

Palliative and End of Life Care

Population Based Needs Assessment

For Cheshire & Merseyside

November 2025

Prepared by



Supported by

MACMILLAN
CANCER SUPPORT

Prepared by:

Dave Nunns. Macmillan Transformation Lead for Palliative & End of Life Care (Cheshire & Merseyside)

Dr Debbie Harvey. PEOL Clinical Lead Cheshire & Merseyside, North West Coast Strategic Clinical Network

Matt Roberts. Transformation Manager, Halton Place

Claire Huntley. Principal Partnership and Transformation Manager, Wirral Place

Dr Susie Roberts. Consultant in Public Health, Cheshire East Council

Jack Chedotal. Public Health Information Analyst, Cheshire East Council

Alison McCudden. Strategic Programme Manager, Cheshire & Merseyside Hospice Provider Collaborative

Karl Booth. Senior BI Lead, End of Life Partnership

On behalf of the Cheshire and Merseyside Palliative and End of Life Care Programme Board

The authors are grateful to all colleagues and stakeholders who have contributed to the development of this needs assessment, their expert advice, guidance and feedback has been invaluable.

Disclaimer:

This report, including the appendices, is intended for informational and planning purposes only.

Whilst every effort has been made to ensure the accuracy and reliability of the data and analysis presented, the authors make no representations or warranties, express or implied, regarding the completeness, correctness, or suitability of the information for any particular purpose. The findings and recommendations should not be construed as legal, financial, or clinical advice.

Readers are encouraged to verify any critical information independently and consider local context and professional judgment when applying insights from this report.

The authors accept no liability for any decisions or actions taken based on this report.

Contents

FOREWORD	5
Introduction	7
Definitions	8
Section 1: Demographics	10
Population and Mortality	10
Socioeconomic Deprivation	13
Ethnicity profile	18
Disability profile	19
Learning Disability and Autism	21
Infants, Children and Young People	23
Children and Young People Mortality	24
Section 2: Mortality Data	28
Major Causes of Death	28
End of life trajectories	29
Projected future needs linked to major causes of death	33
Other conditions to consider	34
Section 3: PEOLC Service Provision	35
Place of Death.....	35
General practice palliative and supportive care registers	43
Early identification	43
Advance Care Planning	44
DNACPR	46
Hospital Provision	48
Community Specialist Palliative Care Services	49
Continuing Health Care and Fast Track	54
Care Home Provision	57
Hospice Provision	61
Palliative Care Beds	62
Hospice at Home	64
Hospice activity	64
Hospice Funding.....	67
Specialist Palliative Care Workforce.....	69
General workforce (non SPC)	70
Community Pharmacy - Urgent Critical End of Life Medication	71

Section 4: Use of Services	73
Patient and Public Experience.....	79
Section 5: Strategic and policy assessment	81
Palliative and End of Life Care - Statutory Guidance for Integrated Care Boards (ICBs) 2022	81
Ambitions for Palliative and End of Life Care	83
NICE Quality Standards (QS13): End of life care for adults	84
NICE Quality Standard (QS160): End of life care for infants, children and young people	87
Planning for the End: A review of the quality of care provided to adult patients towards the end of life.....	88
Commission on Palliative and End-of-Life Care	89
Fit for the future: 10 Year Health Plan for England	91
Section 6: Summary & Recommendations	94
Appendices	97
Acronyms	97
Gap analysis of current CYP PEOLC provision.....	98
NACEL Key Indicators table	101
Hospice Collaborative Service Catalogue	102
National Ambitions Self-Assessment.....	103
Useful resources	104
End notes	106

FOREWORD

I am pleased to introduce this new Population Based Needs Assessment for Palliative and End of Life Care for Cheshire and Merseyside.

As Senior Responsible Officer for End of Life Care for NHS Cheshire and Merseyside and a local GP with an interest in palliative care who has experience working in hospice care, out of hours services, and Care Homes, I know from first-hand experience how important it is to get care for patients and their families right at this time in their lives.

There is a common phrase used in palliative and end of life care that says, “We only get one chance to get this right”. It’s a powerful reminder that every decision and interaction matters deeply. The final moments of a person’s life—and the care they receive during that time - leave a lasting impression on everyone involved. It underlines the importance of delivering compassionate, dignified care that respects a person’s wishes. It means managing symptoms effectively, supporting families, and creating an environment that fosters peace, comfort, and meaningful connection—even in the face of loss.

Across Cheshire and Merseyside last year we had 27,000 chances to get it right and this PBNA shows there are many opportunities for us to do better. We have a long way to go to identify everyone who is nearing the end of life and then have meaningful care planning conversations with them to allow us to manage their last months well and in accordance with their wishes and too many people are being admitted to hospital in an unplanned way near the end of life with above average numbers of patients dying in hospital compared to the England average.

Because of a growing and aging population, we expect the number of people who will die each year will rise to around 34,000 by 2035 and as many as eight out of ten people could benefit from palliative care support. It is vital that we prepare for this rise and the findings of this report will help us to do this.

The report helps to highlight that there are inequalities in life expectancy, outcomes and experience across Cheshire and Merseyside dependent on factors such as deprivation, ethnicity, disability and disease groups.

The specialist palliative care workforce in hospitals, hospices and community teams isn’t large enough to meet national minimum recommendations for our population, and our generalist workforce in primary care, social care hospitals, and hospices are often insufficiently supported and there is not a consistent education offer across our nine places for this workforce. Unless we do something different, we won’t be able to cope with the expected rise in need for palliative and end of life care over the next decade or so.

Last year there were over 60,000 attendances to A&E and 45,000 non-elective / unplanned admissions of people in their last 12 months of life. When people are admitted to hospital, they are staying in hospital longer than the national average and more people die in hospital in Cheshire and Merseyside than the national average.

The Population Based Needs Assessment will support clinicians, commissioners and decision makers across health and care in shaping better palliative and end of life care by:

- Promoting fair and inclusive access to PEOLC, regardless of diagnosis, care setting, or socio-economic background.
- Highlighting gaps and inequalities in service provision to guide future investment and resource planning.
- Enabling earlier identification of individuals who may benefit from advance care planning, helping to improve outcomes and experiences.
- Supporting delivery of national priorities, including the Fit for the Future the 10 Year Health Plan for England and the National Ambitions for Palliative and End of Life Care framework.

This Population Based Needs Assessment will be fundamental in supporting the development of a new Palliative and End of Life strategy for Cheshire and Merseyside helping to inform planning and commissioning to ensure services are aligned with the needs of local communities into the future.

Dr Sinead Clarke

Associate Medical Director for Quality and System Improvement and SRO for End of Life Care,
NHS Cheshire and Merseyside
GP, Wrenbury Medical Practice
Medical Director, End of Life Partnership

Introduction

NHS Cheshire and Merseyside Integrated Care Board (ICB) is responsible for planning NHS services for the local population, which includes the care provided by NHS Trusts, GP practices, local pharmacies, NHS dentists, and NHS opticians. All ICBs have four key aims:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development

The Health and Care Act 2022 states that ICBs have a legal responsibility to commission health services, including palliative care services, that meet their population needs, aligning to the commitments within the Ambitions for Palliative and End of Life Care: A national framework for local action. This responsibility is intended to ensure that “the palliative and end of life care needs of people of all ages, with progressive illness or those nearing the end of their lives, and their loved ones and carers, receive the care and support they need to live and to die well.” (Palliative and End of Life Care: Statutory Guidance for Integrated Care Boards, 2022).

The recently published 10 Year Plan for Health, and supporting guidance, cements ICBs responsibilities for strategic commissioning which specifically includes Palliative and End of Life Care. PEOLC is recognised as part of the broader ambition to shift care from hospital to community settings, improve patient experience, and reduce health inequalities. ICBs are expected to take a population-based approach to commissioning based on local data, risk stratification, and segmentation with an overriding goal to address health inequalities by improving access to services and reducing inequity of outcomes and experience. A comprehensive understanding of need, and variation in need (for example, by age, economic status or geography) and provision across the footprint is key to ensuring the ICB is able to reduce inequalities. It enables the development of proportionate universal approachesⁱ that provide a greater intensity of support for population groups with greater intensity of need.

NHS Cheshire and Merseyside have established a PEOLC Programme Board to oversee the delivery of a programme of work that will enable access to good quality and equitable end of life care across Cheshire and Merseyside. Membership of the Programme Board is made up of representatives from specialist palliative care, primary care, children and young people’s services, local hospices and the PEOLC strategic groups from the nine localities across Cheshire and Merseyside.

The PEOLC Programme Board have committed to producing a Population Based Needs Assessments (PBNA) for the whole of Cheshire and Merseyside, as well as appendices for the nine localities. In line with national recommendationsⁱⁱ, Key elements of the PBNA are:

1. An assessment of the palliative care needs of the population
2. An assessment of the core service components required to meet those needs
3. A mapping of the services currently available to meet those needs
4. A comparison of what services are needed with what is already available in order to identify service gaps
5. An assessment of the priorities for filling the service gaps

The PBNA will help local clinicians, managers, commissioners, service providers and policy makers to improve PEOLC in the future by:

- Raising the profile of PEOLC and supporting local strategic and commissioning discussions to ensure the right services are in place to support local communities
- Supporting early identification of patients who would benefit from advance care planning
- Promoting equitable access to PEOLC regardless of disease condition, place of care or socio-economic background of individuals.
- Identifying disparities in service provision and supporting the planning for projected increased demand for PEOLC
- Supporting the implementation of Fit for the Future: the 10 Year Plan for Health

Definitions

Palliative care

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening or life-limiting illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

(Palliative and End of Life Care: Statutory Guidance for Integrated Care Boards, 2022 ⁱⁱⁱ)

End of Life Care

Patients are 'approaching the end of life' when they are likely to die within the next 12 months. This includes patients whose death is imminent (expected within a few hours or days) and those with: a) advanced, progressive, incurable conditions; b) general frailty and co-existing conditions that mean they are expected to die within 12 months; c) existing conditions if they are at risk of dying from a sudden acute crisis in their condition; d) life-threatening acute conditions caused by sudden catastrophic events. (Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026 ^{iv})

Advance care planning

Advance care planning is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care. The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness.

(Consensus Definition of Advance Care Planning (Sudore et al 2017) ^v)

Specialist Palliative Care (SPC)

Specialist palliative care services are for people (all ages) living with more complex and/or long-term conditions which are life-limiting or life-threatening. The main components are:

- *in-depth specialist knowledge (specialist consultant and specialist nursing services as a minimum) to undertake assessment and management of physical, psychological and spiritual needs to reduce symptoms, suffering and distress not only for the patient but for their family members (both adults and children). This might include a symptom management service*

- *supporting analysis of complex clinical decision-making challenges where medical and personal interests are finely balanced by applying relevant ethical and legal reasoning alongside clinical assessment*
- *providing specialist advice and support to the wider care team who are providing direct core level palliative care to the person.*

(Specialist palliative and end of life care services, NHS England (2023) ^{vi})

Section 1: Demographics

The Cheshire and Merseyside Integrated Care System (ICS) in the North-West of England is one of the largest and most diverse systems in the country. The area is home to over 2.7 million people, spans over 1200 square miles and includes a mix of metropolitan urban areas as well as rural and coastal areas.

The region has a diverse economy; Cheshire is famous for its agriculture and has a strong chemical industry, Merseyside has a rich maritime history and a strong presence in manufacturing, services, and creative industries. Both Cheshire and Merseyside have large health and social care sectors. The region is served well in terms of transport infrastructure; with major airports in Liverpool and south Manchester, major train hubs in Liverpool and Crewe and the motorway network connecting the region via the M62 and M6.



The area borders other care systems such as Lancashire & South Cumbria, Greater Manchester, Derby & Derbyshire, Shropshire and Staffordshire & Stoke on Trent in England, as well as parts of Wales including Flintshire and Wrexham.

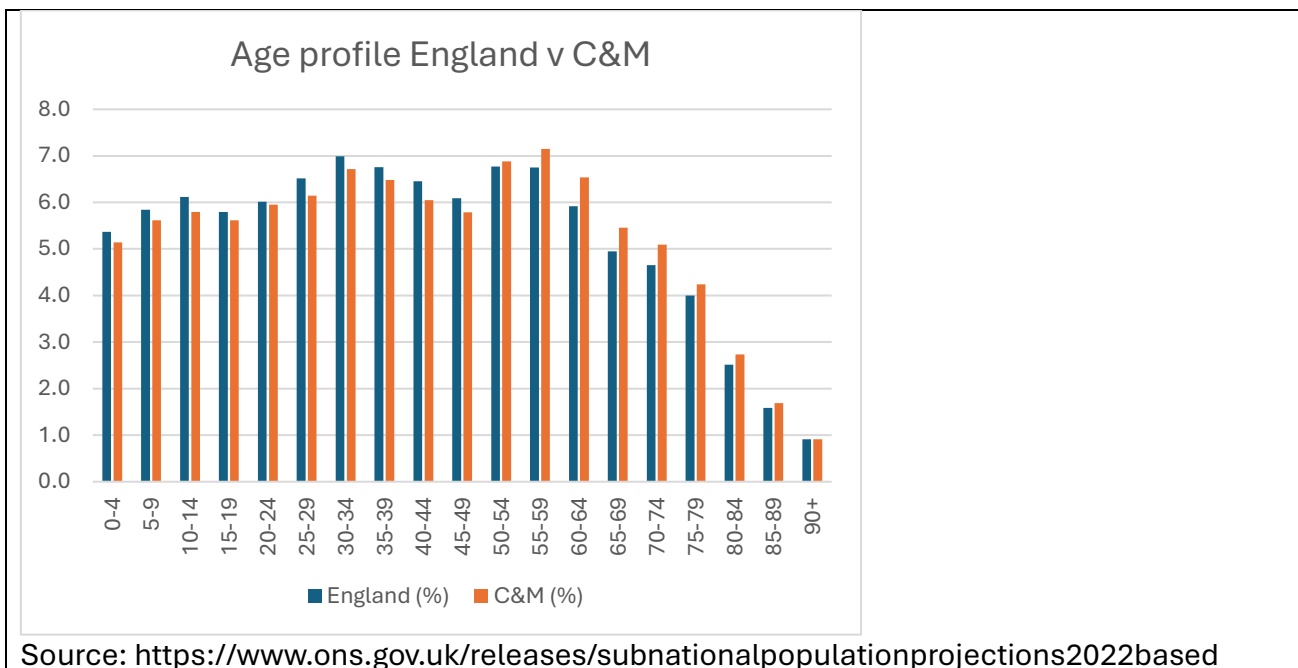
There are nine local authorities within the ICS, plus 17 NHS Trusts, 13 hospices, almost 350 GP practices, over 500 pharmacies, and around 900 care homes.

Across Cheshire and Merseyside approximately 27,000 people, around 1% of the population, die each year. Most people die from long term health conditions such as cancer, dementia, heart failure, or liver disease. Overall death rates across Cheshire and Merseyside are broadly similar to the UK average. However, this figure can vary slightly from year to year and from area to area, and can differ due to a wide range of factors such as demographics, lifestyle and other influences.

Population and Mortality

The population of Cheshire and Merseyside in 2022 was 2,550,353 (ONS ^{vii})

The age profile shows the population of Cheshire and Merseyside is generally older than the England average. The chart below shows proportionally fewer people aged under 50, and more people aged over 50. The same is true for most localities, apart from Liverpool that has a larger 15-39 population than the England average.

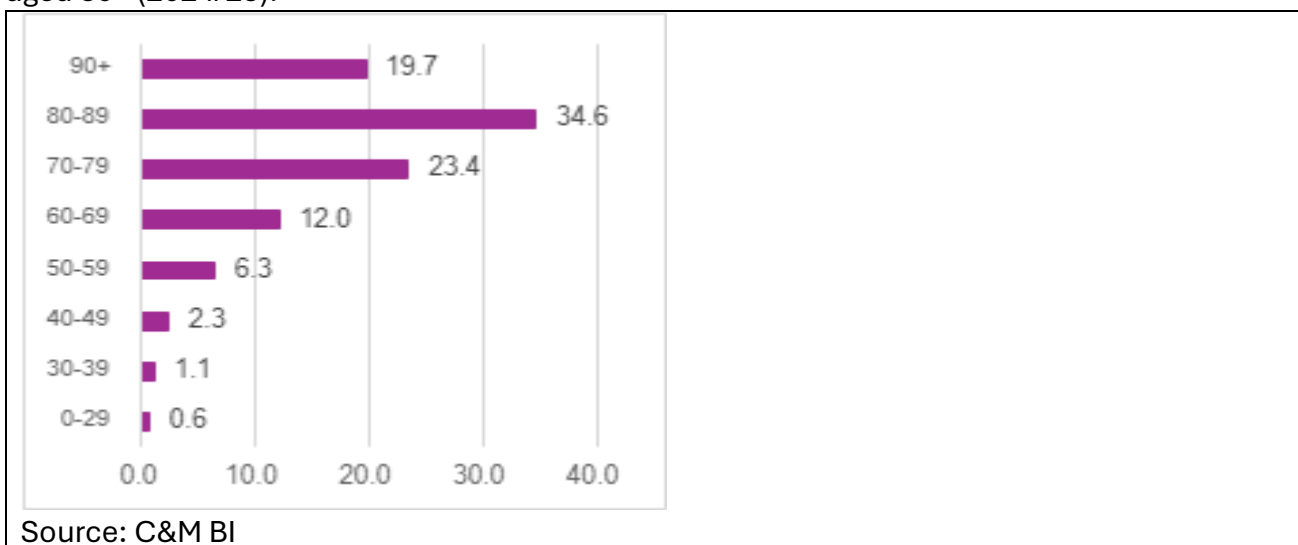


The population is growing and aging: the overall population is predicted to increase by around 211,000 by 2035 and by more than 350,000 by 2047, almost the size of the current population of the Wirral (an overall increase of 13.9% 2022-2047).

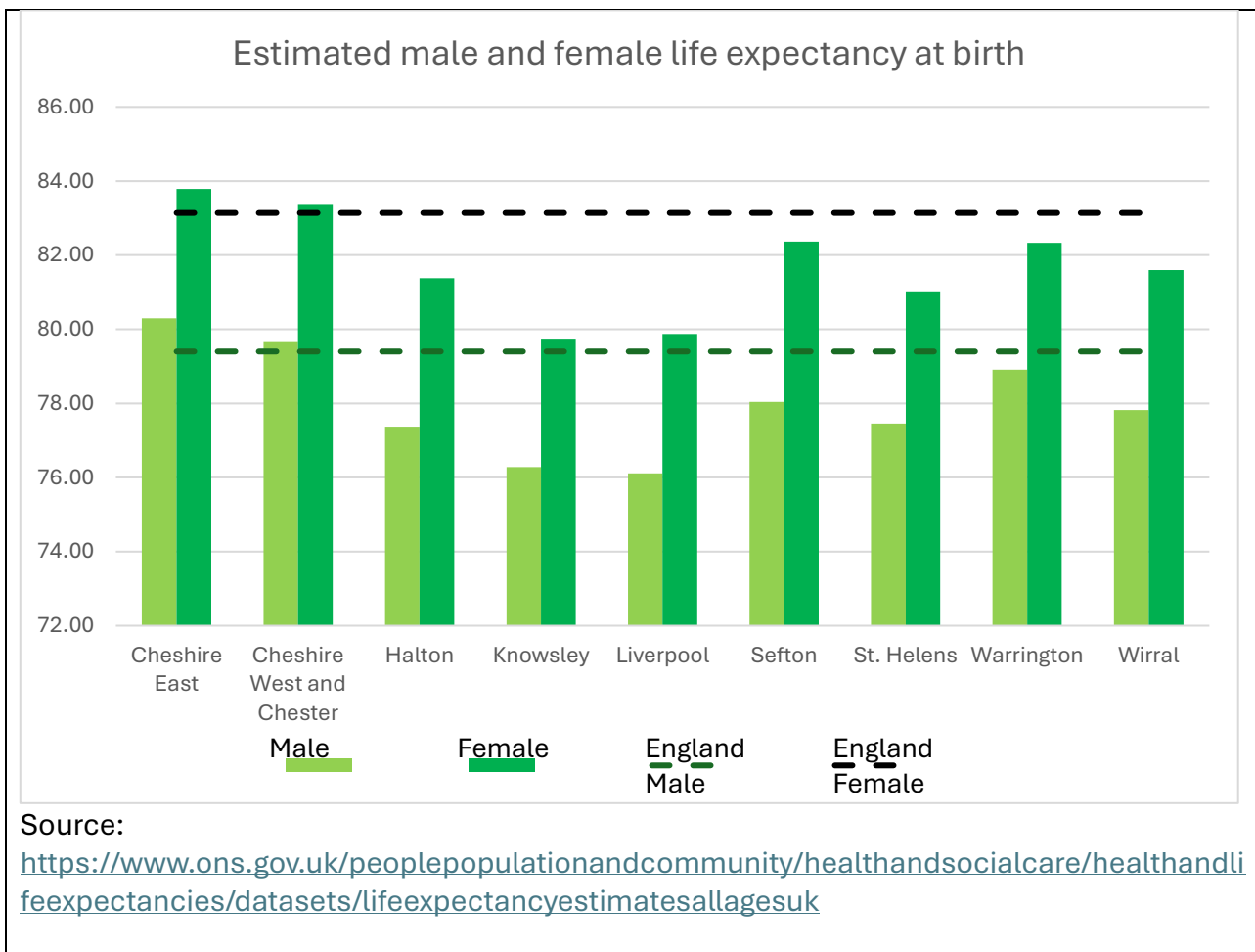
The population aged over 70 is increasing at a faster rate than the overall population. In 2022 there were approximately 350,000 people aged 70 or over, this is predicted to increase to 500,000 by 2047, more than 40% increase ^{viii}.

Age profile of deaths in Cheshire & Merseyside

This chart shows the age breakdown of deaths across Cheshire and Merseyside, alongside the percentage for each age band. We can see from this chart that more than 50% of people die aged 80+ (2024/25).



The chart below highlights variation in life expectancy at local authority level. It shows that Cheshire East and Cheshire West and Chester are the only localities with longer life expectancy than the national average for both women and men.

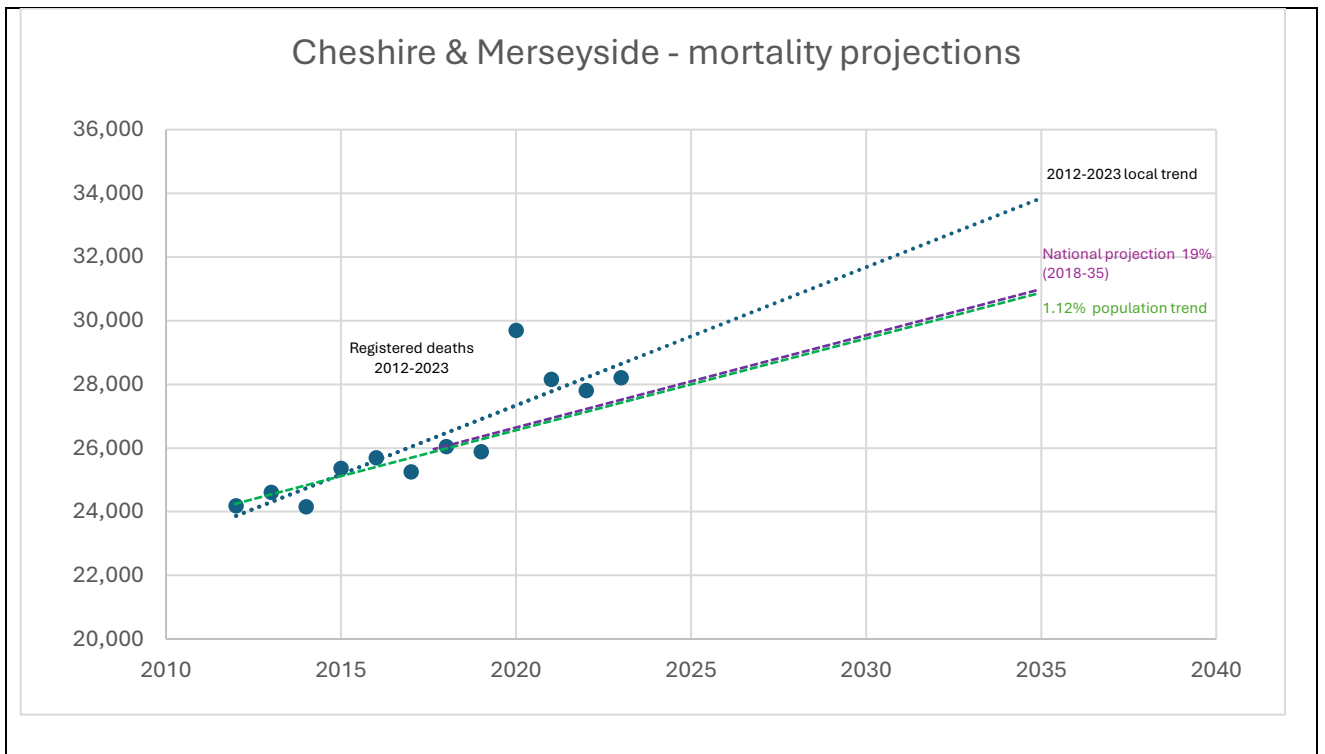


The number of people who die is increasing; this is due to a combination of a growing and aging population. Although there are some annual variations (in particular, seen during the COVID-19 pandemic) we can see that annual deaths between 2012 and 2023 have risen by around 16%. We can also see that over this period that the number of deaths each year is approximately 1.12% of the local population – which is slightly higher than the national rate.

Local projections for future death trends are not available from any national sources such as ONS, therefore a number of assessments have been made, displayed in the graph below.

- If the reported deaths from 2012-23 are extrapolated to 2035, it suggests that there could be as many as 34,000 local deaths each year.
- ONS have predicted a 19% national increase in registered deaths from 2018 to 2035, (2018 Deaths registered in England and Wales - Office for National Statistics, and 2024 National population projections - Office for National Statistics). If Cheshire and Merseyside were to follow the national rate it would mean that there could be approximately 31,000 deaths each year.
- If recent local trends for 1.12% of the population to die each year, based on 2025 ONS estimates for the local population, there could be approximately 30,900 deaths each year by 2035.

These estimates suggest that there could be between 30,900 and 34,000 deaths each year in Cheshire and Merseyside by 2035 – this represents an increase of between 2,690 and 5,800 deaths each year, a rise of 9.5% to 20% compared to 2023.



Socioeconomic Deprivation

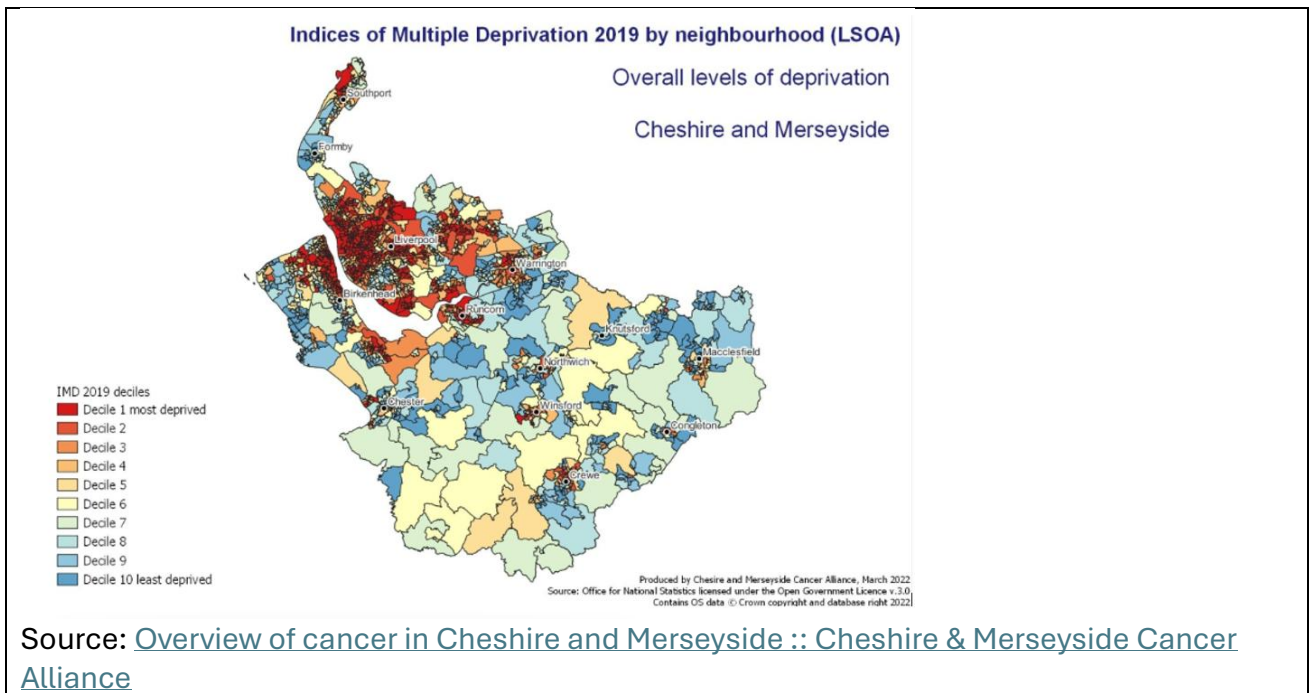
Socioeconomic deprivation is closely associated with lower life expectancy and higher rates of mortality^{ix}.

In 2022, the Cheshire and Merseyside Health and Care Partnership (HCP) published *All Together Fairer: Health equity and the social determinants of health in Cheshire and Merseyside*^x, which provides a significant amount of socioeconomic data relevant to the PBNA. The report includes data for the whole Cheshire and Merseyside area as well and provides breakdowns of the data where appropriate. It paints a picture of a diverse sub-region with significant internal inequalities.

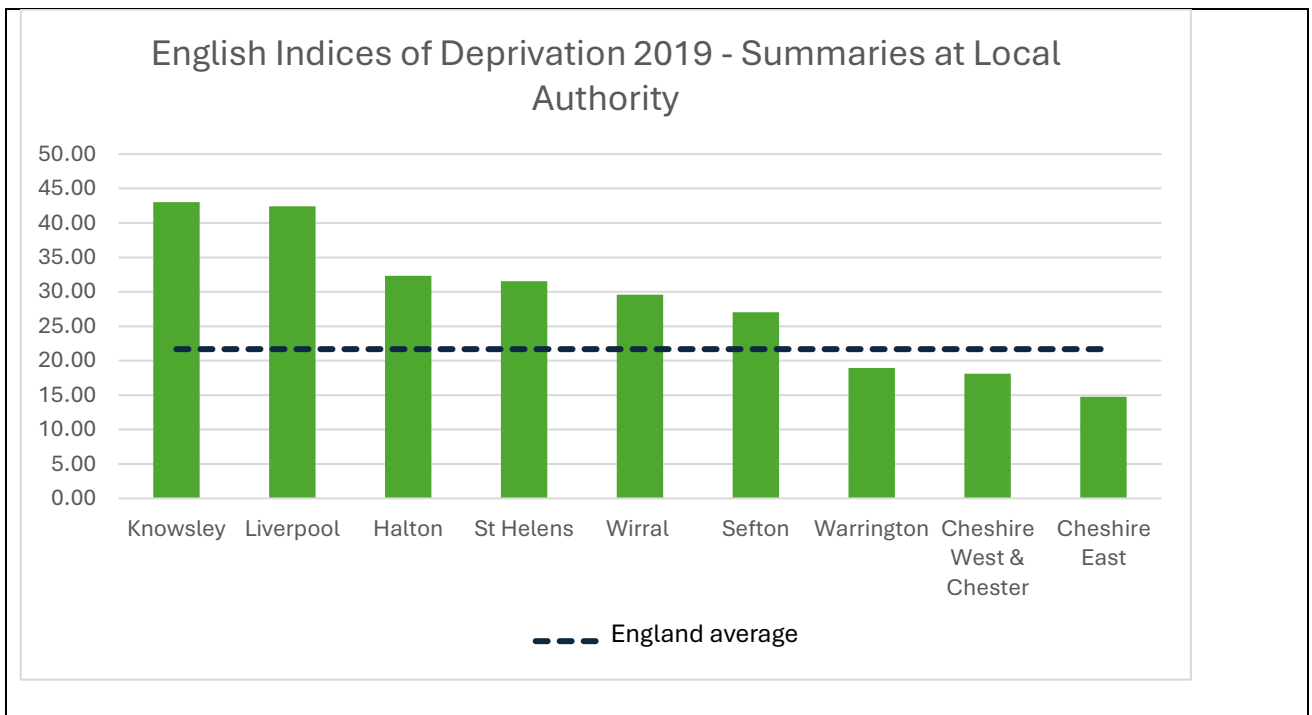
The Office for National Statistics (ONS) records deprivation data in quintiles and deciles based on council ward boundaries, and sometimes on sub-ward level areas.

- Quintile 1 represents the 20% most deprived areas and Quintile 5 the 20% least deprived areas.
- Decile 1 represents the 10% most deprived areas and Decile 10 the 10% least deprived areas.

Analysis of this data shows that Cheshire and Merseyside is a very diverse area, which includes areas of significant wealth as well as areas of significant deprivation. Overall, around a third (over 800,000 people) of the Cheshire and Merseyside population live in the most deprived quintile of neighbourhoods in England, and nearly 300,000 of these people live in the most deprived decile.



The average Index of Multiple Deprivation score in Cheshire and Merseyside is 28.6 compared to 21.6 in England. IMD analysis shows that Knowsley is the second most deprived local authority area in England, Liverpool the third.

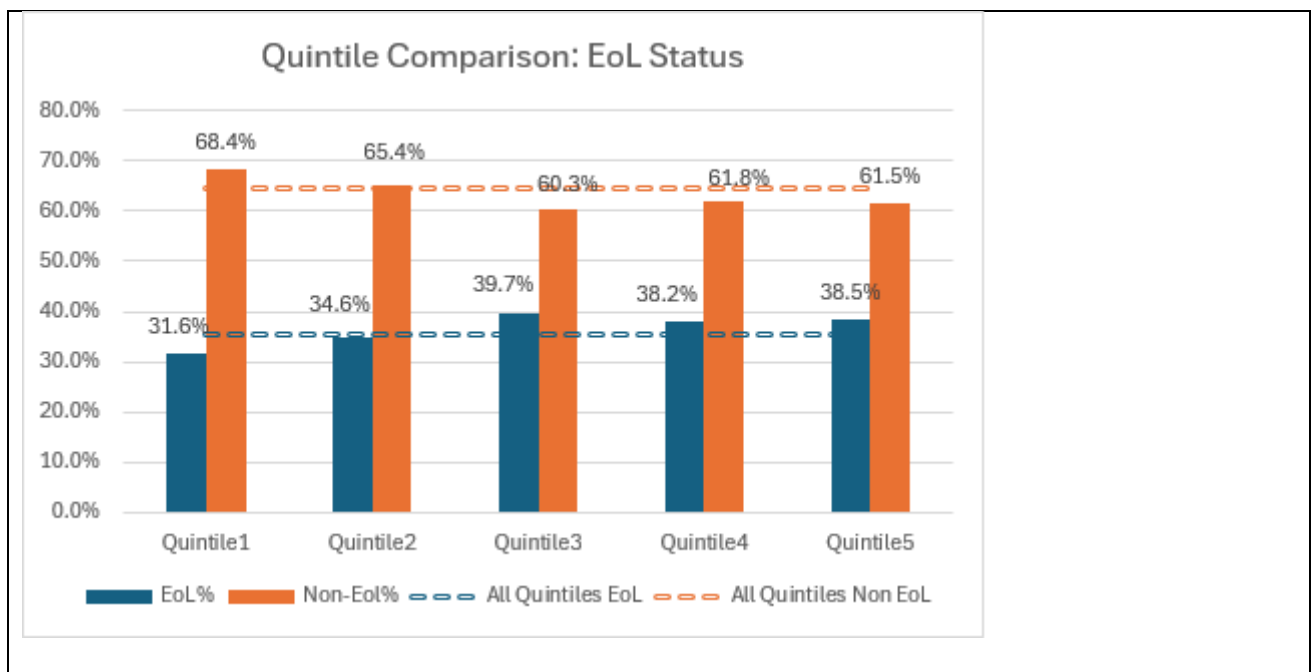


In addition, differences within local authority areas can be stark. For example, overall, Cheshire West & Chester is one of the least deprived areas, 31% of neighbourhoods in Cheshire West and Chester are in the top income quintile (compared with an England average of 20%), but despite this relative wealth, 16% of neighbourhoods in the Borough are in the lowest income decile.

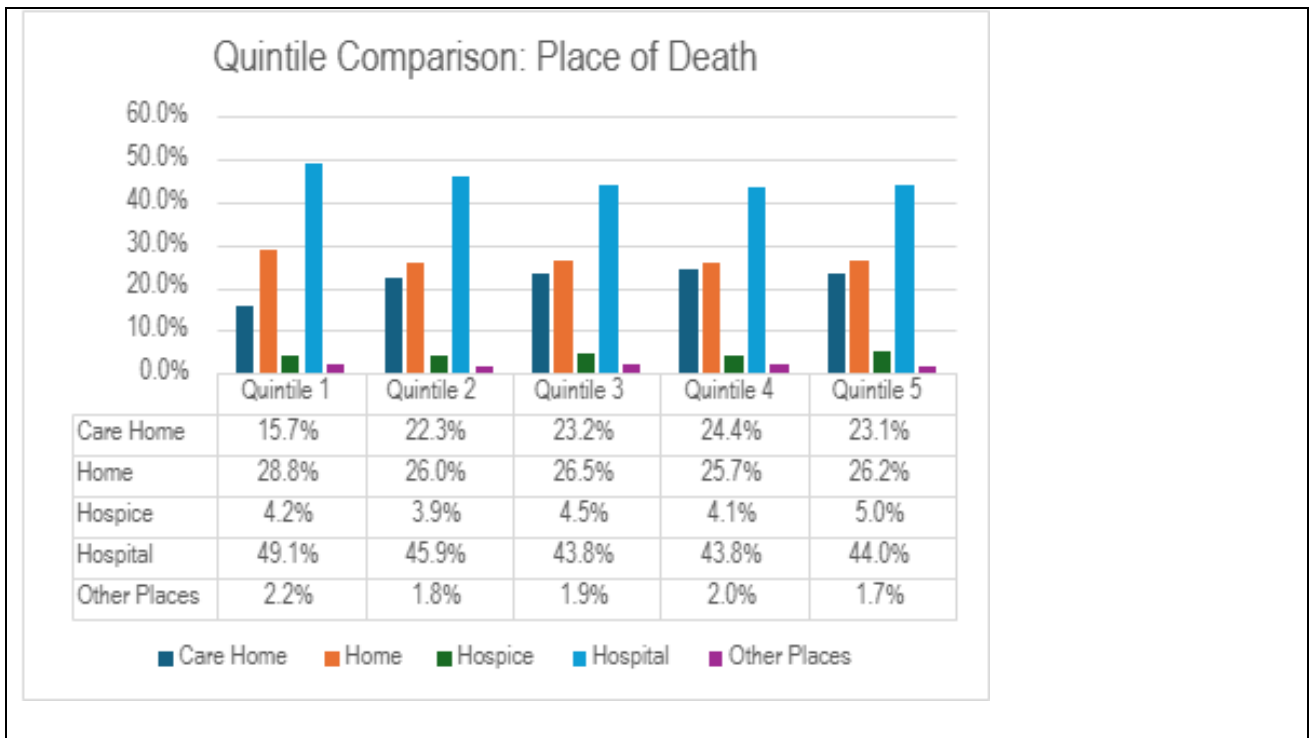
Differences in health and wellbeing and life expectancy can be seen between our least and most deprived areas in Cheshire and Merseyside. In the North West region, life expectancy at birth for men is 78.4 years and 82.1 years for women. Life expectancy for women in Cheshire and Merseyside was 82.7 years in 2018-20, lower than the average for England, of 83.1 years. For men in Cheshire and Merseyside, the average life expectancy of 78 years was also lower than the England average of 79.4 years.

Girls can expect to live to	82.7	<i>(for England it is 83.1)</i>	Girls born in the least deprived areas will live 9.5 years longer than those born in the most deprived area.
Boys can expect to live to	78	<i>(for England it is 79.4)</i>	Boys born in the least deprived areas will live 11 years longer than those born in the most deprived area.
Source: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/datasets/lifeexpectancyestimatesallagesuk			

Our analysis shows that people who live in Quintile 1 are less likely to be identified as being end of life and added to palliative care registers than those living in Quintiles 3, 4 and 5.

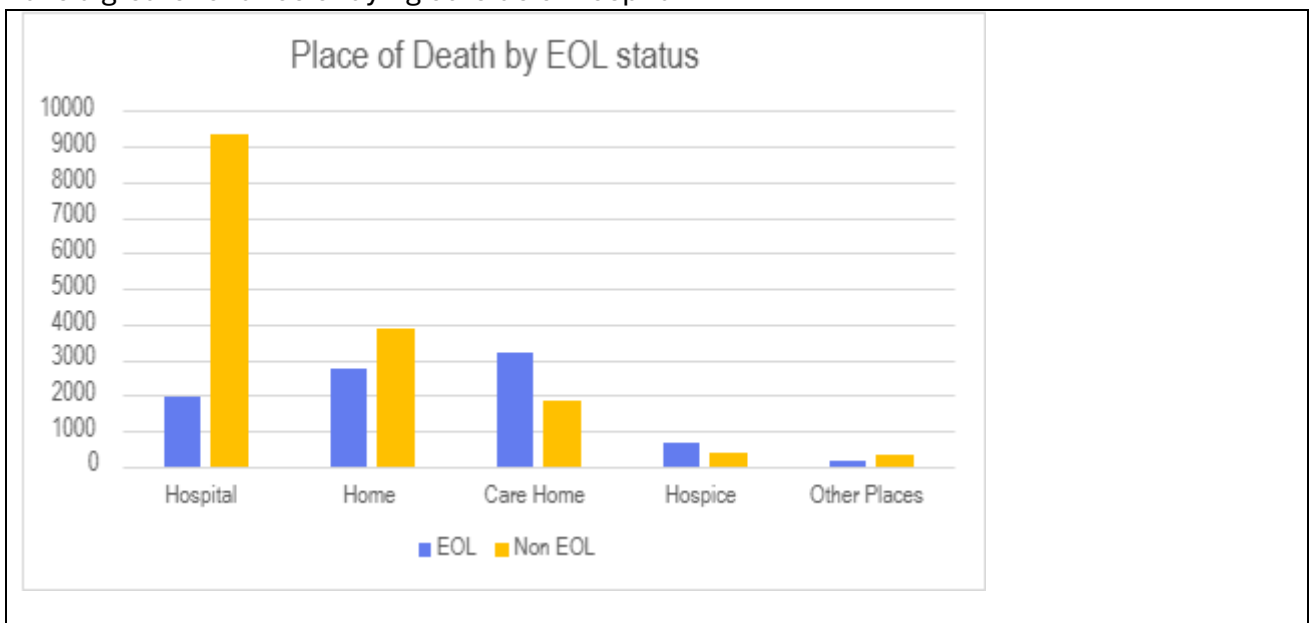


Our analysis also shows that people who live in Quintile 1 are more likely to die in hospital than those who live in Quintile 5 (Q1 = 49.1% / Q5 = 44%), and also less likely to die in a care home (Q1 = 15.7% / Q5 = 23.1%)



It is not possible to simply state that ‘living in quintile 1 increases a person’s chances of dying in hospital’, there is a strong correlation between the proportion of people on the EOL / GSF register and the proportion of people who die in hospital, it may be more realistic to say ‘successfully identifying people who may be in their last 12 months of life can help reduce the number of deaths that occur in hospital, and it is important that we improve on the proportion of people living in Q1 that are identified.’

