# Increasing the number of care home residents supported by a co-ordinate my care plan: An analysis and report on findings from the Lambeth pilot

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# Contents

# Background

Care home residents are particularly vulnerable to COVID-19 and older age is a significant mortality risk factor for people with COVID-19. Across London there was a coordinated campaign to ensure that, where appropriate, people are offered compassionate advance care planning discussions and that these discussions are recorded on Coordinate My Care (CMC), so that urgent care services can view people's preferences, wishes and other useful information.

The Health Innovation Network and London Clinical Networks worked with key partners to rapidly increase the number of CMC plans that were created in three nursing homes in the London Borough of Lambeth.

This report sets out how NHS England and Improvement's £24,000 investment was utilised to rapidly trial and test an innovative partnership between South East London Integrated Care System (ICS), Academic Health Science Network (AHSN), charitable partner and Clinical Network to support people in Care Homes in Lambeth.

This pilot replicates work successfully undertaken by the South West London ICS, using Marie Currie Nurses to have advance care discussions and to create CMC plans.

# Executive summary of learning and recommendations

- 198 CMC plans created for residents in 3 care homes in just 5-weeks, 99% of which were successfully published by the residents GP
- Positive and enhanced ways of working were adopted during the project. For instance, Marie Cure Registered Nurses joining the weekly multidisciplinary team meetings
- Training and ongoing support for Marie Curie staff in remote working, advanced care planning and awareness of the key information Urgent and Emergency Care (UEC) services value the most
- As a result of this project, the Care Homes and their staff have been enthused by innovative approached to working and are committed to further service improvements. In terms of sustainability, 2 out of the 3 care homes are actively working towards embedding CMC into their admission processes

## This report recommends:

Sharing the evaluation report with South East London (SEL) Joint Commissioning Directors for adult care and Personalised Care Lead to disseminate learning and recommends considering the proposed model for further investment and adoption by other SEL geographies.

Cross reference with SWL evaluation to consolidate lessons learned and share with London Clinical Advisory Group to support wider spread and adoption of good practice.

# 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. One of HIN's focus areas is 'Healthy Ageing', whose work is primarily focussed on the promotion of healthy living and the prevention and management of illness and disability affecting older people.

This report focuses on a project conducted to rapidly increase the number care home residents in three Lambeth care homes with a Coordinate My Care (CMC) plan.

## About CMC

CMC is a shared, electronic urgent care record 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 person on how and where they wish to be cared for as well as supporting the notion of 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 shows a clear correlation between patients having a CMC plan in place and achieving urgent care and end of life wishes[1]. Having a CMC plan has also shown to improve the service offered to patients including hospital avoidance if that is their wish. 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 reduces inappropriate hospital admissions[4]. The average cost of treating patients in their last 6 months of life is purported to be £2,102 lower for those with a CMC plan than those without[5] .

CMC was originally developed as an end of life care plan. However, it has 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.

To find out more about the CMC service click here

[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 case for change

There are 104 care homes for older people in South East London (SEL) with a bed capacity of 5500. SEL is ranked 4th out of 5 London Sustainability and Transformation Partnerships (STPs) in terms of published plan for care homes residents. In March 2020 an estimated 580 CMC plans had been created and published for SEL care home residents (based on post code). If bed occupancy is full this represented 10% of care home residents.

Residents with a CMC care plan are more likely to die in their preferred place of death resulting in their choices being respected at the end of life. An audit of 63 residents in SEL found that 92% of residents with a CMC plan died in their preferred place of death. CMC can help avoid inappropriate hospital admissions and treatments, resulting in significant cost savings. The average cost of care in the last 6 months of life for nursing home residents are £4,223 more when the location of death is in hospital (Ennis et al 2015). However, in 2018 in SEL 14.8% of deaths occurred in care homes compared with 22.5% in England. If 1% more care home residents in SEL died in their care home (rather than in hospital) this would equate to a saving of £63,000 per year

