Anticipatory care planning improvements: celebrating success and sharing learning in Edinburgh

Post Event Report
June 2019

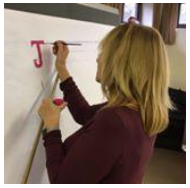
Long Term Conditions Programme

Edinburgh Health & Social Care Partnership

Contents

A graphic illustration of discussions and key themes from the event.

Created by: Jackie Forbes, Principal, [Drawn to Learn]



1. Background

In 2018 the Long Term Conditions Programme in collaboration with Voices of Carers Across Lothian (VOCAL) secured funding from The Improvement Hub (ihub), to deliver the third phase of the Anticipatory Care Planning (ACP) improvement programme. Building on the success of two preceding improvement phases:

- **phase one** tested a structured approach to support four care homes in North East Edinburgh and their aligned GP practices testing ACP questions around specific scenarios to support meaningful ACP discussions and designing a pathway to share key ACP information

- **phase two** refined the approach to structuring ACP discussions and implementing/continuously improving the ACP pathway with a further six care homes and aligned GP practices in North West, South East and South West Edinburgh localities.

Phase three aimed to spread learning and scale improvements to a further 18 care homes[1] and aligned GP practices across all four Edinburgh Health and Social Care Partnership's (EHSCP) localities. Adopting a Quality Improvement approach to test, reflect and improve on the care home ACP model.

Phase 3 improvement aims:

Improvement aim 1: Embed ACP and design reliable processes in 18 care homes in Edinburgh by March 2019

Improvement aim 2: To reduce the number of avoidable admissions by 10% within 18 care homes in Edinburgh by March 2019

Learning from improving ACP with care homes enabled joint working with community and acute services and third sector partners, informing tests of change to support people living with a long term condition in Edinburgh and with carers.

To celebrate progress and share approaches to improving ACP a collaborative learning event was held 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 at the Hibernian Football Club.

[1] Due to the level of interest generated 20 care homes participated in the ACP Care Home improvement project

2. Aims of event

- Share the Long Term Conditions Programme and partners' activities designed to improve Anticipatory Care Planning across Edinburgh City
- Recognise the involvement and achievements of the Phase 3 care home teams and ACP Champions
- Share ACP Improvements underway across community and acute services
- Highlight why ACP matters from a national, out of hours, acute hospital, GP practices and EHSCP locality perspective
- Explore mechanisms that can support new and ongoing ACP improvements
- Begin to scope a fourth phase of the Long Term Conditions ACP improvement programme.

2.1 Presentations and video clips

We are pleased to be able to share copies of the presentations and video clips shown on the day, an outline of the latter are detailed below. Copies are available on the ihub's Living Well in Communities website: EHSCP ACP resources.

- 7 steps to ACP for care home Staff – The Improvement Approach: introduction by 3 care home staff members
- Anticipatory Care Planning: Power of Attorney, Elaine Hogan
- Anticipatory Care Planning: the value of Anticipatory Care Planning in care homes, Dr Andrew Mackay (ACP GP lead, EHSCP)

In addition the following video clips were available at the event's ACP information stall, illustrating an ACP conversation between a carer and their GP about what matters to them and the person they care for should they become unwell.

- Anticipatory Care Planning: for (unpaid) carers
- Anticipatory Care Planning: for person receiving care

2.2 What is 'Let's Think Ahead - 7steps to ACP in Care Homes'

'Let's think ahead – 7 steps to ACP for Care Home Staff' toolkit was developed by the Long Term Conditions Programme within EHSCP. Developed during the 3 years of the ACP improvement programme the toolkit includes guidance and documentation to support:

- having a conversation about ACP with residents/carers/family members as early as possible
- documenting and sharing preferences and wishes regarding treatment and care discussed
- making use of the documents to support decision making in response to an acute deterioration

- care home staff following a consistent and reliable ACP pathway to access, act on, and review ACP information

The 'ACP Improvement Programme Learning Report Phase 3: 2018-2019' provides a more detailed description of the approach and outcomes.

7-Steps to Anticipatory Care Planning for Care Home Staff: Toolkit

Step 1
- **Give** 'Lets Think Ahead' leaflet to care home resident / family / carers / close friend

Step 2
- **Read** document 1: Talking about Anticipatory Care Planning in a Care Home

Step 3
- **Complete** document 2: Nursing / Care home patient registration form

Step 4
- **Complete** document 3: Anticipatory Care Planning Questions: information for Care Home Residents OR
- **Complete** document 4: Anticipatory Care Planning Questions: information for relatives and close friends

Step 5
- **Make and file** a copy of documents 3 OR 4 and document 2 in your residents care plan

Step 6
- **Give the original** of document 3 OR 4 to the GP with a completed document 2

Step 7
- **File** DNACPR and the Key Information Summary report when returned from the GP

3. Morning Session: Care Home Improvements

Chaired by Amanda Fox, Programme Manager, Long Term Conditions Programme, the morning session's key note speaker was Dr Carey Lunan, Chair of the Royal College of General Practitioners (RCGP). Dr Lunan presented on the role of ACP in future NHS sustainability. Following this Dr Andrew Mackay, ACP GP advisor, gave a GP's perspective of working with care homes to improve ACP.

3.1 '7 Steps to ACP for care home staff' – the improvement approach

To explain how care homes took forward ACP improvements a short video clip was played. The representatives from the Phase 3 care homes: Stephen Colquhoun - Manager from Letham Park, Emma Irvine - Team Leader from Drumbrae Care Home and Margaret Stewart - Manager from Marian House described their involvement in the programme and the improvement approach.

