NATIONAL AUDIT OF CARE AT THE END OF LIFE (NACEL)

HEALTHCARE IMPROVEMENT PLAN (HIP) 2026

1. INTRODUCTION

The NACEL has been delivered by NHS Benchmarking Network (NHSBN) since 2017 evaluating the end-of-life care given to adults (18+) who died in hospitals, with a focus on those who were recognised as dying. Audit criteria are derived from national guidance on care at the end of life, including *One Chance To Get It Right* and the relevant *NICE Guidelines* and *Quality Standards (*NG13, NS31, NS144).

The NACEL evaluates the quality and outcomes of care experienced by the dying person, and those important to them, during the last admission before their death in acute, community and mental health hospitals in England and Wales. In the years since its inception, the NACEL has succeeded in helping to develop a tool, incrementally improve this and facilitate hospitals in identifying how well they meet standards in end-of-life care. For full details about all aspects of the NACEL, please visit www.nacel.nhs.uk.

The NACEL was re-commissioned by Healthcare Quality Improvement Partnership (HQIP) to NHSBN in 2022, with a 2-year extension granted in 2025. Since 2024, the NACEL has more frequent data collection, wider scope, amended data points and reporting/outputs directly used to support quality improvement in the care of people who die in a hospital setting, and more widely in end-of-life care. There is a greater ambition to understand how audit results can be prioritised to focus improvement efforts at both national and local level, celebrate improvement success, and support those in frontline roles to initiate and implement these improvement projects. For information on how NACEL data is being used to support quality improvement please visit the NACEL good practice compendium.

The overall aim of the NACEL is to improve the quality of care when somebody dies in a hospital inpatient setting in England, Wales and Jersey.

The NACEL Quality Improvement plan/HIP is designed to help stimulate improvement at local, regional and national (and international) levels, promoting better healthcare outcomes (where needed), in particular better experiences, for the dying person and those important to them. This document has been updated in 2025 in line with the 2024 national recommendations and in response to audit baseline and findings in NACEL 2024.

2. IMPROVEMENT GOALS

The NACEL aims to support, where needed, improvements in the care of the dying person and those important to them, with a particular focus on five improvement goals (Table 1). These goals are aligned to ten primary drivers that describe what quality end-of life should look like in hospital inpatient settings (see Diagram 1). The improvement goals and primary drivers were used as a framework to design the audit.

NACEL identified 5 key recommendations from the 2024 dataset evidence aimed at Integrated Care Boards, Health Boards and Commissioners. The recommendations align to the goals and the primary drivers.

Diagram 1 – The ten audit indicators/primary drivers
The full NACEL Driver Diagram is available here.

