Extending Future Care Planning Across Health and Social Care

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Introduction

- Future Care Plans are established as an effective tool for promoting person-centred care. (Previously known as Anticipatory Care Plan (ACP))
- Key Information Summaries (KIS) are created in Scottish GP practices for appropriate patients. They are use to share Future Care Plans with all health care settings.
- Other professionals are not able to edit the KIS directly, but must share information with GP practices to make changes.
- We have worked with a variety of professionals to develop processes for them to share information with practices to help create these plans.

7 Steps to ACP in Care Homes

Future Care Planning conversations between care home staff and residents (or relatives if they lack capacity) happen soon after arrival in the care home using a **REDMAP** based conversation guide. (1)

A one-page form records functional status, DNACPR status, capacity for decisions (AWI), Power of Attorney (POA) and next of kin details.

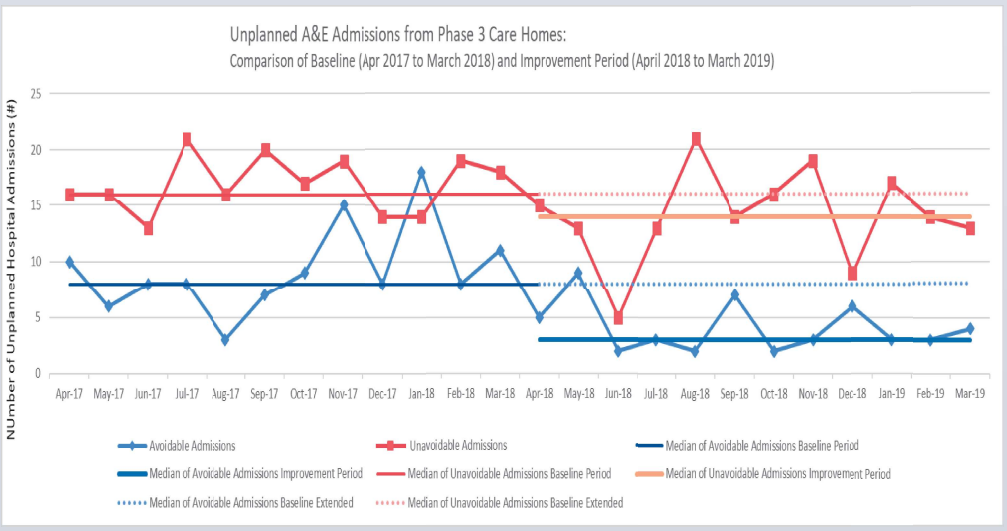
A second questionnaire asks the resident (or relative) to say how they would like to be cared for in the event of **1) a sudden collapse or stroke, 2) an infection not responding to antibiotics, 3) an inability to eat and drink adequately due to advanced illness.**

Previous work had identified these clinical situations as the commonest causes of avoidable admission from a care home.

A copy is printed, discussed with staff and added to the resident's notes.

Talking about Care Planning with REDMAP	
Ready	Can we talk about your health and care? Who should be involved?
Expect	What do you **know**? Do you want to tell/ask me about anything? What has changed? Some people think about what might happen if...
Diagnosis	What we **know** is... We **don't know**... We are **not sure** ... I **hope** that, but I **am worried** about... It **is possible** that you might.... Do you have questions or worries we can talk about?
Matters	What is **important** to you and your family? What would you like to **be able to do**? How **would you like** to be cared for? Is there anything you **do not want**? What would (*name*) **say** about this situation, if we could ask them?
Actions	What we **can do** is... Options that **can help** are.... This **will not help** because.... That **does not work** when...
Plan	Let's **plan ahead** for when/if.... Making some plans in advance helps people get better care.

Does it work?



Feedback

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

ACP principles now feel part of the culture of the care home. Communication with our practice has been excellent and FCP questions for families have greatly improved quality.

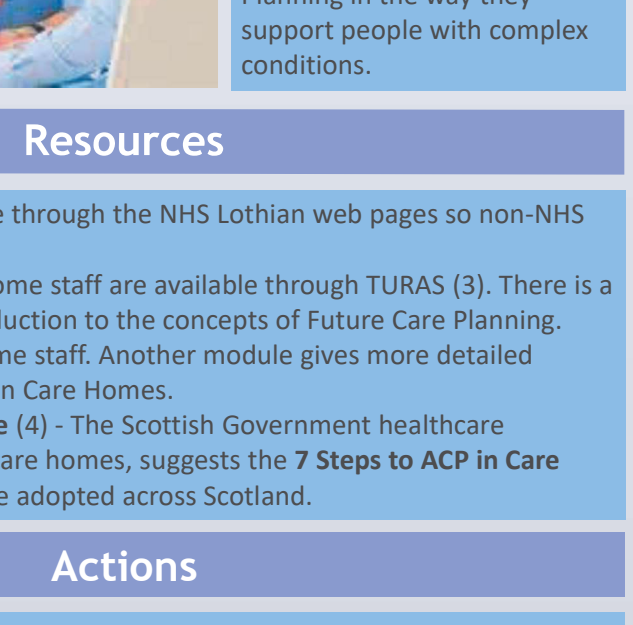
GP

Social care teams

A community based future care plan is more than a plan for future deterioration. It should also describe **who the person is, who is supporting them and what matters to them**.

We have worked with **Alzheimer's Scotland Link Workers**, the **Edinburgh Carer Support Team**, '**Vocal**' carers support, the '**Home Reablement Team** and the **End of Life Home Care Team** to create tools to facilitate ACP discussions focussed on these issues.

A summary of these discussions is then emailed to the GP practice inbox using a standardised covering letter. Practice clinical admin teams then copy and paste the summary into a person's KIS and ask their GP to review the result.



GP practices are now familiar with the process and the vast majority of emails are acted on. Between **100-200 KISs** are being created or enhanced each year using information from these teams.

Community Health Teams

Clinical Genetics and the **Lothian Community Neuro Rehab Service,** for those with progressive neurological conditions, have also worked with us using a similar model. This has helped to embed the concept of Future Care Planning in the way they support people with complex conditions.

Resources

All our resources are accessible through the NHS Lothian web pages so non-NHS agencies can access them. (2)

eLearning packages for care home staff are available through TURAS (3). There is a module that provides an introduction to the concepts of Future Care Planning. This is designed for all care home staff. Another module gives more detailed training on the 7 Steps to ACP in Care Homes.

My Health, My Care, My Home (4) - The Scottish Government healthcare framework for adults living in care homes, suggests the **7 Steps to ACP in Care Homes** is a model that could be adopted across Scotland.

Actions

1. **Supported community based professionals and others to have Future Care Planning conversations with those they are supporting.**
2. **Embedded processes to enable those future care plans to be used to create or update high quality KISs in primary care.**
3. **Created internet pages with future care planning resources available for anyone to use.**

Conclusion

- **The *7 Steps to ACP in Care Homes* enables care home staff and GPs to work together to create high quality Future Care Plans that are effective in reducing inappropriate A&E attendance and hospital admission.**
- **With guidance, support and a simple process a wide variety of professionals can help create high quality future care plans.**

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1: REDMAP-Care-planning-in-the-Community-April-2021-2.pdf (spict.org.uk)

2: https://services.nhslothian.scot/anticipatorycareplanning/

3: TURAS website: http://tinyurl.com/nhfxbzhf

4: https://www.gov.scot/publications/health-care-home-healthcare-framework-adults-living-care-homes/pages/8/