Living and Dying Well at the Partnership conference

The Scottish Partnership for Palliative Care’s Annual Conference on 30 September 2009 opened with a speech from Dr Elizabeth Ireland, National Clinical Lead for Palliative and End of Life Care at the Scottish Government.

Dr Ireland addressed the question, What difference can Living and Dying Well make to palliative care services in Scotland? She began by thanking delegates for their support, drive and commitment since the launch of Living and Dying Well (L&DW) last year. There has since been a significant and rapid development in the profile of palliative care, collaboration that has underpinned the engagement of NHS Boards, clinicians, academics, voluntary bodies, patients, carers, politicians and civil servants. She particularly thanked the Scottish Partnership for Palliative Care for its valued contribution to the whole palliative and end of life care agenda in Scotland, and assured delegates that the Scottish Government remains absolutely committed to achieving the aims of L&DW.

L&DW has retained such a high profile because it reflects a range of factors which research indicates will increase the likelihood of successful change in healthcare. Fundamentally, Living and Dying Well has ensured palliative and end of life care services are now seen in policy terms as mainstream. Most significantly, the approach is about making the right thing easier to do, and the last 12 months have seen many significant achievements. For the first time:

- there are comprehensive, realistic delivery plans in every NHS Board with accountability through the Executive Leads
- there is engagement with key stakeholders at national level to drive implementation, embed improvement and achieve sustainability across a number of initiatives
- there is consistent communication about the palliative care approach
- there is an educational programme delivered through NES to support the implementation of L&DW.

As well as reflecting on the past year it is essential to think about the future, recognising successes as well as identifying challenges. The challenges remain significant in terms of demography, finance, technology, inequalities, epidemiology, growing expectation and the importance of having patients and carers at the centre of all that we do.

L&DW provides direction for the future and linkages to other key policies such as:

- long term conditions, in particular the collaborative work to develop a consistent approach to anticipatory care planning and advance-care planning from diagnosis of a long term condition through to the end of life
- the dementia strategy, where a consistent approach to palliative and end of life care is apparent
- Better Cancer Care, especially the Living with Cancer group
- bereavement framework
- patient safety programme
- Shifting the Balance of Care where palliative and end of life care is one of the eight high impact areas
- transitions of care for children with complex needs

The electronic Palliative Care Summary (ePCS) will improve communication between patients, carers & professionals at all stages of the patient journey, by allowing data to be automatically sent daily from GP systems to Out of Hours (OOH) services. The ePCS fits into day to day work of GPs and District Nurses, keeps all information on patients with palliative care needs in one place in the GP record and allows the most up-to-date information to be available OOH for these vulnerable patients. Pilots have taken place in Ayrshire & Arran, Grampian and Lothian, in all GP systems, with positive evaluation. Board wide rollout has started in Lothian from September 2009 with more detailed evaluation to inform national rollout.

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More on Living and Dying Well on back page)
and minority ethnic groups. The hospice has a variety of projects seeking to meet social needs, including the often neglected importance of financial and practical support.

Meeting current challenges is not so much about improving access to specialist palliative care as improving wider systems of health and social care. A 24-hour District Nursing service is essential to enabling people to die at home. Specialist palliative care should see itself as a resource to enable generalists to deliver good care to individuals, wherever the bed in which they die.

It is important that hospices respond to the changing needs emerging within society. St Christopher’s has developed a number of mechanisms to support care homes. It is now training 90 local care homes in the Gold Standards Framework and shares creative and complementary therapists with care homes, for example running music therapy groups for those with advanced dementia. Shifting resources to areas of greatest need will become increasingly important.

St Christopher’s has also completed a three year research programme into the end of life needs of those with advanced dementia. Only 8% of the patients on the programme died in a hospital. Hospices also have a duty to think about the replicability of any service innovation into generalist settings.

Barbara suggested that hospices have a responsibility to support the training and education needs of generalists and that they are ideally placed to do so. She emphasised that face to face training opportunities are vital if professional inhibitions and anxieties about conversations about death and dying are to be overcome and that the most neglected audience is health and social care assistants. She also emphasised that it was important to generate evidence of assertions about quality and to deliver to the value for money agenda. She described a new model of a one stop shop of coordinated outpatient clinics at St Christopher’s designed to improve patient choice and reduce the time nurses spend travelling to visit patients.

St Christopher’s is also working to engage more widely with the public, including exploring new forms of volunteering, education of professional groups outside health and social care, for example, teachers and police, and a schools project bringing children and hospice patients together in meaningful activities.

