



Cornwall Partnership
NHS Foundation Trust

Palliative & End of Life Care reform programme update

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Outstanding care for all



Definitions

What do we mean by:

- Palliative
- End of Life
- Last days of life?

Definitions

Palliative - Someone with a terminal diagnosis. The term palliative largely relates to symptom management.

End of Life - The General Medical Council definition of End of Life Care, used by the NHS, NICE and others is “People are ‘approaching the end of life’ when they are likely to die within the next 12 months”.

Last Days of Life - when a person is judged by the multiprofessional clinical team to be within a few (2 to 3) days of death.

National & local context



570,988 deaths registered in England and Wales in 2025, an increase of 0.4% compared with 2024 = c.0.92% of the population



6,789 deaths registered in Cornwall & Isles of Scilly in 2025 = about 1.16% of the population (587,427 in mid 2025)



Dementia and Alzheimer's disease continued to be the leading cause of death in England and Wales - 12.7% of all deaths registered in 2025.



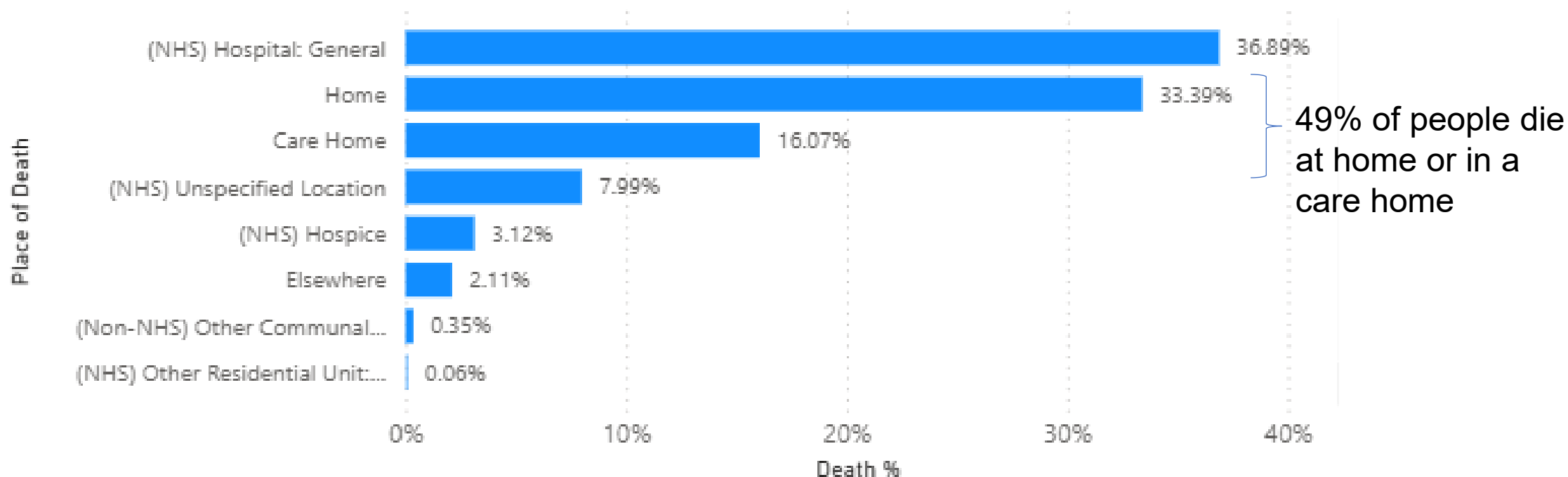
In line with national trends, Cornwall's population is getting **older** as life expectancy rises (>25% of people aged 65+). More than three-quarters of UK deaths happen over age 70.



Britain entering a new demographic era: the number of deaths are projected to exceed births in the UK from mid-2026 onwards. The ONS projects around 450,000 more deaths than births over the next decade.

