SERVICE SPECIFICATION

Service	**Overnight Palliative Care Service**
Commissioner Lead	
Provider Lead	
Period	

1. Purpose

1.1 Aims

- To provide overnight holistic care and advice to palliative and end of life patients and their carers/families.
- To improve the quality of services for patients and their carers at end of life, enabling them to be cared for and die in the place of their choice and avoiding inappropriate hospital admissions.

1.2 Evidence Base

- The End of Life Care Strategy (2008), recommends provision of 24/7 care that is easily accessed and responds quickly to all palliative and end of life care patients regardless of where they are being cared for. It states that provision of such care can avoid unnecessary hospital admissions and enable more people to die in their place of choice.
- NICE Quality Standard - http://www.nice.org.uk/guidance/qualitystandards/endoflifecare/home.jsp
- NICE Guide for commissioners on end of life care for adults - http://www.nice.org.uk/usingguidance/commissioningguides/endoflifecare/endoflifecareadults.jsp
- NHS operating framework 12/13 - http://www.dh.gov.uk/health/2011/11/operating-framework/
- Palliative Care Funding Review - http://palliativecarefunding.org.uk/wp-content/uploads/2011/06/PCFRFinal%20Report.pdf
- Advance Care Planning: A guide for Health and Social Care Staff, University of Nottingham (February 2007)
- The Preferred Priorities for Care, NHS End of Life Programme, December 2007
- Gold Standards Framework www.goldstandardsframework.nhs.uk
- Prognostic Indicator Guidance (June 2006) www.goldstandardsframework.nhs.uk
- The 5 Priorities For Care, as implemented locally.
- NHS Institute for Innovation and Improvement The Productive Ward www.institute.nhs.uk/productiveward
- NHS Institute for Innovation and Improvement The Productive community www.institute.nhs.uk/productivecommunityservices
- NHS Institute for Innovation and Improvement The Productive Community Hospital www.institute.nhs.uk/productivecommunityhospital

It is also intended to support the delivery of the outcomes set out within:

- Our Health, Our Care, Our Say: making it happen. DH (2006)
- End of Life Care Strategy (2008)
- Commissioning for Health and Wellbeing Framework. DH (2007)

The Marie Curie Delivering Choice Programme has identified a lack of access to responsive care and advice for patients at the end of life and their families during the out of hours period. This can be a major potential challenge to providing patient choice at the end of life.

Dedicated Out of Hour's Services for patients at the end of life have shown to be successful in a number of areas. Examples of services which operate effectively within this framework, throughout the country using a variety of cost and staff structures are documented in the End of Life Strategy.

These services have been evaluated and have demonstrated that the service provides timely, quality, palliative and end of life care and enable patients to be cared for and die at home, reducing and preventing inappropriate hospital admissions.

1.3 General Overview

This service will provide end of life patients and their carers/families with:

- Support for community staff who need assistance to provide palliative care
- Provision of advice and support re specialist palliative care to existing clinical staff
- Receipt and triaging of calls from patients and their families registered with a - _____ GP.
- Response to crisis calls by providing crisis nursing hands-on care including physical symptom management, psychological and social support
- Telephone advice and reassurance
- Follow up phone support or home planned visit for patients identified by their key worker when other planned services are not available
- Planned nursing care to facilitate a patient's choice to stay at home
- Carer support immediately after death

1.4 Objectives

- To support the existing District Nursing teams and step in when more specialist services are required, through the provision of advice and practical support for more complex situations
- To improve the quality and clinical effectiveness of care delivered at home to end of life care patients and their carers/families in _____ and to limit the physical and psychological suffering that patients and carers experience at end of life maximising quality of life through the provision of rapid and effective care and support
- To ensure that urgent end of life care needs are met in the community in a timely manner
- To decrease the length of time between seeking assistance and accessing specialised palliative care services in order to mitigate crisis events.
- To act as a flexible, responsive service that can react to unscheduled demand out of hours
- To deliver consistent response and communication with other providers for example Hospices, McMillan services and District Nurses
- To support the transition from care provided in an Acute setting hospital to home

