**Northamptonshire Hospice Charities Strategy**

Please note that sections in *italics* are comments related to the main statement above it.

**Introduction**

This document sets out how the hospice charities in Northamptonshire will help to meet the future needs for Specialist Palliative Care (SPC) in the county and provide a service for those who choose to die in a hospice. This paper has been prepared in response to our discussions with the two Northamptonshire Clinical Commissioning Groups (Nene and Corby) who are responsible for NHS commissioning for this service.

At this stage we have an agreed strategy for Specialist Palliative Care. We do not have a full End of Life strategy document from the CCG’s but do have commissioning intentions regarding support for hospice provision expansion for specialist palliative care (see appendix 1 and attached document for details). However, we recognise that the hospices are an integral part of the wider ‘end of life’ care pathway and in writing this paper have made the assumption that supporting to patients to die ‘in a place of their choice’ (where possible) and reducing costs associated with end of life care will be a priority. We have attempted to look at the longer term need of the county (the next 5-7 years) and plan requirements based on research and population growth.

The data we have, currently, on demand for the services provided by the hospice show that most patients would prefer to die at home but don’t. We have, therefore, addressed community-based projects first to enable more patients to be treated at their place of choice. The demand for community beds and hospice beds cannot be determined while the unmet need of care at home is still so large. Appendix 2 provides a possible breakdown of the likely in-patient bed requirement within the hospices. Appendix 2 also starts to address how the hospice outreach and community nurse teams can be enhanced to support patients dying at home.

The final document is based on the output from the workshop at Forest House, Kettering on 16th January, 2014. Evidence suggests that we require additional hospice beds and we know a higher number of people die in hospital than wish to. In essence, we need to ensure that the right resource is in the right place at the right time to support the patient. The provision of hospice beds and community nursing will be foundations to enable this.
Vision
We aspire to provide compassionate, supportive and high quality care for all adult patients in Northamptonshire and their families and carers through:

- support and relief from the symptoms of serious illness (palliative care) for all those who come to us in the hospice or at home,
- end of life care for those who choose to die in a hospice.

We work with the two Northamptonshire Clinical Commissioning Groups (Nene and Corby) to provide the specialist palliative care and hospice services in the county. We jointly commission and pay for the services and our aim is to provide all such services that do not need the facilities of the acute hospitals. The clinical service is provided by Northamptonshire Healthcare Foundation Trust.

Children’s hospice facilities are provided by a service in Northampton with support from Cynthia Spencer charities.

Values
We aspire to provide holistic care for the patients that we serve. So we include emotional, spiritual and social support in the work that we do.

Principles
To provide holistic care typical of hospices.

To build on and grow the reputation of the hospices in the county.

To meet the demand for specialist palliative care whether at home, in community locations or in a hospice.

To positively and pro-actively provide the right care at the right place at the right time.

To enable patients to be cared for and to die in their place of choice.

Strategic Objectives
We will achieve our vision by increasing our grant in line with the increases in service demand. We will ensure that the services we commission are as efficient and effective as possible.

The CCGs will fund the services provided at the same level as the 2012/13 commitment but with a transition over a number of years from a block payment to a bed day rate. The target for the charities and the service providers will be to deliver a rate that is viable in the health economy in Northamptonshire by the end of this period.

We will provide the funding to deliver:

- Specialist palliative care in the home for patients whose needs can be met at home. Palliative care will be integrated so that the same clinical team supports people at home and in the hospice. Where needed, support at home will be provided 24 hours a day. This will require an increase in staff to support patients at home. However, without this, patients suffering an exacerbation during the night will be transferred to acute hospitals. This will be introduced in phases with the first two components starting operation in April 2015. With a progressive roll out of subsequent phases through to 2017.
• An improved Hospice at Home service for those in the last weeks of life.

• Beds in the wider community for patients needing specialist palliative care between care at home and care in the hospice or an acute hospital. These are known as Step Up/Step Down beds and will be branded with one of the hospices names as appropriate. The demand for these beds is dependent on the effectiveness of the community services in supporting patients at home and so the number of beds required is dependent upon the successful introduction of improved community services.

• Hospice in-patient beds to meet the demand for specialist palliative care for cancer and non-cancer patients, beds for those patients wishing to die in a hospice. Commissioners’ estimates are that there is a current need for between 44-59 beds across the county with and additional 26 for non-cancer care. (See appendix 2 for our estimation of the numbers of beds required).

