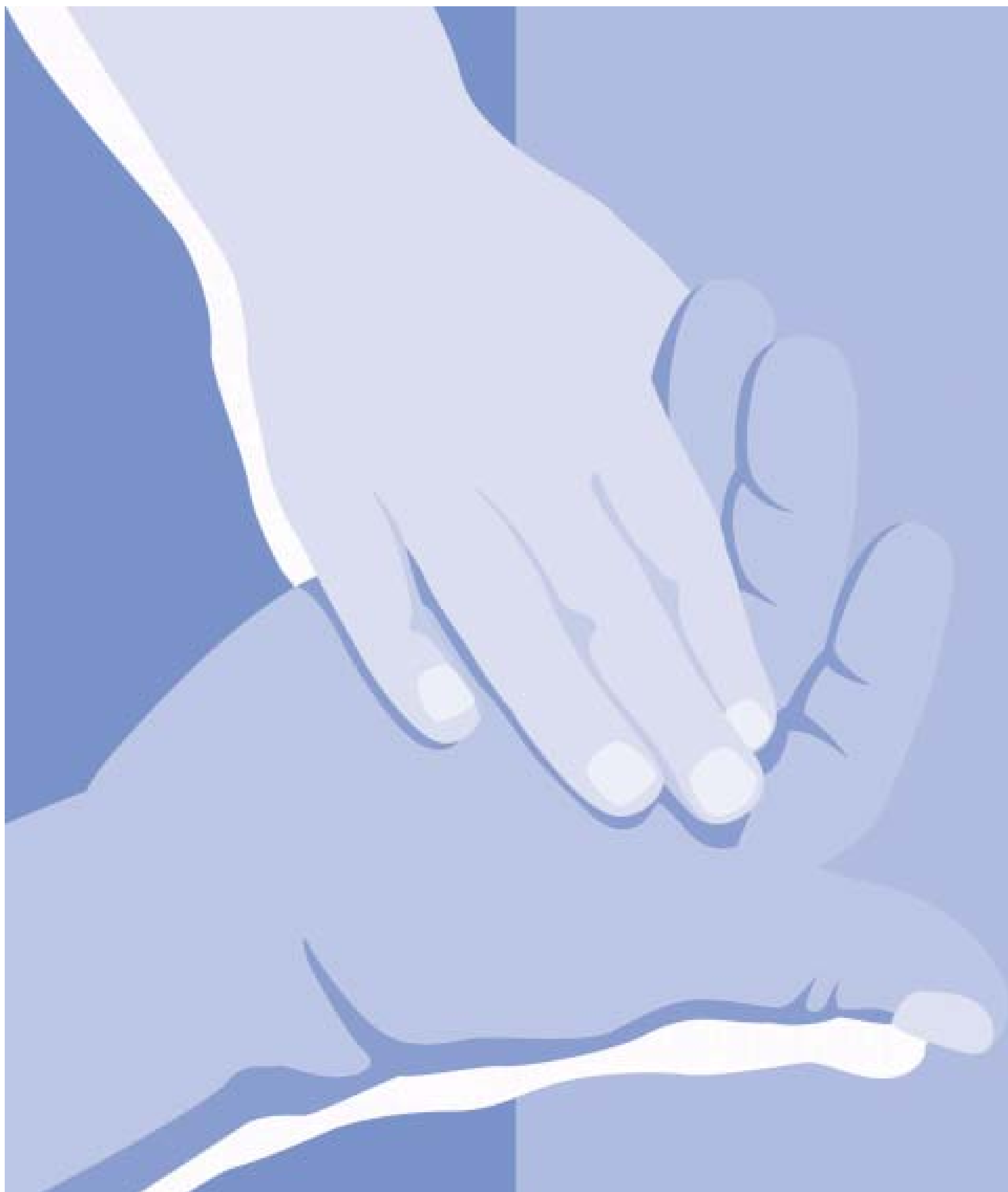
PALLIATIVE CARE IN COMMUNITY HOSPITALS IN SCOTLAND

A FRAMEWORK FOR GOOD PRACTICE 2003



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Scottish Association of Community Hospitals

Scottish Partnership for Palliative Care

PALLIATIVE CARE IN COMMUNITY HOSPITALS IN SCOTLAND
A FRAMEWORK FOR GOOD PRACTICE 2003

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Foreword

Studies continue to confirm what experienced general practitioners have long suspected, namely that people with mortal illness would prefer to die at home, or at least to be cared for there as long as possible, but disappointingly few achieve this wish. Instead they are admitted to a hospital, often far from home and loved ones, cared for by skilled colleagues but not their local doctors and nurses whom they have known for years. In spite of everyone's best efforts their final weeks of life can be lonely as well as frightening.

This publication focuses on one way of enabling people to receive high quality palliative care near their homes and relatives, in the care of doctors and nurses who know them and their families – the community hospitals in Scotland.

There is no doubt that the quality of palliative care provided by many rural primary care teams is better that that provided in some general hospitals. That too has been most convincingly demonstrated in other studies. Perhaps we should not be surprised when it is recalled how many community nurses have in recent years undertaken further training in palliative care and how eager many GPs are to develop their palliation skills. However, as this report shows, that commitment will not in itself guarantee the quality of palliative care every patient has a right to expect. Palliative care is more than an exercise in prescribing, crucially important as the relief of pain and suffering is. Its success depends on more than the availability of syringe drivers, nebulisers and red cell concentrate. Even ensuing that it is patient-centred is not sufficient if the needs of the relatives are not recognised and addressed. Whatever else modern palliative care is, it is holistic care – giving due regard to every aspect of physical, psychosocial and spiritual need. No one person can do that, hence the necessity to care as a team, with shared and well-defined goals, a designated leader and sensitive respect for the contributions brought by each member of that team whether it is the doctor, the nurses, the professions allied to medicine or the trained volunteers.

If community hospitals are to be developed better to care for those who cannot remain at home, much will need to be done to teach and then maintain the necessary knowledge and skills, to develop the quality of team caring and goal setting that are the hallmarks of modern palliative care, and to create in each community hospital the ambience and the atmosphere that change it from a hospital into a home-from-home. It will not be sufficient merely to have a local hospital, easy to visit. Rooms must be set aside for relatives to grieve in or to stay

This publication focuses on one way of enabling people to receive high quality palliative care near their homes and relatives, in the care of doctors and nurses who know them and their families – the community hospitals in Scotland.

overnight. Others will need single rooms for the privacy and the dignity so sought at the end of life. Each community hospital must become what terminally ill patients all speak about – a place where everyone feels safe and understood.

Specialist palliative care services will have to find ways of helping their rural colleagues in remote community hospitals, perhaps by better telephone or video links, occasionally by visiting them but, day and night, being available to share their expertise and experience. Need it be said, this will take resources but is there a better way to spend money than by enabling people to be cared for where they want to be, by those who know them so well. I hope this report will excite and challenge all associated, in any way, with the community hospitals of our country. We are fortunate in having such resources, ready to be developed further to enable us to care for our friends at the end of life.

Derek Doyle, OBE, DSc, FRC SE, FRCP (Lond. and Edin), FRCGP Hon. President of SPPC

As the current Chairman of the Scottish Association of Community Hospitals, I commend this document to you as a mark of integrated working between partner organisations which share the same interests.

This piece of work is important because it is very important for patients; patients with palliative care needs, whatever their diagnosis, need the reassurance of knowing that health and social care professionals place the highest priority on ensuring that patients – with conditions we all fear, and with symptoms we all fear will not be controlled – are comfortable and in control during their illness.

This document goes some way to acknowledge the work done by all the professionals and health care support workers in the community hospitals across Scotland which function as palliative care units for the locality. This is a statement of quality upon which we need to build.

Dr Hamish D. Greig

Executive Summary

This report examines current palliative care provision in the context of community hospitals, and makes recommendations to enhance this aspect of community hospital service in the future. Recommendations are based on information derived from a national stocktake of palliative care provision in Scottish community hospitals (inpatient acute GP beds) which was conducted in 2001-2002. The main findings were:

- All community hospitals contacted provide palliative care.
- All have reasonable equipment with which to provide a service.
- Most (68%) have 20 beds or less.
- Most (69%) were more than 20 miles from the nearest specialist hospice facility, with another 23% being between 10 and 19 miles away.
- Most (83%) have access to 24 hour specialist palliative care advice, but all would like more input/more regular contact.
- Irrespective of the number of acute GP beds, all community hospitals employ nursing staff at mostly grades A, D and E, with part-time posts being a strong feature in many hospitals.
- Training and education are better for nursing staff than for medical or any other members of the multi-disciplinary team, for symptom control and use of equipment.
- There was a lack of training and education in bereavement support and communication skills for most professional and all ancillary groups.
- A significant minority (40%) of hospitals had inadequate single room with ensuite bath/shower room facilities, nor did they have sleeping accommodation for relatives (30%).
- Although there are some designated palliative care beds, many of which have been facilitated by funding external to the NHS, the comments from respondents upon interview indicated that these can cause logistical problems for units as small as most community hospitals, and that in fact they would be better used on a flexible basis.

Following discussion with Scottish community hospital professionals and health support workers, three key areas were identified as priorities in order to improve services for patients:

- Increased education and training of staff.
- Improved accommodation and facilities for patients and their relatives.
- Increased specialist palliative care support.

Issues of quality were considered and relevant sections of applicable NHS Quality Improvement for Scotland clinical standards have been identified to help providers improve the experience of Scottish patients, and their relatives, with palliative care needs across all conditions. The needs of providers of palliative care have also been included.

The main recommendations of this report are applicable to anyone suffering from any terminal or degenerative condition or illness, whether they are in the local community hospital or a local care home.

They are:

General:

- Palliative care should be provided at home, or as close to the patient's home, as possible.
- Palliative care should be available to those who need it from the early stages of their illness.

Communication/integration:

- Links should be facilitated between horizontal networks of community hospitals and relevant vertical specialty networks (see page 14), particularly specialist palliative care networks.
- Communication between the extended primary care team and tertiary/secondary care specialists should be strengthened to prevent potential confusion arising for patients and their relatives where curative or life-prolonging treatments are being given with palliative intent.
- Specific arrangements should be clear and in place for the transfer of clinical information regarding patients with palliative care needs out-with normal hours, which dovetail with local out-of-hours general medical service and community hospital cover.

Training and education:

- Continuing professional development should be available by means of appropriate training, education and skills acquisition for ALL members of the extended primary healthcare team, and for volunteers where appropriate.
- Palliative care specialists should be supported to provide training to meet the needs of professional colleagues in extended primary care teams in community hospitals.

Facilities:

- Community hospital beds should be flexible in usage, rather than being specifically designated, to avoid unintended staffing and equity problems for small units.
- All community hospitals should have suitable equipment and accommodation for palliative care provision so that patients are not disrupted due to logistical but avoidable service shortcomings.
- Patients' relatives should have suitable overnight accommodation within the hospital to facilitate proximity to the patient when required.

Additional services:

- Patients should be able to access alternative/complementary therapies especially in the terminal phase of their illness.
- There should be some form of day care facilities such as diversionary therapy for all patients in community hospital areas including those with palliative care needs.

Current provision of palliative care in community hospitals is important to local populations, often in rural areas of Scotland. If these recommendations are met, they will yield significant improvements in the experiences of patients, relatives and providers.

Introduction

This report examines current palliative care provision in the context of community hospitals, and makes recommendations to enhance this aspect of community hospital service in the future. It is the culmination of a two year project, funded by means of a grant awarded by the New Opportunities Fund, received in June 2001. The project was initiated by the Scottish Association of Community Hospitals, and conducted in collaboration with the Scottish Partnership for Palliative Care, the GP Facilitator for Palliative Care (NHS Grampian) and a representative of the Scottish Association of Trust Medical Directors.

It is intended for:

- All providers of care and treatment to those who need it in community hospitals.
- People who use the services and their relatives.
- Specialist palliative care teams.
- Managers of community hospitals.
- Commissioners of health services.

The aim of the project was to assist in enhancing the quality of palliative care provision in community hospitals.

The project had four measurable targets:

- To establish a knowledge baseline of current palliative care provision in community hospitals, by means of a national stocktake exercise.
- To draw on the empirical findings of the stocktake exercise and other published evidence of good practice in palliative care, to produce a Framework for Good Practice in Palliative Care in Community Hospitals.
- To promote good quality palliative care to all who need it in areas served by community hospitals by means of dissemination of the Framework.
- To raise awareness of palliative care provision in community hospitals across the healthcare spectrum, especially with specialist colleagues in palliative care and other relevant disease specialties.

Initial post-code analysis through the Registrar General's Office revealed a potential population of 1.5 million people with access to such services. Whilst there was a reasonable degree of information regarding palliative care provision through specialist facilities (usually in urban areas) there was no such information regarding the predominantly rural areas of Scotland where community hospitals and their related extended primary care teams provided most care. The Scottish Partnership for Palliative Care document, "Implementing the Palliative Care Chapter of the Scottish Cancer Plan" (December 2001, point 6.4.), recommended that further work should be done to collect data on palliative care provision in the community and in those areas away from specialist provision. The stock-take phase of this project has gone some way to meeting this recommendation.

The stock-take questionnaire itself was originally derived from the recommendations made in the document, "Palliative Care in Community Hospitals – Report of a Working Party of the Scottish Partnership Agency for Palliative and Cancer Care" (1998). It was felt that the combined exercise of undertaking a stock-take, and then formulating a framework, would progress the provision and quality of palliative care to local populations in these areas.

Therefore, this document sets out a Framework for Good Practice to help users and providers of services in areas with community hospitals, which is both valid and contemporary. It addresses the particular issues relating to community hospital provision, and sets recommendations in context.

Part One – Palliative Care

What is Palliative Care?

The description of palliative care offered here is the newest World Health Organisation (WHO) definition, and is more generic than previous versions. Palliative care is an approach which is not restricted to those suffering from cancer, and the WHO definition takes this into account. This accurately mirrors the range of conditions experienced by people who benefit from the provision of palliative care in community hospitals.

"Palliative care is an approach that improves the quality of life of patients and their families facing the problems 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.

Palliative care:

- Provides relief from pain and other distressing symptoms.
- Affirms life and regards dying as a normal process.
- Intends neither to hasten nor postpone death.
- Integrates the psychological and spiritual aspects of patient care.
- Offers a support system to help patients live as actively as possible until death.
- Offers a support system to help the family cope during the patient's illness and in their own bereavement.
- Uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated.
- Will enhance quality of life, and may also positively influence the course of illness.
- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications."

WHO Definition, July 2002 –
http://www5.who.int/cancer/main.cfm?p=0000000427

Who delivers palliative care?

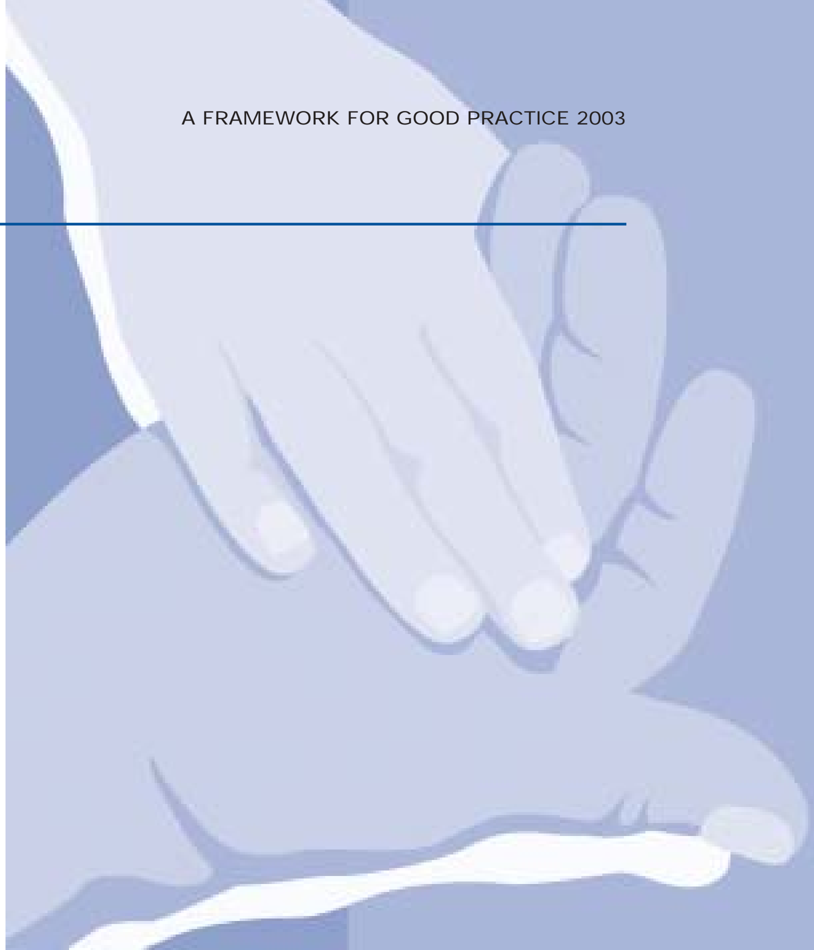
General palliative care can be delivered in all care settings by the usual professional carers of the patient and family, and is appropriate for those with less complex palliative care needs. It should be an integral part of good routine clinical care. Informal carers can also be involved in delivering palliative care. It is important that those delivering general palliative care know when and how to access advice from and referral to specialist palliative care services.

Specialist palliative care is provided for those with more complex palliative care needs by members of multi-professional specialist palliative care teams, such as consultants in palliative medicine and clinical nurse specialists in palliative care, as well as chaplains and social workers, physiotherapists, occupational and speech and language therapists. Palliative interventions to facilitate pain and symptom management when cure is no longer possible can also be provided by clinical specialists such as anaesthetists, radiographers, surgeons etc.

What is the basis of palliative care?

All palliative care is based on a holistic approach, and on the same general principles. These are outlined by the National Council for Specialist and Palliative Care Services* as follows:

- Focus on quality of life which includes good symptom control.
- Whole person approach taking into account the person's past life experience and current situation.
- Respect for patient autonomy and choice (eg over place of care, treatment options).



- Care which encompasses both the person with life-threatening illness and those that matter to that person.
- Emphasis on open and sensitive communication, which extends to patients, informal carers, and professional colleagues.

**Briefing No 11, September 2002: Definitions of Supportive and Palliative Care.*

Although most attention is focused on cancer as a condition which requires palliation at various stages, there are other recognised groups of conditions which also require palliative care. These include*:

Progressive non-malignant disease	
Circulatory diseases	Cardiovascular Cerebrovascular
Respiratory diseases	
Neurological conditions	Motor neurone disease Multiple sclerosis Dementia
AIDS/HIV	
Children's diseases	Hereditary degenerative disorders Muscular dystrophy Cystic fybrosis

**Adapted from Higginson, I.J., Health care needs assessment: Palliative and Terminal Care 1995, in "Providing a Palliative Care Service: towards an evidence base" Bosanquet & Salisbury, 1999.*

People in need of palliative care in areas with community hospitals may suffer from any of the conditions listed above, and all will have some involvement with their local extended primary care team, since all will be registered with their own family doctor. The ideas encapsulated in any Framework for Good Practice for Palliative Care should, therefore, be applicable to any care offered to people suffering from these conditions, whether they are at home, in the local community hospital or a local care home.

