HQIP
Healthcare Quality Improvement Partnership

National Audit of Care at the End of Life 2025

Auditing last days of life in hospitals

2025 State of the Nations Report

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National Audit of Care at the End of Life 2025

2025 State of the Nations Report

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

Visit the resources at the links below:

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

For Healthcare Professionals:

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

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

For the public:

NACEL Patient and Carer Tool
Supporting patients, families, and carers to understand how care at the end of life is delivered in hospitals across different parts of the UK.

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.

The information featured in the State of the Nations Report reflects an annual position of care across acute and community hospitals that has been reviewed, cleansed, and analysed for the period January 2025 – December 2025.

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

1. **Hospital/Site Overview (HSO)**
   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. **Bereavement (Quality) Survey (BQS)**
   A survey completed by bereaved relatives, carers and those important to the person who died in hospital during 2025.
4. **Annual Death Data Collection (ADDC)**
   Collecting the number of deaths that took place in 2025.

This report highlights key audit findings related to the two national recommendations for improving the quality of care at the end of life in hospitals. 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.

NACEL 2025 sample size

232
Hospital/Site Overviews (HSO)

19,705
Case Note Reviews (CNR)

5,994
Bereavement (Quality) Surveys (BQS)

For context, during 2024, 568,613 deaths were reported in England and Wales; 243,590 of these occurred in an NHS hospital (ONS, 2025). The 2022 report by the UK Commission on Bereavement stated that the 1.2 million deaths in England and Wales during 2020 and 2021 left an estimated 6.8 million people bereaved. Given the wider context, the sample size of the NACEL Case Note Review accounts for approximately 8% of hospital deaths, and the NACEL Bereavement Survey accounts for 2% of hospital deaths in England and Wales.

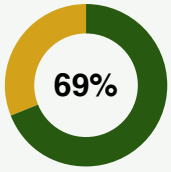
This report highlights key findings from NACEL 2025, with comparisons to previous years where available. Time series charts are presented; however, statistical testing of seasonal variation has not been undertaken. Please note, “not applicable” responses are excluded from the analysis. Participating NHS providers can access the full dataset NACEL Data and Improvement Tool.

Hyperlinks

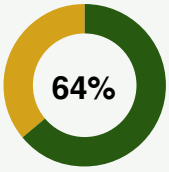
Key findings at a glance

National Audit of Care at the End of Life 2025

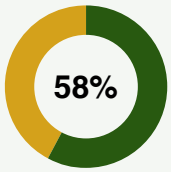
Proportion of hospital/ sites who have shared their end of life care quality improvement plan with the Integrated Care Board (ICB)/ Health Board.



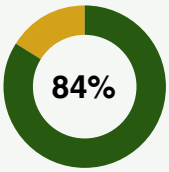
Hospital/sites with a face-to-face specialist palliative care service (nurse and/or doctor) available 8 hours a day, 7 days a week.



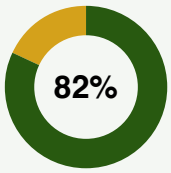
Proportion of patients that were reviewed by a member of the specialist palliative care team/end of life care team during their final admission.



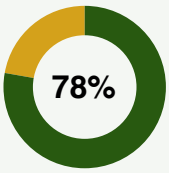
Proportion of deaths expected by clinical staff during the final admission.



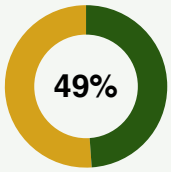
Proportion of clinical case notes with documented evidence of review of hydration options in the last days of life, including drinking if able.



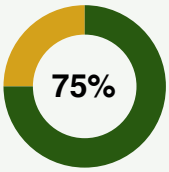
Proportion of bereaved people who agreed that the dying person received sufficient pain relief during their final hospital admission.



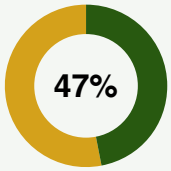
Proportion of clinical notes with an assessment of the spiritual, religious and cultural needs of those important to the dying person, or a reason recorded why not.



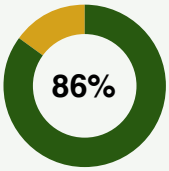
Proportion of bereaved people that rated the overall care and support given to themselves and others by the hospital as excellent or good.



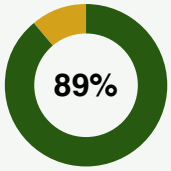
Proportion of clinical notes with evidence that the patient had participated in personalised care and support planning conversations.



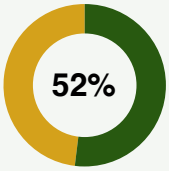
Proportion of people expected to die during the hospital admission with an individualised plan of care addressing their needs at the end of life.



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



Proportion of hospital/ sites where end of life care training was included in the mandatory/priority training.



 Local providers can use the infographic template available at www.nacel.nhs.uk/qi-documents to present their findings alongside the national results.

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 and linked national standards can be found here.

RECOMMENDATION 1:

System-level accountability for care at the end of life quality improvement and equity

Integrated Care Boards, Health Boards and commissioners must ensure robust system-level accountability and oversight of provider quality improvement plans relating to care at the end of life, in line with the NHS England Strategic Commissioning Framework and corresponding planning, quality improvement and commissioning expectations relating to end of life care within Wales and Jersey.

