
Report To: Inverclyde Integration Joint Board **Date:** 4 November 2019

Report By: Louise Long
Corporate Director (Chief Officer)
Inverclyde Health & Social Care
Partnership **Report No:** IJB/63/2019/HW

Contact Office: Helen Watson
Head of Service
Strategy and Support Services **Contact No:** 01475 715285

Subject: **MEMORANDUM OF UNDERSTANDING BETWEEN
INTEGRATION JOINT BOARDS AND INDEPENDENT HOSPICES**

1.0 PURPOSE

- 1.1 The purpose of this paper is to inform the IJB of the development of a Memorandum of Understanding (MoU) between IJBs and independent hospices. The MoU builds on the existing national arrangements and represents a wider statement of intent, recognising the statutory role (set out in the Public Bodies (Joint Working) (Scotland) Act 2014) of IJBs in commissioning palliative care services.

2.0 SUMMARY

- 2.1 The aim of the Memorandum of Understanding is to provide a strategic and financial framework for integration authorities and independent hospices to work in partnership to deliver high quality, responsive and personalised palliative and end of life care. It describes the principles of partnerships that should apply in the development of Service Level Agreements, contracts or commissioning plans developed in a local context.
- 2.2 To ensure the successful delivery of the MoU at a local level, there are a number of responsibilities for both the IJB and Ardgowan Hospice. This includes the joint planning, design and commissioning of the palliative care functions based on an assessment of local population needs, in line with the HSCP's Strategic Plan 2019-24. The responsibilities are detailed in sections 5.2 and 5.3 of this paper.

3.0 RECOMMENDATIONS

- 3.1 It is recommended that the Integration Joint Board adopts the national Memorandum of Understanding between Integration Joint Boards and Independent Scottish Hospices for local delivery in Inverclyde.

Louise Long, Chief Officer

**Helen Watson, Head of Strategy &
Support Services**

4.0 BACKGROUND

- 4.1 Hospices play an important role in the provision of local palliative care services. They work in partnership with Primary Care, District Nurses and other Third Sector organisations. There is one hospice in Inverclyde (Ardgowan), where services were previously planned and commissioned through the NHS Greater Glasgow and Clyde Health Board. From 1st April 2016, this responsibility lies with Inverclyde HSCP.
- 4.2 Ardgowan Hospice has 8 beds and provides 8 day places over 1 day, with a new model opening offering satellite clinics in Port Glasgow and Gourock with information hubs. The hospice also provides a range of other related services (outpatients, community nurse specialists, AHP services, complementary therapies, bereavement services, training and education).
- 4.3 The MoU has been jointly signed by the Chair of the Health and Social Care Scotland (HSCPs) Chief Officers' Group and the Chair of the Hospices' Leadership Group. IJBs are encouraged to adopt and apply this within their local context to create a framework within which HSCPs and hospices can collaborate to provide effective support to people with palliative care needs.
- 4.4 Over the last 12 months, Ron Culley (Chief Officer, Western Isles) led a short-term working group with representatives from partnerships, the Scottish Hospices Leadership Group and the Scottish Government to develop a memorandum of understanding (MoU). The parties have agreed on the content of the MoU and the intention is that this will cover an initial two-year period.

