HQIP
Healthcare Quality Improvement Partnership

National Audit of Care at the End of Life 2025

Auditing last days of life in hospitals

Mental Health Spotlight Audit 2025 State of the Nations Report

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The National Audit of Care at the End of Life (NACEL) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and funded by NHS England and the Governments of Wales and Jersey as part of the National Clinical Audit and Patient Outcomes Programme.

This report was written by the NACEL programme delivery team at NHS Benchmarking Network.

The NHS Benchmarking Network (NHSBN) is a member-led organisation promoting quality improvement in the NHS through benchmarking and sharing good practice. Members are providers and commissioners of NHS services, spanning the acute, community and mental health sectors. The NHSBN team support members in sharing data to compare service provision and performance with the aim of identifying improvement opportunities.

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Available from: National Audit of Care at the End of Life (NACEL) I NHS Benchmarking Network www.nacel.nhs.uk

Audit Contents

Resources

NACEL Portal
Audit website providing information, news and resources, supporting healthcare improvements in end of life care across NHS services.

For Healthcare Professionals:

NACEL Data and Improvement Tool
Online interactive tool hosting the latest audit findings. Data is published in real time, providing NHS healthcare professionals with up-to-date insights.

NACEL Quality Improvement pages
Quality improvement resources, tools and training available on NACEL Portal. Information available to support organisations to address improvement opportunities.

Hyperlinks

Introduction

NACEL is a comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission to hospital before death. The aim of NACEL is to improve the quality of care of adults (18+) at the end of life in NHS-funded hospital inpatient settings in England, Wales and publicly funded care in Jersey.

This Mental Health Spotlight Audit Report presents findings from mental health inpatient services over the period January 2025 to December 2025, building on the previous spotlight audit published in 2021. NACEL reports on deaths from natural causes ("not sudden") and excludes deaths by suicide.

Mental health inpatient services provide assessment, treatment, and support for people with significant mental ill health, including severe mental illness, high levels of distress, risk to self or others, and complex mental and physical health needs. Care is delivered primarily by mental health professionals working in multidisciplinary teams, with input from physical healthcare services where required.

Natural caused deaths in mental health inpatient settings are less common than in acute or community hospitals; however, they occur in the context of increasingly complex patient needs, including behavioural disturbance and co-existing physical health conditions.

The Care Quality Commission's report on deaths in mental health services identified **318** deaths in mental health hospitals in 2022/23, although this is considered likely to be an underestimate. Of these, **189** were from natural causes (that is, a result of old age or a disease, deaths can be expected or unexpected). Comparable national data is not readily available for Wales or Jersey. The figures above and right show the volume of data that underpins the spotlight audit findings.

NACEL Mental Health 2025 sample size

54
Organisational Overview (OO)

179
Case Note Reviews (CNR)

597
Staff Reported Measures (SRM)

This report includes comparisons to acute and community settings where appropriate. These are intended to provide context; however, no statistical testing has been undertaken. Responses recorded as "not applicable" are excluded from the analysis.

The audit uses data from four sources to review the quality of care:

1. **Organisational Overview (OO)**
   Organisational level questions focusing on service model and quality improvement efforts.

2. **Case Note Review (CNR)**
   Data collected from the clinical case notes of adults who died in hospital during 2025.

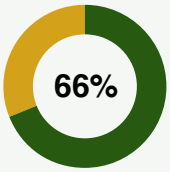
3. **Staff Reported Measure (SRM)**
   A survey completed by inpatient staff who are most likely to come into contact with dying people and those important to them.

4. **Annual Death Data Collection (ADDC)**
   Collecting the number of inpatient deaths that took place in 2025.

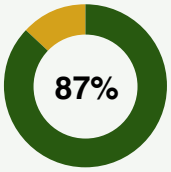
Key findings at a glance

National Audit of Care at the End of Life, Mental Health Spotlight Audit 2025

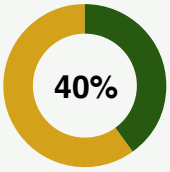
Proportion of patients who died of natural causes, where staff had recognised or expected the likely imminence of death.



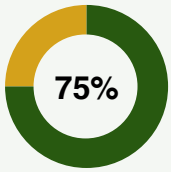
Proportion of clinical case notes with documented evidence that the likelihood of dying was discussed with the dying persons nominated person(s).



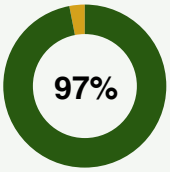
Proportion of patients whose primary cause of death was dementia.



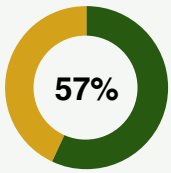
Proportion of mental health trusts/health boards that transfer patients to an acute trust/unit[1] if their physical health deteriorates near the end of life.



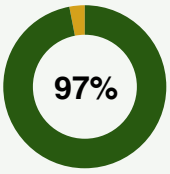
Proportion of clinical case notes with documented evidence of an individualised plan of care addressing the patient's needs at the end of life.



Proportion of clinical notes with an assessment of the spiritual, religious and cultural needs of those important to the dying person, or a reason recorded why not.

