



eHNA &
Mycareplan.co.uk
Userguide

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Getting Started

Overview – eHNA and mycareplan.co.uk

Macmillan's Electronic Holistic Needs Assessment (eHNA) is an individual-held assessment questionnaire that allows an individual to identify their most significant concerns at key points along their cancer pathway. The assessment covers a wide range of physical, practical, emotional, family, and spiritual concerns.

Assessment responses are sent to the team providing their care via Mycareplan.co.uk allowing for a meaningful conversation, to help resolve concerns raised and record the actions to be taken in a care or support plan. Care and Support plans can be shared with the individual and others providing care. Data reports are available to all users via CSV files and can be used for reporting or analysis.

This user guide has been developed to help you use the Macmillan eHNA and the Care & Support planning tools.

Overview of key activities:

- Depending on your level of access as a care and support plan user you will be able to set up assessments, view assessments and care plans, contribute to care plans, lock/unlock care plans, download care plans and view some of the data that eHNA collects.
- The assessment can be completed anywhere by the individual: i.e. while visiting the hospital or organisation site, on their own smartphone, tablet, laptop, or PC.
- Assessment results will automatically appear in the care and support planning website to allow the care planning process to begin.
- Once the care plans are completed, they can be downloaded as PDF files for sharing with the individual or with other members of the team, AHPs, and so on.
- Data from the assessment & care planning is available in a CSV file format for local analysis in Excel or other tools.

Note:

- *The eHNA is made up of two separate websites:*
 - o *one used by the individual to complete the eHNA assessment,*
 - o *one used by the professional to set up assessments and complete the care planning.*

Getting Started:

Logging into mycareplan.co.uk

To log into mycareplan go to <https://mycareplan.co.uk>

If you are working in an NHS organisation you should always select the option to log in via the NHS network, unless you have been told to do otherwise. Organisations not connected to the NHS Network will need to use "another network connection"

To access the mycareplan site, you will need to have a user account. If you do not have an account or you are not sure of your login details, contact your local organisation administrator or ehna@macmillan.org.uk for further instructions. When your user account is set up you will receive an email containing a temporary password.

Enter your email address and the temporary password, then click "Log in".

If you cannot remember your password at any time you can use the "Can't log in? Forgotten your password" link to be sent a new one.

The first time you log in you will be asked to change your password.

Note:

- When changing your password this should contain:
- A minimum of eight characters
- A combination of uppercase letters, lowercase letters, numbers, and special characters (%\$£@!/? etc)

On the right-hand side of the login page for mycareplan you will see our eHNA News section. This section will provide insight into any additions or changes that have been made to the mycareplan system.

The screenshot shows the login interface on the left and the eHNA News section on the right.

Login Form:

- Section: **Log in**
- Field: **Email address** (Input: Email)
- Field: **Password** (Input: Password)
- Button: **Log in**
- Link: [Can't log in? Forgotten your password?](#)
- Text: Need to contact the Helpdesk? Please email: support@mycareplan.co.uk

eHNA News Section:

- Section: **eHNA News**
- Section: **New Macmillan for eHNA**
- Text: Macmillan's new brand is now on the eHNA platform! Things might look a little different, but underneath it will all be the same. My Care Plan, the assessment tool, the Portal and the Signup site will all show the new brand from now! Please let the [eHNA Team](#) know if anything strange happens when you're trying to use it.
- Menu: **My Care Plan** | Activity | Set up assessment | Data | Export | User Guide
- Section: **Activity**
- Text: My activity | Activity in my teams
- Section: **My recent assessments (last 30 days)**
- Table:

ID	Name	Primary ID	Secondary ID	DOB
View #1013	Test Andrew	222.222.2222	Andrew	10/12/1918
- Section: **eHNA new features**
- List:
 - You can now select a reason why the person



My Care Plan

Getting Started:

Overview of Activity Pages

Once you have successfully signed in you will be directed to the Activity Pages.

The purpose of these pages is to show you assessments and care plans developed within the last 30 days, and whether they are in progress or completed.

Note:

- The search option in the top right section. Use this to search for records via primary or secondary ID number, name, or DOB.
- The options you see will depend on the level of access that you have been given. Contact your organisation administrator if you do not have full access for your role. You will find your administrator details in your profile page see page 8.
- Definitions of the assessment status are provided in the activity part of the user guide.
- More information on the Activity page will be further along the guide

Activity

My activity | Activity in my teams

My recent assessments (last 30 days)

ID ▲	Name	Primary ID	Secondary ID	DOB	Team	Type	Status	Date
View #421833	Potts Eoin		Test444	05/06/1992	UKO Breast Team	CC	Expired	11/05/2022
View #427084	Test Andrew	222.222.2222		10/12/1918	UKO Breast Team	Palliative	Expired	25/05/2022
View #431354	Potts Eoin		Test033	06/08/1992	UKO Breast Team	SPARC	In progress	12/05/2022
View #433260	Test Andrew	222.222.2222		10/12/1918	UKO Breast Team	CC	Expired	21/05/2022
View #437158	Test Andrew	222.222.2222		10/12/1918	UKO Breast Team	SPARC	Expired	03/06/2022

Getting Started:

Your Profile

At the top right of Mycareplan, you will see four options: Directory, Profile, Account and Log out.

The Profile page will show you the teams you belong to and the level of access you have.

The access level determines the tasks you can do on my care plan; hence it is important to know.

The access roles that can be allocated to users are:

- **Setup** – this user can: set up assessment only
- **View** – This user can: setup assessment and view assessments and care plans only.
- **Edit** – This user can setup, view and edit care plans.
- **Lock** – This user can do all the above and lock the care plan – this will be the default for most users
- **Admin** – This user can do all the above plus unlock care plans and delete test records for their team.
- **Organisation Admin** – This user can create *Teams and Users* and can be given in addition to any of the roles above.

Note:

- *When logging in for the first time, please check your profile to ensure your teams and permissions are correct as you may work in one or more different groups.*
- *The profile page will also show you your team members & administrators. Administrators can unlock care plans and delete test assessments.*

The screenshot shows the 'Profile' page for Eoin Potts (MACMILLAN CANCER SUPPORT HQ). The page has a green navigation bar with 'My Care Plan' and various menu items. Below the navigation bar, there are two tables: 'My teams' and 'Team members'.

Team	Role
London General Team	Admin
London Gynae Team	Admin
Midlands Breast Team	Admin
North Lower GI Team	Admin
Scotland Breast Team	Admin
Scotland Upper GI Team	Admin
Shared Work Team	Admin
UKO Breast Team	Admin
UKO Head and Neck Team	Admin
Wales Upper GI Team	Admin

Team	Name	Role
London General Team	Andrew Brittle	Lock
London General Team	Eoin Potts	Admin
London General Team	Mary Winter	Lock
London Gynae Team	Andrew Brittle	Admin
London Gynae Team	Eoin Potts	Admin
London Gynae Team	Mary Winter	Lock
Midlands Breast Team	Andrew Brittle	Admin
Midlands Breast Team	Danielle Mellows	Admin
Midlands Breast Team	Wendy Munro	Lock
Midlands Breast Team	Eoin Potts	Admin

Getting Started:

Understanding the Directory

The directory shows all the teams and users that have been set up within the organisation and the teams that they belong to.

