ANGUS
Health & Social Care
Partnership

Adult Palliative & End of Life Care Plan

This plan has been developed in partnership with Lippen Care

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“How we die remains in the memory of those who live on”

(Dame Cicely Saunders)

Contents

ACKNOWLEDGEMENTS

Thank you to the Steering Group members (Appendix 1) who contributed to the development of this plan and to the Tayside Palliative and End of Life Care Network Data Sub-group for sharing the Regional Mortality Data Analysis information.

Foreword

Palliative and end of life care and support is everybody's business. All of us at some point will have a friend, a colleague or a family member who will have a progressive and/or advanced condition that is life limiting or life shortening. Everyone can help make a difference to the way people experience palliative and end of life care. Declining health, death, dying and bereavement are profound and universal human experiences. Though we have become very good at prolonging life, we still cannot prevent death. However, there are many ways we can improve people's experience of death, dying and bereavement [1].

Angus Health and Social Care Partnership and Lippen Care are committed to delivering the best palliative and end of life care and support that we can. We are delighted to be able to introduce this Plan which sets out our shared ambitions for the next three years and covers all aspects of palliative and end of life care provided to adults in Angus. Palliative and end of life care and support is not exclusively for people with cancer and can be appropriate for people living with chronic long term conditions. We recognise that everyone with palliative and end of life care needs regardless of their diagnosis is entitled to high quality care and support tailored towards their particular needs and preferences.

We have recognised this in the Angus Health and Social Care Partnership Strategic Commissioning Plan (2019-22) by focusing support on the development of communities that actively care; compassionate communities that recognise and support people at the end of life and in bereavement.

This plan reflects some of what is already delivered or underway in Angus and helps us to concentrate on areas we need to develop further. The plan will ensure that all people with palliative and end of life care needs, irrespective of their diagnosis, together with their close family and carers, are able to voice their wishes and preferences; and, as far as clinically appropriate and practically possible, these wishes and preferences are met. In addition staff supporting people with palliative and end of life care needs will have the necessary skills, knowledge and compassionate approach to care for people and those closest to them.

We would like to thank all those who have contributed to the development of this plan. This includes members of the public, people who provide care and support, and most importantly people with lived experience of palliative and end of life care.

Vicky Irons - Chief Officer, Angus Health and Social Care Partnership
Moira Nicoll - Chairperson, Lippen Care, Whitehills Health & Community Care Centre

Executive Summary

There is a lot of good work already taking place in Angus by people providing palliative and end of life care across a range of settings. We recognise that there is always more that can be done to improve people's experiences of palliative and end of life care. This plan aims to improve palliative and end of life care and support in Angus.

We engaged widely with members of the public, carers and our workforce* in developing this plan to ensure that individual experiences are at the heart of our work. We asked people what good palliative and end of life care looked like and a number of key themes emerged:

1. Compassionate & person centred care
2. Compassionate communication & conversations
3. Care closer to home
4. Getting it right for the family
5. Education & development for the workforce
6. Public health approaches to palliative and end of life care

We want to ensure that everyone in Angus who needs palliative and end of life care and support will have access to it. This plan outlines how we can ensure that people and their families have the care experience that they expect and that the staff are supported to care. This means that people with palliative and end of life care and support needs should receive the right care, by the right person, at the right time and in the right place.

An Action Plan has been developed that describes how and when the improvements linked to these themes will be delivered and how we will know that this plan has made a difference.

*Workforce includes our volunteers

Introduction

Angus Health & Social Care Partnership has a Strategic Commissioning Plan for 2019-2022 [2]. This adult palliative and end of life improvement plan progresses the vision by providing a more in-depth discussion on how we aim to improve palliative and end of life care and support.

OUR VISION

Working together, developing communities that actively care, promoting wellbeing and creating the best possible health and social care across Angus

MAKING A **DIFFERENCE**

This plan delivers the Scottish Government's plans set out in both the Palliative and End of Life Care Strategic Framework for Action [3] and the Strategic Guidance for Commissioning of Palliative and End of Life Care by Integration Authorities [4].

The evolving Action Plan demonstrates how we will improve the care and support, who this involves, how we will measure the impact of these improvements, and when this will be achieved.

