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Specialist palliative and end of life care services

Adult service specification

18 January 2023

Contents

People with advanced life-threatening illnesses and their families should expect high quality, effective palliative and end of life care (PEoLC), whatever their condition.

This document provides the adult service model for delivering specialist level palliative care (SPLC) services from identification of need through to end of life.

[We have provided guidance for commissioners in square brackets through the specification].

1. Population needs

1.1 National context

People with progressive life-limiting illnesses require different levels of health and social care at different points in their illness. Apart from care and treatment specific to their underlying condition(s), they are likely to have needs that are often referred to as palliative or end of life care (see Appendix 1 for definitions), especially as they approach the last year(s) of their lives.

Throughout their illness, sometimes episodically, sometimes for prolonged periods, they may require expert assessment, advice, appropriate and responsive care, and support from specialists in palliative care.

In addition to physical symptoms such as pain, breathlessness, nausea and fatigue, people who are approaching the end of life may experience anxiety, depression, social and spiritual distress. The proper management of these issues requires effective and collaborative, multidisciplinary working within and between core and specialist teams, whether the person is at home, in hospital or elsewhere.

Specialists can meet the person’s complex needs – physical, psychological, social, religious and/or spiritual – that their core team cannot alone. They work as part of multidisciplinary teams (MDTs), providing the service directly to the person and those important to them and/or supporting others to do so

The main components of SLPC services are:

- specialist knowledge (specialist consultant and specialist nursing services as a minimum) to assess and manage physical, psychological, social, religious and spiritual needs 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 specialist advice, support, education and training to the wider care team who are providing direct core level palliative care to the person.

Those close to the person, including partners, children, friends and informal carers, also play a crucial role at this time and have needs of their own before, during and after the person's death. Arrangements should be in place (which may be via third sector organisations) to offer support for this group.

1.2 Local context

[Commissioners should detail local strategies, responses to national guidance and relevant local data, including patient feedback.]

2. Outcomes

[Using the ambitions framework, commissioners and providers should agree and define the outcomes that demonstrate each of the following is met for their local areas:

- Each person is seen as an individual:
  - evidence of a personalised approach to care
  - example: person-centred outcome and experience measures.
- Each person gets fair access to care:
  - evidence of steps to establish how equitable access to the service is and any measures to improve this
  - example: early identification of people likely to be in their last 12 months of life.
- Maximising comfort and wellbeing:

  - evidence of effective efforts to maximise the person’s comfort and wellbeing using established validated outcome measures, eg the Integrated Palliative Outcome Scale (IPOS)
- Care is co-ordinated:
  - extent to which the service provider engages with local systems to share information that supports better co-ordination of care, eg through participation in electronic palliative care co-ordinating systems (EPaCCS) or equivalent as they are established
  - example: number of discussions that include personalised care and support planning.
- All staff are prepared to care:
  - evidence from outcome measures, uptake of education and training, numbers of complaints received, staff support measures and appraisal systems for own staff, and contribution to the education and training of wider PEoLC teams in the locality
  - example: patient reported outcomes (eg IPOS).
- Each community is prepared to care:
  - evidence of actions the service has taken, or plans to take, in relation to community engagement and understanding of PEoLC
  - example: patient and carer reported experience and number of third sector or community organisations engaged.]

3. Scope

3.1 Aims and objectives of service

[Commissioner to include relevant key aims and objectives for the service provider(s). They should specify:

- the key services to be provided
- an integrated approach to PEoLC services with structures and systems that improve communication and co-ordination between service providers, including seamless transitions of care
- an MDT model of delivery and one that includes future care planning for personalised care and support planning (including advance care planning and

emergency care and treatment planning) and supported self-management, shared decision-making and personal health budgets

- use of IT systems such as EPaCCS (or equivalent) for digitally shared information
- holistic approaches to care with links to social prescribing, assessing and addressing family needs, clear referral pathways to other services such as mental health
- any contribution to a regional or local PEoLC clinical network
- a local training offer
- approaches to ensure delivery is in keeping with the principles of diversity, inclusion and equality.]

