HospiceUK

Hospice service models

A practical guide to the principles and resourcing of care for adults and children

September 2025

HospiceUK

About Hospice UK

Hospice care eases the physical and emotional pain of death and dying. Letting people focus on living, right until the end.

But too many people miss out on this essential care. Hospice UK fights for hospice care for all who need it, for now and forever.

Acknowledgements

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Introduction

Since modern hospice care took its first pioneering steps more than 50 years ago, various descriptors have arisen to identify and label the delivery of emerging models of care and these models are accompanied by a plethora of referral pathways and access routes. However, variations in language used to describe these service offers do not always reflect that employed at health and care system levels, thus risking impact on service visibility.

Intended for hospice providers and commissioners, this publication describes service models operating according to escalations in acuity and urgency within hospice care provision for adults and children across the UK. It seeks to identify and detail the elements of service approaches based upon five underlying principles and the core components of those services, whilst also describing the populations served and staffing skill mixes required.

In providing clear understanding of the constructs of standard service models, this document supports the planning, commissioning and delivery of palliative and end of life care for local populations across the UK. It enables systems to map current and projected population need against good standardised service provision principles when planning synergistic service investment.

The models outlined here work to avoid crisis admissions, as well as enabling living well and counteracting isolation and loneliness; thus underpinning effort to reform healthcare in a shift from treatment to prevention.

The contents of this document also speak to the emerging emphasis across the UK nations on neighbourhood health services delivering responsive integrated care closer to home along with a concomitant shift from analogue to digital ways of working[1, 2, 3, 4, 5, 6, 7], and ultimately demonstrates further the intrinsic value that hospices bring to community and system partners.

How to use this publication

This document outlines the mix of core services which comprise delivery of modern hospice care across the UK. It explains what elements should be present when designing and commissioning hospice care support. It does not, however, specify quantities or combinations because this is a matter for local communities to decide according to the contexts of population need and building upon assets and partnerships.

Page 41 provides an overview of the staff roles required for each service model.

For approaches to planning for need across all UK nations, see the 'Framework for commissioning independent hospices in England', published in 2025 and available from Hospice UK.

For guidance on planning, monitoring, and demonstrating staffing requirements, see the Safe and effective staffing improvement resource, published by Hospice UK in 2025.

1 NHS. Commissioning and investment framework for palliative and end of life care. April 2022
2 NHS England. Standardising community health services. [Internet] 2025 [Updated 30 Jan 2025] [cited 01 Sept 2025].
3 NHS England. Neighbourhood health guidelines 2025/26. [Internet] [Updated 30 Jan 2025] [cited 01 Sept 2025].
4 Scottish Government. NHS Recovery Plan 2021-2026: annual progress update report 2024. [Internet] 2024 [cited 01 Sept 2025].
5 Great Britain. Parliament. Fit for the future. London: Stationery Office. 2025.
6 Department of Health. Health and Social Care NI: A three year plan to: stabilise, reform, deliver. 2024.
7 Welsh Government. A healthier Wales: our plan for health and social care. [s.l.]: Welsh Government; 2021.

Introducing hospice care

The demand for hospice care is on the rise; as many as 90% of people who die in the UK could benefit from receiving palliative care[8]. The rate of deaths per year in the UK is rising faster than the population is growing, meaning that the proportion of the population who die each year will increase. By 2040, around 130,000 more people in the UK will die each year than in 2023[9]. This escalating need within the UK is illustrated in Figure 1 below which shows projected deaths and palliative care needs in the UK from 2020 to 2043.

Figure 1. Projected deaths and palliative care need – UK 2020-2043

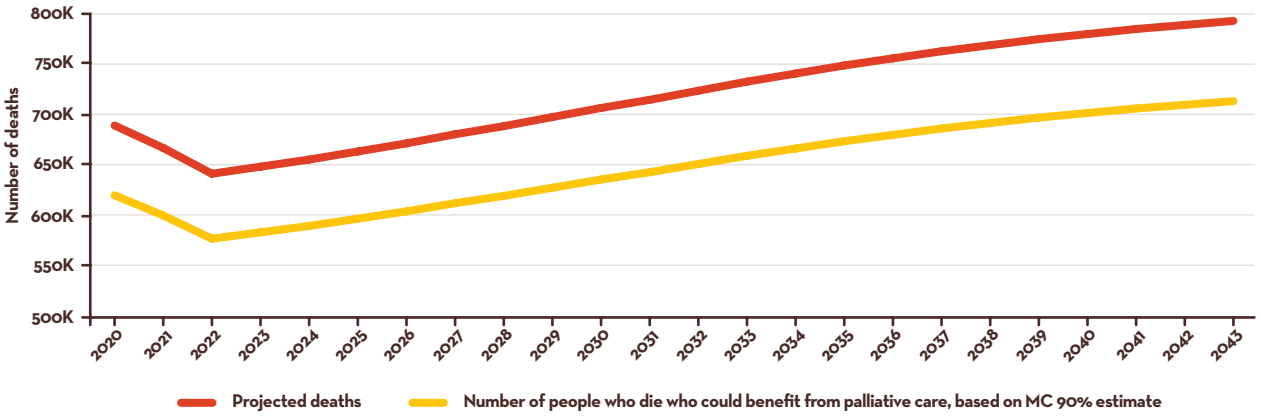


Chart based on data from ONS National population projections: 2020-based interim, released 12 January 2022, Murtagh et al. (2014) How many people need palliative care? and Marie Curie (2023), Updated estimates of palliative care need across the UK, 2017-2021

Hospices are a critical part of the health and care system that provides palliative and end of life care in the community – in people's homes and in specialist inpatient units. As the models presented here indicate, strong relationships with primary and secondary care providers are integral to effective palliative care.

In 2023-2024, hospices across the UK provided palliative and end of life care to 310,000 people; they also provided direct support services to 92,000 family members, friends and carers[10]. Activity service data for this same period shows that 18% of hospices' total service activity was delivered in an inpatient unit whilst 55% of hospices' total activity was delivered at the person's place of residence[10] – thus underlining the intrinsic value of hospice staff to neighbourhood health teams.

Hospices provide palliative care, specialist palliative care and end of life care to people with a life-limiting or terminal condition. This holistic approach aims to improve quality of life and support people to live well until they die. Hospice care includes support for physical needs, such as pain management and stabilising a person's condition, as well as meeting their emotional, psychological and spiritual needs. Importantly, hospices provide care at different stages of a person's illness, not just at the end of life.

8 Marie Curie. How many people need palliative care? Updated estimates of palliative care need across the UK, 2017-2021. Marie Curie; 2023.

9 Based on data from: Office for National Statistics. National population projections: 2020-based interim [Internet]. 12 Jan 2022. [cited 01 Sept 2025] & Office for National Statistics. Vital statistics in the UK: births, deaths and marriages [Internet] 24 Feb 2023. [cited 01 Sept 2025].

10 Data taken from Hospice UK's hospice activity and demographic survey, 2023-24. 82% of Hospice UK members providing direct hospice services responded to the survey. The data provided has been used to calculate figures for UK hospices as a whole.

In addition to caring for adults, hospices play a crucial role in supporting children and young people who have been diagnosed with a life-limiting condition, and those people important to them. And the need for this care is on the rise[11, 12, 13].

The range of services that hospices provide typically include living well services, clinically-led outpatient and other community based care, along with inpatient services. The provision of short breaks is an important aspect of care for children and young people. There are also bereavement support, befriending and compassionate neighbour initiatives which are mainly delivered by volunteers. Support for those important to a patient including family members and others in caring roles is a key part of hospices' work.

Education and research are foundational elements of hospice care and hospice education teams provide significant value to local health systems by enhancing the knowledge and skills of health and social care professionals across the system in providing quality palliative and end-of-life care. Indeed, regular training in palliative and end of life care to upskill patient-facing healthcare staff is recommended in order to build understanding of the importance of recognising the need for, and early introduction of palliative care[14, 15].

Hospices play a crucial role as key community assets by providing compassionate palliative and end of life care, which enhances the quality of life for patients and those important to them. They contribute significantly to social capital by fostering a sense of community, support, connectedness and solidarity. In connecting communities, many hospices model the Asset Based Community Development approach[16] to identify what is important to a community and bring people together to share their strengths and take appropriate action. This includes supporting the development of death literacy[17] within local communities – of which there are many examples beyond those mentioned here[18, 19, 20].

Volunteers working in palliative care are invaluable, offering emotional support, companionship, and practical assistance, which not only supports healthcare professionals but also enriches the lives of those they assist. Their dedication and empathy help create a nurturing environment that values the importance of human connection and dignity in the final stages of life. Volunteers work across all types of hospice service models including bereavement support, counselling and compassionate neighbour schemes.

Hospice care is founded upon the principle of person-centred care and the approaches outlined here reflect what good looks like from an individual's perspective[21, 22] – this means that in operation the models support access to information, honest open communication, best interest decision-making, and coordinated care and symptom management, accompanied by compassionate care for patients and those close to them, as well as family support after death.

The care provided by hospices is free at the point of use and funded partly by the statutory sector but mainly by the voluntary sector.

11 Fraser LK, Gibson-Smith D, Jarvis S, Norman P, Parslow R. 'Make Every Child Count' Estimating current and future prevalence of children and young people with life-limiting conditions in the United Kingdom: final report February 2020.

12 Public Health Scotland. Children in Scotland requiring Palliative Care (ChiSP) 3. Edinburgh: Children's Hospices Across Scotland; 2020.

13 Fraser L, Bedendo A, Jarvis S. Children with a life-limiting or life-threatening condition in Wales: trends in prevalence and complexity: final report May 2023.

14 The National Confidential Enquiry into Patient Outcome and Death. Planning for the end: A review of the quality of care provided to adult patients towards the end of life. London: NCEPOD; 2024.

15 Commission on Palliative and End-of-Life Care. Palliative and end-of-life care: opportunities for England. Vol. 1. Commission on Palliative and End-of-Life Care; 2025.

16 Nurture Development. About ABCD. [Internet] [2018] [cited 01 Sept 2025].

17 Death literacy has been described as 'the knowledge and skills that people need to make it possible to gain access to, understand, and make informed choices about end of life and death care options'. Graham-Wisener L, Toner P, Leonard R, et al. 34 Death literacy in the UK – benchmarking levels of death literacy and validating a new measure. BMJ Support Palliat Care. 2022;12:A14.

18 Tapping House. Compassionate communities. [Internet] [cited 01 Sept 2025].

19 Treetops Hospice. Compassionate communities project. [Internet] [cited 01 Sept 2025].

20 St Mary's Hospice. Compassionate communities [Internet] [cited 01 Sept 2025].

21 National Palliative and End of Life Care Partnership. Ambitions for palliative and end of life care: a national framework for local action 2021-2026. [Internet] [2021] [cited 01 Sept 2025].

22 Chambers L. A guide to children's palliative care. 4th ed., Bristol: Together for Short Lives; 2018.

Key definitions in the context of hospice care

Palliative care

Palliative care is an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual[23].

End of life care

End of life care is defined for adults (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. It also covers support for their families and carers[24]. For children and young people, the trajectory of illness may be much longer and last year of life is not useful terminology.