## Project methodology

The HIN and the End of Life Clinical Network (NHS England and Improvement London region) approached Marie Curie to ask if the charity could lead in providing a CMC service in Lambeth. The project was delivered over a 5-week period from 15th June 2020 to 27th July 2020, equating to 700 hours of register nurse (RN) time. The scope included the lead GP from the Prentis Medical Centre identifying residents living in three Lambeth Nursing homes to:

a. Create a new CMC plan for those residents without one in place
b. Update an existing CMC plan for those where the current plan was assessed as incomplete by the Marie Curie Registered Nurse

Due to shielding and social isolation guidelines, Marie Curie were able to commit to supporting these conversations in a 'virtual capacity', where a Marie Curie RN would hold conversations over the phone or via video conferencing. The RN would hold the responsibility of creating the care plan and leading on these vital conversations with those in need of a CMC plan at end of life. The GP would subsequently review and publish the care plan once the Marie Curie RN documented and submitted the CMC plan to them.

Marie Curie set out to:

- Improve communication between residents, relatives, care home staff, GPs, the London Ambulance Service, OOH GP services, 111, and secondary care services regarding the patient's history and personal preferences as they approach the end of their life.
- Ensure high quality discussions to help support future care, including end of life care, aligned to a person's preference, for example, the individual's location of choice, and that preferred place of death is achieved when possible
- Reduce unnecessary hospital conveyances and admissions
- Improve equity of access to people in care homes offering Advance Care Planning discussions where wanted and an accurate record of the discussion reflected in the completed CMC plan

## Project aims

The aims of the project were to:

- Create a minimum of 200 new CMC plans for care home residents over the short-duration of the pilot
- Intensively support 3 Lambeth Care Homes with the lowest CMC utilisation to rapidly increase the number of residents with a CMC plan
- Share and disseminate learning from the project to allow the other London STPs to rapidly adopt the model.

