NHS
Halton
Clinical Commissioning Group

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WA7 5TD

9th April 2020

Viv Culleton
CEO/Registered Manager
Halton Haven Hospice
Barnfield Avenue
Murdishaw
Runcorn
Cheshire
WA7 6EP

Dear Viv,

SERVICE SUSPENSION NOTICE

This Contract Notice is issued by NHS Halton Clinical Commissioning Group (HCCG) as Co-ordinating Commissioner to Halton Haven Hospice under General Condition 16 (Suspension) of the NHS Standard Contract.

This notice is issued by Halton CCG and relates to concerns regarding the current arrangements that are in place to deliver specialist palliative medical input to the hospice. The CCG continues to have concerns that the current model does not meet the requirements of the existing service specification and has therefore decided that, with immediate effect, the current service specification is to be suspended.

As previously discussed, in the interim period, we would wish to commission an alternative model of hospice care as outlined in the attached service specification. In light of the current COVID19 situation, the CCG would envisage that these proposed arrangements would remain in place for a 6 month period, after which the specification would be subject to further review.

I would wish to provide assurance that during this period the financial contract value for the hospice would remain as previously stated and the CCG will waive the indemnification clause in General Condition 16.4.

It is therefore vital that these new arrangements are communicated to the various stakeholders and regulatory bodies as appropriate. As discussed, the CCG is happy to support the Hospice in undertaking this through involvement of its Communication Team.

If you have any further queries or require any further clarification, please do not hesitate to contact me.

Yours sincerely,

Leigh Thompson
Chief Commissioner
NHS Halton CCG

cc Dr Andrew Davies
Michelle Creed
David Marteau
Mervyn Kennedy

Marie Sherbourne
Karen Eden

Service Specification No.	HHH-2
Service	Hospice End of Life Service
Commissioner Lead	David Marteau, Commissioning Manager, Halton CCG
Provider Lead	Halton Haven Hospice
Period	8th April 2020 – October 8th 2020
Date of Review	8th October 2020

1. Population Needs

1.1 National / local context and evidence base

This service specification and corresponding outcomes are based on a number of key documents that have been published in relation to ensuring high quality care at the end of life care These include:

- Quality Standard for End of Life Care (NICE , 2011)
- End of life care strategy: quality markers and measures for end of life care (Department of Health, 2009)
- National End of Life Care Strategy (Department of Health, 2008)
- Improving supportive and palliative care for adults with cancer. NICE cancer service guidance (2004; NHS Evidence accredited - www.nice.org.uk/guidance/CSGSP).
- Best practice guidance including National Service Frameworks (2007)

In addition the specification will make reference to existing information and supporting resources for end of life planning including:

- NHS National End of Life Care Programme, advanced care planning guidance
  The differences between general care planning and decisions made in advance (17/3/10) www.endoflifecare.nhs.uk
- Gold Standard Framework for EoL Care www.goldstandardsframework.nhs.uk
- Best Interests at End of Life, Practical Guidance for Best Interests http://www.scie.org.uk/publications/mca/files/lancspct.pdf

1.2 Evidence Base

It is calculated that the number of adults needing end of life care services is 0.83% or 830 per 100,000 population aged 18 years or over.

In line with this estimated population QIPP launched its end of life programme 'Find your 1% campaign', which contains resources to assist commissioners and Providers and in particular GP practices in identifying this 1% of the population, so that they can be appropriately cared for at the end of life.

It is estimated, that 53% of deaths in the over 75 age group occur in an acute hospital with 75% of these deaths being associated with diseases of the circulatory system, respiratory system or related to cancer. Locally, data suggests that Halton has a significantly higher than average number of deaths related to respiratory disease and cancer and 54% of deaths occurred in hospital (www.endoflifecare-intelligence.org.uk) between 2008 and 2010.

Evidence suggests, that given the choice, most people would prefer to die at home with the following principles thought to be key in ensuring a 'good death'

- Being treated as an individual, with dignity and respect;
- Being without pain and other symptoms;
- Being in familiar surroundings; and
- Being in the company of close family and/or friends.

