Coordinate My Care (CMC)

CMC is a clinical service delivering **digital multi-disciplinary urgent care planning** focused on coordinating urgent care around a patient’s preferences and clinical needs. The service is underpinned by:

- A robust clinical and system training model;
- A clinical and information governance framework;
- A strong reporting offering; and
- An intuitive and highly interoperable IT platform.

CMC is committed to the creation and maintenance of ‘one version of the truth’ by a patient’s multidisciplinary care team ensuring that urgent care services view live and accurate information.
Key principles

One standard up-to-date multi-disciplinary digital urgent care plan per patient

1. **One...**
   Urgent care services want ‘one version’ of the truth

2. **Up-to-date...**
   Urgent care services do not want to worry about out-of-date information

3. **Standard...**
   Urgent care services want to see consistent structured identical plans

4. **Multi-disciplinary...**
   Urgent care services want to see information from a patient’s whole care team

5. **Digital...**
   Urgent care services want quick and easy access to the plan
Current CMC offering – Urgent Care
Open, secure and collaborative

Urgent care plans must be shared across and used by health and social care organisations in a clinically safe and secure way.

Information Governance – protocols to ensure that information is shared in a controlled and safe way.

<table>
<thead>
<tr>
<th>Employing Organisation</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suitable current HSCIC IG Toolkit attainment</td>
<td>I have completed appropriate IG training (usually online)</td>
</tr>
<tr>
<td>Signed Information Sharing Agreement</td>
<td>I have attended CMC training</td>
</tr>
<tr>
<td>Manager has signed authorisation and I am an authorised user</td>
<td>I have signed and returned CMC Acceptable Use Policy</td>
</tr>
</tbody>
</table>

CMC access is granted
One standard urgent care plan per patient

Non-Urgent Care: data aggregated for interpretation by clinician

- Acute Hospital
- Social Care
- GP
- Hospice
- Community Teams

**AGGREGATION** model

Non-Urgent Care Clinician has time, & patient knowledge, to interpret/benefit from a collection of diverse and potentially contradictory information.

Urgent Care: single version of relevant data only

- Acute Hospital
- Social Care
- GP
- Hospice
- Community Teams

**Intelligent interpretation algorithms**

**CMC/Crisis Care Extract**

**Data flow with or without Subsetting**

**Urgent Care Centre**

**Ambulance**

**A&E**

**Out of Hours GP Provider**

111 Provider

**INTERPRETATION** and **STANDARDISATION** model

Urgent Care Clinician requires a standardised, high quality action plan without superfluous or duplicated information.
A service rather than an IT system

_Urgent care planning requires more than an IT system it requires a change management offering that can embed sustainable change_

- **Clinical quality** – clinically led design, active clinical governance & continuous improvement
- **Clinical training** - patient consent, mental capacity act, advance care planning, communicating CPR decisions etc.
- **System training** – eLearning site covering key system actions e.g. urgent care plan creation
- **Reporting & Audit** – granular activity and KPI reporting from the regional and organisational to the patient level driving research, benefit tracking and uptake of the service
Create Urgent Care Plan

Action Needed

<table>
<thead>
<tr>
<th>Patient</th>
<th>Last Modified</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Smith</td>
<td>4 March 2015</td>
<td>APPROVAL</td>
</tr>
<tr>
<td></td>
<td>9:13 AM</td>
<td></td>
</tr>
<tr>
<td>Jane Davis</td>
<td>1 March 2015</td>
<td>REVIEW</td>
</tr>
<tr>
<td></td>
<td>12:14 PM</td>
<td></td>
</tr>
<tr>
<td>Claudia Morris</td>
<td>24 February 2015</td>
<td>REVIEW</td>
</tr>
<tr>
<td></td>
<td>10:34 AM</td>
<td></td>
</tr>
</tbody>
</table>

