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Strategic Clinical Networks

I-CARE +Share

Lunch and Learn
March 26th 2026

Agenda

- What is I CARE & Share & why is it important?
- EARLY tool
- C&M Personalised Care Plan
- C&M last 12m activity data analysis
- GP Survey – best and most improved analysis
- Sources of help and information
- Q&A

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What is I-CARE +Share ?

- Good planning for PEOLC encompasses many different elements which are all essential to optimise patient care
- **I –CARE & Share** aims to provide a recognised framework and aide memoire

Identify

Communicate
Anticipatory care plan
Resuscitation decision
Escalation plan

+

Share

I CARE + Share is the acronym for the Cheshire & Merseyside Personalised Care Planning Process (which also includes the C&M Personalised Care Plan)

https://www.cheshireandmerseyside.nhs.uk/your-health/i-care-share/

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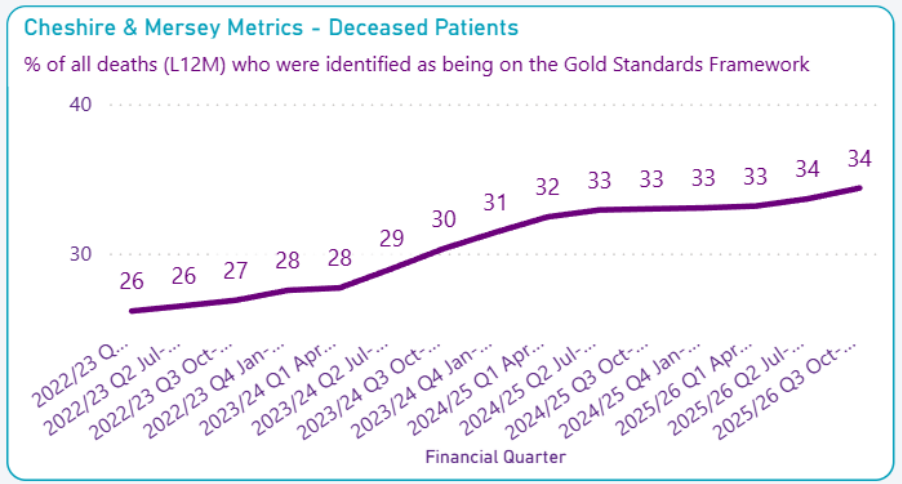
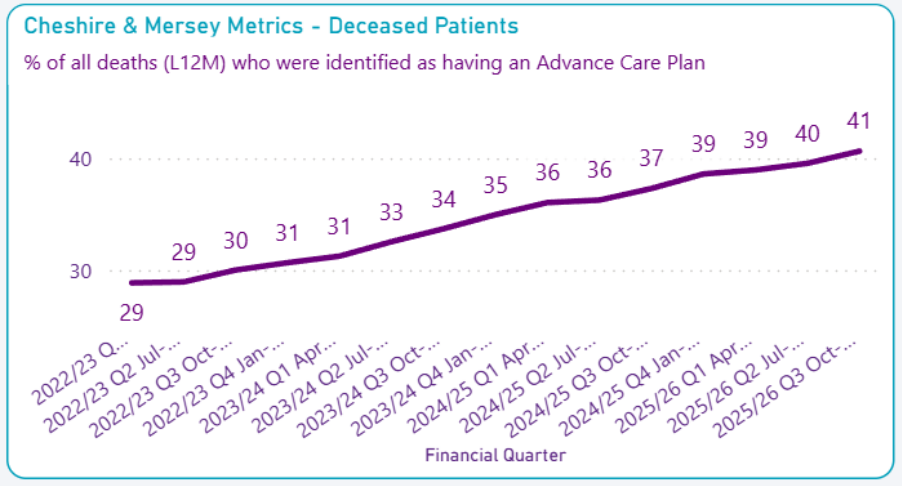
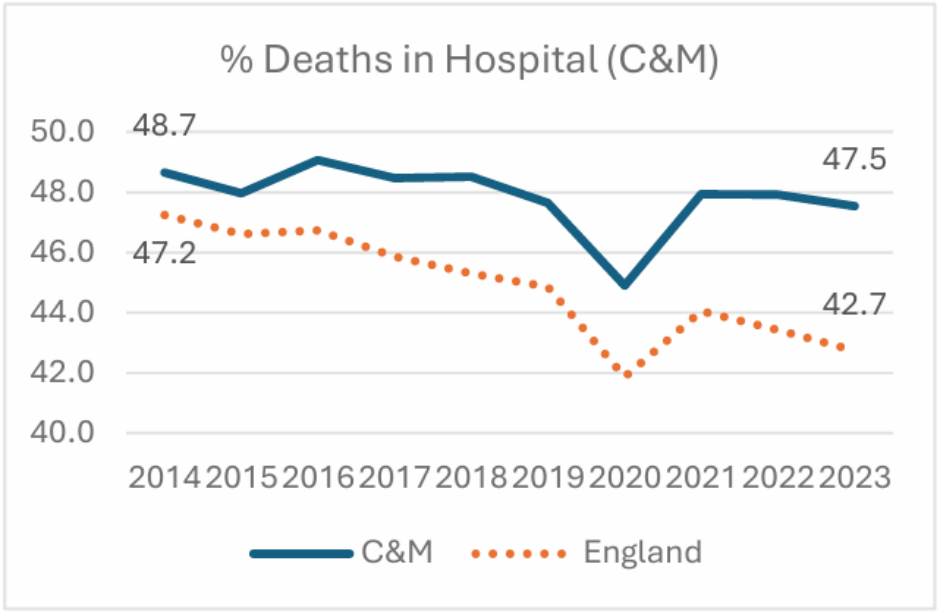
Why is I-CARE +Share important?

- Early identification of patients who may be in the last 12 months of their life is important because it **gives people the opportunity to be involved in planning for their future care.**
- Advance Care Planning can **improve the quality of end-of-life care** and reduce stress, anxiety and depression in surviving relatives. ACP can **give patients more choice and control** over what happens to them as **more health and care professionals know and are more able to follow their wishes**.
- Early identification and advance care planning **can help to reduce unnecessary hospitalisation and enable more people to live and die in their preferred place of care**.

Why is I-CARE +Share important?







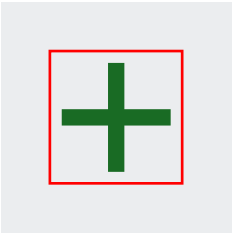
Data:
C&M EOL Dashboard
C&M PEOLC PBNA

‘I’ is for Identification

The new Modern Service Framework places identification for PEOLC as one of the high confidence evidenced interventions

Around 75% of all deaths are ‘expected’. i.e. the vast majority

Proactive, earlier identification of patients who may be in the last 12 months of their life is important because this provides an opportunity for them (or next of kin / carers) to be involved in planning for their future care.



Note the offer is voluntary, may be declined but can be revisited

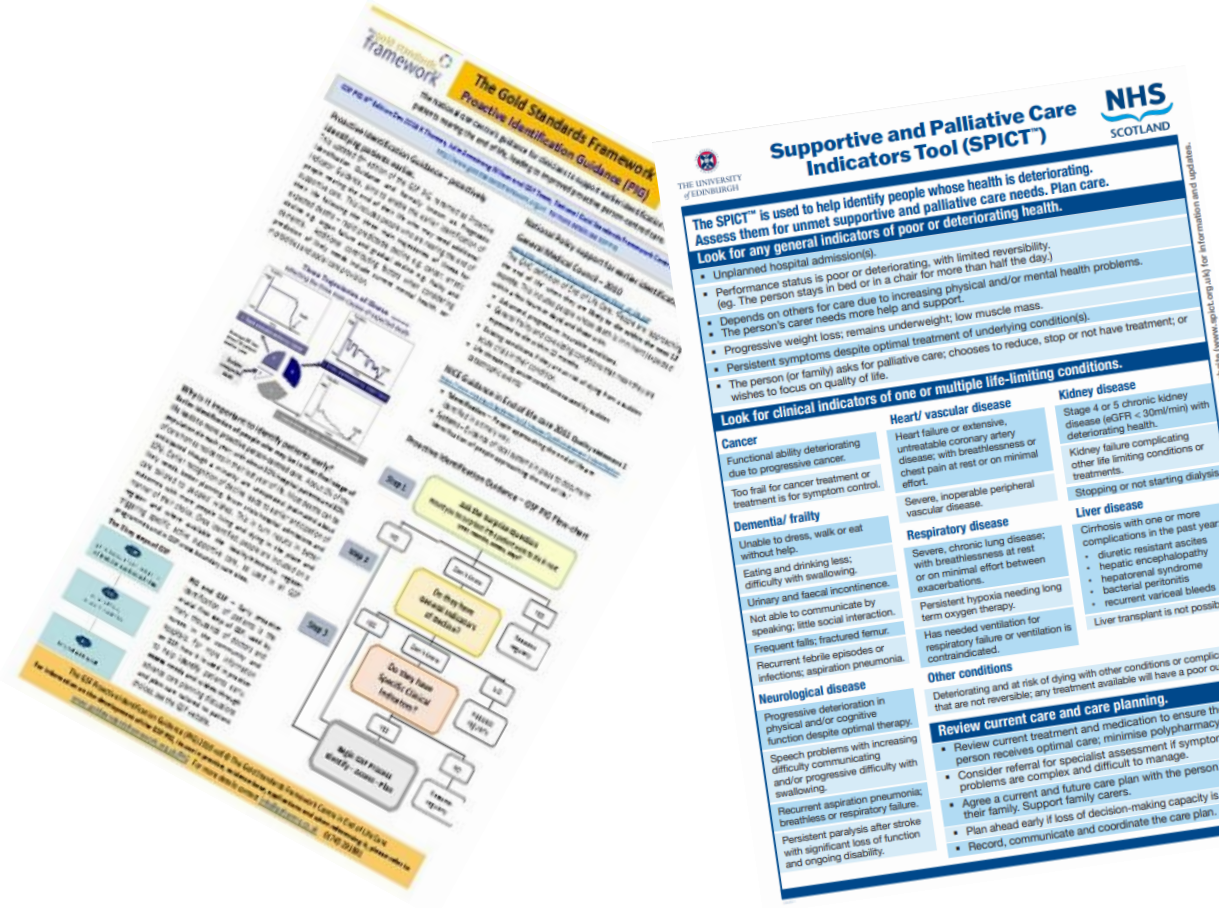
A reactive approach during crises and rapid deterioration or no approach at all means the patient is far more likely to end up in an acute care setting which may not be appropriate for their needs

