

# NUH End of Life Care Collaborative Project

## Improving the sharing of the patients' end of life plan of care between secondary and primary care settings.

Category: Continuity of care

### Project Team –

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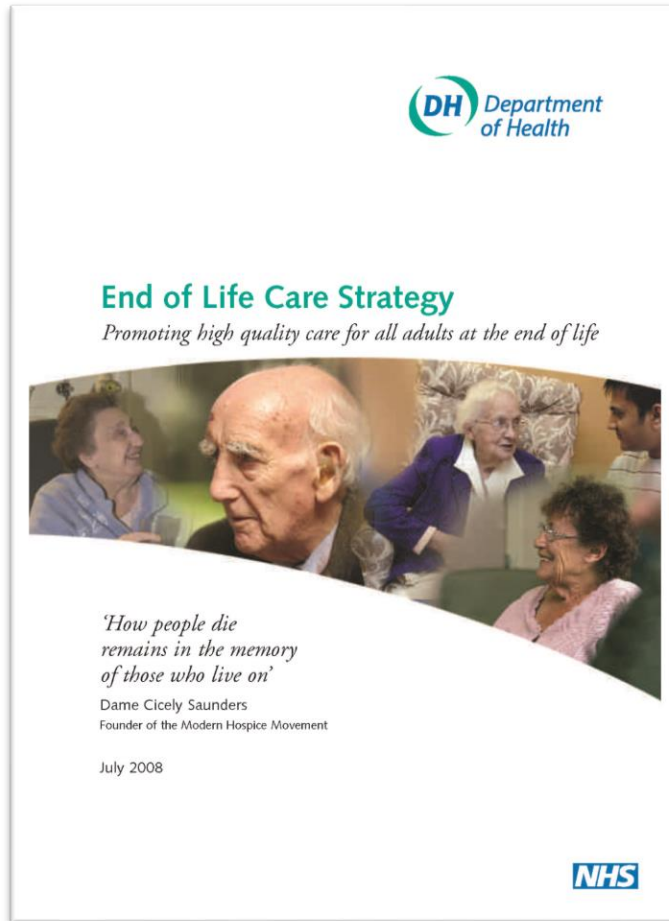
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**Sandra Minich**, Better for You Programme Manager



# National Strategy - End of Life Care (EoLC)

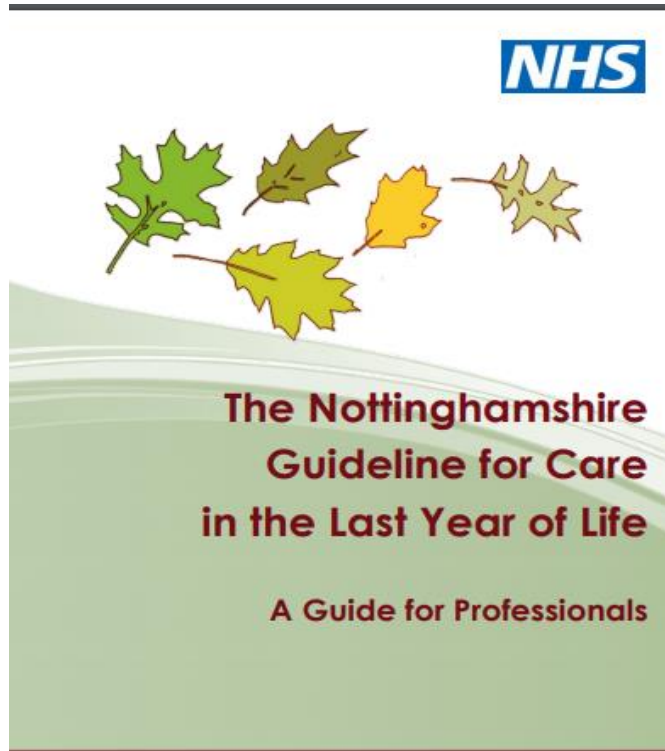


## The Six Ambitions

- 01 Each person is seen as an individual
- 02 Each person gets fair access to care
- 03 Maximising comfort and wellbeing
- 04 Care is coordinated
- 05 All staff are prepared to care
- 06 Each community is prepared to help