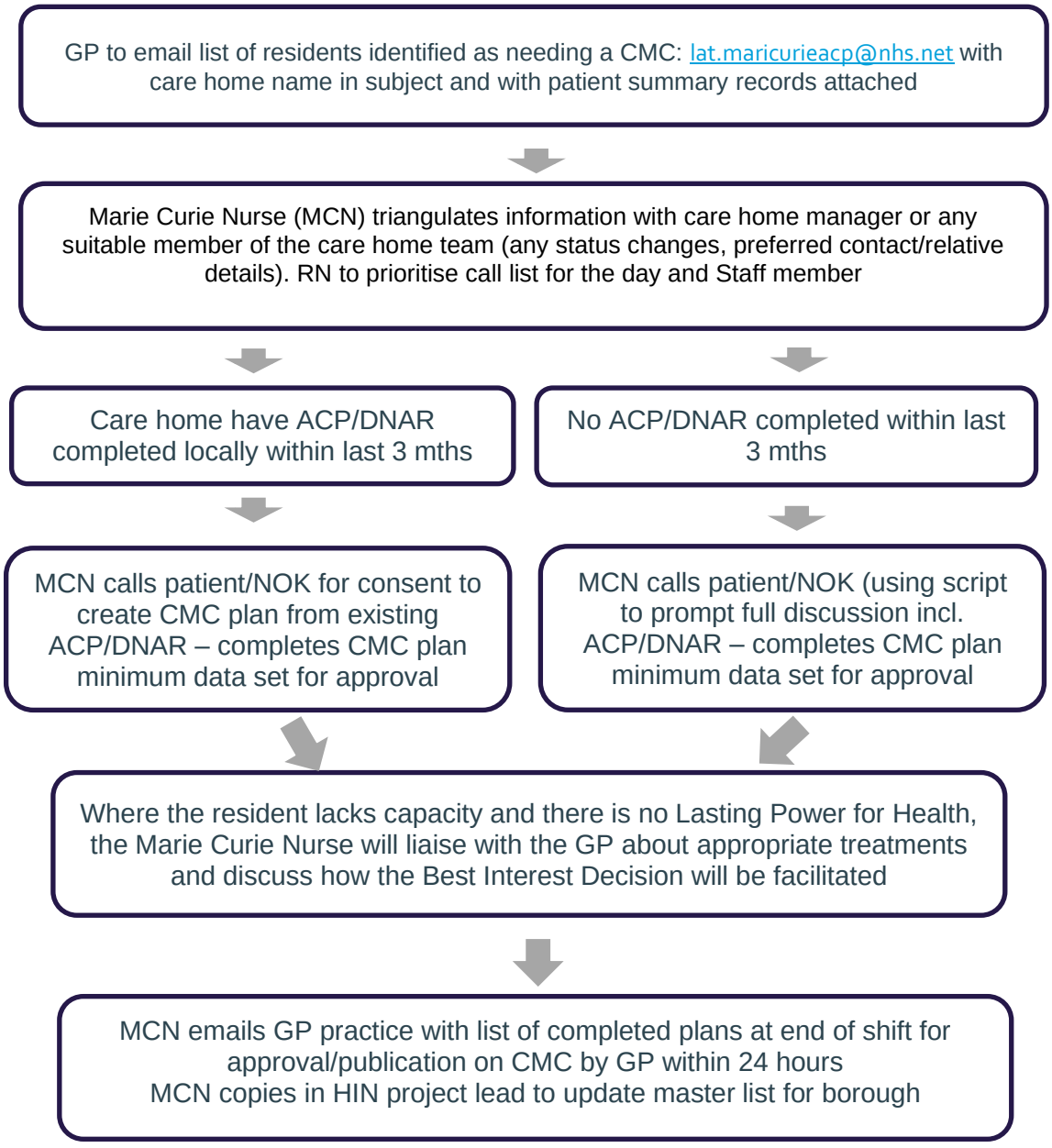
## How the service worked

**Project co-ordination**
The HIN provided project management and support. They engaged key stakeholders and co-ordinated weekly operational and steering group meetings.

The steering group tracked progress, helped shaped the evaluation and considered how this project aligned with local priorities as well as ongoing sustainability of the project. Membership included the NHSE End of Life Clinical Network, SEL personalised care lead, Lambeth CCG representatives and SEL ICS lead commissioner for Care Homes.

**Operational meetings**
The operational meetings were held weekly and conducted using MS Teams. Membership included; Clinical Commissioning Group lead, GPs, Marie Curie project co-ordinators, Excelcare care home business development manager and the HIN. During these meetings the group discussed the weekly progress, any challenges and issue which had arisen and how to overcome them. The meeting provided an important feedback loop between the GPs, Marie Curie and the care homes.

**The referral pathway**
The schematic below demonstrates the referral pathway for CMC plan completion.



# Evaluation

## Evaluation Framework

The project has been evaluated and used a range of quantitative and qualitative methods. The project steering group agreed the following metrics as an evaluation framework for the project:

Outcomes metrics: Quantitative

- Number of referrals to the Marie Curie service
- Number of new CMC plans created for review and publication
- GP practice data
    - Number of plans published by the GP
    - Number of residents achieving their preferred place of death (during the project)

Qualitative:

- Explore methodology to review quality of care plans
- Feedback from care home staff, GPs and Marie Curie nurses
- Feedback from residents and their family members

## Findings

### Outcomes

During the five-week period a total of 237 referrals were made to the Marie Curie service. Marie Curie created 198 plans. They were unable to complete plans for 39 referrals (6 RIP; 10 declined, 7 unable to reach next of kin). 16 referrals were passed back to the GP as Marie Curie were unable to make contact with the care home in the timeframe of the project and therefore unable to initiate a plan.

| Care Home | Number of referrals | Completed for publication | Percentage of referrals converted to CMC |
|---|---|---|---|
| **St Mary's** | 72 | 67 | 93% |
| **Limetree** | 83 | 75 | 90% |
| **Windmill** | 82 | 56 | 68% |

### Published plans

As of the 1st September 2020 196 (99%) plans has been published by the lead GP at Prentis Medical Centre. The GP lead was unable to contact the Next of Kin in two cases, and therefore unable to publish these plans.

### Preferred place of death

During the five-week period of the project 11 residents died. Of the 11 residents that died, 10 had a CMC plan and nine plans documented a preferred place of death for the resident. Of those with a recorded preferred place of death, 100% of residents achieved this. All 11 residents died in the care home during this period.