Specialist palliative care

Specialist palliative care services are for people of all ages living with more complex and / or long-term conditions which are life-limiting or life-threatening. This care is provided by staff who work solely in this area to bring in-depth specialist knowledge to the management of physical, psychological and spiritual needs. These staff also provide specialist advice and support to wider care teams in health systems.

Children's hospice care

Hospice care for children is an active and total approach to care which has commonalities with, but is distinct from palliative care for adults. The care for babies, children and young people may be offered in parallel with and alongside curative treatment, or treatment aimed at significantly prolonging life[22] and it can be provided throughout the course of a child or young person's life. It includes 'the management of symptoms, anticipatory planning, parallel planning and crisis provision through death and bereavement'[25] and the unit of care is that of the child and their family. Additional dimensions such as the importance of play and access to education will call upon the engagement of different services in a whole system best interest response to a child's ongoing physical, emotional and cognitive development. Long illness trajectories highlight the importance of support to enable the transition from child-centred to adult palliative care services.

23 World Health Organization. Palliative care: key facts. [Internet] 2020 Aug 05. [cited 01 Sept 2025].
24 National Institute for Health and Care Excellence. End of life care for adults. {QS13] [Internet] 2011 Nov 28 [Updated 2021 Sept 02] [cited 01 Sept 2025].
25 NHS England. Specialist palliative and end of life care services: children and young people service specification. [Internet] 2023 [cited 01 Sept 2025].

Who has access to hospice services?

Hospice care is available to people with progressive life-limiting illness with or without co-morbidities, where the focus of care is on quality of life, including complex symptom control. It is an approach that supports people with unresolved needs that cannot be met by their existing care team. These needs may be physical, psychological, social and / or spiritual – for example, relating to the management of complex symptoms, rehabilitation or family / carer breakdown.

A specialist palliative care service can be offered alongside the active ongoing treatment of an underlying condition and enables effective management of clinical uncertainty of recovery. Notably, timely access to specialist palliative care is important to provide optimum treatment and quality of life[26].

Hospice care for adults is provided for people aged 18 years and above. Children's hospices provide palliative care from antenatal and neonatal stages through to young adulthood.

No one should miss out on hospice care when they need it. But some groups and communities are missing out and there is a pressing need to do more to reach them[27]. Understanding and meeting individual needs, and providing culturally safe care along with the provision of advocacy, translation and interpretation services are all part of the vital response to these inequities.

26 Johnson MJ, Rutterford L, Sunny A, Pask S, de Wolf-Linder S, Murtagh FEM, et al. Benefits of specialist palliative care by identifying active ingredients of service composition, structure, and delivery model: A systematic review with meta-analysis and meta-regression. PLoS Med. 2024 Aug 2;21(8):e1004436. doi: 10.1371/journal.pmed.1004436.

27 Tobin J, Rogers A, Winterburn I, Tullie S, Kalyanasundaram A, Kuhn I, et al. Hospice care access inequalities: a systematic review and narrative synthesis. BMJ Support Palliat Care. 2022; 12(2):142-151. doi: 10.1136/bmjspcare-2020-002719. Epub 2021 Feb 19.

Key principles underpinning hospice care service models

The hospice care service models outlined within this document are based upon five key principles.

Principle 1:

A population health management approach

Robust, good quality data is fundamental to effective service development in support of better end of life care access, experiences and outcomes for people.

A population health management approach with its emphasis on data-driven planning is key to identifying palliative care need. It requires the assessment of palliative care need across the populations of hospices' catchment areas and takes account of epidemiology, demography, socioeconomic factors as well as indices of deprivation[28].

Hospice UK's population needs assessment tool, PopNAT[29], is an interactive tool which brings together relevant and up to date population data for end of life care across the UK. The tool supports hospices and decision makers in understanding and planning palliative and end of life care services for their local populations.

Informed decision-making, planning and drives to improve patient care require access to good data across the system and more must be done at this level to include and embed hospice data in collection exercises. This is a process of constant refinement, asking what do we need, what do we have, is it effective?

To demonstrate the contribution and value of hospices and evidence impact, Hospice UK undertakes regular collections of service activity, workforce and finance data.

Principle 2:

Service design is informed by patients' voices and those important to them

First and foremost hospice care is about people, and the voices of patients and those close to them in designing, developing and improving services is critical. Learning from lived experiences enables evidence-informed service delivery which highlights the value of research activity such as the findings from a national post-bereavement survey, the QUALYCARE survey, conducted in 2023 across England and Wales[30] and the recent refresh of the Palliative and End of Life Care Priority Setting Partnership[31].

28 Tebbit P. Population-based needs assessment for palliative care: a manual for cancer networks. London: National Council for Hospice and Specialist Palliative Care Services; 2004.

29 Hospice UK. PopNAT. [Internet] [cited 01 Sept 2025]

30 Johansson T, Pask S, Goodrich J, Budd L, Okamoto I, Kumar R, et al. Time to care: Findings from a nationally representative survey of experiences at the end of life in England and Wales. Research report. London: Marie Curie; 2024.

31 Marie Curie. Research priorities for palliative and end of life care Identified and prioritised by people with lived and/or professional experience. [Internet] 2025 [cited 01 Sept 2025].

Principle 3:

Based on an integrated care approach

In essence, integrated care describes person-centred coordinated care[32] and this approach is vital in providing better, less fragmented care across health and social care, and community services for people – especially those with complex needs and long-term conditions. It focuses upon whole system collaborative working to address the palliative care needs of the population so that primary care, secondary care, social care, specialist palliative care and end of life care are coordinated to achieve the best outcomes. It also places emphasis on effective communication systems in place across settings and removes duplication so that an individual receives the right care at the right time in the right place and by the right person. However, the delivery of integrated care is dependent upon an understanding of local populations and their needs, along with the establishment of multi-disciplinary health and care teams and collaborative, accessible digital shared care plans[33].

Principle 4:

The workforce is supported and equipped to care

As the work of the Commission into the Future of Hospice Care pointed out, a truly integrated approach to end of life care is most likely to be achieved when health professionals and social care staff share a common vision and range of skills to work together to the benefit of the person who is dying and their family and carers[34]. This means that staff and volunteers across settings and sectors need to be confident within the context of their roles in the principles and practice of high quality palliative care.

Hospice education departments play a crucial role in equipping community, health and social care partners across the system with the knowledge and tools they need to ensure that everyone has access to quality care. Key areas of palliative care addressed by hospice education programmes include topics such as symptom management, future care planning, psychological support, communication, care after death and bereavement.

Equally, clinical supervision models and staff support are imperative and central to the recruitment, retention and wellbeing of the workforce. National policy recognises that giving 'care day in and day out requires organisational and professional environments in all settings that ensure psychological safety, support and resilience'[21].

Clinical supervision in end-of-life care supports professionals, enhancing their practice and ensuring that patients and their families receive quality care. It addresses practical and emotional complexities inherent to work in end of life care. It can offer a safe space for staff to process their emotions, alleviate workplace pressures such as stress, anxiety and burnout, whilst time to reflect upon clinical practice helps professionals to develop skills and identify areas for improvement[35].

Principle 5:

Evidence-informed

Optimal outcomes for patients are predicated on service models and delivery strategies which are grounded on the best available evidence. Plugging the gap between research, other evidence and clinical practice is vital to the development of robust models of care[36]. This knowledge helps to identify services and interventions which provide the greatest value, enabling healthcare systems to allocate resources effectively.

An active commitment to the systematic and ongoing process of quality improvement to enhance service delivery goes hand-in-hand with this approach.

32 National Voices. A narrative for person-centered coordinated care. Gateway ref. no: 00076. London: NHS England; [2013].

33 Darzi A. Independent investigation of the National Health Service in England. 2024.

34 Help the Hospices Commission into the Future of Hospice Care. The future of hospice education and training: a working paper of the Commission into the Future of Hospice Care. Help the Hospices: London; 2013.

35 Health & Care Professions Council. The benefits and outcomes of effective supervision. [Internet] [Updated 27 Sept 2021] [cited 01 Sept 2025].

36 Davidson P, Halcomb E, Hickman L, Phillips J, Graham B. Beyond the rhetoric: what do we mean by a 'model of care'? Aust J Adv Nurs. 2006;23(3):47-55.

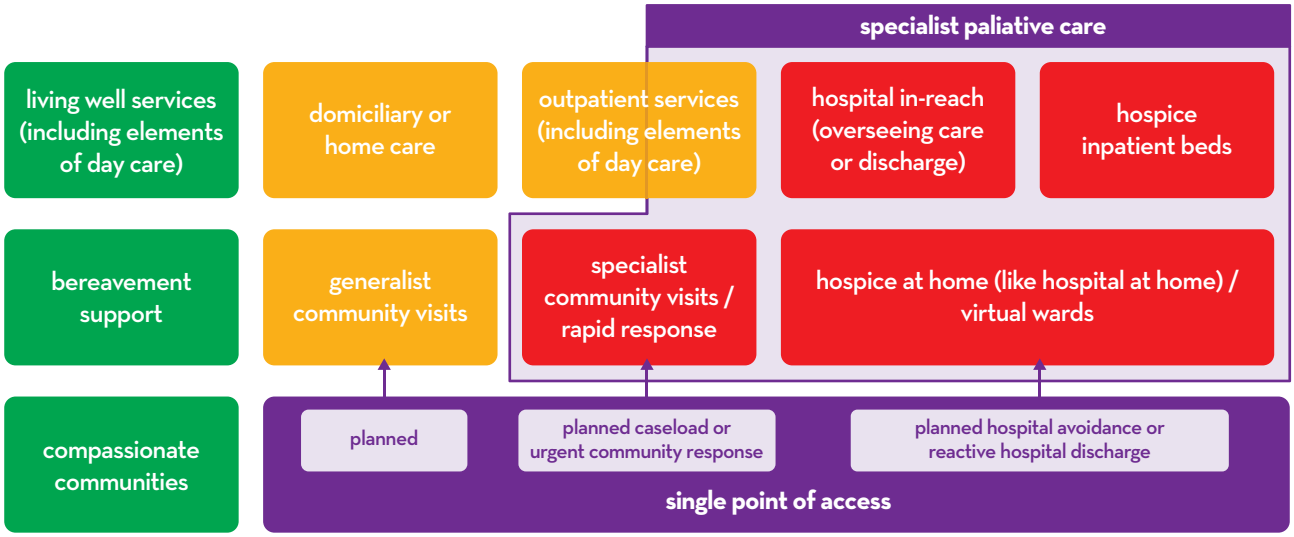
Hospice service models by acuity and urgency

To date, the services provided by hospices have lacked application of consistent descriptive terminology and this resource is a work in progress response to this deficit.

Here we describe standard hospice service models according to increasing escalation in acuity and urgency as well as their deployment according to reactive or planned timescales. An overview is presented for each service type, along with a summary of its constituent elements, intended beneficiaries, workforce composition and other features such as delivery environment, outcomes and quality standards.

Figure 2 shows the progression of service engagement across patients' care pathways.

Figure 2. Hospice service models by acuity (green, amber, red) and urgency (planned, reactive)



Devised by Annette Alcock and Anita Hayes, Hospice UK, 2025.

We begin with a description of the principal entry routes to the progression of hospice care as clinical and support needs direct.

