Shropshire, Telford & Wrekin
Integrated Care System

Palliative and End of Life Care Strategy (Adults)

2022 - 2025

V1.6.4 April 2022

Version control

1.0 Version Control			
Version	Date	Author	Current Status
	25/11/21		Assuring Involvement Committee attended to gain support for the coproduction approach used to develop the strategy
0.1	23/12/21	Alison Massey	First Draft
0.2	25/01/22	Alison Massey	Updated following feedback from PEoLC Steering Group
0.3	21/02/22	Alison Massey	Update following feedback from EOLC review Task and Finish Groups
0.4	24/02/2022	Alison Massey	Strategy milestones included
0.5	28/02/2022	Alison Massey	Update following feedback from other stakeholders - Update definition of palliative care - More explicit reference to reducing inequalities - More explicit references to the care sector - More references to carers and bereavement support
0.6	17/03/22	Alison Massey	- Addition of comments from people with lived experience - Forward signed

Foreword

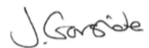
It is the commitment of Shropshire Telford and Wrekin Integrated Care System that for people nearing the end of their life receive high quality and compassionate care and are supported to live well and to die with dignity in a place of their choosing.

In Shropshire Telford and Wrekin we know that for the majority of people we do this, however, we also know that we can do more, particularly for those that do not access or have difficulty accessing services, to ensure that people are better supported to live as well as possible by identifying people earlier on in their last journey of life and to anticipate care needs that can be planned for in advance.

We will be open and honest about the challenges that this may present, particularly as our hospitals have been rated inadequate for End of Life Care Services by the Care Quality Commission, we will not shy away from the collective responsibility we have to work collaboratively to enable the improvements needed.

The learning from the pandemic has given health and care staff the experience of how working together across organisations can provide solutions and allows change to happen quickly, this is the approach we will continue to support and as the Shropshire Telford and Wrekin Integrated Care System becomes a statutory body in 2022, this collaborative and partnership working will be essential to how health and care services are shaped for the future.

We are particularly grateful to the people with lived experience and patient representatives who helped develop this strategy with the work that they completed for the end of life care review, we hope that they will want to continue to work with us to implement this strategy for our region.



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The Vision for Shropshire Telford and Wrekin Integrated Care System

“We will work together with the people of Shropshire, Telford & Wrekin to develop innovative, safe and high-quality services, attracting and retaining the best staff to deliver world class care that meets our current, and future, rural and urban needs.

We will support people – in their own communities – to live healthy and independent lives, helping them to stay well for as long as possible. Creating partnerships to find solutions that work better for the people we serve and those who provide care.

As the world faces up to a climate emergency, we are committed to delivering an internationally recognised system known for its environmentally friendly services that make the best use of our resources.”

Introduction

Palliative and end of life care affects us all, at all ages; the living, the dying and the bereaved.

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. This gives us an opportunity to plan and consider people's wishes and preferences for their end of life care and treatment.

NHS England (2022)
https://www.england.nhs.uk/eolc/introduction/

National Palliative and End of Life Care Framework

Foundations

Personalised care planning	Shared records
Education and training	24/7 access
Evidence and information	Involving, supporting and caring for those important to the dying person
Co-design	Leadership

Ambitions

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

The Scope for this Strategy

This strategy has been developed to support the care of people over the age of 18 in Shropshire Telford and Wrekin who have a palliative care need or who are in the last year, months or days of life.

We recognise that the principles of Palliative and End of Life Care (PEoLC) are the same for all people of all ages, however, we also recognise that there are some specific differences in the care for Children and Young People with life limiting conditions that require a focus that may be lost in an all age strategy.

It is for this reason that a separate Children and Young Persons Palliative and End of Life Care Strategy will be developed in 2022.

Once completed these strategies will 'sit together' as living documents and as an expression of the commitment to working together in support of high quality palliative and end of life care for individuals, their families and loved ones.