### Quality of the plans

The steering group discussed the potential to review the quality of the CMC plans. An audit tool was devised from

reviewing national personalised care planning guidance and in discussions with urgent care colleagues (including 2 x GPs, 1 x physiotherapist, 1 x paramedic). The tool excluded the mandatory fields and included areas which are considered useful to urgent care services such as symptom management.

The audit tool was used to evaluate seven plans, one plan was selected at random for each of the RN's involved in the project. There was an even distribution of plans from all three nursing homes. The plans were reviewed by three clinicians (2 x GP; 1 x physiotherapist) who had a good knowledge of using CMC. The audit tool can be found here.

Against this criteria, it was noted in several plans there was a lack of the softer personalised care planning information, which is likely due to the methodology which focused on completion of the minimal data set (see the referral pathway flow chart). The tool was refined after piloting.

## Feedback from Marie Curie Nurses

A short questionnaire was created to capture the views and experiences of the Marie Curie nurses involved in the project. Five nurses responded to the questionnaire and a summary of their feedback is captured below:

- This project represented a significant change in role for the nurses, moving from a face-to-face role to working virtually.
- Many nurses were initially hesitant about the change in their role. However, they reported that they enjoyed working virtually and being able to continue to deliver personalised care through advance care planning discussions.
- The nurses reported having sensitive discussions which required them to gain trust and build relationships quickly, this was perceived to be more difficult to do virtually than it would have been face-to-face.
- Nurses felt a sense of satisfaction in being able to use their skills and expertise to support residents and their families to make decisions about their end of life wishes

### A selection of feedback

**"Started this [working on the project] as unable to do practical nursing due to medical issues so really enjoyed speaking to families and using my experience in Marie Curie"**

**"Made me realise how important CMC plans are (ACP) and it would be great if these were done routinely"**

**"Felt valued and developed skills I never knew I had. Met nurse from all over the country in many different roles. This experience really helped as the situation was so strange and challenging"**

**Feedback from Care Home staff**
At the time of writing this report none of the staff from the three nursing homes had submitted feedback about their experience of working on the project.

## Feedback from GPs

The GP lead from Prentis Medical Centre provided feedback on their views and experiences of being involved in the project. A summary of their feedback is captured below:

**Timeframe for reviewing and publishing plans**
It was proposed that plans should be reviewed and published within 24 hours of receipt. However, given the volume of plans being received this was unrealistic. The final plans were published 5 weeks after the project closed.

**The time taken to create a plan.**
The time required to review the plan, input missing data and publish a plan was more than anticipated. The GP was required to input prognosis and WHO status for each resident. In some cases, where the resident was not known to the GP, the GP would contact the care home to discuss the resident's condition and prognosis, which took time. It

was suggested the process could be streamlined by having the care home staff record baseline data with involvement from the GP, avoiding the need for duplicated discussions about each resident.

**Quality of plans**
The quality of the plans and amount of information recorded varied from plan to plan. This resulted in each plan requiring a thorough review to ensure all essential past medical history and medication was included and correct. The GP noted there were a number of inconsistencies in the way the medication was recorded, including classification errors e.g. antiplatelets being classified as anticoagulants.

As a result of the time constraints of the project, many plans did not include 'softer' data. However, the GP noted that they felt in general this responsibility should fall to the GP. The GP also noted care homes often make use of PEACE (Proactive Elderly Advance Care Plans) documents, which tend to be produced in the last 6 months of life and are created by the GP or a Geriatrician. As the homes become more adept at creating plans the information from the PEACE document could be included, or a copy of the PEACE document attached to the CMC plan. Although, time pressures within this project did not allow this to happen, it was suggested, where records exist this could be done retrospectively by care home managers. Likewise, other 'softer' data which is usually recorded in the care homes records such as spiritual care could be added in retrospect. The GP also noted variance in the recording of anticipatory medication and felt this should, where information was available, have been recorded.

