List of NHSScotland Board Areas

1  NHS Argyll & Clyde
2  NHS Ayrshire & Arran
3  NHS Borders
4  NHS Dumfries & Galloway
5  NHS Fife
6  NHS Forth Valley
7  NHS Grampian
8  NHS Greater Glasgow
9  NHS Highland
10 NHS Lanarkshire
11 NHS Lothian
12 NHS Orkney
13 NHS Shetland
14 NHS Tayside
15 NHS Western Isles
Specialist Palliative Care

Specialist palliative care is the active total care of patients whose disease is not responsive to curative treatment. A large number of components make up a specialist palliative care service, including effective communication, symptom control, education and training and terminal care. The goal is to achieve the best quality of life possible for patients and their families.

The NHS Quality Improvement Scotland Specialist Palliative Care Project Group developed standards which reflect the patient’s journey following referral to a specialist palliative care service, and represent the range of specialist services provided across Scotland. This report presents the findings from the peer review of performance against the standards.
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NHS Quality Improvement Scotland 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 Quality Improvement Scotland 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.

About this Report

The Clinical Standards for Specialist Palliative Care were published in June 2002. These standards are being used to assess the quality of services provided by NHSScotland and the voluntary sector, in hospital, community and hospice settings.

This report presents the findings from the peer review visit to Grampian University Hospitals NHS Trust. This review visit took place on 26 March 2003, and details of the visit, including membership of the review team, can be found in Appendix 2.
1.1 How the Standards were Developed

In September 2000, a Specialist Palliative Care Project Group was established under the chairmanship of Professor John Welsh, Olav Kerr Professor of Palliative Medicine, University of Glasgow. Membership of the Specialist Palliative Care Project Group includes both healthcare professionals and members of the public (see Appendix 3).

The Specialist Palliative Care Project Group oversees the quality assurance process of:

- developing standards;

- reviewing performance against the standards throughout Scotland, using self-assessment and external peer review; and

- reporting the findings from the review.

When developing the specialist palliative care standards, a Scotland-wide consultation process was undertaken. The views of healthcare staff (within NHSScotland and the voluntary sector), patients, carers and the public were sought, and all the relevant evidence available at the time was taken into account. The draft standards were piloted at four sites: Dumfries & Galloway Royal Infirmary, Dumfries; Marie Curie Centre Hunters Hill, Glasgow; Rachel House Children’s Hospice, Kinross; and the Royal Infirmary of Edinburgh.

1.2 How the Review Process Works

The review process has two key parts: local self-assessment followed by external peer review. First, each Hospice/Trust assesses its own performance against the standards. An external peer review team then further assesses performance, both by considering the self-assessment data and visiting the Hospice/Trust to validate this information and discuss related issues. The review process is described in more detail below (see also the flow chart on page 9).

Self-Assessment by the Hospice/Trust

On receiving the standards, each Hospice/Trust assesses its own performance using a framework produced by NHS Quality Improvement Scotland. This framework includes guidance about the type of evidence (eg guidelines, audit reports) required to allow a proper assessment of performance against the standards to be made.
The Hospice/Trust submits the data it has collected for this self-assessment exercise to NHS Quality Improvement Scotland before the on-site visit, and it is this information that constitutes the main source of written evidence considered by the external peer review team.

**External Peer Review**

An external peer review team then visits the Hospice/Trust and speaks with local stakeholders (e.g., staff, volunteers) about the services provided. Review teams are multidisciplinary, and include both healthcare professionals and members of the public. All reviewers are trained. Each review team is led by an experienced healthcare professional, who is responsible for guiding the team in its work and ensuring that team members are in agreement about the assessment reached. To promote a consistent approach for specialist palliative care, four team leaders have been recruited to undertake the review visits.

The composition of each team varies, and members have no connection with the Hospice/Trust they are reviewing. This promotes the sharing of good practice, and ensures that each review team assesses performance against the standards rather than make comparisons between one Hospice/Trust and another.

At the start of the on-site visit, the review team meets key personnel responsible for the service under review. Reviewers then meet with local stakeholders about the services provided. After these meetings, the team assesses performance against the standards, based on the information gathered during both the self-assessment exercise and the on-site visit.

The visit concludes with the team providing feedback on its findings to the Hospice/Trust. This includes specific examples of local initiatives drawn to the attention of the review team (recognising that other such examples may exist), together with an indication of any particular challenges facing the Hospice/Trust.
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 Hospice/Trust under review.
The process used for this review:
1.3 Reports

After each review visit, NHS Quality Improvement Scotland staff draft a local report detailing the findings of the review team. This draft report is sent to the review team for comment, and then to the Hospice/Trust to check for factual accuracy. The local report is published only after all the visits for that topic have been undertaken nationwide.

Once a national review cycle is completed, the relevant Project Group reconvenes to examine review findings and make recommendations. The Project Group then oversees the production of a national overview of service provision across Scotland in relation to the standards. This document includes both a summary of the findings (highlighting examples of local initiatives and challenges for the service) and recommendations for improvement.

Part of the remit of NHS Quality Improvement Scotland is to report whether the services provided by NHSScotland, both nationally and locally, meet the agreed standards. This does not include reviewing the work of individual healthcare professionals. In achieving this aim, variations in practice (and potentially quality) within a service will be encountered. In such cases, variations are reported.

Please note - all reports published are available in print format and on the NHS Quality Improvement Scotland website.
2. Summary of Findings

2.1 Overview of Local Service Provision

Grampian is situated in north-east Scotland and has a population of around 523,290. About 40% of the local population live in Aberdeen, which is the largest urban area in the region, although a significant proportion live in rural areas. The proportion of older people in the population is lower than the national average, as are levels of illness and deprivation.

Local NHS System and Services

Grampian NHS Board is responsible for improving the health of the local population and for the delivery of the healthcare required. It provides strategic leadership and has overall responsibility for the efficient, effective and accountable performance of the NHS in Grampian.

At the time of the review visit, the Board area contained one Acute and one Primary Care Trust (Grampian University Hospitals NHS Trust and Grampian Primary Care NHS Trust), which together provided its clinical services. Both the NHS Board and the Trusts were accountable for the services provided, through the framework of clinical governance.