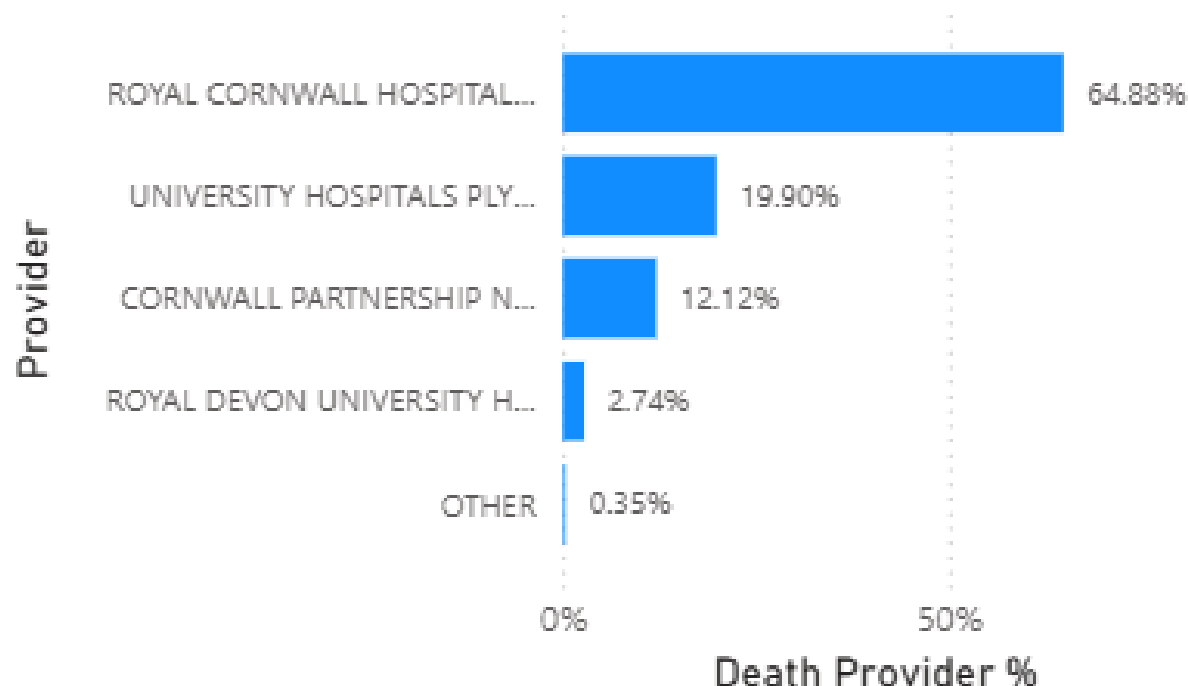
Where do people die?

