Coordinate my Care

An Implementation Guide for Care Homes

Health Innovation Network

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Introduction

This Implementation Guide has been written as a resource to support care homes and care home commissioners to implement the Coordinate My Care (CMC) service in care homes. The guide was developed as a result of a project conducted by Health Innovation Network (HIN), the Academic Health Science Network (AHSN) for south London, who explored the processes, the challenges and the enablers for care homes in implementing the CMC service to create CMC plans for care home residents.

What is CMC?

Coordinate My Care (CMC) is an innovative electronic urgent care coordination service that enables the creation of personalised individual urgent care plans that include key information about the patient, clinical recommendations about future care and the patient's own care wishes.

The CMC plan contains clinical information about the patient's diagnosis, allergies, medications and resuscitation status as well as their wishes and preferences on where they would prefer to be cared for and, if appropriate, where they would wish to die. It can also include any cultural and religious beliefs that are important to the patient.

CMC supports the provision of more effective patient centred care, utilises more appropriate health care resources and reduces the stress of inappropriate hospital admissions for residents and their families.

Who can access CMC?

A patient's CMC plan can be shared electronically with all the health and social care professionals who care for them, including NHS urgent care providers in an emergency. This can include the London Ambulance Service, NHS 111 operators, GPs, out of hours GP services, hospitals, nursing and care homes, hospices and community nursing teams (see diagram 1 overleaf), thus, assuring the patient's care wishes are at the centre of their care.

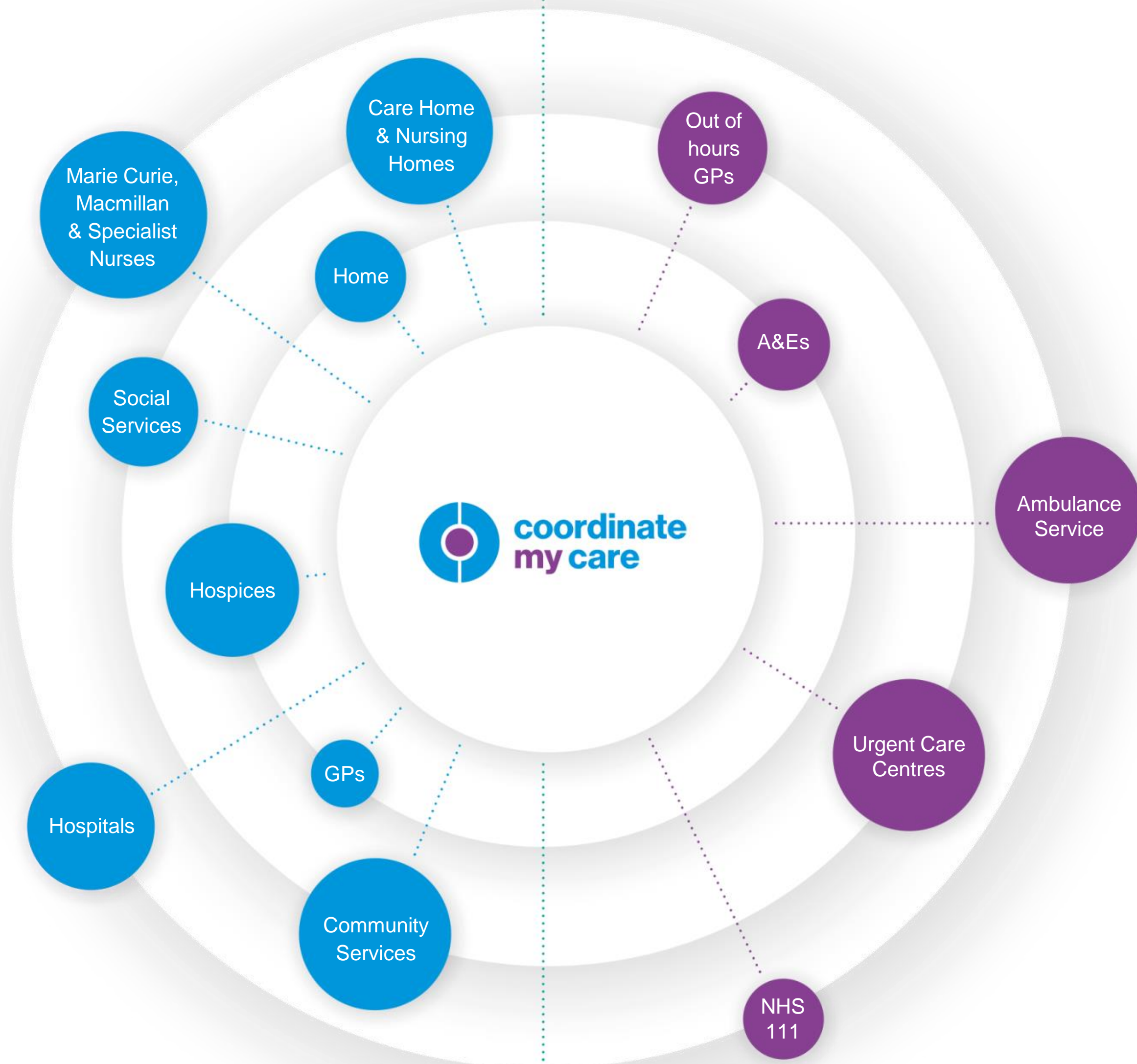
Patients can see their own care plan online through a laptop or smart phone (as a read-only version) if requested and can request changes over time. They can also receive a printed version from their GP or nurse, although viewing online will ensure they are seeing the most up-to-date version.

A patient's CMC plan can be shared electronically with all the health and social care professionals who care for them.

Coordinate My Care Access

Care home providers can create, view and update CMC plans and

Urgent care providers can view and write short notes in CMC plans.



Why care homes?

As an urgent care plan, CMC is beneficial for people who:

- are identified as being at the end of their lives
- are living with long-term conditions
- use the NHS urgent care services frequently
- have a mental health condition, including dementia.

Care home residents live an average of 26 months from the time of their admission, with approximately 50 per cent dying within 14 months. The length of stay is known to be shorter for those in a nursing home compared to those in a residential home . With high levels of cognitive impairment, co-morbidity and complex health and social care needs care home residents are among those who would benefit from having an electronic urgent care plan and a voice on how and where they wish to be cared for.

