



APM response to the development of the Palliative Care Modern Service Framework (MSF)

The APM welcomes the priority given to palliative care and end of life care as one of five proposed modern service frameworks (MSF). The government has recognised there is unwarranted variation in access to palliative care and end-of-life care in England¹

The Government is progressing work on this, and much of the detail remains to be developed. There are a number of areas where we anticipate significant focus will be required:

1. Funding

The geographical variation in access to palliative care services arises from inconsistent funding of services. It is clear that there is no new money, with a focus on more efficient use of existing resources. Given the chronic under-resourcing of palliative care services, the MSF needs to have clear levers to shift money into palliative care services and reduce the substantial reliance on charitable funding.

Earlier, effective and coordinated specialist palliative care saves money through reduced hospital bed days while also improving patient experience². ICBs and health providers investing in palliative care will save money compared to the current model of care. However, initial funding to invest in services will be required before those savings are realised. The MSF will need to explore in detail the mechanism whereby financial savings can be transacted, enabling funding to be moved around the healthcare system to eliminate geographical variation and to develop new approaches to ensuring equitable outcomes for all patients, addressing known unmet needs

Pump priming or transformational funding is usually required to improve an aspect of palliative care provision, prior to efficiency savings being realised. Most healthcare services are too stretched currently to provide such pots of funding.

2. Commissioning

The detail is awaited on the commissioning model for children and adult hospice funding. Palliative Care services are currently provided by a combination of NHS and hospice services. It is crucial that a funding model is developed that leads to co-ordinated, integrated services delivering key patient outcomes, irrespective of the organisational form. Greater specification of what is being provided by hospice services and how this fits within NHS specialist palliative care services is required.



Tel: 01489 668332 Email: Office@compleat-online.co.uk Website: www.apmonline.org.

We agree with the focus on proactive primary & community care, rather than reactive acute care. We welcome the commitment to earlier identification of need, care delivered closer to home by integrated generalist and specialist teams and strengthened out-of-hours health support, including dedicated 24/7 telephone advice. These palliative care services have been shown to improve care and save money.

Specialist palliative care is required in all settings; acute hospitals are also often where the palliative care needs of people are first recognised and assessed, and where nearly half of all people receive care when they are dying. Commissioning must encompass Specialist Palliative Care in all settings, and the coordination between them. When the NHS has multiple priorities, the MSF needs to ensure there are core KPIs and outcome measures to drive improvements.

3. Measurable impact

The only way to eliminate unwarranted variation in Palliative Care service provision is to enforce clear metrics and hold areas and providers to account. The government has recognised there are several documents which set out what palliative care services should be available to all communities. The MSF must have KPIs on availability and access to these services, that are publicly available and accountable. The effectiveness of services must also be measured; national reporting of patient outcomes data collection and patient experience would provide an excellent basis for benchmarking and incentivise ICBs and provider organisations to raise the quality of their services to those areas providing consistently high quality, integrated care.

4. Workforce: more detail awaited in workforce review

The absolute number of SPC doctors has increased in recent years. However, England lags significantly behind other countries. Having pioneered the development of Palliative Care services in the world, the UK is now ranked 20th in the world.³ The UK has approximately 0.85 WTE Consultants per 100,000 population, whereas Australia and Ireland, both ranked higher than the UK, the corresponding national recommendation is 2 WTE Consultants.⁴

5. Training

Identification of need, good communication and decision making are rightly recognised as key elements required for high quality care. Training is required for staff at all levels in a range of skills to feel confident in dealing with some of the most challenging situations a health and social care professional will face. Digital education models such as eELCA have an important role to play, but other models will be required for acquisition of skills relating to communication and decision-making of complexity.



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6. Public education around normal dying and palliative care

The debate on assisted dying has highlighted the low level of death literacy. Without an improvement in death literacy, there is a major barrier in recognising a patient's situation towards the end of life and being able to plan ahead. It also creates a barrier to accessing appropriate services. Specialist Palliative Care services are most effective when started at least 3 months before death, whereas it is currently around two weeks. A funded Public Health campaign around death literacy is a key part of improving palliative care and empowering our populations to both engage well with services and remain in control of their lives.

7. Clinical engagement and leadership

We believe passionately in the importance of developing this MSF as a vehicle to improving care and believe it is urgently needed. Whilst development of policy at pace is laudable, it is more important that a framework is produced that achieves the improvements intended, particularly given multiple initiatives in this area that have not succeeded. We are concerned that a 'policy sprint' with minimal notice for engagement events is at risk of excluding clinical leaders who have an in-depth knowledge of palliative and end of life services.

Within palliative care, clinical leadership to inspire, engage and drive system change across multiple care providers has always been essential and needs to be factored into to any initiatives. There is also a strong track record of sharing innovation for which clinical networks are hugely fruitful. In recent years, the ability of clinicians to engage in planning and delivering services has reduced due to increasing clinical pressures and changes in job planning. The supporting resource for clinical networks across localities, regionally and nationally has atrophied markedly, with a detrimental effect on learning and reducing duplication. We would welcome the MSF recognising the importance of clinical leadership and clinical networking.

Written by Dr Suzanne Kite (President) and the executive of the APM



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References

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