3.2 The service model structure

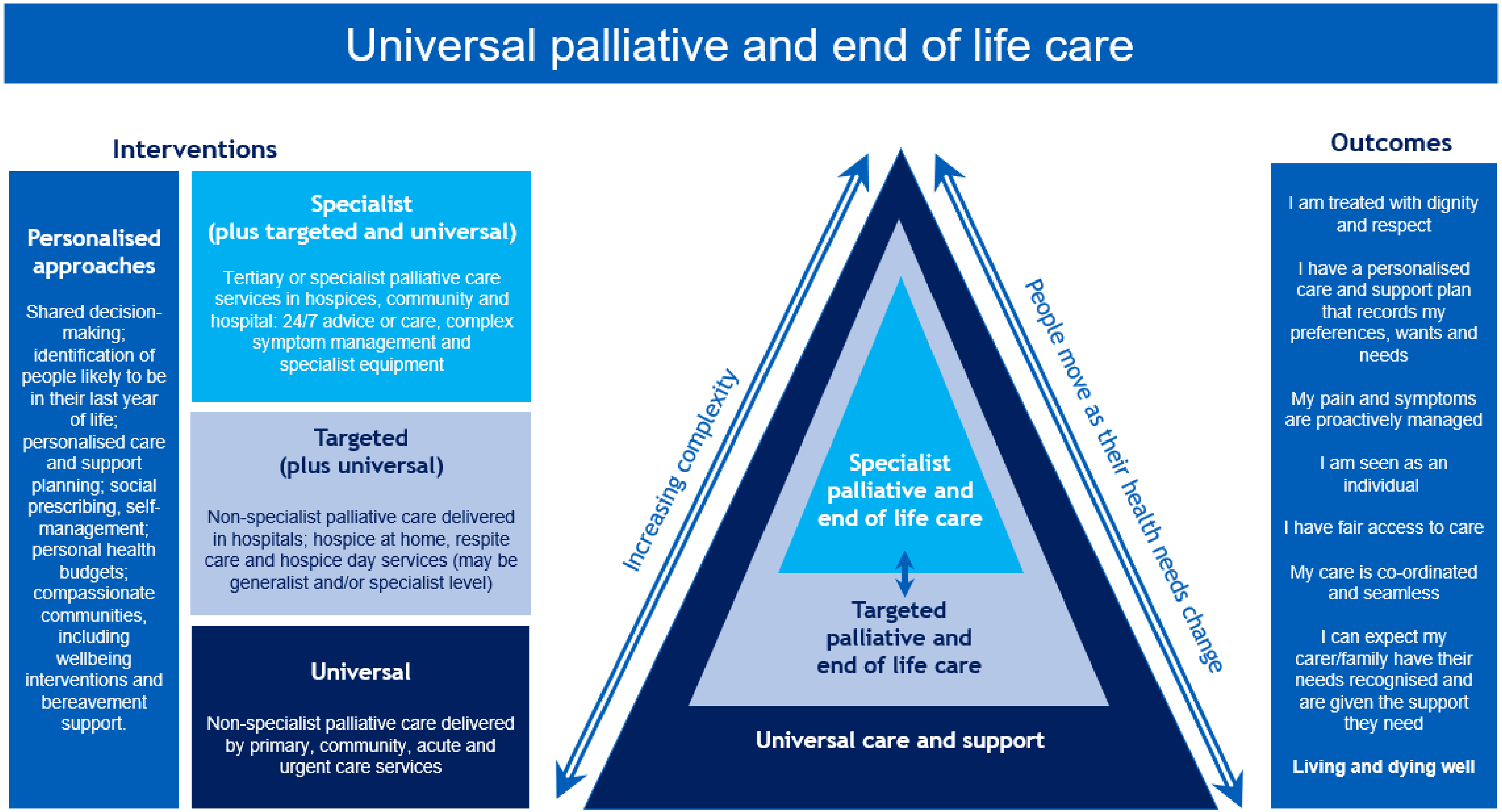
[Figure 1 shows the whole system approach. The tiers of provision are not compartmentalised but joined for a seamless patient journey. The right professional should provide care and support at the right time and in the right place, with no opportunities for support missed and specialist provision targeted where it is needed most.

The model is not a stepped approach. It is flexible with each service area’s involvement fluctuating through a patient’s journey in response to need. Each tier of provision depends on the others to ensure a holistic approach to the health, wellbeing, emotional, social and spiritual needs of the patient and their family and carers. No single provider can provide for all the needs.

