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

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National Audit Office

# The financial sustainability of England's adult hospice sector

## Department of Health & Social Care

**Report by the Comptroller and Auditor General**

Ordered by the House of Commons
to be printed on 27 October 2025

This report has been prepared under Section 6 of the National Audit Act 1983 for presentation to the House of Commons in accordance with Section 9 of the Act

**Gareth Davies**
**Comptroller and Auditor General**
**National Audit Office**

**21 October 2025**

HC 1378 | £10.00

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**016915 10/25 NAO**

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# 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.

# Part One

## Provision of palliative and end-of-life care

**1.1** This part of the report describes:

- the distribution of adult hospices across England;
- current and projected demand for palliative and end-of-life care;
- palliative and end-of-life care delivery; and
- NHS commissioning of palliative and end-of-life care.

### Introduction

**1.2** England's first hospices were created in the 1890s, providing homes and straightforward care for dying people. It was, however, in the 1960s that the modern hospice movement developed, spearheaded by Dame Cicely Saunders. She introduced a focus on pain and symptom relief, and a shift in philosophy to enhancing quality of life for people approaching the end of their life, through considering their individual needs and wishes. The first modern hospice, St Christopher's in south-east London, opened in 1967, set up as a charity independent of the NHS. Over the following decades, similar independent hospices were set up, unsystematically, across England, where communities identified a local need for palliative and end-of-life care and were able to raise funds, for example through donations and charity shops.

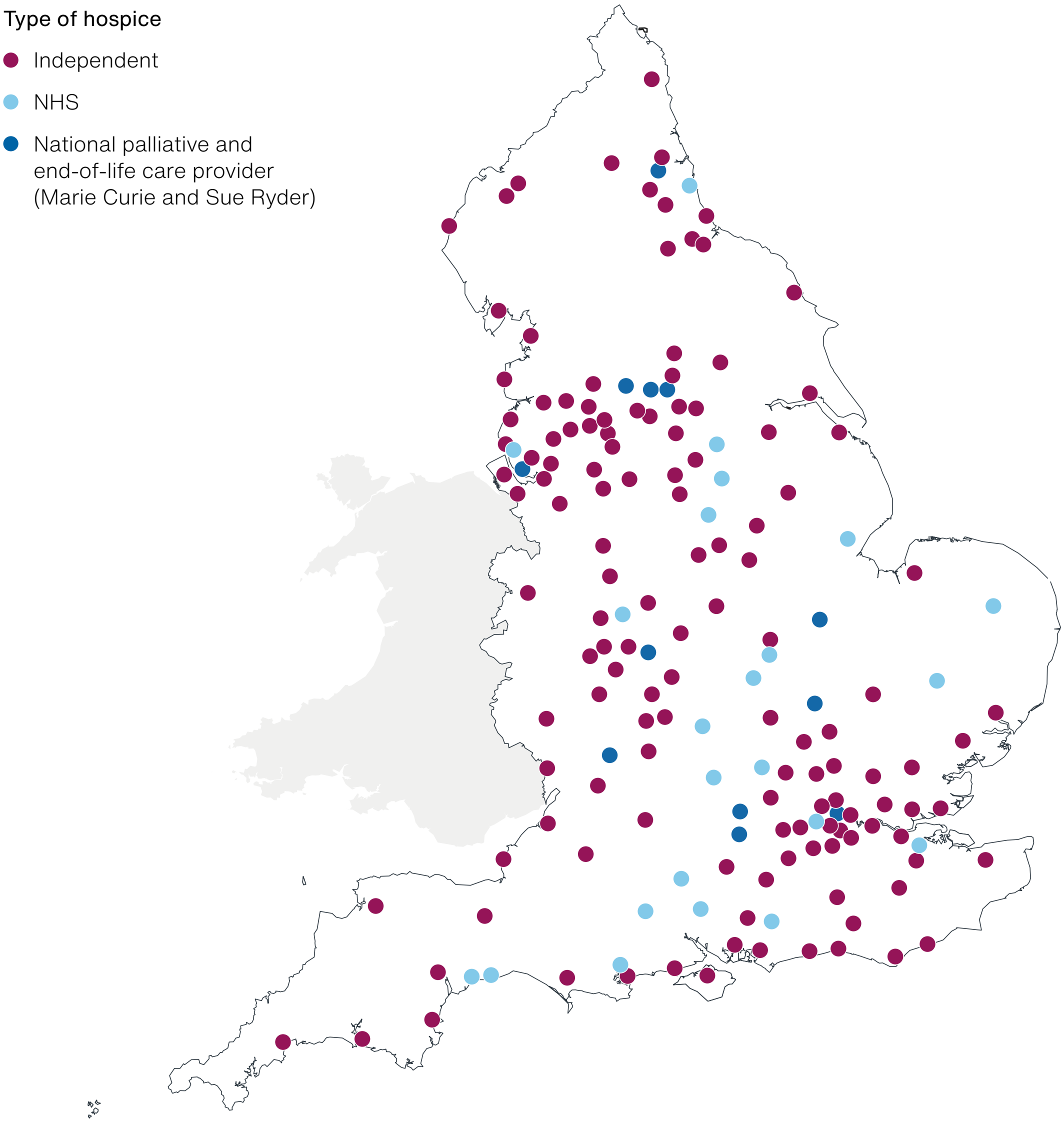
### Distribution of adult hospices across England

**1.3** Access to care provided by independent adult hospices varies across England, reflecting the unplanned way the sector developed (**Figure 1** overleaf). The number of independent adult hospices in Integrated Care Board (ICB) areas, including those run by the national palliative and end-of-life care providers Marie Curie and Sue Ryder, varies between one and 13, although some hospices operate across ICB boundaries. There is substantial variation in the number of people aged 65 or older per independent adult hospice in ICB areas across England (**Figure 2** on page 15). The range of services individual hospices offer also varies, and may include additional complementary services that would not be available through the NHS, as well as highly complex specialist palliative care. There is NHS provision of palliative and end-of-life care in all ICB areas, which includes 23 NHS hospices.

## Figure 1

Distribution of independent adult hospices and NHS hospices across England, 2023-24

**There are areas of England with lower availability of palliative and end-of-life care for adults specifically provided by independent or NHS hospices**




Notes

1 Markers represent the location of each hospice's registered address, although some hospices may operate across multiple sites. Hospices deliver services across local communities, for example through hospice-at-home or community services, and most provide inpatient care at their registered address.

2 With regard to NHS provision of palliative and end-of-life care, the map only shows NHS hospice locations. The NHS provides palliative and end-of-life care services in all other settings, including acute and community hospitals, care homes and people's own homes.

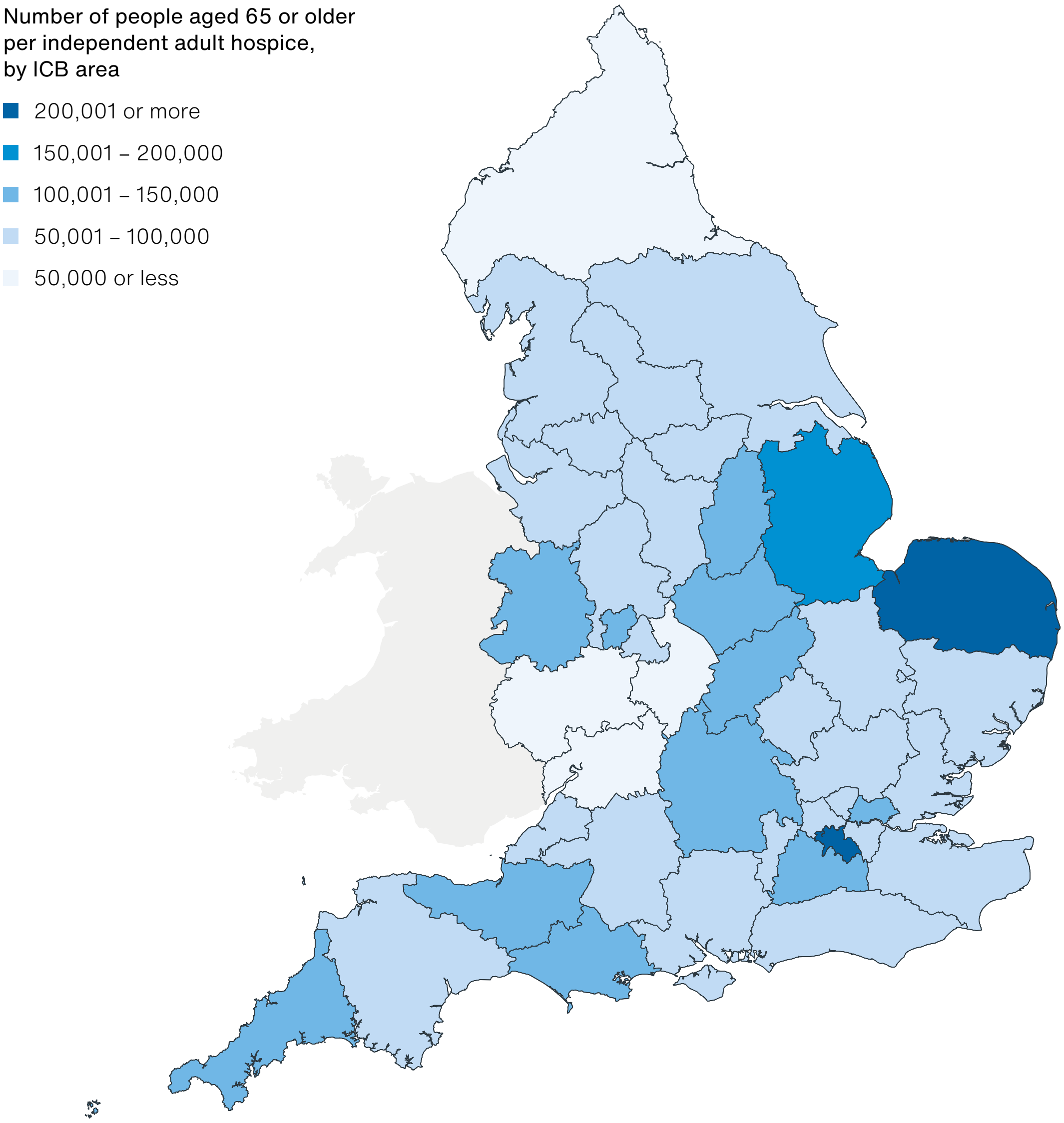
3 We have adjusted some hospice locations by up to several millimetres to prevent overlaps and improve clarity. Therefore, this map shows approximate and not exact locations of hospices.

