

Supplementary					
Table S1	Main findings of the included studies				
Author Year	Intervention Population	Intervention	Description of Public Involvement in Intervention	Sample Size and Demographics	Main Findings
Abbs et al., 2019	Residents and health and social care staff of Cheshire, England	Part of the Cheshire Living Well Dying Well (CLDW) programme. 'Awareness-raising' presentations aimed to raise awareness of the benefits of planning for end of life and taking actions and preferences. Events were 60-90 minutes long. 'How to' workshops aimed to increase participants' confidence and skills to facilitate conversations with loved ones about their end-of-life plans and preferences. Workshops were 150-180 minutes long.	Community not involved with the development or delivery of intervention. It was intended that participants acted as a "seed, spreading ideas within the population" (p. 9).	Attendees (n=676), completed baseline questionnaire (n=496), completed post-intervention questionnaires (n=478), and completed follow-up questionnaires (n=1414). Responders were predominantly female (70%), aged 45-74 (60%), retired (47%), living with a partner or spouse (60%), and resided in the least deprived quintile in England (49%).	Both educational programmes were well received and rated as highly relevant to respondents. Of those who completed all three parts of the survey, 84% indicated that intention to take action' post-intervention, and 64% reported 'taking action' at the 3-month follow-up; the most frequently cited action was engaging in discussion with family and friends. The interventions had limited success in encouraging participants to make a will, with only 2 participants doing so at follow-up.
Ahmed & Pereira, 2020	Healthcare professionals and community leaders across Canada.	The Pallium Project used the 3Cs (coordination, collaboration, and communication) approach to support a rapid scaling-up of learning and development interventions.	"Strategically engaged local clinical and service opinion leaders as active collaborators and champions (i.e., co-owners) in goal-directed (i.e., access, quality and capacity) change interventions, using the aforementioned Action Learning and Collaborative Inquiry approaches" (p. 243).	72 learning and development sub-projects, including but not limited to: 40 weekend courses (n=957); 7 1-day continuing education workshops (n=310); 2 cohorts completed Clinical Palliative Care Education programme (n=not stated); monthly continued professional development auto-conferences (537 instructional contact hours confirmed during first year), and resource development.	Paper synthesises the findings, learning, and recommendations from the 72 sub-projects of the Pallium Project (Phase II).
Boling, Klotenski & Wolf, 2021	General public.	Last Aid Course comprised of four modules: (1) dying as a normal part of life; (2) planning ahead; (3) relieving suffering; and (4) final goodbyes. Each module lasted 45 minutes; all modules were delivered in a classroom setting over the course of one day.	Community not involved with the development or delivery of intervention. Feedback used to refine course content. Intended that participation would "empower citizens to recognise the need for palliative care and to participate in its provision" (p. 140).	408 courses (n=6014); respondents included in analysis (n=5469). Majority of participants were female (87.9%), with a non-medical profession (90.6%), with a median age of 55 years.	Respondents were positive about the course; 75.8% rated it as a "5" (most recommended) to others, and 84.4% reported they had recommended it to others. Qualitative analysis reported five topics (1) atmosphere and surroundings; (2) the instructors; (3) content; (4) effects of the course on the participants' feelings of value; and (5) suggestions for improvement.
Boling, Meyer, Koestl, Schmidt & Bauer, 2021	General public.	Last Aid Course comprised of four modules: (1) dying as a normal part of life; (2) planning ahead; (3) relieving suffering; and (4) final goodbyes. Each module lasted 45 minutes; all modules were delivered online over the course of one day.	Community not involved with the development or delivery of intervention. Feedback used to refine course content. Intended that participants would be empowered to support dying people at home.	15 courses (n=174); respondents included in analysis (n=92). No demographic details provided.	Respondents were positive about the course; 80% rated it as "very good", 100% would recommend it to others, and 96% reported they had recommended it to others. Qualitative analysis addressed the pros and cons of conducting the course online.
Boling et al., 2022	General public.	Last Aid Course comprised of four modules: (1) dying as a normal part of life; (2) planning ahead; (3) relieving suffering; and (4) final goodbyes. Each module lasted 45 minutes; all modules were delivered over the course of one day either online or in a classroom setting.	Community not involved with the development or delivery of intervention. Feedback used to refine course content. Intended that attendance would "empower people to contribute to end-of-life care in the community" (p. 1).	8 courses (n=79); respondents included in quantitative analysis (n=53). Majority of participants were female (80%), with non-medical profession (57%), and a mean age of 60 years. Attended focus group (n=49).	Quantitative findings indicated that the course was well received; 98% rated the course as "good" or "very good" and 96% would recommend it to others. Paper indicates that the EASE ONLINE course was well received but does not report the findings from the pre- and post-course questionnaires.
Hagström, 2021	Families affected by parental suicide.	Weekend camps for families bereaved by suicide using psychoeducational techniques. Parents and children separately explored nine themes: (1) information about suicide and suicide bereavement; (2) the family then and now; what happened; (3) what has changed; (4) grief responses and emotions; (5) my grief/our grief; (6) remembering the deceased parent; (7) what helps and how do I take care of myself; (8) questions I wanted to ask but have not asked; and (9) what is my future.	Community not involved with the development or delivery of intervention.	14 families attended the camps. Of these, 11 families agreed to be interviewed. Majority of parents were mothers (82%); children (8 girls and 5 boys) were aged between 6 and 13.	Results are structured chronologically from narratives about life before to life after the support programme, with meanings and changes highlighted.
