National Clinical Audit and Patient Outcomes Programme (NCAPOP)

Infographics compendium

Version 3, updated 15.03.2019

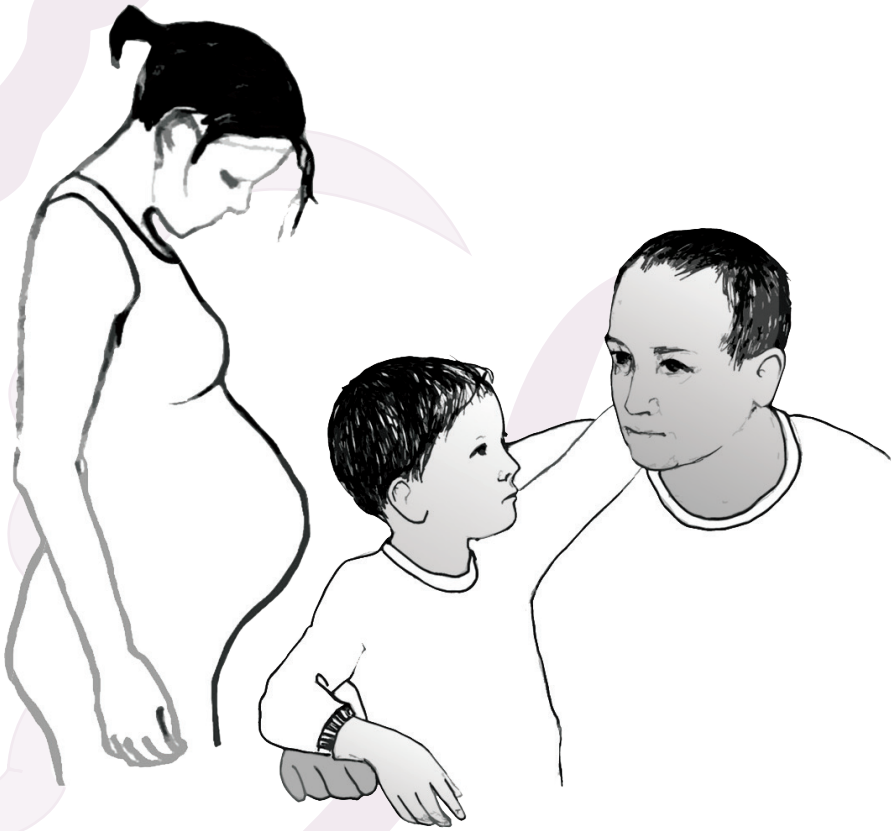
PROJECT NAME	LEAD PROVIDER	FULL REPORT TITLE	HQIP WEBLINK TO REPORT	DOC NUMBER
Maternal, Newborn, Infant	MBRRACE-UK	MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2016	https://www.hqip.org.uk/resource/mbrrace-uk-perinatal-mortality-surveillance-report-2018/	0.001
National Audit of Breast Cancer in Older Patients	RCS	2018 Annual Report - Results of the Prospective Audit in England and Wales for women diagnosed between January 2014 - December 2016	https://www.hqip.org.uk/resource/national-audit-of-breast-cancer-in-older-patients-2018-annual-report/	0.002
National Clinical Audit of Psychosis	RCPsych	National Clinical Audit of Psychosis - National report for the core audit	https://www.hqip.org.uk/resource/national-clinical-audit-of-psychosis-core-audit-report-2018/	0.003
National Ophthalmology Database Audit	RCOphth	Year 3 Annual Report - The Second Prospective Report of the National Ophthalmology Database Audit - 2018	https://www.hqip.org.uk/resource/national-ophthalmology-database-audit-report-2018/	0.004
Oesophago-gastric Cancer	RCS	Annual report 2018	https://www.hqip.org.uk/resource/national-oesophago-gastric-cancer-audit-annual-report-2018/	0.005
National Neonatal Audit Programme	RCPCH	2018 annual report on 2017 data	https://www.hqip.org.uk/wp-content/uploads/2018/09/2018-NNAP-report-on-2017-data-FINAL	0.006
Mental Health	NCISH	The assessment of clinical risk in mental health services - October 2018	https://www.hqip.org.uk/resource/assessment-of-clinical-risk-in-mental-health-service-an-ncish-report	0.007
Mental Health	NCISH	Annual Report: England, Northern Ireland, Scotland, Wales - October 2018	https://www.hqip.org.uk/resource/national-confidential-inquiry-into-suicide-and-safety-annual-report-2018	0.008
Maternal, Newborn and Infant	MBRRACE-UK	Saving Lives, Improving Mother's care report 2018	https://www.hqip.org.uk/resource/maternal-newborn-and-infant-programme-saving-lives-improving-mothers-care/#.XDiLaDD7SJA	0.009
Emergency Laparotomy	RCoA	Fourth Patient Report of the National Emergency Laparotomy Audit (NELA) - December 2016 - November 2017	https://www.hqip.org.uk/resource/the-fourth-patient-report-of-the-national-emergency-laparotomy-audit-nela	0.010
Falls and Fragility Fracture Audit Programme	RCP	National Hip Fracture Database (NHFD) Annual report 2018 (Data from January to December 2017)	https://www.hqip.org.uk/resource/national-hip-fracture-database-nhfd-annual-report-2018	0.011
National Cardiac Audit Programme	Barts Health NHS Trust	NCAP Annual Report 2018 - Towards healthier hearts: driving improvement from real-world evidence	https://www.hqip.org.uk/resource/national-cardiac-audit-programme-ncap-annual-report-2018	0.012
National Vascular Registry	RCS	National Vascular Registry - 2018 Annual Report	https://www.hqip.org.uk/resource/national-vascular-registry-annual-report-2018	0.013
Falls and Fragility Fracture Audit Programme	RCP	Fracture Liaison Service Database Annual Report December 2018 - Achieving effective service delivery by FLS	https://www.hqip.org.uk/resource/fracture-liaison-service-database-fls-db-annual-report-2018	0.014
National Bowel Cancer Audit	RCS	National Bowel Cancer Audit - Annual Report 2018	https://www.hqip.org.uk/resource/national-bowel-cancer-audit-annual-report-2018	0.015
Epilepsy 12	RCPCH	Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People - National Organisational Report 2018	https://www.hqip.org.uk/resource/national-clinical-audit-of-seizures-and-epilepsies-for-children-and-young-people-2018	0.016
Lung Cancer Audit	RCP	Lung cancer clinical outcomes publication 2018	https://www.hqip.org.uk/resource/national-lung-cancer-audit-clinical-outcome-publication-report-2018/	0.017
Prostate Cancer Audit	RSD	Annual report 2018	https://www.hqip.org.uk/resource/national-prostate-cancer-audit-annual-report-2018	0.018

Maternal, Newborn and Infant Clinical Outcome Review Programme

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

MBRRACE-UK
Perinatal Mortality Surveillance Report

UK Perinatal Deaths for Births from January to December 2016



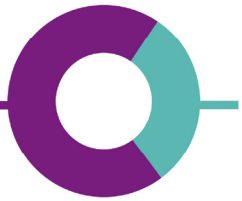
June 2018

UNIVERSITY OF OXFORD
HQIP Healthcare Quality Improvement Partnership
UNIVERSITY OF LEICESTER
TIMMS
UNIVERSITY OF BIRMINGHAM
Sands Stillbirth & neonatal death charity
NHS Bradford Teaching Hospitals NHS Foundation Trust
NPEU

Baby deaths in the UK – the national picture for 2016

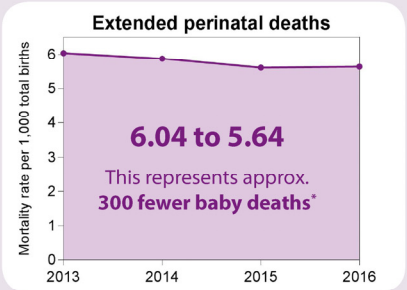
780,043 births
of babies delivered from 24 weeks of pregnancy, excluding terminations of pregnancy

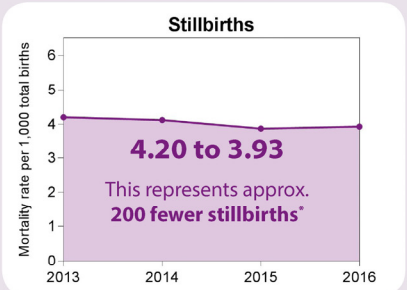
3,065 stillbirths

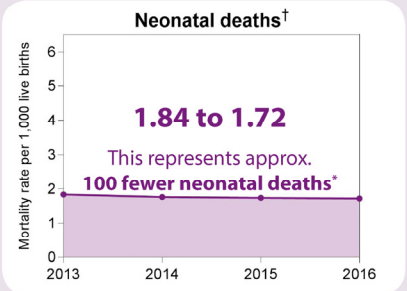


1,337 neonatal deaths

Overall reduced mortality rates between 2013 and 2016







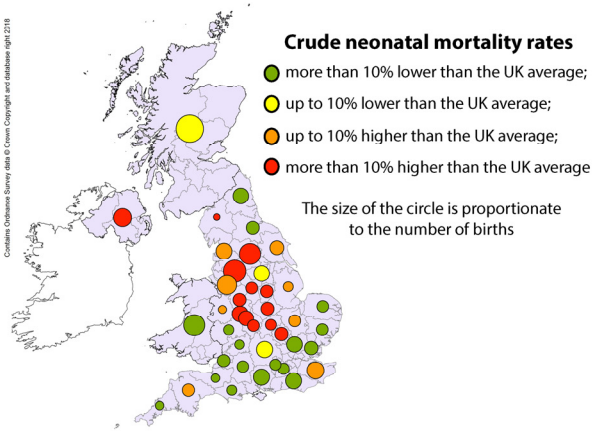
* in 2016 compared with 2013
† a baby born at any time during pregnancy who lives, even briefly, but dies within 4 weeks of birth.

Improved survival for twins

The stillbirth rate in twins has reduced by **almost half** since 2014

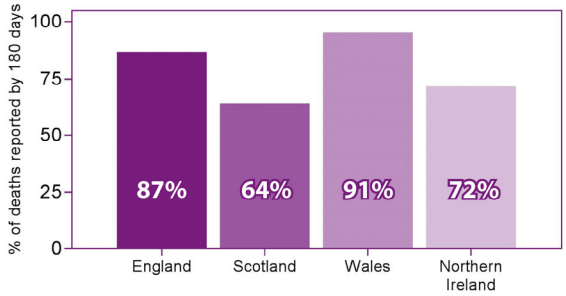
Neonatal deaths in twins have reduced by **almost a third** during the same period

Regional variation still evident in England



Data by STP Footprint (England) and Country (Scotland, Wales and Northern Ireland)

Wide variation in the timing of reporting of deaths to MBRRACE-UK



Post-mortem examination continues to vary between stillbirths and neonatal deaths

Almost all parents of stillborn babies were offfered a post-mortem

Of these parents, **1 in 2** consented to a post-mortem

8 out of 10 parents of babies who died neonatally were offered a post-mortem

Of these parents, **1 in 3** consented to a post-mortem

Placental histology was carried out for:

9 out of 10 stillbirths

but for only

7 out of 10 neonatal deaths which occurred on day 1, or were related to problems during delivery

National Audit of Breast Cancer in Older Patients

Part of the National Clinical Audit and Patient Outcomes Programme

2018 Annual Report

Results of the Prospective Audit in England and Wales for women diagnosed between January 2014 and December 2016

NA BCOP | National Audit of **Breast Cancer in Older Patients**

NABCOP | National Audit of Breast Cancer in Older Patients

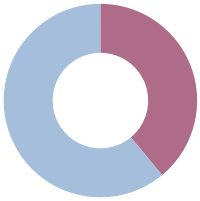
Annual Report 2018

The aim of NABCOP is to evaluate process of care and outcomes for women, aged 70 years or over, diagnosed with breast cancer in England and Wales.

2014–2016

119, 704 new diagnoses of unilateral breast cancer among women aged 50 years and older

61% aged 50–69 years



39% aged 70+ years

How does breast cancer differ by age in England and Wales?

	in women aged 50–69 years	in women aged 70+ years
Presentation through screening	57%	18%
Invasive breast cancer	86%	94%
Early stage invasive breast cancer	76%	70%

Key findings

96% of women aged 50–69 years

76% of women aged 70+ years

had surgery for early invasive breast cancer

98% of women aged 50–69 years

87% of women aged 70+ years

without medical problems received surgery for early invasive breast cancer

Regional variation in treatment patterns for older women

- in rate of surgery
- in rate of radiotherapy

for early invasive breast cancer

Breast CNS were involved in the care of 85% of women, across all ages **

** where reported

Chemotherapy

low use in older women, regardless of tumour characteristics

Recommendations

- **For breast cancer units within NHS trusts/health boards:** To ensure accurate reporting of local practices, there must be improvement in the completeness and quality of data returns to national cancer registration services.
- **For commissioners/ local networks:** To review results of their local organisations, commissioners/local networks must hold providers to account to address areas of variation, including the process for data submission to cancer registration services.
- **For professional stakeholder organisations:** To collaborate and define the need for a reliable, consistent and recordable description of patient fitness. This will improve the accuracy in reporting on treatments and outcomes in older patients.

Further information

www.nabcop.org.uk

@NABCOP_news

NCAP
NATIONAL CLINICAL AUDIT OF PSYCHOSIS

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

HQIP
Healthcare Quality Improvement Partnership

National Clinical Audit of Psychosis

National report for the core audit

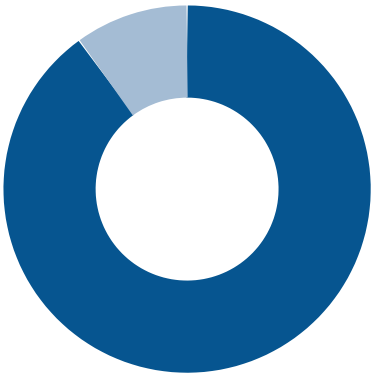
A SNAPSHOT OF THE MAIN FINDINGS

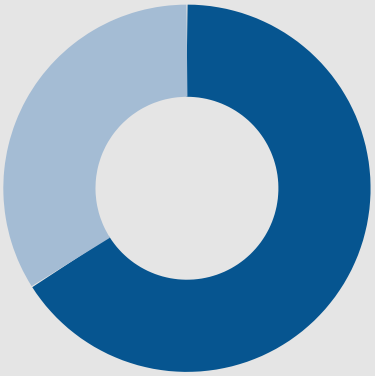
42%

Less than half of patients were screened for 5 cardiovascular risk factors

Medication was prescribed within BNF limits for almost all patients

90%



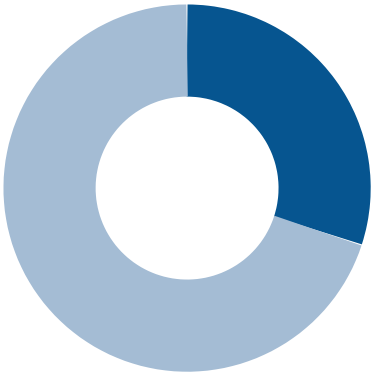


34%

Reasons for prescribing high-dose medication were NOT documented for 1 in 3 patients

30%

Less than a third of patients were given accessible information about their prescribed medication



The ROYAL COLLEGE of OPHTHALMOLOGISTS

NOD
NATIONAL OPHTHALMOLOGY DATABASE
AUDIT

HQIP
Healthcare Quality Improvement Partnership

National Ophthalmology Database Audit

Year 3 Annual Report – The Second Prospective Report of the National Ophthalmology Database Audit

2018

Results

Included in this second prospective report are operations undertaken between 1st September 2016 and 31st August 2017. For comparisons with results from the first year of the prospective audit, the comparison is with operations performed between 1st September 2015 and 31st August 2016. Reported operations for the current period were performed in 75 English and two Welsh NHS Trusts.

Approximately 63% of the 122 eligible NHS trusts in England and Wales are thus represented. In addition, for the first time **an independent provider of NHS cataract surgery has joined the audit,** supplying data for six individual sites. Around 6% of cataract operations were excluded for a variety of reasons such as being done for indications other than visual improvement, or being combined with other significant intra-ocular surgery.

183,812

183,812 eligible cataract operations were available for analysis which approximates to 44% of all NHS funded cataract surgery undertaken in England and Wales during the audit period (the lower overall figure compared with the percentage of trusts being mainly due to recent joiners reporting partial years). Data completeness was excellent (100%) for the PCR outcome as this is a compulsory operative field in the EMRs. **Overall, 1.4% of operations were affected by PCR, slightly above the updated consultant based overall average rate of 1.1% used for risk adjustment**. Case complexity indices have been included in the current report for PCR and VA Loss to reflect patient complexity and the accuracy of the recording of such complexity. An eligible preoperative distance VA was recorded for 86.2% of eyes and a postoperative VA for 71.2% of eyes, 63.8% of eyes had both a preoperative and a postoperative VA measurement. **There was significant variation between centres for completeness of VA data,** a reflection of variations in current modes of use of the data collection systems and diverse patient pathways. The median preoperative VA was 0.50 LogMAR units (6/19 Snellen Equivalent); the median postoperative VA was 0.10 LogMAR units (6/7.5 Snellen); and the median change in VA was a 0.34 LogMAR gain. **A 'good' postoperative VA of 0.30 (=6/12) or better was achieved in 89.2% of eyes overall,** 94.9% of eyes with no ocular co-pathology and 82.0% of eyes with a recorded co-pathology. Overall the VA Loss rate was 0.7%, close to the 0.9% rate used for risk adjustment.

Overall, the audit findings are favourable indicating high quality surgery is being delivered to NHS patients. Specifically, no outlying centres or surgeons have been identified. Whilst the audit is able to report on encouragingly large numbers of procedures, there remain centres from which data for the current period are not available. Many centres have indicated that they wish to participate in future audit cycles and it is anticipated that the next report will provide a more comprehensive picture of the quality of surgery being undertaken in the NHS.

1. Recommendations for Patients

1.1 Information has been made easily accessible to the general public.

1.1.1 Patients, carers and those with an interest in cataract surgery are encouraged to access and view data regarding their local services. Information about the quality of cataract surgery can be viewed online on the National Ophthalmology Audit Database website and the HQIP website. In addition, data can be accessed on the NHS Choices website

1.1.2 Patients should ensure they discuss and understand the risks and outcomes of any eye surgery with their consultant.

