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DIGITAL CARE AND SUPPORT PLAN STANDARD

CASE STUDIES

FEBRUARY 2018

The Professional Record Standards Body

The independent Professional Record Standards Body (PRSB) was registered as a Community Interest Company in May 2013 to oversee the further development and sustainability of professional record standards. Its stated purpose in its Articles of Association is: “to ensure that the requirements of those who provide and receive care can be fully expressed in the structure and content of health and social care records”. Establishment of the PRSB was recommended in a Department of Health Information Directorate working group report in 2012.

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Introduction

The PRSB developed a standard for digital care and support plan, so that these plans can be effectively shared between patients, carers and all the health and care professionals involved in that person's care.

As part of the project, several health and care communities doing work on integrated care planning were identified, approached and consulted. These consultations helped to inform development of the standard.

Four communities were selected to participate in case studies with the purpose of illustrating local care planning work, celebrating achievements and identifying challenges.

The main report is published separately. This is a supplementary document presenting local work from the following communities:

- East London NHS Foundation Trust
- South Somerset Symphony Programme
- Oxfordshire CCG
- Hillingdon Health and Care Partnership / Hillingdon CCG

All of the case studies were reviewed and approved by a representative from each community.

For further information please contact: The Professional Record Standards Body, <http://www.theprsb.org> or support@theprsb.org.

East London NHS Foundation Trust (ELFT)

Deployment of the RiO eCPA forms and the DIALOG+ framework to enhance recovery-focused practice and the delivery of the 'My Recovery Care Plan'

Organisation profile

ELFT Provides a wide range of community and inpatient services to children, young people, adults of working age, older adults and forensic services to the City of London, Hackney, Newham, Tower Hamlets, Bedfordshire and Luton. ELFT provide psychological therapy services to the London Borough of Richmond, Children and Young People's Speech and Language Therapy in Barnet and specialist addiction services in Redbridge.

In addition, the Trust provides forensic services to the London Boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest, and some specialist mental health services to North London, Hertfordshire and Essex. The specialist Forensic Personality Disorder service serves North London and the specialist Chronic Fatigue Syndrome/ME adult outpatient services serve North London and the South of England. The Trust recently acquired community services in Tower Hamlets, including the Foot Health service, Contenance service, Occupational Therapy and District Nursing

Background

The decision to undertake a joint review of the Care Programme Approach (CPA) Policy with Local Authority Partners was taken at the Service Delivery Board in July 2015. The purpose of the Joint CPA Review was to deliver an updated CPA Policy, process and documentation which:

- Provides a single policy for ELFT, jointly agreed with 7 Local Authority partners
- Encourages and supports positive person centred practice
- Is Care Act compliant
- Is recovery focused
- Is meaningful and useful for service users and carers
- Is less time consuming and easier for staff to use and complete
- Is delivered by RiO based information collection and in-line documentation

In December 2016, the Service Delivery Board approved the adoption and implementation of the new CPA Policy and the deployment of the RiO eCPA forms and process across the Trust using the DIALOG+ framework to enhance empowering, recovery-focused practice and the delivery of the My Recovery Care Plan. The new CPA Policy and RiO based CPA Process has been in use across the Trust since April 1st 2017.

Business process

Before the introduction of RiO eCPA forms

Old CPA forms were excessively long and paper-based, requiring collecting demographic details during every CPA visit. Staff survey identified dissatisfaction with a number of key areas with emerging themes around the length of time it takes to complete care planning activities, including the administrative burden, and the irrelevance existing care planning processes are to service users and their families and carers.

After the introduction of RiO eCPA forms

The opening page of the live RiO DIALOG+ screen features three boxes that are about the service user's recovery, goals, "what matters to me" and skills, strengths and experiences. This design change means that clinicians and coordinators undertaking the care plan will be prompted by a more person-centered approach rather than spending time collecting patient information that is already known to RiO.

Functionality of RiO has been integrated with the NHS Spine infrastructure; ensuring contact information is updated and joined up across other healthcare organisations in England.

The Trust has benefitted from the development of the Health Information Exchange network in East London. A hyperlink has been configured within RiO at the individual patient level to a HIE portal with a read only view of relevant Barts and Homerton patient level information. This view is currently being extended to other health service providers such as GPs. The network is also able to view ELFT patient data including the new 'My Care Plan' based on a Recovery approach, recent medical & pharmacology progress notes and safety plans.

