National Clinical Audit and Patient Outcomes Programme (NCAPOP)
Infographics compendium

Q1 (April – June 2021), updated 11/06/2021

PUBLICATION DATE	HEALTHCARE AREA	TYPE	PROJECT NAME	LEAD PROVIDER	FULL REPORT TITLE	HQIP WEBLINK TO REPORT	DOC NUMBER
13/05/2021	Long term conditions	Audit	FFFAP - Falls and Fragility Fracture Audit Programme	RCP: Royal College of Physicians	National Audit of Inpatient Falls Interim report	https://www.hqip.org.uk/resource/naif-audit-report-2020/	0.001
13/05/2021	Long term conditions	Audit	FFFAP - Falls and Fragility Fracture Audit Programme	RCP: Royal College of Physicians	Fracture Liaison Service Database Annual Report	https://www.hqip.org.uk/resource/fracture-liaison-service-report-2020/	0.002
13/05/2021	Long term conditions	Audit	NACAP - National Asthma and COPD Audit Programme	RCP: Royal College of Physicians	National Asthma and COPD Audit Programme- Children and Young People Asthma Report	https://www.hqip.org.uk/resource/cyp-asthma-audit-2019-20/	0.003
13/05/2021	Women and children	Audit	NCMD - National Child Mortality Database	University of Bristol	National Child Mortality Database- Themed report (England only)	https://www.hqip.org.uk/resource/ncmd-child-mortality-social-deprivation-report/	0.004
13/05/2021	Mental health	CORP	Mental Health Clinical Outcome Review Programme	University of Manchester	Mental Health CORP Annual Report	https://www.hqip.org.uk/resource/suicide-safety-mental-health-report-2020/	0.005
13/05/2021	Mental health	CORP	Mental Health Clinical Outcome Review Programme	University of Manchester	Mental Health CORP- Middle Aged Men study	https://www.hqip.org.uk/resource/suicide-by-middle-aged-men/	0.006
10/06/2021	Women and children	Audit	NCMD - National Child Mortality Database	University of Bristol	Second annual report	https://www.hqip.org.uk/resource/child-mortality-ncmd-report/#.YMIpX_lKhPY	0.007
10/06/2021	Long term conditions	Audit	NACAP - National Asthma and COPD Audit Programme	RCP: Royal College of Physicians	COPD clinical audit 2019/20	https://www.hqip.org.uk/resource/copd-clinical-audit-2019-20/#.YMIpW_lKhPY	0.008
10/06/2021	Cancer	Audit	NBoCA - National Bowel Cancer Audit	RCS: Royal College of Surgeons	Trends, characteristics and outcomes for patients diagnosed under 50 years old with metastatic colon cancer in England	https://www.hqip.org.uk/resource/bowel-cancer-audit-nboca/#.YMIpXflKhPY	0.009

Royal College of Physicians | National Audit of Inpatient Falls (NAIF)

National Audit of Inpatient Falls (NAIF)

Interim annual report

Spring 2021

In association with

Commissioned by

Report at a glance – key messages

This report covers 2020 England and Wales facilities audit data and is supported by National Hip Fracture Database (NHFD) clinical audit data from 1 January to 31 December 2019.

161 organisations (74% of those eligible) participated in this audit by submitting facilities audit data. There were 2,016 inpatient hip fractures reported in the NHFD during this period.

Hip fractures sustained in an inpatient setting continue to be associated with poorer outcomes including a two-fold increase in 30-day mortality.

Slightly fewer organisations claim to report **all inpatient hip fractures as severe harm** compared with last year (70% in 2020 compared with 76% in 2019).

76% in 2019

70% in 2020

This is supported by data demonstrating more inpatient hip fractures recorded in the NHFD (n=2,016) than reported falls with severe harm (n=1,553) in the same reporting timeframe.

There was a slight reduction in the proportion of organisations participating in the audit compared with last year (74% vs 77%). This is still very encouraging in the context of the challenges posed by COVID-19.

The use of fall risk screening tools has increased (40%) compared with last year (32%).

In accordance with NICE guidance, organisations should not use screening tools and instead use multi-factorial risk assessment for all inpatients over the age of 65.

Seven-day access to walking aids has improved (64% of organisations) compared with last year (57% of organisations).

In a question asked for the first time, we found that half of organisations mandate training on the subject of falls for all frontline staff.