- A number of tools exist to help identify people in the last 12m of life eg SPICT, GSF PIG

  https://www.spict.org.uk/

  https://www.goldstandardsframework.org.uk/

- However, these rely on health care professionals remembering the key features of deterioration which may not always be apparent nor feel relevant at the time



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'EARLY'

The EARLY toolkit includes a search which can be run in the GP clinical system (EMIS, SystmOne & Vision)

The search is based on key elements such as disease coding, number of admissions etc

The list produced is divided into broad 'disease' headings

The individuals on the list **MUST** then be **clinically validated** as being in the last year of life as the search is **not** 100% sensitive

Developed in London and the North-West, recognised and promoted by NHSE

In a practice of 6000 patients 118 patients were identified in the EARLY search

Name	Population Count	%	Last Run	Search Type	Scheduled	Code System
x Linked searches						
Combined list of patients to be reviewed	118	2%	12-Mar-2025	Patient		N/A
Combined list of patients to be reviewed Auto Report	118		12-Mar-2025	Patient		SNOMED CT
Patients NOT on Palliative Care Register	5754	99%	12-Mar-2025	Patient		N/A
1. Cancer	14	1%	12-Mar-2025	Patient		SNOMED CT
2. Heart Failure	0	0%	12-Mar-2025	Patient		SNOMED CT
3. COPD	20	1%	12-Mar-2025	Patient		SNOMED CT
4. Kidney Disease	3	1%	12-Mar-2025	Patient		SNOMED CT
5a Hepatocellular Carcinoma	2	1%	12-Mar-2025	Patient		SNOMED CT
5b Liver Disease	2	1%	12-Mar-2025	Patient		SNOMED CT
6. Motor Neurone Disease	0	0%	12-Mar-2025	Patient		SNOMED CT
7. Frailty and Dementia	87	2%	12-Mar-2025	Patient		SNOMED CT
8. Idiopathic Pulmonary Fibrosis	1	1%	12-Mar-2025	Patient		SNOMED CT

...but the 118 are helpfully subdivided into disease areas within the search in EMIS

Name	Population Count	%	Last Run	Search Type	Scheduled	Code System
x Linked searches						
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In the example here 20 patients with COPD will require clinical validation and chosen because the practice is already working on the clinical optimisation of patients with COPD

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"C" is for Communicate

Clinically validate the list – 'Would I be surprised if this patient died in the next 12m?'

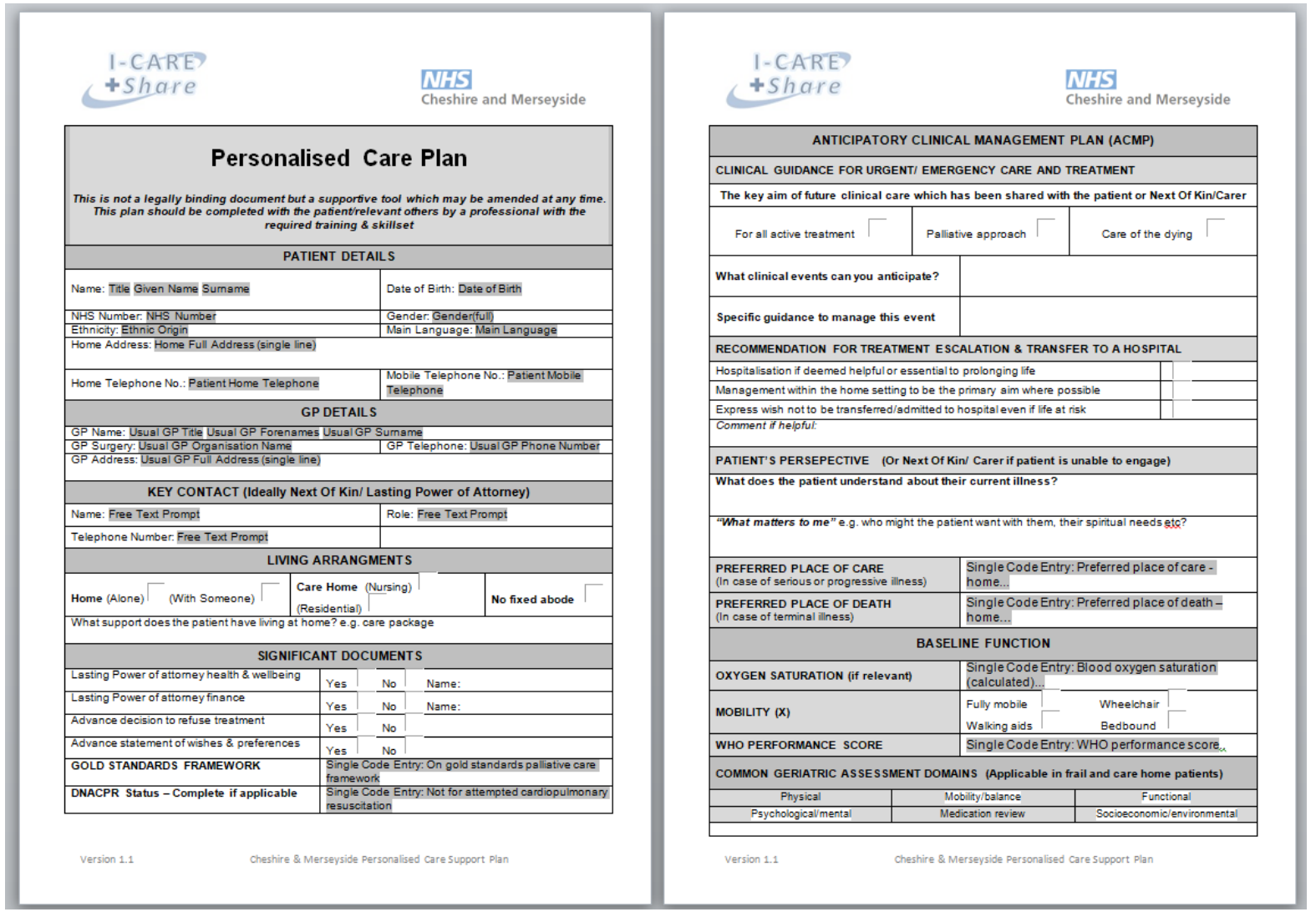
Decide if appropriate to approach end of life care discussions and if so, offer the opportunity to engage

Conversations may then develop into planning using the C&M Personalised Care plan

Get everyone on the same page

- The value is in the conversation
- PCP provides a robust structure for communication
- The authority of a clinicians' signature is crucial in supporting carers
- Coding helps track
- Quality is as crucial as quantity

“A” for is Anticipatory Care Plan



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Personalised Care Plan

This is not a legally binding document but a supportive tool which may be amended at any time. This plan should be completed with the patient/relevant others by a professional with the required training & skillset

PATIENT DETAILS	
Name: Title Given Name Surname	Date of Birth: Date of Birth
NHS Number: NHS Number	Gender: Gender(full)
Ethnicity: Ethnic Origin	Main Language: Main Language
Home Address: Home Full Address (single line)	
Home Telephone No.: Patient Home Telephone	Mobile Telephone No.: Patient Mobile Telephone

GP DETAILS	
GP Name: Usual GP Title Usual GP Forenames Usual GP Surname	
GP Surgery: Usual GP Organisation Name	GP Telephone: Usual GP Phone Number
GP Address: Usual GP Full Address (single line)	

KEY CONTACT (Ideally Next Of Kin/ Lasting Power of Attorney)	
Name: Free Text Prompt	Role: Free Text Prompt
Telephone Number: Free Text Prompt	

LIVING ARRANGMENTS		
Home (Alone) (With Someone)	Care Home (Nursing) (Residential)	No fixed abode
What support does the patient have living at home? e.g. care package		

SIGNIFICANT DOCUMENTS			
Lasting Power of attorney health & wellbeing	Yes	No	Name:
Lasting Power of attorney finance	Yes	No	Name:
Advance decision to refuse treatment	Yes	No	
Advance statement of wishes & preferences	Yes	No	
GOLD STANDARDS FRAMEWORK	Single Code Entry: On gold standards palliative care framework		
DNACPR Status – Complete if applicable	Single Code Entry: Not for attempted cardiopulmonary resuscitation		

