SCHEDULE 2 – THE SERVICES
A. Service Specifications (B1)

Service Specification No.	06/CEOL/0002
Service	End of life care – Community Generalist Palliative Care Nursing in Bournemouth and Poole
Commissioner Lead	CCP for Cancer and End of Life
Provider Lead	
Period	2013/14
Date of Review	To be Agreed

NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	*
Domain 2	Enhancing quality of life for people with long-term conditions	*
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	*

1. Purpose

1.1 Aims

The primary purpose of the service is to provide additional generalist palliative care support in the community to the locality integrated long term condition teams by providing direct clinical care to patients in the last 16 weeks of life.

1.2 Evidence Base

- High quality care for all
- Our vision for primary and community care
- Our health. Our care, our say.
- Transforming adult social care
- End of Life Care Strategy, DOH July 2008
- End of Life Care Strategy Quality Markers and measures for end of life care, DoH June 2009
- High Quality Care for All, DOH June 2008
- Improving Supportive and Palliative Care for Adults with Cancer, NICE 2004
- The NHS Cancer Plan, DOH 2000
- Annual Operational Plan, Bournemouth & Poole PCT March 2008
- Building a Healthier Future, Bournemouth & Poole PCT October 2007
- Workforce Development Strategy, Bournemouth & Poole PCT January 2008
- End of Life Baseline Review, Dorset Cancer Network March 2008

1.2 General Overview

The service works as part of the locality integrated long term condition teams and will provide additional

responsive and quick generalist palliative care support in the last 16 weeks of life.

Patients with complex long term conditions will have a key worker in the integrated locality long term condition team. The key worker will assess needs and request support from the community generalist team to provide direct care to support the patient to die in their preferred place of care.

For patients who are not known to the integrated locality team and who do not have complex long term conditions, the generalist team will provide a key worker for the patient.

The clinical role includes:

- Symptom management
- Emotional support
- Access equipment
- Basic care

The leadership role includes:

- Education to community teams and care homes
- GSF and LCP facilitation in primary care and care homes

1.4 Objectives:

- To offer high quality, impartial care to all patients who are at the palliative or end stages of their disease and to improve symptom management regardless of ethnicity, language, disability, sexual orientation, religious or personal circumstances.
- Work with the key worker or as the key worker effectively assess patient needs as quickly as possible and develop an appropriate care plan with the patient and appropriate carer, which is regularly reviewed using the Gold Standards Framework
- To work in close partnership with health and social care services and the voluntary sector to ensure that the needs of patients and their carers are met in a timely fashion and that different components of social support are accessible from all locations to ensure prompt and/or early discharge from hospital to the patients preferred place of care.
- To provide excellent coordination and continuity of care by working collaboratively with other health care professionals, social services, statutory, voluntary and private agencies to ensure the patients preferred place of care can be achieved.
- To assess and discuss with the patient their physical, psychological, social, spiritual and financial support needs, which should be undertaken at key points.
- To ensure the particular needs of the patient is identified and addressed in the last days of life using the Liverpool Care Pathway.
- To ensure patients have access to the appropriate equipment that will improve their quality of life and maintain independence.
- To provide information, advice and education to patients, carers and professionals.
- To promote the use of the Gold Standards Framework with partners and the Liverpool Care Pathway for the terminal phase.
- To enhance current provision, provide short day respite care and practical help for carers and families in addition to the Marie Curie and night nursing service, social services and voluntary agencies.
- To ensure the needs of families and carers during the patient's life and bereavement are addressed, which reflect cultural sensitivities.
- To ensure staff who may benefit from training are identified and, as an employer, should facilitate their participation in training and ongoing development.
- To develop clinical networks as a basis on which to develop local palliative care services.
- To improve skill mix working across a more joined up primary care health team.