Annual report benchmarking FLS improvement and performance in 2019: Pre-COVID

Data from January to December 2019

April 2021

In association with

Commissioned by

Report at a glance – key messages

A fracture liaison service (FLS) provides secondary prevention for individuals presenting with fragility fractures (defined as a fracture following a fall from standing height or less). These services systematically identify and assess the patient's risk of subsequent fractures, and treat and refer to other services to reduce that risk.

Service performance

We congratulate the achievement of the **67 FLSs* across England and Wales** that submitted 2019 data which contributed towards this report.

88%

of FLSs improved in at least one key performance indicator (KPI) in 2019.

There has been an improvement in most KPIs, but further work is needed for effective and efficient service delivery.

Key findings	Key recommendation
Monitoring contact (41%) 2019 has seen monitoring improve for the first time in 3 years, with 41% of patients who have been prescribed osteoporosis treatment being contacted at 12–16 weeks post fracture. This is up from 36% in 2018, 38% in 2017 and 41% in 2016.	Without effective adherence, an FLS cannot reduce fracture risk or deliver expected improvements in patient outcomes. FLSs should use 16-week monitoring to personalise treatment recommendations according to patients' needs and optimise adherence at 1 year.
Identification (12%) 9/67 (13%) FLSs submitted over 80% of the expected caseload. This is a decrease in comparison with 2018 (10/62, 16%). Identification of spine fractures decreased to 24% in 2019 from 15% in 2018.	Review performance across other parts of the FLS to establish whether vertebral fracture identification is the next priority for the FLS. If so, further recommendations on page 9 of the report.
Quality improvement (88%) Out of 59 FLSs actively participating in both 2018 and 2019, 52 (88%) FLSs improved in at least one KPI compared with 33% of participating FLSs in 2018.	Ensure that FLS staff time is dedicated to delivering at least one complete FLS quality improvement cycle in 2021–22. The aim should be to improve in one KPI while maintaining existing performance in other KPIs.

Patient records

patient records were included in the 2019 audit, an 18.3% increase from 58,979 in 2018.

The number of participating FLSs increased from 63 to 67.

Patient records

Of the 69,771 patient records, the site of index fracture was reported to be:

*Page 18 gives details about the FLSs in England and Wales.

Royal College of Physicians | NACAP

National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP)

Children and young people asthma clinical and organisational audits 2019/20

Clinical (children and young people with asthma attacks admitted to hospital from 1 June 2019 and discharged by 31 January 2020) and organisational audits of children and young people asthma services in England, Scotland and Wales 2019/20

Children and young people asthma 2019/20 audit report

Published May 2021

In association with:

Royal College of General Practitioners

Commissioned by:

Report at a glance

Participant information

8,506

hospital admissions for asthma attacks between June 2019 and January 2020.

152/181 hospitals participated in the clinical audit **84%**

136 in England, **7** in Scotland and **9** in Wales

142/181 hospitals participated in the organisational audit **78%**

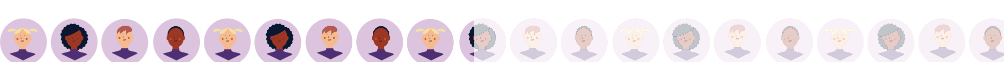
119 provided a full organisational audit record. **110** in England, **2** in Scotland and **7** in Wales

23 provided a partially complete organisational audit record. **18** in England, **3** in Scotland and **2** in Wales

C1 Recording smoking status*and exposure to second-hand smoke

QI priority: Record smoking status and exposure to second-hand smoke for **95%** of children and young people.

*smoking status is only recorded for children and young people aged over 11 years old



46.9% of children and young people did have their smoking status recorded.

57.7% of children and young people did have their exposure to second-hand smoke recorded..

C2 Systemic steroids

QI priority: Administer systemic steroids within 1 hour of arrival at hospital to **95%** of children and young people aged 6 years old or over, who have not received system-ic steroids as part of pre-hospital care.

38.7%

of children and young people aged 6 years or older received systemic steroids within 1 hour of arrival at hospital.

C3 Discharge bundle

QI priority: Provide **95%** of children and young people with the following as part of their discharge bundle:

1. review or issue of a personalised asthma action plan (PAAP)
2. check of their inhaler technique
3. request a follow-up appointment in a paediatric asthma clinic within 4 weeks

45.5%

of children were in receipt of an up-to-date PAAP at discharge.

61.9%

had their inhaler technique checked before discharge.

28.8%

request of a follow-up appointment in a paediatric asthma clinic within 4 weeks

The rationale for each priority and its associated guidelines and standards are included with the key findings at relevant points throughout the report.