Access routes to escalations in hospice care support

Many hospices offer compassionate community and bereavement care services as part of their service offer and these provisions serve also to raise awareness and the profile of hospice support more generally.

Compassionate Communities and bereavement support services

Compassionate Communities offer a public health approach to palliative and end of life care which recognises that enabling more people to die at home requires the support of the wider community. This is a point explained by Kellehear's '95% rule' which notes that patients may have contact with healthcare services for up to 5% of their time, as opposed to the 'civic and neighbourhood networks that make up 95% of the patient's and caregiver's worlds at the end of life'*. In essence, Compassionate Communities in an end of life care context are about supporting community capacity through collaborative social connections with groups of people who support each other during advanced illness, in caregiving, and in bereavement. Hospices may offer a variety of community-based support to help tackle loneliness and isolation, with services such as 'Neighbours' companionship programmes, social events and sessions designed to help people feel more comfortable in talking about dying, death and bereavement.

Hospices are an important provider of bereavement care services in their local health and social care systems. The traditional hospice model offers bereavement support or counselling for family and friends of hospice patients and 440,000 appointments were provided in 2023/24**.

Some hospices have developed bereavement support offers for the wider community and along with involvement in public health approaches to palliative and end of life care plus compassionate communities initiatives, such activities help equip people who live and work in a community to better understand loss and bereavement. Additionally, hospices may also be actively involved in training health and care professionals in bereavement support knowledge and skills.

*Kellehear A. The social nature of dying and the social model of health. In: Abel J & Kellehear A. Oxford textbook of public health palliative care. Oxford: Oxford Academic; 2022.

**Data from Hospice UK's Hospice activity and demographic survey, 2023-24.

However, the logic presented here focuses on two primary entry points within hospice care services which pave the way to accessing more intense or urgent community-based and inpatient support as required. Here we describe Living Well Service support and Single Point of Access in some detail.

As Johnson et al point out, 'Timely involvement in response to relevant concerns at any point during an individual's illness should be the standard of care'[26]. Palliative care can be appropriate from the point of diagnosis, not just in the last 12 months of life. This point is echoed by the Commission on Palliative and End-of-Life Care which remarked upon the value of early palliative care in improving outcomes for people[15].

At earlier points in the trajectory of an illness, responsibility for patients' clinical care lies outwith the hospice. At these stages following diagnosis and alongside curatively focused care, people may be referred to a hospice's Living Well Service in order to benefit from a rehabilitative approach to support which integrates enablement, self-management and self-care to maintain wellbeing. In turn, Living Well Services can act as a conduit to other services provided by a hospice.

Whilst broader in focus, compassionate communities programmes complement and can act as referral points to Living Well Service support.

Single Point of Access is broadly defined as a means of simplifying access to other care and clinical services 'by offering clinicians advice and guidance to support onward referral, ensuring patients get the right care for their needs quickly and safely, to improve patient outcomes regardless of where they present'[37]. This route applies particularly for patients where specialist palliative care has become a clinical need.

Referrals to these services can be via health and care professionals, but access to Living Well Services in particular may be through self-referral.

37 NHS England. Single point of access (SPoA): Guidance to support winter resilience 2024/25. [Internet] [Updated 09 Sept 2024] [cited 01 Sept 2025].

Living Well Services

It is fifty years since the first purpose built day care unit opened at St Luke's Hospice (Sheffield) in 1975. Whilst the nomenclature evolves and we see increasing numbers of hospices choosing to describe their day care provision as Living Well Services, the essence of this care is unchanged. It is a model of care providing access to specialist palliative care from the wider hospice multidisciplinary team – with emphasis, as described by the Association of Palliative Day Services, on a group context of social interaction and support, where 'meaningful relationships are paramount'[38].

Service overview

Living Well Services are designed for adults, children and young people with palliative care needs and their carers / families. They are intended for those who wish to access early rehabilitative approaches and strategies to maintain their wellbeing. The service promotes a proactive, person-centred approach, enabling individuals to stay as well as possible and optimise their quality of life, and also plan for their future care. They also provide pre- and post- bereavement support, often delivered by trained volunteers.

Living Well Services encourage patients to engage in activities that enhance physical, emotional, and social wellbeing, while also offering support in future care planning and shared decision-making, thus addressing anxiety and potential future unwanted hospital admission. This emphasis on rehabilitation, symptom control, and future care planning bridges the gap between active treatment and palliative care.

Arts and crafts activities, gardens with accessible play equipment and the provision of facilities such as hydrotherapy pools, multi-sensory rooms and programmes of family events help support children, young people and their families with age-appropriate activities in having fun, creating memories and connecting with others.

A Living Well Service is part of the wider palliative care network of provision, ensuring patients receive holistic support in collaboration with primary care, hospital services, and community-based /neighbourhood teams. Many hospices accept self-referral into the Living Well Service. (See page 16 for an 'In action' example).

Who it is for

A Living Well Service is designed for individuals who:

- Have a palliative / terminal diagnosis but are in the earlier stages of their illness.
- Are experiencing manageable symptoms but wish to maintain and enhance their wellbeing through early rehabilitation.
- Require support with planning ahead, including future care planning, to ensure their wishes are known and respected.
- Wish to develop self-management strategies to cope with their illness.
- May be seeking emotional, social, psychological, financial support as they navigate their illness trajectory.

Importantly, the service also helps carers and families by providing emotional support and education to assist and support them in their caring roles.

38 Association of Palliative Day Services. About. [Internet] [cited 01 Sept 2025].

The approach

The philosophy of care is based on wellbeing, empowerment, and proactive future planning – ensuring patients feel supported and in control of their health and future. The Living Well Service model is grounded upon:

- Rehabilitation and self-management: helping patients to maximise independence and functional ability through early rehabilitative palliative care approaches, including physiotherapy and occupational therapy to maintain function.
- Holistic symptom management: addressing physical, psychological, emotional, and spiritual needs in a proactive manner.
- Planning ahead: supporting patients to make informed decisions about their care ahead through structured future care planning discussions.
- Emotional and social support: enabling patients to connect with others, share experiences, and access psychosocial care.
- Family and carer involvement: ensuring families and carers are included in the process of care, with support and guidance to help them in their caring roles.

For children and young people, service elements offered at the hospice or in the home environment allow families to spend time together doing fun and memory-making activities, as well as opportunities for parents to re-set. Hospices for children and young people will also provide a dedicated service offering emotional and social support to siblings of babies, children and young people receiving care from the hospice.

Service key components

- Personalised wellbeing plans. Each person receives an individualised wellbeing plan, co-created with a multidisciplinary team, which includes rehabilitative goals, symptom management strategies, and social or emotional support needs. Access to financial advice and support is important.
- Early rehabilitation. People are supported through physiotherapy, occupational therapy, and exercises aimed at maintaining or improving physical function and independence. This may include mobility training, fatigue management, and techniques to manage breathlessness or pain.
- Self-management support. Individuals are empowered to take control of their symptoms and condition through education, training in self-management techniques, and lifestyle advice. This may include, for example, cognitive behavioural therapy.
- Future care planning. The service offers structured discussions to help people plan for the future, covering areas such as preferred place of care, advance directives, and decisions regarding medical management.
- Holistic symptom management: the service focuses on managing both physical symptoms (such as pain or breathlessness) and emotional symptoms (such as anxiety or depression), ensuring that patients are as comfortable as possible.
- Wellbeing and social activities. Hospice care may offer a range of group activities, such as mindfulness, relaxation, creative therapies, and social events, which encourage peer support and help patients engage in meaningful experiences.
- Play and fun activities. Living Well Services for children and young people will include play and fun activities made inclusive for all children to enjoy. Children's hospices may also support play in community settings.
- Family and carer support. The service offers advice, education, and emotional support to families and carers in appropriate formats, including guidance on future care planning and ways to manage the demands of being a carer, including education for carers. Evidence-based and validated tools such as the Carer Support Needs Assessment Tool Intervention (CSNAT-I)[39] are used to identify, express and prioritise domains where carers need more support.

39 CSNAT Intervention. The Carer Support Needs Assessment Tool Intervention (CSNAT-I). [Internet] [cited 01 Sept 2025].

- Regular reviews and monitoring. A person's progress and wellbeing plans are regularly reviewed, with input from the multidisciplinary team, to ensure that goals are met and interventions are adjusted as needed. Outcome measures are used routinely and systematically to assess a person at their first visit and subsequently.

Service team composition

The Living Well Service is delivered by a specialist multiprofessional team which includes a consultant in palliative medicine / appropriately skilled clinician; specialist palliative care nurses; health care support workers; physiotherapist / occupational therapist; clinical psychologist; social worker; spiritual care coordinator; dietitian; future care planning facilitator; administrative staff and volunteers.

Additionally a children's hospice care model will include learning disability nurses (also available at some adults' hospices); play therapist and a transition support worker. Family support workers will offer memory-making activities such as helping family members to create keepsakes. Physiotherapy is also important in supporting the development and delivery of individual care plans for babies, children and young people, along with providing expert advice for families on positioning, equipment and treatment.

See page 41 for overviews of the roles listed above.

Regular multidisciplinary team meetings are held to review a person's progress, refine rehabilitation goals, and ensure coordinated future care planning. They will also be used to review data from outcome measurement instruments such as IPOS[40] to identify how the team can best support an individual. These tools will be used to assess a person at the first visit and thereafter. At the first visit this activity captures what matters to the person / family, it also measures complexity and can provide currency / casemix. Follow-up use of measures delivers patient-centred outcomes and demonstrates quality of care.

Quality standards and outcomes

As a framework for continuous improvement ultimately leading to more effective and more patient-centred care, the following principles and outcomes are critical.

- Measuring what matters with person-centred outcome measures. The service aims to improve patients' quality of life, promote independence, and support their personal health goals. Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) are used systematically to capture a person's experiences and look at outcomes from the point of view of the person experiencing them. See for example, IPOS[41] – part of the Outcome Assessment and Complexity Collaborative's (OACC) suite of measures used to measure different facets of palliative care provision – and C-POS:UK for children's care[42].
- Symptom control and functional improvement. Success is measured through improved symptom management, enhanced physical function, and overall wellbeing.
- Future care planning completion. The service tracks the number of people who have been offered the opportunity to plan for the future, ensuring that future care preferences are clearly documented and respected.
- Family and carer satisfaction. Feedback from patients, families, and carers is regularly sought to ensure the service is meeting their needs and maintaining high levels of satisfaction. For example, the IPOS Views on Care can be used as a supplement to IPOS to assess a person's own ratings of their quality of life, their view of the impact of the service on their principal problem(s) and their overall wellbeing [43].
- Continuous improvement. The service regularly audits its outcomes and incorporates patient feedback in order to improve care delivery and the overall experience of the service.

40 IPOS (Integrated Palliative care Outcome Scale) is a measure of symptoms and concerns which matter to a patient and helps services provide the best care.
41 Palliative care Outcome Scale. Integrated POS (IPOS) in English. [Internet] [cited 01 Sept 2025].
42 Palliative care Outcome Scale. C-POS:UK. [Internet] [cited 01 Sept 2025].
43 Palliative care Outcome Scale. IPOS Views on Care. [Internet] [cited 01 Sept 2025].