1.1.3 Information on cataract surgery is available from hospital trusts and Health Boards. Further information about cataracts can also be obtained from the charity organisations such as RNIB (Royal National Institute of Blind).

2. Recommendations for Providers of contract surgery

2.1 Publicly promote your commitment to fostering good professional practice by involvement in the audit

2.2 Support the improved use of electronic data collection and data completeness in your organisation, enable staff to implement change. Complete data helps ensure all relevant factors such as case complexity are submitted to the audit and can be included in the NOD analysis

2.3 Identify specific areas that need improvement by comparing your results against past performance

2.4 Promote use of the audit information in medical revalidation and appraisal

2.5 Encourage use of the EMR audit tools for continuous monitoring of results for early detection and correction of possible increases in adverse event rates

2.6 Care providers should review their patient pathways to maximise the recording of both preoperative and postoperative VA data for every operation

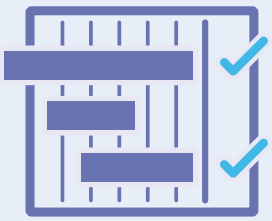
3. Recommendations for Surgeons

3.1 Use your audit outcomes report in appraisal discussions

3.2 Identify specific opportunities for improvement by comparing your results against peers and your own past performance

3.3 Use the EMR audit tools for continuous monitoring of your results for early detection and correction of possible increases in adverse event rates

4. Recommendations for Commissioners



4.1 An increase of around 50% in cataract operations is predicted over the next 20 years (25% increase over the next 10 years - RCOphth Way Forward), plan services appropriately using NOD and other data

4.2 Check the 2017 NICE guidelines on cataract surgery, (recommendations for commissioners 1.9)

4.3 Include submission of data to the NOD as a lever of quality in supplier contracts

4.4 Establish quality focused contracts with providers which include requirements for reporting of National Audit based outcomes

4.5 Establish contracts with community services which require return of postoperative VA and refractive data back to the surgical provider through use of the audit tools

5. Recommendations for the Regulator

5.1 When inspecting NHS organisations, information regarding national audit commissioning, participation and performance should be routinely requested from commissioners and providers of cataract care

5.1.1 Regulators should expect participation in national audits with audit results made available to them when inspecting NHS organisations

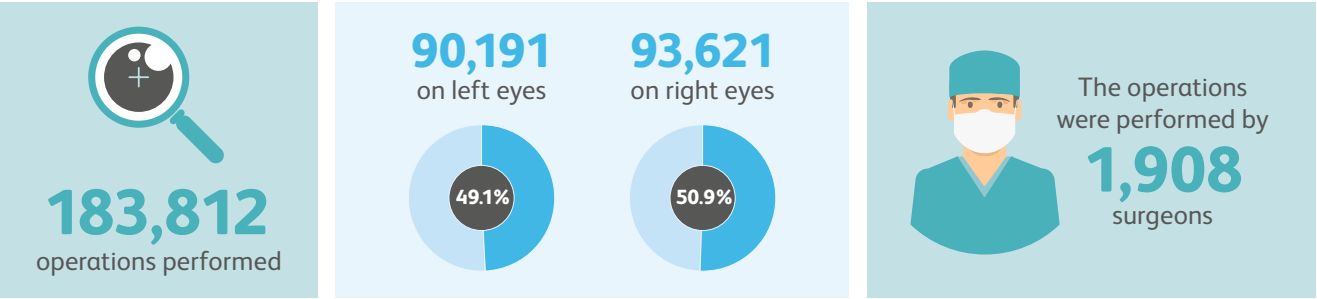
5.1.2 All providers of care should be expected to be in a position to provide quality assurance regardless of whether they are traditional NHS centres or independent providers

8.2 Eligible Cataract operations

In total 194,357 operations were submitted during the audit period (1st September 2016 to 31st August 2017), of these 10,545 (5.4%) operations are excluded from analysis; the reasons for exclusion were as follows:

- 1,333 operations had no record of phacoemulsification ±IOL
- 96 operations were performed on patients <18 years old
- 5,164 operations had a non-cataract indication for surgery
- 2,629 operations included ineligible combined operative procedures
- 16 operations were excluded as they were traumatic cases
- 19 operations were performed under general anaesthesia and also had examination under anaesthetic recorded
- 1,185 operations had no recorded surgeon grade
- 103 operations from five centres were excluded as they contributed <50 eligible operations, this included one centre that was included in the year 1 report, but had only four eligible operations submitted for year 2 therefore of the 88 centres from which data were extracted five centres were excluded)

This left 183,812 operations performed in 83 participating centres eligible for analysis. The operations were performed on 90,191 (49.1%) left eyes and 93,621 (50.9%) right eyes from 148,785 patients. These operations were performed by 1,908 surgeons where 164 surgeons had performed surgery at more than one grade. Whilst these are encouragingly large numbers of procedures, there remain many centres from which data for the current period are not available. As the audit becomes further established, increasing uptake will provide a more comprehensive picture of the quality of surgery being undertaken across the NHS.



The number of surgeons and operations at each surgeon grade were:

- 918 consultant surgeons performed 116,979 (63.6%) operations
- 237 career grade non-consultant surgeons performed 17,503 (9.5%) operations
- 745 more experienced trainee surgeons performed 40,574 (22.1%) operations
- 172 less experienced trainee surgeons performed 8,756 (4.8%) operations

The percentage of operations performed by each grade of surgeon within each centre varied reflecting catchment area, NHS trust differences and training opportunities for junior surgeons within England and Wales, see Table 1 and Figures 2a and 2b (the centre number on the figures can be used to identify the named centre in the table).

8.3 Patient characteristics – Age and Gender

Summary details of the 148,785 patients undergoing cataract surgery in the second year of the prospective audit were as follows:

- 147,602 patients with median age 76.4 years
- 63,449 (42.6%) patients were men with median age 75.7 years.
- 84,920 (57.1%) patients were women with median age 76.8 years.
- The gender was not recorded for 416 (0.3%) patients with median age 76.7 years.
- The ethnicity was not recorded for 67,218 (45.2%) patients.

8.4 First eye, second eye and simultaneous bilateral surgery

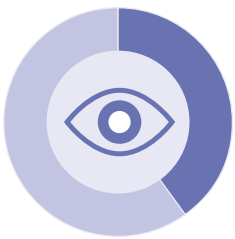
All cataract operations performed during the audit cycle would be in either the patient's first or second treated eye unless simultaneous bilateral surgery was performed. The RCOphth NOD Audit may not have the record for both operations or the first treated eye could have had the operation at another centre or prior to electronic data collection within the centre. For these reasons, no results on time between operations are provided in this report.

Results for first and second treated eye operations are reported for the 183,410 operations performed that were not simultaneous bilateral operations.

First treated eye cataract surgery;

- First eye cataract surgery was performed for 110,228 (60.1%) operations
- The median age at first treated eye surgery was 75.9 years (range; 18.1 – 107.7)
- 27,610 (25.0%) patients were recorded as having diabetes mellitus at the time of their first cataract operation
- 1,073 (1.0%) patients were recorded to be unable to lie flat
- 1,335 (1.2%) patients were recorded to be unable to cooperate during the operation

Second treated eye cataract surgery;



- Second eye cataract surgery was performed for 73,182 (39.9%) operations
- The median age at second treated eye surgery was 77.0 years (range; 18.4 – 104.9)
- 19,718 (26.9%) patients were recorded as having diabetes mellitus at the time of their second treated eye surgery
- 516 (0.7%) patients were recorded as being unable to lie flat
- 651 (0.9%) patients were recorded as being unable to cooperate during the operation

National Oesophago-Gastric Cancer Audit 2018

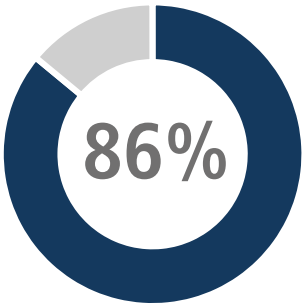
An audit of the care received by people with Oesophago-Gastric Cancer in England and Wales
2018 Annual Report

High-grade dysplasia

The Audit received information about

2,059

patients in England who were diagnosed with high-grade dysplasia of the oesophagus between April 2012 and March 2017.



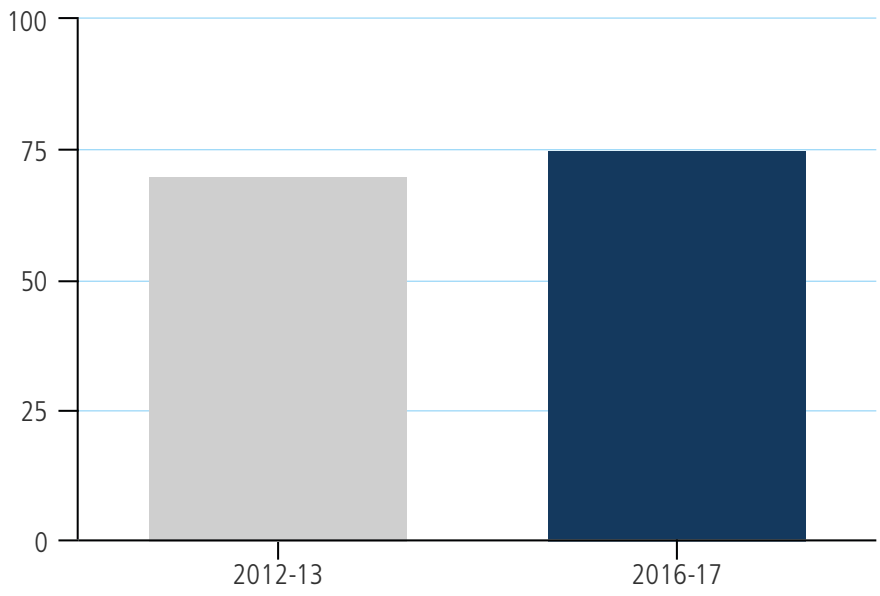
Multidisciplinary team

The majority of patients were discussed at a multidsciplinary team meeting, but this proportion has not changed over time.

Submissions to the Audit

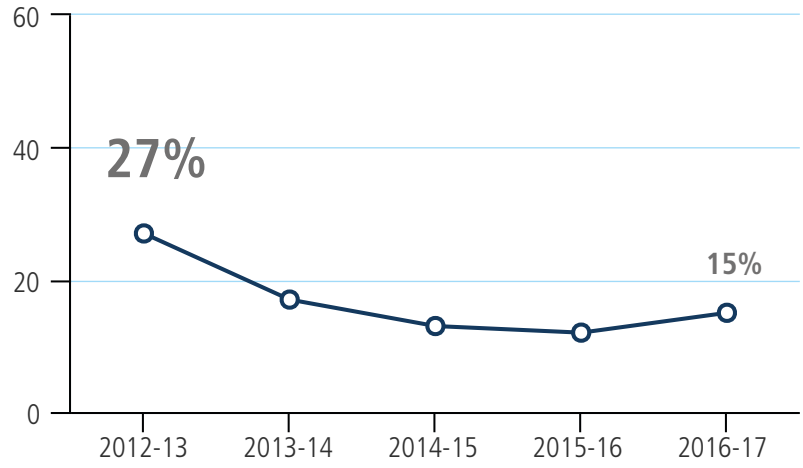
The number of HGD cases submitted to the Audit has declined over five years. Some regions in England may have very low case ascertainment.

Active treatment



Between 2012-13 and 2016-17, the proportion of patients receiving active treatment (endoscopic or surgical treatment) for high-grade dysplasia increased from 70% to 75%.

Surveillance



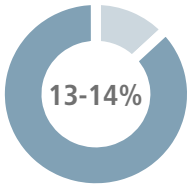
Between 2012-13 and 2016-17, the proportion of patients undergoing surveillance for high-grade dysplasia declined from 27% to 15%.

Oesophago-gastric cancer

The Audit received information about

21,032

patients in England & Wales who were diagnosed with oesophago-gastric cancer between April 2015 and March 2017.



of patients were diagnosed following an emergency admission to hospital.

Waiting times for treatment

Waiting times were longest for patients having curative surgery.

On average, these patients received treatment 94 days after referral, compared to 62 days for patients undergoing neoadjuvant treatment.

Palliative treatments

Only 56% of patients undergoing palliative chemotherapy completed their treatment.

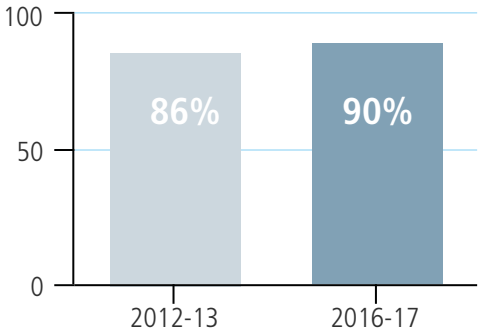
Early diagnosis

12%

of patients were diagnosed with early-stage OG cancer. This proportion has remained unchanged since 2012-13.

Staging investigations

90% of patients had an initial CT scan to assess the spread of cancer. This proportion has increased from 86% in 2012-13.



Outcomes of curative surgery

There has been a steady improvement in the median length of hospital stay after curative surgery, from 10-12 days to 7-9 days.

Mortality rates after curative surgery remain at low levels, with over 96% of patients alive 90 days after surgery.

This figure was similar across NHS hospitals in England and Wales.

National Neonatal Audit Programme (NNAP)

RCPCH Audits

Executive summary

2018 annual report on 2017 data

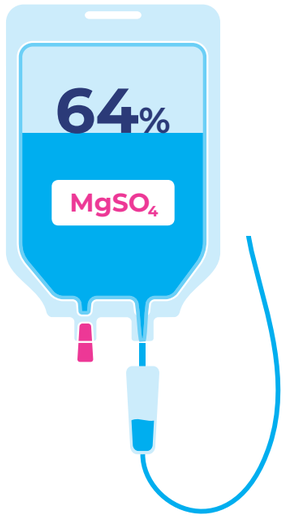
HQIP
Healthcare Quality Improvement Partnership

RCPCH
Royal College of Paediatrics and Child Health
Leading the way in Children's Health

Selected key findings and recommendations

These key findings were selected by consensus at the NNAP key findings workshop by a multidisciplinary and multiagency group of NNAP stakeholder representatives. For a full list of the key findings and recommendations for these, and other measures, see the key findings and recommendations section of the full report , available at: **www.rcpch.ac.uk/nnap-report-2018**

Antenatal magnesium sulphate

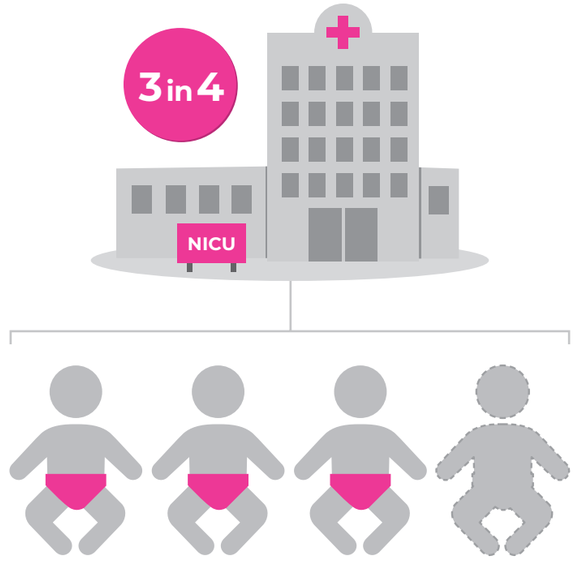


Giving magnesium sulphate to women who are at risk of delivering a preterm baby reduces the chance that their baby will develop cerebral palsy. The NNAP looks at whether mothers who delivered their baby at less than 30 weeks were given antenatal magnesium sulphate. Magnesium sulphate administration was much higher in 2017 than in 2016 (2017 – 64.1% of eligible mothers; 2016 – 53.3% of eligible mothers), reflecting rapid assimilation into practice of this aspect of NICE guidance, which is aimed at reducing cerebral palsy.

Selected recommendation:

To seek missed opportunities, and themes as to why magnesium was not given in line with NICE guidance, **neonatal and maternity care staff** in units with below average rates of administration should formally review records of babies born at less than 30 weeks where magnesium sulphate was not given to the mother.

Birth in a centre with a neonatal intensive care unit (NICU)

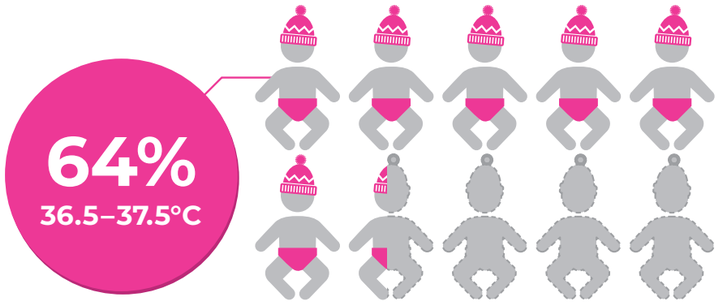


The NNAP looks at the proportion of babies born at less than 27 weeks gestational age who were born at a hospital with an on-site NICU. Babies who are born at less than 27 weeks gestational age are at high risk of death and serious illness. There is evidence that outcomes are improved if such immature babies are cared for in a NICU from birth. Three in four babies born less than 27 weeks gestational age were born at a hospital with an on-site NICU. Only two of 15 neonatal networks have more than 85% of these babies born within a hospital with an on-site NICU. Geographical size of network does not readily explain why more of some networks' babies are delivered in centres with a NICU.

Selected recommendation:

Neonatal networks, maternity networks and local maternity systems in England, and their equivalent bodies in Wales and Scotland, which do not achieve delivery of 85% of babies less than 27 weeks in a hospital with an onsite NICU should review whether they have realistic plans to achieve improvements in this area, and develop plans if required.

