

Night, weekend and bank holiday Specialist Palliative Care Services

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Working Group from the 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 of Palliative Medicine

1. Exec Summary

This guidance document produced by the Royal College of Physicians (RCP) and the Association of Palliative Medicine (APM) recommends levels of Specialist Palliative Care (SPC) medical and nursing staffing for hospital, community and hospice settings at night, at weekends and on bank holidays. The guidance is a response to a growing understanding, within all parts of health and social care, that it is not enough to provide our services in business hours. This was well articulated by the multi-organisational partnership behind the Ambitions for Palliative and End of Life Care; “Every person at the end of life should have access to 24/7 services as needed as a matter of course. The distress of uncontrolled pain and symptoms cannot wait for ‘opening hours’ All 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”¹

The government has responded to this challenge with a commitment, “that by the end of 2019, every local area should establish 24/7 end of life care for people being cared for outside hospital, in line with the NICE quality standard for end of life care, which supports people’s choices and preferences.”²

To address the challenge, a working group was convened from the Joint Specialist Committee for Palliative Medicine for the RCP, the Specialty Advisory Committee for Palliative Medicine from the JRCPTB and the APM to develop guidance about night, weekend and bank holiday SPC services. The group worked closely with the cancer Vanguard in London and Greater Manchester which had identified seven day SPC services as a priority. The working group gathered evidence from the literature, from comprehensive service evaluations carried out in London and Manchester in 2017, from the APM workforce survey and from case studies gathered by NHSE and NCPC³. Consultation with national bodies and expert groups shaped the guidance (see below).

There is already guidance for seven day working for NHS acute hospital teams^{4,5,6} however, important differences exist between acute and SPC services that make these hospital medical models less helpful:

1. SPC services are available in the community and in dedicated specialist palliative care inpatient centres or hospices as well as in acute hospitals.
2. SPC services outside of hospices are usually advisory, with responsibility for decision-making resting with the named hospital consultant or GP.
3. First assessments and much of care is led by SPC trained nurses making the consultant-led model less applicable.
4. SPC addresses holistic needs which may include but are not limited to acute medical needs.

The purpose of this document therefore is to provide a consensus view on minimum and desirable levels of service for 24-hour telephone advice and face-to-face visiting at weekends and bank holidays in hospices, hospitals and in the community. The intended aim is for providers and commissioners to review their services and to develop them to meet the highest level of desirability. In developing these services, commissioners and providers should be mindful to avoid an adverse impact on weekday services. The document makes recommendations about the level of competency for nursing staff and levels of seniority of medical staff to provide night, weekend and bank holiday services. Models of care are identified, where available, for each level of service.

Recommendations for levels and competency of staff working outside the normal working week may be different to those from Monday to Friday. Firstly, we are not aiming to match the service available at weekends and bank holidays to that available during the week. The evidence does not exist at present to support the massive investment this would require. As a consequence, a professional may work in isolation at weekends and may require a greater level of competency than those working in teams during the week with greater support and supervision.

This document identifies models of care for medical and nursing staff. However, there have been no nationally agreed appropriate competencies for non-consultant SPC staff providing night and weekend services. Banding of nursing staff has been used as a surrogate for competency but is not ideal as many SPC organisations are outside of the NHS and do not follow the same banding levels. The opportunity this presented has been taken up by the national nurse consultant group (Palliative Care), who have developed recommended competencies for senior, advanced and consultant non-medical practitioners (Appendix A).

An opportunity to review competencies of Speciality and Associate Specialist doctors (SAS) has also been recognised but has not yet been addressed by the APM SAS group. We have included in this guidance senior SAS doctors who are available to support other professionals working at weekends and bank holidays. An SAS is, as any registered doctor, autonomous and responsible for working within the bounds of their competence. An experienced specialty doctor in most situations would have the requisite expertise to manage patients in need of palliative care, although they would not be expected ordinarily to have the comparable skills and knowledge of a consultant. The national Terms and Conditions of SAS doctors do not specify any requirement for consultant supervision and the BMA Charter for Staff and Associate Specialist Doctors 2014 states;

“Accountability arrangements should be commensurate with the seniority of the practitioner. Local governance systems should consider BMA policy which supports appropriately skilled and experienced SAS doctors working autonomously. NHS Employers and the General Medical Council have confirmed that there is no contractual or regulatory impediment to SAS doctors working autonomously within defined local governance systems”.

There is also no standard set for the number of staff required to provide face-to-face SPC at weekends and bank holidays. More staff will be required for larger hospitals or greater community populations. In addition, complex populations such as those in cancer centres or other specialist hospital may require more staff. More staff may be required in areas of high deprivation or in rural community areas with greater travelling time between patients.

The guidance does not include or reference non specialist palliative care including generalist hospital and community services and or enhanced services for patients at the end of life not provided by SPC staff. The availability of appropriately resourced generalist services in the acute and community settings is essential for good palliative and end of life care (EOL care).

The guidance is limited to recommendations for nursing and medical staff and does not make recommendations about allied health professionals. The guidance does not make recommendations about SPC service specifications in-hours which has been addressed elsewhere⁷.

The working group identified governance issues which will need to be considered alongside the service models including access to IT systems remotely and securely. Models which use cross-organisational working require honorary contracts, attention to data governance and issues concerning indemnity, especially where third sector organisations are concerned.

The guidance aims to be ambitious but not unrealistic. The authors recognise that SPC services are at very different stages in the development of seven day services. However, it may be helpful to benchmark services and a rag rating is provided in Appendix B.

