

National Overview ~ *January 2004*

Specialist Palliative Care

© NHS Quality Improvement Scotland 2004

ISBN 1-84404-195-6

First published January 2004

NHS Quality Improvement Scotland (NHS QIS) consents to the photocopying, electronic reproduction by 'uploading' or 'downloading' from the website, retransmission, or other copying of the findings of this report for the purpose of implementation in NHSScotland and educational and 'not-for-profit' purposes. No reproduction by or for commercial organisations is permitted without the express written permission of NHS QIS.

Copies of this report, the reports on each specialist palliative care service, and other documents produced by NHS QIS, are available in print format and on the website.

Information contained in this report has been supplied by specialist palliative care services, or taken from current specialist palliative care service sources, unless otherwise stated, and is believed to be reliable on publication.

www.nhshealthquality.org

National Overview ~ *January 2004*

Specialist Palliative Care

Introduction and Acknowledgements

NHS Quality Improvement Scotland (NHS QIS) was established as a Special Health Board on 1 January 2003 as a result of bringing together the Clinical Resource and Audit Group (CRAG), Clinical Standards Board for Scotland (CSBS), Health Technology Board for Scotland (HTBS), Nursing and Midwifery Practice Development Unit (NMPDU) and the Scottish Health Advisory Service (SHAS).

The purpose of NHS QIS is to improve the quality of healthcare in Scotland by setting standards and monitoring performance, and by providing NHSScotland with advice, guidance and support on effective clinical practice and service improvements.

A part of this remit is to develop and run a national system of quality assurance of clinical services. For each service, NHS QIS establishes a project group to:

- develop and consult on the standards and self-assessment framework;
- oversee the process of external peer review; and
- report findings to the NHS QIS Board.

The Specialist Palliative Care Project Group was jointly established with the Scottish Partnership for Palliative Care (SPPC) in September 2000, under the chairmanship of Professor John Welsh, Olav Kerr Professor of Palliative Medicine, University of Glasgow. Membership of the Group is given in Appendix 1.

The *Clinical Standards for Specialist Palliative Care* were developed by this Group and published in June 2002 following extensive consultation. Copies of the standards are available on request from NHS QIS or on the website (www.nhshealthquality.org).

Peer review visits to all specialist palliative care services in Scotland were conducted between January 2003 and August 2003 to assess performance against the standards. A local report on each Hospice/Trust¹ visited, including a detailed assessment of their performance against each standard, has also been published and is available on the website or on request from NHS QIS.

This report presents a national overview of specialist palliative care services in Scotland, reporting on performance across Scotland against the standards and including relevant examples of local initiatives.

¹ For simplicity, the term 'Hospice/Trust' is used throughout this document to refer to NHSScotland and voluntary sector organisations included in this national review. All Hospices/Trusts are reviewed independently of each other, however, review teams do look at the communication links between these specialist palliative care services. Please also see glossary entry for 'Trust'.

NHS QIS gratefully acknowledges the work of the Specialist Palliative Care Project Group for overseeing the project from its inception to the publication of this report. In addition, the contribution made by every member of the peer review teams was crucial to the success of the visit programme.

To those staff who contributed to the peer review visits, NHS QIS wishes to record its thanks; in particular, the liaison co-ordinators, local review facilitators and lead clinicians in Hospices/Trusts who were responsible for preparing staff locally for peer review visits, and for the compilation of comprehensive self-assessment material prior to visits.

Contents

Introduction and Acknowledgements	3
Executive Summary	7
1. Setting the Scene	13
1.1 Regional Breakdown and Index of Visits	
1.2 The NHS Quality Improvement Scotland Approach to Assessment	
1.3 Background to the Clinical Standards for Specialist Palliative Care	
1.4 Introduction to Specialist Palliative Care	
1.5 The NHS Quality Improvement Scotland Standards and Your Care	
1.6 Frequently Asked Questions	
1.7 Useful Contacts	
2. National Performance Against the Standards	29
2.1 Standard 1a: Access to Specialist Palliative Care Services: Specialist Palliative Care Unit	
2.2 Standard 1b: Access to Specialist Palliative Care Services: Hospital Palliative Care Support Team	
2.3 Standard 2a: Key Elements of Specialist Palliative Care: Specialist Palliative Care Unit	
2.4 Standard 2b: Key Elements of Specialist Palliative Care: Hospital Palliative Care Support Team	
2.5 Standard 3a: Managing People and Resources: Specialist Palliative Care Unit	
2.6 Standard 3b: Managing People and Resources: Hospital Palliative Care Support Team	
2.7 Standard 4 : Professional Education	
2.8 Standard 5 : Inter-professional Communication	
2.9 Standard 6 : Communication with Patients/Carers	
2.10 Standard 7 : Therapeutic Interventions	
2.11 Standard 8 : Patient Activity	

3. Conclusions 73

4. List of Appendices 77

Appendix 1	Specialist Palliative Care Project Group Members
Appendix 2	The Quality Assurance Process: Approach Used in this Review
Appendix 3	Co-ordinating Specialist Palliative Care Services
Appendix 4	Specialist Palliative Care Review Team Members
Appendix 5	Glossary of Terms

Executive Summary

Life Expectancy Today in Scotland

Life expectancy has improved by 14% for men and women since 1951, a trend that is expected to continue. This is partly due to improvements in the environment and in living conditions, and also, to a large extent, to significant advances in the science and technology of medicine. Fifty years ago a diagnosis of cancer usually meant a rapid and often painful death. This is no longer the case, and many people are now living a long time after a diagnosis of what remains, in many cases, a progressive and life-threatening disease. In those patients with cancer or other life-limiting incurable diseases, the initial news that there is no cure for a disease can be devastating, but a whole range of services quickly commence, with the aim of making sure that the best quality of life is achieved for each patient and their family and friends.

Palliative Care

Palliative care is the term used to describe the care that is given when a cure is not possible; it is derived from Latin and means 'relieving without curing'. The aim of palliative care is to maintain, and, as far as possible, improve quality of life for patients and those who care about them. It focuses on:

- controlling pain and other distressing symptoms;
- helping patients and their families cope with emotional and practical problems;
- helping people to deal with spiritual questions; and
- supporting families and friends in their bereavement.

Everyone suffering from an incurable, progressive illness should receive palliative care, regardless of age, and it is now recognised that it can help at every stage from diagnosis, through treatment, and at the end of life. While palliative care has been traditionally developed mainly for people with cancer and neurological disease, it can also help those with any other incurable, progressive illness such as heart failure or AIDS.

Specialist Palliative Care

Palliative care was first recognised as an important element of health services in Britain in the 1960s, and was initially provided by non-specialists. The 1970s and 1980s saw the development of specialist services, firstly within hospices and then in community teams and hospitals.

Generalist palliative care can be delivered in all care settings by GPs, community nurses, and non-specialist healthcare professionals working in acute hospitals. However, some people have more complex needs that cannot be addressed through simple or routine interventions, particularly in relation to symptom control, and their palliative care is best provided by specialist palliative care teams. These are multi-professional teams that include consultants and nurse specialists in palliative care, chaplains, social workers, physiotherapists, occupational therapists and pharmacists. Other clinical specialists such as anaesthetists and radiologists may also be involved in the team. The Project Group that developed the specialist palliative care standards recognised that it was important to define the extra dimension that specialist palliative care teams provide. Working closely with others providing care, and making sure that communication is effective, is a key challenge.

These specialist teams may be based within hospitals, hospices or in the community. As the care provided in these various settings differs slightly, the first three standards: access to services; key elements of the service; and managing people and resources, are presented to reflect what can be expected in each setting.

Specialist palliative care services are now a well-established feature of NHSScotland services, and much of their development has been co-ordinated by SPPC. The hospice movement in particular has a strong following, involving local communities and high profile support. These services are highly valued by those using them, and this is matched by the compassion and dedication of the healthcare teams providing them.

Summary of Findings

This summary is presented in six sections which link directly to the standards for specialist palliative care services in Scotland:

- Access and referral to services (Standard 1);
- Key elements of care (Standard 2);
- Multidisciplinary teams and professional education (Standards 3 & 4);
- Communication between team members and with patients/carers (Standards 5 & 6);
- Care and treatment (Standard 7); and
- Data collection (Standard 8).



Access and Referral to Services (Standard 1)

It is important to make sure that the right people are referred to these specialised services and that there is 24-hour access, as care and treatment needs cannot always be pre-planned. Standard 1 covers the policies for referral and access, and review teams found that such policies are in place for most services. However, these policies have not always been agreed and developed jointly between specialists and generalists, and most sites could not provide evidence that these policies are effective. While there is 24-hour access to most in-patient services, specialist nursing cover is not routinely available out-of-hours, and the demand for specialist medical care far exceeds the number of trained staff available to provide this. Advisory services are also generally available 24-hours, but again there are not enough specialist nurses to support this service, and increasingly, out-of-hours GP services, with limited and variable specialist knowledge, are being called upon to provide advice. Given the pressure on these services it is critical that referral and access policies are followed, and that patients are prioritised to ensure that those with the most complex problems are admitted to the specialist service. Not all sites could demonstrate that this was the case.

Key Elements of Care (Standard 2)

Specialist palliative care is provided using a range of different services, and particular attention is paid to the environment in which care is provided. Standard 2 covers the key elements of care, and most sites reported that they could provide a wide range of different services, including complementary therapies, day care, counselling and bereavement support. However, very few had written referral guidelines, and arrangements for accessing these were generally informal, which limits the opportunity to plan for supportive services, and meet demand.

Facilities for in-patient specialist palliative care in Scotland are good, and hospices in particular have been able to create a non-clinical setting. Quiet rooms and facilities for relatives to stay with patients are available in most places, and review teams were very positive about the welcoming atmosphere within NHS units and hospices.

Multidisciplinary Teams and Professional Education (Standards 3 & 4)

Effective specialist palliative care can only be provided if a complete range of fully trained team members is available and work closely together. These standards focus on the professionals needed to provide this care and on the education and training they require. Most sites visited do not have dedicated sessional input from the full range of core team members, particularly from social work and pharmacy. There are also problems in accessing other specialties such as anaesthetists, who specialise in pain management, and psychologists.

Throughout Scotland there is a lively interest in, and commitment to, training and education, and there is a wealth of knowledge and expertise in specialist palliative care. All sites have access to education facilities and have developed very effective education programmes, which are made available to a broad range of healthcare professionals.

Communication Between Team Members and with Patients/Carers (Standards 5 & 6)

Communication within the specialist palliative care team, with all others involved in the care of patients, and with the patient and their family and friends, is central to the ethos of these services. Standards 5 and 6 focus on this and it is obvious across Scotland that great importance is placed on the need to keep everyone informed of any relevant information throughout the whole patient journey. There were many examples of the different ways in which information is provided, although it was clear that the pressure of work means that not all the core team members regularly attend multidisciplinary meetings.

Care and Treatment (Standard 7)

Patients with progressive and incurable diseases often have complex needs, which cover every aspect of life - physical, psychological, spiritual, and social. This standard is about assessing and meeting these needs. Symptom management is a cornerstone of specialist palliative care and most symptoms are controlled, at least in part, by medication. There is widespread evidence that physical symptoms are well managed and are well regulated to ensure that treatment is safe. Every site has systems in place to make sure that there is 24-hour access to specialist drugs. Psychological needs are also met, despite a nation-wide shortage of psychology services. Many of these psychology services are provided by the teams on a general level, and only the more complex cases are referred to a psychologist. Not all sites could demonstrate that spiritual and social needs are fully assessed and met. There is also much in place to meet the needs of families and carers during their bereavement, although there is scope to improve this.

Data Collection (Standard 8)

This standard requires systems to be in place to collect data that will inform and support the planning and provision of specialist palliative care services. In particular, information on the preferred place of death should be recorded as there is good evidence that dying patients would prefer to be at home if possible, although most currently die in hospital. While most sites could demonstrate that they have systems in place to collect the required data, this is a relatively new initiative, and data collection has not yet matured enough to fully inform service planning and provision.



Conclusion

Words alone cannot adequately describe the specialist palliative care provided in Scotland. NHS Quality Improvement Scotland (NHS QIS) review teams were privileged to have the opportunity to visit these services and, across the country, without exception, the people providing this care demonstrated commitment, enthusiasm, skill and compassion. There is a 'human warmth' about this service, despite the sophisticated drugs and treatments used, that brings comfort to people who are dying and to their families and those who care about them.

Four key messages emerged from the review:

- Specialist palliative care services are provided both by NHSScotland, and by hospices which are charities. These services are all free of charge to patients, and the funding and cross-cover arrangements that are in place can be quite complex. For example, a hospice with charitable status may be part funded through the NHS but also an active charitable fundraiser. It may provide in-patient hospice and community care, but also offer an outreach service into NHS Trusts, as well as using the local GP out-of-hours service for overnight and weekend cover. As a result, there are a lot of inter-dependencies, and those providing services could easily find themselves faced with conflicting priorities. It is important that the planning and delivery of these services involves all those concerned, and that formal arrangements are in place for the provision of dedicated specialist sessions.
- Because of the nature of this service, there is an 'open-door' policy, and, as a result, patients are not always prioritised by their needs. Specialist medical staff will often feel they need to see everyone, and their input is not always targeted as effectively as it might. There are very few specialist palliative care consultants in Scotland, and it was clear during the visits that this valuable resource is already thinly spread, with many consultants working intolerable hours.
- There is also a shortage of nurses with specialist qualifications, and this impacts particularly on out-of-hours care. At present, it is simply not possible to provide 24-hour specialist nursing cover and advice.
- While specialist palliative care services are actively involved in audit and research, there remains little available evidence of the effectiveness of these teams. Given the pressure they are under, further research to evaluate different types of service configuration, including referrals and the way in which symptom control is managed, would inform decisions about providing these services in the future.

Key Recommendations

- The planning and delivery of specialist palliative care services should include all those involved to ensure that best use is made of resources.
- All patients who may use, or are currently using, specialist palliative care services should be assessed against a set of criteria drawn up jointly by those referring and those providing the service. Referrals should be routinely audited to ensure that the criteria are appropriate, and that referrals comply with these criteria.
- A review of 24-hour cover arrangements should be carried out, and any concerns relating to expertise/skill levels should be addressed, particularly relating to the prescribing of specialist drug regimes.
- Audit of the different types of service provision and delivery linked to outcomes should be carried out to inform future service provision.
- Core features of the considerable wealth of communication skills that have been developed by specialist palliative care teams should be shared across NHSScotland. These skills are inter-professional, and patient and carer focused, and are equally relevant to the effective care of all patients.
- Establish local Managed Clinical Networks (MCNs), which are managerially and administratively supported. These MCNs should work towards developing a quality assurance (QA) framework which is accredited by NHS QIS.
- The availability of psychology services is deficient in many areas of Scotland, and needs to be addressed at a national level.
- The Scottish Commission for the Regulation of Care is responsible for regulating the care provided by hospices. As this care is also provided within, and in partnership with NHSScotland, joint working with the Scottish Commission for the Regulation of Care should be established.

