

*Appendix 4.2.1*

*INSERT WG & JCC LOGOS AT FINAL EDIT*

**AN APPROACH TO THE COMMISSIONING OF HOSPICE CARE IN WALES**

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## **1. INTRODUCTION & PURPOSE**

Hospice providers play a vital role in supporting people to live well until the end of life, offering specialist expertise, compassionate support and a focus on dignity and choice. The approach outlined within this document requires commissioners and providers to work together to strengthen community based care, reduce unwarranted variation and ensure that every person, regardless of diagnosis, background or circumstance has timely access to the support they need.

This commissioning approach establishes a strong commitment to an enhanced focus on the commissioning of hospice based services that are high quality, equitable and sustainable for the Welsh population. Through defining shared priorities, consistent service expectations and a commitment to collaborative working, it provides a foundation for a more integrated and person centred model of palliative and end of life care.

Particular emphasis is placed on planning, procuring and monitoring services in a way that ensures long term viability, high quality outcomes and the responsible use of resources, to ensure that commissioning practices in Wales are sustainable balancing need and demand in a way that supports financial sustainability,

The purpose of this commissioning approach is twofold. Initially it aims to establish a baseline position across all NHS commissioned hospice activity, and secondly to provide advice and guidance to commissioners on effective and streamlined models of commissioning aimed at providing sustainability to the commissioned sector.

The work was initiated by Welsh Government, with the Joint Commissioning Committee and Strategic Programme for Palliative and End of Life Care facilitating engagement with the Hospice sector, Health Boards and specialist technical advisors (i.e. procurement services) to develop this commissioning approach.

## **2. SCOPE**

The approach outlined within this document applies to those services commissioned to provide hospice based (for both adults and children) care by the seven Health Boards in Wales. Whilst it refers to matters of commissioning, procurement and varying contractual

agreements, at this stage it does not aim to enact these. It will however, outline how a consistent, sustainable commissioning approach can be enabled across NHS Wales, through a collaborative and partnership approach between commissioners and providers.

Given commissioning responsibility at this time continues to be within the remit of Health Boards and Welsh Government, Performance management of individual providers, clinical pathway development, and delivery of data or digital infrastructure are also outside the scope of this current approach, however it will make recommendations in this regard as appropriate.

### **3. NATIONAL CONTEXT**

Palliative and end-of-life care (PEoLC) in Wales is delivered through a complex mixed economy of statutory NHS services, independent hospices, and third-sector organisations, shaped by national policy and local commissioning decisions. Responsibility for planning and delivery sits primarily with the seven Local Health Boards, supported by national NHS Trusts and Special Health Authorities, within the strategic direction set by the Welsh Government and the national PEoLC Quality Statement. Most people approaching the end of life are supported by generalist services in primary, community, and acute care, with specialist palliative care providing additional support for people with complex needs across hospital, community, and hospice settings. The system is underpinned by national leadership through NHS Wales Performance & Improvement and the National PEoLC Programme, with increasing emphasis on consistency, equity of access, and system-wide improvement.

Palliative and end-of-life care has been a clear Programme for Government commitment throughout the current Senedd term, signalling sustained ministerial priority and a national expectation for improved quality, access, and system coordination. This commitment has been accompanied by significant financial support, including more than £21 million of additional investment in hospices during this period, strengthening the sector's ability to respond to rising demand and maintain essential services.

Independent charitable hospices continue to play a critical role in the Welsh PEoLC landscape, providing inpatient care, hospice-at-home services, day therapies, bereavement support, education, and specialist clinical expertise. Evidence from organisations such as Hospice Cymru and Marie Curie highlights long-standing variation in access, workforce capacity, and service availability across Wales, alongside a funding model that remains heavily reliant on charitable income. At the same time, demographic change, rising

