National Audit of Care at the End of Life

Auditing last days of life in hospitals

NACEL Northern Ireland 2024/25

Summary Report

Published November 2025

Palliative Care
in partnership

Contents

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National Audit of Care at the End of Life: Northern Ireland 2024/25

Foreword

This report presents the fifth round results of the National Audit of Care at the End of Life (NACEL) in Northern Ireland for 2024/25.

NACEL is an audit of end of life care delivered in inpatient hospital settings which collects information on the key areas of care identified in national guidance, such as the 5 Priorities for Care outlined in One Chance to Get It Right and NICE quality standards and guidelines.

From 2018 to 2022, Northern Ireland took part in all four rounds of NACEL alongside England and Wales. The audit was paused in 2023 while it was redesigned before data collection resumed for England and Wales, with the addition of Jersey, in January 2024 and Northern Ireland in July 2024.

The primary goal of the redesign was to ensure the audit was best placed to facilitate quality improvement activities. This involved reviewing and updating the metrics collected, collecting data for deaths across a full year (from July 2024 to June 2025), and improving the timeliness of reporting to allow more detailed and responsive approaches to quality improvement (QI). In addition, the NACEL NI Data and Improvement Tool, a new interactive reporting platform, was developed to allow greater insights to be derived from the audit findings. Trusts are encouraged to review their local results to benchmark their performance against other submissions and use these findings to inform their quality improvement activities going forward.

All five Health and Social Care Trusts in Northern Ireland took part in NACEL 2024/25, providing valuable insights about end of life care both at a local level and across Northern Ireland as a whole. For the first time, four out of five Health and Social Care Trusts in Northern Ireland participated in the NACEL Bereavement Survey (formerly named the 'Quality Survey'), alongside the three other audit elements: the Case Note Review, Staff Reported Measure, and Hospital/Site Overview. This provided an opportunity to view the findings of NACEL through a different lens, understanding not just if the care documented in patient notes aligned with staff confidence, but also with how those important to the patients perceived the care.

When a patient has been recognised to be dying, it is important for the needs of the patient and those important to them to be assessed and addressed as far as possible. While there has been an improvement in the proportion of patients expected to die with an individualised plan of care in place and increases in the assessments of emotional and psychological needs and social and practical needs since the audit previously ran in 2022, the percentage of patients with a spiritual, religious and cultural needs assessment has reduced from 83% to 68%.

A positive finding of this year's audit is the increase in availability of telephone Specialist Palliative Care advice 24 hours a day, 7 days a week. Thanks to dedicated funding, this has risen from 30% to 82% of submissions having access to 24/7 support. With that said, it remains the case that no Health and Social Care Trusts have access to face-to-face Specialist Palliative Care advice 8 hours a day, 7 days a week. Although there has been an increase in the availability of specialist advice, there has been a decrease in the proportion of staff who agree they have received training specific to end of life care in the past three years, from 52% in 2021 to 44% in 2024.

An objective of the redesigned audit is to understand and reduce health inequalities. To shine a light on this, equitable care is featured in the report for the first time, with the key finding outlining that 39% of patients do not have their ethnicity recorded in their notes. To further support work to deliver equitable care, additional metrics have been introduced to the audit and the reporting platform, the Data and Improvement Tool, includes demographic filters which allow organisations to better understand any variations in care for different groups.

The NACEL NI 2024/25 findings have been used as supporting evidence to develop eight recommendations to improve care at the end of life in hospitals, targeted at Chief Executives of Health and Social Care Trust Boards, the Palliative Care in Partnership Programme and the Department of Health/ Commissioners.

The NHS Benchmarking Network has been awarded a 2-year contract extension to deliver NACEL in England, Wales and Jersey until 2027. NHS Benchmarking Network and the Public Health Agency have agreed that the audit will not run in Northern Ireland throughout 2026 to allow time for quality improvement work to be planned, implemented and embedded. A contract has not yet been agreed beyond this date but discussions around participation in future years are ongoing.

We would like to thank the teams within the Health and Social Care Trusts who contributed to NACEL, whether that was through data collection for the Case Note Review and Hospital/Site Overview, through completing the Staff Reported Measure or through collecting and processing the Bereavement Surveys. We would also like to thank the bereaved people who shared their experiences to allow a deeper understanding of end of life care in hospitals across Northern Ireland.

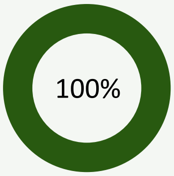
Heather Reid

Interim Director for Nursing, Midwifery and AHPs,
Public Health Agency

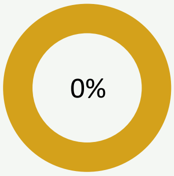
Key findings at a glance

National Audit for Care at the End of Life
Northern Ireland 2024/25

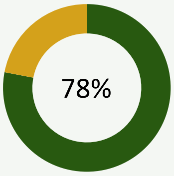
Proportion of hospital/sites who have shared their end of life care quality improvement plan with the Senior Management Team or Trust Board



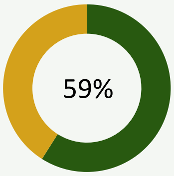
Hospital/sites with a face-to-face specialist palliative care service (doctor and/or nurse) available 8 hours a day, 7 days a week.



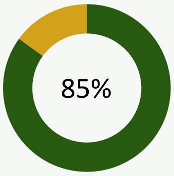
Proportion of deaths expected by clinical staff during the final admission.



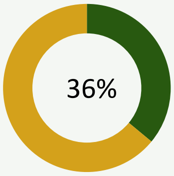
Proportion of clinical notes with evidence of communication about hydration with those important to the dying person, or a reason recorded why not.



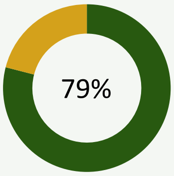
Proportion of bereaved people who agreed that the person received sufficient pain relief during their final hospital admission.



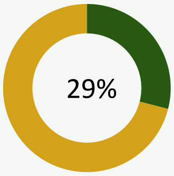
Proportion of clinical notes with an assessment of the spiritual, religious and cultural needs of those important to the dying person, or a reason recorded why not.



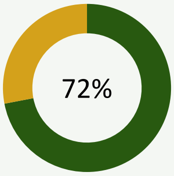
Proportion of bereaved people who rated the care and support they received from the hospital during the person's final admission as excellent or good.



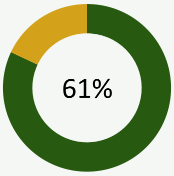
Proportion of clinical notes with evidence the person participated in personalised care and support planning (advance care planning) conversations.



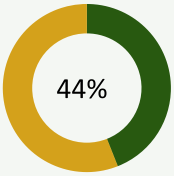
Proportion of people expected to die during the hospital admission with an individualised plan of care addressing their needs at the end of life.



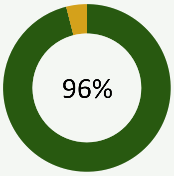
Proportion of people who died with their ethnicity documented in their clinical notes.



Proportion of staff who have completed end of life care training within the last three years.



Proportion of patients expected to die that were prescribed anticipatory medication.



Recommendations

The recommendations from NACEL Northern Ireland (NI) 2024/25 are detailed below. Indicated below each recommendation in brackets is the audit year when the recommendation was first introduced, amendments and the supporting key finding from 2024/25.

The Northern Ireland Palliative Care in Partnership Programme will review these recommendations in line with the regional palliative care work plan and where applicable, a regional approach may be taken to consider the NACEL recommendations. HSCTs should create or update local action plans following review of the audit results as shown in the NACEL Data and Improvement Tool, in the context of the Northern Ireland recommendations and specific guidance.

RECOMMENDATION 1:

See Key Finding 2

Face to face specialist palliative care services

In collaboration with the Palliative Care in Partnership Programme, the Department of Health/ Commissioners should work towards having specialist palliative care doctor and/or nurse face to face availability 8 hours a day, seven days a week. NICE Quality Statement 13 advocates the need for adults approaching the end of their life and their carers to have out of hours care and support at any time.

[NACEL 2019 Recommendation 7 – updated for 2024/25]

RECOMMENDATION 2:

See Key Finding 4

Communicating hydration options

Chief Executives of Health and Social Care Trust Boards should ensure that clinical teams delivering end of life care communicate hydration options at the end of life, with those important to the dying person.

All reviews, communication and support should be clearly documented in the patient's care records. Professional guidance from the GMC, good practice in decision making, Treatment and care towards the end of life: 2022 should be implemented and the NMC's The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates, 2018, should be adhered to.

[NACEL 2019 Recommendation 2 - updated for 2022 and 2024/25]

RECOMMENDATION 3:

See Key Finding 6

Spiritual, religious and cultural needs

Chief Executives of Health and Social Care Trust Boards should ensure that patients at the end of life have an individualised plan of care which assesses & addresses the spiritual, religious and cultural needs of the dying person, and those important to them.

NICE Quality Standard 144 states that care at the end of life should be responsive to the personal needs and preferences of the person who is dying.

[NACEL 2019 Recommendation 3 - updated for 2024/25]

Recommendations

RECOMMENDATION 4:

See Key Findings 6 & 7

Care and support for families and others

Chief Executives of Health and Social Care Trusts should ensure the needs of people important to the dying person are identified, assessed, and addressed with compassion and timeliness both during the person's final days and following death.

Trusts should assign clear senior, strategic, and operational responsibility for this area of care, ensuring sufficient capability and capacity to provide meaningful support. This responsibility must include structured assessment of emotional, practical, spiritual, religious, and cultural needs, so that families and others close to the patient receive holistic, effective, and sensitive care, extending into bereavement support where required.

[NACEL 2024/25 new recommendation]

RECOMMENDATION 5:

See Key Finding 8

Personalised care and support (advance care) planning

Chief Executives of Health and Social Care Trusts should ensure there are mechanisms in place to increase the number of advance care planning (personalised care and support planning) conversations offered to patients in the last year of life, prior to their last admission to hospital.

- Advance care planning should be reflective of the patient's choices, alongside their legal, financial and personal wishes at the end of their life.
- A record of the offer, any discussion and plans should be available to inpatient teams once a patient is admitted to hospital.

[NACEL 2019 Recommendation 4 - updated in 2022 and 2024/25]

RECOMMENDATION 6:

See Key Finding 10

Equitable care

Chief Executives of Health and Social Care Trusts should take responsibility for ensuring that high-quality palliative and end of life care is delivered equitably and is responsive to the specific needs of the local population. This includes:

- Implementing robust and systematic processes to collect and record individual demographic data, with particular emphasis on the accurate documentation of ethnicity.
- Proactively identifying and addressing existing inequalities within their Trust areas.
- Training healthcare professionals to offer an interpreter, or an appropriate communication alternative, to those where English is not their primary language.

[NACEL 2024/25 new recommendation]

Recommendations

RECOMMENDATION 7:

See Key Finding 11

Induction and mandatory/priority training

In collaboration, the Palliative Care in Partnership Programme, the Department of Health/ Commissioners and Health and Social Care Trusts should work towards end-of-life care training programmes becoming embedded in induction programmes and/or mandatory/priority training programmes in Northern Ireland.

End of life care training should ensure that staff have the knowledge and skills to support the patient and family; develop staff competence and confidence to recognise imminent death, communicate with the dying person and people important to them as early and sensitively as possible; and deliver end of life care.

[NACEL 2019 Recommendation 8 - updated in 2022 and 2024/25]

RECOMMENDATION 8:

See Key Finding 11

Communication training

Chief Executives of Health and Social Care Trust Boards should provide training opportunities for health and care staff to improve their end of life care communication skills.

Support health and care staff to gain competence and confidence in communicating effectively and sensitively with patients and families in the last days and hours of life. Training for clinicians and other staff who have contact with dying people should focus on supporting the delivery of NICE Guideline 2015: Care of dying adults in the last days of life (NG31).

