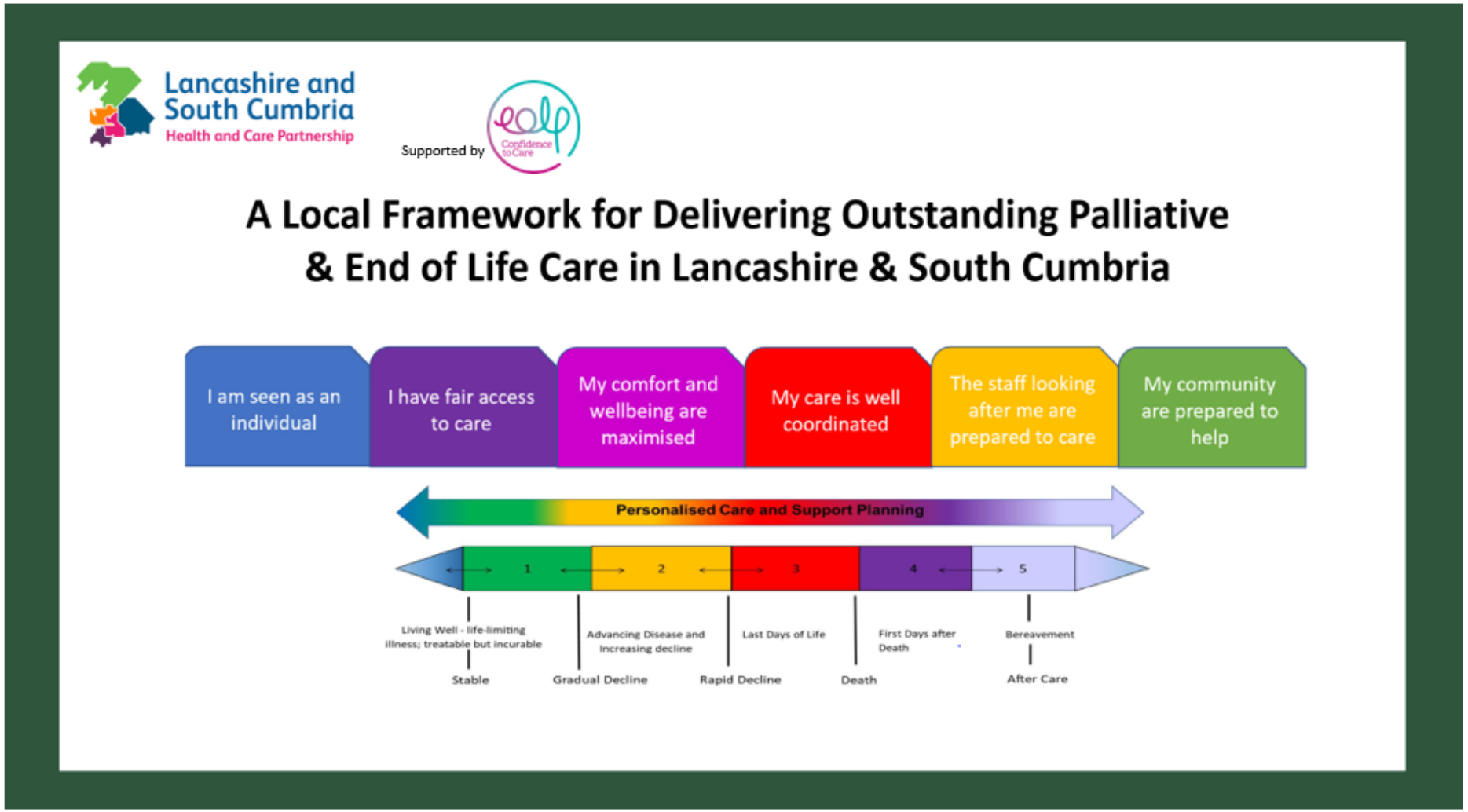
Guidance to Support Getting to Outstanding (GOS) Self-Assessment



North West Coast Clinical Networks

Introduction

This guidance has been developed to assist the process of self-assessment against the framework for delivering outstanding palliative and end of life care across the Integrated Care System.

Self-Assessment is intended to be carried out across the PLACE based partnership area including those who commission, provide and experience palliative and end of life care. **See GOS TOP TIPS for co-ordinating self-assessment**.

The guidance is intended to support those facilitating the self-assessment process and should be used alongside the GOS excel self-assessment tool.

Acknowledgements go to NHSE North West Coast Clinical Network and Marie Curie for developing the guidance to support GOS self-assessment.

Guidance against the GOS excel self-assessment tool.

NATIONAL AMBITION 1: I am seen as an individual

I, and the people important to me, have opportunities to have honest, informed, and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's possible

Level	Locality Level Descriptor
Level 0	Not at all ready to achieve/ anticipate barriers to achievement
Level 1	Desire to achieve this ambition but there are currently no plans in place
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Level 3	Limited achievement across one or two organisations within Place only
Level 4	Partially achieving e.g. across most, but not all care settings within Place
Level 5	Fully achieving e.g. across all care settings at Place, with supporting evidence available
	Fully embedded at Place including regular outcome monitoring and review

Self- Assessment Statement	Getting to Outstanding Commitment(s) linked to the statement – in bold identifies the most pertinent commitment	Points to consider when thinking about self-assessment – prompts for to support discussion	Reminder of the Enablers – these are in the framework document
Early identification tools are used	**Commitment 1.3 We will improve the early identification of those that are likely to be in the last years of life and those approaching days of life** **Commitment 1:1** We will take the time to listen and to find out what matters to you, including	Different settings and their access to the same tools Different tools in different settings – varied outcomes Consistency with use of identification tools used	EARLY clinical search tool Gold Standards Framework SHADOW tool for Care Homes Amber Care Bundle

	understanding your goals and preferences **Commitment 1:2** We will regularly review your care to ensure any changes to your care needs, or your preferences for how you'd like to be cared for are kept updated **Commitment 1.4** We will support people to feel more confident and prepared for having conversations around death and dying and planning for the future	Consistency issues with reviews of care plans Issues with the patients being recognised as last year of life by non specialist teams Funding for training in both early recognition, and difficult conversations	Other digital tools that support early identification
Public health approaches are being taken towards death, dying & bereavement	**Commitment 1.11 We will work together across services to assess and respond to the care and support needs of a person and those important to them, including bereavement support** **Commitment 1.4** We will support people to feel more confident and prepared for having conversations around death and dying and planning for the future **Commitment 1.6** We will value people as active partners in their	Funding in different areas Training Interaction levels in different settings Data reflecting different settings Issues with integration between health and social care in different settings	Compassionate communities Dying matters