13 more

My Patients

<table>
<thead>
<tr>
<th>Patient</th>
<th>Last Modified</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evelyn Morris</td>
<td>28 March 2015</td>
<td>DRAFT</td>
</tr>
<tr>
<td></td>
<td>7:13 AM</td>
<td></td>
</tr>
<tr>
<td>Bob Taftman</td>
<td>24 March 2015</td>
<td>PUBLISHED</td>
</tr>
<tr>
<td></td>
<td>12:13 PM</td>
<td></td>
</tr>
<tr>
<td>Judy Hartfield</td>
<td>21 March 2015</td>
<td>PUBLISHED</td>
</tr>
<tr>
<td></td>
<td>6:27 PM</td>
<td></td>
</tr>
<tr>
<td>Ernie Jones</td>
<td>18 March 2015</td>
<td>DRAFT</td>
</tr>
<tr>
<td></td>
<td>3:02 PM</td>
<td></td>
</tr>
<tr>
<td>Jane Everett</td>
<td>11 March 2015</td>
<td>DRAFT</td>
</tr>
<tr>
<td></td>
<td>9:13 AM</td>
<td></td>
</tr>
</tbody>
</table>

8 more

Summary

65 active plans
13 draft plans
11 plans waiting for approval
5 plans waiting for review

News

CMC Data Centre Move
Date: 18 March 2015

Cras velit neque, interdum eget mattis congue, rutrum sit amet leo. Nulla porta ante id ex venenatis, a ullamcorper ligula vestibulum.
John Smith
DOB: 4 March 1930
Gender: Male
Age: 85

Alerts

<table>
<thead>
<tr>
<th>Alert</th>
<th>Correct as of</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dangerous dog at home</td>
<td>12 April 2014</td>
<td></td>
</tr>
<tr>
<td>Self harm to patient</td>
<td>13 January 2013</td>
<td>Vestibulum consectetur nibh</td>
</tr>
<tr>
<td>Deafness</td>
<td>13 April 2012</td>
<td>Pellentesque nec aliquam nunc</td>
</tr>
</tbody>
</table>

CPR Status: Do Not Attempt

DNA CPR Location
- Drawer in kitchen table

Home Access

Living Condition: Lives Alone
Type of Accommodation: House
Key Code Details: Please contact Sue at 1555 855555
Other Access Information: Lorem ipsum dolor sit amet consectetur adipiscing elit; proin gravida sit et justo commodo, viverra pellentesque.

Diagnoses

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Onset Date</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia</td>
<td>12 March 2014</td>
<td>Slow progression</td>
</tr>
<tr>
<td>Cancer</td>
<td>13 February 2012</td>
<td></td>
</tr>
</tbody>
</table>

Treatment Intent: Curative
Ceiling of Intervention: Full management including ITU
WtO Performance: In Bed | 13 April 2012
EMIS roll-out

![EMIS Roll-Out Graph]

- Created: 1 Apr 2016 to 30 Jun 2016

Data: Data as at 30 June 2016

Data: 1 Apr 2016 to 30 Jun 2016
Urgent care services have access to patients’ care plans 24/7

Data as at 30 June 2016

Data: 1 Apr 2016 to 30 Jun 2016
Where patients had a CMC plan, 80% died outside of hospital, 20% died in hospital.

<table>
<thead>
<tr>
<th>Location</th>
<th>England</th>
<th>CMC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>48%</td>
<td>20%</td>
</tr>
<tr>
<td>Home</td>
<td>23%</td>
<td>38%</td>
</tr>
<tr>
<td>Care Home</td>
<td>23%</td>
<td>25%</td>
</tr>
<tr>
<td>Hospice</td>
<td>5%</td>
<td>17%</td>
</tr>
</tbody>
</table>

¹ 1 Apr 2016 to 30 Jun 2016
² NEOLCIN, 2014-2015
77% of CMC patients have died in their preferred place.
### Notes (Please ignore Item 13)