Further information about the local NHS system can be accessed via the website of NHS Grampian: www.show.scot.nhs.uk/ghb

Local Specialist Palliative Care Service

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 therefore been included in the review programme.

In addition to assessing these sites against the specialist palliative care standards, it was agreed that the review team would meet with palliative care staff working in Acute and Primary Care NHS Trusts not being reviewed, to discuss their links with the specialist palliative care services in their NHS Board area.
The Specialist Palliative Care Service in Grampian is integrated between the Acute Trust and the Primary Care Trust. Grampian University Hospitals NHS Trust has responsibility for the hospital specialist palliative care team, the specialist palliative care out-patient service, The Oaks Day Care Centre in Elgin, and Roxburghe House in Aberdeen. Grampian Primary Care NHS Trust provides a chronic lymphoedema service and has responsibility for the community specialist palliative care service and community Macmillan nurses.

Roxburghe House, Aberdeen, is a 21-bedded hospice, which opened in 1977. In 1990 it expanded its service to provide an additional 10-15 day hospice places. At the time of the review visit, a new Roxburghe House was under construction. This facility is due for completion in May 2004, and will provide three additional in-patient beds, improved facilities for all aspects of specialist palliative care, and a comprehensive research/education centre.

There are two specialist palliative care consultants based at Roxburghe House, Aberdeen, and a Macmillan GP facilitator (clinical assistant) who provides domiciliary visits, and plays a major role in medical education. In addition, there are two specialist registrars and two senior house officers based at the Hospice. Nursing care is provided by a team of experienced nurses, many of whom have completed specialist training in palliative care. The community Macmillan nurses for the Aberdeen area are also based within Roxburghe House.

The Oaks Day Care Centre, Elgin, is due to be opened in April 2003 and will provide additional day hospice care to the local area. One of the specialist palliative care consultants at Roxburghe House, Aberdeen, will provide input to this Centre once it is up and running.

The hospital specialist palliative care team consists of three Macmillan nurses and junior medical staff, with regular input from the two specialist palliative care consultants who are based at Roxburghe House, Aberdeen. Since the hospital service was established in February 2002, it has received 687 new referrals.
2.2 Summary of Findings Against the Standards

A summary of the findings from the review, including examples of local initiatives drawn to the attention of the review team, is presented in this section. A detailed description of performance against the standards/criteria is included in section 3.

Access to Specialist Palliative Care Services

The integration of the Specialist Palliative Care Service across the Acute Trust and Primary Care Trust facilitates access to the Specialist Palliative Care Service. At present, there is an absence of formal access guidelines in routine use throughout the service. However, close working relationships between primary care and acute care staff help to ensure appropriate referrals are made, and that priority is given to patients with the most complex needs. There are also mechanisms in place to enable specialists and generalists to discuss referral and access arrangements. Specialist medical cover is available at all times, although there is no round-the-clock access to nurses with specific palliative care qualifications.

Key Elements of Specialist Palliative Care

A range of facilities for symptom management, rehabilitation, terminal care and day care are available within Roxburghe House, Aberdeen. However, there was recognition among staff interviewed during the review visit that some of the facilities are inadequate. The review team was informed that a new Roxburghe House is currently under construction. This new facility, due for completion in May 2004, will address many of the inadequacies identified at the current premises. In addition, a new day hospice facility is due to be opened in Elgin in April 2003. Arrangements are in place to ensure that a 24-hour telephone advice service is available for healthcare professionals.

Managing People and Resources

The multidisciplinary approach to patient care is fully established within the Specialist Palliative Care Service. All core members of the team meet regularly to discuss patient care and a range of ancillary professionals can be accessed when necessary.
Example of a local initiative

The chronic lymphoedema service is well-established in the region. A specialist clinic is held in Aberdeen and there is a system of regional network key workers. These key workers are situated in clinics throughout the Grampian region, and provide a lymphoedema service in local clinics. Support and training is provided by a physiotherapist with specialist training and experience in lymphoedema management.

The Specialist Palliative Care Service faces the challenge of ensuring that one nurse per shift in the in-patient unit has attained specific qualifications in palliative care. There was evidence that the Service is committed to achieving this objective. At present, a high proportion of nursing staff within the team have attained, or are undertaking, further training in palliative care. In addition, all of the community nurses have attained, or are currently working towards, a degree or postgraduate qualification in palliative care.

Professional Education

The Specialist Palliative Care Service demonstrated a commitment to, and enthusiasm for, the training and education of medical staff. However, there appears to be a disparity of educational opportunities for other healthcare professionals. It is anticipated that the continuing professional development department, based within the Acute Trust, will take forward some of the training initiatives in the future. The Service has no designated individual with overall responsibility for the planning and implementation of education programmes, although, it was noted that funding is currently being sought to fulfil this role.

Inter-professional Communication

There are a number of mechanisms in place to facilitate communication between the different professional groups involved in caring for patients with specialist palliative care needs. These include weekly multidisciplinary team meetings, verbal, written and face-to-face communication.
Example of a local initiative

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.

Arrangements for out-of-hours cover are also established. A system is in place to inform staff at Roxburghe House, Aberdeen, of any anticipated problems with hospital in-patients. For community patients, the Grampian Doctors On Call (GDOCs) out-of-hours service ensures that members of the primary care team are aware of any anticipated problems.

Communication with Patients/Carers

There is a largely informal approach to communication with patients and carers within the Specialist Palliative Care Service.

The review team noted that there is no specific reference to communication and information needs in the care plan, and there is no locally produced information available. Communication and information provision to patients and carers is carried out by all members of the multidisciplinary team. However, there has been no formal evaluation of staff communication skills through the use of satisfaction surveys. The Service has good links with Cancer Link Aberdeen North (CLAN) House, which is an information and support service for cancer patients in the region, and it was reported that this service is a valued resource for specialist palliative care patients and their carers.

Therapeutic Interventions

The Specialist Palliative Care Service has access to a range of therapeutic interventions to meet the needs of patients.