The specification sets out the service model for SLPC services. Commissioners should aim to routinely fund these services. SLPC services can be provided by different types of providers and in multiple environments, including in secondary care, community care and hospices.

Commissioner to insert detail on the agreed service model.]

Figure 1: Relationship between services



Universal palliative and end of life care

Interventions

Personalised approaches

Shared decision-making; identification of people likely to be in their last year of life; personalised care and support planning; social prescribing, self-management; personal health budgets; compassionate communities, including wellbeing interventions and bereavement support.

Specialist (plus targeted and universal)

Tertiary or specialist palliative care services in hospices, community and hospital: 24/7 advice or care, complex symptom management and specialist equipment

Targeted (plus universal)

Non-specialist palliative care delivered in hospitals; hospice at home, respite care and hospice day services (may be generalist and/or specialist level)

Universal

Non-specialist palliative care delivered by primary, community, acute and urgent care services

Outcomes

I am treated with dignity and respect

I have a personalised care and support plan that records my preferences, wants and needs

My pain and symptoms are proactively managed

I am seen as an individual

I have fair access to care

My care is co-ordinated and seamless

I can expect my carer/family have their needs recognised and are given the support they need

Living and dying well

3.3 Delivering specialist level palliative care services

[Commissioners may wish to highlight the sections relevant to their provider and/or detail how each requirement will be achieved locally.

The focus of SLPC is quality of life for people with progressive life-limiting illness and meeting unresolved needs that cannot be met by their core care team. These needs may be physical, psychological, social and/or religious or spiritual. Examples include complex symptoms, rehabilitation or family situations and ethical dilemmas regarding treatment and other decisions.

SLPC services are delivered by an MDT with the requisite qualifications, expertise and experience in offering care for this group of people, to support them to live as well as possible and maintain their comfort and dignity as they come to the end of their lives. Input from SLPC professionals to the care of a person must be based on their needs and not their diagnoses.]

The provider must deliver the key components of a SLPC team: [delete/add as required]

- advanced symptom management:
  - complex symptom management skills
  - knowledge of the deterioration and dying process
  - understanding of rare disorders and their pathways
- parallel planning with condition-specific teams, eg heart failure specialists, respiratory team, complex neurological diseases team – this is appropriate for people whose recovery is uncertain
- support for personalised care and support conversations and advance care planning, including emergency care and treatment planning and accessing NHS continuing healthcare funding and care
- support for end of life decision-making, including preferred place of care if important to the person
- rapid discharge from hospital to hospice or home for care at the end of life
- specialist medical, nursing and therapy support for hospices and community palliative care teams
- specialist equipment in the home [this may be commissioned on a case-by-case basis where unique needs are identified]

- input into MDTs, pre- and debriefs relating to a person's death, and other professional meetings, at hospitals, hospices and in the community
- psychosocial support for patients and their families, and professionals [this may be via referral]
- bereavement support for people with complex needs [this may be via referral]
- education and training programmes [specify which settings].

3.3.1 Specialist level palliative care: multidisciplinary team

[SLPC are delivered by an MDT with the requisite qualifications, expertise and experience in offering PEoLC to people with progressive life-limiting illness and with or without co-morbidities.

The SLPC MDT should have capacity to provide specialist care and support on a 24/7 basis. See section 3.3.2 for SLPC workforce.

The team should work closely with generalist services to achieve seamless care in line with the agreed personalised care and support plan.]

The provider must ensure delivery against the key objectives of a SLPC MDT:
[delete/add as required]

- use the personalised care and support plan co-produced with the patient and their loved ones, and where applicable an advance care plan (or equivalent), and support implementation of a plan where required
- ensure that each person has a named care team who co-ordinate their care and act as a point of contact
- all services required to meet the needs (physical, emotional and psychological) of the patient are engaged and available to access as appropriate
- advise on equipment and resources required to support the patient; ensure this is available at the right time and in the right place
- all medicines and prescribing are available when needed, with appropriate specialist support as required
- all transfers of care are planned for with plans communicated, eg discharge or between care settings

- ensure that the person’s unpaid carers are supported and have their information and practical and emotional needs addressed directly or through signposting to other services
- participate in disease-specific MDTs and offer liaison and a specialist palliative care view to other teams, sharing best practice
- the specialist MDT will deliver training and education as appropriate to professionals (universal and core) and the person’s carers to ensure they have the relevant skills and know when to seek specialist advice. [Commissioner to include details of applicable training arrangements.]

