



HOUSE OF COMMONS

# Health and Social Care Committee

## Oral evidence: Palliative care, HC 632

Wednesday 7 January 2026

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Watch the meeting

Members present: Layla Moran (Chair); Danny Beales; Ben Coleman; Dr Beccy Cooper; Andrew George; Paulette Hamilton; Alex McIntyre; Joe Robertson.

Questions 1 - 122

### Witnesses

[I](#): Stephen Kinnock MP, Minister of State for Care; Dr Amanda Doyle OBE, National Director for Primary Care and Community Services, NHS England; Dr Edward Scully, Director for Primary and Community Health Care, Department of Health and Social Care; and Dr Sarah Mitchell, National Clinical Director for Palliative and End-of Life Care, NHS England.

## Examination of witnesses

Witnesses: Stephen Kinnock, Dr Amanda Doyle, Dr Edward Scully; and Dr Sarah Mitchell.

Q1 **Chair:** Welcome to this one-off session of the Health and Social Care Committee on palliative care. This follows the report put together by the Committee's independent expert panel, which included clinicians and experts from across the spectrum, looking into palliative and end-of-life care, particularly in England. For those watching online, you can find it on the Select Committee website.

To interrogate some of the issues that were found in that report, we are delighted to have with us the Minister of State for Care, Stephen Kinnock MP—thank you for being with us—and others who I will ask to introduce themselves, please.

**Dr Mitchell:** I am Sarah Mitchell. I work clinically as a GP in Sheffield. I am national clinical director for palliative care and end-of-life care at NHS England. I am also an associate clinical professor of palliative care at the University of Leeds.

**Dr Doyle:** I am Amanda Doyle, the national director for primary care and community services at NHS England.

**Dr Scully:** I am Edward Scully, the director for primary and community healthcare at the Department of Health and Social Care.

Q2 **Chair:** Thank you. Viewers will understand the delicate context in which we are holding today's session, namely the assisted dying Bill, which is still making its way through the Lords. This will not be a session on that Bill; this session is about palliative and end-of-life care. Members across this House and on this Committee, and indeed people across the country, have deeply held views on the matter, but I hope we have consensus that palliative and end-of-life care services are simply not good enough, and that they need to improve. This session is not about the assisted dying Bill, as I said, but will the Minister come back to the Committee one day, should we wish it, to answer questions about that Bill?

**Stephen Kinnock:** Yes, absolutely. I am very happy to do so.

Q3 **Chair:** That is very kind of you. Our viewers should watch this space, but let us wait and see if the Bill even passes, let alone what might be in it.

Minister, I understand there is something you wanted to tell us in advance of the session.

**Stephen Kinnock:** Thank you very much, Chair. If I could make a very brief statement, which has some new information that I think the Committee might find useful.

I thank the Committee and its independent expert panel for their excellent report. Palliative and end-of-life care plays an essential part in our health



## HOUSE OF COMMONS

and care system, and it is delivered every day by GPs, district nurses, allied health professionals and social care staff in people's homes and in hospitals, care homes and hospices. Across the UK, the Government spend over £22 billion a year on care and support for those in the last year of life. In England, it amounts to £9 billion per year on the health-related aspects of palliative and end-of-life care alone.

Palliative and end-of-life care in the UK is world-leading. In 2025, the WHO rated the UK in the top 14% that reached the advanced level of development in palliative care. The European Association for Palliative Care notes that we are one of only a handful of countries that integrate palliative care into all medical school curricula, and we are in the top five for specialised paediatric services.

We should be proud of that, but we also recognise that there is much more to be done. The expert panel's report rightly highlights unwarranted variation in access and quality, and we also know that services are too fragmented. I was therefore very pleased to announce to the House in a written ministerial statement on 24 November that we will develop a palliative and end-of-life care modern service framework, or MSF. This is one of just five MSFs, which demonstrates the priority status of palliative and end-of-life care for our Department and the entire Government.

The MSF will set national goals and standards for the services that patients and their families receive at the end of life, and it will enable ICBs to address challenges in access, quality and sustainability through the delivery of high-quality personalised care. We are co-producing the MSF with key stakeholders to ensure that we maximise its potential and galvanise the entire health and social care system.

Finally, I want to recognise the vital importance of hospices in the broader palliative care system, which is why I am delighted to confirm today that we are adding a further £25 million to the £100 million capital funding available for adult and children's hospices this financial year. That is in addition to our commitment in autumn 2025 to provide approximately £80 million of revenue funding for children and young people's hospices for the next three years.

I thank the Chair for allowing me the time to make this statement, and I look forward to our discussion.

**Q4 Chair:** There is a lot in that, and we have a good amount of time to dive into the specifics. I want to start with a reflective question: in your eyes, having been in the job for 18 months, why has this not happened before? Why is it only now that we are developing a modern service framework for palliative care? I heard you say that we are world-leading but, Christ, if we are world-leading, I worry for the rest of the world. The bar is low, is it not? What has changed? Why are we doing this now, and why has it not happened before?

**Stephen Kinnock:** It is absolutely clear that there is unwarranted variation—it is patchy. There are pockets of really good practice, but

certain socioeconomic groups and geographical areas of the country are underserved. We absolutely acknowledge that. Part of this is to do with the integrated care boards, which have a statutory duty to provide palliative and end-of-life care. That is very clear in the Health and Care Act 2022. We also have the model ICB blueprint, which sets out very clearly that ICBs are required to prioritise underserved areas, and that they are required to understand the needs of their population and serve them accordingly.

We also have medium-term policy and planning guidance, and we have the strategic commissioning framework. The point I am making is that there is no shortage of guidance, directives and frameworks, but there is clearly a disconnect between all those documents and all that guidance and the actual delivery on the ground. There is clearly an issue around the capability of ICBs in commissioning, which is why I am pleased that we are launching, from April 2026, a strategic commissioning development plan to talk about and create commissioning as a profession, where real skills are needed.

We have the strategic commissioning framework, which sets out very clearly how ICBs need to understand the health needs of their populations and the context in which they are operating; to create a strategy for dealing with and addressing those needs; to do proper strategic commissioning, working with partners to address the needs of the population; and then to evaluate the impact of what they have done to create that virtuous cycle.

That is not happening. We have too much of a transactional approach to the way that ICBs work and engage with all the partners in their catchment area. It is not strategic enough. The modern service framework is a way to pull all that together, to say, "We have to have some clear national standards and goals. We need a national plan." We understand, as a Government, the need to devolve and empower. We believe passionately in devolution. We cannot possibly micromanage everything that goes on around the country from an office in Whitehall or Westminster.

**Q5 Chair:** This issue predates the system we are changing. Isn't the answer, in part, that there has not been political leadership to make it happen?

**Stephen Kinnock:** I do not want to make too much of a political point here. The reality is that when we came into office in July 2024, I looked across every aspect of my portfolio—general practice, pharmacy, dentistry, palliative and end-of-life care, adult social care—and, frankly, it was a pretty chaotic disaster across every aspect of my portfolio.

**Q6 Chair:** We understand. When the independent expert panel briefed us about their report, they were genuinely shocked. We only commission reports into parts of the system where we think there is a problem. We start there, but it was worse than they were expecting. I don't think I've quite got to the nub. You are saying that strategic commissioning is the thing. Is that it? In your mind, does this modern service framework



## HOUSE OF COMMONS

achieve something that did not happen before? Strategic commissioning is one—is that it?

**Stephen Kinnock:** Early identification is vital. I am pleased to see that, over the last year or so, we have had quite a good increase in the number of people on the palliative care register—I think it has gone up from 0.46% to 0.55% of the population. About 1% of the population dies every year—approximately half a million people—and the key is to get more of those people on to the palliative care register, because if you get early identification right, so much more of the system works more effectively.

Our big goal is to shift care from hospital into the community. Most people want to die at home, and we want to support that to happen. All the health and social care outcomes are significantly improved when people are in the community rather than in hospital—and, by the way, it is much better for the system's efficiency, costs and so on. Early identification is crucial.

GPs play a vital role in that, and we do not have enough GPs. I am very pleased to say that we have appointed 2,500 more GPs through the additional roles reimbursement scheme since July 2024. We need to get more GPs into the field and get them more effectively trained in palliative and end-of-life care skills, so that we can ensure that GPs reach out beyond core GP practice and into the extended roles they need to play in things like palliative and end-of-life care. We need to get the interface working far more effectively with hospitals, hospices and district nurses—we do not have enough of them.

You are absolutely right to say, Chair, that it is not only about strategic commissioning; it is absolutely about early identification, as well as about the integration of services and about the workforce.

Q7 **Chair:** Thank you for mentioning workforce, which we are going to come to later. Can we talk about money, so that we understand the envelope in which we are working? Is it your view that, to shift the dial on this as fast as people out in the country desperately want it to shift, it is going to take more money?

**Stephen Kinnock:** I do not think it is necessarily about the quantum. If you look right across Government, we spend about £22 billion on people in the last year of their life. About £5 billion of that is on social security, about £5 billion is on adult social care, and the remaining £12 billion or so is in the healthcare side of palliative and end-of-life care. That is a large sum of money: it is about 10% of the overall NHS budget of around £220 billion. So £22 billion, as a quantum, is a large sum of money. The question is whether we are spending it where it should be spent, and I think the answer to that is a resounding no.

We have to shift funding flows out of secondary and acute care into community and primary care. In some ways, I see that as the most important aspect of my job. My job is to constantly press the system to make that shift. There is a baked-in tendency for funding to flow into secondary and acute—power resides in secondary and acute. Our 10-year



## HOUSE OF COMMONS

plan is effectively about culture change. It is about saying that we have to get trusts to let go, and that we have to get funding to move from the right to the left. All that needs to happen through ICBs.

- Q8 **Chair:** Yes, we are well versed in that, but even in hospitals, where the vast majority of palliative care happens, the service is substandard. I was speaking to a palliative care doctor over the weekend. They pointed out that the service in their hospital is employed basically Monday to Friday, 9 to 5. For anyone who has had a family member have to go through the services that they provide, that is nonsensical. Even in that setting, the money for palliative and end-of-life care is a minnow compared with everything else. She was pointing out that there is even more pressure on it now, because of the focus on elective waiting lists and so on.

Where is the money actually going to come from? You are talking about the quantum that is spent on that, but is it going to have to come from other parts of the hospital? They cannot even do it 9 to 5 in the hospital, and you are then going to ask it to shift into the community. That is fine, but the need is so great—that is what the report showed. Are you sure that you can do this in the time necessary, and where is that money actually going to come from?