You can locate the Directory from the links on the top right of the page

Eoin Potts (MACMILLAN CANCER SUPPORT HQ) Directory **Profile** Account Log out

My Care Plan Activity Set up assessment Data Export User Guide Project admin Settings

Directory

Users

- Bell, Dany (London Lower GI Team, UKO Breast Team, UKO Head and Neck Team)
- Bowell, Sally (North Lower GI Team, North West Lung Team, UKO Head and Neck Team)
- Brittle, Andrew (Acute leukaemia team, Haematology team, London General Team, London Gynae Team, London Head and Neck Team, London Lower GI Team, Macmillan eHNA Trainers, Midlands Breast Team, NI Breast Team, Shared Work Team, UKO Head and Neck Team)
- Davies, Julie (UKO Breast Team, Wales Upper GI Team)
- Greer, Margaret (Scotland Breast Team, Scotland Upper GI Team, UKO Breast Team, UKO Head and Neck Team)
- Greer, Margaret (Scotland Breast Team, Scotland Upper GI Team, UKO Breast Team, UKO Head and Neck Team)
- Hunt, Richard (North West Lung Team, UKO Breast Team)
- Mellows, Danielle (Midlands Breast Team, NI Upper GI Team)
- Munro, Wendy (Midlands Breast Team, UKO Breast Team)
- Potts, Eoin (London General Team, London Gynae Team, Midlands Breast Team, North Lower GI Team, Scotland Breast Team, Scotland Upper GI Team, Shared Work Team, UKO Breast Team, UKO Head and Neck Team, Wales Upper GI Team)
- Winter, Mary (London General Team, London Gynae Team, Midlands Breast Team, UKO Head and Neck Team)

Teams

Acute leukaemia team

- Brittle, Andrew

Haematology team

- Brittle, Andrew

London General Team

- Brittle, Andrew
- Potts, Eoin
- Winter, Mary

London Gynae Team

- Brittle, Andrew
- Potts, Eoin
- Winter, Mary

London Head and Neck Team

- Brittle, Andrew

London Lower GI Team

Getting Started:

Account

Clicking on account will bring up the **Account page**.

Here you can change your password.

You can also opt in or out of receiving information/newsletters on eHNA and Care Planning from Macmillan.

The signature function is the same as you might find on your email program. The Notes section of each care plan you write will automatically be populated with this information, so you use it for your contact information, for example, meaning you have less to type on the care plan itself.

Account

Password

Old password	<input type="password"/>
New password	<input type="password"/>
Confirm password	<input type="password"/>

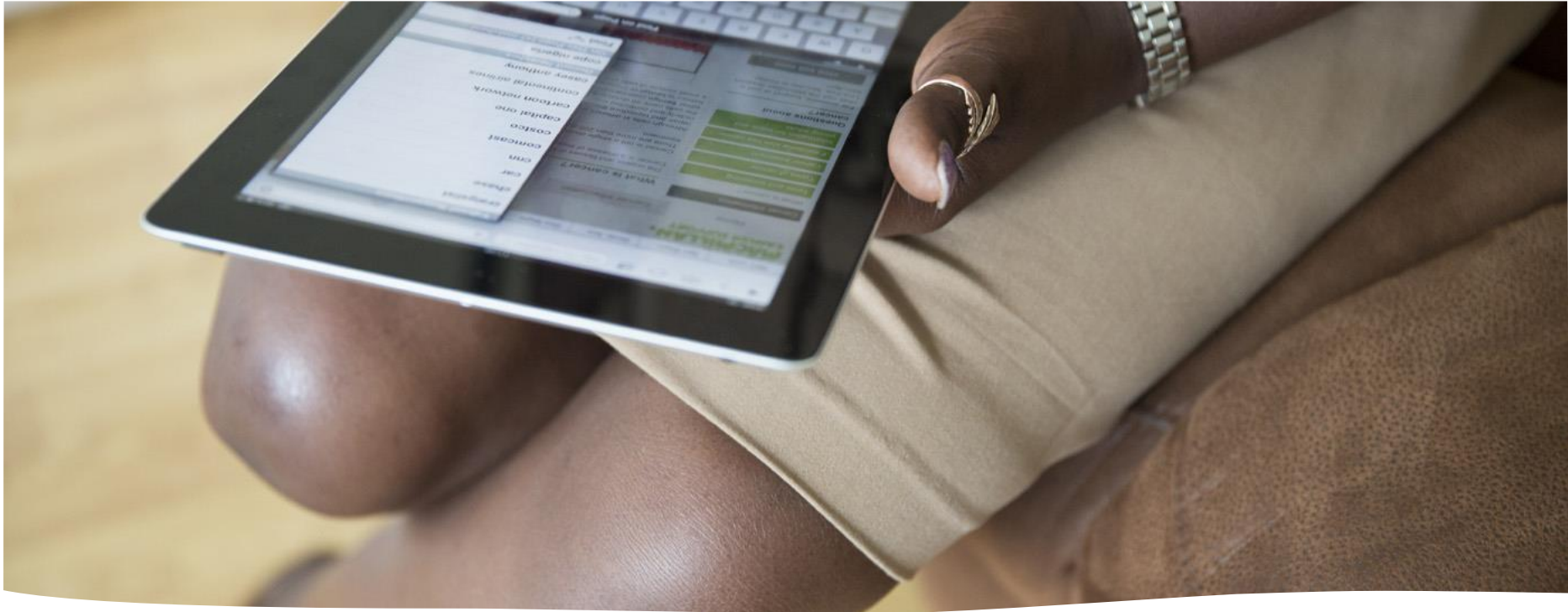
Account settings

First Name	<input type="text" value="Eoin"/>
Last name	<input type="text" value="Potts"/>
Email	<input type="text" value="EPotts@macmillan.org.uk"/>

Macmillan Cancer Support may contact me regarding EHNA and assessment and care planning

Signature

This will be added to care plan notes as a template, which you can delete or edit later	<input type="text" value="Contact Details: Eoin Potts eHNA Support Officer (Technical) EPotts@macmillan.org.uk"/>
---	---



Setting Up Assessment

Setting up assessments:

Primary ID:

In the top green bar click on "Set up assessment".

Where available we would always recommend using the NHS/CHI/H&C number as these will make any future sharing that you might want to do between organisations much easier. It can also help to pull together the assessments an individual has across different providers.

If you have the NHS/CHI/H&C number for the individual, enter it into the primary ID box and click search.

If the individual has had a previous assessment their details will already be recorded, and the information fields will automatically pre-populate. *Please check they correspond to the information you have available.*

If this is their first assessment you will need to add name, DOB and gender and then click Next.

Secondary ID:

If you don't have the NHS/CHI/H&C number available, you can still set up an assessment using the local hospital or service number.

Click on the box: "Primary ID not available, this should now turn purple.

In the secondary ID box enter the individual's hospital or social service number and click search.

As before, if the individual has had a previous assessment in your organisation their details will already be recorded, and the information fields will automatically pre-populate. If this is their first assessment you will need to add name, DOB and gender and then click next.

The screenshot shows the 'Set up assessment' page with the 'Primary ID available' option highlighted in purple. The form below contains the following fields:

- Primary ID* (with example: eg, NHS/CHI/H&C no.)
- Secondary ID (with example: eg, Hospital no.)
- First Name*
- Last name*
- Date of birth*
- Gender identity* (with a dropdown menu)

The screenshot shows the 'Set up assessment' page with the 'Primary ID not available' option highlighted in purple. The form below contains the following fields:

- Primary ID (with value: N/A)
- Secondary ID* (with example: eg, Hospital no.)
- First Name*
- Last name*
- Date of birth*
- Gender identity* (with a dropdown menu)

Setting up assessments:

Upload CSV:

If an organisation needs to set up assessments for an entire group of individuals at once, for example a whole clinic, we have the CSV file method for setting up assessments. This allows the organisation to run a query on their local system, to extract the (typically) patient details, and to have the My Care Plan website attach unique passcodes to each of the patient records in the file.

Some sites manually enter these fields into a spreadsheet and save as CSV, as they find this is easier for them when setting up an entire clinic than going through the individual set up process for each one. Note that the CSV file must not have column headings. You can submit as many columns as you like in your CSV file. The first thirteen columns (A-M) are needed to set up the assessment and must be present, though some can be empty. All columns from the 16th (P) onwards will be returned to you unchanged in the output file and can contain anything.

Note that the "Status" for each row will always be returned in column 14 (N) and the "Passcode" in column 15 (O). These columns will be added to the file if they don't already exist, but please note that if you supply the file with data in these columns they will be overwritten.

