1. INTRODUCTION

Care at the end of life in hospitals touches everyone. Best possible care in this setting has been the focus of national policy and media attention over the last decade. The National Audit of Care at the End of Life (NACEL) was commissioned by the Healthcare Quality Improvement Partnership (HQIP) from the NHS Benchmarking Network (NHSBN), in October 2017. 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, community hospitals and mental health inpatient providers in England and Wales. The audit covered all adult deaths (aged 18 at the time of death), and concentrated upon the last admission to hospital, excluding deaths in A&E, deaths under 4 hours, and sudden deaths. The audit comprised an Organisational Level Audit (covering trust/Health Board (HB) and hospital/submission level questions), a Case Note Review (completed by acute and community providers only, which reviewed all deaths in April 2018 (acute providers) or deaths in April – June 2018 (community providers) and a Quality Survey (completed online, or by telephone, by the bereaved person) measuring the performance of hospitals against criteria relating to national guidance on care at the end of life, including *One Chance To Get It Right*, and the relevant NICE Guideline and Quality Standards.

The audit has succeeded in establishing where trusts/Health Boards are doing well and where they need to focus improvement efforts. Data for all elements of the audit was collected between June and October 2018. In total, 206 trusts in England and 8 Welsh organisations took part in at least one element of the audit (97% of eligible organisations). Northern Ireland also took part in NACEL (organisational level audit only) and has been reported separately.

The patient-centred development of an individualised care plan is central to the guidance in *One Chance to Get it Right*. The *NHS Long Term Plan, 2019* places a continuing emphasis on personalisation of end of life care to enable people’s choices on type of care and location to be supported. Around a quarter of a million people die in hospital each year and, the audit results suggest 75% of bereaved people feel that this was the right place for the person important to them to die. This audit reviews how people’s preferences regarding care at the end of life are identified, discussed and implemented during their last admission in acute and community hospitals.

The aims of NACEL were as follows:

1. To establish whether appropriate structures, policies and training are in place to support high quality care at the end of life.
2. To assess compliance with national guidance on care at the end of life – *One Chance To Get It Right*, NICE Guideline and the NICE Quality Standards for end of life care.
3. To determine what is important to dying people and those important to them.
4. To provide audit outputs which enable stakeholders to identify areas for service improvement.
5. To provide a strategic overview of progress with the provision of high-quality care at the end of life in England, Wales and Northern Ireland.

A quality improvement plan is necessary as NACEL data show there is room for improvement in performance against the following key aspects of care:

- Recording of discussions with the dying person
- Improvement in communications with the families and others important to the dying person
- Scope for improvement in the use of Advance Care Plans (ACPs)
- Gaps in the development and documentation of individualised end of life care plans
- Provision of side rooms and the need for privacy for the dying person and their families
- Scope to improve the quality of care and sensitive communication with both the patient and the family and others.

There is a complete list of recommendations in the National Audit of Care at the End of Life – First round of the audit (2018/19) report. England and Wales.

NACEL is an annual data collection. Data has commenced for the second round of NACEL. NACEL is well placed to support activities aimed at improvement in patient care, and support to those important to the dying person, in line with the wider NHS strategy.

2. IMPROVEMENT GOALS
The focus for improvement in quality over the next 12 months will be on each trust/Health Board to review their NACEL audit outputs and develop internal quality improvement plans based on their results. Baselines for the first year have been established in both the summary score reporting, and in the full set of metrics. Progress against baselines should be monitored following the publication of NACEL round 2 results.

3. IMPROVEMENT METHODS
1. National
   a. NHSE/I and the Welsh Government will encourage engagement with NACEL recommendations through the National Clinical Director for End of Life Care (England) and the Acting Lead for End of Life Care (NHS Wales).
   b. Within England, The Ambitions Partnership, the End of Life Programme Board and the End of Life Care Clinical Leaders Network will be key bodies identified to disseminate the recommendations from NACEL.
   c. Within Wales, the National Palliative Care Implementation Board and the Welsh Government will be key players to disseminate the messages from NACEL.
   d. CQC/HIW will be encouraged to review individual bespoke dashboards as part of their inspection regime, requesting evidence of local action plans.
   e. NHSBN are in the process of working with CQC to share key metrics from the audit for providers to support the CQC’s inspection regime. Emphasis will be placed upon metrics which present the most opportunity for providers to undertake quality improvement opportunities. Consideration will be given to the most appropriate way to present provider performance against the metrics.
   f. Use of the NHS Benchmark Network’s online Knowledge Exchange Forum to share quality improvement ideas and questions. All NACEL participants have access to this functionality on the Network’s website.
   g. NHS Benchmarking Network case studies on NACEL being made available on the Network’s website. The NACEL Team are actively pursuing this with NACEL participants.

2. Regional
   a. The NHSBN team delivered presentations of the NACEL key findings at the Network’s 7 NHSE/I Regional area events during May 2019. Each event was attended by 50 to 60 people from trusts and CCGs in each region, including clinicians and managers.
No further regional activities have been commissioned as part of the procurement of NACEL.