**Stephen Kinnock:** We have to do it, and the point is that we are currently living in a world where the problem the system is facing, and one of the reasons we have such a huge elective backlog, is because we haven't made primary and community care work as effectively as they should. We have to prevent avoidable admissions. Far too many people in their final year of life are going into acute care and using the emergency department. We have to be brave and make that happen.

- Q9 **Chair:** Is it your assessment that the money currently being spent in hospitals on palliative care could be shifted into the community to deliver the 24/7 service that people should be entitled to in their final dying days and hours?

**Stephen Kinnock:** Yes.

- Q10 **Chair:** Do you have the data for that? My understanding is that the data is not robust.

**Stephen Kinnock:** We have to make that work.

- Q11 **Chair:** How?

**Stephen Kinnock:** That is what the 10-year plan is about. It is about creating a neighbourhood health framework and strategy.

- Q12 **Chair:** Can we focus on the MSF? Is that going to be baked into this?

**Stephen Kinnock:** Yes. When we talk about strategic commissioning, the funding flows have to follow the priorities set out under the new approach to commissioning. If you are saying that we are now going to have a holistic view where trust, primary care, adult social care and community care voices are sitting round the table and planning in a much more integrated way, that is where the conversation has to happen with the



## HOUSE OF COMMONS

trust to say, "Listen, if we take some of the funding you currently have and put it into more effective primary and community care, that is going to create savings for you in the long run. It will enable you to focus on the cohorts that you really should be focusing on." Keeping people out of hospital who don't need to be there and enabling people to die a good death at home is better for the patient and a much better way to operate the system, both in terms of primary and community care and of secondary and acute.

- Q13 Chair:** The logic then follows that if you move people out of hospital beds and into the community, the hospital will then have more beds, and saving money in other areas is how you are going to convince them to move. I am not sure that is what happens, though—is it? History tells us that hospitals always find something else to fill the beds. They are not about to take the money out of their coffers willingly. Is the framework going to have any teeth? Is it going to have bite? How are we going to be able to hold you to account on this?

**Stephen Kinnock:** Every ICB is held to account by NHS England every year. They have to produce—

**Chair:** You are abolishing that.

**Stephen Kinnock:** Well, NHS England and DHSC will become a new body corporate that does the same thing. It will be the same function, so every ICB is held to account on that basis. The last outturn on that was January 2025. The ICBs have to show that they are discharging their functions. It is our job to hold them to account, and it is your job to hold us to account. We should be held to account on the basis of what is happening out there in the field, in terms of the ICBs, and our ability to hold them to account and to push through the modern service framework and the new approach to strategic commissioning.

It is not just about the stick; it also has to be about the carrot. That is what I was alluding to earlier. You incentivise the system to change by showing the system that it is to the benefit of the trusts, which currently hold all the power and resources. They need to be convinced that it is better for them and in their interest to let go of some of that power and resource, so that we can push it to the left in the system.

- Q14 Chair:** Are we still aiming for the spring with the modern service framework for palliative and end-of-life care? What is the timeline?

**Stephen Kinnock:** There will be an interim report on it in the spring, and finalisation in the autumn.

- Q15 Chair:** And what will be in the interim report?

**Stephen Kinnock:** It will be an update on the progress we have made. So far there have been five meetings between officials and the large number of stakeholders we are reaching out to. That will continue from January to April. There will be regional-level engagement to include systems and providers. In spring '26 there will be an interim update on MSF development, and in autumn '26 the MSF will be published.



## HOUSE OF COMMONS

Q16 **Chair:** So autumn '26 is the point that we will see it. In there, are we expecting high-level statements, targets, incentives and everything you have spoken about?

**Stephen Kinnock:** National standards and goals.

Q17 **Chair:** Will there be a SMART timeline? When will people start to have faith that this is changing for the better? I appreciate that a 10-year plan does what it says on the tin. It is a 10-year plan—I get that. But people out there want to know, if this happens to them next year, in three years or in five years, at what point they can look across and say, “I can breathe a bit, because it is not going to be in the dire state that it is in now.” What is your hope for that?

**Stephen Kinnock:** I am very conscious of our parliamentary timetable. We have to be able to demonstrate very clearly by 2029 that we have seen a step change in improvements to palliative and end-of-life care in our country. By “step change”, I mean that people need to be confident that they will be identified early as being in the last year of life.

Q18 **Chair:** Are you fully measuring unmet need now?

**Stephen Kinnock:** Yes. If you measure it on the basis of whether a person is on the register of palliative care, there are about 345,000 people on the register of palliative care. That is only about 50% of the total number of people in the last year of life, if we assume that, at any given time, there are about half a million people in the last year of life. I would like to be in a position where 90% of people in the last year of life are on the palliative care register. We are clearly quite a long way from that—30 or 40 percentage points off it—so it is a stretch target, and we need to do everything we can to achieve it. As I said earlier, GPs are an absolutely crucial part of that, because that is where the process starts.

Q19 **Chair:** That brings me quite neatly on to social care. One of the big areas where you would expect very good end-of-life and palliative care is a social care setting, but very often it is not there to the level that people would necessarily expect. What is your plan to integrate this with social care?

**Stephen Kinnock:** We accept that there is not good enough involvement, interface and integration with adult social care.

Q20 **Chair:** Is that going to be covered by the framework? Are you consulting with social care settings?

**Stephen Kinnock:** Yes, absolutely. If you look down the list of stakeholders that we are engaging with for the modern service framework, we have people like the Social Care Institute of Excellence, Skills for Care, the National Care Association and the Care Association Alliance, so we have a whole range of key players.

Q21 **Chair:** We don't have that list. Could we get a copy of it?

**Stephen Kinnock:** Absolutely. I am very happy to do that—with pleasure.

**Chair:** That would be really helpful. Thank you very much.

**Stephen Kinnock:** We recognise that that voice needs to be heard. Obviously, local authorities play a crucial role in that. We have to ensure that local authorities are around the table as we develop this modern service framework. We also want to look at ways in which care workers can be more empowered. We are looking at delegation to enable care workers to do some healthcare checks, blood pressure checks and that sort of thing. We think there is a big opportunity for care workers to be brought much more effectively into the picture, and we recognise that has not been happening to the extent that it should hitherto.

Q22 **Ben Coleman:** It is good to see you all today. Thank you for coming. May I ask a bit about ICBs? To pick up the point that you were talking about with the Chair, if you want local authorities to be more involved in developing palliative care services and other services, why is the Government planning to reduce the number of local authorities that sit on ICBs?

**Stephen Kinnock:** I wasn't aware that we are planning to do that.

Q23 **Ben Coleman:** A paper that the Committee discussed before Christmas, the name of which escapes me, says that only mayors will be on ICBs. At the moment, you have three councils sitting on the North West London ICB, which is unusual—we had to fight for it, and we got it—and in other places it is one or two. You are merging ICBs—obviously, North West London is merging with North Central London—and, as far as I am aware, there is no plan to increase local authority involvement. Indeed, there is a plan to reduce it. I appreciate that you may not have the answer today, but would it be possible for you to write to us and let us know how reducing local authority involvement in ICBs will help with your aims and ambitions to involve local authorities more in delivering better palliative care and, I presume, other services?

**Stephen Kinnock:** I am very happy to do that. We are looking at reforming the Better Care Fund, which plays an absolutely crucial role in bringing local authorities together with the health system to improve delayed discharge, which is a massive challenge that the system is facing. I have been working on that with my officials, and with MHCLG officials, very closely. So I would say that, at least at the level of what is happening in Whitehall, the interface between DHSC and MHCLG on things like reforming the Better Care Fund has been working very well. We need to make sure that cascades down through the system. Your point is well made and well taken.

Q24 **Ben Coleman:** The 10-year plan talks about strategic authority mayors, rather than local councils, sitting on ICBs. We do not have a strategic authority mayor in London who does that, and there are other parts of the country where it might not be appropriate. I think one of the weaknesses of what is otherwise a very impressive 10-year plan is the continuing misunderstanding of the role of local authorities and the lip service that is delightfully and importantly paid to their importance, while actually, at a practical level, things are done or not done. That is just a general point, if



you will forgive me.

On the Better Care Fund, which you have raised, what is the main problem that you are trying to solve—that you say you are engaging quite closely with?

**Stephen Kinnock:** It is about early engagement and planning—all the way from primary and community care through to the trust and then to the local authority. It is about how we make it clearer that the focus has to be on getting that early engagement, and then getting the Better Care Fund—it is a big fund, £9 billion—to deliver improvements in delayed discharge.

I can't say too much about this, because we are launching the new and reformed BCF in the coming months, but one of the key things is around preventing avoidable admissions. It shouldn't just be about the back end of the system, where we tackle delayed discharge; it is about stopping people going into hospital who shouldn't be there in the first place.

Q25 **Ben Coleman:** Absolutely. Prevention is obviously one of the three drivers, and it works much better. My experience of the Better Care Fund—I have only been a Member of Parliament since July 2024, so I appreciate that things may have moved on—is that the NHS dictates to local authorities what is going to happen. There is a sort of negotiation, but it happens very late in the day, and the NHS can even pull the plug at the last moment on what has been agreed. Of course, there is a difficulty also in the NHS's financial timing—its funding is different from that of local authorities. Are you addressing all of that? For example, have you been discussing your new plans with the directors of adult social care?

**Stephen Kinnock:** Yes.

Q26 **Ben Coleman:** And they are on board with this?

**Stephen Kinnock:** I think once every two months I meet the head of ADASS and the head of the LGA jointly, and BCF always comes up. There is good practice. I recently visited a hospital in Bradford where they had a delayed discharge team made up of a combination of hospital staff and local authority staff sitting in the same office in the hospital, and they had an almost airport-style screen up.

**Ben Coleman:** That is brilliant.

**Stephen Kinnock:** They were totally integrated. That is what we need to get to.

Q27 **Ben Coleman:** The problem is not the system approach, which is really effective and also happens in hospitals local to me, but the funding that local authorities know they can rely on and plan ahead for. The problem there is that the NHS has a different timetable for its funding. Its budget has different start and end points. As so often, it still also takes this haut en bas, top-down approach: "We will call local authorities partners, but we will tell them what to do." I am a little concerned that if that doesn't change, whether it is palliative care or other things, we won't really get



the most out of the relationship between local authorities and the NHS—if it is not genuinely more egalitarian.

