

# North East and North Cumbria Integrated Care Board Palliative and End of Life Care Health Needs Assessment

## Supplement 4: Specialist Palliative Care Workforce Review

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# Introduction

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**This report is an overview of Specialist Palliative Care (SPC) services and workforce across North East and North Cumbria Integrated Care Board (NENC ICB) in place at the time of publication.**

It has been compiled through a working group established through the NENC Palliative and End of Life Care (PEOLC) Clinical Network and NENC ICB PEOLC Transformation Programme to:

- Establish an overview of the SPC workforce working in all settings across NENC
- Describe the issues and challenges when providing the workforce to deliver SPC services

It takes account of, and references, a broad range of publications and guidance considered regionally and nationally as key drivers for service improvement in palliative care.

## **In Scope**

Areas in scope for this report included:

- Specialist palliative care in patient unit bed provision against existing guidance
- The substantive SPC medical workforce of Consultants and Specialty Doctors
- The substantive SPC Clinical Nurse Specialist (CNS) workforce in all specialist inpatient, acute hospital and community settings
- The substantive SPC pharmacy professional workforce in all specialist inpatient, acute hospital and community settings
- The named Allied Health and Care Professionals (AHP) working in SPC multi-disciplinary teams (MDTs)
- The Children and Young People's Specialist Workforce
- Staff Confidence and Competence

## **Out of Scope**

- The medical workforce of doctors in training posts
- The SPC workforce providing primarily 'hospice at home' services - even though in some localities they contribute significantly to service provision
- Professionals in roles which are not described within the core MDT provision
- Palliative care delivered within other specialist and generalist clinical areas i.e. Cancer, Heart Failure, and Community nursing.
- Where access to WTE palliative care is specified in condition specific guidance.

## Key Findings

- **SPC workforce capacity across NENC is under sustained pressure**, with demand rising faster than workforce growth due to increasing complexity, deprivation, multimorbidity and non-malignant disease.
- **There is a clear imbalance between medical and nursing capacity.** Consultant and supporting doctor shortfalls limit senior clinical leadership, supervision and seven-day provision, while nursing expansion has often outpaced medical growth, creating risk of unsafe role substitution.
- **Seven-day face-to-face SPC provision remains variable**, commonly prioritised for urgent cases and sustained through informal arrangements, resulting in inequitable access and increased risk of staff burnout.
- **24/7 SPC advice is recognised as a minimum standard but is inconsistently delivered.** Models vary in accessibility and resilience, are frequently maintained through goodwill rather than commissioned capacity, and contribute to avoidable urgent and emergency care pressure.
- **SPC inpatient bed provision remains below recommended levels across NENC**, particularly against upper benchmarks for areas with high deprivation. Community and Hospice at Home provision does not yet consistently mitigate inpatient shortfalls, especially out of hours.
- **Access to the full specialist MDT is uneven and limited**, with significant gaps in psychology, social work, allied health and pharmacy professional capacity, undermining holistic care and increasing pressure on medical and nursing staff.
- **Workforce effectiveness depends on MDT balance and coordination, not numbers alone.** National guidance increasingly emphasises integrated, MDT-based models with sufficient senior medical leadership across settings.
- **Variation in competence and confidence across the wider workforce represents a system risk.** Generalist staff, particularly out of hours, report lower confidence in complex decision-making, symptom control and psychosocial care, increasing defensive practice and escalation.
- **Children and young people's SPC provision is inequitable.** Condition-specific services such as CYPOONs demonstrate that resilient 24/7 models are achievable, but equivalent access is not consistently available for children with non-malignant life-limiting conditions.
- **Overall, SPC services across NENC rely heavily on goodwill to sustain safety and access.** This masks underlying workforce gaps, increases burnout and attrition risk, and highlights the need for coordinated, system-level commissioning aligned to national expectations.

## Key Risks

**These risks outlined in table 1 highlight the need for coordinated system-level action aligned to emerging national frameworks rather than incremental, localised workforce expansion.**

Risk	Impact
Insufficient SPC medical capacity	Limits senior clinical leadership, supervision and complex decision-making; constrains delivery of seven-day face-to-face care; increases reliance on advice-only models and informal cover; elevates clinical risk and professional liability across specialist and generalist services.
Imbalance between medical and nursing workforce growth	Creates risk of unsafe role substitution, undermines sustainability of specialist services, and places increased responsibility and risk on nursing staff without adequate medical support, contrary to national professional guidance.
Inadequate SPC inpatient bed capacity	Reduces system resilience, increases pressure on acute hospitals, limits timely access to specialist care for complex patients, and increases reliance on crisis admissions, particularly during periods of peak demand and out-of-hours.
Variable seven-day SPC provision sustained through goodwill	Leads to inequitable access to specialist assessment at weekends and bank holidays; creates dependency on informal arrangements, extended hours and staff goodwill; increases burnout risk and undermines service sustainability and resilience.
Inconsistent and fragile 24/7 SPC advice arrangements	Creates inequity, safety risk and confusion for professionals; increases avoidable hospital admissions and reliance on urgent and emergency care; undermines confidence and decision-making among generalist staff, particularly out of hours, and is often maintained through goodwill rather than commissioned capacity.
Gaps in specialist MDT provision (psychology, social work, AHPs, pharmacy)	Undermines holistic, person-centred care; limits support for carers; increases burden on medical and nursing staff to manage unmet psychosocial, functional and medicines-related needs; conflicts with neighbourhood health and personalised care models.

Variation in workforce competence and confidence across the system	Reduces quality and consistency of care; increases defensive practice, inappropriate escalation and avoidable hospital admission; particularly impacts out-of-hours care where generalist staff lack timely access to specialist advice and supervision.
Inequity in children and young people's SPC provision	Results in unequal access to senior clinical input, prescribing capability and 24/7 specialist advice based on diagnosis and geography rather than need; exposes commissioning risk due to lack of defined minimum MDT capacity.
Over-reliance on goodwill to maintain service continuity	Masks underlying workforce and capacity gaps; increases risk of burnout, sickness and attrition; reduces resilience during periods of leave, vacancy or surge demand; and creates unsustainable dependency on individual staff rather than commissioned models.
Over-reliance on service configuration rather than population need	Perpetuates unwarranted variation in access, quality and outcomes across NENC; limits the system's ability to deliver equitable, standardised specialist palliative care aligned to national expectations.

## Provider challenges

**In addition to gathering SPC workforce data organisations were asked in the 2025 Gap Analysis Survey about wider workforce challenges facing their service. Across organisations, the single biggest challenge facing the palliative care workforce is inadequate and insecure funding, which underpins many other pressures.**

Hospice providers highlight risk around heavy reliance on charitable income, coupled with NHS financial constraints and efficiency demands, is limiting the ability to recruit, retain and fairly remunerate staff in line with Agenda for Change rates. This is compounded by an ageing workforce, difficulties recruiting specialist clinicians (particularly consultants and registered nurses), and rising sickness and burnout linked to workload pressures. Teams are also facing rapidly increasing demand, including growth in non-cancer caseloads, higher patient complexity, and expectations that palliative care services will “fill the gaps” where wider health and social care provision is stretched.