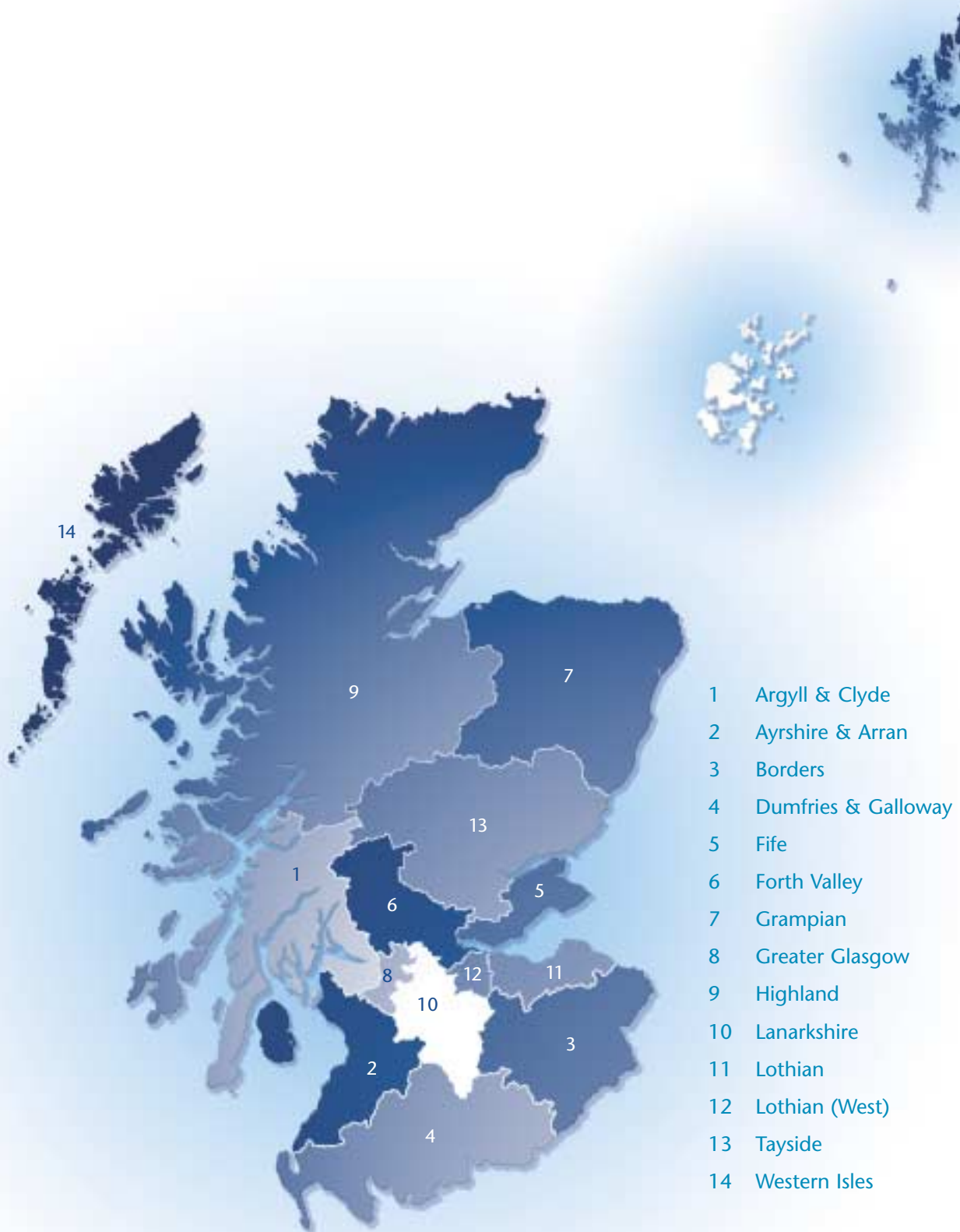
Chapter 1

Setting the Scene

















- Regional Breakdown and Index of Visits
- The NHS Quality Improvement Scotland Approach to Assessment
- Background to the Clinical Standards for Specialist Palliative Care
- Introduction to Specialist Palliative Care
- The NHS Quality Improvement Scotland Standards and Your Care
- Frequently Asked Questions
- Useful Contacts

1. Setting the Scene

1.1 Regional Breakdown and Index of Visits











































The following specialist palliative care services were reviewed during January 2003 - August 2003. Local reports, containing findings of each individual peer review visit and assessment against the standards, are available on the website (www.nhshealthquality.org) or in print format from NHS Quality Improvement Scotland (NHS QIS).

Local Report Area  Estimated Population ²  Area (square km)  Population (per square km)  Number of designated specialist palliative care beds available ³	Specialist Palliative Care Services Visited
1. Argyll & Clyde  418,750  7,531  56  24	Accord Hospice, Paisley Ardgowan Hospice, Greenock St Vincent's Hospice, Johnstone
2. Ayrshire & Arran  367,060  3,338  110  20	Ayrshire Hospice, Ayr
3. Borders  107,400  4,734  23  8	Borders General Hospital NHS Trust





² Population figures are taken from the General Register Office for Scotland mid-year estimates for 30 June 2002. The tables can be viewed on the website (www.gro-scotland.gov.uk/grosweb.nsf/pages/02-mid-year-est).

³ Data source: Hospices/Trusts providing specialist palliative care services. Data provided at time of review visit.

Local Report Area	Specialist Palliative Care Services Visited
<p>4. Dumfries & Galloway</p> <p> 147,310</p> <p> 6,439</p> <p> 23</p> <p> 6</p>	<p>Dumfries & Galloway Acute & Maternity Hospitals NHS Trust</p>
<p>5. Fife</p> <p> 350,620</p> <p> 1,323</p> <p> 265</p> <p> 27</p>	<p>Fife Acute Hospitals NHS Trust and Fife Primary Care NHS Trust</p>
<p>6. Forth Valley</p> <p> 279,370</p> <p> 2,652</p> <p> 105</p> <p> 24</p>	<p>Strathcarron Hospice, Denny</p>
<p>7. Grampian</p> <p> 523,290</p> <p> 8,742</p> <p> 60</p> <p> 21</p>	<p>Grampian University Hospitals NHS Trust</p>
<p>8. Greater Glasgow</p> <p> 866,080</p> <p> 560</p> <p> 1,547</p> <p> 76</p>	<p>Marie Curie Centre Hunters Hill, Glasgow</p> <p>North Glasgow University Hospitals NHS Trust</p> <p>Prince & Princess of Wales Hospice, Glasgow</p> <p>St Margaret's Hospice, Glasgow</p>

Local Report Area	Specialist Palliative Care Services Visited
9. Highland  208,140  25,784  8  10	Highland Hospice, Inverness
10. Lanarkshire  552,910  2,189  253  20	St Andrew's Hospice, Airdrie
11. Lothian  619,140  1,296  601  62	Lothian University Hospitals NHS Trust Marie Curie Centre Fairmile, Edinburgh St Columba's Hospice, Edinburgh
12. Lothian (West)  159,960  425  364  0	West Lothian Healthcare NHS Trust
13. Tayside  387,420  7,558  51  33 ⁴	Rachel House Children's Hospice, Kinross Tayside Primary Care NHS Trust

4. Rachel House Children's Hospice provides eight of these beds, which are available to children referred from any area of Scotland.

Local Report Area	Specialist Palliative Care Services Visited
<p>14. Western Isles</p> <p> 26,200</p> <p> 3,134</p> <p> 8</p> <p> 4</p>	<p>Bethesda Hospice, Stornoway</p>

1.2 The NHS Quality Improvement Scotland Approach to Assessment

NHS QIS uses a methodology which draws upon other quality assurance models to enable it, in partnership with healthcare professionals and members of the public, to develop standards for clinical services and to assess performance across Scotland against these standards.

Further information and definitions of the terms used in the standards and in the assessment of performance are contained in Appendix 2.

Assessment Categories

Each review team assesses performance using the categories ‘met’, ‘not met’ and ‘not met (insufficient evidence)’, as detailed below:

- **‘Met’** applies where the evidence demonstrates the standard and/or criterion is being attained.
- **‘Not met’** applies where the evidence demonstrates the standard and/or criterion is not being attained.
- **‘Not met (insufficient evidence)’** applies where no evidence is available for the review team, or where the evidence available is insufficient to allow an assessment to be made.

A final category **‘not applicable’** is used where a standard and/or criterion does not apply to the service under review.

1.3 Background to the Clinical Standards for Specialist Palliative Care

The work programme of NHS QIS has involved the development of standards for specialist palliative care in collaboration with SPPC.

The SPPC is the national umbrella and representative body for palliative care in Scotland. It is an independent body with charitable status which was set up in 1991 to promote the extension and improvement of palliative care services in Scotland, whether provided by voluntary organisations or by NHSScotland.

Specialist palliative care services have developed in a variety of ways across Scotland. These services are now provided by a range of professionals (and support staff) based within independent voluntary hospices, NHS units, hospital palliative care support teams and community teams. For this first round of reviews, it was decided that NHS specialist palliative care units, independent hospices, and hospital palliative care support teams (where there is a palliative care consultant and specialist nurse based on-site) would be reviewed. On the basis of this approach, 22 sites from across voluntary, Acute/Primary Care NHS Trust, and integrated NHS Trust settings, have been included in the review programme.

The specialist palliative care standards are applicable to all patients, including those with non-malignant disease, who are identified, through assessment by the specialist team, as requiring access to specialist palliative care services. Following consideration, the Project Group agreed that the *Clinical Standards for Specialist Palliative Care* should be applied across children's hospices and adult specialist services.

Specialist palliative care seeks to:

- meet complex needs through a **multidisciplinary team** that meets **regularly**, and where individual team members understand and respect each other's roles and specialist expertise;
- enable team members to be **proactive** in their contact, assessment, and treatment of patients and their families/carers, and to meet their complex needs;



- **discern, respect and meet** the cultural and religious needs, traditions, and practices of patients and their families/carers;
- recognise the importance of **including the needs of families** in the patient's care since good family care improves patients' quality of life and **contributes positively** to the bereavement process;
- **share** knowledge and expertise as widely as possible;
- **promote** and **participate** in research in order to advance the specialty's knowledge base for the benefit of patients and carers; and
- undertake audit to **review** and **inform** the future development of services.

1.4 Introduction to Specialist Palliative Care

The World Health Organisation's (WHO) recently revised definition of palliative care states that:

“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”.

As detailed earlier in the document, palliative care was first recognised as an important element of health services in Britain in the late 1960s, although initially palliative care was provided by non-specialists in hospitals, general practice and community nursing. Further progress in the 1970s and 1980s focused on the development of specialist palliative care services, initially in hospices and then in community teams and hospitals. It is now recognised that many aspects of the palliative care approach can be applied to patients who are in the initial stages of their illness, as well as for those with chronic and terminal disease.

Specialist palliative care requires effective multidisciplinary working within specialist teams and co-ordination across a wide range of professions to ensure that all appropriate patients, including those with non-malignant disease, can access this service and achieve the best quality of life possible.

Care is provided by multidisciplinary teams, who have undergone recognised specialist palliative care training. These teams work in partnership with those providing generalist palliative care to ensure that the complex needs of patients and families are met.



There are a number of essential components that make up a specialist palliative care service. These include:

- effective communication;
- symptom control;
- rehabilitation;
- education and training;
- research and audit;
- continuity of care;
- terminal care; and
- bereavement support.

The Provision of Specialist Palliative Care in Scotland

The need for specialist palliative care is highlighted in the Scottish Executive's cancer strategy, *Cancer in Scotland: Action for Change*. Significant progress has been made in the provision of specialist palliative care services; however, it is important to continue the development of this work in partnership with all relevant professionals throughout Scotland.

Depending upon definition, there are now 21 adult hospices, specialist units or hospital specialist palliative care support teams providing specialist palliative care in Scotland. There is also a children's hospice, which provides specialist services across Scotland for children and their families and carers. Together these services provide 335 beds.

Specialist Palliative Care Units

Specialist palliative care is provided in specialist units, which can be found in:

- Independent voluntary hospices.
- Marie Curie hospices.
- NHS specialist palliative care units.

Patients can be admitted to these units for specialist care for a few days, or for a number of weeks. These units also provide day hospice facilities, home care, support for appropriate patients cared for in care homes, and bereavement support, together with advice services and education.

Hospital Palliative Care Teams

Hospital palliative care teams provide specialist palliative care within hospitals, which involves attending to patients on a variety of different wards, at out-patient clinics, and providing advice to other clinicians.



Community

Specialist palliative care in the community is provided through the integration of the specialist palliative care service and the primary healthcare team. This enables patients to remain at home during their terminal illness, if possible, and if this is their wish, with the full support and care they need during this time. These teams may also provide services for appropriate patients who are looked after in care homes.

It is important to highlight that specialist palliative care services communicate, co-operate, and integrate across all healthcare settings.

1.5 The NHS Quality Improvement Scotland Standards and Your Care

Questions You Might Want to Ask

The specialist palliative care standards have been summarised below and are shown in blue. Each standard is followed by relevant questions you might want to ask about your care.

Specialist palliative care services can be accessed according to need.

- How can I access specialist palliative care services?
- How do I know that I need specialist palliative care services?
- Am I eligible to receive specialist palliative care?

Specialist palliative care is made available to patients and their carers through a range of integrated service components and facilities, designed to respond to varied individual needs.

- What facilities are available to me during my care?
- Is there a support service available to me and my family/carer?
- If I am admitted, can my relative/carer stay with me?

Specialist palliative care is provided by a highly qualified multidisciplinary team.

- Who will be involved in my care?
- Will complementary therapies be available to me, for example acupuncture?

There are effective channels of communication within the specialist palliative care team and with all others involved in the patient's care.

- Will an up-to-date record of my treatment be kept?
- Is this information available to all members of the specialist palliative care team?
- Who will make sure that all these professionals talk with each other about my care?
- How soon will my GP hear about your recommendations?
- Will my family/carer receive information about my condition?
- Will I continue to see other staff (eg my oncologist) when members of the specialist palliative care team become involved in my care?

Patients and those important to them are helped to communicate their feelings and priorities.

- Who will provide psychological support for me and my family?
- Where can I or my family/carer obtain information about my condition/treatment?
- Will I and my family/carer receive advice to help me return home?
- Can I or my family/carer choose where I receive my care?
- What information is available to help me if I have special needs?
- What other support organisations can I contact?
- How can I make a comment or complaint about the service I receive?



All patients with progressive incurable disease have access to specialist palliative care services which address proactively all the symptoms of their condition and the effect these symptoms have on them and their family/carers.

- Do I have a choice about the type of treatment I will receive to help control my symptoms?
- Will my symptoms be regularly reviewed?
- Will my treatment be regularly reviewed?
- Will I have access to counselling services?
- Will my family/carer receive help/support in dealing with my illness?
- Will my family/carer have access to counselling services?

1.6 Frequently Asked Questions

Q. What is specialist palliative care?

A. Specialist palliative care is the total care of patients whose disease cannot be cured. It provides physical, psychological, social, and spiritual support, and involves a broad mix of professionals.

Q. Where can I receive specialist palliative care services?

A. Specialist palliative care services can be provided at home, in a hospice, in a hospital and in a care home.

Q. What is a hospice?

A. A hospice is a place where specially trained doctors, nurses and other healthcare professionals care for people who have advanced progressive diseases. Hospices can also offer respite care. Within the hospice every effort is made to bring symptoms under control and to improve your quality of life. Emotional support can also be provided by social workers, chaplains and bereavement counsellors.

Q. What services are included in specialist palliative care?

A. Hospices and hospital specialist palliative care services provide a variety of services. Care is provided by a range of professionals that are specially trained in pain and control of symptoms, and in giving emotional support to patients and their relatives/carers. A day care service can provide the opportunity for all needs to be assessed and addressed. This may include the provision of a range of therapies as well as social and creative opportunities. Hospices and hospital specialist palliative care services also provide access to services which may include physiotherapy, occupational therapy, dietetics, respite care and bereavement support.

Q. How can I be referred to a hospice or specialist palliative care service?

A. Your own GP, nurse or a hospital doctor will normally arrange for you or a family member to be referred to a hospice or specialist palliative care service.

Q. Can I choose where I am referred to?

A. People are normally referred to the hospice or specialist palliative care service nearest to their home. In special circumstances it may be possible for referrals to be made to services elsewhere.

Q. Do I have to pay for specialist palliative care services?

A. All specialist palliative care services are free to you and your family.

Q. Do all patients who receive specialist palliative care suffer from cancer?

A. People living with cancer form the majority of patients receiving specialist palliative care. However, there is evidence that the quality of life for people with other incurable progressive illnesses can be improved with specialist palliative care.



1.7 Useful Contacts

The following organisations will provide information and support about all aspects of specialist palliative care. Healthcare professionals treating specialist palliative care patients can also provide you with information about local support groups.

