10 Year Workforce Plan

November 2025

Department of Health and Social Care

Section 1: the 3 shifts

The NHS must change. Our 10 Year Health Plan makes clear our ambition to move from a centralised system to one where patients have greater control over their care and frontline staff are empowered to shape and improve services. We know that those working closest to patients understand best how local services can be delivered.

We want to hear from organisations, clinicians, staff groups and partners who are already driving change at a local level.

We are seeking evidence on how the 3 shifts are being implemented locally, and the impact on your workforce. Where possible, please support your submission with data and measurable outcomes, so we can learn from what is working well and apply those lessons across the NHS.

In this section, please submit evidence of:

Where you have delivered or observed new digital initiatives that improved patient care.

Virtual wards

Virtual wards are an effective way of using technology to manage complex and acute needs in the community.

In 2023/24 Sue Ryder piloted a virtual ward for six months at our Wheatfields Hospice in Leeds. The virtual ward enabled patients at high risk of inpatient admission to have complex symptom management and die in their place of choice.

The virtual ward worked as follows:

- Patients were referred to the virtual ward internally
- A daily multidisciplinary team (MDT) meeting took place to review the patient's needs, and a plan of care was made
- The most appropriate member of the MDT team undertook a rapid assessment of the patient, with the aim to begin care within a day of referral
- Care plans were reviewed daily and updated according to patient need
- Once the patient stabilised normal care plans were put in place through the Community Team.

In the pilot 39% of virtual ward patients likely avoided admission to hospital or Sue Ryder Wheatfields in-patient unit (IPU). Additionally, the virtual ward was able to facilitate early/complex discharge for 20% of patients. The service also reduced reliance on community healthcare teams and GPs when a patient was in crisis.

Therefore, as well as improved patient outcomes, the pilot has shown that virtual wards can help to manage the increasing demand on palliative care services, reduce strain on other parts of the health system and share limited staff resourcing effectively.

Sue Ryder will expand its virtual ward model in 2026. In October 2025, Sue Ryder was awarded a significant new NHS contract to grow our expert palliative and end-of-life care (PEoLC) services across Reading, Wokingham, Newbury and South Oxfordshire.[1] This seven-year contract, which has the option to be extended for a further three years, with the NHS Buckinghamshire, Oxfordshire and Berkshire (BOB) West Integrated Care Board (ICB) will bring in several new and improved services. This will include the launch of a virtual ward service across the region, which will provide hospital-level care to people in their own homes to help keep them out of hospital.

Which professions, roles and skills were critical to successful implementation for each example
Our virtual ward required a mix of professionals:

- Virtual ward co-ordinator (Sue Ryder Nurse)
- Senior medical staff (Consultant or Specialty Doctor)
- Community Clinical Nurse Specialist
- Therapy team member (physiotherapist or occupational therapist)
- Family Support team member

The efficiency of the model relies on collaboration across providers. While a virtual ward can be delivered by a single provider, we believe it is more effective when hospice providers and NHS community teams work together.

Where you have already seen or begun to deliver a shift from hospital-based care to community care

PEoLC in the community

Hospices are well-placed to support the shift from hospital-based to community care. In 2023-24 more than half (55%) of UK hospices' total activity was delivered at the person's place of residence[2] and in 2024-25, specialist palliative care nurses and doctors made around 590,000 visits to hospice patients at home.[3]

[1] https://www.sueryder.org/blog/sue-ryder-to-expand-vital-palliative-and-end-of-life-care-in-reading-wokingham-newbury-and-south-oxfordshire/
[2] 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.
[3] https://www.hospiceuk.org/about-us/key-facts-about-hospice-care#content-menu-21315

Sue Ryder is at the forefront of this change, with 80% of our care already provided in people's homes. In recent years we have shifted towards a community-based model in a drive to meet patient preferences - in 24-25 nearly 59,000 face-to-face visits were made by our Hospice at Home and community teams.[4] This shift has included the transformation of our service in South Oxfordshire from an inpatient unit (IPU) to a mixed-model approach. Our Palliative Care Hub in South Oxfordshire cares for patients in the community and has been complemented by the establishment of specialist palliative care inpatient beds at Wallingford Community Hospital. The hospice sector's unique position in the system as independent organisations allow us to be flexible and innovative, helping to ease the strain on the NHS in areas where it's most needed. For example, the right community interventions from the hospice sector can reduce emergency admissions. In 2023/24 Sue Ryder's hospice at home services in Peterborough and Cheltenham cared for 609 patients. Of those patients, 517 acute admissions were avoided.