Hill et al., 2020	Couples living with dementia.	Programme consisted of six sessions: (1) introductions; (2) what affects our relationship; (3) strength, resilience, and change; (4) nurturing ourselves and our relationship; (5) what have we learnt about navigating change; and (6) conclusion. Sessions were conducted in person and lasted 2 1/2 hours (including break).	"The participants played a major role in developing this program beyond its original conception" (p. 3). The authors drew upon participants' reinterpretation of one of the activities to demonstrate this.	3 couples. No demographic details provided.	All participants felt they gained something from the programme. In particular, participants valued connecting with others and being listened to.
Matheson et al., 2014	Community inhabitants.	Employed a four-stage asset-based community approach (ABCC) development approach. Case study 1 (Lumbra Conversations for Life) aimed to improve awareness about, and increase, advance care conversations through stories, outreach and education. Case study 2 (Marselyside and Cheshire Cancer Network): six communities led their own awareness initiatives.	"The process of facilitating community development follows the following four steps: getting started, coming together, action planning and intervention" (p. 2).	Curitiba, Rio and regional newspapers estimated to have reached 20,000 people. The website received 3445 visitors. 11 workshops (n=43), majority female (79%). Morteyside and Cheshire: the activity undertaken across the region led to the participation of 143 organisations.	Findings present (1) the nature of the assets available in communities, and (2) the common priority areas for action (information, outreach, education, leadership, and sustainability).
Martins Pereira et al., 2019	Teenagers who attend the religious activities of the parish, the catechists and community members	Employed the typical cycle of action research: (1) preparatory phase where teenagers were invited to reflect upon religious activities of the parish; (2) educational-intervention phase informed by phase one; and (3) evaluation phase. Delivered over 3 hours in classroom setting.	As part of Action Research cycle education-intervention responded to educational needs of community identified through preparatory phase.	60% were teenagers (n=49); completed evaluation (n=37). Attended educational, 13% parents, 16% catechists, and 6% community members.	The session was rated as "very good" by 71% of respondents, and 65% rated the education phase as "very good". Field research identified teenagers were open and had a positive attitude towards discussion with high levels of engagement.
Mauler et al., 2021	Non-medical hospital staff (although open to all hospital staff).	Last Aid Course comprised of four modules: (1) dying as a normal part of life; (2) planning ahead; (3) relieving suffering; and (4) final goodbyes. Each module lasted 45 minutes; all modules were delivered over the course of one day in a classroom setting.	Community not involved with the development or delivery of intervention. Feedback used to refine course content.	Course attendees (n=56); survey respondents (n=55). Majority of participants were female (90.9%), non-medical staff (87.3%). The sample was heterogeneous with regard to age, profession, and patient contact.	Respondents were motivated to participate in the course to prepare for the emotional and medical aspects in care for the dying, and to gain knowledge in supportive services and facilities. Overall, respondents rated the course highly; 76.4% rated it as "good" or "very good", 99.1% would recommend it to others, and 87.3% reported they had learned something.
Patterson et al., 2022	General public.	End of Life Skills for Everyone (EASE) course consisted of four modules (1) an introduction to death and dying in Scotland; (2) serious illness and health; (3) realities of caring for dying; and (4) caring for the carer. Each module lasted 2 hours; course delivered weekly (i.e., 2 hours per week for 4 weeks, or 2 modules over a morning afternoon).	Working group "brought with them experience of and expertise in course development, education, chaplaincy, bereavement support, general practice, and palliative care nursing" (p. 2) which informed course development. Course content was refined following survey with general public and pilot study. Intended that course would "empower communities and not stay heavily on busy (and scarce) palliative care or other healthcare professionals" (p. 6).	Survey responses (n=203); majority (80%) were from people who had supported someone informally at the end of life. Number of focus group participants not stated. Nurses make up the largest proportion of learners (55.3%), followed by physicians (14.3%), and paramedics (12.9%). In response to Covid-19 pandemic: 103 online courses were delivered to 1879 learners. Additionally, 25 webinars (average 288 registrants) which addressed emergent pandemic-related topics were delivered.	Findings from survey informed course content. The EASE course was piloted in two locations. Experiential evaluation found the course was well received. The course was revised in response to feedback to improve the course. Paper indicates that the EASE ONLINE course was well received but does not report the findings from the pre- and post-course questionnaires.
Paul et al., 2019	Primary school children aged 9-12 years, their parents and teachers.	Employed an Action Research methodology to develop a five-phase educational intervention: (1) preparation and planning; (2) exploration; (3) planning and development; (4) pilot developed practice; and (5) evaluated development.	Used an Action Research methodology "to develop a 'development process' in which participants resolve the issues in question" (p. 3). In order to develop knowledge and learning.	Hoopce (n=2); School 1: staff (n=7), children (n=21), parents (n=4); School 2: staff (n=6), children (n=12). No demographic details provided.	Three action areas were identified: (1) raising awareness of hospice care and end-of-life care issues more broadly; (2) education and training; and (3) providing leadership in death education and bereavement.