Goals
In order to reach our strategic objectives we will need to achieve the following steps.

• Increase capacity of specialist palliative care and end of life care in the home. This will involve both the Clinical Nurse Specialists and the Hospice at Home team. The target is to have the first phases by April 2015.

• Manage a set of beds in the community (probably nursing home beds) to manage patient flow and as part of providing the most appropriate setting for patient care.

• Increase bed utilisation at Cynthia Spencer. The priority will be specialist palliative care patients followed by those wishing to die in a hospice (but not requiring SPC).

• Ensure both in-patient hospices operate effectively and efficiently There are some differences in performance so the units could learn from each other

• Increase service capacity at Cynthia Spencer for further beds over the current 20

• Build new in-patient unit at Cransley

• Increase service capacity at Cransley

• To ensure that referring clinicians understand the offering and use the service as planned, there needs to be a programme of information and education. The primary responsibility for this is with the CCGs but with support from within the service

• Establish a set of measures with CCGs to ensure patients are referred appropriately to the hospice offerings.

• Establish a centre to educate other professionals about what palliative care has to offer including how to identify patients for referral.
Outline Service Provision

Two in-patient hospices as base
Two hospices will provide in-patient beds and the base for “at home” services for Specialist Palliative Care sufficient to meet the demands identified.

End of Life care that is not SPC will follow from the CCGs EoL strategy.

The hospices are Cynthia Spencer in Northampton and Cransley in Kettering and the provision of the service is in proportion to the populations served. As now, this requires close co-operation between the units to maximise the delivery to patients. Note that Lakelands, in Corby, provides a day care and hospice at home service and is part of the delivery of community-based services for End of Life care.

Best Place of Care
Many patients end up in a hospital when a less acute form of care would have sufficed. The strategy is based on providing three levels of intensity of specialist palliative care to ensure that patient is treated in the most appropriate place and that this takes into account patient choice. The different service offerings are:

- in-patient care at the hospice
- a bed in a less specialist unit e.g. a nursing home or community bed with SPC team support known as Step Up/Step Down (SUSD) beds but branded with a hospice name
- care based at home.

24 hour response
Currently, patients at home or in a community setting whose needs change cannot always be seen by the community services and they may end up going to an acute hospital. In order to prevent this happening unnecessarily and to provide patients with better care, we need the ability to respond 24 hours a day to visit patients at home or other non-hospice location. A key factor is a hub (see below) preferably integrated with other crisis teams.

Non-cancer patients
SPC to include non-cancer patients and this will require additional skills and experience to deal with the higher unpredictability of patient response.

Coordination of End of Life Services
The CCG’s have started a tender process for the procurement of a provider to coordinate End of Life services. This means that it is not possible to describe the co-ordination of End of Life services as it might occur in a tender but we can describe what co-ordination we need for the hospice based services to properly address patient’s needs.

At a high level a single organisation will be responsible for coordination of end of life care services in Northamptonshire. It is planned that a patients need will be identified earlier, recorded on an
electronic care record and all providers (including hospices) will have access to that record and plan care around the patient.

From a hospice perspective it is essential that the provider winning the coordination of services fully involves the hospices as the hub is developed. This strategy is dependent on the future demand for hospice beds.

**End of Life Register**

This is part of the End of Life programme.

An End of Life Register will be available to all care providers to enable those already identified as being on the End of Life pathway to be treated accordingly. Patients may be added to the register as a result of being referred to the ‘care coordinator’ hub. The Register is an IT solution. The tool suggested by commissioners is EpaCCS.
Appendix 1 Commissioning Intentions

The agreed joint commissioning intentions of the two Northamptonshire Clinical Commissioning Groups (CCG), Nene and Corby, and the Northamptonshire Hospice Charities are the basis on which this strategy is built.

Background

Currently Specialist Palliative Care (SPC) services are offered to patients via the two hospices in the county i.e. Cynthia Spencer and Cransley Hospices. They also offer SPC services at home but there is no Out-of-Hours coverage. The majority (95%) of patients are people with cancer.

There are some principles that the CCGs and the hospices have applied to this strategy.

- To provide high quality care.
- To provide, where possible, a choice for the patient about where a service is delivered.
- To meet the standards for palliative care set out in <?>.
- To provide an efficient and effective service.