Sources: National Audit Office analysis of Hospice UK data. Map boundaries from the Office for National Statistics licensed under the Open Government License v3.0. Contains OS data © Crown copyright and database right 2024

## Figure 2

Number of people aged 65 or older per independent adult hospice by Integrated Care Board (ICB) area in England, 2023-24

**The number of people aged 65 or older per independent adult hospice in ICB areas across England varies between around 29,000 and 260,000**




**Notes**

1 Population data are sourced from the Office for National Statistics' mid-2022 population and demographic estimates for England and Wales, and includes people aged 65 or older.

2 Data on the number of independent adult hospices per ICB area are from 2023-24. Data include the 12 sites operated by the national palliative and end-of-life care providers, Marie Curie and Sue Ryder.

3 The lowest value for an ICB area is 28,608 people aged 65 or older per independent adult hospice, and the highest value for an ICB area is 260,913 people.

Sources: National Audit Office analysis of Hospice UK data. Map boundaries from the Office for National Statistics licensed under the Open Government License v3.0. Contains OS data © Crown copyright and database right 2024

## Demand for palliative and end-of-life care

**1.4** Demand for adult palliative and end-of-life care is forecast to rise in the coming years, driven by long-term demographic trends.

- The number and proportion of older people in England's population are increasing, with a consequent increase in the number of older people living with multiple comorbidities. The Office for National Statistics (ONS) projects that 8.0 million people living in England will be aged 75 or older by 2044, equating to 12.5% of the population. This compares with 5.5 million people (9.3% of the population) in 2024, suggesting a 47% increase over the 20-year period.
- The number of deaths each year in England is increasing, due to an aging and growing population. Before 2012, the long-term trend had been of decreasing numbers of deaths, but around 2012 the trend reversed (**Figure 3**). In 2023, around 544,000 deaths were registered in England. The ONS projects that the number of deaths each year will rise to around 658,000 by 2044**,** a 21% increase from 2023.

**1.5** Some people die in acute and community hospitals who may have benefitted from improved access to specialist palliative care. The National Audit of Care at the End of Life 2024 found that while 97% of hospitals have access to specialist palliative care services, only 61% of these have access to a face-to-face specialist palliative care service eight hours a day for seven days a week.[2] The proportion of dying people reviewed by a member of a specialist palliative or end-of-life care team during their final hospital admission increased from 47% in 2022 to 55% in 2024.

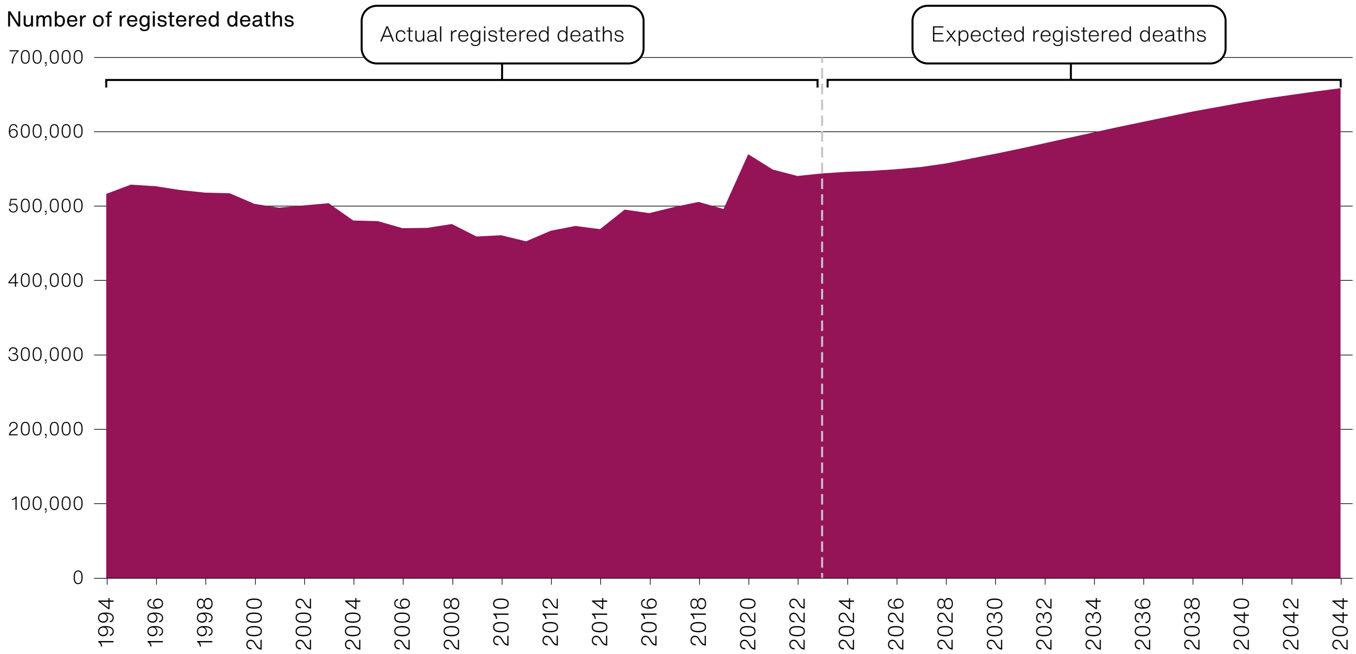
**1.6** Academic analysis funded by Marie Curie of data from 2023, which focused on families across England and Wales who had recently experienced the death of a family member, found that only around half of respondents said that healthcare professionals provided them and the person who died with as much help as was needed in the last three months of life.[3] Almost 30% of respondents reported that no discussions about the possibility of their family member dying had taken place between healthcare professionals and themselves, other family members or friends.

2 Healthcare Quality Improvement Partnership, National Audit of Care at the End of Life, *2024 State of the Nations Report*, August 2025 (viewed on 17 October 2025).

3 T Johansson and others, King's College London, Cicely Saunders Institute; Hull York Medical School at the University of Hull; and University of Cambridge, UK, *Time to care: Findings from a nationally representative survey of experiences at the end of life in England and Wales*. Research report, London (UK): Marie Curie, September 2024 (viewed on 17 October 2025).

**Figure 3**
Actual and expected deaths per year in England, 1994 to 2044

**The number of deaths per year in England is expected to increase by more than 100,000 over the next two decades**




**Note**

1 Figure shows actual registered deaths per year from 1994 to 2023 and expected deaths per year from 2024 to 2044.

Source: National Audit Office analysis of Office for National Statistics data

## Palliative and end-of-life care delivery

**1.7** Palliative and end-of-life care is delivered across a range of settings and by a wide range of professionals, usually through a multidisciplinary approach. Palliative and end-of-life care, including specialist palliative care, is delivered by both NHS providers and independent hospices, with what is delivered and by whom depending on the range of providers, and the services they offer, locally available for ICBs to commission from. Generalist palliative care is provided in many NHS settings – for example primary care, community care and acute care, often by medical staff who do not specialise in palliative and end-of-life care – as well as by independent hospices and the national palliative and end-of-life care providers Marie Curie and Sue Ryder. Specialist palliative care in the NHS is typically delivered in acute and community hospitals by dedicated teams, and in people's homes by district nurses. Independent hospices provide generalist and specialist palliative and end-of-life care through inpatient care, outpatient and day care, and community visits, including 'hospice at home' support in people's homes.

**1.8** In England, care in community settings now accounts for most of independent adult hospices' service activity. Hospice UK reported that in 2023-24, 17% of total service activity was delivered in inpatient units and 55% was delivered in patients' homes. The Nuffield Trust reported that in 2024, 5% of people who died in England did so in a hospice inpatient unit, 28% at home, 21% in a care home, and 42% in hospital.[4] Data published by the Department of Health & Social Care (DHSC) show that in England the proportion of people dying in hospital has been decreasing, from 47% in 2014 to 43% in 2023, while the proportion dying at home has been increasing, from 23% in 2014 to 28% in 2023.[5]

**1.9** A longitudinal study published in 2017 of a sample of people receiving palliative care in England, Ireland and the USA found that over 50% expressed a preference for care at home, with hospices the second most popular choice, and hospitals the least preferred setting.[6] However, the study found a mismatch between preferences and actual place of care, with only 25% of people who preferred home or a hospice receiving care in their preferred setting. An economic modelling study examining home-based and hospital-based palliative care in England found that specialist palliative care reduces adults' hospital bed days, deaths in hospital and healthcare costs, as well as improving quality of life – more so if the care is delivered at home.[7]

**1.10** There are 23 NHS hospices across England, which are NHS-funded palliative and end-of-life care units within NHS trusts. All NHS hospices have charitable arms to raise additional funds, and in some cases own assets such as the hospice building. DHSC and NHS England do not hold information centrally on NHS hospices, however, including information on the scale of each hospice's charitable activity. NHS hospices differentiate themselves from typical hospital wards by providing care in the same way as the independent adult hospice sector. To a member of the public, many NHS hospices appear indistinguishable from independent adult hospices, offering the same services in similar settings. Previously independent adult hospices have become NHS hospices, for example when the NHS Trust has sought to save the hospice from closure by taking it over. We are aware of one NHS hospice that is becoming an independent hospice.

4 S Scobie, *What is behind differences in place of death across the UK?*, Nuffield Trust, Chart of the week, August 2025 (viewed on 17 October 2025).
5 *Palliative and End of Life Care Profiles | Fingertips | Department of Health & Social Care* (viewed on 17 October 2025).
6 IJ Higginson and others, *Social and clinical determinants of preferences and their achievement at the end of life: prospective cohort study of older adults receiving palliative care in three countries*, BMC Geriatr, 17, Article number 271, November 2017 (viewed on 17 October 2025).
7 P May and others, *Specialist palliative care improves patient experience, reduces bed days and saves money: an economic modelling study of home- and hospital-based care*, Medrxiv (preprint), 21 August 2025 (viewed on 17 October 2025).