1. Accord Hospice

Hospital Grounds
Hawkhead Road
Paisley
PA2 7BL

Tel: 0141 581 2000
www.accord.org.uk

2. Alexandra Unit

Dumfries & Galloway
Royal Infirmary
Bankend Road
Dumfries
DG1 4AP

Tel: 01387 241347

3. Ardgowan Hospice

12 Nelson Street
Greenock
Inverclyde
PA15 1TS

Tel: 01475 726830
www.ardhosp.co.uk

4. Ayrshire Hospice

35 Racecourse Road
Ayr
KA7 2TG

Tel: 01292 269200
www.ayrshirehospice.org

5. Bethesda Hospice

Springfield Road
Stornoway
Isle of Lewis
HS1 2PS

Tel: 01851 706222
www.users.zetnet.co.uk/bethesda-hospice

6. CancerBACUP

2nd Floor
30 Bell Street
Glasgow
G1 1LG

Tel: 0141 553 1553
www.cancerbacup.org.uk

7. Cruse Bereavement Care Scotland

Riverview House
Friarton Road
Perth
PH2 8DF

Tel: 01738 444178
www.crusebereavementcare.org.uk

8. Glasgow Palliative Care Information Network

Unit 19
Chapel Street
Maryhill
Glasgow
G20 9BD

Tel: 0141 945 4968
www.palliativecareglasgow.info

9. Highland Hospice

Ness House
Inverness
IV3 5SB

Tel: 01463 243132
www.highlandhospice.org

10. Macmillan Cancer Relief

9 Castle Terrace
Edinburgh
EH1 2DP

Tel: 0131 229 3276
www.macmillan.org.uk

11. Maggie's Centre Dundee

c/o Ward 32
Ninewells Hospital
Dundee
DD1 9SY

www.maggiescentres.org

12. Maggie's Centre Edinburgh

The Stables
Western General Hospital
Crewe Road
Edinburgh
EH4 2XU

Tel: 0131 537 3131
www.maggiescentres.org

13. Maggie's Centre Fife

PTS Building
Victoria Hospital
Kirkcaldy
Fife
KY2 5AH

Tel: 01592 643355 ext. 8868
www.maggiescentres.org

14. Maggie's Centre Glasgow

The Gatehouse
Western Infirmary
10 Dumbarton Road
Glasgow
G11 6PA

Tel: 0141 330 3311
www.maggiescentres.org

15. Marie Curie Cancer Care

29 Albany Street
Edinburgh
EH1 3QN

Tel: 0131 456 3700
www.mariecurie.org.uk

16. Marie Curie Centre Fairmile

Frogston Road West
Edinburgh
EH10 7DR

Tel: 0131 445 2141
www.mariecurie.org.uk

**17. Marie Curie Centre
Hunters Hill**

1 Belmont Road
Springburn
Glasgow
G21 3AY

Tel: 0141 558 2555
www.mariecurie.org.uk

**18. Prince & Princess of Wales
Hospice**

71 Carlton Place
Glasgow
G5 9TD

Tel: 0141 429 5599
www.ppwh.org.uk

19. Rachel House Children's Hospice

Avenue Road
Kinross
Fife
KY13 8FX

Tel: 01577 865777
www.chas.org.uk

20. Roxburghe House

Milltimber
Aberdeen
AB13 0HR

Tel: 01224 555641
www.show.scot.nhs.uk/guh/hospitals/roxburghe/rox.htm

21. Roxburghe House

Royal Victoria Hospital
Jedburghe Road
Dundee
DD2 1SP

Tel: 01382 423000
www.show.scot.nhs.uk/tpct/about/specpalliativeROXHSE.html

22. Scottish Partnership for Palliative Care

1A Cambridge Street
Edinburgh
EH1 2DY

Tel: 0131 229 0538
www.palliativecarescotland.org.uk

23. St Andrew's Hospice

Henderson Street
Airdrie
ML6 6DJ

Tel: 01236 766951
www.st-andrews-hospice.com

24. St Columba's Hospice

Challenger Lodge
Boswall Road
Edinburgh
EH5 3RW

Tel: 0131 551 1381
www.stcolumbushospice.org.uk

25. St Margaret's Hospice

East Barns Street
Clydebank
Dunbartonshire
G81 1EG

Tel: 0141 952 1141
www.smh.org.uk

26. St Vincent's Hospice

Midton Road
Howwood
Renfrewshire
PA9 1AF

Tel: 01505 705635
www.svh.co.uk

27. Strathcarron Hospice

Randolph Hill
Denny
Stirlingshire
FK6 5HJ

Tel: 01324 826222
www.strathcarronhospice.org

28. Sue Ryder Care

Dee View Court
Caiesdyke Road
Kincorth
Aberdeen
AB12 5JY

Tel: 01224 245920
www.suerydercare.org



Chapter 2

National Performance Against the Standards

2. National Performance Against the Standards

This section presents the findings across Scotland in terms of performance against individual standards. A number of examples of innovative local solutions and areas of good practice are highlighted in boxes throughout the text. These examples are not exhaustive - every review team noted examples of good practice during visits and these were often in place in more than one service. Challenges are also listed and there is certainly scope for change and improvements in relation to performance against the specialist palliative care standards. This is recognised by healthcare professionals and by patients and their friends and families, and whilst in the past there was limited patient involvement in specialist palliative care, there are now many examples of successful partnership working.

In common with many conditions, specialist palliative care is complex and most interventions are personally tailored to suit each patient's individual needs. This presents challenges when developing general patient information. It is not easy to achieve a balance between personal expectations and outcomes, and general information.

Feedback from those reviewed and those in review teams is sought after every visit, and nearly 162 people responded. Overwhelmingly, those involved in the review process reported that the opportunity to network and the time to consider different ways of addressing shared issues has been valuable. Giving the public and the service the chance to review many aspects of the way in which care is provided has been fundamental to the approach taken and is a starting point for many activities including:

- identifying good practice;
- disseminating good practice;
- stimulating multidisciplinary working;
- involving those who use the service; and, perhaps most importantly,
- reviving the appetite to ensure that the provision of patient care is balanced by the monitoring of that care against key performance standards, and that the quality of care is continually improved.

During the review of specialist palliative care services, a total of 22 sites across Scotland were visited. These services are based within a variety of settings and resulted in visits to 19 independent voluntary hospices/NHS units and three hospital specialist palliative care support teams. When the Specialist Palliative Care Project Group was developing the standards, it was acknowledged that a number of separate criteria were required for hospital specialist palliative care support teams (who do not have access to dedicated beds to care for patients with specialist palliative care needs). Therefore Standards 1-3 were divided into two sections:

- Section (a) - which is applicable to NHS units and hospices.
- Section (b) - which is applicable to hospital specialist palliative care support teams.

This national overview summarises all of the local reports. Accordingly the findings presented reflect the number of instances where the standard criteria were met, based on the following allocation of standards:

Standards assessed	Definition of sites assessed against these standards	Number of sites assessed using these standards
Standards 1a, 2a & 3a	Self-contained NHS units and independent hospices, all with dedicated specialist palliative care beds.	19
Standards 1b, 2b & 3b	Hospital support teams with no dedicated specialist palliative care beds.	3
Standards 4,5,6,7 & 8	All sites visited regardless of bed provision.	22

Information, Data Collection and Audit

Emphasis on quality improvement is fundamental to the provision of specialist palliative care. Appropriate services can only be provided to patients who will benefit from them, at the time they need them, if those managing and delivering the care have access to reliable, well-structured and timely information.

The majority of specialist palliative care services in Scotland are set within the voluntary sector, and historically hospices have developed individual Patient Administration Systems (PAS) for the collection of general patient information. However, PAS is an administration system only, and can not be used for the collection of clinical data.

With the setting of national standards for specialist palliative care services and the resulting requirement for clinical data, the Scottish Partnership for Palliative Care (SPPC) set up a working party in 1998, in conjunction with the Information and Statistics Division (ISD), to develop a Minimum Data Set (MDS) for specialist palliative care. The MDS is currently in its final draft. It is encouraging to note the commitment of all specialist palliative care services to adopt this MDS, as the provision of such data will help to provide evidence of the services provided by Hospices/Trusts, and to inform the process of service development.

It should be noted that, although the majority of Hospices/Trusts have the software and hardware in place to store the required information, data collection is still in its infancy.

2.1 Standard 1a: Access to Specialist Palliative Care Services: Specialist Palliative Care Unit

Standard Statement

Specialist palliative care services can be accessed according to need.

Essential Criteria

1a.1 There is a clear access policy specific to each service delivered detailing:

- the criteria for access;
- the person with responsibility for access decisions;
- the preferred route of referral;
- who can refer.

This criterion was met in 15/19 sites.

1a.2 Specialists and generalists work together to agree on criteria and routes for referral/access.

This criterion was met in 13/19 sites.

1a.3 The criteria for access demonstrate that priority is given to patients with the most complex needs.

This criterion was met in 16/19 sites.

1a.4 There is evidence that the access policy is being adhered to.

This criterion was met in 4/18 sites. This criterion was not applicable to 1 site.

1a.5 There is evidence that service providers and referrers discuss individual patients' needs.

This criterion was met in 19/19 sites.

1a.6 There is 24-hour access to the in-patient service which includes specialist medical and adequate specialist nursing cover (as defined in the Managing People and Resources Standard).

This criterion was met in 0/19 sites.

1a.7 There is 24-hour access to the advice service which includes specialist medical and adequate specialist nursing cover (as defined in the Managing People and Resources Standard).

This criterion was met in 4/19 sites.

1a.8 There is access to day services during working hours.

This criterion was met in 17/18 sites. This criterion was not applicable to 1 site.

1a.9 There is access to community specialist palliative care services during working hours.

This criterion was met in 18/18 sites. This criterion was not applicable to 1 site.

1a.10 In specialist palliative care units, the time from receipt of referral to initial contact with the patient/carer/professional (either by telephone or face-to-face) is a maximum of two working days.

This criterion was met in 5/19 sites.

1a.11 The reasons for not making initial contact with the patient/carer/professional within two working days are clearly documented.

This criterion was met in 14/19 sites.

1a.12 The referrer is advised of the outcome of the referral within two working days of initial contact.

This criterion was met in 1/19 sites.

Desirable Criteria

1a.13 A validated assessment tool is used to assess need and prioritise admission to the service - eg Palliative Care Outcome Scale (POS).

This criterion was met in 4/19 sites.

1a.14 There is 24-hour access to community specialist palliative care services.

This criterion was met in 0/18 sites. This criterion was not applicable to 1 site.

Summary

In general, most sites have access policies in place which detail how patients can be referred to the service. It was highlighted that the criteria and routes for referral/access to specialist palliative care services were not agreed in partnership with specialists and generalists for all sites. Those who did not meet this criterion acknowledged the importance of involving generalists in the development and/or revision of the access policy.

Most sites provide 24-hour access to the in-patient and telephone advisory services, however, there is a lack of specialist nurses with a degree or postgraduate qualification in palliative care to provide continuous cover for these services. Community services are available during working hours, although these services are not available out-of-hours. The majority of sites were not able to provide audit evidence to confirm adherence to the access policy, and to ensure that patients/carers/professionals are contacted within the required timescales following receipt of referral.

Strengths

- Clear access arrangements to the different aspects of each specialist palliative care service have been developed by the majority of sites across Scotland.
- Patients with the most complex needs are being identified during multidisciplinary discussion and through the use of comprehensive assessment tools.
- Service providers and referrers discuss the needs of individual patients.
- Most sites provide, or have access to, day services and community services during working hours.

Challenges

- The development of criteria and routes for referral/access, which have been agreed in partnership between specialists and generalists.
- To routinely audit adherence to the access policy.
- To ensure 24-hour access to in-patient and advice services, which are supported by specialist nurses who have a degree or postgraduate qualification in palliative care.
- Support for sole consultants in palliative medicine.
- The collection of audit data to demonstrate that specialist palliative care services are making contact with the patient/carer/professional within the required timescales, following receipt of a referral.

- To ensure that validated assessment tools are used to assess patients' needs and prioritise admission to the service.
- To provide out-of-hours community services.

Recommendations

- Specialists and generalists must work together to develop criteria and routes for referral/access to specialist palliative care services to ensure that appropriate care is provided.
- All sites should monitor adherence to the access policy to ensure that the services which are provided, comply with the arrangements agreed with generalists in the region.
- The development of a 24-hour specialist palliative care advice service which could utilise resources available within local, or where appropriate, regional Managed Clinical Networks (MCNs).
- Services must use a validated assessment tool to assess patients' needs, or work towards validating any locally developed/adapted tools.

Examples of local initiatives

Rachel House Children's Hospice, Kinross

The Hospice has reviewed the occupancy rate of its emergency bed, as it was believed that having it available on 'stand-by' resulted in less than 100% occupancy. The referral policy was amended to allow this bed to be used to its maximum occupancy while retaining the Hospice's emergency facility. The emergency bed is now made available to non-emergency referrals on the understanding that, should an emergency referral occur, the bed must be vacated. This not only provides an emergency facility but also allows more families access to Rachel House.

Strathcarron Hospice, Denny

The Hospice referral form has been reviewed, in conjunction with Acute and Primary Care Trust staff, to ensure referrers document an assessment of the patient's needs for specialist services at the point of referral. This comprehensive assessment is carried out using the Support Team Assessment Schedule (STAS) tool, which identifies the patient's physical, spiritual and anxiety symptoms. It is anticipated that the referral form will be circulated widely across Forth Valley for final comment, prior to its full implementation.

2.2 Standard 1b: Access to Specialist Palliative Care Services: Hospital Palliative Care Support Team

Standard Statement

Specialist palliative care services can be accessed according to need.

Essential Criteria

1.b1 There is a clear access policy specific to each service delivered detailing:

- the criteria for access;
- the person with responsibility for access decisions;
- the preferred route of referral;
- who can refer.

This criterion was met in 3/3 sites.

1.b2 Specialists and generalists work together to agree on criteria and routes for referral/access.

This criterion was met in 2/3 sites.

1.b3 The criteria for access demonstrate that priority is given to patients with the most complex needs.

This criterion was met in 0/3 sites.

1.b4 There is evidence that the access policy is being adhered to.

This criterion was met in 0/3 sites.

1.b5 There is evidence that service providers and referrers discuss individual patients' needs.

This criterion was met in 3/3 sites.

1.b6 There is access to the hospital support services during working hours which includes specialist medical and adequate specialist nursing cover (as defined in the Managing People and Resources Standard).

This criterion was met in 3/3 sites.

1.b7 There is 24-hour access to an advice service which includes specialist medical and adequate specialist nursing cover (as defined in the Managing People and Resources Standard)

This criterion was met in 0/3 sites.

1.b.8 In specialist palliative care teams, the time from receipt of referral to initial contact with the referrer (either by telephone or face-to-face) is a maximum of one working day.

This criterion was met in 1/3 sites.

1.b.9 The reasons for not making initial contact with the referrer within one working day are clearly documented.

This criterion was met in 2/3 sites.

1.b.10 The referrer is advised of the outcome of the assessment within one working day of the assessment visit.

This criterion was met in 0/3 sites.

Desirable Criteria

1.b.11 A validated assessment tool is used to assess need and prioritise admission to the service.

This criterion was met in 0/3 sites.

1.b.12 There is 24-hour access to hospital specialist palliative care services.

This criterion was met in 1/3 sites.

Summary

All sites have policies in place which detail how patients can be referred to the service, and evidence was provided to confirm that hospital specialist palliative care teams contact referrers to discuss the needs of individual patients. However, there was a lack of audit evidence available to demonstrate that access policies are adhered to, and to ensure that contact is made with the referrer within the required timescales, following receipt of referral.

All sites provide access to hospital specialist palliative care support services during working hours, which includes specialist medical and adequate specialist nursing cover, although only one site has put systems in place to provide out-of-hours access to this service. All sites provide a telephone advice service during working hours. One site also provides access to out-of-hours medical advice, however, there is no system in place to access specialist nursing advice during these periods. The two remaining sites have arrangements in place to transfer this advice service to a local hospice in the area. However, as noted earlier, there will not always be a nurse with a degree or postgraduate qualification in palliative care available to provide continuous cover for this hospice-based service.

Strengths

- Clear policies are in place for access to hospital specialist palliative care support services across Scotland.
- Service providers and referrers discuss the needs of individual patients.

Challenges

- The development of formal systems to ensure priority is given to those patients with the most complex needs.
- Carrying out audit to ensure the access policy is adhered to.
- To ensure that there is access to a 24-hour specialist advice service which includes specialist medical and adequate specialist nursing cover.
- The collection of audit data to demonstrate that hospital specialist palliative care teams are making contact with the referrer within the required timescales, following receipt of a referral.
- Providing 24-hour access to hospital specialist palliative care support services.

Recommendations

- All sites should monitor adherence to the access policy to ensure that the services which are provided, comply with the arrangements agreed with generalists in the region.
- The development of a 24-hour specialist palliative care advice service which could utilise resources available within local, or where appropriate, regional MCNs.
- The routine use of a validated assessment tool to formally assess need and prioritise admission to the service.

Example of a local initiative

West Lothian Healthcare NHS Trust

A user consultation exercise was undertaken by the hospital specialist palliative care team to facilitate the development of the Specialist Palliative Care Service. This involved the distribution of a questionnaire to potential users of the Service. The feedback received from the user consultation exercise was then used to develop the access/referral policies. These policies were then circulated throughout West Lothian Healthcare NHS Trust for comment, prior to being finalised.

2.3 Standard 2a: Key Elements of Specialist Palliative Care: Specialist Palliative Care Unit

Standard Statement

Specialist palliative care is made available to patients and their carers through a range of integrated service components and facilities, designed to respond to varied individual needs.

Essential Criteria

2.a.1 Dedicated environment with:

- quiet/private areas provided;
- chapel/prayer room;
- facilities for relatives to stay overnight.

This criterion was met in 16/19 sites.

2.a.2 In-patient care facilities:

- for the purposes of symptom management, rehabilitation or terminal care.

This criterion was met in 18/19 sites.

2.a.3 24-hour telephone advice:

- available for any healthcare professionals.

This criterion was met in 18/19 sites.

2.a.4 24-hour telephone support service:

- available for known out-patients and their carers.

This criterion was met in 16/19 sites.

2.a.5 Day services are provided (for example, by an out-patient model or a day hospice model).

This criterion was met in 17/18 sites. This criterion was not applicable to 1 site.

2.a.6 Hospital services:

- formalised arrangements for specialist input to local and community hospitals.

This criterion was met in 5/18 sites. This criterion was not applicable to 1 site.

2a.7 Education programme:

- see Education Standard.

This criterion was met in 16/19 sites.

2a.8 Research and audit are undertaken within a framework of clinical governance.

This criterion was met in 14/19 sites.

2a.9 Written referral guidelines to:

- bereavement services;
- community specialist palliative care services;
- complementary therapies;
- counselling services;
- day services;
- hospital specialist palliative care services;
- lymphoedema services;
- patient transport services;
- psychology services;
- social services;
- spiritual support services.

This criterion was met in 1/19 sites.

Desirable Criterion

2a.10 Formalised arrangements for specialist input to care homes.

This criterion was met in 2/18 sites. This criterion was not applicable to 1 site.