Which professions, roles and skills were critical to successful implementation for each example

Successfully shifting PEoLC into the community depends on a substantial and dedicated workforce. In 2024-25, UK hospices employed 13,250 whole time equivalent clinical and care staff[5] - down from 14,000 in 2022-23.[6] In addition to hospice staff, many non-specialist healthcare professionals such as district nurses, pharmacists and GPs are integral to the delivery of PEoLC in people's homes.

Any barriers to ensuring the right professions, roles and skills were involved, and how you overcame these barriers

There are several barriers to shifting care effectively into the community, with workforce shortages being one of the most significant.

The delivery of high-quality PEoLC at home relies on many services working together, with generalist practitioners - particularly district nurses and social care professionals - providing the bulk of day-to-day support. However, the number of district nurses has fallen sharply in recent years. Between 2009-2024 the number of staff recorded in NHS district nurse roles fell by 43%, from 7,643 to 4,322.[7] In 2009/10 there were 32 million recorded contacts with NHS district nursing services in England across all providers. By 2023/24 this had fallen to 29.2 million, despite the population increasing in size by 11% and estimated need increasing by 24%.[8] The Commission on Palliative and End-of-Life Care recently reported that there is only one district nurse for every 62 deaths each year which occur out of hospital

[4] https://www.sueryder.org/about-us/how-we-make-an-impact/
[5] Key facts about hospice care | Hospice UK
[6] https://hospiceuk-files-prod.s3.eu-west-2.amazonaws.com/s3fs-public/2024-05/Hospice%20UK%20Data%20Insights%20-%20Big%20Conversations%20May%202024.pdf
[7] https://www.nuffieldtrust.org.uk/resource/the-lamentable-decline-of-district-nurses-in-the-nhs-in-england
[8] https://www.nuffieldtrust.org.uk/research/district-nursing-understanding-the-decline-and-mapping-the-future

and with palliative care needs.[9] This shortage represents a major barrier to expanding community-based PEoLC, particularly as demand for PEoLC continues to grow.[10]

Workforce shortages are particularly pronounced in rural and remote areas. Research from Hospice UK found that 65% of rural health and care staff said there were not enough staff with the right skills to support people with life-limiting conditions in the rural community they worked in.[11] The most consistent workforce shortages highlighted were a lack of social care staff and community nurses, particularly out of hours. The report found that, in some rural communities, hospice care organisations are filling gaps where there is a lack of care workers to provide social care.

In order to overcome these barriers, **the refresh of the NHS Workforce Plan must address the need for a workforce that can support the shift of PEoLC into the community.** This must include non-specialists who are essential to the delivery of PEoLC. It must also recognise that charitable PEoLC providers, who are a key part of the health and social care system, play a vital role in shifting care into the community.

The Government has also committed to publication of regular, independent workforce planning across health and social care. This should include the PEoLC workforce, both within the NHS and those employed by charitable providers.

The recent National Audit office report[12] on the financial sustainability of England's adult hospice sector found that ICBs cannot identify their spend on PEoLC provided in NHS settings. It also recognised that ICBs do not collect information on independent hospices' spend. Since a significant portion of this spending relates to the workforce**, the Government's first step in planning for the PEoLC workforce must be to determine how much is currently being spent on the staff delivering these services within the NHS and hospices.**

Without supporting the components necessary to maintain a pipeline of professionals in PEoLC, the Government will find it difficult to realise the positive potential that hospice services can have for the health and care system, particularly with the ambition to shift more PEoLC into the community.

Where you have already seen or begun to deliver preventative care services

Breathlessness Service

At Sue Ryder Leckhampton Court Hospice we run a breathlessness management service. This includes outpatient clinics, home visits, telephone support, teaching sessions and a breathlessness rehabilitation group called *Take a Breath.*

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[9] Commission on Palliative and End-of-Life Care (2025), Palliative Care and End of Life Care: Opportunities for England. https://img1.wsimg.com/blobby/go/e5bbd9ef-01fd-45c0-b4f4-1cf6b62157b9/VOLUME%201%20REPORT%20FINAL%20170625.pdf

[10] Sue Ryder (2021), Modelling demand and costs for palliative care services in England. https://media.sueryder.org/documents/Modelling_Demand_and_Costs_for_Palliative_Care_Services_in_England_1.pdf

[11] Hospice UK (2025), Bringing care closer to home. https://www.hospiceuk.org/publications-and-resources/bringing-care-closer-home

[12] National Audit Office (2025), The Financial Sustainability of England's Adult Hospice Sector. https://www.nao.org.uk/wp-content/uploads/2025/10/the-financial-sustainability-of-englands-adult-hospice-sector.pdf

Take A Breath

Our *Take a Breath* group was established to address a clinical gap for people who need, but are not suitable for, traditional pulmonary rehabilitation. This is often due to the severity of their breathlessness, the deteriorating nature of their illness, or their underlying condition.