Letham Park

Drumbrae Care Home

Marian House

ACP in Care Homes — The Improvement Approach

- Sign up to the ACP improvement programme at information event
- GP + Care Home + ACP Facilitator meet to sign Tri-party (partnership) agreement
- Staff undertake Level 2 Training: 7-steps to ACP in Care Homes
- Recruit Care Home ACP Champions
- Care home implements 7-steps process and pathway
- ACP support and reflective learning to address and support ongoing improvements

(See footnote[2] for more information on the Level 2 Training)

The talking heads video included the following accounts:

> The main driver for me was to get anticipatory care questions started earlier when people come in.

> It wasn't just care staff it was nurses, it was our domestics, everybody is involved in ACP it's not just the frontline staff. For me it was important to get all my staff involved.

> ...on the whole the training has been certainly valued...our ACP champions are basically our ambassadors and pioneers through the home...for new employees coming on board right away we are incorporating this into our induction plan...

[2] The Level 2 Training: 7-steps to ACP in Care Homes is skilled level training developed by the ACP team. The tailored training targets practitioners who regularly provide care and support. The training was delivered during the Phase 3 ACP improvement project alongside the 7-steps to ACP for care home staff toolkit and covers the Care Home-GP pathway.

We identified 4 champions 2 for each floor and myself coordinating and my deputy. So we had 6 people involved, carers wanted to become involved and be part of the process of where we are going.

…I've really enjoyed leading the team…I think the management and manager needs to embrace this as well...I can't expect the team to embrace it if I am not pioneering it

...ACP team support phoning to find out how we are getting on, if we have had any hospital admissions that week, if there have been avoidable hospital admissions, if we have had to use the KIS documentation during the process of that admission...

...people might have their own ideas and [want to] be in control of what happens when they become unwell…It's our job to follow that through

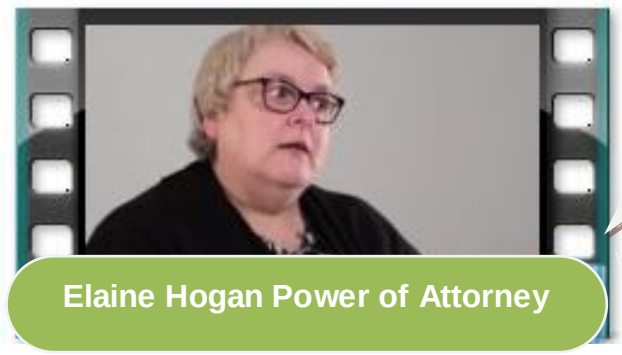
…if you want to enhance your practice you really have to buy into the process…we are supporting person-centred care…this supports us from the very beginning…the person is in the centre and they are telling us want they want and we are there to facilitate that.

3.2 Supporting ACP care home champions - the ECHO network

Hilary Gardner a Community Nurse Specialist and Care Home Support ECHO Lead at St Columbus Hospice (Edinburgh) spoke about the 'Virtual' ECHO network allowing ACP care home Champions an opportunity to share, learn and reflect and hear from expert speakers on key topics of interest. Alison Scobie an ACP Champion from the phase 2 care home Morlich House then spoke about her own experiences as a member of the network.

3.3 What matters: ACP perspective from a power of attorney

Elaine Hogan became Lead Power of Attorney (POA) to an elderly lady with mental illness and no family to support her. Elaine was tasked with finding a place for this person in a care home. Once settled in the care home, staff gave Elaine forms to complete on behalf of the residents on ACP for end of life care. Decisions around DNACPR made by a doctor during a previous hospital admission made agreeing the preferences and wishes on the resident's behalf much easier.



Elaine Hogan Power of Attorney

... it actually threw me a little bit...if you are doing this for a family member you probably have an idea of their wishes. Sadly for this lady I didn't...

...because the DNAR was there I felt it relieved me. I was then able to fill in the forms, I hope appropriately, I'll never be sure that I am, but I have to trust that I am doing the best I can...

3.4 Care home experiences implementing and improving their ACP process

Ten of our 20 Phase 3 care home ACP Champions/Managers shared their experiences of implementing the ACP 7-steps providing reflective, insightful and empowering accounts.

- **'A Good Death'** experience for ACP was described by Mira Alba, Deputy Manager for Colinton Care Home. A resident was kept comfortable and was

able to die peacefully in the care home according to their documented preferred place of care and death

- During implementation of 7-Steps to ACP for care home Staff, Emma Irvine Team leader and ACP Champion spoke about Drumbrae Care Home **'Overcoming challenges'** during the implementation of 7-steps. While these challenges impacted on progress and completion of the ACP process, the care home was able to get staff involvement to ensure pathways and processes were set up

- Esther Bathgate, Care Home Manager, shared that residents from the Neurological Centre at Gilmerton Care Home, tend to be younger on admission, live with a neurological condition requiring continued monitoring, and/or can be a resident in a care home for much longer than residents in the care home. Together these give sufficient rationale for **'Why ACP is important',** particularly for both the resident and staff in the treatment and management of care.

- Nafisa Hussein, ACP Champion of Lennox House shared her experiences and how **'The magic of ACP discussions'** can often provide opportunities in bringing families together to discuss a resident's care and treatment should they become unwell or deteriorate. They can also support family members coming to an agreement on what that care and treatment should be and where it should happen.