	care and decision making, so that they are supported to retain as much control as they wish to have **Commitment 1.9** We will ensure (with your consent), all health and social care professionals have the necessary information to be able to care for you effectively		
There is dedicated private spaces and opportunity for sensitive conversations	**Commitment 1.5 We will provide private space and timely opportunities for end-of-life care planning conversations, if people wish to have them** **Commitment 1.1** We will take the time to listen and to find out what matters to you, including understanding your goals and preferences **Commitment 1.2** We will regularly review your care to ensure any changes to your care needs, or your preferences for how you'd like to be cared for are kept updated **Commitment 1.4** We will support people to feel more confident and	Lack of space available in different settings Community – own homes vs acute settings (wards not having rooms etc) Training for staff to be comfortable to have the conversations Time pressures Resources/support following conversations Continuity of staff	dedicated consulting rooms longer appointment times

	prepared for having conversations around death and dying and planning for the future **Commitment 1.6** We will value people as active partners in their care and decision making, so that they are supported to retain as much control as they wish to have **Commitment 1.7** We will provide accessible information so that people will know what palliative, end of life and bereavement care and **support they can expect** **Commitment 1:9** We will ensure (with your consent), all health and social care professionals have the necessary information to be able to care for you effectively **Commitment 1.11** We will work together across services to assess and respond to the care and support needs of a person and those important to them, including bereavement support		

Personalised Care & Support Planning is being proactively offered and regularly reviewed	**Commitment 1:1 We will take the time to listen and to find out what matters to you, including understanding your goals and preferences** **Commitment 1:2** We will regularly review your care to ensure any changes to your care needs, or your preferences for how you'd like to be cared for are kept updated **Commitment 1:3** We will improve the early identification of those that are likely to be in the last year of life and those approaching their final days of life **Commitment 1:4** We will support people to feel more confident and prepared for having conversations around death and dying and planning for the future **Commitment 1:5** We will provide private space and timely opportunities for end-of-life care planning conversations, if people wish to have them	Continuity of tools used to identify EOL patients Spaces available Training for staff regarding advanced care planning Continuity of staff in different settings for reviews Systems in place to alert for reviews/initial discussion (templates etc) Routinely happening across all services, not just specific	concerns checklist holistic needs assessment Advance Care Planning **and** understanding peoples wishes - for example preferred place of care organ and tissue donation DNACPR Escalation Plans Anticipatory Clinical Management Planning Future Life Planning ICD deactivation Mental Capacity Assessment/Best Interests processes in place for regular review

	Commitment 1:6 We will value people as active partners in their care and decision making, so that they are supported to retain as much control as they wish to have **Commitment 1:7** We will provide accessible information so that people will know what palliative, end of life and bereavement care and support they can expect **Commitment 1:9** We will ensure (with your consent), all health and social care professionals have the necessary information to be able to care for you effectively **Commitment 1:11** We will work together across services to assess and respond to the care and support needs of a person and those important to them, including bereavement support		
Patient and public information on palliative	**Commitment 1:7 We will provide accessible information so that people will know what palliative,**	Forms of accessibility (internet/telephone/face to face) if	setting out what patients and carers can expect

and end of life care is accessible	**end of life and bereavement care and support they can expect** **Commitment 1:2** We will regularly review your care to ensure any changes to your care needs, or your preferences for how you'd like to be cared for are kept updated **Commitment 1:8** We will provide people with personal health budgets to allow them to personalise and coordinate their own palliative and end of life care **Commitment 1:9** We will ensure (with your consent), all health and social care professionals have the necessary information to be able to care for you effectively **Commitment 1:11** We will work together across services to assess and respond to the care and support needs of a person and those important to them, including bereavement support	they are available for all options in all areas Different forms e.g languages/audio etc Continuity of information sharing between services (e.g. community vs acute setting)	available in different formats & languages signposting across statutory and voluntary services and Care Homes
Personal Health Budgets are available to support	**Commitment 1:8 We will provide people with personal health**	Local barriers	Specifically to support end of life care

Palliative & End of Life Care	**budgets to allow them to personalise and coordinate their own palliative and end of life care** **Commitment 1:1** We will take the time to listen and to find out what matters to you, including understanding your goals and preferences **Commitment 1:6** We will value people as active partners in their care and decision making, so that they are supported to retain as much control as they wish to have **Commitment 1:10** We will provide safe and efficient transportation to your preferred place of care where this is available and appropriate to your care needs	Equal access to funding for all patients Awareness of budgets When can people access the budgets - ?if only available at later stages of care Inequality in who can have budgets Variation between areas/access	
Electronic Palliative Care Coordination Systems (EPaCCS) include platforms for patients to share or view their own plans	**Commitment 1:6 We will value people as active partners in their care and decision making, so that they are supported to retain as much control as they wish to have** **Commitment 1:1** We will take the time to listen and to find out what	Lack of consistency with systems in different settings Data sharing agreements Access to relevant systems for patients – barriers with internet	includes platforms for patients to share or to view their own plans

	matters to you, including understanding your goals and preferences **Commitment 1:2** We will regularly review your care to ensure any changes to your care needs, or your preferences for how you'd like to be cared for are kept updated **Commitment 1:7** We will provide accessible information so that people will know what palliative, end of life and bereavement care and support they can expect **Commitment 1:9** We will ensure (with your consent), all health and social care professionals have the necessary information to be able to care for you effectively **Commitment 1:11** We will work together across services to assess and respond to the care and support needs of a person and those important to them, including bereavement support	access and wording of forms – support when completing Different organisations access to the same systems Funding to implement systems and deliver training	

Palliative & End of Life Care Pathways at Place are integrated across health, social, third sector	**Commitment 1:9 We will ensure (with your consent), all health and social care professionals have the necessary information to be able to care for you effectively** **Commitment 1:7** We will provide accessible information so that people will know what palliative, end of life and bereavement care and support they can expect **Commitment 1:11** We will work together across services to assess and respond to the care and support needs of a person and those important to them, including bereavement support	Is there a clear referral pathway throughout all areas which is routinely used Are the referral pathways sufficient (things done timely and effectively, in all areas) Funding available Barriers to accessing different sectors	across health, social, third sector through Joint MDT's trusted assessment processes integrated discharge summaries
Pre & post bereavement support is available for expected, traumatic and sudden deaths	**Commitment 1:7 We will provide accessible information so that people will know what palliative, end of life and bereavement care and support they can expect** **Commitment 1:3** We will improve the early identification of those that are likely to be in the last year of life	Waiting lists Is the same level of bereavement support available across all areas (e.g. acute vs hospice) Gaps in support (suicide, sibling support, unexpected death) Consistency in all levels of support	helping people to prepare for loss, grief, and bereavement across all settings eg: care homes, maternity, children's and adult's services Including expected, sudden & traumatic death

