

## SCHEDULE 2 – THE SERVICES

### A. Service Specifications

<b>Service Specification No.</b>	11J/0271
<b>Service</b>	Support for Palliative Service Users
<b>Commissioner Lead</b>	NHS Dorset ICB Primary and Community Care Team
<b>Provider Lead</b>	Lewis Manning
<b>Period</b>	1/4/22-30/6/22
<b>Date of Review</b>	N/A

#### 1. Population Needs

##### 1.1 National/local context and evidence base

Improving supportive and palliative care for adults with cancer. NICE cancer service guidance (2004; NHS Evidence accredited - [www.nice.org.uk/guidance/CSGSP](http://www.nice.org.uk/guidance/CSGSP))

#### 2. Outcomes

##### 2.1 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	

##### Adult Social Care Outcomes Framework:

- Domain 1: enhancing quality of life for people with care and support needs.
- Domain 2: delaying and reducing the need for care and support.
- Domain 3: ensuring that people have a positive experience of care and support.
- Domain 4: safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm.

##### 2.2 Local defined outcomes

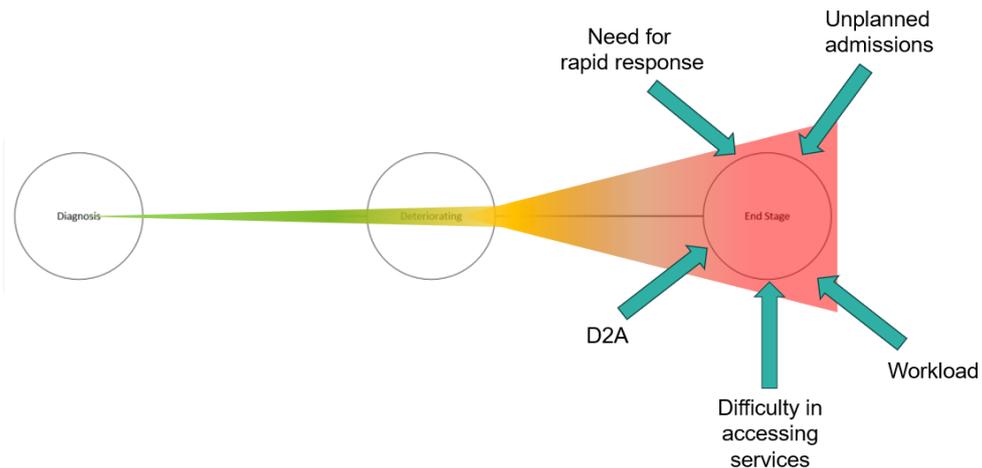
###### Outcome

- Reduction in inappropriate admissions.
- Improved quality of life and promotion of dignity
- An improvement in Service User symptoms
- User feedback

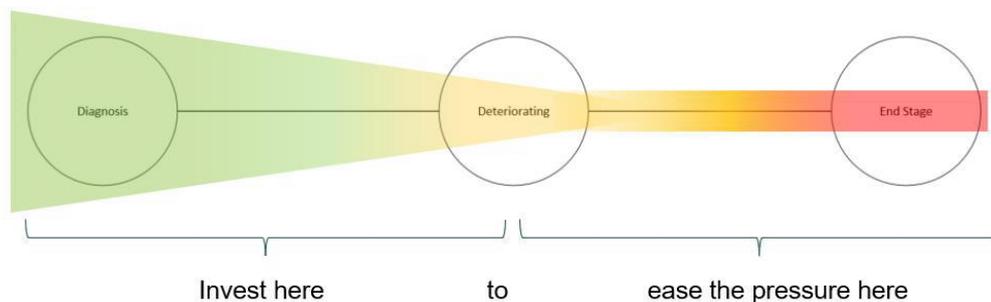
### 3. Scope

#### 3.1 Aims and objectives of service

Palliative Service Users go through three phases in their End of Life journey: Prognosis Deterioration and End Stage. It is widely acknowledged that a lot of the focus on Palliative Care is at the 'End Stage'. This is usually a period of crisis and as such takes up a significant amount of resource, intervention and investment.



Whilst under Single Speciality consultants, and Clinical Nurse Specialists (CNS), a Service User is well supported. When Service Users are informed their condition is palliative there is a perception that they are very much on their own. The information provided is more in term of leaflets rather than being able to have discussions.



