National Audit Office

REPORT

The financial sustainability of England's adult hospice sector

Department of Health & Social Care

SESSION 2024–2026
29 OCTOBER 2025
HC 1378

What this report is about

1 Independent hospices are charities that provide palliative and end-of-life care to local communities across the UK. They are key partners in the local and national health and care systems, led by the NHS, that provide such care. Most palliative and end-of-life care provided by hospices is now delivered in people's own homes, with hospices often working as part of a multidisciplinary approach or in partnership with NHS services, while the amount of inpatient care in hospice buildings is decreasing.

2 Palliative care aims to improve the quality of life of patients and their families who are facing problems associated with life-limiting illness. Palliative care prevents and relieves suffering through the early identification, assessment and treatment of pain and other symptoms, whether physical, mental, emotional, social or spiritual. Specialist palliative care (clinical care for patients who have complex symptoms, requiring care from medical specialists with the requisite training and qualifications) can be distinguished from generalist palliative care, although the distinction at the individual level is not always clear and a patient's care needs may change between the two over the course of their illness. End-of-life care is defined as care provided to people in the last year of life, and as such overlaps with palliative care.

3 The Health and Care Act 2022 set out the requirement for Integrated Care Boards (ICBs) to commission palliative and end-of-life care to meet the needs of each ICB's local population.[1] The Act followed two decades of the NHS developing its approach to palliative and end-of-life care since it launched its first national end-of-life care programme in 2004 and published its first national strategy in 2008. The Health and Social Care Act 2012 established Clinical Commissioning Groups (replaced by ICBs in 2022) and their duty to assess local population needs and provide health services accordingly, including palliative and end-of-life care.

4 ICBs commission palliative and end-of-life care from a range of NHS and non-NHS providers, including NHS Trusts, independent hospices, voluntary sector organisations, community organisations, primary care networks and local authorities. The proportions of palliative and end-of-life care provided by these different types of provider vary by locality across England.

1 Integrated Care Boards (ICBs) are NHS organisations responsible for planning health services for their local populations. There is one ICB in each of the 42 Integrated Care System areas across England. ICBs manage the NHS budget and work with local providers of NHS services, such as hospitals and GP practices, to agree a joint five-year plan which says how the NHS will contribute to each area's integrated care strategy.

5 While the range of services offered by individual hospices varies, the overall range of services offered by the independent adult hospice sector, and the nature of some of those services, broadly distinguishes the sector from other types of provider. Independent hospices seek to improve patients' quality of life in ways that go beyond the provision of high-quality palliative and end-of-life care, for example through being located in pleasant environments or within attractive buildings. They offer additional services that are typically outside the remit of the NHS, for example certain complementary therapies. Hospices also place emphasis on supporting the family, friends and carers of those receiving palliative and end-of-life care, for example through counselling and bereavement support. Additionally, many hospices provide training in palliative and end-of-life care to a broad range of healthcare professionals, including to the NHS, and some hospices undertake clinical research.

6 Charitable donations, fund-raising, legacies and retail activity generate most of the income spent on the care provided by independent adult hospices. Government funding, including from ICBs, forms the second largest source of funding for hospices, around 29% of the sector's total funding in 2023-24. ICBs fund independent adult hospices in two main ways. They provide general financial support for hospices' provision of palliative and end-of-life care through grant funding, and they commission and fund services through contracts. As in the NHS, hospices in England provide care to patients free of charge.

7 There are currently 135 independent adult hospice charities in England that serve local communities, each typically operating from a single hospice location. There are two national charities, Marie Curie and Sue Ryder, which provide the same range of palliative and end-of-life care services as local independent adult hospices and operate hospices at locations across England (five and seven, respectively). Together, these comprise the independent adult hospice sector. In 2023-24, the independent adult hospice sector provided around 251,000 people with palliative and end-of-life care, including approximately 1,227,000 community visits and support to around 69,000 family members, friends and carers of patients. All independent hospice charities across the UK, including Marie Curie and Sue Ryder, are members of the umbrella organisation Hospice UK, which supports the sector and advocates on its behalf.

