Summary report

Death Deserves Better:
The case for transforming palliative and end-of-life care

Because no one should face death or grief alone

Introduction

Extraordinary societal and healthcare advances over the last 60 years mean people are living longer and with increasingly complex conditions. The healthcare system must adapt alongside these changes, and the palliative care sector is no different.

Sue Ryder's mission – **to make sure that everyone needing palliative care, approaching the end of their life or living with grief can access the support they need** – is as urgent today as it has ever been. What must change is how we pursue it. We cannot address today's problems through the delivery of a hospice care model that is 60 years old.

The problem

The evidence is clear – palliative and end-of-life care (PEoLC) needs reform. There is significant unmet need and inequity in access and the current PEoLC model cannot meet this demand with its existing infrastructure or financial position.

The scale of unmet need

- Over 650,000 people die each year in the UK[1] and around 90% are estimated to need some form of palliative care.[2]
- Almost one in three people do not receive the care they need at the end of their life.[3]
- Demand for PEoLC is projected to rise by 55% in the 10 years to 2031.[4]
- 55% of people say they want to die at home;[5] but over 40% currently die in hospital and only 28% die at home.[6]
- Almost 3,000 people a day receive corridor care in the NHS[7] and over half of nurses have reported having to provide end-of-life care in corridors or non-clinical areas.[8]

"For my loved one to remain at home with professional support to ensure comfort, dignity and full pain relief."

Tracy's wish

1 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathregistrationsummarystatisticsenglandandwales/2025
https://www.nrscotland.gov.uk/publications/adoptions-births-deaths-marriages-and-civil-partnerships-in-scotland-2025-registrar-generals-annual-statistical-tables-of-vital-events/
https://www.nisra.gov.uk/publications/weekly-death-registrations-northern-ireland-2025
2 https://www.mariecurie.org.uk/globalassets/media/documents/policy/policy-publications/2023/how-many-people-need-palliative-care.pdf
3 https://www.mariecurie.org.uk/blog/unmet-need-for-palliative-care
4 https://media.sueryder.org/documents/Modelling_Demand_and_Costs_for_Palliative_Care_Services_in_England_1.pdf
5 55% of 3,000 nationally representative UK consumers in research by Censuswide 2026
6 https://fingertips.phe.org.uk/documents/peolc_patterns_of_care_factsheet_2024.html
7 https://commonslibrary.parliament.uk/research-briefings/cbp-10938/
8 https://www.mariecurie.org.uk/media/press-releases/marie-curie-and-nursing-standard-survey-reveals-pressures-on-time-and-care-planning-areaffecting-end-of-life-care

Inequality in access

- Gaps in access are not random, they fall hardest on those with the greatest need.[9] Inequalities such as low socio-economic status, low health literacy and social exclusion increase a person's likelihood of experiencing inequity in PEoLC.[10]
- People who live alone are 52% more likely to die in hospital than those who live with others.[11]
- Ethnic minorities, patients without cancer, the oldest old and those living in rural or deprived areas are less likely to access hospice care.[12]

Financial sustainability

- The total hospice sector spend in 2023–24 was £1.55 billion, the highest on record.[13]
- Hospices across England ended 2025–26 with a collective deficit of more than £70 million – more than double the previous year.[14]
- Almost 60% have either made changes or considered reductions to balance their budgets. Specialist community hospice visits have fallen by 150,000 in a single year.[15]
- Meanwhile, it is becoming increasingly harder to fundraise to pay for services: fundraising return per £1 spent fell from £2.07–£2.15 in 2014–2019 to £1.96 by 2023–24.[16]

While government money is required to close the gap between those who need care and those who receive it, it is also true that more money directed at the current model cannot achieve this aim. Average hospice inpatient units occupancy rates stand at 77%,[17] yet thousands miss out on the care the sector can provide. The question is not only whether there is enough funding – it is also whether the current care models and scope of services being funded are still the right ones.

We need a fundamentally different ecosystem for PEoLC: one that is universal, integrated and proactive.