Version 1.1 Cheshire & Merseyside Personalised Care Support Plan

I-CARE +Share

NHS Cheshire and Merseyside

ANTICIPATORY CLINICAL MANAGEMENT PLAN (ACMP)		
CLINICAL GUIDANCE FOR URGENT/ EMERGENCY CARE AND TREATMENT		
The key aim of future clinical care which has been shared with the patient or Next Of Kin/Carer		
For all active treatment	Palliative approach	Care of the dying
What clinical events can you anticipate?		
Specific guidance to manage this event		

RECOMMENDATION FOR TREATMENT ESCALATION & TRANSFER TO A HOSPITAL	
Hospitalisation if deemed helpful or essential to prolonging life	
Management within the home setting to be the primary aim where possible	
Express wish not to be transferred/admitted to hospital even if life at risk	
Comment if helpful:	

PATIENT'S PERSEPECTIVE (Or Next Of Kin/ Carer if patient is unable to engage)	
What does the patient understand about their current illness?	
"What matters to me" e.g. who might the patient want with them, their spiritual needs etc?	
PREFERRED PLACE OF CARE (In case of serious or progressive illness)	Single Code Entry: Preferred place of care - home...
PREFERRED PLACE OF DEATH (In case of terminal illness)	Single Code Entry: Preferred place of death – home...

BASELINE FUNCTION		
OXYGEN SATURATION (if relevant)	Single Code Entry: Blood oxygen saturation (calculated)...	
MOBILITY (X)	Fully mobile Walking aids	Wheelchair Bedbound
WHO PERFORMANCE SCORE	Single Code Entry: WHO performance score...	

COMMON GERIATRIC ASSESSMENT DOMAINS (Applicable in frail and care home patients)		
Physical	Mobility/balance	Functional
Psychological/mental	Medication review	Socioeconomic/environmental

Version 1.1 Cheshire & Merseyside Personalised Care Support Plan

The C&M Personalised Care Plan

(often referred to as the "I CARE & Share Plan")

Suitable for:

- End of life patients
- Patients receiving palliative care
- Care Home patients (PCN DES)

May also be used for

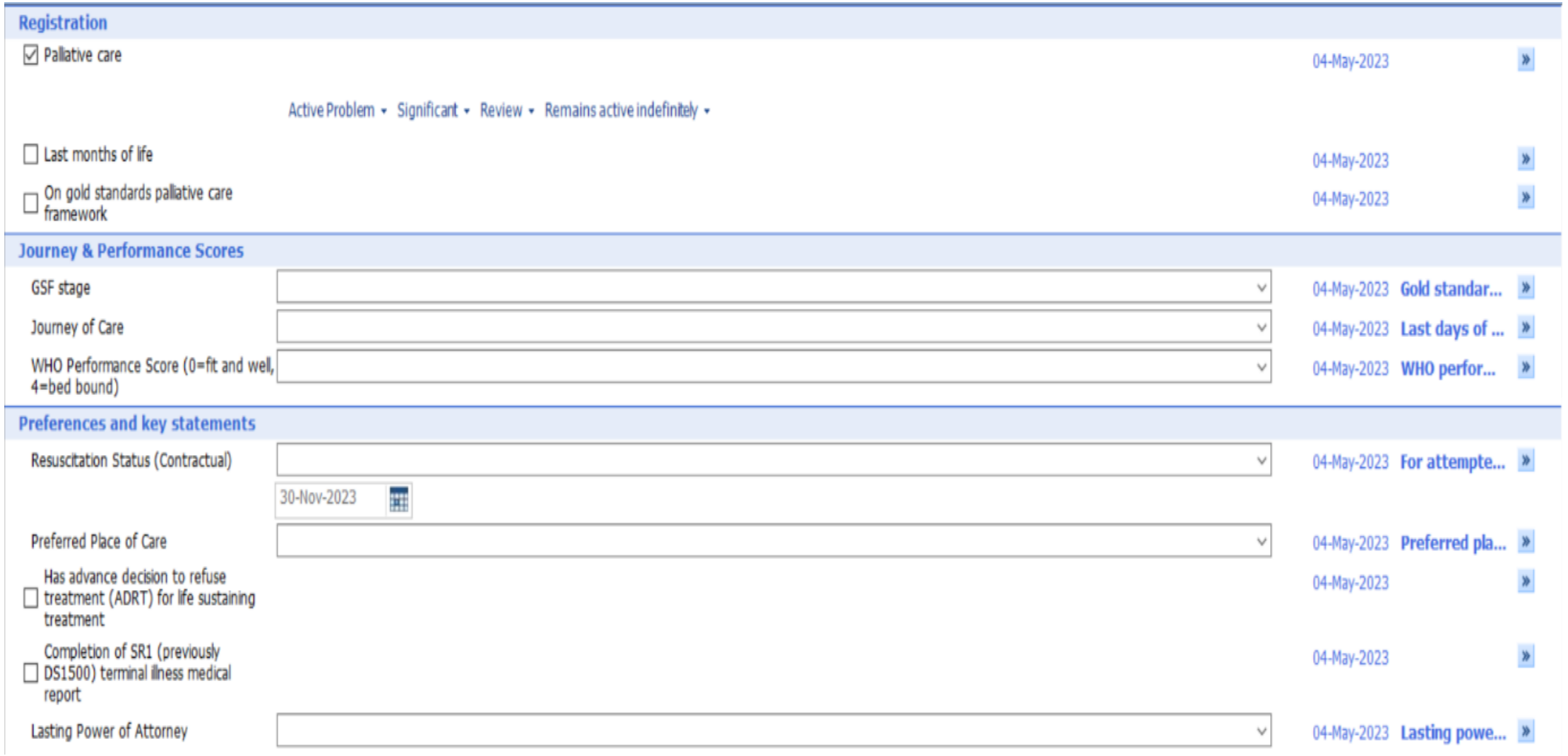
- Patients with complex needs
- Patients with severe long-term conditions

https://www.cheshireandmerseyside.nhs.uk/your-health/i-care-share/resources/

Some localities have agreed alternative options that serve the same purpose BUT coding must align to the requirements for EPaCCS

C&M PCP EMIS template

note that this includes the correct codes for onward sharing ie EPaCCS



Registration

- [x] Palliative care — 04-May-2023 »
  - Active Problem ▾ Significant ▾ Review ▾ Remains active indefinitely ▾
- [ ] Last months of life — 04-May-2023 »
- [ ] On gold standards palliative care framework — 04-May-2023 »

Journey & Performance Scores

GSF stage		04-May-2023	Gold standar... »
Journey of Care		04-May-2023	Last days of ... »
WHO Performance Score (0=fit and well, 4=bed bound)		04-May-2023	WHO perfor... »

Preferences and key statements

Resuscitation Status (Contractual)		04-May-2023	For attempte... »
	30-Nov-2023		
Preferred Place of Care		04-May-2023	Preferred pla... »

- [ ] Has advance decision to refuse treatment (ADRT) for life sustaining treatment — 04-May-2023 »
- [ ] Completion of SR1 (previously DS1500) terminal illness medical report — 04-May-2023 »

Lasting Power of Attorney		04-May-2023	Lasting powe... »

Completing the PCP

- Save the consultation
- Re-open the consultation
- Via ‘Documents’ find:

C&M I CARE & Share Personalised Care Plan v1.4. ewdt

- Merged codes will be populated automatically
- Complete other key patient specific variables
- Save
- Notify administration to share with patient & urgent care providers

‘R’ is for **R**esuscitation Decision

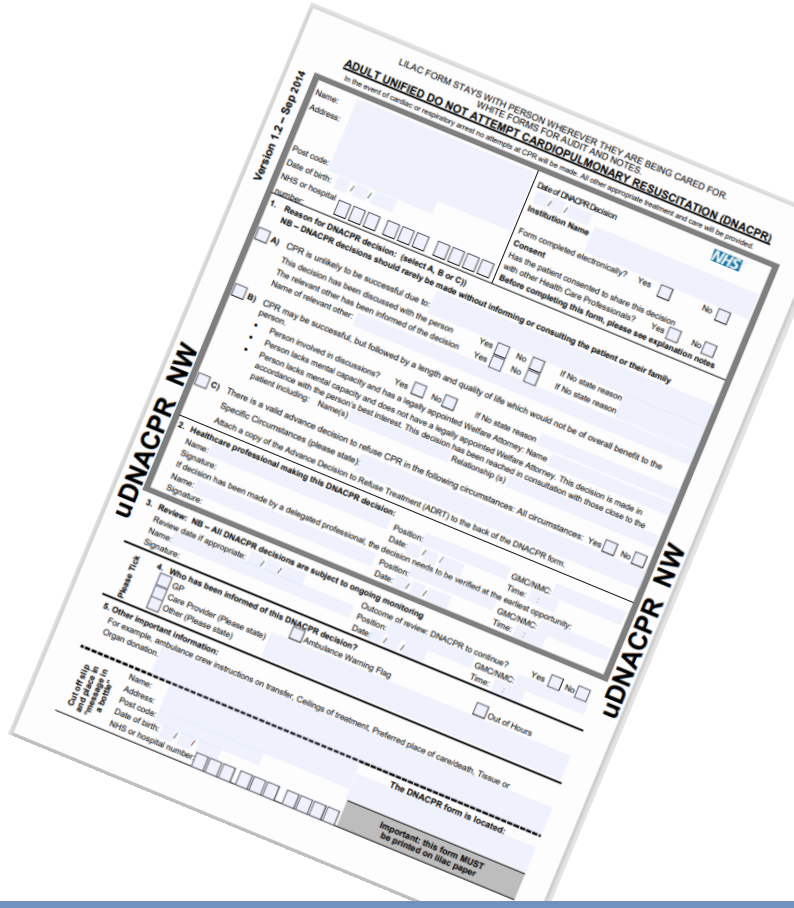
Across C&M we have for many years used the unified DNAR form

