INPS Vision+

EPaCCS template guide

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NHS
Cheshire and Merseyside
Strategic Clinical Networks

NHS
Greater Manchester, Lancashire and South Cumbria
Strategic Clinical Networks

The importance of EPaCCS in supporting End of Life Care

by Dr Peter Nightingale (RCGP)

Introduction

Caring for a patient right through to the end of life can be one of the most satisfying aspects of general practice, but it is also one of the most challenging.

Most people prefer to be cared for at the end of their lives at home, with dignity and their symptoms controlled, but many fail to achieve this. The current situation of multiple admissions in the last year of life, many of which are unplanned and potentially avoidable, is unsatisfactory for patients and does not make the best use of resources.

Many of us have been working hard to find the 1% of patients within our practice likely to be in the last year of life, and take a more proactive approach to their care, but this is not always easy.

In order to effectively identify and support patients we need to use both national and locally developed tools to proactively manage care.

Having recognised a patient might be within the last year(s) of life, it is beneficial both to the patient and their families to proactively manage care. This is likely to support patients to be cared for in the place of their choice and to reduce the likelihood of unnecessary investigations, interventions and hospital admissions. The use of an EPaCCS system should help collect key information about the patient and their care, help shape multidisciplinary team meetings and encourage information sharing across the wider system.

Previously known as locality registers, electronic palliative care coordination systems (EPaCCS) enable the recording and sharing of people's care preferences and key details about their care with those delivering care. The systems support co-ordination of care and the delivery of the right care in the right place, by the right person, at the right time.

There is strong evidence that EPaCCS supports patient choice, shared decision making, individual care planning and integration of care across sectors.
Many areas have already implemented or are in the process of implementing EPaCCS across localities. Available data suggests that their use helps people to die in their preferred place of death, decreases the percentage of hospital deaths and increases the percentage of deaths at home and in hospices.
Other key benefits include improvements in communication and information sharing between healthcare professionals and support for making appropriate decisions about patients' care.

The Electronic Palliative Care Co-ordination System (EPaCCS) template
INPS Vision+ version

This template is for all INPS Vision+ users to enter information for patients considered to be in their last year of life. It is not an EPaCCS on its own, but is standardised to match all other templates across the North West to ensure easy communication between systems once this becomes possible – for this reason, please use only the terms listed (with their underlying Read codes) to enter End of Life Care information.

The template is named the '**End of Life & Palliative Care Co-ordination**' template and it replaces all previous palliative or end of life care templates, such as the Macmillan palliative care template. It has been updated to incorporate all the changes made by the Information Standard Board for Health and Social Care, reference ISB 1580 Amd16/2013. For further information about ISB 1580 and the changes that have been made to this template go to http://www.isb.nhs.uk/documents/isb-1580/amd-16-2013/index_html

The template is divided into the following nine pages to correspond to the elements of End of Life Care:

1. Quick Entry Details
2. Patient Summary
3. Admin & personal
4. EoL Diagnosis Information
5. EoLC Status
6. Carers & Services
7. Advance Care Planning
8. Preferred Place of Care / Death
9. Wishes of Patient / Death Details

This template is intended to facilitate greater continuity of care across all health providers (including NWAS). It includes important patient information that may be required in order to provide optimum care to patients.

The template has been designed to include the Qualifying diagnostic Read codes from the GMS Contract QOF Palliative Care indicator set 2014/15 (Palliative care ruleset_v28.0), highlighted below with a yellow border.

Who is responsible for completing this template?

- The GP or a designated person within the practice.

How frequently does the information need to be updated?

- Following any End of Life Care discussions or on completion of any type of Advance Care Plan, or after any significant change occurs.
- Following receipt of any End of Life Care information from other health providers.

Please refer to the **Revised North West End of Life Care Model 2015** for further details on when to update EPaCCS information (see appendix).

NB - Following the death of a patient, it is important that you complete the Death Details page, to ensure your locality's EPaCCS is suitably updated.

Patient consent

It is important, as part of an End of Life Care conversation with a patient, to explain that they need to give their consent for their wishes and care preferences to be shared with the other organisations potentially involved in their end of life care (such as the ambulance service, out of hours GPs, hospices, hospitals etc) as without consent this will not happen. In the case of a patient lacking capacity this consent will need to be provided by someone acting in their best interests (see below for definitions).

9Nu6.	Consent given for sharing end of life care coordination record
9Nu7.	Withdrawal of consent for sharing end of life care coordination record
9Nu8.	Best interests decision taken (Mental Capacity Act 2005) for sharing end of life care coordination record
9Nu9.	Consent given by legitimate patient representative for sharing end of life care coordination record
9Nu90	Consent given by appointed person with lasting power of attorney for personal welfare (MCA 2005) for sharing end of life care coordination record

These consent codes are accessible via a multiple drop down called **Consent given/Withdrawal/Best interests** on the **Patient Summary** tab. Once consent has been given, subsequent conversations should not need to revisit the consent issue, even if information is being recorded on another system, as the consent given is for the sharing of an "end of life care coordination record" across all of the systems involved in the EPaCCS.

Consent for sharing via the MIG

If information entered on your INPS Vision+ system is being shared with other organisations through the use of the Medical Inteoperability Gateway (MIG) provided by Healthcare Gateway Ltd, then an additional two codes come into play:

93C0.	Consent given for upload to local shared electronic record
93C1.	Refused consent for upload to local shared electronic record