The Status will be "OK" for success, or an error message indicating the reason it failed.

The Pass code will only be shown if the assessment was generated successfully.

If at least one row of the file was processed successfully, a new file will be generated and will download automatically.

If no rows were processed, the system will report that there is an error with the format of the file and will not progress any further. You should check the file and try again.

Please contact the eHNA Team for further assistance – ehna@macmillan.org.uk

Setting up an assessment

Setting up an assessment

Step 2: Set up assessment: A few drop-down boxes will appear.

- Assessment:** Select the assessment tool you want the individual to complete: Concerns Checklist, PCI (Head and Neck), Personalised Care and Support, Rehabilitation Dataset, Palliative Care, Social Difficulties Inventory, SPARC and EQ-5D
 In most cases the Concerns Checklist is used as this is the same as the paper version.
- Setting:** Select where you expect the assessment will take place. (Clinic, Home, Ward, Community, Paper, Telephone and Virtual).
 - If you select 'Home' you will receive an email notification when the assessment has been completed or declined.
 - Select 'Paper' if the assessment has already been completed on paper and you want to manually transcribe the answers to the eHNA.
 - Please tick the 2 tick boxes if you require for the patient to receive an email to the complete the assessment and for the key work to receive when patient has completed the assessment.
- Team:** Select the team that will be responsible for care planning.
 - Speak to your site administrator if your team or Tumour type isn't available so it can be created.
- Expires after:** this allows you to select the length of time the individual will have to complete and submit the assessment – from 10 days to 12 weeks (at the time of writing)

Click "Set up assessment for" to create the assessment

Primary ID available <small>eg, NHS/CHI/H&C no.</small>	Primary ID <u>not</u> available <small>eg, only Hospital no. available</small>	Upload CSV <small>to generate multiple assessments</small>
---	--	--

Step 1: Find/create the person's record

Primary ID*
eg, NHS/CHI/H&C no.
 Secondary ID
eg, Hospital no.
 First Name*
 Last name*
 Date of birth*
 Gender identity*

[Not the right person? Search again](#)
[Details not correct? Update this person's record](#)

Step 2: Set up assessment

Assessment*
 Setting*
 Patient will receive an email asking them to complete this assessment
 Receive an email when the assessment has been submitted by patient
 Team*
 Expires after*

Add diagnosis and pathway stage (optional here)

If you add the diagnosis or pathway stage here you will not need to enter them on the Clinical Info tab when writing the care plan

Diagnosis Show all
 Comorbidity 1 (optional)
 Comorbidity 2 (optional)
 Pathway Stage

Setting up assessments using:

Assessment History:

The Assessment History page will appear, this will show previous activity for this person. The information in the blue box contains instructions for the individual completing the assessment. It can be copied and pasted into an email or letter for them.

If not, please make a note of the unique pass code as this will be needed to complete the assessment.

We have also created some small wallet size cards to record the passcode. See resources at the end of the user guide or contact ehna@macmillan.org.uk

Assessment history

Set up assessment for Andrew Test

Assessment #444584 has been set up for Andrew Test. Please provide Andrew with the following information:

As agreed we have arranged for you to complete an holistic needs assessment online. This will only take you a few minutes to complete, and will let your care team know any concerns you may have had in the last week.

You may only use this code once, and it must be used before **01/07/2022**. After that you'll need to speak to your care team again if you want to get another code.

To access the assessment:

1. Go to <https://mycareplan.co.uk/ehna>
2. Enter your date of birth
3. Enter your unique pass code, which is 509 353
4. Then follow the on-screen instructions

Make sure you Submit the assessment at the end, so that your care team can see it and support you.

ID ▲	Date set up	Assessment	Team	Status	Actions
#145139	24/01/2019	Concerns Checklist	London General Team	■ Assessment declined	
#211539	27/11/2019	Concerns Checklist	UKO Breast Team	■ In progress	
#243685	14/03/2020	Concerns Checklist	UKO Breast Team	■ Expired	Reassign team
#244320	06/03/2020	Concerns Checklist	UKO Head and Neck Team	■ Locked	

eHNA

Completing the Assessment

Completing the assessment:

Completing the assessment

If individual is completing the assessment on their own device they should use <https://mycareplan.co.uk/ehna> they will need to use the unique pass code and their Date of Birth.

The Concerns Checklist assessment is available in other languages. At the time of writing, Welsh and Polish are available, with other languages to follow soon by clicking on the language at the top.

When the individual completes the assessment, they can choose the language they would prefer to use. The responses will always come through to the professional in English.

Welcome!

This assessment tool was developed by Macmillan Cancer Support and is delivered by your care provider, MACMILLAN CANCER SUPPORT HQ. ('Care Provider')

Depending on the assessment tool that your Care Provider has selected, you may be asked about any concerns you have, or how your condition is affecting your quality of life.

The information you provide will help those caring for you understand your situation better and where appropriate create a personalised care and support plan for you.

Although Macmillan provides this tool it does not have any involvement in developing individual care and support plans. Any responsibility or liability for these, or for any treatment or advice provided by clinicians, the NHS, social care teams, or any other services sits with your Care Provider and those other care providers that are appointed to assist you.

There is more information on the next page about who will have access to your information and how it will be used. Please make sure that you read it before going ahead with the assessment.

Completing the assessment:**Patient portal**

When the individual has nearly completed the assessment, it will ask them towards the end if they would like to register to Patient portal.

They will need to enter the email address (highlighted in red) and click submit.

The individual will receive an email to register the personal details.

<https://portal.mycareplan.co.uk/login>

Almost done...

If you would like to receive an email when your care plan is completed, please provide your email below.

Your email address will be visible to the person who writes your care plan, and will be used to help set up your account when you register. It will not be shared with Macmillan, or anyone else, without your permission.

Your care will not be affected if you choose not to provide your email address.

Please click the **Submit** button to submit your answers.

Submit >

Completing the assessment:

Patient Portal

The individual will need to enter the email address and the password that was created.

It will then appear with the dashboard and under My Activity it will appear with all the completed care plan created by the keyworker as a pdf. format.

My Care Plan

Register

Thank you for registering your interest. Please confirm your date of birth and choose a password to create your account.

Email

Date of birth

Password
 Please make sure your password is at least 8 characters long, and has at least 1 number, and both upper case and lower case letters

Confirm password

Register

My Care Plan

Dashboard Settings Log out

Dashboard

You can click below to view "your care plan". It will open as a PDF file that you can save or print, and share with your GP or other care providers.

If you have any new assessments to be completed these will show as "your assessment" and you can click on it and complete it now.

Once you have submitted the assessment it will be waiting for your care provider to discuss it with you and to prepare your personalised care and support plan.

My activity

Your care plan >
 Last updated: 24 June 2022

How Macmillan can help

Macmillan Cancer Support Line >

The Macmillan Support Line offers confidential support to people living with cancer and their loved ones. If you need to talk, we'll listen.

- 0808 808 00 00
7 days a week, 9am - 5pm
- Visit our website >
More help from Macmillan
- Email us >
Get in touch via the form
- Chat online >
7 days a week, 9am - 5pm
- Online Community >
An anonymous network of people affected by cancer which is free to join. Share experiences, ask questions and talk to people who understand.
- Help in your area >
What's going on near you? Find out about support groups, where to get information and how to get involved with Macmillan where you live.



Searching for A Patient

Searching for a patient:

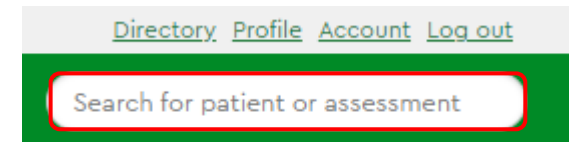
Searching for a patient

There is a search box in the top right corner of the screen that you can use to search for individual at any time.

You can enter part of the name, date of birth, or the primary or secondary identifiers here to search for the individual. To search for the assessment ID, put a # at the start, for example #123456.