[NACEL 2022 Recommendation 6 – no change in 2024/25]

1 Audit background and development

1.1 Policy context in Northern Ireland

Section 1 of *the round one summary report for Northern Ireland* contains the National Policy context for end of life care delivery in Northern Ireland.

1.2 Audit background

Section 1 of *the round four summary report for Northern Ireland* contains information on the background and governance of the first four rounds of the audit.

Following completion of the first four rounds of NACEL, the audit was recommissioned by HQIP on behalf of NHS England, the Welsh Government and the Government of Jersey. The audit was redesigned throughout 2023, with a focus on quality improvement.

The Northern Ireland Public Health Agency (PHA) separately commissioned NHS Benchmarking Network (NHSBN) to audit care in the five Health and Social Care Trusts in Northern Ireland. Throughout the audit period, Trusts participated in the four audit elements: Case Note Review, Bereavement (Quality) Survey, Staff Reported Measure, and Hospital/Site Overview.

1.3 Audit objectives

NACEL is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute and community hospital providers.

The audit aims to improve the quality of care of adults at the end of life through the following objectives:

- Improving quality of care by identifying areas for action in relation to delivery and outcomes, and adapting QI priorities in line with evidence and guidance
- Reducing unwarranted variation through benchmarking of outcome measures as well as identifying and managing outliers using the appropriate guidance
- Understanding and reducing health inequalities in relation to impact on the specified measures
- Sharing and adopting best practice including QI examples, and signposting to resources available in the wider End of Life landscape

1.4 Audit standards

NACEL measures hospital performance against best practice standards for end of life care. To ensure the audit effectively captures key areas and drives quality improvement, its four core elements were redesigned using the NACEL Driver Diagram. Developed in collaboration with the NACEL Steering Group and a bereaved persons' focus group, the diagram is grounded in national guidance, including *One Chance to Get It Right: Five Priorities for Care of the Dying Person*, and NICE standards and guidelines, namely *NICE Quality Standard 13 End of life care for adults (QS13), NICE Clinical Guideline 31 Care of dying adults in the last days of life (NG31),* and *NICE Quality Standard 144 Care of dying adults in the last days of life (QS144)*. Further information on how the audit stimulates improvement at a local, regional and national level can be found in the NACEL Healthcare Improvement Plan. Information on the audit framework and key themes can be found in the NACEL Driver Diagram.

1 Audit background and development

1.5 Audit structure and scope

As in previous rounds of the audit, NACEL 2024/25 covered the last admission to hospital prior to death and included PHA-funded end of life care for adults (18+) in acute and community hospitals in Northern Ireland. Again, hospices were excluded.

NACEL NI 2024/25 uses data from four sources to review the quality of care: the Case Note Review, Bereavement (Quality) Survey, Staff Reported Measure, and Hospital/Site Overview.

Case Note Review	Data collected from the clinical case notes of adults who died in hospital between July 2024 and June 2025.
Bereavement Survey	A survey completed by bereaved relatives, carer and those important to the person who died in hospital during the audit period
Staff Reported Measure	A survey completed by staff who are most likely to come into contact with dying people and those important to them.
Hospital/Site Overview	Organisational-level questions focusing on service model and quality improvement efforts.

2 Methodology

2.1 Eligibility, recruitment and registration

All HSCTs in Northern Ireland were requested to participate, all having sites delivering acute and community hospital provision. The Palliative Care in Partnership Programme Board wrote to all Chief Executives of the five HSCTs requesting participation in NACEL. All five HSCTs participated in NACEL 2024/25. Registration was completed online as in previous rounds. During registration, all organisations had the option of setting up multiple submissions to cover different hospital sites. Community hospital providers were offered the option of combining all sites into one submission where appropriate, however, some organisations chose to register separate hospitals/sites.

2.2 Data collection

Data collection opened on the 1st July 2024 and closed on the 30th June 2025 for the Case Note Review and Quality (Bereavement) Survey. A two-week extension was granted to Southern Health and Social Care to complete the Case Note Review. The Staff Reported Measure and Hospital/Site Overview were both open for data collection for a 3-month period from 1st July until 30th September 2024.

For the Case Note Review, all submissions were asked to audit the first 20-70 eligible deaths per quarter.

Data collection for the Case Note Review and Hospital/Site Overview was via a bespoke online data entry tool. The tool included definitions and guidance for responding to each metric. Excel versions of the data specifications, along with a printable PDF version of the Case Note Review data specification, were available to download to assist with internal data collation prior to inputting the data in the online data entry tool. The NACEL Staff Reported Measure and Bereavement Survey were completed via an online questionnaire with links and QR codes that were unique to each submission. To increase accessibility to the Bereavement Survey, Health and Social Care Trusts had the option to collect survey responses on paper and these responses were then submitted via the submission’s unique link.

No patient or carer identifiable information was shared with NHS Benchmarking Network.

As well as the guidance on the online data collection pages, audit guidance was provided for all audit participants containing a step-by-step guide on how to complete each element of NACEL. Data collection was also supported by the NHSBN team with a telephone helpline and dedicated e-mail support address to deal with specific queries.

2.3 Data validation and cleansing

Data validation controls were implemented on several levels within the online data collection tool. Information buttons next to each metric contained definitional guidance of the data required to ensure consistency of the data collected. In addition, system validation was implemented to protect the integrity of the data collected, including allowable ranges, expected magnitude of data fields, numerical versus text completion, appropriate decimal point placing and text formatting. Validation controls were also built into the tool to ensure that only applicable questions were completed; for example, where questions were only to be completed for Category 1 deaths, these questions were not available to complete when Category 2 was selected.

As the data was submitted throughout the year, validation of the data was undertaken each quarter. A final validation exercise was carried out once data collection was closed, which ensured erroneous responses were reviewed and amended and any blank responses to the two outlier metrics (see section 2.5) were completed for all Case Note Reviews.

2.4 Data confidentiality and security

As required by the Data Protection Act 2018 and General Data Protection Regulation (GDPR), NHSBN has registered with the Information Commissioners Office (ICO) as an organisation which processes data.

NHS Benchmarking Network is 'Cyber Essentials Plus' certified and complies with NHS England's Data Security and Protection Toolkit.

Participating HSCTs were requested to provide NHSBN with key personnel they wished to have access to the online data collection tool. Entry to the online data collection tool was restricted via unique identifiers and passwords assigned to individuals during the registration process.

The NACEL NI Data Protection Impact Assessment (DPIA) outlines the legal basis to process data for the audit, how data is held and used and considers privacy risks. The DPIA states that the data collected for NACEL may be used for clinical audit, service evaluation and research purposes. Any subsequent requests for the use of the Northern Ireland data held for NACEL will be managed via the Northern Ireland Public Health Agency.

An updated NACEL Privacy Notice was also displayed on the NACEL webpages, together with a data flow diagram which illustrated the various elements of data collection and how the data were to be used.

The NHSBN team also provided updated information governance guidance for participating HSCTs for the various elements of NACEL. The guidance was developed with the NHSBN's Data Protection Officer and was reviewed on a regular basis.

No patient identifiable information was collected in any element of NACEL by NHSBN. All data collected by the NHSBN was pseudonymised.

2.5 Management of Outliers Policy

The NACEL NI Management of Outliers Policy is available on the NACEL webpages.

The policy has been informed by NCAPOP Outlier Guidance, Identification and Management of Outliers and approved by the NACEL Steering Group. Two indicators from the NACEL data collection are used to undertake the Management of Outliers analysis.

1. The number of deaths where it was recognised that the patient may die in the final admission as a proportion of the sample 'all deaths' included in the audit (Category 1/Category 1 + 2 deaths)
2. The proportion of people who had an individualised plan of care addressing their needs at the end of life, where it was recognised that the patient may die during the final admission (proportion of Category 1 death).

There were 2 submissions identified as outliers for the metrics above. Please see the annual data sheet for further details.

Please note that the Management of Outliers process has been updated since the audit previously ran in 2022. For more information on the changes, please refer to the NACEL NI Management of Outliers Policy.

3 Participation

3.1 Participation figures

All five Health and Social Care Trusts in Northern Ireland participated in NACEL NI 2024/25. Table 1 outlines the participation figures for each Trust. All sites completed the Hospital/Site Overview and participated in the Case Note Review and Staff Reported Measure. Four of the five Trusts took part in the Bereavement (Quality) Survey, as Southern Health and Social Care Trust unable to take part in this element during the audit period.

17
Hospital/Site Overviews (HSO)

450
Bereavement (Quality) Survey (QS)

1,517
Case Note Review (CNR)

687
Staff Reported Measure (SRM)

Trust	Submission name	H/S	CNR	SRM	QS
Belfast Health and Social Care Trust	Belfast City Hospital	Y	94	51	7
	Mater Hospital	Y	210	36	18
	Musgrave Park Hospital	Y	36	37	2
	NI Cancer Centre	Y	112	63	1
	Royal Hospitals	Y	210	77	82
Northern Health and Social Care Trust	Antrim Area Hospital	Y	80	76	75
	Causeway Hospital	Y	80	56	36
	Mid Ulster, Dalriada, Robinson & Inver Community Hospitals	Y	34	53	4
South Eastern Health and Social Care Trust	Ulster Hospital	Y	85	61	145
	Downe and Lagan Valley	Y	80	13	22
Southern Health and Social Care Trust	Craigavon Area Hospital	Y	80	14	0
	Daisy Hill Hospital	Y	80	2	0
	Lurgan General Hospital	Y	22	10	0
	South Tyrone Hospital	Y	5	0	0
Western Health and Social Care Trust	Altnagelvin Area Hospital	Y	109	59	36
	South West Acute Hospital	Y	148	70	19
	Omagh Hospital	Y	52	9	3

Table 1: The participation figures for each audit element by submission, grouped by Health and Social Care Trust.

3.2 Future rounds of NACEL

NACEL will not run in Northern Ireland throughout 2026 to allow time for action plans to be written, informed by the audit results, and for improvement work to take place as a result. Commissioning the audit in following years will be discussed between the Public Health Agency (PHA), NHS Benchmarking Network (NHSBN) and the Healthcare Quality Improvement Partnership (HQIP).

4 How the findings are presented

The results in this report reflect the results of acute and community hospitals in Northern Ireland who participated in NACEL NI 2024/25 (see Section 3)

4.1 Key findings in this report

This report presents findings of NACEL NI 2024/25 grouped into 12 themes. These themes are:

1. Quality Improvement plans
2. Access to Specialist Palliative Care advice
3. Recognition of dying
4. Communication about hydration
5. Pain relief
6. Spiritual/Religious/Cultural needs assessments
7. Overall rating of care
8. Participation in advance care planning
9. Individualised plan of care
10. Equitable care
11. End of life care training
12. Anticipatory medication

Unlike in previous years, each theme may draw findings from across the four audit elements to present a more complete picture.

The theme of each key finding is outlined at the top of the page, with summarised information about the theme below this. Further information, including figures and tables, can be found outlined below to provide additional background about the key finding. The source of the data (i.e. the audit element) can be found below each figure/table and within the text, where applicable. Due to rounding, the values displayed in some charts may not total 100%; a note to indicate that this is the case can be found on applicable charts. A summary of the Key Findings is available here.

Blanks and ‘Not applicable’ responses are excluded from this total.

4.2 NACEL Northern Ireland outputs

Alongside this Summary Report, there are various outputs available to NACEL NI 2024/25 participants to explore the audit findings.

1. ***Northern Ireland Data and Improvement Tool***

   The NACEL NI Data and Improvement Tool (DIT) is an interactive tool which displays the NACEL findings in a range of views, presenting the audit’s findings at a glance while also allowing users to drill down into the data to explore their results further. The DIT has three main views: Dashboards, Overview, and Explore.