Organisational QI priorities

O1 Respiratory nurse specialist

QI priority: 85% of hospitals should have a respiratory nurse specialist trained in the care of children and young people with asthma.

58.8% of hospitals have a respiratory nurse specialist

O2 Diagnostic tools

QI priority: 80% of hospitals should have access to fractional exhaled nitric oxide (FeNO), as a diagnostic tool for paediatric asthma services.

41.2% of hospitals have access to FeNO as a diagnostic tool for paediatric asthma patients.

The rationale for each priority and its associated guidelines and standards are included with the key findings at relevant points throughout the report.

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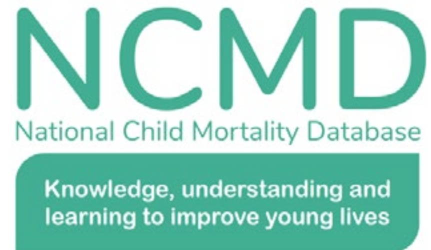


Child Mortality and Social Deprivation

National Child Mortality Database Programme Thematic Report

Data from April 2019 to March 2020
Published May 2021

Over a fifth of all child deaths might be avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived

www.ncmd.info

HQIP

Key findings

Child Mortality and Social Deprivation

April 2019 to March 2020

CLEAR ASSOCIATION between **RISK OF DEATH** and level of **DEPRIVATION** (all categories except malignancy)

Relative **10% INCREASE** in **RISK OF DEATH** between each decile of increasing deprivation (on average)

>1 in 5 CHILD DEATHS might be **AVOIDED** if children living in most the deprived areas had the same mortality risk as those living in the least deprived

INCREASED PROPORTION of deaths with modifiable contributory factors with **INCREASING DEPRIVATION**

1 in 12 CHILD DEATHS reviewed in 2019/20 identified **1 OR MORE** factors related to **DEPRIVATION**

EXEMPLAR PROJECTS highlighting strategies informed by recurring themes and local learning to **REDUCE MORTALITY**

RECOMMENDATION

Use the data in this report to DEVELOP and MONITOR the IMPACT of future strategies to REDUCE SOCIAL DEPRIVATION and INEQUALITIES

ACTION BY: Policy Makers, Public Health Services, Service Planners and Commissioners at local and national level

National Confidential Inquiry

into Suicide and Safety in Mental Health

ANNUAL REPORT: ENGLAND, NORTHERN IRELAND, SCOTLAND AND WALES 2021

Patient and general population data 2008-2018, and NCISH COVID-19 related work

NCISH Annual Report

(2008-2018)

1,601 suicides by people under mental health care in 2018

27% who died by **suicide** had contact with **mental health services** in the **12 months** before death

Mental health **in-patient** and **post discharge** deaths continue to **fall**

Patients who lived alone

746 deaths per year

More self-harm, drug and alcohol use

Higher rates of unemployment, physical and mental illness

Services should address these clinical and social risks

Patients under 25

134 deaths per year

Increasing numbers in 15-17 year olds and female patients

Personality disorder, eating disorders, drug misuse and self-harm more common

Improve skills to respond to clinical complexity

National Confidential Inquiry into Suicide and Safety in Mental Health (2021)

NCISH Annual Report

(2008-2018)

Patients from ethnic minority groups

107 deaths per year

Risk profile differs between ethnic groups

Different prevention for severe mental illness, substance misuse and recent migration

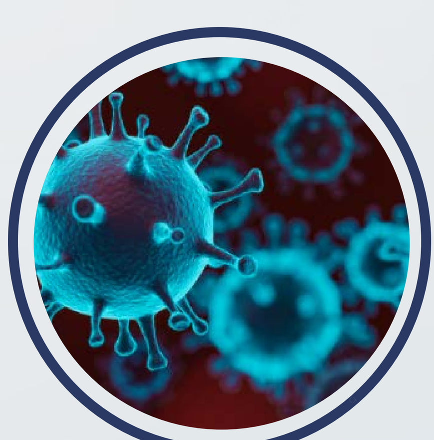
Services to be aware of diverse social and clinical characteristics