The group provides rehabilitation, exercises and education on managing breathlessness that is suitable for those patients with advanced illness. Our staff educate attendees about key topics such as advance care planning and managing fatigue. Carers also attend to receive education on how to support patients.

The groups are run at the Sue Ryder Community Hub and recently a pilot version has been run remotely at a community centre in inner city Gloucester to extend the geographical reach of the service.

Outpatients

Outpatients are seen in the Community Hub and once a fortnight at a GP clinic in inner city Gloucester.

Home Visits

The Specialist Physiotherapist also visits patients in their home if they are unable to visit the service. These visits often take place with our Occupational Therapist to enable adaptations and functional advice to help them remain in their preferred place of care and optimise their symptom control.

There is significant need for this service, and it has seen a substantial increase in referrals over the last year. In the last 3 months we received approximately 69 referrals, which is an 86.5% increase in referrals for the same period last year.

Teaching Sessions

Our Specialist Physiotherapist was approached by another group of GP practices to provide teaching sessions within a COPD course on breathlessness management. They have also expressed a wish to work more closely with the service to explore delivering the group and clinics at their practice.

Impact

One of the aims of the breathlessness service is to empower and provide patients and carers with the tools to self-manage their breathlessness, with access to our support either face-to-face or by telephone. We have seen examples of this in some cases leading to a reduction in calls to emergency services, GP services and admissions to hospital. The local GP service where our remote clinic is held has reported attendees needing fewer medical appointments and requiring fewer rescue medications.

Which professions, roles and skills were critical to successful implementation for each example

This service is run by a Specialist Physiotherapist with a background in managing acute respiratory conditions and over 10 years working in palliative care, which is essential expertise. The service is supported and overseen by the Therapy Team Manager who has over 30 years' experience working in palliative care. Additionally, the Specialist Physiotherapist has strong local links, allowing close working with the acute trust, GP practices and charities.

The Physiotherapist works alongside an Occupational Therapist to deliver the breathlessness service; and the *Take a Breath* group has additional support from volunteers and from other members of the MDT who deliver sessions on wellbeing and advance care planning.

The service being based at the hospice allows for access to support from other members of the hospice MDT including wellbeing, carer support, medical advice and our Community Hub and IPU.

Any barriers to ensuring the right professions, roles and skills were involved, and how you overcame these barriers

Not having an adequate workforce is a huge barrier to extending the breathlessness service. Despite demand, Sue Ryder is currently unable to employ more staff members to run additional services.

The services' existing work with the GP clinic is based on goodwill on both sides and a willingness of staff to go above and beyond as they know the value of the service. The pilot group has been funded by the local Primary Care Network (PCN).

The service is highly valued by patients, carers and the health professionals that we are working in partnership with (including GPs, the acute trust and Clinical Nurse Specialist teams). This is reflected in patient outcomes and feedback, along with a consistently rising number of referrals.

ICB funding of the breathlessness service would ensure it can keep running permanently and can be rolled out to all who need it. This would ultimately create savings for the NHS as the service has been proven to reduce 999 calls, ambulance call outs and A&E attendance.

Section 2: modelling assumptions

The workforce we build today will determine whether we can deliver the ambitions of the 10 Year Health Plan. That means challenging old assumptions, testing new ideas and being honest about what the future demands.

Big changes are coming. Artificial intelligence, breakthroughs in genomics and an ageing population will transform the way care is delivered. We need to capitalise on these shifts now or the NHS risks being left behind.

We need the insight of those who see, every day, what really works for staff and citizens - be that in the NHS, in other sectors or in other healthcare systems around the world. Your evidence will help us build a workforce that is ready, resilient and capable of delivering world-class care.

In this section, please submit evidence of:

Specific assumptions you use in workforce modelling - for example, how service redesign such as new community services or digital models of care might affect the numbers, deployment and/or skill mix of staff.