	and those approaching their final days of life **Commitment 1:11** We will work together across services to assess and respond to the care and support needs of a person and those important to them, including bereavement support	Funding available Level of staffing in bereavement teams Knowledge around referral pathways	
Regular engagement takes place with patients and the public about local palliative and end of life care	**Commitment 1:1 We will take the time to listen and to find out what matters to you, including understanding your goals and preferences** **Commitment 1:4** We will support people to feel more confident and prepared for having conversations around death and dying and planning for the future **Commitment 1:5** We will provide private space and timely opportunities for end-of-life care planning conversations, if people wish to have them **Commitment 1:7** We will provide accessible information so that	Are things available consistently Is engagement routine throughout all areas? Uptake/awareness around public engagement events	gaining service user and carer feedback and involving them in service evaluation and design

	people will know what palliative, end of life and bereavement care and support they can expect **Commitment 1:11** We will work together across services to assess and respond to the care and support needs of a person and those important to them, including bereavement support		
Place has an equality and diversity strategy to deliver palliative and end of life care services that meet the needs of marginalised groups	**Commitment 1:7 We will provide accessible information so that people will know what palliative, end of life and bereavement care and support they can expect** **Commitment 1:1** We will take the time to listen and to find out what matters to you, including understanding your goals and preferences **Commitment 1:2** We will regularly review your care to ensure any changes to your care needs, or your preferences for how you'd like to be cared for are kept updated	Are there policies in place – are they consistent in each area How are patients in marginalised groups identified	working within best practice when supporting individuals that may feel marginalised e.g. LGBTQ+, homeless people, prisoners, immigrants, travelling community

	Commitment 1:4 We will support people to feel more confident and prepared for having conversations around death and dying and planning for the future **Commitment 1:5** We will provide private space and timely opportunities for end-of-life care planning conversations, if people wish to have them **Commitment 1:6** We will value people as active partners in their care and decision making, so that they are supported to retain as much control as they wish to have **Commitment 1:9** We will ensure (with your consent), all health and social care professionals have the necessary information to be able to care for you effectively		

Ambition 2: I have fair access to care

I live in a society where I get good end of life care regardless of who I am, where I live, or the circumstances of my life

Level	Scoring : levels and descriptors
Level 0	Not at all ready to achieve/ anticipate barriers to achievement
Level 1	Desire to achieve this ambition but there are currently no plans in place
Level 2	Plans are in place towards achieving this ambition
Level 3	Limited achievement across one or two organisations within Place only
Level 4	Partially achieving e.g. across most, but not all care settings within Place
Level 5	Fully achieving e.g. across all care settings at Place, with supporting evidence available
	Fully embedded at Place including regular outcome monitoring and review

Self- Assessment Statement	Getting to Outstanding Commitment(s) linked to the statement – in bold identifies the most pertinent commitment	Points to consider when thinking about self-assessment – prompts for to support discussion	Reminder of the Enablers – these are in the framework document
1.1 **Place is taking an all conditions approach to palliative and end of life care**	**Commitment 2:4 We will seek to understand the reasons why people might not access palliative, end of life care and bereavement services** **Commitment 2:5** We will actively involve people/ organisations representing, different age groups, disabilities, illnesses and cultures in future service design and strategy development	**Things to consider:** Staffing/who will gather the information/ Capacity Continuity of each area Funding	An all-conditions approach to palliative and end of life care - e.g. specialist palliative care representation at specific MDT's e.g. neurology, respiratory, cross sector referral to GP palliative care registers, collaborations between palliative care and disease/population specific services

	Commitment 2:6 We will help people that are finding it difficult, for whatever reason, to navigate their way around palliative and end of life services more easily **Commitment 2:2** We will provide accessible services that respond to the diverse palliative, end of life and bereavement care needs of our communities **Commitment 2:1** We will seek to understanding the palliative, end of life and bereavement care needs of the local population		
1.2 **Data dashboards are being used to collate, benchmark and inform priorities for palliative and end of life care outcomes at Place**	**Commitment 2:1 We will seek to understanding the palliative, end of life and bereavement care needs of the local population** **Commitment 2:3** We will continuously improve the quality of palliative, end of life, and bereavement services by evaluating their impact on the people that use them	**Things to consider:** Access to data – different systems in different areas Accuracy of evidence/ how is the data obtained? Different areas may have different priorities – will it all be as 1? If so, how accurate for each area	Data dashboards are being used to collate, benchmark and inform priorities - e.g. representing a system wide response, used to set priorities, to understand and to remedy the reach of current services, use of standardised outcome measures/core metrics in service contracts

	Commitment 2:4 We will seek to understand the reasons why people might not access palliative, end of life care and bereavement services **Commitment 2:5** We will actively involve people/ organisations representing, different age groups, disabilities, illnesses and cultures in future service design and strategy development		
1.3 **Place has an inequalities impact assessment and action plan to improve access to palliative and end of life care services for all**	**Commitment 2:5 We will actively involve people/ organisations representing, different age groups, disabilities, illnesses and cultures in future service design and strategy development** **Commitment 2:4** We will seek to understand the reasons why people might not access palliative, end of life care and bereavement services **Commitment 2:6** We will help people that are finding it difficult, for whatever reason, to navigate their way around palliative and end of life services more easily	**Things to consider:** Do different settings all have the same consistent approach and plan? Are assessments in use and accessible to all teams	Equalities and health inequalities impact assessment and action plan - e.g. addressing improved equity of access to services, reducing inequity of outcomes and experience, reflected in clinical pathway design e.g. homeless, prisons, mental health units, supported living, LGBTQ+

	Commitment 2:2 We will provide accessible services that respond to the diverse palliative, end of life and bereavement care needs of our communities **Commitment 2:1** We will seek to understanding the palliative, end of life and bereavement care needs of the local population		
1.4 **Place is taking an all ages approach to palliative and end of life care**	**Commitment 2:5 We will actively involve people/ organisations representing, different age groups, disabilities, illnesses and cultures in future service design and strategy development** **Commitment 2:1** We will seek to understanding the palliative, end of life and bereavement care needs of the local population **Commitment 2:2** We will provide accessible services that respond to the diverse palliative, end of life and	**Things to consider:** Variations between acute and community/hospice settings Are there clear referral pathways	All ages approach to palliative and end of life care - e.g. adults and children strategy, inclusive of services supporting the transition between childhood and adulthood. Standardised outcomes for children with life-limiting illness

	bereavement care needs of our communities **Commitment 2:4** We will seek to understand the reasons why people might not access palliative, end of life care and bereavement services **Commitment 2:3** We will continuously improve the quality of palliative, end of life, and bereavement services by evaluating their impact on the people that use them **Commitment 2:8** We will ensure that your family and those important to you have access to support and care, including bereavement support after you have died		
1.5 **Place has a strategy for co-designing and evaluating palliative and end of life care service with diverse communities and organisations**	**Commitment 2:5 We will actively involve people/ organisations representing, different age groups, disabilities, illnesses and cultures in future service design and strategy development**	**Things to consider:** Access for all services to the same systems/Sharing agreements	Service co-design and evaluation - e.g. involving people and organisations representing faith groups, cultural communities, all ages, and those with life limiting illness, strategy for seeking service user feedback to inform