Facilities and environment

The hospice environment is designed to be welcoming, supportive, and conducive to wellbeing. Key features include:

- Accessible rehabilitation facilities such as gym spaces and equipment tailored to palliative care patients.
- Quiet spaces for reflection, relaxation and spiritual care.
- Group therapy rooms for workshops, activities, and peer support groups.
- Outdoor areas such as gardens for fresh air and tranquillity, play, sensory experience and gentle physical activity.
- Spaces for family interaction, where patients and their loved ones can spend time together in a comfortable environment.

Partnership and integration

The Living Well Service is integrated within the wider palliative care network of provision, ensuring that patients can access other services as needed. It works closely with community healthcare teams, GPs, hospital specialists, and social care services to ensure continuity of care.

Living Well Services may also work with local not-for-profit organisations as well as charities such as the MND Association and Parkinson's UK to provide support groups which in turn present opportunities for people to become acquainted with the hospice service offer at earlier points in their care trajectory. Onsite hospice cafés and community hubs (perhaps with meeting rooms for hire by local groups and businesses), offer connections and awareness-building opportunities for the wider public.

In action: Living Well Service

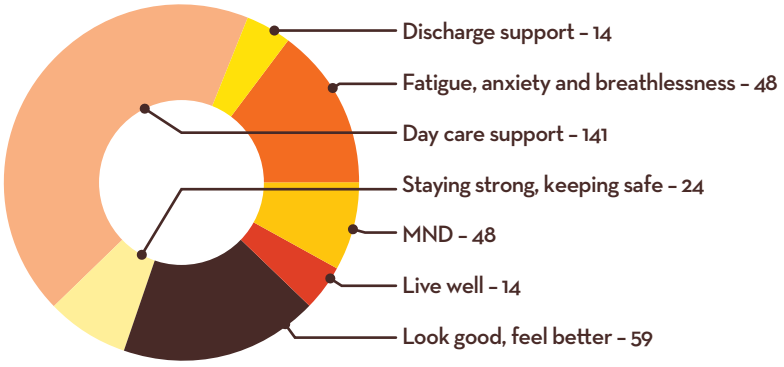
Sunflower Living Well Centre – East Cheshire Hospice

Following a major refurbishment programme, East Cheshire Hospice relaunched its state-of-the-art 'Sunflower Living Well Centre' in 2024. Equipped with cutting-edge technology, the centre provides a welcoming, flexible, and dementia-friendly space for the hospice team to provide care to individuals and their families confronting serious illnesses, whether attending Living Well programmes for the day or through individual outpatient appointments.

Following the relaunch the Centre has seen a substantial increase in activity. With plans to support groups at weekends and in the evenings, the hospice confidently anticipates that activity within the Centre will increase from a weekly current rate of 179 to 400 people within two years of the refurbishment.

Recognising that when informal carers are supported, they are better equipped to provide high-quality care at home, the Sunflower Living Well Centre offers carers opportunities to take part in support programmes alongside their loved ones or attend sessions tailored specifically for them, including one-on-one psychological support sessions.

Number of patients attending various support programmes within the Sunflower Living Well Centre



East Cheshire Hospice. Quality account 2024-2025. [Reproduced with permission]

Single Point of Access

Service overview

Provision of a single, local, 24-hour, seven days a week telephone access-point for patients and carers has been recommended for some years[44]. There have also been more recent calls for a strengthening of co-ordinated and integrated out-of-hours palliative and end of life care support[45].

A telephone Single Point of Access (SPoA) service in palliative care provides a local centralised and streamlined system for patients, families (including those not already known to the services), and healthcare professionals to access the palliative care services within that locality. It ensures timely and appropriate referrals, triages patients to the right level of care, and facilitates coordination across various providers. This service also offers advice and signposting information to health professionals. The service may be co-delivered by partners across a geography.

By offering proactive and planned care, an SPoA service may also contribute to the avoidance of ambulance conveyances and hospital admissions (see page 19 for an 'In action' example) and alleviate anxiety for carers and families.

There are several components which distinguish a Single Point of Access service:

- It is designed to support patients and families (including those not previously known to the service) along with professionals.
- It offers triage, signposting and referral to all palliative and end of life care services – not just those offered by one provider.
- There may be separate provisions for families and professionals, meaning that there could be different contact telephone numbers for each. For patients and families, a generic number is preferable and ideally one that is already established within the healthcare system (such as the NHS 111 number). For professionals, the system must enable a caller to be 'bypassed' to another professional for advice or support with an urgent referral.
- SPoAs are distinguished by the specialist nature of the triage and the immediacy of response.

Who it is for

Single Point of Access services are for the use of patients, relatives, carers, members of the public, GPs and other medical and health and social care professionals.

The approach

The SPoA service model exemplifies a responsive, holistic approach to palliative care delivery. Its benefits include improved access and efficiency, enabling patients to receive the right care at the right time without delays. In turn, a single, reliable contact point reduces stress and confusion for families navigating care, thus enhancing patients' and carers' experiences.

At heart, the SPoA service model embodies integrated and coordinated care in promoting collaboration between services and so ensuring comprehensive person-centred care.

44 National Institute for Clinical Excellence. Guidance on cancer services: improving supportive and palliative care for adults with cancer: the manual. [CSG4] NICE; 2004.

45 Pask S, Davies JM, Mohamed A, Leniz J, Chambers RL, McFarlane P, Bone AE, Barclay S, Higginson IJ, Sleeman KE & Murtagh FEM. Better End of Life 2022. Mind the gaps: understanding and improving out-of-hours care for people with advanced illness and their informal carers. Research report. London: Marie Curie; 2022.

Service key components

- Centralised referral and access. The SPoA service acts as a single, easily accessible contact point (via phone, email, or digital platforms) for all palliative care enquiries and referrals. It simplifies navigation of complex healthcare systems for patients, families, and referrers.
- Professional triage and assessment. Referrals are triaged by experienced palliative care professionals, such as specialist nurses or clinicians. They assess the urgency and acuity of the patient's needs, ensuring that care is prioritised and aligned with clinical requirements.
- Personalised care allocation. Patients are directed to the most appropriate service based on their needs, which may include:
  - Community palliative care teams
  - Hospice care (inpatient or day services)
  - Hospice at Home services
  - Specialist palliative care outpatient clinics
  - Bereavement and psychological support.
  - Other support services such as social work or spiritual care.
- Care coordination. The SPoA service team ensures seamless communication and handover between providers, avoiding duplication of services and ensuring continuity of care.
- 24/7 availability. To support patients and families in urgent situations, an SPoA service can be available around the clock, ensuring that help is accessible at any time. Some services may also provide signposting and advice out of hours.
- Symptom management and specialist advice. Prompt referral to services that manage complex symptoms, such as pain, breathlessness, or nausea.
- Holistic support. Access to psychological, social, and spiritual care tailored to the patient and their family. Acknowledging independent wishes and preferences for involvement.
- Crisis intervention. Rapid response within a two-hour timeframe (concomitant with community response service standards[46]) for patients experiencing acute distress or deterioration, with the potential to help avoid unnecessary hospital admissions. This may be for symptom management or for family reassurance, with appropriate staffing.
- Guidance. Information and support for patients, carers, and healthcare professionals to empower them in managing palliative care needs at home or in other settings such as care homes, primary care and extra care housing.

Standardised triage tools are in use according to service setting for transparent and evidence-based assessment of urgency of need. Examples include validated tools such as the RUN-PC Triage Tool[47] (used for instance at North London Hospice[48, 49]) and SPICT™ which is available in various adaptations[50], There are also tools developed by hospices such as Compton Care[51]. Setting specific examples include the EARLY toolkit[52] in use in primary care.

46 NHS England. Community health services two-hour urgent community response standard: guidance for providers of care, integrated care systems and clinical commissioning groups. [Internet] [Vers.2] [Updated 14 March 2022] [cited 01 Sept 2025].

47 Palliative Nexus. RUN-PC Triage Tool. [Internet] [cited 01 Sept 2025].

48 Pain L, Welch K. P-131 Improving a hospice admission process with the Responding to Urgency of Need in Palliative Care (RUN-PC) triage tool. BMJ Support Palliat Care. 2022;12:A59.

49 McGrath P. P-65 The use of RUN-PC triage tool for community palliative care service. BMJ Support Palliat Care. 2024;14:A34.

50 Supportive & Palliative Care Indicators Tool (SPICT™) [Internet] [cited 01 Sept 2025].

51 Warren J, Greenaway L. P-45 The development of a palliative care triage tool. BMJ Support Palliat Care. 2023;13:A25-A26.

52 NHS England-North West. EARLY Identification in Primary Care (EARLY toolkit). NHS England [Internet] [cited 01 Sept 2025].

Service team composition

A Single Point of Access service is staffed by specialist palliative care nurses; healthcare support workers; palliative care doctors with access to specialist palliative medicine consultant oversight and administrative staff. Ideally, there should be access to on-call paediatric palliative consultant advice in each region. Allied health professionals and psychosocial teams (accessible through referral) offer support according to patients' needs.

See page 41 for overviews of the roles listed above.

Quality standards and outcomes

- Safety and effectiveness. There is clear leadership and collaboration across partner services with rigorous clinical governance in place to provide quality assurance, hold risk and case manage patients.
- Enhanced patient and family experience. Patients receive faster access to the right care and optimised care at home or in the patient's normal place of residence. A single, reliable contact reduces stress and confusion for families navigating care.
- Continuous professional development. Ongoing training is provided to staff so that they remain up-to-date with the latest developments in palliative care and symptom management. Mechanisms are also in place for continuous learning and improvement based on data and patient feedback.

Facilities and environment

In order to facilitate seamless communication, rapid assessment, and appropriate referral, SPoAs require robust infrastructure and IT resource including telephony systems and access to electronic patient record systems.

Partnership and integration

The Single Point of Access service promotes collaboration between services, ensuring comprehensive, patient-centred care.

In action: Single Point of Access

Palliative Care Hub – Arthur Rank Hospice

Launched in April 2021, the community-based Palliative Care Hub Service is staffed by clinical nurse specialists (CNSs) providing improved access to palliative care support, treatment advice, and signposting. It's available to patients, carers, GP or other health professionals by calling 111 and selecting the 'Palliative and End of Life Care' (#4) option. The CNSs can provide direct support or liaise with other services such as out-of-hours primary care, community nursing teams, social care, voluntary organisations, and acute consultants if required. In 2022 the service became available 24 hours a day, 7 days a week.

The service is commissioned by the Cambridgeshire and Peterborough ICB and is operated by Arthur Rank Hospice Charity in partnership with HUC (Herts Urgent Care) who provide the local NHS 111 service and the East of England Ambulance Service Trust. The initiative won the HSJ 'Primary Care Innovation of the Year' award in 2021.

Figures for its third year of service show that the Hub supported 1,486 patients, took 2,376 calls and helped to avoid 87 hospital admissions.

Arthur Rank Hospice Charity. Quality account 2023-2024.

Use of the services described above provide the means of introducing patients and their families to outpatient, higher intensity community and inpatient care support.

