National Audit of Care at the End of Life

England & Wales
Acute & Community Providers
Bespoke dashboard

April 2019

First round of audit dashboard (2018/19)

NC013 - The Royal Wolverhampton NHS Trust -
The Royal Wolverhampton Hospital NHS Trust

Contents

1. Introduction

The National Audit of Care at the End of Life (NACEL) was commissioned in October 2017 by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government. Delivery of the audit is managed by the NHS Benchmarking Network (NHSBN), supported by a multi-disciplinary Steering Group and Advisory Group. Dr Suzanne Kite, Consultant in Palliative Medicine, and Elizabeth Rees, Lead Nurse for End of Life Care, Leeds Teaching Hospitals NHS Trust, provide joint clinical leadership of the audit.

The overarching aim of NACEL is to improve the quality of care of people at the end of life in acute, mental health and community hospitals. The audit monitors progress against the *five priorities for care* set out in *One Chance To Get It Right* and *NICE Guideline (NG31) and Quality Standards (QS13 and QS144).*

Components of NACEL
The first round of the audit, taking place in 2018/19, included three components:

An organisational level audit, which covered trust/UHB and submission level questions relating to 2017/18 data. Participants were able to set up 'submissions' for separate sites (e.g. hospitals).

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). The following categories of deaths were included:

> **Category 1:** It was recognised that the patient may die - it had been recognised by the hospital staff that the patient may die imminently (i.e. within hours or days). Life-sustaining treatments may still be being offered in parallel to end of life care.
>
> **Category 2:** The patient was not expected to die - 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.

Deaths which are classed as "sudden deaths" were excluded from the Case Note Review. These were deaths which were sudden and unexpected; this included, but was not limited to, the following:

- all deaths in Accident and Emergency departments
- deaths within 4 hours of admission to hospital
- deaths due to a life-threatening acute condition caused by a sudden catastrophic event, with a full escalation of treatment plan in place. These deaths would not fall into either category 1 or 2 above.

Acute providers were requested to complete up to 80 Case Note Reviews, with participating organisations being asked to ensure the number of case notes reviewed was no less than 5% of the total annual deaths.

A Quality Survey was developed with the assistance of the Patients Association. The survey was designed to gain feedback from relatives, carers and those close to the person who died on their experiences of the care and support received at the end of life. The Quality Survey is linked to the Case Note Review, so that the same deaths were covered.

2. Project outputs

Bespoke dashboard

This bespoke dashboard presents the results for the submission (hospital site) shown in the table below. The table shows the components of the audit in which you participated, together with the number of Case Note Reviews you completed and the number of Quality Surveys that were returned for this submission. A bespoke dashboard is available for each of the submissions registered by your organisation.

Code	Organisation Name	Submission Name	Peer Group	Trust / UHB	Hospital / Site	Case note review	Quality survey
NC013	The Royal Wolverhampton NHS Trust	Whole organisation	Acute	Y	Y	80	-

This dashboard compares the results for your submission to all acute and community hospitals in England and Wales taking part in the first round of NACEL. Results from the three elements of the audit are presented together. The following key is used in the chart titles to show the source of each indicator:

- T/UHB = trust/UHB organisational level audit
- H/S = hospital/submission organisational level audit
- CNR = Case Note Review
- QS = Quality Survey

The information is presented thematically in nine sections, covering the *five priorities for care* and other key issues. The themes are**:**

1. Recognising the possibility of imminent death
2. Communication with the dying person
3. Communication with families and others
4. Involvement in decision making
5. Needs of families and others
6. Individual plan of care
7. Families' and others' experience of care
8. Governance
9. Workforce/specialist palliative care

The full list of indicators shown in this dashboard, the number of responses to each possible answer and the number of responses used in the denominator, for both the whole sample result and for your submission result, are included at Appendix 5.

Additional information, comparing your submission to the national position on patient demographics, characteristics of deaths in hospitals and use of interventions, is provided at Appendices 1 to 3.

In reviewing the results in this dashboard, it should be noted that the total number of Quality Surveys returned was 790, representing 7% of the Case Note Reviews completed (11,034). The Quality Survey results may not therefore, be representative of the whole Case Note Review sample.

Other audit outputs

In addition to this bespoke dashboard, participants will have access to the following outputs for the first round of NACEL:

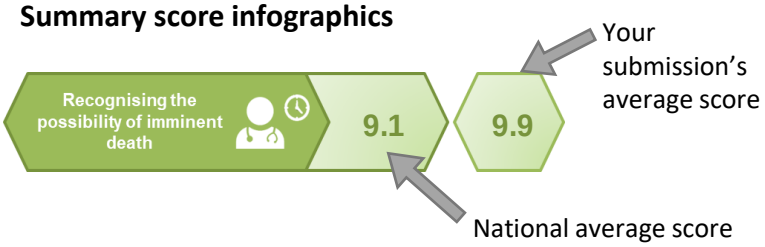
- Online toolkit accessible via the members' area of the NHSBN website. The final version of the toolkit is now available.
- An audit report for the first round of the audit covering England and Wales, acute, community and mental health providers will be published following approval by the audit funders, NHS England and the Welsh Government. This report will include the NACEL recommendations.

The results from the NACEL data reliability study are available via the NACEL webpages.

3. Guidance on using the report

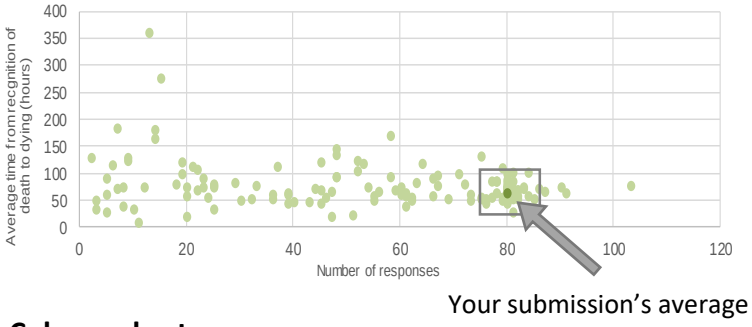
Data within this report is displayed in a number of formats. An example of each format, alongside a brief description is provided below. Please note, the 'national average' is the mean average for all acute/community, English and Welsh NACEL submissions and 'your submission's average/submission's result' relates to the submission shown on the front page of this report. If data for the corresponding metric was not provided during data collection for your submission, then no position will be highlighted or a dash will be displayed.

Summary score infographics



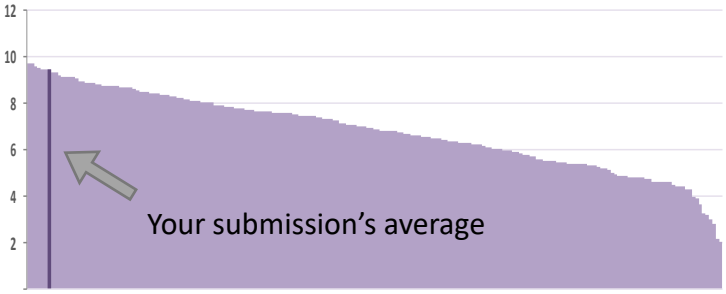
A summary score infographic is provided for each theme within report. The value in the main body of the infographic is the national average score and the value provided in the separate box on the right is the submission's average score.

Scatter chart



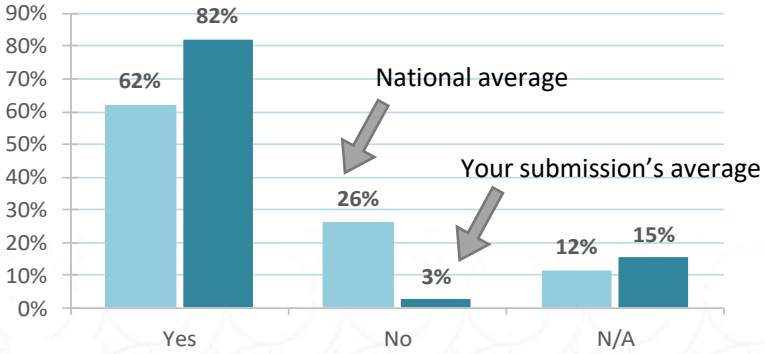
Each point within the scatter chart shows the mean average position for each acute/community, English and Welsh NACEL submission. Your submission's result is highlighted in a darker shade.

Column charts



Each column within the column chart shows the average result for each acute/community, English and Welsh NACEL submission. Your submission's result is highlighted in the darker shade.

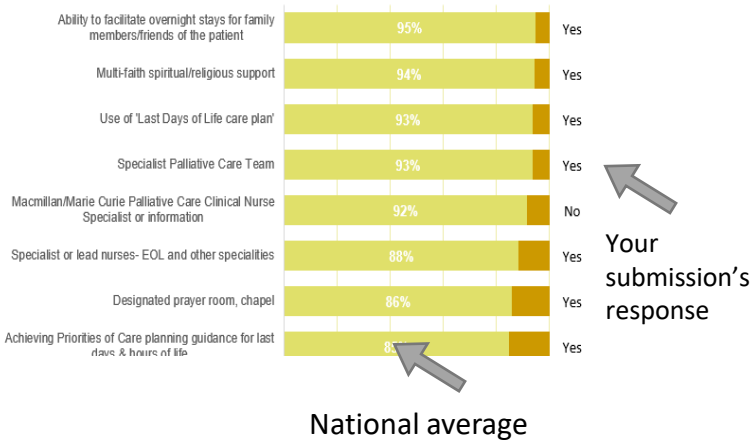
Dual column charts



Within the dual column charts, the lighter shaded column (left) shows the national average and the darker shaded column (right) provides your submission's average.

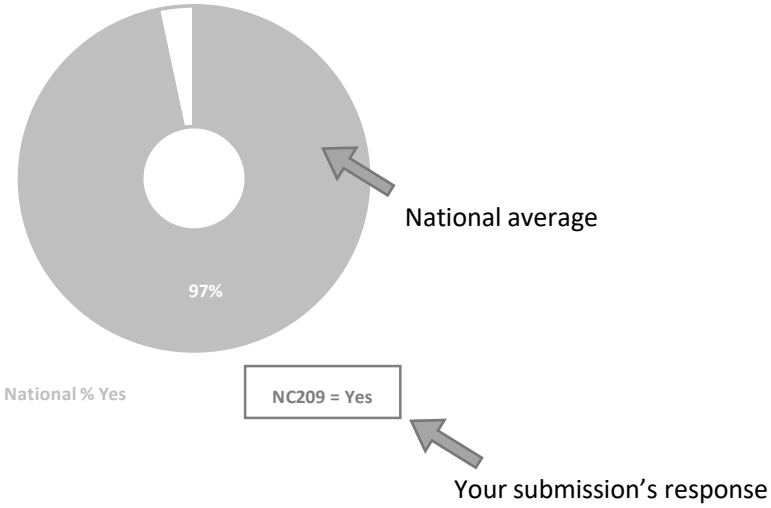
3. Guidance on using the report

Stacked bar chart



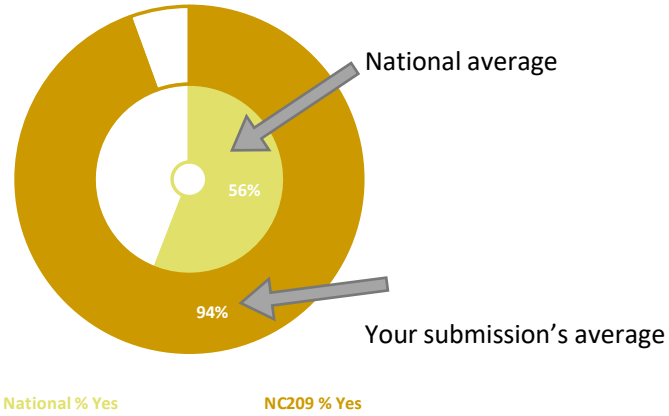
The stacked bar chart shows the national average percentage split for all NACEL participants and your submission's responses are provided in a list next to the chart.

Donut charts



Donut charts are used when the submission's result is a single response, e.g. 'Yes/No' (typically in the organisational level audit). The national average percentage split between the text responses is shown on the chart and your submission's response is shown in the legend below the chart.

Dual donut charts



Dual donut charts are used when the submission's result is a percentage calculated from multiple responses (typically from the Case Note Review). The national average is shown on the inner ring of the chart and your submission's average is shown on the outer ring.

4. Summary scores

For each theme, a summary score has been developed and calculated for each submission/hospital site. The summary scores allow easy comparison between hospitals on the different themes within the audit. Not every hospital submission has received a full set of summary scores. To receive a full set, hospitals were required to provide completed responses for the Governance and Workforce/specialist palliative care summary score component indicators from the organisational level audit, five or more Case Note Review responses for each component indicator and five or more Quality Survey responses.

Note that the mean summary scores for the different themes should not be compared with each other, as they have been calculated from different elements of the audit and are derived by different methods.

Under each theme in this dashboard, the component indicators of the summary score for the theme are shown, together with other relevant indicators from all sections of the audit. Appendix 4 sets out the process undertaken to select the nine key themes and their component indicators, and an explanation of how the scores are calculated. Each summary score can only use indicators from one element of the audit.

Figure 1: National summary scores compared with submission summary scores

	National summary score	Submission summary score
Recognising the possibility of imminent death	9.1	9.9
Communication with the dying person	6.9	8.0
Communication with families and others	6.6	7.7
Involvement in decision making	8.4	9.7
Needs of families and others	6.1	8.5
Individual plan of care	7.4	8.5
Families' and others' experience of care	7.1	-
Governance	9.5	10.0
Workforce/specialist palliative care	7.6	5.8

5.1 Recognising the possibility of imminent death

The importance of early recognition that a person may be dying imminently is emphasised in *One Chance To Get It Right,* and the *NICE Quality Standard 144.*

Priority 1: This possibility [that a person may die within the next few days or hours] is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly *(One Chance To Get It Right).*

NICE QS144: Adults who have signs and symptoms that suggest they may be in the last days of life are monitored for further changes to help determine if they are nearing death, stabilising or recovering (*Statement 1, NICE Quality Standard 144).*

Early recognition that a person may be dying enables an individual care plan to be developed, appropriate discussions with the patient and families to take place, treatment decisions to be made and the needs of the family to be considered. It underpins all the priorities for improving people's experience of care in the last few days and hours of life.

Recognising the possibility of imminent death: summary score

The summary score for recognising the possibility of imminent death is calculated using information collected in the Case Note Review:

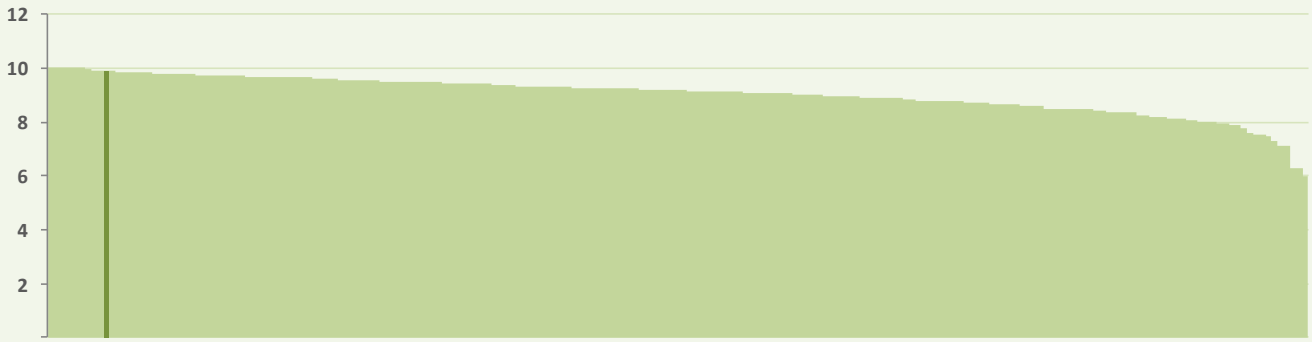
Documented evidence:

- of recognition that the patient may die imminently
- the possibility the patient may die discussed with the patient
- the possibility the patient may die discussed with families/others

The range of hospital mean summary scores for recognising the possibility of imminent death is shown in figure 2. The mean value of the summary score across the whole sample of case notes is 9.1 (n=10,002) and, if available, your submission's value is shown in the infographic above.

It should be noted that the summary score, for technical reasons, does not capture the timeliness of recognition of the possibility that the person may die and may therefore give an overly positive indication of progress on this key priority. Timeliness of recognition is shown in figure 8.

Figure 2: Hospital mean summary score: Recognising the possibility of imminent death



Range 6.0 – 10.0

5.1 Recognising the possibility of imminent death

Summary score component indicators

Figure 3: (CNR) Documented evidence of recognition that the patient may die imminently

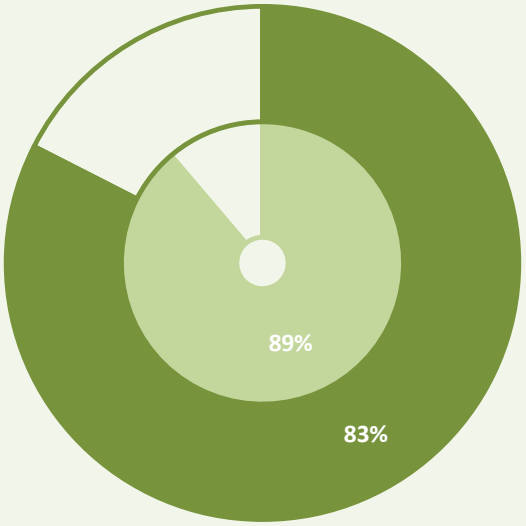


Figure 4: (CNR) Documented evidence the possibility the patient may die discussed with the patient

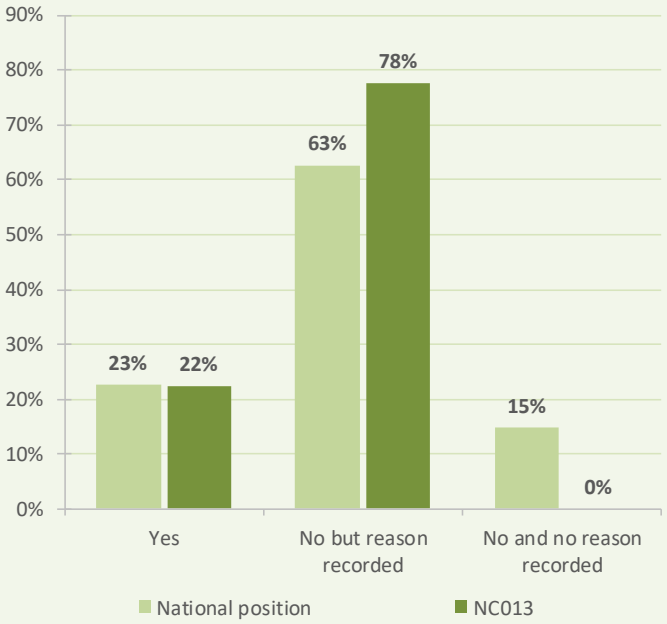
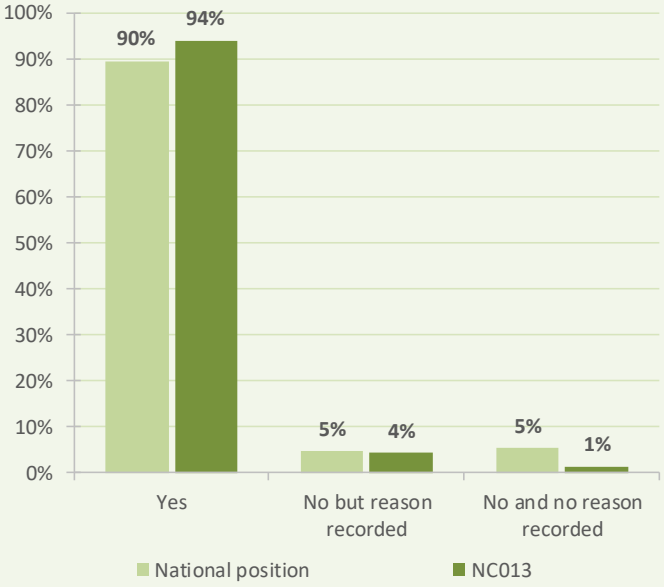


Figure 5: (CNR) Documented evidence the possibility the patient may die discussed with families/others



5.1 Recognising the possibility of imminent death

Additional indicators

Figure 6: (QS) Did a member of staff explain to the patient that they were likely to die?

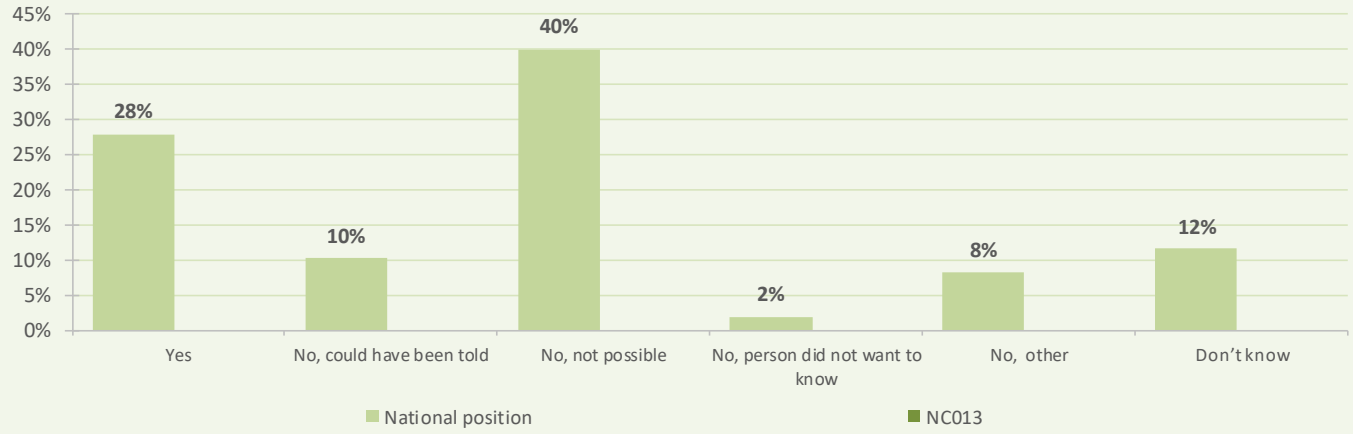


Figure 7: (QS) Did a member of staff explain to you that the patient was likely to die?

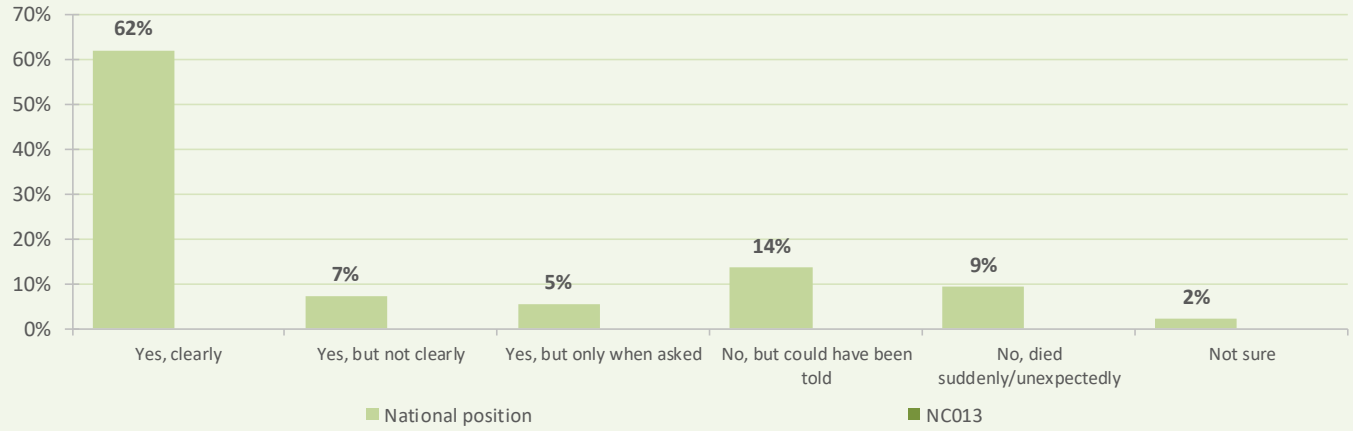
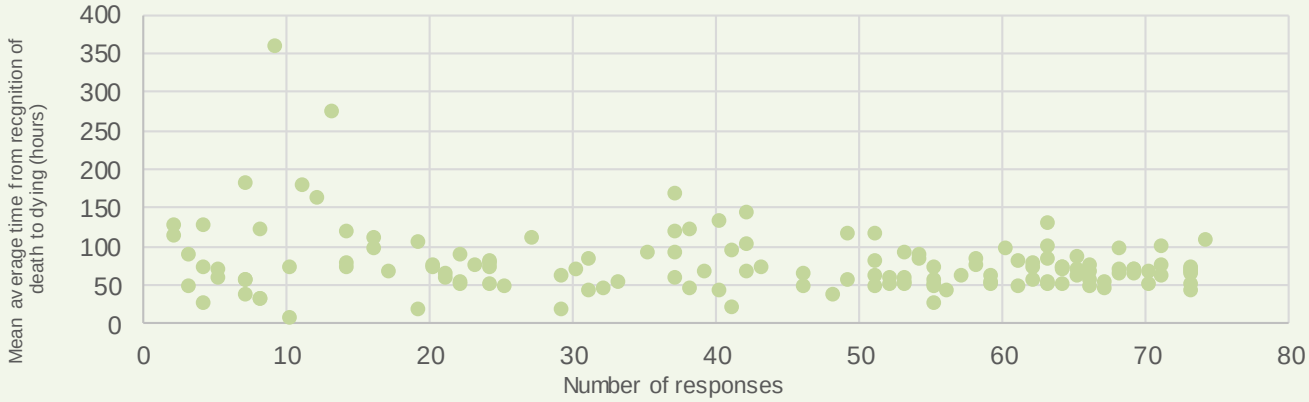


Figure 8: (CNR) Hours from first recognition of dying to death



	Count	Mean average time (hours)
National	8866	74

	Count	Mean average time (hours)
NC013	64	118

5.2 Communication with the dying person

Open and honest communication between staff and the person dying, and those identified as important to them, is critically important to good care. This section presents findings from the Case Note Review and organisational level audit on communication with the dying person. The perspective of those important to the patient on whether communication with the dying person was sensitive was collected in the Quality Survey and is considered in section 5.7, families' and others' experience of care.

Priority 2: Sensitive communication takes place between staff and the dying person, and those identified as important to them *(One Chance To Get It Right).*

NICE QS144: Adults in the last days of life, and the people important to them, are given opportunities to discuss, develop and review an individualised care plan (*Statement 2, NICE Quality Standard 144).*

Notes to Priority 3: The person, and those important to them, must be told who is the senior doctor in the team who has responsibility for their treatment and care, whether in hospital or in the community, and the nurse leading their care *(One Chance To Get It Right).*

In this bespoke dashboard, communication with the dying person and communication with families and others, are reviewed separately, in this and the next section.