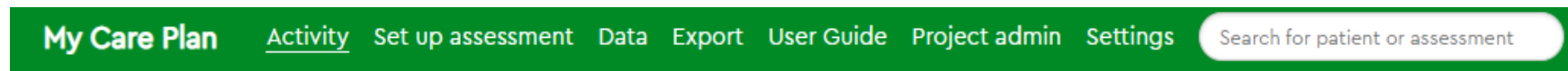
Here, searching for "test" is showing a list of test individuals.

You can view any previous and current assessments and care plans for the required individual by clicking the "View assessment history" button.



Note:

- Searching with the primary ID, secondary ID or assessment ID will look for exact matches so you will need to enter the whole number.



Activity

My activity Activity in my teams

My recent assessments (last 30 days)

ID ▲	Name	Primary ID	Secondary ID	DOB	Team	Type	Status	Date
------	------	------------	--------------	-----	------	------	--------	------

Searching for a patient:

Searching for a patient

Here we've selected individual **222 222 2222**

We can see the individual details, and the list of past and current assessments for the individual. From here we can select the one we want to look at.

In this case, the individual has had assessments that have been completed. Clicking the assessment ID on the left will take us into the detail for that assessment and care plan. If the care plan hasn't been locked, we will be able to contribute to it.

If the assessment ID is shown in black in the Assessment ID column, and there is no link, this means that there is an assessment and care plan for the individual set up by a team that you are not a member of, so you do not have the rights to view it.

Note that if the care plan hasn't yet been started it is possible to reassign the assessment to a different team. This is no longer possible once it has been saved for the first time.

Assessment history

Set up assessment for Andrew Test

ID ▲	Date set up	Assessment	Team	Status	Actions
#145139	24/01/2019	Concerns Checklist	London General Team	■ Assessment declined	
#211539	27/11/2019	Concerns Checklist	UKO Breast Team	■ In progress	
#243685	14/03/2020	Concerns Checklist	UKO Breast Team	■ Expired	Reassign team
#244320	06/03/2020	Concerns Checklist	UKO Head and Neck Team	■ Locked	
#244522	17/03/2020	Concerns Checklist	UKO Skin team	■ In progress	
#244576	09/03/2020	Concerns Checklist	UKO Breast Team	■ Locked	
#244659	19/03/2020	Quality of life questionnaire	UKO Breast Team	■ Expired	Reassign team



Understanding the Activity Pages

Understanding the activity pages:

My Activity Tab

The My activity tab will show you any assessments that you've set up, any care plans that you've contributed to, or written in the last 30 days.

The two tables on this screen will show you the assessments that you have set up yourself, and those e that you've already contributed to.

If you click on the ID for the individual, you will be taken to their "Assessment history" page, where you can see all their assessments.

- When you click the "View" button you will be taken to the care plan page for this assessment.

Quick Tip:

- You can click on the column headings to sort the tables by Name, Primary ID, Team, and so on.

Activity in my teams

Activity

My activity Activity in my teams

My recent assessments (last 30 days)

ID	Name	Primary ID	Secondary ID	DOB	Team	Type	Status	Date ▼
View #457193	Test Test		Test 222222	20/10/1980	UKO Breast Team	CC	🟡 Pending	02/08/2022
View #444584	Test Andrew	222.222.2222		10/12/1918	UKO Breast Team	CC	🟢 In progress	02/08/2022
View #455781	Test Andrew	222.222.2222		10/12/1918	UKO Breast Team	CC	🟢 Submitted	27/07/2022
View #455474	Test Andrew	222.222.2222		10/12/1918	UKO Breast Team	CC	🟢 Submitted	26/07/2022
View #451970	Test Andrew	222.222.2222		10/12/1918	UKO Breast Team	Palliative	🔴 Expired	23/07/2022
View #449518	Test Andrew	222.222.2222		10/12/1918	UKO Breast Team	CC	🔴 Expired	15/07/2022

The Activity in my team's tab will show you all the activity that you and the other members of your team have set up or completed in the last 30 days.

Each User must belong to at least one team.

If you're working in a team, somebody else might have set the assessments up for you, so you'll be able to find them on here and see the status of the assessment.

If your work is across multiple sites, or you're covering other members of your team while they are on leave, you'll be able to find all their recent work here too.

If you click on the ID for the individual, you will be taken to their "Assessment history" page, where you can see all their assessments.

- When you click the "View" button you will be taken to the care plan page for this assessment.

Quick Tip:

- You can click on the column headings to sort the tables by Name, Primary ID, Team, and so on.

Status definitions

On the Activity page there is a status column, the status below explains the definition in more detail.

The screenshot shows the 'My Care Plan' interface with the 'Activity' tab selected. A red box highlights the 'Activity in my teams' filter. Below, a table titled 'All activity from my teams (last 30 days)' displays assessment data.

ID ▲	Name	Primary ID	Secondary ID	DOB	Team	Type	Status	Date
View #427084	Test Andrew	222 222 2222		10/12/1918	UKO Breast Team	Palliative	Expired	25/05/2022
View #437158	Test Andrew	222 222 2222		10/12/1918	UKO Breast Team	SPARC	Expired	03/06/2022
View #440180	Test Andrew	222 222 2222		10/12/1918	London General Team	CC	Expired	17/06/2022
View #441436	Test Andrew	222 222 2222		10/12/1918	UKO Head and Neck Team	CC	In progress	15/06/2022
View #441571	Test Andrew	222 222 2222		10/12/1918	UKO Breast Team	REHAB	Expired	19/06/2022
View #442688	Test Andrew	222 222 2222		10/12/1918	London Gynae Team	CC	Submitted	14/06/2022
View #444584	Test Andrew	222 222 2222		10/12/1918	UKO Breast Team	CC	Pending	21/06/2022

- Pending – The assessment has been set up and is waiting for the individual to complete and submit it.
- Assessment declined – The assessment was set up, but the individual has declined to complete it.
- Unable to complete – The assessment was set up, but the individual was not able to complete it, either through lack of capacity, death, or any other reason. It would be incorrect to say that the individual has declined the assessment as they would have been unable to complete the assessment and would have been similarly unable to decline it. This is included so that organisation where they are working to metrics that require "100% of patients to be offered holistic needs assessments within 31 days of diagnosis" to record that the assessment was considered but was not appropriate.
- Not offered – The assessment was not offered. This category was added to align with COSD.
- Consent declined – The individual signed into the assessment but having read the fair processing/privacy notice information decided they did not wish to continue.
- Expired – The assessment was not completed within the expiry date.
- Submitted – The individual has completed and submitted the assessment.
- In progress – the assessment has been submitted and the key worker has entered some additional information and begun to write the care plan. This status will be set the first time the care plan record is saved and will remain until the care plan is locked.
- Care plan locked – the assessment has been completed, and the care plan written, and the key worker now wishes to finalise the record so that it can be printed, attached to a local system, or shared in some other way.



Creating the Care Plan

Creating the care plan:

Selecting a care plan from activity page.

Once the individual has completed the assessment the status would change on my activity or activity in my team tabs depending on whom had set up the assessment for the individual. You will notice that the status has changed from Assessment pending to Assessment submitted.

Select the View button to open and begin care planning.

My Care Plan
[Activity](#)
[Set up assessment](#)
[Data](#)
[Export](#)
[User Guide](#)
[Project admin](#)
[Settings](#)

Search for patient or assessment

Activity

My activity
Activity in my teams

My recent assessments (last 30 days)

ID ▲	Name	Primary ID	Secondary ID	DOB	Team	Type	Status	Date
<div style="background-color: #008000; color: white; padding: 2px 5px; font-weight: bold; display: inline-block;">View</div> #427084	Test Andrew	222 222 2222		10/12/1918	UKO Breast Team	Palliative	■ Expired	25/05/2022
<div style="background-color: #008000; color: white; padding: 2px 5px; font-weight: bold; display: inline-block;">View</div> #437158	Test Andrew	222 222 2222		10/12/1918	UKO Breast Team	SPARC	■ Expired	03/06/2022
<div style="background-color: #008000; color: white; padding: 2px 5px; font-weight: bold; display: inline-block;">View</div> #441571	Test Andrew	222 222 2222		10/12/1918	UKO Breast Team	REHAB	■ Expired	19/06/2022
<div style="background-color: #008000; color: white; padding: 2px 5px; font-weight: bold; display: inline-block;">View</div> #444584	Test Andrew	222 222 2222		10/12/1918	UKO Breast Team	CC	■ Pending	21/06/2022

Creating the care plan:

Assessment tab

Once you have selected the assessment or care plan that you want to work on – whether through the activity page or by searching – we can see a quick summary of the Assessment tab.

