

The Unified Approach for Wessex

ReSPECT-FUTURE PLANNING INTEROPERATIBILITY

DRAFT DISCUSSION PAPER

Version 1.5

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VERSION HISTORY

For control & tracking purposes

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FOREWARD

The Clinical Executive Group (CEG) of the Hampshire and Isle of Wight Sustainability and Transformation Partnership (HIOW STP) consists of Medical Directors, Nurse Directors, Associate Health Practitioner (AHP) Directors and Public Health Directors from all health organisations and local authorities within HIOW. A report was requested from the then Palliative and End of Life Care Clinical Network by the CEG and sent out to members on 30th April 2018. The report was presented to CEG on 14th June 2018 and members agreed the following recommendations as a mandate to all H&IOW STP partner organisations. This report is almost identical to the one discussed at the meeting (with some updates) and the letter that was sent out as follows:

This letter sets out important recommendations from the Hampshire and Isle of Wight Sustainability and Transformation Partnership (HIOW STP) Clinical Executive Group (CEG) for a unified approach to recording and sharing information in End of Life care:

Recommendation 1:

- Digitise the ReSPECT form and interface the digital version with the existing Future Planning template
- Support a working group to review both Future Planning and ReSPECT to ensure:
 - Treatment Escalation Plan is covered
 - The DNR element is not only covered but very clear
 - The interfaced 'Respect Future Planning' solution can 'talk' to existing electronic systems
 - The information is accessible and amendable by patients

Recommendation 2:

- Develop a safe and comprehensive plan to phase out the use of the existing uDNACPR 'Purple' form. The rationale for this recommendation is:
 - It is a legacy form and is out of date
 - A risk with this form that the assumption is 'DO NOTHING' to assist the patient
 - No Investment or resource available/planned to make improvements to it
 - No collegiate H&IOW STP or national plans to update/digitise

CEG has agreed to a unified approach to the setting up of a working group under the oversight of the Hampshire & Isle of Wight STP Quality Board. We would urge all health and social care partners at place, system and region to support these recommendations with a view to:

- System wide improvement in the quality and depth of the conversations we have with people regarding the care they want to receive and the way in which it is shared across social and healthcare settings.
- System standardisation in recording and sharing of a person's wishes regarding resuscitation.
- System commitment to move to digital solutions, building on existing local and nationally recognised data sharing platforms

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1 Introduction

1.1 Purpose

To provide a unified approach to the recording and sharing of Palliative and End of Life Care information throughout Hampshire & Isle of Wight (H&IOW) by combining and digitising the nationally recognised ReSPECT form with the local existing Future Planning electronic template. This paper was commissioned by the STP from the Wessex Palliative and End of Life Care Clinical Network (2016-2018).

The result will be one electronic form used across H&IOW. The form will 'talk to' a variety of existing systems. By doing this, the intentions of patients will be captured, be updatable, stored securely and shared with the right people at the right time (the time that they need it) across multiple disciplines and multiple stakeholder organisations. Patients and their carers will have access to their information and be able to add to or update it.

The H&IOW Clinical Executive Group approved this approach at its June 2018 meeting. However, there is limited funding to implement this approach from NHSE/NHSI/STP and this implementation plan sets out the resources required. We are hoping to apply for digital funding.

As what we think is a realistic estimate of the implementation process and resource required, this paper needs to be agreed and supported by NHSE/NHSI, CCG (Board of Commissioners), H&IOW STP (Quality Board, Digital Board and EDG).

1.2 Background & Enablers

Future Planning is a locally devised Electronic Palliative Care Co-ordination System (EPaCCS). EPaCCS are expected, and to an extent have been demonstrated, to enable more patients to die at their preferred place and reduce unnecessary hospital admissions and ambulance journeys, inappropriate interventions, use of unscheduled care and repeated 'difficult conversations'. Striking outcomes have been reported around EPaCCS. For instance, 82.4% of patients of the patients of 'Coordinate My Care (CMC)' have died outside of hospital; 77.8% died in their preferred place, with 71.8% of them dying in the place of their first preference (May 2016 data, since inception).

