



Palliative and end of life care in Integrated Care Systems

Appendix

**Exploring how Integrated Care Systems are
responding to the Health and Care Act 2022**

November 2023

Appendices

1. Survey questions

#	Question
1	What is your current role in the ICB?
2	Which ICB do you work for? (Please note responses to this question will be kept anonymous)
3	The Health and Care Act (2022) explicitly references palliative care as a service (or facility) that ICBs have a duty to commission, as they consider it necessary to meet the needs of their local population. To what extent do you believe the services you commission currently meet the palliative and end of life care needs of your local population (in line with the Ambitions National Framework for PEOLC and relevant statutory guidance)?
4	Please provide a short overview of any areas where you feel your ICB is performing particularly strongly in the delivery of PEOLC services.
5	Please describe your top 3 priorities for PEOLC services.
6	To what extent have you understood and assessed the PEOLC needs of your population?
7	Have you conducted an Ambitions for PEOLC self-assessment, to identify progress and gaps against the six Ambitions commitments (including involving people with lived experience), as suggested in the Statutory Guidance?
8	Have you conducted an Equalities and Health inequalities impact assessment and action plan focused on PEOLC, as suggested in the Statutory Guidance?
9	If you answered 'Yes' to question 7 and/or 8, are you able to share this with us? If so, please insert your contact details so we may contact you.
10	In line with the Ambitions National Framework for PEOLC, to what extent are the following in place across your ICS in relation to PEOLC? (24/7 access to care, advice, and support; 24/7 access to medicines; Access to equipment for PEOLC; Ability to identify, assess and support family, carers and those important to the dying person; Ensuring quality of personalised care and support planning; Joined up and coordinated PEOLC services with the NHS, primary care, hospices; Access to electronic shared care records; Bereavement support service
11	Could the ICB work more closely with VCSE partners to deliver improved PEOLC services? If yes, how?
12	To what extent do you believe current spending/investment on PEOLC services is sufficient for the ICB to meet the needs of the local population?
13	Do you understand the role that effective PEOLC can play in managing wider system pressures (e.g. in managing system pressures in A&E, acute services and ambulances)?
14	Has the system made or planned to make any significant capital investments in PEOLC services (e.g. digital solutions)?
15	If you answered 'Yes' to the question above, please outline any plans on capital investments in PEOLC services.
16	Are you using any joint funding arrangements across health and care services for the delivery of PEOLC services?
17	Does your Integrated Care Strategy define your strategic aims in relation to PEOLC?
18	Does your Joint Forward Plan include your five year delivery plan for arranging and delivering PEOLC services?
19	Do you engage with the following to define PEOLC strategies and commissioning needs? (Select all that apply - People with lived experience; specialist palliative care providers; VCSE; local authorities; other)
20	To what extent has the ICB assessed the workforce required to deliver PEOLC services effectively?
21	Please provide a short summary of the key barriers you are facing around planning, recruiting and retaining a skilled workforce to deliver PEOLC services.
22	Please provide a short summary of any effective solutions you have found to ensure you have the right workforce in place to deliver quality PEOLC services.
23	What approaches, resources or tools would be most useful for Marie Curie to provide to help ICBs meet the requirements for PEOLC services?

2. Survey responses

Commissioned PEOLC services

The below summarises findings from questions exploring the extent to which ICBs have understood / assessed local population PEOLC need, have completed the PEOLC self-assessment, how well current PEOLC services meet population need and if ICBs have completed an Equalities and Health inequalities impact assessment and action plan.

While a majority of ICBs have at least moderately understood / assessed the PEOLC needs of their population, only 4% believe they have done this to a 'full extent'.

A majority of respondents (15) reported having done so to a 'moderate extent', followed by 8 ICB respondents who said they have done this to a 'significant extent'. 2 respondents chose 'limited extent'. Only 1 chose 'full extent'.

A large number of ICBs have not completed an Equalities and Health inequalities impact assessment and action plan focused on PEOLC.