The Benefits

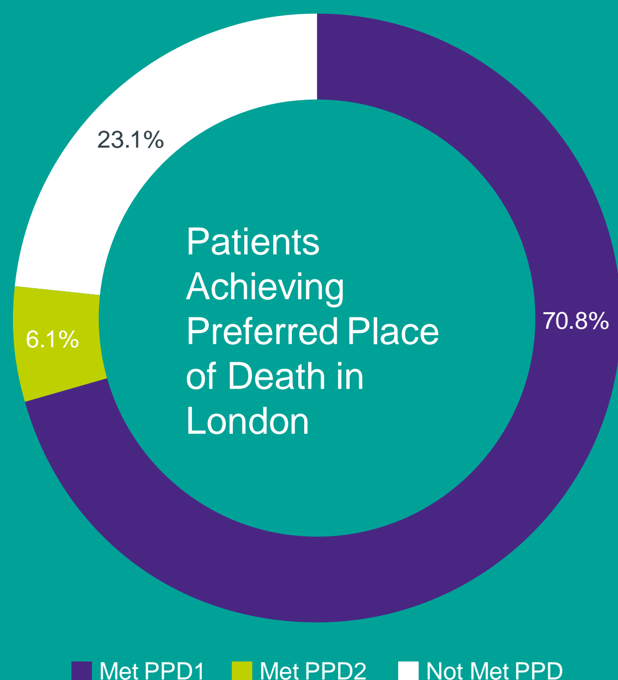
Care home staff spend a long time with their residents and know them and their visiting family and friends well thus, the care home setting offers a valuable opportunity for being able to work together to create quality personalised care plans.

For care home residents

The main beneficiary of having a CMC plan is the care home resident. The CMC plan involves residents in their own decision-making, offering them a voice on how they preferred to be cared for in an urgent care situation, including when they are approaching the end of their life.

A CMC plan enables 'need to know' care information to be available to key health providers in an emergency, without having to rely on getting that information from the resident, the resident's family, the care home or other professionals at this critical time. This prevents repeated conversations with different care professionals along the residents' care pathway.

Aggregated data shows a clear correlation between patients having a CMC urgent care plan in place and achieving their end of life wishes. Less people with a CMC plan are dying in hospital (approximately 18 per cent of those with a CMC plan died in hospital compared to 54 per cent who do not have a CMC plan) and more people with a CMC plan are dying in their preferred place of death, which for many people is in a non-acute (hospital) setting such as at home, in a care home or in a hospice (see Diagram on the right). CMC has also been shown to improve the service offered to patients including hospital avoidance if that is their wish.

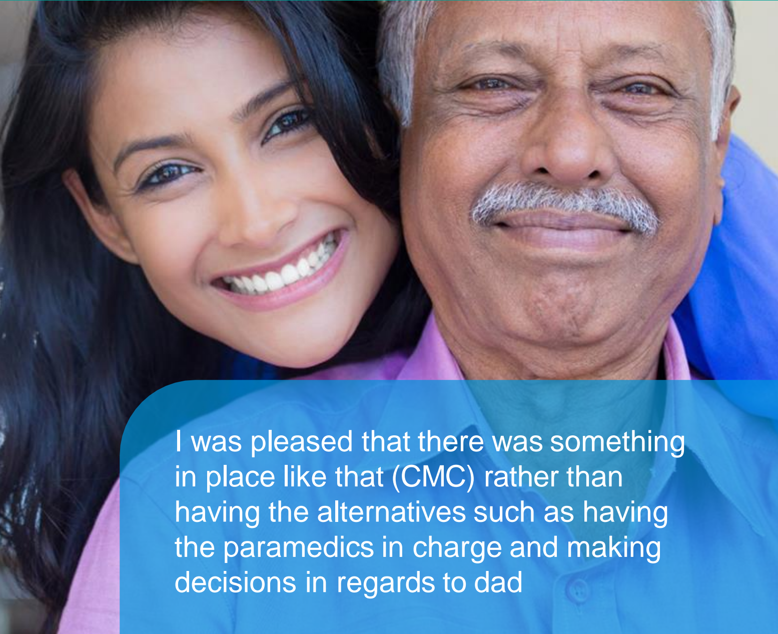


There were **49,381** patients in London with a recorded date of death on CMC as of September 2020. Of these, **42,704** had a place of death recorded, of whom **33,883** had explicitly expressed a preferred place of death (some may have had no preference or were unable to discuss).

For family & friends

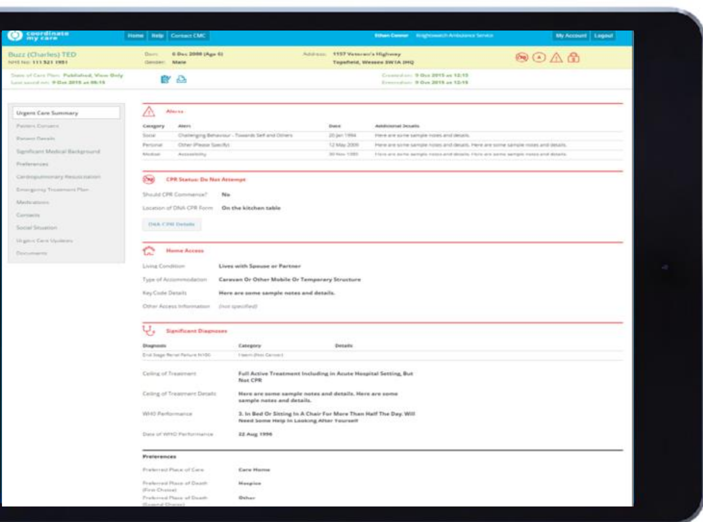
The care homes residents’ family and friends often value the opportunity to have advance care discussions with their loved ones and knowing their loved ones’ care wishes when an emergency arises.