   The Dashboard view presents an overall summary of how a submission is performing against its peers, while the Overview presents the results for each metric collected and allows the results to be filtered and compared against selected peers. The Explore view provides further depth to the results shown in the Overview, displaying results over time and benchmarked against all other participating submissions.

   The DIT is available only to users from organisations that participated in the audit.

2. ***Northern Ireland Good Practice Compendium***

   The Northern Ireland Good Practice Compendium (GPC) collates the examples of quality improvement activity that participating organisations have reported as part of the Hospital/Site Overview element of NACEL.

3. ***Northern Ireland Findings Event***

   An event to present the key findings and recommendations of NACEL NI 2024/25 took place on 14th October 2025. The event was also an opportunity for attendees to hear from key regional speakers and case studies, who highlighted how NACEL data can inform improvements in end of life care provision.

Key Finding 1 Quality Improvement Plans

Of hospital/sites with quality improvement plans relating to end of life care in place, 100% had shared these with the Senior Management Team or Trust Board.

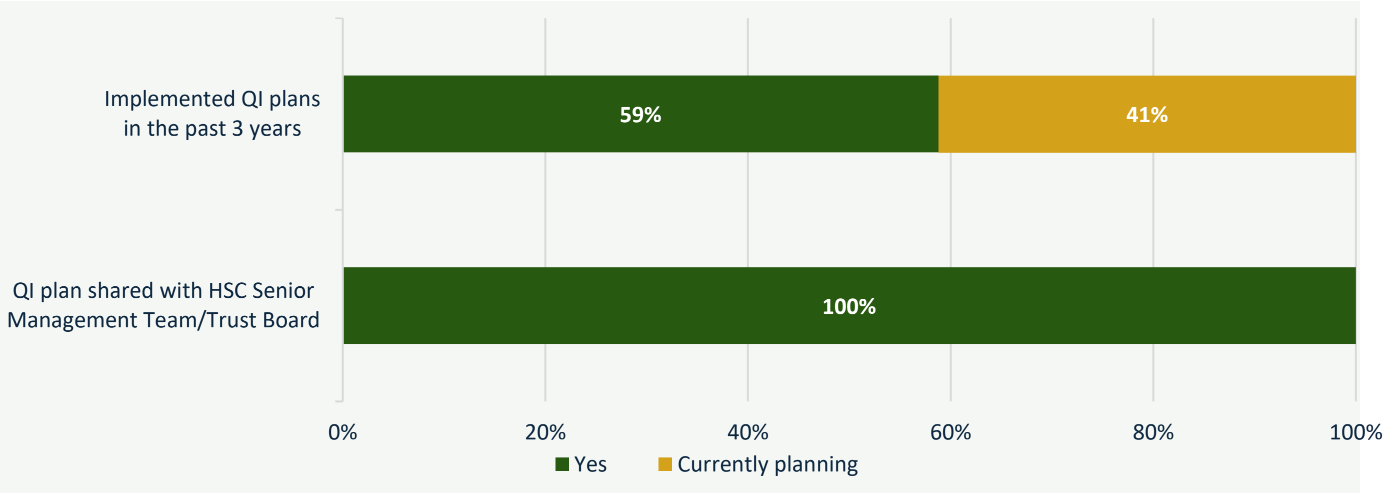


Figure 1 (HSO): The proportion of hospital/sites that have implemented a QI plan in the past 3 years and have shared these with the HSC Senior Management Team/Trust Board

59% of submissions have a quality improvement plan in place, while the remaining **41%** of submissions' quality improvement plans were in development. All participating Health and Social Care Trusts have a Quality Improvement (QI) plan that has been implemented in the past 3 years or was in development at the time of audit. Of those with a plan already in place, **100%** had been shared with the Senior Management Team or Trust Board.

A primary objective of NACEL is to improve the quality of end of life care delivered in hospital inpatients settings by identifying areas for action in relation to delivery and outcomes and adapting QI priorities in line with evidence and guidance. By reviewing the findings of the audit to identify areas for improvement and implementing a QI plan to address these areas, Health and Social Care Trusts can follow an evidence-based approach to making positive changes to the care they deliver.

For more information about the quality improvement work that has taken place, please refer to the NACEL Northern Ireland 2024/25 Good Practice Compendium.

Key Finding 2 — Access to Specialist Palliative Care Advice

100% of hospital providers have access to specialist palliative care services. Yet, of those providers, 0% have access to a face to face specialist palliative care service (doctor and/or nurse) 8 hours a day, 7 days a week. 82% of hospital/sites now have access to a telephone Specialist Palliative Care service 24 hours a day, 7 days a week.

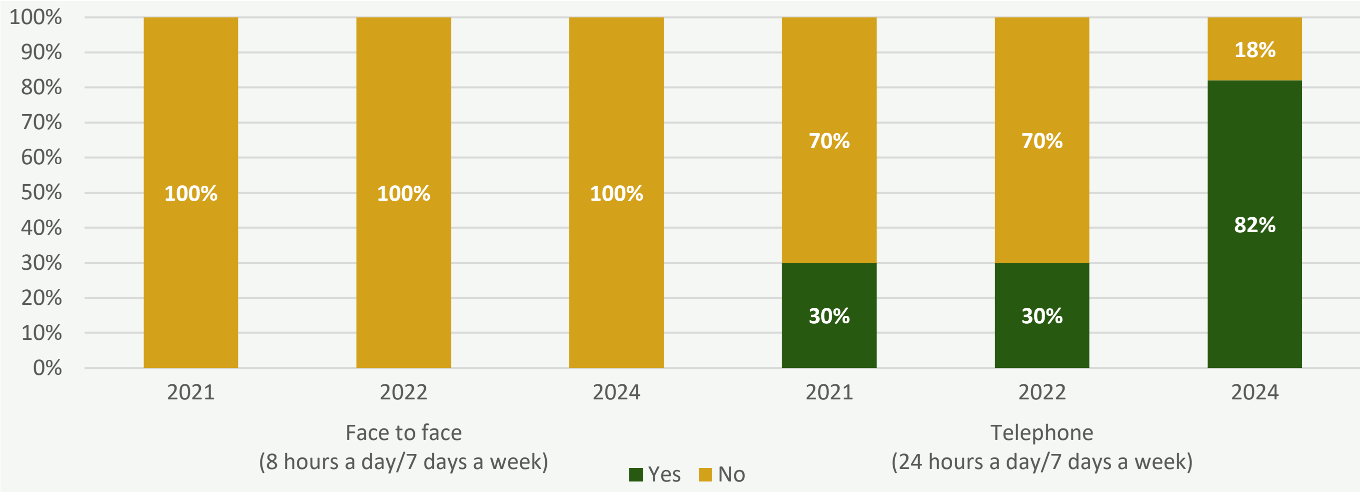


Figure 2 (HSO): The proportion of hospital/sites with access to specialist palliative care services (doctor and/or nurse and telephone) from 2021 to 2024

In contrast, since the previous audit was carried out in 2022, Northern Ireland has seen a positive change in the proportion of hospital/sites reporting access to a telephone specialist palliative care service (doctor and/or nurse) 24 hours a day, 7 days a week, which has increased from **30%** in 2022 to **82%**. This demonstrates progress against Recommendation 7 of NACEL NI 2019/2020 and 2022/2023, that encouraged the Palliative Care in Partnership Programme and the Department of Health/Commissioners to work towards having specialist palliative care doctor/and or nurse telephone advice available 24 hours a day, 7 days a week.

Furthermore, the hospital/sites who do not have access to a 24/7 telephone service reported that this was no longer because the local service model could not support this, but rather, as a result of an evidence-based decision by the Trust that the service was not required.

While the ideal is that all HSCTs have access to 24/7 telephone advice, this result shows a regional improvement against NICE QS13 which states that adults approaching the end of their life should have access to 24/7 support.

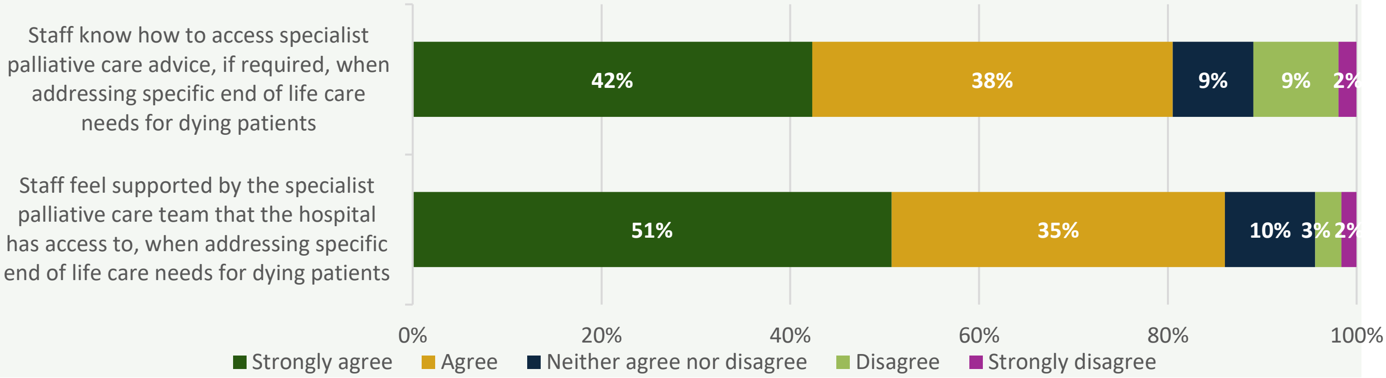


Figure 3 (SRM): The proportion of staff who agreed they know how to access specialist palliative care advice and who feel supported by the specialist palliative care team (N.B. Totals may not equal 100% due to rounding)

86% of staff strongly agree/agree that they feel supported by the specialist palliative care team the hospital has access to, an improvement on **81%** reported in 2022. However, there has been a reduction in the proportion of staff who strongly agree/agree that they know how to access specialist palliative care advice, from **86%** in 2022 to **81%** in 2024. Despite this, there has been a rise in the proportion of patients reviewed by SPCT since 2022; **66%** of patients were reviewed by a member of the specialist palliative care/end of life care team during their final admission to hospital in 2024/25, an increase from **54%** in 2022.

Key Finding 3 Recognition of Dying

Of the patients audited by the Case Note Review, 78% were expected to die during their final hospital admission. For these patients, the median time between first recognition that the patient might die (within days or hours) and death was 71 hours (3 days).

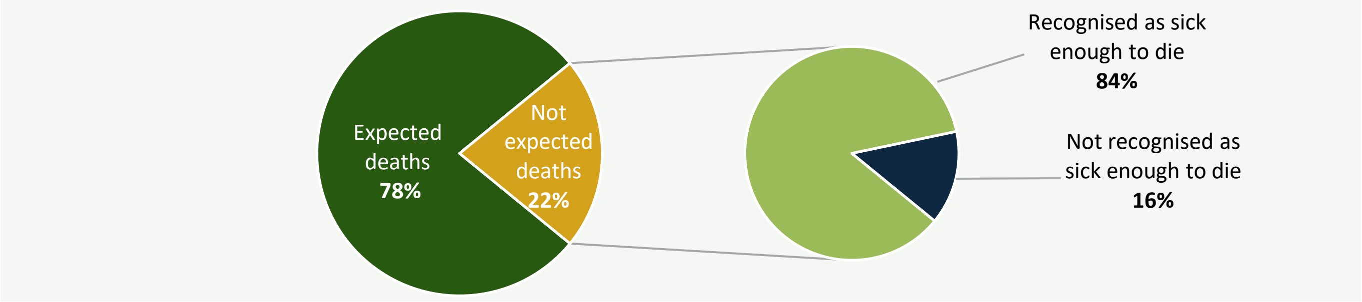


Figure 4 (CNR): The proportion of clinical case notes where it was expected that the person would die during the final admission, or recognised as being sick enough to die

Early recognition that a patient is dying allows more time to have conversations with both the patient and those important to them, and to meet their needs. The results show that there has been a decline in the proportion of patients expected to die in hospital since 2022, where **93%** of deaths were recognised, compared to **78%** in 2024/25 (Figure 4). This suggests that additional training may be required to support staff to recognise when a patient is imminently dying, despite **82%** of staff respondents expressing confidence in their ability to do so (the same value as in 2022).