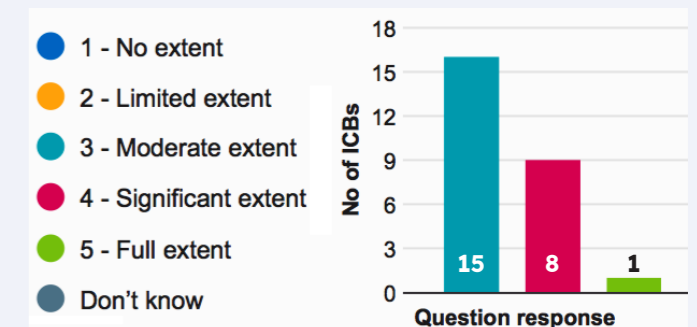
ICB respondents were asked if they had conducted an Equalities and Health inequalities impact assessment and action plan focused on PEOLC as recommended in the statutory guidance. 69% of respondents reported they had not completed this, with only 19% stating they had done so.

A majority of ICBs have conducted a self-assessment against the Ambitions for PEOLC framework.

ICBs were asked 'Have you conducted an Ambitions for PEOLC self-assessment, to identify progress and gaps against the six Ambitions commitments (including involving people with lived experience), as suggested in the Statutory Guidance?' A large proportion (77%) had completed this with 19% of respondents not having conducted this.

While the vast majority of ICBs believe that their locally commissioned PEOLC service is meeting the needs of their local population to at least a 'moderate extent', only 1 reported they believed it was doing so to a 'full extent'.

ICBs were asked 'To what extent do you believe the services you commission currently meet the palliative and end of life care needs of your local population?' A large number of ICBs (15) shared that this was happening to a 'moderate extent' followed by 8 ICBs who chose 'significant extent'. 2 respondents chose 'limited extent' and only 1 answered 'full extent', suggesting that a number of ICBs recognise there may be additional work required to improve PEOLC services in their area.



2. Survey responses (...continued)

Commissioned PEOLC services

The below summarises key themes for the survey question asked to ICBs on question four - 'Please provide a short overview of any areas where you feel your ICB is performing particularly strongly in the delivery of PEOLC services.' 24 ICBs completed this question.

Delivery of PEOLC services

Several respondents outlined aspects of their PEOLC model that they felt are performing well. Common themes included:

- 24/7 access to specialist palliative care (7 ICBs were implementing this)
- Single point of contact model (4 ICBs were implementing this)
- Virtual wards (3 ICBs were implementing this)
- Recording support and care wishes of patients e.g. through ReSPECT, a Universal Care Plan or similar (5 ICBs were implementing this)
- Early Identification of an individual entering the last year of life (4 ICBs were implementing this)

Other aspects referenced included having in place a PEOLC discharge facilitator post, Palliative Care Coordination Hubs and the implementation of Electronic Palliative Care Coordination Systems.

One ICB outlined resources they had created, for example, hosting a Dying Matters Awareness Week podcast "Normalising conversations around death and dying", creating a dedicated PEOLC webpage with curated resources including an Early ID toolkit, Urgent Care Plan support and details of all local bereavement services.

Collaboration & engagement across providers

A large number of ICB respondents (46%) identified engagement and collaboration across providers for the delivery of PEOLC as an area of good practice in their system. Some examples of this included:

- Hospice collaboration: Collaboration across hospices to share good practice and to avoid duplication of activities.
- Engagement with patients: Feedback collected via engagement (e.g. surveys) which for some ICBs has fed into their PEOLC strategy and enabled triangulation of feedback to drive improvements.
- Collaboration across wider system: One ICB shared an example of how they were working with their health and justice services to deliver the Dying in Custody Charter. They had also worked with the Ambulance Service to deliver PEOLC training and education to front line staff.

Effective governance & accountability

29% of ICB respondents identified PEOLC governance structures. Respondents shared that their governance structures helped in defining and updating on PEOLC workstreams, provided relevant guidance and supported in identifying best practice. These included steering groups, a Programme Board and a Commissioning and Clinical Network. Respondents also shared that these governance structures have a breadth of stakeholders represented.