This will show you briefly the concerns that the individual has raised, any information needs, details of when the assessment was set up and submitted.

Quick Tip:

- *The concerns have been sorted into order, with the highest scoring at the top of the list*
- *When you view the screen for the first for the assessment some tabs will be greyed out, once you fill in the mandatory fields, they will become available to use.*
- *Where "I have questions about my diagnosis, treatments or effects" has been selected this will automatically be scored as an 11 to ensure that these more clinically based concerns are highlighted and addressed.*

My Care Plan Activity Set up assessment Data Export User Guide Project admin Settings Search for patient or assessment

TEST PATIENT **Andrew Test** 222 222 2222 10/12/1918 [Update](#) [← Back to Assessment history](#)

Assessment #444584 [Save](#)

Assessment Clinical info Care plan Notes Manage Submitted

Concerns

I have questions about my diagnosis, treatments or effects	11
Eating, appetite or taste	8
Transport or parking	6
Other medical conditions	4

Information needs

No information needs were selected.

Submitted

Submitted on	21/06/2022
Language	English
Email	ceyek36005@ascaz.net (Verified)

Set up

Set up on	21/06/2022
Set up by	Eoin Potts
Assessment	Concerns Checklist
Setting	Home
Pass code	509 353
Team	UKO Breast Team
Organisation	MACMILLAN CANCER SUPPORT HQ

[Save](#)

Creating the care plan:

Collecting Additional Info

The type of details can be gathered here such as:

- Address, postcode, Home, Work and Mobile telephone number, Email with preferred method of contact.
- Next of Kin details.
- GP details

Note:

- This Tab is only available where an organisation has chosen to use it.

TEST PATIENT Andrew Test 222 222 2222 10/12/1918 Update + Back to Assessment history

Assessment #444584 Save

Assessment **Additional info** Clinical info Care plan Notes Manage Submitted

Contact details

Address (without postcode)

Postcode

Home telephone number

Work telephone number

Mobile telephone number

Email

Preferred method of contact

Next of kin details

Name, relation and address

GP details

Name and address

Save

Creating the care plan:

Collecting Additional Info

The type of details can be gathered here such as:

- Ethnic group
- Postcode
- Service user type
- Level of intervention
- How the individual heard of the service
- Has the individual accessed cancer information and support from Macmillan previously
- If individual was not able to attend the care planning session where would they have gone for their information and support.
- As a result of this visit, what will you do now that you have received this information?

TEST PATIENT **Andrew Test** 222 222 2222 10/12/1918 [Update](#) [← Back to Assessment history](#)

Assessment #444584 Save

Assessment Additional info Clinical info *Care plan* Notes Manage ■ Submitted

Ethnic group
Please select

Postcode

Service user type
Please select

Level of intervention
Please select

How did you hear about this service?
Please select

Have you accessed cancer information and support from Macmillan before?
Please select

Where would you have gone today for information and support if you hadn't come here?
Please select

As a result of this visit, what will you do now that you have received this information?
Please select

Creating the care plan:

The Clinical Info tabs

The Clinical Info tab is where you can add some more information to the care plan.

Complete the drop-down boxes:

Note:

- The diagnosis and pathway stage are mandatory and must be completed before you can continue.

Diagnosis: The options you see here are based on the team that you're a member of i.e.: members of the gynae team will see gynae diagnoses by default, the upper GI team will see upper GI diagnoses and so on. You can see the full list by ticking the "Show all" box, this will include all cancers and non-cancer related conditions such as COPD or Parkinson's.

If the diagnosis is not confirmed yet, you can indicate that by putting a tick in the "Diagnosis not confirmed at this stage" box.

Pathway stage: Allows you to record the pathway stage at which the assessment takes place. This list is based on the dataset used in the Cancer Outcomes and Services Dataset, although we have added Rehabilitation and Follow-up.

Stratified follow up: If you have implemented stratified follow up, you can record the type of follow up here.

Condition management: You can record the condition management here. The list includes Curative Treatment, Active Surveillance, Supportive Care, Palliative Care, No Current Management, and Management Unknown.

Note:

- "Save" when you have added the clinical information
- Once you save you will notice the status will change and "Preview", "Download" and "Manage" tabs will appear.

The screenshot shows the 'My Care Plan' interface for a patient named Andrew Test. The 'Clinical info' tab is selected and highlighted with a red box. The form contains several dropdown menus for 'Assessment setting', 'Care plan setting', 'Diagnosis', 'Comorbidity 1 (optional)', 'Comorbidity 2 (optional)', 'Pathway stage', 'Stratified follow up', and 'Condition Management'. A 'Save' button is located in the top right corner of the form area.

Creating the care plan:

Additional Information & Treatments

There are optional sections under Clinical Information.

For organisations where there are metrics in place to ensure the offer of an HNA to all individual within 31 days of diagnosis (for example) there is an opportunity to record this here.

This information is not used within the system but is added to the reporting CSV file, to allow organisations to report against these metrics more easily.

You can use this to indicate the treatment modalities that the individual has had in the past, is receiving currently or are likely to have in the future. Over time this may show specific patterns of concerns that are related to those treatments

Additional information

Entering information in these fields is optional.

Date

Treatments

Entering information in these fields is optional.

	Past	Present	Future
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other systemic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radiotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not known	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Creating the care plan:

The Care Plan tab

On the Care Plan tab, we can go through the concerns and begin to address them.

The screen will show one concern at time, from the list on the left, and each will show a description, a plan of action, and number of recorded actions.

Description – What this means to the person

This is free text and allows you to record the concern as described by the individual. As they are aware of their concerns, this does not necessarily need to be detailed.

Recorded actions

The recorded actions are created by typing certain letters, so if *GP* was typed in then all actions related to GP will show up or if *advise* then all options where the individual is being advised to do something will drop down.

Adding all of those that apply in each case will make your data more meaningful and reduce the amount that you will need to type.

Suggested actions

This is free text and allows you to record suggested actions which don't appear on the drop-down.

Assessment #444584 Save

Assessment Additional info Clinical info **Care plan** Notes Preview Download Manage In progress

Concerns

- I have questions about my diagnosis, treatments or effects (11)
- Eating, appetite or taste (8)
- Transport or parking (6)
- Other medical conditions (4)

Information needs

There are no information needs in this careplan

Add item

Select Add

I have questions about my diagnosis, treatments or effects (11)

What this means to the person

Recorded actions

Start typing, e.g. ref hos

Suggested actions

Include this concern on the individual's copy of the care plan

Outcome

Outcome not recorded v

Outcome notes

Adding another concern

There may be times when the individual expresses another concern which they did not identify when they were completing the assessment. These additional concerns can be added during the care planning discussion and included in the care planning process as if they had been selected originally. This option is on the left-hand side under the concerns raised by the individual in the assessment.

Add item

Select

Recording the outcome

In some cases, you might know at the time that the concern has been resolved through the discussion, in which case you can record whether it is fully resolved, partially resolved, or not resolved at that time. More generally you might want to record whether the actions suggested have been successful in resolving the concern some time afterwards when the individual has had time to complete any outstanding actions. The outcome field and the text box that goes with it are available even when the care plan is locked, so that the resolution of the concern can be recorded. These outcomes will then be available in the reporting CSV files.

