SCHEDULE 2 – THE SERVICES

A. Service Specifications

<table>
<thead>
<tr>
<th>Service Specification No.</th>
<th>Service</th>
<th>Specialist Level Palliative and End of Life Care Services (PEoLC) (Adults)</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Service model for delivering specialist level palliative care services from identification of need through to end of life</td>
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<table>
<thead>
<tr>
<th>Commissioner Lead</th>
<th>Provider Lead</th>
<th>Period</th>
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Green text is guidance to the commissioner and should be removed from the final specification.

1. Population Needs

1.1 National context and evidence base

People who face progressive life-limiting illnesses, require different levels of health and social care at different points in their illness. Apart from care and treatment that is specific to their underlying condition(s), they are likely to have needs that are often referred to as palliative or end of life care, especially as they approach the last year(s) of their lives. Throughout the trajectory of their illness, sometimes episodically, sometimes for prolonged periods, they may require expert assessment, advice, care, and support from professionals who specialise in palliative care. These professionals work as part of multidisciplinary teams, providing the service directly to the person and those important to them and/or supporting others to do so.

Specialist Level Palliative Care (SLPC) services are required for people living with more complex needs which may be physical, psychological, social, and spiritual. The needs of this group cannot be met by the capability of their core team alone. This care requires a workforce with specialist skills and experience. See Appendix 1 for further definitions of palliative and end of life care.

The main components of specialist level palliative care services include, but are not limited to:

- in depth specialist knowledge (specialist consultant and specialist nursing services as a minimum) to undertake assessment and management of
physical, psychological, social, and spiritual symptoms to reduce symptoms, suffering and distress

- supporting analysis of complex clinical decision-making challenges where medical and personal interests are finely balanced by applying relevant ethical and legal reasoning alongside clinical assessment
- providing specialist advice, support, education, and training to the wider care team who is providing direct core level palliative care to the person.

Approximately 500,000 people die in England each year (NICE QS13) with that figure expected to rise year on year into the future. People with advanced life-threatening illnesses, and their families should expect high quality, effective palliative, and end of life care, whatever their condition.

In addition to physical symptoms such as pain, breathlessness, nausea and fatigue, people who are approaching the end of life may also experience anxiety, depression, social and spiritual distress. The proper management of these issues requires effective and collaborative, multidisciplinary working within and between core and specialist teams, whether the person is at home, in hospital or elsewhere.

Those close to the person, including partners, children, close friends, and informal carers also play a crucial role at this time and have needs of their own before, during and after the person's death.

1.2 Local Context

Local strategies, responses to national guidance, data, including patient feedback to be inserted here.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

<table>
<thead>
<tr>
<th>Domain 1</th>
<th>Preventing people from dying prematurely</th>
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<tr>
<td>Domain 2</td>
<td>Enhancing quality of life for people with long-term conditions</td>
</tr>
<tr>
<td>Domain 3</td>
<td>Helping people to recover from episodes of ill-health or following injury</td>
</tr>
<tr>
<td>Domain 4</td>
<td>Ensuring people have a positive experience of care</td>
</tr>
<tr>
<td>Domain 5</td>
<td>Treating and caring for people in safe environment and protecting them from avoidable harm</td>
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2.2 Local defined outcomes

Using the Ambitions Framework, Commissioners and Provider should work collaboratively to agree outcomes for each of the following and define them for their local areas:

- Each person is seen as an individual

  Evidence of a personalised approach to care, e.g. as measured through using person-centred outcome and experience measures.
• **Each person gets fair access to care**
  Evidence of steps taken to establish the extent to which the service provides fair access, and any measures taken to improve this.
  For example: Early identification of people likely to be in the last 12 months of life

• **Maximising comfort and wellbeing**
  Evidence of effective efforts on maximising the person’s comfort and wellbeing using established validated outcome measures, e.g. the Integrated Palliative Outcome Scale (IPOS).
  For example: Recurrent emergency admissions in last 90 days of life

• **Care is coordinated**
  Extent to which the service Provider engages with local systems to share information that supports better coordination of care, e.g. through participation in Electronic Palliative Care Coordinating Systems (EPaCCS) or equivalent as they are established.
  For example: Number of discussions where personalised care and support planning conversations has taken place

• **All staff are prepared to care**
  Evidence, using outcome measures, of education and training, other staff support measures and appraisal systems for own staff, and contribution to the education and training of wider palliative and end of life care teams in the locality.
  For example: Patient reported outcomes (e.g. IPOS)

• **Each Community is prepared to care.**
  Evidence of actions that the service has taken, or plans to take, in relation to community engagement and understanding of palliative and end of life care.
  For example: Patient and carer reported experience.