Outpatient services

Service overview

The outpatient service model for adults offers specialist palliative care clinics and therapeutic interventions to patients with life-limiting conditions in a flexible and relaxed outpatient setting. With focused consultation about increasing need, this model is designed to support ambulatory individuals who require expert specialist assessment, symptom management, and access to interventions such as blood tests, peritoneal drainage, and other treatments that can be safely administered on an outpatient basis.

The service is delivered by a multidisciplinary team of specialist palliative care doctors /appropriately skilled doctors, nurses, and other healthcare professionals. It aims to improve quality of life by addressing complex symptoms, providing emotional support, and helping patients and their families navigate their illness. The service also offers future care planning and facilitates access to other community and inpatient services as appropriate.

The outpatient service model works as part of a broader network of palliative care services, collaborating with:

- Primary care teams. Ensuring seamless communication with GPs and district nurses to coordinate care and monitor patient progress.
- Hospital palliative care teams. Facilitating referrals and ensuring continuity of care for patients transitioning between the hospital and hospice specialist palliative care outpatient settings.
- Other specialties such as cardiology, respiratory and geriatric medicine to run joint clinics.
- Community nursing and hospice-at-home services. Providing additional support for patients who need more intensive or home-based care.

This model provides a crucial service for patients with palliative care needs, offering a blend of clinical expertise, personalised care, and holistic support, including complementary therapies.

By enabling patients to access specialist interventions, symptom management, and emotional support in a non-hospital setting, the service helps patients maintain their comfort, dignity, and quality of life while receiving care that aligns with their individual needs and preferences. Such timely interventions can help make sure that patients do not reach crisis points, whilst also boosting wellbeing and alleviating potential pressure on other services.

Who it is for

The outpatient clinical service model is intended for ambulatory patients with advanced, life-limiting illnesses who:

- Require specialist palliative care but are well enough to attend outpatient appointments.
- Need ongoing symptom management for issues such as pain, nausea, breathlessness, or fatigue.
- Require access to clinical interventions, such as blood tests, medication adjustments, peritoneal dialysis, or lymphoedema services.
- Seek support for future care planning, ensuring that their future healthcare wishes are clearly documented and respected.
- Are looking for a supportive environment where they can receive holistic care, including complementary therapies, along with emotional and psychological support.

Carers and families may also attend for advice, guidance, and emotional support.

The approach

The outpatient clinical service model adopts a holistic, patient-centred approach to care, focusing on improving the quality of life for patients and their families. Key principles include:

- Symptom control. Providing expert management of physical symptoms through tailored interventions and ongoing monitoring.
- Personalised care plans. Collaborating with patients and families to develop individualised care plans that address physical, emotional, psychological, and spiritual needs.
- Future care planning. Facilitating conversations around future care, ensuring patients have the opportunity to document their preferences for care at the end of life.
- Multidisciplinary approach. Working as a coordinated team, the service model brings together doctors, nurses, and other healthcare professionals to address all aspects of a patient's condition.
- Family support. Offering support to family members and carers, helping them manage the challenges of caregiving and understand the evolving needs of their loved ones.

Service key components

- Comprehensive clinical assessments. On their first visit, patients receive a detailed assessment from the specialist team, focusing on physical, emotional, and social needs. The team will work with the patient to develop a personalised care plan.
- Symptom management. The clinic offers expert care for managing complex symptoms, including pain, breathlessness, fatigue, and nausea. Adjustments to medications, referrals for additional therapies, and non-pharmacological interventions are available.
- Access to interventions. Patients attending the clinic may require specific interventions, for example, blood tests for monitoring disease progression or managing symptoms; infusion therapies (such as pain relief or anti-nausea medications); and prescribing and medication reviews to optimise symptom control.
- Future care planning. The team facilitates advance care planning discussions, helping patients explore their options and document their preferences for future treatment, including decisions around resuscitation, hospital admissions, and preferred place of care.
- Family and carer support. Family members and carers are invited to attend, where they can receive practical advice on caregiving, emotional support, and signposting to further services.
- Referral to other services. The service coordinates care with other healthcare providers, ensuring patients have access to community nursing, hospice-at-home services, or inpatient care when needed.
- Follow-up and monitoring. Regular follow-up appointments are offered to ensure that patients' symptoms remain well-managed and that their care plan is adjusted as needed.

Service team composition

The outpatient clinical service is staffed by a multidisciplinary team with expertise in palliative care. A consultant in palliative medicine provides clinical leadership and is joined by specialist palliative care nurses; an advanced practitioner; clinical nurse specialists; a clinical psychologist; social worker; dietitian; pharmacist and allied health professionals.

See page 41 for overviews of the roles listed above.

Quality standards and outcomes

- Patient-centred outcomes. The primary aim of the service is to enhance a patient's quality of life, focusing on effective symptom control and overall wellbeing.
- Safety and effectiveness. The service adheres to rigorous clinical governance standards, with regular audits, incident reporting, and quality assurance processes in place to ensure high standards of care.

- Patient and family satisfaction. Feedback is regularly collected from patients and families to monitor satisfaction with the service and identify areas for improvement.
- Continuous professional development. Ongoing training is provided to the multidisciplinary team to ensure they remain up-to-date with the latest developments in palliative care, symptom management, and clinical interventions.

Facilities and environment

The outpatient clinical service model is designed to be a welcoming, relaxed space where patients and families can feel comfortable during their visits. Key features include:

- Consultation rooms. Private and fully equipped rooms where patients can receive clinical assessments, interventions, and consultations.
- Treatment facilities. A dedicated space for minor clinical interventions, such as blood tests, or intravenous therapies.
- Comfortable waiting areas. Spaces where patients and families can relax before or after their appointments, with access to refreshments and support services.
- Access to complementary therapies. Patients may also benefit from therapies such as massage, or relaxation techniques, which can help alleviate symptoms such as pain or anxiety.

Partnership and integration

This outpatient clinical service model may feature joint clinics and in-reach services – working for example with oncology centres, primary care and specialist services (such as cardiology and renal care). Activity also involves referring patients to other specialist services as needed, such as respiratory teams for joint management of complex symptoms. Patients may also have access to joint clinics run with other specialties at the hospice.

Generalist community visits and domiciliary care

Since hospice home care was pioneered by St Christopher's in 1969, a variety of specialist and non-specialist palliative care models have emerged and evolved to support people living in their home environments and these are well documented[53], along with evidence supporting home-based palliative care, especially if delivered via specialist palliative care models or integrated palliative care models[54].

We begin here with an outline of the principal elements of domiciliary care and generalist community visits before moving on to describe further core models of community-based care.

Service overview

The domiciliary or home care model provides planned personalised generalist palliative care and support to individuals with life-limiting conditions in their own homes, primarily delivered by trained healthcare assistants. This non-specialist model focuses on meeting the holistic needs of patients, promoting comfort, and enabling individuals to remain at home as their condition progresses. Such services do not hold planned caseloads and do not support clinical symptom management.

There are two primary service configurations within this model. Domiciliary care for adults supported by NHS Continuing Health Care Fast Track or other social care funds is provided for a specific length of time (typically up to 12 weeks). Hospices may also offer support which is not funded though the above mechanisms; this support may focus on night sitting, family support and carer type duties such as personal care. See page 25 for an 'In action' example.

The community visiting model delivers personalised generalist palliative care, primarily delivered by healthcare assistants under the supervision of registered nurses. The service offers a range of personal care and practical assistance. It can also support aspects of clinical symptom management – such as catheter care, and where appropriate assisting with medication administration (e.g. prompting or reminding patients) – under the instruction of registered nurses.

Who it is for

Generalist domiciliary care supports individuals living with advanced illness who need assistance with non-clinical symptom management support, daily tasks, personal care, or companionship.

It also takes account of the needs of families and carers for guidance and emotional support as they care for their loved ones at home.

The approach

- Personalised care planning. Care is tailored to the individual's specific needs, preferences, and goals, developed collaboratively with patients, families, and healthcare professionals. Plans are regularly reviewed and updated to reflect changing circumstances.

53 Butler C, Wilson P, Abrahamson V, Mikelyte R, Gage H, Williams P, et al. Optimum models of hospice at home services for end-of-life care in England: a realist-informed mixed-methods evaluation. Health Soc Care Deliv Res. 2022;10(24). https://doi.org/10.3310/MSAY4464

54 Pask S, Okwuosa C, Mohamed A, Price R, Young J, Curtis T, et al. Models, components and outcomes of palliative and end-of-life care provided to adults living at home: A systematic umbrella review of reviews. Palliat Med. 2025 Sep 4:2692163251362567. doi: https://doi.org/10.1177/02692163251362567.

- Healthcare assistant-led care. Healthcare assistants, trained in palliative care principles, deliver hands-on care. This includes personal care (e.g. assistance with bathing, dressing, and mobility), basic nursing tasks and practical tasks such as washing and ironing.
- Focus on symptom management. Whilst the district nursing team are responsible for the administration and management of medications and other clinical needs, healthcare assistants provide non-clinical support to help manage symptoms such as pain, breathlessness, or fatigue under the guidance of registered nurses or GPs. Healthcare assistants ensure adherence to prescribed treatments and monitor for changes that may require escalation.
- Emotional and social support. Patients and families receive compassionate companionship and practical assistance. Healthcare assistants play a vital role in reducing social isolation and offering reassurance during difficult times.

Service key components

- Assistance with personal hygiene, mouth care, pressure area care and positioning. Referral to other hospice services as required.
- Family and carer support. The service includes practical advice and emotional support for families and carers, helping them manage the challenges of caregiving and providing bereavement support where necessary.

Service team composition

The domiciliary model is staffed by healthcare assistants and registered nurses, with appropriate senior leadership and support. The generalist community model is a nurse-led service, whereas a purely domiciliary service model is healthcare assistant-led.

See page 41 for overviews of the roles listed above.

Quality standards and outcomes

- Person-centred outcomes. The service aims to improve a patient's quality of life, supporting effective symptom control and personal dignity.
- Supports place of care preference. By providing timely interventions and continuous support, the service helps people to remain at home and helps to reduce social isolation.
- Integrated care. The service works effectively with primary and secondary care services in support of continuity of care.
- Family and carer satisfaction. Feedback from families and carers is regularly collected to ensure the service is meeting their needs and providing high levels of support.
- Clinical governance. The service is subject to ongoing clinical audits and quality assurance processes, ensuring high standards of safety and effectiveness in care delivery.
- Training and development. Ongoing education and professional development for the team, ensuring that staff are equipped with the latest knowledge and skills in palliative care. Organisational policies are in place to support lone-working.

Facilities and environment

The service provides care in patients' homes, using portable equipment and resources for non-clinical symptom management and to monitor health.

Partnership and integration

Whilst elements of this generalist care model have come to be included in other home visiting services, for clarity in the system it is important that the service model described here should be recognised as domiciliary

care and funded as such through Local Authority and Continuing Healthcare contracting. These are separate services to palliative health care and require regulator registration which is separate to hospice care.

In action: Home care

Sunflower Home Care – Highland Hospice

This partnership service model provides home-based health and social care to rural and remote communities across the Highlands. Sunflower Home Care is funded through a contract with NHS Highland. Highland Hospice employs a Sunflower Home Care Manager and is responsible for the employment and support of all care at home staff and local care at home co-ordinators.