5.0 MEMORANDUM OF UNDERSTANDING (MOU) - IJBS AND HOSPICES

- 5.1 IJBs are asked to adopt the MoU in order to create a framework within which IJBs and hospices can collaborate to provide effective support to people with palliative care needs. The letter dated 15/07/19 to IJB Chairs from Vicky Irons, Chair Health and Social Care Scotland Chief Officers' Group is attached as Appendix 1 and the Memorandum of Understanding between IJBs and Independent Scottish Hospices is attached as Appendix 2.
- 5.2 Responsibilities for Integration Joint Boards in the MoU include:
 - Planning, design and commissioning of the palliative care functions delegated to them under the 2014 Act based on an assessment of local population needs, in line with the IJB Strategic Plan.
 - The development of a local commissioning plan, in partnership with independent hospices and collaborating with other key stakeholders.
 - Ensuring that all statutory obligations to people with palliative and end of life care needs are met.
 - Ensuring that local SLAs are established and maintained which provide financial stability and which operate on the basis of full cost transparency across both parties.
 - Decisions need to be taken in line with all relevant procurement law and strategy.
- 5.3 Responsibilities for Independent Hospices in the MoU include:
 - Contribute to the development of local commissioning strategies underpinning effective palliative and end of life care.
 - Work with IJBs to ensure that the hospice's total operating costs are understood within local SLAs.
 - Continue to deliver high quality service arrangements, which align with the referral mechanisms and operating systems of local HSCPs.

5.4 Next Steps

The HSCP currently works closely with the hospice through regular governance meetings co-chaired by the HSCP Head of Health and Community Care and the Chief Executive from the Hospice. This group will have responsibility for the local delivery of the Memorandum of Understanding (MoU).

5.5 Subject to approval from the IJB on the national Memorandum of Understanding between IJBs and Independent Scottish Hospices an update on local delivery in Inverclyde will be reported to the IJB at a future meeting.

6.0 IMPLICATIONS

6.1 FINANCE

There are no direct financial implications within this report.

One off Costs

| Cost Centre | Budget Heading | Budget Years | Proposed Spend this Report £000 | Virement From | Other Comments |
|-------------|----------------|--------------|------------------------------------|---------------|----------------|
| N/A | | | | | |

Annually Recurring Costs / (Savings)

| Cost Centre | Budget Heading | With Effect from | Annual Net Impact £000 | Virement From | Other Comments |
|-------------|----------------|------------------|---------------------------|---------------|----------------|
| N/A | | | | | |

LEGAL

6.2 There are no specific legal implications arising from this report.

HUMAN RESOURCES

6.3 There are no specific human resources implications arising from this report.

EQUALITIES

6.4 There are no equality issues within this report.

6.4.1 Has an Equality Impact Assessment been carried out?

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YES (see attached appendix)

NO – This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

6.4.2 How does this report address our Equality Outcomes

There are no Equalities Outcomes implications within this report.

| Equalities Outcome | Implications |
|---|---------------------|
| People, including individuals from the above protected characteristic groups, can access HSCP services. | None |
| Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated. | None |
| People with protected characteristics feel safe within their communities. | None |
| People with protected characteristics feel included in the planning and developing of services. | None |
| HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do. | None |
| Opportunities to support Learning Disability service users experiencing gender based violence are maximised. | None |
| Positive attitudes towards the resettled refugee community in Inverclyde are promoted. | None |

6.5 CLINICAL OR CARE GOVERNANCE IMPLICATIONS

There are no governance issues within this report.

6.6 NATIONAL WELLBEING OUTCOMES

How does this report support delivery of the National Wellbeing Outcomes

There are no National Wellbeing Outcomes implications within this report.

| National Wellbeing Outcome | Implications |
|--|---|
| People are able to look after and improve their own health and wellbeing and live in good health for longer. | None |
| People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community | The services offered by the hospice support this outcome. |
| People who use health and social care services have positive experiences of those services, and have their dignity respected. | The hospice values are rooted in dignity and respect. |
| Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. | High quality palliative and end of life care focuses on quality of life and the best possible experience. |
| Health and social care services contribute to reducing health inequalities. | Access is based on need. |
| People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing. | None |
| People using health and social care services are safe from harm. | None |

| | |
|--|------|
| People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide. | None |
| Resources are used effectively in the provision of health and social care services. | None |

7.0 DIRECTIONS

| | | | |
|-----|--|---------------------------------------|---|
| 7.1 | Direction Required to Council, Health Board or Both | Direction to: | |
| | | 1. No Direction Required | X |
| | | 2. Inverclyde Council | |
| | | 3. NHS Greater Glasgow & Clyde (GG&C) | |
| | | 4. Inverclyde Council and NHS GG&C | |

8.0 CONSULTATION

- 8.1 This report has been prepared after due consultation with the Chief Officer and Ardgowan Hospice.