CMC makes you feel reassured. I think for me the right questions have been asked



I was pleased that there was something in place like that (CMC) rather than having the alternatives such as having the paramedics in charge and making decisions in regards to dad

I think it is great that they (the ambulance service) have some knowledge already on mum now if they are called out



For care home staff

Care homes can often be quite isolated from the wider care system, CMC offers an opportunity to participate in ‘virtual’ multidisciplinary care planning review meetings with other health and social care professionals caring for their residents, keeping the patient at the centre of their care. The CMC platform allows for all parties involved in the care of a patient to view the care plan live and for the care plan to be updated by one person accordingly.

CMC plans offer care home staff assurance that all relevant information is held in one place that it is easily accessible (night and day) when a crisis occurs. It gives care home staff more certainty on what action to take. As the care plan is updated in real time all professionals, including care home staff will access the most recent version.

Knowing that an urgent care provider will be more informed when contacted about a resident offers care home staff additional support and reassurance that relevant information about the resident, including their care wishes are communicated.

Preparing the Home for CMC

There isn't a one-size fits all approach when it comes to implementing CMC in the care home.

Care homes vary in the type of care they provide as well as the skills and experience of their staff. Some care homes will have nursing staff, some may have previous experience of advance care planning and some may specialise in palliative care. Although there may be a few care homes who use digital resources already, using electronic systems will be totally new for most care homes. Therefore, care homes will have different needs when it comes to implementing CMC to create care plans. This guide hopes to address these different needs.

The following key processes and enablers will guide care homes and care home commissioners through the necessary steps to start using the CMC service and creating electronic urgent care plans for care home residents. Each step is outlined in more detail within this guide.

1	Achieve 'Standards Met' on NHS Digital Data Security and Protection Toolkit
2	Get buy-in from your care home company or charity
3	Work collaboratively with your care home GP(s)
4	Assess your IT infrastructure
5	Implement CMC's Governance processes
6	Ensure staff have advance care planning discussion skills
7	Identify a CMC lead and some protected time
8	Complete the CMC training

TIP: There will be a named person in either the care home's Local Authority or local Clinical Commissioning Group (CCG) who has (some) commissioning responsibility for care homes in the local borough. It is recommended that the care home manager or corporate care home company contacts this lead, who will be able to inform the care home of what support is available in your local area when considering implementing CMC (e.g. care home support teams, end of life care support and primary care networks (PCNs).

1 Achieve 'Standards Met' on NHS Digital Data Security and Protection Toolkit

A fundamental starting point when considering implementing CMC in care homes is for the care home to have achieved 'Standards Met' on the NHS Digital Data Security & Protection Toolkit (DSPT).

The DSPT is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's data security standards. All organisations that access NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.

There are three levels of attainment on DSPT, see the table below for more information.

Name	Description
1. Entry Level	• time-limited level for social care providers; • evidence items for critical legal requirements are being met; but some expected mandatory requirements have not been met; and • allows access to NHSmail.
2. Standards Met	• evidence items for all mandatory expected requirements have been met; and • access to NHSmail, other secure national digital solution (e.g. Summary Care Records and local digital information sharing solutions).
3. Standards Exceeded	• evidence items for all mandatory expected requirements have been met; • the organisation has external cyber security accreditation; and • evidence of best practice.

In London, as part of the Enhanced Health in Care Homes Programme, Healthy London Partnership (HLP) have developed a DSPT workbook and guidance to support care homes to achieve compliance to 'Entry Level' (the minimum required to gain access to NHSmail) and plan to provide further support to care homes in 2020 to reach 'Standards Met', required for local digital information sharing solutions, like CMC.

If the care home is part of a corporate organisation, their Head Office will be able to inform the home whether the DSPT has been completed and to what level.

If the DSPT has not been completed please go to the DSPT website for further information - https://www.dsptoolkit.nhs.uk

You will need to register on the DSPT to complete it - please use the link here https://www.dsptoolkit.nhs.uk/Account/Register

Care homes will need to review their DSPT status annually via the DSPT website above.

2

Get buy-in from your corporate company or charity

If the care home sits under a broader umbrella company or charity, it is important to contact your head office to inform them of any interest in implementing the CMC service in the care home and to get their approval to go ahead.

In addition, head office will host specific functions and expertise (e.g. Information Governance and Information Technology) and can provide specialist support to the care home in regard to information governance and IT issues when implementing the CMC service.

3

Work collaboratively with your care home GP(s)

When a care home is considering introducing the CMC service into the care home, it is essential that a discussion is had with the care home GP(s) at the outset as the GP will hold important information about the patient (e.g. clinical information and recommendations about future management) that will help inform the CMC plan.

Two types of CMC access rights are available to care home staff, depending on their qualifications. These are 'Clinical rights' and 'Administrator rights' (see below).

Clinical Rights
Only registered clinicians (e.g. doctors, nurses) are given clinical rights. Having clinical rights allows the care home nurses to complete all fields of the CMC plan and finalise (publish) the plan, making it available to urgent care providers.

Administrator Rights
Other care home staff (e.g. a health care assistant) can have administrator access to the CMC system, whereby they can start a plan, read and make changes to a care plan, but cannot clinically complete and finalise (publish) the care plan. Instead they must submit it to a registered clinician to finalise, via the CMC system.

Plans can be created and 'finalised' by registered nurses working in a care home. However, it is recommended that they work in close partnership with the care home GP when completing clinical components of the plan.

Registered nurses in the care home can choose not to finalise the care plan and have a local agreement with their care home GP to finalise the plans.

Administrator access can be granted to other care home staff who can complete non-clinical components of the plan. The plan is then sent to the GP for inclusion of any relevant clinical information and to finalise the plan.

Whichever approach is taken by a care home, the care home GP will need some clinical oversight to ensure essential clinical information is included in the plan. So, it is imperative that the GP(s) are involved and an approach agreed at the outset.

Alternative arrangements can be agreed at the outset for another clinical professional to approve CMC plans initiated by care home staff (e.g. a district nurse or an end of life care nurse, a palliative care doctor). Again, local discussion and agreement will determine this.

Note: It is important that a plan is finalised in a timely manner otherwise it will sit in draft form and will not be viewed by urgent care providers when an emergency arises. A resident and/ or their relative may have given up the time to discuss their care preferences for inclusion in the plan and expect these wishes, along with other relevant information, to be available to urgent care providers when needed.