Promoting normal temperature on admission for very preterm babies



More very preterm babies in England, Scotland and Wales are admitted with a normal temperature than has been recorded for other nations in the international literature.[1,2,3] Sixty four percent of babies had a normal first temperature (36.5 to 37.5°C) measured within an hour of birth. This is an improvement in performance from recent years (2016 – 60.8%; 2015 – 58.1%) without an increase in hyperthermia – temperature above 37.5°C (2017 – 12.2%; 2016 – 12%). However there remains room for significant further improvement in the promotion of normothermia on admission to neonatal units for very preterm babies.

Selected recommendation:

Neonatal units should ensure that they have a care bundle in place, developed with multidisciplinary input, which mandates the use of evidence-based strategies to encourage admission normothermia of very preterm babies.

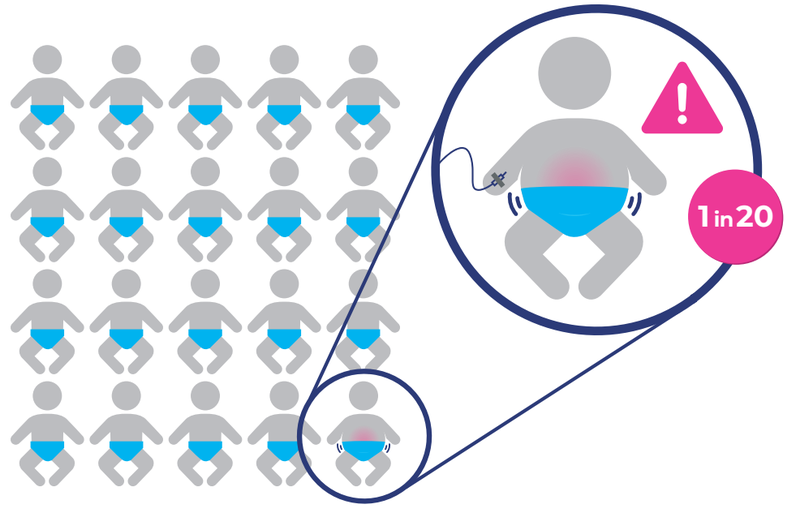
[1] Wilson E., et al. Admission Hypothermia in Very Preterm Infants and Neonatal Mortality and Morbidity. The Journal of Pediatrics 2016; 175: 61-7.

[2] Iyu Y., et al. Association Between Admission Temperature and Mortality and Major Morbidity in Preterm Infants Born at Fewer Than 33 Weeks' Gestation. JAMA Pediatrics 2015; 169e150277-8.

[3] Laptook A.R., et al. Admission Temperature and Mortality and Morbidity among Moderately and Extremely Preterm Infants. The Journal of Pediatrics 2018; 192: 53-9.

National Neonatal Audit Programme 2018 report on 2017 data

Necrotising enterocolitis

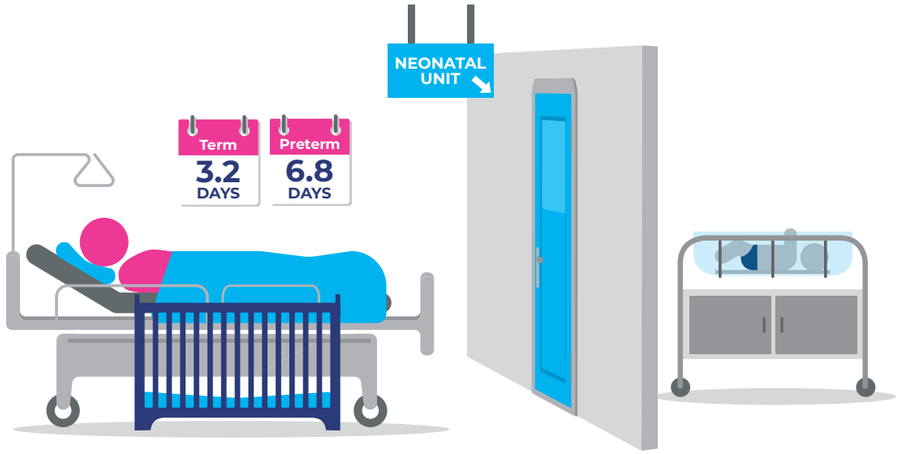


Necrotising enterocolitis (NEC) is a devastating illness which can follow preterm birth. One in twenty (5.6%; 428 of 8,228) babies born at less than 32 weeks gestational age developed necrotising enterocolitis (NEC). The NNAP uses a surveillance definition of NEC based on diagnosis at surgery, post-mortem or on the presence of clinical or radiographic signs.

Selected recommendation:

Neonatal units who validated their NEC data for 2017 should use NNAP Online to compare rates of NEC with other units, and use these comparisons to seek quality improvement opportunities.

Minimising separation of mothers and term and late preterm babies



The NNAP looks at the number of days that term and late preterm babies requiring low dependency care are separated from their mother. Variation exists in the average number of separation days between neonatal units and networks, for both term and late preterm babies. Findings for these two measures suggest that opportunities exist to reduce separation of mothers and term and late preterm babies by providing some neonatal care as transitional care.

Selected recommendation:

Neonatal units and trusts/health boards where transitional care cannot be delivered should work with their commissioners to develop the ability to deliver such care to minimise mother and baby separation, following the BAPM guidance A Framework for Neonatal Transitional Care.[11]

Full key findings by audit measure are available in chapter 2 of the main report, available at:
www.rcpch.ac.uk/nnap-report-2018

[11] British Association of Perinatal Medicine. Neonatal Transitional Care – A Framework for Practice. 2017. Available from: https://www.bapm.org/resources/framework-neonatal-transitional-care

National Neonatal Audit Programme 2018 report on 2017 data

Supporting quality improvement in neonatal care

The NNAP identifies areas for quality improvement in neonatal units in relation to the delivery and outcomes of care. The NNAP presents data to neonatal units and networks to facilitate quality improvement, alongside other initiatives in the following ways:

- **NNAP Online** is the audit's interactive reporting tool. It is available at **http://nnap.rcpch.ac.uk** and can be used to compare performance at a unit, network and national level; supporting neonatal units and networks to share best practice and stimulate quality improvement activities. The NNAP also shares examples of good practice by showcasing **case studies** in the annual report, online and at our annual NNAP and Neonatal Data Analysis Unit (NDAU) Collaborator's Meeting.

- **NNAP unit results posters** summarise a selection of the unit's NNAP results which are most relevant to parents and carers. Neonatal units display the posters in a public area, and complete a second poster, which explains the actions they are taking in response to their audit results. Designed to be used alongside ***Your baby's care*** (available at **www.rcpch.ac.uk/your-babys-care-2018**), our parents' guide to the NNAP, the posters help to communicate the meaning and relevance of the audit results not only to parents, but to the wider team involved in caring for the baby and mother.

- NNAP quarterly reports support neonatal units and networks to monitor data quality and completeness and their ongoing performance throughout the data collection year. Quarterly reports enable units to review their provisional results at the end of the year before inclusion in the NNAP annual report.

- The NNAP works closely with **neonatal networks**, adapting its measures and reporting to be responsive to the needs of the networks. The NNAP works closely with other national bodies and participates in several national initiatives, including the National Clinical Audit Benchmarking project (NCAB, a collaboration between HQIP and CQC), the Neonatal Peer Review Visit programme, NHS Choices and MyNHS Clinical Outcomes Publication and the Transparency and Open Data initiative.

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HQIP
Healthcare Quality Improvement Partnership

The assessment of clinical risk in mental health services

National Confidential Inquiry into Suicide and Safety in Mental Health

October 2018

The University of Manchester

The assessment of clinical risk in mental health services

Healthcare Quality Improvement Partnership

The National Confidential Inquiry into Suicide and Safety in Mental Health

Key findings

We collected data from **all** NHS mental health services in the UK

Risk tools used varied between services

Characteristics of tools

56%

Categorised risk into high, medium or low

94%

Used risk categorisation to inform care

85%

Formatted in a checklist style

42%

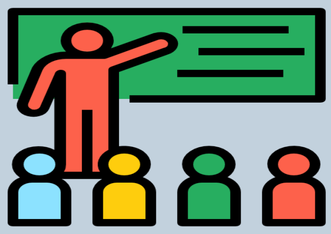
No accompanying guidance

19%

Suggested liaising with GPs

90% of clinicians used a risk assessment tool **but** **29%** had not received training in their use

Staff and patient views



Survey and interviews with staff and patients suggested better training on understanding the nature of risk

"We can't predict human behaviour. Likelihood is an opinion, a professional judgement "

"Training keeps risk at the forefront, it keeps it fresh"

The University of Manchester

The assessment of clinical risk in mental health services

Healthcare Quality Improvement Partnership

The National Confidential Inquiry into Suicide and Safety in Mental Health

Clinical messages

Risk assessment tools should not focus on prediction

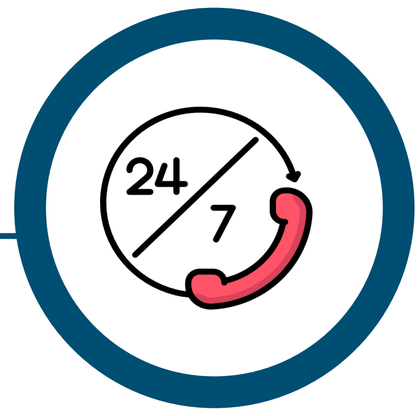
Risk is **not** a number
Risk assessment is **not** a checklist

Essential elements of assessing clinical risk

Account for changing risks

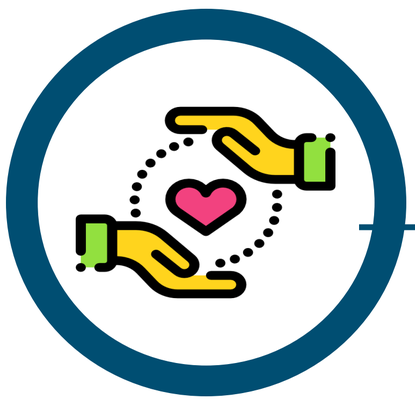
Ask about suicidal thoughts

Involve families and carers



Address what to do in a crisis

Suggestions for improvements



Consistency across services

Staff training and ongoing supervision

Personalised, collaborative management plan

Communication with GPs

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NATIONAL CONFIDENTIAL INQUIRY INTO SUICIDE AND SAFETY IN MENTAL HEALTH

Annual Report: England, Northern Ireland, Scotland, Wales
October 2018

Annual report 2018: Key messages

The University of Manchester

HQIP Healthcare Quality Improvement Partnership

Renewed emphasis on reducing suicide by in-patients

Fall in in-patient deaths has slowed

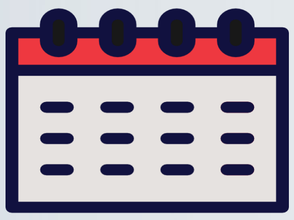
31% (2006-2010) → **11%** (2012-2016)

Improving physical safety on wards

Care plans in place

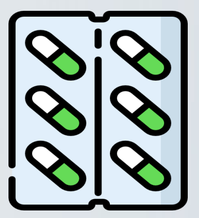
Strengthen nursing observation

Vigilance in specific patient groups



Highest risk on day 3 post-discharge

Safer prescribing

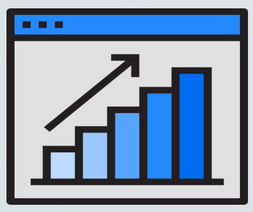


Patients with substance misuse

56%

Reducing alcohol & drug misuse

Suicide prevention in young people



Number of suicides rises in late teens

Promoting mental health in education

Broad range of stressors

Shared role for front-line services

52

Suicides by students (aged 18-21) in England & Wales, per year

Availability of support at times of risk, esp. exam months

National Confidential Inquiry into Suicide and Safety in Mental Health

The University of Manchester

Annual report 2018: Key messages

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Healthcare Quality Improvement Partnership

Female patients

1/2 aged 35-54 years

74% self-harm especially common

15% diagnosis of personality disorder

distinct risk profile compared to men

Recent self-harm

434 patients died within 3 months of self-harm, per year

rising in patients who died

1/2 were female patients aged under 25

should be recognised as suicide warning

NCISH recommendations shown to reduce suicide rates

National Confidential Inquiry into Suicide and Safety in Mental Health

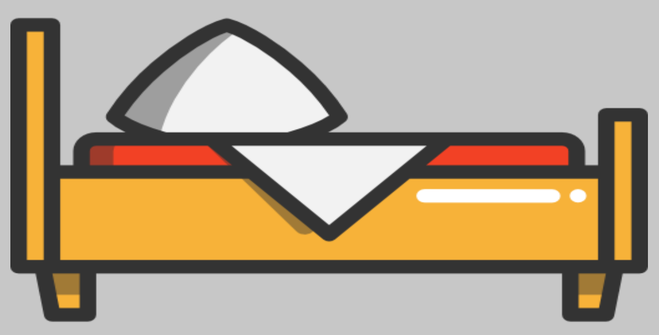
Annual report 2018

National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)

28% people who died by **suicide** had contact with **mental health services** in the previous **12 months**

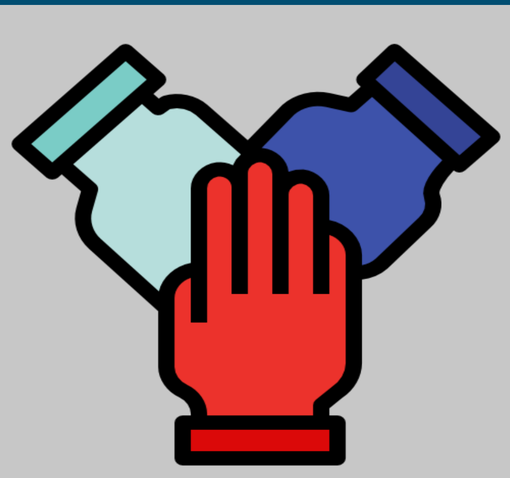
Our findings suggest...

In-patient care

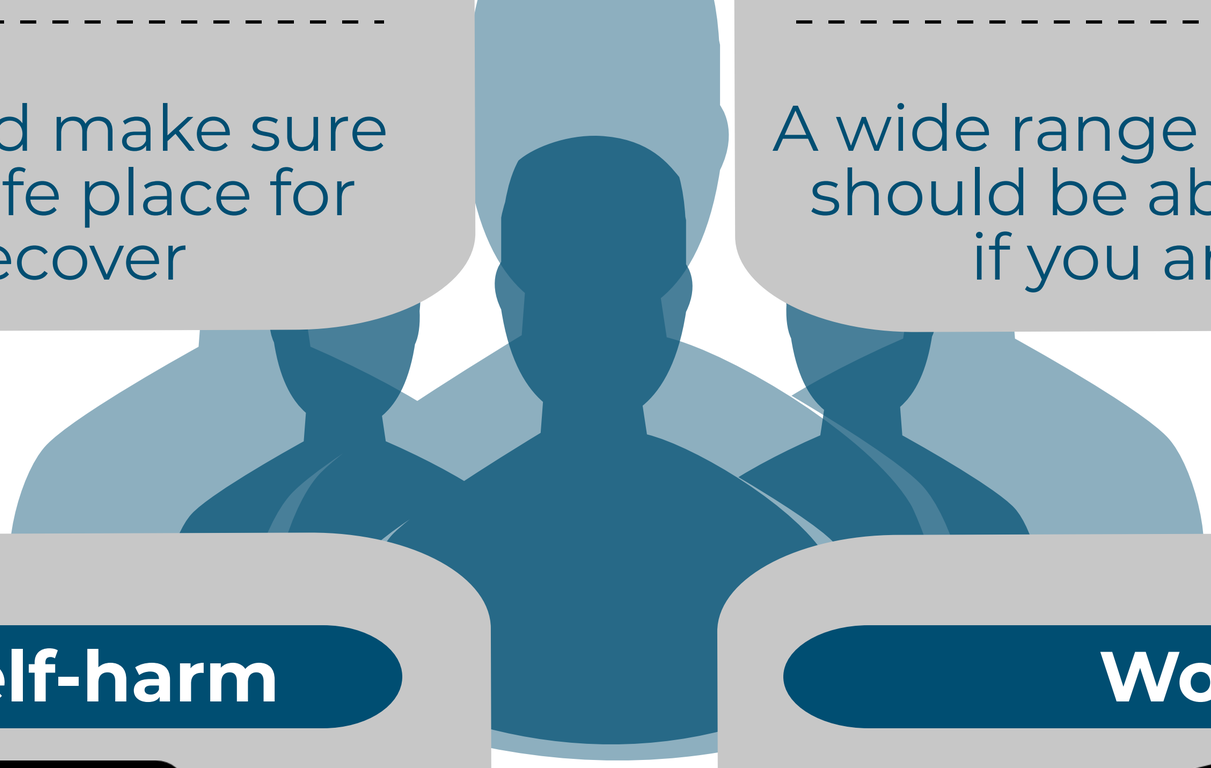


Services should make sure wards are a safe place for you to recover

Young people



A wide range of professionals should be able to help you if you are in crisis



Recent self-harm

Everyone should get a good assessment after self-harm

Women

Services need to recognise why women can be at risk of self-harm and suicide

Icons made by Freepik from www.flaticon.com

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HQIP Healthcare Quality Improvement Partnership

Maternal, Newborn and Infant Clinical Outcome Review Programme

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

Saving Lives, Improving Mothers' Care

Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16

November 2018

HQIP Healthcare Quality Improvement Partnership
University of Leicester
TIMMS
University of Birmingham
Sands Stillbirth & neonatal death charity
NHS Bradford Teaching Hospitals NHS Foundation Trust
NPEU
University of Oxford

Key messages from the report 2018

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

In 2014-16 **9.8** **women** per 100,000 died during pregnancy or up to six weeks after childbirth or the end of pregnancy.

Most women who died had multiple health problems or other vulnerabilities.

