NHS
MEL(1994)104

THE SCOTTISH OFFICE

National Health Service in Scotland
Management Executive

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2 November 1994

Dear Colleague

CONTRACTING FOR SPECIALIST PALLIATIVE CARE SERVICES

Summary

1. This Letter sets out the Department's general policy on palliative care, the development by Boards of palliative care strategies and their general responsibilities for purchasing palliative care and specialist palliative care, which is defined as the care required by those with active and progressive disease whose death is certain in the not-too-distant future and for whom treatment has changed from the curative to the palliative. Such treatment is provided by voluntary hospices and specialist units employing a multi-disciplinary palliative care team.

Action

2. The Letter describes the arrangements which Boards should put in place for the construction of contracts with the voluntary hospices. A number of factors which Boards are expected to take into account in negotiating these contracts are specified in the Letter.

3. Boards are asked to note in particular the arrangements set out in paragraph 15 and Annex C for monitoring the transition to the system of contracts.

4. Names, addresses and phone numbers for those responsible for dealing with enquiries about this Letter are given opposite.

5. NHS Circular No 1990(Gen) 12 and MEL(1993)102 are hereby revoked.

Yours sincerely

David Palmer.

DAVID PALMER
Director of Finance (Acting)

Addresses

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CONTRACTING FOR SPECIALIST PALLIATIVE CARE SERVICES

Introduction

1. NHS Circular No 1990(Gen)12 of 23 March 1990 set out the details of a Ministerial initiative under which the voluntary hospices would receive at least 50% of their running costs from public funds. MEL(1993)102, issued on 12 August 1993, informed Boards and Trusts of the extension of that initiative until 31 March 1995. The initiative served as an interim measure, designed to enable Health Boards and voluntary hospices to work together to construct a sound basis for contractual relationships, in line with the Government's general arrangements for the NHS. The further guidance on palliative care promised in paragraph 12 of MEL(1993)102 forms the subject of the present MEL, which sets out the Department's general policy on palliative care, before dealing with specific aspects of the new, contractual system.

Palliative Care - General

2. The Department recognises the value of palliative care, as defined by the World Health Organisation (1990) (see Annex A, paragraph 1). Palliative care is currently provided mainly for people suffering from cancer, but it is increasingly recognised that people with a range of life-threatening diseases can also benefit from it.

3. A number of recent reports and initiatives in Scotland have underlined the Department's commitment to the development of palliative care as an integral part of cancer services (Annex A, paragraph 2). Of particular relevance in the context of this MEL are the Palliative Cancer Care Guidelines, published jointly earlier this year by the Department's Clinical Resource and Audit Group (CRAG) and the Scottish Partnership Agency for Palliative and Cancer Care to stimulate and facilitate the development of needs assessment and purchasing strategies for palliative cancer care. It is important to distinguish between palliative care for those with active progressive disease and the care of the dying and bereaved from all causes which is being addressed by the National Panel on the Care of the Dying (Annex A, paragraph 3).

4. Boards will also wish to take account of the recent appointment of a Cancer Relief Macmillan Fund/Royal College of General Practitioners Palliative Care Adviser for Scotland, funded by CRMF, whose function is to advise on ways of enhancing the provision of palliative care through primary care teams. He will also be promoting the concept of the GP Facilitator in Palliative Care. The Adviser is Dr David Miller, Department of general Practice, University of Aberdeen, Foresterhill Health Centre, Westburn Road, Aberdeen AB9 2AY (tel: 0224 404463). General Practitioners play a significant role in the provision of palliative care, either to patients at home under the General Medical Services (GMS) arrangements, or to patients in community hospitals. The GMS arrangements are outwith the scope of the present guidance, but should nevertheless be taken into account by Boards in devising their palliative care strategies (paragraph 6).

5. The General Managers Group are funding a project to publish national standards for Nursing Home care. The national standards document, which will be published during 1995, will contain a section on care of people with a terminal illness which

will draw on work done by the Scottish Partnership Agency for Palliative and Cancer Care.