Approach

In August 2015, the East London Foundation Trust (ELFT) was tasked with reviewing the existing Care Programme Approach process and policy jointly with its four Local Authority partners in East London and three Local Authorities in Luton and Bedfordshire to examine its effectiveness for service users, staff groups and to ensure its compliance with the Care Act 2014.

Phase 1 brought together key stakeholders through a series of local workshops to clarify the requirements for a new and improved CPA process, reaching representatives from practitioners and operational leads, administrators, service users and leads from Local Authorities. The result of facilitating engagement activities enabled the State of Requirements and Care Act Key Principles to be drawn up to drive the design and development Phase 2 between November 2015 and January 2016.

During Phase 2 the CPA User Reference Group was established to include a larger number of key users from each Borough to test and comment on the work output of the Design and Development Group, responsible for progressing the work guided by the CPA Statement of Requirements and Care Act Key Principles.

It was agreed to use the DIALOG+ tool as a framework to underpin the architecture of the new eCPA form before working to embed all forms into RiO. DIALOG+ has been rigorously tested in ELFT and promotes a recovery-focused approach that was otherwise not integral to existing CPA process. Key benefits in using DIALOG+ as a clinical outcomes tool encourages discussions between the staff member and service user on self-management and crisis planning, it explores options that are agreed between staff and service users and is a more empowering and therapeutic method for engagement.

Nine services were identified across the Trust in which to pilot the new eCPA form across the broad landscape of clinical settings. The pilot ran between 3rd October and 3rd December 2016 with fortnightly teleconference calls arranged between each site, the Project Lead and ICT services in order to update and monitor progress and to continually refine the new system.

Benefits

The Benefits of using RiO eCPA for care planning include:

- Data from RiO eCPA can be used to directly populate 'My Safety Plan' form which can be emailed or printed for the Service User.
- Similarly, a 'My Care Plan' is auto populated from the form with additional information and is sent to GP using direct electronic transfer into GP EMIS systems and by e-mail to others in the care network. Different output summary reports or care plans can be generated for different care settings based on requirements.
- Additional benefits include cost effectiveness, service user satisfaction, staff user satisfaction, Care Act compliance.
- It is also envisaged that the new CPA process will lead to:
 - a) Increased involvement of service users in agreeing goals and planning care;
 - b) Increased satisfaction with service (PREM) and therapeutic relationships with care coordinators;
 - c) Increased focus on recovery-focused goals, better match between self-defined and professionally defined needs as identified;

- d) Improved clinical outcomes (e.g. meeting service user needs according to PROM ratings, reduced hospitalisation rate, HoNOS scores).

Challenges and lessons learned

The inclusion of 'My Recovery Plan' alongside 'My Safety Plan' have replaced 'risk management' concepts. It was found that it is important to not use the term 'risk' and instead use 'safe'. Patients don't usually want to see a list of what they know is wrong with them but they do want to know how you are going to support and help them.

The main issues that were identified were:

- IT/Technical Issues - a lack of RiO connectivity in service users homes is limiting the ability of Care Coordinators to complete e.g. Dialog+ forms interactively with service users during home visits and meaning a continue reliance on paper. Some Teams also highlighted insufficient laptops or tablets as an issue.
- To what extent should there be a move away from recording mental state examinations and assessments in the Progress Notes on RiO and instead using the Mental State and History and Context screens in eCPA?
- Are some of the RiO screens and reports (printable documents) developed for the new CPA process, relevant and useful for non CPA Patients?
- There is also a need to clarify and agree how the new CPA and DIALOG+ will be used in inpatient settings. How does the new CPA care plan relate to the inpatient Nursing Care Plan?

Training

As part of the implementation, more than 2000 staff have received the co-produced, half-day training in The Principles of Recovery and the new CPA Process. These half-day training sessions continue to be offered to staff, along with other bespoke training and practical support to Teams in the use of the new RiO based CPA Process.

In addition, there is regular WebEx training offered for psychiatrists to familiarise them with the CPA suite of documents and the output reports, including the Recovery Care Plan and Case Summary.