It is advised that commissioners undertake a review of the quality improvement plans on an annual basis ensuring that they contain clear, evidenced, and deliverable actions.

Commissioners should work collaboratively with providers and system partners to support measurable progress against national priorities, including the NACEL 2024 recommendations;

- Ensuring equitable access to specialist palliative care, including face-to-face specialist medical and nursing cover 8 hours a day, 7 days a week and 24/7 telephone advice services
- Increasing the number and quality of personalised care and support planning conversations
- Addressing health inequalities in care at the end of life
- Improving the delivery, uptake, and quality of end of life care training

RECOMMENDATION 2:

Strengthening the evidence base and identifying solutions to reduce inequalities in care at the end of life

The National Institute for Health and Care Research (NIHR) should prioritise a coordinated programme of research focused on reducing inequalities in care at the end of life for adults dying in hospital. This programme should build on findings from the NACEL programme and support the development, evaluation, and implementation of effective interventions to address identified inequalities.

Particular attention should be given to variations in the quality of care experienced by patients from different ethnic groups, including patients whose ethnicity is undocumented.

NIHR should work collaboratively with the NACEL programme and other relevant partners to identify shared research priorities and maximise the use of existing national datasets, including the NACEL dataset (2018–2025), to better understand inequities in care and inform targeted quality improvement initiatives.

National recommendations

Sharing Good Practice

Examples from the NACEL Good Practice Compendium that support the 2024 recommendations.

There are numerous examples of hospitals across England, Wales and Jersey delivering local projects to improve the care of people who are dying and those important to them.

Examples submitted to the audit are included in the NACEL Good Practice Compendium.

Of those submitted in 2025, five were identified as exemplary, particularly where they aligned with areas of care highlighted for improvement in the 2024 NACEL recommendations.

Case studies have been developed for these examples to support shared learning and networking.

Please see below.

CATEGORY	CASE STUDY	HYPERLINK
Supporting greater transparency in quality improvement plans	*System working and collaborative transparency on improvement needs* by University Hospital of Derby and Burton NHS Foundation Trust	Read case study here
Greater provision of specialist palliative care services	*Palliative Care 24/7 out of hours consultant support: A pilot* by The Newcastle upon Tyne Hospitals NHS Foundation Trust	Read case study here
Improving personalised care and support planning	*Improving end of life care and bereavement services* by East Lancashire Hospitals NHS Trust	Read case study here
Supporting equitable care being delivered for all dying people	*Implementing a joint strategy to provide equitable care at the end of life* by University College London Hospitals NHS Foundation Trust	Read case study here
Upskilling staff to deliver care at the end of life	*Staff training for improved care at the end of life outcomes* by Barts Health NHS Trust	Read case study here

 Local providers can use the infographic template available at www.nacel.nhs.uk/qi-documents to present their findings against the audit recommendations.

Key findings

KEY FINDING 1: QUALITY IMPROVEMENT PLANS

81% of hospital/sites had implemented a quality improvement plan relating to end of life care in the past year. Of these hospital/sites, 69% had shared these plans with the Integrated Care Board (ICB)/Health Board in the past year.

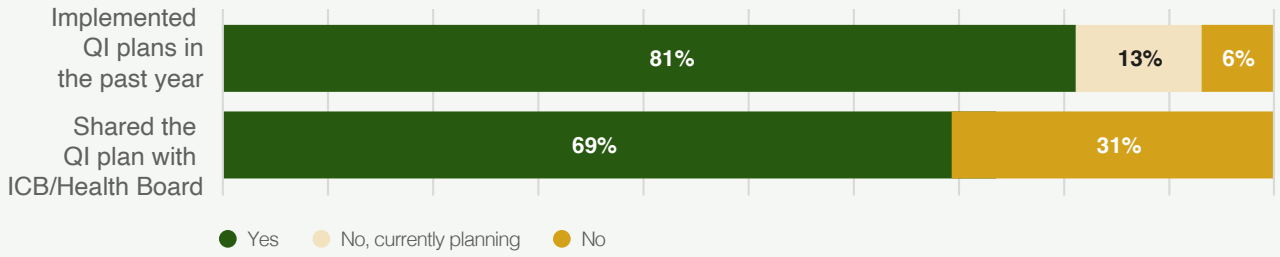


Figure 1: (HSO) Proportion of hospital/sites that have implemented a quality improvement (QI) plan relating to end of life care and shared this with their ICB/Health Board.

The sustainable delivery of high quality end of life care requires ongoing review and continuous improvement to ensure compassionate and appropriate treatment.

Strengthening palliative and end of life care is a core commissioning responsibility of ICBs in England (NHS England, 2022), and equivalent bodies in Wales and Jersey. This requires system-level oversight of provider quality improvement plans, alongside transparent information-sharing between ICBs/Health Boards and providers. NACEL Recommendation 1 supports improvement in this area and aligns with Recommendation 7 of the Review of Patient Safety Across the Health and Care Landscape.

KEY FINDING 2: ACCESS TO SPECIALIST PALLIATIVE CARE SERVICES

97% of hospital providers have specialist palliative care services. Of these, 64% offer face-to-face (nurse and/or doctor) care 8 hours/day, 7 days a week, and 89% provide 24/7 telephone (nurse and/or doctor) support.