**Collaborative working**
The GP valued the effort put in by the MC nurses and acknowledged the time saved by having baseline data from conversations with the resident (where appropriate), the Next of Kin (NoK) and the care home staff inputted into the plan. The GP compared this with two MyCMC plans which they have subsequently completed and took significantly longer (approximately 1 hour). The GP felt the weekly operational meetings were helpful to keep the team on track and updated and to iron out glitches. The GP also noted that as the nursing homes saw the benefit of the project to their resident staff became more enthusiastic, despite their issues with accessibility. The GP lead also noted the care home staff were very pleased to achieve such a high percentage of published CMC plans over the 5-week period.

**Ongoing sustainability**
Two of the three care homes (owned by ExcelCare) are working with the HIN to undertake the IT, IG and training requirements to obtain CMC log-ins. If achieved, this will allow the care home to incorporate creating a CMC plan as part of their six-week admission process and help maintain the percentage of patients with a CMC plan.

## Feedback from residents and relatives

A short online questionnaire was created and sent to relatives of residents at Limetree and Windmill Lodge via the care homes email address asking for their views and experience of being involved in a discussion regarding their relatives CMC plan. Unfortunately, no relatives responded to the questionnaire.

During the course of the project five relatives raised concerns regarding being contacted by a third-party organisation (Marie Curie) to discuss their relatives advance care plan and end of life wishes. Three concerns were raised with the care home and following a conversation with the care home manager no further action was taken. Two relatives' concerns were progressed to the GP and a follow-up call was arranged. Following a conversation with the GP, both relatives felt able to complete a CMC plan for their relative and no further action was required. Although the concerns raised by relatives were resolved during the project, it does reinforce the importance of early, clear and concise communications with relatives around advanced care planning and end of life care.

# Conclusion

The aim of this project was to work with key partners, including a charitable organisation to provide additional clinical capacity and rapidly increase the number of CMC plans created for residents in three nursing homes in the London Borough of Lambeth.

This was a short-term project, conducted at pace in the context of the COVID-19 pandemic. A total of 198 plans were created during the five-week operational period, of which 196 (99%) have been reviewed and published by the residents' GP. However, it must be noted the publication of plans took an additional five weeks due to GP workload and capacity.

The project provided a unique opportunity for multidisciplinary team (MDT) working. A relationship between the three nursing homes staff members, Marie Curie, the GPs and the commissioning managers quickly developed, and the operational team meetings provided an opportunity to feedback on issues and challenges allowing them to be discussed, and resolved, in a timely manner. This resulted in new ways of working, such as the Marie Curie nursing staff joining the care homes weekly MDT meeting at two of the homes.

A audit of seven plans, identified a lack of softer, personalised information which may have been the result of the project methodology. This project emphasised the importance of creating plans at pace by focusing on completing the minimum data set. For many of the Marie Curie staff this role was significantly different to their usual role. A bespoke training course upskilling staff in working remotely and having advance care planning discussions, as well as training on the information most valued by urgent and emergency services may have been beneficial to the staff involved in the project.

Care home staff know their residents and those close to them well which makes them well placed to contribute and create individual and personalised CMC plans. The care homes participating in this project demonstrated enthusiasm for innovation to improve the care they provide. Two of the homes are now working towards embedding CMC into their admissions process and undertaking the necessary set up and training requirements to gain log-in rights to CMC. If achieved, embedding CMC into the admissions process will create long-term sustainability.

The number of residents who were identified as benefiting from a CMC plan (237) may have been daunting if the care home staff or primary care staff were required to complete them. This model of rapid support from Marie Curie created capacity within the workforce and enabled a more manageable number of care plans to be created or updated in the future.

For CMC plans to reflect the wishes of residents, it is important to involve relatives and loved ones, particularly where residents lack capacity or require support in expressing their wishes and preferences. A small number of relatives raised concerns about being contacted 'out of the blue' by a third-party organisation and required additional reassurance from the care home or GP before participating. These concerns may not have arisen if a simple, clear communication had been sent to residents and their relatives ahead of the project starting.

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.

# Appendix 1

## A proposed model for increasing the number of CMC plans in care homes across SEL ICS

**Background**

Coordinate My Care is a digital urgent care plan which is available across London, it enables peoples wishes and preferences, and other useful information to be shared with urgent care staff.

