NHSGGC Palliative Care MCN - V1

1. Your details

Number of respondents: 17

Name	Role	Organisation
Rhona Baillie	CEO	The Prince & Princess of Wales Hospice
Medical Consultant Team	Palliative Medicine Consultants	Marie Curie Hospice Glasgow
Alistair McKeown	Consultant	PPWH/NHSGGC
St Margaret of Scotland Hospice Clinical Team	Managers & Clinicians	St Margaret of Scotland Hospice
Fiona Finlay	Consultant in Palliative Medicine	NHS GG&C (Queen Elizabeth University Hospital)
Elayne Harris	Macmillan Lead Pharmacist	Pharmacy
Paul Corrigan	Information Officer	NHSGGC
Caroline Porter	Diana Children's Nurse	children's Hospice Association Scotland
Mairi-Clare McGowan	Consultant	St Vincent's Hospice
Jill McKane	Inverclyde GP Palliative Care Facilitator	HSCP
Val McIver	Senior Nurse	WD HSCP
Euan Paterson	GP / Mac GP / Chair GGC PC MCN	NHS GGC
lynn McKendrick	Senior Nurse	HSCP Community Nursing
Karen Allen	Practice Development, Paediatric Palliative Care	NHS GGC
Jane Edgecombe	Consultant Palliative Medicine	Beatson
Katie Clark and susanne Gray	GP palliative care facilitator & Macmillan nurse	RHSCP
Ellice Morrison	Professional Nurse Advisor	Glasgow City HSCP

2. Should each HSCP have an equivalent of an HSCP Palliative Care MCN?

Number of respondents: 16

- Yes
- that would be one for Glasgow ,which makes sense to me . Then additional for the Pratnership areas
- Yes
- There needs to be a regular forum and discussion, with key individuals identified who have responsibility for delivery and commissioning of palliative care services. Whether that is a "mcn" depends on the HSCP.
- Each HSCP should already have a planning group "JPPIG" or equivalent. These (at least in Renfrewshire) are already like "mini-MCNs" and currently feed into the main MCN.
- I think each HSCP should have a palliative care working group and strategy.The structure of the MCN has not worked particularly well for quite some time so it would be a good opportunity to review the requirements of the geographical area and organisations within it.
- We do not think there is a requirement for a MCN per se in each HSCP but see need for a Locality Group for Palliative Care within each HSCP. Where there are existing structures in place from CHPs, then decisions would need to be taken locally on how these merge/morph or dovetail with new Locality Group. The Locality Group would have representation from primary care, social care, local hospice, local education and pharmacy networks and other community groups and would decide locally how to share information and possible workstreams with other groups, e.g. Long Term Conditions, Acute group etc. The Locality Groups will determine local priorities and objectives but will take guidance from an overarching group which could continue to be called the GG&C MCN but only oif it has a managed aspect to it. Otherwise this would become a steering

group.

- Yes. We could see our local Palliative Care Joint Planning Performance and Implementation Group (JPPIG) fulfilling this role. This may require some refocusing on the value placed on the priority of this meeting by all organisations.
- No. Although I think each needs clear pall care representation repeating the full structure 6 times over seems time and manpower heavy, when many issues will be GGC wide rather than HSCP specific
- unsure
- Yes
- Yes
- I suspect that this is now essential.
- To have good grip on local needs/issues/priorities this would make sense to me, but keeping membership small to ensure there is a focussed approach would help
- Yes. Within Inverclyde we have Inverclyde JPIG. Roles of both groups would need to be considered.
- The St Margaret of Scotland Hospice Team propose the NHSG&&C Palliative Care MCN focus its role and remit on the aims and ambitions of the Strategic Framework for Action on Palliative and End of Life care and its commitments and facilitate a neutral platform where all Palliative and End of Life Care service providers, including HSCP's report on progress (SFA), share good practice examples/the efficacy of key partnerships/common problems and challenges encountered and how these may or may not have been overcome.

  We propose the MCN should provide an arena where all service providers can demonstrate an integrative approach to improvement rather than become HSCP focussed. This approach will allow members such as Hospices, HSCP's, Regional Services, Acute Services, including Emergency Medicine, SAS, Pharmacy, OOH's, Chaplaincy and Education an equal voice and share in the development and fulfillment of a local strategy to 'put patients first'. The Palliative Care MCN agenda should focus on the needs of the NHSGG&C population across all Local Authority areas with clear action plans of what needs to change, integrate, improve and develop. There are some wonderful good practice examples which require integration into main stream service delivery and this is the arena where discussions such as this should occur.