Barbara concluded by asking whether limitations in care are present because of a lack of money, or because of a lack of will and vision. She believes that Scotland currently has many advantages over England in the way it provides health and social care and urged delegates to make the most of these while they last!

**What difference can the Liverpool Care Pathway really make?**

In the wake of recent high profile newspaper articles highlighting existing controversies over the use of the Liverpool Care Pathway, Phil Saltmarsh explained why he believes that the LCP is making a positive difference to the care of dying patients by changing the culture and the way care is planned, and making care of the dying a priority.

A care pathway is a complex intervention for the mutual decision making and organisation of care processes for a well defined group of patients during a well defined period. The aim of the LCP is to improve care of the dying in the last hours / days of life. Its two key themes are to improve knowledge related to the process of dying, and to improve the quality of care in the last hours / days of life. It is split into three key sections: initial assessment; ongoing assessment; and care after death. The LCP highlights four key domains of care: physical, psychological, social and spiritual. It is not a ‘one way street’, since there have been many instances when patients have been taken off the care pathway when they have shown signs of recovery.

There is currently a gap between people’s hopes relating to aspects of dying such as dignity, respect and symptom control, and the reality of people’s actual experiences. While pockets of excellent care exist in some areas, there are also places where care can be improved. The LCP is designed to help professionals to raise the standard of care provided to dying patients, and to close this gap between aspirations and reality. Bad communication and conflicting messages are common complaints relating to end of life care, and the LCP has a strong emphasis on
communication. Its five key elements are:

- clinical decision making
- management and leadership
- learning and teaching
- research and development
- governance and risk.

Phil went on to illustrate how use of the Liverpool Care Pathway can make a real difference to individual patients by describing how one individual’s care improved dramatically once she was moved to a ward routinely using the LCP.

The national LCP team receives many comments, letters and emails about the LCP, and these usually relate to one of five key themes: sedation, communication, nutrition, hydration, and poor quality of care. The LCP is continually being revised to take account of comments and emerging evidence, and version 12 of the LCP was launched on 25 November 2009.

He went on to highlight ten key message of the LCP:

- the LCP is only as good as the people who are using it
- reflect, audit, measure, learn
- the LCP should not be used in an environment without the support of education and training
- stop, think, assess, change
- diagnosis of dying should be made by the multi-disciplinary team
- the LCP supports continual assessment
- good communication is pivotal to success
- the LCP does not preclude the use of artificial hydration
- the LCP does not recommend the use of continuous deep sedation
- the LCP neither hastens nor postpones death.

Though we shouldn’t ignore the headlines which cast doubt on the use of the LCP, Phil believes that the LCP can and does make a positive difference to the care of dying patients.

**Making a difference through network collaboration**

Dr Paul Baughan explained the advantages of network collaboration, starting with an illustrative example of why developments and progress within palliative care can fail due to lack of appropriate collaboration with the key stakeholders.

He went on to explain how we are all part of various formal and informal networks within our daily lives, a network being an extended group of people with similar interests or concerns who interact and remain in informal contact for mutual assistance or support. The West of Scotland Cancer Network (WoSCAN), of which Dr Baughan is a member, includes various regional and national managed clinical networks, groups and sub-groups. When taken as a whole, the system for information sharing between the different networks that form part of WoSCAN appears complex. It is therefore important for appropriate networks to collaborate on specific projects as appropriate.

There are a number of advantages of network collaboration, which include:

- reduced risk of overlap and wasting of resources by different networks
- progressing similar ideas
- sharing of ideas and taking account of a wide range of views
- sharing of workload for big projects
- ‘ownership’ and ‘buy-in’ from different networks especially if the project has implications for them. This can also help with the implementation.

The specific advantages for palliative care and primary care collaboration are:

- both are networks where symptom control plays an important part in patient care
- most people requiring palliative care are living at home in a community setting
- up-skilling of generalists by specialists and allowing specialists insight into realities of busy community palliative care.

There are however disadvantages to network collaboration, since it can mean that projects move more slowly, and with so many people wanting to comment it is harder to gain consensus. It can also be difficult to establish who is accountable or responsible for a piece of work. Within the context of palliative care, current network systems can also mean that work is focused on cancer, when collaboration also needs to take place regarding care of those with non-malignant conditions.