- **'Change is Good'** were the views from Lisa Hutchinson, Unit Manager for Letham Park, when describing the organisational shift within the care home as

a result of implementing 7-Steps to ACP. Where once only trained staff could discuss and complete documentation on ACP, the care home took the approach of ensuring all staff received ACP training increasing their capacity for team working

- The **'ACP Journey'** as shared by Felisa Aguado, ACP Champion from Marian House, allowed staff at the care home to learn, share reflect and grow confident together

- Margaret Stewart, Manager, Marian House, shared the experiences of implementing **'ACP from a Managers Perspective',** acknowledging how the process has helped to build a team within the care home who are much more confident and empowered in discussing ACP with carers and families and making decisions upon escalation of care

- Helen Somerville, an ACP Champion, talked about how having **'Good shared decision making on avoiding unplanned admissions'** allowed Queens Bay Lodge to look at alternative approaches to managing the treatment and care of residents. Using the Hospital@Home Service has widened the options for preferred place of care helping to reduce the number of avoidable / unplanned hospital admissions which at the same time supports the care home in ensuring that the needs and wishes of a resident are met.

3.5 Panel Discussion

To round off the morning session Dr Andrew Mackay chaired a panel made up of Phase 3 GP Practice Team members and Care Home Managers from across Edinburgh City. The panel was asked a series of questions to get a sense of the practicalities of implementing ACP across care homes and GP practice systems.

Panel members: (from L-R) Julie Crichton – Administrator, Grange Medical Practice; Marion Mikkelsen – Practice Manager, Bangholm Medical Practice; Stephen Colquhoun - Manager at Letham Park Care Home; Dr Andrew Mackay – GP, St. Triduanas Medical Practice; Dr Marjie Hornstra – GP, Craiglockhart Medical Group and Margaret Stewart – Manager, Marion House Care Home

How easy was it to integrate the 7-steps into your practice?

The panel members were all very positive about the implementation of the 7-steps process. The support offered to the care home by the ACP team was a key factor in this. Everyone knows what an ACP is through the training which has meant that integrating the 7-steps has been an easy process on the whole.

Are GP admin teams processing some or all of the forms? How easy has it been to put that in place?

Conversion rates of forms processed by the GP teams varied but it is intended that all ACP-KIS forms are processed. Any delays or backlog were due to some practices not having admin support and so uploading of Key Information Summaries (KIS) would be delayed until the GP returned. Admin processes worked smoothest at the practice and were implemented with the least fuss if this was led by the admin team rather than GPs.

How do you feel the programme has impacted on patient care?

Overall patient care has improved as a result. More ACP conversations are happening in a structured way ensuring care home residents' needs and wishes are documented to allow staff to act on those instructions should a resident become unwell.

How has the 7-steps impacted on your workload?

While panel members have seen an increase in the administration of documents shared to upload information onto KISs for residents, the ACP improvement was seen as an important and valued process. In GPs practices where the admin teams were leading the uploading of KIS information there had been a decrease in their workload associated with generating high quality ACPs.

> If it is an admin task [KIS update, request for hard copies etc.] that needs to be done, please don't ask the GPs to do it. Our team [Practice admin staff] does it much better!

Reinforcing the vital role GP Practice Administrators can play in uploading KIS update requests.

Has 7-steps resulted in unforeseen challenges or benefits?

The success of this programme has shone a light on the need to improve parity of ACP-KIS discussions and information sharing for individuals living at home.

> Community ACP doesn't get as good a deal as it does in care homes as the ACP emphasis is not enough. Care home staff can engage more easily

Other challenges pointed out during the discussion were that in some cases larger care homes have more than one GP practice serving their residents. It was much harder to achieve a consistent approach in the documentation and communication of sharable information through ACP-KIS when there are several practices involved. The existing Care Home GP Enhanced Service already encourages a single caring practice model for this and several other reasons. One GP practice with responsibility for all a care home's residents had achieved 100% compliance / completion rate of ACP-KIS for residents.

Has your team working enhanced through working on the programme?

The panel talked about trust and relationships being strengthened between care home residents, the practice, care home staff and family/carers as a result of working on the improvement programme. The panel shared how the reflective learning introduced by the programme has encouraged the team to continue this approach as it offers a safe and supported space to share experiences and incorporate learning from these sessions to inform how they might approach a similar event in the future.

Dr Hornstra added her views shared by many at the event on where ACP needs to spread next and how practices themselves can start to bring parity of ACP-KIS conversations and documentation for all practice patients.

"…there is an impact on patient care – community [services] operates a system around ACP but there is a lack of continuity; there isn't the same structure, and there are different GPs involved so I would be keen to cascade the care home ACP approach across the practice for all patients."