The integrated structure of the Specialist Palliative Care Service in Grampian enables members of the team to rapidly access a wide range of treatments for the management of symptoms. Comprehensive guidelines are also in place to ensure the safe, effective and consistent delivery of these treatments.
Spiritual and social support is provided by individuals with particular skills and experience in the specialist palliative care field. However, staff noted some concerns about the implications of future vacant posts and the joint futures agenda. Bereavement care was identified as an area of the Specialist Palliative Care Service which requires some development in order to provide a comprehensive in-house service.

Information, Data Collection and Audit (Patient Activity)

Although staff acknowledged the value of data collection, at present there is no robust data collection system in place to enable the Service to evaluate the care it is providing, and to collect the data specified in the Scottish Minimum Data Set for Specialist Palliative Care.
3. Detailed Findings Against the Standards

Standard 1(a): Access to Specialist Palliative Care Services: Specialist Palliative Care Unit

Standard Statement
Specialist palliative care services can be accessed according to need.

Grampian University Hospitals NHS Trust

Essential Criteria

1.a.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.

STATUS: Not met

There is no formal access policy for referral/admission to Roxburghe House, Aberdeen. During the visit, the review team was shown an access policy which is currently being piloted by the hospital-based specialist palliative care team. This policy includes an assessment tool that is used to assess need and prioritise admission. It was reported that there are plans to implement the policy throughout the Specialist Palliative Care Service in the future.

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

STATUS: Met

Although there is no formal written referral/access policy in place, there was evidence that specialists and generalists worked together to agree on criteria and routes for referral/access to the Specialist Palliative Care Service. Specialists and generalists are represented on both the Palliative Care Focus Group and the North East Scotland Cancer Co-ordinating Advisory Group (NESCCAG). It was reported that the criteria and routes for referral/access are discussed within both of these forums.

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

STATUS: Met

There was evidence that priority is given to patients with the most complex needs. It was reported that all referrals are considered by the multidisciplinary team, and that priority is given to patients with the most complex needs.
1.a.4: There is evidence that the access policy is being adhered to.

STATUS: Not met (insufficient evidence)

The review team was provided with documented evidence which confirmed that the hospital specialist palliative care team’s access policy is being adhered to. The review team received verbal confirmation that referrals to Roxburghe House, Aberdeen, adhere to the informal access policy. However, there was no audit evidence available to demonstrate that this criterion is met.

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

STATUS: Met

There was evidence that service providers and referrers discuss individual patients’ needs. All staff interviewed during the review visit commended the approachable nature and easy access to members of the Specialist Palliative Care Service. It was further reported that regular phone discussions take place between members of the specialist team and the patient’s referrer.

1.a.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).

STATUS: Not met

There is no 24-hour access to Roxburghe House, Aberdeen, although it was reported that patients can receive input from the hospital specialist palliative care team at all times. The on-call medical rota at Roxburghe House ensures that there is round-the-clock access to specialist medical cover. The Specialist Palliative Care Service is unable to provide round-the-clock specialist nursing cover due to a lack of nurses with specific palliative care qualifications.

1.a.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).

STATUS: Not met

Staff at Roxburghe House, Aberdeen, can be contacted at all times to provide specialist advice. The medical on-call rota ensures that there is round-the-clock access to specialist medical advice. However, the Service is unable to provide round-the-clock access to specialist nursing advice, due to a lack of nurses with specific palliative care qualifications.
1.a.8: There is access to day services during working hours.

STATUS: Met

Day services are provided during normal working hours at Roxburghe House, Aberdeen. It was further reported that an additional day service facility is being established at a new unit in Elgin.

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

STATUS: Met

A team of community Macmillan nurses, based at Roxburghe House, Aberdeen, provide specialist palliative care services during working hours.

1.a.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.

STATUS: Not met (insufficient evidence)

It was reported that all referral enquiries are received by the secretary at Roxburghe House, Aberdeen, who directs these to an appropriate member of the multidisciplinary team. Where possible, an immediate response to a telephone enquiry is provided. Alternatively, the secretary phones the enquirer back later the same day. For out-patient appointments, the secretary phones the patient directly to inform them of their appointment date and time, and again it was reported that this is carried out on the same day of the enquiry. However, as no audit data were available, the review team concluded that there was insufficient evidence to confirm that this criterion is met.

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

STATUS: Met

It was confirmed that there is documentation of the reasons for not making initial contact with the patient/carer/professional within 2 working days. However, it was the perception of staff that an initial response to all enquiries is provided on the same day.
3. Detailed Findings Against the Standards

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

STATUS: Not met (insufficient evidence)

There is no system in place to ensure that the referrer is advised of the outcome of the referral within 2 working days of initial contact. No audit has been carried out to determine whether this timescale is being achieved.

Desirable Criteria

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

STATUS: Not met

There was no evidence that a validated assessment tool is routinely used to assess need, and prioritise admission to the Specialist Palliative Care Service. However, it was reported that the Palliative Care Outcome Scale (POS) is currently being piloted by the hospital specialist palliative care team, and that there are plans to implement this throughout the Service in future.

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

STATUS: Not met

There is no provision for an out-of-hours community specialist palliative care service. It was reported that the primary care team manages specialist palliative care patients in the community out-of-hours.
Standard 2(a): 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.*

**Grampian University Hospitals NHS Trust**

**Essential Criteria**

2.a.1: **Dedicated environment with: quiet/private areas provided; chapel/prayer room; facilities for relatives to stay overnight.**

**STATUS: Not met**

There are two quiet/private areas within Roxburghe House, Aberdeen, and facilities are available for relatives to stay overnight. However, the review team noted that these facilities are insufficient. It was also noted that there is no dedicated chapel/prayer room within Roxburghe House, although it was reported that opportunities for worship are provided within the communal and quiet areas. These deficiencies will be addressed in the new Roxburghe House, and the review team had the opportunity to see the plans for this new facility during the visit.

2.a.2: **In-patient care facilities: for the purposes of symptom management, rehabilitation or terminal care.**

**STATUS: Met**

The management and terminal care of in-patients is provided within four-bedded areas and single rooms within Roxburghe House, Aberdeen. Facilities for rehabilitation are also provided, including an occupational therapy kitchen and a physiotherapy gym.