The Hospice accepts referrals from NHS Highland, which are passed to the local care at home co-ordinator, who then ensures that the referrals are responded to by their local delivery team. The care provided includes getting someone up and dressed, reminding them to take medications, prepping meals and providing much-needed company.

A recent evaluation shows that the service is highly valued and rated by its users, who report 'significant positive impact on their quality of life in key ways, including reducing loneliness, increasing confidence, helping to maintain independence and being able to stay in their own homes. These services also provide important respite for carers, in turn supporting their health and wellbeing, and peace of mind for family members.'

Highland Hospice. Evaluation of befriending and care at home community partnerships: full report. Highland Hospice; 2023

Specialist community visits

Service overview

The Specialist Community Visits model provides planned specialist palliative care to patients in their own homes, ensuring they receive high-quality, individualised care in a familiar and comfortable environment. The service is designed to meet the needs of patients with life-limiting illnesses who require expert symptom management, holistic support, and early intervention to prevent crises, avoid unwanted hospital admission, and improve overall quality of life.

Delivered by a team of specialist palliative care nurses and advanced practitioners (including allied health professionals)[55] with medical oversight for access to advice etc., the service offers comprehensive assessments, symptom management, and emotional and practical support for both patients and their families. There will be non-medical prescribers able to assess and prescribe. The team works closely with GPs, community nurses, hospital services, and other healthcare professionals to ensure coordinated and seamless care. Care may be provided within 24-48 hours in line with assessment of need.

Who it is for

This service is tailored for patients with advanced, life-limiting conditions who:

- Can be cared for at home but need specialist support to manage their symptoms and care needs.
- Require early palliative care assessment and intervention to maintain comfort and prevent unwanted hospital admission.
- Experience complex symptoms, such as pain, breathlessness, or anxiety, that need specialist management beyond the capabilities of routine community services.
- Need support with end-of-life care planning, ensuring their wishes are respected and their care preferences are clearly documented. This will include implementing emergency care plans such as the ReSPECT[56] process.

It also supports families and carers who need guidance and emotional support as they care for their loved ones at home.

The approach

This service model operates with a philosophy centred on person-centred care, dignity, and the promotion of quality of life for patients in their own homes.

Depending on its size, the service may operate on a 24/7 basis, with scheduled visits during the day and access to urgent care out of hours through telephone advice or home visits.

Key principles include:

- Holistic care. Addressing physical, emotional, psychological, and spiritual needs in a coordinated manner.
- Timely intervention. Providing early assessment and prompt symptom management to prevent crises and avoid unwanted hospital admission.

55 NHS England. Palliative and end-of-life care advanced practice area specific capability and curriculum framework. NHS England; 2023.
56 Resuscitation Council UK. ReSPECT. [Internet] [cited 01 Sept 2025].

- Patient autonomy. Respecting the choices of patients and working with them to plan care that aligns with their goals and values, including advance care planning for future decisions.
- Family / carer involvement. Supporting family members and carers, equipping them with the knowledge and skills to manage their loved one's needs and offering emotional and practical support.
- Integrated care. Ensuring that care is delivered in close collaboration with primary care, community health services, and hospital teams, fostering continuity of care and avoiding duplication.

Service key components

- Early assessment and care planning. Upon referral, patients undergo a comprehensive assessment by the specialist team, which includes a review of physical, emotional, and social needs. An individualised care plan is developed in partnership with the patient and their family.
- Expert symptom management. The service offers specialist care for managing complex symptoms such as pain, breathlessness, nausea, and anxiety. The team provides regular home visits, monitors symptom progression, and adjusts treatment as necessary including non-medical prescribing.
- 24/7 Single Point of Access. The service offers 24-hour access to telephone advice and urgent home visits if needed, ensuring that patients and families feel supported at all times.
- Future care planning. The team supports patients in developing future care plans, discussing their preferences for future care, including decisions about hospital admissions and place of care during the final stages of life.
- End-of-life care. For patients approaching the end of life, the team provides specialist palliative care to ensure comfort, dignity, and respect. They offer physical care, emotional support, and spiritual care, while also supporting family members and carers.
- Family and carer support. The service includes practical advice and emotional support for families and carers, helping them manage the challenges of caregiving and providing bereavement support where necessary.
- Integrated working with other services. The team works closely with GPs, community nurses, district nurses, and other local services to ensure coordinated care. Regular communication and case discussions ensure all professionals involved in a patient's care are informed and working towards shared goals.

Service team composition

The service provided by the hospice specialist community team is multiprofessional in composition and includes specialist palliative care nurses; advanced practitioners; a consultant in palliative medicine / appropriately skilled doctor; clinical psychologist; social worker; occupational therapist / physiotherapist; spiritual care coordinator and pharmacist.

See page 41 for overviews of the roles listed above.

Quality standards and outcomes

- Patient-centred outcomes. The service aims to improve a patient's quality of life, ensuring effective symptom control and respect for their care preferences.
- Avoidance of unwanted, unplanned hospital admissions. By providing timely interventions and continuous support, the service helps to reduce emergency unwanted hospital admissions and keeps patients in their preferred place of care.
- Family and carer satisfaction. Feedback from families and carers is regularly collected to ensure the service is meeting their needs and providing high levels of support.
- Clinical governance. The service is subject to ongoing clinical audits and quality assurance processes, ensuring high standards of safety and effectiveness in care delivery.

- Training and development. Ongoing education and professional development for the team, ensuring that staff are equipped with the latest knowledge and skills in palliative care. Organisational policies are in place to support lone-working.

Facilities and equipment

- Home-based care. The service provides care directly in a patient's home, using portable medical equipment and resources to manage symptoms and monitor health.
- Telemedicine and telephone support. In addition to in-person visits, patients have access to remote support, including telemedicine consultations, to review symptoms, adjust care plans, and offer advice.
- Access to hospice facilities. If required, the team can facilitate admission to hospice inpatient care for patients who need more intensive symptom management or end of life care.

Partnership and integration

The Specialist Community Visit service is fully integrated with local healthcare providers, ensuring that patients experience seamless care across different settings. The service works closely with:

- GPs and primary care teams. Ensuring continuity of care and effective communication about patient progress and needs.
- Community nursing teams. Collaborating to deliver holistic care in the home, particularly for patients requiring regular nursing interventions – for example, medicines being delivered via a syringe driver.
- Hospitals and specialist services. Liaising with hospital palliative care teams and other specialists to ensure appropriate transitions of care and continuity when patients are discharged home.
- Social care and voluntary organisations. Connecting patients and families with additional support services in the community, including respite care, counselling, and social care resources.

Rapid response

Service overview

The rapid response service model provides immediate, specialist support to patients with palliative care needs who require urgent assessment and symptom management. This service is designed to respond swiftly to acute episodes of distress, uncontrolled symptoms, or unexpected changes in a patient's condition. It aims to prevent unwanted hospital admission by delivering timely interventions in the patient's home or, where required, facilitating a smooth transition to hospice inpatient care.

The service operates as part of an integrated palliative care system, collaborating with community teams, GPs, hospitals, and out-of-hours services to ensure patients receive the right care at the right time.

Who it is for

This service is intended for patients with advanced, life-limiting conditions who are experiencing:

- Uncontrolled or worsening symptoms, such as pain, breathlessness, nausea, or agitation, delirium requiring urgent management.
- Acute distress due to psychological, emotional, or spiritual concerns that cannot be managed by routine care.
- Rapid deterioration in condition, necessitating immediate review to determine whether continued home care is appropriate or if admission to hospice or hospital is needed.
- Complex needs that cannot be met through standard care pathways or community services, requiring urgent intervention by specialist palliative care professionals.

The approach

The care philosophy of the rapid response service model is centred on timely intervention, patient dignity, and the prevention of avoidable distress or unwanted hospital admissions.

The model aims to ensure:

- Rapid assessment and intervention are available 24/7 to address urgent symptom control needs.
- Holistic symptom management is provided, taking into account physical, emotional, psychological, and spiritual needs.
- Patient-centred care is at the forefront, ensuring patients and their families are involved in decision-making and their preferences are respected.
- Integrated care is delivered in collaboration with community services, GPs, hospital teams, and other health professionals, ensuring a seamless response.
- Flexible admission pathways are in place, ensuring patients can be admitted to the hospice for further care when home management is no longer appropriate.

Key service components

- Optimally 24/7 access to urgent care. The service can operate around the clock, ensuring patients can access urgent care at any time, whether during the day, at night, or over the weekend. At a minimum, the service should operate from 8am to 8pm, seven days a week[57].
- Rapid response time. A response time target is set, typically within 2 hours of a referral or call, to ensure urgent symptoms or concerns are addressed without delay[57].
- Comprehensive urgent assessment. On arrival, the team performs a full assessment of the patient's condition, reviewing physical symptoms, emotional distress, social factors, and care preferences.
- Immediate symptom management. The team implements rapid interventions to control symptoms such as pain, nausea, breathlessness, anxiety, or delirium, often involving medication adjustments, non-pharmacological interventions, and psychological support.
- Crisis management and stabilisation. In cases of acute distress, such as sudden deterioration or emotional crises, the team provides stabilising care, including emotional support for patients and families.
- Facilitated admission to hospice or hospital. If the patient's condition cannot be managed safely at home, the team arranges a seamless admission to the virtual ward, the hospice for more intensive care or, if necessary, to hospital.
- Family and carer support. The service includes emotional and practical support for families and carers, helping them cope with the urgent situation and offering guidance on next steps.
- Communication and liaison. The rapid response team liaises closely with the patient's GP, community nursing team, and any other healthcare professionals involved in their care to ensure continuity and appropriate follow-up.

Service team composition

The rapid response team is composed of experienced, specialist professionals who provide urgent care tailored to the complex needs of palliative care patients. The team includes a consultant in palliative medicine / appropriately skilled doctor; specialist palliative care nurses; advanced practitioners; clinical psychologist.; social worker and hospice care coordinator.

See page 41 for overviews of the roles listed above.

The team works closely with community nursing teams, GPs, out-of-hours services, and ambulance services to ensure timely interventions and patient-centred care.

Quality standards and outcomes

- Response time targets. The service is committed to responding within a specific time frame (e.g. two hours) from the initial request for urgent support, ensuring timely intervention.
- Patient-centred outcomes. Symptom control, avoidance of unwanted hospital admission, and patient and family satisfaction are key indicators of success.
- Safety and clinical effectiveness. The service is governed by a robust clinical governance framework, including regular audits, incident reporting, and reviews of clinical effectiveness to ensure high standards of care.
- Seamless transitions to inpatient care. Effective coordination of care, ensuring that patients who require hospice admission are transferred smoothly without delays or disruptions.
- Family and carer satisfaction. Ongoing feedback is gathered from patients, families, and carers to ensure the service is meeting their urgent needs and addressing concerns effectively.

57 NHS England. Community health services two-hour urgent community response standard: guidance for providers of care, integrated care systems and clinical commissioning groups. [Internet] [Vers.2] [Updated 14 March 2022] [cited 01 Sept 2025].

- Staff training and development. Regular training and professional development for the rapid response team to maintain skills in urgent palliative care interventions and crisis management.