This used to be printed on lilac paper

PLEASE NOTE THE COLOUR OF THE PAPER

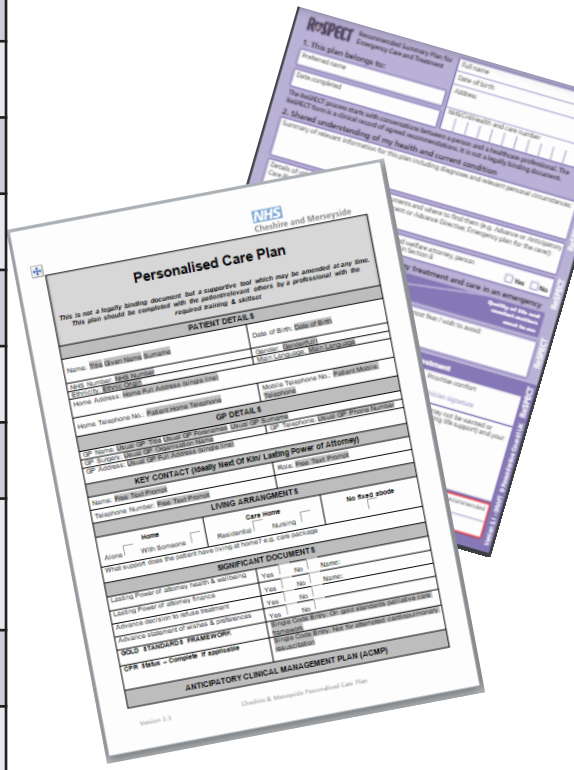
NO LONGER MATTERS **BUT** ACCURATE

COMPLETION DOES

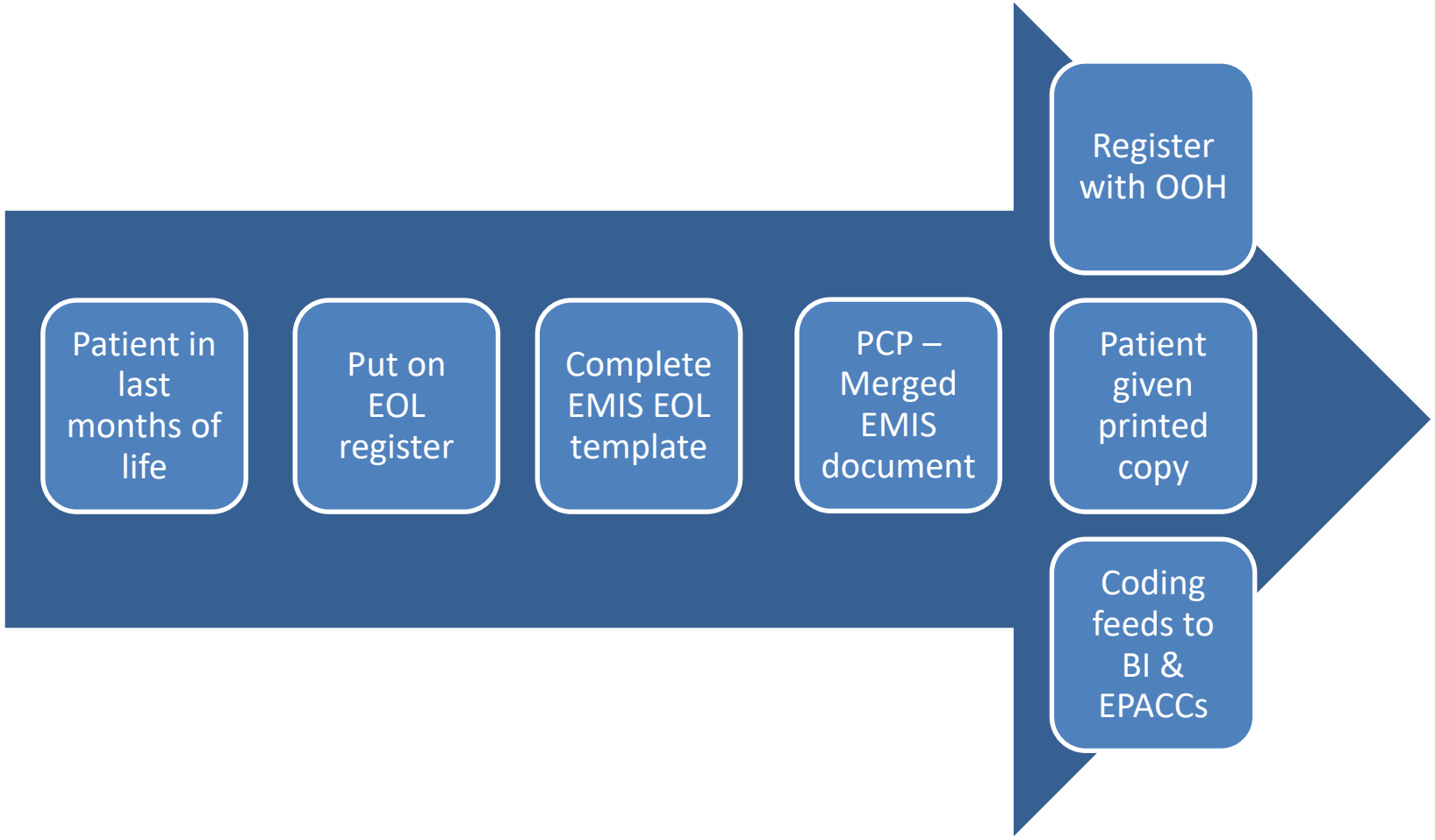


What about ReSPECT?

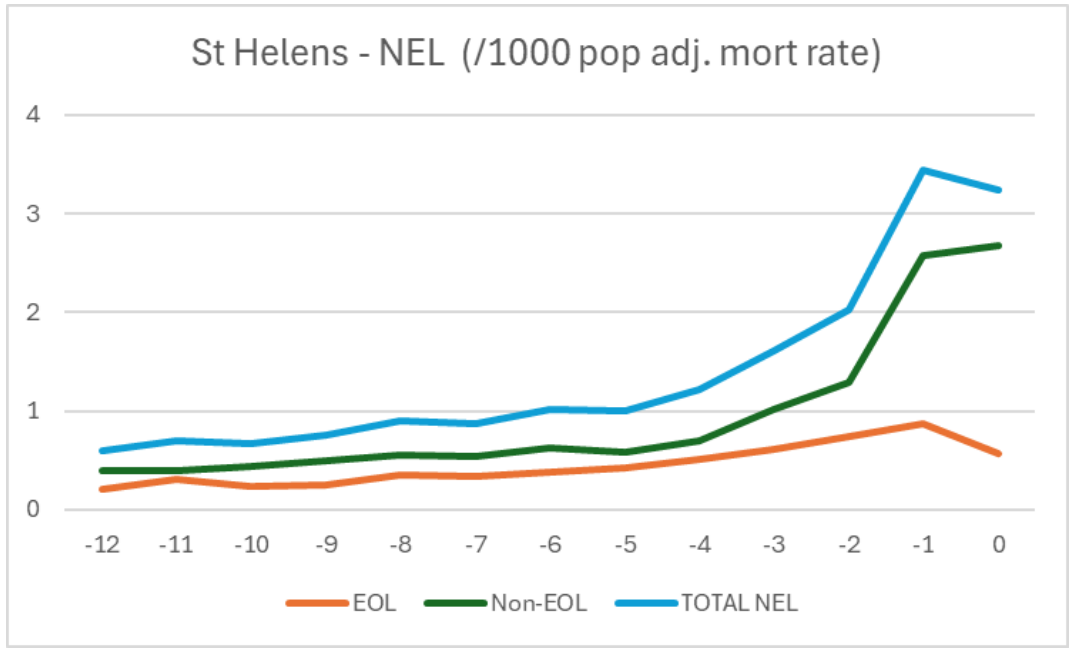
	I-CARE & Share PCP	ReSPECT
DNACPR	NW uDNAR	✓
Escalation thresholds	✓	✓
Personal preferences	✓	✓
Shareable	Word file	Word file
GP / Clinician contacts	✓	X
Suitable for PCN DES (CGA)	✓	X
Specifies significant docs	✓	X
Advance / Anticipatory Care Plan	✓	X
Baseline function	✓	X
Significant problems	✓	X
Codifies key data onto record	✓	X
Meets EPaCCs standards	✓	X
Success measurable through BI	✓	X