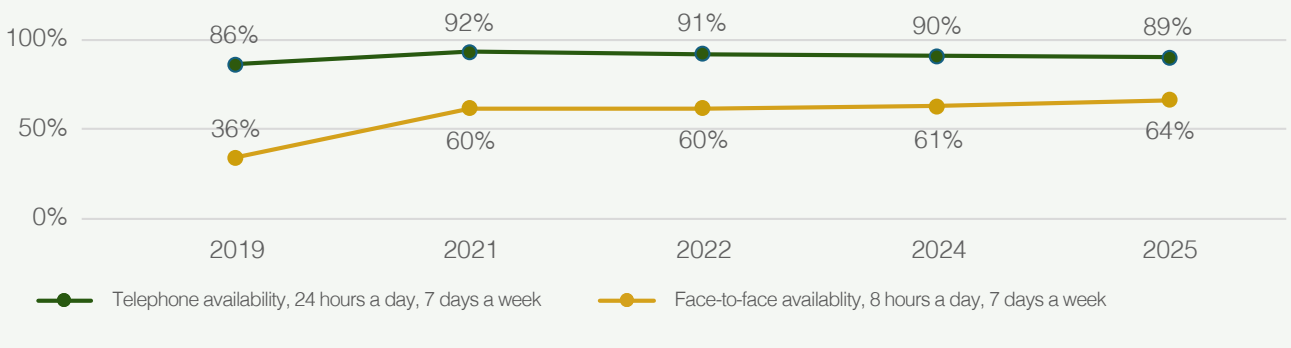


Figure 2: (HSO) The proportion of hospital/sites with specialist palliative service availability (nurse and/or doctor) over five rounds of NACEL.

Nationally, **64%** of services said they had face to face specialist palliative care available 8 hours a day, 7 days a week. The 95% confidence interval (a measure of uncertainty) suggests the true proportion is likely to be between **57.6%** and **70.1%**.

The NACEL 2025 results show no change in the proportion of hospital providers with access to specialist palliative care services since 2024. Among providers with access, a higher proportion report face to face specialist palliative care services 8 hours a day, 7 days a week than in 2024, showing progress against NACEL 2024 Recommendation 2: Integrated care boards, health boards and commissioners should ensure that services provide specialist palliative medical and nursing cover face-to-face, 8 hours a day, 7 days a week and a 24-hour, 7 days a week, telephone advice service.

Further work is required to ensure consistent 24/7 provision. The most notable reasons for not providing 8 hours a day face to face medical and/or nursing advice are service models that do not support this (**35%**) and lack of funding (**33%**).

KEY FINDING 3: TIMELINESS OF SPECIALIST PALLIATIVE CARE SERVICES

58% of patients audited by the Case Note Review had been reviewed by a member of the specialist palliative care team/end of life care team[1] during their final admission.

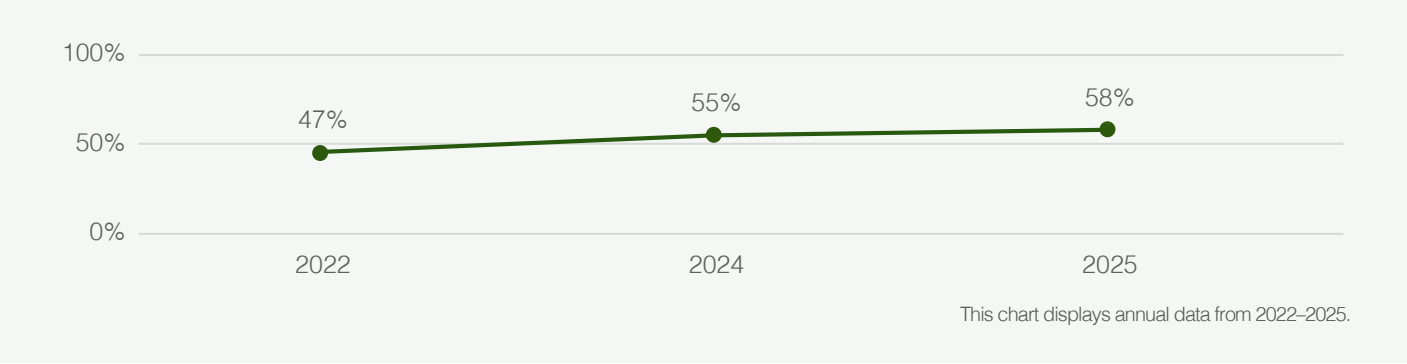


Figure 3: (CNR) The proportion of patients reviewed by a member of the specialist palliative care team/end of life care team during their final admission.

NACEL data indicate an increase in the proportion of patients reviewed by specialist palliative or end of life care teams during their final admission, rising from **47%** in 2022 to **58%** in 2025. **42%** of patients were cared for exclusively by generalist teams and received no input from specialist palliative or end of life care services during their final admission. This reflects the ongoing role of generalist hospital staff in delivering care at the end of life and the importance of appropriate training and education to support this role.

The timeliness of specialist palliative and end of life care team input during the final presentation to hospital was reviewed during 2025, showing a median time of **3 hours** from referral to specialist review. While no national standard exists, the findings indicate that when referrals are made, specialist teams generally respond promptly to meet patient needs. Services with average response times exceeding 3 hours should review their processes to ensure timely and effective care. Boxplot 1 illustrates substantial variation in the time between referral and review across acute and community hospital providers.

