Backbench Business: Future of palliative care

Thursday 5 March 2026

The Royal College of GPs (RCGP) has long championed the importance of delivering high-quality, equitable and person-centred palliative care and end-of-life care (PEoLC) within general practice and the community. General practice, community nurses and specialist palliative care teams are often the most consistent providers of PEoLC but are currently under significant strain.

In partnership with Marie Curie, the RCGP developed the Daffodil Standards, a quality improvement programme for general practice to support continuous improvement in PEoLC and bereavement care. Frameworks such as the Daffodil Standards offer a tested, scalable method to embed this vision in general practice. The RCGP also has an e-learning toolkit for PEoLC and a GP with Extended Role (GPwER) framework.

The Government and NHS England have clearly articulated their intention to shift PEoLC out of hospitals and into community settings. However, system-wide commissioning, equity-led leadership, and meaningful investment are essential to deliver this shift and enable lasting improvement. The upcoming Palliative Care and End of Life Care Modern Service Framework (MSF) for England provides the opportunity to deliver these improvements.

Key asks:

- Rebalance funding to reflect general practice and community teams' role in delivering the majority of PEoLC in the community. Without investment, hospital-based, reactive care will remain the default.
- A national approach to PEoLC equity is urgently needed. This should include standardised data collection, routine health equity impact assessments, and meaningful engagement with under-served groups.
- Commission for continuity and planning, not just crisis response. Proactive PEoLC improves outcomes, reduces avoidable admissions, and aligns with public preferences.
- The full implementation of the RCGP Daffodil Standards in every practice and PCN, with protected time and resources to enable implementation.
- Support general practice with protected time, training, data, and integration to deliver structured, equitable care across their entire registered population—not just those who reach out.

Funding and Capacity

- Current commissioning structures do not recognise or fund the additional complexity involved in caring for people at the end of life in the community.
- The Better End of Life 2024 report identifies major gaps in commissioning effectiveness. This included 1 in 5 people who died had no GP contact in the last three months of life
- General practice is well-positioned to lead anticipatory, community-based care. However, without adequate funding or time, teams cannot consistently provide proactive, person-centred support.
- General practice receives just 11% of the health expenditure for people in the last year of life, despite delivering most of the care. This stark imbalance in resourcing undermines the stated ambition by the Government and NHS England to deliver more care outside hospital settings and impedes the ability of general practice to deliver proactive, early intervention and person-centred care.

The RCGP recommends investment in general practice to lead proactive, population-based PEoLC through:

- Rebalancing funding toward general practice and community teams, recognising their central role in delivering in population-level, community-based PEoLC.
- Resourcing general practice with protected time and ringfenced funding for both in and out of hours care to enable earlier identification, personalised planning and home-based support.

- Embedding PEoLC into national GP contracts, with structured quality improvement frameworks like the Daffodil Standards, would enable every practice to drive improvements and equity.

Variation in access, outcomes and experience

- Too many people experience fragmented, inequitable care-especially those from ethnically diverse communities, people with dementia or learning disabilities, and those in rural and deprived areas.
- The Better End of Life 2024 report highlights significant gaps in access to advance care planning, coordinated care, and specialist support.
- Practices and other providers need data, tools and commissioning support to identify disparities and co-design solutions. Despite the availability of data tools, few ICBs actively monitor or respond to local inequalities in PEoLC. Without a national equity-led framework, under-served populations will continue to miss out on timely, compassionate care.

The RCGP recommends embedding health equity and lived experience assessments in national and local PEoLC strategy.

- A national approach to PEoLC equity is urgently needed. This should include standardised data collection, routine health equity impact assessments, and meaningful engagement with under-served groups. General practice can lead local action when supported with data, time and tools.
- The Daffodil Standards include equity components, but a system-wide commitment is needed to commission for inclusion and enable diverse voices to shape care models.

Limited integration and system fragmentation

- Commissioning remains reactive, with limited incentives for anticipatory care, continuity or bereavement support. This leads to avoidable crises, emergency admissions, and poor experiences.
- Care is often disjointed between general practice, hospitals, hospices, social care and community providers. The Better End of Life 2024 report reported that only 42.5% of people had a named key worker; nearly 20% had no GP contact in their final three months.
- Fragmented records, unclear roles and variable 24/7 support undermine continuity and confidence.
- General practice is well positioned to lead anticipatory care, but integration must be enabled through shared records, joint reviews, and clear commissioning levers that incentivise multidisciplinary collaboration and timely community responses.

The RCGP recommends commissioning PEoLC as a planned, equitable pathway from diagnosis through to bereavement:

- PEoLC should not begin with a crisis. Commissioning must span the full journey - from early identification and shared decision-making through to bereavement support.
- Proactive care should be built into PCN strategies, population health models, and supported by digital tools such as interoperable advance care plans. Equitable access to PEoLC medication and out-of-hours support is essential.
- Care must be culturally competent, personalised, and inclusive - delivered in partnership with carers, voluntary sector and communities.