"I should only have to tell my story once"

Implementing Coordinate My Care in Care Homes

Health Innovation Network, August 2020

Health Innovation Network South London

coordinate my care

Content

Executive Summary

This project aimed to increase the number of residents in selected south London care homes with a CMC plan by utilising the skills and expertise of care home staff. Care home staff know their residents and their families well and can improve the process by discussing future care wishes and populate the CMC plan with this personalised information.

Ten south London care homes for older people participated and helped to create CMC plans for 251 residents over an 18- month period.

Good Wi-Fi, up to date computers and devices, facilitation and training, advance care planning, time and GP support were needed to achieve this.

A follow up review at three months indicated that 96% of residents who died achieved their preferred place of death compared to 83.5% prior to the project.

50% of homes had not continued to create CMC plans at three-month follow-up, citing capacity and staff turnover as key reasons.

We have demonstrated that care home staff can play an important role in creating CMC shared digital urgent care plans given the right resources and training. For this to be sustainable continued leadership and support is required together with adequate staffing levels and a stable workforce.

1. Introduction

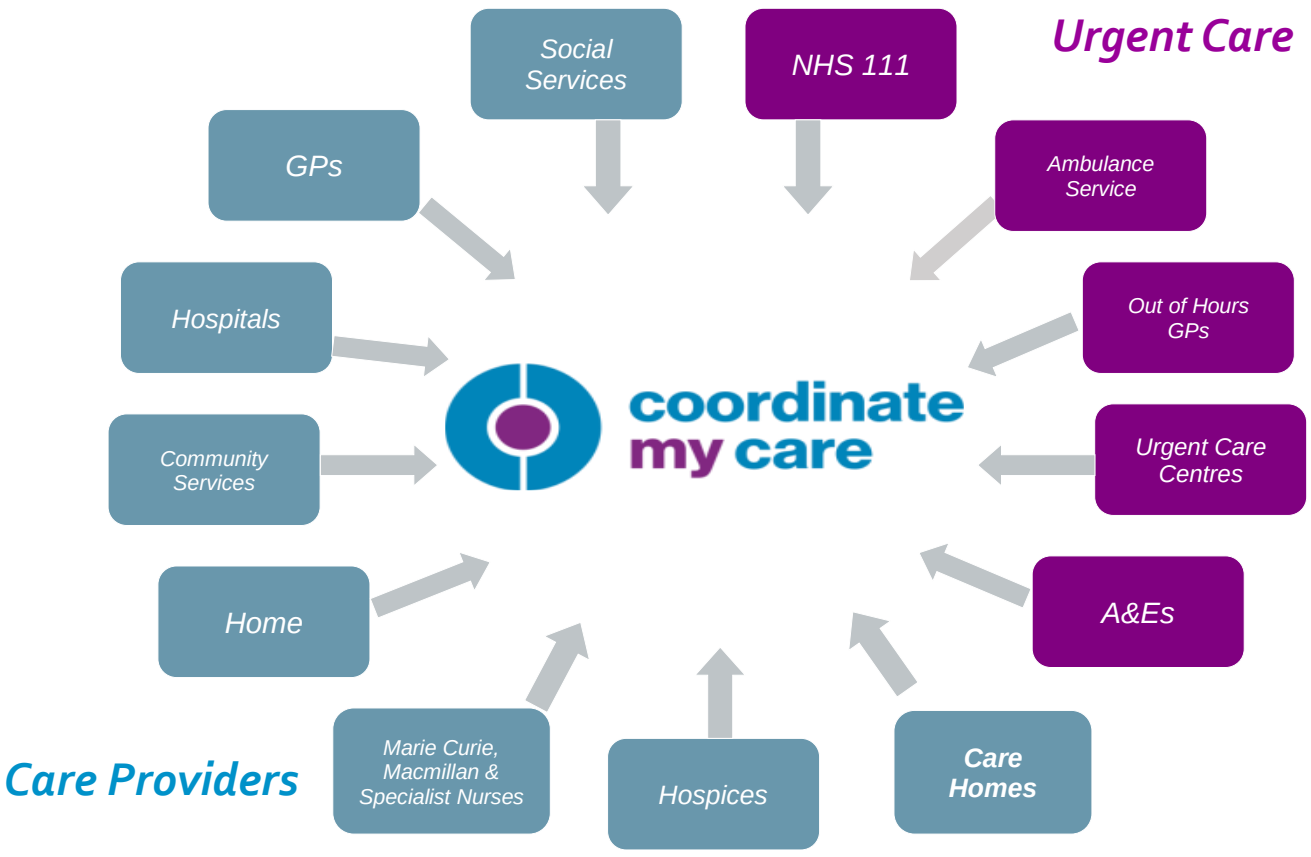
The Health Innovation Network (HIN) is the Academic Health Science Network (AHSN) for south London.

AHSNs connect NHS and academic organisations, local authorities, the third sector and industry and are uniquely placed to increase the spread and adoption of innovation across large populations, at pace and scale. They advise, support and connect health and care teams to adopt innovation in order to improve, patient care, health outcomes and efficiency. 'Healthy Ageing' is one area of focus at the HIN, whose work is primarily targeting the promotion of healthy living and the prevention and management of illness and disability among older people. Working with care homes to embed service change and improve the quality of care for residents is a key component of this team's portfolio.