Use of data to support PEOLC improvements

Some respondents (25%) highlighted the use of data as an area that was working well, in particular the use of a PEOLC dashboard. These respondents outlined the benefit of the dashboard in supporting them to better understand areas of focus for health inequalities and service development/quality improvements. The dashboard also helps to identify areas of good performance to scale up.

The below summarises key themes for survey question five: 'Please describe your top 3 priorities for PEOLC services?' 26 ICB respondents completed this question.

Supporting carers

19% of ICBs outlined the need for a greater focus on supporting carers, including providing bereavement services.

Early identification of end of life patients

38% of respondents included early identification of patients reaching the end of life among their priorities. Some respondents outlined further that this includes management of these patients through communicating this with patients sensitively and ensuring advanced care plans are in place.

Improving equity of PEOLC services

35% of respondents highlighted the importance of equity of PEOLC services and ensuring all patients have access to this, including wider services such as spiritual, emotional and bereavement support. One respondent shared the system requires greater parity between patients at end of life with cancer and those with other conditions.

PEOLC workforce education & training

23% of respondents cited education and training as a priority. This includes ensuring the right PEOLC workforce is in place and that relevant training is provided to them. One respondent outlined a focus on recruiting and supporting PEOLC volunteers.

Enhanced co-ordination of patient services

A number of respondents (35%) identified care co-ordination as a priority. This includes working with different services in the patient pathway to deliver a more seamless end of life care experience, including understanding the experiences of those with lived experience. Some respondents also commented on the need for interoperability of systems to support information sharing, to support enhanced coordination of patient services (e.g., EPaCCS record).

Enhancing access to 24/7 PEOLC services

Although 29% of respondents reported that 24/7 access to PEOLC services is an area of good practice for their system, 35% of respondents have identified this as an area of priority. This included 24/7 accessibility of PEOLC medication and ensuring 24/7 access to support for health and care professionals, patients and relatives.

Other responses

A range of other responses were noted, for example:

- Understanding lived experiences further
- Achieving substantive funding for services
- Ensuring local strategy and planning is in line with national priorities
- PEOLC services, including Virtual Wards

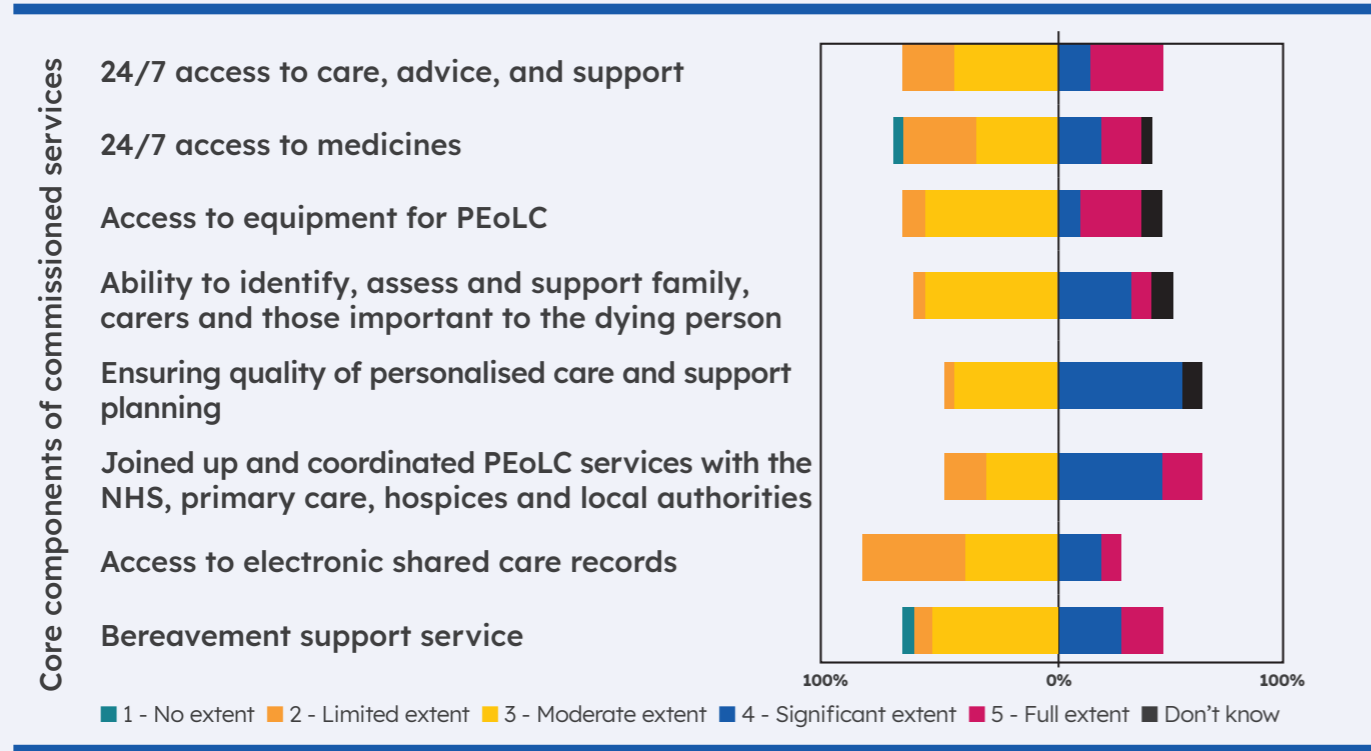
2. Survey responses (...continued)