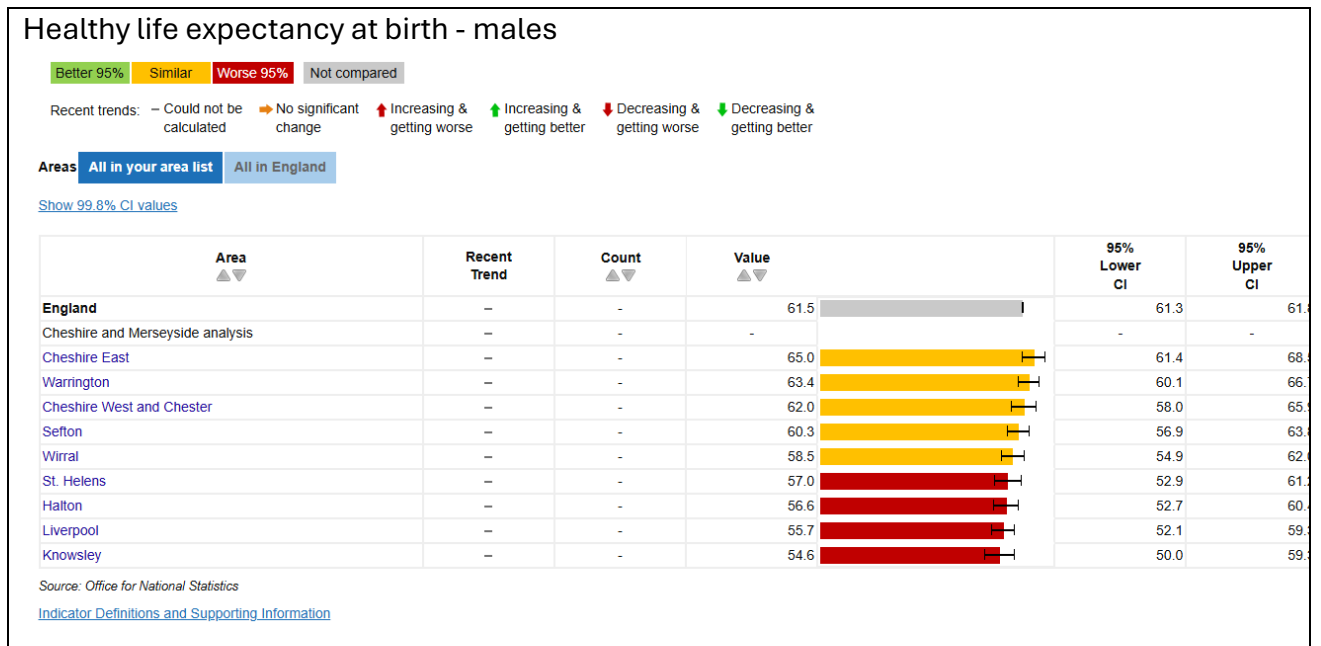
This chart shows the split of where people across Cheshire and Merseyside die split by whether or not they were on the GSF palliative care register at the time of death. Even accounting for the fact that twice as many people are not on the GSF register, the chart clearly shows that those not on the GSF register are much more likely to die in hospital, whereas those on the register have a greater chance of dying outside of hospital.



Healthy Life Expectancy

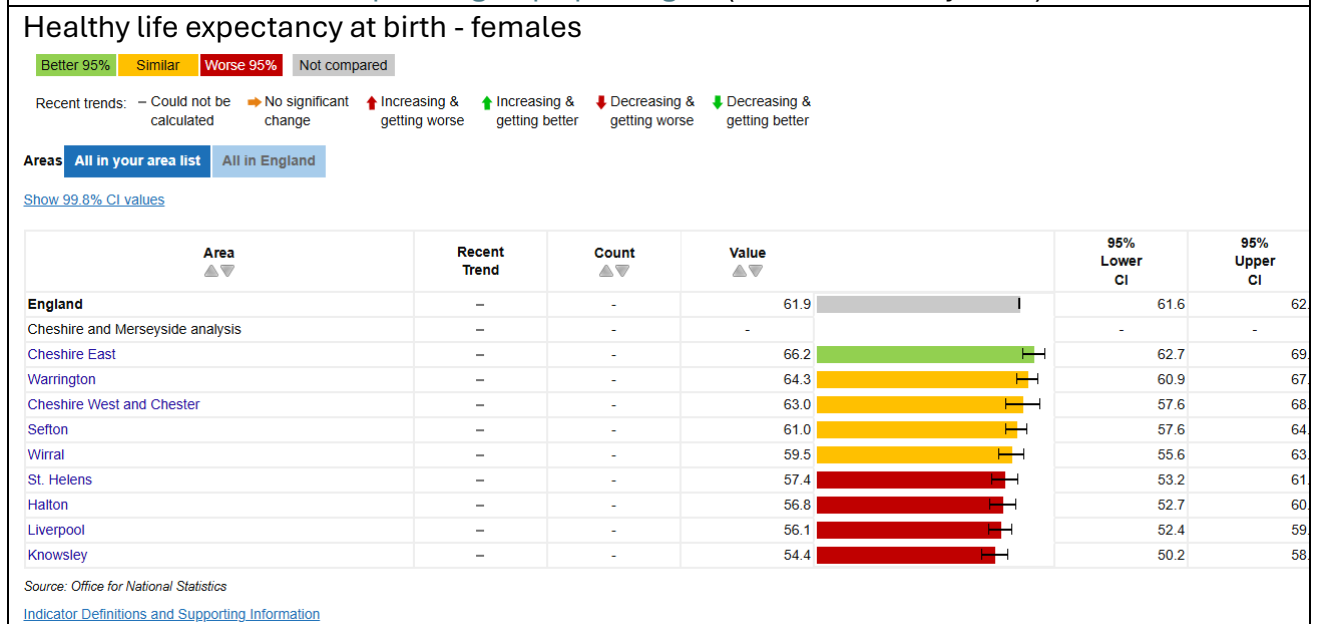
Healthy Life Expectancy (HALE) is the average number of years a person can expect to live in full health, free from serious illness or disability. On average, healthy life expectancy at birth differs by 12 years between the most and least deprived local authorities for men and women.^{xi}

Healthy life expectancy figures for 2018-20 show that for both males and females in 4 out of 9 Local Authorities are below the England figure.^{xii}



Source: Office for Health Improvement & Disparities

Public Health Profiles. <https://fingertips.phe.org.uk> (Accessed: 9 July 2025)



Source: Office for Health Improvement & Disparities

Public Health Profiles. <https://fingertips.phe.org.uk> (Accessed: 9 July 2025)

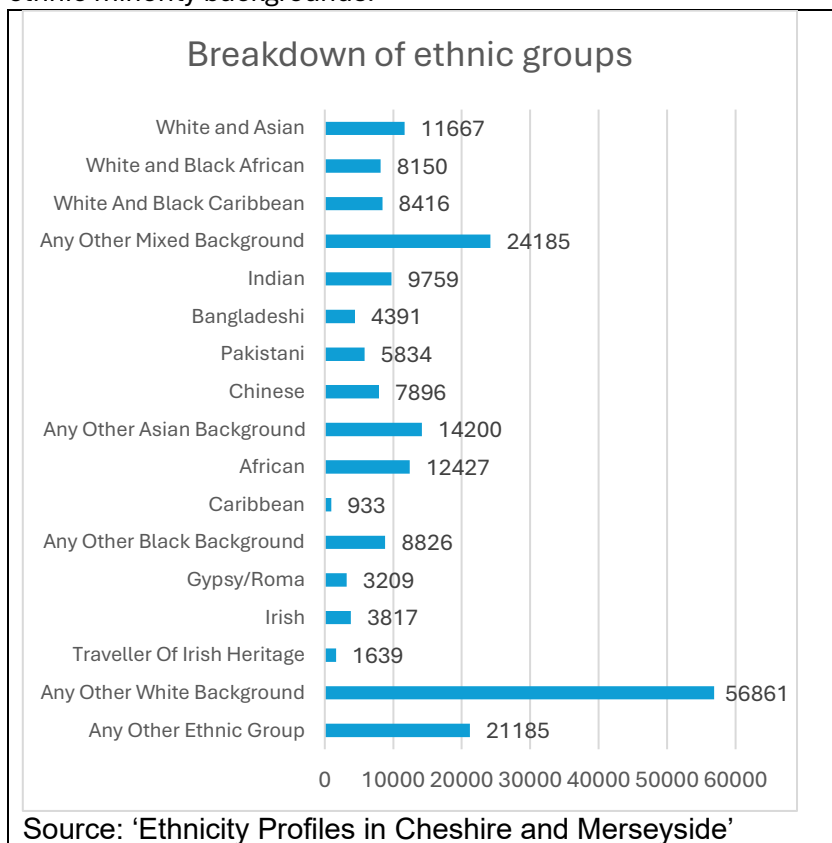
The number of people living with major illness is projected to increase by a third from just below 16.7% to 19%, reaching almost 1 in 5 by 2040. (This could mean an extra 78,231 people in Cheshire and Merseyside).^{xiii}

In addition, people are likely to live longer but spend more years in ill health^{xiv}. The amount of time people will spend with a major illness is expected to increase from 11.2 years in 2019, to 12.6 years by 2040^{xv}. Consequently, end of life care may be more complex. However, this represents a potential opportunity for advance care planning.

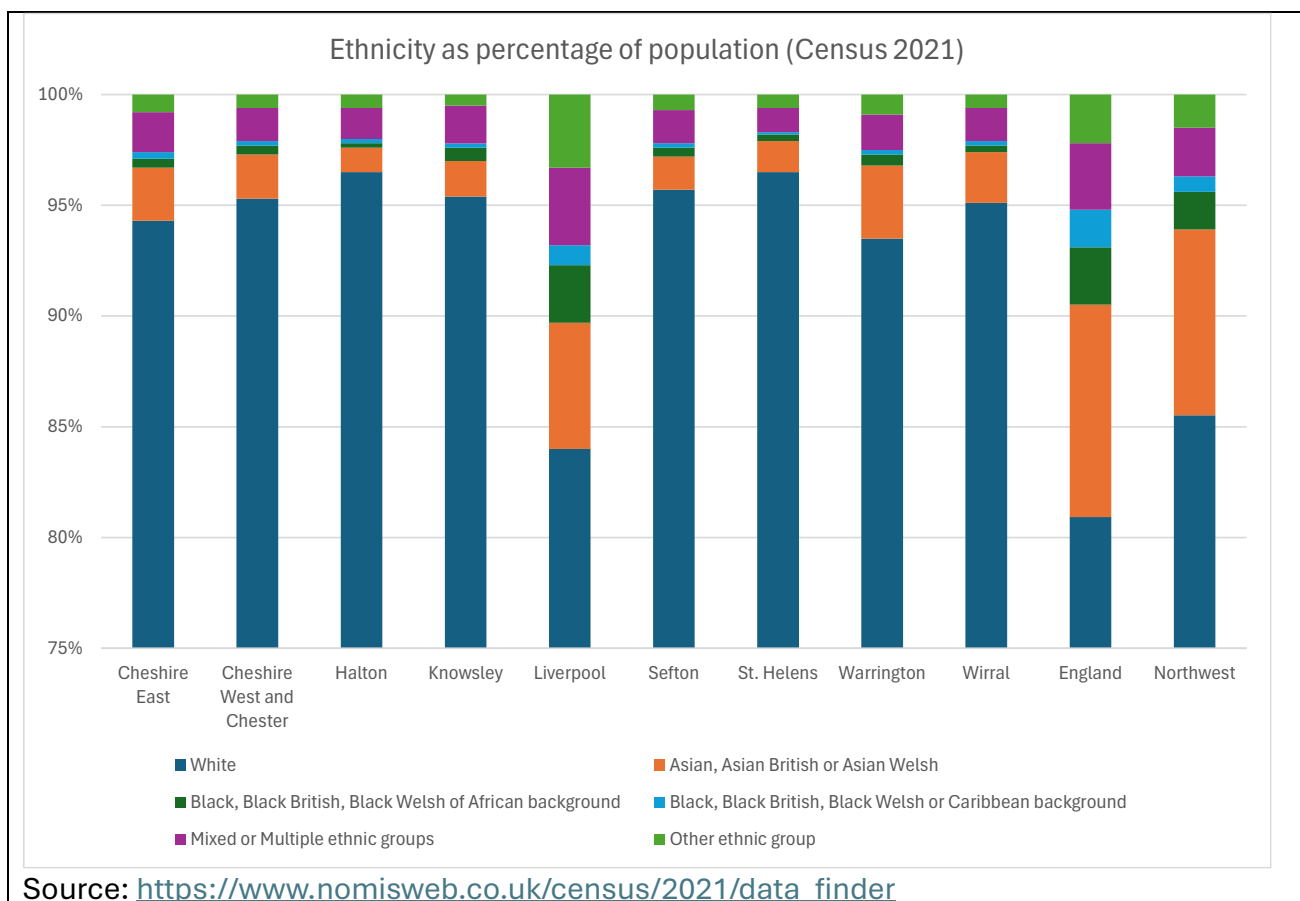
Ethnicity profile

It is important to consider the ethnicity of local populations in planning PEOLC services to ensure equity of access and the provision of culturally appropriate services.

‘Ethnicity Profiles in Cheshire and Merseyside’^{xvi} shows that the population of Cheshire and Merseyside (2.7m) is predominantly White British (91.85%) with a further 8.15% of the population being people from ethnic minority backgrounds.



Overall, Cheshire and Merseyside is less ethnically diverse than England with some areas such as Halton and Knowsley having very low levels of ethnic diversity. Liverpool has the most ethnic diversity across Cheshire and Merseyside. However, it is important to note that there will be smaller areas that are more ethnically diverse within local authorities.



This overall picture of less diversity doesn't mean that there is no diversity. It is important for PEOLC services and planners to recognise this and to plan, tailor and deliver services accordingly.

Life expectancy at birth is generally higher among ethnic minority groups than for white groups ^{xvii} however this conceals several inconsistencies.

- In several groups, Black Caribbean, Other Black, Indian, Other Asian and some Mixed groups, Pakistani and Bangladeshi groups, disability-free life expectancy is estimated to be lower compared to the white population.
- Rates of infant and maternal mortality, cardiovascular disease and diabetes are higher amongst Black and South Asian ethnic populations.
- People from ethnic minority backgrounds are more likely to report being in poor health and have poor experiences using health services than the White British population

Disability profile

Mortality rates for disabled people are more than twice as high as for people without a disability. Among disabled people, the more their day-to-day activities are limited, the higher their mortality rates tend to be ^{xviii}. As such it is important to focus on PEOLC services and study their suitability for people with disabilities.

The Office for National Statistics analysed data from the 2021 Census which shows that 20.5% of the Cheshire and Merseyside population (around 500,000 people) assessed their day-to-day activities as limited by long-term physical or mental health conditions or illnesses and are considered disabled ^{xix}. This compares to an the average ^{xix} across England and Wales of 17.8% (10.4 million people), and across the North West region of 19.8% (1.4 million people).

Proportion rates vary across Cheshire and Merseyside, with Cheshire East having the lowest percentage of people with disability, and Wirral having the highest. As the largest place, Liverpool has the highest number of disabled people, around 130,000 (21.8% of 597,000).

	2021 Census				Disabled (n)
	Limited a lot	Limited a little	Disabled (%)	Not disabled	
Cheshire East	6.90%	10.10%	17.00%	83.00%	73078
Cheshire West	7.70%	10.70%	18.40%	81.60%	70902
Halton	10.70%	11.40%	22.10%	77.90%	30180
Knowsley	12.40%	10.30%	22.70%	77.30%	39523
Liverpool	11.20%	10.60%	21.80%	78.20%	130156
Sefton	10.70%	11.20%	21.90%	78.10%	63398
St Helens	10.90%	11.40%	22.30%	77.70%	45397
Warrington	7.60%	11.40%	19.00%	81.00%	43026
Wirral	11.00%	11.80%	22.80%	77.20%	78886
Cheshire & Merseyside	9.70%	10.80%	20.50%	79.50%	571628
North West Region	9%	10%	19.00%	81%	
England and Wales	7%	10%	17.00%	83%	

Little is known about the experiences at end of life for people with physical disabilities (compared to, for example, those with learning disability) ^{xx} and this is potentially something for the programme to focus on in the future, working with disabled peoples’ charities and organisations.

Medical advances and developments in treatments have increased the life expectancy of many people with long standing physical disabilities such as muscular dystrophy, cystic fibrosis, cerebral palsy and injury, with many surviving into adulthood and beyond. PEOLC is likely to become increasingly complex for more people with such conditions, as well as their family, carers and clinical teams.

Although formal definitions of “end of life” focus on the last 12 months of life ^{xxi} it is important to recognise that people with physical disabilities (indeed many people with longer term conditions such as dementia) may benefit from palliative care for periods longer than 12 months. For some people with a physical disability, dying from their long term condition could mean that their end of life trajectory is less predictable, making parallel planning more complicated and underlining the need for good relations, communications and co-ordination between condition specialists, palliative care teams, and the patients and their families.

Connected services, such as Continuing Health Care (CHC) and the ‘fast track’ pathway for CHC need to be responsive to the needs of patients who are end of life and recognise the complexity of patients with disabilities or long term limiting conditions.

Finding accurate figures for the numbers of people with learning disabilities is difficult. MENCAP estimate there are approximately 1.5 million people with a learning disability in the UK including 1.2m adults and 350,000 children ^{xxii} This would suggest that around 60,000 people in Cheshire & Merseyside could have learning disabilities, however, the ICB Business Intelligence Portal only shows 15,000 people on the learning disability register at their GP practice, just 0.6% of the population.

People with a learning disability or autism generally have worse physical and mental health than people without a learning disability. On average die much younger than the general population and often do not receive the same level of care as those without learning disabilities or autism ^{xxiii}.

Learning Disabilities Mortality Review

The Learning Disabilities Mortality Review (LeDeR) ^{xxiv} is a national service improvement programme focused on people with learning disabilities, autism, or both which aims to:

- Improve care for people with a learning disability and autistic people.
- Reduce health inequalities for people with a learning disability and autistic people.
- Prevent people with a learning disability and autistic people from early deaths.

LeDeR reporting has changed in recent years, data for this section is taken from the Cheshire and Merseyside annual LeDeR reports for the financial year 2022/23 (which includes data from the national 2022/23 report) and for the calendar year 2023 .

Major Causes of Death:

The Cheshire and Merseyside reviews show that pneumonia, cardiovascular diseases and cancer are the most common causes of death in people with learning disabilities and autism

Top 5 causes of death in Cheshire and Merseyside, 2023 (for completed reviews):

	(n)	(%)
Diseases affecting the lungs	35	56.5%
Diseases affecting the heart and circulation	12	19%
Conditions not included in other categories	7	11.3%
Cancer and other tumours	5	8%
Infectious and Parasitic Diseases	3	4.8%

Age at death:

The national LeDeR report identified:

- The median age of death for people with a learning disability across the UK in 2021 was 62, for the North West region this was 59. The median age for the general population 2018-2020 was 82.7. This shows a difference of over 20 years.
 - 28% of people with learning disabilities die under 50 years of age compared with 5% of the general population.
 - 60% of people with a learning disability died before they were 65. This compares to around 10% of the general population

NHS England data ^{xxv} show that

- Life expectancy for autistic people is 76, which is 5.4 fewer than the general population.
- For autistic people without a learning disability, life expectancy is 79.5 years, but for those with a learning disability it is 70.8 years.
- In the 10-13 age bracket approximately 5% of males and approximately 1% of females are diagnosed as autistic but this prevalence is much lower for the age group 35 and over.

Place of death

The national LeDeR report shows that during 2022/23 61% of deaths took place in a hospital and across Cheshire and Merseyside it was 66.3%. The 2023 Cheshire and Merseyside report shows that this has fallen to 56.9%, however, this remains much higher than for the local general population (48%) and the national average (43%).

	C&M 2022/23		C&M 2023	
Usual place of residence	30	28%	42	25%
Acute hospital	71	66.3%	94	56.3%
Hospice	1	0.9%	2	1.2%
Nursing home	5	4.6%	15	9%
Other			14	8.3%

Learning Disabilities and Ethnicity:

Deaths in minority ethnic populations are under reported to the LeDeR programme both nationally and for Cheshire and Merseyside (only 2 out of 207 reviews in 2023). It is important to have accurate population data including ethnic group to ensure that all deaths of people from minority ethnic groups are reported to LeDeR and to help with the interpretation of findings with regard to ethnic disparities.

Long Term Conditions:

The health of many people with Learning Disabilities is also impacted by long term conditions, in fact, on average each person has 2.45 long term conditions. The 5 most frequently reported long term conditions (nationally) were:

1	Epilepsy
2	Cardiovascular disease
3	Mental health
4	Dementia
5	BMI 30 + (*)

(*) The C&M 2023 report suggests that obesity may be a reducing concern locally as a result of awareness raising and improvement work

Grading of Care

The national LeDeR report shows that 58% of care was rated as either 'good' or 'excellent', the C&M report shows this to be 29.3% - significantly lower than the national rating.

C&M focus groups identified a number of areas of concern, the top 5 area were:

1	Professional Practice and the Provision of Care
2	Care Pathways
3	Family and Carer Awareness of Available Support
4	Learning Disability Awareness

Other issues included: DNACPR recommendations and EOL Care, Deterioration, Involving the Coroner, Safeguarding and Training on Specific Conditions

Infants, Children and Young People

Children and Young People with Life-Limiting Conditions

In 2020 ‘Make Every Child Count’^{xxvi} made estimates for current and future prevalence of children and young people with life-limiting conditions across the UK. The report showed that, nationally, prevalence had increased by 65% over the previous decade – this was, in part, due to improved recording, and advances in medicine and improved care where many children who would previously have died in infancy are now living into adolescence or adulthood.

These children and their families will need access to a wide range of professionals and services across hospital and community which in some cases will include specialist palliative care and SPC in hospice services.

The report shows that prevalence is higher amongst boys than girls, highest amongst children of Pakistani origin and lowest among children of Chinese origin, and prevalence is higher in areas of higher deprivation - such differences are important in terms of flexibility to meet the needs of all children.

Local Authority	Number of cases	Total population	Prevalence per 100,000	Key
Cheshire East	506	81125	62.4	<55
Cheshire West and Chester	476	70848	67.2	55.1-70
Halton	259	31296	82.8	70.1-85
Knowsley	307	34744	88.4	>85
Liverpool	774	103071	75.1	
Sefton	388	57963	66.9	
St. Helens	328	38698	84.8	
Wirral	522	72768	71.7	
Warrington	326	47504	68.6	
	3886	538017	72.2	

The report maps prevalence of children and young people living with long term conditions across the UK. In 2017, across England the average rate was 66.4 per 100,000 population. It can easily be seen that prevalence of children and young people living with life limiting conditions is higher in Knowsley, St Helens, Halton, Liverpool and Wirral, which are all areas of high socio-economic deprivation.

The report states that “the distinction between severe disability, complex health needs and palliative care is becoming increasingly less relevant, and children with life-limiting conditions are everyone’s business. This has major implications for service planning, as well as for the training of all those working in children’s services.”^{xxvii}

Children and Young People Mortality

The National Child Mortality Database (NCMD) ^{xxviii} collates data collected by Child Death Overview Panels (CDOPs) in England from reviews of all children who die at any time after birth and before their 18th birthday.

The NCMD data covers all of England, where some regional breakdowns are available, they are for the North West and will be specified below. There is very limited data available for the Cheshire and Merseyside area alone.

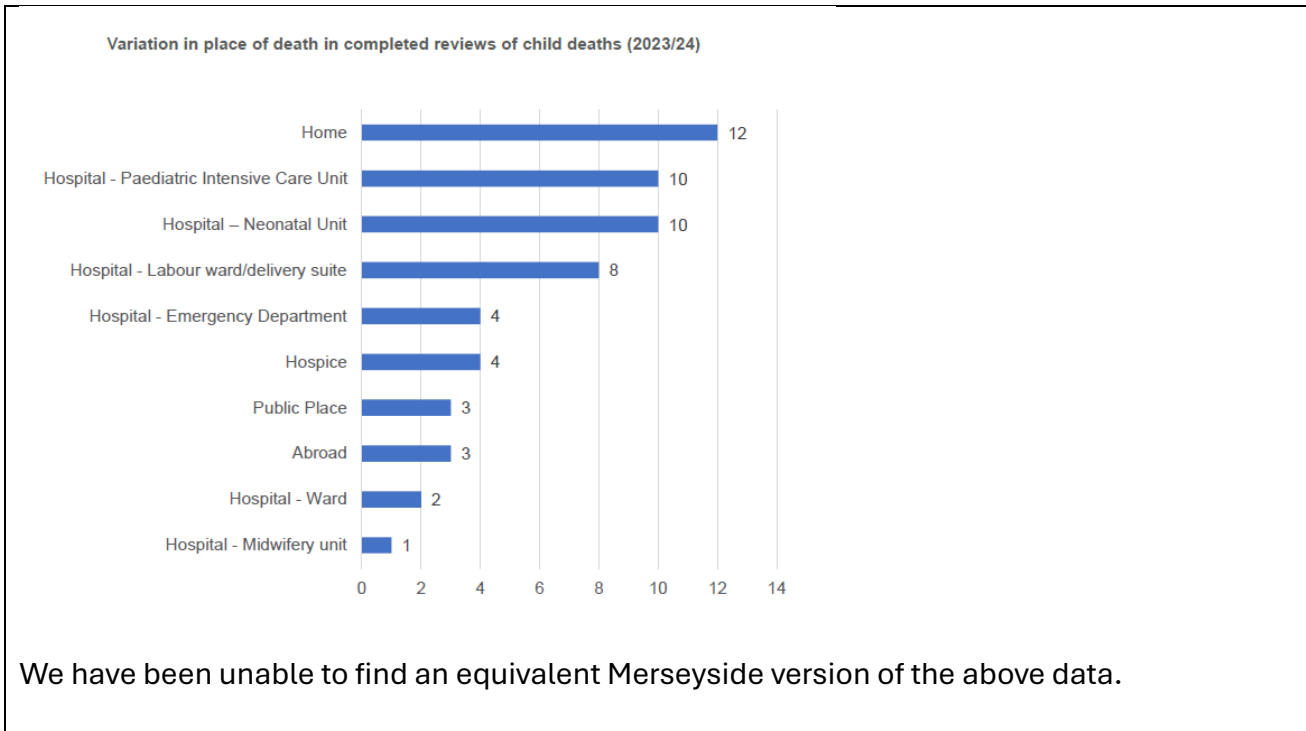
NCMD shows that for the years 2020 to 2024 there were between 136 and 165 deaths notified each year in Cheshire and Merseyside and that between 106 and 169 reviews were conducted

Child Death Overview Panel	Number of child death notifications received where the death occurred in the year ending 31 March					Number of child death reviews which were completed in the year ending 31 March				
	2020	2021	2022	2023	2024	2020	2021	2022	2023	2024
Merseyside	91	88	105	93	104	73	78	91	93	84
Pan Cheshire	45	56	60	55	52	45	28	30	76	57
Total	136	144	165	148	156	0	118	106	121	141

Source: NCMD
A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.

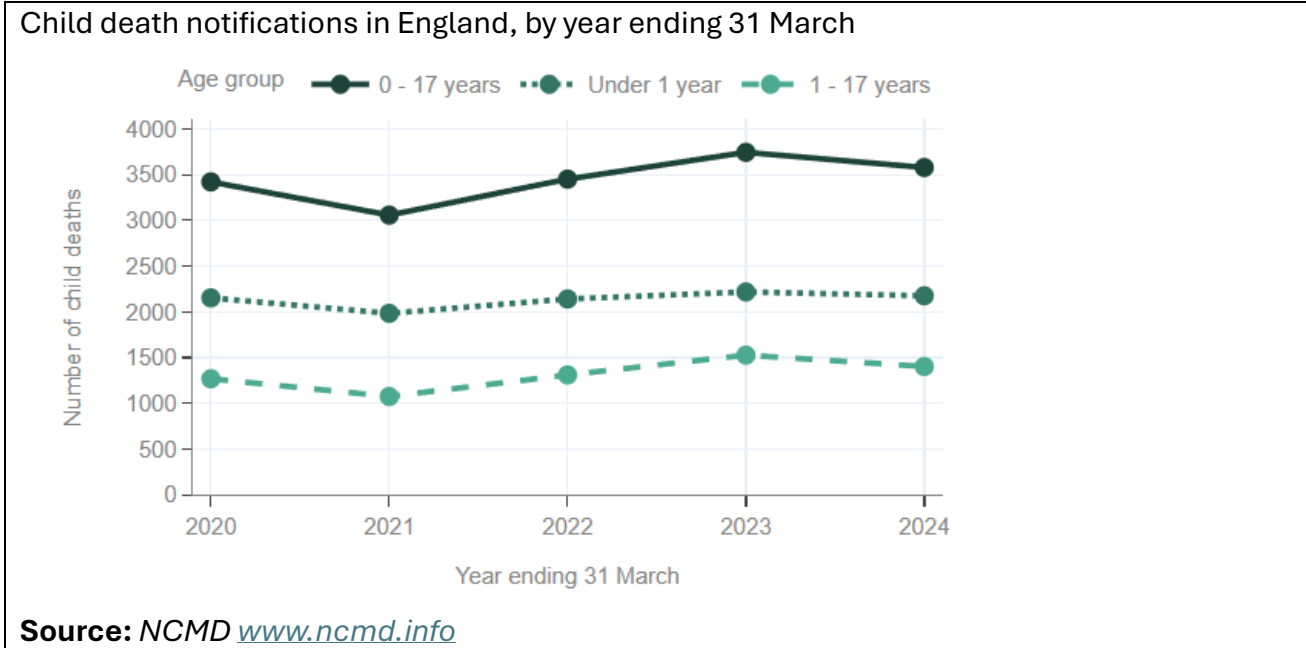
Pan Cheshire Place of Death

In Cheshire 61% (35/57) of deaths took place in hospital settings including neonatal units, paediatric intensive care units, labour wards or delivery suites. 21% (12/57) of deaths were at home.



National data on children and young people

There were 3,577 child (0 – 17 years) deaths in England in the year ending 31 March 2024, an estimated rate of 29.8 deaths per 100,000 children. The North West regional estimate was also 29.8, although in previous years the regional rate has been higher than the national rate.



Neonatal deaths (deaths of babies under 28 days of age) accounted for 42% of all child deaths. The estimated neonatal death rate for babies born at 24 weeks or over was 1.6 deaths per 1,000 live births— the national ambition is to reduce this rate to 1.0 deaths per 1,000 live births of babies born at 24 weeks or over, by 2025.

Deaths of infants (babies under 1 year of age) accounted for 61% of all child deaths in the year ending 31 March 2024. The infant death rate for England and the North West region was 3.9 per 1,000 live births.

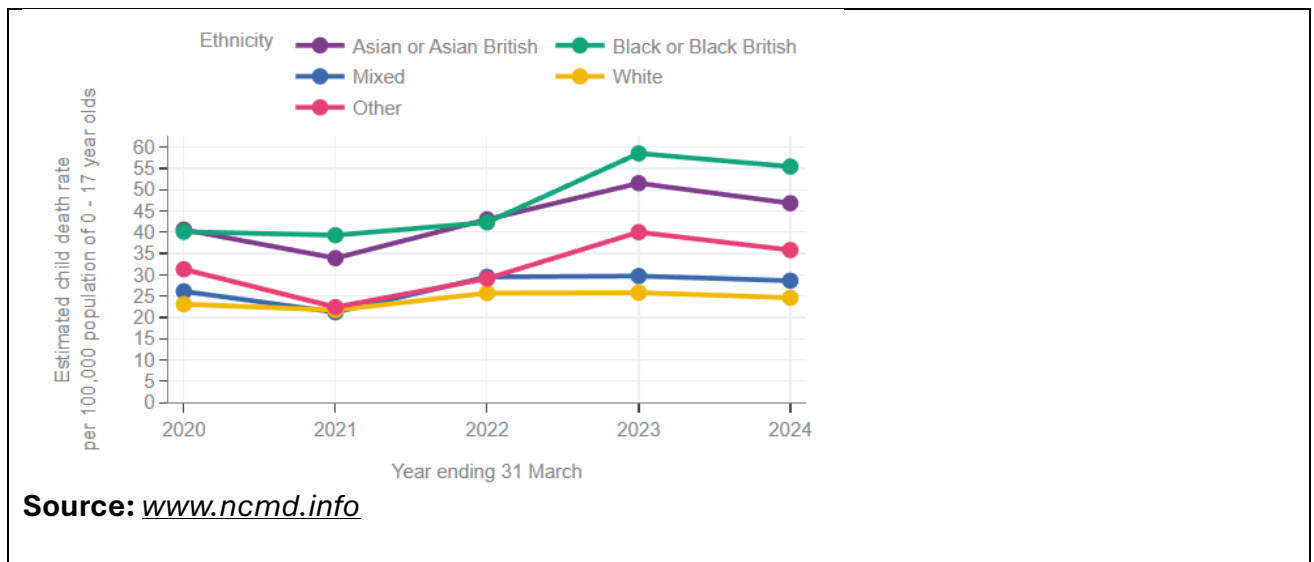
For children aged between 1 and 17 years, the highest death rate is for children aged between 15-17 years (19.3 per 100,000 population), followed by 1-4-year-olds (16.1 per 100,000 population).

Ethnicity

The child death rate in the year ending 31 March 2024 remained highest for children of black or black British ethnicity (55.4 per 100,000 population) and Asian or Asian British ethnicity (46.8 per 100,000 population) (Figure x). The rates for all ethnic groups have decreased in comparison to the previous year.

Although this level of data is not available for children and young people in the North West, it is expected to align with the national trend.

Estimated child death rate per 100,000 population of 0–17-year-olds by ethnicity in England in the year ending 31 March 2024:



Deprivation

The child death rate for children resident in the most deprived neighbourhoods of England was 42.9 per 100,000 population, more than twice that of children resident in the least deprived neighbourhoods (17.2 per 100,000 population).

Although this level of data is not available for children and young people in the North West, it is expected to align with the national trend.

PEOLC provision for children and young people (CYP)

Gap analysis of current CYP PEOLC provision

On behalf of the Cheshire and Merseyside PEOLC Programme, Claire House Children’s Hospice has undertaken an initial self-assessment against the CYP National Service Specification. The Claire House service meets 25 of 28 key areas of Enhanced, Core and Specialist activity and is partially meeting the remaining three.

- professionals (universal and core) have the relevant training and skills, and know when to seek specialist advice.
- specialist medical and nursing support, available 24/7, for hospices, acute trusts, community palliative care teams and tertiary centres

- specialist equipment in the home (where not included in children’s continuing care arrangements)

At this stage, assessment against universal services such as primary care, social care and education has not been made.

The self-assessment is included in this report as an appendix.

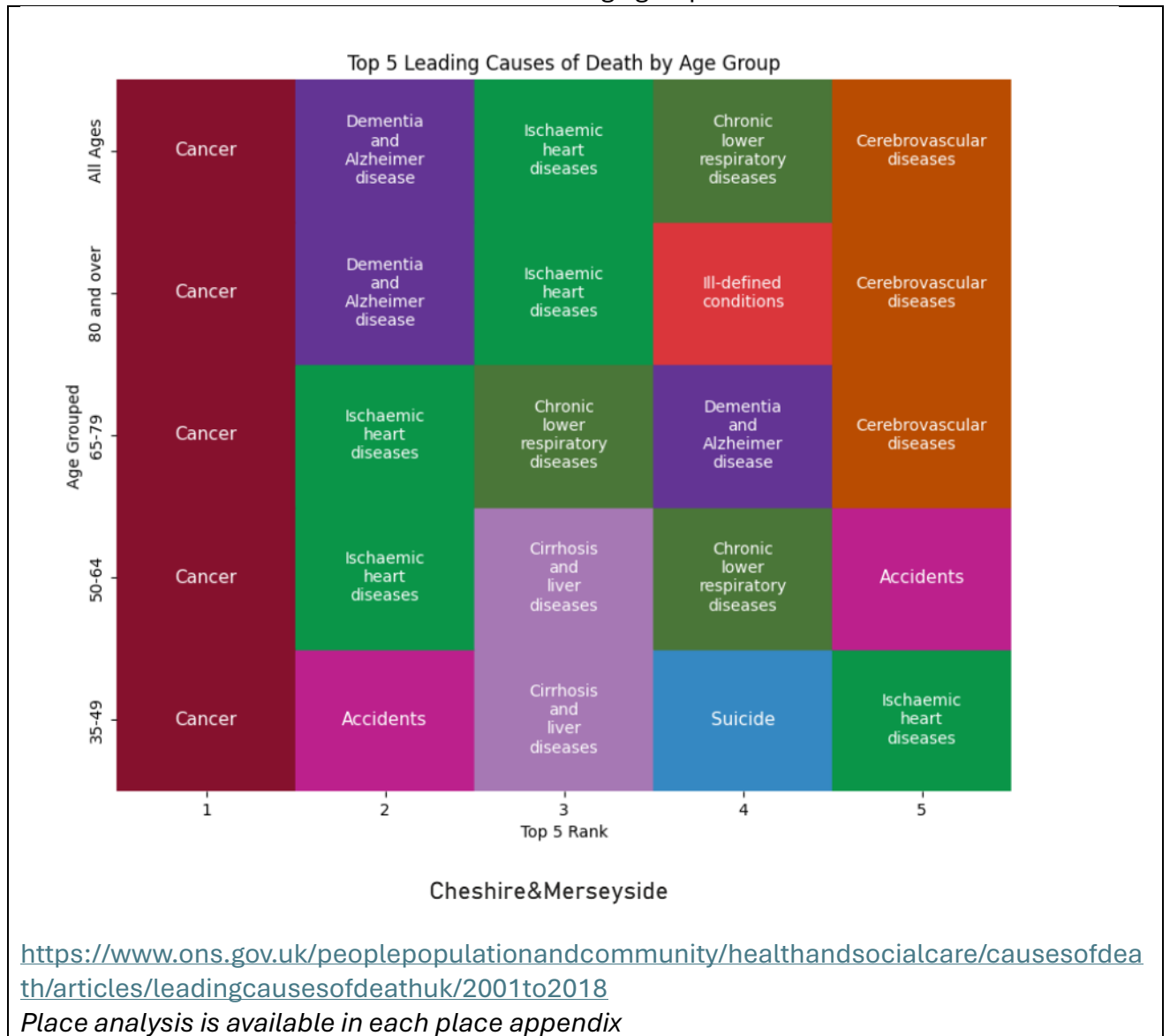
Section 2: Mortality Data

Major Causes of Death

In 2023, the three leading causes of death across Cheshire and Merseyside were cancer, heart disease and dementia, although as we can see from the chart below this does vary depending on the age when someone dies.

Cancer is the most common cause of death in Cheshire and Merseyside, and for all nine places, accounting for 25.7% of all deaths, (England 25.6%).

Heart disease accounts for 11.4% of all deaths in Cheshire and Merseyside (England 11.6%) and Dementia accounts for 11.3% of local deaths (England 11.6%), although for people over 80 it accounts for 19.9% - one in five deaths in that age group.



It is not possible to provide a Cheshire and Merseyside, or place, analysis of death for 0-35 age ranges using ONS data because of the relatively low numbers of deaths in these age ranges.

The major causes of death for children and young people vary by age, the Royal College of Paediatrics and Child Health ^{xxix} & ^{xxx} report that, in 2018,

The top three causes of death in the 1-4 age group in England and Wales are:

- Cancer
- Accidents (including injuries / poisonings)
- Congenital conditions.

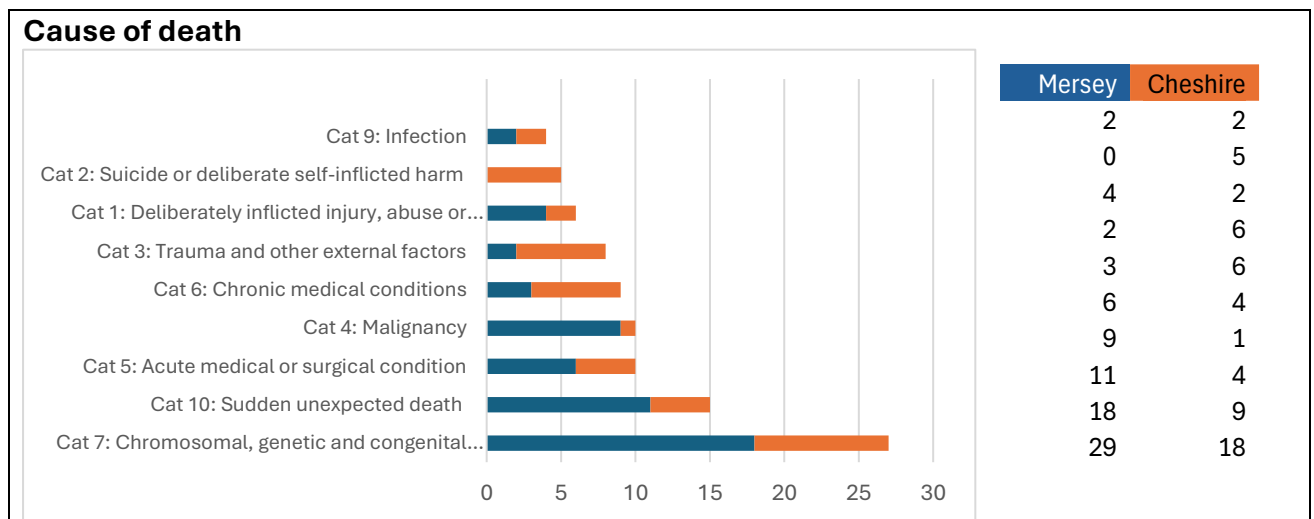
The top three causes of death in the 5-9 age-group in England and Wales are:

- Cancer
- Respiratory causes
- Accidents (including injuries / poisonings).