2.a.3: **24-hour telephone advice: available for any healthcare professionals.**

**STATUS: Met**

Healthcare professionals can contact Roxburghe House, Aberdeen, at any time to access telephone advice.
2.a.4: 24-hour telephone support service: available for known out-patients and their carers.

STATUS: Not met

There is no 24-hour telephone support service provided by the Specialist Palliative Care Service. Out-patients and their carers are informed that the primary care team, which is responsible for their care, provides the 24-hour telephone support service. It was reported that this system meets the needs of the area, as the primary care team has access to the most recent information on the patient’s condition. It was noted that members of the primary care team can contact a member of the Specialist Palliative Care Service for advice if required.

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

STATUS: Met

Traditional day hospice services are provided within Roxburghe House, Aberdeen. In addition, a new facility in Elgin will provide day services in the near future.

2.a.6: Hospital services: formalised arrangements for specialist input to local and community hospitals.

STATUS: Not met (insufficient evidence)

The hospital specialist palliative care team has responsibility for specialist input to local hospitals in the Aberdeen area. There are also formalised arrangements for specialist palliative care input to Dr Gray’s Hospital in Elgin. It was reported that the community Macmillan nurses are regularly involved in the care of patients within community hospitals throughout the rest of the region. The specialist palliative care consultants also visit patients in community hospitals, on request from GPs. However, from the evidence provided, the review team could not confirm whether there are formalised arrangements for specialist input to community hospitals.

2.a.7: Education programme: see Education Standard.

STATUS: Not met (insufficient evidence)

See Education Standard, Criterion 4.8.
2.a.8: Research and audit are undertaken within a framework of clinical governance.

STATUS: Met

It was reported that all research and audit carried out within the Specialist Palliative Care Service is undertaken according to Grampian University Hospitals NHS Trust’s framework of clinical governance.

2.a.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; psychological services; social services; spiritual support services.

STATUS: Not met

There are written referral guidelines to certain aspects of the Specialist Palliative Care Service, including community specialist palliative care, day services, the hospital specialist palliative care team, the lymphoedema service and social work. There are no guidelines for referral to bereavement services, complementary therapies, counselling services, patient transport services or spiritual support services.

Desirable Criteria

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

STATUS: Not met

The review team concluded that there are no formalised arrangements for specialist palliative care input to care homes. It was reported that specialist palliative care staff will provide input to care homes if requested.
3. Detailed Findings Against the Standards

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

**Standard Statement**

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

**Grampian University Hospitals NHS Trust**

**Essential Criteria**

3.a.1: *The core team comprises dedicated sessional input from: chaplain; doctors; nurses; occupational therapist; pharmacist; physiotherapist; social worker.*

**STATUS: Met**

The review team commended the effective multidisciplinary working between all core team members. It was reported that all core team members meet formally on a weekly basis, and there was evidence that informal discussions between members of the team are a valuable source of information.

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.*

**STATUS: Not met**

The Specialist Palliative Care Service has access to a range of other professionals, including an anaesthetist who holds a weekly clinic at Roxburghe House, Aberdeen. Dentistry, dietetics, and speech and language therapy services are provided by Aberdeen Royal Infirmary. Complementary therapies can be arranged through voluntary services, although it was reported that these are not easily accessed and are seldom used. The review team was particularly impressed with the chronic lymphoedema service and the sessional input from psychology services. Staff reported that oncology services are easily accessed, as the Specialist Palliative Care Service is integrated with the oncology service. Psychiatry services can be accessed by referral to the local psychiatric hospital. Some bereavement support is provided by the social work and chaplaincy service, however, they do not consider themselves to be bereavement specialists. The review team concluded that this criterion is not met as there is not ready access to complementary therapists and bereavement specialists.
3.a.3: All clinical staff are supported by administrative staff.

STATUS: Met

Administrative support is provided by two full-time medical secretaries and a full-time receptionist. All staff interviewed during the review visit reported that they were satisfied with the current level of administrative support.

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.

STATUS: Not applicable

There are no stand-alone nurse specialists operating in the Grampian region.

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

STATUS: Not met

The review team did not find the provision of a formal policy for staff support. There were variable reports about the provision of a support system for staff throughout the Specialist Palliative Care Service. Clinical supervision is established in certain areas, but is not in universal use throughout the region. It was reported that a massage service is provided for staff at Roxburghe House, Aberdeen, and the hospital specialist palliative care team. There is a tendency for staff to rely on their colleagues to provide support, and the chaplain is also relied upon as a source of staff support. A number of staff interviewed during the visit reported that the existing informal staff support system was inadequate.

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.

STATUS: Not met

The Specialist Palliative Care Service is led by a consultant who is on the specialist medical register for palliative medicine. There is a lead nurse for the Specialist Palliative Care Service and oncology service, but she does not have a Masters degree in palliative care, and is not recorded as a specialist practitioner in palliative care. It was reported that a senior sister is currently undertaking a Masters degree in palliative care.
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. (The Specialist Palliative Care Project Group acknowledges that palliative care qualifications at degree and postgraduate level have only recently been available and accessible in Scotland. Degree and postgraduate level qualifications in cancer nursing will be recognised as equivalent if commenced before 2002.)

STATUS: Met

There was evidence that the Specialist Palliative Care Service is working towards one nurse per shift in the in-patient unit having a degree or postgraduate qualification in palliative care. A high proportion of nursing staff within the specialist palliative care team have attained, or are currently undertaking, further training in palliative care. All of the community nurses have attained, or are working towards, a degree or postgraduate qualification in palliative care.

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.

STATUS: Not applicable

The Specialist Palliative Care Service does not care for children as patients.

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

STATUS: Not met

The occupational therapist is a member of their specific specialist interest group, although other allied health professions (who are members of the multidisciplinary team) are not.

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

STATUS: Met

It was reported that checks are carried out on the appointment of all practitioners, to ensure that they are registered with their relevant accrediting body. Subsequent checks are the responsibility of the appropriate line managers.
3.a.11: There is evidence that all professionals have personal development plans which demonstrate that training needs are identified and addressed.

