South East London Integrated Care System

NHS South East London

Palliative and end of life care (PEoLC) in the multimorbidity model of care (MMMoC)

Phase II evaluation report

Prepared by the MMMoC evaluation working group

We are a partnership of NHS commissioners and providers, the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark and the voluntary and community sector

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Executive summary

Background
People living with late-stage kidney disease and multiple long-term conditions (mLTCs) often experience a high symptom burden, frailty, clinical uncertainty and frequent contact with fragmented services. Despite strong evidence that palliative and end of life care (PEoLC) and advance care planning (ACP) can improve quality of life, support informed decision-making and reduce unwanted interventions, access to timely palliative care for people with renal disease remains inconsistent and often occurs very late. Misconceptions about palliative care, alongside workforce confidence and system barriers, contribute to these delays. Within South East London (SEL), the multimorbidity model of care (MMMoC) provides a framework to address these challenges by enhancing understanding of PEoLC for people with late-stage kidney disease.

Ambition of the work and its evaluation
The ambition of the PEoLC branch of the MMMoC was to support earlier, equitable and person-centred access to PEoLC for people with advanced kidney disease, particularly those living with multimorbidity and frailty. The work aimed to improve staff and service user understanding of palliative care, normalise earlier conversations focused on "what matters to you?", and challenge misconceptions that palliative care is only relevant at the very end of life. For staff, the ambition was to build awareness, confidence and skills to identify people who may benefit from PEoLC, to initiate and respond to ACP conversations, and to use the Universal Care Plan (UCP) effectively. The evaluation sought to assess changes in staff awareness, confidence and perceived practice, alongside early indications of change in referral patterns.

Describing the intervention
A multi-pronged programme of PEoLC activity was delivered between June and November 2025 across renal services at Guy's and St Thomas' NHS Foundation Trust (GSTT) and King's College Hospital NHS Foundation Trust (KCH). Interventions were co-designed by a multidisciplinary team (MDT) and included hospice education visits, a staff webinar, ward-based awareness and engagement activity ("tea trolley dashes"), and skills-based workshops focused on sensitive conversations and ACP. Together, these interventions aimed to increase understanding of local PEoLC services, demystify hospice and palliative care, and build practical communication skills within renal teams.

Method of evaluation
A mixed-methods evaluation approach was used, drawing primarily on staff surveys completed before, during and after the intervention period. Surveys captured changes in awareness, confidence and perceived impact using Likert-scale and open-ended questions. Quantitative data were analysed descriptively, with statistical testing applied where possible. Qualitative responses were analysed thematically. Quantitative data of renal referrals to SEL hospice services were analysed descriptively to explore early indications of change, acknowledging data and attribution limitations.

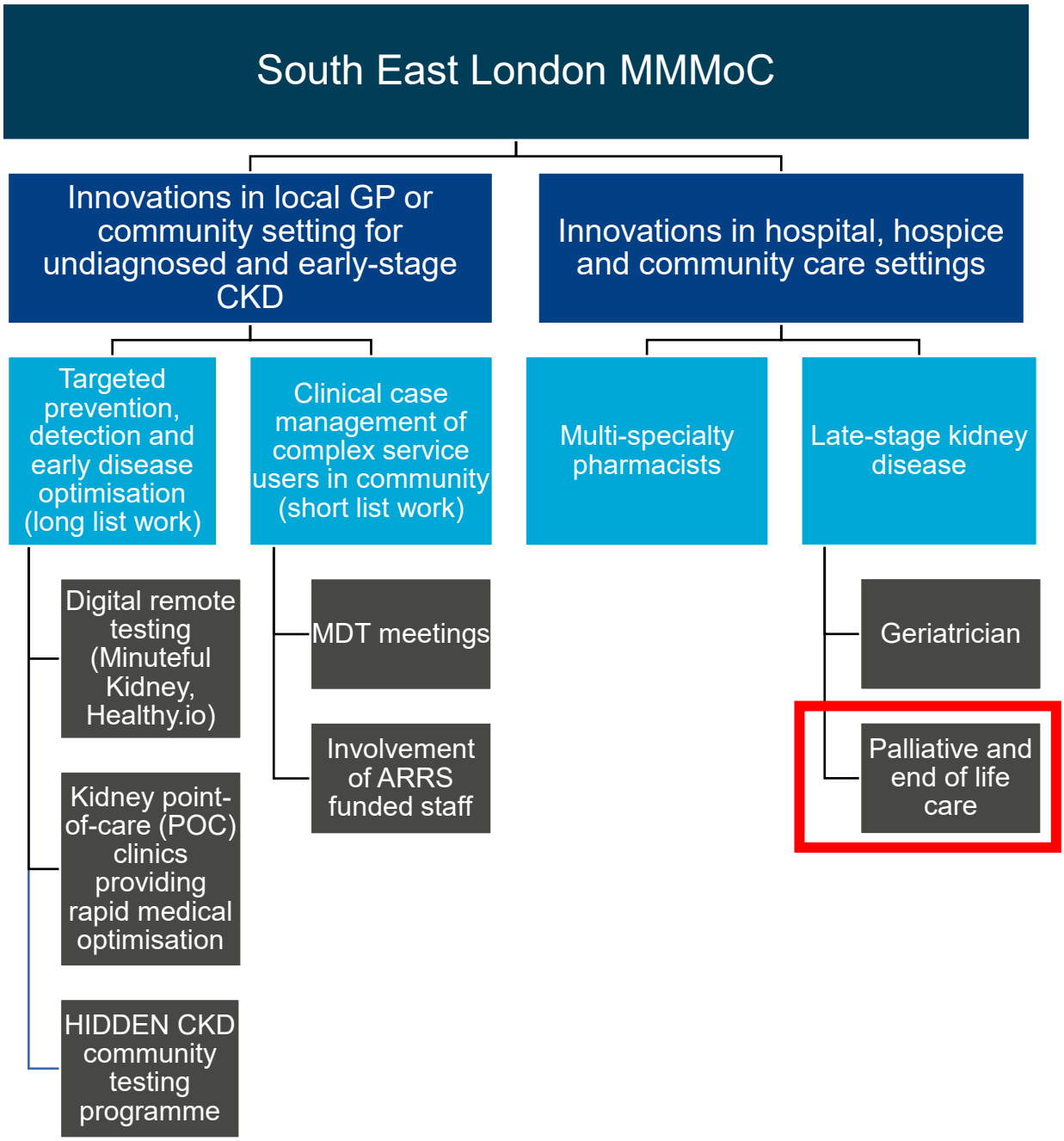
Results
The evaluation demonstrated consistent improvements in staff awareness, knowledge and confidence across all intervention types. Staff reported increased understanding of PEoLC and hospice services, greater confidence in identifying people who may benefit from palliative care, and improved confidence in initiating ACP and UCP-related conversations. Skills-based workshops resulted in particularly large reported gains in confidence and readiness to change practice. Qualitative feedback highlighted increased empathy, improved communication skills and a greater willingness to initiate earlier, person-centred conversations. Early referral data showed routine variation with no clear or consistent trend at this stage.