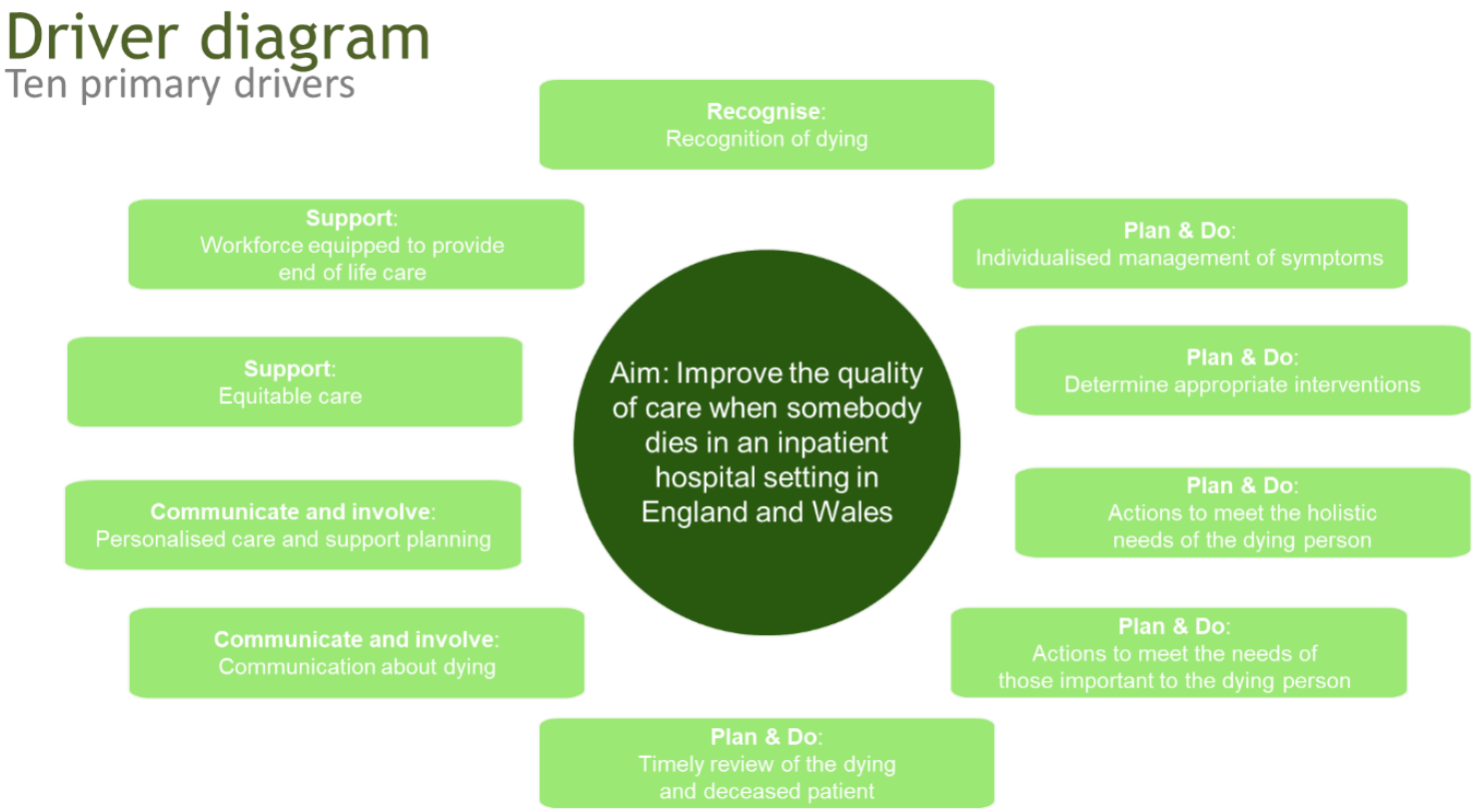


Table 1 – The HIP Goals

Table 1 illustrates the 5 NACEL improvement goals. The table shows how the goals are linked to the ten primary drivers and therefore helps to identify where improvement activity may be needed. Alignment to the audit recommendations featured in the State of the Nations Report and the latest data and measures used to support improvement are also shown in Table 1. Appendix 2 articulates the specific audit metrics mapped against the HIP goals that can be used to measure success.

We acknowledge the distinction between quality assurance and quality improvement goals. However, it is felt that both types of goals can support improvement work. The NACEL is committed to supporting improvement in all organisations, as such a year-on-year improvement is considered important for all the identified quality markers.

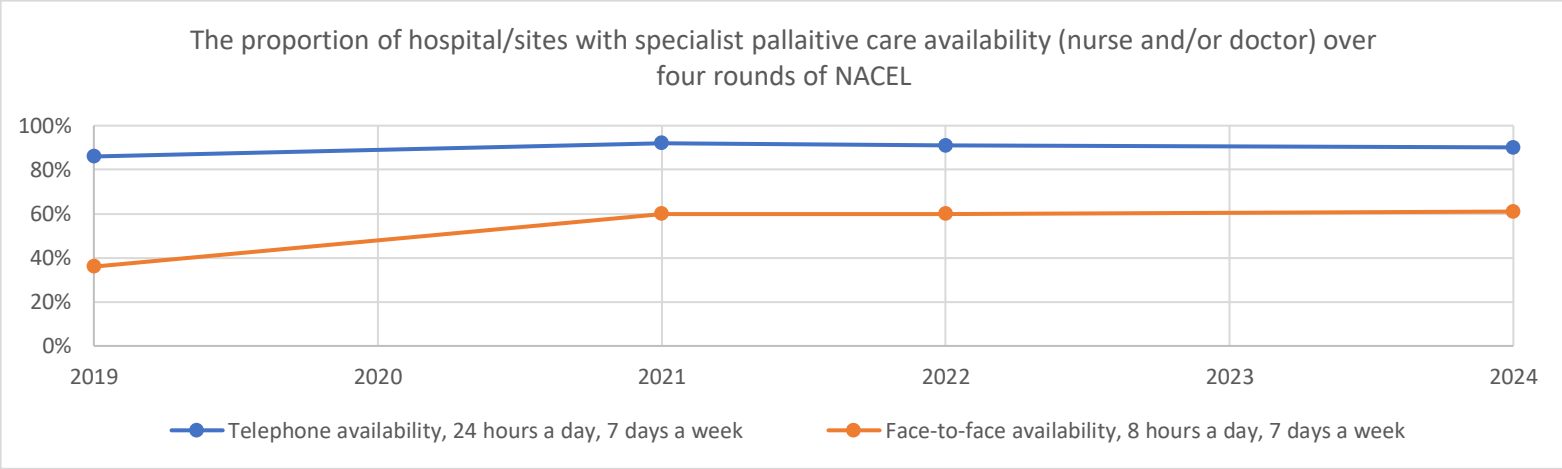
NACEL HIP Goal 1: Improvement in the proportion of people with an **individualised plan of care**, that identifies and addresses key issues for the dying person and those important to them**, to the extent they wish.**	
Quality assurance or improvement	Quality Improvement
Primary Driver	**Communicate and involve:** Personalised care and support planning
Rationale and previous NACEL evidence	Every person nearing the end of their life where dying was expected or recognised should have a holistic individualised end of life care plan that captures the needs and wishes of the dying person, further taking into account the views of those important to them. **Evidence from NACEL 2022** ○ **76%** of people who were recognised as dying had an individualised plan of care ○ The proportion of people who had documented assessments and evidence of management of different components of these plans was variable ○ **54%** of Bereavement Survey respondents agreed there was a plan of care which took into account the individual's wishes and requirements. **Evidence from NACEL 2024** ○ **84%** of people who were recognised as dying had an individualised plan of care ○ The proportion of people who had documented assessments and evidence of management of different components of these plans was variable ○ **55%** of Bereavement Survey respondents agreed there was a plan of care which took into account the individual's wishes and requirements.

