HOUSE OF COMMONS

Public Accounts Committee

Oral evidence: Adult hospices, HC 1236

Monday 12 January 2026

Ordered by the House of Commons to be published on 12 January 2026.

Watch the meeting

Members present: Sir Geoffrey Clifton-Brown (Chair); Mr Clive Betts; Anna Dixon; Sarah Green; Sarah Hall; Chris Kane; Catherine McKinnell; Tristan Osborne; Matt Turmaine.

Health and Social Care Committee member present: Paulette Hamilton.

Gareth Davies, Comptroller and Auditor General, Lee Summerfield, Director, National Audit Office, and David Fairbrother, Alternate Treasury Officer of Accounts, HM Treasury, were in attendance.

Questions 1-80

Witnesses

I: Rt Hon Baroness Ilora Finlay of Llandaff, Co-chair of the APPG on Hospice and End of Life Care; Professor Fliss Murtagh, Professor of Palliative Care, Hull York Medical School; Toby Porter, Chief Executive, Hospice UK.

II: Samantha Jones, Permanent Secretary, Department of Health and Social Care; Sir Jim Mackey, Chief Executive Officer, NHS England; Dr Amanda Doyle OBE, National Director for Primary Care and Community Services, NHS England; Dr Edward Scully, Primary and Community healthcare Director, Department of Health and Social Care; Duncan Burton, Chief Nursing Officer, NHS England.

Examination of witnesses

Witnesses: Baroness Finlay, Professor Murtagh and Toby Porter.

Q1 **Chair:** Welcome to the Public Accounts Committee on Monday 12 January 2026. A happy new year to everybody.

Independent hospices are charities that play a key role in local and national healthcare systems, as they provide palliative and end-of-life care to local communities across the UK. Currently, there are 135 independent adult hospice charities in England, as well as two national charities, Marie Curie and Sue Ryder, which operate across England.

In '23-24, the independent adult hospice sector provided around 251,000 people with palliative and end-of-life care. The majority of independent adult hospices' income is generated through charitable donations—fundraising, legacy gifts from wills, and retail activity. The second largest source of funding for hospices comes from the Government, including from the NHS via integrated care boards. Many adult hospices have recently reported increasing financial pressures and the threat of needing to cut services unless additional funding is sourced. This comes at a time of increasing demand for palliative care due to the UK's ageing population.

Today, we are fortunate to have with us a panel of witnesses with a huge wealth of knowledge and experience working in this sector, ahead of questioning of senior Government officials later this afternoon. We hope to hear from all of you on what you think should be done to guarantee the financial sustainability of adult hospices in England. I would also like to make it clear from the outset that, in this hearing, we are not going to stray into the debate on assisted dying, as that is not the purpose of this inquiry. A very warm welcome to the right hon. Baroness Ilora Finlay, Professor Fliss Murtagh and Toby Porter. I ask each of you to introduce yourselves and say something briefly about your experience in this field.

Baroness Finlay: I am a crossbench peer in the House of Lords. I am also a professor of palliative medicine at Cardiff University. In 2008, I had responsibility for implementing the palliative care strategy in Wales. I could say a lot more. I think my colleague Fliss Murtagh is the person who has all the data to hand, which is really important for your Committee, so I am not going to take more time.

Chair: Thank you very much. We normally refer to each other by our Christian names. Is it pronounced Ilora?

Baroness Finlay: Yes, I am Ilora. Please use my first name.

Chair: Great. Good to have you. Professor Fliss Murtagh, please.

Professor Murtagh: I am Fliss. I am an independent expert and I have no charity affiliations. I am a doctor by background. I have been a GP for nearly 10 years, and I have been a palliative medicine consultant for nearly 20 years, working across all settings including hospices and

hospitals. I lead a palliative care research group of about 40 researchers, which is about the second or third largest group in the UK. I am an NIHR senior investigator, which is a small number of people awarded for their work in applied health and social research by the NIHR.

Chair: Thank you. Toby Porter, please.

Toby Porter: Good afternoon. I am Toby. I am chief executive of Hospice UK, the membership body that represents the UK's adult and children's hospice sector. I have held the position for three years, and prior to that, I was chief executive of a children's hospice in the west midlands for six years.

Chair: We are very pleased to have you. Thank you very much for coming.

Baroness Finlay: Sir Geoffrey, forgive me—I should have declared that I am honorary vice-president of Hospice UK and of Marie Curie, and a patron of various hospices.

Chair: Thank you for that. In addition to you three, whom we are very pleased to have—you are all very experienced people in this field—I would also like to extend a warm welcome to our guest member for this session, Paulette Hamilton, who is a member of the Health and Social Care Committee, and was at their hearing last Wednesday. Let us move on and start the questioning. To start us off with that, I call Anna Dixon.

Q2 **Anna Dixon:** Good afternoon, panel. Before I get into questioning, I would like to draw attention to my entry in the Register of Members' Financial Interests. I am a member of the APPG on hospice and end-of-life care, and I have done paid work before becoming an MP supporting King's College London on setting up an impact centre on palliative and end-of-life care.

It is now over a decade since "Ambitions for Palliative and End of Life Care: a national framework for local action" was published. In the Government's vision for palliative and end-of-life care, it states that every person who needs it should receive high quality, compassionate palliative and end-of-life care. How close do you think we are in realising that ambition?

Professor Murtagh: I should also have mentioned that I am the co-lead of the NIHR-funded policy research unit in palliative care. Before I answer your question, can I start with three points of language? The hospice sector is about the beds, but more importantly, it is about the huge amount of community services and support for people at home, and the training that the hospice sector provides. When we talk about specialist palliative care, the hospice sector plus hospital specialist palliative care teams are the Cinderella services that go under the radar. For the purposes of your considerations, it is really important to think about a system-wide approach, because any solutions that are not system-wide are not likely to work.

In my view, end-of-life care is a pretty meaningless term. If you say it to health professionals, they usually think of the last few days of life for someone. If NHS England are asked, it is the last year of life. The trouble with that is that most people are not identified in anything like the last year, so it is a retrospective understanding.

In answer to your question, no—and it is getting worse. That is the short answer. There used to be a VOICES survey, which was commissioned by the Office for National Statistics from 2011 to 2015. It was a post-bereavement survey, run nationally, to find the answer to your question. In 2015 it was stopped, and that is a real omission because we now do not have the evidence to say what the quality of palliative and end-of-life care is like. Marie Curie had the vision to fund work, which I and Katherine Sleeman led, and, on a smaller scale, we repeated that post-bereavement survey. The report was in 2024 and it is the best recent evidence we have.

One in five families of these people in a nationally representative sample said there had been poor or very poor care from the GPs in the last three months of life—one in five. That compares with 12% in 2015, so it has got worse. We also know that they reported a similar—worse—view of the care from hospital doctors. Fourteen per cent, or one in seven, said there had been poor or very poor care from hospital doctors. That was notably worse than the 9% in 2015.

Q3 **Anna Dixon:** Given that the answer is basically no, we are not meeting that ambition for what sounds like a large minority of patients and families, according to that survey, what do you think are the main issues that the Government must now address, Ilora?

Baroness Finlay: We know what to do, but we are just not doing it. When we ran the inquiry—the commission on palliative care—that came out loud and clear. People can think about different types of scheme, but basically patients and families are just not getting the care that they need. There is inadequate education and training right the way through from early on, right through all postgraduate training, and there is a risk aversion that I fear has come in among some healthcare professionals, which means that they are being less imaginative for the individual patient and individual family. Also, if you do not have 24/7 services, you are going to miss out on when the crises happen and when people are really needed. Seventy-five per cent of the week is out of hours, and without 24/7 services you are not actually going to be there and it will just be too little, too late.

Q4 **Anna Dixon:** The evidence we received in the NAO Report set out many factors, including money, workforce shortages and a lack of strategic commissioning. What would you highlight as the main challenge in achieving that ambition?

Baroness Finlay: If you do not commission against outcomes and you commission only based on activity, you are not going to drive the improvement in outcomes that is necessary. That is it in a nutshell. There are measures of outcomes. In our own cancer centre, we use the really

simple IPOS and we are able to show improvement. Even though the disease progression is happening and people are deteriorating, you can show, where you have specialist palliative care coming in at the right time, that you can actually improve quality of life. But if you do not have the team there, you cannot do it.

Professor Murtagh: If I may, I will pick up one of those points. Over time, specialist palliative care has been coming in later and later. We have shown, in a very robust, systematic review, that you need at least three months to get the impact across, but we now know that people are getting specialist palliative care only in the last two months of life and, if you have a non-cancer condition, only in the last month of life. So we hear from the professionals again and again, and from patients and families, how it is all too little, too late. The pressures on the hospice sector have been such that they have had to retrench when the need is increasing.

Anna Dixon: I am sure we will hear more from Toby in due course, but I will hand over for now.

Q5 **Chair:** I am keen to pick up, Professor Fliss, on your point about the perception, at least, of deteriorating services provided by primary care and the GP. Why do you think that is? Is it because of their workload? What is the problem?

Professor Murtagh: We have done modelling work to show where the formal healthcare costs go in the last year of life for all people who die. That is all people who die, regardless of whether they have had generalist palliative care from their GPs and district nurses and whether they have had specialist palliative care or none of it. That shows that about £22,000 is spent per death, on average. Obviously some people will have a huge amount more and some a huge amount less. Most of that—78% of it—goes to the acute hospital sector, and a pittance, about £800 per death, goes to other partners in formal healthcare: the ambulance service and district and community nursing. Specialist palliative care provided by the hospice sector gets about £1,000 a death, and so on and so forth. Even the GP sector is only between £1,000 and £2,000 per person. So you can see the flow to the acute sector is a problem.

There are other problems—two big problems. I do not think the Department of Health or NHS England know how much hospital specialist palliative care is available. They are tiny teams and they have all been seeing huge volumes. If those teams could work in the hospital to identify and support people and get them out earlier and prevent readmissions, and they could be in the emergency department and liaising with the hospice sector more closely, they would give a wonderful return on investment. We have shown in the modelling that for every death in hospital, specialist palliative care saves the NHS £6,500 per death. If it is in the home, specialist palliative care saves £8,000 per death. That is the current situation. If there was an up-front investment to make sure we had better specialist palliative care teams in the hospitals, they are a tiny resource and will not cost much. If we had the appropriate community services, including proper out-of-hours and including more time allowed

for GPs to actually get to see people, then we would work towards a solution that would save money.

The second problem is that the culture in hospitals is to treat people. We found in our survey—this is not hearsay; this is evidence—that 40% of the families of all the expected deaths told us there had been no conversation with the person in the family who died about possible deterioration and possible approaching death. Some 20% of families had no conversation at all and were completely unprepared for these expected deaths. If the professionals know they are coming, why are the conversations not happening? There needs to be serious illness conversation training mandated for all health professionals, because if they are not supported to have those conversations in a meaningful and timely way, we will not change the oil tanker from acute to community.

Chair: Allied to that, I will ask you later about the item on the "Today" programme from the Society for Acute Medicine. But I will come back to that. We will now move on to Catherine McKinnell, please.

Q6 **Catherine McKinnell:** Some of the data that you have collected is clearly very interesting, but there are gaps as well. We know that demand for hospice care in particular is increasing, as is palliative and end-of-life care. Do you have a clear idea of what that unmet need is currently?

Professor Murtagh: Yes. For a long time it has been said that one in four of those who need palliative care do not get it. Again, Marie Curie have funded some research, which I am working on with Katherine Sleeman, and that now tells us that one in three[1] of those who might be expected to need palliative care do not get it. And that is regardless of whether you ask the people themselves whether they have symptoms and issues that were not addressed, or whether you look at the access to services that they are not getting. And if you look through both lenses, it is one in three[2] of those who need it. We have also projected figures for 2050, which show an increase of between 20% and 25% in the absolute numbers. We have to get this right. Working out how we get to the solution is going to be critical.

Catherine McKinnell: Did you say a 20% to 25% increase?

Professor Murtagh: Yes. That is going to be published in March, and it is funded by Marie Curie.