Suicide prevention during COVID-19

133 suspected suicide deaths

Increase in anxiety, loneliness & isolation

1/3 had reported disruption in regular support

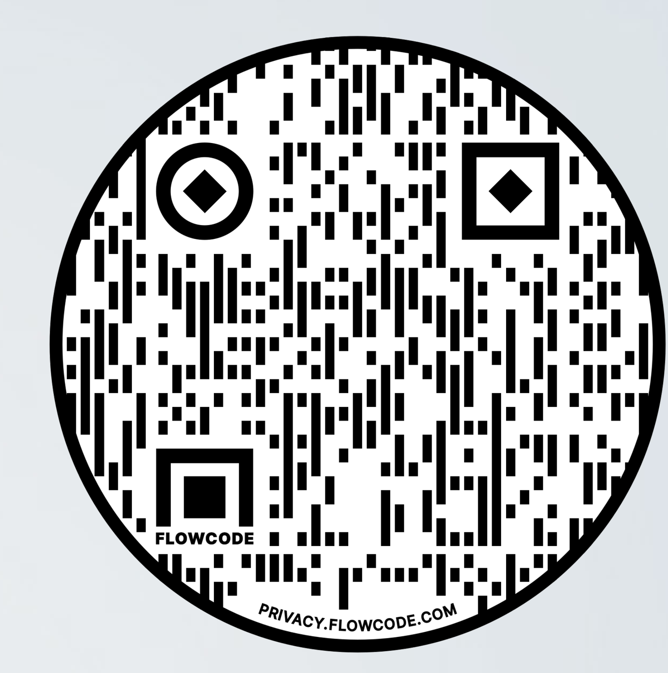


2/3 reported adverse experiences related to the pandemic

Additional support may be needed for vulnerable groups

Suicide prevention in mental health services

Healthcare organisations can self-assess their services using our Safer Services toolkit



Annual report 2021

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

27% people who died by **suicide** had contact with **mental health services** in the **12 months** before death

Our findings suggest...

If you live alone

If you live alone, your care should address both your **health** and **social** risks

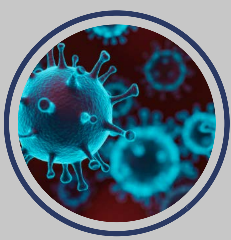
Ethnic differences

Suicide risk **differs by ethnic group**, and your care should consider these differences

Young people

You might feel like you are facing a **range of complex problems**. You should not be excluded from services because of this

Mental healthcare during COVID-19



Services need to support people who are **anxious, isolated, or lonely**. Your usual care should be disrupted as little as possible