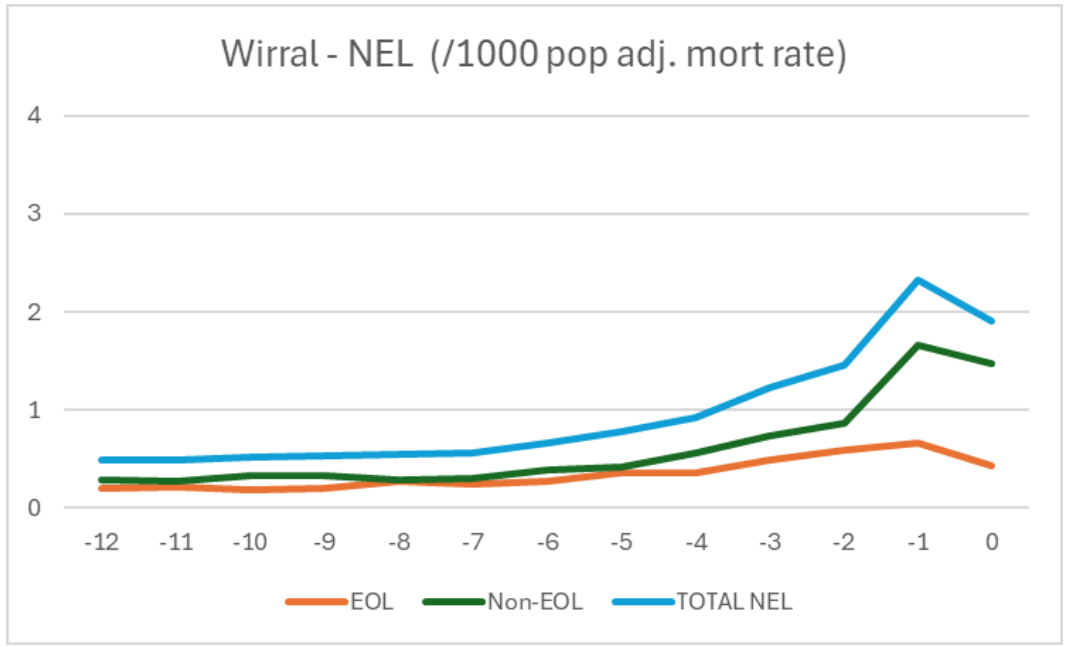


Now “Share”

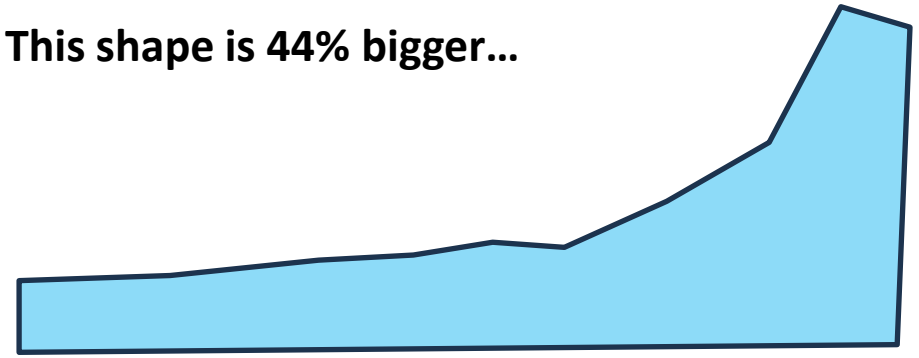

Patient in last months of life
Put on EOL register
Complete EMIS EOL template
PCP – Merged EMIS document
Register with OOH
Patient given printed copy
Coding feeds to BI & EPACCs
Identify
Register
Core coding
Collate
Share

C&M: Last year of life NEL admission / 1000 pop / Adj mortality

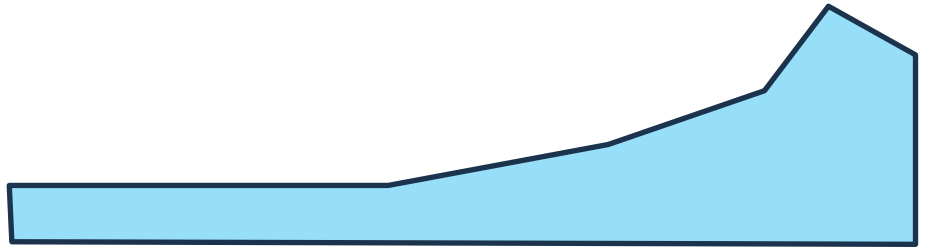




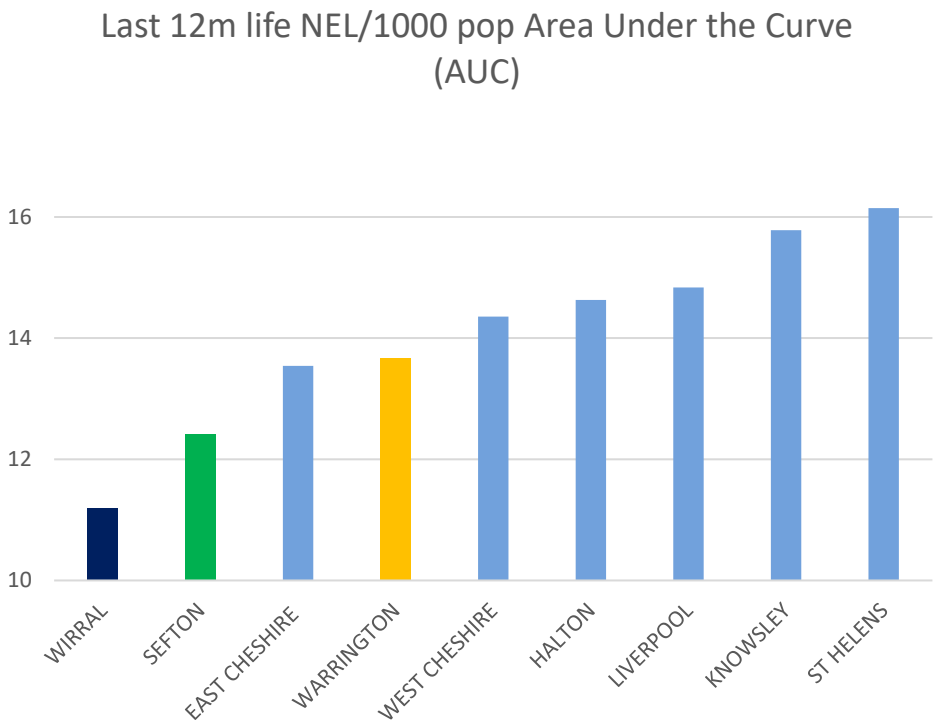
This shape is 44% bigger…

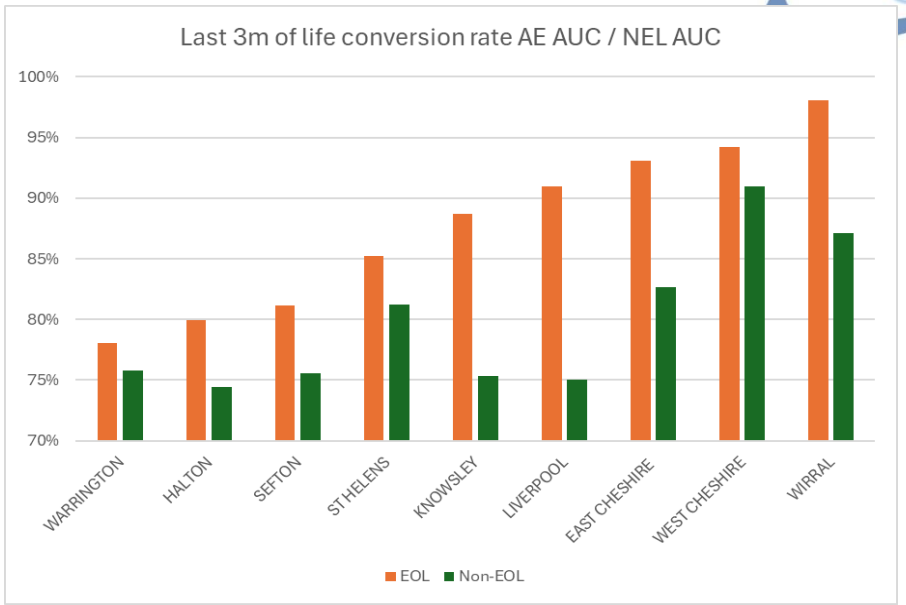


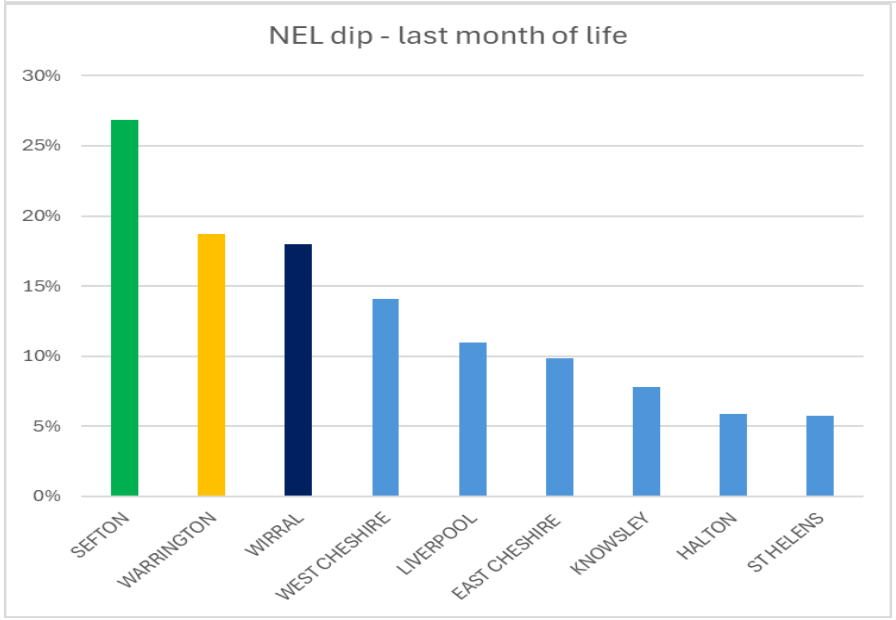
…than this shape (Area Under the Curve analysis (AUC)