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

**1.11** The Health and Care Act 2022 set out the legal duty on ICBs to commission palliative and end-of-life care to meet the needs of their local populations. ICBs can commission palliative and end-of-life care from any suitable provider. They commission such care from a range of generalist and specialist professionals and providers from the independent hospice sector (including from national palliative and end-of-life care providers, Marie Curie and Sue Ryder), other voluntary sector organisations, social care providers and across the NHS. ICBs conduct health needs assessments to better understand what care their local populations require and what they, therefore, need to commission.

**1.12** DHSC and NHS England do not know what proportion of palliative and end-of-life care in England is provided by the independent adult hospice sector. ICBs record the funding they provide to independent hospices through grants and contracts. However, their spend on palliative and end-of-life care commissioned from within the NHS and provided in NHS settings (for example in primary care) is included within broader healthcare spend totals and cannot be separately identified. ICBs cannot therefore measure their total spend on palliative and end-of-life care nor gauge the proportion provided by the independent adult hospice sector. Consequently, DHSC and NHS England have no central oversight of the costs or activity levels of palliative and end-of-life care provided in NHS settings, including the 23 NHS hospices.

**1.13** ICBs use several different funding mechanisms to fund independent hospices.

- **Grants** are payments, usually annual, to voluntary organisations to provide general financial support for activities that contribute to the services that ICBs commission. Historically, ICBs have used grants as the main method for funding hospices. Grants do not involve the commissioning of services and grant agreements are not contracts for services.

- **Block contracts** are fixed payments to providers to deliver a specific, usually broadly defined, service. Block contracts can be annual or multi-year, and the NHS standard contract can be used.

- **Activity-based contracts** involve payments, typically quarterly or monthly, to providers in response to actual levels of service activity. They can be annual or multi-year, and the NHS standard contract supports activity-based payment mechanisms. Some ICBs have contracts with hospices to deliver specific services, for example to provide a hospital's palliative and end-of-life care team.

- **Fast-track continuing healthcare** is funding allocated, on a patient-by-patient basis, to individuals with rapidly deteriorating conditions who may be approaching the end of their life and may require 'fast tracking' for immediate provision of NHS healthcare. Such funding can be used to purchase palliative and end-of-life care from hospices, which will be in addition to funding that the hospices receive through grants or contracts.

**1.14** NHS England advises the NHS standard contract be used by commissioners for all contracts for healthcare services other than primary care. The NHS England Palliative and End of Life Care statutory guidance for ICBs, published in 2022, sets out that ICBs should introduce the necessary service specifications and contracting arrangements when commissioning such care. However, many ICBs continue to use grants to provide general funding to some or all of the hospices in their areas. Hospices that are funded through grant payments are not obliged to report to ICBs against that funding, meaning ICBs cannot easily assess what care is provided for the funding they give to hospices as grants. This makes it harder for ICBs to take a system-wide strategic commissioning approach to the provision of palliative and end-of-life care for their populations. Data collated by Hospice UK in 2023 through freedom of information requests to all 42 ICBs found the following:

- 35 ICBs were using the NHS standard contract for funding some or all of their hospices, while the remaining seven ICBs were only using grants.
- 19 of the ICBs using the NHS standard contract were also using grants to fund some of their hospices. In total, 26 ICBs were using grants.
- Most ICBs using the NHS standard contract were funding hospices through block contracts. Only nine ICBs were using activity-based contracts or activity-based funding.
- 15 of the ICBs using the NHS standard contract were funding hospices mainly or exclusively through multi-year contracts, while the remaining 20 ICBs were using annual contracts only.

**1.15** ICBs we interviewed told us of their intentions to move the hospices they were funding through grants onto the NHS standard contract. However, we heard how this process can reveal disparities in levels of funding between hospices within the same ICB area. ICBs can find that some hospices that have been funded through grants for many years, with funding uplifted each year without reference to levels of service activity, require significant changes in the amount of funding when block or activity-based contracts are introduced. This can lead to disputes between ICBs and hospices that complicate and delay the move away from grant funding.

**1.16** ICBs we interviewed said they would welcome more support from DHSC and NHS England to help move all independent hospices onto the NHS standard contract. Some ICBs suggested that guidance from DHSC on pricing of palliative and end-of-life care would help them commission care equitably and fairly across different providers. DHSC has not set national or regional unit prices or guide prices for palliative and end-of-life care, despite first intending to introduce a national tariff and enable full cost recovery by all palliative and end-of-life care providers in 2008-09.

**1.17** ICBs do not collect data on spend from independent adult hospices as this is outside their remit and statutory responsibility. Similarly, collection of data by ICBs on hospices' patient-level activity is inherently limited, because most activity is funded from charitable sources. The nature of the funding relationship between an ICB and a hospice will also affect the requirement to report on activity, from grants with no requirement for activity reporting, through a range of contracts with varying levels of activity reporting, to activity-based contracts. Hospice UK, however, do collate and analyse activity data from all independent adult hospices and national palliative and end-of-life care provider sites in England, including data on inpatient beds, outpatient services, daycare services and community visits. For example, Hospice UK's most recent analysis showed that, in 2023-24 for the whole of England, there was one hospice inpatient bed per 5,675 people aged 65 or older, ranging by ICB area from around one bed per 2,900 to around one bed per 54,300 people aged 65 or older.

**1.18** Independent hospices that have NHS contracts in England are required to report data on patient-level activity to NHS England, with some hospices already reporting data on the Community Services Data Set. The NHS Community Faster Data Flows programme – which aims to introduce daily automated data collection systems and provide commissioners with faster and better data to inform operational decision making – has started to be rolled out to hospices.

# Part Two

## Hospice funding, income and spend

**2.1** This part of the report describes:

- the principal sources of independent adult hospices' income;
- recent additional government funding for independent adult hospices; and
- trends in spend across the independent adult hospice sector.

### Independent adult hospices' sources of income

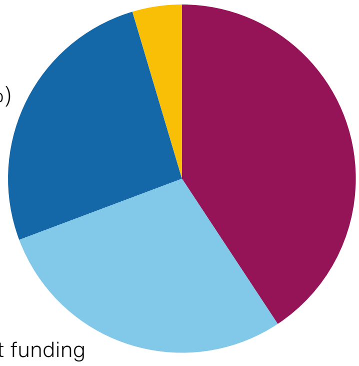
**2.2** In 2023-24, the independent adult hospice sector in England received £1.47 billion in total income. As charitable organisations, independent hospices typically generate most of their income from charitable donations, fund-raising activities, legacies and retail activity. In 2023-24, around two-thirds of the sector's total income came from these sources (**Figure 4**), including the following.

- **Retail activity (26.1%):** From the sale of donated goods in charity shops and online.
- **Donations (15.4%):** For example, funds given to a hospice by individuals or organisations.
- **Fund-raising (5.7%):** Seeking to raise funds for charitable reasons, for example, through a community event.
- **Legacies (14.8%):** A gift left to a hospice in a person's will.
- **Lotteries (4.8%):** Typically organised to raise funds from a hospice's local community.

**2.3** In 2023-24, around 29% of the independent adult hospice sector's income – approximately £420 million – was government funding, primarily from Integrated Care Boards (ICBs) for the provision of palliative and end-of-life care services. Some hospices also receive government funding to provide education and training in palliative and end-of-life care for healthcare professionals, and from local authorities to provide homecare services in a local area. Hospices' remaining income comes from other sources, for example, from investing a portion of their reserves.

## Figure 4
Breakdown of total income for the independent adult hospice sector in England, 2023-24

**Most of independent adult hospices' income comes from charitable donations, fund-raising and retail activity, with 29% comprising government funding**




**Notes**
1 Proportions and nominal income amounts are rounded to one decimal place. Nominal income for each category is shown in millions.
2 'Charitable donations and fund-raising' category includes: charitable donations (15.4%), legacies (14.8%), fund-raising events (5.7%) and lotteries (4.8%).
3 'Other' category consists of: education income, care home income, other service income, sundry income and investment income.
4 Analysis includes the national palliative and end-of-life care providers, Marie Curie and Sue Ryder.

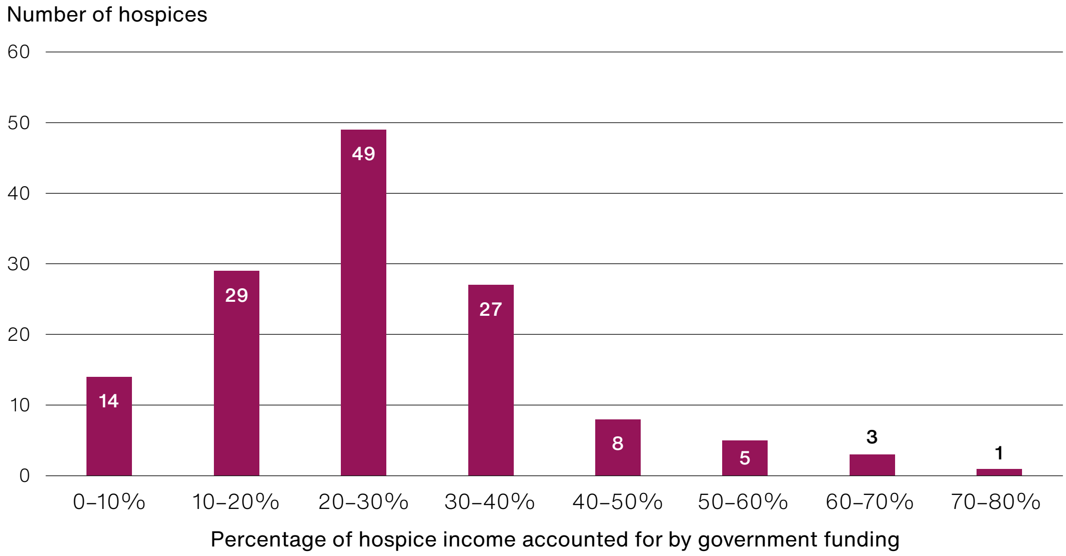
Source: National Audit Office analysis of Hospice UK data

**2.4** The proportion of income sourced from government funding varies at individual hospice level, ranging from 0% to 80% of total income (**Figure 5** overleaf). In 2023-24, 14 independent adult hospices received less than 10% of their total income from government sources, including four hospices that received no government funding. At the other end of the range, nine hospices received over half their income from government funding, including one independent adult hospice that received 80% of its total income from government sources. The proportion of a hospice's income from government sources in a given year is dependent on both how much funding it has received from ICBs and how successful it has been in generating income from voluntary sources and charitable fund-raising activity.

