Position statement on Personalised Care Planning for Places, Primary Care Networks and General Practices

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Introduction

Anticipatory care may be defined in several ways but incorporates the following:

"Advance or anticipatory care planning ensures that someone's wishes are known when it comes to treatment and the future."[1]

Anticipatory care is designed to support those patients who are at high risk of unwarranted health outcomes to live well and independently for longer, through structured proactive care.[2]

A core aspect of anticipatory care is personalised care, which describes a negotiated series of discussions between a patient and a health professional (perhaps with other professionals or family members also present) to clarify goals, options and preferences, and to develop an agreed plan of action based on this mutual understanding.[3]

Similar words way also be used which indicate a different focus but essentially are closely related. These include 'future care planning', 'personalised & supportive care planning' and 'advanced care planning'.[4]

The preferred term within Cheshire and Merseyside ICB is **Personalised Care Planning (PCP).**

However, all terms reflect a fundamental concept ie. **health and care professionals proactively involving the patient and carers in developing an agreed plan to facilitate person-centred care and manage what are expected changes in the patient's condition and symptoms.**

Pro-active care and preventative medicine are much broader topics which can include any intervention seeking to optimise a condition as a means of preventing deterioration or need for further intervention. Many patients receiving anticipatory care planning will be receiving pro-active

care as well – such as medicine management optimisation, long term condition review, patient and carer education etc. This paper is not seeking to cover these topic.

The main groups of patients associated with the personalised care planning are

1. End of life patients
2. Patients receiving palliative care
3. Care Home patients
4. Patients with complex needs
5. Patients with severe long-term conditions

Such patients account for a significant volume of urgent and emergency care. The value of anticipatory care planning is often in the conversation itself. It provides a framework to ensure critical aspects of care are addressed. However, the full impact of anticipatory care planning is only realised when the plan is shared with patient, carers, care team and urgent care providers are notified (such as the ambulance service and GP out-of-hours). Staff in acute trusts are empowered to provide personalised care when they can have access to both coded decisions based on the plan and the plan itself. The Electronic Palliative Care Coordinating Systems (EPaCCS) seeks to standardise such coding to facilitate high quality communication[5].

Contextual changes

NHS England have recently on 26th September 2022 redefined expectations of anticipatory care planning with the DES for Primary Care Networks (PCN)[6]. In particular:

"Updates to the PCN service specifications

8. Update the anticipatory care requirements to better reflect system-level work on anticipatory care. Replace the current specification with:

a. 8.9.1. ICSs have responsibility to design and plan anticipatory care for their system, of which the following PCN requirements form a part. 11

b. 8.9.2. PCNs must contribute to ICS-led conversations on the local development and implementation of anticipatory care working with other providers with whom anticipatory care will be delivered jointly."[7]

Naturally PCN Clinical Directors and primary care managers will be considering what this means and what the next steps will be across the Cheshire & Merseyside system.

This document seeks to outline the medium-term expectations and next steps for Cheshire and Merseyside Health & Care Partnership. For the sake of clarity, the focus is on anticipatory care planning in the community.

Principles and position statement

A. Personalised Care Planning is a priority for Cheshire & Merseyside Health & Care Partnership.

B. Many areas have made good progress in personalised care planning already. However there is also wide variation between Places. Learning from one another about the challenges, successes and innovations is a key opportunity that we are seeking to capitalise on. As such we welcome Places share their stories and current development.

C. We will work with Place-based leadership to support Primary Care Networks in advancing personalised care planning from the current baseline to an agreed minimum standard across all nine places.