Q7 **Catherine McKinnell:** That is really helpful. I appreciate that these assessments and projections have been made, but is there data that is not available currently, but would give you an even clearer vision of that and would be helpful in your work?

Professor Murtagh: There is lots of data, but outcomes data would be really helpful—measuring the things that matter to people and families.

[1] The underpinning work is unpublished, and this figure is yet to be fully verified.

[2] Ibid.

The hospices can do it; 76% of them are starting to use the core outcome measures. NHS England has done work to look at complexity and currencies with those measures. We just need to get faster data flows, make it happen, begin to mandate it and get the data analysts supporting the hospices to do that work.

Catherine McKinnell: And ensure that it is consistent, presumably.

Professor Murtagh: And ensure that it is consistent. That would be one thing. I'm sorry—I have forgotten your question. Could you repeat it?

Q8 **Catherine McKinnell:** Are we able to measure the unmet need that you have said we have? I just wanted to know whether there is additional data and transparency that would help us to identify that.

Professor Murtagh: The question you need to ask is about the hospital teams. We do not know anything about the hospital specialist palliative care teams. We do not know how many are in the workforce, the number of full-time equivalents, the disciplines, or how many are operating in which hospitals and at what bed capacity. Are they in ED, doing a front-door service that says, "These people actually don't need to come in," so the hospice sector can support them to be at home? We do not know that.

We do not know much about continuing care funding, particularly fast-track continuing care funding, and we know very little about social care provision. We have just completed a major study, called the supported study, which looked at domiciliary home care workers. It shows that they have no training and really poor conditions. Is it any wonder that we cannot find packages to support people at home?

Baroness Finlay: May I just come in there? One has to be clear that you are not talking about one group that have need and another group that do not. They tend to dip in and out. If people have their needs met early, you can avoid crises later on. Early intervention becomes crucial, and that is where services that link with the local hospice, whichever it is, will allow rapid turnaround. But if the hospice cannot manage, you do not have the resource for the early respite or for managing the family that is in emotional crisis, as well as the patient who is distressed. You might be able to get everything sorted out in an hour or two, providing you can break the cycle. People think that this might be long term, but if you can dip in early, you can avoid that crisis developing.

That is down to the way that services are commissioned. They are not commissioned adequately; they are commissioned in silos, if at all, and they are not commissioned against outcomes. The one thing that is not being measured—I should declare an interest, because this comes from Cardiff University—is family-reported outcomes. There is a simple scale—FROM-16—and it takes two minutes to complete. You could track, from the time of diagnosis, what is happening in the family. That becomes important, because a family in bereavement will cope better if they have had good care all the way along.

Q9 **Sarah Green:** I should declare an interest: I am a patron of one of the

wonderful hospices that serves our community in Chesham and Amersham, and I know how it would answer this question, but I am keen to get a national perspective. Toby, how would you describe the present state of the independent adult hospice sector in the UK?

Toby Porter: I will answer that in two parts. The first part, which is really important, is the state of service. Every day, hospices are supporting about 270,000 people in England. There are 135 local hospice charities and we are not here for those organisations; we are here for the people they support and the care services they deliver.

We are also here for something broader. To quote something that the founder of the modern hospice movement, Dame Cicely Saunders said: "Approaches to death and dying reveal much of the attitude of society as a whole to the individuals who compose it." I think all of us are very uncomfortable to have seen recent coverage, for example, about people dying in corridors. We should not accept that.

Together, the hospice sector every year provides about 500,000 occupied bed days, 760,000 out-patient appointments, 460,000 specialist palliative care visits and 680,000 generalist visits. It is a huge sector. We are here to talk about statutory contribution to the hospice sector, but can we all start from the point that the UK charity hospice sector is a huge net contributor and donor, effectively, to the NHS? We raise and spend £1.2 billion a year on care and only £400 million comes back in statutory funding. For every £2 raised by the hospice, that is given back.

The reason we are here is because of four years or so of compounding significant cost increases in delivering care coming up against increased demand for palliative and end-of-life care services because of our ageing population and very difficult, flat statutory budgets at local ICB level. Not every hospice, but the sector as a whole would consider itself in financial crisis. The National Audit Office Report talks about the situation in 2023-24—by far the worst year ever for hospices—but the two years since have been worse again. The hospice sector is facing a new cliff edge in April when the period covered by the DHSC's very welcome and useful capital grants programme comes to an end. There is an over-reliance on charitable giving and two out of five hospices are making cuts. I know a lot of the constituencies that Committee members represent and you know that in your own communities. Sorry to give you a long answer.

Q10 **Sarah Green:** You are painting a picture of a sector in financial crisis and Professor Murtagh said to one of the previous questions that the key is moving the oil tanker from acute to communities. Given the context you have just given, I am keen to understand what role hospices can play in moving the service from acute to the community?

Toby Porter: That is our absolute bread and butter. Hospices are the ultimate in community neighbourhood organisations. We are deeply rooted in our communities. We operate with not just the consent, but the active financial support of our local communities. I visit a hospice almost every week and I can honestly say almost every hospice CEO, medical director

or director of care I meet is always thinking about how they can do more, deliver more care in the community and take the pressure off the acute.

Some of the facts that you have learnt for this inquiry, we live and breathe—the illogicality of the sector being told there is not enough money to fund their services, so the very services that would take pressure off the acute—the most expensive part of our system—are cut back, and therefore people end up in hospital or have longer stays in hospital than is necessary. It seems to be a doom loop that continues year by year without logic and is making the system worse.

Q11 **Sarah Green:** It is interesting that you call it a doom loop. It sounds, from what you are saying, that the independent sector is already trying to help to move things to the community?

Toby Porter: Absolutely. Some 53% per cent of hospice care services are delivered in a person's place of residence, and only 47% are delivered in a hospice. I told you there are 830,000 out-patient appointments; often, when people think of hospices, they think of the in-patient unit for the very end of life or for symptom management stays, but that only represents 19% in totality of what the hospice sector does. Some of our best-performing hospices and our largest specialist providers have cut, over the last 12 months, the very programmes that are explicitly designed or co-designed not just to bring humanitarian benefit, but to deliver more care in the community and to take pressure off the hospitals.

Q12 **Sarah Green:** I can see that Professor Murtagh wants to come in.

Professor Murtagh: You might want some data that would help you with that question. The hospice sector delivers 665,000 bed days a year. To give context, in acute hospitals in the NHS, there are 30.5 million hospital bed days following unplanned admissions. I am not thinking about the planned admissions, but the unplanned ones, because that is where we need to save. A third of those 30 million are people in their last year of life.

If you walk on to an acute medical or surgical ward in any of our hospitals, one in three people will be in their last year of life. One of the big challenges is that that is not recognised by staff in the hospital. I cannot say to a surgeon or a general medic, "Which are the one in three?" because they do not think like that. They think, "I've got a battery of interventions; they are hopefully curative or helpful, I'm going to keep giving them." Chris Whitty put that into the chief medical officer's report the year before last: we need to give people less medicine if we are trying to give them better care.

Since there are not conversations with patients and families about what is happening and the likelihood of deterioration, they carry on having lots of high-cost interventions. If we could but get those conversations in earlier, and get them right, the vast majority of people would not choose to have a lot of things done when there are diminishing returns. It is that skilled conversation that does not happen. Some 40% of expected deaths do not

even know the possibility of deterioration or dying, let alone talking about whether to do an intervention.

Dialysis costs over £44,000 a year, but there is no funding stream for not giving dialysis. If the doctors and nurses want to say, "Okay, let's not give you dialysis because it is not going to extend your life"—and it probably will not if you are over 75 with multiple conditions—you could give a bit of funding to get them into a supportive and palliative care pathway. But it is not even funded, and the nephrology teams are left thinking, "Well, what do we do?", because we do not have that service.

Baroness Finlay: Thank you for your question, because there is another whole dimension to hospices that has not been touched on: they are an amazing resource for education. If they can function and take students and staff—whichever discipline they are in—on a rotation, they can get educated and you can raise the standard everywhere. Medical or nursing students who go out on placement will learn more effectively. The evidence is that you learn because of needing to know. That is a unique teachable moment: there is the patient, and you suddenly realise what you could do and how to do it, and you learn very effectively. Those lessons last much longer than sitting somebody down in a classroom or expecting them to read something or watch some video.

Hospices have a role as an important reservoir of expertise for their community and are a source that people can come to for advice. District nurses who feel a bit stuck or care assistants who want to ask somebody they know, who perhaps is also a carer, working in the hospice—they are safe people to ask, and they will ask, so you can drive up standards of care generally. That is not counted or costed anywhere, other than the number of students that walk through the doors. But it is an important resource that is in danger of being lost.

Chair: Thank you very much; that is very interesting indeed.

Q13 **Tristan Osborne:** My question is on the modern service framework is slightly changed, because this Report was commissioned in October and since its commissioning the Minister, Stephen Kinnock, has delivered the framework in November. However, given all the issues that you have just raised and that are in this Report, does the Minister's announcement go far enough?

Professor Murtagh: There are two questions in my mind. I am very heavily involved and have been to all the workshops. As a policy research unit, we have also been asked to provide evidence for interventions under the modern service framework for palliative care. I have been in palliative care since the '80s, and we have been in this place before. Whether we call them frameworks, strategies or whatever, it is actually all about what is in them and whether it is delivered or not. It is the monitoring of the delivery that is really going to matter.

We can, and have, put forward a host of evidence-based interventions, and I am sure that the Department of Health and Social Care will select

from those and others to make sensible decisions about what might be done. I can tell you what I think are the hottest solutions, but it will be about delivery, carrot and stick, what is mandated and what changes to commissioning are going to happen to make those things happen. It will also be reviewing to really see what is changing.

Baroness Finlay: I behind the amendment to the Health and Care Act 2022 that said that palliative care should be a core service for everybody. I had very much wanted the Act to specify "specialist palliative care" and had some criteria. Those amendments did not get into the Act. I accepted 80% of what I wanted, but I regret that I did not push harder because it is about commissioning for what you want to happen, which is the outcomes. You can have a fantastic framework and set it all out as a strategy, but unless you actually implement it and make it happen, it does not happen because there are so many pressures.

One of the problems for commissioners is that they do not actually know what to commission. There is a deficit of knowledge right across the sector. If you have a hospice, it needs to be able to get the necessary medication, yet we still have some hospices having to buy their own, which seems completely appalling. If you have a hospice, but there is not a contract whereby they can get an anaesthetist to come in and do a quick nerve block that might solve the problem for one patient and would take half an hour—quick and simple—then those patients do not get the intervention that would improve their quality of life and outcomes. Whether it is for days or weeks, unless you get that commissioning allowing people to move between the sectors, and support that move, you cannot get the move of patients either.

Toby Porter: Briefly, Hospice UK warmly supports the MSF and the work involved; all the hospices are participating directly and through us in this process. On the specific topic of this inquiry and today's theme of financial sustainability, at intervals you hear that there is no new funding attached with MSFs. The thing is that hospices are facing a cliff edge from April. If there is not an injection of new funding to help the sector in time for the new financial year, then the boards and chief executives of charities will have no choice over the next month or two but to further reduce their services. Therefore, we must warmly invest in the MSF and come up with a plan, but we must not think that we can just carry on kicking proper local funding of charitable hospices down the track, because another year will mean another significant reduction in capacity and service.

Q14 **Tristan Osborne:** Very briefly, would you suggest more long-term funding models? In local government, we have a three-year settlement cycle now. Lastly, on ICBs, in my area the ICB is supporting the Wisdom hospice. I am very lucky to have an NHS-commissioned service there, but it is a postcode lottery around the country. Is there an example of what would be the perfect model? Is that a perfect model?

Professor Murtagh: No.

Q15 **Tristan Osborne:** If there is not a perfect model, we are going around in

circles. Is there one used in other countries that we think might work?

Professor Murtagh: Can I answer a broader question about how you put in commissioning levers to get the results? I think several things need to happen. One is, as we have already said, that we need to commission on outcomes, not just activity. That has to be a move so that you do not destabilise the system, but it should be activities and outcomes. That is already in the NHS in the blended payment approach. It is called the aligned payment and incentive scheme and is in the NHS payment scheme. It is there, so why is it not being used?