KEY FINDING 4: RECOGNITION OF DYING

Of the patients audited by the Case Note Review, 84% 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 52 hours (2.2 days).

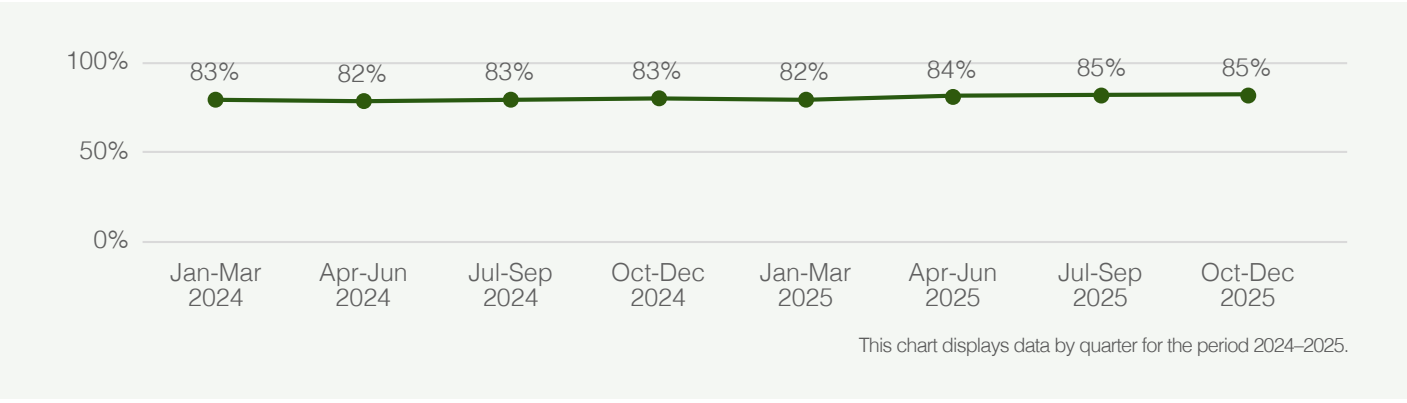


Figure 4: (CNR) The proportion of clinical case notes where it was expected that the person would die during the final admission.

NACEL reports that **84%** of patients were expected to die during their final hospital admission, a 1% increase from 2024. Figure 4 suggests little observable variation in care delivery across quarters, with values appearing broadly similar throughout the year.

Early identification that the patient is dying is key to providing high-quality care at the end of life, a principle strongly emphasised in national guidance, such as One chance to get it right (2014), which highlights the importance of timely recognition, honest communication, and coordinated care in the last days of life. The median time from recognition of dying to death was **2.2 days** in 2025, compared to **2.3 days** in 2024. Earlier identification of dying is essential to support care at the end of life planning and to facilitate transfer to community settings where appropriate.

[1] For NACEL reporting purposes, the term "end of life care team" is used as a descriptor for teams within a provider organisation that have responsibility for coordinating or supporting care at the end of life. Local team structures and titles may vary.

KEY FINDING 5: HYDRATION OPTIONS

82% of the clinical case notes sampled had documented evidence of hydration options in the last days of life, including drinking if able, an improvement from 78% in 2024.

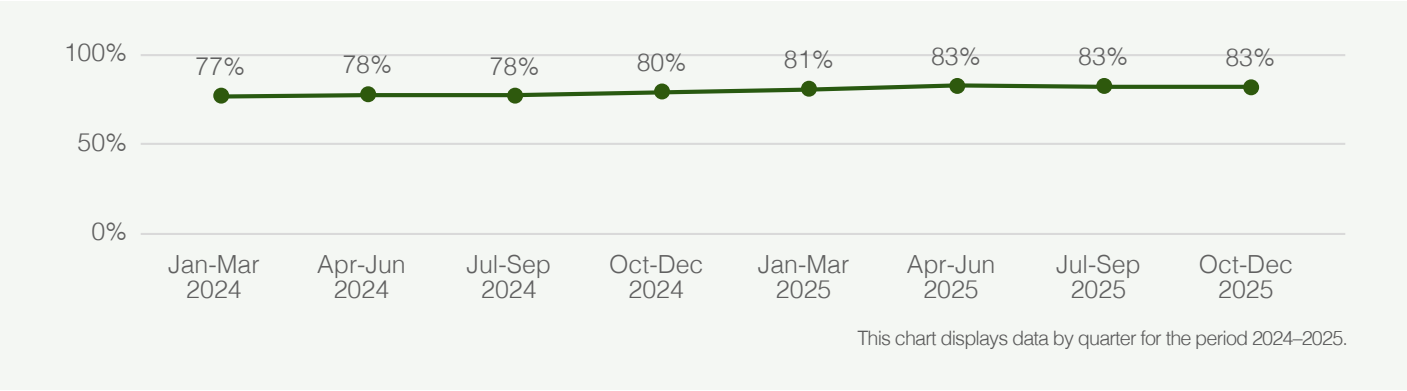


Figure 5: (CNR) The proportion of clinical case notes with documented evidence of review of hydration options in the last days of life, including drinking if able.

Whilst further progress is needed to ensure all patients receive a review and that discussions take place with the appropriate people, these results represent positive movement in addressing a well-known area of public concern during the dying phase and are aligned with NICE Quality Standard (QS144), which emphasises the importance of regular review and shared decision-making about clinically assisted hydration at the end of life.

