Edinburgh Health and Social Care Partnership

Anticipatory Care Planning Quality Improvement Journey Case Study

Date Completed	20.11.2022		
Locality	North West Edinburgh	**Service**	Re-ablement and End of Life Care
Test Period	January 2021 to November 2022		

Aim (overall goal for this project)

Improve personal and clinical outcomes for people referred to the NW Re-ablement & End of Life Care team through Anticipatory Care Planning, ensuring their care preferences are understood and communicated to responding health and social care professionals (including Scottish Ambulance Service/NHS 24/Out of Hours Service).

Test of Change idea

A quality improvement approach was implemented using PDSA (Plan, Do, Study, Act) to undertake a test of change methodology whereby the *Re-ablement and End of Life Care Team* would start to use an ACP Community bundle for Social Care Teams drafted in January 2021 to:

- have an ACP conversation with people referred to talking through the ACP information leaflet
- record information against the ACP quality criteria/discussion prompts
- share information (initially via the ACP Team for editing and checking purposes) with GP practice teams to update ACP-KIS
- print a copy of the updated KIS to keep with the homecare personal plan
- access the ACP-KIS to inform shared decision-making.

Objectives

- 6 members of the Re-ablement team and 4 members of the End of Life Care (EoLC) team were to follow the ACP bundle process, complete the 1-page *ACP-KIS Request Form to GP Practice* form and send to the Hub Co-ordinator
- Hub Co-ordinator would type up the 1-page *ACP-KIS Request Form to GP Practice* form and send to the ACP team to review, eventually completing the forms without the ACP Team needing to review these.
- The ACP team would sense check the form and send this to the GP Practice Clinical GP Mailbox practice.
- Hub Co-ordinator /ACP team would then check to see if the KIS is updated on TRAK.
- Hub Co-ordinator prints the updated KIS, make a note of this in the case notes, and give to the Social Care Worker to include in the individuals personal plan.

Prediction of what would happen when the test was carried out.

Essential care information would be shared across the system to inform shared decision making when a person's health fluctuates or deteriorates.	
Questions we would want answered during test of change	
• Would the Re-ablement and End of Life Care teams be able to implement the ACP process? • Would any improvement/changes be needed? • What information would be helpful to include in an ACP guide for social care (to be developed)?	
Tasks conducted to set up the tests of change including (including key milestones to promote and encourage scale and spread to wider Homecare teams)	
Activity	**Timeline**
Short Life Working Group established to adapt the *ACP Community Bundle for Health Care Teams* to and draft a version for Social Care Teams.	**July, August, October 2020**
➢ Shared draft ACP Community bundle for Social Care Teams with Hub Managers and Home Care Teams for potential testing	12 January 2021
Attend Home Care Coordinators Quality Improvement Forum Meeting to promote the ACP Community Bundle for Social Care Teams	**09 March 2021**
➢ Review ACP Community Bundle for tailoring testing bundle with the NW EoLC and Reablement Coordinator	02 March, 20 April 2021, July 2021 and January 2022
Present the ACP Community Bundle with the NW and SW Hub Managers Homecare Mainstream leads to discuss testing ACP Improvement handover from re-ablement to mainstream services	**05 May 2021**
➢ Investigate the Social Care team gaining access to the GP Clinical Mailbox email addresses with Eileen McGuire Service Manager Primary Care and Health Inequalities	07 June 2022
➢ Home Care Coordinator discusses ACP bundle and test with Homecare Team	
➢ Home Care Coordinator shares CHI number of case load prior to ACP conversation or before ACP-KIS Request form is shared with GP Practice	January 2021 – 18 June 2021
➢ Social Care Workers/Homecare Coordinator follows ACP process with existing/referred clients with support from ACP Team	
▪ NW Home care and Re-ablement team members start to have ACP conversations	January 2021 to present
▪ Homecare coordinator completes and sends ACP forms to ACP team	From 19 June 2021
▪ ACP Team reviews and edits completed ACP-KIS Request form shared by HCC and send to GP Practice Clinical Mailbox	28 January 2021 to 18 June 2021
▪ Home Care Coordinator completes and sends ACP forms to GP Practice directly	From 19 June 2021
▪ ACP Team checks to see if caseload has an existing KIS and follows up to check that has been updated	28 January 2021 to 18 June 2021

