MDA No.: 1704

Title: Health Committee *End-of-Life Care in London* Report

1. Executive Summary

1.1 At the Health Committee on 5 March 2025, the Health Committee discussed end-of-life care in London and resolved:

That authority be delegated to the Chair, in consultation with party Group Lead Members, to agree any output from the discussion.

1.2 Following consultation with party Group Lead Members, the Chair of the Health Committee agreed the *End-of-Life Care in London* Report, as attached at **Appendix 1**.

2. Decision

2.1 **That the Chair of the Health Committee, in consultation with the party Group Lead Members, agree the *End-of-Life Care in London* Report, as attached at Appendix 1.**

Assembly Member

I confirm that I do not have any disclosable pecuniary interests in the proposed decision and take the decision in compliance with the Code of Conduct for elected Members of the Authority.

The above request has my approval.

Signature: 

Printed Name: **Krupesh Hirani AM, Chair of the Health Committee**

Date: **24 April 2025**

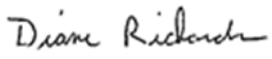
3. Decision by an Assembly Member under Delegated Authority

Background and proposed next steps:

3.1 The exercise of delegated authority approving the letters will be formally noted at the Health Committees' next appropriate meeting.

3.2 The terms of reference for this investigation were agreed by the Chair, in consultation with relevant party Group Lead Members, on 6 September 2024 under the standing authority granted to Chairs of Committees and Sub-Committees. Officers confirm that the response falls within these terms of reference.

Confirmation that appropriate delegated authority exists for this decision:

Signature (Committee Services): 

Printed Name: Diane Richards

Date: 23 April 2025

Financial Implications: NOT REQUIRED

Note: Finance comments and signature are required only where there are financial implications arising or the potential for financial implications.

Signature (Finance): Not Required

Printed Name:

Date:

Legal Implications:

The Chair of the Health Committee has the power to make the decision set out in this report.

Signature (Legal): 

Printed Name: Rebecca Arnold, Deputy Monitoring Officer

Date: 24 April 2025

Email: rory.mckenna@london.gov.uk

Supporting Detail / List of Consultees:

- *Emma Best AM*

4. Public Access to Information

4.1 Information in this form (Part 1) is subject to the FoIA, or the EIR and will be made available on the GLA Website, usually within one working day of approval.

4.2 If immediate publication risks compromising the implementation of the decision (for example, to complete a procurement process), it can be deferred until a specific date. Deferral periods should be kept to the shortest length strictly necessary.

4.3 **Note**: this form (Part 1) will either be published within one working day after it has been approved or on the defer date.

Part 1 - Deferral:

Is the publication of Part 1 of this approval to be deferred? NO

If yes, until what date:

Part 2 – Sensitive Information:

Only the facts or advice that would be exempt from disclosure under FoIA or EIR should be included in the separate Part 2 form, together with the legal rationale for non-publication.

Is there a part 2 form? NO

Lead Officer / Author

Signature: Tim Gallagher

Printed Name: Tim Gallagher

Job Title: Senior Policy Adviser

Date: 23 April 2025

Countersigned by Executive Director:

Signature: 

Printed Name: Helen Ewen

Date: 24 April 2025

LONDONASSEMBLY

Health Committee

Appendix 1

End-of-life care in London: a review

April 2025

Key findings:

- London has an ageing population, meaning more Londoners will be **living longer with multiple conditions and complex palliative care needs.**
- There has been **an increase in the number of people dying at home**. But unplanned **emergency admissions in the last three months of life** are significantly higher in London than in the rest of the country, suggesting a lack of community-based support to prevent crisis-driven hospital admissions.
- Current **workforce levels across health and social care settings are not enough** to meet either existing or future demand for palliative and end-of-life care.
- Voluntary sector partners providing end of life care have been experiencing cost pressures in recent years with **rising costs associated with running buildings, inflation and National Insurance rises.**
- Navigating end-of-life care services can be **complex and overwhelming**, creating barriers to accessing quality and timely care.
- **Improving public understanding of end-of-life care**, also understood as 'death literacy', would help individuals and families feel more prepared, reduce fear, and improve informed decision-making about care preferences.
- Ethnic minority communities face barriers to high-quality palliative care, often due to a **lack of cultural sensitivity among healthcare providers**.
- **Inadequate housing conditions in London** can make it difficult for healthcare professionals to deliver safe care, forcing more patients into hospital settings instead of dying at home as they may prefer.
- Patients often face barriers to getting prescriptions, GP visits, and nursing **support at night, on weekends, and during bank holidays**, leading to avoidable emergency hospital admissions.
- Healthcare providers must **navigate multiple systems** across different Integrated Care Boards (ICBs). This can also lead to confusion for patients in accessing basic palliative care services.