Pereira et al., 2021	Prior to 2013, the LEAP course was only available to community-based primary care professionals. Since 2014, versions for different settings, services, and specific disease groups have been made available.	Learning Essential Approaches to Palliative Care (LEAP) courses (part of Pallium Project) address core palliative care competencies. Programme consisted of the following modules: (1) self-awareness; (2) taking ownership; (3) decision-making; (4) advance care planning and goals of care; (5) essential conversations; (6) pain; (7) dyspnoea; (8) nausea and GI symptoms; (9) psychosocial and spiritual needs; (10) delirium; (11) last days and hour; (12) palliative care; and (13) quality improvement. Originally delivered as a 2-day workshop.	"Pallium positions itself as a Knowledge-to-Action broker [...] that brings together palliative care subject matter experts from across the country to identify best practices and evidence and synthesise and spread them to health professionals" (p. 2).	From 2015-2019, 1603 courses were delivered. A total of 28,123 learners have participated in LEAP courses from 2014-2019. 25 webinars (average 288 registrants) which addressed emergent pandemic-related topics were delivered. 40 staff (almost exclusively women) in 18 pharmacies actively participate in the project. Focus groups with caregivers of people with dementia (n=9); interviews with caregivers of people with dementia (n=9). No demographic details provided.	Paper summarises (1) main findings from programme evaluation and impact research (2) success factors and spread accelerators; and (3) challenges and barriers.
Plunger et al., 2019	People living with dementia who access participating community pharmacies.	Three workshops were conducted with key stakeholders to review the needs. In phase two, pharmacies will carry out small-scale projects to increase the wellbeing of people living with dementia.	Based on Participatory Health Research approach, "the core elements of the approach are participation, action and reflection" (p. 140). Phase two (in progress) involved implementing small-scale "community outreach" projects.	Surveys (n=94), respondents were aged between 30 and 60, the majority were female (84%). 62 focus groups and interviews (n=185) with community members, Elders/Knowledge Carriers, and external health care providers. Enrolled in the Dying/Learn MOOC (n=1156), completed course and action (n=86). Completed the MOOC evaluation at both time points (n=208). The majority of those enrolled were female (82.1%); aged 40 and over (78.2%); self-identified as a health professional (88%); resided in Australia (94%).	Pharmacies reflected upon the unique affordances and challenges supporting people living with dementia in the semi-public environment as well as identifying areas of professional development. People living with dementia identified different obstacles to care based on whether they lived in an urban or rural location.
Price et al., 2019	Community inhabitants.	Paper focuses on community educational strategies of the End-of-Life Care in First Nations Communities (EOLFN) Project. Initiatives unfolded in three phases: (1) assess educational needs in each community; (2) develop recommendations based on the findings; and (3) develop and implement educational responses in response to identified needs.	"Consistent with the PAR (Participatory Action Research) approach, all aspects of the research and palliative care program development were controlled by community members" (p. 4).	Surveys (n=49), respondents were aged between 30 and 60, the majority were female (84%). 62 focus groups and interviews (n=185) with community members, Elders/Knowledge Carriers, and external health care providers. Enrolled in the Dying/Learn MOOC (n=1156), completed course and action (n=86). Completed the MOOC evaluation at both time points (n=208). The majority of those enrolled were female (82.1%); aged 40 and over (78.2%); self-identified as a health professional (88%); resided in Australia (94%).	Findings are organised using the following headers: (1) educational needs of clients and families; (2) educational needs of First Nations community; and (3) education needs of Canada's health care system.
Tieran et al., 2019	General public.	Course consisted of four modules: (1) how we engage with death and dying; (2) representations of death; (3) self-awareness and grief; and (4) final goodbyes. Content was delivered online over six weeks (four modules plus introduction and reflection sessions).	Community not involved with the development or delivery of intervention. It is intended that participation would "build community awareness with death and dying" (p. 2).	Enrolled in the Dying/Learn MOOC (n=1156), completed course and action (n=86). Completed the MOOC evaluation at both time points (n=208). The majority of those enrolled were female (82.1%); aged 40 and over (78.2%); self-identified as a health professional (88%); resided in Australia (94%).	Paper also summarises community-led initiatives developed to address the educational needs identified in the community assessments. Findings indicated the course was well received; 96.5% reported the course was enjoyable, 84.5% would recommend it to others, and 91.2% agreed the course gave them a deeper understanding of death. There was a statistically significant increase in awareness with the statements "death is a normal part of life"; "I am comfortable talking about death/bereavement"; and "social media provides different perspectives to mainstream media on death/bereavement" following participation in the Dying/Learn MOOC.