Pertinent to this document is a caution from the 2016 NHS England document; Specialist Level Palliative Care: Information for commissioners^{7 p8} which reflects that many services will require time and support to meet the levels of service suggested for a variety of reasons. “These may include historical patterns of working, workforce capacity and the ability to recruit and retain specialist staff (which may be more difficult in some parts of the country), capacity to provide education and training for staff and others, as well as the mixed funding streams they reflect. It is vital that these services are not destabilised and so this (guidance) is an indicator of a ‘direction of travel’ for such service providers, supported by their commissioners, to which they should be working. Commissioners can play a pivotal role in bringing providers together and facilitating such dialogue where this is not already happening. “

The guidance was developed in consultation with or using publications from the following groups to whom we would like to express our gratitude;

National EOL Clinical Director

National EOL Regional leads

The national SPC nurse consultants group

The APM Specialty and Associate Specialist doctors (SAS) committee

The Speciality Advisory Committee for Palliative Medicine training

APM Workforce Committee
Hospice UK
National Council for Palliative Care
National Health Service England
Sue Ryder
Macmillan Cancer Support
Marie Curie
APM executive committee

2. Background

2.1 Seven day services in the NHS

Over the last 5 years there has been growing support for providing NHS services at weekends and bank holidays that look more like the care available during the working week^{4,5,6}. This movement has been driven by leaders in the NHS and other healthcare bodies and endorsed widely by professional organisations. For instance;

Dr Nick Bishop, Senior Medical Advisor, Care Quality Commission: “Why should the quality of care you receive depend on the day you are seen? Pressure is increasing from the public and government to provide high quality services to patients in secondary care for seven days a week without the variations currently apparent.”

NHS Medical Director Bruce Keogh: “There is a growing body of evidence to suggest that where there is a lack of access to clinical services over a seven day period, patients do not always experience parity of access to the optimum treatment or diagnostic test. This can result in delays to their treatment that can contribute to less favourable outcomes”⁸

Royal College of Physicians of London (Future Hospital Commission): “Acutely ill medical patients in hospital should have the same access to medical care on the weekend as on a week day. Services should be organised so that clinical staff and diagnostic and support services are readily available on a 7-day basis. The level of care available in hospitals must reflect a patient’s severity of illness. In order to meet the increasingly complex needs of patients – including those who have dementia or are frail – there will be more beds with access to higher intensity care, including nursing numbers that match patient requirements.”⁹

Royal College of Nursing (RCN) (Amanda Cheesley, Professional Lead for Long-Term Conditions & End of Life Care): “Access to specialist support should be available to patients their families and to non-specialist out of hours staff. This may be by phone rather than face to face.”

2.2 Evidence in support of seven day services in acute hospitals

Evidence from a combination of desk-based research of relevant literature, analysis of relevant available data (Hospital Episodes Statistics), self-reported surveys and case-study reports suggests better outcomes for mortality, length of stay, readmission rates and patient experience with seven day services in the general hospital population¹⁰.

The most compelling evidence is for seven day consultant-present care (also applicable to senior SAS doctors) in the context of NHS acute hospital admissions¹¹. This is said to provide benefits including;

- Rapid and appropriate decision making;
- Improved outcomes;
- More efficient use of resources;
- GPs' access to the opinion of a fully trained doctor;
- Patient expectation of access to appropriate and skilled clinicians and information; and
- Benefits of the supervised training of junior doctors.

Improved outcomes from dedicated consultant presence on acute admission wards include lower excess weekend mortality and lower readmission rates¹², as well as a reduction in overall mortality¹³.

2.3 Evidence in support of night, weekend and bank holiday SPC services

The importance of round-the-clock and round-the-week availability of SPC services has been recognised for over a decade, with the 2004 NICE guidance identifying this as a minimum standard¹⁴. In 2016, the NHS England Specialist Level Palliative Care: Information for commissioners⁷ states that the SPC services will “provide medical and nursing cover to allow assessment, advice and active management 7 days a week, and 24-hour telephone advice. This may require collaborative arrangement between a number of service providers and joint commissioning, working towards provision of 24-hour access to specialist palliative care advice from a consultant in palliative medicine, including face to face assessment where this is necessary.”

Where models of 24-hour, seven day access to care have been implemented, evaluation reveals;

- Rapid access to specialist palliative care, 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 into a specialist palliative care bed, at weekends and Bank Holidays

- Prevention of unscheduled acute hospital admissions
- Support for providers of general palliative care, throughout primary and secondary care¹⁵

A review into the failings of the care of the dying pathway, the Liverpool Care Pathway, found that the unavailability of palliative care teams led to poorer experience of care for dying patients and their families¹⁶. Not only did this often result in bad decision-making and communication with patients, their families and carers, but fewer people that wished to could be supported to die at home. The review recommends that patients who are dying in hospital or the community should have funding made available to enable palliative care teams to be accessible at any time of the day or night, both in hospitals and in community settings, seven days a week.

The NHS Services Seven Days a Week Forum identified that the general reduction of services at weekends, across primary/community health settings and social care, combined with a reduced hospital offer, may put additional pressure on, and cause the failure of multi-setting and multi-agency arrangements set up to support people with complex needs, including those in their last days and months of life¹⁰.

The Parliamentary and Health Service Ombudsman report 2015, highlighted the suffering of some patients and carers where there are difficulties accessing palliative care out of hours. “Providing out of hours services – our casework shows the harrowing results when patients cannot get the services they need. For the benefit of their comfort, dignity and wellbeing, all in need should have access to specialist palliative care services whenever they need it¹⁷”

For dying patients admitted under the care of a palliative care team the recommendation, as with general medical admissions is that they be reviewed by a senior clinician at least daily – including weekends and Bank Holidays. “The senior clinician may delegate this responsibility to another clinician who has appropriate training and competence but will remain accountable for the overall care of the dying person.¹⁸”

2.4 Availability of night, weekend and bank holiday SPC services

Despite the minimum standard set by NICE in 2004, there are gaps in SPC provision at nights, weekends and bank holidays across all care settings. A national audit of hospitals conducted by the Royal College of Physicians in England in 2014 found that only 21 per cent of hospitals offered face-to-face access to specialist palliative care seven days a week. Only two per cent of hospitals provided round the clock access¹⁹. A pan-London SPC service evaluation in 2014 revealed that only 70% of community and 30% of hospital SPC teams were providing seven day face-to-face visiting²⁰.