The care pathway outlined in the End of Life Care strategy (2008) identifies the following key steps in the end of life care pathway:

1. Identification of people approaching the end of life and initiating discussions about preferences for end of life care;
2. Care planning: assessing needs and preferences, agreeing a care plan to reflect these and reviewing these regularly;
3. Coordination of care;
4. Delivery of high quality services in all locations;
5. Management of the last days of life;
6. Care after death; and
7. Support for carers, both during a person's illness and after their death.

Locally the North West Model for End of Life Care, based on the end of life care strategy has been adopted to support planning at the end of life and ensure the key steps of the pathway are delivered. More information is available from:
http://www.endoflifecumbriaandlancashire.org.uk/info_health_socialcare_professionals/model.php

1.2 General Overview

In order to monitor the quality of the service provision put in place to deliver the end of life care pathway, NICE has specified 16 clinical and quality statements that should be taken into consideration when

delivering end of life care in order to ensure choice and individualised care planning at the end of life. These quality standards should be integral to all services delivering end of life care and will be delivered collectively across settings and organisations delivering end of life care.

Reducing inequalities and improving identification through de-stigmatising death and dying and encouraging healthcare professionals and people with end of life care needs and their families and carers to engage in open conversations.

Improving the quality of care including care after death, through holistic assessments and timely interventions in the right place by a knowledgeable, caring and competent workforce.

Increasing choice and personalisation through care planning and advance care planning, including advance statements and advance decisions to refuse treatment and provision of resources that enable these choices to be achieved.

Ensuring care is coordinated and integrated across all sectors involved in delivering end of life care.

Improving the psychological, physical and spiritual well-being of people with end of life care needs and their carers through access to an appropriately trained and resourced workforce.

Timely access to information and support to enable people with end of life care needs and their families and carers to make informed decisions.

Timely provision of continuing NHS healthcare funding to support people to die in their place of choice.

Supporting carers and ensuring access to an assessment of need as set out in the Carers and Disabled Children Act 2000 and the Carers (Equal Opportunities) Act 2004.

Timely access to generalist and specialist palliative care services on the basis of need and not diagnosis. This includes the provision of community based support and access to specialist advice (which may be via telephone) 24 hours a day, 7 days a week.

Reducing unnecessary hospital admissions and length of stay by developing capacity to deliver expertise to the person's usual place of residence through pathway redesign and workforce development. This includes supporting staff in social care settings such as care homes and domiciliary workers; supporting relatives and friends who are caring for a person with end of life care needs; and providing the necessary clinical

expertise, medicines and equipment.

Improving cross-boundary and partnership working through close working between health and social care services to ensure flexible and integrated services that have the infrastructure to enable this (for example shared IT networks). This should improve care coordination, minimise unnecessary duplication and reduce costs.

Improving knowledge and skills in generalist and specialist palliative care settings, and in social care settings including independent residential and nursing homes and domiciliary workers.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

The NICE quality standards associated with good quality end of life care can contribute to delivery of the following NHS Outcome Framework Domains:

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 safe environment and protecting them from avoidable harm

2.2 Local defined outcomes

There are a number of outcomes that would be expected as part of the end of life service to ensure that we are addressing the Quality Standards laid out in the NICE guidance, namely:

- More patients achieving their preferred place of care at the end of their lives and an increase in the number of people supported to die at home if that is their wish
- Reduction in the number of unplanned and inappropriate admissions into secondary care
- Supported discharge or a dignified death
- Improved quality of life and the promotion of dignity and self-worth for patients
- Increased awareness of the range of generic and specialist palliative care services and advice available
- Excellent patient satisfaction and a reduction in strain and anxiety for patients, their carers and family

These outcomes will be achieved by aligning care with the North West End of Life Care Model and ensuring the Quality Statements outlining

necessary processes and provisions are met.

3. Scope

3.1 Aims and objectives of service

Palliative Care services can be defined as the health and social care received in the period preceding and directly following death provided to both patients and their carers and families. It is not disease specific and covers patients with increasing general frailty at the end of their life. It is also not defined by a period of time, rather the identification of increasing need for support, within the context of progressive advanced disease and can be delivered in a variety of settings within the hospice.

