About the British Geriatrics Society (BGS)

The BGS is the membership organisation for all healthcare professionals engaged in the treatment and care of older people across the UK. Since 1947 our members have been at the forefront of transforming the quality of care available to older people. Our vision is for a society where all older people receive high-quality patient-centred care when and where they need it. We currently have over 5,600 members working across the multidisciplinary team.

1. Increasing access

Publish a national PCEoLC strategy

The current PCEoLC model in the UK does not serve an ageing population, particularly older people with multiple health conditions, including dementia and frailty, who make up the majority of those dying in any year. 70% of deaths occur in people aged over 75 and most will have multiple health conditions. [i] [ii] [iii] Their needs are considerably different to those dying with single conditions, often having uncertain non-linear dying trajectories. They are also likely to require significant health and social care support of a considerably longer period than those dying of a single condition. Their care is provided by the three million generalist health and social care workforce, rather than the 20,000-strong specialist palliative care workforce. In fact, half of all people who die, largely older adults, have no contact with specialist palliative care at all. ***Recommendation****:* publish a national strategy focused on improving PCEoLC for all, not just focused on improving the specialty of palliative care. This should focus on the role of the generalist workforce and the skills needed to identify when someone with multiple long-term conditions, including frailty and dementia, may be reaching the end of life.

Accreditation for expertise in PCEoLC

Healthcare professionals specialising in geriatric medicine, such as geriatricians, GPs with Special Interest in Frailty or Geriatric Medicine, and specialist nurses and allied health care professionals, have the expertise to identify when older people with multiple long term health conditions may be reaching the end of life. However, there is a lack of awareness and recognition of their role in providing PCEoLC. ***Recommendation:*** recognise expertise in PCEoLC beyond the specialty of palliative care through the establishment of national accreditation for those with an understanding of complex PCEoLC needs in older age.

Training for the generalist workforce

The 20,000-strong specialist workforce does not have the capacity to care for everyone at the end of life and there are not enough professionals with expert understanding of frailty, dementia, and multimorbidity to provide end of life care for the older people who comprise the majority of those coming to the end of life. The wider generalist health and social care workforce needs to be upskilled on supporting people at the end of life, including training on managing uncertainty and parallel planning for different scenarios. The BGS endorses the Gold Standards Framework. ***Recommendation:*** mandate end of life care training for the generalist workforce within national strategies and implementation plans. A training fund should be ringfenced for ICSs to provide training to the generalist workforce. Existing established accredited schemes, such as the Gold Standards Framework, should be scaled up.

Mandate 24/7 PCEoLC

Older people with multiple long-term conditions, including frailty and dementia, do not

always have access to urgent rapid response and PCEoLC 24/7. There is significant geographical variation in the availability and accessibility of these services. Without these services, many have no choice but to present at A&E, which can be a distressing experience*. **Recommendation:*** introduce a statutory requirement for Integrated Care Systems (ICSs) to provide access to urgent rapid response services and PCEoLC, 24 hours a day, 7 days a week.

There is regional variation in the availability of 24/7 PCEoLC advice phone lines for people reaching the end of life and their families. Without such services, there are delays in access to urgent primary and social care, resulting in unnecessary hospital admissions. ***Recommendation****:* introduce a national single point of access PCEoLC phone line for people reaching the end of life and their families, accessed through 111.

Embed PCEoLC into all clinical areas

Not all healthcare specialties will have a generalist understanding of PCEoLC, which will become increasingly important as the population continues to age. ***Recommendation:*** all National Clinical Directors employed by NHS England or DHSC should be required within their job specification to identify and address the PCEoLC needs for their population group. This should be reported on and fed into strategic plans for disease areas, or population groups.

Reinstate the GP palliative care register

The requirement for GPs to keep a palliative care register was removed in the 2025/26 GP contract. Older people with multiple long term health conditions are often not recorded on this register due to diagnostic and prognostic uncertainty. ***Recommendation****:* reinstate the requirement for GPs to keep a palliative care register and require the inclusion of older people with advanced frailty and dementia.

A review of NHS Continuing Healthcare (CHC) and its Fast Track pathway

CHC and its Fast Track pathway is not working well in England, characterised by geographical variations in eligibility, complex assessment processes, insufficient staff training and support, significant delays, and lack of transparency in the entitlement criteria.[iv] This often results in delayed care, and people dying in hospital before a fast-track bed in available in the community. ***Recommendation*****:** a national review NHS CHC and its Fast Track pathway.