Commissioned PEOLC services

The below summarises findings from question 10 designed to understand which aspects of the Ambitions Framework are being met and to what extent. 25 ICBs completed this question.

Only 3 respondents said that they were meeting all aspects to a ‘significant’ or ‘full’ extent. The aspects most adhered to were:

- Joined up and coordinated PEOLC services with NHS, primary care, hospices and local authorities (56%)
- Ensuring quality of personalised care and support planning (48%)



Partnership working

The below summarises responses to question 11 - ‘Could the ICB work more closely with VCSE partners to deliver improved PEOLC services? If yes, how?’ 25 responses were received. Generally, all ICBs agreed that they could be working more closely with the voluntary, community and social and enterprise (VCSE) sector.

- Active engagement with VCSE partners and embedding governance with these organisations: Some ICBs have VCSE partners, including hospices, on key governance groups related to PEOLC. One ICB outlined that their system had a VCSE sector collaborative with 6 representatives linking into each ICB place who are tasked with understanding their place, with each place representative holding a VCSE place based assembly (a collective of VCSE organisations), providing a mechanism to speak as one voice per place.

Current ways of working with the VCSE sector

ICB respondents shared ways in which they are currently working with the VCSE sector, which includes:

- Working with a broad range of partners: ICBs shared that they work with a number of partners, including Marie Curie, Age UK and other charities on key projects. One ICB has been working with a local charity to support homeless people by offering training around the particular needs of this group at the end of life.
- Providing financial support to VCSE partners: One example relates to an ICB which is providing financial support to VCSE organisations that provide bereavement and psychological support. Similarly, another ICB has commissioned two VCSE organisations to provide bereavement services, supports funding of their local charitable adult and children hospices and funds an organisation which serves ethnic minority communities in relation to PEOLC.

- Developing volunteer advisors alongside professionals to deliver public engagement (death cafés etc).
- Developing a centralised VCSE wellbeing support hub for low level bereavement support.

Financial investment in PEOLC

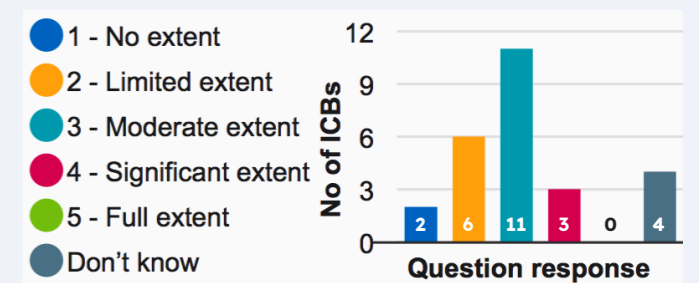
The below summarises responses to the questions designed to explore current and planned financial investment in PEOLC services.