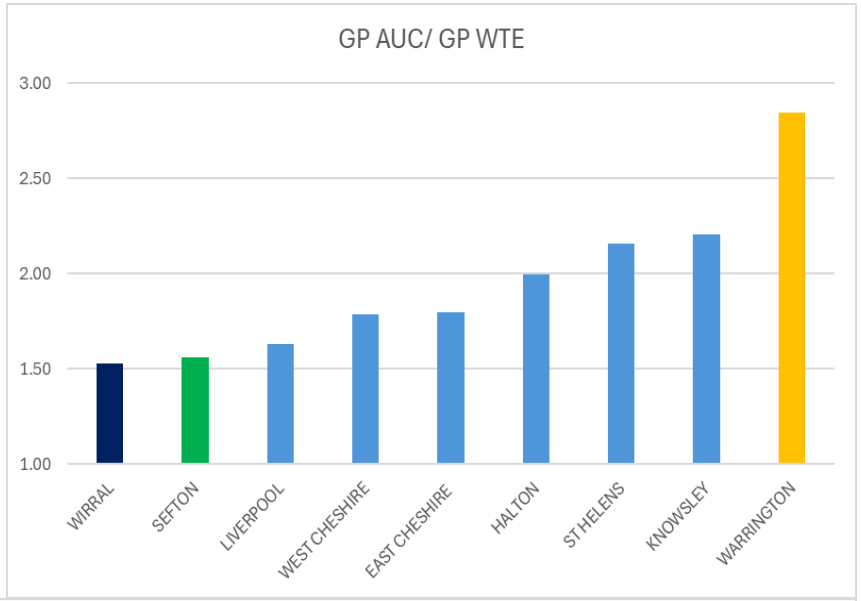
Comparison: NEL admissions in last year of life (Adjusted for mortality rate at Place level)