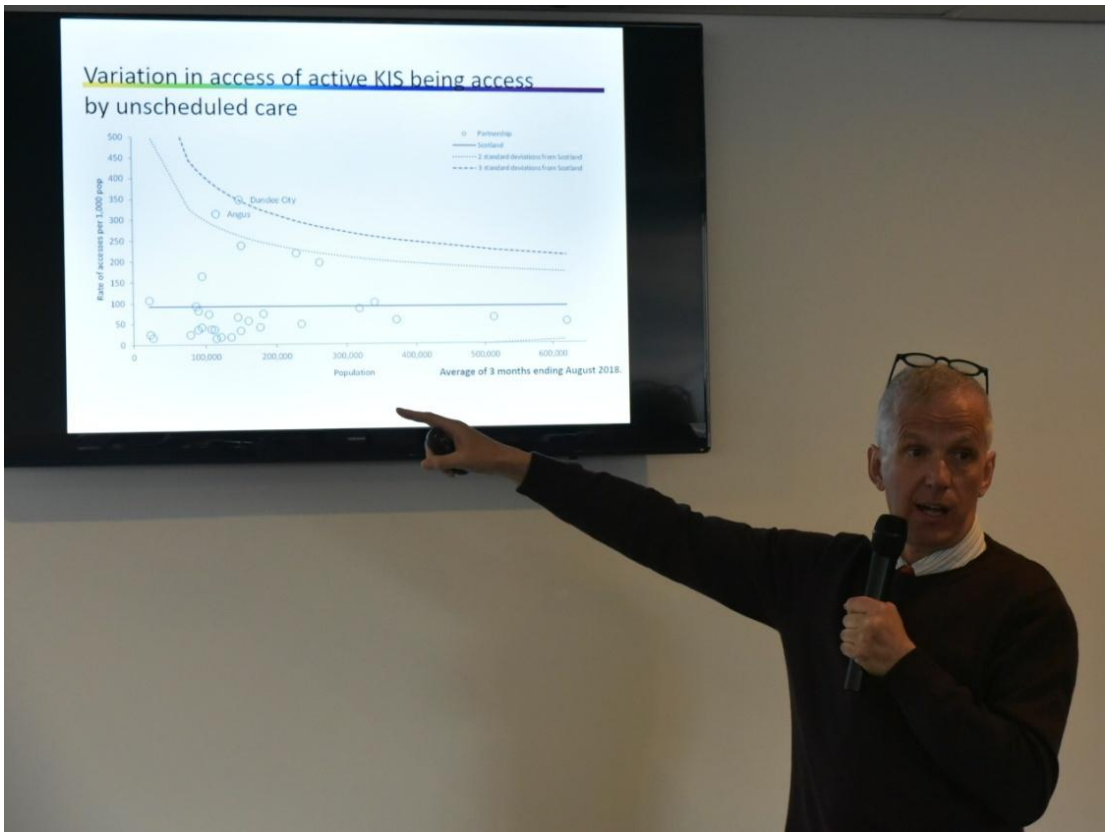
Concluding the morning session the ACP team presented the ACP champions from phase 3 care homes with certificates of achievement in recognition of their outstanding accomplishment and contributions towards ACP improvements in care homes.

4. Afternoon Session: Integrated Services ACP Improvements

Following on from the morning session the afternoon shifted discussions to talk about improving ACP through joint work with community, acute hospital services and third sector partners to support people living with long term conditions.

Introduced by Amanda Fox, the session opened with Tim Warren, the Policy Lead for Palliative and End of Life Care, Scottish Government, setting the context for ACP

improvements for integrated service presenting 'What matters...ACP in the national context'.



4.1 What Matters: a carer's ACP perspective

Mrs Lily Wan, an unpaid carer, was warmly invited to share in conversation with Carrie Ho, ACP facilitator, how discussing ACP with her GP has helped in her carer role for her husband. Having an ACP in place for them both is important as it provides reassurance that health and care professionals they come in contact with know and understand their health and care needs.

"People know our health; I feel safe and no worry..."

From the GP's perspective it was understood by Lily that they found the Carers ACP forms[3] useful and very easy to understand.

[3] The ACP Carers form, designed during the carers' test of change, supports the creation of an ACP for carers and persons receiving care during power of attorney surgeries. This support is delivered through partnership working with VOCAL. Following the POA surgery the carer makes an appointment with their GP to discuss the completed form and gives consent for their health and care needs to be shared with emergency care services e.g. NHS24, ambulance control, out of hours GP services and the hospitals.

"...very easy, very good, useful, she [GP] appreciates the form is good, no need for interpreter for me!

Three further presentations followed from:

- Dr Lisa Carter, Associate Clinical Director, Lothian Unscheduled Care Service, NHS Lothian Primary Care Lead, Quality and Safety discussing 'What matters - ACP from the Perspective of Out of Hours Services'
- Dr Sarah Keir, Consultant Physician and Honorary Senior Clinical Lecturer: Medicine of the Elderly and Stroke Medicine sharing 'What Matters - ACP from the Perspective of Acute Hospital Settings'
- Angela Lindsay, Health and Social Care Locality Manager, North East Edinburgh providing an overview of 'What Matters - ACP from a Health and Social Care Locality Perspective'

Copies of the afternoon presentations are available on the ihub's Living Well in Communities website: EHSCP ACP resources.

4.2 Parallel Session

During the parallel session delegates/discussions were split into two.

The World Café enabled delegates to learn and discuss ACP Improvements happening across community, acute hospital and third sector services.

Running alongside the World Café, a facilitated round-table discussion brought together delegates involved in the Phase 3 care home improvement work to think about and share their views on what they would like to see happening to support and sustain continued ACP improvements in the care homes.

