

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	11J/0270
Service	Dorset (West) Palliative Care Service – Rapid Home to Die
Commissioner Lead	Clinical Commissioning Lead for End of Life
Provider Lead	Weldmar Hospice Care
Period	1 st April 2022 – 31 st March 2023
Date of Review	September 2022

1. Population Needs

1.1 National Context and evidence base

Around half a million people die in England each year. With an ageing population, the annual number of deaths is projected to increase.

The One Chance to Get It Right Report from the Leadership Alliance for the Care of Dying People states that people are ‘approaching the end of life’ when they are likely to die within the next 12 months. This includes people whose death is imminent as well as those with conditions that mean they are expected to die within 12 months.

[\(NICE Impact End of Life Care for Adults September 2020\)](#)

When the end of life is in sight everybody should have the care and support to enable them to live to the end in the best way that they can. National Voices, the National Council for Palliative Care and NHS England have produced a clear description of this vision in ‘Every Moment Counts: A narrative for person centred co-ordinated care for people near the end of life.

“I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s)”

[\(Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026\)](#)

Where people die and their preferences for place of death are important indicators of the quality of end-of-life care. Monitoring who dies and where is important in delivering high quality palliative and end of life care (PEoLC). [The Ambitions for Palliative and End of Life Care Framework](#) highlights that this is not just about distribution of appropriate services, but because personal choice in place of care and death is fundamental to the lived experience of the dying and their families.

A research report - [Understanding patterns of health and social care at the end of life](#) found that most people would prefer not to die in hospital but at home, in a care home or hospice. For several years, the [National Institute for Health and Care Excellence Quality Standard \(QS13\) for End of Life Care](#) has used ‘place of death’ as a quality indicator for Palliative End of Life Care.

[\(Palliative and EOLC Factsheet: Recent trends in place of Death: Dorset CCG May 2022 Office for Health & Improvement & Disparities\)](#)

Local context and evidence base

The Dorset vision statement:

Achieving excellent, proactive, responsive, personalised and equitable palliative and end of life care for the people of Dorset and those important to them.

Strategic Vision and Priorities

1. Achieve timely, personalised care planning for people at end of life taking into account what matters most to them and their individual preferences.
2. Co-ordinated care across services with effective joint working and improving continuity of care at end of life.
3. Supporting people to die in their preferred care setting with timely symptom relief, personal care and healthcare professional support.
4. Supporting education, training, resilience and well-being across Dorset for all Staff involved in end of life care.
5. Ensuring effective, consistent and timely bereavement care for people in Dorset.
6. Helping to develop caring, inclusive communities with openness about death and dying and willingness to help in emotional and practical ways.
7. Ensuring continued feedback and involvement of people at end of life, those people important to them, carers and healthcare professionals in Dorset.

(Extracted from Dorset EoLC Strategy – note currently in Draft

In 2020, there were 9,376 deaths in Dorset, Bournemouth, Christchurch and Poole. Thirty-five percent of deaths occurred in hospital, 30% at home, 28% in care homes and 6% in hospices. Over the last few years, the leading cause of death has been from Dementia and Alzheimer's disease, followed by heart disease and stroke.

In Dorset we have an ageing population, living longer but with increasing co-morbidities. This can increase the support needs and complexity of health and care services required to manage people's conditions, make them comfortable and support their wishes and choices at end of life. Locally we've seen increasing rates of people on the palliative / supportive care register – there were 6,457 people registered in 2019/20 which is higher than England and South West prevalence.

[Palliative/supportive care: QOF prevalence \(all ages\) for NHS Dorset CCG](#)

The proportion of people dying in hospital is reducing and increasing in other settings and at home. Supporting choice and options for care emphasises the importance of consistent access and quality across settings and within the community, to ensure that everybody has the opportunity to experience the same 'good' end of life. The CQC reported that end of life care is variable for some groups, because of their diagnosis, ethnic or demographic characteristics. Not understanding or considering the needs of individuals or communities was a barrier to the provision of quality end of life care.

[Percentage of deaths that occur in hospital \(all ages\) for NHS Dorset CCG](#)

[\(Joint Strategic Needs Assessment EoLC - Public Health Dorset\)](#)

The Home First Board and Commissioners highlighted how recent changes to national policy over 2021/22 have led to significant gaps in the discharge process for Service Users with

imminent end of life needs who are in an acute hospital setting. This has resulted in some Service Users wanting to return home to die not able to and subsequently dying in hospital.