Aspects of this will include:

1. Each of the nine places to have ONE locally agreed personalised care plan that meets EPaCCS standards in regard to core coding requirements. Such a plan will require agreement and sign off by:
    a. The Place based Clinical Director and palliative care lead or equivalent
    b. The Local Medical Committee
    c. A local palliative care consultant or geriatrician
    d. Community provider
    e. The place based local informatics team
2. Practices should be provided with a complementary EMIS/ System One template to facilitate the capture of key codes necessary for a comprehensive process and to facilitate population of the plan.
3. PCNs via practices should test their agreed standardised processes out at very small scale prior to implementation.
4. PCNs should ensure time is given within meetings or training events to socialise the care plan and discuss the principles with staff
5. Where necessary Places and PCNs should flag up if they require help or training and we will support in this area.
6. Personalised care planning may be done by any trained professional who has been signed off as competent by their respective medical lead e.g. pharmacists, nurses, care coordinators.
7. The process should not be dependent on GPs for the totality of care planning

The I-CARE & Share personalised care planning package facilitates the above requirements making it easy for Places to adopt one locally agreed personalised care plan.

Key performance indicators that PCNs and practices and should work towards collectively:

1. Practices should aim for 0.6% of their population to be on the End of Life Register
2. Practices should work towards seeking to provide personalised care plans to 60% of their patients on the End of Life Register
3. Practices should seek to develop a mechanism where they identify the patients who are most suitable for anticipatory care planning. This may include performance scores or internal triggers.
4. PCNs should work towards a baseline of care planning 90% of care home residents over the next 12 months with the intention of care planning a new resident within 3 months of admission.
5. 100% of patients should have a hard copy of their care plan
6. 100% of patients with an active DNACPR decision should have this coded as an EMIS problem code to support staff who only have access to the summary care record.
7. PCNs and practices should share 90% of personalised care plans with their respective out-of-hours provider and North West Ambulance.

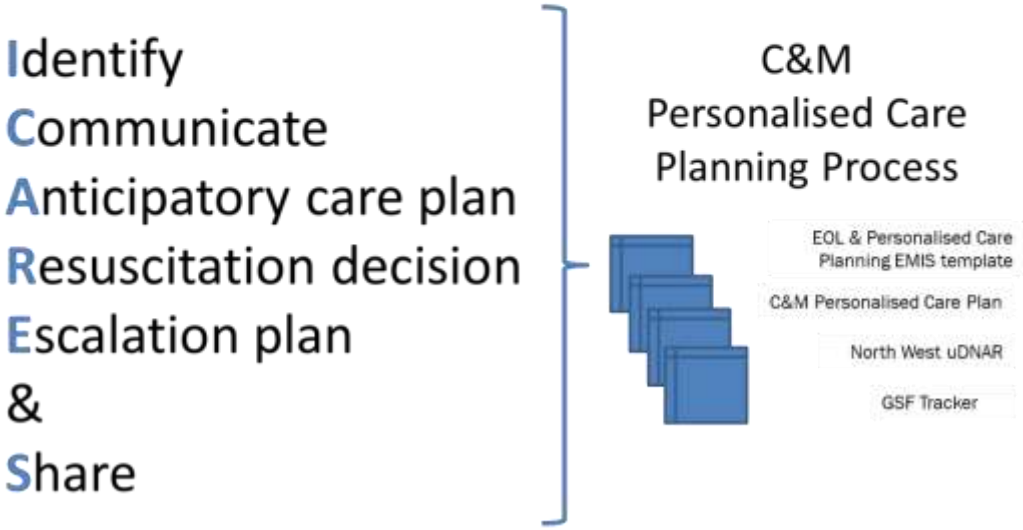
At present, unless present in a local quality contract, there is no extra contractual payment from Cheshire & Merseyside HCP associated with these parameters as the payment for personalised care planning has been moved into a block for PCNs.

Cheshire and Merseyside Health & Care partnership will develop the data mechanisms to help guide improvement and provide assurance to NHS England that we are assisting in the advancement of personalised care planning. Such data will be made accessible to all PCNs.

A suggested personalised care plan and EMIS template that meets EPaCCs standards has been made available to all areas who choose to use it. EMIS searches to support this will also be made available over time.