Appendix 1



Vicky Irons
Chair, Health and Social Care Scotland Chief Officer Group
St Margaret's House
Orchardbank Business Park
Forfar
DD8 1WS

Date: 15 July 2019

Dear IJB chair

Over the last 12 months, Ron Culley (Chief Officer, Western Isles) has led a short-term working group with representatives from partnerships, the Scottish Hospices Leadership Group and the Scottish Government to develop a memorandum of understanding (MoU). The parties have now agreed on the content of the MoU and the intention is that this will cover an initial two year period. This MoU between integration joint boards and independent hospices builds on the arrangements set out in CEL 12 and represents a wider statement of intent, recognising the statutory role (set out in the Public Bodies (Joint Working) (Scotland) Act 2014) of Integration Joint Boards in commissioning palliative care services.

The aim of the MoU is to provide a strategic and financial framework for integration authorities and independent hospices to work in partnership to deliver high quality, responsive and personalised palliative and end of life care. It describes the principles of partnerships that should apply in the development of SLAs, contracts or commissioning plans developed in a local context.

The MoU has been jointly signed by the Chair of the Chief Officers Group and the Chair of the Hospices Leadership Group.

We are writing to you to make you aware of the national MoU and to encourage you to adopt and apply this within your local context by putting it to your members for agreement. As you might imagine, the wording and framing of the MoU was carefully negotiated over a number of months, so we are asking partnerships to adopt it as it is. As indicated above, it serves to create a framework within which IJBs and hospices can collaborate to provide effective support to people with palliative care needs.

If you have any questions, please don't hesitate to contact us or our colleague Ron Culley (ron.culley@nhs.net).

Best wishes

Vicky Irons
Chair, Chief Officer Group
Health and Social Care Scotland

Rhona Baillie
Deputy Chair
Scottish Hospices Leadership Group

Memorandum of Understanding between Integration Joint Boards and Independent Scottish Hospices

Introduction

Across Scotland, Health and Social Care Partnerships and independent hospices are committed to a future which will ensure the provision of high quality and person-centred palliative and end of life care, made available to all who need it, when they need it. This ambition is founded on the following over-arching principles:

- A partnership based on parity of esteem and a commitment to shape palliative care services together;
- A recognition of the importance of financial stability, both within the partnership as a whole and for each independent hospice;
- A commitment to operate openly and transparently, cultivating a position of trust, building strong relationships which are resilient to disagreement and financial pressures;
- A recognition that hospices are autonomous organisations with considerable skills, expertise and charitable income, who nevertheless operate within local health and social care systems and whose aims are aligned to local commissioning strategies.

In approving this Memorandum of Understanding, all parties agree to abide by these principles.

Scope of the Memorandum of Understanding

The principles underpinning the commissioning relationship between NHS Boards and independent hospices specialising in palliative and end of life care in Scotland were set out in a Scottish Government letter to NHS Chief Executives in 2012,¹ commonly referred to as CEL 12. This document has since governed the commissioning relationship between Health Boards and independent hospices.

However, following the Public Bodies (Joint Working) (Scotland) Act 2014, all Health Boards have been required to establish Integration Authorities with their Local Authority partners. Within this context, the functions and resources associated with the provision of palliative and end of life care are now the preserve of Scotland's Integration Authorities.

The terms of CEL 12 do not apply to those Integration Authorities who have established Integration Joint Boards, since in these circumstances the Health Board is no longer the commissioner of palliative and end of life care. By contrast, CEL 12 continues to apply to those Integration Authorities which have elected to establish the NHS Board as a Lead Agency under the 2014 Act. The collaborative commissioning process as set out in CEL 12 has come to fuller fruition in the commissioning process set out in the Public Bodies (Joint Working) (Scotland) Act 2014.

