Leeds Palliative Care Network

Palliative Care

Some patients may already be known to local Specialist Palliative Care services.
Some patients will have established Advance Care Plans. These advance care plans will be documented in EPaCCs or on ReSPECT forms generated by LTHT. The information in EPaCCS will be shared between primary care, neighbourhood team and hospices.

These plans may contain:

- Information about their medical history
- Contact information of their next of kin or those with Lasting Powers of Attorney
- Professionals who are involved in their care
- Records of their wishes and preferences regarding place of care
- Established Treatment Escalation Plans and cardiopulmonary resuscitation decisions
- Symptom control guidance

Care at home

For patients who have severe symptoms and are deteriorating, consider urgent referral to your neighbourhood team and/or local specialist palliative care services, with appropriate consent.
Continuing Healthcare Fast Track Form should also be completed.

This will include patients with an established wish to be cared for at home at end of life, and those who have capacity and decide to remain at home in the current situation.

It may also include patients that are considered to be actively dying and do not have capacity, and for whom transfer to hospital is considered not be in their best interest by the professionals involved.