Workforce challenges are further intensified by small teams covering large and often very rural geographies, limited access to 7-day or out-of-hours face-to-face services, and gaps in the multidisciplinary workforce. Many services report the absence of dedicated AHPs, pharmacy professionals, social prescribers, or bereavement support, alongside fragmented community and

paediatric provision and insufficient hospice or respite options. Shortfalls in senior clinical leadership and the lack of nationally recognised safe staffing standards for palliative care also make workforce planning, benchmarking and service sustainability more difficult.

To mitigate these risks, organisations describe a range of local, often pragmatic measures. These include close joint working with GPs, district nurses and wider NHS teams; upskilling generalist clinicians; prioritising supervision, wellbeing and psychological support; developing SOPs and revised medical models to maintain safety; and piloting new approaches such as triage tools, out-of-hours services or electronic record improvements. Longer-term actions focus on succession planning, education and training pathways, matching AfC pay where possible, strengthening collaborative system-wide working, and focusing resources on core services. However, respondents consistently indicate that these mitigations cannot fully offset the scale of workforce risk without more sustainable funding and system-level solutions.

# Background

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## **NHS England Specialist Level Palliative Care: information for commissioners 2016 defined the main components of specialist level palliative care as:**

- In depth specialist knowledge to undertake assessment and management of physical, psychological and spiritual symptoms to reduce symptoms, suffering and distress; supporting analysis of complex clinical decision making challenges where medical and personal interests are finely balanced by applying relevant ethical and legal reasoning alongside clinical assessment
- Providing care and support to those important to the person receiving care, including facilitating bereavement care; and
- Providing specialist advice and support to the wider care team who is providing direct core level palliative care to the person

Services can be delivered via advisory teams in the hospital or community, via specialist in patient bed provision in hospices or hospitals, and specialist outpatient services. This should be delivered by a specialist multidisciplinary team.

The National Palliative and End of Life Care Partnership comprising 35 organisations across health, social care and the voluntary sector co-authored 'Ambitions for Palliative and End of Life Care; A national framework for local action' that presents an overarching vision to reduce variation in access to, and quality of, end of life care.

The 6 Ambitions are built upon key foundations which include 'access to 24/7 services as needed as a matter of course and that commissioners and providers have to engage in defining how their services will operate to ensure expert responsiveness to needs at any time of day and night'. The Ambitions document challenges leaders at ICB and local level to champion an approach to commissioning that is collaborative, population based and proactive to ensure that each person receives the care they need at the right time.

## **The National NHSE Palliative and End of Life Care (PEoLC) Delivery Plan asks each ICB to have a workforce plan for PEoLC and to demonstrate year on year improvement and describes 3 priorities that contribute to transforming PEoLC:**

1. Improving Access
2. Improving Quality
3. Improving Sustainability

## **It articulates key outputs and measures to be achieved which have helped inform this review:**

- 24/7 remote access to Specialist Palliative care advice for staff and carers provided across all regions
- 7 Day face to face specialist palliative care services provided across all regions

The NHS England Standardising Community Health Services guidance (February 2026) defines adult palliative and end of life care as a core component of community health services, with clear expectations about service function, operating model and workforce capability. The guidance is explicitly aimed at ICBs to support strategic commissioning and workforce alignment, and reinforces the requirement for specialist palliative care services to be available across neighbourhood footprints with consistent access, multidisciplinary working and 24/7 specialist advice.

In November 2025, a report was produced by the Independent Expert Panel (IEP), a group of health and care policy experts commissioned by the Health and Social Care Committee to carry out impartial, in-depth evaluations of palliative and end of life care services in England. The report highlights ongoing pressures across the specialist palliative care workforce, reflecting long-standing challenges with staffing capacity, skill mix and sustainability. Services are delivered by a multidisciplinary workforce across community, hospital and inpatient settings, but provision remains variable, with reliance on small teams, limited resilience and challenges in maintaining seven-day and out-of-hours coverage. Recruitment and retention difficulties, particularly for specialist nurses and medical staff, alongside increasing complexity of need, present risks to equity of access, service responsiveness and future workforce sustainability.

## **The aim of the review is to describe by place area:**

- The current SPC workforce whole time equivalent (WTE) in all care settings
- Where that workforce is providing specialist services 7 days per week
- The provision of, and access to, the wider workforce of specialist advice on a 24/7 basis

All providers were asked to provide data around their current specialist staffing, which was collated into tables to allow comparison and analysis.

Review of the data has enabled key themes and risks to emerge and the project working group sets out recommendations for consideration at ICS and place level. We recommend that this workforce review is considered at each Place and the data and recommendations presented are interpreted with local needs and models of service provision in mind.

# Workforce Analysis

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## Modelling Guidance

**The guidance used in this review, and which we benchmark against, is discussed in detail within each section of the report.**

**The recommendations are based on data from the previous decade and do not include workforce recommendations that respond to:**

- The needs of patients with non-malignant disease and multi-comorbidities
- Local factors such as deprivation
- Provision of 7/7 services and extended hours
- Provision of 24/7 Advice in all settings
- The requirement of SPC services to deliver education to non-specialist providers of palliative care
- Any WTE specialist palliative medical, nursing and MDT access as specified in condition-specific guidance
- The delivery of palliative care within tertiary and specialist centres

The report should be considered in the light of this, and we would suggest that even where workforce currently meets recommendations from 2012 this may not be adequate to meet the needs of patients now and for the future.

The recommendations made for the medical workforce in community services are made on a population basis and combine hospices and community services together. The hospital workforce is considered separately, however, across NENC we have seen increasing integration of services across settings which has made interpreting the data a challenge. Therefore, both medical and nursing numbers have been combined across all settings.

It is accepted that the number of people requiring SPC is increasing and will continue to do so. The report *How many people need palliative care? Updated estimates of palliative care need across the UK, 2017-2021* by Marie Curie, found that up to 90% of deaths would benefit from palliative care, and that the number of people with palliative care needs in the UK will increase by more than 25% by 2048. However, they are clear that this figure is likely to underestimate need as it does not account for demographic changes which will mean more people die at older ages and with

multiple, complex conditions. Again, this analysis does not directly address or account for the current and future rise in demand and complexity.

**The NHS England Standardising Community Health Services guidance (February 2026) states that the adult palliative and end of life care core component must provide:**

- Specialist clinical assessment, care planning and symptom management
- Advice, support and education to non-specialist professionals
- Multidisciplinary working across health, social care and VCSE partners
- Prompt access to specialist advice, including out-of-hours support

This reinforces that specialist palliative care workforce capacity cannot be assessed solely on direct patient contact activity. Consultant, SAS and CNS roles must also be modelled to include indirect clinical work, system leadership, MDT participation, education, and advisory functions.

## Specialist Palliative Care In-patient Beds

**The 2012 commissioning guidance made a recommendation for a minimum of 20-25 SPC inpatient beds for a population of 250,000. This was based on a calculation of the numbers of patients who die each year and would be likely to need SPC.**

Utilising this figure as a range, it is advised that the lower end (20) be used for conservative planning and the upper end (25) where:

- deprivation is high
- non cancer need is significant
- community alternatives are limited

Table 1 describes current provision against 20/250,000, and table 2 outlines provision against the upper value of 25/250,000.

