Electronic Palliative Care Co-ordination System
10 Top Tips for maximising EPaCCS and care plan effectiveness.

1. **Uncertain prognosis or Respect Form/ACP prior to EOL** - use the 'blue' (possibly more than 1 year) to code and share vital information e.g. DNACPR status and other aspects of condition and care plan. Use Prognostic Indicators to identify patients with Frailty and Long Term Conditions.

2. **Time** - it takes 1-2 minutes to refer a patient. Coded updates are also very quick to add at subsequent consultations - the template codes automatically to the patient record. Time is saved by recording in an orderly fashion and easy to search and retrieve. ***Please ensure you click the red edged box 'Refer to EPaCCSs' the first time you use the template before saving it to S1. Failure to do so will mean that the template will not be shared outside the surgery. The gold star icon will appear under the patient demographics.***

3. **Myth busting** - Registering an EOL patient and embarking on advance care planning doesn't shorten their life, it increases it!

4. **Communication** – patients are generally more than happy to have this information shared - they see it as a 'no brainer' and there is no need to say 'End of Life' if not felt to be appropriate - just 'care planning information'. Then give your patient the Patient Call number & leaflet.

5. **Care Plan** - use the txt option next to the 'Preferred place of care' prompt for Care plan details, ceiling of care wishes and escalation plans e.g. 'No hospital admission for any circumstances unless this is felt to be in X's best interests after discussion with X or next of kin or carer'. Location of DNAR form can also be recorded in free txt linked to the status. Don't forget to make use of the **Advance Care Planning** (ACP) document for Notts. Patients appreciate being able to share thoughts - many have already made plans but have not yet shared them with us! We are now using the **Respect Process** form to record key information about a person's priorities and from their ACP. This can be completed on hard copy and uploaded to the patient record or completed digitally via the Ardens/F12 template. See attachments on www.Epaccs.com with clinician guidance.

6. **Times of Need -** Ensure that the patients and their key family members and carers are all aware of and in agreement with what is in the ACP. Coach them to be able to ask effectively for what they feel is needed if they ever have to ring for support out of normal opening hours in order to avoid an ambulance being despatched, with the attendant risks of an unwanted hospital transfer. Being clear and persistent is necessary sometimes. This is particularly important for care home staff and the manager or senior nurse is key to spreading the messages and ensuring care plans are well communicated. Use Patient Call option 2

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when the surgery is closed.

7. **Reporting function** - Please remember to use the EPaCCS template to code all key aspects of advance care plan. This will then appear in the report to inform your GSF meeting discussions. There is information on the EPaCCS website that guides you in using the reporting function which produces an up to date spreadsheet in GSF prognostic groups which is really helpful for your monthly GSF meetings. ***Recording place of death is a key piece of required information that the CCG and CQC will need.***

8. **GSF meetings -** it is best practice to hold these monthly as the patients can change quickly. Concentrate discussions on those whose condition is changing or have complex needs, those who are prognostically amber or red and those whose death has learning to be shared e.g. not on GSF/palliative care register or haven't died in the PPD. Use GSF Report live and update there and then in GSF meeting.

9. **Information & Resources -** use the links on the EPaCCS template to access further information to support your care. The website www.Epaccs.com is mobile friendly and has links to all current tools and guidance. The Respect process Website has some excellent training resources and e-LfH has modules on all key aspects of EOL Care. Newark & Sherwood Practices (the 12 that registered in 2012) can still access Going for Gold GSF training for your team which will support your QOF EOL QI work. Contact Dr Julie Barker for advice.

10. **Help! + Identifying Patients.** The guidance can be found on The EOL webpage on Clinical Pathways Website. Remember to use the specialist palliative care service and other sources of support for help with care planning and symptom control (and remind care home staff of their availability and the helplines currently provided by hospices 24/7 –

- Mid Notts EOLCT service: Patient Call 01623 781891 Option 2
- Beaumond House 01636 610556 (community hospice, nurse led, Newark)
- Haywood House 0115 9691169. (specialist palliative care, Nottingham)
- John Eastwood Hospice 01623 622626 (specialist palliative care, Mansfield))
- Pathways service provide Carer Support and can be accessed for Mid Notts via SPA 0300 4564951.
- **EPaCCS Contacts:**
- NHIS: "RAITHATHA, Kalpesh (NOTTINGHAM CITYCARE PARTNERSHIP)" <kalpesh.raithatha@nhs.net>
- EOL leads, julie.barker20@nhs.net & christina.sharkey@nhs.net
- ICS Mid Notts: carenrice@nhs.net Greater Notts: susan.gill7@nhs.net