A trend towards improvement is observed in the documentation of discussions about hydration options with those important to the dying person (or, where this was not possible, a reason was recorded), with compliance reaching **64%** in 2025, compared with **62%** in 2024.

KEY FINDING 6: PAIN RELIEF / SYMPTOM MANAGEMENT

78% of bereaved respondents agreed that the dying person received sufficient pain relief during their final hospital admission, while 12% disagreed with this statement.

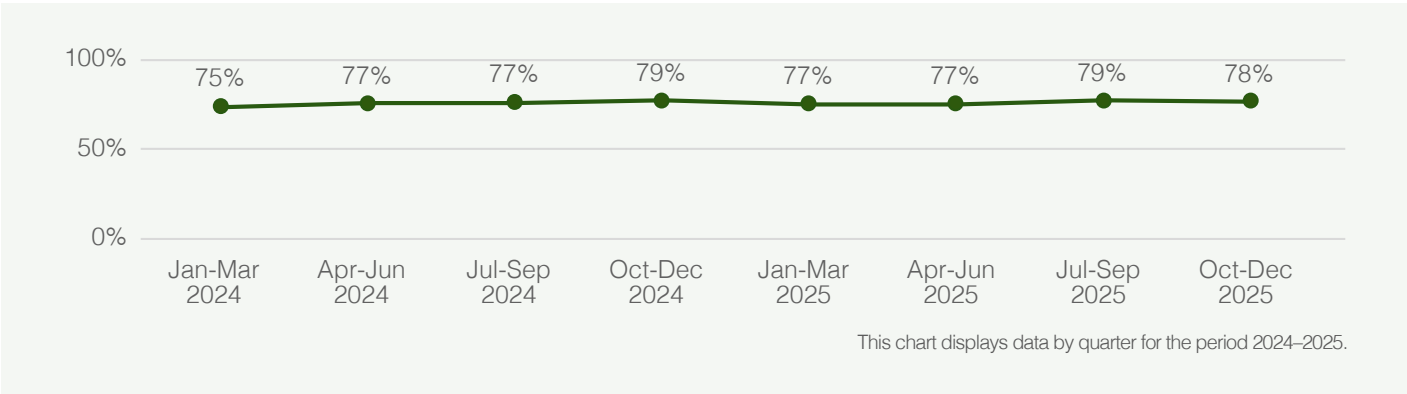


Figure 6: (BQS) The proportion of bereaved people that agreed that the person was given enough pain relief.

The proportion of bereaved respondents who agreed that the dying person received enough pain relief during their final hospital admission was **78%**. The 95% confidence interval (a measure of uncertainty) suggests the true proportion is likely to be between **76.6%** and **78.8%**.

Documentation showed that **91%** of patient clinical notes included a review of dyspnoea/breathing difficulty, and **97%** of clinical notes recorded actions taken to address it.

KEY FINDING 7: SPIRITUAL, RELIGIOUS AND CULTURAL NEEDS

An assessment of the spiritual, religious and cultural needs of those important to the dying person (or a recorded reason if this wasn't possible) was documented in 49% of cases. The 95% confidence interval (a measure of uncertainty) suggests the true proportion is likely to be between 47.9% and 49.3%. This marks an improvement from 41% in 2024.

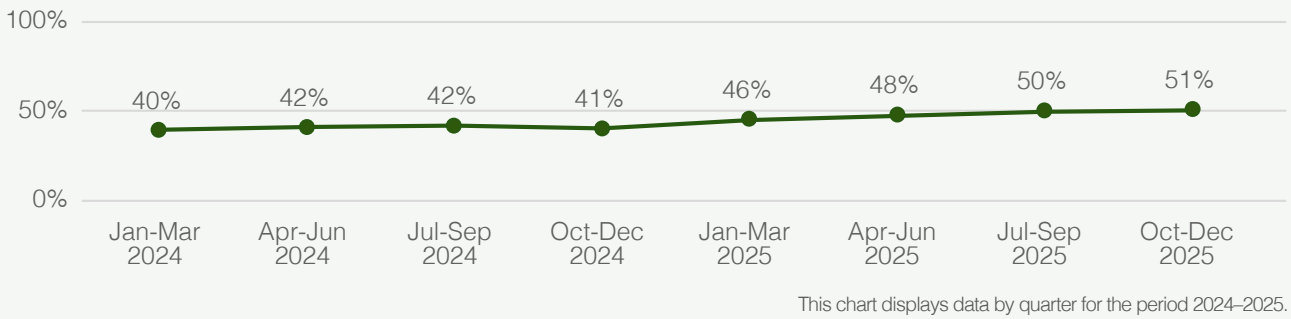


Figure 7: (CNR) The proportion of clinical notes with documented evidence of an assessment of the spiritual/religious/cultural needs of those important to the patient (or, where not possible, a reason was recorded).

NACEL also reports a **13** percentage point increase in the proportion of bereaved people who felt their needs had been met, rising from **46%** in 2024 to **59%** in 2025. These assessments are a fundamental part of individualised care at the end of life, as outlined in NICE Quality Standard (QS144). This finding should be interpreted with caution due to a slight change in question wording between 2024 and 2025[2].