Conclusion
This evaluation shows that a targeted, multidisciplinary PEoLC engagement programme embedded within renal services can make a meaningful contribution to improving staff confidence, capability and culture around earlier palliative care. By addressing misconceptions, strengthening communication skills and supporting integrated working, the work aligns strongly with the ambitions of the MMMoC. Sustained investment, continued evaluation and wider rollout across neighbourhoods and other specialties offer an important opportunity to improve quality, equity and person-centred care for people living with complex, life-limiting conditions.

Structure of the MMMoC

This diagram illustrates the structure of the South East London (SEL) MMMoC from the perspective of the subsequent evaluation and can be used to support understanding throughout. This report focuses on the palliative and end of life care (PEoLC) element of the work, as highlighted by the red box.

Figure 1 Structure of the multimorbidity model of care (MMMoC)



Chapter 1. Introduction and background

Aligned with the 10-year health plan for England [1], the multimorbidity model of care (MMMoC) aimed to shift healthcare provision from hospitals to community and from sickness to prevention. The Government proposed the Neighbourhood Health Service as the solution to delivering this shift, particularly for those with multiple long-term conditions (mLTCs). Integrated neighbourhood teams (INTs) were framed as the proactive delivery vehicle to address health inequalities, improve service user access and outcomes and reduce hospital admissions.

Chronic kidney disease (CKD) is a historically overlooked condition – it is known as a "silent killer" [2] that in its early stages often remains unnoticed and poorly understood by service users. As a condition, deterioration of kidney function does not act in isolation. CKD is part of a cluster of conditions, acting as a risk factor for cardiovascular events [3] and cardiovascular disease [4]. Meanwhile, in the UK, diabetes and hypertension are the leading causes of CKD [5], and yet CKD remains under-detected in these groups, especially among people with hypertension [6]. Whilst CKD is clearly part of a cardiorenal metabolic (CRM) cluster, care for these various conditions is often siloed which further exacerbates the issue of undetected CKD alongside increased risk factors for interconnected events [7]. Whilst we have medications (e.g. ACE-I/ARB, SGLT2i) that, once optimised, may delay progression to end-stage kidney disease in some patients by up to 15 years [8], a significant proportion of our CKD population require regular reviews and medicines optimisation [9].

As CKD progresses to its later stages, service users commonly face a significant symptom burden alongside increasing morbidity and risk of death. However, access to palliative and end of life care (PEoLC) for this group remains inadequate and is often introduced too late. Evidence indicates that individuals with late-stage kidney disease do not consistently engage in early conversations about future care, deterioration, and end of life planning, leading to unmet palliative needs [10].

Advance care planning (ACP) offers a structured approach for individuals to express their values, preferences, and priorities for future care, while also facilitating communication between service users, families, and healthcare professionals. It is also an opportunity to introduce palliative care conversations, breaking down any misconceptions about palliative care to support access at an early stage.

Palliative care asks the patient '*what matters to you?*' and takes a holistic approach, including prevention and management of pain and other symptoms. It also involves emotional, social and spiritual support for people, their families and loved ones. Palliative care aims to help people achieve the best quality of life for as long as possible. Palliative care can also prevent accident and emergency (A&E) attendances and hospital admissions, through supporting service users to remain in their care setting of preference, instead of 'bouncing' in and out of hospital [11]. Despite its recognised benefits, palliative care and ACP are not consistently embedded in renal care and is frequently initiated only in the later stages of illness [10,12]. These patterns reflect both systemic pressures as well as training and education gaps in palliative care, resulting in a lack of confidence and knowledge in hospital and palliative care.

Therefore, joint working between the MMMoC and the South East London Palliative and End of Life Care (PEoLC) Programme provides an important opportunity to address inequities in timely access to proactive, palliative care for people with renal disease. Evidence consistently highlights disparities in access to palliative care affecting older adults, ethnic minority communities and those with chronic non-malignant disease, driven by prognostic uncertainty, organisational cultures and limited awareness of available services [13]. This report evaluates the input of the palliative and end of life care team on renal teams across acute hospital trusts in SEL.

For this report, any relevant definitions and abbreviations are included in the glossary in Chapter 13.

Chapter 2. Ambition of the work

2.1 Ambition of the MMMoC overall

Overall, the MMMoC aimed to **build a person-centred, holistic, and fully integrated model of care for people living with mLTCs across the care pathway in SEL**. The model sought to strengthen both horizontal integration (within care settings e.g. across specialties and roles) and vertical integration (across primary, secondary and community care), improving coordination, access and outcomes for service users with complex needs. The various interconnected areas, as described in Figure 1, functioned collaboratively to deliver effective and equitable care for service users, improve clinical and non-clinical staff experience and collaboration, and build efficiency into the system overall.

2.2 Ambition of the PEoLC branch of the work

The PEoLC branch of work focused on the CRM multimorbid population. The ambitions of the PEoLC programme can be defined at three levels:

For service users to:

- Feel seen, heard and supported as a whole person, with care shaped by what matters most to them
- Have earlier, clearer and more compassionate conversations about future care, deterioration and uncertainty
- Develop a better understanding of palliative and end of life care as an additional layer of support ('parallel care'), not just care for the final days of life
- Feel more confident with staff that their wishes and preferences are known, documented and respected through advance care planning and shared care records

For the multidisciplinary staff (clinical and non-clinical) to:

- Feel more confident and skilled in identifying service users who may benefit from PEoLC earlier in the disease trajectory
- Develop confidence, language and practical skills to initiate and respond to ACP and PEoLC conversations compassionately
- Have improved awareness of local PEoLC and hospice care services
- Work more collaboratively across renal, palliative and hospice care teams
- Embed a shared, person-centred approach to ACP that balances clinical management with quality of life and personal preferences

For the system overall to:

- Enable earlier, more equitable access to PEoLC for people with advanced kidney disease and complex multimorbidity
- Reduce fragmented, reactive and crisis-driven care by embedding proactive planning and shared decision-making
- Improve coordination and continuity of care across acute, community, hospice and primary care settings