NACEL 2024 recommendation	**Recommendation 3:** Integrated care boards, health boards and commissioners should lead on collaborative improvement initiatives to increase the number of personalised care and support planning conversations, including advance care planning conversations, offered to patients. Further ensuring planning is shared across the system, including with the inpatient teams. **Recommendation 5**: Integrated care boards, health boards and commissioners should consider system level initiatives aimed at increasing the uptake and quality of end-of-life care training.

Measure and timeframe	A year-on-year increase in the:
	• proportion of deaths where it was expected that the person would die during the final admission as a proportion of the sample of 'all deaths' included in the audit
	• proportion of patients who had an individualised plan of care
	• proportion of patients with holistic individualised care plans that:
	  ○ Identify and address symptom and comfort levels, nutrition & hydration, communication, psychological, spiritual, cultural, practical, social needs, to the extent the person wishes.
	  ○ Involve those important to the dying person.
	  ○ Demonstrate adequate, sensitive & timely communication in line with the dying person's wishes.
	  ○ Take into account previously expressed wishes, including by assessing any advance care planning wishes and decisions against current circumstance.
	
	The Data and Improvement Tool (DIT) is a quality improvement tool which provides information about how well areas of care are assessed and addressed. Applying data filters such as whether dying is expected or recognised and/or whether an individualised plan of care was used can help organisations understand whether these impact on care in key areas:
	1. Assessment of symptoms and comfort levels
	2. Hydration
	3. Communication
	4. Cultural and spiritual needs
	5. Personalised care and support
	
	See Appendix 2 for the specific audit metrics that can be used to measure success against improvement goal 1.

NACEL HIP Goal 2: Improvement within each organisation and nationally in understanding the **needs of those important** to the dying person.	
Quality assurance or improvement	Quality Improvement
Primary Driver	**Plan & Do**: Actions to meet the needs of those important to the dying person

Rationale and previous NACEL evidence	The needs of families and others identified as important to the dying person should be actively explored, respected and met as far as possible (*One Chance To Get It Right*, 2014). A bereaved persons' focus groups was used to help develop the bereavement survey (previously known as the NACEL quality survey). The Date and Improvement Tool presents information about the care of the bereaved person from the case note review and the bereavement survey. This enables providers to compare information from the case note review and the bereavement survey responses to compare and understand the needs of those important to the dying person, and gaps in practice. **Evidence from NACEL 2022:** • **57%** of bereavement survey respondents report they were asked about their needs. • **32%** of bereavement survey respondents report they were given enough spiritual, religious and cultural support. **Evidence from NACEL 2024:** • **41%** of clinical notes had documented evidence of an assessment of the spiritual, religious, cultural needs of those important to the dying person, or where not possible a reason was recorded. • **46%** of bereavement survey respondents report they were given enough spiritual, religious and cultural support, where this was required.
NACEL 2024 recommendation	**Recommendation 4:** Integrated care boards, health boards and commissioners should ensure that high quality end of life care is equitable and tailored to the needs of the local population by recognising and actively addressing current inequities across the local system.
Measure and timeframe	A year-on-year increase in the proportion of: • bereaved people who are asked about their needs. • bereaved people who are given enough spiritual, religious and cultural support. • bereaved people rating the care and support provided by the hospital as excellent or good. • spiritual, religious and cultural needs assessment of those important to the dying person documented in the clinical notes. • conversations about hydration options with those important to the dying person documented in the clinical notes. See Appendix 2 for the specific audit metrics that can be used to measure success against improvement goal 2.
NACEL HIP Goal 3: Improvement in access to **specialist palliative care** 8 hours a day, 7 days a week and a 24-hour advice line service.	
Quality assurance or improvement	Quality Assurance
Primary Driver	**Plan & Do**: Timely review of the dying and deceased patient

Rationale and previous NACEL evidence	Access to specialist palliative care in hospitals for holistic assessment, advice and active management is essential to the delivery of good care for people who die in inpatient settings. As defined by NHSE in their ICB commissioning specification Adequate access to specialist palliative care services means specialist palliative medical and nursing cover face-to-face, 9am-5pm, 7 days a week and a 24-hour telephone advice service (taken from *One Chance To Get It Right,* 2014). This would most often be provided by palliative care nurse specialists face-to-face supported by specialist palliative care medical telephone advice. **Evidence from NACEL 2022:** ○ 98% of hospital providers had access to specialist palliative care services. ○ Of those providers, 60% had access to face-to-face specialist palliative care services 8 hours a day, 7 days a week. ○ Of those providers, 91% had access to telephone specialist palliative care services 24 hours a day, 7 days a week. **Evidence from NACEL 2024:** ○ 97% of hospital providers had access to specialist palliative care services. ○ Of those providers, 61% had access to face-to-face specialist palliative care services 8 hours a day, 7 days a week. ○ Of those providers, 90% had access to telephone specialist palliative care services 24 hours a day, 7 days a week. 
NACEL 2024 recommendation	**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.
Measure and	A year-on-year increase in:

timeframe	○ Access to specialist palliative care services ○ Availability of the specialist palliative care services, face to face & telephone availability See Appendix 2 for the specific audit metrics that can be used to measure success against improvement goal 3.
NACEL HIP Goal 4: Improvement in equitable care that is tailored to the needs of the local population	
Quality assurance or improvement	Quality Assurance and Quality Improvement
Primary Driver	**Support**: Equitable Care; Support**:** Workforce equipped to provide end of life care
Rationale and previous NACEL evidence	NACEL 2024 provided the first information and analysis of NACEL data with a focus on equitable care. Following consultation, the focus in this NACEL contract period relates to understanding and addressing health care inequalities based on ethnicity. Since the NACEL relates to a sample of care of people who die, local data analysis should be mindful of sample size if undertaking subgroup analysis by ethnicity (this will vary across localities). NACEL 2024 data did demonstrate inequalities of care for people of different ethnicities. Organisations are encouraged to look at their data using filters for different ethnicities, to identify priority areas for local work. **Evidence from NACEL 2024 (Baseline data achieved)** ○ 86% of the clinical case notes included documentation of the patient's ethnicity. ○ 14% reported ethnicity as either not stated or unknown. The 2024 national report defines some of the areas where inequality by ethnicity has been: ○ The clinical case notes sampled often showed the largest difference in care for patients whose ethnicity was reported as 'Unknown'. Discussions about hydration options were documented less often for patients of Unknown ethnicity (51%) compared to the national average (62%), or where not possible a reason was recorded ($p<0.01$). ○ The overall rating of care for patients of Asian (64%), Black (64%), Mixed (64%), Other Minority Ethnic Groups (58%) and Unknown ethnicity (59%) were less likely to be recorded as excellent or good by bereaved people, compared to patients of White ethnicity (76%) ($p<0.01$). ○ The bereavement survey feedback showed that hospital staff were least likely to communicate sensitively with those important to the dying person, when the dying person was of Asian ethnicity (69%), Undisclosed ethnicity (61%) or Other Minority Ethnic Groups (56%), compared to the national average of 83% ($p<0.01$).
NACEL 2024 recommendation	**Recommendation 4**: Integrated care boards, health boards and commissioners should ensure that high quality end of life care is equitable and tailored to the needs of the local population by recognising and actively addressing current inequities across the local system. **Recommendation 5:** Integrated care boards, health boards and commissioners should consider system level initiatives aimed at increasing the uptake and quality of end-of-life care training.
Measure and	A year-on-year increase in:

timeframe	• Documentation of the patient's ethnicity • Proportion of bereaved people who rate care they receive as good or excellent. • Proportion of spiritual, cultural, religious need assessments of bereaved family members. • Proportion of inpatient staff that are confident in responding to the needs of those important to the dying person. The Data and Improvement Tool (DIT) can be used to examine whether performance at the end-of-life changes depending on the following patient characteristics: 1. Age 2. Ethnicity 3. Primary language spoken See Appendix 2 for the specific audit metrics that can be used to measure success against goal 4.
NACEL HIP Goal 5: Improvement in the number of organisations that have system level/HB oversight of their quality improvement and education plans relating to end of life care	
Quality assurance or improvement	Quality Assurance
Primary Driver	**Support**: Workforce equipped to provide end of life care
Rationale and previous NACEL evidence	Local quality improvement and education plans are key to improving care. This includes ensuring the workforce is adequately trained. Quality improvement plans should be developed locally in response to the NACEL data and shared outside of the organisation, to promote a systems approach to quality improvement. This goal has been refined following NACEL 2024 with a focus on improving the sharing of organisation QI plans at a system level. **Evidence from NACEL 2024:** ○ **81%** of hospital/sites have a quality improvement plan relating to end of life care ○ **12%** of hospital/sites were currently planning a quality improvement plan relating to end of life care ○ **7%** of hospitals had no plan and no current plan to develop one ○ Of those hospital/sites with a quality improvement plan (81%), **74%** had shared these plans with the ICB/Health Board in the past three years
NACEL 2024 recommendation	**Recommendation 1:** Integrated care boards, health boards and commissioners should ensure system level oversight of provider quality improvement plans relating to end of life care.
Measure and timeframe	A year-on-year increase in: ○ the number of quality improvement plans at an organisational level (including education)

	○ the number of quality improvement plans which are fed into Integrated Care Systems/Health Boards See Appendix 2 for the specific audit metrics that can be used to measure success against improvement goal 5.