Our scope

8 We decided to investigate the financial sustainability of independent adult hospices following reports in the media and parliamentary interest in financial pressures and service reductions across the sector. Although the Department of Health & Social Care (DHSC) and NHS England have no statutory responsibility in relation to independent hospices, the central role that hospices fulfil within the statutory provision of palliative and end-of-life care means that hospices' financial sustainability matters to DHSC and the NHS greatly. This report examines the independent adult hospice sector in England, with a focus on:

- the distribution of hospices across England;
- trends in hospices' funding, spend and delivery of services; and
- financial challenges across the sector.

9 We decided to examine adult hospices and not include hospices dedicated to supporting children only. While there are strong similarities between the two types of hospice, and some of the issues we examine are common to both, they differ in how they are funded and in the demographic pressures they face. Some hospices provide services to both children and adults (12 in 2023-24); we could not isolate the adult-only data for these hospices so, rather than exclude them from our analyses we included data that relates to their activity caring for both children and adults.

10 We conducted our fieldwork from March to August 2025. We reviewed relevant public documents and documentation provided by DHSC, NHS England and Hospice UK. We interviewed officials from DHSC, NHS England and ICBs, as well as representatives from Hospice UK and the independent adult hospice sector. We analysed data provided by DHSC, NHS England and Hospice UK. Our audit approach is described in Appendix One.

Summary

Key findings

Demand for palliative and end-of-life care

11 Demand for adult palliative and end-of-life care is projected to rise in coming years. The number and proportion of older people in England's population are rising and are projected to continue to do so, leading to more older people living with multiple comorbidities. The number of deaths per year in England has been increasing since around 2012 and this is also projected to continue. In 2023, around 544,000 deaths were registered in England, projected to rise by around 21% to 658,000 by 2044. Recent surveys have found that some people die in acute and community hospitals who might have benefitted from improved access to palliative and end-of-life care (paragraphs 1.4 to 1.6).

12 Demand for palliative and end-of-life care in community settings is increasing. In 2024, 5% of people who died in England did so in a hospice inpatient unit, 28% died at home and 21% in a care home, while 42% died in hospital. Over recent years, the proportion of people dying in hospital has been decreasing, while the proportion dying at home has been increasing. A 2017 study of people receiving palliative care indicated that most would prefer to die at home, a hospice was the second most popular setting, while hospital was the least preferred setting. Palliative and end-of-life care delivered at home has been shown to reduce healthcare costs and improve patients' quality of life at the end of their lives, compared with hospital-based palliative care (paragraphs 1.7 to 1.9).

13 The distribution of independent adult hospices varies across England and by ICB area. The number of independent adult hospices in ICB areas varies between one and 13. This variation reflects the unplanned way the independent adult hospice sector has developed since the 1960s, as local charities outside of the NHS. In 2023-24, there was on average one inpatient bed provided by independent adult hospices per 5,675 people aged 65 or older in England, varying by ICB area between one bed per 2,900 and one bed per 54,300. The range of services that individual hospices offer also varies. Examples of services provided include complementary services not available through the NHS, through to highly complex specialist palliative care (paragraphs 1.2, 1.3 and 1.17).

Hospice income and spend

14 Most of the independent adult hospice sector's income is generated from charitable sources. In 2023-24, around two-thirds of the independent adult hospice sector's total income was generated from charitable sources, principally retail activity, donations and legacies, and around 29% of total income – or approximately £420 million – was government funding, primarily from ICBs. Nine independent adult hospices received over half their income from government funding, while four hospices received no government funding at all. The remaining income was generated from less significant sources, for example, from investments (paragraphs 2.2 to 2.4).

15 Since 2020, independent adult hospices have received several specific financial payments from central government to support the sector's financial position. Over 2020-21 and 2021-22 during the COVID-19 pandemic, NHS England provided the independent adult hospice sector with £384 million in three waves to secure and provide extra capacity for the NHS, including inpatient and hospice-at-home beds. Hospices also received emergency funding in recognition that lockdowns caused retail activity to cease and fund-raising events to be cancelled. In December 2024, DHSC announced a £100 million one-off capital fund over 2024-25 and 2025-26 for adult and children's hospices, in recognition of the financial pressures in the sector and hospices' reliance on charitable funds for capital spend. DHSC intends for the capital funding to ensure hospices do not need to reduce services because of the deterioration of physical facilities (paragraphs 2.5 to 2.9).