What is Palliative and End of Life Care?

Palliative Care is the treatment, care and support given to people that have a life threatening illness, the focus for palliative care is to improve a persons quality of life through prevention and relief of symptoms.

End of Life Care is the treatment, care and support for people in the last year of life

The aim for palliative and end of life care is to support people to live well for longer and for those that are at the very end of their life, to die with dignity in a place of their choosing.

Shropshire, Telford and Wrekin

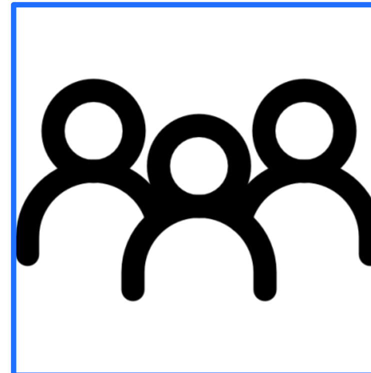
What we know

By 2041 the population in Shropshire will increase by 7.5% and in Telford and Wrekin by 11.2%

Over the next 2 decades the number of people over the age of 85 will increase by 137% in Shropshire and in Telford and Wrekin by 98.4%

90% of people will have accessed emergency care in the last 24 months of their life, with 82% having a least one emergency admission to hospital

Fewer people who have expressed a wish to die at home do so



In their annual report (2020/21) Marie Curie indicated that by 2040 there will be a 42% increase in the need for palliative and end of life care

How we have shaped this strategy - 1

In Shropshire Telford and Wrekin we are lucky in that, for many years, clinicians across a range of organisations have worked together to develop services and resources to support the care of people with life threatening conditions and for those that are nearing the end of their life.

The well established End of life Care group were able to respond quickly at the start of the pandemic in 2020 to introduce a system wide approach to Advance Care Planning and to accelerate the work that had started in early 2019 to embed *ReSPECT as the process to record a persons preferences to care in the event of an emergency.

In 2021, the emerging Integrated Care System recognised the importance of this group in facilitating and influencing improvement for the care of people at the end of their life and the collaboration needed to do this, this group, therefore, has been renamed the Shropshire Telford and Wrekin Palliative and End of Life Care Steering Group and will have the responsibility to oversee implementation of the strategy.

The end of life group has been a group of like- minded people who work in the grass roots of the health care system in Shropshire, Telford and Wrekin. Everyone in the group comes from different organisations and are committed to improving End of Life Care for everyone in the region.

Professor Derek Willis

Steering Group Chair and Clinical Lead

*ReSPECT – The process of summarising a person's preferences in one document to be used in urgent or emergency situations

How we have shaped this strategy - 2

In the autumn of 2020, Shropshire Telford and Wrekin Sustainability and Transformation Partnership initiated a review of End of Life Care for the region.

The aim for the review was to work alongside members of the public, people with experience of end of life care services and health and care colleagues to identify what improvements could be made for people, their families and loved ones.

Working together in Task and Finish Groups the key actions and recommendations from this review have been incorporated into the aims and implementation of this strategy.

We have created a set of universal standards that will support high quality end of life care

Everyone should receive the same level of care and compassion wherever they are cared for.

End of Life Care is everyone's business

We aim to continue the to 'grow the conversation' encouraging people and communities to talk more about death and dying

We have developed a competency framework that will identify the skills and development needed for all staff

All health and care staff should have the knowledge, skills and confidence to safely care for people at the end of their life

People at the end of life may need to access a range of health and care services

We believe and recommend that the role of a Care Coordinator is key to ensure that people can access the right services at the right time

People have told us they had difficulty in getting a quick response to a concern which is why we have recommended a 24/7 advice and guidance line for people and their families

Access to information and support can prevent unnecessary anxiety

What the people with lived experience and patient representatives have said about being involved in the development of this strategy

I volunteered to participate in this project not really sure how, as a member of the public, I could make a difference. I was quickly welcomed into the group which consisted of people with a great deal of experience of End of Life services

Throughout the project I felt comfortable in putting forward comments and suggestions and was happy to get involved with tasks.