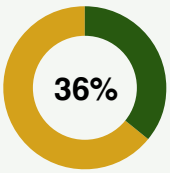


Proportion of clinical case notes with documented evidence of a review of the patient's pain.

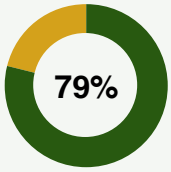


The median time between referral to the specialist palliative care team /end of life care team and review by the specialist palliative care team/ end of life care team.

Proportion of staff that strongly agree or agree that they have completed training specific to end of life care within the last 3 years.



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



[1] In Wales, the term "acute unit" is used to reflect local service arrangements.
[2] All findings relate to care delivered in in-patient mental health wards. Local providers can use the infographic template available at www.nacel.nhs.uk/qi-documents to present their findings alongside the national results. To support comparison, relevant Acute and Community findings can be found in the NACEL 2025 State of the Nations Report.

National recommendations

The below recommendations are evidenced by the data collected from January 2025 – December 2025. A line-of-sight table, outlining the data, supplementary information, linked national standards and supporting resources can be found here.

RECOMMENDATION 1:

Improved recognition of dying

Integrated Care Boards (ICBs), Health Boards and commissioners should ensure that mental health providers have effective arrangements in place to support the timely recognition of dying in inpatient settings, particularly on wards where death and dying are most common (including Older Adult Organic/Dementia and other Older Adult wards). For example:

- Implement mandatory training for inpatient staff on wards where death and dying are most common including recognition of last days of life and aligning with national guidance, including NICE Clinical Guideline NG31 (2015). Training should increase awareness that some deaths are expected within mental health inpatient settings, helping to reduce staff anxiety in recognising and addressing deaths in this setting[3]. It should also explicitly address the risk of diagnostic overshadowing in people with severe mental illness.
- Establish formal clinical advice and escalation pathways that enable inpatient staff to access timely support from clinicians with expertise in palliative and end of life care where there is uncertainty about whether the patient is dying and where staff or family are concerned about management of the holistic needs of the patient and their family.

RECOMMENDATION 2:

Improved national guidance on discharge for dying patients in mental health inpatient settings

The National Institute for Health and Care Excellence (NICE) should update NICE Guideline NG53 (2016) and Clinical Guideline CG136 (2011) to consider guidance on the discharge of dying patients from mental health inpatient settings, and to ensure the needs of those important to the dying patient are recognised and supported. For example:

- Ensuring decisions are person-centred, considerate to mental health complexity, and follow compassionate frameworks supporting preferred place of death.
- Setting clear expectations for coordinated discharge planning that includes multidisciplinary assessment, timely liaison with palliative and community services, and meaningful involvement of those important to the dying patient.

[3] Health Education England's e-End of Life Care for All (e-ELCA) eLearning programme provides free multidisciplinary education modules on recognising dying, communication, advance care planning and end of life care across settings. The Gold Standards Framework identifies proactive approaches for recognising deterioration, advance care planning and enabling people to remain in their preferred place of care where clinically appropriate.

RECOMMENDATION 3:

Reduce unnecessary transfers of dying patients to acute hospitals

Integrated Care Boards (ICBs), Health Boards and Commissioners should work with mental health trusts, specialist palliative care providers and acute partners to reduce default transfers to acute hospitals for people at the end of life. Transfer decisions should be person-centred and based on clinical need, individual preferences, best interests, and expressed wishes.

- Training staff to record and use end of life preferences (for example, through EPaCCS), which should be used to guide person-centred decision-making throughout care, and to recognise when transfer is clinically necessary or in the person's best interests.
- Establishing clear local escalation and decision-making pathways to support the continuity of care within mental health inpatient settings once a patient is identified as being at the end of life, where this reflects their preferences, and those of their families and supporters.
- Strengthening access and awareness of services that support the delivery of high-quality care at the end of life, including timely availability of equipment, medications, specialist palliative care advice, and 24/7 support.

RECOMMENDATION 4:

Equitable access to end of life care support

Integrated Care Boards (ICBs), Health Boards and commissioners should commission and require equitable access to specialist palliative and end of life care for people in mental health inpatient settings, comparable to access in other parts of the health system. For example:

- Mandating clear referral and advice pathways for specialist palliative and end of life care contracts, ensuring these are communicated across the Trust/Health Board so that mental health inpatient staff know how to access timely support.
- Requiring minimum service availability standards for specialist palliative care for at least face-to-face cover 8 hours a day, 7 days a week and a 24-hour, 7 days a week, telephone advice service, in accordance with NICE Standards QS13 (2011)

RECOMMENDATION 5:

Named lead responsible for care at the end of life

Integrated Care Boards (ICBs), commissioners and health boards should ensure that every mental health trust has a named lead responsible for care at the end of life. This role should support the operational and strategic prioritisation of palliative and end of life care across the organisation, including oversight of quality improvement, workforce development, coordination of care, and implementation of national guidance and local recommendations.

Key findings

KEY FINDING 1: 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.