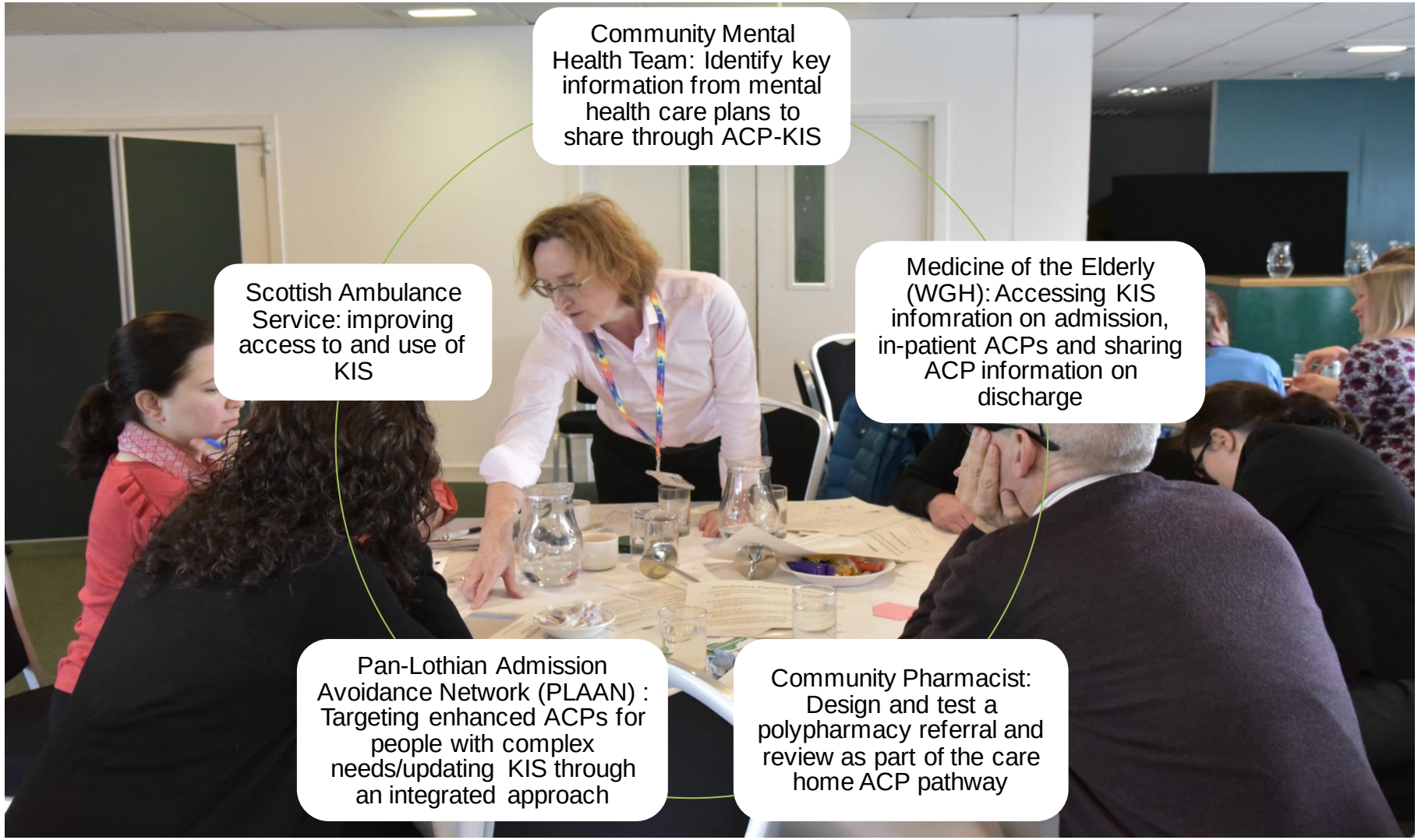
4.2.1 World Café

The aim of the world café was to share different approaches and stages of improving ACP from a variety of teams working across Edinburgh. Experiences were succinct to allow time for participants to discuss ideas and note down emerging thoughts/themes. The purpose was to motivate and encourage everyone to think about why ACP is important and what their role is in designing/testing/improving ACP pathways across Edinburgh's integrated system.

Delegates were invited to visit either the blue of red café.

Blue café table hosts

Red café table hosts



Participants were asked if there were any commonalities in ACP Improvement approaches, and if there are any solutions / enablers that can be developed together. The following common themes emerged from the discussions.

IT Systems

- Different services operate different systems making it difficult for information to be easily transferred between teams
- ACP-KIS being accessible across some systems can be an enabler and needs to utilised, especially for emergency and out of hour's contacts. There is, however, a real need for a digital platform to share important ACP information across all health and social care teams
- Current system 'glitches' (i.e. blank KISs, or KISs going missing when a patient registers with a different GP practice) were voiced as frustrations and recurring disablers to driving forward ACP improvements.

Using / Accessing / updating ACP-KIS

- Practical issues shared relating to who can create, access and update KISs
- There are limitations as to who can update KISs when outwith the GP practice. This is a shared challenge for District Nurses not attached to a GP practice
- Learning from the care home ACP improvement programme shows that care homes providing ambulance service with a hard copy of ACP-KIS on arrival has been invaluable in supporting decisions made on any hospital admission or A&E attendance
- Current systems don't allow all practitioners to update or access KIS, but improvements shared offer ways of allowing information sharing from multidisciplinary teams e.g.:

    - ACP-KIS being routinely accessed and reviewed during multidisciplinary/cross sector team meetings (e.g. multiagency triage team meetings)
    - the KIS compatible word doc being adapted by teams to share key ACP information in a format that is easy for GP practices to transfer to ACP-KIS
    - hard copy KISs printed for individual's to keep at home (e.g. in unpaid carer information packs, care@home care plans) as part of a pathway that considers when the information should be reviewed, and updated copies provided.

Everyone needs to be able to update ACP-KIS!

- For patients who have annual medication reviews this is a good trigger to have or refresh the ACP discussion and update ACP-KIS.

- Spread learning from acute care teams who have ACP discussions during inpatient stay and provide important ACP information in discharge letters to update ACP-KIS.

Shareable information (ACP-KIS)

- Individuals with complex health needs can have large care plans/case notes which can often mean the biggest challenge is about identifying information that would be most useful in a crisis
- Agreeing and testing 'KIS special note criteria' within teams would be an improvement all delegates could test.

Initiating the ACP conversation

Many of the comments focussed on ACP conversations such as what could prompt an ACP discussion, who could initiate those conversations and how early they could start? Early conversations were felt to be more valuable than a conversation during deterioration of health or at the point of crisis.

