Coventry and Warwickshire
Integrated Care System

Coventry and Warwickshire

Palliative and End of Life Care Strategy

2024-2029

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Welcome to the Coventry and Warwickshire Palliative and End of Life Care Strategy 2024-2029

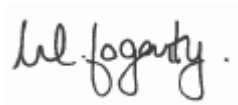
This Strategy is an overview of how health and social care will work together with our communities across Coventry and Warwickshire to improve the lives of people with palliative and end of life care needs and those who look after them.

We have asked people with palliative and end of life care needs, their carers, those who live in Coventry and Warwickshire, as well as our partners in health and social care, what we should focus on to improve the care and support we provide to people.

We have discussed all areas of palliative and end of life care, from activities aimed at improving the understanding of the importance of planning for the end of life across our communities, through provision of care and to bereavement care.

The detailed Palliative and End of Life Care Strategy: Delivery Plan, will hold us accountable for the improvements we will make over the next five years and can be found at Appendix 1

Julie Nugent, Chief Executive
Coventry City Council



Monica Fogarty, Chief Executive,
Warwickshire County Council

Philip Johns, Chief Executive Officer, Coventry and Warwickshire ICB

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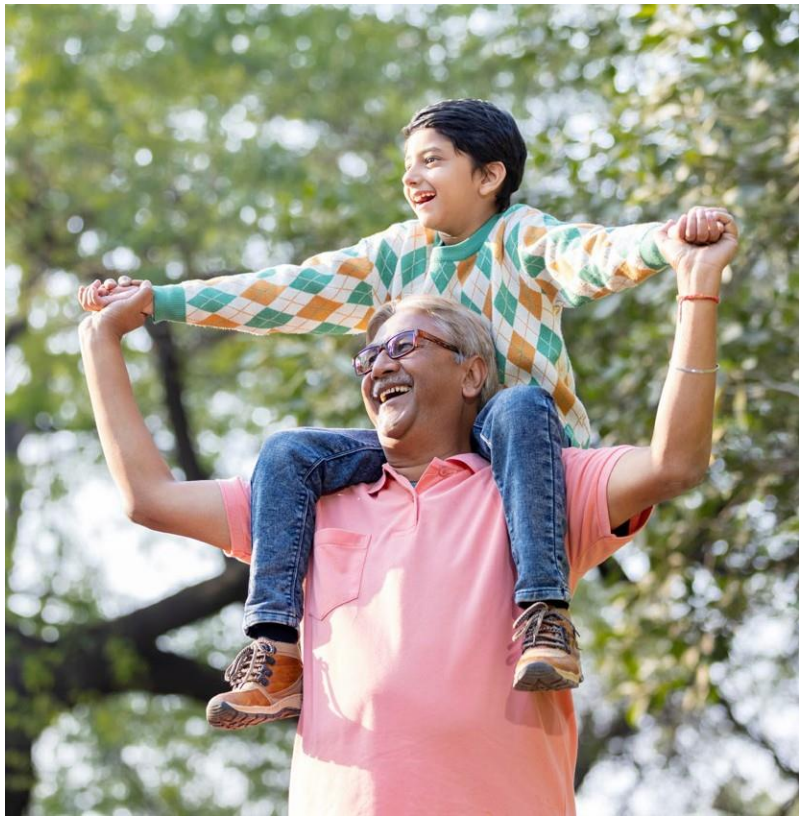
What is Palliative and End of Life Care?

- Palliative care is about improving the quality of life of anyone facing a life-limiting condition. It includes physical, emotional, social and spiritual care as well as practical support.
- Palliative and End of Life Care involves communities supported by health and social care professionals and organisations working together, to provide physical, emotional and spiritual support for the individual and those who matter to them.
- End-of-life care is the treatment, care and support for people who are nearing the end of their lives. It is an important part of palliative care and aims to help people live as comfortably as possible in their last months, weeks or days of life and to die with dignity.
- We want our people of Coventry and Warwickshire to live as well as possible for as long as possible.



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The National Framework: Ambitions for Palliative and End of Life Care

To support people to plan and consider wishes and preferences for their end-of-life care and treatment, we have a national framework to support the delivery of care: Ambitions for Palliative and End of Life Care.

The Ambitions Framework sets out 6 key areas of focus:

01 Each person is seen as an individual

02 Each person gets fair access to care

03 Maximising comfort and wellbeing

04 Care is coordinated

05 All staff are prepared to care

06 Each community is prepared to help

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National Picture:
Palliative and End of Life Care in the UK

More than half a million people are expected to die each year, and many live with a life expectancy of less than a year at any one time.

This is set to increase with a growing older population, so more people are expected to die at an older age.

Children's palliative care is a complex and changing picture which includes rare diseases, and can see children and young people live longer with more complex needs.

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Our Local Picture: Coventry and Warwickshire

Just over 1 million people live in Coventry and Warwickshire.