Balancing choices:

Always consider individual **benefits** and **risks** when making decisions about pregnancy

Things to think about:

Many medicines are **safe** during pregnancy

Continuing medication or preventing illness with vaccination may be the best way to keep both mother and baby healthy - ask a specialist

Be body aware - some symptoms are normal in pregnancy but know the **red flags** and always seek specialist advice if symptoms persist

Black and Asian women have a higher risk of dying in pregnancy

White women		8/100,000
Asian women	**2x**	15/100,000
Black women	**5x**	40/100,000

Older women are at greater risk of dying

Aged 20-24		7/100,000
Aged 35-39	**2x**	14/100,000
Aged 40 or over	**3x**	22/100,000

Overweight or obese women are at higher risk of blood clots including in early pregnancy

Fourth Patient Report of the National Emergency Laparotomy Audit (NELA)

December 2016 to November 2017

Royal College of Anaesthetists

NIAA National Institute of Academic Anaesthesia

HSRC Health Services Research Centre

NELA National Emergency Laparotomy Audit

Royal College of Surgeons ADVANCING SURGICAL CARE

HQIP Healthcare Quality Improvement Partnership

October 2018

NELA National Emergency Laparotomy Audit

An emergency laparotomy (emergency bowel surgery) is a surgical operation for patients, often with severe abdominal pain, to find the cause of the problem and treat it. General anaesthetic is used and usually an incision made to gain access to the abdomen. Emergency bowel surgery can be carried out to clear a bowel obstruction, close a bowel perforation and stop bleeding in the abdomen, or to treat complications of previous surgery. It is one of the most risky types of emergency operation.

These results are from 2016-17, the 4th year of the National Emergency Laparotomy Audit.

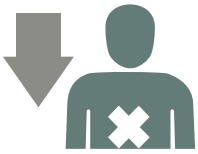
1 **23,929 patients** were entered into the audit, from **183 hospitals** in **England** and **Wales**.

2 The number of days **a patient spends in hospital** has fallen further, to **15.6 days in 2017** down from **16.6 days in 2016** and **19.2 days in 2013**, when NELA began.

3 

This saved acute **NHS Hospitals** an estimated **108,000 bed days** and **£34 million** in 2017.

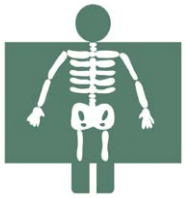
4 Since 2013, national **30-day mortality rate** has fallen from **11.8% to 9.5%**



5 This means that **~700 fewer patients die each year** after emergency laparotomy surgery.

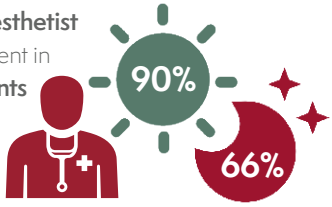
6 **77% of patients are alive** at one year post-surgery, **71%** at two years, and **66%** at three years.

7 **87% of patients received a pre-operative CT scan** compared to **80%** when NELA began, a sustained improvement.



8 **76% of patients with sepsis did not receive antibiotics within timescales** This should happen within **1 hour** of diagnosis.

9 Both a **consultant anaesthetist and surgeon** were present in theatre for **90% of patients during the daytime**, but only **66% of patients out of hours**.



10 **27%** of patients needing the most urgent surgery **did not get to the operating theatre in the recommended timeframes**.

11 

25-35 critical care beds are needed every day to care for emergency laparotomy patients. **90% of patients with a pre-operative risk score of >10%** went to critical care.

12 **77%** **~Half** of patients are **aged over 70**, but **were not seen by a geriatrician**

020 7092 1676 | info@nela.org | www.nela.org.uk | @NELANews

RCoA Royal College of Anaesthetists | NIAA National Institute of Academic Anaesthesia HSRC Health Services Research Centre | Royal College of Surgeons ADVANCING SURGICAL CARE | HQIP Healthcare Quality Improvement Partnership

Royal College of Physicians

Falls and Fragility Fracture Audit Programme (FFFAP)

National Hip Fracture Database (NHFD)

Annual report September 2018
(Data from January to December 2017)

In association with:

British Geriatrics Society
Improving healthcare for older people

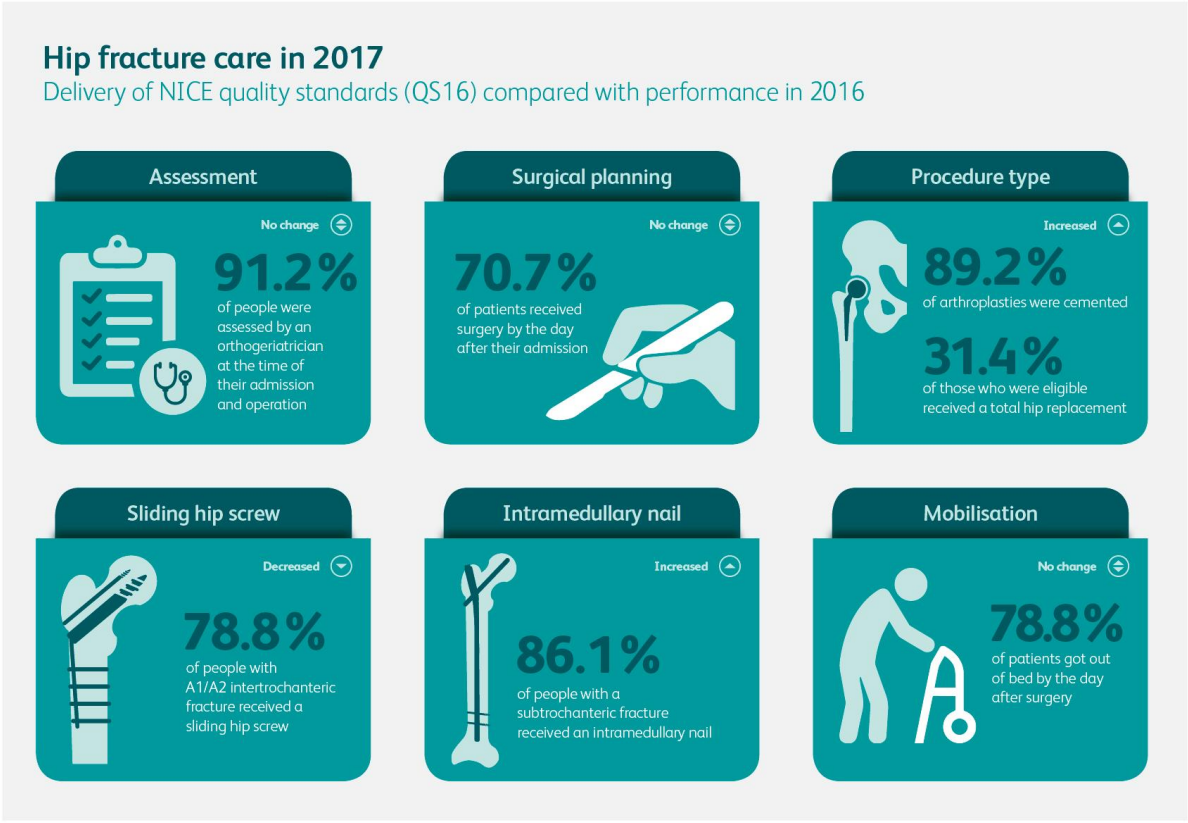
British Orthopaedic Association 1918 – 2018
Caring for Patients ; Supporting Surgeons

National Osteoporosis Society

Public Health England

Commissioned by:

HQIP
Healthcare Quality Improvement Partnership



Information on the different types of procedure can be found in our My hip fracture care booklet, available on our website.

Methodology and case ascertainment

The National Hip Fracture Database (NHFD) was established in 2007 and its methodology has not changed since the detailed description provided in our 2017 report.

All 175 eligible hospitals in England, Wales and Northern Ireland now regularly upload data. This report describes the process and outcome of care provided to 66,668 people presenting with a hip fracture in 2017 – nearly all of the patients in these countries.

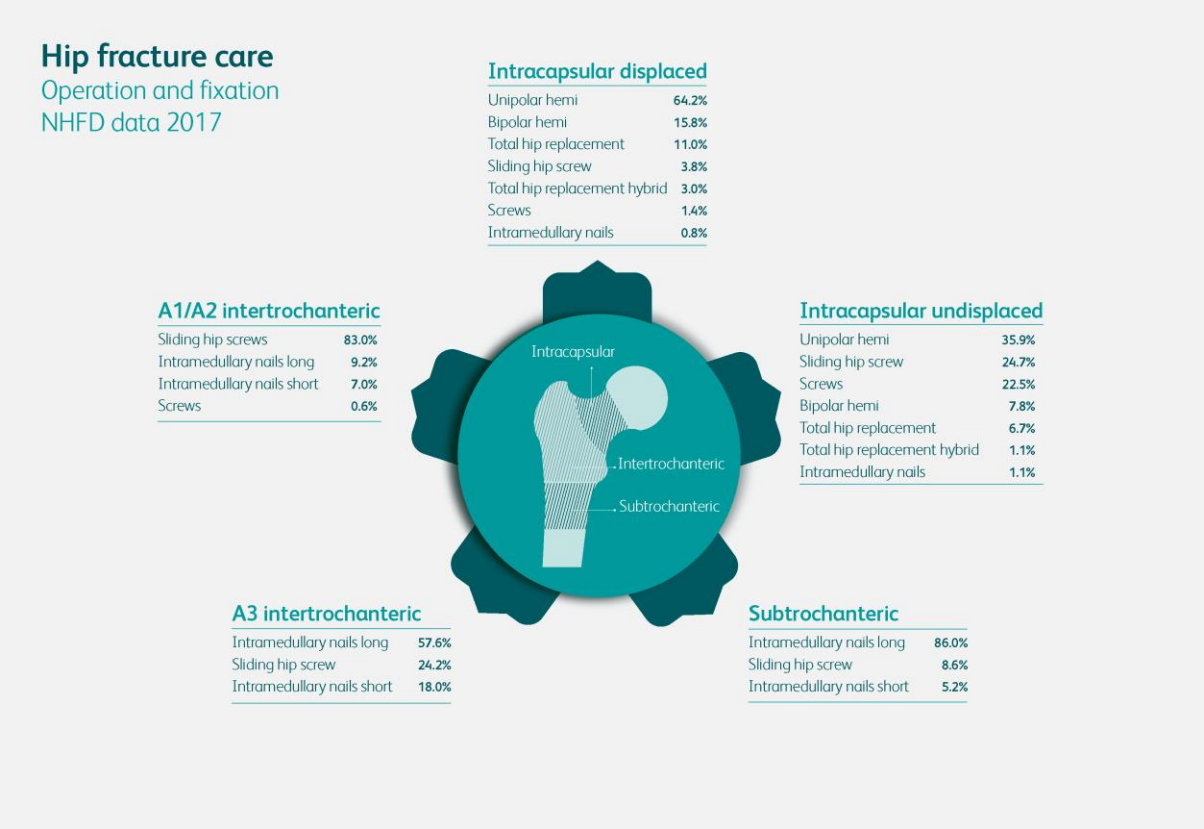
NHFD case ascertainment is more reliable than Hospital Episode Statistics (HES) as a result of hip fracture teams' attention to collection of data about their patients, along with the financial incentive of best practice tariff (BPT) in England. Since 2016 we have viewed NHFD records as the gold standard against which the accuracy of local patient administration systems should be measured.


NHFD Dashboard report for All NHFD 2016

Title	2015	2016	Rating	Progress
Admitted to orthopaedic ward within 4 hours	47.4	39.9	3	
Mental test score recorded on admission	95.0	95.6	2	~
Perioperative medical assessment	88.0	88.7	2	~
Physiotherapy assessment by the day after surgery	No data	90.2	2	
Mobilised out of bed by the day after surgery	78.0	77.3	3	~
Nutritional risk assessment	No data	84.6	2	
Delirium assessment	No data	54.7	2	
Received falls assessment*	96.5	96.1		~
Received bone health assessment*	97.0	96.7		~
Met best practice criteria	61.7	59.2	2	~
Surgery on day of, or day after, admission	73.2	70.6	2	~
Surgery supervised by consultant surgeon and anaesthetist	No data	56.6	3	
General anaesthetic	51.4	51.0		
General anaesthetic and nerve block (of all GA)	58.6	64.2	2	~
Spinal anaesthetic	42.7	43.3		
Spinal anaesthetic and nerve block (of all SA)	33.0	40.2	3	+
Proportion of arthroplasties which are cemented	85.1	86.1	2	~
Eligible displaced intracapsular fractures treated with THR	27.0	30.4	3	+
Intertrochanteric fractures (excl. reverse oblique) treated with SHS	80.0	80.8	2	~
Subtrochanteric fractures treated with an IM nail	79.8	84.2	2	~
Case ascertainment	91.2	95.0		~
Acute length of stay (days)	16.0	16.6	2	~
Overall hospital length of stay (days)	20.5	21.6	2	~
Documented final discharge destination	83.9	86.9	2	~
Discharge to original residence within 120 days	63.8	67.5	2	~
Hip fractures which were sustained as an inpatient	3.9	4.1	2	~
Documented not to have developed a pressure ulcer	95.3	95.7	2	~
Documented not to have had a reoperation within 120 days	50.1	36.7		-
120 day follow up	32.4	37.4	3	+
Crude 30 day mortality rate	7.1	6.7		~
Adjusted 30 day mortality rate	7.1	6.7		~

Rating: 4=Top quartile, 3=Upper middle quartile, 2=Lower middle quartile, and 1=Lowest quartile/poor performance
Progress: '+' = Performance improving, '~' = Performance broadly unchanged, and '-' = Performance declining

NHFD has pioneered the release of clinical audit data to the general public (see thumbnail), making its analyses openly available so that clinical teams, hospital management and the public can share the same access to live information about services in their area.



Information on the different types of procedure can be found in our My hip fracture care booklet, available on our website.

Key performance indicator 3

NICE compliant surgical approach

The surgical techniques appropriate to different types of hip fracture have been extensively examined by NICE in CG124 and QS16, and are discussed in Section 2 at the end of this report. NHFD run charts, tables and dashboards report this in detail.

31.4% of patients who NICE views as eligible for total hip replacement (THR) for displaced intracapsular fracture received this operation. This is an improvement from 30.4% in 2016, but there is still huge variation between units, with rates that varied from 0–100%.

78.8% of people with an A1/A2 intertrochanteric fracture received the sliding hip screw (SHS) – a fall from 80.9% in 2016, which reflects an increase in the use of intramedullary (IM) nails, contrary to the approach recommended by NICE.

Failure to follow NICE guidance for these and other aspects of operative approach meant that in preparing our last annual report we found that in 2016 only 64.2% of all patients appeared to have received an operation that NICE would have recommended – with figures ranging from as low as 15.7% up to 86.0% in different units.

NICOR

NCAP

NATIONAL CARDIAC AUDIT PROGRAMME

ANNUAL REPORT 2018

Towards healthier hearts: driving improvement from real-world evidence

British Cardiovascular Society

BHRS British Heart Rhythm Society

BCIS

UCLPartners
Academic Health Science Partnership

NHS
Barts Health
NHS Trust

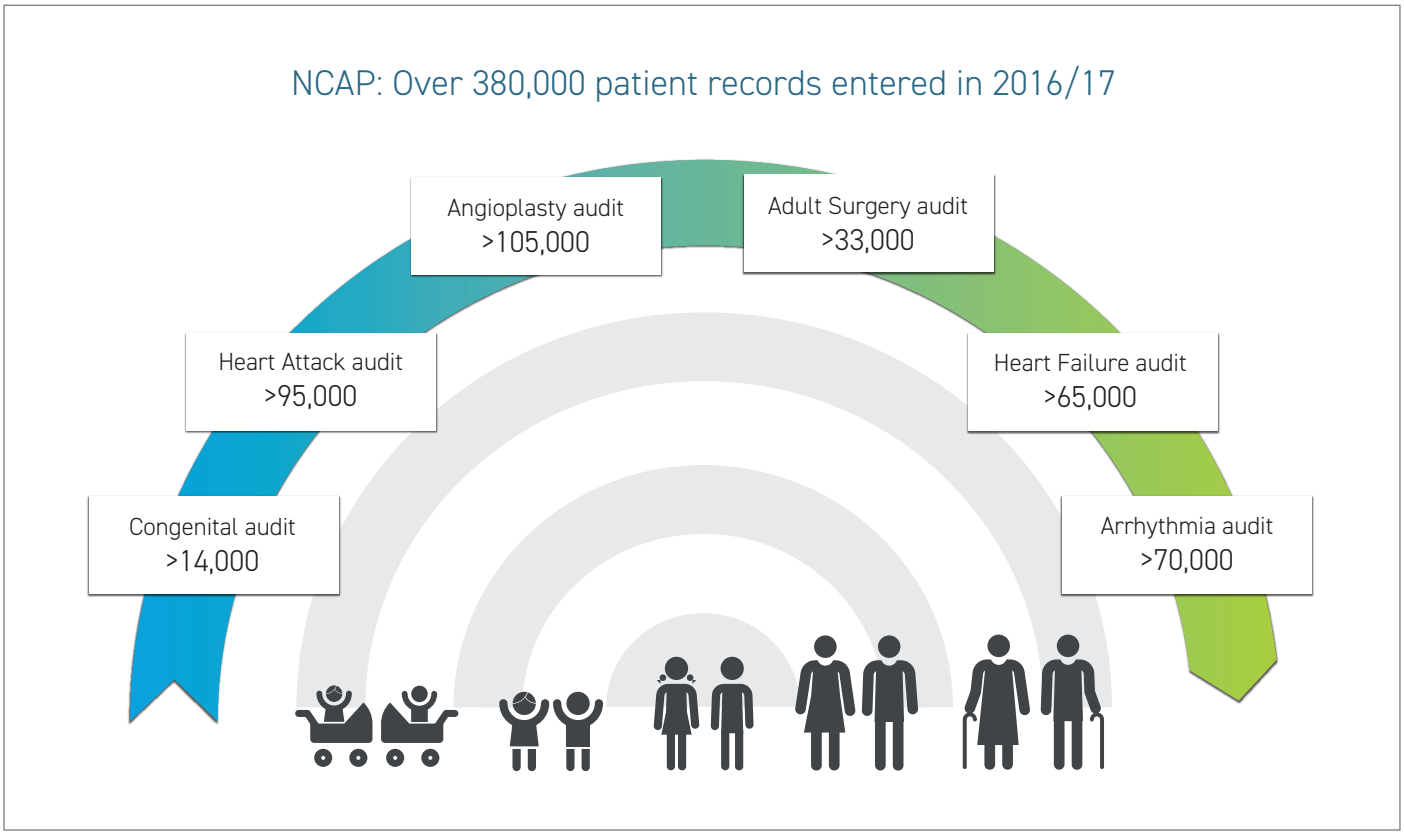
Executive summary and recommendations

The National Cardiac Audit Programme (NCAP) brings together, for the first time, six major national clinical audits of care of patients treated in the UK for heart disease. The six audits are:

- **Congenital audit** – about one percent of children are born with abnormalities of the structures of their heart and/or major blood vessels, known as congenital heart disease. Operations and interventions can be undertaken from birth through to adulthood, encompassing life-long management of these conditions.
- **Heart Attack audit** – a common condition in adults is coronary heart disease, which has a range of consequences, including heart attacks.
- **Angioplasty audit** – coronary patients with obstructions in their arteries may require techniques to improve blood flow (called coronary revascularisation). This could involve the insertion of stents, known as percutaneous coronary intervention (PCI) or 'angioplasty'.
- **Adult Surgery audit** – adult patients with acquired diseases of the blood vessels, valves or the muscle of the heart may require heart surgery. The commonest operation is a coronary artery bypass graft (CABG), where a narrowed coronary artery may be 'bypassed' using a vessel taken from inside the chest wall, the leg or the arm.
- **Heart Failure audit** – patients with diseases of the heart muscle, for example as a result of heart attacks or from congenital conditions, might develop heart failure, which is a worsening of the heart's ability to pump blood.
- **Arrhythmia audit** – patients of all ages are prone to heart rhythm disturbances but the more dangerous rhythm disturbances occur most commonly in patients with badly damaged heart muscle, whatever its cause. The results for the Arrhythmia audit will be presented later in 2018.