Facilities and equipment

The team is equipped with mobile medical equipment, including portable monitoring devices, medication, and supplies necessary for urgent symptom control in the home setting – e.g. access to medication in the home through anticipatory prescribing and 'just in case' boxes[58]. Transport and logistics are supported by close liaison with ambulance services and other transport providers to facilitate rapid transfers from home to hospice or hospital when necessary.

Partnership and integration

The rapid response service is fully integrated with the broader palliative care network, working alongside community palliative care teams, GPs, out-of-hours services, and local hospitals to ensure seamless care for patients. ReSPECT forms and shared care records are accessible and available in the home environment.

58 British Medical Association. Anticipatory prescribing for end-of-life care. [Internet] 2024 June 28. [cited 01 Sept 2025].

Hospice at home and virtual wards

Service overview

Here, 'hospice at home' refers to 'hospital at home' service models and the acute level of physical care provided in a patient's usual place of residence[59]. However, in England particularly, this terminology has blurred with that of the 'virtual ward' and variations in the models and pathways have emerged – which is acknowledged by presenting hospital at home and virtual wards together here.

The models share commonality in that they are designed to offer a safe alternative to inpatient hospice or hospital care, enabling people to be supported in their home environment whilst also helping to build system resilience. They are resourced appropriately with the multi-disciplinary staff, equipment, technologies, medication and skills required for acute clinical support[60].

Such services complement other community-based palliative care support; it is the acuity and complexity of a patient's condition[61] which differentiates this support from other community palliative care services.

'Ward rounds' may be conducted remotely by telephone, through video or monitoring technologies or involve a home visit[62].

See page 34 for an 'In action' example of a virtual ward.

Who it is for

This model supports patients who:

- Require in person symptom monitoring or active management because they are clinically unstable or at high risk of deterioration but can be supported in their home environment.
- Would otherwise need to be in a hospice or hospital bed.
- Can benefit from more intensive daily remote monitoring.
- Are expected to use the service on a short term basis[63].

The approach

With clear admission criteria and assessment processes, a virtual ward offers an alternative to hospice or hospital inpatient admission and can also support early discharge. It also supports:

- Improved patient and carer experience and outcomes.
- Improved patient and carer access to timely and responsive expert professionals.
- Shared decision-making.

59 British Geriatrics Society. Bringing hospital care home: Virtual Wards and Hospital at Home for older people. [Internet] 2022 [cited 01 Sept 2025].
60 NHS England. Virtual wards operational framework. [Internet] 2024 [cited 01 Sept 2025].
61 Hospital at Home. What is Hospital at Home? [Internet] [cited 01 Sept 2025].
62 May-Miller H.115 Palliative and end-of-life-care (PEoLC) virtual wards: A cross-sectional UK survey highlighting models of care, benefits and challenges. BMJ Support Palliat Care. 2025;15:A51-A52.
63 NHS England. Palliative and end of life care (PEoLC) virtual wards guidance document. [Draft] 2022 [Vers. 3.1; March 2023].

Service key components

- For the practice of safe care, the service is available for at least 12 hours (8am-8pm) every day of the week, with provision for out of hours cover[63, 64].
- Daily clinical reviews are conducted with clear processes for escalating concerns and unexpected deterioration, 24 hours a day, 7 days a week[63].
- Clearly defined criteria support admission and discharge.
- Patients and family members caring for them are provided with accessible information on what to do if symptoms worsen and this includes information about who to contact out of hours. They should also have rapid access by telephone or other immediate means to sources of guidance and advice.
- Patients and family members caring for them are informed and supported in the use of relevant equipment and technology.
- Staff training and development. Regular training and professional development enables virtual ward staff to recognise early signs of deterioration and understand fully escalation processes in support of patient safety.

Service team composition

Multidisciplinary in nature, this service is led by a senior clinician and overseen by a consultant doctor / advanced practitioner or other clinician acting as responsible medical officer. They are joined by advanced / specialist practitioners, including nurses and allied health professional; a pharmacist; clinical psychologist and healthcare assistants.

See page 41 for overviews of the roles listed above.

Quality standards and outcomes

- Person-centred outcomes. The service can support a patient's preference to continue to be cared for in their usual place of residence if they wish and measures can be submitted to care teams using technology such as portable hand-held devices.
- Tools such as IPOS (Integrated Palliative care Outcome Scale), Phase of Illness are used at regular intervals to capture and respond to complex symptoms and patients' concerns.
- Avoidance of unwanted, unplanned hospital admissions. By providing timely interventions and continuous support, the service helps to reduce emergency unwanted hospital admissions or enables early discharge from hospital.
- Clinical governance. The service is subject to ongoing clinical audits and quality assurance processes, ensuring high standards of safety and effectiveness in care delivery.

Facilities and environment

- Digital technology. Systems are in place to enable remote monitoring and the routine collection of data to report on the service's safety and effectiveness.
- Transport and logistics. Close liaison with ambulance services and other transport providers to facilitate rapid transfers from home to hospice or hospital when necessary.
- Equipment. To include appropriate technology platforms supporting interoperability with electronic patient record systems or local shared care record systems, and specialist medical devices.

Partnership and integration

The Virtual Ward is integrated with other community services including Single Point of Access and out of hours primary care.

Virtual wards can be palliative in focus or integrated with others such as frailty.

64 NHS England. Virtual wards operational framework. [Internet] 2024 [cited 01 Sept 2025]

In action: Virtual ward

Virtual ward – St Columba's Hospice Care

St Columba's Hospice Care piloted a Virtual Ward over a three-month period from 1 March to May 2023. During the trial the individuals and family members supported benefitted from daily, face-to-face, specialist medical and nursing assessment with additional support available seven days a week. The Virtual Ward (VW) provides support for up to 14 days for people in their own home or usual place of residence, who would otherwise require inpatient admission to a hospice or an acute hospital to meet their palliative care needs.

Evidence

An evaluation of the VW (reporting on 46 patients admitted during the pilot, for whom 1760 clinical contacts were made), concluded that VW care enabled '...positive outcomes for patients and their families. The Virtual Ward can facilitate people to die in their preferred place of death; avoid unwanted hospital admissions; and promote partnership working.' Additionally, primary and secondary care services reported positive views of VW care for their patients, with either no increase or a reduction in their workload.

St Columba's Hospice Care. Pioneering Virtual Ward delivering end-of-life care at home. [News item] 2024 Feb 26

Lloyd A, Bijak M, Young J, et al. Towards an innovative Virtual Ward initiative for specialist palliative care: Service evaluation findings from St Columba's Hospice Care. Edinburgh: St Columba's Hospice Care; 2024

Hospice inpatient beds

Service overview

Hospice inpatient beds provide specialist person-centred care for individuals with complex palliative care needs, focusing on the holistic assessment and management of symptoms, psychosocial support, and end of life care. The service is designed for patients whose symptoms or care needs cannot be adequately managed in other settings, such as home or community-based care.

Additionally, for children and young people, inpatient stays may be on a rehabilitative (respite) planned short break basis and for support following a prolonged hospital stay (step down care). Children's hospices may also provide respite care in the home setting[65].

Inpatient hospice care is for short-term admissions. Care needs are reviewed regularly and those no longer requiring the high level specialist care offered by hospice inpatient units will be supported (in consultation with the patient, family members or a main carer) in transfer to another care setting (including back at home if appropriate). The person may then be re-admitted at later stages for inpatient hospice care whilst continuing in the meantime to receive support as required in their place of residence from the community palliative care team.

The hospice operates as an integral part of wider palliative care provision across the system, working in close collaboration with primary care providers, neighbourhood teams, hospital services, and community-based teams.

Who it is for

This service is specifically for patients with advanced, life-limiting illnesses who experience:

- Uncontrolled or difficult-to-manage physical symptoms (e.g. pain, breathlessness, delirium, nausea, wound management or fatigue).
- Complex psychosocial, spiritual distress, or situations where the home environment is not conducive to meeting care needs.
- Complex needs that require intensive medical or nursing interventions.
- End of life care where complex or unpredictable needs necessitate specialist inpatient support.

The approach

The model is focused upon the principles of holistic, person-centred care, dignity, and compassion. It features:

- Symptom control and management of complex physical, psychological, emotional, and spiritual needs.
- Future care planning to ensure that patient wishes are respected and documented.
- Family / carer support, providing information ,guidance and support to a patient's family and carers, both during the patient's stay and in bereavement.
- A multidisciplinary team approach that ensures comprehensive care delivery and coordination.

65 Together for Short Lives & Julia's House Children's Hospice. Give me a break: how the UK Government can improve parental health and reduce health inequalities by allocating short break funding for seriously ill children in England at the Comprehensive Spending Review. 2020.

Service key components

- Comprehensive admission assessment. Upon admission, patients receive an holistic assessment, identifying their physical, psychological, social, and spiritual needs. Routine symptom assessment and outcome measurement is undertaken to provide staff with information that allows them to assess and monitor changes in the wellbeing of patients[66]. Tools such as the National Early Warning Score (NEWS) 2[67] may be implemented in support of the identification of and response to clinical deterioration in adult patients[68].
- 24/7 specialist palliative care. Patients have access to round-the-clock care from a dedicated team of professionals skilled in complex symptom management and end-of-life care.
- Personalised care and support plans. Each patient has a personalised care plan developed in collaboration with them and their family / carer, detailing their treatment goals, preferences, and symptom management strategies.
- Complex symptom management. Intensive symptom control for issues such as refractory pain, dyspnoea, nausea, and delirium, using advanced interventions and medications.
- End of life care. There is a focus on dignified, comfortable end of life care, with the patient's preferences guiding all interventions and planning.
- Family and carer support. Respite opportunities, emotional support for families and carers after the patient's death, and bereavement services are offered.
- Collaborative discharge planning. For patients stabilised during their stay, the hospice team collaborates with community and hospital services to ensure a smooth transition back home or to other care settings.

Service team composition

The inpatient service's core multidisciplinary team includes a consultant in palliative medicine / appropriately skilled doctor; specialist palliative care nurses; social worker; physiotherapist / occupational therapist; pharmacist and dietitian. Spiritual care support and bereavement support are available and trained volunteers provide companionship, assist with practical tasks, and support families / carers and patients during their stay.

See page 41 for overviews of the roles listed above.

Regular multidisciplinary meetings ensure coordinated care planning and dynamic problem-solving for complex cases.

Quality standards and outcomes

- Person-centred outcomes. The service strives to improve symptom control, enhance quality of life, and support personal goals for each patient. Tools such as IPOS (Integrated Palliative care Outcome Scale) and Phase of Illness are used at regular intervals to capture and respond to complex symptoms and patients' concerns. In due course this will also include use of the C-POS: Children's Palliative care Outcome Scale[69].
- Safety and clinical effectiveness. Continuous monitoring of patient safety through rigorous clinical governance processes, including incident reporting, audits, and regular quality assurance meetings.
- Family satisfaction. Regular feedback is collected from families and carers through validated tools in support of continuous quality improvement and to ensure the highest levels of satisfaction[70].
- Interdisciplinary education and development. Ongoing training and education for the multidisciplinary team to ensure the workforce stays up-to-date with best practices in palliative care.