1. Place Preferences very strong. Prognosis question is very well reported. Reasons to celebrate here.
2. Little communication of the ‘soft’ wishes/awareness of patient & family. Some brief notes would help Urgent Care to respond.
3. Very strong on CPR decision and Ceiling of treatment communication. Little communication of Symptom Control plans. Vital for Urgent Care
4. Less than a third of the care plans had a contact number for the Hospice Team> Even less had a family member/main supporter.
5. Very high numbers of care plans were published or republished within the last 120 days
Areas of **strength** and **weakness** – some easy to turnaround

<table>
<thead>
<tr>
<th>Preferences &amp; Prognosis</th>
<th>General wishes/ awareness/spiritual</th>
<th>Advance Treatment Plan</th>
<th>Contacts &amp; Published Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - PPC</td>
<td>5 - Patient Wishes</td>
<td>8 - CPR Decision</td>
<td>11 - Personal Contacts</td>
</tr>
<tr>
<td>2 - PPD</td>
<td>6 - Family Awareness</td>
<td>9 - Ceiling of Treatment</td>
<td>12 – Contacts – Professional</td>
</tr>
<tr>
<td>3 – Prognosis</td>
<td>7 - Cultural/ Religious</td>
<td>10 - Symptom Treatment Plans</td>
<td>13 – Contacts - Professional Mobile</td>
</tr>
<tr>
<td>4 – Surprise Question</td>
<td></td>
<td></td>
<td>14 - Approval Gap</td>
</tr>
</tbody>
</table>

Notes (Please ignore Item 13)
1. Place Preferences very strong. Prognosis question is very well reported. Reasons to celebrate here.
2. Little communication of the ‘soft’ wishes/awareness of patient & family. Some brief notes would help Urgent Care to respond.
3. Very strong on CPR decision and Ceiling of treatment communication. Little communication of Symptom Control plans. Vital for Urgent Care
4. Less than a third of the care plans had a contact number for the Hospice Team> Even less had a family member/main supporter.
5. Very high numbers of care plans were published or republished within the last 120 days
Diagnosis

Classified diagnoses:
Cancer 43.8%,
Non-Cancer 56.2%
Hospice teams create the majority of CMC care plans.

Data as at 30 June 2016

Record creation

- Hospice, 2616: 35%
- General Practice, 2227: 30%
- Acute Trust, 1931: 26%
- Community Trust, 702: 9%
NHS 111 Learning programme showed patients with a CMC plan are 50% less likely to need an ambulance and 80% less likely to be referred to an ED.
On average £2,100 saving per patient with a CMC plan by reducing emergency admissions and hospital transfer costs

Source: Frontier Economics Evaluation Report

Data as at 30 June 2016
Patient preferences

- 77% of patients with a CMC care plan die in their preferred place
- 80% die outside of an Acute setting

Data as at 30 June 2016
“30% of respondents were ‘shocked, 40% ‘annoyed’ and 61% ‘worried’ that their GP records are not available to A&E. There is energy and expectation for change both in end of life care and record sharing in the UK”

A recent YouGov survey (Date?)
65 yrs
Multiple chronic conditions
Functional disabilities
Behavioural health problems
Material hardships
Near the End of life

David Blumenthal
“ A high performing health system must perform for high-need, high cost patients
Beyond EPaCCS to URGENT CARE PLANS

- Future Planning
  - Organ donation
  - ADRT/Living Will

- Vulnerable, Complex and High needs
  - Long Term Conditions e.g. COPD, diabetes, CF, sickle cell, mental health
  - People living with disability and special needs

- Frail and Elderly
  - Avoiding unplanned readmission and A&E attendances
  - NHS England Enhanced Service Spec

- End of life care
  - Would you be surprised if this patient was alive in a year? Answer yes
FUTURE CARE PLANNING

Electronic Palliative Care Coordination Systems (SCCI1580) plus Urgent Care Plans

EPaCCS + UCP
Professor Julia Riley
Clinical lead
Julia.Riley@rmh.nhs.uk

Tel: 0207 811 8490