Death % by Place of Death



Acute v community hospitals

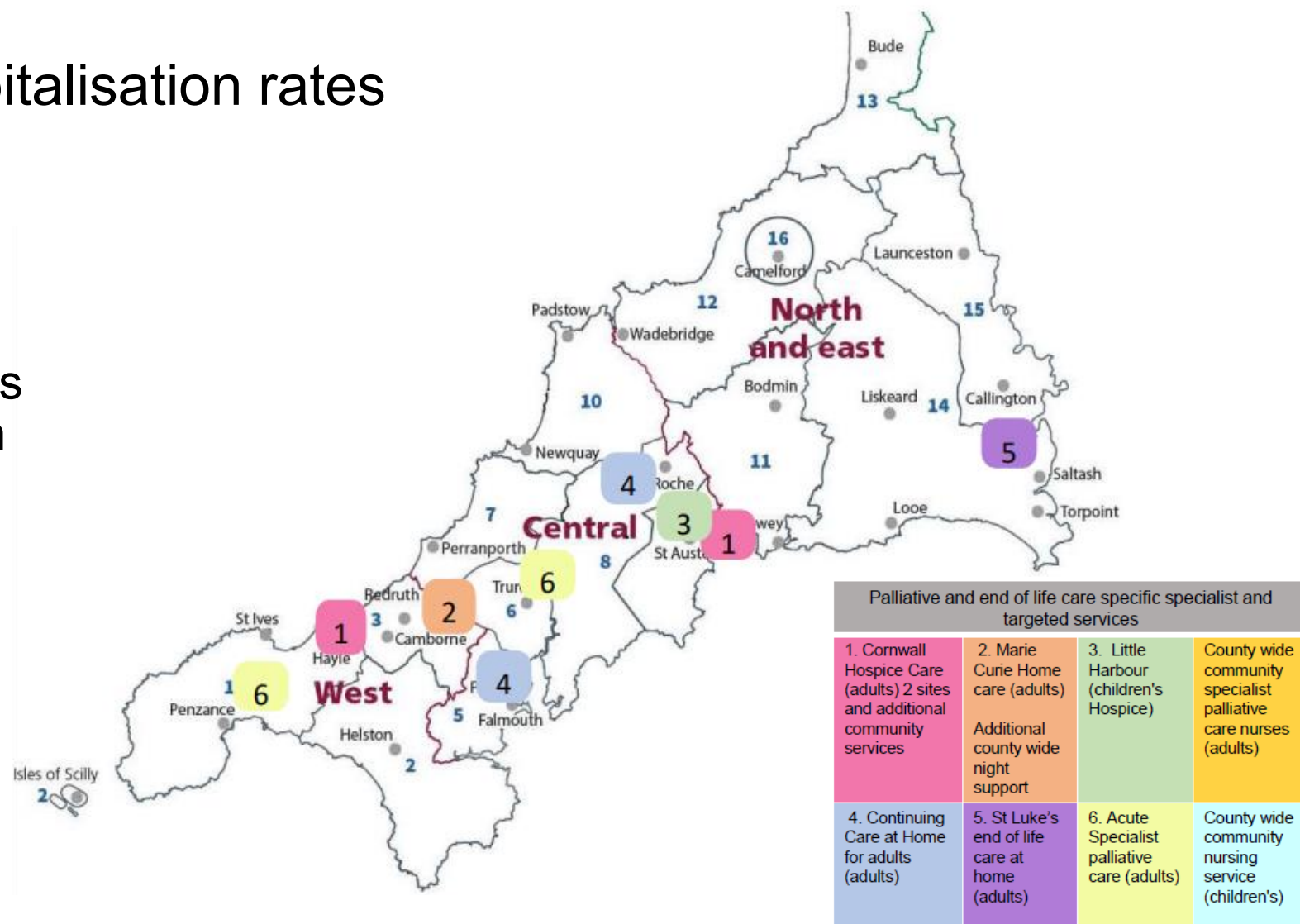
Deaths by Provider %



- Of those that die in hospital, over 87% die in acute hospitals
- 12% die in a CFT community hospital

Local challenges

- National outlier for hospitalisation rates in last 90 days of life
- Deprivation
- Inequalities
 - Geographical
 - Non-malignant conditions
 - People with LD & Autism
 - Homelessness
- Education
 - Earlier identification
 - Coordination of care
 - Symptom control
 - Advance care planning



Palliative and End of Life Care Strategy 2025-2028

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Caring where
it matters



Our vision for Palliative and End of Life Care in Cornwall and Isles of Scilly

'Cornwall and the Isles of Scilly are great places to be born, live and thrive, and to grow old. We have connected, healthy, caring communities for one and all.' Joint Forward Plan 2023-2028

We commit to the six ambitions

1

Each person is seen as an individual

2

Each person has fair access to care

3

Comfort and wellbeing is maximised, with timely symptom control

4

Care is Coordinated

5

All staff are prepared to care

6

Each community is prepared to help

Our strategy to achieve the ambitions

Ensure people are cared for by the right person with the right skills, at the right time, at the right place.

