National information for commissioners on commissioning ‘specialist level palliative care’

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- Published by NHS England April 2016
- “...a framework from which local services can be shaped”
- Aligns with the 6 national ‘ambitions’*
- Relates to “Specialist Level Palliative Care” (SPC) rather than “Core Level Palliative Care” (EoLC)
- Includes partially completed NHS service specification template

*Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020

Specialist Level Palliative Care is...

• Integral & a core part of resourcing care for people (...) assessed at having more complex or complicated palliative care needs

• Determined by the needs of the person not of the diagnosis or illness

• Required by people:
  – With life-limiting illness
  – +/- co-morbidities
  – Focus of care on Quality of Life
  – Unresolved complex needs that cannot be met by current care team
  – May be physical, psychological, social and/or spiritual needs
Specialist Level Palliative Care is...

Staffed by a team with the requisite qualifications, expertise & experience in offering such care, which must include:

- Consultants in palliative medicine
- Nurses specialising in palliative care (if working autonomously, should be Clinical Nurse Specialist or above)
- Adequate admin & secretarial support

Should formally include the following with specialist skills and experience:

- PT, OT & Social workers
- Spiritual & Psychological services at levels 3 - 4

Should have formal access to the following with specialist knowledge:

- Dietetics & SLT
- Pharmacists & Interventional pain management specialists
Key principles from the guidance for providers and commissioners

• Need to ensure sufficient medical & nursing cover to allow assessment, advice & active management 7 days a week and 24/7 telephone advice, working towards the capacity for 24 hour a day access to face-to-face visit from a consultant in palliative medicine, when necessary.

• Patients should have personalised care planning from services that use person-centred outcome and experience measures.

• SPC MDTs are supported to have a lead role in developing best practice in palliative & end of life care and in education / training of the wider workforce, including contribution to education and training at pre-qualifying and post-qualifying levels, especially in medicine, nursing and allied health professions.
Key principles from the guidance for providers and commissioners

• Services should be supported by an Electronic Palliative Care Coordination System (EPaCCS) to facilitate coordination

• Patients must have timely access to end of life care medications & related equipment

• Services should be supported to undertake identification and assessment of carer (or those important to the person) needs

• Competent workforce with recognised expertise in SPC, with staffing levels based on assessment of the known and growing unmet needs of the population, despite the current difficulties in linking staffing levels to outcomes.
Additional information for commissioners

• Activity modelling and contracts should reflect the significant funding contributions made through raising charitable funds by hospice providers, whether NHS or voluntary.

• Because SPC MDTs have a lead role in palliative/eolc best practice development & in education/training of the wider workforce, they should be commissioned to have the resources and time in which to do so.

• Not all services will be able to immediately meet the requirements specified in this guidance. It is vital that such services are not destabilised; this document serves as a ‘direction of travel’ for such service providers, supported by their commissioners, to which they should be working. Commissioners also play a pivotal role in bringing providers together and facilitating such dialogue where this is not already happening.

• Additional services, such as lymphoedema and bereavement support may be provided by specialist level or core level palliative care providers but will need to be commissioned separately.
Additional information for providers

The service characteristics section of the guidance merits close attention, highlighting a range of 17 key expectations of providers, that link with the national ‘Ambitions’ document. This includes evidence of:

• Defined transparent referral criteria, made clear to all referrers, within and beyond 1° & 2° care, with which to demonstrate fair access to services.
• Auditable prioritisation system linked to patient outcomes and use of established validated outcome measures e.g. the Integrated Palliative Outcome Scale (iPOS)
• A demonstrable commitment to partnership working
• Clinical leadership at strategic level
• And finally, SPC MDTs positively contributing to public engagement in end of life care (compassionate communities)
Update on progress re: RM Partners’ palliative care objectives

Sarah Cox,
Chair of LCA Palliative Care Group
RM Partners’ palliative care objectives

• End of Life Care in the community
• 7 day Specialist Palliative Care visiting

• Advance Care Planning

• Medicines
• Workforce
End of life care in the community

Transformational change in the model of community palliative and end of life care to enable better integration, coordination, responsiveness and effective use of resources
End of life care in the community

- To scope existing models of community integrated and coordinated care provision for people at the end of life.

- To evaluate these models and establish common principles including target population, workforce, activity, governance, cost and appropriate output measures including cost savings.

- To recommend implementation of a model that meets these specifications locally.
7 day Specialist Palliative Care visiting

Support for specialist palliative care services to develop and deliver seven day face to face visiting capacity
7 day Specialist Palliative Care visiting

- Link with Greater Manchester Cancer Vanguard and national work with APM and RCP.
- Developing shared definitions of 7 day face to face SPC visiting.
- Identify models of provision of seven day visiting for SPC services in hospital and in the community from London and other UK services.
- Evaluate in terms of the population served, structure and activity, the impact and cost.
- Share details with providers and commissioners about levels and costs for models of 7 day SPC visiting services.
Advance Care Planning

Support earlier advance care planning (ACP) to reduce avoidable hospital deaths of cancer patients

To advance the Oncology team led ACP project in hospital outpatients
Medicines workstream

- Ensure medicines are prescribed, obtained, delivered and administered to the patient promptly, as and when required, and that end of life care drugs information is available 24/7.
- Identify examples of best practice and areas where there is need for improvement.
- Produce a menu of the types of services that could provide a reliable consistent but cost effective all hours end of life care medicines’ service to be produced for commissioners.