A number of factors are likely to be in play when considering why an expansion of in-patient beds has not occurred, but two are significant. Alongside affordability of expansion, it also must be considered that SPC services are evolving to meet the needs of patients whose preference is for care to be provided in their own homes. Some localities are delivering Hospice at Home Services, virtual wards or are working more closely with Community SPC teams to increase the capacity for medical assessment and review at home.

Table 1 – Current SPC beds against 20 SPC inpatient beds for a population of 250,000

	Population	Actual Acute Beds	Actual Specialist Beds	Specialist Beds Required	Specialist Beds Gap
Durham, South Tyneside & Sunderland	1,010,625	2317	34	81	-47
North Cumbria	324,819	536	10	26	-16
North of Tyne & Gateshead	1,085,997	3300	81	87	-6
Tees Valley	737,105	1557	34	59	-25
<b>NENC Total</b>	<b>3,158,546</b>	<b>7275</b>	<b>157</b>	<b>253</b>	<b>-94</b>

Table 2 – Current SPC beds against 25 SPC inpatient beds for a population of 250,000

	Population	Actual Acute Beds	Actual Specialist Beds	Specialist Beds Required	Specialist Beds Gap
Durham, South Tyneside & Sunderland	1,010,625	2317	34	101	-67
North Cumbria	324,819	536	10	32	-22
North of Tyne & Gateshead	1,085,997	3300	81	109	-28
Tees Valley	737,105	1557	34	74	-40
<b>NENC Total</b>	<b>3,158,546</b>	<b>7275</b>	<b>157</b>	<b>316</b>	<b>-157</b>

## Hospice at Home

**As there is no national recommendation for the workforce required to deliver Hospice at Home services this review is unable to benchmark these. However, evidence from the national NIHR evaluation highlights important workforce considerations relevant to community-based palliative care models.**

HAH provision across NENC is variable, with some services relying heavily on Health Care Assistants (HCAs) for hands-on personal care, while Registered Nurses (RNs) typically provide assessment, triage and complex symptom management. Smaller 24/7 HAH services deliver the most intensive levels of care and consistently achieve higher quality-of-dying outcomes, driven by agile staffing models, rapid response capability and strong relationships with patients and carers. However, these services operate within significant workforce constraints, including national shortages of registered nurses, challenges sustaining a flexible workforce, and under-utilisation of volunteers due to governance and training concerns.

The NIHR findings emphasise that the relational, hands-on nature of HAH care (including clinical care and clinical leadership) — combined with sufficient time to care and high staff expertise—is central to achieving good outcomes but is also workforce-intensive and dependent on sustainable funding, staff development and effective integration with district nursing, primary care and wider community teams.

## Medical Workforce

**The 2012, "Commissioning Guidance for Specialist Palliative Care: Helping to Deliver Commissioning Objectives" represented the view of a collaboration of key organisations including the Association for Palliative Medicine (APM) and The Royal Society of Medicine UK. The minimum recommended medical workforce to support working week services at that time was:**

Per population of 250,000 to support community services (hospice and community):

- Consultants or Associate Specialist in palliative medicine – 2 WTE
- Additional supporting doctors (trainee or specialty doctor) – 2 WTE

Plus

Per 250 beds in hospital:

- 1 WTE Consultant

The APM workforce committee recommended in 2015 that the WTE for Community services (hospice and community) should be increased to 2.5 (1/100,000 pop.) but this did not take account of out of working week commitments or the variation in number of hospice beds provided per population.

The 2019 Association for Palliative Medicine Report and Overview of the Palliative Medicine Workforce in the UK described the significant increase in the medical workforce that is required to respond to the demands for high quality SPC provision. The report suggests that the UK should align itself with the recommendations in Australia and Ireland which have similar service models, this would require between 1.5 and 2.2 WTE per 100,000 population. It was noted that at the time of the report the WTE per 100,000 population for Consultants in the UK was 0.8.

For the purposes of this review, we have used the current recommendations accepted in the UK. We describe the substantive medical workforce of Consultants and Specialty Grade doctors.

We have not included doctors in training grades even though in 2012 they were considered an appropriate additional doctor. Whilst an important element of the SPC workforce with regard to service provision doctors in training may not be specialists in training e.g., GP trainees. They are not substantive employed members of the MDT and their placement is reliant on Health Education England via local Deaneries.

Across NENC there are Specialty Grade doctors acting as Responsible Clinicians or Medical Directors. We acknowledge that these doctors may have the skills and knowledge to lead SPC teams, however, it is the position of the RCP and APM that SPC teams should be clinically led by Consultants in Palliative Medicine.

Table 3 describes the WTE Consultants across all settings per population – combining the requirements of 2 WTE per 250,000 population and 1WTE per 250 acute beds. However, it is noted that there are limitations in simply adding population based and bed-based consultants together. Examining population-based roles primarily reflects community/hospice services and leadership of SPC provision while monitoring of numbers against bed-based roles reflect hospital liaison and the availability of inpatient advisory teams. In practice, some consultant WTE will straddle both, but using both metrics would be optimal to show system pressure clearly and better indicate the scale senior specialist input required across community, hospice and hospital settings at place.

The Consultant WTE gap across NENC is 19.7 WTE.

*Table 3 – Consultant workforce across all settings, combining population and bed-based requirements.*

	Population	Actual Acute Beds	Actual Consultant WTE	Required Consultant WTE	Consultant WTE Gap
Durham, South Tyneside & Sunderland	1,010,625	2317	9.9	17.4	-7.5
North Cumbria	324,819	536	2.05	4.7	-2.7
North of Tyne & Gateshead	1,085,997	3300	19.05	21.9	-2.8
Tees Valley	737,105	1557	7.15	12.1	-5.0
<b>NENC Total</b>	<b>3,158,546</b>	<b>7710</b>	<b>38.6</b>	<b>56.1</b>	<b>-19.7</b>

*Table 4 Additional supporting doctors (trainee or specialty doctor)*

	Population	Actual Supporting Doctor WTE	Required Supporting Doctor WTE	Supporting Doctor WTE Gap
Durham, South Tyneside & Sunderland	1,010,625	5.6	8.1	-3.7
North Cumbria	324,819	1.5	2.6	-0.3
North of Tyne & Gateshead	1,085,997	6.6	8.7	-7.6
Tees Valley	737,105	6.3	5.9	0.4
<b>NENC Total</b>	<b>3,158,546</b>	<b>20</b>	<b>25.3</b>	<b>-10.9</b>

It should be noted that most supporting doctors are allocated to hospice inpatient beds rather than community or acute palliative care services, resulting in limited medical capacity to support other areas of palliative care activity. A minimum number of doctors is required to sustain a first

on-call rota for safe out-of-hours cover, which means that even small hospice units need relatively higher staffing levels. Increasing the number of commissioned inpatient beds would allow these fixed staffing requirements to be utilised more efficiently.

