1. Purpose

This specification describes the services which the commissioner expects to be delivered and maintained throughout the period of the contract. It follows that the provider should notify the commissioner promptly of any in year failure to deliver the service as specified. Significant changes in service will be subject to formal written agreement to vary the contract.

This specification should be read in conjunction with the Rotherham Hospice overall contract and schedules.

The primary purpose of the Rotherham Hospice Specialist Palliative Care Service is to provide specialist palliative care to adults with life limiting illness in Rotherham in support of the primary care teams.

1.1 Aims

‘The aim of the service is to work collaboratively with primary care clinicians to enable patients with specialist palliative care needs to maintain their identity and independence, whilst also supporting their family, friends and carers’ during the changing phases of their illness.

The service will adopt a Multi Disciplinary approach across internal and external services to ensure that services provide complex symptom management and holistic care with the aim of ensuring that patients have the optimum quality of life until death. It will achieve this by working collaboratively across primary and secondary care to facilitate choice in respect to preferred priorities for care and death and thereby contributes towards reducing avoidable hospital admissions and reducing length of stay. We will educate and empower individuals and their families, so they can make informed choices about treatments, management of care, EOLC including all palliative current /future care needs.

1.2 Evidence Base

End of Life Care Strategy (DOH 2008)
End of Life Care Programme (DOH 2004)
Improving Supportive and Palliative Care for Adults with Cancer (NICE 2004)
Building on the Best (DOH 2003)
Priorities and Preferences for End of Life Care in England, Wales and Scotland. (NCHPCS 2003)
NHS Cancer Plan (DOH 2001)
1.3 General Overview

In July 2008, the Department of Health published a national end of life strategy to improve provision of end of life care.

People are generally living longer and of the 50,000 people who die each year in England, two thirds are over 80 years old. The majority of deaths occur in an acute hospital and do so following a period of chronic illness such as heart failure, cancer, stroke, chronic respiratory disease, neurological disease or dementia. Rotherham has a higher than national average death rate from cancer, heart disease and stroke (APHO & DOH 2009). End of life care services aim to support people approaching the end of their life to live as well as possible until they die.

Much of the care for patients with life limiting illness can predominately be managed at a generalist level by the primary care teams; however many of these patients will require additional specialist support to manage complex symptoms, disease progression and pre and post bereavement support for their significant others, the hospice multidisciplinary team will liaise with the primary care team to promote the maximum care for these patients’.

In addition the Hospice palliative care services are there to provide specialist education to support the primary care teams in the management of patients in line with national and local policies and initiatives.


1.4 Objectives

The Rotherham Hospice will provide physical, psychological, social and spiritual support for patients with life limiting illness and is committed to patients requiring palliative care during the changing phases of their illness. The hospice multi disciplinary team will liaise with the wider PCT Team as necessary to promote maximum continuity of support for our patients.

- Allow patient choice in their preferred place of care.
- Assist in the prevention of avoidable hospital admissions.
- Provide specialist palliative care 24 hours a day on the hospice inpatient unit which will include complex symptom management, end of life care, and assessment of a patients changing condition, under the care of a palliative care consultant physician.
- Provide specialist palliative care for patients attending the Day Hospice between 10.00-15.00 Monday to Friday which includes ongoing assessment, therapeutic activities and advanced care planning, hair dressing and chiropody.
- Provide an advice line for day hospice patients and their carers Monday to Friday 09.00-17.00.
- Provide a 24 hour advice line for health care professionals.
- Pre and post bereavement support for the patient’s family and carers.
- Enable patients to maintain their identity and independence, whilst we also support their family,
friends’ and carers.
- Multidisciplinary education and support to healthcare workers working at generalist palliative care level.
- Actively support and promote specialist palliative care EOLC services in Rotherham.