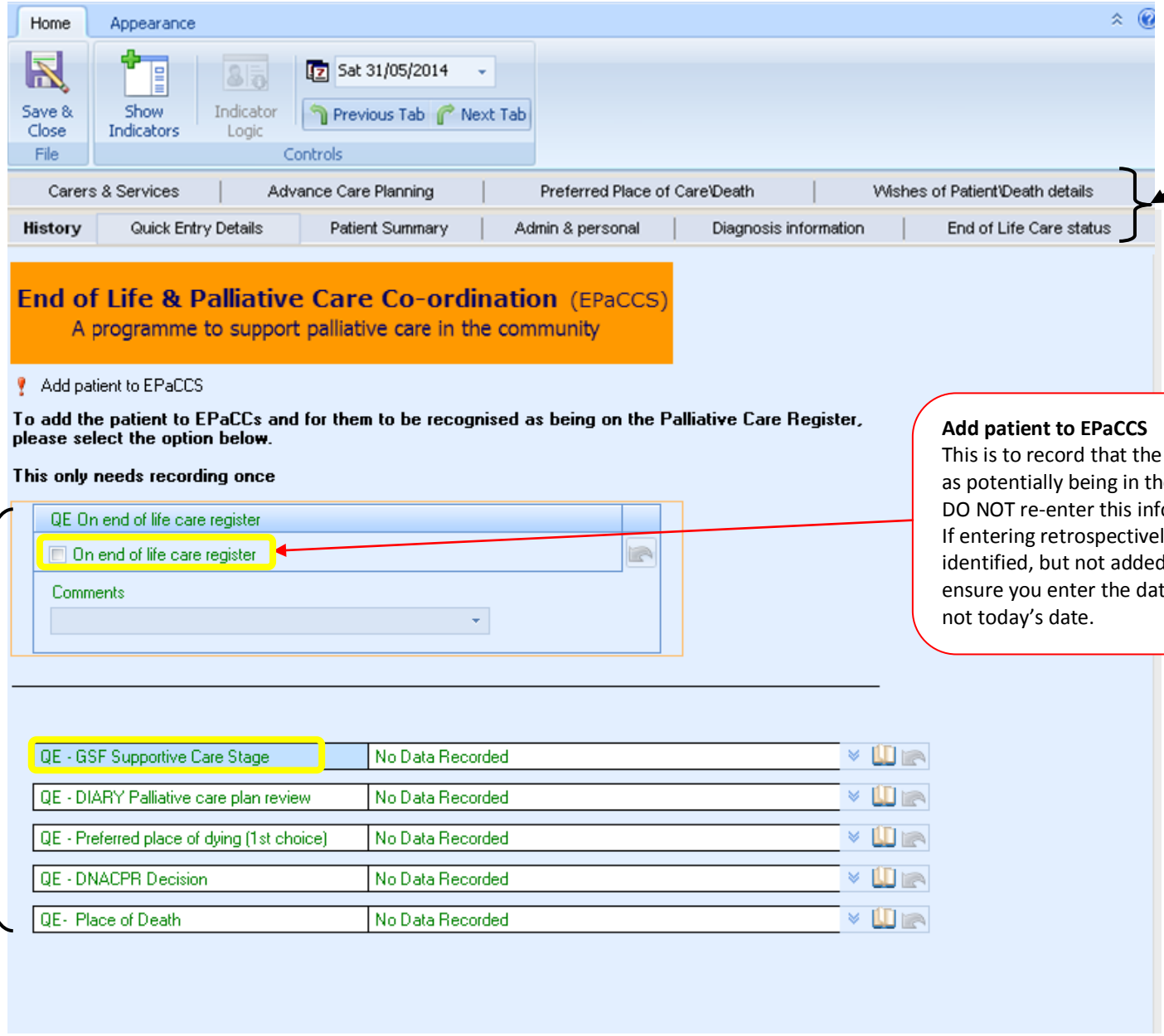
The 93C1. code **blocks all data** from leaving the GP practice for the patient, regardless of any of the other End of Life Care consent codes above being entered. Therefore, it is crucial that this is properly explained to the patient, so that there is no confusion about what is or isn't being shared. If a patient had previously not wanted to share any information, but then wants to have their wishes and care preferences shared with the other organisations potentially involved in their end of life care, it will be necessary to either remove the 93C1. code or add code 93C0. to counter it.

NB - It is therefore crucial that in the case of a patient lacking capacity where a 93C1. code had previously been applied, that if a best interest decision is taken, or consent is given by a legitimate patient representative or lasting power of attorney, the 93C1. code is also removed (or 93C0. applied), to allow the information to be shared.

Quick Entry Details

This cover page is to aid the quick updating of the most frequently recorded details at palliative care meetings.

NB - only entering these six codes is NOT sufficient for an EPaCCS record!



These nine pages group together aspects of the patient's End of Life Care.

An explanation of all six of these data items can be found on the appropriate following page.

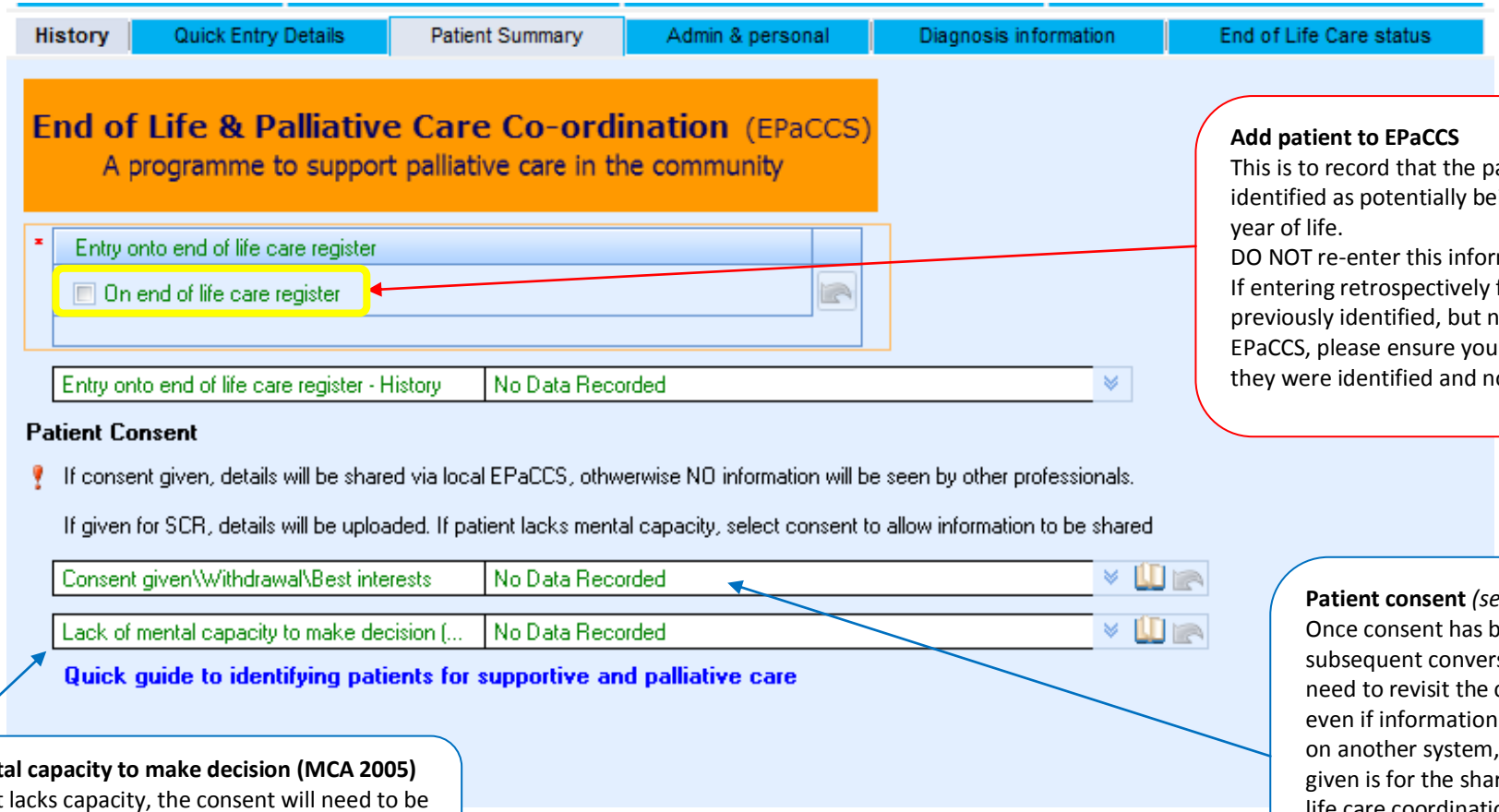
Add patient to EPaCCS

This is to record that the patient has been identified as potentially being in their last year of life.