On many occasions, end of life care may be managed by primary care and community-based teams supported by the Advanced Care Planning Team.
The hospice can support end of life care where the patient's symptom control is stable but they would also benefit from respite care, therapeutic interventions and where the support network of the patient is having difficulties in adjusting to/ coping with the illness functionally, psychologically, spiritually or emotionally.

3.2 Service description / care pathway

The hospice end of life service is required to provide a range of services to the people of Halton that is nurse led and provides high quality, flexible and appropriate care at the end of life as well as meeting the key steps laid out in the end of life strategy. These will include:

- Inpatient care
- Day hospice services
- Family support and bereavement services
- Complimentary therapies
- Clinical advice and support

Inpatient Care

All inpatient care must be nurse led and delivered through a core palliative multidisciplinary team (MDT), to provide holistic care and should be provided 24 hours a day, 365 days a year.

All patients admitted to the inpatient service must be assessed by the MDT. The MDT will be expected to devise a care plan, for the patients' utilising end of life tools where appropriate (unless already in place) which must be discussed and agreed with the patients and family/carer where possible. The care plan must be reviewed on a regular basis by the MDT or appropriate senior health care professionals and must continue to be discussed at local specialist palliative care (SPC) multi-disciplinary team (MDT) meetings where necessary.

Prioritisation of palliative care needs cases must be managed at the weekly MDT and supported by regular team admissions meetings. Admission decisions must be based on clinical need. Urgent admissions can take place out of hours and where possible, will be within 24 hours.

Inpatient Clinical Pathway

Inclusions	Referral criteria	Source of referrals	Exclusions	Managing referrals
+ Patients over the age of 18. + Patients with a life limiting illness at any stage in their illness.	+ End of life care where the patient's symptom control is stable. + Respite care. + Rehabilitation. + Where the support network of the patient is having difficulties in adjusting to/ coping with the illness functionally, psychologically, spiritually or emotionally.	Referrals will be accepted from: + Any health care professional, provided that the patient, carer and general practitioner/ consultant are aware and in agreement with referral to the service.	Patient has uncontrolled physical, psychological or spiritual symptoms.	The referrals meeting in Halton Haven Hospice should be held at least once every week day and led by the senior clinician.

Specialist Medical Palliative Care

Where a patient requires additional specialist support to manage more complex or unresolved symptoms and disease progression, these should be facilitated through out of area placement at either St Roccos Hospice, Warrington or Willowbrook Hospice, St Helens. Referrals to be determined through geographical location of the patient and will be subject to bed availability. Should there be no capacity at either hospice the Provider should liaise with the Palliative Care Team at Warrington and Halton Hospital to discuss whether hospital admission is appropriate.

Medication and Prescribing

- **Admission and discharge**

There must be a process for reconciliation of medication on admission to the unit including defining how the unit will manage and utilise patients own drugs. The process for discharge and how medication will be provided must also be clearly outlined.

- **In patient prescribing**

There must always be a qualified prescriber available to ensure safe and timely access to the appropriate medication and treatments for patients whilst an inpatient on the unit. The unit should have access to an agreed stock of medication and should also have a process to obtain medication outside of this stock list should the need arise.

For any Non-Medical Prescribers (NMP) there must be arrangements in place for ongoing clinical supervision and mentorship as well as availability of Medical oversight and input to support prescribing that may be outside of their scope of practice. All clinical staff working on the unit should have regular clinical supervision and professional development to ensure they are developing their skills in this area of practice and to ensure safe, effective prescribing.
The unit can choose to utilise skills from community specialist teams where this supports more effective clinical management of patients, this includes utilising the local OPAT service for IV therapy support if applicable.

- Policy, documentation and governance

There will be a medicines policy and associated standard operating protocols that will cover all aspects of safe handling of medicines in the unit. This should cover everything from admission, inpatient stay through to discharge. The policies must also include safe management of controlled drugs and a non-medical prescribing policy.