This report focuses on a project conducted to explore the feasibility of implementing Coordinate My Care (CMC), a shared electronic urgent care plan, in care homes.

1.1 About CMC

Coordinate My Care (CMC) is a shared electronic urgent care plan currently available across London, offering a digital solution to future care planning. It enables patients' wishes and clinical recommendations about their future care to be viewed by the health and social care providers who care for them and by urgent care providers 24/7 in a medical emergency, such as, GP Out of Hours services, 111, ambulance services, urgent care centres and hospital emergency departments.



CMC supports provision of more effective person-centred care, giving a voice to the patient on how and where they wish to be cared for as well as supporting the patient only having to tell their story once. Holding 'need to know' information, the plan includes specific clinical information, the person's care preferences in anticipated deterioration, as well as their end of life wishes.

CMC data show a clear correlation between patients having a CMC plan and achieving urgent care and end of life wishes[1]. Studies have shown that people with a CMC plan are less likely to die in hospital than those without a plan (approximately 20% vs 54%, respectively[2],[3]).There is also evidence that CMC plans enable more appropriate use of health care resources and reduce inappropriate hospital admissions[4]. The average cost of treating patients in their last six months of life has been shown to be £2,102 lower for those with a CMC plan than those without[5] .

CMC was originally developed as an electronic palliative care coordination service however, it has also been shown to be beneficial for those who access urgent care services frequently such as, those living with frailty or dementia or who have long term physical or mental health conditions. Care home residents are likely to benefit from having a CMC plan, and this project aimed to increase CMC use by engaging, enabling and empowering care home staff to create CMC records in partnership with clinicians.

To find out more about CMC click here.

1.2 Project overview

The HIN worked with 10 care homes to test the feasibility of implementing CMC in care homes. A total of three approaches were used and are described in more detail below. The project aimed to increase the number of care homes residents having a CMC plan, to share the learning and make key recommendations to speed up the adoption and spread of CMC to other care homes across south London.

1.3 Project aims

The primary aims of the project were to:

- Identify up to 12 care homes for older people, to test approaches that enable care home staff to create CMC plans for their residents
- Identify the possibilities and the challenges for care home staff
- To share learning and key recommendations.

1.4 Project method

Care homes implemented one of the following approaches (see table below for more information about each):

- Working with an external advance care planning nurse (ACPN) to create the CMC plans
- Registered care home nurses creating and publishing the CMC plans
- Care home staff initiating the CMC plans for a senior clinician (e.g. GP) to finalise and publish.

[1] Coordinate My Care Website. CMC: An Introduction for Professionals (2017)
[2] Coordinate My Care Website CMC: Introduction for professionals (2017)
[3] National End of Life Care Intelligence Network, NEOLCIN (2008-10)
[4] National End of Life Care Intelligence Network, NEOLCIN (2008-10)
[5] Frontier Economics Evaluation Report End of Life Care – CMC Pilot Cost Analysis Final Report (2013)

The three approaches:

1. **External ACPNs** were used to support the creation of the CMC plans in two homes. ACPNs are nurses with specialist skills and training in advance care planning, they are employed by external agencies such as Marie Curie and were deployed to the home to create CMC plans on behalf of the care home and to be published by the care home GP. One of these care homes did not have the necessary IG compliance so this approach assured access to CMC and offered care home staff additional learning and support through the care home staff and the ACPN nurse working together to create the plans. There was an associated cost to this approach and the ACPN time and expertise was funded by Health Foundation Q-Exchange project.

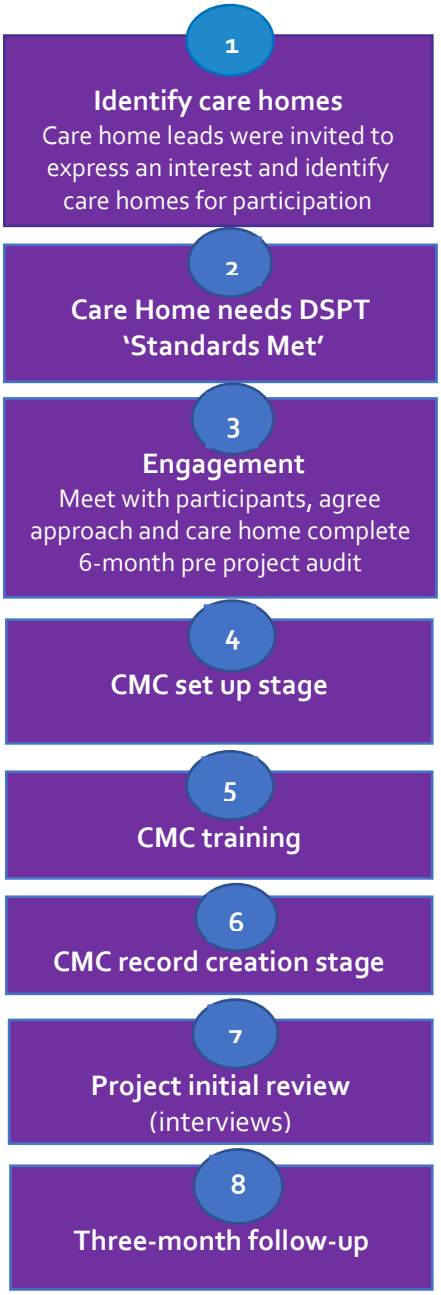
2. **Registered care home nurses** can have **'clinical rights'** whereby they are given full access to the CMC system and complete all fields of the CMC plan and finalise (publish) the plan, which is when it is made available to urgent care providers.