There are some areas of the UK where there is seven day face to face SPC visiting and senior telephone support 24/7^{3,15}. These services are often collaborations between the NHS and third sector organisations – often hospices. NHS England and the National Council for Palliative Care published seven case studies demonstrating solutions organisations had found to the challenge of night, weekend and bank holiday working³. Models such as these and other examples shared during this work will be offered as potential solutions for the recommended levels of service.

Information about medical consultant work patterns is available from the 2016 APM workforce survey²¹. Of a total of 603 UK SPC consultants, 407 consultants responded (67%). The majority (91%) provide some level of on call service. The majority of UK Consultants (>90%) provide telephone advice on call to hospices and community palliative care teams and 66% for hospital palliative care teams. 77% undertake emergency face-to-face reviews in hospices but only 32% are available for hospital and 29% for community face-to-face reviews²¹. Consultants commonly cover multiple organisations (sometimes more than 5) for telephone advice or face to face visit out of hours.

Table 1. SPC Medical Consultant on-call and sites provided 2016²¹

	Hospice	Hospital	Community
Telephone advice OOH	85%	70%	75%
On call emergency face to face	70%	32%	23%

3. Nursing competencies for night, weekend and bank holiday SPC services

These are the nursing competencies required to deliver a night, weekend and bank holiday (OOHs) specialist palliative care service. Many services have established core competencies for nurses working within specialist palliative care services which should be adhered to. These specific competencies contextualise those required for the delivery of a safe and effective OOHs service where the nurse (usually a sole practitioner) will be faced with additional challenges in response to unpredictable clinical needs either face-to-face or via telephone advice. These challenges include; the usual day-time services not being available; the need to make autonomous complex decisions; and assessing and managing risks in a lesser resourced situation.

Nurses providing an OOHs service should be competent in both the established core competencies and these additional specific competencies for the delivery of OOHs service and be able to draw on their knowledge, skills and experience.

This document defines the specific nursing competencies to be achieved by Registrants in Nursing, at senior or advanced practitioner levels to deliver OOHs specialist palliative care.

The competencies are based around:

- 1 Clinical/direct patient care
- 2 Leadership and collaborative practice
- 3 Improving quality and developing practice
- 4 Developing self and others.

Specific competencies are identified and colour coded for Nursing Registrants practicing at Senior (Red) or Advanced (Blue) practitioner levels (note the titles are aligned with Levels 6-7 of Skills for Health (2010) Career Framework).

In achieving the competencies, the advanced practitioner will also meet the competencies of the senior practitioner. It is evident that the competencies required for the delivery of a safe and effective OOHs service demands that the nursing practitioner will be working autonomously and therefore the additional competencies of the advanced practitioner are required in more complex cases as described in the framework.

The consultant practitioner will meet the competencies of both the senior and advanced practitioner and would be recognised in a similar way to the medical consultant in providing a higher level of expert clinical practice, critical reasoning, application and synthesis of knowledge.

4. Recommended models of care and staffing for delivery of seven day specialist palliative care across settings

The following section suggests various models for the delivery of seven day specialist palliative care across different settings and includes both nursing and medical cover. The document initially sets out the minimum recommended level of service and staffing. This document refers to both the medical and nurse consultant roles. It is important to recognise that both of these roles will offer differing levels of expertise and support. It then provides a description of escalating levels of desirable services and staffing beyond the minimum.

4.1 Specialist Palliative Care 24 hour telephone advice all settings

Minimum specification	
<i>Definition</i>	Specialist Palliative Care telephone advice to healthcare professionals

	in all settings and patients and carers where known to the SPC service
<i>Staffing</i>	Senior nurse practitioner 1 st line providing urgent response telephone advice 24/7 with triaged access to an advanced nurse practitioner and/or SPC medical advice at Specialist Trainee 3+ (St3+) when required, with support provided by a palliative medicine consultant or consultant nurse practitioner or SAS doctor recognised as competent to work autonomously in palliative medicine Or; St3+ doctor in palliative medicine or equivalent providing urgent response telephone advice 24/7 supported by a palliative medicine consultant or consultant nurse practitioner or SAS doctor recognised as competent to work autonomously in palliative medicine
<i>Models</i>	Typical model is hospice based with calls taken first by a senior nurse on shift. During working hours, these calls may be directed to the CNS if community related Medical back up may be through a hospice medical on-call rota For hospital services 24 hour telephone SPC advice is often procured through non-hospital organisations/hospices

Level 1 Desirable specification	
<i>Definition</i>	Specialist Palliative Care telephone advice to healthcare professionals in all settings and patients and carers where known to the SPC service
<i>Staffing</i>	Advanced nurse practitioner 1 st line providing urgent response telephone advice 24/7 with triaged access to SPC medical advice at St3+ when required, with support provided by a palliative medicine consultant or consultant nurse practitioner or SAS doctor recognised as competent to work autonomously in palliative medicine Or; St4+ doctor in palliative medicine or equivalent providing urgent response telephone advice 24/7 supported by a palliative medicine consultant or consultant nurse practitioner or SAS doctor recognised as competent to work autonomously in palliative medicine
<i>Models</i>	As above but will require more senior staff 1 st line

Level 2 Desirable specification	
<i>Definition</i>	Dedicated SPC telephone advice line manned 24 hours a day by trained staff available to healthcare professionals and patients and carers in all settings
<i>Staffing</i>	Senior nurse practitioner 1 st line providing telephone advice 24/7 with triaged access to an advanced nurse practitioner and/or SPC medical advice at St3+ when required, with support provided by a palliative medicine consultant or consultant nurse practitioner or SAS doctor recognised as competent to work autonomously in palliative medicine
<i>Models</i>	1. Model may be hospice based, calls taken by senior nurse on shift. During working hours, these calls may be directed to the senior or

