

# North West EOLC – EARLY Identification and Personalised Care Planning



## North West End of Life Care NHS England and Improvement 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 a local Electronic palliative Care Coordination System (EPaCCS).

*Additional locality specific guidance may be available.*

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Version 2



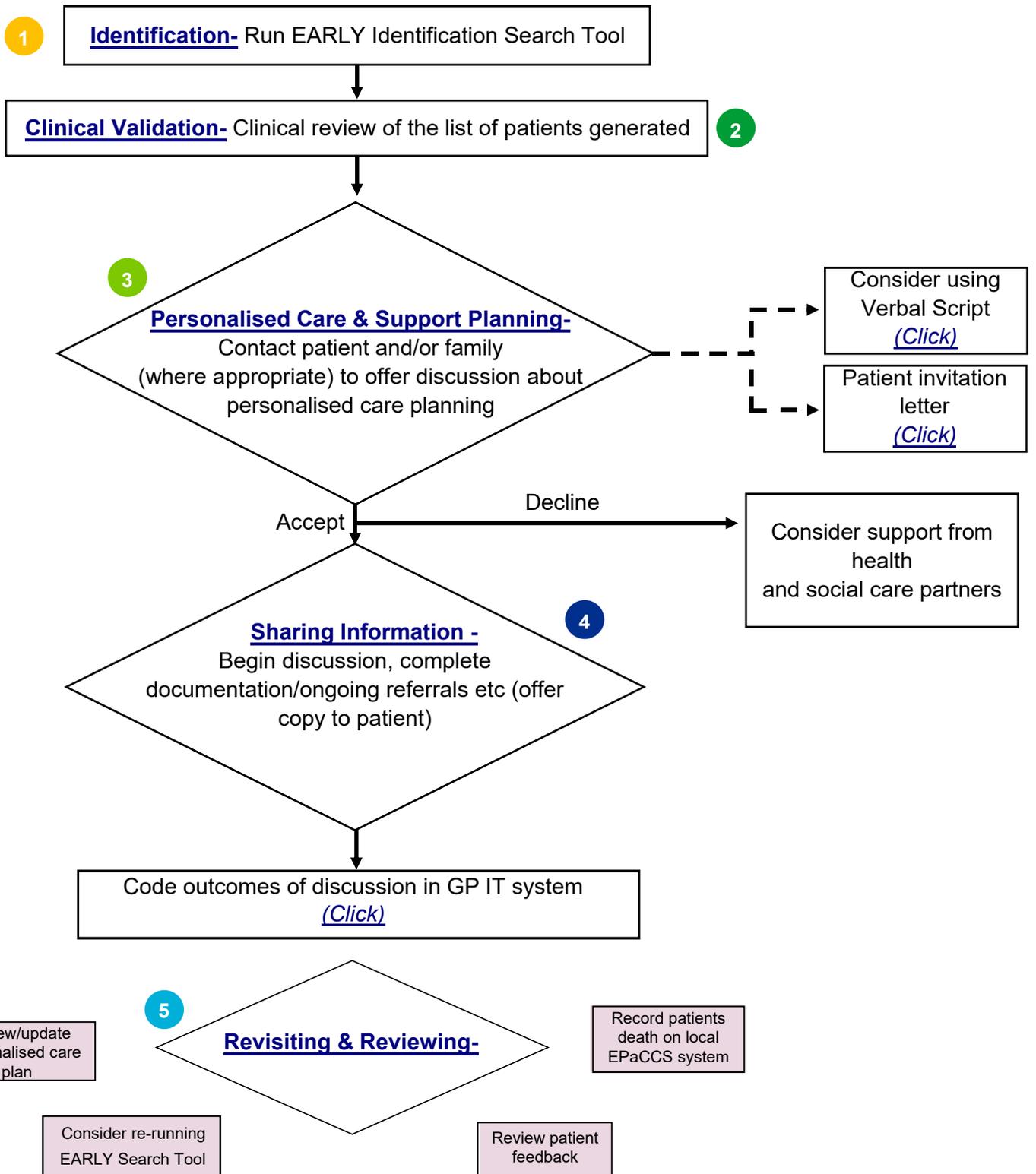
## INTRODUCTION

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 your local Electronic palliative Care Coordination System.

