Cheshire & Merseyside

Palliative and End of Life Care Programme

Overview of the Specialist Palliative Care Workforce across Cheshire and Merseyside

Our vision:

For the adults, children and young people of Cheshire & Merseyside to live well, before dying with peace and dignity, in the place where they would like to die, supported by the people important to them. The access to care should be equitable across Cheshire & Merseyside with no post code lottery.

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INTRODUCTION

This report is an overview of Specialist Palliative Care (SPC) services and workforce across Cheshire and Merseyside (C&M) in place at the time of publication.

It has been compiled through a project working group established through the Cheshire and Merseyside Integrated Commissioning System Palliative and End of Life Care (PEOLC) Programme, at the request of the Programme Board to:

- Establish an overview of the SPC workforce working in all settings across Cheshire and Merseyside (adult services)
- Quantify provision of 7/7 working in hospitals, community and hospices
- Understand access to SPC advice via 24/7 Advice Lines for health and care professionals in all settings
- Describe the issues and challenges when commissioning and 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:

- Ambitions for Palliative and End of Life Care; A national framework for local action 2021-2026
- Commissioning Guidance for Specialist Palliative Care: helping to deliver commissioning objectives 2012
- NHS England Specialist Level Palliative Care: information for commissioners 2016
- Cheshire and Merseyside PEOLCN Service Specifications for 24/7 Advice Lines and 7/7 working 2007
- Night, Weekend and Bank holiday Specialist Palliative Care Services – Royal College of Physicians and Association for Palliative Medicine 2018
- Royal College of Physicians Medical Services; designing care 2018
- Association of Palliative Medicine (APM) Report and Overview of the Palliative Medicine Workforce in the UK 2019
- Service Descriptor for Specialist Palliative Care – Cheshire and Merseyside Palliative and End of Life Care Clinical Network 2020
- Framework for assessing SAS doctors to act as Responsible Clinicians and Medical Directors Cheshire and Merseyside Palliative and End of Life Care Clinical Network 2021
- NICE Quality Standard for End of Life Care in Adults QS13 updated 2021

IN SCOPE

For this phase of the project the working group considered:

- The substantive SPC medical workforce of Consultants, Associate Specialists (AS) and Specialty Doctors
- The substantive SPC Clinical Nurse Specialist (CNS) workforce in hospital and community settings

- The Allied Health and Care Professionals (AHP) working in SPC multi-disciplinary teams (MDTs)
- The provision of 24/7 SPC advice to health care professionals
- 7-day SPC service provision in hospitals, hospices and the community setting
- Specialist palliative care in patient unit bed provision against existing guidance

OUT OF SCOPE

- The medical workforce of doctors in training posts
- The SPC workforce providing primarily 'hospice at home' services
- Professionals in roles which are not described within the core MDT provision

KEY FINDINGS

- The Consultant and Associate Specialist workforce across C&M is substantially below recommendations with a WTE gap of **12.1** in hospitals and **9.4** in community services
- In 5 of the 8 acute hospitals in C&M and in 1 large specialist tertiary hospital there is 1 WTE or less Consultant or AS provision
- 6 out of 11 hospitals (acute and specialist) have no specialty grade doctor in palliative care
- 7out of 10 place-based partnership area do not meet the recommendation for Specialty Grade doctors working in community settings (hospice and community). This represents a gap in provision of **4.3** WTE
- The number of CNSs in hospitals is at or above the recommendation of 1CNS to 250 beds in all but 1 hospital (East Cheshire NHS Trust)
- In 3 out of 9 place based partnership areas the number of CNSs providing community services is at or around the recommended 1CNS per 50,000 population, however this is based on a 5 day working week therefore is likely to be inadequate for provision of 7 day services
- In Merseyside there is access to face to face 9-5 7/7 SPC provision in all community services and all but one hospital (Liverpool Women's Hospital)
- In Cheshire there is **no** access to 9-5 7/7 SPC provision in community or hospital
- 9 out of the 10 hospices in C&M accept admissions on a 7/7 basis but criteria and frequency varies
- In all place-based partnership areas health professionals have access to 24/7 SPC telephone advice
- 9 out of 10 hospices have an MDT which substantially or fully meets the recommendations for core professionals
- In NHS provided services the SPC MDT is most frequently comprised of doctors and nurses with minimal or no dedicated time from other allied health professionals
- 1 out of 10 hospices has the recommended number of specialist beds for the local population

KEY RISKS

The key findings highlight some risks that are likely to impact on the provision of sustainable high quality SPC services and patient care.