**Stephen Kinnock:** I completely agree. This is part of the culture change that I was discussing with the Chair earlier—how do you create an integrated approach? I think the neighbourhood health framework will help with that, as it is about almost starting with a blank sheet of paper and saying, “We now need to do away with all the old power structures and funding flows and move to a neighbourhood health and wellbeing approach, which brings in GPs, community care and local authorities.” Everybody needs to be around the table to make that work, to make it happen and to deliver it at a neighbourhood level.

Q28 **Ben Coleman:** That is very helpful, and I completely agree with you. As a conceptual approach, I very much support that. There were some very interesting comments about your experience of coming in as a Health Minister and dealing with the situation and the system as you found it. How keen are you to overcome the blockage in the relationship where effectively the NHS still thinks its job is to dictate to local authorities what happens, and that it is the local authorities’ job, furiously, to try and stop being bulldozed by the NHS?

**Stephen Kinnock:** I think it varies from area to area. We do see some examples of ICBs winning the argument with the trust, and the trust accepting—

Q29 **Ben Coleman:** But the ICB itself is so often the problem, because it is the NHS. There is one, or maybe two or three, but that is going to change. As I say, the 10-year plan wants to reduce the already rather small presence of local authorities on ICBs. The ICBs are effectively NHS organisations that tell local authorities what to do. They are not part of the problem.

**Stephen Kinnock:** ICBs have to be an umbrella organisation that looks at primary care, community care, secondary care and acute care holistically and on a level playing field, not where you just continue with the “business as usual” approach of favouring secondary and acute. If that continues, the 10-year plan will fail.

**Dr Doyle:** I think it is important that the reform of the Better Care Fund is about enabling consistent and effective joint planning, commissioning and funding of services across health and local authorities. We have a bunch of services that are clearly almost entirely health, and a bunch that are clearly entirely local authority. But we have this huge overlap area in the middle whereby if services are not integrated, if they are not jointly planned and commissioned, they just do not work for people and patients. Palliative and end-of-life care is a clear example of being able to properly link up health support services with domiciliary care services, for example, so that the default for people is not calling an ambulance because a care worker or a family member does not know what to do. People do not call ambulances because they think—

Q30 **Ben Coleman:** I am a little lost. Are you saying they do not know what to do because they are not properly trained?



**Dr Doyle:** Not because they are not properly trained, but because the services are often not very integrated and co-ordinated in a way so that everybody knows how to pull on the support that is available, so what we get is disjointed services. The approach through the Better Care Fund should be jointly planning those services so that both health and social care staff and, importantly, families and carers know how to access support at home, so the default is not an ambulance. This is about linking domiciliary care services, adult social care services, home care support, the voluntary sector support and things like night sitting with primary care specialist, palliative and end-of-life care services and some of the other range of services.

Q31 **Ben Coleman:** I understand that, and it is all on paper. In practice, the NHS tends to say what needs to happen in a quite unpartnership-focused, if I can use horrible jargon, or—in normal language—dictatorial way. Are you aware of that?

**Dr Doyle:** I am aware of places throughout the country where there are less functional working relationships, and where things are not planned jointly as effectively as they might be.

Q32 **Ben Coleman:** You do not see at the top of the NHS an intellectual challenge in respecting local authorities and working with them on a genuine partnership basis, as opposed to, “We have to get them in line as well as everybody else”? It is about how you start thinking about a problem and who your partners really are, and whether there is any equivalence there, or whether you just have to drive things through, and they have to do what you think makes sense, in the way that you have described.

**Dr Doyle:** I think we all accept that this needs to be genuinely approached in partnership.

Q33 **Ben Coleman:** What will you change in the way that the NHS thinks and behaves when it comes to local authorities to enable palliative care—or whatever area—to become better?

**Dr Doyle:** The ICBs, as the strategic commissioners and convenors working in partnership with local authorities, should absolutely be thinking in terms of those wider local partners as they develop neighbourhood health services.

Q34 **Ben Coleman:** Will you check whether they are doing that properly?

**Dr Doyle:** That is part of how we will assess ICBs’ delivery of their statutory functions.

Q35 **Dr Cooper:** I will finish Ben’s point on integration. Looking at some of the evidence that our expert panel had—and none of this is going to come as a surprise to you—patients and families reported “encountering a complex, disjointed system, which led to delays and gaps in care.” They found that only a quarter of published integrated care strategies referenced bereavement at all, and that over 40% of people who wanted bereavement support in England were not able to get any. Do you think it



## HOUSE OF COMMONS

is appropriate that all integrated care strategies should reference bereavement and end-of-life care—have a specific area that says what they are going to do?

**Stephen Kinnock:** Yes.

Q36 **Dr Cooper:** Is it being a quarter of integrated care strategies simply unacceptable?

**Stephen Kinnock:** Yes, absolutely. Bereavement support is absolutely vital. We have things like universal principles for advance care planning. Advance care planning is the key to a lot of this because if you get that early identification to work then you start to have those conversations with the patient, their family and their carer so that you have that personalised, patient-centric approach—sensitive conversations about how they want to be treated, how they want to be cared for and where they would like to die.

Q37 **Dr Cooper:** In order for frontline care professionals to do that, would you agree that integrated care strategies should reference bereavement and this strategy? Not just a quarter of them, as our expert panel found?

**Stephen Kinnock:** Absolutely. I see no downside whatsoever in getting to 100% on that.

Q38 **Dr Cooper:** Excellent. To move on slightly, what plans do the Government have to increase and improve out-of-hours palliative and end-of-life care services? This came up as a serious issue.

**Stephen Kinnock:** That is going to be one of the key points in our modern service framework. We want to set national standards and goals, for example, by looking at having a 24/7 telephone line available everywhere in England at least.

Q39 **Dr Cooper:** To remind us, what is the current coverage of that 24/7 helpline?

**Stephen Kinnock:** I think it is about 24%.

Q40 **Dr Cooper:** So less than a quarter?

**Stephen Kinnock:** Hospice UK has done a report, and it is clear that having that 24/7 telephone line would be extremely beneficial. Coverage is not where it should be, so that is something we are going to be looking at in the modern service framework.

Q41 **Dr Cooper:** Over what timeline would we expect to see 100% coverage?

**Stephen Kinnock:** If we get the modern service framework published by the autumn, then we would be looking at implementation in 2027.

Q42 **Dr Cooper:** In terms of staffing the 24/7 helpline, and other human resources that will be necessary to allow sufficient end-of-life services out of hours, where are you in terms of the national health workforce and putting in place plans to ensure that it is adequately staffed?

**Stephen Kinnock:** The workforce piece is complex because so many people are involved in palliative and end-of-life care, such as GPs, district nurses and specialist doctors.

**Q43 Dr Cooper:** We are going to come on to the specialist workforce—I think my colleague is going to ask about that—but, specifically, around the out-of-hours care, because that is an issue across the national health service. We are not a seven-days-a-week health service, so do you see that, in this particular instance, this could pose a serious problem for out-of-hours care?

**Stephen Kinnock:** I have not yet done the modelling of what kind of workforce would be required to staff that telephone line, but it would be a single central number. One assumes that it would not have enormous staffing issues. Its round-the-clock nature would require some thought to make sure we staff it properly. There is no point in us saying that we want to commit to a round-the-clock telephone service without being able to staff it. Those two things have to go together.

**Q44 Dr Cooper:** We look forward to seeing that modelling at the earliest possible opportunity.

Our expert panel identified data collection as a key barrier to understanding population need for end-of-life care. That is a recurring theme for this Committee: regardless of who is in front of us and what we are talking about, data collection and sharing seems to be extraordinarily poor across many aspects of the health service. What plans do you have to improve data collection in this particular area?

**Stephen Kinnock:** I think there are tools that are not being used properly.

**Q45 Dr Cooper:** Such as?

**Stephen Kinnock:** The palliative care dashboard. I would be very happy to share more information about the dashboard with the Committee. I might ask Dr Mitchell to talk a bit about that, as she is very much leading on the clinical side. The dashboard is a powerful tool because it provides an ICB-by-ICB breakdown; looks at how many people in the ICB area are dying at home, how many are dying at hospital, how many people are dying in hospices, et cetera; and then looks at the outcomes for each of those. That really helps to inform ICBs. The problem is patchy use by ICBs: some are really leaning into the dashboard, and others are not. You also have client-level data for adult social care. I do not think we are doing enough to utilise that data and bring it into our thinking about how palliative and end-of-life care is working across the country.

**Dr Mitchell:** The palliative and end-of-life care dashboard was developed by NHS England. It is intended to be a resource—

**Q46 Dr Cooper:** When was it developed?

**Dr Mitchell:** It was developed and first launched in 2021. It brings together existing datasets. We use the existing palliative care QOF data



## HOUSE OF COMMONS

from general practice, hospital episode statistics and death data so that the dashboard provides information that can be broken down by ICB to give numbers of patients who have been identified in primary care as having palliative care needs or being at the end of life. We can then—

Q47 **Dr Cooper:** Just to move you along, the Minister said that ICB data collection was patchy. Are you able to give a percentage of how many ICBs are actually contributing these data?

**Dr Mitchell:** The dashboard covers every ICB.

Q48 **Dr Cooper:** So every ICB contributes. Do you have any gaps in your data collection on this dashboard?

**Dr Mitchell:** The dashboard makes use of the data that exists—that we have. It is retrospective data.

Q49 **Dr Cooper:** Let me try this question again. Is there missing data that you would want in this dashboard?

**Dr Mitchell:** We would like to see more data to understand current patient need, related to the complexity of need and to population trends. The population health management tools that are being developed and used in ICBs give us more live data.

Q50 **Dr Cooper:** What does the current palliative care dashboard allow you to do in terms of planning service delivery now, and what would you need in order to make that more effective?

**Dr Mitchell:** The dashboard gives us information about trends in an ICB area. It gives us information about the age of death of patients and their socioeconomic background. It also gives us evidence on associations between where people are dying and their use of healthcare services. It breaks it down so we can see rates of patient attendance in the emergency department followed by urgent and emergency admissions to hospital and out-patient activity. It gives a sense of the trends that should be informing our healthcare service.

Q51 **Dr Cooper:** Using those trends, are population health experts able to model future need and requirement? Is that something that they can use those data for?

**Dr Mitchell:** I think that data would be part of a suite of tools to model future need.

Q52 **Dr Cooper:** But it is currently not being used to model future need.

**Dr Mitchell:** I think it is being used. I could not tell you exactly how many ICBs are using it, but we are working through our regional colleagues with ICBs to highlight the importance of all that data.

Q53 **Dr Cooper:** Is it fair to say that it is currently unclear whether the ICBs and their population health colleagues are utilising the data that we have efficiently and effectively?