We need system-wide commissioning; we need people to get around the table, and NHS partners and hospice sector partners to deliver together, so that there are not perverse incentives for any one party. There needs to be a five-year commissioning cycle, at least. There need to be risk-sharing agreements. The hospice sector is delivering its 660,000 bed days a year, and they are the most complex people. There is a lot of risk there, particularly because the demand is rising so fast. There need to be risk-sharing agreements between the ICBs and the commissioned services, but also payment limits for over and underperformance.

We also need to bring hospital specialist palliative care to the party, because they are completely off the radar. They are Cinderella services, but they could do a lot on very little. We could also think about them becoming commissioner-requested services, which have a greater degree of governance and which protects continuity and essential services. Some of the tools are already there, but they need to be implemented across all ICBs, and the ICBs need to be very clear what needs to be commissioned. The service specifications are there; we have them, but it is just not happening.

I would also add that we need to invest in specialist palliative care to save the NHS money. The elephant in the room is, why does the NHS not consider death part of its business, in the way that birth is. For many years, we have had a system where charities stump up the money, and people in the NHS system are happy to let that happen. The charitable sector is there, so why would you disturb something that is giving you plenty of service? We cannot seriously carry on like that, for two reasons. One is the complexity of people's needs. People now have multiple conditions, and it is complicated. All the GPs and district nurses I have talked to have told me that it is very complicated now, and the hospice sector picks up the most complex. Also, the need is going up vastly, and the charities cannot keep up.

Q16 **Matt Turmaine:** We spoke a little about the commissioning process and some of the funding. Fliss, you mentioned some of the "what" to do. Could you tell us a little about the recent innovations in the provision of palliative care that you think have the most potential for the future?

Baroness Finlay: In the commission, we looked at different innovations, but I think that can almost be a distraction. As I said, we know what to do; we are just not doing it.

If you are going to innovate, you have to innovate for your population, to meet its specific needs. If you are looking after a population in, for example, Bradford, where Jamilla Hussain has done amazing work with a very ethnically diverse population, there are very different expectations from perhaps leafy parts of Surrey—the Epsom-type area. You have very different populations, and what will work is different in different areas.

I worry that people think innovation is going to be the answer to this. The answer is to do what we know needs to be done first of all—and quite frankly, get on with it—and give people the space to be able to innovate, because if you do, they come up with fantastic ideas.

I chair the Bevan Commission in Wales, and we have an exemplary programme. We do it with remarkably little money, but we encourage healthcare people who have got some idea of how they want to improve something in their service to try it out, develop it and really experiment with it. Some of those things fail and some are successful, but you cannot just take the successful ones and say, "Adopt this and spread it everywhere," because the template that you need in place is not necessarily there.

The one thing that we must not forget is the importance of research. The specialist palliative care teams, often in conjunction with hospice services that have got specialist teams in them, are undertaking the research, particularly multi-centre, and that is the thing that will move the frontiers forwards. Do not just stand still, but recognise that, locally, people will have ideas, and they need to be supported to develop them.

That should come within that context of risk as well, because some ideas will fail and some will be successful. I do worry that there is an over-reliance on the belief that some brilliant new idea will come along, when we have known the simple basics for decades. It is tragic that we get referrals for patients about whom we say, "If only we'd seen them weeks ago," or, "If only we'd seen them months ago," and they have not even had the basics of pain and symptom control sorted out, let alone the difficult conversations and the psychological support for the family.

Chair: I will bring in our guest, Paulette, in a minute, but I will bring in Anna Dixon first.

Q17 **Anna Dixon:** You mentioned Bradford, and I could not resist, that being my local patch—thank you, Ilora. I have something that might be an example of, "This really works, so why doesn't everywhere do it?" I visited the REACT service, which is a partnership between Bradford Royal infirmary's A&E department and Marie Curie's Bradford hospice. It puts those specialist clinicians in the emergency room, so that when people come with an emergency admission, they could be turned around quickly and be discharged through partnership. West Yorkshire also has a provider collaborative. Do you see those as part of the package of what the MSF should be doing in future, particularly to meet the needs of the more deprived and diverse communities that we serve in Bradford?

Professor Murtagh: I absolutely agree with you. When I talk about hospital specialist palliative care, that is exactly the kind of thing I mean: enough of a team to do the basic—I should not say basic—specialist palliative care that is needed, but also to be in the ED and to work collaboratively with the hospice sector. I absolutely agree that that needs to happen everywhere, but we do not even know at the moment how many people are working in the hospital specialist palliative care teams, let alone what they are doing and whether they are adopting that kind of ED approach.

There are a few other things that need to be thought about in relation to the MSF. We have talked about timely identification. I know that Stephen Kinnock spoke last week about palliative care registers with GPs. I would not put my money in that space, because we do not know what happens to people after they go on the register. You are also much more likely to get on a palliative care register from your GP if you have cancer; those with dementia or multiple conditions do not get on those at all, so it is very inequitable. That is why I say that bringing earlier identification into hospitals has to happen. Almost everybody gets admitted and all the groups that miss out are admitted more. The ethnic minority communities, the people who are more financially under pressure and those from the socioeconomic deprivation areas are all in the hospitals. That is why we have to act in that space to complement the work of the hospice sector; otherwise, it just does not work. We have to have a system-wide approach.

Chair: Paulette, welcome to the Committee.

Q18 **Paulette Hamilton:** Thank you. Before I start, I should declare my interests: I was a nurse, until I gave up my registry last year, and I worked in the palliative care field at points in my life. Also, up until November, I was joint chair of the APPG on hospice and end-of-life care.

Let me start by saying good afternoon to all three witnesses. I would like to direct my question to you, Toby, because through the 10-year plan, we have looked at the shift from hospital to community care. We all know that palliative care is really important. The thing that bothers me most is that, although we are moving towards strategic commissioning—this is what they are talking about—the way the service is being funded at the moment is very ad hoc. We have talked this afternoon about grant funding and charitable funding, but everywhere you are within the country, it is slightly different. As you know, I am from Birmingham, and the money we get for charitable funding is nothing like you guys would see in, say, Oxford or York. My question is about strategic commissioning: what are the benefits of shifting to strategic commissioning and contracting of palliative care, Toby?

Toby Porter: There are huge benefits, Paulette. The first one is that it is a recipe for reducing—ultimately, eliminating—the inequality. Over-reliance on charitable fundraising to deliver an essential healthcare service is inherently inequitable. We should celebrate the generosity of our communities but, obviously, if you outsource to a local community the

responsibility for paying for specialist and generalist hospice care services, it is a statement of fact that a hospice in a wealthy stockbroker community in the south-east is going to have more abilities to fund services than your community in Erdington, which has seen cuts in the services. You know that very directly.

In terms of strategic commissioning, we are obviously hugely in favour of the strategic commissioning framework, and specifically the ICB's move away from grants into providing contracts. The only caveat—this does not dilute that support—is that the way that hospices are funded now is so un-strategic that we are not even at first base. We are at such divergence. It is the same when Fliss talks about moving away from activity towards outcomes: hospice CEOs would give their eye teeth to be funded on activity. The rest of the NHS is already talking about moving to outcomes, whereas hospices just get a grant—a contribution—without accountability on either side. We believe that the most broken part of the system is the local commissioning of hospice care services. We think that, after several decades, it clearly cannot be left to every ICB individually to fix a system that is hugely variable and inequitable. That is where there has to be some kind of central mandate or framework that has to be followed.

Q19 **Paulette Hamilton:** May I just make a follow-on point? I know we have to move on. For me, the big issue—and I have a thing about this—is data. We are struggling to get the data from hospices. I do not mind who answers this question, but what would you like the Government to do to increase their data collection to enable us to get proper strategic commissioning?

Toby Porter: If you look at paragraph 20 of the NAO Report, it says: "DHSC and NHS England do not know what proportion of the total amount of palliative and end-of-life care provided in England is delivered by the independent adult hospice sector." There is not enough data. There is an absolute lack of good data locally and nationally, and that should be a concern. I note that towards the end of the Committee's oral evidence session on 13 March, on the DHSC annual report and accounts, the Chair and Anna said to Professor Whitty that they were concerned that there was hardly anything on palliative or end of life—spend, performance, outcomes, volume or the hospital services that Fliss has been talking about.

Q20 **Paulette Hamilton:** I wonder if Fliss would like to come in, because I have to hand back to the Chair. Say you had three Government Ministers sat here, what message would you give them, so that we can really see strategic commissioning?

Professor Murtagh: I agree with Toby that we need to know the activity. We do not know the activity well enough. Some hospices have done a lot of work to build a dashboard and get their information to the ICBs, and into the linked health and social care datasets that are beginning to emerge around the country, so there is some innovation in that space.

The trouble is that it is a very fragmented sector. As we know from the NAO Report, there is a lot of variability in the provision, and there is also a lot of variability in the "data-ability", both in capturing it and reporting on it, as well as feeding it into the centre. We have lost a lot of what we had in the past, and we need to rebuild that. We used to have annual reports on all the activity, but it is much less good now, although there have been really great efforts by Hospice UK to be leaders in the sector and move it forward on this. So it is going in the right direction.

Q21 **Paulette Hamilton:** I am going to move straight to Baroness Finlay for the last word, because I have to hand back.

Baroness Finlay: What I would say, quite simply, is that there needs to be a clear funding formula. You need to know the workforce that is actually working at specialist level. You need to know where availability is 24/7, with telephone support for all the families and patients you have listed, working with your local hospice so that you are including them within your funding formula framework. You also have to know the number of your workforce; I am not sure that people even know, from one ICB to another, how many staff they have working at a specialist level, and how many they have working in different ways.

Paulette Hamilton: That is a good place to stop. I will hand back to the Chair. Thank you.

Chair: Thank you very much. That was very succinct, Paulette.

Q22 **Mr Betts:** I will just focus on the overview that you have taken, and you have already answered some questions about it. We talk sometimes as though hospices and the NHS are two completely different worlds, but actually they are dealing at the end of the day with the same people who need treatment, but in different forms. How can we get a proper overview and integrate the services? You have referred to the fact that A&E departments ought to be referring people on, as GPs do, and the reach-out care from hospices goes into the same communities district nurses are operating in. How can we get a better, joined-up, integrated approach?

Baroness Finlay: I do not want to take up much time, but may I say very briefly what we did in Wales from 2008? We came up with a funding formula for the number of specialist people that we needed for a population, for a number of hospital beds and for a number of tertiary care centres. That included the number of hospice beds that we needed, irrespective of who was funding those, and the number of home care team staff that we would need for a population. It was pretty rough and ready, but it was better than nothing, and it gave us a starting point.

I would completely agree that, up until then, it seemed as if we were operating in different worlds. We had to be able to get staff to move around between the different bits of the sector to meet the needs of the patients, because the patients move around between the different bits of the sector, and we had to have integrated clinical notes and so on.

Professor Murtagh: On the ground, a lot of teams work very well together. What is not happening is commissioning at a system or strategic level, where those elements in one area might be provided by different folk than in another area. It is the population needs that we need to drive it from.

Q23 **Mr Betts:** I have one additional point. We talk about data and looking at the best way to do things. As a Committee, we look at value for money. Should there be value-for-money assessments of how services are delivered between different organisations to see how money is being spent, and how it could be better spent?

Baroness Finlay: If you collect outcomes against knowing what you are commissioning, you will get that information. I know that sounds a bit simplistic, but unless you actually measure outcomes, you will not know whether you are getting value for money or not.

Professor Murtagh: You have to be very careful in this space, because the cheapest person is the person who died six months ago. What I mean is that, if you want to give them good care and ensure the best possible end-of-life experience, we as a society have to commit to using some of our health service money to support that. Therefore, the outcomes you are looking for are quality of care and quality of life for those people. We can deliver it, and we do deliver it—just not enough of it. We also know that if they desisted from some of the high-tech, hospital-based interventions, we would have a lot more money to make sure those people had a better end, with better symptom control and better support for the family.

Toby Porter: To close on that question, I agree with what the Minister said before the Health and Social Care Committee last week, which was that hospices are not looking to be absorbed into or fully taken over by the NHS. We value our independence; it allows us to innovate. Cicely Saunders said, "We stepped out of the NHS in order for new ideas to flow back in."

