SERVICE REQUIREMENTS

Aims and Objectives of the Service
The provision of planned one to one carer support by a Senior Health Care Assistant ('SHCA') covering a single individual per shift. Registered Nurses ('RN') can provide assessment and advice where the requirement for support is identified. Alternatively, local District Nurses ('DNs') can also undertake the assessment, and then refer to the service. The level of nursing support required will be assessed on referral and on regular review during the episode of care by the Senior Nurse in collaboration with the Referrer. The care is for individuals who are in the end of life stage of their illness; whose needs can be met through short episodes of care, and care is to take place in the individual's usual place of residence. Care can also be provided in care homes where required.

Care is delivered at any time between 22:00-07:00, 7 days per week, 365 days a year, as appropriate to support the needs of the individual and carers. The agreement is made between the Referrer, individual/family/carer, and the Provider (Senior Nurse), and the need for care is regularly reviewed every two weeks by the Provider Senior Nurse in conjunction with the District Nurse.

Service Description

Care
The Provider will provide SHCAs to deliver care and support for referred individuals with terminal illness, which will comprise management of pain and other symptoms and provision of emotional and practical support as set out in the care plan provided by the Referrer. Pain management will entail SHCAs communicating increasing symptoms to RNs or DNs. RNs can provide assessment and advice where the requirement for support is identified.

Location
Care will be delivered in the individual's home (or other agreed location) on a single individual shift/visit basis. Agreed location may include care homes, private residence or the individual's choice of location, which must be a safe and practical environment.

Referrals
Requests for care will be made by agreed Referrers, covering District Nurses ('DNs'), Advanced Nurse Practitioners ('ANPs), General Practitioners ('GPs') and local Specialist Palliative Clinicians. The Provider's will confirm whether they are able to fulfil the request at the point of initial referral.

To ensure the individual is still in need of the service, re-referrals must be made for each individual by the Referrer every two weeks.

The DN remains the key-worker responsible for the individual's care planning at all times.

It is expected that demand for the service is managed using the Gold Standard Framework referral to treatment timescales/categories as a guide when prioritising access to visits:
A – Stable from diagnosis years: 72 hours
B – Unstable, advanced disease months: 48 hours
C – Deteriorating, exacerbations weeks: 24 hours
D – Last days of life pathway days: 12 hours

Patient Assessment
It is agreed that the local DN team are the gatekeepers for the individual's care and the Provider will provide support based on the DN's full assessment and Advanced Care Plan ('ACP') (including for example, DNA CPRs; Advanced Decision to Refuse Treatment etc.). The DNs will supply up to date and accurate information on initial referral

The Provider(s) will ensure:

- All staff must be level 1 End of Life/Palliative Care trained
- Staff must be trained in the use of any equipment they might need to use such as but is not limited to; *suctions, syringe drivers, terminal agitation, medication training level 1*
- The Service is charged to the Commissioner at prescribed hourly rates for care delivered.
- The service is open to individuals who are registered with a GP within Calderdale, Kirklees geographical areas.
- The service works in conjunction with district nursing services

Outcomes of the service

- Individuals to be cared for holistically, in their preferred place at the end of their lives.
- Individuals to have a positive experience of care, quality of life, and the promotion of dignity at the end of life
- Individual, families and carers to feel supported and empowered, and wherever possible, strain and anxiety to be reduced
- Reduction of avoidable hospital admissions and/or avoidable accident and emergency attendances
- Any palliative individual to have access to the service irrespective of diagnosis
- Collaboration between providers to enable a comfortable and dignified end of life experience for individuals and their families/ carers
- Ensure an equitable and accessible service

Indicative Activity - Commissioned hours broken down by each geographical area (as detailed under the 'process' section of the market test advert).