## HOUSE OF COMMONS

**Dr Mitchell:** It is unclear. However, I will say that some of the ICBs have got spectacularly advanced dashboards that can break down—

**Dr Cooper:** Well done them—excellent.

**Dr Mitchell:** There are excellent examples around the country.

Q54 **Dr Cooper:** What we would want is for all of them to have that.

**Dr Mitchell:** Yes, absolutely.

Q55 **Dr Cooper:** Going back to the Minister, am I right to think that there are plans to improve that holistic approach so that all ICBs are outstanding?

**Stephen Kinnock:** Absolutely. That is what the modern service framework will be about—and our approach to strategic commissioning, because strategic commissioning will not work unless you are using the data properly. It is a population health management approach, and you cannot develop a strategy unless you really have that data. On data, I would add that the policy research unit in the NIHR is doing a deep dive on inequalities to try to give us much more robust data on inequalities.

Q56 **Dr Cooper:** Okay, so it sounds like there is room for improvement in the usage of data, and perhaps understanding, in all ICBs.

**Stephen Kinnock:** Yes.

Q57 **Alex McIntyre:** Moving on to advance care plans, the expert panel found that, even when advance care plans were in place, people were often unable to access their preferred services due to limited resources or inflexible clinical pathways. What are your visions for the future of advance care planning?

**Stephen Kinnock:** We have the “Universal Principles for Advance Care Planning”, published in 2022, which focus on the importance of providing opportunities for a person and their family or carers to engage in meaningful discussions, led by the person concerned, that consider the person’s priorities and preferences, including place of care and treatment choice, when they are nearing the end of life, so I do not think there is any argument about the theory. That is probably a bit of a red thread that goes through all of this conversation. We have the frameworks, principles, guidance, documents and plans. The question is about execution. That is where early identification is absolutely crucial.

Q58 **Alex McIntyre:** Sorry to interrupt, but presumably, if someone has an advance care plan in place, they will have been identified fairly early, yet they are still not being provided with the service intended. So what is the gap there? We can fall back on commissioning, but if they are advanced enough to have an advance care plan, they have been going through the system and presumably services have been commissioned, but then there is a stop at that point and they are not getting access because of either resources or clinical pathways not being there. What is the answer? Is it that more resources are needed at that point?



**Stephen Kinnock:** I think there are two issues. One is that we do not have enough people on advance care plans. That comes back to the identification point: 345,000 people are on the palliative care register; we want there to be more. You are not going to get an advance care plan until you are on the register, so the first step is to get more people on to the register. A lot of that is about improving the way in which GPs are working, and increasing the number of GPs, which we have done. That is an important aspect of your question: the coverage in terms of advance care plans.

Then, your question is very much about the quality of the advance care planning process once someone is on that pathway. In terms of improving the quality of the workforce around that, we have training tools, such as the e-ELCA—end-of-life care for all—programme, which actually has good take-up in the number of people doing that training course. That is all about training the entire system around how to be better at having those conversations and doing end-of-life care.

Q59 **Alex McIntyre:** I think one of my colleagues will come on to the workforce later in the session. To move on slightly, how do you see bereavement and other support services for families, loved ones and carers fitting into the framework for palliative care going forward?

**Stephen Kinnock:** Can I ask Dr Mitchell to add anything extra on the advance care planning question, because I think there may be more to say on that?

**Dr Mitchell:** I think it is important to be clear that the evidence around advance care planning as a discrete intervention is quite mixed and variable. These patients are so vulnerable, and living with highly complex and dynamic needs that can change unexpectedly, so even with the very best advance care plan, there might be a clinical scenario that we have not foreseen that requires a change of plan.

The most important context for the care-planning process is continuity of care delivered. There is compelling evidence that there is an association between continuity of care—with primary care and the wider multidisciplinary team, including specialist colleagues—and reduced use of urgent and emergency care towards the end of life. It is about trusted relationships and a way to manage those changing care needs as they go. It is really important that that is understood.

Q60 **Alex McIntyre:** Thank you. To return to my last question, how do bereavement and other support services fit in with the modern service framework?

**Stephen Kinnock:** There was a report on bereavement in 2022 called “Bereavement is everyone’s business”. After that, the Department established a cross-Government bereavement working group to ensure better collaborative working across Government Departments. The question is the extent to which that working group is effectively improving the way that we do bereavement support across the system. It is a vital part of the way in which palliative and end-of-life care is about both



psychological support and socioeconomic issues, as well as symptom management and control. The question is the extent to which we are getting that right.

With bereavement support, I find that it is quite difficult to measure because, by definition, the kind of bereavement support that a family might want can vary hugely according to the cultural context and the psychological situation in which they find themselves. The whole grieving process is very subjective, so it is quite difficult to measure the quality of those bereavement services. I do not know whether colleagues want to add something to that.

**Dr Mitchell:** We would consider bereavement care to be a public health issue. We know that the impact of bereavement on carers and relatives can be profound. We tend to split our thinking about bereavement services into three levels, the first of which is about preventive measures. That fits with my continuity of care piece; if we are providing compassionate care and doing some pre-bereavement work with families, we can help them through the whole care at death and the death processes afterwards, which include the interface with the medical examiner system. They have a good practice series, which includes care for bereaved relatives.

Level 2, which would fit for about 30% of the population, targets those most at risk of complicated bereavement. There is lots of innovation around the country in how we can be proactively identifying those people where there might be a risk of complicated bereavement, and how we can work with, for example, volunteers, compassionate community approaches and our voluntary sector partners.

Q61 **Chair:** What is your definition of complicated bereavement?

**Dr Mitchell:** It is about 10% of people—those who are more likely to have prolonged grief disorders. Their grief goes on for a very long time and can have an impact on their health, wellbeing and ability to work, for example. Complicated grief is associated with really strong mental health problems. We would need to work collaboratively with our partners in mental health to ensure that those services are available for our patients.

**Chair:** I winced, because we have recently done a report on that.

**Dr Scully:** On the statutory guidance from NHS England systems, the 2022 Act sets out that everyone should be providing bereavement services. Clearly, that is not happening everywhere. There is a bereavement quality survey, and we can share its findings with you. The Department, on the back of that survey, as well as the commission that the Minister mentioned, undertook some research that we plan to feed into the modern service framework. It is something that we are actively thinking about.

Q62 **Alex McIntyre:** Moving on to death literacy, the panel found in its report that society generally has quite low levels of it, meaning that there is very limited understanding and—as my wife will attest to—a reluctance to engage in conversations about death and dying. Is this an area that the



Government are planning to do any work on?

**Stephen Kinnock:** Yes. I think you are right that, as a country, we do not talk about death enough. For all sorts of perfectly understandable reasons, it has a certain stigma around it, and people do not talk about it enough. I think there are two sides to the coin: one is the system and the workforce, and the other is the public. It is probably a bit easier for us to talk about the former than the latter, but it is also interesting to think about how we might get the public more engaged on this issue.

From the point of view of the former, or the workforce, death literacy and bereavement counselling are part of the e-ELCA training programme that I mentioned earlier. We also have the force of adult social care workers and the learning and development system—LDSS—training programme, which also includes modules on death literacy and bereavement support.

There are pockets of good practice. There is a project called Compassionate Sheffield, which is St Luke's hospice and the local ICB. That is looking at the whole issue of how we change the conversation around death and make it almost a social and cultural conversation about how we plan for a good death. That does not happen unless conversations take place between the individual, their family, their carers and the providers of support, whether through domiciliary care, a hospice or, if necessary, in hospital. It is about looking at things like the Compassionate Sheffield project and saying, "Why is not that happening more widely across the country?"

With regard to improving the way we talk about it across the public, I know we are not here to talk about the assisted dying Bill, but I would posit that whatever our views on assisted dying, one of the by-products of the tremendous amount of attention and debate generated by the Bill is an increase in people having conversations about dying and planning for death. Whatever our views on the Bill, I would argue that that is a good thing.

**Dr Mitchell:** I think the death literacy conversation is really important, particularly because we have data from the Policy Research Unit to suggest that there is not a great understanding of what palliative care is among the public. In particular, compared with white people, people of Asian ethnicity and those of black, Caribbean and African ethnicity are less likely to be aware of palliative care, have the correct knowledge of palliative care or trust our healthcare systems to deliver it. This will be a really strong theme for us to consider as we develop the MSF.

- Q63 **Andrew George:** We all agree that it is better to shift from hospital to community. People want to be treated closer to home, not further from home. But the expert panel found that it would be completely inappropriate to shift the burden of palliative care into the community unless sufficient planning and resources were in place. You have the MSF, which is due to be implemented in the autumn, one assumes. How will you ensure you have the capacity to deliver more palliative care in community settings?



**Stephen Kinnock:** Thank you for that question. I think this pivots back to what I was discussing with the Chair earlier, which is that we have to make this happen because, otherwise, we are just going to see a prolongation of the status quo. The question is how to make it happen in a way that still enables the stability and sustainability of the system. Obviously, if you were just to pull the rug out from under secondary and acute care and say, "Right, we're slashing your budget overnight and putting it all into primary and community," that would seriously jeopardise the stability of the system.

It has to be a gradual and managed change and shift, but the first step on that road is to define the model of care that we want—to define the future vision and picture of where we want to be. The 10-year plan does that. It says that we are going to shift from hospital to community, from treatment to prevention, and from analogue to digital. Coming down from that, we are going to have a neighbourhood health approach, which is going to be the way that we enable those shifts, particularly the hospital to community shift. Once you have all that model in place, then the money and the resources have to flow from that. You have to define where you want to go first.

Q64 **Andrew George:** We have been through the model many times, and we understand it and the three shifts. But the workforce is not there; it has declined in the last decade. After all, 130 of the 168 hours in a week are out of hours. People needing palliative care need those specialist services delivered to them, whether it be hospice at home or in hospices themselves. The resources and staff are simply not there, so you are a long way from being able to deliver the palliative care that you talk about in the MSF.

**Stephen Kinnock:** There are two sides to the workforce in palliative and end-of-life care: the specialist side and the generalist side. On the specialist side, we have actually seen quite a significant increase in the number of specialist doctors. I believe we have 910 specialist palliative and end-of-life care doctors now, which is an increase of 40 since 2024.

Q65 **Andrew George:** There are 78 senior consultant vacancies, and 55 retirements are expected very soon.

**Stephen Kinnock:** In specialist doctors?

Q66 **Andrew George:** Yes. You are putting on a brave face, but it is still not good, is it?