***The National Strategy recognises the importance of coordinated care within teams and between services in primary and secondary care.***

# Regional guidance



This guide was produced in partnership between

Nottinghamshire Healthcare NHS Foundation Trust | Nottingham CityCare Partnership  
Nottingham University Hospitals NHS Trust | NHS Bassetlaw CCG  
Sherwood Forest Hospitals NHS Foundation Trust

- Focused around the 5 priorities for care of a dying person:
- It emphasized on the importance of coordination of care, and sharing and recording of patient's individual care plan
- Recommended Electronic palliative care coordination system (EPaCCS) as a tool for effective communication between primary and secondary care

# NUH Strategy - End of Life Care (EoLC)

Nottingham University Hospitals   
NHS Trust

## End of Life Care is everyone's business at NUH

### Strategic objectives:

- To provide care of the highest quality
- To provide the best experience for patients and their loved ones
- To have confident and supported staff

### Measures of success:

#### For our patients, families and carers

- Treated with compassion and as a whole person
- Acknowledged by all that their time is valuable
- All patients recognised as dying have an individual end of life care plan that facilitates their choices
- Where feasible, patients are able to die in their preferred place of choice

#### For our staff

- Divisional leads for EoLC are visible for all staff and are driving forward improvements in end of life care in their divisions that are specific for their specialities
- Staff have increased competence and confidence in caring at EoL through an increase in the number of staff receiving face-to-face training and mandatory online training for EoLC

#### For NUH

- NUH has a reputation for delivering a high standard of EoLC for the benefits of patients, families, carers and staff
- NUH will know what choices matter for their patients, families and carers at EoL and will actively engage to enable these choices to be met
- The Trust has effective stakeholder involvement and engagement including local community groups, public, volunteers and commissioners in steering and planning priorities for EoLC across the STP

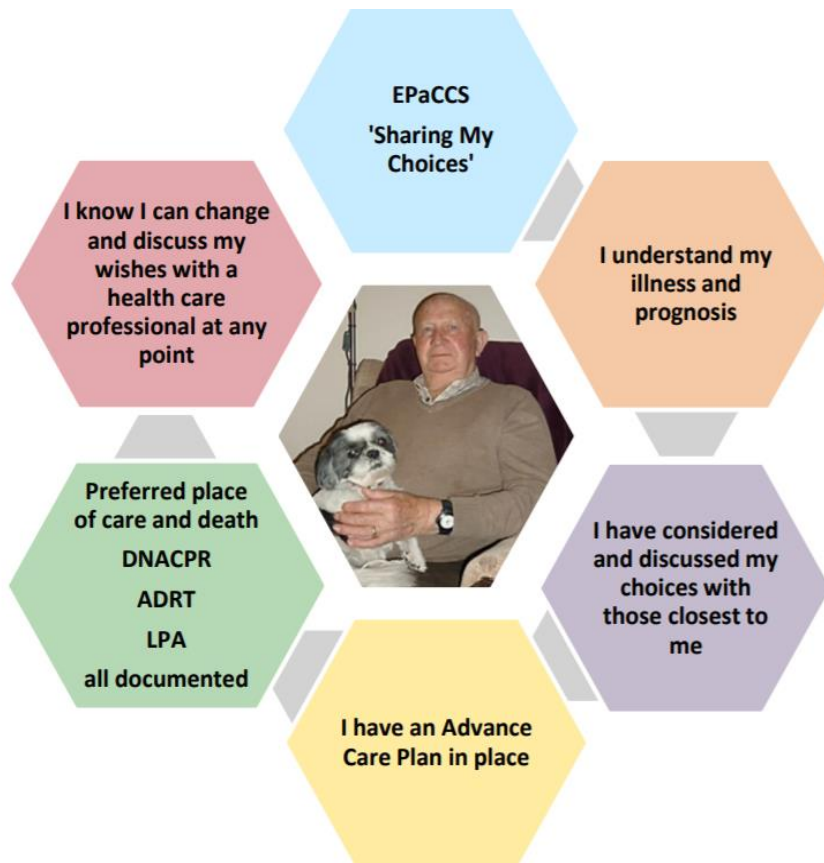
EoLC objectives

*We are here for you*

## NUH EoLC Strategy

To provide care of the highest quality	To provide the best experience for patients and their loved ones	To have confident and supportive staff
Roll out of improved EOL care plan documentation across NUH	Participation in the National Audit of the care of the dying	Electronic palliative care coordination system (EPaCCS) to be implemented in key clinical areas within acute care at NUH