- To educate patients and carers on self-care and the best use of services

1.5 Expected Outcomes

- Increase and provide quality end of life care at home
- Increase the quality of life for patients through the reduction of distressing symptoms
- Reduce carers/families strain and anxiety
- Increase the numbers of patients dying at home
- Increase the number of patients at the end of life that are cared in their own home
- Reduce the number of inappropriate hospital admissions
- Reduce the number of contacts for patients and carers with Out of Hours Services and emergency services
- Increase in provision and improved access to specialist out of hours nursing services
- Increase patient and carer satisfaction
- Increase the number of patients and carers who have access to the relevant information at the right time
- Improved choice for patients

2. Scope

2.1 Service Description

Overall description:

This service is closely connected with the key worker of the patient. This service will provide end of life patients and their carers/families with:

- Receipt and triaging of calls from patients and their families registered with a _____ GP
- Respond to crisis calls by providing crisis nursing hands-on care including physical symptom management, psychological and social support
- Telephone advice and reassurance
- Follow up phone support or home planned visit for patients identified by their key worker when other planned services are not available
- Planned care for short periods when a care package breaks down to facilitate a patient's choice to stay at home
- Support for community staff who need assistance or advice to provide palliative care
- Carer support immediately after death

Prognosis and Communication

- The service will communicate any unscheduled contact to the Key Worker, who is the professional who has case management responsibility. The Key worker will ensure this information is cascaded to all professionals involved in care
- The service will ensure that patients are given the opportunity and are supported to consider the care they wish to receive based on the best information available
- The service provider will ensure any change in the patient's prognosis and their / their carers' preferences are communicated to all members of the patient's team, across all agencies via the patient's Key Worker

Assessment and Care Planning

- All care, support or advice provided by the service will include an assessment of the patient and carer needs and situation
- Every person (and carer) will have a care plan, which sets out their needs and preferences. The service will ensure that the care plan is appropriately updated and reviewed to reflect, any out of hours advice, care or support which has been provided by the service. Any change will be communicated to the Key Worker to be cascaded as appropriate. The Key Worker is the owner of the care plan and retains overall responsibility for its implementation.
- The service will support a single record of care and use a preferred local health community solution
- There will be recognition of the Mental Capacity Act (2005) which sets out provisions for people to state in advance what they would like to happen should they be unable to make decisions in the future.
- High quality and up to date information will be provided to patients and carers about the assessment and duration of their stage of condition and what to do if their circumstances change unexpectedly, this will include:
    - education
    - treatment and support options
    - how to access services
    - Carer support

Co-ordination of Care

- The Service will liaise with the Key Worker to ensure effective co-ordination across all teams and providers of care (in statutory, voluntary and independent sectors) who are involved in the care of patient and family

Delivering High Quality Care check

- The service provider will ensure that staff employed in the service are trained to manage physical symptoms.
- The staff will demonstrate advanced communication skills in order to offer psychological care and support for both patient and carers
- The service will contribute to the multi agency planning meetings where appropriate
- The service will work to promote integrated working and liaison with involved health and social care agencies.
- The service will advise generalist palliative care providers on symptom control, for example, pre-emptive prescribing and the use of “Just in case” boxes where appropriate
- At the end of any contact with the service, the patient and / or carer will be clear of the outcome, including (where appropriate) the timescale within which further action will be taken and how to access further support if necessary
- The Service must ensure that all staff are trained to manage syringe drivers & administration of controlled drugs

Last Days of Life

- The Service will recognise when someone enters the dying phase and communicate with the patient’s Key Worker around The 5 Priorities For Care

Care after Death

- The Service will be able to verify an expected death
- The Service will inform all relevant agencies of the patient's death
- The Service will support the bereaved and assess their needs
- Consider if there are any suspicious circumstances, if there are seek immediate advice from on call GP or police
- Establish wishes / directions of relatives / directions given in care plan
- Ensure patients GP/DN are informed of patients death including the coroner where appropriate
- Inform Key Worker
- Document all care provided in the patients care plan and leave in the patient's home.

2.2 Accessibility/acceptability

- The service will be accessible to all patients who have a terminal illness or are identified as being in need of End of Life care who are registered with a _____ GP.
- The service will operate during the out of hours period. To endure that the service has a clearly defined and agreed time to ensure the effective handover of information to day time services the proposed operating times are for example 4pm-9.15am.
- The service will accept referrals from families, carers and professionals involved in patient care and will offer a rapid response to referrals as well as a pre-booked service for short visits.