- Support the NHS 10 Year Plan ‘left shift’ of care from the acute hospital setting to the community, which can be achieved through earlier palliative care, through the prevention of A&E attendances and hospital admissions.
- Support more appropriate use of services by aligning care with service user preferences and avoiding unwanted or burdensome interventions such as dialysis
- Strengthen integration between long-term condition management and palliative care within the multimorbidity model of care
- Build a culture where learning, reflection and confidence in PEoLC are sustained through ongoing collaboration, education and shared practice

Chapter 3. Describing the intervention

3.1 The MMMoC overall

The interventions implemented as part of the MMMoC span innovations in local GP or community settings for service users with undiagnosed and early-stage CKD as well as innovations in hospital, hospice and community care settings for those with late-stage CKD. The work took place at various locations across SEL, a diverse and relatively deprived population with over two million residents. Each element of the MMMoC, as reflected in Figure 1, took an integrated approach to service-user care. Across all elements, there was horizontal and vertical collaboration to ensure a service-user-centric approach that engaged with the whole person, their priorities and needs. In addition, population health data was used in each instance to ensure care was proactive, preventative of disease progression and worked to reduce inequalities. A comprehensive list of the stakeholder organisations involved in the MMMoC can be found in Appendix 1 and includes primary care networks, hospital trusts, hospices, clinical effectiveness groups and numerous other local organisations.

3.2 The PEoLC branch of the work

An initial staff awareness and confidence survey highlighted opportunities for the PEoLC branch of work, driving the activity in the direction of predominantly staff-facing awareness and engagement activity. The 44 respondents from renal teams at GSTT and KCH expressed varying confidence levels around PEoLC and highlighted opportunities to increase awareness and use of Universal Care Plans [14] (UCPs). Staff expressed a clear preference for face-to-face learning, keen to build confidence in ACP and palliative care conversations.

It was recognised that a public-facing awareness campaign would have limited impact without corresponding levels of staff awareness. If service users are encouraged to initiate conversations about PEoLC, healthcare professionals must feel educated and confident in responding. Establishing this internal readiness was therefore a necessary first step before engaging service users and families.

Following this, a **multidisciplinary project team developed and appraised a range of interventions**. This resulted in a programme of activity that ran from June to November 2025 which included:

- **Educational hospice visits** for renal nurses (four half-day visits): The visit was attended by 46 staff members and included a tour of the hospice, an overview of rehabilitation and social care services, information on referral routes, what service users can expect from hospice care and an “ask me anything” session with hospice staff.
- **Staff webinar** as part of the GSTT and KCH Champion Nurse Education Programme: The webinar was attended by 16 people and run by the Clinical Lead for the SEL PEoLC Programme, who is also the Chief Executive of the Community Hospice in Greenwich and Bexley. The hour-long session ran

through what palliative care is, with a spotlight on hospice care in SEL, and concluding with a rich Q&A session.

- **Hospital tea trolley dashes** (18 visits across GSTT and KCH renal wards)**:** An awareness campaign titled “What matters to you? Let’s talk about it.”, supported by the slogan “Ask your team about palliative care – let's make every moment matter,” was developed to enhance understanding of PEoLC across renal services. Nearly 500 branded ‘goodie bags’ were produced, including tote bags, water bottles, lanyard cards, credit-card-sized leaflets and stationery, all directing staff to the new SEL PEoLC webpages. These were distributed to renal wards and units through informal ‘tea trolley dashes’ led by PEoLC specialists, UCP leads and the Trust’s Supportive Care Nurses. This approach enabled relaxed, ward-based engagement around ACP, the UCP, initiating conversations about death and dying, addressing misconceptions about hospice and palliative care, and raising awareness of the SEL PEoLC offer.

Figure 2: An example of the PEoLC campaign lanyard card.

- **Sensitive conversations and confidence building staff workshops** (four half-day workshops): 62 staff members were trained on how to approach ACP conversations with opportunity for role-play and practice with professional actors on initiating conversations and challenging reactions to build confidence. The workshops were identified as a need from staff following the hospital tea trolley dashes.

Chapter 4. Key areas for evaluation

The evaluation of the PEoLC element of the work seeks to assess its impact on staff confidence, capability and practice in supporting people with multimorbidity to access timely, person-centred palliative and supportive care.

The key areas of the evaluation are to:

- Assess changes in staff awareness and understanding of PEoLC and hospice services
- Evaluate changes in staff confidence to identify service users who may benefit from PEoLC
- Assess the impact of the interventions on staff confidence and skills in ACP and PEoLC conversations
- Evaluate staff confidence, understanding and use of the UCP
- Examine perceived impacts on clinical practice and multidisciplinary working, including referral behaviours, escalation and knowledge-sharing across renal teams.
- Explore early indications of change in referrals to PEoLC services, using descriptive analysis of renal hospice referrals alongside staff-reported outcomes.

Chapter 5. Methodology of the evaluation

A **series of staff surveys** were used to evaluate the activities delivered before, during and after the PEoLC intervention period. A baseline staff awareness and confidence survey was circulated to renal teams at GSTT and KCH prior to the start of activities and was repeated following completion of the intervention to assess changes over time. In addition, post-activity surveys were distributed following each individual activity to capture immediate feedback and perceived impact. Each survey was held open for a period of up to six weeks, with most surveys closing after two weeks. Across the surveys, 220 responses were analysed. The number of people who responded to each survey can be found in Appendix 2.

All surveys included a combination of Likert-scale questions (using three- or five-point response options) and open-ended questions, enabling both quantitative assessment and qualitative feedback. **Where possible, the surveys used a consistent set of core questions**. These included an **assessment of awareness, confidence and perceived impact** alongside open-ended questions on **learning gained, intended changes in practice** and **general feedback**. A blank version of each of the surveys can be found in Appendix 3.

Quantitative data from Likert-scale questions were analysed descriptively, reporting raw counts and percentages for each response option. Where comparable data were available at two time points, Mann–Whitney U tests [15] were used to assess whether observed changes were statistically significant. Qualitative data from open-ended questions were analysed using thematic analysis to identify overarching themes. Quotations presented within the findings are representative of the main themes identified.

Renal referrals to SEL hospice services were also analysed descriptively to explore changes in the volume and pattern of referrals during the intervention period. Referral data for St Christopher's Hospice (covering the remaining four boroughs) and the Community Hospice (covering Greenwich and Bexley) services covering June 2024 to November 2025 were collected. The data covered a year pre-intervention, and until the end of the intervention period. In a future evaluation we would look to analyse further data, but this was not possible due to reporting requirements. While changes in referral numbers cannot be directly attributed to the intervention, the analysis aimed to begin to understand whether trends could align with increased awareness of, and access to, PEoLC for renal service users following the awareness campaign. Findings were considered alongside survey results to support a more rounded assessment of the intervention's potential influence and were also tested for statistical significance.