3. **Scope**

3.1 **Aims and objectives of service**

Commissioner to include relevant key aims and objectives for the service Provider(s):

This may include:

- A list of the key services to be provided
- Specify an integrated approach to palliative and end of life services with structures and systems which improve communication and coordination between service providers including seamless transitions of care
- Specify an MDT model of delivery
- Specify a model of delivery that includes future care planning that includes personalised care and support planning, including advance care planning and emergency care and treatment planning; and supported self-management, shared decision making and personal health budgets
• Specify use of IT systems such as EPaCCS (or equivalent) for digital shared information
• Specify holistic approaches to care with links to social prescribing, assessing, and addressing family needs, clear referral pathways to other services such as mental health
• Specify any contribution to a Regional or Local PEOlC Clinical Network
• Specify a local training offer.

3.2 The Service Model Structure

The service structure will consist of a whole system approach. This tiered view of the framework does not seek to compartmentalise but to join the provision into a seamless patient journey. Care and support should be provided by the right professional, at the right time and in the right place. This will ensure opportunities for support are not missed and specialist provision is targeted where needed most. See Figure 1.

The level of involvement from each service area will fluctuate throughout a patient’s journey. This is not a stepped approach but a flexible model that responds to need. Each tier of provision is dependent upon the others to ensure a holistic approach to health, wellbeing, emotional, social, and spiritual needs of the patient and their families and carers. No single provider can provide for all the needs.

Figure 1: Relationship between services

The specification sets out the service models for specialist level palliative care services. These services should aim to be routinely funded by the CCG/ICB commissioners. Specialist level palliative care services can be provided by
different types of providers, in multiple environments, including in secondary care, community care, and hospice.

Commissioner to insert detail on the agreed service model.

3.3 Delivering Specialist Level Palliative Care Services

Commissioners may wish to highlight the sections relevant to their provider and/or add details of how each requirement will be achieved locally.

Specialist level palliative care is required by people with progressive life-limiting illness, where the focus of care is on quality of life and who has unresolved needs that cannot be met by their current care team. These needs may be physical, psychological, social and/or spiritual. Examples include complex symptoms, rehabilitation or family situations and ethical dilemmas regarding treatment and other decisions.

Specialist care is provided by experts in their field with a range of knowledge and experience about the conditions and issues it presents. Specialist level palliative care services are delivered by a multidisciplinary team (MDT) of staff with the requisite qualifications, expertise and experience in offering care for this group of people, to support them to live as well as possible during their illness ensuring their comfort and dignity are maintained as they come to the end of their lives. Input from specialist level palliative care professionals to the care of a person must be based on the needs of the person and not the diagnoses they have.

The provider must deliver the key components of a specialist level palliative care team which include: *(delete/ add as required)*

- Advanced symptom management:
  - Complex symptom management skills
  - Knowledge of the deterioration, death and dying process
  - Understanding of rare disorders and their pathways
- Parallel planning with condition-specific teams e.g. heart failure specialists, respiratory team, complex neurological diseases team – this is appropriate in people whose recovery is uncertain
- Support for personalised care and support conversations and advance care planning, including emergency care and treatment planning and accessing CHC funding and care
- Support for end of life decision making, including preferred place of care if important to the person
- Rapid discharge from hospital for care at the end of life to hospice or home
- Specialist medical, nursing and therapy support for hospices and community palliative care teams
- Specialist equipment in the home *(this may be commissioned on a case by case basis where unique needs identified)*
- Input into MDTs, pre- and debriefs relating to a person’s death, and other professional meetings, at hospitals, hospices and in the community
- Psychosocial support for patients and their families and professionals *(this may be via referral)*
• Bereavement support for people with complex needs (this may be via referral)
• Education and training programmes (specify which settings).

Key Specialist Services

3.3.1 Specialist level palliative care: Multi-Disciplinary Team (MDT).

Specialist level palliative care can be delivered by a multidisciplinary team (MDT) of staff with the requisite qualifications, expertise, and experience in offering PEOLC, with or without comorbidities.