**STATUS: Not met**

It was reported that the Specialist Palliative Care Service is working towards implementing personal development plans for all staff.

**Desirable Criteria**

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

**STATUS: Not met**

The allied health professions, who are members of the multidisciplinary team, do not have multidisciplinary diplomas in palliative care.

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

**STATUS: Not met**

It was reported that complementary therapies can be arranged through voluntary services and Cancer Link Aberdeen North (CLAN) House. However, there is no system to access these services. There are no guidelines for their use and staff reported that these services are rarely accessed. It was further reported that the provision of complementary therapies within Roxburghe House, Aberdeen, is under review, and it is envisaged that this will result in the provision of relevant guidelines and policies to ensure the safe delivery of therapies.

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

**STATUS: Not met**

It was reported that the anaesthetist, lymphoedema specialists, oncologist and psychologists have a specific interest, and experience, in palliative care. There is no evidence that other ancillary team members have a specific interest in palliative care.
3. Detailed Findings Against the Standards

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.*

Grampian University Hospitals NHS Trust

**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.*

**STATUS: Not met**

There is no member of the Specialist Palliative Care Service with a remit for planning and implementing in-house and out-reach education programmes. It was reported that the Service is currently in the process of applying for a New Opportunities Fund (NOF) for a clinical lecturer, who will take on this role.

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

**STATUS: Not met**

The Specialist Palliative Care Service does not have access to an educator to facilitate curriculum development.

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

**STATUS: Met**

There was evidence that all members of the Specialist Palliative Care Service, who are involved in teaching, have attended a course on teaching and learning. It was reported that the nursing staff who are involved in teaching have completed teaching modules as part of their further education in palliative care. Similarly, medical staff who are involved in teaching have attended training in teaching and learning.
4.4: The unit/team has on-site teaching facilities and a range of audio-visual aids.

STATUS: Met

The Specialist Palliative Care Service has access to a tutorial room and study centre where a television, video, a library and computers can be accessed within Roxburghe House, Aberdeen. It was reported that the new Roxburghe House building will have a dedicated teaching facility.

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

STATUS: Met

The Specialist Palliative Care Service has access to a small library, internet facilities and specialist palliative care databases within Roxburghe House, Aberdeen.

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.

STATUS: Met

It was reported that several members of the Specialist Palliative Care Service are involved in teaching and presenting at conferences, both at national and international levels. This enables them to access international, national and local syllabi, to be used in the process of devising an innovative and dynamic curriculum.

4.7: Communication skills training programmes are in place to enable all team members to respond sensitively and effectively to patients’ needs.

STATUS: Not met

It was reported that communication skills training is incorporated into the further education programmes of different multidisciplinary groups. However, there was no evidence of any structured programme of communication skills training available to all members of the Specialist Palliative Care Service. It was further reported that there are plans to introduce a communication skills training programme in conjunction with the Acute Trust’s continuing professional development department.
3. Detailed Findings Against the Standards

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.

STATUS: Not met (insufficient evidence)

There was evidence that there is a comprehensive programme of education in place for medical staff, however, the review team was unclear about education opportunities for nursing, allied health professions and other staff.

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

STATUS: Not met (insufficient evidence)

There was evidence that different members of the multidisciplinary team participate in teaching on the medical education programme. However, the review team could not confirm that there is a multidisciplinary approach to learning.

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

STATUS: Met

There was evidence that teaching takes place at different levels of palliative care, including at specialist and generalist levels.

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

STATUS: Not met

The Specialist Palliative Care Service does not produce an annual report on its education activities.

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.

STATUS: Met

The Specialist Palliative Care Service has established links with both Robert Gordon University, Aberdeen, and Aberdeen University. It was reported that medical, nursing and allied health professions contribute to the palliative care education programmes at both these sites.
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.

Grampian University Hospitals NHS Trust

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.

STATUS: Met

It was reported that the details of all key professionals involved in a patient’s care are documented in the patient’s casenotes, as part of the admission procedure. This documentation is carried out by the admitting nurse.

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

STATUS: Met

There are a number of mechanisms to disseminate information to all key professionals involved in a patient’s care. The weekly multidisciplinary team meeting is the main forum for disseminating information among members of the core team. Information is disseminated to professionals in primary care by telephone, letter and direct contact where possible. It was also reported that the monthly Palliative Care Focus Group includes representatives from primary and secondary care, and is an additional forum to disseminate information between professional groups.

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.

STATUS: Met

Weekly multidisciplinary meetings are held to discuss the care of new and existing patients. There was evidence that all members of the core team attend this meeting, and that further professionals are co-opted when necessary. It was reported that there are no minutes taken during this meeting, but the outcome of discussions are documented during the meeting in the patient’s casenotes.
3. Detailed Findings Against the Standards

5.4: Advice given by telephone is clearly documented.

STATUS: Met

Details of all telephone enquiries are recorded on a telephone advice sheet, including information on the outcome of the telephone call, together with any advice given. It was reported that all completed telephone advice sheets are held in a central folder.

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.

STATUS: Met

The review team commended the system in place for the notification of anticipated patient problems to those providing specialist 24-hour telephone advice. It was reported that a fax is sent to Roxburghe House, Aberdeen, prior to the weekend, to inform members of the Specialist Palliative Care Service of any anticipated problems with hospital in-patients. For community patients, the Macmillan nurses contact members of the primary care team about any anticipated patient problems.

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.

STATUS: Met

The Grampian Doctors on Call (GDOC) out-of-hours system is in place to ensure that members of the primary care team are notified of anticipated patient problems. It was reported that details of specialist palliative care patients with complex needs are faxed to the GDOC service. It was further reported that a palliative care kit is available to GPs providing the GDOC service, and that they are encouraged to contact the on-call specialist palliative care consultant for advice where necessary.

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 5 working days.

