

Summer 2026

Palliative and End of Life Care: Maximising Effectiveness of Allied Health Professionals (AHPs)

To deliver equitable, person centred, high quality Palliative and End of Life Care (PEoLC) in Wales, Allied Health Professionals (AHPs)¹ must be optimally utilised.

As the third largest NHS workforce, spanning thirteen professions, AHPs play a vital role in supporting physical, mental, and social wellbeing.

Their contribution improves quality of life, supports preferred place of care and death, enhances bereavement experiences, and strengthens PEoLC outcomes across Wales.

Demand for PEoLC is expected to rise significantly due to demographic changes and chronic life limiting conditions, highlighting the need for integrated, multi-professional rehabilitation and palliative care services².

Despite this growing need, AHPs are inconsistently deployed, poorly understood, or insufficiently embedded in PEoLC pathways across Wales.

This paper highlights key AHPs involved in PEoLC, designed to support an understanding of skillsets and roles, to maximise their effective utilisation as an integral part of the multi-professional team and PEoLC delivery model within each Health Board area.

Demand for PEoLC is set to rise. Dementia and cancer are expected to drive much of this demand, with trends towards many other conditions including respiratory disease, heart failure, liver failure and renal failure and many people will have multiple chronic conditions.

The World Health Organisation Policy on Universal Health Coverage states Rehabilitation and Palliative Care are essential services in quality health systems³.

Both should be integrated within primary, secondary, and tertiary health systems using a multi-professional workforce.

AHPs utilise their unique skills to provide assessment, interventions and leadership to ensure a palliative rehabilitation approach is taken, supporting adjustments of goals during deteriorating health. For people with palliative and end of life care needs, this impacts on their highest areas of concerns; loss of independence and being a burden on carers.

Palliative rehabilitation

defined: Helps individuals with progressive diseases achieve their physical, psychological, and social potential within their limitations and preferences, with AHPs leading this holistic approach.

AHPs work across the continuum of PEOLC service provision and across all organisations and settings including Health, Local Authority, Trusts and Third Sector including hospices. Ensuring quality of life is maximised through a range of pharmacological and non-pharmacological methods; helping individuals achieve their priorities and reduce unnecessary hospital admissions in the final year of life through timely and effective interventions.

AHPs facilitate transitions, proactively engage in future care planning, and provide support for end-of-life care, consistently acknowledging the significance of living well until death.

Their comprehensive understanding of the effects of life-limiting illnesses on daily activities uniquely positions them to empower individuals in making informed decisions regarding their future care.

Those working in PEOLC environments may have undertaken additional competencies training in Future Care Planning and discussions concerning Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR)⁴.

Consequently, when implementing the PEOLC Service Specification, it is vitally important commissioners and providers include AHPs as an integral part of the PEOLC multi-professional team and delivery model within each Health Board area^{5,6}.

Occupational Therapists

are unique among AHPs; trained in both mental and physical health they evaluate complex and evolving needs.

Occupational Therapists provide psychological and emotional support as part of their role, alongside palliative rehabilitation, enabling individuals to engage with and undertake those occupations and activities important and meaningful to them, within their preferred environment. Helping individuals express their end-of-life preferences.

Occupational Therapists provide practical support such as self-management strategies including fatigue and pain management, equipment recommendations and environmental modifications, alongside psychological and emotional interventions including anxiety management⁷.

Through helping people engage in valued roles and occupations, Occupational Therapists enable individuals to sustain identity, functional independence, dignity, quality of life and connection with others.

Physiotherapists assess and address physical limitations caused by illness or treatment side effects, designing individualised exercise programmes to improve strength, balance, and flexibility, enabling individuals to remain active and engaged in their lives. Physiotherapy can help manage common symptoms such as dyspnoea, fatigue, and pain using techniques like chest physiotherapy, breathing exercises and manual therapy which can provide relief and improve comfort.

Physiotherapists also provide education on symptom management, activity maintenance, and adaptation, supporting both individuals and their families in understanding the illness and its effects^{8,9}. By addressing physical, emotional, and practical challenges, palliative physiotherapy empowers individuals to live as fully and independently as possible, with dignity and comfort.

Individuals with palliative conditions often face challenges related to communication, swallowing, and nutrition. Speech and Language Therapists and Dietitians play a crucial role in addressing these difficulties.

Timely referrals to Speech and Language Therapists can help proactively manage issues with communication and swallowing, ultimately preserving function and quality of life for as long as possible¹⁰.

They carry out specialised assessments and interventions to support communication, enabling individuals to engage in meaningful social interactions and share their preferences concerning care and decision-making.

This may include the implementation of Augmentative and Alternative Communication (AAC) devices, sometimes in partnership with electronic assistive technology teams.