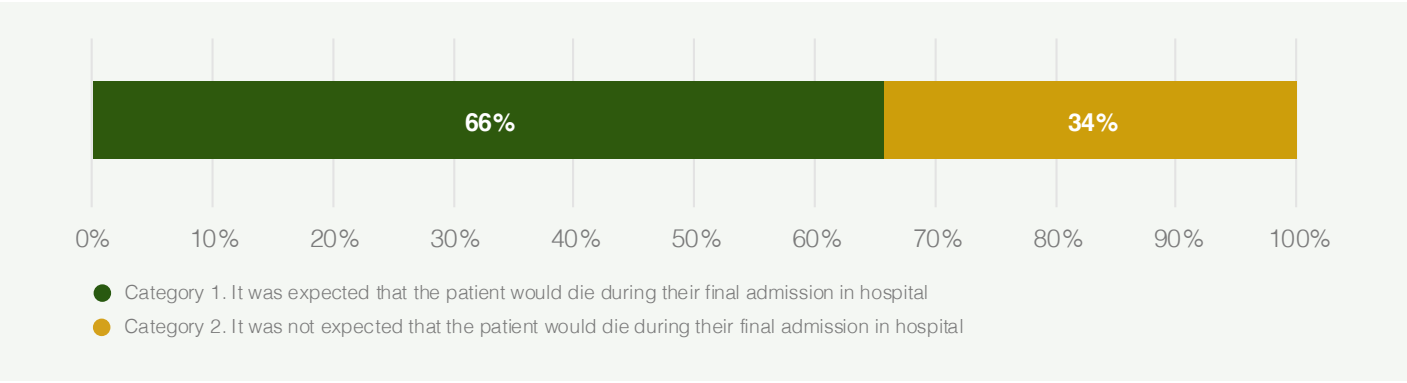


Figure 1: (CNR) The proportion of clinical case notes where the likelihood of imminent death during the admission to a mental health in-patient ward was recognised or expected.

This compares to **84%** of patients whose deaths were recognised as imminent in acute and community hospitals. The results further show that patients with a severe mental illness (SMI) were less likely to be recognised as imminently dying. During the final admission, death was expected in **58%** of patients with an SMI, compared to **70%** of patients without an SMI.

These findings may suggest an increased risk of diagnostic overshadowing, where physical deterioration and signs of dying are misunderstood or attributed primarily to a person's mental health condition.

For all patients whose death was recognised, the median time between first recognition and death was **170 hours (7 days)**, compared with **52 hours (2.2 days)** in acute and community settings.

Recognising deteriorating health and the dying phase is essential for timely, person-centred end of life care. In mental health inpatient settings, the median time from admission to death was **94 days,** compared with **9 days** in acute and community settings. Longer stays in Mental Health Units give staff more opportunity to know patients and, with training, recognise the end of life stage.

The importance of and opportunity for recognition of the patient moving into the end of life stage inform Recommendation 1, which focuses on improving timely identification of dying and strengthening training and support for staff on wards where death and dying are most common.

KEY FINDING 2: COMMUNICATION OF DYING

The likelihood of dying was discussed with 87% of the dying person's 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.

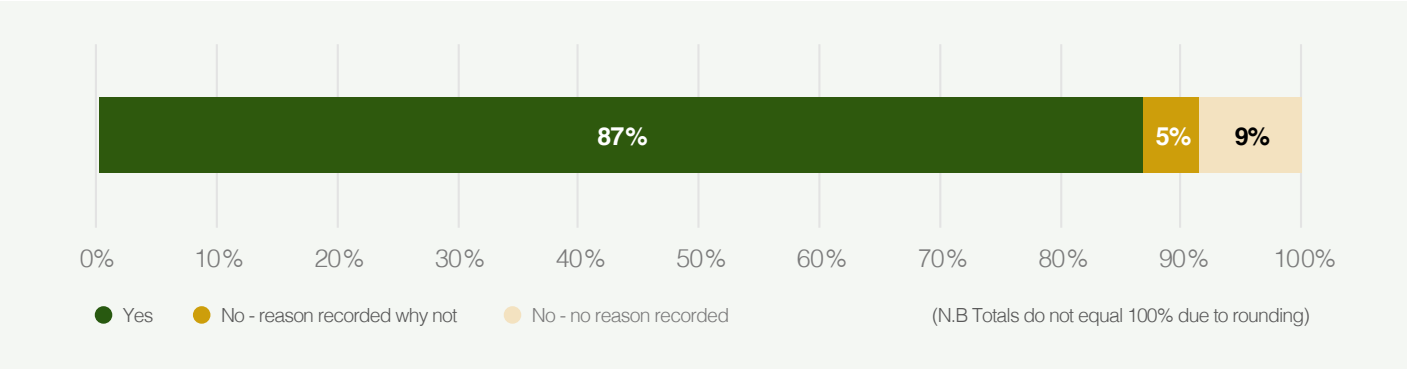


Figure 2: (CNR) The proportion of clinical case notes with documented evidence that the likelihood of dying was discussed with the nominated person(s).