In the case of cancer, recent research[1] into Scottish rural survival rates, suggest that there may be a proportionately enhanced need for palliative care in rural areas, including those with community hospitals. The reasons for this are not entirely clear, but there is some evidence that people sometimes do not wish to go to large hospitals for treatment, away from their local settings.[2,3] Therefore, given the finding of the stocktake of current palliative care service provision in Scotland's community hospitals, that 92% of community hospitals were more than 21 miles away from their nearest specialist palliative care centre (see Appendix A), it is important that professionals in these areas are enabled to support those people who need such services locally.

1 Campbell, N.C. et al, "Rural factors and survival from cancer: analysis of Scottish cancer registrations". British Journal of Cancer 2000; 82:1863-6.

2 Gesler, W.M. "Therapeutic Landscapes:Medical Issues in Light of the New Cultural Geography" Social Science & Medicine, 1992, 34(7) 735-746.

3 Grant, J.A., Dowell, J., "A qualitative study of why general practitioners admit to community hospitals". British Journal of General Practice, 2002 52(481) 628-635.

When should palliative care begin?

Palliative care should be available to those who need it from the early stages of their illness. This should be borne in mind by health professionals so that those who require such assistance are identified at a time which benefits them most. This represents a departure from previously accepted practice, when patients were offered palliation only in the terminal phase of illness.

The World Health Organisation discusses this change in approach in its report, National Cancer Control Programmes: policies and managerial guidelines (2002) 2nd edition (page 83):

"Today, however, there is wide recognition that the principles of palliative care should be applied as early as possible in the course of any chronic, ultimately fatal illness. This change in thinking emerged from a new understanding that the problems at the end of life have their origins at an earlier time in the trajectory of disease. Symptoms not treated at onset become very difficult to manage in the last few days of life."

This is expressed in figure 1, below:

Figure 1 Continuum of Care

WHO National Cancer Programmes 2002 page 84

Part Two – Community Hospitals

What is a community hospital?

The following is the most widely used definition of a community hospital:
"A local hospital, unit or centre providing an appropriate range and format of accessible health care facilities and resources.

These will include inpatient and may include outpatient, diagnostic, day care, primary care and outreach services for patients provided by multidisciplinary teams. Medical care is normally led by general practitioners in liaison with consultant, nursing and paramedical colleagues, as necessary. Consultant long stay beds, primary care nurse-led and midwife services may also be incorporated."

Ritchie, L.D. 1996 Community Hospitals in Scotland: promoting progress University of Aberdeen Aberdeen p11.
Addendum – in the above definition, the term "paramedical" refers to Allied Health Professionals.

Geographical spread of community hospitals

Community hospitals in Scotland are located mainly in rural or semi-rural areas, away from main conurbations and from large acute care providers (District General Hospitals, Tertiary Centres, Teaching Hospitals, Specialist Hospice facilities) as demonstrated in figure 2. Most specialist hospice facilities are situated either around the central belt area of Scotland, or mainly at a distance greater than 20 miles from community hospitals nationally. See figure 3.

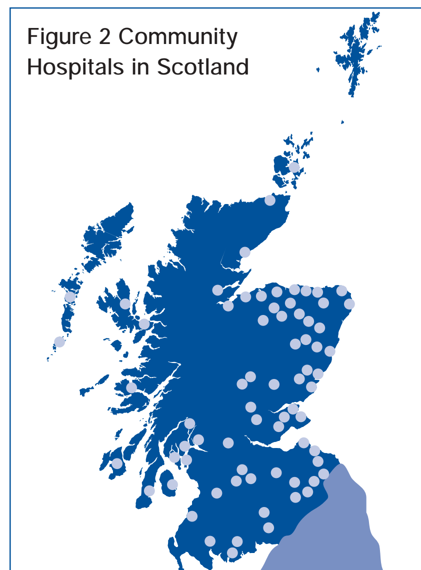


Figure 2 Community Hospitals in Scotland

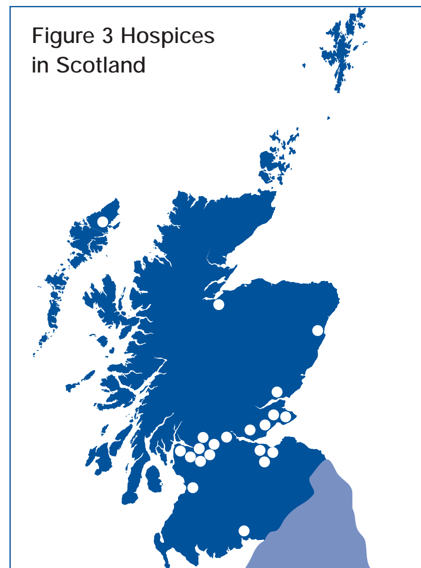


Figure 3 Hospices in Scotland

COMMUNITY HOSPITALS

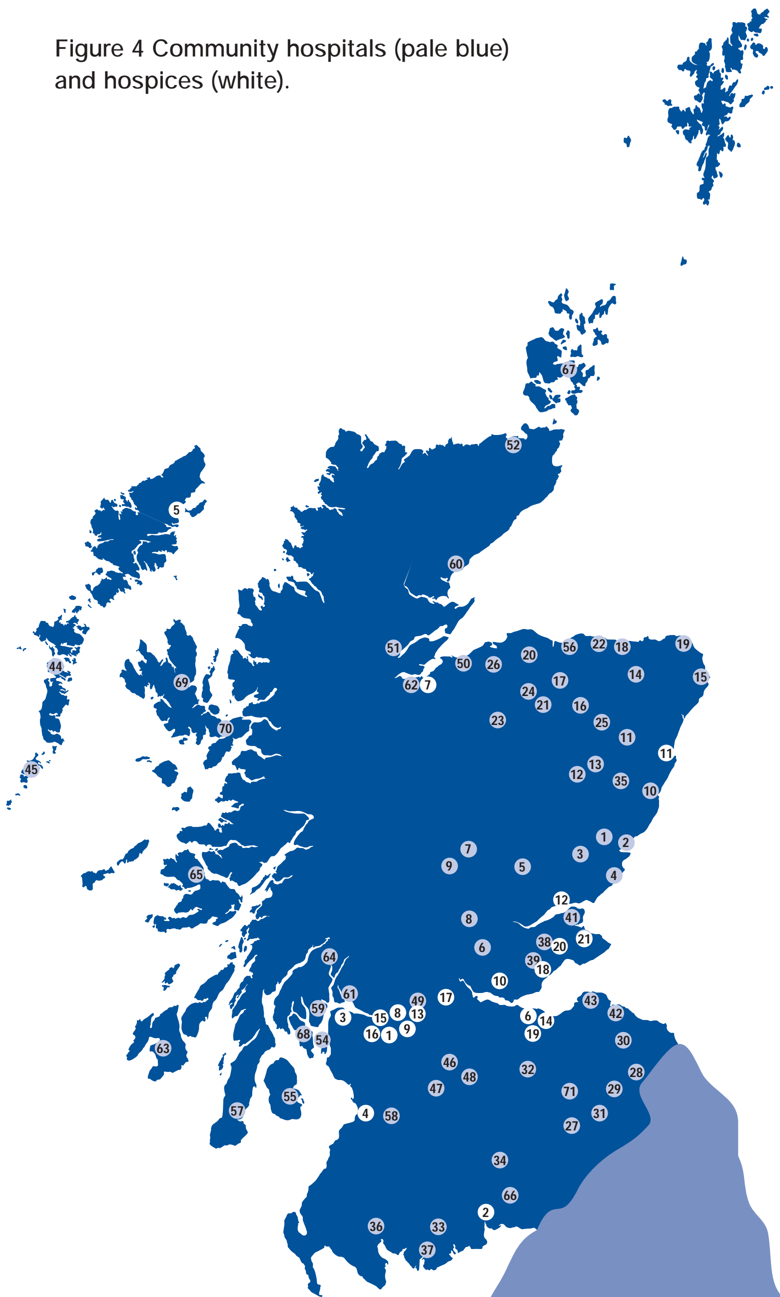
1 Brechin Infirmary
2 Montrose Royal Infirmary
3 Forfar Infirmary
4 Arbroath Infirmary
5 Blairgowrie Community Hospital
6 St Margaret's Hospital
7 Irvine Memorial Hospital
8 Crieff Community Hospital
9 Aberfeldy Community Hospital
10 Kincardine Community Hospital
11 Inverurie Hospital
12 Aboyne Hospital
13 Kincardine O'Neil War Memorial Hospital
14 Turriff Cottage Hospital
15 Peterhead Community Hospital
16 Jubilee Hospital
17 Turner Memorial Hospital
18 Chalmers Hospital
19 Fraserburgh Hospital
20 Spynie Hospital
21 Stephen Cottage Hospital
22 Campbell Hospital
23 Ian Charles Hospital
24 Fleming Cottage Hospital
25 Insch & District War Memorial Hospital
26 Leanchoil Hospital
27 Hawick Cottage Hospital
28 Coldstream Cottage Hospital
29 Kelso Hospital
30 Knoll Hospital
31 Sister Margaret Cottage Hospital
32 Hay Lodge Hospital
33 Castle Douglas Hospital
34 Moffat Hospital
35 Glen O'dee Hospital
36 Newton Stewart Hospital
37 Kirkcudbright Hospital
38 Adamson Hospital
39 Glenrothes Hospital
40 St Andrews Memorial Hospital
41 Netherlea Hospital
42 Belhaven Hospital
43 Edington Cottage Hospital
44 Uist and Barra Hospital
45 St Brendan's Hospital
46 Lockhart Hospital
47 Lady Home Hospital
48 Kello Hospital
49 Victoria Memorial Cottage Hospital
50 Town and County Hospital Nairn
51 Ross Memorial Hospital
52 Dunbar Hospital
53 Davidson Cottage Hospital
54 Lady Margaret Hospital
55 Isle of Arran War Memorial Hospital
56 Seafield Hospital
57 Campbeltown Hospital
58 East Ayrshire Community Hospital
59 Dunoon & District General Hospital
60 Lawson Memorial Hospital
61 Victoria Infirmary Helensburgh
62 Royal Northern Infirmary
63 Islay Hospital
64 Mid Argyll Hospital
65 Dunaros and Salen
66 Lochmaben Hospital
67 Balfour Hospital
68 Victoria Hospital
69 Portree Hospital
70 Mackinnon Memorial Hospital
71 Borders General Hospital (GP ward)

HOSPICES

1 Accord Hospice, Paisley
2 Alexandra Unit, Dumfries & Galloway Royal Infirmary, Dumfries
3 Ardgowan Hospice, Greenock
4 Ayrshire Hospice, Ayr
5 Bethesda Hospice, Stornoway
6 Fairmile Marie Curie Centre, Edinburgh
7 Highland Hospice, Inverness
8 Hunters Hill Marie Curie Centre, Glasgow
9 Prince & Princess of Wales Hospice, Glasgow
10 Queen Margaret Hospital Hospice Ward (Ward 16), Dunfermline
11 Roxburghe House, Aberdeen
12 Roxburghe House, Dundee
13 St Andrew's Hospice, Airdrie
14 St Columba's Hospice, Edinburgh
15 St Margaret's Hospice, Clydebank
16 St Vincent's Hospice, Johnstone
17 Strathcarron Hospice, Denny
18 Victoria Hospice, Kirkcaldy
19 Milestone House, Edinburgh
20 Hospice Unit, Adamson Hospital, Cupar
21 Hospice Unit, Adamson Hospital, St Andrew's

Most community hospitals are situated out-with the central belt area of Scotland, therefore the two types of facility are complementary to one another as demonstrated by figure 4, below:

Figure 4 Community hospitals (pale blue) and hospices (white).



In addition, there are Hospital Specialist Palliative Care Teams in:

Aberdeen Royal Infirmary
Ninewells Hospital, Dundee
Raigmore Hospital, Inverness
Western/Gartnaval Hospitals, Glasgow
Western General Hospital, Edinburgh
Crosshouse Hospital Falkirk Royal Infirmary
Glasgow Royal Infirmary
Hairmyres Hospital, East Kilbride
Inverclyde Hospital, Greenock
Wishaw Hospital
Monklands Hospital
Royal Alexandra, Paisley
Southern General, Glasgow
Stobhill, Glasgow
Stirling Royal Infirmary
Ayr Hospital
Victoria Infirmary, Glasgow
Borders General Hospital, Melrose
Dumfries & Galloway Royal Infirmary
Edinburgh Royal Infirmary
Perth Royal Infirmary
Queen Margaret Hospital, Dunfermline
Victoria Hospital, Kirkcaldy

This geographical representation highlights the importance of the role of specialist palliative care providers in education and training for providers at some distance from them, including extended primary care teams working within and around community hospitals. The interview schedules completed during stocktake of palliative care provision in community hospitals (Appendix A) demonstrated a variation in the availability of specialist input to these local areas from their nearest specialist facility.

The Importance Of Managed Clinical Networks

Given the growing importance of Managed Clinical Networks as a means of tailoring services to bring people care as near to their homes as possible with robust quality assurance, it will be important for existing vertical specialty networks and horizontal functional networks to forge links and to be extended to cover all areas. This will include horizontal, functional Managed Clinical Networks of community hospitals as indicated in the NQIS standards for community hospitals (2004).

Evidence gathered from the Stocktake of current palliative care provision in community hospitals (see Appendix A) demonstrates that even where there are good links with specialist palliative care provision, there is a desire to enhance these links, particularly in relation to on-going local education for professionals. Suggestions for achieving this include the use of telemedicine and teleconferencing to facilitate specialist input for all members of the extended primary health care team, including ancillary staff.

Steps should therefore be taken by the responsible agencies to facilitate links between horizontal networks of community hospitals and vertical networks of relevant specialties, including those dealing with the type of conditions listed in Part 1, page 9 of this report.

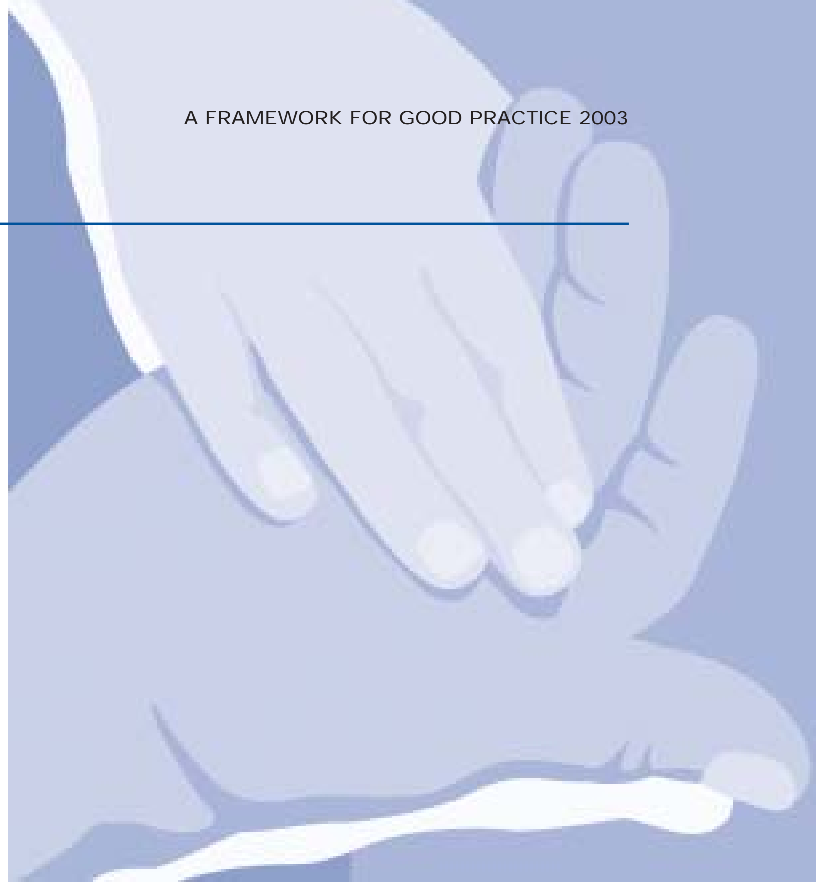
Community hospitals "out-of-hours" issues

Medical input to the hospitals discussed in this document is usually provided by local general practitioners as part of their extended primary care role. This means there are implications for service provision to patients in community hospitals arising from the way in which general medical services are provided in the hospital's area. This is of particular importance when considering the provision of "out-of-hours" services, which means 6/6.30pm-8.30am Mondays to Thursdays, and 6/6.30pm on Fridays to 8.30am on Mondays, plus national holidays such as Christmas and New Year. Out-of-hours care is provided in a variety of ways throughout the country.

Out-of-Hours GP Co-operatives

Local Practice(s) cover

There are still many community hospital areas which are NOT covered by co-operative arrangements, sometimes due to geographical factors. This may be the case where hospitals and practices are situated on the periphery of geographical areas which can reasonably be covered by the larger co-operatives. In these cases, medical input out-of-hours is provided by the local practice(s') doctors, which means that this will regularly be the patients' own GP who may have admitted him/her to the hospital originally.



NHS24

The picture is further complicated by the gradual roll-out of NHS24 to all areas of Scotland. This has introduced another dimension to the out-of-hours picture, which also features different approaches for different areas with community hospitals: generally, those hospitals covered by GP out-of-hours co-operatives link to NHS24 provision in one way, whilst those areas not covered by out-of-hours co-operatives are dealt with in a different way by NHS24. This is an evolving situation at the time of writing, and remains a challenging area for all concerned.

New GP contract

The terms of the new contract for general practitioner services, "Investing in General Practice" (2003)[4] change the basis of the provision of out-of-hours services further, by potentially enabling general practices to "opt out" of providing out-of-hours services to patients on their lists provided suitable alternative accredited arrangements can be made. It is the responsibility of the local primary care organisation to ensure that suitable alternatives are available. In areas with community hospitals this poses an additional challenge as the services normally covered by local general practitioners within the community hospital will also require to be covered during these hours. The contract terms for general medical services out-of-hours stipulate the provision of a suitable system of clinical information transfer between the patient's practice and the out-of-hours service for palliative care patients in the terminal stages of illness who will die at home (Quality (Records) Indicator 13). It will be important to ensure similar specific arrangements have been made for patients in the community hospital, and indeed that the general medical services arrangements dovetail neatly with those made to cover the community hospital.

The way in which medical (and to some extent nursing and other) services generally are provided outwith normal surgery hours has changed over the past few years. The trend towards the formation of so-called out-of-hours co-operatives for general medical services has increased and is now commonplace in many areas of Scotland including some with community hospitals, where medical input to either the inpatient beds or casualty/minor injury units is provided by the relevant out-of-hours co-operative to which the hospital's admitting GPs belong. This has potential implications for the level of input to community hospitals and to the movement of patients from the secondary care sector to community hospitals and vice versa.

4 New GMS Contract 2003 Investing in General Practice – Supporting Documentation BMA/NHS Confederation London

Night Nursing Staffing Levels – in and out of hospital:

The stocktake of palliative care provision (Appendix A) revealed for the first time on a national scale the staffing levels and grades in Scottish community hospitals. These levels are fairly low in general, and most are less than G grades, thus having an impact on task allocation. It is important to note that in most community hospitals the nurses have various roles covering both the inpatient beds and the casualty/minor injuries unit.

Larger towns with urban community hospitals often have a night/weekend nursing service which offers patients a greater opportunity to remain at home throughout their illness, which is a different situation from that found in most rural areas. Here, there is frequently little or no night or weekend nursing service at present. This makes the provision of palliative care in the community hospital all the more important. Whilst district nursing staff and visiting specialist nurses (MacMillan Clinical Nurse Specialists in Palliative Care in particular) usually work together with local general practitioners to ensure patients are comfortable at home when in receipt of palliative care during normal working hours, there are times when nursing input during the night is also required.