# What is EPaCCS ?



- A system that enables the recording and sharing of information about patient's end of life care wishes and preferences with those delivering care.
  - It supports coordination of care
  - Increases the proportion of people dying in their preferred place of death
  - Reduces hospital deaths and increases deaths in the home and in hospices
- (Public Health England, 2013)

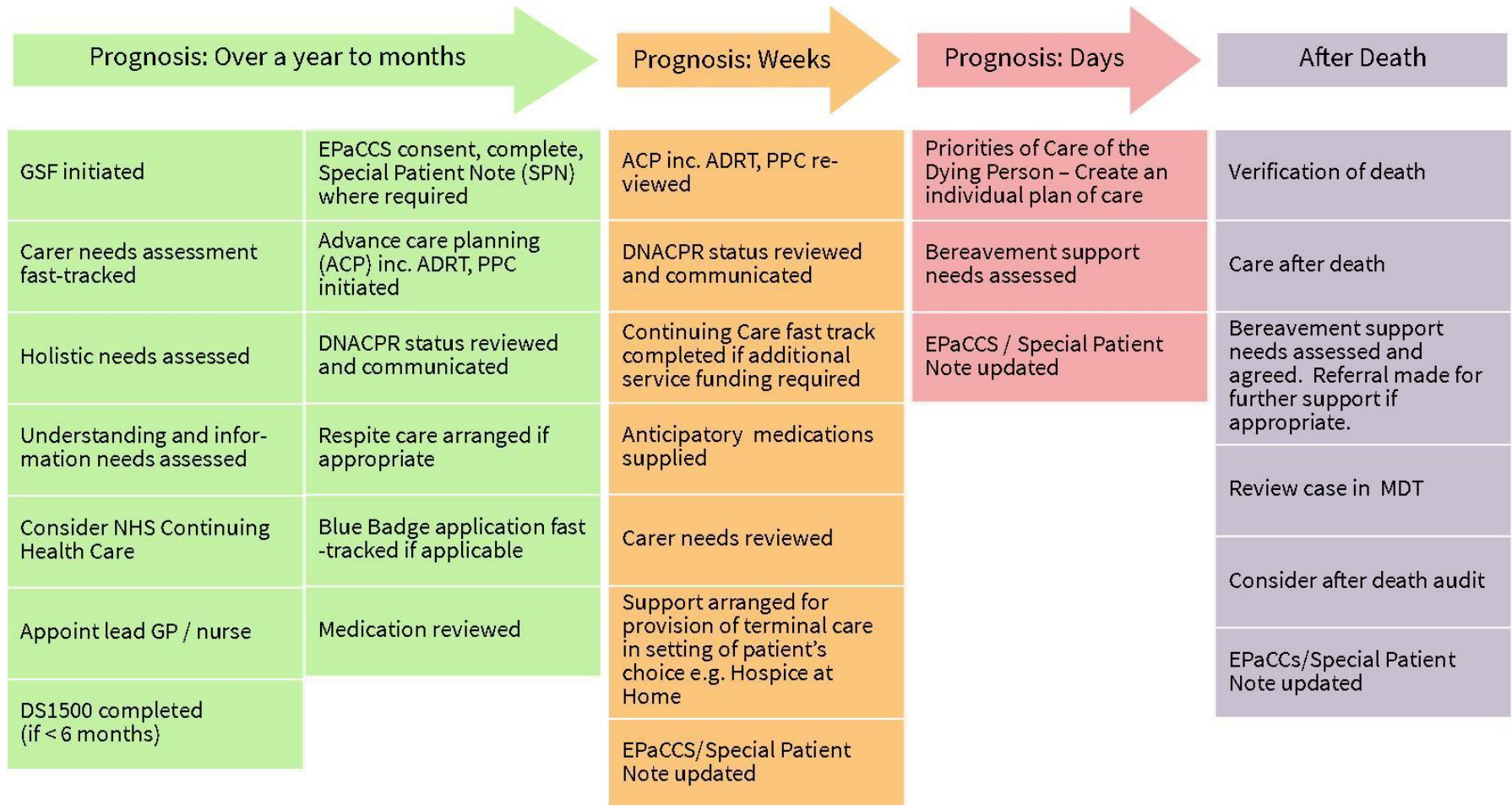
# EPaCCS template

The image displays five sequential screenshots of the EPaCCS (End of Patient Care Consultation) template interface. Each window is titled "EPaCCS template" and shows a different section of the form, with a consistent date of "Fri 19 Aug 2015".

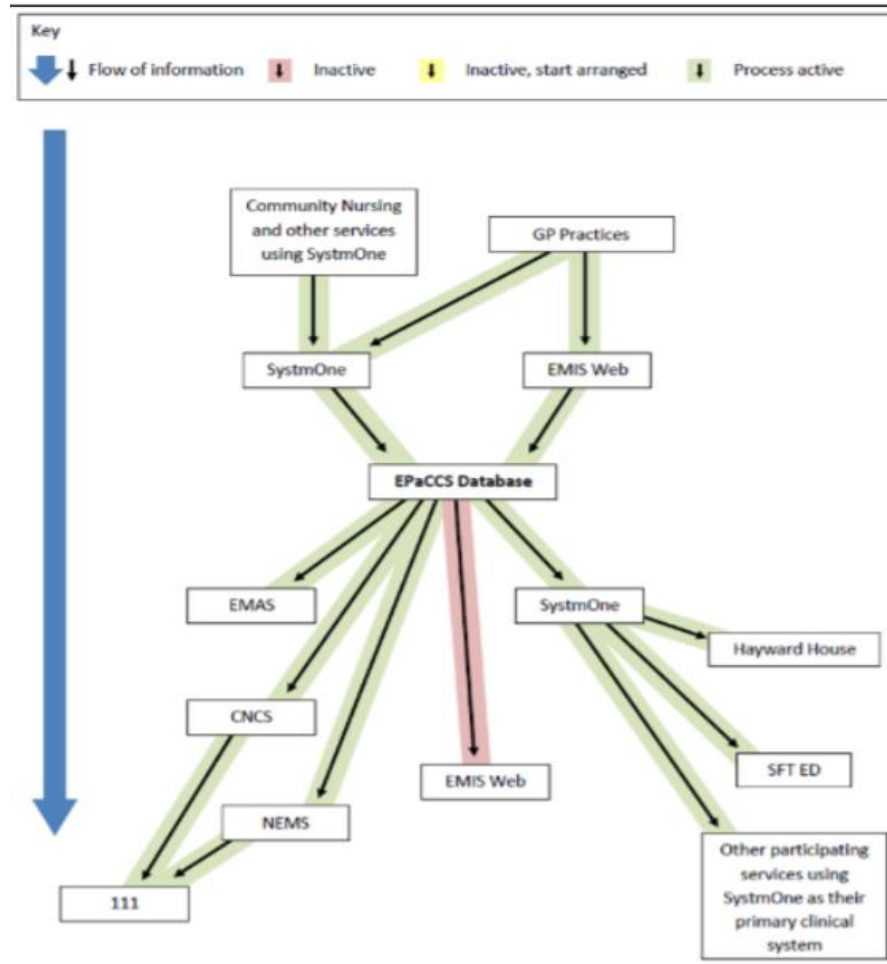
- Window 1 (Blue background):** "Initial Information". Fields include "On end of life care register", "Select Gold Standard Framework Stage", "Consent to share End of Life Care Information", "Primary End of Life Diagnosis", "Awareness of Diagnosis", "Awareness of Prognosis", "Informal Care and Main Care", and "Personal Care".
- Window 2 (Green background):** "Preferred Place of Care". Fields include "Preferred place of care", "Hospital", "Advance Care Planning", "Advanced decision to refuse treatment", "DNR/Do Not Resuscitate Status", and "Patient's Resuscitation Status".
- Window 3 (Orange background):** "Preferred Place of Care". Fields include "Preferred place of care", "Hospital", "Advance Care Planning", "Anticipatory prescribing", and "DNR/Do Not Resuscitate Status".
- Window 4 (Pink background):** "Red Stage (Pink Days)". Fields include "Preferred place of death - 1st Choice", "Preferred place of death - 2nd Choice", "Anticipatory prescribing", "Preferences After Death", and "DNR/Do Not Resuscitate Status".
- Window 5 (Purple background):** "After Death". Fields include "Place of Death", "Date of death", "Bereavement support organised for family", "After Death Analysis Audit completed", and "Place of Death" (with a dropdown menu).