RISK	IMPACT
There are **21.5** WTE fewer doctors in SPC at Consultant and AS level than recommended 5 of 8 acute hospitals have 1 **WTE** or less SPC Consultants or AS doctors	Reduced access for patients and health professionals to specialist symptom control and advice during normal working and out of hours which compromises optimum clinical treatment and care The current Consultants and AS doctor workforce is required to provide out of hours cover with frequent and onerous on call rotas. Out of hours cover is vulnerable, especially where there are fewer senior medical staff. This has the potential to compromise optimum clinical treatment and for patients to be admitted into the acute setting Access to supervision and support for CNSs working in SPC teams in community and hospital may be limited so 7-day access to SPC face to face assessment will not be supported, compromising clinical care and ability to support the patient in the place of their choice
In 3 place-based partnership areas the number of CNSs in the Community SPC team is not sufficient to support the provision of 7 day working	Stretching the workforce numbers to accommodate 7-day compromises response times, patient assessment and review and support for health professional colleagues e.g., education.
In C&M SPC services in hospital and community are primarily delivered by the CNS workforce	Reliance on one professional group means that maintaining services requires a sustainable workforce
There are no 7/7 SPC services in community or hospice in Cheshire	Patients do not have access to SPC assessment or advice at weekends and bank holidays which may result in inadequate symptom management or inappropriate hospital admissions

In addition to gathering SPC workforce data organisations were asked about wider workforce challenges facing their service. Issues reported were:

- The challenge for voluntary sector organisations in offering comparable salaries and terms and conditions to the NHS for staff which directly affects recruitments and retention
- The limited number of SPC Consultants available to take up posts even when funding is available
- The changing role of the CNS with an expectation of managing increasingly complex cases without additional resources or medical support
- The lack of knowledge or understanding of SPC at system level and the failure to prioritise or plan for palliative care services

BACKGROUND

NHS England Specialist Level Palliative Care: information for commissioners 2016 (4) 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 Integrated Commissioning Board (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/I Palliative and End of Life Care (PEoLC) Delivery Plan 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 by 2024/5 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
- Each ICS has a workforce plan for PEoLC and demonstrates year on year improvement

This review is a key priority of the C&M PEoLC Programme delivery plan and responds to the 'Ambitions Framework' and the 'NHSE/I Delivery Plan'.

The aim of the review is to describe by place-based partnership 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

Gathering of information was conducted via interviews with identified leaders in each locality and setting. The data collected has been collated into tables to allow comparison and analysis. Data has been verified with localities prior to completion of the report in January 2022. The individualised data for localities is included separately.

For the purposes of the report population numbers have been rounded to the nearest thousand and all staff numbers are WTE and include vacancies. In some place-based partnership areas there is overlap between services particularly in the community and West Lancashire, Southport and Formby is included, although West Lancashire is not in Merseyside. This does not substantially change the overall picture.

Review of the data has enabled key themes and risks to emerge and the project working group sets out recommendations for consideration at C&M ICS level and within local Place Based Partnerships. **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.**

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

The guidance relating to the medical and nursing workforce and hospice beds is contained in *Commissioning Guidance for Specialist Palliative Care: helping to deliver commissioning objectives 2012 (*6). A broad review of specialist palliative care workforce has not been conducted since. 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 24/7 Advice in all settings
- The requirement of SPC services to deliver education to non-specialist providers of palliative care

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 meets 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. In the past decade we have seen increasing integration of services across settings which has made interpreting the data a challenge. We have indicated in the report where this is the case.

It is accepted that the number of people requiring SPC is increasing and will continue to do so. The report Modelling demand and costs for Palliative Care Services in England commissioned by Sue Ryder and published in February 2021 found *'based on mortality statistics and population projections for England and Wales, annual deaths will rise by 25.4% by 2040. Based on the annual increase in deaths from chronic, progressive illnesses such as dementia, cancer and organ failure over the period from 2006-2014, the number of individuals who will need palliative care will increase by 42.4%'.*

Rightly, patients and those important to them expect that specialist care should be available to anyone with complex needs and a life limiting illness whatever their diagnosis and wherever they live. Service improvement initiatives regionally and nationally have shown that patient outcomes, including reducing inappropriate admissions to hospital and length of stay, are improved with SPC input.