Ambition 1, 2, 3, 4, 5 & 6

Timely information is available to allow choice

Ambition 1, 2, 3 & 5

Staff are equipped and educated

Ambition 3, 5 & 6

Raise public awareness with death and dying talked about sensitively and openly, breaking down taboos

Ambition 5 & 6

'What matters to me' is at the center

Ambition 1 & 2

Care is personalised, including wishes and preferences

Ambition 1, 2, 3 & 5

Improvement in end of life being identified early along with opportunities for early advance care planning

Ambition 1, 2, 3, 4, 5 & 6

Ensure high quality care is available irrespective of age, diagnosis, circumstances, gender, preferences, place or time

Ambition 1, 2, 3 & 5

Support is available when needed for the person, their carers, and those important to them in a format that is accessible to them

Ambition 1 & 4

Cornwall and Isles of Scilly Palliative and End of Life Care Charter



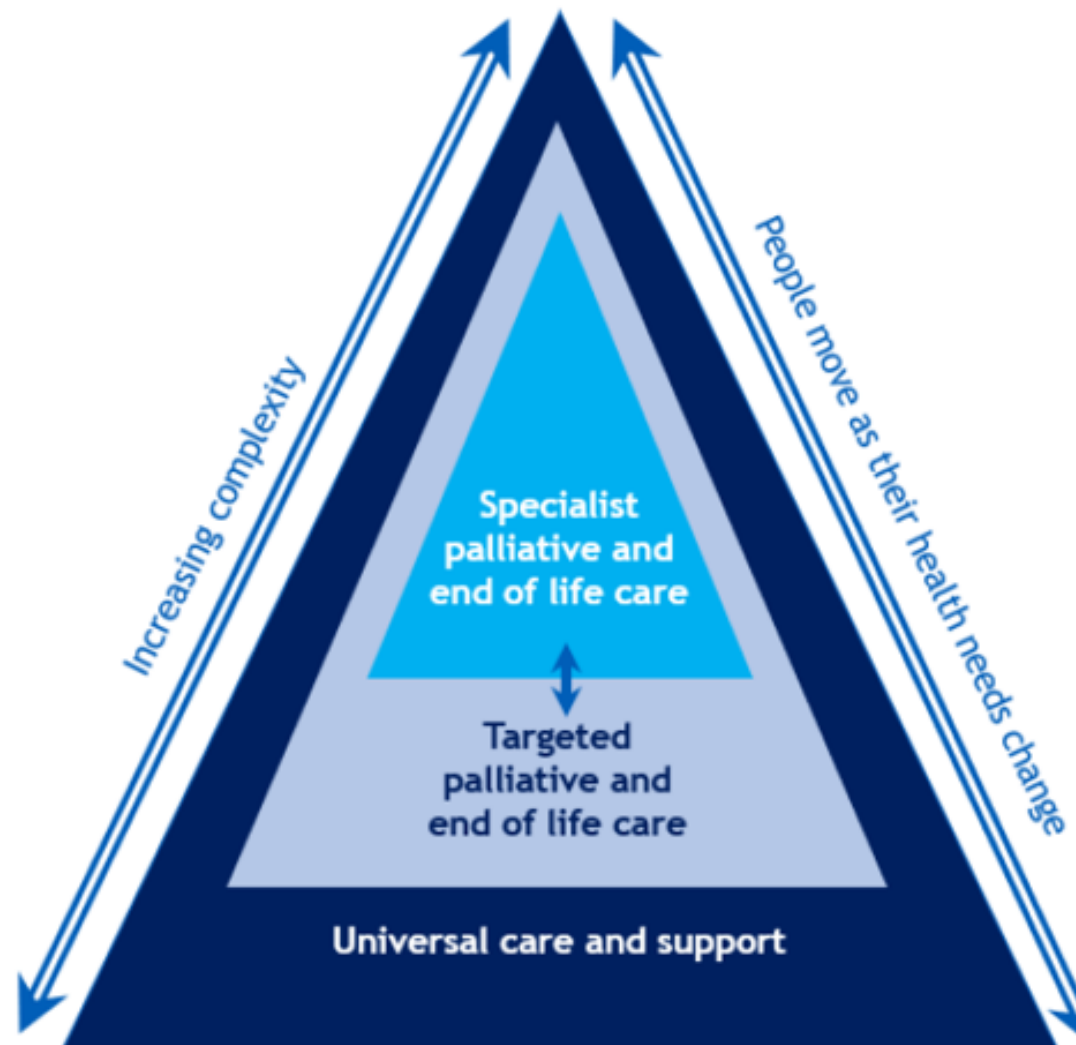
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'We would like everyone to receive high quality care, delivered compassionately and with dignity, by the right person, with the right skills at the right time. By doing so, we hope this will ensure people at the end of their lives and those close to them, will experience a calm, peaceful and dignified death where possible.'