## Nursing Workforce

**The Association of Palliative Medicine Workforce Committee does not prescribe a single national ratio for specialist palliative care Clinical Nurse Specialists. While historic benchmarks, 1 CNS per 250 acute beds or 5 per 250,000 population are commonly referenced, this is unlikely to be an adequate resource given that the 2012 guidance does not include delivering education, 7/7 working patterns or services for patients with non-malignant disease.**

APM has cautioned that these are outdated and do not reflect current service complexity, seven-day working or rising non-malignant demand, and emphasises that CNS staffing must be determined locally, based on complexity, deprivation, service model and expected out-of-hours provision.

As expected, given the APM caveat, in all places across NENC the number of CNS' is above that recommendation. This suggests that organisations have responded to the increased need for specialist nurses, however an expansion in the medical workforce alongside this has not occurred and so we must consider that the increase in nursing roles is actually replacing the medical reach of SPC teams rather than extending it. This is contrary to APM guidance which warns that: expanding CNS capacity without commensurate medical capacity creates unsafe substitution, increases professional risk, and undermines sustainability of the specialist workforce.

When viewed alongside the availability of AHP roles in SPC MDTs, it can also be assumed that elements of these roles are being undertaken by nursing staff, in particular psychology.

As with the medical workforce modelling, the figures presented represent the total number of specialist nurses working across community services and acute hospital wards. Disaggregation of these roles is increasingly challenging due to the development of more integrated service models. This analysis therefore presents aggregated nursing capacity across the stated settings and does not attempt to differentiate activity, workload or function by care environment. It should be noted that roles undertaken in different settings vary in scope, skill mix and clinical focus, and local interpretation of these findings should take account of service configuration and operational context. Therefore, CNS nursing capacity within specialist inpatient units has not been included within this modelling, as the comparison across such a wide variation of staffing models requires a much more detailed focus than this review provides.

Table 5 - the number of specialist nurses across acute and community settings

	Population	Actual Acute Beds	Actual Specialist Nurse WTE	Required Specialist Nurse WTE	Specialist Nurse WTE Gap
Durham, South Tyneside & Sunderland	1,010,625	2317	39	29.5	9.5
North Cumbria	324,819	536	11.6	8.6	3.0
North of Tyne & Gateshead	1,085,997	3300	63.3	34.9	28.4
Tees Valley	737,105	1557	36.6	21	15.6
<b>NENC Total</b>	<b>3,158,546</b>	<b>7275</b>	<b>150.4</b>	<b>64</b>	<b>56.4</b>

## Specialist MDT

**In 2016 a group of experts led by the National Clinical Director for Palliative Care wrote NHS England Specialist Level Palliative Care: information for commissioners 2016. This guidance describes the core requirements when commissioning SPC services and the importance and constitution of the specialist MDT.**

*“Specialist level palliative care is delivered by a multidisciplinary team (MDT) of staff with the requisite qualifications, expertise and experience in offering care for this group of people”.*

Whilst there is guidance regarding the type of professional who should contribute to the core SPC MDT there is none with regard to the WTE expectation for size of population or bed base. These professional MDT roles include:

- Physiotherapists
- Occupational Therapists
- Social Workers
- Spiritual Services
- Psychological services (level 3 or 4)

- With formal access to advice and input provided by the following professional groups with specialist knowledge:
  - Dieticians
  - Speech and Language Therapists
  - Pharmacy professionals
  - Specialists in interventional pain management

It is acknowledged that SPC MDTs often include other professionals such as complementary therapists whose contributions improve patient outcomes. This provision however is more variable and goes beyond that which should always be accessible.

*Table 6 - Allied Health Professionals within SPC MDT*

<b>Specialists:</b>	<b>Pharmacist WTE</b>	<b>Occupational Therapist WTE</b>	<b>Physiotherapist WTE</b>	<b>Social Worker WTE</b>	<b>Social Prescriber WTE</b>	<b>Psychologist WTE</b>	<b>Educator WTE</b>
Durham, South Tyneside & Sunderland	1.8	4.8	1.8	1.2	0	2.6	5.3
North Cumbria	0.2	1.2	0.1	0.9	0	0.4	0.8
North of Tyne & Gateshead	2.3	7.65	8.83	4.5	0.6	1.8	3.6
Tees Valley	0.79	2.55	2.66	0.8	0	0.8	2.1
<b>NENC Total</b>	<b>5.09</b>	<b>16.2</b>	<b>13.39</b>	<b>7.4</b>	<b>0.6</b>	<b>5.6</b>	<b>11.8</b>

Across NENC, non-medical SPC capacity is limited and unevenly distributed, with provision concentrated in a small number of providers. This is inconsistent with national commissioning guidance, which emphasises access to a fully constituted specialist MDT as a core component of specialist palliative care (NHS England, Specialist Level Palliative Care: Information for Commissioners, 2016). Headline MDT totals mask significant inequity, with access to specialist input varying by organisation and geography rather than population need.

Psychology and social work represent the most pronounced gaps when assessed against national expectations for holistic end-of-life care. NICE NG142 and NHS England guidance highlight the importance of psychosocial, carer and practical support as integral to quality end-of-life care, yet specialist psychology provision is minimal and largely confined to large acute providers, with most hospices reporting no access. Social work capacity is similarly limited, constraining the system's ability to address benefits, housing, safeguarding, carers' assessments and fast-track CHC processes.

Social prescribing is effectively absent from specialist palliative care, indicating that community connector roles central to neighbourhood-based, personalised and preventative models of care have not yet been embedded, despite alignment with wider national policy direction as outlined in NHSE publications Universal Personalised Care, 2019 and Neighbourhood Health Framework, 2023. AHP capacity is also heavily skewed towards large Trusts, leaving many hospices with little or no access and limiting functional, rehabilitative and comfort-focused support in community settings.

NHS England Standardising Community Health Services guidance (February 2026) indicate that nurse specialist and medical staffing must be considered together, and that gaps in one part of the MDT (for example CNS or AHP input) create pressure and inefficiency elsewhere. Workforce modelling therefore needs to be MDT-based rather than role-by-role, particularly when describing community, hospice-at-home and advisory functions.

Overall, the current workforce profile does not align with the, albeit limited, national guidance on equitable, multidisciplinary specialist palliative care delivery (NHS England, 2016; APM, Palliative Medicine Workforce Report, 2019). Provision remains overly reliant on a small number of providers, with psychology, social work and social prescribing representing the greatest areas of system risk.

## Specialist Palliative Care Pharmacy

**Specialist palliative care pharmacy professional input across NENC is currently limited and inconsistently embedded. Regional analysis identifies persistent gaps in access to specialist medicines expertise across community, hospital and hospice settings, particularly for people with complex symptom burden and polypharmacy approaching the end of life.**

Pharmacy professionals are identified as critical in enabling proactive, anticipatory palliative care. The absence of sufficient specialist pharmacy capacity contributes to avoidable symptom crises, medicines-related harm and unplanned hospital admissions, placing additional pressure on CNS caseloads and acute services.

