

Schedule 2 Part 1: Service Specifications

Service Specification Number	06/CEOL/0004
Service	East Dorset Specialist Palliative Care Services
Commissioner Lead	End of Life & Cancer Clinical Commissioning Programme
Provider Lead	
Period	1 April 2013 – 31 March 2014
Review date	1 September 2013 (once new commissioning structures are in place to reflect these changes)

1. Purpose

1.1 Aim

The primary purpose of the service is to provide evidence based specialist palliative care services for the population of East Dorset through direct clinical support to patients with complex palliative care needs that cannot be dealt with by a patient's own clinical team and through support to services that provide general palliative care to patients, such as primary care and community teams

Specialist palliative care will be commissioned as part of an integrated end of life care pathway. The Dorset vision for end of life care is that everyone at the end of life has access to the best possible care, available 24 hours a day, seven days a week, with options for choice based on need about where and how they die and ensuring that they and their carers are treated with dignity, kindness and respect, and an opportunity to experience their idea of a "good death".

Specialist palliative care is defined as care for the most complex cases where symptoms can not be managed by generalists. Specialist palliative care services will provide specialist assessment, treatment and will support primary care, community integrated locality teams and hospital services for people with complex end of life care needs, non-cancer and cancer related. Specialists will work collaboratively with the primary healthcare teams and secondary care to provide support and advice. Specialist services may dip in and out of care depending on the assessed complexity of need.

1.2 Evidence Base

The services described in this service specification have been considered inline with the End of Life Care Strategy (Department of Health 2008) and NICE Improving Supportive and Palliative Care for Adults with Cancer (NICE 2004).

The service must comply with all relevant End of Life Care Quality Markers (DH June 2009) and with the NICE Improving Supportive and Palliative Care for Adults with Cancer measures. All key staff within the service will be aware of and up to date with all national and local developments and reports related to end of life care, and in particular, specialist palliative care.

1.3 General Overview

End of Life Care services face some specific challenges in terms of the increasing demand for specialist palliative care services in the future, be it in specialist palliative care units and/or services in a patients home.

1.4 Objectives

The objective is to commission a service that builds on existing good practice in end of life

care. The principles of the service will be:

- end of life care will be provided predominantly by mainstream primary and community services;
- specialist palliative care services will provide specialist assessment, treatment, review and will support primary care teams, community integrated locality teams and hospital services for those people with complex end of life needs, both non cancer and cancer;
- complex patients will have their needs for end of life care assessed and reviewed as appropriate on an ongoing basis by specialist palliative care services;
- able to dip in and out of specialist palliative care services and move between specialist and generalist services depending on the patients needs;
- access across East Dorset to specialist in-patient care and support and professional advice 24 hours a day, seven days per week if clinically indicated;
- families and carers are involved in the end of life care planning and decisions to the extent that they and the patient wish;
- providers of specialist palliative care will work effectively with other agencies and with each other to maximise the patient experience and improve quality and cost effectiveness;
- there will be an appropriately trained workforce;
- The service will help to reduce the number of people at the end of life dying in an acute hospital bed.

1.5 Expected Outcomes

NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with long-term conditions	X
Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care	
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	X

- To achieve a better patient and carer experience in the end of life phase of illness;
- To improve care co-ordination across all services involved in contributing to the patients' care;
- To increase the number of patients enabled to receive end of life care in their preferred place of care;
- To reduce the number of unscheduled admissions and re-admissions to hospital for end of life care;
- To assist in reducing deaths in acute hospitals by 5% cumulatively per year (from the 2008 baseline) for each of the next five years;

- To identify and increase the percentage of cases where the preference about place of death has been delivered;
- To identify and increase the number of people with a plan for their end of life care and death.

2. Service Scope

2.1 Service Description

The service is commissioned to provide specialist palliative care services to adults and their carers with any advanced, progressive, incurable illness (e.g. advanced malignancy, organ failure, stroke, chronic neurological conditions and dementia) requiring specialist palliative care in East Dorset. This includes physical, psychosocial and spiritual needs of both patients and their carers.

The clinical role includes:

- Holistic assessment and care planning for patients with complex palliative care needs;
- Information on disease process, treatment, medication, local and national services;
- Advice on symptom control;
- Psychosocial support for patient/carer;
- Prescribing medications and medication reviews;
- medical review, advice and support via:
 - outpatients
 - domiciliary visits;
- bereavement and support service.