In order to clarify any ambiguities in understanding in the national policy framework, a working group was established to develop a Memorandum of Understanding between Scotland's Integration Joint Boards and Independent Hospices. The Working Group involved representatives of senior management within Integration Authorities, independent hospices, the Scottish Partnership for Palliative Care, Healthcare Improvement Scotland and the Scottish Government. Scotland's independent hospices are represented by the Scottish Hospice Leadership Group, which has formed to represent the interests of independent hospices at a national level.

This Memorandum of Understanding ("MOU") between Integration Joint Boards and independent hospices builds on the arrangements set out in CEL 12 and represents a wider statement of intent, recognising the statutory role (set out in the Public Bodies (Joint Working) (Scotland) Act 2014) ("the Act") of Integration Joint Boards in commissioning palliative care services.

¹ *A Partnership For Better Palliative And End Of Life Care: Creating A New Relationship Between Independent Adult Hospices And NHS Boards In Scotland*

For the purposes of this MOU, we refer to Integration Joint Boards (IJBs) as the responsible party for the planning and commissioning of palliative care services. When the document refers to independent hospices, this also includes Marie Curie, a UK-wide organisation, which currently runs two hospices in Scotland as part of its wider provision of specialist palliative care services. The MOU does not include provisions made to secure specialist palliative care for children, which is provided by CHAS, and which is subject to separate financial governance arrangements.

The MOU will cover an initial two year period (1 April 2019 to 31 March 2021) and is structured to set out the key aspects relevant to facilitating the delivery of effective joint commissioning. It does not impinge on the autonomy of independent hospices as charitable organisations, although it does encourage the establishment and maintenance of Service Level Agreements (SLAs) to govern the relationship between independent hospices and Integration Joint Boards within local systems. SLAs will define mutual expectations and place rights and responsibilities on both parties.

The aim of the MOU is to provide a strategic and financial framework for Integration Authorities and independent hospices to work in partnership to deliver high quality, responsive and personalised palliative and end of life care. It describes the principles of partnership that should apply in the development of SLAs, contracts or commissioning plans developed in a local context.

This MOU will be reviewed and updated by the Scottish Hospice Leadership Group and the IJB Chief Officers parties before 31 March 2021.

Policy Context

[The Strategic Framework for Action on Palliative and End of Life Care](#) is Scotland's national policy and is a direct response to the resolution passed in 2014 by the World Health Assembly, requiring all governments to recognise palliative care and to make provision for it in their national health policies.

Launched by Cabinet Secretary for Health, Wellbeing and Sport in December 2015, it outlines the key actions to be taken that will allow everyone in Scotland to receive services that respond to their individual palliative and end of life care needs. The Framework seeks to drive a new culture of openness about death, dying and improvement and sets out to achieve the following outcomes:

- People receive health and social care that supports their wellbeing, irrespective of their diagnosis, age, socio-economic background, care setting or proximity to death.
- People have opportunities to discuss and plan for future possible decline in health, preferably before a crisis occurs, and are supported to retain independence for as long as possible.
- People know how to help and support each other at times of increased health need and in bereavement, recognising the importance of families and communities working alongside formal services.
- People access cultures, resources, systems and processes within health and social care services that empower staff to exercise their skills and provide high quality person-centred care.

The national policy is currently being implemented via a National Implementation and Advisory Group, comprised of representatives of the Scottish Government, Integration Authorities, independent hospices, community care bodies and a range of other stakeholders.

Following the establishment of Integration Authorities, the Scottish Government has also published guidance on a range of subjects, including on strategic commissioning. This was followed up by a specific [publication](#) on the commissioning of palliative and end of life care in April 2018.

The guidance describes the key considerations when planning, designing and commissioning palliative and end of life care, including understanding local data and trends around mortality; activity levels and any variation within those; service and support arrangements across the local health and social care system, including any gaps; a map of the total resources available to the partnership - the analysis of which will underpin the key reforms that emerge from local commissioning plans. It will be important that once the total resource is understood (including the total capacity of the hospices), opportunities are taken to reimagine how it can be invested to improve outcomes.