Outcome

Outcome not recorded

Outcome notes

Additional Information Leaflets

On some of the frequently raised concerns on the care plans will have additional one-page information which can be printed, emailed to the individual or can be used as prompt during the concern's discussion.

If you tick the box next to the link, it will embed the link on the completed care plan.

Eating, appetite or taste (8)

Include in care plan?
 Eating, appetite and taste

What this means to the person

Quick Tip:

- You can delete any recorded actions that you've selected accidentally by clicking the "x".

Creating the care plan:

The Notes tab

On the Care plan notes you can add any other details the individual might need, such as your contact details, appointments times, or notes for the GP to follow up.

Quick Tip:

- *If you have set a signature on your account it will show up here, please remember to click on Save so the information carries over.*

On the Notes for the GP tab you can add any other details the GP might need to know, if sending the completed care plan via Docman.

Assessment #444584

Save

Assessment Additional info Clinical info Care plan **Notes** Preview Download Manage

In progress

Care plan notes

Contact Details:
Eoin Potts
eHNA Support Officer (Technical)
EPotts@macmillan.org.uk

Notes for the GP

These notes will be visible on the first page when transferred directly to the GP using Docman.

Creating the care plan:

The Preview tabs

The Preview tab shows you what the printed care plan will look like.

This is useful as a final check before you lock the care plan, as you won't be able to make any further changes once it's been locked.

Assessment #444584

Save

Assessment Additional info Clinical info Care plan Notes **Preview** Download Manage

In progress

Andrew Test's Care Plan

Created on 21 June 2022 with Eoin Potts

MACMILLAN CANCER SUPPORT HQ

* Starred concerns will not show up on the patient's version of the care plan

Concern(s) identified	What this means to me	Suggested actions
Eating, appetite or taste		Macmillan information sheets: Eating, appetite and taste

Summary

My concerns	My information needs
I have questions about my diagnosis, treatments or effects (11) Eating, appetite or taste (8) Transport or parking (6) Other medical conditions (4)	

We're here to help everyone with cancer live life as fully as they can, providing physical, financial and emotional support.
So whatever cancer throws your way, we're right there with you. For information, support or just someone to talk to:



0808 808 00 00
7 days a week, 8am - 8pm



Visit our website >
More help from Macmillan



Email us >
Get in touch via this form



Chat online >
7 days a week, 8am - 8pm



Creating the care plan:

The Download tabs

The Download tab is where you will be able to lock the care plan and download a copy for printing or saving to an individual record.

You will be asked to identify 'What's going to happen to this care plan?' Please select one of the options highlighted in red.

Note:

- *your site administrator can unlock records for you if you have locked them in error. You can find your administrator details in the Directory.*

Once you have locked the care plan the "Download" section will appear you to download the care plan as a PDF, RTF or TIFF file if required.

Most organisations use only the PDF option, as this is more easily recognisable and can be printed or shared most easily.

Note:

- *your organisation will have a preferred option for downloading and/or printing the care plan files for the individual record and the GP systems.*

The screenshot shows the 'Assessment #444584' interface. At the top right is a green 'Save' button. Below it is a navigation bar with tabs: 'Assessment', 'Additional info', 'Clinical info', 'Care plan', 'Notes', 'Preview', 'Download' (highlighted with a red box), and 'Manage'. On the far right of this bar is a blue 'In progress' indicator. The main content area has a heading 'When was this care plan discussed?' followed by a text input field containing '21/06/2022'. Below this is another heading 'What's going to happen to this careplan?' with a 'Patient *' section containing five radio button options: 'I will share this careplan with the patient on paper', 'I will share this careplan with the patient on email', 'No care plan is required', 'The patient declined a copy of this careplan', and 'This careplan will not be shared with the patient for another reason:'. There is a text input field below these options. Underneath is a 'GP' section with a checked radio button for 'I will send this care plan to the GP' and another text input field. At the bottom is a 'Lock' section with a text input field and a green 'Lock' button. A note at the bottom states: 'Locking a care plan will prevent you from making further changes. Your administrator will be able to unlock it for you if required.'



Organisational Administration

Organisational Administration:

Creating a team

Before you set up users you will need to create teams.

The "condition" you choose will determine the range of diagnoses that the user can see - if the condition is "Breast", users in that team will only see relevant breast diagnoses; if the condition is 'Upper GI', the team will only see upper GI diagnoses, and so on.

If the condition is "Other", there will be no restriction on the diagnoses that the user will be able to see. You can name the team anything you like, and any user can belong to a team.

What do you need to do?

From the home page of mycareplan.co.uk you will find a section called 'Teams/Users.

- Go to Teams/Admin
- Click on 'Teams'
- Go to Create a team
- Choose the site that you want your team to belong to
- Select the condition
- Name your team – Free text box
- Click on Save

The screenshot shows a form with three main input fields and two buttons. The first field is labeled 'Site*' and is a dropdown menu with 'Select' and a downward arrow. The second field is labeled 'Condition*' and is also a dropdown menu with 'Select' and a downward arrow. The third field is labeled 'Team name*' and is a text input box containing the placeholder text 'Team name'. Below these fields are two buttons: a green 'Save' button and a white 'Cancel' button with a black border.

Note:

- This section is only relevant if you have permissions to create teams and users.

Organisational Administration:**Create a user**

It's now time to check that you can create a user accounts for a member of staff who will be using the eHNA. For this you will need to have the email address of the person you are creating an account for, personal accounts must not be used only approved organisation provided email address and nhs.net addresses.

Users will also need to be allocated to one of the following roles:

- Setup – set up assessment only
- View – setup assessment, view assessment and care plans
- Edit – setup, view and edit care plan
- Lock – all the above and lock the care plan
- Administrator – all the above, unlock care plans and delete test records.

Note:

- *The user can belong to multiple teams, so various levels of accessibility should be used for keeping the individuals' details secure.*
- *The user can have the ability to create and manage teams, user and download identifiable data files, ensure you grant the appropriate permission to the user.*

Organisational Administration:

What do you need to do?

From the home page of mycareplan.co.uk you will find a section called 'Teams and Users'.

- Click on Teams/Users
- Find organisation site that you belong to
- Click on 'Create user'
- Fill in details (user must be set up in at least one team)
- User can belong to multiple teams
- If you want that user to manage other teams and users, tick the box
- If you want that user to download identifiable data files, tick the box
- Click 'Save'

Note:

- *You can disable user accounts from this page for when staff leave or transfer to another organisation. If staff transfer to a new organisation, they will need to be registered again on to mycareplan.*

My Care Plan Activity Set up assessment Data Export User Guide **Teams & Users** Settings Search for patient or assessment

St Albert Test Org > Teams & Users

Teams
Create new teams; update existing teams.

Users
View all users for the organisations; create new users; manage user permissions and roles.

User details

First Name*

Last name*

Email address*

Email login instructions and password to user

Job title*

Job category*

Teams

User's teams
Remove selected

Add user to team

Other

This user can create and manage Teams and Users

This user can download identifiable data files

Organisational Administration:

Care plan additional information settings

On the Care plan section there is an extended option for the community team if requested, to enable this extension to the eHNA dataset we will need an email formally requesting for us to turn it on for you.

This section enables to gather further individuals' details so duplication of data entry does not occur, this function is requested by the organisation to macmillan, for more details please contact eHNA@macmillan.org.uk.

Is be managed by Settings. Selecting either of these options creates an additional tab on the care plan page just before the clinical info tab.

Settings

General Automatic transfers Local actions

Legal basis for collection and processing of data

- Use consent as the legal basis for the collection and processing of data

Care plan section

- Collect patient, next of kin and GP contact details when creating care plans
- Collect information required by Macmillan community and Information Centre teams

Save settings

Note:

- Both options can be selected if required.

Organisational Administration:

Docman - Automatic Transfers

To enable the function – Login into My Care Plan and at the top click on 'settings'

Click on the 'Automatic Transfer' tab and it will outline guidance on how to use the function. Please read the guidance in the grey box.

