House of Commons

Health and Social Care Committee

Palliative Care

Sixth Report of Session 2024–26

HC 1763

Health and Social Care Committee

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Contents

Summary

Throughout the debate on the Terminally Ill Adults (Assisted Dying) Bill there has been broad agreement that palliative and end of life care services in England are inadequate. These services are under significant pressure, with providers struggling to fund and commission the right care, and individuals entering a 'postcode lottery' of care in their most vulnerable moments at the end of life. These issues are further compounded by a workforce declining in numbers, a lack of access to and use of effective data, a poorly equipped social care system, and an unsustainable funding model.

The Government's plan for improving services hinges on the introduction of a Modern Service Framework (MSF). Similar structures setting out what services should look like already exist. To ensure the MSF succeeds where other structures have not, this report—among other recommendations—recommends that:

- the Government sets out clear accountability arrangements, including what steps the Department will take where ICBs do not meet the required expectations of the MSF;
- the Government includes specific standards for the provision of children and young people's palliative care services, and for the transition between child and adult services in the MSF;
- the MSF includes specific guidelines and requirements for ICBs to enable access to 24/7 Palliative and End of Life Care (PEoLC) services, including access to medication, and in-person care where necessary;
- the Government should set out how it will increase the capacity of the specialist palliative and end of life care workforce, including a specific target for the staffing of children and young people's palliative care;
- the Government reconsiders its decision to remove local authority representation on ICBs, to ensure social care is appropriately commissioned to deliver end of life care;
- the Department sets out how it will monitor ICBs' current delivery of bereavement services, and what steps will be taken with ICBs that do not deliver an acceptable level of service; and

- the Government introduces a more sustainable and predictable model of funding for hospices, financing their running as well as investment costs, which reflects the increasingly central role they will play in delivering end of life care.

Introduction

1. Palliative and end of life care has risen in public attention as the Terminally Ill Adults (End of Life) Bill has been debated in Parliament. Through the Bill's stages to date, Members of both Houses and from all sides of the debate have agreed that palliative and end of life care services in England are simply not good enough. In December last year, the Secretary of State told us that, should the Bill pass, "high quality" services would need to be in place so that there is a "real choice" for individuals at the end of life, noting, "[T]hat is not where we are as a country at present."[1] We commissioned our Independent Expert Panel[2] to evaluate this policy area, to give us an in-depth understanding of the key issues to help us recommend improvements. We encourage readers to look at the Expert Panel's report[3] and the Government's response.[4]

What is palliative and end of life care?

2. Palliative and end of life care (PEoLC) is an approach to care that improves the quality of life of individuals who are facing life-threatening illness, as well as supporting those individuals' families. The focus is prevention of suffering through early identification, assessment and treatment of pain and other problems, whether physical, psychosocial, or spiritual.[5] Palliative care is typically started within two weeks before death, but it can start at any time. The NHS defines end of life care as a form of palliative care that can be received in the final year of life.[6]

3. PEoLC standards are underpinned by NICE guidance for adults and children's care, an NHS England palliative and end of life care standard, NHS England service specifications for adults and children's PEoLC, and an Ambitions Framework co-produced by the NHS with stakeholders. The majority of PEoLC is provided by NHS staff and services, but voluntary sector organisations, including hospices, also play a key role in service provision.

1 Oral evidence taken on 17 December 2025, Q148
2 Hereafter the Expert Panel
3 Health and Social Care Committee, Third Special Report of Session 2024–26, Expert Panel: Evaluation of Palliative Care in England, 28 November 2025
4 Health and Social Care Committee, Fourth Special Report of Session 2024–26, Evaluation of Palliative Care in England: Government Response, HC 1722
5 WHO, Palliative care, 5 August 2020
6 NHS England, Palliative and end of life care (accessed 28 January 2026)

The Independent Expert Panel's evaluation of palliative care in England

The Expert Panel

4. In 2020, our predecessor Committee established and commissioned a panel of experts [known as the Committee's Independent Expert Panel] to evaluate—independently of the Committee—progress the Government has made against its own commitments in different areas of health and social care policy.

5. The Core members of the Expert Panel are Professor Dame Jane Dacre (Chair), Professor Emma Cave, Professor Anita Charlesworth, Sir Robert Francis QC, Sir David Pearson and Professor Stephen Peckham. For this evaluation, the core Expert Panel members were joined by palliative care specialists:

- Dr Sabrina Bajwah, Honorary Consultant Palliative Medicine at King's Health Partners and Clinical Reader at Cicely Saunders Institute;
- Anita Hayes, Clinical Quality Lead at Hospice UK;
- Professor Vic Rayner OBE, Chair at Global Ageing Network and CEO at National Care Forum;
- Dr Sam Royston, Executive Director for Research and Policy at Marie Curie UK; and
- Dr Michael Tatterton, Chief Nursing Officer at Bluebell Wood Children's Hospice and Clinical Associate Professor at the University of Bradford.

The Panel's findings

6. The Expert Panel evaluated five 'focus areas', analysing the extent to which existing Government and other national commitments or guidelines ('statements of intent') were being met. These focus areas and the Panel's headline findings are set out in the table below.

Focus area	Headlines
Commissioning of palliative and end of life care services (PEoLC)	**Commissioning priorities amongst ICBs are variable, creating a 'postcode lottery' in the provision of PEoLC.** **Most ICBs are not equipped to understand the PEoLC needs of their populations well enough to commission the right services.** **Competing financial pressures for ICBs result in insufficient funds being allocated to PEoLC.** **There is a lack of a commissioning framework for social care.**
Delivery of PEoLC services	**PEoLC services are under significant strain, across all settings.** **People struggle to navigate a complex and fragmented PEoLC system.** **PEoLC patients, service users and their families are too rarely given the opportunity to plan effectively for the future.** **Bereavement support is valuable, but frequently inaccessible.**
Shifting to community	**Shifting PEoLC to community is challenging because of current funding approaches.** **The transition of PEoLC to the community is hindered by inadequate provision of social care and widespread workforce and skill shortages.** **Integrated care services contribute to the transition to community-based care.**

Focus area	Headlines
Workforce, training and education	**The health and social care workforce is ill-equipped to meet the needs of people at the end of life because of the insufficient provision of education and training.** **The specialist palliative care workforce is in a "critical situation" and there are additional workforce shortages across the generalist workforce.** **Children and young people's PEoLC services have serious workforce shortages, including social care shortages.**
Inequalities and inequities	**Structural and systemic inequality persists throughout PEoLC.** **There are geographic inequalities in access and outcomes for PEoLC.** **Underserved and marginalised communities have significant unmet needs in PEoLC.**

7. Following receipt of the Expert Panel's report we held an evidence session with Stephen Kinnock MP, Minister of State for Care to question him on the report's findings.[7]

8. **CONCLUSION**

We were highly concerned by the findings of the Expert Panel's report, which revealed a sector in need of urgent support across all settings, underserving individuals from already vulnerable patient groups. The end of life system is fragmented, difficult to navigate, and leaves individuals in the 'gap' between health and social care all too often. Without safeguards, the Government's intention to shift palliative care to the community risks placing further unsustainable pressure on the community workforce, who are already overworked and under capacity.

7 Oral evidence, Palliative Care (HC 632)

1 The Modern Service Framework

9. Since the Expert Panel concluded its work, the Government announced plans on 24 November to develop a Modern Service Framework (MSF) for palliative care. The MSF is intended to set out national standards and goals to enable consistency and improvements across services and Integrated Care Boards (ICBs). An interim report is due to be published in the Spring with the full MSF published in Autumn 2026, although it is unclear what this report will contain.

10. MSFs were introduced in the 10 Year Health Plan, and are intended to:

- define an aspirational, long-term outcome goal;
- identify the best evidenced interventions that would support progress towards this goal, with a focus on those with the best means to drive up value and equity;
- set standards on how those interventions should be used, alongside a clear strategy to support and oversee uptake by clinicians and providers;
- set out 'challenge areas', where significant progress is possible, but where innovative ideas and products are needed; and
- include a plan to partner with the wider eco-system to support the creation, adoption and spread of novel ideas.