Purchasing specialist palliative care services

6. Health Boards have a general duty to ensure that the identified health needs of the population they serve are met. This applies equally to the special needs of terminally ill people, who are defined as those with active and progressive disease whose death is certain in the not-too-distant future and for whom treatment has changed from the curative to the palliative. Health Boards should therefore develop local strategies for palliative care which recognise the difference between the care for terminally ill people provided in a range of settings, including registered nursing homes, and the specialist palliative care provided, for those needing more intensive care and support, by hospices and specialist units employing a multi-disciplinary palliative care team. Local strategies, based on needs assessments, should be drawn up in collaboration with all relevant local professional care groups, including primary care services, and palliative care providers including the voluntary sector. Boards will find it helpful to refer to the Scottish Partnership Agency's Palliative Cancer Care Guidelines. The development of hospice care has been dependent on the initiative of the voluntary sector, and this has resulted in uneven provision. Boards' strategies will need to take account of this situation. Boards should also ensure that new service developments form an essential part of the overall strategy and do not compete with existing high quality services.

7. It will be a priority for Boards before the end of the current financial year to commission, through service contracts, an appropriate level of specialist palliative care services for terminally ill people. In drawing up such contracts, Boards will wish to ensure that the high quality of service provided at present by established specialist palliative care units and services, including the voluntary hospice sector, can be maintained. We expect Boards to agree 3 year contracts wherever possible, to ensure stability of funding and of service provision. Purchasers may find it helpful to refer to the directory of palliative care services, listed by Health Board area, which the Scottish Partnership Agency is producing.

8. From 1995-96, each Board's general allocation will contain funds for palliative care, including pharmaceutical services. The funds currently top-sliced and made available under the Ministerial Hospice Funding Initiative will be distributed to Boards on a weighted capitation basis. The figures will be notified to Boards shortly after the general allocation letter is issued in December.

9. In purchasing specialist palliative care, Boards should have regard to the totality of funding available to them, and not solely to their share of the funding separately identified for palliative care referred to in the previous paragraph. Some Boards already fund NHS specialist palliative care provision. In addition, Boards with a voluntary hospice in their area have used part of their general allocation to contribute towards funding specialist palliative care, as required by the Ministerial funding initiative. Existing levels of support should wherever possible be maintained, taking account of Boards' strategies for palliative care (see paragraph 6).

10. Where a hospice or specialist palliative care service covers more than one Health Board area, it may be helpful to agree a contract through a consortium arrangement or lead purchaser, rather than each Health Board negotiating individual contracts.

11. Good communication between purchasers and specialist palliative care providers is essential in order to ensure agreement of service contracts and to develop local strategies for specialist palliative care as part of their overall palliative care strategy. Boards should ensure that providers of specialist palliative care are aware of local purchasing strategies and local identified health needs. Providers should, in turn, continue to co-operate in making available the information which purchasers need to enable them to assess quality of service and cost-effectiveness, and monitor service contracts. ISD has recently written to Boards about the Hospice Activity Data Collection system which is being piloted and which should become fully operational from April 1995. This will allow comparability between hospices and the NHS.

12. In negotiating contracts for the provision of specialist palliative care services by voluntary hospices, there are a number of factors which we would expect Boards to take into account. Because a large element of hospice running costs relates to nursing staff salaries where increases in national salary scales apply, they, as small units, have difficulties in meeting demands for efficiency savings without reducing the quality of their service. The continuously increasing workload of the voluntary hospices should be taken into account in this context.

13. In their discussions with voluntary hospices, Health Boards are asked to emphasise the importance of developing services which help to move the focus of care towards the community. Hospices should be expected to look closely at home care, day care, respite and in-patient admission for symptom control, as distinct from terminal in-patient care. An essential part of this process is the continuation of the vital role of education and training which hospices have provided. This has resulted in the dissemination of expertise to medical, nursing and other students and to doctors, nurses and others. One aspect of this activity is the production of educational materials, but it also includes small group teaching and lectures. Purchasers should ensure that funding arrangements take account of the need for these activities to continue.

Health Care in the Community

14. Annex B deals with the general principles relating to the provision of specialist palliative care to patients resident in an NHS setting or in facilities provided under contract to the NHS. It also deals with the provision of such care to those resident in the community.