MEDICAL WORKFORCE

In December 2012, "Commissioning Guidance for Specialist Palliative Care: Helping to Deliver Commissioning Objectives" (6) was published. This 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

Per 250 beds in hospital:

- 1 WTE Consultant

A key recommendation was that Consultant posts should be matched by another non-consultant grade.

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 (5) 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, Associate Specialists (palliative medicine) 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. In addition, the specialist trainee workforce is likely to be substantially affected by the implementation of 'Shape of Training' in the near future.

Across C&M 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 and have developed an assessment framework that enables doctors in these roles to evidence this. (1) However, it is the position of the RCP (2) and APM that SPC teams should be clinically led by Consultants in Palliative Medicine. In October 2021 the APM (3) stated "The APM reaffirms the view of NHSE (4) and The RCP that the medical lead role (Consultants, Associate Specialists (AS) and the new specialist grade (SGS) doctors) cannot be replaced by other professional groups or non-specialist grades"

This review therefore benchmarks against currently available guidance in relation to medical workforce provision.

Table 1 describes the Consultant and AS workforce based in hospices and the community setting combined per population. With some exceptions most Consultant time is focused in in-patient units. Some Community SPC teams have minimal dedicated Consultant support. No locality meets the **minimum** recommendations. **The WTE gap for C&M combined is 9.4 WTE**.

Table 1: Consultants & Associate Specialists in Community Settings:

CONSULTANTS AND ASSOCIATE SPECIALISTS: 1/100,000 (REC = RECOMMENDED)					
HOSPICE + LOCALITY COMBINED	**POPULATION**	**CONSULTANTS / ASSOCIATE SPECIALISTS CURRENT POSITION**	**WTE / POPULATION**	**REC**	**GAP**
WSJ & Wirral	323,000	2.7	1/120,000	3.2	0.5
St R & Warrington	210,000	1.4	1/150,000	2.1	0.7
HHH & Halton	129,000	0.6 (community)	1/215,000	1.3	0.7
WBH & St Helens and Knowsley	328,000	1.8	1/186,000	3.3	1.5
QCH & Southport and Formby	235,000	1.3	1/180,000	2.3	1
MC & South and Central Liverpool	375,000	3.2	1/117,000	3.7	0.5
WDL /Nth Liverpool/ South Sefton & Knowsley	330,000	2.6	1/126,000	3.3	0.7
St L & South Cheshire &Vale Royal	306,000	0.9	1/340,000	3	2.1
HOGS & West Cheshire	269,000	2	1/135,000	2.7	0.7
ECH & East Cheshire	215,000	1.2	1/180,000	2.2	1.0
C&M		**17.7**		**27.1**	**9.4**

Table 2 describes the numbers of Specialty Grade doctors working in community settings (hospice and community). The majority of time supports specialist in-patient units which vary in size. 7/10 areas have some gap in provision. The locality of West Lancs, Southport and Formby meets the recommendation but the specialty doctors also provide an in reach service in to the hospital daily.

Table 2: Hospice/Community Specialty Doctors:

HOSPICE/COMMUNITY SPECIALTY DOCTORS: RECOMMENDATION 1/100,000			
HOSPICE / LOCALITY Combined	**NUMBER PER POPULATION**	**RECOMMENDATION**	**GAP**
East Cheshire/ East Cheshire Hospice	2.0/215,000	2.15	0.15
South Cheshire and Vale Royal/St Luke's	0.7/306,000	3.0	2.3
West Cheshire/HOGS	2.6/269,000	2.7	0.1
Wirral/ Wirral St Johns	1.5/323,000	3.2	1.7
Warrington/St Rocco's	2.3/210,000	2.1	none
Halton/Halton Haven	2.5/129,000	1.3	none
St Helens and Knowsley/WBH	2.6/328,000	3.2	0.6
West Lancs, Southport & Formby/ Queenscourt	4.4/235,000	2.3	none
Liverpool South and Central/ Marie Curie	2.6/375,000	3.7	2.1
North Liverpool, South Sefton & Knowsley/Woodlands	1.5/330,000	3.3	2.3
C&M	**22.7**	**27**	**4.3**

Table 3 describes the number of Consultants and AS doctors working in hospitals. The 2012 commissioning guidance recommended 1/250 beds which should be increased for specialist hospitals e.g. Cancer Centres. Only 2 hospitals meet the requirements both of which are specialist hospitals. LUHFT (the combined Trusts of the Royal Liverpool Hospital and Aintree University Hospital) has 12 SPC beds within The Royal Liverpool site, Wirral UHFT also supports 8 SPC

beds. Despite this they both have below the recommended number of WTE Consultants. There is no guidance at a National level that recommends Consultant WTE provision in hospitals that have SPC beds.