I just hope my small involvement will have helped towards a move of openness in the conversations about End-of-Life choices; this should be integral and very natural to all our thoughts as a society.

I have been involved with the work of the Growing the Conversation Group since it was formed trying to bring a patient perspective to the discussion. I feel very strongly that death and dying are still taboo subjects to many people and will support any effort to change this view within our society

Taking part in the End of Life work enabled us to bring lived experiences by the people on their end of life journey and the friends and families which included what went well and the not so good, ensuring the service going forward to be to the gold standard.

I have been impressed with the people I have had the pleasure of working alongside, their commitment and drive to review and improve the standards of End-of-Life Care has been amazing.

I feel the Group has worked well together and that my views were taken seriously by others, and that the events organised during Grief Awareness week were a success.

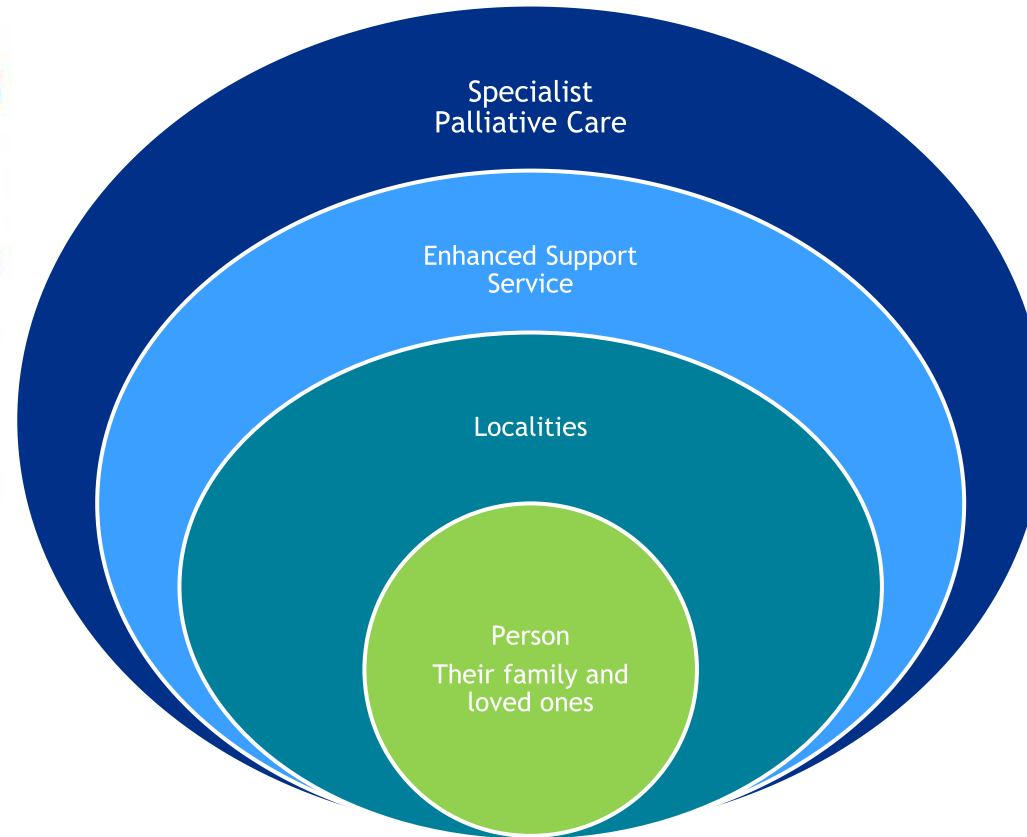
Working on the End of Life strategy has been incredibly rewarding. As an expert by experience I have been listen to, involved and I have contributed to the new Standards for EOL care. I have helped, along with others, produce outcomes for the benefit of improved services to patients and carers

Shropshire Telford and Wrekin
Model for Palliative and End of Life Care

National Ambitions

- 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

Shropshire Telford and Wrekin Model for integrated Palliative and End of Life Care



Our Aims.