DO NOT re-enter this information.

If entering retrospectively for someone previously identified, but not added to the EPaCCS, please ensure you enter the date they were identified and not today's date.

Patient Summary



Add patient to EPaCCS
This is to record that the patient has been identified as potentially being in their last year of life.
DO NOT re-enter this information.
If entering retrospectively for someone previously identified, but not added to the EPaCCS, please ensure you enter the date they were identified and not today's date.

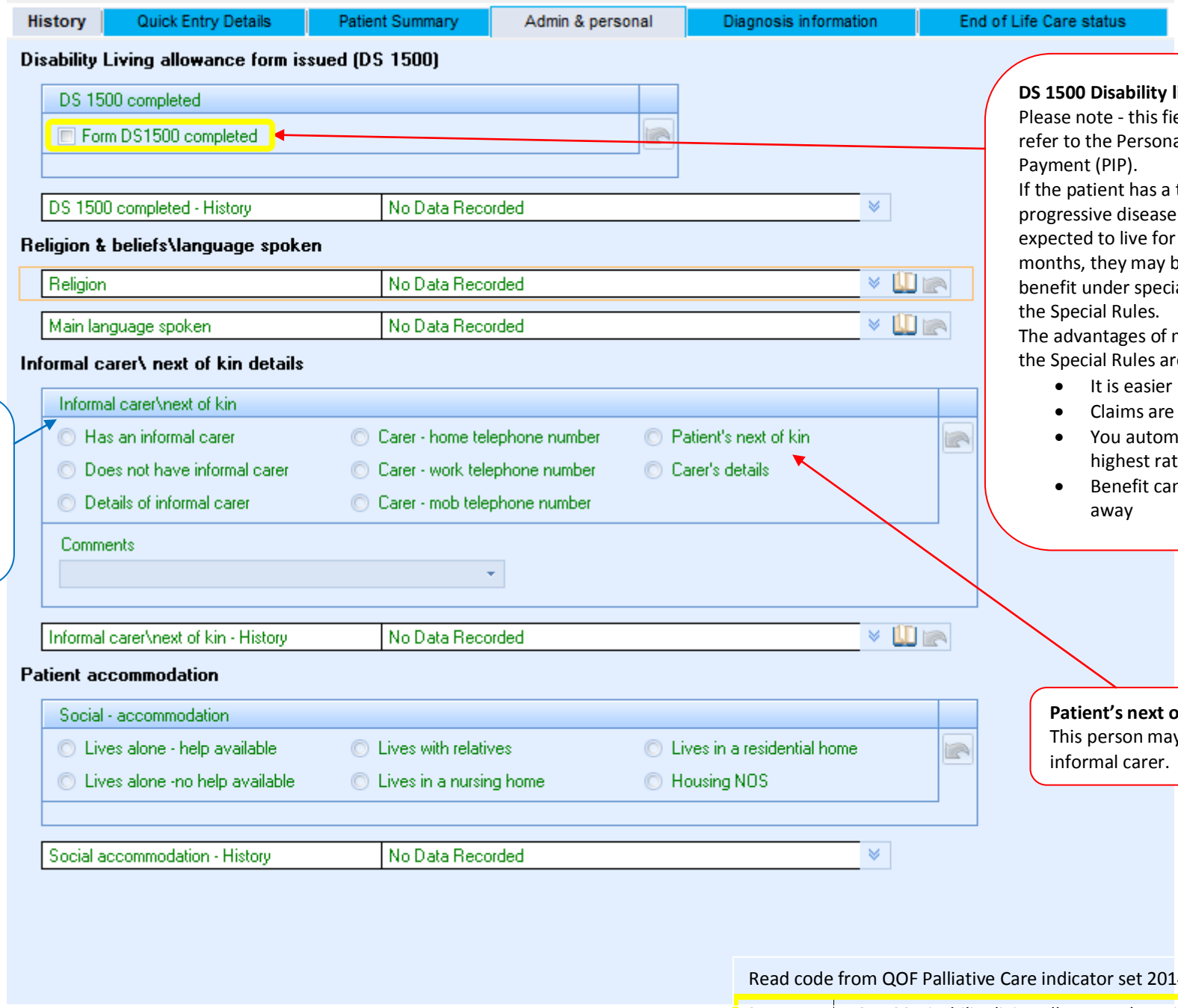
Lack of mental capacity to make decision (MCA 2005)
If the patient lacks capacity, the consent will need to be obtained through a best interest decision, a legitimate patient representative, or appointed person with lasting power of attorney.

Patient consent *(see advice above)*
Once consent has been given, subsequent conversations should not need to revisit the consent issue, even if information is being recorded on another system, as the consent given is for the sharing of an "end of life care coordination record" across all of the systems involved in the EPaCCS.

Read code from QOF Palliative Care indicator set 2014/15

9Ng7.	On end of life care register

Admin and Personal



Main Informal carer
This would be the main carer (a family member or friend) who has agreed to take on this role.