The specialist care team should have the ability to provide specialist care and support on a 24/7 basis. See 3.3.2 for SLPC workforce.

The team should ensure liaison between the specialist and generalist services to achieve seamless care that works to the agreed personalised care and support plan.

The provider must ensure delivery against the key objectives of a specialist level palliative care team which include: (delete/ add as required)

• Utilise the personalised care and support plan, and where applicable an Advance Care Plan (or equivalent), and support implementation of a plan where required
• Ensure that each person has a named care team who coordinates their care
• All relevant services required to meet the needs of the patient are engaged and are available for access as appropriate. This includes physical, emotional, and psychological services
• Advise on equipment and resources required to support the patient. Ensure they are available at the right time and in the right place
• All medicines and prescribing are available when needed, with appropriate specialist support as required
• All transfers of care are planned for with good communication e.g. discharge planning or between care settings
• Ensure that the person’s unpaid carers are supported and have their information, practical and emotional needs addressed directly or through signposting to other services
• Participate in disease-specific MDTs and offer liaison and a specialist palliative care view to other teams
• The specialist MDT will deliver training and education as appropriate to professionals and the person’s carers (universal and core) to ensure they have the relevant training and skills, and they know when to seek specialist advice. Commissioner to include local details.

3.3.2 Specialist level palliative care: Staffing requirements

Regardless of the service model, to be considered as a Provider of specialist level palliative care service.
The Provider must ensure the following professionals are included in the SLPC MDT:

- Consultants in Palliative Medicine - who may provide clinical leadership across a number of locality teams.
- Nurses specialising in palliative care – where a nurse is leading a service or has a role with a significant autonomous advisory component, such as in a community or hospital liaison settings or nurse-led outpatient clinics, it is expected that the nurse would be at the level of Clinical Nurse Specialist (CNS) in palliative care or nurse consultant in palliative care.
- Within a locality, the SLPC MDT must have arrangements in place to include input from the following professionals/services who must have specialist skills and experience in palliative care:
  - Physiotherapists
  - Occupational Therapists
  - Social Workers
  - Practitioners with recognised post graduate qualifications in psychological care and experience
  - Practitioners with spiritual care experience
  - Dieticians
  - Speech and Language Therapists
  - Pharmacists
  - Specialists in interventional pain management
- Liaison with Primary Care Networks and social care must be established and mechanisms for them to contribute to MDTs in place.

There must be adequate administrative and secretarial support for the SLPC MDT so that professionals can carry out their work efficiently and effectively, and data collected for service monitoring, audit, and quality purposes.

It should also be recognised that as specialists, the MDT has obligations, not only to provide education and training for the wider workforce delivering core palliative care, but also to support and contribute to education and training at pre-qualifying and post-qualifying levels, especially in medicine, nursing and allied health professions. The time and resources needed to carry out these obligations fully should be considered in discussions about commissioning for service, and education and training.

### 3.3.3 Specialist level palliative care: Liaison services

These services support the person’s care by their usual caring team. This may be undertaken in the hospital or in the community, but both involve the clinical responsibility remaining with the person’s key consultant/GP. A specialist assessment can be undertaken leading to recommendations for care that may be provided directly to the person or carried out by the usual caring team who retain clinical responsibility.
The provider must ensure delivery, by a specialist level palliative care team, for the following: (delete/ add as required)

- The person's needs should be reviewed at MDT meetings constituted to consider all specialised level aspects of their care which includes, as necessary, a palliative care specialist contribution into the meetings held by the usual caring team. Examples may include disease specific multidisciplinary meetings (MDMs) in hospital, Palliative Care or Supportive Care meetings in primary care, and Multidisciplinary Team or individual review meetings in residential facilities.

### 3.3.4 Specialist level palliative care: In-patient/ residential services

The provider must ensure delivery, by a specialist level palliative care team, for the following: (delete/ add as required)

- Bed-based care in a palliative care unit (in hospital or a hospice or may be delivered by the expert team in the person's own home (inclusive of care homes)).
- Ensure each person's needs are assessed, and their care is planned and delivered by medical, nursing, and other care staff who specialise in palliative care, in partnership with other practitioners who are not specialists in palliative care.
- Arrangements are put into place for specialist level support to wider care teams at all times (24/7).

