



HQIP

Healthcare Quality
Improvement Partnership

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

Q2 (July – September 2022), updated 03/10/2022

PUBLICATION DATE	HEALTHCARE AREA	TYPE	PROJECT NAME	LEAD PROVIDER	FULL REPORT TITLE	HQIP WEBLINK TO REPORT	DOC NUMBER
14/07/2022	Long term conditions	Audit	NACEL - National Audit of Care at the End of Life	NHS Benchmarking	National Audit of Care at the End of Life - Third round of the audit (2021/22) - report, England and Wales	https://www.hqip.org.uk/resource/national-audit-of-care-at-the-end-of-life-third-round-of-the-audit-2021-22-report/#.Ys_IQHbMKUk	0.01
14/07/2022	Long term conditions	Audit	NACEL - National Audit of Care at the End of Life	NHS Benchmarking	Mental Health Spotlight Audit Summary Report, England and Wales (2021/22)	https://www.hqip.org.uk/resource/national-audit-of-care-at-the-end-of-life-mental-health-spotlight-audit-summary-report-2021-22/#.Ys_WVXbMKUk	0.02
14/07/2022	Long term conditions	Audit	Ep12 - National Audit of Seizures and Epilepsies	Royal College of Paediatrics and Child Health	National Clinical Audit of Seizures and Epilepsies for Children and Young People	https://www.hqip.org.uk/resource/national-clinical-audit-of-seizures-and-epilepsies-for-children-and-young-people-epilepsy12-report-england-and-wales-2019-21/#.Ys_WQ3bMKUk	0.03
14/07/2022	Long term conditions	Audit	NACAP - National Asthma and COPD Audit Programme	Royal College of Physicians	Pulmonary rehabilitation 2021 organisational audit - Summary report	https://www.hqip.org.uk/resource/pulmonary-rehabilitation-2021-organisational-audit-summary-report/	0.04
14/07/2022	Long term conditions	Audit	NACAP - National Asthma and COPD Audit Programme	Royal College of Physicians	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) - Wales primary care clinical audit 2021	https://www.hqip.org.uk/resource/national-asthma-and-chronic-obstructive-pulmonary-disease-audit-programme-wales-primary-care-clinical-audit-2021/#.YtAjz3bMKUk	0.05
14/07/2022	Mental Health	Audit	NCAP - National Clinical Audit of Psychosis	Royal College of Psychiatrists	Early Intervention in Psychosis Audit - National report for England 2022	https://www.hqip.org.uk/resource/national-clinical-audit-of-psychosis-early-intervention-in-psychosis-audit-report-england/#.Ys_IkHbMKUk	0.06
14/07/2022	Mental Health	Audit	NCAP - National Clinical Audit of Psychosis	Royal College of Psychiatrists	National report for Wales - Early Intervention in Psychosis Audit	https://www.hqip.org.uk/resource/national-clinical-audit-of-psychosis-early-intervention-in-psychosis-audit-report-wales/#.Ys_IkHbMKUk	0.07
11/08/2022	Long term conditions	Audit	NAD - National Audit of Dementia	Royal College of Psychiatrists	National Audit of Dementia - Memory Assessment Services Spotlight Audit 2021	https://www.hqip.org.uk/resource/national-audit-of-dementia-memory-assessment-services-spotlight-audit-2021/	0.08
08/09/2022	Women and children	Audit	NPDA - National Paediatric Diabetes Audit	RCPCH: Royal College of Paediatrics and Child Health	National Paediatric Diabetes Audit: Parent and Patient Reported Experience Measures (PREMs) 2021	https://www.hqip.org.uk/resource/national-paediatric-diabetes-audit-report-parent-and-patient-reported-experience-measures/#.Yx8LRXbMKUk	0.09
30/09/2022	Women and children	Audit	PMRT - Perinatal Mortality Review Tool	MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK, University of Oxford	PMRT - Learning from Standardised Reviews When Babies Die	https://www.hqip.org.uk/resource/perinatal-mortality-review-tool-annual-report/#.Yzahi3bMJPY	0.10