The Coventry and Warwickshire Integrated Care System enables people across Coventry and Warwickshire to start well, live well and age well, promote independence and put people at the heart of everything we do.

We do this through a range of collaborative working arrangements:

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Our Local Picture: Palliative and End of Life Care

At any one time 1% of our population: 10,000 people, will be thought to be in the last 12 months of life.

- Across Coventry and Warwickshire, we have a range of health, social and third sector providers working with communities to support people over the age of 18 years who are thought to be in the last 12 months of life.
- For babies, children and young people with life limiting conditions, support is provided through the course of their short lives, by a number of providers working together.

Our Trusts

- Coventry and Warwickshire Partnership NHS Trust
- George Eliot Hospital NHS Trust
- South Warwickshire NHS Foundation Trust
- University Hospitals Coventry and Warwickshire NHS Trust

Our main locations

- University Hospitals, Coventry
- George Eliot Hospital, Nuneaton
- Warwick Hospital
- 1 Brooklands, Solihull
- 2 Caludon Centre, Coventry
- 3 Ellen Badger Hospital, Shipston-on-Stour
- 4 Hospital of St Cross, Rugby
- 5 Leamington Spa Hospital
- 6 Manor Court, Nuneaton
- 7 St Michael's Hospital, Warwick
- 8 Stratford Hospital
- 9 Woodloes House, Warwick
- 10 The Shakespeare Hospice
- 11 Myton Hospice Warwick
- 12 Myton Hospice Coventry
- 13 Myton Hospice Rugby
- 14 Shipston Home Nursing
- 15 Mary Ann Evans Hospice
- 16 Zoe's Place

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Our Local Picture: Our Communities

Within Coventry and Warwickshire, we have a rich diversity in our communities.

We aim to provide care at the end of life to meet the needs of our diverse communities.

Coventry

is ethnically diverse with

34%

of the population from minority ethnic groups

120

languages spoken in Coventry and Warwickshire

Most common languages spoken (after English)

Coventry	Warwickshire
- Bengali	- Polish
- Polish	- Punjabi
- Urdu	- Gujurati
- Tamil	- Nepalese
- Punjabi	- Urdu

English is a second language for **14%** of Coventry residents

Active LGBT+ communities
Warwickshire PRIDE
Coventry PRIDE

89.6%

of the population in Warwickshire are not from minority ethnic groups

The main religions in Coventry and Warwickshire after **Christianity** are **Islam, Sikhism** and **Hinduism**

Warwickshire

has an older population with

21%

of the population over 65 – higher than both the West Midlands and National averages

Coventry

has a much younger age profile than England in general – two universities contribute to the average age being **32.1 years**,

14.6% between 18-24

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How the strategy was developed: Engagement

We **co-produced** this strategy speaking to the people of Coventry & Warwickshire:

- Those diagnosed with a life limiting condition
- Their carers and loved ones
- People who had been bereaved

We held a full engagement on the draft strategy between **June-July 2023** and produced a 'You Said We Did Report' main themes identified:

- Language & Layout
- Workforce Mapping
- Access to services

We **engaged** with stakeholders from across Coventry & Warwickshire, including NHS providers, councils, community leaders & third sector providers

We held a series of **meetings, group discussions and surveys** where we discussed:

- What matters most
- Challenges and Opportunities
- Priorities

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Engagement

We reached out to:

Over

1,600

people

including patients, the public, health, social and third sector professionals.

Over

300

organisations

across Coventry and Warwickshire.

We directly spoke with:

Over

30

different community

groups and health and social care organisations via face to face or small group meetings.

A series of public and stakeholder surveys have been completed with a total of

239

responses

from across the system

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Our Priorities:
What we want to do

1. Provide **information** which focuses on identification, early intervention and support for people with palliative and end of life care needs.
2. **Access** to timely palliative and end of life care with support throughout, for all of our diverse communities.
3. **Support** people diagnosed with a life limiting condition and those who matter to them, carers and communities.
4. **Improve** the quality of personalised care and support planning for people with palliative care needs, including planning for the end of life, through education and training for all.
5. Deliver a **sustainable** system of integrated palliative and end of life care.

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The people we will focus on in the first 2 years of the palliative and end of life care strategy.

In the first 2 years of the strategy, we will focus our actions on the following groups:

- People over the age of 18 years, thought to be in the last 12 months of life.
- Babies, children and young people diagnosed with a life-shortening condition or those for whom curative treatment for a life-threatening condition is not an option.