The top three causes of death in the 10-19 age group in England and Wales are:

- accidental injury,
- cancer
- intentional self-harm (including suicide),
- followed by neurological, cardiovascular and respiratory disorders.

This chart represents data taken from Child Death Overview Panels on major causes of death for children and young people in Cheshire and Merseyside. It shows major causes of death for all children and young people are congenital conditions, accidents, acute medical and surgical conditions, and cancer.



End of life trajectories

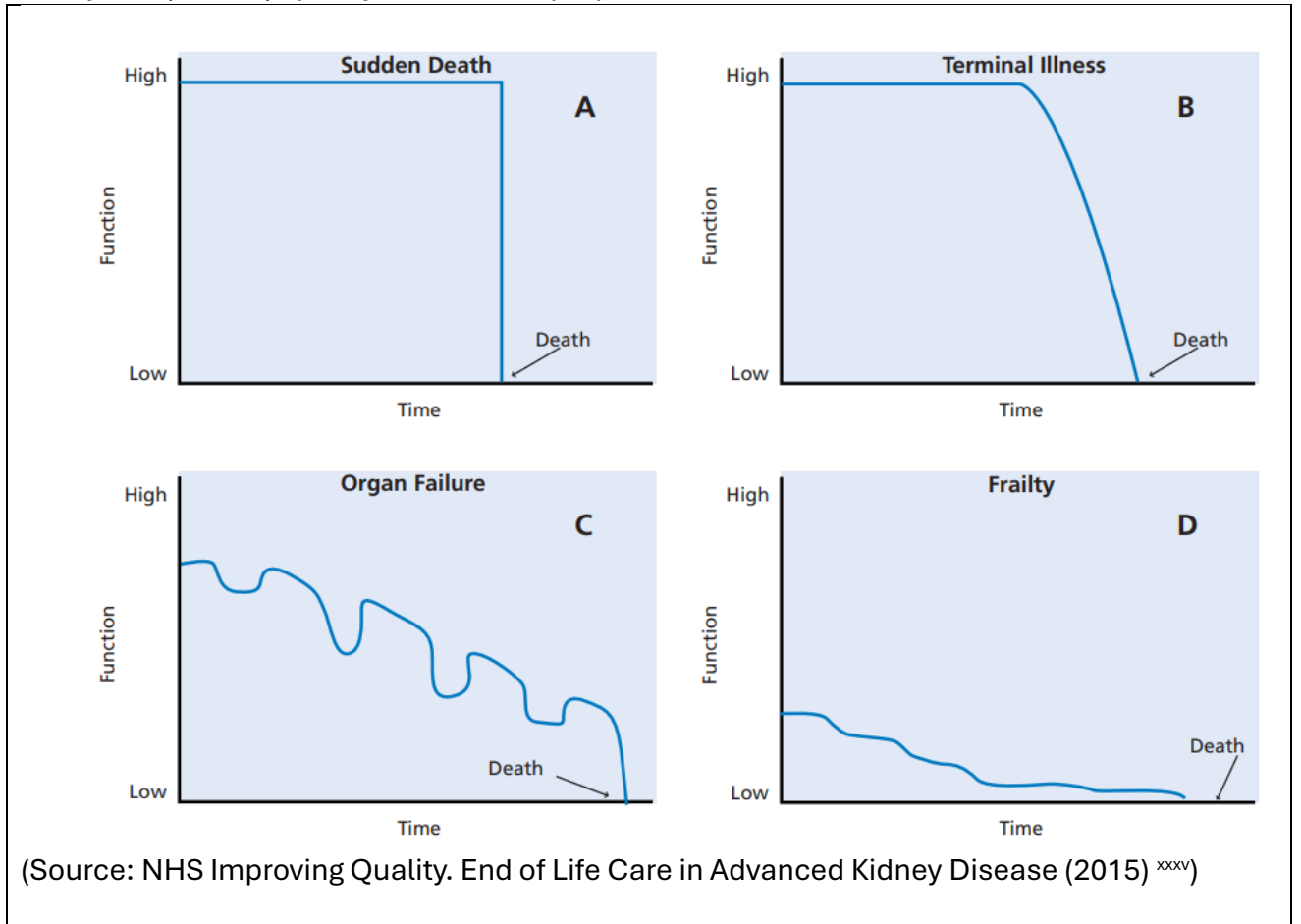
All those living with a life limiting illness could benefit from a palliative care approach to care which reflects their individual holistic needs (physical, social, psychological and spiritual) and their anticipated disease trajectory. Predicting prognosis and anticipating an individual's

disease trajectory can be complex, given that many are living with multiple morbidities, and disease modifying treatments are constantly evolving.

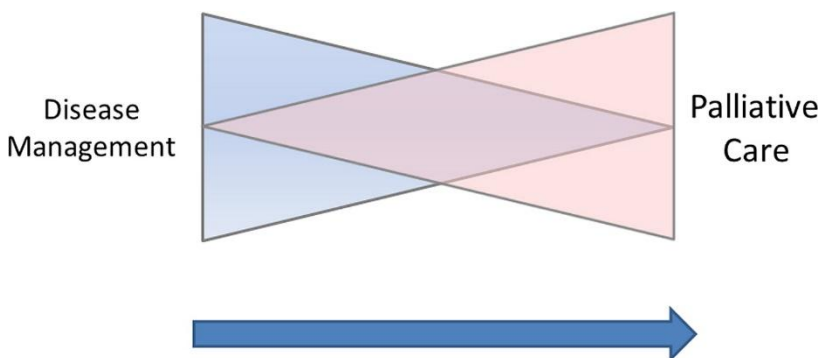
Various authors and reports describe a number of general trajectories of decline at the end of life. In 2003 Lunney et al^{xxxii} set out four general trajectories of decline at the end of life, these trajectories have been used and referred to several times in NHS documents ever since. In 2005 Murray et al^{xxxiii} described three broad illness trajectories and described their relationship with palliative care. Murray has continued this work, expanding our understanding in 2017^{xxxiii} and most recently revising the descriptions and definitions in 2024^{xxxiv}. There is much overlap in these models, and below we seek to represent the key elements of both. It is important to understand these trajectories as it can help in planning services more appropriately to meet patients' and carers' needs.

		National Prevalence	Number of deaths each year in C&M *
Sudden Death (Lunney)	Deaths where there was no obvious life limiting illness until the last days. (e.g. heart attack, accident)	14%	3,780
Terminal Illness (Lunney) Or Rapid decline (Murray)	Many people with terminal illness may remain in reasonably good health until experiencing a rapid decline in the last few weeks or months of life, predominately related to a terminal cancer but may include other terminal illnesses	Cancer 21% Other terminal illness 4%	5,670 1,080
Organ Failure (Lunney) Or Intermittent decline (Murray)	Others will experience a slow functional deterioration, punctuated by abrupt, partially reversible troughs. During an acute crisis, it is uncertain whether active treatment will result in recovery or whether there will be a rapid deterioration resulting in death. Parallel planning is required to prepare for both eventualities in diseases such as end stage heart failure, liver disease or Chronic Obstructive Airways Disease.	19%	5,130
Frailty (Lunney) Or Gradual decline (Murray)	Others will experience a much slower decline in function over months to years, as seen in the frail elderly or those living with dementia. Early recognition and planning enables appropriate treatment for episodes of acute illness and anticipated deterioration.	42%	11,340

*Cheshire and Merseyside estimates are based on total number of deaths in Cheshire & Merseyside (27,000) split by the national proportion of deaths.



Taking a palliative care approach to care early in persons illness improves a patient’s experience and outcomes, yet this is often delayed until the last days or weeks of life. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report stresses the importance of “parallel planning” ^{xxxvi} – offering palliative care alongside the existing disease-modifying treatments offered by other clinicians. This is usefully illustrated in the Bow Tie Model of 21st Century Palliative Care ^{xxxvii}



Recognising different disease trajectories can enable palliative care to be incorporated into the wider care of all patients early, enabling future care planning and early specialist palliative care support to meet the holistic needs of the person (physical, psychosocial and spiritual domains of care). It is recommended that the initial diagnosis of a life-limiting condition, together with critical events and changes in disease progression as indicated in the trajectories, should be recognised in all care settings as triggers for the introduction and subsequent stepping up and stepping down of palliative care input.

For patients who experience sudden death, for example those who have a heart attack, palliative care focuses on improving the quality of life for patients and their families **through using existing future care planning to inform clinical decision making, timely** symptom management, and by providing emotional, practical, and spiritual support **pre- and post-bereavement**.

For any person where death may be anticipated in the coming months, their recognition and inclusion on and End of Life registers such as the Gold Standard Framework helps teams to recognise those who may be approaching the end of their life, and co-ordinate their care effectively across multiple health care settings.

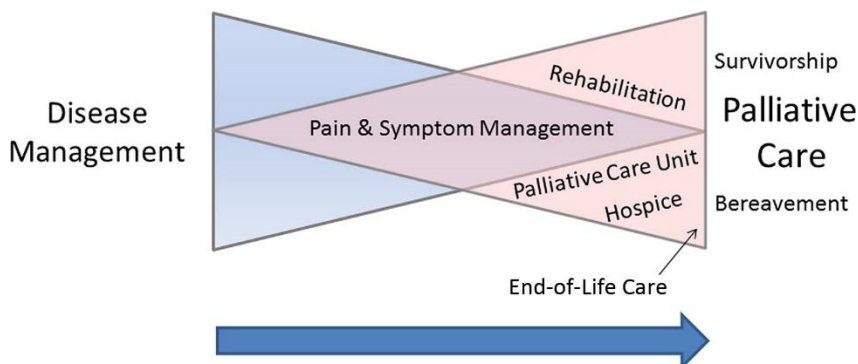
For people with terminal diagnosis such as cancer, early identification of patients facilitates a timely holistic assessment, future care planning, early referral to local specialist palliative care services or enhanced supportive care clinics and ongoing supportive care tailored to the person’s needs.

For patients with intermittent decline, for example liver disease, collaboration between condition specialists and palliative care specialists may help to identify patients early, at a time when clinical recovery from acute illness can be uncertain. Local models of MDT working are being introduced in some areas to support interdisciplinary care and parallel planning.

A parallel approach to care is required, with management of the underlying disease aiming to reduce the frequency and severity of exacerbations, and a palliative care approach addressing the multi-dimensional needs of care and undertaking future care planning which reflects clinical uncertainty, and enables people, their families and health care teams to *“hope for the best, and prepare for the rest”*.

The needs of those living with frailty or dementia may be met predominantly by primary care / care home / frailty services, whereas those living with complex neurological conditions such as MND are likely to require a multi-professional interdisciplinary approach to meet their complex needs.

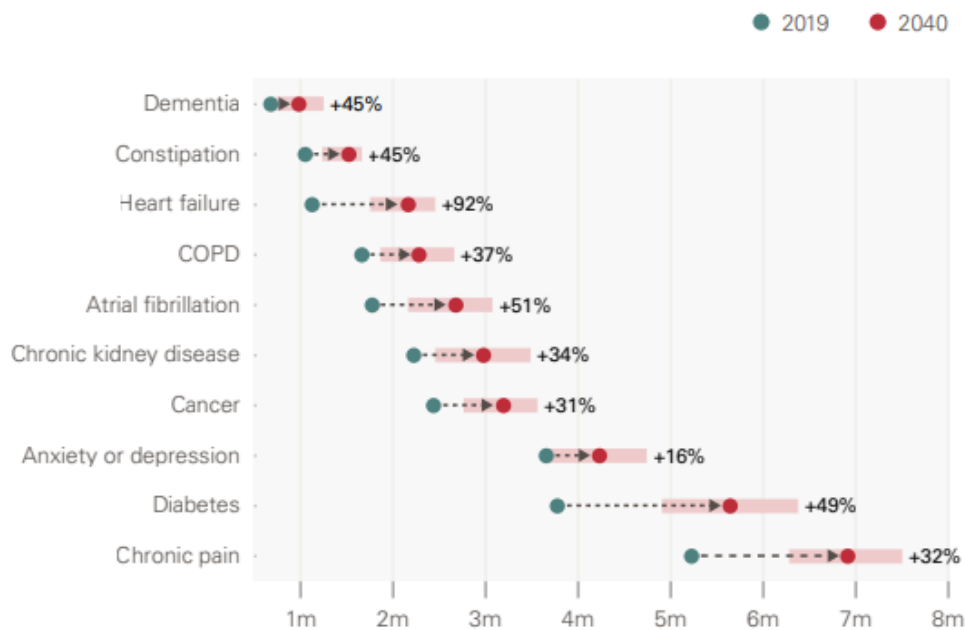
The shape of the bow tie will vary depending on the disease trajectory, and palliative care may have a greater or lesser involvement in the support for some patients than with others.



Projected future needs linked to major causes of death

In 2023, the Health Foundation (working with the University of Liverpool) predicted that, by 2040, 9.1 million people in England will be living with major illnesses, which is 2.5 million more than in 2019^{xxxviii}. Most of this increase is the result of an aging population (80% of the projected increase in major illness is among those aged 70 years and older). The report predicts increases in conditions which are often the major causes of death such as cancer, heart disease, dementia and respiratory disease.

Projected total number of diagnosed cases for the 10 conditions with the highest impact on health care use and mortality among those aged 30 years and older, including demographic changes, England, 2019 and projected for 2040



(Source: Health Foundation)

Using data from the Quality and Outcomes Framework, 2019-20^{xxxix} we can model what these predicted rises may mean for people living with these long-term conditions and for PEOLC services in Cheshire and Merseyside.

Condition	Cheshire and Merseyside (QOF 2019/20)	Modelled Change (England)	Cheshire and Merseyside 2040 Estimate	Increase 2019-2040
Cancer	94,820	31%	124,214	+ 29,394
Heart diseases				
<i>Heart Failure</i>	29,892	92%	57,393	+27,501
<i>Atrial fibrillation</i>	67,216	51%	101,496	+ 34,280
Dementia	23,110	45%	33,510	+ 10,400
COPD	68,903	37%	94,397	+ 25,494

End of life care may get more complex as our population ages and more people live with multiple chronic conditions, increasing the need for co-ordinated care and parallel planning.

Other conditions to consider

Liver disease:

In addition, we can see from the section of Major Causes of Death that Cirrhosis and Liver Disease are major causes of death, particularly for the 20-64 age ranges, and this is predicted to increase, linked to rises in obesity and alcohol consumption. The Office for Health Improvement and Disparities (OHID) show that the England rate of premature deaths from liver disease increased by over 70% and deaths from alcoholic liver disease increased by 61.3% over the last 20 years in England ^{xi}. The British Liver Trust states that liver cancer is the fastest rising cause of cancer death in the UK (with no predictions for future growth). ^{xii}

Neurological Conditions:

Although overall deaths from Neurological conditions such as Parkinsons Disease, Motor Neurone Disease, Multiple Sclerosis and Huntington's disease are statistically low (11,600 deaths nationally around 2% of all deaths, estimated to be 500-600 in Cheshire and Merseyside), the disease trajectory and lack of specialist services locally justifies inclusion in the PBNA. Palliative care, combined with rehabilitation, can be beneficial for people and their carers from the point of diagnosis through to the end of life. It helps the person manage their condition and symptoms, and to maintain the best possible quality of life.

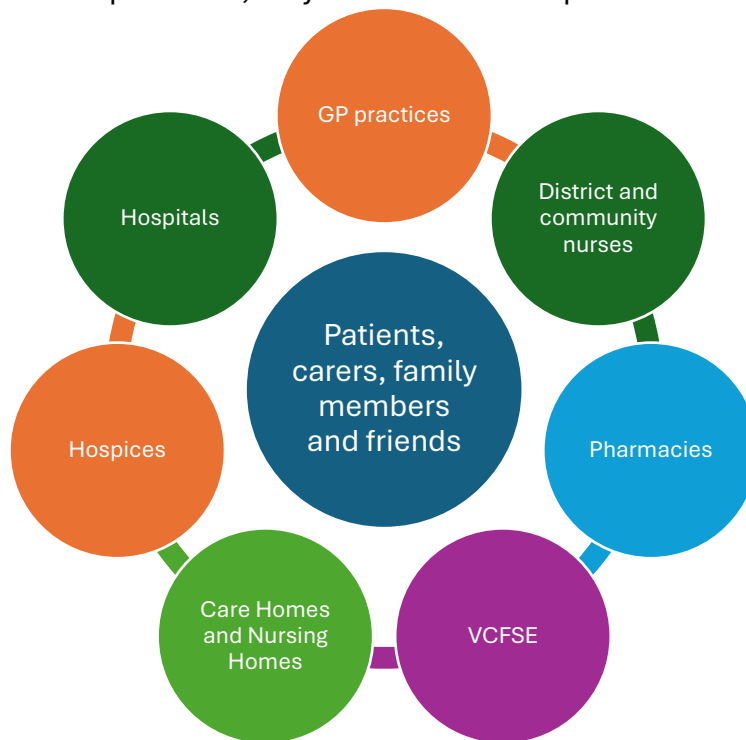
The National Service Framework for long term conditions in 2005 ^{xiii} recommended that people in the later stages of long-term neurological conditions should receive a comprehensive range of palliative care services when they need them to control symptoms, offer pain relief, and meet their needs for personal, social, psychological and spiritual support, in line with the principles of palliative care

Section 3: PEOLC Service Provision

Different health and social care professionals may be involved in providing palliative and end of life care. For example, hospital doctors and nurses, GPs, community nurses, hospice staff and counsellors may all be involved, as well as social care staff, chaplains (of all faiths or none), physiotherapists, occupational therapists or complementary therapists.

If people are receiving care at home or in a care home, GPs have overall responsibility for the care being provided. Community nurses will often visit people at home, and family and friends may be closely involved in caring for patients.

Some people will need specialist palliative care. This may be provided by consultants trained in palliative medicine, specialist palliative care nurses, or specialist occupational therapists or physiotherapists. As specialists, they also advise other professionals on palliative care.



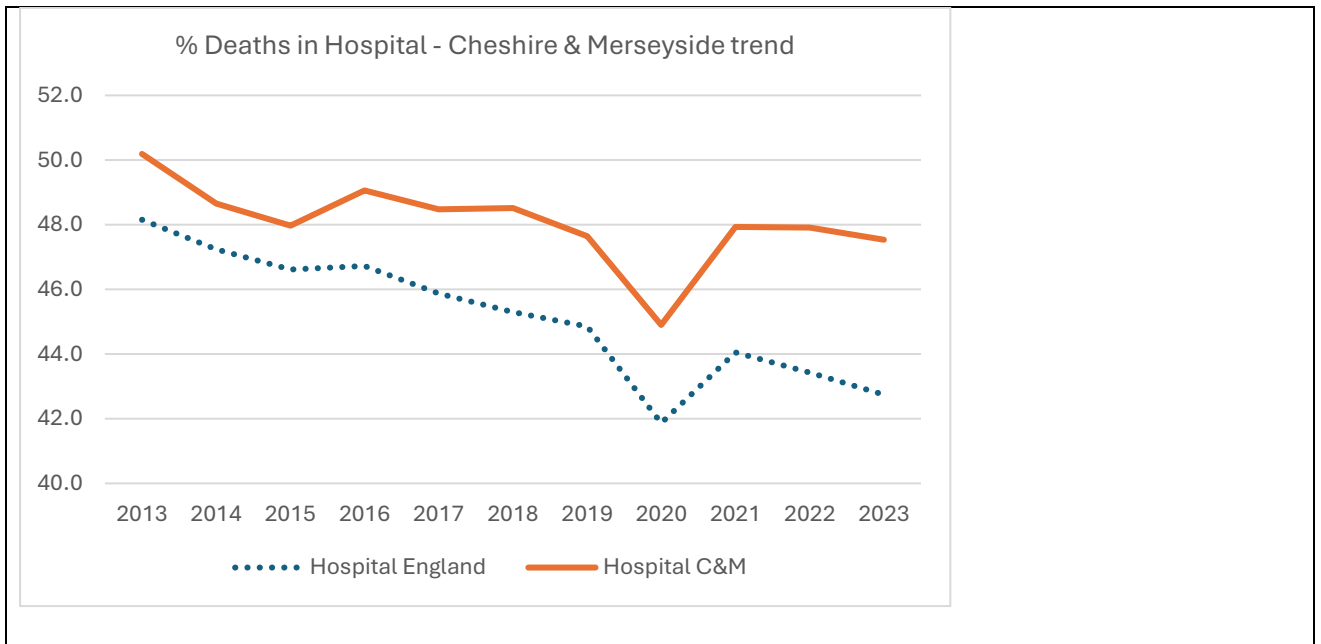
The following sections feature relevant data and analysis on different services involved in delivering PEOLC in Cheshire and Merseyside.

Place of Death

Recording the place of death is widely recognised as an important indicator of the strength of a palliative care system^{xliii}.

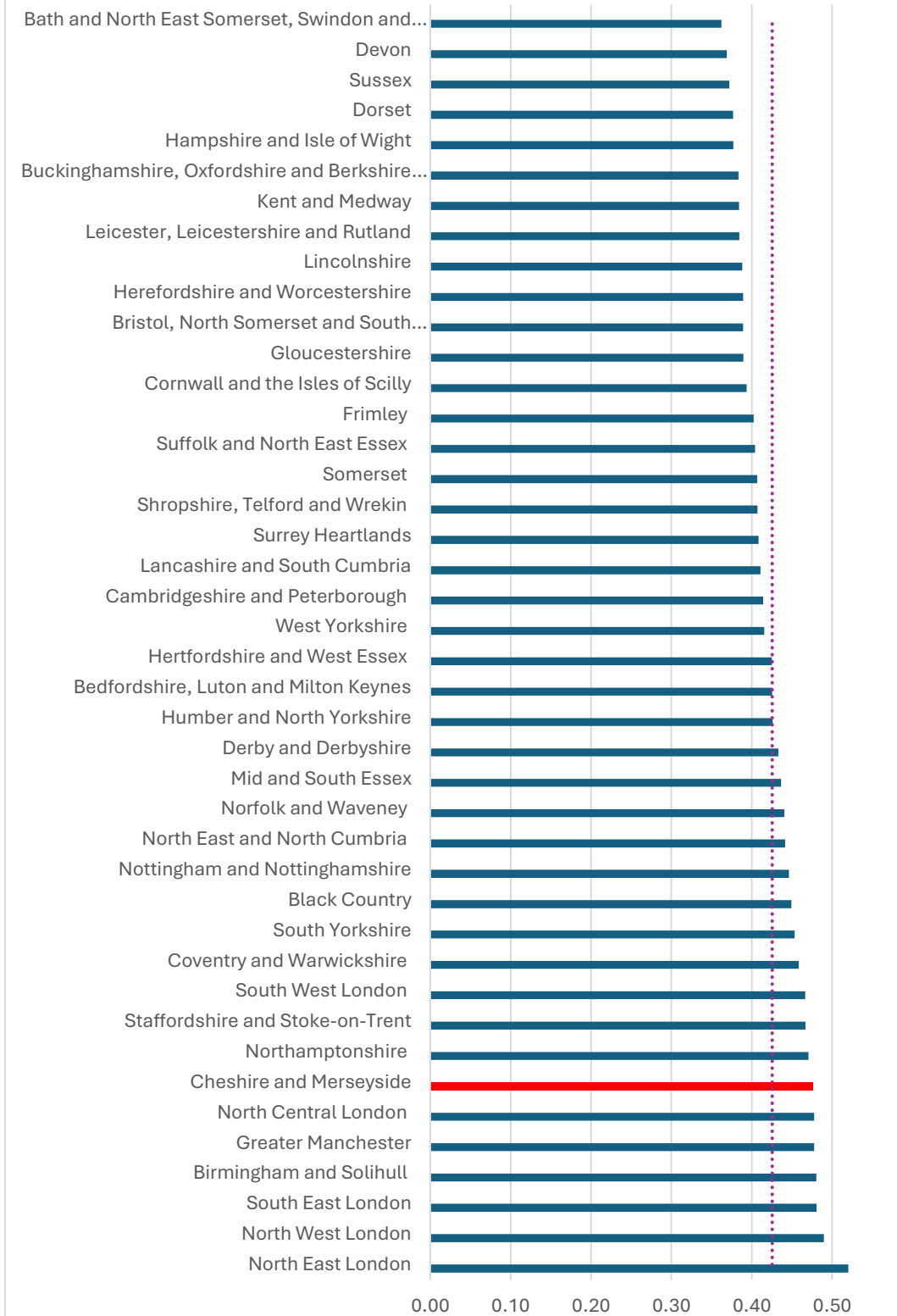
We know that most people would prefer to die at home or in a hospice^{xliiv} yet many people die in hospital. Respondents to the national 2014 VOICES survey reported that more than 82% of people would prefer to die at home, with 8% preferring to die in a hospice, 6% in a care home, 3% in a hospital and 1% somewhere else. However, the 2014 VOICE survey did also show that individual preferences change as death approaches, with fewer individuals wanting to die at home and more wanting to die in a hospice.

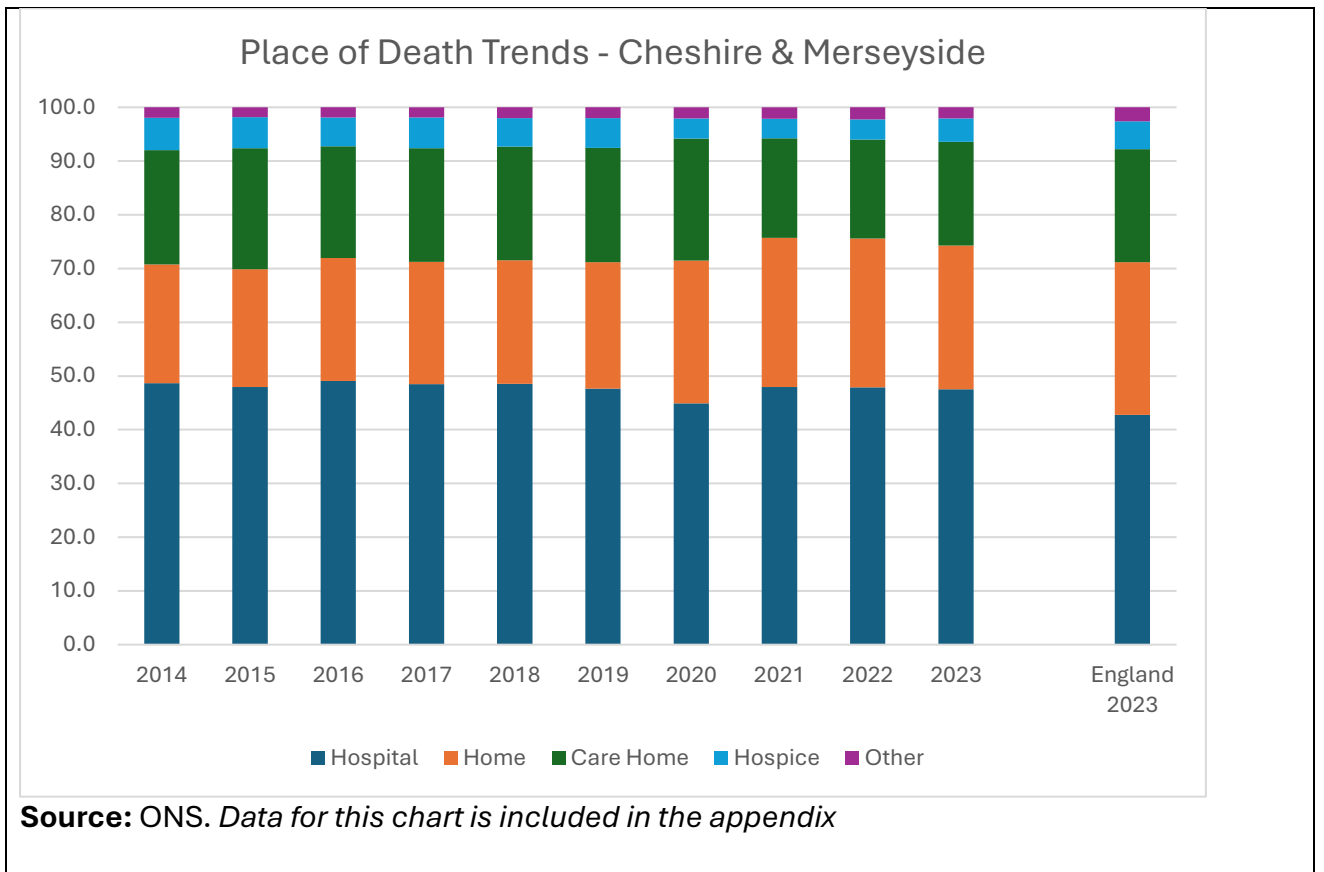
Data from the Office of National Statistics ^{xiv} show that across England, from 2014 to 2023, the proportion of deaths that occurred in hospital fell from 47.2% to 42.7%. Across Cheshire and Merseyside, the proportion has fallen from 48.7% to 47.5% - we can see from the chart below that, whilst local and national rates are falling, the rates in Cheshire and Merseyside are higher than the national average and that the gaps is widening.



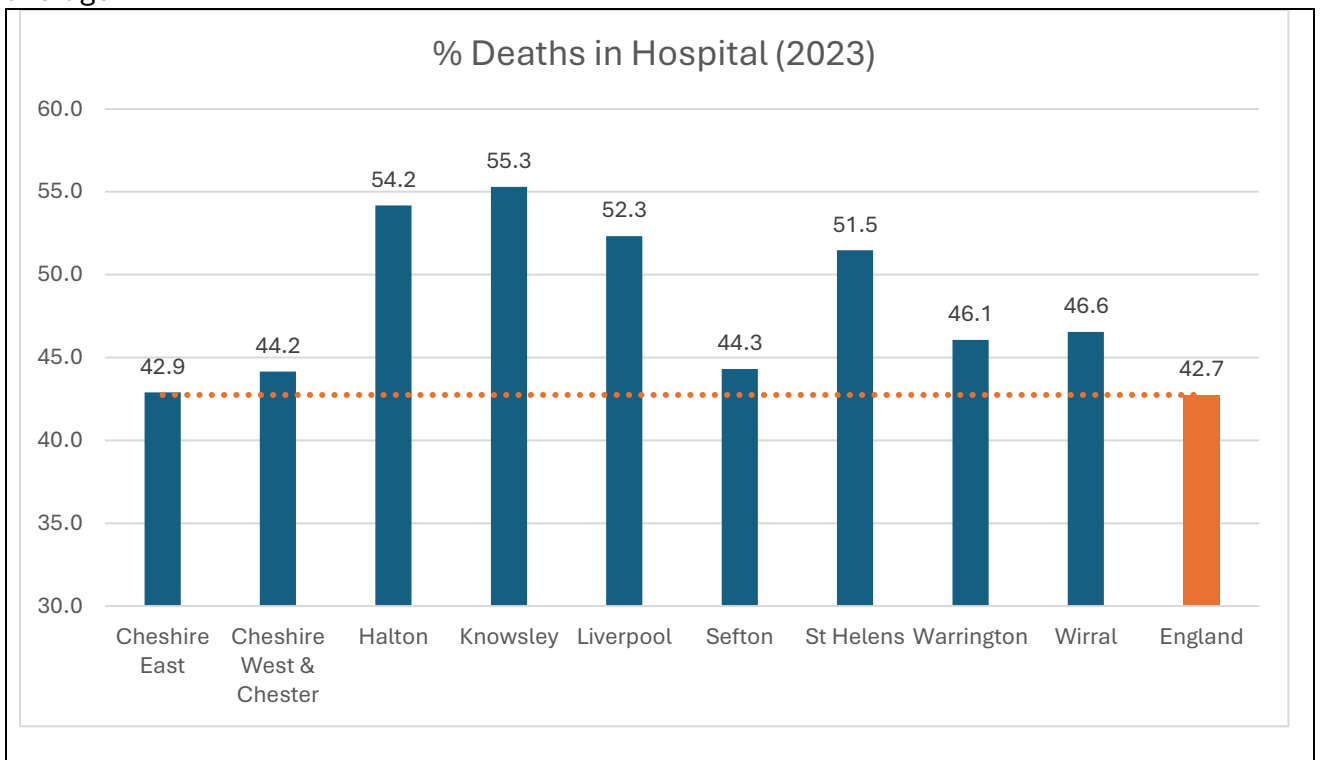
In fact, we can see that as a system, Cheshire and Merseyside ICB were the 7th worst performing ICB (out of 42 ICBs) for this key metric in 2023 (the system was also 7th in 2022). If Cheshire and Merseyside were to reach the same performance as the England average, it would require 1,300 more people being supported to die outside of hospital; either at home, in a care home or hospice – each year.

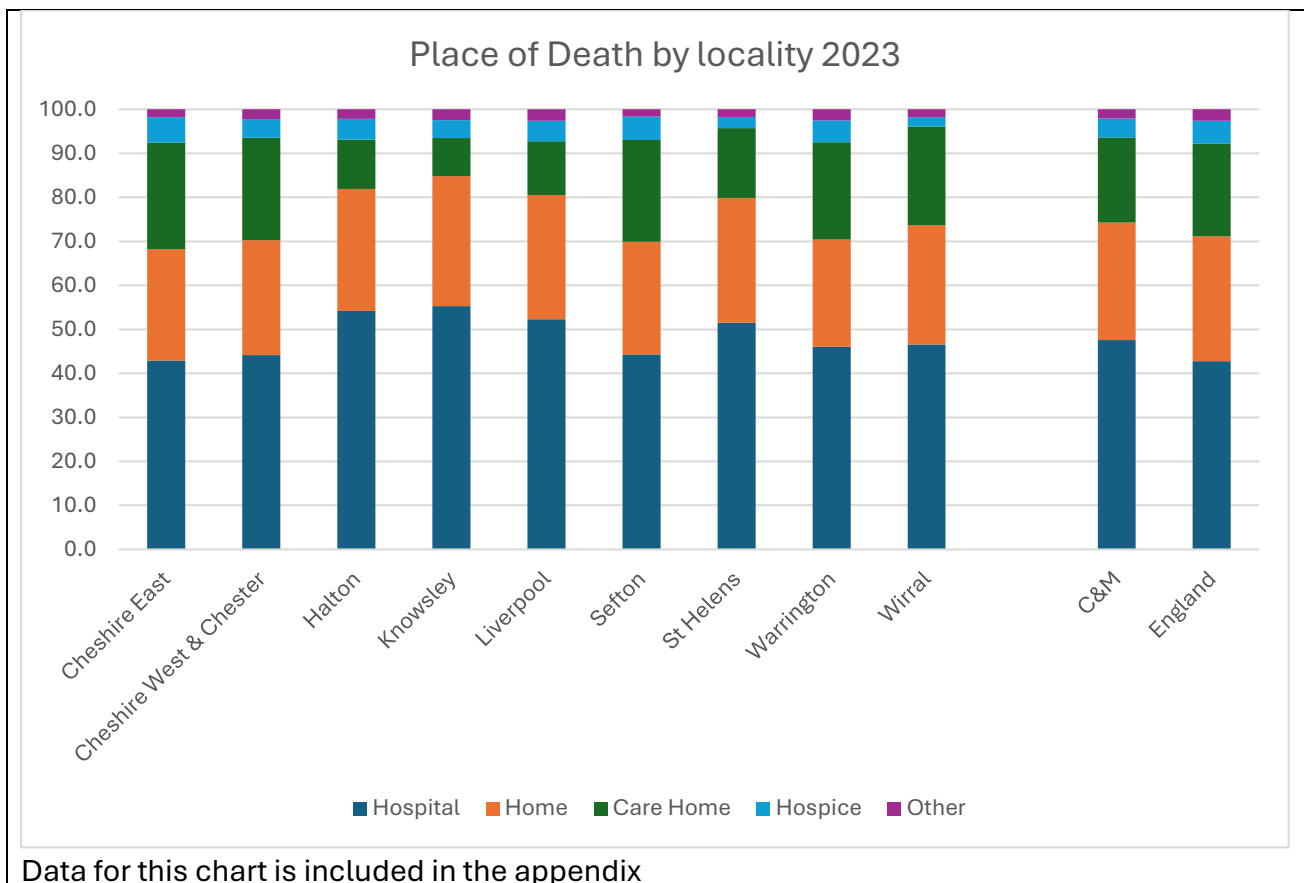
ICB comparison: % deaths in hospital 2023





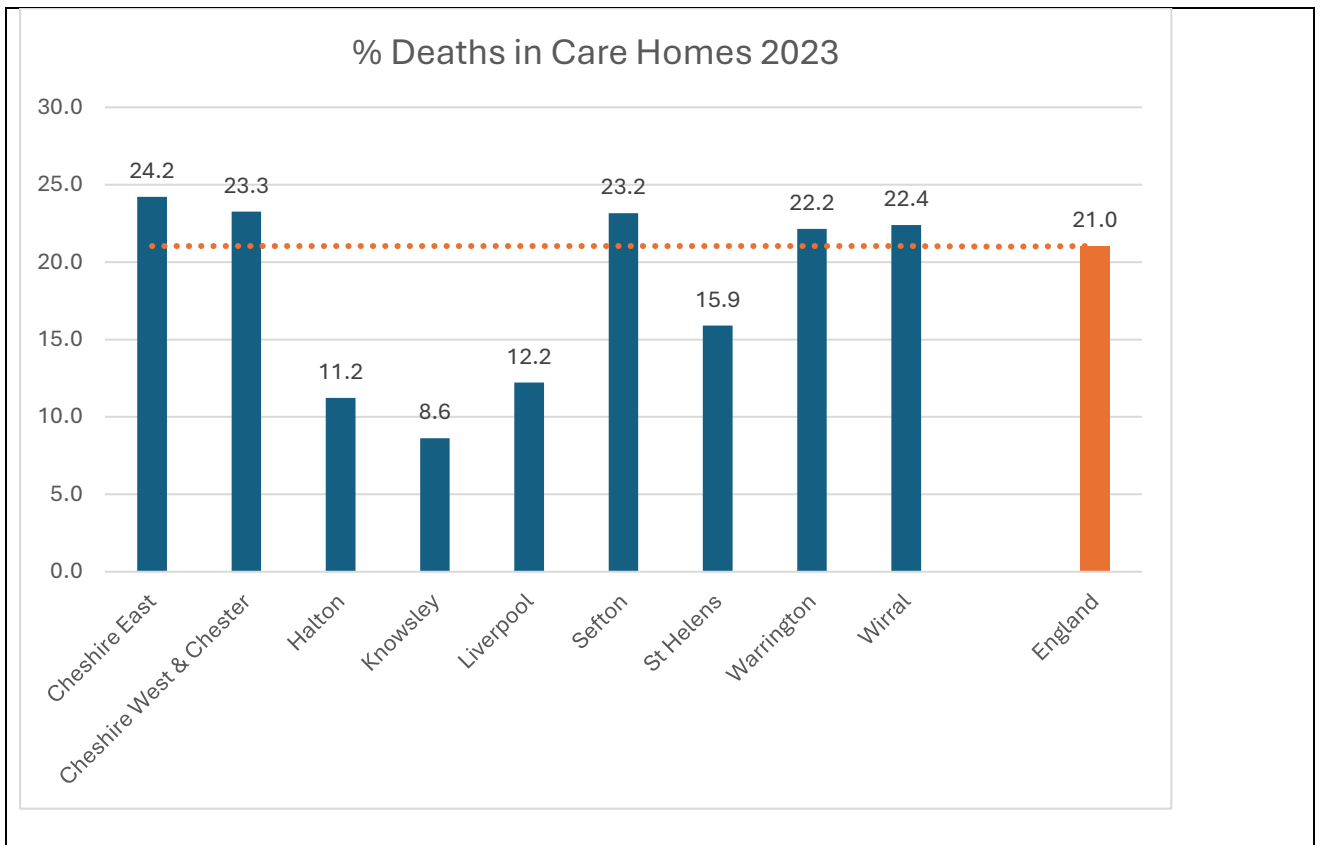
We can see on a place-by-place analysis of deaths in hospital that in 2023 all localities in Cheshire and Merseyside are higher than the national average – although Cheshire East is generally lower (for all years 2013-2022) and North Sefton (the former CCG footprint covering Southport & Formby) is also generally lower than the national average. For the period 2012-2023 all other areas, including South Sefton and Sefton overall performed worse than the national average.



