

SERVICE SPECIFICATION

Service	Hospice at Home – Draft 2
Commissioner Lead	To be completed after discussion at Contract Implementation Group
Provider Lead	To be completed after discussion at Contract Implementation Group
Period	To be completed after discussion at Contract Implementation Group

1. Purpose**1.1 Aims**

The aims of this service are;

1. To contribute to a comprehensive Hospice at Home service for palliative and End of Life patients across Hertfordshire, Luton and Bedfordshire on a 24/7 basis 365 days a year.
2. To provide an equitable service to all patients with need including hands on practical and social support, crisis and planned response, respite for carers and specialist assessment on a 7 day basis by a Clinical Nurse Specialist.
3. The service will be complementary to the District Nursing service and will work in partnership to provide seamless care.
4. To achieve the preferred place of care for patients.
5. To increase the number of patients who die at home.
6. To prevent inappropriate hospital admissions and to facilitate rapid/early discharge from hospital.
7. The service will be available to all on the basis of need not diagnosis.

1.2 Evidence Base

- NICE Guidance (2004) Improving Supportive and Palliative Care for adults with cancer.
- East & North Herts, West Herts, Luton and Bedfordshire PCTs; Baseline Review of End of Life services.(2008)
- Department of Health; Our NHS Our Future.
- Department of health; National End of Life Care strategy (2008)
- Towards the best Together (2009) A clinical vision for our NHS now and for the next decade. Pledges 1 & 7.
- National Forum for Hospice at Home Strategic Framework (2007)

1.3 General Overview

This service is provided by organisations working in partnership to enable patients to die in their preferred place of care acknowledging the need to identify patient choice. Money made available in 2004 following recommendations from NICE established the service development process and the aim now is to provide equitable access to this service across Hertfordshire, Luton and Bedfordshire..

One of the key outcomes of the national End of Life programme is to increase the numbers of patients with any diagnosis to be cared for in their preferred place of care.

1.4 Objectives

1. To increase the number of patients who are cared for in their preferred place of care.
2. To reduce inappropriate hospital admissions and enable patients to be discharged from hospital where appropriate particularly in the last year of life.
3. To facilitate the increased numbers of patients who die at home if this is their choice.
4. To provide an equitable service to all who require it across Hertfordshire, Luton and Bedfordshire.
5. To act as a source of specialist advice and support to generalist staff.

1.5 Expected Outcomes

1. Increased numbers of deaths at home or in preferred place of care.
2. Reduced inappropriate hospital admissions.
3. Increased numbers of patients with a palliative diagnosis other than cancer being cared for at home.
4. To increase the numbers of patients who spend the last four weeks of their lives in their preferred place of care.
5. To decrease the numbers of patients who die in hospital.
6. Meeting National Standards for End of Life Care.

2. Scope**2.1 Service Description**

This is an integrated service that provides care at the end of life incorporating NICE guidance and using End of Life tools. The service will be integral to existing End of Life tools such as the Liverpool Care Pathway, the Gold Standard Framework and the preferred priorities of care. It will require an integrated collaborative approach to providing care and open and free communication between organisations.

This will be provided by;

1. Using a key worker to coordinate and plan care.
2. Providing hands on practical nursing and emotional and social support.
3. Rapid response to patient need regardless of diagnosis
4. Crisis response when required to prevent inappropriate admission to hospital.
5. Planned response to patient need regardless of diagnosis.
6. Respite for carers using integrated skill mix.
7. Clinical Nurse Specialist assessment 7 days a week.
8. Access to specialist medical advice
9. Bereavement and pre bereavement support
10. Ongoing audit and governance to be in place across all organisations to establish ongoing standards of practice.

2.2 Accessibility/acceptability

Palliative and End of Life patients will be assessed and identified by their GP/DN, Specialist Nurse, hospital consultant or other appropriate Health Care Professional.

Patients access the service through the following mechanisms;

- Referral from other HCP/GP

- Referral from hospital
- Referral from District Nursing Service
- Self referral supported by GP.

Where patients do not meet the referral criteria they will be signposted to other appropriate agencies.

2.3 Whole System Relationships

The Hospice at Home service will work in partnership with GPs, DNs, the Acute Trusts and all Out of Hours services across Hertfordshire, Luton and Bedfordshire. Also all providers working within the system.