Summary

Overall, performance of the specialist palliative care sites against the criteria in this standard was good, and all sites are actively addressing areas in which they did not meet the criteria. Facilities in the specialist palliative care units are generally good, with the majority of sites able to provide access to private/quiet areas and a range of in-patient facilities for symptom management, rehabilitation and terminal care. Two of the sites that do not currently provide all the required facilities noted that plans have been developed to replace the existing sites with new, purpose-built units.

The majority of sites provide a 24-hour telephone advice service for professionals, and a 24-hour telephone support service for known out-patients and their carers. A number of sites that did not meet these criteria noted that these services are provided during working hours. However, out-of-hours callers are advised to contact the patient's GP. The majority of sites have not developed formalised arrangements for specialist input to community hospitals and care homes. A number of sites provide dedicated medical input to local hospitals in the area.

Although all sites indicated that a range of services can be accessed to meet the needs of patients and their families/carers, only one site provided evidence to indicate that written referral guidelines are in place for all services required.

Strengths

- Provision of a dedicated environment for the care of patients and their families/carers.
- A 24-hour telephone support service for known out-patients/carers.
- Research and audit is rapidly becoming an integral component of specialist palliative care services. The recruitment of audit facilitators, and liaison between hospice and NHS audit departments, is facilitating this process.

Challenges

- Formalising input to community hospitals and care homes.
- Producing written referral guidelines to all services which may be required for patients with specialist palliative care needs.

Recommendations

- Specialist palliative care services should negotiate written formal agreement to provide specialist palliative care to patients in:
 - a. community hospitals;
 - b. care homes.
- All sites should develop written referral policies and guidelines to ensure patients have access to necessary services when required.

Examples of local initiatives

St Columba's Hospice, Edinburgh

A research fellow based at the Hospice is undertaking a 5-year research project, aimed at bridging the perceived gap between hospices and nursing homes in the Lothian region. The 'Bridges Initiative' is an action research study involving nursing homes that have volunteered to be part of the study. With two-thirds of cancer occurring in people over the age of 65, a large number of cancer patients are likely to be cared for in care homes. This project aims to ensure that care home staff are equipped with appropriate knowledge of the specialist palliative care approach, to enable them to meet the needs of older people at the end stages of their lives.

St Margaret's Hospice, Clydebank

St Margaret's Hospice offers a day service for up to 10 patients in the day rehabilitation unit. Day patients are provided with a variety of services including: pain and symptom management; counselling; rehabilitation; physiotherapy; occupational therapy; lymphoedema management; acupuncture; and other complementary therapies.

Patients attend the day unit as a group on a weekly basis and have access to all the rehabilitation services. In addition the Hospice offers diversional therapies, art and music, hairdressing, and the opportunity to enjoy conversation and a meal together with other patients. The review team commended this innovation and the large range of services provided to day hospice patients.

2.4 Standard 2b: Key Elements of Specialist Palliative Care: Hospital Palliative Care Support Team

Standard Statement

Specialist palliative care is made available to patients and their carers through a range of integrated service components and facilities designed to respond to varied individual needs.

Essential Criteria

2.b1 Access to a dedicated environment with:

- quiet/private areas provided;
- chapel/prayer room;
- facilities for relatives to stay overnight.

This criterion was met in 2/3 sites.

2.b2 Each specialist palliative care team has:

- a nominated office within the hospital;
- access to an interview room on each ward.

This criterion was met in 1/3 sites.

2.b3 Access to in-patient care facilities:

- for the purposes of symptom management, rehabilitation or terminal care.

This criterion was met in 3/3 sites.

2.b4 24-hour telephone advice:

- available for any healthcare professionals.

This criterion was met in 1/3 sites.

2.b5 24-hour telephone support service:

- available for known out-patients and their carers.

This criterion was met in 0/3 sites.

2.b6 Education programme:

- see Education Standard.

This criterion was met in 3/3 sites.

2.b.7 Research and audit are undertaken within a framework of clinical governance.

This criterion was met in 3/3 sites.

2.b.8 Written referral guidelines to:

- bereavement services;
- community specialist palliative care services;
- complementary therapies;
- counselling services;
- day services;
- lymphoedema service;
- patient transport services;
- psychology services;
- social services;
- specialist palliative care in-patient unit;
- spiritual support services.

This criterion was met in 0/3 sites.

Summary

All sites have access to in-patient care facilities for symptom management, rehabilitation and terminal care, although none of the sites have access to designated beds. The facilities available at two sites are extremely limited, and staff noted that they did not consider these areas adequate for the purposes of specialist palliative care. It was noted that a new purpose-built area is planned at one site, and it is envisaged that those deficits highlighted will be addressed during the construction process.

Only one site currently provides a 24-hour telephone advice service and none of the sites are able to provide a 24-hour telephone support service for known out-patients and their carers. All sites demonstrated a commitment to undertaking a range of research and audit projects in line with their respective Trust's clinical governance framework. Although sites indicated that other services can be accessed to meet the needs of patients and their families/carers, there was an absence of written referral guidelines to these services across all sites.

Strength

- Commitment to carrying out a range of valuable research and audit projects. Clinical governance frameworks are also firmly established to facilitate these processes.

Challenges

- To gain access to adequate office and interview facilities.
- Providing 24-hour telephone support services for known out-patients and their carers across all sites.
- Producing written referral guidelines to all services which may be required for patients with specialist palliative care needs.
- Links with providers of complementary therapy services.

Recommendations

- Sites should work towards providing 24-hour telephone support services for known out-patients and their carers.
- All sites should develop written referral policies and guidelines to ensure patients have access to necessary services when required.
- To sustain the commitment from the current workforce, which has resulted in responsive and committed specialist palliative care services across Scotland.

Example of a local initiative

North Glasgow University Hospitals NHS Trust

The review team commended the Team's commitment to carrying out research and audit, which was evident in the range of projects currently underway. The review team was provided with examples of recent audits. These included looking at: the response time of the specialist palliative care team; patients' deaths within the Beatson Oncology Centre, Glasgow; and the patient's perception of the Western Infirmary, Glasgow. Research has also been carried out by the Team to look at: breakthrough pain in the West of Scotland; cancer pain relief using lozenge treatment; and morphine rinse in control of oral mucositis. The Team has a dedicated research nurse, and regular research meetings are held by the Team. All research within the Team is undertaken according to the North Glasgow University Hospitals NHS Trust Research and Development Strategy.

2.5 Standard 3a: Managing People and Resources: Specialist Palliative Care Unit

Standard Statement

Specialist palliative care is provided by a highly qualified multidisciplinary team.

Essential Criteria

3.a.1 The core team comprises dedicated sessional input from:

- chaplain;
- doctors;
- nurses;
- occupational therapist;
- pharmacist;
- physiotherapist;
- social worker.

This criterion was met in 7/19 sites.

3.a.2 There is ready access to other professionals including:

- anaesthetist (who is a specialist in pain management);
- bereavement specialists;
- complementary therapists;
- dentist;
- dietitian;
- lymphoedema specialists;
- oncologist;
- psychiatrist;
- psychologist and/or counsellor;
- speech and language therapist.

This criterion was met in 7/19 sites.

3.a.3 All clinical staff are supported by administrative staff.

This criterion was met in 14/19 sites.

3.a.4 Formal arrangements are jointly agreed between stand-alone nurse specialists in palliative care and their local specialist palliative care service to ensure multidisciplinary working.

This criterion was met in 5/8 sites. This criterion was not applicable to 11 sites.

3.a.5 There is a policy/procedure for the provision of a staff support system.

This criterion was met in 17/19 sites.

3.a.6 The following qualifications are required:

- a consultant who is on the specialist medical register for palliative medicine;
- a lead nurse of a service who has either a Masters degree in palliative care or is recorded as a specialist practitioner in palliative care.

This criterion was met in 11/19 sites.

3.a.7 The unit can demonstrate how they are working towards all community specialist nurses and one nurse per shift in an in-patient unit having a degree or postgraduate qualification in palliative care.

This criterion was met in 17/19 sites.

3.a.8 In a setting where children are being cared for there is at least one nurse on each shift with an RSCN qualification.

This criterion was met in 1/1 sites. This criterion was not applicable to 18 sites.

3.a.9 All professions allied to medicine (who are members of the multidisciplinary team) are active members of their specific specialist interest group.

This criterion was met in 15/17 sites. This criterion was not applicable to 2 sites.

3.a.10 All practitioners are registered with their relevant accrediting body.

This criterion was met in 17/19 sites.

3.a.11 There is evidence that all professionals have personal development plans which demonstrate that training needs are identified and addressed.

This criterion was met in 10/19 sites.

Desirable Criteria

3.a.12 All professions allied to medicine (who are members of the multidisciplinary team) have a multidisciplinary diploma in palliative care.

This criterion was met in 0/17 sites. This criterion was not applicable to 2 sites.

3.a.13 There is ready access to complementary therapists who provide a range of therapies.

This criterion was met in 15/19 sites.

3.a.14 The professionals listed in 3.a.2 can demonstrate a specific interest in palliative care.


This criterion was met in 1/19 sites.

Summary

A considerable number of sites lack dedicated sessional input from the full range of core team members. This applies particularly to social work and pharmacy representation, however, input from occupational therapy and chaplaincy was also identified as a challenge. In addition, sites noted variable access to a range of other supporting professionals, with particular difficulties observed when trying to access psychology services, and anaesthetists who are specialists in pain management.

At present, three sites do not have a consultant who is on the specialist medical register for palliative medicine, and a number of sites do not have a lead nurse with an appropriate qualification in palliative care. However, there was evidence of these sites developing plans to achieve this criterion in the future. There is also widespread commitment to working towards ensuring that all community specialist nurses, and one nurse per shift within in-patient units, have a degree or postgraduate qualification in palliative care. This was evident through the implementation of education strategies and personal development plans to support these staff members in undertaking further education.

Robust systems for staff support are in place at most sites, and include the availability of a range of internal and external services. Where this criterion was not met, staff reported that there are a number of informal systems of support in place.



A number of sites have developed formal arrangements with local stand-alone nurse specialists, which include attendance of these nurses at multidisciplinary meetings held by the specialist palliative care service, and regular discussion of patients' needs with the consultants in palliative care. A number of allied health professions (AHPs) working in specialist palliative care services are active members of their specialist interest group. None of the sites currently meet the desirable criterion, which requires that all AHPs, who are members of the multidisciplinary team, have a multidisciplinary diploma in palliative care.

Strengths

- Robust systems of staff support are in place.
- Commitment to working towards all community specialist nurses, and one nurse per shift within in-patient units, having a degree or postgraduate qualification in palliative care.
- Most AHPs, who are members of the specialist palliative care multidisciplinary team, are active members of their specialist interest group.
- Widespread access to a range of complementary therapies.

Challenges

- Securing dedicated sessional input from the full complement of professions required as part of the core team.
- Accessing psychology services.
- Ready access to other professionals, particularly anaesthetists who are specialists in pain management.
- Implementation of personal development plans across all sites.

Recommendations

- Services should work towards achieving the full complement of professions required for the core team.
- The lack of availability of psychology services across Scotland needs to be addressed at a national level.
- The lack of ready access to other professionals needs to be addressed directly with the providers, as this deficit places considerable constraints on the optimisation of patient care.

Examples of local initiatives

Accord Hospice, Paisley

There is a strong commitment to the continuing professional development of nursing staff working within the specialist palliative care team. This commitment means that the Service is well on the way towards achieving all community specialist nurses, and one nurse per shift in the in-patient unit, having a degree or postgraduate qualification in palliative care. At the time of the review visit, all of the community nurses had attained a degree or postgraduate qualification in palliative care. A number of nursing staff in the in-patient unit had completed, or were currently undertaking, a degree or postgraduate qualification in palliative care. Wherever possible a nurse with a specific palliative care qualification is on duty within the in-patient unit, and it is anticipated that within the next 2 years all nursing staff within the in-patient unit will be qualified, to at least degree level, in palliative care.

Dumfries & Galloway Acute & Maternity Hospitals NHS Trust

There is impressive provision of psychology support for staff, patients and their families/carers. This can be provided in the Unit or in the patient's home, and is provided by a consultant clinical psychologist in cancer care, who is a member of the specialist palliative care team. The psychologist attends weekly multidisciplinary team meetings, and guidelines are also in place for referral to this service. The remit of this psychologist includes education and training, and conducting audit and research.

Fife Acute Hospitals NHS Trust and Fife Primary Care NHS Trust

A volunteer service is in place, providing a valuable resource for the Service. The Service employs a full-time volunteer co-ordinator who co-ordinates over 100 volunteers. All volunteers receive training and support from the Service. A volunteers newsletter is produced and social occasions are held for volunteers. A team of volunteer drivers bring patients to the Victoria Day Hospice, Kirkcaldy, each morning and return them home in the afternoon. Trained volunteers also provide a range of complementary therapies.

2.6 Standard 3b: Managing People and Resources: Hospital Palliative Care Support Team

Standard Statement

Specialist palliative care is provided by a highly qualified multidisciplinary team.

Essential Criteria

3.b.1 The core team comprises dedicated sessional input from:

- doctors;
- nurses.

This criterion was met in 3/3 sites.

3.b.2 The core team has ready access to other co-opted staff (who have agreed service level input) including:

- anaesthetist (who is a specialist in pain management);
- bereavement specialist;
- chaplain;
- dentist;
- dietitian;
- lymphoedema specialist;
- occupational therapist;
- oncologist;
- pharmacist;
- physiotherapist;
- psychiatrist;
- psychologist and/or counsellor;
- social worker;
- speech and language therapist.

This criterion was met in 0/3 sites.

3.b.3 All clinical staff are supported by administrative staff.

This criterion was met in 2/3 sites.

3.b.4 Formal arrangements are jointly agreed between stand-alone nurse specialists in palliative care and their local specialist palliative care service to ensure multidisciplinary working.

This criterion was not applicable to 3 sites.

3.b.5 There is a policy/procedure for the provision of a staff support system.

This criterion was met in 2/3 sites.

3.b.6 The following qualifications are required:

- a consultant who is on the specialist medical register for palliative medicine;
- a lead nurse of a service who has either a Masters degree in palliative care or is recorded as a specialist practitioner in palliative care.

This criterion was met in 3/3 sites.

3.b.7 The team can demonstrate how they are working towards all hospital team nurses having a degree or postgraduate qualification in palliative care.

This criterion was met in 3/3 sites.

3.b.8 All professions allied to medicine (who are members of the multidisciplinary team) are active members of their specific specialist interest group.

This criterion was not applicable to 3 sites.

3.b.9 All practitioners are registered with their relevant accrediting body.

This criterion was met in 3/3 sites.

3.b.10 There is evidence that all professionals have personal development plans which demonstrate that training needs are identified and addressed.

This criterion was met in 3/3 sites.

Desirable Criteria

3.b.11 All professions allied to medicine (who are members of the multidisciplinary team) have a multidisciplinary diploma in palliative care.

This criterion was not applicable to 3 sites.

3.b.12 There is ready access to complementary therapists who provide a range of therapies.

This criterion was met in 2/3 sites.

3.b.13 The professionals listed in 3.b.2 can demonstrate a specific interest in palliative care.

This criterion was met in 0/3 sites.

Summary

Specialist palliative care is provided by highly qualified core teams in all three hospital specialist palliative care support teams. However, there is variable access to other healthcare professionals supporting the core team. Even when ready access is available, there was an absence of service level agreements to ensure the ongoing provision of these services.

All sites have a consultant who is on the specialist medical register for palliative medicine, and lead nurses who have either a Masters degree in palliative care or are recorded as a specialist practitioner in palliative care. Further evidence was provided which indicated that a number of additional nurses in each site have, or are currently in the process of undertaking, a degree or postgraduate qualification in palliative care. All sites have implemented systems to ensure that training needs are identified and addressed through the use of appraisals and personal development plans.

Strengths

- Highly qualified core teams.
- Training and educational needs are identified and addressed through personal development plans and appraisal.

Challenges

- Ready access to professionals supporting the core team, who have agreed service level input.
- Development of policies and procedures across all sites to ensure access to staff support services.
- To ensure equity of access across Scotland, to a range of complementary therapies.

Recommendations

- Sites should initially work towards developing service level agreements to obtain ready access to: chaplaincy services; occupational therapy; pharmacy; physiotherapy; and social work services.
- Establish designated sessional input from other staff ancillary to the core team.

Example of a local initiative

West Lothian Healthcare NHS Trust

The Specialist Palliative Care Service is currently running a shadowing project to enable allied health professions (AHPs) to work with the specialist palliative care team in order to gain specialist experience in this field.

2.7 Standard 4: Professional Education

Standard Statement

The specialist palliative care unit/team provides palliative care education at all levels, ie for staff providing generalist palliative care and for staff providing a specialist palliative care service.

Essential Criteria

4.1 There is a member of the unit/team with designated sessions, or a remit in their job description, for planning and implementing in-house and out-reach education programmes.

This criterion was met in 20/22 sites.

4.2 The unit/team has access to an educator in order to facilitate curriculum development.

This criterion was met in 18/22 sites.

4.3 Members of the unit/team who are involved in teaching have attended a course on teaching and learning.

This criterion was met in 15/22 sites.