An EPaCCS project needs to involve: GP practices; emergency telephone lines; ambulance services; GP out of hours services; acute hospitals; community nursing teams; specialist palliative care services; hospices and care homes.

This translates into huge numbers of settings and teams when it is implemented at an advanced level. It is likely that more than 50% of patients whose intentions are recorded on EPaCCs will not die within a year. The need for a dynamic record that can be updated is evident from this and many EPaCCS projects are also expanding their scope— for example, towards urgent care plans for frail and elderly patients.

2 Future Planning & ReSPECT

Future Planning is well-liked and utilised by GP practices in Hampshire and Surrey. It does link to the Care and Health Information Exchange (CHIE - formerly known as the Hampshire Health Record). It has been developed with comparatively little resource (compared say to CMC) by enthusiastic clinical champions.

However, it is limited by the resources available to it, to expand, by the fact that it is not “owned” by the NHS or third-party organisation with the resources to invest in it and the governance arrangements behind it. There is currently no editorial board or IT team behind it and this will be needed if it is to expand its scope as is planned.

ReSPECT is a process that creates personalised recommendations for a person’s clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person’s care and treatment. ReSPECT can be complementary to a wider process of advance/ anticipatory care planning. It has endorsement from the Resuscitation Council UK and many other bodies and was developed in conjunction with the University of Warwick, but its use has not been mandated by NHS England or NHS Improvement (NHSE/NHSI).

The ReSPECT form was created following a systematic review of DNACPR (which highlighted the misunderstandings, poor or absent communication and poor or absent documentation causing huge risk to patients). The content is fixed but is regularly reviewed by a panel. A version of DNACPR called uDNACPR was introduced by South Central SHA before SHAs were abolished. This was used throughout the South Central area (the geography covered by South Central Ambulance Services).

Concern was expressed by members of the Palliative and End of Life Care Clinical Network (2016-2018) that ReSPECT could be mistaken for uDNACPR by a busy professional and it might not be fit for purpose as a treatment escalation plan (TEP) in the acute hospital setting, but it is being used in Hampshire in this way (without a uDNACPR form) already. The intent was for ReSPECT to replace DNACPR nationally, but this never happened, resulting in both forms still being used.

There is no electronic version of ReSPECT, yet which gives us an opportunity to model what an electronic version might look like locally. We should be well-placed to merge the ReSPECT and Future Planning processes digitally given the level of resource allocated to the H&IOW system.

University Hospital Southampton (UHS) was selected as a digital exemplar in September 2016.

The digital exemplars will get up to £10m funding to invest in digital infrastructure such as Wi-Fi to deliver benefits for patients and doctors, nurses and other NHS staff. They will share learning and resources with other NHS organisations through networks. The aims of a digital exemplar are:

- Comprehensive use of electronic patient records – making patient records available to doctors and nurses in real time for documentation of observations and assessments, granting patients online access to their medical records, and use of electronic medicines management which can halve medication errors.
- Information sharing across the local health and care system –digital correspondence and test results for patients and online medical record and care plan sharing between health and care teams.
- Robust data security – a plan to respond to threats to data security with senior accountability and fully supported operating systems throughout their organisation.

In January 2018, South Central Ambulance Service NHS Foundation Trust (SCAS) was one of three NHS ambulance trusts that have been awarded a share of £5m to develop into world class digital organisations. Over the next two years, SCAS will receive an additional c£1.7m from NHS England (which the Trust will match fund) to continue its pioneering work in digital transformation. Innovations already implemented by SCAS to make its services more efficient, resilient and safe include:

- digitally integrated clinical patient management systems and dispatch systems
- virtual digital telephony platforms
- electronic patient record system

Earlier this year, (2018) NHS England announced that three areas, covering 14 million people, have been chosen to become 'Local Health and Care Record Exemplars' (LHCRE). H&IOW in partnership with Dorset (which is the same geography as 'Wessex') was one of the selected areas.

Each new partnership will receive up to £7.5 million over two years to put in place an electronic shared local health and care record that makes the relevant information about people instantly available to everyone involved in their care and support.

Because the LHCRE programme is Wessex-wide, there is an aspiration to extend the 'unified approach to Dorset ICS.