5* acute hospitals and 2** specialist hospitals have 1 or less WTE Consultants or AS. These consultants are likely to be in Clinical Lead roles with a substantial commitment to leadership, management and education. **The WTE gap in provision is 12.1 in those hospitals where the recommendation is not met.**
A table for Specialty doctors is not included as only 3 acute hospitals and Clatterbridge Cancer Centre have any support at this grade.

WUHFT – 0.7 WTE CoCH – 0.2 WTE, LUHFT 2.0 WTE CCC 0.6 WTE

Table 3: Hospital Consultants / Associate Specialists:

CONSULTANTS & ASSOCIATE SPECIALISTS HOSPITAL: RECOMMENDATION 1/250 BEDS			
HOSPITAL (BEDS)	**WTE**	**RECOMMENDATION**	**GAP**
East Cheshire NHS Trust* (333)	0.5 (1/666 beds)	1.3	0.8
Mid Cheshire HFT* (487)	0.9 (1/537 beds)	2.0	1.1
Countess Of Chester* (625)	1.0 (1/625)	2.5	1.5
Wirral UHFT (900)	3.1 (1/290 beds) 8 SPC	3.6	0.5
Warrington & Halton (600)	1.2 (1/500)	2.4	1.2
LUHFT (1570)	3.4 (1/460 beds) 12 SPC	6.3	2.9
STHKTHT* (887)	1 (1/887 beds)	3.6	2.6
CCC (110)	2.3 (1/55)	Meets recommendation	0
LHC** (187)	0.4 (1/467 beds)	0.7	0.3
LWH (24)	0.175/24	Meets recommendation	0
S&OHT* (550)	0.8 (1/687 beds)	2.0	1.2
C&M	**14.8**		**12.1**

NURSING WORKFORCE

Table 4 includes the number of Clinical Nurse Specialists (CNSs) working in the hospital setting. The recommendation from a decade ago was for 1 CNS for 250 beds in the acute setting. In all but one case (East Cheshire) the number of CNSs is above that recommendation and in some cases substantially. In East Cheshire an integrated team of 5.4 WTE CNSs work across hospital and community with 1 WTE dedicated to the hospital (this does not meet the recommendation). In West Lancs, Southport & Formby the community and hospital teams are integrated with 2.2 WTE for hospital.

The data suggests that organisations have responded to the huge need for SPC teams in hospitals through an expansion in the number of specialist nurses. An expansion in the medical workforce alongside this has not occurred and so where the recommendation was for a CNS to be matched by a Consultant colleague (6) the model in hospitals in C&M is of services delivered primarily by CNSs.

Table 4: Hospital Clinical Nurse Specialists:

CNSS IN HOSPITALS: RECOMMENDATION 1/250 BEDS		
HOSPITAL	**NO. CNSS/BED NUMBER**	**MEETS RECOMMENDATION?**
East Cheshire NHS Trust	1/333	No
Mid Cheshire Hospital FT	3/487	Yes
Countess of Chester	3.6/625	Yes
Wirral University Teaching Hospital	9.2/900	Yes
Warrington & Halton Hospitals	4/600	Yes
St Helens and Knowsley Teaching Hospitals	8/887	Yes
West Lancs, Southport & Formby	2.2/550	Yes
Liverpool University Foundation Trust	19.26/1570	Yes
Clatterbridge Cancer Centre	6.2/110	Yes
Liverpool Heart and Chest	2.4/187	Yes
Liverpool Women's Hospital	5.4/24	Yes – CNSs are predominantly oncology

In Table 5 we see the nursing workforce numbers for community services. On average 1WTE CNS is provided/ 37,000 population. **3/9 localities* have CNS provision at or around the recommended 1/50,000 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.**

Table 5: Community Clinical Nurse Specialists:

COMMUNITY CNSS: RECOMMENDATION 1/50,000		
LOCALITY	**POPULATION**	**MEETS RECOMMENDATION?**
Cheshire East*	4.6/215,000	Yes (1 CNS/47,000)
South Cheshire and Vale Royal*	6.2/306,000	Yes (1 CNS/49,000)
West Cheshire	7.1/269,000	Yes (1 CNS/37,000)
Wirral	12.2/323,000	Yes (1 CNS/26,000)
Warrington	5.4/210,000	Yes (1 CNS/38,000)
Halton	5/129,000	Yes (1 CNS/25,800)
West Lancs, Southport and Formby	9.2/235,000	Yes (1 CNS/25,000)
Liverpool and South Sefton	17.6/655,000	Yes (1 CNS/37,000)
St Helens and Knowsley*	7.0/328,000	Yes (1 CNS/47,000)

SPECIALIST SERVICE HOSPICES

The medical workforce in hospices has already been described and further discussion is included later in this report.

Hospice at home services are considered out of scope even though in some localities they contribute significantly to service provision. There is no national recommendation for the workforce required to deliver Hospice at home type services and therefore this review is unable to benchmark these.

The data gathering process included nurses working in hospices at all grades. The 2012 guidance makes reference to a standard of 1.2 qualified nurses/specialist bed. There are a number of other models to support safe staffing in hospices and The Care Quality Commission considers using more than one good practice. This data is included in the individual place based partnership

summary tables but is not tabulated at C&M level as there is considerable variation in the models that hospices use. As a result it is not possible to benchmark the data in a meaningful way.

Specialist MDT – Hospices

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.*(4)
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".

In 2020 the Cheshire and Merseyside Palliative and End of Life Care Network developed regional guidance (9) (Service Descriptor for Specialist Palliative Care – Cheshire and Merseyside Palliative and End of Life Care Clinical Network 2020) that describes the key professionals that should always be included in a specialist MDT.

Medical Consultant	Occupational Therapist	Psychologist
Specialty doctors	Physiotherapist	Social Worker
Nurses with specialist qualifications	Pharmacist	Chaplain/Spiritual care

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.

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 hospice, community service or hospital.

This review gathered information from all settings regarding the makeup of the SPC MDT. In most cases in hospitals and community settings the MDT was made up of specialist nurses and doctors with access to other professionals via usually provided NHS services. Across Cheshire and Merseyside when the SPC team is employed by an NHS organisation they do not constitute a Specialist MDT that includes the full complement of professionals.

In contrast as table 6 shows hospices usually have a specialist MDT with professionals whose role it is to contribute their specialist skills and knowledge. The specialist MDT primarily supports the in-patient unit in hospices, but some elements will support wider services such as hospice therapy services or hospice at home.

The SPC MDT is provided through a variety of different models and often responds to local need. Funding is sometimes from external sources e.g., commissioners and local authorities but a key theme is that hospices are making a significant contribution to the funding of the SPC MDT.

SPIRITUAL SUPPORT

Three hospices operate a volunteer model of spiritual support, these are volunteers with the skills and background to offer appropriate spiritual care for patients and time is dedicated for the MDT. No hospice had provision of more than 1 WTE and usually substantially less with a total WTE of 3.96 substantive posts across C&M.

PHARMACY

Pharmacists are identified in the 2016 Commissioning guidance as key members of the MDT. They support patient safety through medicines reconciliation, audit and the development of clinical practice guidance with other clinical colleagues. Pharmacy technicians who often support hospices alongside pharmacists are not included as they are not qualified pharmacists. All but one hospice reports some provision, but it is variable even in hospices of comparable size.

PSYCHOLOGICAL SUPPORT

It is recommended that SPC services can access psychological support for patients up to and including the level 4 support that a qualified psychologist would provide. We have included other professionals that hospices have identified as providing psychological support but only 2 hospices have access to a psychologist via their MDT and some have no access at all. There is significant variation in the number of WTE across the region. Cheshire has a substantially higher number of WTEs than Merseyside. This may be because they are commissioned to provide bereavement support for the wider community. Models also vary within some hospices where professionals such as social workers provide some of the psychological support service. Overall, they represented the biggest group of professionals working within the MDTs which is likely to reflect the significant needs of patients and those important to them for psychological support during the illness and into bereavement.

SOCIAL WORKERS

One hospice reports access to a social worker via local authority provision as required. All others have some dedicated social worker input to the MDT. Half have 1 WTE or more but this does not necessarily equate to the size of the hospice. Social workers make an enormous contribution to the holistic support of patients and families. They offer expert guidance to the MDT beyond coordinating discharges including knowledge of financial support and safeguarding regulations.