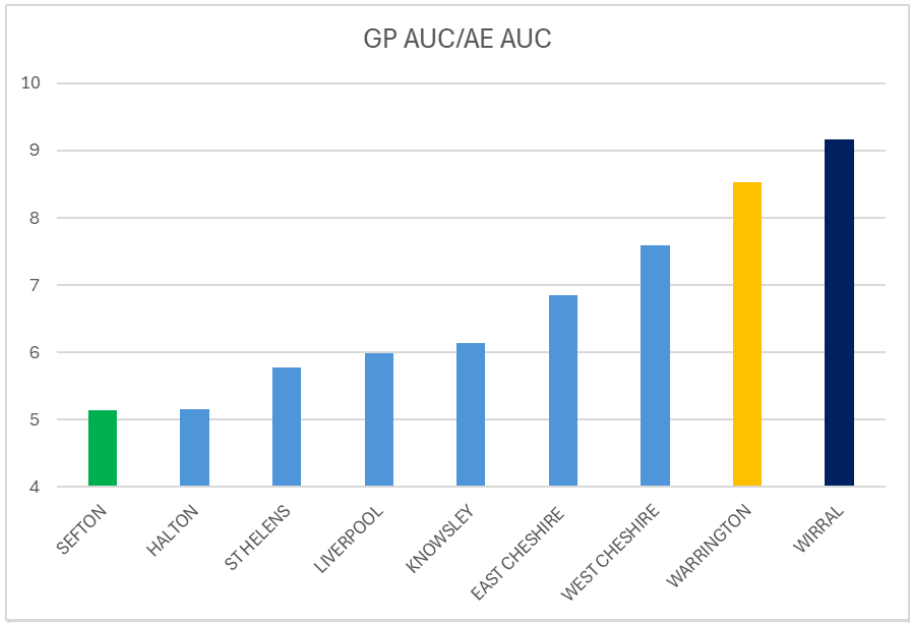


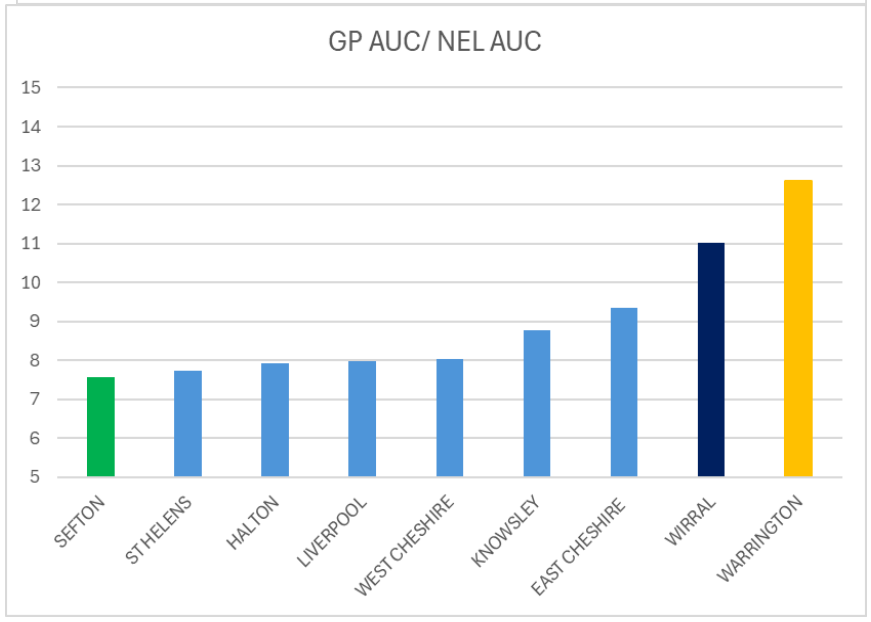


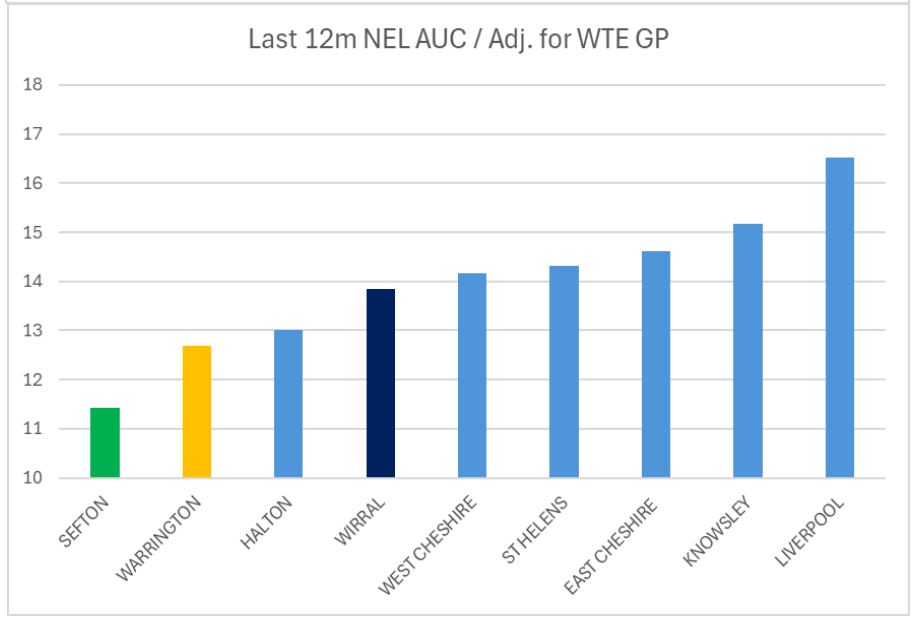


Comparison GP input in last 12m of life: Place ratios

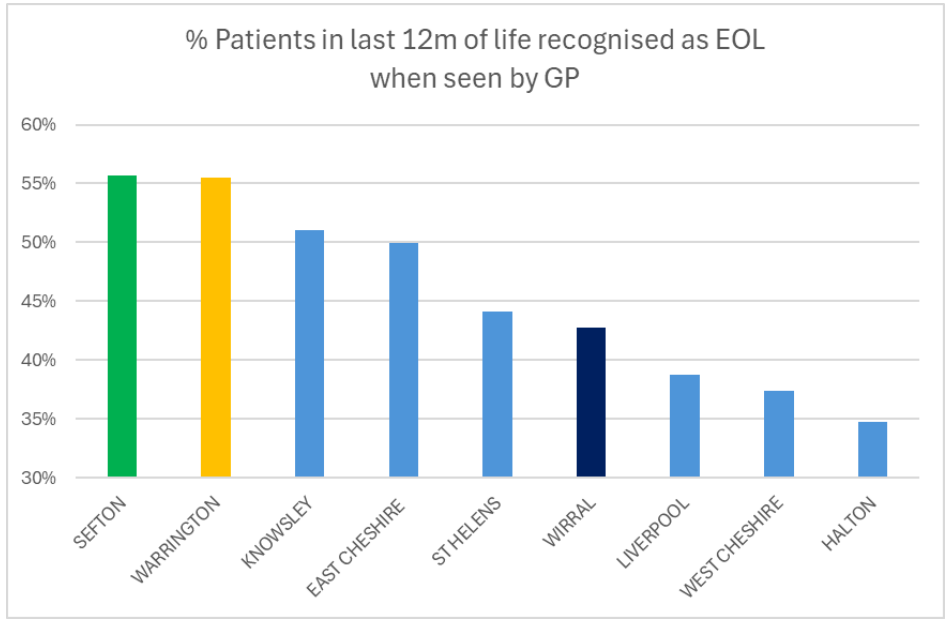


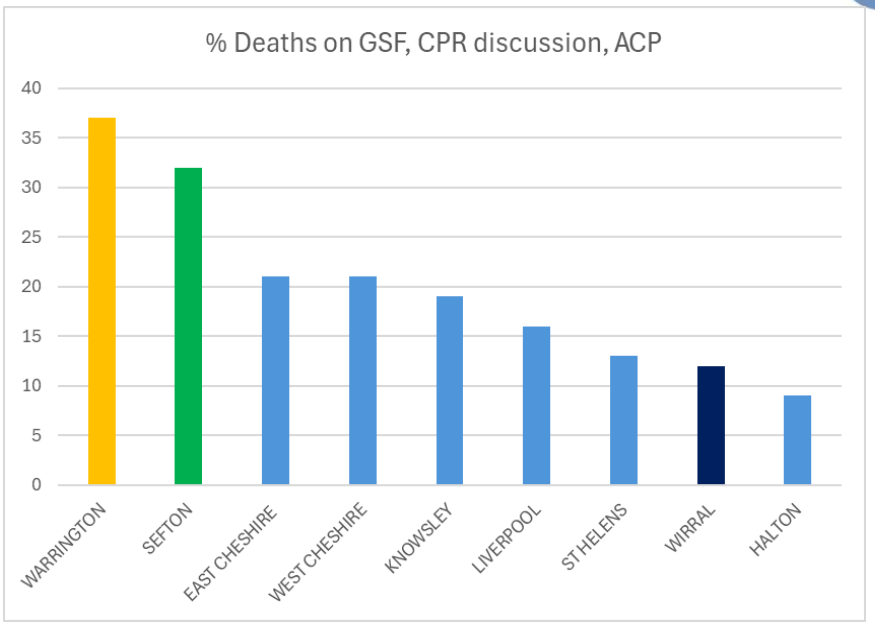


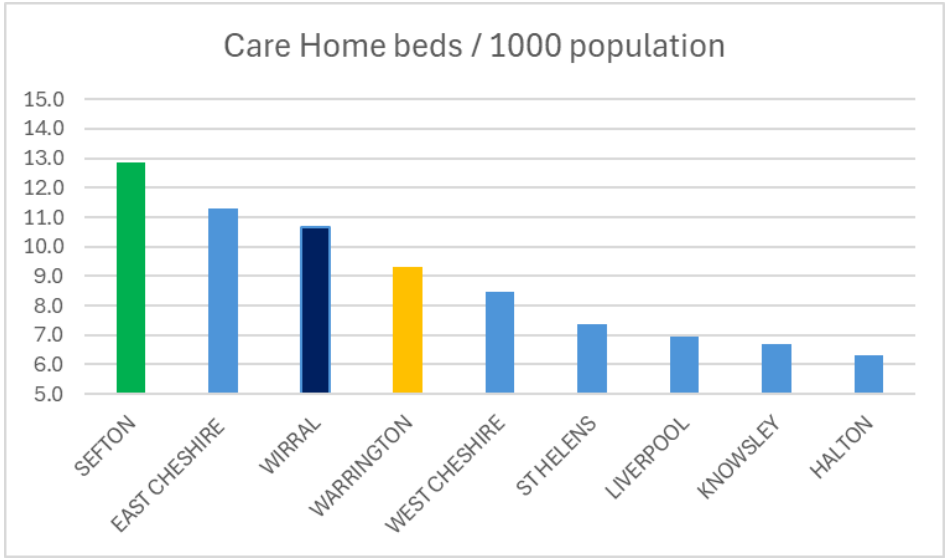




Comparison: Place ratios







Correlation (R2): NEL admission AUC in last year of life (y)

(X)	Care Home per 1000 pop	GP AUC	GP WTE	Id GSF	CPR discussion	ACP	All 3 processes
R	-0.81	0.183	-0.56	0.11	-0.54	-0.33	-0.2
R2	0.65	0.03	0.32	-0.33	0.29	0.11	0.06
P	0.009	0.64	0.114	0.38	0.136	0.384	0.526
No Wirral							
R	-0.87	0.22	0.01	-0.6	-0.66	-0.78	-0.68
R2	0.75	0.047	0.13	0.36	0.44	0.61	0.46
P	0.005	0.607	0.791	0.118	0.073	0.022	0.065
No Sefton							
R	-0.78	-0.05	-0.75	-0.23	-0.54	-0.21	-0.06
R2	0.61	0.0026	0.56	0.051	0.29	0.43	0.0041
P	0.022	0.905	0.33	0.592	0.17	0.621	0.88

GREEN
R> =/- 0.75
R2>0.5
P <0.05
RED
R< +/- 0.3
R2<0.25
p>0.2

R: The correlation between the predictor variable, x, and the response variable, y. (-1 to +1)
R2: The proportion of the variance in the response variable (y) that can be explained by the predictor variable (X) in the regression model (0 to 1) *higher is better*
P: The probability that the relationship is random (0 to 1) *lower is better*

Correlation (R2): A&E AUC in last year of life

	Care Home per 1000 pop	GP AUC	GP WTE	Id GSF	CPR discussion	ACP	All 3 Processes
R	-0.55	0.24	-0.54	0.03	-0.28	-0.02	0.112
R2	0.3	0.057	0.29	0.0008	0.08	0.0003	0.013
P	0.124	0.535	0.133	0.941	0.46	0.965	0.774
No Wirral							
R	-0.49	0.27	-0.16	-0.07	-0.29	-0.27	-0.12
R2	0.24	0.075	0.026	0.006	0.086	0.07	0.013
P	0.219	0.51	0.704	0.861	0.482	0.513	0.784
No Sefton							
R	-0.69	0.26	-0.57	0.04	-0.28	-0.004	0.148
R2	0.47	0.07	0.32	0.002	0.08	0.000013	0.022
P	0.059	0.526	0.142	0.92	0.5	0.993	0.727

GREEN
R> =/- 0.75
R2>0.5
P <0.05
RED
R< +/- 0.3
R2<0.25
p>0.2

R: The correlation between the predictor variable, x, and the response variable, y. (-1 to +1)
R2: The proportion of the variance in the response variable that can be explained by the predictor variable in the regression model (0 to 1)
P: The probability that the relationship is random (0 to 1)

Last year life activity - Data summary

- There is a wide variety of activity across different Places in last year of life
- In some areas GPs are seeing EOL patients more frequently having adjusted for WTE
- One Place (Sefton) has low NEL admissions in the last year of life which cannot be accounted for by GP activity or GP WTE.
- I Care & Share embedded for last 3 years may be a factor
- When one outlier for low GSF activity was removed, ACP coding rates had a statistically significant inverse correlation with NEL admission. This supports the above assertion. High Care Home beds is inversely correlated with NEL
- Similar observations were not demonstrated with A&E attendance alone
- Opportunities to understand themes in other Places especially Wirral

Palliative and End of Life Care

Findings of GSF and ACP General Practice Survey

NHS
Cheshire and Merseyside

eolp Confidence to Care

MACMILLAN CANCER SUPPORT

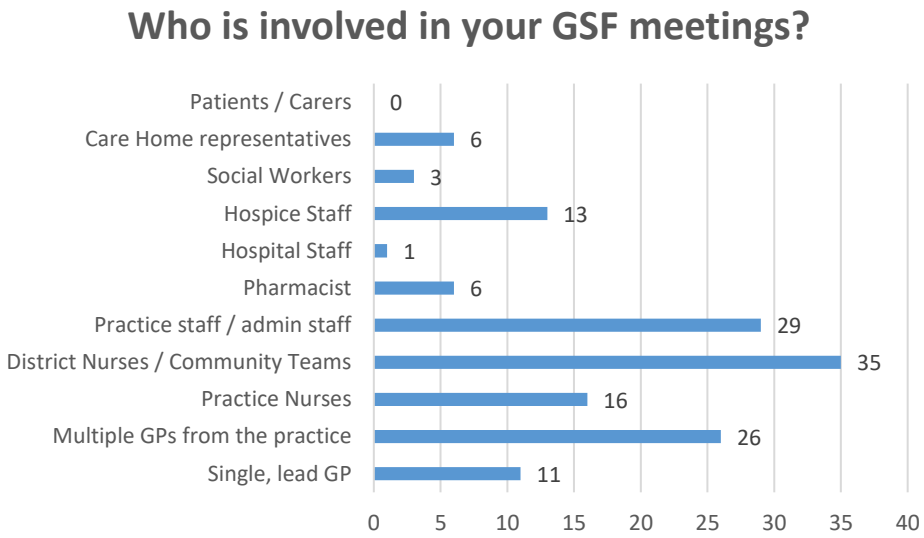
In February 2026, the PEOLC Programme reached out to 85 of the best performing, and recently most improved GP Practices with a simple survey asking about their experiences of Palliative Care, Gold Standards Framework and Advance Care Planning.

