Supplementary Written Evidence Submission to the Health Bill Public Bill Committee

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Summary

This supplementary submission builds on written evidence HB83, which proposed the establishment of a Geriatric Health Service (GHS) as a devolved operational arm within the restructured NHS. It addresses palliative and end-of-life care as a specific and critical use case for the GHS model, drawing on Freedom of Information data obtained from NHS Cheshire and Merseyside Integrated Care Board.

The data reveals a significant geographic variation in palliative care funding within a single ICB footprint, active decommissioning of palliative care services during the period the Health Bill has been under development, and a series of structural failures in out-of-hours and community palliative care that a properly resourced GHS community response model would be directly positioned to address. The systemic failures identified in this submission are independently corroborated by Marie Curie's written evidence to this Committee, confirming that what has been observed in

Cheshire West reflects a national pattern of failure rather than a local anomaly.

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1. The Palliative Care Postcode Lottery: FOI Evidence

In October 2025, this submission's author submitted a Freedom of Information request to NHS Cheshire and Merseyside ICB requesting annual budget allocations and expenditure on palliative and end-of-life care services, broken down by provider, for each financial year since the ICB's establishment in July 2022 (FOI reference: FOI01651CMICB, response dated 29 October 2025).

The data returned by the ICB reveals a significant geographic variation in palliative care funding between providers serving different areas within the same ICB footprint, not clearly explained by available population data.

Overall ICB palliative and end-of-life care budget:

Financial Year	Annual Budget (£)	Annual Spend (£)
2022/23 (Q2–Q4)	10,366,976	10,039,764
2023/24	13,835,475	13,629,951
2024/25	14,001,464	13,590,026

Provider-level breakdown revealing geographic variation:

Provider	22/23 Budget (£)	23/24 Budget (£)	24/25 Budget (£)
Hospice of the Good Shepherd (Chester)	752,067	892,706	923,691

Provider	22/23 Budget (£)	23/24 Budget (£)	24/25 Budget (£)
Wirral Hospice St John's	1,428,384	2,784,779	2,907,772
Halton Haven Hospice	1,174,728	1,595,106	1,631,033
St Rocco's Hospice	800,307	1,084,247	1,130,783
Willowbrook Hospice	1,432,792	1,720,614	1,657,431
Marie Curie	2,217,047	2,044,735	2,137,670

The disparity between the Hospice of the Good Shepherd, which serves the Chester and Cheshire West population, and Wirral Hospice St John's is particularly stark and is not clearly explained by available population data. By 2024/25, Wirral Hospice St John's received £2,907,772 — more than three times the £923,691 allocated to the Hospice of the Good Shepherd. On a per capita basis, using mid-2024 ONS population estimates of 328,873 for Wirral and 371,652 for Cheshire West and Chester, Wirral Hospice St John's received approximately £8.84 per resident, compared to approximately £2.49 per resident served by the Hospice of the Good Shepherd — a per capita funding ratio of more than 3.5 to 1 in favour of Wirral, despite Cheshire West having a larger population. Between 2022/23 and 2023/24, Wirral Hospice St John's budget nearly doubled — from £1,428,384 to £2,784,779 — while the Hospice of the Good Shepherd's budget increased by only £140,639 over the same period.

This significant geographic variation in funding within a single ICB is not clearly explained by the available data. No population needs assessment or commissioning rationale has been provided by the ICB to account for it.

2. Active Decommissioning of Palliative Care Services

The FOI response also disclosed details of efficiency savings, funding reductions, and service decommissioning applied to palliative care services since July 2022. The following actions were confirmed as having taken place in the 2024/25 financial year alone — the same year the Health Bill was introduced:

- **St Joseph's Hospice:** Contracted beds decommissioned. Budget fell from £364,912 in 2023/24 to £45,239 in 2024/25 — a reduction of approximately 88%.
- **St Catherine's Hospice:** Decommissioned entirely in 2024/25.
- **Hospice of the Good Shepherd:** Bereavement grant ended in 2024/25.

Three palliative care services cut or significantly reduced in a single financial year, while the ICB's overall palliative care budget increased by only £165,989 — from £13,835,475 to £14,001,464. The FOI response provides no evidence that the funds previously allocated to these services were reinvested in equivalent provision elsewhere, while the most vulnerable patients — those at the end of their lives — lost access to services they depended upon.

The ending of the Hospice of the Good Shepherd's bereavement grant is of particular note. Bereavement support is not a luxury. The evidence base for bereavement intervention in reducing subsequent mental health deterioration, GP demand, and hospital admissions is well established. Cutting it is a false economy that transfers cost from the palliative care budget to mental health, primary care, and acute services — precisely the demand displacement that the GHS model proposed in HB83 is designed to address.

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3. Structural Failures in Out-of-Hours and Community Palliative Care

Marie Curie's written evidence to this Committee (HB96) independently documents the systemic failures that FOI data from Cheshire West illustrates at the local level. Marie Curie's own research found that only 7 of 42 ICBs in England have a dedicated 24/7 single point of access to palliative care advice. Their PAR-AID study found that 77% of paramedics often or always lacked access to existing advance care planning documentation at the point of care. Marie Curie's submission further references the Health and Social Care Committee's Palliative Care report (HC 1763), which found that poor data sharing and lack of integration across NHS, social care, voluntary and private providers creates confusion, delays and gaps in continuity for people at the end of life, frequently placing the burden of coordination on patients and carers.