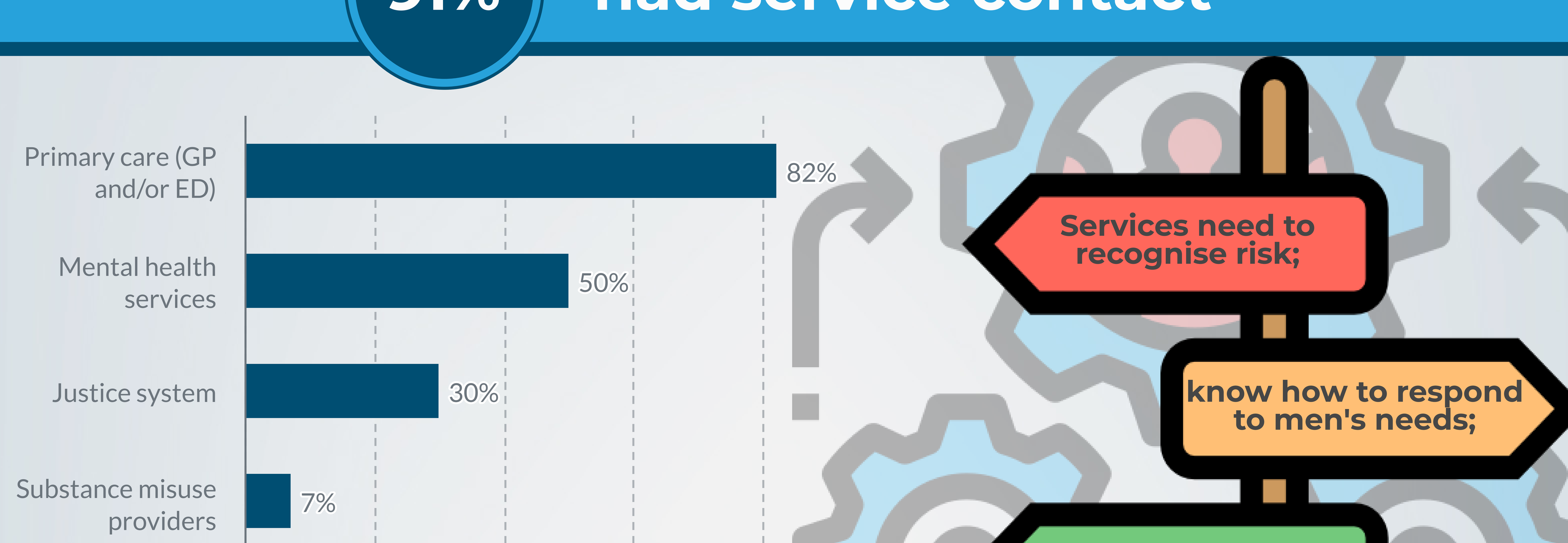
Suicide by middle-aged men

National Confidential Inquiry
into Suicide and Safety in Mental Health

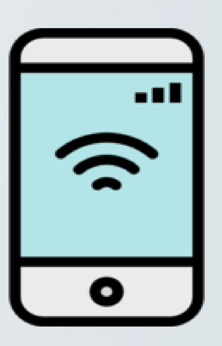
2021

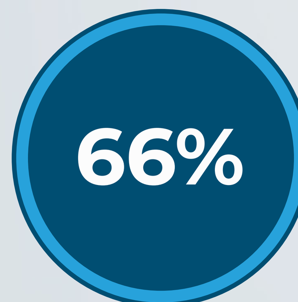
Suicide by middle aged men

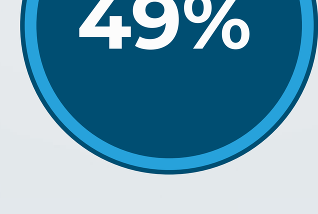
91% had service contact

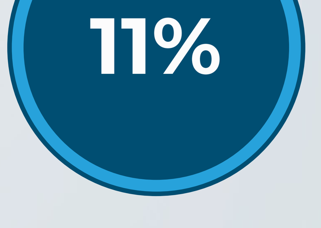


Higher rates of key risk factors



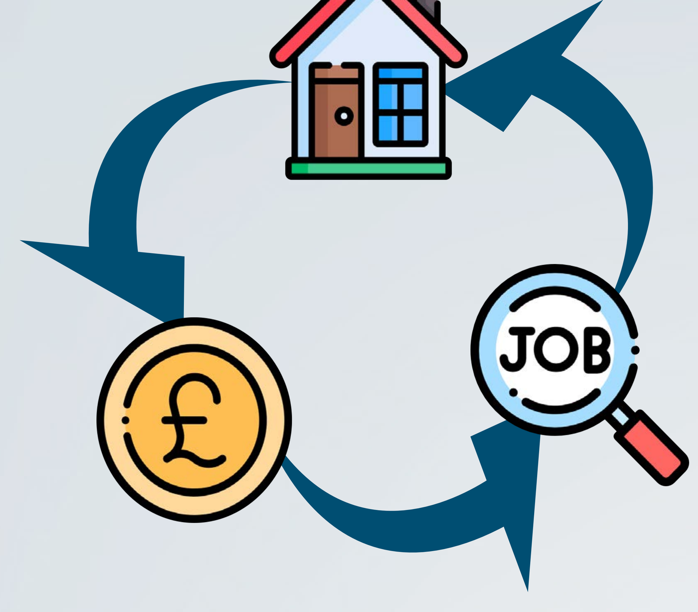






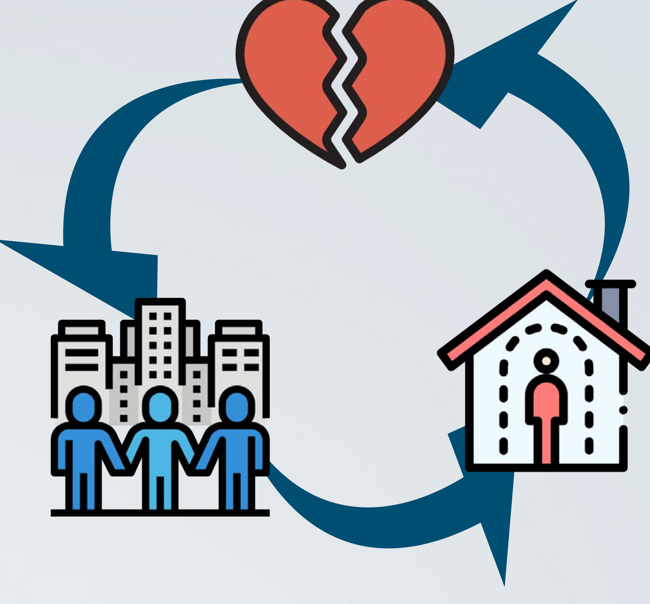
66%	52%	49%	34%	11%
Mental health diagnosis	Physical health condition	Alcohol and drug misuse	Bereavement	Suicide-related internet use