### 3.3.5 Specialist level palliative care: Out-patient services

The provider must ensure delivery, by a specialist level palliative care team, for the following: (delete/ add as required)

- Provision for needs assessment and care planning by specialists working in out-patient clinics or day centres in a variety of settings
- Specialist level palliative care out-patient clinics and therapies are provided by relevant clinicians with expertise in palliative care from medicine, nursing, allied health professionals, as well as psychology, spiritual advisors or social work that match both the needs of the person and people important to them and their carers
- Clinical accountability and responsibility for the coordination and delivery of the person’s personalised care and support plan is shared between the specialist clinician and the person’s primary care team in this situation, and clearly agreed arrangements must be in place.

### 3.4 Key Service Characteristics

The service characteristics are structured below to make the links to ‘Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026.

These should be worked through and adapted to available or planned local services.

The Provider must:
## Service Characteristic

<table>
<thead>
<tr>
<th>REFERRAL</th>
<th>Link to Ambitions Framework</th>
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<tbody>
<tr>
<td>1. Have defined referral criteria which include specialist level palliative care for:</td>
<td>Ambition 2 and 3</td>
</tr>
<tr>
<td>a. the person with progressive life-limiting illness, with or without comorbidities, where the focus of care is on quality of life, including complex symptom control;</td>
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<tr>
<td>b. the person with unresolved needs that cannot be met by the capability of the current team. These needs may be physical, psychological, social and/or spiritual. Examples include complex symptom, rehabilitation or family situations and ethical dilemmas regarding treatment and other decisions;</td>
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<tr>
<td>c. The SLPC service can be offered alongside active treatment of an underlying condition.</td>
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<tr>
<td>2. Have a referral process which includes a system for prioritisation that is auditable and linked to patient outcomes.</td>
<td>Ambitions 2 and 4</td>
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<tr>
<td>3. Accept referrals based on need rather than disease label.</td>
<td>Ambition 1 and 2</td>
</tr>
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## ASSESSMENT & CARE

| 4. Provide medical and nursing cover to allow assessment, advice, and active management seven days a week, and 24-hour telephone advice. This may require a collaborative arrangement between a number of service providers and joint commissioning, working towards provision of 24-hour access to specialist level palliative care advice from a consultant in palliative medicine, including face to face assessment where this is necessary. | Ambitions 2, 3 and 4 |
| 5. Have timely-access to medication and equipment, for specialist-level in-patient or home-based care, to meet the needs of the person. *Commissioner to include specific parameters.* | Ambitions 2, 3 and 4 |
| 6. Work in partnership with people, those important to them and their carers to develop and support personalised care planning, including identifying and recording personal preferences, and helping them navigate to services that will deliver the required | Ambitions 1 and 4 |
information and care, at any time of day or night that that is needed.

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<tr>
<th>7. Identify and assess the needs of those important to the person, including psychological and social needs, and provide support, preparation for the caring role at whatever level is required to be undertaken, and facilitate access and signposting to other services, including pre-bereavement and bereavement.</th>
<th>Ambitions 1, 3 and 6</th>
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<tr>
<td>8. Be responsive to age, culture, faith and ideology, disability, sexuality, and gender issues in relation to palliative care, dealing with them in a sensitive and inclusive way, including access to advocacy, translation, and interpretation services.</td>
<td>Ambitions 1 and 2</td>
</tr>
<tr>
<td>9. Use a multi-disciplinary approach to care, with a competent workforce with recognised expertise in specialist level palliative care that uses evidence based best practice. People must be reviewed, and discussed by the multidisciplinary team regularly, as defined by local operational policy.</td>
<td>Ambitions 3 and 5</td>
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### COORDINATION & PARTNERSHIP WORKING

| 10. Work in partnership with other services to meet the person’s needs, ensuring that assessments and personalised care planning are reliably communicated and coordinated with other services involved with the person in a timely fashion. | Ambitions 1 and 4 |
| 11. Access and use an electronic palliative care coordination system to facilitate this coordination, as such systems become available locally, and where the individual agrees to its use. | Ambitions 1 and 4 |
| 12. Have a defined operational policy for multi-disciplinary and partnership working to include arrangements for multidisciplinary team meetings, and communication across care settings and organisational boundaries within a quality and governance framework. | Ambitions 4 and 5 |

### LEADERSHIP & GOVERNANCE

| 13. Have specialist level palliative care clinical leadership at senior strategic level within the organisation (e.g. Senior Management Team level). | Ambition 5 |
| 14. Have a suitably resourced quality, IT, and governance framework, which should include:  
  a. audit and Quality Improvement methodology;  
  b. patient centred outcome and experience measures and user feedback; | Ambitions 1, 2, 3, 4 and 5 |
c. data collection and sharing (including shared care records) to aid service; improvement at local and national level;

d. adequate access to electronic clinical information, including pathology and imaging;

e. arrangements for engagement in research in line with the service’s objectives; and

f. arrangements for all staff and volunteers to be appropriately trained and supported to give competent, reliable, confident, and compassionate care.

