SCHEDULE 1 - THE PROJECT

SERVICE SPECIFICATION

Service	**Inpatient Hospice, Day Hospice and Family Support Jigsaw Children's Hospice**
Commissioner Lead	**Sharon Kelly, Head of Commissioning**
Provider Lead	**Eden Valley Hospice – Julie Clayton**
Period	**1st April 2023 – 31st March 2024 (subject to annual review)**

1. Purpose

1.1 Overall principles

- The service specification for this service has been developed by the commissioner taking account of local need, other commissioned services and the health needs of the local population. Any significant changes proposed by the provider that could impact significantly on the service will be discussed and agreed with the commissioner prior to implementation. Minor changes or temporary changes to accommodation operational issues should be notified to the commissioner as part of the service issues log discussed at the regular service review meetings – at a minimum of six monthly.

- The provider is expected to engage with the commissioning body/bodies in all instances of service development or anticipated re-design consultations for the benefit of service delivery across the whole health community.

- The provider is required to provide age - appropriate services.

- The provider is expected to engage with the commissioner regarding such commissioning policies (as published on the website) that are relevant to the service

- The provider is expected to provide representation on all relevant working or commissioning groups as appropriate.

- The provider is expected to participate in surge planning as part of the wider Health Economy response to pressures throughout the year, whether those pressures be anticipated or unplanned and be prepared to deploy the workforce flexibly where this is indicated. The provider will be expected to notify the commissioning body and key Health Economy stakeholders of agreed levels of escalation. Unforeseen surges in activity as a result of escalation in the health community will be discussed at contract meetings and alterations to activity profiles reviewed.

Aims

This service specification aims to describe the relationship that Eden Valley Hospice has with: secondary care; primary care and other specialist palliative care providers to ensure the delivery of a fully integrated service that improves patient and carer experience and is easily accessible.

The aim of the service is to work in partnership with a range of providers to support adults in Cumbria, with any condition, who require palliative care expertise to supplement the care provided by the core Primary Health Care Team and secondary care services. A Hospice service will also be offered to children and young people with life

limiting and life threatening conditions. The service will also provide specialised palliative care support, training and advice to primary and secondary care services.

1.2 Evidence Base

- DoH End of Life Strategy – promoting high quality care for all adults at the end of life (July 2008)
- Our commitment to you for end of life care: The Government Response to the Review of Choice in End of Life Care July 2016
- DoH End of Life Care Strategy – quality markers (June 2009)
- NICE Guidance (2004) Improving Supportive and Palliative Care for adults with cancer.
- Equity and Excellence 'Liberating the NHS
- 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)
- Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020
- The Government's mandate to NHS England for 2017-18
- NHS Five Year Forward View 2014
- NICE Guidance (2016) – End of life care for infants, children and young people with life limiting conditions: Planning and management (NG61)
- NHSE Long Term Plan 2019

Local strategic direction Documents

- Commissioning Strategy for End of life Care for Adults in Cumbria (2016-2021)
- Care Closer to Home, offering support for patients to die at home should they choose (Cumbria 2008)
- Cumbria Joint Health and Wellbeing Strategy 2019-29
- West North & East Cumbria Sustainability and Transformation Plan (2016-2021)
- North Cumbria Health & Care Strategy 2020-2024

1.3 General Overview

The service is provided by working in partnership with all generalist and specialist health care providers and other statutory and voluntary organisations. The aim is to support patient choice, particularly around preferred place of care, acknowledging the need to identify and document these choices. 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. This is in line with the NECN priority to reduce Hospital deaths by 10%.

The role of the Charity is to support the provision and development of palliative care provided to people in the local community in line with the National Health Services (NHS) agenda, local need and the Cumbria End of Life Strategy (2016). This is in accordance with the Memorandum and Articles of the Association of the Company. The mission statement being:

Eden Valley Hospice provides palliative care services for adults and children with incurable or life limiting illnesses, enabling them and their carers to live life as fully and independently as possible.

Our purpose is to maintain and extend the availability of high quality palliative care services for adults and children.

1.4 Objectives

The objectives of the service are to;

- Deliver a comprehensive specialist palliative care service, including in patient care, out patients and day hospice care.
- Deliver a comprehensive specialist service for children and young people with life limiting and life threatening conditions including in patient support and develop future support in community settings.
- Deliver specialist advice, for health professionals, on a 24/7 basis 365 days of the year.