Of the **22%** of patients who were not expected to die during their last hospital admission, **84%** were recognised as being 'sick enough to die' (Figure 4). This refers to documentation that the patient was deteriorating, clinically unstable with limited reversibility and at risk of dying during the episode of care despite treatment. This cohort of patients suggests a clinical opportunity to identify the dying phase earlier.

For patients who were recognised as dying, the results show improvement compared to the 2022 audit; the median time between recognition that the patient might die and death has increased from **63 hours** (2.7 days) in 2022 to **71 hours** (3.0 days) during this audit period (Figure 5), suggesting additional time to implement care specific to the dying patient's end of life wishes. However, although the median time from recognition of dying to death has increased, further work is needed to return to the 2019 median average of **89 hours**.

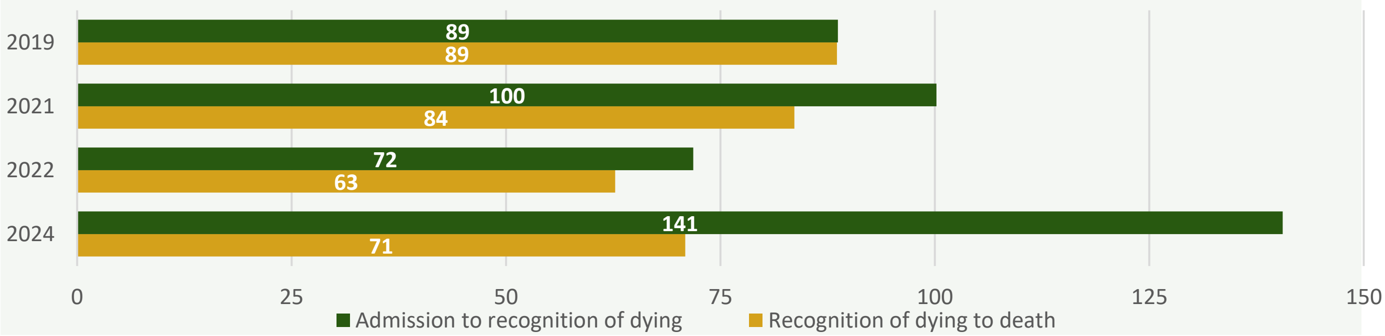


Figure 5 (CNR): The median average time from admission to recognition of dying and recognition of dying to death, in hours

Despite evidence to suggest that most deaths were recognised, the results from the Bereavement Survey indicate that this was communicated to only around a third of patients; **37%** of bereaved people report that the patient was told that they were likely to die imminently (Figure 6), with the main reason for lack of communication being the person was too unwell, unconscious or unable to understand (**30%**).

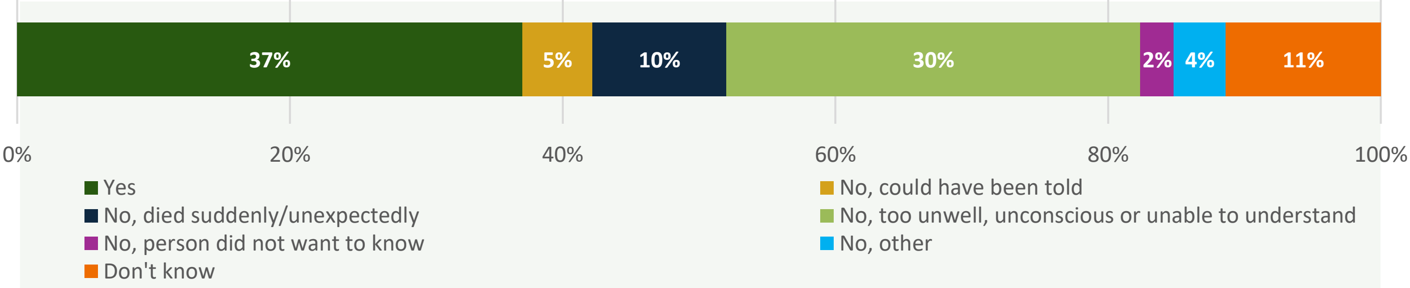


Figure 6 (QS): The proportion of bereaved people who stated that a member of staff explained to the person that they were likely to die in the next few days
(N.B. Totals may not equal 100% due to rounding)

Key Finding 4 Hydration Options

In 59% of Case Note Reviews, there was documented evidence of communication about hydration with those important to the dying person or, where this was not possible, a reason was recorded why not.

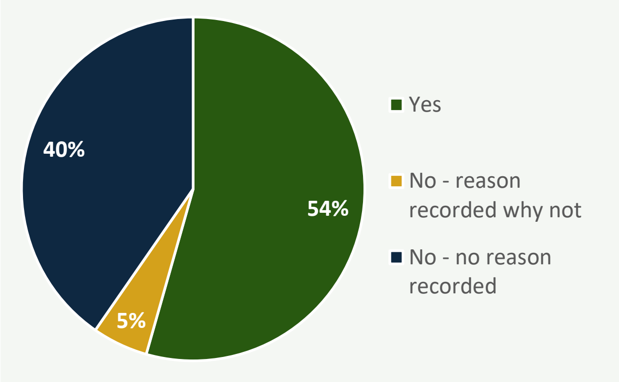


Figure 7 (CNR): The proportion of patients with documented evidence of communication about hydration with those important to the dying person (N.B. Totals may not equal 100% due to rounding)

40% of the case notes sampled did not have evidence of communication about hydration options with those important to the patient and no documented reason for this.

A recommendation of the audit since its second round in 2019 has been that hydration options should be discussed with the dying person and those important to them, and this communication should be clearly documented in the patient's care records. This is supported by NICE guidance, which outlines that adults in the last days of life should have their hydration status assessed daily and have a discussion about the risks and benefits of hydration options (NICE Quality Standard 144). The NACEL results suggest that further work is required to be compliant with the NICE guidance.

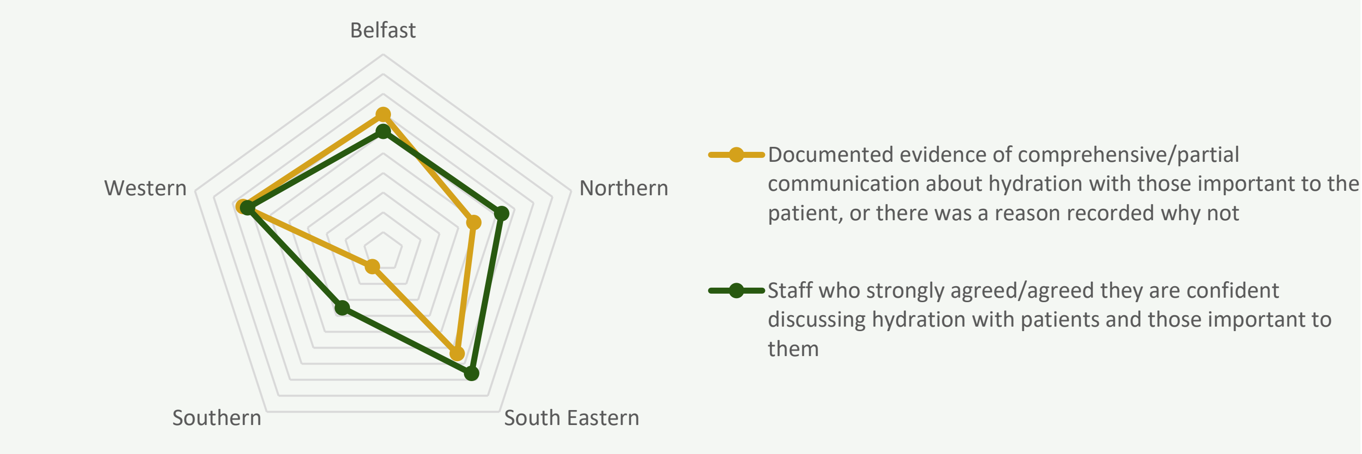


Figure 8 (CNR/SRM): The proportion of patients with documented evidence of communication about hydration with those important to the dying person (CNR) and the proportion of staff who agree they are confident discussing hydration with patients and those important to them (SRM)

Across Trusts, the proportion of patients with documented evidence of communication with those important to them, or a reason recorded why not, varies significantly, ranging from **9%** to **74%** (Figure 8). Notably, Figure 8 also indicates that in most Trusts, staff report a higher level of confidence in discussing hydration with patients and those important to them than is reflected in the documentation of these conversations; only two Trusts show alignment between confidence and documentation. This discrepancy suggests that, while staff may feel capable of having these discussions, additional support, training, or initiatives may be needed to ensure these conversations are consistently carried out and properly recorded.

The Case Note Review indicates that **78%** of patients had documented evidence of a review of hydration options in the last days of life. However, this proportion ranges widely between Trusts, from **14%** to **96%**. These results align with feedback from the Bereavement Survey, where **78%** of respondents strongly agree/agree that the person had support to drink or receive fluid if they wished.

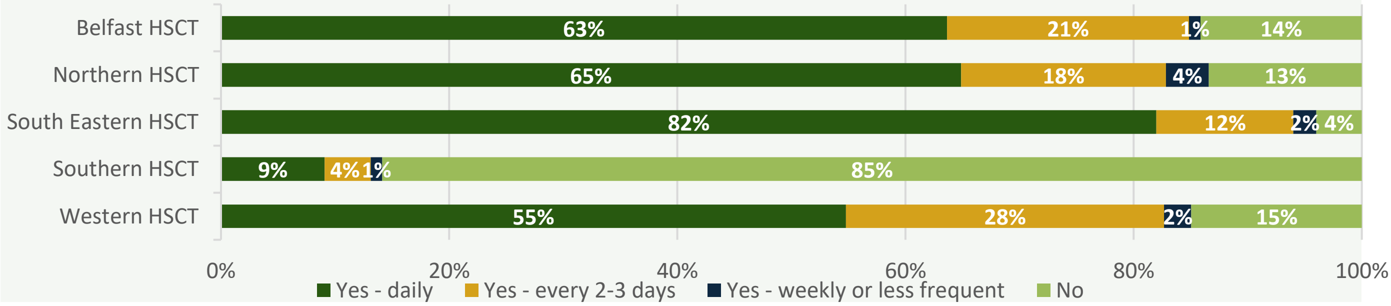


Figure 9 (CNR): The proportion of patients with documented evidence of a review of hydration options (N.B. Totals may not equal 100% due to rounding)

Key Finding 5 Pain Relief

According to the Bereavement Survey, 85% of friends, families and others strongly agreed or agreed that the dying person received enough pain relief during their final hospital admission, while 8% disagreed or strongly disagreed with this.