# End of Life Planning: Details of Care Provision



# Flow of information with EPaCCS



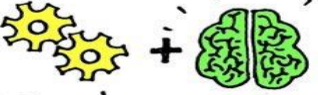
Source: <http://www.e-paccs.co.uk/sharing-through-epaccs/>



# Our Collaborative and Quality Improvement (QI)




RECOGNIZING THAT DIGITAL AGE REQUIRES NEW **MINDSET** ALONGSIDE SKILLSET



DEVOLVING RESOURCES AND **INFLUENCE** TO THOSE CLOSEST TO THE PROBLEM



NOT ROLLING OUT ANYTHING UNTIL YOU HAVE **EVIDENCE** THAT IT WORKS



**CHANGING SLOWLY** THROUGH SMALL SCALE EXPERIMENTATION



**REFLECTION AND CONTEMPLATION** RATHER THAN LOTS OF MANAGEMENT ACTIVITY



Tanmay Vora QAspire.com @tnvora

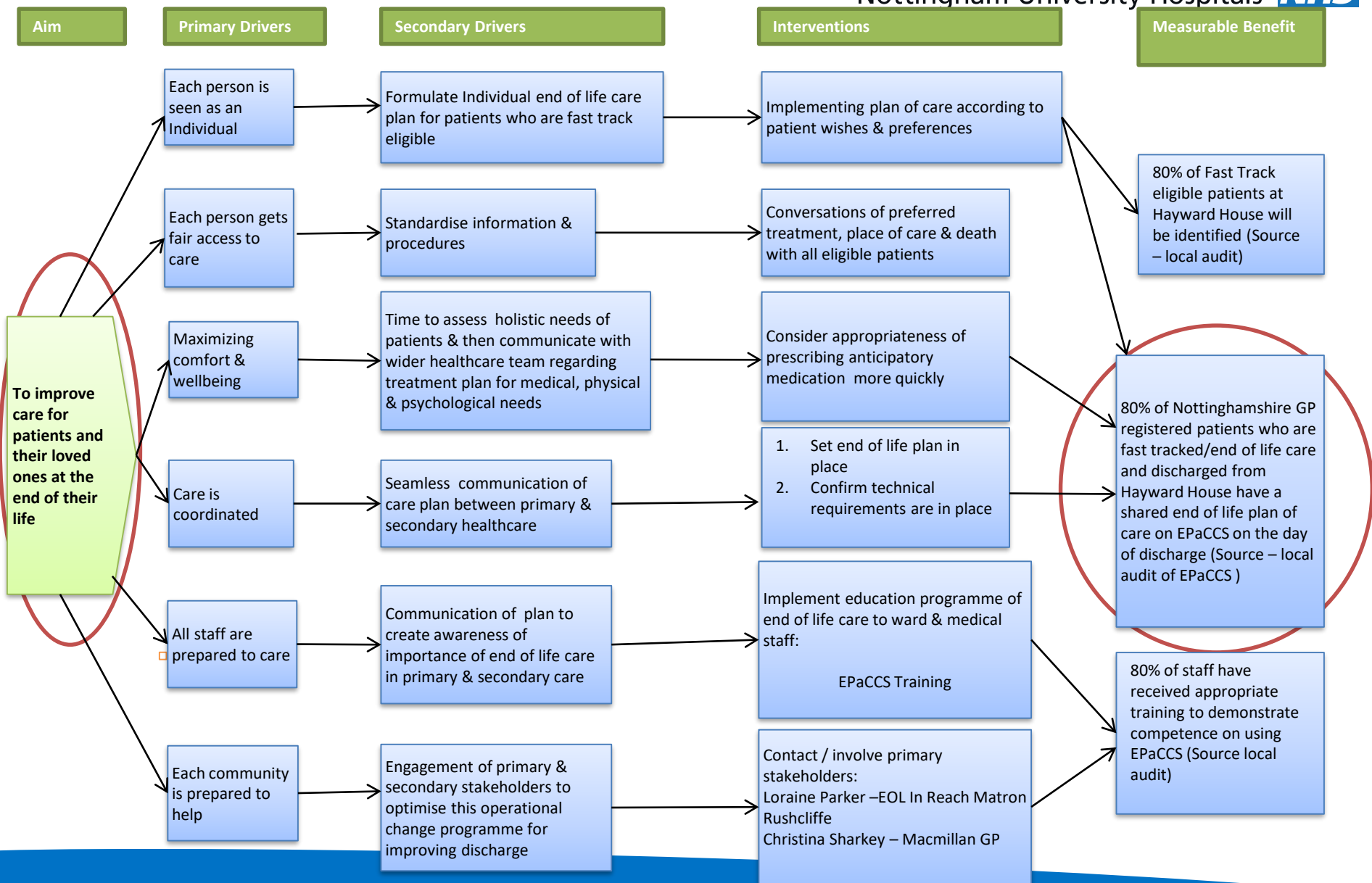
## Quality:

- Safe
- Effective
- Patient-centred
- Timely
- Efficient
- Equitable

## Quality Improvement:

‘A better patient experience and outcomes achieved through changing individual and organisation behaviour by using systematic change method and strategies.’

# NUH Drivers - EoLC



## Initial challenges

- Leadership and collaborative working
- IT engagement
- Clinical engagement
- Interoperability of different systems
- Funding
- Implementation of project within 150 days
- Securing sustainability

## Rapid improvement cycle

The aim of this programme is to:

- Improve the experience and quality of care received by patients at end of life
- Learn about quality improvement tools and techniques and put into practice
- Share best practice
- Improve our CQC rating for EoLC



## What have we done PDSA's:



Secured one year funding for the licences to use EPaCCS



Identified key IT support personnel in the community



Engagement of clinical staff at different levels with the inpatient SpR and ward sister part of the project team



Improved efficiency of the discharge process for junior doctors by introducing the E-Discharge information guide



Formulated a communication plan with all primary and secondary care stakeholders and obtained feedback



Processes in place for ongoing monitoring and measuring outcomes

## E Discharge information guide

<b>H</b>	<b>History of diagnosis/admission</b>
<b>E</b>	<b>End of life register, EPaCCS</b>
<b>A</b>	<b>Advance care planning, anticipatory medications</b>
<b>R</b>	<b>Resuscitation status</b>
<b>T</b>	<b>Treatment plan, escalation of treatments</b>

# Quality of information in discharge summaries from Hayward House since implementation

## BEFORE USE OF DISCHARGE GUIDE

### Information regarding discharge

“ She was assessed by physiotherapy and OT teams and the impression is that she will need to be nursed in bed at home. Both she and her husband seem to understand”

## AFTER USE OF DISCHARGE GUIDE

### Information regarding discharge

“We have completed the EPaCCS template on the following-

P has been a fast track discharge.

She has been prescribed anticipatory medications.

She has a DNACPR in place.

Her preferred place of care has been home & she has been keen to attend her grandson's marriage in November.