These findings point to a consistent national pattern of structural failure in the following areas:

- Absence of dedicated out-of-hours palliative care, leaving patients dependent on generalist out-of-hours GP services insufficiently resourced or trained to respond appropriately
- Out-of-hours clinicians failing to engage with advance care plans, resulting in unwanted and clinically unnecessary hospital admissions contrary to patients' expressed wishes
- Inaccessibility of Macmillan and Marie Curie services in some areas despite their availability in neighbouring localities within the same ICB footprint
- No reliable mechanism to access emergency palliative medication out of hours, causing avoidable suffering
- Hospital at Home services with inadequate palliative care training, including instances of refusing to attend patients

incorrectly assessed as actively dying
- Information silos between out-of-hours GPs, Hospital at Home, hospital services, and community nursing teams, contributing to unsafe decision-making and preventable admissions
- Poorly coordinated discharge processes leading to unsafe discharges and avoidable readmissions

These are not failures of individual clinicians. They are structural failures of a system that lacks the dedicated operational infrastructure to provide safe, dignified palliative care outside of a hospital setting.

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4. The Connection to HB83 and the Geriatric Health Service

Every failure identified in section 3 above is a failure that a properly resourced GHS community response model, as proposed in HB83, would be directly positioned to address.

The GHS proposal argues for a devolved operational arm within the NHS — modelled on the ambulance service — with its own community response teams, step-down facilities, and specialist workforce, operating alongside the NHS rather than within the acute system. Palliative care is one of the clearest use cases for this model.

Advanced care plan compliance requires a system that treats the document as operationally binding rather than advisory. A GHS community response team with a dedicated palliative care specialism could provide the framework within which advanced care plans become the primary clinical reference, reducing the incidence of unwanted hospital admissions at end of life.

Out-of-hours palliative response requires a dedicated response model — not a generalist GP service asked to perform a specialist function without adequate training or support. A GHS community response model could provide exactly this framework.

Emergency medication access requires a system with the infrastructure to hold and administer palliative medications in the community. This is a logistics and governance question, not a clinical one — and it is one that a ring-fenced GHS with its own supply chain and protocols could be designed to address.

Information sharing between Hospital at Home, community nursing, district nurses, GPs, and hospital services requires a shared operational framework. Marie Curie's written evidence to this Committee has specifically proposed an amendment to Clause 47 requiring single patient records to be made available to all palliative and end-of-life care providers, including voluntary sector and social care providers. This submission supports that amendment and notes that the GHS submission's recommendation that ICBs be required to report on step-down care capacity and care home coordination directly addresses this systemic fragmentation from the operational side.

Hospital at Home clinical governance requires a dedicated palliative care pathway as an alternative to both acute admission and a generalist service unequipped to respond. A GHS community response model with embedded palliative care training could provide the specialist palliative overlay that currently does not exist.

Bereavement support — decommissioned in Cheshire West in 2024/25 — would be protected within a GHS model that treats the full palliative pathway, including bereavement, as within its operational remit rather than as an optional extra subject to efficiency savings.

The palliative care postcode lottery evidenced in this submission is not primarily a funding problem. The ICB's total palliative care budget increased modestly year on year. It is an architectural problem — the same architectural problem identified in HB83. Services are commissioned and decommissioned without coherent strategic logic, without a dedicated operational model to hold them, and without ring-fenced protection from the broader NHS financial pressures that have repeatedly cannibalised palliative care provision across England.

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5. The Ask

This supplementary submission calls on the Committee to note the following in addition to the recommendations set out in HB83:

1. That the Health Bill's restructuring of ICB commissioning functions must explicitly address the geographic inequality in palliative and end-of-life care funding that the current ICB model has demonstrably failed to resolve — and in some cases actively worsened. This submission supports Marie Curie's proposed amendment to Clause 20 requiring annual ICB performance assessments to include an assessment of whether each ICB is meeting its duty to provide palliative care services that meet the needs of its population.
2. That the Secretary of State's new direction powers over ICBs under Clause 11 should be used to require ICBs to publish palliative care funding allocations by provider and geographic area on an annual basis, enabling transparent scrutiny of postcode disparity.
3. That any feasibility study into a devolved geriatric operational model, as recommended in HB83, must specifically consider palliative and end-of-life care as a core function of the GHS — not as an adjacent service, but as a defining purpose of a

community response model designed to support people through the end of their lives with dignity, in the place they choose, with the clinical support they need.

The people who have experienced avoidable distress at the end of their lives because the out-of-hours palliative infrastructure did not exist represent a category of systemic failure that Parliament is now in a position to begin to address. The Health Bill is an opportunity to do that. This submission asks the Committee to take it.

Sources and Evidence Base

- NHS Cheshire and Merseyside ICB. *FOI Response FOI01651CMICB: ICB Funding for Palliative and End-of-Life Care (Historic and Current)* (29 October 2025). Publicly available at: https://www.whatdotheyknow.com/request/icb_funding_for_palliative
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- Office for National Statistics. *Mid-Year Population Estimates, United Kingdom, June 2024* (September 2025). Cheshire West and Chester: 371,652; Wirral: 328,873.

- Health and Social Care Committee. *Palliative Care: Sixth Report of Session 2024-26* (HC 1763). https://committees.parliament.uk/work/8372/palliative-care/publications/