Respondents were asked about the extent to which current spending / investment on PEOLC services is sufficient for the ICB to meet the needs of the local population (question 12). There were a mix of responses, with 3 ICBs reporting they were doing this to a ‘significant extent’, 11 to a ‘moderate extent’ and 6 respondents to a ‘limited extent’. 2 respondents chose ‘no extent’.

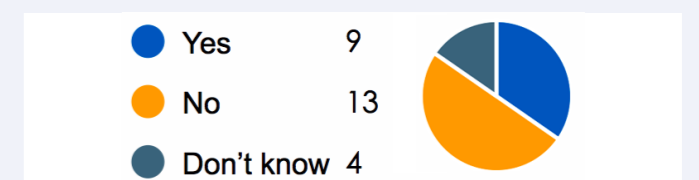
Planned initiatives for working with the VCSE sector

ICB respondents shared planned initiatives / projects to facilitate closer working with the VCSE sector. These include:

- Roll out of integrated neighbourhood teams.
- End of life champions in primary care.
- Working collaboratively with Macmillan to build Single Point of Access and Early Identification offers via the Social Finance Scheme.
- Working with VCSE organisations to understand patient and wider experience to better understand unmet need, what good looks like and improve services.
- A buddy up programme to informally support or deliver basic training for individuals and families caring for people at end of life.



Responses to question 14 ‘Has the system made or planned to make any significant capital investments in PEOLC services (e.g., digital solutions)?’ showed that 50% of respondents had not made or planned to make any capital investments in PEOLC.



2. Survey responses (...continued)

Financial investment in PEOLC

Those who answered yes to question 14 were asked about their plans on capital investments in PEOLC services in question 15. Examples shared included:

- Developing a single electronic treatment electronic escalation plan to improve patient experience and allowing patient records to be accessed via an app
- Electronic prescribing in all settings
- Rollout out of a tool to support identification and use of remote monitoring / virtual beds for end of life patients

Question 16 asked ‘Are you using any joint funding arrangements across health and care services for the delivery of PEOLC services?’. Most ICBs (62%) indicated that they used some form of joint funding arrangement for PEOLC while 19% stated they did not.

Strategy and engagement

The below summarises responses to questions relating to ICB Integrated Care Strategies and Joint Forward Plans and coverage of PEOLC within them, and stakeholders ICBs are consulting with to define PEOLC strategies and commissioning needs.

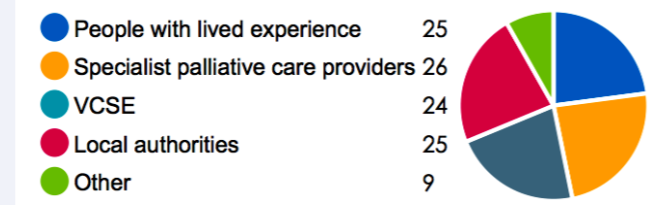
Around 20 – 30% of systems lack a sufficient strategic focus on PEOLC services, as reflected in representation in Integrated Care Strategies and Joint Forward Plans.

Respondents were asked if their Integrated Care Strategy defines their strategic aims for PEOLC. 73% felt that it does, while 19% felt it didn’t.

Respondents were also asked if their Joint Forward Plan includes their five-year delivery plan for arranging and delivering PEOLC services. Similar to before, a large number of respondents (81%) chose ‘yes’ with 12% choosing ‘no’.

Systems engage with a variety of PEOLC stakeholders and partners.

Question 19 sought to understand which stakeholders ICBs are engaging with to define strategies and commissioning needs.



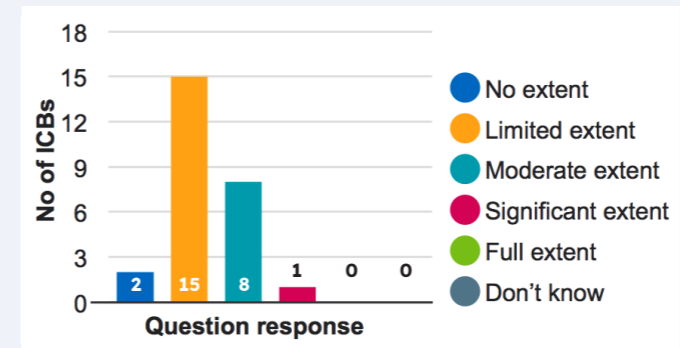
Large numbers of respondents ticked specialist palliative care providers, people with lived experience, VCSE and local authorities. Stakeholders listed under ‘other’ included justice services, ambulance services, acute hospitals, community providers, primary care, mental health trusts, care homes, public health, unpaid careers, Healthwatch and other independent sector organisations.