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<thead>
<tr>
<th>15.</th>
<th>Be configured and established to lead and/or contribute to the delivery of education, training and continuing professional development (CPD) to the wider workforce regarding best practice in palliative and end of life care.</th>
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<tr>
<td>Ambition 5</td>
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<th>16.</th>
<th>Use the growing evidence base to enable the development of innovative practice.</th>
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<tr>
<td>Ambitions 3 and 5</td>
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<th>17.</th>
<th>Contribute to, and encourage, public understanding, involvement, and engagement in developing compassionate communities, including local awareness, practical support, and planning for future care.</th>
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<td>Ambition 6</td>
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### 3.4.1 Care Planning

**Personalised care and support planning (PCSP)** is a series of facilitated conversations in which people, or those who know them well, actively participate to explore the management of their health and well-being within the context of their whole life and family situation. This process recognises the individual’s skills and strengths, as well as their experiences and the things that matter the most to them. It addresses issues and identifies outcomes and actions to resolve these.

Personalised care and support planning should be key for anyone receiving palliative and end of life services. It is an essential tool to integrate the person’s experience of all the services they access so they have one joined-up plan that covers their health and wellbeing needs. Specialist palliative teams can support, advise, and in some circumstances, develop the plan with the patient and their families. This includes Advance Care Planning which is a form of personalised care and support planning but focused on the future.

The Provider must:

- Implement a framework for capturing and recording conversations, decisions and agreed outcomes in a way that makes sense to the individual and their family.
• Ensure personalised care planning is proportionate, flexible, and coordinated and adaptable to a person’s health condition, situation and care and support needs

• Ensure a description of the individual, what matters to them and all the necessary elements that would make the plan achievable and effective, is included.

Advance Care Planning (ACP) is recommended by NICE (NG142) to be considered for each person with a palliative diagnosis. It is a voluntary process of person-centred discussion between the individual and their care providers about their preferences and priorities for future care, while they have the mental capacity for meaningful conversations about these. The process, which may involve a number of conversations over time, must have due consideration and respect for the person’s wishes and emotions at all times. As a result, the person should experience a greater sense of involvement and the opportunity to reflect and share what matters most to them.

The Provider must offer service users support with: (the outputs of these discussions may include one or more of the following)

• Developing an advance statement of wishes, preferences, and priorities, which may include nomination of a named spokesperson

• An Advance Decision to Refuse Treatment (ADRT)

• Nomination of a Lasting Power of Attorney (LPA) for health and welfare who is legally empowered to make decisions up to, or including, life sustaining treatment on behalf of the person if they do not have mental capacity at the time, depending on the level of authority granted by the person

• Context-specific treatment recommendations such as emergency care and treatment plans, treatment escalation plans, cardiopulmonary resuscitation decisions, etc.

The Universal Principles for Advance Care Planning are:

• The person is central to developing and agreeing their advance care plan including deciding who else should be involved in the process

• The person has proactive personalised conversations about their future care focused on what matters to them and their needs

• The person agrees the outcomes of their advance care planning conversation through a shared decision-making process in partnership with relevant professionals

• The person has a shareable advance care plan which records what matters to them, and their preferences and decisions about future care and treatment

• The person has the opportunity, and is encouraged, to review and revised their advance care plan

• Anyone involved in advance care planning is able to speak up if they feel that these universal principles are not being followed.

Note on Decision making:
All decision-making must be within an ethical and legal framework. In the UK clinicians should follow the 2010 General Medical Council guidance on treatment and care towards the end of life. The GMC guidance can be accessed at: https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/treatment-and-care-towards-the-end-of-life.

Advice on decision making, assessing mental capacity and advance care planning can also be found in NICE guideline on decision-making and mental capacity.