3. What would be the role/remit of an HSCP Palliative Care MCN?

Number of respondents: 14

- strategic planning for palliative care for their individual locality
  assist in the operational delivery of said strategy
- To lead on Palliative Care withinin the HSCP. Provide direction ,support for the Services within the HSCP. I am not sure if they could have an operational role but i think there needs to be the "permissions and recognition and support from them " to enable Services to take work forward ,there needs to be some feedback mechanism when things become static. I dont think they should be just an information sharing group. I am not sure re the answer for the question below.
- To deliver on strategic aims of Palliative Care Framework
- Delivery of Palliative Care in all care settings within HSCP - strategic and operational
- This group should be responsible for the work-plan for palliative care in its area. It has previously been mainly operational (using the strategic plans from the MCN and Scottish Government) but probably now needs to have a more strategic viewpoint.
- To ensure that the voice of the patient and family are truly heard.

  To encourage true multidisciplinary working when planning and funding models of care.

  To have a palliative care directory / atlas of all services in the locality.

  To have a robust strategy incorporating national legislation and local need.

  To have a supporting action plan to ensure outcomes are achieved.

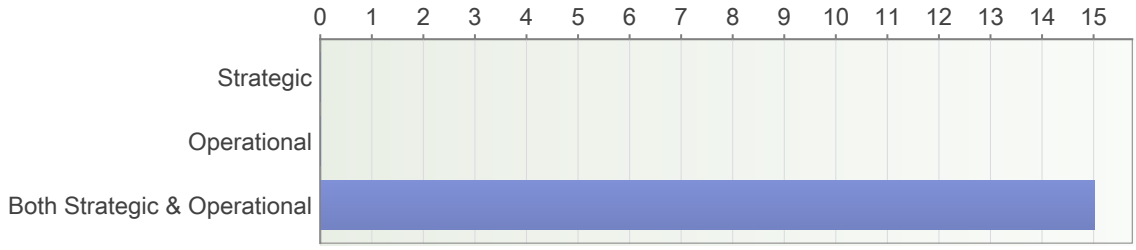
To ensure an excellent communication system accross all services.

To review the requirement for leadership in palliative care and a review system of this post or posts.

- Please see locality group as above. Questions 4, 5 and 6 will refer to a Locality Group
- To share developments across services involved in palliative care and offer a coordinated and planned approach to continuous improvement.
  To cascade national strategy developments and use this to inform local priorities and work streams.
  To provide a forum for feedback from local teams, services and lay members.
- unsure
- Governance of palliative care within each area.
- group of health & social care professionals from primary, secondary, and tertiary care,
- 1. Identifiying key priorities to improve access to/equity of provision of/standards of care for patients with life limiting illness, in the area served by the HSCP pall care MCN.
  2. Ensuring these are in alignment with national strategic policy
  3. Feeding up to some sort of overarching GG&C wide palliative care group that has executive function to ensure that there is resource to allocate to identified areas of need/development
- To manage Palliative care Services and Funding within Inverclyde?
- Each HSCP should integrate fully into the 'Palliative Care' MCN structure. As it stands, there appears to be no noticeable connection between each IJB across NSHGG&C, therefore the Palliative Care MCN could/should act as the HUB of connectivity with one specific yet shared key focus – the SFA. A collective Palliative Care MCN would not prevent each HSCP from meeting after/before each MCN meeting to share discussions, findings, problems or challenges more widely with key stakeholders. A feedforward/feedback mechanism could support local developments and discussions.