For the purpose of clarity we provide the following definitions for the terms that are used in this plan:

Palliative care "is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or 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 patients 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.[5]" Palliative care is not synonymous with death and someone may have many years remaining in their life [6].

End of Life Care is a term that is being used more and more across the UK. Just like palliative care it includes physical, emotional, social and spiritual care but it is used to describe the needs of people thought to be in the last year of life [3].

The last days and hours of life is the final stage of a life limiting or life shortening illness leading to a person's death.

People in Angus with palliative and end of life care needs have access to a wide range of care and support as illustrated in Figure 1, Appendix 2. Although much has been achieved to support palliative and end of life care in Angus, we know that more needs to be done to ensure that everybody receives high-quality palliative and end of life care, at the right time, in the right place, by the right people with the right skills. We have used a collaborative and integrated approach, engaging with both the public and the health and social care workforce, identifying the services that we currently have available in Angus, the perceived gaps and the actions that require to be taken.

Palliative and end of life care and support is delivered by a diverse group of people and non-specialist services and staff. For example; Allied Health Professionals (e.g. Dietician, Occupational Therapist, Physiotherapist, Speech & Language Therapist), General Practioners and Hospital Doctors, Nurses, Pharmacists, Social Care & Social Service Workers, Volunteers, Faith Leaders, Families, Carers, Friends and Neighbours. The majority of care is provided in the community; in people's own homes or a homely setting. Care and support is also provided in other settings such as acute hospitals, community hospitals, and other community facilities.

Additional services and support can be accessed for people with palliative and end of life care needs living in Angus and includes:

Angus Specialist Palliative Care Services

- Day Care Services at Arbroath Infirmary, Stracathro Hospital and Whitehills Health and Community Care Centre.
- Community Macmillan Nurse Support and Advice; Clinic and/or home visits for people who cannot attend a clinic
- In-patient services in Roxburghe House, Dundee
- Occupational Therapy support via Angus Macmillan Specialist Palliative Care Services
- Symptom Management Clinics at Arbroath, Stracathro Hospital and Whitehills Health and Community Care Centre
- Macmillan Welfare Rights support.

Marie Curie Nursing Services

Provides tailored care and support in people's homes. The service works closely with local community nursing services to ensure the person and their family receive the right kind of support, at the time they need it.

Maggie's Centre, Ninewells Hospital, Dundee

In addition to the above services people with cancer can access Maggie's Centre at Ninewells Hospital. Maggie's offer practical, emotional and social support to people, their families and friends.

What people told us

We asked the public, carers and the workforce what they thought good palliative and end of life care looked like, what we could do differently and what the priorities for the plan should be. The following themes emerged from this engagement.

TABLE 1. Themes and Sub themes developed from Public and Workforce feedback

Theme	Sub theme
Compassionate and Person Centred Care	• Continuity, coordination and connected care • Flexible • Honest and Individualised • Paced transitions; including young people • Relationships with people; including in and between teams • Maximising comfort and well-being • Valuing the person and the workforce • Tone • Ways of being – workforce
Compassionate Communication and Conversations	• Identifying people with palliative and end of life care needs • Better use of technology and systems to support effective sharing of information • Advance/anticipatory care planning • Honest and clear information • How to contact and navigate services
Care closer to home	• Access and place – service provision • Control and choice where and when possible • Consistency of care pathways across Angus • Non-clinical environment
Getting it right for the family	• Information • How to navigate services and systems • Support including bereavement support
Education and Development for workforce	• People have confidence that the staff caring for them have the right knowledge and skills • Staff have confidence in what they do and have time to learn and reflect on their care and support • Resilience and support for the workforce
Public Health Approaches to palliative and end of life care	• Awareness; greater public and personal discussion of bereavement, death, dying and care at the end of life • Compassionate communities

People's experience of palliative and end of life care

Every adult who needs it will receive high quality palliative and end of life care at the right time in the right place

Our workforce is knowledgable, skilled, confident & resilient and are able to respond in a timely manner

(The following stories are based on people's real experiences)

Mary's story

Mary is 78 years old and has lived with several long term and life limiting conditions for many years. She has lived on her own since her husband died 12 years ago. Mary's daughter lives in Canada, but they keep in contact every week. Mary is not as mobile as she used to be and spends a lot of time in her chair. She is visited regularly by Community Nurses. Mary has a community alarm and daily social care services. Good neighbours pop in every day to help prepare meals for her.