On the question of integration, so many hospices are sharing consultants with the acute hospitals and housing district nursing teams with community hospice at home teams. Some hospices are totally integrated into the hospital and GP practice information system, so a lot of good practice is going on.

We should not allow this to be an either/or, and suggest that in order to be fairly funded, hospices need to become part of the NHS. They do not; they just need to be fairly funded by the NHS. It is a very different thing.

Q24 **Chair:** I have two very quick questions, because we are almost out of time, on the back of Clive's questions. I am sorry to boil this down to numbers. It is because we deal with numbers in this Committee, but we understand that behind all the numbers there is a person who needs treatment, and particularly their family needs supporting.

The evidence from Rotherham hospice is that a night in a hospice costs

£765, compared with £1,000 or £1,200 in the NHS. If you agree with those figures, Professor Fliss, your 30 million patients at any one time in the NHS, a third of whom are in their last year of life, so 10 million—

Professor Murtagh: Not 30 million patients—30 million bed days in hospitals.

Q25 **Chair:** Okay. If a third of those are in the last year of life, I am sure that a significant proportion of patients would be more correctly referred to hospices. The figures that I have just given seem to indicate that there is a substantial financial imperative to getting the data and, much more importantly, the diagnosis, correct, so that we can get—

Professor Murtagh: Earlier identification—not earlier diagnosis.

Q26 **Chair:** Yes. There is a big financial incentive to get it done earlier and quicker, so that we can get people into the most appropriate setting towards the end of their life.

Professor Murtagh: Yes. If you give people specialist palliative care, be it in hospital or be it in the hospice sector—in hospices and in their homes—they will have fewer hospital bed days and better quality of life. And it is cheaper, so why are we not doing it?

Q27 **Chair:** Thank you. That is what I expected you to say.

I don't know whether you heard Dr Vicky Price, president of the Society for Acute Medicine, on the "Today" programme this morning. To summarise, looking at the third that I have just referred to, she said that we admit them and then overtreat them. She said that one patient she saw recently was in his late 80s and had 14 appointments booked for the next two months for health problems including cardiac and renal issues, and liver and eye problems. She said she talked to him, and the only thing he really wanted to keep an eye on was his eye treatment. Are we in a position of overtreating people towards the end of their life?

Professor Murtagh: Yes, we are. If you look at the right care series, which was published by *The Lancet* a few years back, it is very clear that we overtreat people. What that means is that we have a whole barrage of interventions that can now be done, mainly in the acute sector. They are highly technical and brilliant, and they sometimes save lives—or extend lives is the real term.

The trouble is that we keep doing those things, which have usually been developed in one-condition evidence, not in multiple-condition evidence with older people. We keep offering people those treatments, and they keep taking them because the conversation goes like this: "This is the treatment I can offer you." It is not, "Actually, you are not doing so well. You might deteriorate. Things might not go so well. Shall we think about what benefit you might get from my fancy treatment, as well as what benefit you might not get?" That complex conversation, what I call a serious illness conversation, does not really happen often enough. We have the evidence for that: 40% of those families did not think that had

ever been discussed with the person concerned in the last three months of life.

So I think we do overtreat people hugely and we need to be much more judicious about understanding what a treatment can or cannot offer for older people with multiple conditions, but also being up front and being trained to have what are very difficult and sensitive conversations. I am not advocating that we withhold or ration treatment.

When people understand what a treatment, an intervention, can or cannot offer them, most of them—the older people—actually do not want it. They tell you, "I don't want to be messed around with. I don't want to be sent for another MRI scan, another CT scan or another investigation." We hear again and again from families, "I wish I had known the trauma and distress associated with being in hospital and having lots of tests and treatments." It is not easy, and if they had known that somebody was deteriorating, they would have said, "No, can we just take her home?"

Q28 **Chair:** On that sad but important note, may I thank all of you? This has been a fascinating session. It looks as though we should be making and can make significant changes, hopefully for the better of people towards the end of their lives. So we thank all three of you. You are all very busy and very knowledgeable people. We are very grateful to you for your evidence this afternoon. Sorry, do you wish to say something, Professor Fliss?

Professor Murtagh: I was just going to say that I have a briefing paper with the sources of evidence that I have spoken about, if the Committee—

Chair: I was going to ask for that. I would be very, very pleased to see it—thank you. The clock stands at 16:36. Could people be back here by 16:45—quarter to 5—at the latest? Thank you.

Sitting suspended.

On resuming—

Examination of Witnesses

Witnesses: Samantha Jones, Sir Jim Mackey, Dr Amanda Doyle OBE, Dr Edward Scully and Duncan Burton.

Chair: Welcome back to the Public Accounts Committee on Monday 12 January 2026. We now move into our main session.

We have just heard from an excellent panel of witnesses about the challenges facing the adult hospice sector. The NAO's recent Report on the subject found that NHS commissioning of palliative and end-of-life care has not yet moved on fully from its historical use of grants to commissioning through contracts. The picture is therefore not always clear about what services are being commissioned or whether local demand is being met. The Report also found that NHS commissioners are unable to understand fully how the funding that they provide to hospices is being

used to support patients and their families.

Today, therefore, we will look to challenge the Department and NHS England on the sufficient provision of palliative and end-of-life care and on the role of independent adult hospices. We will also examine how NHS England commissions and funds palliative and end-of-life care in independent adult hospices in England, and will explore how the Department plans to support the long-term financial stability of England's independent adult hospice sector. I reiterate that we are not going to stray into a debate on assisted dying, as that is not the purpose of the inquiry.

We have with us the permanent secretary, who we are pleased to welcome. Would you be kind enough to introduce yourself, and then each member of your team can introduce themselves? Then I will not get anything wrong.

Samantha Jones: Thank you, and good afternoon. I am Sam Jones, permanent secretary at the Department of Health and Social Care.

Sir Jim Mackey: I am Jim Mackey, chief exec of NHS England.

Duncan Burton: I am Duncan Burton, the chief nursing officer for England; I should also note that I am the trustee of a hospice.

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

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

Chair: A particularly warm welcome to you, Ed, Amanda and Duncan—I think it is the first time before this Committee for all of you, so a special welcome. Thank you all for coming. To start off our questions, please, let us go to Paulette.

Q29 **Paulette Hamilton:** Good afternoon, one and all. Samantha—if you do not mind me calling you that—I will direct my question, which is a simple one, at you. With the 10-year plan and the left shift that we have talked about, we know that things are moving more and more into the community. For palliative care, that means that we will get larger numbers of people in the community setting. Can you explain how the NHS will meet the expected increase in demand for palliative care in the coming years?

Samantha Jones: If the Committee agrees, I will start and then hand over to Jim for the details. For all the panel members and certainly for me personally, hospices are a core part of the service provided, not a "nice to have". Many of us will have personal experiences of end-of-life care, whether a member of our family or other people we have been with over such a time. It is extraordinary to be part of that experience of someone's end of life, particularly in a hospice.

As the Secretary of State has said previously, we know that there is a gap between where things are now and where we would like them to be; none of us believes that end-of-life care and the services provided are where we would like them to be. There is a gap between where we want hospices to be now and in the future.

Reform is not an option and, from our collective perspective and that of the Secretary of State, we are committed to making sure that the reform happens in practice. *[Interruption.]* I am not avoiding your question.

Q30 **Paulette Hamilton:** I was just going to butt in, but I will give you a few more seconds.

Samantha Jones: I just wanted to start with a very clear and personal statement that this is not a "nice to have" for any of us—for the Department and for NHS England regarding your question around the future of NHS England and the demand.

Sir Jim Mackey: In all the discussion about this, there is a lot of common ground. None of us is happy with where we are now. It is very inconsistent around the country, and we are not as clear nationally on the standards—how we are paying for things and how they are being commissioned.

The 10-year plan sets off some direction of vision around neighbourhoods. There is all the stuff that we are doing around modern service frameworks and more of a focus on quality and outcomes, and payment mechanisms. Over time, all those things should allow ICBs to commission a consistent set of national standards for end-of-life care.

We will all probably agree that we have people in the wrong places and sometimes people are in more expensive settings than they need to be. Over time, that will become more ordered. There will have to be some growth over time as well.

Q31 **Paulette Hamilton:** You and I know each other well, so I am just going to stop you right there: how will we do that?

Sir Jim Mackey: The intention is that the modern service framework will set out what "good" should look like. There will be support for commissioners in all that. We will expect them to start getting clearer about palliative and end-of-life care in their patch as a whole system regarding how everything fits together.

Over time, we will produce clearer payment mechanisms, contractual guides and so on. That will start putting this thing together and ensuring the consistency of standards and the focus on outcomes and value for money. One of the big things in this is the emphasis that is required on engagement with families and with the individual, and making decisions together. All those things must happen together for that to work properly. It will take time to get there from where we are now.

Q32 **Paulette Hamilton:** Finally, my biggest thing is about data. How do you find out where that deficit is so that we can then do what needs to be

done? What has NHS England and the Department of Health and Social Care got planned to ensure that hospice care is not seen as the second cousin once removed, but as an expert, first-class service that you are able to measure?

Sir Jim Mackey: Absolutely. You have heard me bang on before about the evil block contracts and stuff, where we have got into a position where we have very large sums of money with very little specificity about what that is commissioning or buying. That will be built out and it is all being unbundled now.

Over time, we will get to these services so there is more clarity about what is actually being commissioned. We will have to get better and stronger data standards and consistency against a set of national standards. That will take a few years.

We will then be clearer about what the differences are and what the variation is. Commissioners will then have more data to drive commissioning decisions, and we will have better data to hold the system to account. That is not where we are now. It is very inconsistent, the data is very poor and there are huge variations behind all that. It is going to take quite a bit of unravelling.

Paulette Hamilton: I am going to hand back now. I do not want you to answer, but I am going to leave you with this: Toby from the last panel said that by April many organisations will go under—they have not got years. As members of the Committee are asking their questions, you need to answer that point.

Q33 **Chair:** I should have welcomed Paulette to this session. Paulette is from the Health and Social Care Committee and is guesting here. You are very welcome, Paulette.

I want to follow Paulette's question. We are going to abolish NHS England and therefore the ICBs are in considerable flux at the moment. I think we would all admit that the hospice care sector has been neglected. If we are putting ICBs under additional flux by all this change, you can produce all the 10-year plans you like, but how do we know that anything is really going to change in this sector?

Samantha Jones: Whether NHS England is abolished or not, the functions remain, and the functions are required. Over the next year, as we go through and design the operating model for the future of the Department, as we have talked about before, these functions are very clearly required for ICBs.

The Committee will of course be aware that the published medium-term planning guidance requires ICBs and providers to understand their need, their population and their future demand projections, so that we can ensure that we understand the data—to pick up Jim's point. The modern service framework that Jim describes will set out, with people—it is really important that we do this with people and families, let alone with the hospice sector itself—what is required, whether it is now or over the next

year, subject to the abolition, the will of Parliament and the future of the Department.

Chair: Okay. We will test that in the future, but thank you for that answer for now.

Q34 **Sarah Hall:** Good afternoon. I want to look at the number of people who are dying in hospitals at the moment. We know that the demand for palliative and end-of-life care in community settings is increasing. What is being done to reduce the number of people dying in hospitals, and to support the greater number of people who wish to die at home? Samantha, do you want to start?

Samantha Jones: If I may, I will hand over to Amanda, if that is okay.

Dr Doyle: One of the things we are doing, as Sam and Jim mentioned, is that we have asked ICBs to treat the cohort of people who need palliative and end-of-life care as a priority cohort for starting to develop the shift out of hospital from April this year. A big part of that is understanding their data, as well as the needs of that population and the prevalence.

We have a palliative and end-of-life care dashboard, which covers all the ICBs. ICBs can drill and look in quite some detail at their population, including the numbers of people in hospital at the end of their life, or those who die at home or in hospices. We know that there is a significant number of people in hospital to whom we are not offering anything that they can additionally benefit from, and who would rather be at home.