## Figure 5

Number of independent adult hospices in England by proportion of income from government funding, 2023-24

**In 2023-24, over three-quarters of independent adult hospices received between 10% and 40% of their income from government funding**




**Notes**

1 Proportions in each range are up to, but not inclusive of, the upper bound. For example, a hospice with 10.0% of its income from government funding would be included in the 10–20% range.

2 The proportion of income sourced from government funding varies at individual hospice level, ranging from 0% to 80% of total income.

3 There are four hospices that received no income from government sources; these are included in the 0–10% range.

4 Analysis includes the national palliative and end-of-life care providers, Marie Curie and Sue Ryder, as single data points. Marie Curie falls within the 30–40% range, Sue Ryder falls within the 20–30% range.

Source: National Audit Office analysis of Hospice UK data

## Recent additional funding for hospices

### COVID-19 funding

**2.5** Alongside government income through funding from ICBs, the independent adult hospice sector received additional government funding during the COVID-19 pandemic to provide the NHS with extra palliative and end-of-life care capacity.

**2.6** Between April 2020 and March 2022, NHS England provided £384 million to independent adult hospices for this additional support, administered in three waves.

- **First wave (April 2020 to July 2020):** Over the first national lockdown, NHS England provided £155 million to independent adult hospices in England, securing 80% of inpatient and hospice-at-home beds and community support capacity for use by the NHS. This reduced pressure on NHS services by enabling it to discharge patients to hospices for generalist care and allowing it to provide out-of-hospital support for patients without COVID-19.
- **Second wave (November 2020 to March 2021):** In response to the second COVID-19 lockdown and winter pressures, NHS England provided £130 million aligned to hospice activity to secure and increase NHS capacity and patient flow.
- **Third wave (December 2021 to March 2022):** Hospices received a further £98 million in funding that was aligned to hospice activity to secure and increase NHS capacity and patient flow.

**2.7** The COVID-19 pandemic disrupted hospices' fund-raising activities. During lockdowns, retail activity ceased and fund-raising events were cancelled, and outside of lockdowns such activities generated less income than usual. Independent adult hospices, including Marie Curie and Sue Ryder, could apply for financial assistance from government financial support schemes that were not specific to the hospice sector, for example from COVID-19 support schemes for businesses and charities, such as the Coronavirus Job Retention Scheme.

## One-off capital funding

**2.8** In December 2024, the Department of Health & Social Care (DHSC) announced £100 million of one-off capital funding for adult and children's hospices in England, in recognition of financial pressures in the sector and hospices' reliance on charitable funds for capital spend (unlike providers within the NHS, which can access dedicated capital funding streams). DHSC's aim was to ensure that hospices would not need to reduce services, nor be unable to meet increased demand, due to deterioration of their physical facilities. DHSC acknowledged that a reduction in the public's charitable giving had exacerbated the challenge for hospices of maintaining or growing their estates and other assets, and that capital spend diverted hospices' funds from service delivery.

**2.9** DHSC is issuing the capital funding in two tranches over two financial years. Rather than give the funding to ICBs to distribute to the hospices they commission services from, DHSC asked Hospice UK to distribute the funding on its behalf. Hospice UK has allocated the funding based on hospices' 2023-24 service delivery spend. It distributed £25 million in 2024-25, which hospices spent in that financial year. Of this, adult hospices received nearly £22 million, spending over £10 million on building and refurbishment, nearly £6 million on digital and IT, and nearly £3.5 million on equipment and vehicles. Hospice UK has allocated the remaining £75 million, to be spent by hospices in 2025-26. Up to the end of August 2025, adult hospices had spent around £14.4 million – £8 million on building and refurbishment, £2.7 million on digital and IT, £1.6 million on energy efficiency, and £1.6 million on equipment and vehicles.

## Income

**2.10** From 2014-15, total income in real terms for independent adult hospices increased steadily up to the start of the COVID-19 pandemic in 2020, but has been decreasing since (**Figure 6**). Total income in real terms (2023-24 prices) increased from £1.38 billion in 2014-15 to £1.52 billion in 2019-20. The growth in income was maintained over the COVID-19 pandemic by the additional government funding, with income totalling £1.62 billion in 2021-22. Since 2021-22, total income in real terms has fallen, in part because inflation rose more steeply than total income in cash terms. In 2023-24, independent adult hospices in England generated a similar level of income in real terms (2023-24 prices) as they did in 2017-18, around £1.47 billion.

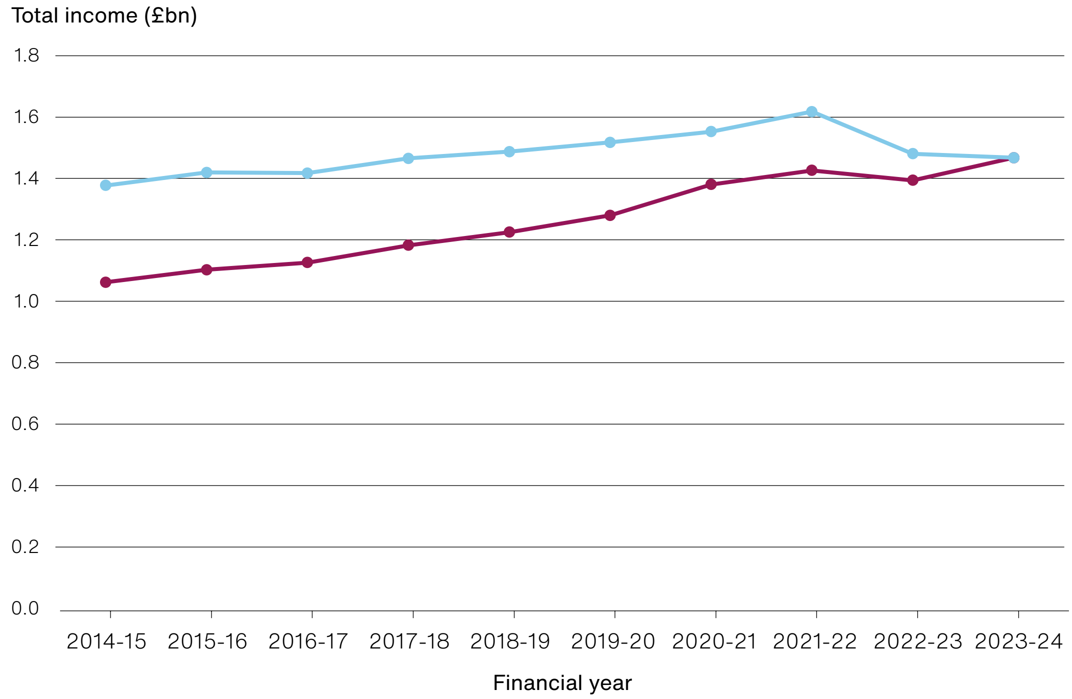
## Spend

**2.11** The total spend in real terms of England's independent adult hospice sector rose year on year from 2014-15 to 2019-20, then fell in 2020-21 at the start of the peak COVID-19 period (**Figure 7** on page 28). From 2021-22, the pre-pandemic trend resumed, with total spend in real terms increasing in the subsequent two years. By 2023-24, total spend for the sector was £1.55 billion, the highest yearly amount to date. Hospice UK attributes the recent rise in spending to the effects of high inflation on hospices' costs. Increases in wage rates have increased hospices' costs, given that typically around 70% of a hospice's spend is on staff costs, as have higher gas, electricity and fuel prices. From April 2025, hospices' costs will have risen further as employer National Insurance contributions increased from 13.8% to 15% and the earnings threshold above which contributions are applied decreased.

## Figure 6

Total income of the independent adult hospice sector in England, 2014-15 to 2023-24

**Since 2021-22, the total income of the independent adult hospice sector has not kept up with inflation**




| | 2014-15 | 2015-16 | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 | 2023-24 |
|---|---|---|---|---|---|---|---|---|---|---|
| Total income – cash terms (£bn) | 1.06 | 1.10 | 1.13 | 1.18 | 1.23 | 1.28 | 1.38 | 1.43 | 1.39 | 1.47 |
| Total income – real terms (£bn) | 1.38 | 1.42 | 1.42 | 1.47 | 1.49 | 1.52 | 1.55 | 1.62 | 1.48 | 1.47 |

**Notes**

1 Income is presented both in cash terms (the amount as it was in the financial year it relates to) and in real terms in 2023-24 prices. We used the GDP deflator series published by HM Treasury in June 2024 to convert amounts to 2023-24 prices for years before 2023-24.

2 Values have been rounded to two decimal places.

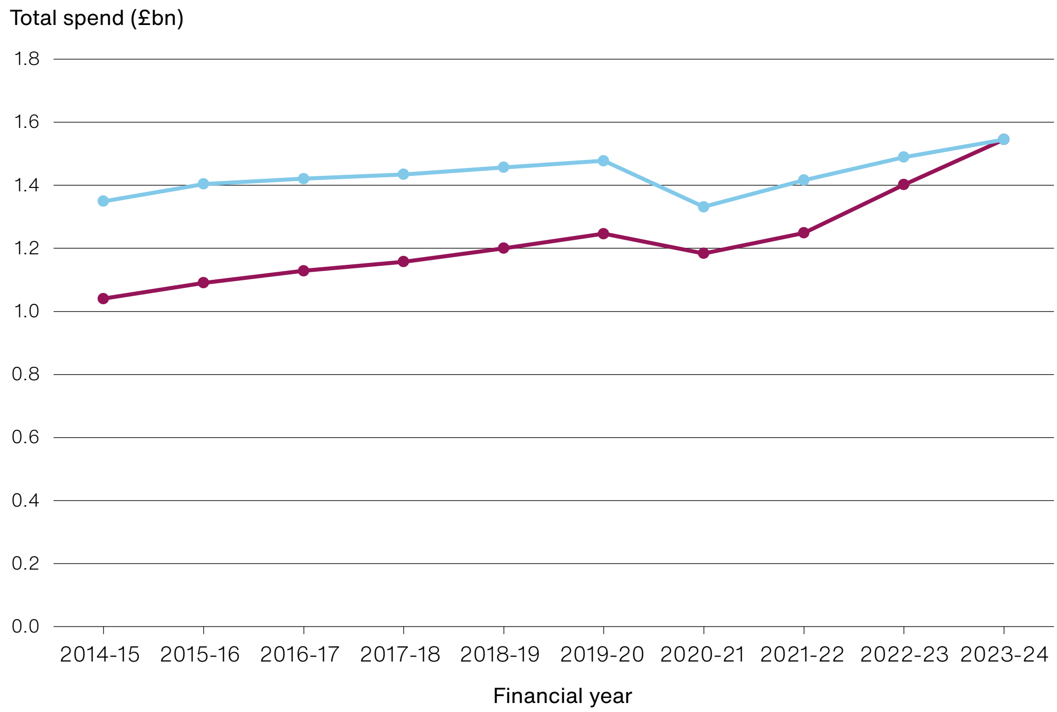
3 Analysis includes the national palliative and end-of-life care providers, Marie Curie and Sue Ryder. It does not include NHS hospices.