3. **Other care home staff** (e.g. a health care assistant, administrator) can be given **'administrator rights'** enabling them to initiate, read and make changes to a care plan but not finalise and publish the plan. Instead they must submit it to a registered clinician to finalise and publish.

Key stakeholders

Project stages

The project consisted of the following stages:



1.3.1. Identify care homes

Local Authority (LA) and Clinical Commissioning Group (CCG) Care Home leads from the 12 boroughs across south London were invited to express an interest and identify care homes for participation in the project.

1.3.2 Care home needs DSPT 'Standards met'

Care homes require '*Standards Met*' on the NHS Digital Data Security & Protection Toolkit (DSPT) to be able to access and use the CMC system.

The DSPT is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's data security standards. All organisations that have access to NHS

patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly. There are three levels of attainment on the Data Security and Protection Toolkit (DSPT): Entry Level, Standards Met and Standards Exceeded.

A range of organisations supported identification of care homes with the appropriate DSPT standards, including local Sustainability Transformation Partnerships, CCG and LA Commissioners and the Healthy London Partnership[6]. The DSPT register also lists organisations with DSPT compliance, although this is currently being redesigned to be more user friendly.

1.3.3 Engagement stage

Where interest was expressed by Commissioners and care homes, a meeting was arranged with the commissioner, the care home manager and senior staff as well as the care home GP. This enabled an opportunity to explain the project in more detail and to assess the care home's position or preparedness for implementing CMC. This sometimes led to further communications with other stakeholders such as the care home corporate company.

If ready and willing to participate, an approach to creating CMC plans was agreed. The approach taken was dependent on the skill mix of the staff at the care home, any previous training received, and confidence to undertake advance care planning. The care home was also asked to complete a pre-project audit on deaths in the care home over the previous six months. See audit template here.

1.3.4 CMC set up stage

In addition to meeting DSPT standards, CMC information governance (IG) and IT set up processes needed to be completed by the care home and included:

- Signing CMC's Information Sharing Agreement (ISA) by the care home Data Protection Officer (DPO) or equivalent
- Downloading CMC's non-HSCN (N3) secure licence to each electronic device used for CMC work
- The care home manager completing the CMC's user access form, providing CMC with a list of users for governance and CMC login purposes.

1.3.5 CMC training

CMC provided a group CMC training session for staff at the care home. The care home manager identified staff to attend the CMC training, some wanted a range of staff to attend to understand CMC and to potentially input in the creation of CMC plans. Other homes chose to train their nurses only. They were also encouraged to use CMC resources (e.g. CMC Quick Reference Guide, CMC on-line modules and video links, found here) for additional learning and support. Where needed, the CMC trainer returned to the care home once a couple of plans had been initiated by care home staff to review the plans and respond to any follow up questions. The trainer would also return to a home where there had been a delay in starting to create plans to support the creation of one or two plans together.

1.3.6 CMC plan creation stage

Either an agreed number of CMC plans or an agreed time frame was set to give the care home time to create CMC plans for their residents. The time period varied from a couple of weeks to a couple of months, depending on the number of residents in the home, the number of CMC plans to be created and, the care home's reported capacity to create the plans. Some homes set themselves a target to have CMC

[6] Partners include the NHS in London (Clinical Commissioning Groups, Health Education England, NHS England, NHS Digital, NHS Improvement, trusts and providers), the Greater London Authority, the Mayor of London, Public Health England, London Councils.

plans for all their residents, other homes agreed they would target a specific number of residents (e.g. one unit in the home, or a set number to complete that was realistically achievable within a two month period).

1.3.7 Project initial review (interviews)

Following record creation, semi-structured interviews were conducted with all the participants' (e.g. care home staff, GPs, residents and relatives) to seek their experience of creating CMC plans, using a semi-structured interview schedule. The data were analysed for common themes and indication of what worked well for care homes and what were the challenges.

1.3.8 Three-month follow up

A follow up visit was made to the care home three months after the plan creation period. The care home was asked to complete an activity questionnaire to capture the number of new residents admitted to the home, the number of new CMC plans created, the number of deaths recorded in the previous three month period and the number of residents who achieved their preferred place of death. The number of emergency calls to 111 and 999 and action taken was also requested.

2. Care home participation

Twenty-two care homes were initially identified for participation in the project of which, 15 had 'standards met' on the DSPT toolkit and had further engagement. Ten of these 15 care homes went on to complete the required set-up processes and receive CMC training and eight care homes created CMC records for their residents during the project's duration.

Care Homes who did not proceed sited the following reasons:

- Difficulty with the care homes Corporate company signing the CMC's Information Sharing Agreement (ISA)
- Lack of engagement from the care home GPs
- Staff turnover, including managers.

Care homes vary significantly in terms of the type of care provided, their staffing capacity, the skills and experience of staff and their digital maturity.