Palliative and End of Life Care Charter

PEoLC service model

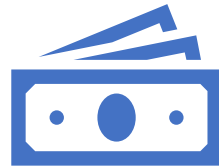
Interventions



PEoLC reform programme



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Macmillan Social
Investment funded
programme

‘Pump prime’ investment
to improve palliative &
end of life care services
in Cornwall & Isles of
Scilly



Aims to address critical gaps in
provision, prevent crises, ensure
individuals remain in their
preferred place of care, and
facilitate rapid discharge from
hospital when appropriate.

PEoLC reform programme



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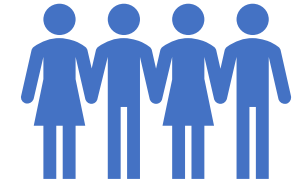
1. Hospital at Home
Palliative & End of
Life ward
(step down, step up)



2. 24/7 PEoL Care
Urgent Community
Response



3. 24/7 Telephone
helpline for public
and professionals



4. Community
Support Service
(non-regulated
support)

How can we work Better together: who does what?



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Palliative and End of Life Ward and H@H Nursing, Medical, Pharmacy and Case Co-ordination	Community Specialist Palliative Care Nursing
Referral via Strata with patient consent	Referral via generic account cpn-tr.spcreferral@nhs.net with patient consent
To discuss referrals pre-Strata: Tel: 01726 873400	
Setting Expectations: What a patient and family can expect from each service as part of the Consent conversation.	Setting Expectations: What a patient and family can expect from each service as part of the Consent conversation.
Urgent Community Response short term SPC and EOL care, same day triage, patient contact within 24 hours	Planned complex psychological and symptom control, telephone triage within two working days that guides assessment
Hospital at Home Palliative and End of Life Ward takes medical responsibility for duration of admission to PEOL ward, on discharge reverts to GP	GP maintains medical responsibility
Average of Two-week intervention – to enable preferred place of care and death, prevent inappropriate admission	Episodic case management (Levels of intervention – variable length of intervention)
Prescribing service	Prescribing advice service
To enhance existing services	To enhance existing services
Discharge following episode of care and discussion with patient as well as existing services, Discharge Letter to GP	Discharge following episode of care
On discharge closed to PEOL ward (may have telephone helpline number) Re-referral required for ward admission via patients/family/healthcare professionals/STRATA.	Open referral from patients/family/healthcare professionals via Bodmin Switchboard
HCP contact via Tel: 01726 873400, Hospital at Home ask for PEOL ward	HCP contact via Bodmin Switchboard or generic email account
7 day service 8am – 8pm	7 day service 9am – 4.30pm

Palliative and End of Life Ward / Phone 'MDT'



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How could you utilise these resources to support the EOL Care you deliver?

- Palliative Care Consultants
- Palliative GP's
- Palliative Care Nurse(s)
- Pharmacist
- Case Coordinators
- Volunteer Sector (via Gateway)
- PEOLC Advice Phonenumber

The future - an integrated approach



All people equipped and ready to provide 'generalist' PEOLC



Integrated Neighbourhood
Team working

Removing organisational boundaries
Working together
Minimising bureaucracy
'Devolution' in healthcare



Focus on the patient and those important to them



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What can you do to help?