2.3 Whole System Relationships

The Overnight Palliative Care Service will ensure that services are used efficiently and effectively by building good relationships between all care providers. This transparent and trustful relationship will allow for flexibility and integrated working across service providers to meet unplanned need and the challenges of providing end of life care in a community setting. The Overnight Palliative Care Service success will be reliant on excellent working relations with health and social care professionals across your locality and it is expected that good working relationships will be developed with all providers of end of life care across the locality.

In addition to the patient and his/her carers, key relationships will include primary and secondary care, social care and the voluntary sector. The service will be well co-ordinated and flexible to ensure that service users and carers receive efficient and effective delivery of services.

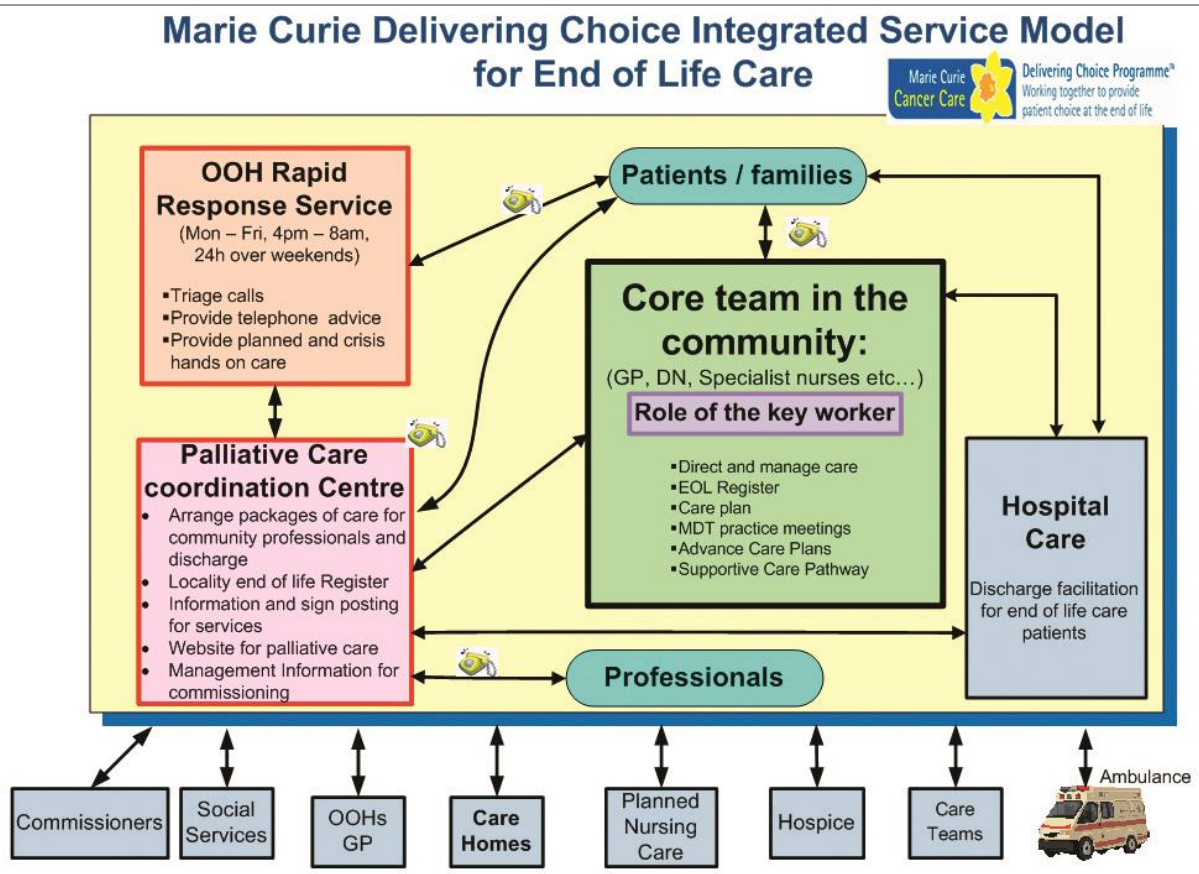
For the service to be effective it is vital that it is integrated with all providers of palliative and end of life care. This includes, but is not limited to:

- Patient's key worker
- GPs
- Community Nursing
- Out Of Hours (OOH) GP provision
- Specialist Palliative Care Service
- Local hospice and care homes
- Ambulance Service
- Acute services including hospital discharge and Occupational Therapy
- Social Services
- Continuing Care Team
- Hospital Discharge Team

- Other agencies involved in patient care

It is also vital that a shared system for the communication of information between professionals in a safe, timely and appropriate manner is utilised by all services involved in palliative and end of life care.