- Provide multi-disciplinary support to palliative patients and their carers. This includes counselling and bereavement support, emotional and social care. These will be provided through the use of Day Hospice, outpatient clinics, carer support groups, One to One support and Complementary Therapy.
- Provide relief for patients from pain and other distressing symptoms
- Provide specialist support and advice for carers and members of the primary care team in complex situations where advanced communication skills are required, including 24 hour specialist medical advice for other health care professionals
- Offer a support system to help families and carers cope during the patients' illness and in bereavement.
- Complement, and work in partnership with, the North Cumbria Integrated Care System, to provide high quality care to patients who are palliative or at the end of life and their families and carers.
- Reduce inappropriate hospital admissions and enable patients to be discharged from hospital where appropriate particularly at end of life.
- Seek to continually improve patient and carer experience
- Act as a specialised support to generalist staff providing hands on support and training
- Work in partnership with other services to provide care.
- For the children and young people's service, work as one integrated team with the NCIC Children's Community Nursing Team.

1.5 Outcomes

- People supported to make choices and decisions about their care
- Improved patient and carer satisfaction around palliative care and bereavement support.
- The needs of families and others identified as important to the person are actively explored, respected and met as far as possible.
- High quality care delivered by well trained staff.
- Contribution to increased numbers of deaths in preferred place of care.
- Contribution to reduced inappropriate hospital admissions.
- Contribution to increased numbers of patients with a palliative diagnosis, for all conditions, being cared for at home.
- Contribution to decreased numbers of patients who die in hospital.
- Collaborative and integrated working with all local providers of palliative an end of life care both within and outside the NHS.
- Improved advanced care planning, choice and preference recording,
- Contribution to a reduction in the number of delayed transfers of care.
- Contribution to a reduction in the number of non-elective admissions.

2. Scope

2.1 Service Description

Eden Valley Hospice is one of a number of integrated services which provide care at the end of life incorporating NICE guidance and using End of Life tools. Delivery of the service requires an integrated collaborative approach to providing care and open communication between organisations. It will provide specialist palliative care support and advice to patients with complex needs and their personal and professional carers. The service will be delivered both within the hospice and reaching out into the community.

The service will provide:

- Specialised inpatient care
- Inpatient, outpatient and community medical assessment
- Day hospice care
- Family Support Services including:
  - Bereavement, social and spiritual care, support groups, creative therapies and complementary therapies.

This will be provided through

- Skilled nursing
- Specialist medical care (for adults)
- Emotional, social and therapeutic support
- Prompt response to patient need
- Planned admission and assessment for patients to support carers.
- Access to specialist medical and nursing advice 24/7
- Access to a skilled multi-disciplinary team.

All of the above will be delivered within the principles of ***Deciding Right – an integrated approach to making care decisions in advance with children, young people and adults*** and the evolving ReSPECT framework

It is considered best practice for children with complex medical needs to have an advanced care or emergency health care plan which covers issues relevant to the urgent and emergency care of the child as well as outlining expected practice for respiratory and cardiac support during life threatening episodes. Our expectation would be that the responsible clinician for the child holds that discussion with the family and the wider care team and agrees the details of that plan before communicating it to all relevant professionals. The service will therefore be expected to provide care that is consistent with advanced care or emergency health care plans.

Ongoing audit and governance to be in place across the organisation to establish ongoing standards of practice in line with DoH Quality Markers and other agreed standards.

2.2 Accessibility/acceptability
Palliative and End of Life patients will be assessed and identified by their GP, Community Nurse, Clinical Nurse Specialist or other Health or Social Care Professionals.
Referrals to this service will be discussed with the patient and/or their family/carers, and consent gained, prior to the referral being made.

Once a referral is received, contact with the patient and family will be within one working day if the referral is urgent and 1-3 working days if the referral is non-urgent.

Referrals will be accepted from:

- Any health or social care professional
- Any independent sector specialist palliative care provider
- The patient or their carer/relative

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

2.3 Whole System Relationships
The North East & North Cumbria Integrated Care Board (North Cumbria Place) will ensure integrated services across the entire health economy, reducing boundaries and increasing integration of pathways. Successful delivery will depend on a working relationship between providers to ensure the delivery of a seamless service in the community for patients with health (physical and mental) needs taking account of the priorities identified by the North Cumbria Integrated Care Partnership Board

2.4 Interdependencies
Provision of high quality care for both patients and carers depends heavily on collaborative working across a wide range of agencies who may be involved in the delivery of care.