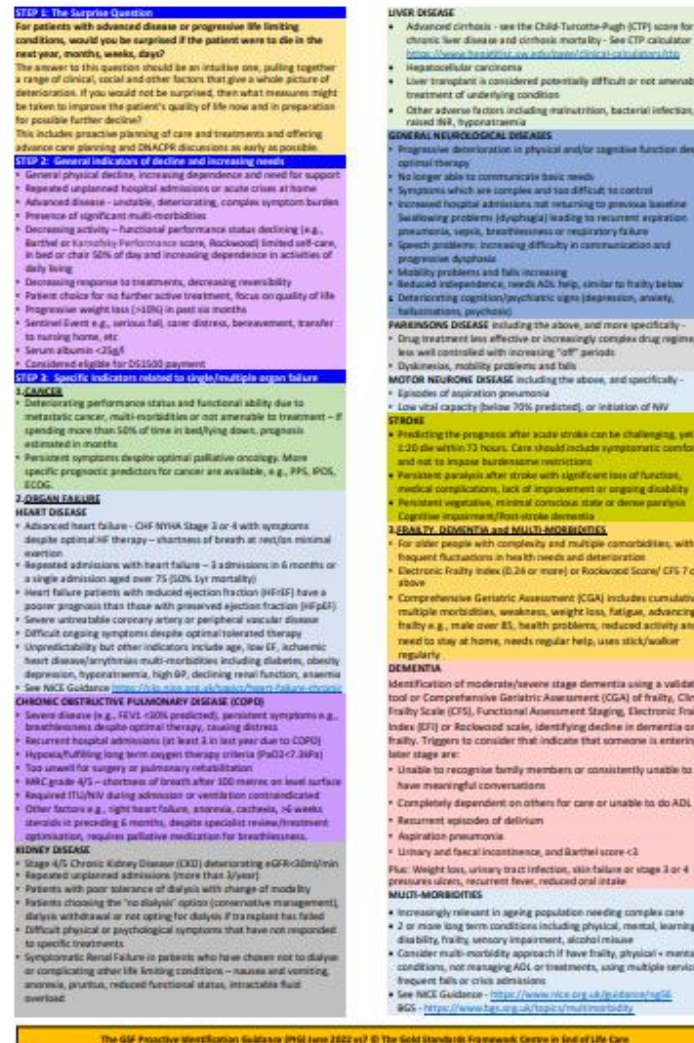
Great people

Help identify people in the last 12 months of life

Use the Gold Standards Framework Proactive Identification Guidance (PIG)

Discuss with GP/MDT
and agree GSF code:

- Blue: > 1 year
- Green: Months
- Amber: Weeks
- Red: Days



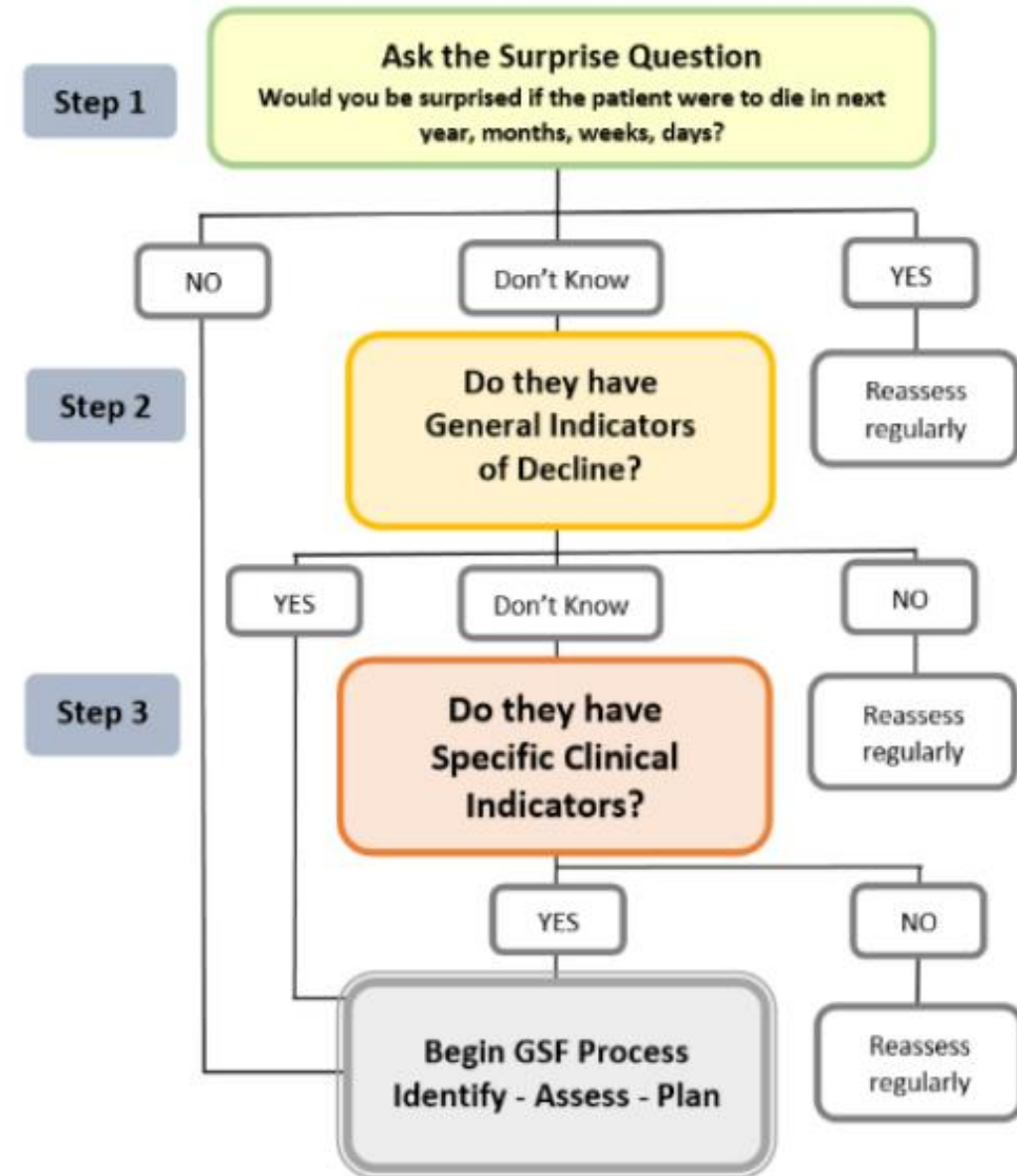
Identification: 3 Steps

1. Surprise Question

2. General Indicators of Decline

3. Specific Clinical Indicators

Proactive Identification Guidance – GSF PIG Flow-chart



Start Advance Care Planning conversations

- Give 'Planning for the Future' leaflet
- Start Advance Care Planning discussions (can take place over time and be revisited later if necessary)
- Complete Advance Care Plan & share with patient and MDT
- eTEP on DCCR
- PCSP/ACP on DCCR coming soon...



Planning for the future

A guide to support advance care plan discussions



Visit our website at:
<https://www.royalcornwall.nhs.uk/services/advance-care-planning/>

One + all | we care



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My advance care plan

This document contains information that should be taken as an expression of my preferences, my wishes and what matters to me. Once completed this should be used to inform decisions at a time when I do not have the capacity to speak for myself.



'We all deserve the opportunity to communicate what matters to us, sharing our thoughts helps others to care'

*Before completing this document please read the document 'Planning ahead', visit the website, or seek alternative advice & information on Advance Care Planning to ensure terms such as 'Advance decision to refuse treatment' & 'best interests' are understood. This document is not legally binding and can be revised by you at any time.

Visit our website at: <https://www.royalcornwall.nhs.uk/services/advance-care-planning/>

End of Life Care Learning Path



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Welcome to the
Cornwall and Isles of Scilly
End of Life Learning Path

I make a positive difference to the experience
of people who are dying, and their families,
carers and those important to them.

NAME

ORGANISATION



- 2 hours of formal face to face end of life care education
- 11 core e-ELCA sessions (20-30 minutes per session)
- 1 additional e-ELCA session relevant to your area of practice
- 1 reflective account related to your practice
- 1 reflective account of the total learning path experience



**Great
care**

**Great
organisation**

**Great
people**

**Great
partner**



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Questions?