4

Assess your IT infrastructure

Using a digital resource effectively relies on robust IT infrastructure and support, thus the care home needs to assess their IT infrastructure in preparation for CMC.

CMC requires a good internet connection (one that allows access to the BBC). If the coverage is not consistently good in all areas of the home, a decision may need to be made to create CMC plans in specific areas of the home where the Wifi strength is good and more reliable.

The care home will then need to consider which devices they will want to use to host the CMC system and where they will be best located to create the CMC plans.

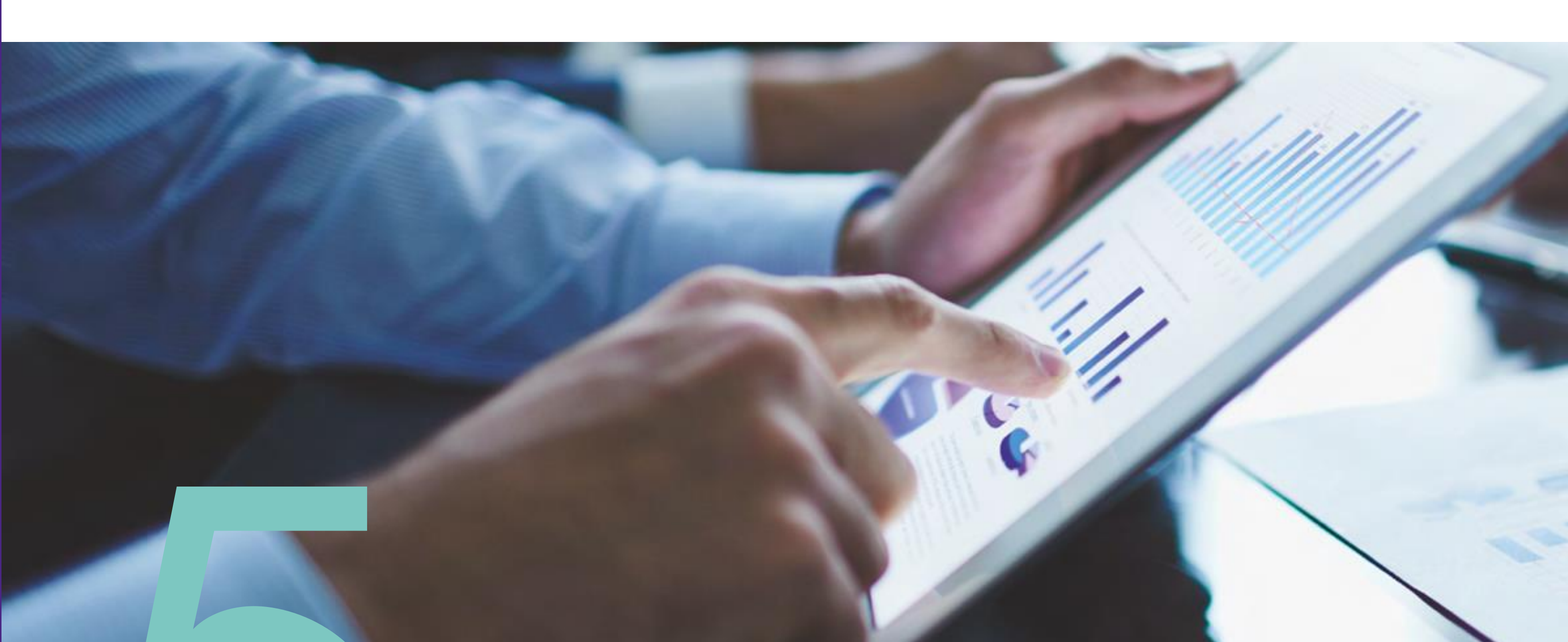
Options are to use stationary devices (e.g. PCs), or mobile ones (e.g. work-owned laptops or tablets).

If a stationary device (e.g. a PC) is the preferred option, assess the Wifi coverage in that location. It is also important to consider whether the device is located somewhere that is easily accessed by staff to create CMC plans, whilst also offering some privacy from constant interruption.

Care homes may want to access CMC on a number of devices (e.g. on a PC for each floor or wing). The CMC system can be made available on any number of devices along as they have been identified and logged with CMC (see page 15 for more information).

Devices require good security and protection, with up-to-date antivirus software. Ensure your security software is set to scan for updates regularly (daily or weekly) and accept these updates when they are presented.

Many care homes may benefit from IT support. If the home is part of a larger corporate company or charity, an IT lead (often based at head office) may be best placed to provide this support. Independent care homes may need the support from their independent IT provider. Identifying an IT lead responsible for solving any CMC issues which may arise is recommended.



5

Implement CMC's governance processes

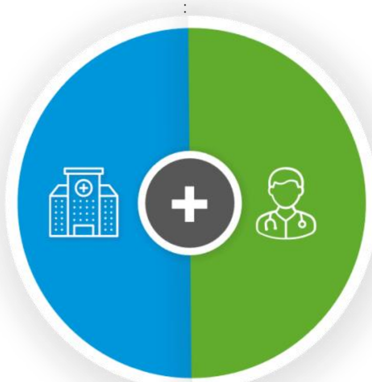
Both organisational and individual information governance processes need to be signed off by an organisation and its staff users of the CMC service before access to the CMC service is granted.

This includes adherence to CMC's Information Sharing Agreement, acceptance of CMC's Acceptable Use Policy, keeping an up-to-date record of the CMC users, self-certifying that users' IG training is up to date and being in receipt of appropriate CMC training.

CMC Information Governance Pathway Summary

Employing Organisation

- Suitable current NHS Digital Data Security & Protection Toolkit attainment
- Signed CMC Information Sharing Agreement
- CMC User Access Form authorising me to use CMC



Individual

- I am up to date with my NHS Digital Data Security & Protection training
- I have the knowledge I need to use CMC safely and appropriately
- I have formally agreed to CMC's Acceptable Use Policy (on screen)

CMC access is granted

Follow this link to see the CMC Governance Pathway in full - www.coordinatemycare.co.uk/wp-content/uploads/2020/10/cmc-clinical-governance-framework.pdf

Sign CMC's Information Sharing Agreement

The Care Home's Caldicott Guardian, Data Protection Officer or Senior Information Responsible Officer needs to sign CMC's Information Sharing Agreement (ISA).