It is clear that there may be differences in the way out-of-hours medical and nursing services are provided in different parts of Scotland with community hospitals. This variation in the way services are provided means there is the possibility of a disparity in the actual service provision to palliative care patients for purely logistical reasons between different areas out-of-hours. This is a situation which should be avoided by clarifying the manner in which services are organised out-of-hours in each locality with a community hospital, and by those responsible ensuring that although the way service is delivered may differ, the output in terms of the quality of the service to patients, should not be compromised.

This means being realistic about what existing medical and nursing staff can do in terms of workload, and ensuring they are facilitated to give good quality care to patients within the locality by removing any unnecessary hurdles and barriers. Examples might include ensuring arrangements for accessing suitable pharmacy input out-of-hours are clear and efficient, and that links with specialist services are established, so that emergency contact is made easier should it be required.

Part Three – Palliative care in Community Hospitals

Current provision of palliative care in community hospitals

A national stocktake of palliative care provision in Scottish community hospitals with inpatient acute GP beds was conducted between 2001-02. Seventy such hospitals were identified, and of these sixty-eight participated.

Representatives from each community hospital were sent a semi-structured questionnaire by post, and then contacted to complete the questionnaire by telephone, which gave them the opportunity to make additional comments.

The main findings were:

- All community hospitals contacted provide general palliative care.
- All have reasonable equipment with which to provide a service.
- Most (68%) have 20 beds or less.
- Most (69%) were more than 20 miles from the nearest specialist hospice facility, with another 23% being between 10 and 19 miles away.
- Most (83%) have access to 24 hour specialist palliative care advice, but all would like more input/more regular contact.
- Irrespective of the number of acute GP beds, all community hospitals employ nursing staff at mostly grades A, D and E, with part-time posts being a strong feature in many hospitals.
- Training and education are better for nursing staff than for medical or any other members of the multi-disciplinary team, for symptom control and use of equipment.
- There was a lack of training and education in bereavement support and communication skills for most professional and all ancillary groups.
- A significant minority (40%) of hospitals had inadequate single room with ensuite bath/shower room facilities, nor did they have sleeping accommodation for relatives (30%).
- Although there are some designated palliative care beds, many of which have been facilitated by funding external to the NHS, the comments from respondents upon interview indicated that these can cause logistical problems for units as small as most community hospitals, and that in fact they would be better used on a flexible basis.

Full details of the Stocktake of the Provision of Palliative Care in Scottish Community Hospitals can be found in Appendix A of this report. The exercise illustrated specific areas relating to service provision which required attention. These issues have been confirmed through several events which offered the opportunity for ready consultation with and feedback from those providing services. (SACH Conference 2001/SPA Specialists in Palliative Care Meeting/visit to Lanarkshire/SPPC Conference 2002/SACH Conference 2002).

The main areas to be addressed are as follows:

- The need for continuing professional development by means of appropriate training, education and skills acquisition for ALL members of the extended primary healthcare team and for volunteers where appropriate. This includes the need to provide and facilitate appropriate professional educational opportunities for general practitioners which at present is the most obvious shortcoming under this heading of education and training. It was frequently asserted that whilst local teams provide a reasonable standard of service, there was the possibility of extending the scope of the service to the benefit of patients if more continuing education were available locally.
- While all community hospitals had the basic equipment to provide palliative care (with the exception of a very few hospitals where simple items such as recliner chairs were not available) there were some gaps in simple equipment provision which directly reduced the service to patients and meant they would have to travel to receive services unnecessarily. A specific example of this situation concerns the presence of suitable blood fridges to enable blood transfusions to be given. This lack of basic equipment prevents adequately skilled professionals from delivering services as near to patients' homes as possible.
- Accommodation for patients and their relatives is presently often inadequate. Many community hospitals do not have many single rooms, and some have none. Most have inadequate toilet and washing facilities for palliative care patients (and other patients) admitted to the hospital, by modern standards. This is frequently due to the age of buildings which are no longer fit for purpose. The difference in such facilities in the minority of hospitals which have been renovated or rebuilt was evident in the stocktake answers. It is important to note that provision of accommodation with private bathroom and minimum kitchen facilities for relatives to stay overnight was either absent or poor in many of the hospitals; even those which had been renovated/renewed sometimes did not have adequate relatives' facilities to enable a high quality of service provision.
- There is widespread prevention of the provision of complementary therapies for palliative care patients, especially those in the terminal phase of their illness. In many hospitals members of the extended primary care team (or other local individuals) are suitably qualified to provide complementary therapies, such as massage and aromatherapy. However, many respondents indicated that local health boards imposed a ban on such services which was viewed negatively in terms of meeting the needs of local patients. There are undoubtedly real issues which may make such service provision more challenging when considering the responsibilities of Health Boards in relation to the provision of safe and appropriate services, but the overall feeling was that these interventions would enhance the quality of life of some patients and staff felt frustrated in being prohibited from assisting in these ways;
- There is a lack of day care facilities such as diversionary therapy for all categories of patients in community hospital areas including those with palliative care needs (with the exception of one locality which has a specific day hospice facility). However palliative care patients benefit from these services at the few hospitals which indicated they do have general day care services.

Quality issues

Assuring the quality of clinical care has become an important aspect of all healthcare services and community hospitals are no exception. Whilst it has been acknowledged that these present particular challenges, given that they sit at the interface of so many different types of services and agencies, steps have been taken to address this requirement none-the-less. NHS Quality Improvement Scotland (part of which was previously the Clinical Standards Board for Scotland) has been working to produce a set of statutory clinical standards applicable to community hospitals with acute GP beds (as defined in Appendix B). These standards are due to be finalised during 2003, following which time community hospitals will be monitored against them by means of a process of peer and lay review. The standards will include the generic NHS QIS standards applicable to all healthcare services, together with seven initial specific "tracer" conditions or services provided through community hospitals. One of the tracer conditions is palliative care, as it is common to all community hospitals in Scotland.

NHS Quality Improvement Scotland (CSBS) Community Hospital Standards include the following requirements or questions to be answered by each community hospital:

- National and Locally agreed targets worked to by the community hospital team.
- Protocols for referral from
  - Primary care
  - Secondary care.
- Ensure wider awareness of these protocols, within the District General Hospital, or among GPs, and district nurses.
- A system of assessment should be in place for palliative care, with relevant documentation.
- Following assessment, there is a comprehensive multidisciplinary care plan agreed between patient, staff teams and if appropriate the patient's carer(s), which assesses and documents a patient's needs and preferences, including physical, emotional, social, spiritual and nutritional.
- State name of clinical lead in palliative care.
- Clinical lead should have professional links to other agencies to ensure development and continuity of best practice.
- Evidence of regular reviews of patient problems and actions taken.
- Continuity of care between
  - Secondary and primary care
  - General Practitioners & Out of Hours Co-operatives where applicable
  - Designated Social Worker and community hospital/primary care personnel
- What Managed Clinical Networks does the hospital participate in for palliative care?
- Designated area for palliative care (or an area within the hospital which is appropriate to be used as such)
- How are clinical guidelines maintained/audited?
- Audit – suitable arrangements must be in place for regular audit?
- Have staff undertaken appropriate training?

The Community Hospital standards for respite care may be appropriate in certain situations:

- How do you ensure there is a bed available?
- National and locally agreed targets?
- Consideration should be given to the suitability of patients with terminal illness for planned health respite.

In addition to the Community Hospital Standards, it is important to note that there are aspects of the statutory NHS Quality Improvement Scotland Specialist Palliative Care Standards which have implications for community hospitals. (These are to be found under standard 2(a), criteria 2.a.3 and 2.a.6 on page 29 of the Specialist Palliative Care Standards, which can be accessed on the web at www.nhshealthquality.org).

These stipulate the introduction of formalised arrangements for specialist input to local and community hospitals where this has not already been achieved, and for specialist palliative care providers to link with their own local community hospitals to provide 24-hour telephone advice for health professionals.

The Stocktake of Palliative Care Provision in Community Hospitals has revealed that most have access to 24 hour telephone advice, but this is not always the case (some have indicated the advice is only available between 9am and 5pm, which may not be accurate but is what is understood by those who may need to access such advice).

Those responsible for clinical governance in each community hospital area should check with their counterpart in the relevant specialist palliative care team or service, that there is a mutual awareness of the need to comply with this standard.

Palliative care out-of-hours

The various ways services are provided out-of-hours and the current changes to this aspect of service delivery as described in Part 2 on page 14, are being studied through a Chief Scientist Office-funded project. This qualitative research studied the views of palliative care patients and their informal and professional carers. The project specifically assesses patients' and carers' views on out-of-hours co-operatives, and the roll out of NHS24. One of the areas being studied has several community hospitals, which makes the research of direct relevance to those managing and providing these services. The study is due for completion towards the end of 2003, and details are available from Dr Scott Murray at the Department of General Practice at the University of Edinburgh.

Links with palliative care and other specialist colleagues

The national stocktake of palliative care provision highlighted the value of contact with palliative care specialists to the extended primary care teams within community hospitals. Closer links with palliative care specialist colleagues, especially in their role as educators and trainers for generalist palliative care providers, was one of the top three priorities for development amongst community hospital personnel.

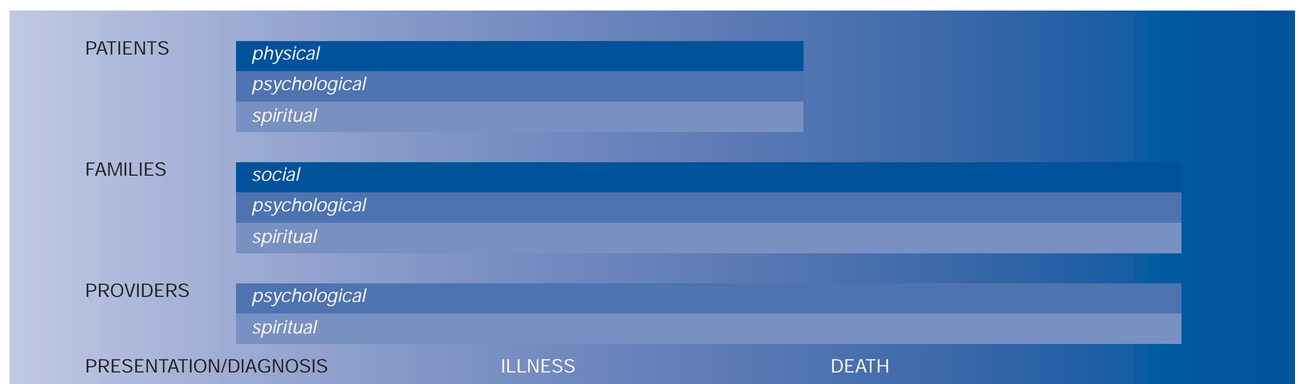
As well as forging better and more flexible links with specialists in palliative care, there is some desire to raise awareness amongst other specialist colleagues who may be involved in the treatment of patients. Discharge back to the community hospital for continuation of some treatments may be more beneficial to the patient than remaining in a secondary or tertiary care unit at a distance from their homes. There may be some benefit in linking with colleagues in specialist palliative care teams within DGH or tertiary hospital facilities to help facilitate such discharge arrangements.

In circumstances where patients receive curative or life-prolonging treatments which are being given with palliation in mind, this should be clearly established between the tertiary or secondary care specialists and the extended primary care team, so that communication with patients and families is clear and confusion does not arise.

Needs of patients, relatives and providers

People who need palliative care, and their carers, may have a range of needs which those providing services should be able to meet either directly or by arranging assistance from appropriate agencies or individuals. Needs may be physical, psychosocial or practical in nature. The balance of needs may change during the course of the episode of palliative care depending on where the person's condition is located on the care continuum as illustrated in Part 1, page 9, and may include carer needs in the case of terminal care. Therefore, those involved in meeting the needs of people using services should be ready to respond flexibly to these needs in order to minimise users' potential distress and discomfort. If all criteria listed under NQIS clinical standards for community hospitals providing palliative care are met, service users should be assured of such flexibility. Those providing palliative care also have needs which require to be addressed, in order to ensure they are able to support patients and their relatives and friends in the flexible manner described above. The World Health Organisation has depicted these various needs in a diagram entitled Quality of Life Dimensions of Palliative Care, and this is reproduced below in Figure 3.

Figure 3 Quality of Life Dimensions of Palliative Care



WHO National Cancer Programmes 2002, page 85

Taking each of these needs in turn, specific needs are listed below for patients, families/relatives (including close friends), and those providing services. We have added some practical needs which may need to be considered in certain circumstances.

Patients' Needs

Physical needs of patients

- Pain relief, including:
  - Systematic assessment of pain.
  - Provision of appropriate drug therapy, including reliable out-of-hours process.
  - Access to alternative/complementary therapies such as aromatherapy, therapeutic massage, reflexology.
- Nutritional needs, including:
  - Access to individual food preferences (e.g. what the patient wants/feels like eating).
  - Facility to eat smaller amounts perhaps more frequently/at odd times.
- Effective symptom control, including:
  - Nausea & vomiting.
  - Constipation.
  - Weakness/fatigue.
  - Mouth care.
  - Breathlessness.
  - Anxiety & depression.
  - Anorexia.
  - Confusion.
  - Restlessness.
  - Insomnia.
  - Lymphoedema.
- Comfortable Environment, including:
  - Single rooms where preferred.
  - Ensuite facilities.
  - comfortable reclining chairs.
  - Easy access to telephone with adequate privacy.
  - Facility to eat with family/friends if preferred.

- Psychological and spiritual needs of patients:
  An open and honest approach to communication, together with the willingness to simply "be there" for the patient, is fundamental to meeting psychological and spiritual needs. Patients need:
  - To continue to feel valued as a person, and to be treated as an individual, with dignity and respect.
  - To continue to exercise choices/preferences, and for these to be acknowledged.
  - To continue to have their need for confidentiality respected.
  - NOT to feel abandoned/rejected/alone.
  - To have someone who will listen/"be there", when wished.
  - To be able to express fears and anxieties, and to discuss the future.
  - To be able to access appropriate sources of religious support according to the patient's faith, if wished.
  - To be able to access alternative sources of support, if wished.
- Practical needs:
  - To be able to access suitable assistance in dealing with any outstanding practical needs, e.g. financial affairs, including benefits.
  - To have appropriate and timely written information available to them on their condition.

Families' and Friends' Needs

- Social/Practical needs:
  - Time with patient, to suit own and patient's preferences.
  - Comfortable overnight accommodation near patient, with ensuite facilities.
  - Minimum self-catering facilities (kettle, small fridge, crockery, small sink, etc).
  - Access to private use of telephone.
- Psychological and spiritual needs:
  - To be able to talk to specifically identified member(s) of staff.
  - To be able to express feelings, fears and anxieties or concerns.
  - To have access to additional religious or alternative sources of support, as wished.

Providers' Needs

Providers of services include all medical, nursing, allied health professionals, care support staff, and volunteers who may be involved in the provision of palliative care to patients locally.

- Practical needs:
  Training tailored to the various professionals and individuals involved, provided in multi-disciplinary team sessions, uni-professional sessions or individual sessions as appropriate, in:
  - Assessment of pain, covering the use of various pain measurement methods.
  - Symptom control.
  - Use of equipment (e.g. syringe drivers, etc – see "Tools to do the job" below).
  - Open and honest communication.
  - Bereavement and anticipatory grief counselling.
  - Reflective practice.
- Cover for absence to complete training.
- Local training sessions wherever possible.
- Educational materials in a variety of formats to suit.
- Appropriate "tools to do the job" with access to suitable facilities and equipment such as:
  - Syringe drivers.
  - Access to pharmacy supplies in-hours and out-of-hours.
  - Fridges suitable for storing blood.
  - Suction.
  - Oxygen.
  - Nebuliser.
  - Electric fan.
  - Pressure relieving equipment, mattresses, cushions.
  - Recliner chairs.
  - Electric heat pad.
  - TENS machine.
- Psychological and spiritual needs:
  The psychological and spiritual needs of those providing the service are often overlooked. But it is important to meet these needs in order to ensure the best service possible will continue to be available to those who need it, by avoiding undue distress amongst "hands-on" providers. Needs include:
  - Acknowledgement of local connections – patients may be well known to providers especially in small towns.
  - Someone to talk to about experiences, fears, anxie.

Recommendations

The ideas encapsulated in this Framework for Good Practice for Palliative Care are applicable to anyone suffering from any terminal or degenerative condition or illness, whether they are at home, in the local community hospital or a local care home.

- Palliative care should be provided at home, or as close to the patient's home, as possible.
- Palliative care should be available to those who need it from the early stages of their illness.
- Steps should be taken by responsible agencies to facilitate links between horizontal networks of community hospitals and vertical networks of relevant specialties, including those dealing with the type of conditions listed in Part 1, page 9 of this report. This is especially important in relation to specialist palliative care colleagues.
- Continuing professional development should be available by means of appropriate training, education and skills acquisition for ALL members of the extended primary healthcare team, and for volunteers where appropriate.
- The education and training role of palliative care specialists should be drawn upon to help meet the educational and training needs identified by community hospital personnel through the national stocktake exercise.
- In circumstances where patients receive curative or life-prolonging treatments which are being given with palliation in mind, this should be clearly established between the tertiary or secondary care specialists and the extended primary care team, so that communication with patients and families is clear and confusion does not arise.
- The contract terms for general medical services out-of-hours stipulate the provision of a suitable system of clinical information transfer between the patient's practice and the out-of-hours service for palliative care patients in the terminal stages of illness who will die at home (Quality (Records) Indicator 13). It will be important to ensure similar specific arrangements have been made for patients in the community hospital, and indeed that the general medical services arrangements dovetail neatly with those made to cover the community hospital.
- Differences may occur in the way out-of-hours medical and nursing services are provided in community hospitals in different parts of Scotland. These differences mean there is the possibility of a difference in the actual service provision to palliative care patients for purely logistical reasons between different areas out-of-hours. This is a situation which should be avoided by being clear about the way services are organised out-of-hours in each locality with a community hospital, and by those responsible ensuring that although the way service is delivered may differ, the output in terms of the quality of the service to patients should not be compromised.
- Assistance from external agencies in terms of funding to establish good facilities amenable to palliative care provision is greatly appreciated in those areas where this has occurred. However, actual designation of these (or any other) beds as specifically for palliative care may be counterproductive in such small units. Flexible usage of all facilities in community hospitals is recommended, so that maximum benefit may be derived by the local population.
- Gaps in simple equipment provision which directly reduce the service to patients should be remedied by those responsible for running community hospital facilities.
- The current inadequacy of accommodation for patients and their relatives should be addressed wherever this is a problem.
- Provision should be made to enable access to alternative/complementary therapies such as aromatherapy, therapeutic massage and reflexology for palliative care patients, especially those in the terminal phase of their illness.
- There should be some form of day care facilities such as diversionary therapy for all patients in community hospital areas including those with palliative care needs.

Conclusion

Based on the findings of the national stocktake of palliative care provision in community hospitals, it is clear that extended primary care teams in community hospitals in Scotland provide invaluable local services to their communities, which suit their contextual situations. This service is complementary to the services provided by their specialist palliative care colleagues, and the two professional groupings need to forge meaningful clinical links in order to provide the care their patients need.

The top three priorities of community hospital personnel regarding palliative care provision in community hospitals are:

- Increased education and training of staff.
- Improved accommodation and facilities for patients and their relatives.
- Increased specialist palliative care support.