3.3.2 Specialist level palliative care: staffing requirements

The provider must ensure the SLPC MDT include:

- consultants in palliative medicine – who may provide clinical leadership across a number of locality teams
- nurses specialising in palliative care – where a nurse leads a service or has a role with a significant autonomous advisory component, such as in a community or hospital liaison setting or nurse-led outpatient clinic, they should be a clinical nurse specialist in palliative care or nurse consultant in palliative care
- within a locality, the SLPC MDT must have arrangements in place to include input from the following professionals who must have specialist skills and experience in palliative care:
  - physiotherapists
  - occupational therapists
  - social workers
  - practitioners with recognised postgraduate qualifications in psychological care and experience
  - practitioners with spiritual care experience
  - dietitians
  - speech and language therapists
  - pharmacists
  - specialists in interventional pain management
- established liaison with primary care networks and social care, and mechanisms for them to contribute to MDTs.

SPLC MDTs must have adequate administrative and secretarial support, so that professionals can carry out their work efficiently and effectively, and data can be collected for service monitoring, audit and quality purposes.

[As specialists, the MDT have obligations not only to educate and train the wider workforce delivering core palliative care, but also to support and contribute to education and training at pre- and post-qualifying levels, especially in medicine, nursing and allied health professions. The time and resources needed to carry out these obligations fully should be considered in discussions about commissioning services and education and training.]

3.3.3 Specialist level palliative care: liaison services

[These services support the person's care by their usual caring team – in hospital or the community, but with clinical responsibility remaining with the person’s key consultant/GP. A specialist assessment can recommend care provided by the specialist MDT or the usual caring team; in both cases the latter retains clinical responsibility.]

The provider must ensure the SLPC MDT deliver: [delete/add as required]

- review of the person's needs at MDT meetings constituted to consider all specialised level aspects of their care, including, as necessary, a palliative care specialist contribution to the meetings held by the usual caring team. [Examples may include disease-specific multidisciplinary meetings (MDMs) in hospital, palliative care or supportive care meetings in primary care and MDT or individual review meetings in residential facilities.]

3.3.4 Specialist level palliative care: inpatient/residential services

The provider must ensure the SLPC MDT deliver: [delete/add as required]

- bed-based care in a palliative care unit (in hospital or a hospice) or in the person's own home (including care homes)
- assessment of each person's needs and planning of their care and its delivery by medical, nursing and other care staff who specialise in palliative care, in partnership with other practitioners who are not specialists in palliative care
- specialist level support to wider care teams 24/7

- monitoring of progress and mitigation and recording of concerns.

3.3.5 Specialist level palliative care: outpatient services

The provider must ensure the specialist MDT deliver: [delete/add as required]

- specialist needs assessment and care planning in outpatient clinics or day centres in a variety of settings
- outpatient clinics and therapies by clinicians with expertise in palliative care from medicine, nurses, allied health professionals, as well as psychologists, spiritual advisors or social workers whose expertise matches the needs of the person, the people important to them and their carers
- clinical accountability and responsibility for the co-ordination and delivery of the person's personalised care and support plan are shared between the specialist clinician and the person's primary care team in this situation and agreed arrangements must be in place.

3.4 Key service characteristics

[The service characteristics below are structured so as to make clear the links to Ambitions for palliative and end of life care: a national framework for local action 2021-2026.

These should be adapted to available or planned local services.]