In relation to the PEoLC input within the MMMoC, there are some limitations to consider within the data and methodology. Although data was collected for renal referrals to two of SEL's three community specialist palliative care services, we were unable to capture the volume of referrals to the GSTT community specialist palliative care team and also referrals made from the renal teams to their hospital-based specialist palliative care teams. As a result, the full impact of the PEoLC team's work to raise awareness and improve access to PEoLC services may not be fully reflected in

the findings. In addition, comprehensive data on the volume of referrals from both KCH and GSTT to hospice and PEoLC services were not available. This limits the ability to assess more precisely whether awareness-raising and engagement activities influenced referral behaviours among GSTT and KCH staff.

Chapter 6. Results

To evaluate the impact of the multi-pronged PEoLC awareness campaign, this section includes findings from the pre- and post- awareness campaign staff confidence surveys, analysis of staff surveys completed following intervention activities and an early analysis of hospice referral rates.

Surveys

A full breakdown of individual activity analysis is provided in Appendix 2. Appendix 4 also documents some more detailed feedback and anecdotes written by staff about their experiences of the PEoLC activities.

Overall staff awareness and confidence survey

44 people completed the pre-campaign survey and 33 individuals filled in the post-campaign survey. Of those 33 people, 21 members of staff indicated that they had taken part in one or more of the campaign activities. Therefore, analysis was undertaken on those 21 responses. Pre-campaign responses were fairly evenly split between GSTT (43%) and KCH (55%), with post-campaign respondents primarily being from GSTT (71%).

All staff who completed the pre- and post-intervention survey work in a renal area. Respondents to both the pre- and post-campaign surveys were mainly professionals with over 15 years' experience (52% and 57%, respectively). The most popular activities attended by staff who completed the survey were the tea trolley dashes by 15 people (43%) and the sensitive conversations workshop, by 11 people (31%).

The survey asked members of staff pre- and post-campaign to rate how confident they felt about their understanding of and capabilities to support PEoLC service users. Figure 3 below gives an overview of responses to the question 'How confident are you with the following statements?' in relation to various aspects of PEoLC relevant to staff. This includes identifying patients who might benefit from PEoLC, knowing how to access PEoLC services, providing holistic care, talking about PEoLC and the UCP and understanding of both of these. Post-campaign respondents showed higher confidence across all statements. The largest improvement in confidence was around discussing the UCP with service users, with an increase of 36%. It is important to note here that because the post-campaign sample size was small, this may mean results are influenced by positive experience bias.

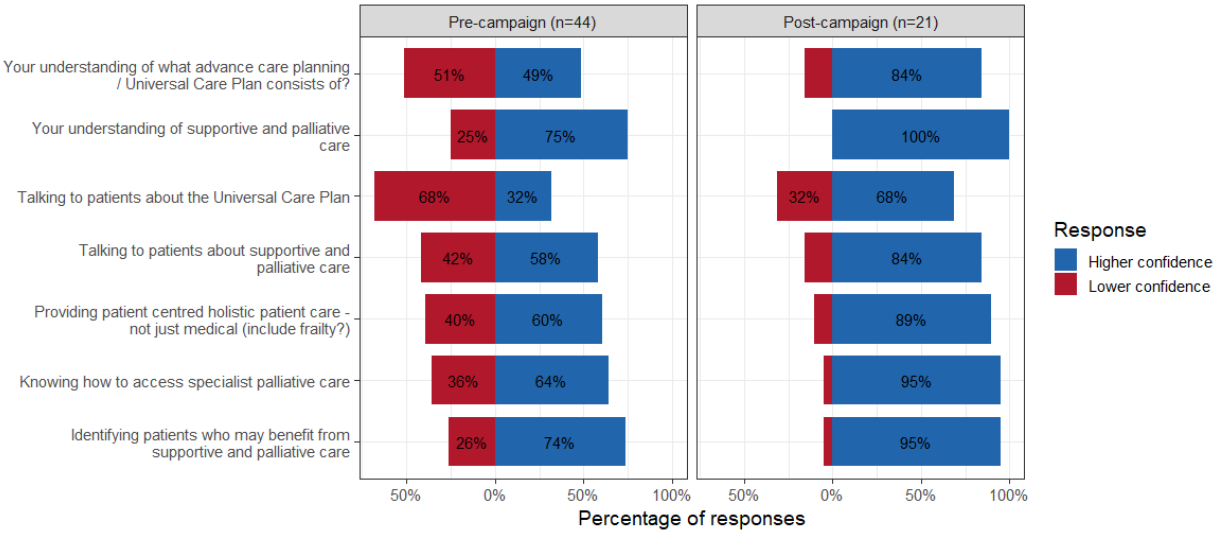


Figure 3: Change in confidence about knowledge and understanding of PEoLC pre- and post- awareness campaign.

In addition, staff members were asked about their engagement with planning discussions and the UCP. The proportion of respondents who never had advance care planning discussions dropped from 52% pre-campaign to 14% post-campaign, indicating a notable shift toward more regular engagement. Respondents reporting weekly or monthly planning discussions increased from 14% to 33%, suggesting greater confidence and routine involvement after the campaign. The share of respondents who never initiated or contributed to an online UCP decreased from 80% to 57%. It is again important to understand the analysis is limited as the post-campaigns sample size was small, so results could be influenced by positive-experience bias.

Combined activity analysis

The same survey was used to collect feedback from staff participants across the hospice visits, tea trolley dashes and webinars. In total, 125 responses were collected across these activities.

Overall, staff feedback on the PEoLC awareness activities was extremely positive, as captured in Figure 4. When asked to rate their overall experience: 81% of respondents rated the activities as ‘excellent’, 17% as ‘good’ and 2% as ‘average’. No respondents rated the activities as ‘poor’ or ‘very poor’ indicating a consistently positive experience across the activities.