Mary says "I've told people that I want to die at home. This is really important to me because I want to be surrounded by all my things like my photos of my family and friends. I'm very lucky and have a beautiful views and I love looking at the birds from my window. These things mean a lot to me and are a comfort. I'm not quite sure what the future holds for me, but I know I might need more help soon and am really worried that I'll end up in hospital."

Claire is one of the community nurses and has known Mary for a long time. Claire has noticed that Mary is becoming increasingly frail. Claire said "At the weekly team meeting today I raised my concerns about Mary. I'm not sure it should be me that has the conversation with Mary about what the future may hold. I find these

really difficult conversations to have with people. I'm worried about Mary dying alone. It feels to me that the time is right to make a plan for Mary's future care and support."

What difference will the Angus palliative and end of life care plan make?

Through our actions we will develop a consistent, flexible and inclusive approach to learning, development and support and will ensure all staff have the necessary skills, knowledge and attitude to care for people with palliative and end of life care needs. As a result staff will feel more enabled to have conversations in a supportive and sensitive way that helps people with palliative and end of life care needs and their families.

People living with palliative and end of life care needs will feel that others understand what matters to them about their future care needs and will have a better understanding of the services and support available to them.

Anticipatory care approaches will be embedded so that people with palliative and end of life care needs and their families are offered the opportunity to create a personalised care plan.

Bob's story

Bob is 66 years old and has advanced cancer. He lives at home with his wife Jane. Bob was admitted to a community hospital a few weeks ago because of increased pain.

Jane said "Bob really wanted to stay at home, but we were struggling to cope. I feel that I've let him down, but I'm worried about what's going to happen in the future. Bob doesn't like to talk about his illness very often, but I know the last few weeks have been hard for him."

Bob said "I'm annoyed that I've had to come into hospital, but I realise now that things were getting on top of me. I know the staff are really busy on the ward and I don't want to trouble them with my worries. I don't think they understand what I'm going through. I've got a lot of trust in the staff who are looking after me, but I wish I could speak to someone about my worries."

Emma is a Staff Nurse and has worked in the community hospital for the past two years. Emma said "This is a really busy ward. Although I've looked after a lot of people like Bob it's not easy caring for someone when they are in pain or dying. Sometimes I go home and will still be thinking about the people I have been looking after".

What difference will the Angus palliative and end of life care plan make?

Through our actions we will work to better understand the lived experience of people with palliative and end of life care needs in Angus. We will encourage feedback on the care people receive and the impact this has on the person with palliative and end of life care needs and their family and carers.

We will explore the impact on staff caring for the very ill and dying so we better understand how to support our workforce. We will explore ways to support staff.

People will know where to turn to for information about palliative and end of life care.

Jenny's story

Jenny is 92 years old and has lived in a local care home for 14 months. She came to the care home as she was struggling to live alone due to her advancing dementia and increased frailty. Throughout Jenny's stay her health has gradually deteriorated and she has required more personal care and support with everyday activities. For the past month Jenny has become weaker and has spent most of her days in bed. One night the staff noticed that Jenny was less responsive when they were providing personal care and they wondered if Jenny was now dying. The staff felt they had a good and trusting relationship with Jenny and her family. They felt that they were the right people to be discussing what was happening with the family. The care home staff were aware that Jenny had spoken with her family and the other team members involved in her care about her wishes and preferences as she approached the end of her life. Jenny had stated that that she did not wish to die in hospital and if possible to stay in the care home with her family present.

Although there was a plan in place, some family members were asking if Jenny should be admitted to hospital. The staff knew that this would not be in keeping with Jenny's wishes or appropriate at this stage in Jenny's life. Despite knowing this the staff found having these difficult conversations challenging.

The care home staff requested a GP visit and she explained why hospital admission would not be of benefit to Jenny. The GP reaffirmed the staff's assessment that Jenny was dying and likely to be in the last days of her life. The goals of care were to ensure Jenny's comfort and support her family.

What difference will the Angus palliative and end of life care plan make?

Our workforce will be able to recognise and respond to the support needs of families and carers. Through our actions we will support staff to develop their skills and confidence that will enable open and honest communication and conversations with people and their families. Anticipatory care approaches will be embedded, so that people with palliative and end of life care needs and their families are offered the opportunity to create a personalised care plan. By fostering more open and honest discussions about death and dying, families will be aware of the person's wishes and preferences for their care and support in the last days of life. They will be informed about what to expect when someone is dying.