	<p>advanced nurse practitioner if community related</p> <p>Medical back up may be the medical on-call rota</p> <ol style="list-style-type: none"> 2. May be linked to single point of contact 3. May be linked to urgent care centre 4. May be linked to clinical decision units 5. May include access to telemedicine – eg Airedale model
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Level 3 Desirable specification	
<i>Definition</i>	Dedicated SPC telephone advice line manned 24 hours a day by trained staff available to healthcare professionals and patients and carers in all settings
<i>Staffing</i>	Advanced nurse practitioner 1st line providing urgent response telephone advice 24/7 with triaged access to SPC medical advice at St3+ when required, with support provided by a palliative medicine consultant or consultant nurse practitioner or SAS doctor recognised as competent to work autonomously in palliative medicine
<i>Models</i>	As above

4.2 Face to face visiting weekends and BHs

4.2.1 For hospital or community settings

Minimum specification	
<i>Definition</i>	Face to face SPC visiting Saturday, Sunday and BHs
<i>Staffing</i>	<p>1st on call either;</p> <p>Senior nurse practitioner with experience in relevant SPC setting on site 9-5 with support provided by telephone and urgent face to face advice if required from a palliative medicine consultant or consultant nurse practitioner or SAS doctor recognised as competent to work autonomously</p> <p>Or;</p> <p>St3+ doctor in palliative medicine or equivalent on site and visiting 9-5 supported by a palliative medicine consultant or consultant nurse practitioner or SAS doctor recognised as competent to work autonomously in palliative medicine</p>
<i>Models</i>	<p>Typical model is hospital or community based and delivered by SPC senior nurse practitioners or SPC StR doctors providing the 1st line service.</p> <p>Consultant on-call most likely to be cross-site or single site depending on intensity of need and size of hospital/community population and must be recognised with either time of in lieu and/or appropriate recognition in job plan</p>

Level 1 Desirable specification

<i>Definition</i>	Face to face SPC visiting Saturday, Sunday and BHs
<i>Staffing</i>	1 st on call either; Advanced nurse practitioner with SPC experience in relevant SPC setting and appropriate competency for setting on site 9-5 with support provided by telephone and urgent face to face advice if required from a palliative medicine consultant or consultant nurse practitioner or SAS doctor recognised as competent to work autonomously in palliative medicine Or; St4+ doctor in palliative medicine or equivalent on site and visiting 9-5 supported by a palliative medicine consultant or consultant nurse practitioner or SAS doctor recognised as competent to work autonomously in palliative medicine
<i>Models</i>	Some hospices are setting up Emergency Palliative Care Assessment Units which may be attached to hospice/ Hospital Medical Assessment Unit/ Community Single point of access service where patients could be assessed OOH by SPC staff. May result in admission or discharge back home but avoid A and E.

Level 2 Desirable specification	
<i>Definition</i>	Face to face SPC visiting Saturday, Sunday and BHs
<i>Staffing</i>	As in minimum or desirable level 1 plus; palliative medicine consultant or consultant nurse practitioner or SAS doctor recognised as competent to work autonomously in palliative medicine for set routine agreed hours Sat, Sun and BH
<i>Models</i>	May be achievable through cross-site working for example, with a consultant doing a ward round at the hospital and then the hospice with defined sessions which must be recognised with either time of in lieu and/or appropriate recognition in job plan Some hospices are setting up Emergency Palliative Care Assessment Units which may be attached to hospice/ Hospital Medical Assessment Unit/ Community Single point of access service where patients could be assessed OOH by SPC staff. May result in admission or discharge back home but avoid A and E.

4.2.2 Hospice

Hospices currently provide 24/7 care for their in-patients but there is variability in the availability of enhanced clinical review and support including the practice around admitting patients at weekends and Band Holidays.

Minimum specification	
<i>Definition</i>	Care of hospice inpatients 24/7 Senior nurse practitioner on site providing care with triaged access to

	SPC St3+ medical telephone and face to face advice when required, with support provided by telephone and face to face advice from a palliative medicine consultant or consultant nurse practitioner or SAS doctor recognised as competent to work autonomously in palliative medicine
<i>Models</i>	Patients requiring admission at weekends and night would need to be seen by usual medical and nursing team in the community and may need to be admitted to hospital

Level 1 Desirable specification	
<i>Definition</i>	Care of hospice inpatients 24/7 and hospice admissions seven days a week Senior nurse practitioner on site providing care with triaged access to SPC St3+ medical telephone and face to face advice when required, with support provided by telephone and face to face advice from a palliative medicine consultant or consultant nurse practitioner or SAS doctor recognised as competent to work autonomously in palliative
<i>Models</i>	Consensus view is that all hospice units should be moving towards 24/7 admission of patients although this is not achievable in some areas yet

Level 2 Desirable specification	
<i>Definition</i>	As minimum specification plus proactive telephone or face to face ward round by a palliative medicine consultant or consultant nurse practitioner or SAS doctor with appropriate competency in palliative medicine with option of face to face patient reviews by senior doctor as required.
<i>Models</i>	Some hospices run “board rounds” or virtual ward rounds with discussion with SAS doctor or consultant of all patients/all seen at the weekend

Level 3 Desirable specification	
<i>Definition</i>	As minimum specification plus palliative medicine consultant or consultant nurse practitioner or SAS doctor with appropriate competency in palliative medicine visiting for set agreed hours Sat, Sun and BH
<i>Models</i>	This could be face to face one weekend day or half a day Saturday and half a day Sunday.

5. Workforce Challenges

There will be medical workforce implications depending on the models and levels of service delivery adopted.