The provider must:

Service characteristic	Link to ambitions framework
Referral	
1. Have defined referral criteria that include specialist level palliative care (SLPC) for: a. the person with progressive life-limiting illness and with or without co-morbidities, where the focus of care is on quality of life, including complex symptom control b. the person with unresolved needs that cannot be met by the current team. These needs may be physical, psychological, social and/or spiritual, eg complex symptoms, rehabilitation or family	Ambition 2 and 3

Service characteristic		Link to ambitions framework
	situations and ethical dilemmas regarding treatment and other decisions c. the SLPC service can be offered alongside the active treatment of an underlying condition.	
2.	Have a referral process that includes an auditable system for prioritisation linked to patient outcomes.	Ambitions 2 and 4
3.	Accept referrals based on need rather than diagnosis.	Ambition 1 and 2
Assessment and care		
4.	Provide medical and nursing cover to allow assessment, advice and active management seven days a week, and 24-hour telephone advice. This may require a collaborative arrangement between a number of service providers and joint commissioning, working towards provision of 24-hour access to SLPC advice from a consultant in palliative medicine, including face-to-face assessment where necessary.	Ambitions 2, 3 and 4
5.	Have timely access to the medication and equipment needed for specialist-level inpatient or home-based care. [Commissioner to include specific parameters.]	Ambitions 2, 3 and 4
6.	Work in partnership with people, those important to them and their carers to develop and support personalised care planning, including identifying and recording personal preferences, and helping them navigate to services that will deliver the required information and care, at any time of day or night it is needed.	Ambitions 1 and 4
7.	Identify and assess the needs of those important to the person, including their psychological and social needs; support, and prepare them for the caring role at whatever level; and facilitate access and signposting to other services, including pre-bereavement and bereavement.	Ambitions 1, 3 and 6
8.	Respond to people with protected characteristics in a sensitive and inclusive way, including by providing access to advocacy, translation and interpretation services.	Ambitions 1 and 2

Service characteristic	Link to ambitions framework
9. Use a multidisciplinary approach to care, with a competent workforce with recognised expertise in SLPC and using evidence-based best practice. People must be regularly reviewed and discussed by the MDT, as defined by local operational policy.	Ambitions 3 and 5
Co-ordination and partnership working	
10. Work in partnership with other services and the third sector to meet the person’s needs, ensuring that assessments and personalised care planning are reliably communicated to and co-ordinated with other services involved with the person in a timely fashion.	Ambitions 1 and 4
11. Access and use an electronic palliative care co-ordination system to facilitate this co-ordination, as such systems become available locally, and where the individual agrees to its use.	Ambitions 1 and 4
12. Have a defined operational policy for multidisciplinary and partnership working to include arrangements for MDT meetings, and communication across care settings and organisational boundaries within a quality and governance framework.	Ambitions 4 and 5
Leadership and governance	
13. Have SLPC clinical leadership at senior strategic level within the organisation (eg senior management team level).	Ambition 5
14. Have a suitably resourced quality, IT and governance framework, which should include: • audit and quality improvement methodology • patient-centred outcome and experience measures and user feedback (in keeping with the requirements of the Accessible Information Standard) • data collection and sharing (including shared care records) to aid service improvement at local and national level • adequate access to electronic clinical information, including pathology and imaging • arrangements for engagement in research in line with the service’s objectives	Ambitions 1, 2, 3, 4 and 5

Service characteristic	Link to ambitions framework
• arrangements for all staff and volunteers to be appropriately trained and supported to give competent, reliable, confident and compassionate care.	
15. Be configured and established to lead and/or contribute to the delivery of education, training and continuing professional development to the wider workforce regarding best practice in palliative and end of life care.	Ambition 5
16. Use the growing evidence base to enable the development of innovative practice; share and celebrate good practice.	Ambitions 3 and 5
17. Contribute to and encourage public involvement and engagement in developing compassionate, understanding communities, including through raising local awareness, practical support and planning for future care that meets the needs of local demographics.	Ambition 6

3.4.1 Care planning

[**Personalised care and support planning (PCSP)** involves a series of facilitated conversations with people, or those who know them well, to explore the management of their health and wellbeing within the context of their whole life and family situation. This process recognises the individual's skills and strengths, as well as their experiences and the things that matter most to them. It identifies issues and actions to resolve these.

Personalised care and support planning should be central for anyone receiving palliative and end of life services. It is an essential tool to integrate the services the person accesses, so they have one joined-up plan that covers their health and wellbeing needs. Specialist MDTs can support, provide advice on and, in some circumstances, develop the plan with the patient and their families.]