Please click on the tick box and save settings.

Once the function has been enabled, you will need to build a list of GP practice.

You can do this by doing a lookup with either postcode, name or ODS code.

Select the GP and it will format into a list shown in the screenshot. Select the 'Remove' function to remove a GP practise.

Settings

General **Automatic transfers** Local actions

Transfer to GPs (via Docman)

Enabling sharing with Docman may change the way data flows from your organisation to the GP practice systems. You should make sure that your local IG team are aware of this change before you enable it.

It relies on the GP practice code being added to each care plan record when that record is locked. Please make sure that your teams know where to find the GP practice name or practice code on your organisation's systems.

Sharing with Docman can be switched on or off at any time, but note that care plans will only be sent overnight if this setting is enabled at the time when the care plans are sent (4am). Once this is enabled, you acknowledge that switching it off overnight will prevent these records being sent.

You should build and manage your list of local GP practices here. Practices added here can be selected by name when locking care plans. Note that care plans can be sent to any practice in England, including those on this list, by using the GP practice code when locking the care plan rather than looking up by name.

By switching on Docman Connect functionality on behalf of your organisation you are confirming that you have taken the steps necessary above.

Automatically send each locked care plan to the selected GP

[Save settings](#)

Local GPs

Your care plans can automatically be transferred to a GP, if the above option is enabled and at least one GP is selected below. These GPs will appear in a drop down when locking a care plan, you can then select or search a GP to send the care plan to.

Search all GPs:

ODS	Name ▲	Address	Postcode	
K81645	240 WEXHAM ROAD	THE SURGERY, 240 WEXHAM ROAD, SLOUGH, BERKSHIRE	SL2 5JP	Remove
K81081	ABBAY MEDICAL CENTRE	ABBAY MEDICAL CENTRE, 41 RUSSELL STREET, READING, BERKSHIRE	RG1 7XD	Remove
P88014	ADSHALL ROAD MEDICAL PRAC	ADSHALL ROAD MEDICAL PRAC, 97 ADSHALL ROAD, CHEADLE, CHESHIRE	SK8 2JN	Remove
P88019	ALVANLEY FAMILY PRACTICE	WOODLEY HEALTH CENTRE, HYDE ROAD, WOODLEY, STOCKPORT, CHESHIRE	SK6 1ND	Remove
P88625	ARCHWOOD MEDICAL PRACTICE	WOODLEY HEALTH CENTRE, HYDE ROAD, WOODLEY, STOCKPORT, CHESHIRE	SK6 1ND	Remove
K81655	ASCOT MEDICAL CENTRE	BROOK HSE HEATHERWOOD HSP, BROOK AVENUE, ASCOT, BERKSHIRE	SL5 7GB	Remove
Y00436	ASCOT MEDICAL CENTRE	ASCOT MEDICAL CENTRE, GATE 3- HEATHERWOOD HOSP, LONDON ROAD, ASCOT, BERKSHIRE	SL5 8AA	Remove
K81014	BALMORE PARK SURGERY	BALMORE PARK SURGERY, 59A HEMDEAN RD, CAVERSHAM, READING, BERKSHIRE	RG4 7SS	Remove

Organisational Administration:

Docman Integration

Docman interface provides a very simple way of automatically sending completed care plans to 94% of GP practices in England via a common document management platform – Docman. This can work as a document management system surfacing patient documents as part of the patient records within the GP IT systems (EMIS, SystemOne, or Vision), so one solution will work across the whole of England.

The patient identifier is the NHS number. The eHNA system does not allow an invalid NHS number to be used. This replaces the current process of post and is therefore more secure.

To use the function – Tick the box 'I will send this care plan to the GP' and select the patients GP practice from the dropdown.

Lock the completed care plan. It will then send a pdf copy to the selected GP overnight.

Assessment #444584 Save

Assessment Additional info Clinical info Care plan Notes Preview **Download** Manage In progress

When was this care plan discussed?

By default, this is today's date. This will be displayed at the top of the care plan.

What's going to happen to this careplan?

Patient *

- I will share this careplan with the patient on paper
- I will share this careplan with the patient on email
- No care plan is required
- The patient declined a copy of this careplan
- This careplan will not be shared with the patient for another reason:

GP

- I will send this care plan to the GP

Lock

Locking a care plan will prevent you from making further changes. Your administrator will be able to unlock it for you if required.

Organisational Administration:

Local Actions

To set-up and manage custom actions – Login into My Care Plan and at the top click on 'settings'. Click on the Local actions.

You can have as many local actions as you need, and they will be available to your users as soon as you create them.

Add a new action - Enter the named action to the 'Local action text' and then fill out the other fields and update the new action.

My Care Plan Activity Set up assessment Data Export User Guide Project admin Settings Search for patient or assessment

Settings

General Automatic transfers **Local actions**

New local actions

You can use this page to manage your local actions. These will only be available for staff in your organisation, and can help to streamline the care planning process.

Each new action has a type, for example *Advise, Information, Referral, Signpost*, etc.

- **Advise** actions are used where you are suggesting that the individual should do something. These are automatically recorded as *Patient actions*.
- **Information** actions are used where the individual is given information to take away and read (and/or act on). These are recorded as *Patient actions*.
- **Signpost** actions are used where the individual is given the information they need, and makes contact with a service for themselves. These are recorded as *Patient actions*.
- **Referral** actions are used where the professional makes a formal referral to another service on the individual's behalf. These are recorded as *Key worker actions*.

Within each type there are a number of subtypes to further define the action - for example *Advised to attend, Advised to contact, Advised to do something*.

Choosing the action type and subtype will decide which type of action you're creating.

You can then give your action a unique and meaningful name, and optionally provide a URL or other information as a link. This will appear on the care plan as a clickable link.

The service provider is whoever/whatever will be carrying out the action. For *Patient actions* it will be the individual themselves, while other actions might be carried out by health or social care, third sector, Macmillan, or other types of organisation. This is recorded so that you can analyse the types of referrals you make, and to which types of partner, in more detail.

Finally you can set your action to appear in the dropdown action list, or turn it off so that it can no longer be selected. It will still appear on any care plans that you've previously added it to.

[+ New local action](#)

New local action

Type*

Subtype*

Local action*

URL

Will be displayed as

Service provider

Status*

The new custom action will appear in the list as show in the screenshot. You can update the action from the list by clicking 'Update'

Custom actions will appear on the dropdown list under recorded actions when a few letters of the name are typed. They will appear in the same way as the actions that are available nationally.

My organisation's local actions								
Local action ▲	Action for	Service Provider	Type	Subtype	URL	Status	Date Created	Update

Organisational Administration:

The Manage tab

The Manage tab is where the additional options can be accessed such as allowing the administrators for each team to unlock any records that have been locked in error, allowing further changes to be made.

Marking the assessment was completed on paper – this is used if the assessment was set up to be completed electronically but the individual has since completed it on paper.

Disable or enable the assessment to be shared with care teams in other organisations – this is used where data is automatically shared on the eHNA platform with other organisations. Note that this does not prevent any other form of sharing.

The team administrator will also be able to delete any test records that have been created.

Note:

- You can record Declined Assessments through this page.
- This tab will only appear once the care plan has been saved for the first time, and only applies to team administrators.
- Depending on your access level, certain actions will be limited.

Assessment #444741

Assessment Additional info **Manage**

Change assessment status

These actions are non-reversible

Assessment declined Not offered Unable to complete ▾

Change setting to "Paper" and submit an empty assessment

Assessment/care plan completed on paper

Manage patient's consent for remote sharing

Disable remote sharing for this assessment

Delete Assessment

This option deletes the assessment (and care plan if it exists).

Delete Assessment

Organisational Administration:

Individual declining eHNA

There will be times when the individual does not want to complete the eHNA, and this could be for a variety of reasons.