11. The plans to produce an MSF for palliative and end of life care featured prominently in both the Government's response to the Expert Panel's evaluation and the Minister's evidence. We were told that the MSF would aim to:

- reduce unwarranted variation and strengthen commissioning at the most appropriate scale;
- improve access, quality, and sustainability of services for all ages, specifically targeting inequalities and underserved groups;
- provide quality standards, a delivery plan and a mechanism for continuous improvement;

- improve earlier identification, proactive care and bereavement support;
- shift care from hospitals to community settings, strengthen 24/7 and out of hours provision, and support system flow and reduce unnecessary hospital admissions;
- address workforce challenges and expand capacity to ensure personalised, compassionate, and culturally competent care;
- clarify roles of social care and integrate social care provision; and
- improve coordination, data sharing, and digital infrastructure.

12. The Minister emphasised that a key element of the MSF would be to enable ICBs to "address challenges in access, quality and sustainability through the delivery of high-quality personalised care."[8] He also stressed that PEoLC's inclusion as one of the first five MSFs was a sign of the Government's commitment to improving PEoLC, describing it as a "bat signal to the entire system" that palliative and end-of-life care was a top priority.[9]

13. The MSF is set to be co-produced with stakeholders including Age UK, Together for Short Lives, the National Care Association, Marie Curie and Hospice UK, many of whom previously worked with NHS England to produce the current National Framework (Ambitions Framework) for PEoLC 2021–2026. The response from such stakeholders to the announcement of the MSF has generally been positive, while expressing concern that this intervention may be coming too late. Marie Curie described the MSF as "vital", but "long overdue",[10] while Hospice UK said that change could not "come soon enough" for the "broken" system:

> For too long, palliative and end of life care was not a government priority […] Two in five hospices are now making cuts. Services are withering. People aren't getting the care they need.[11]

The MSF and accountability

14. The Expert Panel report noted the lack of effective accountability mechanisms for ICBs who are responsible for commissioning palliative care services. As Hospice UK noted:

8 Q3
9 Q120
10 Marie Curie Marie Curie responds to the government's PEOLC Framework 24 November 2025
11 Hospice UK, Hospice UK responds to news of a modern service framework for palliative and end of life care, 24 November 2025

> [ICBs are] not currently held to a standard or held accountable for the provision of palliative and end of life care in their patch. There are no targets or reporting requirements of ICBs relating to PEoLC and there seems to be very little oversight from central NHSE or DHSC of the variation in provisions between ICBs and their justification for this.[12]

15. We asked the Minister who would be accountable for ensuring that the standards and expectations set out in the MSF were met, particularly given the Government's plans to abolish NHS England. The Minister told us that ICBs would be directly accountable to the Department which would be absorbing NHSE functions as part of the reorganisation. Dr Amanda Doyle, National Director for Primary Care and Community Services, NHS England told us:

> The MSF will set very clear expectations on interventions, timelines and metrics. We will measure those as part of our oversight and assurance process, in which we measure ICBs and have regular meetings through our regional teams to look at the progress of ICBs.[13]

16. **CONCLUSION**
We welcome the Government's plans to introduce a Modern Service Framework to set national standards for palliative and end of life care services, and the Department's commitment to co-produce this work alongside key stakeholders. However, we approach this with a level of scepticism, given the number of issues this Framework purports to resolve, and the risk the Government runs if this is not achieved.

17. **CONCLUSION**
We are unclear about what is fundamentally different about this framework compared to existing documents, such as the Ambitions Framework and the NHS National Standards for Palliative and End of Life Care. In particular, what different approach it will take to ensure that the Framework is effectively implemented across ICBs and setting out the consequences of inaction.

12 Health and Social Care Committee, Third Special Report of Session 2024–26, Expert Panel: Evaluation of Palliative Care in England, 28 November 2025, para 28

13 Q92

18. **RECOMMENDATION**
If the Modern Service Framework is to deliver meaningful change it must be more than a well-intentioned ambition. ICBs and the Department need to be held accountable for meeting the Framework, with clear consequences if its standards are not met. We call on the Government to set out, in its interim Report this Spring, what accountability arrangements will be in place to support implementation of the MSF and what concrete steps the Department will take with ICBs that fall short. The Government must also ensure that ICBs have the support, tools and resources they need to deliver on the MSF.

19. We discuss what this support should look like in the rest of this Report.

2 Commissioning

Commissioning and the Modern Service Framework

20. PEoLC services are generally commissioned by Integrated Care Boards (ICBs). The Health and Care Act 2022 established a statutory obligation for ICBs to commission 'appropriate' services for their populations, which is accompanied by NHS England (NHSE) statutory guidance.[14] As we saw in Chapter 1, an 'Ambitions for Palliative and End of Life Care' framework was also produced by the National Palliative and End of Life Care Partnership, to set standards for the delivery of care.[15]

21. The Expert Panel identified significant inadequacies in the commissioning of PEoLC services across England, with inconsistencies in service provision, ICBs struggling with tight budgets, competing priorities and a lack of access to meaningful population data to help them plan services. Minister Kinnock also told us there was presently "too much of a transactional approach to the way that ICBs work and engage with all the partners catchment areas", leading to a landscape that was insufficiently strategic.[16] In this Chapter we consider areas where we found particular gaps in commissioned services:

- babies, children and young people's palliative care;
- "out of hours" or 24/7 services; and
- joint commissioning with the social care sector.

Babies, children and young people's PEoLC

22. The Expert Panel identified serious inadequacies of the PEoLC system for babies, children and young people (CYP), describing them as a "vulnerable and underserved population group" with significant variation in care

14 NHS England, Palliative and End of Life Care: Statutory Guidance for ICBs, 29 September 2022

15 National Palliative and End of Life Care Partnership, Ambitions for Palliative and End of Life Care: A national framework for local action 2021–2026, May 2021

16 Q4

and outcomes.[17] Together for Short Lives told the Panel that there were "significant inconsistencies in the way in which ICBs commission children's palliative care and meet [their] legal duty".[18] These inconsistencies were further exacerbated where the individual had one or more further recognised health inequalities (around 9% of CYP receiving PEoLC). The most cited inequalities were a learning or physical disability, lower socioeconomic status, English as a second language, being part of an inclusion health group, or suffering from a severe mental illness.[19]

23. Due to the relatively small number of individuals needing CYP's palliative care, commissioning arrangements often span multiple ICBs, presenting a particular challenge. DHSC and NHSE told us that they were in the process of "setting up specific, formalised pan-ICB commissioning arrangements within regions for those services that are largely specialist services", but that it was "for the ICBs to decide" which services, including CYP's PEoLC, it might cover.[20] The Panel also identified major concerns in the care received by individuals transitioning from CYP's to adult PEoLC services, with contributors calling for there to be clear expectations for continuity of care at this "critical" point, noting that there were no such standards at present.[21]

24. We asked the Minister whether the MSF would differentiate between PEoLC for adults, and for children, providing a set of standards and expectations specific to this group and the transition period between CYP's and adult care. We were told:

> We should certainly be paying attention to the nuances around children's palliative care […] We also need to make sure there is a specific focus on transition to adult services, including the role of the whole healthcare system in supporting those children and families.[22]

25. Despite this, the Minister and his colleagues were unable to confirm that specific standards, guidelines and guidance for babies, children and young people would feature in the framework.[23] Following the session the Minister wrote to us to say:

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17 Health and Social Care Committee, Third Special Report of Session 2024–26, Expert Panel: Evaluation of Palliative Care in England, 28 November 2025, para 186

18 Health and Social Care Committee, Third Special Report of Session 2024–26, Expert Panel: Evaluation of Palliative Care in England, 28 November 2025, para 31

19 Health and Social Care Committee, Third Special Report of Session 2024–26, Expert Panel: Evaluation of Palliative Care in England, 28 November 2025, para 166

20 Qq99–107, Correspondence from Minister Stephen Kinnock to the Health and Social Care Committee, 22 January 2026

21 Health and Social Care Committee, Third Special Report of Session 2024–26, Expert Panel: Evaluation of Palliative Care in England, 28 November 2025, para 189

22 Q95

23 Qq94–110

> With the ongoing development of the MSF in discussion, I agreed that this must improve palliative care and end-of-life care services for all, including for children and young people, and those transitioning from child to adult services.[24]

The letter did not commit to the provision of specific standards for babies, children and young people's palliative care, or for the MSF to specifically cover the transition between child to adult services.