3. IMPROVEMENT METHODS

All levels	○ The **NACEL driver diagram** describes actions that will impact on good quality end of life care. The driver diagram can be found at https://www.nacel.nhs.uk/quality-improvement. ○ The use of **quarterly data** enables the impact of improvements to be measured locally through trajectories on the tool. ○ **Statistical input** informs outputs and where appropriate, results are presented with confidence intervals and statistical significance, including the frequency and granularity of reporting. ○ The **Data and Improvement Tool** is the main programme output. It helps to identify improvement opportunities by benchmarking at differing system levels, from local to national, accessible to those with varying literacy in interpreting data: https://data.nacel.nhs.uk The tool is still evolving, partly in response to feedback from users. The tool acts as a mechanism to monitor and report achievement against improvement goals. The tool includes all available NACEL metrics from 2024 – present. Characteristics of the tool include: ○ The results shown in the online tool name the individual hospital/site to support shared learning (The tool is accessible to participants, ICBs and others with third party access. For more information about publicly accessible results, refer to the "Patient and Carer Tool" below. ○ Ability to peer group the data (by type of provider, by country & by region). ○ Ability to apply filter options (by types of deaths, age, ethnicity, primary language spoken, reviewed by SPC/EoLC team, individualised plan of care, staff feedback group). ○ Data updated continuously ○ Enables users to review the data for their organisation, compared to regional and national averages. ○ Extraction of data/charts ○ Timeseries format to allow users to easily identify trends or issues. ○ Compliant data results are summarised and presented in Power BI dashboard views, mapped to the primary drivers for improving care at the end of life. ○ **State of the Nations Report** includes the summary of the national findings on the current state of care at the end-of-life care across England, Wales and Jersey —highlighting progress, challenges, areas for improvement and national recommendations. ○ A **Patient and Carer Tool** to help patients, families, and carers understand how care at the end of life is delivered in hospitals across different parts of the UK. The data tool is interactive to enable users to explore five key areas on care at the end of life at a national and regional level. During 2026, additional data will be reported in the tool and presented at hospital/site level (development is ongoing).

	○ Ten **Key Indicators** have been identified by the NACEL Team and NACEL Steering Group as the audit headline metrics to support quality improvement in care at the end of life – See Appendix 3. ○ The **Communications Strategy** helps to identify differing audiences, **stakeholders** and forums enabling the dissemination of insight and resources according to the audience receiving them. This will help identify key audiences central to achieving the improvement goals. In 2024 NACEL were awarded as an audit hero for 'Communicating for Impact' https://www.hqip.org.uk/clinical-audit-heroes-awards-2025 ○ Development of **Forums and events** co-facilitated in partnership with key national quality improvement and end of life care colleagues as well as end users. The aim of these will be to share quality improvement ideas and questions and celebrate success. This will include case studies, Good Practice Compendiums and the creation of networks, groups and spaces to support quality improvement. This will be responsive to need and the NACEL results and utilise patient and public involvement where possible. ○ To celebrate success, the hospitals selected for the **NACEL Good Practice Compendium** receive a certificate, with examples of excellence in practice being acknowledged and put forward to other QI competitions (for example, NQICAN audit heroes). In 2024, University College London Hospital were awarded as an audit hero for 'Influencing Change' following this NACEL process. https://www.hqip.org.uk/clinical-audit-heroes-awards-2025/
National (and international)	• **National End of Life Clinical Leadership** – NHSE and the Welsh Government will engage 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). In addition, Jersey representative is in place. These individuals are members of the NACEL Steering Group and actively engage with the audit. • **National Strategy and Stakeholders -** Within England, The Ambitions Partnership and National End-of-Life care Programme at NHSE are key bodies that NACEL is engaged with and who will disseminate the recommendations from NACEL. The NACEL recommendations are discussed at the National Quality Board to inform national strategy. The NACEL team has established good working relationships with a number of ICBs via the MacMillan ICB Transformation Leaders network to support them in their use of NACEL data and intelligence within the system at each level, to inform local quality and service improvement plans which in turn helps the delivery of the national PEOLC Delivery Plan. Within Wales, the National Palliative Care Implementation Board and the Welsh Government are key players to disseminate the messages from NACEL. • **National Regulatory Bodies -** CQC/HIW (Health Inspectorate Wales) will be encouraged to work with hospitals, requesting evidence of local action plans from NACEL findings. Metrics will need to be agreed with CQC and HIW to inform this process, with emphasis placed upon the metrics which present the most opportunity for providers to undertake quality improvement opportunities. Outliers will also be flagged to these bodies. • **Linkages with other national and international programmes of work.** Links are established with other end of life programmes to create and make use of effective partnerships, share and collaborate where possible. The aim of this is to ensure no duplication of work, consider data burden for audit participants and bereaved carers and ensure strategic linkage of findings including quality improvement recommendations.
Regional	• Described under 'all levels'.
Local	• Feedback on performance ○ All participants in NACEL have the ability to access the online **benchmarking Data and Improvement Tool** containing all metrics collected. The ten key indicators (shown in Appendix 3) and associated results are summarised in a visually accessible way. Key areas will be presented clearly, for example in radial plots, so that local and national quality improvement work can be targeted. ○ All underlying data is available for Trusts/Health Boards/ ICBs to access and interrogate in various ways through the data and improvement tool. ○ Providing support to outlier Trusts/Health Boards/ ICBs with helping them define their action plan, for example uploading templates on the NACEL portal.