2. Improving quality

Ensure continuity of care in the community

*C*ommunity health and social care is under resourced, under capacity and not well configured to provide good PCEoLC for older people with multiple conditions reaching the end of life. Evidence suggests that older people prefer to use local services and value continuity of care.[v] Historically, GPs took on this role and were best placed to understand the care needs of their patients. In addition to being preferred by patients, providing end of life care through primary care is often more cost effective and results in fewer emergency admissions. ***Recommendation:*** investment is needed to ensure that primary and community care teams can provide continuity of care to patients in the community, acting as their key point of contact right until the end of their life and supporting them to live in their preferred place of death. Specialist PCEoLC should be provided in the community, alongside district nurses. This approach should be integral to the government's neighbourhood health plans.

Enable honest conversations around end of life and treatment options
Recognition that the end of life is approaching should trigger early and evolving conversations related to the benefit versus burden of active treatment, identification of realistic goals, and shared decision-making with the person dying and their families. This ensures people are supported to live their remaining days focussed on what matters to them in their preferred place of death and prevents overmedicalisation. There are many barriers preventing early honest conversations, including a culture of not wanting to talk about death and the time pressures of clinicians. ***Recommendation:*** develop a national information campaign led by DHSC or NHS England aimed at healthcare professionals and the public, demystifying the dying process and encouraging early conversations about death and dying.

Increase access to advance care planning
Most of the public (78%)[vi] are unaware of the term 'advance care planning' and one study revealed that less than a third of respondents discussed end of life wishes in the last year of their life or formally documented their wishes.[vii] Uptake is particularly low among older people living with frailty, as well as ethnic minority groups.
Recommendation: develop a DHSC/ NHS England-led public information campaign focused on the importance of advance care planning, and targeted at groups where uptake is low, such as older people with multiple long-term conditions and ethnic minority groups.

Facilitate co-ordinated care
Older people dying with multiple long-term conditions, including frailty and dementia, will require health and social care support from a range of different health and social care teams. Lack of co-ordination results in disjointed care which can cause anxiety for the person dying and their loved ones. ***Recommendation:*** require ICSs to develop shared PCEoLC workplans between different clinical teams and organisations involved in providing care for those reaching the end of life, focused on integrating the workforce, facilitating parallel planning and providing holistic support enabling people to live well until their death.

There is technological fragmentation within the NHS, with different parts of the system using different software and hardware to capture information about patients. Effective health communication systems are needed to share information, including advance care plans incorporating advance decisions to refuse treatment and preferred place of death, between specialists, generalists and informal carers who are involved at the end of life. ***Recommendation:*** introduction of a national standardised approach to data and information-sharing across services supporting palliative and end of life care.

Deprescribing
Older people often take multiple medications which may have limited benefits as someone comes towards the end of life and cause harms, including increasing the risks of falls and confusion. Deprescribing can reduce this, but its application varies, with no standardised approach across England. ***Recommendation****:* set up a national working group to operationalise deprescribing with a specific remit to reduce treatment burden at the end of life.

Define PCEoLC expectations for healthcare professionals
Responsibility for initiating early, honest conversations with the person reaching the end of life and their family are often vague and diffused across multiple health teams. This is

especially the case for older people with multiple long-term conditions, who may see may see a range of specialists. ***Recommendation:*** national guidance is needed outlining who is responsible for initiating end of life conversations with patients, alongside clear criteria about when to initiate conversations, including identifying those with multiple conditions reaching the end of life. This should be supported by a national helpline or information hub for healthcare professionals, provided by NHS England or DHSC.

Define expectations around PCEoLC judgements

There is a lack of clarity on the expectations of healthcare professionals making PCEoLC judgements, such as stopping treatment or withdrawing medications. Fear of referral to the coroner can lead to overmedicalisation, reluctance to deprescribe, delayed care, and unnecessary investigations. ***Recommendation****:* DHSC to work with HM Coroners to develop guidance on the expectations and documentation required by healthcare professionals making PCEoLC judgements.