3 Benefits

The benefits of the unified approach are:

- Having shared templates feeding a single system, one digital database will enable patients, their families and health care professionals in the future to view on a phone or PC or hear (via a digital assistant using voice queries with appropriate levels of security) everything related to their future plans that is recorded about them, regardless of where they are located
- It stops the ongoing creation of bespoke 'forms' and tools which cause confusion to patients, their families and health care professionals alike
- Assuming the information is captured and up to date (responsibility of healthcare professionals who come in contact with that patient) it will really help SCAS to determine whether a 'blue light' call out is necessary or not, hospital admission is necessary or not – and whether help can be given at a local level and patient can remain in their preferred place of care, thus saving money, time, resource and unnecessary stress to all parties.

4 The Current Costs

- Dying patients who need hospital treatment in England cost the NHS an average of £7,415 each in their last year of life . 67% of these people received hospital care only (not nursing, residential or social care).
- There were approximately 27,000 deaths in H&IOW in 2016 so we can assume that 18,090 people received hospital care only in the last year of life.
- The cost of one ambulance call out for Palliative or End of Life Care (Cat 1, Cat 2) is £261.49.

- The average person admitted in the last year of life had 21.8 days stay due to emergency admission - the cost of this hospital care would be £253.91 per inpatient day or £5,535 per person. The total cost to H&IOW was therefore over £100m. Obviously if these people were not in hospital they may need nursing care, so this cannot be regarded as the total saving.
- Hospice care is £425.00 per inpatient day but nursing home care (local authority and NHSE funded) is £96.24 per day so £2,098 per person or a total cost to H&IOW of £38m.
- There are potentially savings of up to £62m to be made if the right care is provided at the right time in the last year of life.
- Support packages in the home are difficult to cost as home care and district nurses are costed by the hour and depend on the needs of the individual.

Example:

1 x End of Life patient admitted to hospital for 2 weeks.....

£261.49 x 1 (Ambulance call out)

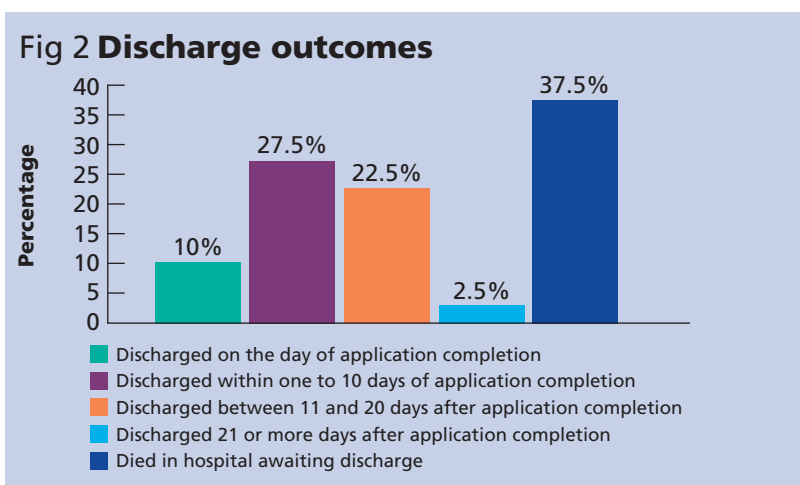
£253.91 x 14 (Nights in hospital)

TOTAL = £3660.86

5 Hospital Admissions Impact

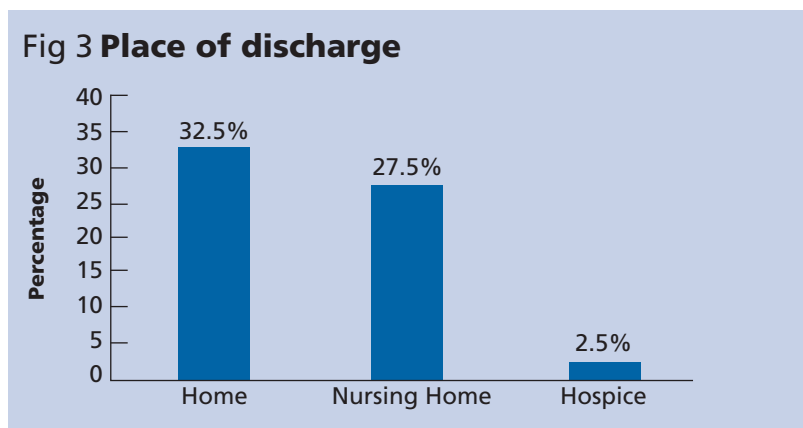
Admission to hospital for an end of life patient can often accelerate rather than slow down deterioration. Older people can lose up to 5% muscle mass per day of treatment in a hospital bed. As Steve Powis, NHSE Medical Director has pointed out the person over 80 who spends 10 days in hospital loses 10 per cent of muscle mass, equivalent to 10 years of ageing.

