



# Palliative and end-of-life care

## RCP position statement | August 2025

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Physicians deliver care across all healthcare settings, providing palliative support and guidance to patients as they approach and reach the end of life.

There are important cultural shifts required in healthcare and UK society with respect to palliative and end-of-life care. There remains a focus on curative treatments, whereas many of our patients have progressive life-limiting conditions (particularly frail and older people who make up the majority of patients in hospital) and are the most likely to die in hospital. [Approximately 70% of people die from long-term health conditions that can follow a predictable course](#), with death anticipated well in advance of the event. Despite this, patients and their families often feel unprepared for the end of life. However, patients in their final months of life can benefit from open supportive conversations that help them to recognise this and may result in a change in approach to their treatment and support. The RCP provides resources to support these open conversations, including [Talking about dying](#).

Commissioned by Marie Curie, a recent [Nuffield Trust and Health Economics Unit research report](#) estimated that £22 billion of public funding is spent on people in their last year of life, with £12 billion spent on healthcare and £5 billion on social care. Of the healthcare costs, 81% was spent in hospital and 56% was spent on emergency hospital care. The report suggests that this equates to nearly 10% of all hospital costs, although this may be underestimated.

Sadly, currently in the NHS, most patients requiring medical admission to hospital spend a considerable time in temporary care environments, including emergency department corridors. Many of these patients are older vulnerable patients approaching the end of life.

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report [Planning for the end](#) examined the care of a sample of people with dementia, heart failure, lung cancer or liver disease who had died. The report emphasises the need for parallel planning – that is active treatment for symptoms and quality of life alongside wider palliative care planning; this was only received by 31% of the cohort. Conversations around end-of-life care wishes were not recorded for 72% of patients. Coordination of care by a named person was not recorded for 35% of patients. Specialist palliative care over 7 days was only available in 60% of hospitals, while training in end-of-life care was priority training in just over half of hospitals (51%).

There are multiple opportunities when people who are approaching the end of life can be identified during healthcare events, either during admissions to hospital, or when monitoring their condition

and responses to treatment. These are often missed opportunities that could result in more appropriate palliative care, parallel planning, and reduced hospitalisation, resulting in the redistribution of resources for better end-of-life and palliative care in health and social care.

The current approach to resuscitation decisions through DNACPR discussions, decisions and documentation skews conversations to a specific intervention, which is inappropriate for many people with progressive life-limiting conditions. It should be part of wider discussions on the nature of the patient's condition, appropriate active and palliative treatments, and the patient's priorities, preferences and wishes as they near the end of their life. The ReSPECT approach embraces this wider approach as part of wider advance care plans.

Caring for people approaching the end of their lives should be a core component of all physicians' generalist practice and embedded in training and continuing professional development, integrated with approaches to personalised care. This includes recognition of when a patient is approaching the end of their life, communication skills for conversations with patients and families, the use of palliative treatments and services, and shared documentation of discussions, preferences, decisions and plans, including advance care plans. Specialist palliative care services have a key role in educating other clinicians in these skills.

Specialist palliative care services are under provided and under strain in the UK. There are widespread workforce shortages and increasing demand. Services are provided in the community, hospitals and hospices, as well as leadership and education roles, but there is very wide variation and inequity in where, when and how the services are delivered or available.

The significant role in end-of-life care delivered by social care providers in care homes and people's individual homes is under recognised and under resourced. These staff, alongside healthcare staff, need education and training in end-of-life care.

Palliative and end-of-life care is delivered in all care settings and must be a significant component of the government's drive to move more care from hospital to community. This can only be achieved by services working across current care boundaries to deliver integrated care, where specialists and other professionals work together in all care settings to ensure the best possible care for patients. While this is important for all medical specialties, it is particularly important for those involved in end-of-life and palliative care, including geriatricians, palliative medicine physicians, oncologists, acute and respiratory physicians, and cardiologists. Integrated care can only be delivered when patient information is also shared across these boundaries, and this is perhaps most important when the patient is approaching the end of their life. Financial flows must enable this, and both commissioning and regulation must be aligned to integration of care.

While governments, the NHS and professionals can align to these ambitions, they will be difficult to achieve without a significant shift in public understanding and attitude to acute vs palliative and end-of-life care. We all have a role to play in this.

### **The RCP calls on the government to:**

- > develop a public campaign on end-of-life and palliative care
- > support a professional campaign to improve education, recognition and care delivery for end-of-life care
- > commission a national strategy for end of life and palliative care that includes:
  - a national service framework for end-of-life and palliative care
  - an agreed data set to understand and track our delivery of end-of-life and palliative care
  - clear goals and trajectories for delivery
  - training requirements and resource development for health and social care staff.

This shared ambition currently has significant barriers, including challenges in social care, and the imbalance of funding and workforce in healthcare.

Any national strategy for end-of-life and palliative care must have the right workforce to deliver it across health and social care, generalist and specialist services – this must be accounted for in the government’s long-term workforce strategies for the NHS.

### **How this position was developed**

The Royal College of Physicians (RCP) is the membership body for physicians – doctors who work in the medical specialties. We are the largest professional body for UK hospital doctors, supporting physicians to deliver the best healthcare possible for patients and improve standards of care. We represent around 40,000 members and fellows in the UK and internationally, including specialist doctors delivering and supporting palliative care and the majority of hospital doctors caring for patients with progressive life-limiting conditions.

This policy position statement was developed by RCP Medical Specialties Board and informed by the Palliative Care Joint Specialty Committee. It was approved by RCP Council prior to publication.

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