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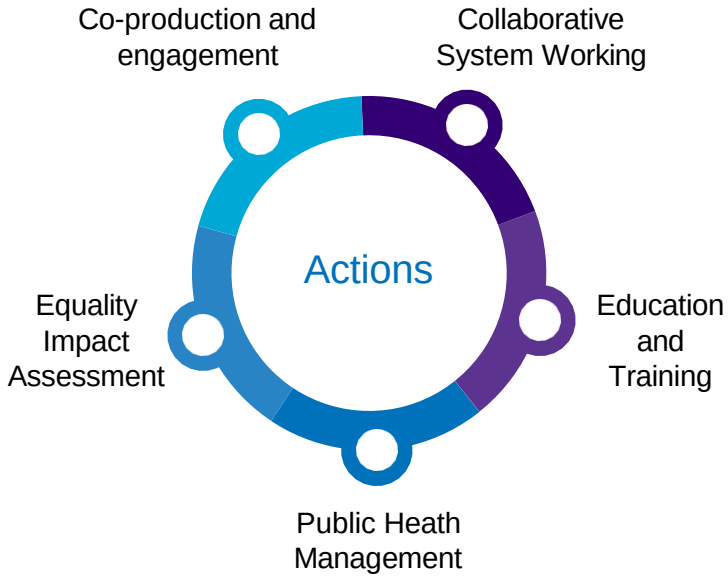
Health Inequalities in Coventry and Warwickshire

Actions we will take to promote Health Equity in Palliative and End of Life Care

We value the importance of fair access to care for our differing Communities.

We are determined to take actions to reduce health inequalities being experienced by our most vulnerable people.

We have identified the challenges we want to tackle and the actions we will take in all of our work across all ages to enable this to happen.



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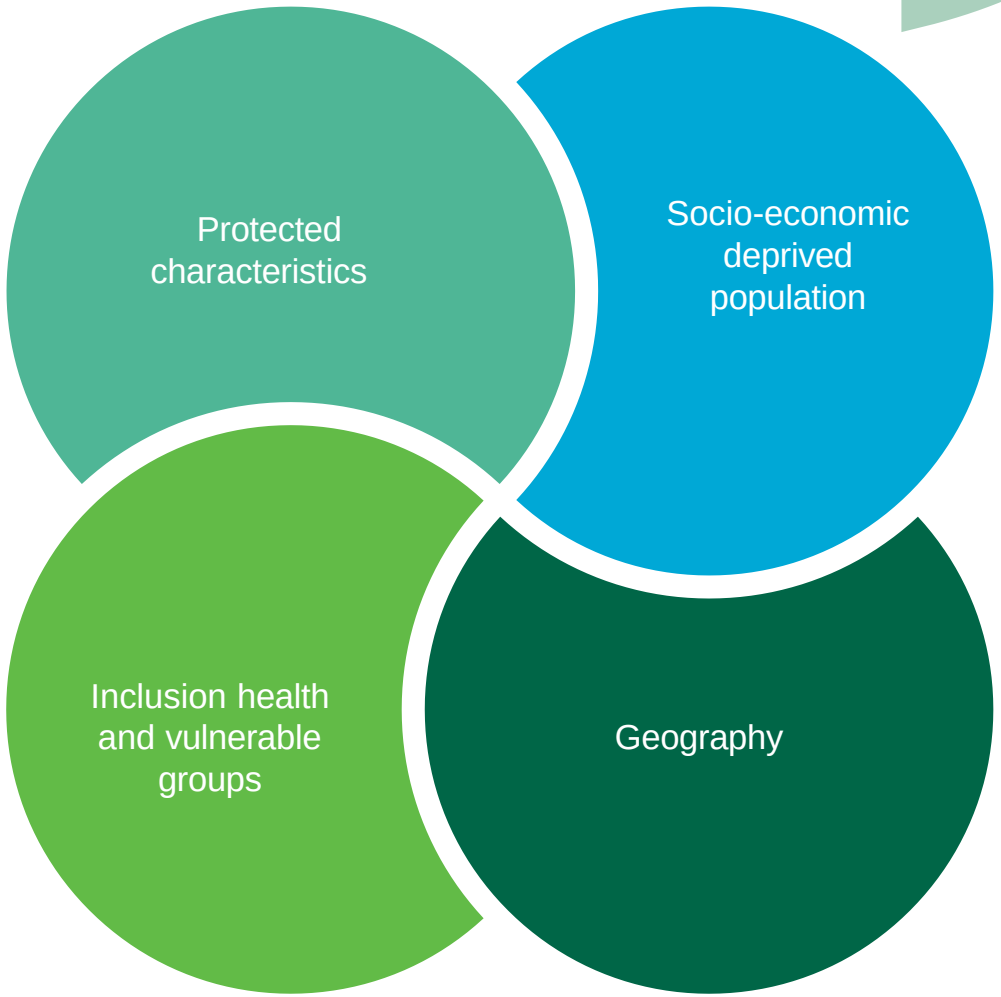
Health inequalities are unfair differences in health between our community groups.

In Coventry and Warwickshire these differences result in some of our communities having poorer access to information, appropriate services and planning for end-of-life care.

Our aim is to provide fair access for all our diverse communities.

