

## SCHEDULE 2 – THE SERVICES

### A. Service Specifications

<b>Service Specification No.</b>	<b>QVV/0286</b>
<b>Service</b>	<i>Purbeck Care Support Workers (Proof of Concept)</i>
<b>Commissioner Lead</b>	<i>NHS Dorset ICB</i>
<b>Provider Lead</b>	<i>Dorset Healthcare University NHS Foundation Trust</i>
<b>Period</b>	<i>1<sup>st</sup> January 2023 to 31<sup>st</sup> December 2023</i>
<b>Date of Review</b>	<i>N/A</i>

#### 1. Population Needs

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

Although people in Dorset have historically lived longer in good health than the English average, Public Health England have projected that Dorset will have a 26% increase in deaths by 2040, as people live longer with more 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. 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.

[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 care. Care Quality Commission (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](#)

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

End of Life Care is available for Service Users with diagnoses deemed to be palliative including all cancers, end stage heart failure, renal and liver, neurological conditions, respiratory conditions (COPD), end stage dementia and any other end stage Long Term Condition. Currently, End of Life Service Users receive home based palliative care from a range of different health and social care services. Service Users remain under the Lead of the District Nurse within their caseload. Depending on the individual Service User's needs, visits may be provided by; District Nurses, Palliative Specialist Nurses, Support workers –from ICRT/IC, Marie Curie, Night Nursing Service, Agency care Staff, Occupational Therapists, Physiotherapists and GPs. These Service Users may also be under the care of local Hospices.

Currently there are different funding streams and access points for End of Life (EOL) care. For instance, Service Users accessing care via a fast-track application may have a change of care provider as different funding streams are approved. In some cases, this change may be for the last few days of a Service User's life, meaning their care moves from a team with an established relationship and care plan to a new team where conversations need to be repeated and relationships built. The Discharge to Assess (D2A) pathway has also created some challenges for EOL Service Users, such as delays in packages of care, not being identified as end of life and poor communication in the system whilst adding pressure in the community teams due to the need for bridging services. Packages of care are difficult to source leading to some Service Users dying in an acute setting rather than in a setting of their choice. Where Service Users are cared for in the community, often there is not enough workforce available to meet the needs of Service Users, especially when double up care is required. In this situation Service Users may be conveyed and spend the last days of their life in an acute setting.

Due to the difficulties in sourcing packages of care, District Nurses often tend to Service User's social needs whilst managing their health needs, this extends the length of time District nurses spend with Service Users leading to a reduction in capacity.

Via the Integrated Community and Primary Care Services investment of 2018, 2 areas of Dorset received investment for Community Support Workers (CSW) to support acute discharges where Service Users were experiencing a long length of stay (LOS) due to lack of care availability. Whilst the investment didn't have the intended impact on LOS, the CSW roles did play a part in admission avoidance and in Purbeck provided additional support for end of life and palliative Service Users. Purbeck has a well-developed team for EOL care with the makings of a good model of care, for this reason and the difficulties in recruitment in the social care sector, it has been agreed to test the model in Purbeck, further building on the great work they have done.

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

## 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]**

### 3. Scope

#### 3.1 Aims and objectives of service

The aims of this proof of concept are that:

- Service Users are supported at point of diagnosis and throughout their end of life journey
- Service Users are able to have a good death in their preferred place of care.
- Reduction in number of conveyances relating to lack of care provision in last days of life.
- Service Users share their information once, have their wishes and what matters to them captured early and where possible catered for, and reviewed as their prognosis progresses.
- Service Users have access to consistent, suitably trained and experienced teams
- Release capacity for district nurses by shifting Service Users' social care needs to the Community Support Worker role

#### 3.2 Service description/care pathway

The model of care aims to enhance care provision, provide an anticipatory care approach earlier and consistently in a Service Users' EOL journey and develop closer links with the voluntary sector to provide a personalised, holistic approach to palliative and end of life care by:

- Increasing CSWs capacity
- providing care later in the evening
- shortening the gap between visits
- aim to provide up to 4 visits a day
- reduce impact on out of hours services
- increase support to carers and families

With this additional capacity and non-medical care and support, not only will Service Users receive a good experience at the end of life, but capacity in the community will be created, releasing district nursing time to focus on the medical needs of Service Users. To be clear, Service Users will remain on the District Nurses case load.

With this approach we aim to demonstrate the benefits of an anticipatory care approach to the Service User and healthcare system:

- Service User is reviewed at MDT, and palliative and end stage care planning discussed much sooner with the Service User

- The Service User and their carers are better prepared for their palliative and end of life journey, understand and know what to expect towards the end of life

Service Users will receive more timely visits meaning gaps in between visits will be reduced. This in turn will decrease risk for Service Users overnight needing to contact out of hours services, risk of conveyancing and increase support to families and carers reducing reliance on out of hours services.

Access to support from time of diagnosis will increase support to Service Users and their families and carers. This will allow time for advance care planning and reduce pressures on other areas of the system.

### **3.3 Population Covered**

Service provision is for adults who have been identified as being in the last 12 months of life, and who can be managed within the community living in the Purbeck area.

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

- Does not include children's Palliative/EOL care
- The proof of concept will serve end of life Service Users in the Purbeck PCN (Primary Care Network) area

### **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 – including specialist palliative care services
- Local Authority colleagues

## **4. Location of Provider Premises**

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

Services are to be provided at the Service User's home