	Commitment 2:3 We will continuously improve the quality of palliative, end of life, and bereavement services by evaluating their impact on the people that use them		service development and improvement
1.6 **Data provided through Electronic Palliative Care Coordination Systems (EPaCCS) is being used across Place to benchmark outcomes**	**Commitment 2:5 We will actively involve people/ organisations representing, different age groups, disabilities, illnesses and cultures in future service design and strategy development** **Commitment 2:3** We will continuously improve the quality of palliative, end of life, and bereavement services by evaluating their impact on the people that use them **Commitment 2:1** We will seek to understanding the palliative, end of life and bereavement care needs of the local population **Commitment 2:4** We will seek to understand the reasons why people	**Things to consider:** Acute vs Community systems differing Access to view documents on different systems Is data shared with all relevant teams if not on same system	Electronic Palliative Care Coordination Systems (EPaCCS) - e.g. to provide consistent data that can be benchmarked across localities and regions

	might not access palliative, end of life care and bereavement services		
1.6 **Place has a published list of providers of palliative and end of life care and bereavement support**	**Commitment 2:8 We will ensure that your family and those important to you have access to support and care, including bereavement support after you have died** **Commitment 2:2** We will provide accessible services that respond to the diverse palliative, end of life and bereavement care needs of our communities **Commitment 2:6** We will help people that are finding it difficult, for whatever reason, to navigate their way around palliative and end of life services more easily **Commitment 2:1** We will seek to understanding the palliative, end of life and bereavement care needs of the local population **Commitment 2:9** We will ensure that you have 24/7 access to	**Things to consider:** If patient is not referred to specialist teams, are they given the details Staff awareness of providers throughout all areas (Acute vs hospice) Funding issues for services Capacity of bereavement support	Published list of providers of palliative and end of life care and bereavement support- readily available to the public and across the health economy to support future commissioning of services, and to facilitate partner collaborations

	someone that can help if you are struggling		

Ambition 3 – please see next page

Ambition 3: Maximising comfort and wellbeing

My care is regularly reviewed, and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.

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Self- Assessment Statement	Getting to Outstanding Commitment(s) linked to the statement – in bold identifies the most pertinent commitment	Points to consider when thinking about self-assessment – prompts for to support discussion	Reminder of the Enablers – these are in the framework document
1.1 **There is 24/7 access to specialist palliative care advice across Place**	**Commitment 3:3 We will ensure that everyone has access to specialist palliative care advice 24/7** **Commitment 3:4** We will provide 7-day access to face-to-face assessment from specialist palliative care **Commitment 3:1** We will provide rapid response services to support people to manage symptoms that are causing them distress e.g. pain, agitation	Staffing Funding for new services to develop	24/7 access to specialist palliative care advice - e.g. regardless of setting, available for professionals, patients, and their significant others, advice line with consultant on-call

1.2 **Specialist palliative care services across Place provide 7 day face to face asessment**	**Commitment 3:4 We will provide 7-day access to face-to-face assessment from specialist palliative care** **Commitment 3:1** We will provide rapid response services to support people to manage symptoms that are causing them distress - e.g. pain, agitation **Commitment 3:9** We will deliver individualised care to the dying person and those important to them **Commitment 3:3** We will ensure that everyone has access to specialist palliative care advice 24/7	Staffing of services Funding of new services	7-day access to face-to-face assessment from specialist palliative care services - e.g. community and hospital, care homes and specialist units - e.g. learning disabilities, prisons, 24/7 availability of hospice admissions
1.3 **Place has an identified single point where patients, families and professionals can access a range of palliative and end of life care comfort and wellbeing services**	**Commitment 3:2 We will provide the right palliative, end of life and bereavement care support services that respond to the common causes of distress** **Commitment 3:3** We will ensure that everyone has access to specialist palliative care advice 24/7 **Commitment 3:6** We will provide	Will all areas have access to the same system/patient details Funding Staffing	Single point of referral/care coordination for palliative and end of life care - e.g. regardless of care setting, care coordination and advice, open to health care professionals, patients and their carers

	accessible information about different symptom management options so that people can make informed decisions **Commitment 3:9** We will deliver individualised care to the dying person and those important to them		
1.4 **Electronic Palliative Care Coordination Systems (EPaCCS) are being used across Place, including during out of hours periods to support comfort and wellbeing including delivering the Five Priorities for Care of the Dying Adult**	**Commitment 3:7 We will maximise comfort and wellbeing by ensuring everyone involved in a person's care has timely access to their individual care and support plan** **Commitment 3:3** We will ensure that everyone has access to specialist palliative care advice 24/7 **Commitment 3:6** We will provide accessible information about different symptom management options so that people can make informed decisions	Cost of implementing the same system throughout all areas Data transfer from current systems used	Electronic Palliative Care Coordination Systems (EPaCCS) - e.g. includes out of hours and ambulance sharing, last days of life care aligned to the five priorities, inclusive of care homes and domiciliary care
1.5 **Place has an agreed approach to support Anticipatory Clinical Management Planning**	**Commitment 3:2 We will provide the right palliative, end of life and bereavement care support services that respond to the common causes of distress**	Cost of prescribing course for staff Time to complete course for all staff	Anticipatory clinical management planning - e.g. treatment escalation plans, anticipatory medications, processes for regular review of medications

including anticipatory prescribing	**Commitment 3:1** We will provide rapid response services to support people to manage symptoms that are causing them distress - e.g. pain, agitation **Commitment 3:3** We will ensure that everyone has access to specialist palliative care advice 24/7		including within nursing homes Non-medical prescribers - e.g. within palliative care, education in palliative and end of life care symptoms to nurse prescribers across generalist services
1.6 **Place has a strategy for succession planning and training of non-medical prescribers to support palliative and end of life symptom management**	**Commitment 3:2 We will provide the right palliative, end of life and bereavement care support services that respond to the common causes of distress** **Commitment 3:1** We will provide rapid response services to support people to manage symptoms that are causing them distress - e.g. pain, agitation	Length of time to train the staff Cost of training	Non-medical prescribers - e.g. within palliative care, education in palliative and end of life care symptoms to nurse prescribers across generalist services
1.7 **There are arrangements at Place to provide palliative pharmacy services that facilitate access to medications at any time of the day or night**	**Commitment 3:2 We will provide the right palliative, end of life and bereavement care support services that respond to the common causes of distress**	Areas of pharmacy's – can everyone get to them? Funding to be able to do this	Palliative pharmacy services - e.g. opening hours and access to palliative and end of life drugs, just-in case boxes