Communication with the dying person: summary score

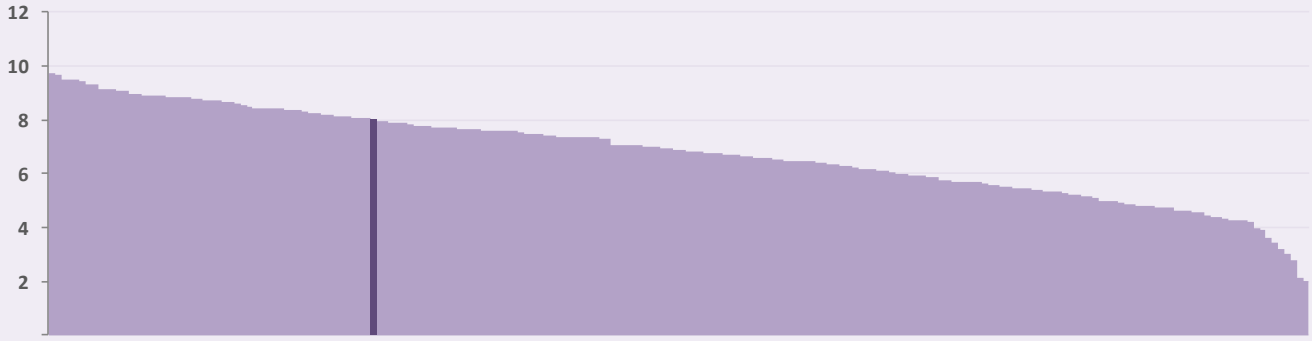
The summary score for communication with the dying person is calculated using information collected in the Case Note Review:

Documented evidence:

- the patient had the opportunity to be involved in discussing their plan of care
- the patient was informed of the professional responsible for their care
- the possibility of side effects of medication was discussed with the patient
- risks and benefits of hydration was discussed with the patient
- risks and benefits of nutrition was discussed with the patient

The range of hospital mean summary scores for communication with the dying person is shown in figure 9. The mean value of the summary score across the whole sample of case notes is 6.9 (n=8,831) and, if available, your submission's value is shown in the infographic above.

Figure 9: Hospital mean summary score: Communication with the dying person



Range 2.0 – 9.7

5.2 Communication with the dying person

Summary score component indicators

Figure 10: (CNR) Documented evidence the patient had the opportunity to be involved in discussing their plan of care

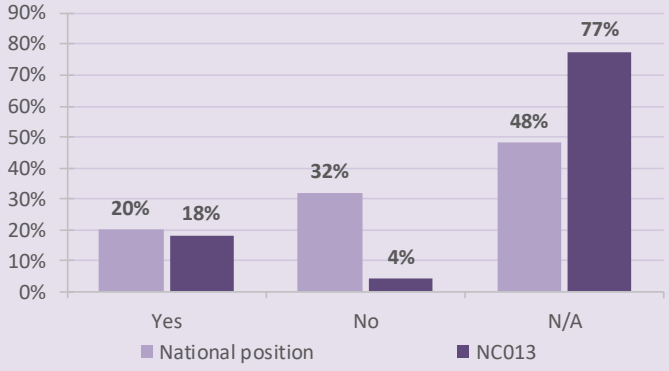


Figure 11: (CNR) Documented evidence the patient was informed of the professional responsible for their care

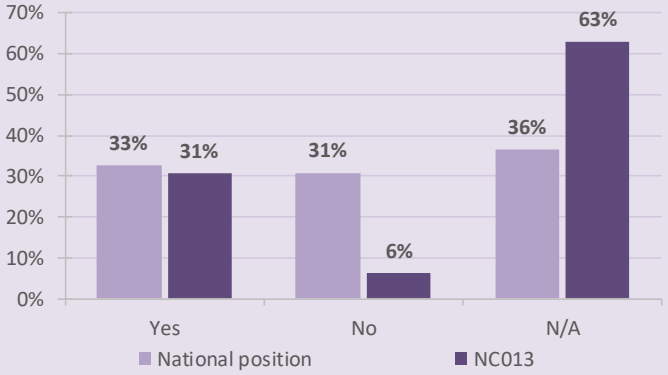


Figure 12: (CNR) Documented evidence the possibility of side effects of medication was discussed with the patient

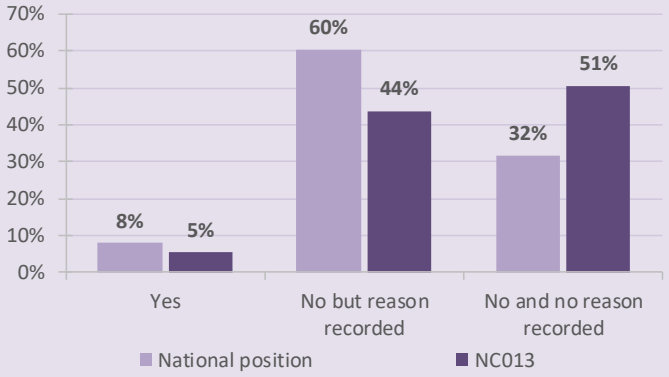


Figure 13: (CNR) Documented evidence risks and benefits of hydration was discussed with the patient

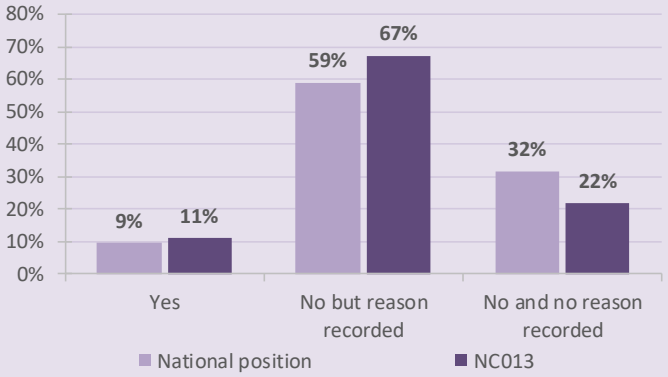
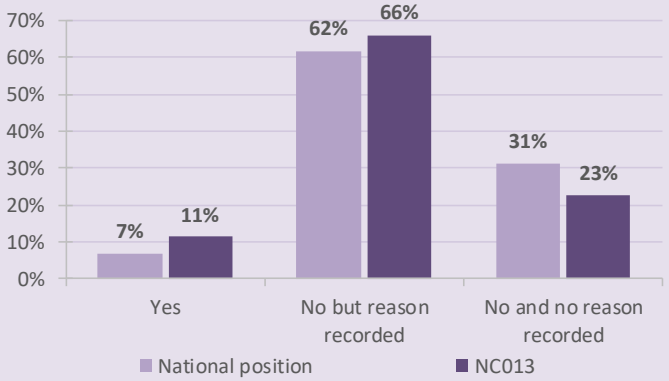


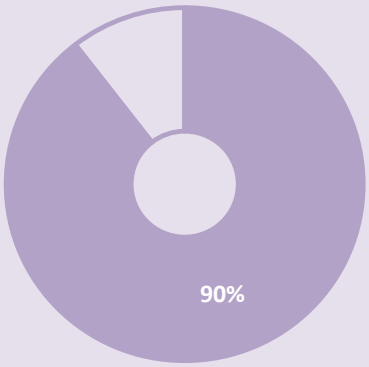
Figure 14: (CNR) Documented evidence risks and benefits of nutrition was discussed with the patient



5.2 Communication with the dying person

Additional indicators

Figure 15: (T/UHB) Guidelines to promote dignity



National % Yes

NC013 = Yes

5.3 Communication with families and others

As noted in section 5.2, open and honest communication between staff and the dying person, and those identified as important to them, is critically important to good care. In this section, findings from the Case Note Review, organisational level audit and Quality Survey, on communication with families and others, are presented.

Priority 2: Sensitive communication takes place between staff and the dying person, and those identified as important to them *(One Chance To Get It Right).*

NICE QS144: Adults in the last days of life, and the people important to them, are given opportunities to discuss, develop and review an individualised care plan (*Statement 2, NICE Quality Standards).*

Notes to Priority 3: The person, and those important to them, must be told who is the senior doctor in the team who has responsibility for their treatment and care, whether in hospital or in the community, and the nurse leading their care *(One Chance To Get It Right).*

Communication with families and others: summary score

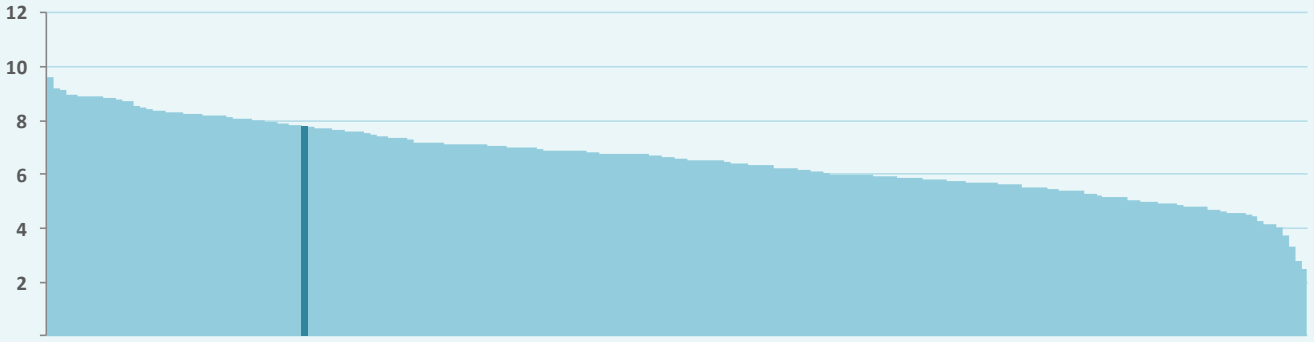
The summary score for communication with families and others is calculated using information collected in the Case Note Review:

Documented evidence:

- families/others had the opportunity to discuss the patient's plan of care
- families/others were notified of the professional responsible for the patient's care
- families/others were notified of the patient's imminent death
- the possibility of side effects of medication was discussed with families/others (weighting 0.33)
- risks and benefits of hydration was discussed with families/others (weighting 0.33)
- risks and benefits of nutrition was discussed with families/others (weighting 0.33)

The range of hospital mean summary scores for communication with families and others is shown in figure 16. The mean value of the summary score across the whole sample of case notes is 6.6 (n=8,622) and, if available, your submission's value is shown in the infographic above.

Figure 16: Hospital mean summary score: Communication with families and others



Range 2.5 – 9.6

5.3 Communication with families and others

Summary score component indicators

Figure 17: (CNR) Documented evidence families/others had the opportunity to discuss the patient's plan of care

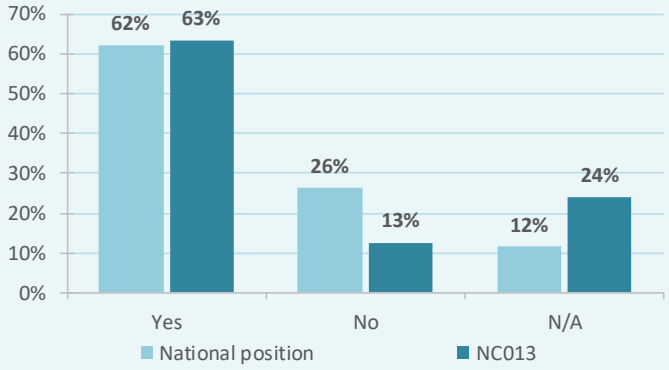


Figure 18: (CNR) Documented evidence families/others were notified of the professional responsible for patient's care

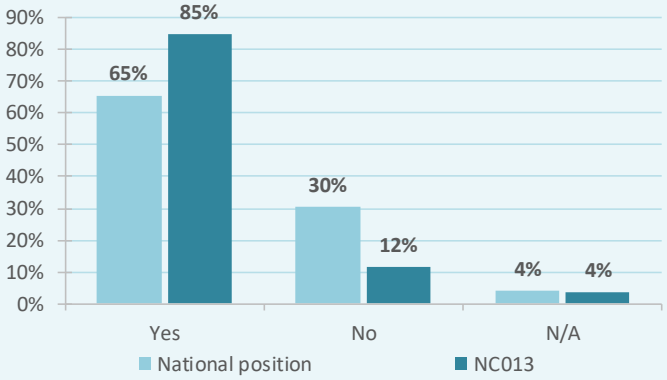


Figure 19: (CNR) Documented evidence families/others were notified of the patient's imminent death

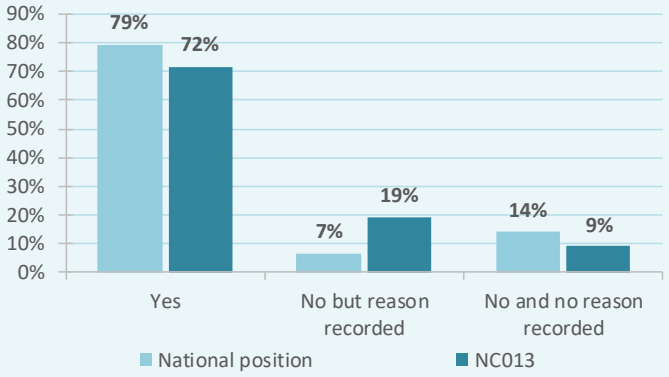


Figure 20: (CNR) Documented evidence the possibility of side effects of medication was discussed with families/others

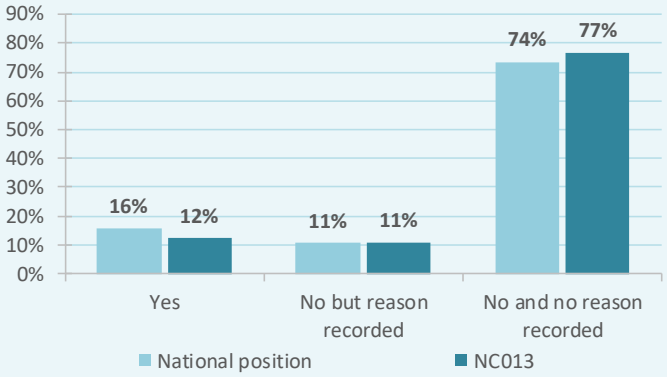


Figure 21: (CNR) Documented evidence risks and benefits of hydration was discussed with families/others

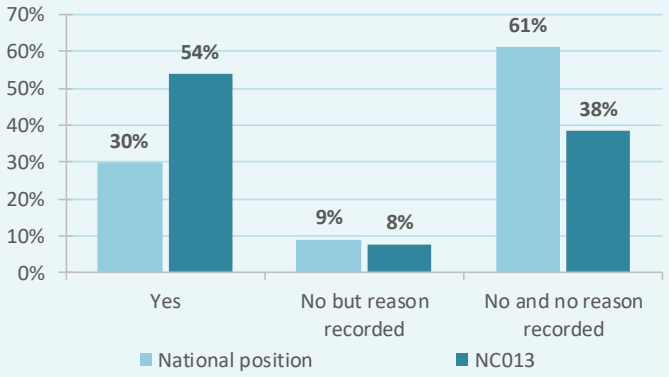
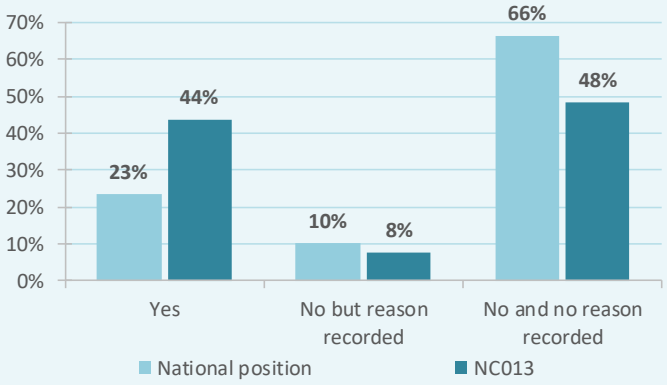


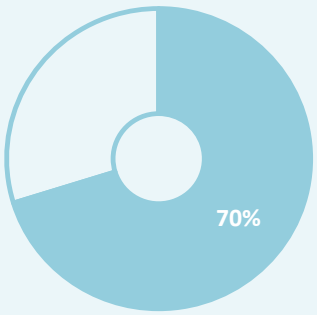
Figure 22: (CNR) Documented evidence risks and benefits of nutrition was discussed with families/others



5.3 Communication with families and others

Additional indicators

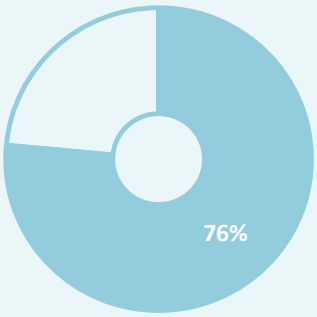
Figure 23: (T/UHB) Guidelines for meaningful and compassionate engagement with bereaved families and carers



National % Yes

NC013 = No

Figure 24: (H/S) Views from bereaved relatives' or friends' views sought during the last two financial years



National % Yes

NC013 = Yes

Figure 25: (QS) Did those close to the patient receive clear communication about imminent death soon enough to be there when the patient died?

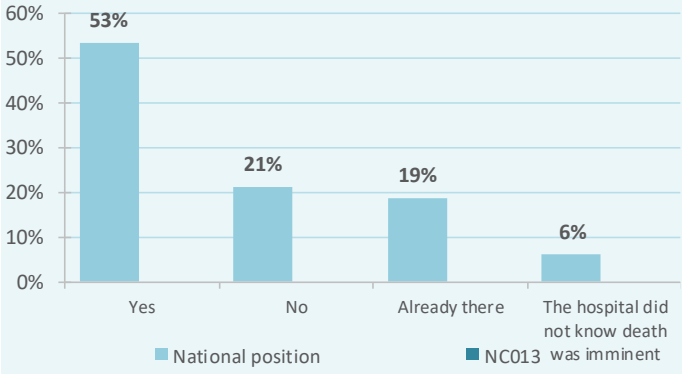


Figure 26: (QS) Were given the name of the doctor and nurse responsible for his/her care?

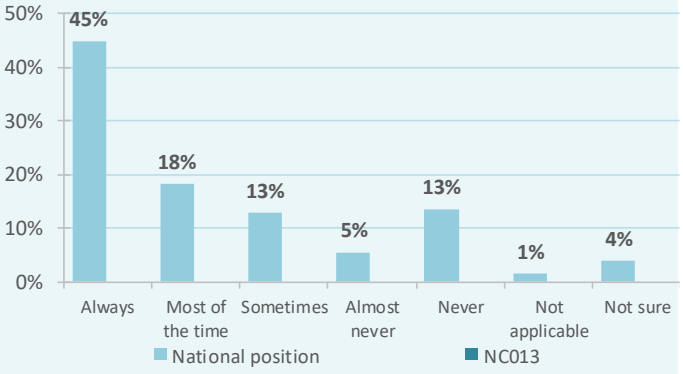


Figure 27: (QS) Did those close to the patient feel that they had enough opportunity to ask questions and discuss patient care?

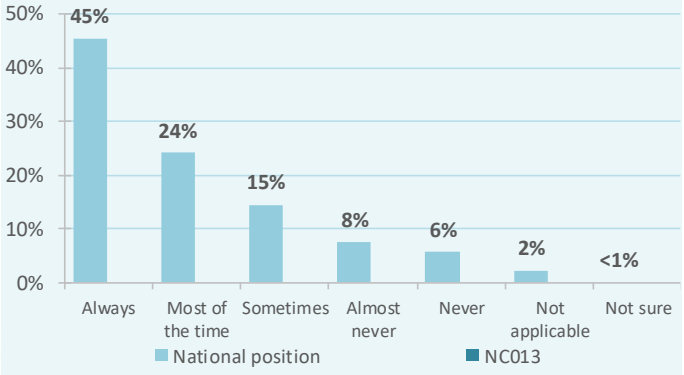
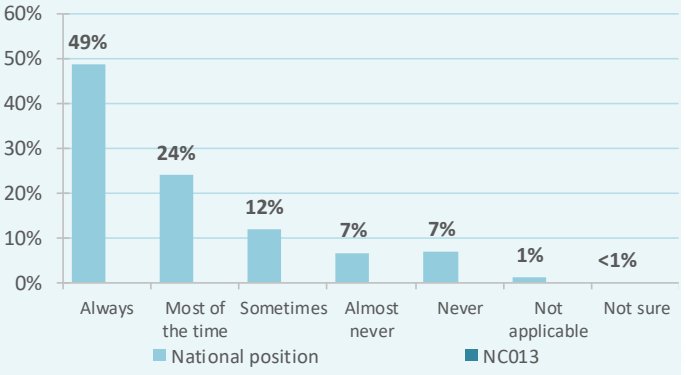


Figure 28: (QS) Did those close to the patient feel that they were kept informed by staff about the patient's condition?



5.4 Involvement in decision making

The right to be involved in decisions about your health and care, including your end of life care, is enshrined in the *NHS Constitution for England*. Where appropriate, this right includes the families and carers. In this section, the findings from the Case Note Review and Quality Survey on involvement in decision making are presented.

Priority 3: The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants (*One Chance To Get It Right*).

Notes to Priority 1: The goals of treatment and care must be discussed and agreed with the dying person, involving those identified as important to them and the multidisciplinary team caring for the person (*One Chance To Get It Right*).

Involvement in decision making: summary score

The summary score for involvement in decision making is calculated using information collected in the Case Note Review:

Documented evidence:

- the extent the patient wished to be involved in decisions about care
- the patient had capacity assessed to be involved in care planning
- life-sustaining treatments discussed with the patient
- life-sustaining treatments discussed with families/others
- a clinician discussed CPR with the patient
- a senior clinician discussed CPR with families/others

The range of hospital mean summary scores for involvement in decision making is shown in figure 29. The mean value of the summary score across the whole sample of case notes is 8.4 (n=9,170) and, if available, your submission's value is shown in the infographic above.

Figure 29: Hospital mean summary score: Involvement in decision making

Range 3.3 – 10.0

5.4 Involvement in decision making

Involvement in decision making	8.4	9.7

Summary score component indicators

Figure 30: (CNR) Documented evidence of the extent the patient wished to be involved in decisions about care

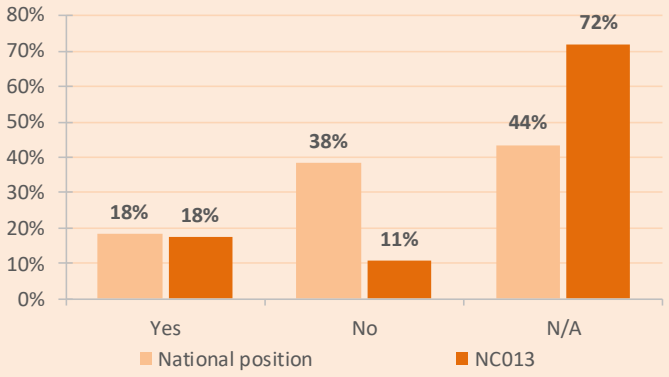


Figure 31: (CNR) Documented evidence the patient had capacity assessed to be involved in care planning

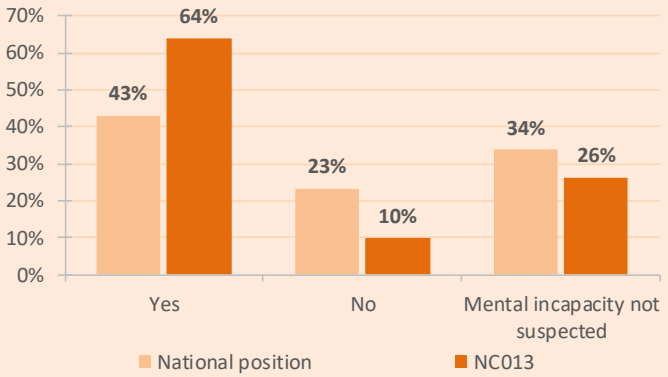


Figure 32: (CNR) Documented evidence life-sustaining treatments discussed with the patient

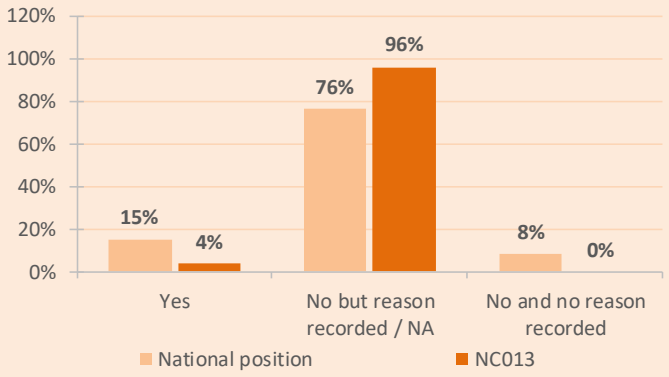


Figure 33: (CNR) Documented evidence life-sustaining treatments discussed with families/others

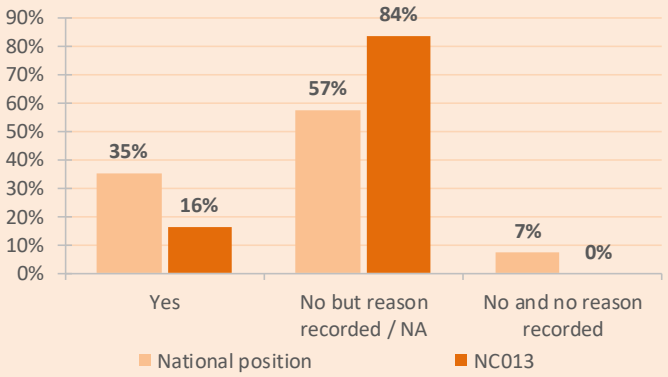


Figure 34: (CNR) Documented evidence a clinician discussed CPR with the patient

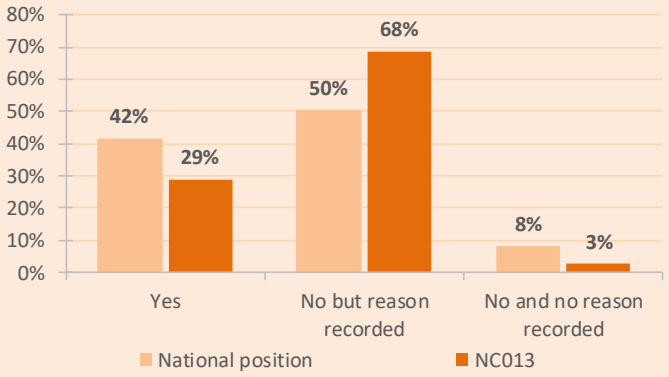
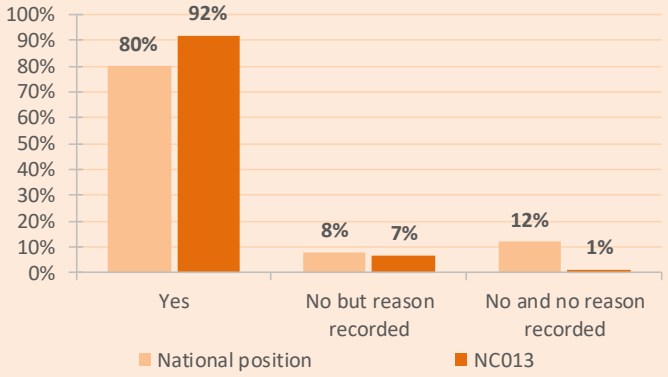


Figure 35: (CNR) Documented evidence a senior clinician discussed CPR with families/others



5.4 Involvement in decision making

Additional indicators

Figure 36: (QS) Did staff involve the patient in decisions about care and treatment?