Effective commissioning will result in a comprehensive and cohesive approach to the planning and improvement of palliative and end of life care. It will situate palliative and end of life care as integral aspects of the care delivered by any health or social care professional, focusing on the person, not the disease, and applying a holistic approach to meet the physical, practical, functional, social, emotional and spiritual needs of patients and carers facing progressive illness and bereavement.

The following principles should underpin the approach to commissioning:

- transparency and openness
- a focus on system outcomes
- clinical effectiveness
- cost effectiveness
- value for money

It is important that local commissioning plans also consider national priorities. The Scottish Government's national delivery plan sets out a number of high level ambitions to ensure that the right supports and services are in place for people at the end of life. By 2021, we should seek to ensure that:

- Everyone who needs palliative care will get the right care, in the right setting to meet their needs;
- All who would benefit from a 'Key Information Summary' will have access to it;
- The availability of care options will be improved by doubling palliative end of life provision in the community, which will result in fewer people dying in a hospital setting.

Partnerships should consider these priorities within the context of local commissioning plans.

HSCPs should collaborate with independent hospices as *equal partners*, and both parties will actively contribute to the development and delivery of local commissioning strategies. Independent hospices bring considerable expertise, capacity and resource to the commissioning table and this should be recognised in the commissioning relationship. Through their volunteering capacity, charitable income sources, clinical and strategic leadership, hospices have a strong track record of developing personalised, responsive and imaginative palliative care, which will be important to build upon as part of the commissioning process.

Responsibilities (of parties to the MOU)

The respective responsibilities of the parties to this MOU are:

Integration Joint Board responsibilities:

- Planning, design and commissioning of the palliative care functions delegated to them under the 2014 Act based on an assessment of local population needs, in line with the IJB Strategic Plan.
- The development of a local commissioning plan, in partnership with independent hospices and collaborating with other key stakeholders.
- Where there is an independent hospice providing services to more than one IJB, the IJBs will collaborate under Section 22 of the 2014 Act in relation to the effective and efficient use of resources (e.g. buildings, staff and equipment) to achieve coherence and equity across service planning, design and commissioning.
- Ensuring that all statutory obligations to people with palliative and end of life care needs are met.
- Ensuring that local SLAs are established and maintained which provide financial stability and which operate on the basis of full cost transparency across both parties.
- Decisions need to be taken in line with all relevant procurement law and strategy.

Independent Hospice responsibilities:

- Contribute to the development of local commissioning strategies underpinning effective palliative and end of life care.
- Work with IJBs to ensure that the hospice's total operating costs are understood within local SLAs.
- Continue to deliver high quality service arrangements, which align with the referral mechanisms and operating systems of local Health and Social Care Partnerships.

Wider Engagement

IJBs have a statutory duty via the Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014 to consult a wide range of local stakeholders and professional groups on their local strategies and take decisions on the size and shape of local health and social care services on a collective basis based on dialogue with the local communities and service users.

In relation to the development of local commissioning plans, that would include (but not be limited to): patients, their families and carers; local communities; health and social care professionals; hospices (both NHS and independent); social care providers

In order to ensure that the provision of any new or reconfigured service has a patient-centred approach to care based on an understanding of patients' needs, life circumstances and experiences, it is important that patients, carers and communities are engaged as key stakeholders in the planning and delivery of new services. HSCPs should ensure that this engagement is a key part of their local commissioning plans.

Resources

Integration Joint Boards and Scottish Hospices invest millions of pounds annually in the provision of palliative and end of life care. Independent hospices in particular make a significant contribution to Scotland's health economy, generating over £50 million in charitable donations from the public, which supplements core statutory funding. In service to their overall mission, independent hospices will continue to bring these charitable resources to the table.