1.8 **Place has a dedicated Ambulance Service to support end of life transfers**	**Commitment 3:3 We will ensure that everyone has access to specialist palliative care advice 24/7** **Commitment 3:9** We will deliver individualised care to the dying person and those important to them	Waiting times Staffing Training for specific ambulance staff	Dedicated ambulance service - e.g. end of life transfers, including for children's hospice transfers
1.9 **People with a palliative diagnosis can access dedicated financial assessment and support that is tailored to their individual circumstances**	**Commitment 3:9 We will deliver individualised care to the dying person and those important to them** **Commitment 3:8** We will help people to maximise their independence and social participation to the extent that they want, and for as long as possible **Commitment 3:2** We will provide the right palliative, end of life and bereavement care support services that respond to the common causes of distress	Different criteria for assessments Length of time to get the financial support When can they access the financial support Lengthy process for application	Financial assessment and support - e.g. DS1500, PIP, CHC, tailored advice
1.10 **Place has dedicated Allied Health Professional (AHP) roles working within palliative and end of life care that support**	**Commitment 3:2 We will provide the right palliative, end of life and bereavement care support services**	Communication between services - how are they shared? To avoid things missing	AHP roles within palliative care – social worker, therapy teams:

the holistic care of the individual and those important to them	**that respond to the common causes of distress** **Commitment 3:7** We will maximise comfort and wellbeing by ensuring everyone involved in a person's care has timely access to their individual care and support plan **Commitment 3:4** We will provide 7-day access to face-to-face assessment from specialist palliative care	Staffing/recruitment	OT, physio and clinical psychology as a minimum
1.11 **There are services at Place where people can access rehabilitative palliative care**	**Commitment 3:2 We will provide the right palliative, end of life and bereavement care support services that respond to the common causes of distress** **Commitment 3:7** We will maximise comfort and wellbeing by ensuring everyone involved in a person's care has timely access to their individual care and support plan **Commitment 3:8** We will help people to maximise their independence and social participation to the extent that they want, and for as long as possible	Number of beds available Funding Space for this/where will it be	Rehabilitative palliative care services - dedicated team

	Commitment 3:9 We will deliver individualised care to the dying person and those important to them		
1.12 **Rapid response services and processes are available at Place that can specifically respond to the urgent comfort and wellbeing needs of people that are palliative or at the end of life**	**Commitment 3:1 We will provide rapid response services to support people to manage symptoms that are causing them distress - e.g. pain, agitation** **Commitment 3:3** We will ensure that everyone has access to specialist palliative care advice 24/7 **Commitment 3:2** We will provide the right palliative, end of life and bereavement care support services that respond to the common causes of distress	Staffing Funding Can everyone access the same systems with patient details on Training Recruitment for service	Rapid response services - e.g. regardless of care setting, including for equipment and ambulance conveyancing, access to GP appointments and prescribing for priority patients e.g. gold lines
1.13 **Place has a recognised and consistent approach to assessing and supporting carers that are specifically looking after a person with palliative or end of life care needs**	**Commitment 3:5 We will recognise and respond to the needs and expectations of informal caregivers** **Commitment 3:3** We will ensure that everyone has access to specialist palliative care advice 24/7	Staffing for this Consistency in different areas Awareness of the support available Funding	Care for carers - e.g. carer check in, carer breaks, respite, engagement groups
1.14 **There is a recognised approach across Place to applying and evaluating**	**Commitment 3:9 We will deliver individualised care to the dying person and those important to them**	Consistency in areas How is it being evaluated?	Care of the dying person - e.g. approach is aligned to the five priorities of care

the Five Priorities for Care of the Dying Person	**Commitment 3:7** We will maximise comfort and wellbeing by ensuring everyone involved in a person's care has timely access to their individual care and support plan **Commitment 3:2** We will provide the right palliative, end of life and bereavement care support services that respond to the common causes of distress		
1.15 **Domiciliary care at Place is integrated with other palliative and end of life care services including the provision of CHC fast track and access to specialist assessment, medication and equipment**	**Commitment 3:2 We will provide the right palliative, end of life and bereavement care support services that respond to the common causes of distress** **Commitment 3:7** We will maximise comfort and wellbeing by ensuring everyone involved in a person's care has timely access to their individual care and support plan **Commitment 3:9** We will deliver individualised care to the dying person and those important to them	Different systems/data sharing Training for staff in palliative care Funding	Integrated domiciliary care - e.g. dedicated palliative and end of life domiciliary care providers linked to CHC fast track, with appropriate access to patient information, access to specialist services, equipment and medication when required
1.16 **There is a coordinated system to support Syringe Pump**	**Commitment 3:2 We will provide the right palliative, end of life and bereavement care support services**	Cost of syringe pumps Access to them – how to request	Syringe pumps - availability and coordination across care settings including to nursing homes

availability and support across Place	**that respond to the common causes of distress** **Commitment 3:7** We will maximise comfort and wellbeing by ensuring everyone involved in a person's care has timely access to their individual care and support plan **Commitment 3:3** We will ensure that everyone has access to specialist palliative care advice 24/7		

Ambition 4: Care is Coordinated

I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night.

Level	Scoring : levels and descriptors
Level 0	Not at all ready to achieve/ anticipate barriers to achievement
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Level 2	Plans are in place towards achieving this ambition
Level 3	Limited achievement across one or two organisations within Place only
Level 4	Partially achieving e.g. across most, but not all care settings within Place
Level 5	Fully achieving e.g. across all care settings at Place, with supporting evidence available
	Fully embedded at Place including regular outcome monitoring and review

Self- Assessment Statement	Getting to Outstanding Commitment(s) linked to the statement – in bold identifies the most pertinent commitment	Points to consider when thinking about self-assessment – prompts for to support discussion	Reminder of the Enablers – these are in the framework document
1.1 **Electronic Palliative Care Coordination Systems (EPaCCS) are being used to coordinate anticipatory care across Place including with Ambulance Services, Out of Hours and third sector organisations**	**Commitment 4:2 We will coordinate multi-disciplinary team working across palliative and end of life care services** **Commitment 4:1** We will commission joined up palliative, end of life and bereavement care services across health, social and the VCFSE sector so that services understand how they fit together	How will all areas have access and use of the same systems Funding Training for staff in the same system	Electronic Palliative Care Coordination Systems (EPaCCS) - e.g. shared across health, social and third sector organisations, shared with the ambulance service and out of Hours, including clinical management planning documentation e.g. DNACPR, escalation plans