This document is largely driven by the SPC strategy but also addresses components of the End of Life strategy and supports the ‘out of hospital’ strategy.

- The SPC service should be an integrated operation across the hospices and at home with full Out-Of-Hours coverage.
- Capacity should be increased to meet the expected demand.
- Some SPC patients are reaching end of life and so require to be treated on that pathway.
- Places should be available for those who have chosen to die in a hospice but do not require SPC.
- In line with the rest of the country, in Northamptonshire, we do not achieve the levels of patients dying at a hospice or home or in a hospice that surveys say patients want.
- As nationally, the acute hospitals need to be able to reduce the number of patients being treated there and to enable patients to move to a more appropriate setting when they do not require the services of an acute hospital. Some of these patients would be more appropriately treated with SPC in a hospice or at home.

Historically, the NHS has been the larger contributor to Specialist Palliative Care services in Northamptonshire through the two hospices (Cynthia Spencer and Cransley). This not the usual pattern in the country generally where, typically, charities fund 65% of the service cost for NHS hospice located services.

Meeting the Need

Increasing the capacity of the hospices to provide more SPC beds would enable us to match the demand from patients and to relieve the pressure on hospitals.

Specialist Palliative Care services have mainly been offered to patients with cancer but it is now recognised that this should be offered to other conditions. There will also be an increase in demand for the service as the county population increases. Non-cancer cases can be more complex and experience in dealing with these cases will need to be built up.

The estimates for current and future need are in Appendix 2 Demand Levels.
Cynthia Spencer hospice has the ability to increase by 4 beds in its current location but will need further building capacity to meet the expected demand. In order to meet longer term demand Cynthia Spencer will need additional premises.

Cransley hospice cannot expand further in its current location and needs to relocate to larger premises with the facility to further expand when needed.

See separate ‘Hospice strategy briefing v4’ for more detail.
### Appendix 2 Demand Levels

#### Specialist Palliative Care
**Cohort 1 On current patient profile**

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**Cohort 2 For non-cancer patients**

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#### End of Life in a hospice

**Cohort 3 Non-SPC wanting to die in a hospice**

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#### Emergency assessment/care

**Cohort 4 Step-up/step-down support**

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**At Home Service Demand**

We currently do have demand figures for this service.

However, at a high level, for the expected population who will require end of life care is:

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With 60% of patients wishing to die at home:

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<td>60% who wish to die at home</td>
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Further work is required to identify what percentage of these patients the hospice at home and CNS nursing teams would need to support.

However, we know from performance indicators that these teams are enabling c.90% of the patients they manage to die in a place of their choice.
Appendix 3 Terminology

End of Life Care
Care which helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support.
Source: National Council for Palliative Care 2006

General(ist) Palliative Care
Services in all sectors providing day-to-day care to patients with advanced disease and their carers, designed to alleviate symptoms and concerns, but not expected to cure the disease.
Adapted from: Improving Supportive and Palliative Care for Adults with Cancer, 2004

Hospice care
A hospice is not just a building; it is a way of caring for people. Hospice care aims to improve the lives of people who have a life-limiting or terminal illness, helping them to live well before they die. Hospice care not only takes care of people’s physical needs, but looks after their emotional, spiritual and social needs as well. It also supports carers, family members and close friends, both during a person’s illness and during bereavement.
http://www.helpthehospices.org.uk/about-hospice-care/what-is-hospice-care/

Palliative care
Palliative care is an approach that improves the quality of life of patients and their families facing the problems 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.

Specialist Palliative Care
Specialist palliative care is the active, total care of patients with progressive, advanced disease and their families. Care is provided by a multi-professional team who have undergone recognised specialist palliative care training. The aim of the care is to provide physical, psychological, social and spiritual support...
Source: Tebbit, National Council for Palliative Care, 1999

Supportive care
This is care which helps people with cancer and other life-threatening illnesses and their families to cope with the disease and its treatment throughout the patient pathway. It helps the patient to maximise the benefits of treatment and to live as well as possible with the effects of the disease.
Adapted from: Improving Supportive and Palliative Care for Adults with Cancer 2004
Appendix 4 Outline plan for bed expansion
Below is an early estimate of the number of beds required. Further work on demand is needed following the work on community based strategies.

Supply Strategy

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