For patients, discussions about the likelihood of dying took place for **12%** of individuals. For **51%** of patients, a reason was recorded for why this discussion did not take place[4], while **37%** had no reason recorded. **77%** of staff agree or strongly agree that they are confident in their skills to communicate clearly and sensitively to dying patients and those important to them.

KEY FINDING 3: DIAGNOSIS AND DETENTION[4,5]

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.

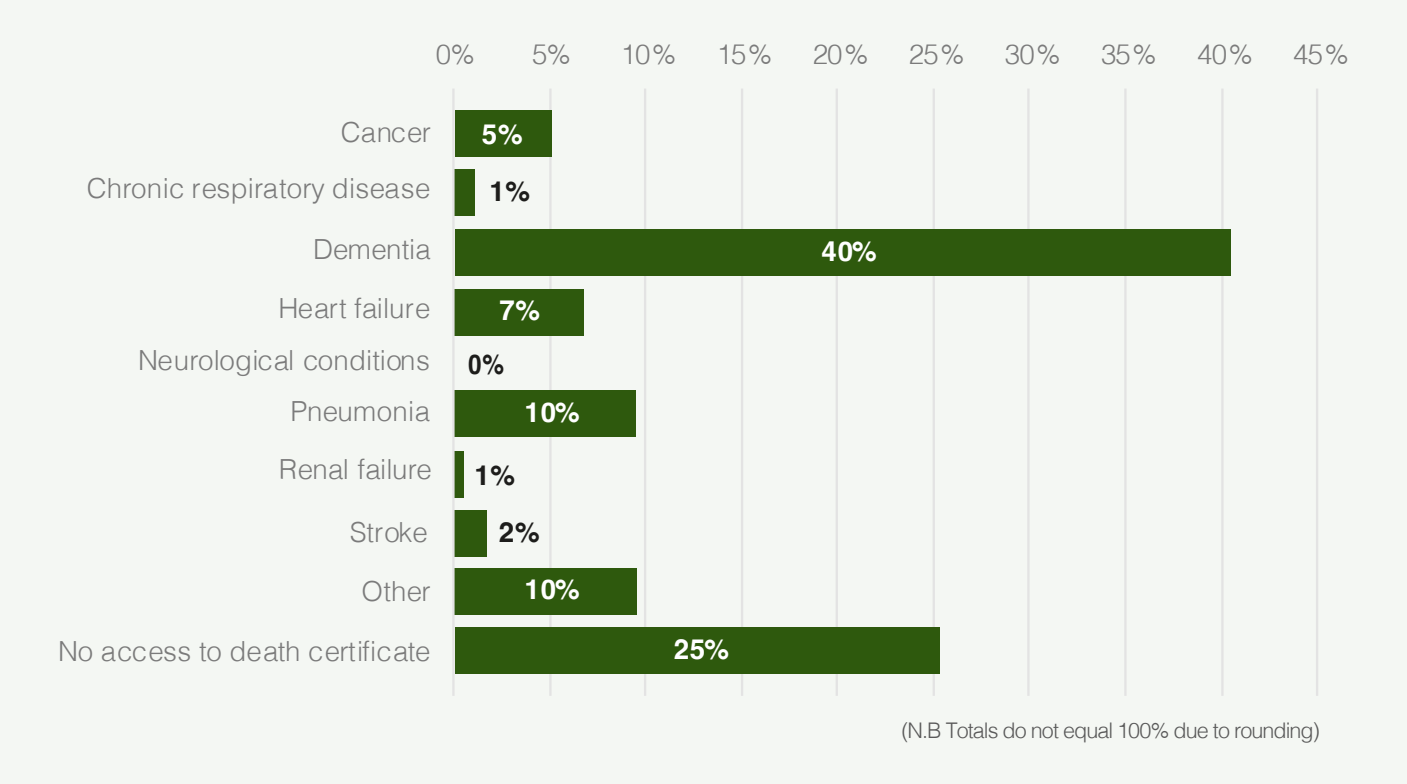


Figure 3: (CNR) Primary cause of death within the patients audited by the Case Note Review.

Dementia was recorded as the primary cause of death in **40%** of cases, representing the largest proportion within the dataset, this is an increase from 2021 findings where dementia represented **36%** of the primary cause of deaths. This indicates that a substantial proportion of deaths occurred among patients with dementia, highlighting the relevance of end of life care for people with dementia within mental health inpatient settings[5,6]. In a further **25%** of cases, no death certificate was available, meaning the primary cause of death could not be confirmed.

The most commonly recorded wards at the time of death were Mental Health Older Adult Organic/Dementia (**72%**) and Mental Health Other Older Adult (**13%**).

26% of patients had a recorded diagnosis of a severe mental illness, excluding dementia. This compares with **3%** in acute and community settings, indicating a higher prevalence of recorded severe mental illness within the mental health inpatient cohort. This finding highlights the importance of tailored end of life care for this group, who face well documented barriers to timely, appropriate care. NIHR evidence shows that people with severe mental illness often experience fragmented care, delayed recognition of dying, reduced involvement in advance care planning, and uncertainty about responsibility for managing end of life needs.