November 2017

The South Somerset Symphony Programme

Organisation profile

The South Somerset Symphony Programme is a collaboration between the South Somerset GP Federation (19 practices), Yeovil District Hospital, Somerset Partnership NHS Foundation Trust, Somerset County Council, South West Ambulance Service Trust and other local providers including third sector.

Background

The South Somerset Symphony Programme is an NHS PACS Vanguard site (Integrating Primary and Acute Care Services). They used the Symphony data set which showed 4% of population were using 50% of the NHS budget and another 17% using 75% of the budget. The programme was set up in response to look at how to deliver care differently.

The Complex Care team was tasked with identifying and managing the most complex patients. Health coaches (non-clinical) were set up in GP practices supporting next tier down to prevent them becoming more complex. Emergency services (out-of-hours and ambulance) were involved along with nursing homes, district general hospital, GPs and community services.

This case study will focus more on the Symphony Care Plan aspect of the Symphony Programme.

Business process

Initially there were many different care plans that everyone was using, so the work was undertaken to have a single care plan. Currently the Symphony care plan is being used which is comprised of several modules.

Approach

Complex Care Team (Symphony Care Hub) initially wanted to develop a patient held care plan which multi-disciplinary team could also access. They started using Patient Knows Best (PKB) system but at the time it didn't integrate well with existing computer system used in Somerset. Around this time CCG had developed a multi-organisational My Life Plan (based around House of Care goal setting) which was around 60 pages long. There was also work being done around avoiding unplanned admissions with a rudimentary care plan. These care plans were then streamlined into the Symphony Care Plan which is a modular care planning document.

This plan is not a clinical record but includes essential information to help plan for the future. It is modular due to existing electronic health record system (EMIS) not being able to handle document updating very well and to encourage completion of modules when opportunity arises, rather than feeling a whole plan needs to be created at once. The care plan is divided into elements:

- a) About me – requires fair amount to put together initially and manual typing. However, does not need frequent updating.
- b) My medical facts – may need frequent updating as diagnoses are added or medications change but is fully merged from the existing record and involves no typing
- c) Goal planning – for patient to work on with health coach and GP.
- d) Self-management plans (ie asthma, heart failure, angina, depression, etc) - general advice, mostly pre-written – a starting point to be edited and personalised to the patient.
- e) Treatment escalation plan (TEP) – about advance care planning and treatment.
- f) Specific care plans that need sharing (eg wound dressing).

All main providers have access to EMIS Viewer which doesn't allow sight of the whole record but does allow viewing all documents attached to the patient record. As documents are created, a read code is automatically generated which can be used to inform users that they exist. The Symphony Care plan is therefore widely visible.

The Symphony Care Plan document supports the care planning process. One of the core elements to the Symphony Programme's success has been the creation of a new Enhanced Primary Care model (EPC) – primary care linked in with secondary care. As part of the EPC model, new specialist healthcare roles have

been created to focus on prevention, care coordination and patient support. Seventeen GP practices across South Somerset are now operating the model, with over 50 Health coaches in place across the practices who have seen over 5000 patients to date.

Health coaches not medically trained. If a person is activated in their care, they have a coaching role to support their goals. For those patients less activated, health coaches are helping with care coordination, ensuring they have support in place which is coordinated, ie their benefits are coming in, ensures input from social services, district nurses, OT assessment. Health coach support results in a smoother pathway across multiple care providers, reduces duplication and contributes to “seamlessness”.

Benefits

Different team members update the plan. Health coaches are good at putting background information, particularly regarding carers and support networks, and working with patients on the goals and what's important for them. Health coaches also support GPs, asking what needs to go in the plan from medical perspective and what discussions patient requires and any educational needs to make it into a reality going forward. Nurses and GPs add medical content, and sign off these and the Treatment Escalation Plan.

Alongside that, Complex Care Teams assist with the more complex cases including medical issues but also capacity, best interests and power of attorney. They work with number of practices and alongside the community team – physiotherapists, occupational therapists and district nurses to write a really effective care plan. They have an ongoing role in educating the wider team about what works in care plans, feeding back and improving the process.

Nursing homes have been engaged in the TEP process. They felt comfortable to have discussions with their residents and used a variant of the RCGP “Three Questions” document to stimulate discussion and lay the groundwork. GPs or senior nurses do the final TEP and sign off.