Zungu-Vituvana et al., 2021	Bereaved inhabitants of city.	Session was divided between (1) psychosocial covering topics related to loss, grief, and bereavement; and (2) discussion of personal loss. Delivered as weekly 2-hour sessions.	"The grief and bereavement support program emerged from within the community, recently, a local palliative care service has partnered with the program" (p. 10).	New attendees registered (n=427). Majority female (82%), religious (84%), and had experienced one loss (59%). Median age 43.8 years.	Most common reasons for attending the programme were personal experience of loss (89.5%) and wanting to learn about grief (29%). Most frequent type of losses were the death of a partner (50.1%), death of a parent (14.3%), and death of a child (8.4%). There was no statistically significant difference between the types of losses among men and women.
Cultural Interventions					
Marsh et al., 2017	Community inhabitants.	Adopted a Participatory Action Research framework which consisted of: (1) information evening; (2) four "listening conversations" sessions facilitated by an artist based on the themes of death and dying; and (3) one-day workshop to develop the garden. Sessions were held over the course of three months.	"Adopted a Participatory Action Research (PAR) framework, a key principle of which is that research participants are active, informed community members who share the end goal of producing 'action and knowledge that is directly useful to a group of people'" (p. 112).	Information session (n=33); listening conversations (n=18); one-day workshop (n=36); interview (n=5); focus group (n=1). No demographic details provided.	Themes identified (1) "Conversations" – the need to talk about death and dying; (2) "informal cafes" – the need to be with others in the time of grief and to give and receive support; and (3) "Community gardening" – needing food, tea, and tranquility.
McLaughlin et al., 2016	Community inhabitants.	The World Café approach was used to organise themed discussions about the importance and challenges thinking and talking about death, dying, loss and care. Discussions were supplemented with presentations and short films. Events were delivered in person and lasted 2 1/2 hours.	Framed as "community engagement"; community not involved with the development or delivery of intervention. Course content refined following pilot.	Attended information session (n=14); completed evaluation (n=51). Respondents were predominantly female (84%) with a mean age of 55.6 years.	All respondents would recommend Café Conversations to a friend. Statistically significant post-Café improvements were observed in all key domains, with the exception of participant's self-rating of difficulty discussing death, grief, and bereavement.
Mills et al., 2020	General public.	Twitter hashtag (e.g., #PANZAN #PanCovid) were used to engage the public on both community and professional issues pertaining to palliative care.	Community not involved with the development or delivery of intervention but responded to discussion themes. Intended that intervention would "support both professional and community capacity for end-of-life care" (p. 252).	See main findings.	The #PANZAN hashtag enabled interaction between 25 participants who posted 230 tweets generating close to 750,000 impressions, followed by 55 participants sharing 107 tweets resulting in a further 210,000 impressions over the next 24 hours. A second chat involved 32 participants posting 266 tweets, followed by 67 participants sharing 120 tweets in the subsequent 24 hours.
Richards et al., 2020	General public.	Death Cafés – "pop up" events where people meet informally to discuss aspects of death and dying. Cafés are inclusive stipulate that Death Cafés are (1) on a non-for-profit basis; (2) with no intention of leading participants to any conclusions, product or course of action; (3) an open, respectful, and confidential space; and (4) that food and refreshments are served.	Death Cafés are framed as opportunities to "engage in death talk" (p. 30) but "should not be used as a method of community consultation or engagement" (p. 5).	Death Cafés participants (n=49). Majority were women (71%) working in the death industry (n=13), healthcare (n=9), or mental health (n=5). Organisers had a mean age of 45-50 years.	Findings organised into the following sections: (1) how international is the Death Café movement? (2) who are the organisers and who are the attendees? (3) internationalisation of the Death Café form; (4) why organisers think Death Cafés are needed; and (5) the perceived effects, beyond the event itself.
Service Interventions					
Abel et al., 2018	Patients identified using broad criteria, including anyone giving 'cause for concern'.	The Health Connections Mandy approach consisted of: (1) patient identification; (2) goal setting and care planning; (3) enhancement of naturally occurring supportive networks; and (4) linkage to community resources. Delivered from April 2013 to December 2017.	"The aim of community development is to enable as much resource as possible to exist within the community, without always involving health and social care services" (p. 466).	During study period, there were 225,195 unplanned admissions to hospital for patients registered in Somerset, 8888 in Frome. No demographic details provided.	There was a progressive reduction by 7.9 cases per quarter in unplanned hospital admissions across Frome; a decrease of 14%. In comparison, there was a 26.5% increase in admissions per quarter within Somerset. Cost of unplanned admissions in Frome reduced by 20.8% between 2013/14 and 2016/17.
Abel & Townsend, 2015	Carees of hospice patient.	Volunteer Community Champion (VCC) were recruited from hospice pool of volunteers (i.e., carers, group, bereavement and grief supporters) and received training that included but was not limited to communication, bereavement, end of life, boundary setting. VCCs were matched with carer of hospice patient with the aim to provide emotional support, network development, and bereavement support.	Community Development was used to "start to develop naturally occurring supportive networks" (p. 17).	At the 18-month evaluation: VCCs recruited and trained (n=17); VCCs confident to provide support (n=2); carers supported (n=28). Average caring period was 6.1 months. No demographic details provided.	Paper provides descriptive summary of key outcomes and reflects upon the lessons learned implementing the programme.