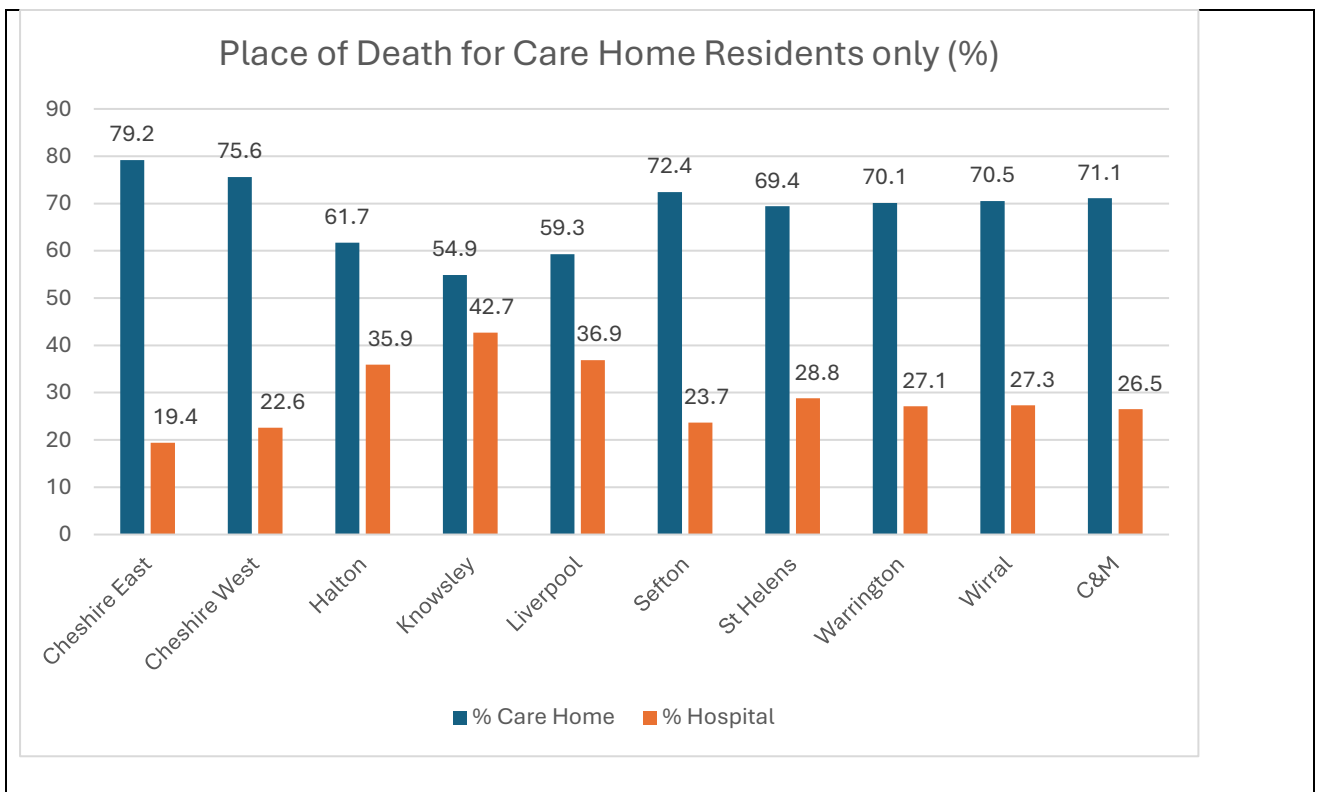


Across this same 10-year period (2014-2023), we can see that the proportion of people dying at home in Cheshire and Merseyside has risen from 22.1% to 26.7%, which is broadly in line with the national trend (23%-28.4%). There appears to be little variation across the nine localities of Cheshire and Merseyside with rates only ranging from 25.3% in Cheshire East to 29.3% (in Knowsley) in 2023.

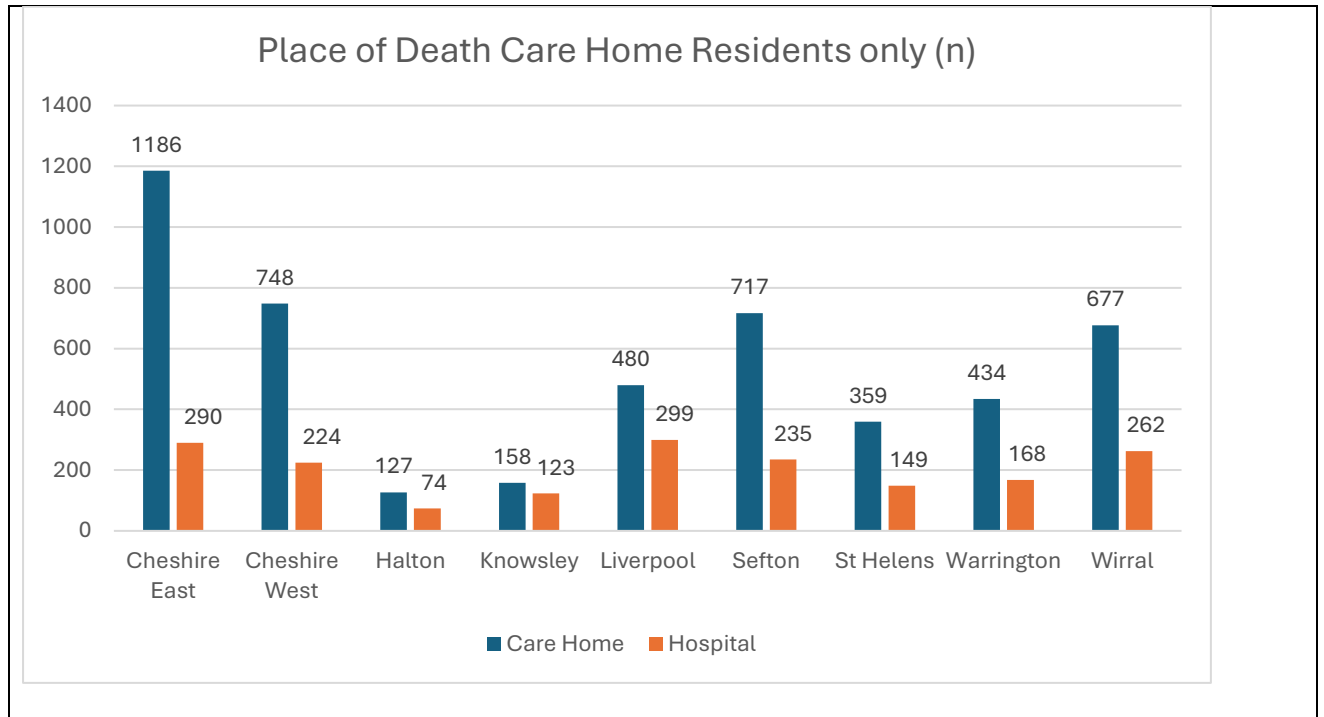
Those dying in a care home in Cheshire and Merseyside has fallen slightly from 21.2% to 19.3% (2014-2023), which is slightly lower than the national average (21.7% in 2014, 21% in 2023), although this average figure does disguise some place-by-place variation, we can see that in 2023 the proportion of people dying in a care home varied from as few as 8.6% in Knowsley to 24.2% in Cheshire (and in 2022 was as high as 30.8% in North Sefton). Such local variation does warrant further analysis with local partners; for example, North Sefton has the highest percentage of care home deaths and the lowest number of hospital deaths, the converse is true for Knowsley with the highest proportion of hospital deaths and lowest in care homes.



It is informative to consider what proportion of care home residents who die, die in their care home, or in hospital settings, this chart (based on data from C&M ICB) shows some variation across Cheshire and Merseyside with 70% to 80% of residents being supported to die within their own care home in areas such as Cheshire East, Cheshire West, Sefton, St Helens, Warrington and Wirral, but this being at least 10% lower in Halton, Knowsley and Liverpool.

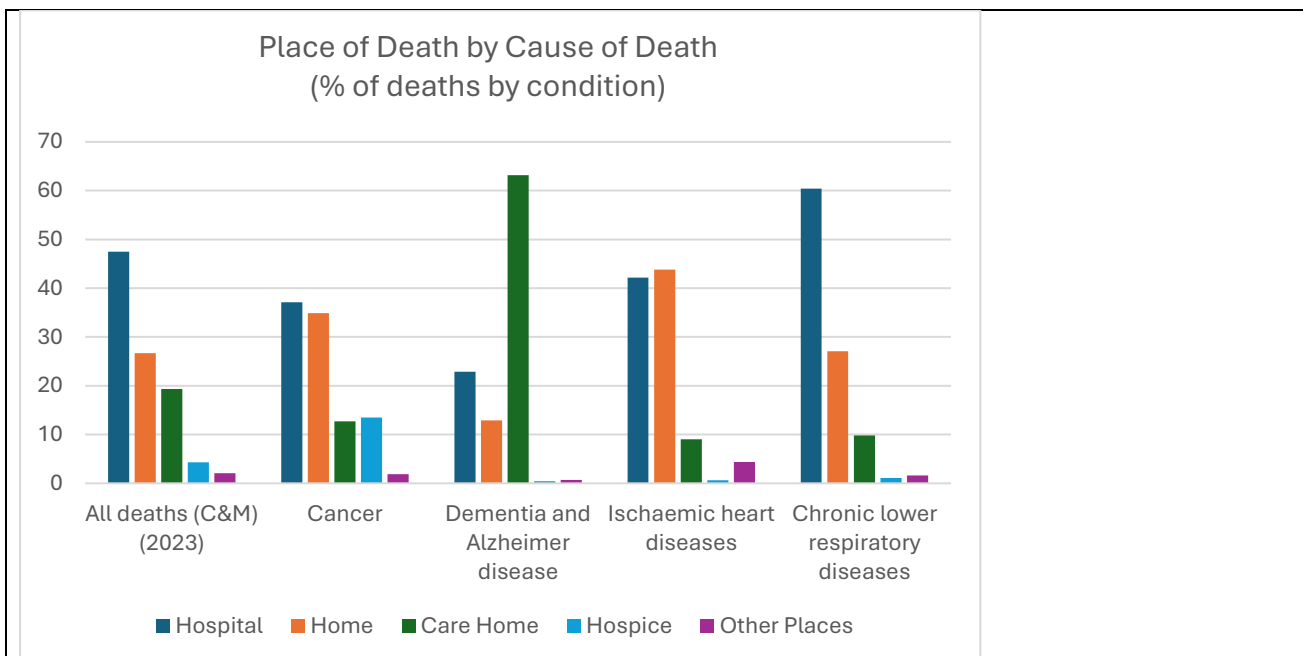


It is also worth considering the overall numbers of people involved in these figures, with areas such as Cheshire East, Cheshire West, Sefton and Wirral having higher numbers of care home residents.



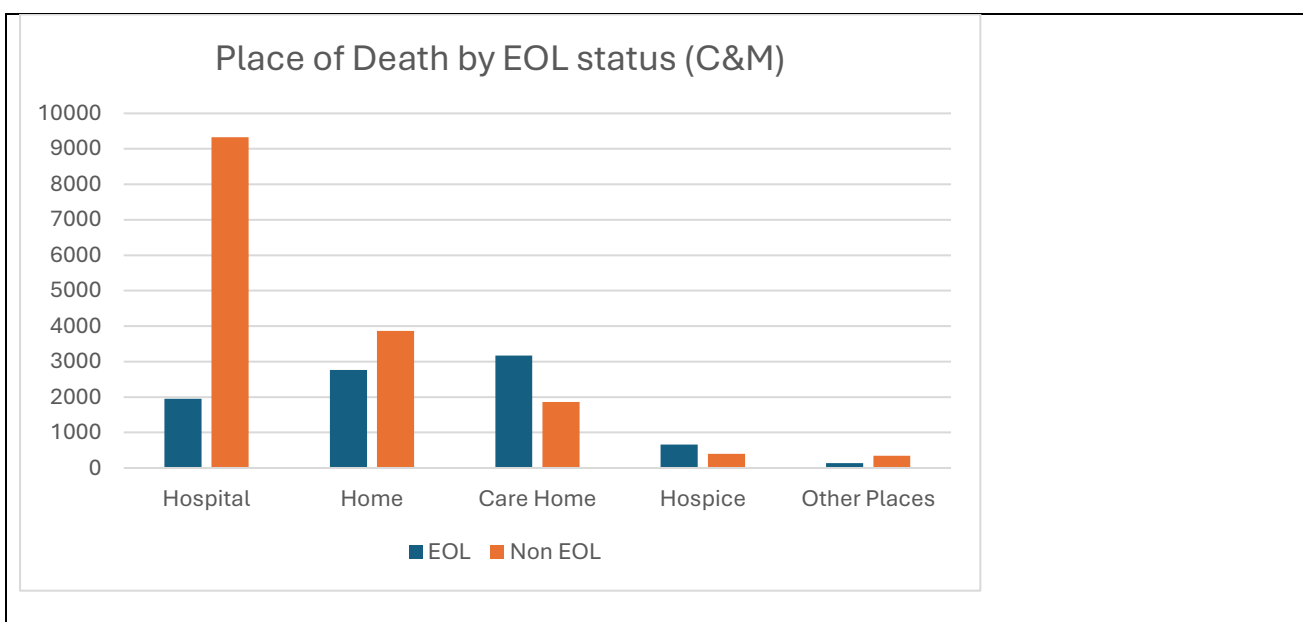
Deaths in hospices do appear to be slightly lower than the England average (4.3% in Cheshire & Merseyside, 5.2% in England in 2023), although overall numbers are relatively small (1200 people). Rates in hospices do appear to fluctuate from year to year and from hospice to hospice; only 2.1% of Wirral deaths occurred in a hospice in 2023, but for Cheshire East it was 5.8%. Again, the Sefton split is interesting, in 2022 the figures were 3.3% for North Sefton and 6.8% for South Sefton. Multiple factors could be behind this variation, including the model of care delivered by a local hospice, availability of hospital and community PEOLC services (including Hospice at Home services), patient preference, socio-economic factors and cultural factors.

Our analysis shows that people who died from Cancer or Dementia were less likely to die in hospital, and those who died from respiratory disease or heart disease were more likely to die in hospital than the overall population.



	Hospital	Home	Care Home	Hospice	Other Places
All deaths (C&M) (2023)	47.5	26.7	19.3	4.3	2.1
Cancer	37.1	34.9	12.7	13.5	1.9
Dementia and Alzheimer disease	22.9	12.9	63.2	0.4	0.7
Ischaemic heart diseases	42.2	43.8	9	0.6	4.4
Chronic lower respiratory diseases	60.4	27.1	9.8	1.1	1.6

We reported earlier that there is a strong correlation between place of death and whether a patient is on the GSF palliative care register. With patients on the register having a much higher chance of dying outside of a hospital setting than those not on the register.



General practice palliative and supportive care registers

The Cheshire and Merseyside End of Life Dashboard ^{xlvi} takes data from General Practice registers using the EMIS and Electronic Palliative Care Coordination Systems (EPaCCS) as well as other Business Intelligence data. The dashboard reports at System, Place, Primary Care Network (PCN) and General Practice level and aims to:

Enable Place Based Partnerships, Primary Care Networks and General Practices:

- Assess how well they are doing at identifying patients in the last year of life and coding this correctly on their system so it can be shared in real-time with those involved with their care.
- Assess how well they are doing at Care Planning for patients in the last year of life and documenting the key elements of this information in a way that is coded and can be shared in real-time with those involved with their care.
- Benchmark themselves against others in the system and monitor how they are progressing over time.

Support the Integrated Care Board and PEOLC Transformation Programme Leads:

Understand which areas are doing well with the metrics and which are not to allow targeting of support to reduce inequalities and sharing of best practice to steer and embed service improvement

- Inform a C&M PEOLC commissioning framework to enable consistent high quality service provision.

Support the Integrated Care System:

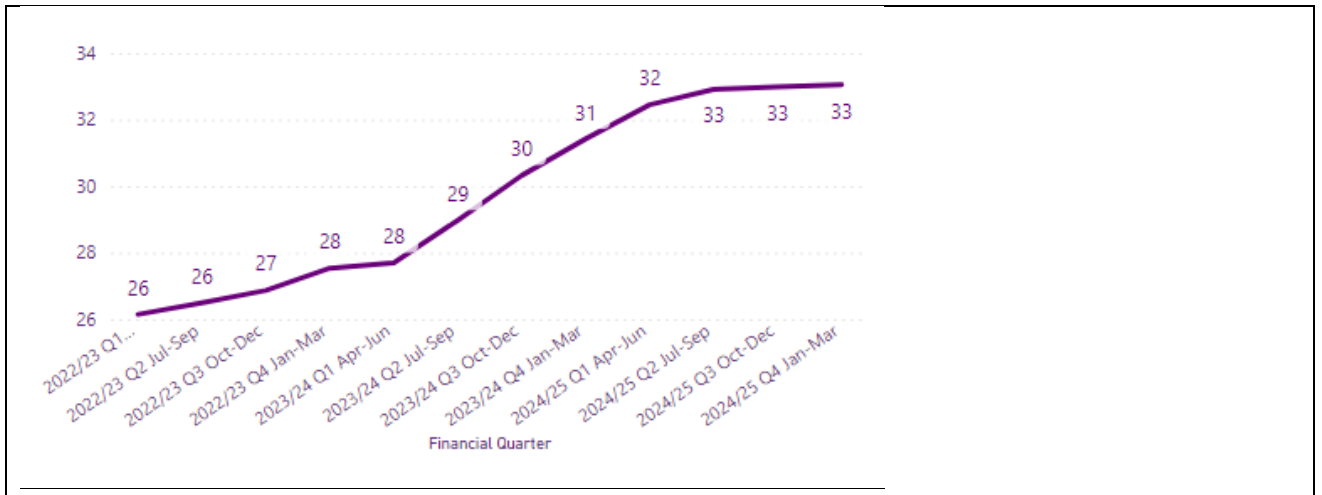
- Improve and be confident in accurate clinical coding.
- Monitor equitable access to high quality palliative and end of life care for all, irrespective of medical condition, diagnosis or where they live.
- Support those delivering clinical care to be confident in Anticipatory Clinical Management Planning including DNACPR clinical decision making, record keeping, communication with patients, relatives and fellow health care professionals.

Early identification

Early identification of patients who may be in the last 12 months of their life is important because it gives people the opportunity to be involved in planning for their future care. This could include thinking about the type of care they would like or would not like, where they would like to be cared for, who should be involved in their care and can help with planning for loved ones. Early identification can help to reduce unnecessary hospitalisation and enable more people to live and die in their preferred place of care.

<https://www.cheshire-epaige.nhs.uk/wp-content/uploads/2023/03/EARLY-Toolkit-V2.0-March-2023.pdf>

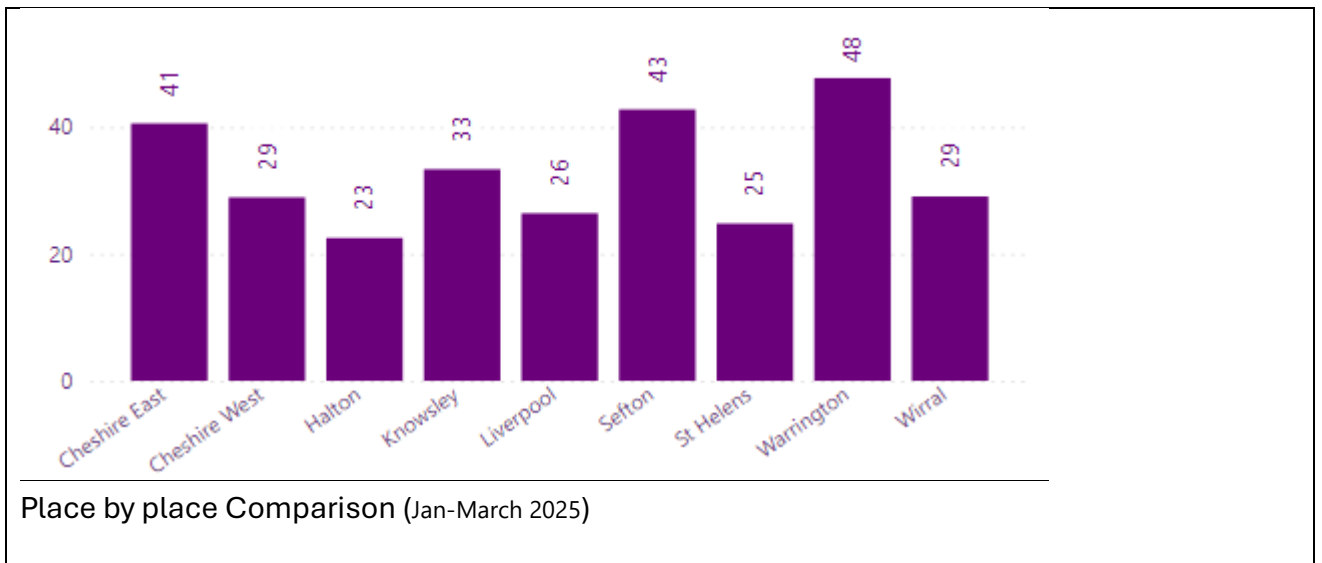
Cheshire and Merseyside ICB have agreed ambitions to identify 60% of people who are likely to be in the last 12 months of life. We can see from the Cheshire and Merseyside End of Life Dashboard that performance against this measure is improving, from 26% in the first quarter of 2022/23 to 33% in the 4th quarter of 2024/25, but that the system remains some way off the 60% ambition.



A place-by-place analysis shows significant differences in performance against this measure, with areas such as Cheshire East, Knowsley, Sefton and Warrington identifying over 40% of people who are likely to be in their last 12 months of life, whereas Cheshire West, Halton, Liverpool, St Helens and Wirral all identifying less than 30%.

Trends in performance for each place as well as practice by practice analysis will be included in place PBNA reports as an appendix to this report.

We recognise that this measure has been retired from the national GP contract^{xlvii} it remains important to local partners and this measure will remain a local priority.

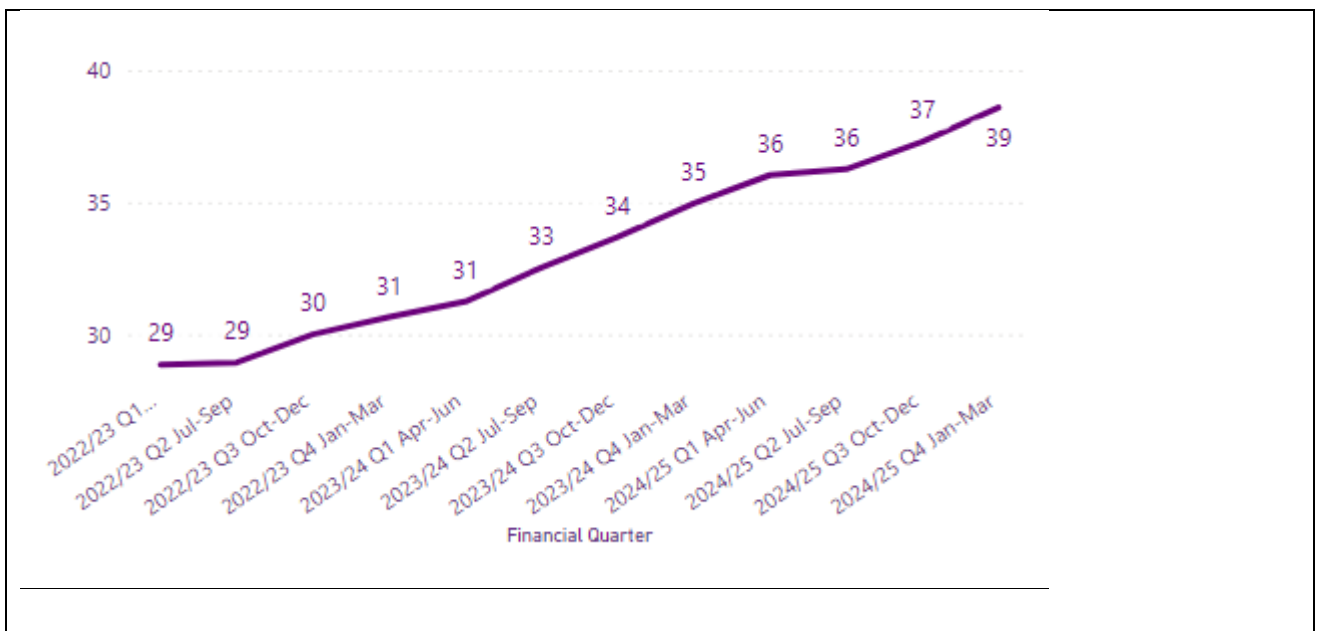


Advance Care Planning

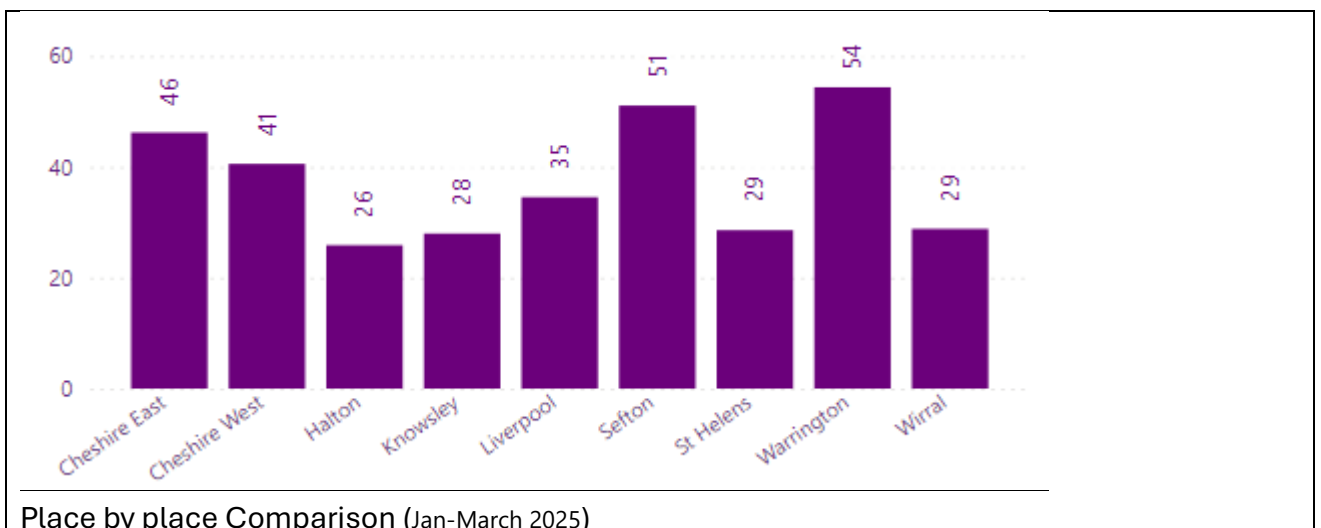
Advance Care Planning (ACP) is a personalised process that emphasises reflection, choice and communication and gives people the chance to think about and write down what is important to them. As part of the process a person might choose to describe the type of care they would like at the end of their life. <https://www.mariecurie.org.uk/professionals/palliative-care-knowledge-zone/advance-care-planning#:~:text=It%20allows%20the%20person%20to,to%20help%20them%20make%20decisions.>

Cheshire and Merseyside ICB have also agreed ambitions for 60% of people who die to have had an Advance Care Plan in place, such plans are important as they allow patients to have more choice and control over what happens to them as more health and care professionals know and are more able to follow their wishes. ACP can improve the quality of end-of-life care and reduce stress, anxiety and depression in surviving relatives. ACP is associated with less time being spent in hospital in the last year of life, people dying in their place of choice and reduced hospital costs ^{xlviii}.

We can see from the Cheshire and Merseyside End of Life Dashboard that performance against this measure is improving, from 29% in the first quarter of 2022/23 to 39% in the 4th quarter of 2024/25, but that the system remains some way off our 60% ambition.



Again, a place-by-place analysis shows significant differences in performance against this measure, with Warrington having care plans in place for more than 50% of those people who have died, whereas areas such as Halton, Knowsley, St Helens and Wirral having care plans in place for less than 30% of those who died.



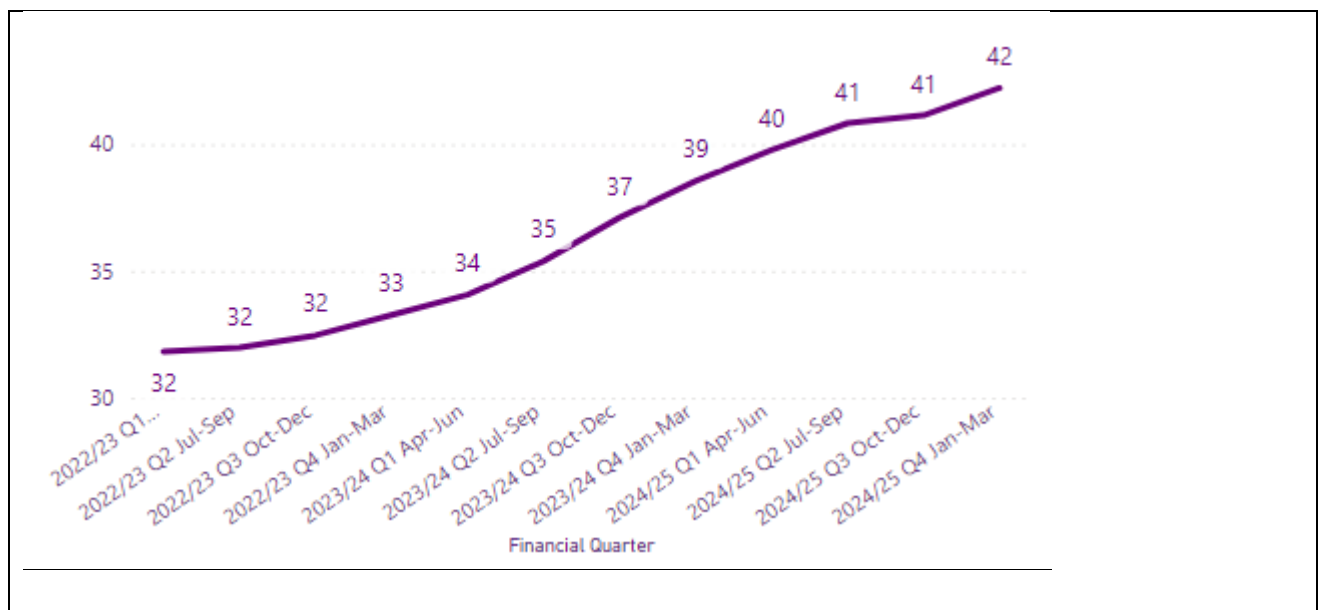
Trends in performance for each place as well as practice by practice analysis will be included in place PBNA reports as an appendix to this report.

DNACPR

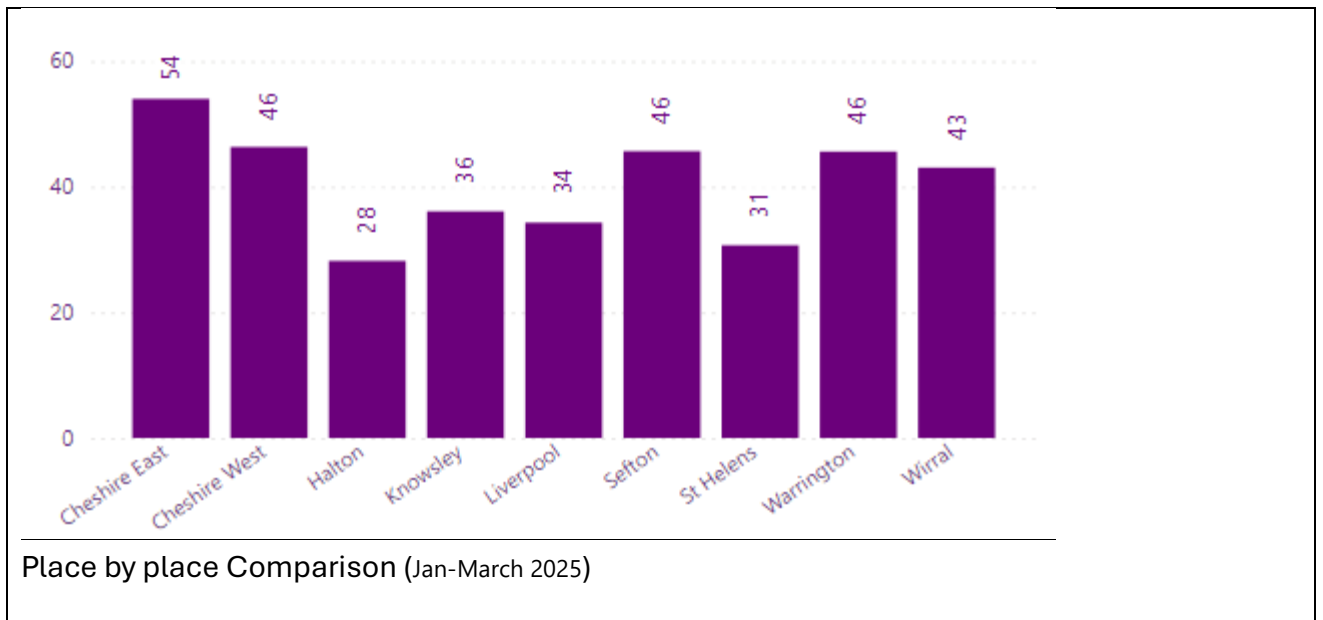
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) is sometimes called DNAR (do not attempt resuscitation) or DNR (do not resuscitate) but they all refer to the same thing. It is a medical directive that instructs healthcare professionals not to perform CPR if a person's heart stops beating or they cease to breathe.

DNACPR ensures that treatment aligns with the patient's wishes and medical needs and plays a crucial role in supporting dignity. Understanding and implementing DNACPR allows patients and their families to focus on comfort, compassion, and meaningful moments during the final stages of life. <https://www.nhs.uk/tests-and-treatments/do-not-attempt-cardiopulmonary-resuscitation-dnacpr-decisions/>

We can see from the Cheshire and Merseyside End of Life Dashboard that performance against this measure is improving, from 32% in the first quarter of 2022/23 to 42% in the 4th quarter of 2024/25, but that overall improvement is slow.



As with GSF and ACP, a place-by-place analysis shows significant differences in performance against this measure, with Cheshire East recording CPR discussions for more than 50% of those people who have died, whereas Halton only has records in place for less than 30% of those who died (Jan-Mar 2025).



Trends in performance for each place as well as practice by practice analysis will be included in place PBNA reports as an appendix to this report.

There are no stated targets (locally or nationally) for the % of people who died who were identified as having a CPR discussion or decision. Ideally, all patients identified under Gold Standards Framework ^{xlix} as likely to be in the last 12 months of life should also have ACP in place and have a CPR discussion or decision, it therefore follows that the logical ambition for DNACPR should be 60%

There are 15 hospitals run by 12 NHS Trusts across Cheshire and Merseyside that provide care for palliative and end of life patients. Patients may be cared for in Accident and Emergency Departments (A&E), or on medical or surgical wards. Many hospitals have specialist palliative care teams, who work alongside and help hospital teams to care for people nearing the end of their life.

Elsewhere in this report we focus on deaths in hospital, A&E attendances and hospital admissions. In this section, we focus on the care provided by hospitals to patients.

National Audit of Care at the End of life

The National Audit of Care at the End of life (NACEL) is a national comparative audit assessing the quality and outcomes of care for dying patients and their families during the final hospital admission leading to death. The audit includes acute hospitals, community hospitals, and mental health inpatient providers in England, Wales and Northern Ireland. The audit involves reviewing data from healthcare records, bereaved persons' surveys, staff surveys, and organisational data.

12 hospitals in Cheshire and Merseyside participate in the NACEL audit. We have compiled data for these hospitals to assess how each hospital performed against the 10 Key Indicators used by NACEL. A table of results for Cheshire and Merseyside is attached as an appendix, the table shows:

1. Half (6 out of 12 hospitals) performed below the national average in terms of **anticipating a person's death** during their final admission.
2. Most scored around average (4) or above (5) for having documented evidence relating to **patient hydration**, only 3 hospitals scored statistically lower than the average.
3. That all hospitals scored around the national average, or higher, for the proportion of people who died with documented evidence in their clinical records that **anticipatory medication** was prescribed for symptoms likely to occur in the last days of life.
4. Emotional needs Most scored around average (5) or above (5) for having documented evidence relating to **the emotional/psychological needs of the patient**, a minority (2) hospitals scored statistically lower than the average.
5. Patient feedback is generally positive – 5 of 10 hospitals scored above the national average for bereaved people **rating care as either Excellent or Good**, with another four scoring close to the national average.
6. The proportion of hospitals offering a **7-day face to face service** shows a split across the system, with all hospitals in Merseyside offering a 7-day service, but no hospitals in Cheshire (including Warrington) offering a 7-day service.
7. In terms of whether bereaved people thought that they were **communicated with in a sensitive way**, most scored in line with the national average (4) or above (4), only one hospital was statistically lower than the national average, and three hospitals provided no score.
8. Individual care plan Eight hospitals scored better than the national average for the proportion of people who died who had an **individualised plan of care**, two were statistically average, and three hospitals were statistically below the average.
9. Generally good scores for hospitals **recording patient ethnicity**.
10. Most (7 out of 11) hospitals scored below the national average for staff thinking there is a **culture that prioritises compassion and support** in all interactions with dying patients.

Whilst this clearly shows some good results in fields such as prescribing anticipatory medication, recording patient ethnicity, sensitive communications and overall ratings for care. The results also highlight potential concerns linked to, identifying patients who are likely to die during their final admission, developing a culture that prioritises compassion and support and a split between Merseyside and Cheshire in terms of the provision of 7-day services.

Aintree hospital, Clatterbridge Cancer Centre, Walton Centre and Arrowe Park hospital generally performed better than the national average across the suite of key indicators. Whereas East Cheshire Trust, Warrington and Halton generally performed below the national average across the suite of indicators.

The NACEL audit is intended to identify areas for improvement in end-of-life care and provides valuable information for local providers to assess their performance and support national reporting. The audit is intended to be an annual exercise, each Trust that participates in the audit is expected to agree an improvement plan.

The 2024 National Audit of Care at the End of Life: State of the Nations Report (2024) was published in August 2025¹ It includes national recommendations on improving personalised care and support planning, and access to specialist palliative care services. Their recommendations include greater oversight of hospital improvement plans by commissioners, and suggests that providers should share their annual NACEL report and recommendations with commissioners and system wide oversight groups within 4 weeks of publications.

Community Specialist Palliative Care Services

We have identified 30 community specialist palliative care teams in Cheshire and Merseyside. It is worth noting that in some areas, some hospital-based teams may also provide specialist-level support to patients in community settings that is not captured below.

	Community SPC Teams
Cheshire East	Central Cheshire Integrated Health Palliative Care in Partnership (Mid Cheshire Hospitals NHS FT) (CCICP)
	East Cheshire Hospice (ECH)
	East Cheshire Trust - Care Community Teams (ECT)
Cheshire West	Central Cheshire Integrated Health Palliative Care in Partnership (Mid Cheshire Hospitals NHS FT)
	Countess of Chester Hospital (COCH)
	Hospice of the Good Shepherd (HOGS)
	St Luke's Hospice
	The West Cheshire Community Specialist Palliative Care Team (Cheshire & Wirral Partnership FT) (WC SPC)
Halton	Halton Community Palliative Care - District Nurses (Bridgewater) (Halton DN)
	Halton Community Palliative Care - Specialist Palliative Care Team (Bridgewater) (Halton SPC)
	Halton Haven Hospice
Knowsley	Knowsley & St Helen's Specialist Palliative Care Team (Mersey Care K&StH)
	Willowbrook Hospice
Liverpool	Community Specialist Palliative Care Service for Liverpool & South Sefton (Mersey Care CSPP)

	Integrated Mersey Palliative Care Team (IMPACT)
	Marie Curie Liverpool
	Woodlands Hospice
St Helens	Knowsley & St Helens' Specialist Palliative Care Team (Mersey Care K&StH)
	Willowbrook Hospice
Sefton	Community Specialist Palliative Care Service for Liverpool & South Sefton (Mersey Care CSPC)
	Integrated Mersey Palliative Care Team (IMPACT)
	Queenscourt Hospice
	Queenscourt Specialist Palliative Care Services (North Sefton) (Queenscourt SPC)
	St Joseph's Hospice
	Woodland's Hospice
Warrington	Bridgewater Community Clinical Nurse Specialists for Palliative Care (Bridgewater CNS)
	St Rocco's Hospice
Wirral	Wirral Hospice
	Wirral Specialist Palliative Care Community Service / End of Life Care Service (WCHCFT)
C&M Wide	Claire House Children's Hospice

Effective community SPC services use a mix of professional groups to offer holistic care to patients at the end of life. In 2016 NHS England identified different components of services that formed the core part of the specialist level service, those that should be available via formal arrangements and those where access to advice or input may be required. ⁱⁱ

We can see from the table below, that palliative medicine consultants and specialist nurses form a core part of almost all teams, and where this isn't the case, most teams can reach out and access support when required.

Trust	Community SPC Teams	Workforce	
		Palliative Medical Consultant	Clinical Nurse Specialist
Cheshire East	CCICP	Core	Core
	ECH	Core	Core
	ECT	Core	Core
Cheshire West	CCICP	Core	Core
	COCH	Core	Core
	HOGS	Core	
	St Luke's Hospice	Core	Core
	WC SPC		Core
Halton	Halton DN	Core	
	Halton SPC	Core	Core
	Halton Haven Hospice	Core	Extended
Knowsley	Mersey Care K&StH	Core	Core
	Willowbrook Hospice	Core	
Liverpool	Mersey Care CSPC	Extended	Core

	IMPACT	Core	Core
	Marie Curie Liverpool	Core	Core
	Woodlands Hospice	Core	Core
St Helens	Mersey Care K&StH	Core	Core
	Willowbrook Hospice	Core	Core
Sefton	Mersey Care CSPC	Extended	Core
	IMPACT	Core	Core
	Queenscourt Hospice	Extended	Extended
	Queenscourt SPC	Extended	Core
	St Joseph's Hospice	Extended	Core
	Woodland's Hospice	Core	Core
Warrington	Bridgewater CNS	Core	Core
	St Rocco's Hospice	Core	Extended
Wirral	Wirral Hospice	Core	Core
	WCHCFT	Extended	Core
C&M Wide	Claire House	Core	Core
	Teams with core component	23	24
	Teams with Core or Extended component	29	27

Physiotherapists, occupational therapists are a core part of approximately half of the teams, and a core or extended element of most. Social workers, psychologists and spiritual care services are less widely available, available in half to two-thirds of all teams.

Trust	Community SPC Teams	Formal Access Arrangements Required				
		Physio-therapist	Occupatio- nal Therapist	Social Worker	Psycholog- ist	Spiritual Care Service
Cheshire East	CCICP	Core	Core			
	ECH	Core	Extended	Extended	Core	Core
	ECT	Core	Core	Extended	Extended	Extended
Cheshire West	CCICP	Core	Core			
	COCH	Extended	Extended			Extended
	HOGS	Extended	Extended	Core		Core
	St Luke's Hospice	Extended	Core	Core	Extended	Core
	WC SPC	Core	Core			
Halton	Halton DN	Extended	Extended			
	Halton SPC	Extended	Extended			
	Halton Haven Hospice	Extended	Extended		Core	Core
Knowsley	Mersey Care K&StH	Extended	Extended			
	Willowbrook Hospice	Core	Core	Core		Core
Liverpool	Mersey Care CSPC	Extended	Extended		Extended	
	IMPACT	Core	Core	Core	Core	Core
	Marie Curie Liverpool	Core	Core	Core	Core	Core
	Woodlands Hospice	Core	Core	Core	Extended	Extended
St Helens	Mersey Care K&StH	Extended	Extended			
	Willowbrook Hospice	Extended	Core	Core	Extended	Core
Sefton	Mersey Care CSPC	Extended	Extended		Extended	

	IMPACT	Core	Core	Core	Extended	Extended
	Queenscourt Hospice	Core	Core	Core	Extended	Extended
	Queenscourt SPC	Core	Core	Core	Extended	Extended
	St Joseph's Hospice	Extended	Extended	Extended	Extended	Extended
	Woodland's Hospice	Core	Core	Core	Extended	Extended
Warrington	Bridgewater CNS	Extended	Extended			
	St Rocco's Hospice	Core	Core	Extended		Core
Wirral	Wirral Hospice	Core	Core	Core	Extended	Core
	WCHCFT	Core	Core	Core	Extended	Extended
C&M Wide	Claire House	Core	Extended	Extended	Core	Extended
Teams with core component		17	17	13	5	10
Teams with Core or Extended component		30	30	18	18	20

Around two-thirds of all teams report having access to a dietician, pharmacist and specialist pain management.