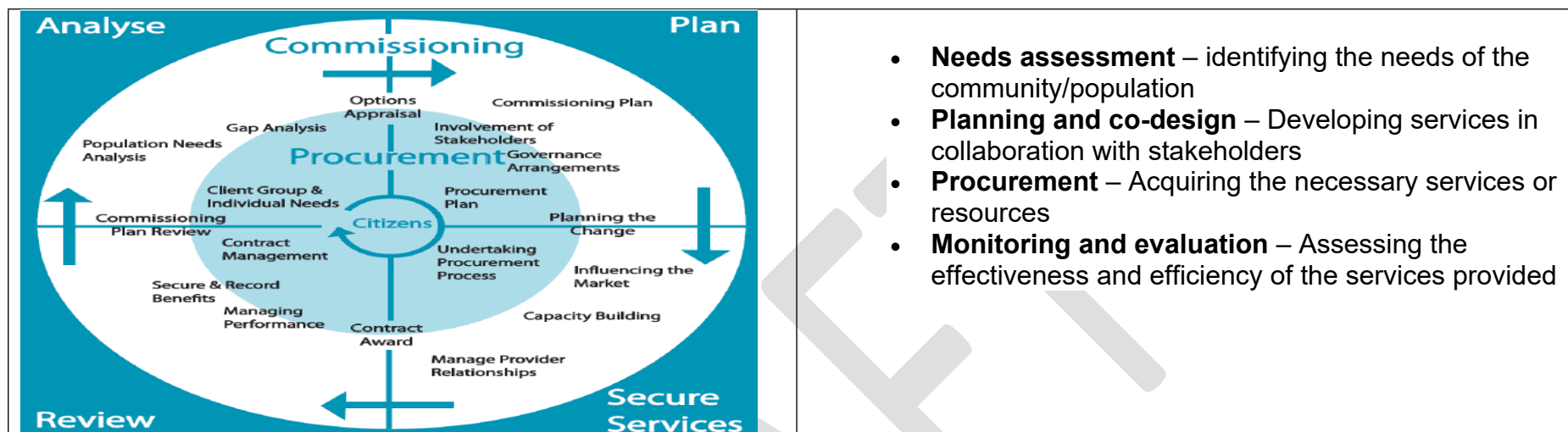
multimorbidity, and increasing expectations to deliver care closer to home are placing growing pressure on both NHS and voluntary sector provision. This baseline assessment is therefore situated within a system characterised by strong partnership working and a clear national commitment to improvement, but also by structural fragility, variation, and the need for clearer commissioning, workforce, and delivery frameworks to support sustainable, equitable PEO LC across Wales.

#### **4. COMMISSIONING CONTEXT WITHIN NHS WALES**

NHS Wales has a policy context underpinned by principles of collaboration and partnership, however also a very clear commissioning model that reflects an appropriate purchaser/provider split. There are many commissioning arrangements across NHS Wales, and a range of policy directives and frameworks within which this work has been developed. Of specific reference is the Welsh Government's Third Sector Scheme: Code of Practice for Funding the Third Sector (2025) which establishes five mandatory principles which also underpin this approach:

- Early & continuous dialogue
- Flexibility
- Proportionate and transparent funding
- Equity and support for smaller organisations
- Outcomes and social value focus

Commissioning is the means through which NHS organisations (and many other public bodies) plan, purchase and monitor services, aimed at meeting population need effectively and sustainably. Core elements of commissioning activity include:



- **Needs assessment** – identifying the needs of the community/population
- **Planning and co-design** – Developing services in collaboration with stakeholders
- **Procurement** – Acquiring the necessary services or resources
- **Monitoring and evaluation** – Assessing the effectiveness and efficiency of the services provided

It offers a clear and robust framework through which to

- **Improve health outcomes** – Through robust assessment of population need, and the planning and securing of services against this
- **Secure value for money** – through the most prudent use of resources, the allocation of resources to areas of most need and or biggest impact, whilst ensuring robust contractual arrangements that ensure the best use of public resource, avoidance of duplication and reduction of waste
- **Actively encourage equity** – seeking to ensure that services are available to all welsh residents regardless of where they live through fair access and consistent delivery
- **Ensure quality and safety** – Through proportionate performance management and contract management commissioners can be ensured on the quality and safety of the service they commission, ensuring relevant standards are met, that safety concerns are considered and acted upon and patient experience is harnessed and used to drive future commissioning decisions

- **Foster collaboration and integration** – Bringing together a range of commissioning and provider partners in order to ensure service provision which is joined up, reduces fragmentation and ultimately improves care.
- **Encourage innovation and sustainability** – Through open and collaborative dialogue between those commissioning and providing the service, as well as through strong patient and carer voice.

