EOLC CN – EARLY Identification and Personalised Care Planning

NHS
London
Clinical Networks

| Introduction | 5 Step Approach | Identification | Clinical Validation | Personalised Care & Support Planning | Sharing Information (CMC) | Revisiting & Reviewing | Health Inequalities |

End of Life Care Clinical Network

NHS England and Improvement (London Region)

EARLY Identification and Personalised Care Planning Toolkit

The purpose of this toolkit is to support colleagues in Primary Care settings in the early identification of people who may be in their last year of life and benefit from an opportunity to discuss a personalised care plan (PCP) which is shared on Coordinate My Care (CMC)

Introduction	5 Step Approach	Identification	Clinical Validation	Personalised Care & Support Planning	Sharing Information (CMC)	Revisiting & Reviewing	Health Inequalities

INTRODUCTION

This toolkit has been developed to support Primary Care to identify and, where appropriate, offer an opportunity to discuss and develop a personalised care plan with those who are likely to be in the last year of life and supports the documentation of the personalised care plan on Coordinate My Care.
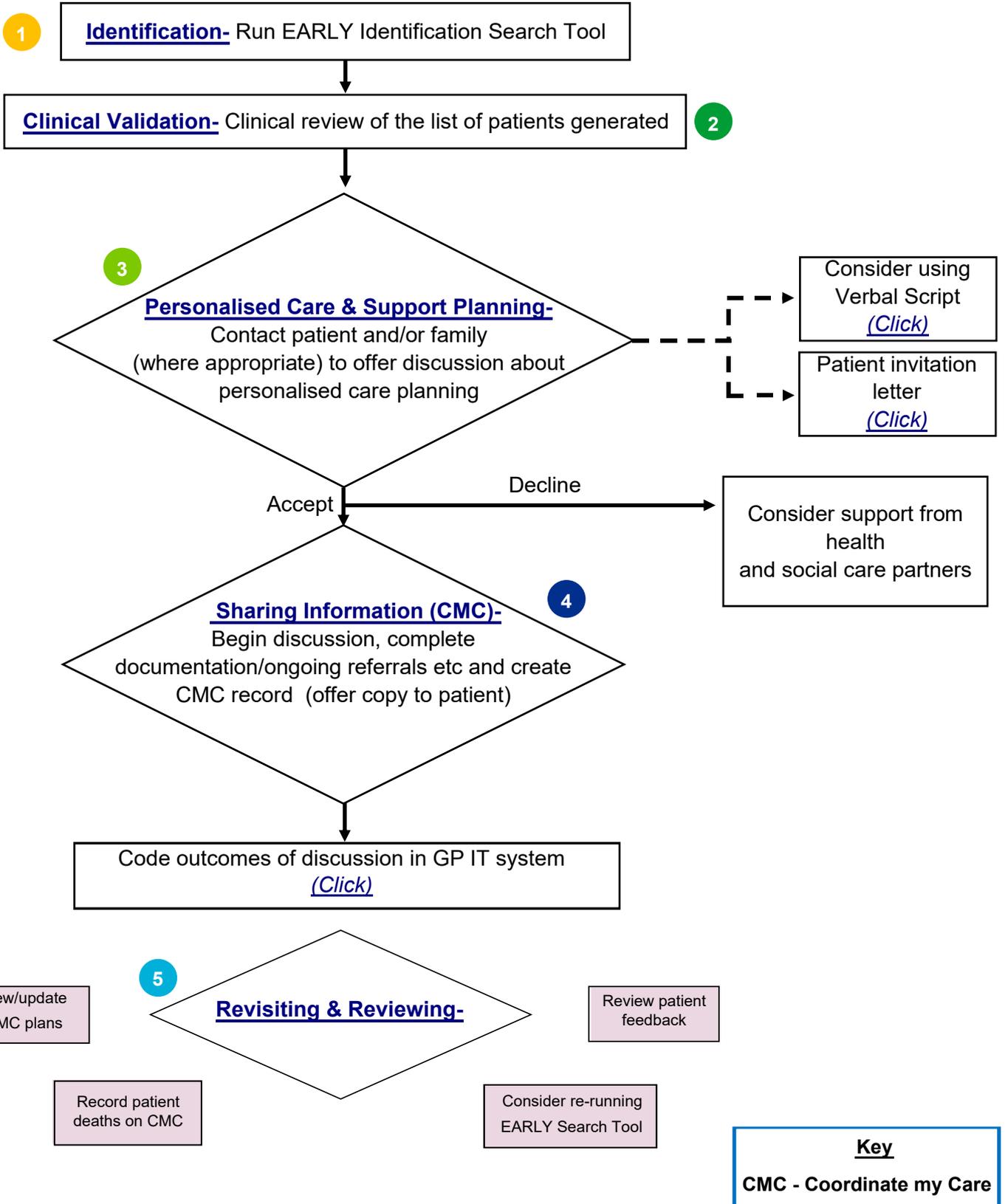
A new Search Tool (EARLY) has been developed within GP electronic patient records to help identify people who are likely to be in their last year of life. It searches Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) codes based on a range of prognostic indicator guidance including the Gold Standard Framework Proactive Identification Guidance (GSF PIG) and the Supportive and Palliative Care Indicators Tool (SPICT) resources, and following extensive clinical development.