It is about ensuring that we develop the MSF so that it is very clear what the evidence base is and what we expect ICBs to commission. It is also about supporting ICBs to become better strategic commissioners, so that, despite reducing in size, they increase their capacity to understand the data and apply it to improving the outcomes for their population. We are starting a strategic commissioning development and improvement programme for ICBs to help that to happen, and we are launching that in April.

It is then really important that we tie this to some of the other things that we are doing, such as the long-term workforce plan that will be published this year. It is really clear that the workforce focus is going to be important if we are to look after more people in their own homes. We not only need more people who can deliver specialist palliative care; there is an equally large group of people who may not need specialist palliative care but need general end-of-life and palliative care in their own home, and that involves general practice, particularly community nursing, so we need to focus on community nursing input.

We then need to work with other sectors such as pharmacy; we need to have the medication available so that people are not left in pain or with symptoms and end up defaulting to an ambulance. There is quite a significant piece of work for ICBs to look across that data so that they can understand those needs and deliver that shift in services.

Duncan Burton: I think it is really important that conversations happen earlier, when we identify people in the last year of life. It is about being able to have those conversations and making sure that there are advance care plans in place. We have seen the number of advance care plans go up, but we have much more to do in that space, because there is something about having honest and open conversations with patients and family members about the choices they have towards the end of life—whether that is the choice to die at home, in a hospice or in a hospital. It is therefore about making sure the plan is set, so that all the clinicians who are working them up know what the care around those patients is.

Q35 **Sarah Hall:** Given the challenges that this is going to bring, are you confident that ICBs have that knowledge? It is not just a question of funding, is it? It is things like the way in which services are currently organised and, as you said, the co-ordination that maybe is not happening, or the communication so that families know what is available. One of the things that I know has been highlighted in the MSF is the lack of 24/7 community care. Obviously, things like that need to be put in place so that families have confidence. Do you think that ICBs, in terms of that wider, strategic side, have the knowledge about what the challenges are—

Dr Doyle: A group of ICBs, Hospice UK and independent hospices co-produced and wrote some ICB commissioning guidance last year to support ICBs with a greater range of information about what the evidence tells us and the steps they should be taking. That has been circulated to all ICBs. We now have the strategic commissioning framework. As I say, we are about to launch the development programme. It is really important that we do not leave ICBs to guess at some of this stuff. We know, as we have evidence about the interventions that make a difference—24/7 access to advice about specialist palliative care and support and the co-ordination of services are key.

Q36 **Sarah Hall:** It is also important to have one set of guidance that everybody follows.

Dr Doyle: That is right.

Sarah Hall: Obviously, there is a lot of variation at the moment. Does having one set of guidance, which they all adhere to—

Dr Scully: Sorry to interrupt, but that is something that Minister Kinnock said at the Health Committee last week. As Amanda says, there are different service specifications, there is commissioning guidance and we have the broader strategic framework for commissioning. As Minister Kinnock said, the modern service framework is a way to bring it all together in one place—to set, in one place, what the framework will be, what the vision will be, what the data will be and, as Professor Murtagh was saying earlier, how it will be delivered and how it will be measured to ensure it is delivered. That, I think, was Minister Kinnock's ambition with the MSF.

Q37 **Sarah Hall:** I have read quite a lot about workforce shortages. Is there a

plan for tackling some of this to make sure you have the right people in place to do the jobs?

Duncan Burton: Clearly, we have the 10-year workforce plan that has been developed. Obviously, it looks at the workforce within the NHS, and it needs to factor in those services that support and are commissioned by the NHS. There are a number of things we have to do, going back to how we shift from hospital to community. In my profession, for example, we are still trained in a very hospital-centric way. If I think back to my training 30 years ago, I did probably 12 weeks in a community setting—that was out of three years of training. It is still very similar, so we have a big job to do about how we change the way in which we are training professionals to work in community settings, because this is about not just those who work in hospices but those who work in community services. One commitment in the 10-year plan was to develop a strategy for nursing and midwifery, which we will come out with in the spring and will have elements of that in there.

Dr Doyle: One of the key pieces of evidence about good-quality palliative and end-of-life care, and therefore good outcomes, is that continuity of care makes a difference. It is absolutely vital that we recognise that to have good continuity of care, you need the capacity in the workforce to deliver that. I was a GP for 25 years, and you see that really clearly. You are much better able to support families and patients at home if you know them and see them.

Sarah Hall: You can have those honest conversations.

Dr Doyle: Absolutely.

Dr Scully: One thing that came up about the workforce in the previous session was that we do not know the numbers. That is not quite right; we do know the numbers. We know there are 910 FTE palliative care doctors, and that 420 of them are consultants. But it will obviously be for the long-term workforce plan—a lot of this will be built into neighbourhood health, because of what the three-year planning guidance sets out. Areas need to focus on two priority cohorts: those who are frail and those receiving end-of-life care. Quite a lot of push has already gone to focus the system on palliative and end-of-life needs.

Q38 **Sarah Hall:** I want to ask a question about inequality of access to palliative and end-of-life care. We know that there are significant inequalities in access, based on geography, conditions or just the affluence or deprivation of an area and whether there is a charitable hospice that is able to raise the funds needed for it to exist. This is also a reflection of the lack of planning in the way the sector has developed. How do we address it? How do we make sure there is equitable access across the country?

Dr Scully: Can I make three quick points? I will then hand over to colleagues. You are right that there is a correlation. If you look at where hospices are the place of death against the indices of multiple deprivation, you see the numbers jump up in wealthier areas, I think by 2% for every

decile you go up. There is a huge correlation. As you are getting at, the system developed organically without a national overview.

I do not know whether Toby is still here, but Hospice UK is doing a lot on how hospices diversify and look across different areas, trying to boost provision in other areas. The requirement on the NHS is to provide palliative and end-of-life care to everyone, across the whole country, so regardless of whether there is a hospice in an area, the NHS has to meet that statutory duty.

May I add one thing that a hospice chief exec said to me, which I found helpful to understand some of the funding issues? They said that, basically, there are three levels of palliative and end-of-life care treatment: first, core and general support, which is the vast bulk of it; secondly, specialist palliative care; and, at the top, the enhanced level, which is what hospices add and is not the NHS offer. When I have spoken to hospice chief execs, they fully accept that that is what they should be funding themselves and what the charitable donations should be funding. What they are looking for is fair remuneration for the core and specialist care. I found that to be a helpful framework to understand how they see their funding.

Q39 **Sarah Hall:** Going back to the data, which I know we will expand on later, there is a need to improve data collection and understanding, because we have a limited idea of activity, equality and spending in community services more broadly. We talk about that statutory service or provision, but how do we know that people are getting what they need? How do we know that people have access to choice? Do they want to choose to die at home or in a hospice, if the provision is not there and we do not have the data to know what is going on?

Dr Scully: There are two key bits of information—Amanda might want to come in—of which the first is the dashboard, which Amanda mentioned. It is a substantive and comprehensive piece of data, a retrospective of previous years that shows how many people died, what area they died in and what they died of. It includes inequality things around ethnicity and indices of multiple deprivation. We have a really good understanding there, and it is a tool that ICBs can use to plan.

The other thing we do is a national audit of end-of-life care at the end of every year. NHS England funds that. The statistics are slightly different from what Professor Murtagh was saying earlier, but we know, for example, that 97% of hospital providers have access to specialist palliative care; that only 61% have face-to-face cover eight hours a day, seven days a week; and that 73% of bereaved people rated overall care and support to be good. We have data. We need more, but we have quite a few sources already.

Q40 **Sarah Hall:** Would you say that you are aware of where the gaps in provision are at the moment?

Samantha Jones: I do not think we would say that yet. None of us would say that our data is strong or robust enough to be able to do exactly as you say.

Dr Doyle: Independent hospices that are contracted and funded by ICBs to provide services—as opposed to being given grants with which they provide services—are obliged to report data on patient-level activity. Just the fact of that reporting means that we can add that activity to our community services dataset. Even two or three years ago, we had very poor data in general on community services, which made it very difficult for us when we were trying to understand the commissioning needs and spend. That has significantly improved.

We have a programme called Faster Data Flows, which is about onboarding community providers to automated, daily, patient-level data collection. We do it for acute trusts, we are onboarding community providers, and we have started to onboard independent hospices. That will be a game changer, because the more hospices we get on board with the data flows, the more we can have understanding. It is absolutely crucial, though, that we use that data to move to properly commissioned contracts for services, on which we can then assure ourselves, overseeing and evaluating them, rather than having the application of grants.

There was an attempt in the early 2010s to move to tariffs and contracts for activity but, first, we did not have the data we have now and, also, the standard NHS contract at the time—largely using PBR—was not really fit for purpose. The contract was designed more to measure episodes, and end-of-life and palliative care obviously is never episodic in that way. The blockers at the time that made the introduction unsuccessful have, we think, largely gone away, so the quicker that we get hospices and other community providers of palliative care onboarded to automated data collection, the easier it will be for us to implement.

Q41 **Sarah Hall:** Do you agree that, at the moment, there seems to be a lack of oversight? Do you think it is important to have that national accountability, which does not really exist, to ensure equitable access?

Dr Doyle: It is really important that each ICB understands the patient-level need, as well as the activity and spend within their ICB area. It is very helpful for us to have that national-level oversight, particularly when we are looking at whether we are delivering consistent standards of care across the country. It is important that palliative and end-of-life care is consistent, as we recognise, because of the way the hospice movement developed since the ’60s, that we do not have equitable access to an independent hospice for every population.

Chair: We must be careful about not cutting across other people’s questions. I call Chris Kane.

Chris Kane: Thank you, Chair, but I was just going to make a general observation, which I think is going to get picked up shortly. With what I am hearing from this panel on data collection, and what I heard from the

previous panel, it is almost like we are talking about two different subjects. That is just an observation, and I will leave it to colleagues to pick up on that later.

Q42 **Catherine McKinnell:** It sounds like, in theory, with the evidence we have been hearing and the answers you have given, that we want to go in the same direction. I think the challenge is the reality that we are starting from and where we want to get to—we need to understand how we get there. The evidence so far has come across quite clearly to us that there is some measuring of activity, but that there is insufficient measuring of outcomes. While we absolutely need to improve the collection of data, I think we always need to be careful that we collect not just numbers but the experiences of people and their families.

Dr Doyle, you touched on some of the challenges around grant funding and the inability actually to measure the outcomes from that funding. There were some attempts back in 2010 to move away from grant funding—and a previous report from this Committee recommended doing so—but here we are in 2026 and this is still a challenge. What is being done to move away from grant funding, which seems to be agreed as the direction of travel that needs to be pursued?

Sir Jim Mackey: As a general principle, we are moving away from things being in block contracts with a lack of detail on what they are buying. That is happening across the NHS generally. Specifically, we have set out that we would expect a movement away from block funding, and over time, more clarity on what is being purchased—effectively, commissioned locally. We have set off a process that if we could get it done tomorrow, we would, but it is a long, complicated process of unravelling how all the money works and how things are connected to each other—where you think it is related to this, but it is actually related to that.

Q43 **Catherine McKinnell:** Would you forgive me if I say that this conversation has now been happening for 15 years, and that answer feels quite vague and not very specific? What reassurance can you give that this is something that is not just an ambition, but is a deliverable achievement that can be made?

Sir Jim Mackey: There are all the changes we are making around the financial regime, such as rebuilding commissioning under the operating model changes, and the introduction of modern service frameworks, where it is very clear what good looks like. People should be commissioning from an ICB perspective. We have set off a process that is now live, with some changes in the current year, and some coming in future years, around new tariffs, new payment mechanisms and incentives for the left shift so that money can move with the patient. I think you can be more confident about this working for end-of-life care because it is part of a general direction of movement for the NHS as a whole, away from centralisation and big blocks—"Don't worry about what it's buying, just work it out locally"—towards rebuilding the more specific and active nature of commissioning.

Q44 **Catherine McKinnell:** Would you be able to give an example of what

some of those incentives might look like?

Sir Jim Mackey: In some of the discussions that you and we have had with the sector, there is a clear appetite for people to be paid and rewarded more in line with clear standards and better outcomes. As Amanda said, it is not as episodic as it is in elective care, so we are going to have to find new payment mechanisms to support that, which is absolutely what we want to be getting into. On Ed's point, there is a specialist palliative care bundle of things that we can start building prices for over time, with colleagues in the sector.