26. **RECOMMENDATION**
We are concerned that the Minister was unable to commit to providing clear and specific standards and guidance for babies, children and young people's palliative and end of life care in the Modern Service Framework (MSF). We strongly recommend that the Department includes specific standards within the MSF for the provision of children and young people's palliative care services, and for the transition between child and adult services. Pan-ICB commissioning guidance should contain specific information on how to commission these services effectively.

Commissioning 24/7 care

27. One aspect of PEoLC services that the Expert Panel identified as being particularly poorly commissioned was 24/7 care. As the Panel's report outlined, such services improve patient outcomes and reduce unnecessary hospital attendances, however there is limited availability of palliative care services out of hours and at the weekends.[25]

28. NICE guidance sets out that commissioners should ensure that they commission services that are available 24 hours a day, 7 days a week for adults approaching the end of their life and their carers, including an advice line and out of hours access to symptoms management through access to healthcare professionals and pharmacy services.[26]

24 Correspondence from Minister Stephen Kinnock to the Health and Social Care Committee, 22 January 2026

25 Health and Social Care Committee, Third Special Report of Session 2024–26, Expert Panel: Evaluation of Palliative Care in England, 28 November 2025, para 74

26 Quality statement 4: Out-of-hours care | End of life care for adults | Quality standards | NICE

Telephone advice lines

29. 24/7 PEoLC advice lines can offer guidance and reassurance, supporting care at home and potentially reducing avoidable emergency care use in the last months of life.[27] At present, 18 ICBs (43%) offer 24/7 telephone coverage, providing advice, guidance and onward referral to other services covering the whole ICB area.[28] 23 ICBs (55%) have "some coverage across parts of their catchment", and one ICB is reported to have none. This is despite access to 24/7 telephone advice being recommended as a minimum service requirement by NICE and the Department for nearly two decades.[29]

30. When we asked the Minister about improving out of hours services, he told us this would be "one of the key points" in the MSF, setting "national standards and goals, for example, by looking at having a 24/7 telephone line available everywhere in England at least",[30] setting a deadline for 100% coverage of the 24/7 phoneline for 2027. However, he did not have robust data to support the resourcing required:

> I have not done the modelling of what kind of workforce would be required to staff that telephone line, but it would be a single central number.[31]

24/7 symptom management

31. Stakeholders have also raised significant concerns that choosing to die at home might mean poor quality care[32] with limited access to support and pain management.[33] The RCGP told the Expert Panel that many ICBs still lack the infrastructure to deliver care planning and symptom control 24/7, leading to disparities in access to and quality of care in the community.[34]

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27 Johansson T, Chambers RL, Curtis T, Pask S, Greenley S, Brittain M, Bone AE, Laidlaw L, Okamoto I, Barclay S, Higginson IJ, Murtagh FEM, Sleeman KE, "The effectiveness of out-of-hours palliative care telephone advice lines: A rapid systematic review", Palliative Medicine, 38(6), 2024, in Cicely Saunders Institute of Palliative Care, Policy and Rehabilitation (PLC0023)

28 Correspondence from Minister Stephen Kinnock to the Health and Social Care Committee, 22 January 2026

29 Marie Curie, '"Urgent action" needed to resolve dangerous gaps in out of hours palliative care in England', 8 May 2025

30 Q38

31 Qq40–43

32 Oral evidence taken by the Public Accounts Committee on 12 January 2026, Q2 [Professor Fliss Murtagh]

33 End of Life Doula UK (PLC0018)

34 Health and Social Care Committee, Third Special Report of Session 2024–26, Expert Panel: Evaluation of Palliative Care in England, 28 November 2025, para 74

32. The Expert Panel highlighted that pharmacy played a "vital role" in the provision of PEoLC, and that efforts to shift care into the community would need to "address issues surrounding "insufficient" 24/7 access to symptomatic medication in the community and at home, and in some regions, no 24/7 pharmacies." The RCGP told the Panel that delays in access to out of hours medication and appropriately trained staff outside of acute settings continued to "drive avoidable hospital attendances".[35]

33. Dr Doyle emphasised the important role that the community pharmacy should play in providing "access to the medicines that might be needed at the end of life",[36] clarifying what this meant for pharmacies:

> We are not expecting pharmacies to open at 1 am and provide these drugs; we are expecting people to have anticipated the need. Some patients might have a sealed box containing those drugs in the home for some weeks, because we anticipate that we could need them at any time, so just-in-case boxes are available. It is about involving community pharmacies in the preparing of that, being ready and anticipating which patients are going to need those sorts of support and having them there and then.[37]

34. Currently, community and district nurses spend more than a fifth of their time providing PEoLC.[38] Acknowledging the decreased number of community nurses over the last decade, Dr Doyle stated that there was "a significant need to increase the capacity of the community nursing workforce […] The cohorts that we are asking ICBs to focus on supporting out of hospital first are those with severe frailty and those at the end of life".[39]

35. **CONCLUSION**

It is unacceptable that access to 24/7 palliative and end of life care services remains patchy throughout England. Individuals nearing the end of life should be able to access the right care, advice and medication, wherever they are and regardless of the time of day. We are pleased that the Minister committed to 100% telephone line coverage in England by 2027, but this is not enough. While telephone advice lines provide support and may prevent unnecessary hospital admissions, they are insufficient to build a resilient and effective out of hours palliative care service on their own.

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35 Health and Social Care Committee, Third Special Report of Session 2024–26, Expert Panel: Evaluation of Palliative Care in England, 28 November 2025, para 107

36 Q81

37 Q81

38 Correspondence from Minister Stephen Kinnock to the Health and Social Care Committee, 22 January 2026

39 Q70

36. **RECOMMENDATION**
We recommend that the MSF includes specific guidelines and requirements for ICBs to enable access to 24/7 PEoLC services, including access to symptomatic medication, and in-person care where necessary. We call on the Government to provide an assessment of both the workforce needed to deliver such a service and the potential savings to the wider health and care service that such an offer would deliver.

Commissioning with local authorities

37. Local authorities have a key role in commissioning social care for their populations and consequently have a significant role to play when individuals near the end of life. Of the approximately 1% of the population who die each year, around half may be receiving social care, including the 22% who die in a care home and significant proportion of the 28% who die at home.[40] Under the Care Act 2014, local authorities have a duty to assess and provide social care. Local authorities, alongside ICBs also have core responsibilities in planning and delivering the Better Care Fund (BCF), a national funding programme designed to integrate health, social care and housing support for individuals with complex needs, "bringing local authorities together with the health system to improve delayed discharge".[41]

38. Our Expert Panel highlighted that, despite evidence that effective PEoLC requires coordination of care across health and social care services, NHS commissioners' engagement with social care was "variable". One ICB described a "considerable disconnection" between health and social care services in the planning and delivery of PEoLC.[42] Care Rights, a charity focusing on the rights of older people in care, highlighted that the MSF as set out did not address the "essential role" that social care would play in delivering palliative care in communities.[43] Similarly, the Expert Panel's report noted that there was a "lack of clear and specific expectations or documented standards for social care in PEoLC, despite the significant contribution from social care to people at the end of their lives".[44]

40 Office for National Statistics, Death registration summary statistics, England and Wales: 2024, 20 May 2025 (accessed 29 January 2026)
41 Q23
42 Health and Social Care Committee, Third Special Report of Session 2024–26, Expert Panel: Evaluation of Palliative Care in England, 28 November 2025, para 55
43 Care Rights UK, Palliative and end of life care modern service framework announced, 27 November 2025
44 Health and Social Care Committee, Third Special Report of Session 2024–26, Expert Panel: Evaluation of Palliative Care in England, 28 November 2025, Executive Summary

39. The Minister accepted that the involvement, interface and integration with adult social care as "not good enough"[45] in the commissioning and provision of palliative and end of life care services. When pressed about the role social care would play in the development of the MSF, we were told:

> We recognise that that voice needs to be heard. Obviously, local authorities play a crucial role in that. We have to ensure that local authorities are around the table as we develop this modern service framework.[46]