The EARLY search tool and toolkit were developed collaboratively by the Greater Manchester and Eastern Cheshire and the North West Coast Clinical Network, the Newham CCG EOLC Clinical lead and Midlands and Lancashire Commissioning Support Unit and from the learning and outcomes of the NHSE/I London EOLC CN 6 month pilot project supporting 3 Newham GP Practices.

Currently, the tool runs on EMIS, SystmOne and Vision web GP IT system.

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1 **Identification-** Run EARLY Identification Search Tool

Clinical Validation- Clinical review of the list of patients generated **2**

3 **Personalised Care & Support Planning-**
Contact patient and/or family
(where appropriate) to offer discussion about
personalised care planning

Consider using Verbal Script *(Click)*

Patient invitation letter *(Click)*

Accept — Decline → Consider support from health and social care partners

Sharing Information (CMC)- **4**
Begin discussion, complete
documentation/ongoing referrals etc and create
CMC record (offer copy to patient)

Code outcomes of discussion in GP IT system
(Click)

5 **Revisiting & Reviewing-**

Review/update of CMC plans

Review patient feedback

Record patient deaths on CMC

Consider re-running EARLY Search Tool

Key
CMC - Coordinate my Care

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IDENTIFICATION

It is important to identify and support people with advanced progressive illness who might die within the next twelve months. Early identification will support them to have well-planned and coordinated care that is responsive to the patient's changing needs with the aim of improving the experience of care

Follow this link of how to access the EARLY search tool in VISION Plus Accessing Practice Reports (visionhealth.co.uk)

Follow this link for the EARLY search tool and instructions on how to run the search tool in EMIS and SystmOne web

EARLY is an acronym for:

E - **Early** identification

A - **Advance** care planning

R - **Record**

L - **Look** again

Y - **You** can continually improve

VIDEO - Why identification of patients nearing the end of life is important

EARLY– An Introduction to a clinical search tool for early identification

Please use this email to share any thoughts or ideas on potential future version updates of the EARLY tool. England.EARLY@nhs.net

In order to ensure that you are using the correct version please do not adapt or amend the tool yourself.
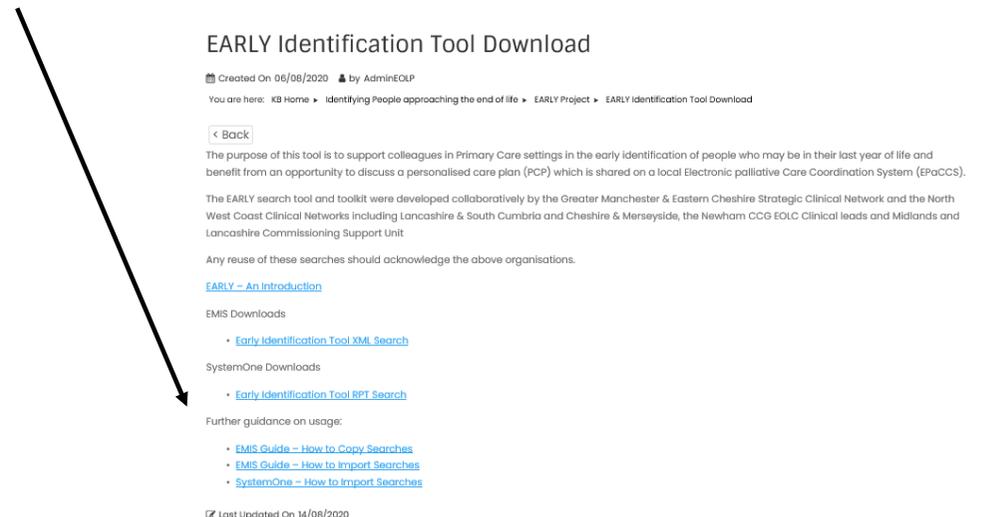
EARLY Identification Tool Download

📅 Created On 06/08/2020 👤 by AdminEOLP

You are here: KB Home ▸ Identifying People approaching the end of life ▸ EARLY Project ▸ EARLY Identification Tool Download

‹ Back

The purpose of this tool is to support colleagues in Primary Care settings in the early identification of people who may be in their last year of life and benefit from an opportunity to discuss a personalised care plan (PCP) which is shared on a local Electronic palliative Care Coordination System (EPaCCS).