The provider must:

- implement a framework for recording conversations, decisions and agreed outcomes in a way that makes sense to the individual and their family

- ensure personalised care planning is proportionate, flexible, inclusive, equitable and co-ordinated, and adaptable to a person's health condition, situation and care and support needs
- ensure what matters to the individual is documented, their plan is directed towards these concerns, and all the necessary elements that would make the plan achievable and effective are included.

[NICE (NG142) recommends consideration of **advance care planning (ACP)** for every person with a palliative diagnosis. This is a process of person-centred discussion between the individual and their care providers about their preferences and priorities for future care, while they have the mental capacity for meaningful conversations about these. The process, which may involve a number of conversations over time, must have due consideration and respect for the person's wishes and emotions at all times, and give them the opportunity to reflect and share what matters most to them.]

The provider must offer people support with [the outputs of these discussions may include one or more of the following]:

- developing an advance statement of wishes, preferences and priorities, which may include nomination of a named spokesperson
- an Advance Decision to Refuse Treatment
- nominating a Lasting Power of Attorney for health and welfare who is legally empowered to make decisions up to, or including, about life-sustaining treatment on behalf of the person if they do not have mental capacity at the time, depending on the level of authority granted by the person
- context-specific treatment recommendations, such as emergency care and treatment plans, treatment escalation plans and cardiopulmonary resuscitation decisions
- signposting to organisations that can support a person with sorting their affairs such as drawing up a will.

[The universal principles for advance care planning can be accessed in full.]

[**Note on decision-making**

All decision-making must be within an ethical and legal framework. In the UK clinicians should follow the 2010 General Medical Council guidance on treatment and care towards the end of life.

The NICE guideline on decision-making and mental capacity provides advice on decision-making, assessing mental capacity and advance care planning.]

3.4.2 Personal health budgets

[Personal health budgets (PHBs) give people in their final weeks and months of life the opportunity to have a more personalised experience of care, by widening choice in the care they receive, who provides it and where, and their preferred place of death.

People who become eligible for NHS continuing healthcare funding have a legal right to a PHB.

Commissioner to include any relevant local PHB offers for people in palliative or end of life care, including the pathway and relevant criteria.]

3.4.3 Family and carer needs

[Quality PEoLC includes giving care and support to families, friends, carers and all those who are important to the dying person. This must encompass good bereavement and pre-bereavement care, including for children and young people, and consideration of intergenerational and individual circumstances.]

The provider must ensure:

- processes are in place to assess the needs of the family and loved ones and where possible to address them
- the carers are adequately supported to enable management in a home environment where desired
- where there are opportunities to do so, the family is offered training to enable self-management within the family.

3.4.4 Care of the team

[Supporting a person with PEoLC needs and their wider family and loved ones will at times be emotionally challenging.]

The provider must ensure every member of the team receives support and an opportunity to feedback and discuss what is happening. Professionals as well as volunteers should have access to ongoing support and supervision, mental health wellbeing advice and debriefing sessions with their line manager.

3.4.5 Communication

[Good communication is vital to ensure that the person and their family understand their condition, their plan, their key points of contact and what they may expect in their journey.]

The provider must ensure: [add or delete as required]

- there is a key contact for the person and/or their family/carers who know them and the system well
- communication is sensitive, responsive and the information is understood and where required made available in different formats
- professionals communicate well with each other and work as a team
- the person and their family are listened to about what works for them and what is important
- next steps in treatment and care are always well communicated in advance.

3.4.6 Transition requirements

[It is important for adult teams to be aware of the transition needs of children and young people.

This specification does not set out how transition should be managed as local services will vary in regard to age criteria, but it is important that local commissioners and providers ensure transition processes are in place for children and young people with palliative needs. The process of transition into adult services should begin, where appropriate, at the age of 14. NICE (NG43) makes recommendations for transition.

The provision of palliative care to children and young people is covered in a separate specification, but it is important that young people at a transitional age are catered for within both this adult and the children and young people specifications.]

The provider must ensure there are mechanisms and processes in place to support the transition of young people into adult services.

3.5 Population covered

This specialist palliative care specification is concerned with providing SLPC to adults aged 18 years and older.

[Commissioner to include any relevant local geographical boundaries such as areas covered by GPs or ICBs. Ensure that people who are not registered with a GP are able to access services.]