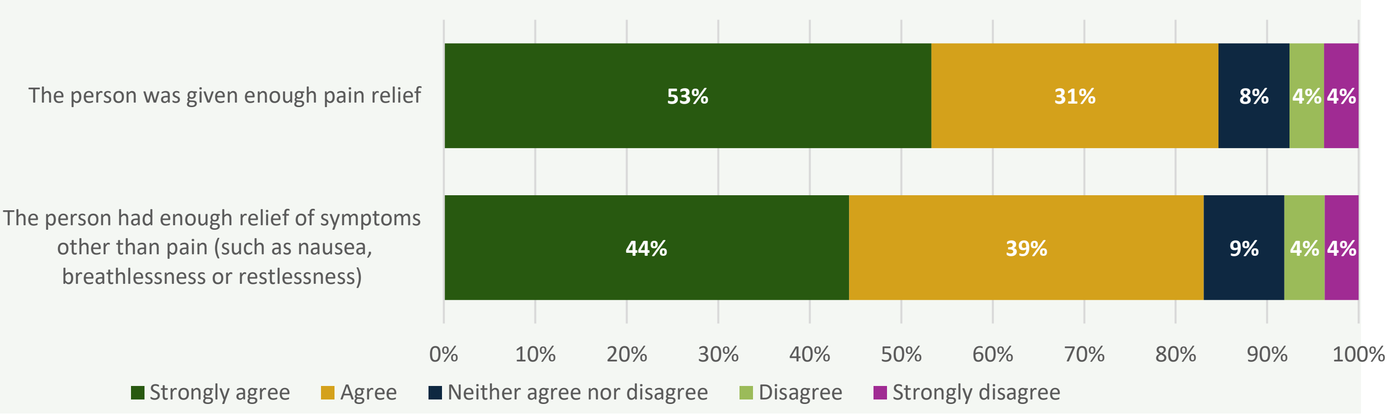


Figure 10 (QS): The proportion of bereaved people who agreed the person was given enough pain relief and relief of symptoms other than pain

Similarly, **83%** of bereaved people perceived the dying person to have had enough relief of symptoms other than pain, such as nausea, breathlessness or restlessness (Figure 10).

The proportion of friends, families and others who strongly agree/agree that the person was given enough pain relief varies by Trust, ranging from **79%** to **89%** (Figure 11).

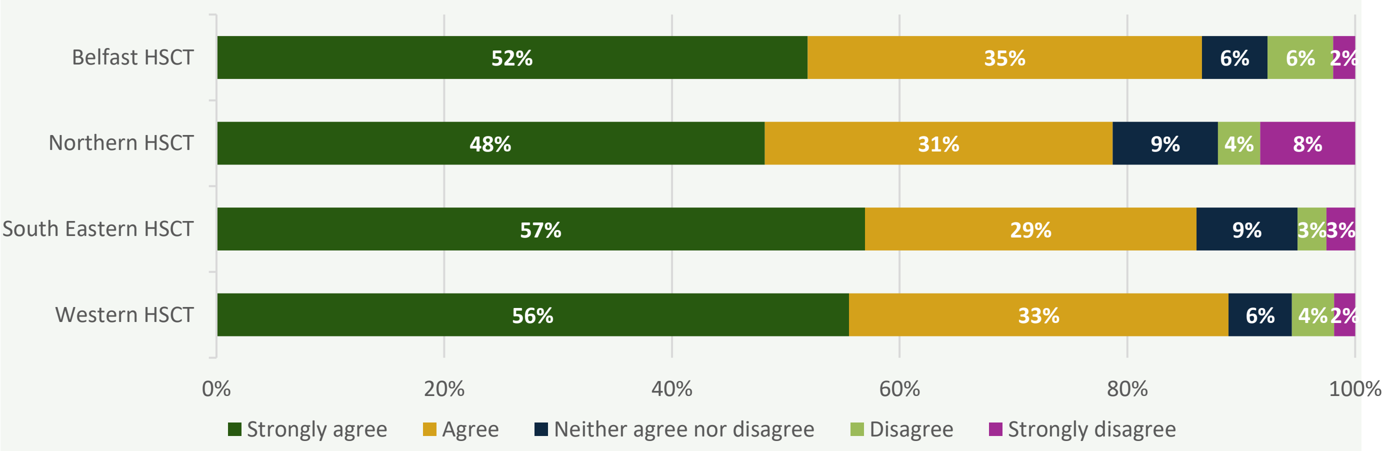


Figure 11 (QS): The proportion of bereaved people who agreed the person was given enough pain relief, broken down by Trust
(N.B. Totals may not equal 100% due to rounding)

The importance of managing pain when caring for patients at the end of life, through non-pharmacological and pharmacological methods of symptom management, is outlined in NICE Guideline 31 (NG31). The guideline states that pain should be managed promptly, effectively and any reversible causes of pain should be treated once identified. The audit results suggest that effective management of symptoms, including pain at the end of life, is delivered to most dying patients, with room to improve this for around a tenth of cases.

In the Staff Reported Measure, **73%** of staff strongly agree/agree that they are confident in assessing and managing patient pain and physical symptoms at the end of life.

Key Finding 6 Spiritual, Religious and Cultural Needs Assessments

Spiritual, religious and cultural needs were least assessed when compared to other needs (communication, emotional/psychological and social/practical needs). An assessment of those important to the dying person's spiritual, religious and cultural needs was documented in 36% of cases (or where not possible, a reason was recorded).

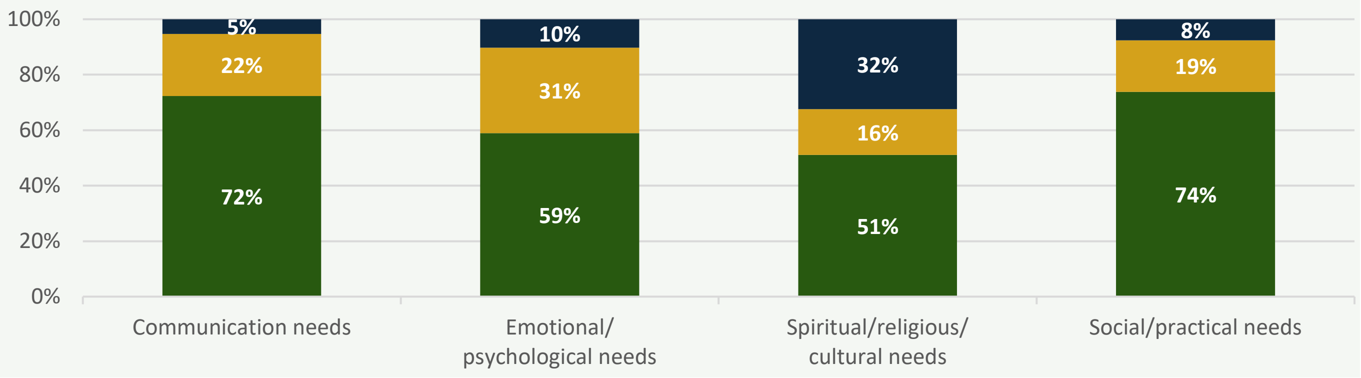


Figure 12 (CNR): The proportion of clinical case notes with documented evidence that the person had their needs assessed
(N.B. Totals may not equal 100% due to rounding)

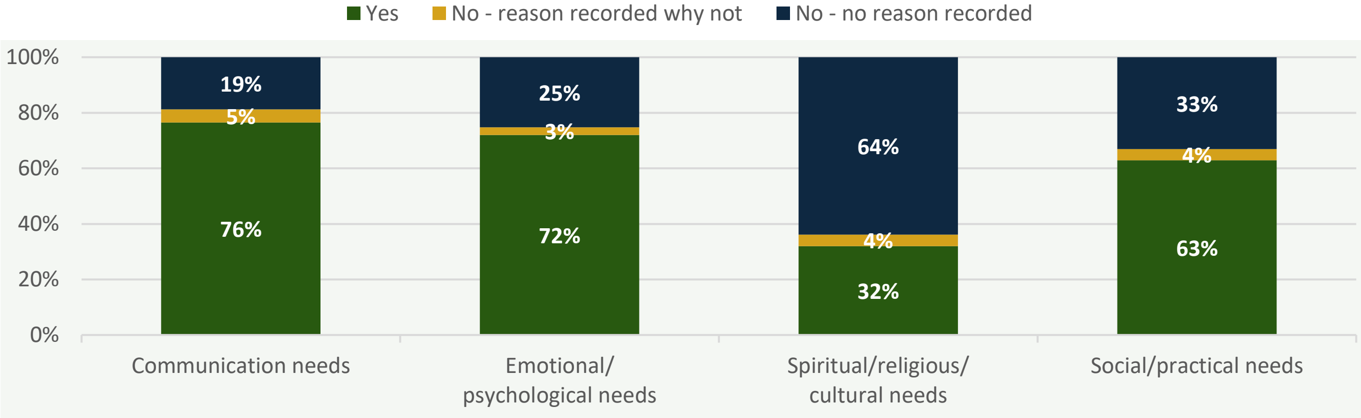


Figure 13 (CNR): The proportion of clinical case notes with documented evidence that those important to the person had their needs assessed

In order for staff to be able to address the needs of the dying person and those important to them, these needs should first be identified and assessed. While generally there is a small proportion of patients who do not have their needs assessed and no reason is recorded for this (Figure 12), this is not the case for those important to the patient, where between **19%** and **64%** of needs were not assessed and no reason was recorded (Figure 13).

For both the patient and those important to the patient, spiritual, religious and cultural needs were least likely to be assessed. Additionally, when compared to the 2022 findings, there has been improvement in the percentage of patients with assessments of their emotional and psychological needs (from **83%** to **90%**) and social and practical needs (from **89%** to **92%**) however, there has been a decrease in spiritual, religious and cultural needs assessments (from **83%** to **68%**) (Figure 14).

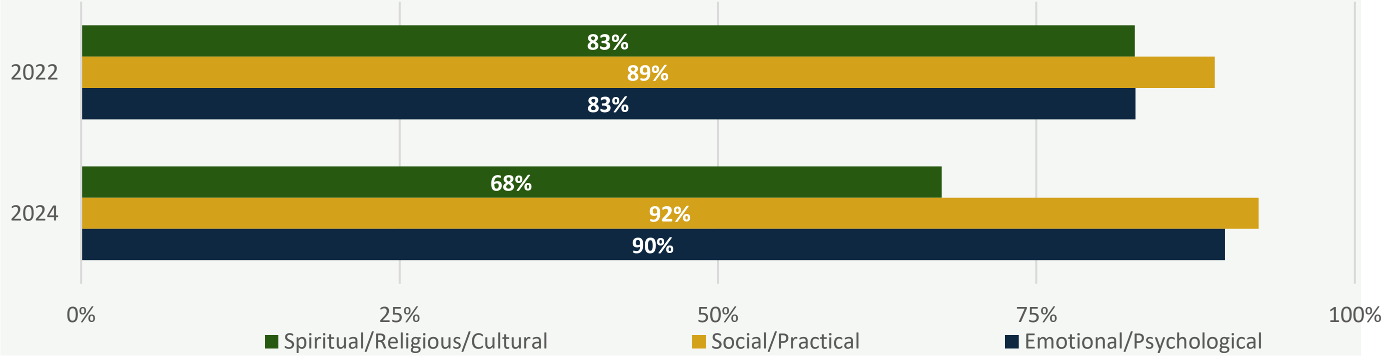


Figure 14 (CNR): The proportion of clinical case notes with documented evidence that the person had their needs assessed in 2022 and 2024

Figures 13 and 14 show gaps in the assessment of spiritual, religious, and cultural needs, underlining the need for renewed focus on carrying out these assessments. Such assessments are a fundamental part of individualised end of life care, as outlined in NICE Quality Statement 144.

Key Finding 7 Care and Support

The care and support provided to the dying person was rated as excellent or good by 85% of bereaved respondents, whilst 79% of bereaved respondents rated the care and support given to themselves and others as excellent or good.