Specialist palliative care pharmacists mitigate these risks through anticipatory prescribing, medicines optimisation and deprescribing, rapid clinical advice, and support to community teams. Embedding pharmacy professionals within the MDT strengthens clinical decision-making, improves access to timely symptom control, and supports patients to remain safely in their preferred place of care, reducing reliance on emergency and inpatient services

National guidance supports the integration of pharmacy professionals alongside nursing and medical staff within palliative care MDTs. The NHS England Ambitions for Palliative and End of Life Care and statutory guidance for Integrated Care Boards emphasise coordinated, multidisciplinary approaches to care, including timely access to specialist advice and medicines optimisation, as key enablers of quality and equity at end of life.

A 2024 regional stakeholder briefing proposes a system-wide palliative care pharmacy workforce, led by a consultant pharmacist and supported by specialist pharmacists and pharmacy technicians. This model is intended to operate in close alignment with existing SPC teams, providing direct patient care, advice to generalists, education, and medicines governance support across settings.

Clinical expertise and strong leadership are critical to the palliative care pharmacy workforce. Palliative care routinely involves complex, high-risk pharmacological decision-making in the context of limited evidence, fluctuating patient needs and rapidly changing goals of care. Advanced and consultant-level palliative care pharmacists bring the specialist knowledge and clinical judgement required to manage this complexity safely and confidently, while supporting and upskilling generalist clinicians across settings. In addition, these roles provide vital clinical leadership, including medicines safety, pathway development, workforce education and quality improvement. In addition to a limited specialist pharmacy workforce, NENC does not currently have any Palliative Care Consultant Pharmacists – a model deployed successfully elsewhere in the UK.

Pharmacy technicians have an emerging role within the palliative care workforce, supporting effective skill mix across the MDT. They contribute through medicines reconciliation, supply coordination, governance, audit, and practical support for patients and carers, particularly around safe use of medicines. In palliative care, where system reliability and timely access to medicines are critical, this role strengthens medicines safety and continuity of care. Embedding pharmacy technicians allows pharmacist expertise to be focused on complex decision-making while technicians underpin safe, efficient and responsive medicines processes. Not all organisations have access to specialist pharmacy technician support.

As with CNS provision, the requirement is not for pharmacy roles to operate in isolation, but to be integrated within multidisciplinary palliative care teams, strengthening overall capacity and improving continuity of care. Addressing the pharmacy workforce gap is therefore a key in supporting safer prescribing, reducing avoidable hospital activity, and improving patient and carer experience at end of life.

*Table 7 - outlines the existing specialist pharmacy professional workforce WTE across NENC.*

	Specialist Palliative Pharmacist WTE	Specialist Palliative Pharmacy Technician WTE
Durham, South Tyneside & Sunderland	1.8	0
North Cumbria	0.2	0.6
North of Tyne & Gateshead	2.3	0.6
Tees Valley	0.79	0
<b>NENC Total</b>	<b>5.09</b>	<b>1.2</b>

## 7-Day Week Services

**National bodies have repeatedly called for SPC Services to be available to patients 7 days per week and for non-specialist providers of palliative care to be able to access advice at all times of the day or night.**

NHSE guidance sets an expectation that systems should be working towards provision of 24-hour access to SLPC advice from a consultant in palliative medicine, including face-to-face assessment where necessary.

Reference is made to improved outcomes for patients and carers “where models of 24-hour, seven-day access to care has been implemented” including:

- Rapid access to SPC, across primary and secondary care, improving outcomes and experiences for patients and their families, and increasing quality and standards of care
- Access to hospice inpatient admission for patients requiring urgent transfer
- Prevention of unscheduled acute hospital admissions

Although 7-day face-to-face Specialist Palliative Care assessment is available across North East and North Cumbria, it is typically delivered as an extended service rather than a full 7-day equivalent to weekday provision. Weekend and bank holiday face-to-face input is commonly reserved for urgent or complex situations, supported by 24/7 specialist advice. Variation in availability by geography and care setting means that some patients rely on generalist services supported by specialist advice rather than direct specialist review, which may impact responsiveness and consistency of care, particularly for people wishing to remain in the community.

The absence of a consistent, fully resourced 7-day face-to-face SPC model increases reliance on crisis responses and places additional pressure on urgent care, particularly during weekends and holidays. Strengthening staffing to ensure equitable access to timely specialist assessment remains a key opportunity for system improvement.

The 2026 Community Services core component description confirms that adult palliative care services are expected to provide timely access to specialist assessment and support 24/7 access to specialist palliative care advice for professionals.

This represents the following implications for NENC workforce planning:

- Existing staffing levels are insufficient to sustainably support 7-day services and 24/7 advice without reliance on goodwill or short-term arrangements
- Out-of-hours provision must be explicitly built into workforce numbers, job plans and on-call models
- Workforce gaps present a system risk, particularly in relation to avoidable hospital admissions and inequitable access across places

## 24 / 7 Advice

**National guidance is consistent that 24/7 access to Specialist Palliative Care advice is a minimum requirement, not an enhancement. NICE Quality Standards, NHS England service specifications and APM guidance all expect systems to provide continuous access to SPC advice to support symptom control, urgent clinical decisions, and avoid unnecessary hospital admissions.**

The absence of a reliable 24/7 SPC advice function represents a quality and safety gap, particularly for people in the last months and weeks of life and increases reliance on crisis services.

While there is some provision across all NENC areas there is significant variation in how services are arranged, delivered, accessed, promoted and funded.

Recent national commentary and evaluations, including Marie Curie highlight that:

- 24/7 advice lines should ideally function as a single point of access
- Advice should not be limited only to patients already known to specialist services
- Best practice includes access for patients, carers and professionals

While not always mandated in statutory guidance, this is increasingly regarded as the minimum safe model for out-of-hours PEOC systems, however none of the models across NENC feature all of these components.

# Children's Specialist Workforce and Access

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**There is currently no national NHS guidance that specifies mandatory headcount or WTE staffing numbers for children's palliative care services. NHS England service specifications define required roles, competencies and 24/7 availability but intentionally leave workforce size to local determination.**

Professional bodies such as APPM, RCPCH and RCN provide workforce evidence and safe-staffing principles, but no organisation recommends population-based staffing ratios for children's palliative care. Workforce gaps therefore represent a commissioning risk rather than non-compliance with national standards.

The NHS England CYP Specialist Palliative and End of Life Care Service Specification requires a consultant-led specialist MDT comprising paediatric palliative medicine consultants, specialist palliative care nurses, named care coordination, and access to AHPs, psychological support, social work and spiritual care. It outlines that the MDT must operate across all settings, provide 24/7 specialist advice, and work as part of an integrated system with acute, community, hospice and social care services. While the specification sets out clear expectations regarding roles, competencies and availability, it does not prescribe MDT headcount or staffing ratios, placing responsibility on ICBs to ensure sufficient MDT capacity to meet local need.

As a service area, CYP SPC sees significantly fewer patients, which may account for why it is not prominent when challenged services are being prioritised. This report presents the known staffing numbers for dedicated CYP SPC however, it is clear, work is needed to develop longer term, equitable approaches to combined Health and Social Care support for CYP with life limiting conditions across NENC.