4. Would the role(s) of the HSCP MCNs be

Number of respondents: 15



5. What should the membership consist of?

Number of respondents: 15

- Specialist Palliative Care; Old age psychiatry, Community Nursing, General Practice; Social Work; Home Care; Pharmacy; HSCP management; HSCP Lead for palliative care; PPF; possibly Acute depending on impact of integration; AHP though need to be mindful of number on group; CHLN
- Older Peoples Services - ,SW ,LD ,OPMH,Service Manager ,Senior Nurse and /or NTL to ensure all areas are represented(egNE/NW/S) .Public Partnership rep ,Head of Service,GP and/or CD, third sector,discharge planners,macmillan support . Cordia? (but then we comission from them so not sure)
- A mix of Senior and front line clinicians
- Palliative Care Specialists from all appropriate care settings
  Management structure individuals with appropriate decision making powers
  Hospice management
  GP/Community Leads - medical and nursing
- Palliative Care "Lead" for the HSCP; administrative support; representation from Community (i.e. GPs, DNs etc); Acute; Hospices (if there is one or more in their area); Social services/carer agencies; Pharmacy (and should probably have patient/user involvement also
- Small group including all disciplines.
  One hospice representing all 6.
- As above in Q1
- Locality Manager; GP; Care at home Manager; Clinical Nurse Specialists - malignant and non-malignant disease; Scottish Care; Hospice Representative; Secondary Care representative; Children's services; Council representative; District Nursing Representative; Mental health Representatives; Patient/Carer/Service User Representatives; Voluntary Sector; SW Services Manager; Charities representative; Carer Centre Representative; Care Home Liaison Nurse; Pharmacy
- Practicing Health and Social Care clinicians, policy makers , managers, 3sector organisations, health
- A range of health / social care professional from each service - use of deputies in different roles from main representative to ensure balanced input into discussions.
- a group of health & social care professionals from primary, secondary, and tertiary care,
- Wide range of health and social care professionals as well as patient representation.
- Small groups with representation from acute/community/hospice +/- care home +/- children/transitional palliative care
- HSCP Managers.
  Hospice Managers / Clinicians.
  GP and DN Managers.
  Care Home Lead.
  Third Sector Services and Lay person representation.
  GP Pall Care Facilitators.
  Hospital Managers / CNS Pall Care Inverclyde.
  Chaplaincy / Pharmacy.
- Taking into account the response to Q1, we propose the following membership of the NHSGG&C Palliative Care MCN. The total number of members = 35 if there is a Care Home Representative and one Lead Nurse representing Marie Curie Nursing Service
  •Hospices - all 6
  •Acute Services - Lead Nurse & Medic
  •Emergency Medicine - Lead Nurse & Medic
  •Regional Service - Lead Nurse & Medic
  •Mental Health - Lead Nurse & Psychiatrist
  •Child and Young Person Representatives - Lead Nurse & Medic
  •Care Home Representative - not sure what structure is in place for Care Homes though this may be covered by the HSCP Rep
  •Older Adult Services - Lead Nurse & Medic

•Scottish Ambulance Service Representative
•eHealth Representative
•Website Editor
•Palliative Care Practice Development Steering Group Lead (Chair)
•Chaplaincy
•Pharmacy
•OOH - Lead Nurse & Medic
•HSCP - Lead for Palliative & End of Life Care from all IJB's – all 6
•Marie Curie Nursing Services - Lead Nurse
•Health Improvement Representative/Public Health

6. What are the minimum and maximum number of individuals that an HSCP MCN should comprise of?

Number of respondents: 12

Minimum

- 10
- 10
- 8
- 8
- 8
- 8
- 6
- 10
- 10
- hard to say exactly
- at a guess 4
- 5

Maximum

- 16
- 12-14
- 15
- 16
- 12
- 16
- ?
- 20
- 11 !
- again difficult to say as will depend on the size of the HSCP
- at a guess 8
- 10

7. What would the impact of these changes be on the Acute Palliative Care Group?

Number of respondents: 13

- Should enable the Acute group to interact in a more relevant fashion with the individual HSCPs when required. little if any in the way of structural impact
- Still not clear - will depends where the Hospital Teams sit, and how it interacts with the HSCPs.
- No, the acute needs to be represented locally on their own "MCN" but there also needs to be an over-arching acute group that can look at a "whole-systems approach" to the Acute.
- All groups should be restructured under the new system to prevent duplication.
- Will need at the very least, good channels of communication with Acute Group and ideally Acute would be represented on the locality group but also on the overarching group (MCN/Steering Group), i.e. need strong interface
- We are unsure but feel there does need to be acute representation at HSCP meetings.
- The Acute Pall Care group will deal with issues in the acute sector, but this includes the interface between primary and secondary care. The acute group needs representation form community/HSCP and also robust channels of communication.
- Unsure
- allow a more focussed direction from both groups
- The Acute Group would need to have awareness of the what is being discussed at the relevant HSCPs as this should also influence how acute services are planned and delivered.
- I'm not sure there would be a huge impact on this group - it would still serve the issues facing acute/hospital palliative care - but it would be useful for there to be representation for each hospital at the local HSCP pall care MCNs, so that there is some "joining up" of issues that span different care settings
- Co-ordinated approach to Palliative Care Services, commissioning and innovative working project work and development. Development of local policies / procedures / guidelines where appropriate.
- If the Palliative Care MCN were to become HSCP focussed, it could be to the exclusion of those services which sit outside the current HSCP model. This would include, for example Hospices as Independent Charitable Organisations (only up to 50% of funding will be provided by IJB's), Regional Services, SAS, Education, Chaplaincy, Pharmacy, Health Improvement/Public Health, eHealth and Acute Services, including Emergency Medicine. Each service requires an equal voice as a key partner within the Palliative Care MCN.