The EARLY search tool and toolkit were developed collaboratively by the Greater Manchester & Eastern Cheshire Strategic Clinical Network and the North West Coast Clinical Networks including Lancashire & South Cumbria and Cheshire & Merseyside, the Newham CCG EOLC Clinical leads and Midlands and Lancashire Commissioning Support Unit

Any reuse of these searches should acknowledge the above organisations.

EARLY – An Introduction

EMIS Downloads

• Early Identification Tool XML Search

SystemOne Downloads

• Early Identification Tool RPT Search

Further guidance on usage:

• EMIS Guide – How to Copy Searches
• EMIS Guide – How to Import Searches
• SystemOne – How to Import Searches

✏ Last Updated On 14/08/2020

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CLINICAL VALIDATION

Once the EARLY tool has been run and a list of patients generated, the list requires validation by a clinician to ensure that each patient is appropriate for a personalised care and support planning discussion. Below are some factors that may help decide whether each patient would benefit from this process:

- Frequent attendance at GP Surgery

- Does this patient already have a personalised care plan? If yes, has the pre-existing care plan been reviewed within the last 3 months and is it on CMC?

- Has the patient had 3 or more admissions into hospital in the last 6 months?

- Has the patient had 3 or more encounters with emergency and out of hours services?

- Does the patient have pre-existing long term condition(s) which means that s/he is likely to deteriorate?

- Is this patient's primary residence at a care home for older people?

- Has the person been identified as frail?

- Is the person known to palliative care or end of life services?

- Has the person had recurrent falls?

- Does the patient have cancer which is stable or in remission?

- Is this patient on a transplant wait list or post-transplant and stable?

- Would I be surprised if this patient would die in the next year?

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PERSONALISED CARE & SUPPORT PLANNING

There are many different approaches to care planning and conversations around end of life can be challenging. Open and sympathetic communication with patients and those important to them enables care wishes to be expressed. It is important that people do not feel pressurised in to such conversations and decisions before they are ready. It is an opportunity to discuss the patient's current conditions and future care, wishes and preferences and a plan of care for emergency situations including, if appropriate, cardiopulmonary resuscitation (CPR).

Patient Resources
MyCMC Patient Portal
Dying matters 'Preferred priorities of care'
Macmillan
Marie Curie
Cancer Research (UK)
AgeUK
Alzheimer's Society
NHSE

Professional Resources
REDMAP Framework for compassionate conversations - EC4H- Scotland's NHS communication training programme
Blank CMC template
SPICT app for Iphone and Android
Dying matters - guide to decisions on CPR
Macmillan Top 10 tips on Advance Care Planning
E-Paige Cheshire: A resource library for Electronic Proactive Assessment and Information Guide for End of Life
RCGP End of Life Care Quality Improvement Resource
NHSE/I GP Education - Advance care planning video

	Personalised Care & Support Planning	Click to go back

SCRIPT TO SUPPORT GP PRACTICE STAFF WITH TELEPHONE INVITATION TO PATIENTS IDENTIFIED USING THE EARLY SEARCH TOOL

1. Hello, I am [your name] calling you from [the GP practice name]. 'Please may I speak with [patient name]?' If Yes go to 3

2. If No:
- Try to establish why it isn't possible to speak to the patient (lack of capacity, non – English speaker etc)
- Continue conversation with patients' nominated representative or arrange another time

3. I am inviting you to make an appointment to create a personalised care plan

   This would be an opportunity to discuss your current conditions and future care, your wishes and preferences and a plan

   of care for emergency situations.

   Please may I book you an appointment? If No go to 5

4. If Yes:
- Book appointment with appropriate GP practice colleague
- Do you require an interpreter ?
- Would it be helpful for us to send you some information about the appointment?
- Please be advised you can bring anyone you wish to the appointment to support you

5. If No:
- Please may I ask the reasons why you have refused?
- Could I send you further information about this opportunity?

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PRACTICE LETTER TO INVITE PATIENTS FOR PERSONALISED CARE PLANNING

Insert GP practice details

Insert date

Dear *Insert patient name,*
You have been identified from our records as someone who is eligible to make a Coordinate My Care (CMC) urgent care plan. I am writing to invite you to make an appointment to discuss your wishes and your concerns.