## 5. NEW PROCUREMENT REGULATIONS

The Public Contracts Regulations 2015 have been replaced. Welsh public bodies must now follow three main pieces of legislation:

- Procurement Act 2023 (Procurement Regulations 2024)
- Social Partnership and Public Procurement (Wales) Act 2023
- Health Service Procurement (Wales) Act 2024 (and the Provider Selection Regime (Wales) Regulations 2025)

The Provider Selection Regime (PSR Wales) sets out the rules for procuring in-scope health services—those involving treatment, diagnosis, or prevention of physical or mental health conditions for individuals or groups. It applies to all relevant health services with no minimum threshold, and services must fall under specified CPV codes.

PSR Wales replaces competitive tendering as the default route for awarding health service contracts, giving authorities greater flexibility while keeping patient needs central.

Goods and services not classed as in-scope health services must follow the Procurement Regulations 2024, unless they meet the PSR Wales definition of a mixed procurement.

This is of particular consideration in defining a commissioning approach for the hospices sector. Readers will note from the baseline position below that extant contracts held between Health Boards and Hospice providers are **predominantly** historical and managed through traditional Service Level Agreements. Any significant change will require compliance with the new procurement rules.

## **6. FINANCIAL CONTEXT**

The financial position within the public sector in Wales (indeed across the United Kingdom) is unprecedented, with system wide concerns about long term financial sustainability. The context is equally precarious for the hospice sector in Wales where increasing demand for services, workforce costs and reducing charitable income creates challenge for the delivery of services at previous levels. This approach then seeks to find a balance between investment and delivery, and proposes a co-produced model of delivery within the resources available.

## **7. HOSPICE SERVICES IN WALES (WHERE ARE WE NOW?)**

### **7.1 Population need for palliative and end of life care in Wales**

Around 35,000 people die in Wales each year, equating to almost 100 deaths per day. Established population-based methods indicate that between 69% and 82% of people who die have palliative care needs, equating to approximately 24,000–29,000 people per year in Wales who would benefit from a palliative care approach. This reflects the high prevalence of progressive, life-limiting illness, including cancer, organ failure, dementia and frailty.

Population projections show that the number of people requiring palliative and end of life care will continue to increase over the coming decades, with deaths in Wales projected to rise by around 10–15% to approximately 36,500 per year by the late 2030s. This growth is driven primarily by the expansion of the population aged 85 years and over, the group with the highest intensity of palliative care need. Demand is expected to increase faster than overall population growth, as people live longer with advanced illness and require support over longer periods before death.

### **7.2 Increasing complexity of need**

Need is not only increasing in volume but also in complexity. Specialist palliative care activity in Wales has increased substantially, with around 17,000 referrals and over 14,500 patients supported annually. The proportion of patients aged 85

years and over has risen to over 23%, and the proportion of people with non-cancer diagnoses has increased to almost 30%, reflecting a growing population of people living and dying with multiple long-term conditions.

People approaching the end of life increasingly live with combinations of cancer, dementia, frailty and organ failure, resulting in more complex symptom burden, more unpredictable illness trajectories and longer periods of functional decline. Services report that patients now commonly present with multiple comorbidities and require more frequent contact and greater coordination of care, indicating that demand is increasing in both scale and complexity.