Characteristics of the ten care homes which continued to engage and received CMC training are outlined in **Table 1** below, and included:

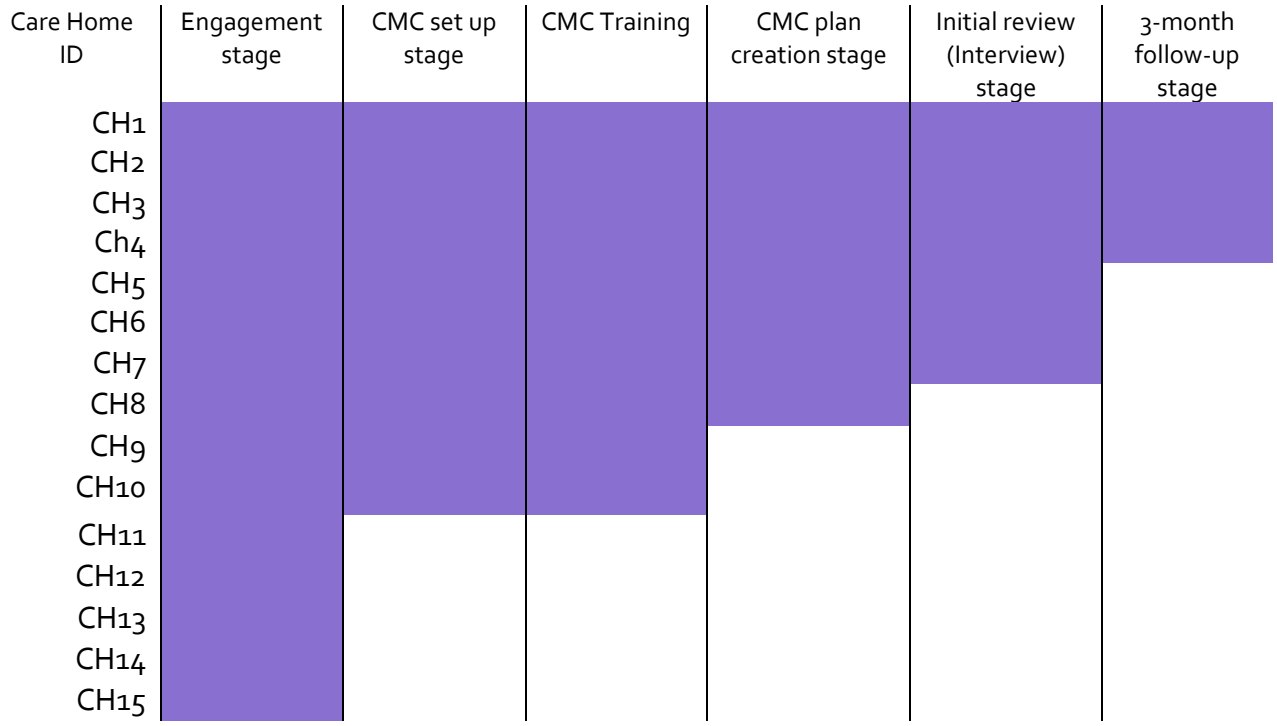
- **Nine** care homes with nursing and **one** residential home for older people
- **Six** homes were part of a corporate care home company or charity and four were independent homes
- **Eight** homes had a 'Good' CQC rating and two had an 'Outstanding' rating
- Number of residents varied between 24 – 72
- Previous ACP experience ranged from just recording of DNAR status to achieving and using the 'Gold Standards Framework' for end of life care[7].
- **Eight** homes had staff members familiar with CMC either because they had used it before in another role or because they had worked with local end of life care support teams who created these plans for their residents as part of end of life care.
- **Four** homes reported they had some staff who had some experience of using a digital care planning system.

[7] The National Gold Standard Framework (GSF) Centre is the UK's leading training provider for generalist frontline staff in caring for people in the last years of life. Its aim is to enable a 'gold standard' of care to help people live well before they die, and to die well in the place and the manner of their choosing. The GSF Centre provide nationally recognised training, quality improvement training and accreditation.

Table 1: About the care homes

About the Home						ACP and digital experience				
Care Home ID no	Part of Corporate / Charity?	Type of care provided	CQC rating	no of beds	% of residents with Dementia	Achieved National GSF Standard	Receive EoLC training	ACP is routine practice	Familiar with CMC	Using digital planning system
CH1	√	Residential and Nursing	Good	42	70%	√	√	√		
CH2	√	Residential and Nursing	OutSt	72	50%					
CH3		Nursing	Good	43	35%	√	√	√	√	√
CH4	√	Residential and Nursing	Good	60	35%		√	√	√	√
CH5	√	Residential and Nursing	Good	36	50%			√	√	
CH6	√	Residential and Nursing	OutSt	68	50%	√	√	√	√	√
CH7		Residential	Good	34	98%				√	
CH8		Nursing	Good	24	65%	√	√	√	√	
CH9	√	Residential and Nursing	Good	60	60%		√	√	√	
CH10		Residential and Nursing	Good	63	60%	√	√	√	√	√

Table 2: Project stages completed by care homes



- **Forty-seven** members of the care home team received CMC training as part of the project. Thirty-six were care home nurses, three carers, one GP, one administrator, five care home managers and one care homeowner.
- **Eight** of the above ten care homes had started to create CMC plans for their residents by the end of the project.
- **Seven** participating care homes reached the initial review stage of the project and 28 participants were asked about their experience of creating CMC plans, via a 1-1 interview or a brief questionnaire. This included 12 care home staff, five care home GPs, one ACP nurse, five residents and five relatives. The data were transcribed and analysed for themes that indicated what was working well for care homes and what challenges they faced when implementing CMC.
- **Four** care homes completed the whole project cycle and reached the follow-up review stage three-months after the initial review (interview). The other four homes did not reach this stage of the project due to insufficient time before project closure.