At North Middlesex University Hospital in 2016, 15 out of the 40 patients, whose case notes were reviewed, died at the hospital waiting to be discharged. Audit results showed a variety of reasons for delayed discharge, including deterioration of patients’ condition, delays in organising care packages, and poor communication between hospital and community teams.



Among the 25 patients discharged, 13 (52%) went home, 11 (44%) went to a nursing home and one (4%) went to a hospice (Fig 3). They were all discharged to their preferred place of care.

Among the 15 patients who died in hospital awaiting discharge, the preferred place of care was home for six (40%), a nursing home for four (26.5%) and a hospice for two (13.5%); for the remaining three (20%) the preferred place of care was not documented.



6 Solution Overview

One digitised template utilising the content & presence of the already existing ReSPECT paper form & the digitised Future Planning template. That form needs to be accessible and amendable by patients and MUST include the following:

- Treatment Escalation Plan – TEP
- DO NOT RESUSSITATE – the DNR element should be explicitly clear.
- Ability to ‘talk to’ GP systems such as EMIS and SystemOne, CHIE & Summary Care Record

6.1 Other Systems Interlinking

One of the major issues is the fact that the paper forms/digital information is inaccessible to those who need it at key places and times. Single sign on has already made CHIE more accessible to health care professionals. The ‘unified approach’ solution needs to be able to ‘talk to’/link into already existing systems that GPs, Hospitals and other healthcare settings use. To do this, a common set of data across all the systems/templates/forms is the best solution. There is a national EPACCs solution initiative created by John Willis and team at NHS Digital – the End of Life common data-set does exist and therefore could be used.

Patient information could be captured clearly using the common data set and then shared with other systems who can pick up the information easily because they also use that same common data set. The key systems to ‘talk to’ are listed below:

6.2 CHIE – Care & Health Information Exchange

CHIE computer system has existed for some time and has access to GP records, community, and hospital records and is being used across the south by a variety of organisations including South Central Ambulance Service system, EMIS and SystemOne:

<http://www.careandhealthinformationexchange.org.uk/wp-content/uploads/2018/07/CHIE-User-Guide-for-SCAS-v1.0.pdf>

6.3 SCR – Summary Care Record

The SCR is the primary national solution currently in place that can share Palliative and End of Life Care data from GP systems – EMIS & SystemOne with clinicians, patients and their loved ones. They get to see core SCR data or SCR with additional data or they can ‘opt out’ of their information being shared. Currently 55 million patient records are on the SCR with 1,500 geographical areas viewing data on a regular basis.

CHIE is not part of the Summary Care Record project and does not provide information to the national system. Instead, CHIE is a more detailed record, but is limited to staff and patients within Hampshire and the Isle of Wight and does not yet link into the SCR. However, this is likely to be available in the future:

<https://digital.nhs.uk/services/summary-care-records-scr>

7 Patient Access to their records

Without health data access, patients cannot fully review their personal health information and cannot be fully engaged in their care. As the healthcare industry transitions into patient-centered care models, it's important that H&IOW providers see the benefits of empowering patients with their own health data and use that to foster patient engagement – which we know is an issue for patients who may be at the end of life not having those key communications with their healthcare professionals, early enough or not at all.

NHSX inherited the work of NHS Online which was tasked with delivering a ministerial directive that states that patients will be given the opportunity to express end of life care preferences online or through an app. How NHSX intends to deliver this remains unclear (as, at the time of writing, the team is still undertaking discovery work), but the integration programme may be needed to help define a national minimum dataset for the “view” and thereafter constructively discuss what parts of that dataset may be edited directly by the patient.