#### The aims of this service are to:

- Support Service Users at time of Diagnosis through early conversations
- Support Service Users and those important to them between Diagnosis and the need for End Stage Specialist care.
- Help manage and coordinate care at the point of Deterioration

Able to hand over care needs at EoL to specialist teams whilst still being there for the Service Users and their families

**The goals will be:**

- Reduction in conveyances
- Reduction in avoidable hospital admissions
- Reduction in crisis
- Reduction in costs at end of life
- Reduction in strain on GP services
- Supporting GPs, DNs and other providers

Collaboration with other services

- Increase in personalised care and supporting planning conversations

**3.2 Service description/care pathway**

**At the diagnosis stage:**

Work with GPs, single specialty Consultants and CNS's to offer support to newly diagnosed palliative Service Users and those with life-limiting illnesses

Promote self-referral for palliative Service Users and those with life-limiting illnesses

Building relationships with Service Users;

- Providing support and promoting Service User independence to live well throughout
- Providing a single point of access (duty nurse number 9 am to 5 pm)
- Avoiding abandonment – being there should the need arise

Planning ahead

- Nurse led assessments (risk, environment, safeguarding) for all newly referred Service Users using a triage model. Service Users will be seen either as an outpatient or in their usual place of residence (based on referral requests and needs).
- Service User preferences – capturing '**what matters to me**'
- Putting in place treatment escalation plans
- Discussing Advanced Care Plans
  
- Signposting and advocacy
- Pre-bereavement support

**During the deteriorating stage support by:**

Monitoring Service User's symptoms

- escalating as appropriate
- Preventing inappropriate and unwanted admissions
- Supporting D2A for Service Users when admission cannot be avoided

Regular communication with GPs, and Palliative Care Consultants and CNSs

- at regular MDT and/or GSF meetings

- to request symptom control interventions when necessary
- Supporting Day Hospice or Virtual Hospice attendance for psychosocial support
- Providing respite care based on need
- Discussing/reviewing ACP

**At 'End Stage' facilitate:**

Seamless transfer of care to District Nurses and/or SPC

Rapid referrals through access to specialists, GPs, DNs

Continue to support Service Users and their families

- Respite sits
- Family Support and Bereavement counselling
- Taking time to listen

At all stages, Service Users would have access to other LMHC services such as Day Hospice, Better Breathing and Complementary Therapy.

Whilst the service is developing further, it is likely that we will see more 'Deteriorating' and End Stage Service Users, but the medium-term goal is to build a caseload of early diagnosis Service Users.

### **3.3 Population Covered**

The population covered is Service Users registered with Shore Medical Practice who are aged 18 years and over with advanced, progressive, incurable conditions; adults who may die within 12 months; and those with life-threatening acute conditions. It also includes support for the Carers of Service Users.

### **3.4 Any acceptance and exclusion criteria.**

The service is provided for Service Users registered at Shore Medical with a Palliative Prognosis, excluding those under 18 years of age.

### **3.5 Interdependence with other services/providers**

Services required by Service Users approaching the end of life span different sectors and settings. The Provider shall adopt an integrated approach to planning, contracting and monitoring of service delivery across health and social care.

The quality standard requires that services are commissioned from and coordinated across all relevant agencies, including specialist palliative care, and encompass *the whole end of life care pathway*. To implement the care pathway, the Provider shall work with other health and social care professionals in an integrated way to ensure Service Users and Carers receive a joined-up and streamlined services tailored to meet their specific needs.

## 4. Applicable Service Standards

### 4.1 Applicable national standards (e.g. NICE)

NICE quality standards are a concise set of prioritised statements designed to drive measurable quality improvements within a particular area of health or care.

NICE quality standards are derived from high quality guidance such as that from NICE or other sources accredited by NICE. Quality standards are developed independently by NICE, in collaboration with healthcare professionals and public health and social care practitioners, their partners and service users. Information on priority areas, people's experience of using services, safety issues, equality and cost impact are also considered during the development process.

NICE quality standards are central to supporting the Government's vision for a health and social care system focussed on delivering the best possible outcomes for people who use services, as detailed in the Health and Social Care Act (2012).

### 4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- Commissioning Guide in End of Life Care (RCGP: March 2013).

[www.rcgp.org.uk](http://www.rcgp.org.uk)

- Commissioning person centred end of life care (October 2012)

[www.endoflifecareforadults.nhs.uk](http://www.endoflifecareforadults.nhs.uk)

## 5. Location of Provider Premises

### The Provider's Premises are located at:

Lewis manning Hospice Care  
Longfleet House  
56 Longfleet Road  
Poole  
Dorset  
BH15 2JD