Trust	Community SPC Teams	Formal Access to Advice and Input Required		
		Dietician	Pharmacist	Specialist Pain Management
Cheshire East	CCICP	Core		
	ECH		Core	Core
	ECT	Extended	Core	Extended
Cheshire West	CCICP	Core		
	COCH			
	HOGS	Extended	Extended	
	St Luke's Hospice	Extended	Core	Core
	WC SPC			
Halton	Halton DN			Extended
	Halton SPC			Core
	Halton Haven Hospice	Extended	Extended	Core
Knowsley	Mersey Care K&StH	Extended		
	Willowbrook Hospice		Core	
Liverpool	Mersey Care CSPC	Extended	Blank	Blank
	IMPACT	Extended	Core	Extended
	Marie Curie Liverpool	Extended	Core	Extended
	Woodlands Hospice	Extended	Core	Extended
St Helens	Mersey Care K&StH	Extended		
	Willowbrook Hospice	Extended	Core	
Sefton	Mersey Care CSPC	Extended	Blank	Blank
	IMPACT	Extended	Core	Core
	Queenscourt Hospice		Core	Core
	Queenscourt SPC		Core	Core
	St Joseph's Hospice	Extended	Core	Extended
	Woodland's Hospice	Extended	Core	Extended
Warrington	Bridgewater CNS		Extended	Core
	St Rocco's Hospice	Extended	Extended	Extended

Wirral	Wirral Hospice	Extended	Core	Core
	WCHCFT	Core	Extended	Extended
C&M Wide	Claire House	Extended	Extended	Core
Teams with core component		3	14	10
Teams with Core or Extended component		21	20	19

Teams reported the availability of several other service components. Education / training / information services, Bereavement services, financial advice and complementary therapy services are available in around two-thirds of all teams. With Lymphoedema specialists, night sitting and rapid response available in fewer teams.

Trust	Community SPC Teams	Other Service Components						
		Financial Advice	Lymphoedema Specialist	Education/Training/Information	Bereavement Support	Complementary Therapy	Night sitting	Rapid Response
Cheshire East	CCICP		Core			Core	Core	
	ECH	Extended	Core	Core	Core	Core	Core	Core
	ECT	Extended	Extended	Extended	Extended	Extended	Extended	Core
Cheshire West	CCICP		Core			Core	Core	
	COCH							
	HOGS				Core	Core		
	St Luke's Hospice	Core	Core	Core	Core	Core		
	WC SPC							
Halton	Halton DN	Extended		Extended			Extended	
	Halton SPC	Extended		Core			Extended	
	Halton Haven Hospice			Core	Core	Core	Extended	
Knowsley	Mersey Care K&StH			Core	Extended			Extended
	Willowbrook Hospice	Extended		Core	Core	Extended		
Liverpool	Mersey Care CSPC	Blank	Extended	Core	Core	Blank	Blank	Extended
	IMPACT	Core	Extended	Core	Core	Core	Core	Core
	Marie Curie Liverpool	Core	Extended	Core	Core	Core	Core	Extended
	Woodlands Hospice	Core	Extended	Core	Core	Core	Core	Core
St Helens	Mersey Care K&StH			Core	Extended			Extended
	Willowbrook Hospice	Extended		Core	Core	Extended		
Sefton	Mersey Care CSPC	Blank	Extended	Core	Core	Blank	Blank	Extended
	IMPACT	Core	Extended	Core	Core	Core		
	Queenscourt Hospice	Extended		Core	Core	Core	Core	

	Queenscourt SPC	Extended		Core	Core			
	St Joseph's Hospice	Core	Extended	Extended	Core			
	Woodland's Hospice	Core	Extended	Core	Core	Core	Core	Core
Warrington	Bridgewater CNS	Extended		Core				
	St Rocco's Hospice	Extended	Extended	Core	Core	Core		Extended
Wirral	Wirral Hospice	Core	Extended	Core	Core	Core	Core	Core
	WCHCFT	Extended	Extended	Core	Extended	Extended	Extended	Extended
C&M Wide	Claire House	Extended	Extended	Core	Core	Core	Extended	Core
Teams with core component		8	4	22	19	15	9	7
Teams with Core or Extended component		20	17	25	23	19	15	14

We can see from these tables that most of our community teams are able to offer, either as a core function or by extension, most of what was included in the 2016 SPC guidance issued

Feedback also shows that the boundaries between each identified team is somewhat porous, and it might not be so important to specify the split between each, especially when considering whether services are available by extension. Closer partnership working at a place level could increase the availability of these services across more teams to support PEOLC patients.

Continuing Health Care and Fast Track

NHS Continuing Healthcare (CHC) offers fully funded care for individuals who meet specific eligibility criteria ⁱⁱⁱ & ⁱⁱⁱⁱⁱ. This care is provided without means testing, meaning those who qualify are not required to contribute financially. To be eligible, a person must be assessed as having a *primary health need*—a level of care that goes beyond what social care alone can provide. This care package can be delivered in a range of settings, including the person's own home, a care home, or a hospice.

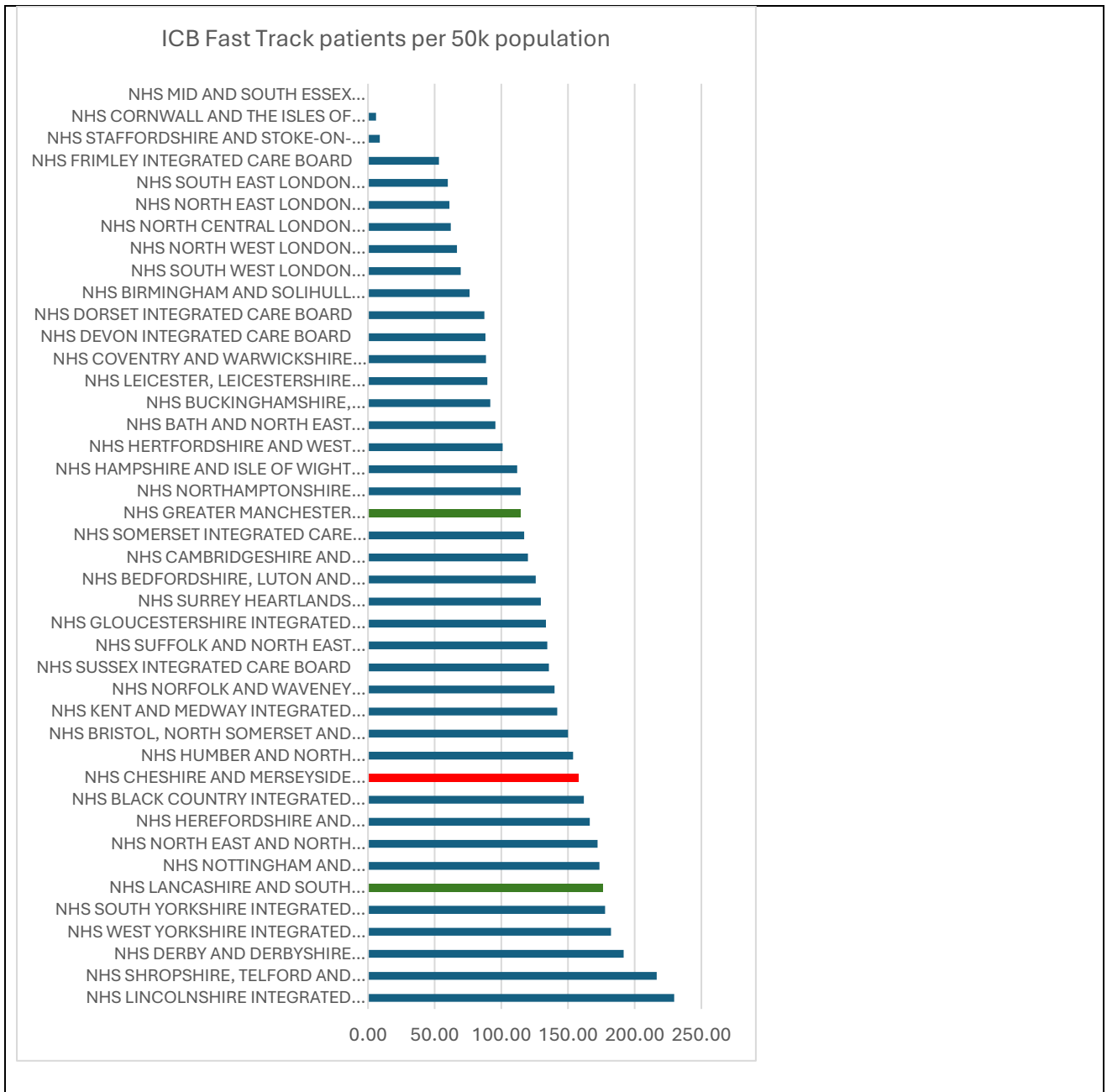
There are two main routes to access CHC:

- **Standard Pathway:** This involves a comprehensive assessment by a multidisciplinary team and can take several weeks to complete.
- **Fast Track Pathway:** This can be initiated by a single healthcare professional ('appropriate clinician') and is designed to be implemented quickly. It is intended for individuals with rapidly deteriorating conditions, often approaching the end of life.

CHC is available for all age groups (and is frequently referred to as "All Age Continuing Health Care") however the majority of those eligible are older people and likely to include large concentrations of people aged over 85.

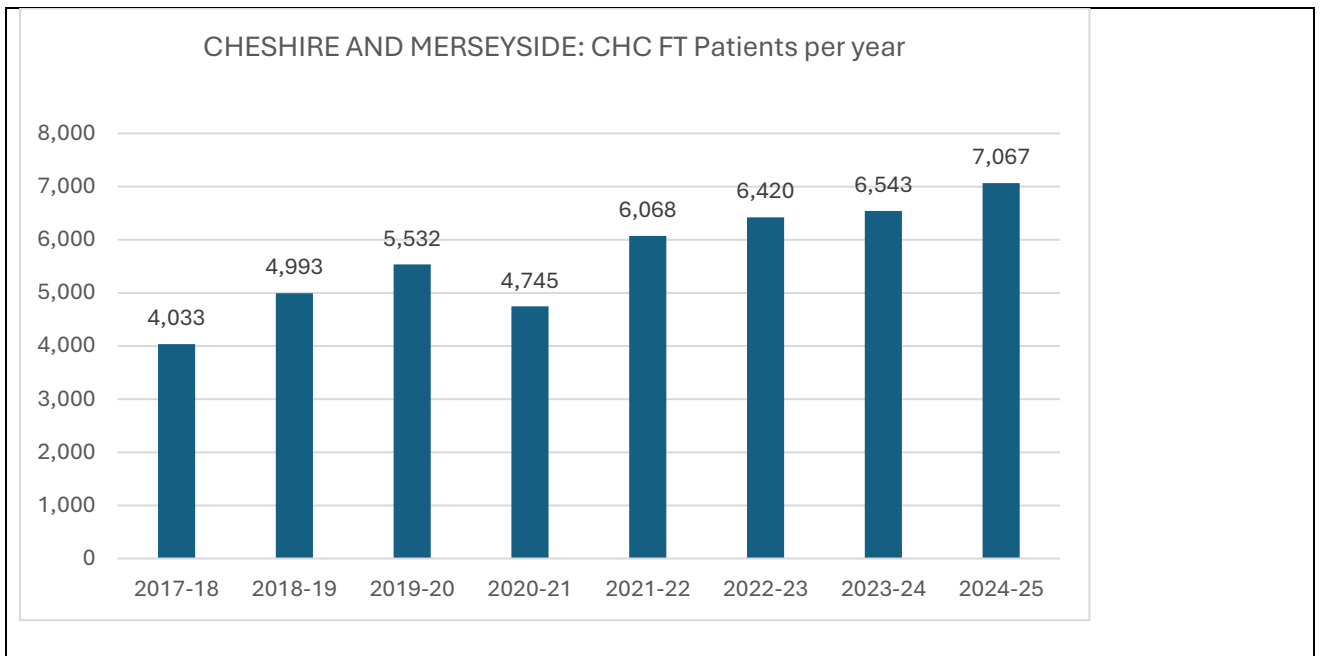
Age UK and the Nuffield Trust both report that recent increases in the numbers of recipients of CHC are made up entirely by new Fast Track recipients (which have risen by 30.9% from April 2017 to December 2024) and suggest that these rates may be accelerating ^{liv} & ^{lv}. Both also highlight significant variation across the country where eligibility for Fast Track CHC can vary between different ICBs, rates in the North West of England are higher than the rest of England

Analysis of NHS England data ^{lvi} shows that in 2024/25 Cheshire and Merseyside ICB were ranked 11th (out of 42) for the proportion of patients eligible for Fast-Track CHC, North West neighbours in Greater Manchester and Lancashire & South Cumbria are also highlighted.

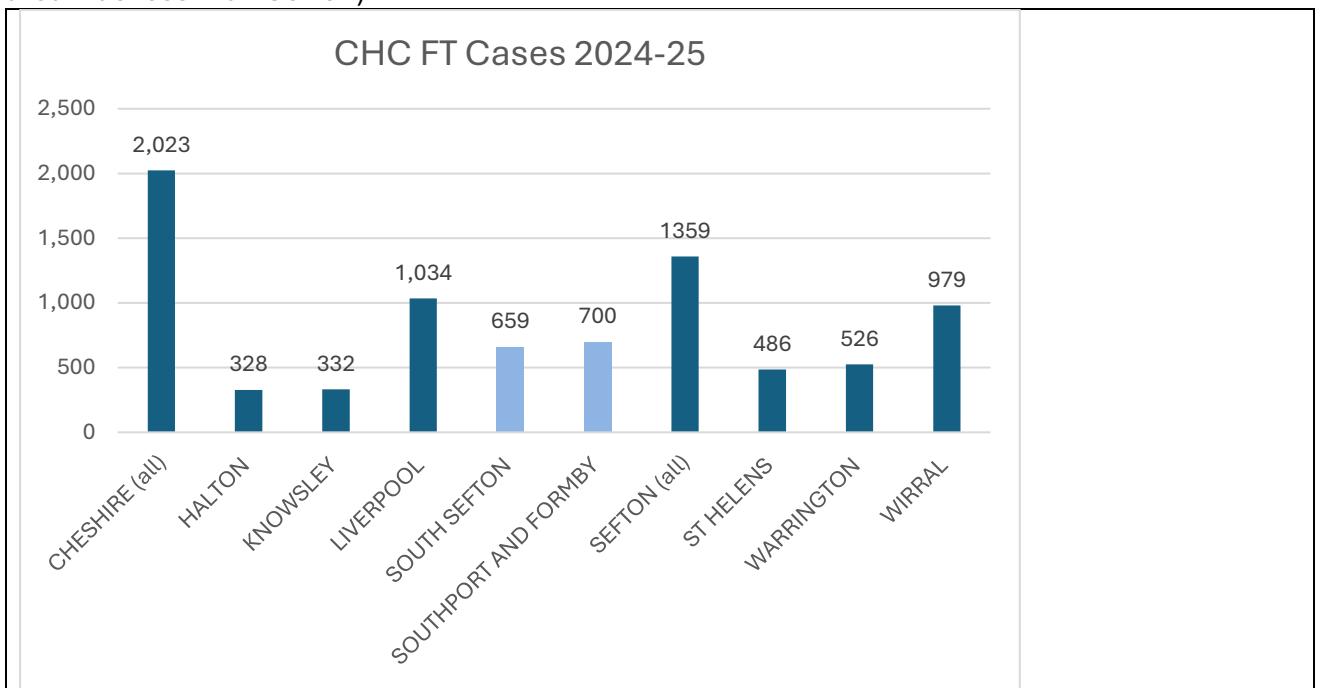


Nuffield show that between 2017/18 and 2022/23, fast-track CHC spending increased at a faster rate than overall CHC spending, growing by more than 55% in real terms, and state that this reflects the rising number of individuals qualifying for this type of care.

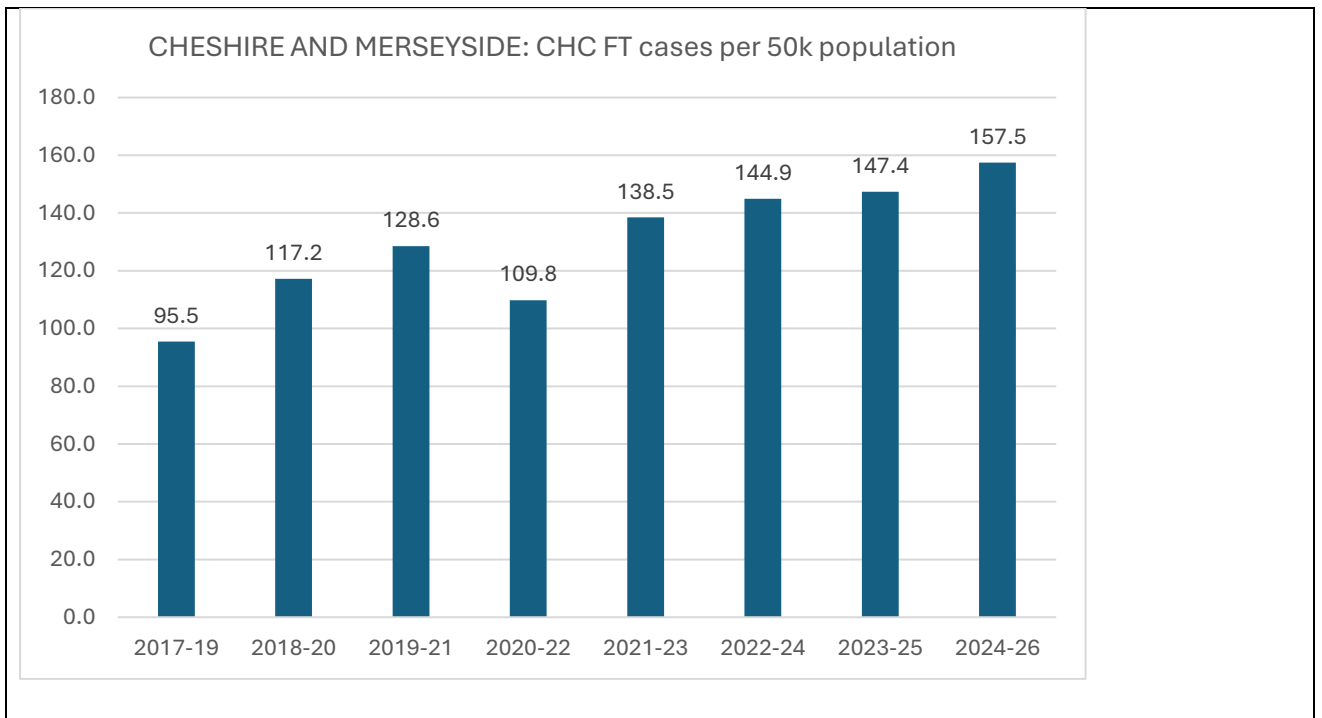
Analysis of NHSE data for Cheshire and Merseyside shows a 75% rise in Fast Track since 2017. 7,067 patients in 2024/25 represents around one-quarter (25.9%) of all deaths in Cheshire and Merseyside that year.



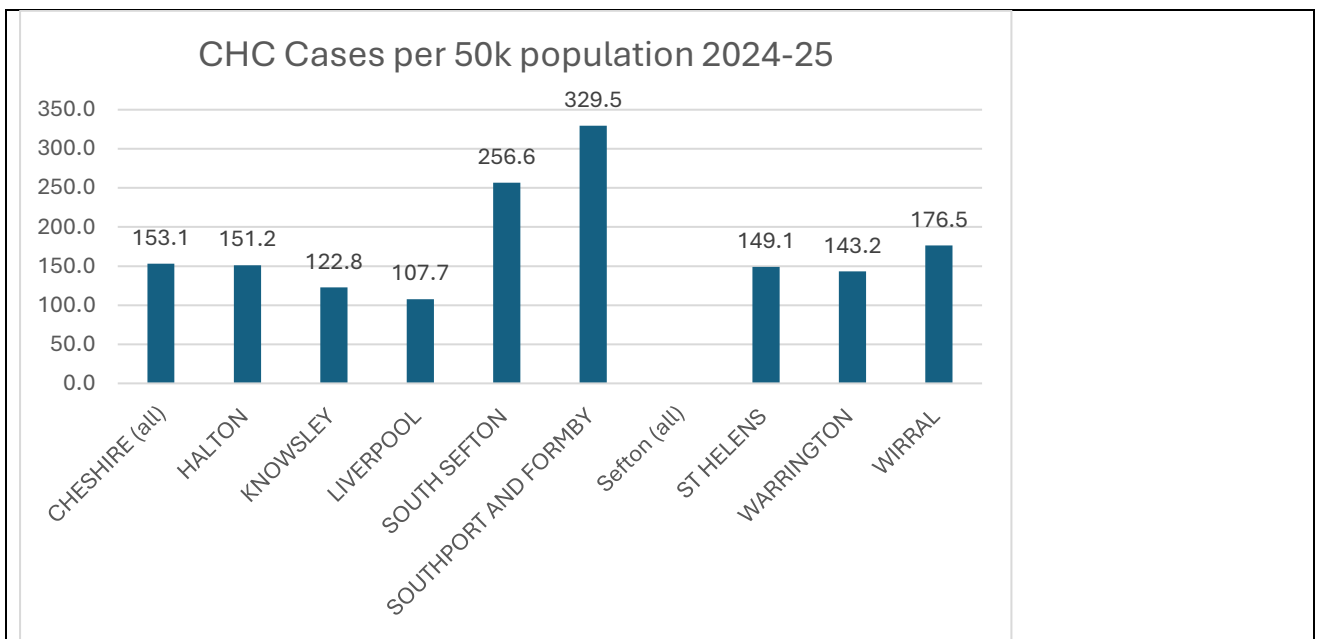
NHS England provide data based on the old CCG footprints rather than the localities the ICB currently operates. Data for 2024 shows that Cheshire (both East and West) and Sefton (all) are the areas that use Fast Track the most (although a Cheshire East / West split would show each area was less than Sefton).



The number of cases per head of 50,000 population across Cheshire and Merseyside has increased by approximately 65% since 2017.



When considering the cases per head of 50,000 population, South Sefton and Southport & Formby are by far the largest users of Fast Track (it has not been possible to calculate an average for the whole borough).



Some contributors to the Nuffield research suggested that variation in referrals and expenditure could be linked to factors such as the need to discharge patients from hospital, and the general organisation of palliative and end of life care services in any local area. Any local assessment of this data will need to consider these factors.

Care Home Provision

For many people, especially older people with long term conditions such as dementia, a care home may be their permanent home, their normal place of residence, others may stay in a care home temporarily whilst recovering from illness or following a stay in hospital.

The British Geriatrics Society state that the average life expectancy for someone living in a residential care home is 24 months, and for nursing homes it is 12 months ^{lvii}, of course, included within these figures are people who may enter a home with one or more rapidly deteriorating medical conditions as well as those who live in a care home for much longer. In line with GSF guidance ^{lviii}, it follows that all care home residents should be considered for end of life care, but it should be recognised that not all will need it straight away.

Around 70% of people living in care homes have dementia ^{lix} many will have other long-term conditions and have complex packages of care.

Across Cheshire and Merseyside 19.3% of all deaths took place in a care home in 2023, this is slightly lower than the England average of 21%. Some estimates suggest that by 2040, a combination of increasing numbers of deaths, and increasing number of deaths of people aged 85+ or from dementia, the most common place of death will be in a care home, and that overall provision of care homes needs to double by 2040 ^{lx}.

There are around 14,500 care homes in England with an estimated 453,000 residents. Around 70% of care homes offer residential care, while nursing homes make up the remaining 30% of care homes ^{lxi}. The ratio is slightly different in Cheshire and Merseyside where there are 646 care homes registered with the Care Quality Commission; 382 (60%) providing residential care and 264 (40%) nursing homes, with over 23,000 beds ^{lxii}.

1st March 2024	Care Homes		Residential only care homes*		Nursing Homes*	
Local authority	Care Homes	Number of care home beds	Care Homes	Number of care home beds	Care Homes	Number of care home beds
Cheshire East	102	4,576	53	1,605	49	2,971
Cheshire West and Chester	80	3,051	35	924	45	2,127
Halton	26	807	18	432	8	375
Knowsley	25	1,034	14	348	11	686
Liverpool	85	3,378	45	1,210	40	2,168
Sefton	121	3,595	86	1,907	35	1,688
St. Helens	40	1,359	27	674	13	685
Warrington	55	1,976	34	614	21	1,362
Wirral	112	3,411	70	1,403	42	2,008
Cheshire and Merseyside	646	23,187	382	9,117	264	14,070
North West	1,845	61,558	1,237	30,127	608	31,431
England	14,587	453,423	10,366	232,810	4,221	220,613

Source: CQC HSCA Active Locations as of 1st March 2012, 1st March 2023, and 1st March 2024. Excludes dormant care homes. Accessed 24th July 2025.

Please note: Some nursing homes also provide residential care services. For this purpose, nursing homes which also provide residential care services have been classified as a nursing home.

Residential only care services contains care homes which only exclusively provide residential care.

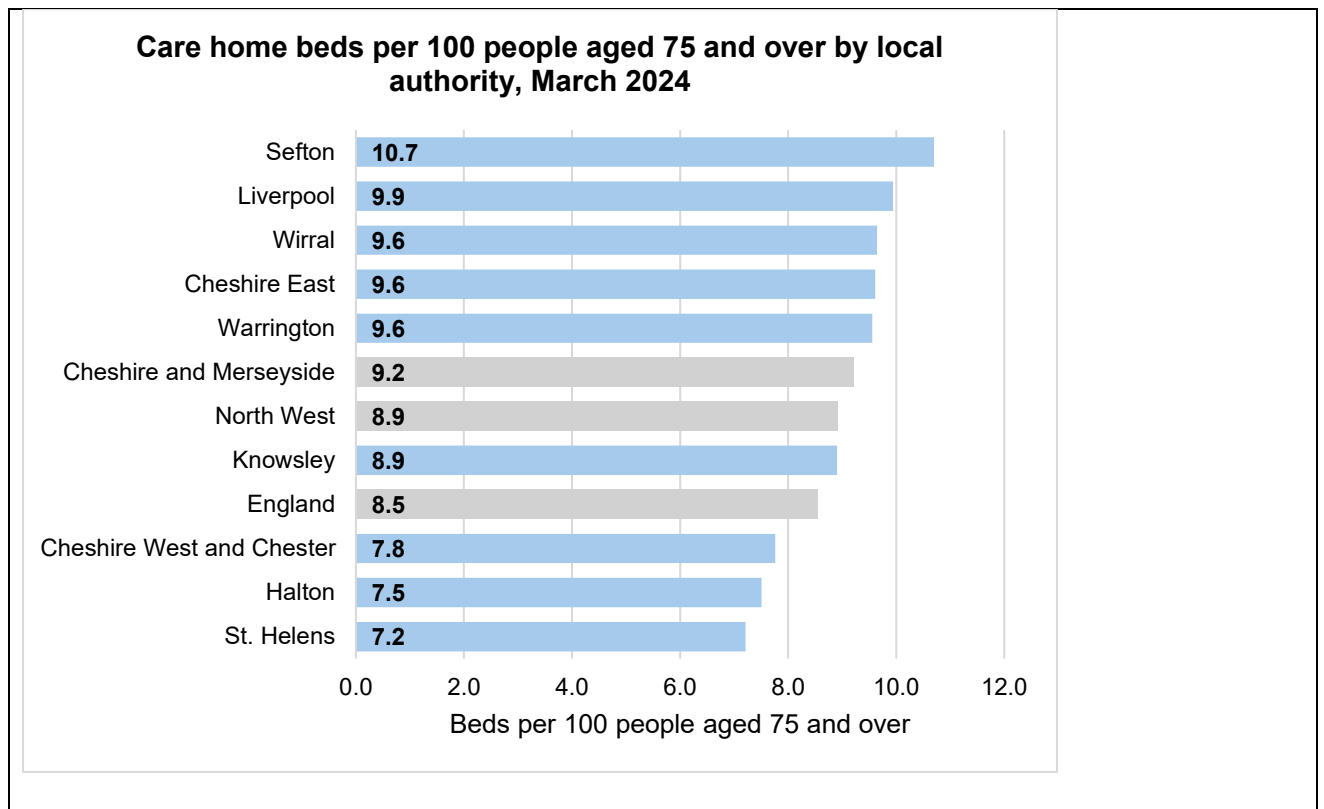
Care Homes is the total number of care homes including both residential and nursing homes.

Comparing the availability of care home beds for the local over 75 population is seen as a good indicator of the capacity of the local system to care for the needs of an aging population by supporting people in the community. The data is published regularly by the ONS in their End of

Life Profiles ^{lxiii} and monitored (nationally) by the Nuffield Trust over time. Nuffield have seen that national capacity has fallen by 13.5% between 2013 and 2023 ^{lxiv}.

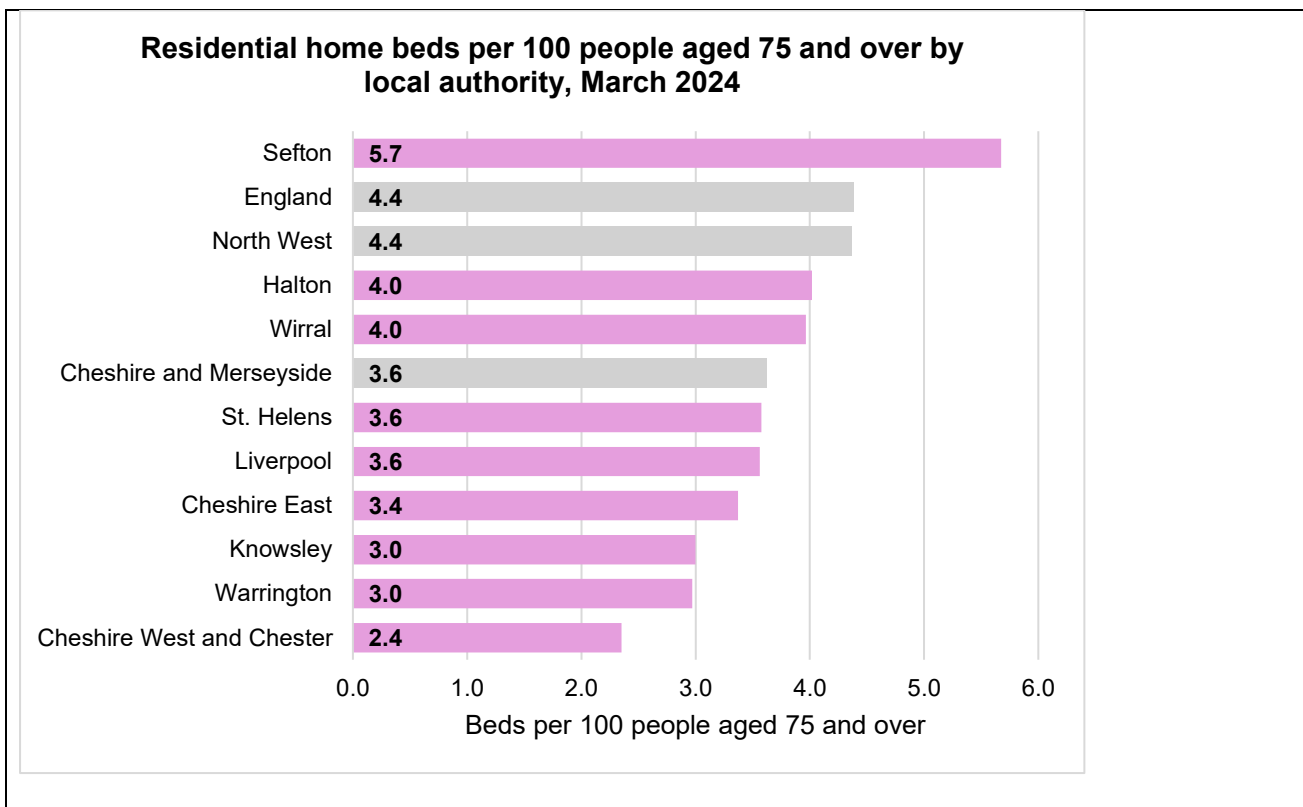
Locally we can see a fall of 12.8% in the overall availability of care home beds in Cheshire and Merseyside between 2012 and 2023; this combines a fall of 17.9% of residential care home beds and a rise of 4% in nursing home beds.

Understanding local variation is important in understanding local needs and our capacity to respond to growing demand and the need for community-based services.



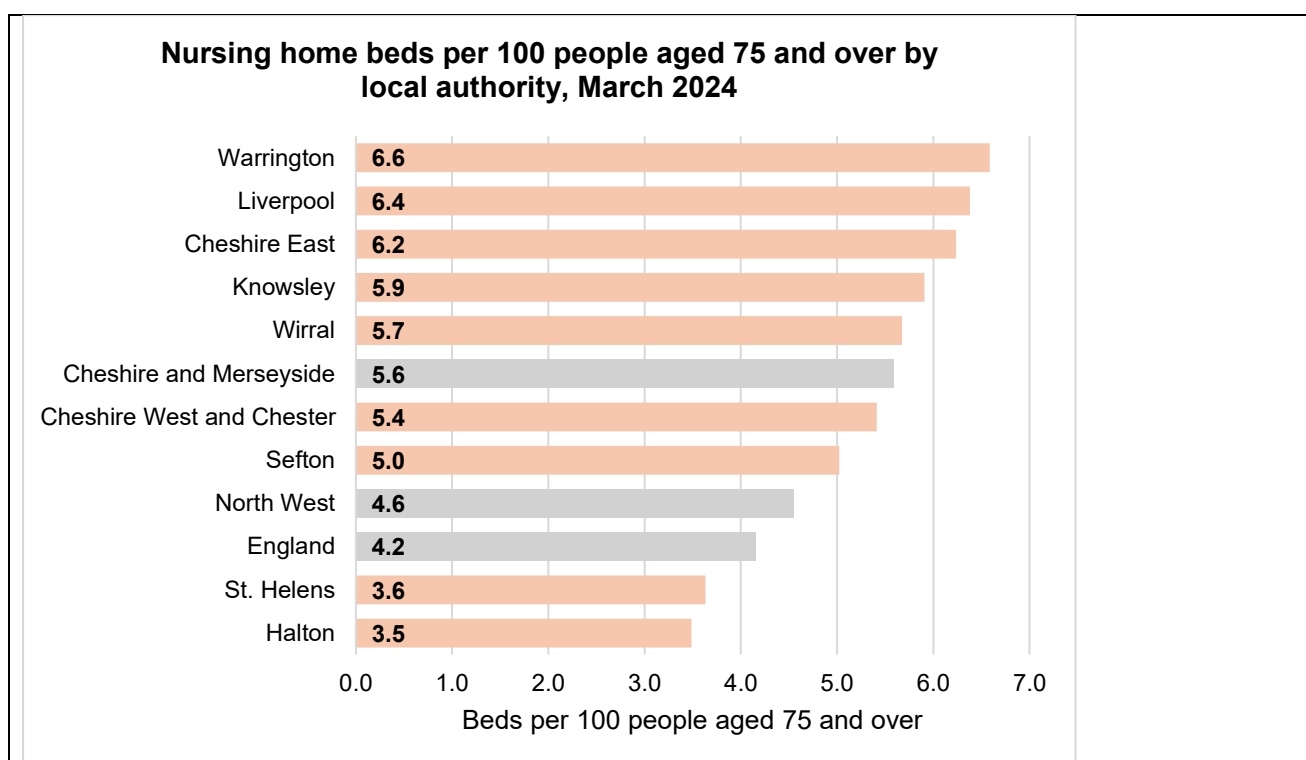
Overall, across Cheshire and Merseyside we can see that there are 9.2 care home beds per 100 people over 75 and that this is higher than the national average of 8.5. However, we can also see that localities such as St Helens, Halton, and Cheshire West & Chester are all below the England average.

To rise to the national average, an additional 245 beds would be required for St Helens, 100 beds in Halton, and Cheshire West & Chester would require 270 beds.



Similarly, we can see that 3.6 residential care home beds per 100 people over 75 and that this is lower than the national average of 4.4. We can see that six localities are lower than the national average.

To rise to the national average, an additional 2,000 residential care home beds would be required across Cheshire and Merseyside. Individual localities would require the following: St Helens 150, Liverpool 270, Cheshire East 470, Knowsley 162, Warrington 286 and Cheshire West 770.



Overall, across Cheshire and Merseyside we can see that there are 5.6 nursing home beds per 100 people over 75 and that this is higher than the national average of 4.2. However, as above, we can also see that Halton and St Helens are below the England average.

To rise to the national average, an additional 75 nursing beds would be required for Halton, and 115 beds in St Helens.

Hospice Provision

Hospices aim to improve the lives of people who have an incurable illness. They provide care for people from the point at which their illness is diagnosed as terminal to the end of their life, however long that may be. Hospices place a high value on dignity, respect and the wishes of the person who is ill. They aim to look after their medical, emotional, social, practical, psychological, and spiritual needs, and the needs of the person's family and carers. Care also extends to those who are close to the patient, as well as into the bereavement period after the patient has died.

Cheshire & Merseyside ICB commission hospice services from the following providers:

Hospice	Serving
Claire House Children's Hospice	Cheshire & Mersey +
Douglas Macmillan Hospice	Cheshire East
East Cheshire Hospice	Cheshire East
Halton Haven Hospice	Halton
Hope House Children's Hospice	Cheshire West
Hospice of the Good Shepherd	Cheshire West
Marie Curie (Liverpool)	Liverpool
Queenscourt Hospice	Sefton
St Anns Hospice/Pal Care	Cheshire East
St Joseph's Hospice	Sefton
St Luke's Hospice	Cheshire East and West (Central)
St Rocco's Hospice	Warrington
Willowbrook Hospice	Knowsley & St Helens
Wirral Hospice St John's	Wirral
Woodlands Hospice	Liverpool & Sefton
Zoe's Place Baby Hospice	Liverpool

Benchmarking the delivery of Hospice services is not a straightforward exercise: hospices offer a range of services, e.g. Inpatient, medical outpatient clinics, palliative and end of life advice lines (for professionals and patients/carers), community and acute in reach, hospice at home, virtual ward, specialist education and training to the wider community, bereavement support/counselling/psychological support and hospices can have geographies that do not align to NHS commissioning boundaries.

The following sections will consider provision and availability of palliative care beds, referrals, admissions and hospice funding.

Palliative Care Beds

In 2012, the National Council for Palliative Care published “Commissioning guidance for specialist palliative care”^{lxv} which made a recommendation for a minimum of 20-25 SPC inpatient beds for a population of 250,000 – these figures are widely used and correspond with recommendations made by the Association of Palliative Medicine and the European Association for Palliative Care in 2020^{lxvi}.

These recommendations suggest that the population of Cheshire and Merseyside (2.78m people registered with a GP) should be served by between 222 and 278 SPC beds.

There are 153 Palliative Care inpatient beds serving the Cheshire and Merseyside population. 141 of these beds are provided by hospices and 12 by NHS hospitals. 143 of these are for adults and 10 for children and young people. Not all of these beds should be classed as “specialist” for a variety of reasons such as whether the service is led by a consultant in palliative medicine, whether there is full specialist multi-professional team supporting the patient or whether all types of specialist services^{lxvii} are available.

Provider	Inpatient Beds	Additional commentary
Children’s Palliative Care Beds		
Claire House Children’s Hospice)	10	Claire House provide inpatient beds for children and young people
Adult Specialist Palliative Care Beds		
East Cheshire Hospice	15	
Halton Haven Hospice	10	
Hospice of The Good Shepherd	10	
Queenscourt Hospice	6	Queenscourt Hospice has a total of 10 beds, nominally six are for Merseyside patients, four are for patients from West Lancashire
St Luke’s Hospice	10	
St Rocco’s Hospice	10	
Willowbrook Hospice	10	
Wirral Hospice St John’s	14	
Woodlands Hospice	15	Woodlands Hospice has 14 inpatient beds, plus one ambulatory bed. These beds are staffed by NHS staff from LUHFT.
Adult Enhanced End of Life Beds		
St Josephs Hospice	31	St Joseph’s operate a nurse led service, as such, beds should not be considered as “specialist”, the term “enhanced” may be more appropriate.
Acute Palliative Care Beds		

Royal Liverpool University Hospital (NHS)	8	Hospital NHS PC beds do not have 24/7 SPC cover and do not offer the types of specialist level care offered by hospices.
Arrowe Park Hospital, Wirral (NHS)	4	Hospital NHS PC beds do not have 24/7 SPC cover and do not offer the types of specialist level care offered by hospices.
Total beds	153	

We recognise that not all of the Palliative Care beds listed above should be seen as “Specialist”, but still, 153 beds represents a potential deficit across Cheshire and Merseyside of between 69 and 125 beds compared to the recommended standards.

It is difficult to break this figure down for each place because the populations served by each facility are not strictly aligned to place boundaries. However, an assessment for the needs of Cheshire and of Merseyside separately could be helpful.

Cheshire Assessment (Cheshire Devolution footprint)	
Total population of Cheshire East, Cheshire West and Chester, and Warrington.	1,041,658
PC beds	
East Cheshire Hospice	15
Hospice of The Good Shepherd	10
St Luke’s Hospice	10
St Rocco’s Hospice	10
Claire House	5
Total	50
Recommended number of beds for total population	83-104
Deficit of SPC beds for the Cheshire Devolution area	33-54

Liverpool City Region Assessment	
Total population of Halton, Knowsley, Liverpool, Sefton, St Helens and Wirral.	1,746,772
PC beds	
Halton Haven Hospice	10
Queenscourt Hospice	6
Willowbrook Hospice	10
Wirral Hospice St John’s	14
St Josephs Hospice	31
Woodlands Hospice	15
Claire House (Children & Young People)	5
Royal Liverpool Hospital (NHS Hospital)	8
Arrowe Park (NHS Hospital)	4
Total	103
Recommended number of beds for total population	139-175
Deficit of SPC beds for the Liverpool City Region area	36-72
Removing St Joseph’s beds as non-specialist would increase this deficit to 67 – 103 for the Liverpool City Region	

It may be worth noting that Hospice UK state that there are 2200 hospice beds in England, serving a population of 56,500,000. This equates to only 39 beds per million – around half of the recommended standards cited above. This would suggest that Cheshire and Merseyside, whilst not meeting the recommended standards, are better served by palliative care beds than most places in England.