Professor John Welsh went on to give some specific examples of where network collaboration between the regional networks of Palliative and Primary care has helped with specific projects, including the following:

- there are relatively few psychologists in the West of Scotland, and network collaboration has been helpful in creating a Psychosocial Reference Group. One aim of this group is to take forward projects of joint interest and concern
- at a national level, Living and Dying Well Short Life Working Group 3 has drawn on the collaborative efforts of existing networks to look at developing a national approach to the use of assessment and, prognostication tools, and promotion of the concept of Advanced Care Planning resulting in the production of an anticipatory care plan
- the two networks have been active in the morphine/diamorphine debate, have produced regional guidance on Methylaltrexone use and are currently working on guidelines for the use and titration of the new fast acting Fentanyl formulations
although network collaboration has delayed the roll out of West of Scotland guidelines for symptom control in palliative patients out of hours, it has allowed a wider perspective to be taken into account, and therefore a higher quality of more useful guidelines to be produced in the long term.

In conclusion, network collaboration promotes understanding of issues affecting others, reduces duplication of effort and allows staff with different areas of expertise and experience to influence change for the greater good of larger numbers of patients.

How can we make a difference to palliative care services for children and young people?

Andrea Cail explained that the Guide to developing Children’s palliative care services published by ACT and the Royal College of Paediatrics and Child Health (updated in 2009) identifies palliative care as being required for children and young people with chronic conditions, progressive incurable conditions, life-threatening illness, and some non-progressive conditions. It also identifies four possible patterns for the relationship between palliative/curative treatments:

• as the illness progresses the emphasis gradually shifts from curative to palliative treatment
• highly technical invasive treatments may be used both to prolong life and improve quality alongside palliative care, each becoming dominant at different stages of the disease
• no cure is possible and care is palliative from the time of diagnosis
• at first it is not apparent that this will be a terminal illness and palliative care starts suddenly once the realisation dawns.

Cancer remains the second largest cause of death in the 1-19 year age group. Collectively deaths due to diseases of the nervous system, respiratory systems, and congenital anomalies almost double the percentage of deaths from cancer. Increasing numbers of children and young people are living with significant chronic illness and disability. Some challenges faced by professionals working in children and young people’s palliative care are:

• the focus in paediatrics is still on curing disease
• aggressive treatment provided in tertiary paediatric centres is at odds with the philosophy of palliative care
• end of life decisions represent complex ethical and moral dilemmas that are likely to increase with advances in medical technology.

Palliative care provision for children and young people operates from similar principles to palliative care for adults, but the specialty does have its own challenges and frameworks. Policy documents encompassing palliative care must acknowledge these if they are to support services for children and adults.

The underlying principles of health policy for children and young people include: putting the child and family first, developing sustainable services, providing equity of access and quality, improving quality and outcomes, and workforce planning effectively. ACT has developed frameworks and good practice guidelines, for example the ACT Care Pathway approach demonstrates how families should be able to access services which reflect the stage a child has reached in their condition. The ACT Family Companion shows families what standards they can expect from services, with outcome measures for breaking news, planning for going home, multi-agency assessment of needs, multi-agency care plan, and end of life planning.

Investment has been made in managed clinical networks and specialist posts through the National Delivery Plan for Children and Young People’s specialist services in Scotland. Improvements will also be made by identifying training and education needs. It is anticipated that Living and Dying Well short life working group (6), looking at transition issues and future service configuration for adolescents and young adults, will also lead to improvements being made.

Collaboration, including work across the UK, is essential as the numbers of children requiring this kind of care are relatively small. In recognition of this, CHAS has recently invested in a piece of research to study the symptom experience of children with rare life-limiting conditions. This study will involve children and families from six UK Children’s hospices.

There are ongoing challenges. There is currently a gap in the data collected about children with palliative care needs,
and it is hoped that the recently established managed clinical network for children with exceptional healthcare needs will make a difference. The transition from children’s to adult’s services continues to be a challenge, and many young people feel that there aren’t adequate services for them to be ‘transitioned’ to, particularly in relation to short planned breaks. Working with the whole family as a child or young person approaches the end of their life is always a challenge, and it is important to remember that though families want to have an idea of what is likely to happen in the future and some want to plan for that, they also want to live for today.

**How can we make a difference to palliative care in hospitals?**

Dr Pam Levack spoke from her specialist palliative care experience in Ninewells Hospital, observing that hospitals are essentially large groups of people. Thus change can be difficult and slow. The large and often impersonal nature of hospitals can easily intimidate patients, especially the most vulnerable which clearly includes those who are dying. Given that 60% of people die in hospital, and 30% of in-patient bed days in acute hospitals are occupied by patients in the last year of life, hospitals need to provide good palliative and end of life care and provide easy access to specialist palliative care when needed. Not infrequently, patients’ and families’ experiences could be better, hence the Acute Setting short life working group of Living and Dying Well is timely and important.