Again, there is a demarcation for the enhancements that are funded through the charitable context, so we will not be looking at those sorts of things and trying to price and incentivise them. On all this work, we agree with the recommendations—there is strong support for all that. It is just not where we are, and for whatever reason, it is not where we have been in recent years. It has become very vague. There is an awful lot of rebuilding required to allow us to get to where we need to get to.

Q45 **Catherine McKinnell:** I know it is a 10-year plan that the NHS generally is working to, but we are seeing the challenge around the cost base for all businesses—hospices operate on that basis—rising, and demand rising. These challenges around funding are squeezing hospices. What kind of timeframe are you working towards to get these incentives in place to what I think you are describing as a more tariff-based system that will measure the outcomes, rather than just activity?

Dr Scully: The work is part of the modern service framework. We have done some internal work already on what some of the unit costs could be. We have not tested them with the system yet, but we would envisage the contracting and commissioning as being part of the modern service framework. That gets published in the autumn—we are aiming for September—and will hopefully kick in for the following financial year. That is what we are aiming for.

Through the national cost collection, we collect all the data on the previous year's activity, and we have some unit prices for some things. For example, the unit price for specialist palliative care visits out in the community is, give or take, £150. We have some already, so ICBs have something to draw on. As you have got at, it is patchy. Some ICBs are commissioning on that basis—I think nine out of the 42 ICBs. West Yorkshire is a good example. West Yorkshire is ahead of the game. West Yorkshire has a really good system. If you talk to the chief execs up there, quite a few are doing some of the activity-based payments already, but it is, "How do you level it up?"

Samantha Jones: I am reluctant to say, "We recognise the situation; it will all be sorted through the MSF," but that is what we are working to, and we are particularly making sure that we do the right engagement over the next couple of months to get it right. This is also something about how the new department wants to work, which is, rather than us sitting centrally saying, "This is how it needs to be," it being done with experts in

the sector, as Minister Kinnock set out. That is how we are trying to address bringing together all the disparate things that you have heard about through the modern service framework, but really importantly, ensure that there is engagement with people who are experts, including all the examples of good practice that we know are up and down the country.

Q46 **Anna Dixon:** We have focused a lot on data for commissioning. I thank you, Jim, for your honesty in saying that it is poor and inconsistent, and Sam, for saying that it is not strong or robust. It is a shame that we are in this position when we have had statutory commissioning since 2022, and ambitions long before that to have moved in this direction. Obviously, there are various sources of data. It seems that it is about bringing the right data together in the right places. Sorry, before I carry on, I should decare a conflict of interest: I worked at the Department of Health between 2013 and 2015, so I know Ed and some of the other colleagues from that time.

I want to get to this value for money question, which is what ultimately concerns us. When we previously had colleagues here before us, looking at the Department of Health accounts, it was very clear—it is in the NAO Report—that we do not know what we are spending on palliative and end-of-life care, and certainly not very specifically on what we are spending on hospices and what we are getting back. If you add in continuing healthcare, it seems that that is another black hole. We do not how much continuing healthcare spend is going on palliative and end-of-life care. Moving beyond just commissioning, how can we be confident that we are getting value for money in terms of what we are spending on palliative and end-of-life care, and the outcomes that we are getting?

Dr Scully: On the spend, you heard evidence from Professor Murtagh earlier. The Department set up the policy research unit in 2024, which she mentioned, partly because we do not have enough information. The report that Professor Murtagh published last year, which she mentioned earlier, set out that the average cost of someone dying is £24,000 a year. In 2024 money, that means that £12.8 billion was spent on palliative and end-of-life care. That includes the statutory spend on hospices, but not the charitable spend. If you include the charitable spend, it takes you to about £13.4 billion—so, give or take, you are in the region of 7% or 8% of the overall NHS budget.

Being able to account it in a real-time way is quite tricky. First, you have the different funding mechanisms that work across the different systems. In general practice, you have the Capitec system, and you probably have the best data in the acute system. But not all episodes will be coded as palliative and end-of-life care, so it is incredibly difficult to do it in real time, and I do not know how to do it.

Q47 **Anna Dixon:** I guess it comes to the point of allocative efficiency. We heard a lot of evidence from our pre-panel that basically says, "If you spend less on community hospice services, you will end up spending more on acute hospital beds." Amanda has talked about wanting to shift more into the community, and that would suggest spending more on hospice

community activity, if you are going to shift out of hospital. I realise that the accounting might be difficult, but is it not absolutely necessary for you to make decisions about where to put the money to get the best return in palliative and end-of-life care?

Sir Jim Mackey: It is, absolutely. As Ed has pointed out, you can look at this in different ways and come up with estimated costs for what is currently being spent. I am just thinking about my previous chief exec lives; using the north-east as an example, because of the differences in the way that palliative care is provided, I would not be confident that everybody is counting things in the same way. Sometimes it is provided in the NHS and sometimes in the hospice sector, and sometimes it is in hospital and sometimes in the community. It is a real patchwork.

What we are trying to describe is that we are setting off on a process, and the MSF—let's not over-commit it—will set out what good looks like. We are being clear with commissioners what they need to do. We want the NHS to work with the sector effectively. We will be more transparent with the data, when we have started getting data on outcomes and value for money, which will help with accountability and clarity on how it all works together, including what good looks like and who is closest to it.

The thing we will keep going back to is that we are not in that place today, and we could not do that today without it being hugely inaccurate. It is going to have to be built up over a period of time. It is also part of the broader rebuild of how accountability works, how commissioning works and how value for money works, as well as transparency—it is all part of the same thing.

Samantha Jones: And of course, as you would expect me to say, it is all part of the shift in neighbourhood health through the 10-year health plan, and being very clear about where and how people should be receiving their treatment, and the fact that they should be part of the decisions around their treatment.

What we are acknowledging is that we know the data, in itself, will not fix the issue, but we also know that we need the data to do this stuff—it is absolutely required. We have to break down the data because it cuts across multiple pathways, as we have described, so it is about making sure that we understand what the data is, to support the ICBs to make their commissioning decisions, focusing on avoidable admissions. Really importantly, as Amanda said, we need to make sure that people are involved and have a choice about where they want to be treated, including where they would like to die in the future.

Q48 **Anna Dixon:** You brought up West Yorkshire—I am enjoying this inquiry today because I have had two local examples praised: Bradford was praised by the pre-panel, and now we have West Yorkshire. We are obviously hearing about the stress that hospices around the country face, and that it is urgent and immediate. There is a real risk that, if they further reduce their services from April, it will lead to additional demand and cost in other parts of the NHS.

While we are waiting for all this perfect information, strategic commissioning and leadership support and guidance to come through, do you think that we need the provider collaborative model like West Yorkshire's, where you just say, "Get together in an area and find your solutions locally"? I worry that we will otherwise see ourselves going backwards, rather than forwards, which will make it even more difficult. You held up the example of the provider collaborative model in West Yorkshire. Do you believe that that model is something that other parts of the country could look at, so that they can more immediately work in partnership with their hospice sector to sort out where the money is best spent?

Dr Doyle: Absolutely. There are huge benefits, not least because small individual independent hospices cannot benefit from the economies of scale that they can benefit from, increasingly, if they work as a collaborative. Also, for ICBs, looking at their patient level need across a patch, it is much, much easier to effectively commission from collaborative providers.

What we do know—we do not need to wait for the absolutely accurate data to find this out—is that we are treating many more people in the most expensive part of the sector than are able to benefit from it. They are actually not getting a service that a much more cost-effective part of the sector could give them, so it is really important that we do not sit back and wait until we have completed everything before we get on—in West Yorkshire and other places, as you have described—with actually letting local people move forward.

Q49 **Chair:** Permanent Secretary, I am struggling with this. What I am hearing from you is that you have good data from these dashboards, but on the other hand, the NAO Report says time after time that, because you have been giving out grants for years and years, you cannot have the data to know precisely where you ought to put your money—in other words, a precise contract to provide a precise service. Dr Edward Scully said that it should be the core service, not an add-on service. You cannot know, yet you are about to produce an MSF that is going to transform the whole system, according to Sir Jim. How can you transform the system if you do not have the data?

Samantha Jones: If I may, Chair, I don't think we have said that we have perfect data. We are at pains to acknowledge to the Committee that we do not have perfect data. We have dashboards across the ICBs, which is giving us some data. It is not consistent, and it is not giving us the level of detail that we require to be able to do the things that you are describing. I would not want the Committee to feel that we are sitting here saying that we have good data. We have some, and the ICBs have some data.

I think what Jim was describing, as Minister Kinnock did last week at the Health and Social Care Committee, was that the purpose of the MSF is to bring all the disparate elements together—whether it is the data collection

or the different types of funding—to stop what has happened in the past, which is that there are a number of different elements.

We have some data. It is not consistent across the country. None of us would say that the dashboards are consistent, or to the level that is required to do the commissioning level of detail, which is why NHS England set out what it did in its strategic framework. That is the first point. The second point is that we are not saying that the MSF is the be-all and end-all. That would be the wrong message to give the Committee, but what we are saying, as Jim has reinforced, is that it is absolutely bringing together all the different elements, and it is crucial that we have the sector involved in putting that MSF together. As Minister Kinnock said, it will be published later in the year.

Q50 **Chair:** That is a fair answer, but we heard from the previous panel that there are certainly some hospices—I do not know how many and I do not know how quickly—that are already running into financial difficulties and will have to cut back their services. What you are describing, which is a perfectly logical, reasonable thing to do, sounds as though it is going to take some while, if not years, to achieve. How do the two things square?

Samantha Jones: The decision on funding allocation is, of course, for Ministers—we have discussed that with the Committee—but they have moved quickly to demonstrate their commitment and seriousness towards hospices and the sector. There is a difficulty, in that hospices are not part of the NHS provision, but there is no question about their importance—this is what I said to Paulette right at the beginning—and I think Ministers have demonstrated that. It is an uncomfortable reality that hospices are charities and independent of the NHS, but they are not the only place where palliative and end-of-life care is provided. Ed has set out the different areas.

In summary, there is no question about the seriousness with which Ministers are taking the sector. They have moved quickly. You heard previously about the £125 million capital that was supported very quickly out to the sector, so that the sector can decide what it wants to do with it. At the same time, you would rightly hold me and others to account at some point in the future, to say, "What are you actually doing to build the reality of what is going on where, across the country?" so that we can do all the things that you are describing.

Chair: The reality is that if a hospice has to reduce services or even cease performing its function, those services have to fall back on the NHS, so it is in the NHS's interest to keep the hospices going. Colette, I mean Paulette, your question.

Paulette Hamilton: I will follow straight on from you, Sir Gregory. *[Laughter.]*

Chair: Touché.

Q51 **Paulette Hamilton:** The Chair has more or less asked the question that I was going to ask. Let me start by saying that I absolutely appreciate that

Government, through you, have tried to support hospices, especially over the past 18 months. About £125 million has been given in capital to hospices. I have taken on board what was said earlier by Toby Porter, the chief exec of Hospice UK. He made it absolutely clear that hospices have run out of time—there is no more rubber on the road. He is saying that in the next couple of months, they will be losing staff. I say that, because when we lose services in the health service, as you know, we are talking about our key commodity, which is staff. My question is: how can hospices maintain the current level of palliative care provision while cutting services? I will start with you, Sir Jim.

Sir Jim Mackey: We are all in an uncomfortable position. We are going to have to make savings right across the health service, as you have described—all very necessary, because of where we will be and the overall financial position. In this specific instance, we expect ICBs with local providers in the hospice sector to be identifying where anyone is especially at risk of going out of business in the way that you described. If that were clearly attributable to under-commissioning from the NHS, we would expect people to resolve that locally—if that meant paying for something that should have been paid for, and so on.