The service will provide education and training support to services involved with end of life care through:

- education and training;
- advice and support to the patients clinical team.

All specialist palliative care services will have common:

- electronic record keeping;
- referral, acceptance and discharge criteria;
- management arrangements within teams;
- policies;
- clinical governance arrangements.

The specialist palliative care services will work collaboratively with other end of life care services providing an integrated end of life care pathway and patients will access the service intermittently according to need.

2.2 Accessibility/acceptability

- Specialist palliative care services will manage complex palliative care problems that cannot be dealt with by a patient's own clinical team;
- To include difficult symptom control and / or psycho-social support;
- Referrals will be accepted from doctors, qualified nurses and other health and social care professionals;
- Self-referrals will be initially assessed and if they meet the criteria will be discussed as soon as possible by the multi-professional team;
- Initial assessment will usually be carried out by the professional to whom the referral was originally directed and then discussed as soon as possible by the multi-professional team.

Initial assessment will usually be undertaken by the accepting professional, and as indicated by the referrer.

Services are available, dependent on need and the complexity:

- Telephone advice, 24 hours a day, 365 days a year;
- Face to face assessment in the community or in hospital, for at least 8 hours a day, seven days a week;
- Inpatient admission, available 7 days a week, from at least 8am – 8pm, working towards 24 hours a day.

There is equity of service provision to all patients regardless of ethnicity, language, disability, sexual orientation, religious or personal circumstances providing they meet the service referral criteria requirements.

Some patients choose not to accept the service provision and that is respected.

2.3 Whole System Relationships

The service must work with partners to address the needs of the individual and have awareness of future developments in order to attain optimum outcomes. Partners will include:-

- Primary Health Care Team;
- Locality Community Health Services –generalist palliative care services, community matron’s, community nurses, allied health professionals;
- Clinical nurse specialists (all diseases);
- Marie Curie;
- Social services;
- Mental health and learning disabilities;
- Private agencies;
- Lewis Manning Hospice;
- Acute Hospitals;
- Community Hospitals;
- Equipment services;
- Children’s Hospices wheretransition is required.

2.4 Interdependencies

The service will work in close collaboration with primary and community health care services as part of an integrated end of life care pathway to improve the patient journey i.e. GPs, locality community health services. They will also work with other health care professionals to reduce unnecessary hospital admission and where hospital admission is required, to expedite patient discharge i.e. OOHs; Mental health; care agencies; voluntary and statutory agencies.

The service will liaise closely with other health professionals i.e. specialist nurses, Marie Curie service, twilight and night nursing service, private agencies and social care services involved in the patients care. There will be close liaison with secondary care when a patient is admitted from their caseload to hospital, ensuring a seamless service.

The service will use the Network agreed End of Life Care Register for all patientswhen it is available.

2.5 Relevant networks and screening programmes

- End of Life & Cancer Clinical Commissioning Programme
- Wessex Strategic Clinical Networks
- Local Area Team/Public Health England

3. Service Delivery

3.1 Service model

Education and Training	
	<ul style="list-style-type: none">• To provide education and training in a variety of settings to non specialist staff of all levels in order to