Source: National Audit Office analysis of Hospice UK data

## Figure 7

Total spend of the independent adult hospice sector in England, 2014-15 to 2023-24

**The rate of rise in the independent adult hospice sector's total spend has been broadly consistent since 2014-15, except for a dip at the start of the COVID-19 pandemic, reaching £1.55 billion in 2023-24**




| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| ● Total spend – cash terms (£bn) | 1.04 | 1.09 | 1.13 | 1.16 | 1.20 | 1.25 | 1.18 | 1.25 | 1.40 | 1.55 |
| ● Total spend – real terms (£bn) | 1.35 | 1.40 | 1.42 | 1.43 | 1.46 | 1.48 | 1.33 | 1.42 | 1.49 | 1.55 |

**Notes**

1 Total spend is the sum of service delivery spend, fund-raising spend and retail activity spend.

2 Spend is presented both in cash terms (the amount as it was in the financial year it relates to) and in real terms in 2023-24 prices. We used the GDP deflator series published by HM Treasury in June 2024 to convert amounts to 2023-24 prices for years before 2023-24.

3 Values have been rounded to two decimal places.

4 Analysis includes the national palliative and end-of-life care providers, Marie Curie and Sue Ryder. It does not include NHS hospices.

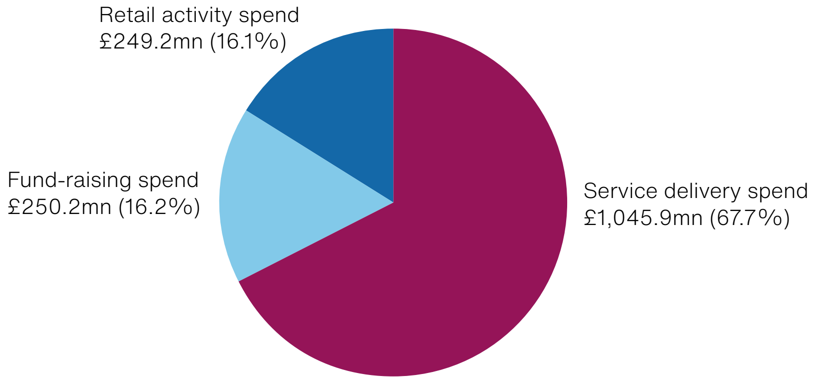
Source: National Audit Office analysis of Hospice UK data

**2.12** Hospices' total spend comprises spend on service delivery, fund-raising and retail activities. Service delivery spend includes spend on the provision of palliative and end-of-life care and other services provided by hospices (for example, clinical care costs), as well as spend to facilitate service delivery (for example, the costs of maintaining and running hospice buildings). It also includes spending on educating and training healthcare professionals. Fund-raising spend covers the costs of hospices running fund-raising activities, including conducting fund-raising events and organising lotteries, while retail activity spend includes, for example, running charity shops. Hospices aim to maximise the return in income they generate from their spend on fund-raising. In 2023-24, around two-thirds of the independent adult hospice sector's spend was on service delivery (67.7%), and around one-third was on fund-raising and retail activities (32.3%) (**Figure 8**).

## Figure 8

The independent adult hospice sector in England's total spend by type, 2023-24

**Just over two-thirds of the independent adult hospice sector's total spend in 2023-24 was on service delivery**




**Notes**

1 'Fund-raising spend' includes fund-raising costs, including organising and running fund-raising events, as well as lottery spend.

2 Proportions and nominal spend for each category are rounded to one decimal place. Nominal spend is shown in millions.

3 Analysis includes the national palliative and end-of-life care providers, Marie Curie and Sue Ryder. It does not include NHS hospices.

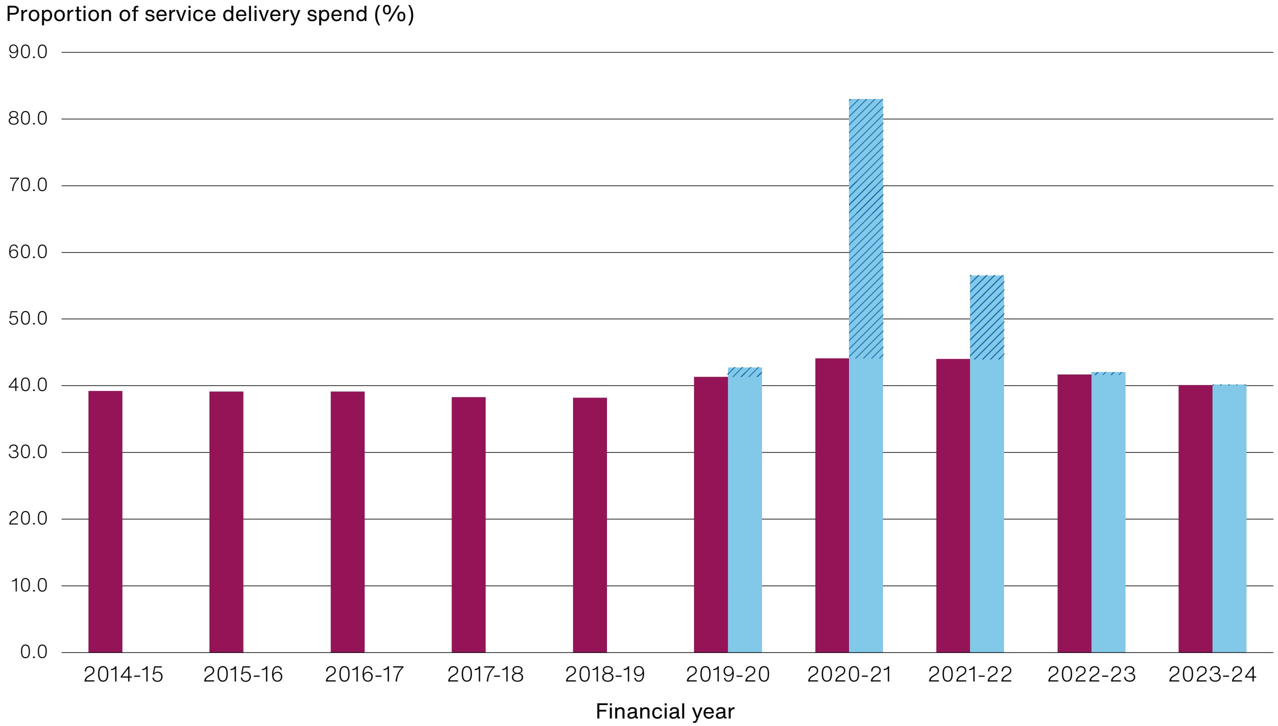
Source: National Audit Office analysis of Hospice UK data

**2.13** Between 2014-15 and 2018-19, government funding consistently equated to between 38.2% and 39.2% of the sector’s service delivery spend (which excludes the cost of fund-raising activity) (**Figure 9** on pages 31 and 32). From 2019-20, hospices began to receive additional funding from the government as a part of its COVID-19 emergency response. The independent hospice sector received £384 million in emergency funding to secure extra capacity for the NHS during the COVID-19 pandemic, as well as other sources of emergency COVID-19 financial support from the government. In 2020-21, total government funding for the sector was equivalent to 83.0% of the sector’s service delivery spend, dropping to 56.6% in 2021-22. In subsequent years, as additional COVID-19-related funding diminished, the proportion decreased to near pre-pandemic levels and by 2023-24 government funding (£420 million) equated to 40.1% of service delivery spend. Between 2014-15 and 2023-24, excluding additional COVID-19 funding, the proportion of service delivery spend accounted for by government funding remained between around 38% and 44%.

## Figure 9

Government funding as a proportion of service delivery spend for the independent adult hospice sector in England, 2014-15 to 2023-24

**The proportion of service delivery spend accounted for by government funding (excluding the COVID-19 period) has remained broadly consistent since 2014-15**




| | 2014-15 | 2015-16 | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 | 2023-24 |
|---|---|---|---|---|---|---|---|---|---|---|
| ■ Recurrent government funding – cash terms (£mn) | 270.2 | 281.3 | 291.2 | 291.0 | 300.3 | 335.2 | 361.9 | 368.5 | 393.1 | 419.4 |
| Additional COVID-19 government funding – cash terms (£mn) | – | – | – | – | – | 11.3 | 319.1 | 104.7 | 3.4 | 0.3 |
| ■ Government funding including additional COVID-19 funding – cash terms (£mn) | – | – | – | – | – | 346.5 | 681.1 | 473.3 | 396.5 | 419.6 |
| **Service delivery spend – cash terms (£mn)** | **688.9** | **718.7** | **744.2** | **759.7** | **786.4** | **811.0** | **820.5** | **836.8** | **942.6** | **1,045.9** |
| Recurrent government funding as a proportion of service delivery spend (%) | 39.2 | 39.1 | 39.1 | 38.3 | 38.2 | 41.3 | 44.1 | 44.0 | 41.7 | 40.1 |
| Government funding, including additional COVID-19 funding, as a proportion of service delivery spend (%) | – | – | – | – | – | 42.7 | 83.0 | 56.6 | 42.1 | 40.1 |

**Figure 9** *continued*

Government funding as a proportion of service delivery spend for the independent adult hospice sector in England, 2014-15 to 2023-24

**Notes**

1 Figures may not sum, due to rounding.

2 Proportions are rounded to one decimal place.

3 Analysis includes the national palliative and end-of-life care providers, Marie Curie and Sue Ryder, as single data points. It does not include NHS hospices.

Source: National Audit Office analysis of Hospice UK data

# Part Three

## Financial challenges facing independent adult hospices

**3.1** This part of the report describes:

- trends in England's independent adult hospices' reporting of deficits;
- trends in hospices' levels of reserves; and
- the financial challenges facing hospices.