End-of-life care in London: a review

April 2025

What are the issues?

London has an **ageing population**. By 2035, the number of people aged above 60 years is predicted to rise by 48 per cent and the number aged above 80 is set to rise by 70 per cent.[1] This will only increase the demand for end-of-life care provision in the capital.

The charity Marie Curie has stated that **end-of-life care in the UK is "in crisis"**, with one in four people not getting the care they need, one in three dying in overwhelming pain, and one in five unable to access GPs in the last three months of life.[2]

Older people and people with advanced disease can now live with eight or more different chronic health conditions, such as heart disease, cancer, chronic obstructive pulmonary disease (COPD), and dementia. The National Institute for Health and Care Research (NIHR) Applied Research Collaborations South London, a research organisation focusing on social care, argues this will create **more demand for palliative care services and increased costs for the NHS**, as around 20 per cent of all healthcare costs are spent on people in the last year of life.[3]

The London Assembly Health Committee last looked into the issue of end-of-life care in 2015-16.[4] Nearly a decade later, the Committee revisited the issue to understand how the picture has changed and what progress has been made on our previous recommendations. We received evidence from key stakeholders – including clinicians, organisations delivering end-of-life care, and charities – at a meeting in March 2025 and in writing.

What is end-of-life care?

End-of-life care (EOLC) is usually defined as care for people likely to die within a year. It is intended to enable people to live as well as possible until they die, and to die with dignity. People at the end of life include those who:

- have an advanced incurable illness, such as cancer, dementia or motor neurone disease.
- are generally frail and have co-existing conditions that mean they are expected to die within 12 months.
- have existing conditions if they are at risk of dying from a sudden crisis in their condition.
- have a life-threatening acute condition caused by a sudden catastrophic event, such as an accident or stroke.[5]

What the Committee heard

24-hour access to EOLC Services

One of the strongest themes to emerge from our meeting was the urgent need for 24/7 access to end-of-life and palliative care services across London. Evidence from healthcare professionals and experts highlighted the gaps in round-the-clock support, with patients and families struggling to access essential care, medication, and advice outside of standard working hours.

> "The other thing I would say is there would be particular value in the Mayor leading a discussion around the idea of 24/7 access to this care in London. Terminal illness does not respect the clock. People get really unwell at nights and weekends and bank holidays, and you have heard a lot about their struggle to access medicines through community pharmacies and prescribers."
>
> **Ruth Driscoll,** Associate Director for Policy and Public Affairs, Marie Curie[6]

> "Whilst the GP needs to be the final point of contact in holding that care, you then need to make sure that there is specialist palliative care advice available 24 hours a day."
>
> **Dr Libby Sallnow,** Associate Professor and Head of Marie Curie Palliative Care Research Department, University College London[7]

> "Even in hospitals, not every hospital in London is able to provide face-to-face, 24-hour palliative care specialist access, which is one of the Government's recommendations. That is something that needs to happen so that our patients have access to specialist advice and care."
>
> **Dr Armita Jamali,** Consultant in Palliative Medicine, The Royal Marsden and Royal Brompton Hospitals[8]

Poverty and end-of-life care

We were concerned to hear evidence about the intersection between poverty and end-of-life care, particularly the impact of housing quality, financial insecurity, and access to benefits. Poor housing conditions—such as overcrowding or damp—can make it difficult for healthcare professionals to provide safe, high-quality care at home. Additionally, while fast-tracked benefits are available for those at the end of life, awareness and uptake remain low.

"Affluence is associated with being much more likely to access specialist palliative care services than those in poverty. We also know that it is affecting patients being able to stay in their own home, for instance, being able to afford the electricity that allows them to plug in their hospital bed and their air mattress when they have got electricity meters that are just eating up cost."

Dr Katherine Buxton, Consultant in Palliative Medicine at Imperial College London and Clinical Director for Palliative and End-of-life Care Network, NHS England - London[9]

"There are a number of benefits that people can get fast-tracked, special rules at the end of life. There is a lot potentially that perhaps the Mayor's office could do around making that more well-known and improving uptake."