This appointment will include discussion of the following, with a healthcare professional:
- Your condition(s) and future care
- Your wishes and preferences
- Plan of care in an emergency situation

A patient leaflet with more information on Coordinate My Care is included.

If you would like, you can develop your care plan using My CMC (https://www.coordinatemycare.co.uk/mycmc/) or by completing the CMC template included with this letter.

You can find more information about CMC urgent care plans via: http://coordinatemycare.co.uk/patients-carers/

You are welcome to bring family member(s) or carer(s) to the appointment.
Yours sincerely,
Insert Name

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SHARING INFORMATION (CMC)

Creation of a CMC plan enables urgent care staff to view a patient's wishes, clinical recommendations and other important information.

Resources for Patients
CMC patient leaflet
Blank CMC template
Resources for Professionals
Getting a CMC log on
NHSE/I GP Education- Capacity and information
CMC training
Dr Williams Brent CCG Loom Video's
Part 1: What is CMC and How to Log In (5 minutes)
Part 2: How to create a quick CMC care plan (9 minutes)
Part 3: Top Tips for using CMC (5 minutes)

CMC Contact Details:
Email - coordinatemycare@nhs.net   **Telephone -** 02078118513

EOLC CN – EARLY Identification and Personalised Care Planning

Sharing Information (CMC)	Click to go back

POTENTIAL SNOMED CODES THAT CAN BE USED TO DOCUMENT PERSONALISED CARE AND SUPPORT PLANNING

There is no specific preferred codes for GP IT systems to document a personalised support care plan or CMC care plan .

The below are options of SNOMED codes you may wish to use following discussion with your local system .

Task	SNOMED Description	SNOMED Code
To document completion of Personalised Care Planning	Has anticipatory care plan	792871000000101
	Advance care planning	713603004
To document creation of a CMC plan	Coordinated support plan	376531000000105
For people with Dementia	Dementia advance care plan	1095121000000102

Task	SNOMED Description	SNOMED Code
Consider if appropriate to add patient to end of life care register	On end of life care register	526631000000108

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REVISITING & REVIEWING

It is important that care plans remain relevant and up to date to support patient's preferences and wishes. Monthly or quarterly Palliative and supportive care meetings are a good opportunity to revisit and review a patient's care plan.

- Top tips guide   Click here for-EARLY TOP TIPS   Click here for– EARLY TOP TIPS Additional Information

- VIDEO (RCGP) - How to undertake a retrospective death audit and interpret an initial baseline audit

- CMC Reviewing, Updating and Recording Death

- 3-6 month re-running of the EARLY search tool

- Collating and reviewing patient feedback

Revisiting & Reviewing	Click to go back to

SUGGESTED QUESTIONS FOR PATIENT FEEDBACK QUESTIONANAIRE

1. How did you feel about being contacted by your GP Practice to talk about your care plan?

2. How helpful did you find discussing your care plan (1= not helpful to 10= very helpful)

3. Were you and/or family member involved as much as you would like to be in decision about your future care and treatment when you saw your GP today (or appointment day)

4. Has having this discussion about where you want to receive your future care changed your thoughts?

5. Do you think your wishes, cultural, humane and religious needs have been adequately covered in these discussions?

6. Did you receive a copy of your care plan?

7. Is there anything that you feel that could have been done better?

8. Any other comments and suggestions (you think would be useful for improving the service):

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HEALTH INEQUALITIES

Everyone deserves high quality and compassionate care that meets their individual needs and responds to their wishes and choices in the last years, months and days of life. In order to address inequity, it is not enough to improve quality of care for the majority. Those living with health inequalities have unique needs and considerations which must be identified and addressed during personalised care planning. Below are some key resources.

Learning Disabilities	Homelessness	Other
NHSE- RADiANT ACP guide for people with intellectual disability	Pathways & The Faculty for Homeless and Inclusion Health: Palliative Care	NHSE- dementia ACP guide
Dying matters- EOLC for adults with LD	Homelessness and Inclusion Health Standards for commissioners and service providers: Palliative Care	Public Health England- Faith at end of life
NHSI- Achieving quality EOLC for people with LD		Care Committed to Me—Improving End of Life Care for Gypsies and Travellers, LGBT people and people experiencing homelessness
Macmillan- Easy Read Booklets for people with LD	Healthy London Partnership's- Homeless Health	
Palliative care for people with LD	LHF- Atlas of London homelessness services	
NHSE- Nottinghamshire and Sherwood Forest Hospitals NHSFT Resource Pack		
NHSE/I- London community LD services		
Mencap- Hospital Passport		