

## Bedfordshire, Luton & Milton Keynes [BLMK] System Charter

**Programme Name:** Palliative and End of Life Care (PEoLC) – What matters most in your last year?

### Problem statements:

1. **Fragmented offer** – there are currently three Palliative Care Hubs across BLMK with disparities in funding and specialist nursing services. Signposting to services across the Bedfordshire geography is further complicated for residents across Central Bedfordshire, Bedford Borough and Luton where there are currently two hubs in situ, with two single points of access across two community providers.

Improved coordination of care pathways could enhance patient experiences while reducing unnecessary hospital admissions and readmissions. For example, in 2023, BLMK recorded 64,851 unplanned palliative care bed days and 5,982 palliative care emergency admissions, where enhanced pathway coordination could alleviate these pressures and see more patients cared for in the right place, by the right clinician, at the right time.

2. **Identification** - the palliative care register is underutilized, with only ~3000 patients recorded out of an expected 10,000 [based on assumption at any one time 1% of population can have an anticipated death], presenting missed opportunities for meaningful and personalised care plans to be used, and resulting in preferred places of death not being known or realised.

3. **Communication** – there are societal barriers for us all, but the reluctance to talk about death and dying could contribute to delays in initiating palliative care discussions.

These delays could lead to inappropriate treatment decisions being made and personalised care plans not being initiated or used.

4. **Projected growth** - population growth in BLMK has been approximately twice the national rate, and the area's age profile will continue shifting, with the population over age 50 set to grow significantly, and the population over 79 projected to double within the next two decades.

Any future service needs to be equipped for an increase in demand over time and enabled to maximise the resources available.

### Aim statements:

- To have a maximum of 2 coordination centres across Bedfordshire, Luton and Milton Keynes delivering standardised care with a single point of access.
- To reduce the number unplanned palliative care bed days in hospital in the last 3 months of life by 50% by end of year 2, following development of the co-ordination centres.
- To increase recognition of people in their last year of life and evidence an improving

trend of palliative care registrations with ambition to have 80% expected registered by year 3 [~8000 patients].

- Hospital staff within identified clinics [tbc: eg heart failure, respiratory, oncology] feel more confident to facilitate meaningful conversations about end-of-life choices and signpost to the co-ordination centres accordingly.
- 100% of co-ordination centre contacts offer an advanced care plan [ACP].
- To raise the profile and talk more about death and dying across communities.

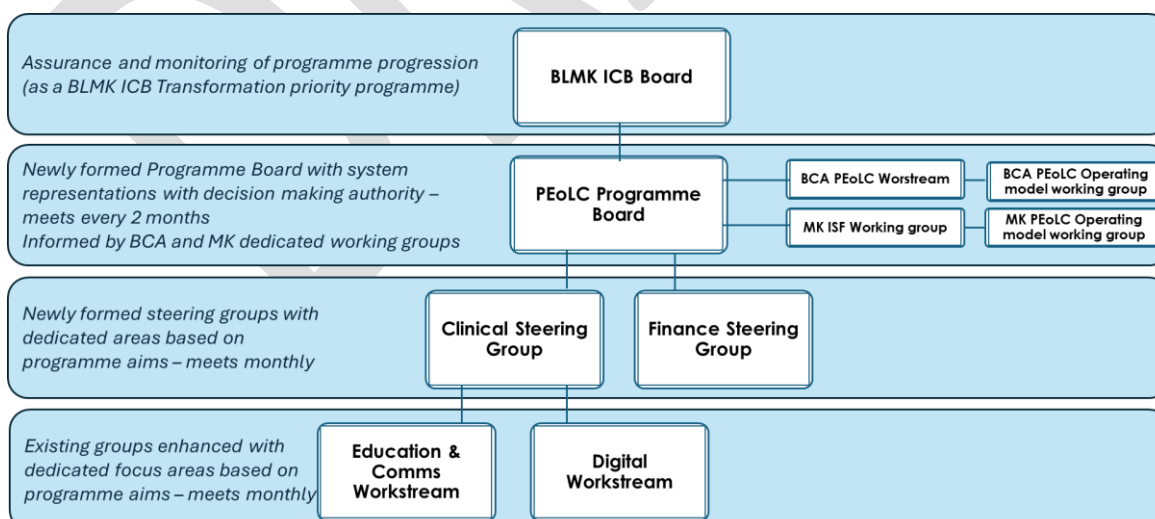
### Scale and scope:

- Population: all patients across BLMK system with an anticipated death within one year
- Out of scope: children and young people

### Measures:

Process	<ul style="list-style-type: none"> <li>• Increased number of contacts made to coordination centres</li> <li>• Source of contacts made to coordination centres</li> <li>• Increased number of patients on register</li> </ul>
Outcome	<ul style="list-style-type: none"> <li>• Staff reported increased confidence in having a conversation about death</li> <li>• Service users and their families report good experience/ value added of use of coordination centre</li> <li>• Aversion rate (% of contacts where conveyance is averted)</li> <li>• Reduction of palliative bed days in secondary care</li> <li>• Reduction of end of life dying in hospital, if not their choice of place to die</li> </ul>
Balancing	<ul style="list-style-type: none"> <li>• Increased patient complaints</li> <li>• Increased patient safety incidents</li> </ul>

### Governance:



An internal ICB Programme group consisting of System Transformation Team [STT] and Transformation Lead hosted by Keech Hospice will continue to meet weekly to maintain Verto, programme management system, and assure Senior Responsible Officer [SRO] of progress made to date against plan.