Sarah Scobie, Deputy Director of Research, Nuffield Trust[10]

Use of emergency services and unplanned hospital admissions

We were concerned to hear about the high reliance on emergency services for people at the end of life in London. Hospitals are the most common place of death in England, accounting for 42.8 per cent of deaths in 2023, but this figure is even higher in London at 48.8 per cent.[11] Although the proportion of people dying in hospital has declined over time, the use of other hospital services in the final months of life, such as emergency departments, is increasing.[12] Frequent hospital admissions are indicative of poor care planning and poor quality of end-of-life care.[13] This is particularly concerning as home is often the preferred place for end-of-life care and death.[14]

Ruth Driscoll, Associate Director for Policy and Public Affairs at Marie Curie pointed out that in the last three months of life, seven per cent of people who died in London had more than three emergency admissions, while 62 per cent had more than one, highlighting how frequent hospital visits can indicate a crisis rather than planned, coordinated care.[15]

Sarah Scobie, Deputy Director of Research at Nuffield Trust, also highlighted the significant costs of this reliance. Over half of healthcare spending for people in their last year of life goes to emergency hospital care, with emergency admissions and A&E visits accounting for 56 per cent of total costs.[16]

End-of-life care in London: a review

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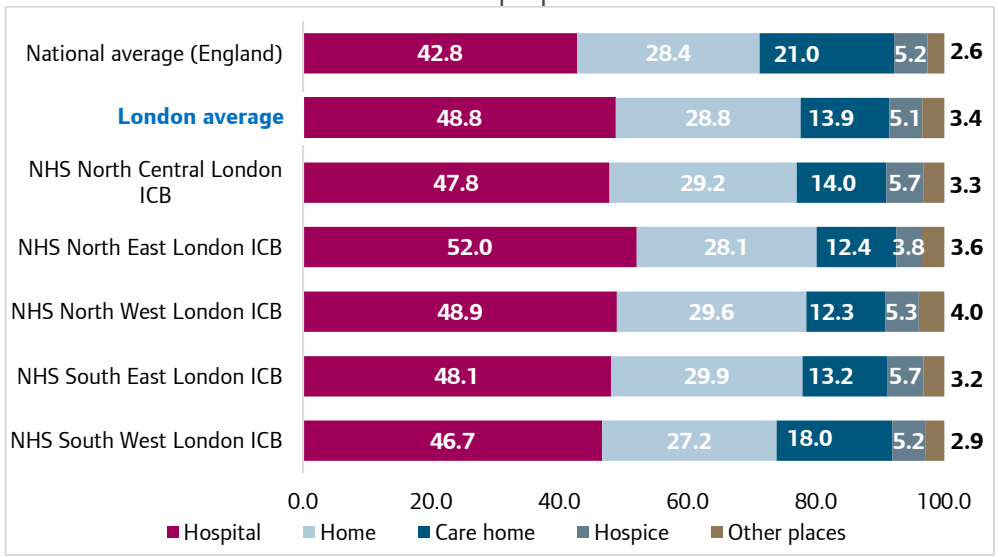
Figure 1: Place of death, 2023

A higher proportion of people die in hospital in London than in England and Wales as a whole and a lower proportion die in a care home*



Source: Department for Health and Social Care[17]

**values may not add up to 100 due to rounding*

"What we also know in London is that, again compared to the other regions, we have a much higher unplanned emergency admission rate in the last three months of life."

Dr Katherine Buxton, Consultant in Palliative Medicine at Imperial College London and Clinical Director for Palliative and End-of-life Care Network, NHS England - London[18]

"When you ask people where they would like to be at the end of their life, most people's preferred place of care is at home but in London what is happening is that a much higher than average proportion of people are dying in hospital, so 48.8 per cent of people died in a hospital in London and that is higher than the England average of 42.8 per cent."

Ruth Driscoll, Associate Director for Policy and Public Affairs Marie Curie[19]

Integrated Care Boards (ICBs) and variation in London's health services

As part of the Health and Care Act 2022, ICBs replaced Clinical Commissioning Groups (CCGs) and took on a legal responsibility to commission palliative care services to meet local needs.[20] Dr Armita Jamali shared with the Committee that the introduction of ICBs had brought some benefits, especially during COVID-19, when there was a more unified approach to discharge planning and social care in London, leading to efficient patient transitions from hospital to home.[21]

However, Dr Armita Jamali reported that variation between ICBs has increased, with different policies, processes, and care pathways emerging across boroughs. As a result, healthcare providers are having to navigate

multiple systems across the five different ICBs in London. This can also lead to confusion for patients in accessing basic palliative care services.