3. Activity

3.1 CMC plan creation

CMC plans were created for care home residents in eight care homes:

- In two homes the care home nurses worked with an ACPN to create the plans and the GP published the plans
- In three homes the care home nurses created and published the plans
- In three homes care home staff initiated the plans for the GP to finalise and publish.

Four care homes created their target number of plans within the agreed timeframe. The time was extended in the remaining four homes from one week to four months. Some care homes had log-in issues or were delayed due to installing or purchasing new IT systems or equipment.

Two hundred and fifty one CMC plans were either created (192) or updated (64) by the eight care homes. Four homes created CMC records for all their residents, one home created the target number of plans agreed at the start of the project, albeit not for all their residents. The other three homes were still working towards their goal at project close (see **Table 3**).

Table 3: CMC creation by care homes

ID No.	No. of residents at outset	No. with a CMC plan at outset	No. agreed to create during set time frame	No. CMCs Created at end of time frame[i]	No. of CMC records updated	Consent refused[ii]	% of target achieved
CH1	34	5	29	29	5	0	100%
CH2	72	4	68	67	4	1	100%
CH3	43	39	4	7[i]	34	0	100%
CH4	58	15	40	11	14	not reported	28%
CH5	68	0	20	5	1	not reported	25%
CH6	33	4	20	19	4	1	100%
CH7	24	2	24	24	2	0	100%
CH8	45	0	45	30	0	1	69%

i. Numbers will fluctuate over time due to deaths and new residents

ii. A CMC record can only be created with **patient consent.** However, best interest decisions can be made by a clinician if the patient lacks capacity and there is no lasting power of attorney for health and welfare to act on behalf of the resident. Best interest decisions are to be made in collaboration with residents' family and friends where possible.

In five of the care homes the GP published the plans. In two of these homes there was a significant delay of up to two months, between the time the plans were submitted to the GP for approval and the GP publishing the plan. One GP had a high volume of cases to publish and the other GP was supporting a residential home and had to add additional information to the plans. Both GPs reported some difficulty in finding time to finalise and publish the plans.

3.2 Three-month follow-up

Four of the participating care homes above reached the three-month follow-up stage where information

on the number of plans created during the post three-month period was requested. This revealed:

- Two care homes had created CMC plans for all 15 new residents that had been admitted
- Two care homes had not created plans for the 11 new residents that had been admitted.

3.2 Preferred place of death

Twenty-three residents died in the four care homes during the three-month follow-up period, **22 (96%)** of whom died in the care home, which was their preferred place of death (PPD).

At the start of the project care homes provided data on the number of residents who had died in the previous six months and preferred place of death. This data indicated that 85 residents had expressed a PPD and that 71 out of 85 (83.5%) achieved their preferred place of death. This data suggests that having a CMC plan increased the chance of both residents' wishes being recorded and their wishes being met.

3.3 Use of emergency services

Emergency call out data was received from three of the care homes. Calls to urgent care providers were made for **ten** care home residents during the follow up three-month period. In nine out of ten cases, the action taken was in accordance with the residents' care plan (see **Table 4** below).

Table 4: Urgent care activity

Case No	Who was contacted? **OOHGP/111 /LAS**	Resident conveyed to hospital	Compliance with PPC? **Y/N**	Did urgent care view the plan? **Y/N**	Additional comments
1	LAS	Yes	Yes	Yes	
2	111/OOHGP/ LAS	Yes	No	No	There was no indication that the CMC plan had been accessed across the urgent care pathway
3	LAS	Yes	Yes	No	On discharge the GP updated the plan to reflect that further hospital admission was no longer appropriate.
4	LAS	Yes	Yes	Yes	Admission was in keeping with the resident's CMC plan
5	111/LAS	Yes	Yes	No	
6	LAS	Yes	Yes	No	
7	LAS	No	Yes	Yes	Paramedic came but did not take resident
8	111	No	Yes	No	111 were pushing for the resident to be taken to hospital but care home referred to CMC plan
9	LAS	Yes	Yes	Yes	Admission, as reversible condition
10	LAS	Yes	Yes	Yes	

Highlight Box 3

- **251 CMC plans** were either created or updated by 8 care homes
- A CMC plan was created for all (15) new residents admitted to 2 of the care homes in the 3 months following the project
- **96%** of residents with a CMC plan achieved their preferred wish to die in the care home and **90%** received care in their preferred place following an urgent care call.
- Care homes reported to record PPD for the majority of the residents prior to using CMC, however, use of CMC increased the proportion with a PPD as well as the proportion who's PPD was met.
- **90%** of residents involved in an urgent call out during the post 3-month period received care in accordance to their CMC plan.