3.4.2 Personal Health Budgets

Personal health budgets provide an opportunity for people in their final weeks and months of life to have a more personalised experience of care, by giving individuals more of a say in the care they receive and helping to ensure it meets their needs and preferences.

A personal health budget can help to give people more choice about who provides their care, where their care is received, and their preferred place of death. People who become eligible for NHS Continuing Healthcare funding have a legal right to have a personal health budget.

Commissioner to include any relevant local PHB offers for people in palliative or end of life care including the pathway and relevant criteria.

3.4.3 Family and Carer Needs

Quality palliative and end of life care includes giving care and support to families, friends, carers, and all those who are important to the dying person. This must encompass good bereavement and pre-bereavement care, including for children and young people, and considering intergenerational and individual circumstances.

The Provider must:

- Ensure processes are in place to assess the needs of the family and loved ones and where possible address them.
- Ensure the carers are adequately supported to enable management in a home environment where desired
- Where there are opportunities to do so, the family should be offered training to enable self-management within the family.

3.4.4 Care of the Team

Everyone who is called upon to support a person with PEOlC needs and their wider family and loved ones will at times find it emotionally challenging.

The Provider must ensure every member of the team receives support and an opportunity to feedback and discuss what is happening. Professionals as well as volunteers should have access to ongoing support and supervision.
3.4.5 Communication

Good communication is vital to ensure that the person and their family understand their condition, their plan, their key points of contact and what they may expect in their journey.

The Provider must: (add or delete as required)

- Ensure there is a key contact for person and or family/carers who knows them and the system well
- Ensure communication is sensitive and that information is understood
- Ensure professionals communicate well with each other and work as a team
- Ensure the person and their family are listened to about what works for them and what is important
- Ensure next steps in treatment and care are always well communicated in advance.

3.4.6 Transition Requirements

It is important for adult teams to be aware of transition needs of children and young people.

This specification does not set out how transition should be managed as local services will vary in regard to age criteria, but it is important that local commissioners and providers ensure transition processes are in place for children and young people with palliative needs. The process of transition into adult services should begin, where appropriate, at the age of 14. Guidelines for transition are a recommendation in NICE NG43.

There is a separate Palliative Care specification concerned with providing palliative care to Children and Young People. It is important that young people at a transitional age are catered for within both of these specifications.

The Provider must ensure there are mechanisms and processes in place to support the transition of young people into adult services.

3.5 Palliative and End of Life Care Clinical Networks

One effective way to achieve more integrated working is through clinical networks. Networks have the potential to bring together different organisations to share best practice and provide a structure through which providers and commissioners can strategically plan for service development and plan services effectively. They also offer potential for hearing the voices of service users and benefitting from managed co-production.

From 2020-21, there are seven Palliative Strategic Clinical Networks, one for each region, leading on PEOeLC.

Providers must communicate and collaborate as required with their Palliative Strategic Clinical Network and, where applicable, any other relevant networks such as local clinical networks or managed networks at system-level.
3.6 **Population covered**

This Specialist Palliative Care specification is concerned with providing specialist level palliative care to adults aged 18 years and older.

*Commissioner to include any relevant local geographical boundaries such as areas covered by GPs or CCG/ICBs.*

*Ensure that people who are unregistered with any GP are also able to access services.*

3.7 **Any acceptance and exclusion criteria and thresholds**

3.7.1 **Acceptance Criteria**

Specialist Level Palliative Care services should be accessible to adults (aged 18 and over) with advanced, progressive, incurable conditions and people with life-threatening acute conditions. This includes people who are likely to die within 12 months and who are approaching the end of their life. It also covers support for their families and carers/those important to the patient.

*Commissioner to include any relevant local criteria.*

The providers of specialist level palliative care services will have clear acceptance criteria that are transparent and made clear to referrers. Commissioners may wish to consider:

- What happens to those instances where people are not eligible for referral?
- What information is needed locally on services available and how this is accessed?
- What assurances are in place about reducing inequity of access for underserved groups?
- Support for integrated cross sector/agency working
- Support for early identification.

3.7.2 **Discharge from the SLPC Service:**

Discharge from the SLPC service will usually take place where the following criteria are met:

- Patient and family’s needs can be met by their usual team who have access to specialist support if required
- Patient no longer wishes to have input from the SLPC service
- Patient moves area. In this situation, discussion should have taken place about how access to the local SLPC services may be enabled if required, and any necessary handover arrangements made.
3.8 Interdependence with other services/providers

Services required by people in need of specialist level palliative care span different sectors and settings. Providers shall adopt an integrated approach to planning, contracting, and monitoring service delivery across all health and social care sectors.

