SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	QVV/0287
Service	**Fast Track (CHC) Domiciliary Service- End of Life Care**
Commissioner Lead	**Sarah Hayward, Head of Commissioning and Placements**
Period	**1 September 2022 – 31 March 2024**
Date of Review	**Dec 2022**

1. Population Needs

1.1 National/local context and evidence base

End of Life Care: This is an important part of palliative care for people who are nearing the end of life. For people who are considered to be in the last year of life (although this timeframe can be difficult to predict), end of life care continues for as long as it is needed. End of life care is a holistic form of care which aims to help people live as well as possible and to die with dignity. It also refers to treatment during this time and can include additional support, such as help with legal matters. It also provides support for families and carers throughout the last phase of the Service User's life and into bereavement.

Increasing need: Over the next 25 years, the number of deaths will increase by around 100,000 more deaths each year *ONS (2014) 2012-based National Population Projections).*

Life expectancy is also increasing; the population aged 75 and over is projected to increase to 7.2 million by 2033 and the number of people aged over 90 to increase to 1.2 million *(National End of Life Care Intelligence Network, Deaths in Older Adults in England, October 2010).*

Preference for care at home: Numerous studies have found that a large proportion of the general population would prefer to die at home. Gomes et al (2011) showed that 63% of participants reported home and 29% reported hospice as their preferred place of death (8% reported other places including hospital, care home or elsewhere). Studies using Service Users at the end of their lives also suggest that most would prefer to die at home. The National Bereavement Survey showed that of the Service Users who had mentioned a preference for place of death, 71% said home, 7% hospice, 5% care home, 3% hospital and 14% 'somewhere else' (ONS, National Bereavement Survey (VOICES), 2011).

However in England in 2013, only 43% of people died in their usual place of residence. (PHE)

Conditions: 43% of the 400,000 people each year that have a palliative care need will have cancer. The remaining 57% will be diagnosed with a terminal illness other than cancer *(Fliss EM Murtagh et al., How many people need palliative care? A study developing and comparing methods for population based estimates, Palliative Medicine 2014, 28: 49)*.

NHS Dorset serves a population of over 809,726, although the population is expected to grow more slowly than the national average it is expected that the older population (65+) in the area will grow at a rate above the national average. In turn the number of people living with long term illnesses will grow in relation to the older population providing key challenges for NHS Dorset.

Life expectancy in NHS Dorset is higher than the national average although there are areas of deprivation in the county. A significant number of people in Dorset live in rural areas whereas the national average is 5%, impacting on access to services in both primary and secondary care.

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 a safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

The service aims to provide holistic care and advice to Service Users approaching the end of their lives, that have been assessed and are eligible for NHS Continuing Healthcare (CHC) when End of Life Specialist care is needed. Delivery of this service

will improve the quality of services for Service Users at the end of life, enabling them to be cared for and die in the place of their choice and avoiding inappropriate hospital admissions. Service outcomes include:

- Timely access to end of life care support in the home with the capacity to identify staff availability at the point of referral
- Work in partnership with other service Providers to provide a comfortable and dignified end of life experience, in the Service Users' preferred place of care and dying, ensuring this care is safe for Service Users who are eligible for CHC,
- Improved quality of life and the promotion of dignity and wellbeing for Service Users.
- Increase the percentage of Service Users at the end of life who are in their preferred place of death

Key Performance Indicators

See Local Quality Requirements in Schedule 4

The Provider will issue the Commissioner with activity reports on a monthly basis detailing the last 12 months trend history.

The Commissioner and Provider will meet on a quarterly or other agreed basis to review progress and operation of the service.

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. Continual Service Improvement will be an item for discussion as part of Contract Review Meetings.

3. Scope

3.1 Aims and objectives of service
The service will be provided to Service Users who have been determined by the Commissioner as being eligible for CHC. The Provider will ensure that the services can be provided every day of the year, 24 hours a day.

For Service Users, the Provider will ensure that the services are based on the health and social care needs identified in the referral as part of the application for CHC. This will be shared with the Provider.

The aim is to provide care that is of a high quality and is person-centred, working with Staff who comply with the fundamental standards for quality and safety and who are pro-active in continuously improving the services they provide. As part of this service, Staff are expected to look beyond the commissioned tasks and consider

what assistance the Service User requires to ensure they are safe, comfortable and in a clean environment.

The objective of the service is the delivery of a Personalised Care as per the requirement in Regulation 9 Health and Social Care 2008 Regulation 2014 that is safe and promotes a good quality of life, meets assessed health and social care needs and contributes to the outcomes identified for and by the Service User. The service will contribute to the reduction of inappropriate hospital admissions where Service Users have expressed a wish to be cared for within their own home.