4. The learning

This section highlights the key learning that emerged throughout the project including the preparation process, initial review (interviews with participants) and the three-month follow-up.

4.1 Preparing for CMC

4.1.1 Meeting DSPT 'standards met'

The need

Care homes need to have achieved '*Standards Met*' on the NHS Digital Data Security & Protection Toolkit (DSPT) to be able to access and use the CMC system.

What worked well

- We opted to work with care homes who already had DSPT standards met
- For homes that are part of a corporate company, the IG lead was contacted to check the homes DSPT status.
- Checking the DSPT register in advance of starting the project. This is currently being reconfigured to make it more user friendly.

The learning

- To achieve 'Standards Met' on DSPT, the care home needs to complete ten information governance standards, totalling the implementation of 70 governance processes. Given the expertise and time required this can be a challenge for care homes to achieve without additional training and support.
- We promoted the toolkit and its value in accessing NHSmail and electronic data sharing resources, referring to the DSPT website and how to register.
- Care homes unable to achieve the DSPT standard could continue to inform the content of the CMC plan by gathering information and communicating with residents and relatives and working collaboratively with other senior clinicians who can create the plan.

4.1.2 Engaging the stakeholders

The need

To create a holistic and person-centred urgent care plan all the key stakeholders need to participate and work together.

What worked well

- External facilitation such as, having a project manager to facilitate communications across the provider groups on behalf of the care homes, liaise with care home commissioners to identify any local expertise or services that may be able to support care homes create CMC plans and broker local relationships
- Having a single GP or GP practice for the care home, with a pre-existing good relationship and communications
- The care home having and using NHS mail, as NHSmail is a useful tool for communication between healthcare professionals and the care home

The learning

- The care home doesn't have enough internal resources to facilitate and broker relationships.

External facilitation supported this process and helped reduce the workload for the care homes
- It was important to establish a relationship where the GP trusted the care home as the expert in their knowledge of the resident.

4.1.3 CMC's Information Governance (IG) requirements

The need

Care homes need to meet the strict CMC governance requirements to access and share highly sensitive personal healthcare information.

What worked well

- For corporate care homes' Head Office to be on board and supportive
- Early identification of the homes IG lead to sign CMC's Information Sharing Agreement (ISA)
- Where someone in the care home took ownership and responsibility for completion of the DSPT and other governance processes, providing leadership and championing CMC
- Early identification of IT support to the download the secure licence and support staff manage login processes.

The learning

- Care homes often require external IG and IT support to complete processes such as downloading the non-NSCN licence and setting up the log-in processes
- Understanding the relationship between the care home and the corporate head office
- Recognising care home staff have different levels of digital literacy and may require additional training and support.

"A challenge was setting up the connection for the home" ***Care home GP-2***

"Some staff struggle with computerised tasks and log-ons etc, they have different levels of efficiency when it comes to IT" ***Care home manager-5***

"Once you get passed the CMC administrative set up aspects, the log-in and downloading the system [non N3 secure certificate] I think it is relatively straight forward" ***Care home GP-5***

"We were lucky that our Head Office were cooperative and signed off the relevant paperwork and downloaded the licences" ***Care home manager-5***

4.1.4 IT infrastructure

The need

CMC is an electronic urgent care plan so to enable CMC record creation care homes require good Wifi coverage and devices to access the system.

What worked well

- Assessing the care homes IT infrastructure in preparation for CMC
- Where a care home did not have sufficient equipment but were able to aquire it
- For some, using mobile devices better suited their needs when working with the resident

The learning

- The existing IT infrastructure in care homes is not always good enough to introduce an electronic system and an upgrade may be necessary
- Being able to take a mobile device to the resident streamlined the process for care home staff, preventing later transfer of information from paper to the CMC system, reducing the workload

- Slow or out of date devices create frustration and put care home staff off using CMC as it is perceived to be time consuming.

"Better Wi-fi would be more beneficial, so they can just upload information directly instead of writing and then uploading" ***Care home manager-1***

"The nursing staff struggled, and continue to struggle, to access CMC on the care homes computers. This is due to outdated and slow equipment, and the need for the manager to access a password to facilitate the [non]N3 secure connection, secure internet and computer access is needed in all care homes." ***Care home GP-1***

"They need a log in from my computer. This can be disruptive as I may have relatives, CQC, social services here etc. I don't know why the password gets sent to care home managers email" ***Care home manager-1***

"We were planning an IT up-grade to 3 machines, CMC pushed this forward in many ways" ***Care home manager-5***

"I found an iPad is more flexible….I can take the iPad to the room with the cupboard and do many together" ***Care home nurse-4***

4.2 Creating the CMC plan

4.2.1 Roles & responsibilities

The need

To understand the requirements for creating a CMC plan and who is the most appropriate person to complete the relevant fields and publish the plan.

What worked well

- When the approach is agreed at the outset and people have a clear understanding of their roles and responsibilities
- Where staffing levels in the care home are sufficient and stable to allow time for ACP conversations and record creation
- Where there was one GP for the care home who championed and supported the care home staff in using CMC
- When the GP was able to complete and publish records in a timely manner
- Where external expertise could support care home staff to create CMC plans and complete plans at pace.