My Care Plan **Activity** Set up assessment Data Export User Guide Project admin Settings which can help to evidence compliance with

Activity

My activity **Activity in my teams**

All activity from my teams (last 30 days)

ID ▲	Name	Primary ID	Secondary ID	DOB	Team	Type	Status	Date
View #427084	Test Andrew	222 222 2222		10/12/1918	UKO Breast Team	Palliative	Expired	25/05/2022
View #437158	Test Andrew	222 222 2222		10/12/1918	UKO Breast Team	SPARC	Expired	03/06/2022
View #440180	Test Andrew	222 222 2222		10/12/1918	London General Team	CC	Expired	17/06/2022
View #441436	Test Andrew	222 222 2222		10/12/1918	UKO Head and Neck Team	CC	In progress	15/06/2022
View #441571	Test Andrew	222 222 2222		10/12/1918	UKO Breast Team	REHAB	Expired	19/06/2022
View #442688	Test Andrew	222 222 2222		10/12/1918	London Gynae Team	CC	Submitted	14/06/2022
View #444584	Test Andrew	222 222 2222		10/12/1918	UKO Breast Team	CC	Pending	21/06/2022

After you have clicked on the view button you will be provided details of the assessment. Please ensure that you have the correct record before continuing.

Now click on the "Manage" tab and you will see several options, depending on your access level.

To mark the assessment as "Declined", click the "Assessment declined" button.

Note:

- *That this action is not reversible.*

After you clicked on the button you will automatically be redirected to the activity page with a notification that the assessment has been updated

The assessment history will now show you the new statuses.

Assessment Additional info **Manage**

Change assessment status
These actions are non-reversible

Assessment declined Not offered Unable to complete ▾

Change setting to "Paper" and submit an empty assessment

Assessment/care plan completed on paper

Manage patient's consent for remote sharing

Disable remote sharing for this assessment

Delete Assessment
This option deletes the assessment (and care plan if it exists).

Delete Assessment

Organisational Administration:

Unlocking a care plan

If a care plan has been locked before it was fully completed, and you need to go back to amend or add to the text, your Team Administrator can unlock it again for you.

If you are a Team Administrator and you need to unlock a care plan:

Search for individual and open the correct assessment via the view link.

Select the Manage tab and click on the Unlock care plan button

Note:

- You may not have the correct access to unlock so you will have to contact your team lead or the admin staff under your directory.

The screenshot shows the 'My Care Plan' interface for a patient named Andrew Test. The 'Manage' tab is selected, and the 'Unlock care plan' button is highlighted with a red box. Other buttons visible include 'Save outcome', 'Patient declined a copy', and 'Disable remote sharing for this assessment'.

Organisational Administration:

Deleting the care plan

You may need to remove the Assessment or Care plan for test individual, so it does not show on your data. You can remove them through the manage tab and selecting Delete Assessment and Care plan.

The screenshot shows the 'My Care Plan' interface for a patient named Andrew Test. The 'Manage' tab is active, displaying several management options:

- Assessment #444584** (with a 'Save outcome' button)
- Navigation tabs: Assessment, Additional info, Clinical info, Care plan, Notes, Preview, Download, **Manage**, and Locked.
- Change status to "Care plan in progress"**: This option unlocks the care plan. A button labeled 'Unlock care plan' is present.
- Patient declined a copy of the care plan**: This only updates the relevant COSD9 field (CR8000). A button labeled 'Patient declined a copy' is present.
- Manage patient's consent for remote sharing**: A button labeled 'Disable remote sharing for this assessment' is present.
- Delete Assessment**: This option deletes the assessment (and care plan if it exists). A button labeled 'Delete Assessment and Careplan' is present.

Organisational Administration:

Disable shared access to care plan

By default, your organisation will act as data controller for the care plans that you create. If it decides that sharing or making these completed care plans available to another organisation such as a GP or tertiary provider is in the individual interest it can facilitate that sharing.

Where the organisation has instructed Macmillan to facilitate this sharing, the other organisation will be able to search for completed care plans and read them. This can greatly help with continuing the care of the individual rather than having them re-tell the same story again.

Some individuals may not want their care plan to be shared with their GP or with other care providers. At the discretion of the Organisation Administrator it is possible to prevent that direct sharing on the system by clicking the "Disable remote sharing for this assessment". Other organisations searching for the individual will not be able to find the individual assessment records or view them.

Note:

- Once selected a notice will show up on the top of the screen to state it has worked.
- Remote sharing can be re-enabled from the same tab.

The screenshot shows the 'My Care Plan' interface for a patient named Andrew Test. The top navigation bar includes 'My Care Plan', 'Activity', 'Set up assessment', 'Data', 'Export', 'User Guide', 'Project admin', and 'Settings'. A search bar is present on the right. Below the navigation, the patient's name and details are shown: 'TEST PATIENT Andrew Test 222 222 2222 10/12/1918 Update'. A 'Back to Assessment history' button is on the right. The main content area is titled 'Assessment #444584' and has a 'Save outcome' button. A 'Manage' tab is selected, showing several options: 'Change status to "Care plan in progress"' (with a sub-note 'This option unlocks the care plan.' and an 'Unlock care plan' button), 'Patient declined a copy of the care plan' (with a sub-note 'This only updates the relevant COSD9 field (CR8000)' and a 'Patient declined a copy' button), 'Manage patient's consent for remote sharing' (with a red-bordered button 'Disable remote sharing for this assessment'), and 'Delete Assessment' (with a sub-note 'This option deletes the assessment (and care plan if it exists).' and a red-bordered button 'Delete Assessment and Careplan').



Additional Information

Additional information:

SCR Integration

Login into My Care Plan and click on the export button at the top.

It will appear with the COSD report (For SCR) and a short description. Enter the date range and click on the download button.

The file will automatically download and will appear at the bottom of the screen.

Save as XML file.

Please [see](#) the SCR Macmillan XML Data Import User Guide on how to upload the XML file to the SCR platform.

The screenshot shows the 'My Care Plan' navigation bar with the 'Export' button highlighted. Below it is the 'Data export' section with a date range selector set to 28/05/2022 - 28/06/2022. A table lists a 'COSD report (for SCR)' with a 'Download' button.

Report	Description	Action
COSD report (for SCR)	This is an XML version of the file, which can only be used for import into SCR. Please use the Data tab for the version you can open and validate in Excel. Note: only completed non-test care plans with NHS number, diagnosis and pathway stage will appear in this report.	Download

Additional information:**Recovery Package resources**

Recovery Package Main Page - view all latest resources via our main page

www.macmillan.org.uk/recoverypackage

Recovery Package Learn Zone page – learn about each of the interventions of the Recovery Package and have access to our videos, templates, and other resources

www.learnzone.org.uk/recoverypackage.

URL for video presentation

<https://vimeo.com/207469651/205b8498d4>

Have a look at some of our other key resources. All of them are available to order via be.macmillan.org.uk

For Professionals



Mac Code:
MAC16402_PROFS_1
017

This leaflet provides details of the most used files on the treatment and recovery package resources that Macmillan and other organisations provide for professionals.



A guide to providing Holistic Needs Assessment Care and Support Planning

Mac Code:
MAC16266
A4 Booklet

The HNA guide covers all areas of the HNA, highlighting the key benefits and eight core principles of an HNA, and advice on suitable environments and how to best prepare for an HNA.



The Holistic Needs Assessment (HNA) helps us to help you

Code and key worker contact details inside

Mac Code:
MAC15618_Leaf
A7 Leaflet

This handy resource provides a brief explanation of what a HNA is and highlights that individual can gain extra support by completing one.

Space is provided for key workers to enter their contact details and the individual eHNA passcode to enable them to complete it online.

For Individuals



Mac Code:
MAC16184
A5 Leaflet

This leaflet is about how you can take an active role in your care. It looks at some of the support you can ask for after a cancer diagnosis, what options may be available to you for your follow-up care, and what information you need and ways you can look after yourself.



Mac Code:
MAC12957_E04_N
A5 Booklet

This booklet explains how care is planned for people affected by cancer.