We have identified greater differences in access to palliative and care at the end of life for:

- Asylum Seeker and Migrant communities
- Looked After Children
- People diagnosed with Dementia
- Ethnic Minority communities
- Gypsy, Roma and Traveller communities
- Homeless communities
- Learning Disability communities
- LGBTQIA+ communities
- People diagnosed with severe Mental Health challenges
- Prison communities



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Palliative and End of Life Strategy

What does good Palliative and End of Life Care look like?

In Coventry and Warwickshire, our vision is to provide Palliative and End of Life Care for all of our diverse communities, which enables patients and their loved ones to live as well as possible, supported by their own communities.

We want to enable fair access to professional palliative and end of life care and support, when this becomes necessary, in the setting of choice for the individual and those important to them, in a planned and pro-actively supported way.

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How we will provide good Palliative and End of Life Care

The Ambitions Framework enables the delivery of the NHS Long Term Plan, which contains a specific commitment to provide more personalised palliative and end of life care.

A systemwide approach with co-ordinated care across organisations and communities, is an essential element of enabling personalised, pro-actively planned care for individuals and those important to them, in the final months and weeks of life.

Personalised care in the last year(s) and months of life will result in a tailored plan around what really matters to the person, to improve experience and quality of sustainable health and care services.

Teams of professionals and community members working together to provide co-ordinated care to those thought to be in the last 12 months of life. This will be achieved through shared-decision making conversations which lead to personalised care and support planning.

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How we will deliver improvement

Through the Strategy and Delivery Plan, we are aiming to provide palliative and end of life care in the following ways:

- Care seamlessly co-ordinated across settings with clear communication and referral pathways.
- Pro-active personalised care and support planning for care at the end of life.
- Collaborative approach across health and social care for those with palliative and end of life care needs.
- Clear communication with the individual and those important to them.

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PEoLC Delivery Plan - Overview

Key priorities	Areas of focus

1. Provide information which focuses on identification, early intervention and support for people with palliative and end of life care needs.	• Ensure up to date information for PEoLC services, referral pathways and support options are available to patients, professionals and the public.
	• Pathway Reviews:
	  • Continuing HealthCare Fast Track
	  • Early Identification
	  • Transition from children and young people's services to adult services
	• Identify work streams across the system which dovetail into PEoLC
	• Improve availability of data regarding palliative and end of life care

See Appendix 1 for Delivery Plan in full

How we will deliver improvement: PEoLC Delivery Plan - Overview

Key priorities	Areas of focus

2. Access to timely palliative and end of life care with support throughout, for all of our diverse communities. 	• Identification of underserved communities
	• Pathway Reviews:
	  • 24/7 access to care
	  • Psychological Therapy
	  • Bereavement
	  • Personal Health Budgets
	• Access to medication workstream
	• Review of support for emotional and spiritual as well as practical living needs.

3. Support people diagnosed with a life limiting condition and those who matter to them, carers and communities. 	• Personalised Care & Support Planning to include
	  • Advance Care Planning Review:
	  • Documentation
	  • Systemwide communication
	• Pathway Reviews:
	  • Unpaid Carer Support
	  • Children & Young People: Sibling and Friend Support
	• Poverty Proofing Workstream

See Appendix 1 for Delivery Plan in full

How we will deliver improvement: PEoLC Delivery Plan - Overview

Key priorities	Areas of focus
4. Improve the quality of personalised care and support planning for people with palliative care needs, including planning for the end of life, through education and training for all. 	• Development of an Education & Training Framework for Palliative and End of Life Care • Dying Matters: a systemwide approach to awareness raising
5. Deliver a sustainable system 	• A comprehensive systemwide review of workforce, pathways, roles and responsibilities. • Integrated Commissioning Model: contracts and funding review.

See Appendix 1 for Delivery Plan in full

Glossary

- Advance Care Plan (ACP) - A record of your preferences about your future care and support, including decisions about medical treatment and end of life care. It is sometimes known as an Advance Statement.
- Babies, Children and Young Peoples (BCYP) services
- Inclusion health and vulnerable groups - For example Gypsy, Roma, Travellers and Boater communities, people experiencing homelessness, offenders/ former offenders and sex workers.
- Integrated Commissioning Model - Integrated commissioning is when two or more agencies come together to commission services which are delivered across the system for service users with Health, Social Care and/or Educational needs.
- Geography - For example, population composition, built and natural environment, levels of social connectedness, and features of specific geographies such as urban, rural and coastal.
- Palliative and End of Life Care (PEoLC)
- Protected characteristics - Age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation.
- Rapid Response (RR)
- Socio-economic deprived population - Includes impact of wider determinants, for example: education, low-income, occupation, unemployment and housing.
- Urgent Care Response (UCR)