This service is to provide additional capacity to enable those Service Users with a prognosis of less than 4 weeks to live, who want to return home, from an Acute setting can do so.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	X
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	X
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	X

NICE End of Life Care for Adults Quality Standards (QS13):

Statement 1 Adults who are likely to be approaching the end of their life are identified using a systematic approach. **[2011, updated 2021]**

Statement 2 Adults approaching the end of their life have opportunities to discuss advance care planning. **[new 2021]**

Statement 3 Adults approaching the end of their life receive care that is coordinated between health and social care practitioners within and across different services and organisations. **[2011, updated 2021]**

Statement 4 Adults approaching the end of their life and their carers have access to support 24 hours a day, 7 days a week. **[2011, updated 2021]**

Statement 5 Carers providing end of life care to people at home are supported to access local services that can provide assistance. **[new 2021]**

2.2 Local defined outcomes

- To ensure all Service Users with imminent end of life needs, wanting to return home to die who are currently in an acute setting, are able to do so.
- Test out and monitor proof of concept models including the introduction of additional capacity, to inform future pathway and commissioning
- Greater system understanding around pathway and process for Service Users in hospital who have imminent EoL care needs
- Monitoring of proof of concept models to inform future pathway and commissioning
- To develop an EoL 'Rapid Home to die' pathway to enable those who want to die at home do so, with specialist and generalist support provided
- To have a multidisciplinary team approach to decision making that supports a personalised model of care resulting in minimal delays and multiple hand-offs
- To release some provider capacity within the generalist care system that has to date been called upon to support EoL discharges

Outcomes and metrics

Outcomes (Dorset EoLC Strategy)	Possible Metrics
1. Achieve timely, personalised care planning for people at end of life taking into account what matters most to them and their individual preferences.	<i>Adherence to care plans in place (Weldmar feedback)</i>
2. Co-ordinated care across services with effective joint working and improving continuity of care at end of life.	<i>Close working with Marie Curie (Weldmar feedback)</i>
3. Supporting people to die in their preferred care setting with timely symptom relief, personal care and healthcare professional support.	<i>No. of requests for care packages, no of care packages provided (Marie Curie data collection)</i>
4. Supporting education, training, resilience and well-being across Dorset for all Staff involved in end of life care.	<i>Mandatory Training for Staff & evidence of continuous professional development (Weldmar to evidence).</i>
5. Ensuring effective, consistent and timely bereavement care for people in Dorset.	<i>Signposting where appropriate to services to bereaved family and friends. (Weldmar to evidence as part of quarterly contract review meeting).</i>
6. Helping to develop caring, inclusive communities with openness about death and dying and willingness to help in emotional and practical ways.	N/A
7. Ensuring continued feedback and involvement of people at end of life, those people important to them, carers and healthcare professionals in Dorset.	<i>Friends and Family Feedback (Weldmar)</i>

3. Scope

3.1 Aims and objectives of service

The service aim to support Service Users with imminent end of life needs (less than 4 weeks) who are in an acute setting and that wish to go home to die can do so, by providing an appropriate care package to be delivered in the Service Users home.

This will be additional capacity and form part of a wider service offer to this cohort of Service Users.

The additional service will run for 12 months and use quality improvement methodologies to understand and map the current pathway and processes and in turn how this looks after the new models/services/capacity are in place. Due to tight timescales, it is expected that this work will be iterative and inform the models/services as they are introduced

3.2 Service description/care pathway

To provide a hospice-style care at home, for Service Users who are End of Life, rapidly deteriorating and being discharged from an acute setting. Marie Curie will act as a co-ordination service and will liaise with the hospital and in turn work with care providers, including Weldmar to arrange appropriate support.

This could include Weldmar providing morning, afternoon, evening and overnight care. It

could involve a single or double up support. It is likely to involve linking with other service providers such as Dorset County Hospital, Dorset Healthcare, Marie Curie, Dorset Council as well as the Service Users family and friends.

The new pathway is detailed in appendix 1.

3.3 Population Covered

Adult Service Users registered with a GP in North, West and South Dorset who are being discharged from an acute hospital setting with imminent (less than 4 weeks) End of Life care needs.

3.4 Any acceptance and exclusion criteria.

Includes Service Users being discharge from an Acute setting with a prognosis of less than four weeks to live, who wish to return home to die that have been referred to Weldmar via Marie Curie (co-ordination service).

Does not include anyone under the age of 18 years old.

Does not include Service Users who have longer than four weeks to live.

Does not include Service Users that reside outside of specified area (as detailed in section 3.3).

3.5 Interdependence with other services/providers

This service will need to work with partners to support the needs of the individual. Partners include:

- Local community health teams – generalist palliative care services, district nurses, allied health professional
- Marie Curie and other brokerage / coordinators
- Primary Care Networks – GPs, Frailty Teams
- Acute Palliative and End of life team – incl; specialist palliative care services
- Local Authority colleagues

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

[NICE End of Life Care for Adults Quality Standards \(QS13\)](#)

5. Location of Provider Premises

The Provider's Premises are located at:

Services are to be provided from a Service Users home.

6. Individual Service User Placement

N/A – Equipment needs to be arranged before Service User returns home

APPENDIX 1: West Dorset Rapid Home to Die Pathway