- Change of culture/support needed for those who find it difficult to discuss end of life, palliative care
- Help needed to support initiation of conversations much earlier, particularly difficult conversations relating to end of life care and wishes regarding resuscitation
- Starting discussions earlier with a broader emphasis on care provision when a person is well/stable. Having that first ACP conversation at a point of crisis is much harder and traumatic for family and relatives than when a person is well
- Can ACP discussions become embedded in hospital discharge planning?
- Understanding that ACP conversations are much more than planning for the care of someone reaching the end of life
- Patients with complex needs may require more frequent and longer ACP conversations – it's not just a one-off conversation it's an on-going ACP dialogue
- Learning from the Pan-Lothian Admission Avoidance Network (PLAAN) ACP test of change demonstrates how much patients with complex health needs value ACP and how it can improve relationships between patients and the different practitioners providing care and support.

Championing ACP

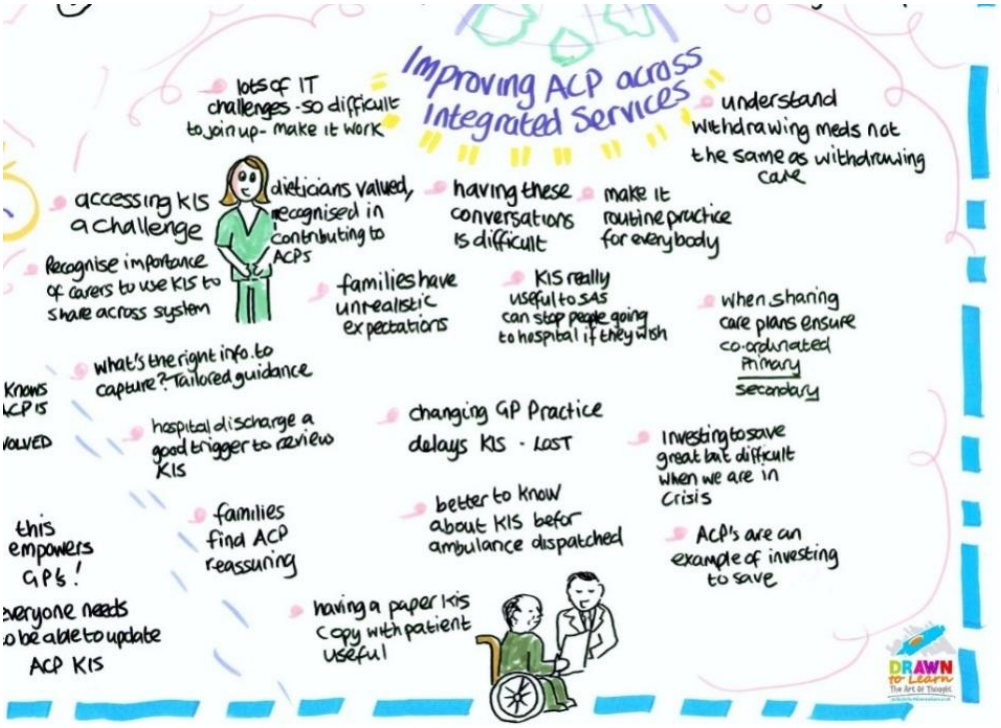
- There is still a need to raise awareness of the value of ACP-KIS with members of the public
- Empowering people to:
    - ask "do I have an ACP-KIS?"
    - consider their care and treatment options, wishes and preferences
    - have the confidence to share their ACP-KIS with health and social care and voluntary teams
    - remember to say "I have a KIS" when calling 999

- Encourage people to consider ACP as part of retirement planning
- It should be everyone's business to support ACP conversations. What can I do in my role? What ACP improvements can my team make?
- Can we expand the care home ACP champion network to include ACP champions from across health and social care and voluntary teams? Can we support the development of ACP champions across the integrated service?

Sharing learning and scaling improvements from the care home ACP improvement programme

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 was 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), discussions included:

- ensuring EHSCP teams don't take forward ACP improvements in silos, ACP pathways have to work across all teams that provide treatment, care and support
- given that KIS software limits the creating/updating of ACP-KIS to those that have access to GP practice systems, who else in the wider/GP practice team could access and update KIS – community nurses, physiotherapists, pharmacists, community psychiatric nurses, specialist nurses (e.g. diabetes/palliative), others?
- as the GP practice teams continue to develop through Primary Care Transformation, can ACP-KIS be improved and supported through new ways of working? For example:
    - supporting mental health services in primary care
    - pharmacists working as part of GP practice teams to support people with long term conditions
    - development of out of hours services
    - increase, and development of digital services
- working with Scottish Ambulance Service and NHS 24 when developing local ACP pathways will raise awareness of challenges and help to create solutions
- giving teams permission to 'invest to save'; to take time to test ACP improvements and reflect on what they find is important, improvement support (as provided to care homes) would be welcomed.



4.2.2 Care Home Discussion

For this discussion delegates were asked to share:

- What plans they have in place and what they are planning to do locally with ACP work in the care home?
- What support would they like to facilitate this?
- What suggestions or advice would you give to other care homes planning to implement the 7-Steps?

Local plans for ACP in Care Homes

Delegates during this discussion shared their plans to continue to discuss ACP using opportunities such as a hospital admission, acute deterioration or annual/six-monthly reviews to discuss a residents ACP. To highlight the importance of ACP conversations:

- care homes are choosing to incorporate ACP as part of induction for new employees. This will support care workers to have the confidence to start ACP discussions with residents, families, carers and POA
- a continuation of staff training, recruitment of ACP champions
- the use of ACP documentation within care homes, were identified as improvements care homes wanted to see fully embedded into their practice.

Support to facilitate / sustain practice

The ACP team provided a range of improvement support to the 20 care homes that participated in phase 3 of the ACP improvement programme. During discussions, care home teams were able to share, discuss and reflect on the benefits of using '7 steps' to improve ACP.