57% experienced economic adversity



Unemployment, financial or housing problems common

Recent adverse life events experienced by many

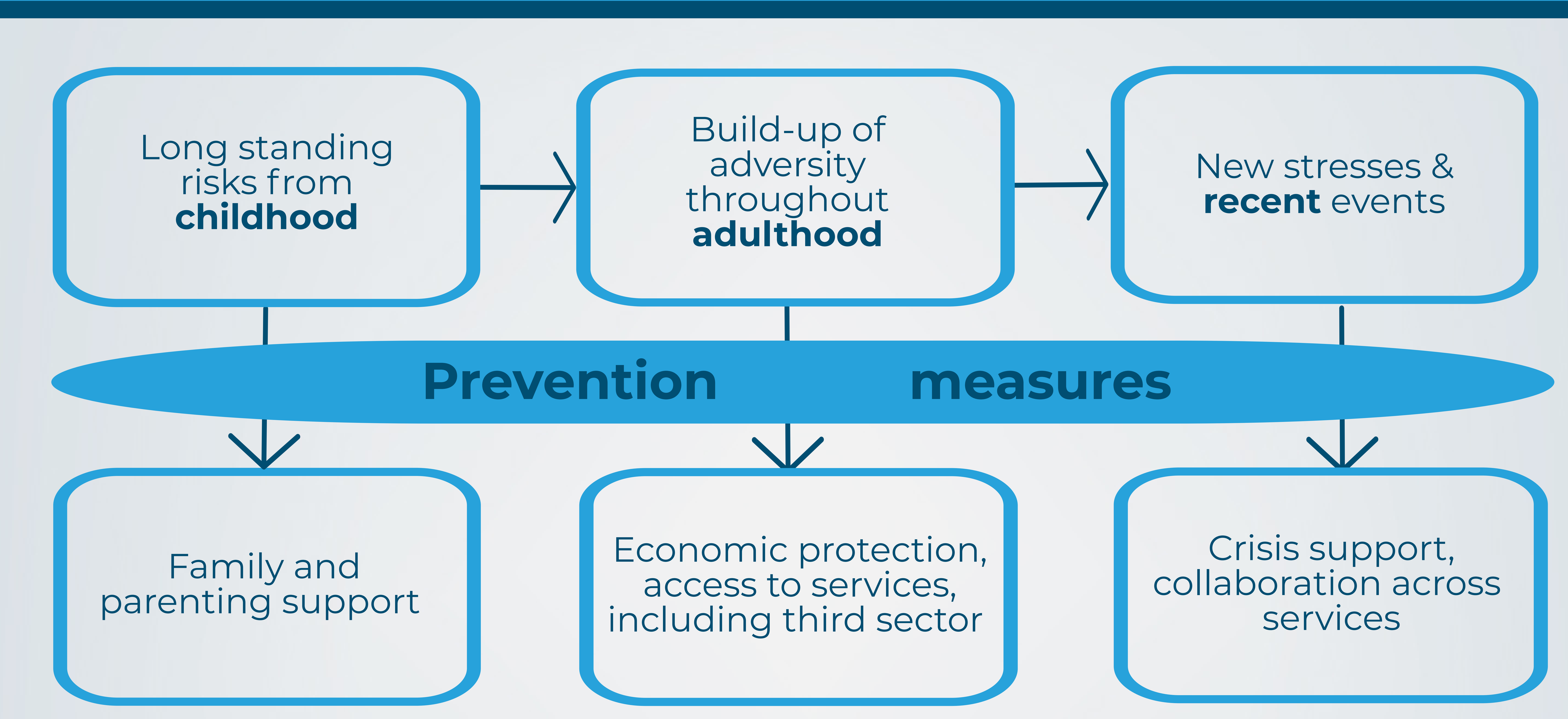


Relationship break-up, problems at work, social isolation

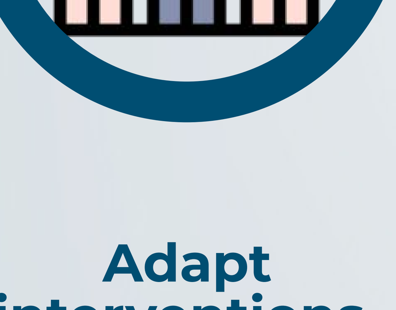
National Confidential Inquiry into Suicide and Safety in Mental Health (2021)