To build on what we have to improve the experience and care for people that are in the last year of life, their families and loved ones.
To enable:

- People in the last year of life to be systematically identified and offered an assessment and advance care plan
- All people on an end of life care register will have an identified coordinator
- Everyone will have access to the care they need at any time of the day
- People their families and loved ones will have access to 24/7 advice and guidance
- A workforce with the knowledge skills and confidence to deliver compassionate care
- Address inequalities to ensure that access to care is available to all
- Localities working together for people, their families and loved ones
- An enhanced service to provide an additional level of care for those with more complex needs
- Digital enhancement to support, electronic shared care records, centralised information to support care delivery and monitor progress
- Palliative and end of life care is seen as everyone's responsibility
- Offer support for families and loved ones in the care of someone that is dying and after their death

Palliative and End of Life Care for Shropshire Telford and Wrekin

The Vision

National Foundations at every level

- Personalised care and support planning
- Shared Records
- Education and training
- Evidence and Information
- Co - design
- Involving, supporting and caring for those important to the dying person
- Leadership

Each person is seen as an individual

- Honest conversations
- Integrated assessment and care planning
- Electronic shared care record
- Continuity of care delivery
- Carer assessment and plan
- Personal budgets and commissioning

Each person gets fair access to care

- All people predicted to be in the last year of life
- A fully integrated seamless offer in place
- Coordinated process for referral
- Transition
- Protected characteristics Homelessness Prison
- EOLC dashboard

Maximising Comfort and Wellbeing

- Living well approach. Enablement and rehabilitation
- People supported to die in their preferred place
- Workforce confidence and skills
- Specialist palliative care
- Symptom management and prescribing
- Safe and effective handovers inc Out of Hours

Care Is coordinated

- Partnership working
- Identified EOLC Coordinator
- 24/7 access to advice and guidance
- 24/7 access to care
- One assessment one care plan

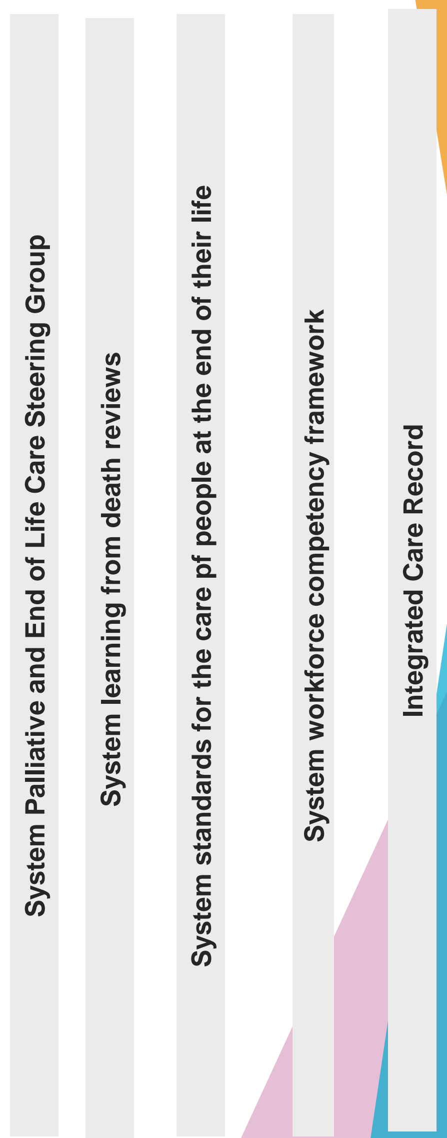
All staff are prepared to care

- One training offer
- Integrated training programme
- Clinical Leadership
- Executive leadership