However, the Government's 10 Year Health Plan intends to remove local authority representation on ICBs, replacing them with strategic authority mayors through legislation to "best align the opportunities for strategic planning between the NHS and the renewed commitment within local government to support the strategic authority as a key body for growth and prosperity".[47] When we raised this with the Minister, he told us that he was "not aware" of the Government's intention to do this and committed to writing to us with detail of the role of local authorities in the commissioning process going forward, to ensure they were involved in discussions from the start.[48]

40. The Minister's subsequent correspondence explained that local authorities were "absolutely central" to improving health and care locally and noted that the strategic commissioning framework encouraged ICBs to work with local government. However, he reaffirmed the Government's commitment to replace local authority representation on ICBs with strategic authority mayors. Local authorities would instead "play a key role through their health and wellbeing boards, which will lead the development of neighbourhood health plans, incorporating public health, social care, and the Better Care Fund".[49]

45 Q19
46 Q21
47 UK Government & NHS, 'Fit for the future: 10 Year Health Plan for England' (CP1350), 3 July 2025, p79
48 Q22
49 Correspondence from Minister Stephen Kinnock to the Health and Social Care Committee, 22 January 2026

41. **RECOMMENDATION**

The role of social care in the provision of palliative and end of life care has been overlooked for far too long, and we are concerned that the Government's plans to remove local authorities from ICBs will only make the current situation worse, particularly in the context of the Government's aim to shift care into the community. We urge the Government to reconsider its decision to remove, through legislation, local authority representation on ICBs, to ensure social care is represented, understood and appropriately commissioned to deliver end of life care.

3 Data

42. Robust data is required to plan and commission palliative and end of life services to meet population need, and to understand how well services meet these needs. The Expert Panel found that, through a lack of access to, and usage of, effective data, most ICBs were "not equipped to understand the PEoLC needs of their populations well enough to commission the right services".[50]

Early identification and the palliative care register

43. Around 1% of the population dies each year, and this is anticipated in 74–96% of cases.[51] Individuals reaching the end of their life, irrespective of age, should be included in the primary care Palliative Care Register,[52] which is used locally as an early identification system to direct individual care planning, and in aggregate to identify service need. However, in 2023–24, only 0.55% of the population were included on the Palliative Care Register,[53] meaning that more than 20% of people whose death was anticipated had not been recorded. This was despite a financial incentive for GPs to maintain the register. The 2025/26 changes to the GP contract removed this incentive,[54] but the Government's expectation for GPs to complete the register remains. Minister Kinnock told us:

> There are about 345,000 people on the register of palliative care. That is only about 50% of the total number of people in the last year of life […] I would like to be in a position where 90% of people in the last year of life are on the palliative care register. We are clearly quite a long way from that—30 or 40 percentage points off it—so it is a stretch target, and we need to do everything we can to achieve it.[55]

50 Health and Social Care Committee, Third Special Report of Session 2024–26, Expert Panel: Evaluation of Palliative Care in England, 28 November 2025, 1 Commissioning of palliative and end of life care

51 Fantoni ER, Wynee N, Finucane AM, 'Estimates of population-level palliative care need in the UK: a descriptive analysis of mortality data before and during the COVID-19 pandemic', BMC Palliative Care; 2024: 25(23):271

52 NICE 'GP services: palliative care register', 19 August 2023

53 Q6

54 NHS England, 'Changes to the GP contract in 2025/26', 11 March 2025

55 Q18

44. The Minister's follow-up correspondence emphasised that "there is more work to be done on early identification (specifically prior to the last three months before death)", however the 90% target was relaxed to 75–90% by 2029.[56]

45. **CONCLUSION**
We support increasing use of the Palliative Care Register for early identification of individuals, including children and young people with PEoLC needs. However, we are concerned that its use is likely to decrease given the removal of funding incentives for primary care practitioners to add patients to the Register.

46. **RECOMMENDATION**
We recommend that the Department implement the 90% target for the percentage of individuals in the last year of life documented on the Palliative Care Register and that it reports annually on progress against this target to monitor the impact of its decision to remove the financial incentive to add patients to the Register.

Palliative and end of life care dashboard

47. Palliative and end of life care patterns in England are published annually using data from the NHSE PEoLC dashboard.[57] Lead time between the end of data collection and publication is approximately 12 months. The published dataset includes a breakdown for four major conditions (cancer, cardiovascular disease, dementia and respiratory disease), and age, sex, ethnicity, deprivation, place of death and region. Dr Sarah Mitchell, National Clinical Director for Palliative and End-of Life Care, NHSE, described the dashboard as bringing together existing datasets, including "existing palliative care QOF [Quality and Outcomes Framework] data from general practice, hospital episode statistics and death data".[58]

48. Evidence submitted to the Expert Panel emphasised a lack of data collection by ICBs to enable appropriate PEoLC commissioning or assessment of implementation. Marie Curie advised of a specific data gap in measuring activity, quality and spending.[59] One ICB emphasised that they needed access to "more granular, real-time data to drive improvements", citing the

56 Correspondence from Minister Stephen Kinnock to the Health and Social Care Committee, 22 January 2026
57 Office for Health Improvement and Disparities, 'Palliative and end of life care factsheet: patterns of care', England 2022, 6 February 2024
58 Q46
59 Marie Curie (PLC0032)

need for robust data to assess gaps between patient need, eligibility for services and successful referral.[60] Service providers were also concerned that when they contributed data to ICB dashboards, the outcomes were not shared back with the provider, and did not appear to be acted upon.[61] Particular challenges were identified with the collection of data around the needs of children and young people, with Dr Mitchell saying that the evidence base was less developed than other parts of the service.[62]

49. Evidence submitted from the Royal College of General Practitioners suggested that the use of ICB dashboards and disaggregated data should be mandated, primarily to "identify, monitor and reduce inequalities across the PEoLC pathway".[63] Marie Curie emphasised that accurate and consistent data provision to ICBs could enable needs-based commissioning with data "shared between providers and systems to increase the visibility of PEoLC in the commissioning process and address the under-commissioning of services".[64] The International Observatory on End-of-Life-Care noted that data could also be used as the basis for future investment choices by ICBs: "investments in palliative and end-of-life care should be based on the best available research to avoid unproven interventions and focus on proven methods".[65]

50. When we questioned the Minister on how PEoLC data was being used to drive decision making, Minister Kinnock argued that effective data collection and use would be key to the MSF, saying that strategic commissioning would "not work unless you are using the data properly".[66] However he accepted that there was "patchy use" of the PEoLC dashboard and client-level data for social care by ICBs.[67] The Minister stated:

> I do not think we are doing enough to utilise that data and bring it into our thinking about how palliative and end of life care is working across the country.[68]

Similarly, Dr Mitchell told us that they could not provide any assurance of how many ICB were using data to commission services.[69]

60 NHS North East London Integrated Care Board (PLC0008)
61 Mountbatten Hospice Group (PLC0012)
62 Qq95–96
63 Royal College of General Practitioners (PLC0038)
64 Marie Curie (PLC0032)
65 Lancaster University (PLC0009)
66 Q55
67 Q45
68 Q45
69 Q50

51. **CONCLUSION**
National palliative and end of life care data provide valuable insight into patterns of healthcare use and location of death, however the evidence presented demonstrates substantial gaps in local data collection and utilisation. Without consistent, granular and timely data, ICBs and providers cannot reliably commission, plan, or improve palliative and end of life services in line with their population needs.

52. **RECOMMENDATION**
We urge the department to mandate ICBs to maintain a fully populated palliative and end of life care dashboard that is actively used for commissioning, service planning, quality improvement, and inequality monitoring across their local system.

Data sharing and integration

53. People at the end of life may receive care from a range of NHS, local authority, voluntary sector and private services. It is therefore essential that there is effective data sharing between services to enable practitioners to provide continuity of care for patients. The Electronic Palliative Care Co-ordinating Systems (EPaCCS), a palliative care record sharing system, was introduced in England in 2008, in an effort to meet this need.[70] However, the Expert Panel heard that uptake was inconsistent, and effectiveness under-researched.[71]

54. The Expert Panel report identified several instances where effective data sharing was not happening. These included:

- Failure in co-ordination during discharge from hospital. Roundtable participants with lived experience of PEoLC consistently described confusion, delays, and stress caused by poor communication between services.[72]
- People nearing end of life, and their carers having to take on the burden of coordinating care across different services, due to lack of integration.[73]

70 Wolfson Palliative Care Research Centre (PLC0046)
71 Health and Social Care Committee, Third Special Report of Session 2024–26, Expert Panel: Evaluation of Palliative Care in England, 28 November 2025, para 83
72 Lived experience roundtable: summary note, breakout room 2 (23 April 2025)
73 Lived experience roundtable: summary note, breakout room 2 (23 April 2025)

- Shared records, included the EPaCCS, not being effectively used due to a lack of interoperability across systems, particularly between health and social care or voluntary sector settings.[74]

The Government's response to the Expert Panel report emphasised the role that the introduction of the Single Patient Record would play in "bring[ing] together a patient's medical record all into one place".[75] However, the response did not directly address how such a system would enable integration across social care and voluntary sector PEoLC providers.