National Audit of Care at the End of Life

**Third round of the audit (2021/22)
report**

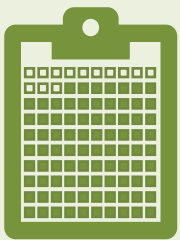
England and Wales



National Audit of Care at the End of Life 2021

Key findings at a glance


	171 Trust/Health Board overviews (T/HB)		239 Hospital/site overviews (H/S)		6,823 Case Note Reviews (CNR)		3,118 Quality Surveys (QS)		11,045 Staff Reported Measures (SRM)
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(CNR – Cat 1)

87%


Case notes recorded that the patient might die within hours or days



(CNR– Cat 1)

95%


Case notes, with an individualised plan of care, recorded a discussion (or reason why not) with the patient regarding the plan of care



(CNR – Cat 1)

98%


Case notes recorded a discussion (or reason why not) with families/carers regarding the possibility the patient may die



(CNR – Cat 1)

86%


Case notes recorded extent patient wished to be involved in care decisions, or a reason why not



(CNR – Cat 1)

73%


Case notes recorded an individualised plan of care



(QS)

57%

Families/carers were asked about their needs




(QS)

68% 74%

Care provided to families/carers Care provided to the patient

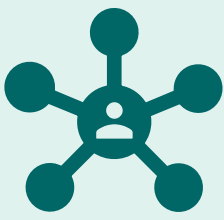
Families/carers felt the quality of care provided was good, excellent or outstanding



(T/HB)

99%


Trusts/Health Boards have guidelines on how to respond to/learn from deaths of patients



(H/S)


60%

Hospitals have face-to-face specialist palliative care service available 8 hours a day, 7 days a week




85%

Staff feel confident they can recognise when a patient might be dying imminently



77%

Staff feel supported by their specialist palliative care team



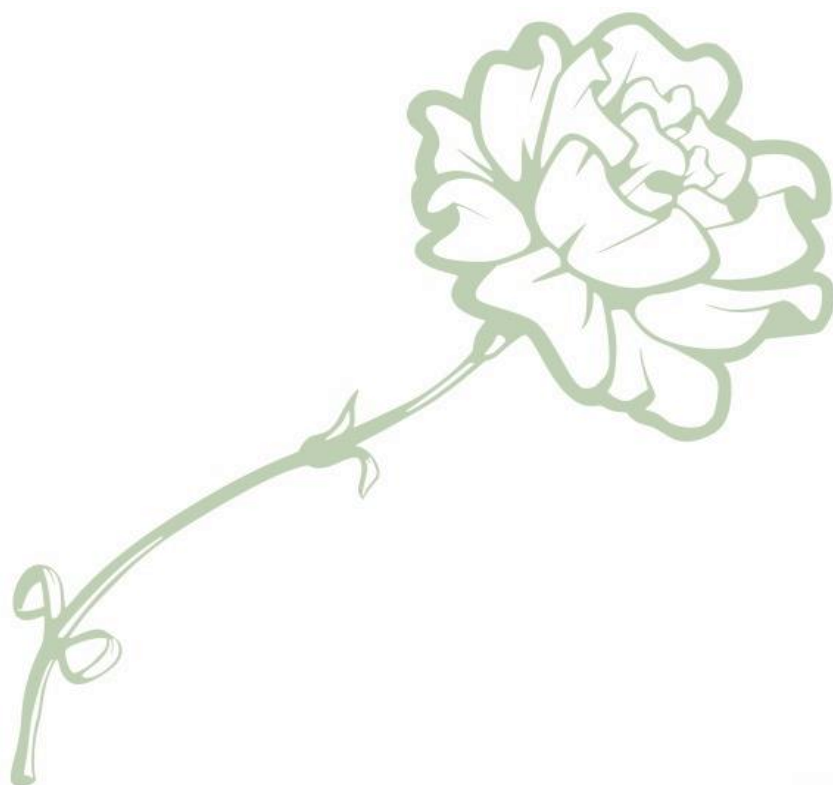
(SRM)

80%

Staff feel they work in a culture that prioritises care, compassion, respect and dignity