It is hoped that this Framework will act as a guide for everyone involved in providing palliative care in community hospitals, in ways to suit the circumstances of each locality. There may be many different ways of achieving the same desired outcome, namely of improved services for patients, provided by personnel who are appropriately supported in their endeavours.

G. Black 2003

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- The Project Steering Group members for their expertise and persistence.

Copies of this document can be downloaded in pdf format from the web at:

www.scotcommhosp.org.uk

(With effect from November 2003)

Appendices

Appendix A

Centre for Health and Social Research

The Provision of Palliative Care in Community Hospitals in Scotland

This report was commissioned by Scottish Association of Community Hospitals and was carried out by the Centre for Health and Social Research

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1 SUMMARY

There are approximately seventy community hospitals in Scotland, varying in size from five to over seventy beds. Community hospitals have an important role in the provision of palliative care in terms of both providing continuity of care to patients and ensuring that they have access to high quality palliative care facilities, particularly in rural areas. At present little is known about the level of staffing, services and facilities in these hospitals.

The Scottish Association of Community Hospitals (SACH) received funding from the New Opportunities Fund in 2001 to establish a framework for good practice in palliative care in community hospitals. In order to establish a baseline for future evaluation and to identify good practice, SACH commissioned the centre for Health and Social research (CHSR) to carry out a stocktake of the palliative care provided in all of the community hospitals in Scotland.

A questionnaire which had been developed in the Borders to conduct a local audit was adapted for use in this study. This was extended further to include information required for a piece of national research on palliative care in order to avoid duplication of information gathering for community hospital personnel. Questionnaires were sent out to lead clinicians of all community hospitals in Scotland requesting information on: nursing establishment; palliative care training of clinical staff; continuing education; accommodation and equipment; communication and liaison with other services; perceived priorities for advancing palliative care provision; examples of good practice; policies and guidelines relating to palliative care; sources of funding; and any other comments.

Respondents were requested to complete the questionnaire as fully as possible and were then invited to participate in a short telephone interview with a researcher from CHSR at their convenience. The researcher completed the questionnaire during the telephone interview and was able to probe respondents for additional information where necessary.

Data from the questionnaires were entered onto an Access database and analysed using SPSS. Chi-squared analysis was used to compare data from community hospitals of different size based on bed numbers.

Of the seventy community hospitals which were contacted, two were closed for refurbishment at the time of the study and were therefore unable to participate. Of the remaining 68 hospitals, completed questionnaires were obtained from 60, resulting in a valid response rate of 88%. The majority of the questionnaires (70%) were completed by telephone and the remainder were completed and returned by post.

Most of the nursing staff employed in the community hospitals which participated in the survey were A, D and E grade. Only two of the hospitals employed I grade nurses and 38 of the 60 hospitals employed between 2.1 and 53.6 WTE nurses on a part-time basis.

At the time of the survey, 50% of the hospitals which participated in the study employed nursing staff who had received post-registration training in palliative care and 45 of the hospitals had nursing staff with post registration training which may be nationally accredited. Fifty-seven percent of hospitals employed nursing staff who had had previous work experience in palliative care.

Seventy-eight percent of the hospitals which participated had doctors admitting to the hospital with an interest in palliative care. Nine hospitals (15%) had doctors admitting with a Diploma in Palliative Care Medicine and 13% had doctors with post-registration training which may be nationally accredited.

Continuing education for nursing staff was provided by the majority of hospitals: use of equipment (86%); symptom control; (83%); bereavement support (70%); communication skills (62%); and team working (53%). However, continuing education for medical staff was provided by fewer hospitals: symptom control (52%); use of equipment (38%); communication skills (33%); bereavement support (33%); and team working (30%). The majority of hospitals did not provide continuing education on the use of equipment, bereavement support, communication skills or team working for other staff (volunteers, ancillary staff and therapists/pharmacists).

The majority of hospitals (68%) had a total of 20 beds or less. All of the hospitals surveyed had at least one GP bed and 38% had at least one designated palliative care bed.

Forty percent of participating hospitals had no single rooms with a toilet, basin, shower or bath and 25% had no single rooms with a toilet and basin. Thirty-seven percent of hospitals did not have any single rooms with a folding bed for a relative or carer. The majority of hospitals had a quiet room for relatives/carers (68%), a telephone available for patients to use (63%) and facilities for preparing drinks and snacks without interrupting nursing staff (60%). A separate overnight room for relatives/carers was available in 53% of the hospitals surveyed.

Twenty-five percent of hospitals had day care facilities for patients requiring palliative care.

All of the hospitals surveyed had syringe drivers, suction, oxygen, nebulisers and electric fans available on site, nearly all had pressure-relieving equipment (98%), and recliner chairs (93%) and most had TENS machines (85%) and electric heating pads (68%) on site.

Only 8% of hospitals had an in-patient hospice either on site or located less than 10 miles away and for most hospitals, the nearest in-patient hospice was between 21 and 40 miles away. The majority of hospitals (83%) had access to 24-hour advice on patient care from specialist palliative care services.

Most of the hospitals surveyed received regular routine visits from GPs (98%), physiotherapists (90%) and OTs (85%). The majority of hospitals received a visit when requested from a consultant in palliative care (67%) and Macmillan nurses or nurse specialists (63%). More than 50% of the hospitals never received visits from complementary therapists.

The top three priorities for advancing the standard of palliative care provision identified by community hospital staff were:

- Increased education and training of staff.
- Improved accommodation and facilities for patients and relatives/carer.
- Increased specialist palliative care support.

Forty-two percent of hospitals identified either innovative ways in which they supplied palliative care services or current pilots/initiatives being undertaken in this area.

The majority of community hospitals had written polices or guidelines relating to the following issues in palliative care patients: symptom control (70%), pain (65%), constipation (60%); nausea (55%); and breathlessness (50%). Less than one quarter of hospitals had policies or guidelines relating to: use of complementary therapies (13%); shared care (13%) and patients from black and ethnic minorities (10%).

Of the hospitals that participated in the survey, 57% had received additional funding for palliative care facilities from a local League of Friends, 27% from Macmillan, 7% from Marie Curie and 28% from other sources.

Nearly half of the respondents (49%) made further comments concerning palliative care in their hospital. A number of respondents felt that whilst palliative care provision was good or adequate, there was room for improvement, particularly in relation to development of multidisciplinary holistic practices such as complementary therapies.

2 BACKGROUND

There are around seventy GP community hospital units in Scotland, although the number tends to fluctuate. They vary in size from five or six beds to over seventy. The provision of palliative care is a substantial proportion of the workload of the hospital[1]. In May 1998 the Scottish Partnership for Palliative and Cancer Care (SPA) published the report[2] of a working party on palliative care in community hospitals giving guidance on the staffing, training, specialist input and facilities which a community hospital needs in order to provide good palliative care. A survey of services available in Borders community hospitals was undertaken in 1999[3] and this study would roll out an amended version of that survey to the whole of Scotland in 2001.

At present little is known about the level of staffing, services and facilities in community hospitals in Scotland. However, community hospitals have an important role in the provision of palliative care both in terms of providing continuity of care to patients and in ensuring that patients have access to high quality palliative care facilities particularly in rural areas. They have been shown to deliver very good standards of care[4, 5].

The Scottish Association of Community Hospitals (SACH) was awarded £67,823 from the New Opportunities Fund in 2001 to establish a framework for good practice in palliative care in community hospitals. The framework will improve palliative care by establishing and developing collaborative partnerships to provide effective palliative care. In order to identify good practice and establish a baseline for future evaluation, SACH commissioned the Centre for Health and Social Research (CHSR) to undertake a stocktake of the palliative care provided in all of the community hospitals in Scotland in July 2001.

3 AIM

To assess the current position of staffing, services and facilities available within community hospitals in Scotland for the provision of palliative care.

4 METHODS

A questionnaire which had been developed by Dr Paul Cormie[3] was selected and adapted for use in this study (Appendix 1).

4.1 PILOTING OF QUESTIONNAIRE

Contact details for each of the community hospitals in Scotland identified as having designated GP beds at the time of the study and contact details for their lead clinicians were obtained from SACH.

Questionnaires were initially sent out to the lead clinicians of ten of the 70 community hospitals in Scotland, together with a joint covering letter from the chairman of the Scottish Association of GP Community Hospitals and a researcher at CHSR (Appendix 2). Respondents were requested to complete the questionnaire as fully as possible which may involve speaking with other members of staff in order to answer some questions. It was then explained that respondents should not return the questionnaire as they would be invited to participate in a telephone interview with a researcher which would take 20-30 minutes at their convenience.

Approximately one week later the lead clinicians were contacted at their GP practice by an administrative assistant from CHSR and arrangements were made for a researcher from CHSR to undertake a telephone interview with a researcher. A researcher interviewed the GP by telephone at the appointed time and completed the questionnaire. GPs were requested to send copies of any written policies and/or guidelines relating to palliative care used in their hospital in the Freepost envelope provided.

A steering group meeting was held once the first ten telephone interviews had been completed in order to discuss the suitability of the questionnaire. It was felt that only minor amendments to the questionnaire were necessary. It was decided that the practice manager of each practice in which the community hospital lead GPs were located should also be sent a questionnaire and covering letter for their information.

4.2 MAIN STUDY

Questionnaires were sent out to the remaining 60 community hospitals and telephone interviews were conducted with all of the lead clinicians who agreed to participate.

4.3 DATA ANALYSIS

Data from the questionnaires were entered onto an Access database and analysed using SPSS. Chi-squared analysis was used to compare data from community hospitals of different sizes based on bed numbers.

5 RESULTS

The lead clinicians of 70 community hospitals in Scotland were contacted. Two hospitals were closed for refurbishment at the time of the survey and were therefore unable to complete the questionnaire. Of the remaining 68 hospitals that were contacted, 60 completed the questionnaire resulting in a valid response rate of 88% (table 1).

Table 1: Questionnaire response rate

Number of hospitals contacted	70
Number of hospitals closed	2
Number of hospitals eligible to complete questionnaire	68
Number of questionnaires completed	60
Valid response rate	**88%**

The majority of questionnaires (70%) were completed by telephone (table 2). Whilst every effort was made to undertake a telephone interview with a representative of each community hospital, this was not possible in all cases, usually due to time constraints. Eighteen questionnaires (30%) were therefore completed and returned by post.

Table 2: Method of questionnaire completion

	n	%
Number completed by telephone	42	70
Number returned by post	18	30
Total	**60**	**100**

Although the majority of questionnaires were completed by community hospital GPs or other members of the hospital medical staff (39, 65%), the data had often been gathered by a combination of medical and nursing staff.

5.1 QUESTIONNAIRE DATA

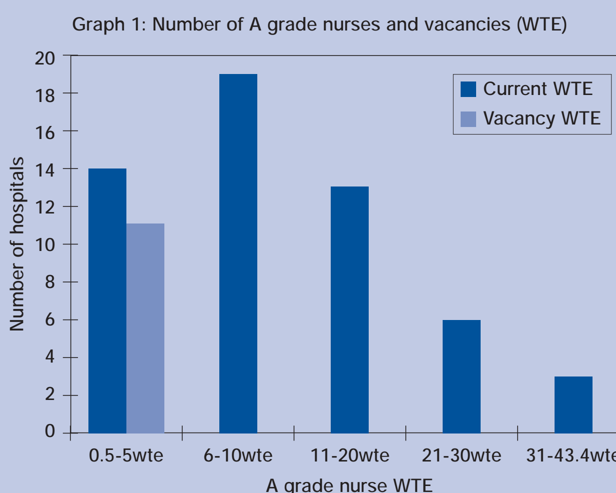
5.1.1 NURSING STAFF

Each community hospital was asked to provided details of the nursing establishment of their in-patient wards at the time of the survey as whole-time equivalents (WTE), including the number of nursing staff employed part-time and any current vacancies.

A grade nurses

The number of A grade nurses (WTE) and vacancies in the hospitals surveyed are shown in graph 1. Most of the nursing staff employed in community hospitals were A grade nurses, with 55 of the 60 hospitals who participated in the survey employing between 1.0 WTE and 43.4 WTE A grade nurses.

Graph 1: Number of A grade nurses and vacancies (WTE)



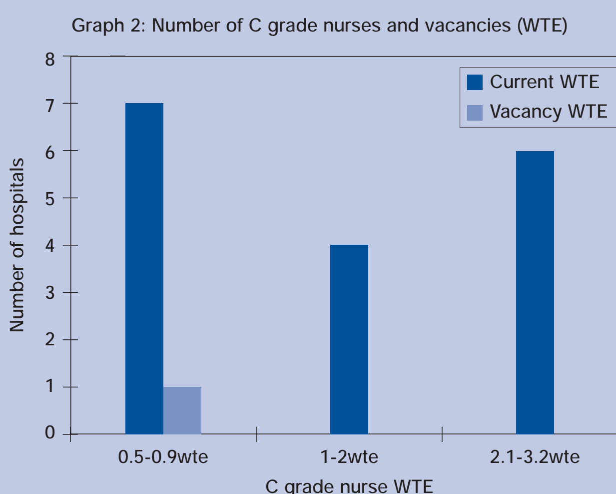
B grade nurses

Five hospitals employed B grade nurses, one 0.6 WTE, one 1 WTE, one 1.3 WTE, one 2.0 WTE and one 3.6 WTE.

C grade nurses

The number of C grade nurses (WTE) and vacancies in the hospitals surveyed are shown in graph 2.

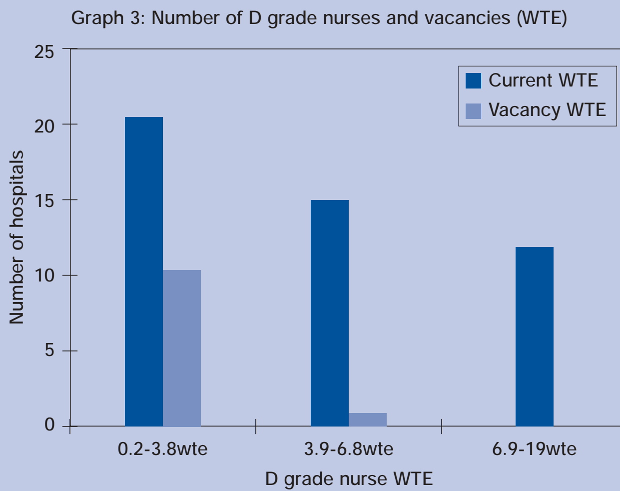
Graph 2: Number of C grade nurses and vacancies (WTE)



D grade nurses

The number of D grade nurses (WTE) and vacancies in the hospitals surveyed are shown in graph 3.

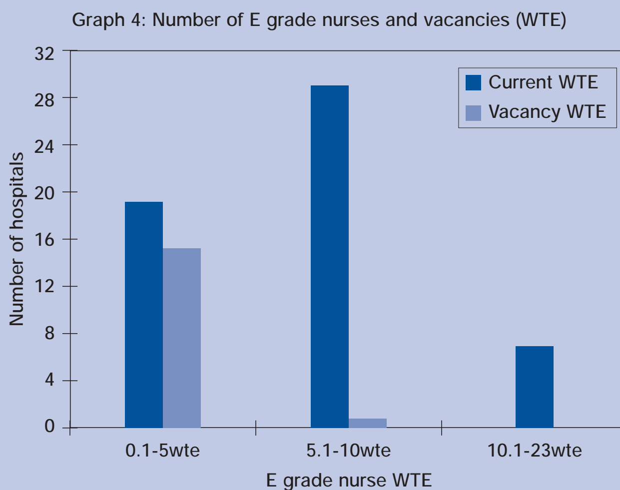
Graph 3: Number of D grade nurses and vacancies (WTE)



E grade nurses

The number of E grade nurses (WTE) and vacancies in the hospitals surveyed are shown in graph 4.

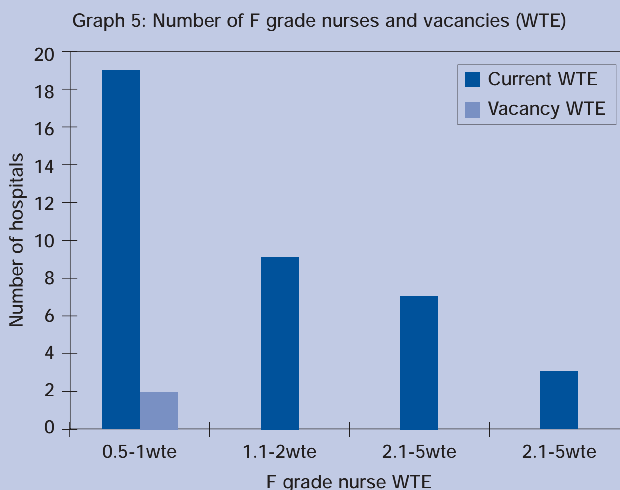
Graph 4: Number of E grade nurses and vacancies (WTE)



F grade nurses

The number of F grade nurses (WTE) and vacancies in the hospitals surveyed are shown in graph 5.

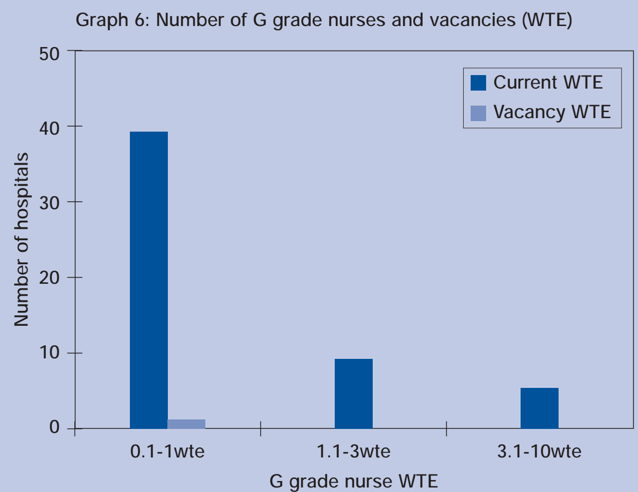
Graph 5: Number of F grade nurses and vacancies (WTE)



G grade nurses

The number of G grade nurses (WTE) and vacancies in the hospitals surveyed are shown in graph 6.

Graph 6: Number of G grade nurses and vacancies (WTE)



H grade nurses

Nine hospitals employed H grade nurses, two hospitals employed 0.5 WTE, six employed 1.0 WTE and one hospital employed four WTE H grade nurses.

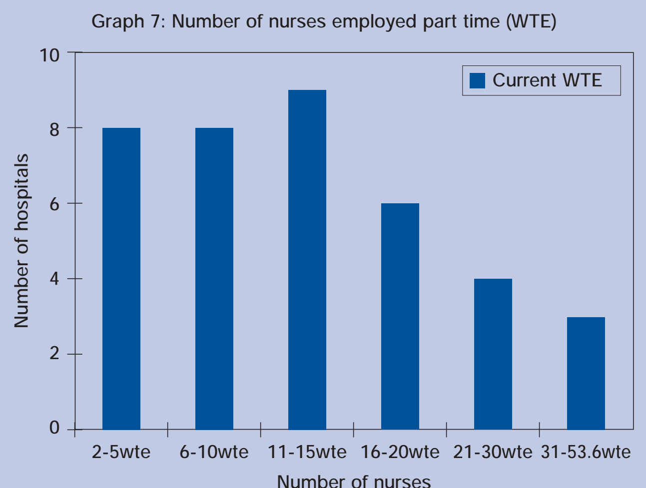
I grade nurses

Only two of the 60 hospitals which participated in the survey employed I grade nurses, one 0.3 WTE and one 1.0 WTE respectively.