	○ Providing support to Trusts/Health Boards/ ICBs struggling to improve, for example via email contact and meetings were requested. • Improvement tools ○ The Data and Improvement Tool is able to filter results to help identify improvement opportunities. For example, helping organisations and staff understand specific gaps in the discussion, planning and delivery of an individualised end of life care plan. ○ Signposting and providing **QI resources, tools and training** supports organisations to address improvement opportunities identified by the tool ; https://www.nacel.nhs.uk/qi-about ○ The NACEL data specifications are available for use as a template questionnaire for providers to adapt for local use (with permission from HQIP). There will be strong encouragement for any adaptations to feed into a central group so learning can be shared, and recommendations aligned and strengthened. ○ Narrative examples of local quality improvement plans are collected and published in the Good Practice Compendium. • Improvement workshops and collaboratives ○ Targeted engagement methods that will be used to support quality improvement. Workshops/ a series of events will be co-facilitated with quality improvement and end of life care colleagues using structured QI methodology to support quality improvement. This will be responsive to need and the NACEL results. Registration for NACEL events available here: www.nacel.nhs.uk/events ○ NACEL has a new community of practice hosted by the Q Community which is in development and aims to support improvement in end-of-life care in hospitals. • Individuals in frontline roles partaking in QI projects. ○ It is the ongoing intention of future iterations of NACEL to support frontline staff in being more familiar with NACEL data using communications to increase presence and reputation to reach this audience. ○ The NACEL driver diagram articulates how individuals in frontline positions should be supported to undertake QI end of life projects with measures associated to drive this. ○ An online community of practice hosted by the Q community as described above, signposting of QI resources, tools and training will support individuals.

3.1 Patient and Public Involvement

During 2023/4, NHSBN engaged with a group of bereaved people with lived experience of care at the end of life for adults in hospitals in England and Wales to inform the redesign of the audit. This took the form of three focus groups to discuss:

1. The overarching re-design of the audit with particular focus on aim, drivers and metrics.
2. The NACEL Bereavement Survey review and development, and
3. Audit outputs including public facing report and the Healthcare Improvement Plan.

One participant from this group recorded his experiences as a video to be shared for improvement work : https://www.nacel.nhs.uk/patients-and-carers-voice .

In 2025, NHSBN held a further PPI exercise in 2 stages to support the development of an online public facing too which is due to be released in the summer of 2025.

By incorporating this feedback at the centre of improvements, NACEL can better align with the needs and preferences of those receiving end-of-life care, and those important to them. A further PPI exercise to review NACEL more widely is due to be undertaken in 2026.

3.2 Communications

The improvement plan will be communicated to stakeholders, providers, patients and the public in varying means. As a summary the following communications will be adopted with the following:

<table>
<tr><td>Keep Satisfied Stakeholders

Provide project assurance on deliverables via:
Updates to scheduled meetings</td><td>Manage Closely Stakeholders

Provide detailed updates and consult stakeholders about changes via:
NHSBN hosted platform with update and alert functions
Regular meetings</td></tr>
<tr><td>Monitor Stakeholders

Provide high-level updates via:
Attendance at any annual events as appropriate (Kings Fund)
Engagement with events e.g. NQICAN
Presence on email updates distribution lists
Membership to specialist groups (e.g. NQICAN)
Annual newsletter</td><td>Keep informed Stakeholders

Provide high-level and targeted updates via:
Quarterly newsletter
Attendance at events (Palliative Care Congress (PCC)/International Summer school)
Participation & outputs for events (academic posters at PCC, speaker slots, etc.)
Engagement with events e.g. Dying Matters week (Hospice UK)</td></tr>
<tr><td colspan="2">ALL
Website
Social media platforms (e.g. X/Twitter)
Newsletter
Webinars/education events/communities of practice
NHSE Futures Platform with NACEL dedicated area
Online community of practice via Q Community</td></tr>
</table>

4. EVALUATION

The Healthcare Improvement Plan will be reviewed annually to ensure the improvement goals, measures and activities are having the desired impact and remain valid. It will be approved by the NACEL Steering Group initially. Ongoing evaluation of the NACEL Healthcare Improvement Plan will take place via the following avenues:

- NACEL Steering Group and Advisory Group
- HQIP Contract Review Meetings
- Feedback from audit participants
- Bereaved Persons' Focus Group analyses and feedback.
- Google analytics with regard to website, Data and Improvement Tool, number of enquiries, number of members in QI community of practice, once developed.
- Analysing data over time against improvement goals and indicators

An evaluation of the impact of NACEL can be found in the following documents:

- NACEL 2025 Impact Report
- NACEL 2025 Impact Report – QI in focus

5. Appendices

Appendix 1 – Category 1 and 2 death definitions

- **Category 1:** It was expected that the patient would die during their final admission in hospital. Life sustaining treatments may still be being offered in parallel to end of life care.

- **Category 2:** It was not expected that the patient would die during their final admission in hospital - 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.

Appendix 2: NACEL metrics mapped to HIP Goals.

The table below shows the specific audit metrics mapped against the HIP goals that can be used to measure success. There are four data collection methods across NACEL: the case note review, bereavement survey, staff survey and hospital site survey. For full details, please refer to www.nacel.nhs.uk.