Suicide by middle aged men

Cumulative risk



Opportunities for prevention



Adapt interventions to suit men's needs

Safer prescribing in accordance with national guidelines

Recognise risks after self-harm

Bereavement support tailored to men

Improved online safety in line with current initiatives

National Confidential Inquiry into Suicide and Safety in Mental Health (2021)

Suicide by middle-aged men

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

1,516 men aged 40-54 died by **suicide** in 2017, nearly a **quarter** of the deaths by suicide in the UK

Our findings suggest...

Services working with you

You should be offered a **range** of support that is **meaningful** to you, your needs and preferences

Safer prescribing

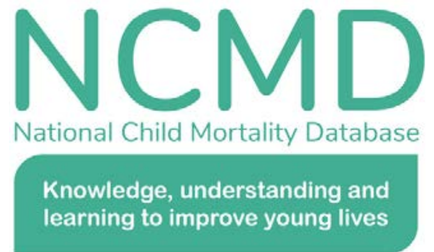
If you have a **physical health condition**, services might ask you to discuss the best plan for **managing your medication**

Asking for help

If you feel uncomfortable seeking help, you should be able to access information on **local informal sources of help**

Psychological therapy

You should be offered therapy – a **chance to talk**, take **practical steps** to help you address your risks



Second Annual Report

National Child Mortality Database Programme

Data from April 2019 to March 2020

Published June 2021

Insights from NCMD's first year of national child death review data collection

www.ncmd.info

HQIP

Child deaths (England): Age
1 Apr 2019 to 31 March 2020

42% under 28 days old
21% between 28 and 364 days old
37% 1 year and over

Child deaths (England): Deprivation
1 Apr 2019 to 31 March 2020

most deprived

(1,066 deaths)

approx. **3X** DEATHS

least deprived

(359 deaths)

Child deaths (England): Location
1 Apr 2019 to 31 March 2020

78% in hospital trust

22% outside hospital setting

Child deaths (England): Prematurity
1 Apr 2019 to 31 March 2020

69% infant deaths (under 1 year old) are born preterm (before 37 weeks)

Most frequent modifiable factors

Based on child death reviews (England); 1 April 2019 to 31 March 2020

1. Smoking (parent/carer)
2. Quality of service delivery
3. Unsafe sleeping arrangements
4. Substance/alcohol misuse (parent/carer)
5. Maternal obesity during pregnancy
6. Challenges with access to services
7. Poor communication/ information sharing
8. Domestic abuse
9. Poor home environment
10. Consanguinity (parents are close blood relatives)
11. Mental health (parent/carer)

National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP)

COPD clinical audit 2019/20

(people with COPD exacerbations discharged from acute hospitals in England, Scotland and Wales between October 2019 and February 2020)

Data analysis and methodology report

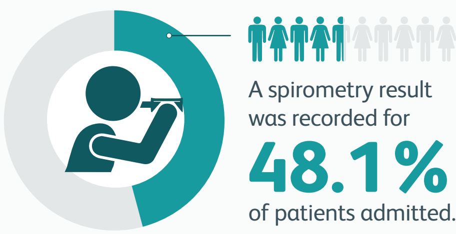
Published June 2021

In association with:

Commissioned by:

Report at a glance

Spirometry



A spirometry result was recorded for **48.1%** of patients admitted.

QI priority

Ensure spirometry results are available for all patients admitted to hospital with an acute exacerbation of COPD.

Non-invasive ventilation (NIV)

Only **24.8%** of patients who received NIV did so within 120 minutes of arrival at hospital.

QI priority

Ensure all patients requiring NIV receive it within 120 minutes of arrival at hospital.

Respiratory review

87.5% of patients admitted were reviewed by a member of the respiratory team.

66.7% of admitted patients were reviewed within 24 hours of admission.

Smoking cessation

35.5% of patients with smoking status recorded on admission were current smokers.

53.1% of current smokers were referred for behavioural change intervention and/or prescribed a stop smoking drug.

QI priority

Ensure that all current smokers are identified and, if they accept, referred for behavioural change intervention and/or prescribed a stop smoking drug.

Discharge bundles

75.5% of patients admitted received a discharge bundle.