Reform of PEoLC must be seen as an opportunity to align funding, services and needs, ensuring community and neighbourhood care works across the spectrum of people and places. This requires sustainable funding, effective commissioning, stronger accountability for equitable provision, and better integration across primary and community care. **The political and policy conditions for bold reform are better now than they have been in a generation. Change must happen.**

9 https://committees.parliament.uk/publications/50461/documents/273119/default/
10 https://www.sueryder.org/blog/inequity-report/
11 https://www.strategyunitwm.nhs.uk/news/playing-our-part-conversations-about-death
12 https://spcare.bmj.com/content/12/2/142
13 https://www.nao.org.uk/wp-content/uploads/2025/10/the-financial-sustainability-of-englands-adult-hospice-sector.pdf
14 https://www.hospiceuk.org/latest-from-hospice-uk/hospice-deficits-have-more-doubled-year
15 https://www.hospiceuk.org/latest-from-hospice-uk/hospice-deficits-have-more-doubled-year
16 https://www.nao.org.uk/wp-content/uploads/2025/10/the-financial-sustainability-of-englands-adult-hospice-sector.pdf
17 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

The solution: the five shifts needed

Shift one: home and neighbourhood as the primary place of care

The only place where the capacity to deliver PEoLC can significantly increase without drastic and unrealistic increases in funding is in people's own homes and communities.

Current patterns of expenditure remain heavily weighted towards managing crises in hospital – of all healthcare expenditure on people in their final year of life, 56% is spent on emergency hospital care, while only 11% is spent on primary and community care.[18]

Sue Ryder modelling estimates that better access to care at home could mean around **300,000 fewer emergency hospital bed days and around 44,000 fewer deaths in hospital each year**. That would be a reduction of nearly 20% in hospital deaths.[19]