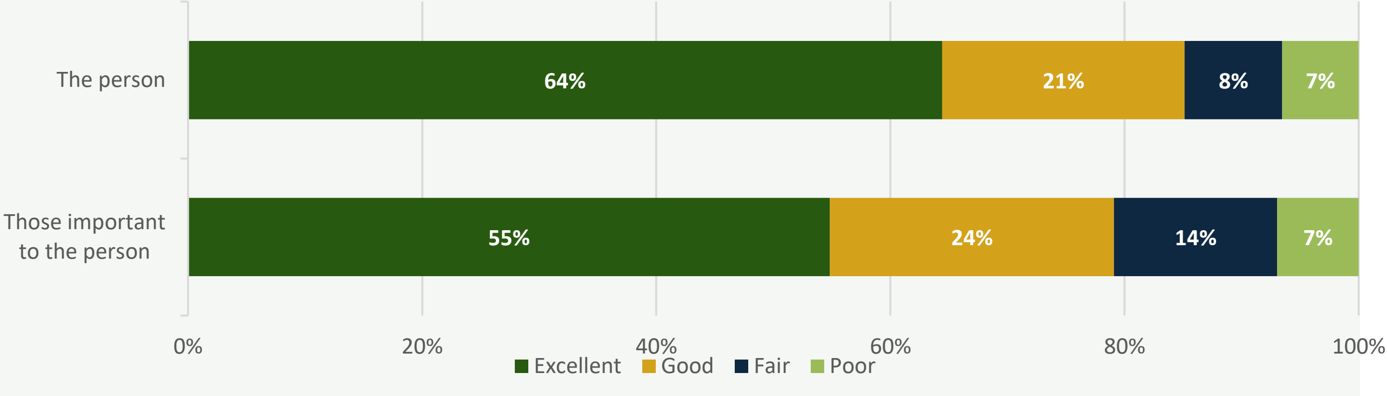


Figure 15 (QS): Bereavement Survey respondents' rating of care and support given by the hospital to the person and to those important to the person

Overall, a greater proportion of Bereavement Survey respondents rated the care and support given to the person as excellent or good (**85%**) than they rated the care and support given to themselves and other close relatives and friends **(79%)** (Figure 15).

Across the Trusts, the care and support given to the person is rated equal to or better than the care and support given to those important to the person (Figure 16). However, ratings of care and support given to the person range more widely, from **79%** to **89%** compared to ratings for those important to the person, which range from **77%** to **84%**.

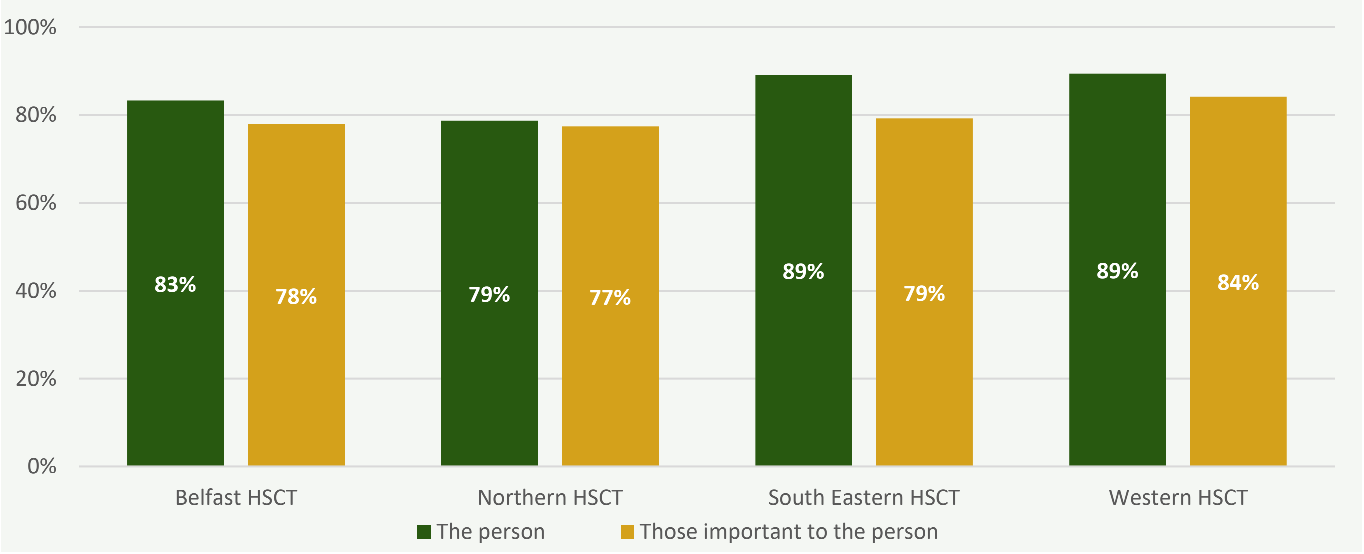


Figure 16 (QS): The proportion of Bereavement Survey respondents who rated the care and support given to the person and to those important to the person as excellent or good

Key Finding 8 Participation in personalised care and support (advance care) planning

29% of Case Note Reviews had documented evidence that the patient participated in personalised care and support (advance care) planning conversations. 42% of Bereavement Survey respondents said that the person had an advance care plan in place.

Personalised care and support planning allows patients to express what is most important to them regarding their health and overall wellbeing.

Few patients are shown to be admitted to hospital with evidence of prior personalised care and support planning conversations (**6%**) (Figure 17). This suggests there is improvement required across the system to increase the amount of personalised care and support planning conversations held with patients at the end of life, to document this, and to ensure that it is accessible to staff involved in the person's care across the community and in hospital.

Further analysis shows that the proportion of patients who participated in personalised care and support planning (advance care planning) conversations was higher where they were reviewed by a member of the specialist palliative care team, with **34%** of patients who were reviewed participating in advance care planning conversations, while just **17%** of patients who were not reviewed participated in these conversations.

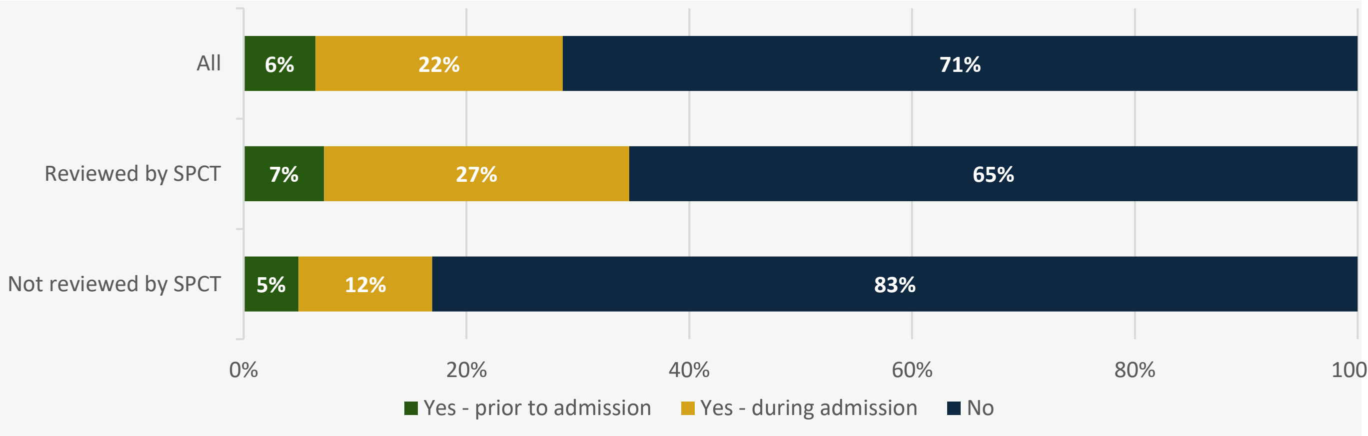


Figure 17 (CNR): The proportion of clinical case notes with documented evidence that the patient participated in personalised care and support planning conversations, split by whether the patient was reviewed by the specialist palliative care team or not
(N.B. Totals may not equal 100% due to rounding)

42% of Bereavement Survey respondents said that the person had an advance care plan in place (Figure 18). While this is a higher proportion than is reported in the Case Note Review, it still indicates that less than half of patients participate in personalised care and support planning.

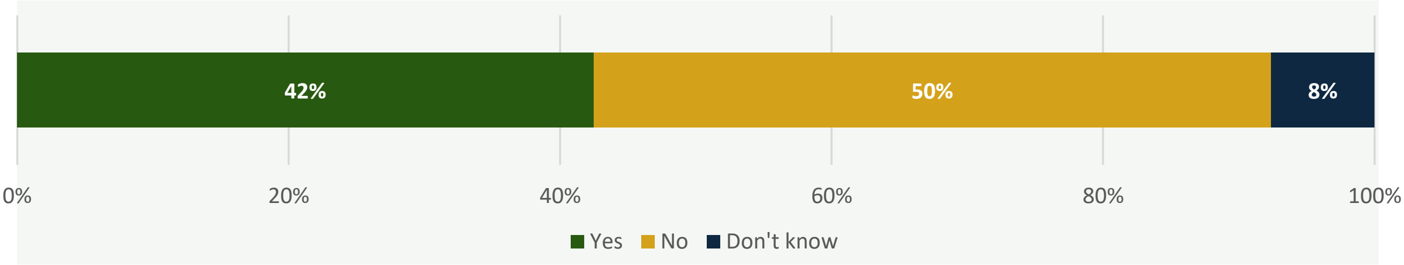


Figure 18 (QS): The proportion of bereaved people who agreed the person had an advance care plan in place before they died

Key Finding 9 Individualised Plan of Care

Of the people expected to die during the hospital admission, 72% had an individualised plan of care addressing their needs at the end of life. Of these, 1% were documented on a standalone template and 99% within the general clinical notes.

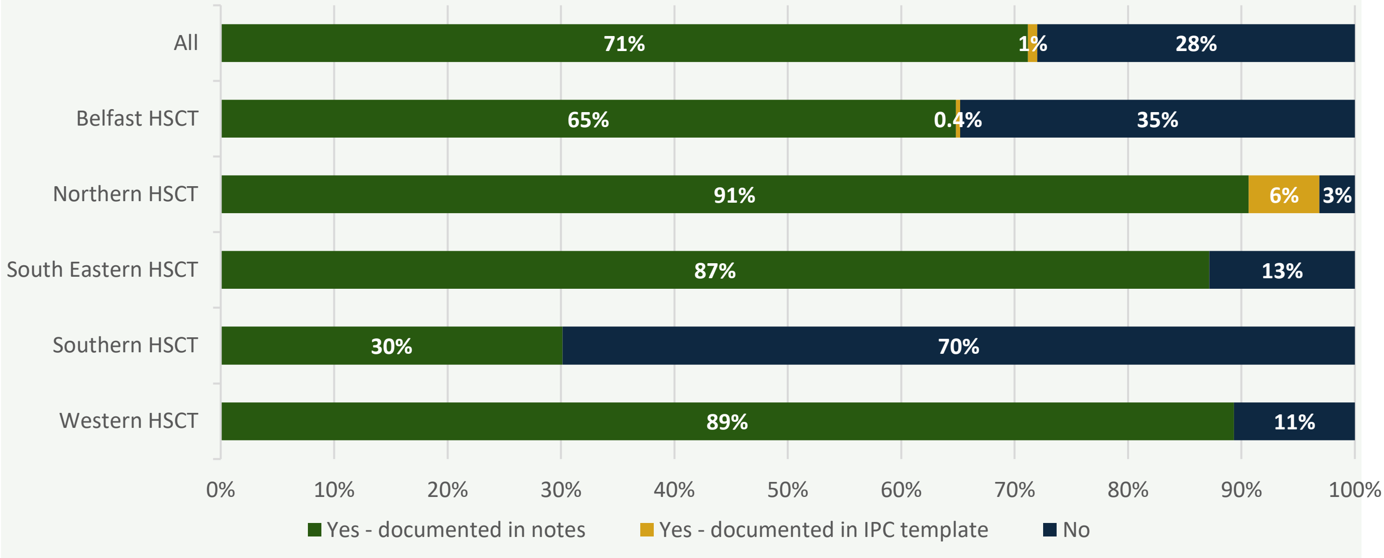


Figure 19 (CNR): The proportion of clinical case notes with documented evidence that the person who was dying had an individualised plan of care addressing their end of life care needs, broken down by HSCT (Category 1 deaths only)

Although the proportion of patients who were recognised as dying that had an IPC in place increased from **77%** in 2021 to **83%** in 2022, this improvement has not been sustained, with the percentage dropping to **72%** in 2024; over a quarter (**28%**) of patients who were expected to die did not have an individualised plan of care in place to address their end of life care needs (Figure 20).

