Financial sustainability of adult hospices in England

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Public Accounts Committee

About the hospice sector

The hospice sector provides a specialised form of palliative care designed for individuals with life-limiting conditions. It combines specialist medical care with emotional and practical support to help manage symptoms and improve quality of life.

In 2024-25 UK adult hospices cared for 300,000 patients.[1]

Hospices provide a range of care in different locations. In 2022/23, 18% of hospices' total service activity was delivered in an in-patient unit (IPU) and 55% of hospices' total activity was delivered at the person's place of residence.[2]

About Sue Ryder

Sue Ryder hospice services include inpatient hospice care, day services, community services, physiotherapy and occupational therapy, wellbeing and community support, befriending, complementary therapy and lymphoedema services. We have seven hospice services across four Integrated Care Systems and demand for our services continues to increase year on year. 80% of the care we provide is in people's homes.

Access to hospice care

Estimates suggest that up to 90% of all dying people need palliative and end-of-life care (PEoLC) every year[3] and 1 in 4 are not able to access the end-of-life care they need.[4] This is at risk of worsening as demand for palliative care services is expected to rise by 55% between 2021 and 2031.[5]

Unequal access to hospice care

While work across the hospice sector is being done to address disparities, there are still persistent inequities in access to hospice care.

A Sue Ryder and University of Birmingham[6] evidence review found socio-economic inequalities such as low economic status, social exclusion and low health literacy increase a person's likelihood of experiencing inequity in PEoLC. It found that disadvantaged individuals face higher hospitalisation rates

[1] https://www.hospiceuk.org/about-us/key-facts-about-hospice-care
[2] Hospice UK (2025), https://www.hospiceuk.org/about-us/key-facts-about-hospice-care#content-menu-21317
[3] https://www.mariecurie.org.uk/globalassets/media/documents/policy/policy-publications/2023/how-many-people-need-palliative-care.pdf
[4] https://hukstage-bucket.s3.eu-west-2.amazonaws.com/s3fs-public/2021-10/Equality%20in%20hospice%20and%20end%20of%20life%20care%20-%20May%202021_0.pdf
[5] https://media.sueryder.org/documents/Modelling_Demand_and_Costs_for_Palliative_Care_Services_in_England_1.pdfhttps://media.sueryder.org/documents/Modelling_Demand_and_Costs_for_Palliative_Care_Services_in_England_1.pdf
[6] https://media.sueryder.org/documents/Inequity-in-palliative-andend-of-life-care-and-bereavement-support-an-umbrella-review.pdf

before hospice admission and have limited primary care visits. Additionally, limited access to essential medicines and healthcare services, exacerbated by stigma and fear of discrimination, is a shared experience. Geography was a structural determinant of inequity in access to PEoLC. This is partly because of access issues, such as being in rural and remote areas, poor infrastructure, limited transport options and long travel times.

Socio-economic factors influence the eventual place of death, with people in more deprived areas being more likely to die in hospital.[7] Additionally, 43% of White people who died between 2019 and 2021 died in a hospital setting, compared to 59% of Asian/Asian British people and 52% of Black/ African/ Caribbean/ Black British people.[8] This is concerning as just 6% of people want to die in hospital and the majority want to die at home.[9]

These issues of inequity are also present in specialist PEoLC. The hospice population is still disproportionately White, of higher social economic status and middle-aged.[10] As many hospices are independent, some have the misconception that you must pay to be cared for by a charitable hospice, which we know anecdotally can discourage people from accessing these services as they think they can't afford them.

Additionally, it is important to consider the context of the current hospice funding model. Evidence to the APPG on Hospice and End of Life Care emphasised how the reliance on donations deepens socio-economic inequalities, with communities in the most economically deprived areas least likely to be able to donate to their local hospice. As a result, their local hospice may have a lower income than hospices in more affluent areas and its community may have poorer access to services.[11]

Work is being done across the PEoLC sector to reduce inequity, with individual hospices taking a proactive approach to address disparities and widen access to care. However, widespread action to diversify models of care to meet the unique needs of diverse communities and populations is essential to achieving equitable care.