Nurses employed on a part-time basis

The number of hospitals which employed nursing staff part-time is shown in graph 7. Thirty-eight of the 60 hospitals surveyed employed between 2.1 WTE and 53.6 WTE nurses part-time.

Graph 7: Number of nurses employed part time (WTE)



5.1.2 CLINICAL STAFF WITH PALLIATIVE CARE TRAINING/EXPERTISE

Nursing staff

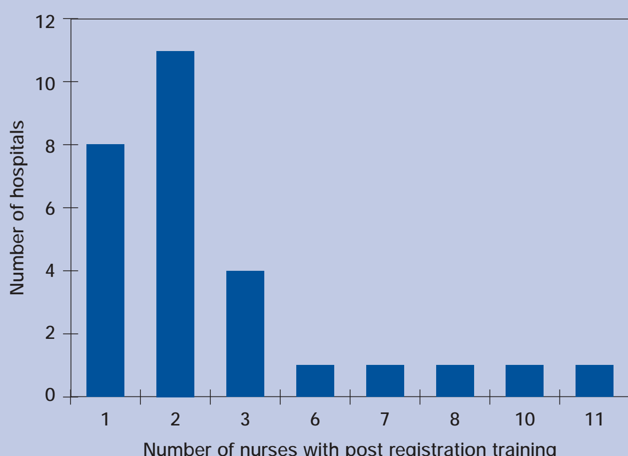
Half of the hospitals surveyed had nursing staff who had received post registration training in palliative care (50%) (table 3).

Table 3: Have any of your qualified nursing staff had post registration training in palliative care?

	n	%
Yes	30	50
No	22	36
Don't know	6	10
Did not respond	2	4
Total	**60**	**100**

Of the 28 hospitals which answered 'yes' and gave further details, 39% stated that they had two nursing staff with post registration training in palliative care (graph 8).

Graph 8: Nursing staff with post registration training in palliative care



Comments about post registration nursing training included:

- Local hospice-based training for nursing staff (East Airdrie Community Hospital).
- Auxiliary nurses attend day training for symptom control (Hawick Cottage Hospital).
- In house training in palliative care (Turriff Community Hospital).
- One nurse has undertaken distance learning in palliative care (Victoria Hospital, Rothesay).
- Would welcome more post registration training in palliative care for nursing staff, at present training via staff study days (Montrose Royal Infirmary).
- Marie Curie course (Kincardine Community Hospital).
- Nurse with BSc in Marie Curie Nursing (Uist and Barra Hospital).
- Four members of nursing staff with modules towards BSc in palliative care, six nurses with pain and symptom management modules (Central borders Community Hospital).
- Nurse due to complete a postgraduate diploma in specialist palliative care in 2002 (Kilsyth Victoria Memorial Hospital).
- Several nurses with post registration training, including Marie Curie diploma in palliative care nursing and one nurse completing BSc with Marie Curie (Lockhart Hospital, Lanark).
- One nurse with ENB931, another working towards a BSc in palliative care (Irvine Memorial Hospital).
- One nurse with ENB237 and two who have completed a palliative care course at Robert Gordon University (Peterhead Community Hospital).
- One nurse has completed a palliative care course at Robert Gordon University and one is about to start (Insch war Memorial Hospital).

Forty-five percent of hospitals stated that they had nursing staff with post registration training in palliative care which may be nationally accredited (table 4).

Table 4: Have any of nursing staff had post registration training in palliative care which may be nationally accredited?

	n	%
Yes	27	45
No	18	30
Don't know	10	17
Did not respond	5	8
Total	**60**	**100**

Fifty-seven percent of hospitals had nursing staff who had had previous work experience in palliative care (table 5).

Table 5: Have any of nursing staff had previous work experience in palliative care?

	n	%
Yes	34	57
No	14	23
Don't know	11	18
Did not respond	1	2
Total	**60**	**100**

Of the 24 hospitals which answered 'yes' and gave further details, half of them stated that they had one member of nursing staff with previous work experience in palliative care.

Doctors

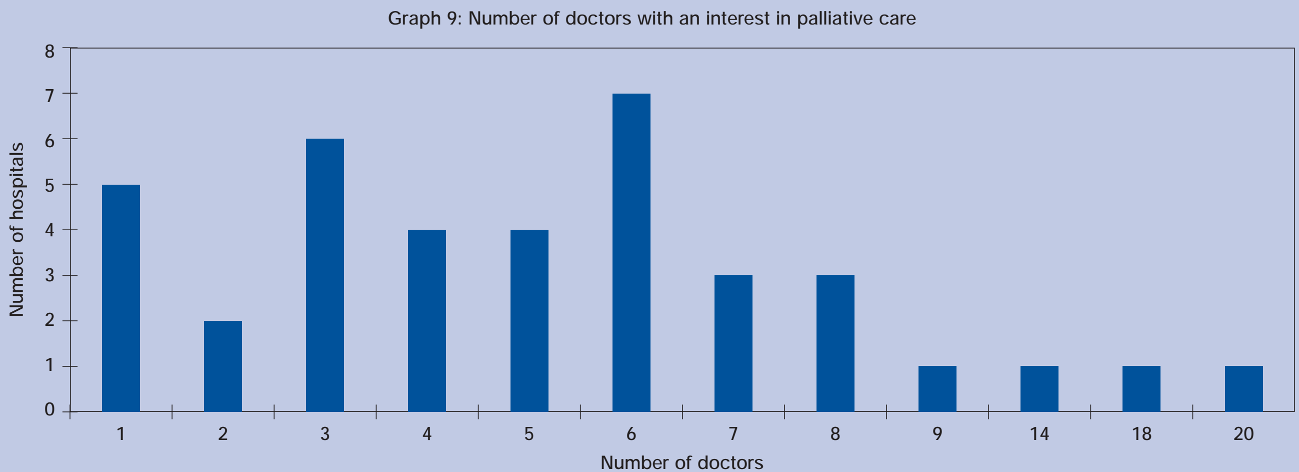
Approximately three quarters of respondents (78%) said that they had doctors with an interest in palliative care admitting to their hospital (table 6).

Table 6: Do any of doctors who admit to your hospital have an interest in palliative care?

	n	%
Yes	47	78
No	7	12
Don't know	6	10
Total	60	100

The number of hospitals with doctors who have an interest in palliative care are shown in graph 9.

Graph 9: Number of doctors with an interest in palliative care



The majority of hospitals did not have doctors with a Diploma in palliative Medicine admitting patients to their hospital (63%) (table 7). Of the nine hospitals who replied 'yes', eight had one doctor and one hospital had two doctors with a Diploma in palliative care admitting to their hospital.

Table 7: Do any of doctors possess a Diploma in Palliative Medicine?

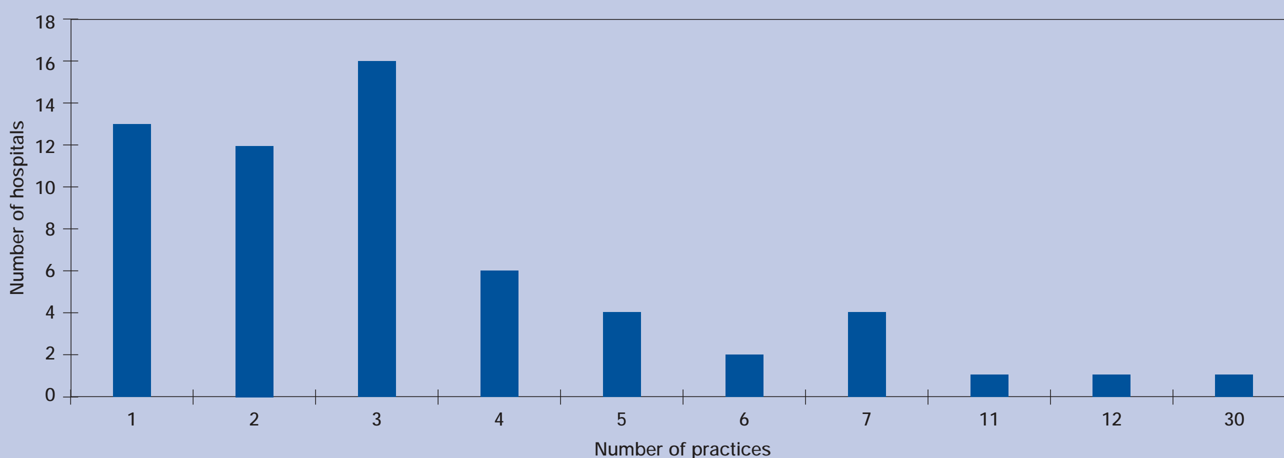
	n	%
Yes	9	15
No	38	63
Don't know	12	20
Did not respond	1	2
Total	60	100

Half of the respondents (50%) did not know whether any of the doctors admitting to their hospital had had in house post registration training in palliative care which may be nationally accredited (table 8). Thirteen percent of hospitals did have doctors admitting to their hospital who had in house post registration in palliative care which may be nationally accredited.

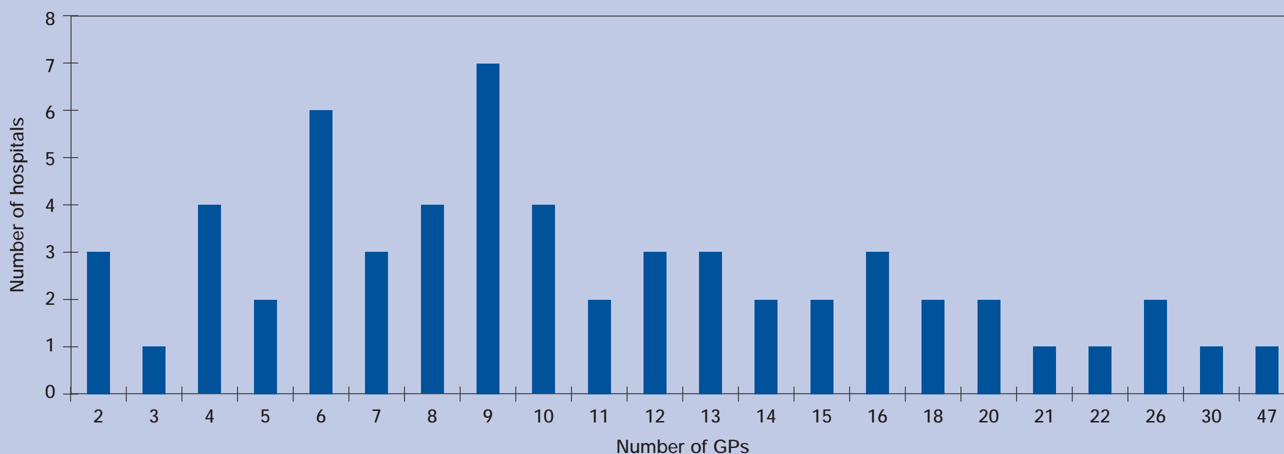
Table 8: Have any of doctors who admit to your hospital had in house post registration training in palliative care which may be nationally accredited?

	n	%
Yes	8	13
No	21	35
Don't know	30	50
Did not respond	1	2
Total	**60**	**100**

The number of practices admitting to community hospitals are shown in graph 10.



The number of GPs admitting to community hospitals are shown in graph 11.



5.1.3 EDUCATION

Symptom control

The majority of hospitals provided continuing education on symptom control for nursing staff (83%) and approximately half of the hospitals had continuing education on symptom control for medical staff (52%) (table 9).

Table 9: Is there any continuing education on symptom control in your hospital or nearby for:

	Yes		No		Total	
	n	%	n	%	n	%
Nursing staff	50	83	10	17	60	100
Medical staff	31	52	29	49	60	100
Volunteers	9	15	51	85	60	100
Ancillary staff	13	22	47	79	60	100
Therapists and pharmacists	19	32	41	68	60	100

Communication skills

Sixty-two percent of hospitals stated that continuing education on communication skills was provided for nursing staff (table 10). The majority of hospitals did not provided continuing education on communication skills for other staff.

Table 10: Is there any continuing education on communication skills in your hospital or nearby for:

	Yes		No		Total	
	n	%	n	%	n	%
Nursing staff	37	62	23	38	60	100
Medical staff	20	33	40	67	60	100
Volunteers	9	15	51	85	60	100
Ancillary staff	14	23	46	77	60	100
Therapists and pharmacists	15	25	45	75	60	100

Team working

Approximately half of the hospitals surveyed of provided continuing education team working for nursing staff (53%) (table 11). The majority of hospitals did not provided continuing education on team working for other staff.

Table 11: Is there any continuing education on team working in your hospital or nearby for:

	Yes		No		Total	
	n	%	n	%	n	%
Nursing staff	32	53	28	47	60	100
Medical staff	18	30	42	70	60	100
Volunteers	10	17	50	83	60	100
Ancillary staff	14	23	46	77	60	100
Therapists and pharmacists	16	27	44	73	60	100

Bereavement support

Continuing education on bereavement support was provided by the majority of hospitals for nursing staff (70%) (table 12). Most hospitals did not provide continuing education bereavement support for other staff.

Table 12: Is there any continuing education on bereavement support in your hospital or nearby for:

	Yes		No		Total	
	n	%	n	%	n	%
Nursing staff	42	70	18	30	60	100
Medical staff	20	33	40	67	60	100
Volunteers	9	15	51	85	60	100
Ancillary staff	14	23	46	77	60	100
Therapists and pharmacists	15	25	45	75	60	100

Use of equipment

Most of the hospitals surveyed provided continuing education on the use of equipment for nursing staff (86%) (table 13). The majority of hospitals did not provide continuing education on the use of equipment for other staff.

Table 13: Is there any continuing education on use of equipment in your hospital or nearby for:

	Yes		No		Total	
	n	%	n	%	n	%
Nursing staff	52	86	8	13	60	100
Medical staff	23	38	37	62	60	100
Volunteers	5	8	55	92	60	100
Ancillary staff	6	10	54	90	60	100
Therapists and pharmacists	12	20	48	80	60	100

Other education

Thirteen percent of hospitals stated that they provided continuing education on other subjects for their nursing staff (table 14), including claiming benefits and other financial services, updates re medication for pain control and nausea, spiritual issues and palliative care updates by Macmillan service.

Table 14: Is there any other continuing education in your hospital or nearby for:

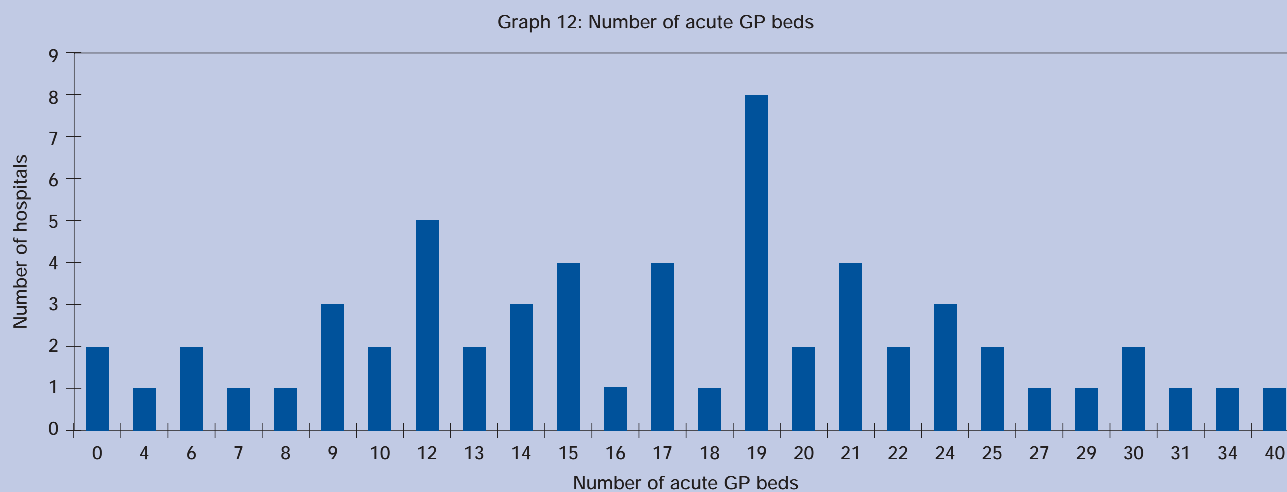
	Yes		No		Total	
	n	%	n	%	n	%
Nursing staff	8	13	52	87	60	100
Medical staff	5	8	55	92	60	100
Volunteers	4	7	55	93	60	100
Ancillary staff	3	5	57	95	60	100
Therapists and pharmacists	3	5	57	95	60	100

5.1.4 ACCOMMODATION AND EQUIPMENT

Acute GP beds

The community hospitals surveyed had between four and 40 acute GP beds (graph 12). Although respondents from two hospitals stated that they had no acute GP beds, ISD data confirms that they do have designated acute GP beds[6].

Graph 12: Number of acute GP beds



The majority of hospitals surveyed had less than 20 acute GP beds (70%) and 20% had 10 acute GP beds or less (table 15).

Table 15: Number of GP beds

	n	%
10 beds or less	12	20
11-15 beds	14	23
16-20 beds	16	27
21-30 beds	13	22
31-40 beds	5	8
Total	60	100

Nursing complement in relation to number of acute GP beds

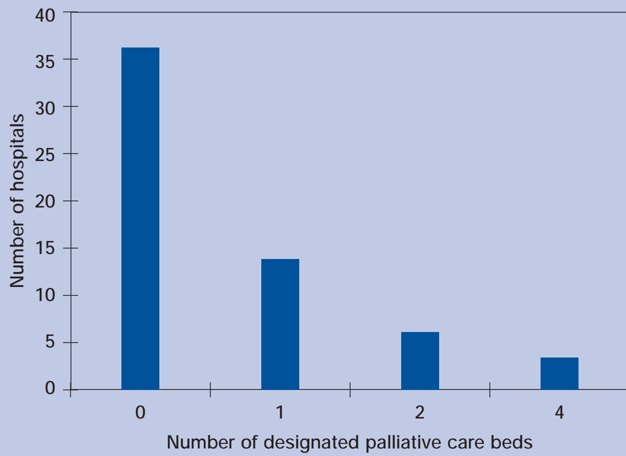
The nursing complement of the hospitals analysed according to the number of acute GP beds per hospital is shown in table 16. It can be seen that, irrespective of the number of acute GP beds in each hospital, all of the hospitals employed mainly A, D and E grade nurses.