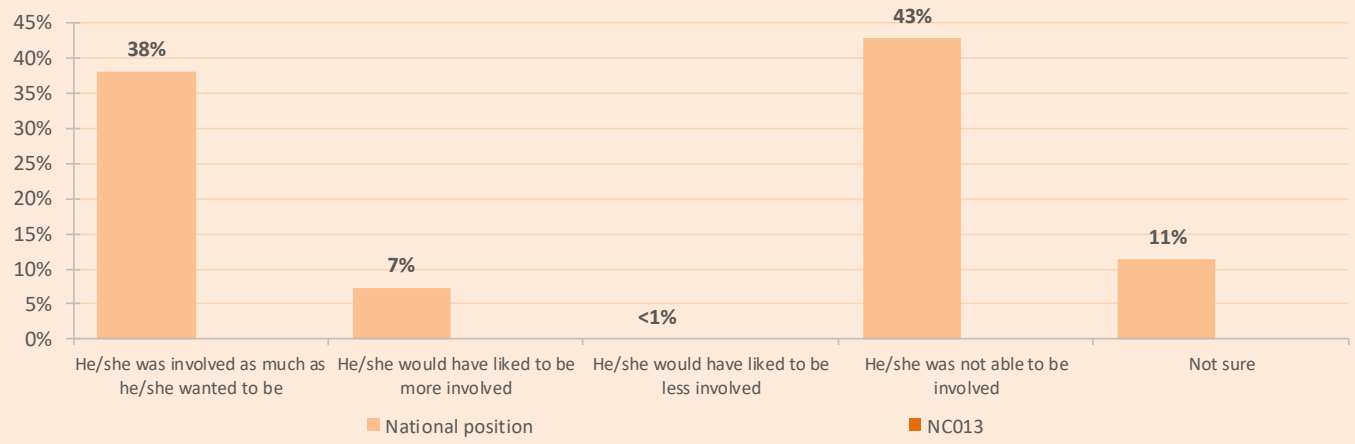
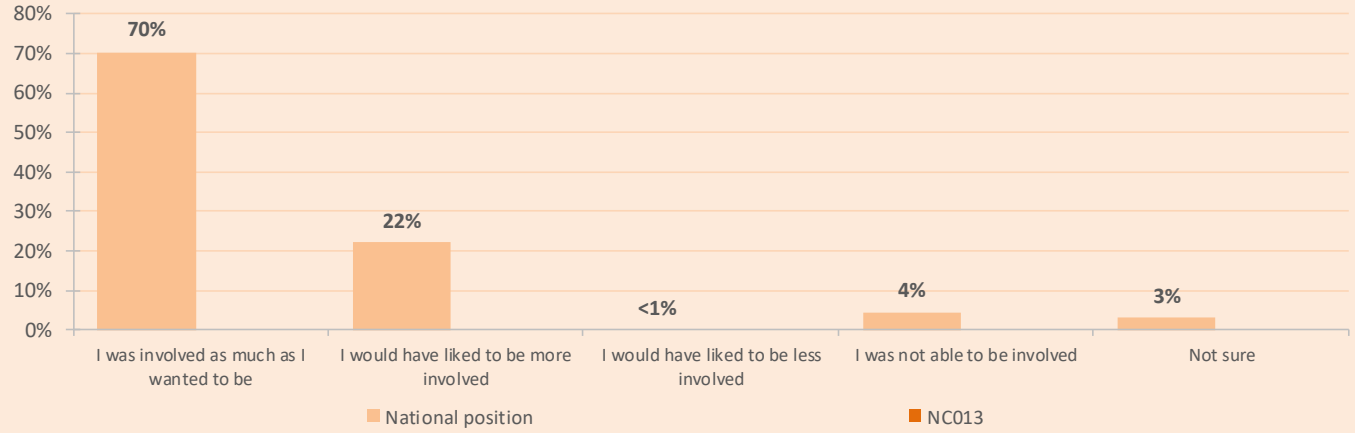


Figure 37: (QS) Did staff involve those close to the patient about care and treatment?



5.5 Needs of families and others

Families and those important to the dying person have their own needs, which they, and others, can overlook in times of distress. In this section, the results from the Case Note Review, organisational level audit and Quality Survey pertaining to the needs of the families and others are presented.

Priority 4: The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible (*One Chance To Get It Right).*

Notes to Priority 4: Where they have particular needs for support or information, these should be met as far as possible. Although it is not always possible to meet the needs or wishes of all family members, listening and acknowledging these can help (*One Chance To Get It Right).*

Needs of families and others: summary score

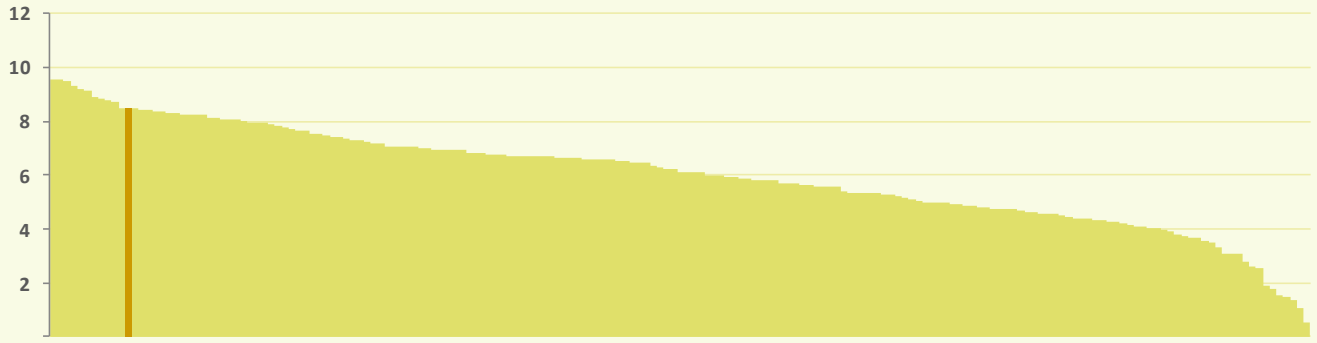
The summary score for the needs of families and others is calculated using information collected in the Case Note Review:

Documented evidence:

- the needs of families/others asked about
- of the care and support provided to families/others at the time of and immediately after death
- needs of families/others were assessed (weighting 0.2 each point):
    - emotional/psychological needs
    - spiritual/religious needs
    - cultural needs
    - social needs
    - practical needs

The range of hospital mean summary scores for needs of families and others is shown in figure 38. The mean value of the summary score across the whole sample of case notes is 6.1 (n=6,108) and, if available, your submission's value is shown in the infographic above.

Figure 38: Hospital mean summary score: Needs of families and others



Range 0.6 – 9.6

5.5 Needs of families and others

Summary score component indicators

Figure 39: (CNR) Documented evidence the needs of families/others asked about

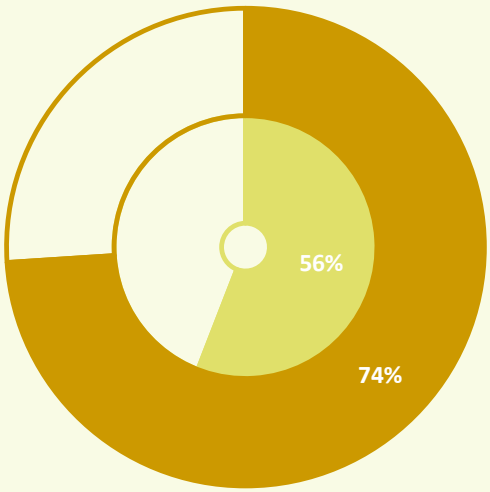


Figure 40: (CNR) Documented evidence of care and support provided to families/others at the time of and immediately after death

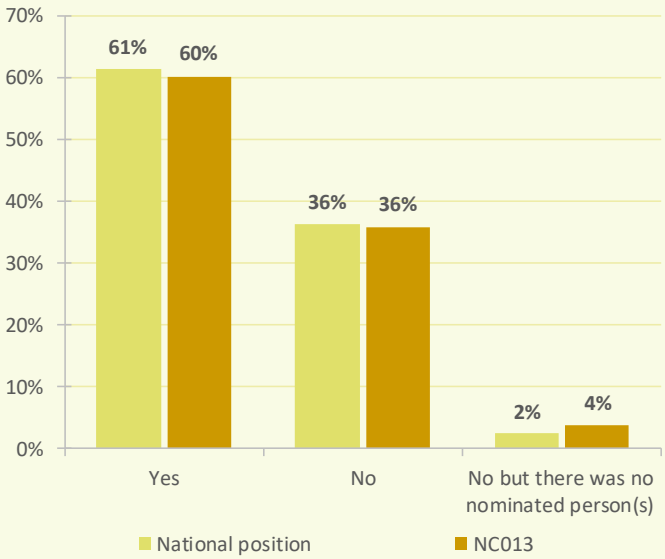


Figure 41: (CNR) Documented evidence the emotional/ psychological needs of families/others were assessed

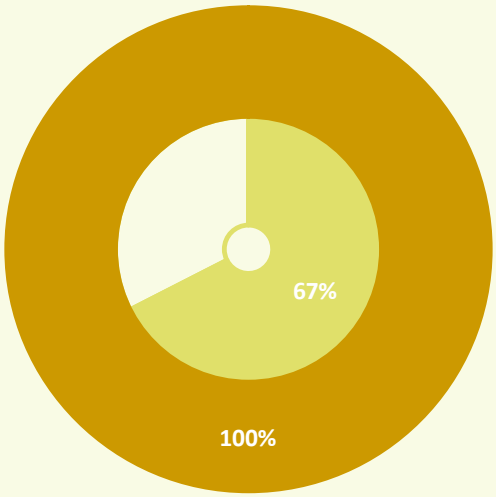
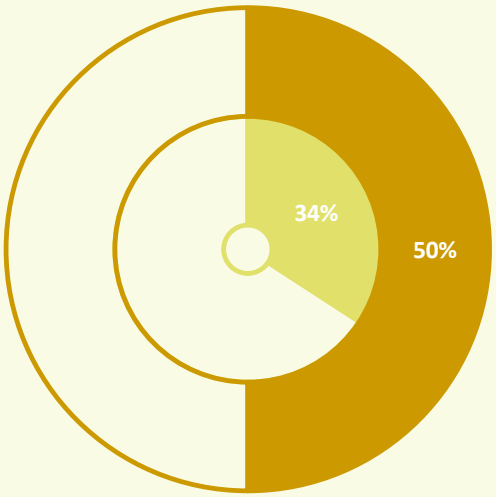


Figure 42: (CNR) Documented evidence the spiritual/religious needs of the families/others were assessed



5.5 Needs of families and others

Summary score component indicators

Figure 43: (CNR) Documented evidence the cultural needs of families/others were assessed

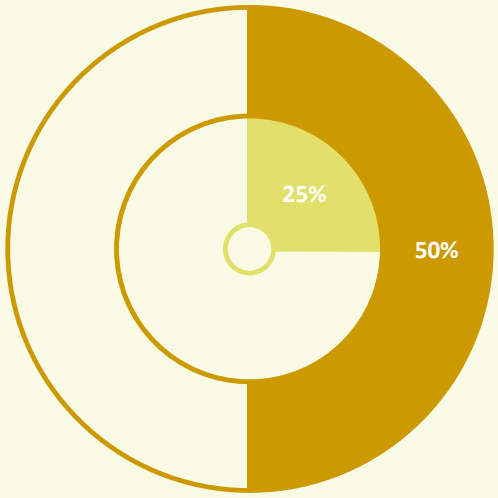


Figure 44: (CNR) Documented evidence the social needs of families/others were assessed

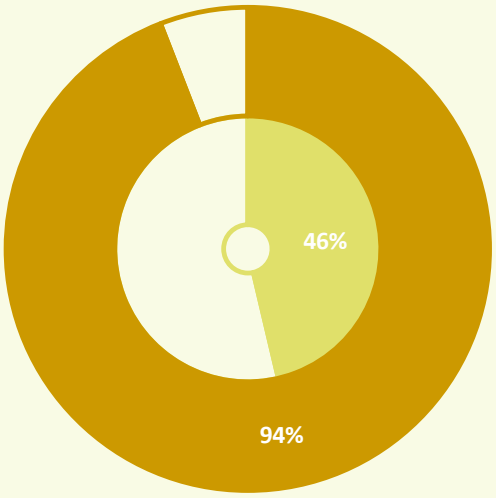
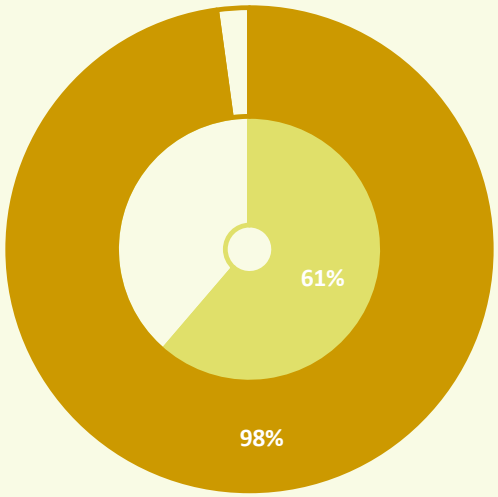


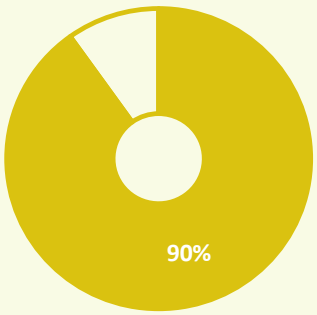
Figure 45: (CNR) Documented evidence the practical needs of families/others were assessed



5.5 Needs of families and others

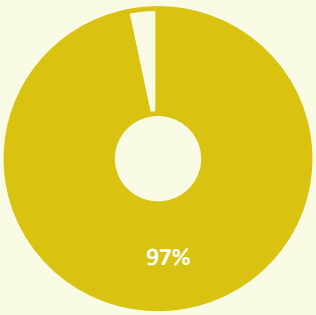
Additional indicators

Figure 46: (T/UHB) A care after death and bereavement policy



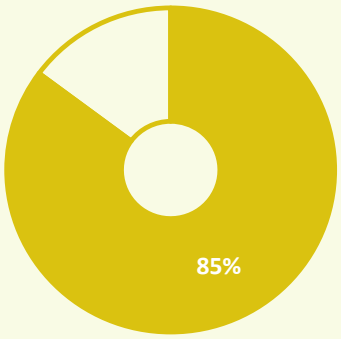
National % Yes NC013 = Yes

Figure 47: (T/UHB) Guidelines for providing relatives/carers with verification and certification of the death



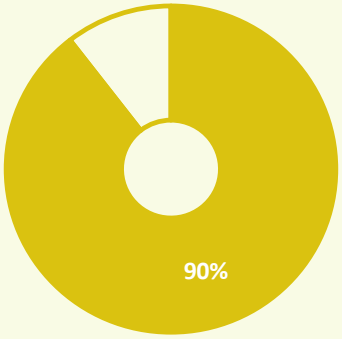
National % Yes NC013 = Yes

Figure 48: (T/UHB) Guidelines for referral to 'Pastoral care/Chaplaincy team'



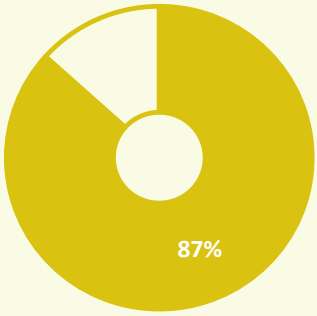
National % Yes NC013 = Yes

Figure 49: (T/UHB) Guidelines for viewing the body in the immediate time after the death of a patient



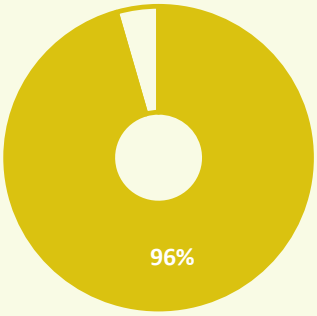
National % Yes NC013 = Yes

Figure 50: (H/S) Department of Work and Pensions leaflet 'What to Do After a Death in England and Wales' or equivalent provided



National % Yes NC013 = Yes

Figure 51: (H/S) A leaflet explaining local procedures to be undertaken after the death of a patient provided

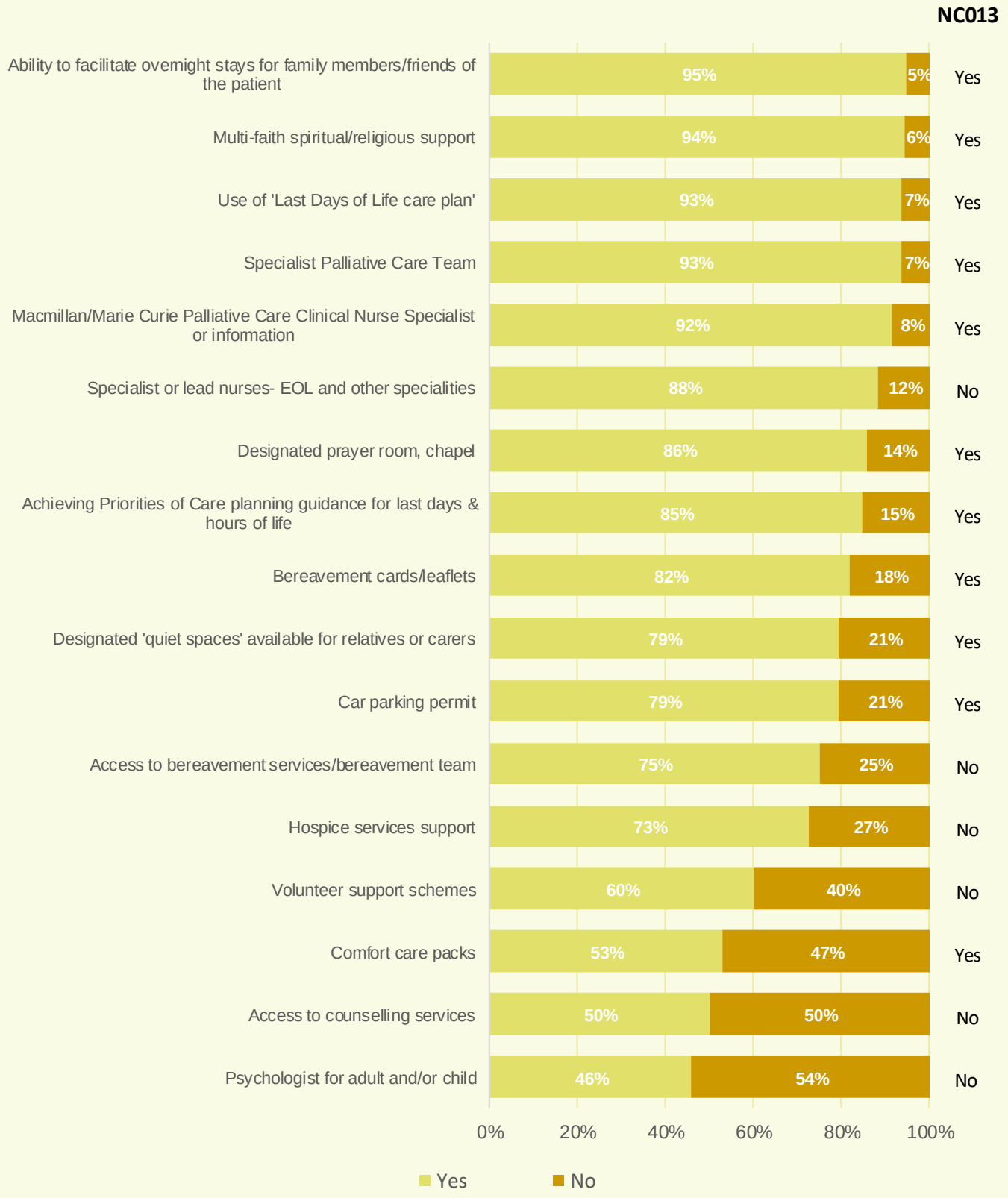


National % Yes NC013 = Yes

5.5 Needs of families and others

Additional indicators

Figure 52: (H/S) Support processes available in the hospital for people important to the dying person: National



5.5 Needs of families and others

Additional indicators

Figure 53: (QS) Did those close to the patient feel supported by hospital staff after the patient's death?

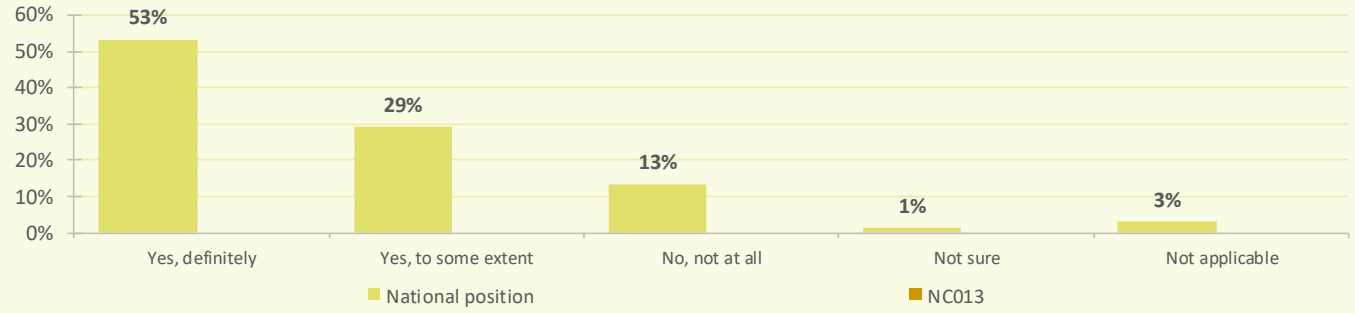


Figure 54: (QS) Did those close to the patient feel they were given enough emotional help and support?

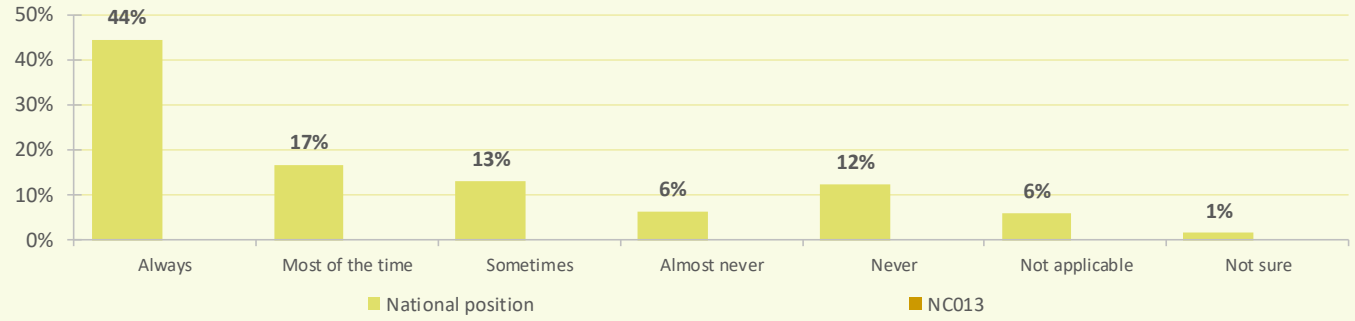


Figure 55: (QS) Did those close to the patient feel they were given enough practical support?

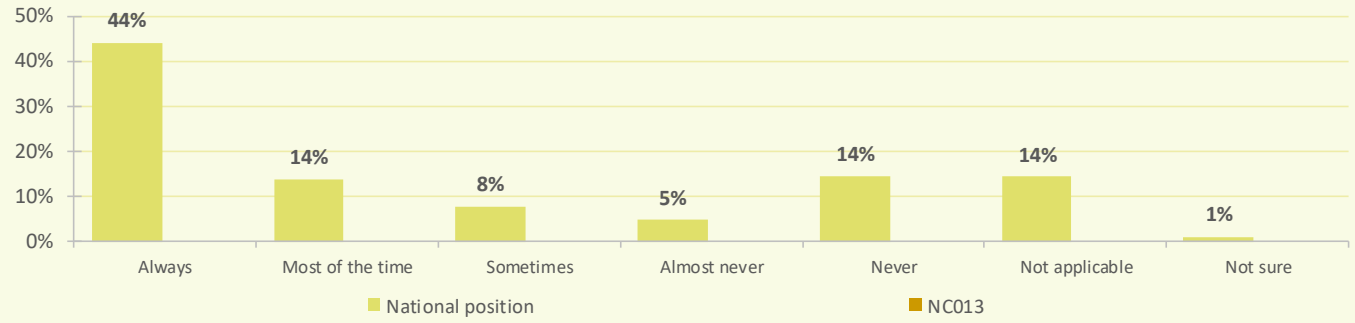
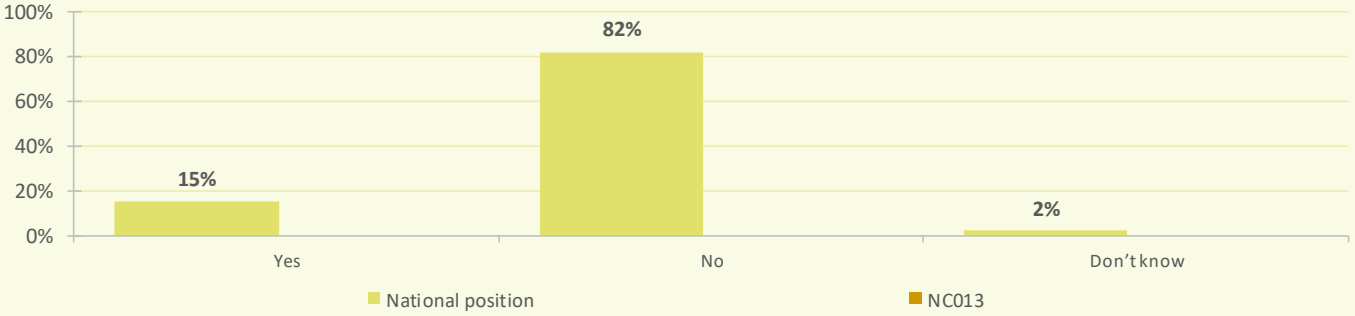


Figure 56: (QS) Were there any unexplained delays in the hospital providing you with certification of death?



5.6 Individual plan of care

The *five priorities for the care* of the dying person (*One Chance To Get It Right*) make clear that there must be an individual plan of care. The plan for end of life care should be documented and should be part of other care planning processes. The dying person and those important to them should have the opportunity to discuss the plan.

In this section, the results from the Case Note Review and the Quality Survey relating to the individual plan of care are presented.

Priority 5: An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion (*One Chance To Get It Right*).

NICE QS144: Adults in the last days of life who are likely to need symptom control are prescribed anticipatory medicines with individualised indications for use, dosage and route of administration *(Statement 3, NICE Quality Standard 144).*

NICE QS144: Adults in the last days of life have their hydration status assessed daily, and have a discussion about the risks and benefits of hydration options (*Statement 4, NICE Quality Standard 144).*

Individual plan of care: summary score

The summary score for the individual plan of care is calculated using information collected in the Case Note Review:

- documented evidence the patient had an individual end of life care plan (weighting 0.5)
- regular review of the patient and their plan of care (weighting 0.5)
- documented evidence of the preferred place of death as indicated by the patient
- documented review of (weighting 0.25 each):
  - routine recording of vital signs
  - blood sugar monitoring
  - administration of oxygen
  - administration of antibiotics
- documented assessment of hydration status between recognition and time of death
- documented assessment of nutrition status between recognition and time of death
- assessment of needs covering 16 domains (weighting 0.25 each)

The range of hospital mean summary scores for the individual plan of care is shown in figure 57. The mean value of the summary score across the whole sample of case notes is 7.4 (n=6,463) and, if available, your submission's value is shown in the infographic above.