At the time of producing this report a decision had been taken to permanently close the inpatient unit at Marie Curie (Liverpool) hospice, this represents the permanent loss of 13-18 specialist inpatient beds from the local system (this is already factored into the assessments above). Liverpool Place have recognised the importance of ensuring sufficient Palliative Care beds and is working to ensure the beds lost due to the closure of the inpatient unit at Marie Curie (Liverpool) are replaced with appropriately staffed and resourced beds within the local health system.

The need for more community and home based SPC is evident from the high impact of current service provision, and previous pilots which could not continue due to a lack of funding. The sector highlights the risk of losing more beds and services due to funding issues.

Hospice at Home

In addition to the bed recommendations above, the European Association for Palliative Care also make recommendations for the numbers of staff working in community teams ranging from 40 to 50 per million people served.

The National Association of Hospice at Home describe Hospice at home as “an integral component of community end of life care bringing the skills, ethos and practical care associated with the Hospice movement into the home environment; putting the patient and those who matter to them at the centre of the care”^{lxviii}. Some Cheshire and Merseyside Hospices currently offer Hospice at Home; East Cheshire Hospice, Wirral Hospice St John’s, Marie Curie (Liverpool), Woodlands Hospice, Queenscourt Hospice and Claire House Children’s Hospice.

In addition, some offer a “Hospice in Your Care Home” service (St Lukes, East Cheshire, St Rocco’s, Wirral, Woodlands, Queenscourt).

A breakdown of the community-based services offered by each hospice in each place is included in the community services section above. It is likely that place of death data will include people who have been supported to die at home with care provided by a hospice where such services are offered, but that information has not been separated out in place of death data.

Hospice activity

12 hospices in Cheshire & Merseyside cooperate as the Cheshire and Merseyside Hospice Provider Collaborative. We are grateful to the collaborative for providing detailed management information on issues such as, total registered in-patient beds, occupancy, referrals, and length of stay in support of this report. A copy of the current (June 2025) Hospice Collaborative Catalogue of Services is attached as an appendix.

Although the ICB has contracts with 16 hospices, the 12 members of the collaborative represent most of the hospice activity for the local population. Of the remaining four, three are outside of Cheshire and Merseyside and only support a small number of people who live on the outer borders of Cheshire and Merseyside, and one is a specialist unit for babies that offer respite, therapies and bereavement care to families.

The following table sets out key performance data such as the available beds days, occupancy, number of admissions, average length of stay and overall utilisation rates for all 11 adult hospices in Cheshire and Merseyside.

Cheshire and Merseyside Hospice Bed Utilisation Analysis 2024/25					
Name of Hospice	Available bed days	Occupied Bed Days	Admissions	Average Length of Stay (days)	Utilisation Rate (%)
East Cheshire Hospice	5475	3621	290	11.7	66.1%
Halton Haven Hospice *Ave as bed availability fluctuated	3070	1842	113	16.3	60.0%
Hospice of The Good Shepherd *ave as bed availability fluctuated	4380	847	72	12.6	19.3%
Marie Curie (Liverpool) *service restrictions 24/25. Service closed July 2025	6570	n/a	n/a	n/a	n/a
Queenscourt Hospice *Based on 6 C&M beds only	2190	1737	142	11.3	79.3%
St Josephs Hospice	11315	no data	191	no data	no data
St Lukes Hospice	3650	2704	194	13.3	74.1%
St Rocco's Hospice	3650	2729	154	17.6	74.8%
Willowbrook Hospice *Average Occupied bed days used Apr to Sept 24	3650	2891	197	14.3	79.2%
Wirral Hospice St John	5110	3457	199	17.4	67.7%
Woodlands Hospice *Average Occupied Bed Days used Apr to Sept 24	5475	4877	275	17.7	89.1%

It should be noted that activity was significantly impacted during 2024/25 due to referral pathway issues and building works at Halton Haven, consultant gaps and CQC oversight at Hospice of the Good Shepherd and the closure of the inpatient unit at Marie Curie (Liverpool) due to staffing and funding issues.

Due to staffing issues, building refurbishment or infection control not all beds are always available, typically 88% of all beds are normally available,

Based on a stable 6-month period of activity extrapolated to 12 months, the 11 Adult Hospices will receive approximately 3000 referrals per annum and admit 2680 patients to inpatient units (IPU). The closure of the inpatient unit at Marie Curie will displace approximately 300 referrals, of which 225 are related to cancer patients and an average of 282 patient admissions.

Referral pathways across Cheshire & Merseyside are different as shown below in the sources of referral into IPU.

Source of Inpatient Referrals										
	East Ches	Halton Haven	HoGS	Marie Curie	Queen scourt	St Lukes	St Rocco	Willow brook	Wirral St J	Wood lands
Acute:	286 (64%)	76 (43%)	40 (24%)	6 (12%)	6 (4%)	132 (36%)	37 (17%)	70 (23%)	118 (37%)	68 (19%)
Community (incl. Macmillan):	2 (0%)	88 (50%)	115 (70%)	9 (17%)	69 (44%)	174 (47%)	26 (12%)	62 (21%)	117 (37%)	34 (9%)

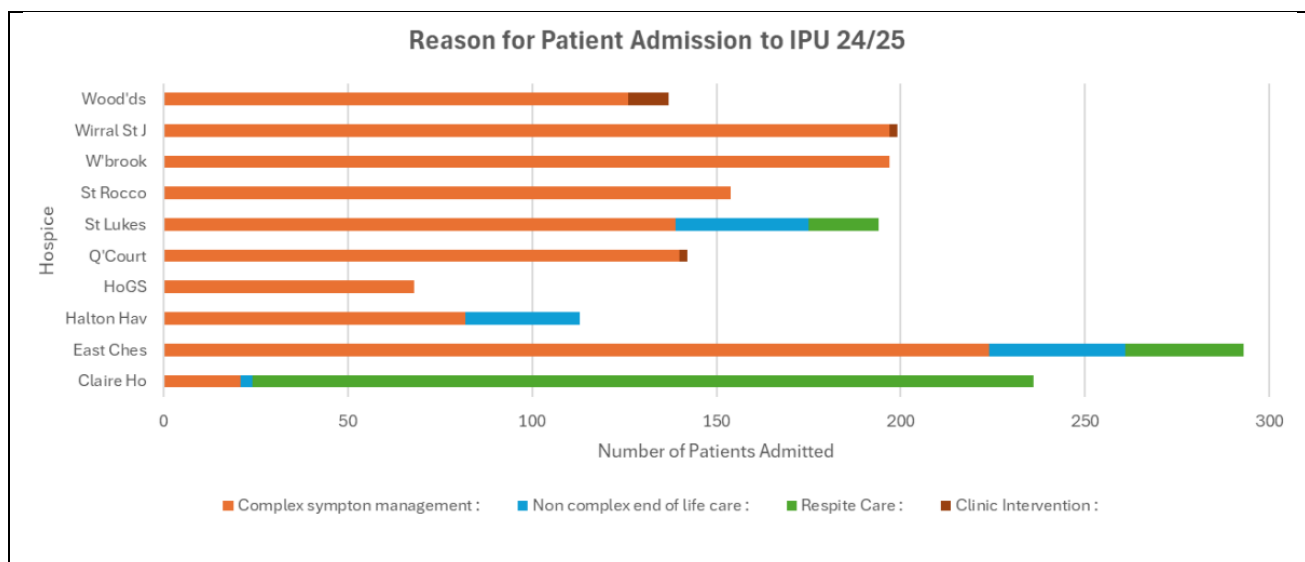
GP:	84 (19%)	10 (6%)	5 (3%)	0 (0%)	58 (37%)	35 (9%)	3 (1%)	16 (5%)	21 (7%)	12 (3%)
Internal:	51 (11%)	0 (0%)	1 (1%)	8 (15%)	23 (15%)	27 (7%)	75 (35%)	10 (3%)	59 (18%)	51 (14%)
Other/not categorised:	23 (5%)	1 (1%)	3 (2%)	29 (56%)	0 (0%)	2 (1%)	71 (33%)	140 (47%)	5 (2%)	193 (54%)
Total	446	175	164	52	156	370	214	298	320	358

Overall, around 33% of referrals to hospices come from Acute Hospitals, 27% from Community teams (eg District Nurses or Macmillan), and 10% from GPs. There is some variation across hospices, most likely linked to their relationships with acute or community providers rather than any underlying population-based issues.

Not all referrals result in a patient being admitted, this could be due to a number of factors including; late referral where the patient is too ill to transfer or has died before admission, the patient does not meet the hospice criteria for care or there is lack of available beds (Hospices would seek the best care for Patients jointly with the Multi-Disciplinary SPC Teams, offering services such as Hospice at Home where service exists).

Around 80% of patients referred to these hospices had a primary cancer diagnosis. This is in line with national figures These figures suggest that that patients with cancer remain disproportionately served by hospice care – and that the experience in Cheshire and Merseyside is in line with the national picture.

Admissions analysis show that most patients are admitted to hospice to support complex symptom management, or to provide end of life care. Approx 30 Patients were discharged and re-referred to the Hospice within a 3-month period, taking pressure off Acute Hospital care.



Average length of stay per patient differs from patient to patient, and from hospice to hospice. The performance tables above show the overall average length of stay for a patient admitted to a Cheshire & Merseyside hospice in 2024/25 (excluding Marie Curie Liverpool and St Joseph's) was 13.6 days – with Marie Curie Liverpool having the lowest at 5 days, but 3 having an average length of stay over 18 days. The Ann Robson Trust state that the average length of stay for patients in hospices across the country is 10 days ^{lxix}

Average Inpatient Unit Length of Stay 24/25													Ave per Hospice
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	
Claire Ho	4	4	4	4	4	4	5	3	3	9	3	2	4.1
ECH	10	11	11	7	7	9	12	12	15	11	12	10	10.6
HHH	16	12	10	11	15	11	11	10	9	12	13	15	12.1
HoGS	16	10	14	14	11	7	17	6	12	13	19	12	12.6
Qcourt	13	12	11	11	9	13	11	14	12	10	9	10	11.3
StLuke	11	22	12	13	13	10	14	8	15	14	17	16	13.8
StRocco	20	16	17	18	28	24	10	22	12	21	10	19	18.1
W'brook	22	17	15	18	13	14	14	12	17	12	8	18	15.0
Wirral StJ	24	19	22	19	18	29	15	22	14	11	15	15	18.6
Woodlands	21	21	21	21	21	21	21	14	15	26	24	15	20.1
Ave per mth	15.7	14.4	13.7	13.6	13.9	14.2	13	12.3	12.4	13.9	13	13.2	13.6

1475 Complex Care patients were admitted to hospice inpatient beds during the year, with an average length of stay of 15 days, this totals 22,125 bed days. If these patients had not been admitted to hospice they would otherwise have been treated in hospital, thus avoiding £24.3m in costs to the acute sector^{lxx}.

We have been unable to include any analysis on hospice usage by people from ethnic minority backgrounds due to data not being uniformly collected.

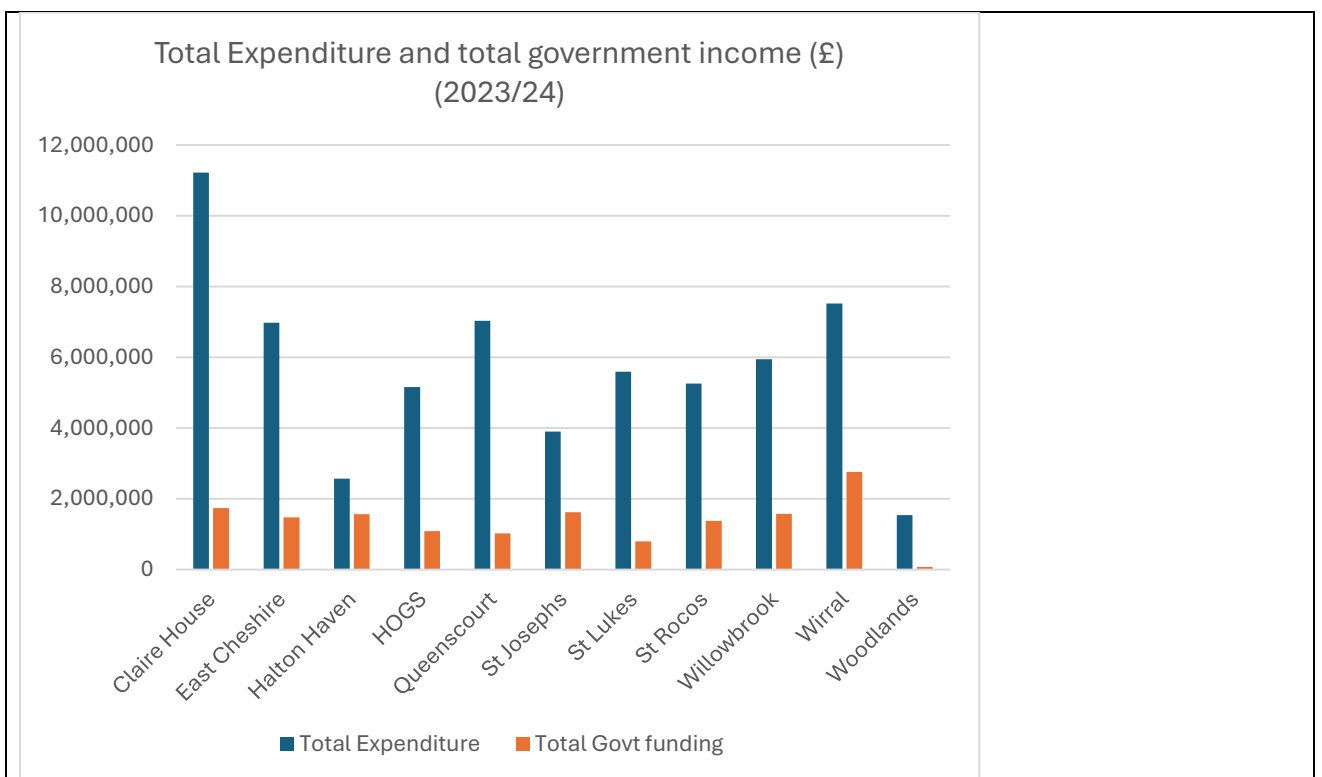
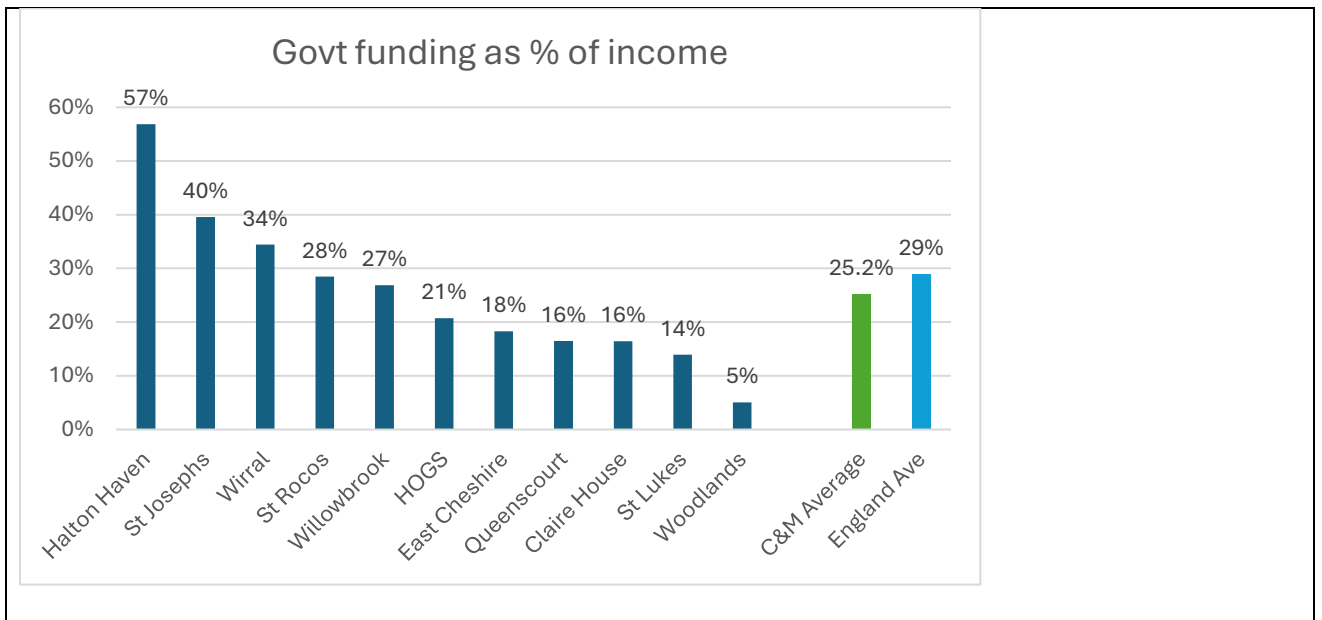
Hospice Funding

Hospices in the UK primarily rely on charitable donations from the public for most of their income, with government funding (including NHS and local authority funding) accounting for less than a third of hospice funding nationally^{lxxi}

Analysis of Charity Commission returns shows that in 2023/24 the total income of hospices across Cheshire and Merseyside (excluding Marie Curie and Zoe's Place as it is not possible to separate the costs of the local hospices from the national charity accounts) was £62,970,000, and total expenditure was £62,720,000.

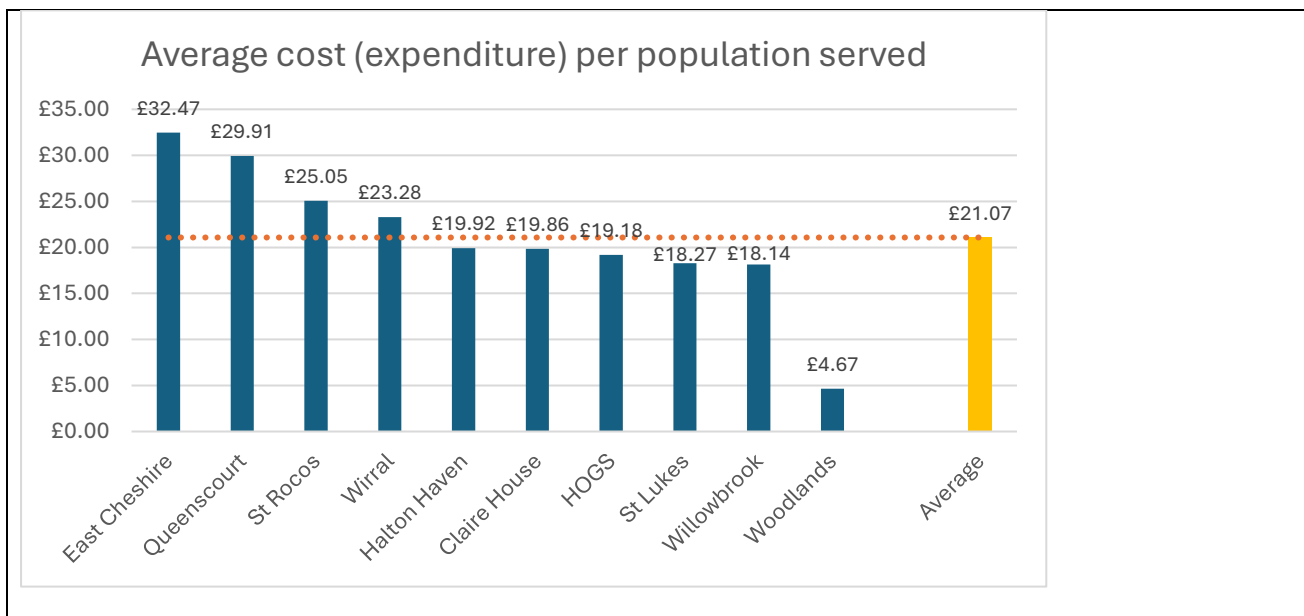
Total income from Government sources is reported as £15,127,000. Overall, this shows that government funding for Hospices across Cheshire and Merseyside is approximately 24% of total income (also 24% of expenditure). This government investment for hospices across Cheshire and Merseyside represents £5.44 per head of population, which is below the UK average of £7.16^{lxxii}. The gap between 24% in Cheshire and Merseyside to the 29% national average is approximately £3.1 million.

The proportion of government funding does vary from as little as 14% at St Lukes, to 57% at Halton Haven (excluding Woodlands as the Inpatient Unit at this hospice is not run by the charity, but by Liverpool University NHS FT).



(note, figures for Queenscourt show total expenditure and total government income, no attempt has been made to split these figures across Cheshire & Merseyside or West Lancashire footprints).

Total expenditure per head of population served also varies significantly from as little as £18.14 at Willowbrook to £32.47 at East Cheshire, the average is £21.07. It is worth noting that, overall, around three-quarters of all funding is raised from charitable donations.



In 2025, the ICB have launched a Hospice Review to identify the clinical/medical, workforce and financial sustainability challenges of hospices across Cheshire and Merseyside to inform potential shorter-term support and to inform a broader end of life strategy.

Specialist Palliative Care Workforce

Specialist level palliative care is required by people with progressive life-limiting illness, with or without comorbidities, where the focus of care is on quality of life and who have unresolved complex needs that cannot be met by the capability of their current care team.

Specialist palliative care (SPC) is delivered by a multidisciplinary team (MDT) of staff with the requisite qualifications, expertise and experience in offering care for this group of people, to support them to live as well as possible during their illness ensuring their comfort and dignity are maintained as they come to the end of their lives. Input from specialist level palliative care professionals to the care of a person must be based on the needs of the person and not the illness they have.

In 2022 the PEOLC programme undertook a research survey into the SPC workforce across Cheshire and Merseyside; it found that SPC medical workforce provision does not meet the minimum recommendations as set out in the Specialist Palliative Care Commissioning Guidance of 2016.

The model for SPC provision in Cheshire and Merseyside is therefore heavily reliant on clinical nurse specialists (CNS) who have additional qualifications in palliative care and have more than 5 years' experience in the speciality.

With the expected increase in the requirement for specialist palliative care it is likely that many services will be unable to respond to demand if the workforce remains as it is.

Key Findings from the Cheshire and Merseyside SPC Workforce Survey (2022)

- The Consultant and SASS^{lxiii} doctor workforce across Cheshire and Merseyside is substantially below recommendations with a Whole Time Equivalent (WTE) gap of **12.1** in hospitals and **9.4** in community services

- In 5 of the 8 acute hospitals in Cheshire and Merseyside and in 1 large specialist tertiary hospital there is 1 WTE or less Consultant or SASS provision
- 6 out of 11 hospitals (acute and specialist) have no specialty grade doctor in palliative care
- 7 out of 9 place-based partnership areas do not meet the recommendation for Specialty Grade doctors working in community settings (hospice and community). This represents a gap in provision of **4.3** WTE
- The number of CNSs in hospitals is at or above the recommendation of 1 CNS to 250 beds in all but 1 hospital (East Cheshire NHS Trust)
- In 3 out of 9 place-based partnership areas the number of CNSs providing community services is at or around the recommended 1 CNS per 50,000 population, however this is based on a 5-day working week therefore is likely to be inadequate for provision of 7-day services
- In Merseyside there is access to face to face 9-5 7/7 SPC provision in all community services and all but one hospital (Liverpool Women's Hospital)
- In Cheshire there is **no** access to 9-5 7/7 SPC provision in community or hospital
- 9 out of the 10 hospices in Cheshire and Merseyside accept admissions on a 7/7 basis but criteria and frequency vary
- In all place-based partnership areas health professionals have access to 24/7 SPC telephone advice
- 9 out of 10 hospices have an MDT which substantially or fully meets the recommendations for core professionals
- In NHS provided services the SPC MDT is most frequently comprised of doctors and nurses with minimal or no dedicated time from other allied health professionals
- 1 out of 10 hospices has the recommended number of specialist beds for the local population

General workforce (non SPC)

For most people PEOLC is not actually delivered by the SPC workforce, rather it is delivered by the generalist health and care workforce in primary care, acute hospitals, community teams, district nurses, care homes, and domiciliary care, supported by millions of families, informal carers, and support organisations.

The Coalition for Frontline Care estimate the generalist workforce across the UK to be around 3 million compared to around 20,000 SPC ^{lxxiv}

Across Cheshire and Merseyside, this workforce includes:

Primary Care	Hospitals and Community services	Hospices
<p>There are 349 GP practices in Cheshire & Merseyside.</p> <ul style="list-style-type: none"> • 2417 GPs • 1074 nurses • 319 Advanced Nurse Practitioners • 341 Healthcare Assistants • 324 Pharmacists and 117 Pharmacy technicians • 124 Social Prescribing Link Workers 	<p>There are over 40,000 medical, Nursing, Midwifery, Health visiting AHP and other patient facing staff working across 16 NHS hospitals across Cheshire & Merseyside</p>	<p>1,300 staff and 4,600 volunteers work in the 12 hospices across C&M</p>
<p>Adult Social Care 82,000 people work in the adult social care sector across Cheshire and Merseyside</p> <ul style="list-style-type: none"> • 68,000 work in the independent sector • 6,500 work for local authorities 		
<p>The majority of these staff will not have specialist training in PEOLC, they will have received generalist training with varying inclusion of education in PEOLC. Ongoing provision of training and support is essential to ensure that staff are kept up to date and have the skills to provide safe and effective generalist PEOLC to their patients.</p>		
<p><i>General Practice data taken from:</i> <i>Primary Care Network Workforce database (Dec'24) ^{lxxv} and General Practice Workforce Interactive Dashboard (Dec '24) ^{lxxvi}</i> <i>Adult Social Care data taken from www.skillsforcare.org.uk</i> <i>Hospital data taken from trust annual reports 2023/24</i> <i>Hospice data taken from Hospice Collaborative</i></p>		

Community Pharmacy - Urgent Critical End of Life Medication

It is common for people to experience distressing symptoms towards the end of life including anxiety, pain, nausea and vomiting, and noisy chest secretions. Timely access to end of life medications in the community is extremely important for adequate management of these symptoms and convenience of access for professionals and carer/families.

The demand for palliative care drugs is often urgent and involves treatments not routinely used in primary care. While all pharmacies are expected to meet routine supply needs, some situations require rapid access to a broader range of medications that may not be routinely stocked.

Currently there is unwarranted variation across Cheshire and Merseyside in terms of the number of pharmacies that stock vital end of life medications, the range of medications stocked and in the accessibility of them outside of normal hours. This has been exacerbated in recent years as more pharmacies seek to reduce evening and weekend opening hours. To reduce this variation, the ICB has been working with GPs, palliative care specialists and community pharmacy to review and harmonise arrangements, this work has considered the physical location of pharmacies, prioritise pharmacies that open extended hours and aim to provide one pharmacy per 30,000 head of population.

Following the review, the following arrangements will be in place for the provision of end of life medications across Cheshire & Merseyside:

	Current no. of pharmacies	Proposed no. of pharmacies	Out of Hours arrangements
Cheshire	33	24	Only 1 pharmacy open from 8am Coverage until 21:00 at 4 pharmacies
Halton	5	5	Only 1 pharmacy open from 8am 2 pharmacies open later than 18:00
Knowsley	5	4	None
Liverpool	22	18	Only one pharmacy open from 8am Majority of pharmacies open past 18:30
Sefton	6	6	Yes
St Helens	9	8	None
Warrington	9	8	No coverage 8-8.45am Coverage in the evenings
Wirral	11	11	None
Total	100	84	

The limited availability of end of life medications via community pharmacy underlines the importance of early identification and advance care planning for patients who are end of life. Being able to prescribe anticipatory medicines in advance of them being needed will allow community pharmacies to order any non-stock medications and ensure they are available when needed by the patient.

Section 4: Use of Services

Understanding and assessing the use of services for people in their last 12 months of life is a complex process that involves collecting and analysing data from numerous sources. We are grateful to the Business Intelligence team at NHS Cheshire and Merseyside for their support in helping to collect and interpret much of the data laid out in this section; their support has allowed us to review use of services never previously collected, and to sense check nationally available data.

Cheshire & Merseyside Assessment

NHS Cheshire & Merseyside Business Intelligence team has been able to examine the use of resources data of 24,493 (*) patients who died between April 2024 and March 2025 in relation to their use of primary, secondary and community services over the last 12 months of their lives.

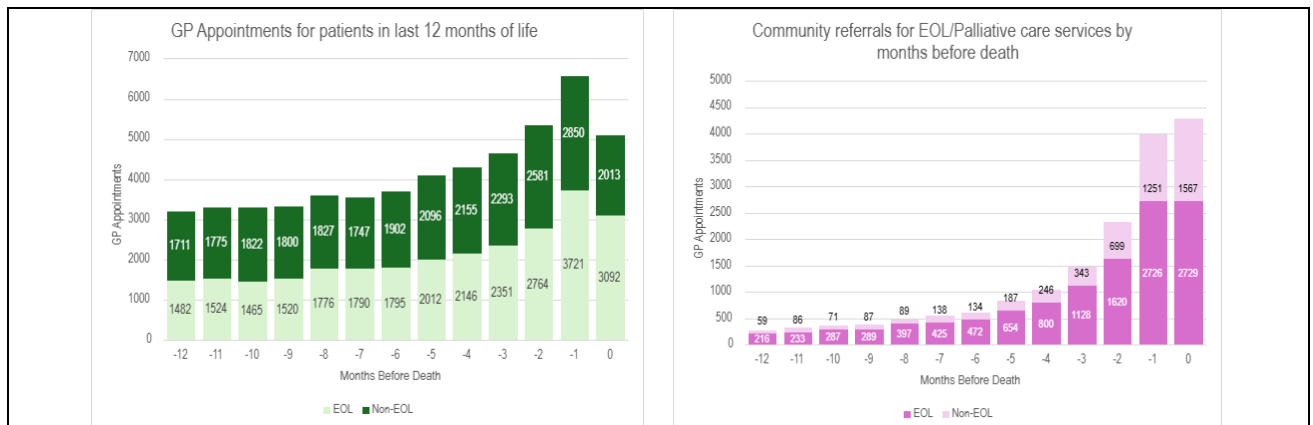
(24,493 deaths represent approximately 90% of all known people who died in Cheshire and Merseyside in 2024/25. This is in line with broader analysis of some patient databases where around 10% of patients, or their practices, opt out of sharing data. Where appropriate this report will extrapolate these findings to represent the 27,103 known deaths that year that are included in the Cheshire and Merseyside End of Life Dashboard.)*

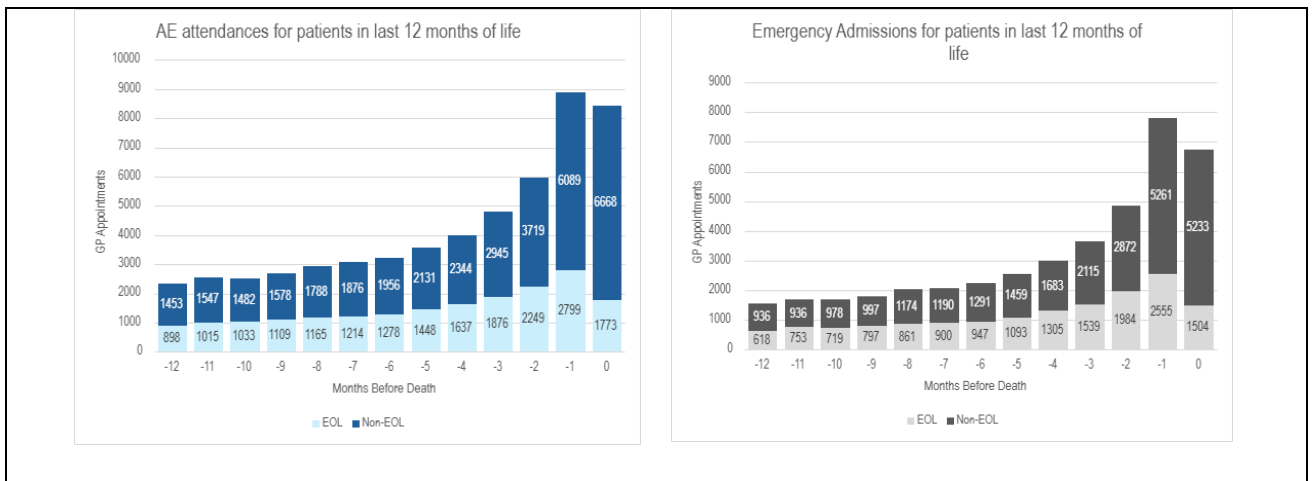
Our analysis shows that, across Cheshire and Merseyside, people in their last 12 months of life used:

- 363,104 GP appointments (*which can be extrapolated to 399,414*)
- 55,070 visits to A&E (*which can be extrapolated to 60,577*)
- 41,700 non-elective admissions (*which can be extrapolated to 45,870*)
- 1,915 critical care admissions (*which can be extrapolated to 2,106*)
- 16,933 community referrals (*which can be extrapolated to 18,826*)
- 6,196 calls to NHS 111 (*which can be extrapolated to 6,816*)
- (note: data on calls to NHS 999 was not available)

It can be seen from the charts below that the use of resources increases significantly in the final 3 to 4 months of life.

- 33% of GP appointments take place in the last 3 months of life
- 65% of referrals to community services take place in the last 3 months of life
- 42% of A&E attendances take place in the last 3 months of life
- 45% of emergency admissions take place in the last 3 months of life



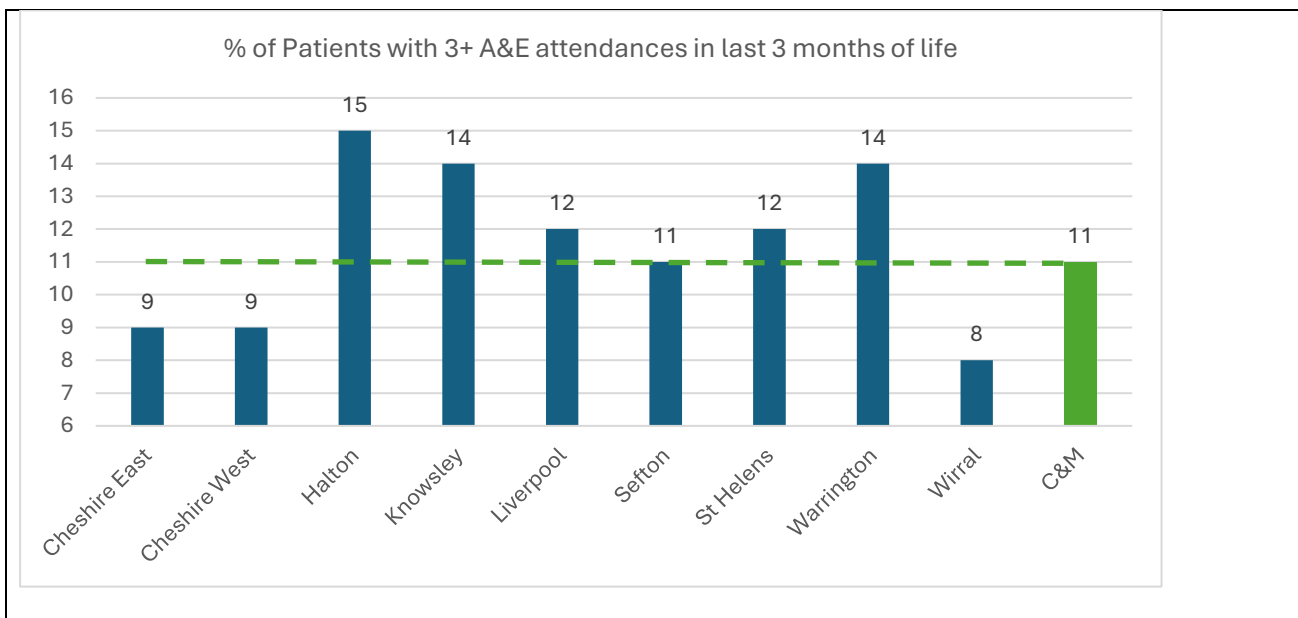


The split between “EOL” and “Non EOL” in these charts represents those patients who were recognised as likely to be End of Life and added to primary care palliative care records. These patients are also referred to elsewhere in this report as being “GSF” because they have been added to the Gold Standards Framework registers of GP practices.

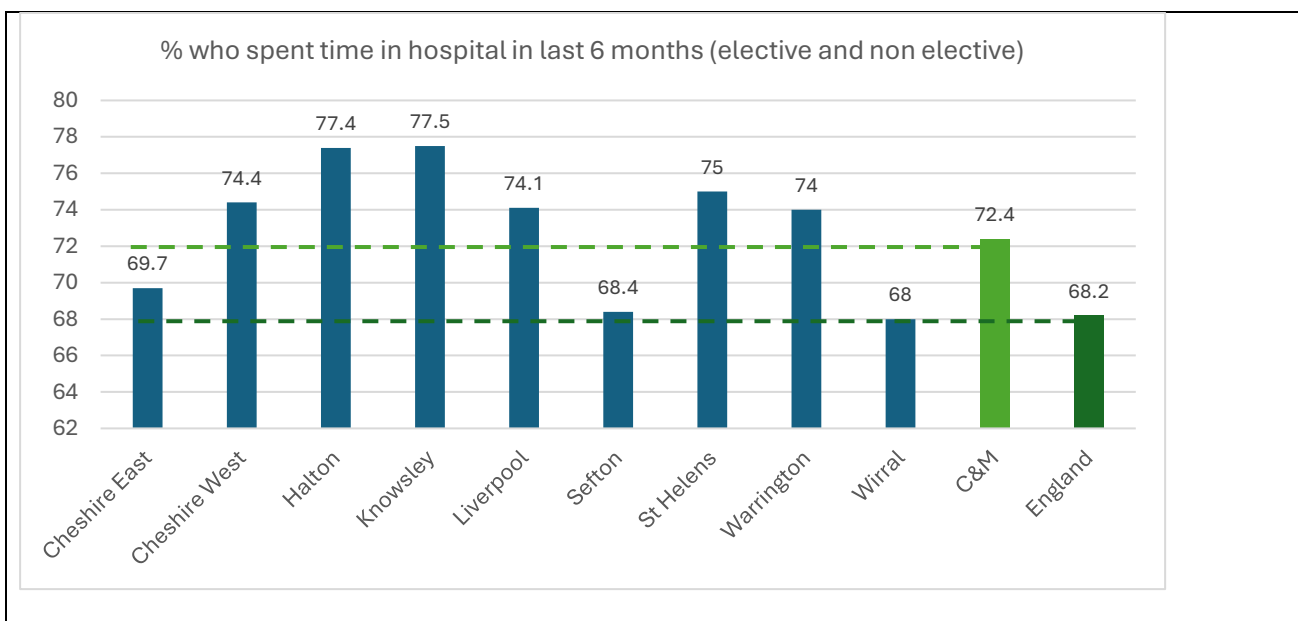
The Cheshire and Merseyside End of Life Dashboard shows that 33% of all patients who died in 2024/25 were identified as likely to be end of life. Therefore, any usage illustrated in these charts that is not broadly a 1/3 to 2/3 split is worthy of note:

- It can be clearly seen that the split in GP appointments shows a higher use by patients recognised as EOL – overall the 1/3 of patients identified as EOL use roughly the same number of appointments as the 2/3 of patients not identified as EOL in fact in the last 2 months of life it is more than 50% (56% and 60%). This is good for patients because, in combination with community services, it helps to optimise community based care and reduce the risk of unplanned hospital care.
- Clearly, referrals to community services are higher for EOL patients as GPs, hospitals and hospices make appropriate referrals for patients to be supported by community teams (eg District Nursing).
- Attendances at A&E and emergency admissions show an even use by EOL and non EOL patients across the full year (35% to 65%), this changes in the final two months of life when recognised EOL patients use A&E less and are admitted less often than non-recognised EOL patients (25% to 75%)

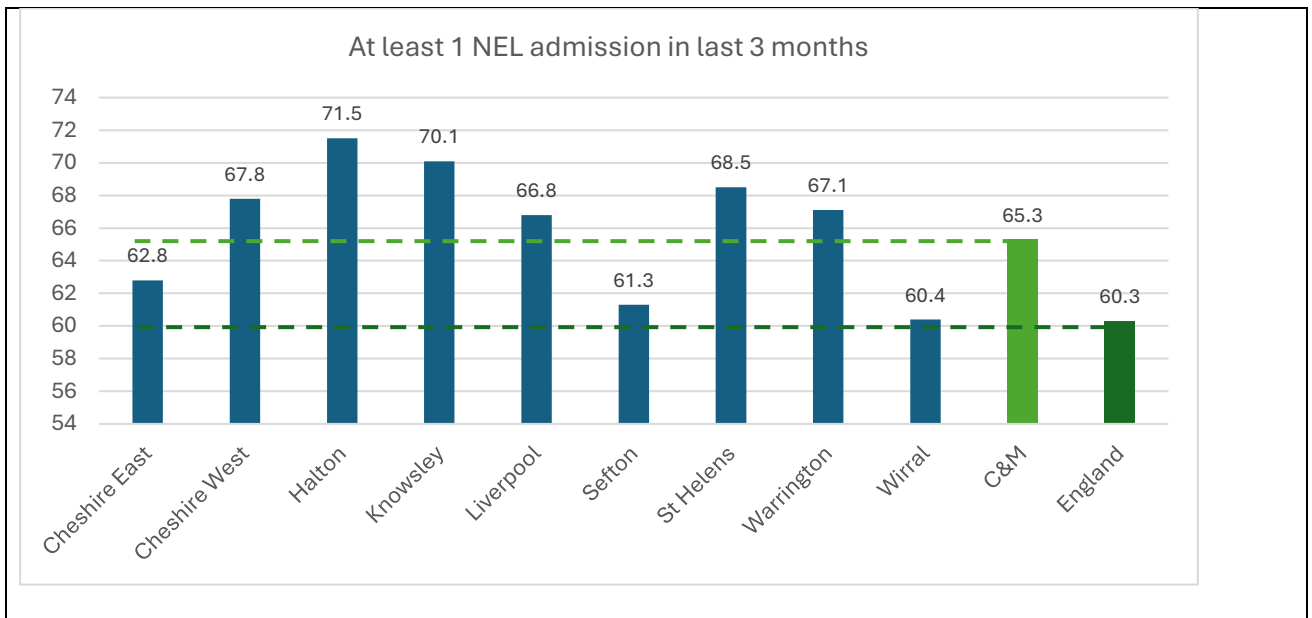
2,641 people (extrapolated to 2,905) attended A&E 3 or more times in the last three months of life – approximately 11% of all people who died. There is some place variation in these average figures, ranging from as few as 8% in Wirral to 15% in Halton.