Table 16: Nursing complement of hospitals in relation to number GP beds

Grade nurse	10 beds or less	11-15 beds	16-20 beds	21-30 beds	31-40 beds
			Mean WTE		
A	5.0	11.3	9.2	17.1	19.9
B	0	1.8	0.6	0	2.0
C	1.1	1.1	1.0	1.6	3.2
D	2.7	5.7	4.0	5.5	10.8
E	5.3	6.4	6.0	7.6	11.2
F	2.0	2.9	1.4	2.2	4.7
G	1.0	1.9	1.7	1.7	2.8
H	1.0	1.9	1.7	1.7	2.8
I	0	0	0.5	0.3	0

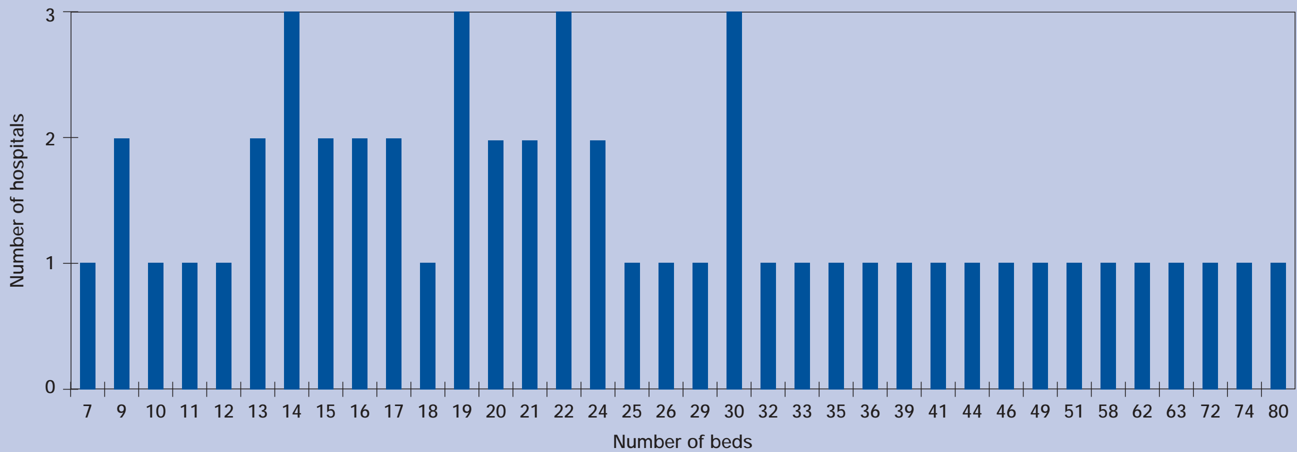
Designated palliative care beds

Twenty-three hospitals stated that they had at least one designated palliative care bed (defined as single rooms which have been funded specifically for palliative care) (graph 13).



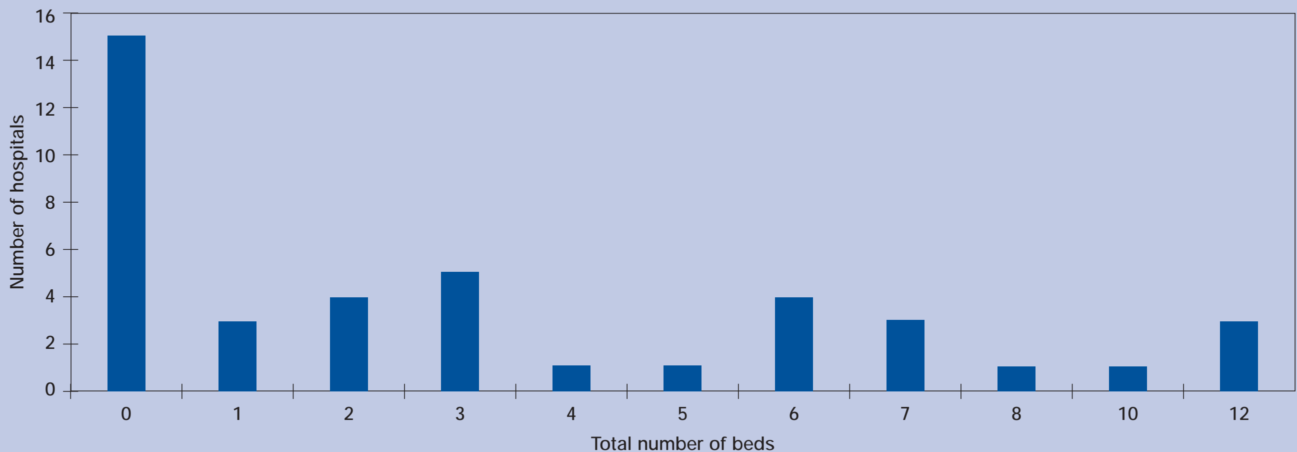
Total number of beds

The majority of community hospitals had a total of 20 beds or less (68%) (graph 14). (Total number of beds includes acute GP, palliative care designated and any others).



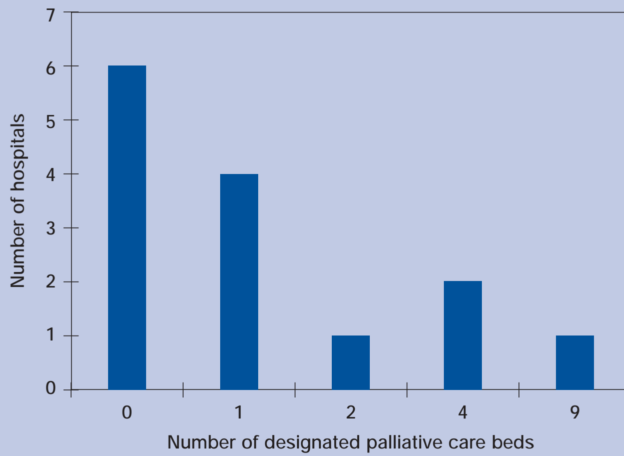
Facilities for patients and their relatives/carers

The number of hospitals with single rooms with a toilet and basin for total number of beds are shown in graph 15.



The number of hospitals with single rooms with a toilet and basin for designated palliative care beds are shown in graph 16.

Graph 16: Number of hospitals with single rooms with toilet and basin (designated palliative care beds)

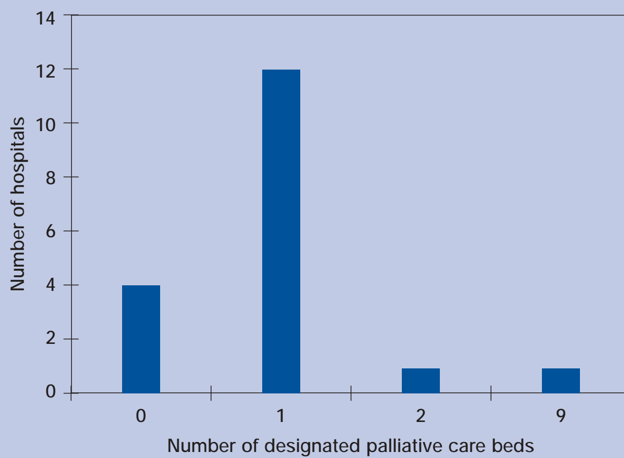


The number of hospitals with single rooms with a toilet and basin and shower/bath for total number of beds are shown in graph 17.

Graph 17: Number with single rooms with toilet and basin and shower/bath (all beds)

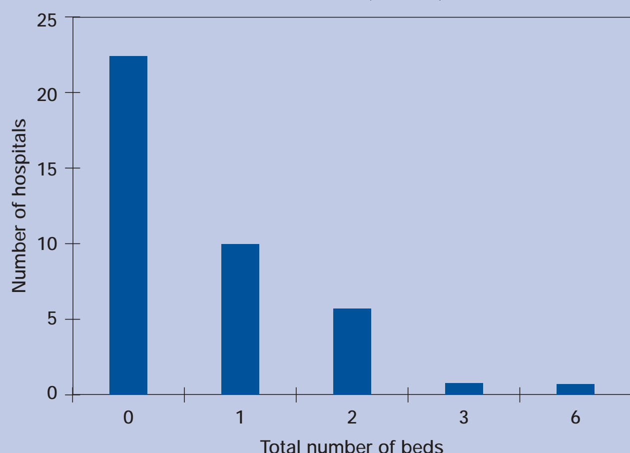
The number of hospitals with single rooms with a toilet and basin and shower/bath for designated palliative care beds are shown in graph 18.

Graph 18: Number with single rooms with toilet and basin and shower/bath (designated palliative care beds)



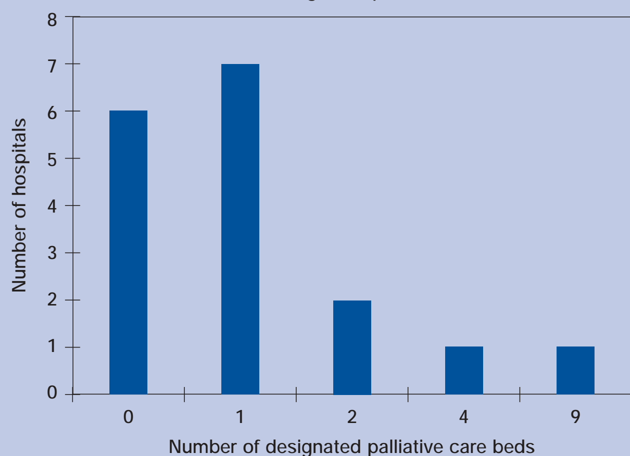
The number of hospitals with single rooms with folding bed in patient's room for relatives/carers for total number of beds are shown in graph 19.

Graph 19: Number with single rooms with folding bed in patient's room for relatives/carers (all beds)



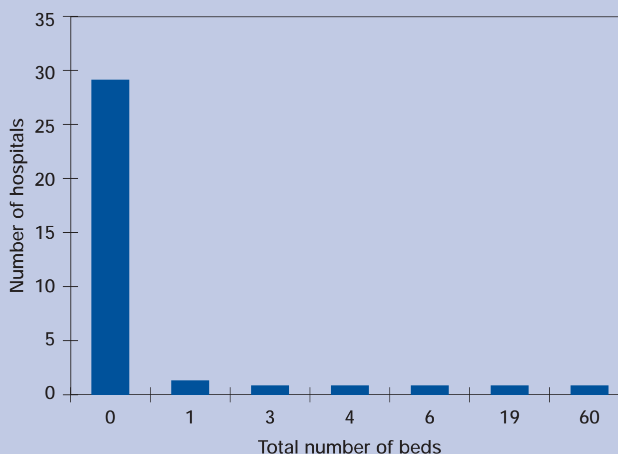
The number of hospitals with single rooms with folding bed in patient's room for relatives/carers for designated palliative care beds are shown in graph 20.

Graph 20: Number with single rooms with folding bed in patient's room for relatives/carers (designated palliative care beds)



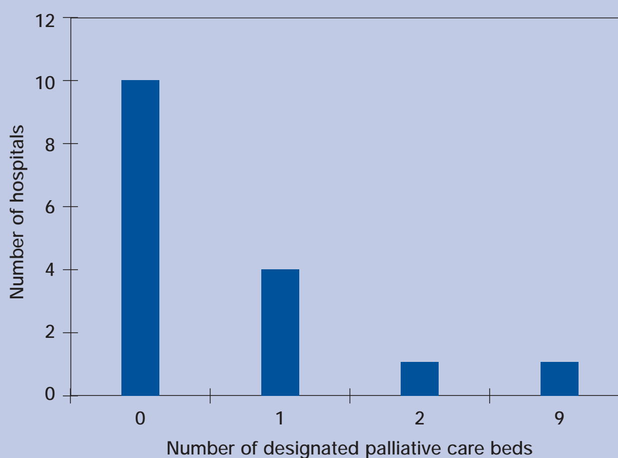
The number of hospitals with private telephone in patient's room for total number of beds are shown in graph 21

Graph 21: Number of hospitals with private telephone in patient's room (all beds)



The number of hospitals with private telephone in patient's room for designated palliative care beds are shown in graph 22.

Graph 22: Number with private telephone in patient's room (designated palliative care beds)



The majority of the hospitals surveyed had a quiet room for relatives and carers and/or patients (68%), a private telephone available for relatives/carers not in the patient's room (63%) and facilities for preparing drinks and snacks without interrupting nursing staff (60%) (table 17). Just over half of the hospitals who responded had a separate overnight room available for relatives/carers to stay in (53%).

Table 17: Facilities for relatives/carers (all beds)

	Yes		No		Did not respond		Total	
	n	%	n	%	n	%	n	%
Separate overnight room	32	53	22	37	6	10	60	100
Private telephone not in patient's room	38	63	16	27	6	10	60	100
Tea/coffee/snack making facilities	36	60	18	30	6	10	60	100
Quiet room for relatives and carers and/or patients	41	68	13	22	6	10	60	100

Of the 23 hospitals who stated that they had designated palliative care beds (shown in graph 13), over 60% had all of the facilities for relatives/carers listed in table 18.

Table 18: Facilities for relatives/carers (designated palliative care beds if any)

	Yes		No		Did not respond		Total	
	n	%	n	%	n	%	n	%
Separate overnight room	15	25	3	5	42	70	60	100
Private telephone not in patient's room	14	23	2	3	44	75	60	100
Tea/coffee/snack making facilities	15	25	2	3	43	72	60	100
Quiet room for relatives and carers and/or patients	15	25	1	2	44	75	60	100

Respondents made the following additional comments about the facilities that they could provide for patients and their relatives/carers:

Refurbishment

- We are in what used to be the general hospital and are about to undergo significant refurbishment, will be more single rooms with en suite facilities when finished (Royal Northern Infirmary Community Hospital, Inverness).
- Telephone points in all rooms for trolley phone. Intend to increase number of palliative care en suite bedrooms in 2002 (Dunoon and District General).
- Hospital is 100 years old, requires refurbishment, facilities limited although use single rooms for palliative care when possible (Mid Argyll Hospital, Lochgilphead).
- Unit recently upgraded to have more designated palliative care beds and relatives rooms (Blairgowrie Cottage Hospital).
- Palliative care bid for funding to improve facilities such as en suite bathroom for single room (Kelso Cottage Hospital).
- Number one priority of local review is to designate a palliative care suite, proposal has been submitted to trust to re-design two rooms (Jubilee Hospital, Huntly).
- Have two wards with 7/ward sharing bath/shower. Will move to more single rooms over next 2 years, extension to be built onto hospital with day centre, rehabilitation and OT facilities (St Margaret's Hospital, Auchterader).
- New Opportunities Fund money in Spring 2002 to provide a designated palliative care room with en suite facilities for patients and similar for relatives (Coldstream Cottage Hospital).
- We have six single rooms with toilets plus six-bedded rooms with toilets. The beds are not designated for palliative care but many palliative care patients have care provided in single rooms (Central Borders Community Hospital, Melrose).

- Vending room but no kettle etc. Relative's room doubles up as quiet room (Kincardine Community Hospital).
- Will accommodate relatives if possible. New building being discussed as hospital is 100 years old (Victoria Hospital, Rothesay).
- Recently commenced video library in relatives' room with portable TV and video. Chaplaincy available (Kilsyth Victoria Memorial Hospital).
- Poor facilities as old building, aiming for single room provision when build new hospital (Hawick Cottage Hospital).
- Planning a new building with better facilities (Town and Country Hospital, Nairn).

Quiet room

- Quiet room available if able to go upstairs (Sister Margaret Cottage Hospital, Jedburgh).
- No designated quiet room although other places can go (Dunaros Hospital, Isle of Mull).

Relatives' rooms

- No separate overnight room for relatives but can use ordinary bed (Lady Margaret Hospital, Millport).
- Relatives room available but not adjacent to single rooms (Peterhead Hospital).
- In the process of converting a room into a relative's room within the GP unit which is where our palliative care bed will be located from November 2001 (East Airdrie Hospital).

Telephone

- All single rooms have telephone sockets (Turner Memorial Hospital, Keith) Portable phone available (Glen O'Dee Hospital, Banchory).
- Radio phone which can be used anywhere, hoping to upgrade hospital (Portree Hospital).
- Telephone trolley available (Lawson Hospital).
- Fourteen telephone points for mobile phone (Spynie Hospital).
- Portable telephone available (Insch War Memorial Hospital).
- Portable telephone (Belhaven Hospital, Dunbar).
- Mobile phone for patient use (Ross Memorial, Dingwall).
- Telephone points in all rooms (Edington Cottage Hospital, North Berwick).
- Mobile phone available (Kirkcudbright Cottage Hospital).
- Mobile phone trolley available (Glenrothes Hospital).
- Mobile phone available in all rooms (Turriff Community Hospital).

Other comments

- Have a discreet Macmillan unit for palliative care (Balfour Hospital, Kirkwall).
- Space is at a premium in community hospitals, more is required (Adamson Hospital, Cupar).
- Plug point in all rooms for phone, no folding bed in patient's rooms (Moffat Hospital).
- One single room with basin but no toilet (Lady Home Hospital, Douglas).
- Hospital may close in future as some services move into primary care, situation of inpatients will then be reviewed (Montrose Royal Infirmary).
- Two single rooms but no toilet, trolley phone for patients (Lockhart Hospital, Lanark).
- Dedicated palliative care suite with toilet and two further single rooms in unit. Also need to use acute GP beds for palliative care. Mobile phone and long cord phone available (Brechin Infirmary).
- Two electric reclining chairs, adjustematic bed, TV and radio/CD, ceiling fan and light dimmer (Stephen Cottage Hospital, Dufftown).

Day care facilities

One quarter of hospitals surveyed stated that they had day care facilities for patients requiring palliative care (25%) (table 19).

Table 19: Do you have day care facilities for patients requiring palliative care?

	n	%
Yes	15	25
No	44	73
Did not respond	1	2
Total	**60**	**100**

Respondents who stated that their hospital did have day care facilities were asked to describe them briefly:

- Respite, chemotherapy, symptom control, emotional support, massage and aromatherapy available (Balfour Hospital, Kirkwall).
- Can cater for up to eight patients daily Monday-Thursday, Cancer Care drop-in day on Friday (Dunoon and District Hospital).
- Patients can attend on a daily basis for treatment (East Airdrie Community Hospital).
- Day care facilities not officially recognised as such but patients can attend for different treatments such as blood transfusions (Spynie Hospital).
- No separate facilities but day treatment such as calcium-reducing drugs and blood transfusions can be provided (Blairgowrie Cottage Hospital).
- Have four day places available but have not had palliative care patients to date (Aberfeldy Cottage Hospital).
- Use palliative care suite for day care if available (Leanchoil Hospital).
- Day care facility not up and running at present, occasionally patients come in to be bathed (Kincardine Community Hospital).
- Day care facilities four days/week (Insch War Memorial Hospital).

Equipment available on site

All of the hospitals surveyed had syringe drivers, suction, oxygen, nebulisers, and electric fans on site (table 20). Nearly all hospitals had pressure-relieving equipment (98%) and recliner chairs (93%) on site and most had TENS machines (85%) and electric heating pads (68%).

Table 20: What equipment is available on site?

	Yes		No		Did not respond		Total	
	n	%	n	%	n	%	n	%
Syringe drivers	60	100	–	–	–	–	60	100
Suction	60	100	–	–	–	–	60	100
Oxygen	60	100	–	–	–	–	60	100
Nebuliser	60	100	–	–	–	–	60	100
Electric fan	60	100	–	–	–	–	60	100
Pressure-relieving equipment	59	98	1	2	–	–	60	100
Recliner chairs	56	93	4	7	–	–	60	100
Electric heat pad	41	68	15	25	4	7	60	100
TENS machine	51	85	9	15	–	–	60	100
Other	16	27	–	–	44	73	60	100

Other equipment available on site for treatment of palliative care patients included: Jacuzzi, steamer and microwave heat pads, hoists and other lifting equipment, electric split beds, acupuncture, Flowtron, feeding pumps, volumatic infusion devices, hi/low bathing equipment and portable backrests.

5.1.5 COMMUNICATION AND LIAISON WITH OTHER SERVICES

Location of nearest in-patient hospice

The majority of community hospitals had an in-patient hospice situated between 21 and 40 miles away (41%) (table 21). Three hospitals had an in-patient hospice on site; two of the island hospitals had hospices located more than 100 miles away on the mainland (Uist and Barra Hospital and Islay Hospital)

Table 21: How far is it to your nearest in-patient hospice?

	n	%
On site	3	4
Less than 10 miles	3	4
11-20 miles	13	23
21-40 miles	23	41
41-60 miles	9	16
61-90 miles	3	4
More than 90 miles	3	4
Did not respond	3	4
Total	60	100

Access to 24-hour advice from specialist palliative care services

The majority of community hospitals had access to 24-hour advice on patient care from specialist palliative care services (83%) (table 22).