Figure 57: Hospital mean summary score: Individual plan of care

Range 4.7 – 9.7

5.6 Individual plan of care

Summary score component indicators

Figure 58: (CNR) Documented evidence the patient had an individual end of life care plan

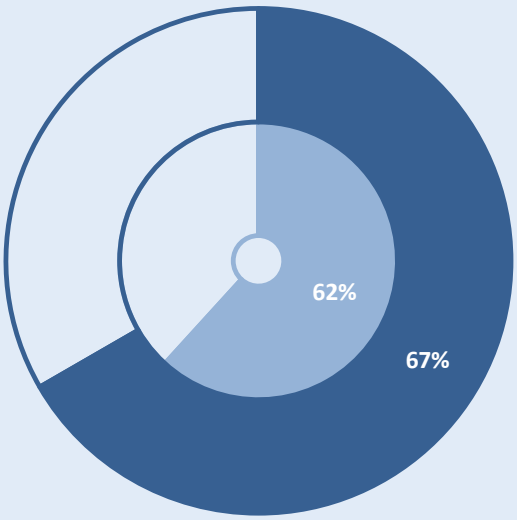


Figure 59: (CNR) Regular review of the patient and their plan of care

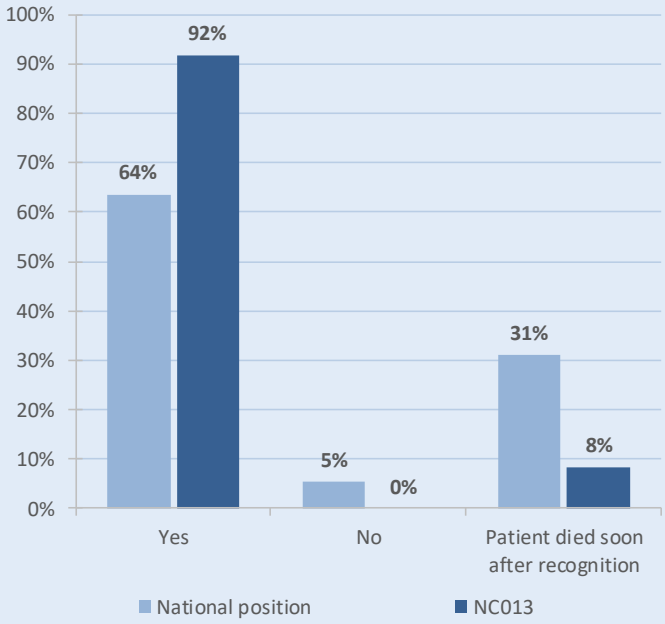


Figure 60: (CNR) Documented evidence of the preferred place of death as indicated by the patient

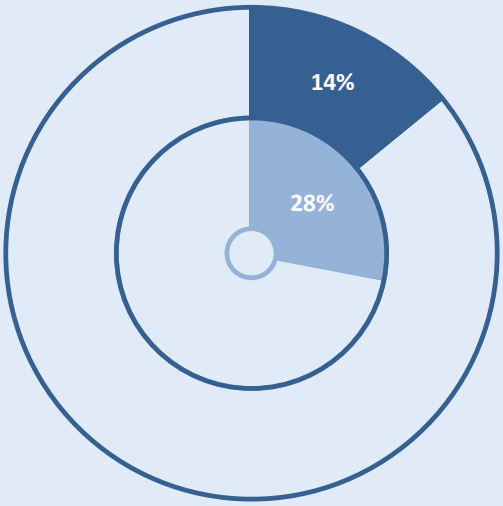
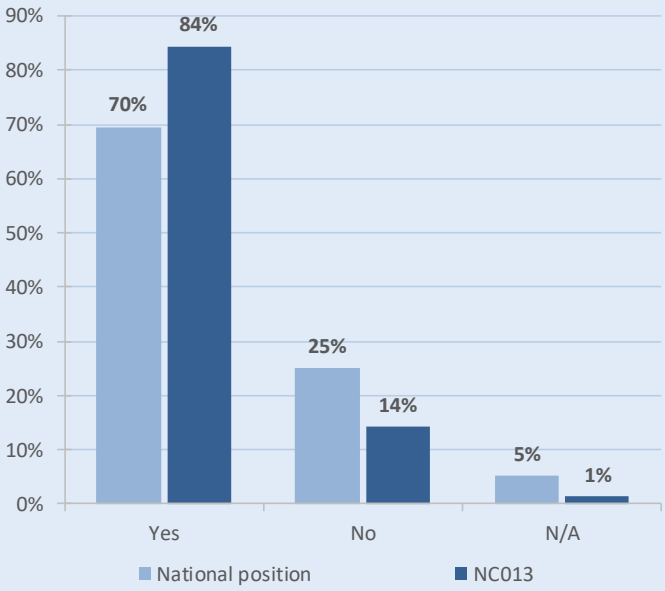


Figure 61: (CNR) Documented review of routine recording of vital signs



5.6 Individual plan of care

Summary score component indicators

Figure 62: (CNR) Documented review of blood sugar monitoring

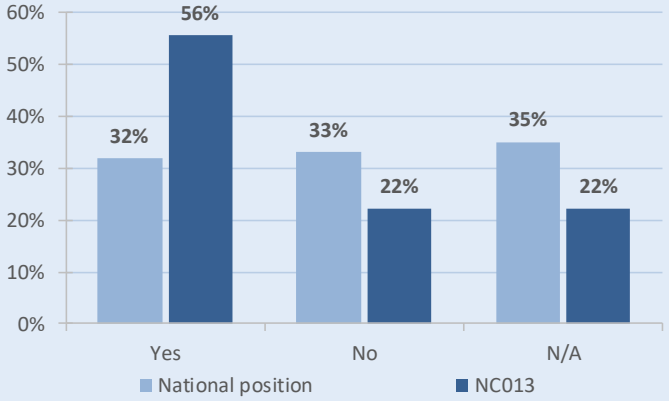


Figure 63: (CNR) Documented review of administration of oxygen

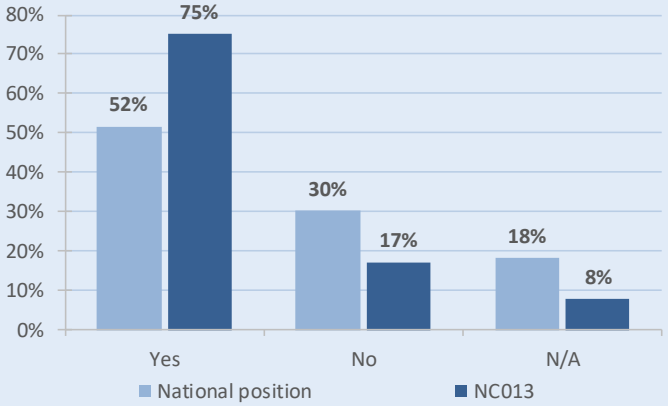


Figure 64: (CNR) Documented review of administration of antibiotics

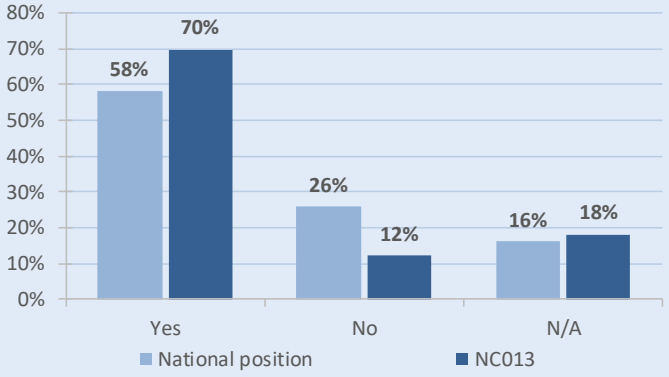


Figure 65: (CNR) Documented assessment of hydration status between recognition and time of death

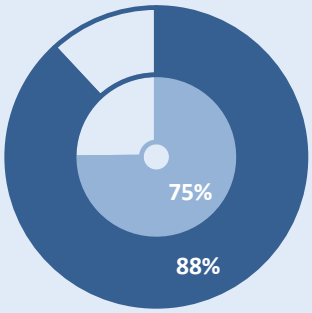
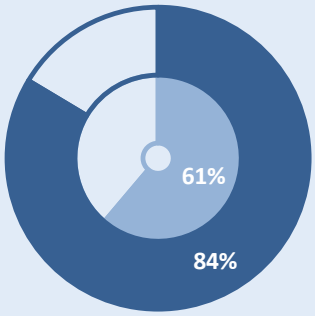


Figure 66: (CNR) Documented assessment of nutrition status between recognition and time of death



5.6 Individual plan of care

Summary score component indicators

Figure 67: (CNR) Assessment of the following needs: national

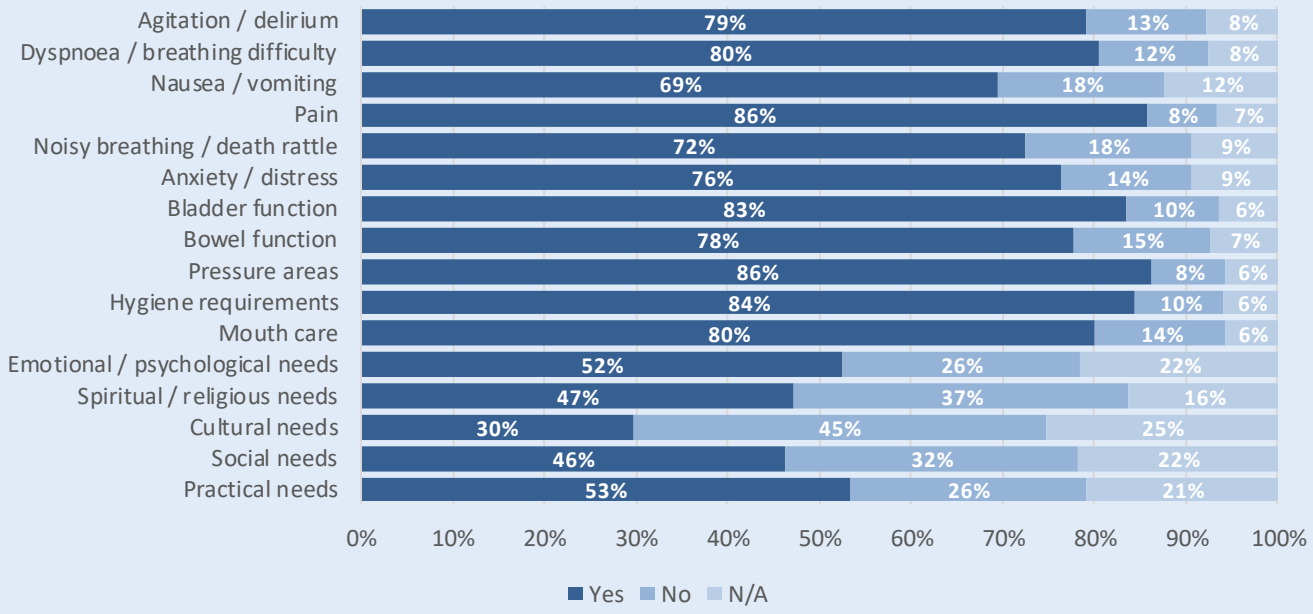
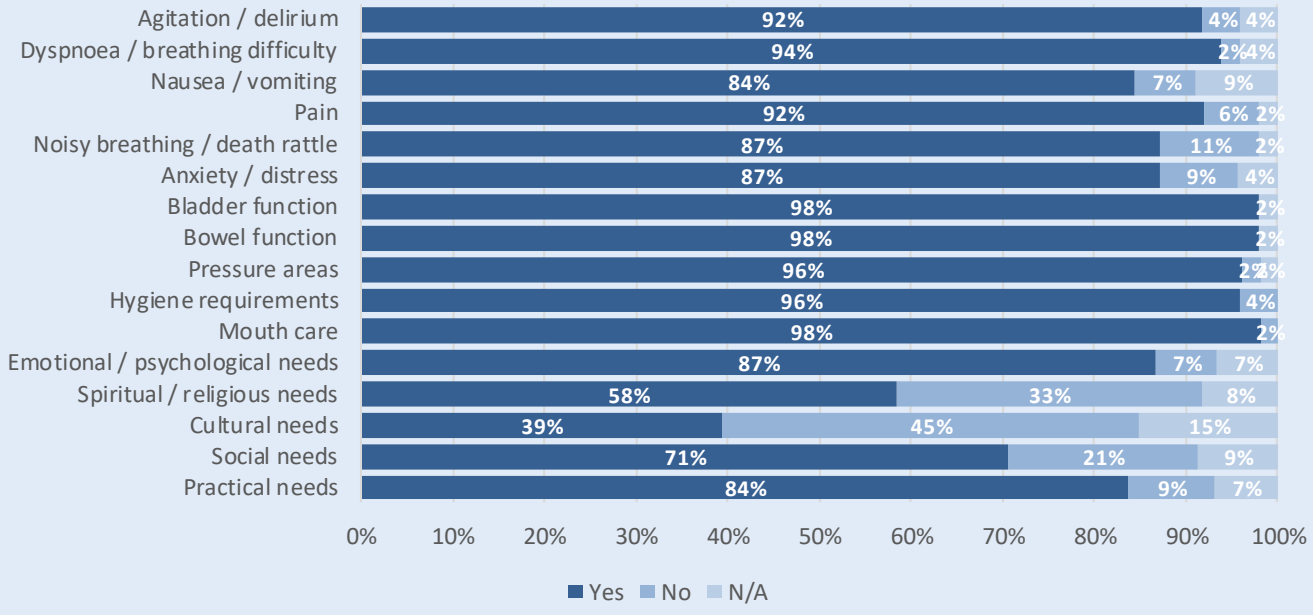


Figure 68: (CNR) Assessment of the following needs: submission



5.6 Individual plan of care

Additional indicators: holistic care

Figure 69: (QS) Do you feel that staff at the hospital took time to explore what was important to him/her in terms of individual requirements and care in the last few days of life?

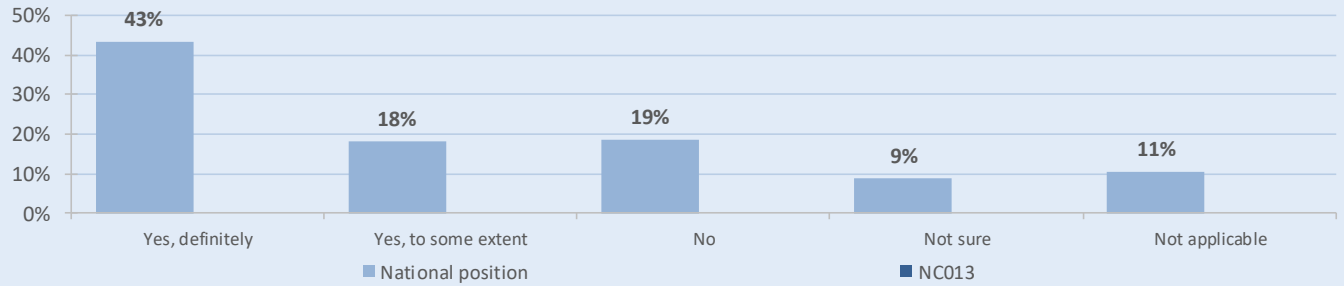


Figure 70: (QS) Do you feel that staff at the hospital made a plan for the person's care which took account of his/her individual requirements and wishes?

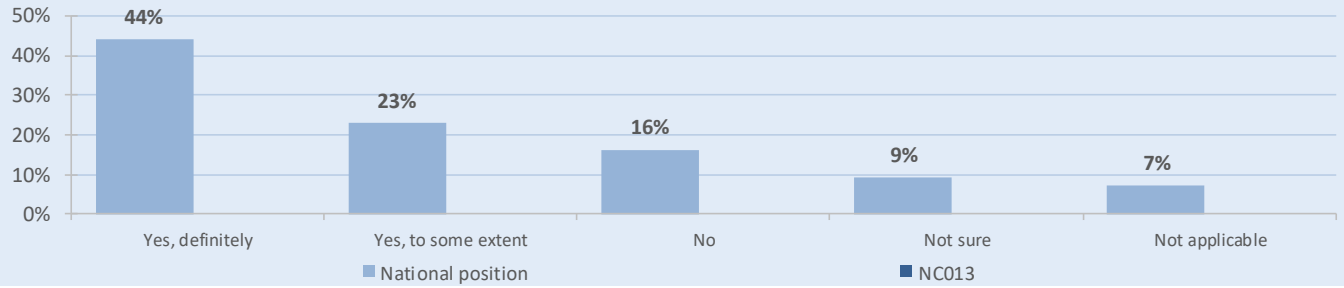


Figure 71: (QS) Had care for emotional needs (e.g. feeling low, feeling worried, feeling anxious) met by staff

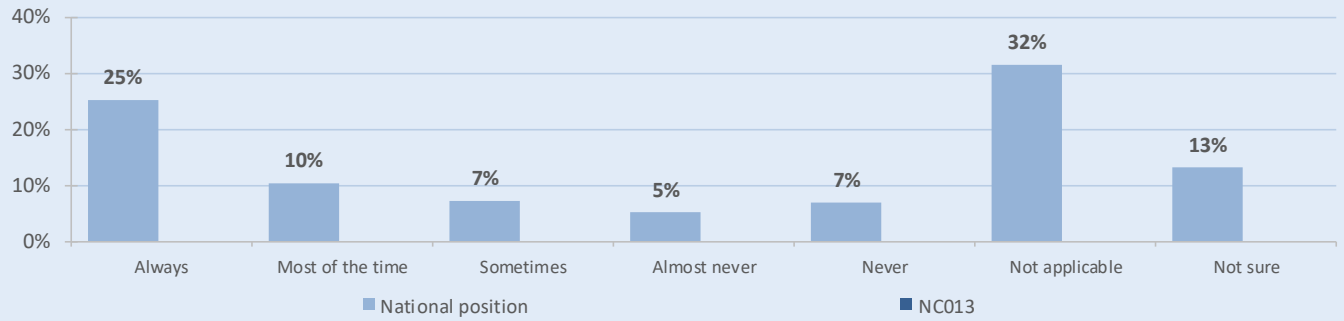
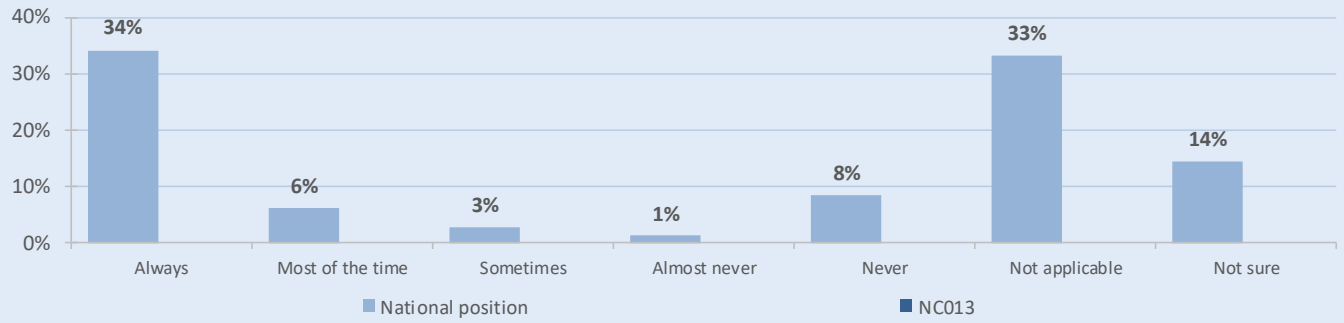


Figure 72: (QS) Staff took into account his/her beliefs, hopes, traditions, religion and spirituality



5.6 Individual plan of care

Additional indicators: physical care

Figure 73: (QS) Was given sufficient pain relief

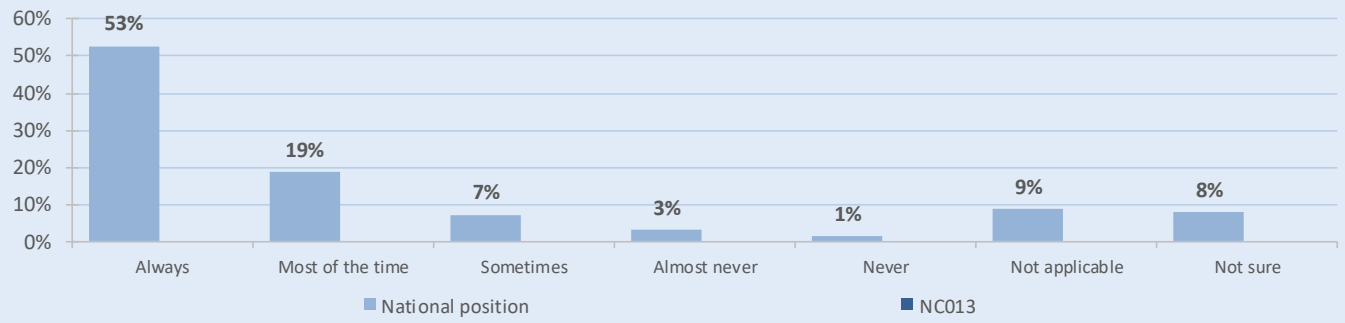


Figure 74: (QS) Had sufficient relief of symptoms other than pain (such as nausea or restlessness)

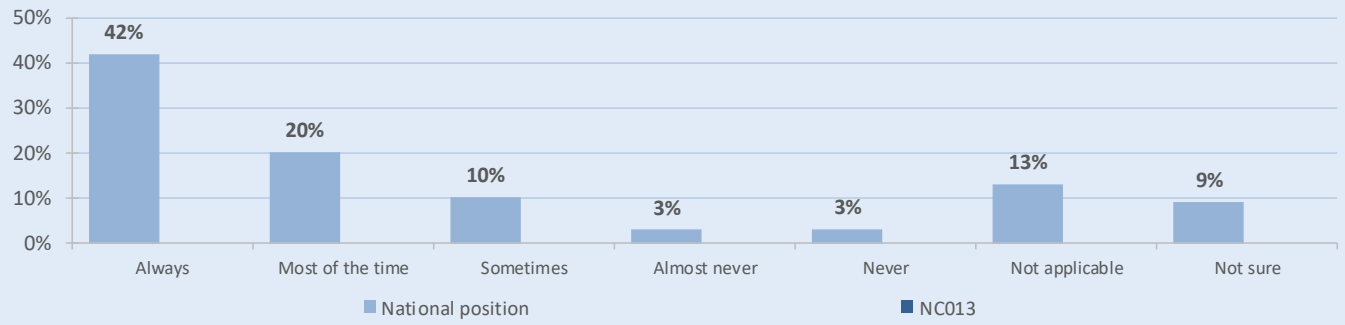


Figure 75: (QS) Had support to drink or receive fluid if he/she wished

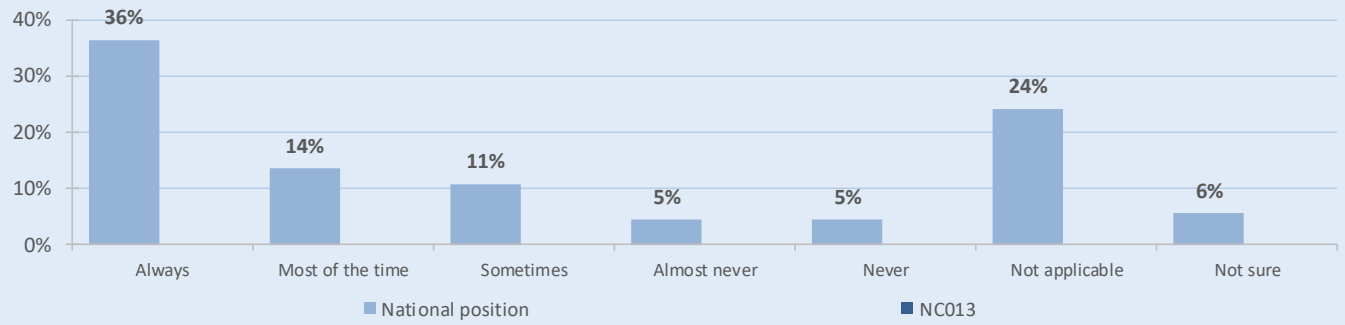
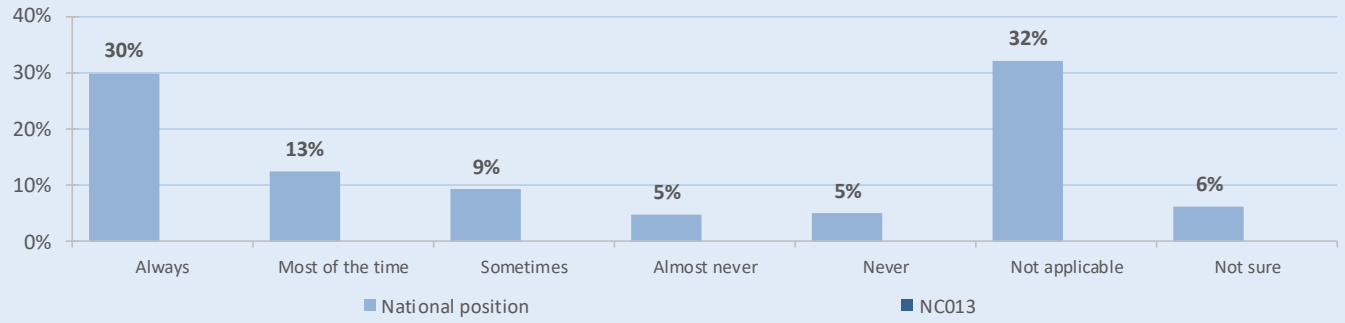


Figure 76: (QS) Had support to eat or receive nutrition if he/she wished



5.6 Individual plan of care

Additional indicators: place of care

Figure 77: (CNR) Attempts made to move the patient home/to a hospice

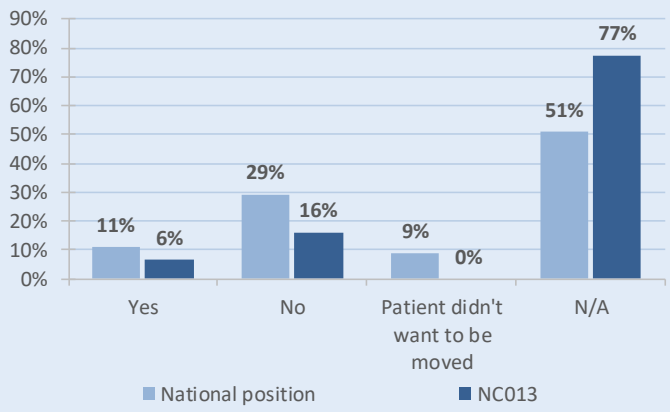


Figure 78: (CNR) Documented that if a side room was requested it wasn't available

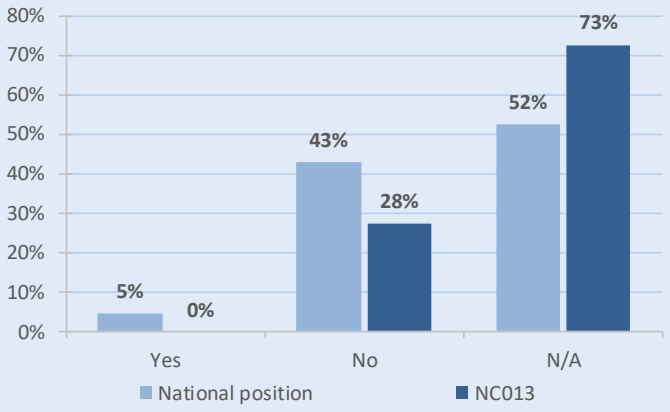


Figure 79: (QS) In the last two to three days of life, were efforts made to transfer the person from hospital if that was his/her wish?

