Guidance for practices using Ardens templates and resources to support delivery of the Year of Care approach – EMIS Web

This document is for practices that already use Ardens® and are implementing the Year of Care process of personalised care and support planning. There is an introductory page on the Ardens website (Year of Care : Ardens EMIS Web) that gives an overview of the tools and templates available and links to them, however below we outline in more detail how each maps to the Year of Care process.

Year of Care delivered a webinar with the Ardens team to navigate users through the resources available and how they are used throughout the Year of Care process. This can be viewed here Using the Ardens Resources to Streamline Multiple Long-Term Condition Care.

Stage of the Year of Care process	How IT supports the Year of Care process	Links to Ardens EMIS Web guidance
Recall and appointments	• A single recall system which identifies individual patients and combines all their long-term conditions • Some practices choose to run this in birth month	Choose searches Ardens LTC Recall System
Information gathering	An intelligent data entry template which avoids duplication across conditions and is weighted towards all the task based/data entry components being completed at this review rather than the PCSP conversation • Identifies what tests, questions and assessments need to be completed for the combination of conditions the person has without the need for interpretation of assessments or tests • Identifies which annual blood tests are due for conditions or drugs monitoring • Allows the HCA to identify and record any early patient concerns • Has red flags against urgent parameters that require more immediate review • Allows the HCA to document completion of this step and trigger the next part of the process including identifying patient preferences about mode of review (telephone or face to face) and method of results sharing (letter or email)	Ardens Multi-Morbidity Templates Ardens Blood Test Due Analyser
Professional Preparation and Triage	Practices will need to devise a local process of dealing with results • Lab results are identified as part of the PCSP process or separated from other routine results and not released to the admin team/patient until they have been reviewed • The system generates a note to the admin team to create the preparation prompt and an appointment with an appropriate professional and duration Able to add notes from triage which might include • Patient concerns or special notes (e.g. needs an interpreter) • Professional advice or areas of concern, including red flags • Initial medication review	Practices will need to devise a method of dealing with results and adding notes from triage to clinical record

Information sharing/patient preparation	The admin team generate the appropriate letter for the patient dependant on the combination of conditions the person has • A range of letters to match the combination of conditions the patient has • Letters are embedded with smart tags to bring in the most recent and previous results with SNOMED codes aligned to those used in the data entry template • The letter includes a patient identifier/name • The letter can be posted or shared digitally (email, text or NHS app) depending on patient preference • The admin team code completion of this part of the process	See step 3 – preparation at this link*: Year of Care: Ardens
The personalised care and support planning conversation	The clinician who does the review has a template which includes • A summary of the conditions • Information from triage displayed in a format that is easy to view plus the completed tests and assessments, including identification of results which are out of range and access to the preparation material • Space for a summary of the patient story and what is important for them • Intelligent templates that only display the conditions the person has and allow documentation of the clinical review to be recorded easily with links to disease review codes/medicines review/exemption reporting • Space for a summary of the professional story	Use the multi-morbidity template to complete the clinical review Multi-Morbidity Templates
Recording the agreed care and support plan	A template that allows the clinician to record • The patient goals and a level of importance (1-10) • The patients action plan with a level of confidence (1-10) • Actions for professional • Referrals and referral forms linked into the template • Period until next review • Completion of the PCSP conversation and plan	Use the care and support planning tab in the multi-morbidity template to record goals and action plans Multi-Morbidity Templates

*Contact Year of Care (enquiries@yearofcare.co.uk) for access to colour versions of the preparation documents that are suited to reading on handheld devices.