### Deficits

**3.2** Before the COVID-19 pandemic, the independent adult hospice sector's total income and spend were closely aligned and both steadily increasing (**Figure 10** overleaf). During the peak COVID-19 period, the sector's income substantially exceeded its spend, when the government provided additional funding to the sector and total spend decreased. For example, in 2020-21, the sector's income exceeded its spend by £220 million. In 2022-23 and 2023-24, total spend increased while total income fell in real terms, and in 2023-24 the sector spent £78 million more than it generated in total 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.

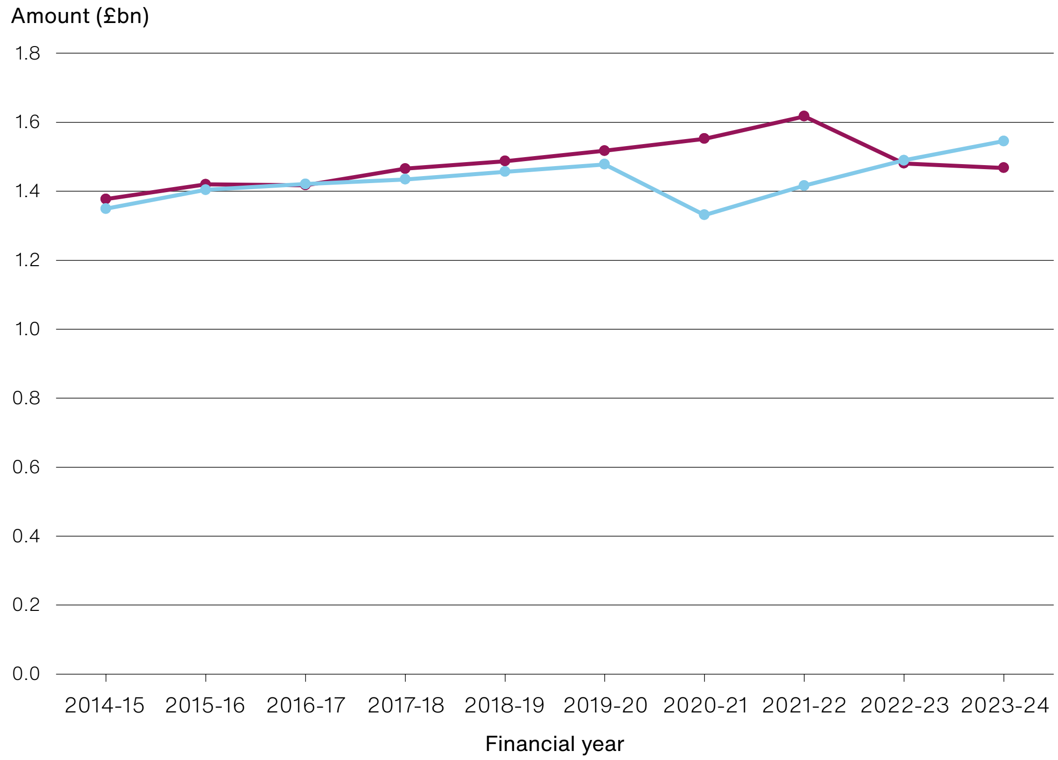
**3.3** The independent adult hospice sector's financial improvement during the peak COVID-19 period, and deterioration in subsequent years, are reflected in the proportion of hospices reporting deficits per year.[8] Between 2014-15 and 2019-20, the proportion of hospices reporting deficits per year 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. In 2022-23, the proportion of hospices reporting a deficit returned to pre-pandemic levels (45%), before increasing in 2023-24 to 64%, the highest over the period examined (**Figure 11** on page 35).

8 A deficit is when a hospice's spend exceeds its income in a given year.

## Figure 10

Total income and spend in real terms (2023-24 prices) of the independent adult hospice sector in England, 2014-15 to 2023-24

**In 2023-24, the independent adult hospice sector spent around £80 million more than they generated in total income**




| | 2014-15 | 2015-16 | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 | 2023-24 |
|---|---|---|---|---|---|---|---|---|---|---|
| Total income – real terms (£bn) | 1.38 | 1.42 | 1.42 | 1.47 | 1.49 | 1.52 | 1.55 | 1.62 | 1.48 | 1.47 |
| Total spend – real terms (£bn) | 1.35 | 1.40 | 1.42 | 1.43 | 1.46 | 1.48 | 1.33 | 1.42 | 1.49 | 1.55 |

**Notes**

1 Income and spend are presented in real terms in 2023-24 prices. We used the GDP deflator series published by HM Treasury in June 2024 to convert amounts to 2023-24 prices for years before 2023-24.

2 Values have been rounded to two decimal places.

3 Analysis includes the national palliative and end-of-life care providers, Marie Curie and Sue Ryder. It does not include NHS hospices.

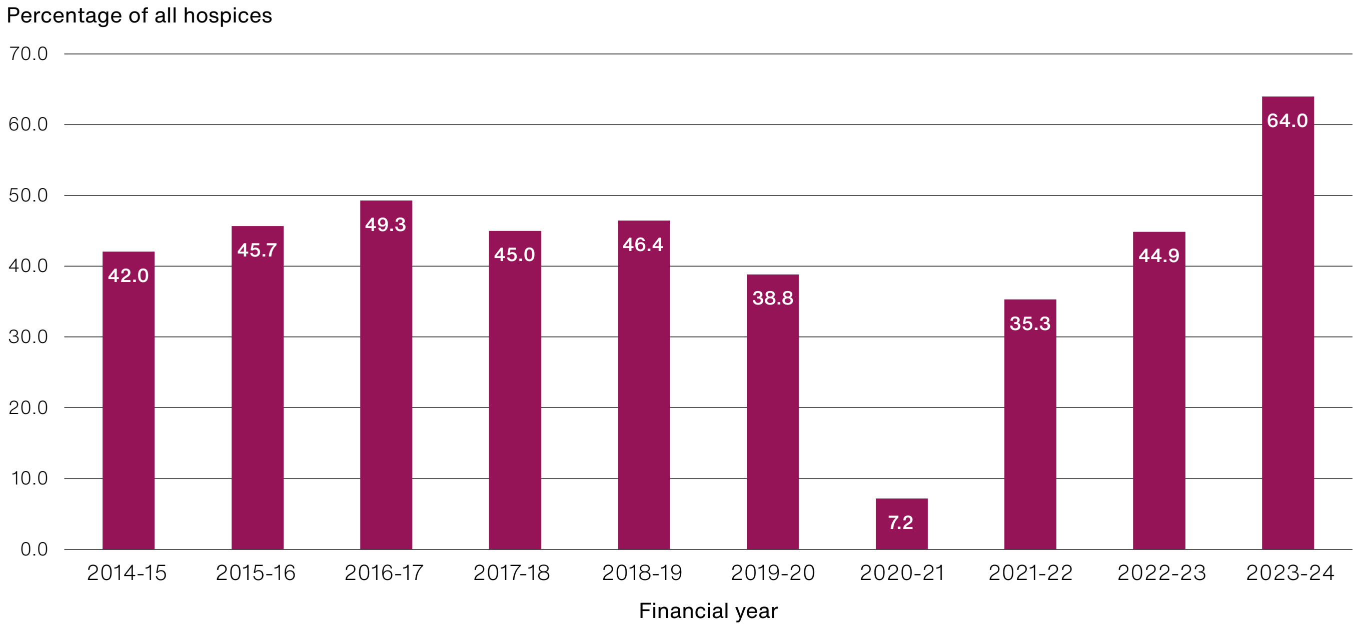
4 Total spend exceeded total income, in real terms (2023-24 prices), in 2016-17 by £3 million. This is not apparent in the figure, due to rounding.

Source: National Audit Office analysis of Hospice UK data

## Figure 11

Proportion of independent adult hospices in England reporting a yearly deficit, 2014-15 to 2023-24

**The proportion of hospices reporting a deficit fell markedly in the first year of the peak COVID-19 period, subsequently increasing and reaching a record high in 2023-24**




**Notes**

1 Proportions have been rounded to one decimal place.

2 Analysis includes the national palliative and end-of-life care providers, Marie Curie and Sue Ryder, as single data points. It does not include NHS hospices.

Source: National Audit Office analysis of Hospice UK data

## Reserves

**3.4** Reserves serve as a financial safeguard for hospices, helping them to manage unexpected costs and fund shortfalls in income without compromising service delivery. Each hospice sets its own reserves policy, explaining the level of reserves they aim to hold and why. The levels of reserves set by hospices' policies vary, reflecting hospices' individual circumstances and the risk appetites of trustees. As charitable organisations, all hospices must state their reserves policy, or state that they do not operate a policy, in their annual reports.

**3.5** Between 2014-15 and 2019-20, the proportion of independent adult hospices that held available reserves equating to six months or more of their average spend remained similar at between 57% and 62% (**Figure 12**). 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 average spend by 2021-22. Subsequently, hospices' levels of reserves decreased as the independent adult hospice sector's financial landscape became more challenging. By 2023-24, 73% of hospices held six months or more of available reserves, reflecting the increase in the number of hospices in deficit and using their reserves to fund their service provision.