1.5 Expected Outcomes

- More patients achieving their preferred place of care at the end of their lives.
- A reduction of inappropriate hospital admissions.
- All patients within the last stage of their life are on the End of Life Care Pathway (LCP).
- Improved quality of life and the promotion of dignity and self worth for patients.
- Patients and their families and carers are supported through the changes of their disease progression to death and bereavement.
- Patients experience an improvement in their symptoms.
- Compliance with CQUINS peer review measures.

2. Scope

2.1 Service Description

- The Hospice Inpatient Unit provides specialist palliative care 24 hours a day, 7 days a week for patients requiring end of life care, complex symptom management and assessment of their changing condition and/or disease progression.
- The Day Hospice provides specialist palliative care for 15 patients a day between the hours of 10.00-15.00 Monday to Friday. Individualised patient care includes ongoing assessment of the patients’ condition, therapeutic activities and advanced care planning.
- The service is a resource for advice and support for health care professionals in the community and hospital settings.
- The holistic needs of the patients will be assessed.
- Holistic needs of the carers will be assessed and support and advice given if required.
- The multidisciplinary team provide a holistic package of clinical care, including pain management, addressing the physical, psychological and spiritual needs of patients.
- The hospice services also includes the provision of complex symptom management, end of life care, specialist assessment.
- The service will provide specialist palliative care education to health care professionals in both the community and acute services.
- Bereavement support offered.
- Services available are; Medical Care, Nursing Care, Occupational Therapy, Physiotherapy, Social Worker, Dietician, Chaplain Support, Complementary Therapies, Psychological Support.
- The Hospice will provide and promote best practice in accordance with local and national end of life care initiatives.
- The current GPwSI provision is under review.

2.2 Accessibility/acceptability

The service is available to adults over the age of 18 years, regardless of ethnicity, sexuality,
faith or gender. It is provided for patients requiring specialist palliative care who have an active, progressive, advanced and terminal illness & a complex level of need. The service will encourage a positive and sensitive approach to issues of sexual orientation and gender identity and ensure that questions and activities do not assume that service users are heterosexual.

The service will work closely with families and carers to encourage appropriate packages of support are in place.

The service will strive to ensure that it is fully accessible and responsive to the diverse needs of all groups and communities it serves. The service will provide tailored support for black and minority ethnic (BME) elders their carer’s and families. Training needs will be identified and facilitated that will provide staff with the appropriate training to ensure a culturally sensitive approach is adopted. The team will actively engage with the BME community and individuals with learning disabilities including their family/carers, with a view to raising awareness of palliative medical care to ensure preferred priorities of care is offered.

Complex level of need means exceeding the skills, facilities etc of an appropriately resourced primary health care team (including community matron or disease-specific nurse specialist), hospital ward or residential/nursing home. Complex needs can be patient, carer or health care team centred and the help required may be intermittent or continuous depending on the level of need and rate of disease progression.

Integrated working across the hospice and community palliative care services ensures that patients are provided with continuity of care and easy access to all areas of the service when required.

Acceptance of a patient is at the discretion of the provider.

2.3 Whole System Relationships

The service is provided as part of an integrated approach to end of life care within the Rotherham area which includes collaborative working with GP’s practices, district nursing services, community physiotherapists and occupational therapists and other community services, nursing homes, community hospitals and establishments, the Foundation hospital trust.

2.4 Interdependencies

- GP’s
- All community nursing and therapy services.
- Foundation Hospital Trust.
- Macmillan
- Marie Curie/Liverpool Care Pathway
- Voluntary sector

2.5 Relevant networks and screening programmes
• North Trent Cancer Network
• Rotherham Cancer Centre
• National Council for Palliative Care

2.6 Cross Border Care Agreement

Access to the hospice specialist palliative care services is available to patients registered with a Rotherham GP.

Access for patients outside this criterion is at the joint provider and host commissioners discretion.