66 Hull York Medical School. Outcome measures in palliative care. [Internet] 2019 [cited 01 Sept 2025].
67 Royal College of Physicians. National Early Warning Score (NEWS) 2. [Internet] 2017 [cited 01 Sept 2025].
68 Ireland H, Davies K, Donohue J, et al. P-115 Introduction of NEWS2 in a hospice setting. BMJ Support Palliat Care. 2019;9:A52.
69 Harding R, et al. C-POS: Children's Palliative care Outcome Scale. [Internet] King's College London [cited 01 Sept 2025].
70 NHS Improving Quality. Measuring experience of care in end of life care: an overview. [Internet] [2018] [cited 01 Sept 2025].

Facilities and environment

The hospice inpatient unit is designed to provide a peaceful, supportive environment with features that enhance patients' comfort and dignity, including private, en-suite rooms with space for family members / carers to stay.

Many hospices, particularly those for children and young people, have onsite facilities for caring for the deceased person and support loved ones in visiting after death.

Hospital in-reach

Service overview

Where palliative medicine teams are not in situ, hospital in-reach services see hospice staff extending their expertise into the hospital setting to improve identification of palliative and end of life care need and support discharge where appropriate.

Hospital-based support is a common feature of the work of children's hospices where staff bring their expertise and continuity of care into episodes of hospital admissions. As such, children's hospices may have nurses employed to work in children's hospitals across their catchment areas and in neonatal units.

Hospice staff work in close partnership with teams and specialty doctors (such as geriatricians, cardiologists, respiratory and renal physicians) within NHS acute hospitals in supporting patients and providing a joined-up approach to care. In-reach services promote early and timely referral to hospice and other community services as well as assisting with future care planning and supporting earlier discharge from hospital to hospice or home.

Additionally, some in-reach services provide support within Emergency Departments (ED) for patients known to, or suitable for palliative care in order to enable admission avoidance, facilitate timely discharge and support symptom management.

See page 39 for an 'In action' example of a hospital in-reach service.

Who it is for

Hospital in-reach teams enhance the care provided to patients in a hospital. This model of support is particularly important in the care of babies, children and young people. The opportunities for education and support also means that the team's presence directly benefits hospital clinical and medical colleagues.

The approach

This approach features expert guidance on symptom management and complex psychological and emotional support for patients and their families. In-reach services foster better communication and coordination between hospitals and hospices.

Service key components

This service is available seven days a week, from 8am until 5pm. Out of hours, hospital staff can access hospice advice from Single Point of Access services – see page 17 above.

Service team composition

Hospital in-reach services are provided hospice staff (such as medical consultants or advanced practitioners) present at the hospital.

Children's hospices may also provide social workers and assistance from other family support team members, particularly if a child is in hospital for a long time.

See page 41 for overviews of the roles listed above.

Quality standards and outcomes

- Person-centred outcomes. In common with all other models, through their work with hospital teams, the in-reach service aims to improve symptom control, enhance quality of life, and support personal goals for each patient.
- Education and training. The in-reach team offer education for hospital staff on palliative care principles, symptom management, and communication skills.

Facilities and environment

In-reach teams work on wards and across the hospital, e.g. within the Emergency Department.

Partnership and integration

Hospice in-reach services aim to integrate palliative care expertise into the hospital setting, improving the quality of care for patients with serious illnesses.

In action: Hospital in-reach

Hospital in-reach – Derian House Children's Hospice

Derian House Children's Hospice has worked with the Central Preston Clinical Commissioning Group and Lancashire Teaching Hospitals to improve palliative and end of life care for children and families.

The hospice undertook a NHS England Exemplar project aiming to explore and create:

- in-reach roles where hospice staff are based in a hospital
- education and training for NHS colleagues about palliative and end of life care (including advance care planning across the integrated care system)
- support for community teams to avoid hospital admissions.

Derian House's advanced clinical practitioners now have honorary NHS contracts so they can provide in-reach expertise at Lancashire Teaching Hospital Trust. They are included in ward rounds, which means they are able to recognise and refer children and families who need hospice support as early as possible. An alert system has been developed to help hospital staff identify families already known to the hospice as soon as they are admitted. This enables the hospice team and hospital to work together and improves continuity of care.

Overall, there has been an increase in referrals to Derian House and the profile of children's palliative care in general has improved. There is now more information sharing between the hospice and hospital, and a greater number of avoidable admissions to hospital are being prevented.

Read more about this initiative in Hospice UK's online library of innovations.

Connect and reflect

A selection of resources and contacts.

Hospice UK. PopNAT.
An interactive tool that brings together relevant and up to date population data for end of life care across the UK.

Hospice UK. Examples of innovation.
An online library of case studies.

Association of Palliative Day Services.
The representative body for palliative day service professionals in the UK and Ireland.
Visit the website

National Association for Hospice at Home.
The representative body for Hospice at Home services in the UK.
Visit the website

Commissioning pack document set

NHS Norfolk and Waveney ICB, Hospice UK. Commissioning independent hospices guide. London: Hospice UK; 2025.

Hospice UK. Hospice service models: a practical guide to the principles and resourcing of care for adults and children. London: Hospice UK; 2025

Casey A. Safe and effective staffing for palliative care inpatient services: an improvement resource. London: Hospice UK; 2025

Hospice UK. Hospice costing model toolkit. London: Hospice UK; 2025

Service team composition

An overview of staff roles required for each service type.

Role	Responsibility overview
Administration staff	To support efficient operation of the service, handling enquiries and managing referral processes.
Advanced practitioner	Reflecting NHS England's scoping, this umbrella term describes health and care professionals from 'multi-professional registrant backgrounds who work at advanced practice level; exercising autonomous decision making in a context of complexity, uncertainty, and varying levels of risk, holding accountability for decisions made.'[71] Post-holders will also liaise with other teams within that setting (e.g. hospital) and more widely to co-ordinate and evaluate care as well as support future care planning. A range of job titles may be used to describe this role.
Allied health professional	For example, physiotherapists and occupational therapists. Help patients maintain mobility, independence, and quality of life through tailored therapies.
Bereavement support workers	Counsellors and trained volunteers support families and loved ones, helping them cope with grief and bereavement.
Clinical nurse specialist	Provides advanced nursing care, particularly for patients with complex symptoms or care needs. They liaise closely with other health professionals to ensure seamless care.
Clinical psychologist	Provides psychological support for patients experiencing emotional distress, anxiety, or depression or other psychological challenges that may arise due to illness. Can be available for urgent psychological or emotional support, especially in cases of acute distress or anxiety.
Consultant in palliative medicine	Provides remote or in-person clinical leadership, undertakes clinical assessments, and manages complex or rapidly changing symptoms to ensure best practice in symptom control and care planning. Also contributes to future care planning and decision-making, including treatment escalation plans.
Counsellor	Provides emotional and psycho-social support mainly to patients as well as pre-bereaved or bereaved family members.
Dietitian	Offers nutritional advice and support, particularly for patients experiencing weight loss, appetite issues, or other diet-related concerns.

71 Centre for Advancing Practice. Multi-professional framework for advanced practice in England. NHS England; 2025. See also: The Centre for Advancing Practice. Palliative and end-of life advanced practice area specific capability and curriculum framework. NHS England; 2023.

Role	Responsibility overview
Future care planning facilitator	Helps patients explore and document their preferences for future care, including end-of-life decisions, to ensure their wishes are respected.
Healthcare assistant	Provides core service support. According to service model setting, assists patients with personal and emotional care and assesses and responds to their needs.
Hospice care coordinator	Facilitates communication between the patient, family, and healthcare professionals to ensure a coordinated response and the smooth organisation of hospice admission if necessary.
Learning disability nurse	Working within both adults' and children's services, this role brings specialist skills to support people with learning disabilities and to plan for the future. Helps to build therapeutic relationships through enhanced communication approaches, management of acute deterioration and behavioural support.
Occupational therapist	Supports people in maintaining functional ability through rehabilitation programmes tailored to their abilities in order to optimise independence and quality of life.
Palliative care doctor	This input may be from a GP with an extended role or a specialty grade doctor, with access to specialist palliative medicine consultant oversight. Available for advice, complex case review and clinical decision-making.
Pharmacist	Provides expert advice on medication management, ensuring effective and safe use of medications for symptom control with an emphasis on minimising side effects.
Physiotherapist	Supports people in maintaining physical function and mobility through rehabilitation programmes tailored to their abilities in order to optimise independence and quality of life.
Play therapist	This qualified specialist offers tailored therapeutic play and activities to help children with physical and educational development, social interaction, pain management, communication and exercise.
Psychosocial team	Includes social workers, counsellors, and spiritual care providers.
Registered nurse (including registered children's nurse)	Uses 'evidence-based knowledge, professional and clinical judgement to assess, plan, implement and evaluate high-quality person-centred nursing care'[72].
Social worker	As registered practitioners, palliative care social workers offer a wide range of support to patients and families. This may include sourcing practical help at home, accessing other services, advice around debt or income maintenance, help with housing, advocacy, working with schools or employers, or offering psychosocial support. They may also be skilled in therapeutic work such as systemic family therapy or counselling .

72 Royal College of Nursing. Definition of the registered nurse and the principles of nursing. London: RCN; 2023.

Role	Responsibility overview
Specialist palliative care nurse	At the service frontline providing rapid assessment, expert symptom management, direct care, advice, and emotional support to patients. Also assists with clinical interventions, such as administering medications or monitoring symptoms. Responsible for triaging referrals, ensuring appropriate escalation and coordinating daily care plans. They work closely with other members of the care team to develop and implement individualised care plans.
Spiritual care coordinator	Addresses the spiritual needs and existential concerns of patients and families, respecting diverse beliefs and values.
Transition support worker	Supports young people and their families in all aspects of transition to adults' services, including health, education, social and welfare. Also advises colleagues on transition-related issues.
Volunteer	Trained volunteers offer and support a variety of roles across the service models. This may include provision of complementary therapies, companionship and bereavement support services.

Glossary

Term	Description
Advance care planning	See 'Future care planning'
Definitions: palliative and end of life care	See page 7 for definitions of palliative care, end of life care, specialist palliative care and children's hospice care.
Future care planning	This is a voluntary process of person-centred discussion between an individual with mental capacity for meaningful conversation and their care providers about that person's preferences and priorities for their future care. Likely to involve a number of conversations over time, this process can help people feel more in control and able to manage changes in their health and wellbeing[73, 74]. For children and families, discussions will include decisions relating to care in the case of acute deterioration and may also address preferences for organ and tissue donation[75].
Hospital at home	Hospital at Home describe models of consultant-led acute levels of care which are physically delivered in a person's usual place of residence.
Virtual wards	With advanced practitioner oversight, virtual wards support patients with longer-term conditions in their home environment who become clinically unstable or at high risk of deterioration and would otherwise receive inpatient hospital or hospice care. This includes supporting the early discharge from hospital or hospice.

73 Universal principles for Advance Care Planning (ACP). [Internet] NHS England; 2022 [cited 01 Sept 2025].
74 NHS Inform. Future care planning. [Internet] [Updated 31 July 2025] [cited 01 Sept 2025].
75 Widdas D, McNamara K, Edwards F. A core care pathway for children with life-limiting and life-threatening conditions. Bristol: Together for Short Lives; 3rd ed., 2013.

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