The list of inter-organisational interdependencies includes, but is not limited to:

- Independent and voluntary sector specialist palliative care providers
- Cumbria County Council Adult Social Care directorate (From 1 April 2023 this will be replaced by Cumberland Unitary Authority)

- Cumbria County Council Children's Services (From 1 April 2023 this will be replaced by Cumberland Unitary Authority)
- North Cumbria Integrated Care Communities
- Care homes
- GPs, consultants, community nurses and other health care professionals in both a primary and secondary care setting
- North West Ambulance Service
- Cumbria Health On Call (CHOC)
- Pharmacies
- Domiciliary care agencies
- Early help providers

Delivery of the service is also heavily dependent on the full understanding, and use of, the nationally recognised End of Life Care Tools:

- **The Gold Standards Framework (GSF)**

And, the NHS North of England end of life framework:

- **Deciding Right**.
- **ReSPECT**
- **Care of the Dying Patient**
- **Childrens standards for Palliative care (NICE quality standards)**

In order to ensure compliance with the above the service will need to:

- Provide an appropriately trained workforce – in line with the Cumbria and Lancashire End of Life Network Education Strategy and the North Cumbria end of life education implementation plan.
- Play an active role in multi-disciplinary team meetings to discuss and review the patients' conditions and care plan
- Ensure flexibility to allow care to be provided in a setting that meets the patients' needs and preferences
- Comply with the requirements of the EPaCCS and Section 11, below, using EMIS as supplied and maintained by the CCG.

2.5 Relevant networks

The provider of the service described in this specification will be expected to nominate a representative to take an active part in the following groups:

- West North East Cumbria End of Life Care Strategy Group
- North Cumbria Palliative and End of Life Care Education Group
- Children's Integrated Implementation Group

The provider will also be expected to keep fully informed of the activities and direction from the:

- North of England Strategic Clinical Network
- Cumbria End of Life Prescribing Group

2.6 Information Sharing

Eden Valley Hospice will use EMIS to store and record patient records and service activity.
Eden Valley Hospice will complete the NHS Information Governance toolkit (Business Partner Section).
Commitment to the information sharing agreement will be maintained by all organisations.
Eden Valley Hospice will comply with Information sharing requirements, as identified by the roll out and implementation of the EPaCCS system – See 2.4 above.

2.7 Sub-contractors

The provider will not sub-contract delivery of any aspect of this service without prior agreement from commissioners. However, Eden Valley Hospice may work in partnership with other specialised palliative care providers to provide care across service boundaries.

3. Service Model

3.1 Service model
The service model for the delivery of specialist palliative care in North Cumbria is based on the Cumbria service model for the treatment of long term conditions, where a specialist team is both a support for complex patients and a resource for GP practices and system leaders in implementing high quality standards of care.

The specialist palliative care service includes: specialist nursing; medical input; support services and training into GP practices and other services such as: generalist community nursing teams; secondary care teams and social care providers, who may be required to deliver care to palliative and end of life patients. The 3 North Cumbria independent charitable hospices are an integral part of this model with all providers working collaboratively to deliver high quality end of life care.

To achieve a whole system and care pathway approach that will ensure the delivery of a fully integrated service North Cumbria has adopted the model of care developed by the North West End of Life Care Clinical Pathway Group – see Appendix 1

3.2 Local care pathway
North East & North Cumbria ICB (North Cumbria Place), as part of the North Cumbria Integrated Care Partnership, is committed to making a difference to people's lives by improving the health and wellbeing of individuals and their families and improving the day to day experience of patients and those working to deliver better health care.
The ICB is part of an Integrated Care System (ICS) – a way of working that enables all organisations to combine their collective resources and expertise locally and regionally to plan, deliver and join-up health and care so our communities can live happier and healthier lives.

Integrated Care Communities (ICCs) are in place across North Cumbria recognising that people in Cumbria need to be at the centre of an integrated health and social care service, and need to be empowered to stay well rather than simply be treated for ill health.