While ICBs must commission services independently to meet local needs, evidence suggests that fundamental aspects of palliative care – such as access to community support, specialist equipment, and clear referral pathways – vary significantly across London. Addressing these inconsistencies would help ensure that all patients receive timely and equitable care, regardless of their borough.

> "I completely understand that the whole point of ICBs is that they are looking at their local communities and commissioning services for those needs but at the same time when we are talking about palliative and end-of-life care, there are really basic services that we need for our patients that need to be unified across the board. Accessing those and being able to request those needs to be unified and simplified so that services can be streamlined and efficient."
>
> **Dr Armita Jamali,** Consultant in Palliative Medicine, The Royal Marsden and Royal Brompton Hospitals[22]

The complexity of navigating end-of-life care is not only a challenge for providers working across multiple ICBs but also for patients and carers, who often struggle to access the right support. Dr Libby Sallnow, Associate Professor and Head of Marie Curie Palliative Care Research Department at UCL, highlighted the potential of care navigators – semi-professional or volunteer-led roles – to help individuals manage complex care pathways, advocate for their needs, and ensure continuity of support, particularly in the community.[23]

Marie Curie shared with the Committee its recommendation to ICBs to explore the case for commissioning innovative and integrated models of palliative and end-of-life care in community and NHS settings. The Committee fully supports this view, recognising the potential of such models to improve patients' experiences at the end of life and reduce wider pressures on the health and care system.[24]

Pressure on hospices

In September 2024, Hospice UK estimated that the hospice sector is heading for a deficit in the region of £60 million for the current financial year – and has called for the funding model to be reviewed.[25] [26] Becca Trower, Joint CEO and Clinical Director at St Raphael's Hospice, highlighted the significant financial challenges hospices are facing, particularly the heavy reliance on charitable funding, the impact of funding cuts, and increasing demand for services.

In response to financial pressures, Becca Trower told us that the hospice was forced to make £1 million in cuts last year, leading to reduced community services, including the loss of its Hospice at Home team, which previously provided in-home end-of-life care. She emphasised that hospices play a critical role in education and collaboration with both health

and social care providers, yet this contribution is often overlooked in broader discussions on end-of-life care.[27]

National insurance rises have increased funding available to the NHS but it has also added a cost pressure to the voluntary sector organisations.[28] While the Government's £100 million grant for digital services and capital projects was welcomed,[29] Becca Trower explained, "it is not to be spent on staffing so that money that we are getting at St Raphael's will soon be wiped out by the £140,000 national insurance hike."[30]

> "We have £6.5 million a year that it costs for us to run, £1.7 million comes from the ICB and the rest is down to us. Last year we made £1 million worth of cuts and that has meant that we have had to cut our community services, which seems so counterintuitive when we are talking about supporting people at home."
>
> **Becca Trower,** Joint CEO and Clinical Director, St Raphael's Hospice[31]

Death literacy

Experts often highlighted the lack of a common language around death and dying, which affects both healthcare professionals and the public. Several guests called for a greater promotion of 'death literacy', which concerns the "the knowledge and skills that people need to make it possible to gain access to, understand, and make informed choices about end of life and death care options."[32]

> "If there is anything that I would really like to see, it is called death literacy. In health and care, everyone has a different understanding of what these words mean… It would be lovely to see a unified understanding in London."
>
> **Dr Lyndsey Williams,** General Practitioner and Clinical Lead for End-of-Life Care, North West London Integrated Care Board[33]

> "Conversations about wills, lasting power of attorney, and understanding what the end of life might hold need to be normalised—and held outside of the NHS. Something public-facing to support what we are doing in health and social care would be incredibly beneficial."
>
> **Dr Katherine Buxton,** Consultant in Palliative Medicine at Imperial College London and Clinical Director for Palliative and End-of-life Care Network, NHS England - London[34]

The lack of open conversations about dying was further highlighted by Marie Curie's 2024 nationally representative survey in England and Wales, showing that only one in three people who died had a healthcare professional discuss death and dying with them.[35] [36]

The evidence we have gathered highlights the need for greater public and professional understanding of end-of-life care, including clearer definitions, normalising conversations about death, and improving confidence among families and carers.