Each community is prepared to help

- Compassionate communities across all localities
- Volunteers as an arm of health and care services
- Commissioning arrangements
- Public prepared to talk about death and dying

System Enablers



Shropshire Telford and Wrekin Model for Palliative and End of Life Care

Specialist Palliative Care

Enhanced Support Services

Localities

Person

Their family and loved ones

Working with the person their families, loved ones and health and care workers to offer holistic assessment and specialist advice, comfort and support

Wrapped around localities to offer an enhanced level of support for those with more complex needs or circumstances

Health and care services work with local communities to enable care needs to be met.
One assessment, one care plan, one identified care coordinator

The person at the centre, supported to stay as well as possible as long as possible and to die with dignity in a place of their choosing

Achieving our aims

Aim People in the last year of life to be systematically identified and offered an assessment and advance care plan		
What good looks like	**How we will get to good**	**How will we measure success**
There are processes in place to proactively identify any person who is predicted to be in the last year of life.	There is agreement across STW that end of life care is last year of life. The PEoLC steering group will develop guidance to include evidence based tools that will support this identification.	Organisations and services have adopted the Shropshire Telford and Wrekin Standards for End of Life Care and there are processes in place for these organisations and services to benchmark themselves against these standards.
A register of people considered to be in the last year of life will be held at locality level and centrally with the Enhanced Service	Building on the GP practice EOLC register, we will work with Primary Care to develop the protocols including data sharing agreements and clinical assurance to enable a centralised register	All people identified as last year of life will be recognised on a system level register. All appropriate care providers are able to refer into and update the register.
All people on an end of life care register will be offered an assessment and advance care plan.	Building on the work in 2020/21 we will continue to engage with system partners to embed ACP as the recognised process for assessment and care planning for EOLC. We will work to understand the opportunities of the integrated care record to enable and audit this; the Electronic Palliative Care Co-ordination System (EPaCCs) is likely to be the option.	All people on an EOLC register are offered an ACP and this is evidenced via EPaCCs or similar System Palliative and End of Life Care Steering Group will support the audit and monitoring processes.
People will have the opportunity to express their wishes and their worries.	The integrated workforce competency framework will support staff to gain the confidence and skills needed to have difficult conversations to enable people to express there wishes and concerns. One training offer will allow for all staff to access the same level of training.	Person and carer experience metrics.
Assessment and care plans will be shared with the person and relevant services.	We will work to understand the opportunity to digitalise the ACP and how this fits with the current digital developments of the shared care record	Contemporaneous single record Shared Care Records

Achieving our aims

Aim: All people on an end of life care register to have an identified coordinator		
What good looks like	**How we will get to good**	**How will we measure success**
All people on an end of life care register will have an identified End of Life Care Coordinator.	End of Life Care Coordinator role descriptor agreed. Processes in place to identify a coordinator once a person is recognised as end of life.	End of Life Care register includes names coordinator.
End of Life Care Coordinator as a member of the Multidisciplinary Team (MDT)	EOLC MDT approach is consistent across the region EOLC Coordinator identifies people for MDT review and manages actions following meetings	EOLC dashboard measures MDT development
EOLC Coordinator as a key contact for people their families/loved ones	The role of the EOLC Coordinator is embedded in practice	Person and carer experience metrics

Achieving our aims

Aim: Everyone to have access to the care they need at any time of the day		
What good looks like	**How we will get to good**	**How will we measure success**
A proactive approach to assessment, review and care planning will facilitate any anticipatory care needs to ensure that increasing care needs are identified and planned for.	All people in the last year of life will have an ACP, regular reviews and anticipatory care needs are identified and responded to in a timely manner.	Reduced need for crisis intervention. Number of people who die in their preferred place of care.
People their families/loved ones have access to 24/7 support	Services are integrated to respond appropriately to enable care needs to be supported. 24/7 access to care	Reduced need for crisis intervention. Number of people who die In their preferred place of care. Person and carer experience metrics.
A person is supported to be cared for in their preferred place throughout the day and night.	Services are integrated to respond appropriately to enable care needs to be supported. 24/7 access to care.	Reduced need for crisis intervention. Number of people who die In their preferred place of care. Person and carer experience metrics.
People die in their preferred place of care or there is a clear rationale for why this could not be facilitated.	Services are integrated to respond appropriately to enable care needs to be supported. 24/7 access to care.	Number of people who die In their preferred place of care. Learning from Death Reviews.
Carers needs are assessed and supported.	Carers are identified and offered a needs assessment.	Carer experience metrics.