8. Would the structure and membership of the Acute Palliative Care Group need any revision?

Number of respondents: 13

- No idea - I don't have enough knowledge of it's current structure / membership
- Acute Group only just re-formed and discussing new remit
- I'm not familiar with the current structure, but it needs a wide membership from across the various hospitals. It needs nursing, medical and managerial input and also from a variety of specialties, not just palliative care if it is to be effective in truly widening access to palliative care for patients in all hospital wards who need it.
- Yes
- We actually need more information on the current structure, membership and work streams of the Acute Group before we can comment on this. Would like to see the Agenda, Minutes and Action Plans uploaded onto palliative care Glasgow website
- ?
- no!
- Unsure
- probably
- Not sure. Possibly not but there would need to be clear communication between the Acute Group and the HSCPs.
- I'm not sure about this
- Would need to consider this.

- Each service should have as part of its ‘shared’ accountability to MCN members, a reporting on progress mechanism, whereupon the MCN be updated on discussions, decisions, developments and initiatives. A report could be submitted prior to each MCN meeting or be uploaded to the MCN website when available according to the group meeting calendar. The MCN is not and should not be a decision making group as each partner group should have ToR/Objects of Memorandum; rather it should facilitate a shared communication mechanism.

9. How would the Hospices best fit with the new organisational structures?

Number of respondents: 12

- Through the HSCP that they are now attached to
- Ideally, I think that they need to have strong links with their own HSCP. This means that there needs to be representation for the hospices (at senior level) in their local JPPIG/MCN. However, it would also be helpful if the hospices could feed into the overarching group (see below). Ideally, this would not require one representative from each hospice, but an agreed number, perhaps two (one medical, one nursing) from the six (and also split so that both Glasgow and Clyde are presented).
- One or two representatives from the 6 hospices.

  Consider leadership of the group from the hospices or other non NHS organisations .
- Hospices will need to have representation on locality group(S) - 1 Person from each hospice on each HSCP. The Locality group would then nominate one person to represent group on the MCN/Steering group
- Should be a hospice presence within the HSCP meeting. It could be any member best placed to contribute - for example the CNS covering the geographical area of the HSCP.
- Should be integral to them
- Represented at HSCP groups within own catchment area.
- Hospice rep on each Local Palliative group
- Possibly via the HSCP group in which they are located but they also need to know what is happening in acute.
- I'd suggest that there be representation for each hospice at the pall care HSPC MCN
- Part of a co-ordinated integrated approach.
- All 6 Hospices, as Specialist Palliative Care providers, should be represented within the MCN as 'Independent' organisations. Hospices cannot be represented by an HSCP or another Hospice or professional group.

10. Is there a need for an additional group with ‘oversight’ of the whole system of Palliative Care across the entire Local Authority and Health Board area?

Number of respondents: 17

- Yes
- I would think so
- Yes
- I think someone requires oversight - if only just to be advisory to the HSPC groups and to aid in communication of good practice/joint working etc.
- Yes.
- Potentially.
- See above. We recognise that more discussion requires to be held on the function of the overarching group and the level of managerial input (? from where) needs to be determinted but we see a role for this group in terms of networking, maintaining lines of communication and providing opportunities for cross working across the locality groups and also with setting the direction of travel using the Strategic Framework as blueprint. It is also possible that this group could then feed into the National Implementation and Advisory Group (NIAG)
- Yes
- Yes. Otherwise there will be no strategic overview of national drivers etc
- I think there should be a group that looks over the whole system of Palliative Care that includes W&C services. Although our needs differ greatly at present I think it is important that we become better integrated within adult

services, as we may have much to learn and there is the potential to adapt systems that are already in place for use in paediatrics.