Before a care home can install the CMC system it must have an ISA in place to cover its relationships with CMC and other participating organisations.

CMC has a single ISA that is used across all user organisations. The agreement is based on the principle that all CMC user organisations are joint Data Controllers (with each CMC user organisation being the Data Controller for the CMC records it creates or engages with), with CMC being the Data Processor.

The purpose of this agreement is to formalise the data sharing arrangement between the CMC user organisations (e.g. the care home), whilst also outlining the ISA's compliance to Information Governance standards. Each CMC organisation is agreeing to share the patient information they enter on the CMC system with all other CMC user organisations (e.g. GPs, urgent care providers) who have a legitimate reason to access this information.

The Information Sharing Agreement & signature page can be found on the following link - www.coordinatemycare.co.uk/for-healthcare-professionals/become-a-user

The CMC ISA has an accompanying signature sheet that needs to be completed and signed by the Care Home's Caldicott Guardian, Data Protection Officer, Senior Information Responsible Officer or the functional equivalent and returned to CMC via coordinatemycare@nhs.net

Complete CMC's User Access Form

A list of the care home staff who require access to the CMC system needs to be sent to the CMC service by completing a CMC user access form.

There is an electronic form for those using nhs mail and a form that can be downloaded for those without nhs mail, which can be printed off and returned by email to coordinatemycare@nhs.net

Both forms can be found at www.coordinatemycare.co.uk/for-healthcare-professionals/become-a-user

By completing this form the care home is agreeing with the Information Sharing Agreement and is making a commitment to inform CMC about any users who leave the care home.

Once the users have completed CMC training, each user will be sent individual login details to the email address provided when completing user access form. Each user needs to login with these unique details. Once logged in they need to create a new password, using something that is more memorable to them. It is also good practice to set up some security questions that may be asked if the user forgets their password.

Acceptable Use Policy

When users login to the CMC system for the first time, they will also need to formally agree to the CMC Acceptable Use Policy which will appear on screen. This explains the purpose and context of CMC, the responsibilities of the user, and the information governance and other requirements with which they must comply.

Any suspected inappropriate access raised with CMC will be fully investigated. All accesses to the care plan, who accessed, where, when it happened, what they did is available to the CMC team and can be fully audited if an appropriate need arises.

Request a non-HSCN secure licence (Authen2cate)

Most care homes do not have access to the NHS Health & Social Care Network (HSCN) connection, which provides a safe, reliable, efficient and more flexible way to access and exchange confidential electronic information. However, CMC can issue non-HSCN secure licences to care homes, using 'Authen2cate', a software that maintains all the necessary security measures.

Identify the devices that will be used for CMC planning and give each device an identification number (e.g. the name of the unit, a computer number or computer 1,2,3). A record of the identification numbers need to be kept for any future correspondence with CMC.

The identification numbers for each device, along with an email address (that can be accessed easily by most or all identified users) needs to be sent to the CMC office via coordinatemycare@nhs.net

A non-HSCN secure licence will be forwarded to the email provided for download to each device, along with the Authen2cate Enrolment Guide.
Each licence has a User ID associated with it. This is not for accessing CMC generally but just for allowing the successful downloading of the licence certificate.

Administration rights to each computer will be required to download the certificate. These rights might be required from your care home's IT support provider, which can be completed remotely if they are not based at the care home.

Once the licence has been downloaded a CMC icon can be placed on the computer's desktop for ease of access by the care home CMC users.

The CMC system will automatically lock down an account after 180 days of inactivity.

The licence will need to be re-downloaded every 9 months with the original User ID associated with the licence. If you cannot remember it please contact the CMC Helpdesk - 020 7811 8513

CMC Passwords

Passwords should be at least 10 characters in length, include at least one capital letter, and at least one lower case letter. Special characters are not required but can be used.

If the password has been set up with security questions the password can be renewed through the Forgotten Password button. Passwords will not expire if used within a six month period. Simply logging in will ensure it does not expire.

CMC also have a 24/7 password reset service 020 7811 8513

Data Protection Impact Assessment

Creating CMC plans for residents involves processing personal data and so the care home will need to assess whether they need to conduct a Data Protection Impact Assessment (DPIA) for this change to service provision, and should seek advice from the care home Caldicott Guardian or Data Protection Officer or equivalent role.

A DPIA is a risk assessment with a specific focus on data protection and privacy, and as a process helps you identify and minimise the data protection risks of a project. The DPIA assess the likelihood and severity of the potential harm to individuals as a result of this change process.

It is good practice to complete a DPIA when you are bringing in any new system that could impact on an individual data rights. For example, if you move from a paper to an electronic care planning system.

A DPIA may not be necessary if a substantially similar DPIA for a similar process change has been previously conducted. When making this decision you need to be confident that you can demonstrate that the nature, scope, context and purposes of the processing are all similar. Please see the Information Commissioner Office (ICO) guidance on this here:

ICO guidance

If you are planning to use technology you have not used before, even if it is not brand new, we recommend that you still do a DPIA. The technology itself may have been tested by others, but you need to ensure that you understand the risks and implement it in the most privacy- friendly way – and it may still be considered a 'new technology' if you are actually using the existing technology in a new or innovative way. You may be able to rely to some extent on any earlier DPIAs carried out on existing technologies by the developer or by another controller who has already put it to use, but it is important to add on an assessment of your own specific implementation plans including the specific nature, scope, purposes and context of your processing.

Further advice can be found on the ICO website: https://ico.org.uk/for-organisations/guide-to-data-protection/ guide-to-the-general-data-protection- regulation-gdpr/data-protection-impact-assessments-dpias

Guidance on how to complete the CMC's DPIA with essential information can be found via the following link - https://www.coordinatemycare.co.uk/wp-content/uploads/2019/12/CMC-Data-Privacy-Impact-Assessment-Dec-2019.pdf

6 Ensure staff have advance care planning discussion skills

Creating a quality personalised CMC plan involves having a discussion with each resident and their relatives about advance care planning, including their end of life care wishes.