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Some of our Partnerships

Warwickshire County Council

Coventry City Council

North Warwickshire Borough Council

Nuneaton & Bedworth United to Achieve

Borough Rugby Council

Stratford-on-Avon District Council

Warwick District Council

NHS Coventry and Warwickshire

NHS Coventry and Warwickshire Partnership NHS Trust

NHS George Eliot Hospital NHS Trust

NHS University Hospitals Coventry and Warwickshire NHS Trust

NHS South Warwickshire University NHS Foundation Trust

NHS West Midlands Ambulance Service University NHS Foundation Trust

Shipston Home Nursing Hospice Care at Home

The Shakespeare Hospice

Carers Trust Heart of England

Zoë's Place Baby Hospice

acorns Your local children's hospice

Marie Curie Care and support through terminal illness

Mary Ann Your Local Hospice

myton hospice

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Appendix 1

– Coventry and Warwickshire Palliative and End of Life Care Strategy Delivery Plan

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Palliative and End of Life Care Strategy

2024-2029

Delivery Plan:
January 2024 - December 2026

Coventry and Warwickshire
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Overview

Coventry and Warwickshire Palliative and End of Life Care (PEoLC) Strategy Delivery Plan

This Delivery plan is intended to support the delivery of the Palliative and End of life Care Strategy for Coventry and Warwickshire.

Identified Priorities for PEoLC

5 priorities have been identified for our Palliative and End of life care strategy:

- Information
- Access
- Support
- Improving
- Sustainability

Coventry and Warwickshire Partnership Board

In January 2023 the PEoLC Partnership Board was launched, bringing together health, social care, local authority, third sector and lived experience representatives to drive forward PEoLC across Coventry and Warwickshire. This Board enables PEoLC oversight across the Integrated Care System, including this delivery plan, which will be monitored through reporting of the identified workstreams to the Board support the delivery of the Palliative End of Life Care Strategy 2024-9.

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Information

Information which focuses on identification, early intervention and support for people with palliative and end of life care needs.

Issue to be addressed	Action	By When	Outcome	What good looks like	How will we get there	How will we measure success	Organisations responsible /lead
Improve identification of people in the last 12 months of life.	Improve access to and quality of data around palliative and end of life care.	Apr-24	Increase in the number of adults identified as likely to be in the last 12 months of life: focus on under-served communities including frail elderly. Review of CYP identification with palliative and end of life care needs.	Robust systemwide processes in place to proactively identify adults who is thought to be in the last year of life. Assurance that CYP palliative and end of life care identification processes are robust.	Agreement of system wide approach to identification of adults thought to be in the last year of life. Robust process in place for Information gathering across the system.	NHSE Core Metric 1: Pallaitive and End of life identification & PCSP for adults Agree Core Data measures for PEoIC for the system, to be utilised to assure the Pallaitive & End of Life Partnership Board of improvements and developments.	Lead: ICB Support from: System wide providers
Health and social care staff will have access to information in order to understand the all-age palliative and end of life care pathways and services which are available to support people across Coventry & Warwickshire.	Ensure up to date information re: PEoLC services, referral pathways and support options are available to professionals.	Nov-24	Increase awareness of available systemwide support, improve collaborative working and the quality of care through a seamless, systemwide delivery of palliative and end of life care.	Robust up to date PEoLC information , accessible to health and social care professionals	Information mapping across the system Identify portal to host information Identify key administrator of the site	Metrics data: e.g. Clicks on the portal Feedback from professionals Formal survey	Lead: ICB Support from: System wide providers

Information (continued)

Issue to be addressed	Action	By When	Outcome	What good looks like	How will we get there	How will we measure success	Organisations responsible /lead
The people of Coventry and Warwickshire will be able to access all-age information regarding palliative, end of life care and support services across Coventry and Warwickshire.	Ensure up to date information re: PEoLC services, referral pathways and support options is made accessible to the general public.	Nov-24	Increase awareness of available PEoLC systemwide care and support options.	Robust up to date information , accessible to anyone.	Information mapping across the system Review host site Identify key administrator of the site	Metrics data: e.g. Clicks on the portal Feedback from EBEs and the public Formal survey	"Lead: ICB Support from: System wide providers"
Transition from children and young people's services to adult services for PEoLC	Collation and process map Transition Pathways for PEoLC Using the Mapping, gap analysis and pathway consolidation to inform needs and requirements moving forward	Sept 2024 April 2025	Improved and supported PEoLC transition from CYP to Adult services.	Support and planning which is clear and transparent, with clear expectations for both the patient and their families	Working across the system with key stakeholders to map current processes and identify where there may be gaps in support. Develop Action Plan for improvement in 2024-5.	Patients of transition age will make a smooth transition to adults services -the success of this will be measured by patient/ carer experience surveys and professional feedback	ICB, NHS, LA & Third Sector Providers

Information (continued)