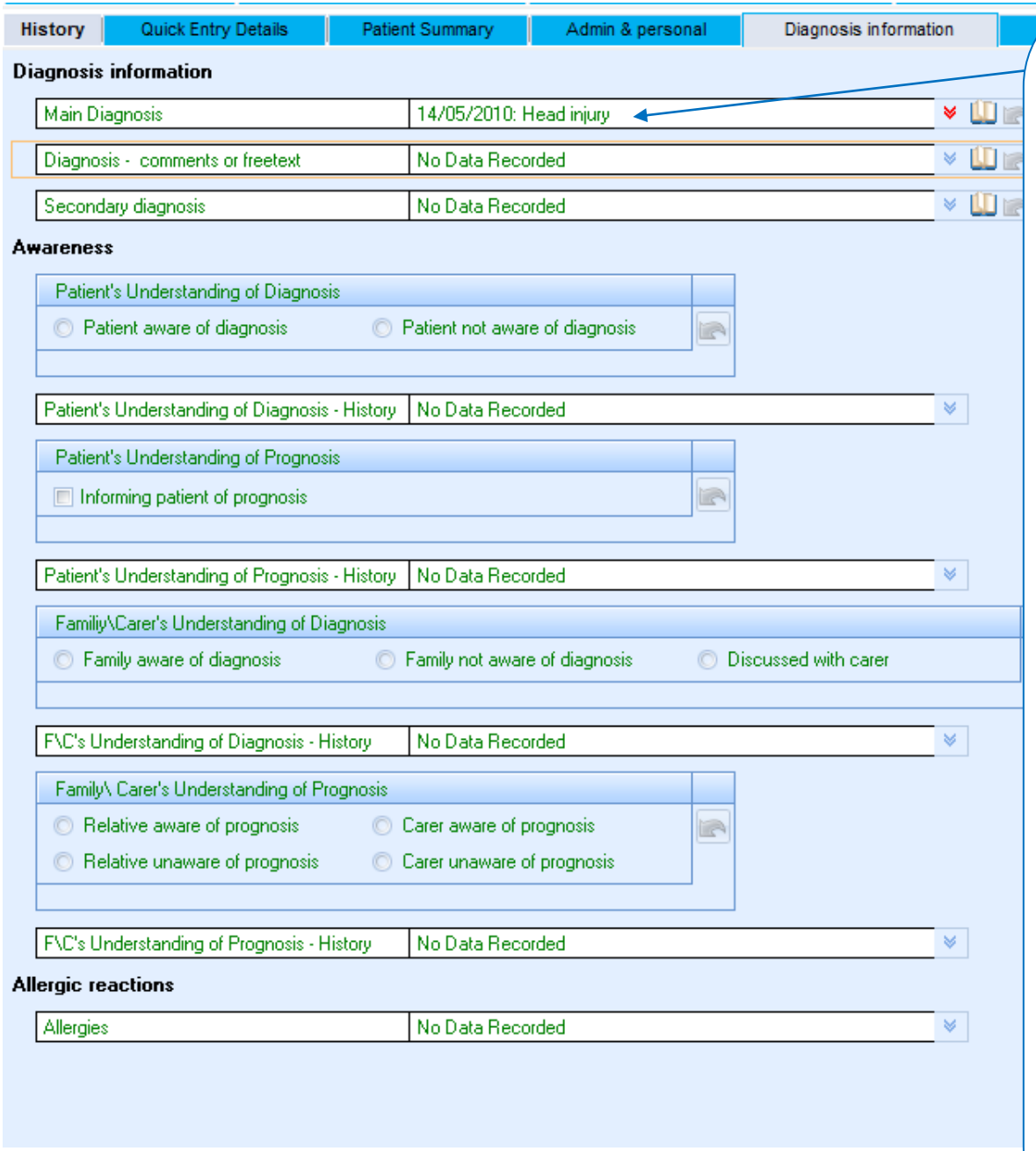
DS 1500 Disability living allowance
Please note - this field will be updated to refer to the Personal Independence Payment (PIP).
If the patient has a terminal illness or progressive disease and are not expected to live for longer than six months, they may be able to apply for benefit under special benefit rules called the Special Rules.
The advantages of making a claim under the Special Rules are:

- It is easier
- Claims are dealt with faster
- You automatically get the highest rate of benefit
- Benefit can be paid straight away

Patient's next of kin
This person may differ from the main informal carer.

Read code from QOF Palliative Care indicator set 2014/15	
9EB5.	DS 1500 Disability living allowance (terminal care) completed

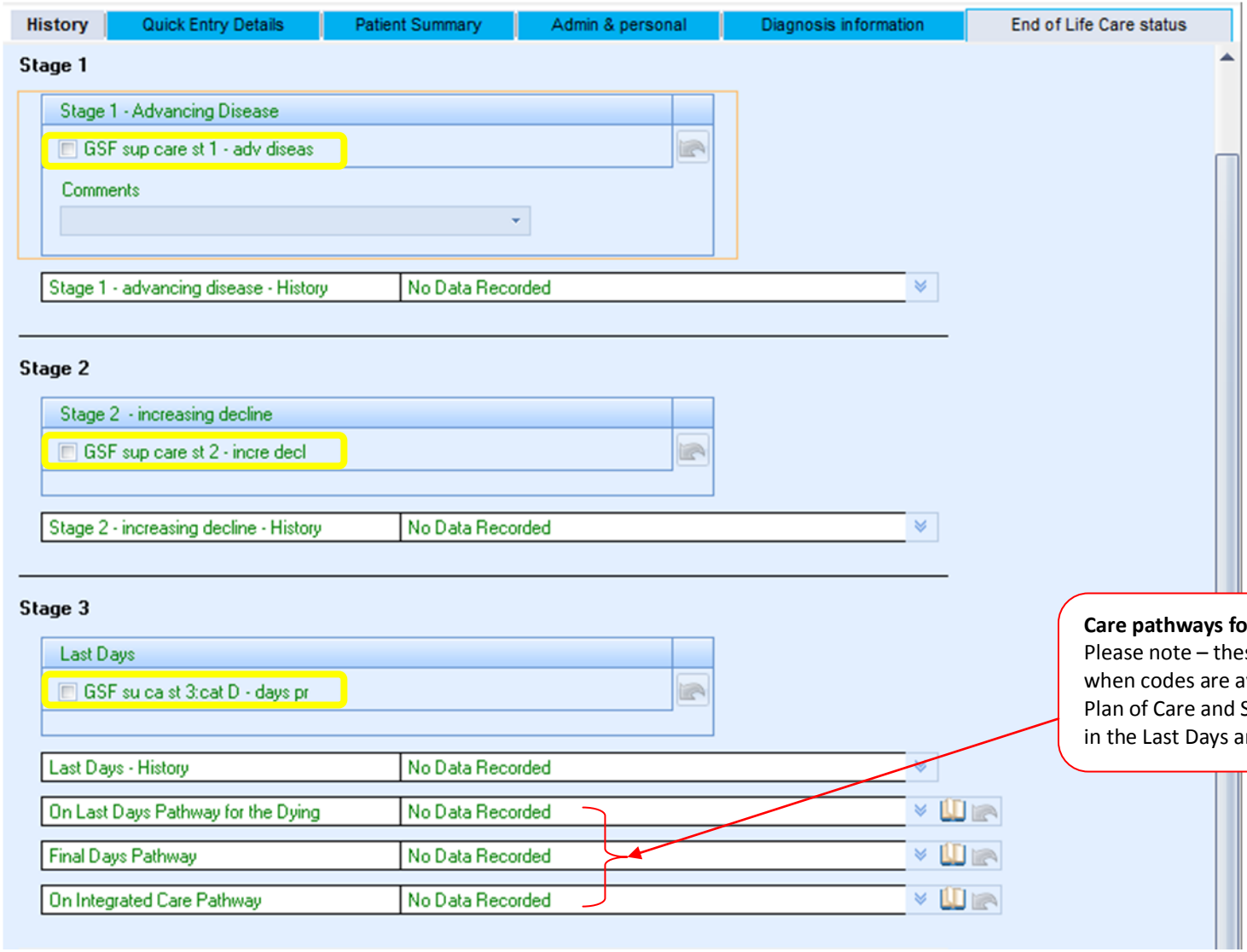
Diagnosis Information



Primary End of Life Diagnosis
This refers to the main life-limiting illness. The following list can be used as a guide:

- cancer/malignant disease (breast)
- cancer/malignant disease (CNS tumour)
- cancer/malignant disease (colo-rectal)
- cancer/malignant disease (gynae/cervix)
- cancer/malignant disease (gynae/ovary)
- cancer/malignant disease (gynae/uterus)
- cancer/malignant disease (haematological)
- cancer/malignant disease (head/neck ca)
- cancer/malignant disease (lung ca/mesothelioma)
- cancer/malignant disease (other)
- cancer/malignant disease (unknown primary)
- cancer/malignant disease (upper GI/liver)
- cancer/malignant disease (upper GI/oesophagus)
- cancer/malignant disease (upper GI/pancreas)
- cancer/malignant disease (upper GI/stomach)
- cancer/malignant disease (urological/bladder)
- cancer/malignant disease (urological/kidney)
- cancer/malignant disease (urological/prostate)
- cancer - unknown
- chronic renal failure
- chronic respiratory disease
- dementia / Alzheimer's
- frail / elderly
- heart failure
- motor neurone disease
- neurology
- other heart and circulatory conditions
- all other conditions – please specify

End of Life Care Status



Care pathways for the dying
Please note – these fields will be updated when codes are available for the Individual Plan of Care and Support for the Dying Patient in the Last Days and Hours of Life.

Read code from QOF Palliative Care indicator set 2014/15

8CM1.%	On gold standards palliative care framework

End of Life Care Status *(cont.)*

Personal care plan completed
A personal care plan (sometimes known as a 'support plan') documents the care and treatment actions necessary to meet a person's needs, preferences and goals of care. These must have been agreed with the person receiving care or by those acting in the person's best interests as part of a comprehensive holistic assessment.
This is different from advance care planning which is about preferences and wishes for future care.

Disabilities affecting care
These fields flag any additional disabilities that would potentially impact on the patient's care needs.

