

Issues for non-executive
NHS board members

Review of palliative care services in Scotland



Prepared for the Auditor General for Scotland
August 2008

Introduction

1. Audit Scotland published its national report, *Review of palliative care services in Scotland*, on 21 August 2008. This paper accompanies that report and sets out some issues that non-executive members may wish to consider in relation to how services are managed within their own boards and with their partners. It also aims to help them pose questions they may want to ask of executive directors to seek assurance about local service delivery.
2. Copies of the national report can be downloaded from our website www.audit-scotland.gov.uk

Reference to main report	Issue	Questions for non-executive board members to consider	
Part 1. Planning palliative care			
P8	The Scottish Government plans to publish a palliative care action plan in October 2008.		<ul style="list-style-type: none"> ▪ What will the board do to respond to the national palliative care action plan?
P9	Not every NHS board has an up-to date palliative care strategy based on a comprehensive assessment of the current and predicted future needs of their population.		<ul style="list-style-type: none"> ▪ Does the board have and up-to date strategy for palliative care? ▪ Is it based on the assessed needs of the local population for specialist and generalist palliative care for people with all conditions and for all demographic groups?
P9	There is low representation of councils on palliative care networks. Community Health Partnerships (CHPs) have had limited involvement in palliative care services.		<ul style="list-style-type: none"> ▪ Does each CHP have clear management arrangements and an action plan for palliative care? ▪ Are all partners represented on the palliative care network? ▪ Has the board actively engaged the local council(s) in developing palliative care services?
Part 2. Specialist palliative care			
P12 - 18	The availability of specialist palliative care services and the ease with which patients can access these varies significantly. Specialist services are largely focussed on people with cancer.		<ul style="list-style-type: none"> ▪ Does the board and its partners have plans to ensure that everyone in the local population (including rural areas) can access specialist services appropriate to their level of need? ▪ Are the board and the voluntary sector hospices monitoring access to specialist services by age, gender, ethnicity, religious belief, disability, sexual orientation, diagnosis or socioeconomic status and taking action to resolve any inequality? ▪ Is the board working with its partners to develop, agree and implement protocols for referring patients to specialist palliative care services?
P19	NHS boards are required to fund 50 per cent of the agreed running costs of voluntary sector hospices. Commissioning arrangements are improving but there are still difficulties agreeing what should be included in the voluntary hospice funding allocation provided by boards.		<ul style="list-style-type: none"> ▪ Is the board meeting the 50 per cent funding requirement for all voluntary hospices which deliver palliative care in this area? ▪ Does the board have a service level agreement or equivalent arrangement with all voluntary hospices in this area which agrees costs and ensures that services are commissioned in line with the local palliative care strategy? ▪ Are the service level agreements monitored?

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P19	NHS boards do not currently evaluate value for money in the palliative care services they commission or provide.	<ul style="list-style-type: none"> ▪ Does the board have commissioning and monitoring arrangements that ensure value for money is achieved?
Part 3. General palliative care		
P22	Patients are not always offered a community care assessment and may not have their needs met.	<ul style="list-style-type: none"> ▪ Has the board and its partners taken action to ensure that community care assessments are offered to people with palliative care needs?
P24	Primary care teams provide a significant level of support to patients with palliative care needs. Practices should have an accurate and up-to-date register of patients with palliative care needs to ensure that their needs are assessed and a coordinated care plan put in place. Across Scotland, only around 12% of patients with potential palliative care needs had them recorded on a palliative care register.	<ul style="list-style-type: none"> ▪ Has the board taken action to ensure that patients requiring palliative care have their needs recognised and recorded on a palliative care register, and a coordinated plan put in place? ▪ What training, guidance and support does the board provide to GPs, district nurses and other generalist staff to help them recognise palliative care needs?
P24	Generalist staff such as GPs, district nurses, home carers and hospital staff need education, training and support to help them identify people with palliative care needs and improve the quality of palliative care they provide.	<ul style="list-style-type: none"> ▪ What training does the board have in place to ensure that all staff providing palliative care have the skills and knowledge necessary to identify and care for patients with palliative care needs?
Part 4. Improving service delivery		
P29	The quality of palliative care available out-of-hours does not always meet the needs and expectations of patients and their families.	<ul style="list-style-type: none"> ▪ What arrangements does the board have in place to ensure that specialist assessment and care are available out-of-hours? ▪ Do the information systems automatically link information about patients who are registered with palliative care needs to an Emergency Care Summary sheet that is available to out-of-hours providers?
P32	The Gold Standards Framework Scotland (GSFS) has improved palliative care in primary care but not all GP practices are signed up to it.	<ul style="list-style-type: none"> ▪ How many GP practices are signed up to the GSFS in this board area? ▪ Is the board taking action to promote the use of GSFS?

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P33	The Liverpool Care Pathway (LCP) is used to care for patients in the last days or hours of life after it has been confirmed that they are dying. The LCP is not used in all care settings.	<ul style="list-style-type: none"> ▪ Is the board using the LCP in all care settings? ▪ Are all staff trained to use the LCP? 	
P33	A consistent Do Not Attempt Resuscitation (DNAR) policy is not applied in all settings. This causes confusion for staff and families making decisions about patients moving between settings and makes it more difficult to implement the patient's wishes.	<ul style="list-style-type: none"> ▪ Does the board have a consistent DNAR that applies in all settings? 	
p34	Family and friends provide a significant amount of palliative care but often lack support for their own needs.	<ul style="list-style-type: none"> ▪ Has the board and its partners reviewed the provision of respite care to ensure that this is available and appropriate to meet current and future needs? ▪ Has the board and its partners reviewed the provision of bereavement care to ensure that this is available and appropriate to meet current and future needs? ▪ Does the board and its partners have arrangements to ensure that family and friends who provide palliative care at home receive a carer's assessment and have any additional support needs met? 	
P35	There are gaps in the provision of psychological, social and spiritual care.	<ul style="list-style-type: none"> ▪ Has the board and its partners reviewed the provision of psychological, social and spiritual care to ensure it meets current and future needs? 	

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