Complexity is also shaped by social factors, including deprivation, housing insecurity, limited availability of informal carers and rurality, which increase both the duration and intensity of support required. As a result, future demand cannot be understood solely in terms of numbers of deaths, but must be understood in terms of the volume, duration and specialist nature of care required. While the number of people needing palliative and end of life care is rising, the complexity of need is rising more rapidly, placing increasing pressure on specialist services, including hospices.

### **7.3 Outcomes and experiences in Wales**

Outcomes and experiences of palliative and end of life care in Wales remain variable. Many people continue to die in hospitals, despite consistent evidence that most would prefer to be cared for and die at home or in a hospice setting. Access to specialist palliative care services is uneven and influenced by geography, diagnosis and local service configuration, resulting in differing experiences and outcomes for patients and families depending on where they live.

Current hospice capacity does not consistently align with assessed population need. National analysis of the distribution of hospice inpatient beds indicates that around 25% of the population of Wales resides in areas without reasonable geographical access to a hospice or equivalent specialist palliative care bed, resulting in unwarranted variation in access to specialist palliative care and increased use of acute hospital services for people nearing the end of life.

National audit and service data indicate that access to high-quality palliative and end of life care remains inconsistent and that outcomes vary depending on service availability. The National Audit for Care at the End of Life shows that only around half of people who die in hospital are reviewed by a specialist palliative care team, fewer than half have documented

personalised care and support planning, and only around three-quarters of bereaved relatives rate care as excellent or good, demonstrating persistent gaps in holistic, coordinated care. Specialist palliative care activity in Wales has increased, with over 14,500 patients supported annually, but access remains uneven by geography and diagnosis. These findings reinforce that variation in hospice and specialist service availability directly affects the likelihood of achieving key outcomes such as symptom control, coordinated care and support for families, and risks widening existing health inequalities at the end of life.

Evidence indicates that commissioned hospices play a critical role in supporting the wider health and care system to meet palliative and end of life care need. Specialist hospice services contribute to improved symptom control, crisis management and care coordination, and are associated with reduced unplanned hospital admissions and increased likelihood of people being cared for and dying in their preferred place. Where hospice and specialist palliative care capacity is constrained, reliance on acute hospital care increases, particularly in the final weeks of life. This demonstrates that hospice provision is not supplementary to the system, but a core component of how palliative and end of life care outcomes are achieved across community and hospital settings.

**7.2 Current commissioned services landscape (baseline)**

Whilst this initial baseline has focussed on the provision of adult services, a similar exercise is currently being undertaken in respect of hospice based care for children, and this approach will be updated on its conclusion.

The baseline assessment is measured against the core statutory service model set out in the [National Service Specification for Palliative & End of Life Care \(August 2025\)](#) the information has been provided by Health Boards in collaboration with providers. :

<ul style="list-style-type: none"> <li>• Access, referral and navigation</li> </ul>	<ul style="list-style-type: none"> <li>• Urgent and Out of Hours care</li> </ul>
<ul style="list-style-type: none"> <li>• Community nursing and 7 day Clinical Nurse Specialist (CNS) provision</li> </ul>	<ul style="list-style-type: none"> <li>• Hospice, inpatient and hospice at home</li> </ul>
<ul style="list-style-type: none"> <li>• Specialist Palliative Care Medical services</li> </ul>	<ul style="list-style-type: none"> <li>• Care co-ordination and future care planning</li> </ul>
<ul style="list-style-type: none"> <li>• Specialist MDT capacity</li> </ul>	<ul style="list-style-type: none"> <li>• Bereavement care</li> </ul>

Strengths within the current configuration of services include:

- Universal access to specialist advice
- Strong professional commitment and leadership
- Examples of highly mature local practice
- Growing national alignment through the Service Specification

There are however a number of system wide risks:

- Inequity of access to hospice and community services
- Fragile 7-day provision, particularly at weekends
- Workforce sustainability and succession planning
- Underdeveloped bereavement care
- Digital interoperability and data maturity

More detail on each of the service components is outlined below:

Service maturity and resilience vary significantly across Wales, influenced by population density, geography, workforce availability and historic commissioning models, with more fragile arrangements evident in rural and smaller systems.