Formalise care home medical arrangements

About 20% of deaths of those over the age of 65 take place in care homes.[viii] The number of deaths occurring in care homes is set to double over the next 25 years, and care homes are set to become the most common place of death, especially as dementia rates are increasing.[ix] Care homes often lack structured medical input, and arrangements vary geographically across England. This can lead to unplanned hospital admissions, medication errors, and missed opportunities for advance care planning. Hospices provide a gold standard level of PCEoLC, but there are not enough of them to support everyone at the end of life. Care homes should be considered the hospices of the future. ***Recommendation****:* DHSC to formalise medical arrangements in care homes to ensure older people receive good PCEoLC. Medical arrangements may include the requirement for every care home to have a named clinical lead, routine structured medical reviews, and out of hours support arrangements. We also recommend that advance care planning is mandated as a CQC requirement in care homes.

Update NICE guidance to consider older people with frailty

While there is NICE guidance on caring for older people with multiple health conditions, there is no dedicated NICE guideline on frailty as a clinical syndrome or trajectory, or on cognitive impairment. ***Recommendation***: DHSC to work with NICE to produce guidance on caring for older people with frailty at the end of life.

3. Embedding sustainable approaches

Commissioning

Only 35% of Integrated Care Boards (ICBs) report that they significantly or fully understand PEoLC population health needs.[x] One in four ICBs have not incorporated PEoLC in their Integrated Care Strategy. **Error! Bookmark not defined.** Recently, NHS England have provided grants to hospices, but this is the setting for just 5% of deaths in those over the age of 65, with hospitals (40%) being the most common place of death followed by the person's home (30%) and care homes (20%).[viii] Investment is needed at a national level focusing on a whole system approach, prioritising the needs of those dying in older age. ***Recommendation:*** DHSC/NHS England should require ICBs to produce a strategic plan explaining how they will meet the PEoLC needs of their ageing population. Funding should be ringfenced to ICBs who can illustrate they will invest in a

whole system approach to PEoLC, recognising the importance of the generalist workforce.

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[ii] National Records of Scotland. *Birth, deaths, marriages and life expectancy.* Available at: https://www.nrscotland.gov.uk/statistics-and-data/births-deaths-marriages-and-life-expectancy/ (accessed 18 September 2025).
[iii] Northern Ireland Statistics and Research Agency, 2024. Registrar General Annual Report 2023 Cause of Death. Available at: https://www.nisra.gov.uk/publications/registrar-general-annual-report-2023-cause-death (accessed 18 September 2025).
[iv] Nuffield Trust, 2024. *Falling through the gaps? A closer look at NHS Continuing Healthcare*. Available: https://www.nuffieldtrust.org.uk/resource/falling-through-the-gaps-a-closer-look-at-nhs-continuing-healthcare (accessed 18 September 2025).
[v] Wu Y-T, Prina M, and Matthews F, 2022. 'The availability of local primary care services, satisfaction with health services and self-rated health in older English adults: A population-based study.' *Preventative Medicine Reports.* Jun; 27. doi: https://doi.org/10.1016/j.pmedr.2022.101786.
[vi] Marie Curie, 2021*. Public Attitudes to death, dying and bereavement in the UK.* Available: https://www.mariecurie.org.uk/globalassets/media/documents/policy/policy-publications/2024/n401_padd_report_final.pdf (accessed 18 September 2025).
[vii] Marie Curie, 2024. *Public attitudes to death, dying and bereavement in the UK re-visited: 2023 survey* Available: https://www.mariecurie.org.uk/document/policy-briefing-death-dying-bereavement-2023 (accessed 18 September 2025).
[viii] Office for Health Improvement & Disparities, 2025. *Palliative and end of life care profiles January 2025 update: statistical commentary.* Available: https://www.gov.uk/government/statistics/palliative-and-end-of-life-care-profiles-january-2025-update/palliative-and-end-of-life-care-profiles-january-2025-update-statistical-commentary (accessed 19 September 2025).
[ix] Bone A, Gomes B, Etkind S N, Verne J, Murtagh F E, Evans C J, and Higginson, I J, 2017. 'What is the impact of population ageing on the future provision of end-of-life care? Population-based projections of place of death.' *Palliative Medicine.* 32(2):329-336. doi:10.1177/0269216317734435
[x] Marie Curie, 2023. *Palliative and end of life care in Integrated Care Systems.* Available: https://www.mariecurie.org.uk/document/palliative-end-of-life-care-integrated-care-systems-survey-report-2023 (accessed 18 September 2025).