3.6 Acceptance and discharge criteria

3.6.1 Acceptance criteria

SLPC services should be accessible to adults (aged 18 and over) with advanced, progressive, incurable conditions and people with life-threatening acute conditions. This includes people who are likely to die within 12 months and who are approaching the end of their life, and services should also support their families and carers and others important to them.

[Commissioner to include any relevant local criteria.

The providers of SLPC services will have acceptance criteria that are clear to referrers.

Commissioners may wish to consider:

- what happens where people are not eligible for referral?
- what information is needed locally about services available and how is this accessed?

- what assurances are in place about reducing inequity of access for underserved groups?
- support for integrated cross-sector/agency working
- support for early identification.]

3.6.2 Discharge from SLPC services

A person is usually discharged from SLPC services when they meet the following criteria:

- their and their family's needs can be met by their usual team who have access to specialist support if required
- they no longer wish to have input from the SLPC service
- they move area. Accessing their new local SLPC services should have been discussed and enabled if required, and any necessary handover arrangements made.

3.7 Interdependence with other services/providers

3.7.1 System-wide working

[The services people in need of SLPC require span different sectors and settings. Providers will adopt an integrated approach to planning, contracting and monitoring service delivery across all health and social care sectors.

The NICE quality standard QS13 requires that services are co-ordinated across all relevant agencies and they encompass all phases and complexities of PEoLC. To implement the services, the provider will work with other health and social care professionals in an integrated way to ensure people with SLPC needs, their carers and those important to them receive joined-up and streamlined services tailored to their needs.

In the delivery of an integrated service, interdependence exists between the SPLC services and:

- primary and community providers – GPs, district nurses and out of hours services
- other multidisciplinary specialist teams

- rapid response team
- adult social care services – both in hours and out of hours
- providers of domiciliary care and residential and nursing homes
- other providers of PEoLC services: statutory and voluntary
- providers of acute care
- urgent and emergency care services, including NHS 111 and ambulance services
- providers of services for individuals with long-term conditions
- local authority services.]

3.7.2 Palliative and end of life care clinical networks

[One effective way to achieve more integrated working is through clinical networks. Networks can bring together different organisations to share best practice, and provide a structure through which providers and commissioners can strategically plan service development, with an understanding of patient pathways. They also provide a forum to hear the voices of service users and the benefits of managed co-production.

From 2020/21, seven palliative strategic clinical networks, one for each region, are leading on PEoLC development.]

Providers must communicate and collaborate as required with their palliative strategic clinical network and, where applicable, any other relevant networks such as local clinical networks or managed networks at system level.

Appendix 1: Definitions of key terms

Adult	Refers to everyone aged 18 and over as specified by NICE Quality standard for end of life care for adults (QS13).
Palliative care	WHO definition of palliative care An approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care: • provides relief from pain and other distressing symptoms • affirms life and regards dying as a normal process • intends neither to hasten or postpone death • integrates the psychological and spiritual aspects of patient care • offers a support system to help patients live as actively as possible until death • offers a support system to help the family cope during the patient's illness and in their own bereavement • uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated • will enhance quality of life and may also positively influence the course of illness • is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.
End of life	NICE (QS13) defines end of life as people (aged 18 and over) who are approaching the end of their life. This includes people who are likely to die within 12 months, people with advanced,

	progressive, incurable conditions and people with life-threatening acute conditions.
‘Core’ services	Key palliative and end of life activities that are commissioned and funded by ICBs or local authorities. These are essential non-specialist services, including district nursing, community pharmacy, etc that underpin specialist level palliative care.
Specialist services	Specialist level palliative care (SLPC) services are required for people (all ages) living with more complex and/or long-term conditions which are life-limiting or life-threatening. The needs of this group cannot be met by the capability of their core team alone. This care requires a workforce with specialist skills and experience. They should be commissioned and funded by ICBs, local authorities or a combination of both. The main components of SPLC are: • in-depth specialist knowledge (specialist consultant and specialist nursing services as a minimum) 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 specialist advice and support to the wider care team who are providing direct core level palliative care to the person.
Enhanced services	Non-essential services that contribute to the health and wellbeing of the person and their families. May be funded by charitable monies and will not be routinely commissioned.

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