1.5 Expected Outcomes including improving prevention

The high level outcomes for this service are:

- reduce the number of unscheduled admissions and re-admissions to hospital for people at the end of life

- For those patients registered on the Gold Standards Framework admitted to acute hospitals to ensure that the length of stay is no greater than 10 days.

- To reduce 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. Scope

2.1 Service Description

The long term condition service will as part of the locality integrated teams made up of nurses (district nurses, community nurses and matrons), therapists, generic support workers, and (generalist palliative care teams) working with general practitioners, domiciliary carers and voluntary sector providers and other partners in each locality.

The service will provide additional support to other palliative care services provided by the locality integrated long term condition team, (Specialist Palliative Care Teams, social services, voluntary and private organisations during the last 16 weeks of life through:

- Holistic generalist palliative care assessments and re-assessments
- Organisation and management of complex packages of care
- Advice on symptom control
- Medications management
- Prescribing medications by Independent prescribers
- Physical, emotional, psycho-social and spiritual support
- Signposting for financial advise
- Help with personal care needs and maintaining Activities of Daily Living
- Equipment to enable patients to stay at home safely
- Bereavement follow up telephone call with signposting and visits as and when needed
- Information and support to patients and their carers about their illness, symptoms, prognosis, dying

The service enables patients whose preferred place of care is home is to remain in their own home during the end stages of their life, and to facilitate a dignified and comfortable death with their loved ones around them by providing:

2.2 Accessibility/acceptability

- 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;
- The service is provided in the patients homes;
- Some patients choose not to accept the service provision and that is respected.

2.3 Whole System Relationships

- Community based nurse led service that works with:
    - Community nurse specialist palliative care team
    - General practitioners
    - Long term conditions teams
    - Intermediate care services
    - Specialist palliative care teams (Macmillan Unit and Forest Holme)
    - Twilight and night nursing service
    - Marie curie

- Social services
- Private agencies
- Lewis Manning Hospice
- Acute trust wards
- Equipment services

2.4 Interdependencies

The following agencies either directly or indirectly influence the work of the generalist palliative care team and it will therefore be essential to ensure that systems are in place to provide good communication and a smooth transition for patients and carers between and across these services:

- GPs
- Specialist Palliative Care Services
- Acute Care Closer to Home Teams
- Long term condition teams
- Social Services
- OP CMHT
- Carers
- Equipment Services
- Community Pharmacies
- Acute Services
- Care Homes
- Ambulance services
- Out of Hours
- Marie curie
- Twilight and Night nursing service

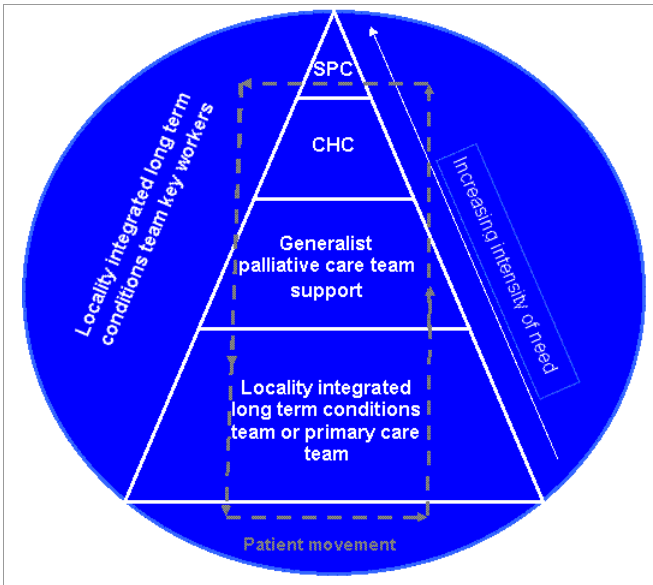
2.5 Relevant networks and screening programmes

- Dorset Cancer Network and the Dorset End of Life Steering Group (all diagnoses) and the Bournemouth and Poole End of Life Care Operational Group
- Dorset Urgent and Emergency Care Network
- Dorset Cardiac and Stroke Network

3. Service Delivery

3.1 Service model

The Generalist Palliative Care Team is a nurse led service that provides direct holistic generalist palliative care for patients and carers at the end stages of their disease, defined as the last 16 weeks of life.