55. **CONCLUSION**

Poor data sharing and lack of integration across NHS, social care, voluntary and private providers creates confusion, delays and gaps in continuity for people at the end of life, frequently placing the burden of coordination care on patients and carers during what is an extremely emotional and challenging period. Despite existing systems for data sharing, inconsistent uptake, poor interoperability and limited outcome-level information reduce effectiveness.

56. **RECOMMENDATION**

If the Government intends for the introduction of the Single Patient Record to address concerns about a lack of service integration for palliative and end of life care, then this record must be available to all providers—including social care, the voluntary sector and private providers. The Government should also set out in its response to this Report how it will use the introduction of the Single Patient Record to drive integration across different types of providers.

74 Wolfson Palliative Care Research Centre (PLC0046)

75 Health and Social Care Committee, Fourth Special Report of Session 2024–26, Evaluation of Palliative Care in England: Government Response, HC 1722, page 7

4 Workforce

57. Palliative and end of life care is delivered by a diverse health and social care workforce. This includes specialists for whom PEoLC is their core role, for example palliative care clinicians and hospice staff, and generalists such as GPs, pharmacists, community nurses, allied health professionals, and carers, who work with a broad caseload of patients, only some of whom are at the end of life. During its evaluation, the Expert Panel found that inadequate workforce provision had led to overstretched specialist services, while unclear pathways and inadequate generalist training were causing gaps in care, particularly in community settings.[76]

Generalist workforce

58. Generalist frontline teams provide the majority of care for most people in the last years of life, and predominantly in community settings.[77] Under existing NICE guidance all staff "managing services should ensure that health and social care practitioners caring for adults approaching the end of their life have the training and skills to sensitively carry out holistic needs assessments".[78] However, despite this existing guidance, the Expert Panel found that the health and social care workforce was "ill-equipped to meet the needs of people at the end of life because of the insufficient education and training".[79]

59. Contributors to the Expert Panel evaluation advised that generalist training for end of life care should focus on managing uncertainty, parallel planning for different scenarios, and enabling staff and systems to make 'risk confident' decisions with appropriate support, including out of hours.[80] Without these capabilities, the default was emergency services callouts and hospital admissions, which were "at odds" with what people wanted for

76 Cicely Saunders Institute of Palliative Care (PLC00023), Marie Curie, 'Better End of Life 2024 - Time to Care: Findings from a nationally representative survey of experiences at the end of life in England and Wales', September 2024

77 Gold Standard Framework Centre (PLC0036)

78 NICE, 'Care of dying adults in the last days of life', 16 December 2015

79 Health and Social Care Committee, Third Special Report of Session 2024–26, Expert Panel: Evaluation of Palliative Care in England, 28 November 2025, 4 Workforce, education and skills

80 Clinicians and service providers roundtable summary note: breakout room 2 (26 March 2025)

themselves[81] (often to receive care in their home) and at increased cost.[82] Baroness Ilora Finlay, Co-Chair of the APPG on Hospice and End of Life Care, told the Public Accounts Committee:

> There is inadequate education and training right the way through […] 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.[83]

60. The Expert Panel identified specific gaps in training for:

- Generalist health and social care staff supporting children and young people approaching the end of life. Unlike the NICE guideline for adults, existing guidance for children and young people's PEoLC does not provide training requirements for the generalist workforce.[84]
- Social care workers, including those working in care homes.[85] The Expert Panel found this particularly concerning, given that more than a fifth of deaths occur in care homes.[86]
- Delivery of culturally competent care, particularly for staff working in rural, socioeconomically deprived areas or with minority communities.[87]

61. When we raised this with Minister Kinnock, he highlighted existing staff training programmes, including the e-learning for health modules 'End of Life Care for All' (e-ELCA), and Learning and Development Support Scheme (LDSS) available for social care staff, which "includes modules on death literacy and bereavement support".[88] He also told us that the forthcoming 10 Year Workforce Plan would define the additional skills and competencies that generalists need, including the specific skills and competencies required for palliative and end of life care.[89] However, following the session the Minister wrote to us to say that:

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81 Compassion in Dying (PLC0043)
82 Nuffield Trust and Health Economics Unit, 'Public expenditure in the last year of life', February 2025
83 Oral evidence taken by the Public Accounts Committee on 12 January 2026, Q3 [Baroness Ilora Finlay]
84 NICE, End of life care for infants, children and young people with life-limiting conditions: planning and management, 07 December 2016
85 Skills for Care, Adult Social Care Workforce Data (accessed 28 January 2026)
86 Office for Health Improvement and Disparities, Palliative and end of life care profile December 2023 update: Statistical commentary, 17 September 2024
87 Royal College of General Practitioners (PLC0038)
88 Q58, Q62
89 Q85

> On workforce, I intimated that our workforce plan will define the additional skills and competencies that generalists need. To clarify, we will publish the 10 Year Workforce Plan in the spring. This will set out action to create a workforce ready to deliver the transformed service set out in the 10 Year Health Plan.[90]

62. On training for the social care workforce, the Government's response to the Expert Panel report highlighted the introduction of the 2024 Care Workforce Pathway which recommends that adult social care workers complete the Level 2 Adult Social Care Certificate, which covers supporting individuals' wellbeing, and includes end-of-life care".[91] However, end of life care is only a very small component of this qualification.[92] Additionally, the Department announced the Qualification in Specialism Standard for Palliative and End-of-Life-Care, which "will be published in due course"[93] and is anticipated to include health and social care.

63. **CONCLUSION**

Generalist staff, who provide most end of life care, often lack the skills, confidence and specialist support required to deliver high-quality, person-centred care. Despite existing initiatives, a clearer, system-wide approach to upskilling the generalist workforce is urgently needed.

64. **RECOMMENDATION**

We recommend that end of life care be included as a core skill for the generalist health and social care workforce, with a clear and defined set of competencies required to deliver high-quality and person-centred palliative and end of life care. This should be reflected in the forthcoming 10 Year Workforce Plan. In particular, the critical role that social care staff play in delivering palliative care should be acknowledged in the Plan, and reflected in the training and support social care staff receive to enable them to provide this care in a more systematic way. While we welcome the Qualification in Specialism Standard for Palliative and End-of-Life Care, we ask the Department to provide further information in its response to this Report on who will be required to complete this training and when it will become available.

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90 Correspondence from Minister Stephen Kinnock to the Health and Social Care Committee, 22 January 2026

91 Health and Social Care Committee, Fourth Special Report of Session 2024–26, Evaluation of Palliative Care in England: Government Response, HC 1722, pages 7–8

92 Skills for Care, Level 2 Adult Social Care Certificate qualification, August 2025 (accessed 03 February 2026)

93 Health and Social Care Committee, Fourth Special Report of Session 2024–26, Evaluation of Palliative Care in England: Government Response, HC 1722, page 11

Specialist workforce

65. NICE guidance states that adults approaching the end of their life and their carers should have access to "a healthcare professional available 24 hours a day, 7 days a week, who can access the person's records and advance care plan, and make informed decision about changes to care".[94] Similar expectations are outlined in the children and young people's service specification: "[T]he provider must ensure that a specialist children and young people's palliative care team can provide the workforce to support children and young people on a 24/7 basis, this may be remote support or as part of a wider regional offer".[95]