The learning

- Care homes who had the required experience and expertise to create and complete plans and who opted for 'clinical rights' reported more autonomy in being able to publish the plans themselves, albeit still working closely with the GP at the care homes weekly ward round
- An ACP nurse from a third party can create and complete plans and provide additional learning to care home staff if completed together. However, if the ACP completes them for the home this doesn't necessarily translate in to care home staff feeling empowered to create records themselves
- GPs valued the care home staff's input, no matter how limited
- GPs learnt that it took less time than they previous thought it would
- In most homes the responsibility for finalising and publishing the plans fell to the care home GP. However, it was helpful when the care home staff notified the GP so that records where published in a timely manner.

"We specialise in palliative, so this is very useful, I can do it. It's effective because I know my patient is on CMC if their condition changes I can up-date the system and if they passed away they can be removed…" ***Care home nurse-4.***

"We work with the GP when he comes to home. He comes weekly and works very directly with our patients" ***Care home nurse-5***

"They [the care home] complete the more social components better than I could have done, so they are being done more completely so it's been good and the fact they are doing the administrative component saves the clinician doing it, so saves consulting time" ***GP-5.***

"Having an ACPN has helped to upscale skills used. The way she approaches introducing herself, asking how they would like to be cared for etcetera has been a learning curve and we can take on these approaches" ***Care home nurse-1***

"I very much appreciated the assistance in completing the plans, as she had the flexibility and time to contact relatives" ***Care Home GP-2***

4.2.2 Involving the resident and relatives

The need

A high-quality CMC plan should contain a personalised care plan so that residents' only have to tell their story once. The plan should reflect their needs, wishes and preferences.

What worked well

- If a resident lacked capacity to consent to a CMC plan, speaking to their LPA, care home staff and those close to them was helpful and supported a best interest decision
- Providing written information for residents and relatives about CMC prior to getting consent
- Giving residents and relatives opportunities to ask questions
- Giving residents and relatives time to consider their wishes and preferences
- Involving residents and relatives in ACP discussions as early as possible on admission to the home

The learning

- Ensuring there is enough time for good communication and for people to consider their wishes and preferences
- When people are well informed about CMC, they rarely withhold consent. In this project only three residents/relatives were known to withhold their consent to participate out of 195, where consent was sought
- Engaging residents and relatives in discussions about ACP on admission made these discussions standard practice for the resident and relatives, raising less concern
- Residents and relatives reported valuing the opportunity to have ACP discussions and having a plan that can be shared across services.

"The launch night was good, but the majority of residents here have dementia or vision issues so couldn't really engage fully so it is hard to tailor this to one size fits all using a launch event. The leaflets are useful but with this group of people you should sit down and talk to the residents, so they understand as, like I said, everybody is different with different abilities to take everything in" ***GP-1***

"Explaining to relatives, that's the number one thing, as everybody wants to know where the information going, how is accessed, where is it stored, what is the magnitude of data and how does it impact their lives" ***Care home manager-2***

"Challenges are like getting families to discuss, especially when person has no capacity. Some of them do not want to discuss" ***Care Home Nurse-5***

" We have the what's now called platinum GSF standard, so it is standard practice for us to get this information ASAP either pre or post admission" ***Care Home manager-4***

"We work with the GP when he comes to home. He comes weekly and works very directly with our patients" ***Care home nurse-5***

"One relative gave me feedback that her mum found it hard to understand as she lives with dementia…We saw that residents need to be reassured" ***Care home Manager-1***

"It's good to have a record that a number of healthcare professionals can access" ***Resident-3***

"Never had the opportunity to talk about end of life care before .. I thought everything was helpful. Before this I didn't know I had the option not to be resuscitated" ***Resident-2***

"I was pleased that there was something in place like that, rather than having the alternatives such as having the paramedics in charge and making decisions in regard to dad" ***Relative-6***

4.2.3 Time & Capacity

The need

Sufficient time and skills are needed to have ACP discussions and create high quality CMC plans.

What worked well

- Providing protected time for staff to focus on ACP discussions and create CMC plans
- Early identification of training and support for staff who expressed interest to enable them to develop familiarity and expertise
- Having an advocate within the care home with expertise and confidence to drive the required culture change.

The learning

- Without a stable workforce it was difficult to deliver the training and for staff to develop their knowledge and expertise
- With sufficient workforce capacity it was possible to prioritise creating CMC plans
- Staff need to be trained and have confidence in having ACP discussions and in using CMC as a way of documenting these discussions
- Streamlining processes around record keeping reduced duplication and saved time
- Staff reported that once confident, creating CMC plans didn't take as long as they had expected.

"An issue with talking to a [relative] is to set up a time to talk about end of life care" ***ACP Nurse***

"We had limited time due to staffing constraints and other responsibilities" ***Care home nurse-2***

"We could never have done this work without the advance care planning nurse as it takes time to do it well" ***Care home nurse-2***

"The time…honestly …. sometimes I just have to prioritise myself. The workload is too much …if he is not around, I am the management as well. I also have the CMT going on…which is a report for head office. Sometimes I also have to order things too and deal with investigations". ***Care home nurse-5***

"My concern was I thought it would take a long time….we were worried there would be extra on our hands but no… it took about an hour .. for some people you have more to write about than others, you just need to be sure about the information you are putting in… It's quite user friendly" ***Care home administrator-1***

"At first it was difficult, but after the first, second third, he just got into the groove, and it became more common. It seemed better to have one person then they become familiar with the process and therefore quicker, more efficient that's why we did it that way" ***Care home manager-4***

4.2.4 Sustainability

The need

A shared care plan enables residents' preferences and wishes to be achieved and reduces inappropriate hospital admissions and interventions.