Presenting workforce numbers for NENC is also challenging as models of provision and funding add additional complexity, and SPC provision becomes blurred with CHC and local authority-funded respite provision for children and young people with life limiting conditions. How this section explores CYP SPC workforce across NENC is directly dictated by this opacity.

## Children's Holistic Integrated Palliative Care Service (CHIPs)

**Based at the Great North Children's Hospital in Newcastle, this specialised team provides specialist palliative care for babies, children, and young people with serious and life-threatening conditions throughout the region.**

As a regional service, the team of specialist nurses and doctors provide physical, emotional, social, and spiritual support including end-of-life care for children and their families, working alongside other specialist and generalist clinical teams including NENC Children and Young People's Oncology Outreach Nurse Specialists Team (CYPOONS), and paediatric community nursing.

In a recent business case to NENC ICB, the service has identified workforce limitations which stem directly from gaps in staffing, expertise, and out-of-hours capacity which have resulted in substantial inequity across:

- Diagnosis type (better provision for oncology vs non-oncology)
- Geography (support varies depending on locality)
- Age (service provision differs between paediatric and adult palliative care pathways)

Currently, the service does not currently operate a 24/7 specialist nursing or medical rota, meaning that children and families (non-cancer) do not have continuous access to specialist palliative clinical advice or symptom management outside core hours. The service has identified that extending to a fully resilient 24/7 model would require significant additional capacity and expertise.

It has also identified gaps within the MDT that limit the ability to deliver fully holistic, family-centred palliative care, however, this report notes that through additional investment and service development, administrative support has been bolstered, along with the addition of a WTE Psychologist and part time psychology assistant, bringing support for complex psychosocial need, and improving the quality and consistency of bereavement care. At the time of writing, the service is also currently recruiting senior nursing and medical roles in order to develop a resilient model with out of hours access.

*Table 8 - outlines the staffing compliment for CYP SPC across NENC within the CHIPs MDT.*

Consultant WTE	Supporting doctors	Specialist Nurse WTE	AHP Roles WTE
2.5	0.3	5.3	Specialist Pharmacist 1 Specialist Psychologist 1 Specialist Educator 1

*Table 9 - outlines the SPC staffing within other CYP providers, however as outlined above, it is not clear which elements of this workforce provide specialist SPC outwith respite care. It must also be noted that consultant oversight is often delivered by other providers.*

Area	Provider	Consultant WTE	Supporting doctors WTE	Specialist Nurse WTE
North Cumbria	Jigsaw	0	0	6.8
North of Tyne & Gateshead	St Oswalds	0	0	
Tees Valley	Zoe's Place	0	0.3	13
Tees Valley	Butterwick	0	0	4.96

## CYPOONs

**Although out of scope of this review as a condition-specific service, CYPOONs provides specialist palliative care to babies, children and young people (under 19) with cancer across NENC and meets minimum expectations for seven-day face-to-face care, 24/7 on-call cover and access to inpatient beds. The service is delivered through a small specialist nursing workforce, with nurse prescribers supporting a continuous rota and consultant oncology support available at all times.**

CYPOONs illustrates that a resilient, 24/7 specialist palliative care model for children and young people is achievable where workforce configuration, prescribing capability and senior clinical availability are aligned. However, as a condition-specific oncology service, it also exposes inequity across the wider CYP palliative care system, where equivalent levels of access are not consistently available for children with non-malignant life-limiting conditions.

This reinforces that current variation is driven by service configuration and workforce investment rather than need, and that replicating core elements of this model will be critical to delivering equitable, system-wide CYP specialist palliative care.

# Staff Confidence and Competence

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**Background to the survey from May to July 2023 a survey, largely based on NACEL, was launched by the NEY Regional PEOLC Workforce subgroup to understand staff confidence across a number of key areas of PEOLC. The survey received 880 responses from NENC with over 50% of responses coming from nursing roles, with good representation from medical, emergency services and AHP colleagues.**

Overall, the survey shows a mixed but clearly patterned picture of confidence and competence across the workforce. Staff working routinely in hospices, specialist palliative care teams and established community roles report high confidence in recognising dying, managing symptoms and communicating with patients and families. In contrast, generalist staff, those with infrequent exposure to end-of-life care, and newer entrants to community, acute and ambulance roles consistently report lower confidence, particularly in complex decision-making and psychosocial care.

Confidence is strongest in core relational skills, including sensitive communication, maintaining dignity and involving patients and families in decisions. However, confidence is less consistent when conversations involve nutrition and hydration, withdrawal of treatment, DNACPR decisions and ethical dilemmas, especially where staff feel unclear about local policy, legal responsibilities or access to senior support.

Clinical competence in symptom recognition and basic symptom control is higher among specialist and experienced community staff but less consistent among generalists, particularly out of hours. Uncertainty around recognising imminent dying, managing pain and agitation, and using palliative medications appropriately is common, with newer staff frequently describing a gap between theoretical knowledge and practice.

Confidence in addressing psychological, spiritual, cultural and social needs is uneven, reflecting limited training, unclear referral pathways and restricted access to specialist psychology and social work. Awareness of how to access specialist palliative care advice, particularly out of hours, is a consistent system weakness and contributes to anxiety, defensive decision-making and avoidable hospital admission.

In summary, while there is a committed and skilled core workforce, confidence and competence are not consistently embedded across the wider system. Experience and exposure strongly influence capability, indicating a system-wide developmental gap that will require coordinated,

role-specific and career-stage-appropriate workforce development, supported by accessible specialist advice.

# Conclusion and Recommendations

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## Conclusion

**This workforce review demonstrates that Specialist Palliative Care (SPC) across North East and North Cumbria (NENC) is delivered by a committed and highly skilled workforce, but one that is operating under sustained and increasing pressure. While there are pockets of strength and innovation, the overall workforce profile does not consistently align with national expectations for equitable, multidisciplinary, seven-day specialist palliative care, nor with the growing complexity and scale of population need.**

The analysis highlights a persistent mismatch between demand and capacity. Rising population need driven by deprivation, multimorbidity and non-malignant disease has not been matched by commensurate growth in the medical workforce. Consultant and supporting doctor capacity falls short of recommended benchmarks across most areas, constraining senior clinical leadership, supervision, and the ability to deliver consistent seven-day face-to-face care. In contrast, expansion of specialist nursing roles has often outpaced medical growth. While responsive to unmet need, this imbalance risks unsafe role substitution rather than sustainable extension of specialist reach, contrary to national professional guidance.

Evidence remains insufficient to define a single optimal workforce size for specialist palliative care. However, national guidance and service evaluations are consistent that service impact is driven less by absolute staff numbers than by the composition, balance and functioning of the multidisciplinary team, and by continuity and coordination across settings. This reinforces the need for integrated workforce models with sufficient senior medical leadership, clearly defined roles and effective MDT working across hospital, hospice and community services, rather than a narrow focus on individual role expansion.

