National Care at the End of Life (NACEL) results guide

- CQC and HQIP have collaborated with the NACEL and agreed to present these 'key' metrics about the quality of services
- The audit report may also be reviewed if necessary here

What this measures & rationale for inclusion	Interpretation	CQC prompts for follow-up
The proportion of deaths where it was recognised that the patient may die imminently (Category 1) out of Category 1 and Category 2 deaths (effective)		
The percentage of deaths where it was recognised that the patient may die (category 1) out of all deaths. All deaths consist of category 1 deaths and category 2 deaths (where the patient was not expected to die but hospital staff were "not surprised" that the patient died). It is important that imminent death is recognised in a timely way. Timeliness in recognising imminent death underpins the priorities for improving the experience of end-of-life care in the last few days and hours of the dying person's life.	Higher proportions indicate better performance. Providers (with 10 or more cases) with a proportion of Category 1 deaths below 2 standard deviations are worse than expected, and providers with proportions lower than 3 standard deviations from the mean are classified as an outlier. Likewise, providers who are 2SD higher are better than expected, and those who are 3SD higher are much better than expected. Outlier analysis is conducted and runs separately for acute and community providers. It may not always be possible to recognise imminent death, for example when there is little time between admission to death. Sudden deaths are excluded from NACEL, including deaths in A&E and deaths within 4 hours of admission.	People approaching the end of life should be identified in a timely way. Identifying imminent death earlier and documenting this allows more time to plan the patients care and meet the specific needs and preferences for the patient and those important to them. Category 2 deaths may indicate a missed opportunity to identify imminent death. Sudden deaths are excluded from NACEL. NACEL recommends that Medical Directors and Nursing Directors should: Ensure that staff are aware of the possibility or likelihood of imminent death, and that staff acknowledge and communicate to the dying person and people important to them as early and sensitively as possible. Staff should have be aware of the importance of recognising uncertainty and communicating uncertain prognosis early in hospital admission and continuing conversations with patients and those important to them at all stages. Ensure that patients who have signs and symptoms that suggest they may be in the last days of life are monitored for change. Furthermore, medical notes can be checked for person-centred care plans and symptom observations; monitoring for change does not necessarily mean that the patient is having vitals observations checked regularly. Can staff members access relevant training to support this?
Is the face to face specialist palliative care service (doctor and/or nurse) available 8 hours a day, 7 days a week? (effective)		
This shows the availability of the specialist palliative care team the hospital/inpatient site service accesses. This team can be based within or outside the hospital depending on SPCT access arrangements. National guidance reinforces the need for providers to work with	Organisations answer whether they have access to face-to-face specialist palliative care service 8 hours a day, 7 days a week by Nurse and/or Doctors. 'Yes' is considered to meet the standard. 'No' is worse performance. No outlier analysis is done on this metric.	Hospitals should be able to make prompt referral to, and gain input from, specialist palliative care services for patients that require this. Reasons why some hospitals may not have access to specialist palliative care services 8 hours a day, 7 days a week face to face include: recruitment issues; local service model

<table>
<tr><td>commissioners to ensure access to an adequately resourced SPC workforce.
'Adequate' means that service providers and commissioners are expected to ensure provision for specialist palliative medical and nursing cover routinely 9am –5pm seven days a week and a 24-hour telephone advice service.</td><td>This metric aligns with Priority 5 from One Chance to Get it Right, 2014.</td><td>won't support this/not commissioned; operational problems.
Executive Boards should: Ensure adequate access to specialist palliative care in hospitals for holistic assessment, advice and active management. 'Adequate' means specialist palliative medical and nursing cover 9am to 5pm, 7 days a week and a 24-hour telephone advice service. This is often provided by palliative care nurse specialists face-to-face supported by specialist palliative care medical telephone advice. Where this service does not exist, an action plan committing to provision of such services within a specified timeline should be developed.</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">Is there documented evidence that the patient who was dying had an individualised care plan addressing their end of life care needs (Category 1 deaths only)? (responsive)</td></tr>
<tr><td>The percentage of patients recognised to be dying (Category 1) with a personalised plan of care documented, which covered their specific end of life care needs such as food and drink, symptom control, psychological, social and spiritual support.
The five priorities for care of the dying person make clear that there must be an individualised plan of care. The plan for end of life care should be documented and should be part of other care planning processes.</td><td>Auditors are asked to indicate whether there was documented evidence of an individualised plan of care personalised to the patient's needs. This plan of care does not need to be a separate document to the general clinical and nursing care.
A higher percentage of individualised plans of care indicates better performance.
Providers (with 10 or more cases) with a percentage of patients that had an individualised care plan addressing their needs below 2 standard deviations are worse than expected, and providers with proportions lower than 3 standard deviations from the mean are classified as an outlier. Likewise, providers who are 2SD higher are better than expected, and those who are 3SD higher are much better than expected.
Outlier analysis is conducted and runs separately for acute and community providers.
This metric aligns with Priority 5 from One Chance to Get It Right, 2014 and Statement 3 & 4 from NICE QS144.</td><td>It is important the patient can discuss their needs, wishes and preferences and for this to be listened to and followed by those caring for them where possible. Documentation of the individualised plan of care is vital for this to be accessible to staff providing the care.
If the patient lacks capacity, involvement from NOK/family should be sought to create an individualised care plan.
Executive Boards should: Ensure that people who are recognised to be dying have a clearly documented and accessible individual plan of care developed and discussed with the dying person and those important to them to ensure the person's needs and wishes are known and taken into account. The plan will be based on the holistic care standards set out in the five priorities for care (One Chance To Get It Right, 2014) and NICE Quality Standards and take into account previously expressed wishes. Documentation for the individual plan of care may vary locally and may be part of standard care plans. Mechanisms to ensure the communication and coordination of this plan must be in place, especially at handover of care.
If the target is not being met, is there evidence of QI being undertaken to improve service?</td></tr>
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NOK: Next of Kin
QI: Quality Improvement
SPC: Specialist Palliative Care
SPCT: Specialist Palliative Care Team

Version	Live date	Author	Details
20221208	08/12/22	MR	Content provided by NACEL here, reviewed by VOB and EA here.

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