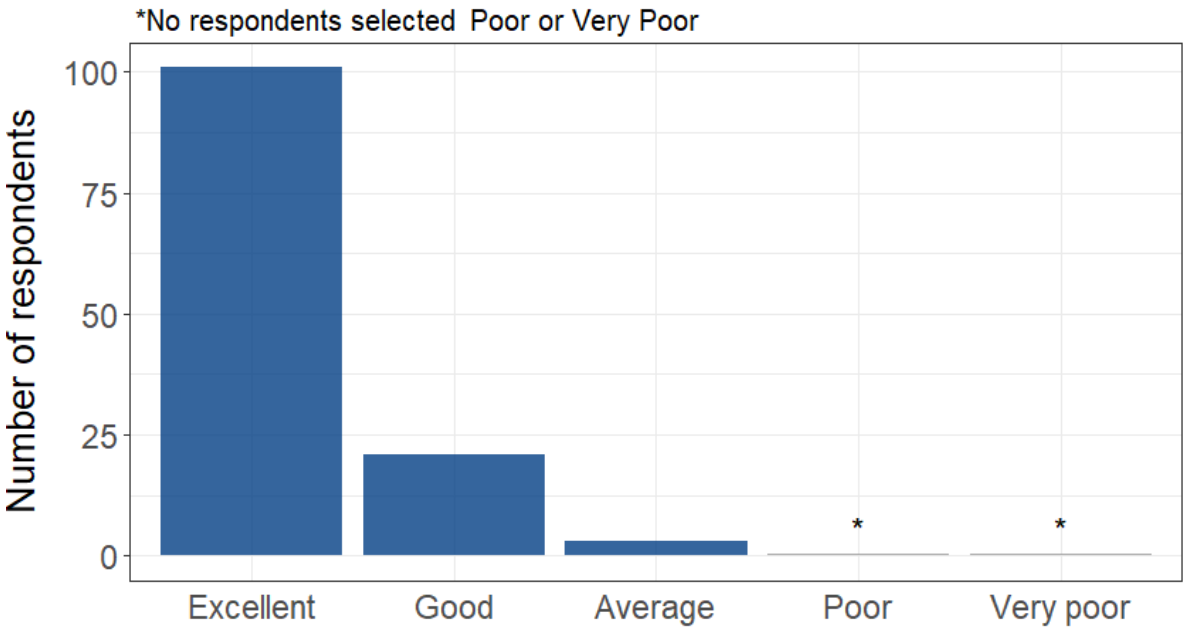


Figure 4: Overall rating of the activity that the respondent was involved in.

Almost all the respondents reported having learnt something new about either PEoLC or hospice care from the interventions. 99% of respondents reported learning something about PEoLC from the activities: 87% learned a lot and 12% a little. Similarly, 97% reported learning something about hospice care: 82% learned a lot and 15% a little.

Staff were also asked whether they had learned important key information about PEoLC from the different activities, or whether they already knew this information beforehand. These elements focused on common misconceptions held about palliative care with responses collated in Figure 5.

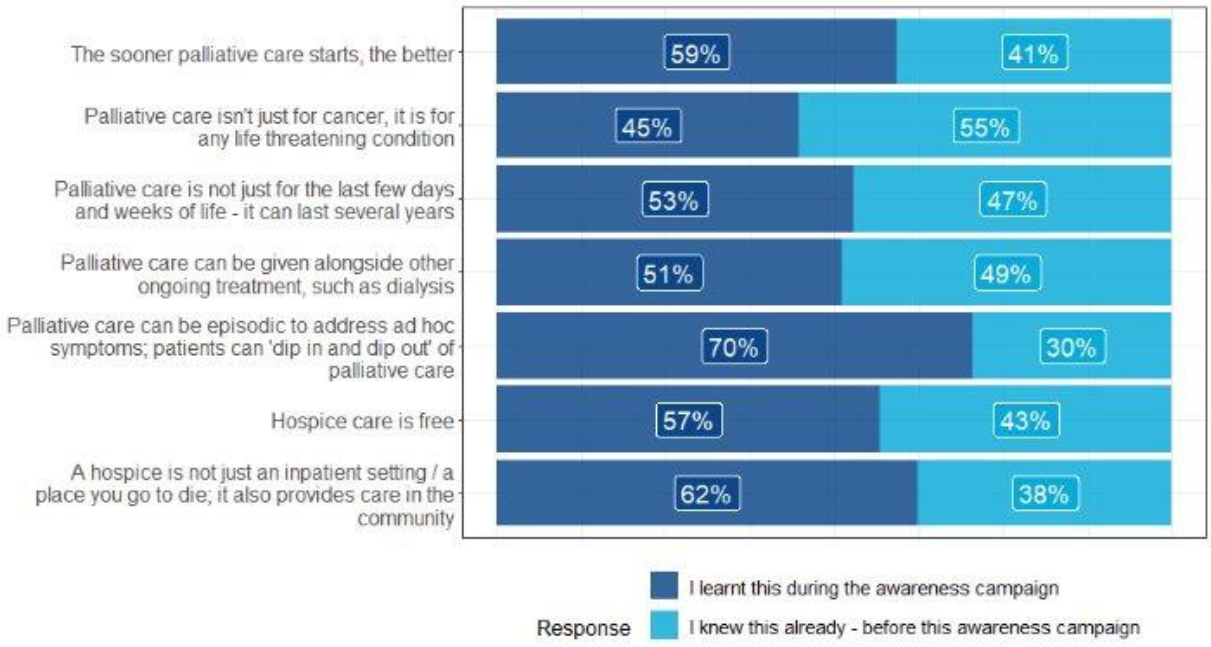


Figure 5: Overview of 125 responses to learning key information about PEoLC during or before the awareness campaign.

The majority of respondents learnt each piece of information for the first time during the awareness campaign, suggesting that the activities were effective in increasing awareness and understanding of PEoLC services and pathways. The statement most commonly identified as new learning during the awareness campaign was that 'palliative care can be episodic, allowing service users to dip in and out to address ad hoc symptoms', with 70% of respondents selecting this. "PEoLC isn't just for cancer, it is for any life-threatening condition" was the only piece of information that most respondents reported already knowing prior to the campaign. This survey question also indicates that 100% of respondents now know these pieces of information, which is a positive change.

Free text responses echoed these trends of increased staff confidence and capability (19%) around PEoLC, with staff activation as a clear outcome of the various intervention activities. One staff member who attended the hospice visit stated that after the visit,

"I will be more confident in identifying when service users may benefit from palliative care and encourage earlier discussion about available support".

Staff also reported that they felt they could improve referrals, escalation and joint working for PEoLC service users, with a staff member who attended the webinar wishing to,

"Be more proactive in discussing palliative care with service users, relatives and members of the nursing team"

Other staff members felt that they would be able to promote awareness and learnings to colleagues and their wider team, with a staff member who participated in the tea trolley dashes wanting to,

"Discuss with my team on a different perspective regarding palliative care that is not only for dying service users"

Sensitive conversation workshops

Findings from the sensitive conversation workshops (30 responses) are presented separately as more specific questions were used to understand their impact on staff practice.