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Trends, characteristics and outcomes for patients diagnosed under 50 years old with metastatic colon cancer in England

NBOCA: Short Report
Date of publication: Thursday 10th June 2021

The Healthcare Quality Improvement Partnership (HQIP) is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing, and National Voices. Its aim is to promote quality improvement in patient outcomes, and in particular, to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality in England and Wales. HQIP holds the contract to commission, manage, and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP), comprising around 40 projects covering care provided to people with a wide range of medical, surgical and mental health conditions. The programme is funded by NHS England, the Welsh Government and, with some individual projects, other devolved administrations, and crown dependencies. www.hqip.org.uk/national-programmes.

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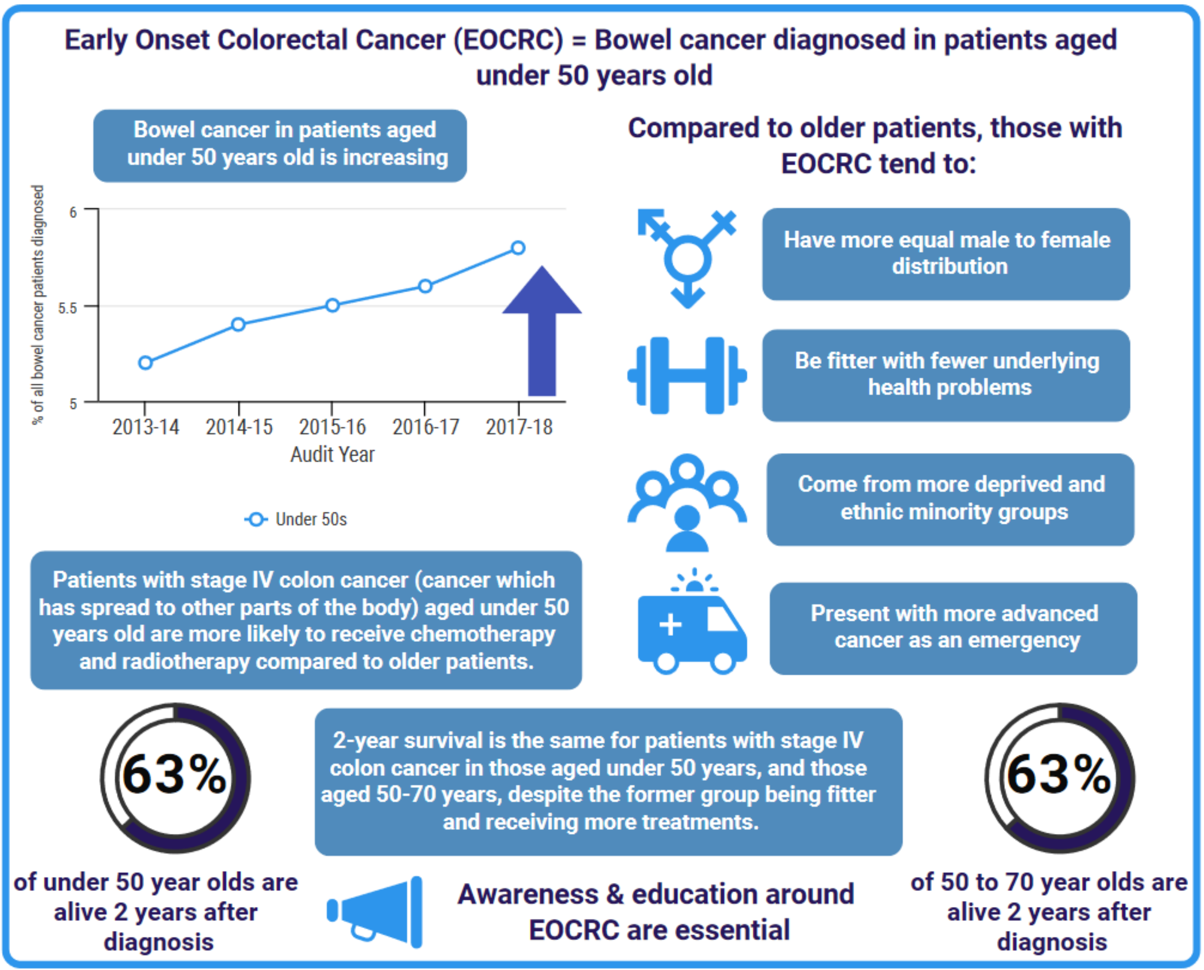

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