16 The independent adult hospice sector's total income increased yearly up to 2021-22 but has since been declining. Total income for all England's independent adult hospices, comprising funding from all sources, increased in real terms (2023-24 prices) from £1.38 billion in 2014-15 to £1.52 billion in 2019-20. Specific government funding to hospices during the COVID-19 pandemic to secure NHS provision of services resulted in total income in 2023-24 prices of £1.62 billion in 2021-22. In the subsequent two financial years, total income fell in real terms, in part because inflation rose more steeply than total income in cash terms. The independent adult hospice sector generated a similar level of income in real terms in 2023-24 as in 2017-18, around £1.47 billion in 2023-24 prices (paragraphs 2.6 and 2.10).

17 Government funding accounted for just over 40% of the independent adult hospice sector's service delivery spend in 2023-24. Around two-thirds of the sector's spend is on service delivery and around one-third is on fund-raising and retail activities, such as conducting fund-raising events, running charity shops and organising lotteries. Total spend rose year on year in real terms from 2014-15 to 2019-20, fell in 2020-21 at the start of the peak COVID-19 period, but from 2021-22 has again been increasing. By 2023-24, the sector's total spend was £1.55 billion, the highest yearly amount to date. The increase reflects the effects of high inflation on hospices' costs and increases in employers' wage costs. The increase in employer National Insurance contributions from April 2025 will have increased hospices' service delivery and fund-raising costs further. Since 2014-15, excluding additional COVID-19 funding, the proportion of the sector's service delivery spend accounted for by government funding remained consistently between around 38% and 44%. Most recently, in 2023-24, government funding (£420 million) equated to 40.1% of service delivery spend (paragraphs 2.11 to 2.13).

NHS commissioning and oversight of palliative and end-of-life care

18 Most ICBs commission some palliative and end-of-life care from hospices through contracts, but many also support hospices financially – in part, or in some cases only – through grants. NHS England advises that commissioners use the NHS standard contract for all contracts for healthcare services other than primary care. The Health and Care Act 2022 set out the legal duty on ICBs to commission palliative care services that meet their populations' needs. In 2022, 35 out of the 42 ICBs across England were using the NHS standard contract for commissioning some or all of the care from hospices they fund, of which 19 were also providing hospices with funding through grants. The remaining seven ICBs were exclusively using grants (paragraphs 1.11 and 1.14).

19 Funding hospices through grants makes it harder for ICBs to take a system-wide commissioning approach to the provision of palliative and end-of-life care for their populations. ICBs conduct health needs assessments to better understand what care their local populations require and what care they, therefore, need to commission. However, hospices that are funded through grants are not obliged to report to ICBs against that funding**.** ICBs cannot therefore easily assess what care is provided for the funding they give to hospices as grants. Some ICBs want DHSC to set unit prices for commissioning palliative and end-of-life care, to help them commission care equitably and fairly across different providers (paragraphs 1.11, 1.14 and 1.16).

20 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, and therefore how reliant they are on the sector. ICBs know how much funding they give to independent hospices through grants and contracts, but they cannot identify their spend on palliative and end-of-life care provided in NHS settings, including 23 NHS hospices, as such spend is subsumed within broader healthcare spending totals. Consequently, DHSC and NHS England do not know the total amount the NHS spends on palliative and end-of-life care, nor the proportion provided by the independent adult hospice sector. ICBs do not collect information on independent hospices' spend, as that is outside of their remit and statutory responsibility, and their collection of data on hospices' patient-level activity is limited and variable, largely determined by the nature of the funding relationship between each hospice and ICB. Hospice UK, however, do collate and analyse activity data from the sector (paragraphs 1.10, 1.12 and 1.17).

The independent adult hospice sector's financial resilience

21 Nearly two-thirds of independent adult hospices recorded a deficit in 2023-24, by far the highest proportion over the preceding ten years. In 2023-24, the independent adult hospice sector, including Marie Curie and Sue Ryder, overall spent around £78 million more than they generated in income. During the time period analysed, 2023-24 was the first year when total spend exceeded total income by more than £10 million in real terms. Between 2014-15 and 2019-20, the proportion of hospices reporting deficits per year fluctuated between around 39% and 49%, before decreasing sharply in 2020-21 to 7% as the sector's financial situation improved during the peak COVID-19 period. By 2022-23, the proportion of hospices reporting a deficit had returned to pre-pandemic levels, before increasing substantially in 2023-24 to 64%, the highest proportion across the period examined (paragraphs 3.2 and 3.3).