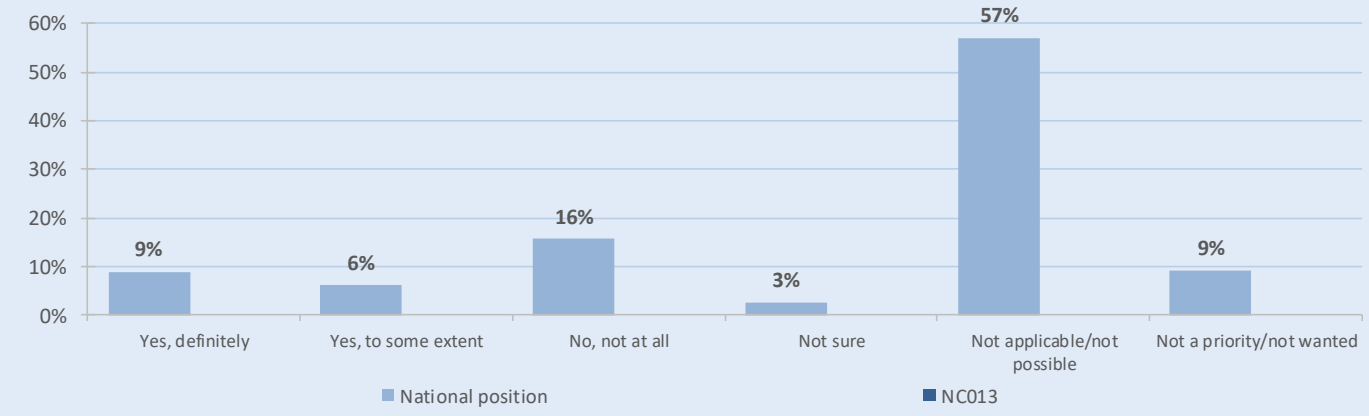
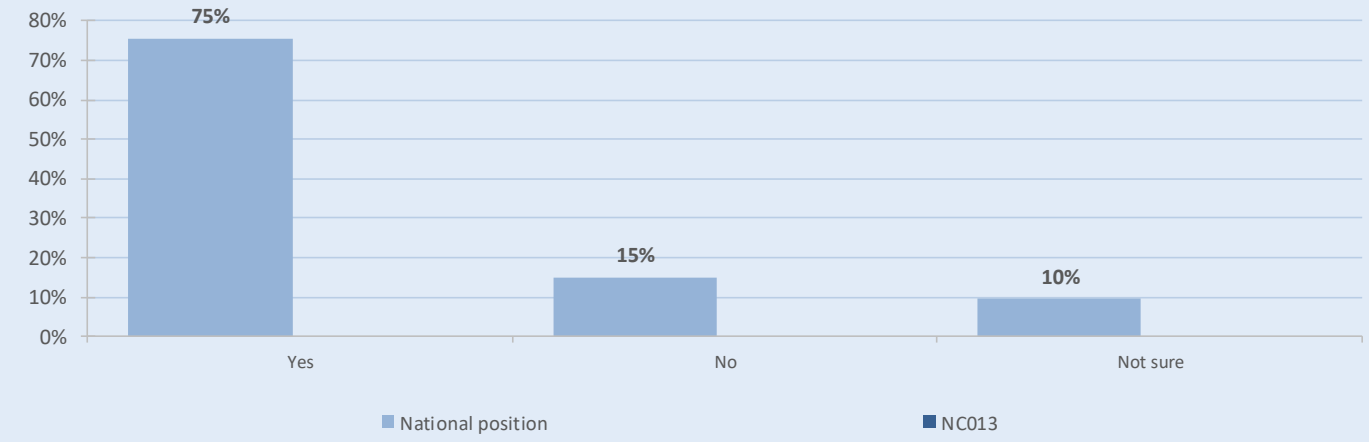


Figure 80: (QS) On balance, do you think that hospital was the right place for him/her to die?



5.6 Individual plan of care

Additional indicators: place of care

Figure 81: (QS) Within the hospital where did the person die?

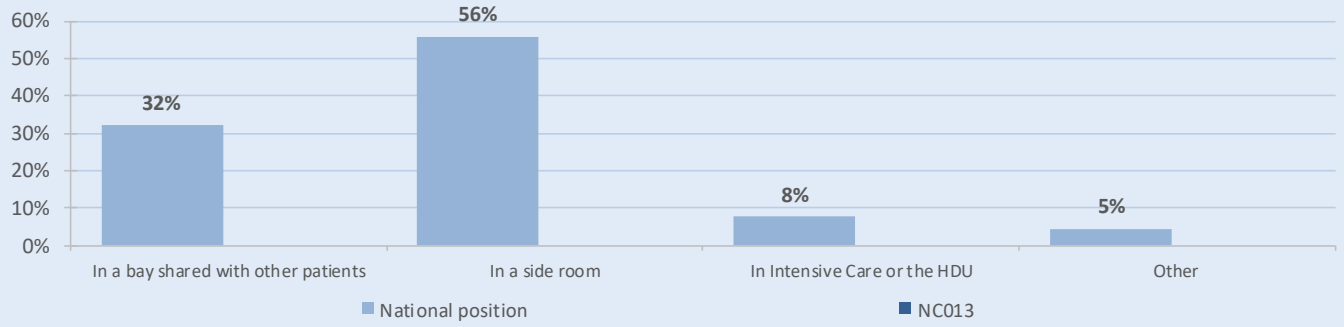


Figure 82: (QS) Were you satisfied that this location within the hospital was appropriate?

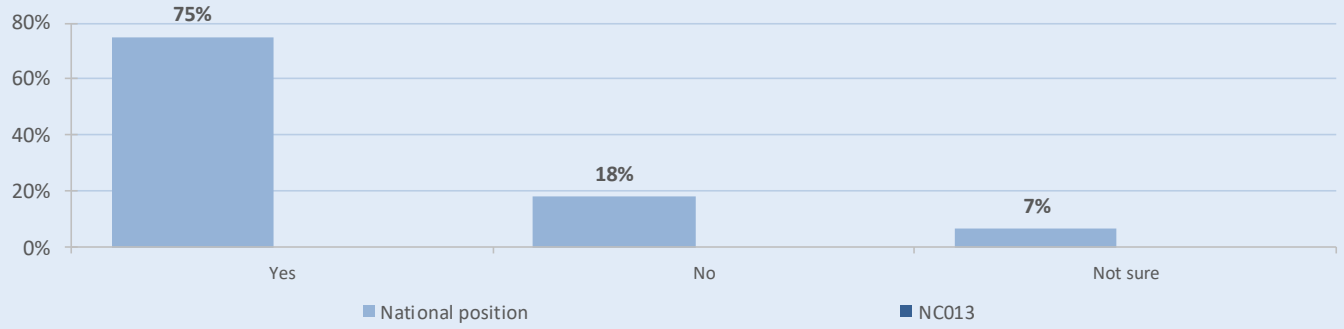


Figure 83: (QS) Had adequate privacy

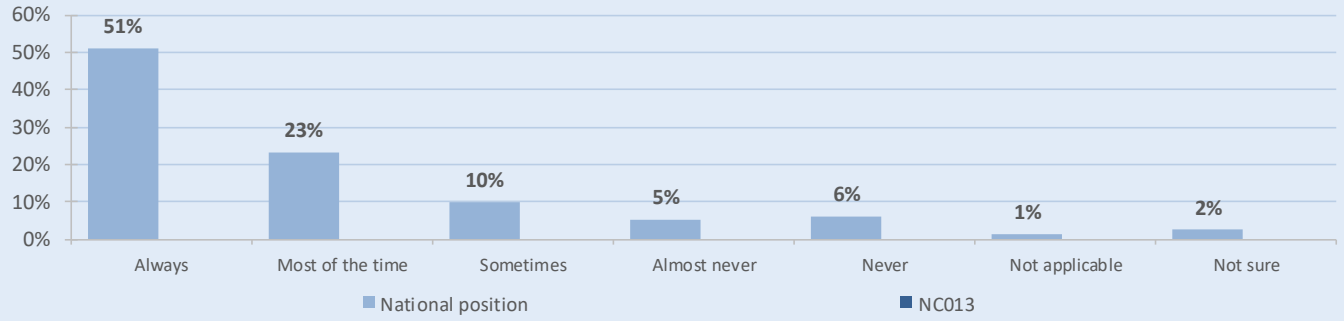
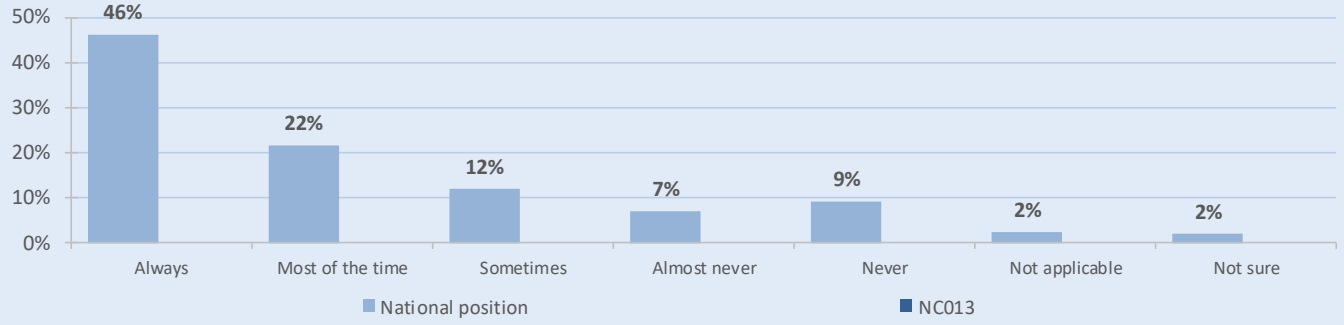


Figure 84: (QS) Had a suitable environment with sufficient peace and quiet



5.7 Families' and others' experience of care

The *NHS Outcomes Framework,* which sets out high level national outcomes for the NHS, has five domains, including ensuring that people have a positive experience of care. When a person has died, those important to the person, be it families, carers, friends or others, are best placed to comment on both the experience of care of the patient and the support they received themselves. In this section, evidence on the experience of care from the Quality Survey is presented.

Families' and others' experience of care: summary score

In reviewing the results for this theme, it should be noted that the total number of Quality Surveys returned was 790, representing 7% of the Case Note Reviews completed (11,034). The Quality Survey results may not, therefore be representative of the whole Case Note Review sample. The number of responses used to calculate each of the summary score component metrics for both national and submission results, is shown at Appendix 5.

The summary score for families' and others' experience of care is calculated using information collected in the Quality Survey:

- overall quality of care provided to the patient
- overall quality of care provided to friends and family of the patient
- staff looking after the patient communicated sensitively
- patient treated with compassion
- family/friends communicated with compassionately

The range of hospital mean summary scores for families' and others' experience of care is shown in figure 85.

The mean value of the summary score across the whole sample of Quality Survey responses is 7.1 (n=682) and, if available, your submission's value is shown in the infographic above.

Figure 85: Hospital mean summary score: Families' and others' experience of care

Range 4.3 – 9.7

5.7 Families' and others' experience of care

Summary score component indicators

Figure 86: (QS) Overall quality of care and support provided to the patient

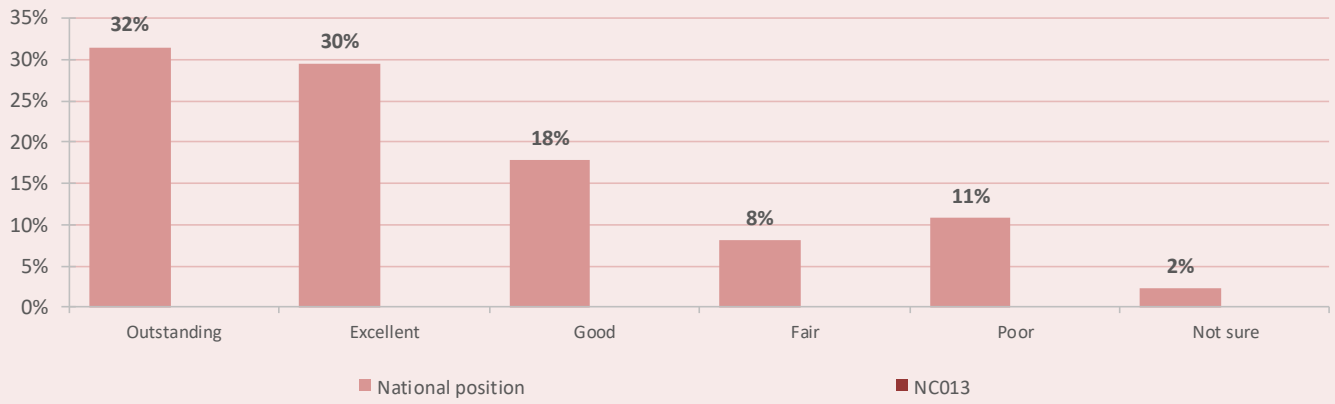


Figure 87: (QS) Overall quality of care and support provided to friends and family of the patient

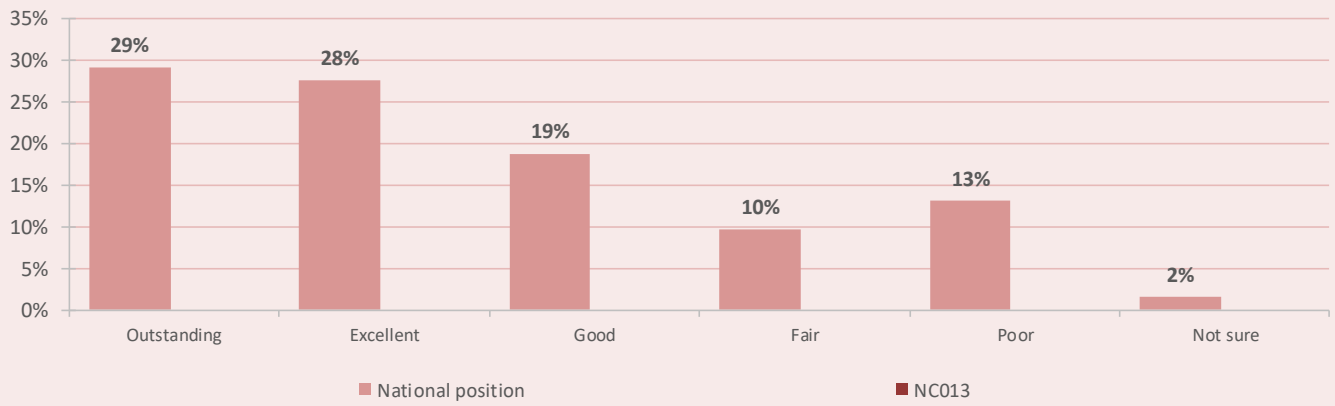
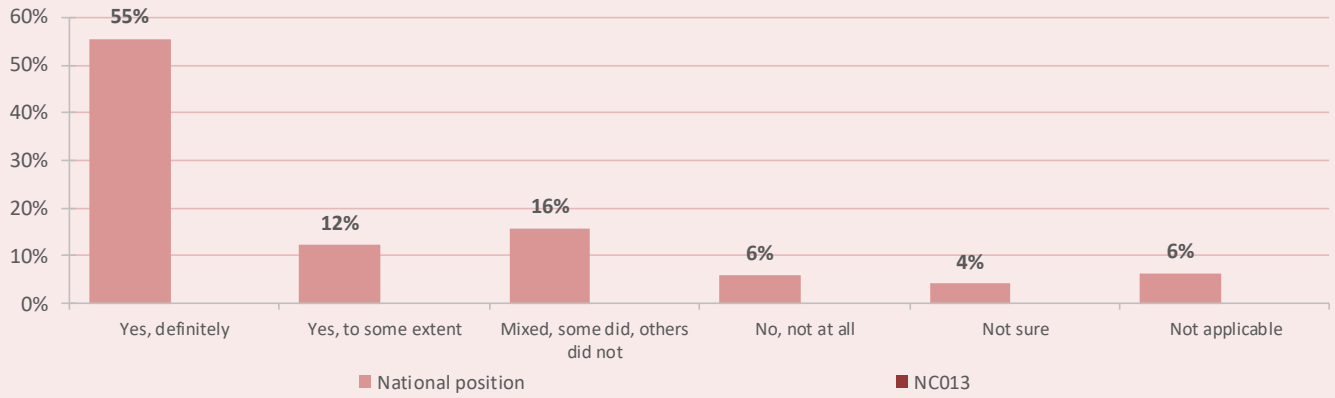


Figure 88: (QS) Staff looking after the patient communicated sensitively



5.7 Families' and others' experience of care

Summary score component indicators

Figure 89: (QS) Patient treated with compassion

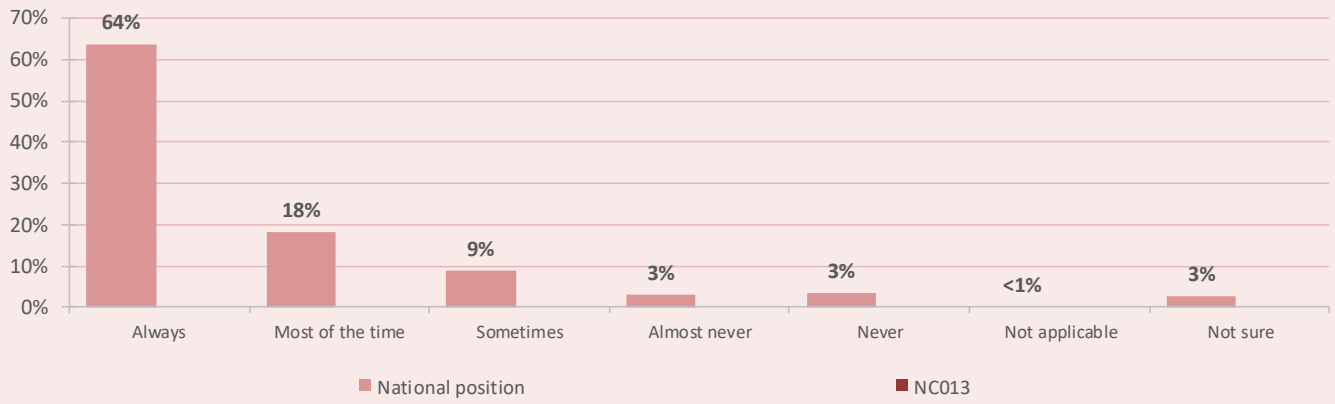
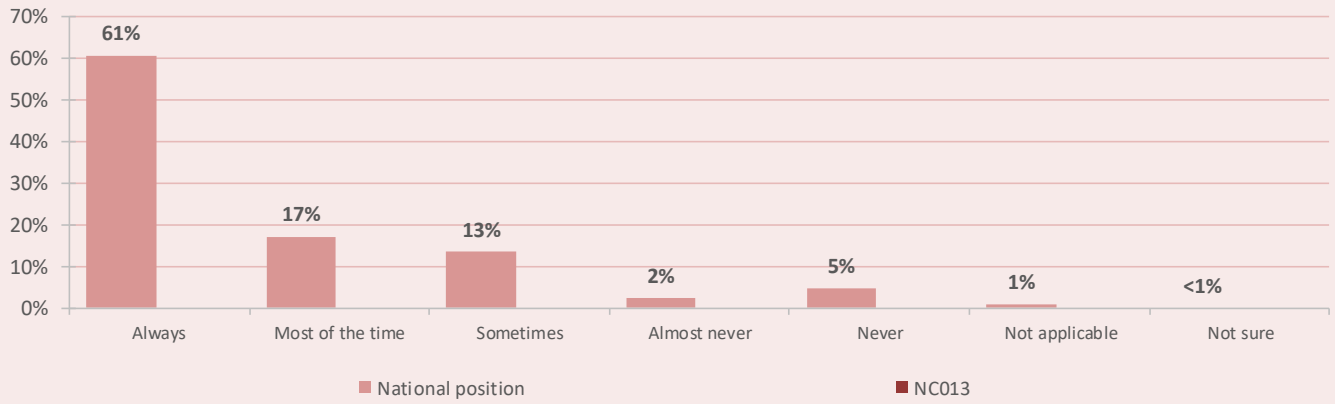


Figure 90: (QS) Family/ friends communicated to compassionately



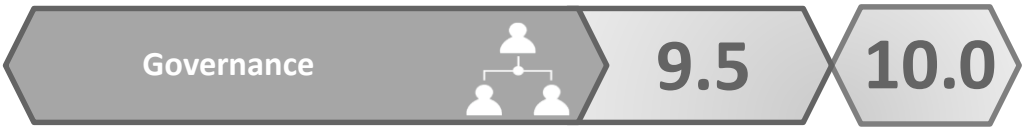
5.8 Governance

Local leadership is essential to securing improvements in the overall care of people in the last few days and hours of life. In this section, evidence on governance arrangements for end of life care from the organisational level audit are presented.

Organisational leadership and governance: Each [organisation] needs to have leadership that is committed to ensuring that those people to whom it provides services who are dying receive high-quality, compassionate care, focused on the needs of the dying person and their family (*One Chance To Get It Right*).

Education, training and professional development: Individual providers of health and care are responsible for ensuring their staff have the experience and competence they need to do their jobs well. This includes making time and other resources available for staff to undergo professional development *(One Chance To Get It Right).*

Governance: summary score

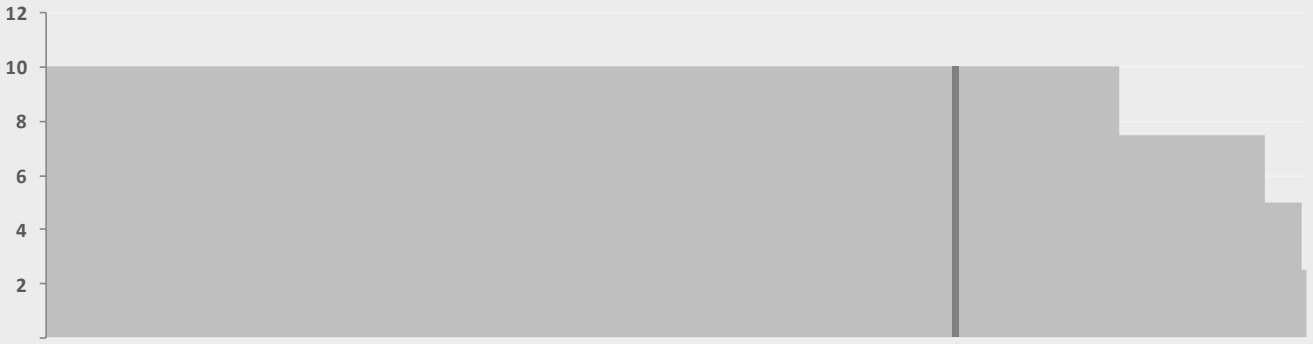


The summary score for Governance is calculated using information collected in the trust/UHB level audit:

- an identified member of the trust/UHB board with a responsibility for end of life care
- a policy on how to respond to and learn from the death of patients under the organisation's management and care
- specific care arrangements to enable rapid discharge home to die, if this is the person's preference
- a care plan to support the *five priorities for care* for the dying person (*One Chance To Get It Right*)

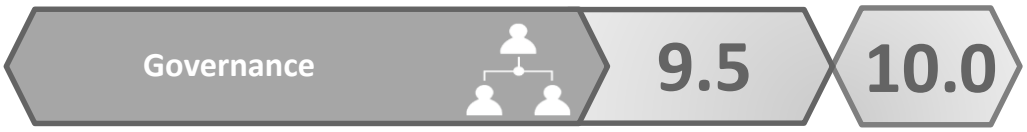
The range of hospital mean summary scores for governance is shown in figure 91. The mean value of the summary score across the participating hospitals is 9.5 (n=177) and, if available, your submission's value is shown in the infographic above.

Figure 91: Hospital mean summary score: Governance



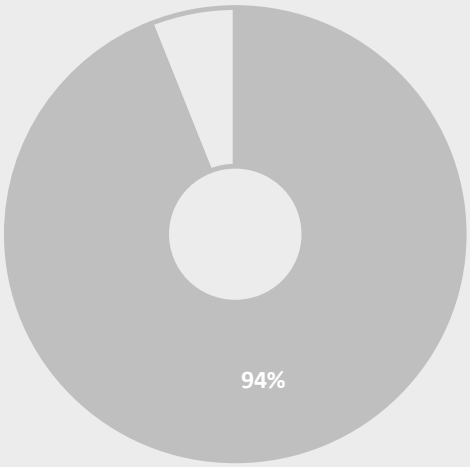
Range 2.5 – 10.0

5.8 Governance



Summary score component indicators

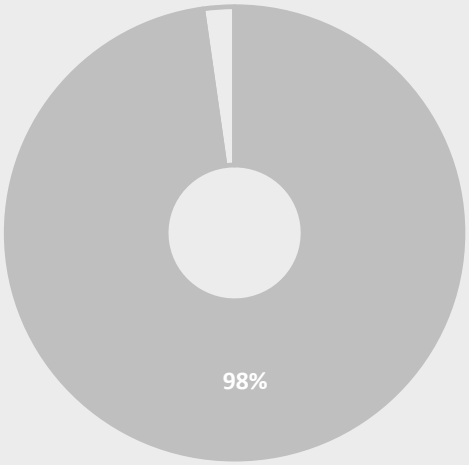
Figure 92: (T/UHB) An identified member of the trust/UHB board with a responsibility for end of life care



National % Yes

NC013 = Yes

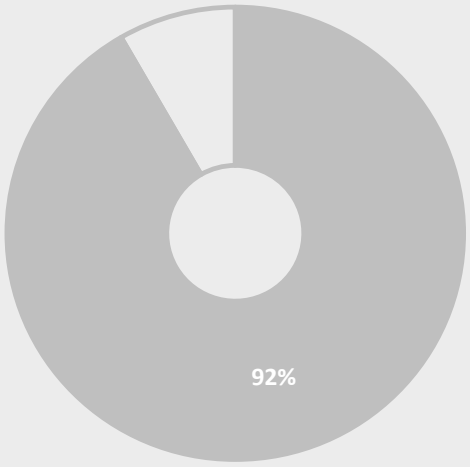
Figure 93: (T/UHB) Policy on how to respond to and learn from the death of patients under the organisation's management and care



National % Yes

NC013 = Yes

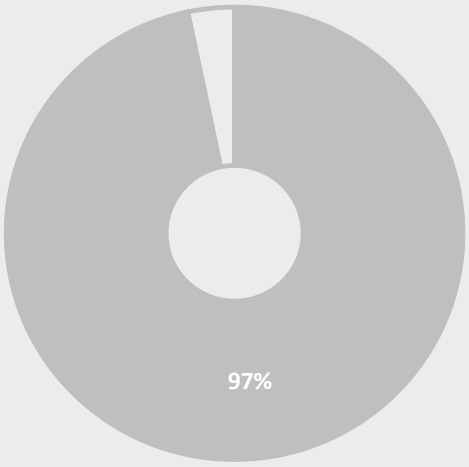
Figure 94: (T/UHB) Specific care arrangements to enable rapid discharge home to die, if this is the person's preference



National % Yes

NC013 = Yes

Figure 95: (T/UHB) A care plan to support the *five priorities of care* for the dying person



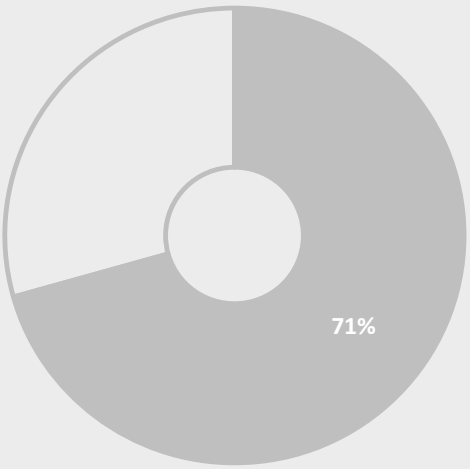
National % Yes

NC013 = Yes

5.8 Governance

Additional indicators

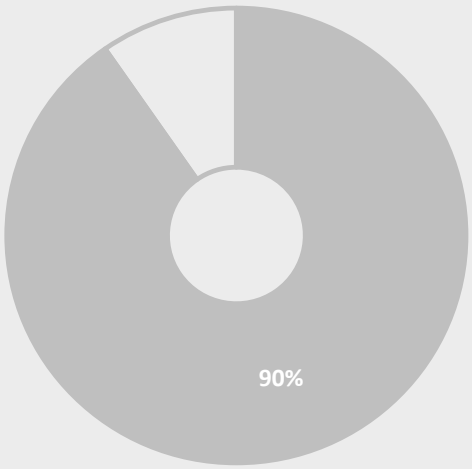
Figure 96: (H/S) Formal process for discussing and reporting on the *five priorities for care* within your trust/UHB quality governance structure



National % Yes

NC013 = Yes

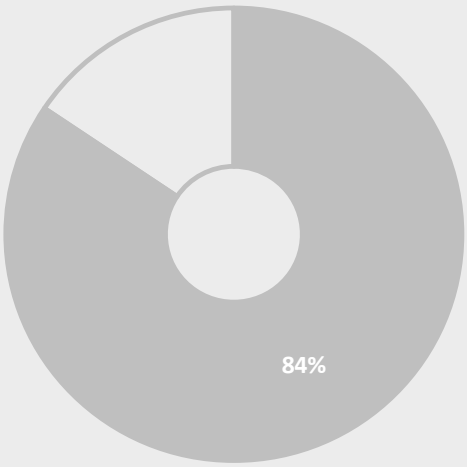
Figure 97: (H/S) Action plan produced in the last financial year to promote improvement in end of life care



National % Yes

NC013 = Yes

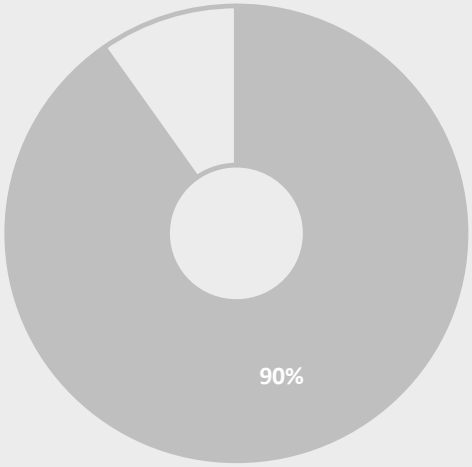
Figure 98: (T/UHB) A non-executive director responsible for the oversight of the national guidance on *learning from deaths* agenda progress



National % Yes

NC013 = Yes

Figure 99: (H/S) Mechanism for flagging complaints that relate to end of life care



National % Yes

NC013 = No

5.9 Workforce/specialist palliative care

National guidance recognises the need for providers to work with commissioners to ensure access to an adequately resourced specialist palliative care (SPC) workforce to provide leadership, education and training, including for pre-qualifying education, and support to non-specialist front-line health and care workers. In this section, findings for the organisational level audit and Quality Survey regarding the specialist and non-specialist workforce are presented.