What's working well?

During the Committee meeting, several innovative models of care were highlighted as effective approaches that could improve palliative and end-of-life care in London. Expanding these models or increasing public awareness of them could enhance access, coordination, and quality of care for patients and their families.

Whole Systems Integrated Care (WSIC) Dashboard

North West London ICB has made use of the WSIC dashboard, a data system that integrates information from NHS and social care records to help identify patients in need of more targeted and proactive care.[37] By pulling data from multiple sources – including GPs, hospitals, and community services – the system helps identify patients earlier and supports proactive care planning.

Dr Lyndsey Williams told us that North West London ICB is planning to introduce a new adult community specialist palliative care model, aimed at expanding access to those in need. [38] The WSIC dashboard will track its success by monitoring patient engagement with the new services.[39]

> "We have something called the Whole Systems Integrated Care (WSIC) dashboard in North West London… It is a data warehouse where we can pull codes from all systems of the NHS and social care. … If coded properly, we have a reasonable idea of how many patients would or could have palliative care needs."
>
> **Dr Lyndsey Williams**, General Practitioner and Clinical Lead for End-of-Life Care, North West London Integrated Care Board[40]

While the WSIC Dashboard system is accessible across London, its use varies between ICBs, highlighting the need for greater adoption and awareness among healthcare professionals. Dr Lyndsey Williams noted that its effectiveness depends on whether everyone is using it and whether they have the time to do so.[41]

Universal Care Plan (UCP)

The UCP is a digital record that allows doctors, nurses, care homes, and palliative care teams to see and update a patient's end-of-life care plan.

This helps ensure that a patient's wishes and medical needs are known across different services, leading to improved continuity of care and fewer unnecessary hospital visits. [42]

Beyond professional use, the UCP also allows patients and families to take a more active role in their care planning, helping to normalise conversations about death and empower people to make informed choices.[43] Despite its potential, public awareness and engagement with the UCP remain low, and greater efforts are needed to ensure wider adoption in London.

> "The Universal Care Plan supports death literacy, earlier identification, and empowers people to take control of their own health and social care."
>
> **Dr Katherine Buxton,** Consultant in Palliative Medicine at Imperial College London and Clinical Director for Palliative and End-of-life Care Network, NHS England - London[44]

Initiatives outside London

Responsive Emergency Assessment and Community Team (REACT)

The REACT model, a partnership between Marie Curie and Bradford Teaching Hospitals, helps identify palliative care patients in emergency departments and transition them to community-based care instead of hospital admission. It provides short-term intensive support (up to 72 hours) through a virtual ward model, ensuring patients receive urgent care in their preferred setting.[45]

Dr Katherine Buxton shared that the REACT model has been highly successful in some areas, and there is ongoing work in North Central London to pilot a similar approach.[46] Expanding REACT or introducing similar pilots across London's ICBs could reduce pressure on hospitals, prevent unnecessary admissions, and provide faster, more coordinated care for palliative patients.

Cambridgeshire & Peterborough Palliative Care Hub

A 24/7 single point of access for palliative care patients can dramatically improve service coordination and access to specialist advice and support. This model has been a recommendation of the National Institute for Health and Care Excellence (NICE) for over a decade, yet it is not widely implemented in London.[47]

There are good examples of this model working elsewhere: the Cambridgeshire & Peterborough Palliative Care Hub integrates with the NHS 111 system, ensuring that end-of-life patients calling 111 are immediately transferred to a specialist palliative nurse who can rapidly coordinate their care.[48]

> "If you ring 111 in Cambridge and Peterborough as an end-of-life patient, you are immediately connected to a palliative care nurse who can quickly and efficiently link you to local services. This has massively improved access for deprived communities."
>
> **Ruth Driscoll,** Associate Director for Policy and Public Affairs, Marie Curie[49]

A London-wide rollout of a 24/7 single point of access for palliative care patients could significantly improve timely access to palliative care services, particularly for underserved groups.

What more needs to be done?

Convening for change: The Mayor's role in bringing London's health leaders together

A key theme emerging from our scrutiny was the importance of improving public understanding of end-of-life care and the importance of collaboration across end-of-life care services. The Mayor is well-placed to bring together key stakeholders, including ICBs, local authorities, and community organisations, to support these aims.

