

# REPORT

## Memorandum of Understanding (Independent Scottish Hospices)

Edinburgh Integration Joint Board

4 February 2020

### Executive Summary

The Memorandum of Understanding (MoU) builds on the previous arrangements as set out in CEL 12. This represents a broader statement of intent, recognising the statutory role of Integration Joint Boards (as set out in the Public Bodies (Joint Working) (Scotland) Act 2014).

CEL 12 offered guidance to NHS Boards and therefore Integration Joint Board (IJBs) should adopt and make reference to the renewed MoU as IJBs now hold the commissioning authority.

Currently palliative care is 'hosted' by Edinburgh on behalf of all 4 Partnerships in Lothian – it is not anticipated that these arrangements will be altered by the introduction of the MoU.

The MoU will cover an initial period from April 2019 to March 2021. During this period the MoU will be reviewed with any updates ready for implementation beyond this end date. While formal agreement at IJB level has yet to be reached, the operational principles that this framework sets out are well recognised.

Currently, Service Level Agreements (SLAs) are in place for both hospices in Edinburgh which are due for renewal from April 2021.

The ratification by the EIJB is the formal step in publicly adopting the framework.

### Recommendations

It is recommended that the Edinburgh Integration Joint Board (EIJB):

1. Agreed to adopt the Memorandum of Understanding (MOU) as the framework on which the future delivery of hospice palliative and end of life care services in Edinburgh and the Lothians are planned and negotiated.
2. Note currently, Service Level Agreements (SLAs) are in place with both hospices which are due for renewal from April 2021.

## Directions

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Direction to City of Edinburgh Council, NHS Lothian or both organisations	No direction required	✓
	Issue a direction to City of Edinburgh Council	
	Issue a direction to NHS Lothian	
	Issue a direction to City of Edinburgh Council and NHS Lothian	

## Report Circulation

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1. This report has not been presented to any other EIJB Committee.

## Main Report

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2. Historically, Service Level Agreements (SLAs) have been negotiated with each hospice independently, typically covering a set period of 3 years. These SLAs were negotiated with reference to the Scottish Government's letter to Chief Executives of 2012, commonly referred to as CEL 12.
3. Since the transformational change to Scotland's Health and Social care environment in April 2016, Integration Joint Boards (IJBs) now hold devolved responsibilities for the planning and monitoring of community health and social care services.
4. The Health & Social Care Partnership (HSCPs), the body through which the IJBs operate, are now the organising and delivery mechanisms for providing integrated health and social care in primary and community services. Since palliative care was agreed to be 'hosted' within the Edinburgh Health and Social Care Partnership (the Partnership), further SLAs have been negotiated and agreed, the latest being in place with both Hospices to the end of March 2021.
5. The Memorandum of Understanding (Appendix 1) reflects these statutory changes and heralds a new principled approach.
6. Access to hospice services is based on geographical alignment with St Columba's covering residents in Edinburgh North and East Lothian, with Marie Curie Edinburgh working across Edinburgh South, Midlothian and West Lothian.
7. This Memorandum of Understanding (MoU) is the culmination of the work undertaken by a Short Life Working Group (SLWG) led by Ron Culley, Chief Officer, Western Isles. The SLWG included representatives from Health and Social Care Partnerships, the Scottish Hospices Leadership Group as well as the Scottish Government.

8. This MoU has been developed to ensure the provision of high quality and person centred palliative and end of life care is made available to all who need it, when they need it. This commitment is underpinned by the following principles:
  - a. A partnership based on parity of esteem and a commitment to shape palliative care services together;
  - b. A recognition of the importance of financial stability, both within the partnership as a whole and for each independent hospice;
  - c. A commitment to operate openly and transparently, cultivating a position of trust, building strong relationships which are resilient to disagreement and financial pressures;
  - d. 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.

#### **Hospice provision across Lothian**

9. There are 2 hospices located within the City of Edinburgh, providing a range of specialist inpatient and community led palliative and end of life care services to those residing across the whole of Lothian.
10. St Columba's Hospice is located in the North of the City. It has access to 30 specialist inpatient palliative care beds. It typically serves residents in the North of the City and also across East Lothian.
11. Marie Cure Edinburgh Hospice is located in the South of the City. It has access to 20 inpatient beds and typically serves the populations in the South of the City, Midlothian and also West Lothian.