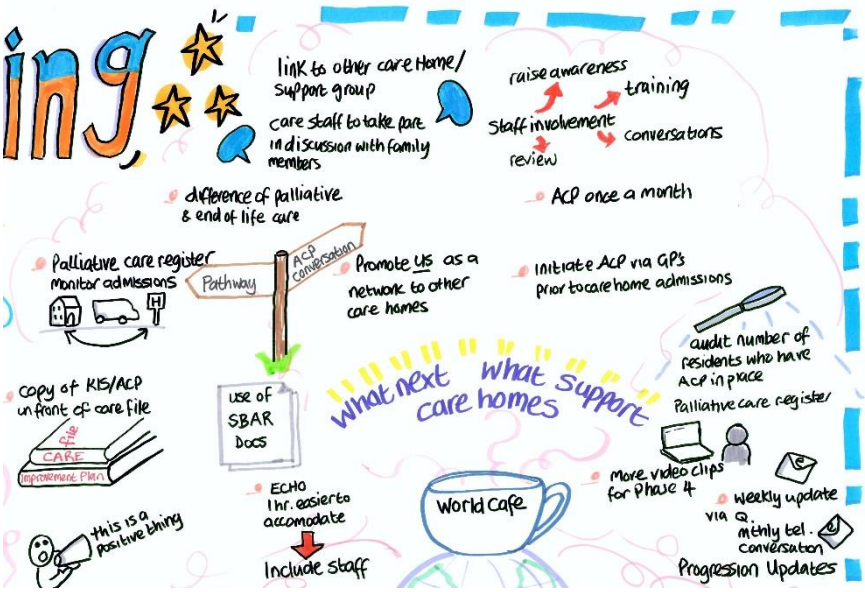
Three main themes stood out from the discussions:

- Opportunities to continue shared learning with other care homes through the ECHO network
- Ongoing delivery of ACP training
- Expert input from the ACP team for reflective learning.

Advice to other care homes

Through experiences gained from their involvement in the programme, delegates had plenty of advice for other care homes (applicable in many cases to practitioners supporting people living at home) wishing to put in place a reliable ACP process and pathway.

- Conduct an audit or review baseline data to determine how many ACP-KISs are in place before starting to use the '7-steps'.
- Monitor hospital admissions and discharges, ask if the ACP process was followed, review if admissions could be avoided
- Provide opportunities for care staff to take part in ACP discussions with relatives and families
- Getting involved in the ACP improvement programme allows care homes to demonstrate their quality improvement work providing evidence during inspections against the six quality indicators outlined in the Care Inspectorate's 'Quality framework for care homes for older people'[4]
- Ensure copies of ACP-KIS are kept at the front of residents care plan
- Promote phase 3 care homes as a network of peers/champions to other care homes
- Encourage regular local clinical / ACP champion meetings and reflective practice.



[4] The Care Inspectorate. 'A quality framework for care homes for older people'. (July 2018). Accessed online. http://www.careinspectorate.com/images/Professionals/Quality_framework_for_care_homes_for_older_people_2018.pdf

5. Summary

Throughout the day delegates were encouraged to use the comment wall to share their thoughts and visions for future ACP improvements and sustainability, outlining 'what they would like to improve' and 'how we can work together'.

There was a sense of frustration regarding existing health and social care IT systems. Systems currently don't talk to one another in a way practitioners would like; information isn't always updated on KIS in a way that is meaningful or adds value for services responding to an emergency nor were ACP-KISs seen as being accessible enough (at key points) for creating or updating ACP-KIS, as that responsibility sat with GP practices.

Examples of improvements showcased at the event demonstrate the range of approaches being taken forward to work-around and circumnavigate some of the challenges raised. These included having ACP discussions at different points during a patient's care pathway; facilitating KIS update requests through emailed word compatible documents to GP practices; reviewing the quality of ACP-KIS and discussing these with GP practices; recommending a copy of an individual's ACP-KIS is kept at home; and encouraging all practitioners to think to access ACP-KIS to support shared decision making.

Key themes

How best to sustain current ACP improvements in care homes:

- engaging others to spread the approach
- ensure new staff and GPs are trained
- in 2018 the Care inspectorate rolled out a new quality framework for inspecting the quality of care and support, to help support improved services for people experiencing care. Buy-in to the ACP process as it allows care homes to demonstrate and evidence their quality improvements
- continue the collaboration with the ECHO network as care home staff valued the support they received and have the opportunity for continued reflective learning
- single GP leads attached to all care homes.

Finding the right time to engage people in ACP conversations:

- involving other practitioners and services in ACP conversations e.g. community psychiatric nurse/specialist nurses/physiotherapists/home care teams/carer support teams etc. could start or refresh conversations
- starting ACP conversations sooner (perhaps at point of diagnosis)

Roll out and engagement beyond care homes:

- people engaged with services such as Home Care and Care@Home should have good quality ACPs
- expand ACP approach to care home providers and spread learning to other health and social care partnerships across Lothian
- enable council employees and unpaid carers to access ACP-KIS.

Funding for the third phase of the ACP improvement programme has come to an end, however it is clear from the event's conversations that ACP improvements are: valued by practitioners and care home staff; should be continued; and rolled out more widely for people living in their own home. Delegates wanted to see in particular:

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

Many of these views are shared by the ACP team and ACP Stakeholder Group members and are currently considering all the valuable contributions from the event. Please refer to the ACP Improvement Programme Learning Report, Phase 3: 2018-19, for a detailed review of progress to date as well as recommendations for continued integrated ACP improvements.

6. Contributors

On a final note the ACP Team would like to recognise everyone who contributed to the programme and making it a success.

We'd like to thank the speakers for their motivating and empowering presentations serving to set the scene and context for why ACP matters in the various health and social care settings.