KEY FINDING 8: CARE AND SUPPORT

The care and support provided to the dying person was rated as excellent or good by 77% of bereaved respondents, whilst 75% of bereaved respondents rated the care and support given to themselves and others as excellent or good. Bereaved respondents were more likely to rate the care as excellent or good when delivered in a community hospital.

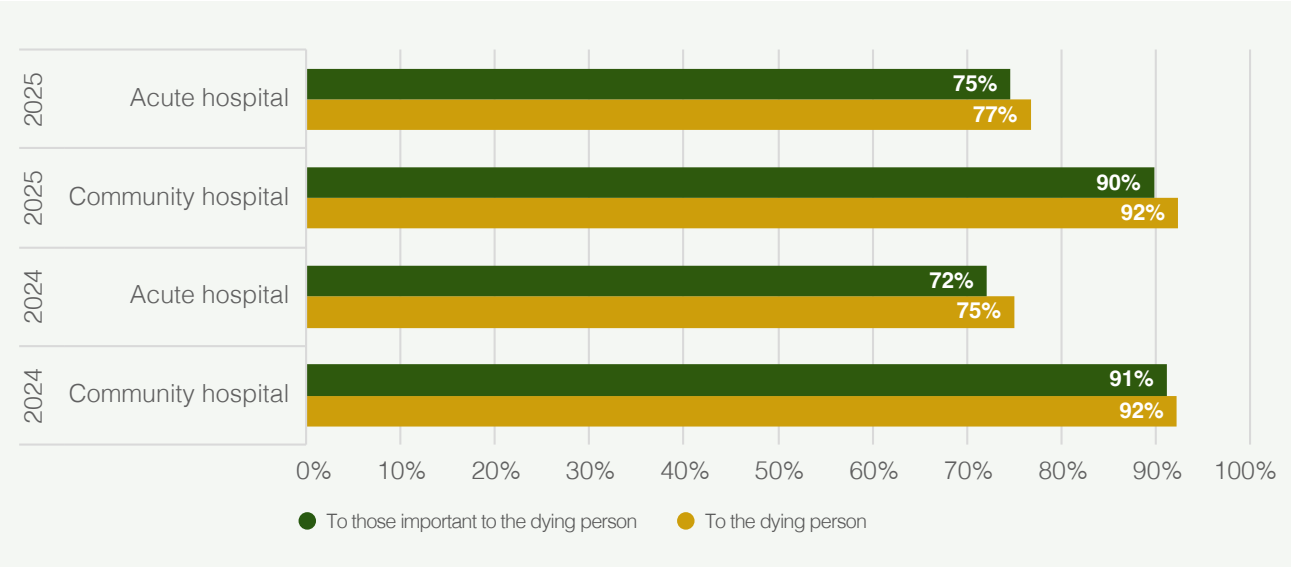


Figure 8: (BQS) The proportion of bereaved people that rated the care and support given by the hospital to the dying person and those important to them as excellent or good.

Acute hospital colleagues should be encouraged to learn from practice in community hospitals and to recognise the strong quality of care delivered within these settings. Further examples of differences in care are provided in the Annual Report Data Sheet.

[2] Changes to question wording: 2024: Staff tried to provide me with spiritual/religious/cultural support to meet my needs. 2025: Staff provided me with spiritual/religious/cultural support to meet my needs.

KEY FINDING 9: PERSONALISED CARE AND SUPPORT PLANNING

From the Case Note Review, 47% of patients whose clinical notes were sampled had evidence that they had taken part in personalised care and support planning, including advance care planning conversations[3]. The 95% confidence interval (a measure of uncertainty) suggests the true proportion is likely to be between 46.5% and 47.9%.

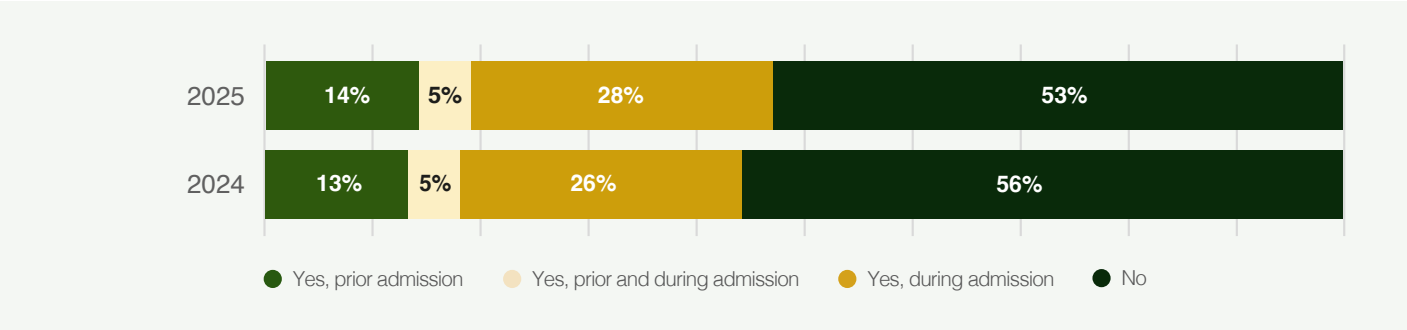


Figure 9: (CNR) The proportion of clinical case notes with documented evidence that the patient participated in personalised care and support planning (advance care planning) conversations.