Challenges and lessons learned

- The out-of-hours service has not been keen to use EMIS Viewer as they have their own system. There is currently engagement to look at how barriers to use can be addressed and benefits for the provider identified and maximised.
- The ambulance service works across counties – they feel that they can't use EMIS Viewer due to the number of systems they already need to access simultaneously. Currently, documents are emailed once created so ambulance then uses their system to view them.
- Currently GPs are responsible for updating and maintaining documents. There is a county-wide project looking at implementation of FHIR to push data back and forth to allow documents to be updated easily by other providers.

Training

There have been several iterations of care planning training over recent years across Somerset under the House of Care banner. Use of the principles is widely understood and incentivised through the Somerset Practice Quality Scheme.

Health Coaches have a documented training scheme in place during initiation and subsequent refreshers and meetings to share best practice.

Treatment Escalation Planning is an evolving area with a tension between community use of the forms which often documents patient preferences as opposed to hospital based use which tends to centre around not offering treatments which will not benefit the patient – recognising futility of escalation in some circumstances. A new county-wide TEP has recently been developed and there are discussions ongoing as to what training is needed to support this and perhaps help community teams recognise more situations where hospital interventions will be unhelpful in the patient's particular circumstances.

The Complex Care Teams have an ongoing role in supporting and enhancing use of the care plans.

Oxfordshire Care Summary and the digital Proactive Care Plan

Organisation profile

Established in 2013, Oxfordshire Clinical Commissioning Group (CCG) is the organisation that plans, buys and oversees health services for more than 700,000 people living in Oxfordshire. They work with local people, local GPs, hospital clinicians and other partners, including local government and the voluntary sector.

All GP practices in Oxfordshire are members of the CCG, and the views of the health professionals who work in these surgeries and that have first-hand experience of treating patients, inform their priorities

Background

In 2014, NHS England incentivised GP practices to identify the 2% of their practice population most at risk of unplanned admissions, to work with the community MDT to develop a plan to reduce the risk of admission, and to share this plan with the patient and urgent care providers.

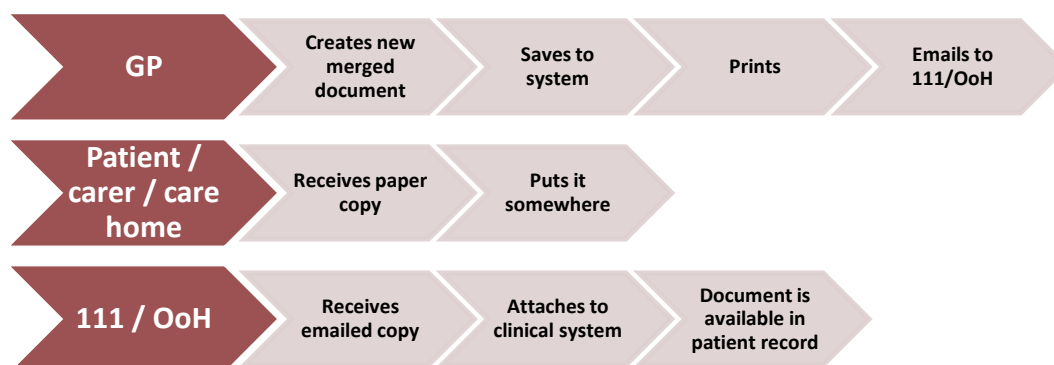
In Oxfordshire a clinical group met to consider the requirements of the Unplanned Admissions Care Plan and concluded that these requirements overlapped with a number of other care plans and decided to create a single Proactive Care Plan (PCP). This plan incorporated the requirements of Palliative Care, Care Homes and the Frail Elderly. It was originally created as a merged Word template on GP systems; the resultant document was saved on to the system, printed for patients and emailed to urgent care settings.

In the meantime, the Oxfordshire Care Summary (OCS), a health information exchange displaying Primary Care Data from the Medical Interoperability Gateway (MIG), had become an early adopter of structured data. This meant that data could be transformed by the OCS to be displayed in different formats.

Members of OCCG requested that this functionality could be used to develop a view of the PCP.