## Rate of return on fund-raising spend

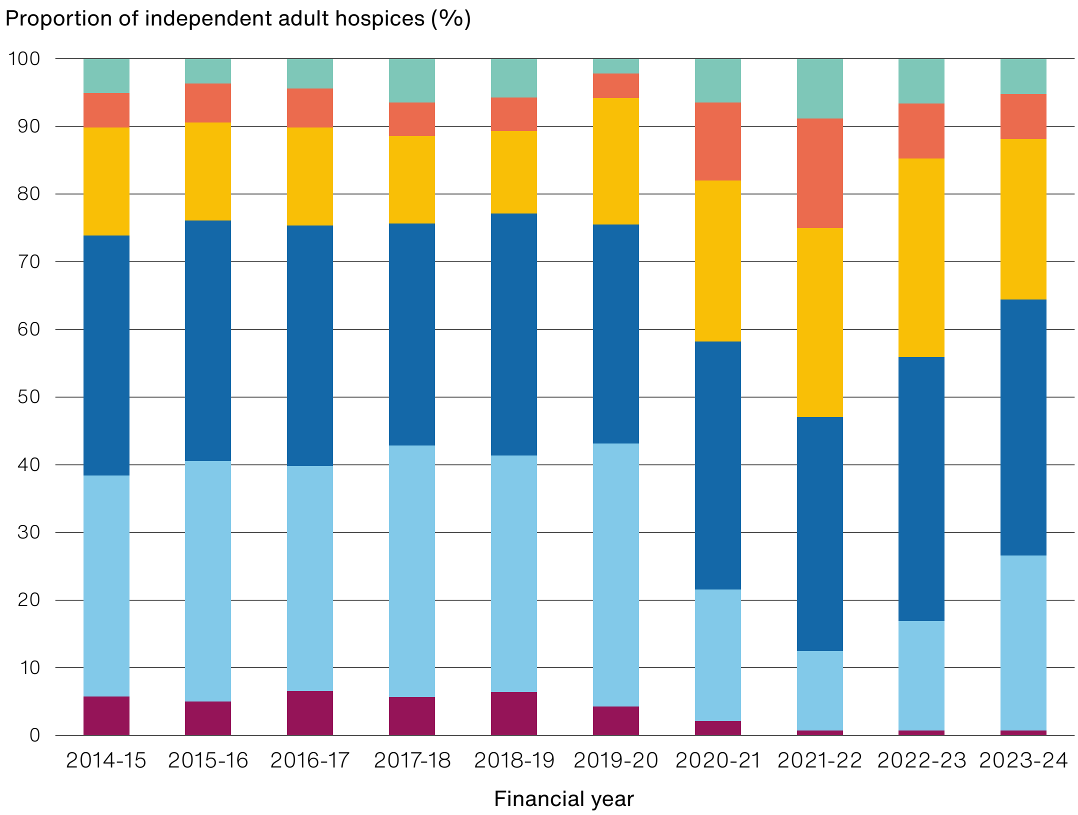
**3.6** The independent adult hospice sector's overall rate of return from spend on fund-raising – how much income is generated in relation to fund-raising spend – was broadly consistent before 2019-20 but has been declining since the peak COVID-19 period (**Figure 13** on page 38). From 2014-15 to 2018-19, the sector consistently generated a rate of return of between £2.07 and £2.15 for every £1 spent on fund-raising, before dropping to £2.02 in 2019-20. The rate of return was volatile during the peak COVID-19 period, falling further to £1.77 in 2020-21 before increasing the following year to £2.22 for every £1 spent.

**3.7** The independent adult hospice sector's overall fund-raising rate of return has been decreasing since 2021-22, falling to £1.96 raised for every £1 spent in 2023-24. Excluding in 2020-21, during the peak COVID-19 period, this was the first time the sector had generated less than £2 for every £1 spent on fund-raising activity during the period examined. 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. If this downward trend continues, the sector will become more reliant on government funding to maintain levels of service.

## Figure 12

Levels of available reserves measured in months of average spend for independent adult hospices in England, 2014-15 to 2023-24

**Independent adult hospices increased their levels of available reserves during the two peak years of the COVID-19 pandemic, before depleting them in subsequent years**




Number of independent adult hospices in reserve level range

| | 2014-15 | 2015-16 | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 | 2023-24 |
|---|---|---|---|---|---|---|---|---|---|---|
| Less than 0 months | 8 | 7 | 9 | 8 | 9 | 6 | 3 | 1 | 1 | 1 |
| 0–6 months | 45 | 49 | 46 | 52 | 49 | 54 | 27 | 16 | 22 | 35 |
| 6–12 months | 49 | 49 | 49 | 46 | 50 | 45 | 51 | 47 | 53 | 51 |
| 12–18 months | 22 | 20 | 20 | 18 | 17 | 26 | 33 | 38 | 40 | 32 |
| 18–24 months | 7 | 8 | 8 | 7 | 7 | 5 | 16 | 22 | 11 | 9 |
| 24 months or more | 7 | 5 | 6 | 9 | 8 | 3 | 9 | 12 | 9 | 7 |

**Notes**

1 Available reserves are defined as unrestricted reserves, including designated funds, less tangible fixed assets.

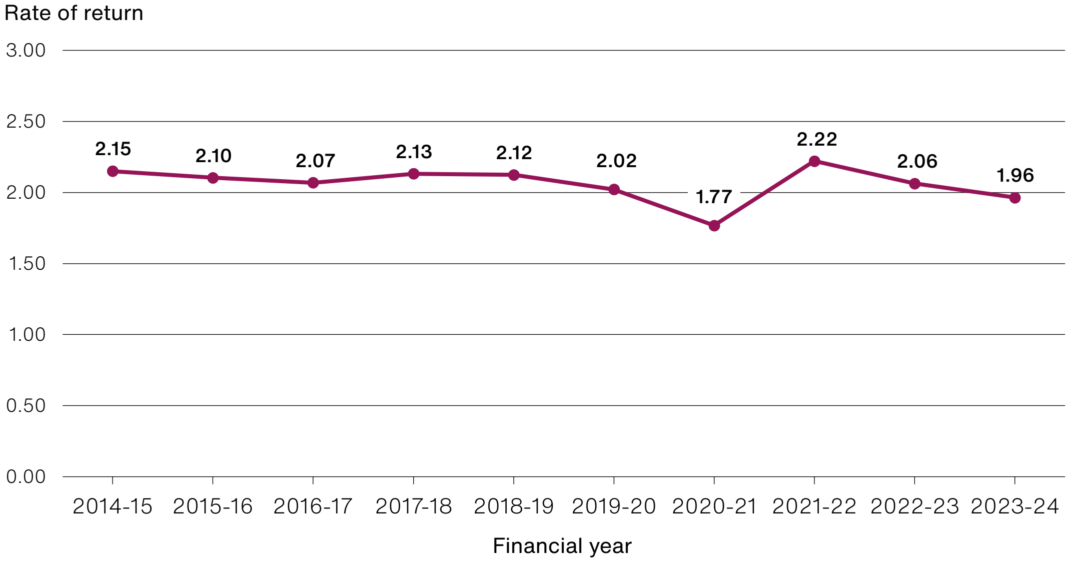
2 Analysis includes the national palliative and end-of-life care providers, Marie Curie and Sue Ryder, as single data points. It does not include NHS hospices.

3 Average monthly spend is determined on a per hospice basis to accurately calculate how many months of available reserves each hospice held relative to their own spend.

Source: National Audit Office analysis of Hospice UK data

## Figure 13
Overall rate of return from fund-raising spend for the independent adult hospice sector in England, 2014-15 to 2023-24

**Despite an increase between 2020-21 and 2021-22, the rate of return from fund-raising spend in 2023-24 was lower than the typical rate before the COVID-19 pandemic**




**Notes**

1 Values have been rounded to two decimal places.

2 Analysis includes the national palliative and end-of-life care providers, Marie Curie and Sue Ryder. The analysis does not include NHS hospices.

3 Rate of return includes income from charitable donations, legacies, fund-raising events, retail activity and lotteries. It excludes government funding, including additional funding given to hospices during the COVID-19 pandemic.

4 Rate of return is the ratio of fund-raising income generated compared with fund-raising spend.

Source: National Audit Office analysis of Hospice UK data

## Service continuity

**3.8** At the end of 2024, independent adult hospices in England had reported that around 300 inpatient beds had been deregistered or withdrawn from operation, equal to 14% of the national total. Hospice UK reported that, based on end-of-year estimates, this reduction prevented access to 110,000 days and nights of care. Some of this reduction may represent a shift to more people receiving palliative and end-of-life care in their homes. We are aware of 11 hospices that announced service reductions or staff redundancies in response to financial challenges in 2024-25, and other hospices that have announced plans to reduce services, including reducing inpatient bed capacity. One hospice told us it has reduced its total service provision to remain financially viable, and that this included making 19 staff members redundant and reducing the hours of nine more, cutting its community support services and reducing the number of inpatient beds. Other service reductions reported by hospices included reducing bereavement support, closing hospice-at-home services and reducing psychological support, wellbeing, therapy and education services. 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.

**3.9** Around six hospices have 'commissioner requested services' status conferred by their Integrated Care Board (ICB), designating them as essential services which must continue to be provided locally should the current provider fail. Hospices with such status typically report to the ICB quarterly on their activity and finances, to ensure the ICB is forewarned of potential difficulties with service continuity. Commissioner requested services status requires more robust governance of both providers and commissioners, to ensure essential services do not fail causing a significant negative impact on the local population.

## Hospice collaboratives

**3.10** Some independent hospices have begun working in partnership and forming collaboratives within ICB areas, developing a more coordinated approach to the provision of palliative and end-of-life care within a region. Marie Curie and Sue Ryder hospices are also members of collaboratives in some areas. Collaboratives enable groups of hospices to engage with their ICB with a single voice and offer the opportunity to plan provision collectively and share financial risks.

**3.11** Hospice UK told us that there are currently seven fairly well established collaboratives covering individual ICBs: three in the North West region, two in the North East and Yorkshire region and two in the South East region. We interviewed representatives of hospices within the West Yorkshire Hospice Collaborative – they described how they are working together to strengthen the resilience, integration and long-term sustainability of the hospices within their region, with the overarching aim of ensuring that high-quality palliative and end-of-life care is available to everyone who needs it. Hospice UK described another five collaboratives that have been established but are at an early stage of development, and six groups of hospices that are considering collaboratives.

# Appendix One

## Our investigative approach

### Scope

**1** We reached our findings on the financial sustainability of England's adult hospice sector after analysing evidence collected from March to August 2025. Our investigation primarily examined the independent adult hospice sector, and the areas we focused on included:

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

**2** We decided to investigate the financial sustainability of independent adult hospices following reports in the media and parliamentary interest in the 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 hospices' financial sustainability matters to DHSC and the NHS greatly. We did not examine the whole system of palliative and end-of-life care provision in England and its financial sustainability.

**3** 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 – but we could not isolate the adult-only data for these hospices so included data on their total operations in our analysis rather than exclude them completely. According to Hospice UK, the majority of these hospices' service provision is for adult patients.