Notes to Priority 5: There must be prompt referral to, and input from, specialist palliative care for any patient and situation that requires this (*One Chance To Get It Right*).

Notes to Priority 5: [service providers must] work with commissioners and specialist palliative care professionals to ensure adequate access to specialist assessment, advice and active management. '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 (*One Chance To Get It Right*).

Ongoing education and training for all health and care staff: [..all] staff who have contact with dying people must have the skills to do this effectively and compassionately. This includes clinical and support staff (e.g. porters, reception staff and ward clerks.) Those organisations that deliver such care have the prime responsibility for ensuring that the people they employ are competent to carry out their roles effectively, including facilitating and funding ongoing professional development, where this is appropriate (*One Chance To Get It Right*).

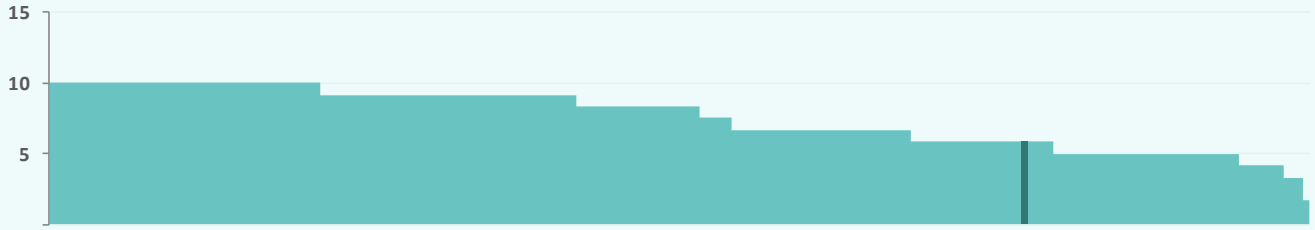
Workforce/specialist palliative care: summary score

The summary score for workforce/specialist palliative care is calculated using information collected in the organisational level audit:

- does the hospital provide/have access to a specialist palliative care service
- nurses in SPC team available 9am-5pm, 7 days a week, face-to-face (or better/equivalent)
- training (weighting 0.25 each)
  - end of life care training included in induction programme
  - end of life care training included in mandatory/priority training
  - training to improve the culture, behaviours, attitudes around communication skills
  - other training in relation to end of life care

The range of hospital mean summary scores for workforce/specialist palliative care is shown in figure 100. The mean value of the summary score across participating hospitals is 7.6 (n=196) and, if available, your submission's value is shown in the infographic above.

Figure 100: Hospital mean summary score: Workforce/specialist palliative care

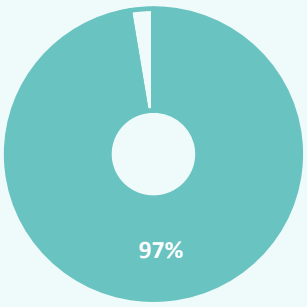


Range 1.7 – 10.0

5.9 Workforce/specialist palliative care

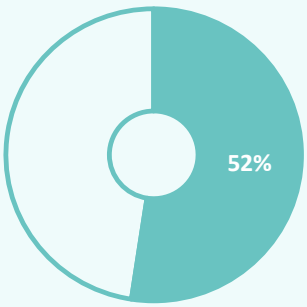
Summary score component indicators

Figure 101: (H/S) Does the hospital provide/have access to a specialist palliative care service?



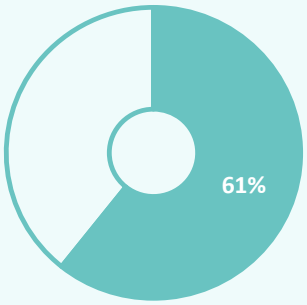
National % Yes NC013 = Yes

Figure 102: (H/S) Nurses in SPC team available 9am-5pm, 7 days a week, face-to-face (or better/equivalent)



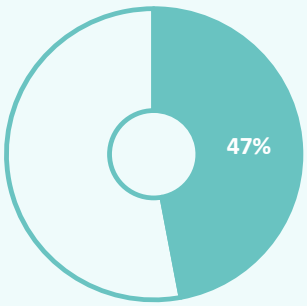
National % Yes NC013 = No

Figure 103: (H/S) End of life care training included in induction programme



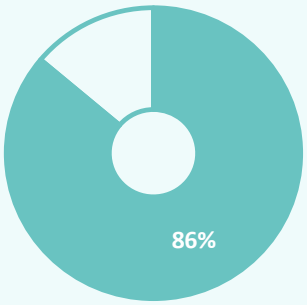
National % Yes NC013 = Yes

Figure 104: (H/S) End of life care training included in mandatory/priority training



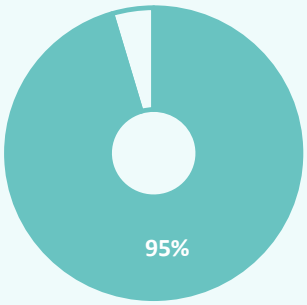
National % Yes NC013 = No

Figure 105: (H/S) Training to improve the culture, behaviours, attitudes around communication skills



National % Yes NC013 = Yes

Figure 106: (H/S) Other training in relation to end of life care

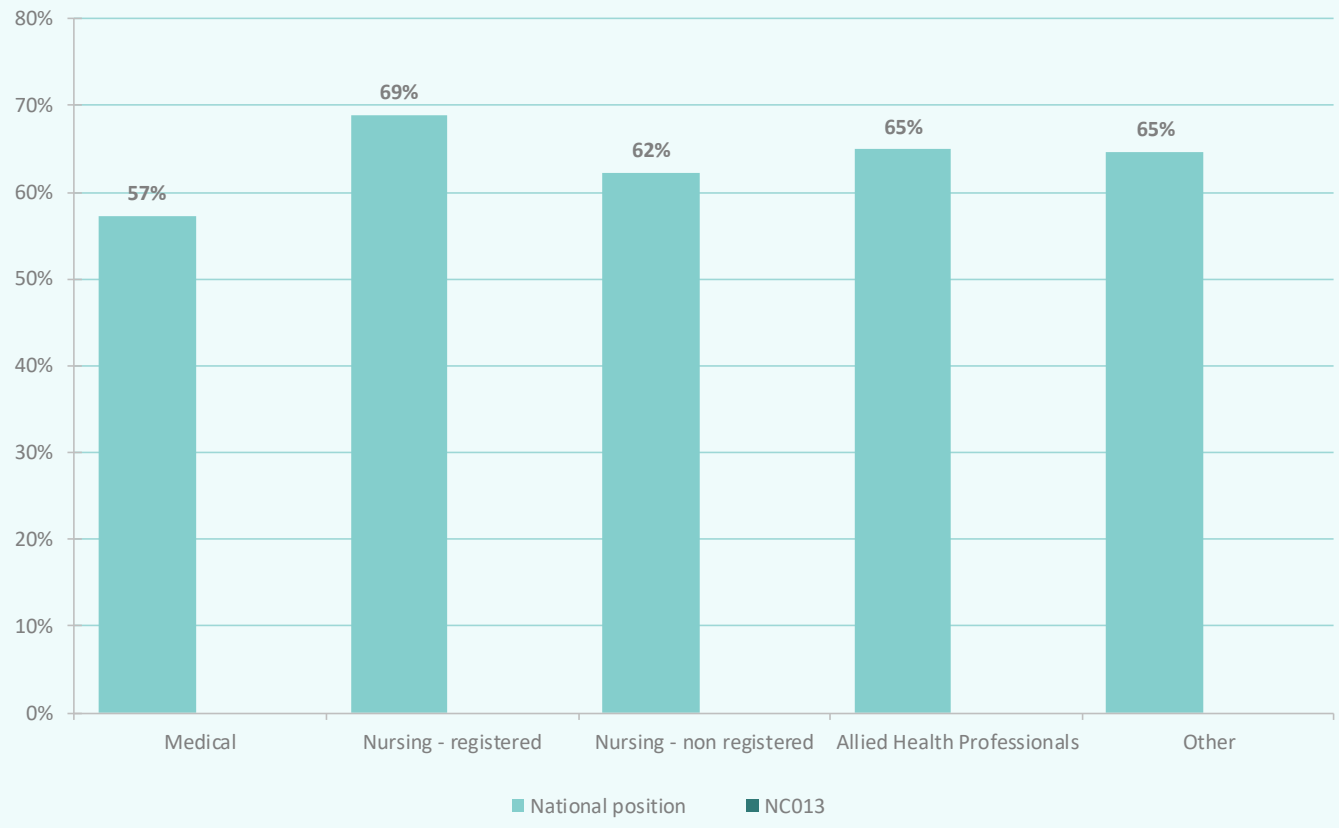


National % Yes NC013 = Yes

5.9 Workforce/specialist palliative care

Additional indicators

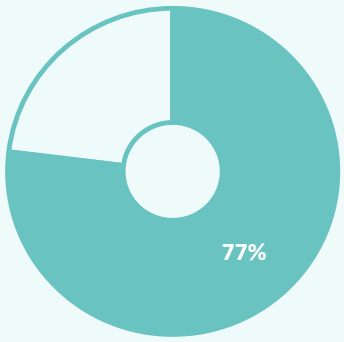
Figure 107: (H/S) Percentage of staff who have received mandatory/priority end of life care training



5.9 Workforce/specialist palliative care

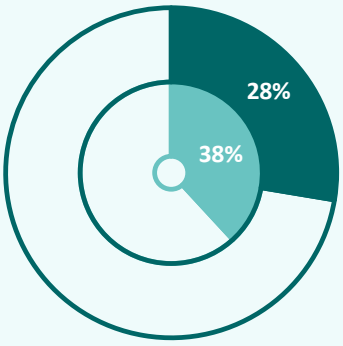
Additional indicators

Figure 108: (T/UHB) Opportunities for staff to reflect on the emotional aspects of their work



National % Yes NC013 = Yes

Figure 109: (CNR) Patient reviewed by the specialist palliative care team during final admission



National % Yes NC013 % Yes

Figure 110: (QS) Were you confident that healthcare staff looking after him/her had enough skill and experience to care for someone at the end of their life?

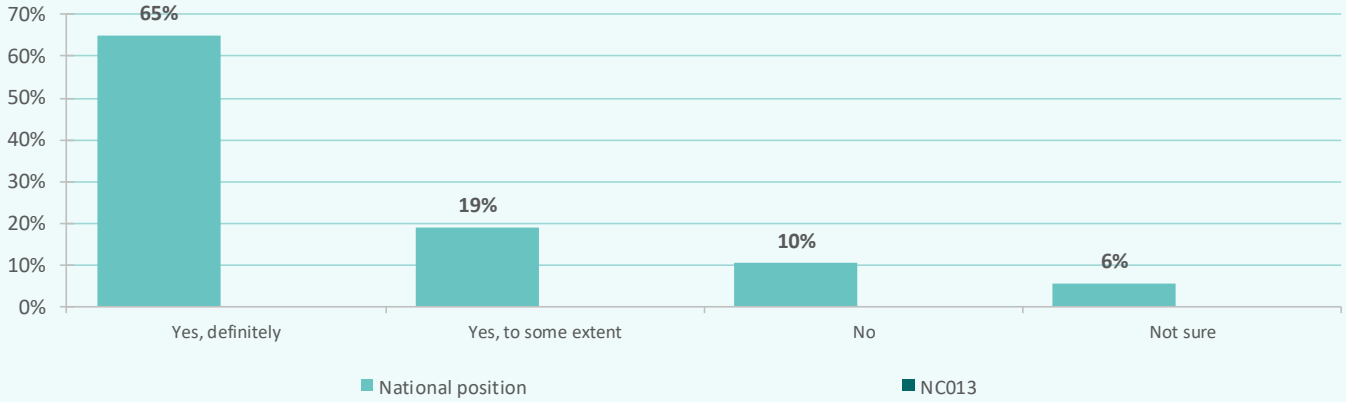
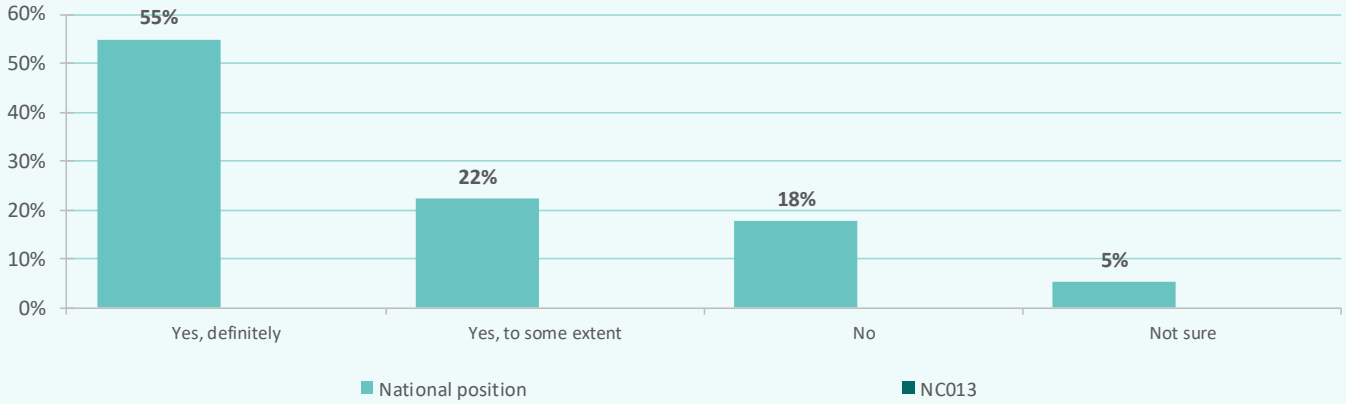


Figure 111: (QS) Did you feel that there was a consistent team approach and good coordination between different members of staff?



6. Next steps

This bespoke dashboard summaries the results of the first round of NACEL for your submission (hospital site) under nine key themes. The report includes your summary scores for each of the key themes, compared to the whole sample results. The component indicators for the summary scores are included, together with additional relevant metrics for these themes. The summary scores for each theme should not be compared to each other.

The full results for all of the indicators included in the first round of NACEL can be found in the NACEL online toolkit accessible in the members' area of the Network website. If you require a log-in for the members' area, or any other assistance, please contact nhsbn.nacelsupport@nhs.net.

The audit report for the first round of the audit covering England and Wales will be published following approval by the audit funders, NHS England and the Welsh Government. This report will include the NACEL recommendations.

Ahead of the publication of the national report and recommendations, participants are encouraged to review their local results as set out in this dashboard, and in the online toolkit, and develop a local action plan.

Second round of the audit (NACEL 2019)

The second round of the audit will take place in 2019. As in 2018, the audit will include an organisational level audit, Case Note Review and Quality Survey. The scope and content of each of the components is under discussion with the Steering Group, however, it is likely that:

- The definition of deaths will be as for the first round of NACEL, to ensure comparability.
- The content of the organisational level and Case Note Review will be reduced substantially to reduce the data burden for participants.
- The number of case notes to be reviewed will be reduced.
- The timescales will be as for the first round of NACEL, with minor amendments to allow a greater number of Quality Surveys to be collected.

References

The Leadership Alliance for the Care of Dying People. *One Chance to Get it Right. Improving people's experience of care in the last few days and hours of life*. June 2014. (This document includes the *five priorities for care* of the dying person.)

NICE. Quality Standard 13, *End of life care for adults*. November 2011

NICE. Quality Standard 144, *Care of dying adults in the last days of life*. March 2017

NICE. Guideline NG31, *Care of dying adults in the last days of life*. 2015

NHS Constitution (p17)

NHS Outcomes Framework (p34)

Appendix 1: Patient demographics

Age range	National %	National N =	NC013 %	NC013 N =
18-64	12%	1308	19%	15
65-74	17%	1827	15%	12
75-84	31%	3339	28%	22
85-94	34%	3733	36%	29
95+	6%	666	3%	2
Total		**10873**		**80**

Age	National	NC013
Range	18 - 110	35 - 101
Mean	79	76
Median	82	79

Gender	National %	National N =	NC013 %	NC013 N =
Male	49.3%	5391	64%	51
Female	50.6%	5535	36%	29
Other	0.1%	9	0.0%	0
Total		**10935**		**80**

Ethnicity profile	National %	National N =	NC013 %	NC013 N =
White	81.39%	8649	81%	65
Mixed	0.47%	50	0%	0
Asian or Asian British	2.20%	234	13%	10
Black or Black British	1.27%	135	5%	4
Other Ethnic Groups	0.77%	82	0%	0
Not stated	13.90%	1477	1%	1
Total		**10627**		**80**

Religious affiliation	National %	National N =	NC013 %	NC013 N =
Baha'i	0.01%	1	0%	0
Buddhist	0.10%	11	0%	0
Christian	50.26%	5332	63%	50
Hindu	0.42%	45	1%	1
Jain	0.02%	2	0%	0
Jewish	0.37%	39	0%	0
Muslim	1.23%	131	4%	3
Pagan	0.00%	0	0%	0
Sikh	0.37%	39	6%	5
Zoroastrian	0.00%	0	0%	0
Other	2.82%	299	3%	2
None	7.94%	842	14%	11
Declined to disclose	0.56%	59	3%	2
Unknown	35.90%	3809	8%	6
Total		**10609**		**80**

Appendix 1: Patient demographics

Primary cause of death	National %	National N =	NC013 %	NC013 N =
Cancer	17.7%	1922	20%	16
Chronic respiratory disease	5.0%	541	5%	4
Dementia	2.2%	240	5%	4
Heart failure	7.6%	822	1%	1
Neurological conditions	0.9%	101	1%	1
Pneumonia	26.8%	2905	33%	26
Renal failure	1.8%	198	3%	2
Stroke	4.8%	516	8%	6
Other	23.8%	2575	19%	15
No access to death certificate	9.4%	1013	5%	4
Total		**10833**		**79**

Documented co-morbidities	National %	National N =	NC013 %	NC013 N =
Cardiovascular	25%	3720	30%	40
Central nervous system	5%	782	5%	7
Dementia	8%	1128	10%	13
Endocrine	8%	1253	10%	14
Frailty	10%	1469	11%	15
Genitourinary	6%	921	9%	12
Malignancy	7%	1066	9%	12
Musculoskeletal	3%	487	2%	3
Respiratory	14%	2044	9%	12
Other	14%	2072	4%	6
Total		**14942**		**134**

Appendix 2: Characteristics of deaths in hospitals

Day of death	National %	National N =	NC013 %	NC013 N =
Monday	15.66%	1703	12%	9
Tuesday	14.48%	1575	18%	14
Wednesday	13.96%	1518	14%	11
Thursday	13.77%	1498	22%	17
Friday	13.77%	1498	6%	5
Saturday	12.70%	1381	15%	12
Sunday	15.67%	1704	13%	10
Total		**10877**		**78**

Time of death	National %	National N =	NC013 %	NC013 N =
00:00 - 06:00	24%	2552	21%	16
06:01 - 12:00	25%	2738	30%	23
12:01 - 18:00	27%	2917	29%	22
18:01 - 23:59	24%	2543	21%	16
Total		**10750**		**77**

Hospital department	National %	National N =	NC013 %	NC013 N =
Care of the Elderly	21.92%	2378	8%	6
Cardiology	3.12%	339	3%	2
Respiratory	10.36%	1124	9%	7
Oncology	4.02%	436	6%	5
Medical	19.01%	2062	38%	30
Neurology	0.47%	51	0%	0
Stroke	4.77%	518	8%	6
Surgical	5.12%	556	8%	6
Trauma	0.26%	28	0%	0
Orthopaedics	1.65%	179	1%	1
Urology	0.41%	45	0%	0
Renal	1.00%	109	4%	3
Critical Care Level 2 (HDU)	1.54%	167	0%	0
Critical Care Level 3 (ICU)	7.12%	772	9%	7
Acute assessment / admissions	7.82%	848	5%	4
Specialist palliative care unit	1.99%	216	0%	0
Rehabilitation unit	1.70%	184	0%	0
Other	7.71%	837	1%	1
Total		**10849**		**78**

Appendix 2: Characteristics of deaths in hospitals

Length of stay profile	National %	National N =	NC013 %	NC013 N =
0-1 days	7.0%	741	4%	3
2-10 days	46.9%	4946	46%	35
11-20 days	22.9%	2419	33%	25
21-30 days	10.6%	1114	7%	5
31-40 days	5.6%	593	7%	5
41-50 days	2.9%	309	1%	1
51-60 days	1.5%	160	1%	1
61-70 days	0.9%	91	0%	0
71-80 days	0.7%	69	1%	1
81-90	0.3%	28	0%	0
90 +	0.7%	79	0%	0
Total		**10549**		**76**

Appendix 3: Use of interventions

DNACPR in place	National %	National N =	NC013 %	NC013 N =
Yes	97%	10349	96%	76
No	3%	347	4%	3
Total		**10696**		**79**

Medication prescribed subcutaneously	National %	National N =	NC013 %	NC013 N =
Pain				
Yes	80%	8322	66%	53
No	20%	2062	34%	27
Total		**10384**		**80**
Agitation				
Yes	79%	8182	64%	51
No	21%	2236	36%	29
Total		**10418**		**80**
Dyspnoea				
Yes	73%	7598	64%	51
No	27%	2779	36%	29
Total		**10377**		**80**
Nausea				
Yes	74%	7722	65%	52
No	26%	2656	35%	28
Total		**10378**		**80**
Noisy breathing				
Yes	75%	7791	64%	51
No	25%	2582	36%	29
Total		**10373**		**80**

Nil by Mouth order in place	National %	National N =	NC013 %	NC013 N =
Yes	10%	981	9%	6
No	90%	8633	91%	61
Total		**9614**		**67**

Appendix 3: Use of interventions

Use of clinically assisted hydration	National %	National N =	NC013 %	NC013 N =
Yes	31%	3073	56%	37
No	69%	6745	44%	29
Total		**9818**		**66**

Route of clinically assisted hydration	National %	National N =	NC013 %	NC013 N =
SC	9%	269	11%	4
NG	4%	120	11%	4
PEG	1%	39	5%	2
IV	82%	2505	73%	27
N/A	4%	117	0%	0
Total		**3050**		**37**

Use of clinically assisted nutrition	National %	National N =	NC013 %	NC013 N =
Yes	7%	689	14%	9
No	93%	9010	86%	57
Total		**9699**		**66**

Route of clinically assisted nutrition	National %	National N =	NC013 %	NC013 N =
NG	64%	469	67%	6
PEG	8%	60	22%	2
IV	15%	112	11%	1
N/A	13%	95	0%	0
Total		**736**		**9**

Appendix 4: Method for scoring

A scoring system has been devised to summarise the results of the audit under nine key themes.

This appendix sets out the process undertaken to select the nine key themes and their component indicators, and an explanation of how the scores were calculated.

Selection and content of the nine key themes

The NACEL key themes were developed by the NACEL Steering Group and discussed with the wider Advisory Group. The starting point was the *five priorities for care* from *One Chance To Get It Right* as follows:

1. Recognition of dying
2. Sensitive communication
3. Involvement in decision making
4. Needs of families and others
5. Individual plan of care

Priority 2, concerning sensitive communication, was split into two themes; communication with the dying person and communication with families and others, as the Steering Group felt it was important to distinguish these linked, but different, aspects of communication. In addition, a theme on the overall rating of experience by the bereaved from the Quality Survey was included as an overarching measure of the quality of care. Finally, two further themes on governance and workforce/specialist palliative care were added to cover key aspects of the infrastructure that trusts/UHBs need to put in place to ensure good end of life care.

The component indicators for the summary scores are drawn from all three elements of the audit, including measures from the Case Note Review, the organisational level audit (trust and hospital level responses) and the Quality Survey, which provides the perspective of bereaved families and carers. However, in order to create a summary score, only indicators from one element of the audit were used for each theme. At least three indicators were used for each summary score, to provide granularity in the results. The themes and component indicators are summarised as follows:

Key theme	Source of component indicators (audit element)	Component indicators
Recognising the possibility of imminent death	Case Note Review	3 questions on recognition of death and related discussions with dying and nominated person
Communication with the dying person	Case Note Review	5 questions on discussions with the dying person on plan of care, senior clinician, side effects of medications, hydration and nutrition
Communication with families and others	Case Note Review	6 questions on discussions with nominated person on plan of care, notification of imminent death, senior clinician, side effects of medication, hydration, nutrition
Involvement in decision making	Case Note Review	6 questions on decision making including involvement, capacity, stopping life-sustaining treatments and CPR
Needs of families and other	Case Note Review	3 questions on asking about needs, needs assessed and care and support at time of death
Individual plan of care	Case Note Review	7 questions on having a care plan, reviewing the plan, holistic assessment (4 points in total), review of 4 interventions (1 point in total), review of hydration and nutrition status and preferred place of death
Families' and others' experience of care	Quality Survey	5 questions covering care and support, sensitive communication and compassionate treatment
Governance	Organisational level audit	4 questions on responsibility for end of life care, policy on learning from deaths, policy for discharge home, care plan to support 5 Priorities of Care
Workforce/ specialist palliative care	Organisational level audit	3 questions on specialist palliative care access, seven day availability and training

Appendix 4: Method for scoring

Methods of scoring

The basic principle for scoring for each audit element is outlined below.