The reporting of six audits as a unified cardiovascular pathway reflects the intention to move towards a single national dataset and harmonisation of the audit processes, including data validation, analysis and reporting. This is a large-scale undertaking, with over 380,000 patient records entered into the NCAP dataset in 2016/17 financial year (Figure 2). The Angioplasty audit is based on data entered in the 2016 calendar year.

Figure 2 – Number of patient records across the NCAP pathway (2016/17)



1 Using audit to improve services for heart conditions

The newly-integrated National Cardiac Audit Programme (NCAP) covers cardiovascular medical and surgical specialties, bringing together six major national clinical audits of patients treated in the UK for heart disease. The NCAP outputs are delivered by the National Institute for Cardiovascular Outcomes Research (NICOR).

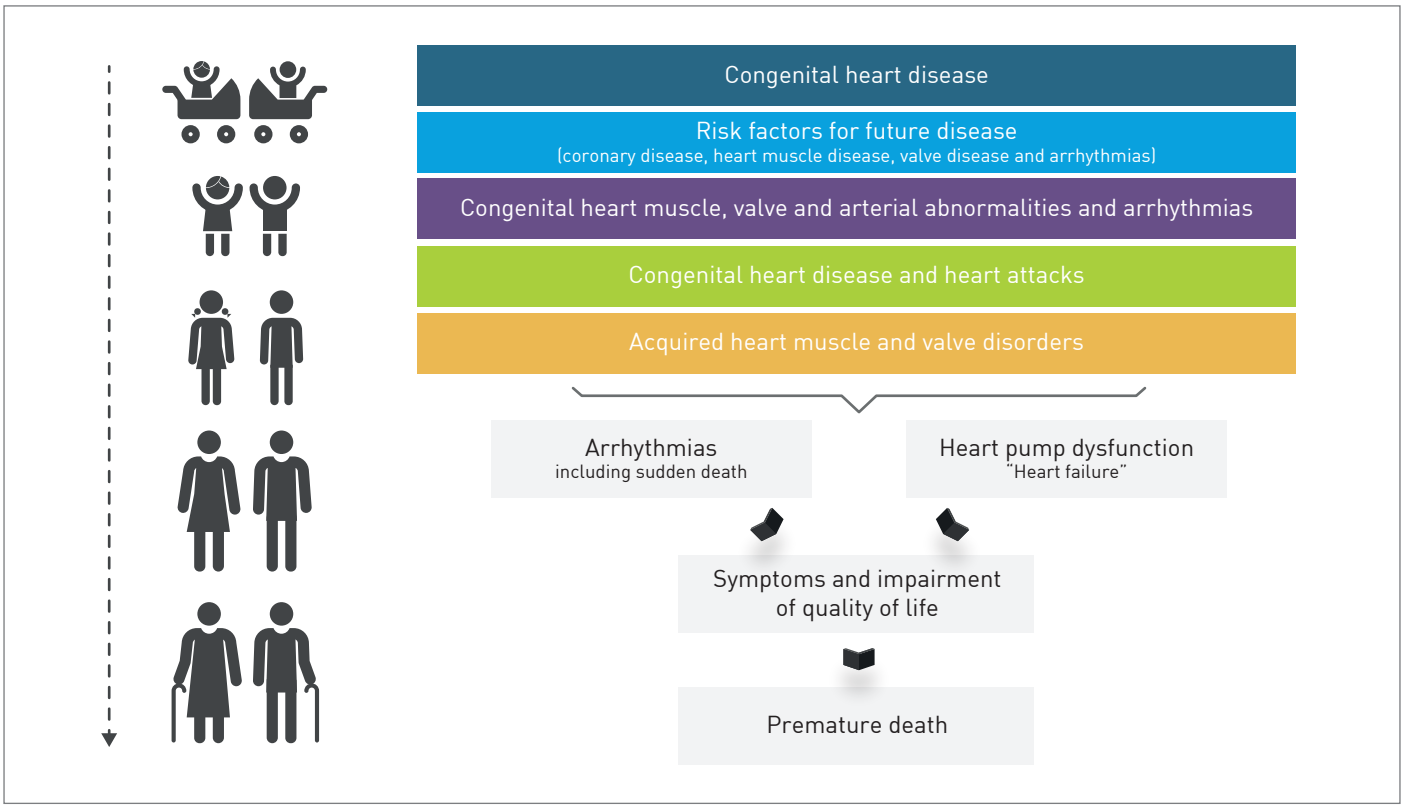
Commissioned by the Healthcare Quality Improvement Partnership (HQIP) with funding from NHS England and GIG Cymru/NHS Wales, this is the first combined report that NCAP has published. Funding from Scotland has now been provided for some of the six audits and funding from Northern Ireland and the Republic of Ireland is under consideration. The report's primary aim is to share key messages and recommendations concerning quality improvements in the management of cardiovascular disease.

This aggregate report summarises quality improvements based around three themes: safety, clinical effectiveness and patient outcomes. It does not include all the analyses from the audits; the full set of analyses separated by each sub-specialty is available here.

1.1 NCAP tracks the major treatments that patients with heart conditions might need throughout their lifetime

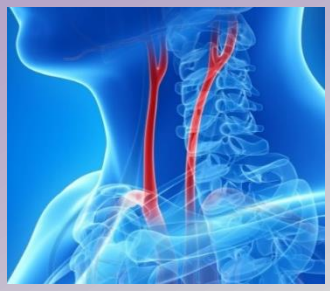
Heart disease can affect people at any point in their life (Figure 3).

Figure 3 – Continuum of heart conditions covered by NCAP



Across this continuum, the six audits within NCAP are:

- **Congenital audit** – about one percent of children are born with abnormalities of the structures of their heart and/or major blood vessels, known as congenital heart disease. Operations and interventions can be undertaken from birth through to adulthood, encompassing life-long management of these conditions.
- **Heart Attack audit** – a common condition in adults is coronary heart disease, which has a range of consequences, including heart attacks.
- **Angioplasty audit** – coronary patients with obstructions in their arteries may require techniques to improve blood flow (called coronary revascularisation). This could involve the insertion of stents, known as percutaneous coronary intervention (PCI) or 'angioplasty'.
- **Adult Surgery audit** – adult patients with acquired diseases of the blood vessels, valves or the muscle of the heart may require heart surgery. The commonest operation is a



NATIONAL VASCULAR REGISTRY

2018 Annual Report

November 2018

Royal College of Surgeons
ADVANCING SURGICAL CARE

VASCULAR SOCIETY
OF GREAT BRITAIN AND IRELAND

British Society of Interventional Radiology
Registered Charity No: 1084852

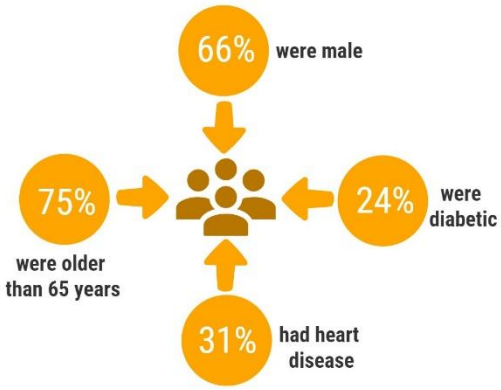
HQIP
Healthcare Quality Improvement Partnership

Carotid artery surgery to prevent stroke

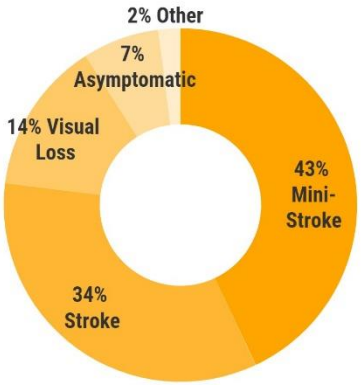
A procedure in which build-up of plaque is removed from the carotid artery in the neck is called a carotid endarterectomy (CEA).

There were 4,148 CEAs submitted to the NVR in 2017, which is approximately 90% of all procedures in the UK.

Which people had surgery?

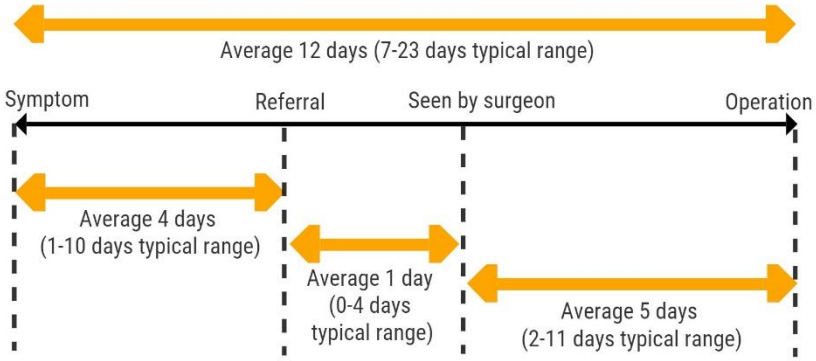


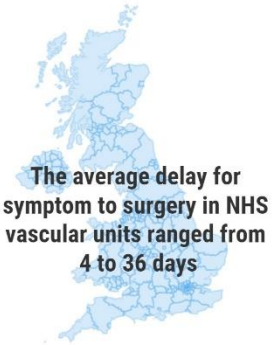
Reasons for surgery



Treatment times for symptomatic patients

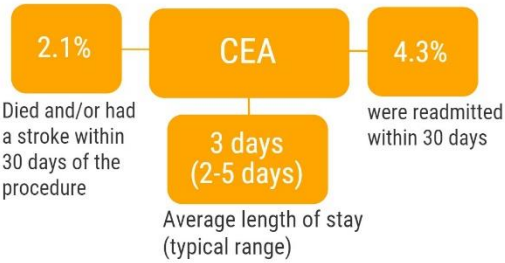
Recommended time from symptom to surgery is within 14 days





The average delay for symptom to surgery in NHS vascular units ranged from 4 to 36 days

Outcomes of surgery



Glossary

A mini stroke, also known as a transient ischaemic attack (TIA), resolves completely within 24 hours.

Visual loss, also know as amaurosis fugax, which is the loss of vision in one eye due to an interruption of blood flow to the retina.

The average is the median; "typically between" is the interquartile range.

Repair of abdominal aortic aneurysm (AAA) to prevent rupture

AAA is an abnormal expansion of the aorta (the largest vessel taking blood away from the heart). If left untreated, it may enlarge and rupture causing fatal internal bleeding. An infra-renal aneurysm occurs below the level of the renal (kidney) arteries within the aorta.

There were 4,208 elective infra-renal AAA repairs submitted to the NVR in 2017, which is approximately 90% of all procedures carried out in the UK.

Of these

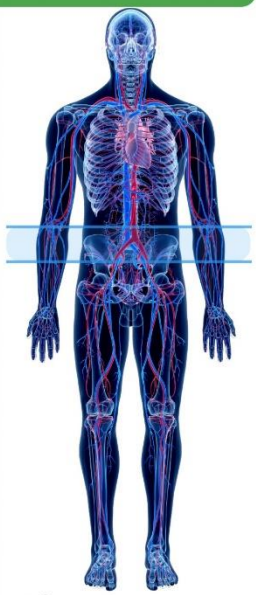
4,208

1,338 (32%) were open repair

- 89% were male
- 74% were older than 65 years
- 67% had hypertension
- 87% were a current or ex-smoker

2,870 (68%) were endovascular repair (EVAR)

- 90% were male
- 92% were older than 65 years
- 70% had hypertension
- 85% were a current or ex-smoker

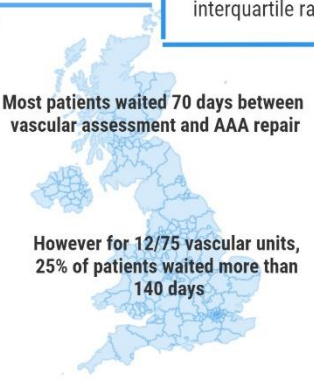


Glossary

The average is the median; "typically between" is the interquartile range.

How were patients assessed?

- 83% Discussed at multi-disciplinary team meeting
- 85% Had fitness measured
- 89% Had pre-operative angiography assessment
- 96% Had formal anaesthetic review
- 92% Of these had review by consultant vascular anaesthetist



Most patients waited 70 days between vascular assessment and AAA repair

However for 12/75 vascular units, 25% of patients waited more than 140 days

Patient outcomes after surgery

Open

- 3.2% Died in hospital
- 5.5% were readmitted within 30 days
- 8 days (6-11 days) Average length of stay (typical range)

EVAR

- 0.7% Died in hospital
- 5.8% were readmitted within 30 days
- 2 days (1-4 days) Average length of stay (typical range)

Repair of elective complex aortic aneurysms to prevent rupture

The term complex is used to describe those aneurysms that occur above the level of the renal (kidney) arteries. These are more complicated that the standard infra-renal repairs and will require specialist teams, often within a specialist hospital.

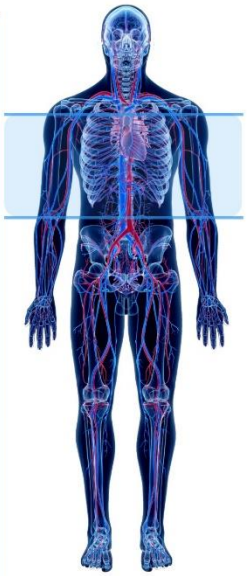
There were 2,303 repairs of elective complex AAAs carried out in 2015-2017.

Of these

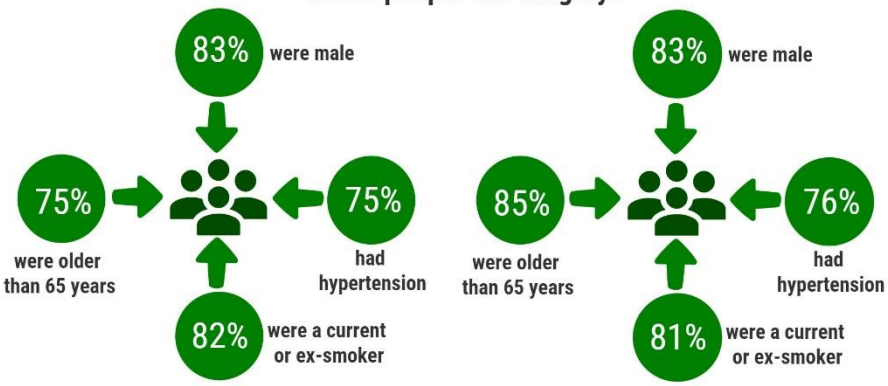
2,303

229 (10%) were open repair

2,074 (90%) were endovascular repair (EVAR)



Which people had surgery?



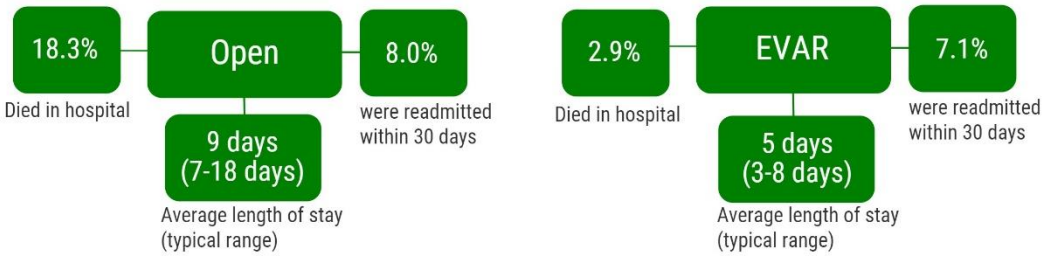
Glossary

The average is the median; "typically between" is the interquartile range.

The most common complex EVAR procedures were:

Fenestrated EVARs (FEVAR), which involves a graft containing holes (fenestrations) to allow the passage of blood vessels from the aorta.
Branched EVAR (BEVAR), which involves separate grafts being deployed on each blood vessel from the aorta after the main graft has been fitted.
Thoracic endovascular aortic/aneurysm repair (TEVAR).

Patient outcomes after surgery

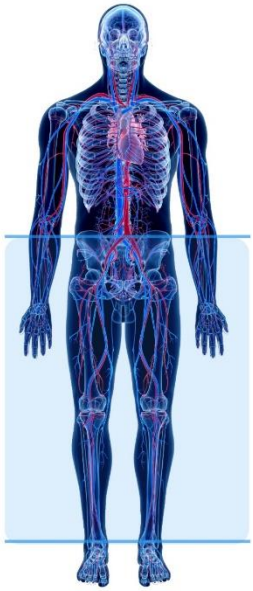


Lower limb bypass for peripheral arterial disease to prevent limb loss

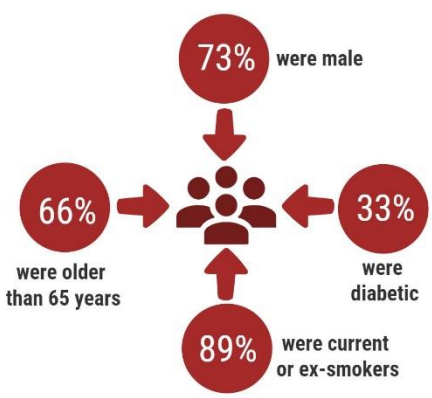
Peripheral arterial disease (PAD) is a restriction of the blood flow in the lower limb arteries that can severely affect a patient's quality of life, and risk their limb.