Feedback from the sensitive conversation workshops showed positive staff responses. When staff were asked questions about their overall experience, 90% of respondents rated the session as 'excellent' and the remaining 10% rated the session as 'good' as presented in Figure 6. All respondents (100%) stated that they would recommend the workshop to their colleagues.

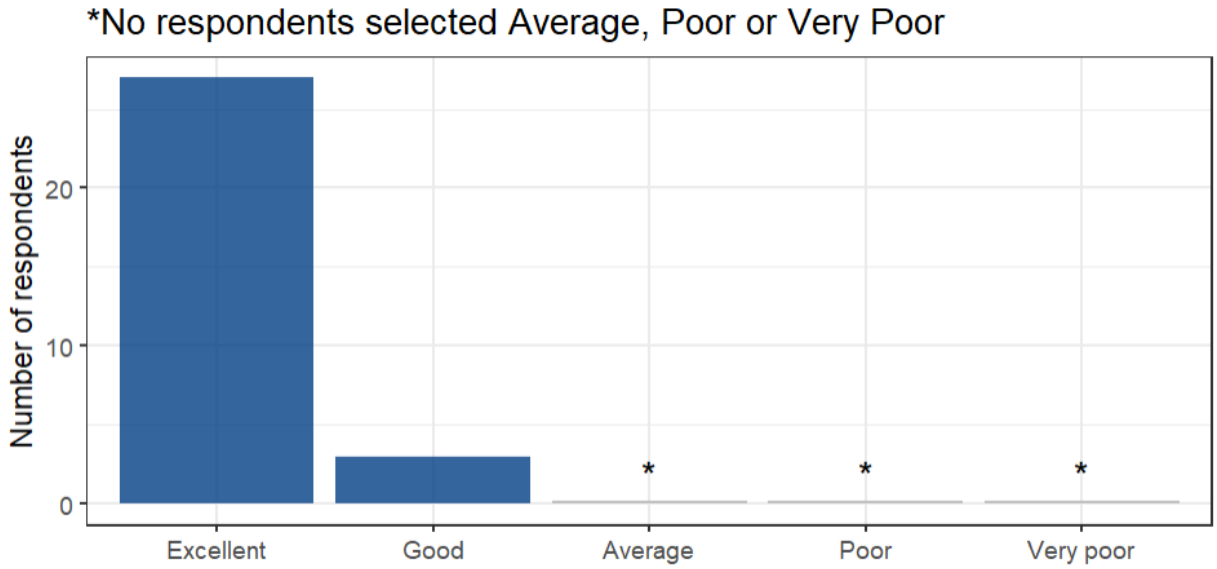


Figure 6: Overall rating from respondents of the sensitive conversation workshops.

Learning outcomes were also rated highly. Almost all respondents (97%) reported that they had learned "very much" or "a lot" about how to have ACP conversations with service users.

Changes in staff confidence were assessed by comparing confidence levels before and after the workshops. This specifically sought information on initiating conversations about palliative care and responding to service user- or carer-led discussions around ACP. Following the workshop, there was a large increase in staff reporting higher confidence with both of these statements, with both measures increasing by 70% as shown in Figure 7.

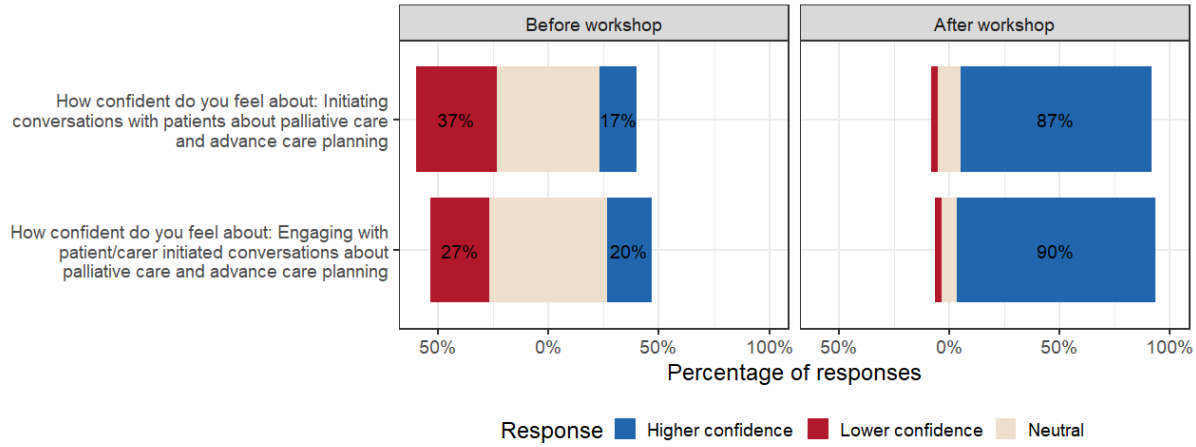


Figure 7: Graph showing the change in staff confidence in initiating conversations about PEoLC and responding to service user- or carer-led discussions around ACP before and after the workshop.

Staff were also asked about the anticipated impact of the workshop on their future practice. When asked "to what extent is this workshop likely to impact your practice?", 80% reported 'very likely', 17% reported 'likely' and 3% reported 'neither likely nor unlikely' as indicated in Figure 8. No respondents felt the workshop was unlikely to impact their practice.