Issue to be addressed	Action	By When	Outcome	What good looks like	How will we get there	How will we measure success	Organisations responsible /lead
Identification of CHC FastTrack	Review CHC Fast track pathway for PEoLC care in the community	Mapping & data baseline: June 2024 Pathway review April 2025	Improved systemwide patient flow, more effective utilisation of available community support services, early discharge from hospital setting and improved experience for patients and those important to them.	Timely access to the most appropriate PEoLC support for individual need with PCSP.	Mapping CHC Fast track current pathway. Identify current system challenges and opportunities to improve the PEoLC CHC FT pathway. Patient & Carer surveys. Develop Action Plan to support opportunities for quality improvement and mitigate challenges.	Improved identification of appropriate CHC Fast Track patients. Improved patient and carer experience.	ICB, CHC, NHS, LA & Third Sector providers.
Urgent and Emergency Care (UEC) /Urgent Community Response (UCR) for palliative and end of life care.	Baseline of available UEC / UCR data for people thought to be in the last 12 months of life. Pathway mapping for PEoLC in the UEC / UCR setting with identification of points of challenge. Develop systemwide approach taking into account the individuality of place to support access to UEC/UCR in the individual's preferred place of care.	April 2024 Sept 2024 April 2025	Learning from this deep dive will support the further development of PEoLC community UEC/ UCR pathways, improve access for underserved communities and patient/carer experience.	24/7 systemwide response to urgent and emergency palliative care cases, increase in the number of patients where clinically appropriate, who can be cared for in their preferred place.	Systemwide approach with partners including WMAS to further develop robust, easily navigable pathways of communication, care and support.	Measurement of data metrics, e.g. Number of episodes of urgent and emergency care utilised by people in the last 12 months of life. Number of episodes of urgent and emergency care utilised by people in the last 12 months of life were people could stay in their preferred place of care. Patient and carer feedback.	ICB & NHS & Third sector Providers

Information (continued)

Issue to be addressed	Action	By When	Outcome	What good looks like	How will we get there	How will we measure success	Organisations responsible /lead
Un-optimised co-ordination between programmes of work.	Identify the main workstreams across the system which dovetail into PEoLC. Map current position of PEoLC within each identified workstream. Deep dive into challenges within each work stream for the timely delivery of care at the end of life.	April 2024 Sept 2024 Dec 2025	Develop clear and co-ordinated work across programmes and PEoLC programme with a collaborative system approach, e.g. Dementia; Frailty; Learning Disabilities; Long Term Conditions; Ageing Well, Virtual Wards etc	Systemwide collaborative approach to programme working. Shared understanding of services and quality improvement work. Improved quality of PEoLC across the workstreams.	Joint Forward Plan Networking Attending programme meetings Information sharing Joint areas of workstream development	Increase number of people identified as thought to be in the last 12 months of life. Improvements in access to information /signposting	System & workstream leads.

Access

Access to timely palliative and end of life care with support throughout, for all of our diverse communities.

Issue to be addressed	Action	By When	Outcome	What good looks like	How will we get there	How will we measure success	Organisations responsible /lead
Identification of underserved communities.	Engagement Equality and Quality impact Assessment (EQIA) Mapping of currently available services Gap analysis	Oct-24	Improved equity of access to PEoLC for the whole of Coventry and Warwickshire	Under-served communities identified. EQIA completed and agreed across the system and reviewed every 12 months. Engagement and on-going co-production to develop greater understanding of challenges within current service provision.	Utilise national and local data, identify quality issue with current data sets. Research & clinical evidence reviewed and EQIA completed. Areas of focus identified to support equitable provision.	Service user demographic data. Feedback through engagement with communities identified as underserved.	ICB
24/7 availability of care	Mapping of services Gap Analysis Pathway development to scope co-ordinated and collaborative out of hours PEoLC provision	Sept 2024 April 2025	Increased quality of life and ease of access to responsive care for people with PEoLC needs and those important to them.	24/7 care which is resilient and able to meet the needs of the population and is clearly communicated across the system / place.	Identification of current challenges and review of available resources to develop clear pathways of support 24/7.	Reduction in utilisation of urgent and emergency care services. Reduction of incidents and complaints regarding out of hours services.	ICB, NHS Providers & third Sector Providers.

Access (continued)

Issue to be addressed	Action	By When	Outcome	What good looks like	How will we get there	How will we measure success	Organisations responsible /lead
Psychological Therapy	Mapping Gap analysis Current Pathway review to understand needs and requirements Development of an equitable proposal for access to psychological therapies for those with PEoLC needs across the system	"Sept 2024 April 2025"	All patients and those who matter to them with PEoLC needs across Coventry and Warwickshire have equity of access to psychological support services when clinically required. Staff should have access to health and wellbeing support as required.	Access to psychological support in each place area	Work with NHS and other provider organisations to establish what is currently in existence and where gaps in provision are impacting on patients' access to psychological support.	Activity of access to psychological services across the system. Allocation of psychological support services in each place. Feedback from patients and staff.	ICB, NHS Providers & third Sector Providers.
Bereavement	Map the current bereavement offer across the system Establish where there is inequity or gaps in service. Review provision for the system and equity of access.	"Nov 2023 April 2024 Dec 2025"	Clear, available information to support signposting our population to available bereavement services. Clear understanding of the gaps of provision in each place. Review of strategies to support equity of access for all communitites.	There is a range of pre- and post-bereavement support services available which can be accessed by bereaved people in a timely and efficient way.	Working with system partners to build on the work already done to review bereavement services and fully understand the current statutory and voluntary / community service provision.	Mapping and needs analysis review undertaken Information available for the public and professionals.	System