In order to make institutional change, it is necessary to understand the many pressures under which hospitals are operating. Productivity and waiting times are the reality. Furthermore, at a time of financial restriction we have no accurate figures about the resources currently allocated to hospital palliative care.

Palliative care professionals may be passionate about palliative care, but those working in other specialties have other passions. We need to find ways to simply and effectively explain the value of palliative care to patients, families and staff. Each hospital must own palliative care, and we must engage with the most senior people who influence hospital thinking.

The L&DW Acute Setting short life working group (5) will be making a number of recommendations including the need to establish a formal national hospital group, develop standards specifically for hospitals and advise that each hospital has its own palliative care programme.

Everyone has increasing workloads and wishes more resource but personal stories illustrating the impact of palliative care are a very effective way of getting support. It is important to work with whatever local support is offered and then build on it. In the case of Ninewells Hospital, the surgical Directorate offered three single rooms in the middle of the acute surgical receiving ward and the benefits and joint working with surgeons has been very satisfying. Pam has also had good support from management and with the help of a bequest was able to employ seven nurses, a consultant and a secretary for a one year pilot period. Other staff committed their support - allied health professionals, a chaplain, social worker and pharmacist. It was explained to patients admitted to these specialist beds that all these different professionals worked as a team and that patients would be routinely visited by all members – unless there were any objections, which rarely occurred.

Developing the service in Ninewells has not been straightforward. In the first few months, several staff left as they found it difficult to care for patients with intensive palliative care needs in a busy hospital environment. This was especially difficult for staff returning to hospital after a number of years. An essential part of the pilot was to prospectively collect data to measure the improvement in symptoms etc which can be achieved.

Ultimately, it is essential to work alongside and gain the respect of others already working in the acute setting. We owe it to patients, families and the staff to make it work.

**Making a difference for people with learning difficulties**

Linda McEnhill’s role as Widening Access Manager for Help the Hospices is to develop a programme of work which will equip hospices to increase access to currently under-represented groups. One such group are people with learning disabilities (LD) who experience a ‘black hole of need’. Linda’s presentation sought to describe some of the issues to enable delegates to consider how to respond to these needs within their own areas.

A learning disability is ‘a reduced ability to understand new or complex information (impaired intelligence) and reduced ability to cope independently (impaired social function) which began before adulthood and which has a lasting effect on development’. Due to improved paediatric healthcare, there are increasing numbers of adults with LD, often with additional complex physical disabilities. People with LD are likely to live longer than in previous years, and are consequently likely to experience conditions which require palliation. Long stay hospitals which previously filled some of the needs of this group no longer exist and therefore these needs will require to be met within the community.

Since a third of people with LD have carers over the age of 70, many of these individuals may therefore require psychosocial support to help them deal with the implications of having elderly family or carers who require palliative care. People with LD are likely to have more healthcare needs but less access to healthcare services than other sections of the
population. The Disability Rights Commission reports that people with LD are four times more likely to die of a treatable illness and a research study has found that people with LD are 58 times more likely to die before the age of 50. On average, this group is likely to have five undiagnosed conditions at any given time and is also likely to have higher levels of mental ill health, schizophrenia, dementia, epilepsy and respiratory deaths. People with LD also:

- often don’t access screening
- more regularly experience ‘diagnostic overshadowing’
- tend to be diagnosed late
- have a different cancer incidence (6%:26%) and profile
- experience inequality in terms of access and range of treatments
- die earlier of their disease.

People with LD are more likely to get life threatening illnesses early and to die prematurely from them. They are less likely to receive the full range of expected evidenced based checks and treatments. People with LD from black and minority ethnic (BME) communities are three times more likely to be admitted to psychiatric hospital and 25 times more likely to be admitted to secure accommodation (20-30% of prisoners have a LD).

Linda went on to describe the story of Martin, who had LD, and died in hospital at the age of 43 after a catastrophic break down of communication that allowed him to go without food for 26 days. Martin’s family are convinced that if he hadn’t had a LD he would have been given the care he needed to keep him alive (see ‘Death by indifference’ www.mencap.org.uk).