▪ Homecare Coordinator checks to see if caseload have an existing KIS and follows up to check that has been updated	From 10 May 2021
▪ ACP teams reviews KIS meeting the quality criteria	28 January 2021 to present
➢ Hub Co-ordinator prints off updated ACP-KIS, notes on case note, and includes in personal plan for each person accessing service.	From 28 January 2021
➢ 3 Learning cycle meetings held to review implementation of the test of change, and 4 Checks ins to monitor ACP Improvement work as this moved into Business as Usual.	February & July 2021; January, March, June and August 2022
LTC Programme delivers ACP training to mainstream North West and South West Home Care Coordinators providing recording of training as a source of reference for team.	**21 July 2021**
NW Homecare Coordinator shares their ACP Improvement Journey with mainstream (long term care) Home Care Coordinators invited from across the partnership at the Edinburgh ACP Stakeholder meeting to explore potential uptake across other Homecare locality teams.	**28 June 2022**

STUDY

Would the Re-ablement and End of Life Care teams be able to implement the ACP process?

The Home Care Coordinator demonstrated the teams understanding of the ACP Improvement implementation process by describing the steps they followed:

Social Care workers (SCW's) have a conversation with the service user (SU) to ask if they are in agreement to sharing information for their KIS, SCW's explain the content of the ACP leaflet and why the information is required, SCW's provides the SU with ACP leaflet for their reference. SCW's use the form available to update any changes to the person's circumstances, SCW's returns the form to the Home Care Coordinator (HCC) who will fill in KIS update and send to GP for this to be updated. **NW Re-ablement and End of Life Care Coordinator**

Social Care Workers are given allocated time to have the conversations to gather information and sometimes this involves a family member/carer. **NW Re-ablement and End of Life Care Coordinator**

The process is not at all time consuming as you can just copy and paste most of the information, so I can raise this at the next homecare managers meeting for anyone who would like help and to show how easy it is to do. **NW Re-ablement and End of Life Care Coordinator**

There was also positive feedback on the teams' experiences of having the ACP conversations throughout the test of change learning cycles in the use / implementation of the ACP Community Bundle for Social Care Teams.

This has been working well within the team and the Social Care Workers are enjoying having these conversations with Service Users. Social Care Workers feel this [ACP Improvement Process] is essential to ensure the Service User [person] is receiving the correct care to meet their needs.
NW Re-ablement and End of Life Care Coordinator

Post ACP conversation, evidence of the process being implemented to record; share; and upload agreed care and treatment preferences that are captured through ACP Conversations is evidenced by the number of completed *ACP-KIS Request to GP Form* sent to GP practices resulting in either through creation of a new KIS or an existing KIS being updated by GP Practice Teams.

Table 1: NW Re-ablement and End of Life Care Team learning cycle ACP Improvement Measure.

	Learning Cycle and Business AS Usual Review				
	1	2	3	BAU	Total
Number of people on teams' caseload (baseline)	13	3	1	7	24
Number of people referred to the teams during test/BAU period	13	3	1	7	24
Number of people with an existing ACP-KIS	10				14
Unknown status of original KIS prior to ACP conversation	2	2	0	4	8
Number of people with an ACP-KIS including up-to-date quality criteria	See Figure 1 for baseline and improvements				
Number of people supported to have an ACP conversation	8	3	1	7	24
Number of ACP-KIS forms sent to ACP team/GP practices	8	3	1	7	23
Number of existing ACP-KISs updated	7	2	1	7	13
Number of New KIS created	1	2	0	1	4
Number updated where unclear if person had a KIS prior to ACP conversation	2	2	0	4	8
Number of ACP-KISs printed, noted on case note, and kept in homecare personal plan	7	2	1		22

This test of change started in the height of the Covid-19 pandemic and as a result the Re-ablement and End of Life Care Team experienced a number of challenges impacting on the service provided:

- private home care provider review
- EHSCP mainstream homecare services temporarily taking on caseloads from the private homecare contractors
- Reablement service was put on hold so the team could support mainstream homecare provision
- End of Life Team had a waiting list building up
- staffing issues
- service block leading to people not being discharged to home,

and is reflected in the number of ACP conversations taking place during the latter learning cycles and business as usual figures in **Table 1** above.

Everything is going well with ACP although the service has been blocked for a while, so no ACP conversations have taken place during March – June 2022.
NW Re-ablement and End of Life Care Coordinator

Feedback from GP practices acting on the shared information by uploading this to the patients KIS was positive when responding to the added value of the KIS quality Criteria captured by Social Care Teams. This has prompted one GP practice to share with their team in the South West on how the process could work for them and helped our team to think about refining the *ACP-KIS GP Request Form* and prompts.