Access (continued)

Issue to be addressed	Action	By When	Outcome	What good looks like	How will we get there	How will we measure success	Organisations responsible /lead
24/7 access to anticipatory medication is available	Develop the work commenced in the Access to medication workstream to scope a robust proposal for 24/7 access to anticipatory medication and that anticipatory prescribing is utilised and in place when needed	Dec-25	Mapping to clarify processes and identify gaps. Identification of areas of challenge. Review current service provision. Develop options apprisal for a robust systemwide process to 24/7 access to anticipatory medication.	Agree system approach for access to anticipatory medication. 24/7 access to anticipatory medication which enables those important to people with end of life care needs to spend the optimum amount of time with them.	Systemwide Task and Finish Group which includes experts by experience.	Agreed systemwide approach to the provision of anticipatory medication. Agreed systemwide pathway for access to anticipatory medication 24/7. Reduction in complaints and reduction of incidents where poor patient/family experience is reported.	System
Personal Health Budgets for EoL patients	Review the systemwide approach to the utilisation of personal health budgets for care at the end of life. Determine if increased utilisation of PEoLC PHBs could increase personalised care provision for care at the end of life.	Dec-25	Improved experience of care at the end of life which is tailored to the patient's needs and enables care in their preferred place.	People who become eligible for NHS Continuing Healthcare funding under the fast track pathway have a legal right to have a personal health budget	Systemwide review of the utilisation of PHBs and how this works for patient's in the last months of life	Increase in patients in the last 12 weeks of life accessing a personal health budget.	System

Access (continued)

Issue to be addressed	Action	By When	Outcome	What good looks like	How will we get there	How will we measure success	Organisations responsible /lead
Support for emotional and spiritual needs as well as practical living support where needed.	Continue to engage with and support compassionate communities development work	Dec-25	Enhance the "safety net" of support around a person with PEoLC needs and those important to them is strengthen through community support - Everyone is prepared to care	How we come together to care and support people through life experiences is instrumental to our health, quality of life and happiness. Increased quality of care and community support for people at the end of life.	Work with colleagues and groups across the system to develop this approach and raise the profile of compassionate communities.	Collation of information to develop resources of support networks for the people and health and social care professionals. Develop a collaborative approach with colleagues in the arts and communities to raise the profile of what matters most at the end of life.	System wide. Lead: UHCW leading Compassionate Communities Workstream

Support

Support people diagnosed with a life limiting condition and those who matter to them, their carers and their communities to prevent crisis.

Issue to be addressed	Action	By When	Outcome	What good looks like	How will we get there	How will we measure success	Organisations responsible /lead
Support for Carers	Mapping of services and available support for carers Gap analysis Pathway consolidation	Dec-24 Apr-25 Dec-25	Map of current pathways and available support. Gap analysis: Under-served communities Service provision Increased identification of PEoLC unpaid carers and referral for support. Increase in the completion of carer's assessments.	Unpaid carers are identified. Unpaid carers are referred / signposted for needs assessment and support. Pro-actively support people with palliative and end of life needs and their unpaid carers across health and social care to prevent crisis.	Unpaid carers are identified and offered a needs assessment. Unpaid Carer Experience Surveys.	Increase inf the number of identified unpaid carers for those with palliative and end of life needs in C & W. Increased numbers of individuals accessing carer support services. Gap Analysis: understanding of where issues sit within our system. Delivery of webpages for people of C & W on current PEoLC services and support services https://csnat.org/	System wide
Socio-economic demographics (Poverty proofing)	Mapping Gap analysis Pathway consolidation to inform needs and requirements Expand the learning from the PEoLC Poverty Proofing work conducted in the North of Warwickshire across the system to determine opportunities to improve care.	Dec 2024 June 2025	Address barriers faced by those in poverty throughout care but particularly those identified as having palliative and end of life care needs.	'No activity or planned activity will identify, exclude, treat differently or make assumptions about those who have less financial resource.'	Learning from the Poverty Proofing report, work with colleagues across health and social care to understand the barriers presented by poverty and identify actions to support equity of care.	Review and monitor 'Considerations' identified within the Poverty Proofing report. Identification of opportunities / pilots, proof of concept projects to eliviate the barriers identified through the Poverty Proofing report.	Systemwide

Support (continued)