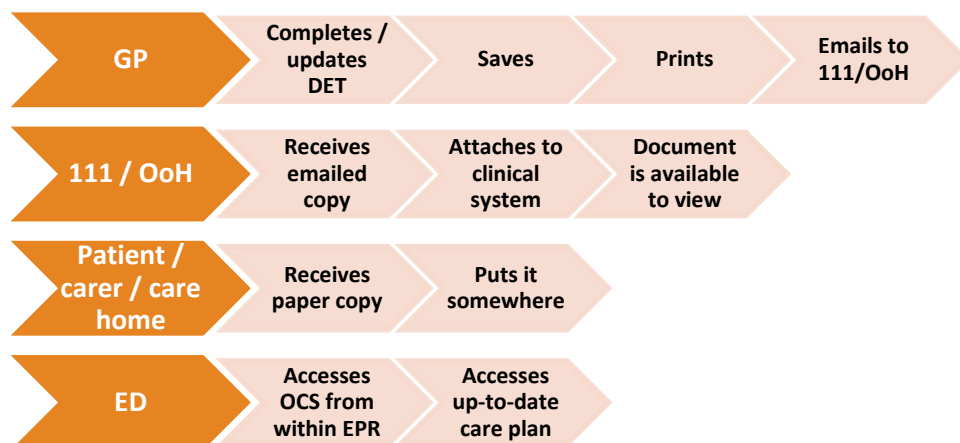
Business process

Before the introduction of OCS Digital Proactive Care Plan



After the introduction of OCS Digital Proactive Care Plan

- GPs enter data onto EMIS using a Data Entry Template (DET) (this ensures that they are using the correct terms);
- The MIG searches for these terms (and the associated free text) and returns them as structured data;
- The OCS displays these terms in a patient-centred view.



Approach

- The Read terms associated with the PCP were identified and, where necessary, additional codes were procured from the MIG.
- An EMIS data entry template was designed to allow GPs to capture the data intuitively and reliably.
- A view of the data was designed, based on the work done on the Buckinghamshire Coordinated Care Record and on workshops with users.
- The data entry template and the view were built, tested and assured, and released in July 2015.

Planned Developments

- Improvements to the Data Entry Template and the OCS view are developed and released regularly.
- Urgent care system suppliers have been approached by stakeholders across South, Central and West (SCW) and the Sustainability and Transformation Partnerships (STPs) and have agreed to facilitate click-through access to Local Care Records.
- As part of the Oxford University Hospitals Global Digital Exemplars (OUH GDE) programme, the OCS is moving to a Cerner platform. The PCP will persist on the new platform as we expect.

Benefits

- The data entry template is now the standard method of creating and updating a PCP, meaning that live data is always used.
- The data is instantly available on the OCS and is used regularly in ED, with anecdotal evidence of an improvement in the quality of care.
- Safer patient care – reported by 96% of users.
- Improved outcomes – reported by 81% of users.
- Improved productivity – estimated at £2m productivity savings in first year.
- OCS reduces average length of stay in OUH by 5 days (statistical analysis of 2 cohorts, sample sizes 11,000 (OCS) and 30,000 (control)).

Challenges and lessons learned

Routine access to the OCS by urgent care services is hindered by constraints in logging on to the system. This means that care plans are still emailed to these services, and have to be manually attached to their systems.

Training

Supporting documentation, manual, FAQs and training videos have been prepared and are available to staff.

Hillingdon Health and Care Partners Integrated Care Partnership

Organisation profile

The Hillingdon Health and Care Partnership (HHCP), supported by Hillingdon CCG, is an integrated care alliance between the Hillingdon Primary Care Federation (currently 44 GP practices), The Hillingdon Hospital NHS Foundation Trust, Central and North-West London NHS Foundation Trust and H4ALL (a community interest company composed of five charities: Age UK Hillingdon, DASH, Hillingdon Carers, Harlington Hospice and Hillingdon Mind).

Background

In 2014, Hillingdon CCG supported the main health and care providers in Hillingdon to come together to deliver a model of care for Hillingdon's older adult population (over 65s); a population of approximately 40,500 (55% female). A clinical model was co-produced which had several components including a multidisciplinary risk stratification strategy, care and support planning and proactive case management by 15 Care Connection Teams (CCTs); each consisting of a non-clinical care coordinator and a community matron working across 2-3 practices.