Some respondents have also outlined that they have ran or plan to run surveys to understand the lived experiences of patients and carers. One ICB shared that they used their survey to inform the development of their PEOLC strategy and have now established an ‘expert by experience’ group to support this.

Workforce

Only 3% of ICBs responded that they had significantly assessed the required workforce to deliver services effectively.

Respondents were asked ‘To what extent has the ICB assessed the workforce required to deliver PEOLC services effectively?’ All 26 ICBs completed this question. Only 3% of ICBs responded that they had significantly assessed the required workforce to deliver services effectively. No ICBs reported having done this to a ‘full extent’.



In the following questions respondents then were asked to provide a short summary of the key barriers they are facing recruitment and retention of a skilled workforce to deliver PEOLC services and outline some of the solutions which have pursued. Common themes are outlined below.

Shortage of health and care professionals

A large number of ICB respondents (74%) cited a shortage of health and care professionals as a barrier in relation to workforce, in particular, district nurses, community nurses, specialist palliative care consultants and allied health professions. Remuneration of roles and a lack of career development were offered as potential factors.

ICB respondents outlined some of the solutions they use to help with attracting and retaining end of life care staff. These include offering a range of PEOLC roles e.g., trainee roles focused on PEOLC for consultant nurse specialists and health care assistants, as well as apprenticeships. Other solutions included shared roles, rotational roles, using Macmillan nurses and using the Additional Roles Reimbursement Scheme (ARRS) to recruit into primary care. Some respondents mentioned the importance of the role of the VCSE sector in supporting to deliver key services and the availability of a 24/7 specialist PEOLC advice line system to reduce pressures on community nursing.

Funding pressures

Most ICB respondents (61%) cited challenges around funding of PEOLC posts in relation to workforce. This was felt to have been exacerbated by the pandemic and short term funding. Furthermore, most of these respondents noted that remuneration of PEOLC roles is not attractive and that charitable organisations can struggle to compete with NHS terms and conditions. One ICB respondent shared that they employ Hospice Consultants via the local NHS Trust to address this.

2. Survey responses (...continued)

Career pathways for PEOLC health and care professionals

17% of ICBs shared challenges around upskilling and development opportunities for health and care professionals on end of life care, with no defined career pathway or training in end of life care. One ICB felt this was exacerbated by the pandemic. Shortages of specialist end of life care professionals is making it even more difficult to release time to support upskilling colleagues, thus also impacting succession planning. Some respondents outlined learning and development initiatives they have in place for PEOLC staff, for example providing training programmes for health and social care professionals at all levels (specialist and generalist) across the ICB with champions in all services (with some having an Education Hub for PEOLC). One respondent shared that their local hospice were extending their medical student placements in the hope that this will attract future doctors into the specialty. Some respondents shared that they have conducted a training needs analysis.

Support required to meet ICB PEOLC requirements

A large number of respondents felt that evidence on the case for investment would be helpful for them to meet the requirements for PEOLC services.

Question 23 asked ‘What approaches, resources or tools would be most useful for Marie Curie to provide to help ICBs meet the requirements for PEOLC services?’, with options outlined below. Evidence for a case for investment was the most popular form of support. In additional comments, respondents shared that they agreed the other types of resources listed would also be helpful.



3. Deep Dive Process and Purpose

Deep Dive process

Alongside our survey of all 42 ICBs in England, we have also conducted a “deep dive” discovery exercise with two ICBs – Suffolk and North East Essex (SNEE) and Birmingham and Solihull (BSol). These ICBs were selected as two systems that would provide insight from areas with varying characteristics – for example significantly different levels of rurality, population demographics and density.