Aoun et al., 2020	Adult patients with advanced illnesses/ palliative care needs.	Volunteer Compassionate Communities (VCCCs) will attend a 2-day training programme delivered by content experts. VCCCs will be matched with vulnerable older adults with the aim of mobilising their network of Caring Helpers (friends, family, and neighbour willing and able to provide practical support). VCCCs will visit/telephone the client a minimum of six times over the course of three months.	Intervention framed as a "community-led" (p. 1) "partnership between the community and the palliative care service" (p. 8). Intervention relied on community volunteers, but community members were not involved with intervention design.	Proposed sample size of 10 VCCCs and 30 patients/families.	Not yet available.
Bruce et al., 2021	Community dwelling older adults with advanced chronic illness.	Part of the Nav-CARE Navigation – Connecting, Accessing, Resourcing, Engaging programme (see Pesut et al., 2021). Volunteers are trained and matched to clients with the aim to connect them with persons, resources, and services in the community to improve their quality of life. Volunteers visit clients every two weeks for 1-2 hours.	Level of public involvement unclear. But frames programme as "working in collaboration with patients, families and communities" (p. 572).	Clients (n=23), majority female (73.9%) living at home (80.9%) with mean age 72.06 years. Volunteers (n=33), majority female (84.1%), with mean age 64.81 years.	Paper reports three themes (1) pandemic emotions; (2) negotiating social interactions; and (3) growing through the Covid-19 pandemic: more fully or less.
Crovin, 2015	Practice population of Shelton Medical Practice identified to be in greatest need.	Compassionate Communities (Co-Co) in Streaphale matched Community Volunteers with older person identified as being at risk of loneliness and/or social isolation. The type of support and frequency of contact to be agreed between volunteer and client and is regularly reviewed.	Described as a "locally derived model developed in response to feedback from frail and vulnerable people" (p. 31). "It is not a service provided by an organisation but rather a community development supported by Seven Hospice workers" (p. 34-4, emphasis is original).	Compassionate Community Developments (n=14); Community Volunteers (n=40); clients (n=38). No demographic details provided.	A year after commencement of the programme in family doctors was undertaken. Total visits to practice, total phone calls to assist out-of-office, total A&E admissions, total hospital admission, total calls to visits by out-of-hours services decreased over the 6-month period following deployment of volunteers. Total planned hospital admissions increased.
Howard et al., 2018	Adults living with disabilities in the catchment areas).	A community facilitator will coach individuals to identify needs and priorities, and link with resources.	Level of community involvement unclear. States "intervention aimed at reducing social isolation by mobilizing individuals to act on their health and social needs individually, and in collaboration with fellow members of their community". Programme stemmed from community observation. Authors state, "we are exploring further the foundation of our practice experience with community development, policy reform and social and political change" (p. S112).	Proposed sample size of 1000 participants.	Not available.
Krakowiak et al., 2018	Patients in hospice setting.	Prisoners are trained, after which they are gradually introduced to join teams in caring for patients in the hospice wards. Volunteers work up to 8 hours a day for no payment. From 2003-2009 project limited to one hospice in Odanski but has since expanded to other hospices in Poland.	Intervention relied on community volunteers, but community members were not involved with intervention design. Steps to address unmet patient needs "through mobilisation of the community" (p. 2).	Survey (n=852); interviews with prisoners (n=14). No demographic details provided.	93% of survey respondents agreed that prisoners should have opportunities to work in places like hospices. The qualitative research identified differences in how prisoner-volunteers relate to the world, to others, and to themselves compared to prisoners who had not volunteered.
Librada Flores et al., 2018	Residents of Sallve with an advanced or terminal illness, are receiving palliative care supervision, and identified as having unmet needs.	RECOJUDA (part of the All With You programme) intervention will match a Community Promoter with person living with advanced illness and/or their families to identify unmet needs and mobilise support networks). The intervention will be delivered in person over seven weeks.	Intervention relied on community volunteers, but community members were not involved with intervention design. Study builds upon findings from pilot studies.	Proposed sample size of 300 patients per group.	Not yet available.
McLaughlin et al., 2015	Community dwelling adults with advanced life-limiting illness in Liverpool.	In accordance with MRC Framework for the Evaluation of Complex Interventions the INSPIRE study (part of the Good Neighbour Partnership) will be completed in three phases: (1) explore relevant theory and evidence to inform intervention development; (Phase 2) identify the intervention and the underlying mechanisms; and (Phase 3) exploratory delayed randomised controlled trial. Compassionate Community Volunteer (CCV) will be trained and matched with person living with life limiting illness to mobilise community support. Delivered in person over the course of eight weeks.	Described as a "volunteer-led model of social and practical care/support for community dwelling adults living with advanced life-limiting illness" (p. 3). Intended to support community volunteers, but community members were not involved with intervention design.	Proposed sample of 10 CVAs and 80 community dwelling adults living with the limiting illness.	Not available.