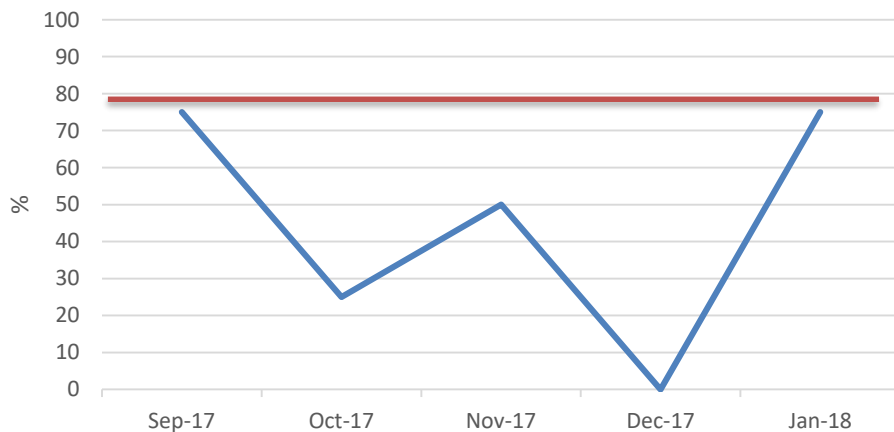
I would be grateful if you could put her on the end of life register.

It would be appropriate to treat her reversible causes, for example infections with oral antibiotics”



# Audit on EPaCCS entry

% of FT patients that had care plan on EPaCCS on discharge



## PDSA's



Standardised the Hayward House discharge process – Amending the existing discharge guidance in Hayward House junior doctors Guidance



Continuous clinical staff engagement by presenting project and its potential benefits to the Hayward House Quality, Risk & Safety meeting and educational meeting.



Made the identification of patients for EPaCCS straight forward. From Jan 2018 onwards, EPaCCS entry for all discharges from Hayward House



Ensured that patients for discharge planning are identified early to enable entry onto EPaCCS . Daily reminder at morning Board Round



Process in place to provide in house training for new doctors as part of their induction

# Qualitative feedback from the community & NUH team

'Information entered onto EPaCCS was useful and helped coordinate patient's care.'

'the discharge letter was clear and concise'

*GPs*

'avoided repeated difficult discussion'

'reduce the need for patients to tell their story again'

*DNs*

'helps coordinate patient's care in the community and provides continuity'

*Community Palliative Care nurse*

<https://www.youtube.com/watch?v=U2C4mqG9LGA&feature=youtu.be>

*Hayward House Junior doctor*

' We get one chance to get this right for both the patient and their family '  
'EPaCCS gives us the opportunity to holistically care for a patient by communicating with colleagues in other settings and therefore provides continuity that hasn't been possible in this setting before.'

*Hayward House Ward sister*

# Qualitative PPI feedback

**Trish Cargill – Chair of  
Patient Partnership Group**



**Katie Moore – Head of  
Patient and Public  
Involvement**



## Terence's story



72 yr old man with metastatic pancreatic cancer.  
Fast track discharged from Hayward House to home for EOLC and has preferences of care recorded on EPaCCS.  
Lives in Nottingham but has Derbyshire GP and DN team  
Passed away peacefully at home 18 days later.

'Information on the EPaCCS template was useful and avoided the repeated discussion on DNACPR'