**4** We included Marie Curie and Sue Ryder, the national palliative and end-of-life care providers, within the scope of our report. Marie Curie has five hospice sites in England, and Sue Ryder has seven. Marie Curie also has four other hospice sites across the UK – two in Scotland, one in Wales and one in Northern Ireland – and both Marie Curie and Sue Ryder undertake fund-raising activity (such as retail) outside of England but within the UK. We attempted to isolate data relating to both organisations' England-based operations for inclusion in our report, such as only including Marie Curie's hospices in England; however, this has not always been possible. Rather than exclude Marie Curie and Sue Ryder from some sections of the report, particularly financial analysis, we have included data on their total operations in some of our analysis on the independent adult hospice sector in England.

**5** We had substantial engagement with Hospice UK during this study, as an umbrella organisation for the independent hospice sector. Hospice UK supports the sector and advocates on its behalf. All independent hospice charities across the UK, including Marie Curie and Sue Ryder, are members of Hospice UK.

## Methods

### Interviews with DHSC, NHS England and Integrated Care Boards

**6** We conducted interviews with officials from DHSC and NHS England, including staff responsible for policy development in the palliative and end-of-life care team. We used these interviews to develop our understanding of DHSC and NHS England's role in commissioning palliative and end-of-life care in England, and to gather information about the wider palliative and end-of-life care system as context for our investigation. We also explored DHSC and NHS England's palliative and end-of-life care strategy and how this had evolved in recent years. Where possible, we triangulated interview evidence with documentary and other evidence. As well as interviews on specific topics, we held weekly meetings with DHSC and NHS England during scoping and fieldwork to facilitate and progress our audit.

**7** We held four interviews with representatives from Integrated Care Boards (ICBs) in England. The purpose of these interviews was to understand more about how ICBs commission palliative and end-of-life care provision in their areas and explore their commissioning arrangements with independent adult hospices. We also discussed the relationships some ICBs have with hospice collaboratives in their areas.

## Interviews with independent adult hospice sector stakeholders

**8** We interviewed key stakeholders within the independent adult hospice sector in England, to establish the sector's perspective on its financial sustainability, commissioning arrangements with ICBs, and its relationship with government bodies. We spoke with the following stakeholders.

- **Hospice UK:** We engaged with Hospice UK regularly during the audit, contributing significantly to our investigation. As the umbrella organisation and main advocate for the independent hospice sector, Hospice UK was uniquely placed to represent the views of England's independent hospices. We also held weekly meetings with Hospice UK during scoping and fieldwork to facilitate our audit and develop our understanding of the palliative and end-of-life care system in England and the independent hospice sector.
- **Marie Curie and Sue Ryder:** We held two interviews with Marie Curie and one with Sue Ryder, the national palliative and end-of-life care providers in the UK. These interviews helped us establish national providers' perspectives on the financial sustainability of the independent adult hospice sector.
- **West Yorkshire Hospice Collaborative:** We interviewed representatives of the collaborative to gather information about why their hospices decided to collaborate and how this has changed the provision of services by independent hospices in their region.
- **Individual hospices:** We spoke with representatives of individual adult hospices to understand how services are delivered, including non-core services such as the provision of education and training to healthcare professionals.

We also interviewed a prominent academic in the field of palliative care research, whom several stakeholders from the sector recommended we speak with as part of our investigation. We explored some key themes about palliative and end-of-life care provision in England during the interview.

## Document review

**9** We reviewed around 30 published and unpublished documents provided to us by DHSC, NHS England and ICBs during fieldwork, to develop our overall understanding of the independent adult hospice sector and wider palliative and end-of-life care system. These documents included:

- unpublished NHS England and DHSC documents such as programme board minutes, the one-off capital funding business case, and a ministerial submission related to capital funding; and
- published documents by government bodies such as NHS England's palliative and end-of-life care strategy and its statutory guidance for ICBs.

**10** We reviewed approximately 50 published and unpublished documents provided to us by stakeholders within the independent hospice sector. Documents provided included, but were not limited to, annual reports, research papers and policy documents. These documents helped us to establish perspectives within the independent adult hospice sector of its financial sustainability and understand how the sector is commissioned to provide palliative and end-of-life care in England.

**11** We reviewed each document within the context of our audit scope and objectives, allowing us to determine audit findings and triangulate findings from other sources. Our review was also used to inform further discussion and follow-up with DHSC, NHS England, other government bodies and stakeholders from the independent hospice sector.

## Quantitative analysis

**12** We present time series of financial data both in cash terms (the amount as it was in the financial year it relates to) and in real terms in 2023-24 prices. We used the GDP deflator series published by HM Treasury in June 2024 to convert amounts to 2023-24 prices for years before 2023-24.

**13** We conducted quantitative analysis on the independent adult hospice sector using data provided to us by Hospice UK. As the sector's umbrella organisation, Hospice UK collects financial and activity data from its membership, including national palliative and end-of-life care providers Marie Curie and Sue Ryder. We used time series data from 2014-15 to 2023-24 for our quantitative analysis on the sector.

**14** We used Hospice UK's data to determine the number of independent adult hospices, including national palliative and end-of-life care providers, in each financial year of our analysis. Over the period 2014-15 to 2023-24, the number of independent adult hospices sometimes changed between financial years. Reasons for differences between years included hospices merging, joining Hospice UK for the first time, transferring into the NHS or leaving the NHS and becoming independent. We accounted for this in our analysis and confirmed the sector's hospice list for each year of the period with Hospice UK. The number of hospices per year may vary across our analysis, depending on availability of relevant data and whether analysis is at hospice level or site level. For example, one hospice is a member of Hospice UK but has not provided financial information so is not included in our financial analysis, but is included in the total number of independent hospices in England. Hospice UK is not aware of any independent hospices in England that meet its membership criteria, of being Care Quality Commission registered and primarily providing palliative and end-of-life care, which are not currently members of its organisation.

**15** Our quantitative analysis focused on adult hospices in the independent sector. Some hospices, however, provide services to both adults and children and we were not able to isolate adult-only services in the financial information provided to us by Hospice UK. In consultation with Hospice UK, we decided to include these hospices in our quantitative analysis rather than exclude them, on the basis that the majority of services delivered by these hospices was for adult patients rather than children.

**Data on demographic trends in England**

**16** We used official published data from the Office for National Statistics (ONS), including population projections and registered deaths, to conduct analysis and present statistics on long-term demographic trends in England. In particular, we conducted analysis on actual and expected registered deaths in England using this data, as well as presenting statistics on projected demographic changes.

**Hospice mapping**

**17** We mapped hospice locations at site level in England for independent adult hospices, national palliative and end-of-life care providers Marie Curie and Sue Ryder, and NHS hospices. Hospice UK provided us with registered addresses for independent adult hospices and sites operated by Marie Curie and Sue Ryder. We sourced the registered addresses for NHS hospices in England. We adjusted some hospice locations on Figure 1 by up to several millimetres to prevent overlaps and improve clarity; this map therefore shows approximate and not exact locations of hospices.

**Activity data and analysis of people aged 65 or older per inpatient bed**

**18** We analysed hospice activity data from Hospice UK, including number of people receiving care, number of inpatient beds and number of community visits. Hospice UK was able to identify adult-only activity data for most of the hospices in England that provided services to both adults and children, so we included adult-only data in our analysis. Data for Marie Curie and Sue Ryder were provided at hospice-site level and only included hospices in England.

**19** We analysed the number of people aged 65 or older per registered inpatient bed in each of England's ICB areas. We used Hospice UK activity data from 2023-24 to determine the number of registered inpatient beds per ICB area. Hospice UK collected data through a mix of self-reporting by independent adult hospices and its own reconciliation exercise. We excluded one ICB area's data from our analysis, however, because there were no inpatient beds in the area and we did not want to imply people in this area would not have access to inpatient beds, as hospices operate across ICB boundaries. We also present registered inpatient bed data from Hospice UK elsewhere in our report, in the context of bed reductions.

**20** We used Hospice UK data, sourced from its population needs assessment tool, to determine the number of people aged 65 or older per ICB area for our analysis. We conducted our analysis in August 2025 at which time Hospice UK's population needs assessment tool used ONS data from 2024 that returned mid-2022 population estimates.

**Financial data on independent adult hospices income and spend**

**21** We used financial data for independent adult hospices, provided to us by Hospice UK, in our quantitative analysis. We conducted analysis both at an aggregate level for the sector and at hospice level. Our analysis included:

- a breakdown of sources of income for independent adult hospices in England in 2023-24;
- the proportion of each hospice's income sourced from government funding in 2023-24;
- total income for the independent adult hospice sector, in cash and real terms (2023-24 prices), from 2014-15 to 2023-24;
- total spend for the independent adult hospice sector, in cash and real terms (2023-24 prices), from 2014-15 to 2023-24;
- a breakdown of spend by independent adult hospices in England in 2023-24;
- government funding as a proportion of service delivery spend for independent adult hospice providers in England, from 2014-15 to 2023-24;
- the proportion of hospices in a budget deficit from 2014-15 to 2023-24; and
- the fund-raising rate of return for the independent adult hospice sector from 2014-15 to 2023-24.

**22** We included the national palliative and end-of-life care providers Marie Curie and Sue Ryder, as either singular data points or at a national level for each organisation in our analysis, depending on which was most appropriate. We could not separate data on Marie Curie's and Sue Ryder's operations in England from their operations across the whole of the UK. Rather than exclude Marie Curie and Sue Ryder, we used financial data for their total UK operations in our analysis.

**23** We present the total income and total spend data for the sector in both cash and real terms in Figures 6, 7 and 10. We used GDP deflators for 2023-24 published by HM Treasury in June 2024 to convert financial data for years before 2023-24 into 2023-24 prices.

**Financial data on independent adult hospices' reserves**

**24** We analysed independent adult hospices' reserves using data provided to us by Hospice UK stating each hospice's available reserves in terms of months of spend. Hospice UK defines available reserves as unrestricted reserves, including designated funds, less unrestricted tangible fixed assets.

**25** Some hospices express their available reserves in their annual reports as months of average monthly spend while others express it in cash terms. For relevant hospices, Hospice UK convert reserves in cash terms into months of average monthly spend by dividing available reserves in cash terms by average monthly spend. We used Hospice UK's calculation as the basis for our analysis. Data on reserves were not available for some hospices so they were excluded from our analysis. We included the national palliative and end-of-life care providers, Marie Curie and Sue Ryder, as single data points, based on their reserve position at a national level.

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National Audit Office

Design and Production by NAO Communications Team
DP Ref: 016915-001

£10.00
ISBN: 978-1-78604-638-3