The survey asked questions about PEOLC leadership, GSF meetings and the use of tools such as EARLY and ACP templates

39 practices responded to our survey (46% response rate). The findings are presented here.

Leadership

- All practices have a named lead for Palliative & End of Life Care, or for GSF
  - *in most cases this is a GP Partner (26/39), or salaried GP (8/39)*
  - *A small number have a nurse lead, and in one case responsibility was split between a clinical and non-clinical lead.*
- 37/39 practices hold regular GSF meetings
  - *More than half are held monthly.*
- Overwhelmingly (34/39), responders say these meetings are “very useful” or “somewhat useful”



‘Other’ examples:
IMPaCT Team, Macmillan Specialist Nurse, Community Matron, Respiratory Palliative Care Lead Nurse, SPCT as able, Palliative nurse, Cancer Care Support Worker, Specialist Palliative Care Nurse, Contact Cares PCN Frailty Team, PCN Care Co-ordinators, Physician Assistant will also be joining and taking a lead.

GSF Meetings

The feedback on GSF meetings shows clear variation across practices.

- Where administrative support and structured processes exist, GSF meetings are highly effective, productive, and valued.
- However, inconsistent attendance - particularly from community nursing - and limited information-sharing infrastructure significantly reduce MDT effectiveness in many places.
- There is a strong need for improved digital systems, consistent coordination roles, and better cross-team communication pathways.

Example Quotes

"Our GSF meetings are very well supported and structured. We have a dedicated admin team member who reviews and updates our GSF lists on a weekly basis, which ensures the information we discuss is current and accurate. Prior to our monthly meetings, she prepares updates, circulates a clear agenda, and revisits actions from the previous meeting to ensure continuity and accountability. This level of preparation makes the meetings focused and productive, and it supports effective follow-up on agreed actions. We are continually reviewing and refining our processes to improve efficiency and patient care. Overall, the organisation, administrative support, and commitment to ongoing improvement are real strengths of our GSF meetings."

"Community nurses are invited to our meeting but are sometimes unable to attend so can be difficult to share info, as we do not have access to their notes or who is on their list."

"We feel the meetings need to be improved and streamlined with more IT support needed. Would appreciate help in improving the meetings further"

Early tool

- Only 8 practices (15%) said that they used the Early tool.
  - 6 were ‘best performing’ practices
  - 2 were ‘most improved’
- 20 said they had not heard of it (50%+).
- 5 of the 8 who use it said it was “extremely” or “somewhat” useful.
  - 2 said it was not useful.
- 6 practices reported using other tools to identify potential GSF patients (non specifically named)

Feedback on using Early

- The current tool generates **large numbers of patients**, some of whom are **not appropriate** for end-of-life (EOL) conversations at this stage.
- Some practices have **adapted the search criteria** to improve relevance—for example, including housebound patients or those with DNACPR, EHCP, or SR1 status.
- Some practices already have **internal systems** (e.g., Docman, or simple spread sheet) for identifying new cancers, chronic deterioration, discharges, home visits and co-morbidity for GSF discussions.
- A few respondents have **only recently become aware** of the Early tool.
- There is **limited awareness** of what *SPICT* or *Cipha* are.

Example Quotes

“Early produces a reasonable list of patients who should be on GSF- the problem is, finding the time to see, explain, have ACP discussions etc… I feel we spend our time "fighting fires" that need dealing with - the proactive identification work is just as important but hard to find the time. It’s really import”

“We have found the "housebound flu vaccine" list is a good proxy for a life expectancy of less than 18 months”

Care Planning

22/39 (56%) practices told us they used the C&M Personalised Care Plan Template

- Usage was slightly higher in the best performing practices (60%) than in the most improved practices (44%)
- 13 of the 22 (60%) said it was “extremely” or “somewhat useful”

29 practices told us that they used other tools to help with advance care planning such as uDNACPR, EPACCS, STARS and Respect.

Practices in areas such as Halton and Warrington are encouraged to use local templates (often modified versions of the C&M template)

Feedback on using Templates and Tools

1. Lack of Consistency and Too Many Changing Templates

- Clinicians feel overwhelmed and confused by multiple templates (e.g., Supportive Care, EPACCS, I Care and Share, STARS, Macmillan, Halton template).
- Frequent changes make it unclear which tool should be used and when.
- Desire expressed for one **unified, stable approach**.

2. Existing Local Systems Are Working

- Some areas (e.g. nursing homes) already have processes in place that work well.
- There is **reluctance to change** to new templates when current methods are familiar and effective.

3. DNACPR / uDNACPR Use Varies

- Several teams use **uDNACPR**, DNAR forms, and spreadsheets to track patients with DNACPR.
- There is clearly variation in documentation methods across the system.

4. Additional Tools Mentioned

- Advance Care Plans, admission avoidance forms, GSF care home tools.
- The Halton template noted as useful for complex MDT and palliative patients.

What works well	Identified Challenges	Some tips
Structured, consistent GSF and ACP processes, with: • Leadership and strong MDT engagement • Dedicated admin support • Well prepared meetings with clear agendas and action reviews. • Embedded ACP and GSF into routine practice rather than separate tasks. **Experienced GPs** regularly discuss ceilings of care and ACP within **routine chronic disease reviews**. Use of **unplanned admissions** as an identification tool.	**District nursing workload pressures**, often struggling to attend GSF meetings **Communication issues with hospitals**, particularly when patients are discharged at end of life **Lack of IT infrastructure** to generate useful reports for GSF meetings. **Limited capacity** to deliver high-quality GSF and ACP work consistently due to overall system pressures.	**A clear written policy, or guide, for your practice** can help when new people take on leadership roles. **Use Early to focus on patient groups often overlooked** in GSF and ACP such as respiratory or CVD **Review ACP, DNACPR and 'housebound' lists** to consider whether patients should be added to GSF GSF "green or above" patients having a **named GP**, improving continuity GSF patients and carers given a **phone number** that bypasses the automated GP system

NHS
Cheshire and Merseyside

NHS
North West Coast
Strategic Clinical Networks

Questions and Answers?

The suite of tools and resources to support

are listed here

(localities may have agreed alternative options that serve the same purpose BUT coding must align to the requirements for EPaCCS)

- **NHS North West (Strategic Clinical Network)** pages on Palliative care NHS England — North West » Palliative and end of life care
- **NHS Cheshire & Merseyside (ICB)** pages on I CARE & Share I-CARE & Share - NHS Cheshire and Merseyside

- **'EARLY'** NHS England — North West » EARLY Identification in Primary Care (EARLY toolkit)
- **'SHADOW'** (for care home residents) NHS England — North West » Early Identification in Care Homes (SHADOW)
- **'MAYFLY'** communication skills NHS England — North West » MAYFLY
- **C&M Personalised Care Plan 'PCP'** - NHS England — North West » Personalised Care Planning – C&M
- **uDNAR** Electronic-uDNACPR-NW-form-v1-2.pdf (england.nhs.uk)
- **EPaCCS** NHS England — North West » Eleic Palliative Care Coordinating Systems (EPaCCS)

- To request access to the C&M EOL Dashboard, complete this form https://dynamis-birequestform.xmerseyhc.nhs.uk/
- The C&M PEOLC Population Based Needs Assessment and appendices can be downloaded from https://eolp.co.uk/pbna/

Evidence of ACP/PCP in reducing hospitalisation

Retrospective cohort study (n~16000) - Aus

PCP >6m before death 18% less NEL admissions (aOR 0.83, 95% CI 0.74 to 0.92)

PCP <6m before death – higher ED & NEL

Scott I, et al. BMJ Open 2024; doi: 10.1136/bmjopen-2023-082766

Within Alzheimers Dementia (n=254) - USA

Reduction in likelihood of being hospitalised (mean: 0.74; standard deviation: 0.31; $p < 0.01$)

25% reduction in hospital costs (p<0.01)

Ji Won Yoo et al. Int. J. Environ. Res. Public Health **2023** **https://doi.org/10.3390/ijerph20126157**

Meta-analysis (9 studies n=57180)

Reduced hospitalisation ((RR) 0.54, 95% CI 0.47-0.63)

No statistically significant effect on ED visits, hospice enrolment or satisfaction with care

Apiradee et al. J Am Med Dir Assoc 2022 DOI: 10.1016/j.jamda.2022.07.017

Meta-analysis (113 studies)

- Advance care planning was often found to decrease life-sustaining treatment
- Increase use of hospice and palliative care
- Increase compliance with patients' end-of-life wishes

A Brinkman-Stoppelenburg et al 2014 https://doi.org/10.1177/0269216314526272

RCT (n=309) - UK

- Wishes known and followed: ACP 86% vs Non-ACP group 30% (p<0.001)
- Significantly less stress, anxiety, depression and higher family satisfaction

KM Detering et al. BMJ 2010;340:c1345 https://doi.org/10.1136/bmj.c1345