**Stephen Kinnock:** No, but there has been about an 80% increase in the number of specialist palliative care doctors since 2010 and about a 5% increase since 2024, so there is some increase in the specialist workforce. I absolutely accept that it is not where we would like it to be, but it has been moving in the right direction.

Q67 **Chair:** What is the number you want?

**Stephen Kinnock:** I don't know the answer to that question.

**Dr Mitchell:** We don't have a number. What I think is important—

Q68 **Chair:** You don't have a number?

**Dr Scully:** That is part of the long-term workforce plan modelling.

**Chair:** Okay. We are going to come to the specifics of how you work that out.

Q69 **Andrew George:** It seems to me that specialist consultants are running at about 10 per 1 million of population. Is that the target? Is that the right ratio, or should it be higher than that?

**Stephen Kinnock:** Well, as Ed says, we are publishing our workforce plan in the spring, and that will set out our targets right across the board. That is why I don't know the answer to that question yet, but it is important that we have strong specialist care capability.

From the point of view of the generalist workforce, it is quite difficult to define because it cuts across so many different aspects, from GPs to community healthcare, district nurses and adult social care. If you look at the GP side of it, we have hired 2,500 more GPs since July 2024, so we are moving in the right direction on that aspect of the generalist workforce, but I absolutely accept that there is still a long way to go.

Q70 **Andrew George:** There has been a fall of 5% in community nurses in the last decade. Just coming down to the practicalities of providing palliative care in the home, setting up a syringe driver, the titration and so on cannot be done by a care worker. It has to be done by a qualified, competent registered nurse, or nurses working in tandem. There simply isn't the workforce to provide that level of care in the home at the level that is required. Am I wrong in that?

**Dr Doyle:** No, you are not wrong. There is a significant need to increase the capacity of the community nursing workforce if we are going to succeed in what we say in the 10-year plan. The cohorts we are asking ICBs to focus on supporting out of hospital first are those with severe frailty and those at the end of life, which includes the services we have been talking about. It is absolutely key that we have a community nursing and primary care workforce that can support those patients, and that is what the left shift is going to start with. We need to ensure that, along with the patients and the services we deliver to them, we pull funding from the acute sector into primary and community care services in order to build that capacity.

**Dr Scully:** To give a bit of context on specialist palliative care, the overall cost of treating people who are dying or are in their last year accounts for only 6% of overall spend, because the vast majority is general care. I know it is still significant, but it is 6% of the overall spend.

Q71 **Andrew George:** I understand that, but before the shift happens, we have to make sure the baseline within the acute sector is coping with the demand. As I understand it, because of the iron-clad financial constraints on acute trusts, there is a recruitment freeze across a lot of them. Is that



## HOUSE OF COMMONS

something that you, Minister, could look at, and could you perhaps loosen those restrictions? Presently, there are a lot of vacancies and recruitment freezes, and therefore services are under tremendous pressure. You cannot shift until you get the baseline under control and safe.

**Stephen Kinnock:** Yes, it is absolutely a priority for me to enable the shifts in our 10-year plan. If we are going to operationalise the 10-year plan, resources are a really important part of that, but it is also about reforming the system. Through better integration and better use of technology, you can be more productive without necessarily needing significant headcount increases. I absolutely accept the basic premise of your argument, which is that if you are going to change, you have to resource that change, but it is not just about headcount.

Q72 **Chair:** Can I jump in to clarify? We are not talking about increased numbers; it is simply that if people are leaving, for maternity, retirement, long-term illness or whatever, the acute trusts are not recruiting behind. What you have is not more based on a headcount—they have already assessed what they need. They are not recruiting behind people who are leaving through natural attrition. That strikes me as deeply worrying for a system that is so under pressure and underdelivering, based on the report. Would you not agree?

**Stephen Kinnock:** There is a statutory duty for trusts and ICBs to deliver the best possible care to their populations. They need to ensure that they are discharging their functions on the basis of their statutory duties.

Q73 **Andrew George:** But you are sending them two messages: on the one hand, they must work within their budgets; on the other hand, they must not engage in recruitment freezes. The two things do not add up at the moment, do they? You have left them in an impossible position.

**Stephen Kinnock:** I am certainly not arguing that it is not challenging. If we look at, for example, the progress we are making on getting the backlog down—even in the face of industrial action—there are some pretty impressive results there on electives. That, of course, has cost a huge amount of money—£250 million is what that strike has cost us. There is huge pressure on the system. I accept the basic premise of your argument, but I also think the quantum—the financial envelope—that we have is what we have, and we have to work more smartly within that. I do not know whether Amanda or the team want to add anything.

**Dr Doyle:** We are not directly instructing acute trusts not to employ clinical staff where they need them. They do have a responsibility to live within their means and to balance their budgets, as well as their responsibility to deliver appropriate care for their patients. Individual trusts are taking individual decisions about how they balance those two responsibilities.

Q74 **Andrew George:** Point taken. We have highlighted the issue.

Shifting to capacity elsewhere, and particularly hospices, I do not want to tread on my colleagues' toes and ask about the funding of them, but the NHS and hospices do not appear to be as integrated as they could be in



## HOUSE OF COMMONS

providing a seamless care relationship. In my area, Cornwall Hospice Care gets 9% of its funding from the NHS, and it is struggling. My colleagues will come on to the wider issues, but how can you shift from acute care out into the community if the people out there wanting to help you are not being given the support they need?

**Stephen Kinnock:** I very much hope that the hospice in your constituency has benefited from the additional funding that we have put in. Is it an adult hospice?

Q75 **Andrew George:** Yes, it is. But Cornwall Hospice Care—St Julia's, as was—has been hit by the national insurance increase, which cost it a quarter of a million a year on its turnover. There seems to be a balancing message at the moment, but certainly one that puts it under a lot of pressure.

**Stephen Kinnock:** We are doing what we can to support hospices with the extra £25 million I announced earlier in this session, and the £80 million for children's hospices. Clearly, hospices have that independent role, which I personally think is a good thing. Most hospices welcome it, because it gives them a lot of flexibility to provide all kinds of services that you would not get on the NHS. They are so embedded in the community, with all the fundraising that goes on around them. They are a huge asset in the community, and their independence helps.

Some people argue for hospices being 100% funded by the NHS, but I personally would not support that position, and the Government do not support that position. Nevertheless, we need to ensure that they are an integral part of the strategic commissioning process—a big part of the MSF. When you get the list of all the stakeholders we are engaging with on the MSF, you will see that hospices are front and centre, and are going to play a crucial role in shaping that. When we get commissioning to where we need it to be, the commissioners will then be fully cognisant of what the hospice in their community can provide, and receiving funding accordingly to deliver those activities.

**Andrew George:** Okay. The question was about the integration, rather than the funding.

**Dr Scully:** Can I add a bit on the integration? It is different in different areas. If we look at some of the good examples, like in Leeds, which are part of the West Yorkshire Hospice Collaborative, they are all part of the shared care record—the two different hospices in Leeds, and all those in West Yorkshire. Somewhere like St Francis in Berkhamsted, which was actually commissioned by the community health trust, shares all the records. I know that that is not the case in every area, so it is different in different areas. The challenge as part of the commissioning bit is, how do you pull everyone up to that bit where you have the really good ones that operate seamlessly? But not everywhere does.

Q76 **Andrew George:** Looking more widely, I think the patient and family point of view is, yes, shift out to the community, but to a certain extent there is a fear of out of sight, out of mind, and they would feel safer in the



## HOUSE OF COMMONS

hospital. There is not the 24/7 access to medication, advice and specialist palliative care when needed. Therefore, you will get the avoidable admissions into the emergency department, will you not? How can you be sure that there is the integration between services in the community?

**Stephen Kinnock:** The way to ensure that is to have a modern service framework that works effectively, with very clear national standards and goals, and with every ICB crystal clear on how they should be achieving those and on the vital role that hospices play. When you look at the statistics, I think about 40% of people die in hospital; 28% die at home, with something similar in care homes; and about 6% die in hospices. From the palliative care dashboard, we see clearly that the people who are at home or being looked after in the community are far less likely to go into hospital, into emergency care, in that last year of life. There is a very clear connection. It is much better for the hospital and the system more broadly for people to be at home or in the community in terms of the downward pressure that that exerts on avoidable admissions.

Q77 **Andrew George:** More so than a residential home? There would be admissions to hospital from there.

**Dr Mitchell:** There is an association. There are fewer admissions of people at the end of life from home and care homes. It is a trend, though—an association.

Q78 **Andrew George:** You mean there is a gradual diminution of numbers and proportions that are admitted.

**Stephen Kinnock:** Yes.

**Andrew George:** That seems to be contrary to—

**Stephen Kinnock:** The trend from the dashboard shows that the closer you are to the community, the less likely it is that you would have to go into emergency admissions.

**Andrew George:** Right.

**Dr Doyle:** I am pleased you mentioned medicines, because it is worth highlighting the important role of community pharmacy. We know the interventions that make people less likely to have to have an emergency admission: 24/7 advice and, importantly, access to the medicines that might be needed at the end of life. In the places where we are really seeing integrated, proactive palliative and end-of-life care, that involves community pharmacy and having the drugs that might be needed ready and available in the patient's home, so that, if needed at night or over a weekend, a syringe driver, for example, can be set up there and then.

Q79 **Andrew George:** As well as the patient, there is also the family around them in the home. The expert panel identified that the value of unpaid carers is effectively about £29 billion, in terms of supporting those in need of end-of-life and palliative care. Is that going to be part of your MSF? Is your MSF going to be integrated with other services, including the DWP, to make sure that unpaid carers get the support they need? Otherwise, it is



going to be a great deal more expensive to provide these services.

**Stephen Kinnock:** Unpaid carers have a voice in the MSF. The name of the organisation escapes me now, but one of the main voices for unpaid carers is one of the voices in the MSF stakeholder engagement process. We are also very proud of the fact that we provided the uplift to carer's allowance, which was the largest uplift since the scheme was created in the 1970s.

**Chair:** The Liberal Democrats were absolutely delighted.

**Stephen Kinnock:** The Liberal Democrats were very pleased with that as well, I am sure. I also chair a cross-departmental working group with DFE, because of young carers; DWP, because of exactly the social security dimension to this; and DBT, because of the employment side, and trying to encourage employers to have a more progressive approach to unpaid carers. We hugely value the role that they play; they are the lifeblood of our care system in this country, and we have to do more to help them.

**Dr Doyle:** The DWP is very committed to supporting this agenda. We have what we call special rules for the end of life. Where people are approaching the end of life, they are fast-tracked, in effect, for certain benefits, so that they do not have to wait or go through all the assessment processes. That is very helpful for enabling people to get care in place quite quickly.