Sue Ryder has been awarded a major new NHS contract to grow our expert palliative and end-of-life care services across Reading, Wokingham, Newbury and South Oxfordshire. This will bring in a number of new services, including a hospice at home service across Berkshire West.[13] When modelling the hospice at home service we made a number of key assumptions around the caseload (numbers and complexity), geography, shift patterns and lone working. However, an equally important consideration is the financial envelope we must operate within, which plays a significant role in shaping how charitable hospice services are designed and delivered.

How that impacts on workforce supply and demand, including career and training pathways
Please provide clear examples and, where possible, support them with data.

Section 3: productivity gains from wider 10 Year Health Plan implementation

In his independent investigation of the NHS in England, Lord Darzi said:

Falling productivity doesn't reduce the workload for staff. Rather, it crushes their enjoyment of work. Instead of putting their time and talents into achieving better outcomes, clinicians' efforts are wasted on solving process problems, such as ringing around wards desperately trying to find available beds.

To deliver transformational change we must improve productivity. This does not mean asking staff to work harder, it means changing the way we deploy staff in response to other developments, making it easier for them to do their jobs and bringing back their enjoyment of work.

In this section, please provide evidence of:

The top digital initiatives you have delivered - in the NHS, other sectors or internationally - that have successfully increased workforce productivity or reduced demand

Actions taken to identify and address gaps in training (pre or post-registration) that support delivery of the 3 shifts

Sue Ryder International Learning Academy

[13] https://www.sueryder.org/blog/sue-ryder-to-expand-vital-palliative-and-end-of-life-care-in-reading-wokingham-newbury-and-south-oxfordshire/

All healthcare staff must feel well-equipped and educated in PEoLC. Many healthcare professionals do not receive training in PEoLC either as an undergraduate or as part of job induction programs.[14] Additionally, healthcare staff can feel unprepared for initiating conversations around care planning and end-of-life care, particularly when death and dying remain taboo topics.[15] All healthcare professionals will support patients who are nearing or at the end of life, therefore all healthcare professionals need PEoLC as standard in their pre-registration and post-registering training. This should form part of the revalidation process for each healthcare profession.

The Sue Ryder International Learning Academy delivers evidence-based education and practical training designed to enhance the quality of life for patients and their families. Our current course offerings are CPD accredited and rigorously assessed against the NHS Health Education England Quality Framework.

Current courses include Advance Care Planning and ReSPECT; symptom management in palliative care; ethical decision making in healthcare; bereavement, grief and loss; and an introduction to palliative and end-of-life care. These provide key opportunities for healthcare staff at all levels to upskill themselves in providing high-quality PEoLC.

Policies or initiatives that have enabled the NHS to play a bigger role in local communities (for example, widening access, creating opportunities or supporting underserved groups)

Where you have managed changing expectations and increased patient participation in their care through digital tools and, where applicable, you have adjusted workforce planning to reflect this (for example, increased training to deliver new approaches to diabetes management to reflect new digital tools). Please provide specific examples, supported by data where available.

Section 4: culture and values

The 10 Year Health Plan made it clear that great culture and great leadership go hand in hand with better quality care. When staff feel valued and supported, patients see the benefits.

We are committed to empowering leaders and managers at every level of the NHS to do better - to focus relentlessly on access, experience and outcomes for patients and communities. We know the best ideas often come from those already driving change on the ground.

[14] Commission on Palliative and End-of-Life Care (2025), Palliative Care and End of Life Care: Opportunities for England. https://img1.wsimg.com/blobby/go/e5bbd9ef-01fd-45c0-b4f4-1cf6b62157b9/VOLUME%201%20REPORT%20FINAL%20170625.pdf

[15] Macmillan Cancer Support (2018), Missed Opportunities: Advance Care Planning Report. https://www.macmillan.org.uk/dfsmedia/1a6f23537f7f4519bb0cf14c45b2a629/9238-10061/missed-opportunities-advance-care-planning-report

We want your evidence and experiences on what works in building a positive culture where leadership is strong, the quality of care is high and staff are supported to thrive - and what must change to make that the norm everywhere.

In this section, please provide evidence of:

Policy interventions that have directly improved workforce outcomes and patient outcomes (for example, retention, staff wellbeing, reducing sickness absence, as well as better quality care)

Bereavement Leave

As one of the UK's leading bereavement support charities, Sue Ryder recognises that dealing with bereavement can be amongst the biggest challenges of an employee's life. We realise that the personal nature of bereavement and grief impacts all individuals differently, and at different times.