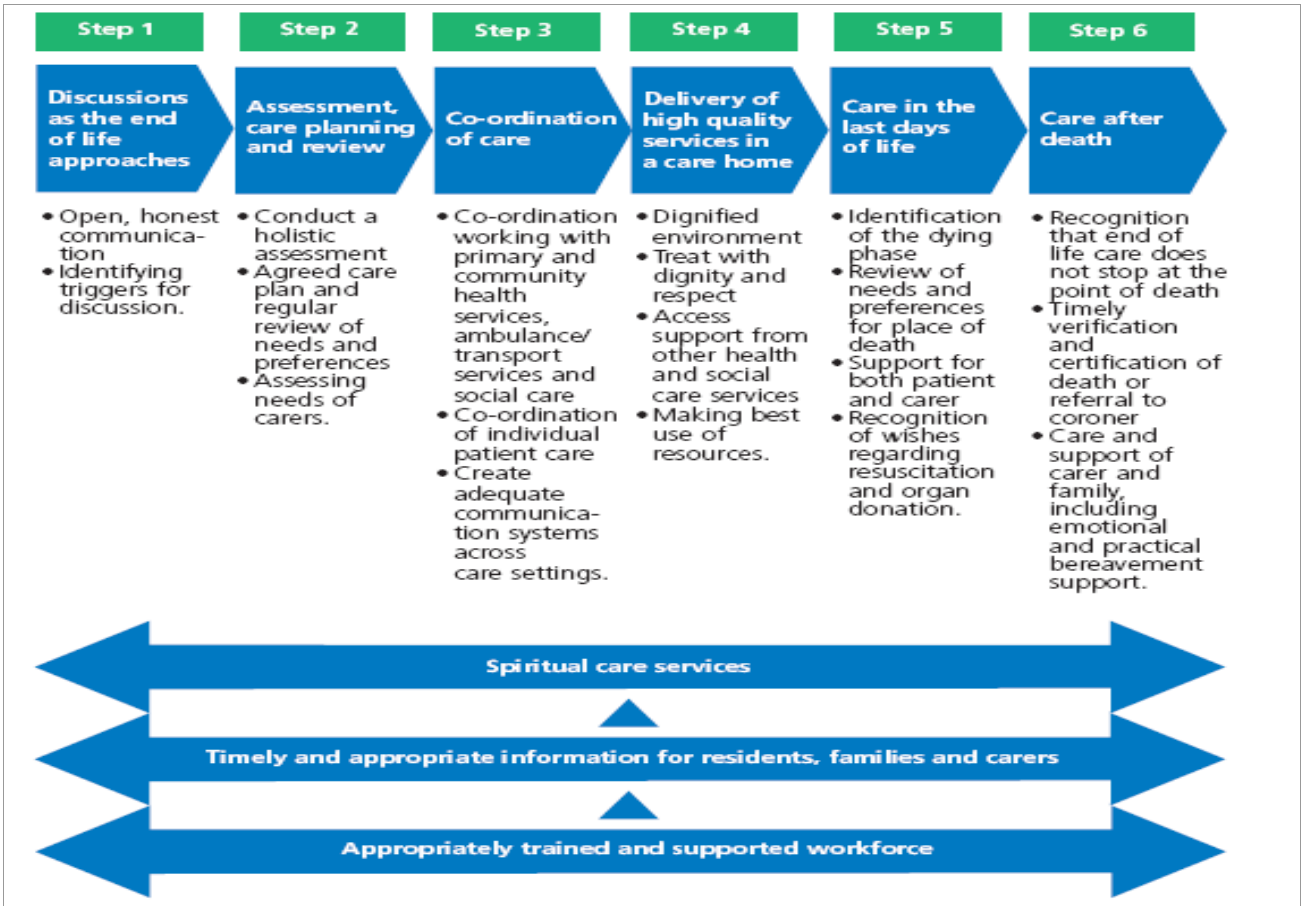
The long term conditions team will be the key worker through all stages of the pathway. The generalist palliative care team will support the long term condition team if the patients' needs are greater than the long term conditions team can provide.