3. Service Delivery

3.1 Service model

• The service will be delivered by staff at the Rotherham Hospice who work in collaboration with the community palliative care service to ensure that the patient and their families receive the optimum standard of care and support.
• Care will be provided in the hospice inpatient unit and day hospice.
• The service will adhere to Care Quality Commission standards and ensure that CQC registration status is maintained.
• The service will provide a 24 hour advice line for the advice and support of other healthcare professionals.
• The service will be expected to maintain accurate and contemporaneous clinical records in accordance with PCT and Hospice policy and in adherence to professional regulatory bodies (e.g. NMC).
• The service will be expected to make full use of the IT systems, particularly Clinical Information Systems (i.e. System one) for maintaining accurate records in order to facilitate audit, reporting and performance management.
• The service will ensure that all staff are competent practitioners through the use of competency packages and ongoing mandatory training programmes and clinical supervision
• The key elements of the service;
  o The provision of hospice based specialist palliative care to patients in Rotherham.
  o The provision of palliative care education and training to the wider healthcare community.
  o Advice and support to healthcare professionals.

3.2 Care Pathways

The service is to provide care in accordance with agreed local clinical guidelines.
• Liverpool Care Pathway- Version 12
• Gold Standard Framework
• Preferred Priorities for Care
4. Referral, Access and Acceptance Criteria

4.1 Geographic coverage/boundaries

Access to the hospice specialist palliative care services is available to patients registered with a Rotherham GP.

Access for patients outside this criterion is at the joint provider and host commissioners discretion.

4.2 Location of service delivery

<table>
<thead>
<tr>
<th>Location</th>
<th>Days/months</th>
<th>Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rotherham Hospice Inpatient</td>
<td>365 days per year</td>
<td>24 hours a day</td>
</tr>
</tbody>
</table>
4.3 Referral Criteria and sources

- Referrals can be made for any adults over the age of 18 years, requiring specialist palliative care who have an active, progressive, advanced and terminal illness & a complex level of need.
- Referrals for inpatient unit admission are accepted from any Health care professional involved in the care of the patient.
- Referrals for Day Hospice can be made by anyone including the patient themselves.
- Referrals are managed and prioritised on a daily basis by the hospice medical and nursing staff.

4.4 Referral route

- By faxed, posted or emailed referral form.
- Telephone but referrals must be supported by a written referral form which can be faxed for urgent attention.
- Self referral by patients and carers to the day hospice can be made by telephone only.

All referrals to the inpatient unit will be triaged as soon as possible or at the latest the following morning by the hospice doctor and senior nursing staff. Admission is made on a priority basis. For all patients referred to the Inpatient Unit, the referrer will be contacted within 24 hours and the patient contacted only if appropriate. The referrer is then advised of the bed status at the Hospice at that current time. Contact is then maintained with the referrer until an Inpatient Unit bed becomes available.

Patients referred to the day hospice will be contacted by phone within 3 days. An assessment will be made within 2 weeks and attendance at the day hospice facilitated in 3 weeks. Referrals to day hospice are triaged according to urgency and then by date of referral.

4.5 Exclusion criteria

- Anyone under the age of 18 years with the exception of children or young adults requiring pre/post bereavement support.
- Anyone who does not require palliative care intervention at level 3 (except for day hospice attendance where a level 2 requirement is acceptable).

5. Discharge Criteria & Planning
Patients at the end stage of their disease are never discharged from the specialist palliative care service but discharge from the hospice to other parts of the service for community support, day care or family support does occur.

Patient discharge from both the Inpatient unit and Day hospice is based on individual patient needs and wishes; a multidisciplinary approach is taken to discharge planning.

Discharge criteria;
- Patient choice.
- Improvement to symptoms reducing care requirement to level 2.
- Optimum level of health reached.

An MDT / all systems approach is utilised to ensure that other services such as Hospice at home, Macmillan nurse specialists, district nurses and social services are involved as appropriate on the patients discharge.

6. Self-Care and Patient and Carer Information

On admission to the service every patient has a holistic assessment and an individualised plan of care which addresses their physical, psychological, social and spiritual needs. This plan is developed with the agreement of the patient and family and is continuously reviewed and evaluated with their involvement.