Work is underway within Scotland to address similar issues. For example:

- the development of the ‘Lothian model’ of dedicated LD nursing liaison in acute services & NHS Quality Improvement Scotland LD education modules
- the National Network for Palliative Care for People with Learning Disabilities (NNPCPLD) Scottish group has been re-launched, meets quarterly and hosted a national conference in Glasgow on 10 November 2009
- a Lothian group hosted by Marie Curie is bringing together palliative care and learning disability professionals to work across boundaries and develop accessible information.

Linda concluded by urging delegates to consider how they could make a difference by addressing some of these issues within their own area.

**Make a difference to the majority of people with palliative care needs: people with non-malignant conditions**

Dr Jacquelyn Chaplin highlighted that the majority of people with palliative care needs do not have cancer, but have one of many different non-malignant conditions. Jacquelyn has been involved in work within NHS Greater Glasgow and Clyde (GG&C) to identify the palliative care needs of people with non malignant conditions at a population level. The data collected indicate that each year, over 10,000 people in GG&C will need palliative care, approximately 3,500 of these being people with cancer, and approximately 6,500 of these being people with other conditions. Of those with non-malignant conditions approximately 67% will need help with pain, 49% will experience breathing difficulties, and 36% will experience depression. These figures are similar for those with cancer.

The limited evidence in the literature, and many policy documents, suggest that many people would like to die at home. The GG&C data indicate that 23% of people manage this, with the majority of people (61%) dying in hospital. However, there are several complexities to be considered when considering place of care, place of death and advanced care planning. Firstly, most data relate to people with cancer. In addition, preference regarding place of care is different from preference regarding place of death, and there can also be differences between the preferences of patients and carers. Furthermore, people may change their preferences over time, and recent research indicates that dying at home is not as important as other factors such as freedom from pain, not dying alone, and being treated with dignity and respect. It is also difficult to define the optimum way and time for eliciting preferences, acknowledging that not talking about death is a way of coping for some people. Given the variable access to services, there are also fundamental issues to be considered regarding the ethics of asking patients their preferences and not having the resources available to achieve that preference. What is our purpose in a policy that implies that all patients wish to discuss these issues, when that may not be the case?

Within the community, GPs and District Nurses are key. In order to improve the care received by people with non-
malignant palliative care needs there needs to be an integration of nursing and social care. In addition, enhanced development and integration of out of hours services is required. These two actions are likely to have the biggest impact on people with non-malignant palliative care needs who are being cared for at home. Within care homes, enhancing skills in recognising changing need and proactive planning is crucial. It should also be recognised that many people will continue to die in hospital especially with and / or from non-malignant conditions. Therefore, in a hospital setting a key priority is the creation of a culture and environment where professionals are able to care with dignity, respect and compassion. The clinical leadership of charge nurses is essential in order to ensure that nurses accept responsibility for the quality of palliative care provided in their ward. In addition all staff should be educated in an holistic approach. Consequently specialist palliative care services need to further develop their educative and consultative role in relation to non malignant palliative care.

The Audit Scotland Review of palliative care services in Scotland and the Scottish Government palliative and end of life care action plan Living and Dying Well provide some hope and direction for the future. There are many opportunities at a strategic, local and individual level to improve palliative care for those with non-malignant conditions, for example by ensuring relevant disease specific strategic and / or service development plans at a national and local level include palliative care.

Jacquelyn also stressed that it is important to learn from the past. She urged all to remember that the focus should not just be about end of life care. Palliative care is not just about dying, palliative care is also about helping people to live.

**Therapeutic encounters – how can you make a difference?**

**Dr David Reilly** concluded the conference with a calming session designed to give delegates some reflective space and at the same time illustrate the importance of mental and emotional factors in influencing outcomes for staff and patients.

When asked, most conference delegates agreed that the human side of care is currently under strain, and that the stress of colleagues affects the quality of care they provide. David highlighted that this is a situation that has serious implications, and that burn out within health and social care is common, beginning with disengagement at subtle levels. He asked delegates to reflect on their own ‘inner peace’ score, and what this means for what they bring to the space they share with others. He questioned how a healthcare worker can provide soothing and sincere care for others if they are feeling stressed and strained within themselves.

There is evidence to suggest that the process of going through medical school causes students to experience a ‘hardening of heart’, as illustrated by a significant drop in their empathy scores after training in comparison to before training. David questioned how we have arrived at a situation where professionalisation can apparently lead to reductions in empathy.