STATUS: Not met (insufficient evidence)

Staff verbally reported that key members of the care team are informed of a patient’s death by the next working day, and members of the extended care team are informed within 5 working days. The receptionist at Roxburghe House, Aberdeen, plays a key role in informing key members of the team of a patient’s death, on the day of death, or the following day. It was also reported that all patient deaths are acknowledged during the multidisciplinary team meeting. However, as no audit data were presented, the review team concluded that there was insufficient evidence to demonstrate that this criterion is met.
5.8: *Practitioners in a specialist palliative care service are members of their local Managed Clinical Network in palliative care.*

**STATUS: Met**

The review team commended the Palliative Care Focus Group, which is fully established in the Grampian region. This multidisciplinary Group is made up of both specialists and generalists in palliative care, and includes primary and secondary care representatives. Staff confirmed that this Group fulfills the role of a local Managed Clinical Network (MCN) for palliative care.

(Please note: When these standards were developed, it was not a requirement for MCNs to be accredited. The remit of NHS Quality Improvement Scotland has now been extended to include the accreditation of the quality assurance (QA) framework of all MCNs. In the future, this criterion will only be met if practitioners in a specialist palliative care service are members of a local MCN which has a QA framework accredited by NHS Quality Improvement Scotland.)

**Desirable Criteria**

5.9: *Integrated records.*

**STATUS: Not met**

Integrated records are not in use within the Specialist Palliative Care Service.

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

**STATUS: Met**

There was evidence that the specialist palliative care consultant is a member of the North East Scotland Cancer Co-ordinating and Advisory Group (NESCCAG), and participates in site-specific MCNs which feed into this Group.
### Standard 6: Communication with Patients/Carers

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

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#### Grampian University Hospitals NHS Trust

**Essential Criteria**

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>6.1:</strong></td>
<td>There is a needs assessment and care plan for each patient to pro-actively focus on communication and information needs.</td>
</tr>
</tbody>
</table>

**STATUS: Not met**

There was evidence that all patients have an individual documented care plan, however, these do not specifically focus on communication and information needs. It was reported that work has commenced on developing core care plans for specialist palliative care patients, and core plans have already been produced in areas of patient care that are deemed the most urgent. Staff acknowledged the need to develop comprehensive care plans for all aspects of patient care.

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<tbody>
<tr>
<td><strong>6.2:</strong></td>
<td>There is supported access to information and education resources for patients and their families/carers.</td>
</tr>
</tbody>
</table>

**STATUS: Met**

It was reported that national information is available, and that patients and their families/carers are directed to CLAN House as a source of information. There is no locally produced information available within the Specialist Palliative Care Service. The review team encouraged the service to raise awareness between different professional groups of the information that is available to patients and their families/carers.

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<tbody>
<tr>
<td><strong>6.3:</strong></td>
<td>There is information specifically for children/adolescents and for those adults and children with sensory impairment or special needs.</td>
</tr>
</tbody>
</table>

**STATUS: Not met**

There is no access to information for children/adolescents, and for those adults and children with sensory impairment or special needs, within the Specialist Palliative Care Service.
6.4: There is evidence that the team regularly carries out patient/family satisfaction surveys in order to evaluate staff communication skills.

STATUS: Not met

No evidence was provided to indicate that the Specialist Palliative Care Service has carried out any patient/family satisfaction surveys in order to evaluate staff communication skills.

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.

STATUS: Met

There was evidence that guidance and advice are offered to patients and their families/carers to facilitate rehabilitation of the patient in the community. It was reported that the allied health professions are actively involved in the rehabilitation process, and that there is effective liaison between secondary and primary care to facilitate patient rehabilitation into the community. It was further reported that case conferences are frequently held, including primary and secondary care representatives, to aid the rehabilitation process.

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

STATUS: Met

It was reported that the patient’s preferred place of care is identified, agreed and documented in their casenotes. It was further reported that the patient’s preferred place of care is reviewed on a regular basis, as their condition dictates.

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

STATUS: Met

The Specialist Palliative Care Service provides bereavement information packs to all bereaved families/carers. These packs include advice on emotional and practical issues.
Standard 7: Therapeutic Interventions

Standard Statement

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

Grampian University Hospitals NHS Trust

Essential Criteria

7.1: (Physical) 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.

STATUS: Not met (insufficient evidence)

The review team was unable to reach a decision as to whether this criterion was met throughout the Specialist Palliative Care Service, given the available evidence. The Roxburgh House Philosophy Statement emphasises the holistic approach to patient care adopted by the Service. The review team was also shown assessment tools for pain and other symptoms, that are reported to be in use by the hospital specialist palliative care team. However, the team could not confirm whether these tools were being used throughout the Specialist Palliative Care Service.

7.2: (Physical) A wide range of modalities of treatment are available for symptom management.

STATUS: Met

It was reported that members of the Specialist Palliative Care Service can rapidly access a wide range of modalities of treatment for the management of symptoms.

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

STATUS: Met

There was evidence that guidelines are in place to ensure the safe and effective use of different treatment modalities. These include syringe driver and epidural guidelines. The review team noted that these guidelines have recently been finalised and the Specialist Palliative Care Service now faces the challenge of ensuring that they are disseminated and implemented throughout the Service.
3. Detailed Findings Against the Standards

7.4: (Physical) 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.

STATUS: Met

There was evidence of safe and effective management of specialist interventions to allow patients to be cared for in their place of choice. Guidelines for syringe drivers and epidurals were provided as evidence during the review visit, and it was also noted that a comprehensive set of palliative care guidelines are available on the local intranet.

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

STATUS: Met

The on-call pharmacy service, based within Aberdeen Royal Infirmary, is available to ensure 24-hour access to specialist palliative care drugs.

Desirable Criteria

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

STATUS: Not met

There is no pharmacy technician who manages the medicines supply system at Roxburghe House, Aberdeen.

Essential Criteria

7.7: (Psychological) 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.

STATUS: Met

There was evidence that patients, and those important to them, receive ongoing support to address emotional issues, including those arising from the process of loss and change. It was reported that all staff involved in caring for specialist palliative care patients provide emotional support, and that the Macmillan nurses, social work and chaplaincy staff are particularly skilled in providing this support.
3. Detailed Findings Against the Standards

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

**STATUS: Met**

The review team found evidence of referral to psychology services for specialist palliative care patients. The review team was impressed with reports that, on occasion, the psychologist attends the multidisciplinary team meeting. However, staff noted that following referral there can be delays in patients obtaining access to these services.