Delays in access to hospice care

Too many people at the end of life are identified to receive PEoLC too late, meaning they experience unnecessary pain and other health issues. Patients are accessing PEoLC when they are already at crisis

[7] Davies JM, Maddocks M, Chua K-C, Demakakos P, Sleeman KE and Murtagh FEM (2021) 'Socio-economic position and use of hospital-based care towards the end of life: a mediation analysis using the English Longitudinal Study of Ageing', The Lancet Public Health. www.thelancet.com/journals/lanpub/article/PIIS2468- 2667(20)30292-9/fulltext. Accessed 1 December 2022.
[8] ONS (2022), Number of deaths by ethnicity, place of death, region and age: England, 2011 to 2021. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/14716numberofdeathsbyethnicityplaceofdeathregionandageengland2011to2021
[9] Marie Curie (2024), Public attitudes to death, dying and bereavement in the UK re-visited: 2023 survey. https://www.mariecurie.org.uk/globalassets/media/documents/policy/policy-publications/2024/n401b_padd_briefing_final.pdf#:~:text=Most%20people%20in%20the%20UK,their%20preferred%20place%20of%20death.&text=Being%20free%20from%20pain%20and,days%20(38%25)%20of%20life
[10] Tobin J, Rogers A, Winterburn I, et al. BMJ Supportive & Palliative Care 2022;12:142–151. https://arc-eoe.nihr.ac.uk/sites/default/files/uploads/files/Hospice%20care%20access%20inequalities%20a%20systematic%20review%20and%20narrative%20synthesis_2.pdf
[11] APPG on Hospice & End of Life Care (2024). Government funding for hospices. https://hukstage-new-bucket.s3.eu-west-2.amazonaws.com/s3fs-public/2024-02/APPG%20Report%20%20Government%20funding%20for%20Hospices%20HUK.pdf?VersionId=0l8T4jC5V2C0zRKQLFs9ClZ5QZ5xEiOs

point. For example, 8% of people referred to a Sue Ryder IPU between September 2023 and October 2024 died before admission, indicating admissions are being left too late. Hospice UK data found that 11% of patients enter hospice when they are dying (as opposed to the other three Palliative Phases of Illness: stable, unstable and deteriorating).[12]

A key reason for late referrals is people not being identified as needing palliative care by healthcare professionals soon enough.

Lack of access to community care

Thousands of patients who need clinical support at the end of life could be supported by community hospice services rather than hospitals. However, a third of hospital inpatient care is for people in the last year of life[13] and in the year ending August 2023 9% of all emergency admissions were people in the last month of life.[14]

In many instances these admissions are preventable. In recent Sue Ryder polling of primary care health professionals, a lack of resource and equipment, poor advance care planning, and poor communication between healthcare providers were the key reasons given why people could not be treated or supported in the community. These are all issues that can be addressed by improving integration within the system improving PEoLC provision in the community. In the same polling of primary care health professionals 49% of respondents reported that pressure ulcers are the most common reason for emergency admissions at the end of life for patients in the community. This is despite the fact that the NHS reports that 80-95% of pressure ulcers are thought to be avoidable with the right care and prevention strategies.[15]

The hospice sector is well placed to provide these care and prevention strategies and support a shift in care to the community. In 2022/23 55% of hospices' total activity was delivered at the person's place of residence.[16] The hospice sector provides high quality care and our unique position in the system as independent organisations allows us to be flexible and innovative, helping us to ease the strain on the NHS in areas where it's most needed. For example, in 2023/24 Sue Ryder's hospice at home services in Peterborough and Cheltenham cared for 609 patients. Of those patients, 517 acute admissions were avoided.

Financial impact of lack of access

[12] https://hospiceuk-files-prod.s3.eu-west-2.amazonaws.com/s3fs-public/2025-11/Hospice%20Sector%20Data%202024-25%20-%20Big%20Conversation%20October%202025%20(1).pdf
[13] https://spcare.bmj.com/content/14/Suppl_1/A20.3
[14] Nuffield Trust (2024), How are hospital services used at the end of life? https://www.nuffieldtrust.org.uk/news-item/how-are-hospital-services-used-at-the-end-of-life-0#:~:text=In%20the%20most%20recent%20study,first%20wave%20of%20the%20pandemic
[15] https://www.homerton.nhs.uk/preventing-pressure-ulcers/
[16] https://www.hospiceuk.org/about-us/key-facts-about-hospice-care#content-menu-21317

People being unable to access timely and high quality PEoLC, particularly in the community, puts unnecessary strain on the health service. This is incredibly costly, £6.6 billion is spent on emergency hospital care for people in the last year of life.[17]

Improving access to timely PEoLC, and in particular care in the community, can reduce strain on the NHS and the healthcare workforce and save money in the longer term.

Financial challenges faced by the hospice sector

In England, on average the NHS funds around 40% of the care that a hospice provides[18] and hospices are reliant on charity retail, fundraising activities and voluntary donations to cover the remaining costs. Increasing costs and difficult economic circumstances are making it increasingly challenging for the sector to raise the funds it needs to provide vital care.