The current recommendations for specialised level palliative care (Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives, December 2012) which describes the minimum workforce to support working week services: Per population of 250,000, the MINIMUM requirements are:

- Consultants in palliative medicine – 2 full-time equivalent (FTE)
- Additional supporting doctors (e.g. trainee/specialty doctor) – 2 FTE
- Community specialist palliative care nurses – 5 FTE

Inpatient specialist palliative care beds MINIMUM requirements:

- 20-25 beds with 1.2 nurse: bed ratio

Per 250-bed hospital, the MINIMUM requirements are:

- Consultant/associate specialist in palliative medicine – 1 FTE
- Hospital specialist palliative care nurse – 1 FTE
- This is dependent on the type of hospital provision and specialist services provided

These recommendations are probably insufficient to meet growing levels of need in the population and an increase in non-cancer activity.

5.1 Medical

5.1.1 Consultant

- There has been no expansion of UK Consultants in palliative medicine with headcounts of 609 and 603 in 2015 and 2016 respectively, and only represent 471 and 459 FTEs, (Table 2. SPC speciality advisory committee for training (SAC) data 2015 and 2016) as 61% and 66% are working less than full-time (LTFT). Overall the participation ratios are reduced to 77% and 76% and partly explained by the fact that 74% of the consultant workforce is female (RCP Census 2015-16).
- The UK palliative medicine consultant vacancies are 61 posts (53.8 FTE) using SAC data September 2016, with approximately 30 new posts in development. Hence the current average annual number of 40 doctors competing SPC training is inadequate to meet the existing and anticipated annual consultant vacancy rates.
- The self-reported planned average retirement rate is 4-5 consultants per year in 2016-2020 increasing to 13-14 annually for 2021-2026 (RCP census 2015-2016) and 58 anticipated retirements over the next 5 years (SAC data 2016).
- A significant decline in the number of appointments of SPC Consultants in 2015 (RCP data 2016) decreased by 30% from 70 to 49 with 34 appointed (69%).

- There are on average 40 specialty trainees annually achieving their certificate of completion of specialist Training (CCT). Over the last 5 years, 87% of trainees are female (JRCPTB data) and taking into account maternity leave, LTFT in both male and female trainees, and out of programme experience the average length of training increases from 4 to 5 years.
- With the extension of palliative care activity to non-malignant disease, end of life and supporting patients during active treatment and in survivorship, this is likely to increase the overall workforce need.
- There is regional variation in the number of Consultant FTEs per population; to address this consideration needs to be given to the recruitment of additional funded National Training Numbers in those geographical areas with the lowest FTE per population.
- The majority of UK Consultants (>90%) provide telephone advice on call to hospices and community palliative care teams and 66% for hospital palliative care teams. 77% undertake emergency face-to-face reviews in hospices but only 32% available for hospital and 29% for community reviews²¹.

Table 2 .UK Consultants by Country.

UK Consultants	England	N Ireland	Scotland	Wales
SAC 2015				
N = 609	505	20	49	35
FTE = 471	385.6	17.3	39.2	29.2
SAC 2016				
N = 603	500	18	51	34
FTE = 457.6	376.1	13.2	39.25	29.05
RCP 2015-16				
N = 586	484	18	51	33
FTE = 497	411	15	43	28

Table 3. UK Consultant provision of seven day services²¹

	Hospice	Hospital with Palliative Care Team	Hospital with <u>No</u> Palliative Care Team	Community with Palliative Care Team	Community with No Palliative Care Team	Not applicable	Total
Where do you provide Consultant 9am-5pm reviews?	228 (67%)	227 (67%)	12 (4%)	193 (57%)	9 (3%)	10 (3%)	340
Where do you provide Consultant face-to-face planned OOH review?	130 (43%)	35 (11%)	8 (3%)	26 (9%)	5 (2%)	165 (54%)	305
Where do you provide emergency consultant face-to-face on call?	228 (70%)	104 (32%)	28 (9%)	76 (23%)	13 (4%)	78 (24%)	328
Where do you provide 9am – 5pm telephone advice?	235 (71%)	242 (73%)	44 (13%)	236 (71%)	32 (10%)	15 (5%)	332
Where do you provide on call telephone advice?	287 (85%)	234 (70%)	107 (32%)	251 (75%)	60 (18%)	27 (8%)	336

5.1.2 Specialty Trainees

Specialist training in palliative medicine is unique amongst the medical specialties. The training programme aims to produce physicians with a breadth and depth of experience and

competence to work safely as a consultant in palliative medicine in any care setting in the UK, and within the NHS and charitable sectors.

The curriculum is covered through a sequence of posts in a training rotation. Trainees occupy posts that provide experience of palliative medicine in a full range of settings including patients' own homes, day hospices and hospice inpatient units and other inpatient specialist palliative care units, outpatients and general hospitals.

The training to be provided at each training site is defined to ensure that, during the programme, the entire curriculum is covered. The current Curriculum requires that; "doctors will learn to manage emergencies in palliative care through working on call for a minimum of 20 full weekends (Saturday - Monday) during the delivery of this curriculum, for units and teams who accept out-of-hours admissions and/or referrals. They will also provide out of hours advice to non-specialist colleagues". Work based experiential learning is also provided by specialty-specific out-of-hours admissions and/or referrals. This will include out of-hours telephone advice to non-specialist colleagues. Trainees should have the opportunity to discuss their on-call clinical activity and receive feedback from their clinical supervisor.