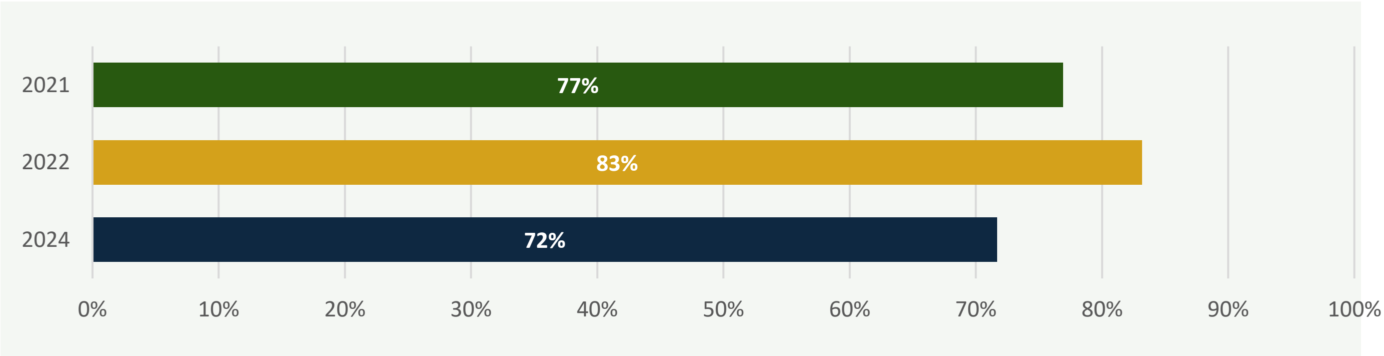


Figure 20 (CNR): The proportion of clinical case notes with documented evidence that the person who was dying had an individualised plan of care addressing their end of life care needs from 2021 to 2024 (Category 1 deaths only)

Quality Statement 2 of NICE Guideline 144 outlines the importance of giving adults in the last days of life and those important to them the opportunity to discuss, develop and review an individualised plan of care (IPC) to ensure care at the end of life is responsive to the personal needs and preferences of the person who is dying.

Since 2019, NACEL has recommended that patients at the end of life should have an IPC in place that addresses the patient's emotional and psychological; spiritual, religious, and cultural; and social and practical needs. While **72%** of expected deaths had documented evidence of an IPC, the results of Key Finding 6 indicate that these plans may not fully reflect the complete range of recommended needs, despite potential opportunities for a more comprehensive assessment being available. **79%** of Bereavement Survey respondents strongly agree/agree that staff at the hospital made a plan for the person's care which considered the person's needs and wishes.

Key Finding 10 Equitable care

When reviewing patient ethnicity, 61% of the clinical case notes included documentation of the patient's ethnicity while 39% reported patient ethnicity as either not stated or unknown.

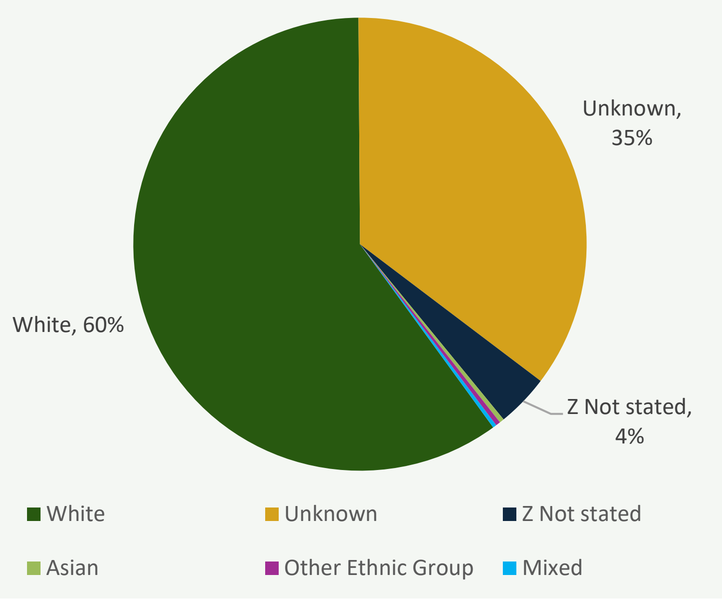


Figure 21 (CNR): The proportion of clinical case notes where the patient's ethnicity is documented

Accurate and standardised documentation of patient demographic information is required to be able to address disparities in care at the end of life.

The findings shown in Figure 21 highlight the need to strengthen ethnicity recording across the region to enable further investigation into potential differences in care and to support equitable provision for all patients. Without robust data, local trusts and national bodies cannot reliably identify or act on inequities at the end of life.

In 2024, additional questions were introduced to strengthen understanding of equitable end of life care, including support for people whose primary spoken language is not English. Findings of the Case Note Review indicated that **82%** of patients were offered an interpreter or suitable alternative, where needed to ensure they could be communicated with, while **62%** of those important to the patient were offered an interpreter or suitable alternative (Figure 22).

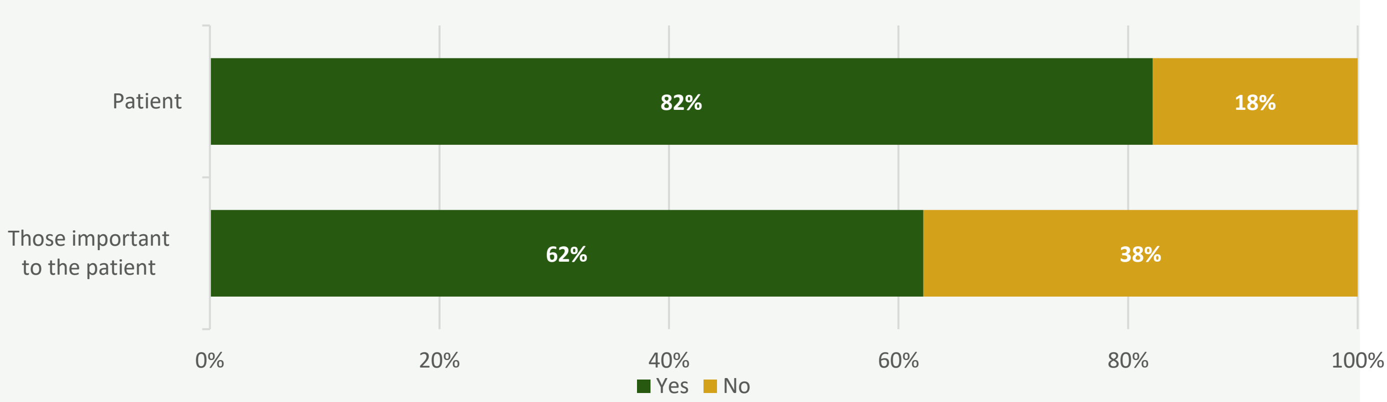


Figure 22 (CNR): The proportion of clinical case notes with documented evidence that, where needed, an interpreter or suitable alternative was offered to the person or those important to the person

Effective communication is fundamental to providing high quality care at the end of life. National guidance highlights the importance of identifying and addressing the communication needs and preferences of people who are dying, and those important to them (NICE Guideline 31). This includes clearly explaining the prognosis, engaging in sensitive discussions about fears and anxieties, and exploring individual preferences for care during the final days of life.

Findings from NACEL suggest there may be a disparity in care for individuals requiring an interpreter or alternative communication support, however, due to the small sample size, it is not possible to confirm this. Without effective communication, key aspects of end of life care cannot be fully achieved or understood, leading to potential gaps in dignity, comfort, and person-centred support.

Key Finding 11 End of life care training

44% of Staff Reported Measure respondents strongly agreed or agreed that they have completed training specific to end of life care within the last three years. 47% of staff disagreed or strongly disagreed with this.

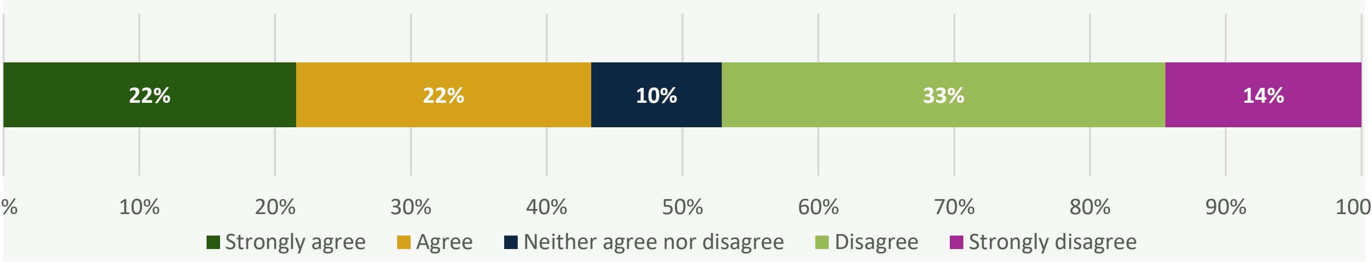


Figure 23 (SRM): The proportion of staff who agree they have completed training specific to end of life care within the last three years
(N.B. Totals may not equal 100% due to rounding)

Just **44%** of staff strongly agree/agree that they have completed training specific to end of life care within the last three years, a reduction from **52%** in 2021. A greater percentage of respondents disagree/strongly disagree with this statement, an increase from **42%** in 2021 to **47%** in 2024. A breakdown of the 2024 results by staff groups is shown in Table 2.

Staff grouping	Strongly agree/agree	Neither agree nor disagree	Disagree/strongly disagree
Doctor	45%	11%	44%
Nurse	54%	10%	36%
Healthcare assistant	50%	8%	42%
Other clinical/ patient-centred staff	21%	8%	71%
Non-clinical staff	20%	40%	40%
Other	42%	5%	53%

Table 2 (SRM): The proportion of staff who agree they have completed training specific to end of life care within the last three years, broken down by staff grouping

In addition to collecting feedback from staff, NACEL reviewed what training was available within the hospital/site during 2023/24 (Figure 24). Figure 24 shows **100%** of hospital/sites included end of life care in their ‘other’ training programmes between 1st April 2023 – March 2024, yet **12%** included this in mandatory/priority programmes and **53%** of hospital/sites had end of life care training included in the induction programme. Figure 24 further shows that the percentage of hospital/sites offering end of life care communications skills training has dropped from **80%** in 2021 to **47%** in 2024.