	and where to signpost or refer onto **Commitment 4:4** We will enable the sharing of care records across services so that the right information is available at the point of care		
1.2 **Place has a recognised approach to nominating a named professional that is responsible for reviewing and coordinating an individual's palliative and end of life care**	**Commitment 4:7** We will ensure that your palliative and end of life care is coordinated by a named person	Staffing/recruitment obstacles	Key worker/named person - responsible for reviewing the overarching care plan, named GP
1.3 **Patients, families and professionals have access to a single point where palliative and end of life care can be triaged and coordinated 24/7 across Place**	**Commitment 4:4 We will enable the sharing of care records across services so that the right information is available at the point of care** **Commitment 4:1** We will commission joined up palliative, end of life and bereavement care services across health, social and the VCFSE sector so that services understand how they fit together and where to signpost or refer onto **Commitment 4:2** We will coordinate	Systems in place in different areas Cost of data sharing or implementing same systems in all areas	Single point of contact/ coordination for palliative and end of life care services - e.g. from triage, care coordination and advice, open to health and social care professionals, patients, carers 24/7

	multi-disciplinary team working across palliative and end of life care services		
1.4 **Patients, families and professionals have access to 24/7 specialist palliative care advice at Place including access to priority admissions to specialist units where clinically appropriate**	**Commitment 4:5 We will ensure that people at the end of life, and those important to them always have a point of contact, day, or night where their care and support can be coordinated** **Commitment 4:6** We will empower people to access palliative and end of life services by providing up to date service directories **Commitment 4:2** We will coordinate multi-disciplinary team working across palliative and end of life care services **Commitment 4:4** We will enable the sharing of care records across services so that the right information is available at the point of care	number of beds in units for admissions funding for implementing services staffing	24/7 specialist palliative care advice to include hospice advice and admissions where clinically appropriate, coordinated palliative consultant cover across place or ICS
1.5 **Place has arrangements to provide 7 day general palliative care that includes access**	**Commitment 4:5 We will ensure that people at the end of life, and those important to them always have a point of contact, day, or**	Staffing Funding for services and also equipment/transport	7-day working - e.g. across all core services involved in palliative and end of life care

to end of life care transport, equipment and medications	**night where their care and support can be coordinated** **Commitment 4:2** We will coordinate multi-disciplinary team working across palliative and end of life care services		including equipment and transport
***1.6*Place is taking an integrated and collaborative approach to commissioning palliative and end of life care services across statutory and third sector services and with communities groups**	**Commitment 4:1** We will commission joined up palliative, end of life and bereavement care services across health, social and the VCFSE sector so that services understand how they fit together and where to signpost or refer onto • **Commitment 4:2** We will coordinate multi-disciplinary team working across palliative and end of life care services • **Commitment 4:3** We will meet the needs of diverse groups by establishing integrated care and support pathways e.g. the homeless, learning disabilities, dementia, frailty and old age, children and young people	• Funding • Staffing • Inconsistency in areas	Integrated commissioning - e.g. active partnerships that bring together providers and commissioners to collectively plan services, responding as a whole system approach to locally identified needs

1.7 **Care pathways across Place consistently take a multi-disciplinary approach to identify and communicate the needs of those that are palliative or at the end of life**	**Commitment 4:2 We will coordinate multi-disciplinary team working across palliative and end of life care services** **Commitment 4:1** We will commission joined up palliative, end of life and bereavement care services across health, social and the VCFSE sector so that services understand how they fit together and where to signpost or refer onto **Commitment 4:6** We will empower people to access palliative and end of life services by providing up to date service directories **Commitment 4:4** We will enable the sharing of care records across services so that the right information is available at the point of care	How is communication done/how to avoid people being missed Systems in use – will they all be the same/have access to all	Multi-disciplinary approach - e.g. cross sector MDT meetings including social care, hospital integrated discharge summaries, integrated care pathways (including for diverse needs), neighbourhood teams
1.8 **There are virtual wards in operation to specifically support the out of hospital care and coordination of patients that are palliative or at the end of life**	**Commitment 4:5 We will ensure that people at the end of life, and those important to them always have a point of contact, day, or night where their care and support can be coordinated**	Staffing of the wards How many available virtual beds and will they be all over for access Funding	Virtual wards - specifically for palliative and end of life care and involving the GP

1.9 **Transition between childrens and young peoples' and adult palliative care services are supported by recognised pathways across Place**	**Commitment 4:3 We will meet the needs of diverse groups by establishing integrated care and support pathways e.g. the homeless, learning disabilities, dementia, frailty and old age, children and young people**	Pathway clear – not missing any patients Stability for patients – new teams etc	Transition pathways - between children and young people, and adult palliative and end of life care services
1.10 **There are agreed pathways across Place to support Rapid Discharge or Transfer to a person's preferred place of death, that include expected death notifications to out of hours, and that consider further continuity of care e.g. Anticipatory Prescribing and Nurse Verification of Expected Death**	**Commitment 4:4 We will enable the sharing of care records across services so that the right information is available at the point of care** **Commitment 4:3** We will meet the needs of diverse groups by establishing integrated care and support pathways e.g. the homeless, learning disabilities, dementia, frailty and old age, children and young people	Data sharing systems if different systems in use Issues with transport/time taken	Care of the dying - rapid discharge/ transfers, nurse verification, expected death notifications for OOH
1.11 **Place has an agreed approach to coordinating and accepting out of area**	**Commitment 4:2 We will coordinate multi-disciplinary team**	Training for staff Availability of beds	Out of area coordination - local pathways take into consideration cross boundary working including

palliative and end of life discharges or transfers that include how to manage syringe pumps and medication across boundaries	**working across palliative and end of life care services**	Access to records if out of area	transportation and admission and discharge for people with palliative and end of life care needs, medication, and syringe pumps.

Ambition 5 All staff are prepared to care

Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident, and compassionate care.

Level	Scoring : levels and descriptors
Level 0	Not at all ready to achieve/ anticipate barriers to achievement
Level 1	Desire to achieve this ambition but there are currently no plans in place
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Level 4	Partially achieving e.g. across most, but not all care settings within Place
Level 5	Fully achieving e.g. across all care settings at Place, with supporting evidence available
	Fully embedded at Place including regular outcome monitoring and review