There are 104 care homes for older people in South East London (SEL) with a bed capacity of 5500. In July 2020 there were an estimated 2987 CMC records for SEL care home residents, this is a significant increase from 580 in March 2020. There has been a significant drive to increase the number of plans created across SEL as a direct response to COVID19. Many of the individuals involved in creating records during the pandemic where seconded from their substantive post and have subsequently returned. Estimating from full bed occupancy, around 46% of residents in SEL care homes still do not have a CMC plan. The very high numbers of residents who would benefit from a CMC plan but do not have one is a significant challenge on clinical capacity.

Residents with a CMC are more likely to die in their preferred place of death resulting in their choices being respected at the end of life. An audit of 63 residents in SEL found that 92% of residents with a CMC record died in their preferred place of death. CMC can help avoid inappropriate hospital admissions and treatments, resulting in significant cost savings. The average cost of care in the last 6 months of life for nursing home residents are £4,223 more when the location of death is in hospital. (Ennis et al 2015). However, in 2018 in SEL 14.8% of deaths occurred in care homes compared with 22.5% in England. If 1% more care home residents in SEL died in their care home (rather than in hospital) this could equate to a saving of £63,000 per year

A project was completed with the Health Innovation Network(HIN) to test a model of Marie Curie nurses supporting CMC plan creation in three care homes in Lambeth. An investment of 24,000 was used for Marie Curie Nurses (700 hours of nursing time) to complete care plans over a 5-week period. 198 plans were created across the three care homes.
The purpose of this paper is to set out a proposed model to sustainably expand this work across south east London ICS using learning from the HIN project.

**Proposed Model**
This model would involve intensive short-term support to a specific number of care homes in order to rapidly increase the number of CMC plans, and begin to support the care home and local primary care with sustainability. The intensive support would then move on to another group of care homes.
Prior to starting

- Revise Marie Curie pathways so that CMC plans focus on areas of personalised care such as symptom management, communication and 'what matters to me' as well as mandatory fields. (This is recommended from learning from the HIN project)
- ICS identify care home groups around a PCN/individual GP practice with around 300 care home beds.

Model

| | |
|---|---|
| Week 1-2 | • Engagement with care home and primary care staff<br>• Ensure relevant primary care staff have a CMC logon<br>• Ensure understanding of referral and care plan sign off process<br>• Collate baseline data e.g number of residents with a CMC plan<br>• Develop sustainability plan – who is going to complete plans for new residents and update plans e.g support care home to become DSPT toolkit compliant or care home to support residents with MyCMC.<br>• Primary care start to identify residents for Marie Curie to complete CMC plans |

| | |
|---|---|
| | • Agree how care homes will communicate with Marie Curie, including appointment times and how the required information about residents will be shared.<br>• Communicate with residents and family members, outlining the project and the benefits of a CMC plan |
| Week 3-6 | • Primary care continue to identify residents for Marie Curie to complete CMC plans<br>• Marie Curie complete care plans<br>• Marie Curie complete some of the personalised care planning conversations and CMC plans with care home staff supporting them to learn and understand the process<br>• Primary care approve the care plans |
| Week 7 | • Review data – number of plans created<br>• Review learning to embed into next cycle (PDSA approach)<br>• Finalise sustainability actions with ICS support as required (this will likely go beyond week 7) |

The Marie Curie nurses would then move on to support another group of care homes. Dependant on number of Marie Curie nurses available two groups could run simultaneously.

**Costings**
The clinical costing for Marie Curie nurse time is likely to be around £24,000 per cycle on a presumption of 700 hours of time to support 300 beds at a time. This costing may reduce at the model is refined. If all care home bed were supported in this way, the estimated cost for SEL would be £440,000. Looking at data from the SEL care home data pack. If the number of deaths in care homes increased by 10% (147 deaths) this would equate to a saving of approximately £621,000.
Project management time would be required which has not been included in these costings

**Summary**
The Lambeth care home project successfully created 198 plans over a 5 week period. This model has taken that concept to explore how it can be scaled up across the STP