Table 22: Does your hospital have access to 24 hour advice on patient care from specialist palliative care services?

	n	%
Yes	50	83
No	10	17
Total	60	100

Approximately 70% of respondents who answered 'yes' stated that they could obtain 24-hour advice on patient care from their nearest hospice (72%). Other sources of advice included: Macmillan nurses, hospital oncology consultants, specialist advice available on site.

Professional visits to hospital

Respondents were asked how often people made professional visits to their hospital. Regular routine visits were defined as either ward rounds, case conferences, clinics, or multi-disciplinary meetings.

Primary health care team

GPs made regular routine visits to all of the community hospitals except one (98%) (table 23).

Table 23: How often do GPs visit your hospital?

	n	%
Regular routine visits	59	98
Visit only when asked	1	2
Never visit	0	0
Total	60	100

Half of the hospitals (50%) received regular routine visits from community nurses (table 24).

Table 24: How often do community nurses visit your hospital?

	n	%
Regular routine visits	30	50
Visit only when asked	29	48
Never visit	1	2
Total	60	100

Other members of the primary health care team made regular routine visits to 7% of the hospitals surveyed and visits when asked to 5% (table 25). These included: dentist, optician, health visitors, specialist nurses e.g. continence nurse, and mental health team.

Table 25: How often do other members of the primary health care team visit your hospital?

	n	%
Regular routine visits	3	7
Visit only when asked	4	5
Did not respond	53	88
Total	60	100

Specialist palliative care services

The majority of community hospitals received visits from a specialist palliative care consultant when requested (67%) (table 26).

Table 26: How often does a consultant in palliative care visit your hospital?

	n	%
Regular routine visits	2	3
Visit only when asked	40	67
Never visit	16	27
Did not respond	2	3
Total	60	100

The majority of hospitals (63%) received visits from a Macmillan Nurse or Nurse Specialist upon request (table 27).

Table 27: How often does a Macmillan Nurse or Nurse Specialist visit your hospital?

	n	%
Regular routine visits	21	35
Visit only when asked	38	63
Never visit	1	2
Total	60	100

Social worker

Forty-two percent of hospitals received regular routine visits from a social worker (table 28).

Table 28: How often does a social worker visit your hospital?

	n	%
Regular routine visits	25	42
Visit only when asked	35	58
Total	60	100

Related professional services

Most hospitals surveyed received regular routine visits from physiotherapists (90%) and occupational therapists (85%) (table 29). Approximately half of the hospitals received routine visits from pharmacists (57%) and chiropodists/podiatrists (50%).

Table 29: How often do PAMs visit your hospital?

	Regular routine		When asked		Never visit		Did not respond		Total	
	n	%	n	%	n	%	n	%	n	%
Physiotherapy	54	90	4	7	–	–	2	3	60	100
Occupational therapy	51	85	7	12	–	–	2	3	60	100
Dietetic services	25	42	32	53	2	3	1	2	60	100
Chiropody/podiatry	30	50	28	47	–	–	2	3	60	100
Pharmacy	34	57	19	32	5	8	2	3	60	100
Counsellor/CPN/ psychologist	12	20	43	72	5	8	–	–	60	100
Other	1	2	3	5	–	–	56	93	60	100

Four hospitals stated that they received regular routine visits or visits when requested from other related professional services: speech and language therapists, dentist, CPN and geriatrician.

Complementary therapists

More than half of the hospitals never received visits from complementary therapists (table 30). Five percent of respondents stated that their hospital received regular routine visits from acupuncturists and 3% from aromotherapists and reflexologists.

Table 30: How often do complementary therapists visit your hospital?

	Regular routine		When asked		Never visit		Did not respond		Total	
	n	%	n	%	n	%	n	%	n	%
Aromatherapy	2	3	18	30	33	55	7	12	60	100
Reflexology	2	3	13	22	36	60	9	15	60	100
Dietetic services	5	42	32	53	2	3	1	2	60	100
Acupuncture	3	5	21	35	32	53	4	7	60	100
Other	2	3	7	12	–	–	51	85	60	100

Nine hospitals stated that they received regular routine visits or visits when requested from other complementary therapists: hypnotherapist, homeopathist, Reiki practitioner and pet therapist.

Approximately half of the hospitals surveyed had staff trained in complementary therapy (table 31).

Table 31: Staff trained in complementary therapy?

	n	%
Yes	32	53
No	19	32
Did not respond	6	10
Total	**60**	**100**

Four respondents commented that although some hospital staff were trained in complementary therapies, trust protocols did not allow them to administer complementary therapy to hospital patients.

One quarter of hospitals (25%) received regular routine visits from individual volunteers and 43% from representatives of voluntary organisations (table 30). These included League of Friends volunteers (18 hospitals), WRVS (13 hospitals), Red Cross (9 hospitals), Crossroads (1 hospital), Therapet (1 hospital), Pat a Dog (1 hospital), Cruise (1 hospital).

Table 32: How often do voluntary organisations visit your hospital?

	Regular routine		When asked		Never visit		Did not respond		Total	
	n	%	n	%	n	%	n	%	n	%
Individual volunteers	15	25	7	12	18	30	20	33	60	100
Voluntary organisations	26	43	11	18	13	22	10	17	60	100

All of the hospitals except one stated that they received regular routine visits or visits when requested from the clergy/minister of faith (98%) (table 33).

Table 33: Do members of the clergy/ministers of faith visit your hospital?

	n	%
Yes	59	98
Did not respond	1	2
Total	**60**	**100**

More than half of the hospitals surveyed stated that they received visits from a Church of Scotland minister either routinely or upon request (table 34).

Table 34: Denomination of spiritual support?

	n	%
Church of Scotland minister	32	54
Church of England minister	4	7
Catholic priest	21	36
All denominations	12	20
Hospital chaplain	21	36
Patient's own	5	8
Other	7	12

N.B. Respondents were able to name more than one denomination providing spiritual support in their hospital.

'Other' included Episcopalian, Salvation Army, Baptist, Presbyterian, Free Church of Scotland, and Protestant minister.

5.1.6 PRIORITIES

Respondents were asked to identify their top three priorities for advancing the standard of palliative care provision in their hospital. The three priorities that were identified most frequently were: increased education and training of staff (33%); improved community hospital accommodation and facilities for patients and relatives/carers (20%); and increased specialist palliative care support (14%) (table 35).

Table 35: Priorities for advancing standard of palliative care locally

	n	%
Increased education and training of staff	53	33
Improved community hospital accommodation and facilities for patients and relatives	32	20
Increased specialist palliative care support	14	6
More multidisciplinary approach to palliative care	7	4
Introduction of alternative/complementary therapies	6	4
Day care facilities	4	3
Designated palliative care beds	3	2
Provision of more equipment	3	2
Effective palliative care policy and guidelines	3	2
Improved pain control	3	2
Audit of service to ensure improvement	3	2
Other	33	20
Total	**163**	**100**

N.B. Not all of the respondents suggested three priorities.

Other priorities that were identified included: further development of chemotherapy service so that patients do not have to travel to Glasgow for treatment; reliable bed availability at all times; easier access to palliative care services for patients and relatives; more nursing interventions and improved bereavement care; better communication with Macmillan nurses; provision of adequate staffing levels; 24-hour community outreach palliative care service; regular monthly visit from member of hospice staff; comparable resources for funding palliative and terminal care in hospices and community hospitals; care offered closer to patient's home; greater input of PAMs; telemedicine link with palliative care consultants; improved transport for patients to hospital; more consistent approach from visiting GPs; not providing patients with palliative and therapeutic interventions concurrently; improved communication with secondary care.

5.1.7 Good practice

Forty-two percent of respondents felt that their hospital had innovative ways of supplying palliative care services or current pilots/initiatives in this area (table 36).

Table 36: Do you have any innovative ways of supplying palliative care services or current pilots/initiatives in this area?

	n	%
Yes	25	42
No	7	12
Did not respond	29	46
Total	60	100

Respondents who answered 'yes' were asked to briefly describe these initiatives:

Multi-disciplinary working

- Regular meetings of the primary care groups, three groups get together to look at policies and protocols and re-evaluating. Patients requiring palliative care given priority re admission to ward. Close working with carers which is extremely important (Spynie Hospital).
- Weekly multidisciplinary meetings, close links between hospital and Primary health care trust. Auxiliaries attend St Columba's hospice for training (Coldstream Cottage Hospital).
- Very close working team as GPs, community staff, OTs, social work department and care management team all located in same building providing good continuity of care to patient and relatives. Good support form Marie Curie and Macmillan nurses (Turriff Cottage Hospital).
- LHCC courses (Campbell Hospital, Portsoy).
- Multidisciplinary care plans in patient-held documentation; hospital booklet; named nurse initiative; de-briefing exercise for nursing staff after death of patient; bereavement pack (Sister Margaret Cottage Hospital, Jedburgh).
- Palliative care group set up comprising GPs, nurses, ancillary and community staff (Leanchoil Hospital, Forres).

Training

- Clinical development nurse ensures that all of staff are appropriately trained and regularly updated about palliative care issues e.g. syringe drivers, symptom control, patient choice. Seminars every six months by specialists from different areas about palliative care issues (Glen O'Dee Hospital, Banchory).
- LHCC palliative care cancer group run courses (4 evenings), attempt to supply continuing education (Chalmers Hospital, Banff).
- Link nurse training and Macmillan support nurse training with Wishaw General Hospital (Lockhart Hospital, Lanark).
- Chemotherapy training for nurses (cannula use, administration of cytotoxic drugs) began in June 2001 (Uist and Barra Hospital).
- Palliative care course set up in conjunction with Highland Hospitals-6 weeks in February/March 2002 for local GPs and community hospital staff (Ian Charles Cottage Hospital, Grantown on Spey).

Location of death

- Dying at home service provided involving hospital staff (Kirkcudbright Cottage Hospital).
- Flexibility about where patients die (at home or in hospital) (Town and Country Hospital, Nairn).

Other comments

- Have been the driving force along with the Cowal Hospice Trust in getting a hospice in this area, sister in charge would like to develop hospice at home service in the future (Dunoon and District Hospital).
- Try to work through the Cancer Strategy and how to involve the financial advisory service and take a holistic approach (Lawson Hospital, Golspie).
- We feel that the availability of care at the community hospital encourages carers to provide care at home (Aberfeldy Cottage Hospital).
- Pilot currently being undertaken looking at the role of the community hospital as a model for palliative care (Inverurie Cottage Hospital).
- About to be part of a pilot audit by Scottish Office (run by Borders General Hospital) to look at pain control (Kelso Cottage Hospital).
- Tele-medicine training through Roxburghe House (Jubilee Cottage Hospital, Huntly).
- Networking in rural areas (Victoria Hospital, Rothesay).
- GP in area has palliative care website (Hawick Cottage Hospital).
- Nurse-led admissions; has accreditation for care of the dying; audit every 3 months by cancer care nurse adviser (Davidson Hospital, Girvan).
- Re-design project going on for past two years; qualitative survey carried out by Paisley University, acting on some of their recommendations at present (Campbelltown Hospital).
- Standardising palliative care guidelines across all Moray community hospitals (Stephen Cottage Hospital, Dufftown).

5.1.8 POLICIES AND GUIDELINES

The majority of community hospitals had written policies or guidelines relating to symptom control in palliative care patients (70%) (table 37).

Table 37: Do you have any written policies and/or guidelines that apply to symptom control in palliative care patients?

	n	%
Yes	42	70
No	18	30
Total	60	100

Respondents who had stated that they had written policies and/or guidelines relating to symptom control were asked to specify which symptoms. 65% of respondents had written policies and/or guidelines for pain, 60% for constipation, 55% for nausea and 50% for breathlessness (table 38). Seven respondents (12%) stated that they had written policies or guidelines that apply to management of other symptoms.

Table 38: Written policies and/or guidelines that apply to management symptom management.

	Yes		No		Total	
	n	%	n	%	n	%
Breathlessness	30	50	30	50	60	100
Pain	39	65	21	35	60	100
Nausea	33	55	27	45	60	100
Constipation	36	60	24	40	60	100
Other	7	12	53	88	60	100

Respondents who stated that they had other written policies and/or guidelines specified the following:

- Chemotherapy; extravasation; syringe driver (Balfour Hospital, Kirkwall).
- Communication; patient advice; guidelines for using extra staff; oral care (Spynie Hospital).
- Written syringe driver protocol for nursing staff (Kelso Cottage Hospital).
- Information and SIGN guidelines via Macmillan (Forfar Infirmary).
- Palliative care manual from Glasgow Royal Infirmary (Campbelltown Hospital).
- Scottish partnership agency booklet for palliative and cancer care (Lockhart Hospital, Lanark).
- Controlled drug procedure 'Guidelines to good practice – Grampian' (Glen O'Dee Hospital, Banchory).

Policies/guidelines applying to other aspects of palliative care

More than half of the community hospitals contacted had written policies and/or guidelines for discharge planning (55%) and approximately one third (33%) had policies relating to contacting social services (table 39).

Table 39: Written policies and/or guidelines that apply to other aspects of palliative care.

	Yes		No		Total	
	n	%	n	%	n	%
Patients from black and ethnic minorities	6	10	54	90	60	100
The use of volunteers	15	25	45	75	60	100
The use of complementary therapies	8	13	52	87	60	100
Shared care	8	13	52	87	60	100
Bereavement support	18	30	42	70	60	100
Discharge planning	33	55	27	45	60	100
Contacting a patient's minister/spiritual advisor	18	30	42	70	60	100
Contacting social services	20	33	40	67	60	100
Admitting patients with conditions other than cancer for palliative care	15	25	45	75	60	100
Patient needs assessment	26	43	34	56	60	100

Thirty percent of hospitals which responded to the questionnaire had written policies or guidelines that apply to carer needs assessment (table 40).

Table 40: Written policies and/or guidelines that apply to carer needs assessment?

	n	%
Yes	18	30
No	42	70
Total	**60**	**100**

When asked to specify who carries out the carer needs assessment, the answers included: nursing staff; community services; district nurse; palliative care nurse liaises with patient and carer; nursing staff, OT and physiotherapist; social services; health and social service personnel; nursing staff and community nurses; OT and social services; nurses and OTs, discharge planning co-ordinator and social work care manager; district nurse, Macmillan nurse and social care; care manager and social work; and 'multidisciplinary'.

One third of hospitals had written policies/guidelines that relate to mechanisms for continuous monitoring and audit (33%) (table 41).

Table 41: Written policies and/or guidelines that apply to mechanisms for continuous monitoring and audit?

	n	%
Yes	20	33
No	40	67
Total	**60**	**100**

These respondents were asked to identify any audits that they had undertaken which had included aspects of palliative care:

- Recent audit at St Margaret's Hospital, Auchterarder had shown that 85% of patients registered at GP practice died either at home or in the community hospital.
- An audit on transdermal patches had been carried out by Moffat Hospital.
- Forfar Infirmary had audited the nutritional status of palliative care patients.
- Pain control audit undertaken by district nursing sister at Montrose Royal Infirmary.

5.1.9 – FUNDING

More than half of the hospitals that took part in the survey stated that they had received additional funding for palliative care facilities from a League of Friends (57%) (table 42).

Table 42: Additional funding for palliative care facilities

	Yes		No		Total	
	n	%	n	%	n	%
Macmillan	16	27	44	73	60	100
League of Friends	34	57	26	43	60	100
Marie Curie	4	7	56	93	60	100
National Lottery	–	–	–	–	–	–
Other	17	28	43	72	60	100

Twenty-eight respondents (46%) indicated that they had received additional funding from other sources which included: Orkney Health Board; Coal hospice trust; Spynie Care Group and Cancer Care Support Group, Cancer Link Buckie, Thomas Davidson Trust, New Opportunities funding, Lippencare, RAF Kinloss; Palliative Care Group and private donations.

Eight percent of community hospitals had received recurring costs rather than only capital (table 43).

Table 43: Have any of these funding bodies provided any recurring costs rather than only capital costs?

	n	%
Yes	5	8
No	40	67
Did not respond	15	25
Total	60	100

Respondents were asked to give further details if these recurring costs included palliative care patients. Cowal hospice trust operates in partnership with Argyll and Bute Primary Care Trust and provides recurring costs in addition to a volunteer travel service (Dunoon and District Hospital) and Moray LHCC has provided money for palliative care courses when no other funding has been available (Leanchoil Hospital). Macmillan have provided funding for training a Macmillan nurse who is community-based but provides clinical advice to hospital staff and keeps in touch with patients (Islay Hospital).

5.1.10 OTHER COMMENTS

Twenty-nine (49%) respondents had further comments concerning palliative care in their community hospital which were recorded at the end of the questionnaire.

A number of respondents felt that whilst palliative care provision was good or adequate in their hospital, there was room for improvement. Suggestions for particular areas of improvement in relation to palliative care included developing multidisciplinary holistic practices particularly complementary therapies.

One respondent commented that it is necessary to advance palliative care by working jointly with their LHCC and other community hospitals to develop policy and joint education initiatives rather than working on an individual basis.

A minority of respondents felt that their facilities were inadequate and could not cater for the number of palliative care patients who wished to die in the community.

Community hospitals in remote rural areas were identified as having particular problems. One respondent felt that sharing palliative care provision with other areas could help to support patients who were geographically isolated. One respondent from a remote community hospitals felt that the demand for palliative care in their area was mainly catered for on a domiciliary basis by GPs and community nursing teams.

One respondent expressed enthusiasm for the survey and felt that it had stimulated ideas for improving practice locally.

5.2 COMPARISON OF HOSPITALS ACCORDING TO BED NUMBER

There were no significant differences between hospitals based on numbers of acute GP beds, designated palliative care beds and total bed numbers for any of the areas addressed by the questionnaire using chi squared analysis.

6 DISCUSSION

The majority of community hospitals responded to the questionnaire, resulting in a good response rate of 88%. The aim of this study was to provide an overview of across Scotland. This report should provide an accurate reflection of the staffing levels, services and facilities for palliative care provision in community hospitals at the time of this study (December 2001) due to the participation the majority of community hospital identified when the project proposal was first drawn up in December 1999.

The intention at the outset of this study had been to conduct interviews with a representative from each community hospital by telephone. Although some respondents chose to return questionnaires by post due to time constraints, seventy percent of the questionnaires were completed by telephone. This allowed the interviewer to probe for more information from respondents where necessary and clarify any queries which arose immediately. However, attempting to make appointments to speak with the lead GP of each community hospitals was complicated and time consuming in many cases and often involved a number of telephone calls. Although over two thirds of the questionnaires were completed by the community hospital lead GP or another member of the hospital medical staff, in many cases the answers to questions were the result of the combined input of medical and nursing staff.

7 CONCLUSIONS

7.1 COMPLEMENT OF NURSING STAFF

Most of the nursing staff employed in the community hospitals which participated in the survey were A, D and E grade. Only two of the hospitals employed I grade nurses and 38 of the 60 hospitals employed between 2.1 and 53.6 WTE nurses on a part-time basis.

7.2 STAFF PALLIATIVE CARE TRAINING AND EXPERTISE

7.2.1 Nursing staff

Fifty percent of the hospitals which participated in this study currently employed nursing staff who had received post registration training in palliative care and 45% of hospitals had nursing staff with post registration training which may be nationally accredited. Fifty-seven percent of hospitals employed nursing staff who had had previous work experience in palliative care.

7.2.2 Medical staff

Approximately three quarters of community hospitals (78%) had doctors admitting to the hospital with an interest in palliative care. Nine hospitals (15%) had doctors who possess a Diploma in Palliative Care Medicine and eight hospitals (13%) had doctors with post registration training in palliative care which may be nationally accredited.