I-CARE & Share

The ICB have adopted the I-CARE & Share approach



A number of colleagues have enquired why we are not adopting ReSPECT. Following an options appraisal the ICB decision is **not** to pursue a move to adopting ReSPECT at this time for the following reasons:

The C&M ICB **I-CARE & Share** Personalised Care Planning process and tools ensure the following where ReSPECT could not:

- Provide a more comprehensive care plan including listing significant documentation, anticipatory clinical management plan, treatment escalation decisions, baseline function, active clinical problems and patient centred wishes.
- Ensures Personalised Care Plans meet the PCN DES requirement in regards to the common geriatric assessment principles
- Is digitally enabled ensuring merging of fields and ease of sharing with urgent care providers
- Works in tandem with tools always embedded and ubiquitous across the ICB such as the North West uDNAR form
- Key EPaCCs codes are collected on the patient record that enables potential tracking of patients by clinicians, notification to secondary care and business intelligence evidence.

- The Personalised Care Plan is suited to end of life, palliative care, care home residents, long term conditions and patients with complex care needs.

Case example: Sefton Place

Sefton came from a position of traditionally having a low rate of personalised care planning. The place first developed a locally agreed personalised care plan in 2016. This was supported by a frailty initiative as part of the local quality contract seeking to review all severely frail patients with the aim of optimisation and admission prevention. During the covid-19 pandemic the plan was adjusted to help practices have appropriate conversations with patients, families and carers. The care plan has had several iterations following patient and clinician feedback. Leads have sought to include a wide array of stakeholders locally in co-design. Alignment to EPaCCs coding along with a supplementary EMIS template have enabled the care plan to carry more weight and facilitate ease of completion. More recently the improved care plan has been re-introduced back into the local quality contract with a focus on palliative care and end of life, involvement of families and carers and sharing with urgent care providers. PCNs have utilised the care plan for care home residents and expanded training to suitable ARRS roles involved in patient care.

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References

1. Macmillan Advance Care Planning

https://www.macmillan.org.uk/coronavirus/healthcare-professionals/advance-care-planning

2. Anticipatory Care EOI - HEE

https://www.hee.nhs.uk/sites/default/files/Anticipatory%20Care%20EOI%20Form.docx

3. Anticipatory Care Planning Intervention for Older Adults at Risk of Functional Decline: A Primary Care Feasibility Study (Host Organisation – QUB)

https://research.hscni.net/chitin/trial/anticipatory-care-planning-acp

4. What is Advance Care Planning?

https://www.england.nhs.uk/north-west/north-west-coast-strategic-clinical-networks/our-networks/palliative-and-end-of-life-care/for-professionals/advance-care-planning/

5. Electronic Palliative Care Coordinating Systems (EPaCCS)

https://www.england.nhs.uk/north-west/north-west-coast-strategic-clinical-networks/our-networks/palliative-and-end-of-life-care/for-professionals/electronic-palliative-care-coordinating-systems-epaccs/

6. Network Contract Direct Enhanced Service Draft Outline Service Specifications (pages 22-28)

https://www.engage.england.nhs.uk/survey/primary-care-networks-service-specifications/supporting_documents/Draft%20PCN%20Service%20Specifications%20December%202019.pdf

7. Supporting general practice, primary care networks and their teams through winter and beyond

https://www.england.nhs.uk/wp-content/uploads/2022/09/B1998-supporting-general-practice-pcn-and-teams-through-winter-and-beyond-sept-22.pdf

8. Cheshire & Merseyside I-CARE & Share Personalised Care Planning Support Package

   https://www.england.nhs.uk/north-west/north-west-coast-strategic-clinical-networks/our-networks/palliative-and-end-of-life-care/for-professionals/personalised-supportive-care-planning/

9. Timely identification of people in the last year of life in primary care, 'EARLY' NHS England — North West » EARLY Identification in Primary Care (EARLY toolkit)

10. Timely identification of residents in care homes in the last year of life, SHADOW NHS England — North West » Early Identification in Care Homes (SHADOW)

11. Advance care planning and communication skills NHS England — North West » MAYFLY

12. uDNAR Electronic-uDNACPR-NW-form-v1-2.pdf (england.nhs.uk)

13. EPaCCS NHS England — North West » Electronic Palliative Care Coordinating Systems (EPaCCS)