Pesut et al., 2017	Clients had to be over 55 years of age and have one or more advanced chronic illnesses that could reasonably lead to death within the next year.	Nav-CARE pilot study recruited and trained volunteers who were then matched with a client to identify unmet care needs and mobilise community-based resources and supportive networks. Volunteers visited client according to client preference (typically every 2-3 weeks) over 12 months.	Study followed a "community-based research approach" that included advisory committee representation from hospice societies and allied professionals to guide project. Intervention relied on community volunteers whose feedback had been used to refine programme training materials.	Volunteers (n=7); all female, mean age of 60 years. Clients (n=18); majority female (n=10), mean age of 70 years.	Volunteers dedicated 378.4 direct contact hours visiting clients engaged in multiple activities with clients. Including but not limited to, facilitating greater connection with other hospice volunteers, responding to services and resources, and engaging strategies to assist clients to become more fully in life. Overall, there was high degree of satisfaction/participation in supporting clients over the long term. Clients reported volunteer navigators had transformed their lives experience. Both clients and volunteers expressed some uncertainty over the meaning of "navigation activities". Key contextual factors that determined the ease with which Nav-CARE was implemented included: (1) the individual skills and characteristics of the volunteer coordinator champion; (2) organisational capacity and connection; (3) the successful recruitment of older persons; (4) the adequacy of volunteer preparation and mentorship.
Pesut et al., 2020	People living with advanced illnesses who accessed the participating hospice societies.	Expansion of Nav-CARE programme to eight community-based hospice societies. Volunteers are recruited, trained, and matched with clients to identify unmet care needs, mobilise community-based resources and supportive networks, and support client with desired activities. Volunteers visit clients in person every 2-3 weeks. The planned action cycle was 12 or 18 months, depending on site.	Described as a "volunteer-led navigation intervention" (p. 3). Intervention relied on community volunteers, but community members were not involved with intervention design. Study builds upon findings from pilot studies.	Clients (n=49; family (n=38); volunteers (n=38); stakeholders from healthcare and hospice settings (n=50). No demographic details provided.	The findings are presented in the following sections: (1) participant characteristics; (2) intervention characteristics; (3) programme processes – taking time, advocacy, and empowerment; and (4) impacts and opportunities for improvement.
Pfaff et al., 2021	People with chronic disease, people living in social isolation, older people.	Vulnerable Persons Project part of Windsor-Essex Community Corporation overview staff and volunteers. Intervention varies from in-person conversations with fully integrated health and social care supports, to scheduled calls to assess client goal setting and quality of life. Clients are never discharged.	WECCO "is a collective of volunteers and 65 healthcare care organisations that partner in identifying and reducing the unmet needs of persons living with complex health and social issues" (p. 5). Intervention relied on community volunteers, but community members were not involved with intervention design.	Focus group with clients (n=15); interview with clients (n=3); stakeholders (n=16). No demographic details provided.	The findings are presented in the following sections: (1) participant characteristics; (2) programme processes – taking time, advocacy, and empowerment; and (4) impacts and opportunities for improvement.
Riley et al., 2018	Bereaved people who had accessed Weston HospiceCare.	Peer-led bereavement support for carers of palliative care patient. Meetings happen monthly for two hours; it has no structured therapy sessions.	Aligned with "participatory development" where "the hospice had a role in facilitating this process rather than leading it" (p. 69). Group developed in response to community needs and delivered by Hospice. Facilitation has since been assumed by former carers.	150 bereaved people have attended Buddy Groups. No demographic details provided.	Buddy Groups have been self-sustaining with bereaved participants taking on facilitation and organisation roles. In addition to monthly meetings, the group also go on social outings (e.g., cinema, city trips, coffee mornings). Participants valued having people outside of their family to talk to and to empathise with their experiences.
Urmel et al., 2021	People bereaved by Covid-19 infections or during the Covid-19 pandemic.	Online support group for bereaved people based around: (1) education and training; (2) hospices and nursing homes; (3) media and social media; (4) communication; (5) observations; (6) arts; practice and storytelling; (7) memorialized photographs; and (8) review and evaluate.	"The overall research design was informed by participatory research approach, which emphasises research as a collaborative, practical, emancipatory, critical, and reflexive social process between the researchers and participants" (p. 3). Activities were co-constructed with community members.	Community participants (n=35). Majority of participants were female (57.1%), Canadian (86%) women (86.6%) bereaved by parental death (71%). Majority of deaths occurred in hospital (85.7%) caused by Covid-19 (71.4%). Only 17.1% had been able to hold in-person ceremonies.	Paper reflects upon the eight areas of activities co-constructed within the intervention (see "Intervention").
Wahne et al., 2016	Adult patients identified to be in the last year of life and self-identified informal carer.	End-of-Life Social Action Study (ELSA) protocol. Volunteers will be trained and provide support (befriending, signposting, practical assistance) to people identified to be in their last year of life. Support will be provided 1-3 times per week in person or by telephone. The trial will last 8-12 weeks, but support may continue beyond this.	Intervention framed as a "social action volunteer befriending service" (p. 3) for adults in the last year of life. Intervention relied on community volunteers, but community members were not involved with intervention design.	Proposed sample size 500 participants per arm. Qualitative case studies will be completed at eight sites with a proposed sample of 86-188 participants (including patients, informal carers, volunteers, key managers or coordinators).	Not yet available – see Wahne et al. (2016) below.