When supporting dysphagia (swallowing problems),

Speech and Language Therapists focus on enhancing the safety, comfort, and enjoyment of eating and drinking. They collaborate closely with Dietitians and the wider multi-professional team to provide support to individuals with complex swallowing needs, as well as contributing to conversations about artificial nutrition and hydration which has ethical and legal considerations.

Dietitians in specialist palliative care provide overall holistic assessment and support for individuals and carers with regards to nutrition related symptoms and hydration, associated with both disease and its treatment.

Symptoms affecting oral intake in PEOLC are significant and include nausea, oral health issues, fatigue, taste changes, sore or dry mouth (xerostomia), vomiting, constipation and dysphagia.

Anorexia, cachexia syndrome and weight loss are commonly seen and are often irreversible. These cause high levels of distress for both individuals and their families.

Consequently, Dietitians are an essential member of the multi-professional team to minimise food-related discomfort, maintain or improve nutritional status, and support overall quality of life¹¹.

Dietitians provide education and support in PEOLC for individuals, carers and the wider multi-professional team. Recognising the emotional, social, and cultural significance of food, they can reduce this nutrition-related distress by providing tailored advice, reassurance and individualised nutrition care plans that incorporate high-energy high-protein dietary strategies and the use of oral nutritional supplements.

Paramedics play a vital and often time critical role in supporting people with palliative and end of life care needs¹². Working at the interface of urgent, emergency and community care, they provide rapid assessment, symptom management, and crisis intervention, helping to stabilise changes in condition and relieve distress.

Notably, Rotational Palliative Care Paramedics bring expertise in assessment and symptom management and future care planning.

They help maintain dignity and comfort, prevent unnecessary hospital admissions, coordinating seamlessly with community services and specialist palliative care teams, and enable care in preferred settings. Their advanced clinical skills, including delivery of pharmacological interventions for pain, breathlessness, agitation and other complex symptoms, enable timely, compassionate responses that uphold dignity and comfort.

Psychological care importance: Equally important to support physical symptoms is the psychological care needing during periods of change and deterioration.

Arts Psychotherapists (Art, Music, Drama) use creative media as their primary communication tool and work across all ages in NHS, education, and social settings, focusing on the therapeutic process rather than artistic skill. In PEOLC, Arts Psychotherapists help individuals process complex emotions like fear, grief, and loss, offering tailored sessions individually or in groups, to explore, communicate, understand and process complex emotions¹³.

These registered professionals work within multi-professional teams to improve quality of life and help individuals, families, and staff address grief, anxiety, and bereavement and grief after a loss when verbal communication is difficult^{14,15}.

Practitioner Psychologists

deliver a range of evidence-based interventions and provide indirect support with multi-professional team members in their delivery of universal psychological care,^{16,17} as well as in the direct delivery of more targeted and specialist psychological interventions^{18,19}.

Direct clinical work can include acceptance and commitment therapy, eye movement and desensitisation reprocessing, CALM, dignity therapy, mindfulness-based cognitive behaviour therapy and cognitive analytic therapy (CAT).

Indirect working may include education provision, advocacy, consultation, team formulation, supervision, staff support and reflective practice, and undertaking research and evaluation initiatives.

The potential benefits include improved staff wellbeing and retention, improved psychological health and quality of life for individuals and their significant others, and reduced risks of treatment non-adherence, suicide and self-harm, higher symptom burden, and compromised relationships with health care providers⁴.

Consequently, their role is vital for individuals’ psychological health, shared decision-making, and reducing risks related to mental health challenges in PEOLC²⁰.

Conclusion

Allied Health Professionals’ (AHPs) wide ranging skills are essential to the delivery of person-centred holistic care and achieving the quality statement for PEOLC²¹.

They contribute positively to the experiences and outcomes of people receiving palliative and end of life care in Wales; supporting self-management, adjusting goals, and challenging assumptions about inevitable functional decline.

Through palliative rehabilitation, AHPs help individuals prioritise and achieve what matters, adapt goals, and enable end-of-life care in their preferred location and are an integral workforce to. Their work adds value across the entire health and care system through maximising health, delivering personalised care and improving person-centred outcomes and experience, reducing harm, and supporting prudent utilisation of resources.

This includes reducing hospital stay lengths, optimising service pathways and avoiding unnecessary hospital presentation and admission.

Allied Health Professionals (AHPs) are an integral component in the comprehensive effective delivery of palliative and end of life care (PEoLC) in Wales.

AHPs specialist knowledge and skills combined with a person-centred, holistic approach, contribute significantly to helping individuals achieve their priorities, supporting transitions, and reduce unnecessary hospital admissions in the final year of life through timely and effective interventions.

In implementing the PEoLC Service Specification, it is vitally important commissioners and providers include AHPs as an integral part of the PEoLC multi-professional team and delivery model within each Health Board area.

