EPaCCS Data Explained

Key Points:

1. The 6 monthly data reports provided to GP Practices were obtained confidentially via the GP Alliance and from EMIS - GP Practices have been provided with their individual practice level data reported against Care Community and Place comparisons.

2. Practices who wish to run their own independent reports can do so using the coding information on the Cheshire EPAIGE – search for 'SNOMED codes for Cheshire end of life searches'

3. The below explanations describe the **High Level Outcomes (HLOs)** which have been used in Cheshire since 2015 and that were agreed between Partners.

4. EOLP will continue to work with all Partners including GP Practices to better understand how the High level Outcomes can be used to support quality improvements in palliative and end of life care.

Your data explained - High Level Outcomes (HLOs)	**Local Standard**	**Supporting Explanatory Notes**
High Level Outcome 1: Spot audit of 'living patients' on the GSF/with a GSF needs based code at a particular date	**0.60%**	Links to national campaign – 'find your 1%' i.e. roughly 1% of the practice population will die every year There is some evidence that at best a practice has the potential to anticipate and therefore identify 0.75% due to the nature of dying. Coding options include on the GSF Register as well as needs-based coding based upon the stages of the North West Model
High Level Outcome 2: Deceased patients where a consent code for sharing end of life information has been ticked or on the end of life care register code used	Removed from reporting in 2021	This coding was historically used by Public Health England to indicate a person had an EPaCCS. Within Cheshire this measurement was felt to not represent meaningful use of EPaCCS because EPaCCS is not operated as a separate care record.
High Level Objective 3: Deceased patients with a locally defined 'meaningful EPaCCS'	**45%**	Locally we have defined a 'meaningful EPaCCS' as being: 'by the time a person has died they will have all three of the following areas of care recorded through EPaCCS coding : • Identified as nearing end of life (GSF/needs-based coding) • Offered/had an ACP conversation (includes declined or not appropriate codes and PPoC/D location codes) • CPR status or discussion recorded

High Level Objective 4 & 5 & 6: Deceased patients identified with either one of the locally defined meaningful EPaCCS areas coded	**45%** **45%** **60%**	These three areas of coding have been separated out to allow GP Practices to identify if there is a particular area of their coding that is affecting their achievement of the 'meaningful EPaCCS' standard i.e., HLO 3 • **HLO 4** - Identified as nearing end of life (GSF/needs-based coding) • **HLO 5** - Offered/ had an ACP conversation (includes declined or not appropriate codes, and PPoC/D location codes) • **HLO 6** - CPR status or discussion recorded
High Level Objective 7: Deceased patients with a recorded: Preferred Place of Death/Care AND Actual Place of Death	**25%**	Recording of both Preferred Place of Care/Death and Actual Place of Death will have the following three benefits locally: 1. CQC inspection evidence as some practices are being asked how they know patients are dying where they want to 2. After Death Analysis at GSF meetings – quick way of identifying patients that didn't die where they preferred so that these can be discussed and reflected upon at palliative care meetings 3. As more GP Practices record this information, we will be able to pick up any geographical trends around people achieving their wishes and seek to understand if this is a result of gaps or variations in service provision
High Level Objective 7a: Achievement of Preferred Place of Care	No target	To measure the achievement of Preferred Place of Care (PPC) or Preferred Place of Death (PPD) the person's EPaCCS record needs to firstly establish a preference using EPaCCS coding (a 2nd choice preference can also be added), and secondly needs to record an actual place of death. As part of quality improvement initiatives, it is important for services to understand if people they are caring for are achieving their wishes and if not, why not? This information can form part of CQC evidence and can help to identify any geographical or condition specific gaps that may need addressing.