Care will predominantly be provided by the locality integrated long term conditions team or primary care team. As the intensity of need increases the locality integrated long term condition team may need additional support to care for a patient in the last 16 weeks of a patient's life. If the increasing intensity is greater than the generalist palliative care team can provide then a CHC referral should be made. Specialist palliative care will be required for the most complex cases where symptoms can not be managed by generalists.

The generalist palliative care team will identify an associate key worker that will work in partnership with the locality integrated long term conditions team key workers.

To ensure the patients received the right level of care at the right time according to intensity of needs, patient movement needs seamless transition between levels of care. Complex patients will have their needs for end of life care assessed and reviewed on an ongoing basis and specialist palliative care may dip in and out dependent on need.

3.2 Care Pathway(s)



4. Referral, Access and Acceptance Criteria

4.1 Geographic coverage/boundaries

Working as a supra-locality the team will work with the seven locality areas and provide services for patients registered with Bournemouth and Poole General Practices.

4.2 Location(s) of Service Delivery

There are two supra-localities based on the Bournemouth and Poole local authority area. The office bases are Moordown Medical Centre for the Bournemouth team and Forest Holme for the Poole Team.

4.3 Days/Hours of operation

- The service will be provided 7 days per week 08:30 to 21:00
- Trained nurses are available 08.30-18.00 Monday to Friday and 10:00-18:00 Saturday and Sunday
- Out of hours contact via mobile
- With the intention to align hours of operation with the locality integrated long term conditions team

4.4 Referral criteria & sources

- Patients with a prognosis of 16 weeks or less
- Patients registered with a Bournemouth and Poole GP
- Referrals made by health professionals in both primary and secondary care and social services

4.5 Referral route

Currently referrals are received in writing by letter or verbal referral only by GP and by Forest Holme Specialist Palliative Care Consultants followed up with a referral otherwise all referrals go via SPOA form. As the single point of access develops this will be the preferred route for all referrals.

4.6 Exclusion criteria

- People aged under 18 years old
- Patients whose disease is stable and inactive
- Patients who have a long term condition who are not at the end stages of their life

4.7 Response time & detail and prioritisation

- Patient and referrer contact within 24 hours
- Home visit and assessment within 24-48 hours or within one week depending on the referrers identified patient/carer need

5. Discharge Criteria and Planning

- A patient may be discharged following the completion of the agreed care plan.
- Patients are discharged at death but carers will receive bereavement support and signposting as needed
- Notification of the completion of an episode of care is sent to the appropriate professional involved.
- On completion of the agreed care, contact details are offered to the patient/carer

6. Prevention, Self-Care and Patient and Carer Information

- The service aims to promote independent living whilst in receipt of palliative care.
- 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.

7. Continual Service Improvement/Innovation Plan

- Work with the network to develop single advance care planning documentation
- Work with the network to deliver one locality end of life care register
- Implement the networks guidelines on key workers
- Align hours with the locality integrated long term conditions team depending upon capacity and funding

8. Baseline Performance Targets – Quality, Performance & Productivity

Performance Indicator	*Indicator*	*Threshold*	*Method of Measurement*	*Frequency of Monitoring*
Quality				
All patients on an end of life pathway to have a personalised care plan		100%	Monthly Score Card	Monthly
85% of people on an end of life pathway dying in their preferred place of death		85%	Monthly Score Card	Monthly
Additional Measures for Block Contracts:-				
Staff turnover rates				

Sickness levels				
Agency and bank spend				
Contacts per FTE				