Advance care planning is a voluntary process of discussion and review to help an individual who has capacity to anticipate how their condition may affect them in the future and, if they wish, set on record the choices about their care and treatment and/or an advance decision to refuse a treatment in specific circumstances, so that these can be referred to by those responsible for their care or treatment (whether professional staff or family carers).*

NICE guidelines (2019) highlight that how "managers and care staff have an important role to play in supporting people to consider advance care planning".

This includes care home staff who may benefit from advance care planning training before implementing CMC. ACP training will include how to open up discussions with residents and relatives about their future care wishes.

Advance care planning training may be available from your local Hospice or sourced via End of Life Care teams or care home commissioners. Training resources are also available on the CMC website.
(see links to resources below)

*nhsiq, 2014

CMC resources

- A short video on Advance care planning
- Cardio-pulmonary Resuscitation (CPR) decisions

Both are available the following link -
www.coordinatemycare.co.uk/for-healthcare-professionals/clinical-training

There are also a number of National on-line resources available:

Macmillan ACP resources
www.macmillan.org.uk/information-and-support/organising/planning-for-the-future-with-advanced- cancer/advance-care-planning-england-wales

Marie Curie ACP resources
www.mariecurie.org.uk/professionals/palliative-care-knowledge-zone/proving-good-quality-care/advance-care-planning

National Institute for clinical excellence (NICE) – good practice guides
www.nice.org.uk/about/nice-communities/social-care/quick-guides/advance-care-planning

Macmillan's Primary Care top 10 tips to having difficult conversations
www.coordinatemycare.co.uk/wpcontent/uploads/2020/09/macmillian-primary-care_sep-2020.pdf

What's Best for Lily" - an end of life care training resource for care homes
https://uclpartners.com/work/whats-best-for-lily-end-of-life-training-for-care-home-staff

7

Identify a CMC lead and some protected time

Identifying a CMC 'champion' or 'lead' in the care home is recommended to ensure staff confidence and motivation to make the transition to this new way of working. This could be the care home manager, the care home clinical lead, a palliative care lead for the home, or the care home GP, or anyone else who has sufficient knowledge of what is needed and who has the drive and commitment to implement and embed this change.

Care homes may also benefit from allocating some protected time for their staff to focus on creating CMC plans in the initial stages until staff feel confident in creating CMC plans. Once created, the residents' CMC plans will need to be reviewed regularly to ensure they are current. A review date can be set when the plan is created. Review times range from three months up to 12 months. CMC plans also need reviewing after an illness or hospital admission.

8

Complete the CMC training

All CMC users must complete appropriate CMC training before receiving a CMC login to access the CMC platform and create CMC plans.

CMC offer scheduled webinars, video and face-to-face training sessions.
www.coordinatemycare.co.uk/for-healthcare-professionals/clinical-training

We can also offer customised training based on your availability and training needs. Please contact our clinical facilitators on cmctraining@nhs.net to arrange a customised training session.

Scheduled training webinars are on Tuesdays (am) and Thursdays (pm).
You can book via this link:
www.coordinatemycare.co.uk/for-healthcare-professionals/training-overview

There are also a range of short videos to assist completing specific sections of the CMC plan.

Recommended short videos

- CMC 100: Example short videos:
  Introduction to CMC / Accessing CMC / Find a patient and start a care plan
- CMC 101: Logging in to the CMC system
- CMC 102: Creating a new Care Plan
- CMC 103: Reviewing, Updating and Recording Death

CMC have created a variety of training materials to help professionals to develop their knowledge of using the CMC system. How to use it can be found here:
www.coordinatemycare.co.uk/for-healthcare-professionals/clinical-training

A CMC plan exists to facilitate communication about a patient's urgent care needs and preferences to a range of providers.

All provider organisations who use CMC, including care homes, will have signed an agreement to share the information they enter on the CMC platform with other users via the CMC Information Sharing Agreement (see page 14).