The deep dive process involved a series of structured interviews with key system stakeholders within each system to understand how palliative and end of life care services are commissioned, managed and delivered. We also requested a range of documentation and data from each system to provide additional insight and evidence to support our conversations with system stakeholders.

Purpose and objectives

The primary purpose of the deep dive process was to build on the insights gained through the survey to understand, in more detail, how ICBs are responding to their new legal requirement and what additional support would be most helpful.

Our key objectives through the deep dive interviews were to understand:

- Key strengths and areas of good practice in the commissioning, management and delivery of PEOLC services across each system
- Key challenges and barriers experienced within each system that impact their ability to commission PEOLC services that best meet the needs of their local population

- What resources they may find most useful to support them in meeting their requirement to commission palliative care services that meet the needs of their population contained in the Health & Social Care Act.

Engagement

Through the deep dive process, we sought to engage with key individuals across each system who were able to provide us with valuable information and insight into the commissioning, management and delivery of PEOLC services.

Through our engagement with SNEE, we held interviews with:

- Deputy Director of Performance Improvement
- Chief Clinical Officer
- Chief Executive Officer of St Elizabeth Hospice (also SRO for end of life care)
- Transformation Leads for End of Life across the 3 different places / alliances
- Director of Patient Service and the contact for the Palliative Care Coordination Hub at St Elizabeth Hospice
- Transformation Project Manager – Children & Young People

We have also engaged with relevant system working groups and governance forums where appropriate, for example, the Integrated Care System End of Life Group

4. Case Studies

Palliative Care Coordination Hub in Suffolk and North East Essex ICB

The below case study for the Palliative Care Coordination Hub in Ipswich and East Suffolk illustrates how care can be co-ordinated in the community to reduce hospital admissions and ensure more patients are able to die in their place of choice.

Summary

The Palliative Care Coordination Hub was created from a long term ambition to address the need to coordinate care and limit footfall through caring for people in their own homes. The Palliative Care Coordination Hub provides specialist palliative care across the Ipswich and East Suffolk (IES) area. This service can be accessed via One Call – a 24-hour advice line – which provides essential support for patients and their families, and professionals caring for individuals nearing the end of life.

Key aims of the service are to provide:

- Enhanced and expanded coordination of care through the hub
- Increased availability of PEOl advice and support across the 24 hour period
- Patient choice in remaining at home (care homes included), if desired, reducing unwanted hospital admissions
- Increased resilience in the system to react to urgent and end of life episodes of care need, making better use of resources
- A patient and family centred response in the community that reduces the need to tell their story repeatedly
- A central resource and support of emotional and bereavement care
- A logistic resource for urgent deliveries such as small equipment.

The hub also provide a satellite clinic in Stowmarket to enable those who cannot access Ipswich can receive bereavement support closer to home.

Outcomes achieved

Patients, families and partners value this service as it supports patient choice to remain at home and supports others in symptom control.

Some of the outcomes achieved include:

- More home deaths than at the start of the Hub
- Identification of patients at the end of their lives allow supporting advance care planning and joined up care.
- Everyone in East Suffolk now has access to bereavement information via <https://www.livinggriefeastssuffolk.co.uk> Residents have a central point of contact for emotional and bereavement support via the Living Grief Enquiry phone line. All referrals are triaged within three working days. NICE guidance recommends a three tier model of bereavement support which the Living Grief service provides. This also helps to reduce demand on the primary sector.
- Often providing equipment to allow patients to remain at home instead of being admitted to hospital.
- Therapy provision on a Saturday and bank holidays reduces demand on the local healthcare teams.

Personal Health Budgets in Birmingham and Solihull ICB

The below case study provides information on how Personal Health Budgets are being used to support PEOlC patients and how effective ICB governance structures can support the delivery of PEOlC.

Personal Health Budgets

Personal Health Budgets in BSol are helping to tackle health inequalities and allowing for personalised care. This has provided end of life patients with funds for items and services which may better support their needs, for example cleaning services or funds for grocery shopping. Patient feedback has shown that this has made a significant positive impact to patients. Below is an example of how this has worked.