8 National End of Life Dataset

Above we mentioned about a ‘common data set’ of patient information (recognized via codes) which has already been created by John Willis and team from NHS Digital as part of their work in creating a new national EPACCs system (2017/18). This same data set would be used for the new digitised ReSPECT plus Future Planning template, enabling other systems to recognise these codes and to link into the template.

The data set with codes and the example of what a digital record would look like has been shared with H&IOW STP Digital Leads.

9 The Working Group/Project Team

There is a need to create a team with the right skills, background, experience and knowledge to work in a collegiate and collaborative way to deliver to a successful outcome, choosing people from the former H&IOW Palliative and End of Life Care Clinical Network or the Steering Group of clinicians for learning and education (which has existed for some time) and other areas if necessary. The working group should be made up of stakeholders from across a variety of patient and healthcare settings. People with the right skillset, knowledge and expertise in subject matter are necessary. The working party needs to include (as a minimum):

- Chair and Vice Chair – suggest nominated members of the STP Digital and Quality Boards
- Clinical Chair of the Palliative and End of Life Care Clinical Network (N.B. there is no funding at present for this post)
- Patient/Carer voice - People with lived experience of palliative, end of life care or bereavement
- South Central Ambulance Service representation – SCAS are at the front line of dealing with patients, their loved ones and health professionals daily. Their expertise and input is invaluable.
- Palliative Care clinicians from acute, community and hospice sector
- Other acute sector clinicians (e.g. geriatricians, AHPs)
- Doctors, nurses, care assistants working in a variety of settings (e.g. community, hospital, locality hub, care homes, domiciliary care agencies, social care, hospice)
- Non-clinical support staff (including management and administrative) i.e. Agile project manager
- IT expertise

The list above is not exhaustive, and others should be involved as appropriate through the course of the project.

10 Governance Arrangements

It is proposed that the STP Quality Boards and the Digital Programme Board would have oversight of the project. The Quality Board would have responsibility for safeguarding patient safety during planning and implementation and the Digital Board for making sure that the correct resources were in place at every stage of the project.

10.1 Human Factors

Within healthcare settings, human factors underpin patient safety and quality improvement science. This will be a complex project and the members of the working group will require support in project management and clinical leadership (if they do not have access to this already). Other clinicians have found the Clarity 4D process to be insightful – to ascertain the right mix of personalities, projective techniques, and behaviours for this work.

We are recommending the use of agile project management tools to deliver this project. One of the key things about agile are the characteristics of the team, and we are keen to ensure we have the ‘right’ kind of team working together on this.

10.2 Team Characteristics

T-shaped – a wide breadth of basic knowledge about their subject but also deep knowledge, experience, and ability in one (or more) specific areas

Cross-functional - skills outside their traditional areas, e.g. data analysis, html, etc.

Adaptable - diverse skill set, they know how to use it. No matter the environment, their output remains consistent

Curious – asking questions and challenging (in a productive manner) the way things are done (as/when appropriate)

Entrepreneurial - doesn't wait to be told what to do, they're ready to fill in and develop campaigns where they see a need

Team-oriented – Has to be a real team player and will prioritise the success of the team and work over their own personal glory

Committed to excellence - One of the key benefits of agile projects is delivering quality work, faster. Team members who are committed to excellence don't settle for average. They're not hung up on perfection, but they're dedicated to always producing their best work

10.3 Team Roles

Our recommendation is that the following team is in place to implement 'the unified approach' across Hampshire and the Isle of Wight:

Role	Who	Responsibility	Availability	Cost (2018/19)
Agile Project Manager	Not in post	Responsible for the entire project	Full-time	Band 8b (c.£69k)
Deputy Project Manager	Not in post	Responsible for the entire project in the absence of the Project Manager	Full-time	Band 8a (c.£58k)
Stakeholder (team) Engagement manager	Not in post	Responsible for ensuring collegiate and collaborative working and ensuring everyone has their input, and all stakeholders work as a team	Full-time	Band 7 (c.£46K)
Project Support	Not in post	Supporting the manager and others in the team	Full-time	Band 6 (c.£39K)
Clinical Chair of the End of Life Network	Not in post	To give clinical leadership to the network	1 X PA a week	Urgent and Emergency Care Lead?
End Users	Members of the Palliative and End of Life Clinical Network	Anyone who will use the combined digitised form/ template-clinicians, health professionals, patients and others)	3 consultants @ 10 hours each per week (£190 per annum)	