Self- Assessment Statement	Getting to Outstanding Commitment(s) linked to the statement – in bold identifies the most pertinent commitment	Points to consider when thinking about self-assessment – prompts for to support discussion	Reminder of the Enablers – these are in the framework document
1.1 **Place education in palliative and end of life care is delivered according to locally agreed standards**	**Commitment 5:1 We will include the provision of funded education and training into service contracts to ensure that patients and those important to them are being cared for by appropriately trained staff and volunteers** Commitment 5:2 We will identify and respond to the palliative and end of life care education and	Funding for training Staff engagement Staff pay - ?increase if more training Staffing levels to deliver training Consistency in training across all areas	Education standards - e.g. workforce education is provided in accordance with the L&SC end of life care education standards

	training needs for informal carers & for health and social care staff and volunteers **Commitment 5:4** We will deliver engaging, diverse, and dynamic education and training to the workforce, making the best use of advancing technology **Commitment 5:5** We will assure the quality of our education and training provision against quality assurance frameworks and education standards **Commitment 5:9** We will include legislation within our education and training to improve safe practice at the end of life **Commitment 5:10** We will evaluate education and training so that we can evidence that this is making a difference for patients, families, and carers		
1.2 **There are recognised systems at Place for quality assuring palliative and end of life care education**	**Commitment 5:5 We will assure the quality of our education and training provision against quality**	Staffing levels to deliver the training Funding	Quality assured education – education is delivered by skilled and competent clinicians, facilitators, and educators, e.g. aligned to the standards and

	assurance frameworks and education standards	How will it be monitored that all areas are compliant	guidelines for end of life care facilitators and educators
1.3 **Palliative and end of life care education and training is coordinated across Place**	**Commitment 5:2 We will identify and respond to the palliative and end of life care education and training needs for informal carers & for health and social care staff and volunteers** Commitment 5:10 We will evaluate education and training so that we can evidence that this is making a difference for patients, families, and carers Commitment 5:1 We will include the provision of funded education and training into service contracts to ensure that patients and those important to them are being cared for by appropriately trained staff and volunteers	Funding for training Where will training be held? Will it be accessible to everyone in all areas	Coordination of education - palliative/end of life training centrally coordinated and monitored to ensure accessibility and applicability to all including informal carers and volunteers, e.g. palliative education hubs or hospice education centres
1.4 **Place has a sustainability plan for the provision of palliative and end of life care education for all**	**Commitment 5:1 We will include the provision of funded education and training into service contracts to ensure that patients and those**	Funding Staffing Consistent across all areas	Sustainable provision - palliative and end of life care education is specifically commissioned, included in service contracts, and

	important to them are being cared for by appropriately trained staff and volunteers Commitment 5:10 We will evaluate education and training so that we can evidence that this is making a difference for patients, families, and carers Commitment 5:4 We will deliver engaging, diverse, and dynamic education and training to the workforce, making the best use of advancing technology Commitment 5:9 We will include legislation within our education and training to improve safe practice at the end of life	Time to train all current staff	seen as a core component of place provision
1.5 **Place can evidence impact on practice of palliative and end of life care education and training**	**Commitment 5:10 We will evaluate education and training so that we can evidence that this is making a difference for patients, families, and carers**	Consistency of evaluations across all areas and frequency Who will monitor the evaluations and implement changes	Impact on practice - education is evaluated to monitor effectiveness and impact on quality of care, evaluations are used as part of continuous improvement processes
1.6 T**hose working in palliative and end of life care across Place have**	**Commitment 5:3 We will invest in the leadership, development and**	Time for staff to access these Funding to set them up	Mentorship, supervision and coaching - e.g. staff forums focusing on sharing experiences

access to mentorship, supervision and coaching	**succession planning of the palliative and end of life care workforce** **Commitment 5:7** We will prioritise the health and wellbeing of the workforce		and enablers/ barriers to putting things into practice, clinical and management supervision, access to mentorship and coaching
1.7 **Staff and volunteers working in palliative and end of life care settings across Place are provided with an opportunity to participate in reflective practice forums e.g. Schwartz Rounds**	**Commitment 5:8 We will ensure care is more inclusive by raising staff and volunteer awareness of equality and diversity issues at the end of life** **Commitment 5:6** We will develop champions in palliative and end of life care that advocate for best practice and have the courage to challenge poor care	Time to allow staff to attend, staffing pressures How will this be fairly done across all areas	Schwartz Rounds - or similar models available that facilitate a safe space and time for staff reflection
1.8 **Where Place staff spend some, or all of their time in palliative and end of life care, this features as a core component of their induction programme and annual updates**	**Commitment 5:2 We will identify and respond to the palliative and end of life care education and training needs for informal carers & for health and social care staff and volunteers** **Commitment 5:4** We will deliver engaging, diverse, and dynamic education and training to the	Who will deliver training Funding Staffing issues Adequate pay for staff if doing extra training	Induction and annual updates - palliative/end of life care training included on staff induction and annual updates with communication skills, equality and diversity, and advance care planning being taught to all roles and disciplines

	workforce, making the best use of advancing technology **Commitment 5:8** We will ensure care is more inclusive by raising staff and volunteer awareness of equality and diversity issues at the end of life	How will this be standardised across all services and will it be 1 training for all areas	
1.9 **Place has an agreed approach to the payment and release of staff to attend palliative and end of life training that has been locally defined as core to their role**	**Commitment 5:1 We will include the provision of funded education and training into service contracts to ensure that patients and those important to them are being cared for by appropriately trained staff and volunteers** **Commitment 5:3** We will invest in the leadership, development and succession planning of the palliative and end of life care workforce **Commitment 5:5** We will assure the quality of our education and training provision against quality assurance frameworks and education standards	Funding Staffing levels	Release of staff - staff are paid and released to attend palliative/end of life care training that is considered core to their role e.g. as defined by the L&SC educational standards

1.10 **Mechanisms are available across Place to identify gaps in palliative and end of life care knowledge, skills and confidence and to signpost to a range of development opportunities**	**Commitment 5:6 We will develop champions in palliative and end of life care that advocate for best practice and have the courage to challenge poor care** **Commitment 5:8** We will ensure care is more inclusive by raising staff and volunteer awareness of equality and diversity issues at the end of life **Commitment 5:5** We will assure the quality of our education and training provision against quality assurance frameworks and education standards	How frequent will the training be offered Consistency across all areas Staff having confidence to speak up about gaps	Staff appraisals - mechanisms in place to identify gaps in knowledge, skills and confidence, signposting to available training aligned to core competencies
1.11 **Specialist palliative care teams take an active role in the provision of education at Place and support their own specialist development though appropriate learning pathways**	**Commitment 5:4 We will deliver engaging, diverse, and dynamic education and training to the workforce, making the best use of advancing technology** **Commitment 5:1** We will include the provision of funded education and training into service contracts to ensure that patients and those important to them are being cared for by appropriately trained staff and volunteers	Time pressures for teams to deliver training Staffing levels Varied teams e.g. acute vs community – will the same training be relevant?	Specialist palliative care - delivery of education to generalists is part of their job plan, specialist level education is accessible to support team development