The Integrated Care Community (ICC) model focuses on improving Out of Hospital services, enabling more care to be provided in the community, closer to home – in the right place at the right time

The ICC is made up of three elements:
1. the place based – understanding the local population and commissioning local health and care services by working with local communities in ICCs
2. the experience – this is about empowering local people to stay fit and healthy so ICCs will link to local groups and community assets to bring about change in population health
3. the integrated health and social care team. These are integrated teams comprising health and social care professionals working in the same team to deliver coordinated care.

4. Referral, Access and Acceptance Criteria

4.1 Geographic coverage/boundaries

Locality	Allerdale	Copeland	Carlisle	Eden
Service available	North Allerdale			

Primarily, for adults, the service will operate across Carlisle, Eden and North Allerdale localities although referrals are also accepted from South Allerdale and Copeland localities.

For children and young people the service will accept referrals from across North Cumbria. Referrals from south Cumbria are outwith this service level agreement.

2 Location(s) of Service Delivery
This service will be provided from Eden Valley Hospice, also offering outreach support into the community.

3 Days/Hours of operation
Adult:
Inpatient Care:
24 hour service, 7 days a week; 365 days a year.

Day Hospice:
Monday to Friday 9.am – 5pm

Family Support Team:
Accessible Monday to Friday 9am – 5pm

Jigsaw Children's Hospice:
24 hour service, 7 days a week; 365 days a year (currently open 5 days out of 7)

4.4 Referral criteria & sources
The service will be available to adult patients with progressive, life threatening, incurable illness. These will be patients who have difficult and/or complex needs, which cannot be met by other teams, and require specialist palliative care, or are in the last few days of life and seek end of life care in their preferred place of care.

The source of referral for all services are:
- GP
- Community Nurses
- Specialist Doctors/Specialist Nurses
- Other Health Care professionals
- Voluntary Organisations
- Self or carer referral

4.5 Referral route
Primary source via EMIS and Strata but also accepted via telephone, letter, email or in person.

4.6 Exclusion criteria
People requiring acute investigation, or with suspected spinal cord compression needing urgent investigation and treatment, will not usually be admitted to Eden Valley Hospice inpatient service

4.6 Response time and prioritisation

A response being defined as care being provided within 24 hours of the requested shift (to be managed through EMIS)

Inpatient Care:
Priority will be given to all patients classified as "urgent".

Urgent would be those patients who:

- Are nearing the last days of life.
- Urgently require symptom control
- Are no longer able to cope in their existing care setting
- Wish to be discharged from hospital to their preferred place of care
- Are at risk of being admitted to hospital
- Patients at risk of palliative care emergencies

Non-urgent would be those patients who require

- Input into pain and symptom management
- Respite care to relieve carer stress/distress
- A comprehensive assessment of a care situation/environment

Planned would be those patients who require:

- Carer support
- Patient support

Response times will be;
Urgent – within 24 hours
Non-urgent – within 1-3 days
Planned – as appropriate

4.8 Out of Hours Access
24/7 Medical advice for health professionals is provided by Eden Valley Hospice. Patients are admitted to the inpatient service 7 days a week

5. Compliance with Legislation and Registration

Services must be delivered in compliance with statute, legislation, professional and organisational registration requirements; for example with the Care Quality Commission, safeguarding, infection prevention, security, fire and health and safety requirements.

6. Discharge Criteria and Planning

Discharge process and criteria

This service will be provided according to client needs and will not automatically be time limited however clients will be regularly reviewed and progress discussed between therapists and other providers involved in delivering the package of care. A service user will be ready for discharge if they are stable, able to self-care or the prognosis improves.

The discharge process will be as follows:

- Assess and plan the discharge – involving all agencies involved in delivery of the care plan.
- Refer on to other agencies if required.
- Contact the GP/DN/CCN/Keyworker.
- Ensure that the patient/carer has details of a point of contact if required.
- Complete special patient form and NWAS/transport provider notification.
- Share patient documentation with the GP and other providers as required.

7. Self-Care and Patient and Carer Information

The provider will develop specific end of life care education tools and information materials, in line with the North Cumbria end of life education implementation plan, to support patient self care and the ongoing development of other health and social care professionals.

8. Business Continuity and Emergency Planning

Eden Valley Hospice shall be required to demonstrate that contingency plans are in place for the following circumstances:

- Peaks in demand
- Impact of adverse weather
- Risk of Cyber attack
- Emergencies, whether due to loss of staff or major health incident

As a minimum the provider will:

- Perform a business impact analysis and a risk assessment
- Take steps to mitigate or eliminate risks
- Create business continuity plans for high risks to ensure that the service will be maintained in the event of disruption however caused.
- Exercise, debrief and review business continuity plans annually.