The individualised plan of care should include;
- A thorough and holistic assessment of the patient.
- Individualised plan of care tailored to the patient’s needs.
- Ongoing assessment and evaluation of the patient’s condition.
- Medication monitoring, evaluation and review.
- Appropriate patient and carer information.

The hospice provides a range of printed information for patients, carers and health professionals that meet the required national and local information regulations. The service also ensures that patients and carers have information about other services available to them for example PPE, Carers forums and local authority support services.

Information on user involvement and complaint/comment procedures is available in the hospice in patient and day care units.

7. Quality and Performance Standards

<table>
<thead>
<tr>
<th>Quality Performance Indicator</th>
<th>Threshold</th>
<th>Method of measurement</th>
<th>Consequence of breach</th>
<th>Report Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention/Control</td>
<td>Through Quality &amp; Patient services framework</td>
<td>audit</td>
<td></td>
<td>Internally 3months</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Commissioner</td>
<td>Annually</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Internally 3months</td>
</tr>
<tr>
<td>Service User Experience</td>
<td>Governance framework</td>
<td>Audit</td>
<td>Commissioner Annually</td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td>----------------------</td>
<td>-------</td>
<td>-----------------------</td>
<td></td>
</tr>
<tr>
<td>Improving Service Users &amp; Carers Experience</td>
<td>Through Governance framework</td>
<td>audit</td>
<td>Internally 3months Commissioner Annually</td>
<td></td>
</tr>
<tr>
<td>Unplanned admissions</td>
<td>% of planned admissions</td>
<td>Electronic patient Information database</td>
<td>Internally 3months Commissioner Annually</td>
<td></td>
</tr>
<tr>
<td>Outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Preferred place of care.</td>
<td>Through Governance framework</td>
<td>Patient records</td>
<td>Internally 3months Commissioner Annually</td>
<td></td>
</tr>
<tr>
<td>• Reduction in inappropriate admissions.</td>
<td>% of admissions</td>
<td>Electronic patient Information database</td>
<td>Internally 3months Commissioner Annually</td>
<td></td>
</tr>
<tr>
<td>• Patients on the Liverpool Care Pathway (LCP) at death.</td>
<td>Through Governance framework</td>
<td>End of Life Care Pathway audit</td>
<td>Internally 3months Commissioner Annually</td>
<td></td>
</tr>
<tr>
<td>• Improved quality of life and promotion of dignity.</td>
<td>Through Governance framework</td>
<td>Patient records</td>
<td>Internally 3months Commissioner Annually</td>
<td></td>
</tr>
<tr>
<td>• An improvement in patient symptoms</td>
<td>Through Governance framework</td>
<td>Patient records</td>
<td>Internally 3months Commissioner Annually</td>
<td></td>
</tr>
<tr>
<td>• CQUINS</td>
<td>% of compliance with CQUINS peer review measures.</td>
<td>Audit</td>
<td>Annual review</td>
<td></td>
</tr>
</tbody>
</table>

Additional Measures for Block Contracts:-

<table>
<thead>
<tr>
<th>Staff turnover rates</th>
<th>Through Governance framework</th>
<th>HR Database</th>
<th>Internally 3months Commissioner Annually</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sickness levels</td>
<td>Through Governance framework</td>
<td>HR Database</td>
<td>Internally 3months Commissioner Annually</td>
</tr>
<tr>
<td>Agency and bank spend</td>
<td>Through Governance framework</td>
<td>Hospice report</td>
<td>Internally 3months Commissioner Annually</td>
</tr>
</tbody>
</table>

Quality is demonstrated by the patient surveys that are regularly carried out and also the letters of appreciation and thank you cards that are received.
- All assessments and treatments to be performed by staff with appropriate qualifications, training and experience.
- For all patients referred to the Inpatient Unit, the referrer will be contacted within 24 hours and the patient contacted only if appropriate. The referrer is then advised of the bed status at the Hospice at that current time.
- Contact is then maintained with the referrer until an Inpatient Unit bed becomes available.
- Service specific audits are undertaken each year.
- Regular Patient/User Surveys are carried out for the Inpatient Service.
- All staff have annual Personal Development Reviews and access to ongoing training and support.