One of the primary functions of CEL 12 was to outline the financial contribution that Health Boards should make to the running costs of independent hospices. Specifically, it was proposed that 50% of agreed running costs be met by Health Boards, and the CEL 12 letter defined the parameters of what could fall within the scope of agreed costs.

However, this led in some instances to a transactional relationship developing between Health Boards and hospices, which focused on how the agreed costs should be understood. The Scottish Hospice Leadership Group has also produced evidence that the gap between actual and agreed costs has grown over time, thereby eroding the worth of the original commitment.

Within this context, this MOU does not prescribe the proportion of agreed costs to be met by Integration Joint Boards. Rather, it envisages a new relationship developing, based on the following principles:

- A transparent assessment of the *total* resource both parties bring to the table, including charitable income sources;
- A transparent assessment of the *total* costs of service provision, analysed through an "open book" approach between Integration Joint Boards and independent adult hospices
- Value for money and efficiency
- Benchmarking of costs, activity and quality
- Quality outcome measures

This process should avoid the need to debate what counts as *agreed* costs in favour of a relationship that looks at the *total* operating costs of independent hospices, which will include back office costs associated with fundraising, corporate functions, marketing and promotion, volunteering, and management. Within this context it will be important to describe existing patterns of expenditure and impending pressures. National organisations should be transparent in allocating overheads against local hospice running costs. Likewise, there is an expectation that IJBs will provide transparency in respect of their financial position, including the impact of any budgetary adjustments on the palliative care agenda.

In particular, the need for independent hospices to provide pay increases in line with NHS arrangements should be recognised. This further assumes that independent hospices will want to move towards the Agenda for Change pay model. Hospices, IJBs and, where relevant, the Scottish Government, will consider how best to fund any pay increases. These arrangements should be set out within local Service Level Agreements.

There should be a commitment to agree and sign-off Service Level Agreements in a timely fashion, as part of the overall commissioning cycle. A three year agreement is preferred as a means of delivering financial stability, which is especially important during times of service redesign. In the absence of redesign, it is important to note that while

this MoU moves away from a specific agreement to meet 50% of agreed costs, individual hospices should not receive a *reduction* in financial support from IJBs against 2018/19 levels, for this could foment the very financial instability that the MoU seeks to protect against. In circumstances where services are being redesigned, overall financial contributions will necessarily be reconsidered, and in these cases, it is important that funding levels are commensurate with the new service provided.

It is also important to note that IJBs do not hold capital budgets and so if hospices want to enter into discussion about accessing capital investment for health and social care buildings, this will require the Health Board and/or Local Authority's participation.

Conflict Resolution

It is important that local provision is made for conflict resolution. Given that the parties to this MoU consistently operate under financial pressure, mechanisms should be in place to remedy disputes. Such disputes may emerge out of the financial or wider commissioning relationship. In the event of any disagreement or dispute between the parties, they will use their best endeavours to reach a resolution without resort to conciliation or mediation. If conciliation or mediation becomes required an independent third party will be sought as deemed acceptable to the NHS Board/HSCP and Partner/Provider.

Oversight

The national working group will monitor the development of local commissioning plans and associated SLA's to consider whether the terms of the MOU are applied consistently and abide by the spirit of partnership.

The benchmarking of the cost, activity and quality of independent adult hospice services should be done at local level but the national working group may also consider this benchmarking to support local partnerships.

Healthcare Improvement Scotland is available to partnerships to support quality and service improvement.

Signatories

Signed on behalf of IJB Chief Officers

Name: Vicki Irons, Chief Officer, Angus HSCP and Chair, Chief Officers, Health and Social Care Scotland