Overall, **76%** of patients were detained under a section of the Mental Health Act (1983) prior to death, **11%** were detained at the time of death, and **12%** were not detained under the Act. NACEL does not collect further information regarding time of detention under the Mental Health Act or when detention was lifted.

[4] 'Reason recorded why not' may include attempts to contact the nominated person(s) were unsuccessful/no nominated person(s), patient had not consented for these discussions to take place with the nominated person(s), Independent Mental Capacity Adviser (IMCA) unavailable or another reason recorded.

[5] Useful learning can be drawn from the Dementia Palliative Care Services Toolkit, which includes examples of good practice in supporting people with dementia to receive high-quality, compassionate palliative and end of life care, including support for families and carers, holistic assessment, and advance care planning.

[6] National guidance on Advance Care Planning (ACP) for people living with dementia supports professionals across all care settings to discuss and document future wishes, underpinning person-centred care at the end of life.

KEY FINDING 4: TRANSFER OF PATIENTS

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

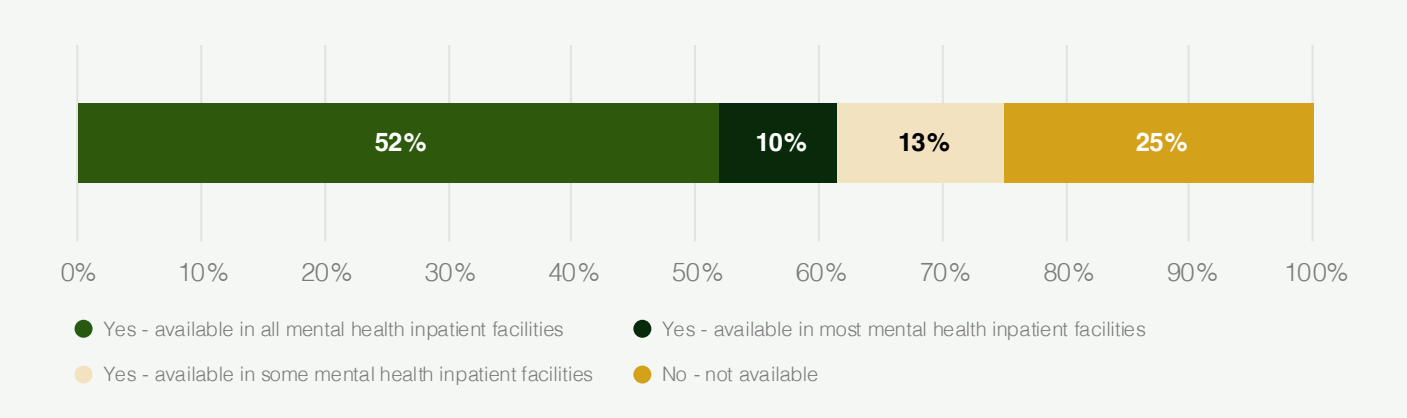


Figure 4: (OO) The proportion of mental health trusts/health boards that operate under a model whereby if a patient's physical health significantly deteriorates and are potentially at the end of life, they will be transferred to an Acute Trust.

Figure 4 indicates that transfer to Acute Trusts is a commonly reported approach when end of life care needs arise within mental health inpatient settings. This approach doesn't fully support the ambitions of the NHS 10 Year Health Plan, which promotes a reduction in avoidable hospital transfers, and improved person-centred care.

The NACEL Mental Health Spotlight recommends the development and implementation of national guidance to support the safe and compassionate discharge of dying patients from mental health inpatient settings, and to reduce avoidable transfers of patients at the end of life to acute hospitals (Recommendation 2 & 3). Decisions should remain person centred, supporting continuity of care and enabling patients to remain, where appropriate, in familiar environments that support their wellbeing, cared for by staff who know them.

KEY FINDING 5: 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.

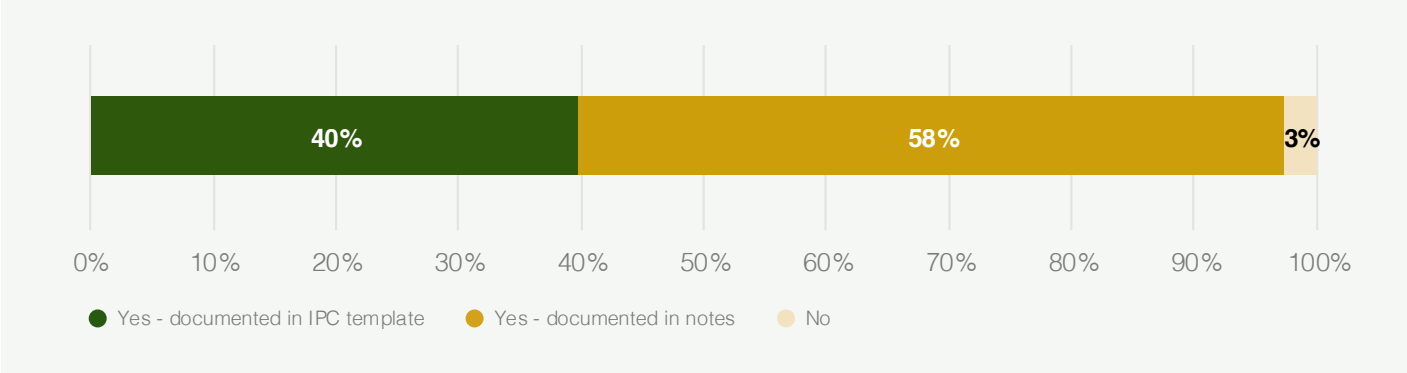


Figure 5: (CNR) The proportion of clinical case notes with documented evidence of an individualised plan of care addressing the patient's needs at the end of life.