Information about next of kin and power of attorney details if any is very useful. How often carers go in is useful but in the KIS we don't need to know the band or how long they go in for. What level of support though is good to know like you have put medication prompts, help washing and dressing, making their breakfast etc... The other main things we put in a KIS which is helpful for out of hours and A+E is main health conditions and current care plans, and patient wishes.

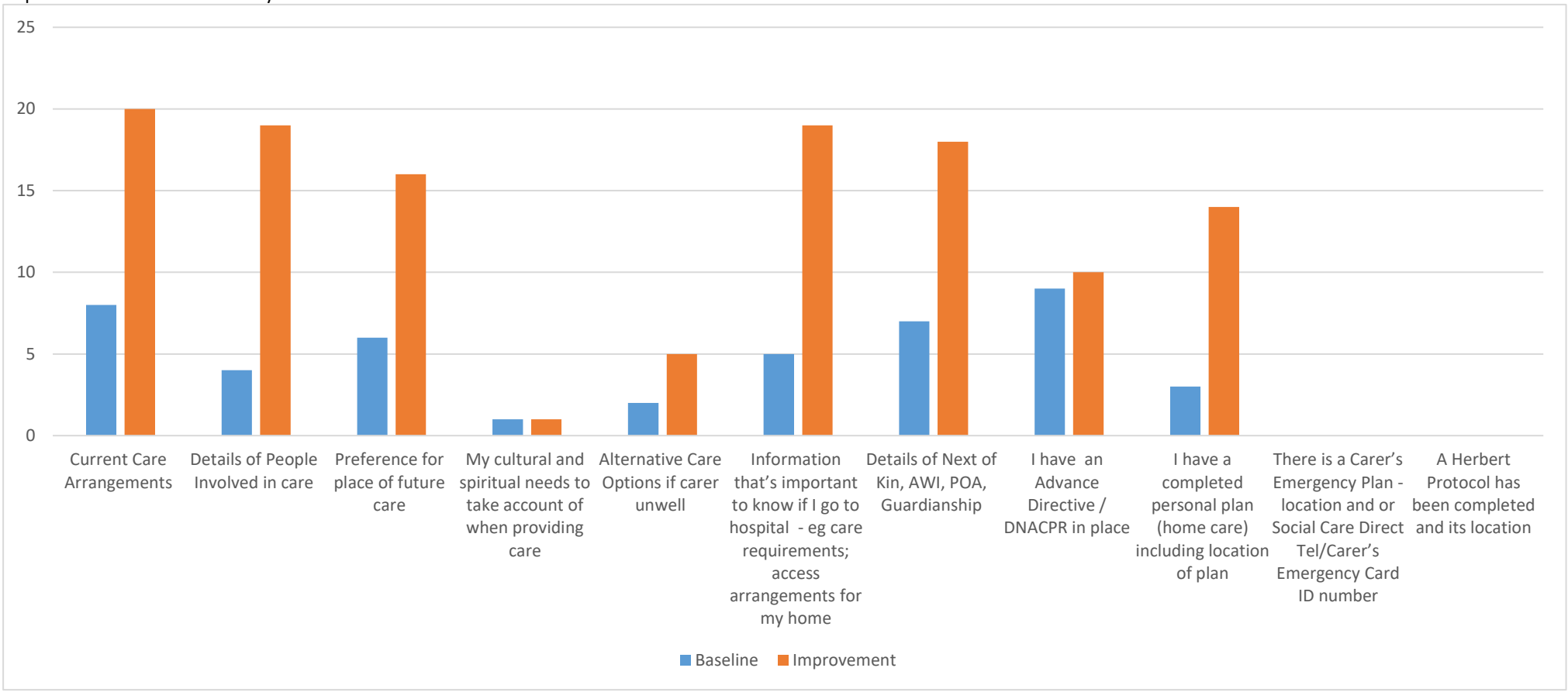
GP, Kirkliston Medical Practice

It was really useful, thanks for your help.

GP, Whinpark Medical Practice

Despite these challenges **Figure 1** below illustrates a noted improvement in the capturing of peoples ACP-KIS preferences with an increase in 8 out of the 11 Key quality criteria such as details of NOK/POA etc, location of personal care plans, current care arrangements and preference for future care and treatment.

Figure 1: Comparison of KIS Quality Criteria recorded in the KIS of 24 people receiving support from the North West Re-ablement & End of Life Care Team at Baseline and following ACP Improvements between January 2021 - November 2022.



Are any improvements needed?