4.4 The unit/team has on-site teaching facilities and a range of audio-visual aids.

This criterion was met in 22/22 sites.

4.5 The unit/team has local access to specialist palliative care library and internet facilities, and databases relevant to specialist palliative care.

This criterion was met in 22/22 sites.

4.6 The unit/team has access to international, national and local syllabi, which can be referred to in the process of devising an innovative and dynamic curriculum.

This criterion was met in 22/22 sites.

4.7 There is communication skills training programmes in place, which enable all team members to respond sensitively and effectively to patients' needs.

This criterion was met in 18/22 sites.

4.8 The unit/team provides an evidence-based programme of education for professionals addressing:

- physical, psychological, social and spiritual aspects of palliative care;
- ethical issues for patients approaching the end of life;
- communication issues.

This criterion was met in 19/22 sites.

4.9 Within this education programme there is evidence of multidisciplinary teaching and learning.

This criterion was met in 20/22 sites.

4.10 There is evidence of teaching at different levels of palliative care.

This criterion was met in 21/22 sites.

4.11 The unit/team produces an annual report on its education activities, including needs assessment and evaluation.

This criterion was met in 9/22 sites.


4.12 The unit/team has established links with an institution of higher education and contributes to pre-registration, undergraduate and postgraduate education in palliative care.

This criterion was met in 22/22 sites.

Summary

All sites have on-site education facilities and a range of equipment to carry out education and training. A number of sites also have an educator in post, and in the majority of those units/teams which did not, there are staff clearly identified who have a remit in their job descriptions to plan and implement education programmes. The provision of education across generalist and specialist palliative care is developing well. Nearly all sites have a training strategy in place and most have access to curriculum development expertise.

All sites have developed formalised links with higher education facilities, as well as outside bodies such as SPPC. Many examples of training programmes were presented as evidence, and showed a broad range of education provision. Although there was widespread commitment to multidisciplinary teaching at all levels in palliative care, there was evidence in some areas that learning opportunities were primarily aimed at medical and nursing staff. It was noted that a significant number of



sites could not demonstrate that all staff involved in teaching had attended an appropriate course on teaching and learning.

All sites acknowledged the importance of providing communication skills training for all team members, and a variety of training programmes are in place to meet the needs of staff in this area. The four sites that did not meet this criterion have plans to address this deficit.

Strengths

- There is considerable commitment and enthusiasm across Scotland to provide specialist palliative care education.
- Most sites have team members clearly designated to provide training and education.
- All sites have local access to teaching, library and internet facilities.

Challenges

- Supporting those team members involved in teaching to attend a course on teaching and learning.
- Ensuring communication skills training is provided to all team members.
- Provision of training and education to all members of the multidisciplinary team.
- The preparation of an annual report to review the education activities provided by the specialist palliative care service.

Recommendations

- All staff involved in teaching should be supported to undertake a course in teaching and learning in order to ensure they are equipped with the specialist skills required.
- All sites should continue work to ensure communication skills training is provided to all members of the multidisciplinary team.
- All sites should produce an annual report on its education activities, including education and training needs assessment, and analysis.

Examples of local initiatives

Ardgowan Hospice, Greenock

The Hospice's education service is committed to ensuring that staff are well informed about developments and learning opportunities in specialist palliative care. This is facilitated by the production of two bi-monthly newsletters, which are placed on the notice boards in the two Hospice buildings, and distributed to heads of department.

The 'Palliative Care Roundup' newsletter is designed to provide clinical staff with an informal and accessible summary of new developments in palliative care. Sections include 'Breaking Bad News', 'Pushing Back the Boundaries', and 'Web Wisdom'. There is also a section where a staff member is asked to contribute some insight or lesson gained from their practice.

The 'Education Matters' newsletter is intended to keep staff and volunteers up to date with subjects relating to education. Sections include a list of in-house events, details of external courses and study days, contents of current journal issues, and details of books received by the library.

Highland Hospice, Inverness

Highland Hospice offers a wide range of palliative care educational activities in conjunction with Marie Curie Cancer Care. This includes the Marie Curie diploma and degree in cancer and palliative care, and a variety of short courses on palliative care issues. The innovative approach to education also incorporates a competency framework and reflective practice sessions.

Tayside Primary Care NHS Trust

The Specialist Palliative Care Service provides a comprehensive, evidence-based programme of education for generalists and specialists working with specialist palliative care patients. The programme includes short courses such as 'New Dimensions in Cancer Pain Management', and longer 6-week courses such as 'An Introduction to Symptom Control in Palliative Care'. Specific training is also carried out by the Macmillan pharmacist for secondary and primary care pharmacists, and medical students. The service also holds major bi-annual palliative care conferences, covering a range of palliative care issues.

2.8 Standard 5: Inter-professional Communication

Standard Statement

There are effective channels of communication within the specialist palliative care team and with all others involved in the patients' care.

Essential Criteria

5.1 There is clear documentation in patients' notes (specialist palliative care notes) of all key professionals from primary, secondary and tertiary care who are involved in their care.

This criterion was met in 18/22 sites.

5.2 There is evidence of a system to disseminate information to these key professionals.

This criterion was met in 19/22 sites.

5.3 Regular multidisciplinary meetings are held to discuss the care of new and existing patients. All members of the core team attend these meetings and further professionals can be co-opted when necessary.

This criterion was met in 9/22 sites.

5.4 Advice given by telephone is clearly documented.

This criterion was met in 19/22 sites.

5.5 There is notification of anticipated patient problems from the specialist palliative care team to those providing the local specialist 24-hour telephone advice service.

This criterion was met in 21/21 sites. This criterion was not applicable to 1 site.

5.6 There is notification of anticipated patient problems from the specialist palliative care team to the relevant member(s) of the primary care team.

This criterion was met in 21/22 sites.

5.7 Key members of the care team are informed of a patient's death (within a specialist service) by the next working day and members of the extended care team are informed within five working days.

This criterion was met in 2/19 sites. This criterion was not applicable to 3 sites.

5.8 Practitioners in a specialist palliative care service are members of their local Managed Clinical Network in palliative care.

This criterion was met in 11/22 sites.

Desirable Criteria

5.9 Integrated records.

This criterion was met in 13/22 sites.

5.10 Representation on site-specific Managed Clinical Network multidisciplinary meetings.

This criterion was met in 18/22 sites.

Summary

It is obvious that all sites place great importance on the need to keep key healthcare professionals informed of any relevant information throughout the patient's journey. A number of systems are utilised to facilitate clear and comprehensive communication, including attendance of specialist palliative care staff at meetings held in the community, comprehensive discharge documents, and regular telephone/fax communication. Automated systems for data collection and audit are generally lacking, which resulted in a number of sites being unable to provide audit evidence to confirm that the required timescales are achieved following the death of a patient. All sites demonstrated a commitment to holding regular multidisciplinary meetings to discuss the care of patients, however a number of sites did not meet this criterion as there was not full representation from all required core members.

There was evidence that local Managed Clinical Networks (MCNs) in palliative care are developing erratically across NHS Boards. At present, none of those MCNs have a quality assurance (QA) framework accredited by NHS Quality Improvement Scotland (NHS QIS).

Strengths

- The importance of communication with key professionals is recognised and practised across all sites.
- The use of comprehensive palliative care handover forms which are faxed to NHS 24 and local community out-of-hours services to ensure continuity of care.
- Development of regional integrated care pathways for the management of pain.

Challenges

- Ensuring representation from all core team members at multidisciplinary meetings.
- To carry out regular audit and promote quality assurance.
- To maintain specialist palliative care representation on site-specific MCNs.

Recommendations

- Extend multidisciplinary meetings to ensure all members of the core team attend, and other co-opted staff attend as necessary.
- Establish local MCNs which are managerially and administratively supported. These MCNs should work towards developing a QA framework which is accredited by NHS QIS.

Examples of local initiatives

Ayrshire Hospice, Ayr

The Hospice has developed a procedural checklist, which is followed by staff in the event of a patient's death. The list includes details of all healthcare professionals who should be contacted, and the timescales within which contact should be made. Staff reported that an audit was previously carried out to confirm compliance with this checklist.

Borders General Hospital NHS Trust

The local MCN in palliative care is well established in the region, and is a valuable resource for all staff involved in caring for patients with palliative care needs. The review team commended the MCN pain project, which enables the close monitoring of pain scores and pain relief in conjunction with the patients, and is about to be rolled out across the region.

Grampian Specialist Palliative Care Service

The Palliative Care Focus Group is a well-established regional network planning group. This network facilitates discussion and communication between the different professional groups who are involved in the care of specialist palliative care patients. The Group meets on a monthly basis and consists of palliative care specialists and generalists, as well as representatives from social work, and primary and secondary care.

2.9 Standard 6: Communication with Patients/Carers

Standard Statement

Patients and those important to them are helped to communicate their feelings and priorities.

Essential Criteria

6.1 There is a needs assessment and care plan for each patient to proactively focus on communication and information needs.

This criterion was met in 18/22 sites.

6.2 There is supported access to information and education resources for patients and their families/carers.

This criterion was met in 22/22 sites.

6.3 There is information specifically for children/adolescents and for those adults and children with sensory impairment or special needs.

This criterion was met in 18/22 sites.

6.4 There is evidence that the team regularly carries out patient/family satisfaction surveys in order to evaluate staff communication skills.

This criterion was met in 4/22 sites.

6.5 Evidence exists that guidance and advice are offered to patients and their families/carers to facilitate rehabilitation of the patient in the community.

This criterion was met in 22/22 sites.

6.6 The patient's preferred place of care is identified, agreed and regularly reviewed with the patient/carer.

This criterion was met in 22/22 sites.

6.7 There is provision of bereavement information booklets which give information on emotional and practical issues.

This criterion was met in 20/22 sites.



Summary

All sites demonstrated a commitment to proactively assess patients' needs. A variety of care plans and assessment tools are in use to address a wide range of needs. However, it was noted that a number of sites do not utilise care plans which specifically focus on patients' communication and information needs. All sites produced evidence to confirm that patients and carers are provided with a wide range of information. There is also supported access to a number of patient education resources including: patient/carer support groups; internet access and library facilities; and information and education facilities provided by organisations such as Maggie's Centres, Macmillan Cancer Relief, and CancerBACUP. The needs of children appear to be well addressed by support programmes, books, leaflets and the availability of appropriately skilled staff. However, the needs of adults and children with sensory impairment or special needs were less well addressed, although most sites demonstrated an ability to find information when required.

Many sites have systems in place to gather feedback about the general environment, and overall satisfaction with the services provided. However, only a small number of sites specifically evaluate staff communication skills on a regular basis. All sites are involved in rehabilitating patients back into the community, and provide verbal/written guidance and advice to families/carers. This is further supported by widespread input from occupational therapists, physiotherapists and primary healthcare teams. All sites demonstrated a clear commitment to discussing, documenting and reviewing the patients preferred place of care. Evidence was provided to indicate that, generally, families/carers are provided with written information about bereavement issues, and it was highlighted that a number of sites have produced local booklets and information packs.

Strengths

- Provision of information and supported access to a range of education resources for patients and families/carers.
- Staff identifying the patient's preferred place of care.

Challenge

- Ensuring that regular patient/family satisfaction surveys are carried out in order to review and evaluate staff communication skills.

Recommendation

- Sites should build on existing processes already developed within Scotland to gather feedback from patients and families in order to evaluate staff communication skills.

Examples of local initiatives

Bethesda Hospice, Stornoway

The review team commended the provision of a locally produced bereavement information booklet. This includes sections detailing 'Practical Advice Following Death', 'Understanding Bereavement', and a list of local and national contacts.

Marie Curie Centre Hunters Hill, Glasgow

The Hospice hosts a drop-in monthly carers support forum, to provide guidance and advice on a number of issues. These forums allow carers to fully support patients who are being rehabilitated back into the community.

St Vincent's Hospice, Johnstone

The specialist palliative care team is committed to ensuring that the patient's preferred place of care is identified, agreed and regularly reviewed with the patient/carer. The family page within the patient's record includes a section for identifying the patient's preferred place of care, and there is provision to review this on a regular basis. The 'Home Respite Service' system allows patients with specialist palliative care needs to be cared for at home if they wish.

2.10 Standard 7: Therapeutic Interventions

Standard Statement

All patients with progressive incurable disease have access to specialist palliative care services which address proactively all the symptoms of their condition and the effect these symptoms have on them and their family/carers.

Essential Criteria

Physical

7.1 There is evidence that:

- patients are actively involved as partners in symptom assessment and control;
- the changing pattern of pain and other symptoms is anticipated;
- a variety of methods are used to assess pain and other symptoms;
- a plan of symptom management is devised to include pharmacological and non-pharmacological approaches;
- review of pain and other symptoms is regularly undertaken.

This criterion was met in 21/22 sites.

7.2 A wide range of modalities of treatment are available for symptom management.

This criterion was met in 22/22 sites.

7.3 Guidelines are in place to ensure safe and effective use of these modalities of treatment.

This criterion was met in 21/22 sites.

7.4 There is evidence of safe and effective management of specialist interventions (eg tracheostomy, percutaneous gastrostomy and epidurals) to allow patients to be cared for in their place of choice.

This criterion was met in 20/22 sites.

7.5 Systems are in place to ensure 24-hour access to necessary specialist drugs for all patients.

This criterion was met in 22/22 sites.

Desirable Criterion

7.6 Self-contained units holding a stock of medicines employ a pharmacy technician to manage the supply system.

This criterion was met in 3/16 sites. This criterion was not applicable to 6 sites.

Essential Criteria

Psychological

7.7 Evidence exists of ongoing support to assist patients and those important to them to address emotional issues, including those arising from the process of loss and change.

This criterion was met in 22/22 sites.

7.8 There is evidence of referral to specialist psychological and/or counselling support services according to identified need.

This criterion was met in 20/22 sites.

7.9 Specialist services demonstrate that the needs of children as patients, and as relatives, have been recognised and met with services suitable to age and stage of development.

This criterion was met in 21/22 sites.

Essential Criteria

Spiritual

7.10 Evidence exists that patients and those important to them have had the opportunity for their spiritual needs to be assessed and addressed.

This criterion was met in 22/22 sites.

7.11 Evidence exists that religious needs have been assessed and addressed.

This criterion was met in 22/22 sites.

7.12 There is evidence of referral to specialist spiritual support services according to identified need.

This criterion was met in 19/22 sites.

Essential Criteria

Social

7.13 Evidence exists that patients and those important to them have their social needs assessed and addressed.

This criterion was met in 18/22 sites.

7.14 Systems are in place to ensure patients and their family/carers have access to priority assessment of their service requirements.

This criterion was met in 19/22 sites.

7.15 Evidence exists that staff are assisting patients and families/carers to address anticipated change in the family structure and that children affected by illness/disability are given support to cope with changes in their, or their family's, circumstances.

This criterion was met in 22/22 sites.

Essential Criteria

Bereavement

7.16 Evidence exists that families'/carers' bereavement needs have been assessed and addressed.

This criterion was met in 13/22 sites.

7.17 There are local guidelines for referral to a bereavement service

This criterion was met in 15/22 sites.

Summary

There was widespread evidence that patients' physical symptoms are effectively managed across all sites. A wide range of modalities of treatment are used, and guidelines are in place to ensure the safe and effective use of specialist interventions, thus allowing patients to be cared for in their place of choice. Two sites did not meet this criterion, due to the lack of specialist medical cover and limited access to interventions. All sites provided evidence which indicated that patients are actively involved as partners in assessment and control of symptoms. Resulting management plans are prepared for patients, which include non-pharmacological and pharmacological approaches. Systems are in place at all sites to provide 24-hour access to necessary specialist drugs for all patients.


All sites demonstrated that ongoing support is provided to assist patients and those important to them to address emotional issues, including those arising from the process of loss and change. There was also widespread evidence of referral to specialist counselling and psychology services according to identified need. In almost all sites, the needs of children as patients, and as relatives, have been recognised and met through the availability of a comprehensive range of services suitable to age and stage of development. The only site which did not meet this criterion, acknowledged the limitations of current facilities, but highlighted that these deficits will be addressed when a new purpose-built centre is constructed.

All sites demonstrated that patients, and those important to them, have the opportunity for their spiritual and religious needs to be assessed and addressed. There was widespread evidence of referral to specialist spiritual support services when required. Those sites which did not meet this criterion highlighted the limited access to chaplaincy services. Although staff in all sites confirmed that the social needs of patients, and those important to them, are assessed, it was considered that those sites which lack dedicated social work input to the multidisciplinary team are not able to fully address those needs. A number of mechanisms within specialist palliative care services are in place across Scotland to support patients and families who are coping with changes in circumstances and family structure.

The review teams reported that, generally, most sites assessed families' and carers' bereavement needs. However, in a number of sites, it was noted that established systems were not in place to formally assess and address these needs.

Strengths

- Physical symptoms are well managed in all sites using a wide range of modalities of treatment.
- Guidelines are in place to ensure the safe and effective use of specialist interventions.
- All sites provide ongoing psychological support to assist patients and those important to them to address emotional issues, including those arising from the process of loss and change.
- The needs of children as patients, and as relatives, have been recognised and met with services suitable to age and stage of development.
- Spiritual and religious needs of patients and those close to them are assessed and addressed across all sites.