66. The Expert Panel evaluation concluded that the specialist palliative care workforce was in a "critical situation",[96] neither able to meet current need nor support the desired shift to support more PEoLC delivery in the community. The UK Palliative Medicine Specialist Advisory Committee raised concerns about vacant consultant posts (78 in 2022)[97] and reported that approximately a third of the consultant workforce were expected to retire within 10 years.[98] The Expert Panel heard that approximately 30–40 doctors qualify as palliative care consultants annually, which did not meet current or projected need.[99] Shortages of nurses and other specialist PEoLC professionals were also reported.[100] Particular shortages were identified in the children and young people's palliative care workforce. The Expert Panel heard that only one third of consultant-led paediatric palliative care teams had the professional configuration recommended in NICE guidance and of these, three quarters relied on charity funding for at least one post.[101]

67. The Government's response to the Expert Panel's report stated that there were "over 420 FTE [fulltime equivalent] consultants" in PEoLC, an increase of 20 compared with 2024, and 80 compared with 2020.[102] When he appeared before us, Minister Kinnock was unable to provide a recommended workforce number for specialist PEoLC roles but said that the Government was publishing its workforce plan in the spring, and that

94 NICE, End of life care for adults: service delivery, 16 October 2019.
95 NHS England, 'Specialist palliative and end of life care services: children and young people service specification', 18 January 2023
96 Health and Social Care Committee, Third Special Report of Session 2024–26, Expert Panel: Evaluation of Palliative Care in England, 28 November 2025, 4 Workforce, education and skills
97 Dr Polly Edwards and Dr Fiona Wiseman (PLC0003)
98 Hospice UK (PLC0039), Association for Palliative Medicine, 'Report and overview of the palliative medicine workforce in the United Kingdom', March 2019
99 Dr Polly Edwards and Dr Fiona Wiseman (PLC0003)
100 Dr Polly Edwards and Dr Fiona Wiseman (PLC0003), Hospice UK (PLC0039)
101 Cicely Saunders Institute of Palliative Care (PLC0026)
102 Correspondence from Minister Stephen Kinnock to the Health and Social Care Committee, 22 January 2026

would set out its targets.[103] Dr Amanda Doyle, National Director for Primary Care and Community Services, NHSE, highlighted that workforce planning for children and young people's PEoLC services would be facilitated by joint commissioning, given the small population.[104]

68. **CONCLUSION**
Current shortages in the specialist workforce are putting palliative care services in an unsustainable position which threatens their ability to deliver equitable and high-quality palliative and end of life care. Extensive consultant vacancies, impending retirements, limited training places and widespread nursing shortages all contribute to an inability to meet demand, with particular staff shortages experienced in children and young people's palliative care. This is an unacceptable situation, and urgent action is needed address these shortages.

69. **RECOMMENDATION**
The Government need to publish an evidence-based plan, supported by up-to-date workforce modelling, setting out how it will increase the capacity and sustainability of all sectors of the specialist palliative and end of life care workforce, as part of the 10 Year Workforce Plan. This should include plans for clear training pathways and a specific target for the staffing of children and young people's palliative care.

103 Q69
104 Qq99–107

5 Bereavement

70. Bereavement is a multifaceted natural response to the death of someone close, involving emotional, physical and behavioural reactions. Approximately 10% of bereaved individuals will experience long-lasting symptoms, described as complicated bereavement or prolonged grief disorder.[105] Bereavement care is a holistic approach to supporting people with the death of someone close to them, including anticipatory or pre-bereavement care, which is support provided before the death of a loved one.[106] As the current Ambitions Framework for PEoLC sets out, bereavement support should be provided as part of PEoLC services:

> Good palliative and end of life care includes giving care and support to families, friends, carers, and all those who are important to the dying person. This must encompass good bereavement and pre-bereavement care, including for children and young people.[107]

71. Attendees at the Expert Panel roundtable for people with lived experience of PEoLC highlighted the benefits of pre-bereavement and bereavement counselling in helping people 'get back on their feet' and helping families prepare and understand what to expect when a person was nearing the end of their life.[108] However, evidence submitted from a range of national organisations identified issues with both awareness and availability of bereavement support, and dependence on voluntary organisations for provision.[109] The Association for Palliative Medicine specifically highlighted unmet needs in relation to caring for a child or young person with life-limiting illness and child bereavement.[110]

72. The Expert Panel heard that bereavement support for people from diverse ethnic, religious and cultural backgrounds was particularly inaccessible. This was also acknowledged in the Ambitions Framework, which stated that

105 Lundorff M, Holmgren H, Zachariae R et al. 'Prevalence of prolonged grief disorder in adult bereavement: a systematic review and meta-analysis', Journal of Affective Disorders 2017; 212:138–149

106 Marie Curie, 'Grief and practical tasks when someone dies' (accessed 29 January 2026)

107 NHS England, 'Ambitions for Palliative and End of Life Care', 10 February 2022

108 Lived experience roundtable: summary note, breakout room 1 (23 April 2025)

109 Association for Palliative Medicine of Great Britain and Northern Ireland (PLC0027), Royal College of General Practitioners (PLC0038), Marie Curie 'Better End of Life 2024 - Time to care: Findings from a nationally representative survey of experiences at the end of life in England and Wales', September 2024, National Bereavement Alliance (PLC0040)

110 Association for Palliative Medicine of Great Britain and Northern Ireland (PLC0027)

the "widespread lack of knowledge about the way different communities may approach the challenges of dying, death and bereavement is not acceptable."[111] On this basis, the Expert Panel concluded that "bereavement support is valuable, but frequently inaccessible".[112]

73. Dr Edward Scully, Director of Primary and Community Health Care, Department of Health and Social Care, told us that while "the 2022 [Health and Care] Act sets out that everyone should be providing bereavement services", "clearly, that is not happening everywhere".[113]

74. Minister Kinnock stated that bereavement support was "absolutely vital" and agreed that all integrated care strategies should include specific planning for bereavement and end of life care.[114] The Minister suggested that advance care planning would facilitate bereavement care by enabling conversations with the patient and their family.[115] Writing after the session, Minister Kinnock emphasised the statutory guidance for ICBs in relation to bereavement support and stated the Government expected these requirements to be reflected in local strategies.[116] The Government's response to the Expert Panel report highlighted the availability of NHS Talking Therapies, and the recent prioritised funding for this service although this did not offer any additional actions specifically for bereavement support.[117]

75. **CONCLUSION**

Bereavement, and pre-bereavement support are essential, yet access remains patchy, poorly commissioned, and often difficult to navigate. Despite its inclusion in the current Ambition Framework, significant gaps persist, particularly for culturally diverse communities and children and young people.

111 National Palliative and End of Life Care Partnership, 'Ambitions for Palliative and End of Life Care: A national framework for local action 2021–2026', May 2021 (accessed 29 January 2026)

112 Health and Social Care Committee, Third Special Report of Session 2024–26, Expert Panel: Evaluation of Palliative Care in England, 28 November 2025, 2 Delivery of palliative and end of life care

113 Q61

114 Qq35–37

115 Q36

116 Correspondence from Minister Stephen Kinnock to the Health and Social Care Committee, 22 January 2026

117 Health and Social Care Committee, Fourth Special Report of Session 2024–26, Evaluation of Palliative Care in England: Government Response, HC 1722, page 6

76. **RECOMMENDATION**

The Government must hold ICBs to account for delivering bereavement services. This does not need to wait for the forthcoming Modern Service Framework as there are already clearly defined expectations for what ICBs should deliver in this area. In its response to this Report, we ask that the Department sets out how it will monitor ICBs' current delivery of bereavement services, and what steps will be taken with ICBs that do not deliver an acceptable level of service.