	<p>equip them with relevant skills and competencies to manage patients in other settings;</p> <ul style="list-style-type: none"> • To ensure all staff have training in Holistic Needs Assessment; • To ensure all senior SPC nursing staff have the skills and competencies to support physical assessment and prescribing for patients.
Community Service Out - reach	<ul style="list-style-type: none"> • To provide a comprehensive community based palliative care service to patients with complex palliative care issues (including the control of physical or psychological symptoms and psycho-social support) whose clinical team in the community are seeking expert advice; • To carry out regular audits on patients' preferred place of care at the end of life, and review patients whose preference was not met to understand the reasons for this; • To ensure that SPC community CNSs review their caseload on a regular basis to ensure that patients are referred back to the community services team as soon as they no longer need specialist care; • To support GSF within primary care and nursing homes.
Hospital Team	<ul style="list-style-type: none"> • To provide a comprehensive hospital based palliative care service to patients with complex palliative care issues (including the control of physical or psycho-social symptoms and psychological support) whose clinical team in the acute setting are seeking expert advice; • To provide education, support and advice to staff within the acute trust around the management of patients with end of life care needs; • To aspire to a model where the consultants and Hospital Palliative Care Teams support the patient flow through the urgent care, the Emergency Department and out of hours, avoiding unnecessary admission; • To promote the provision of specialist palliative care services to patients who are still receiving disease-modifying treatment.
Inpatient Beds	<ul style="list-style-type: none"> • To provide a comprehensive inpatient palliative care service to patients with complex palliative care issues (including the control of physical or psychological symptoms and psycho-social support).
Medical Review	<ul style="list-style-type: none"> • To provide an expert opinion on all referrals to the specialist palliative care service; • To provide medical assessment where appropriate, either in a clinic, in the patient's own home or on a hospital ward depending upon the needs of the patient.
Day Care	<ul style="list-style-type: none"> • To provide an inclusive programme for patients with identified palliative care needs within a day unit setting, incorporating medical assessment, psycho-

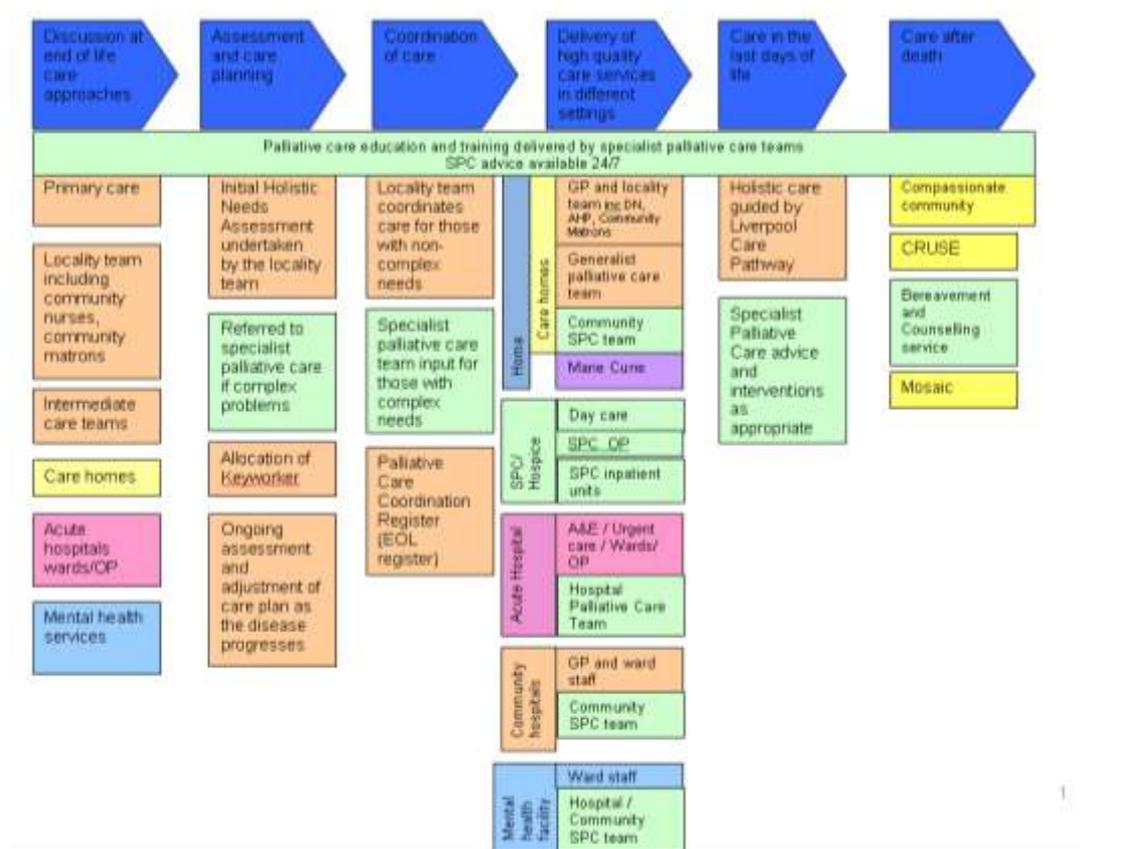
	<p>social support, and AHP provision;</p> <ul style="list-style-type: none"> To ensure that all referrals to the day unit are objective and goal focused and are reviewed after a regular 6 or 12 week session, linked in with the cycle of need; Core elements will include: <ul style="list-style-type: none"> a) clinical care (medical, nursing and rehabilitation support for patients with SPC need) b) symptom management (including the cost of drugs) c) pre-bereavement assessment (when not provided within another SPC setting) d) psychological assessment (at levels 1,2 and 3) Non core elements will include: <ul style="list-style-type: none"> a)complementary therapies b)bereavement care (supported by state and society) c)respite
Psychological Support	<ul style="list-style-type: none"> To be able to recognise and screen for psychological distress/need. To provide psychological support at levels 1, 2 and 3, and signpost to level 4 services where appropriate.
Bereavement Support	<ul style="list-style-type: none"> To assess the needs of the bereaved carers/families and to signpost to appropriate bereavement support; To ensure that cultural needs of individuals are met.
Education and Training	<ul style="list-style-type: none"> To provide education and training in a variety of settings to non specialist staff of all levels in order to equip them with relevant skills and competencies to manage patients in other settings; To ensure all staff have training in Holistic Needs Assessment; To ensure all senior SPC nursing staff have the skills and competencies to support physical assessment and prescribing for patients.
Community Service Out - reach	<ul style="list-style-type: none"> To provide a comprehensive community based palliative care service to patients with complex palliative care issues (including the control of physical or psychological symptoms and psycho-social support) whose clinical team in the community are seeking expert advice; To carry out regular audits on patients' preferred place of care at the end of life, and review patients whose preference was not met to understand the reasons for this; To ensure that SPC community CNSs review their caseload on a regular basis to ensure that patients are referred back to the community services team as soon as they no longer need specialist care; To support GSF within primary care and nursing homes.
Hospital Team	<ul style="list-style-type: none"> To provide a comprehensive hospital based palliative care service to patients with complex palliative care issues (including the control of physical or psycho-