Wahne et al., 2016	Adult patients identified to be in the last year of life and self-identified informal carer.	ELSA Study: volunteers trained and provided support (befriending, signposting, practical assistance) to people identified to be in their last year of life. Support was in response to client needs but was typically once a week for 1-3 hours. Intervention duration was eight weeks, although support could continue beyond this.	"The content (signposting strategies to maintain wellbeing) and chosen delivery mechanism (via trained peer mentors) are derived from our previous qualitative study" (p. 2). Intervention relied on community volunteers, but community members were not involved with intervention design.	Intervention (n=100); control (n=90). Participants were recruited from all 11 sites (range 3-40 participants per site). Participants mean age was 72, and 60% were female. No significant demographic differences were observed between groups.	No statistically significant difference in effectiveness between volunteer provided support and "treatment as usual" (control). There was however a pattern of deteriorating levels of quality of life in the control group, a decrease not observed in the intervention group, and which tended to disappear when all received the intervention.
Wahne et al., 2020	Adults living with advanced cancer and their family/informal carer.	Peer mentors attended 2-day training and were matched with patient participants. Support was delivered either in person or by telephone in response to need. Typically volunteers met with clients 1-2 times per week (ranged 4-2 hours) for up to 12 weeks.	Intervention framed as a "social action volunteer befriending service" (p. 2) for people in the last year of life. Intervention relied on community volunteers, but community members were not involved with intervention design.	Interventions (n=8); control (n=10); peer mentor (n=2). Interviews conducted with clients (n=4); carers (n=2); mentors (n=7). Majority of patients in control (87%) and 90% of patients in intervention group were male, with mean age of 69.6 and 64.8 years respectively. All participants were British and most (75%) were married and living with together with no children. Majority of peer mentors were female (67%), British (81.7%) with an average age of 60.8 years.	Peer mentor recruitment and training met feasibility targets. (1) peer mentors identified as important for supporting people with advanced cancer; (2) peer mentors identified as important for supporting people with advanced cancer; (3) peer mentors identified as important for supporting people with advanced cancer.
Wang et al., 2020	Adults aged 18 years and above willing to complete training and provide 6 months' care in hospice communities for end-of-life patients and their families.	The following phases were followed (1) recruitment and motivational screening; (2) training; and (3) evaluation of training effects in building volunteers' confidence providing end-of-life care (EoLC).	"The transformative sustainability-learning framework was adapted to guide the development of the four-step capacity building program" (p. 410) for volunteers in EoLC.	Recruitment (n=171); eligible participants after motivational screening (n=92); participants who join the training and complete pre-test (n=88); participants who complete training and post-test (n=81); participants who complete 6-month follow-up (n=65). Majority of course attendees were female (74.7%), nearly 60% were aged 50-69 years, and more than half were retired or unemployed.	Competence in EoLC, awareness of self-care, and death work competence all significantly improved after training and remained intact at 6-month follow-up.
Warner et al., 2021	People living with advanced illness.	Nav-CARE study delivered in eight sites across three Canadian provinces. Support offered a 2-day training course and then matched with older person to provide support and help them navigate community services. The precise frequency and timing of visits was negotiated with the client.	Intervention relied on community volunteers, but community members were not involved with intervention design. Intervention focused to inform programme development.	Participants (n=16) included, hospice staff, volunteers, advisory committee members, and community stakeholders. 43-day entries were submitted. No demographic details provided.	Five themes are reported: (1) intragenerational perceptions of Nav-CARE; (2) public and healthcare professional' perceptions of palliative care; (3) intergenerational partnerships and relationships; (4) community and national-level factors that should have facilitated Nav-CARE implementation; and (5) suggested changes to Nav-CARE.
West et al., 2021	Bereaved people during Covid-19 Pandemic.	Intervention consisted of: (1) Bereavement Support Project provided peer support for bereaved people living within ExtraCare Charitable trust, and (2) Cruise Bereavement Care's national support service.	Bereavement Support Project sought "to develop the capacities of communities to support friends, neighbours, and family members through 'normal' processes of grief" (p. 4).	8 districts (3 Cruise Bereavement Volunteers and 5 ExtraCare Resident Supporters), 43-day entries were submitted. No demographic details provided.	Themes identified (1) when only physical presence will do; (2) talking and remembering on behalf; (3) absence of formal momentum; (4) virtual space of bereavement support; and (5) co-lective/benevolent memory; and (6) welcome response from "mandatory momentum".
Clinical Interventions					
Aoun et al., 2022	Parents of children receiving palliative care	The Care Support Needs Assessment Tool was adapted for use with parent caregivers. Parents used the tool independently or in discussion with health professionals to identify their unmet needs and develop an action plan. The tool was completed a second time 2-6 weeks later.	Goal of study was to "obtain feedback (from parents) regarding their experience using the CSNAT (Paediatric)" (p. 32).	28 parents completed the intervention. All of whom were interviewed. The majority were female (93%), were married/partnered (82%), and aged between 27 and 55 years.	Five themes were identified (1) caregiving challenges, perceived gaps, and feelings of isolation; (2) practicality and usefulness of the systematic assessment; (3) emotional responses to self-reflection; (4) validation and empowerment; and (5) receiving support responsive to their needs.