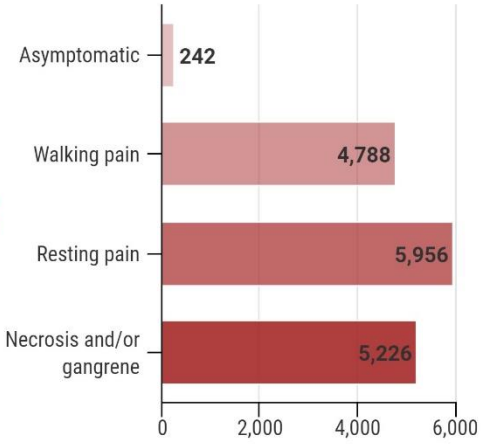
Open surgical (bypass) interventions become options when conservative therapies have proved to be ineffective.

17,475 lower limb bypass procedures carried out in 2015-2017



Patient characteristics

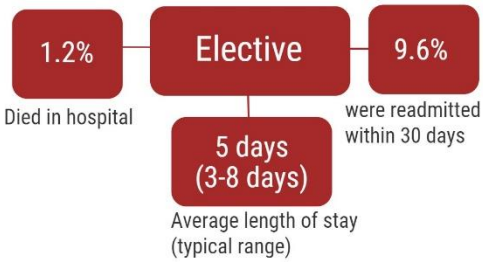


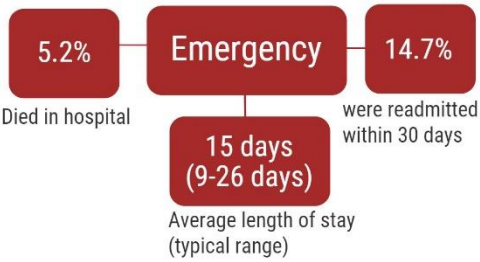


Glossary

The average is the median; "typically between" is the interquartile range.

Patient outcomes post bypass





Lower limb angioplasty/stenting for peripheral arterial disease

Peripheral arterial disease (PAD) is a restriction of the blood flow in the lower limb arteries that can severely affect a patient's quality of life, and risk their limb.

Endovascular interventions become options when conservative therapies have proved to be ineffective.

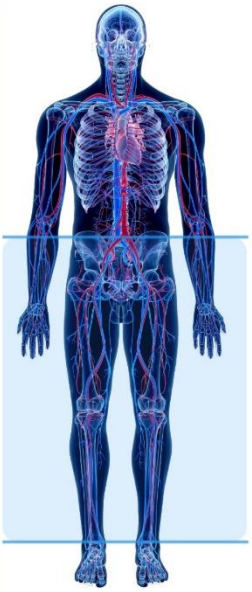
19,009 lower limb angioplasty/stent procedures carried out in the UK in 2015-2017

Patient characteristics

- **67%** were male
- **72%** were older than 65 years
- **42%** were diabetic
- **82%** were current or ex-smokers

Patient outcomes post procedure

- **1.6%** Died in hospital
- **Angio/Stent**
- **8.9%** Readmitted within 30 days
- **1 day (0-7 days)** Average length of stay (typical range)

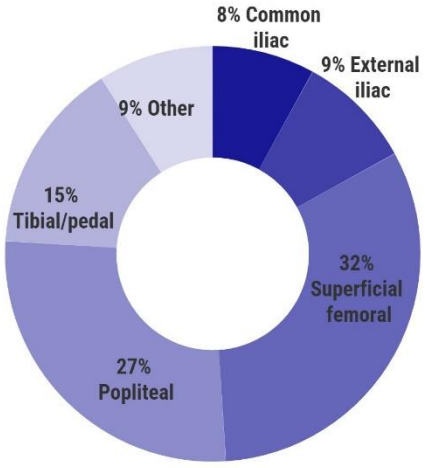


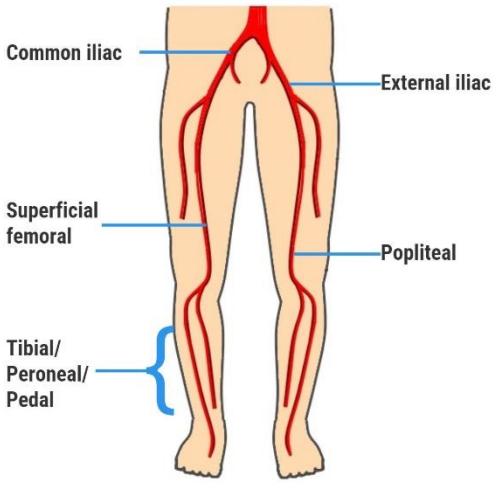
Glossary

The average is the median; "typically between" is the interquartile range.

Procedures by anatomical location

Lower limb angioplasty/stent procedures are carried out in various artery locations within the leg. The breakdown of these procedures is shown below



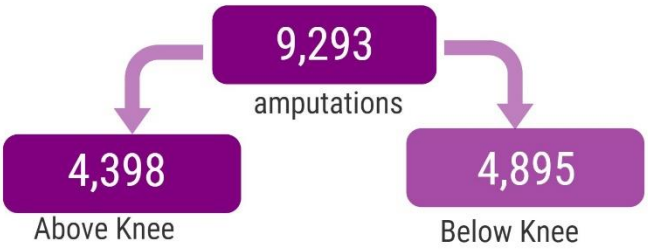


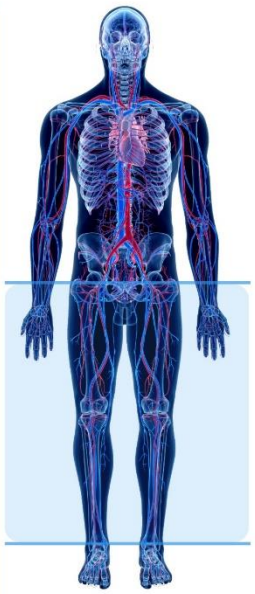
Lower limb major amputation for peripheral arterial disease

Peripheral arterial disease (PAD) is a restriction of the blood flow in the lower limb arteries that can severely affect a patient's quality of life, and risk their limb.

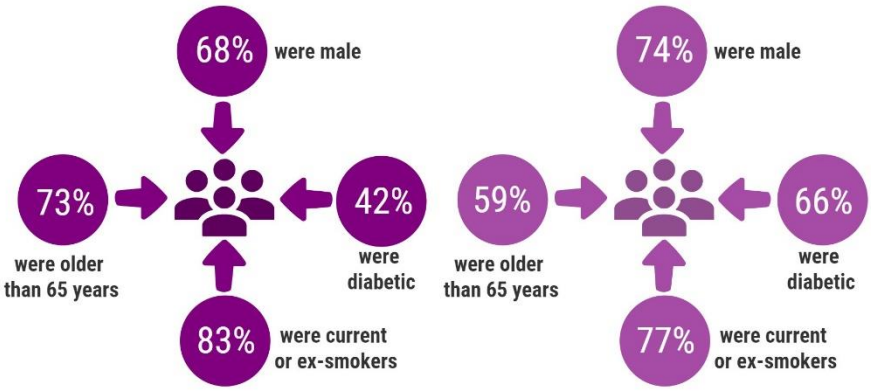
Despite open and endovascular revascularisation procedures, PAD can gradually progress in some patients to critical limb ischaemia. In these situations, patients will require amputation of the lower limb.

In 2015-2017 there were 9,293 major lower limb amputations submitted to the NVR, which is about xx% of the actual cases performed across the UK.





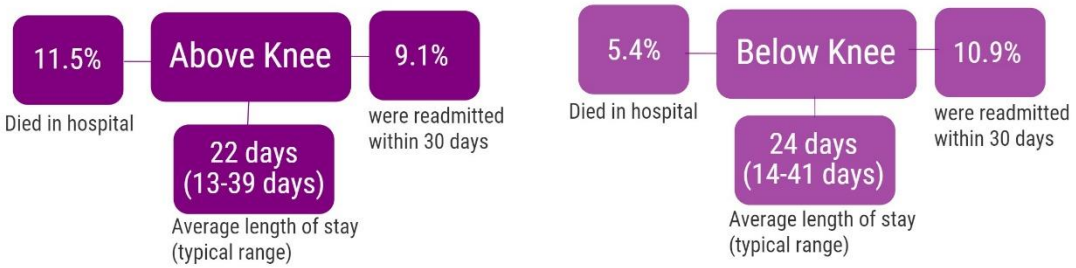
Which people had surgery?



Glossary

The average is the median; "typically between" is the interquartile range.

Patient outcomes after surgery



Royal College of Physicians

Falls and Fragility Fracture Audit Programme (FFFAP)

Fracture Liaison Service Database Annual report December 2018

Achieving effective service delivery by Fracture Liaison Services

Data from January to December 2017

In association with:

British Geriatrics Society
Improving healthcare for older people

British Orthopaedic Association
Caring for Patients; Supporting Surgeons

National Osteoporosis Society

Commissioned by:

Public Health England

HQIP
Healthcare Quality Improvement Partnership

Key messages – report at a glance

A fracture liaison service (FLS) aims to reduce the risk of subsequent fractures by systematically identifying, assessing, treating and referring to appropriate services all eligible patients aged 50 and over who have suffered a fragility fracture.

Demographics and data completeness

We congratulate the achievement of the 55 FLSs* across England and Wales that submitted data which contributed towards this report.

53%
of FLSs had good levels of data completeness, defined as fewer than five fields (out of 17) with more than 20% missing data.

52,731
patient records
were included in 2017, an increase from 42,589 in 2016.

Of the 52,731 records, the index fracture site was:

6% spine

19% hip

69% other fragility fractures

There has been an improvement in most key performance indicators (KPIs) but further work is needed for effective and efficient service delivery.

* Page 15 gives details about the number of commissioned FLSs in England and Wales.

Key findings

43% **Identification** – In 2017 identification of all fractures had improved at to **43%** compared with 40% in 2016.

6% **Identification** – On average **6%** of patients had a spine fracture in 2017, compared with 4% in 2016.

43% **Treatment recommendation** – The percentage of patients being recommended anti-osteoporosis medication increased to **43%** in 2017 from 38% in 2016.

46% **Falls assessment** – **46%** of patients received (or were referred for) a falls assessment compared with 40% in 2016.

38% **Monitoring contact** – There was a decline in monitoring in 2017 with only **38%** of patients recommended anti-osteoporosis medication being contacted at 12–16 weeks post fracture compared with 41% in 2016.

Key recommendations

50% FLSs should ensure identification is **above 50%** of their expected caseload.

>10% FLSs with **>10%** of all submitted patients presenting with a spine fracture should work together to define the best practice pathways for spinal fracture identification.

FLSs should ensure their services **meet with NICE and NOGG* guidelines** for treatment.

FLSs that are not routinely recommending or referring their patients for falls assessment **should pilot an agreed falls pathway** in their FLS.

>50% FLSs with **>50%** identification of their expected fracture caseload are advised to prioritise improving monitoring over improving identification.

* National Osteoporosis Guideline Group (NOGG)

Results

KPIs 2 and 3 – Identification of patients with any fragility fracture and those with a spine fracture as their index fracture site

Guidelines

- NICE QS 149: Adults who have had a fragility fracture have an assessment of their fracture risk.
- NOS 2015: All patients aged 50 years and over who have a new fragility fracture or a newly reported vertebral fracture will be systematically and proactively identified.
- NOGG: Coordinator-based FLSs should be used to systematically identify men and women with a fragility fracture.

Why is the metric important and how has the standard been set?

Systematically identifying all patients aged over 50 years with a fragility fracture is a core function of an FLS. Without systematic identification the local impact of an FLS to improve secondary fracture prevention and reduce future fractures will be blunted.

The standard has been set at 80% of the estimated fragility fracture caseload. The estimated caseload is derived using the 'rule of five' method developed in the feasibility study of the FLS-DB and was determined by multiplying the local count of hip fractures in 2017 from the NHFD by five.

Key findings

The average rate of submitted identification has increased from 40% in 2016 to 43% in 2017 with 20 FLSs now identifying at least 50% of their expected caseload compared with 16 FLSs in 2016.

The number of FLSs identifying at least 10% of their caseload from spine fractures has increased from six in 2016 to 14 in 2017. However, across all FLSs identification rates remain low at 6%.

Identifying spinal fractures systematically has proven challenging for all FLSs as shown in this report. 61% of FLSs said they don't cover opportunistic radiological spinal fractures and 73% said they don't cover vertebral fracture assessment (VFA) using DXA spine imaging. The most frequently reported barriers in finding patients with spinal fractures included lack of standardised practice/language for radiology reporting (37%) and the pathway still being in development (47%).

KPI 7 – Bone therapy recommended

KPI 7 increased to

43%

Guidelines

- NOS 2015, NOS 2017, NOGG, NICE TA 464, NICE TA 204, NICE QS 149: Patients at increased risk of further fracture will be offered appropriate bone protection treatments.

Why is the metric important and how has the standard been set?

Not every patient with a fragility fracture requires anti-osteoporosis medication. However, those patients identified to be at high imminent risk of another fracture require rapidly effective anti-osteoporosis medication with good adherence as this is the highest impact intervention to reduce patients' risk of another fracture. There are a number of national and local thresholds used for intervention which has led to marked variability in recommendation rates between FLSs.

The standard has been set at 50% of the total number of submitted to ensure FLSs are not only identifying the patients at the extremes of fracture risk but also those at moderate fracture risk.

Key findings

The average rate of bone recommendation being recorded has increased from 38% in 2016 to 43% in 2017 with 17 FLSs now recommending anti-osteoporosis medication in at least 50% of patients with a fragility fracture.

Anti-osteoporosis medication was recommended in 56% of patients aged over 75 years and 31% in patients aged under 75 years.

The presence of missing data makes it challenging to interpret the treatment recommendation rate for an FLS. This is because those FLSs with a high proportion of missing treatment data have a consequently lower proportion of treatment recommendation compared with the number of cases submitted, as shown in fig 4.

KPIs 6 and 8 – Falls assessment and strength and balance class training

KPI 6 increased to 46%

KPI 8 increased to 4%

Guidelines

- NOS 2015, NOGG, NICE CG 161, NICE QS86 and the BOA: Older people who present for medical attention because of a fall or have reported recurrent falls in the past year should be offered a multi-factorial falls risk assessment.
- NICE CG 161, NICE QS 86 and NOGG: A muscle-strengthening and balance programme should be offered. This should be individually prescribed and monitored by an appropriately trained professional.

Why is the metric important and how has the standard been set?

Achieving reduction in secondary fracture prevention requires a holistic approach addressing both bone health and falls risk. Addressing risk factors for falls permits interventions that have rapid effects on falls risk, eg addressing cardiovascular disease or specific medications. All patients presenting with a fragility fracture should have a falls assessment or be recommended for one.

Strength and balance training is the best-evidenced intervention for falls prevention. It is effective as a single intervention, as well as part of a multifactorial approach. A Cochrane collaboration systematic review on interventions to prevent falls in community dwelling adults found that group exercise reduced the rate of falls by 29% and the risk of falling by 15%. Home-based exercise reduced the rate of falls by 32% and the risk of falls by 22% (Gillespie LD, *et al*). Following advice from the NHFD advisory group, this KPI excludes patients with hip fractures.

Key findings

The average rate of falls assessment or referral for falls assessment has increased from 40% to 46% between 2016 and 2017. Twenty-six FLSs now record a falls assessment or referral for one in over 50% of their patients compared with 19 FLSs in 2016.

Thirty-six percent of FLSs said they could refer patients for strength and balance training, and 31% of these programmes were delivered by appropriately trained healthcare professionals. However, the average reported initiation of strength and balance classes in patients recommended anti-osteoporosis medication is 4%, although two FLSs were able to report initiation of strength and balance classes in over 50% of patients.

Recommendations for FLSs

- Co-develop, with expertise from local falls services, an agreed falls pathway within their FLS by April 2019 (for FLSs that are not routinely recommending or referring their patients for falls assessment).
- Demonstrate evidence of working with other stakeholders (such as falls services, community physiotherapy teams, local authorities and third sector providers) towards implementing effective strength and balance training provision for this frail population in their locality by 2019.

Recommendation for national policy makers

- Develop options for delivering effective strength and balance class provision for this frail population.

KPI 9 – Monitoring

KPI 9 has decreased to

38%

Guidelines

- NOS 2015, NOS 2017: Patients who are recommended anti-osteoporosis therapy to reduce risk of fracture will be reviewed within 4 months of initiation to ensure appropriate treatment has been started, and every 12 months to monitor adherence with the treatment plan.
- NICE QS 149: Adults prescribed drug treatment to reduce fracture risk are asked about adverse effects and adherence to treatment at each medication review.

Why is the metric important and how has the standard been set?

Given up to 50% of the risk of re-fracture occurs in the first 2 years following an index fracture, it is essential that eligible patients are rapidly started on anti-osteoporosis medication and stay on therapy for at least this length of time. Oral bisphosphonates are the recommended first-line therapy for osteoporosis. These medications have a complex administration regimen for patients to follow, produce no beneficial effect on symptoms and are sometimes associated with troublesome side effects. This leads to rates of persistence of less than 30% at 12 months, and 10% of patients do not even initiate anti-osteoporosis medication. This level of non-compliance is not compatible with an effective FLS. FLSs should actively monitor patients' recommended therapy to support patient choices, including therapeutic switches to other anti-osteoporosis medications with better persistence rates.