<table>
<thead>
<tr>
<th>Activity Performance Indicators</th>
<th>Threshold</th>
<th>Method of measurement</th>
<th>Consequence of breach</th>
<th>Report Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time from referral to referrer contact (inpatient)</td>
<td>24 hours</td>
<td>Electronic patient record</td>
<td>Internally 3months Commissioner Annually</td>
<td></td>
</tr>
<tr>
<td>Time from referral to 1st contact (day hospice)</td>
<td>3 days</td>
<td>Electronic patient record</td>
<td>Internally 3months Commissioner Annually</td>
<td></td>
</tr>
<tr>
<td><strong>Number of patients with a diagnosis other than cancer</strong></td>
<td>Decrease in non-cancer to cancer ratio</td>
<td>Electronic patient Information database</td>
<td>Internally 3months Commissioner Annually</td>
<td></td>
</tr>
<tr>
<td>Bed Occupancy</td>
<td>80% occupancy level</td>
<td>Electronic patient Information database</td>
<td>Internally 3months Commissioner Annually</td>
<td></td>
</tr>
<tr>
<td>Day hospice DNA / CAN</td>
<td>% attendance</td>
<td>Electronic patient Information database</td>
<td>Internally 3months Commissioner Annually</td>
<td></td>
</tr>
<tr>
<td>Deaths (day hospice/inpatient unit)</td>
<td></td>
<td>Electronic patient Information database</td>
<td>Internally 3months Commissioner Annually</td>
<td></td>
</tr>
<tr>
<td>Discharges (day hospice/inpatient unit)</td>
<td></td>
<td>Electronic patient Information database</td>
<td>Internally 3months Commissioner Annually</td>
<td></td>
</tr>
<tr>
<td>Reason for admission (inpatient unit)</td>
<td></td>
<td>Electronic patient Information database</td>
<td>Internally 3months Commissioner Annually</td>
<td></td>
</tr>
<tr>
<td>Referral source (day hospice/inpatient unit)</td>
<td></td>
<td>Electronic patient Information database</td>
<td>Internally 3months Commissioner Annually</td>
<td></td>
</tr>
</tbody>
</table>
Support for professionals  | Number of structured educational sessions delivered  | Training records  | Internally 3months Commissioner Annually
---|---|---|---

**Activity Plan**

1. activity/contact data  
2. evidence based protocols/guidance  
3. audit  
4. patient/user/carer satisfaction survey

**9. Continual Service Improvement Plan**

Service provision and development is informed by the Department of Health’s initiatives in palliative care and the End of Life Care Strategy [http://www.endoflifecareforadults.nhs.uk/eolc/](http://www.endoflifecareforadults.nhs.uk/eolc/)

Yet to be agreed but would include:

- Broadening support for wider end of life care/palliative care services through more structured training and education
- Redesign to ensure compliance with forthcoming updated CQUINS peer review measures (due September 2010)
- Consideration of adoption of RBC model of care.

Any future developments will be considered through the hospice governance framework and submitted and approved through contract review processes

**10. Prices & Costs**

See finance schedule

**10.1 Price**

<table>
<thead>
<tr>
<th>Basis of Contract</th>
<th>Unit of Measurement</th>
<th>Price</th>
<th>Thresholds</th>
<th>Expected Annual Contract Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block/cost &amp; volume/cost per case/Other</td>
<td></td>
<td>£</td>
<td></td>
<td>£</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>£</td>
<td></td>
<td>£</td>
</tr>
</tbody>
</table>

*delete as appropriate*
### 10.2 Cost of Service by commissioner

<table>
<thead>
<tr>
<th>Total Cost of Service</th>
<th>Co-ordinating PCT Total</th>
<th>Associate PCT Total</th>
<th>Associate PCT Total</th>
<th>Associate PCT Total</th>
<th>Total Annual Expected Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
</tbody>
</table>