THERAPY SERVICES

Occupational and Physiotherapy services are essential components of the SPC MDT. They make assessments and develop management plans that contribute to patient safety, independence, rehabilitation and support safe discharge. All but one hospice includes occupational therapists and physiotherapists in their MDT. Again, provision varies and does not always equate to hospice size; this is likely to reflect the local model and, in some cases, may be related to available funding.

Table 6: Specialist MDT Hospices:

HOSPICE (BEDS)	SPIRITUAL SUPPORT	PHARMACIST	PSYCH SUPPORT	SOCIAL WORKER	OCC THERAPY	PHYSIO
EC (15)	0.64	0.3	2.4	0.5	0.4	1.7
St L (10)	0.42	0.2	2.27	1.0	0.8	0
HOGS (10)	0.6	0.15	3.7	0.8	0.1	0.3
WSJ (16)	0.4	1.0	0.5	1.3	1.0	1.4
WBH (10)	Volunteer model	0.27	1.0	1.0	0.75 OT & Physio	-
St R (10)	0.3	0.4	1.4	0.8	1.04	0.8
HHH (12)	Volunteer model	0.1	0.2 Psychologist	0	0	0
MC (17)	0.6	0.5	1.0	0.8	1.4	1.0
WDL (12)	1.0	0.5	Provided by SW	2.0	1.3	1.6
QCH (10)	Volunteer model	0	0.1 Psychologist	1.0	1.0	1.0
Network total	**3.96 WTE** substantive	**3.42**	**12.57**	**8.4**	**7.79**	**7.8**

Specialist Palliative Care In-patient Beds

The 2012 commissioning guidance made a recommendation for a **minimum of** 20-25 SPC in-patient 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.

Table 7 describes current provision against 20/250,000 =1/12,500. Only 1 hospice meets this recommendation with some very substantially below. A number of factors are likely to be in play when considering why this expansion in in-patient beds has not occurred, but two are significant:

- Hospices are charitable organisations and the average NHS grant in C&M is 28% of running costs, with some as low as 17%. The additional capital outlay and ongoing staffing costs for this level of expansion is not affordable without a substantial increase in external funding
- 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 or are working more closely with Community SPC teams to increase the capacity for medical assessment and review at home

Hospices and Commissioners may wish to consider how specialist palliative care in-patient bed provision for the locality fits within the place-based partnership wider strategy for SPC Services

Table 7: Hospice Beds:

HOSPICE BEDS: RECOMMENDATION 1/12,500		
HOSPICE	**BED / POPULATION**	**RECOMMENDATION**
East Cheshire Hospice	15/215,000	17
St Luke's Hospice	10/306,000	24
Hospice of the Good Shepherd	10/269,000	21
Wirral St Johns Hospice	16/323,000	26
Willowbrook Hospice	10/328,000	26
Woodlands Hospice	12/330,000	26
Marie Curie Hospice	17/375,000	30
St Rocco's Hospice	10/210,000	17
Halton Haven Hospice	12/129,0000	10
Queenscourt Hospice	10/235,000	19

7-DAY WEEK SERVICES

As already outlined, 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 (7) (8). They are key outcomes for the NHSE/I PEOLC Programme Board to see achieved consistently by 2024/5.

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
- Support for providers of general palliative care

Tables 8 and 9 describe the availability of 7-day SPC in all settings across C&M.

Currently there are no CNS delivered 7-day (9-5) services operating in Cheshire in the hospital or community. East Cheshire Hospice operates a hospice at home service which is out of scope for this review.

All acute hospital trusts and community services in Merseyside have a 7 day per week service, most frequently operating 9-5. Clatterbridge Cancer Centre operates a 7-day service, LHCH has 7/7 service provided via the RLUH CNSs for patient assessment as required, LWH has access to advice at weekends.

The data on CNS numbers in the hospital and community settings contained in tables 4 and 5 does not fully explain why there are no 7-day services in Cheshire. Two of the hospitals in Cheshire have CNS numbers working Mon-Friday that exceed the 2012 recommendations and are similar per bed to some other hospitals in Merseyside that do operate 7 days per week. Cheshire East and South Cheshire and Vale Royal are 2 of 3 localities that have CNS numbers for community services close to the 2012 recommendation of 1/50,000 which did not account for 7/7 working. It is the case that to operate effective services that are safe and do not compromise weekday services any locality should ensure that absolute numbers of nurses are adequate to operate a 7/7 rota and that CNSs have access to senior medical support at weekends and on bank holidays.