The Marie Curie Delivering Choice Integrated Service model for end of life care is an example of how high quality end of life care can be delivered using a whole systems approach.



2.4 Interdependencies

To be able to respond in a timely, appropriate and efficient manner, the service will rely on receiving up-to-date information on patients' and carers' physical and psychological wellbeing and be able to provide information reciprocally to the Key Worker to advise of the service's involvement in patient care.

Although it is anticipated that much of this information will come from the Key Worker it is also vital that the service has direct relationships with the other professionals involved in the provision of care to enable

- direct referrals from other services
- direct provision of information about patient and carer wellbeing that includes the Key Worker and, when appropriate the rest of the MDT
- provision of information from the service direct to professionals where necessary

For the service to be successful, communication and interdependencies between all professionals involved in the MDT caring for the patient are vital.

2.5 Relevant Clinical Networks and Screening Programmes

The service will need representation or access to the outcomes of all clinical networks associated with palliative and end of life care. Anticipated key networks are;

- _____ EoLC Steering Group
- _____ Cancer Network
- SHA EoLC Clinical Innovations Team

It is not anticipated that any links will need to be made with screening programmes.

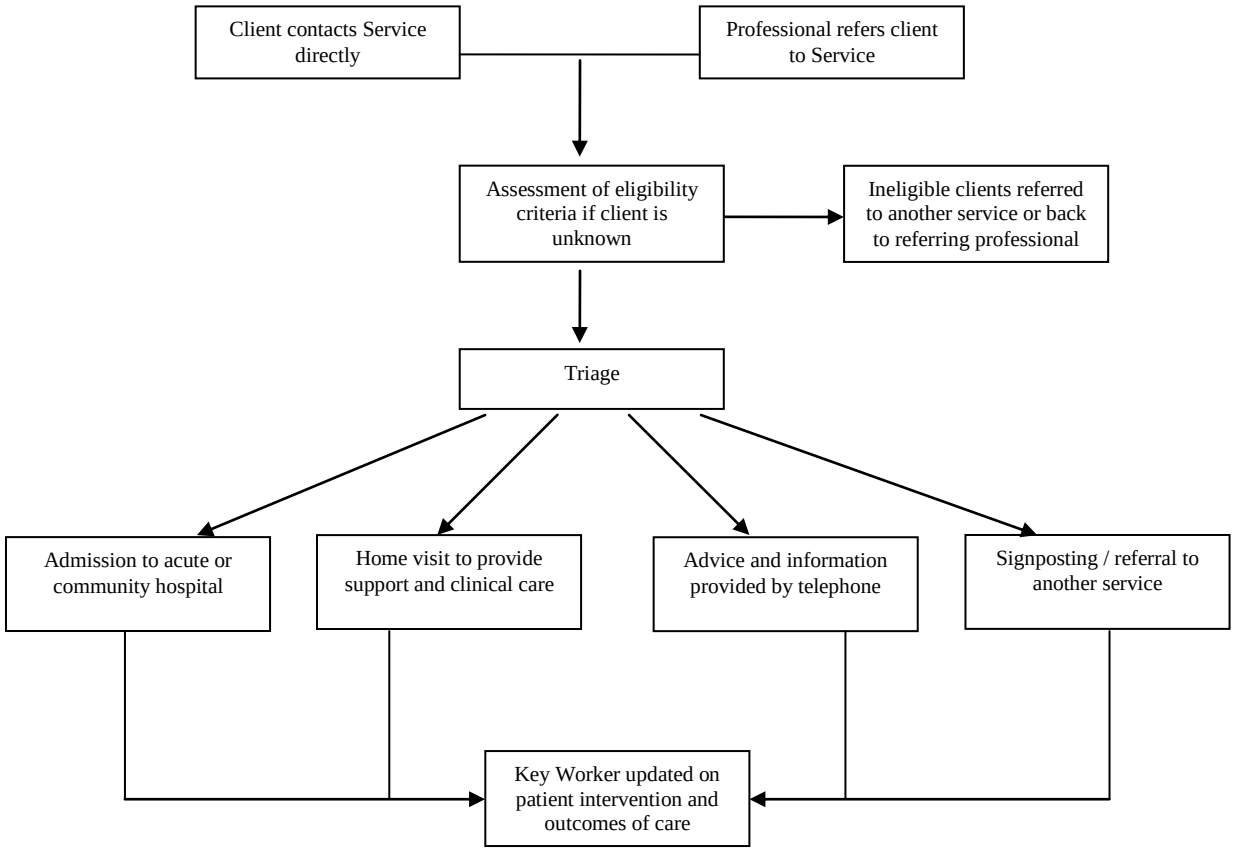
2.6 Sub-contractors

In order to deliver this specification new providers may be invited to tender alongside existing internal providers. Any proposed sub-contract must be agreed by the End of Life Care Commissioner ahead of any agreement being made. The management of sub contracting arrangements will be in accordance with the requirements National Community Contract.

3. Service Delivery

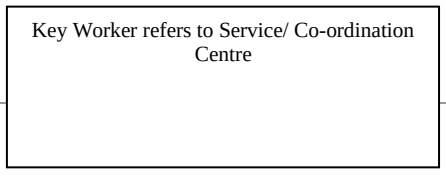
3.1 Service Model

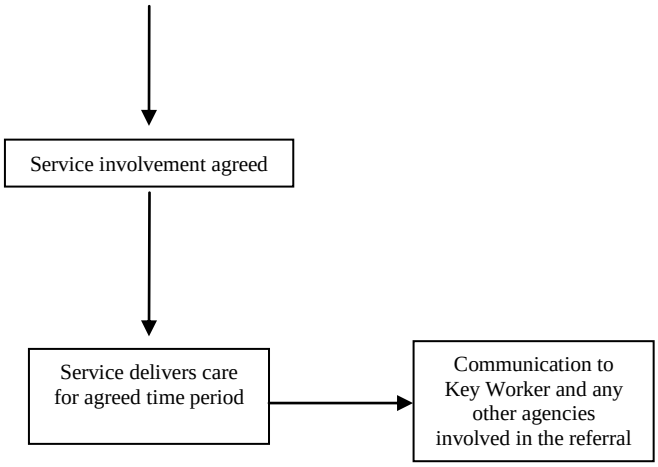