What worked well

- Having a CMC champion in the home to lead, encourage and embed this change, albeit the GP, care home manager or clinical lead
- Project management support & facilitation to support connection with wider health system
- Care homes with staff with experience and confidence with ACP and using digital systems
- Workforce stability
- Positive working relationship with the care home GP(s)
- Care home attitude to the value of CMC.

The learning

- Care homes varied in their ability to continue to create and up-date CMC plans going forward
- When CMC creation fell to the care home GP to do, they also struggled to find the necessary time to keep up with new residents as they were admitted, reinforcing the advantages of care home staff completing or initiating the plan
- Where external expertise is used to create CMC plans this expertise needs to be embedded within the care home to enable care home staff to learn and develop their own skill and knowledge. When the expertise worked in silo in the home (doing it for the home) this did not result in the care home staff continuing this work
- Transitioning to digital ways of working and creating CMC plans was a significant culture change for many care homes and required IG and IT maturity as well as extended skills that some homes needed to develop.

"The [named care home] has not yet moved to the use of digital resident records. This remains a significant barrier to the integration of CMC from a practical viewpoint, and will require a change in culture and ethos at the home" ***Care home GP-1***

"It was also pretty straight forward really, guiding some of the nurses through it all was smooth, not as difficult as I thought it would be" ***Care home manager-5***

"Fridays is always a scary day for any care home as that is the end of the week and you have to prepare for the weekend, so if the patient tends to be at end of life, all of sudden then there is no way at that late time we can up-date the system, but now I can do it myself" ***Care home nurse-4***

"There had been some hope that the nurses would be able to assist in the creation of CMC plans having observed some of the work carried out by the advance care planning nurse. Unfortunately, there have been several barriers to their involvement… the nurses were often understaffed and they are unable to take time out of their daily schedule to carry out this work, without formal ACP training, and with limited experience, many nurses lacked confidence and the skills needed, some felt that ACP conversations fall outside their remit, and finally there were IT issues, with nurses struggling to access CMC on the their computers" ***Care home GP-1***

Highlight Box 4

- Care homes varied in their ability to implement CMC and create plans for their residents
- Robust IT equipment, IT literacy, good Wifi coverage, confidence in advance care planning, GP involvement, leadership and capacity are key requirements to enabling care homes to implement and sustain the creation of CMC plans
- Commissioners need to recognise the ongoing costs in terms of time, training and equipment for both care homes and GPs, to ensure successful implementation of CMC in the care home setting.

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5. Conclusion

The aim of this project was to test the feasibility of implementing CMC in a small number of care homes and to share the learning and make key recommendations to speed up the adoption and spread of CMC to other care homes across south London.

Care homes vary in terms of the type of care provided, their staffing capacity, the skills and experience of staff and their digital maturity. The HIN found that there wasn't a 'one size fits all' approach to implementing CMC in care homes. Some care homes whose staff had experience and confidence in advance care planning learned to use CMC with relative ease. However, others found having end of life care discussions and using a new digital system overwhelming. The high turnover of staff, common in many care homes, added to the challenge.

The type of support required to implement CMC has been shown to vary from home to home. **A needs assessment** to assess the homes readiness for CMC will determine what necessary infrastructure, support and training is required. A check list of requirements can be found here.

Care homes need **NHS Digital Data Security and Protection Toolkit** compliance at 'Standards met' to use CMC. Completing the DSPT toolkit is a new process for many care homes who have not historically been bound by NHS information governance procedures. We found that care homes which were part of a larger Corporate care home organisation were more likely to have completed the DSPT to 'standards met' and the Healthy London Partnership is supporting an increasing number of London care homes to complete the toolkit.

Engagement with the care home GP(s) is needed from the outset to support and encourage care home staff, add relevant clinical details and publish the CMC records so they can be viewed by urgent care services. It is likely that evolving Primary Care Networks will develop closer partnerships with care homes which should support this model of care.

Having a **dedicated senior nurse or GP championing this service change** and allowing protected time for the work was helpful in achieving the culture change required.

Care home staff know their residents and those close to them well which makes them well placed to create individual and personalised CMC plans. In this project 96% of the residents, who had a CMC plan achieved their preferred wish to die in the care home and 90% received care in their preferred place following an urgent care call.

The care homes participating in this project demonstrated enthusiasm for innovation to improve the care they provide and overcame significant challenges. Implementing electronic CMC plans was welcomed and achievable for care homes with the right training and support.

CMC offers an opportunity to bridge the gap between health and social care, acknowledge care home staff as experts in the care of their residents, and be recognised as important and valued colleagues.

We hope this report excites and inspires others to build on this work for the benefit of people who live in care homes.

HIN have produced an ***CMC Implementation Guide for Care Homes***, in partnership with the CMC service. This offers Commissioners, Care Homes and other stakeholders a useful resource to speed up the adoption and spread of CMC planning in care homes.

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