6 Hospices

Hospice funding

77. Whilst the majority of PEoLC services are delivered in the NHS, hospices provide essential specialist services in a variety of settings, including inpatient hospice care, care homes and people's homes.[118] According to Hospice UK, in 2023–24, hospices in England provided care to approximately 260,000 people.[119] In December 2024, the Secretary of State said that hospices would have a "big role to play" in shifting a greater proportion of care to community settings .[120]

78. Contributors to the Expert Panel evaluation expressed concerns about the funding of hospice care, particularly in the context of the Government's intention to shift more care into the community. The Wolfson Palliative Care Research Centre told the Expert Panel:

> Current funding models are a barrier to shifting to community based PEoLC. It currently costs £1.8 billion each year to run the hospices in the UK and less than £0.5 billion of this comes from the Government. Demand for PEoLC is rising, in part due to an ageing population, and hospices are fundraising to their full capacity. This makes it challenging for the hospice sector to keep up with rising demand and develop new models of care to ensure people get the right care at the right time.[121]

79. The Expert Panel found that this reliance on charitable donations led to "stark regional disparities in [hospice] service provision", with many hospices having to rely heavily on charitable donations.[122] Where an area is more affluent, the funding of services was likely to be greater, but in economically deprived and rural areas, services were underfunded and access to care limited. Stakeholders told the Panel that, without systemic

118 Hospice UK, Key facts about hospice care (accessed 25 June 2025)
119 Hospice UK, Statistics about hospice care in each UK nation (accessed 6 June 2025)
120 Hospices, UIN HCWS348, 19 December 2024
121 Wolfson Palliative Care Research Centre (PLC0046)
122 Health and Social Care Committee, Third Special Report of Session 2024–26, Expert Panel: Evaluation of Palliative Care in England, 28 November 2025, para 164

reform—such as improved funding models, national minimum service standards, and improved accountability for ICB commissioning decisions—these inequalities would continue to deepen.[123]

80. Minister Kinnock told us that access to population data would play a key part in addressing inequalities in access to hospice care, arguing that such data would "help ICBs and commissioners to do what they are required to do. The model ICB blueprint is very clear that a priority of every ICB must be to prioritise underserved areas and underserved communities."[124] The Minister also highlighted the importance of "bringing hospices into the conversation" from the beginning, as an "important partner" for ICBs, ensuring they were able to "feed in data", despite the fact that they were "not 100% part of the system".[125]

81. On funding, the Minister announced a new package of funding for hospices during our evidence session:

> I am delighted to confirm today that we are adding a further £25 million to the £100 million capital funding available for adult and children's hospices this financial year. That is in addition to our commitment in autumn 2025 to provide approximately £80 million of revenue funding for children and young people's hospices for the next three years.[126]

The Minister outlined that the £125 million given to adult hospices had been co-ordinated through Hospice UK, who undertook a "needs-based assessment of the projects and proposals that each hospice has on—for example, whether it needs the boiler fixed, the roof fixed, or the IT infrastructure upgraded" to differentiate between the need for capital or revenue funding.[127] However, concerns remain in the hospice sector that revenue funding is also required to create sustainable hospice workforce models.[128]

123 Health and Social Care Committee, Third Special Report of Session 2024–26, Expert Panel: Evaluation of Palliative Care in England, 28 November 2025, 5 Inequalities and inequities,

124 Q111

125 Q114

126 Q3

127 Q117

128 Hospice UK, National report into financial sustainability of England's Adult hospices, 29 October 2025 (accessed 12 February 2026)

82. **CONCLUSION**
Hospices form an integral part of palliative and end of life care provision at home and in the community and we welcome the fact that the Government intends for them to play a bigger role as part of its shift to neighbourhood health. However, if the Government want hospices to deliver a universal and equitable service, this must be matched with additional resources. We were unconvinced by the Government's argument that this will be addressed simply by improving the data that ICBs have access to.

83. **RECOMMENDATION**
We recommend that the Government moves towards sustainable and predictable models of funding for hospices, financing their running as well as investment costs, which reflects the increasingly central role they will play in delivering end of life care. This funding should be accompanied by conditions that require hospices to play a greater role in actively addressing inequalities in access to their services.

Conclusions and recommendations

Introduction

1. We were highly concerned by the findings of the Expert Panel's report, which revealed a sector in need of urgent support across all settings, underserving individuals from already vulnerable patient groups. The end of life system is fragmented, difficult to navigate, and leaves individuals in the 'gap' between health and social care all too often. Without safeguards, the Government's intention to shift palliative care to the community risks placing further unsustainable pressure on the community workforce, who are already overworked and under capacity. (Conclusion, Paragraph 8)

The Modern Service Framework

2. We welcome the Government's plans to introduce a Modern Service Framework to set national standards for palliative and end of life care services, and the Department's commitment to co-produce this work alongside key stakeholders. However, we approach this with a level of scepticism, given the number of issues this Framework purports to resolve, and the risk the Government runs if this is not achieved. (Conclusion, Paragraph 16)

3. We are unclear about what is fundamentally different about this framework compared to existing documents, such as the Ambitions Framework and the NHS National Standards for Palliative and End of Life Care. In particular, what different approach it will take to ensure that the Framework is effectively implemented across ICBs and setting out the consequences of inaction. (Conclusion, Paragraph 17)

4. If the Modern Service Framework is to deliver meaningful change it must be more than a well-intentioned ambition. ICBs and the Department need to be held accountable for meeting the Framework, with clear consequences if its standards are not met. We call on the Government to set out, in its interim Report this Spring, what accountability arrangements will be in place to support implementation of the MSF and what concrete steps the

Department will take with ICBs that fall short. The Government must also ensure that ICBs have the support, tools and resources they need to deliver on the MSF. (Recommendation, Paragraph 18)

Commissioning

5. We are concerned that the Minister was unable to commit to providing clear and specific standards and guidance for babies, children and young people's palliative and end of life care in the Modern Service Framework (MSF). We strongly recommend that the Department includes specific standards within the MSF for the provision of children and young people's palliative care services, and for the transition between child and adult services. Pan-ICB commissioning guidance should contain specific information on how to commission these services effectively. (Recommendation, Paragraph 26)

6. It is unacceptable that access to 24/7 palliative and end of life care services remains patchy throughout England. Individuals nearing the end of life should be able to access the right care, advice and medication, wherever they are and regardless of the time of day. We are pleased that the Minister committed to 100% telephone line coverage in England by 2027, but this is not enough. While telephone advice lines provide support and may prevent unnecessary hospital admissions, they are insufficient to build a resilient and effective out of hours palliative care service on their own. (Conclusion, Paragraph 35)

7. We recommend that the MSF includes specific guidelines and requirements for ICBs to enable access to 24/7 PEoLC services, including access to symptomatic medication, and in-person care where necessary. We call on the Government to provide an assessment of both the workforce needed to deliver such a service and the potential savings to the wider health and care service that such an offer would deliver. (Recommendation, Paragraph 36)

8. The role of social care in the provision of palliative and end of life care has been overlooked for far too long, and we are concerned that the Government's plans to remove local authorities from ICBs will only make the current situation worse, particularly in the context of the Government's aim to shift care into the community. We urge the Government to reconsider its decision to remove, through legislation, local authority representation on ICBs, to ensure social care is represented, understood and appropriately commissioned to deliver end of life care. (Recommendation, Paragraph 41)

Data

9. We support increasing use of the Palliative Care Register for early identification of individuals, including children and young people with PEoLC needs. However, we are concerned that its use is likely to decrease given the removal of funding incentives for primary care practitioners to add patients to the Register. (Conclusion, Paragraph 45)

10. We recommend that the Department implement the 90% target for the percentage of individuals in the last year of life documented on the Palliative Care Register and that it reports annually on progress against this target to monitor the impact of its decision to remove the financial incentive to add patients to the Register. (Recommendation, Paragraph 46)

11. National palliative and end of life care data provide valuable insight into patterns of healthcare use and location of death, however the evidence presented demonstrates substantial gaps in local data collection and utilisation. Without consistent, granular and timely data, ICBs and providers cannot reliably commission, plan, or improve palliative and end of life services in line with their population needs. (Conclusion, Paragraph 51)

12. We urge the department to mandate ICBs to maintain a fully populated palliative and end of life care dashboard that is actively used for commissioning, service planning, quality improvement, and inequality monitoring across their local system. (Recommendation, Paragraph 52)

13. Poor data sharing and lack of integration across NHS, social care, voluntary and private providers creates confusion, delays and gaps in continuity for people at the end of life, frequently placing the burden of coordination care on patients and carers during what is an extremely emotional and challenging period. Despite existing systems for data sharing, inconsistent uptake, poor interoperability and limited outcome-level information reduce effectiveness. (Conclusion, Paragraph 55)

14. If the Government intends for the introduction of the Single Patient Record to address concerns about a lack of service integration for palliative and end of life care, then this record must be available to all providers—including social care, the voluntary sector and private providers. The Government should also set out in its response to this Report how it will use the introduction of the Single Patient Record to drive integration across different types of providers. (Recommendation, Paragraph 56)