Signed on behalf of the Scottish Hospice Leadership Group

Name: Rhona Baillie, the Prince & Princess of Wales Hospice and Deputy Chair, Scottish Hospices Leadership Group

| <u>Integration Joint Boards</u> | <u>Independent Hospices</u> |
|---------------------------------|--------------------------------------|
| Aberdeen City | ACCORD Hospice |
| Aberdeenshire | |
| Angus | Ardgowan Hospice |
| Argyll and Bute | |
| Clackmannanshire and Stirling | Ayrshire Hospice |
| Dumfries and Galloway | |
| Dundee City | Bethesda Hospice |
| East Ayrshire | |
| East Dunbartonshire | Highland Hospice |
| East Lothian | |
| East Renfrewshire | Kilbryde Hospice |
| Edinburgh City | |
| Falkirk | Marie Curie Hospice |
| Fife | |
| Glasgow City | Prince and Princess of Wales Hospice |
| Highland | |
| Inverclyde | St Andrew's Hospice |
| Midlothian | |
| Moray | St Columba's Hospice |
| North Ayrshire | |
| North Lanarkshire | St Vincent's Hospice |
| Orkney Islands | |
| Perth and Kinross | Strathcarron Hospice |
| Renfrewshire | |
| Scottish Borders | |
| Shetland Islands | |
| South Ayrshire | |
| South Lanarkshire | |
| West Dunbartonshire | |
| Western Isles | |
| West Lothian | |

Annex A: Palliative Care

Palliative Care

Palliative care is defined by the World Health Organisation as “an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and

relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual”.

Specialist Palliative Care

Specialist Palliative Care is the active total care of patients with progressive, advanced disease and their families. Care is provided by a multi-professional team who have undergone recognised specialist palliative care training. The aim of the care is to provide physical, psychological, social and spiritual support, and it will involve practitioners with a broad mix of skills. (Tebbit, 1999)

Specialist Palliative Care requires effective multi-professional 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 the appropriate service and achieve the best quality of life possible.

These teams work in partnership with those who provide generalist palliative care, to ensure that patients' and families' complex needs are met.

Complex needs are identified as needs that cannot be addressed through simple or routine interventions/care.

Specialist Palliative Care seeks to:

- meet complex needs through a multi-professional 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;
- discern, respect and meet the cultural, spiritual 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 speciality's knowledge base for the benefit of patients and carers.

A number of essential components make up a specialist palliative care service and the lists below are not exhaustive. These include:

- effective communication
- symptom control
- rehabilitation
- education and training
- research and audit
- continuity of care
- terminal care
- bereavement support for adults, young people and children

The core clinical specialist palliative care services comprise:

- In-Patient care facilities for the purposes of symptom management, rehabilitation and terminal care
- 24 hour access to the In- Patient service which includes specialist medical and adequate specialist nursing cover
- 24 hour telephone advice service for healthcare professionals
- 24 hour telephone support service for known out-patients and their carers
- Day services provided by an out-patient model or day hospice model where patients attend for a determined part of the day (e.g. from 11-3)
- Education programme
- Research and audit undertaken within a framework of clinical governance
- Formalised arrangements for specialist input to local and community hospitals
- Spiritual and psychological/counselling support services'

Key Elements of Specialist Palliative Care within a Specialist Palliative Care Unit

The core team comprises dedicated sessional input from

- Chaplain
- Doctors
- Nurses
- Occupational therapist
- Pharmacist
- Physiotherapist
- Social worker
- Counsellor

The range of integrated service components which can meet patients' needs at different stages of the disease process will include 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
- Psychological support services
- Social services
- Spiritual support services

ANNEX B: MEMBERSHIP OF SHORT LIFE WORKING GROUP

- Rhona Baillie, The Prince and Princess of Wales Hospice
- Helen Simpson, Accord Hospice
- Jackie Stone, St Columba's Hospice
- Craig Cunningham, South Lanarkshire HSPC
- Steven Fitzpatrick, Glasgow City HSPC
- Karen Jarvis, Renfrewshire HSPC

- Michael Kellet, Fife HSPC
- Pam Gowans, Moray HSCP
- Ron Culley, Western Isles HSPC (Chair)
- Mark Hazelwood, Scottish Partnership for Palliative Care
- Tim Warren, Scottish Government
- Christina Naismith, Scottish Government
- Diana Hekerem, Healthcare Improvement Scotland