At Sue Ryder our net retail income fell from £11.4 million in 2023-24 to £3.5 million in 2024-25.[19] In this same time period underlying pay costs across Sue Ryder went up £2.4m, with retail pay costs seeing the largest increase of £1.9m. This increase is mainly due to the National Living Wage (NLW) increasing by 8.9% in the year, annual uplifts in rates of pay to keep pace with market rates and contribution increases to workplace pensions. The increase in NLW in April 2026 will cost Sue Ryder an estimated £434,000 to bring employees up to this new minimum. The full impact will be much higher as employees whose pay is currently in line with, or slightly over, the new NLW will also need pay increases to keep pay differentials.

On top of this, consumable prices increased in healthcare services by approximately 10%. During 2023–24 our utilities contract came to an end and for the 2024–25 financial year the cost of utilities increased by approximately 30%. This strain is being felt across the sector, 43% of hospices in England recorded a deficit in 2022-23, followed by 62% in 2023-24. This fell to 57% in 2024-25 due to the £100 million in capital funding that the Government announced in December 2024. The funding was welcomed by the sector, though it is not a long-term solution.

Additionally, hospices have historically not been commissioned on a level playing field with NHS services. Evidence submitted to the APPG on Hospice and End of Life Care[20] revealed that 28% of Integrated Care Boards (ICBs) provided annual increases to hospice contracts that were below increases offered to NHS services in their area and 5% gave no uplift at all. Encouragingly, in February 2025 we received confirmation from West Yorkshire ICB that hospice grant values would be uplifted from 2025/26 at a level equivalent to the NHS cost uplift factor (this equates to 2.15%). However, this is just one ICB across England.

[17] https://www.nuffieldtrust.org.uk/news-item/over-80-of-healthcare-cost-in-the-final-year-of-life-spent-on-hospitals#:~:text=More%20than%20half%20of%20this,spent%20on%20emergency%20hospital%20care.
[18] https://www.hospiceuk.org/fair-funding-hospices
[19] https://media.sueryder.org/documents/Sue_Ryder_Trustees_Annual_Report_and_Accounts_2024-25_signed.pdf
[20] https://hukstage-new-bucket.s3.eu-west-2.amazonaws.com/s3fs-public/2024-02/APPG%20Report%20-%20Government%20funding%20for%20Hospices%20HUK.pdf?VersionId=0l8T4jC5V2C0zRKQLFs9ClZ5QZ5xEiOs

Short-term funding

For the most part, hospice contracts are short-term which can lead to uncertainty and is detrimental to innovation in hospice care as providers must frequently focus their efforts on the next round of commissioning. When contracts are longer-term they often don't commit to providing inflationary increases over time. Any extra funding that is provided to address shortfalls is often given in the form of non-recurrent grants, which can help with short-term cash flow, but does not sustain services in the longer-term.

Variations in funding

Funding for our services varies significantly across different ICBs. In 2024/25, grant funding for the in-patient unit (IPU) at Sue Ryder St John's Hospice in Bedford covered 63% of the total IPU costs. In the same year, grant funding for the IPU at Sue Ryder Leckhampton Court Hospice in Cheltenham covered just 35% of total IPU costs.

There is also inconsistency of funding across different hospices operating within the same ICB. For example, one of our hospices received funding for nurse-led beds via the acute trust while another hospice in the same ICB struggled to get funding for medically-light beds. By raising this issue with commissioners, funding was secured to change this across the ICB. However, funding is currently non-recurrent.

An additional income stream is Continuing Healthcare (CHC) Funding for delivery of hospice at home services. However, annual uplifts are not automatically awarded between ICBs which creates inequitable funding models. There are situations where a patient dies before their CHC paperwork is complete, so we don't get paid for the care delivered. Patients can also get 'stuck' in hospice while their CHC award is disputed, meaning they're being cared for in an inappropriate setting, and Sue Ryder is paying for the care.

Workforce costs

In 2025, a Whole Time Equivalent of 13,250 clinical and care staff were contracted by hospices in the UK[21] and staffing represents the largest area of expenditure for hospices.[22] Although hospices employ clinical staff across many of the same roles found within the NHS, Government funding falls significantly short of covering these staffing costs. In 2024, Sue Ryder's palliative staffing costs were 170% of the total income we received from ICBs.

On top of this, hospices hire staff from the same pool as the NHS and, consequently, recruitment and retention is linked to our ability to keep pace with Agenda for Change (AfC). To put the challenges the

[21] https://www.hospiceuk.org/about-us/key-facts-about-hospice-care#:~:text=In%202024%2D25%2C%2013%2C250%20whole%20time%20equivalent%20clinical,work%20across%20a%20hospital%20and%20a%20hospice).

[22] https://www.hospiceuk.org/latest-from-hospice-uk/hospice-sector-facing-collective-deficit-ps77m

sector faces into perspective, UK hospices would have had to raise an additional £66 million pounds to match the increased pay for NHS staff announced in July 2024.[23]

Hospice UK's four-point plan[24] calls for NHS pay deals that reflect the cost of hospice staff. We support this ask. Without it, there is a significant risk that we will be unable to maintain parity with NHS pay, jeopardising our ability to sustain high-quality palliative care.