We want to thank the care home teams and world café hosts and facilitators for sharing accounts of their personal ACP improvement developments, innovations and journey as well as Jackie Forbes of Drawn to Learn for capturing conversations so brilliantly in her illustrations.

Lastly we'd like to extend a thank you to all the delegates and stallholders travelling from localities across Edinburgh and further afield for all of your contributions and your engagement in discussions throughout the day, adding to its overall success.

7. Event Evaluation

Fifty one evaluation forms were returned following the event, examples of feedback include:

A good way of being able to bring ACP into general conversation with the MDT Team

Helpful to receive updates, and to consider how clinical networks can support...encourage completion of KIS/ACP for those with Long Term Conditions.

Great snappy speakers, a consistent message. Plenty of time for questions.
(Callum Johnston, SAS)

Everything went well. I liked and learned more from all presenters. Gained confidence to continue with ACP and to ensure I play my part being involved in ACP reviews to keep ACP updated and KISs
(Susan Dube, ACP Champion)

Really enjoyed presentations by Andrew Mackay = video (excellent) = Tim Warren. The networking was excellent especially meeting folk from the borders."

Reinvigorated my appreciation of the benefits of KIS.
(Mat Stephenson, SAS)

Exceptionally well planned, great success very informative
(Marie MacCallum)

Enjoyed the world cafe very much

Very informative

This is the best event that I have attended in the last 2 years

Delegates also shared in their feedback on the various things they would go back and share with colleagues/clients/friends/family about what they learnt or heard about from the event:

- work already underway to reduce hospital admission from care homes
- the importance of ACP for everyone and for ACP to become a routine recommendation for everybody
- suggestions of improvements their own team can start to take forward

8. More information

You can find out more about ACP improvements across EHSCP on the EHSCP ACP resources section of the ihub website.

You can get in touch with the EHSCP ACP team:
✉: AnticipatoryCarePlanning@nhslothian.scot.nhs.uk

💻:
http://intranet.lothian.scot.nhs.uk/Directory/AnticipatoryCarePlan/Pages/default.aspx

✎: Read our blog on ACP in care homes published on 9 April 2019
https://livingwellincommunities.com/2019/04/09/acp-in-care-homes/

Find out more about the Care Home Pilot ECHO network:
https://www.hospiceuk.org/what-we-offer/clinical-and-care-support/project-echo/project-echo-knowledge-networks/care-homes-pilot-echo
Email: echo@hospiceuk.org

Appendices

Appendix 1: Event Programme

CELEBRATING SUCCESS - ANTICIPATORY CARE PLANNING (ACP) EVENT

Wednesday 06 March 2019, 9:45 to 15:30

Edinburgh Suite, Hibernian Football Club

Easter Road Stadium, 12 Albion Place, Edinburgh, EH7 5QG

9:45 to 10:10 Refreshments and registration on arrival
10:10 **Welcome & introductions** Amanda Fox, Long Term Conditions Programme Manager
The role of ACP in future NHS sustainability: a perspective from the RCGP Dr Carey Lunan, Chair Royal College of General Practitioners (Scotland)
10:30 to 10:55 Improving Anticipatory Care Planning in Care Homes
ACP in Care Homes: perspective from GP ACP Advisor Dr Andrew Mackay, St Triduana's Medical Practice **7-steps to ACP for Care Home staff – the improvement approach** Video clip from Phase 3 Care Home Managers **Supporting ACP Care Home champions through the ECHO network** Hilary Gardner, St Columba's Hospice & Alison Scobie, Morlich House
10:55 to 11:10 Comfort Break & Refreshments
11:10 to 12:45 Sharing stories of the 7-steps implementation
What matters to me – perspective from a care home resident's Power of Attorney Short film clip with Elaine Hogan
Care Homes experience of implementing and improving ACP Phase 3 ACP Care Home Champions & Managers
12:15 Panel Discussion Chaired by Dr Andrew Mackay Medical Practice – GP, Practice Managers & Administrator; Care Homes – Managers & ACP Champions
ACP champion and Care Home certificate of achievement presentation ACP Care Home Champions & Managers

Long Term Conditions Programme

Canaan Park, Astley Ainslie Hospital
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12:45 to **13:30** Lunch and networking
13:30 to 14:05 Improving Anticipatory Care Planning across the integrated service
ACP in the national context – what matters? Tim Warren, Policy Lead for Palliative and End of Life Care, Scottish Government
ACP – what matters to carers Mrs Lily Wan
ACP Improvements – What Matters: Out of Hours, Acute Hospital, and Partnership perspective **Out of Hours** perspective – Dr Lisa Carter, Associate Clinical Director, Lothian Unscheduled Care Service, NHS Lothian Primary Care Lead, Quality and Safety **Acute Hospital** perspective – Sarah Keir, Consultant Physician and Honorary Senior Clinical Lecturer: Medicine of the Elderly and Stroke Medicine **Partnership** perspective – Angela Lindsay, Health & Social Care Locality Manager, North East Edinburgh
14:05 to 15:25 Parallel Sessions
Parallel Session 1: World Cafe – join your hosts at either the blue or red cafe to share and discuss ACP improvements
Parallel Session 2: What Next for ACP in Care Homes? Led by Carrie Ho, ACP Facilitator
Feedback: Emerging themes from parallel session discussions Andrew MacKay, Jackie Forbes, Carrie Ho
15:25 to 15.30 Round up and close of event Amanda Fox, Long Term Conditions Programme Manager

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Appendix 2: ACP Team

Carrie Ho, ACP Facilitator

Amanda Fox, Programme Manager Long Term Conditions Programme

Dr Andrew Mackay, GP ACP Advisor, St Triduana's Medical Practice

Tracey Rogers, Project Support Manager

Anna Wimberley, Project Team Manager