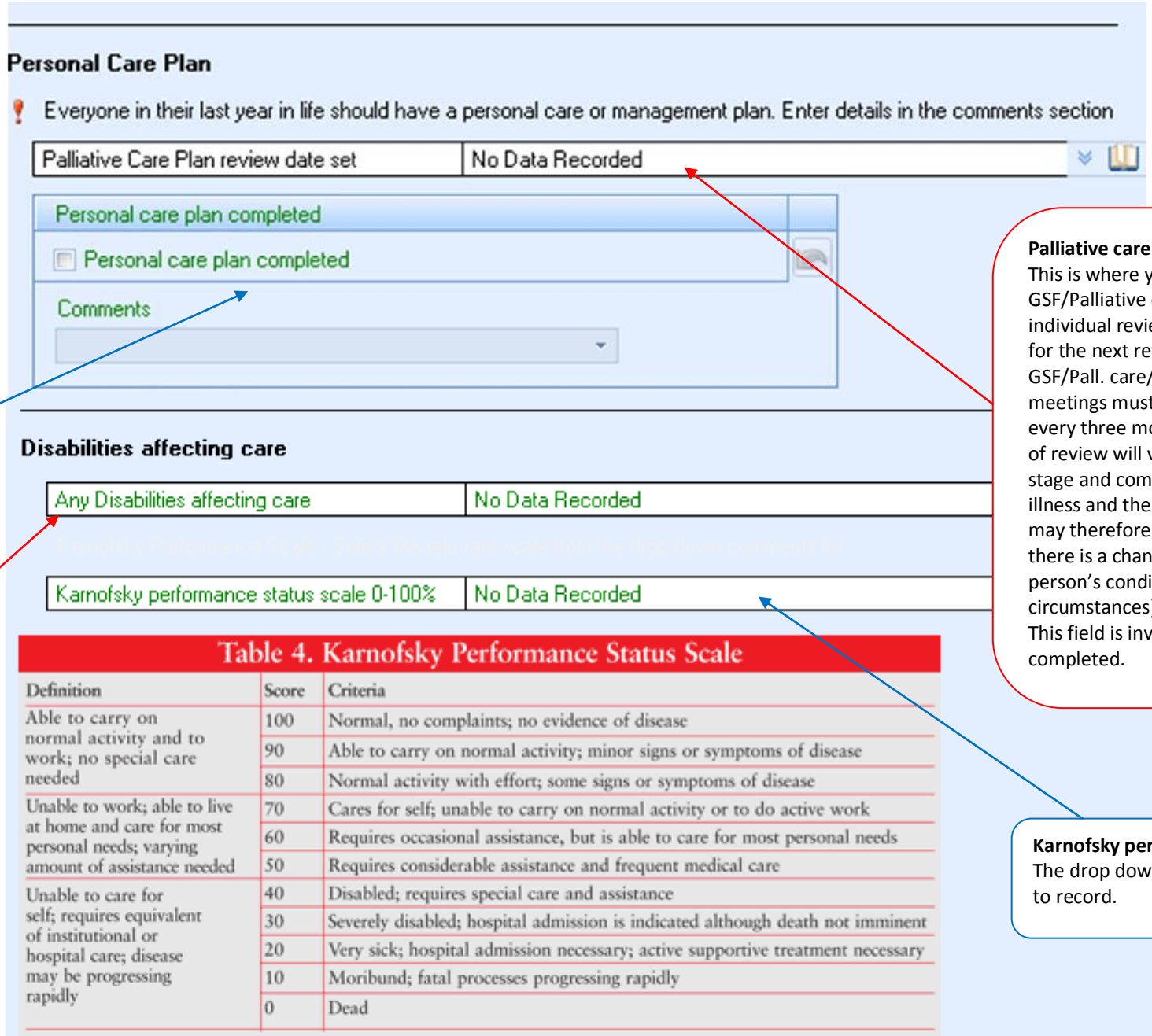


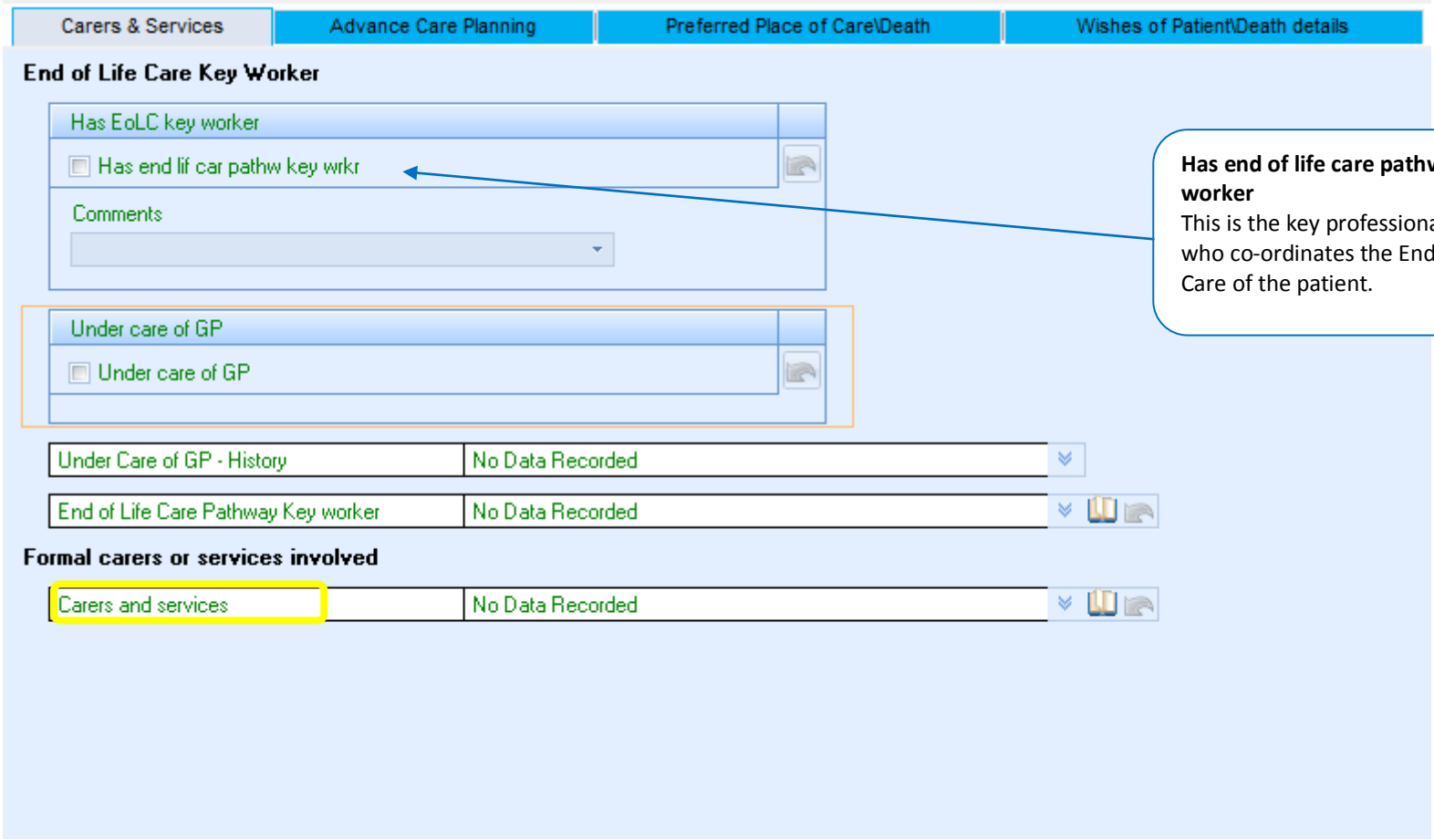
Table 4. Karnofsky Performance Status Scale

Definition	Score	Criteria
Able to carry on normal activity and to work; no special care needed	100	Normal, no complaints; no evidence of disease
	90	Able to carry on normal activity; minor signs or symptoms of disease
	80	Normal activity with effort; some signs or symptoms of disease
Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed	70	Cares for self; unable to carry on normal activity or to do active work
	60	Requires occasional assistance, but is able to care for most personal needs
	50	Requires considerable assistance and frequent medical care
Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly	40	Disabled; requires special care and assistance
	30	Severely disabled; hospital admission is indicated although death not imminent
	20	Very sick; hospital admission necessary; active supportive treatment necessary
	10	Moribund; fatal processes progressing rapidly
	0	Dead

Palliative care plan review
This is where you can log the recent GSF/Palliative care/MDT meeting, or individual review, and add a DIARY entry for the next review (e.g. at the next GSF/Pall. care/MDT meeting). These meetings must take place at least once every three months, but the frequency of review will vary depending upon the stage and complexity of the person's illness and their circumstances. This date may therefore need adjustment (e.g. if there is a change or deterioration in a person's condition or in their personal circumstances).
This field is invisible until a GSF Stage is completed.

Karnofsky performance status scale
The drop down provides 0-100% values to record.