3. **Local**
   a. All participants in NACEL received access to an online benchmarking toolkit containing all metrics collected in the first round of NACEL.
   b. All participants received a bespoke dashboard containing benchmarked findings against key metrics, together with their summary score against the nine themes reported. The summary scores provide a baseline indicator of progress against each of the nine themes. Following the launch of the NACEL First round of audit (2018/19) report, participants will be able to compare summary scores against all other trusts/Health Boards.
   c. Participants also received a NACEL First round of the audit (2018/19) report which includes recommendations for trust/Health Board boards, Chief Executives and Medical and Nursing Directors.
   d. Participants are expected to use the audit outputs to develop local quality improvement and action plans for areas where scores are below the national average. These action plans should consider the NACEL recommendations and national guidance. The NACEL audit outputs can also be used to identify good practice and areas where the trust/Health Board is performing well.
   e. the wider system e.g. Integrated Care Systems/Commissioners to put in place systems and processes to support people approaching the end of life to die according to their needs and wishes. There are a number of recommendations for local systems in the National Audit of Care at the End of Life – First round of the audit (2018/19) report. England and Wales.

   *(Note: There are a number of resources published by HQIP which will be useful aids to assist participants with developing their quality improvement plans. See the following guide [https://www.hqip.org.uk/resource/guide-to-quality-improvement-methods/#.XcWOglf7SUK]*

4. **Patient and public involvement**
   a. Findings at a glance have been developed with key messages on one page.
   b. An easy read/patient friendly report will be published once the current Purdah period is over.
   c. A slide set of key findings has been approved by HQIP for use (this was used in the pre-publication phase prior to publication of the NACEL First round of the audit (2018/19) report.
   d. The Patients Association is a key partner in NACEL and a strategy for patient and public involvement will be developed with the link at the Patients Association.

5. **Communications**
   a. A Dissemination and Engagement Strategy has been agreed with HQIP following launch of the NACEL First round of the audit (2018/19) report in July 2019.
   b. A key element of the strategy is the involvement of all care at the end of life stakeholders. The NACEL governance structure has been formulated with all stakeholders represented on either the NACEL Steering Group or the NACEL Advisory Group. A joint meeting was to be held on 17th July 2019 which discussed...
stakeholder dissemination plans. All stakeholders have identified communications leads to assist with this strategy.
c. The NACEL Team is requesting opportunities to present the NACEL findings at various national conferences e.g. RCP Acute Medicine Conference, Palliative Care Congress, British Geriatrics Society Autumn Meeting, etc
d. All stakeholders will be kept up to date via the NACEL webpages and through regular communications from the NACEL Team with audit participants.
e. This Quality Improvement plan will be placed on the NACEL webpages for the use of participants and stakeholders with a news piece regarding the plan. This will also be given to HQIP to link with their Quality Improvement strategy. The Quality Improvement Plan will be reviewed at the end of each audit cycle in order to capture new audit elements accordingly.

4. EVALUATION

Evaluation of the quality improvement plan will take place via the following avenues: -

• NACEL Steering Group and Advisory Group
• HQIP Contract Review Meetings
• The Patient and Public Involvement Strategy – yet to be developed with the assistance of the Patients Association
• Subsequent iterations of NACEL

5. NACEL DRIVER DIAGRAM

Driver diagrams are a useful tool to represent a logic model for a quality improvement project. The diagram visually represents what drives or contributes to the overall project aims as a visual representation. The NACEL driver diagram can be found overleaf in Appendix 1.

November 2019
Appendix 1 – NACEL driver diagram

**Aim**

**Primary Drivers**

- Identify and improve communication pathways across organisations to ensure dying people and those important to them receive the best quality care
- Ensure that the quality of care for those at the end of life is supported at all levels within the organisation, encourage a caring organisational culture
- Ensure training and support is available to enable staff to recognise when a patient is dying and put a plan in place to meet the needs of both the dying person and those important to them
- Ensure staff have the skills and confidence to recognise death, and to communicate this to both the dying person and those important to them
- Assess implementation and compliance of all current guidance regarding care for those at the end of life
- Ensure all dying people and those important to them have the opportunity to be involved in creating an individualised end of life care plan which addresses the patient's needs and wishes

**Secondary Drivers**

**Interventions**

**Integrated Care Systems/Commissioners should:**

- Put in place systems and processes to support people approaching the end of life to receive care that is personalised to their needs and preferences
- Review capability and capacity with primary care, community services and social care, to provide appropriate care at the end of life, and to support families through to bereavement, with the aim of better meeting people's needs and preferences
- Implement processes to enable rapid discharge to home, care home or hospice, from hospital to die if that is the person's wish
- Ensure adequate access to specialist palliative care in hospitals for holistic assessment, advice and active management

**Trust/Provider Boards should:**

- Promote and support an organisational culture which prioritises care, compassion, respect and dignity as fundamental in all interactions with dying patients and the people who are important to them

**Chief Executives should:**

- Require and 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
- Ensure systems are in place to assess and address the needs of the families of dying patients in a timely manner

**End of Life Care Lead should:**

- As part of a strong governance framework for end of life care, report annually to the Board with a performance report and action plan

**Medical Directors and Nursing Directors should:**

- Ensure that staff have an understanding of, and communicate, as early and sensitively as possible, the possibility or likelihood of imminent death
- Ensure that priority is given to the provision of an appropriate peaceful environment, that maximises privacy, for dying people and their families
- Ensure that patients who are recognised to be dying have a clearly documented and accessible individual plan of care developed and discussed with the patient and those important to them to ensure the person's needs and wishes are known and taken into account
- Ensure that the intended benefit of starting, stopping or continuing treatment for the individual is clear, with documentation of the associated communication with the patient and/or person important to them
- Ensure the dying person is supported to eat and drink if they are able and wish to do so

**Improve the quality of care at the end of life in inpatient settings in England and Wales**