7.3 PALLIATIVE CARE CONTINUING EDUCATION

Continuing education in symptom control was provided in the community hospital or nearby for 83% of nursing staff and 57% of medical staff. Over three quarters of hospitals provided nursing staff with continuing education on the use of equipment (86%) and bereavement support (70%). Continuing education on communication skills was provided by sixty-two percent of hospitals for nursing staff and approximately half of the hospitals surveyed provided nursing staff with continuing education on team working. The majority of hospitals did not provide continuing education on the use of equipment, bereavement support, communication skills or team working for other staff (volunteers, ancillary staff and therapists/pharmacists).

7.4 FACILITIES

7.4.1 Accommodation

The majority of community hospitals (68%) had a total of 20 beds or less. Nearly all of the hospitals surveyed (98%) had at least one acute GP bed and 38% of hospitals had at least one designated palliative care bed.

Forty percent of community hospitals surveyed had no single rooms with a toilet, basin and a shower or bath and 25% of hospitals had no single rooms with a toilet and basin. Thirty-seven percent of hospitals did not have any single rooms with a folding bed in the patient's room for a relative/carer and nearly half of the hospitals did not have rooms for patients with a private telephone.

The majority of hospitals had a quiet room for relatives and carers and/or patients (68%), a private telephone available but not in the patient's room (63%) and facilities for preparing drinks and snacks without interrupting nursing staff (60%). Fifty-three percent of hospitals surveyed had a separate overnight room available where relatives/carers could stay.

7.4.2 Day care facilities

Twenty-five percent of hospitals surveyed had day care facilities for patients requiring palliative care.

7.4.3 Equipment

All of the hospitals who responded to the questionnaire had syringe drivers, suction, oxygen, nebulisers and electric fans available on site. Nearly all hospitals had pressure-relieving equipment (98%) and recliner chairs (93%) on site and most had TENS machines (85%) and electric heating pads (68%).

7.5 COMMUNICATION WITH OTHER SERVICES

Three community hospitals had an in-patient hospice on site and the majority had a hospice situated between 21 and 40 miles away (41%). Eighty-three percent of hospitals stated that they had access to 24-hour advice on patient care from specialist palliative care services.

GPs made regular routine visits to all hospitals except one (98%) and 50% of hospitals received regular routine visits from community nurses. Most hospitals received regular routine visits from physiotherapists (90%) and OTs (85%). The majority of hospitals received a visit when requested from a consultant in palliative care (67%) and Macmillan nurses or nurse specialists (63%). Approximately half of the hospitals surveyed received regular routine visits from pharmacists (57%) and chiropodists/podiatrists (50%) and less than half were visited routinely by a social worker (42%).

More than half of the community hospitals never received visits from complementary therapists. One quarter of hospitals were visited on a regular routine basis by individual volunteers and 43% by representatives of voluntary organisations. All hospitals except one (98%) stated that they received either regular routine visits or visits upon request from the clergy/minister of faith.

7.6 PRIORITIES

The top three priorities for advancing the standard of palliative care provision identified by representatives of community hospital staff were: increased education and training of staff; improved accommodation and facilities for patients and relatives/carers; and increased specialist palliative care support.

7.7 GOOD PRACTICE

Forty-two percent of respondents felt that their hospital had innovative ways of supplying palliative care services or had current pilots/initiatives being undertaken in this area.

7.8 POLICIES AND GUIDELINES

Seventy percent of hospitals had written policies and/or guidelines relating to symptom control in palliative care patients: pain (65%); constipation (60%); nausea (55%); and breathlessness (50%).

Fifty-five percent of community hospitals had written policies and/or guidelines for discharge planning and 43% had policies relating to patient needs assessment. Less than one quarter of hospitals had written policies and/or guidelines relating to: use of complementary therapies (13%); shared care (13%) and patients from black and ethnic minorities (10%).

7.9 FUNDING

Fifty-seven percent of hospitals which participated in this study had received additional funding for palliative care facilities from their local League of Friends, 27% from Macmillan, 7% from Marie Curie and 28% from other sources.

7.10 Further comments

Nearly half of respondents (49%) made further comments concerning palliative care in their community hospital. A number of respondents felt that whilst palliative care provision was good or adequate in their hospital, there was room for improvement. Suggestions for particular areas of improvement included developing multidisciplinary holistic practices in relation to palliative care, particularly complementary therapies.

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Alison Hinds PhD
Senior Researcher
4 June 2002

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APPENDIX 1: QUESTIONNAIRE

The provision of palliative care in community hospitals

PROFILE OF COMMUNITY HOSPITALS

Please do not return this questionnaire to CHSR. A researcher will telephone you to arrange a convenient time to complete the questionnaire by telephone.

Name of Hospital: ....

Questionnaire answered by: .... Date: ....

Job Title: ....

Qualifications: ....

1. **Staffing – All nursing staff**

What is the nursing establishment (including health care assistants) in the IN-PATIENT WARDS at your hospital?

Please enter numbers as per example:

	Grade (or equivalent)	Whole Time Equivalents (WTE)	Current vacancies (as WTE)
Example		☐☐.☐	☐☐.☐
Nurses	I	☐☐.☐	☐☐.☐
	H	☐☐.☐	☐☐.☐
	G	☐☐.☐	☐☐.☐
	F	☐☐.☐	☐☐.☐
	E	☐☐.☐	☐☐.☐
	D	☐☐.☐	☐☐.☐
Health Care Assistants (HCAs)	C	☐☐.☐	☐☐.☐
	B	☐☐.☐	☐☐.☐
	A	☐☐.☐	☐☐.☐

How many nursing staff are employed part-time? WTE

2. Staffing – clinical staff with palliative care training/expertise

2.1 Nursing Staff

Have any of your qualified nurses had post registration training in palliative care?

☐ Yes ☐ No ☐ Don't know

If yes, how many? ....

Please comment ....

....

....

Have they got a qualification?

☐ Yes ☐ No ☐ Don't know

If yes, how many?

Which qualification? ....

Have any of your qualified nurses had post registration training in palliative care which may be nationally accredited?

☐ Yes ☐ No ☐ Don't know

If yes, how many and what? ....

....

Do any of your qualified nurses have previous work experience in palliative care?

☐ Yes ☐ No ☐ Don't know

If yes, how many? ....

2.2 Doctors

Do any of the doctors who admit to your hospital have an interest in palliative care?

☐ Yes ☐ No ☐ Don't know

If yes, how many? ....

How many of these doctors also possess a Diploma in Palliative Medicine?

☐ Yes ☐ No ☐ Don't know

If yes, how many? ....

Have any of the doctors who admit to your hospital had in house post registration training in palliative care which may be nationally accredited?

☐ Yes ☐ No ☐ Don't know

If yes, how many? ....

How many General Practices admit to your hospital?

Number of practices ☐☐

Number of GPs ☐☐

3. Education

3.1 Is there any continuing education in palliative care in your hospital or nearby?

☐ No – please go to question 4

☐ Yes – please complete the next section

3.2 What is currently provided in terms of continuing education in palliative care in your hospital or nearby?

Please tick all that apply.

	Nursing staff	Medical staff	Volunteers	Ancillary Staff	Therapists* & pharmacist
Symptom control	☐	☐	☐	☐	☐
Communication skills	☐	☐	☐	☐	☐
Team working	☐	☐	☐	☐	☐
Bereavement support	☐	☐	☐	☐	☐
Use of equipment (e.g. syringe drivers)	☐	☐	☐	☐	☐
Other (please specify)	☐	☐	☐	☐	☐

....

*i.e. Occupational therapists, physiotherapists etc.

4. Facilities – Accommodation and Equipment

4.1 How many beds do you have?

	Number
Acute GP	☐☐
Designated palliative care beds*	☐☐
All beds (include acute GP, palliative care designated and any others)	☐☐

*Designated palliative care beds are defined as single rooms which have been funded specifically for palliative care.

4.2 What facilities do you have?

Please put the numbers of rooms in the boxes

	All beds	*Designated palliative care beds (if any)
Single rooms with toilet and basin only	☐☐	☐☐
Single rooms with toilet, basin & shower/or bath	☐☐	☐☐
Sleeping facilities for relatives/carers: folding bed in patient's room	☐☐	☐☐
Private telephone in patient's room	☐☐	☐☐

Please tick yes or no

	All beds		*Designated palliative care beds (if any)	
	Yes	No	Yes	No
Sleeping facilities for relatives/carers: separate overnight room	☐	☐	☐	☐
Private telephone available for relatives/carers: not in patient's room	☐	☐	☐	☐
Tea/coffee/snack making facilities for relatives/ carers (without interrupting nursing staff)	☐	☐	☐	☐
Quiet room for relatives & carers and/or patients	☐	☐	☐	☐

If necessary, please add any additional comments regarding your local situation here.

....

....

....

4.3 **Do you have Day Care Facilities for patients requiring palliative care?**

☐ Yes

☐ No

If yes, please describe briefly ....

....

4.4 **What equipment is available on site?**

Please tick yes or no and enter time taken to obtain.

	Available on site		If not on site, how long does it take to obtain	
	Yes	No	Hours	Mins
Syringe drivers	☐	☐	☐	☐
Suction	☐	☐	☐	☐
Oxygen	☐	☐	☐	☐
Nebuliser	☐	☐	☐	☐
Electric fan	☐	☐	☐	☐
Pressure relieving equipment, mattresses, cushions	☐	☐	☐	☐
Recliner chairs	☐	☐	☐	☐
Electric heat pad	☐	☐	☐	☐
TENS machine	☐	☐	☐	☐
Other (please specify)	☐	☐	☐	☐

....

5. Communication and liaison with other services

How far is it to your nearest inpatient hospice?

Number of miles:

Does your hospital have access to 24 hour advice on patient care
from SPECIALIST PALLIATIVE CARE SERVICES?

☐ Yes

☐ No

If yes, please describe briefly ....

Do any of the following people make professional visits to your hospital on a regular basis?

*Regular routine visits can be ward rounds, case conferences, clinics, multi-disciplinary meetings etc.

Please tick ONE box for each type of service.

		Never visit	Visit only when asked	Regular routine visits*
5.1	**Primary Health Care Team**			
	GPs	☐	☐	☐
	Community nurses	☐	☐	☐
	Other (please specify)	☐	☐	☐
	....			
5.2	**Specialist Palliative Care Services**			
	Consultant in Palliative Care	☐	☐	☐
	Macmillan Nurse or Nurse Specialist	☐	☐	☐
5.3	**Social Work**			
	Social worker	☐	☐	☐
5.4	**Related Professional Services**			
	Physiotherapy	☐	☐	☐
	Occupational Therapy	☐	☐	☐
	Dietetic Services	☐	☐	☐
	Chiropody/Podiatry	☐	☐	☐
	Pharmacy	☐	☐	☐
	Counsellor/Psychologist/ CPN	☐	☐	☐
	Other (please specify)	☐	☐	☐
	....			
5.5	**Complementary Therapists**			
	Aromatherapy	☐	☐	☐
	Reflexology	☐	☐	☐
	Acupuncture	☐	☐	☐
	Other (please specify)	☐	☐	☐
	....			

Are any hospital staff trained in complementary therapy?

☐ Yes ☐ No ☐ Don't know

		Never visit	Visit only when asked	Regular routine visits*
5.6	**Voluntary Organisations**	☐	☐	☐
	Individual volunteers	☐	☐	☐
	Voluntary organisations			

Please list here ....

....

		Never visit	Visit only when asked	Regular routine visits*
5.7	**Spiritual Support**			
	e.g. Clergy/ministers of faith – please specify all options			
	1.	☐	☐	☐
	2.	☐	☐	☐
	3.	☐	☐	☐
	4.	☐	☐	☐

6. Priorities

What do you perceive to be your top three priorities to advance the standard of palliative care provision in your hospital?

1. ....

....

....

2. ....

....

....

3. ....

....

7. Good Practice

Do you have any innovative ways of supplying palliative care services or have any current pilots or initiatives in this area? If yes, please could you supply brief details and forward copies of relevant documents, if available, to CHSR in the FREEPOST envelope provided.

....

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....

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8. Policies and Guidelines

Do you have any WRITTEN policies and/or guidelines relating to Palliative Care in your hospital?

Please tick all that apply and forward a copy if available to CHSR in the FREEPOST envelope provided.

- ☐ Symptom control. If yes, which symptoms:
  - ☐ Breathlessness
  - ☐ Pain
  - ☐ Nausea
  - ☐ Constipation
  - ☐ Other (please specify) ....
- ☐ Patients from black and ethnic minority groups
- ☐ The use of volunteers
- ☐ The use of complementary therapies
- ☐ Shared care
- ☐ Bereavement support
- ☐ Discharge planning
- ☐ Contacting a patient's minister/spiritual advisor [omit on admission]
- ☐ Contacting social services [omit on patients admission]
- ☐ Admitting patients with conditions other than cancer for palliative care
- ☐ Patient needs assessment: If yes who carries out assessment?

  ....
- ☐ Carer needs assessment: If yes who carries out assessment?

  ....
- ☐ Mechanisms for continuous monitoring and audit of the services you provide

  If yes, please describe briefly if your audit has included aspects of palliative care

  ....

  ....

  ....
- ☐ Other (please specify) ....

9. Funding

Have you received any additional funding for palliative care facilities?

Please tick those received.

- ☐ Macmillan
- ☐ League of Friends
- ☐ Marie Curie
- ☐ National Lottery
- ☐ Other (please specify) ....

Have any of these funding bodies provided any recurring costs (rather than only capital costs) for example, for additional recurring staffing?

- ☐ Yes
- ☐ No

If yes, please describe briefly if they include palliative care patients.

....

....

....

....

10. Comments

Please add any further comments you may have

Thank you for collecting this information. Please do not return the questionnaire to CHSR. A researcher will telephone you to arrange a convenient time to complete the questionnaire with them by telephone.

APPENDIX 2: COVERING LETTER

Dear

Stocktake of Provision of Palliative Care in Community Hospitals in Scotland

You may have been aware of the intention of the Scottish Association of Community Hospitals (SACH) to bid for funding from the New Opportunities Fund to do a "stocktake" of Palliative Care as part of the development of a Framework for Good Practice in Palliative Care in Community Hospitals (those with acute GP beds) in Scotland.

We are now delighted to let you know that we have succeeded in securing funding, announced in May 2001, and are now in a position to begin this project, in conjunction with partner agencies with an interest in Palliative Care.

The Stocktake is an important step, as only when we are aware of what is presently being done can plans be made for the future. No one at the moment knows exactly how much palliative care occurs in Community Hospitals; this research aims to find out, and is in response to the consistent pleas of those of us working in Community Hospitals throughout the country.

As the first of a series of research projects which the Association has been funded to undertake/commission into the work of our Community Hospitals, it will only succeed through your input, and we hope that you will be able to make time to take this opportunity to begin to bridge this gap in knowledge, by agreeing to participate in these projects.

The Centre for Health and Social Research (CHSR) have been commissioned by SACH to assess staffing, services and facilities currently available for provision of palliative care within community hospitals in Scotland. We are contacting you as the lead clinician for [name of community hospital] and enclose a questionnaire which outlines the information that we require.

We request that you fill in this questionnaire as fully as possible and appreciate that you may need to speak with other members of staff in order to answer some questions. Please do not return the questionnaire to us. A researcher from CHSR will be contacting you within the next few days and arranging a convenient time at which she can telephone you and complete the questionnaire with you. The telephone call should take 20-30 minutes and we would be most grateful if you could spare the time to speak with the researcher. We also enclose a Freepost envelope to enable you to send copies of any written policies, standards or guidelines for palliative care which you currently use (see questionnaire section 6).

The information that you give to us will be confidential and will not be linked with your name. This project is due to report back to SACH in December 2001. The results will be posted on the RARARI website and fed back to all participants by the SACH.

Many thanks in advance for your help with this work.

Yours sincerely

Dr Hamish Greig	Alison Hinds PhD
Chairman SACH	Senior Researcher CHSR

APPENDIX B

Extended Primary Care Teams:

- All Community Nursing and Professions Allied to Medicine.
- General Medical (and Dental whenever available) Practitioners.
- Community-based Pharmacists (NHS and commercial),
- Local optometrist (if possible).
- Community Hospital personnel including Leagues of Friends.
- Community Mental Health staff.
- Visiting Consultant colleagues to the Community
- Hospital/Primary Care.
- Social Work personnel.
- Voluntary Service personnel (paid & voluntary).
- Local Ambulance crew.

The Extended Primary Care Team and is generalist and holistic in nature. It places the person and his/her needs at the centre of the thinking and decision-making process. It seeks to provide for individual needs within the community as much as possible, and to secure appropriate specialist interventions as and when required, so that visiting consultant colleagues become part of the team at those times. This approach ensures that the exact team composition is dictated by the needs of the individual and is not hampered by artificial organisational constraints. The aim is to help people to maintain their independence whenever possible, but to arrange and provide suitable support when this is not possible.

Scottish Association of Community Hospitals Report from Annual Conference 2001, "Intermediate and Integrated Care" June 2002.

Intermediate Care

"Intermediate Care can be described as those services that do not require the resources of a general hospital but are beyond the scope of the traditional primary care team. This includes:

- Intermediate care which substitutes for elements of hospital care (substitutional).
- Intermediate care which integrates a variety of services for people whose health needs are complex and in transition (complex care)".

Source: Oxford and Anglia Intermediate Care Project, 1997

APPENDIX C

Regional Breakdown of Identified Needs – Training and Facilities

The completed questionnaires from the Stocktake (Appendix A) have been further analysed to give a general picture of two key areas for attention by NHS Boards, by Health Board area, in order to assist with planning. The two areas identified are:

- Training and education issues for various staff groups.
- Facilities for patients and relatives.

(Answers from hospitals within health board areas have been categorised as "adequate" or "inadequate", depending on the level of provision reported. For example, if a hospital's response to question 3.2 of the Stocktake questionnaire was that continuing education in symptom control, communications skills, use of equipment, team working and bereavement support was available to the nursing staff group, then this has been categorised as A: "adequate". If no provision is mentioned for other staff groups, for example for medical staff or volunteers, then this has been categorised as I: "inadequate". Figures indicate the incidence of each category in stocktake responses. NB. Not every hospital answered every question)

NHSBoard	Training						Facilities			
	Nurses		Doctors		Others		Patients		Relatives	
	A	I	A	I	A	I	A	I	A	I
Orkney	0	1	0	1	0	1	1	0	1	0
Western Isles	1	0	0	1	0	1	1	0	1	0
Tayside	4	4	1	7		8	2	6	1	7
Grampian	14	1	4	11	4	11	3	7	2	11
Highland	2	6	1	7	1	7	2	6	0	8
Fife	2	1	1	2	1	2	2	1	1	2
Ayrshire & Arran	3	3	1	5	2	5	2	4	0	6
Argyll & Clyde	1	3	1	3	1	3	1	3	0	4
Borders	3	4	1	6	3	4	2	5	1	6
Lothian	1	1	0	2	0	2	0	2	0	2
Dumfries & Galloway	2	3	0	5	0	5	2	3	1	4
Lanarkshire	3	1	1	3	0	3	1	2	2	2

Scottish Association of Community Hospitals
c/o Jedburgh Health Centre
Queen Street
JEDBURGH TD8 6EN
Tel: 01835 863361
email: sagpch@aol.com

Scottish Partnership for Palliative Care
1a Cambridge Street
EDINBURGH EH1 2DY

Tel: 0131 229 0538
email: office@palliativecarescotland.org.uk

Designed by dynam, Inverness.