Sue Ryder offers an enhanced bereavement leave policy, granting employees two weeks of paid bereavement leave following the death of an immediate family member or someone whose death has a significant emotional impact. Our bereavement leave can be taken in a block of 10 days at the time of the bereavement, or in two blocks, with the first taken immediately and the second within 56 weeks of the bereavement. This allows leave to be taken at a later point at a particularly difficult time, such as the birthday of the person who died. We offer four weeks of paid parental bereavement leave following the death of a child under the age of 18, including a stillbirth after 24 weeks of pregnancy. We also recognise that not all bereavements require extended leave. Therefore, Sue Ryder offers two days of paid bereavement leave following the death of someone who was not an immediate family member but with whom the employee had a close personal relationship.

Over the past 12 months, Sue Ryder healthcare staff who used bereavement leave took an average of just over one full-time equivalent week (37.66 hours).

The Employment Rights Bill is a welcome step towards strengthening bereavement leave provision. **However, we believe the Bill should go a step further by introducing two-weeks statutory paid bereavement leave as a day one right for all employees.** This is an important measure, as two-weeks paid leave would allow employees a crucial period of time to start processing their grief and relieve financial stress at one of the most difficult times.

According to the UK Commission on Bereavement, a third of adults reported feeling either not at all supported or only minimally supported by their employer.[16] Similarly, Sue Ryder polling found 61% of adults felt their employer did not fully support them* in the six months following the bereavement.[17] The impact of this is not only felt by the individual but ripple into the wider economy. Our economic

[16] The UK Commission on Bereavement (2022), Bereavement is everyone's business. https://www.mariecurie.org.uk/document/bereavement-is-everyones-business-full-report

[17] On behalf of Sue Ryder Censuswide polled 2,015 18+ people who had experienced a bereavement in the last two years. *Combined responses: I received some of the support I needed, I did not receive much of the support I needed and I did not receive any of the support I needed.

research shows that grief experienced by employees who have lost a loved one costs the UK economy £23 billion a year and costs HM Treasury nearly £8 billion a year, through reduced tax revenues and increased use of NHS and social care resources.[18]

In addition to paid bereavement leave, we also have Mental Health First Aiders, access to counselling through our employee assistance programme (EAP) and bereavement awareness e-learning. Annual engagement survey results demonstrate that employees feel well-supported in this area, with consistently high scores for the statement 'Sue Ryder provides appropriate support to those experiencing a bereavement whilst working for the charity'.

Salary and benefits

Hospices hire staff from the same pool as the NHS and, consequently, recruitment and retention are directly linked to our ability to keep pace with Agenda for Change (AfC).

In 2022, Sue Ryder conducted a pay review to bring healthcare salaries in line with AfC. This resulted in a 50% reduction in vacancies due to reduced attrition rates and a faster recruitment process—cutting the average time to hire a registered clinical role from six to four weeks. The £1.9 million annual investment was essential to attract and retain qualified staff. To remain competitive, we also offer NHS-equivalent benefits, including enhanced annual leave and pension contributions.

Staffing represents the largest area of expenditure for hospices.[19] In 2024, Sue Ryder's palliative staffing costs were 170% of the total income we received from ICBs. Although hospices employ clinical staff across many of the same roles found within the NHS, Government funding falls significantly short of covering these staffing costs, let alone supporting necessary pay increases. To put the challenges the sector faces into perspective, UK hospices would have had to raise an additional £66 million pounds to match the increased pay for NHS staff announced in July 2024.[20]

Hospice UK's four-point plan calls for NHS pay deals that reflect the cost of hospice staff. **We support this ask.** Without it, there is a significant risk that we will be unable to maintain parity with NHS pay, jeopardising our ability to sustain high-quality palliative care.

Approaches that have successfully embedded strong core values into everyday leadership, decision making and service delivery

Systems or practices that ensure leaders at all levels actively listen to staff feedback - particularly from underrepresented groups - and act on it. Please provide specific examples, supported by data where available.