7.9:  (Psychological) 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.

**STATUS: Not met**

The social work and chaplaincy services do provide some input to meet the needs of children who are relatives of specialist palliative care patients. Staff interviewed during the visit acknowledged that the current facilities are not designed for the needs of children. It was reported that the new Roxburghe House will address this deficit.

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

**STATUS: Met**

At present there is a full-time chaplain who divides his time between the Anchor Clinical Services, Grampian University Hospitals NHS Trust, and Roxburghe House, Aberdeen. It was reported that the chaplain visits all specialist palliative care patients and assesses their religious and spiritual needs. It was further reported that the chaplain will soon be leaving the post, and there is concern among staff about funding to fill this post.

7.11:  (Spiritual) Evidence exists that religious needs have been assessed and addressed.

**STATUS: Met**

The chaplain who works between the Anchor Clinical Services, Grampian University Hospitals NHS Trust, and Roxburghe House, Aberdeen, makes contact with specialist palliative care patients to assess their religious needs. It was also reported that a religious service is held in Roxburghe House, Aberdeen, on a weekly basis. In addition, the chaplain is able to contact ministers of other denominations on request.
7.12: (Spiritual) There is evidence of referral to specialist spiritual support services according to identified need.

STATUS: Met

All specialist palliative care patients are seen by the chaplain, who is able to provide specialist spiritual support as required. The chaplain attends the weekly multidisciplinary team meeting, where all patients are discussed, and those with specialist spiritual needs identified.

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

STATUS: Met

There was evidence that patients and those important to them have their social needs assessed and addressed. There is no social worker dedicated to the Specialist Palliative Care Service. However, the social work service is provided by four social workers with particular skills and experience in this field. The senior social worker with responsibility for the Specialist Palliative Care Service attends the weekly multidisciplinary team meeting, where the social needs of all patients are discussed. Some concern was expressed about the potential developments in the social work service, which are felt may result in a less comprehensive service for specialist palliative care patients.

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

STATUS: Met

It was reported that priority is given to specialist palliative care patients for assessment of their service requirements. It was further reported that those patients with urgent social needs are given priority over less urgent cases.

7.15: (Social) 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.

STATUS: Met

It was reported that a large amount of pre-bereavement work is undertaken with families/carers. All staff involved in the care of specialist palliative care patients are experienced and skilled in providing support to patients, and those important to them, to cope with changes in their, or their family’s, circumstances.
3. Detailed Findings Against the Standards

7.16: (Bereavement) Evidence exists that families’/carers’ bereavement needs have been assessed and addressed.

STATUS: Not met

Staff interviewed during the review visit acknowledged that they are unable to provide a comprehensive bereavement support service to families/carers. A bereavement pack is sent out to families/carers, and this includes details of support groups such as Cruse Bereavement Care Scotland. However, staff considered that the current bereavement service is inadequate.

7.17: (Bereavement) There are local guidelines for referral to a bereavement service.

STATUS: Not met

There are no local guidelines for referral to a bereavement service.
Standard 8: Patient Activity

Standard Statement

There is 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.

Grampian University Hospitals NHS Trust

Essential Criteria

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.

STATUS: Not met

At present there is no system in place to collect the data specified in the Scottish Minimum Data Set for Specialist Palliative Care. The Specialist Palliative Care Service is currently involved in ongoing negotiations with the IT department, based in Grampian University Hospitals NHS Trust, to implement suitable databases.
## Appendix 1 — Glossary of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>CLAN</td>
<td>Cancer Link Aberdeen North</td>
</tr>
<tr>
<td>CRAG</td>
<td>Clinical Resource and Audit Group</td>
</tr>
<tr>
<td>CSBS</td>
<td>Clinical Standards Board for Scotland</td>
</tr>
<tr>
<td>GDOC</td>
<td>Grampian Doctors On Call</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HADS</td>
<td>Hospice Activity Data Set</td>
</tr>
<tr>
<td>HCAS</td>
<td>Hospice Computerised Administration System</td>
</tr>
<tr>
<td>HTBS</td>
<td>Health Technology Board for Scotland</td>
</tr>
<tr>
<td>MCN</td>
<td>Managed Clinical Network</td>
</tr>
<tr>
<td>NESCAG</td>
<td>North East Scotland Cancer Co-ordinating and Advisory Group</td>
</tr>
<tr>
<td>NMPDU</td>
<td>Nursing and Midwifery Practice Development Unit</td>
</tr>
<tr>
<td>NOF</td>
<td>New Opportunities Fund</td>
</tr>
<tr>
<td>QA</td>
<td>Quality Assurance</td>
</tr>
<tr>
<td>SHAS</td>
<td>Scottish Health Advisory Service</td>
</tr>
<tr>
<td>SIGN</td>
<td>Scottish Intercollegiate Guidelines Network</td>
</tr>
<tr>
<td>TENS</td>
<td>Transcutaneous Electrical Nerve Stimulation</td>
</tr>
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</table>
Appendix 2 — Review Team Members

**Details of Review Visit**

The review visit to Grampian University Hospitals NHS Trust was conducted on 26 March 2003. The review team members for this visit were:

<table>
<thead>
<tr>
<th>Name</th>
<th>Title and Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Rosaleen Beattie (Team Leader)</td>
<td>Medical Director/Consultant in Palliative Care, St Margaret's Hospice, Greater Glasgow</td>
</tr>
<tr>
<td>Dr Cath Dyer</td>
<td>Macmillan Lead GP, Forth Valley</td>
</tr>
<tr>
<td>Ms Evelyn Howie</td>
<td>Senior Clinical Nurse, St Columba's Hospice, Lothian</td>
</tr>
<tr>
<td>Ms Mareth Irvine</td>
<td>Lay Representative, Dumfries &amp; Galloway</td>
</tr>
<tr>
<td>Ms Susan Munroe</td>
<td>Caring Services Manager Scotland, Marie Curie Centre Hunters Hill, Greater Glasgow</td>
</tr>
<tr>
<td>Ms Jane Urie</td>
<td>Senior Pharmacist, Highland Acute Hospitals NHS Trust</td>
</tr>
<tr>
<td>Mr John Watson</td>
<td>Lay Representative, Ayrshire &amp; Arran</td>
</tr>
<tr>
<td>NHS Quality Improvement Scotland Personnel</td>
<td></td>
</tr>
<tr>
<td>Mrs Angela Balharrie</td>
<td>Project Officer, NHS Quality Improvement Scotland</td>
</tr>
<tr>
<td>Ms Hilary Davison</td>
<td>Review Team Manager, NHS Quality Improvement Scotland</td>
</tr>
</tbody>
</table>

