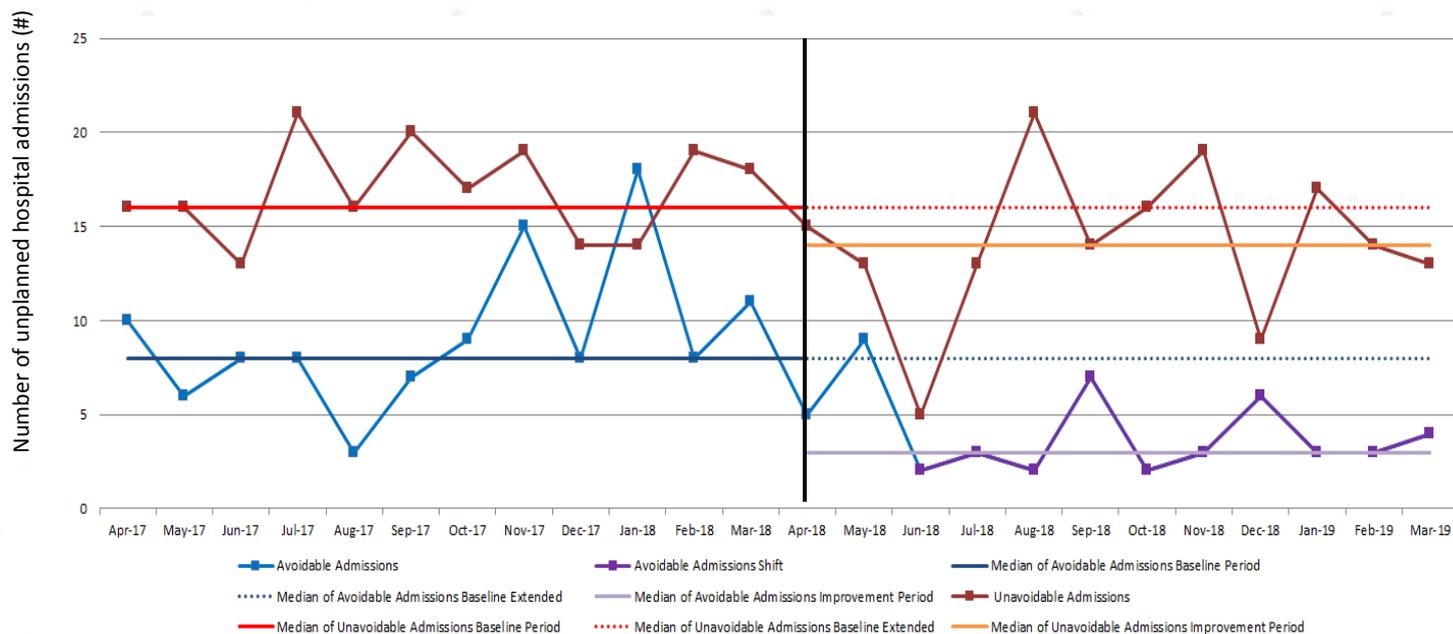


Impact

By embedding reliable ACP processes, 183 ACP-KISs have been created for residents who did not have one in place, and 276 ACP-KISs have been reviewed and updated. A blended approach of facilitating reflective learning and informing improvement discussions with locally owned real-time data enabled care home teams and GPs to test and implement ACP improvements.

Care home teams and GPs significantly improved personal and clinical outcomes for care homes residents through implementing and continuously improving the *7 steps to ACP* toolkit.

Unplanned hospital admissions from Phase 3 Care Homes: Comparison of Baseline (Apr 2017 to Mar 2018) and Improvement Period (Apr 2018 to Mar 2019)



When comparing the baseline period (Apr 2017-Mar 2018) with the improvement period (Apr 2018-Mar 2019), the care homes and GP practices achieved:

- 31% reduction of unplanned admissions to hospital
- 56% reduction of avoidable admissions to hospital.

The approach has been shown to reduce hospital inpatient activity costs. The observed total cost saving in NHS Lothian was £325,557. The savings represent a more efficient use of resources, and while they are not cash releasing, they also lead to a greater likelihood that appropriate care is provided in appropriate settings.

Feedback from improvement programme participants

"It's a very good process and I think this kind of support should be there for all care homes all the time because care is always evolving: care home staff are supported, GPs are involved, we will continue to see positive results." **Care Home Manager**

"7 steps to ACP is a good guide for the staff - where to start, how to approach family - staff are happy with this in place. Everyone in my unit has got an ACP now." **Care Home Manager**

"Thank you for all your hard work with this. We are totally committed to working together for Realistic Conversations, shared decisions about care with patients, family and care home staff and sharing this with all those clinicians who might be involved to ensure high quality appropriate care in accordance with patient wishes." **GP**

"ACP enables professionals to have a framework to work with, it also empowers nurses to lead in the front we are working in collaboration now very much so." **Care Home Manager**

"ACP principles now feel part of the culture of the care home. Communication with our practice has been excellent and the anticipatory questionnaires for families have greatly improved ACP quality." **GP**

"I find that staff are initially shocked that someone might not want to go into hospital for treatment and might want to be kept comfortable in the care home. It's been really important in providing us with confidence to speak about what people's wishes are if they become really unwell." **Care home ACP champion**

"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." **Care Home Manager**

Lessons learned

Delivering ACP training and developing a tailored toolkit has enabled ACP improvements to be scaled across Edinburgh, resulting in positive outcomes for residents.

The training provided helped the care home staff, both nurses and social care workers, become confident in managing conversations on future care and treatment wishes for residents and relatives. Reflective learning helped to embed improvements by resolving any process issues and by highlighting clear examples of positive clinical outcomes.

This programme has demonstrated that care home staff and GP practices will embrace ACP with enthusiasm and commitment when given support to do so. This results in significant improvements in appropriate care for their residents.

Next steps

The ACP team has started using some of the learning from improving ACP with care homes to raise awareness of the benefits of ACP with unpaid carers. Working with Voices of Carers Across Lothian (VOCAL) and the Edinburgh Carer Support Team they are testing ways of creating ACP-KISs both for carers and the people they care for.

The ACP team is working with colleagues across Edinburgh's integrated health and social care system, supporting teams to take a structured approach to improving ACP for people with complex health and support needs who live at home.

The ACP team will continue to work collaboratively to:

- develop a care home ACP improvement and support package to sustain improvements and test a scalable care home ACP improvement model
- carry out an economic evaluation to help understand the cost saving of dramatically reducing avoidable admissions for care home residents, and how the allocation of ACP resources could achieve the greatest benefit
- work in partnership with health and social care and voluntary teams to improve ACP for people living with long term conditions at home
- work towards individuals having current copies of their ACP-KIS at home to inform shared decisions about their care and treatment
- engage with citizens to understand the level of ACP awareness and utilisation among the general public, and co-produce resources to empower people to make the best use of ACPs when making informed choices about their care and support.

Find out more

You can access the ACP improvement programme learning report and other programme resources on the ihub website at <https://ihub.scot/improvement-programmes/living-well-in-communities/anticipatory-care-planning/edinburgh-health-and-social-care-partnership-acp-resources/>