At a national level, Wales has strong foundations, clear areas of good and emerging practice, and a small number of systemic risks that, if not addressed, will continue to drive inequities in access and variable patient and family experiences.

### **7.2.1 Access, referral and navigation**

All Health Boards operate need-based, diagnosis-agnostic access models for specialist palliative care. However, no single, consistent all-Wales model for access or Single Point of Access (SPA) exists.

- More mature systems rely on embedded, high-visibility models that function effectively but are workforce-dependent.
- Other Health Boards operate multiple access routes, increasing the risk of fragmented navigation, particularly out of hours.
- Powys Teaching Health Board operates within a uniquely fragmented system, relying heavily on GP out-of-hours services and neighbouring Health Boards for access.

Nationally, access works best for patients already known to specialist services, and is less reliable for those newly identified, non-cancer patients, or those deteriorating rapidly outside weekday hours.

### **7.2.2 Community nursing and 7-day Clinical Nurse Specialist provision**

- Most Health Boards deliver some form of 7-day CNS availability, but depth, consistency and resilience vary significantly.
- Weekend and bank holiday provision is commonly reduced to CNS-only models, with limited MDT input.
- Powys Teaching Health Board does not meet the core statutory requirement for 7-day specialist CNS provision, operating a weekday-only specialist nursing service.
- Rural Health Boards face additional challenges due to geography, travel time and workforce availability.

Across Wales, weekend and bank holiday resilience remains fragile, often dependent on goodwill, overtime, or redeployment from weekday services.

### **7.2.3 Specialist palliative care medical services**

At a national level:

- 24/7 specialist palliative medical advice is available everywhere in Wales, either through local rotas or regional collaborative arrangements.
- However, reliable urgent face-to-face specialist medical assessment out of hours is inconsistent, particularly in community settings.

Key patterns include:

- Stronger inpatient and hospital-based medical resilience in Cardiff and Vale UHB and Swansea Bay UHB.
- Heavy reliance on collaborative or externally commissioned cover in more rural areas and a smaller service base.
- Velindre University NHS Trust provides robust in-hospital specialist medical advice but is dependent on regional rotas and has no community provision.

Workforce sustainability, particularly consultant recruitment and succession planning, is a national strategic risk.

#### **7.2.4 Specialist Multi Disciplinary Team (MDT) capacity**

Across Wales, no Health Board consistently delivers the full core MDT across all settings and all days of the week.

- MDTs are strongest within hospice and inpatient settings, where charitable funding often supplements NHS provision.
- Allied Health Professionals (AHPs), psychology, social work and specialist pharmacy input is variable, frequently weekday-only, and often accessed via shared or indirect arrangements rather than embedded roles.
- Innovative MDT models (e.g. paramedic integration in Cardiff and Vale; ANP-led models in Velindre) represent good practice but are not yet standardised or scaled nationally.

MDT fragility is most pronounced at weekends and in rural geographies.

### **7.2.5 Urgent and out-of-hours care**

Urgent and out-of-hours care is largely advice-led across Wales, supported by:

- 24/7 telephone advice
- CNS weekend cover
- Emergency Department interfaces
- Hospice inpatient admission where available

However:

- Community urgent face-to-face response is inconsistent, particularly outside urban areas.
- Admission avoidance is strongest where hospice inpatient beds and hospice-at-home services are well commissioned.
- Rurality, travel time and workforce shortages continue to drive avoidable hospital admissions in some areas

### **7.2.6 Hospice, inpatient and hospice-at-home services**

Access to hospice inpatient beds and hospice-at-home services is one of the most inequitable elements of provision across Wales.

- Cardiff and Vale UHB and Swansea Bay UHB demonstrate comparatively strong hospice and inpatient integration.
- Hywel Dda UHB has a single small inpatient unit, creating clear geographic inequity.
- Powys Teaching Health Board has no hospice or inpatient beds, relying entirely on commissioned access in neighbouring Health Boards.
- Velindre University NHS Trust provides no hospice or community provision.