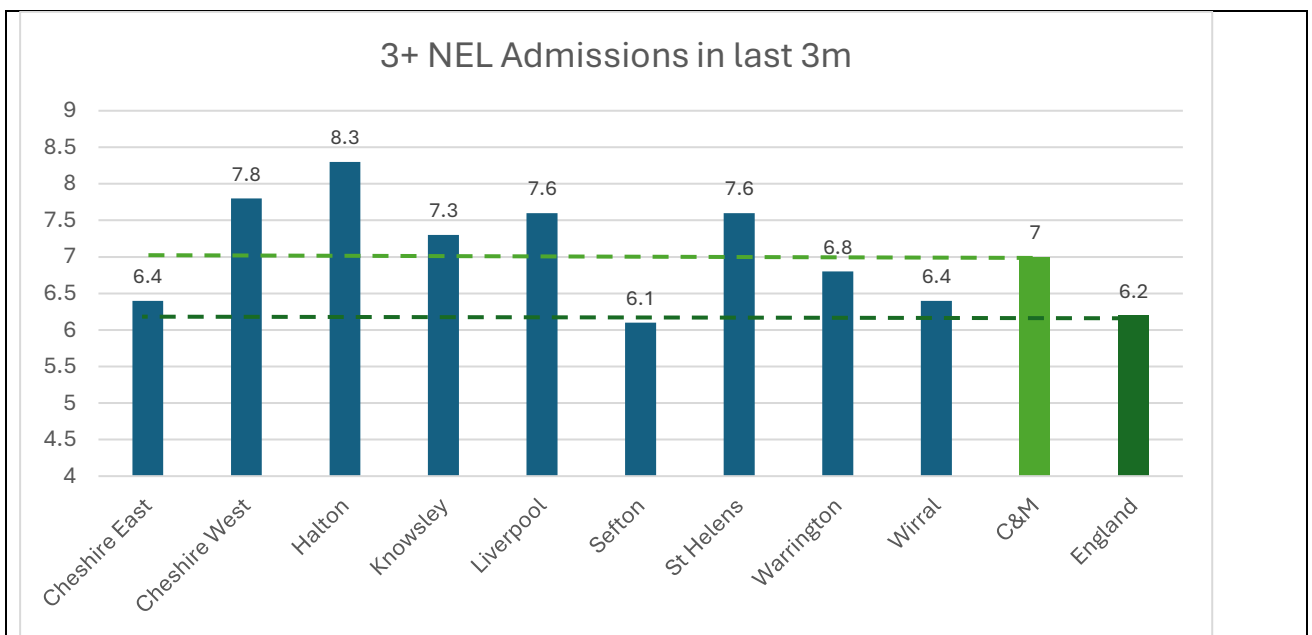
72.4% of those who died in Cheshire and Merseyside spent some time as an inpatient (either as an elective or non-elective patient, or both) in their final 6 months of life, this is higher than the England average of 68.2%^{lxvii}. Again, there is some local variation from 68% in Wirral to 77.5% in Knowsley



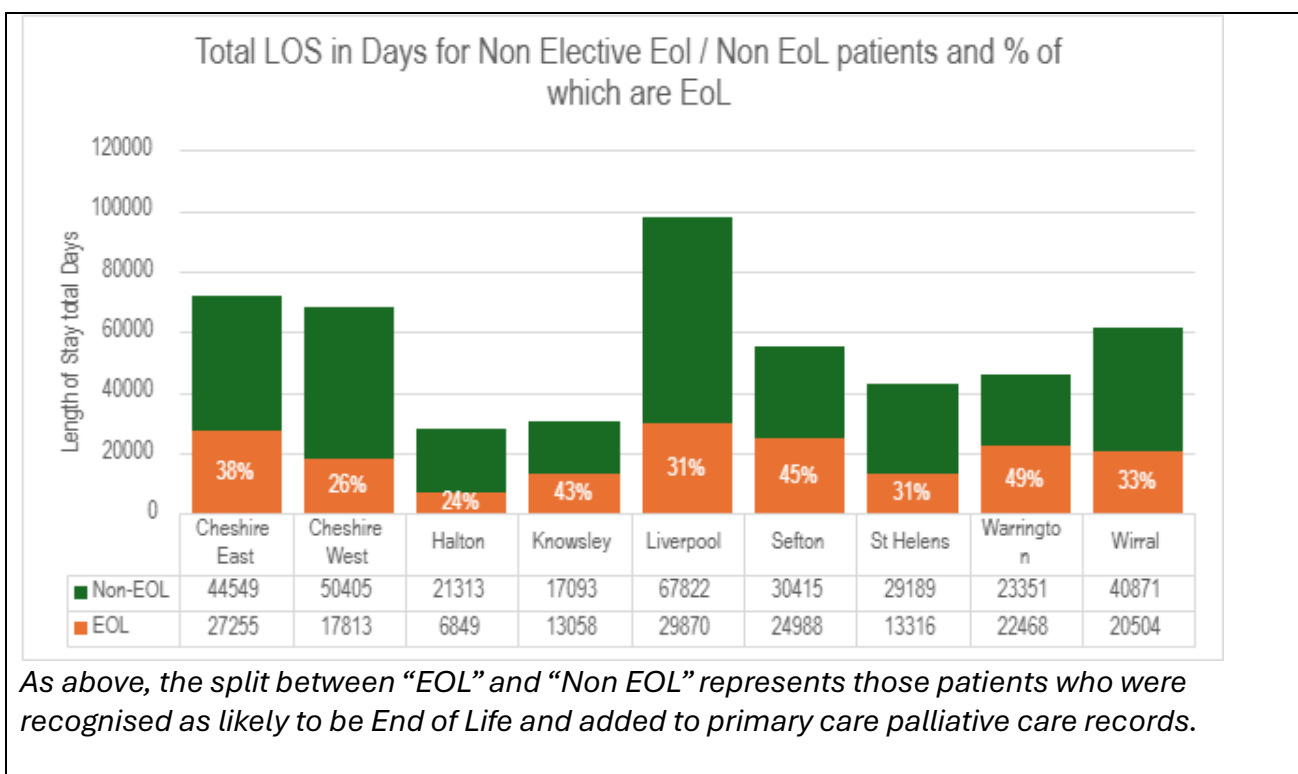
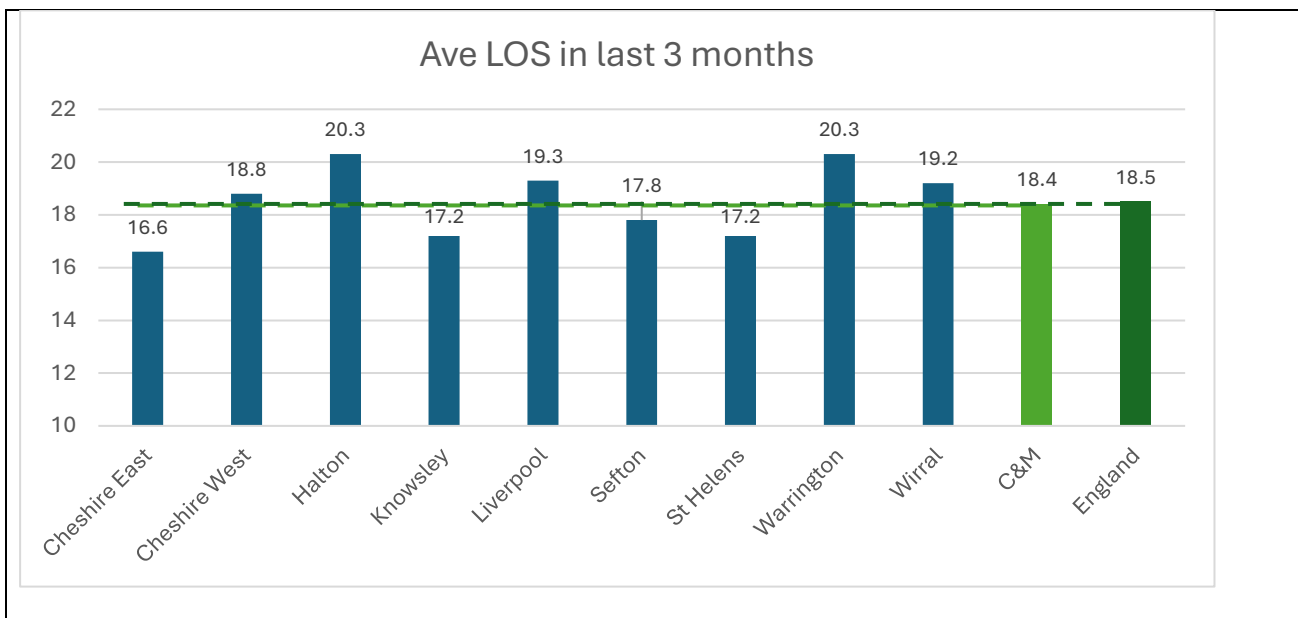
We can see above that use of services increases significantly in the final 3 months of life, especially for unplanned non elective activity. 65.3% of all people who died had at least one non elective hospital admission in their final 3 months of life, which is higher than the England average of 60.3%. Again, we can see local variation in the chart below.



Furthermore, 7% of people who died had 3 or more non elective admissions in their last 3 months of life which is higher than the national average of 6.2%^{lxxviii}. Again, we can see local variation with all but one place higher than the England average.

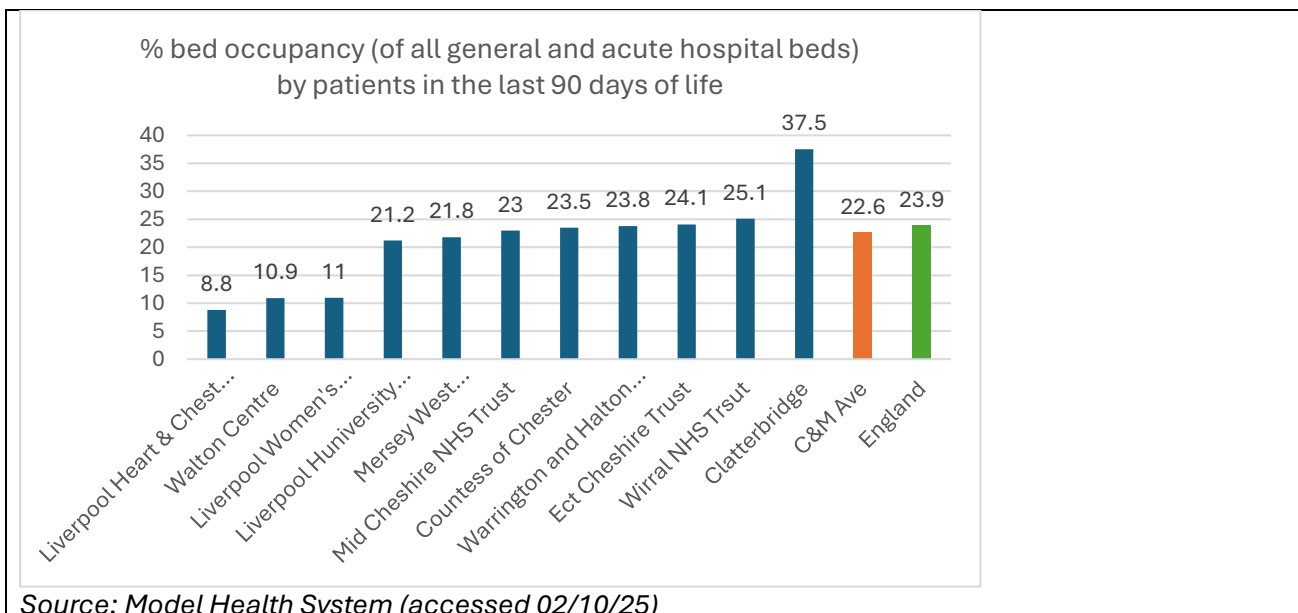


Overall, the average length of stay for all those who are admitted in their final 3 months of life is 18.4 days which compares well to the England average of 18.5 days, although, again, there is variation across localities.



The chart above shows total non-elective length of stay of patients who died in 2024/25. This represents 501,129 beds days (which can be extrapolated to 551,241 bed days). This represents around 27% of all general and acute hospital beds across the whole of Cheshire and Merseyside.

It has not been possible for us to break this down by each provider, however, the NHS Model Health System dashboard does provide a breakdown of bed occupancy by patients in their last 90 days of life which shows that between one in four and one in five hospital beds across Cheshire and Merseyside are likely to be occupied by someone in their last 90 days of life.



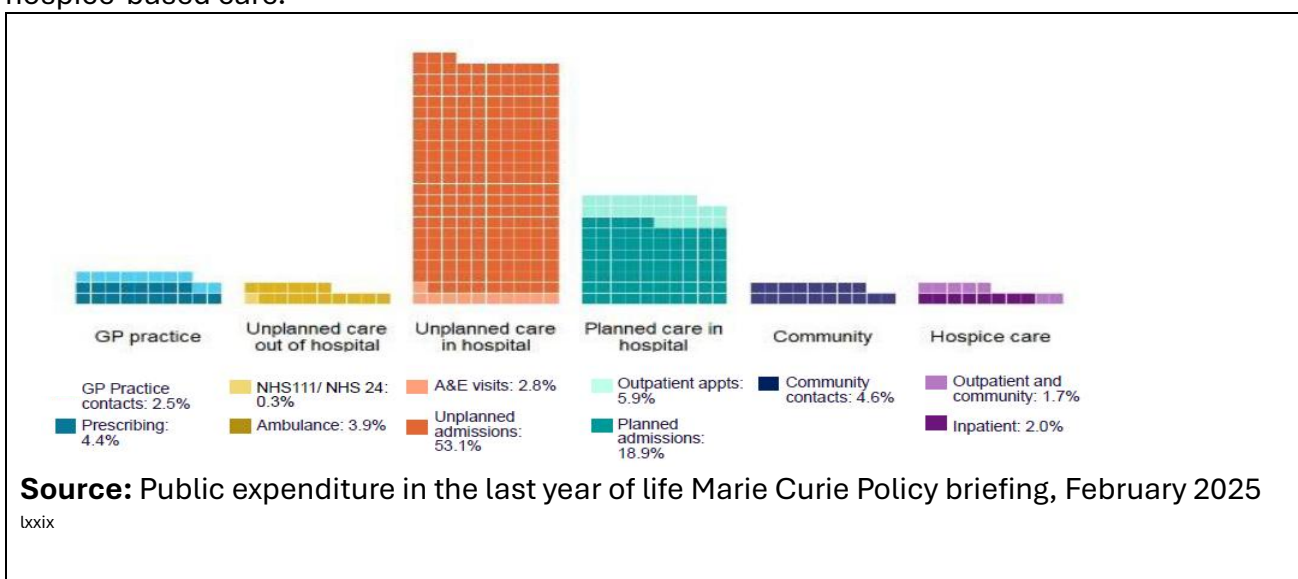
Economic Analysis

National comparisons for the economic analysis of use of resources are not readily available in the PBNA type documents we have reviewed from across the country.

In February 2025 Marie Curie published findings from the Health Economics Unit and Nuffield Trust who had calculated in 2022 that public expenditure on health care, social care and social security on people in the last 12 months of life across England was in the region of £18 billion – or £33,460 per person who died.

- Over half (53%) was spent on health care £9.5 billion, which is £17,600 per person who died.
- 22% was spent on social care (£3.9 billion)
- 26% was spent on social security payments (£4.6 billion)

More than half of healthcare spending (55.9% or £9,680 per person) was spent on unplanned hospital care, with lesser amounts spent on planned hospital care, GP activity, community and hospice-based care.



lxix

Through our analysis of use of resources in Cheshire and Merseyside, it is possible to place a monetary value on some of the activity:

Activity	C&M BI (90% of people who died)	Extrapolated to 100% of all known people who died
Non-elective admissions	£214,286,457 (which represents £8,750 per person who died)	£235,715,103
Elective admissions	£26,388,747 (£1077 per person)	£29,027,622
GP Appointments	£13,434,848 (based on Kings Fund £37 per 10 min appt ^{lxxx}) (£547 per person who died)	£14,778,333
A&E attendances	£11,907,305 (which represents £486 per person who died, or £216 for each A&E visit)	£13,098,036
Total	£266,017,357	£292,619,093

These figures do not represent a forensic assessment of NHS expenditure linked to patients who are palliative or End of Life and do not include any calculations for community services (such as district nursing), pharmacy, 111 or 999 calls, NWS response, hospital outpatients, critical care inpatient activity, or hospice care (this list is not exhaustive).

It does, however, provide an illustration of the size and scope of the impact that Palliative and End of Life patients have on the wider health system and underline the importance of understanding how better PEOLC could reduce this impact in terms of fewer NEL admissions, fewer days spent in hospital and fewer people dying in hospital.

Patient and Public Experience

It has not been possible to conduct any original patient and public engagement in support of this PBNA. We recognise that this is weakness for this report, and that as a result we have not received input or feedback into local services to report and nor do we have any local insight into the experience of different communities' experiences of local services. We commit to undertaking primary engagement in support of the development of an End of Life Strategy later in 2025.

There is some limited intelligence available from national reports

Kings College London reported in 2024^{lxxxi} that 24% of people do not know much about PEOLC and that 65% of adults are worried about access to PEOLC.

In 2024 Marie Curie published Time to Care^{lxxxii} which reported the findings from the 2023 QUALYCARE survey, a nationally representative post-bereavement survey. Key findings from this survey showed:

- 57.4% of respondents rated the care provided by GPs as good, very good, or excellent, while 36.7% rated it as very poor, poor, or fair.

- Palliative care teams and community or district nurses received higher ratings for the quality of care provided, with 67.5% rating specialist palliative care as good, very good, or excellent.

The National NACEL Audit showed that 71.7% of bereaved people rated the care received in hospital by their loved one as either Excellent or Good. Locally, five of 10 hospitals scored higher than the national average, three others scored around the national average (see section above on local NACEL).

Feedback received from bereaved relatives via Medical Examiners ^{lxxxiii} shows that poor communication is often cited as an issue when concerns have been raised, this includes difficulty contacting the healthcare team, families not feeling listened to, duplication (eg, repeatedly asking for information) or a lack of empathy from staff.

Section 5: Strategic and policy assessment

Palliative and End of Life Care - Statutory Guidance for Integrated Care Boards (ICBs) 2022 ^{lxxxiv}

Integrated Care Boards were established across England under provisions set out in the Health and Social Care Act 2022, replacing Clinical Commissioning Groups and taking on a new and expanded remit. Their remit includes commissioning palliative care services that meet the needs of their local populations. NHS England published its Statutory Guidance to support ICBs to deliver this duty in September 2022 ^{lxxxv}, and published further guidance in January 2023 via ‘Palliative and End of Life Care Handbook for Integrated Care Boards’ (only available via the Future NHS platform national PEOLC workspace).

The guidance and handbook are both based on the ‘Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026’ (discussed below). The Guidance sets out five key considerations for ICB legal duties:

- 1. People with palliative and end of life care needs should be supported by a whole system approach. This means that care and support should be provided by the right professional, at the right time. This includes access to out of hours palliative and end of life care.*
- 2. People’s palliative and end of life care needs, and complexity of their needs, will fluctuate throughout their journey, and this means that a flexible model of care is required. No single provider can provide for all needs and people will require access to a wide variety of non-specialist palliative care delivered by primary, community, acute and urgent care services, as well as specialist-level palliative care services to enable the system to provide personalised care to the person.*
- 3. The consideration of commissioned palliative and end of life care services applies to people of all ages. There are important differences between adults and children’s palliative and end of life needs, including at the transition between childhood and adulthood, which must be taken into account in the commissioning and design of services.*
- 4. ICBs should have a clear vision of how the package of services they commission locally deliver against the Ambitions Framework and should actively seek out commissioning resources to achieve this.*
- 5. There must be sufficient workforce in place across all settings, with the knowledge to deliver the care required. Regard should be given to supporting general clinicians to build knowledge, skills and confidence to deliver high quality, personalised PEOLC, supported by specialist palliative care clinicians and services where appropriate.*

To realise this duty, ICB commissioners should:

- action an Ambitions for Palliative and End of Life Care self-assessment, to identify progress and gaps against the six Ambitions commitments (involving people with lived experience)*
- develop and implement a PEOLC service specification that aligns closely with the national PEOLC service specifications.*
- specify clearly what needs to be in place to deliver high quality end of life care for their populations.*

- *work to ensure that there is sufficient provision of care service providers available to deliver this, paying particular attention to access to specialist palliative care services, hospice beds, bereavement services, pharmacy services, equipment, spiritual care (as part of mental health and wellbeing support) and access to information.*
- *ensure access to general medical and nursing services, out of hours services and rapid response to maintain continuity of care, thereby supporting the patient's preferences and choice.*
- *Complete an Equalities and Health inequalities impact assessment and action plan focused on PEOLC*

PEOLC is one of seven transformation programmes^{lxviii} for Cheshire and Merseyside ICB, and the ICB have established an all age PEOLC Programme Board to oversee the delivery of a programme of work that will enable access to good quality and equitable end of life care across the whole system. Membership of the Programme Board is made up of representatives from specialist palliative care, primary care, children and young people's services, local hospices and the PEOLC strategic groups from the nine localities across Cheshire and Merseyside.

The Programme Board has overseen a wide-ranging programme focussed on clinical excellence, access, sustainability, early identification, personalised care planning and workforce.



Under an overarching approach known as I CARE & Share – the programme has helped to develop

- An EARLY toolkit for use in the primary care setting to aid earlier identification of patients who may be approaching end of life
- An Electronic Palliative Care Co-ordination System (EPaCCS) to help to capture and share information electronically from people's discussions about their care
- A Personalised Care Planning template for use in primary and community care settings with plans to roll this out into secondary care
- A Mayfly education programme on Advance Care Planning and Communication skills

In addition, the programme has resulted in:

- Workforce mapping for specialist palliative care workforce
- Assessment of the provision of 24/7 specialist advice and support and of 7-day face to face assessments

The Ambitions framework ^{lxxxvii} was developed by a national partnership of over 30 organisations involved in the delivery, development and regulation of palliative care services. It sets out a vision to improve end of life care through partnership and collaborative action between organisations at local level throughout England.

The framework sets out six key ambitions (*supported by several “I” statements*) for the delivery of high quality, equitable and personalised care for patients nearing the end of their lives, their families and carers. These ambitions are:

- 1. Each person is 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.*
- 2. Each person gets 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.*
- 3. Maximizing 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.*
- 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.*
- 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.*
- 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.*

In 2025 the Cheshire and Merseyside PEOLC Programme Board undertook a self-assessment against the Ambitions framework which has helped to inform the development of a delivery plan.

The national self-assessment tool, originally developed in Cheshire and Merseyside led by the End of Life Partnership, was originally designed as a tool to be used by CCGs in their respective place, the tool has therefore been adapted slightly to be suitable as an ICS wide tool – specifically, the level descriptors for Level 3 and 4 have been modified to reflect the full ICS rather than a single place.

Level	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
Level 2	Plans are in place towards achieving this ambition
Level 3	Limited achievement across one or two localities only
Level 4	Partially achieving e.g. across most, but not all localities
Level 5	Fully achieving e.g. across all care settings, with supporting evidence available

The overall assessment shows good progress against indicators across all 6 ambition themes:

- 11.5% of scores were at level 0 “Not at all ready to achieve/ anticipate barriers to achievement”
- 4.3% of all scores were at level 1 “Desire to achieve this ambition but there are currently no plans in place”
- One quarter (24.6%) of all scores were at level 2 “Plans are in place towards achieving this ambition”
- Half (50.6%) of all scores are level 3 “Limited achievement across one or two localities only”
- One fifth (22.2%) of all scores are for level 4 “Partially achieving” and level 5 “Fully achieving”

	Level 0	Level 1	Level 2	Level 3	Level 4	Level 5
Ambition 1: Each Person Seen as an Individual	5.3%	0.0%	15.8%	47.4%	26.3%	5.3%
Ambition 2: Each person gets fair access to care	0.0%	0.0%	50.0%	50.0%	0.0%	0.0%
Ambition 3: Maximising comfort and wellbeing	6.3%	0.0%	6.3%	56.3%	31.3%	0.0%
Ambition 4: Care is coordinated	0.0%	4.3%	21.7%	60.9%	0.0%	13.0%
Ambition 5: All staff are prepared to care	0.0%	0.0%	28.6%	14.3%	14.3%	42.9%
Ambition 6: Each community is prepared to help	0.0%	0.0%	25.0%	75.0%	0.0%	0.0%

Areas where the self-assessment shows strengths include:

- PEOLC being part of the ICB strategy
- PEOLC leadership
- EPACCs, Advance care plans and recording CPR decisions
- Education and training for specialist and generalist staff
- Skilled assessment and symptom management

Areas where the self-assessment show potential areas for improvement, include:

- Access to bereavement support
- Monitoring of “5 priorities of care for the dying person”
- Approaches to community based social prescribing
- Advance care planning for children and young people
- Public and professional information
- Understanding inequalities
- 7-day assessments
- Strategy for using technology

Note: The Ambitions Framework is being reviewed in 2025 around the same time this PBNA was being produced. Depending on the nature of this review it may be necessary to reassess this section of the needs assessment.

NICE Quality Standards apply to England and Wales and are designed to improve the quality of care that is commissioned and provided. Each standard includes a set of specific, concise and measurable statements. NICE do not specify any expected levels of achievement, although they do state that 100% (or 0% if the quality statement says that something should not be done) should be aspired to.

QS13 covers care for adults (aged 18 and over), who are likely to die within 12 months, people with advanced, progressive, incurable conditions and people with life-threatening acute conditions. It also covers support for their families and carers.

The standard includes five quality statements:

	NICE Standard	Assessment
1	<i>Adults who are likely to be approaching the end of their life are identified using a systematic approach.</i>	<p>The EARLY toolkit has been developed by clinicians in the North-West and promoted nationally by NHS England. It works within GP electronic patient records to help identify people who are likely to be in their last year of life. It searches Systematized Nomenclature of Medicine Clinical Terms (SNOMEDCT) codes based on a range of prognostic indicator guidance including the Gold Standards Framework Proactive Identification Guidance and the Supportive and Palliative Care Indicators Tool (SPICT) resources.</p> <p>Adoption of EARLY, and the overall identification of patients who may be in the last 12 months of their life is mixed. Overall, across Cheshire and Merseyside, only 33% of patients who died in 2024/25 had been identified on the register, against an ambition of 60%. Performance varies across each place and from General Practice to General Practice with some practices surpassing the 60% ambition and other practices not engaging.</p>
2	<i>Adults approaching the end of their life have opportunities to discuss advance care planning.</i>	<p>Responsibility for planning and improving personalised care plans or Advance Care Plans (ACP) passed from NHS England to ICBs upon their formation in 2022. Cheshire and Merseyside ICB have agreed that each place should adopt a single care plan template to be used by all providers in the place, such templates need to be EPaCCS compliant and should be shareable with urgent care providers. To support this, the PEOLC network has developed a template for ACP (<i>regularly referred to as the I CARE & Share template</i>) that localities can adopt if they do not wish to develop and adopt their own system.</p> <p>By March 2025, not all localities have adopted a single ACP template, consequently, performance against this key measure is mixed. Overall Cheshire and Merseyside performance at the end of 2024/25 was that 37% of patients who died had an ACP in place against an ambition of 60%, and (as with early identification), this overall figure masks variation across localities and across General Practice where some practices are achieving over 60% but others are much lower.</p>

3	<p><i>Adults approaching the end of their life receive care that is coordinated between health and social care practitioners within and across different services and organisations.</i></p>	<p>Sharing patient details and care preferences is crucial for high-quality care. The Cheshire and Merseyside EPaCCS system has been developed using standard codes recognised by the Professional Records Standards Board (PRSB) which means it can be viewed and used by other NHS and care systems such as the Cheshire Care Record and Merseyside Share to Care.</p> <p>Analysis of usage of the eXchange systems shows usage across localities to be mixed, the system was used over 17,000 times between April 2024 and March 2025, an average of 1,900 per, but in practice this varies from as little as 169 in Warrington (most likely because of alternative IT systems in use locally and 7,475 in Liverpool (most likely because of the presence of tertiary hospitals caring for patients from across Cheshire and Merseyside).</p> <p>However, North West Ambulance Service crews currently lack access, though call centres and senior clinicians have some access. Efforts are ongoing to improve NWAS access. Four hospices have access via Cheshire and Wirral shared care records, but not via Merseyside Share to Care.</p>
4	<p><i>Adults approaching the end of their life and their carers have access to support 24 hours a day, 7 days a week.</i></p>	<p>24/7 advice and support services are generally provided by clinicians based within hospices, offering support to other professionals and directly to patients and carers.</p> <p>There is good provision of 24/7 support and advice for professionals across Cheshire and Merseyside, although there may, from time to time, be occasional suspension of services in some localities due to temporary staffing issues. At the time of producing the PBNA, the service delivered by Hospice of the Good Shepherd was suspended (last assessment June 2025).</p> <p>Access to advice and support for patients and carers is also generally good, although not always available 24/7, for example, the service delivered by Queenscourt Hospice is available across 7-days, but only between 9am and 8pm (with professionals able to access the service out of these hours) and the service offered by Hospice of the Good Shepherd under review.</p>
5	<p><i>Carers providing end of life care to people at home are supported to access local services that can provide assistance.</i></p>	<p>Carers who support patients who may be end of life are offered support via multidisciplinary teams working in localities, this is often a combination of staff (and volunteers) from NHS Trusts, GP practices, local hospices and other key voluntary organisations. The range of services offered and how carers access them differs for each place.</p>

NICE Quality Standard (QS160): End of life care for infants, children and young people (2017) ^{lxxxix}

Thankfully, the number of infants, children and young people who die each year is relatively small. Specialist palliative care is provided by Alder Hey Children's Hospital and Claire House Children's Hospice. QS160 includes six quality statements. Many of these NICE standards are incorporated within the National Service Specification which is report on in section X where we can see that performance / compliance is generally very good.

	NICE Standard	Assessment
1	<i>Infants, children and young people with a life-limiting condition and their parents or carers are involved in developing an advance care plan.</i>	Cheshire and Merseyside providers have agreed to adopt the national Children and Young People's Advance Care Plan https://cypacp.uk/ This document is designed to capture advance care planning discussions between professionals, patients and their families. Significant work has gone into its design to make it suitable for all babies, infants, children and young people.
2	<i>Infants, children and young people with a life-limiting condition have a named medical specialist who leads and coordinates their care.</i>	Care at Alder Hey is led by a specialist palliative care consultant. Care delivered by Claire House is usually led and co-ordinated by a senior experienced palliative care nurse or nurse consultant with access to specialist CYP PEOLC support and advice, rather than being lead and co-ordinated by a lead medical specialist.
3	<i>Infants, children and young people with a life-limiting condition and their parents or carers are given information about emotional and psychological support, including how to access it.</i>	All infants, children and young people and their families are provided with information about emotional and psychological support.
4	<i>Infants, children and young people with a life-limiting condition are cared for by a multidisciplinary team that includes members of the specialist paediatric palliative care team.</i>	Specialist Palliative Care Teams participate in Multidisciplinary Team meeting for all infants, children and young people identified as palliative or likely to be near the end of life.
5	<i>Parents or carers of infants, children and young people</i>	Parents and carers are offered support for bereavement, grief and loss when their child is nearing the end of their life and after their death.

	<i>approaching the end of life are offered support for grief and loss when their child is nearing the end of their life and after their death.</i>	
6	<i>Infants, children and young people approaching the end of life and being cared for at home have 24-hour access to both children's nursing care and advice from a consultant in paediatric palliative care.</i>	Claire House are commissioned by the ICB to provide a 24/7 Rapid Response Specialist Palliative Care to all areas of Cheshire and Merseyside, except for Cheshire East – this exclusion is due to the physical distance between the hospice and the area. This means that infants, children and young people approaching the end of life who live in Cheshire East are not able to be supported to die at home.

Planning for the End: A review of the quality of care provided to adult patients towards the end of life (2024) ^{xc}

This report, published by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), collated feedback from over 700 hospital consultants, reviewed 350 sets of case notes and assessed data from the NACEL audit. The review had a particular focus on patients who died in hospital (including people who were discharged and died within 6-months) between 1st April 2022 and 30th September 2022 with one or more of the following conditions: dementia, heart failure, lung cancer and liver disease. The review focussed on:

- Management of multiple admissions
- Informed choices
- Assessing adequate communications with the patient, and their family and/or carers
- Use of evidence recorded from discussions and decision-making
- The extent to which patients' wishes and preferences were achievable
- Advance care planning discussions, and their quality
- Prompt recognition of the dying patient
- Evidence to support advance care planning in achieving key quality outcomes
- Treatment, escalation decisions and support for people at the end of their lives.

Key findings from the review include:

- Not enough patients had access to early palliative care alongside existing treatments to improve symptoms and quality of life. Only around 1/3 patients benefited from such parallel planning.
- Death and dying was not discussed as often as it could have been. Only around 70% of patients had their preferences for care at the end of their life recorded. More people need to have their end of life care wishes recorded.
- Only around 65% of patients had a documented lead person for their care. Care co-ordinators are an accepted standard in cancer services but were less common for other advanced chronic conditions –

- Specialist palliative care services were not always available in hospitals nor involved when needed. Nationally, 7-day SPC services were only available in around 60% of hospitals (in Cheshire and Merseyside this is 66%; all eight hospitals on Merseyside offer 7-day services, but none of the four Cheshire hospitals are able to offer this)
- Training in end of life care for all healthcare staff who see patients is needed to recognise who would benefit from specialist palliative care to treat the symptoms of advanced chronic disease. Such training is not always provided or available – only 64% of hospitals include it in their induction training, and only 51% include it as mandatory or priority training.

Consequently, NCEPOD made a series of recommendations, including:

- Ensuring that patients with advanced chronic disease have access to palliative care alongside disease modifying treatment (parallel planning) to improve symptom control and quality of life.
- Normalise conversations about palliative/end of life care, advance care plans, death and dying.
- Ensure all patients with an advanced chronic disease are allocated a named care co-ordinator.
- Provide specialist palliative care services in hospitals and in the community, to ensure all patients, including those with non-malignant diseases receive the palliative care they need.
- Ensure that existing advance care plans are shared between all providers involved in a patient's care.

The findings from the NCEPOD report have been shared with clinical colleagues across Cheshire and Merseyside where they were broadly supported. It is clear that some of the recommendations from this report are being implemented in parts of Cheshire and Merseyside, but this is not consistent:

- Parallel planning does occur, but too often it is late in a patient's end of life trajectory,
- Through Mayfly training the PEOLC programme has promoted the normalisation of conversations about death and dying, this could be extended to include work with communities,
- Named care co-ordinators are more commonplace for patients with cancer and dementia (Cancer Nurse Specialists and Specialist Dementia Nurses), but this is not the case for all conditions or for all patients,
- There is a split in terms of the availability of 7-days services, in general most of Merseyside has 7-day services, but Cheshire does not,
- The Cheshire and Merseyside Personalised Care Plan supports care planning and escalation; however, visibility and awareness of the plans is mixed and needs to improve.

The development of a PEOLC strategy needs to consider the NCEPOD report and its potential to improve services across Cheshire and Merseyside.

Commission on Palliative and End-of-Life Care ^{xci}

The Commission on Palliative and End of Life Care has been established by Professor Ilora Baroness Finlay of Llandaff and Rachael Maskell MP, with Professor Sir Mike Richards as its independent chair because parliamentarians on both sides of the assisted dying debate recognised the urgent need to improve the quality of palliative care and the care given to people approaching the end-of-life.

The commission has sought to identify the current strengths and shortfalls in the provision of care and make recommendations to parliament and the government to improve PEOLC across the UK. The commission held several sessions in public, hearing from PEOLC experts from across the country, including people with lived experience, and received over 500 written responses.

At the time of producing this PBNA the commission had published two reports ^{xcii}.

Vol 1 (May 2025) detailed evidence of uneven care across the UK and a growing need for PEOLC as deaths are expected to rise and more people expected to live with long term conditions. The report also cited several examples of good practice from across the country, including REACT in Bradford, RIPEL in Oxford and the Frailty Hub in York. The Commission made 10 key recommendations:

1. Develop a National Strategy for palliative care and end-of-life care
2. Mandate and fund 24/7 specialist palliative care, coordinated with general care
3. Improve rapid response to advice and access to community services
4. Education and training for all health and social care staff
5. Dual accreditation and recognition of prior experience
6. Fund research to improve care, evaluating interventions and treatments
7. Support informal carers and families
8. Integrate health and social care data systems, including with outcomes data
9. Ensure compassionate, open, and timely communication, supporting future care plans
10. Improve understanding around palliative care, hospices and dying

Clearly some of these recommendations are for Government to respond to, however several speak clearly to local PEOLC systems and several overlap / correspond with priorities and actions in Cheshire and Merseyside such as an ambition for 24/7 specialist care, improving rapid response, education and training, improving communication, improving support to families and informal carers and improving public understanding around PEOLC.

Vol 2 (June 2025) focussed on providing a summary of the evidence received by the commission, grouped into feedback received from patients, carers and families, and from clinicians and academics. Where relevant, the report reflects on ambitions contained within the recently published 10 Year Health Plan for England.

In July 2025 the Department for Health and Social Care released its 10 Year Health Plan for England ^{xciv}. The report builds on the findings of the Darzi report from 2024 ^{xcv} that highlighted the critical condition of parts of the NHS that led the government to declare that “NHS is broken but not beaten” ^{xcvi}

The 10 year plan focuses on what it terms “Three Radical Shifts”:

- Hospital to Community: Emphasising greater community-based care.
- Analogue to Digital: Transitioning to digital healthcare solutions.
- Sickness to Prevention: Focusing on preventive measures.

The plan outlines several key points about PEOLC:

- New Era for General Practice: new GP contracts will create “single neighbourhood providers” (SNPs) that will deliver services over a single neighbourhood – typically over a population of 50,000, each neighbourhood will have a health centre open at least 12 hours a day, 6 days a week. “Multi neighbourhood providers” (MNPs), working to support a population of around 250,000, will co-ordinate services such as end of life care.
- Neighbourhood Teams: staff working in hospice outreach are specifically named as examples of staff who will be part of neighbourhood teams delivering high quality end of life care
- Personalised, patient-centred care: Personal Health Budgets (PHBs) will be expanded (from 180,000 people at present to 1 million by 2030) to help make end-of-life care from hospices or the voluntary sector more accessible, allowing more people to die in the place of their choosing.
- Community-based advice and support: will help keep people out of hospital and support more to die at home.
- Rapid response teams: will include hospice outreach staff and palliative care professionals. Rapid response teams will help symptom management, including pain.
- Care planning: Care plans will be co-created with patients with complex needs and their carers and include their preferences for end-of-life care, ensuring their wishes are respected. Community teams will work closely with care homes and paramedics to share care plans to reduce unnecessary visits to A&E.
- New financial incentives: to drive neighbourhood health and move activity away from hospitals

To some extent, there is nothing radically new in the 10 Year Plan in terms of PEOLC – focussing on personalised care, and seeking to support more people in their preferred place of death (where most people say they would prefer to be cared for and ultimately die at home rather than in hospital) is something the national Ambitions programme has been focussed on for some time, and the Cheshire and Merseyside PEOLC programme has been focussed on improving care planning for many years.

A focus on community based advice and support and on the development of rapid response teams will also be welcomed by many working in PEOLC – where we currently see mixed provision across Cheshire and Merseyside in terms of 24/7 advice and support to professionals and to patients and carers, and several localities have, to varying degrees, implemented urgent response teams to support people to remain at home, or support early rapid discharge from hospital.

In practice, SNPs will look very much like PCNs and a MNP will in most instances feel like each of our 9 localities – with the possible exception of Liverpool with a population of almost 500,000 and a combined Cheshire East and Cheshire West population of 750,000.

In October 2025 NHS England produced both a Medium Term Planning Framework ^{xcvii} and Strategic Commissioning Framework ^{xcviii} for ICBs

The Planning Framework sets out an ambition to shift the NHS agenda from short-termism to long-term, locally led improvement. Short and medium term priorities include a focus on end of life care, in particular reducing unnecessary non-elective admissions and bed days, and creating a plan to more effectively manage end of life patients.

PEOLC is explicitly listed as a service area that ICBs will be responsible for under the strategic commissioning framework (which is in line with the 2022 Statutory Guidance for Integrated Care Boards detailed above). The Framework describes four stages of Strategic Commissioning as:

- Understanding the context – deep population health analysis using linked data and lived experience.
- Developing long-term population health strategy – 5-year plans focused on outcomes and equity.
- Delivering through payor function – resource allocation, contracting, market shaping.
- Evaluating impact – rigorous outcome measurement and adaptation.

Implications for PEOLC within the framework include:

- Person-Centred Approach:
 - Commissioning will be based on population segmentation and risk stratification, ensuring PEOLC addresses equity in access, experience, and outcomes.
- Integration Across Pathways:
 - PEOLC will be part of neighbourhood health models, linking primary, community, and social care.
 - Greater collaboration with local government and VCSE organisations.
- Data-Driven Planning:
 - Use of predictive modelling to identify people at risk of needing EoLC earlier.
 - Co-production with people and families to design services that reflect lived experience.
- Quality and Value Focus:
 - Contracts will include quality metrics for PEOLC.
 - Potential for decommissioning or redesigning services that do not meet standards or deliver value.
- Innovation and Technology:
 - Digital tools (e.g., apps for advance care planning) and AI for predictive analytics.
- Workforce and Skills:
 - Emphasis on multidisciplinary teams, including palliative care specialists.
 - Training and capability development for commissioners and providers.
- Financial Model:
 - Move towards outcome-based contracts and possibly “year of care” tariffs for long-term conditions, which could include palliative pathways.

At the time of producing this Needs Assessment, further specific guidance was expected (in November 2025) on Neighbourhood Health.