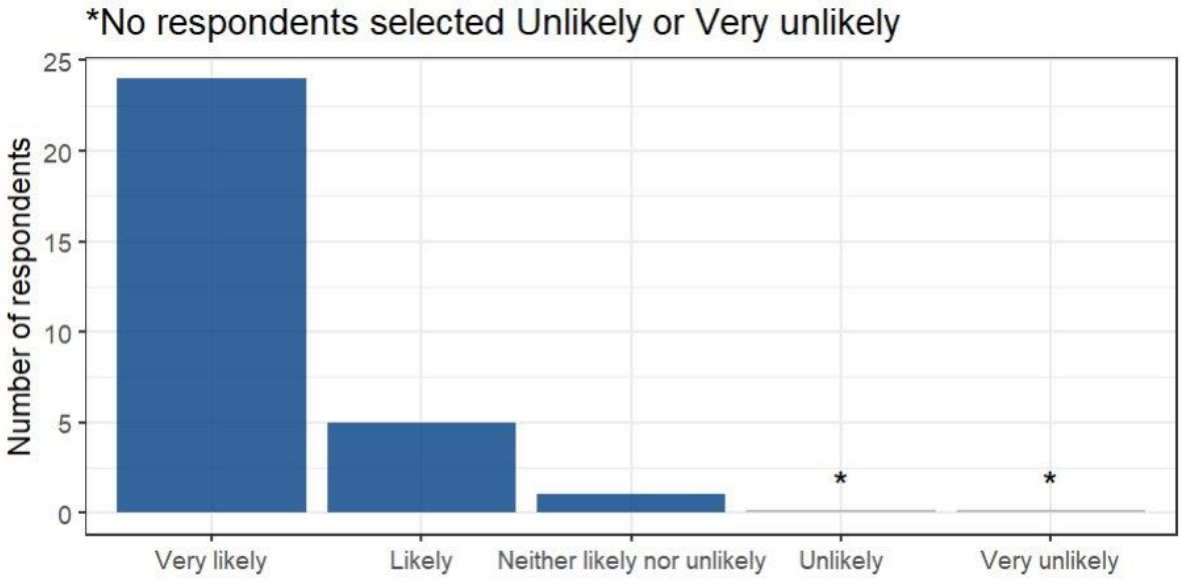


Figure 8: Graph showing the number of respondents who rated how likely they were to change their practice based on the workshops.

Free-text responses further reinforced these findings, with key themes emerging when asked what staff will do differently following the workshop. Many staff members felt that the workshop had increased their confidence in communication skills and conversation techniques with a more empathetic, reflective and person-centred approach, with one staff member saying,

"[I will] hold a conversation rather than asking questions. [I will also] allow time for reflection and more active listening"

Furthermore, staff reported more confidence and proactivity in conversations about ACPs, as well as increased knowledge, with one member of staff wanting to,

"Try to engage more about ACP conversations, even if [it is] a bit uncomfortable, because that's the way [for me] to get better at it".

Given the small cohort size of respondents to the PEoLC surveys, we were unable to achieve statistical significance on quantitative findings. Further work to collect data from a larger cohort of staff would perhaps enable the achievement of statistical significance in the impact of the PEoLC team.

A full analysis of responses to the PEoLC surveys can be found in Appendix 2.

Hospice referrals

Analysis of renal referral data from Community Hospice and St Christopher's Hospice between June 2024 and November 2025 shows sustained referral activity across the period, with month-to-month variation in volume across both providers.

Across the 18-month period with complete data, a total of **138 renal referrals** were made to Community Hospice and **253 renal referrals** to St Christopher's Hospice. Overall referral volumes were consistently higher for St Christopher's Hospice, reflecting its broader geographical coverage.

Monthly referral numbers for both services fluctuated over time rather than following a clear linear trend. Both providers saw periods of higher activity in early 2025, with St Christopher's showing an additional increase in autumn 2025. Longer-term data, including referrals to the GSTT community palliative care team, would be needed to determine whether these patterns are significant. While changes cannot be directly linked to the PEoLC input within the MMMoC, the observed increases may align with greater awareness and engagement with palliative and end of life care services. Findings were considered alongside staff survey data to support interpretation.

Chapter 7. Discussion

This evaluation demonstrates that a targeted, multi-pronged PEoLC engagement programme embedded within renal services can meaningfully improve staff awareness, knowledge and confidence. These findings align closely with existing evidence highlighting workforce confidence, misconceptions about palliative care and lack of communication skills as key barriers to timely PEoLC access for people with advanced kidney disease and multimorbidity [10,12].

Across all intervention types, staff reported learning new information about PEoLC and hospice care, with the campaign successfully addressing common misconceptions, particularly that palliative care is not episodic and is only relevant at the very end of life or only for people with cancer. This is consistent with wider literature identifying misunderstanding of the scope and role of palliative care as a major contributor to late or absent referrals in non-malignant conditions, including renal disease [10,13]. Achieving 100% awareness of these key concepts following the campaign suggests that combining informal ward-based engagement with structured education and experiential learning can be effective in shifting understanding within busy acute settings.

Improvements in staff confidence were observed across all measured domains, with particularly notable gains in confidence to initiate ACP discussions and to discuss the UCP. The observed reduction in staff who reported “never” having ACP discussions, alongside increased routine engagement with planning conversations, reflects a meaningful change in practice behaviour. This finding is important given the consistent evidence that people with late-stage kidney disease frequently miss opportunities for early ACP, often resulting in care that is poorly aligned with their values and preferences [10].

The sensitive conversations workshops appeared to play a critical role in translating knowledge into confidence and practice. Large increases in confidence to initiate and respond to ACP-related conversations reflect previous findings that communication skills training, particularly when it includes experiential learning and reflection, can reduce professional anxiety and avoidance around discussions of uncertainty, deterioration and end of life [12]. Qualitative feedback from participants suggests that staff not only felt more confident, but also adopted a more empathetic, reflective and person-centred communication style, which is central to high-quality palliative care.

While this evaluation did not demonstrate a clear, attributable change in hospice referral volumes, referral data limitations, short follow-up timeframes and the inability to capture referrals to hospital-based and community palliative care teams restrict the conclusions that can be drawn.

Crucially, evidence suggests that timely access to community palliative care is associated with reduced A&E attendances and hospital admissions, alongside improved symptom control and patient-reported experience [11]. Although this evaluation cannot directly measure these outcomes, the observed increases in staff confidence, earlier conversations and improved use of care planning tools represent

the enabling conditions required to support such downstream impacts. By increasing staff readiness to identify palliative needs earlier and to engage in proactive planning, this work aligns with evidence-based mechanisms known to reduce crisis-driven care and unnecessary hospital utilisation.
From a system perspective, the findings support the broader ambitions of the MMMoC and the national shift towards proactive, integrated and community-based care. Earlier, more confident engagement with PEoLC has the potential to improve coordination across renal, hospice and community services, support people to remain in their preferred place of care, and avoid unwanted or burdensome interventions, including unwanted dialysis escalation [10,11].

Several limitations should be acknowledged. Survey response numbers, particularly post-campaign, were relatively small and may be subject to positive response bias, with more engaged or motivated staff more likely to participate. Improvements in confidence are self-reported and may not fully translate into sustained practice change without ongoing reinforcement. However, the consistency of findings across multiple activities, confidence measures and qualitative feedback strengthens confidence in the overall direction of impact.

In summary, this evaluation provides credible evidence that a co-designed, multi-pronged PEoLC engagement programme can improve knowledge, confidence and readiness among renal staff to support earlier, person-centred palliative care. While longer-term evaluation is required to assess impacts on service utilisation and service user outcomes, the findings align strongly with existing literature and demonstrate that workforce development is a critical lever for improving access, quality and equity of palliative care for people living with advanced kidney disease and complex multimorbidity.