Across Wales, hospice-at-home provision is variable, often not available seven days a week, and constrained by funding and workforce.

### **7.2.7 Care co-ordination and Future Care Planning**

Future Care Planning (FCP) and DNACPR represent a national strength in policy intent, but variable in execution.

- Most Health Boards use Welsh Clinical Portal (WCP) and All-Wales documentation.
- However, digital interoperability is inconsistent, with limited access for ambulance services, GP out-of-hours and cross-border providers.
- Care coordination is strongest for patients known to specialist services and weaker for those managed primarily by generalist teams.

System-wide benefit is constrained by digital and operational limitations.

### **7.2.8 Bereavement care**

Bereavement care demonstrates the widest variation in maturity across Wales.

- Some Health Boards deliver comparatively strong, proactive, tiered bereavement models.
- One Health Board does not meet core statutory expectations for bereavement care, with no consistent Health Board-wide service.
- Rural Health Boards tend to rely on commissioned and third-sector provision, with acknowledged capacity constraints.
- Velindre University NHS Trust provides proactive bereavement support and a bridging role but is dependent on variable local services.

Nationally, bereavement care remains underdeveloped, under-resourced, and inconsistently commissioned.

### **7.2.9 Workforce sustainability**

Workforce sustainability is the single greatest national risk, with common themes including:

- Consultant shortages and reliance on rotational or external cover
- CNS vacancy and succession planning gaps
- Small teams delivering 7-day services with limited resilience
- Heavy reliance on goodwill and unpaid overtime
- Limited protected time for education, quality improvement and service development

These risks are most acute in rural Health Boards but are evident across all organisations.

### 7.2.10 Governance, data and quality assurance

Governance arrangements are generally in place across Wales, with identified Executive Leads and reporting structures. However:

- Dedicated PEO LC risk registers are not universal
- PROMs, PREMs and outcome data collection is inconsistent
- Digital infrastructure limits routine reporting and benchmarking
- Data burden frequently falls on small clinical teams

This limits national visibility of quality, outcomes and unwarranted variation.

### 7.3 Funding, contractual arrangements

The current level of investment into the hospice sector from the NHS/Welsh Government is:

<b>Welsh Government</b>	£6,195,579
<b>Health Boards</b>	£13,645,784
<b>Total</b>	£19,841,363

- *Note further work will be required through the proposed needs assessment process here*

It should be noted that these figures do not take account of the investment in NHS delivered care or indeed funds raised by hospices in Wales through fundraising.

#### **7.4 Challenges and opportunities with current arrangements (what we have heard)**

In working to develop this approach, engagement across both providers and commissioners has taken place with the following challenges being presented:

- Unpredictable funding and contracting
- Inequity
- Lack of transparency
- Lack of knowledge in the true cost of provision
- Instability in partnership arrangements
- Disproportionate reporting arrangements
- Protracted contract negotiations
- Short term funding
- Different approaches from commissioners with regard inflation and staffing uplifts
- Variance in contracting arrangements across Health Boards
- Difficulty in disaggregating reporting on what is funded from broader provision
- Absence of a mechanisms to develop a consistent service model across Health Board areas
- No underpinning assessment of need for resource allocation
- Opportunity to explore increased collaboration across Health Boards
- Differences in organisational and staffing models
- Variation in assumptions and expectation around funding responsibilities
- Opportunities to strengthen transparency
- Approaches to public communication and advocacy
- Service development outside of existing planning frameworks
- Need for an increased, and shared understanding of governance and accountability for all parties

## 8 COMMISSIONING PRINCIPLES (WHERE DO WE WANT TO BE?)

Based on this feedback, this guidance therefore signals system commitment in the commissioning of the hospice sector to the principles set out below, further guidance to Health Boards and Commissioned services can be found in section 9 below