97% people who died had an individualised plan of care addressing their needs at the end of life, demonstrating compliance against NICE QS144, Quality Statement 2, an improvement from **82%** reported in the 2021 NACEL Mental Health Spotlight Audit. This compares with **86%** in acute and community settings, demonstrating that person centred care is more consistently implemented in mental health inpatient settings, potentially reflecting longer admission periods that allow staff to develop a more comprehensive understanding of individuals and their needs. End of life care planning discussions should take place in advance so that patient wishes can be understood and supported.

Despite the high proportion of individualised care plans, only **67%** of staff agree or strongly agree that they have the skills to involve the dying patient and those important to them in decisions about end of life care in line with their wishes and preferences.

KEY FINDING 6: 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).

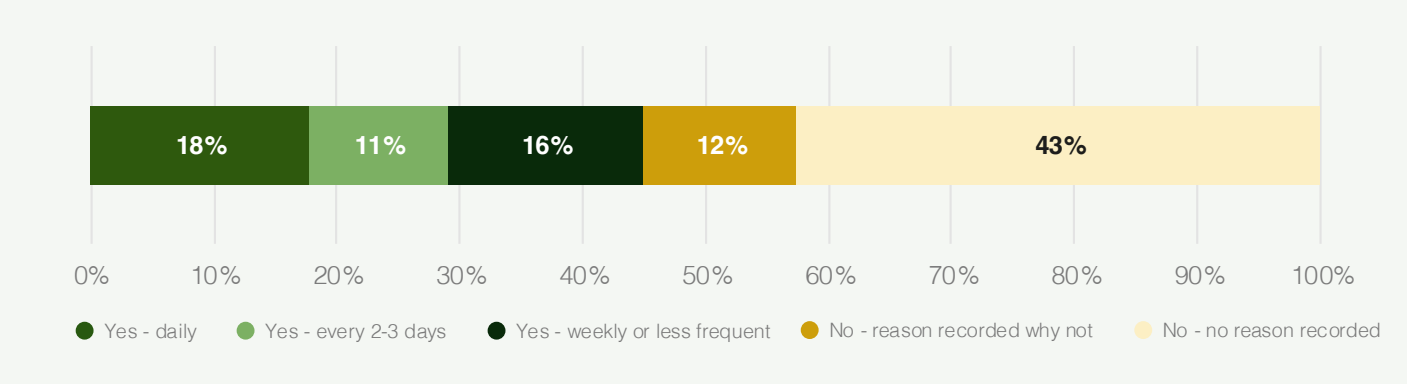


Figure 6: (CNR) The proportion of clinical case notes with documented evidence of an assessment of those important to the dying person's spiritual, religious and cultural needs.

This was higher than in acute and community settings, where **49%** of cases had documented evidence of an assessment of the spiritual, religious, or cultural needs of those important to the patient, or, where this was not possible, a reason was recorded.

Identifying the cultural, religious, social, or spiritual preferences of the dying person and those important to them is a key component of individualised care planning, as outlined in NICE QS144, Quality Statement 2. Whilst Key Finding 5 reports documented evidence of an individualised care plan, Key Finding 6 highlights the need for further assessments to ensure that all needs are comprehensively addressed, enabling truly personalised end of life care tailored to the individual's wishes and preferences.

KEY FINDING 7: INDIVIDUALISED MANAGEMENT OF SYMPTOMS

Of the patients audited by the Case Note Review, 97% had documented evidence of a review of their pain. Although only 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.