Goal 1: Improvement in the proportion of people with an individualised plan of care, that identifies and addresses key issues for the dying person and those important to them, to the extent they wish.		
Case Note Review	**Bereavement Survey**	**Staff Survey**
• Is there documented evidence of timely escalation to the specialist palliative care/ end of life care team, if the ward team were unable to address a dying person's needs? (2024) • Is there documented evidence that the patient's symptoms were reviewed? (2024) • If the patient had physical symptoms, is there documented evidence that possible actions were discussed with the patient? (2024) • If actions were agreed, is there documented evidence that they were implemented? (2024) • Is there documented evidence of the review of food/ nutrition options in the last days of life? (2024) • Is there documented evidence of review of hydration options in the last days of life? (2024 & 2025) • Is there documented evidence of communication about hydration with the patient? (2024 & 2025) • Is there documented evidence of communication about hydration with those important to the dying person? (2024 & 2025) • Is there documented evidence of an assessment of the communication needs of the patient? (2024) • Is there documented evidence that staff sought to address the communication needs of the patient? (2024) • Is there documented evidence of an assessment of the emotional/psychological needs of the patient? (2024 & 2025) • Is there documented evidence that staff sought to address the emotional/psychological needs of the patient? (2024 & 2025) • Is there documented evidence of an assessment of the spiritual/religious/cultural needs of the patient? (2024 & 2025) • Is there documented evidence that staff sought to address the spiritual/religious/cultural needs of the patient? (2024 & 2025) • Is there documented evidence of an assessment of the social and practical needs of the patient? (2024 & 2025) • Is there documented evidence that staff sought to address the social and practical needs of the patient? (2024 & 2025) • Is there documented evidence that the patient who was dying had an individualised plan of care addressing their end-of-life care needs? (2024 & 2025)	• The person was given enough pain relief. (2024 & 2025) • The person had enough relief of symptoms other than pain (such as nausea, breathlessness, or restlessness) (2024 & 2025) • Staff at the hospital made a plan for the person's care which considered the person's needs and wishes. (2024 & 2025) • The person had support to eat or receive nutrition if they wished. (2024 & 2025) • The person had support to drink or receive fluid if they wished. (2024 & 2025) • Staff tried to provide care for the person's emotional needs (e.g., feeling low, feeling worried, feeling anxious). (2024 & 2025) • The hospital staff regularly checked and addressed the person's needs (e.g., emotional, spiritual, cultural, religious, social, or practical needs) (2024) • Staff tried to provide care for the person's spiritual, religious and cultural needs (2025)	• I am confident I have the skills to involve the dying patient and those important to them in decisions about end-of-life care in line with their wishes and preferences (2024) • I am confident to respond to the practical and social needs of the dying person (2024) • I am confident to respond to the spiritual, emotional, and cultural needs of the dying person (2024) • I am confident in my ability to discuss hydration options with dying patients and those important to them (2024) • I am confident in assessing and managing patient pain and physical symptoms at the end of life (2024) • I am confident in adapting and delivering care, so it is sensitive to an individual's cultural needs (2024)

• Is there documented evidence that the patient participated in personalised care and support planning (advance care planning) conversations? (2024 & 2025) • Is there documented evidence that the patient was reviewed by a member of the specialist palliative care team/end of life care team during their final admission? (2025) • What was the date of referral to the specialist palliative care/end of life care team? (2025) • What was the time of referral to the specialist palliative care/end of life care team? (2025) • Is there documented evidence of a review of the patient's pain? (2025) • Is there documented evidence that actions to address pain were implemented? (2025) • Is there documented evidence of a review of the patient's agitation/delirium? (2025) • Is there documented evidence that actions to address agitation/delirium were implemented? (2025) • Is there documented evidence of a review of the patient's dyspnoea/breathing difficulty? (2025) • Is there documented evidence that actions to address dyspnoea/breathing difficulty were implemented? (2025)		

Goal 2: Improvement within each organisation and nationally in understanding the needs of those important to the dying person.

Bereavement Survey • I was asked about my needs (e.g., emotional, spiritual, cultural, religious, social, or practical needs). (2024) • Staff tried to provide me with emotional help and support. (2024 & 2025) • Staff tried to provide me with practical support (e.g., with finding refreshments and parking arrangements). (2024 & 2025) • Staff tried to provide me with spiritual/religious/cultural support to meet my needs. (2024 & 2025) • I was supported by hospital staff after the person had died (e.g., signposting to bereavement services, offered emotional/cultural/spiritual support). (2024 & 2025)	**Staff Survey** • I am confident to respond to the practical and social needs of those important to the dying person, including after death (2024) • I am confident to respond to the spiritual, emotional, and cultural needs of those important to the dying person, including after death (2024)

Goal 3: Improvement in access to specialist palliative care 8 hours a day, 7 days a week and a 24-hour advice line service.