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[18] Sue Ryder (2020), Grief in the workplace. https://media.sueryder.org/documents/Sue_Ryder_Grief_in_the_workplace_report_0_rW0nAiA.pdf

[19] APPG on Hospice and End of Life Care (2024), Government funding for hospices. https://hukstage-new-bucket.s3.eu-west-2.amazonaws.com/s3fs-public/2024-02/APPG%20Report%20-%20Government%20funding%20for%20Hospices%20HUK.pdf?VersionId=0l8T4jC5V2C0zRKQLFs9ClZ5QZ5xEiOs

[20] https://www.hospiceuk.org/latest-from-hospice-uk/nhs-pay-rise-response

Sue Ryder has implemented several feedback channels to ensure staff feedback reaches leaders across all levels of the organisation. Each channel serves a distinct purpose, helping to foster transparency and continuous improvement. Key examples include:

Let's Talk

- Each year, we conduct 'Let's Talk', an engagement survey that gives staff the opportunity to share their thoughts about working at Sue Ryder. The insights gathered help us understand what we're doing well and identify areas for improvement, ensuring we continue to meet the evolving needs of our people.
- Survey feedback leads to significant organisation-wide changes, as well as improvements at a local level. Senior leadership teams use the scores to create action plans for their directorate, which are communicated and tracked throughout the year.
- Our 'Connected Colleagues Days' were introduced in 2024 as a result of Let's Talk feedback. Designed to strengthen collaboration across teams, the initiative gives Business Support colleagues the opportunity to spend time in one of our shops or assist at a fundraising event. Participation across the charity was high, helping staff to gain a deeper understanding of the roles and contributions of their peers.
- To promote transparency and accountability, Sue Ryder shares a 'You Said, We Did' update every year. This communication outlines the key actions taken in response to feedback from the previous year's 'Let's Talk' survey, demonstrating how staff voices directly shape organisational improvements.

Speak Up

- In July 2025 Sue Ryder launched a new online reporting tool for staff and volunteers, Speak Up. Provided by Work in Confidence, an independent organisation, Speak Up can be used to report a wide range of concerns anonymously.
- Ideally, concerns or complaints should be raised with line managers or HR. However, we recognise that this isn't always possible. Speak Up offers an alternative route for colleagues to report issues that remain unresolved or that they feel uncomfortable discussing through traditional channels.

Equity, Diversity and Inclusion Networks

- At Sue Ryder, we believe in the power of our Equity, Diversity and Inclusion (ED&I) Networks. We have four Networks that bring together staff and volunteers with shared lived experience and shared identity, plus allies.
- Each Network has an Executive Leadership Team (ELT) member as their sponsor, providing a link between staff with lived experience and senior leadership. ELT members act as champions for their respective Networks, providing support and guidance as appropriate and elevating key issues and initiatives with ELT.

Section 5: any additional comments

Please include any other comments, information or evidence you would like to share as part of this call for evidence that you think would help deliver the ambitions of the 10 Year Health Plan. (Optional, maximum 250 words.)

The commitment to shift care into the community is welcome. However, with 42% of deaths in England still occurring in hospital[21] it remains essential that high-quality PEoLC is available across all healthcare settings, and that healthcare staff are equipped to provide this.

We believe the solution to delivery of PEoLC in hospitals is the introduction of Sue Ryder Alongside Suites, providing specialist PEoLC adjoined to hospital footprints. This would ensure high-quality patient care in hospital for people who cannot be discharged into the community. Patients who are expected to be in the last year of life would be transferred to a Sue Ryder Alongside Suite from ambulances, A&E and other wards within the hospital. Each Alongside Suite has the potential to care for hundreds of patients every year, rapidly freeing up bed space and staff time within the wider acute setting.

Not only will this improve PEoLC care for inpatients, it will also help to shift care to the community. Once in our care, we can put packages in place to discharge people back to the community. In the current system, there are considerable delays and challenges when discharging patients nearing the end of life from hospital. Alongside Suites will be in a better position to facilitate efficient transfer to community settings through their links with and knowledge of local hospice services. This is much needed - 8% of people referred to a Sue Ryder IPU between September 2023-October 2024 died before admission, indicating referrals are being left too late.

Innovative workforce models could also help strengthen PEoLC in hospitals. For example, PEoLC nurses in the community could run clinics in A&E to provide care to end of life patients and ensure they have been triaged. As another example, PEoLC charities such as Sue Ryder could explore sponsoring specialist nurses to provide expert PEoLC in the hospital, manage discharge planning, refer to care outside of the hospital and support Advance Care Planning. This has been evidenced - the National Audit of Care at the End of Life (NACEL) Good Practice Compendium outlines the benefits of having a palliative care nurse in the emergency department of King George's Hospital & Queen's Hospital.[22]

[21] Office for National Statistics (2025), Deaths registered weekly in England and Wales, provisional. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/weeklyprovisionalfiguresondeathsregisteredinenglandandwales

[22] https://www.nacel.nhs.uk/good-practice-compendium (under theme: 'emergency department')