#### **Memorandum of Understanding**

12. The Memorandum of Understanding (MoU) builds on the previous arrangements as set out in CEL 12. This represents a broader statement of intent, recognising the statutory role of Integration Joint Boards (as set out in the Public Bodies (Joint Working) (Scotland) Act 2014).
13. The aim of the MoU is to provide a strategic 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 also describes the principles that should apply to the development of any future SLAs, contracts of commissioning plans.
14. These new arrangements have been jointly approved by the Chair of the Chief Officers Group and the Chair of the Hospices Leadership Group.

15. Every IJB in Scotland is now being encouraged to agree to adopt the MoU as the basis for future service planning arrangements with independent hospices.
16. CEL 12 offered guidance to NHS Boards and therefore IJBs should adopt and make reference to the renewed MoU as IJBs now hold the commissioning authority.
17. These new arrangements cover a defined time period of two years (April 2019 to March 2021). The MoU will be reviewed and updated by the Scottish Hospice Leadership Group and the IJB Chief Officers group before 31st March 2021.
18. The national working groups will also monitor and review the development of any future plans and SLAs to ensure these are developed consistently and in line with the principles set out in the MoU.

### **Current Service Level Agreements**

19. New SLAs were required to be negotiated and approved due to the previous three year arrangements coming to a close as of 31 March 2018.
20. Service Level Agreements are currently in place with each hospice. These were developed in line with CEL 12 and cover a three year period from 1st April 2018 to 31st March 2021.
21. A breakdown of the services provided across both hospices along with the associated payments is attached in Appendix 2.
22. The Partnership has extremely positive relationships with both hospices and are engaged on an ongoing basis with both in terms of blue sky thinking as to the opportunities and challenges that may lie ahead and what this may mean for palliative care both in the hospices but also in the wider community.
23. Given the ongoing nature of this relationship, the release of the Memorandum of Understanding is well timed.

## **Implications for Edinburgh Integration Joint Board**

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### **Financial**

24. Whilst the NHS and Local authorities retain budgetary responsibilities for significant portions of their traditional areas of delivery, e.g. NHS acute care, Palliative Care has in the vast majority of cases in Scotland, been incorporated into the responsibilities of the Partnerships

25. Under the previous arrangements, CEL 12 outlined the financial contribution of health boards towards the running costs of independent hospices – broadly speaking this proposed 50% of running costs be met by the Health Board.
26. The MoU heralds a shift in approach and does not prescribe the proportion of costs to be met by IJBs. Instead it envisages a new approach based around:
  - a. A transparent assessment of the total resource both parties bring to the table, including charitable income
  - b. A transparent assessment of the total costs of service provision, analysed through an ‘open book’ approach between IJB and independent hospice;
  - c. Value for money and efficiency
  - d. Benchmarking of costs, activity and quality;
  - e. Quality outcome measures
27. Current funding for each hospice is in excess of £2m per annum.
28. In setting out the above changes, the MoU also states that individual hospices “...should not receive a reduction in financial support....against 2018/19 levels...” However as indicated earlier, three year SLAs are already in place with both hospices to end of March 2021.
29. The MoU also alludes to future hospice pay increases in line with NHS arrangements, noting that such arrangements should be set out within any new SLA.

#### **Legal implications**

30. New SLAs will be required to be developed for April 2021 with both hospices. In doing so we will continue to seek legal guidance and support from the Central Legal Office (CLO).

#### **Equality and integrated impact assessment**

31. An equality and impact assessment has not been undertaken

#### **Environment and sustainability impacts**

32. There are no known environmental/ sustainability issues as a result of any transition to the MoU.

#### **Quality of care**

33. The quality of care will not be negatively impacted as a result of any transition to the MoU.

## Consultation

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34. The matter of 'sign-up' to the new MoU has been raised by the Lothian Palliative Care MCN. In response to the proposed new approach, the MCN is keen to have a clear understanding of the future commissioning approach to be adopted in Edinburgh and across Lothian and the extent to which this differs or otherwise from the rest of Scotland.
35. Subject to approval and sign off by the IJB membership, it would be the intention to continue to engage with both hospice management teams in developing and ultimately approving new 3 year Service Level Agreements, founded on the principles of this MoU, in readiness for 1<sup>st</sup> April 2021.