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.

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





## 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](#)

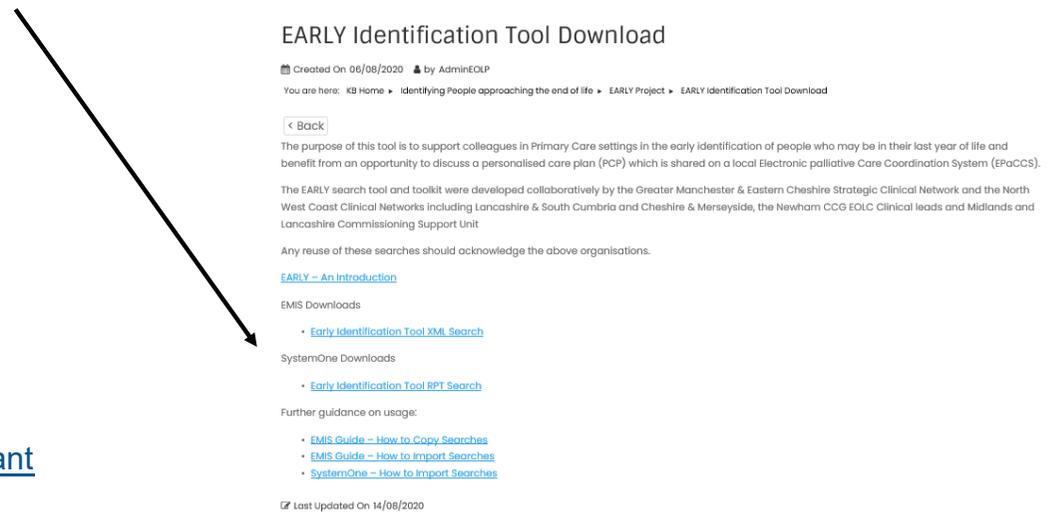
EARLY is an acronym for:

- 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](mailto:England.EARLY@nhs.net)  
In order to ensure that you are using the correct version please do not adapt or amend the tool yourself.





## 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?
- 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?



## 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
<a href="#">Dying matters 'Preferred priorities of care'</a>
<a href="#">Macmillan</a>
<a href="#">Marie Curie</a>
<a href="#">Cancer Research (UK)</a>
<a href="#">AgeUK</a>
<a href="#">Alzheimer's Society</a>
<a href="#">NHSE</a>

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



## 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?



Personalised  
Care & Support  
Planning

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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 *\*Insert name of local EPaCCS\** 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 Insert name of local EPaCCS is included.

If you would like, you can develop your care plan by completing the Insert name of local EPaCCS template included with this letter. You can find more information about Insert name of local EPaCCS via: \*\*\*\*\*

You are welcome to bring family member(s) or carer(s) to the appointment.

Yours sincerely,  
*Insert Name*



## SHARING INFORMATION

∇ [Assessing mental capacity](#)

∇ [Assessing mental capacity](#)

∇ [VIDEO - Capacity and information sharing](#)

∇ [EPaCCS Patient Information Trifold](#)

∇ [EPaCCS Patient Information Trifold](#)

∇ Input patient's wishes, clinical recommendations and other important information on local EPaCCS system



Sharing Information

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

Task	SNOMED Description	SNOMED Code
<b>To document completion of Personalised Care Planning</b>  Documentation on EPaCCs system	Has anticipatory care plan	792871000000101
	Advance care planning	713603004
	Coordinated support plan	376531000000105
	Consent given for sharing end of life care coordination record (finding)	882921000000109

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



## 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](#)
- 3-6 month re-running of the EARLY search tool
- [Collating and reviewing patient feedback](#)



Revisiting & Reviewing

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## SUGGESTED QUESTIONS FOR PATIENT FEEDBACK QUESTIONNAIRE

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):



## 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	<b>Dying Well</b>	Ambitions for Palliative and EOLC 2 <sup>nd</sup> edition
Palliative care for people with LD	Dying Well in Custody Charter	
NHSE- Nottinghamshire and Sherwood Forest Hospitals NHSFT Resource Pack	Dying Well in Custody Self-Assessment Tool	
Mencap- Hospital Passport		