Chapter 8. Next steps

Building on the findings of this evaluation and the wider comprehensive evaluation of the MMMoC, the following next steps are proposed to support sustainability, scale and system learning:

1. Secure continuous funding to continue and embed PEoLC awareness, education and skills-based interventions within renal services, recognising their impact on staff confidence and capabilities to support PEoLC.
2. Explore opportunities to implement similar PEoLC interventions in other specialties, particularly in other long-term conditions, where similar gaps in confidence, awareness and access to PEoLC have been identified, supporting a more system-wide approach.
3. Support neighbourhood-level working by aligning the PEoLC approach with INTs, enabling locally responsive, multidisciplinary care and improved continuity for people living with mLTCs. Learning from this work could inform rollout beyond South East London.
4. Sustain and strengthen multidisciplinary working, continuing collaboration between renal teams, palliative and hospice services, community teams and wider system partners to reinforce shared responsibility for ACP and coordinated PEoLC.
5. Continue to drive cultural change, embedding confidence, permission and skills for early PEoLC conversations as a routine part of care for people with advanced kidney disease and complex needs, rather than as late or crisis-led interventions.
6. Embed learning and evaluation into central system improvement and evaluation capacity, ensuring ongoing data collection, feedback and shared learning. Future evaluation should involve larger cohorts and longer follow-up to assess sustainability, spread and emerging impacts across services and populations.

Chapter 9. Conclusion

This evaluation demonstrates that the targeted PEoLC engagement within the MMMoC meaningfully improved staff awareness, confidence and capability to support people living with late-stage kidney disease. The multi-pronged approach, combining education, informal engagement and skills-based workshops, was well received and contributed to increased confidence in ACP, use of the UCP and earlier consideration of PEoLC. While changes in referral patterns cannot be directly attributed to the intervention, the overall findings suggest growing readiness among renal teams to initiate timely, person-centred conversations and to challenge misconceptions about palliative care. Embedding this approach more widely offers an important opportunity to improve access, integration and the quality of care for people with complex, life-limiting conditions.

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Chapter 12. Appendices

Appendix 1. List of stakeholder organisations involved in the MMMoC

Clinical Effectiveness South East London
Crossman Connections Ltd
Crosspath Consulting Ltd
Guy's and St Thomas' NHS Foundation Trust
King's College Hospital NHS Foundation Trust
Kings College London
Kings Health Partners
Ladywell Pharmacy
Lewisham and Greenwich NHS Foundation Trust
London Kidney Network
NHS England
Primary Care Networks across South East London: Albion, Lyndhurst and Plas Meddyg; Clocktower; Heritage; Hills, Brook and Dales; Improving Health Limited; Mottingham, Downham and Chislehurst; North Lambeth and Clapham; Orpington; Penge; Quay Health Solutions; The Lewisham Care Partnership
Queen Mary's APL-Renal Risk Stratification Tool
South East London Integrated Care System
South East London Workforce Development Hub
South London Office of Specialised Services
South London Health Innovation Network
St Christopher's
The Community Hospice
Universal Care Plan
Vital 5

Appendix 2. PEoLC survey analysis

- Accessible via this web link: https://www.selondonics.org/download/22000/

Appendix 3. PEoLC surveys – blank versions

Accessible via the following web links:

- Hospice visit survey: https://www.selondonics.org/download/21994/
- Post-intervention staff survey: https://www.selondonics.org/download/22003/
- Pre-intervention staff survey: https://www.selondonics.org/download/22006/
- Sensitive conversation workshop survey: https://www.selondonics.org/download/22009/
- Staff webinar survey: https://www.selondonics.org/download/22012/
- Tea trolley dashes survey: https://www.selondonics.org/download/22015/

Appendix 4. Staff feedback on PEoLC awareness campaign

- Accessible via this web link: https://www.selondonics.org/download/21997/

Chapter 13. Glossary

The following definitions and abbreviations are key for understanding the contents of this report:

Term	Full term	Definition
ACP	Advanced care plan	A voluntary, person-centred process to record an individual's values, preferences and intentions for future medical care.
ARRS	Additional roles reimbursement scheme	NHS England funding scheme to expand the primary care workforce by providing recurrent funding for specific multi-disciplinary roles at PCN and practice level.
CKD	Chronic kidney disease	A chronic condition where the kidneys cannot effectively filter waste and excess fluid from the blood. It can lead to kidney failure, requiring dialysis or a transplant.
CRM	Cardiorenal metabolic	The interconnected dysfunction of the heart, kidneys and metabolic system (including obesity and diabetes).
GSTT	Guy's and St Thomas' NHS Foundation Trust	A large hospital trust in providing specialist and community care in south east London.
ICB	Integrated care board	NHS regional bodies responsible for planning and funding health services across a geographical area.
ICS	Integrated care system	The NHS, council, social services and voluntary services form a partnership across regions to help improve the delivery of health and social care for their populations. An ICB sits within the ICS.
INT	Integrated neighbourhood team	Where all parts of the health and care system – primary care, social care, community health, mental health, acute, and wider system partners – work closely together to support service user's needs more systematically.
KCH	King's College Hospital NHS Foundation Trust	A hospital trust providing specialist and community care in south east London.
MDT	Multidisciplinary team	A group of professionals from different disciplines who collaboratively assess and plan care, ensuring holistic, coordinated, and service user centred management.

mLTCs	Multiple long-term conditions	When a person lives with two or more chronic illnesses at the same time (e.g., diabetes, heart failure, CKD).
MMMoC	Multimorbidity model of care	A person-centred, holistic, and fully integrated model across all care settings delivered through INTs. Aims to shift care nearer to the service user, through community-based INTs and optimising proactive care.
NHS	National Health Service	The NHS is the UK's publicly funded healthcare system that provides medical care, free at the point of use for residents.
PEoLC	Palliative and end of life care	Care that focuses on symptom control and quality of life for people with life-limiting conditions, and support for families, especially in (but not limited to) the final phase of life.
POC	Point of care	Diagnostic tests delivered at the time of care, enabling faster decision making.
SEL	South East London	A geographic area and NHS Integrated Care System covering the London boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark.
SGLT2i	Sodium-glucose co-transporter 2 inhibitors	A class of medications that lower blood glucose levels by increasing glucose excretion in the urine. These medications are protective of the kidney and the heart.
UCP	Universal Care Plan	A London-wide digital platform that stores interoperable personalised care plans to support coordinated care across services.