During its investigation into end-of-life care in 2016, the Committee recommended that the London Health Board considers end-of-life care as a priority and that the GLA Health Team integrates it into any future review of the Health Inequalities Strategy. Nearly a decade on from this investigation, there has been limited progress in these areas.

Dr Libby Sallnow, Associate Professor and Head of Marie Curie Palliative Care Research Department at UCL, noted that there has been a lack of progress on the areas covered by the Committee's previous investigation.[50] Despite greater awareness and evidence on inequalities in end-of-life care, she explained that there has been a lack of concrete change. Some local Health and Wellbeing Boards (the focus of one of our recommendations in 2016), such as Camden, have shown interest in discussing the issue, but substantive improvements have yet to materialise.[51]

> "At Marie Curie, we would like palliative care to be a strategic priority for the London Health Board and we would like it to have an action plan to tackle inequalities in access to and experience of that care. We would like the Mayor to include palliative care in his Health Inequalities Strategy, which was one of the recommendations that you made last time."
>
> **Ruth Driscoll,** Associate Director for Policy and Public Affairs Marie Curie[52]

While the Mayor's role in end-of-life care is limited, the London Health Board (which he chairs) provides a key platform for strategic collaboration across health and care services in the capital. Ruth Driscoll highlighted results from a national Marie Curie survey, which "painted a really bleak picture of poorly joined up services for people at the end of life."[53] The Mayor and the London Health Board can help to improve this picture in London.

As discussed above, variations in palliative care commissioning across London's ICBs are creating complex, inconsistent pathways for patients and care providers. Whilst we recognise that ICBs must tailor services to meet local needs, there are basic palliative and end-of-life care services that would benefit from a unified approach.

The Committee also received evidence about the lack of importance placed on quality of life and ensuring people have support on their physical health through access to key community support services such as nutrition and physiotherapy.[54]

Recommendation 1

The Mayor should use his convening powers to raise awareness of end-of-life care and promote death literacy across London. To achieve this, the Mayor should instruct his health team during this Mayoral term to provide visible leadership and drive coordinated action in this area.

Recommendation 2

The London Health Board should prioritise end-of-life care, with a particular focus on ensuring equality of access for all groups within London.

Recommendation 3

As part of a wider effort to improve end-of-life care, the Committee urges the Mayor to use his convening powers and position as Chair of the London Health Board to drive greater collaboration between Integrated Care Boards (ICBs), NHS providers, local authorities, and hospices. Partners should work together to better coordinate care and ensure quality of life is optimised for people on an end-of-life pathway.

Addressing inequalities in end-of-life care

We heard evidence about the intersection between poverty and end-of-life care, particularly the impact of housing quality, financial insecurity, and access to benefits. Poor housing conditions—such as overcrowding or damp—can make it difficult for healthcare professionals to provide safe, high-quality care at home. Additionally, while fast-tracked benefits are available for those at the end of life, awareness and uptake remain low.[55]

Recommendation 4

The Mayor should ensure that his Cost of Living Hub includes clear signposting to financial and practical support for people receiving end-of-life care and their families. The Mayor's Cost of Living Hub already

provides signposting for Londoners struggling financially. The Committee recommends that this resource be expanded to:

- Include clear information on financial and practical support available for those at the end of life, including fast-tracked benefits.
- Work with public health teams to raise awareness of support services among patients, families, and healthcare professionals.
- Explore how linked data and research can better identify the financial and social barriers people face at the end of life, helping to shape future policy interventions.

Who we heard from

We are very grateful to all who contributed to this meeting on 5 March 2025.

We held one meeting with the following guests:

- **Dr Katherine Buxton**, Consultant in Palliative Medicine at Imperial College London and Clinical Director for Palliative and end of life care network, NHS England – London
- **Ruth Driscoll**, Associate Director for Policy & Public Affairs, Marie Curie
- **Dr Armita Jamali**, Consultant in Palliative Medicine, The Royal Marsden and Royal Brompton Hospitals
- **Dr Libby Sallnow**, Associate Professor, Head of Marie Curie Palliative Care Research Department, University College London
- **Sarah Scobie**, Deputy Director of Research, Nuffield Trust
- **Becca Trower**, Joint CEO and Clinical Director, St Raphael's Hospice
- **Dr Lyndsey Williams**, GP and Clinical lead, North West London Integrated Care Board Palliative and End of Life Care Programme

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End-of-life care in London: a review

April 2025

Health Committee

The London Assembly Health Committee reviews health and wellbeing issues for Londoners, particularly public health issues. To read more about our work, please visit our website.