Probably, though, I think that what we will find is that it is a general underlying fragility—changes in the charity sector over recent years, cost pressures or small providers that are probably unsustainable in the medium term. Again, there is a range of actions where we can see that if people maybe worked together a bit more—share some functions, work as a collaborative—there might be a way through that, but none of us can guarantee that no one will go out of business, given existing circumstances. We might also expect ICBs, if they are in that position, to be able to do risk plans and understand what would happen if there were a reduction in provision, and to put in place alternative arrangements through the NHS or another system. All that is happening and has been happening.

Again, when we talk about the inconsistency nationally and the lack of clarity in what is being bought across the service, though, there is general, quite good line of sight of what is going on in local systems, of what is provided here and of what would happen if something got in trouble. That is going on, and people are talking about and working through that. As of today, no one is telling us that they are worried that someone is going to go out of business and that there is a continuity of service that they would require help with.

We can, after this, go around and double check. We have, we hope, a session with ICB chief execs later on in the week about other things, so we can pick it up there as well. We can encourage a bit of a sweep on where the risk is and what that means for service provision.

Dr Doyle: We have examples of when that has happened in the past—when hospices have started to go under—such as Katharine House hospice in Oxford in 2022, which was really suffering from financial instability. The local NHS trust was supported to move in to support service delivery while

the hospice charity remained as a stand-alone charity for fundraising to continue with the enhanced services. The NHS trust moved in to support continuity in the actual delivery of services.

We have examples that we have learned from, where we have managed to support hospices in difficulty. However, the example before of hospices working across a patch as a collaborative is perhaps the most effective first stage for hospices, because some of those efficiencies in working in collaboration with others can come into play.

Q52 **Paulette Hamilton:** My next question is simply on that. Cutting services must be done in a professional way, and you have to think about the quality of services, not just the quantity. My last point is that people are talking about cuts in services. How is it being measured that people will still get a high-quality service, when we are seeing that they are consistently losing services—for want of a better word—at the moment within the system?

Sir Jim Mackey: Any big change like that, such as a big service change, cost reduction or a change in commissioning, would be subject to a quality impact assessment. If that happens, you would expect colleagues locally to work through the following: what is the risk? What would happen? How would you mitigate the risk to try to prevent an overall drop in standards and impact on outcomes? That happens in different parts of the system with any big change. With this specific change, if there was an issue, such as a change in revenue flow to the hospice sector that would potentially have that impact, we would expect the commissioner to be doing a QIA as part of that process in assessing the risk.

Q53 **Paulette Hamilton:** I have a final question for you, Duncan—you know I have to bring you in, because we are both nurses. I worked in hospice services as a district nurse, so I went in and out—you know the way that system used to work. How are you ensuring that we are not losing that high quality of profession as we are losing and cutting services in hospice and palliative care?

Duncan Burton: As I have said before, as a trustee of a hospice, this is really important to me. Getting care at the end of life is fundamental, and it is a fundamental component of every nurse's role in this country. It is really important that we get this right.

I think there are several things here. One is about making sure that we have the right numbers of staff in the right place, and that, as I said before, we are training staff to be able to work in community settings and exposing more staff to work in community settings. Part of that is about how well our nurse leaders are working together locally with their hospice equivalents, for example, in the trusts.

When I was a chief nurse in a trust, I worked very closely with my hospices to makes sure that I supported them with rotations of staff, for example, because there is that exposure between the two. One of the great things about the hospice that I worked with is that it had a significant training offer out to the NHS and social care to provide those

palliative and end-of-life care skills for as many staff as possible. It is really important that we continue to do that.

As I said, we are developing a nursing and midwifery strategy for England at the moment, which will be out in the spring. Part of that will be about how we educate, train and support nurses in the future. I expect that it will absolutely lean into the fact one of our core, fundamental roles as nurses is making sure that we get good care at the end of life, and better conversations about people towards the end of their life as well.

Q54 **Sarah Green:** I want to follow up on the conversation that we have just been having, Sir Jim. First, how much do we rely on independent hospices to deliver the palliative care provision in England? Are they mission critical? How would you describe that? Secondly, we have heard from Dr Doyle an example of how a previously failing hospice was supported. Given the April cliff edge described by the previous panel, if a hospice was facing a cliff edge and went under, how would you respond to that?

Sir Jim Mackey: They are material to the quality of service, and a key part of this system—a key partner for us. It is inconceivable that we could function and deliver the standards that we need to deliver without them. Everything we are doing is about how we will work together, introduce better clarity and ensure everybody gets fairly rewarded—all those sorts of things.

If there was a genuine example of a specific hospice that was going to go out of business within a period of time—as Amanda has pointed out, it has happened before, and we have some other issues going on with independent sector providers in other settings—that triggers a process locally, and within NHS England we will look at what the alternatives are. Does that mean that the NHS has to and can step in? Is there another provider that can step in? How would the money work? That is all coming from a perspective of continuity of service to try to avoid and mitigate the risk that the service does end up being significantly reduced.

Q55 **Sarah Green:** Is this something that you are actively looking at right now, given what we have been told earlier? It sounds as if it is a looming possibility.

Sir Jim Mackey: As of today, nobody has communicated directly with me about a hospice that is close to going out of business—not one. I have heard all the concern; we are all concerned. I had a session with Hospice UK last week. I met with some hospice chief execs last week as well. All are concerned about their financial sustainability, but as of today, there is not one single specific case that has been put to me that says, "This service is going to go out of business."

Q56 **Mr Betts:** I want to come on to the relationship between the money the NHS puts into hospices and the charitable giving that funds many of them to varying degrees. It is by no means obvious why different hospices get different amounts of money, except perhaps to top up what they are getting from their charitable donations. Is that the approach essentially that happens now—a hospice keeps going as much as it can with its own

donations, and then the NHS tops it up to make sure it can survive?

Sir Jim Mackey: I think we have all heard that there is a historical set of arrangements that, over time, defined where the boundaries are and what the NHS pays for versus what is paid for through charitable donations. Ed and others have described that we would like to be in a position where we are clearer and more precise in saying, "The NHS will buy these levels of services, and above that it can be funded, but funded through charitable donations or commercial sources or whatever."

Hand on heart, I think at the minute that will be largely historical—largely accidental. There are all the consequences that people have described. In not having the specific contracts and the data to support it with absolute clarity about what is being purchased or commissioned where, none of us can be absolutely certain that that is consistent and uniform.

Q57 **Mr Betts:** I think we can all agree with that. It is certainly difficult to explain logically why different funding is put into different hospices, but they do rely to different degrees on charitable donations. If those donations are being reduced significantly in some areas—we know the pressure on household finance at present—is that a point where the NHS has to step in, not because the hospice might actually close completely, but because it might have to reduce significantly what it offers?

Sir Jim Mackey: It goes back to the points earlier about understanding what the implications would be, and making an impact assessment about what would happen there. If that were something that could not be allowed to change in terms of reduction of service, because there was a disproportionate impact or an impact we could not cope with, we would have to look at the alternatives. Whether that meant that the NHS had to step in or that it had to be provided by other providers or whatever, that would be part of the consideration.

Dr Doyle: I think the aim is that for services that you would clearly expect the NHS to commission—specialist palliative care interventions, bed-based care, and support to community services—we would expect ICBs to be moving to specifically commissioning that activity to a level that their population needs or to the level that their hospice can provide. We do not want to remove the ability, obviously, of hospices to go over and above and to provide some of the therapies and additional services and support that they provide from their charitable funds. So it is important that what we do is accurately understand and count what NHS-commissioned services or what should be NHS-commissioned services the hospices are providing, and contract for them, measure them and ensure that they are properly funded.

Q58 **Mr Betts:** I have written in the past about St Luke's hospice in Sheffield. They do an absolutely wonderful job. The city is actually split in terms of provision. There is St Luke's, but then there is a palliative care unit at the Northern general hospital. St Luke's were clearly running a financial deficit. I, along with MP colleagues, wrote in support of them. Should I assume, therefore, that when extra funding was provided—not enough, in

my view but a bit of extra funding—to St Luke's, this analysis was done as to what they provide and then the acute-type services or the services that the NHS would require them to provide were funded on the basis of a new financial assessment? Was that done, or should it have been done?

Dr Doyle: I do not know specifically what the ICB in South Yorkshire did in that case.

Q59 **Mr Betts:** It might be helpful if someone could tell me; if you are saying that is what should happen when a hospice gets into financial difficulties, it would be nice to know whether it does happen or not.

Dr Scully: Are you talking about the additional £125 million, or just generally?

Dr Doyle: It should happen regardless of whether a hospice is in difficulty. It is important that we move to understanding the data, commissioning services that we should be commissioning and supporting and recognising the fact that hospices want to provide services over and above, or things that the NHS might not commission.

Q60 **Mr Betts:** But if that is being done, you ought to be able to explain the continuing massive difference in terms of grants that go to some hospices rather than others.

Dr Doyle: It is not being done consistently everywhere, in all cases, at the moment.

Mr Betts: Even within the same ICB!

Dr Doyle: I can find out about Sheffield; I can certainly find out how it was done for St Luke's and write to you.

Q61 **Mr Betts:** How they assess the differences there—okay. Coming back to the "over and above" services that hospices might provide through charitable donations, we come back to the equality issue. Does this not essentially mean, because you are always going to raise more money from charitable donations in more affluent areas, that people who stay in hospices in more affluent areas will always or often get a lot nicer surroundings to end their lives in?

Duncan Burton: One of the factors here is that clearly, as independent charities, they have the ability to raise funds and find different methods of raising funds. You are absolutely right: as others have said, the hospice movement did not happen in a linear way across the country so that every area is served in the same way. The reality is that some hospices will attract more funding because of the local population that they have and the ability to do that.

One of the important things then, and the challenge for some of those hospices, is how they help and support other hospices, how they continue to develop in research areas and in education and are able to offer support to others. Certainly, working with a hospice myself, I have seen the work that they are doing to try to make sure that they are reaching all the

different communities that they serve within those areas. I know that many are trying to do that.

Q62 **Mr Betts:** It is a difficult one. It is about the difference with the provision of palliative and end-of-life care in the NHS properly, in an NHS palliative unit. They have much more difficulty raising charitable donations, compared with the brand that a hospice can put out there to get them. Who wants to give money to the Government, in a way? It is slightly different, but are people in those units not entitled to end their life in the same sort of surroundings as people who—probably just across the city in Sheffield—are staying in a hospice?

Duncan Burton: I think we would all sit here and say we would want the same level of palliative and end-of-life care for everyone. I would want that for my mum; I would want it for any of my family.

Q63 **Mr Betts:** How are you going to do that, then?

Duncan Burton: This is why things such as the MSF are really important. That is about how we make sure we are commissioning in the right way, looking at the standards in the right way and delivering them. But it is also a fact that, where we have a charitable system of hospices, some will continue to be able to raise greater levels of funds than others.

Q64 **Mr Betts:** I will just come on to one other issue—multi-year funding. Children's hospices have multi-year funding, but adult hospices do not. Any organisation that is trying to plan, particularly one relying on charitable donations, needs a bit of certainty. Is it that difficult to give a multi-year settlement?

Sir Jim Mackey: Again, part of the push that we have made on medium-term planning is to try to give people more certainty and more ability to plan over a period of time. That has set off now, as we described before. It is not where we are now, but every ICB and every provider in the NHS has to produce a medium-term plan. Through this year, we would expect people to get more certainty on how the next two or three years look, after the year that we are just about to start. It is the first time in seven or eight years that we have done multi-year planning.

There is one thing that works against what I am describing. There is a push for those providers to be paid more on a tariff basis—a volume basis—and there is an uncertainty with that. If we are not going to be giving block contracts and block grants, and if it is more episodic and paid per activity levels, there is an uncertainty and a risk about income flows over time. We will all have to work out how that gets managed. We cannot have all things at the same time. We can give people reasonable assumptions about the future—commissioners would give the hospice sector confidence about what will be commissioned over a period of time—but there will be fluctuations in volume, and income levels might go up and down according to that.

Q65 **Mr Betts:** But if hospice providers at least knew what those fluctuations would mean in terms of income, that would be helpful.

Sir Jim Mackey: Absolutely. That is why I am saying that we will all work together on that, but no one is going to say, "Here's a guaranteed level of income—a block contract—for three or five years that gives you absolutely certainty," without clarity about volumes, about what happens, about whether quality is being delivered and so on.