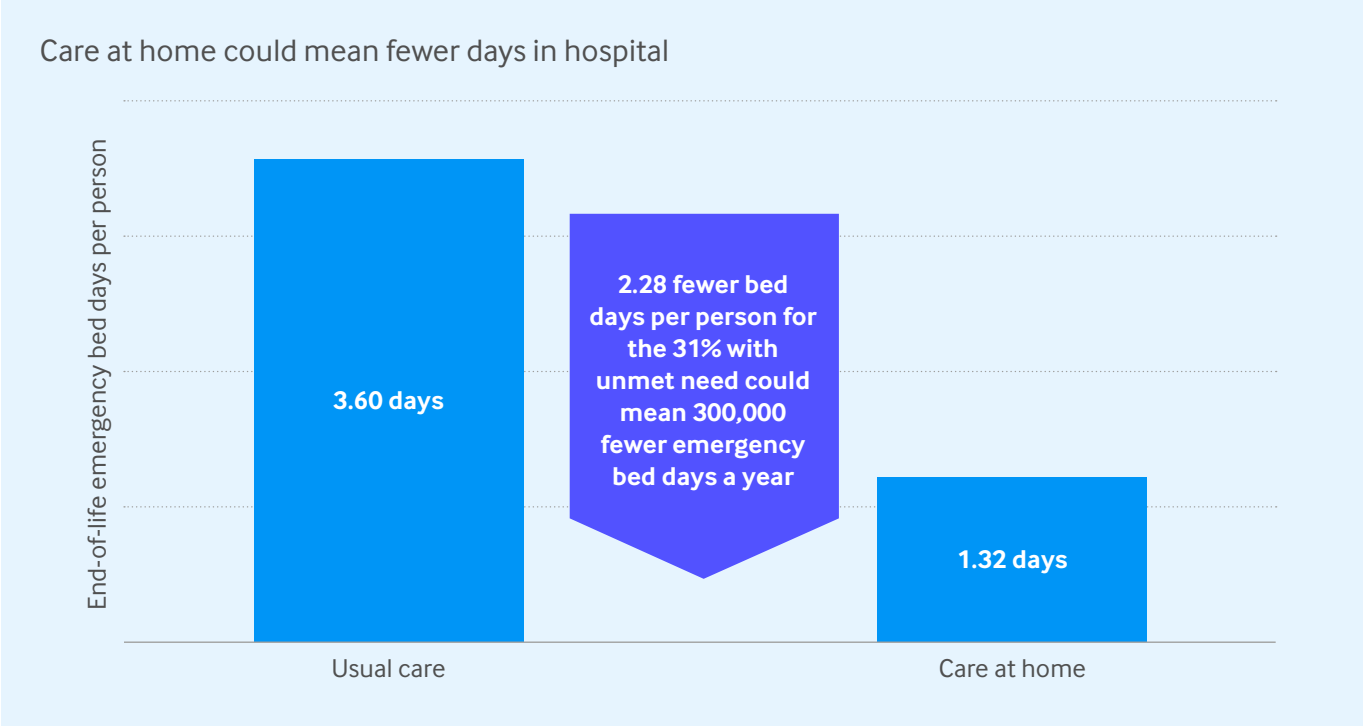


Figure 1. Reduction in bed days with increased care at home

Our projected modelling suggests home could become the most common place of death in England. Those dying at home would rise from 28% to 36%, while those dying in hospital would fall from 42% to 34%.[20, 21] In practice, some people could be supported to die in the care home where they live.[22]

This modelling shows community palliative care is not a compromise – it is the direction the evidence, the people we serve, the policy environment and the funding models are all signalling.

18 https://www.mariecurie.org.uk/document/public-expenditure-in-the-last-year-of-life-report
19 https://media.sueryder.org/documents/Projected_Care_Model_Shift_2026.pdf
20 https://media.sueryder.org/documents/Projected_Care_Model_Shift_2026.pdf
21 https://fingertips.phe.org.uk/documents/peolc_patterns_of_care_factsheet_2024.html
22 Existing research used for the modelling does not tell us how a national shift would split between people's own homes and care homes. (https://www.nuffieldtrust.org.uk/sites/default/files/2017-01/marie-curie-end-of-life-full-web-final.pdf, https://fingertips.phe.org.uk/documents/peolc_patterns_of_care_factsheet_2024.html)

The shift to community is not only in line with the majority of patients' preference, it is also more cost effective. Research from 2026 found home-based, specialist palliative care was associated with reduced costs of £7,908 per person who died.[23]

Shift two: specialist palliative care embedded in every hospital

Some individuals may continue to require support in a hospital setting, particularly where community-based care is not feasible, their condition deteriorates rapidly, or their needs are especially complex.

Currently, while specialist palliative care is available in many hospitals, it's not consistent and it's not 24/7. A 2025 audit found that 64% of hospitals offer face-to-face (nurse and/or doctor) palliative care 8 hours per day, 7 days a week.[24]

Working closely with ward teams, specialists can provide in-reach support across hospital sites, helping people to be discharged home or to their usual place of residence, where possible, whilst also supporting those to have a good death in hospital for those who need to remain there.

This could be done through dedicated wards, in-reach services working alongside emergency departments and generalist teams, or coordination hubs that identify patients requiring palliative support and ensure they receive it on-site or are discharged swiftly to the right community setting. Hospital leaders must make this care a priority, creating clear pathways, helping patients receive appropriate care and making better use of beds.

Shift three: hospice beds – right capacity, well-located, sustainably funded

Inpatient units (IPUs) will continue to play a role for people with complexity at the end of life – this is not in question. But they must be the right capacity, well-located, and sustainably funded – determined by population need.

Where inpatient capacity is needed and a hospice is the right provider, the clinical care should be fully funded by the NHS. Where community services can meet more people's needs at lower cost, resources should shift accordingly.

These are local decisions that should be made in genuine partnership with Integrated Care Boards (ICBs), NHS commissioners, and other providers to ensure the right level and location of services across all PEoLC needs.

Shift four: a society confident enough to talk about death

As a society, we are bad at talking about death and dying, and this silence has a harmful impact on people at the end of life and their families.