NACEL continues to recommend increasing the number of personalised care and support planning conversations offered to patients, including advance care planning discussions. While hospital inpatient staff play an important role in initiating these conversations, in line with the NHS (2025) 10-Year Plan, there is an important role for community teams as well as inpatient hospital teams in initiating these conversations earlier. This supports the wider ambition to strengthen personalised care and increase earlier community-based support.

This also links to NCEPOD Recommendation 6, which states that existing advance care plans should be shared between all providers involved in a patient's care. Currently, **40%** of bereaved people reported that the person had an advance care plan in place before they died.

KEY FINDING 10: INDIVIDUALISED PLAN OF CARE

Of the people expected to die during the hospital admission, 86% had an individualised plan of care addressing their needs at the end of life. Of these, 56% were documented on a standalone template and 29% within the general clinical notes.

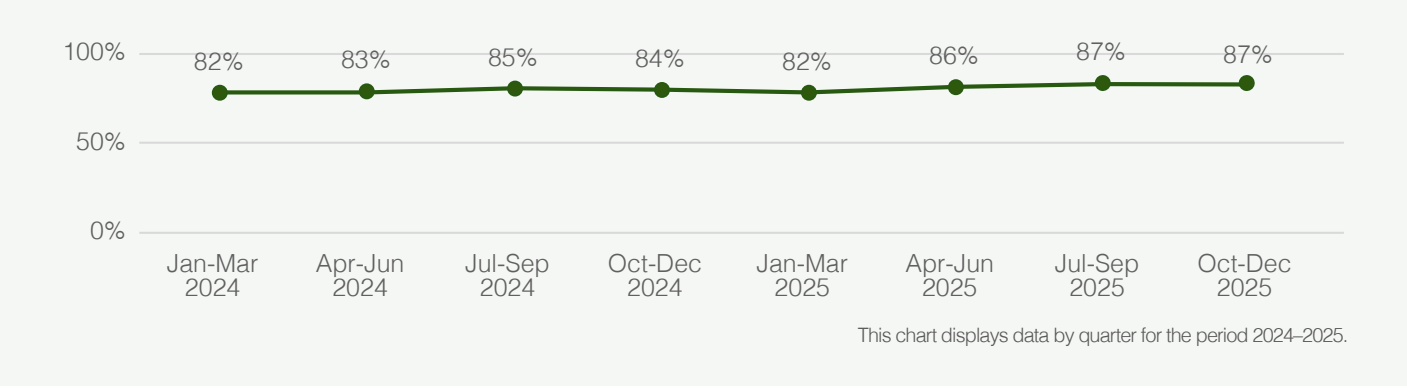


Figure 10: (CNR) The proportion of clinical case notes with documented evidence that the patient who was expected to die had an individualised plan of care addressing their care at the end of life needs.

A higher proportion of patients who were dying had documented evidence of an individualised plan of care addressing their care at the end of life needs in community hospitals (**92%**) than in acute hospitals (**85%**). While the recorded presence of a care plan is high, findings from the Bereavement Survey suggest that further work may be needed to ensure these plans are consistently implemented and followed. In the survey, **69%** of bereaved people strongly agreed or agreed that hospital staff made a care plan that considered the person's needs and wishes.

NICE Guideline (NG31) emphasises the importance of developing, documenting and regularly reviewing an individualised care plan for dying adults, to ensure care is aligned with the person's needs, preferences and wishes in the last days of life.

[3] NACEL records personalised care and support conversations that involve the patient directly and does not capture the reasons why such conversations may not have taken place—for example, where a patient lacked the capacity to participate.

KEY FINDING 11: **EQUITABLE CARE**

When reviewing patient ethnicity, 89% of the clinical case notes included documentation of the patient's ethnicity and 11% reported ethnicity as either not stated or unknown.

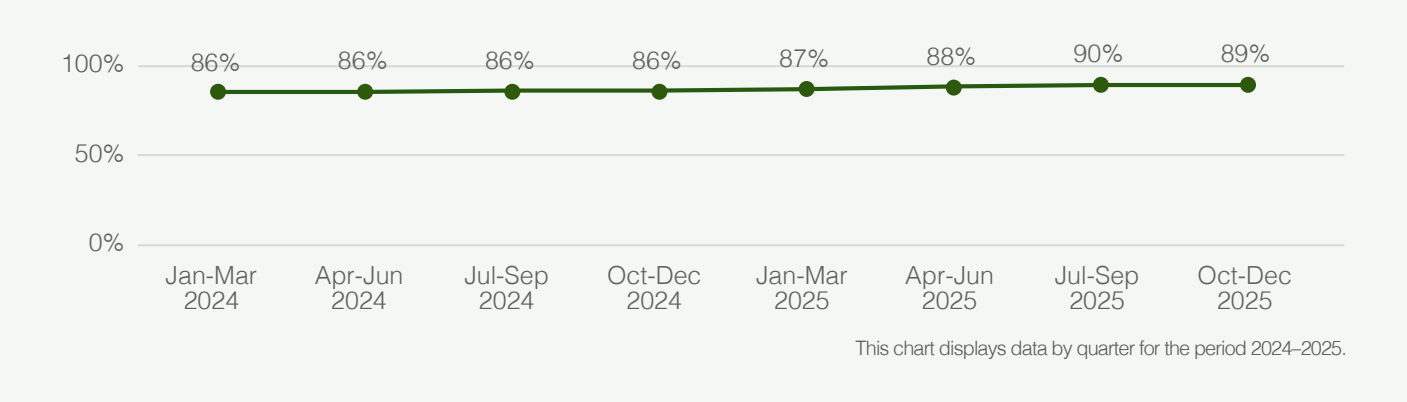


Figure 11: (CNR) The proportion of people who died with ethnicity documented in their clinical case notes.