Audit element	Scoring for each component indicator	Total score for theme
Case Note Review	Yes = 1* No, but reason recorded or N/A = 1 No and no reason recorded = 0 *Please note, a number of metrics are weighted as detailed in the tables below	• Each component indicator scored for each case note • Total score for each case note calculated by summing indicator scores • Case note scores averaged (over whole sample or hospital) • Shown as score out of 10 (equating to maximum available score)
Organisational level	Yes = 1 No = 0	• Each component indicator scored for each hospital • Total score for each hospital calculated by summing indictor scores • Hospital scores averaged • Shown as score out of 10 (equating to maximum available score)
Quality Survey	Outstanding/ Yes definitely/Always = 4 Excellent/Most of the time = 3 Good/yes to some extent/Sometimes = 2 Fair/Mixed/Almost never = 1 Poor/No not at all/ Never = 0	• Each component indicator scored for each Quality Survey • Total score for each Quality Survey calculated by summing indictors • Quality Survey scores averaged (over whole sample or hospital) • Shown as score out of 10 (equating to maximum available score)

Recognising the possibility of imminent death						
Source: Case Note Review					**EXAMPLE SCORING**	
Section	**Question**	**Scoring per question**			**Response**	**Score**
		Yes	**No but reason recorded or N/A**	**No and no reason recorded**		
Recognition of death	Is there documented evidence within the final episode of care that it was recognised that the patient might die imminently i.e. within a few hours or days?	1	-	0	Yes	1
Recognition of death	Is there documented evidence that the possibility that the patient may die had been discussed with the patient?	1	1	0	Yes	1
Recognition of death	Is there documented evidence that the possibility that the patient may die had been discussed with the nominated person(s)?	1	1	0	No and no reason recorded	0
	Total possible	**3.00**			**Total score this patient**	**2.00**
					Out of 10	**6.67**

Appendix 4: Method for scoring

Communication with the dying person						
Source: Case Note Review					**EXAMPLE SCORING**	
Section	**Question**	**Scoring per question**			**Response**	**Score**
		Yes	**No but reason recorded or N/A**	**No and no reason recorded**		
Individualised EoL care planning	Is there documented evidence that the patient had the opportunity to be involved in discussing the plan of care?	1	1	0	No and no reason recorded	0
Individualised EoL care planning	Is there documented evidence that the patient had been informed about the senior doctor/nurse in the team who has professional responsibility for their care and treatment?	1	1	0	No and no reason recorded	0
Physical care	Is there documented evidence that the possibility of side effects of medications such as drowsiness were discussed with the patient?	1	1	0	No and no reason recorded	0
Physical care	Is there documented evidence that a discussion about the risks and benefits of hydration options was undertaken with the patient once death was recognised as a possibility?	1	1	0	Yes	1
Physical care	Once it was recognised that the patient may die within the next few days and hours, was there documented evidence that a discussion about the risks and benefits of nutrition options was undertaken with the patient?	1	1	0	Yes	1
	Total possible	**5.00**			**Total score this patient**	**2.00**
					Out of 10	**4.00**

Communication with families and others						
Source: Case Note Review					**EXAMPLE SCORING**	
Section	**Question**	**Scoring per question**			**Response**	**Score**
		Yes	**No but reason recorded or N/A**	**No and no reason recorded**		
Individualised EoL care planning	Is there documented evidence that the nominated person(s) had the opportunity to develop and discuss an individualised plan of care for the patient?	1	1	0	No and no reason recorded	0
Individualised EoL care planning	Is there documented evidence that the nominated person(s) had been informed about the senior doctor/nurse in the team who has professional responsibility for care and treatment?	1	1	0	N/A	1
Immediately prior to and after death	Is there documented evidence that the nominated person(s) were notified of the patient's imminent death?	1	1	0	Yes	1
Physical care	Is there evidence that the possibility of side effects of medications such as drowsiness were discussed with the nominated person(s)?	0.33	0.33	0	No and no reason recorded	0
Physical care	Is there documented evidence that a discussion about the risks and benefits of hydration options was undertaken with the nominated person(s)?	0.33	0.33	0	No but reason recorded	0.33
Physical care	Once it was recognised that the patient may die within the next few days and hours, was there documented evidence that a discussion about the risks and benefits of nutrition options was undertaken with the nominated person(s)?	0.33	0.33	0	No and no reason recorded	0
	Total possible	**4.00**			**Total score this patient**	**2.33**
					Out of 10	**5.83**

Appendix 4: Method for scoring

Involvement in decision making						
Source: Case Note Review					**EXAMPLE SCORING**	
Section		**Scoring per question**			**Response**	**Score**
	Question	**Yes**	**No but reason recorded or N/A**	**No and no reason recorded**		
Individualised EoL care planning	Is there documented evidence about the extent to which the patient wished to be involved in decisions about their care?	1	1	0	Yes	1
Treatment decisions	Is there documented evidence in the notes that the dying person had their capacity assessed to be involved in their end of life care planning?	1	1	0	No and no reason recorded	0
Treatment decisions	Is there documented evidence within the final admission of a discussion with the patient by a senior clinician regarding whether to continue or stop life-sustaining treatment offering organ support such as assisted ventilation, implanted defibrillator, renal dialysis?	1	1	0	No but reason recorded	1
Treatment decisions	Is there documented evidence within the final admission of a discussion with the nominated person(s) by a senior clinician regarding whether to continue or stop life-sustaining treatment offering organ support such as assisted ventilation, implanted defibrillator, renal dialysis?	1	1	0	No but reason recorded	1
Treatment decisions	Is there documented evidence that a discussion with the patient regarding Cardiopulmonary Resuscitation (CPR) was undertaken by a clinician?	1	1	0	Yes	1
Treatment decisions	Is there documented evidence that the Cardiopulmonary Resuscitation (CPR) decision was discussed with the nominated person(s) by a senior clinician?	1	1	0	No but reason recorded	1
	Total possible	**6.00**			**Total score this patient**	**5.00**
					Out of 10	**8.33**

Needs of families and others						
Source: Case Note Review					**EXAMPLE SCORING**	
Section		**Scoring per question**			**Response**	**Score**
	Question	**Yes**	**No but reason recorde d or N/A**	**No and no reason recorded**		
Individualised EoL care planning	Is there documented evidence that the needs of the nominated person(s) were asked about?	1	-	0	Yes	1
Individualised EoL care planning	Of which of the following needs of the nominated person(s) is there documented evidence that they were assessed and addressed?					
Individualised EoL care planning	emotional/psychological needs	0.2	-	0	Yes	0.2
Individualised EoL care planning	spiritual/religious needs	0.2	-	0	Yes	0.2
Individualised EoL care planning	cultural needs	0.2	-	0	No	0
Individualised EoL care planning	social needs	0.2	-	0	No	0
Individualised EoL care planning	practical needs	0.2	-	0	Yes	0.2
Immediately prior to and after death	Is there documented evidence of the care and support provided to the nominated person(s) at the time of and immediately after death?	1	1	0	No and no reason recorded	0
	Total possible	**3.00**			**Total score this patient**	**1.60**
					Out of 10	**5.33**

Appendix 4: Method for scoring

Individual plan of care						
Source: Case Note Review					**EXAMPLE SCORING**	
Section		**Scoring per question**			**Response**	**Score**
	Question	**Yes**	**No but reason recorded or N/A**	**No and no reason recorded**		
Individualised EoL care planning	Is there documented evidence that the patient who was dying had an individualised end of life care plan?	0.5	-	0	Yes	0.5
Individualised EoL care planning	If there was a care plan, was the patient and their plan of care reviewed regularly?	0.5	0.5	0	Yes	0.5
Immediately prior to and after death	Was there documented evidence in the case notes of the preferred place of death as indicated by the patient?	1	-	0	Yes	1
Treatment decisions	In the period between the recognition that the patient might die and death, were any of the following interventions documented as being reviewed in the patient's plan of care?					
	routine recording of vital signs	0.25	0.25	0	Yes	0.25
	blood sugar monitoring	0.25	0.25	0	No	0
	the administration of oxygen	0.25	0.25	0	Yes	0.25
	the administration of antibiotics	0.25	0.25	0	No	0
Physical care	Is there a documented assessment of the patient's hydration status in the time between when death was recognised and time of death?	1	-	0	Yes	1
Physical care	Once it was recognised that the patient may die within the next few days and hours, was there documented assessment of the patient's nutrition status?	1	-	0	Yes	1
Individualised EoL care planning	Is there documented evidence within the individualised end of life care plan of an holistic assessment of the patient's needs? - If yes, does this include an assessment of the following					
	agitation/delirium	0.25	0.25	0	No	0
	dyspnoea/breathing difficulty	0.25	0.25	0	Yes	0.25
	nausea/vomiting	0.25	0.25	0	Yes	0.25
	pain	0.25	0.25	0	Yes	0.25
	noisy breathing/death rattle	0.25	0.25	0	Yes	0.25
	anxiety/distress	0.25	0.25	0	No	0
	bladder function	0.25	0.25	0	No	0
	bowel function	0.25	0.25	0	No	0
	pressure areas	0.25	0.25	0	No	0
	hygiene requirements	0.25	0.25	0	No	0
	mouth care	0.25	0.25	0	Yes	0.25
	emotional/psychological needs	0.25	0.25	0	Yes	0.25
	spiritual/religious needs	0.25	0.25	0	Yes	0.25
	cultural needs	0.25	0.25	0	No	0
	social needs	0.25	0.25	0	No	0
	practical needs	0.25	0.25	0	No	0
	Total possible	**9.00**			**Total score this patient**	**6.25**
					Out of 10	**6.94**

Appendix 4: Method for scoring

Families' and others' experience of care									
Source: Quality Survey								**EXAMPLE SCORING**	
Question	**Question**	**Scoring per question**						**Response**	**Score**
		Outstanding	**Excellent**	**Good**	**Fair**	**Poor**	**Not sure**		
Q15	Overall, how would you rate the care and support given to the person who died by the hospital in the last two to three days of life?	4	3	2	1	0	0	Excellent	3
Q23	Overall, how would you rate the care and support given to you and other close relatives or friends by the hospital in the last two to three days of his/her life?	4	3	2	1	0	0	Good	2
		Yes definitely	**Yes to some extent**	**Mixed**	**No not at all**	**Not sure**	**N/A**		
Q8	Did you feel that members of healthcare staff looking after him/her communicated sensitively during the last two to three days of life?	4	2	1	0	0	0	Yes to some extent	2
		Always	**Most of the time**	**Sometimes**	**Almost never**	**Never**	**Not sure & N/A**		
Q19d	During the last two to three days of his/her life, did you feel that he/she was treated with compassion?	4	3	2	1	0	0	Most of the time	3
Q14g	During the last two to three days of his/her life, did you feel that you were communicated to by staff in a sensitive and compassionate way?	4	3	2	1	0	0	Sometimes	2
	Total possible	**20.00**						**Total score this Quality Survey**	**12.00**
								Out of 10	**6.00**

Governance					
Source: Organisational level				**EXAMPLE SCORING**	
Section	**Question**	**Scoring per question**		**Response**	**Score**
		Yes	**No**		
Trust/UHB overview	Does your trust/UHB have an identified member of the trust/UHB board with a responsibility/role for End of Life Care?	1	0	Yes	1
Trust/UHB overview	Does your trust/UHB have policies in place which include how it responds to and learns from, deaths of patients who die under its management and care?	1	0	Yes	1
Trust/UHB overview	Which of the following are used within your trust/UHB: Specific care arrangements to enable rapid discharge home to die, if this is the person's preference?	1	0	No	0
Trust/UHB overview	Which of the following are used within your trust/UHB: A care plan to support the *five priorities for care for the dying person*?	1	0	Yes	1
		4.00		**Total score this hospital**	**3.00**
				Out of 10	**7.50**

Appendix 4: Method for scoring

Workforce/specialist palliative care					
Source: Organisational level				**EXAMPLE SCORING**	
Section	**Question**	**Scoring per question**		**Response**	**Score**
		Yes	**No**		
Hospital/ site overview	Is there a Specialist Palliative Care service provided by the hospital, or does your hospital have access to a Specialist Palliative Care service funded and/or based outside of the hospital/site?	1	0	Yes	1
Hospital/ site overview	Is the Specialist Palliative Care team commissioned to provide: Nurses available 9-5, 7 days a week, face-to-face (better/equivalent)	1	0	No	0
Hospital/ site overview	In the period between 1st April 2017 and 31st March 2018 what continuing End of Life education and training was available:				
Hospital/ site overview	induction Programme	0.25	0	Yes	0.25
Hospital/site overview	mandatory/ Priority Training	0.25	0	Yes	0.25
Hospital/site overview	other training in relation to End of Life Care	0.25	0	No	0
Hospital/site overview	Does your hospital provide training to help improve the culture, behaviours, attitudes around communication skills?	0.25	0	No	0
	Total possible	**3.00**		**Total score this hospital**	**1.50**
				Out of 10	**5.00**

Appendix 5: Indicators in the bespoke dashboard

Recognising the possibility of imminent death							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p9,3	Case Note Review - Recognition of death	Is there documented evidence within the final episode of care that it was recognised that the patient might die imminently i.e. within a few hours or days?	Yes	89%	9538	83%	66
			No	11%	1206	18%	14
			Total		**10744**		**80**
p9,4	Case Note Review - Recognition of death	Is there documented evidence that the possibility that the patient may die had been discussed with the patient?	Yes	22.59%	2284	22%	15
			No but reason	62.55%	6324	78%	52
			No and no reason recorded	14.86%	1502	0%	0
			Total		**10110**		**67**
pg9,5	Case Note Review - Recognition of death	Is there documented evidence that the possibility that the patient may die had been discussed with the nominated person(s)?	Yes	90%	9038	94%	63
			No but reason	5%	492	4%	3
			No and no reason recorded	5%	551	1%	1
			Total		**10081**		**67**
p10,6	Quality Survey	Did a member of healthcare staff at the hospital explain to the person that he/she was likely to die in the next few days?	Yes	28%	215	-	-
			No could have been told	10%	79	-	-
			No not possible	40%	308	-	-
			No person did not want to know	2%	15	-	-
			No other	8%	63	-	-
			Don't know	12%	89	-	-
			Total		**769**		**-**
p10,7	Quality Survey	Did a member of healthcare staff at the hospital explain to you that the person was likely to die in the next few days?	Yes clearly	62.08%	465	-	-
			Yes but not clearly	7.21%	54	-	-
			Yes but only when asked	5.47%	41	-	-
			No but could have been told	13.62%	102	-	-
			No died suddenly	9.35%	70	-	-
			Not sure	2.27%	17	-	-
			Total		**749**		**-**
p10,8	Case Note Review - Recognition of death	Date and time of first recognition of death & Date and time of death	Mean time from first recognition of death to death (hours)	74	8866	118	64

Appendix 5: Indicators in the bespoke dashboard

Communication with the dying person							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p12, 10	Case Note Review - Individualised EOL care planning	Is there documented evidence that the patient had the opportunity to be involved in discussing the plan of care?	Yes	20%	2002	18%	13
			No	32%	3211	4%	3
			N/A	48%	4816	77%	55
			Total		**10029**		**71**
p12, 11	Case Note Review - Individualised EOL care planning	Is there documented evidence that the patient had been informed about the senior doctor/nurse in the team who has professional responsibility for their care and treatment?	Yes	33%	3271	31%	24
			No	31%	3087	6%	5
			N/A	36%	3653	63%	49
			Total		**10011**		**78**
p12, 12	Case Note Review - Physical care	Is there documented evidence that the possibility of side effects of medications such as drowsiness were discussed with the patient?	Yes	8%	789	5%	4
			No but reason recorded	60%	6035	44%	32
			No and no reason recorded	32%	3160	51%	37
			Total		**9984**		**73**
p12, 13	Case Note Review - Physical care	Is there documented evidence that a discussion about the risks and benefits of hydration options was undertaken with the patient once death was recognised as a possibility ?	Yes	9%	919	11%	7
			No but reason recorded	59%	5792	67%	43
			No and no reason recorded	32%	3092	22%	14
			Total		**9803**		**64**
p12, 14	Case Note Review - Physical care	Once it was recognised that the patient may die within the next few days and hours, was there documented evidence that a discussion about the risks and benefits of nutrition options was undertaken with the patient?	Yes	7%	661	11%	7
			No but reason recorded	62%	5967	66%	41
			No and no reason recorded	31%	3036	23%	14
			Total		**9664**		**62**
p13, 15	Trust/ UHB overview	Does your Trust/ UHB have policies in place which include - guidelines to promote dignity?	Yes	90%	162	-	1
			No	10%	19	-	0
			Total		**181**		**1**

Appendix 5: Indicators in the bespoke dashboard

Communication with families and others							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p15, 17	Case Note Review - Individualised EOL care planning	Is there documented evidence that the nominated person(s) had the opportunity to develop and discuss an individualised plan of care for the patient?	Yes	62%	6205	63%	45
			No	26%	2626	13%	9
			N/A	12%	1162	24%	17
			Total		**9993**		**71**
p15, 18	Case Note Review - Individualised EOL care planning	Is there documented evidence that the nominated person(s) had been informed about the senior doctor/nurse in the team who has professional responsibility for care and treatment?	Yes	65.48%	6552	85%	66
			No but reason recorded	30.33%	3035	12%	9
			No and no reason recorded	4.19%	419	4%	3
			Total		**10006**		**78**
p15, 19	Case Note Review - Immediately prior to and after death	Is there documented evidence that the nominated person(s) were notified of the patient's imminent death?	Yes	79%	8446	72%	56
			No but reason recorded	7%	698	19%	15
			No and no reason recorded	14%	1506	9%	7
			Total		**10650**		**78**
p15, 20	Case Note Review - Physical care	Is there evidence that the possibility of side effects of medications such as drowsiness were discussed with the nominated person(s)?	Yes	15.7%	1538	12%	9
			No but reason recorded	10.8%	1055	11%	8
			No and no reason recorded	73.5%	7199	77%	56
			Total		**9792**		73
p15, 21	Case Note Review - Physical care	Is there documented evidence that a discussion about the risks and benefits of hydration options was undertaken with the nominated person(s)?	Yes	30%	2918	54%	35
			No but reason recorded	9%	890	8%	5
			No and no reason recorded	61%	5983	38%	25
			Total		**9791**		**65**
p15, 22	Case Note Review - Physical care	Is there documented evidence that a discussion about the risks and benefits of nutrition options was undertaken with the nominated person(s)?	Yes	23.4%	2264	44%	28
			No but reason recorded	10.2%	981	8%	5
			No and no reason recorded	66.4%	6410	48%	31
			Total		**9655**		**64**

Appendix 5: Indicators in the bespoke dashboard

Communication with families and others							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p16, 23	Trust/ UHB overview	Does your Trust/ UHB have policies in place which include: guidelines for meaningful and compassionate engagement with bereaved families and carers?	Yes	70%	125	-	0
			No	30%	53	-	1
			Total		**178**		**1**
p16, 24	Hospital/ Site overview - Quality and outcomes	Did your hospital/ site seek bereaved relatives' or friends' views during the last two financial years? (i.e. from 1st April 2016 and 31st March 2018)	Yes	76.5%	169	-	1
			No	23.5%	52	-	0
			Total		**221**		**1**
p16, 25	Quality Survey	Did you and/ or others close to the patient receive clear communication about the patient's imminent death soon enough to be with the person when he/she died?	Yes	53.48%	400	-	-
			No	21.39%	160	-	-
			Already there	18.85%	141	-	-
			The hospital did not know the death was imminent	6.28%	47	-	-
			Total		**748**		**-**
p16, 26	Quality Survey	Were given the name of the doctor and nurse responsible for his/her care?	Always	44.73%	335	-	-
			Most of the time	18.16%	136	-	-
			Sometimes	12.82%	96	-	-
			Almost never	5.47%	41	-	-
			Never	13.48%	101	-	-
			N/A	1.47%	11	-	-
			Not sure	3.87%	29	-	-
			Total		**749**		**-**
p16, 27	Quality Survey	During the last two to three days of his/her life, did you feel that you were given enough opportunity to ask questions and discuss his/her condition and care with staff?	Always	45.35%	346	-	-
			Most of the time	24.12%	184	-	-
			Sometimes	14.55%	111	-	-
			Almost never	7.60%	58	-	-
			Never	5.64%	43	-	-
			N/A	2.23%	17	-	-
			Not sure	0.52%	4	-	-
			Total		**763**		**-**
p16, 28	Quality Survey	During the last two to three days of his/her life, did you feel that you were kept informed by healthcare staff about his/her condition and treatment in a way which was easy to understand?	Always	48.75%	371	-	-
			Most of the time	23.92%	182	-	-
			Sometimes	11.96%	91	-	-
			Almost never	6.70%	51	-	-
			Never	6.96%	53	-	-
			N/A	1.18%	9	-	-
			Not sure	0.53%	4	-	-
			Total		**761**		**-**

Appendix 5: Indicators in the bespoke dashboard

Involvement in decision making							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p18, 30	Case Note Review - Individualised EOL care planning	Is there documented evidence about the extent to which the patient wished to be involved in decisions about their care?	Yes	18%	1795	18%	13
			No	38%	3772	11%	8
			N/A	44%	4288	72%	53
			Total		**9855**		**74**
p18, 31	Case Note Review - Treatment decisions	Is there documented evidence in the notes that the dying person had their capacity assessed to be involved in their end of life care planning?	Yes	43%	4584	64%	51
			No	23%	2492	10%	8
			N/A	34%	3597	26%	21
			Total		**10673**		**80**
p18, 32	Case Note Review - Treatment decisions	Is there documented evidence within the final admission of a discussion with the patient by a senior clinician regarding whether to continue or stop life-sustaining treatment offering organ support such as assisted ventilation, implanted defibrillator, renal dialysis?	Yes	15.36%	1631	4%	3
			No but reason recorded	76.37%	8107	96%	76
			No and no reason recorded	8.27%	878	0%	0
			Total		**10616**		**79**
p18, 33	Case Note Review - Treatment decisions	Is there documented evidence within the final admission of a discussion with the nominated person by a senior clinician regarding whether to continue or stop life-sustaining treatment offering organ support such as assisted ventilation, implanted defibrillator, renal dialysis?	Yes	35.3%	3702	16%	13
			No but reason recorded	57.3%	6009	84%	66
			No and no reason recorded	7.4%	776	0%	0
			Total		**10487**		**79**

Appendix 5: Indicators in the bespoke dashboard

Involvement in decision making							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p18, 34	Case Note Review - Treatment decisions	Is there documented evidence that a discussion with the patient regarding Cardiopulmonary Resuscitation (CPR) was undertaken by a clinician?	Yes	42%	4408	29%	22
			No but reason recorded	50%	5332	68%	52
			No and no reason recorded	8%	868	3%	2
			Total		**10608**		**76**
p18, 35	Case Note Review - Treatment decisions	Is there documented evidence that the Cardiopulmonary Resuscitation (CPR) decision was discussed with the nominated person(s) by a senior clinician ?	Yes	80%	8239	92%	68
			No but reason recorded	8%	830	7%	5
			No and no reason recorded	12%	1224	1%	1
			Total		**10293**		**74**
p19, 36	Quality Survey	Did staff at the hospital involve the person in decisions about care and treatment as much as he/she would have wanted in the last two to three days of life?	He/ she was involved as much as he/she wanted to be	38.0%	294	-	-
			He/she would have liked to be more involved	7.4%	57	-	-
			He/she would have liked to be less involved	0.4%	3	-	-
			He/she was not able to be involved	42.8%	331	-	-
			Not sure	11.4%	88	-	-
			Total		**773**		**-**
p19, 37	Quality Survey	Did staff at the hospital involve you in decisions about his/her care and treatment as much as you wanted in the last two to three days of life?	I was involved as much as I wanted to be	70.3%	526	-	-
			I would have liked to be more involved	22.1%	165	-	-
			I would have liked to be less involved	0.1%	1	-	-
			I was not able to be involved	4.4%	33	-	-
			Not sure	3.1%	23	-	-
			Total		**748**		**-**

Appendix 5: Indicators in the bespoke dashboard

Needs of families and others							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p21, 39	Case Note Review - Individualised EOL care planning	Is there documented evidence that the needs of the nominated person(s) were asked about?	Yes	56%	5534	74%	54
			No	44%	4367	26%	19
			Total		**9901**		**73**
p21, 40	Case Note Review - Immediately prior to and after death	Is there documented evidence of the care and support provided to the nominated person(s) at the time of and immediately after death?	Yes	61.3%	6425	60%	47
			No	36.3%	3801	36%	28
			No but there was no nominated persons	2.4%	252	4%	3
			Total		**10478**		**78**
	Case Note Review - Individualised EOL care planning	Of which of the following needs of the nominated person(s) is there documented evidence that they were assessed and addressed?					
p21, 41		Emotional/psychological needs	Yes	67%	4951	100%	50
			No	33%	2386	0%	0
			Total		**7337**		**50**
p21, 42		Spiritual/religious needs	Yes	34%	2309	50%	7
			No	66%	4450	50%	7
			Total		**6759**		**14**
p21, 43		Cultural needs	Yes	25%	1622	50%	7
			No	75%	4854	50%	7
			Total		**6476**		**14**
p21, 44		Social needs	Yes	46%	3160	94%	32
			No	54%	3663	6%	2
			Total		**6823**		**34**
p21, 45		Practical needs	Yes	61%	4356	98%	45
			No	39%	2754	2%	1
			Total		**7110**		**46**
p23, 46	Trust/ UHB overview	Does your Trust/ UHB have policies in place which include : a care after death and bereavement policy?	Yes	90%	164	-	1
			No	10%	18	-	0
			Total		**182**		**1**
p23, 47	Trust/ UHB overview	Does your Trust/ UHB have policies in place which include : guidelines for providing relatives/carers with verification and certification of the death?	Yes	97%	176	-	1
			No	3%	6	-	0
			Total		**182**		**1**
p23, 48	Trust/ UHB overview	Does your Trust/ UHB have policies in place which include: guidelines for referral to 'Pastoral care/Chaplaincy team?	Yes	85%	155	-	1
			No	15%	27	-	0
			Total		**182**		**1**