- 
- Support is provided in all sites to assist patients, and families and carers, to address anticipated change in the family structure.
 - The needs of children affected by illness or disability are acknowledged in all sites, and support given to cope with changes in their family's circumstances.

Challenges

- Dedicated social work input to the core team.
- Formal assessment of bereavement needs.
- Availability of local guidelines for referral to bereavement services.

Recommendations

- Work towards obtaining formalised sessional input from a social worker, to ensure patients' and their families'/carers' needs are fully addressed.
- Development of formal bereavement risk assessment across all sites.
- Implementation of local guidelines for referral to bereavement services.

Examples of local initiatives

Marie Curie Centre Fairmile, Edinburgh

The Hospice has recently introduced the Marie Curie Cancer Care spiritual and religious competency framework to assist staff in addressing patients' spiritual and religious needs. The competencies are set out in four levels and specify levels of competency that should be achieved by staff and volunteers working in all areas of care.

Lothian University Hospitals NHS Trust

Guidelines are in place to ensure the safe and effective management of specialist interventions to allow patients to be cared for in their place of choice. The Lothian Specialist Palliative Care Guidelines Group is a multidisciplinary group of specialist and non-specialist healthcare professionals from hospital, community and hospice settings. The Group has developed comprehensive, evidence-based guidelines, for many aspects of specialist palliative care, including symptom control, access to palliative care drugs, psychosocial aspects of care, and support services/patient information.

Prince & Princess of Wales Hospice, Glasgow

An impressive integrated care pathway (ICP) for the management of chronic cancer pain is in use within South Glasgow. This joint project has been established between primary, secondary and tertiary care. A uniform system of assessing and managing chronic cancer pain has been developed, with ICP documentation, contained in a patient-held record, to which all healthcare professionals contribute. This project has facilitated communication between multi-professional disciplines, and organisations, and is being rolled out to the Greater Glasgow area.

St Andrew's Hospice, Airdrie

The Hospice has recognised the importance of helping children and young people cope with major changes in their life by providing them with an 8-week 'Seasons for Growth' programme. The programme is offered at several levels, catering for young people aged 6-18. It uses symbolism drawn from the different seasons of the year as a framework in which to explore issues of loss and grief.

2.11 Standard 8: Patient Activity

Standard Statement

Specialist palliative care units ensure efficient and effective use of specialist resources in order to enable patients with complex needs to have access to the services according to identified need.

Essential Criterion

8.1 A system is in place to collect the data specified in the Scottish Minimum Data Set for Specialist Palliative Care under the following headings:

- general;
- in-patient units;
- day services/out-patients;
- home care;
- hospital support;
- place of death.

This criterion was met in 17/22 sites.

Summary

The requirement for clinical data to contribute towards a national comparable report is a relatively new feature for specialist palliative care services. At the time of this report, nearly all sites had access to the hardware and software necessary to gather all fields within the Minimum Data Set produced by the SPPC.

Strength

- All specialist palliative care services are committed to collecting the Scottish Minimum Data Set for Specialist Palliative Care.

Challenge

- To provide sufficient administrative support for clinical audit.

Recommendations

- The voluntary sector should be included in information and technology developments within NHSScotland.
- The development of a national MCN to facilitate further developments in data collection and clinical audit, building on the work of SPPC and of local and regional MCNs.
- To make use of the work and resources of existing and developing local and regional MCNs, and to support the production of an annual report on the activity within specialist palliative care services including: community services; day services; and in-patient services.



Chapter 3

Conclusions

3. Conclusions

This national overview sets out the performance of specialist palliative care services in Scotland as a whole against the specialist palliative care standards published in June 2002. The accompanying local reports set out the performance of each Hospice/Trust providing specialist palliative care against the same standards. A number of general themes have emerged which apply across the country.

Firstly, the review team was struck by the commitment, dedication and hard work of the staff involved in providing specialist palliative care services, frequently under considerable pressure. It is clear that these services seek, wherever possible, to be responsive to patient needs, and a number of innovative service developments were seen. However, many specialist palliative care units/teams are currently reaching capacity, and Hospices/Trusts need to take this into account when planning services.

Secondly, there is much informal networking taking place across Scotland among those providing specialist palliative care services. The reliance on the goodwill of staff, coupled with low staff turnover, has resulted in the development of comprehensive local knowledge, and effective working relationships with external colleagues. However, review teams noted a lack of formal procedures in place to support these arrangements, and felt that specialist palliative care services would benefit from developing accredited Managed Clinical Networks (MCNs). This would allow staff to share expertise, specialist resources and data, and would also prompt the development of innovative solutions to the variety of problems faced throughout the service.

Thirdly, members of the public have been involved at every stage of the specialist palliative care project. This has provided an invaluable perspective to the work of the Project Group in setting the standards and on review visits. It has also given members of the public a chance to contribute to all aspects of the review process, rather than just receive a report prepared without their input.

Fourthly, review teams found that there are policies and protocols in place for the treatment and care of specialist palliative care patients. However, the use of such policies and protocols should now be regularly audited to assess their effectiveness. Review teams concluded that staff providing specialist palliative care services across Scotland are well trained and have a high level of awareness of the needs of specialist palliative care patients.

3. Conclusions



Finally, review teams found that specialist palliative care services across Scotland aspire to achieve an excellent standard of physical, social, spiritual and psychological care. However, the high demand, and short supply of specialist staff to provide cover for these services, together with the complexity of providing specialist palliative care services between NHSScotland and voluntary hospices, means there should be a review of provision to ensure equitable access to services across Scotland.

NHS Quality Improvement Scotland (NHS QIS) looks to each Hospice/Trust providing specialist palliative care services to ensure that, in close collaboration with the staff responsible for providing this service, practice is reviewed in the light of this report's findings and recommendations, and appropriate action is taken.

Considerable momentum has been built up, and it is important to use this enthusiasm to progress the work on strengthening and improving specialist palliative care services. The public, both locally and nationally, also has an important role to play in ensuring these changes are made. NHS QIS reserves the right to revisit a Trust where it considers there are serious issues that need further external monitoring. The Scottish Commission for the Regulation of Care will be responsible for the ongoing monitoring of services provided within hospices in the future. NHS QIS intends periodically to review and raise these standards in light of the latest evidence about 'best practice' and the performance of the service, and to conduct further national and local reviews where appropriate, so as to encourage continuing quality improvement.



Appendices

Specialist Palliative Care Project Group Members

Chair

Professor John Welsh
Olav Kerr Professor of Palliative
Medicine, University of Glasgow

Project Group Members

Ms Joan Adam
Nurse Lecturer in Palliative Care,
St Columba's Hospice, Lothian

Ms Alison Barclay
Senior Occupational Therapist,
Lothian University Hospitals
NHS Trust

Ms Margaret Colquhoun
Senior Nurse Lecturer
in Palliative Care,
St Columba's Hospice, Lothian

Dr Cath Dyer
Macmillan Lead GP, Forth Valley

Ms Kate Macleod
Social Worker - Family Support,
Rachel House Children's Hospice,
Tayside

Dr Lindsay Martin
Consultant in Palliative Medicine,
Dumfries & Galloway Acute &
Maternity Hospitals NHS Trust

Reverend David Mitchell
Chaplain, Marie Curie Centre
Hunters Hill, Greater Glasgow

Dr Alison Morrison
Medical Director, Ardgowan
Hospice, Argyll & Clyde


Ms Susan Munroe
Caring Services Manager Scotland,
Marie Curie Centre Hunters Hill,
Greater Glasgow

Mrs Margaret Smith
Lay Representative, West Lothian

Ms Margaret Stevenson
Director of the Scottish Partnership
for Palliative Care
(until July 2002)

Ms Cara Taylor
Macmillan Cancer Nurse
Consultant, Tayside Primary Care
NHS Trust

Ms Jane Urie
Senior Pharmacist, Highland Acute
Hospitals NHS Trust



The NHS Quality Improvement Scotland Board member specifically working with the Specialist Palliative Care Project Group was **Mr Norman Sharp**.

Support from NHS Quality Improvement Scotland was provided by:

Mrs Angela Balharrie
Project Officer

Mrs Elaine Mackay
Project Administrator

Mrs Selina Clinch
Project Officer

Ms Susan Shields
Senior Project Officer

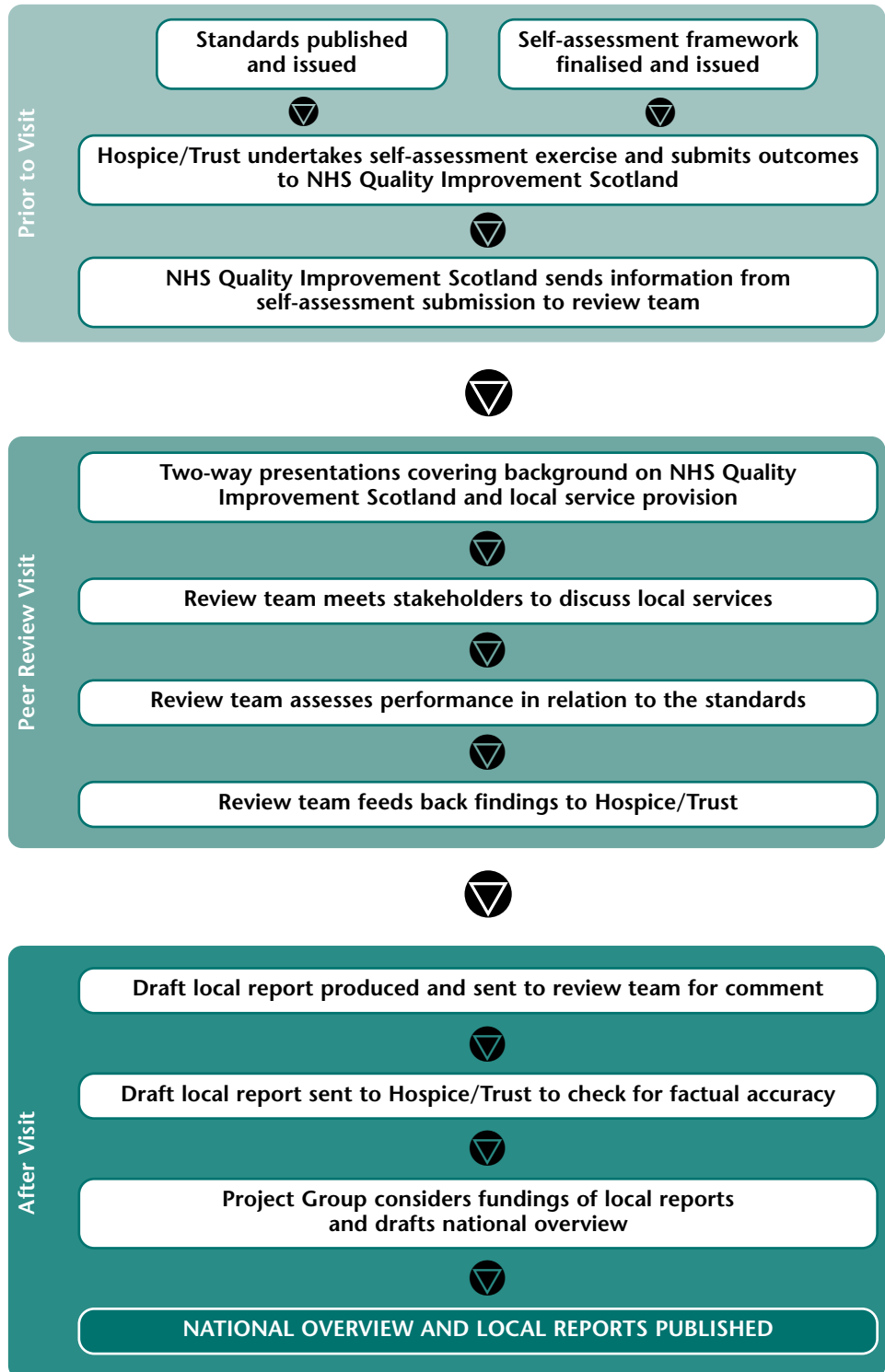
Ms Hilary Davison
Review Team Manager

Ms Frances Smith
Director of Nursing and Quality,
Standards and Reviews

Ms Nanisa Feilden
Project Officer

Mr Alan Ketchen
Project Assistant

The Quality Assurance Process: Approach Used in this Review





Standards

All standards set by NHS Quality Improvement Scotland (NHS QIS) comprise a standard statement and related criteria.

Standard Statement

Describes the agreed performance for the specific area, determined by those who are involved in the delivery/receipt of the service.

Criteria

State exactly what must be done for the standard to be reached.

Some criteria are **essential** as it is expected that they will be met wherever a service is provided. Others are **desirable/aspirational** in that they will promote continuous quality improvement as they are being met in some parts of the service and demonstrate levels of quality, which other providers of a similar service should strive to achieve.

Self-Assessment

Each set of clinical standards has an accompanying self-assessment framework. This framework gives guidance about the type of evidence required to demonstrate performance against the standards. It is completed and submitted to NHS QIS prior to a peer review visit, together with extensive additional documentation. The evidence obtained from this self-assessment exercise comprises the main source of written evidence considered by each peer review team.

Peer Review

Peer review is the process by which a multidisciplinary review team, including members of the public, carries out a Hospice/Trust visit to validate the quantitative data submitted through the self-assessment. This is achieved by means of gathering qualitative information both through discussions with staff in clinical areas, and observation. To promote a consistent approach for specialist palliative care, four team leaders have been recruited to undertake the review visits.

During each review, the review team was guided by a team leader to ensure a multidisciplinary consensual assessment was reached. At the conclusion of the review, the review team provided feedback to the

Hospice/Trust giving a broad overview of its assessment, which was based on the written self-assessment, and on evidence obtained during the review visit.

To enhance the consistency of the process, an NHS QIS manager and project officer accompanied each visit, both of whom provided the secretariat and developmental support for the Project Group during the standard-setting phase of the project.

The schedule for a Specialist Palliative Care external peer review visit included:


- initial meeting with key personnel responsible for the service under review;
- dialogue with clinicians, audit staff and managers based on the written evidence;
- scrutiny of documentation;
- interviews with staff members;
- regular team briefings throughout the day to assess progress and to compile the local report; and
- feedback to the Hospice/Trust representatives on conclusion of the visit.

In addition, the NHS QIS review team met with patient representatives, GPs and representatives from the area NHS Board.

The composition of each review team varies, and all review team members come from outwith the geographical area they are reviewing. Although this presents challenges in achieving consistency of process, it promotes sharing of good practice and ensures that each review team assesses the performance of a Hospice/Trust against the standards, not by comparing one Hospice/Trust with another.

In order to determine whether a particular criterion is 'met' or 'not met', each review team requires to identify evidence on a variety of levels. For example, to demonstrate that a particular issue is addressed in a local protocol, evidence is sought during the peer review process as follows:

- description of the issue and how it should be managed in a local written protocol (submitted as part of the self-assessment);
- confirmation of awareness of the location and content of the protocol through staff interviews;

- 
- evidence of a process in place for the protocol to be regularly updated; and
 - collection of data through an integrated care pathway/audit sheet, leading to provision of collated audit data confirming compliance with the local protocol.

Until a legal interpretation of the Data Protection Act is made as to whether patient records can be accessed for purposes other than managing patient care, NHS QIS review teams are not scrutinising individual patient records. Therefore, in cases where it is stated that information is recorded in individual patient case notes, and the claim is corroborated in staff interviews during the visit, an assessment of 'met' will be made.

The responsibility of NHS QIS is to report whether the services provided by NHSScotland, both nationally and locally, meet agreed standards, but not to review individual cases or the work of individual healthcare professionals. In achieving this aim, variations in practice (and potential quality) within a service will be encountered. Where such variation exists between Hospices/Trusts, this will be stated; treatment variations will also be reported, but will not identify patients or healthcare professionals.

Reports

A local written report was drafted at the time of each visit by NHS QIS. The draft report was then circulated to the review team for comment, and to the Hospice/Trust concerned to allow a check for factual accuracy.

