Key findings

Mental Health Spotlight Audit , National Audit for Care at the End of Life England, Wales and Jersey 2025

Findings relate to care provided in mental health inpatient facilities from 1 January – 31 December 2025

Recognition of dying

Of the patients audited by the Case Note Review that died of natural causes in in-patient mental health wards, staff had recognised or expected the imminence of death during that hospital stay in **66**% of cases.

1

Communication of dying

The likelihood of dying was discussed with **87**% of the dying persons nominated person(s). For **5**% of nominated person(s), a reason was recorded for why this discussion did not take place, and **9**% had no reason recorded.

2

Diagnosis and detention

Dementia was identified as the primary cause of death in **40**% of patients, making it the most frequently recorded cause of death within the patients audited by the Case Note Review.

3

Transfer of patients

75% of mental health trusts/health boards operate under a model whereby if a patient's physical health significantly deteriorates and are potentially at the end of life, they will be transferred to an Acute Trust.

4

Individualised plan of care

97% of patients had an individualised plan of care addressing their needs at the end of life. Of these, **40**% were documented on a standalone template and **58**% within the general clinical notes.

5

Key findings

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Spiritual, religious and cultural needs

An assessment of those important to the dying person's spiritual, religious and cultural needs was documented in **57**% of cases (or where not possible, a reason was recorded).

6

Individualised management of symptoms

Of the patients audited by the Case Note Review, **97**% had documented evidence of a review of their pain. Although, **49**% of staff reported that they strongly agree or agree that they are confident in assessing and managing patient pain and physical symptoms at the end of life.

7

Access to specialist palliative care services

The median time between referral to the specialist palliative care team and review during the final admission was **21** hours, compared with **3** hours in acute and community hospital settings.

8

End of life care training

36% of mental health inpatient staff have completed training specific to end of life care within the last 3 years.

9

End of life care lead

79% of mental health trusts/health boards have an identified member of staff with a responsibility/role for end of life care.

10