## Report Author

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**Judith Proctor**

**Chief Officer, Edinburgh Integration Joint Board or relevant Executive lead**

Contact for further information:

Name: Neil Wilson

Email: [neil.wilson@nhslothian.scot.nhs.uk](mailto:neil.wilson@nhslothian.scot.nhs.uk) Telephone: 07792 385956

## Appendices

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Appendix A	Memorandum of Understanding
Appendix B	Breakdown of Hospice Service Provision and Associated Payments



## Memorandum of Understanding

### 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,<sup>1</sup> 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.

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

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.

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

*Vicky Irons*

**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

*Rhona M Baillie*

**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

## APPENDIX B

### Breakdown of Hospice Service Provision and Associated Payments

#### Marie Curie

##### The Services Provided

The services provided will be in line with the recently published Scottish Government Health and Social Care Standards (2017)

##### Specialist Palliative Inpatient Services

A service for patients who need specialist assessment and support in an in-patient setting in relation to the following issues:

- Symptom control which cannot be easily achieved in their usual care setting
- Multidisciplinary team assessment of complex problems associated with the dying process
- Care in the last few weeks or days from a specialist team;
- An emotional, psychological or spiritual burden of illness or prognosis which they, or their family, need support with
- Future planning needs that are challenging for the patient, their family or their care team
- Limited Rehabilitation and enablement in a palliative care context
- Provision of telephone advice to professionals, in-patients and their families via hospice team in hours and out of hours through the pan Lothian Palliative Medicine out of hours service

##### Specialist Palliative Medical Services

A Palliative Care Consultant led service for Lothian patients. This will include:

- Provision of consultant medical services in support of the hospice specialist palliative inpatient day therapy and out-patient services and community specialist palliative care services 24 hours per day, 7 days per week;
- Provision of consultant medical services in support of the specialist palliative services within NHS Lothian facilities (as agreed); and
- Contributing to the Lothian Palliative Care Consultant “on-call” rota.

**Specialist Day Therapy and Out Patient Services**

A service for patients who are at home or in a community setting which focuses on therapeutic and rehabilitation approaches through group and individual support including::

- Specialist assessment of complex problems and management plan provided by the multidisciplinary team;
- Rehabilitation and enablement approaches
- Follow up and liaison with appropriate professionals;
- Telephone contact and advice

**Specialist Palliative Community Services**

Services for patients and carers who are at Home or in a Community Setting, in collaboration with the primary care team, including:

- Provision of a clinical nurse specialist service, with advice and support 7 days per week
- specialist palliative care assessment and care planning
- advice and support for symptom management;
- provision of telephone advice for professionals, patients and families

**Marie Curie – Charges/ Payments**

The following sums will be paid in year 1, year 2, and year 3 during which the Agreement remains in force.

**2018/19 – 2020/21: £2,186,988 p.a.**

Breakdown	Costs
Core Inpatient Services (incl Drugs & fellowship)	£1,893,113
ACT Funding	£25,375
West Lothian (See Schedule 7)	£268,500

The charges for each year of the 3 year Agreement will be paid in full within 60 days of the Provider rendering its invoice.

The above sum reflects the funding available for the types of services to be provided. The agreement is in compliance with the CEL 12 (2012).)

## **Marie Curie: Managed Care and Fast Track**

### **Managed Care**

A service co-ordinated locally by a Senior Nurse to provide planned palliative nursing care to patients in their usual place of residence, who are in the end of life stage of their illness, whose needs can be met through short episodes of care, delivered through an agreed combination of days and/or evenings and/or nights as appropriate to support the needs of patients and carers.

The Services will be provided as follows:

**Care:** The Provider will provide an agreed combination of Registered Nurses and Healthcare Assistants to deliver care and support for referred patients with a terminal illness, which will comprise management of pain and other symptoms and provision of emotional and practical support as set out in the care plan provided by the referrer.