2.4 Interdependencies

- Community Nursing Team
- General Practice
- Hospices
- Community Pharmacies
- Out of Hours urgent care services
- Hospital services
- Out of Hours equipment services
- Therapy services
- Chaplaincy
- Marie Curie
- Commissioners of services

2.5 Relevant networks and screening programmes

- Mount Vernon Cancer Network
- Hertfordshire, Luton and Bedfordshire End of Life/ Palliative Care steering Groups

2.6 Sub-contractors

“The service does not use sub-contractors in the delivery of any aspect of service delivery at this present time”

3. Service Delivery

3.1 Service model

This model will include Clinical Nurse Specialists, Registered Nurses and health Care Assistants to provide a mix of specialist assessment, hands on care and ongoing skilled care. This will be linked with the multidisciplinary team and inpatient hospices.

3.2 Care Pathways

The Luton Community Service RAG tool will be used to assess and respond to patient needs.

Pathway 1 – Red – will respond within 4 hours

Pathway 2 – Amber- will respond within 24 hours

Pathway 3- Green – will respond within 3 days.

4. Referral, Access and Acceptance Criteria**4.1 Geographic coverage/boundaries**

The service is operational across Hertfordshire, Luton and Bedfordshire.

4.2 Location(s) of Service Delivery

This service is available to patients in their own home wherever this is deemed to be.

4.3 Days/Hours of operation

Mon	Tue	Wed	Thu	Fri	Sat	Sun

4.4 Referral criteria & sources

This service is available to adult patients over the age of 18 with a palliative care diagnosis who requires; symptom control, complex social support, support for carers and has psychological or spiritual needs. The service is also available to those who require a rapid intervention to support them remaining at or returning to home

The referral criteria for the service are:

- GP/DN
- Hospital doctor/specialist nurse
- Community Specialist Nurses
- Other Health Care professionals
- Self referral supported by the GP.

The sources of referral for the service are:

- Self refer supported by GP
- GP referral direct to service by telephone/fax/email
- DN as GP
- All others via the formal referral route.

4.5 Referral route

- Via fax/email/telephone.

4.6 Exclusion criteria

- Patients who are not registered with GP practices within Hertfordshire, Luton and Bedfordshire.
- Patients under 18 years of age.

4.7 Response time & detail and prioritisation

Priority will be established using the RAG tool. Priority will be given to patients within the Red criteria. Response times will be;

- Red – within 4 hours
- Amber – within 24 hours
- Green- within 3 days.

Assessment of urgency will be carried out and agreed between the referrer and service assessor.

5. Discharge Criteria & Planning

Discharge criteria

The service decides that a patient is ready for discharge if the patient is stable, able to self care or the prognosis improves.

The following procedures are undertaken prior to or upon discharge of each patient.

- Assessment and planning for discharge by.
- Planning and referral on to other agencies if required.
- Contact with GP/DN/Keyworker.
- Ensuring that the patient/carer knows who to contact if their needs change and they have concerns.

6. Self-Care and Patient and Carer Information

- Provision of education around long term conditions
- Provision of group education sessions around long term conditions
- 1:1 counselling sessions
- Signposting to community pharmacies
- Information to signpost patients and carers to self help groups
- Information on the patients condition
- Information and support available via the West Herts Patient and Information and support service via Grove House and WHHT.

7. Quality and Performance Standards

Quality Performance Indicator	Threshold	Method of measurement	Consequence of breach	Report Due
(Infection Control)				

Service User Experience				
Improving Service Users & Carers Experience		Audit of patient surveys		
Unplanned admissions		Record of rapid response events		
Reducing Inequalities				
Reducing Barriers				
(Improving Productivity)				
Access		Number of referrals		
Care Management		PPC, ACP, Rapid response packages, Fast track, Care plan, LCP, number of OOH visits, calls to advice line.		
Outcomes				
Additional Measures for Block Contracts:-				
Staff turnover rates				
Sickness levels				
Agency and bank spend				
Contacts per FTE				

8. Activity

Activity Performance Indicators	Threshold	Method of measurement	Consequence of breach	Report Due

Activity Plan

9. Continual Service Improvement Plan

As part of the monitoring and evaluation procedures, each service will identify a method of agreeing and measurements for continuously improve the service being offered and work to ensure unmet need is both identified and brought to the attention of the Commissioner.

10. Prices & Costs

10.1 Price

Basis of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value
Block/cost & volume/cost per case/Other_____*		£		£
Total		£		£

**delete as appropriate*

10.2 Cost of Service by commissioner

Total Cost of Service	Co-ordinating PCT Total	Associate PCT Total	Associate PCT Total	Associate PCT Total	Total Annual Expected Cost
£	£	£	£	£	£