**Dr Mitchell:** I would just add that the assessment of family carer needs, and support to address those needs, has already been identified as one of the evidence-based interventions for the modern service framework.

Q80 **Chair:** A lot of stock has been put into this modern service framework; I am desperate to see it now. Before we move on, can I come back to the community pharmacy point? You have outlined what we need to get to, but how are we going to achieve that? Community pharmacy has been struggling over the last few years. Are we looking to have an on-call, 24-hour pharmacy? Is that the vision? What is the vision here? I am assuming that they are being closely consulted with as part of this as well.

**Stephen Kinnock:** We have the pharmacy quality scheme. Under the community pharmacy contract, pharmacies get certain payments, based on their quality criteria, one of which is palliative and end-of-life care. Do they stock the 16 end-of-life care medications? If they do, they qualify for that under the community pharmacy contract. They are then monitored on the basis of actually being open and accessible and delivering those services to people who require end-of-life care.

Q81 **Chair:** So you are saying that it should already be happening.

**Dr Doyle:** It is happening in lots of places, and it should not be taking people by surprise. We are not expecting pharmacies to open at 1 am and provide these drugs; we are expecting people to have anticipated the need. Some patients might have a sealed box containing those drugs in the home for some weeks, because we anticipate that we could need them at any time, so just-in-case boxes are available. It is about involving



## HOUSE OF COMMONS

community pharmacies in the preparing of that, being ready and anticipating which patients are going to need those sorts of support and having them there and then.

Q82 **Chair:** So this is linking back to the end-of-life care plan.

**Dr Doyle:** Absolutely.

Q83 **Joe Robertson:** Good morning, Minister. The Government published its 10-year health plan over the summer. It did not contain a workforce plan, so you are writing one. It did not contain a palliative care end-of-life plan, so you are writing one. It did not contain a social care plan; are you writing one of those?

**Stephen Kinnock:** The independent Casey commission is going to report this year on its first piece of work to define the national care service—the standards and goals that we need to see through the national care service—and then, of course, there will be a second-phase report that will look more at the funding of adult social care.

Q84 **Joe Robertson:** Turning to a report that we know is coming out this year—or you say it is—the workforce plan will, we hope, be a plan for across the spectrum of health and social care. Can you give the Committee an assurance that a specific part of that will deal with the palliative and end-of-life workforce?

**Stephen Kinnock:** The workforce plan is going to look at the different professions across every aspect of the workforce, so palliative and end-of-life care will absolutely be covered in that process. My colleague Karin Smyth is leading on the development of the workforce plan, and it is all being quite closely guarded until publication in the spring. I do not know whether my colleagues can say a bit more about that.

**Dr Doyle:** It is worth saying that the vast majority of palliative and end-of-life care is provided by primary care and by community nursing services, and obviously those teams provide a whole range of care, so it is quite difficult to narrow it down to a specific aspect of what they might offer to patients. We do need to recognise the impact of shifting and focusing more on palliative and end-of-life care on the workforce capacity requirement in both community nursing services and general practice, which are very much part of the workforce plan.

Q85 **Joe Robertson:** I was not asking about the way in which it will be presented, or how it will be formatted; I am looking for assurances that the specific needs within end-of-life care and palliative care will be dealt with in the workforce plan. Clearly, there is a need in respect of general staffing, as there is across the whole of health and social care, but how will the workforce plan seek to address specific and, indeed, specialist workforce needs for end-of-life and palliative care?

**Stephen Kinnock:** Let's take GPs, for example. We currently have the GPwER—the general practitioners with extended roles—framework, which defines the skills, capabilities and standards to which a GP should be able to work when it comes to dealing with a patient who needs palliative or



end-of-life care. That would be the basic building block for looking at how GPs are going to be trained and have the capacity and skills they need to do palliative and end-of-life care, beyond what you might call pure and simple, core GP capabilities. That will be the same for district nurses and for adult social care workers.

What training and personal development plans and programmes need to be put in place to say, "You are a generalist—a district nurse, a GP, an adult social care worker—but these are the specific skills and competencies you need for palliative and end-of-life care"? The workforce plan will define the additional skills and competencies that generalists need. Then, of course, on the specialist side it is about the advanced clinical specialism, and I discussed earlier with Mr George the 910 specialist palliative care doctors we currently have in the country.

**Dr Doyle:** In terms of the modelling to get to the answer, we need a combination of, "What is the clinical model of care?"—that is what we have been describing—and, "What do the demographics tell us is going to be the volume of need, and therefore, how does that model up to what workforce we need?" That is absolutely being taken into account in planning.

**Q86 Joe Robertson:** From what we are hearing, it sounds like however it is presented, there will be considerable detail within the workforce plan about how we meet the needs of end-of-life care and palliative care. Can the Committee take that as a given?

**Dr Doyle:** I can confirm that will be taken into account in the modelling. I am not sure whether it will be presented as a separate, detailed section, but it will be counted.

**Dr Scully:** On what the long-term workforce plan will contain, part of the discussion has been about the shift to out-of-hospital delivery. Certainly within the three-year guidance that went out to the NHS just before Christmas, there is a really strong steer—almost an instruction—to start considering how you shift to provision out of hospital, and it says there are two priority cohorts for that: frailty and end-of-life care. That is what will shape the long-term workforce plan. It is inconceivable that there will not be something on end-of-life care in the framing and context of how a neighbourhood health service is provided through the workforce.

**Q87 Joe Robertson:** Given that health and social care is awash with plans and strategies—indeed, a workforce strategy from the last Government was put aside for the new Government strategy that has not come in yet—and the modern service framework may not be available until the autumn, and we know how deadlines slip, can the Minister give some assurances that, regardless of when various plans will be published, the work to address issues is already happening, particularly in end-of-life care and palliative care, given the context of today's discussion?

**Stephen Kinnock:** Absolutely. To take your point about the adult social care plan, we are not sitting on our hands and waiting for the Casey commission to report. We have done the uplift for unpaid carers, we are



## HOUSE OF COMMONS

working on a revolutionary fair pay agreement for adult social care workers to address vacancies in the workforce, and we have significantly uplifted the disabled facilities grant. That is an example of the work going on.

We recognise that there are some big strategic pieces of work that need to happen that take a longer timeframe but, at the same time, we have to keep delivering and improving the quality of services. All that work continues; we are looking to improve palliative and end-of-life care every single day. But we believe that the modern service framework will enable us to deliver that step change.

**Q88 Danny Beales:** Good morning. The independent expert panel's report emphasised that one in four people in the UK die without the services they need at the end of life. That is particularly the case for certain population groups, and there is disproportionate unmet need among groups that have experienced disadvantage throughout their lives—for instance, ethnic minority populations, babies, children and young people, individuals with dementia or other cognitive conditions, and people with learning difficulties.

You touched on inequalities in your opening remarks, and we have talked a lot about the differential performance of ICBs. Has an ICB-led commissioning process with a lack of clear national oversight contributed to the issue of unmet need and disproportionate outcomes?

**Stephen Kinnock:** Yes, I think that one of the reasons that there has been fragmentation and inconsistency in the delivery of services and in tackling inequalities is that there has not been a national set of standards and goals. That is what the MSF will seek to address.

We know that improving services for underserved areas is an integral part of the model ICB blueprint. We have said very clearly to ICBs, "You are not doing what you should be doing if you're not improving services for underserved areas in particular." That is a very clear priority in the model ICB blueprint.

**Q89 Danny Beales:** Will the MSF specifically deal with inequalities in outcomes? Will that be a specific focus of the MSF?

**Stephen Kinnock:** Yes, because the strategic commissioning piece of the MSF is, by definition, about tackling or improving services for underserved areas. What you are saying is, with the finite resource we have, where should that resource be prioritised? It is absolutely clear that it should be prioritised on underserved areas, whether that is geographical areas or underserved communities, either socioeconomic ones or ethnic minorities, for example. The strategic commissioning will fail unless it is addressing underserved areas.

**Q90 Danny Beales:** It is welcome to know that the MSF will specifically deal with the inequalities present in palliative care. I want to talk about how the MSF will have bite, I suppose, and lead to change. We have referenced, at different points today, standards that already exist and are not implemented. You talked about the data, which is vital, and it will be



## HOUSE OF COMMONS

really important to judge the progress on inequalities and the data dashboard, but you mentioned that participation is patchy. What is the carrot, and what is the stick, if that does not change—if participation in the data dashboard does not change, if the adoption of current standards does not improve, or if the MSF does not deal with delivering practical progress and change? How does accountability work?

**Stephen Kinnock:** Every year, ICBs have to provide officials, and ultimately Ministers, with a report on how they have discharged their functions, based on the agreed targets that they have, the quality of patient outcomes and the quality of access—there is a huge panoply of targets and agreed outcomes that we have with the ICBs. Officials then hold ICBs to account on the basis of that annual report. Clearly, you also have the CQC, which I think is an excellent tool for us, and it has certainly improved a lot in recent months. It helps us to hold ICBs and local authorities to account.

Q91 **Danny Beales:** Where in that system is the failure, then? With the level of inequalities that we see, and the standards that are not being met in palliative care, it feels like there are ICBs that are not currently fulfilling their responsibilities. I do not know whether you agree that that is a fair assessment, but if that is the case, or if the mechanisms already exist for accountability, why are they not being used? At what level does it sit? Is it at the CQC level, or is it once the reports come in from ICBs to show that there are these issues?

**Stephen Kinnock:** It is an excellent question. When you have such a complex system, accountability is one of the most difficult things to achieve. For example, looking at the way the CQC works, if there is a local authority that is not doing what it should be in adult social care, it will go into special measures. It gets a “requires improvement” grading, and a team are then sent in and they have six months to turn it around. I do not think we are where we need to be in having accountability of that level and robustness with ICBs, but Amanda or Ed might want to come in.

Q92 **Danny Beales:** Will the MSF be setting very clear metrics?

**Dr Doyle:** The MSF will set very clear expectations on interventions, timelines and metrics. We will measure those as part of our oversight and assurance process, in which we measure ICBs and have regular meetings through our regional teams to look at the progress of ICBs. Where ICBs are outliers, we look at any improvement support. With some ICBs, we have some improvement support to look at where the focus needs to be. That process will be ongoing, and it will use some of the expectations in the various publications like the MSFs—don’t forget that this is not the only MSF—where ICBs are delivering against our expectations, and within the round of the range of issues we are assuring ourselves on.