Advance Care Planning is essential to changing this, yet nine out of ten people in the UK have not written an Advance Care Plan.[25] People who plan for the end of their lives are almost twice as likely to die in their preferred place.[26] All patients should have the opportunity to engage in collaborative discussions with healthcare professionals to explore values, treatment preferences, and goals of care which should include preferred place of death.

23 https://journals.sagepub.com/doi/10.1177/02692163261423755
24 https://s3.eu-west-2.amazonaws.com/nhsbn-static/NACEL/2025/NACEL%202025%20State%20of%20the%20Nations%20Report%20-%20FINAL.pdf
25 Attitudes to palliative care research conducted by Censuswide and commissioned by Sue Ryder, March 2024
26 https://www.macmillan.org.uk/dfsmedia/1a6f23537f7f4519bb0cf14c45b2a629/9238-10061/missed-opportunities-advance-care-planning-report

Conversations should not stop after a death. We need a public health approach to grief – providing pathways that focus on a spectrum of support, from service providers and community-based approaches to formal therapy support.

The taboo around death is cultural, not inevitable. Public campaigns, accessible digital tools, community conversations, and health professionals equipped and confident to raise the subject can all shift the norm.

Shift five: skills and training across the whole system

The health and social care workforce is not adequately equipped to meet the needs of people at the end of life because of the insufficient provision of education and training.[27]

GPs, community nurses, care home workers, paramedics, pharmacists and allied health professionals, such as physiotherapists and occupational therapists, support dying people every day, often with little specialist training. Improving and increasing training for healthcare professionals will enable earlier identification, better symptom management, more appropriate use of specialist services and fewer crisis admissions. It will also help normalise conversations about dying.

The NHS should work with organisations like Sue Ryder to draw on years of expertise in training, education and development of practical tools.

"That no one has to lie in a hospital ward waiting for palliative care and passes away still waiting – I hope everyone can have a quiet calm place where they can be with family or friends or even on their own when they pass away."

Susan's wish

"For everyone to be treated with the dignity and respect they deserve, regardless of their postcode or economic background."

Michael's wish

27 https://committees.parliament.uk/publications/50461/documents/273119/default/

What we're asking

The NHS and the Government to:

- Commission differently and increase accountability. Set targets for palliative and end-of-life care to drive strategic commissioning, improving consistency, resourcing and equity.
- Set a baseline for the integration of PEoLC care as a core component of neighbourhood health infrastructure – within Primary Care Networks, ICBs, and the developing neighbourhood health teams.
- Sustainably fund the clinical cost of specialist palliative care delivered by hospice and community providers on the same basis as other contracted NHS services.
- Bridge the gap in funding required to support sector transformation and to extend services.
- View PEoLC as a core component of the prevention and NHS capacity agendas.
- Invest in workforce training, embedding palliative care skills as a core part of clinical education.

Our colleagues across the hospice and palliative care sector to:

- Prioritise reaching more people and start new conversations with other local providers and the NHS to review and reform provision – stretching our collective resources to match local population need.
- Be open about fairness in funding – we can only define what percentage of costs are covered by the NHS if we are clear as a sector what a reasonable cost for delivery is.
- Lead the public reframing: bed closures are not always a sign of decline – they can be a sign of progress.

We ask everyone to:

- Start the conversation with family, loved ones and your GP about what matters to you at the end of life.
- Make an Advance Care Plan to set out your wishes and guide your family through difficult decisions.
- Demand better from the NHS, hospice providers and the Government: end-of-life care that is available to everyone who needs it, whoever and wherever they are.
- Keep donating to help charities like Sue Ryder reach more people and provide the extra time, choice and family support that make a difficult time more manageable.

Thanks

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- Sue Ryder's Board of Trustees

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Sue Ryder is alongside people through terminal illness, death and grief. We provide expert palliative and end-of-life care and grief support, offering hope, dignity, and kindness.

For more information about Sue Ryder

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