Q66 **Mr Betts:** I get that, but when are we going to get some clarity, on a multi-year basis, about the tariff framework in which hospices operate?

Sir Jim Mackey: I think we have answered that already. The MSF will be ready and live by about September. We will try to build new financial mechanisms through the coming year. The NHS is in a medium-term planning process now. All these things will come to life over the next 12 months.

Q67 **Mr Betts:** So the financial year coming in April will be the last year that it is just a one-year offer to hospices.

Sir Jim Mackey: No. I am not saying that at any point anybody will get a cast-iron guarantee that they are going to get £20 million for the next three years. We are going to build all these things—clarity on what good looks like, what the NHS should commission and some payment mechanisms. But what should happen—it should be happening now, but it should definitely happen through the coming year—is that ICBs should work with the hospice sector, other NHS providers and other partners to provide a clarity of direction about what will be commissioned over time. Colleagues will be more certain that, if they are delivering to the right standards within that framework—they are not providing things that are not being commissioned—then they will have reasonable certainty.

Q68 **Mr Betts:** Right, so the framework that is operating in the next financial year will be a multi-year framework.

Samantha Jones: The MSF is obviously going to be subject to Ministers' approval—that is the first thing you would expect me to say. As Jim has said, that is what we are hoping: that the MSF will be able to bring it all together. I just want to give the slight caveat that that is obviously subject to that approval.

Mr Betts: Right, so if Ministers approve, the multi-year element will kick in from this April—subject, of course, to fluctuations in throughput in what the hospices deal with.

Q69 **Matt Turmaine:** I should declare that, prior to being elected, I was working in the health and care sector, mostly on the better care fund and locality provision in Hertfordshire.

The 10-year plan says: "Community-based advice and support will help more people die in their home, while community teams will work closely with care homes and paramedics to share care plans to avoid people being taken to A&E by default." Can you tell me a bit about what role hospices have in the community-based approach to care provision going forwards?

Dr Doyle: Hospices are a part of the neighbourhood services that will provide palliative and end-of-life care. Increasingly, hospices are providing not just the traditional bed base for people, but specialist palliative care support into wider community services, such as care homes and general practice. In lots of places, the hospices are the providers of 24/7 palliative care advice and support lines. We would expect the shift away from hospital to make better use of those capabilities in hospices.

It is also really important that we do not forget the work happening around shared care records and better digitisation of services, because it is very clear that where hospices, community services and primary care in particular are able to view patients' records and see what interventions other staff have made, that provides a much more co-ordinated and better supported service for patients.

It is really important that when an ICB is planning its shift out of hospital and its development of its neighbourhood health services that every bit of the sector—including hospices, but also the wider voluntary sector, such as the people who provide night-sitters, for example, to give respite to families looking after people at the end of life at home, and all the wider sector—is able to be part of that planning.

Q70 **Matt Turmaine:** Do you think they are at a stage yet where they are ready and able to do that, or will it take a certain chunk of the 10 years?

Dr Doyle: We are starting. Obviously, everything cannot change overnight, but we have given directions or—I cannot think of the word, but anyway, we have given guidance to ICBs in the medium-term planning guidance for '26-27 about where to start. Patients at the end of life are one of the two priority cohorts of patients to start building integrated neighbourhood teams for, and to start not only increasing the capacity in the community to look after them and support them, but to start developing that co-ordination of care.

The two priority cohorts are people at the end of life and people suffering from severe frailty. Obviously, there is quite an overlap between the two.

Dr Scully: The only thing I would add is that, in a way, hospices are ahead of the game. I mean, they did a left shift before. I think that only 20% of hospice beds, give or take, are now in-patient. So, hospices are innovators; when you talk to them, you realise they are proper innovators. They were ahead of the game and they have done some of this work already.

You get certain systems—I think that it is Nottinghamshire where hospices are part of the fabric, working really closely with the out-of-hospital services. I think this work happens already in lots of areas, just not everywhere. It is a question of how you support other areas to get to that place.

Duncan Burton: Hospices have a really important role. Many places will do things such as providing support and education in care homes, because they are people's homes, and they want to make sure that people are able

to have a good death in care homes. We cannot underestimate the wider impact of the role of hospices in areas such as providing education and support to other parts of the sector as well.

Q71 **Tristan Osborne:** I picked up on your point earlier that you are not aware of any hospices that are in financial distress. I mean, that—

Sir Jim Mackey: No. We are aware, and we have heard very clearly, that every hospice provider is worried about financial sustainability. As of now, I have no specific cases that an organisation is immediately at threat of going out of business.

Q72 **Tristan Osborne:** Okay. I appreciate that clarity, because part of this Report shows really clearly—I think Paulette mentioned this earlier— that, in my view, there is a glaring red light about finances. It is not only about financial sustainability; we are in a financial distress moment now. Quite a lot of hospices are closing beds down as we speak. They are also announcing redundancies.

How can it be that I see in the news that there are redundancies being announced here or bed closures being announced there, yet you are telling me that those organisations are not in financial distress? Why would they be doing redundancy—

Sir Jim Mackey: I am not saying that they are not in financial distress; I am saying that I am not aware of any that are at immediate threat of going out of business.

Q73 **Tristan Osborne:** My point to you, sir, is that if they are making redundancies and reducing bed numbers, that suggests to me that there is financial distress within those organisations, because they are having to go through those processes, including redundancies. Obviously, if they were expanding headcount, that would be because they were doing well or they are getting more finance, but they are reducing headcount and beds.

So, my question to you is this: have you analysed the hospice sector for the financial resilience of those hospices that you are partnering with and more broadly, to identify what happens if there is a systemic problem when one of these hospices collapses, to see what the impact will be on a particular area?

Sir Jim Mackey: As we are currently set up, ICBs would be responsible for that locally. There is a broader question, which at some point we will talk about. We will rebuild the system around economic regulation and sustainability for providers generally—NHS providers, independent sector providers, the charitable sector and any organisation that we are reliant on for continuity of service. We have started thinking about that as we start moving more into a market-based approach.

As of now, you would expect ICBs to have some oversight in terms of what they are commissioning from the hospice sector, and for there to be an impact assessment if changes are going to be made that could have an impact on service, as we discussed. As part of that, again, if there were a concern and an ICB thought that a business or organisation were in

distress and we needed to do something, I would expect to have a conversation about what would happen.

Q74 **Tristan Osborne:** Lastly, as a follow-up, do you accept that the number of beds is reducing in certain parts of the country? Given that the Report indicates that there will be increasing demand, as Paulette highlighted earlier, right now it is going in the wrong direction: we are seeing redundancies, bed closures and reductions in the number of beds. Is that not telling you that the sector itself is fundamentally in a distress position, and are you not worried about that? I am trying to get a sense of whether there is an acceptance that we are not in a good place at the moment.

Sir Jim Mackey: There is absolute acceptance. Throughout, we have agreed with pretty much everything that has been said. None of us want to be where we are at. We agree with pretty much everything that has been said in the Report and in the discussion, but it is the position that we have inherited. We are trying to work through it over time.

If there is a need to move quickly to resolve and fix a problem, we will absolutely do that, but what we do not want to do is perpetuate problems. We could support a provider that is delivering substandard care, so we would expect that to be challenged. There might be alternatives around working together and getting scale—it might be that it is just subscale and it cannot be sustainable. You would expect those sorts of things to be happening.

I want to emphasise that we expect that to be an active process where all these things are being considered, rather than the NHS just sitting and watching their capacity disappear and hospices go out of business. None of us wants that. If there is any evidence of that or if any Member has a specific case that they want me to look into, I will do that.

Q75 **Tristan Osborne:** I am conscious of time, but I will summarise some of the cases that I have seen. Prospect hospice in Swindon, Birmingham hospice in Birmingham and St Giles hospice in Lichfield are all individual cases that have announced redundancies in the last 18 months and have closed in-patient beds. Those are just three examples around the country. Those are in-patient beds that will, presumably, have to be supported elsewhere within the system. As we heard from our pre-panel, that is an additional cost that the NHS is having to bear. It is not cost-effective for us to see these beds close, is it?

Sir Jim Mackey: If we can get the specifics, we will go back to the ICBs in the system and get assurance that there has been an impact assessment, that people have considered what the impact would be, and that there is alternative provision in place for the NHS-provided elements.

Q76 **Anna Dixon:** We have talked quite a lot about the modern service framework. Sam, you said it is not the be all and end all, but it is clearly a significant piece of policy development in this area. At the time, the NAO reported that it was slated for spring. Can I confirm that, Sir Jim, you said it will be September now?

Samantha Jones: Autumn.

Q77 **Anna Dixon:** Okay. Can we expect that there will be clarity on the accountability for how you are going to monitor delivery against the modern service framework? Again, we heard from the pre-panel that there is no point writing another fancy framework that, at the end of the day, makes not a jot of difference to the fact that there is unmet need, inequality in access and poor quality on the ground. How will we make sure that it actually bites?

Sir Jim Mackey: The MSF will have to have, alongside it, clarity on the oversight mechanisms—what we are expecting in terms of outcomes, what the metrics will be, how providers will be overseen and how ICBs will be overseen in terms of what they commission for all of this. That will all be part of the same package.

Anna Dixon: That will all be part of it. Okay, thank you very much.

Q78 **Chair:** Sir Jim, on a point of clarification, if this MSF will not come out until the autumn, and it will take your ICBs time to alter their current commissioning arrangements away from grants and towards contracts, as we have talked about earlier this year, does it not effectively mean that no change will take place for a year from this April—in other words, not in the coming financial year, but in the financial year after that? We have tons of evidence that beds and services are being lost. I imagine that, by then, a considerable number more services will have been lost.

Sir Jim Mackey: I do not think it is that straightforward.

Q79 **Chair:** Let me finish the question. I have to say, I am getting, from this hearing, a certain degree of complacency from that side of the table.

Sir Jim Mackey: Honestly, that is really not the case. We are describing how we are building things that will help in the future. We all acknowledge and are unhappy with where we are—there is absolutely no question about that. We are describing how there is a process that will have to take place over a period of time to build the systems and mechanisms to make this more sustainable, and getting into this position more avoidable, in future.

On the questions earlier on, there is then a more tactical, day-to-day question on how ICBs and local systems can solve problems as they arise, while these new mechanisms are coming into place. It is not the case that everything just stops and will wait for these things. It has to be actively managed in the meantime.

Q80 **Chair:** To put a practical step that you could operate from in the coming financial year, are you going to alter the way you commission from grants to contracts at the beginning of the coming financial year?

Sir Jim Mackey: We have said a lot today that we are trying to move away from block contracts, but ICBs are having to make a huge number of changes in how the NHS is commissioned, in moving away from blocks and the unbundling of the block into new arrangements. If ICBs can take some of those steps more quickly, we will absolutely support them to do

that. What none of us can commit to is that this happens quickly right across the NHS, but we will absolutely be expecting ICBs to have read this report, listened to this discussion—we pick up with them specifically—understand the local circumstances and try to manage the risk that has been described this afternoon.

Samantha Jones: I see it set out in the planning guidance that from April, ICBs are required to have an understanding of their current projected service utilisation to understand what the demand is and, more importantly than just understanding it, be very clear about how they will meet that demand. That is very clear from April onwards.

The next bit on from that of course is how we are going to manage effectively. Certainly, to support what Jim is saying, there is absolutely not nothing happening—too many double negatives in that—between now and the MSF being published.

Chair: We will wait eagerly for that publication. I have to say that I think the position is not entirely clear, even from this hearing today. I would like to have a note from you please, setting out very clearly how you are going to move, and in what time scale, from grants to contracts—specific contracts for the specific services that Dr Scully was talking about—because I am still not clear as a result of this hearing that I understand from your answers how that is going to work. I would be grateful for that note. If we could have it in time for when we need to produce our report, which is in the next couple of weeks, it would be helpful.

I thank you all very much for coming today. This is not an easy subject, and we understand that, at the end of money, there is always a sad person to look after and their family to support. That is inherent in this system. Thank you all very much.

A corrected version of the transcript will come out in the next few days, following which we will produce a report with recommendations, which we ask you to consider carefully.