Dawson & Stanley, 2021	Patients accessing palliative care.	Head's Have a Go programme supported patients to pursue unique experiences and 'have a go' at something they have not done before. There is no predetermined schedule of activities but instead responds to patient requests.	"It is a uniquely palliative care program in a regional locale, providing non-clinical, informal environments with no predetermined schedule nor outcomes, positioned within an integrated model of palliative care" (p. 533).	Survey (n=10) and interviews (n=4) with staff/volunteers who had participated in the programme. No demographic details provided.	Staff reported that the programme had helped them understand patient priorities (80%) and needs (70%); 60% noticed changes to patients' physical wellbeing and 70% noticed changes to patients' emotional wellbeing. Three themes are reported (1) privileging the whole person; (2) strengthening networks of care; and (3) shifting the balance of power in care relationships.
Stanley & Dawson, 2022	Patients accessing palliative care.	Head's Have a Go programme supported patients to pursue unique experiences and 'have a go' at something they have longed to do. There is no predetermined schedule of activities but instead responds to patient requests.	Intervention "features no pre-determined programme activities and responds to individual and family requests as they emerge from conversations with clinical, allied staff and volunteers" (p. 4).	Survey (n=10) and interviews (n=4) with staff/volunteers who had participated in the programme. No demographic details provided.	Three themes are reported (1) providing respite from a medicalised focus; (2) nurturing emotional processing and legacy; and (3) altering perceptions of palliative care.
Multi-dimensional Interventions					
Gómez-Bastida et al., 2018	Residents of W. Spain.	The full extent of intended and/or completed activities including: Paper focuses on cultural and educational activities.	"A group of eight organisations composed the "core nucleus" of the project, helped in the design of activities, and met regularly to follow up" (p. S34). "The core nucleus" then partnered with community organisations who committed to various degrees to "establish policies and protocols to promote positive attitudes and volunteer proposals in their organisations" (p. S35). H.E.P. is a "community-based participatory action research project" (p. 2). Study was part of an "initial community consultation" that sought to "centre the voices of LGBTIQ2S+ people from outside of this larger project" (p. 3).	Organisations registered (n=48); attended training course, workshop, or activities (n=147). No demographic details provided.	The training was well received by the 51 attendees who completed the survey. SWAT analysed informed program development for the 2nd year.
Grossu et al., 2021	OSPN coordinating committee.	Study is part of the Healthy End of Life Project (HELIP) Ottawa, a community-based participatory action research project to build the community capacities needed to form, maintain, and sustain Compassionate Communities. This paper focuses on community consultation with LGBTIQ2S+ people as part of phase one of the project.	The Ottawa Charter for Health promotion, "a public health standard for shaping and creating health through participatory action" (p. 573) was used as the organising framework for HELIP.	Four focus group (n=8). Majority were white women who identified as lesbian, mean age 72 years. All participants had attended university and had had a post-graduate degree.	Analysis identified independent of 5 dimensions of trauma: (2) "when can I go that is safe?" Creating our own safety; (3) "connection is very important": disrupting ageism and stigma; and (4) asking for – and receiving – help.
Grindrod & Rumbold, 2018	Community inhabitants.	The study is part of HELIP which seeks to build the community capacities needed to form, maintain, and sustain Compassionate Communities. (1) while population approach through the distribution of information and resources; (2)			

Table S2 Taxonomy of Interventions at the end-of-life [reproduced from Clark *et al.* (9)]

Focus	Definition
Policy	Decisions taken or rules adopted by governing authorities to deliver, facilitate, monitor, or regulate end-of-life issues
Advocacy	Expressions or actions on end-of-life issues that aim to influence decisions on the institutional elite and/or promote the interests of specific populations, groups, or individuals in particular contexts
Educational	Development of knowledge, skills, good judgment, and character required for the delivery of appropriate end-of-life care
Ethico-legal	Frameworks included within laws, guidelines or ethical codes that relate to issues at the end of life and which permit, facilitate, or require specific courses of action
Service	Medical, nursing, and other services for the prevention, alleviation, and/or reduction of suffering at the end of life through inpatient, outpatient, home care, or other forms of services
Clinical	Medical, nursing, allied health, and psycho-social procedures at the individual level to relieve symptoms and sufferings associated with advanced illnesses and when death is imminent
Research	Systematic enquiry on end-of-life issues for the purposes of establishing new knowledge and understanding by description, prediction, improvement and/or explanation
Cultural	Initiatives taken to influence patterns of shared knowledge and symbolic meanings in particular communities, through which people perceive, interpret, express, and respond to end-of-life issues
Intangible	Actions to promote the recognition and significance of aspects of human existence that have intrinsic value at the end of life
Self-determined	Actions, decisions, or choices made by individuals to engage in or refrain from something that has implications for them at the end of their life or the life of another
Multi-dimensional	Not included in original taxonomy. These were multi-faceted, multi-phased, multi-agency initiatives that embraced a multi-dimensional approach by incorporating three or more intervention categories from Clarke <i>et al.</i> 's taxonomy