In West Lancs, Southport and Formby the integrated service has 11.4 WTE CNSs who operate a rota for weekends and Bank Holidays that covers both hospital and community.

All the hospices in C&M clearly operate a 7-day service in that they provide care for patients in in-patient beds 24/7.

The guidance document *Night, Weekend and Bank Holiday Specialist Palliative Care Services (7)* describes a 4 level specification for 7-day operation of hospices from minimum to level 3. Level 1 (desirable) includes the recommendation that “all hospice units should be moving towards 24/7 admission of patients”.

One hospice does not admit patients at weekends and a second in exceptional circumstances. All other hospices do admit but the frequency with which this happens, and the criteria applied is variable. Operating across 7 days can represent significant challenges for hospices for reasons that have previously been discussed. Specialty doctors who are relied upon for 24/7 rota cover are invariably funded by hospices and on call rates of pay can compare unfavourably to the NHS and often do not compensate doctors for the hours that are actually worked as the care of patients becomes increasingly complex. In one audit of OOH medical activity in a Merseyside Hospice doctors worked the equivalent of 2 full shifts over 2 days in addition to on call at night and admitted at least one patient on 50% of all weekends.

Table 8: 7-Day Week Services:

7-DAY WEEK SERVICES		
AREA	**HOSPITAL**	**COMMUNITY**
East Cheshire	No	No
Vale Royal and east Cheshire	No	No
West Cheshire	No	No
Wirral	Yes	Yes
Liverpool and South Sefton	Yes	Yes
St Helens and Knowsley	Yes	Yes
Warrington	Yes	Yes
Halton	No acute hospital	Yes
West Lancs, Southport and Formby	Yes	Yes
SPECIALIST HOSPITALS		
Clatterbridge Cancer Centre	Yes	N/A
Liverpool Heart and Chest Hospital	Yes – RLUH CNS	N/A
Liverpool Women's Hospital	No – advice via MC	N/A

24 / 7 ADVICE

Health and care professionals in all localities across C&M have access to SPC advice 24/7. In all cases this is provided by hospices out of hours. Some advice lines also operate support for patients and families although this is not consistent.

Operating models and commissioning arrangements do vary and are likely to represent how they have developed historically. A C&M service specification for 24/7 Advice Lines was developed in 2007 and refreshed in 2012. A more comprehensive national specification (7) has since been published and an outcome from this review could be to consider an agreed specification for C&M which includes 24 hour and 7-day access to SPC advice and services.

Table 9: 7/7 Hospice & 24/7 Advice Line:

HOSPICE	WEEKEND & BH ADMISSSIONS	CRITERIA	COMMENTS	24/7 ADVICE PROFESSIONALS
East Cheshire Hospice	Yes (infrequent)	Urgent	Restricted hours	Yes
St Luke's Hospice	Yes	Urgent	Approx. monthly	Yes
Hospice of the Good Shepherd	In exceptional circumstances	Urgent	Staffing levels prevent	Yes
Wirral St Johns	Yes	Urgent	Infrequent due to medics off site	Yes
Willowbrook	Yes	Urgent	Frequently	Yes
Woodlands	Yes	Urgent	Frequently	Yes
Halton Haven	No admissions	_	_	Yes – provided for locality by WBH
St Rocco's	Yes	As weekdays	Frequent	Yes
Marie Curie	Yes	As weekdays	Frequent	Yes
Queenscourt	Yes	As weekdays	Frequent	Yes

SUMMARY and RECOMMENDATIONS

This review sets out the current position in C&M in the provision of SPC services across all settings. With the expected increase in the requirement for specialist palliative care it is likely that many services will be unable to respond to demand if the workforce remains as it is. This position reflects the national picture. A survey conducted by The Association for Palliative Medicine and Marie Curie (January 2022) of SPC practitioners said that only 19% felt that there was sufficient workforce capacity to meet the demand for high quality end of life care in their locality. 93% did not feel confident that SPC services would be sufficient to meet future demand.