Evidence of the above will be provided to North East & North Cumbria ICB (North Cumbria Place) annually.
In the case of a serious untoward incident, the provider will follow the North East & North Cumbria ICB 9North Cumbria Place) reporting protocol and provide reports, updates on action plans and lessons learned to the relevant ICB committee.

9. Continual Service Improvement and Education

Re-designing integrated pathways that are patient centred and that are accessible close to home is the key strategic objective of North East & North Cumbria ICB (North Cumbria Place). Providers will demonstrate their plans for the continual improvement and development of their service; including, wherever appropriate, the ongoing professional development and education of the provider workforce. This will ensure the establishment of a flexible workforce that can deliver an integrated pathway approach. Improvement plans must be based on the performance framework set out in section 11. Provider's must co-operate with North East & North Cumbria ICB (North Cumbria Place) in all ongoing performance improvement initiatives and audit programmes.

This may be achieved through the use of collaborative learning networks for example CLIC and the use of continuous service improvement methodologies.

The provider will develop a strategic plan and action plan.

10. Equality and Diversity

The provider shall not discriminate between, or against patients or carers on the grounds of gender, age, ethnicity, disability, religion or belief, sexual orientation or any other non-medical characteristics. The provider shall make available appropriate assistance and make reasonable adjustments for patients and carers who do not speak, read

or write English, or who have communication difficulties (including without limitation hearing, oral or learning impairments). Refer to NHS Standard Contract Service Conditions for specific legislative requirements

11. Quality and Performance Standards

Delivery of this specification will play a key role in achieving national and local indicators. These indicators rely on joint working across organisational boundaries in the delivery of seamless care.

Performance Indicator	Indicator	Threshold	Method of Measurement
National Indicators	Increase of deaths at home	Target – 50% of deaths	Local data capture
Local indicators: Personalised Care Planning	Increased use of Care plans, and education programmes	Every patient who is admitted to the caseload will undergo an individualised holistic assessment. This will be repeated at key intervals.	Audit care plans – 6 monthly
	Increased use of Advanced Statements.	100% of patients with capacity to consent will be offered an opportunity to make and record an advanced statement	Audit care plans – 6 monthly
Improving Service Users & Carers Experience	Improved Patient satisfaction	Positive response in 75% of questions	Patient survey – annually, but also ongoing as captured by 'I want great care'
	Improvement of service provision in line with patient experience.	Evidence of service user and patient input to design of service	Minutes of meetings. Quality Accounts Response to complaints and feedback
	Improvement in the Service Users assessment of their ability to cope	60% positive	Local Audit
Improving quality	Development and implementation of service improvement plan in partnership with West North East Cumbria End of Life Care Strategy Group	Agreed plan with timescales in place.	Introduction of OACC as quality assessment tool
Improving Productivity	Maintain activity and cost	Breakeven and achieve service delivery and cost improvement	Annual accounts
Reducing Inequalities	Equality Impact Assessment (EIA) to be applied to all Eden Valley Hospice policies as they are developed and reviewed.	100% of policies to be assessed	Evidence of EIA to be provided annually
Mental Capacity Act & Deprivation of Liberty	All staff should receive appropriate level training in relation to the mental capacity act and deprivation of liberty	All existing staff and new staff within 6 months of commencement of employment	Evidence on training record – to be shown as % of workforce. Evidenced in the bi-annual Hospice dashboard.

Complaints, compliments, concerns and comments	Numbers reported, themes, actions and lessons learned	100%	Issue, actions taken and lessons learned to be reported six monthly.
Serious untoward incidents	Numbers reported, themes and lessons learned.	100%	SUIs by numbers, service, type and lessons learned to be reported six monthly. (See 8 above)