	<p>social symptoms and psychological support) whose clinical team in the acute setting are seeking expert advice;</p> <ul style="list-style-type: none"> • To provide education, support and advice to staff within the acute trust around the management of patients with end of life care needs; • To aspire to a model where the consultants and Hospital Palliative Care Teams support the patient flow through the urgent care, the Emergency Department and out of hours, avoiding unnecessary admission; • To promote the provision of specialist palliative care services to patients who are still receiving disease-modifying treatment.
Inpatient Beds	<ul style="list-style-type: none"> • To provide a comprehensive inpatient palliative care service to patients with complex palliative care issues (including the control of physical or psychological symptoms and psycho-social support).
Medical Review	<ul style="list-style-type: none"> • To provide an expert opinion on all referrals to the specialist palliative care service; • To provide medical assessment where appropriate, either in a clinic, in the patient's own home or on a hospital ward depending upon the needs of the patient.
Day Care	<ul style="list-style-type: none"> • To provide an inclusive programme for patients with identified palliative care needs within a day unit; setting, incorporating medical assessment, psycho-social support, and AHP provision; • To ensure that all referrals to the day unit are objective and goal focused and are reviewed after a regular 6 or 12 week session, linked in with the cycle of need; • Core elements will include: <ul style="list-style-type: none"> e) clinical care (medical, nursing and rehabilitation support for patients with SPC need) f) symptom management (including the cost of drugs) g) pre-bereavement assessment (when not provided within another SPC setting) h) psychological assessment (at levels 1,2 and 3) • Non core elements will include: <ul style="list-style-type: none"> a)complementary therapies b)bereavement care (supported by state and society) c)respite
Psychological Support	<ul style="list-style-type: none"> • To be able to recognise and screen for psychological distress/need. • To provide psychological support at levels 1, 2 and 3, and signpost to level 4 services where appropriate.
Bereavement Support	<ul style="list-style-type: none"> • To assess the needs of the bereaved carers/families and to signpost to appropriate bereavement support; • To ensure that cultural needs of individuals are met.