Carers & Services

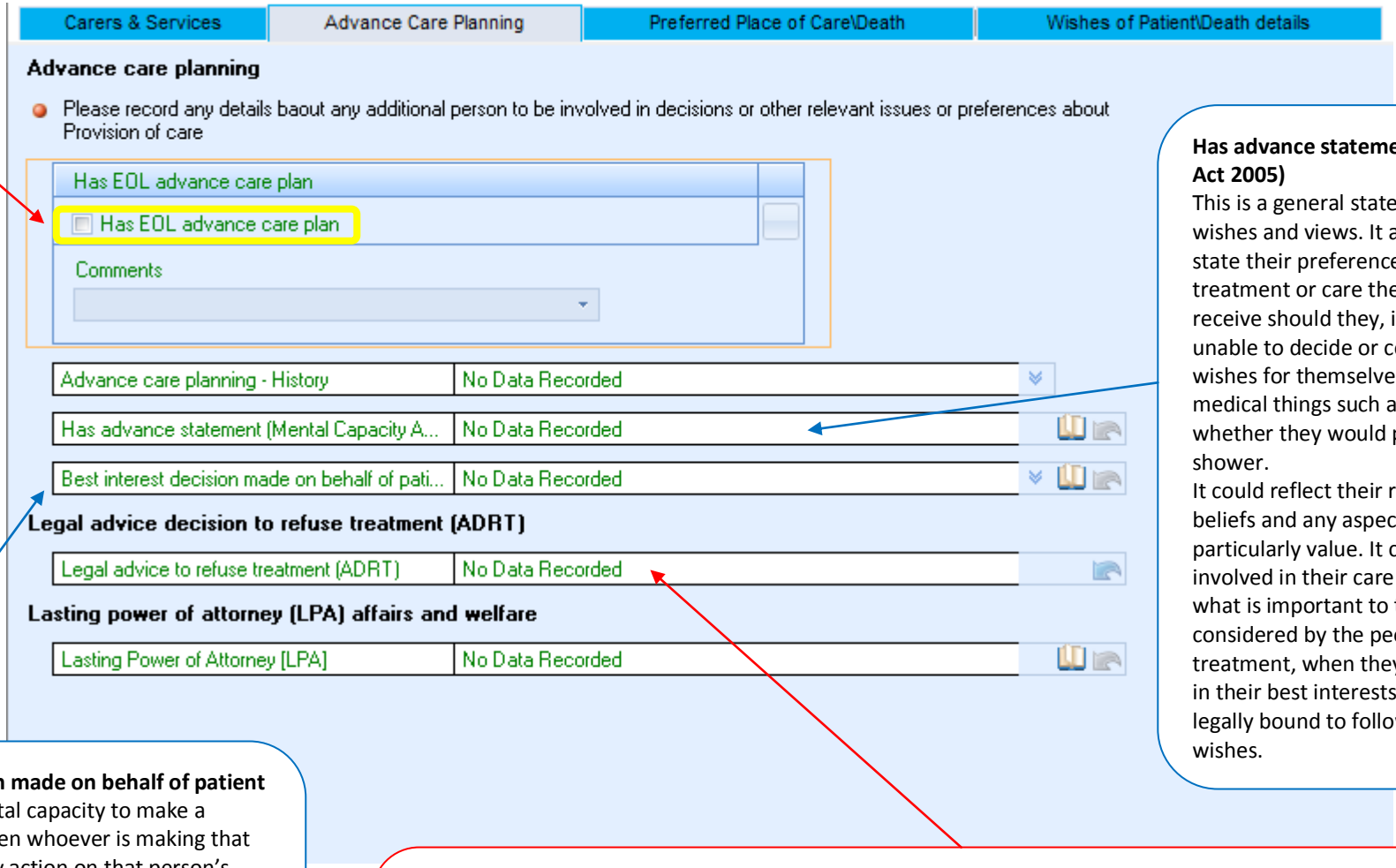


Read codes from QOF Palliative Care indicator set 2014/15

9NNd.	Under care of palliative care specialist nurse
9NNf0	Under care of palliative care physician
9NgD.	Under care of palliative care service

Advance Care Planning

Has end of life advance care plan
Has the same meaning as an advance statement but it more likely to refer to a patient's preferred place of care at the end of life or maybe where they would prefer to die.



Has advance statement (Mental Capacity Act 2005)
This is a general statement of a patient's wishes and views. It allows a patient to state their preferences and indicate what treatment or care they would like to receive should they, in the future, be unable to decide or communicate their wishes for themselves. It can include non-medical things such as food preferences or whether they would prefer a bath to a shower.
It could reflect their religious or other beliefs and any aspects of life that they particularly value. It can help those involved in their care to know more about what is important to them. It must be considered by the people providing their treatment, when they determine what is in their best interests, but they are not legally bound to follow the patient's wishes.

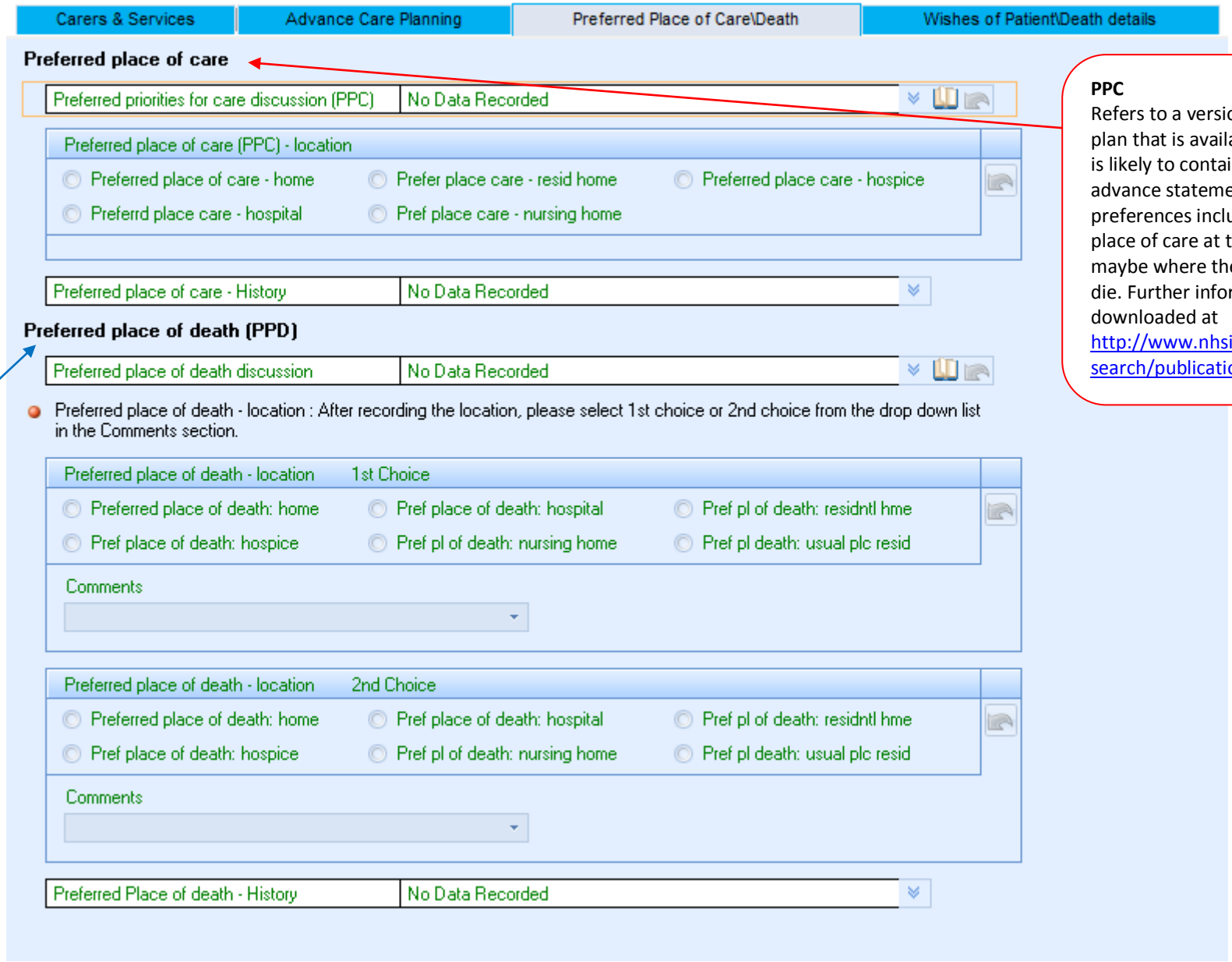
Best interest decision made on behalf of patient
If a person lacks mental capacity to make a particular decision then whoever is making that decision or taking any action on that person's behalf must do this in the person's best interests. They should take into account any evidence they have of the patient's past wishes, their beliefs and values, and they should consult the patient's friends, family and carers where appropriate. The law gives a checklist of key factors which decision makers must consider - further information can be found at http://www.bestinterests.org.uk/best_interests/