- **Services commissioned based on need** – A national needs assessment process will be undertaken, resulting in the development of a national service specification for hospice based care (note also wider strategic work on delivery of hospice care at home) to ensure hospice services are accessible to all eligible patients regardless of diagnosis, age, ethnicity, or socioeconomic status.
- **Services secured are of high quality** – Services will be commissioned and evaluated against the principles of Safety, Timeliness, Effectiveness, Efficiency Equity and Patient centred (STEEEP), contractual arrangements between the NHS and providers of hospice care will consistently reflect this approach. (Insert reference)
- **Services are commissioned to optimum effect within available resources** – Core services will be defined as part of the service specification and resources utilised against this – this may mean the need to repurpose/recommission funding investments, and will need consideration of the new NHS Wales procurement rules (insert reference).
- **Enable more predictability for the sector** – Through appropriate funding models, to enable multi year funding arrangements, contracts that reflect true care costs and inflationary pressures, with clear review points, avoiding annual uncertainty
- **An equitable approach across Health Boards** – Consistent application of commissioning approaches across Health Boards with an aim to reducing unwarranted variation
- **Enhanced transparency** – There will be transparency on both resources and their utilisation with a focus on commissioning for outcomes, taking consideration the wider system and organisational contexts within which they take place
- **A proportionate approach to reporting** – Reporting arrangements will be identified at the administration of contracts- consideration will be given to a single reporting framework for NHS Wales
- **Streamlined commissioning processes** – Consideration will be given to blended funding models and system-wide resource pooling, as well as appropriate levels of commissioning, for example where there is a single organisation providing across multiple Health Boards. An initial assessment of the potential levels is outlined below:

Level of Commissioning	Pros	Cons
<b>National commissioning</b>	<ul style="list-style-type: none"> <li>• Standardisation of care</li> <li>• Efficiency</li> <li>• Increased bargaining power</li> <li>• Enhanced equity of access</li> <li>• Simplified governance</li> <li>• Consistency &amp; equity</li> <li>• Efficiency &amp; scale</li> <li>• Strategic alignment</li> <li>• Streamlined data</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced local control</li> <li>• Risk of over generalisation and standardisation</li> <li>• Systemic risk</li> <li>• Loss of local responsiveness/relations</li> <li>• Potential barriers for smaller providers</li> </ul>
<b>Local commissioning</b>	<ul style="list-style-type: none"> <li>• Local responsiveness</li> <li>• Agility in decision making</li> <li>• Direct community accountability</li> </ul>	<ul style="list-style-type: none"> <li>• Resource inefficiency</li> <li>• Inconsistent standards</li> <li>• Limited bargaining power</li> <li>• Potential for inequity</li> </ul>
<b>Hybrid model</b>	<ul style="list-style-type: none"> <li>• National consistency with local flexibility</li> <li>• Strategic investment alongside community empowerment</li> <li>• Inclusion of small and specialised providers through tailored models</li> <li>•</li> </ul>	

## 9 COMMISSIONING IN PRACTICE (HOW DO WE GET THERE?)

In order to realise the ambitions outlined above, core commissioning practice should be followed

- A robust **needs assessment** should be undertaken focussed on identifying the needs of people requiring palliation and end of life care across Wales
- Providers and commissioners should work together to **co-produce** a future sustainable core **service model**, against which commissioners will develop a **national service specification** for hospice based care
- Commissioners will work **collaboratively** to identify the optimum means of **securing services**, considering streamlined practice and a less complex commissioning landscape, remaining compliant with NHS Wales procurement regulations

- Opportunities for **value, recommissioning and efficiency** should be fully explored by both commissioners and providers
- Clear (and streamlined) processes around **monitoring and evaluation** should be in place with an increased focus on commissioning for **patient outcomes**.