He then described a historical analysis of healthcare in the UK over the last two centuries which interprets four distinct ‘waves’ of healthcare, associated with three major shifts in thinking and themes of history since the 18th century Enlightenment. The first of these ‘waves’ took place in the first half of the 19th century and involved great public works and municipalism. (For example the introduction of a public water supply to Glasgow reduced cholera dramatically). Since then, other waves have been: the refinement of scientific approach and the germ theory of disease; the restructuring of institutions and welfare reforms; and most recently, a focus on the risk theory of disease and lifestyle issues such as smoking.

All of these different ‘waves’ had an incredible impact on the health of the population at the time, however, we are now in an era of diminishing returns, whereby it is difficult to make a difference within the current health system, and professionals feel that they can’t positively influence many of the problems they come across. This is a demoralising experience for professionals.

Further, David suggested that a new way of dealing with current issues needs to be developed, and suggested that this needs to involve care based on continuous caring relationships. He suggested that our ‘inner world’ is inherently connected to our physical wellbeing and we therefore need to bear in mind emotional and spiritual matters at all times. He cited some examples of placebo trials whose results indicated that a placebo can have a genuine positive effect on outcomes for patients, and suggested that this indicates that ‘hope’ may be an important factor in recovering from illness. There is also highlighted evidence indicating that views from a hospital window can affect recovery rates from operations, and research showing the real effects of certain types of meditation on a person’s wellbeing, particularly in the medication focuses on ‘compassion’.

David has done some research which indicates that outcomes for patients are dramatically affected by their first meeting with a doctor and their perceptions of the doctor’s understanding of their situation. Within his own practice, David aims to focus not on people’s weaknesses, but on the inherent strength of the individual. He believes that individual human encounters can be transformative, and that the consulting professional needs to be calm within themselves and focus entirely on the patient, ‘listening to them as if time stopped’. Healthcare professionals cannot provide this kind of care to patients unless they first take care of their own emotional wellbeing. (For more information see: [www.davidreilly.net](http://www.davidreilly.net))
Living and Dying Well sharing progress event

A full-day conference, Living and Dying Well - a chance to share progress, took place at Heriot-Watt University, Edinburgh on 3 December 2009. In her opening speech Nicola Sturgeon, Cabinet Secretary for Health and Wellbeing, made particular reference to the dedication and enthusiasm of those involved in the implementation of L&DW. She believes that this work stands out as a great example of how well the NHS can work in partnership with stakeholders from a broad range of sectors, with everyone looking to achieve the same results.

The event allowed delegates to receive up-to-date information about the work undertaken to implement L&DW, as well as opportunities to give their own views on specific areas of work by completing feedback sheets and participating in workshops, including workshops on the electronic Palliative Care Summary (ePCS) and the developing national Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) policy.

As well as discussing some of the achievements and challenges of L&DW, the Cabinet Secretary announced that to ensure that the profile of this work is not lost beyond 2011, NHS Quality Improvement Scotland (QIS) will develop and implement an improvement programme for palliative and end of life care to build on and ensure an ongoing focus of continuous improvement and quality assurance. This will aim to ensure the right care is provided at the right time and in the right setting in accordance with the wishes of the patient, their family and their carer, and will be undertaken as NHSQIS morphs into the new organisation of Healthcare Improvement Scotland. Nicola Sturgeon also referred to the upcoming NHS Scotland Quality Strategy, and felt that the recommendations contained within L&DW fit in very well with this strategy and its person centred approach.

A number of L&DW short life working groups are now nearing completion, and Nicola Sturgeon looks forward to receiving the recommendations of all the working groups, confident that they will move towards the people of Scotland receiving the care they so richly deserve.

For more information about Living and Dying Well and the sharing progress event visit the following website:

http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/LivingandDyingWell

New constitution

It's all change at the Scottish Partnership for Palliative Care. A new constitution, streamlining corporate governance procedures and taking account of all the views expressed during a lengthy consultation process with member representatives, was approved unanimously at the AGM on 30 September 2009. The new version makes provision for the first time for a category of Associate Membership, which will be introduced in the new year. Details are available on request from office@palliativecarescotland.org.uk

New Director

A new Director has also been appointed to take over from Pat Wallace, who retired in December after 8 years with the Partnership. Mark Hazelwood, who was until recently manager of Scotland's Mental Health Research Network and previously Director of the Multiple Sclerosis Society Scotland, is looking forward very much to his new role. Tribute has been paid to Pat's contribution to the Partnership and to palliative care in Scotland, and she would like to thank everyone for their very generous gifts, comments and good wishes.