Role	Who	Responsibility	Availability	Cost (2018/19)
Senior IT Supplier	Digital Programme Board to nominate	IT Expertise	Part time – 15hrs per week	Band 7 (£0 -18K) may be available from NHS Trust
Project Assurance	Quality Board to nominate	Patient and Public involvement, the system has to meet their needs	Full-time	Band 7 (£0-£46K) may be provided from Quality Board
Test/Trial Lead	Not in post		Full-time	Band 6 (c.£39K)
Miscellaneous expenses (travel, meetings, etc.)				c.£10K
				TOTAL – £240,000- £297,000

The above costs do NOT include:

- Software requirements
- Hardware requirements

11 Project Risks and Issues

There are obvious risks of the 'do nothing option' which is the continued use of the paper uDNACPR and ReSPECT forms in South Central: the uDNACPR form can get lost, family or carers are unaware of its existence, health and social care professionals do not have sight of it because it is in one location and they and the patient are in another.

The most highly scored risks from a register for the project compiled with input from the Palliative and End of Life Care Clinical Network is included at Appendix A.

12 Schedule/Timeline

This project would take 24-48 months, if the funding is allocated in line with this implementation plan.

12.1 Gantt Chart

As the project is not yet funded, this only covers the first four months at present.

	Month 1	Month 2	Month 3	Month 4
1. Secure funding for implementation	Agreement from the STP Quality and Digital Board			
2. Recruit to Working Group		Write to stakeholders asking for representation on working group		
2.1. Agree Selection Process	Discussion with CSU about use of Clarity4D to select working group			
2.2. Recruit all members who are not new posts/ substantive		Recruitment to working group		
2.3. Recruit Working Group members who are substantive and not in post (e.g. Network Clinical Chair, Project Manager)	Draft job descriptions	Job banding		Job description on NHS Jobs as soon as funding agreed
3. Scoping – how far is each organisation from sharing Palliative Care and End of Life data with other organisations?	Commenced and shared with H&IOW Digital Leads			

13 Budget

There is no current budget for this project.

14 Current Constraints

- No budget for this project
- No NHSE/NHSI funding for Palliative Care and End of Life Care Clinical Network/Clinical Programme in 2019/20
- Software and other technology to be reused or purchased – fit for purpose has not been assessed
- Constraints associated with product interfaces
- Complexity of project with multiple organisations involved
- Risks which need to be mitigated.

15 The Vision

We anticipate that this work will:

- Provide one digital form/record where patient information can be easily entered, stored, shared and disseminated across other systems and healthcare stakeholders with ease
- Provide all stakeholders including SCAS with electronic/digital access to the patients record
- The patient will have access to their own record
- Increase identification opportunities to improve recognition of approaching end of life
- Identify opportunities to improve care which focuses on the person, which sees the person's strengths as well as their hopes, fears, needs and wishes – truly person-centred care
- Improved patient information sharing between all healthcare providers and others that patients encounter
- Improve our understanding as a system, developing our ability to learn as a system about the way things currently work, and our ability to improve together
- Further improve our ability to work together as a community, with people approaching the end of their life, their families, across organisational and professional boundaries
- Provide a digital database which could be interrogated in the future wherever the patient is located (with appropriate security arrangements) verbally by means of a voice assistant (e.g. Alexa, Google Assistant, Siri, and Cortana).

16 Do Nothing Option

We anticipate that:

- End-of-life care in STP areas will continue to be fragmented, intensive, and costlier than it should be and patients' wishes will often not be met due to poor communication between organisations

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- Healthcare settings will act in silos, work in un-collaborative and un-collegiate ways
 - Those who need access to full data will not be able to access it – the ‘knock on’ effect of turning up at patient residence with lack of knowledge or access to patient history
 - SCAS blue light call outs and hospital attendances and admissions will continue to rise
 - Staff in various settings will show low levels of confidence and insufficient training in end of life care, particularly in relation to symptom control and communication
 - Electronic records will not interlink efficiently with each other
 - Patients will not be able to access their records or have a fuller richer knowledge of their own healthcare
 - Nothing will change culturally to encourage conversations about wishes at end of life to take place.