Section 6: Summary & Recommendations

This PBNA has, for the first time, set out to assess the palliative care needs of the population, and to map and assess the service components to meet these needs. In doing so we have seen that:

- demand for services is expected to grow over the next decade as the population ages and has to live with multiple long-term conditions,
- people's experience of death and dying varies significantly depending on factors such as ethnicity, learning disability, disability and deprivation,
- too many people are dying where health and care agencies have not identified they are likely to die and where people haven't had the opportunity to think and plan for what might be important to them
- too often, people who are end of life attend A&E and are admitted to hospital when they could be cared for, and ultimately die, in more appropriate settings such as home, care home or hospice,
- the places where people are cared for and ultimately die vary depending on the conditions they are diagnosed with, or the places that they live,
- Cheshire and Merseyside sees far higher numbers of people dying in hospital compared to most parts of the country, and fewer deaths in care homes, despite having higher than average number of homes and beds for the population,
- Hospices across Cheshire and Merseyside receive less government funding (including ICB and local authority funding) than most of the rest of the country

In addition to such assessment and mapping, a PBNA should also make recommendations around priorities and service improvement, here we set out recommendations in three broad categories:

Data collection and reporting:

Through the process of developing the PBNA we have analysed data from a wide range of publicly available sources as well as internal ICB Business Intelligence. Some of this data is useful in an ad hoc, periodic review such as a PBNA, other data may be useful to review on a more regular basis and where possible to be able to report this at Place, PCN or Practice level.

The Cheshire and Merseyside End of Life Dashboard currently presents data on General Practice palliative and supportive care registers such as GSF, ACP and DNACPR. The dashboard should be expanded to incorporate data from this PBNA, and this data should be regularly updated. Recommended additional data includes:

- Length of time people spent on GSF registers, had ACP or a DNACPR preferences prior to death
- To be able to breakdown GSF, ACP and DNACPR registers by major causes of death, by ethnicity and by deprivation decile or quintiles.
- Reporting use of resources in the last 12 months of life such as hospital attendances and admissions, again to be able to break this down by major causes of death, by ethnicity and by deprivation decile or quintiles.
- Data held by hospices, hospitals and community teams should also be incorporated into the dashboard – this could include patients identified in hospital as likely to be in the last 12 months of life, or ACPs developed whilst people were supported by hospices.

In developing the PBNA we have also found that data on ethnicity has been limited – too often patient ethnicity is recorded as “not known” or simply not recorded – to make any analysis worthwhile, with so many gaps it simply hasn’t been possible to assess whether services are being used in an equitable way. This is compounded when other factors are considered such as disability and ethnicity or learning disability and ethnicity. We recognise that this issue is not unique to PEOLC. NHS organisations and other providers need to improve their recording of ethnicity data to inform and improve future service provision.

Similarly, information on patient experience has been limited, and the PBNA project has not had the capacity to undertake any new engagement activities to support the PBNA. In order to develop a PEOLC Strategy, partners across the health and care system (including the voluntary, community and faith sectors) need to work together to undertake engagement activities to understand the experience of dying people, their families and carers of local PEOLC services.

National Ambitions Framework:

The first ever Cheshire and Merseyside wide self-assessment against the national Ambitions of Palliative Care framework has been informative. Subject to capacity, and subject to future national developments of the framework, this exercise should be repeated on a 3-yearly basis to review progress.

On an annual basis, a self-assessment against Macmillan’s 10 Key Questions from the self-assessment would be informative.

PEOLC Strategy:

This PBNA is designed to inform the development of a PEOLC Strategy for Cheshire and Merseyside. Our analysis shows priorities for this strategy should include:

- Quality:
 - Improvements in hospice sustainability. This includes hospice funding, as well as workforce and future models of care
 - Addressing gaps in the provision of 7-day working
 - Improving performance against metrics for early identification and advance care planning, improving the access to and interoperability of Electronic Palliative Care Coordination Systems, and improving the quality of advance care plans.
- Place of Death:
 - Cheshire and Merseyside are an outlier in terms of the proportion of people who die in hospital, a future strategy should commit to reducing this and aim for the national average as a minimum.
- Building, training and sustaining the workforce:
 - Support and strengthen the learning and development for all staff involved in palliative and end of life care.
 - Build a strong team of specialists with the skills and ability to give expert support, advise other colleagues, and lead ongoing improvements in care across the system.
- Mitigate system impact:
 - We can see that too often that PEOLC patients are taken to hospital, admitted and have extended lengths of stay– many of these episodes are unnecessary and could be avoided. They worsen the experience of the individual patients and have negative consequences on the system in terms of delays in A&E, hospital bed availability and elective activity. A stronger PEOLC system, with greater community provision will not only improve the experience of patients who are

end of life and for their families and carers, it will also reduce this unnecessary negative impact on the wider health and care system

- 10 Year Plan:
 - PEOLC is mentioned several times in the Government's recent 10 Year Health Plan for England and supporting guidance. Specifically, this includes PEOLC working across multi neighbourhood providers and being seen as part of neighbourhood teams.
 - Implied within the 10-year plan is a need to support the Government's three "left shifts" – from hospital to community, from analogue to digital and from sickness to prevention.

Appendices

List of appendices

Acronyms used in this report

Gap analysis of current Children and Young People's PEOLC provision

Place of Death Trends - Cheshire and Merseyside

Place of Death by place 2023

NACEL Key Indicators table

Hospice Collaborative Service Catalogue (June 2025)

National Ambitions Self-Assessment

Useful resources

x9 place reports are available as separate downloads, but should be considered as appendices to the main PBNA report

Acronyms

A&E – Accident and Emergency Department

ACP - Advance Care Planning

BAME - Black Asian and Minority Ethnic

CHC - NHS Continuing Healthcare

CNS - Clinical Nurse Specialists

DNACPR - Do Not Attempt Cardiopulmonary Resuscitation

ED – Emergency Department

EPaCCS - Electronic Palliative Care Coordination Systems

GSF - Gold Standards Framework

HALE - Healthy Life Expectancy

ICB - Integrated Care Board

ICS - Integrated Care System

IPU – Inpatient Unit

MDT - Multidisciplinary Team

OHID - Office for Health Improvement and Disparities

ONS - Office for National Statistics

PBNA - Population Based Needs Assessments

PCN - Primary Care Network

PEOLC - Palliative and End of Life Care

SASS - Specialty and Specialist Grade

SPC - Specialist Palliative Care

VCSE – Voluntary, Community and Social Enterprise sector

Gap analysis of current CYP PEOLC provision

On behalf of the Cheshire and Merseyside PEOLC Programme, Claire House Children's Hospice has undertaken an initial self-assessment against the CYP National Service Specification.

Theme	Area of Activity	Do you provide this? RAG rate
1. Universal	Primary Care	
	Health Visitors	
	Social Care	
	Education	
	Community Groups	
2. Enhanced	bereavement support for non-complex grief	
	emotional and practical support, including advocacy	
	parent/carer support and groups	
	sibling support including activities	
	complementary therapies	
3. Core	The key objectives of the core PEoLC MDT are:	
	ensure a personalised care and support plan, and where applicable an advance care plan, are offered, agreed and followed by all services in regard to care and support	
	plan and deliver symptom control	
	for each child or young person identify a care co-ordinator or key worker who is responsible for co-ordinating their care	
	all relevant services to meet the needs (physical, emotional and psychological) of the child or young person are engaged and available for access as appropriate	
	the equipment and resources needed to support the child or young person are available at the right time and in the right place	
	all medicines and prescribing are available when needed, with appropriate specialist support as required	
	all transfers of care are planned and plans communicated, eg discharge planning	
	short breaks or respite within age appropriate settings are offered (see note)	
	professionals (universal and core) have the relevant training and skills, and know when to seek specialist advice.	

4. Specialist	The provider must ensure the delivery of the components of a specialist palliative care team, which include:	
	advanced symptom management:	
	– complex symptom management skills	
	– knowledge of the dying process	
	– understanding of rare disorders and their pathways	
	parallel planning and enhanced supportive care	
	support for advance care planning, including emergency care planning and accessing children’s continuing care	
	support for end of life decision-making, including preferred place of care	
	rapid discharge for end of life care, including fast track to hospice or home	
	specialist medical and nursing support, available 24/7, for hospices, acute trusts, community palliative care teams and tertiary centres	
	specialist equipment in the home (where not included in children’s continuing care arrangements)	
	input into MDTs, ‘team around the child’ (TAC), pre- and debriefs relating to a child or young person’s death, and other professional meetings, at hospitals, hospices and in the community	
	identification of those with complex grief and at ‘high risk’, and their signposting/referral to appropriate local and/or specialist bereavement services	
	education and training programmes across care settings, including bespoke patient-specific training of professionals in the use of specialist paediatric palliative care equipment, eg community patient-controlled analgesia and drug infusion devices.	
	Specialist short breaks (see note)	

Place of Death Trends (%) - Cheshire and Merseyside

	Hospital	Home	Care Home	Hospice	Other
2013	50.2	21.5	20.8	5.7	1.8
2014	48.7	22.1	21.2	6.0	1.9
2015	48.0	21.9	22.5	5.8	1.8
2016	49.1	22.9	20.8	5.4	1.9
2017	48.5	22.8	21.1	5.8	1.9
2018	48.5	23.0	21.2	5.3	2.0
2019	47.6	23.5	21.2	5.5	2.0
2020	44.9	26.6	22.7	3.8	2.0
2021	47.9	27.8	18.5	3.7	2.1
2022	47.9	27.6	18.4	3.8	2.2
2023	47.5	26.7	19.3	4.3	2.1
England 2023	42.7	28.4	21.0	5.2	2.6

Source Mortality by place of death in 2023, ONS

<https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/mortalitybyplaceofdeathin2023>

Place of Death by Place 2023					
	Hospital	Home	Care Home	Hospice	Other
Cheshire East	42.9	25.3	24.2	5.8	1.8
Cheshire West & Chester	44.2	26.1	23.3	4.3	2.2
Halton	54.2	27.7	11.2	4.7	2.1
Knowsley	55.3	29.5	8.6	4.1	2.5
Liverpool	52.3	28.2	12.2	4.6	2.6
Sefton	44.3	25.6	23.2	5.3	1.7
St Helens	51.5	28.4	15.9	2.5	1.7
Warrington	46.1	24.3	22.2	4.9	2.5
Wirral	46.6	27.1	22.4	2.1	1.8
C&M	47.5	26.7	19.3	4.3	2.1
England	42.7	28.4	21.0	5.2	2.6

Source Mortality by place of death in 2023, ONS

<https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/mortalitybyplaceofdeathin2023>

NACEL Key Indicators table

NACEL key indicators		National (%)	Countess of Chester	East Cheshire Trust - Macclesfield (%)	Liverpool Heart and Chest (%)	LU Aintree and LU Aintree Broadgreen (%)	LU Royal Liverpool and Broadgreen (%)	Mersey and West Lancashire = Southport & Ormskirk (%)	Mersey and West Lancashire = Southport & Ormskirk (%)	Mid Cheshire Trust - Leighton (%)	The Clatterbridge Cancer Centre (%)	The Clatterbridge Cancer Centre (%)	Warrington and Halton (%)	Wirral - Arrowe Park Clatterbridge (%)
The number of deaths where it was expected that the person would die during the final admission as a proportion of the sample 'all 1 deaths' included in the audit		82.9%	63.7%	66.1%	59.0%	88.8%	85.0%	72.4%	92.2%	87.9%	73.7%	100.0%	76.7%	88.1%
The proportion of people who died with documented evidence in their clinical records of communication about hydration with those 2 important to the dying person, or a reason recorded why not		60.8%	70.6%	47.9%	68.1%	57.5%	60.0%	41.4%	65.6%	69.5%	77.1%	53.7%	62.7%	57.3%
The proportion of people who died with documented evidence in their clinical records that anticipatory medication was prescribed for 3 symptoms likely to occur in the last days of life		86.1%	93.9%	93.5%	90.1%	93.5%	93.7%	89.5%	92.0%	86.8%	95.7%	96.4%	90.4%	93.9%
The proportion of people who died with documented evidence in their clinical records of an assessment of the emotional/psychological 4 needs of the person, or a reason recorded why not		81.7%	77.5%	42.4%	94.0%	85.0%	78.8%	77.6%	95.6%	91.4%	93.2%	95.1%	70.2%	77.1%
The proportion of bereaved people that rated the overall care and support given to themselves and others by the hospital as excellent or 5 good		71.7%	80.0%	69.3%	-	100.0%	-	70.8%	76.1%	65.7%	100.0%	83.3%	81.4%	81.4%
The proportion of hospital/sites with a face-to-face specialist palliative care service (doctor and/or nurse) available 8 hours a day, 7 6 days a week		62.7%	0.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%
The proportion of bereaved people that strongly agree or agree that 7 they were communicated to by staff in a sensitive way		82.6%	100.0%	84.4%	-	100.0%	-	82.6%	80.4%	80.0%	100.0%	75.0%	89.1%	89.1%
The proportion of people who died who had an individualised plan of care addressing their needs at the end of life, where it was recognised 8 that the person may die during the final admission		74.1%	87.1%	66.9%	61.7%	87.5%	86.3%	71.9%	87.4%	78.6%	83.9%	92.3%	58.5%	76.2%
The proportion of people who died with ethnicity documented in their 9 clinical records		86.4%	98.0%	80.6%	88.5%	85.0%	70.0%	91.4%	100.0%	99.6%	94.1%	82.9%	96.5%	96.4%
The proportion of staff respondents that strongly agree or agree that within the area they work there is a culture that prioritises compassion and support as fundamental in all interactions with dying patients and those important to them														
10 (Hiatus on reporting indicator in 2025, but will be re-included in 2026)		87.7%	84.2%	81.4%	98.1%	85.6%	80.0%	89.9%	91.6%	82.4%	100.0%	86.8%	81.6%	83.4%

Hospice Collaborative Service Catalogue

Cheshire and Merseyside Hospice Provider Collaborative - Catalogue of Services @ JUNE 2025												
Hospice Service Map	Cheshire Devo				Merseyside							Claire House Children's Hospice - Region+
	St Luke's Hospice	Hospice of The Good Shepherd	East Cheshire Hospice	St Rocco's Hospice	Halton Haven Hospice	Wirral Hospice St Johns	Woodlands Hospice	Willowbrook Hospice	St Joseph's Hospice	Queenscourt Hospice		
Specialist Palliative Care Services (Inpatient)												
Inpatient Unit	St Luke's Hospice	Hospice of The Good Shepherd	East Cheshire Hospice	St Rocco's Hospice	Halton Haven Hospice	Wirral Hospice St Johns	Woodlands Hospice	Willowbrook Hospice	St Joseph's Hospice	Queenscourt Hospice (approx 60% for C&M)	Claire House Children's Hospice - Region+	
	Central Cheshire	West Cheshire	East Cheshire Place	Warrington Place	Halton Place	Wirral Place	Liverpool Place	Knowsley and St Helen's Place	Sefton Place, Liverpool Place	Sefton Place		
Total no. physical bed spaces	10	10	15	10	10	14	15	10	31	6	10	
'Baseline' capacity: no. registered IPU beds budgeted for & open for admissions	10	10	15	10	10	14	14 + 1 ambulatory	10	31	6	7	
Weekend and Bank Holiday Admissions	Y		Y emergency only OOHs	Y emergency only OOHs	Y	Y emergency only OOHs	Y	Y	Y	Y	Y	
5pm to 9am Admissions			Y emergency only OOHs	Y emergency only OOHs		Y	Y emergencies only OOH	Y	Y	Y	Y	
24-hour specialist palliative care advice lines												
Specialist Palliative and End of Life Care Advice Line	St Luke's Hospice	Hospice of The Good Shepherd	East Cheshire Hospice	St Rocco's Hospice	Halton Haven Hospice	Wirral Hospice St Johns	Woodlands Hospice	Willowbrook Hospice	St Joseph's Hospice	Queenscourt Hospice	Claire House Children's Hospice - Region+	
	Central Cheshire	West Cheshire	East Cheshire Place	Warrington Place	Halton Place	Wirral Place	Liverpool Place	Knowsley and St Helen's Place	Sefton Place	Sefton Place		
Hospice provides 24/7 advice line	Y	Under Review	Y	Y collaborative provision	Y via Willowbrook	Y	Y	Y	Y	Y	Y	
In operation 24/7	Y	Under Review	Y	Y collaborative provision	Y	Y	Y	Y	Y	Y For professionals only	Y	
Access:												
Available to health and social care professionals, including care home staff? (Y/N)	Y	Under Review	Y	Y		Y	Y	Y	Y	Y	Y	
Available to patients and carers? (Y/N)	Y	Under Review	Y	Y (9-5/7 day)		Y	Y		Y	Y (9-8pm)	Y	
On Site Services (Not Inpatient)												
Clinics	St Luke's Hospice	Hospice of The Good Shepherd	East Cheshire Hospice	St Rocco's Hospice	Halton Haven Hospice	Wirral Hospice St Johns	Woodlands Hospice	Willowbrook Hospice	St Joseph's Hospice	Queenscourt Hospice (approx 60% for C&M)	Claire House Children's Hospice - Region+	
	Central Cheshire	West Cheshire	East Cheshire Place	Warrington Place	Halton Place	Wirral Place	Liverpool Place	Knowsley and St Helen's Place	Sefton Place, Liverpool Place	Sefton Place		
Medical Outpatients		Y (suspended)		Y	Y	Y	Y	Y		Y	Y	
Disease Specific Outpatient Clinics:												
Neurological support					Y	Y						
Motor Neurone Disease Clinic	Y		MND wellbeing day		Pending	Y		N - general OP				

Services for people with Dementia											
Trained dementia champion available (staff member or external advisor)	Y	Y	Y	Y (Dementia friends)	Y	Y	Y	Y	Y	Y	Y
Staff have access to training in dementia care	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Lead Dementia Nurse			Y		Y	Y Via Acute	Y	Y	Y	Y	Y
Patients with Dementia can access:											
Inpatient unit admissions	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Advance care planning service offered for patient and those important to them	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	ACP and ACMP are developed during individual patient assessments
Holistic outpatient assessment offered for patient and those important to them	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Well being/day therapy services	Y	Y	Y	Y	Pending			Y			
Dementia carers well being programme	Y		Y		Pending						
Nurse-led Clinic	Y		Y				Y				
Community Dementia Companion Service			Y		Pending						
Day care for patient so their carer can attend the course	Y		Y								
Love to Move Class for Dementia	Y		Y								
Singing Together for Dementia Wellbeing	Y		Y						Y		
Dementia friendly facilities	Y	Y	Y	Y			Y	Y	Y	Y	Y
Work closely with local memory clinics	Y		Y	Y							
Dementia support specific activities at Weekend	Y		Y								

Community care where hospice attends individuals in own care setting

Community services available:	St Luke's Hospice Central Cheshire	Hospice of The Good Shepherd West Cheshire	East Cheshire Hospice East Cheshire Place	St Rocco's Hospice Warrington Place	Halton Haven Hospice Halton Place	Wirral Hospice St Johns Wirral Place	Woodlands Hospice Liverpool Place & Sefton	Willowbrook Hospice Knowsley and St Helen's Place	St Joseph's Hospice Sefton Place	Queenscourt Hospice Sefton Place	Claire House Children's Hospice - Region+
Virtual Ward	Under Review	Under Review		Y			Sep-25			charitable funded service ceased 2024	
Hospice at Home (hands-on care, e.g. during last days of life)			Y			Y	Y			Y	Y
Hospice in Your Care Home	Y - unfunded w/end visits		Y	Y (would visit as part of virtual ward)		Y medical visits with Community Trust SPCN/ EOLC team input	Y medical ACP assessment to support community teams			Y	
Night support service provided by Hospice			Y			Y	Y			Y	
Domiciliary care provided by Hospice			Y			Y + meals & light tasks if req	Y				Y
Therapies in the home	Y	Y	In progress	Y		Y	Y	Y		Y	Y

Education & Training for external health & care staff and unpaid carers

Education & Training	St Luke's Hospice Central Cheshire	Hospice of The Good Shepherd West Cheshire	East Cheshire Hospice East Cheshire Place	St Rocco's Hospice Warrington Place	Halton Haven Hospice Halton Place	Wirral Hospice St Johns Wirral Place	Woodlands Hospice Liverpool Place	Willowbrook Hospice Knowsley and St Helen's Place	St Joseph's Hospice Sefton Place	Queenscourt Hospice Sefton Place	Claire House Children's Hospice - Region+
Education & training available for local health care staff external to the hospice	Y via End of Life Partnership	Y Funded by the Hospice via EoLP for Hospice only since West Place funding withdrawn 24/25	Y Hospice provides internally and to 3rd parties and visa versa. Integrated delivery and some training via End of Life Partnership	Y Hospice provides internally and to 3rd parties and visa versa. Integrated delivery	Y	Y Joint delivery through Ed hub	Y	Y	Planned for future	Y	Y
Pre and post graduate health care professional training	Y			Y		Y	Y	Y		Y	Y
Education & training available for local social care staff	Y	Y Primarily end of life partnership	Y	Y	Y	Y	Y	Y		Y	

National Ambitions Self-Assessment

This document is too large to insert as appendix, and is available as a separate download from the End of Life Partnership website <https://eolp.co.uk/pbna/>

Useful resources

Finger tips <https://fingertips.phe.org.uk/>

Fingertips is a large public health data collection maintained by Public Health England.

Data is organised into themed profiles including significant data linked to palliative and end of life care such as mortality rates for various diseases and conditions and place of death data.

NHS Futures <https://future.nhs.uk/>

The NHS Futures Palliative and End of Life Care Network workspace is for colleagues working to improve palliative and end of life care (PEOLC) for people, patients, families and carers. Members can share best practice, upcoming events, and start a discussion to learn from each other. All national updates and key publications are shared on the workspace.

Hospice UK Pop Nat <https://popnat.hospiceuk.org/>

PopNAT is Hospice UK's population needs assessment tool. Created to bring together relevant and up to date population data for end of life care across the UK. For use by hospices and decision makers to understand and plan palliative and end of life care services for their local populations.

Better End of Life Care <https://www.mariecurie.org.uk/research-and-policy/policy/better-end-life-report>

This important new research from Marie Curie is the largest nationally representative survey of people affected by dying, death and bereavement since 2015 (when the National Survey of Bereaved People (VOICES) ceased).

Cheshire and Merseyside End of Life Dashboard

The Cheshire and Merseyside Palliative & End of Life Care programme aims to ensure equitable access to high-quality end-of-life care across Cheshire & Merseyside. To support this, the programme has developed an End of Life data dashboard, which is populated from clinical systems for all GP practices in Cheshire and Merseyside.

For queries on the EOL Dashboard, or to request access, email **datamanagement.bi@cheshireandmerseyside.nhs.uk**

E Paige <https://www.cheshire-epaige.nhs.uk/>

EPAIGE (Electronic Proactive Assessment and Information Guide for End-of-Life Care) is the go-to place for relevant information and resources for anyone working in palliative and end of life care in Cheshire. EPAIGE has been designed to support palliative and end of life care professionals working in any care setting. It serves as a “library”, leading you to wide range of key resources, including:

- Best Practice Documentation
- National and Local Guidelines
- Assessment Tools
- Useful Contacts

North West Coast Clinical Networks, Palliative and End of life Care

<https://www.england.nhs.uk/north-west/north-west-coast-strategic-clinical-networks/our-networks/palliative-and-end-of-life-care/>

North West Coast Clinical Networks work with commissioners and providers of healthcare to reduce variation and improve quality of care including working in palliative and end of life care.

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

<https://ncepod.org.uk/2024eolc.html>

Published “Planning for the End” in 2024. This is a review of the quality of care provided to adult patients with a diagnosis of dementia, heart failure, lung cancer or liver disease towards the end of life, The report produced a number of recommendations for improving care which have been widely endorsed by clinicians.

Ambitions for palliative and end of life care: A national framework for local action 2021-2026 <https://www.england.nhs.uk/eolc/ambitions/>

The Ambitions framework was developed by a partnership of national organisations across the statutory and voluntary sectors. It sets out our vision to improve end of life care through partnership and collaborative action between organisations at local level throughout England.

Macmillan Palliative and end of life care resources for healthcare professionals

<https://www.macmillan.org.uk/healthcare-professionals/cancer-pathways/palliative-and-end-of-life-care>

End notes

- i Marmot et al. (2020) Health Equity in England: The Marmot Review 10 years on. Executive summary. Institute of Health Equity. Available from: <https://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on/the-marmot-review-10-years-on-executive-summary.pdf> (Accessed 9 July 2025).
- ii Requirements for a PBNA were originally set out in the 2006 End of Life Care Strategy by the National Council for Palliative Care https://www.ncpc.org.uk/sites/default/files/NCPC_EoLC_Submission.pdf
- iii Palliative and end of life care: Statutory guidance for integrated care boards [NHS England » Palliative and end of life care: Statutory guidance for integrated care boards \(ICBs\)](#) (accessed 20/08/2025)
- iv *Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026* <https://www.england.nhs.uk/publication/ambitions-for-palliative-and-end-of-life-care-a-national-framework-for-local-action-2021-2026/> (accessed 20/08/2025)
- v Consensus Definition of Advance Care Planning (Sudore et al 2017) <https://pubmed.ncbi.nlm.nih.gov/28062339/> (accessed 20/08/2025)
- vi *Specialist palliative and end of life care services, NHS England (2023)* <https://www.england.nhs.uk/wp-content/uploads/2023/01/B1674-specialist-palliative-and-end-of-life-care-services-adult-service-specification.pdf> (accessed 20/08/2025)
- vii ONS Population Projections <https://www.ons.gov.uk/releases/subnationalpopulationprojections2022based> (accessed 20/08/2025)
- viii ONS Population Projections <https://www.ons.gov.uk/releases/subnationalpopulationprojections2022based> (accessed 20/08/2025)
- ix What are health inequalities? Kings Fund <https://www.kingsfund.org.uk/insight-and-analysis/long-reads/what-are-health-inequalities#:~:text=The%20gap%20in%20healthy%20life,shorter%20lives%20in%20poor%20health.> (accessed 09/07/2025)
- x All Together Fairer: Health equity and the social determinants of health in Cheshire and Merseyside , which provides a significant amount of socioeconomic data relevant to the PBNA. <https://www.instituteofhealthequity.org/resources-reports/all-together-fairer-health-equity-and-the-social-determinants-of-health-in-cheshire-and-merseyside> (accessed 12/02/25)
- xi Healthy life expectancy <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/bulletins/healthstatelifeexpectanciesbyindexofmultipledeprivationimd/2015to2017#:~:text=4.,Image%20.csv%20.xls>
- xii Review of health data shows key areas of concern for Cheshire and Merseyside <https://champspublichealth.com/review-of-health-data-shows-key-areas-of-concern-for-cheshire-and-merseyside/> (accessed 12/04/2025)
- xiii Review of health data shows key areas of concern for Cheshire and Merseyside <https://champspublichealth.com/review-of-health-data-shows-key-areas-of-concern-for-cheshire-and-merseyside/> (accessed 12/04/2025)
- xiv House of Lords (2021) Science and Technology Committee inquiry. Ageing society: the grand challenge. Available from: [Science and Technology Committee report—Ageing: Science, Technology and Healthy Living - House of Lords Library](#) (Accessed 9 July 2025).
- xv Health in 2040: projected patterns of illness in England https://www.health.org.uk/sites/default/files/upload/publications/2023/Projected%20patterns%20of%20illness%20in%20England_WEB.pdf (accessed 09/07/2025)
- xvi ‘Ethnicity Profiles in Cheshire and Merseyside’ <https://static1.squarespace.com/static/57d2317e579fb3d5c112ad5a/t/646b8e99ef30617fa5a24d17/1684770468624/Ethnicity+profiles+in+Cheshire+and+merseyside.pdf> (accessed 20/02/25)

-
- xvii The health of people from ethnic minority groups in England, Kings Fund May 2023
<https://www.kingsfund.org.uk/insight-and-analysis/long-reads/health-people-ethnic-minority-groups-england>
(accessed 04/11/2025)
- xviii Inequalities in mortality rates by disability | The Health Foundation <https://www.health.org.uk/evidence-hub/health-inequalities/inequalities-in-mortality-rates-by-disability#:~:text=Mortality%20rates%20for%20disabled%20people%20are%20more%20than,the%20higher%20their%20mortality%20rates%20tend%20to%20be.>
- xix Disability data from 2021 national Census
<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/disabilityenglandandwales/census2021> (accessed 21/02/25)
- xx End-of-life care for adults with long-standing physical disability from the perspectives of bereaved family members: a qualitative exploratory study (2023)
<https://www.tandfonline.com/doi/full/10.1080/09687599.2023.2279480#d1e359> (accessed 09/07/2025)
- xxi NHS England: Palliative and end of life care <https://www.england.nhs.uk/eolc/> (accessed 09/07/2025)
- xxii Mencap Learning Disability Statistics <https://www.mencap.org.uk/learning-disability-explained/research-and-statistics/how-common-learning-disability> (accessed 23/04/25)
- xxiii Learning from Lives and Deaths – people with a learning disability and autistic people (LeDeR), Kings College <https://www.kcl.ac.uk/research/leder>
- xxiv <https://www.england.nhs.uk/learning-disabilities/improving-health/learning-from-lives-and-deaths/>
- xxv NHS England’s “Health and Care of People with Learning Disabilities Experimental Statistics
<https://digital.nhs.uk/data-and-information/publications/statistical/health-and-care-of-people-with-learning-disabilities#summary> (accessed 25/07/25)
- xxvi ‘Make Every Child Count’ Estimating current and future prevalence of children and young people with life-limiting conditions in the United Kingdom. <https://www.togetherforshortlives.org.uk/resource/make-every-child-count/>
- xxvii ‘Make Every Child Count’ Estimating current and future prevalence of children and young people with life-limiting conditions in the United Kingdom. <https://www.togetherforshortlives.org.uk/resource/make-every-child-count/>
- xxviii National Child Mortality Database (NCMD) www.ncmd.info
- xxix Child mortality – RCPCH – State of Child Health
<https://stateofchildhealth.rcpch.ac.uk/evidence/mortality/child-mortality/#:~:text=The%20top%20three%20causes%20of%20death%20in,deprived%20areas%20are%20more%20likely%20to%20die.>
- xxx Adolescent mortality – RCPCH – State of Child Health
<https://stateofchildhealth.rcpch.ac.uk/evidence/mortality/adolescent-mortality/>
- xxxi Patterns of Functional Decline at the End of Life Lunney et al (2003)
<https://jamanetwork.com/journals/jama/fullarticle/196538>
- xxxii Illness trajectories and palliative care, Murrat et al 2005
https://www.pure.ed.ac.uk/ws/portalfiles/portal/10174041/Illness_trajectories_and_palliative_care.pdf
- xxxiii Palliative care from diagnosis to death Murray et el 2017 <https://www.bmj.com/content/356/bmj.j878.full>
- xxxiv Using illness trajectories to inform person centred, advance care planning, Murray et al (2024)
<https://www.bmj.com/content/384/bmj-2021-067896>
- xxxv NHS Improving Quality. End of Life Care in Advanced Kidney Disease (2015)
<https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/Advanced-kidney-disease.pdf>
- xxxvi NCEPOD - End of Life Care: (2024) <https://www.ncepod.org.uk/2024eolc.html>
- xxxvii The Bow Tie Model of 21st Century Palliative Care - Journal of Pain and Symptom Management
[https://www.jpmsjournal.com/article/S0885-3924\(13\)00609-X/fulltext](https://www.jpmsjournal.com/article/S0885-3924(13)00609-X/fulltext) (accessed 22/04/25)

-
- xxxviii The Health Foundation – Health in 2040: projected patterns of illness in England <https://www.health.org.uk/reports-and-analysis/reports/health-in-2040-projected-patterns-of-illness-in-england> (accessed 26/03/25)
- xxxix Quality and Outcomes Framework, 2019-20 <https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2019-20>
- xl Liver disease profile, April 2024 update <https://www.gov.uk/government/statistics/liver-disease-profile-april-2024-update/liver-disease-profile-april-2024-update> (accessed 03/04/25)
- xli British Liver Trust statistics <https://britishlivertrust.org.uk/information-and-support/statistics/> accessed 02/04/25).
- xlii National service framework: long term conditions (2005) <https://www.gov.uk/government/publications/quality-standards-for-supporting-people-with-long-term-conditions>
- xliii Independent investigation of the NHS in England (The Darzi Report) <https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england> (accessed 20/08/2025)
- xliv 2014 VOICES survey <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/nationalsurveyofbereavedpeoplevoices/2015-07-09> (accessed 29/03/25)
- xlv Mortality by place of death in 2023, ONS <https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/mortalitybyplaceofdeathin2023>
- xlvi To request access to the C&M EOL Data Dashboard, use this link <https://dynamis-birequestform.xmerseyhc.nhs.uk/>
- xlvii Changes to the GP Contract in 2025/26, NHS England <https://www.england.nhs.uk/long-read/changes-to-the-gp-contract-in-2025-26/> (accessed 01/08/2025)
- xlviii Palliative and end of life care, UK Parliament Research Briefing <https://researchbriefings.files.parliament.uk/documents/POST-PN-0675/POST-PN-0675.pdf> (accessed 01/08/2025)
- xlivx Gold Standards Framework weblink <https://www.goldstandardsframework.org.uk/>
- l National Audit of Care at the End of Life: State of the Nations Report (2024) <https://www.nacel.nhs.uk/outputs> (accessed 18/08/2025)
- li NHS England Specialist Level Palliative Care: Information for commissioners <https://www.england.nhs.uk/wp-content/uploads/2016/04/speclst-palliatv-care-comms-guid.pdf> (accessed 12/04/2025)
- lii NHS England » NHS Continuing Healthcare [https://www.england.nhs.uk/healthcare/#:~:text=NHS%20Continuing%20Healthcare%20\(NHS%20CHC,.be%20found%20on%20nhs.uk](https://www.england.nhs.uk/healthcare/#:~:text=NHS%20Continuing%20Healthcare%20(NHS%20CHC,.be%20found%20on%20nhs.uk) (accessed 03/10/2025)
- liii Department of Health and Social Care (2022) ‘Fast-track pathway tool for NHS continuing healthcare guidance’. www.gov.uk/government/publications/nhs-continuing-healthcare-fast-track-pathway-tool/fast-track-pathway-tool-for-nhs-continuing-healthcare-guidance . Accessed 03 10 2025.
- liv Continuing to care? Older people let down by NHS Continuing Healthcare, Age UK December 2024 <https://www.ageuk.org.uk/siteassets/documents/reports-and-publications/consultation-responses-and-submissions/health--wellbeing/continuing-to-care---nhs-continuing-healthcare-report.pdf> (accessed 03/10/2025)
- lv All or nothing? Access and variation in NHS continuing health care, Nuffield Trust, September 2025 https://www.nuffieldtrust.org.uk/sites/default/files/2025-09/Nuffield%20Trust%20-%20Continuing%20health%20care_WEB.pdf (accessed 03/10/2025)
- lvi Continuing Healthcare and NHS-funded Nursing Care, NHS England <https://www.england.nhs.uk/statistics/statistical-work-areas/nhs-chc-fnc/> (accessed 03 10 25)

-
- lvii End of Life Care in Frailty: Care homes | British Geriatrics Society <https://www.bgs.org.uk/end-of-life-care-in-frailty-care-homes#:~:text=The%20average%20life%20expectancy%20in,for%20care%20homes%20with%20nursing>
- lviii Gold Start Framework, Care Home Guidance <https://www.goldstandardsframework.org.uk/training-accreditation/care-homes/>
- lix NHS England » Enhanced health in care homes framework (2020) <https://www.england.nhs.uk/publication/enhanced-health-in-care-homes-framework/#:~:text=This%20framework%20is%20for%20primary,read%20alongside%20these%20contractual%20requirements.> (accessed 17/07/25)
- lx Predicted future care home deaths <https://journals.sagepub.com/doi/10.1177/0269216317734435>
- lxi Care home facts & stats | Settings, population & workforce <https://www.carehome.co.uk/advice/care-home-stats-number-of-settings-population-workforce>
- lxii Care home beds, CQC data taken from <https://popnat.hospiceuk.org/>
- lxiii ONS End of Life Profiles <https://fingertips.phe.org.uk/profile/end-of-life/data#page/1/gid/1938133060/ati/15/cid/4/tbm/1>
- lxiv Nuffield Quality Watch information on Care Home Beds <https://www.nuffieldtrust.org.uk/resource/care-home-bed-availability#:~:text=Between%202012%20and%202023%2C%20the,usually%20not%20be%20provided%20elsewhere.>
- lxv Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives (December 2012). <https://apmonline.org/wp-content/uploads/CommissioningGuidanceforSpecialistPalliativeCare.pdf>
- lxvi Revised recommendations on standards and norms for palliative care in Europe from the European Association for Palliative Care (2020) https://pmc.ncbi.nlm.nih.gov/articles/PMC9006395/pdf/10.1177_02692163221074547.pdf (accessed 12/03/25)
- lxvii Specialist palliative and end of life care services: Adult service specification, NHS England <https://www.england.nhs.uk/wp-content/uploads/2023/01/B1674-specialist-palliative-and-end-of-life-care-services-adult-service-specification.pdf> (accessed 31/07/2025)
- lxviii Hospice at Home definition <https://www.nahh.org.uk/about-hospice-care/what-is-hospice-at-home>
- lxix Anne Robson Trust average length of stay for hospice inpatients <https://annerobsontrust.org.uk/surely-thats-what-hospices-do/#:~:text=The%20average%20length%20of%20stay,to%20provide%20long%20stay%20care> (accessed 23/04/25).
- lxx Cheshire and Merseyside ICB have determined the average full cost of a Hospice Inpatient bed per day for 25/26 to support costing methodologies in the Hospice Review Programme.
- lxxi The financial sustainability of England's adult hospice sector, National Audit Office, October 2025 <https://www.nao.org.uk/reports/the-financial-sustainability-of-englands-adult-hospice-sector/> (accessed 04/11/2025)
- lxxii The financial sustainability of England's adult hospice sector, National Audit Office, October 2025 <https://www.nao.org.uk/reports/the-financial-sustainability-of-englands-adult-hospice-sector/> (accessed 04/11/2025)
- lxxiii The term 'SAS doctor' includes specialty doctors and specialist grade doctors with at least four years of postgraduate training, two of which are in a relevant specialty. <https://www.healthcareers.nhs.uk/explore-roles/doctors/career-opportunities-doctors/sas-doctors>
- lxxiv The Coalition of Frontline Care Report <https://www.goldstandardsframework.org.uk/coalition-of-frontline-care> (accessed 12/04/2025)
- lxxv Primary Care Network Workforce database (Dec'24) <https://app.powerbi.com/view?r=eyJrIjoiYmEyMTk4NGYtOWFiMC00MTA2LTk5NmUtZmExZjFjMGI3NWFlwliwidCI6IjM3YzM1NGlyLTg1YjAtNDdmNS1iMjlyLTA3YjQ4ZDc3NGVlMyJ9> (accessed 12/04/2025)

-
- lxxvi General Practice Workforce Interactive Dashboard (Dec '24) <https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/31-december-2024> (accessed 12/04/2025)
- lxxvii Public Health England, Palliative and end of life care factsheet: Patterns of care, England 2023 https://fingertips.phe.org.uk/documents/peolc_patterns_of_care_factsheet_2023.html
- lxxviii Public Health England, Palliative and end of life care factsheet: Patterns of care, England 2023 https://fingertips.phe.org.uk/documents/peolc_patterns_of_care_factsheet_2023.html
- lxxix Public expenditure in the last year of life Marie Curie Policy briefing, February 2025 <https://www.mariecurie.org.uk/document/public-expenditure-in-the-last-year-of-life-briefing> (accessed 14/08/2025)
- lxxx Key facts and figures about the NHS, Kings Fund <https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/key-facts-figures-nhs> (accessed 14/08/2025)
- lxxxi 65% of adults are worried about access to palliative care, Kings College <https://www.kcl.ac.uk/news/65-of-adults-are-worried-about-access-to-palliative-care> (accessed 12/04/2025)
- lxxxii Marie Curie Time to Care (2024) <https://www.mariecurie.org.uk/globalassets/media/documents/policy/beol-reports-2024/beol-2024-report-england-commentary.pdf> (accessed 03/03/25)
- lxxxiii Feedback from bereaved relatives via Medical Examiners: what kinds of concerns are raised? BMJ <https://bmjopenquality.bmj.com/content/14/1/e003152> (access 12/04/2025)
- lxxxiv Palliative and End of Life Care Statutory Guidance for Integrated Care Boards (ICBs) <https://www.england.nhs.uk/wp-content/uploads/2022/07/Palliative-and-End-of-Life-Care-Statutory-Guidance-for-Integrated-Care-Boards-ICBs-September-2022.pdf>
- lxxxv Palliative and end of life care: Statutory guidance for integrated care boards (ICBs) NHS England <https://www.england.nhs.uk/publication/palliative-and-end-of-life-care-statutory-guidance-for-integrated-care-boards-icbs/> (accessed 25/04/2025)
- lxxxvi NHS Cheshire & Merseyside Transformation Programmes 2024-29 <https://www.cheshireandmerseyside.nhs.uk/media/32hj2aic/our-core-transformation-programmes-plans-on-a-page.pdf>
- lxxxvii Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026 <https://www.england.nhs.uk/publication/ambitions-for-palliative-and-end-of-life-care-a-national-framework-for-local-action-2021-2026/>
- lxxxviii End of life care for adults, NICE Quality standard:QS13 <https://www.nice.org.uk/guidance/qs13>
- lxxxix End of life care for infants, children and young people, NICE Quality standard :QS160 <https://www.nice.org.uk/guidance/qs160>
- xc Planning for the End: A review of the quality of care provided to adult patients towards the end of life (2024) <https://ncepod.org.uk/2024eolc.html>
- xc Commission on Palliative and End-of-Life Care <https://palliativecarecommission.uk/>
- xcii Commission on Palliative and End-of-Life Care – reports <https://palliativecarecommission.uk/reports> (accessed 07/07/25)
- xciii Fit for the Future: 10 Year Health Plan for England <https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future> (accessed 05/07/25)
- xciv Fit for the Future: 10 Year Health Plan for England <https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future> (accessed 05/07/25)
- xcv The Darzi Report “Independent investigation of the NHS in England” (2024) <https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england> (accessed 05/07/25)
- xcvi ‘Lord Darzi review: Keir Starmer says NHS is broken but no extra funding without reform’ - BBC News <https://www.bbc.co.uk/news/live/c0qejsx03zjnt> (accessed 21/07/25)
- xcvii Medium Term Planning Framework – delivering change together 2026/27 to 2028/29, NHS England <https://www.england.nhs.uk/publication/medium-term-planning-framework-delivering-change-together-2026-27-to-2028-29/> (accessed 07/11/2025)
- xcviii Strategic commissioning framework, NHS England <https://www.england.nhs.uk/long-read/strategic-commissioning-framework/> (accessed 07/11/2025)
-