There must be clear documentation regarding administration of medication which should be audited on a regular basis to ensure adherence to local policy. Storage of medication of medication should also be audited regularly to ensure safety and quality.

Use of medication and prescribing should adhere to all legislative and statutory requirements as well as being in line with the local formulary and recommendations and national guidelines such as NICE. A system for ensuring that clinicians are kept up to date on changes in formulary and guidance must be in place.

The unit clinical manager will work with the Head of Medicines Management within the CCG to ensure the above policies and protocols are agreed and in place. They will also work with the CCG with regards to local audits and quality improvements with regards to prescribing and medication.

St Roccos Hospice Referral/Discharge Pathway
All onward referrals for out of area (borough) placements will be approved by the coordinating CCG Chief Commissioner following the agreement with the receiving hospice.

Referral criteria:

- Community referrals - all patients must have been assessed by the community Macmillan team or community palliative consultant to identify the requirement for specialist palliative medical intervention for uncontrolled physical, psychological or spiritual symptoms.
- Hospice referrals – patients under their care that have deteriorated and now require specialist palliative medical intervention as above.

- Hospital referrals – direct referral route for patients requiring ongoing specialist palliative medical intervention either through follow up out-patient appointments or in-patient bed facility.

Referral process:

- Referrals are to be completed on the electronic referral form and forwarded to the Warrington Integrated Palliative Hub Single Point of Contact warccg.srhspa@nhs.net (Telephone number: 03333 661066).
- Urgent referrals requiring specialist palliative medical intervention are discussed at the daily hub allocation meeting at 1.30pm daily.
- Halton Haven will be informed following the meeting of the outcome, including bed availability and expected timescales.

Discharge process:
Once the need for specialist palliative medical intervention has been addressed and the patient is stable, the patient may be either be:

- discharged back to the community, or
- transferred back to Halton Haven Hospice if there is a requirement for further therapeutic interventions or there are delays in community support being available.

Willowbrook Hospice Referral/Discharge Pathway;
All onward referrals for out of area (borough) placements will be approved by the coordinating CCG Chief Commissioner following the agreement with the receiving hospice

Referral criteria:

- Community referrals - all patients must have been assessed by the community Macmillan team or community palliative consultant to identify the requirement for specialist palliative medical intervention for uncontrolled physical, psychological or spiritual symptoms.
- Hospice referrals – patients under their care that have deteriorated and now require specialist palliative medical intervention as above.
- Hospital referrals – direct referral route for patients requiring ongoing specialist palliative medical intervention either through follow up out-patient appointments or in-patient bed facility.

Referral process:

- Referrals are to be completed on the electronic referral form.
- Urgent referrals requiring specialist palliative medical intervention are discussed at the daily hub allocation meeting.
- Halton Haven will be informed following the meeting of the outcome, including bed availability and expected timescales.

Discharge process:
Once the need for specialist palliative medical intervention has been addressed and the patient is stable, the patient may be either be:

- discharged back to the community, or
- transferred back to Halton Haven Hospice if there is a requirement for further therapeutic interventions or there are delays in community support being available.

3.3 Discharge Planning

Before a patient is discharged by the Provider, to home or another care setting, a "Discharge Package" will be in place.

Every patient as part of their MDT assessment and family support team assessment, must have details of the following provisions documented and provisions must be put in place to meet them in place:

- Where the patient is to be transferred to.
- What care packages (social and healthcare) have been arranged.
- Confirmation that the GP has been informed. This must be done electronically where possible.
- Information and a contact number have been provided to the Patient /Carer.
- The Provider will ensure that all discharges are planned on an individual basis based on discharge criteria.
- The discharge/transfer planning will involve the patient and if appropriate, the family/carer of the patient.
- Transfer or discharge planning is multidisciplinary and follows agreed pathways for referrals to other services.
- The discharge/transfer process will ensure continuity of care for the patient through communication and working relationships with relevant health and social care professionals and agencies.
- Prior to discharge the patient will be given an appropriate amount of medication with details that the patient and/or carer can understand of when and how to take it, or of how it will be given.
- Patients and their carers will be given information on how to access specialist advice and out-of-hours support.
- If appropriate, patients will be offered access to Day Services if they wish.
- The patient's GP, DN and Consultant will be advised of the inpatient's care plans and progress whilst in the hospice and on discharge (with the patient's permission).
- If the patient is transferred to another service, relevant information will be shared with the team taking over the patient's care, with the patient's permission.