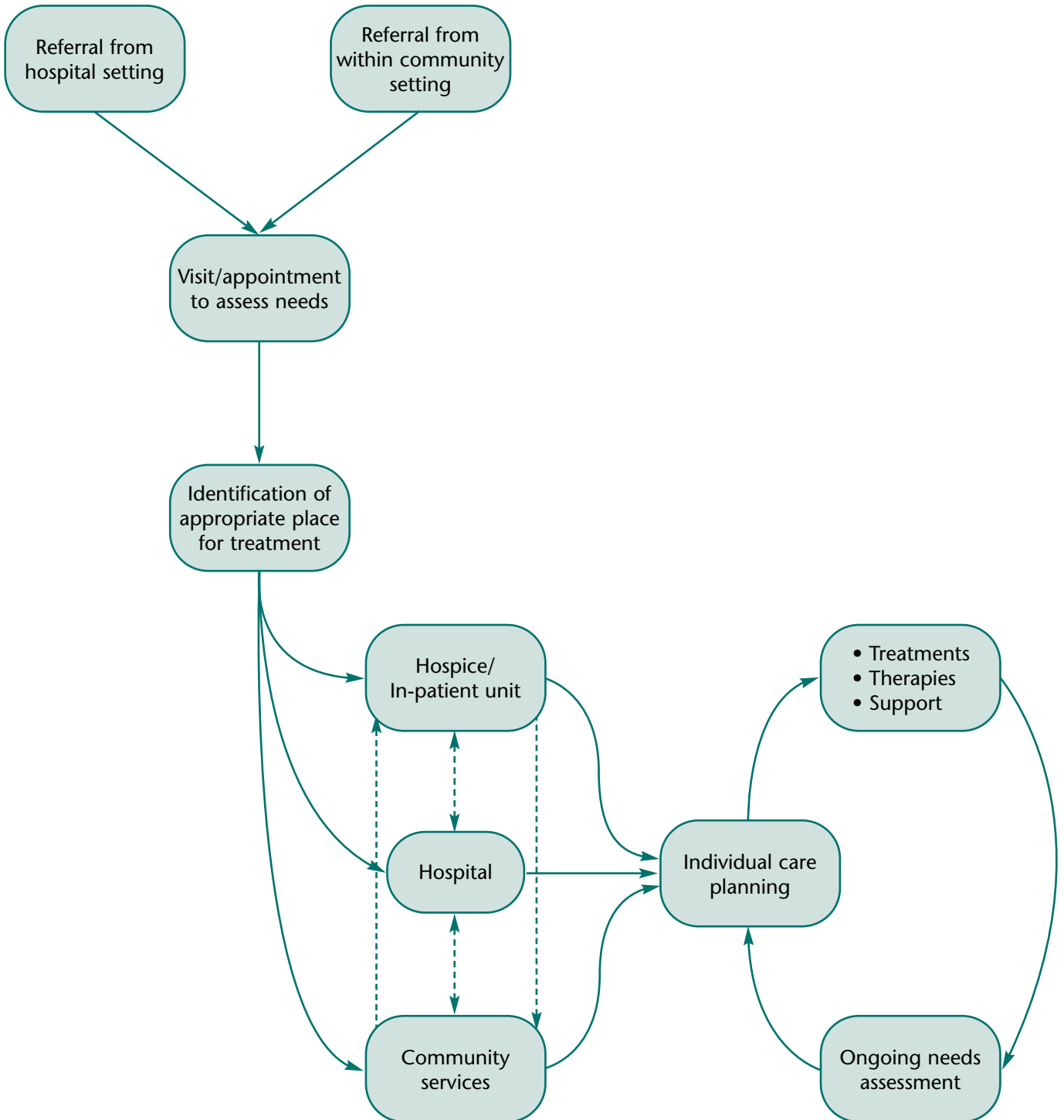
On conclusion of the peer review programme, the Project Group reconvened to study the findings and examine trends in order to draw conclusions and make recommendations to NHS QIS.

Co-ordinating Specialist Palliative Care Services

Patient Pathway of Care for Specialist Palliative Care Services

Stage	What might happen	Where	Who might be involved
Initial Contact and Referral	<ul style="list-style-type: none"> • Discussion of symptoms causing concern • Assessment of current situation • Referral to Hospice/Hospital 	<ul style="list-style-type: none"> • GP Surgery • Hospital • Home • Hospice Day Care 	<ul style="list-style-type: none"> • GP • Community nurse • Hospital staff • Social worker • Carer • Family
Options for Treatment	<ul style="list-style-type: none"> • Assessment of needs • Information and advice • Discussion of options • Development of care plan 	<ul style="list-style-type: none"> • Hospice • Hospital • Home 	<ul style="list-style-type: none"> • Specialist palliative care doctor • Specialist palliative care nurse • Physiotherapist • Oncologist • Dietitian • Chaplain • Psychologist • Lymphoedema specialist • Anaesthetist • Social worker • Occupational therapist • Surgeon
Treatment and Care	<ul style="list-style-type: none"> • Therapies (physiotherapy, aromatherapy etc) • Pain control • Symptom control • Spiritual and religious fulfilment • Social help 	<ul style="list-style-type: none"> • Hospice • Hospital • Home 	<ul style="list-style-type: none"> • Specialist palliative care doctor • Specialist palliative care nurse • Physiotherapy • Pharmacist • Dietitian • Chaplain • Occupational therapist • Psychologist • Psychiatrist • Lymphoedema specialist • Oncologist • Complementary therapist • Anaesthetist • Social worker
Monitoring and Follow-up	<ul style="list-style-type: none"> • Ongoing needs assessment • Ongoing social assessment • Ongoing psychological assessment • Discharge planning • Bereavement counselling 	<ul style="list-style-type: none"> • Hospice • Hospital • Home 	<ul style="list-style-type: none"> • Specialist palliative care doctor • Specialist palliative care nurse • Physiotherapist • Pharmacist • Dietitian • Chaplain • Occupational therapist • Psychologist • Psychiatrist • Lymphoedema specialist • Oncologist • Complementary therapist • Anaesthetist • Social worker

Patient Pathway of Care for Specialist Palliative Care Services



Specialist Palliative Care Review Team Members

Dr Jim Adam

Medical Director, Marie Curie
Centre Hunters Hill,
Greater Glasgow

Ms Joan Adam

Nurse Lecturer in Palliative Care,
St Columba's Hospice, Lothian

Mrs Alison Allan

Day Hospice Sister, St Columba's
Hospice, Lothian

Ms Aileen Anderson

Director of Nursing and Hospice
Services, Ayrshire Hospice,
Ayrshire & Arran

Dr Sarah Aveyard

Specialist Registrar, St Columba's
Hospice, Lothian

Ms Alison Barclay

Senior Occupational Therapist,
Lothian University Hospitals
NHS Trust

Mr Bill Barclay

Lay Representative, Grampian

Dr Rosaleen Beattie

Medical Director/Consultant in
Palliative Care, St Margaret's
Hospice, Greater Glasgow

Ms Patricia Black

Senior Clinical Nurse Specialist -
Palliative Care, West Lothian
Healthcare NHS Trust

Mr Tom Brighton

Lay Representative, Tayside

Dr Duncan Brown

Locum Consultant in Palliative
Medicine, St Columba's Hospice,
Lothian

Ms Isobel Brown

Lay Representative, Grampian

Mrs Patricia Bryson

Lay Representative,
Greater Glasgow

Mr Rodney Chapman

Lay Representative,
Greater Glasgow

Ms Suzanne Clark

Lay Representative,
Greater Glasgow

Mr Tony Collins

Lay Representative, Grampian

Mrs Margaret Colquhoun

Senior Nurse Lecturer in Palliative
Care, St Columba's Hospice, Lothian

Ms Sheila Cowe

Team Leader - Community
Palliative Care Service,
St Columba's Hospice, Lothian

Ms Margaret Dakers-Thomson

Lay Representative, Highland

Dr Sonia Devereux

Lead Cancer General Practitioner,
Tayside Primary Care NHS Trust



Mrs Isabel Dosser

Palliative Care Nurse Specialist,
West Lothian Healthcare NHS
Trust

Dr Cath Dyer

Macmillan Lead GP, Forth Valley

Mrs Dawn Foxley

Service Manager Palliative Care,
Fife Primary Care NHS Trust

Mr Thomas Galbraith

Lay Representative, Lothian

Reverend Tom Gordon

Chaplain, Marie Curie Centre
Fairmile, Lothian

Mr Thomas Haswell

Lay Representative,
Greater Glasgow

Ms Victoria Hill

Staff Nurse, St Columba's Hospice,
Lothian

Ms Susan Hogg

Deputy Head of Care, Rachel
House Children's Hospice, Tayside

Mrs Carol Horne

Lay Representative, Lanarkshire

Ms Evelyn Howie

Senior Clinical Nurse, St Columba's
Hospice, Lothian

Mr Brian Hunter

Charge Nurse, Accord Hospice,
Argyll & Clyde

Ms Mareth Irvine

Lay Representative,
Dumfries & Galloway

Ms Shirley Kelly

Macmillan Principal Pharmacist in
Palliative Care, Tayside Primary
Care NHS Trust

Ms Linda Kerr

Nurse Specialist - Training Officer
in Palliative Care, Ayrshire & Arran
Acute Hospitals NHS Trust

Ms Trudy Lafferty

Matron, St Vincent's Hospice,
Argyll & Clyde

Ms Alice Leckie

Principal Social Worker, Marie
Curie Centre Fairmile, Lothian

Ms Dorothy McArthur

Principal Pharmacist,
St Columba's Hospice, Lothian

Mrs Kathryn McCall

Macmillan Clinical Nurse Specialist,
Highland Primary Care NHS Trust

Ms Sandra McDonald

Centre Director, Marie Curie
Centre Fairmile, Lothian

Ms Dorothy McElroy

Director of Nursing and Patient
Services, Ardgowan Hospice,
Argyll & Clyde

Ms Maria McGill

Centre Manager and Lead Nurse,
Marie Curie Centre Hunters Hill,
Greater Glasgow

Ms Alison McGilvray

Lay Representative, Forth Valley

Ms Kate Macleod

Social Worker - Family Support,
Rachel House Children's Hospice,
Tayside

Ms Alison MacRobbie

Palliative/Community Care
Pharmacist, Highland Primary Care
NHS Trust

Mrs Winifred Main

Lay Representative, Grampian

Dr Lindsay Martin

Consultant in Palliative Medicine,
Dumfries & Galloway Acute &
Maternity Hospitals NHS Trust

Dr Stuart Milligan

Education Facilitator/Lecturer in
Palliative Care, Ardgowan Hospice,
Argyll & Clyde

Dr David Millar

Macmillan GP Advisor,
Grampian Primary Care NHS Trust

Reverend David Mitchell

Chaplain, Marie Curie Centre
Hunters Hill, Greater Glasgow

Ms Fiona Montgomery

Macmillan Palliative Care
Pharmacist, Strathcarron Hospice,
Forth Valley

Ms Rhona Moyes

Community Palliative Care Sister,
Marie Curie Centre Fairmile,
Lothian

Ms Susan Munroe

Caring Services Manager Scotland,
Marie Curie Centre Hunters Hill,
Greater Glasgow

Mr James Neil

Principal Social Worker, Marie
Curie Centre Hunters Hill,
Greater Glasgow

Ms Carol Notman

Lay Representative, Fife

Ms Claire O'Neill

Palliative Care Clinical Nurse
Specialist, North Glasgow
University Hospitals NHS Trust

Ms Linda Pratt

District Charge Nurse, Fife

Dr Clive Preston

Consultant in Palliative Medicine,
Fife Primary Care NHS Trust

Ms Agnes Quinn

Nurse Teacher/Practitioner,
St Andrew's Hospice, Lanarkshire

Dr James Rodgers

Consultant in Palliative Medicine,
NHS Borders

Mr Stephen Smith

Clinical Services Manager,
Marie Curie Centre Fairmile,
Lothian

Mr Harrison Stevenson


Lay Representative, Lothian

Mr Raymond Strachan

Lay Representative, Grampian

Ms Cara Taylor

Macmillan Cancer Nurse
Consultant, Tayside Primary Care
NHS Trust



Ms Tricia Tierney

Regional Audit Co-ordinator,
Marie Curie Centre Hunters Hill,
Greater Glasgow

Ms Elizabeth Travers

Senior Lecturer, Marie Curie Centre
Hunters Hill, Greater Glasgow

Ms Jane Urie

Senior Pharmacist, Highland Acute
Hospitals NHS Trust

Ms Roseanne Urquhart

Head of Acute Care Planning &
Performance, NHS Highland

Reverend Alison Wagstaff

Chaplain, St Columba's Hospice,
Lothian

Mr John Watson

Lay Representative,
Ayrshire & Arran

Professor John Welsh

Olav Kerr Professor of Palliative
Medicine, University of Glasgow

Ms Sue Wilkinson

Senior Speech & Language
Therapist, Argyll & Clyde Acute
Hospitals NHS Trust

Glossary of Terms

accreditation	A process, based on a system of external peer review using written standards, designed to assess the quality of an activity, service or organisation.
acute sector	Hospital-based health services which are provided on an in-patient or out-patient basis.
AHPs	See allied health professions.
allied health professions (AHPs)	Healthcare professionals directly involved in the provision of primary and secondary healthcare. Includes several groups such as physiotherapists, occupational therapists, dietitians, etc. Formerly known as professions allied to medicine (PAMs).
anaesthetist	A medically qualified doctor who administers an anaesthetic to make a patient unconscious before a surgical operation and who may also be a specialist in pain management.
assessment	The process of measuring patients' needs and/or the quality of an activity, service or organisation.
audit	Systematic review of the procedures used for diagnosis, care, treatment and rehabilitation, examining how associated resources are used and investigating the effect care has on the outcome and quality of life for the patient.
bereavement services	Bereavement services aim to acknowledge and contain the emotional impact of a death on the family and carers affected by it, through a variety of activities or means. These include one-to-one counselling, support groups, telephone support, memorial services, the provision of information and literature on grief processes.
cachexia	A condition of abnormally low weight, weakness, and general bodily decline associated with chronic disease.
cancer	The name given to a group of diseases that can occur in any organ of the body, and in blood, and which involve abnormal or uncontrolled growth of cells.
care plan	A document which details the care and treatment that a patient/user receives, and identifies who delivers the care and treatment.

carer A person who looks after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid.

case record Patient's notes; documentation of care.

chaplain A person appointed to provide spiritual and religious care to all patients, visitors, staff and volunteers in the healthcare setting, regardless of faith or life stance. A chaplain can be ordained or lay with an acknowledged status within a mainstream faith community.

clinical effectiveness Clinical effectiveness is the extent to which specific clinical interventions, when deployed, do what they are intended to do, ie maintain and improve health, securing the greatest possible health gain from the available resources. In the health technology assessment field it has a different meaning: the evaluation of benefits against risk in a standard clinical setting using outcomes of importance to the patient.

clinical governance A framework through which NHS organisations are accountable for both continuously improving the quality of their services, and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish. Management of clinical risk at an organisational level is an important aspect of clinical governance. Clinical risk management recognises that risk can arise at many points in a patient's journey, and that aspects of how organisations are managed can systematically influence the degree of risk.


Clinical Resource and Audit Group (CRAG)	CRAG was the lead body within the Scottish Executive Health Department promoting clinical effectiveness in Scotland. The main committee, together with its subcommittees provided advice to the Health Department, acted as a national forum to support and facilitate the implementation of the clinical effectiveness agenda and funded a number of clinical effectiveness programmes and projects. On 1 January 2003 CRAG was merged with four other clinical effectiveness bodies to create NHS Quality Improvement Scotland. See NHS Quality Improvement Scotland.
clinical service	Service provided by healthcare professionals.
Clinical Standards Board for Scotland (CSBS)	The Clinical Standards Board for Scotland was a statutory body, established as a Special Health Board in April 1999. Its role was to develop and run a system of quality control of clinical services designed to promote public confidence that the services provided by the NHS met nationally agreed standards, and to demonstrate that, within the resources available, the NHS was delivering the highest possible standards of care". On 1 January 2003, CSBS was merged, along with four other clinical effectiveness bodies, to form NHS Quality Improvement Scotland (NHS QIS). See NHS Quality Improvement Scotland.
clinician	A healthcare practitioner who specialises in seeing, diagnosing and/or treating patients.
college	In the UK, the term college, when used relating to healthcare, as for example in "The Royal College of...", refers to organisations which usually combine an education role with promotion of professional standards.
complementary therapies	Alternative therapies such as acupuncture, hypnosis, and aromatherapy.
complex needs	Needs that cannot be addressed through simple or routine interventions/care.

continuing professional development (CPD)	An ongoing commitment to learning in various forms, which maintains and enhances professional standards of work, and develops the ability to recognise good practice.
core team	A multidisciplinary group made up of an identified number of healthcare professionals who are considered essential for the management of patients. All members of this team meet on a regular basis to discuss the care of new and existing patients.
counselling services	Counselling services offer a 'being with' kind of support, to allow an open-ended exploring of feelings to help someone express and work through their feelings and grief.
CRAG	See Clinical Resource and Audit Group.
criterion(s)/ criteria(pl)	Provide the more detailed and practical information on how to achieve the standard, and relate to structure, process or outcome factors.
CSBS	See Clinical Standards Board for Scotland.
data set	A list of required and specific information.
data source	The source of evidence to demonstrate whether a standard or criterion is being met.
degenerative disease	A condition which results in progressive deterioration and loss of function.
dentist	A member of the dental profession who in the UK must be registered with the General Dental Council unless he/she holds a medical qualification.
desirable (criterion/criteria)	Good practice that is being achieved in some parts of the service and demonstrates levels of quality to which other providers of a similar service should strive.
diagnosis	Identification of an illness or health problem by means of its signs and symptoms. This involves ruling out other illnesses and causal factors for the symptoms.
dietitian	An expert in nutrition who helps people with special health needs plan the kinds and amount of foods to eat.

discharge	A discharge marks the end of an episode of care. Types of discharge include in-patient discharge, day-case discharge, day-patient discharge, out-patient discharge and allied health professions (see AHPs) discharge.
dyspnoea	Laboured or difficult breathing.
educator	An educator is a healthcare individual who has undertaken a recognised qualification in teaching and learning in higher education.
essential (criterion/criteria)	A criterion that should be met wherever a service is provided.
evaluation	The study of the performance of a service (or element of treatment and care) with the aim of identifying successful and problem areas of activity.
evidence-based medicine	Evidence-based clinical practice is an approach to decision making in which the clinician uses the best evidence available, in consultation with the patient, to decide upon the option which suits that patient best.
formal arrangement	Agreement in the form of a written document, forming local strategy/documentation.
generic standards	Standards that apply to most, if not all, clinical services.
GP	General Practitioner.
guidelines	Systematically developed statements which help in deciding how to treat particular conditions.
HDL	See Health Department Letter.
Health Board	See NHS Boards.
Health Council	Each NHS Board area has a Health Council, an organisation whose aim is to promote public consultation and participation in health-related matters. Sometimes referred to as a Local Health Council.
Health Department Letter (HDL)	Health Department Letter (formerly known as Management Executive Letter - MEL), formal communications from the Scottish Executive Health Department to NHSScotland.