Achieving our aims

Aim: People their families and loved ones to have access to 24/7 advice and guidance		
What good looks like	**How we will get to good**	**How will we measure success**
All people on an end of life care register will have access to 24/7 advice and guidance	We will work with commissioners and providers to develop a sustainable process to ensure that telephone advice and guidance is available 24/7 for people their families/loved ones.	Contractual mechanisms and specifications in place to provide 24/7 telephone advice and guidance. Activity and performance is monitored via an EOLC dashboard and contractual processes.

Achieving our aims

Aim: A workforce with the knowledge skills and confidence to deliver compassionate care		
What good looks like	**How we will get to good**	**How will we measure success**
All Health and Care professionals and the Care Sector Workforce recognise their responsibility to care for people and their families.	Health and Care organisations adopt the Shropshire Telford and Wrekin End of Life Care Competency Framework to support workforce development and the recognition that EOLC is everyone's responsibility. There is one training offer across the region, to enable all relevant workforce to access the same level of training.	Training need analysis. Access to training. Training gap analysis. Performance measures in place to monitor progress.
Health and care professionals and the care sector workforce have the knowledge skills and confidence to care for people at the end of life	There is one training offer across the region, to enable all relevant workforce to access the same level of training. Workforce support to evidence and maintain competency.	Access to training. Performance measures in place to monitor progress. Person and carer experience metrics. Workforce feedback.
Communities are prepared to help	The EOLC competency framework is inclusive of community and voluntary organisations Health and Care organisations support the development of this extended workforce	Access to training. Feedback processes to be developed. Relevant contractual processes in place.

Achieving our aims

Aim: Addressing inequalities to ensure that access to care Is available to all		
What good looks like	**How we will get to good**	**How will we measure success**
All people in Shropshire Telford and Wrekin will receive safe, effective and care of a high quality regardless of their personal characteristics, social, economic or environmental circumstances	We will work together with our communities to understand how personal characteristics, social, economic or environmental circumstances impact on a person in need of end of life care. We will seek to understand more about cultural and societal barriers to talking about death and dying. We will monitor access to services to understand the difficulties people may have in accessing these services. We will create an action plan to deliver our requirements of equitable access and service delivery.	Delivery on the action plan of the requirements to equitable access and service provision.
* Services are commissioned to reduce health inequalities and to respond to the diversity of our local population	We will use population health data, the information and intelligence we have gained to influence design and redesign of services. We will ensure that commissioning and contracting arrangements are reflective of these design and redesign principles. We will work with our local voluntary, community and third sector organisations to commission services with them at a local level and to support the diversity of these local populations.	Commissioned services meet the statutory requirements of equity and addresses heath inequalities. Local voluntary, community and third sector organisations are commissioned to deliver care and support which is reflective of the needs of the local population.
Services respond to individual needs and to those important to them.	We will seek to understand how Personal Health Budgets could be utilised to enhance Person Centred Care and Patient Choice at the end of life.	There are routine arrangements in place to offer individuals Personal Health Budgets. Access to Personal health Budgets. Number of people at the end of their life with a personal health budget.
All health and care staff have the knowledge, skills and confidence to provide personalised and compassionate care.	Our ‘one training offer’ will be made available to all health and care staff to include domiciliary care, voluntary and community organisations. Training arrangements include, communication, the diversity of the local population, priorities of care, the care for the people with protected characteristics, the care of people with a Learning Disability, Dementia, Mental ill health and for those living alone, those that are homeless and for the prison population.	Access to training. Performance measures in place to monitor progress. Person and carer experience metrics. Workforce feedback.