## Roles and responsibilities of Programme Board Members:

Roles	Name	Organisation	RASCI matrix: Responsible, Accountable, Supporting, Consulted and Informed
System Champion	Maxine Taffetani [MT]	Healthwatch MK	
Senior Responsible Officer	Sarah Stanley [SS]	BLMK ICB	
Deputy Senior Responsible Officer	Simon Hardcastle [SH]	BLMK ICB	
PEoLC Transformation Lead	Joanne Morris [JM]	Keech Hospice	
System Transformation Team [STT] Programme management and co-ordination	Tara Dear [TD] Samita Dass [SD] Angela Gosling [AG] Denise Faehndrich (DF)	BLMK ICB	
BCA Clinical Lead	Dr Tammy Angel [TA]	Bedfordshire Hospitals Foundation Trust	
MK Deal Clinical Lead	Emma Jones [EJ]	Community Services CNWL	
System Hospice representative	Liz Searle [LS]	Nominated Hospice representative	
System Clinical Lead	Role to be appointed to		
System Finance Lead	Fran Barnes [FB]	BLMK ICB	
System Digital/Data Lead	Mark Peedle [MP]	BLMK ICB	
System Education Lead	Chris May [CM]	Keech Hospice	
System VCSE representative	Sonal Mehta [SMe]	BLMK ICB	
System Comms representative	Michelle Summers [MS]	BLMK ICB	
System Place representative	Faith Haslam [FH]	BLMK ICB	
System Primary Care representative	Dr Nina Bursell [NB]	BLMK ICB	

## Resourcing requirements:

System Clinical lead, currently in recruitment process.

## Key Tasks and Milestones: *to be captured and managed on Verto moving forwards*

Description	Owner	Plan date	Comments
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EoL agreed as an ICB priority	SS	Dec 2024	Dying well report and recommendations endorsed by ICB Board
Agreed methodology for identification of indicative benefits	SM	February 2025	Workshop chaired by SM. No further efficiencies identified in year.
Indicative benefits included within 25/26 Operational Plan response	STT	March 2025	No further efficiencies identified in year.
Programme Board establishment	SS/STT	March 2025	31/03 was used as a smaller planning group. First Programme Board established and took place on 16/06/25.
Finance working group establishment	SM/STT	April 2025	Group objectives drafted and agreed by programme board. Meeting date confirmation in progress.
Education working group establishment	JM/STT	April 2025	Existing group in situ to be enhanced to include programme aims.
Clinical working group establishment	JM/STT	April 2025	Chair recruitment under way. Group objectives to be drafted and signed off by Programme Board.
Business case for single BCA PEoLC hub developed and signed off through programme governance processes	TA/STT/JM	August 2025	STT to populate ICB template based on TA's papers and share with TA.
Education and comms plan agreed and signed off by programme board for implementation	CM/JM/STT	August 2025	Dates subject to change – informed by clinical steering group
Business case MK PEoLC model developed and signed off through programme governance processes	EJ/STT/JM	October 2025	Dates to be reviewed following clinical model development
Business case for single BCA PEoLC hub developed and signed off through ICB and external all governance processes	TA/SS	September / October 2025	
Dashboard and scorecard in place to monitor measures	JM/STT	November 2025	
BCA PEoLC hub pilot established (one co-ordination centre)	TA	December 2025	

MK PEOLC model pilot established	EJ	TBC	
A 50% reduction in the number of unplanned palliative care bed days in hospital by end of year 2		March 2027	Informed through BCA and MK working groups
80% of people who are recognised of being in their last year of life are referred to a palliative care hub by the end of year 3		March 2028	

### Risks & Issues – to be captured and managed on Verto moving forwards

Risks	Impact	RAG
Interdependency: current CHC fast track process.	£150k efficiency programme associated to this.	
Fragmented offer across coordination centre[s]		
To implement changes to the coordination centre offer, there may be financial investment required which presents a cost pressure to the organisation	Cost pressure of invest to save modelling in financially constraint environment	

Issues	Impact	RAG

### System agreement and key principles:

#### System Agreements

##### Shared Vision and Governance

A unified vision for EoL care across the ICB footprint. Clear governance structures with defined roles and responsibilities.

##### Collaborative Commissioning

Joint commissioning arrangements. Aligned funding models to support sustainability and innovation.

##### Data Sharing and Digital Integration

Agreements on shared care records and real-time data access. Use of digital tools to support care coordination and outcome tracking.

##### Community Engagement

Co-production with people with lived experience. Public awareness and education about EoL care options and planning.

##### Outcome-Based Accountability

Use of national and local metrics (e.g., place of death, hospital admissions in last 3 months of life). Regular reporting and transparent performance monitoring.

## Key Principles

### **Person-Centred Care**

Care must be tailored to the patients needs, preferences, and values. Emphasis on dignity, compassion, and respect at every stage of care.

### **Equity of Access**

Ensure all patients have equal access to high-quality palliative and end of life care services.

### **Integrated and Coordinated Care**

Seamless collaboration across health settings. System interoperability and multidisciplinary team working are essential.

### **Early Identification and Planning**

Proactive identification of patients approaching end of life. Advance care planning and shared decision-making with patients and families.

### **Support for Families and Carers**

Recognise and support the role of carers. Provide bereavement support and practical assistance.

### **Workforce Development**

Ensure staff are trained, supported, and confident in delivering EoL care. Promote compassionate leadership and reflective practice.

### **Continuous Improvement**

Use data, feedback, and research to drive quality improvement. Embed learning from patient experiences and service evaluations.