Solutions

Existing good practice

Sue Ryder's significant new NHS contract to grow our expert PEoLC services across Reading, Wokingham, Newbury and South Oxfordshire is an example of good practice when it comes to funding and commissioning PEoLC. This seven-year contract, which has the option to be extended for a further three years, with the NHS Buckinghamshire, Oxfordshire and Berkshire ICB will bring in several new and improved services, including a brand-new Hospice at Home service in Berkshire West which will prioritise comfort and quality of life for patients who wish to be at home. It will also see the expansion of a 'Virtual Ward' service across the region, which will provide hospital-level care to people in their own homes to reduce hospital admissions. Included in the new service will be a dedicated out-of-hours clinical advice line for patients, their families and their carers, alongside bereavement support, therapy and wellbeing services.

New ecosystem for PEoLC

There must be a shift from a grant model to a model with multi-year contracts based on NHS tariffs for this care. This would be a sustainable and fair route forward, allowing for new models of care that meet challenges in the sector and helping to shift more care to the community.

We want to work with the Government to create a new ecosystem for PEoLC to improve outcomes for patients, tackle inequalities, and reduce pressure on the wider health and care system. This will help the Government to achieve its ambitions laid out in the 10 Year Health Plan, including improving personalised care and moving care into the community.

Our PEoLC ecosystem involves Sue Ryder Alongside Suites being created on hospital sites. In our model, patients who are expected to be in the last year of life would be transferred to a Sue Ryder Alongside Suite from ambulances, A&E and other wards within the hospital.

Once in our care, we can put packages in place to discharge people back to the community, helping contribute to the Government's vision and, crucially, helping people live the rest of their lives to the fullest, and in the place they most want to be – home. In the current system, there are considerable delays and challenges when discharging patients nearing the end of life from hospital. Alongside Suites

[23] https://www.hospiceuk.org/latest-from-hospice-uk/nhs-pay-rise-response#:~:text=Toby%20Porter%2C%20CEO%20of%20Hospice,compound%20the%20hospice%20funding%20crisis.
[24] https://www.hospiceuk.org/fair-funding-hospices

will be in a better position to facilitate efficient transfer to community settings through their links with and knowledge of local hospice services.

For people who are at the end of life and cannot be discharged, Sue Ryder Alongside suites provide the "home for home" setting that people so greatly value from our hospices but all on the same grounds as the hospital. This gives families the space they need and gives the patient the high- quality care that hospices do so well.

Each Alongside Suite has the potential to care for hundreds of patients every year, rapidly freeing up bed space within the wider acute setting. The bed capacity of Alongside Suites could be scaled up or down dependent on need within the acute setting and the landscape of existing services in the area that can support admissions prevention and discharge.

We propose Alongside Suites are co-funded by the charitable sector and the NHS on a tariff basis, creating a more sustainable way for both government and hospices to deliver this care. By splitting the cost of this model down the middle – 50:50 – the hospice sector would see a dramatic improvement to the Government income it currently receives. This model does not require additional Government funding. Instead, our proposed funding mechanism is the redirection of some of the existing funding spent on PEoLC within Trusts to pay for Alongside Suites on a currency/tariff basis. This ensures that money follows the patient – Alongside Suites will take patients directly out of the acute setting.

While this does represent a considerable shift in the approach to PEoLC commissioning, Alongside Suites will deliver substantial value for money for the NHS. Our model would provide dying people admitted to hospital with the expert compassionate care that families value so much from hospices. It would be a more cost-effective use of available funds and would free up beds in our stretched and crowded hospitals. Not to mention, the model would realise wider savings in the system through the early identification of need for bereavement interventions.

Sue Ryder is well-placed to lead this change, with 80% of our care already provided in people's homes. In recent years we have shifted towards a community-based model in a drive to meet patient preferences. This has included the transformation of our PEoLC service in South Oxfordshire from an IPU to a mixed-model approach. Our hospice at home service in South Oxfordshire cares for patients in the community and this has been complemented by the establishment of specialist palliative care inpatient beds at Wallingford Community Hospital.

Specialist hospice inpatient care continues to be an essential component of the community PEoLC delivery model and should be funded through a combination of charitable income and statutory funding, in line with NHS tariffs. Hospice IPUs must also be considered as a support mechanism for patients facing increasing complexity in their lives as they enter their final 1000 days, working alongside Neighbourhood Health Centres to provide local support with symptom management, respite and holistic care at the right time. However, specialist hospice inpatient care must be complemented with other approaches if we are to ensure everyone has access to appropriate care when needed.

Sue Ryder

Because no one should face death or grief alone