* Commissioners have a legal duty to commission services that are equitable and services that address health inequalities

Achieving our aims

Aim: Localities work together for people, their families and loved ones		
What good looks like	**How we will get to good**	**What is the measure of success**
Local service provision is integrated to offer a coordinated approach to care delivery.	MDT working. EOLC Care Coordinator identified. Volunteers/community workers/social prescribers are seen as members of the MDT.	All localities have an integrated approach to MDT working. Monitoring processes in place.
There is a single and contemporaneous care record that is accessed and contributed to by all.	Integrated advance and end of life care plan as a single record Integrated care record available in clinical systems.	All people have an integrated advance care plan. All relevant workforce have access to the integrated care record. Monitoring process in place.
Single trusted assessment process.	Integrated advance and end of life care plan as a single record. Protocols in place to supported trusted assessor processes.	Protocols and guidance in place. Monitoring process in place.
Volunteers/community workers/social prescribers are seen as members of the MDT.	We will develop protocols and guidance to support the integration of all relevant individuals/organisations/services contribute to care.	Protocols and guidance in place. Commissioning arrangements developed. Monitoring process in place.

Achieving our aims

Aim: An enhanced service to provide additional level of care for those with more complex needs		
What good looks like	**How we will get to good**	**How will we measure success**
Enhanced service provision is integrated into existing EOLC provision.	Business case in development	Business case approved. Enhanced service in place. Performance and monitoring measures in place.
People with more complex needs are offered additional support.	There are processes including risk stratification in place to support recognition of complex needs.	Reduced need for crisis intervention. Number of people who die In their preferred place of care. Person and carer experience metrics.
Inequalities in access and provision will be identified and addressed.	Population health management and risk stratification will help to identify inequalities. Service specification will include criteria, aims and objectives. Access to support will be streamlined and simplified to include a single point of contact. Resources are organised so that people at risk of inequalities are identified, do not fall through any gaps and are easily directed to support.	Identification of areas of inequalities. Performance measures in place to monitor progress.

Achieving our aims

Aim: Digital enhancement, electronic shared care records, centralised information to support care delivery and monitor progress		
What good looks like	**How we will get to good**	**How will we measure success**
Relevant information is available to the person and to all involved in the care of individuals.	We will work to ensure that EOLC is sighted across all digital developments with in the ICS. We will create a working group or will facilitate for a member of the PEoLC steering group to have representation on other system groups. We will scope out if the Electronic Palliative and Care Coordination System (EPaCCS)functionality of the Integrated Care Record is a viable option to develop.	Integrated care record is live and ACP is included Records are auditable (EPaCCS)
Care is coordinated across all care settings	As above	As above
Information is available in one place	As above	As above
Actions are managed quickly and appropriately	As above	As above
Information is available 24/7	As above	As above

Achieving our aims

Aim: Palliative and end of life care is seen as everyone's responsibility		
What good looks like	**How we will get to good**	**How will we measure success**
The Integrated Care system recognises that palliative and end of life care is a priority for our region.	We will continue to build on the System PEoLC Steering group to develop robust mechanisms to ensure the ICS is sighted on progress We will ensure that the strategy is widely recognised as a system transformation programme.	Palliative and End of Life Care is consistently recognised as everyone's responsibility. Palliative and End of Life Care is included in strategic planning. STW has regional status as high performing system for the care of people at the end of life. Our organisations are rated CQC outstanding for the care of people at the end of life.
Strategic leaders with a recognised PEoLC responsibility.	We will continue to build on the System PEoLC Steering group to develop robust mechanisms to ensure the ICS is sighted on progress with an Executive Lead at this level Clinical Leaders as representatives at regional meetings Steering group members are seen as role models/champions/ambassadors	Palliative and End of Life Care is consistently recognised as everyone's responsibility Palliative and End of Life Care is included in strategic planning STW has regional status as high performing system for the care of people at the end of life Our organisations are rated outstanding for the care of people at the end of life
Coproduction is embedded in the culture of quality improvement.	We will build on the approach taken by the system end of life care review to ensure that people with lived experience, patient/carer representatives are equal partners in development and improvements.	People with lived experience/patient public representatives feedback.
Conversation about end of life care is seen as a societal norm.	We will continue with the work commenced as part of the end of life care review to see that the Growing the Conversation task and finish group evolves into a strategy implementation working group	We will monitor the progress of the Growing the Conversation working group and report into the ICS on progress