Q93 **Danny Beales:** If those metrics are not met, what will be the difference in action? How will the result differ from the current situation where the standards that are in place, as we have heard, are not met?



**Dr Doyle:** We are placing greater focus on the process by which we measure. Not hitting standards is really a trigger for a series of questions, because the reasons for not hitting them will be different in different places. It is a trigger for us to ask the detailed questions, or for our regional teams, which are largely responsible for performance assurance in ICBs and providers, to start to dig more deeply into what is happening in individual ICBs. Obviously, each ICB is starting from a different position and making sometimes really quite difficult prioritisation decisions. It is important that we assure ourselves that they are prioritising the areas that we agree are key priorities for development.

- Q94 **Danny Beales:** Turning specifically to children's palliative care, this is one of the areas where inequalities exist, as we heard about in the report. I recently visited the Shooting Star hospice that serves children and families in Hillingdon. Like many children and young people's hospices, it serves quite a large footprint because of the population size—for example, I think three ICBs are meant to commission services for Shooting Star.

Children's palliative care is quite different from adult palliative care. Children and young people can be using the service for years, potentially into adulthood. As I said, the geographical footprints are quite different, and the involvement of families is also more complicated. Will the MSF respond specifically to the issues and different challenges that children's palliative care faces?

**Stephen Kinnock:** Yes, absolutely. There are several key players in the children's palliative and end-of-life care sector, including, of course, Together for Short Lives, which have a strong voice in the MSF development process.

- Q95 **Danny Beales:** Will there be a specific section, or specific expectations and standards, for that sector within the MSF, so that there is not just a generic set of measures for all palliative care, but specific reference to the issues of children and young people?

**Stephen Kinnock:** I am looking at Sarah, but I am assuming that—

**Dr Mitchell:** We should certainly be paying attention to the nuances around children's palliative care. I have a PhD in children's palliative care and I am cognisant of the challenges in that space. It is not just babies, children and young people; it is also antenatal palliative care. We also need to make sure there is a specific focus on transition to adult services, including the role of the whole healthcare system in supporting those children and families.

- Q96 **Danny Beales:** Not to push you, but the words were slightly loose: will there be specific sections, specific metrics and a specific mention in the MSF, rather than just "paying attention to" it?

**Dr Mitchell:** We will be guided by the existing evidence. One of the challenges in this space is that the evidence base is less than in the rest of palliative care. We will be working with academic stakeholders and our partners to set those standards.



**Q97 Danny Beales:** On transition, which you briefly mentioned, the sector reports that is an increasing issue as medicine advances. Children are living longer with life-ending conditions, and they are transitioning into adult services from children's palliative care. Going from a children's service to an adult palliative care service is often quite a leap. Most people there are usually in their 60s, 70s or 80s, perhaps with dementia, so they are often very different facilities where the care is provided. Do you think that there needs to be more of a focus on co-ordinating suitable transition services?

**Dr Mitchell:** Yes, I do. We are leading research at the University of Leeds around the role of the whole system to support those children and young people and their families at transition.

**Q98 Danny Beales:** Would that be something picked up in the MSF?

**Dr Mitchell:** Yes.

**Stephen Kinnock:** Yes, I think it will have to be. It is clearly an area that needs more work.

**Q99 Danny Beales:** Lastly, on children and young people's services, as I mentioned, the service I met covered three ICB areas. We have already heard about the challenges of ICB commissioning, but this is particularly acute in the children's sector because they are dealing with multiple ICBs and usually have different commissioning arrangements with all of them. Is there a case for looking at whether there needs to be greater co-ordination of commissioning for children and young people's palliative care?

**Stephen Kinnock:** It is a really good example of why we need those national, coherent and consistent standards, approaches and goals. That is precisely because, even if you are a children's hospice and deal with two or even three different ICBs, you are going to be getting a very similar approach from each of those, rather than the very fragmented landscape that we see now. It is an excellent example of why we need the MSF and those more coherent and consistent approaches. That is an important part of why we want to get that consistency.

**Dr Doyle:** There are several services whereby ICBs need to jointly commission, because the volume of patients affected is much smaller than for more general services. We are setting up specific, formalised pan-ICB commissioning arrangements within regions for those services that are largely specialist services. That is a good example.

**Q100 Danny Beales:** Would a similar arrangement be suitable for children?

**Dr Doyle:** That is the sort of thing that pan-ICB arrangements will be appropriate for. We are formalising that because we recognise it is very important for a small number of services—largely very specialist services.

**Q101 Danny Beales:** Can you provide information to the Committee about when that pan-ICB arrangement will be established for children and young people's palliative care?



## HOUSE OF COMMONS

**Dr Doyle:** We can certainly send more information about the pan-ICB commissioning approach.

Q102 **Danny Beales:** Okay, so it is not yet in train for children and young people's palliative care?

**Dr Doyle:** We are starting to put it in place as part of the changes for ICBs and commissioning, which are part of the abolition of NHS England requiring a shifting of commissioning. There are specialist commissioning services now largely led by NHS England, which will be delivered jointly by ICBs in the future.

Q103 **Danny Beales:** There will obviously be a move of specialised services on that basis, but this is an existing ICB-commissioned service at the moment.

**Dr Doyle:** It is.

Q104 **Danny Beales:** The challenge at the moment is that there isn't co-ordination, so the sector has pointed quite strongly to measures like this. Joint boards of ICBs, requirements on joint commissioning and even national commissioning have been suggested. I want to push on this because we often hear positive ideas, but is there any timeline for changes that might take place on that basis?

**Dr Doyle:** Shall I send you information about the pan-ICB commissioning approach as and when that is likely? It is in train.

Q105 **Danny Beales:** Okay. Is it in train for children and young people's palliative care?

**Dr Doyle:** It is in train for the services that need to be commissioned across ICBs, and this is an example of the sort of services that single ICBs often do not—

Q106 **Danny Beales:** I guess we are talking about some services hypothetically. I want to get a sense of whether we are talking about children and young people's palliative care or not—which would be fine, but I'd want to understand what the timeline might be for considering whether children and young people's palliative care should be commissioned at a shared ICB level.

**Dr Doyle:** That is for the ICBs to decide, but the structures will be in place to enable it. At the moment, what you often see with the sort of service you are describing is that one ICB commissions it on behalf of three or four ICBs.

Q107 **Danny Beales:** The children's sector reports—at least in what I have seen from Shooting Star—that they have to have separate conversations with all the different ICBs that are making separate decisions about palliative care for children and young people, which makes it very hard to plan workforces and facilities. Also, young people and children obviously do not necessarily follow ICB boundaries in their lives. You provide some general information, but do you feel that this issue, around the need for co-ordinated commissioning of children and young people's palliative care



## HOUSE OF COMMONS

services, is one that the MSF could pick up?

**Dr Doyle:** One of the things that the MSF will look at is commissioning arrangements.

Q108 **Ben Coleman:** Can I clarify something? This is quite broad, but I want to be very specific. My colleague has raised one of the most important points. Children with life-limiting or life-threatening conditions who need palliative care and who may live into their 30s or 40s are different, as my colleague said. Have you clearly got that difference written down, accepted and understood, and are you explicitly going to provide a different nature of services? Or will you just say, "Well, we'll look at it when it comes to specialist commissioning, and I hope you'll be glad with what you see there"? Is there an explicit recognition in the Department that children and young people's palliative care is different from adult palliative care?

**Dr Scully:** There are two different service specifications from NHS England. One is on children's palliative care, and one is on adult's palliative care. There is specific recognition, and I think they were updated in the last couple of years. Sarah will know better than I do, but there are definitely different service specifications, and they define and set out what the good characteristics are.

Q109 **Ben Coleman:** Will that definition be repeated and bleed through to all the guidance that you come out with, and the framework and all that stuff? Are you going to make the difference explicit in the two?

**Dr Scully:** It will have to be.

Q110 **Ben Coleman:** Is it going to be palliative care as a whole, and children may not specifically be mentioned? The point we are making is that children and young people have to be explicitly mentioned. Children are already the poor relation in the NHS generally, but when it comes to children who have palliative care needs, that is even more the case. We are just making an argument that you spell it out at every stage, and that there is a distinction in everything that you produce.

**Dr Doyle:** It will explicitly be referenced separately in the MSF. It is only a very small part of the commissioning arrangements that might need to be done across more than one ICB. You have given an example of a children's hospice, but most commissioning of services to children and their families is very local. But it is different from adult palliative care, and that will be made explicit.

Q111 **Paulette Hamilton:** Good morning, Minister Kinnock. I will be talking about rural palliative and hospice care. My first question follows on from what Danny has been talking about: diversity. When you look at people who live in rural areas, the research shows that they struggle to get any form of palliative care. They have further problems getting hospice care, and their outcomes tend to be poorer. What are the Government going to do for this group, which I believe to be very special and which needs to be looked at for the future?



## HOUSE OF COMMONS

**Stephen Kinnock:** One of the crucial issues is that the data on inequality of access is not very robust. The policy research unit within the NIHR is doing a deep dive on inequality and trying to give us a more robust dataset around geographic inequality, socioeconomic inequality and inequality along ethnic lines. The first answer to your question is that we need to get much better data. That data will help ICBs and commissioners to do what they are required to do. The model ICB blueprint is very clear that a priority of every ICB must be to prioritise underserved areas and underserved communities. There is a very clear ask of every ICB to prioritise underserved areas, but there is not good enough or robust enough data on identifying those communities and areas and then commissioning work that actually delivers accordingly.

Q112 **Paulette Hamilton:** That is a really good point for me to move on to my next point around hospices. Let me start by saying that the £25 million that has been announced is fantastic, fantastic, fantastic. How did you get to that sum of money at this point?

**Stephen Kinnock:** The £100 million—

**Chair:** Which sofa was it?

**Stephen Kinnock:** I would never put it in such undiplomatic terms.

**Paulette Hamilton:** Considering you have just talked about data, how did you get to that?

**Stephen Kinnock:** I will be absolutely up front on this. We have a capital budget right across the Department of Health and Social Care. Where there are opportunities for spotting an underspend in a particular area of activity it is my job to go in, roll up my sleeves and fight like hell for my portfolio. A top priority for me in doing that is hospices. I was very pleased that we managed to get the £100 million. We have now added £25 million to that. The £80 million over three years has really helped children's hospices, but they no longer have an annual cycle.