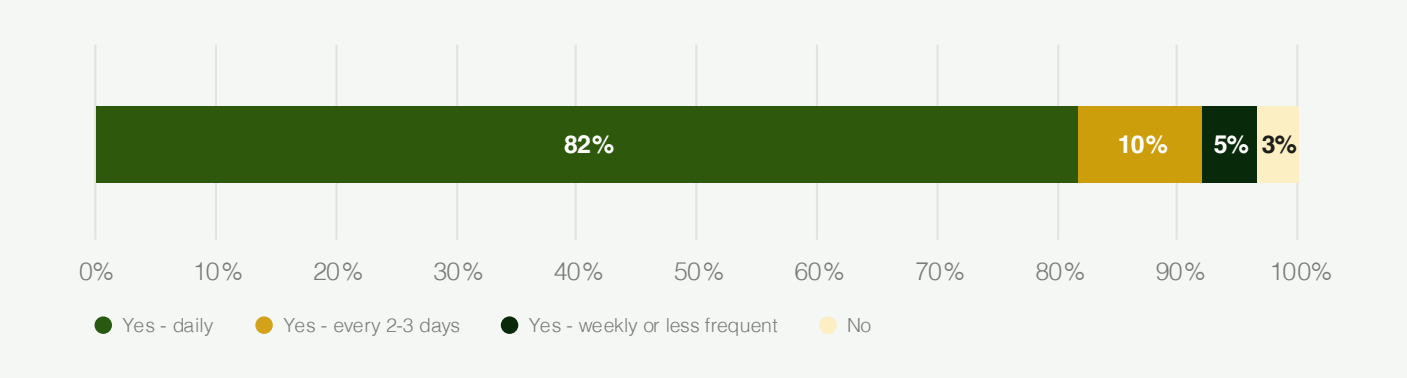


Figure 7: (CNR) The proportion of clinical case notes with documented evidence of a review of the patient's pain.

Pain was reviewed for **97%** of patients, with **98%** having documented evidence that actions to address pain were fully or partially implemented. Agitation or delirium was reviewed for **94%** of patients, with **99%** having actions fully or partially implemented. Dyspnoea or breathing difficulties were reviewed for **94%** of patients, with **98%** having actions fully or partially implemented. Despite this high level of documentation, only **49%** of staff agreed or strongly agreed that they were confident in assessing and managing patient pain and physical symptoms at the end of life.

Hydration options were reviewed for **96%** of patients. Communication about hydration occurred with **86%** of patients and **80%** of those important to the patient, or a reason was recorded if not. Despite evidence of hydration reviews, this remains an area of care where staff report lower confidence. **52%** of staff agreed or strongly agreed that they were confident in discussing hydration options with dying patients and those important to them.

KEY FINDING 8: **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.

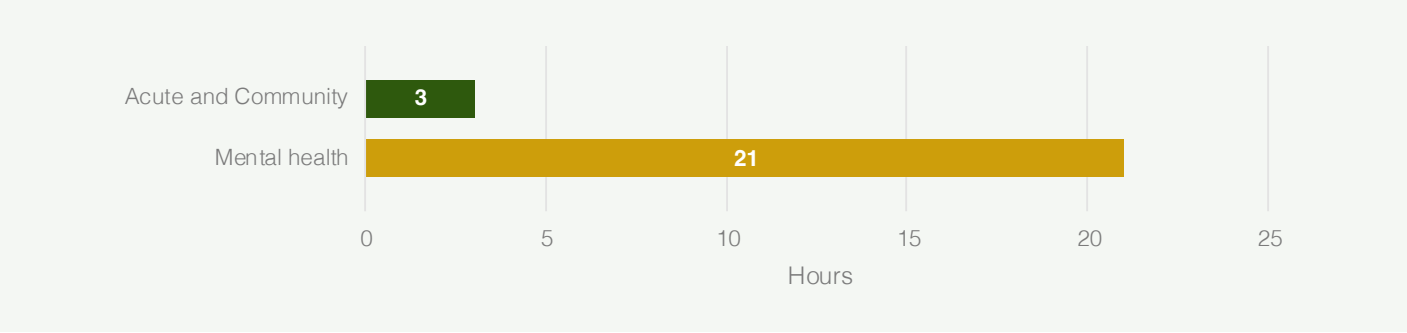


Figure 8: (CNR) The median time between referral to the specialist palliative care team /end of life care team and review during the final admission by the specialist palliative care team/end of life care team (hours).

The median time between referral to the specialist palliative care team and review was **21 hours**, compared with **3 hours** in acute and community hospital settings, indicating a longer interval before review in mental health inpatient settings. Boxplot 1 illustrates the variation in the time between referral and review across mental health providers.

66% of patients had documented evidence of a review by a member of the specialist palliative care team during their final admission, which is **8%** higher than in acute and community settings.

All trusts reported access to specialist palliative care services with availability across all facilities at **85%**, most facilities at **6%**, and some facilities at **9%**. This represents an improvement from 2021 when **89%** of trusts reported access. Face-to-face specialist palliative care services (doctor and/or nurse) available 8 hours a day, 7 days a week were reported by **66%** of trusts, up from **44%** in 2021. While improvements have been made, a gap remains in meeting NICE QS13 requirements for 24/7 access to support.

In organisations where the specialist palliative care service is funded and/or based outside of the hospital, the service is provided by a local acute trust in **60%** of cases, a local community trust in **33%**, a local hospice in **76%**, and other providers in **26%**. This variation in provider arrangements suggests there is no single standardised model for accessing specialist palliative and end of life care support across Trusts, with services frequently relying on multiple providers and local arrangements. This reinforces the importance of ensuring staff understand how to access specialist support within their local system. In the staff survey, **63%** of respondents agreed that they knew how to access specialist palliative and end of life care advice when required.

NACEL findings highlight the importance of establishing formal agreements and referral pathways to ensure timely and equitable access to the specialist palliative care services; the absence of such arrangements may help explain the observed **21 hour** wait. These findings support Recommendation 4.

KEY FINDING 9: 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.