Active monitoring of patients should ideally take place within 16 weeks of index fracture to ensure rapid initiation and be repeated at 52 weeks to ensure ongoing persistence. Currently active monitoring of adherence is not standard within the NHS with only 38% of patients who were recommended anti-osteoporosis medication having any monitoring contact. At this early stage of the audit we are reporting whether there is any monitoring of a patient by an FLS and will focus on improving the timing of monitoring in later reports.

Key findings

Monitoring remains challenging for FLSs and the average rate of any monitoring information being recorded decreased from 41% to 38% between 2016 and 2017.

Twenty FLSs were able to submit monitoring information in over 50% of patients in 2017 and 2016.

Reported proportion of adherence at 12 months was 19% of patients who were recommended or referred for therapy, with 5/55 FLSs able to confirm this in over 50% of their patients.

Nearly half (46%) of FLSs reported that they delegated some monitoring to primary care, in which case it becomes almost impossible for hospital-based FLSs to track individual patients and identify whether the patient has continued with their treatment.

NBOCA | National Bowel Cancer Audit

Patient Report 2018

The National Bowel Cancer Audit aims to improve patient care. By looking at what is done now, the audit can suggest changes to improve care for people with bowel cancer in the future. The audit compares the care bowel cancer patients receive across England and Wales, including whether hospitals are meeting national standards.

What is bowel cancer?

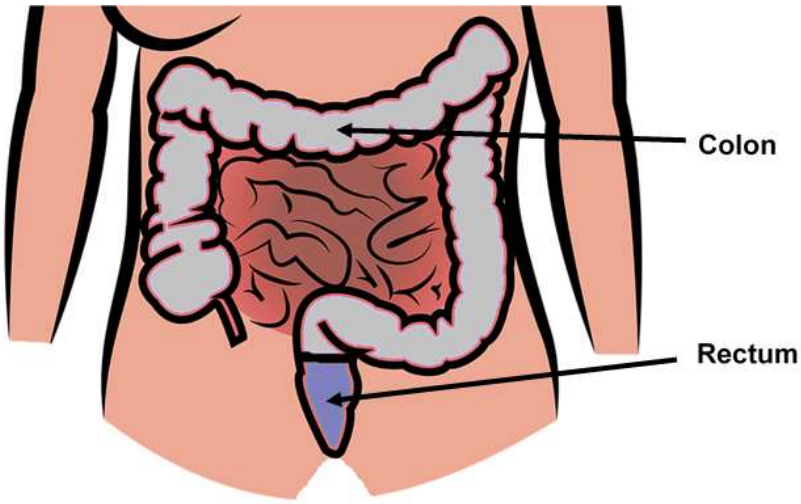
Bowel cancer is the 4th most common cancer in the United Kingdom, with over 41,000 people diagnosed every year

The average age of a patient diagnosed with bowel cancer was 72 years old

7 out of 10 patients with bowel cancer have cancer of the colon, 3 out of 10 have cancer of the rectum

4 out of 5 patients diagnosed with bowel cancer do not have spread of the cancer to other parts of the body

Bowel cancer includes colon cancer and rectal cancer



Non-cancerous growths (polyps) can form in the lining of the bowel. Over time, some of these polyps may develop into cancers. Once a cancer has formed, it can spread through the bowel wall and into blood vessels and lymph glands. The cancer can then sometimes spread to other parts of the body.

What are the routes to diagnosis?

Screening

A tenth of patients are diagnosed through screening. It involves providing a stool sample.

GP Referral

Just over half of patients are diagnosed by their GP referring them to a bowel specialist.

Emergency

A fifth of patients are diagnosed through an emergency hospital admission.

Other

Patients diagnosed, for example, from referrals from different specialists.

What difference does the route to diagnosis make?

Screening — **9 in 10**

GP Referral — **7 in 10**

Emergency — **6 in 10**

Patients diagnosed via screening are more likely to have their cancer found at an early stage and be cured. The numbers above show how likely patients are to be cured depending on their route to diagnosis.

How is bowel cancer treated?

Bowel cancer treatment can involve surgery to remove the section of bowel containing the cancer.

As well as surgery, many patients may also require treatment with chemotherapy and/or radiotherapy.

Treatments for colon and rectal cancer are different. Colon cancer tends to be treated with surgery with or without chemotherapy. Rectal cancer patients may have radiotherapy in addition to this.

Surgery

6 out of every 10 people diagnosed with bowel cancer have surgery to remove the tumour

Chemotherapy

6 out of every 10 people diagnosed with bowel cancer have chemotherapy after surgery if there is cancer in their glands

Radiotherapy

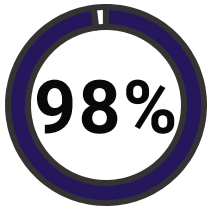
4 out of every 10 people diagnosed with rectal cancer have radiotherapy with or without chemotherapy before surgery

Surgery for bowel cancer

The surgical removal of bowel cancer can have excellent outcomes but, like all surgery, is not without its risks.

Surgery can lead to serious complications and, occasionally, can put a patient's life at risk.

To measure outcomes after bowel cancer surgery, NBOCA reports the number of patients who are alive at 90 days after their surgery. Some patients may require an emergency operation for bowel cancer. Emergency surgery has more risks than planned surgery.



of patients are alive 90 days after planned surgery

of patients are alive 90 days after emergency surgery

The numbers of patients alive at 90 days after both planned and emergency surgery have improved significantly over the past 5 years.

Length of Stay

Prolonged stays in hospital after surgery can put patients at increased risk of problems such as infections.

Length of Stay
Planned surgery - 7 days
Emergency surgery - 10 days

Keyhole Surgery

This can help with a faster recovery after surgery. The audit has shown more patients are having keyhole surgery year on year.

6 in 10 patients have keyhole surgery (laparoscopic)

Readmissions

Patients may need to come back in to hospital after their surgery. This may be due to complications such as problems with their wounds.

1 in 10 patients are re-admitted within one month of their operation

What is the survival 2 years after diagnosis with bowel cancer?

For most patients, survival and cure remain the primary concern after diagnosis.

If a bowel cancer returns after treatment, this is most likely to occur within the first 2 years. This is why NBOCA measures 2-year survival.

Patients may not have surgery for these reasons:
'Too little' cancer - early cancers are sometimes removed without major surgery
'Too much' cancer - their disease has spread too far to be cured
'Too frail' - the patient is not fit enough to have surgery due to other medical problems

Surgery

8 out of 10 patients survive beyond 2 years if they have had their cancer removed by surgery

No Surgery

3 out of 10 patients survive beyond 2 years if they have not had their cancer removed

Overall

For all patients diagnosed with bowel cancer, 6 out of 10 will survive beyond 2 years.

Recommendations for patients and the public

The full NBOCA report detailing care by hospital and region is available at www.nboca.org.uk/reports/
The 2018 Organisational Survey listing the bowel cancer facilities available in every English Trust/hospital and Welsh multidisciplinary team is available at www.nboca.org.uk/reports/organisational-survey-results-2018/

- If your bowel cancer is found early, your bowel cancer is more likely to be cured. Be aware of the signs and symptoms of bowel cancer and visit your GP promptly if you have concerns. You can find information about signs/symptoms of bowel cancer here: https://www.nhs.uk/conditions/bowel-cancer/symptoms/
- You are less likely to have your bowel cancer cured if it is found as an emergency. People aged 60-74 should take part in bowel cancer screening every 2 years to help prevent this. More information can be found at www.nhs.uk/conditions/bowel-cancer-screening/ or provided by your GP. Patients aged 75+ may still be able to request screening every 2 years by contacting the bowel cancer screening helpline.
- You may require more than one treatment for your bowel cancer. Speak to your healthcare team to seek advice on treatment options. Find out if your hospital has each treatment available on-site or if you would need to travel for treatment at www.nboca.org.uk/reports/organisational-survey-results-2018/.
- Outcomes from bowel cancer surgery are improving. Use of keyhole surgery is increasing and you should ask your surgical team whether this is appropriate for you.

Further information: www.nboca.org.uk @NBOCA_CEU

2018 National Organisational Audit Report

RCPCH Audits

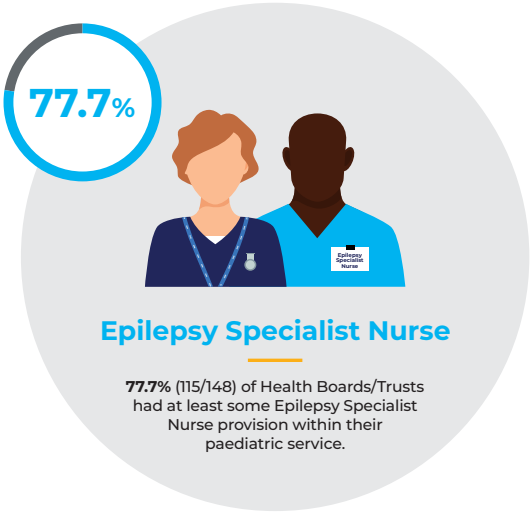
EPILEPSY12

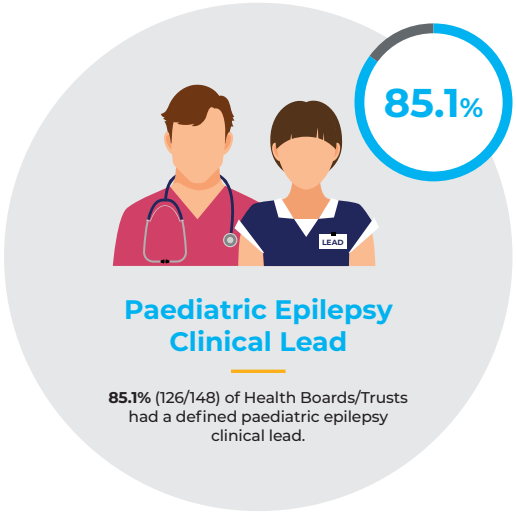
National Clinical Audit of Seizures and Epilepsies for Children and Young People

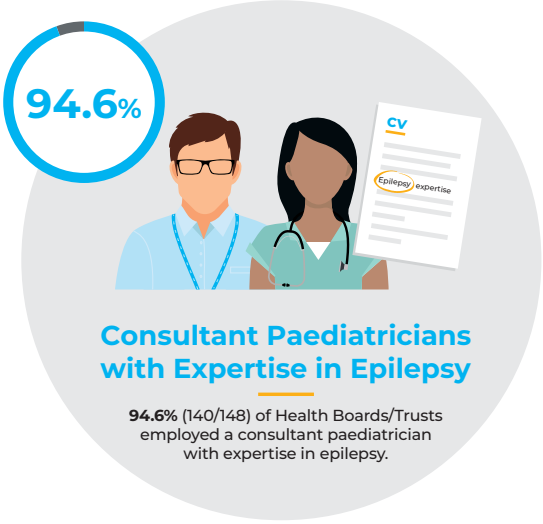
HQIP
Healthcare Quality Improvement Partnership

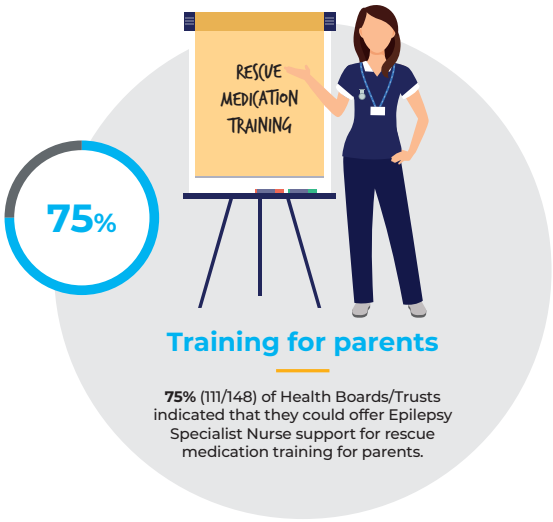
RCPCH
Royal College of Paediatrics and Child Health
Leading the way in Children's Health

2.1 Workforce









Key findings

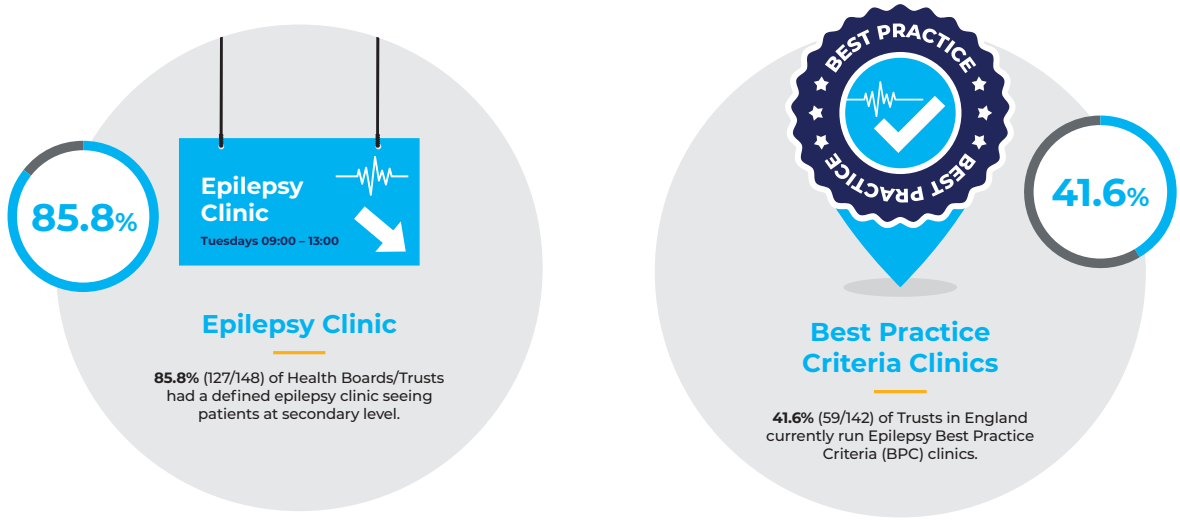
- 94.6% (140/148) of Health Boards and Trusts employed a consultant paediatrician with expertise in epilepsy (Table 3, page 38). There has been an increase in the total number of whole time equivalent (WTE) consultant paediatricians with expertise in epilepsy employed across England and Wales, compared to Rounds 1 and 2 (Figure 1, page 35)

- 85.1% (126/148) of Health Boards and Trusts Health Boards and Trusts had a defined paediatric epilepsy clinical lead (Table 4, page 39)

- 77.7% (115/148) of Health Boards and Trusts had some epilepsy specialist nurse (ESN) provision within their paediatric service. 22.3% of Health Boards and Trusts still have no epilepsy specialist nurse provision (Table 6, Page 43). There has been an increase in the total number of WTE epilepsy specialist nurses employed across England and Wales, compared to Rounds 1 and 2 (Figure 2, page 40)

- 75% (111/148), of Health Boards and Trusts indicated that they could offer ESN support for rescue medication training for parents (Table 7, page 45)

2.2 Epilepsy clinic configuration



Key findings

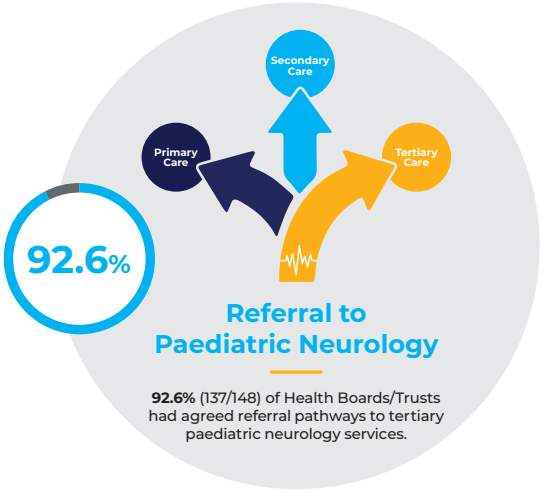
- 85.8% (127/148) of Health Boards and Trusts had a defined epilepsy clinic seeing patients at secondary level (Table 9, Page 49)
- 41.6% (59/142) of Trusts in England currently run Epilepsy Best Practice Criteria (BPC) clinics (Table 12, Page 53)

Recommendations

6. **Health Boards and Trusts** should ensure provision of sufficient follow up epilepsy clinic capacity. Where appropriate, children with epilepsy currently in a general paediatric clinic should be identified and streamed through designated epilepsy clinics.
7. **Health Boards and Trusts** should provide epilepsy services fulfilling Best Practice Criteria (BPC). **Health Boards and Trusts** with different funding mechanisms should still specify and embed Best Practice Criteria within secondary epilepsy clinics. Barriers to BPC implementation should be explored and overcome by **commissioners** working with Health Boards and Trusts.

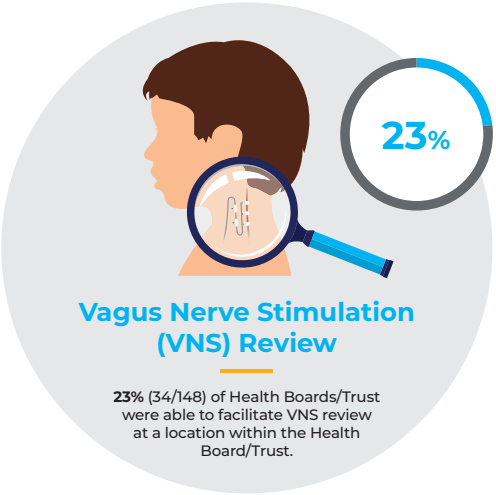
Full 2018 results for Epilepsy clinic configuration are found on page(s) 48-53.

2.3 Tertiary provision



Referral to Paediatric Neurology

92.6% (137/148) of Health Boards/Trusts had agreed referral pathways to tertiary paediatric neurology services.



Vagus Nerve Stimulation (VNS) Review

23% (34/148) of Health Boards/Trust were able to facilitate VNS review at a location within the Health Board/Trust.