Where we want to get to

1. Compassionate and person centred care

To achieve compassionate and person centred care we need to proactively identify people who may have palliative and end of life care and support needs. The Scottish Government's Palliative and End of Life Care Strategic Framework for Action vision is that by 2021 everyone who needs palliative care will have access to it [3]. It is important that we include people and groups* who may be disadvantaged from accessing care and support.

Compassionate and person centred care emerged as a prominent theme from the feedback received from the public and workforce engagement exercise. Being treated with respect, dignity and compassion is extremely important to people and may reflect a concern amongst the public that this will be ignored when they are dying [7]. People need to be seen as an individual; their personal wishes and preferences for care and support listened to and carried out to the best of all our abilities. This helps people to feel they have some control over what is happening to them. Being person centred can maximise personhood and well-being and is applicable even in the final days of life [8].

Providing the right care and support involves exploring, assessing, responding to and reviewing people's needs and issues. Distress may be caused by physical, social, emotional and/or spiritual issues. People receive care and support across many different settings including their own home and communities, care homes, community and acute hospitals and Roxburghe House in Dundee. Co-ordinated and collaborative working is required so that people receive seamless care and support during times of transition.

*people with conditions other than cancer, older people, people with dementia, people from black and minority ethnic (BME) groups, lesbian, gay, bisexual or transgender people, people with a learning disability, people with a mental health condition, people who are homeless, people from the gypsy and travelling community.

Outcome 1

People receive care and support that is compassionate, respectful and person centred.

What do we want to achieve?

1. People who have palliative and end of life care or support needs are identified and offered access to appropriate services and support.
2. We are proactive in identifying people and groups who may be disadvantaged from accessing care and support.
3. Personal needs and issues (physical, emotional, social and spiritual) are explored and discussed in a sensitive, paced and compassionate manner.
4. Distress related to physical, emotional, social or spiritual reasons are recognised, acknowledged, assessed and responded to.
5. Ways of managing distress are explored in collaboration with the individual.
6. Existing and additional resources and sources of support and help are considered and utilised.
7. People receive continuity of care and support which is co-ordinated, collaborative and seamless across and between services.
8. Transitions of care are effective and orientated to the individual's situation and wishes.
9. People feel safe and informed during transitions of care.

2. Compassionate communication and conversations

Good communication improves outcomes and the quality of life of individuals [9]. The importance of good communication was expressed by the public, carers and our workforce. This included one to one communication with the person and/or their family; communication between and in teams; and communicating information to people about their health and well-being, treatments, care option and services.

Compassionate communication and conversations requires all of us to be open and honest with people about what is happening to them, what is likely to happen to them and what care and support is available to them and their families. Conversations need to be paced to a person's willingness and readiness to engage in these discussions. With the individual's consent, sharing appropriate information with the appropriate staff and teams is crucial to supporting wishes and preferences.

Outcome 2

People have person centred and compassionate conversations with our workforce.

What do we want to achieve?

1. People have open and honest conversations about their situation and these conversations include what matters to them.
2. Conversations are paced to meet the individual's preparedness and perspective.
3. People's values are understood and respected.
4. Enable conversations that allow people to explore what they understand is happening to them, how they feel about that and what their expectations are about their care and support now and in the future.
5. Planning for the future through Anticipatory/Advance Care Plans which include the personal wishes and preferences of the person with palliative and end of life care needs.
6. Provide information to people on services and support that are available, what they can expect from the services and how they can access them.
7. Support people to consider how technology enabled care could help them to live and die well. For example, community alarm and falls detectors, home mobile health monitoring, Near me Tayside.
8. Integrate the use of digital technology in our work.

3. Care closer to home

The majority of people when asked where they would wish to be cared for in a palliative and end of life care context will say at home [10]. The feedback we received from the public survey and engagement events were similar; people responded by saying that they believed good palliative and end of life care would be at home or as near to home as possible.

Our data tells us that during the last six months of life people in Angus will spend an average of 90.7 % of their time at home or in a community setting (Table 2 & 3). As a result of improvement work that has been undertaken in Angus over recent years, people living in a care home setting are much less likely to be admitted to hospital in the last six months of their life.