**Location:** Services will be delivered in the patient's home (or other agreed location).

### **Operational Hours:**

Care is flexible and is based on patient need. Standard shifts are 9 hour Night visits delivered between the hours of 22:00 and 07:00. Day and Evening visits are of variable length and flexible between the hours of 07:00 to 23:00, subject to a minimum of 3 hours.

### **Fast Track**

The provision of planned palliative nursing care covering multiple patients per shift in their usual place of residence, who are in the end of life stage of their illness, whose needs can be met through short episodes of care, delivered through an agreed combination of days and/or evenings and/or nights as appropriate to support the needs of patients and carers.

The Services will be provided as follows:

**Care:** The Provider will provide Healthcare Assistants to deliver care and support for referred patients with a terminal illness, which will comprise management of pain and other symptoms and provision of emotional and practical support as set out in the care plan provided by the referrer.

**Location:** Services will be delivered in the patient's home (or other agreed location).

**Operational Hours:** 08:00-14:00 and 16:00-22:00 seven days a week.

**Managed Care & Fast Track Charges**

Managed Care and Fast Track	YEAR 1	YEAR 2	YEAR 3
Annual Budget	£346,491	£360,000	£374,000
Invoice Frequency	Annually in Advance	Annually in Advance	Annually in Advance

The agreed fixed charges for Year 2 will be paid in full within 60 days of Marie Curie rendering its invoice, therefore during the first 2 months of year 2.

The agreed fixed charges for Year 3 will be paid in full within 60 days of Marie Curie rendering its invoice, therefore during the first 2 months of year 3.

**St Columba’s Hospice**

**The Services Provided**

The services provided will be in line with the recently published Scottish Government Standards Health and Social Care Standards (2017)

**Specialist Palliative Inpatient Services**

A service for patients who need specialist assessment and support in an in-patient setting in relation to the following issues:

- Symptom control which cannot be easily achieved in their usual care setting
- Multidisciplinary team assessment of complex problems associated with the dying process
- Care in the last few weeks or days;
- Rehabilitation and enablement
- Provision of telephone advice to professionals, patients and families

**Specialist Palliative Medical Services**

A Palliative Care Consultant led service for Lothian patients. This will include:

- Provision of consultant medical services in support of the hospice specialist palliative inpatient day therapy and out-patient services and community specialist palliative care services 24 hours per day, 7 days per week;
- Provision of consultant medical services in support of the specialist palliative services within NHS Lothian facilities (as agreed); and
- Contributing to the Lothian Palliative Care Consultant “on-call” rota.

### **Specialist Day Therapy and Out Patient Services**

A service for patients who are at home or in a community setting which focuses on therapeutic and rehabilitation approaches through group and individual support including::

- Specialist assessment of complex problems and management plan provided by the multidisciplinary team;
- Rehabilitation and enablement approaches
- Follow up and liaison with appropriate professionals;
- Telephone contact and advice.

### **Community Specialist Palliative Care Service**

A multi-professional service for patients who are at Home or in a Community Setting, in collaboration with the primary care team, including:

- specialist palliative care assessment and care planning
- advice and support for symptom management;
- provision of telephone advice for professionals, patients and families
- access to clinical nurse specialist advice and support 7 days per week

In addition to the specialist palliative care services outlined above, St. Columba's Hospice education and research services will include the following:

- Multidisciplinary academic courses, in co-operation with Higher Education Institutions
- An outreach programme of palliative care education for health and social care staff
- Taught input and clinical placements for students of medicine, nursing, allied health professions, social work, chaplaincy and counselling.
- Input into professional/ practice development initiatives in Lothian
- Professional development placements for health and social care professionals both locally and internationally
- Participation in the Lothian Palliative Care Research Network contributing to a coordinated approach to research practice.

### **St Columba's Hospice: Charges/ Payments**

The following sums will be paid in year 1, year 2 and year 3 during which the Agreement remains in force.

- **2018/2019:** £2,093,109
- **2019/2020:** £2,093,109
- **2020/2021:** £2,093,109

The above sum reflects the funding available for the four types of Services to be provided.  
The Agreement is in compliance with the CEL 12 (2012).)