With Training occurring over multiple sites, current changes to the structure and terms of junior doctors training and a predominant LTFT trainee workforce, unique challenges to the provision of a 7 day SPC service arise;

- In the UK, RCP 2015-16 Higher Specialist Training (HST) Census reported 218 trainees (161 FTE), 177 female (81.2%) and 41 male (18.8%); England 189 (140 FTE), Wales 9 (7 FTE), Scotland 14 (10 FTE) and Northern Ireland 6 (4 FTE). SAC data 2016 reported 240 (201.9 FTE) UK trainees with 35% working LTFT. See Table 4.
- There are on average 40 specialty trainees annually achieving their certificate of completion of specialist Training (CCT). Over the last 5 years, 87% of trainees are female (JRCPTB data) and taking into account maternity leave, LTFT in both male and female trainees, and out of programme experience the average length of training increases from 4 to 5 years.
- 89% of trainees undertake on-call telephone advice with 94% providing face-to-face emergency reviews in hospices, 30% in hospital and 30% in the community. (APM Workforce survey 2016).
- A new contract for Junior Doctors in England has now been implemented. For core medical trainees' this is in effect from August 2017. For HST in palliative medicine this is in effect from October 2017 (at the latest). The terms and conditions of the new contract limit working hours to :
 - not more than 1:2 weekends
 - not more than one consecutive 24 hour shift/on-call unless a weekend

- limit of 8 consecutive shifts then 48 hours off, unless low intensity = <3hrs shift and ≤3 episodes of work then 12 consecutive shifts allowed
- 8 hours rest and 5 hours between 10pm-7am.
- These terms and conditions will impact upon CMT and HST availability to provide out of hours, on call cover and telephone advice will require “time of in lieu” during the “normal working week”. Exception reporting is required for work outside this work plan. Individual services and encouraged to work with the local HR department in drawing up Rota’s which are compliant with these terms and conditions.
- Shape of Training may result in a shorter length of time in specialty training that may influence voluntary sector hospices to fund speciality doctors rather than speciality trainees (StRs) that could potentially reduce the annual output of the numbers of consultants.
- The estimated need is for 60 StRs to undertake HST annually to achieve the number of CCTs required each year to fill the current 50 FTE consultant vacancies, the 30 anticipated new posts over the next 5 years and to support the increasing workload of existing post-holders. However, no increase in training numbers is expected in the current financial climate. The annual average output of 40 CCTs is not sufficient to cover the demand of >60 consultant posts each year.

Table 4. Comparisons of UK Higher Specialty Trainee Numbers (RCP and SAC 2015-2016 data).

Registrars	RCP 2015-16	SAC 2015	SAC 2016
UK	218 (161 FTE)	236 (204 FTE)	240 (201.9FTE)
England	189 (140 FTE)	202 (175 FTE)	209 (175.2 FTE)
Northern Ireland	6 (4 FTE)	7 (6.4 FTE)	7 (6 FTE)
Scotland	14 (10 FTE)	14 (12.5 FTE)	13 (11 FTE)
Wales	9 (7 FTE)	13 (10.4 FTE)	11 (9.7 FTE)

5.1.3 SAS doctors

- SAS doctors make a significant contribution to the medical workforce yet their contribution tends to be are under-reported.

- SAC 2016 data indicate there are 482 (293 FTE) SAS doctors of whom 78% work LTFT.
- The APM Survey 2016 included SAS grades.
 - For the UK 81 SAS doctors (84%) responded, 88% of who are female.
 - 79% provide on call for telephone advice; 92% covering hospices; 87% covering community services, and 27% covering acute hospitals
 - 71% undertake emergency face-to-face reviews with the majority (88%) covering a combination of hospice and community services.
- SAS doctors will need expansion and appropriate development to support service models, which require these doctors to be available on Saturdays, Sundays and Bank Holidays.
- The APM SAS committee intend to use the opportunity to develop competencies relating to clinical responsibility. A report about SAS doctor development and summary of resources and further work has been produced by the Academy of Royal Medical Colleges and others²⁴ which will be used as a basis for the ongoing work along with the end of life competencies from other areas of the United Kingdom and Ireland.

5.2 Nursing

- There is a national aging nursing workforce and recruitment will be challenging even if funding is made available locally. NCPC's workforce survey has run since 2008, surveying specialist palliative care providers across England, and in each year of the survey the reported proportion of specialist palliative nurses aged over 50 has increased from 30% to 40%. (NCPC workforce survey 2013).
- There is a shift to challenge current nurse bandings in view of present financial constraints. It is thus essential that nurses have appropriate competency to provide advice at weekends and bank holidays.
- Limited access to funding to develop career pathways and undertake post-registration continuing professional development/postgraduate level study also impacts on the development of nursing staff.
- There is growing population of patients both cancer and non-cancer
- Macmillan Cancer Support identified a gap of 3,400 CNSs across the UK which they estimate will rise to 7000 by 2030.²⁵
- A report by The King's Fund (Workforce Planning in the NHS 2015) highlights serious continuing problems with nurse shortage staffing levels, which trusts are solving by using temporary nursing staff in the absence of sufficient permanent workers. In addition the number of trusts requesting temporary shift cover is increasing, which may indicate

that these nursing shortages are becoming more widespread. Furthermore, the number of senior district nurses has fallen by 30 per cent (a reduction of nearly 50% in the last 11 years) and there are 16 per cent fewer community matrons. This together with significant cuts in social care budgets has reduced the number of available support staff to provide personal care to people in the last days of life. These changes in the workforce are the result of a combination of; an aging workforce; inadequate training and succession planning for workforce needs: an aging population and; demand exceeding the available resources.

The consequences of these recent trends in nurse staffing, will impact on the provision of a seven day specialist palliative care nursing provision in terms of:

- The availability, recruitment and retention to senior, advanced and consultant level nursing posts
- Opportunities for personal / professional development
- Patient choice and preferences at the end of life
- Poor continuity of care
- Low staff morale
- Risk of burn out.

To address these challenges Macmillan Cancer Support recommends²⁵;

- Improving career pathways to and through specialist (cancer) roles.
- Improving skill mix and introducing new types of cost-efficient roles.
- Enhancing the skills and confidence of existing staff, and communication between them.
- Improving ways of working.
- Exploring how new ways of understanding the (cancer) population can be utilised to support workforce planning based on need rather than tumour type.

The modelling to deliver these services will require innovation and potentially cross site/ locality working.