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Notes

[1] Applied Research Collaboration South London, About our palliative and end-of-life care research
[2] Marie Curie, End of life care doesn't need to be in crisis | Marie Curie, 5 November 2024
[3] Applied Research Collaboration South London, About our palliative and end-of-life care research
[4] London Assembly Health Committee, End of life care, March 2016
[5] NHS, What end-of-life care involves
[6] London Assembly Health Committee, Transcript - Panel 2, 5 March 2025
[7] London Assembly Health Committee, Transcript - Panel 2, 5 March 2025
[8] London Assembly Health Committee, Transcript - Panel 2, 5 March 2025
[9] London Assembly Health Committee, Transcript - Panel 1, 5 March 2025
[10] London Assembly Health Committee, Transcript - Panel 1, 5 March 2025
[11] DHSC, Patterns of care (2023 data contained in 'place of death spreadsheet')
[12] Marie Curie, Better End of Life Report, November 2024
[13] Nuffield Trust, End of life care, October 2024
[14] Marie Curie, Better End of Life Report, November 2024
[15] London Assembly Health Committee, Transcript - Panel 2, 5 March 2025
[16] London Assembly Health Committee, Transcript - Panel 1, 5 March 2025
[17] DHSC, Patterns of care (2023 data contained in 'place of death spreadsheet')
[18] London Assembly Health Committee, Transcript - Panel 1, 5 March 2025
[19] London Assembly Health Committee, Transcript - Panel 2, 5 March 2025
[20] NHS England, Palliative and End of Life Care - Statutory Guidance for Integrated Care , September 2022
[21] London Assembly Health Committee, Transcript - Panel 2, 5 March 2025
[22] London Assembly Health Committee, Transcript - Panel 2, 5 March 2025
[23] London Assembly Health Committee, Transcript - Panel 2, 5 March 2025
[24] Written evidence from Marie Curie
[25] Hospice UK, Hospice Financial Benchmarking Report, September 2024
[26] Hospice UK, Hospice UK strategy 2024–2029: Hospice care for all, for now and forever, April 2024
[27] London Assembly Health Committee, Transcript - Panel 2, 5 March 2025
[28] London Assembly Health Committee, Transcript - Panel 2, 5 March 2025
[29] UK Government, Biggest investment into hospices in a generation - GOV.UK, 19 December 2024
[30] London Assembly Health Committee, Transcript - Panel 2, 5 March 2025
[31] London Assembly Health Committee, Transcript - Panel 2, 5 March 2025
[32] Good Life, Good Death, Good Grief, Death Literacy and Grief Literacy
[33] London Assembly Health Committee, Transcript - Panel 1, 5 March 2025
[34] London Assembly Health Committee, Transcript - Panel 1, 5 March 2025
[35] London Assembly Health Committee, Transcript - Panel 2, 5 March 2025
[36] Marie Curie, Better End of Life Report, November 2024
[37] North West London ICS, Whole Systems Integrated Care (WSIC)
[38] North West London ICS, Palliative and end of life care
[39] London Assembly Health Committee, Transcript - Panel 1, 5 March 2025
[40] London Assembly Health Committee, Transcript - Panel 1, 5 March 2025
[41] London Assembly Health Committee, Transcript - Panel 1, 5 March 2025
[42] London Assembly Health Committee, Transcript - Panel 1, 5 March 2025
[43] London Assembly Health Committee, Transcript - Panel 1, 5 March 2025
[44] London Assembly Health Committee, Transcript - Panel 1, 5 March 2025
[45] Written evidence from Marie Curie
[46] London Assembly Health Committee, Transcript - Panel 1, 5 March 2025
[47] Written evidence from Marie Curie
[48] Palliative Care Hub 111 - Arthur Rank Hospice Charity
[49] London Assembly Health Committee, Transcript - Panel 2, 5 March 2025
[50] London Assembly Health Committee, Transcript - Panel 2, 5 March 2025
[51] London Assembly Health Committee, Transcript - Panel 2, 5 March 2025
[52] London Assembly Health Committee, Transcript - Panel 2, 5 March 2025
[53] London Assembly Health Committee, Transcript - Panel 2, 5 March 2025
[54] Written evidence from the Chartered Society of Physiotherapy
[55] London Assembly Health Committee, Transcript - Panel 1, 5 March 2025