Throughout each learning cycle together we were able to gain a better understanding of the systems the teams had access to and therefore any improvements we would need to make for the ACP Bundle for Social Care Teams work for re-ablement, end of life and potentially homecare teams in practice.

"Going forward when a client is first referred organisers in the office print off the leaflet and blank ACP KIS request form to put it in the personal plans. Social care workers can then have ACP conversations at the same time as the personal care plan review (so not having to go back to have an ACP conversation like they did this time round with existing clients). Social care workers will fill in ACP forms at the same time as completing the personal care plans, so it works well doing it at the same time/fits in well with existing process".

NW Re-ablement and End of Life Care Coordinator

- Having a clear understanding of how the Re-ablement and End of Life Care team works during the learning cycles we were able to adapt/improve the draft *ACP Process Pathway for creating and updating an ACP-KIS* to better reflect the needs of this homecare Team.

- Improvements were made to the *Template Text Email to GP Practices* to include a prompt reminder for GP Practice teams to ensure the Consent Status Summary for VISION IT system users is checked to enable the KIS is shareable through TRAK. Omission of this was often found by the ACP team to stall timely upload of new information onto a person's KIS. Evidence of agreed care and treatment preferences has an impact on decision in cases of acute clinical deterioration and potential avoidance of hospital admission.

- To facilitate the Re-ablement and End of Life Care teams desire to move towards *Business as Usual* we were able to gain permissions from the Service Manager for Primary Care and Health Inequalities to give them access to the *Clinical GP Email addresses*. Thus, allowing safe transmission of the *ACP-KIS Request to GP Forms* (containing patient information) between @edinburgh.gov.uk and @nhslothian.scot.nhs.uk directly to the relevant GP Practices, and removing ACP from this process. This would help streamline the process for the NW re-ablement and End of Life Care team and reduce any delays in editing and sending on the completed documents.

- Thinking about the short timeframe that individuals are on a case load the Home Care Coordinator considered what steps could be explored next as part of the ACP Improvement for when a person moves into the mainstream homecare service to receive longer term support as part of scale and spread as well as expanding to private homecare / care at home providers.

We haven't had many new clients and our caseloads are with us for a short time so it would be helpful to test handover to other providers providing more longer-term support… Perhaps explore again getting the mainstream service leads on board to help capture the journey of caseloads following handover from re-ablement.

NW Re-ablement and End of Life Care Coordinator

What information would be helpful to include in an ACP guide for social care (to be developed)?

Question not answered not sure what to put here Anna?

Impact of KIS updates on avoidance of hospital admission outcomes

- 3 are now under the care of a nursing home and KIS has since been updated.
- 1 was discharged to Hospital@Home.
- 1 was referred to Hospital to Home after a long hospital stay.
- 15 out of the 24 caseloads are now deceased.

Of the 15 that had passed away, 11 (73%) had died in their preferred place (e.g., home or hospice)

- 1 death at hospital followed admission after a collapse and laceration to scalp.
- 1 death followed an admission due to worsening mobility and unable to cope despite a new package of care put in place 3 days prior to readmissions. This individual was discharged to Ward 456 at the WGH with their symptoms being managed by the palliative care team. It was stated in the notes on TRAK the patient disliked being in hospital and that they would prefer to be kept comfortable at home if they became increasingly frail and in and out of hospital regularly. Patient died comfortable on Ward 456 WGH.

His wish was to try discharge home, but unfortunately this has proven not to be successful and subsequent to this discharge summary he has been re admitted **Consultant Physician, WGH**

- 1 person possibly died in hospital the notes on TRAK were unclear to specify exact place of death. Their KIS stated they were for escalation of care and CPR.A request to update the ACP-KIS was sent to GP practice approximately 11 days prior to death, but not attached to the email and person died before an update was possible.

	Preferred Place of care (including end of life) stated	**Actual**
Home	**14 (**Care & treatment or end of life)	**9**
Hospice (or community palliative care)	**2** (if end of life)	**3**
Hospital (if reversible)	**1**	**2**
Not stated	**1**	**1**

At the end of the third learning cycle the NW Re-ablement and End of Life Team moved to a Business-as-Usual removing much of the ACP teams input and thus freeing up capacity within the team to look at the impact of the updated KIS. During June 2022 we looked at the outcome of hospital admissions for two individuals that had received support from the Re-ablement and End of Life Care Team.

Figure 2: Edinburgh: Increase in the number of Key Information Summaries (KISs) pre and post Covid-19 guidance dissemination to GP practices (Jan 2020-Oct 2022)