6. Governance issues

The key clinical governance areas are threefold: structure, processes and accountability. When a service may be delivered across different settings by health care professionals who are employed by different organisations, have differing skills, varying clinical practices and different levels of understanding of the organisation with which they are delivering care, the governance issues become increasingly complex.

Table 5. Areas to be considered in relation to seven	Structure	Processes	Accountability
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day working with examples below;			
Generic governance issues for seven day working across settings	Tiered approach Clear pathways Access to clinical information	Handover and Handback Information governance Clinical practice-uniform and evidence based. Agreement re protocols and clinical guidelines Audit/QA Uniform services	Education and Training Feedback Supervision and support Clinical responsibility Service user and public involvement Management of complaints/serious incidents Competencies/skills Contracts

6.1 Structures;

- Requires dedicated telephone line/pager number/mobile number for clarity
- Standard call/visit recording form/electronic record
- Information about the advice line and how this information is shared with acute and community generalist teams.
- Require secure remote access to clinical information
- An indication of availability of the line to patients/carers in their area or a plan to develop the line for use by patients and carers.

6.2 Processes;

- Data governance
- Monitoring of activity
- Regular audit of service eg recording, quality of advice given,
- Clear procedures for handover for key unstable and complex cases. Resources such as BMA's Safe Handover, Safe Patient²⁶ may be useful .
- Clear procedures for handback to patient's responsible team and /or shared access to the episode and advice provided. Electronic recording through shared IT systems will support better information sharing.

- Lines of communication between out of hours service providers
- Access to operational links for the exchange of clinical information with the relevant health and social care teams
- Clear procedures for recording and reviewing advice
- Use of information sharing agreements need to be formalised
- Clear clinical guidelines and protocols
- For telephone advice lines, evidence of how a record of calls and advice given is kept and reviewed by a senior clinical member of staff and frequency monitored.

6.3 Accountability;

- Training in IT systems for all sites covered
- Training to achieve competency in role
- An understanding of the organisation and the levels of clinical expertise in those settings. This is especially important where staff are working in different organisations at weekends.
- Details and frequency of training provided to and competencies of staff.
- Evidence of regular audit on the use of line and outcome of advice and action plans formulated.
- Honorary contract for all organisations covered (with HR and Occupational health clearance)
- Indemnity for doctors covering non-NHS organisations
- Service level agreement for cross-organisational services
- Agreed competencies for providing each level of service
- Employing organisation responsible for assuring competency

7. Examples of Models of Care from England and Wales

- Ambitions for Palliative and End of Life Care - 24/7 Models of Care. Seven case studies from English SPC services in different settings³.
- North Wales:
 - An OOH telephone advice line delivered by Palliative Medicine Consultants and Associate Specialists with face to face medical assessments in exceptional circumstances due to geographic area
 - CNS seven day service 9-5, split in to three areas (each approximately 200,000)
- South East Wales:
 - Three Health Boards and all provide 7/7 CNS face-to-face services 9am - 5pm across all statutory areas in community and hospital areas. There is access to one 24/7 advice line.

- Routine weekend review in all settings does vary depending on service type i.e. whether a specialist palliative care inpatient service or hospital / community service
- Use of urgent care hubs should be explored as means of coordinating centralised SPC services for nights, weekends and bank holidays over a larger geographical area. Ambulance hubs are also an option for centralised SPC services
- Wales model for Face-to-face cover In North East and Central North Wales on Saturday, Sunday and bank holidays there is one CNS covering This service provides face to face and telephone assessment and advice. In North West Wales there is a CNS providing cover for the district general and Llandudno DGH and hospice at home nurse providing community.

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Appendix A. Nurse competencies for Saturday, Sunday and Bank Holiday working

Summary of Definitions, Guidelines and Guidance for Best Practice: Framework for the development of the EoLC Outcomes

Context of Palliative / EoLC Delivery (Gormondi, 2013a, b)	Role Title / Level (Skills for Health, 2010; DH, 2010)	Theme of Practice (DH, 2010; NHS Wales, 2010; NHS Scotland, 2008; GMC, 2009; NMC, 2010; HCPC, 2013a,b,c; HCPC, 2012) Clinical / Direct Patient Care	Academic level and workplace preparation
Specialist Palliative Care	Level 8 Competency Consultant Practitioner	Consolidation and continuing development focused on clinical / direct patient care (and includes telephone advice)	Masters/Doctorate level Workplace learning/ experience
	Level 7 Competency Advanced Practitioner		Postgraduate level (Masters, Postgraduate Diploma, Postgraduate Certificate, Modules)
	Level 6 Competency Senior		Continuing professional development Workplace

	Practitioner		learning/experience
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With kind permission from NHS Health Education Yorkshire and the Humber, End of Life Care Learning Outcomes for Unregistered Support Workers, Pre-qualifying Students, Registered Professionals in Health and Social Care (Taylor, 2017).

End of Life Learning Outcomes for senior and advanced level practitioners providing 7-day specialist palliative care out of hours services

Please note the numbering reflects the original *HEE End of Life Care Learning Outcomes* document (Taylor 2016).