3.2 Care Pathways

The national end of life care pathway (Adapted Figure Below) comprises six steps and was developed to help understanding for anyone providing health and social care to people nearing end of life. The care pathway aims to ensure that high quality, person-centred care is provided which is well planned, co-ordinated and monitored while being responsive to the individual's needs and wishes. Best practice indicates that End of Life Care is delivered in a range of settings. In Dorset this would include community hospitals which are integral to the delivery of services in this area.

Specialist services may never be needed in this pathway if symptoms and problems are adequately controlled by generalists. Indeed, specialist palliative care services are needed by a significant minority of people whose deaths are anticipated, and may be provided directly by specialist services or indirectly by means of professional advice to those caring for the patient. If symptoms or problems are not controlled at any point in this pathway then there should be consultation with the specialist palliative care teams.



4. Referral, Access and Acceptance Criteria

4.1 Geographic coverage/boundaries

The Specialist Palliative Care Services will cover the population registered with Dorset GPs in East Dorset (Bournemouth Borough Council, Borough of Poole, East Dorset District Council, Christchurch Borough Council and Purbeck District Council).

4.1 Location(s) of Service Delivery

The service is provided both within patients homes, nursing and residential care homes, hospices, community hospitals, clinic and acute hospitals;

4.2 Days/Hours of operation

To support this the following hierarchy of services will be available:

1. Telephone advice, 24 hours a day, 365 days a year
2. Face to face assessment in the community or in hospital, for at least 8 hours a day, seven days a week
3. Inpatient admission, available 7 days a week, from at least 8am – 8pm, but ideally 24 hours a day.

4.3 Referral criteria and sources

Criteria for accepting patients:

- Specialist palliative care services will manage complex palliative care problems that cannot be dealt with by a patient's own clinical team
- This includes difficult symptom control and / or psychological support
- Referrals will be accepted from doctors and from qualified nurses and social care professionals
- Self-referrals are accepted

4.4 Referral route

- Referrals will be accepted from doctors and from qualified nurses and social care professionals
- Self-referrals are accepted

Initial assessment will usually be undertaken by the accepting professional, and as indicated by the referrer. Patients will then be seen by the most appropriate person following triage.

4.5 Exclusion criteria

- Under 18 year olds (except as children of the patient where bereavement support is needed or preparing for transition from children's to adult services)
- Patients and families who do not have complex specialist palliative care needs

4.6 Response time & detail and prioritisation

Referrals should be dealt with according to the following criteria

- Urgent within 24 hours
- Non-urgent telephone contact within 3 working days
- Non Urgent Face to face contact within 5 working days

To support this the following hierarchy of services will be available:

1. Telephone advice, 24 hours a day, 365 days a year
2. Face to face assessment in the community or in hospital, for at least 8 hours a day, seven days a week
3. Inpatient admission, available 7 days a week, from at least 8am – 8pm, but ideally 24 hours a day.

And the following levels of intervention:

1. Advice as a one off discussion
2. One off assessment to provide additional support
3. Short planned episode of care offered according to need
4. Care is offered on longer term basis where there is ongoing complex need

5. Transfer of and Discharge from Care Obligations

- A patient may be discharged back to the locality team, once fully assessed and a management plan has been agreed;
- Patients are discharged at death but if the carers have an abnormal grief process they will be referred to receive specialist bereavement support;
- When a patient episode of care is complete a letter is sent to the appropriate professional involved within the locality team and to the primary care team;

- On completion of the agreed care, the patient / carer is informed to contact their own Primary Health Care Team if they have further concerns;
- A new referral is not required to recommence care but notification is required to the specialist palliative care team from the patient, carer or professional;
- Early discharge planning for discharge from inpatient beds.

6. Self-Care and Patient and Carer Information

- Service leaflets are given on initial contact with the patient and their carer that identifies service provision, how the service works with other health professionals, what palliative care is and contact details both in working hours and out of hours.
- The service aims to promote an acceptable quality of life for patients and to retain independent living as much as it is feasible within the limitations of the patients' condition.

7. Continual service improvement/innovation plan

For inclusion in quality schedule

It is anticipated that across East Dorset the SPC service will be able to provide:

- Common electronic record keeping
- Common referral, acceptance and discharge criteria
- Common policies
- Common clinical governance arrangements

These should be available and evidenced for the commissioner.