For patients who have died there must be a formal care after death policy/guideline to ensure that the dignity of the patient and respect for the family remains paramount at all times. The Provider must also ensure notification of death to the GP is made within **24 hours** to ensure that GP's are able to assist with bereavement issues or coordinate care

for other dependants

Families who are assessed as requiring bereavement support must be referred appropriately and efficiently to the bereavement service at the earliest opportunity.

Day hospice services
Day hospice services must operate on a minimum of 4 days per week and must maintain a minimum of 5 hours of operation per day. The service should be operated flexibly, where possible, and be responsive to patient need. Day hospice services should be available to patients for a minimum of 12 weeks and transport provision must be made for patients.

Subject to availability of places, the Provider will endeavour to accept patients whose assessed needs can be suitably met by them and, when they feel unable to do so will, upon request of the CCG put those reasons in writing. Details of the relevant referral and admission criteria along with assessment procedures shall be available for inspection on request.

The hospice must also include provision for the following support services as part of the day hospice service:

Family Support and Bereavement Clinics
The family support service will maintain the provision of

- Listening Services
- Bereavement Counselling
- Carers support

This support must be available in a variety of formats and environments to provide as much patient choice as possible and this must include 1-1 sessions and group sessions. The need for support should be identified as part of the care planning process with patients and families.

Complimentary Therapies and Physiotherapy
Complimentary therapies and physiotherapy should be made available to any patients who are deemed to require this provision as part of their initial assessment.

Specialist Nursing and Medical Review
This provision should be provided, where possible, as part of the day hospice service to ensure appropriate advice on symptom management is available and an offer clinical support to patients.

Clinical Advice and Support
In addition to the services provided as part of the day hospice service, the hospice must continue to act as a resource for Nurse Led Palliative

Care Advice to the healthcare community of Halton. The Provider will be required to provide clinical information and advice to referrers or general advice on end of life if required. This advice and clinical support should be delivered via the 24/7 Telephone Advice Line Service wherever possible.

3.4 Referrals

Requests for care into any of the above services can be made by any primary or secondary health or social care professional or other agreed professionals. All referrals should be completed electronically on a Specialist Palliative Care Referral form, where possible. The Provider will accept verbal referrals by telephone but these should be followed up by an electronic form/fax at the earliest opportunity.

All referrals to the inpatient unit must be triaged as soon as possible or at the next earliest opportunity by the Senior Nurse Led Clinical Team. Admission is made on a priority basis. For all patients referred to the Inpatient Unit, the referrer will be contacted **within 24 hours**. The referrer must be advised at the earliest opportunity 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.

In addition, self-referral to day hospices services should be available and can be requested by telephone. Patients referred to the day hospice must be contacted by phone within **3 days** and an assessment carried out. Patients should be offered the choice of assessment within the hospice or within their own home.

Any other referrals required as part of the assessments of patients should be made at the earliest possible opportunity which will include referrals to complimentary therapies and support services.

3.5 Information Management and Technology

It is expected that as a basic core minimum the following IM&T requirements need to be met Including:

- Connecting for Health
- Electronic Government Interoperability Framework
- Information Governance Statement of Compliance (IGSoC)

Additionally, to meet NHS Halton CCG IM&T requirements and in order to support the service model the following process and Information Management Technology requirements should also considered by the Provider.

Referrals into the service should be processed electronically, where

possible. Clinical Information and Patient consultations will be recorded electronically by the Provider into an electronic patient administration/reporting system, or equivalent that meets Information Governance Statement of Compliance (IGSOC) requirements and must be able to provide all necessary returns to the commissioner in the required format.

It is expected that Provider's discharges summaries and outpatient correspondence will be messaged to GP's electronically and should, where possible, integrate with the GP's Clinical system in line with local IM&T Strategy and local CCG Electronic messaging hubs.