17 This Is Not a Technical Project

This is a people project; this is about end of life patients and trying to make things better for them and their loved ones. This work is about ‘behind the scenes’ and getting that right to ensure end of life patients can have as best an experience as possible of facing a good death. This work should be carried out, cradle to grave with the end of life patient in mind, and the continued questions like ‘what do they need’, ‘what would make it better for them and their loved ones’. If these elements are successful it has a positive knock on effect on costs reduction, admissions reductions and reduced call outs and uptake of beds.

If this work is in the NHS Digital transformation work programme only, the danger is that it becomes a technical implementation project like all the others and the real crux of reasoning and background for why this work needs to happen is forgotten.

Crash course in EPaCCS (Electronic Palliative Care Coordination Systems): 8 years of successes and failures in patient data sharing to learn: <https://spcare.bmj.com/content/8/4/447>

Whole Systems Partnership for NHS Improving Quality. Economic evaluation of the electronic palliative care coordination system early implementer sites. February 2013.

<http://www.thewholesystem.co.uk/wp-content/uploads/2014/07/economic-eval-epaccs.pdf>

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/611692/end-of-life-care-economic-tool.xlsx

<https://www.nao.org.uk/wp-content/uploads/2015/12/Discharging-older-patients-from-hospital-Summary.pdf>

https://www.nursingtimes.net/clinical-archive/end-of-life-and-palliative-care/improving-hospital-discharge-for-patients-at-the-end-of-life/7021751_article

Risk	Likelihood (1-5)	Impact (1-5)	Score	Suggested Mitigation
The onus is on health professionals to record and enter patient data onto the clinical systems, so the information can be accessed later, shared and updated where necessary. At present we don't know what % of patients who are receiving palliative or end of life care in different settings have their wishes recorded across H&IOW.	5	5	25	Audit - check when the wishes of all patients who died were registered on CHIE and how long before the death their wishes were recorded
Anecdotally, clinicians report that ReSPECT is good at guiding the discussion between patient and clinician to achieve shared decision making but not as clear as an instruction to other clinicians as say the uDNACPR form.	5	4	20	Evaluation of the ReSPECT implementation at Hampshire Hospitals (HHFT) may demonstrate the benefit of implementing ReSPECT and not retaining uDNACPR and introducing separate treatment escalation plans
Some NHS Trusts use separate treatment escalation or de-escalation plans alongside ReSPECT and uDNACPR and this has added complexity.	5	4	20	
ReSPECT is in paper format only which means that it cannot be accessed by stakeholders who do not hold the paper record. At present only HHFT are using it. They have identified a method of capturing the data on ReSPECT electronically, but this methodology hasn't been applied or investigated in any other Trust.	5	4	20	Work is underway nationally to digitise ReSPECT and link it to the Summary Care Record. If CHIE data could cross-check with data from the Summary Care Record, this problem would be solved

Risk	Likelihood (1-5)	Impact (1-5)	Score	Suggested Mitigation
The current practice for the ambulance service tends to be to ask the call operator for patient details on CHIE as they can only view Summary Care Record and/or ask relative or carer who is present at the scene. The default is to rely on the paper uDNACPR form.	5	4	20	South Central Ambulance is aiming for single sign on to CHIE so that ambulance crew can easily access
FUTURE PLANNING is locally devised and supported by a few clinical and IT experts so if they were unable to continue with the work it is not clear how maintenance and spread would continue.	3	5	15	A Business continuity plan should be compiled for FUTURE PLANNING
uDNACPR (purple form) has been in use in South Central for some time and many organisations are comfortable with it from clinical governance perspective.	5	3	0	NHS Trusts should not underestimate the preparation, detailed planning and staff training necessary to move away from uDNACPR to a combination of ReSPECT and FUTURE PLANNING across H&IOW (and Dorset)

Thank you to the members of the Palliative and End of Life Care Clinical Network who contributed to this work.