However, about one third of people will spend more than 10% of their last six months of life in hospital, this equates to an average of 18 days. We do not yet fully understand if these admissions to hospital were to receive appropriate clinical treatment or if this was in keeping with their wishes and preference. We know that people's views alter when they are unwell or are dying [11]. Emerging evidence suggests that how people are cared for when they are dying and feeling safe may be more important than the actual place of their death [12, 13, 14].

Outcome 3

People receive palliative and end of life care closer to home where clinically appropriate and practically possible.

What do we want to achieve?

1. People receive care and support that enables them to live and die well within their own community.
2. When an admission to an Angus community hospital is required, all relevant information is communicated and available to the multi disciplinary team.
3. Discharge home from an Angus community hospital, when appropriate, is timely, co-ordinated, effective and ensures communicating with the right people.

4. People are given information in a sensitive and timely manner that explains what care at home may look like, what services and support is available and how they can access these services.
5. The environments within organisations that provide end of life care should be welcoming and comfortable.
6. For people whose preferred place of death is a hospital setting the environment should be welcoming and a 'sense of home' is included in the care experience.
7. To understand further why people are admitted to hospital in the last six months of their life and if this is in keeping with their wishes and preferences.

4. Getting is right for the family

Families, carers and friends play an important role in providing palliative and end of life care and support. Families may require support to maintain and continue in their caring role. In the survey people said it was important to them that their family received support. The support requested included emotional, practical (including what to expect when someone is dying), sign posting to services and bereavement support.

The Carers (Scotland) Act 2016 [15] came into effect last year and will ensure better and more consistent support for carers and young carers so that they can continue to care, if they so wish, in better health and to have a life alongside caring.

Outcome 4

Families** feel supported to care and have access to support in their bereavement.

What do we want to achieve?

1. Provide support to family and carers, acknowledging and responding to their needs by ensuring carers support plans and young carers statements are in place promptly.
2. The workforce is able to recognise factors which may increase vulnerability and risk of encountering difficulties in grief and sign post people to services and support.
3. Families including children and young people are offered appropriate bereavement support.

** Family is a universal term and can include relations, friends, neighbours and carers.

5. Education and development for the workforce

Most of our workforce will have contact with people with palliative and end of life care and support needs. The workforce responded to our engagement by voicing their commitment to providing high quality palliative and end of life care. There exists already considerable skills and expertise. We need to build on this by providing a consistent, flexible and inclusive approach to learning, development and support. Enriching & Improving Experience [16] is the national framework to support the learning and development needs of the health and social service workforce. The framework identifies the knowledge and skills required by all workers who come into contact with people with palliative and end of life care needs. The framework can be used by individuals, managers, service providers and education providers to determine their strengths and identify development needs in relation to their roles and responsibilities.

We recognise the challenges organisations and services face in releasing staff to attend face to face learning and development events. Accessing a variety of resources and formats for learning and developing may help with these challenges. To support our workforce we will create an online directory of palliative and end of life learning and development resources.

We know that in order to continue to work with death, dying and loss our colleagues and workforce require support to sustain their compassion, values, resilience and well-being. Our workforce supporting people and their families with palliative and end of life care needs should be able to access formal and informal support. For example supervision, team debriefs, staff wellbeing resources and peer support.

Outcome 5

A workforce that is appropriately developed and supported.

What do we want to achieve?

1. Staff working in health and social care services are supported to learn and develop their knowledge and skills in palliative and end of life care, appropriate to their role and responsibilities.

2. The workforce is confident in applying their knowledge and skills in the care and conversations they provide to people with palliative and end of life care needs.
3. The workforce has support to sustain their compassion, values and resilience via formal and informal strategies.

6. Public health approaches to palliative and end of life care

A public health approach to palliative and end of life care will create more openness about death. Compassionate responses to death, dying and bereavement in all communities will increase people's confidence of getting the right support when they need it, from the right people. The public told us they require more knowledge and skills to support family and friends with palliative and end of life care needs.

Outcome 6

People in Angus are informed about palliative and end of life care and are compassionate in their responses to death, dying and bereavement.

What do we want to achieve?

1. To foster more open and supportive attitudes and behaviours relating to death, dying and bereavement.
2. Increase the knowledge and skills for palliative and end of life care in Angus communities.