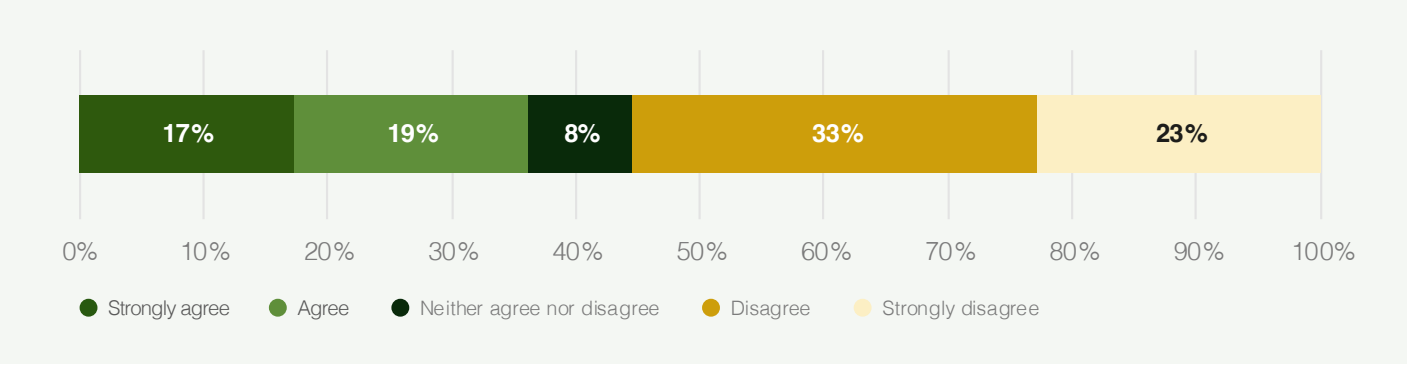


Figure 9: (SRM) The proportion of staff have completed training specific to end of life care within the last 3 years.

Organisations differ in how end of life care training is provided and prioritised. Only **22%** of mental health trusts/health boards include end of life care training in induction programmes, **23%** offer it as part of mandatory or priority training, **50%** provide communication skills training specifically addressing end of life care, and **76%** offer other training in relation to end of life care. Compared to acute and community hospital sites, mental health facilities provide notably fewer structured training opportunities specific to end of life care. This aligns with staff reported confidence levels, with fewer than half of staff feeling confident in areas such as assessing and managing pain or discussing hydration options, suggesting that limited training may be contributing to reduced confidence in recognising and supporting patients approaching the end of life.

KEY FINDING 10: 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.

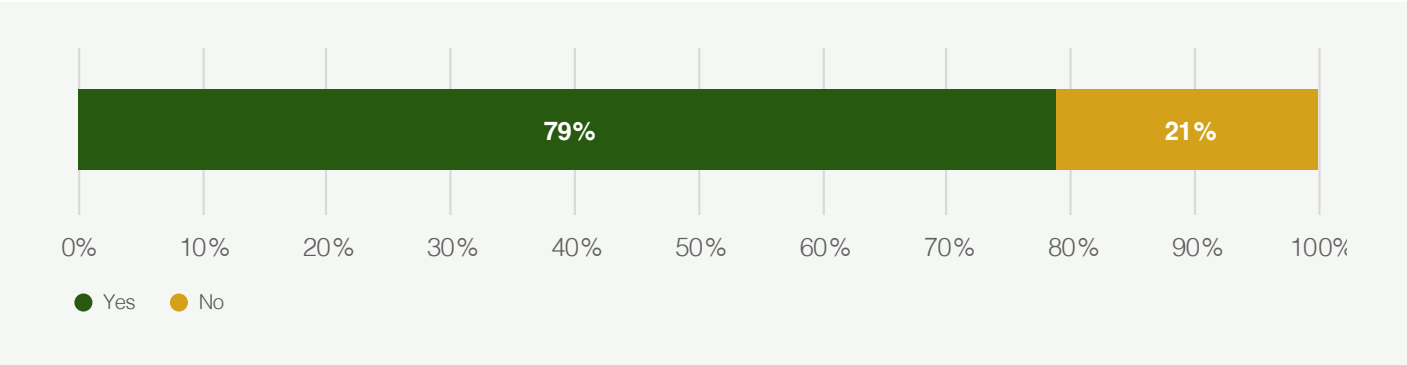


Figure 10: (OO) The proportion of mental health trusts/health boards with an identified member of staff with a responsibility/role for end of life care.

79% of mental health trusts and health boards have a designated staff member responsible for end of life care, while **21%** do not. This represents a reduction from the 2021 NACEL Mental Health Spotlight Audit findings which reported this at **89%**. A named lead can support coordination, provide guidance, contribute to staff training, help maintain consistent end of life care practices across the organisation, and play a key role in supporting the consideration and implementation of recommendations highlighted in this report. Recommendation 5 calls for all mental health trusts to have a designated end of life care lead, supporting the strong leadership and organisational commitment outlined in the Ambitions for Palliative and End of Life Care 2021–2026 framework.

Find out more about this audit

For more information about the audit, please visit the NACEL Portal.

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National Audit of Care at the End of Life 2025

Auditing last days of life in hospitals

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