	Commitment 5:2 We will identify and respond to the palliative and end of life care education and training needs for informal carers & for health and social care staff and volunteers		
1.12 **Place has a succession plan in place to support the recruitment, supervision and development of the specialist palliative care workforce**	**Commitment 5:3 We will invest in the leadership, development and succession planning of the palliative and end of life care workforce** **Commitment 5:7** We will prioritise the health and wellbeing of the workforce	Funding Recruitment issues	Palliative care workforce plan - e.g. covering succession planning, recruitment and retention, staff wellbeing and education and training
1.13 **There are opportunities at Place to develop and support leaders in palliative and end of life care**	**Commitment 5:3 We will invest in the leadership, development and succession planning of the palliative and end of life care workforce**	Funding Staffing levels	Palliative care leadership - e.g. developing leaders education and training, coaching and mentorship, workplace experience, end of life care champions to cascade best practice and inspire and influence the practice of others
1.14 **At Place, Dementia is recognised as a palliative condition featuring at both core and specialised**	**Commitment 5:8 We will ensure care is more inclusive by raising staff and volunteer awareness of**	Staffing levels to deliver training Funding Consistency between settings	Dementia education - e.g. specific to meeting palliative and end of life care needs, raising awareness of dementia being a life-limiting

components within palliative and end of life care education and training	**equality and diversity issues at the end of life** **Commitment 5:6** We will develop champions in palliative and end of life care that advocate for best practice and have the courage to challenge poor care **Commitment 5:2** We will identify and respond to the palliative and end of life care education and training needs for informal carers & for health and social care staff and volunteers		condition, mental capacity training
1.15 **Place has a recognised approach to educating staff and volunteers around recognising and responding to loss, grief and bereavement**	**Commitment 5:8 We will ensure care is more inclusive by raising staff and volunteer awareness of equality and diversity issues at the end of life** **Commitment 5:6** We will develop champions in palliative and end of life care that advocate for best practice and have the courage to challenge poor care **Commitment 5:5** We will assure the quality of our education and training provision against quality assurance	Local support in each area – is this consistent? Funding for bereavement support Accessibility – will this be standardised throughout all areas	Bereavement support training - to staff and volunteers in recognising and responding to grief and loss and signposting to local support

	frameworks and education standards		

Ambition 6 – please see next page

Ambition 6 Each community is prepared to help

I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing, and confident to have conversations about living and dying well and to support each other in emotional and practical ways.

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Self- Assessment Statement	Getting to Outstanding Commitment(s) linked to the statement – in bold identifies the most pertinent commitment	Points to consider when thinking about self-assessment – prompts for to support discussion	Reminder of the Enablers – these are in the framework document
1.1 **Place is taking a compassionate communities approach to build and to maximise community assets that support palliative, end of life and bereavement care**	**Commitment 6:1 We will build end of life care capacity by developing and nourishing compassionate communities** **Commitment 6:2** We will support the public to have more informed and confident discussions around dying, death and bereavement **Commitment 6:4** We will coordinate the recruitment, connecting and	Funding for each area Awareness and engagement from the public	Compassionate communities - awareness and promotion with the public, dedicated approach and resources to building and maximising the use of community assets, volunteer led models of end of life care and bereavement support.

	training of volunteers so that their contribution and value can be best utilised **Commitment 6:3** We will ensure practical support, information and training on end of life matters is accessible and relevant to those that need it by working closer with families, neighbours and the community		
1.2 **There is a recognised and all year round approach to engaging members of the public in having conversations about death and dying including planning for the future**	**Commitment 6:2 We will support the public to have more informed and confident discussions around dying, death and bereavement** **Commitment 6:5** We will ensure that people know what support they can access from their community **Commitment 6:3** We will ensure practical support, information and training on end of life matters is accessible and relevant to those that need it by working closer with families, neighbours and the community	Consistency across all areas How will this be recorded/accessed by all providers Funding for this	Public conversations and future life planning - e.g. ongoing public engagement around future life planning, platforms and resources to support members of the public to think about, talk about, record, and share what is important to them.
1.3**Place consistently take a coordinated approach**	**Commitment 6:2 We will support the public to have more informed**	Funding	Public health campaigns - e.g., local approaches to National

to public health campaigns that promote awareness of palliative and end of life issues e.g. national grief week, organ donation, dying matters	**and confident discussions around dying, death and bereavement** **Commitment 6:5** We will ensure that people know what support they can access from their community **Commitment 6:3** We will ensure practical support, information and training on end of life matters is accessible and relevant to those that need it by working closer with families, neighbours and the community	How will this be monitored If standardised throughout all areas – will it be relevant to all groups?	Dying Matters and National Grief Week where all organisations, members of the public and businesses and encouraged to participate, social media is used to communicate public health messages far and wide, joint working with population health and public health to support messaging e.g. organ donation.
1.4 **Patient representatives and members of the public are actively engaged at both strategic and operational levels across Place that involve the design and improvement of palliative, end of life and bereavement care services**	**Commitment 6:4 We will coordinate the recruitment, connecting and training of volunteers so that their contribution and value can be best utilised** **Commitment 6:5** We will ensure that people know what support they can access from their community	how to promote engagement how will this be incorporated so it isn't missed? Staffing issues Funding	Public/patient representatives - active engagement within palliative and end of life strategic and operational groups across the locality.
1.5 **Social prescribers across Place are trained and knowledgeable in**	**Commitment 6:3 We will ensure practical support, information and training on end of life matters is**	Staffing levels Who will manage these teams	Social prescribing - e.g. social prescribers are trained to be knowledgeable, skilled, and

palliative, end of life and bereavement care so that they can confidently identify individual need and signpost to appropriate support services	**accessible and relevant to those that need it by working closer with families, neighbours and the community** **Commitment 6:4** We will coordinate the recruitment, connecting and training of volunteers so that their contribution and value can be best utilised	Funding	confident to recognise and signpost to palliative and end of life care support and services.
1.6 **Collaborations exist at Place between generic carer support services and palliative and end of life care services so that the unique needs of those caring for this group of people can be recognised and responded to appropriately**	**Commitment 6:3 We will ensure practical support, information and training on end of life matters is accessible and relevant to those that need it by working closer with families, neighbours and the community** **Commitment 6:5** We will ensure that people know what support they can access from their community **Commitment 6:2** We will support the public to have more informed and confident discussions around dying, death and bereavement	Funding for further services Accessibility of information Who will follow them up? Will all services have access to same systems so the patient isn't missed	Informal caregivers - carers of people with palliative and end of life care needs are recognised, education and support packages are available, they have access to bereavement support, collaborations with VCFSE sector.
1.7 **Place is taking a strategic approach to engaging with the**	**Commitment 6:3 We will ensure practical support, information and training on end of life matters is**	Will these take place all over or just 1 area?	VCFSE groups - active and frequent engagement with the VCFSE sector to plan, implement

Voluntary, Charitable, Faith and Social Enterprise (VCFSE) sector to plan and improve local palliative, end of life and bereavement care services	**accessible and relevant to those that need it by working closer with families, neighbours and the community** **Commitment 6:1** We will build end of life care capacity by developing and nourishing compassionate communities **Commitment 6:4** We will coordinate the recruitment, connecting and training of volunteers so that their contribution and value can be best utilised	Staffing Monitoring of this – who will do this? Funding	and evaluate palliative, end of life care and bereavement services including services to carers.