Contributors

Jackie Pottle

(former) National AHP Lead
Palliative and End of Life Care,
National Palliative and End of
Life Care Programme, Wales

Kerrie Phipps

National AHP Lead Primary and
Community Care, NHS Wales
Performance and Improvement

Alison Docherty

Macmillan Specialist
Practitioner Occupational
Therapist, Cwm Taf Morgannwg
University Health Board

Lowri Jarrett

Specialist Occupational
Therapist, Cwm Taf Morgannwg
University Health Board

Jeanne Dore

Clinical Specialist Palliative
Care Occupational Therapist,
Betsi Cadwaladr University
Health Board

Reena McClure

Specialist Physiotherapist,
Cwm Taf Morgannwg University
Health Board

Uma Wong

Physiotherapist, Cwm Taf
Morgannwg University Health
Board

Suzannah Minns

Clinical Specialist
Physiotherapist, Cwm Taf
Morgannwg University Health
Board

Elinor Evans

Highly Specialist Speech and
Language Therapist, Cwm Taf
Morgannwg University Health
Board

Ellen Buffery

Head of Dietetics, Powys
Teaching Health Board

Natalie Harrison

Consultant Dietitian-
Malnutrition and Hydration,
Aneurin Bevan University
Health Board

Rhiannon McDonald

Highly Specialist Palliative Care
Dietitian, Cwm Taf Morgannwg
University Health Board

Lisa Heaton Brown

Consultant Clinical
Psychologist, Betsi Cadwaladr
University Health Board

Edward O'Brian

Clinical Lead Palliative and End
of Life Care, Welsh Ambulance
Services NHS Trust

Dr Natalie Elliott

National Consultant AHP Lead
for Dementia, Wales

**National Palliative and
End of Life care (PEoLC)
Programme**

PEOLC – NHS Wales
Performance and Improvement

References

1. Allied Health Professions: art therapists, dramatherapists, music therapists, podiatrists, dietitians, occupational therapists, orthoptists, prosthetists and orthotists, paramedics, physiotherapists, speech and language therapists, psychologists.
2. [Cicely-Saunders-Manifesto-A4-multipage_Jan2021-2.pdf](#)
3. [Policy brief on integrating rehabilitation into palliative care services](#)
4. [Advance and Future Care Plans – NHS Wales Performance and Improvement](#)
5. [PEOLC – NHS Wales Performance and Improvement](#)
6. [performanceandimprovement.nhs.wales/functions/networks-and-planning/peolc/documents/national-service-specification-for-wales-peolc/](#)
7. [Actual Roles of Occupational Therapists in Palliative and Hospice Care: A Scoping Review – PubMed](#)
8. [Physical Therapy in Palliative Care: From Symptom Control to Quality of Life: A Critical Review – PMC](#)
9. [Physiotherapy applied to palliative care patients: a descriptive practice-based study – PubMed](#)
10. [End of life care overview | RCSLT](#)
11. [The Role of Registered Dietitians in Cancer Palliative Care: Responsibilities, Challenges, and Interdisciplinary Collaboration – A Cross-Sectional Survey – PubMed](#)
12. [Paramedics delivering palliative and end-of-life care in community-based settings: A systematic integrative review with thematic synthesis – PMC](#)
13. [The Arts Therapies in Palliative and End-of-Life Care: Insights from a Cross-Cultural Knowledge Exchange Forum – PMC](#)
14. [Top Ten Tips Palliative Care Clinicians Should Know About Music Therapy and Art Therapy – Melissa Srolovitz, Jennifer Borgwardt, Moreen Burkart, Amy Clements-Cortes, Johanna Czamanski-Cohen, Mabel Ortiz Guzman, Molly G. Hicks, Girija Kaimal, Lindsay Lederman, Jordan S. Potash, Sarah Yazdian Rubin, Daniel Stafford, Angela Wibben, Michèle Wood, Jean Youngwerth, Christopher A. Jones, Ian B. Kwok, 2022](#)
15. [The Arts Therapies in Palliative and End-of-Life Care: Insights from a Cross-Cultural Knowledge Exchange Forum – PMC](#)
16. [Full article: Evaluating provision of psychological assessment and support in palliative care: A national survey of hospices in England](#)
17. [Research Evaluating Staff Training Online for Resilience \(RESTORE\): Protocol for a single-arm feasibility study of an online Acceptance and Commitment Therapy intervention to improve staff wellbeing in palliative care settings – PMC](#)
18. [Psychosocial intervention in palliative care: What do psychologists need to know – PubMed](#)
19. [04.-Clinical-Psychologists-in-specialist-palliative-care-what-do-we-actually-do.pdf](#)
20. [Prevalence of burnout in healthcare professionals providing palliative care and the effect of interventions to reduce symptoms: A systematic literature review – PubMed](#)
21. [Quality statement for palliative and end of life care for Wales \[HTML\] | GOV.WALES](#)