The following actions should be taken forward by both commissioners and providers:

### 9.1 Commissioners

Short Term (1 year)	Medium Term (within 3 years)	Long Term (5-10 years)
<ul style="list-style-type: none"> <li>• Bring to conclusion contract negotiations for 2026/2027 financial year</li> </ul>	<ul style="list-style-type: none"> <li>• Undertake a national approach to securing the provision of hospice care in line with the National procurement (Wales) legislation seeking to establish long term contractual arrangements</li> </ul>	<ul style="list-style-type: none"> <li>• Develop and implement a national strategy and rolling approach to the commissioning of hospice care</li> </ul>
<ul style="list-style-type: none"> <li>• Undertake a joint needs assessment process across Wales facilitated by the Joint Commissioning Committee and the National Strategic Programme for Palliative and End of Life Care – Engage current providers as experts in delivery</li> </ul>	<ul style="list-style-type: none"> <li>• Explore blended models of funding, where appropriate identify a lead commissioner – supported as needed by a consortia model</li> </ul>	
<ul style="list-style-type: none"> <li>• Develop from the needs assessment a national service specification for core hospice provided services giving particular consideration to areas of rurality</li> </ul>	<ul style="list-style-type: none"> <li>• Re-baseline funding opportunities according to assessment of need, identification of core services and specification</li> </ul>	

<ul style="list-style-type: none"> <li>Determine (collectively) the optimum means of commissioning the sector (both level of commissioning and appropriate procurement route)</li> </ul>	<ul style="list-style-type: none"> <li>Review historical funding arrangements from multiple sources (</li> </ul>	
<ul style="list-style-type: none"> <li>Plan to move towards a consistent and streamlined model of commissioning from April 2027</li> </ul>	<ul style="list-style-type: none"> <li>Centralise commissioning arrangements for childrens hospice services</li> </ul>	
<ul style="list-style-type: none"> <li>Agree NHS Wales approach to inflation/A4C</li> </ul>		
<ul style="list-style-type: none"> <li>Commence work to agree a single performance framework</li> </ul>		

## 9.2 Providers

Short Term (1 year)	Medium Term (within 3 years)	Long Term (5-10 years)
<ul style="list-style-type: none"> <li>Work with commissioners to finalise contract negotiations for 2026/27</li> </ul>	<ul style="list-style-type: none"> <li>Engage with processes that seek to confirm future provider arrangements</li> </ul>	Work collaboratively with commissioners on the longer term strategic direction for the provision of palliative and end of life services
<ul style="list-style-type: none"> <li>As experts in provision to work with commissioners to identify potential future service model and areas of service improvement in line with best practice</li> </ul>	<ul style="list-style-type: none"> <li>Contribute to future strategic direction related to the provision of services for people requiring palliative and end of life care</li> </ul>	

<ul style="list-style-type: none"> <li>• Contribute to the performance reporting requirements</li> </ul>		
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### 9.3 A focus on implementation

Subject to approval, Welsh Government and Health Board commissioners will wish to move with haste to develop a robust implementation plan that sets out key deliverables and milestones for the implementation of this approach. Working closely with current and future potential providers throughout to ensure all opportunities for co-design and co-production are harnessed. The approach will lead to a shift from current commissioning arrangements to those that will offer a sustainable approach to the sector in line with varying ministerial commitments over recent years. To enable this transition, Welsh Government will wish to consider a short term sector stabilisation grant.

The following mechanisms have been instrumental in achieving development of this approach, and it is proposed that they are retained with a focus now on implementation:

- Welsh Government Commissioning Oversight Group
- Cross Health Board Project Group
- Expert Hospice providers forum

## 10. CONCLUSION

Hospice providers play a vital role in supporting people to live well until the end of life, offering specialist expertise, compassionate support and a focus on dignity and choice. The approach outlined within this document requires commissioners and providers to work together to strengthen community based care, reduce unwarranted variation and ensure that every person, regardless of diagnosis, background or circumstance has timely access to the support they need.

This commissioning approach establishes a strong commitment to an enhanced focus on the commissioning of hospice based services that are high quality, equitable and sustainable for the Welsh population. Through defining shared priorities, consistent

service expectations and a commitment to collaborative working, it provides a foundation for a more integrated and person centred model of palliative and end of life care.

DRAFT