22 Across the sector as a whole, independent adult hospices boosted their levels of reserves during the peak COVID-19 period, but since then levels have reduced. Hospices hold available reserves for contingency, helping them to manage unexpected costs and fund shortfalls in income without compromising service delivery. Individual hospices have different risk appetites and aim to hold different levels of reserves. Levels of reserves across the independent adult hospice sector remained similar over the period 2014-15 to 2019-20, when between 57% and 62% of hospices had available reserves equating to six months or more of their average spend. Most independent adult hospices increased their levels of reserves during the peak COVID-19 period, when they typically generated surpluses, with 88% holding available reserves equating to six months or more of their average spend by 2021-22. In subsequent years, however, hospices' levels of reserves reduced overall, and by 2023-24 the proportion with over six months' worth of available reserves had dropped to 73% (paragraphs 3.4 to 3.5).

23 Since the peak COVID-19 period, the rate of return that hospices have achieved from their spend on fund-raising has declined. From 2014-15 to 2018-19, the independent adult hospice sector's overall rate of return from spend on fund-raising was consistently between £2.07 and £2.15 for every £1 spent. Since 2021-22, however, there has been a decline in the overall rate of return, decreasing to £1.96 for every £1 spent in 2023-24. This is the first time, excluding during the peak COVID-19 period, that the rate of return has dropped below £2 for every £1 spent. The decline in fund-raising rate of return reflects the reduced profitability of fund-raising activities, such as retail, and a reduction in the public's charitable giving (paragraphs 3.6 and 3.7).

24 Some hospices have recently reduced the volume or range of services they provide and others are planning to do so. In 2024-25, 11 independent adult hospices in England reported service reductions or staff redundancies, and other hospices announced plans to reduce services, in response to reduced income or increased costs. Cuts appear to be across all types of services offered by hospices. Most hospices reported the increase in the costs of service delivery within the palliative and end-of-life care sector as being the primary reason for service reductions. At the end of 2024, around 300 inpatient beds were reported deregistered or withdrawn from operation, although some of this reduction may represent a shift to more people receiving palliative and end-of-life care in their homes. Six hospices have been designated by ICBs as 'commissioner requested services', a mechanism to forewarn ICBs of potential difficulties with services that, should they discontinue, would have significant negative impact on the local population (paragraphs 3.8 and 3.9).

25 Hospices within ICB areas are increasingly working in partnership in collaboratives. Collaboratives enable groups of hospices to engage with their ICB with a single voice. They offer the opportunity for hospices to plan provision collectively and share financial risks. There are currently seven fairly well established collaboratives and five that are established but at early stages of development. Other groups of hospices are considering forming collaboratives (paragraphs 3.10 and 3.11).

Concluding remarks

26 The advent and spread of independent hospices from the end of the 1960s resulted in an uneven distribution of hospices across the country, but helped to improve understanding of the importance of palliative and end-of-life care. Over time, recognition of the importance of palliative and end-of-life care by DHSC and the NHS has improved, culminating in the specific inclusion of the requirement for ICBs to commission palliative and end-of-life care to meet their populations' needs in the Health and Care Act 2022.

27 NHS commissioning of palliative and end-of-life care from hospices has not yet fully moved on from its historic use of grants to commissioning through contracts, meaning it is not always clear what services are being commissioned or whether local demand is being met. Equally, NHS commissioners are unable to fully understand how the funding they provide to hospices is being used to support patients and their families. Standardising the commissioning and funding of palliative and end-of-life care from hospices across all ICBs would go some way to help with this. To ensure equity of choice of care for people at the end of their lives across England, ICBs need, with guidance from DHSC and NHS England, to understand what services they require and how best to use the funding they already spend on care for these people. With the number of people in England who die each year increasing, and the key positioning of high-quality palliative and end-of-life care in the assisted dying debate, the sustainability of the independent adult hospice sector is of national importance.