<p>Theme of Practice</p> <p>(DH, 2010; NHS Wales, 2010; NHS Scotland, 2008; GMC, 2009; NMC, 2010; HCPC, 2013a,b,c; HCPC, 2012)</p>	<p>Common Core Principles and Competences for Social Care and Health Workers Working with Adults at the End of Life</p> <p>(Skills for Health and Skills for Care, 2014)</p> <p>Outcomes informed by Speciality Training Curriculum for Palliative Medicine</p> <p>(Joint Royal Colleges of Physicians Training Board, 2014)</p> <p>Five Priorities for Care</p> <p>(The Leadership Alliance for Care of Dying People 2014)</p>	<p>Registered Practitioner – Specialist Palliative Care</p>	<p>Senior Practitioner – Specialist Palliative Care</p>	<p>Advanced Practitioner – Specialist Palliative Care</p>
<p>1 Clinical Practice/Direct Patient Care</p>	<p>1.1 Communication Skills: The practitioner will be able to:</p>			
	<p>1.1b Develop and maintain communication with people about difficult and complex matters or situations related to end of life care.</p>			
	<p>1.1c Present information in a range of formats, including written and verbal, as appropriate to the circumstances.</p>			

	1.1f Work with colleagues to share information appropriately, taking account of issues of confidentiality, to ensure that people receive the best possible care.			
	1.1i (<i>Modified outcome</i>) Apply knowledge of evidence and skills related to breaking bad news in order to effectively break bad news or convey uncertainty in a range of formats, written or verbal, as appropriate to the circumstances.			
1 Clinical Practice/Direct Patient Care	1.2 Assessment and Care Planning: The Practitioner will be able to:			
	1.2c Assess pain and other symptoms in ways appropriate to your role, including using assessment tools, pain history, appropriate physical examination and relevant investigation. Know when to refer concerns to specialist colleagues.			
	1.2h Communicate with a range of people on a range of matters in a form that is appropriate to them and the situation.			
	1.2m (<i>Modified outcome</i>) Elicit a relevant focused history as part of a holistic assessment and rapid appraisal from patients with complex end of life care needs/issues and in increasingly challenging situations, including prioritising the patient's agenda encompassing their beliefs, concerns, expectations and needs. Document and report the history/assessment accurately			
	1.2n (<i>Modified outcome</i>) Synthesise relevant focused history and assessment with appropriate clinical examination, establishing a problem list/differential diagnosis (relevant to own professional group) and formulate a management plan that takes account of likely clinical evolution.			
	1.2o Communicate effectively, including managing any disagreement, a management plan to the multi-professional team, other services/agencies and the patient applying the			

	principles, guidance and laws regarding ethics and confidentiality.			
1 Clinical Practice/Direct Patient Care	1.3 Symptom management, maintaining comfort and well-being: The Practitioner will be able to:			
	1.3a (<i>Modified outcome</i>) Demonstrate knowledge/understanding that symptoms have many causes, including the disease itself, its treatment, a concurrent disorder, including depression or anxiety, or other psychological or practical issues and develop an appropriate management plan.			
	1.3i (<i>Modified outcome</i>) Independently review and monitor interventions and management plans, including medications and non-medication based interventions, identifying indications, contraindications, side effects, drug interactions and dosage of commonly used drugs communicating appropriately to multi-professional team, patients (and carers).			
1 Clinical Practice/Direct Patient Care	1.4 Advance Care Planning: The Practitioner will be able to:			
	1.4b (<i>Modified outcome</i>) Demonstrate understanding of the legal status and implications of the Advance Care Planning process and apply these in accordance with the provisions of the Mental Capacity Act 2005.			
	1.4g (<i>Modified outcome</i>) When appropriate, establish what the Advance Care Planning statement contains, and how this will impact upon a person's care and support.			
	1.4j (<i>Modified outcome</i>) Co-ordinate optimal care for the imminently dying patient and their family including: Recognition of the dying phase, assessment of the dying patient, assessment of required care and medications, management of symptoms in the dying phase, psychological care of			

	the family, recognition and engagement with ethical dilemmas in the dying phase, and appropriate use of relevant/required end of life care documentation.			
1 Clinical Practice/Direct Patient Care	1.6 Knowledge: The Practitioner will be able to:			
	1.6a Demonstrate awareness of own professional role and boundaries.			
	1.6f (<i>Modified outcome</i>) Select appropriate approaches to risk assessment, risk management, risk taking and escalation.			
	1.6k (<i>Modified outcome</i>) Apply professional and legal frameworks with regard to patient consent, confidentiality, autonomy, advance directives, mental health legislation, organ donation, communicable disease notification, legal aspects related to patients death.			
2 Leadership & Collaborative Practice	The Practitioner will be able to:			
	2.3 (<i>Modified outcome</i>) Demonstrate a range of leadership behaviour appropriate to different situations in own practice.			
	2.7 (<i>Modified outcome</i>) Explain the role, availability of, and indications for, referral of other services to facilitate delivery of palliative and end of life care in any environment (hospice, hospital, care homes, day care and the patient's home).			
3 Improving Quality & Developing Practice	The Practitioner will be able to:			
	3.3 Critically appraise own and other clinical practice to identify strategies to improve/enhance palliative and end of life care for individual patients and their carers.			
	3.7 Lead service improvement/quality improvement programmes within own service			

	drawing on service user feedback/engagement where available/appropriate.			
4 Developing Self & Others	The Practitioner will be able to:			
	4.4 (<i>Modified outcome</i>) Recognise limitations of own knowledge, skills, professional role, professional boundaries, the effect of personal loss or difficulties – being able to ask for help or hand over to others where necessary.			
	4.5 Demonstrate support of professional colleagues, recognize the manifestations of stress on self and others, and being aware of where and when to look for support.			

Appendix B. Rag rating example

	Locality 1	Locality 2	Locality 3	Locality 4	Locality 5	Locality 6
Specialist Palliative Care 24 hour telephone advice all settings						
Minimum	A	Y	Y	N	N	Y
Level 1	N	Y	N	N	N	A
Level 2	N	N	N	N	N	N
Level 3	N	N	N	N	N	N
Face to face visiting weekends and BHs For hospital or community settings						
Minimum	N	Y	Y	Y	N	Y
Level 1	N	A	N	N	N	Y
Level 2	N	N	N	N	N	N
Face to face visiting weekends and BHs For Hospice						
Level 1	A	N	Y	A	N	Y
Level 2	N	N	N	N	N	N
Level 3	N	N	N	N	N	N

KEY

A
Y
N
NR

Amber - Almost at level
 Yes - meets
 No - does not meet
 Not relevant for this site