Appendix 5: Indicators in the bespoke dashboard

Needs of families and others							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p23, 49	Trust/ UHB overview	Does your Trust/ UHB have polices in place which include: guidelines for viewing the body in the immediate time after the death of a patient?	Yes	90%	162	-	1
			No	10%	19	-	0
			Total		**181**		**1**
p23, 50	Hospital/ site overview - Quality and Outcomes	Does your hospital/site give the following written information to families and those people that are important to the patient during the patients admission and when the patient has died: DWP leaflet 1027, 'What to do after death in England and Wales' or equivalent ?	Yes	87%	188	-	1
			No	13%	29	-	0
			Total		**217**		**1**
p23, 51	Hospital/ site overview - Quality and Outcomes	Does your hospital/site give the following written information to families and those people that are important to the patient during the patients admission and when the patient has died: A leaflet explaining procedures to be undertaken after the death of a patient?	Yes	96%	215	-	1
			No	4%	10	-	0
			Total		**225**		**1**
p24, 52	Hospital/site - Quality and outcomes	Support process available in the hospital/ site for people important to the dying patient -					
		Ability to facilitate overnight stays for family members/friends of the patient	Yes	95%	213	-	1
			No	5%	12	-	0
			Total		**225**		**1**
		Multi-faith spiritual/religious support	Yes	94%	214	-	1
			No	6%	13	-	0
			Total		**227**		**1**
		Use of 'Last Days of Life care plan'	Yes	93%	213	-	1
			No	7%	15	-	0
			Total		**228**		**1**
		Specialist Palliative Care Team	Yes	93%	213	-	1
			No	7%	15	-	0
			Total		**228**		**1**
		Macmillan/Marie Curie Palliative Care Clinical Nurse Specialist or information	Yes	92%	207	-	1
			No	8%	19	-	0
			Total		**226**		**1**
		Specialist or lead nurses- EOL and other specialities	Yes	88%	198	-	0
			No	12%	26	-	1
			Total		**224**		**1**
		Designated prayer room, chapel	Yes	86%	195	-	1
			No	14%	32	-	0
			Total		**227**		**1**
		Achieving Priorities of Care planning guidance for last days & hours of life	Yes	85%	187	-	1
			No	15%	34	-	0
			Total		**221**		**1**
		Bereavement cards/leaflets	Yes	82%	186	-	1
			No	18%	41	-	0
			Total		**227**		**1**

Appendix 5: Indicators in the bespoke dashboard

Needs of families and others							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p24, 52	Hospital/site - Quality and outcomes	Designated 'quiet spaces' available for relatives or carers	Yes	79%	180	-	1
			No	21%	47	-	0
			Total		**227**		**1**
		Car parking permit	Yes	79%	168	-	1
			No	21%	44	-	0
			Total		**212**		**1**
		Access to bereavement services/bereavement team	Yes	75%	170	-	0
			No	25%	57	-	1
			Total		**227**		**1**
		Hospice services support	Yes	73%	161	-	0
			No	27%	61	-	1
			Total		**222**		**1**
		Volunteer support schemes	Yes	60%	131	-	0
			No	40%	87	-	1
			Total		**218**		**1**
		Comfort care packs	Yes	53%	118	-	1
			No	47%	105	-	0
			Total		**223**		**1**
		Access to counselling services	Yes	50%	113	-	0
			No	50%	113	-	1
			Total		**226**		**1**
		Psychologist for adult and/or child	Yes	46%	102	-	0
			No	54%	120	-	1
			Total		**222**		**1**
p25, 53	Quality Survey	Did you feel supported by hospital staff after he/she had died?	Yes, definitely	53.03%	402	-	-
			Yes, to some extent	29.16%	221	-	-
			No , not at all	13.32%	101	-	-
			Not sure	1.45%	11	-	-
			N/A	3.03%	23	-	-
			Total		**758**		**-**
p25, 54	Quality Survey	During the last two to three days of his/her life, did you feel that you were given enough emotional help and support by staff?	Always	44.4%	338	-	-
			Most of the time	16.7%	127	-	-
			Sometimes	13.0%	99	-	-
			Almost never	6.3%	48	-	-
			Never	12.3%	94	-	-
			N/A	5.9%	45	-	-
			Not sure	1.4%	11	-	-
			Total		**762**		**-**
p25, 55	Quality Survey	During the last two to three days of his/her life, did you feel that you were given enough practical support (e.g. finding refreshments and parking arrangements)?	Always	44%	333	-	-
			Most of the time	14%	104	-	-
			Sometimes	8%	59	-	-
			Almost never	5%	36	-	-
			Never	14%	109	-	-
			N/A	14%	108	-	-
			Not sure	1%	8	-	-
			Total		**757**		**-**
p25, 56	Quality Survey	Were there any unexplained delays in the hospital providing you with certification of death?	Yes	15.4%	117	-	-
			No	82.4%	626	-	-
			Don't know	2.2%	17	-	-
			Total		**760**		**-**

Appendix 5: Indicators in the bespoke dashboard

Individual plan of care							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p27, 58	Case Note Review- Individualised EOL care planning	Is there documented evidence that the patient who was dying had an individualised end of life care plan?	Yes	62%	6527	67%	52
			No	38%	4042	33%	26
			Total		**10569**		**78**
p27, 29	Case Note Review- Individualised EOL care planning	If there was a care plan, was the patient and their plan of care reviewed regularly?	Yes	64%	4760	92%	44
			No	5%	406	0%	0
			Patient died soon after recognition	31%	2322	8%	4
			Total		**7488**		**48**
p27, 60	Case Note Review- Immediately prior to and after death	Was there documented evidence in the case notes of the preferred place of death as indicated by the patient?	Yes	28%	2880	14%	11
			No	72%	7409	86%	67
			Total		**10289**		**78**
p27, 61	Case Note Review- Treatment decisions	In the period between the recognition that the patient might die and death, was routine recording of vital signs documented as being reviewed in the patient's plan of care?	Yes	70%	7088	84%	59
			No	25%	2562	14%	10
			N/A	5%	539	1%	1
			Total		**10189**		**70**
p28, 62	Case Note Review- Treatment decisions	In the period between the recognition that the patient might die and death, was blood sugar monitoring documented as being reviewed in the patient's plan of care?	Yes	32%	3163	56%	35
			No	33%	3279	22%	14
			N/A	35%	3489	22%	14
			Total		**9931**		**63**
p28, 63	Case Note Review- Treatment decisions	In the period between the recognition that the patient might die and death, was administration of oxygen documented as being reviewed in the patient's plan of care?	Yes	52%	5185	75%	48
			No	30%	3031	17%	11
			N/A	18%	1825	8%	5
			Total		**10041**		**64**
p28, 64	Case Note Review- Treatment decisions	In the period between the recognition that the patient might die and death, was administration of antibiotics documented as being reviewed in the patient's plan of care?	Yes	58%	5856	70%	46
			No	26%	2605	12%	8
			N/A	16%	1626	18%	12
			Total		**10087**		**66**
p28, 65	Case Note Review- Physical care	Is there a documented assessment of the patient's hydration status in the time between when death was recognised and time of death?	Yes	75%	7493	88%	59
			No	25%	2518	12%	8
			Total		**10011**		**67**
p28, 66	Case Note Review- Physical care	Once it was recognised that the patient may die within the next few days and hours, was there documented assessment of the patient's nutrition status?	Yes	61%	6007	84%	56
			No	39%	3813	16%	11
			Total		**9820**		**67**

Appendix 5: Indicators in the bespoke dashboard

Individual plan of care							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p29, 67,68	Case Note Review- Individualised EOL care planning	Is there documented evidence within the individualised end of life care plan of an holistic assessment of the patient's needs? - If yes, does this include an assessment of the following					
		Agitation / delirium	Yes	79%	6191	92%	45
			No	13%	1019	4%	2
			N/A	8%	609	4%	2
			Total		**7819**		**49**
		Dyspnoea / breathing difficulty	Yes	80%	6284	94%	46
			No	12%	932	2%	1
			N/A	8%	595	4%	2
			Total		**7811**		**49**
		Nausea / vomiting	Yes	69.49%	5382	84%	38
			No	18.13%	1404	7%	3
			N/A	12.38%	959	9%	4
			Total		**7745**		**45**
		Pain	Yes	85.7%	6719	92%	46
			No	7.7%	603	6%	3
			N/A	6.6%	519	2%	1
			Total		**7841**		**50**
		Noisy breathing / death rattle	Yes	72.42%	5625	87%	41
			No	18.12%	1407	11%	5
			N/A	9.46%	735	2%	1
			Total		**7767**		**47**
		Anxiety / distress	Yes	76.46%	5949	87%	41
			No	14.06%	1094	9%	4
			N/A	9.48%	738	4%	2
			Total		**7781**		**47**
		Bladder function	Yes	83.4%	6487	98%	49
			No	10.2%	794	0%	0
			N/A	6.4%	496	2%	1
			Total		**7777**		**50**
		Bowel function	Yes	78%	6013	98%	47
			No	15%	1158	0%	0
			N/A	7%	573	2%	1
			Total		**7744**		**48**
		Pressure areas	Yes	86%	6729	96%	51
			No	8%	619	2%	1
			N/A	6%	447	2%	1
			Total		**7795**		**53**

Appendix 5: Indicators in the bespoke dashboard

Individual plan of care							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p29, 67,68	Case Note Review- Individualised EOL care planning	Hygiene requirements	Yes	84%	6567	96%	47
			No	10%	751	4%	2
			N/A	6%	454	0%	0
			Total		**7772**		**49**
		Mouth care	Yes	80%	6223	98%	51
			No	14%	1101	2%	1
			N/A	6%	441	0%	0
			Total		**7765**		**52**
		Emotional / psychological needs	Yes	52%	4026	87%	39
			No	26%	1998	7%	3
			N/A	22%	1656	7%	3
			Total		**7680**		**45**
		Spiritual / religious needs	Yes	47%	3606	58%	21
			No	37%	2804	33%	12
			N/A	16%	1243	8%	3
			Total		**7653**		**36**
		Cultural needs	Yes	30%	2238	39%	13
			No	45%	3406	45%	15
			N/A	25%	1917	15%	5
			Total		**7561**		**33**
		Social needs	Yes	46%	3508	71%	24
			No	32%	2421	21%	7
			N/A	22%	1661	9%	3
			Total		**7590**		**34**
		Practical needs	Yes	53%	4008	84%	36
			No	26%	1942	9%	4
			N/A	21%	1574	7%	3
			Total		**7524**		**43**
p30, 69	Quality Survey	Do you feel that staff at the hospital took time to explore what was important to him/her in terms of individual requirements and care in the last few days of life?	Yes, definitely	43%	336	-	-
			Yes, to some extent	18%	142	-	-
			No	19%	145	-	-
			Not sure	9%	70	-	-
			N/A	11%	83	-	-
			Total		**776**		**-**
p30, 70	Quality Survey	Do you feel that staff at the hospital made a plan for the person's care which took account of his/her individual requirements and wishes?	Yes, definitely	44.0%	341	-	-
			Yes, to some extent	23.0%	178	-	-
			No	16.4%	127	-	-
			Not sure	9.4%	73	-	-
			N/A	7.2%	56	-	-
			Total		**775**		**-**
p30, 71	Quality Survey	During the last two to three days of his/her life, did you feel that he/she had care for emotional needs (e.g. feeling low, feeling worried, feeling anxious) met by staff?	Always	25.30%	191	-	-
			Most of the time	10.46%	79	-	-
			Sometimes	7.28%	55	-	-
			Almost never	5.17%	39	-	-
			Never	7.02%	53	-	-
			N/A	31.52%	238	-	-
			Not sure	13.25%	100	-	-
			Total		**755**		**-**

Appendix 5: Indicators in the bespoke dashboard

Individual plan of care							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p30, 72	Quality Survey	During the last two to three days of his/her life, did you feel that staff took into account his/her beliefs, hopes, traditions, religion and spirituality?	Always	34.14%	254	-	-
			Most of the time	6.05%	45	-	-
			Sometimes	2.69%	20	-	-
			Almost never	1.21%	9	-	-
			Never	8.47%	63	-	-
			N/A	33.06%	246	-	-
			Not sure	14.38%	107	-	-
			Total		**744**		**-**
p31, 73	Quality Survey	During the last two to three days of his/her life, did you feel that he/she was given sufficient pain relief?	Always	53%	401	-	-
			Most of the time	19%	142	-	-
			Sometimes	7%	55	-	-
			Almost never	3%	23	-	-
			Never	1%	11	-	-
			N/A	9%	67	-	-
			Not sure	8%	61	-	-
			Total		**760**		**-**
p31, 74	Quality Survey	During the last two to three days of his/her life, did you feel that he/she had sufficient relief of symptoms other than pain (such as nausea or restlessness)?	Always	42%	315	-	-
			Most of the time	20%	151	-	-
			Sometimes	10%	76	-	-
			Almost never	3%	22	-	-
			Never	3%	24	-	-
			N/A	13%	99	-	-
			Not sure	9%	68	-	-
			Total		**755**		**-**
p31, 75	Quality Survey	During the last two to three days of his/her life, did you feel that he/she had support to drink or receive fluid if he/she wished?	Always	36.47%	275	-	-
			Most of the time	13.66%	103	-	-
			Sometimes	10.88%	82	-	-
			Almost never	4.64%	35	-	-
			Never	4.51%	34	-	-
			N/A	24.14%	182	-	-
			Not sure	5.70%	43	-	-
			Total		**754**		**-**
p31, 76	Quality Survey	During the last two to three days of his/her life, did you feel that he/she had support to eat or receive nutrition if he/she wished?	Always	30%	227	-	-
			Most of the time	13%	95	-	-
			Sometimes	9%	70	-	-
			Almost never	5%	37	-	-
			Never	5%	38	-	-
			N/A	32%	244	-	-
			Not sure	6%	48	-	-
			Total		**759**		**-**
p32, 77	Case Note Review - Immediately prior to and after death	Was any attempt made to move the patient home / to a hospice if that was their preferred place of death?	Yes	11%	923	6%	4
			No	29%	2473	16%	10
			Patient didn't want to be moved	9%	757	0%	0
			N/A	51%	4293	77%	48
			Total		**8446**		**62**

Appendix 5: Indicators in the bespoke dashboard

Individual plan of care							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p32, 78	Case Note Review - Other	Is there documented evidence that if a side room had been requested for this patient, that it wasn't available?	Yes	5%	431	0%	0
			No	43%	3987	28%	22
			N/A	52%	4868	73%	58
			Total		**9286**		**80**
p32, 79	Quality Survey	In the last two to three days of life were efforts made to transfer the person from hospital if that was his/her wish?	Yes, definitely	9%	70	-	-
			Yes, to some extent	6%	48	-	-
			No, not at all	16%	122	-	-
			Not sure	3%	21	-	-
			N/A / not possible	57%	442	-	-
			Not a priority/ not wanted	9%	72	-	-
			Total		**775**		**-**
p32, 80	Quality Survey	On balance, do you think that hospital was the right place for him/her to die?	Yes	75%	583	-	-
			No	15%	116	-	-
			Not sure	10%	74	-	-
			Total		**773**		**-**
p33, 81	Quality Survey	Within the hospital where did the person die?	In a bay shared with other patients	32.07%	246	-	-
			In a side room	55.67%	427	-	-
			In Intensive Care or the HDU	7.69%	59	-	-
			Other	4.56%	35	-	-
			Total		**767**		**-**
p33, 82	Quality Survey	Were you satisfied that this location within the hospital was appropriate?	Yes	75%	580	-	-
			No	18%	142	-	-
			Not sure	7%	52	-	-
			Total		**774**		**-**
p33, 83	Quality Survey	During the last two to three days of his/her life, did you feel that he/she had adequate privacy?	Always	51.02%	376	-	-
			Most of the time	23.34%	172	-	-
			Sometimes	10.04%	74	-	-
			Almost never	5.43%	40	-	-
			Never	6.24%	46	-	-
			N/A	1.49%	11	-	-
			Not sure	2.44%	18	-	-
			Total		**737**		**-**
p33, 84	Quality Survey	During the last two to three days of his/her life, did you feel that he/she had a suitable environment with sufficient peace and quiet?	Always	46%	341	-	-
			Most of the time	22%	160	-	-
			Sometimes	12%	88	-	-
			Almost never	7%	52	-	-
			Never	9%	67	-	-
			N/A	2%	17	-	-
			Not sure	2%	14	-	-
			Total		**739**		**-**

Appendix 5: Indicators in the bespoke dashboard

Families and others' experience of care							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p35, 86	Quality Survey	Overall, how would you rate the care and support given to the person who died by the hospital in the last two to three days of life?	Outstanding	31.5%	237	-	-
			Excellent	29.5%	222	-	-
			Good	17.8%	134	-	-
			Fair	8.1%	61	-	-
			Poor	10.8%	81	-	-
			Not sure	2.3%	17	-	-
			Total		**752**		**-**
p35, 87	Quality Survey	Overall, how would you rate the care and support given to you and other close relatives or friends by the hospital in the last two to three days of his/her life?	Outstanding	29.15%	209	-	-
			Excellent	27.62%	198	-	-
			Good	18.83%	135	-	-
			Fair	9.76%	70	-	-
			Poor	13.11%	94	-	-
			Not sure	1.53%	11	-	-
			Total		**717**		**-**
p35, 88	Quality Survey	Did you feel that members of healthcare staff looking after him/her communicated sensitively during the last two to three days of life?	Yes, definitely	55.47%	431	-	-
			Yes, to some extent	12.23%	95	-	-
			Mixed, some did, others did not	15.83%	123	-	-
			No, not at all	6.05%	47	-	-
			Not sure	4.12%	32	-	-
			N/A	6.31%	49	-	-
			Total		**777**		**-**
p36, 89	Quality Survey	During the last two to three days of his/her life, did you feel that he/she was treated with compassion?	Always	63.6%	475	-	-
			Most of the time	18.1%	135	-	-
			Sometimes	8.7%	65	-	-
			Almost never	2.9%	22	-	-
			Never	3.3%	25	-	-
			N/A	0.7%	5	-	-
			Not sure	2.7%	20	-	-
			Total		**747**		**-**
p36, 90	Quality Survey	During the last two to three days of his/her life, did you feel that you were communicated to by staff in a sensitive and compassionate way?	Always	60.5%	460	-	-
			Most of the time	17.2%	131	-	-
			Sometimes	13.4%	102	-	-
			Almost never	2.4%	18	-	-
			Never	4.9%	37	-	-
			N/A	1.1%	8	-	-
			Not sure	0.5%	4	-	-
			Total		**760**		**-**

Appendix 5: Indicators in the bespoke dashboard

Governance							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p38, 92	Trust/ UHB overview	Does your trust/UHB have an identified member of the trust/UHB board with a responsibility/role for End of Life Care?	Yes	94%	172	-	1
			No	6%	11	-	0
			Total		**183**		**1**
p38, 93	Trust/ UHB overview	Does your trust / UHB have policies in place which include how it responds to and learns from, deaths of patients who die under its management and care?	Yes	98%	175	-	1
			No	2%	4	-	0
			Total		**179**		**1**
p38, 94	Trust/ UHB overview	Which of the following are used within your trust/UHB: Specific care arrangements to enable rapid discharge home to die, if this is the person's preference?	Yes	92%	165	-	1
			No	8%	15	-	0
			Total		**180**		**1**
p38, 95	Trust/ UHB overview	Which of the following are used within your trust/UHB: A care plan to support the Five Priorities of Care for the Dying Person?	Yes	97%	176	-	1
			No	3%	6	-	0
			Total		**182**		**1**
p39, 96	Hospital/Site - Quality and outcomes	Within your trust/UHB quality governance structure was there a formal process for discussing and reporting on the fire priorities of care, between 1st April 2017 and 31st March 2018?	Yes	71%	154	-	1
			No	29%	64	-	0
			Total		**218**		**1**
p39, 97	Hospital/Site - Quality and outcomes	Was an action plan produced in the financial year (i.e. between 1st April 2017 and 31st March 2018 to promote improvement in end of life care in your trust/UHB?	Yes	90%	205	-	1
			No	10%	22	-	0
			Total		**227**		**1**
p39, 98	Trust/ UHB overview	Does your trust/UHB have a non executive director responsible for the oversight of the national guidance on learning from deaths agenda progress?	Yes	84%	146	-	1
			No	16%	27	-	0
			Total		**173**		**1**
p39, 99	Hospital/Site - Quality and outcomes	Does your hospital/site have a mechanism for flagging complaints that relate to end of life care?	Yes	90%	203	-	0
			No	10%	22	-	1
			Total		**225**		**1**

Appendix 5: Indicators in the bespoke dashboard

Workforce/specialist palliative care							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p41, 101	Hospital/ Site - Specialist palliative care workforce	Is there a Specialist Palliative Care service provided by the hospital? Or does your hospital have access to a SPC service funded and/or based outside of the hospital/site?	Yes	97%	225	-	1
			No	3%	6	-	0
			Total		**231**		**1**
p41, 102	Hospital/ Site - Specialist palliative care workforce	Is the Specialist Palliative Care team commissioned to provide: Nurses available 9-5, 7 days a week (face-to-face) (or better/equivalent)	Yes	52%	108	-	0
			No	48%	100	-	1
			Total		**208**		**1**
p41, 103	Hospital/ Site - Staff training	EoLC training included in induction programme	Yes	61%	136	-	1
			No	39%	88	-	0
			Total		**224**		**1**
p41, 104	Hospital/ Site - Staff training	EoLC training included in mandatory/priority training	Yes	47%	103	-	0
			No	53%	116	-	1
			Total		**219**		**1**
p41, 105	Hospital/ Site - Staff training	Training to improve the culture, behaviours, attitudes around communication skills	Yes	86%	192	-	1
			No	14%	31	-	0
			Total		**223**		**1**
p41, 106	Hospital/ Site - Staff training	Other training in relation to end of life care	Yes	95%	208	-	1
			No	5%	10	-	0
			Total		**218**		**1**
p42, 107	Hospital/ Site - Staff training	Percentage of staff who have received mandatory / priority EOL care training					
		Medical	%	57%	53	-	-
		Registered	%	69%	67	-	-
		Non-registered	%	62%	52	-	-
		AHPs	%	65%	44	-	-
		Other	%	65%	27	-	-
p43, 108	Trust/ UHB overview	Which of the following are used within your Trust/UHB : Opportunities for staff to reflect on the emotional aspects of their work (e.g. Schwartz rounds)?	Yes	77%	140	-	1
			No	23%	42	-	0
			Total		**182**		**1**

Appendix 5: Indicators in the bespoke dashboard

Workforce/specialist palliative care							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p43, 109	Case Note Review - Final admission	Was the patient reviewed by a member of the specialist palliative care team during their final admission?	Yes	38%	4068	28%	21
			No	62%	6594	72%	55
			Total		**10662**		**76**
p43, 110	Quality Survey	Were you confident that healthcare staff looking after him/her had the skills and experience to care for someone at the end of their life?	Yes, definitely	65%	495	-	-
			Yes, to some extent	19%	145	-	-
			No	10%	79	-	-
			Not sure	6%	43	-	-
			Total		**762**		**-**
p43, 111	Quality Survey	Did you feel that there was a consistent team approach and good coordination between different members of staff?	Yes, definitely	55%	418	-	-
			Yes, to some extent	22%	170	-	-
			No	18%	136	-	-
			Not sure	5%	40	-	-
			Total		**764**		**-**

Appendix 6: Submission's summary scores

	Recognising the possibility of imminent death	Communication with the dying person	Communication with the families and others	Involvement in decision making	Needs of families and others	Individual plan of care	Families and others' experience of care
	9.900497512	8.0	7.7	9.7	8.5	8.5	
0094-012018-001702	10.0	8.0	5.8	10.0	8.7		
0094-012018-001703				10.0			
0094-012018-001704							
0094-012018-001705	10.0	10.0	8.3	10.0	8.7	7.8	
0094-012018-001706							
0094-012018-001707	10.0	10.0	9.2	10.0	8.7	8.3	
0094-012018-001708	10.0	8.0	2.5	10.0		7.5	
0094-012018-001709	10.0	10.0	10.0	10.0			
0094-012018-001710	10.0	8.0	7.5	8.3	5.3	8.1	
0094-012018-001711	10.0	10.0	5.0	10.0	4.0		
0094-012018-001712	10.0	8.0	8.3	10.0	8.7	9.4	
0094-012018-001713							
0094-012018-001714	10.0	10.0	8.3	10.0	10.0	10.0	
0094-012018-001715	10.0	10.0	2.5	6.7			
0094-012018-001716	10.0	10.0	9.2	10.0	5.3	8.3	
0094-012018-001717		10.0	10.0	10.0			
0094-012018-001718							
0094-012018-001719							
0094-012018-001720	10.0	8.0	8.3	10.0	9.3	8.9	
0094-012018-001721	10.0	10.0	2.5	10.0			
0094-012018-001722	10.0	6.0	8.3	10.0			
0094-012018-001723	10.0	10.0	7.5	6.7			
0094-012018-001724	10.0	4.0	7.5	10.0			
0094-012018-001725	6.7	10.0	0.0	10.0			
0094-012018-001726				10.0			
0094-012018-001727	10.0	6.0	5.0	10.0			
0094-012018-001728	10.0	4.0	9.2	10.0			
0094-012018-001729	10.0	8.0	9.2				
0094-012018-001730	10.0	4.0	7.5	10.0			
0094-012018-001731	10.0	10.0		10.0			
0094-012018-001732	10.0	4.0	8.3	10.0		8.9	
0094-012018-001733	10.0	10.0					
0094-012018-001734	10.0		8.3	8.3			
0094-012018-001735	10.0	4.0	7.5	10.0		8.9	
0094-012018-001736	10.0	4.0	7.5				
0094-012018-001737	10.0	8.0	9.2	10.0			
0094-012018-001738	10.0	6.0	9.2	10.0	10.0	8.9	
0094-012018-001739	10.0	10.0	10.0	10.0		8.3	
0094-012018-001740	10.0	10.0	10.0	10.0	10.0	8.9	
0094-012018-001741	10.0	10.0	10.0	10.0		8.1	
0094-012018-001742	10.0	8.0	9.2	10.0			
0094-012018-001743	10.0	10.0	2.5	8.3			
0094-012018-001744	10.0	8.0	9.2	10.0		7.2	
0094-012018-001745	10.0	10.0	9.2	10.0			
0094-012018-001746	10.0	8.0	9.2	10.0		6.9	
0094-012018-001747	10.0						
0094-012018-001748	10.0						
0094-012018-001749	10.0	10.0	7.5	10.0		8.9	
0094-012018-001750	10.0	4.0	7.5	10.0			
0094-012018-001751				8.3			
0094-012018-001752	10.0	4.0	7.5	10.0		7.8	
0094-012018-001753							
0094-012018-001754	10.0	10.0	10.0	10.0	10.0	8.9	
0094-012018-001755	10.0	10.0	10.0	10.0		10.0	
0094-012018-001756	10.0	4.0	7.5	10.0			
0094-012018-001757	10.0	8.0	9.2	10.0			
0094-012018-001758				10.0			
0094-012018-001759	10.0	4.0	5.0	10.0			
0094-012018-001760				8.3			
0094-012018-001761	10.0	10.0	10.0	10.0		9.4	
0094-012018-001762	10.0			10.0			
0094-012018-001763	10.0	10.0	9.2	8.3			
0094-012018-001764	10.0	10.0	7.5	10.0			
0094-012018-001765	10.0	10.0	7.5	8.3			
0094-012018-001766	10.0		0.0	10.0		6.1	
0094-012018-001767	10.0	10.0	5.8	8.3			
0094-012018-001768	10.0	10.0	9.2	10.0		5.3	
0094-012018-001769	10.0						
0094-012018-001770	10.0	4.0	10.0	8.3		8.3	
0094-012018-001771	10.0	8.0	9.2	10.0	10.0	8.9	
0094-012018-001772	10.0	8.0	9.2	10.0			
0094-012018-001773	10.0	8.0	8.3	10.0		7.8	
0094-012018-001774	10.0	8.0	8.3	10.0			
0094-012018-001775	10.0	8.0	8.3	10.0		8.9	
0094-012018-001776				10.0			
0094-012018-001777	10.0	8.0	9.2	8.3			
0094-012018-001778	10.0	8.0	9.2	10.0	10.0	8.9	
0094-012018-001779	6.7			10.0			
0094-012018-001780	10.0	6.0	7.5	10.0		10.0	
0094-012018-001781	10.0	8.0	9.2	10.0		10.0	