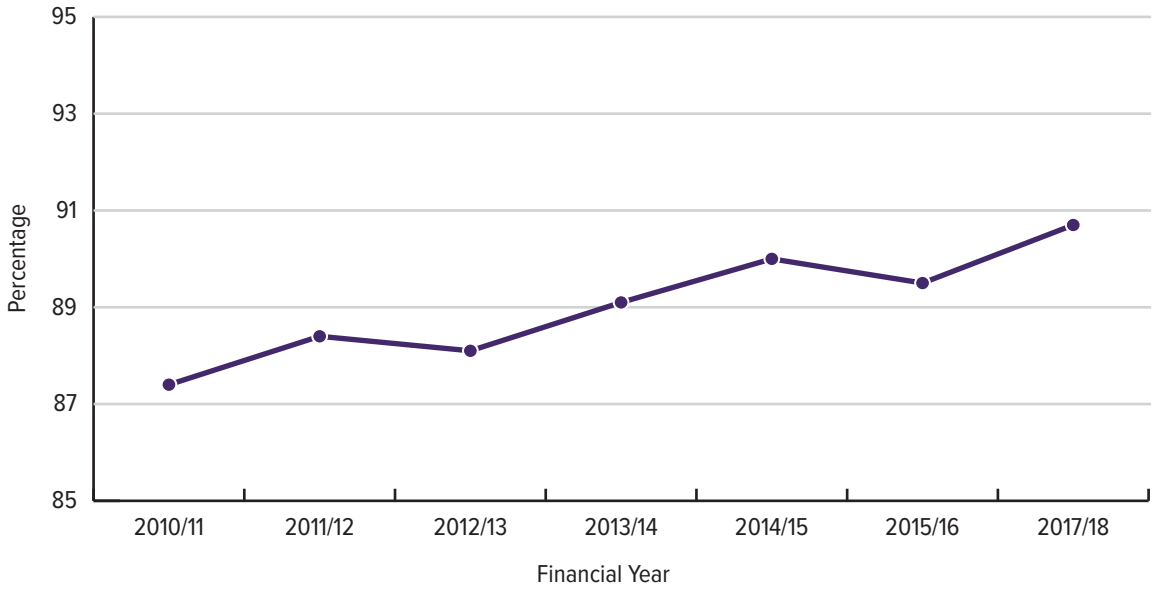
What is the data telling us?

Regional and national mortality analysis

In 2016/17 there were 1,344 potentially expected* deaths for Angus residents (Table 4). It is understood that around 75% of these people will have had needs arising from living with deteriorating health for the years, months or weeks before they died [4]. Not all of these individuals will have had a typical or predictable trajectory towards their death.

TABLE 2. Percentage of last six months of life spent at home or in a community setting in Angus 2010 – 2018 [17]

(2017/18p = Data for 2017/8 are provisional and may be revised in the future)



*Expected deaths or potentially expected deaths are terms used by Information Services Division for National Services Scotland. These figures do not include deaths caused by pregnancy, childbirth or obstetric causes, injury, poisoning, sudden and acute injuries and accidents or self harm.

TABLE 3. Percentage of End of Life Care spent at home or in a community setting by Health and Social Care Partnerships across Scotland 2017/18 [17]

Health and Social Care Partnership	Number of Deaths	% time spent at home/ in the community	Average number of days spent at home/in the community
Aberdeen City	2,098	88.9	162
Aberdeenshire	2,388	90.1	164
Angus	**1,376**	**90.7**	**166**
Argyll & Bute	1,045	90.0	164
Clackmannanshire and Stirling	1,410	87.3	159
Dumfries & Galloway	1,956	9.2	163
Dundee City	1,684	89.0	162
East Ayrshire	1,433	89.2	163
East Dunbartonshire	1,128	89.3	163
East Lothian	1,144	87.0	159
East Renfrewshire	987	86.6	158
Edinburgh	4,218	87.4	159
Falkirk	1,665	86.9	159
Fife	4,122	89.3	163
Glasgow City	6,394	87.9	160
Highland	2,443	90.6	165
Inverclyde	1,091	88.0	161
Midlothian	870	88.0	161
Moray	960	90.0	164
North Ayrshire	1,691	87.1	159
North Lanarkshire	3,696	88.2	161
Orkney Islands	251	91.6	167
Perth & Kinross	1,676	89.8	164
Renfrewshire	2,037	89.6	164
Scottish Borders	1,317	87.8	160
Shetland Islands	204	95.6	174
South Ayrshire	1,472	87.0	159
South Lanarkshire	3,504	87.9	160
West Dunbartonshire	1,073	89.7	164
West Lothian	1,623	89.5	163
Western Isles	327	89.4	163
Scotland	**57,283**	**88.6**	**162**