Staff Survey • I am supported by the specialist palliative care team that the hospital has access to, when addressing specific end of life care needs for dying patients (2024)	**Hospital Site Survey** • Does your hospital/site have dedicated specialist palliative care beds? (2024 & 2025) • Does your hospital/site have access to a Specialist Palliative Care service? (2024 & 2025) • Is the face-to-face specialist palliative care service (doctor and/or nurse) available 8 hours a day, 7 days a week? (2024 & 2025) • Is the telephone specialist palliative care service (doctor and/or nurse) available 24 hours a day, 7 days a week? (2024 & 2025) • Total medical staff in the Specialist Palliative Care Team as of 31st March 2024 (PAs) (2024 & 2025) • Total nursing staff in the Specialist Palliative Care Team as of 31st March 2024 (WTE in post) (2024 & 2025) • Total AHP staff in the Specialist Palliative Care Team as of 31st March 2024 (WTE in post) (2024 & 2025) • Total other staff in the Specialist Palliative Care Team as of 31st March 2024 (WTE in post) (2024 & 2025)

Goal 4: Improvement in the organisational measurement of equity of care delivered to a dying person and those important to them.

Case Note Review

- Age (in years, at the time of death) (2024 & 2025)
- Ethnicity (2024 & 2025)
- What was the person's religion or faith? (2024 & 2025)
- What was the person's primary language spoken? (2024 & 2025)
- Is there documented evidence that where the patient's spoken language is not the national primary language[s], the team have accessed an interpreter, or suitable alternative, to ensure that the patient was able to be communicated with? (2024 & 2025)
- Is there documented evidence that where those important to the patient's spoken language is not the national primary language[s], the team have accessed an interpreter, or suitable alternative, to ensure that those important to the patient were able to be communicated with? (2024 & 2025)
- Is there documented evidence of timely escalation to the specialist palliative care/ end of life care team, if the ward team were unable to address a dying person's needs? (2024)
- What was the date of review by the specialist palliative care/end of life care team? (2025)
- What was the time of review by the specialist palliative care/end of life care team? (2025)

Bereavement Survey

- The person was offered an interpreter or other language support so they could communicate with staff (2024 & 2025)
- Were you offered an interpreter or other language support so you could communicate with staff? (2024 & 2025)
- What did the person who died regard as their ethnicity? (2024 & 2025)
- What do you regard as your ethnicity? (2025)

Hospital Site Survey

- Does the hospital/site routinely record whether the patient is from the following communities: prisoner (2024 & 2025)
- Does the hospital/site routinely record whether the patient is from the following communities: refugee (2024 & 2025)
- Does the hospital/site routinely record whether the patient is from the following communities: gypsy or traveller (2024 & 2025)
- Does the hospital/site routinely record whether the patient is from the following communities: vulnerably housed (2024 & 2025)

Goal 5: Improvement in the number of organisations that implement quality improvement plans, including relating to education, within their organisation, shared with their ICS/HB.

Staff Survey

- I am supported to engage in quality improvement (QI) projects and training specific to end of life care (2024)

Hospital Site Survey

- For the following specialist palliative care staff, is there time for quality improvement work? Medical staff (2024)
- For the following specialist palliative care staff, is there time for quality improvement work? Nursing staff (2024)
- For the following specialist palliative care staff, is there time for quality improvement work? AHP staff (2024)
- For the following specialist palliative care staff, is there time for quality improvement work? other staff (2024)
- Has your hospital/site implemented quality improvement (QI) plans relating to end of life care in the past 3 years? (2024 & 2025)
- Have these been shared with your ICB/Health Board? (2024 & 2025)

Appendix 3: NACEL 10 key indicators

Ten key indicators are identified by the NACEL Team and NACEL Steering Group as the audit headline metrics to support quality improvement in care at the end of life.

No.	NACEL key indicator	Data source
1.	The number of deaths where it was expected that the person would die during the final admission as a proportion of the sample 'all deaths' included in the audit	Case Note Review
2.	The proportion of people who died with documented evidence in their clinical records of communication about hydration with those important to the dying person, or a reason recorded why not	Case Note Review
3.	The proportion of people who died with documented evidence in their clinical records that anticipatory medication was prescribed for symptoms likely to occur in the last days of life	Case Note Review
4.	The proportion of people who died with documented evidence in their clinical records of an assessment of the spiritual/religious/cultural needs of the person, or a reason recorded why not *(This is a new key indicator for 2026. In previous years, the focus was on emotional/psychological needs)*	Case Note Review
5.	The proportion of bereaved people that rated the overall care and support given to themselves and others by the hospital as excellent or good	Bereavement Survey
6.	The proportion of hospital/sites with a face-to-face specialist palliative care service (doctor and/or nurse) available 8 hours a day, 7 days a week *(Hiatus on reporting indicator in 2026, but will be re-included in 2027)*	Hospital/Site overview
7.	The proportion of bereaved people that strongly agree or agree that they were communicated to by staff in a sensitive way	Bereavement Survey
8.	The proportion of people who died who had an individualised plan of care addressing their needs at the end of life, where it was recognised that the person may die during the final admission	Case Note Review
9.	The proportion of people who died with ethnicity documented in their clinical records	Case Note Review
10.	The proportion of staff respondents who strongly agree or agree that within the area they work there is a culture that prioritises compassion and support as fundamental in all interactions with dying patients and those important to them *(Hiatus on reporting indicator in 2025, but will be re-included in 2026)*	Staff Reported Measure