- Paediatrics
- Yes
- Yes
- I think this would be necessary due to the size and complexity of GGC coupled by the fact that we also have regional services.
- Yes, definitely - otherwise we risk becoming more fragmented than we already are. I have a sense that there are already lots of palliative hamster wheels turning across GG&C, in different care settings, without streamlined means of cohesion, despite the best efforts of the existing MCN to join these up. Having a group with an overview of what's happening across the piece, with executive function, may facilitate gaining enough momentum to drive improvements forward, especially if each satellite pall care HSCP MCN feeds into this
- Yes - information sharing is essential.
- The Palliative Care MCN should reshape to ensure its role and remit focus on National Policy and Priorities (whatever this may be). The Agenda should reflect the gathering of key aims and ambitions as agreed by member organisations. There are 6 Local Authorities within the NHSGG&C Health Board area, therefore the MCN should be the group with oversight of Palliative and End of Life Care.

11. What would the role/remit of such a group be?

Number of respondents: 13

- Advisory; Communicative;
- ensure that there was consistency
- There is a need to have an oversight group to ensure consistency of approach to Palliative care and sharing good practice. It would be responsible for this group to set direction with local palliative care groups to work to
- Recommendations and guidance
  Communication
- As stated above, it needs to have oversight of the whole system. There may be initiatives in one area that are working well and could be rolled out to others if they know about it. The MCN should be a conduit for communication between the HSCPs for palliative care. The group should also be able to lead on areas such as education and potentially research.
- Strategic Direction and management of Action plan if it was felt it couldnt be managed locally.
- SEE ABOVE
- Considering the size of GGC and the number of HSCPs with their own palliative care group it will be important to try to avoid areas working in silos.
  This group could encourage and facilitate sharing of good practice, learning from what has worked well or not so well in different areas, thereby avoiding creating gaps or inequalities in provision across GG&C.
- Overseeing palliative care in all settings, providing a forum for discussing work of all HSCP and Acute Palliative Care Groups, dissemination of information on all palliative care groups as required, maintaining work of MCN sub groups that are retained.
- the function of the over sight group is to work in a coordinated way that is not constrained by existing organisational or professional boundaries
- Unsure at this stage
- Discussion and facilitation.
- N/A

12. What should this group be called?

Number of respondents: 13

- If there is a collective name/term for the 6 HSCPs then that & NHS GGC Palliative Care Advisory Group
- ? NHSGGC Palliative Care Steering Group
- ?
- Don't know ?"Advisory Board"
- SEE ABOVE
- Unsure
- Steering group?
- Palliative Care Health & Social Care Network
- MCN Steering Group
- Unsure at this stage
- ??Greater Glasgow and Clyde Regional Palliative Care Advisory Group??
- Palliative Care Network
- N/A

13. Where should the membership of this group be drawn from?

Number of respondents: 14

- Acute group (1-2); HSCP (2); Hospices? (1); Pharmacy (1); Patient/carer (1); Public Health (1); Lead clinician (ha ha); Lead Nurse; Senior managerial figure; Chaplaincy; Regional services
- theose leading the HSCP groups or a deputy from those same groups
- Leads from HSCP Palliative Care group, Professional Nursing input, Clinical Director, GP Lead for Palliative care, A Lead for Hospices
- A rotational rep from each HSCP?
- It needs to be from across the area, but kept to a small enough group to make it functional. I suspect if it is acting as a high level "advisory group" then the membership needs to have enough seniority/experience to be taken seriously by the HSCP Palliative Care Leads. In fact, there should probably be at least two HSCP leads on the group as well as representation from acute and hospices.
- Nominated individuals.
- Representation from each Locality Group, Acute Group, Regional Services and possibly areas such as Chaplaincy, CHAS, pharmacy and some of the current action sub groups that do no easily fit into Locality Group but need to be around the table, e.g. HI&T
- People representing palliative care within GG&C at SPPC, NAG and Scottish Government level.
- Representatives from each HSPC group, acute, regional services and sub groups.
- a group of health & social care professionals from primary, secondary care
- Each HSCP group, the acute group and cross-board services such as chaplaincy and pharmacy
- representation from each HSCP MCN
- HSCP representation / chair.
- N/A