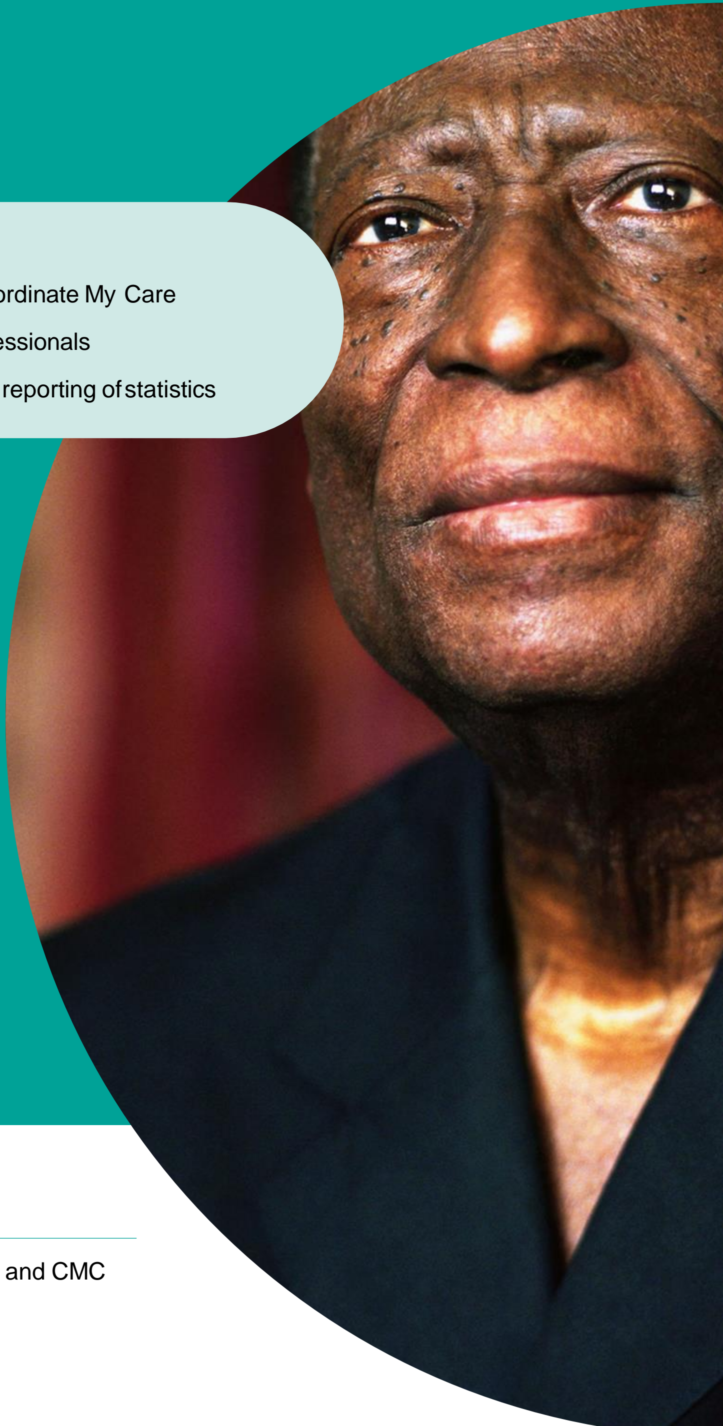
1

Consent

A CMC plan cannot be created without consent.

Consent covers the following:

1. creation of an electronic care plan stored by Coordinate My Care
2. sharing of the care plan among healthcare professionals
3. secondary use of data, such as the anonymous reporting of statistics



When starting a CMC plan, the user will be asked to indicate how consent (agreement to create the CMC plan) was obtained.

Consent should be obtained verbally and is sought from the person whom the plan is being created for. However, if a care home resident lacks the mental capacity to give their consent, residents' Lasting Power of Attorney (LPA) for Health and Welfare can consent on their behalf.

Where there is no LPA, the clinical team (a registered nurse or doctor) can make a decision in the resident's best interest, involving and family and carers where possible, whilst adhering to the Mental Capacity Act 2015. See CMC's consent and mental capacity information resources and guidance below:

CMC resources

You can find more information about patient consent and CMC care plans in
www.coordinatemycare.co.uk/for-healthcare-professionals/resposibility-to-patient-consent

www.coordinatemycare.co.uk/for-healthcare-professionals/training-viewing-creating-cmc-care-plans

CMC leaflets for residents and families explaining the service and what the resident is consenting to:
https://www.coordinatemycare.co.uk/wp-content/uploads/2018/12/cmc-patient-leaflet.pdf

Guidance on assessing mental capacity and making best interest decisions:
https://www.gov.uk/government/collections/mental- capacity-act-making-decisions

If at any time a resident requests to have the support of a care plan withdrawn at any time, the CMC plan can be withdrawn from view by the care home nurse or by the CMC team on request.

2

CMC system fields

A CMC plan allows healthcare providers (and patients) to record significant information about the patient, including:

- Diagnoses and prognosis
- Medication
- Allergies
- Contact details for professional care team and family
- Social support structure
- The patient's preferred places of care (if deteriorating or dying) where expressed by the patient
- Decisions about resuscitation
- Anticipated problems and guidance on their immediate management

The purpose of the CMC plan is to provide timely, meaningful, need to know information to urgent care providers in a crisis or in an emergency. Clinicians are encouraged to complete as much **relevant** information as necessary to ensure the most useful picture is available to urgent care services. Each resident is unique with their own needs and care wishes thus their care plan should be unique too.

CMC Care Plans seek to share with Urgent Care services 4 answers to 4 questions…

Where does the resident wants to and should be cared for

How much clinical/medical intervention is appropriate?

What to expect and do? e.g. Expected symptoms and management plans.

Who to call on? Contacts (professional and personal) to support the best outcome for the resident.

Where?

How?

What?

Who?

A CMC plan cannot be finalised (published) until the mandatory fields listed on the left of the CMC screen have been completed. The minimum information required to allow the care plan to be published on the system is:

CMC Screens	Mandatory information required
Patient Consent	• Patient name, NHS Number, Gender & Date of Birth (auto-populated from the NHS spine) • Type of patient consent - including justification if the care plan is being created following a clinical / Lasting Power of Attorney (LPA) decision taken on behalf of the patient if they lack mental capacity • Date consent obtained
Patient Details	• As above plus primary address • GP practice and/or name of GP (auto-populated from the NHS spine)
Significant medical background *	• Main diagnosis • WHO performance status & date • Prognosis
Patient care preferences place of care & place of death)	• Preferred place of care (options for 'not yet discussed' etc. available) • Preferred place of death (options for 'not yet discussed' etc. available)
Cardiopulmonary Resuscitation	• Do not attempt resuscitation (DNACPR) discussions taken place • Dates • Discussion summary or reason why not discussed • DNACPR Decision • If decision is no to CPR, complete eight questions in line with National Resuscitation Council's policies.
Clinical Recommendations *	Summary of expected treatment in specific situations (requires consistency with the CPR decision)
Medication	• Allergies information • Or 'No Known Allergies' and either 'I don't know' or 'No allergies known by patient'
Approval	• Enter a Review Date (three months is default) but can be up to one year • Name of clinician who will review the CMC care plan. (Registered CMC users only)

*The categories marked with an asterisk would primarily fall to the GP or other agreed registered clinician to complete. In the case of registered nurses it is recommended these items are completed in collaboration with the resident's GP.

Relevant Resources

Short 20-minute training video on viewing and creating CMC plans:
www.coordinatemycare.co.uk/for-healthcare-professionals/training-viewing-creating-cmc-care-plans

On request, the resident can view their own care plan on a personal device via CMC's patient portal 'myCMC'. They can also request some changes to the care plan. To do this a care home clinician clicks on the 'Subscribe' button on the care plan and enters the resident's email address.

A resident's relative or friend can also view the CMC plan as a proxy viewer. To enable this the care home clinician adds the relatives details in the 'myCMC' section of the CMC care plan.

CMC Support

For help with any CMC queries, please contact the CMC office via the following:

CMC Helpdesk

Monday – Friday 09.00 – 17.00 - 020 7811 8513

For password issues, for questions about the care plan or any trouble shooting issues.