Provision of specialist palliative care inpatient beds remains below recommended levels across NENC, particularly when assessed against the upper benchmark intended for areas with high deprivation and limited community alternatives. While there is a clear strategic shift towards care closer to home, current community, hospice and hospital configurations do not yet provide sufficient capacity or consistency to fully mitigate inpatient bed shortfalls, particularly during periods of peak demand and out-of-hours.

Access to the full specialist MDT is uneven and, in some areas, minimal. Gaps in psychology, social work, allied health and pharmacy capacity undermine delivery of holistic, person-centred care and

place additional pressure on medical and nursing staff. This pattern is increasingly misaligned with national policy direction, including neighbourhood health and personalised care models, which rely on integrated, multidisciplinary approaches to manage complexity and reduce crisis escalation.

Although 24/7 specialist advice is widely recognised as a minimum standard, current arrangements across NENC remain variable in accessibility, scope and resilience. Seven-day face-to-face specialist provision is frequently delivered as an extended or prioritised service rather than a fully equivalent model, increasing reliance on crisis responses and generalist care, particularly at weekends and during out-of-hours periods.

Children and young people's specialist palliative care presents a distinct and significant commissioning challenge. While national service specifications clearly define required roles, competencies and availability, the absence of mandated staffing ratios places responsibility on systems to ensure sufficient and equitable capacity. The CYPOONs service demonstrates that resilient, 24/7 specialist palliative care for children is achievable where workforce configuration, prescribing capability and senior clinical availability are aligned. However, as a condition-specific oncology service, it also exposes inequity across the wider CYP palliative care system, where equivalent levels of access are not consistently available for children with non-malignant life-limiting conditions. Current variation is therefore driven by service configuration and workforce investment rather than need.

Overall, this review reinforces that workforce numbers alone are insufficient to resolve system pressure. Sustainable improvement in palliative and end-of-life care across NENC will depend on restoring balance between medical and nursing capacity, strengthening MDT composition, improving coordination and continuity across care settings, and ensuring timely access to senior specialist advice for adults and children. The NHS England Standardising Community Health Services guidance (February 2026) strengthens the conclusion that current variation in specialist palliative care capacity, skill mix and operating hours represents structural non-alignment with national expectations rather than isolated local delivery challenges.

This is reinforced in the 2025 findings from the Health and Social Care Committee's Expert Panel, which reports that workforce shortages across specialist and generalist palliative care roles represent a fundamental system constraint affecting people of all ages. It underscores how insufficient capacity undermines 24/7 access, weakens the shift to community-based care and creates fragility in small, specialist services, particularly children's palliative care. The report frames these challenges as failures of system planning and commissioning rather than individual provider performance, requiring coordinated, all-age solutions aligned to population need

This report provides a robust evidence base to support informed decision-making at ICB and Place level. It should be used to prioritise workforce planning, inform service specifications, and guide phased, system-level investment that strengthens clinical leadership, restores MDT balance, and delivers equitable access to high-quality specialist palliative care for adults, children and families across North East and North Cumbria.

## Recommendations

### **Recommendation 1. Align local workforce planning to national and regional SPC frameworks**

The ICB should ensure that Specialist Palliative Care (SPC) workforce planning across NENC is explicitly aligned to emerging national and regional competency frameworks, including the NHS England Specialist Palliative Care workforce strategy, the Modern Service Framework and the Standardising Community Health Services guidance (February 2026). The findings of this review should be used to assess system readiness, identify gaps against emerging expectations, maximising and sharing best practice across providers, and support providers to adapt workforce models as national guidance is finalised.

### **Recommendation 2. Use this review as the baseline for system-wide implementation planning**

This workforce review should be adopted as the baseline evidence to support phased implementation of national palliative and end-of-life care expectations at Place and ICB level. Commissioners and providers should map current workforce capacity and service configuration against national standards to identify priority gaps, inform service specifications and guide coordinated, system-level investment rather than incremental local expansion.

### **Recommendation 3. Restore balance between medical and nursing capacity**

The ICB should prioritise targeted investment to address gaps in consultant and supporting doctor capacity in order to restore sustainable senior clinical leadership, supervision and decision-making within SPC services. Expansion of specialist nursing roles should be commissioned alongside, not ahead of, medical capacity to avoid unsafe role substitution and professional risk. Workforce planning should focus on how medical and nursing roles operate together across settings to safely extend specialist reach and resilience.

### **Recommendation 4. Strengthen seven-day specialist face-to-face provision**

Commissioners and providers should strengthen seven-day face-to-face SPC provision, particularly within community and hospital liaison services, as systems move towards delivery of the Modern

Service Framework. This should include explicit commissioning expectations for consultant input, senior clinical decision-making and MDT availability at weekends and bank holidays, rather than reliance on extended weekday or advice-only models.

#### **Recommendation 5. Standardise and strengthen 24/7 Specialist Palliative Care advice**

The ICB should continue to prioritise the development of a consistent, resilient 24/7 SPC advice model across all Places, aligned to national best practice and emerging NHS England expectations. As a minimum, this should operate as a single, well-publicised point of access for professionals, with clear clinical governance, escalation pathways and consultant involvement. Variation in access, scope and resilience should be reduced to minimise inequity, safety risk and avoidable acute escalation.

#### **Recommendation 6. Clarify the role of Hospice at Home within Specialist Palliative Care**

In line with national and regional work to better define Hospice at Home (HaH) services, the ICB should support clearer articulation of how HaH models contribute to specialist provision across NENC. This should include clarity on workforce roles, skill mix, clinical governance, integration with community SPC teams, and the extent to which HaH services can safely and consistently offset inpatient bed pressures. Workforce planning should avoid assuming HaH capacity as a substitute for core SPC medical and MDT provision without explicit evidence and agreed standards.

#### **Recommendation 7. Address inpatient bed capacity alongside community and HaH provision**

The system should explicitly acknowledge that SPC inpatient bed provision remains below recommended levels across NENC. Decisions to expand or rely on community and HaH alternatives should be taken alongside a clear assessment of workforce capacity, clinical risk and system resilience. Commissioning decisions should consider inpatient, community and HaH models together to ensure that shifts in care setting are supported by sufficient specialist staffing and senior medical input.

#### **Recommendation 8. Strengthen access to the full specialist MDT**

Commissioners should prioritise improved and more equitable access to the wider specialist MDT, particularly psychology, social work, allied health and pharmacy roles, which represent the most pronounced system gaps. Workforce planning should move beyond a narrow focus on medical and nursing roles and reflect national policy direction towards holistic, personalised and neighbourhood-based models of care, addressing inequity of MDT access by geography and provider.

### **Recommendation 9. Develop a coordinated approach to children and young people's SPC**

Given the absence of mandated staffing ratios for children and young people's palliative care, the ICB should develop a coordinated, system-wide approach to CYP SPC workforce planning. This should align with national service specifications, define minimum MDT expectations, and address inequity in access to senior clinical input, prescribing capability and 24/7 specialist advice across acute, community, hospice and social care settings. Learning from resilient condition-specific models should be used to inform wider system design, while avoiding inequity by diagnosis.