TABLE 4. Indicative breakdown of potentially expected deaths by locality and place of death 01/04/16-31/03/17. Local Intelligence Support Team, Angus Health and Social Care Partnership

Place of residence at time of death	Angus Hospitals	Other Hospitals	Roxburghe House	Home	Care Home	Total
Angus - North West	68	126	17	139	64	414
Angus - South East	37	80	26	109	81	333
Angus - North East	38	80	11	100	59	288
Angus - South West	19	81	29	90	67	286
Total	**162** (12%)	**367** (28%)	**83** (6%)	**438** (33%)	**271** (21%)	**1,321***

*The total figure for potentially expected deaths in Angus = 1,344. 23 deaths occurred out with the Angus area and are not included in this table.

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Appendix 1

Steering Group Membership

Ann Bowdler	District Nurse Locality Lead, Angus Health & Social Care Partnership
Dr Deans Buchanan	Consultant & Lead Clinician, Specialist Palliative Care Services, Dundee Health & Social Care Partnership
Vivien Clifford	Forfar Airways Self-Management Group
Elaine Colville, Chairperson	Senior Nurse for Palliative Care, Angus Health & Social Care Partnership
Ivan Cornford	Lead Integration Officer (Scottish Care) and Care Home Manager
Jacqui Dillion	Development Officer, Angus Carers Centre
Mike Easton	Senior Charge Nurse, Prosen Ward, Whitehills Health & Community Care Centre
Karen Fletcher	Lead Nurse, Angus Health & Social Care Partnership
Marion Gaffney	Angus Macmillan Community Care Project Nurse, Angus Specialist Palliative Care Service
Marc Jacobs	GP, Edzell Health Centre
Carey Liversedge	District Nurse, Angus Health & Social Care Partnership
Dr Ian Logan	Consultant & Clinical Lead in Medicine for the Elderly, Angus Health & Social Care Partnership
Hayley Mearns	Strategic Lead for Economy and Health, Voluntary Action Angus
Careen Mullen-McKay	Advanced Nurse Practioner, Medicine for the Elderly, Angus Health & Social Care Partnership
Moira Nicoll	Chairperson, Lippen Care
Val Norrie	Macmillan Occupational Therapist, Medicine for the Elderly, Angus Health & Social Care Partnership
Liz Paterson	Clinical Team Manager & Interim Lead for Medicine for the Elderly & Community Hospitals, Angus Health & Social Care Partnership
Sally Wilson	Integration Improvement Manager, Improvement and Development Team, Angus Health & Social Care Partnership
Dr Sheila Wilson	Member of Angus Lippen Care Board

Appendix 2

How we support people with palliative and end of life care needs in Angus

- Angus Carers Centre & Voluntary Action Angus
- Out of Hours GP Services & NHS 24
- Welfare Rights Advice & Support
- Roxburghe House, Dundee
- Specialist Teams (hospital & community)
- Psychiatry of Old Age
- Social Care Officers including Enablement & Response Team & independent providers
- Diagnostic tests & treatments at Ninewells & Stracathro Hospitals
- Pharmacy
- Angus MacMillan Services incl. Day Care, Home Visits & Symptom Management Clinic
- Equipment & Community Meals
- Marie Curie Nursing Service
- Online advice & support from NHS Inform & other charitable organisations
- Community Service for Dietetics, Occupational Therapy, Physiotherapy, Podiatry & Speech & Language Therapy
- GP & Practice Nurses
- Community Alarm & Technology Enabled Care
- Medicine for the elderly incl. Day Assessment & Treatment & Hospital Services at Arbroath, Stracathro & Whitehills
- Community Mental Health
- Transport
- Advanced Nurse Practitioners
- Listening & Chaplaincy Service
- Community Nursing & Enhanced CommunitySupport Teams