Unplanned Care:



See Section 4.7 for details of timescales

Planned Care:





Staffing

The Service provider must ensure that all staff employed for the delivery of the service have received sufficient specialist training in end of life and palliative care in order to meet the requirements of the service specification.

The service should have an appropriate skill mix to provide the service requirements as outlined above.

3.2 Pathways

This service will operate within the _____ overarching pathway for palliative and EoLC.

The following care and information pathways will also need to established and utilised:

- **Referral pathway into Service – emergency / unplanned care**
- **Referral pathway into Service – planned care**
- **Information pathway from Key Worker to Service**
- **Information pathway from Service to Key Worker**
- **Referral pathway from Service to other services**
- **Referral pathway with District Nursing teams**

4. Referral, Access and Acceptance Criteria

4.1 Geographic coverage/boundaries

The service will be available to residents of _____ of patients that are registered with a _____.

4.2 Location(s) of Service Delivery
The service will operate to cover _____.

The service provider will be expected to find suitable premises to enable them to provide the services as stipulated in the service specification. The Provider must ensure that the location of the service supports the efficient and effective delivery of services across _____.

4.3 Days/Hours of operation
To be agreed locally, depending upon existing service provision and need.

- For example the service will operate 4pm-9.15am seven days a week 365 day's a year

4.4 Referral criteria & sources

Referral Criteria:

Users must be:

- 18 or over
- Registered with _____ GP
- A palliative care patient with diagnosis of life limiting illness
- The referring clinician will answer "no" to the intuitive question integrating co-morbidity, social and other factors "Would you be surprised if this patient were to die in the next 6 - 12 months", from the Prognostic Indicator Guidance.

