Coordinate My Care: joining up London’s end of life care services

*This resource has been taken from the NHS Improving Quality website*

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**Key points**

This case study was published by the National End of Life Care Programme

- Coordinate My Care (CMC) is an integrated model of care, currently operating across 97% of London
- Each patient gives consent to set up an electronic record of their wishes, which ensures all care providers are in the picture
- As a result most patients are dying in the community, where they wish
- It is planned to roll out the scheme across London by the spring of 2013

**Background**

The ability to capture and share information across the patient pathway is critical to any sustainable model of integrated end of life care. In the past that has not always happened in London.

**Challenge identified and actions taken**

Coordinate My Care (CMC) is an integrated model of care, underpinned by IT, which is currently being rolled out across London.

The service focuses on working with patients and families to understand their wishes and preferences for place of treatment and death and ensures that this is honoured, even when the instinct may be to focus on other aspects of care. Its aim is to provide better coordinated services by improving communications between hospital, out of hours services and community teams. CMC helps to link teams together to deliver the care that is designed specifically for each individual patient.

The priority is to provide integrated health and social care both for individual patients and for populations by bridging the divide between community and acute care settings and integrating with the voluntary sector, which remains a key provider in end of life care.

CMC is a further development of Electronic Palliative Care Co-ordination Systems (EPaCCS). Specialist providers offering training and disease specific pathways have helped to create a multi-professional service viewable by all legitimate professionals, including out of hours providers, NHS 111 and the London Ambulance Service (LAS).
Outcomes

The result is that any trained professional in the acute or community sector can set up a CMC record for any patient, regardless of diagnosis, who is identified as being in the last year of life. Each patient gives consent for a CMC record and this electronic record reflects ongoing end of life care discussions and advance care plans so that all care providers are kept up to date.

The CMC record can be accessed 24/7 through a central password-protected secure internet connection used by the NHS. This allows professionals access only to that information which is relevant to them and their geographical areas of work.

CMC integrates end of life care pathways both in and out of hours, including GPs, community nurses, community palliative care teams, hospitals, hospices, social workers, London Ambulance Service, 111, intermediate care and nursing/care homes.

The service is led by clinicians with clinical governance embedded in its framework. Information added by any health care professional is immediately viewable by all other legitimate professionals.

CMC works closely with the NHS 111 service and the two services are now inter-operable. The 111 call handlers have direct links to CMC. If the patient is on CMC, the 111 system flags their details and the call is handed over to a nurse within the 111 service who can navigate the caller through the CMC record to help them access the right care in the right place at the right time.

As well as providing integrated patient care CMC has the potential to monitor the care of patients approaching the end of life by auditing clinical practice. It can also aid caseload management by allowing different professional teams to produce reports and patient lists for their area of work.

Impact on quality and productivity

To date, CMC is being implemented across 97% of London, with the remaining area of Tower Hamlets coming on line soon. A total of 5273 individual patient records have been created and there are 5025 trained users across both voluntary and NHS organisations in the acute, primary care and community sectors.

Over the past 31 months 973 patients have a place of death recorded on CMC, 78% of whom died in the community (home 34%, care homes 30% and hospices 14%), 21% in hospital, 1% in other locations. In 2010 the ONS data for London reported that 59% patients died in hospital.
Of those patients who had a preferred place of death (PPD) documented, 77.4% achieved their PPD (72.3% achieved their first PPD and 5.2%, who changed their minds, their second PPD).

Half of the patients on CMC have a non-malignant diagnosis.

**Future plans and sustainability**

The CMC end of life care service is reaching patients with generic and specialist palliative care needs. More patients are dying in the community and fewer are dying in hospital compared to ONS data for the city. CMC will be rolled out across the whole of London, by the spring of 2013.