The aim of the service is to deliver domiciliary (home) care that:

- puts the health, safety, quality of life and preferences of the Service User at the centre of care provision;
- supports the Service User to make informed choices about their care, as per the NHS Constitution;
- supports the health, safety and quality of life of Carers as outlined by The Care Act 2014 and National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (July 2022 (revised));
- meets the outcomes outlined in section 2 of this service specification through effective working partnerships;
- strives to continuously improve the quality of care for the Service User;
- provides continuity of care for the Service User, wherever possible;
- is delivered by the required number of Staff who arrive on time, carry out the commissioned activities, interact with Service Users and stay for the full time that is set out in the Service Users care plan;
- Staff have the required skills to meet their needs, including for Service Users receiving end of life care;
- the care provided is carried out in a way that shows an understanding of and a concern for the Service Users and their support network,

The Provider will provide care in line with the Service Users care needs. Care can be delivered through a combination of days and/or evenings and/or nights as appropriate to support the needs of Service Users and their families as approved by the Commissioner and identified on the Package of Care request form (POCR) (Appendix B).

3.2 Service description / care pathway

The domiciliary (home care) service is described below (the “**Service**”):

The Commissioner block funds staff hours, at an agreed fixed cost, per financial year. For day and evening care visits these hours include travel and Service User facing time to ensure maximum flexibility. Any Service User facing hours provided in excess of these hours per annum will be charged at an agreed rate as detailed in Section 3 – Payments, Local Prices.

Care: The Provider will provide Healthcare Assistants to deliver care and support for Service Users approaching the end of their lives, that have been assessed and

are eligible for NHS Continuing Healthcare (CHC) when End of Life Specialist care is needed. This could include management of symptoms as well as provision of emotional and practical support. The Referrer and the Commissioner will identify specific care requirements. These will be identified and detailed within the referral and POCR form.

The Provider must notify the Commissioner should the Service Users health needs change or require a different pathway for their health and social care needs. If additional health needs are identified that were not present at the point of referral or the Service User's health needs have decreased or stabilised the Provider must notify the Commissioner by email to PHC.centralFT@nhsdorset.nhs.uk on the next available working day of this becoming known to the Provider.

The Commissioner will conduct any reviews and any full assessment for NHS Continuing Healthcare as required.

The Commissioner will inform the Provider of the outcome and an allocated care coordinator will liaise with the Provider to agree a transfer date for care. Should the Service User be no longer eligible the Commissioner will work with the Local Authority if appropriate and agree a transfer date and send a notification to cease National Health Services (NHS) funding to the Service User, the Local Authority if appropriate and the Provider. There is a 28 day cease funding period/notice period with the Local authority / self-funding Service Users however every endeavor is made to decrease this and transfer care as soon as possible. Care must be provided through the notice period regardless of the Service User's funding status until the transfer date has been agreed. Cases that exceed 28 days will be dealt with on a case by case basis working in collaboration with the Provider.

Shifts: The service operates over a 24-hour period Monday to Sunday.
The care coordinator will liaise with the Provider on the Service Users' needs.

Referrals: A referrer is defined in the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care as an "appropriate clinician".
Paragraph 244 States "An 'appropriate clinician' is defined as a person who is:
- responsible for the diagnosis, treatment or care of the individual under the 2006 Act in respect of whom a Fast Track Pathway Tool is being completed.
- a registered nurse or a registered medical practitioner.

When care is being sourced from the end of life Providers, the Provider will in the first instance attempt to provide the care to the Service User, however should they not have the capacity, the Provider will inform the Commissioner via the fasttrack.commissioning@nhsdorset.nhs.uk within 24 hours.

Case management responsibilities will remain in line with the agreed Case Management Protocol (Appendix A)

Service User Assessment:

A completed referral form which provides information including prognosis and basic care needs is shared with the Provider.

Should a Service User be discharged from hospital and has been provided with equipment under some circumstances there may be access to a moving and handling assessment.

The Provider, following consultation with the Service User and any other health and social care professional involved with the Service User's care, will create a personal file detailing how they are going to care for the Service User. This will be in line with the Health and Social Care Act 2008 (Regulated Activities) Regulation 9.

Out of hours:
For any decrease or increase in packages of care the Provider should complete a form and submit to the Commissioner via email to PHC.centralFT@nhsdorset.nhs.uk on the next available working day of this becoming known to the Provider. The Provider will then provide care to the Service User as indicated in the form. The Commissioner will inform the Provider of their agreement and if the hours are within non block a revised memorandum of agreement will be sent to the Provider.

Safeguarding is everybody's business and if an HCA has a safeguarding concern this must be raised in line with the Provider's own safeguarding policy. The Provider will report the safeguarding in line with the Pan Dorset Safeguarding policy Safeguarding-Adult-Children-Policy-v1.6.pdf (dorsetccg.nhs.uk)

Provider Staff:

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- The Provider supports its staff delivering the Service with a "Lone Worker" security system.
- The Provider will submit information on the demand and capacity of services to Commissioners.