A chi-square test of independence was performed to examine the relationship between care delivered at the end of life and patient ethnicity. The relationship between these variables was significant for several areas of care, including the below:

- Findings from the Case Note Review show that patients with unknown ethnicity have worse outcomes. This strengthens the need for inpatient staff to record patient ethnicity, to ensure that inequities in care at the end of life can be identified and addressed in order to support high quality care.
- Cultural and religious needs seem to be being met, especially for Asian patients and their families, as well as for Black, Mixed, and Other ethnicity patients and their families.
- Documented evidence of sufficient pain relief or reviews of other non-pain related symptoms, such as nausea or breathlessness, seems to be lacking in Asian patient groups.

More information on the differences in care based on the patient's ethnicity can be found in the Annual Report datasheet.

NACEL report on ethnicity as one marker of equitable care; however, the findings indicate notable variation in the provision and experience of care by ethnicity, suggesting that inequalities may extend beyond ethnicity alone to a broader range of factors influencing care quality and access. These findings demonstrate the need for further research to better understand the drivers of these inequalities and identify effective approaches to reducing them systematically within hospital settings.

There is also an opportunity to make greater use of existing NACEL data to strengthen the evidence base on inequalities in care at the end of life. Linking and analysing national datasets, including NACEL data collected between 2018 and 2025, could support a more comprehensive understanding of inequities in care and help inform targeted improvement activity at both local and national levels.

NACEL Recommendation 2 calls on NIHR to take forward research to better understand and address inequalities in care at the end of life.

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KEY FINDING 12: **END OF LIFE CARE TRAINING**

Progress in the availability of care at the end of life training remains limited. 52% of hospital/sites provided mandatory care at the end of life training during 2024/25.

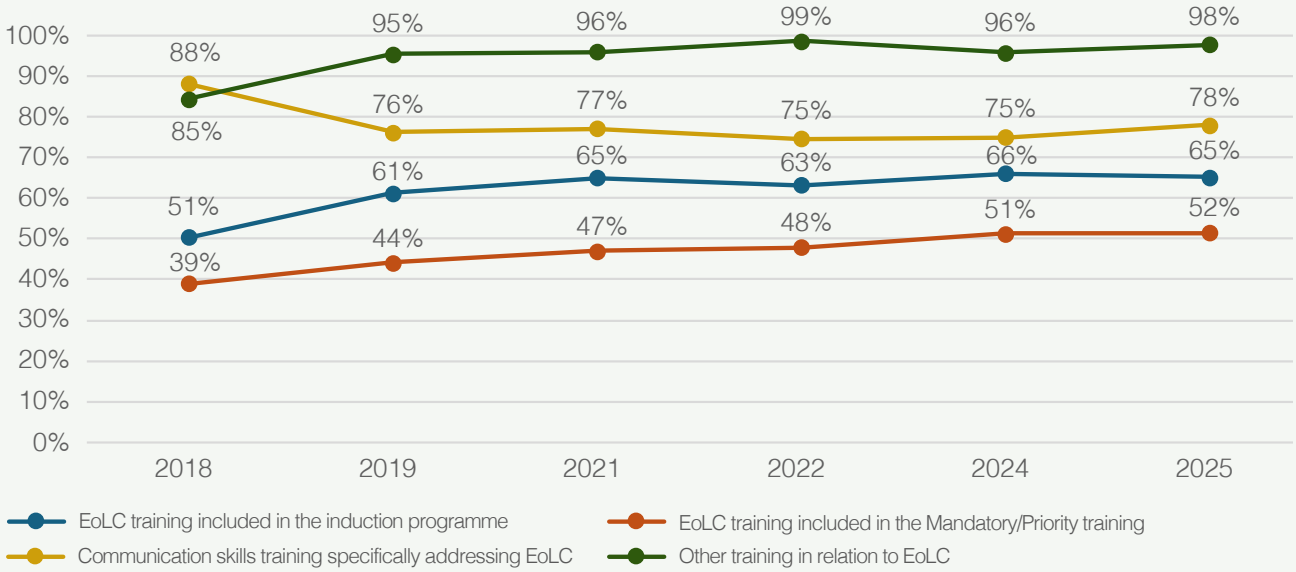

Figure 12: (HSO) Proportion of hospital/sites that have end of life education and training available.

Figure 12 reinforces NACEL 2024 Recommendation 5, which advises integrated care boards, health boards, and commissioners to consider system-level initiatives to increase the uptake and quality of care at the end of life training. NCEPOD Recommendation 5 further reflects the importance of all patient-facing healthcare staff receiving training in care at the end of life.

The reduction in communication skills training specifically addressing end of life care presents an important challenge, as these skills are fundamental to delivering high quality personalised care. Strengthening system-level training initiatives may help improve staff confidence and consistency in initiating earlier, person-centred conversations and translating these discussions into effective individualised plans of care.

Find out more about this audit

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

www.nacel.nhs.uk

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Auditing last days of life in hospitals

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