Monitoring the Transition

15. Health Boards' performance in purchasing specialist palliative care services for their populations will be monitored closely by the Management Executive during the transitional period, to ensure that the needs of their populations are met. To assist this process, Boards should complete and return the pro forma at Annex C **no later than 31 March 1995**.

Palliative Care

Definition

1. The most generally accepted definition of palliative care is that produced by the World Health Organisation in 1990:

> "the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness...Palliative care:
> - affirms life and regards dying as a normal process;
> - neither hastens nor postpones death;
> - provides relief from pain and other distressing symptoms;
> - integrates the psychological and spiritual aspects of patient care;
> - offers a support system to help patients live as actively as possible until death; and
> - offers a support system to help the family cope during the patient's illness and in their own bereavement".

Current initiatives

2. The Pringle Report (1992), *The Management of non-surgical cancer services*, recommended the full integration of palliative medical and terminal care with other non-surgical cancer services, and this is being overseen by the Scottish Cancer Co-ordinating and Advisory Committee, whose remit covers all aspects of the prevention, diagnosis and treatment of cancer. The Scottish Cancer Therapy Network recognises that palliative medicine can contribute to the achievement of the Network's aim of ensuring that the best cancer treatments and therapies are recognised and spread throughout Scotland.

3. The report *Everybody's Death Should Matter to Somebody*, published in 1991 by a Working Group of the Scottish Health Service Advisory Group, is being implemented by the National Panel on the Care of the Dying. This has resulted in the establishment of task forces in each Health Board to develop an appropriate strategy to enhance and extend good practice in the care of the dying and the bereaved in all hospital and community settings.

ANNEX B

Health Care in the Community

1. People who require continuing specialist medical and nursing supervision are clearly the responsibility of the NHS. Health Boards are required by statute to secure the provision of services free at the point of delivery. There are only a few exceptions to this, and these are clearly defined in statute. Where diagnosis reveals that a person is terminally ill and requires specialist palliative care, it is for the Health Board to ensure that the necessary provision is available. It therefore falls to the NHS to meet the full costs of their care, although the provision of that care may be undertaken by an NHS Trust, a directly managed unit, a voluntary body or a private sector company.

2. People in the community, whether in their own home or a residential or nursing home, are cared for by their GP and the primary care team. Where an individual living in a nursing or residential care home under the care of a GP is assessed as requiring specialist palliative care, the Health Board will be responsible for providing such care. Broadly, for those in residential care homes, Boards will be expected to arrange for specialist palliative care for them as if those people were living at home. For those in nursing homes, Boards should arrange for the provision of any necessary additional specialist palliative care in addition to general nursing (which will continue to be included in the local authority's contract with the home). Specific arrangements for this should be agreed locally between the Health Board and the local authority. Local discussion and agreement are the key to seamless and responsive care.

3. Guidance on social care costs relevant to those in the residential care sector (including nursing homes) is set out in Social Work Services Group Circular No. SW13/92, National Assistance (Assessment of Resources) (Regulations) 1992: Regulations and Guidance.

ANNEX C

Purchasing specialist palliative care: return for **Health Board**

Funding 1994-95 & Planned Funding 1995-96

Unit[1]	Total Revenue expenditure of provider unit[2]		Funding from specified allocation[3]		Funding from other NHS resources [4]		Other Information[5]
	1994-95	1995-96	1994-95	1995-96	1994-95	1995-96	

Notes on completion

1. Show name and location of each specialist palliative care provider (specifying whether NHS or voluntary unit) for whom funding is being provided through contractual arrangements. If funding is being provided through means other than a contract, please give details.
2. Show, where known, the total revenue expenditure for the unit for each year.
3. Show here use of centrally specified funding in contracting for specialist palliative care services.
4. Show here use of general allocations in addition to separately centrally identified funding used to contract for specialist palliative care services.
5. Show here any other relevant information, including NHS capital.

Boards are also asked to submit a brief narrative summarising improvements in the quality of care achieved in the last 12 months, and any new service developments planned or initiated. Please send returns by ***31 March 1995*** *to Mr C Naldrett, Directorate of Finance, Management Executive, Room 254A, St Andrew's House, Edinburgh EH1 3DG.*