SPC medical workforce provision across Cheshire and Merseyside does not meet even the minimum recommendations as set out in the Commissioning Guidance of 2012. Reviews of The SPC Medical workforce confirm that this is in line with the national picture (5) and the number of doctors in specialist training is expected to meet only 50% of that required to fill Consultant vacancies. The North West Deanery in 2021 reports 4.1 WTE Consultant vacancies with 3.7 WTE vacant for over 2 years.

The gap in the Consultant and AS workforce in C&M equates to **21.5** WTEs, the current workforce is approximately 30 WTEs, meaning the consultant workforce should increase by 70% in order to meet guidance. With inadequate numbers of doctors in specialist training nationally addressing the significant shortfall will prove challenging but the impact on patient care should be acknowledged.

The number of Specialty grade doctors is also below recommended levels with a gap of **4.3** WTE across C&M.

SPC services are overwhelmingly provided by the Clinical Nurse Specialist workforce in hospitals and community settings and often without the recommended level of support from medical colleagues. This is most apparent in Cheshire where the small absolute numbers of CNSs in hospital in particular and a Consultant and AS workforce below recommendations means that providing 7/7 working that is sustainable and safe for clinical staff and patients is likely to be a challenge.

Some community services are operating with CNS numbers that are likely to be inadequate to meet the expectation to deliver high quality specialist palliative care for all patients with life limiting conditions available 7 days per week. Some CNSs are in leadership and education roles which will also reduce time for clinical service delivery.
That SPC services in the hospital and community are delivered by and therefore reliant on one staff group is identified as risk.

It is widely acknowledged that Hospices make a substantial contribution to the provision of the SPC workforce (on average 70% of the cost of SPC provision in hospices is raised through charitable activities) and this is becoming increasingly unaffordable. Expansion of the workforce in specialist palliative care in-patient units is unlikely to occur without a commissioning model that supports this. The PEOLC Programme is working to address this through the Hospice Sustainability Working Group which is tasked to describe the core clinical interventions that should be provided by all specialist units and outline framework to support sustainable safe clinical SPC service delivery through a hospice with an associated tariff

RECOMMENDATIONS

- The ICB via the Transformation Board prioritise and plan the provision of high quality end of life care for all those with far advanced progressive illness living in C&M
- A C&M wide population based needs assessment should be conducted to inform a comprehensive C&M SPC workforce strategy
- A C&M specification for 24/7 Advice Lines is developed and endorsed by the ICB
- A C&M review of the CNS workforce is conducted that considers the expectation of the role, medical support and the staff group profile
- Commissioners and providers at Place use the information in this report to support local workforce planning for SPC services which addresses gaps and key risks
- Commissioners and providers at Place are advised to use the Cheshire and Merseyside Palliative and End of Life Care Clinical Network 2021 Framework for assessing SAS doctors to act as Responsible Clinicians and Medical Directors to assure speciality grade Drs acting in senior roles have the skills and competency to do so.

REFERENCES

1. Framework for assessing SAS doctors to act as Responsible Clinicians and Medical Directors Cheshire and Merseyside Palliative and End of Life Care Clinical Network 2021.
2. Royal College of Physicians Medical Services; designing care 2018.
3. Statement to promote the role of Senior Palliative Medics within the Palliative Care MDT APM October 2021.
4. NHS England Specialist Level Palliative Care: information for commissioners 2016.
5. Association of Palliative Medicine (APM) Report and Overview of the Palliative Medicine Workforce in the UK 2019.
6. Commissioning Guidance for Specialist Palliative Care: helping to deliver commissioning objectives 2012.
7. Night, weekend and bank holiday Specialist Palliative Care Services. Joint Specialist Committee for Palliative Medicine for the Royal College of Physicians, the Specialty Advisory Committee for Palliative Medicine from the JRCPTB and the Association for Palliative Medicine 2018.
8. NICE Quality Standard for End of Life Care in Adults QS13 updated 2021.
9. Service Descriptor for Specialist Palliative Care – Cheshire and Merseyside Palliative and End of Life Care Clinical Network 2020

KEY TO ORGANISATIONAL ABBREVIATIONS

EC	East Cheshire Hospice
St L	St Luke's Hospice
HOGS	Hospice of the Good Shepherd
WSJ	Wirral St John's Hospice
WBH	Willowbrook Hospice
St R	St Rocco's
HHH	Halton Haven Hospice
MC	Marie Curie
WDL	Woodlands
QCH	Queenscourt Hospice