Neighbourhood Health Service: hospice evidence briefing November 2026

Independent charitable hospices provide holistic care and support for people with life-limiting illness and their families. Their services range from living well support, rehabilitation and bereavement care, through to community, outpatient and inpatient services, including specialist palliative and end of life care. Hospices are deeply rooted in the communities they serve, and connected to with patients, families, community groups, primary care and wider health services.

Hospices are already supporting people to remain at home, coordinating care with primary and community services, upskilling the wider workforce, and providing specialist palliative and end of life care outside hospital. This improves outcomes for patients and families while reducing pressure on the NHS, with specialist palliative care delivered at home or in a hospice has been shown to reduce costs by around £8,000 per person.[1]

However, evidence from hospices across England shows that their involvement is often not built into the design of neighbourhood health. This limits the benefits of integrated neighbourhood health services that can be realised for people with a palliative and end of life care need.

To gather the evidence, I reached out to the 180 members of Hospice UK in England to ask them if they were involved in neighbourhood pilots. I then interviewed all the hospices who responded and the results of those interviews formed the basis of this briefing.

Hospices are already reshaping services around neighbourhoods

Hospices are adapting to support neighbourhood health and care closer to home by reshaping services, workforce models and organisational structures to align more closely with neighbourhood working. St Clare Hospice in Essex has embedded Clinical Nurse Specialists within neighbourhood teams and community settings, including GP practices. St Peter's Hospice in North Somerset has expanded its community presence through community hubs and by delivering more services outside the hospice building.

By reshaping services around local structures, hospices are demonstrating how specialist palliative and end of life care can be better connected with community, primary care and other voluntary sector support. ICBs need to work with hospices as core partners in this process, ensuring that wider neighbourhood services understand hospice expertise, refer people at the right time, and build pathways that make the best use of existing hospice services.

How hospices are being brought into neighbourhood health

Hospice involvement in neighbourhood health is heavily shaped by the strength of their relationship with their local ICB. Where there are strong, established relationships, hospices are more likely to be brought into neighbourhood health early and meaningfully, with opportunities to shape design and delivery. Where those relationships are weaker, less formal, or reliant on individual contacts, involvement is more likely to be inconsistent or delayed.

[1] May P et al. *Specialist palliative care improves patient experience, reduces bed days and saves money: an economic modelling study of home- and hospital-based care*. medRxiv, published 21 August 2025.

In some cases, these relationships are formal and well established, which has translated into clear involvement in neighbourhood health. For St Elizabeth Hospice in Suffolk, the ICB executive team actively brings the hospice and wider voluntary sector into system planning, including the place board and the oversight group for the National Neighbourhood Health Implementation Programme. These formal roles allow the hospice to support the direction of the programme and, in this case, ensure that palliative and end of life care is included as its own workstream, which the ICB asked St Elizabeth's CEO to chair.

These formal involvements are also due to place level relationships where neighbourhoods can be further advanced. St Michael's Hospice in Herefordshire had built strong links across the local health sector, and worked closely with the Health and Wellbeing Board and the local Acute Trust. These links allowed St Michaels to ensure that Palliative and End of Life Care was a key priority for neighbourhood health, with the CEO taking on the role of senior responsible officer for relevant workstreams.

In other areas, involvement has relied on existing relationships or ICB knowledge. In North Somerset, the locality lead brought St Peter's Hospice into the programme because its Community Nurse Specialists and Hospice at Home team already supported the target population. Despite joining the core team two months later than other partners, the hospice contributed to community co-production and its Education Team secured a role supporting multidisciplinary team education.

However, recent changes have created challenges. Some hospices report that navigating mergers, staff reductions and evolving governance arrangements can make it harder to maintain momentum. This is particularly challenging for hospices working across more than one ICB, where arrangements can differ significantly. Princess Alice Hospice, for example, has reported that changes in London's ICBs have created these kinds of challenges. Hospices feel this more keenly where relationships have depended on one or two key contacts who have since left. Springhill Hospice reported that this has led to a loss of momentum within their pilot scheme.

This variation demonstrates the need for national guidance on Neighbourhood Health to include a clear expectation that ICBs bring hospices into the development and delivery of services.

Funding Neighbourhood Health

Hospices, along with other voluntary sector organisations, are rightly recognised as crucial to the successful rollout of Neighbourhood Health because of their existing services and strong community knowledge. Hospices are contributing time, expertise and services to help shape the future of Neighbourhood Health. However, much of this work is currently being delivered on a goodwill basis and without dedicated funding, leaving hospices to absorb the work into already stretched teams.

Several hospices highlighted that involvement has only been possible by temporarily changing working patterns or freeing up resources, including St Peter's Hospice. Others, such as Lewis-Manning Hospice Care, are being more explicit about the need for future funding arrangements and are highlighting how their current services link to Neighbourhood Health's goals. As Neighbourhood Health develops, hospices and the voluntary sector will need clear funding streams to support engagement, coordination and delivery.

This is particularly important when some hospices interviewed, such as St Clare Hospice, are having to scale back or cut services due to the hospice funding crisis.

Recommendations

1. Issue national guidance to ICBs setting out when and how hospices should be engaged in Neighbourhood Health design and delivery.
2. Recognise palliative and end of life care within Neighbourhood Health, and ensure pilots consider how to support people who need this care.
3. Provide dedicated funding for hospice and VCSE engagement and delivery, including the time required to participate in service design, coordination and partnership working.
4. Implement Hospice UK's four-point plan, including full funding for specialist palliative care and proper contracts for hospices, to provide the sustainable basis for hospice involvement in Neighbourhood Health.

More information on the four point plan, and the hospice funding crisis can be provided on request.

If you would like to talk more about what is in this briefing, please do contact a.staplesmccall@hospiceuk.org