A 90-year-old patient with multiple co morbidities was diagnosed with incurable cancer and was struggling to accept that he needed help. When the Clinical Nurse Specialist visited the patient, she noted that he was losing weight and struggling with personal care. The patient then admitted that he was struggling with personal care and meal preparation. The patient consented to a social services referral, for one call per day for personal hygiene needs, which the PHB team completed. Once the patient had met the PHB Team, he became more comfortable and was able to discuss other support needs, to help him stay at home in his preferred place of care. The team also arranged support for washing and ironing services. The PHB team arranged weekly support with his shopping, ensuring the patient had appropriate food to eat each day. Later that month the patient had an acute admission to hospital, an unavoidable admission due to an acute episode which required emergency care.

The Complex discharge team called the PHB team to inform them that although the patient was medically fit for discharge, he would require a deep clean of his home before he could be safely discharged. The PHB Team arranged a deep clean with a cleaning company to facilitate a speedy hospital discharge.

Personal Health Budgets

BSol have strong governance arrangements in place in relation to PEOlC. An End of Life (EoL) Collaboration System Steering Group is in place to steer and oversee delivery of the BSol Adult End of Life work programme. The work programme covers all aspects of End of Life care for adults, including transition care for young people, and will link with the existing Children and Young People's EoL programme across the BSol system.

Two groups which report in to the EoL Collaboration System Steering Group include the EoL Operational Group and EoL Ambitions Action Plan Workstream Review Groups. The Operational Group meet monthly with 40 representatives across acute, voluntary and private sectors. This Operational Group is responsible for mapping current service provision from all providers in EoL and works to enable a joint up approach towards end of life care. This group also supports frontline staff focus groups from across EoL providers to discuss issues and good practice.

Data Dashboard in Suffolk and North East Essex ICB

The below case study for the North East Essex Alliance shows how an End of Life Care dashboard can be used to understand and monitor end of life outcomes and drive targeted interventions. The dashboard provides a comprehensive view of outcomes (by condition, primary care network, deprivation etc) and can be accessed by a range of health and care professionals.

Summary

The North East Essex Alliance have produced a dashboard to monitor outcomes in end of life care and provide targeted interventions where required to drive improvements. Provides an overview on the outcomes for patients in their last 12 months of life and is available to clinicians and managers in the North East Essex area. The dashboard was produced in consultation with patients to agree ten priorities for good end of life care and an associated metric to track whether these outcomes were being delivered. For example one of the ten priorities is patient identification and the associated metric captured on the dashboard to measure this is whether a patient is included on the My Care Choices Register.

The End of Life Care dashboard links quantitative data from four sources: Office of National Statistics, Hospital Episode Statistic, the local Electronic Palliative Care Coordination System called the My Care Choices Register and patient feedback. Metrics measured in the dashboard include: patients who died in their place of preference, hospital admissions, recurrent admissions, percentage of hospital deaths, percentage of patients who have a care plan in place within care homes, percentage who died who had an emergency admission

in the last 90 days of life and the percentage who died who had 3 or more emergency admissions in the last 90 days of life.

Data can be filtered by: Four main diagnostic condition groups (cancer, dementia, heart disease and COPD); Primary Care Networks; Neighbourhoods; Deprivation; Ethnicity; Care homes.

Outcomes

The dashboard has supported system leaders to understand equity of access across demographic groups. During the Covid-19 pandemic there was an increased focus on reaching out to end of life patients to understand their end of life choices, and there was an increase in the sharing of end of life preferences. However, a review of deprivation data revealed this was not happening to the same extent in deprived areas. This knowledge allowed commissioners to make more informed decisions about potential interventions.

The dashboard has also been used to improve care coordination and symptom control across all the services within North East Essex for patients with advanced respiratory disease. Data from the dashboard has been used to increase early identification of people approaching the last phase life, provide earlier advance care planning, including access to the My Care Choices Register and the ReSPECT process.

It is predicted that improved care coordination will improve outcomes and decrease unnecessary hospital admissions as has been shown on the North East Essex End of Life dashboard in relation to other conditions. It is known that people who have received advance care planning are less likely to have unplanned hospital admissions, which reduces costs to the wider system.