14. What would be the minimum/maximum number of members of this group?

Number of respondents: 12

Minimum

- 12
- 15
- 8
- 10
- 4
- 10
- 10
- 10
- 1 member from each HSCP MCN
- 10

Maximum

- 16
- 20
- 12
- 10
- 20
- 10
- 20
- 20
- 15
- 15 to20
- 2 members from each HSCP MCN
- 20

15. How would Regional Services, Chaplaincy & Pharmacy fit with any new structure?

Number of respondents: 13

- Via membership of Advisory group
- Would Regional Services be part of Acute Services? Pharmacy would link with local groups and Chaplaincy with steering group
- Chaplaincy will fit with HSPC? Pharmacy - not sure. Regional services - not sure.
- I think they should probably have one representative each on the Advisory MCN group.
- Restrucure would determine this.
- as above
- Unsure. Locally we have pharmacy representation and have recognised would be desirable to have chaplaincy.
- Regional Services, Chaplaincy & Pharmacy represented in oversight group and responsible for gathering information on work in own area from local HSCP Palliative Care Groups.
- Pharmacy rep on over sight group & HSCP Palliative Group & local Palliative Group
  Chaplaincy - local Palliative Group
  Regional - oversight group - but unsure
- This will be extremely challenging for ourselves in pharmacy. We work across all sectors of the board in hospices, hospitals and primary care but are a small team in comparison to medicine and nursing. Consideration would need to be made as to the sustainability of being able to be involved in all the HSCP group, Acute Group and any oversight group.
- Regional services - Depends how they link up with HSCPs
  Chaplaincy and Pharmacy - difficult to say, especially as there are pharmacists/chaplians in hospice, in hospital palliative care teams, and in the community - would it be worth having 1 representative in each HSCP MCN,

who would gather the views of their colleagues in different settings and represent these at meetings, rather than each come along? The alternative is a chaplain from the local hospice, local hospital, and/or community, at each HSCP MCN, so that everyone's views are represented on the group. If this were replicated for each discipline though, it soon becomes a lot of people round a table...
- Link to local Network Group. Chaplaincy / Pharmacy should be part of local group.
- As per previous response

16. Would the current Standing sub-groups continue and if so where would they sit?

Number of respondents: 14

	Continue - sit under oversight group	Continue - sit under HSCP MCNs / Acute Group	Continue - different placement	Discontinue Group	Undecided	Total	Average
Communications	12	1	0	0	1	14	1.36
Education & Training	9	2	2	0	1	14	1.71
HI&T	11	1	0	0	1	13	1.38
Therapeutics	10	1	1	0	2	14	1.79
Web Development	12	0	0	0	2	14	1.57
Total	54	5	3	0	7	69	1.56

17. If you have any other comments on the Standing sub-groups please add them here.

Number of respondents: 11
- E&T i think would be best dealt with by splitting it into an Acute group which would sit under the Acute group and a Primary care group which would sit under a collective/combined HSCP group. a bit the way the 6 Hospices link educationally?
- HI&T absolutely has to remain as a board-wide group. This was discussed at the meeting on 22nd Sep and all were in agreement with that. It is simply not practical for the IT/eHealth departments to liaise with all the HSCPs individually when there are so many common threads being worked on.
- All functions are required locally with oversight group being strategic.
- We are referring to HSCP Locality group in the second column. We see a role for Education and Training in both Locality and overarching group
- Some groups function better than others. However need to share expertise and not have unnecessary duplication
- I would really like to see the development of a paediatric sub group that incorporates acute, community and hospice teams together as the provision of palliative and end of life care is currently very fragmented in paediatrics. It would be most helpful to have support from any new structure put into place which promotes partnership working between specialist palliative care services.
- Paediatrics must be represented within an MCN type group in order for NHSGGC to meet the commitments of the Strategic Framework for Action.
- could sit under HSCP MCN. also
- Not sure if the last 2 should sit under oversight group or HSCP MCNs and oversight group
- Undergraduate education group is also key - should we link with Universities.
- All MCN Subgroups should dovetail into the new ‘SFA Commitment’ Structure. A national/strategic group has been set up for each commitment; therefore MCN subgroups should map the aims and objectives of these

groups with a local focus. New groups should be created where necessary. The current structure is not so different to what is ultimately required. There has to be a direct correlation and dialogue between the NAiG and the MCN if the aims and ambitions of the SFA are to be realised. The agenda and outcomes of each SFA Commitment Groups should communicate clearly and directly to each MCN Sub Group – this could be a key role of the Communication Sub-Group.
The Chair of the MCN should have direct communication with the Chair/Secretariat of the NAiG and subgroup communication should be established from the outset.