*Derbyshire District Nurse*

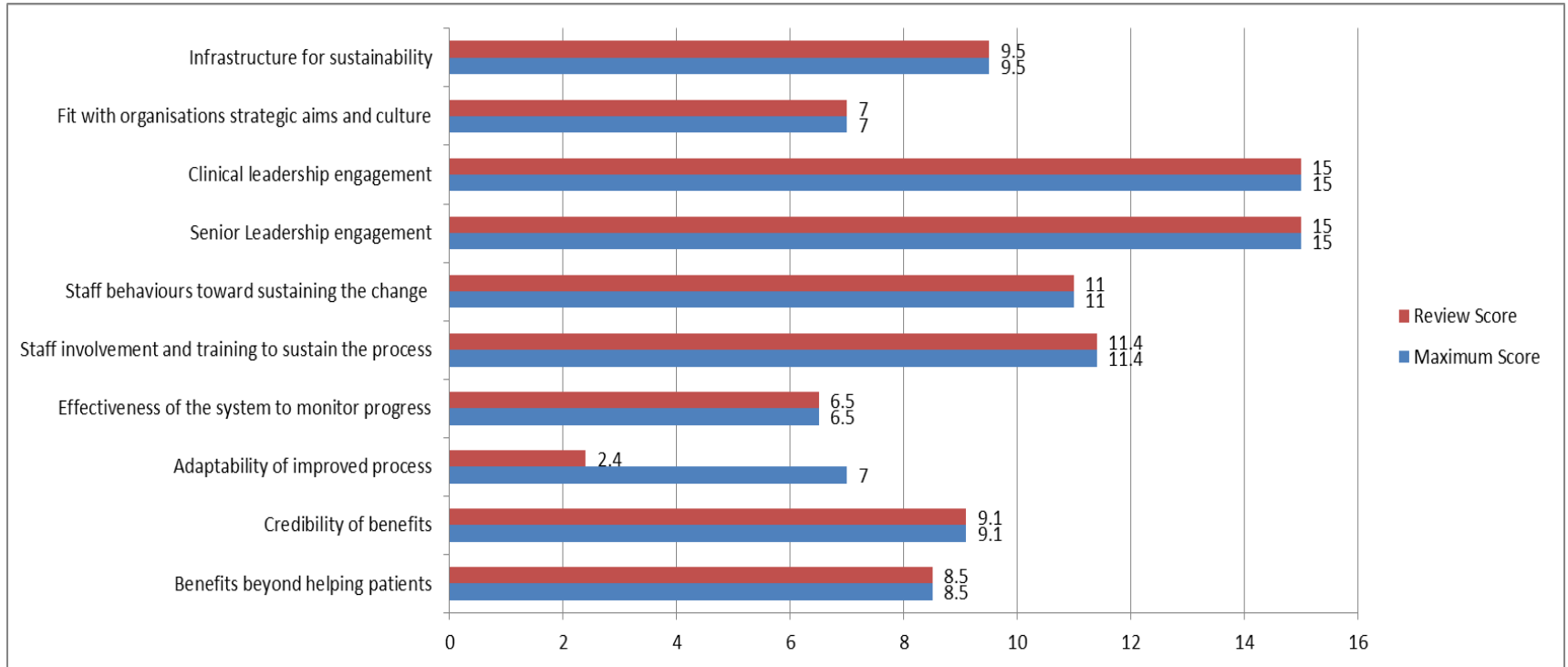
'His preferences of care were clear on SystemOne'  
'has made the referral process more efficient'

*Derbyshire Community Macmillan Nurse*

## Next steps

- Change the measurable outcome to include all discharge from Hayward House from Jan 2018 onwards
- Continue to review effectiveness of the E-discharge guidance
- Continue to audit the measurable outcome from Jan 2018 onwards
- Identify another key IT support in the community and set up a more efficient way of transferring licences and gaining log in.
- Expanding project to other wards in the Trust

# Aiming High – Sustainability Scores



## Raising Awareness:

**We are very proud of what has been achieved. We have shared and presented our outcomes at the National EoLC Collaborative Event, with Moorfields Eye Hospital as part of their visit to NUH, with our Nursing and Midwifery Board, through our internal Communications and via our Chief Nurse Blog. We also aim to share with our Patient and Partnership Group, NUH members and NUH Volunteers via their newsletters.**



# Closing Comments

Collaborative working has brought an energy of engagement, relationship connections. *"us and us"* rather than *"us and them"*

## The 5 Energies of High-Performing Teams

### Social

Personal engagement, relationships and connections between people.

### Intellectual

Analysis, planning, thinking.

### Spiritual

Commitment to a common vision for the future, driven by shared values and purpose.

### Psychological

Courage, resilience, feeling safe to do things differently... and take risks.

### Physical

Getting things done! Making progress.

*The Mountain of Progress*  
@HorizonsNHS

The collaborative energy of commitment to a shared vision has driven the confidence to move towards a different future, more compelling than the status quo

### Model for Improvement



High energy from gaining insight from sustainability plans



Collaborative approach reinforced teams feeling supported to make changes. We used the 'ginger model' to gain feedback and insight



## Developing People – Improving Care

A national framework for action on improvement and leadership development in NHS-funded services