Workforce

15. Generalist staff, who provide most end of life care, often lack the skills, confidence and specialist support required to deliver high-quality, person-centred care. Despite existing initiatives, a clearer, system-wide approach to upskilling the generalist workforce is urgently needed. (Conclusion, Paragraph 63)

16. We recommend that end of life care be included as a core skill for the generalist health and social care workforce, with a clear and defined set of competencies required to deliver high-quality and person-centred palliative and end of life care. This should be reflected in the forthcoming 10 Year Workforce Plan. In particular, the critical role that social care staff play in delivering palliative care should be acknowledged in the Plan, and reflected in the training and support social care staff receive to enable them to provide this care in a more systematic way. While we welcome the Qualification in Specialism Standard for Palliative and End-of-Life Care, we ask the Department to provide further information in its response to this Report on who will be required to complete this training and when it will become available. (Recommendation, Paragraph 64)

17. Current shortages in the specialist workforce are putting palliative care services in an unsustainable position which threatens their ability to deliver equitable and high-quality palliative and end of life care. Extensive consultant vacancies, impending retirements, limited training places and widespread nursing shortages all contribute to an inability to meet demand, with particular staff shortages experienced in children and young people's palliative care. This is an unacceptable situation, and urgent action is needed address these shortages. (Conclusion, Paragraph 68)

18. The Government need to publish an evidence-based plan, supported by up-to-date workforce modelling, setting out how it will increase the capacity and sustainability of all sectors of the specialist palliative and end of life care workforce, as part of the 10 Year Workforce Plan. This should include plans for clear training pathways and a specific target for the staffing of children and young people's palliative care. (Recommendation, Paragraph 69)

Bereavement

19. Bereavement, and pre-bereavement support are essential, yet access remains patchy, poorly commissioned, and often difficult to navigate. Despite its inclusion in the current Ambition Framework, significant gaps persist, particularly for culturally diverse communities and children and young people. (Conclusion, Paragraph 75)

20. The Government must hold ICBs to account for delivering bereavement services. This does not need to wait for the forthcoming Modern Service Framework as there are already clearly defined expectations for what ICBs should deliver in this area. In its response to this Report, we ask that the Department sets out how it will monitor ICBs' current delivery of bereavement services, and what steps will be taken with ICBs that do not deliver an acceptable level of service. (Recommendation, Paragraph 76)

Hospices

21. Hospices form an integral part of palliative and end of life care provision at home and in the community and we welcome the fact that the Government intends for them to play a bigger role as part of its shift to neighbourhood health. However, if the Government want hospices to deliver a universal and equitable service, this must be matched with additional resources. We were unconvinced by the Government's argument that this will be addressed simply by improving the data that ICBs have access to. (Conclusion, Paragraph 83)

22. We recommend that the Government moves towards sustainable and predictable models of funding for hospices, financing their running as well as investment costs, which reflects the increasingly central role they will play in delivering end of life care. This funding should be accompanied by conditions that require hospices to play a greater role in actively addressing inequalities in access to their services. (Recommendation, Paragraph 84)

Formal minutes

Tuesday 17 March 2026

Members present:

Layla Moran, in the Chair

Danny Beales

Jen Craft

Josh Fenton-Glynn

Alex McIntyre

Greg Stafford

Palliative Care

Palliative Care Draft Report (*Palliative Care*), proposed by the Chair, brought up and read.

Ordered, That the draft Report by read a second time, paragraph by paragraph.

Paragraph 1 to 84 agreed to.

Summary agreed to.

Resolved, That the Report be the Sixth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available (Standing Order No. 134).

Adjournment

Adjourned till Wednesday 18 March at 9.15 am.

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Wednesday 7 January 2026

Stephen Kinnock MP, Minster of State, Department of Health and Social Care; **Dr Edward Scully**, Director for Primary and Community Health Care, Department of Health and Social Care; **Dr Amanda Doyle OBE**, National Director for Primary Care and Community Services, NHS England; **Dr Sarah Mitchell**, National Clinical Director for Palliative and End-of Life Care, NHS England Q1–122

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

PLC numbers are generated by the evidence processing system and so may not be complete.

1	Anderson, Dr Anna-Karenia (Consultant in Paediatric Palliative Medicine and Medical Director, Shooting Star Children' Hospice and Royal Marsden Hosptial)	PLC0002
2	Anglia Ruskin University	PLC0049
3	Association for Paediatric Palliative Medicine	PLC0001
4	Association for Palliative Medicine of Great Britain and Ireland	PLC0027
5	Association of Ambulance Chief Executives	PLC0005
6	Association of Palliative Care Social Workers	PLC0031
7	British Geriatrics Society	PLC0020
8	Care Rights UK	PLC0028
9	Cicely Saunders Institute	PLC0026
10	Cicely Saunders Institute of Palliative Care, Policy and Rehabilitation, Florence Nightingale Faculty of Nursing, Midwifery & Palliative Care, King's College London	PLC0023
11	Community Hospitals Association	PLC0016
12	Compassion in Dying	PLC0043
13	Dean, Dr John (Clinical vice president, Royal College of Physicians)	PLC0033
14	Dementia UK	PLC0024
15	Department for Health and Social Care	PLC0044
16	Edmonds, Dr Polly (Consultant in Palliative Medicine, King's College Hospital NHS Foundation Trust); and Dr Fiona Wiseman (Consultant in Palliative Medicine, Northamptonshire Healthcare Foundation Trust)	PLC0003
17	End of Life Doula UK	PLC0018
18	Gold Standards Framework Centre	PLC0036

19	Healthwatch England	PLC0029
20	Hospice UK	PLC0039
21	Institute for Medieval Studies, University of Leeds; Institute for Medieval Studies, University of Leeds; Institute for Medieval Studies, University of Leeds; Institute for Medieval Studies, University of Leeds; Institute for Medieval Studies, University of Leeds; and Institute for Medieval Studies, University of Leeds	PLC0010
22	Local Government Association	PLC0014
23	Marie Curie	PLC0032
24	Mountbatten Hospice Group	PLC0012
25	NHS Benchmarking Network	PLC0021
26	NHS Norfolk and Waveney Integrated Care Board	PLC0022
27	NHS North East London ICB	PLC0008
28	NHS Surrey Heartlands ICB	PLC0007
29	NIHR Policy Research Unit in Healthy Ageing	PLC0013
30	National Bereavement Alliance	PLC0040
31	Northamptonshire ICB	PLC0015
32	Palliative and End of Life Care research group, Department of Public Health and Primary Care, University of Cambridge	PLC0006
33	Preston, Professor Nancy (Professor of Supportive and Palliative Care , Lancaster University)	PLC0004
34	Price, Marie (Co-Chair, Association of Palliative Care Social Workers)	PLC0048
35	RAND Europe	PLC0047
36	Rainbow Trust Children's Charity	PLC0041
37	Royal College of General Practitioners	PLC0038
38	Sam, Professor Emeritus (Professor Emeritus, University o Sheffield)	PLC0034
39	Sue Ryder	PLC0042
40	Together for Short Lives	PLC0025
41	University of Bristol; and South West of England End of Life Matters Health Integration Team (HIT)	PLC0030
42	University of Leeds	PLC0019
43	Walshe, Professor Catherine (Professor of Palliative Care, Lancaster University)	PLC0009

44	West Yorkshire Integrated Care Board	PLC0017
45	Wolfson Palliative Care Research Centre	PLC0046
46	Woodthorpe, Dr Kate (Reader in Sociology, University of Bath)	PLC0011

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

Session 2024–26

Number	Title	Reference
7th	Community Mental Health Services: Commentary on the Government Response to the Committee's Fourth Report of the Session 2024–26	HC 1769
5th	First 1000 days: a renewed focus	HC 802
4th	Community Mental Health Services	HC 566
3rd	Black Maternal Health	HC 895
2nd	Adult Social Care Reform: the cost of inaction	HC 368
1st	Appointment of the Chair of NHS England	HC 743
4th Special	Evaluation of Palliative care in England: Government Response	HC 1722
3rd Special	Expert Panel: Evaluation of Palliative care in England	HC 632
2nd Special	Expert Panel: Evaluation on meeting patient safety recommendations: Government Response	HC 617
1st Special	Pharmacy: Government Response	HC 602