Referral sources:
The patient or carer will have direct access to the service.

Referrals will be accepted any professional who is in contact with the patient and feels that there is a care need. This will include:

- Key Worker
- Community Nursing teams
- GPs
- Emergency Care Practitioner
- Hospital staff
- Specialist Palliative Care Team
- Clinical Nurse Specialists (Specialist Palliative Care and Heart Failure Nurses Etc.)
- Other health care professionals
- Social Care
- Palliative care co-ordination centre
- Carer

4.5 Referral route

- All clients will be referred via a single service number. Professionals, patients and carers can all access the service directly.
- Out of service hours answer machine service will be in operation and messages will be retrieved as soon as the service opens.
- Planned visits will be agreed between the service, the patient's Key Worker, the patient/carer and where applicable the Palliative Care Co-ordination Centre
- Referrals will be assessed by the appropriately trained staff and inappropriate referrals will be referred back to source.
- For inappropriate referrals, the Service will sign post the referrer to more appropriate services

4.6 Exclusion Criteria

- Clients under 18
- Clients are not identified as palliative care or end of life;

- The referring clinician will answer “yes” to the intuitive question integrating co-morbidity, social and other factors “Would you be surprised if this patient were to die in the next 6 - 12 months”, from the Prognostic Indicator Guidance.

4.7 Response time and prioritisation – for discussion and local agreement

- All emergency calls received by the service will be prioritised and, for patients that require a visit, an ‘at-home’ crisis response will be offered within 1 hour of receiving a call during the operational hours of the service.
- If staff are unable to come to the phone, the service will respond by phone to the referrer within 15 minutes from when an unplanned referral is made within working hours.
- If the service is unable to respond within 15 minutes, then the Service will liase with the existing OOH teams to discuss action to be taken
- Planned visits will be agreed between the service, patient’s key worker and the patient/carer. And potentially Palliative care co-ordination centre
- The service can book planned visits for patients on subsequent shifts if deemed clinically appropriate.
- For inappropriate referrals, the service will sign post the referrer to more appropriate services

5. Discharge Criteria & Planning

Patients on the Palliative Care / End of Life registers will only be discharged through death.

Patients will be deemed to be discharged at end of life and, following an initial appropriate referral, will remain on the Services records/register until end of life.

6. Self-Care and Patient and Carer Information

All Advance Care Plans will be reviewed on referral to the service and at regular intervals after initial referral and patients will continue to be offered information, advice, referral and support throughout their contact with the service.

All carers will be offered a carers’ assessment and will continue to be offered information, advice, referral and support throughout their contact with the service.

The Service will offer information and advice around self care for patients and carers and will provide an OOHs contact for carers and families and will be available to advise and educate patients and carers about the best use of services.

7. Quality and Performance Indicators	*Quality and Performance Indicator(s)*	*Threshold*	*Method of Measurement*	*Consequence of Breach*

HCAI Control	**Training for new staff** **Number of HCAIs**			
Service User Experience	**Number of complaints** **Nature of complaints** **Outcome of complaints**		**Record logs** **Interviews** **Questionnaires**	
Improving Service Users & Carers Experience	**Number of complaints** **Nature of complaints** **Outcome of complaints** **Action taken** **Carer and family feedback after patient death**		**Record logs** **Interviews** **Questionnaires**	
Unplanned admissions	**Number of A&E hospital admissions prevented**		**Through monthly report generated by Service software**	
Reducing Inequalities	**Audit of patient and carer demographics**		**Through monthly report generated by Service software**	
Reducing Barriers	**Audit of registered users in comparison to number of patients on palliative care register**		**Through monthly report generated by Service software**	
Improving Productivity	**Number of referrals processed within**		**Through monthly report generated**	

	contracted time period **Number of episodes of planned care** **Number of episodes of unplanned care** **Audit of communication between MDT**		**by Service software**	
Access	**Number of referrals processed within contracted time period** **Number of episodes of planned care** **Number of episodes of unplanned care** **Number of referrals to OOH and SPCT** **Number of inappropriate referrals received by the agencies**		**Through monthly report generated by Service software**	
Personalised Care Planning	**Number of Advanced Care Plans Discussed** **Number of Advance Care Plans Updated**		**Through monthly report generated by Service software**	
Outcomes				
Additional Measures for Block Contracts:-				