Q113 **Paulette Hamilton:** I am going to stop you there, Minister, because the £80 million is revenue, which means it is recurring over three years. The problem with capital is that you give that money once. People feel that they are out of the crisis at one point, but within 12 to 18 months they are back into crisis. You have talked about how hospices are a key part of your priority and how you give them money whenever you can find it. You have talked about the MSF and made some fantastic references to not wanting hospices to really come under the NHS. Do you feel that what you have actually done by saying that ICBs have to deliver on all of this is put them in such a stranglehold that you have set them up to fail? You have taken 50% out of their budget. They have so many other priorities, but you are now saying that they have to find the data, do the strategic commissioning, and deliver on all of this. How is that going to work?

**Stephen Kinnock:** We are definitely setting the system a challenge to work more effectively, but our view is that by doing strategic commissioning more effectively, getting a better understanding of the population's health needs, creating a robust strategy and bringing all the



## HOUSE OF COMMONS

key partners together—including the voluntary sector like hospices—you are going to drive up efficiency and productivity. By working more smartly, you can deliver what needs to be delivered without necessarily having all the resources that you have right now. Improved technology can also play a major part in driving up productivity and efficiency.

**Q114 Paulette Hamilton:** Going back to NHSE, and the new department that is going to be set up, do you not think that hospices—especially given that, in your vision, you want them to remain in the charity sector—will have a role relating to data, as well as ICBs?

**Stephen Kinnock:** Yes, absolutely. Hospices, on average, receive about 30% of their funding from the state—from the NHS. They are a really important partner for us, but they are a kind of hybrid model of some state funding and what they raise through charity. Therefore, we see them as an integral part of what we want to do on commissioning and the way that ICBs work. We need them to feed in data.

On data, that is one of the challenges with hospices—because they are not 100% part of the system, we do not always get all the data that we need. Sarah may wish to comment on that. It is partly about bringing hospices into the beginning of the conversation, rather than coming to them halfway through to say, “By the way, we need this and that from you,” when we have not really developed the relationship and partnership from the outset. Sarah, do you want to say something on data and the role of hospices?

**Dr Mitchell:** As we move forward with the MSF, data that helps us to understand outcomes for patients and their families is the most important, and hospices are absolutely key partners in how we come together and make that dataset. They already have a lot of good data about their activity, such as how many patients they are managing to meet in the community. Some of the palliative care outcome scores are in use more widely in hospices, and we can follow their example across the rest of the system. So yes, I think the data can be much more—

**Q115 Paulette Hamilton:** I beg to differ, if you don’t mind. Having given that sum of money to hospices, how as a Government are we ensuring that it is being distributed in a way that is needs-led, because it is data driven? At the moment, I cannot see how that is being done.

**Dr Scully:** Can I say two things? I think you are attending the Public Accounts Committee with us next week—

**Paulette Hamilton:** I am.

**Dr Scully:** So you will have seen the report that shows the distribution of them. By their very nature, because they emerged so unsystematically, there is almost an inequality inherent in where hospices are situated. I think the figure varies between one and 13 hospices per ICB. That is just part of their make-up. They are not the only part of palliative care, obviously, in that you have to commission the services. In an ICB where



## HOUSE OF COMMONS

there is only one hospice, the ICB has to commission the care that is required otherwise.

On how they are funded, there are basically two different ways of them being funded at the moment. Some get grants, which is the traditional way, and some are starting to move on to more activity-based payments—

**Q116 Paulette Hamilton:** I am going to stop you. We know how they are funded. My issue is not with how they are funded; my issue is that we are giving money to hospices—which I absolutely support—but what work is being done under that to say where that money is going, what it is for, and how as a Government we ensure, even with the MSF going forward, that we are being fair and equitable?

I am going to give an example from my local area. We have a wonderful hospice, but they have lost 50% of their staff—something like that—because they have not had enough funds. When the local ICB realised that, when the hospice first told it that they were in trouble, it did give them some support, just like the Government have given support, but what I am trying to get at is, how are we ensuring that we have the right data to make sure that the right hospices are getting the support they need? We do not want just a scattergun effect, which means that in some parts of the country, like York or Oxford, where people have lots of money—

**Chair:** In Oxford, we have our own issues.

**Paulette Hamilton:** In areas with very expensive properties, the hospices are able to survive, but in other areas, where we are not getting all that charitable funding, these organisations will continue to struggle, even with the MSF that is coming on board.

**Dr Scully:** One of the things that I was going to say is that traditionally they are funded by grants, but in partnership with lots of them and with the push through the strategic commissioning framework, it is whether they can move more to activity-based payments as a way of getting fairly remunerated for what they do. How do we start to generate that data about what they are doing now?

It is complex. I know one hospice, for example, that was commissioned by two ICBs, because it is near a border. One ICB gives the money by a grant and the other one by an activity payment, but the activity payment starts to reflect more fairly and accurately what they are doing. That is the bit that Minister Kinnock was talking about—how do ICBs evolve as smarter, more strategic commissioners, which are paying fairly? We are at a point of transition in terms of how a lot of hospices are being paid. In the Leeds example of St Gemma's hospice, it is moving towards trying to get paid by activity, exactly as you are getting at, but not everywhere is there. It is quite a mix and there is quite a challenge to get everyone in that place of getting the preferred payment.

**Q117 Paulette Hamilton:** What are the Government doing to get everyone to that point? I am concerned that by leaving it all on ICBs, you are setting



## HOUSE OF COMMONS

yourselves up to fail—I will be honest with you—because of the issues currently within ICBs, with some of the major cuts that they have to do, and the fact that you are joining up a number of them so that they have bigger footprints that go across some of the different hospices. What are the Government doing, in their strategic position, to ensure that hospices are protected going forward, not just being given pots of money when Government find little bits down an armchair? I do not like saying that.

**Stephen Kinnock:** Let me say two things. You raised a really important point about whether the money is going to the communities and parts of the country that need it the most. We are looking at the funding formula—the core allocation formula—for ICBs, to ensure that it is aligned with socioeconomic need. Another example of that is the review we are doing of the Carr-Hill formula, to ensure that GPs in the most deprived areas of the country are getting funding. At the moment, that formula does not work at all, which is why we are changing it. The Government are absolutely motivated by saying that we have a finite resource, and we need to ensure that that resource is going to the parts of the country and the communities that need it the most.

I think the second part of your question is about not just giving money here or there, willy-nilly, without thinking it through. On the £125 million that we have given to adult hospices, that has been co-ordinated through Hospice UK. They have done a needs-based assessment of the projects and proposals that each hospice has on—for example, whether it needs the boiler fixed, the roof fixed, or the IT infrastructure upgraded, because that is capital expenditure. Hospice UK have done an excellent job with understanding what the needs are and ensuring that the money that has been given—which has all been committed, by the way—has gone to good projects that are going to help to upgrade the capability for the long term for those hospices. There are two parts to your question: the first is about making sure that the money is distributed across the country to the ICBs that need it the most in a fairer way; and the second is about the money that we have given to hospices so far, and how that has been co-ordinated.

Q118 **Paulette Hamilton:** My final point, before I hand back to the Chair, is about staffing. Staffing is a major issue within hospices. Capital funding is not normally used towards staffing, so how are you supporting hospices to ensure that they are not still losing staff? The money that you are giving them absolutely cannot be used towards staffing.

**Stephen Kinnock:** On the children's hospices side, that was revenue funding, so that is for staffing. But on the adult side, our view is that when you look at the ledger for any hospice, and the income and expenditure it has, if you can help with expenditure on the capital side—those projects about fixing the roof that have never happened because the budget has been too stretched, or where they vitally had to do it, and they were going to take money out of revenue to put it into fixing the roof—we have taken the pressure off their entire budget. Our view is, even though we were only able to find that money on the capital side of our ledger, that money has helped to ease cost pressures right across the board for hospices.



**Q119 Chair:** We are very nearly done, but a question has come to me about how much heavy lifting this MSF is going to have to do. Looking at the five areas that you are planning to have MSFs in, among them are four areas that the Committee has already taken a keen interest in and done inquiries on: the current topic, frailty, dementia, and mental health. The reason we have done that is because they are quite intractable issues that we feel need fixing. I am struck that there is already a palliative and end-of-life care standard, updated November 2025. Are these MSFs just another way of kicking cans down the road, and what is going to be different with these? I am not sure I am clear on that. Let us just take this one, because it is the first time we have had a chance to interrogate and understand them a bit better in this specific context. How can you assure me that this is not just another plan to kick the can down the road on a really difficult problem?

**Stephen Kinnock:** I think it is because it is part of a systemic shift, which is set out in the 10-year plan. The MSF will not exist in isolation from all the other change that we want to deliver. That is articulated in the 10-year plan, and that makes it very clear to the entire system. I do think that the entire system has understood this.

**Q120 Chair:** But why do you need an MSF? You already have the standard, and you are doing the shift. We agree with the shift, and we think the standard is right, by and large—people just want it to happen. Specifically, what role will the MSF play in making this work? Why do you need it? Why have you done this?

**Stephen Kinnock:** A big part of it is because of the stakeholder engagement that we have got through it. There will be an entire system to come behind it. It is not just something that we are developing in isolation.

The other thing is that we have identified that there is too much fragmentation, with each ICB going off and doing its own thing. The reason we need the modern service framework is that there is not currently a national plan—a national set of standards and goals—so that every ICB and every other stakeholder in the system understands that this is what is expected of them and that they will be held to account on that basis. It is about saying, “Okay, we are going to have strategic commissioning.” We have the model ICB framework, but a real priority for this Government is palliative and end-of-life care. It is one of only five modern service frameworks. That sends out a bat signal to the entire system, which is that palliative and end-of-life care is a top priority of this Government. We need to fix it, and the MSF will be a way of mobilising the system to do that.

**Q121 Chair:** So it is a reprioritisation exercise, in part. Are we expecting new standards, or is the current standard going to be subsumed into the MSF? Is that how it is going to work?

**Stephen Kinnock:** I don’t want to pre-empt it. It is so important that we co-produce it with the stakeholder group. Five meetings have already

taken place. I think there will be an answer to that question when we do the—

Q122 **Chair:** Do you sit in on those meetings?

**Stephen Kinnock:** I don't, no. It is officials and stakeholders—

**Chair:** It is at an official level.

**Stephen Kinnock:** I get regular updates from officials, and I am pretty sure they will wheel me in at some point, but not yet.

**Chair:** Thank you very much. That was very helpful.

Thank you very much, all, for coming. I also want to say a public thank you to Jane Dacre and the team at the independent expert panel for the excellent report on which we based all our questions today. We will be writing our own recommendations and report off the back of that. Some of the specialists are in the room and have watched the whole session. Thank you very much to them for their incredible work.