18. Would the current Action sub-groups continue and if so where would they sit?

Number of respondents: 14

	Continue - sit under oversight group	Continue - sit under HSCP MCNs / Acute Group	Continue - different placement	Discontinue Group	Undecided	Total	Average
Care Homes	1	11	0	0	2	14	2.36
Care in Latter Stages Of Life	4	8	0	0	2	14	2.14
Heritage / Legacy/ Bereavement	4	5	1	0	4	14	2.64
Non-Malignant Palliative Care	1	9	0	1	3	14	2.71
OOH Period	4	9	0	0	1	14	1.93
Patient / Carer Involvement	3	8	0	0	2	13	2.23
Power of Attorney	5	4	0	2	3	14	2.57
QEUH	1	5	1	3	4	14	3.29
Recognition of palliative/supportive needs	2	7	0	1	4	14	2.86
Total	25	66	2	7	25	125	2.53

19. If you have any other comments on the Action sub-groups please add them here.

Number of respondents: 7

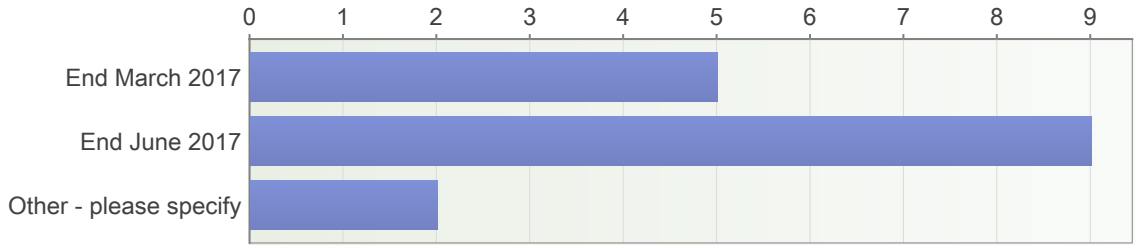
- I think these groups would become the remit of the HSCP ,but how do we link what each area is doing as they will all be off doing their own thing ,which may be ok to meet the needs of very different and diverse groups in local areas, the leads of theses groups need to be cohesive in their direction of travel
  I assume there would be a shared workplan of some kind .
- I'm quite uncertain about a lot of these. I think they have been doing some good work and should ideally continue, but I'm not sure how well they'll be taken up by the individual HSCP groups, but at the same time I don't think they will work as board-wide groups any more.
- I think it is still unclear how the pall care bit of the HSCPs is going to work, or the interface with acute. Some sort of overarching group needed but difficult to know whether this should be strategic? operational? communication?
- a review of progress of these group would be helpful
- Please excuse my lack of knowledge about the strategic/operational landscape of palliative care in GG&C - I'm a relatively new Consultant (I started a locum post at the Beatson in Feb 2015, and was appointed as a substantive consultant in June 2016) and having come from Tayside, which is a more straightforward set up (there are only 2 hospices, both NHS), it's hard to get my head round 1. how everyone's interests/views/organisations are served without the group that does that being overwhelmed by so many people, and 2. How HSCPs work (?!) - where acute palliative care fits into these, if at all; who holds the

pursestrings for palliative care, both in hospital and in the community; where does the palliative care team funded by Regional Services fit into all this (are they included in the same pot of money?) - so my answers to these questions come from not really knowing what I'm talking about, and under these circumstances, I usually keep quiet, but thought seeing as you've taken the time to seek views, I should give responses to this survey. Happy to discuss any of my non-sensical responses.
Fiona

- I think action groups should be at local level.
- Supplementary Groups should be created where there is little or no representation by an SFA Commitment Sub-Group. All MCN Subgroups should have a ToR specific the aims of the SFA with a focus on local needs and priorities.

20. What should be the timescale to complete this transition?

Number of respondents: 16



Open text answers: Other - please specify

- I dont really know ...sorry
- Ideally, end March 2017, but I suspect that is not realistic by the time a plan is finalised and then put out to members for agreement (or not).