The NICE quality standard requires that services are commissioned from and coordinated across all relevant agencies, including SLPC, and encompasses all phases and complexities of palliative and end of life care. To implement the services, the provider shall work with other health and social care professionals in an integrated way to ensure people with SLPC needs and those important to them and their carers receive joined-up and streamlined services tailored to their needs.

The following should represent local services covering the geographic area. In the delivery of this integrated service, key interdependencies are for example:

- Primary and Community Providers – GPs, district nurses, and out of hours services
- Other multi-disciplinary specialist teams
- Rapid Response Team
- Adult Social Care services – both in hours and out of hours
- Providers of domiciliary care, and residential and nursing homes
- Other providers of Palliative and End of Life Care services: statutory and voluntary
- Providers of Acute Care
- Urgent and Emergency Care services, including 111 and ambulance services
- Providers of services for individuals with long-term conditions
- Local authority services.

4. Applicable Service Standards

4.1 Applicable National Standards


NICE Quality standard QS 144: 2017 Care of dying adults in the last days of life. https://www.nice.org.uk/guidance/QS144
4.2 **Applicable standards set out in Guidance and/or issued by a competent body**

- Ambitions Framework
- NHS Long Term Plan
- Hospice UK Future Vision Programme
- Universal Model of Personalised Care

4.3 **Applicable local standards**

*Subject to agreement between Provider and Commissioner.*

5. **Applicable quality requirements and CQUIN goals**

5.1 **Applicable Quality Requirements (See Schedule)**

*Subject to agreement between Provider and Commissioner but should include a form of patient and family reported feedback as a minimum.*

6. **Location of Provider Premises**

The service should be commissioned to provide care for people as close to home as possible. The place of care will depend on the clinical need and the person’s choice.

*Commissioner to specify as appropriate.*
Appendix 1: Definitions of key terms

**Adults**
The term ‘Adult’ refers to everyone aged 18 and over as specified by NICE Guidance (QS13) Quality Standard for End of Life Care for Adults.

**Palliative Care**
**WHO Definition of Palliative Care**
Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:
- provides relief from pain and other distressing symptoms
- affirms life and regards dying as a normal process
- intends neither to hasten or postpone death
- integrates the psychological and spiritual aspects of patient care
- offers a support system to help patients live as actively as possible until death
- offers a support system to help the family cope during the patient’s illness and in their own bereavement
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated
- will enhance quality of life, and may also positively influence the course of illness
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

**End of Life**
NICE (QS13) defines EoL as people (aged 18 and over) who are approaching the end of their life. This includes people who are likely to die within 12 months, people with advanced, progressive, incurable conditions and people with life-threatening acute conditions.

**‘Core’ services**
Key palliative and end of life activities that are commissioned and funded by CCG/ICBs or Local Authorities. These are essential non-specialist services, including district nursing, community pharmacy, etc. that underpin specialist level palliative care.

**‘Specialist’ services**
Specialist level palliative care services are required for people (all ages) living with more complex and/or long-term conditions which are life-limiting or life-threatening. The needs of this group cannot be met by the capability of their core team alone. This care requires a workforce with specialist skills and experience. They should be commissioned and funded by CCG/ICBs, local authorities, or a combination of both. These activities are not to be confused with specialised services as those are services commissioned by NHSE/I Specialised Commissioning.
As at July 2020, no *specialised* services were identified as commissioned by NHS England and NHS Improvement Specialised Commissioning. Therefore, at present, all specialist services are commissioned and paid for by CCG/ICBs.

The main components of specialist level palliative care include, but are not limited to:

- in depth specialist knowledge (specialist consultant and specialist nursing services as a minimum) to undertake assessment and management of physical, psychological, and spiritual symptoms to reduce symptoms, suffering and distress
- supporting analysis of complex clinical decisions-making challenges where medical and personal interests are finely balanced by applying relevant ethical and legal reasoning alongside clinical assessment
- providing specialist advice and support to the wider care team who is providing direct core level palliative care to the person.

‘Enhanced’ services

These are non-essential services which contribute to the health and well-being of the person and their families. These may be funded by charitable monies and will not be routinely commissioned.