Mrs Angela Balharrie
Project Officer, NHS Quality Improvement Scotland

Ms Hilary Davison
Review Team Manager, NHS Quality Improvement Scotland
### Appendix 3 — Specialist Palliative Care Project Group Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professor John Welsh (Chairman)</strong></td>
<td>Olav Kerr Professor of Palliative Medicine, University of Glasgow</td>
</tr>
<tr>
<td><strong>Ms Joan Adam</strong></td>
<td>Nurse Lecturer in Palliative Care, St Columba’s Hospice, Lothian</td>
</tr>
<tr>
<td><strong>Ms Alison Barclay</strong></td>
<td>Senior Occupational Therapist, Lothian University Hospitals NHS Trust</td>
</tr>
<tr>
<td><strong>Ms Margaret Colquhoun</strong></td>
<td>Senior Nurse Lecturer in Palliative Care, St Columba’s Hospice, Lothian</td>
</tr>
<tr>
<td><strong>Dr Cath Dyer</strong></td>
<td>Macmillan Lead GP, Forth Valley</td>
</tr>
<tr>
<td><strong>Ms Kate Macleod</strong></td>
<td>Social Worker – Family Support, Rachel House Children’s Hospice, Tayside</td>
</tr>
<tr>
<td><strong>Dr Lindsay Martin</strong></td>
<td>Consultant in Palliative Medicine, Dumfries &amp; Galloway Acute &amp; Maternity</td>
</tr>
<tr>
<td></td>
<td>Hospitals NHS Trust</td>
</tr>
<tr>
<td><strong>Reverend David Mitchell</strong></td>
<td>Chaplain, Marie Curie Centre Hunters Hill, Greater Glasgow</td>
</tr>
<tr>
<td><strong>Dr Alison Morrison</strong></td>
<td>Medical Director, Ardgowan Hospice, Argyll &amp; Clyde</td>
</tr>
<tr>
<td><strong>Ms Susan Munroe</strong></td>
<td>Caring Services Manager Scotland, Marie Curie Centre Hunters Hill, Greater</td>
</tr>
<tr>
<td></td>
<td>Glasgow</td>
</tr>
<tr>
<td><strong>Mrs Margaret Smith</strong></td>
<td>Lay Representative, West Lothian</td>
</tr>
<tr>
<td><strong>Ms Margaret Stevenson</strong></td>
<td>Formerly Director of the Scottish Partnership for Palliative Care (until</td>
</tr>
<tr>
<td></td>
<td>July 2002)</td>
</tr>
<tr>
<td><strong>Ms Cara Taylor</strong></td>
<td>Macmillan Cancer Nurse Consultant, Tayside Primary Care NHS Trust</td>
</tr>
<tr>
<td><strong>Ms Jane Urie</strong></td>
<td>Senior Pharmacist, Highland Acute Hospitals NHS Trust</td>
</tr>
</tbody>
</table>
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 Ms Frances Smith (Director of Nursing & Quality, Standards and Reviews), Ms Hilary Davison (Review Team Manager), Ms Susan Shields (Senior Project Officer), Ms Nanisa Feilden (Project Officer), Mrs Angela Balharrie (Project Officer) and Ms Elaine Mackay (Project Administrator).
## Appendix 4 — Timetable of Review Visits

<table>
<thead>
<tr>
<th>Organisation Reviewed</th>
<th>Visit Date</th>
</tr>
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<tbody>
<tr>
<td>Argyll &amp; Clyde</td>
<td></td>
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<tr>
<td>Accord Hospice, Paisley</td>
<td>17 April 2003</td>
</tr>
<tr>
<td>Ardgowan Hospice, Greenock</td>
<td>15 April 2003</td>
</tr>
<tr>
<td>St Vincent’s Hospice, Johnstone</td>
<td>16 April 2003</td>
</tr>
<tr>
<td>Ayrshire &amp; Arran</td>
<td></td>
</tr>
<tr>
<td>Ayrshire Hospice, Ayr</td>
<td>15 January 2003</td>
</tr>
<tr>
<td>Borders</td>
<td></td>
</tr>
<tr>
<td>Borders General Hospital NHS Trust</td>
<td>26 February 2003</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td></td>
</tr>
<tr>
<td>Dumfries &amp; Galloway Acute &amp; Maternity Hospitals NHS Trust</td>
<td>11 February 2003</td>
</tr>
<tr>
<td>Fife</td>
<td></td>
</tr>
<tr>
<td>Fife Acute Hospitals NHS Trust and Fife Primary Care NHS Trust</td>
<td>7 May 2003</td>
</tr>
<tr>
<td>Forth Valley</td>
<td></td>
</tr>
<tr>
<td>Strathcarron Hospice, Denny</td>
<td>28 May 2003</td>
</tr>
<tr>
<td>Grampian</td>
<td></td>
</tr>
<tr>
<td>Grampian University Hospitals NHS Trust</td>
<td>26 March 2003</td>
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<td>Marie Curie Centre Hunters Hill, Glasgow</td>
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<td>North Glasgow University Hospitals NHS Trust</td>
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<td>Highland</td>
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<td>Highland Hospice, Inverness</td>
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<td>Lanarkshire</td>
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<td>Lothian</td>
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<td>Marie Curie Centre Fairmile, Edinburgh</td>
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<td>St Columba’s Hospice, Edinburgh</td>
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<td>Tayside Primary Care NHS Trust</td>
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<td>Western Isles</td>
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<tr>
<td>Bethesda Hospice, Stornoway</td>
<td>5 August 2003</td>
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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

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