Issue to be addressed	Action	By When	Outcome	What good looks like	How will we get there	How will we measure success	Organisations responsible /lead
Siblings/ Friendships	CYP support for Siblings / Friends - review of available support. Children and young people experience grief just as much as adults but show it in different ways. They may need help to understand what has happened and to express their feelings.	"Nov 2023 - identification of current available support Dec 2025 - systemwide review to include gap analysis	Clear avenues of support and signposting are available for siblings, family and friends of those children and young people who are thought to be at the end of their lives.	Identification of services and community groups and referral pathways accessible to the public and professionals.	Map current offer Identify gaps Connect with providers who offer support	Collated support services information publically available.	Systemwide
Advance Care Planning (include. DNACPR/ ReSPECT)	Work across the system to agree consistent documentation and access to this information Pro-active PCSP to include ACP Collect data on ethnicity of those accessing PEoLC services across the system	Dec-25	Increased pro-active care planning for people identified as being in the last 12 months of life.	Planning care in advance makes it more likely that wishes will be understood and pro-actively planned for, resulting in more people being cared for and dying in their preferred place.	Workstream to review current PEoLC documentation, communication avenues and how this is improved through Shared Care Record opportunities. Education and Training Framework for PEoLC to develop our communities and workforce to support those with end of life care needs.	No. of people identified with PEoLC who have PCSP to include ACP. Development of consistent competency framework for PEoLC Education and Training for Coventry & Warwickshire.	Systemwide

Improve

Improve the quality of personalised care and support planning for people with palliative care needs, including planning for the end of life, through education and training for all.

Issue to be addressed	Action	By When	Outcome	What good looks like	How will we get there	How will we measure success	Organisations responsible /lead
Education and Training Framework across the system	Develop a competency framework for the system including a training directory for public through to specialist palliative care clinicians.	Dec-25	Increase access to PEoLC education programmes for communities, health and social care professionals and carers. Increase the confidence of those caring for people at the end of their life. Increase the quality of palliative and end of life care available within the system.	Work collaboratively regarding Education and Training across health and social care to support providing palliative and end of life care. Increased confidence and competence of all staff delivering PEoLC. Increase confidence of communitites in supporting their members with palliative and end of life care needs.	Training Needs Analysis. Mapping of current training provision Training gap analysis. Development of PEoLC Systemwide Education and Training Framework.	Raise awareness to health and social care professionals of education packages. Report from training providers detailing the number of staff / public accessing training sessions Undertake survey of training with participants following sessions.	Systemwide
Dying Matters awareness week - system co-ordination	Establish a Task and Finish group to plan an annual system wide approach to Dying Matters week	May 2024 and then annually	Collaborative communication plan to raise the profile of PEoLC across Coventry & Warwickshire	Engage with communities, system partners in health and social care, arts providers, radio and local TV and compassionate communities to raise the profile of PEoLC.	Systemwide Task and Finish Group to Commence planning Jan 2024	Delivery of systemwide co-ordinated Dying Matters Week Events. Further evaluation methods to be identified through the Task and Finish group	Systemwide

Sustainability

Issue to be addressed	Action	By When	Outcome	What good looks like	How will we get there	How will we measure success	Organisations responsible /lead
Finance Mapping	Map current financial provision for PEoLC service delivery across the system Benchmark PEoLC provision in Coventry & Warwickshire in line with NHSE guidance.	Apr-24	Understand the current financial commitment to PEoLC services in Coventry & Warwickshire. Development of gap analysis in service provision.	Sustainable financial position for PEoLC for the system	Integrated system working with needs analysis, gap analysis and comparison to current position.	Review and identification of potential funding gap, other avenues of support or funding. Understanding of current service impact on urgent and emergency care utilisation.	ICS
Contract mapping	Map current contractual arrangements for PEoLC service delivery across the system to include service specifications.	Apr-24	Scope a cohesive contracting approach to PEoLC services across the system, taking into account wider pieces of system review, e.g. Out of Hospital Contract Review	Collaborative commissioning model with clear, aligned service specifications which work in an integrated way to support the development of PEoLC across the system.	Task & Finish group to review current position and develop options for a future commissioning model for the system, in line with wider workstreams.	Options appraisal of proposed commissioning models	ICS
Workforce	In line with wider system workforce review, map current PEoLC staffing for health and social care across Coventry & Warwickshire. Undertake gap analysis.	April 2024	Understand the current PEoLC workforce position and challenges in relation to recruitment and retention.	Clear picture of current PEoLC workforce position and future trajectory. Identification of issues and risks over next 5 years.	Integrated system working with needs analysis, gap analysis and comparison to current workforce position.	Options appraisal of proposed workforce models	ICS

Sustainability (continued)

Issue to be addressed	Action	By When	Outcome	What good looks like	How will we get there	How will we measure success	Organisations responsible /lead
Integrated Commissioning Model	Development of a systemwide approach to PEoLC through a collaborative, integrated commissioning model which supports the Strategy and Delivery Plan.	April 2024	Commissioning model development	Systemwide agreement of a commissioning model for PEoLC.	Collaborative approach in line with Out of Hospital Services programme and Improving Lives programme	Options appraisal of proposed commissioning models	ICS