The Provider must ensure that they are familiar with and comply with the NHS minimum information technology standards and ensure (and be able to demonstrate) that they have the necessary systems and processes in place to comply with the NHS information governance requirements.

Providers must ensure that the storage of medical records and information which is relevant to treatment and on-going care is passed between all parties in accordance with the Caldicott Principles and Data Protection Act (1998).

In addition, the Provider should also:

- Ensure that service Provider data on specified targets and clinical audit will be extracted electronically.
- The Provider should ensure that all members of staff are adequately trained in the use of any relevant information systems.
- Have robust business continuity with regard to their IM&T Systems to ensure that services are not affected and to safeguard information.
- Ensure that patient records are transferable in the case of the Provider ceasing to provide NHS services or in the case of the patient changing to another provider. This preferably should be done electronically

The NHS Halton CCG IM&T Commissioning Strategy sets out the importance of enabling a local shared electronic patient record through systems interoperability. It is expected that the Provider will work collaboratively with the CCG to progress the implementation on an electronic patient system as and when required.

3.6 Population covered

The population covered will be all people registered with a Halton GP, aged 18 years and over with advanced, progressive, incurable conditions; adults who may die within 12 months; and those with life-threatening acute conditions. Access for patients outside this criterion is

at the Provider and host Commissioners discretion.

Care must be provided in a location that is accessible to the patients of Halton. Where a patient requires Specialist Palliative Care support to manage more complex or unresolved symptoms and disease progression, these can be facilitated through out of area placements at St Roccos Hospice, Warrington or Willowbrook Hospice, St Helens based on the geographical location of the patient and subject to bed availability.

3.7 Any acceptance and exclusion criteria and thresholds

Inclusion criteria:

- Registered with a Halton GP
- Patients over the age of 18
- Patients with a life limiting illness who may die within 12 months
- Where the patient's symptom control is stable, but they would benefit from respite care, therapeutic interventions and where the support network of the patient is having difficulties in adjusting to/ coping with the illness functionally, psychologically, spiritually or emotionally.

  The Provider aims to be inclusive, but should an issue of exclusion arise it will be discussed with the commissioner.

Exclusion criteria:

- Patients requiring Specialist Palliative Care. These patients are to be referred to out of area placements at St Roccos Hospice, Warrington or Willowbrook Hospice, St Helens based on the geographical location of the patient and subject to bed availability.

3.8 Interdependence with other services / providers

The Service should be provided as part of an integrated approach to End of Life Care within the NHS Halton CCG catchment population, delivered in collaboration with multiple providers and working closely with the Commissioning body to ensure best practice, quality standards and regular reporting of outcomes. As part of this integrated approach, the service will be expected to work with the following organisations and bodies:

- Halton GP practices
- Community & Acute Services/Trust
- St Roccos Hospice, Warrington
- Willowbrook Hospice, St Helens
- Medicines Management and Pharmacy
- Halton Borough Council
- Marie Curie
- Local Healthwatch
- Third Sector and Voluntary Organisations
- Strategic Clinical Networks

In addition to any other bodies or organisations relevant to the delivery of End of Life care within Halton.

4 Applicable Service Standards

4.5 Applicable national standards (e.g. NICE)

- NICE Quality Standard for End of Life Care (2011)

4.6 Applicable standards set out in Guidance and / or issued by a competent body (e.g. Royal Colleges)

- RCGP Guidelines for End of Life Care

4.7 Applicable local standards

Adherence to the NHS Halton CCG formulary, policy, statements and guidance when prescribing or when making recommendations for prescribing medication to the referring clinician.
http://www.panmerseyapc.nhs.uk/index.html

5 Applicable Quality Standards & CQUIN goals

5.5 Applicable quality requirements (See Schedule 4 Parts A-D)

N/A

5.6 Applicable CQUIN goals (See Schedule 4 Part E)

N/A

6 Location of Provider Premises

The Providers Premises are located at:

Halton Haven Hospice
Barnfield Avenue
Murdishaw
Runcorn
Cheshire
WA7 6EP