Staff turnover rates				
Sickness levels				
Agency and bank spend				
Contacts per FTE				

8. Activity

Activity Performance Indicators	***Threshold***	***Method of measurement***	***Consequence of breach***
Total number of patients that received services in the month broken down by (i) Patients that have used the service before (ii) New referrals		**Through monthly report generated by Service software**	
Number of patient deaths during the month		**Through monthly report generated by Service software**	
Of which, number of deaths at home		**Through monthly report generated by Service software**	
Number of patients alive at the end of the month		**Through monthly report generated by Service software**	
Number of referrals from (i) Patient or carer (ii) GPs (iii) Emergency Care Practitioner (iv) Hospital staff (v) District Nurse (vi) End of Life Care Co-ordination Centre (vii) Clinical Nurse Specialists (Specialist Palliative and Heart Failure Nurses Etc.) (viii) Other health and social care professionals		**Through monthly report generated by Service software**	
Type of referrals broken down by Planned (i) Visit (ii) Phone advice		**Through monthly report generated by Service software**	
Type of referrals broken down by Emergency or urgent (i) Visit		**Through monthly report generated by**	

(ii) Phone advice		**Service software**	
Referrals made to other services, broken down by service		**Through monthly report generated by Service software**	
Number of inappropriate referrals broken down by type (i) Non-palliative diagnosis (ii) Under 18/?16 (iii) Not in catchment area (iv) Other		**Through monthly report generated by Service software**	
Average response time for urgent referrals (in minutes)		**Through monthly report generated by Service software**	
Length of urgent visits (i) Total hours / month (ii) Average minutes / visit		**Through monthly report generated by Service software**	
Length of planned visits (i) Total hours / month (ii) Average minutes / visit		**Through monthly report generated by Service software**	
Length of urgent telephone advice (i) Total hours / month (ii) Average minutes / visit		**Through monthly report generated by Service software**	
Length of planned telephone advice (i) Total hours / month (ii) Average minutes / visit		**Through monthly report generated by Service software**	
Total number of planned and unplanned advice and minutes per month		**Through monthly report generated by Service software**	
Medication needs broken down by (i) Prescription obtained (ii) Medication obtained (iii) Prescription not obtained (iv) Medication not obtained		**Through monthly report generated by Service software**	
Number of A&E hospital admissions prevented		**Through monthly report generated by Service software**	
Number of patients admitted to		**Through**	

hospital with reason		**monthly report generated by Service software**	
Number of visits for symptom control broken down by (i) Pain (ii) Breathlessness (iii) Oxygen Flow (iv) N&V (v) Low blood sugar (vi) Loss of appetite (vii) Sleeplessness (viii) Terminal restlessness (ix) Blocked catheter (x) Constipation (xi) PAC (xii) Loss of bladder control (xiii) Loss of bowel control (xiv) Personal care (xv) Syringe driver (xvi) Wound care (xvii) Other		**Through monthly report generated by Service software**	
Number of visits for psychological support broken down by carer and patient into (i) Depression (ii) Anxiety (iii) Mental confusion (iv) Agitation		**Through monthly report generated by Service software**	
Number of visits for social reasons broken down by (i) Manual Handing (ii) Patient dying (iii) **Other**		**Through monthly report generated by Service software**	
Number of visits for other reasons broken down by type (i) Medication advice (ii) Unmet need (iii) Service awareness (iv) Other		**Through monthly report generated by Service software**	
Primary diagnosis broken down by condition with summary for number of patients with (i) Cancer (ii) Heart disease (iii) Respiratory Disease (iv) Other		**Through monthly report generated by Service software**	
Secondary diagnosis broken down by condition		**Through monthly report generated by Service software**	

Activity Plan

9. Continual Service Improvement Plan

As part of the monitoring and evaluation process, this service will identify methods of agreeing measurement for continuously improving the service being offered and work to ensure that any unmet needs are identified and brought to the attention of commissioners.

The development of the service to provide an inreach function to proactively identify patients at the end of life and provide support to facilitate discharge within the Acute Setting could be considered as a future development.

10. Prices & Costs

10.1 Price

Basis of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value
Block Arrangement				
2009 Quality Payment				
Total		£		£

delete as appropriate