The Provider will rota staff so that mobilisation of care will commence within 24 hours of acceptance of offer to enable compliance with the National Framework for NHS Continuing Healthcare and NHS funded Nursing Care, paragraph 262.

Cancellations: For block and non-allocated hours day or night
A request for care can be cancelled at any time. The Provider will use its reasonable endeavours to reallocate the care hours to another Service User. Should the Provider be unable to do this and the visit was cancelled by

a. referrer/Service User/relative/carer within commencement of a shift within 24 hours (including where the Service User has died); or

b. the visit is no longer required but has not been cancelled by referrer/Service User /relative/carer with travel undertaken (including where the Service User has died).

The Provider will be paid the full hourly rate.

Should a Service User need to go into hospital, in order to support Hospital Discharge, a space on the Provider's rota may be reserved for a period of 5 (five days in total including the 24 hours above) days, which will be fully funded by the Commissioner, following written permission.

Upon hospital admission the contract will terminate after a period of 5 days. This period is to enable the package of care to be kept open should the Service User be discharged during that time. Extensions to this period must be obtained in writing, from the Commissioner.

Discharge Criteria and Planning

The care will continue until:

- The death of the Service User
- The Service User is admitted to hospital/hospice/Care home
- The Service User no longer remains CHC eligible and as such the Commissioner will notify the Provider on the outcome of a review or DST. Funding ceases on the date of transfer or 28 days whichever is earlier. Cases that exceed 28 days will be dealt with on a case by case basis working in collaboration with the Provider.
- The Service User or their duly appointed representative advises the Provider in writing that they wish to self-fund or that they will not accept care. In which case the Commissioner must be notified immediately to ensure ongoing care is safe and sustainable. Such cases will be dealt with on a case by case basis in collaboration with the Provider.

The Commissioner will determine whilst reviewing the Service User if it is appropriate to review eligibility for continuing healthcare. If appropriate the Commissioner will arrange a full assessment of CHC. If, following a full assessment for CHC the Service User is no longer eligible the standard cease funding arrangements will apply.

Local data indicates that The average length of stay for Service Users found eligible for CHC via the use of the fast track tool is 6 to 8 weeks, however occasionally there may be Service Users who exceed this period. In such cases clinical judgement by the Commissioner will be made regarding the appropriateness of completing a full assessment for CHC.

Prevention, Self-Care and Service User and Carer Information

The Provider will work in partnership with all relevant care Providers commissioned by NHS Dorset to ensure that Service Users, carers and staff have good knowledge of the service.

3.3 Population Covered

- The service will be available to adults registered with a GP who is part of NHS Dorset, provided that they meet the CHC eligibility criteria, when End of Life Specialist care is needed as per the National Framework or as per commissioning authority requested

3.4 Any acceptance and exclusion criteria and thresholds

Acceptance criteria

- All Service Users that are eligible for CHC when end of life specialist care is required
- Those Service Users approaching end of life for whom the Rapid Home To Die pathway is not appropriate but will need prompt access to end of life care as referred to Providers by the Commissioner
- Acceptance of a request for care is subject to capacity of the Provider.

Exclusion criteria

- Service Users not registered with an NHS Dorset GP.
- Service Users not eligible for CHC
- Service Users under the age of 18. Service Users between the age of 16 and 18 years will be considered on a case by case basis and subject to consent from the Provider's relevant regulatory body.
- Service Users that have Palliative Care needs but are no longer in receipt of CHC

3.5 Interdependence with other services/Providers

Dependencies: The Commissioner shall be responsible either directly or indirectly through other commissioned services (as applicable) for providing or procuring the provision of: (i) all clinical consumables and drugs required for the delivery of the Service (ii) and maintenance of all necessary Equipment including enhanced PPE iii) Copy of the fast track referral document

The Commissioner shall notify local health care professionals and referrers about the Services and promote referral of Service Users to the Service.

The Commissioner acknowledges that the Providers shall not be obliged to provide staff of a particular gender or any other protected characteristics unless this would be necessary to meet the social, cultural or spiritual requirements of the Service User or their carers.

If the Service is prevented or delayed by any act or omission of the Commissioner or any failure or delay of in performance of the obligations of the Commissioner or any third party, the Provider shall not be liable for any loss, damage, costs, charges incurred that arise directly or indirectly from such prevention or delay.

The Commissioner designates health professionals who are able to refer to the service and who remain Case Managers.

The Commissioner will share with the Provider the referral which outlines the Service User’s need. The Provider should carry out their own assessment of the Service User and develop and agree relevant care.

The overall care needs of the Service User will be identified by the Commissioner through the referral.

The Case manager may in some circumstances have intervention specific care plans (such as wound care plans) and or information around the preferences around End of Life care.

The service will be expected to work in ways which are sensitive to the social, cultural and spiritual requirements of each Service User and their carers. This will include access to translation and interpreting services.