ADRT
If a patient makes an advance decision to refuse life-sustaining treatment, it must meet certain requirements set out in the Mental Capacity Act. Life-sustaining treatment is defined in the Act as treatment that, in the view of the person providing health care to the person concerned, is necessary to sustain their life. This could include artificial nutrition and hydration to someone who cannot eat or drink by mouth. The legal requirements for a valid advance decision to refuse life-sustaining treatment are as follows:

- The decision must be in writing. The patient can ask someone else to write it down.
- The patient must sign the document. They can instruct someone to sign it on their behalf in their presence if they can't sign it themselves.
- Their signature (or the signature of the person signing on your behalf) must be witnessed. The witness must also sign the document in the patient's presence.
- They must include a written statement that the advance decision is to apply to the specific treatment even if their life is at risk

Further information can be downloaded at http://www.adrt.nhs.uk/

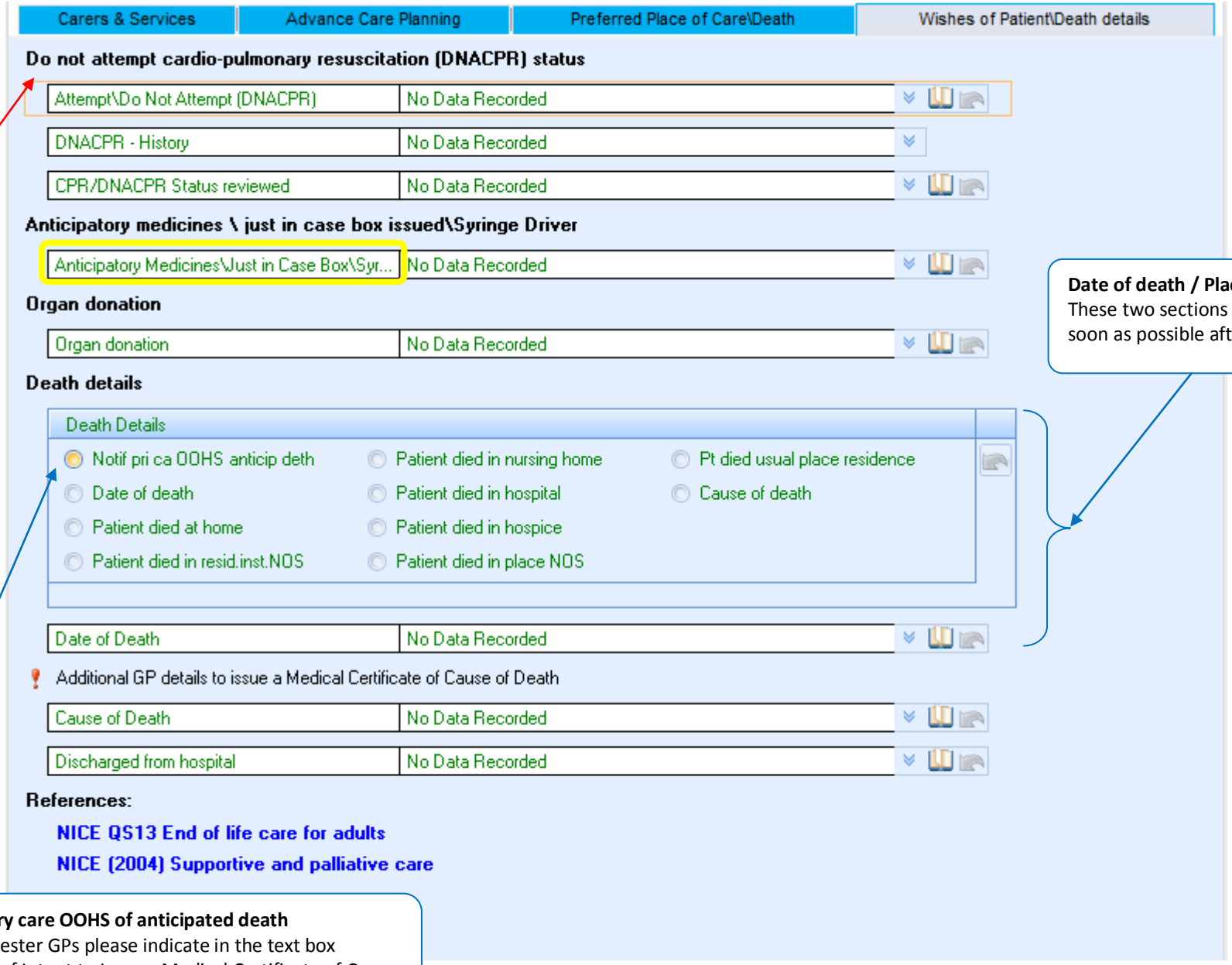
Preferred Place of Care/Death



PPD
Some patients will choose to discuss their preferred place of death or this may have been previously written down within an advance care plan.

PPC
Refers to a version of an advance care plan that is available to download. It is likely to contain the patient's advance statement of wishes and preferences including their preferred place of care at the end of life or maybe where they would prefer to die. Further information can be downloaded at http://www.nhsiq.nhs.uk/resource-search/publications/eolc-ppc.aspx

Wishes of Patient/Death details



DNACPR
Please refer to the Unified DNACPR policy.

Date of death / Place of death
These two sections **MUST** be completed as soon as possible after a patient's death.

Notification to primary care OOHS of anticipated death
For all Greater Manchester GPs please indicate in the text box whether a Statement of Intent to Issue a Medical Certificate of Cause of Death has been completed.

Read code from QOF Palliative Care indicator set 2014/15

8B2a.	Prescription of palliative care anticipatory medication

Appendix 1

Other useful resources

The Revised North West End of Life Care Model 2015
http://www.gmlscscn.nhs.uk/index.php

Find Your 1% Campaign - www.dyingmatters.org/gp

End of life Care - http://www.nhsiq.nhs.uk/improvement-programmes/long-term-conditions-and-integrated-care/end-of-life-care.aspx

National Council for Palliative Care - www.ncpc.org.uk

The Gold Standards Framework - http://www.goldstandardsframework.org.uk

Guidance on QOF - http://www.nhsemployers.org

Guidance on confidentiality and consent - http://www.gmc-uk.org/guidance

Electronic Palliative Care Coordination Systems (EPaCCS) - http://www.nhsiq.nhs.uk/improvement-programmes/long-term-conditions-and-integrated-care/end-of-life-care/coordination-of-care.aspx

EPaCCS in England: Survey of clinical commissioning groups (2013) - http://www.endoflifecare-intelligence.org.uk/resources/publications/epaccs_in_england

Locality Registers and EPACCS - http://www.networks.nhs.uk/nhs-networks/locality-registers