Health Technology Board for Scotland (HTBS)	The Health Technology Board for Scotland (HTBS) worked to improve Scotland's health by providing evidence-based advice to NHSScotland on the clinical and cost-effectiveness of new and existing health technologies (medicines, devices, clinical procedures and healthcare settings). On 1 January 2003, HTBS was merged, along with four other clinical effectiveness bodies, to form NHS Quality Improvement Scotland (NHS QIS). See NHS Quality Improvement Scotland.
healthcare professional	A person qualified in a health discipline.
hospice	A place where specially trained doctors, nurses and others are committed to the care of patients with active, progressive, far-advanced illness, and to the support of their relatives.
HTBS	See Health Technology Board for Scotland.
Information and Statistics Division (ISD)	The Information and Statistics Division is part of the Common Services Agency, NHSScotland. Health service activity, manpower and finance data are collected, validated, interpreted and disseminated by the division. This data is received from NHS Boards, NHS Trusts and general practices. Website address: www.showscot.nhs.uk/isd/index.htm
in-patient	A person who is admitted to hospital for observation, examination or treatment.
integrated records	Complete medical notes relating to a patient and including information from every treatment service which they have used.
intervention	Action intended to benefit the patient.
ISD	See Information and Statistics Division.
Island NHS Board	There are three Island NHS Boards (Orkney, Shetland and the Western Isles). They have always had a combined strategic and operational role. See NHS Board.
IT	Information Technology.
jointly agreed	Where both parties involved (if one is the patient, include the carer with patient's consent) have decided together on a particular course of action/non-action, to benefit the patient.

journey of care	The pathway through the health services taken by the patient (the person who is receiving treatment), and as viewed by the patient.
lay representation	The inclusion of a member(s) of the general public in a professional group.
lead consultant	Clinician with administrative responsibilities for a specific service.
lead nurse	A nurse at senior level with input into strategic planning.
lymphoedema	The swelling of an arm, leg or another part of the body which sometimes happens when lymph nodes and vessels in the armpit or groin have been removed or damaged by surgery or radiotherapy, or have been blocked by a tumour.
malignant	Cancerous. Malignant tumours can invade and destroy surrounding tissue and have the capacity to spread.
Managed Clinical Network (MCN)	A formally organised network of clinicians. The main function is to audit performance on the basis of standards and guidelines, with the aim of improving healthcare across a wide geographic area, or for specific conditions.
Management Executive Letter (MEL)	Formal communications from the Scottish Executive Health Department to NHSScotland, now known as Health Department Letters (HDLs).
median	The middle value or average of the two middle numbers in an ordered sequence of numbers.
medical records	Patients' notes; documentation of care.
medication	Drugs prescribed to treat a condition.
MEL	See Management Executive Letter.
microscope	An instrument used to obtain an enlarged image of small objects.
minimum data set (MDS)	A minimum set of information related to a specific medical condition - may include demographic, clinical management and outcome data.
modality	One form of therapy as opposed to another, such as the modality of physiotherapy contrasted with that of radiotherapy.




monitoring	The systematic process of collecting information on clinical and non-clinical performance. Monitoring may be intermittent or continuous. It may also be undertaken in relation to specific incidents of concern or to check key performance areas.
multidisciplinary	A multidisciplinary team is a group of people from different disciplines (both healthcare and non-healthcare) who work together to provide care for patients with a particular condition. The composition of multidisciplinary teams will vary according to many factors. These include: the specific condition, the scale of the service being provided, and geographical/socio-economic factors in the local area.
multi-professional	Consisting of members of more than one profession.
national guidelines	Guidelines defined at national level. See guidelines.
national standards	Standards defined at a national level.
NHS	National Health Service.
NHS Board	NHS Boards are responsible for strategic planning, performance management and governance of each of Scotland's 15 local health systems. Most Board areas (excluding Island NHS Boards) contain one Acute and one Primary Care Trust, with operational and employment responsibilities, but since 2001 they have operated within a strategic framework drawn up by the NHS Board. By 2004 Trusts will have been abolished and replaced by operating divisions of the NHS Board (see also NHS Trust).
NHS priorities	The three national clinical priorities are mental health; coronary heart disease and stroke; and cancer.
NHS QIS	See NHS Quality Improvement Scotland.

NHS Quality Improvement Scotland (NHS QIS)	NHS Quality Improvement Scotland is a statutory body, established as a Special Health Board in January 2003. Its role is to focus on improving the quality of patient care and the health of patients. It will have a particular emphasis on the quality of care and the patient journey for vulnerable groups. NHS Quality Improvement Scotland has been created by the merger of five organisations: Clinical Standards Board for Scotland (CSBS); Health Technology Board for Scotland (HTBS); Scottish Health Advisory Service (SHAS); Nursing and Midwifery Practice Development Unit (NMPDU), and the Clinical Resources and Audit Group (CRAG). Website address: www.nhshealthquality.org
NHS Trust	A Trust is an NHS organisation responsible for providing a group of healthcare services for the local population. An Acute hospital Trust provides hospital services. A Primary Care Trust provides primary care/community health services. Mental health services (both hospital and community based) are usually provided by Primary Care Trusts. Since 2001 Trusts have operated within an overall framework drawn up by their NHS Board. Subject to legislation, Trusts will be dissolved by April 2004, becoming operating divisions of the NHS Board. The NHS Board will be the single employer for the local system. In two areas - Borders and Dumfries & Galloway - since April 2003 there have been no Trusts or operating divisions with the NHS Board fulfilling a dual strategic and operational role (like the three Island Boards). The term 'Trust' is retained in NHS QIS publications during the period of Trust abolition. Where unification has occurred, the term 'Trust' should be taken to signify an operating division of the local NHS Board. See also NHS Board.
NHSScotland	The National Health Service in Scotland.
NMPDU	See Nursing and Midwifery Practice Development Unit.
nurse	A person who is specially trained to provide services that are essential to or helpful in the promotion, treatment, maintenance, and restoration of health and wellbeing.

Nursing and Midwifery Practice Development Unit (NMPDU)	NMPDU was set up in December 1999 in response to the White Paper 'Designed to Care' (1997). The overall aim of the Unit is to ensure that practice/role development is taken forward across Scotland in a consistent and cohesive way, so that benefits gained from new practice in one area can be easily identified and shared within the profession. On 1 January 2003 NMPDU was merged with four other clinical effectiveness bodies to create NHS Quality Improvement Scotland. See NHS Quality Improvement Scotland.
occupational therapist	A health professional, also known as an OT, who finds ways to help people live at home and be independent, despite their illness.
oncologist	A doctor who specialises in the treatment of cancer patients. A clinical oncologist, or radiotherapist, specialises in treating cancer with radiation or drugs, and a medical oncologist specialises in treating cancer with drugs.
outcome	The end result of care and treatment and/or rehabilitation. In other words, the change in health, functional ability, symptoms or situation of a person, which can be used to measure the effectiveness of care and treatment, and/or rehabilitation.
out-of-hours	Between 5pm - 9am Monday to Friday and also weekends (not between 9am - 5pm Monday to Friday).
out-patient	A patient reviewed in a hospital but who does not need to be admitted to the hospital.
palliative care	Palliative care is the active total care of patients and their families by a multi-professional team when the patient's disease is no longer responsive to curative treatment.
PAMs	See professions allied to medicine.
patient	A person who is receiving care or medical treatment. A person who is registered with a doctor, dentist, or other healthcare professional, and is treated by him/her when necessary. Sometimes referred to as a user.

patient journey	The pathway through the health services taken by the patient (the person who is receiving treatment), and as viewed by the patient.
PCT	Primary Care Trust. See NHS Trust and primary care.
peer review	Review of a service by those with expertise and experience in that service, either as a provider, user or carer, but who are not involved in its provision in the area under review. In the NHS Quality Improvement Scotland approach, all members of a review team are equal.
percutaneous gastrostomy	A gastrostomy is where an opening is made into the stomach from the outside and is usually performed to allow food and fluid to be poured directly into the stomach when swallowing is impossible because of disease or obstruction of the oesophagus. This procedure was formerly always performed surgically but it can now be done using an endoscope (percutaneous endoscopic gastrostomy).
pharmacist	A qualified professional who understands the nature and effect of medicines and how they are produced and used to prevent and treat illness, relieve symptoms or assist in the diagnosis of disease. Pharmacists use their expertise for the wellbeing and safety of users and the public.
pharmacy technician	An individual working in a healthcare setting who, under the supervision of a licensed pharmacist, assists in activities not requiring the professional judgment of a pharmacist.
physician	A specialist in medicine.
policy	An operational statement of intent in a given situation.
postgraduate qualification	A degree or qualification that is awarded after a period of further training.
prescription	Usually a written recipe of treatment.



primary care	The conventional first point of contact between a patient and the NHS. This is the component of care delivered to patients outside hospitals and is typically, though by no means exclusively, delivered through general practices. Primary care services are the most frequently used of all services provided by the NHS. Primary care encompasses a range of family health services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners.
procedure	The steps taken to fulfill a policy.
professions allied to medicine (PAMs)	Healthcare professionals directly involved in the provision of primary and secondary healthcare. Includes several groups such as physiotherapists, occupational therapists, dietitians, etc. Now called allied health professionals (AHPs). See allied health professions.
prognosis	An assessment of the expected future course and outcome of a person's disease.
protocol	A policy or strategy which defines appropriate action in specific circumstances. Protocols may be national, or agreed locally to take into account local requirements.
psychology	The scientific study of human behaviour and the corresponding mental processes. A psychologist is a non-medical professional who has completed special advanced training and is therefore qualified to undertake psychological research, treatments and therapy.
public consultation	The process of formal consultation and feedback on NHS QIS standards with healthcare professionals and members of the public.
QA	See quality assurance.
quality assurance (QA)	Improving performance and preventing problems through planned and systematic activities including documentation, training and review.
quality of life	The overall appraisal of an individual's situation and subjective sense of wellbeing.
rationale	Scientific/objective reason for taking specific action.

referral	The process whereby a patient is transferred from one professional to another, usually for specialist advice and/or treatment.
review	See peer review.
Scottish Executive Health Department (SEHD)	The Scottish Executive Health Department is responsible for health policy and the administration of NHSScotland. Website address: www.show.scot.nhs.uk/sehd/
Scottish Health Advisory Service (SHAS)	The Scottish Health Advisory Service was an independent body, originally set up in 1970, and reporting to the First Minister. SHAS existed to help to improve the quality of health service care and the quality of life for people with a mental illness; people with a learning disability or physical disability; and frail older people. On 1 January 2003 SHAS was merged with four other clinical effectiveness bodies to create NHS Quality Improvement Scotland. See NHS Quality Improvement Scotland.
Scottish Intercollegiate Guidelines Network (SIGN)	SIGN was established in 1993 by the Academy of Royal Colleges and Faculties in Scotland, to sponsor and support the development of evidence-based clinical guidelines for NHSScotland. Where a SIGN guideline exists for a specialty or service for which CSBS had set standards, or NHS QIS is taking forward standards, it will be referenced. For further information relating to SIGN guidelines or the methodology by which SIGN guidelines are developed, contact: SIGN Executive, Royal College of Physicians, 9 Queen Street, Edinburgh EH2 1JQ. Website address: www.sign.ac.uk/
Scottish Partnership for Palliative Care (SPPC)	The Scottish Partnership for Palliative Care is the national umbrella and representative body for palliative care in Scotland. It is an independent body with charitable status that was set up in 1991 to promote the extension and improvement of palliative care services in Scotland, whether provided by voluntary organisations or by the NHS. Website address: www.palliativecarescotland.org.uk

secondary care	Care provided in an acute sector setting. See acute sector.
SEHD	See Scottish Executive Health Department.
self-assessment	Assessment of performance against standards by individual/clinical team/Trust providing the service to which the standards are related.
sensory impairment	Reduction of the input from the senses.
SHAS	See Scottish Health Advisory Service.
SIGN	See Scottish Intercollegiate Guidelines Network.
SIGN guideline	Scottish Intercollegiate Guidelines Network guideline. See also guideline.
social work	Social work services provide advice and practical help for problems resulting from social circumstances. A social worker is a person who has obtained a professional qualification in social work. A social worker supports vulnerable people and their carers with the aim of enhancing the quality of all aspects of their daily lives.
Special Health Board	The name is given to Health Boards with a national remit. These boards are focused on specific areas - eg, NHS Education for Scotland, or NHS Quality Improvement Scotland. Special Health Boards match regional NHS Boards in terms of administrative grading.
specialist	A person who after education, training and experience, has become an expert in their field.
specialist palliative care	Specialist Palliative Care is the active total care of patients with progressive, far-advanced disease and limited prognosis, and their families, by a multi-professional team who have undergone recognised specialist palliative care training. It provides physical, psychological, social and spiritual support, and will involve practitioners with a broad mix of skills.
SPPC	See Scottish Partnership for Palliative Care.
standard	Required level of quality.
standard statement	An overall statement of desired performance.
statutory	Enacted by statute; depending on statute for its authority as a statutory provision. Required by law.

symptom	A reported feeling or observable physical sign of a person's condition that indicates a physical or psychological abnormality.
systematic	Methodical, according to plan and not casually or at random.
telephone advice	This is a service which is available to professional callers wishing guidance in clinical management. This may involve recommendations on drug use and dosage.
telephone support	This service is available to patients and lay carers who make contact. As well as empathetic listening, it will include advice about contacting the appropriate GP and District Nursing Services. It is not anticipated that specific instruction will be given regarding drugs and dosages.
terminal care	Specialised care during the final stage of an illness, with the emphasis on relief of symptoms in order to allow the patient to feel as comfortable as possible.
therapeutic intervention	A medical or non-medical initiative which increases the comfort or wider well-being of a patient.
therapy	A word often used to mean treatment.
tracheostomy	Surgical operation in which an opening is made in the windpipe (trachea), through the neck, to relieve obstruction to breathing.
treatment plan	Protocol of care which specifies what should be done, when and with what aim.
Trust	See NHS Trust.
unified Board	See NHS Board.
WHO	See World Health Organisation.
World Health Organisation (WHO)	A United Nations agency dealing with issues concerning health and disease around the globe. Website address: www.who.int/en/
WTE	Whole Time Equivalent.

Our Commitment

Our work will be undertaken in line with the following values:

- **patient and public focus**
 - ~ promoting a patient-focused NHS that is responsive to the views of the public
- **independence**
 - ~ reaching our own conclusions and communicating what we find
- **partnership**
 - ~ involving patients, carers and the public in all parts of our work
 - ~ working with and supporting NHS staff in improving quality
 - ~ collaborating with other organisations such as public bodies, voluntary organisations and manufacturers to avoid duplication of effort
- **evidence-based**
 - ~ basing conclusions and recommendations on the best evidence available
- **openness and transparency**
 - ~ promoting understanding of our work
 - ~ explaining the rationale for our recommendations and conclusions
 - ~ communicating in language and formats that are easily accessible
- **quality assurance**
 - ~ aiming to focus our work on areas where significant improvements can be made
 - ~ ensuring that our work is subject to internal and external quality assurance and evaluation
- **professionalism**
 - ~ promoting excellence individually and as teams and ensuring value for money in the use of public resources (human and financial)
- **sensitivity**
 - ~ recognising the needs, opinions and beliefs of individuals and organisations and respecting and encouraging diversity

This document can be viewed on the NHS Quality Improvement Scotland website. It is also available, on request, from NHS Quality Improvement Scotland in the following formats:

- Electronic
- Audio cassette
- Large print

NHS Quality Improvement Scotland

Edinburgh Office ~ Elliott House 8-10 Hillside Crescent Edinburgh EH7 5EA Tel 0131 623 4300

Glasgow Office ~ Delta House 50 West Nile Street Glasgow G1 2NP Tel 0141 225 6999

comments@nhshealthquality.org www.nhshealthquality.org