Continual Service Improvement will also include:

- Continue to provide SPC services that meet NICE IOG and Peer Review standards
- Provide a palliative care training programme to non specialist palliative care clinicians and Practitioners within the East Dorset community who are providing end of life care services
- Continue to provide support for sustainability and improved use of Gold Standards Framework
- GP liaison and education programme
- Annual audit of standards and quality markers for SPC
- Support roll out and use of End of Life Care Register in East Dorset

8. Quality Requirements

<i>Performance Indicator</i>	<i>Indicator</i>	<i>Threshold</i>	<i>Method of Measurement</i>	<i>Consequence of breach</i>
<u>Quality</u>				
Individuals helped to receive end of life care services in their preferred place of care	I. % of patients who are cared for in their identified preferred place of care	Increase	Via Excel Sheet	3 Monthly
	II. Active discharge planning with safe and		Via Excel Sheet	3 monthly

	appropriate discharge facilitated			
To achieve a better patient experience in the end of life phase of illness	I. Patient feedback indicates positive experiences; and where necessary changes are implemented if feedback indicates concerns		Patient feedback/ questionnaire	Annually
	II. Patient and Carer feedback indicates improved knowledge via better education of patients and their families		Patient feedback/ questionnaire	Annually
To achieve good access to services to ensure patient needs are met 24/7	I. Telephone advice is available 24 hours a day, 365 days a year		Audit of access to service	6 monthly
	II. Face to face assessment in the community or in hospital is available for at least 8 hours a day, Monday to Friday		Audit of access to service	6 monthly
	III. Urgent face to face assessment is available at weekend for at least eight hours a day			
	IV. Inpatient admission, available 7 days a week, from at least 8am – 8pm, but ideally 24 hours a day.		Audit of access to service	6 monthly
Improved recruitment and retention of	I. Staff turnover figures		Electronic Staff Record	

specialist skills				
To provide excellent education and training	I. Education is provided in a variety of settings to non-specialist staff at all levels		Audit of training provision	Annually
	II. All staff have undertaken holistic needs assessment training		Audit of specialist staff training	Annually
	III. Senior SPC nursing staff have the skills and competencies to support physical assessment and prescribing for patients.	Increasing numbers of nurse prescribers over x years	Electronic staff record	Annually
<u>Performance & Productivity</u>				
Patients have an appropriate personalised care plan	I. patients on an end of life pathway who have an appropriate personalised care plan	100%	Via excel spreadsheet	
Supporting the use of Advance Care Planning	(i) Number and % of patients who have an Advanced Care Plan in place when they are referred to the Service	n/a	Via excel spreadsheet	
	(ii) Number and % of patients who have an Advance Care Plan undertaken whilst with the Service	n/a		
Increasing the % of patients accepted by the Service who have a diagnosis other than cancer	(i) % of patients with diagnosis other than cancer, broken down by diagnosis	Increase in support given (trend)	Via Excel spreadsheet	
Reduction in inappropriate hospital admissions and deaths in hospital	Reduction in hospital emergency admissions resulting in death	Decrease in deaths in hospital (trend)		

	in hospital			
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9. Activity

9.1

Activity Performance Indicators	Threshold	Measurement Method	Consequence of Breach
Maximise service delivery	Details of patient numbers accessing inpatient services		
	Referral route for inpatient services		
	Details of patient numbers accessing day care services		
	Details of specialist community nurse activity		
	Details of hospital specialist nurse activity		
Referrals	Numbers of referrals to the inpatient service by method of referral and numbers unfulfilled and details why		
	Numbers of referrals to the community service by method of referral and numbers unfulfilled and details why		
Education	Details of education provided		

9.2 Activity Plan

To be confirmed

9.3 Capacity Review

To be confirmed

10. Prices & Costs

10.1 Price

Basis of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value
National Tariff plus	TBC	TBC	TBC	TBC

Market Forces Factor				
Non-Tariff Price (cost per case/cost and volume/block/other)*	TBC	TBC	TBC	TBC
Total		£ TBC		£ TBC

**delete as appropriate*

10.2 Cost of Service by commissioner (To be confirmed)

Total Cost of Service	Co-ordinating PCT Total	Associate PCT Total	Associate PCT Total	Associate PCT Total	Total Annual Expected Cost
£	£	£	£	£	£