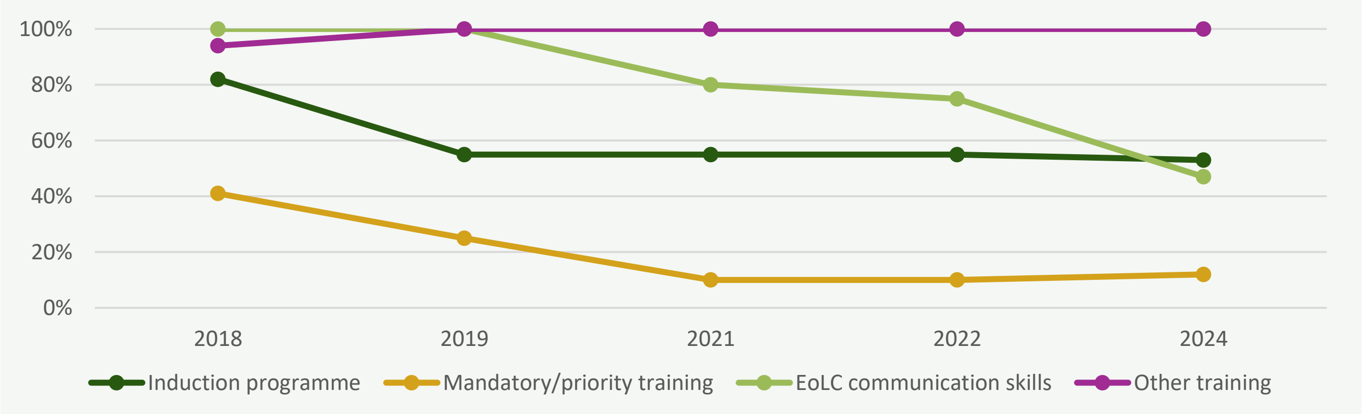


Figure 24 (HSO): The proportion of hospital/sites where end of life care training was included since 2018

The results show little progress made against recommendations 6 and 8 of the NACEL Northern Ireland fourth round of the audit report. The recommendations remain that more work is to be done to embed end of life care training programmes as part of induction programmes and as part of mandatory/priority training programmes in Northern Ireland. This is currently being considered under the Palliative Care in Partnership Priority 3 to develop a regional palliative and end of life care education and learning framework. The NACEL Northern Ireland recommendations also promote the provision of specific training for heath and care staff to improve their end of life care communication skills.

Key Finding 12 Anticipatory medication

96% of patients who were expected to die were prescribed anticipatory medication. Of the anticipatory medications that were prescribed, 94% were administered.

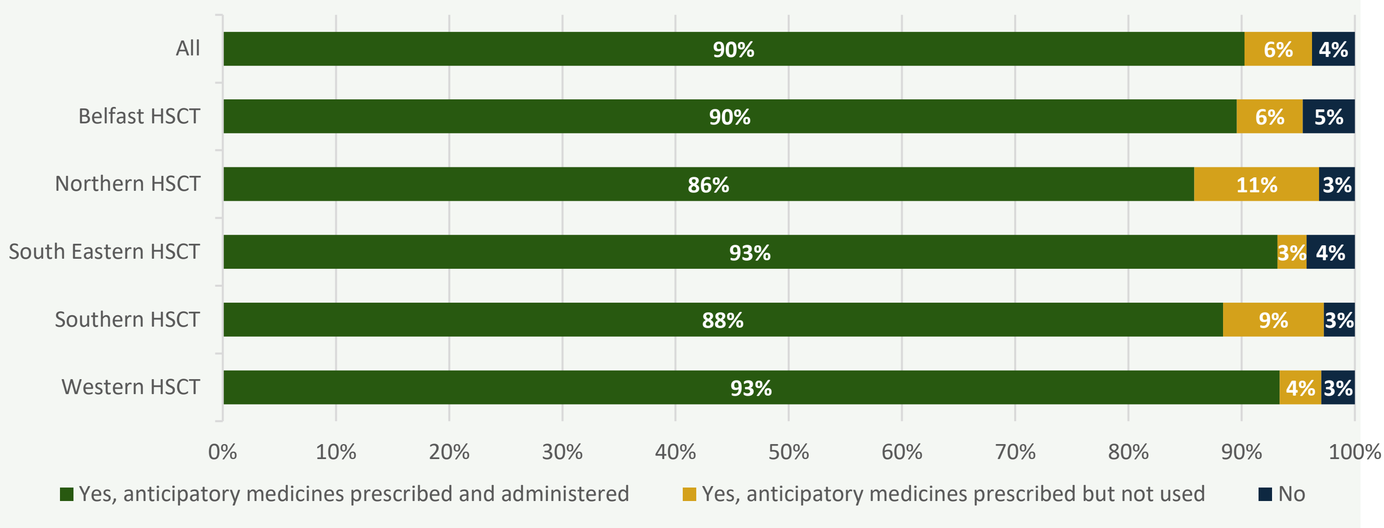


Figure 27 (CNR): The proportion of patients with documented evidence that anticipatory medications were prescribed for symptoms likely to occur in the last days of life (Category 1 only)
(N.B. Totals may not equal 100% due to rounding)

The proportion of patients who were expected to die that had anticipatory medications prescribed has increased from **90%** in 2022 to **96%** in 2024. There has also been an increase in the proportion of prescribed medications that were administered, from **87%** in 2022 to **94%** in 2024.

Statement 3 of NICE Quality Statement 144 states that adults in the last days of life who are likely to need symptom control should be prescribed anticipatory medicines with individualised indications for use, dosage and route of administration.

Of the patients who were expected to die that had anticipatory medication prescribed, **81%** had all prescribed medications individualised to their needs and a further **15%** had some prescribed medications individualised to their needs.

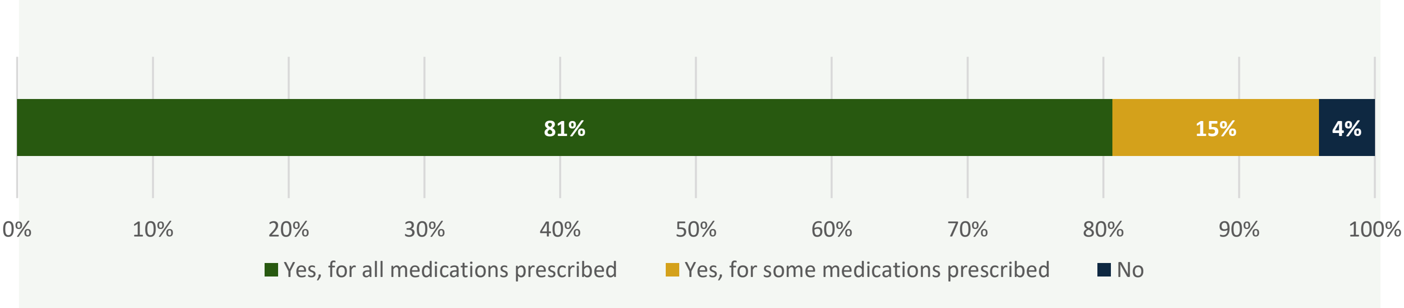


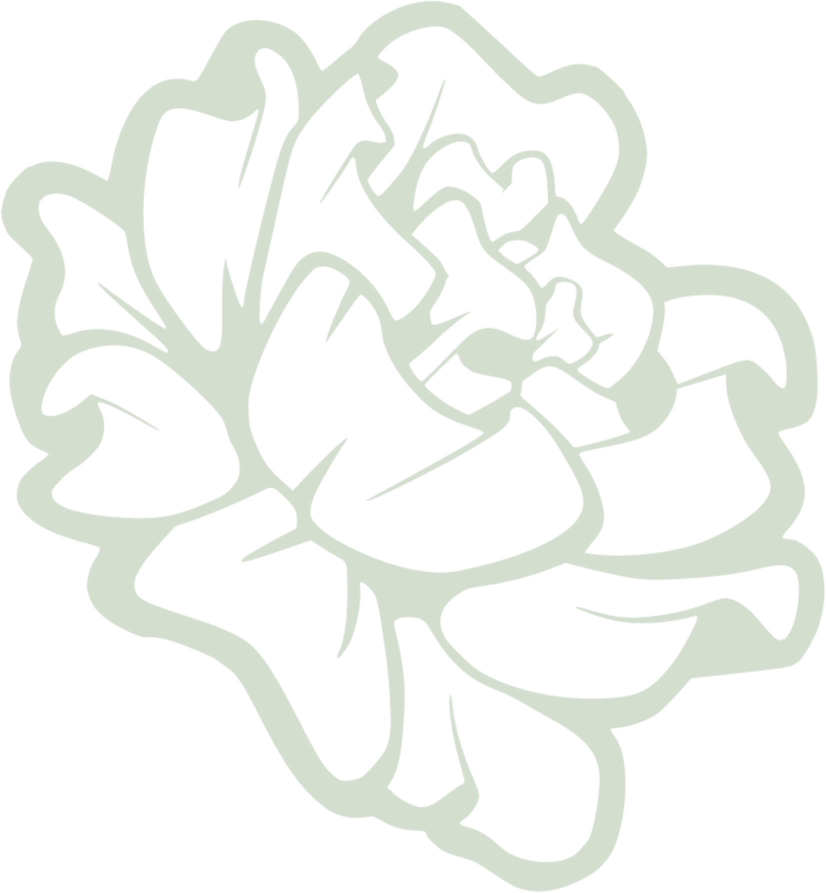
Figure 28 (CNR): The proportion of anticipatory medications prescribed that were individualised to the patient (Category 1 only)

6. Glossary

Acronyms and abbreviations	
CNR	**Case Note Review** (see page 27 for definition)
DPIA	**Data Protection Impact Assessment**
GDPR	**General Data Protection Regulation**
GMC	**General Medical Council**
HSO	**Hospital/Site** Organisational Level Audit
HQIP	The **Healthcare Quality Improvement Partnership** is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices
HSCT	**Health and Social Care Trust**
NACEL	The **National Audit of Care at the End of Life** commissioned by HQIP from NHSBN in October 2017
NCAPOP	**National Clinical Audit Programme and the Clinical Outcome Review Programmes**
NHSBN	The **NHS Benchmarking Network** is a member-led organisation promoting quality improvement in the NHS through benchmarking and sharing good practice
NICE	**National Institute for Clinical Health and Excellence**
NMC	**Nursing and Midwifery Council**
QS	Bereavement **Quality Survey** (see page 27 for definition)
SPC	**Specialist Palliative Care**
SRM	**Staff Reported Measure** (see page 27 for definition)

6. Glossary

Terms used in this report	
Anticipatory medication	Medication prescribed in anticipation of symptoms, designed to enable rapid relief at whatever time the patient develops distressing symptoms.
Bereavement (Quality) Survey	An online survey to capture the views of those important to the dying person.
Case Note Review	The Case Note Review is a set of questions completed for each death in the audit period regarding care received during their final admission to hospital.
Category 1 death	Definition of deaths to be included in NACEL. Category 1:It was expected that the patient would die in the final admission. Life sustaining treatments may still be being offered in parallel to end of life care.
Category 2 death	Definition of deaths to be included in NACEL. Category 2: It was not expected that the patient would die during the final admission - imminent death was not recognised or expected by the hospital staff. However, the patient may have had a life limiting condition or, for example, be frail, so that whilst death wasn't recognised as being imminent, hospital staff were "not surprised" that the patient died.
Hospital/Site Overview	The Hospital/Site Overview element of NACEL is where a set of questions is completed once at the overall hospital or site level. The metrics requested related to the financial year 2023/24.
'Families and others', 'nominated person', 'next of kin', 'carer'	These terms are used interchangeably in this report to refer to 'those important to the dying person' as used in One Chance To Get It Right. It is recognised that some dying people do not have such a person.
Five priorities for care	The Five priorities for care of the dying person as set out in One Chance To Get It Right.
Individualised plan of care	An 'individualised plan of care' as envisaged in One Chance To Get It Right. This could include any form of care plan that documents an individualised plan for care at the end of life.
Learning from deaths	This is a national framework for NHS trusts (England only) on identifying, reporting and learning from deaths in care.
Personalised care and support planning	Personalised care and support planning provides patients the opportunity to outline what matters to them within the context of their health and wellbeing (NHS England). Personalised care and support includes advance care planning.
Project Lead	The lead contact for this project within participating organisations. This role is the primary recipient of any correspondence and is responsible for co-ordinating the data collection.
Staff Reported Measure	The Staff Reported Measure element of the audit, which was piloted in round two, and implemented in round three, captures the views of staff who work closely with people who are dying and those important to them.
Submission	A hospital or site identified by the participating organisation to be audited separately.
Sudden death	Deaths which were sudden and unexpected; this included, but was not limited to, the following: • all deaths in Accident and Emergency departments • deaths within 4 hours of admission to hospital • deaths due to a life-threatening acute condition caused by a sudden catastrophic event, with a full escalation of treatment plan in place.



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