Achieving our aims

Aim: Offer support for families and loved ones in the care of someone that is dying and after their death		
What good looks like	**How we will get to good**	**How will we measure success**
All carers are offered an assessment and support plan.	We will develop the process for a carers assessment to be included at the same time as the person at the end of their life.	The number of carers offered an assessment and support plan.
There is a range of support services on offer within local communities.	We will understand the current service available and to identify any gaps. We will work to close these gaps with new commissioning arrangements with local voluntary and community organisations	Carer experience metrics. Commissioning new services.
Carers have access to information to include bereavement support services.	We will understand what is currently available and work to ensure that carers have access to this information. We will work to identify and close any gaps.	Carer experience metrics. Number of new resources developed.

How we will measure success

Over the next 4 years

- More people that are predicted to be in the last year of life will be identified
- All people on an End of Life Care register will be offered an assessment and advance care plan
- All people on an End of Life Care register will have a named Care Coordinator
- More people will be enabled to die in their preferred place, with dignity and with the care that they need
- All carers will be identified and offered a needs assessment
- Fewer people, who are predicted to die, will do so in hospital
- Fewer people, that are predicted to die, will need emergency care
- Our workforce will have the knowledge skills and confidence to care for people at the end of their life and their families and loved ones

Implementation Plan

High level Milestones 2022/23

No	High level Milestones	Q1	Q2	Q3	Q4
1	**2022/23**				
1.1	Business case development and service implementation plan				
1.2	Reporting arrangements via dashboard				
1.3	Audit plan in place				
1.4	Business case service implementation to include Care Coordinator 24/7 access to care via rapid response Single point of access 24/7 advice and guidance phone line				
1.5	Workforce competency framework approved				
1.6	One training offer agreed				
1.7	Carers assessment in development				
1.8	Activities and resources for Dying Matters week and grief awareness week				
1.9	Commissioning Arrangements for 2023/24				

Implementation Plan

High Level Milestones 2023/24

2	2023/24	Q1	Q2	Q3	Q4
2.1	Evaluation of new service and delivery				
	Planned audit activity				
2.2	Qualitative measures in place				
2.3	Workforce Training Needs analysis				
2.4	Workforce training in place (one training offer across all relevant organisations)				
2.5	Engagement with volunteers and community organisations to understand the opportunities for support and care				
2.6	Suite of patient related information and resources available				
2.7	Population health management approach developed to identify and address health inequalities and in support of equitable access to care				
2.8	Carers assessment in place				
2.9	Commissioning Arrangements 2024/25				

Implementation Plan

High Level Milestones 2024/25

3	2024/25	Q1	Q2	Q3	Q4
3.1	Single assessment and contemporaneous care record				
3.2	Planned audit activity				
3.3	Evaluation of training				
3.4	Service evaluation				
3.5	Strategy evaluation				
3.6	Strategy development and commissioning post 2025				

Strategy Governance

Integrated Care System Quality Group

Integrated Care System Palliative and End of Life Care Steering Group

- Workforce
- Digital and dashboard
- Commissioning and Contracting
- Growing the conversation
- Children and Young People
- Clinical Development

Strategy implementation working groups