Key findings

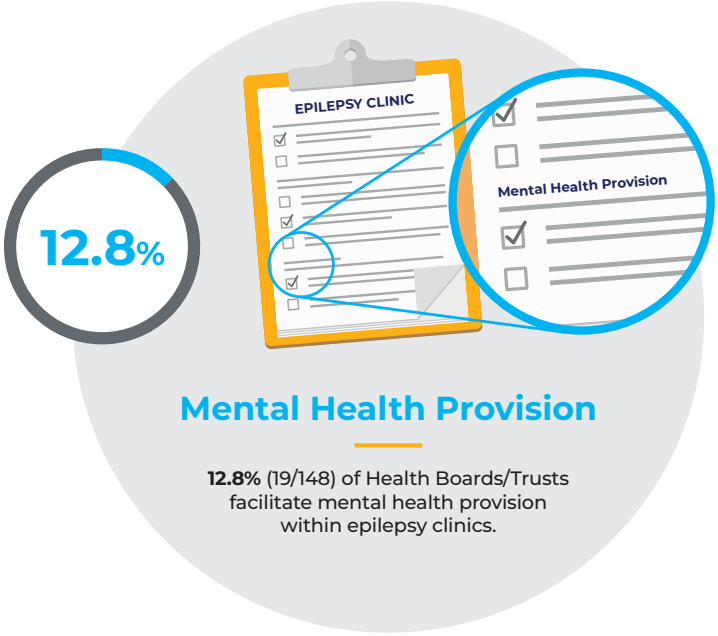
- 92.6% (137/148) of Health Boards and Trusts had agreed referral pathways to tertiary paediatric neurology services (Table 15, Page 57)
- 23.0% (34/148) of Health Boards and Trusts were able to facilitate Vagus Nerve Stimulation (VNS) review at a location within their Health Board or Trust (Table 21, Page 64)

Recommendations

8. **Health Boards and Trusts** should have agreed referral pathways to tertiary paediatric neurology services. Referral processes should ensure that after referral ongoing shared care is maintained. Referral pathways should also be clear to ensure appropriate timely referral for epilepsy surgery evaluation, ongoing complex epilepsy management or both.
9. **Health Boards and Trusts** should consider whether Vagus Nerve Stimulation (VNS) review and programming could be achieved more locally via satellite specialist neurology/epilepsy clinics.

Full 2018 results for Tertiary provision are found on page(s) 54-64.

2.4 Mental health



Key findings

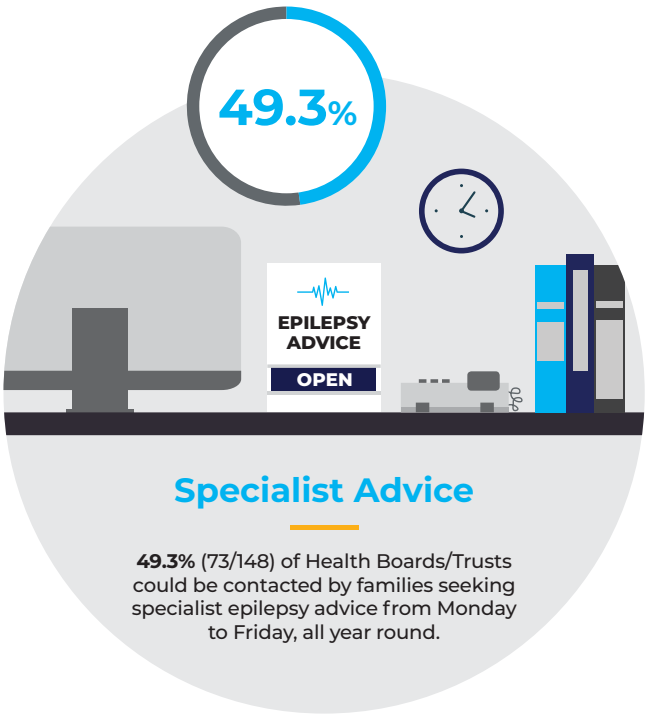
- 12.8% (19/148) of Health Boards and Trusts facilitate mental health provision within epilepsy clinics (Table 37, Page 95)
- Of the 129 Health Boards and Trusts that did not facilitate co-located mental health provision within epilepsy clinics, 6.2% (8/129) had a current Trust action plan describing steps towards achieving it (Table 39, Page 97)

Recommendations

10. **Commissioners, Health Boards and Trusts** should ensure that ongoing epilepsy care includes mental health assessment, diagnosis and treatment alongside management of seizures. If paediatric services do not have co-located mental health provision, Commissioners, Health Boards and Trusts should ensure they have action plans towards achieving co-located professionals with mental health competences within epilepsy clinics.

Full 2018 results for Mental Health are found on page(s) 91-99.

2.5 Service contact



Key findings

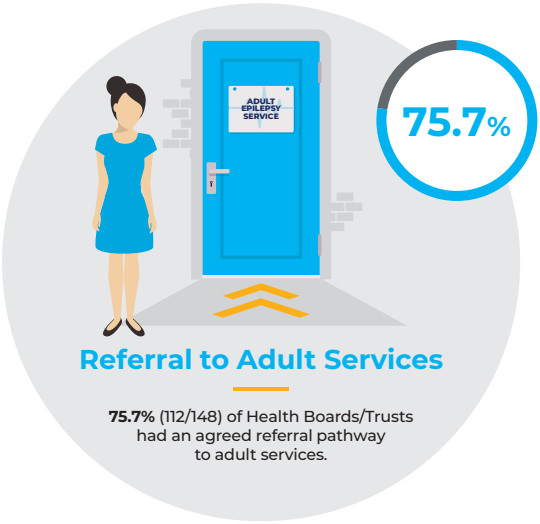
- Whilst nearly all (144/148) Health Boards and Trusts could provide some specialist epilepsy advice between scheduled reviews (Table 23, page 76), only 49.3% (73/148) were able to provide specialist epilepsy advice between scheduled reviews throughout Monday to Friday, all year round (Table 24, Page 77)

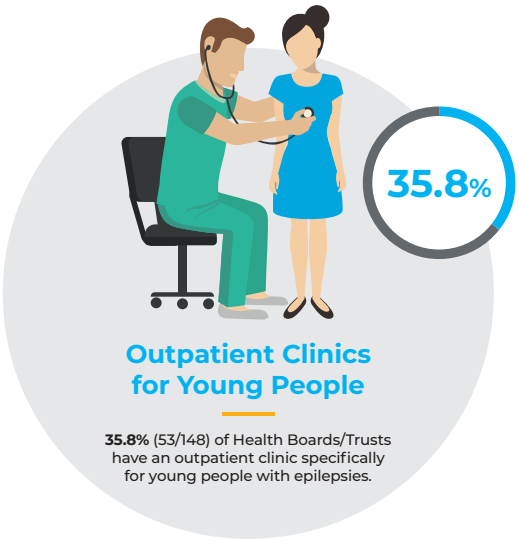
Recommendations

11. **Health Boards and Trusts** should review how 'service contactability' could be improved for their families.

Full 2018 results for Service contact are found on page(s) 75-79.

2.6 Transition





Key findings

- 75.7% (112/148) of Health Boards and Trusts had an agreed referral pathway to adult services. (Table 27, Page 83)
- 35.8% (53/148) of Health Boards and Trusts have an outpatient clinic specifically for young people with epilepsies (Table 28, Page 84)

Recommendations

12. **Health Boards and Trusts** should formally agree transition pathways from paediatric to adult services. Local arrangements should define how this is achieved for different young people with epilepsies with different associated problems, for example children and young people with an intellectual disability or neurodisability. In addition to providing epilepsy clinics for children, **Health Boards and Trusts** should also establish secondary tier clinics specifically for young people with epilepsies. This should support the evolving needs of the young person and their family throughout adolescence as well as during referral and handover to appropriate adult services.

Full 2018 results for Transition are found on pages 80-90.

Royal College of Physicians

Society for Cardiothoracic Surgery in Great Britain and Ireland

Lung cancer clinical outcomes publication 2018

(for surgical operations performed in 2016)

December 2018

In association with:

British Thoracic Oncology Group

National Lung Cancer Forum for Nurses NLCFN

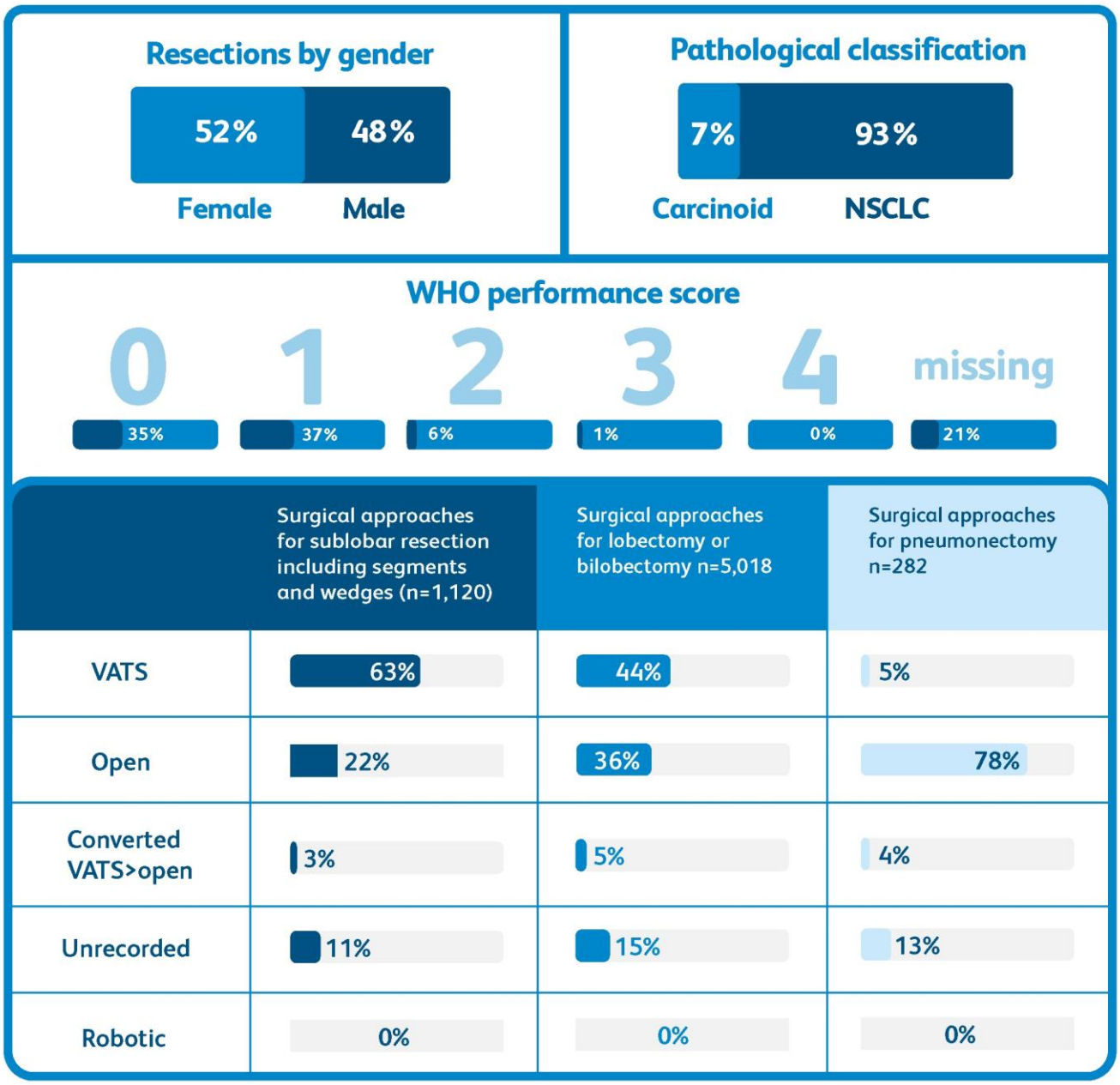
Roy Castle Lung Cancer Foundation

Public Health England

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

HQIP
Healthcare Quality Improvement Partnership

Fig 4 Demographic and surgical data

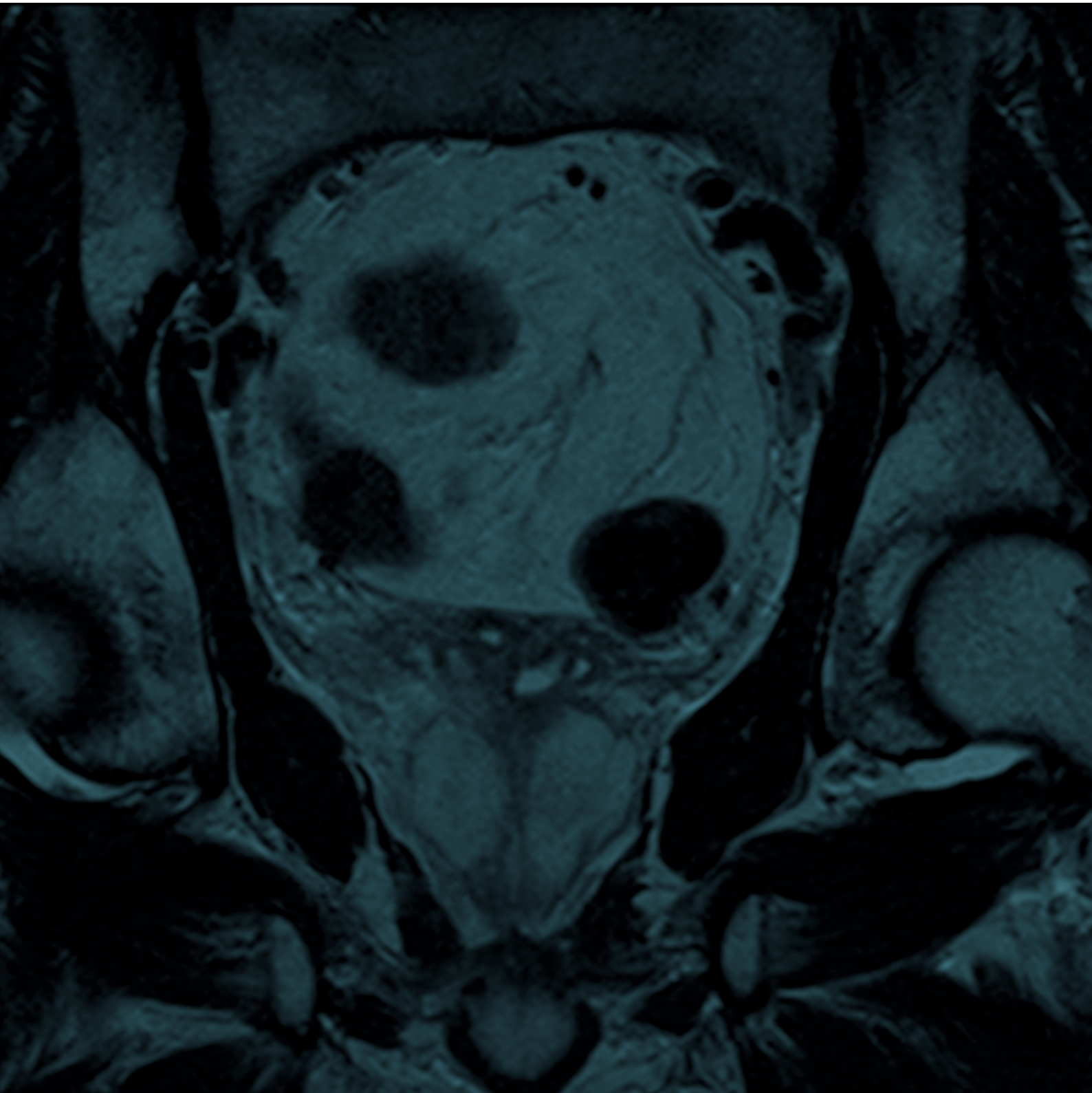


NB small-cell lung cancer surgery was excluded from LCCOP in 2018. This is because surgical resection for small-cell lung cancer surgery is rare, with only 94 cases reported in the 2017 (2015 data) LCCOP report, 1.6% of all resections that year.[2]

NPCA
National Prostate Cancer Audit

Annual Report 2018

Results of the NPCA Prospective Audit in England and Wales for men diagnosed from 1 April 2016 to 31 March 2017 (published February 2019).



NPCA
National Prostate Cancer Audit

Annual Report 2018

DIAGNOSIS AND STAGING

42,975

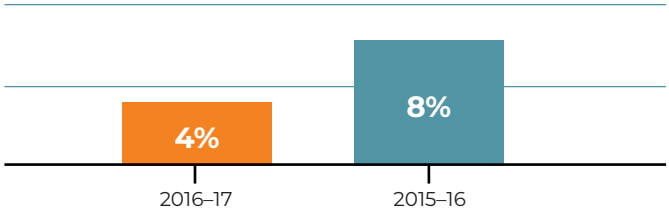
men were diagnosed with prostate cancer in England and Wales between 1st April 2016 and 31st March 2017

	England	Wales	
	80%	41%	of men had a pre-biopsy multiparametric MRI
	12%	4%	of men had a transperineal biopsy

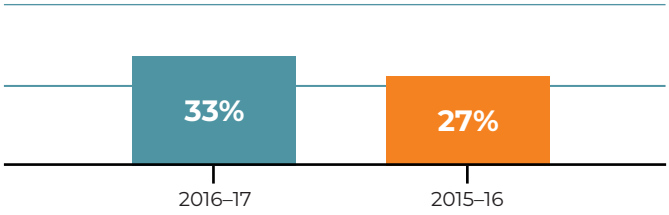
55% of men were 70 years or older

16% of men presented with metastatic disease – no change from 15/16

TREATMENT ALLOCATION



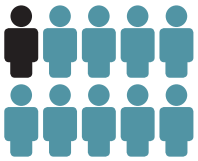
Fewer men with low-risk, localised disease had radical treatments and were potentially 'over-treated'



Slightly more men with locally-advanced disease did not have radical treatments and were potentially 'under-treated'

TREATMENT OUTCOMES

13% of men were **readmitted** within 3 months **following surgery**



Within **2 years of treatment** 1 in 10 men experienced a **severe genitourinary complication after surgery** or a **severe gastrointestinal complication after external beam radiation**

After surgery, men reported their **sexual function** to be **23** and **urinary continence** to be **71** on a scale of 1 to 100

After external beam radiation, men reported their **sexual function** to be **17** and **bowel function** to be **85** on a scale of 1 to 100

PATIENT EXPERIENCE OF CARE

90% of men said they were **given the 'right amount' of information**

83% of men said they were **'given the name of a clinical nurse specialist'**

72% of men said they were **involved as much as they wanted to be in treatment decision making**

89% of men rated their care as 8/10