12. Activity

Activity Performance Indicators	Threshold	Method of measurement	Consequence of breach
In patient Preferred Priorities of Care	60% deaths in place of choice - measured against individual Advanced Statement , where completed		
Care planning Number of people with agreed care plans	100%		
Response times within: • Urgent – within 24 hours • Non-urgent – within 1-3 days • Routine – within 5 working days	100% as detailed – measured via internal audit.		
Activity Data **In Patient** Bed occupancy Average Length of stay Number of admissions Outcome of admissions **Day Hospice** Number of new patients Number of attendees **Out patients** Number of new patients Follow up appointments	70% occupancy Minimum of 200 adults per year - inpatient Minimum of 80 adults per year – attendees at day hospice		
Family Support Number of people receiving bereavement support			

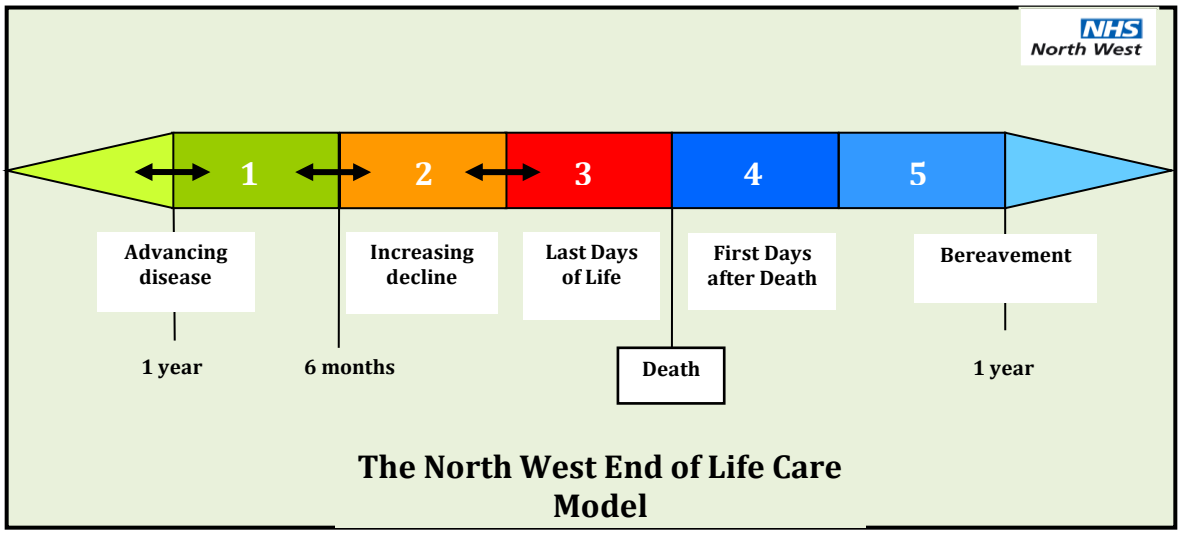
13. Terms of Agreement

Delivery of the service described within this specification will be supported by the provision of:

- Access to NHS IT support to clinical staff
- Access to NHS Training via the NCIC Learning Network
- Cost of bloods, Oxygen, medicines, x rays, scans, dressings as required – EVH will recharge North East & North Cumbria ICB..
- A fixed contribution of £37,791 towards the increase in NHS Pension contributions from 7 –14 per cent – as introduced in 2003.

Appendix 1

The North West End of Life Care Model



The model spans a two year period commencing twelve months before end of life and continuing to twelve months after death. This specification will include the following aspects of stages 1 to 5:

Stage 1 -

- Robust communication between in and out of hours services
- 24/7 access to basic palliative care/end of life information
- Integrated information system across health and Adult Social Care
- Integrated health and social care service provision
- Choice and control – allowing people to direct as much as possible their own care
- Access to appropriate services according to need regardless of diagnosis or care setting

Stage 2 – All of the above plus:

- Access to self directed support mechanisms
- Rapid response to the person's medical, nursing and personal care needs without delay
- Access to pre-bereavement practical and emotional support
- Coordination of documentation across service boundaries

Stage 3 – All of the above plus:

- Access to short periods of 24/7 nursing or carer input into the home
- Access to *Specialised* Care
- Support district nurses in the provision of rapid response services for access to medication.

Stage 4 –

- Prompt verification of death and support to families in obtaining certification.
- Provision of D49 leaflet – what to do after a death
- Provision of a list of local funeral directors
- Access to family support and bereavement service
- Access to spiritual support, as preferred

Stage 5 –

- Provision of a comprehensive range of co-ordinated bereavement support services via the Hospice hub.
- Access to psychology/psychiatry services for complex bereavement reactions