24/7 Password Reset line - 020 7811 8513

Email: coordinatemycare@nhs.net

Care Home CMC Preparation Check List

Action	Achieved (Please tick)
The care home has achieved 'Standards Met' on the NHS Digital Data Security & Protection Toolkit (DSPT)	
Our corporate care home provider/charity (if applicable) has been informed and are willing to support us with the CMC governance processes	
We have discussed CMC with our GP(s) who provide clinical care to our residents and we have agreed to work together to create CMC plans for our residents	
We have good Wifi coverage and high functioning computers (or other electronic devices) that are antivirus protected	
Our information governance lead has signed the CMC Information Sharing agreement and forwarded to the CMC service via coordinatemycare@nhs.net	
We have sent the CMC service a generic care home email address and identification numbers for each device to be used for CMC planning to receive the non-HSCN secure connection licence (authen2cate).	
The care home manager has completed and signed CMC's user access form, listing all the care home staff who will be CMC users and require access to the CMC system	
The non-HSCN secure connection licence (authen2cate) has been downloaded (by our IT lead)	
The care home staff have received Advance Care Planning (ACP) training and are confident to have ACP discussions with residents and relatives	
The home has identified a CMC lead to engage, motivate and support staff to embed CMC	
Protected time has been agreed to ensure CMC has some focus initially and is embedded as standard practice	
The care home team have received CMC training	

Who are the Health Innovation Network?

We connect academics, NHS commissioners and providers, local authorities, patients and patient groups, and industry.

We work to **accelerate the spread and adoption of evidence-based** innovations and best practice across South London and beyond.

Population
3.5+ Million

Healthcare of Workforce of
60,000

55
Member Organisations

of 15
AHSNs in England

12
South London Boroughs

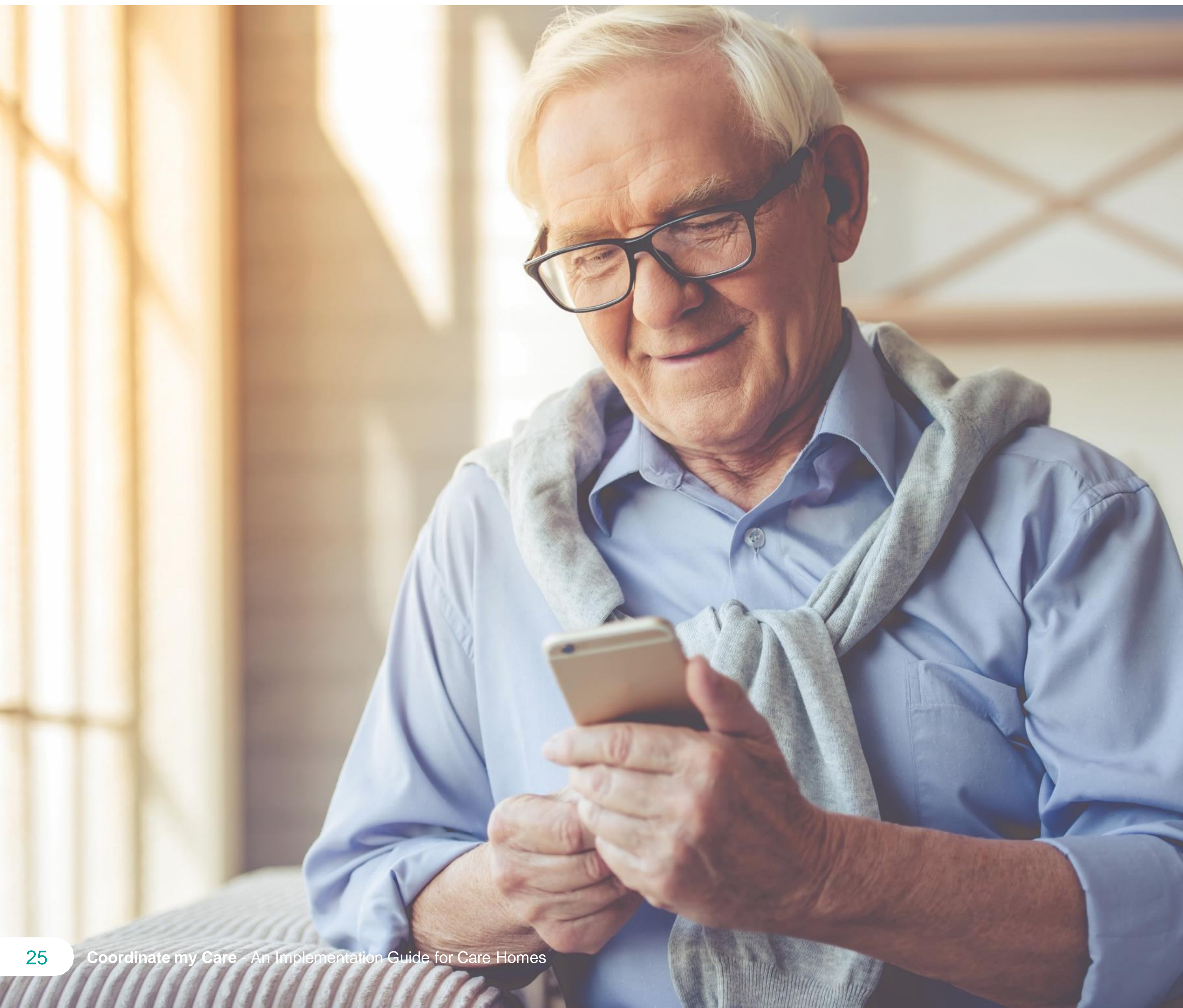
2
STP Areas

Who are Coordinate my care?

Coordinate My Care is a digital NHS service that was launched in August 2010 to deliver integrated, coordinated and high quality medical care, built around each patient's personal wishes. Once finalised and approved a Coordinate My Care personalised care plan can be viewed in real-time by all the urgent care services - 111, out of hours GPs, the Ambulance service and the Emergency Department.

Part of the Royal Marsden NHS Foundation Trust, the service is funded by London's 32 Clinical Commissioning Groups (CCGs). We currently work across London but are working towards expanding our service to other regions so as many people as possible can benefit from it.

Our core partner organisations that not only help deliver this service but were instrumental in its creation are London Clinical Commissioning Groups, London Ambulance Service, NHS111, Intersystems, NHS England.



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Revised October 2020
Review date April 2021

coordinate my care

Health Innovation Network South London