This case study will focus on the Care Planning aspect of the model.

Business process

Care Planning gained momentum in Hillingdon following The North West London Collaboration of CCGs' selection as an Integrated Care Pioneer site. Care Planning was initially undertaken using a selection of templates that were devised for various long-term conditions and included a process for frail elderly patients. As processes matured, individual LTC templates were amalgamated into a more holistic person-centred template. The resulting care plans were printed from primary care systems for patients and also for the urgent care system.

The formation of an outcomes based framework for the care of older adults using a capitated budget gave rise to the need for multidisciplinary care planning to take place. In order to achieve this, a digital solution was sought and Hillingdon applied to become a pilot site for the Imperial College Charity-funded North West London Care Information Exchange (NWL CIE). Over the last year, Hillingdon has been working with the NWL CIE to pilot structured data flows from EMIS Web, Hillingdon Hospital's Pathology and Patient Administration System (PAS) systems, and for data to be sent to our local 111 provider's system, Adastra.

Approach

The CIE pilot in Hillingdon has just started and will involve:

- Structured data from EMIS Web (GP system) – nightly extract: Demographics, Diagnoses, Medication, Allergies
- Structured real-time data from Hillingdon Hospital: Pathology and Radiology results, Inpatient Admissions, Discharges and Transfers, Outpatient Appointments and A&E Attendances.
- Sharing of electronic patient Care Connection Team (CCT) flags between Community Systems and The Hillingdon Hospitals NHS Foundation Trust's Digital Care Record; The Hillingdon Care Record. These flags will enable Hillingdon Hospital to identify patients that have been admitted as belonging to a certain CCT and therefore allow prompt communication to the CCT to facilitate better care coordination and outcomes.
- Care Planning functionality within the NWL CIE designed to allow manual entry of goals, actions and owners
- A view of the Adult Social Care support plan

The NWL Digital team are currently working with the NWL CIE and also the London Health and Care Information Exchange (LHCIE) to develop an interoperable solution to support multidisciplinary care planning. This is an interim measure; Seamless multi-agency/ multi-disciplinary care planning will require open Application Programming interfaces (APIs) to enable Primary Care, Acute Care, Mental Health,

Community and Social Care systems to support the exchange of care plans, tasks and data requests for care plan creation, maintenance and tracking.

Benefits

The NWL CIE will provide a holistic view of the health and social care needs of older adults with complex needs. It will also enable better care coordination across health and social care in Hillingdon. Structured nightly and real-time data flows, as detailed above, will ensure updated, accurate information about a patient is available to all health and care providers including, but not limited to, primary care, secondary care, A&E, 111, community services and adult social care. The platform will also enable a step change with respect to integrated care planning being perceived as a static primary-care led activity to a more dynamic, collaborative multi-agency/ multi-disciplinary activity that evolves with a patient's health and care journey.

Challenges and lessons learned

Gaining traction to implement across an entire health and care economy has had challenges with respect to stakeholder engagement and training. Information Governance, technical limitations and subsequent development work has also taken longer than expected.

Training

Training has occurred for the first set of Care Connection Teams (CCTs) who will be initiating the CIE pilot across the first three practices in Hillingdon. Further training is planned in the near future as the programme is evaluated and expanded.

February 2018

Glossary of Terms

Term / Abbreviation	What it stands for
CCG	Clinical Commissioning Group
CPA	Care Programme Approach is a package of care used to plan mental health care
DIALOG+	a therapeutic intervention that improves the communication between a health professional and a patient and, through that, outcomes of mental health care. It combines assessment, planning, intervention and evaluation in one procedure
eCPA	Electronic Care Programme Approach
EMIS	EMIS Health supplies electronic patient record systems and software used in primary care in England
HoNOS	Health of the Nation Outcome Scales
LTC	Long term condition
MDT	Multi-disciplinary team
MIG	Medical Interoperability Gateway
OT	Occupational Therapist
PACS	Primary and Acute Care Systems
PREM	Patient reported experience Measures
PROM	Patient Reported Outcome Measures
RCGP	Royal College of General Practitioners
RiO	CSE Servelec's RiO electronic care record system
TEP	Treatment Escalation Plan
WebEx	online meeting, web conferencing and videoconferencing application