### **Recommendation 10. Embed workforce development, competence and skills as enablers of system transformation**

The ICB should recognise national workforce development, professional competency frameworks, and skills as core enablers of safe, high-quality and sustainable palliative and end-of-life care. Investment should support a coordinated, system-wide approach to education, supervision and skills development across both specialist and generalist workforces, aligned to the Modern Service Framework and neighbourhood health models.

For the specialist workforce, this should include protected time and capacity for clinical supervision, advanced skills development, MDT working, education of others and senior clinical leadership. Consultants, SAS doctors and Clinical Nurse Specialists must be supported to practise at the top of their licence, provide effective supervision and advice, and sustain safe decision-making across seven-day and out-of-hours services.

For the generalist workforce, commissioners should prioritise access to consistent, role-appropriate education and development, underpinned by timely access to specialist advice and clear escalation pathways. This should focus on areas of lower confidence and competence identified through workforce surveys, including recognising dying, complex symptom management, ethical and legal decision-making, DNACPR discussions and psychosocial care, particularly in community, acute and ambulance services and during out-of-hours periods.

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# Appendix 1: Inpatient beds, medical and nursing WTE

ICB Sub-location	Services	No. of specialist inpatient beds	No. of acute hospital beds	WTE Consultants	WTE vacant consultant posts	WTE SSAS Doctors	No. of 8b Nurses	No. of 8a Nurses	No. of b6 Nurses	No. of b7 Nurses	WTE SPC nurses	WTE Inpatient nurses – qualified	WTE Inpatient nurses – non-qualified
Durham, South Tyneside & Sunderland	S. Tyneside & Sunderland FT	14	1135	5.8	1.7	2.4	0	1	2	17	12.95		
Durham, South Tyneside & Sunderland	County Durham & Darlington FT	0	1029	3.8	0.7	1	1	1	*3.8	*22.21	26.01		
Durham, South Tyneside & Sunderland	Willow Burn Hospice	4	0	0.1	0	0.4						10	10
Durham, South Tyneside & Sunderland	St Cuthbert's Hospice	10	0	0	0	1.8						13.28	9.04
Durham, South Tyneside & Sunderland	St Teresa's Hospice	6	0	0.2	0	0						15	
North Cumbria	NCIC		536	2.025	0	0	0	2	2	12	11.6		
North Cumbria	Eden Valley Hospice	10		0	0	1.5						16	18
North Cumbria	Jigsaw Children's Hospice	5		0	0	0.3						13	8

North Cumbria	Hospice at Home West Cumbria			0	0	0						12	18
North Cumbria	HaH Carlisle & N. Lakeland			0	0	0						2.48	4
North of Tyne & Gateshead	Marie Curie Hospice	18	0	1.8	0	2						25	14
North of Tyne & Gateshead	St Oswald's Hospice	15	0	2.4	0	2.1						33.93	
North of Tyne & Gateshead	Newcastle Hospitals FT	0	1473	5.35	0	0.6	0	1	*4.6	*23.57	28.17		
North of Tyne & Gateshead	Gateshead Health FT	10	580	2.8	0	0.9	0	1	0	8	7.8		
North of Tyne & Gateshead	Northumbria Healthcare FT	38	724	6.7	0	1	1	1	10	26	29.08		
North of Tyne & Gateshead	Tynedale Hospice at Home	0	0	0	0	0							
North of Tyne & Gateshead	Hospice Care N. Northumberland	0	0	0	0	0							
Tees Valley	Teesside Hospice	10	0	0	0	2.6						15.08	8.36
Tees Valley	South Tees	0	1235	2.9	0	0.5	0	2	17	14	23.95		
Tees Valley	North Tees	0	563	3.45	0	1	1	0	*3.4	*9.2	12.6		
Tees Valley	Alice House Hospice	10	0	0.4	0	2.2						15.3	9.52
Tees Valley	Butterwick Hospice	8	0	0.4	0	0						9.4	
Tees Valley	Zoe's Place	6	0	0	0	0						6.8	
All	CHIPs	0	0	2.5	1.6	0.3	0	0	0	6	5.3	0	0

		<b>164</b>	<b>7275</b>	<b>40.63</b>	<b>4</b>	<b>21</b>	<b>3</b>	<b>9</b>	<b>43</b>	<b>118</b>	<b>157.4</b>	<b>187.8</b>	<b>98.92</b>
											<b>6</b>	<b>7</b>	

*\* shows where numbers were given in wte*

## Appendix 2: Non-medical / nursing

ICB Sub-location	Services	WTE Specialist Pharmacist	WTE Specialist Occupational Therapist	WTE Specialist Physiotherapist	WTE Specialist Social Worker	WTE Sp. Social Prescriber	WTE Specialist Psychologist	WTE Specialist Educator
Durham, South Tyneside & Sunderland	S. Tyneside & Sunderland FT	1	3.8	1	0	0	2.6	5.3
Durham, South Tyneside & Sunderland	County Durham & Darlington FT	0	0	0	0	0	0	0
Durham, South Tyneside & Sunderland	Willow Burn Hospice	0	0	0	0	0	0	0
Durham, South Tyneside & Sunderland	St Cuthbert's Hospice	0.8	1	0.8	0.6	0	0	0
Durham, South Tyneside & Sunderland	St Teresa's Hospice	0	0	0	0.6	0	0	0
North Cumbria	NCIC	0	1	0	0	0	0	0.8
North Cumbria	Eden Valley Hospice	0.2	0.2	0.1	0.9	0	0.4	0
North Cumbria	Jigsaw Children's Hospice	0.1	0	0	0.6	0	0	0
North Cumbria	Hospice at Home West Cumbria	0	0	0	0	0	0	0
North Cumbria	HaH Carlisle & N. Lakeland	0	0.8	0	0	0	0	0
North of Tyne & Gateshead	Marie Curie Hospice	1	1.8	2	1.8	0	0	1
North of Tyne & Gateshead	St Oswald's Hospice	0	0.6	3.38	2.2	0	0	0
North of Tyne & Gateshead	Newcastle Hospitals FT	0	0	0	0	0	1.3	1

North of Tyne & Gateshead	Gateshead Health FT	0.3	0	0	0	0.6	0.5	1.6
North of Tyne & Gateshead	Northumbria Healthcare FT	1	5.25	3.45	0.5	0	0	0
North of Tyne & Gateshead	Tynedale Hospice at Home	0	0	0	0	0	0	0
North of Tyne & Gateshead	Hospice Care N. Northumberland							
Tees Valley	Teesside Hospice	0.09	0.6	0.56	0.8	0	0	0.4
Tees Valley	South Tees	0.6	1.85	1	0	0	0.8	1.1
Tees Valley	North Tees							
Tees Valley	Alice House Hospice	0.1	0.1	0.1	0	0	0	0.6
Tees Valley	Butterwick Hospice	0	0	1	0	0	0	0
Tees Valley	Zoe's Place	0	0	0	0	0	0	0
All	CHIPs	1	0	0	0	0	1	1
		<b>6</b>	<b>17</b>	<b>13</b>	<b>8</b>	<b>1</b>	<b>7</b>	<b>13</b>