National Audit of Care at the End of Life

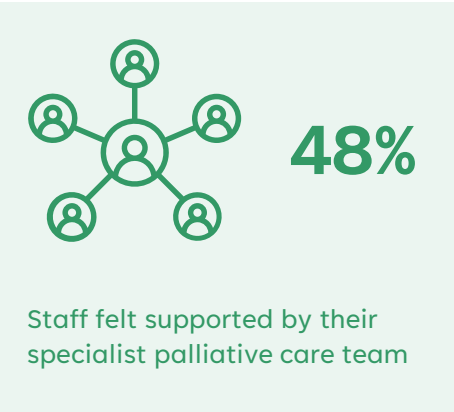
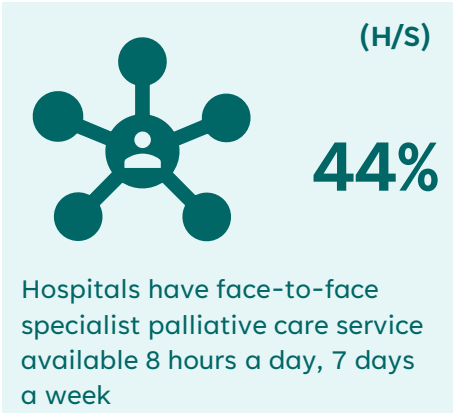
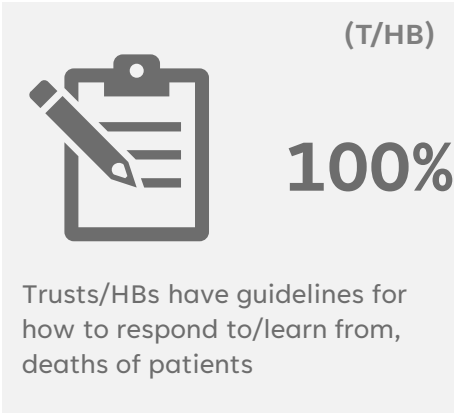
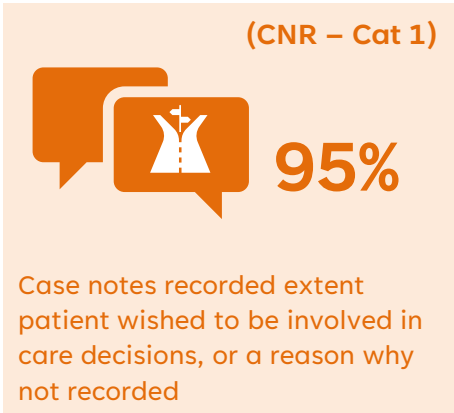
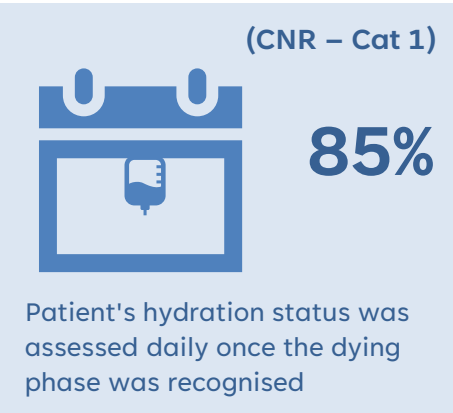
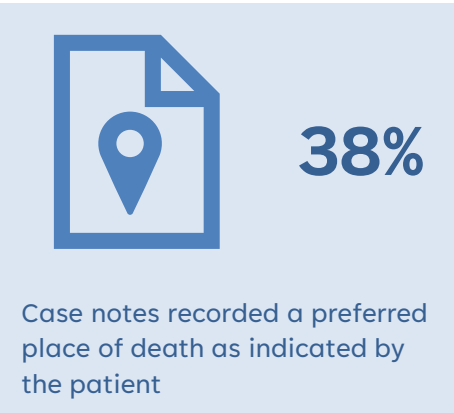
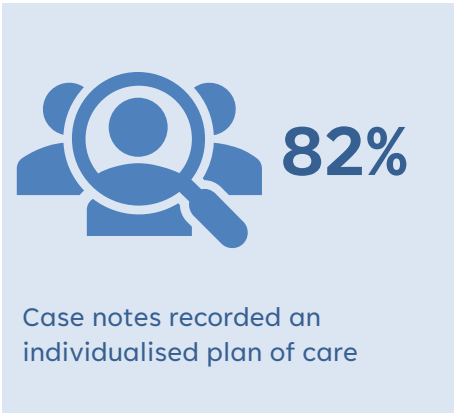
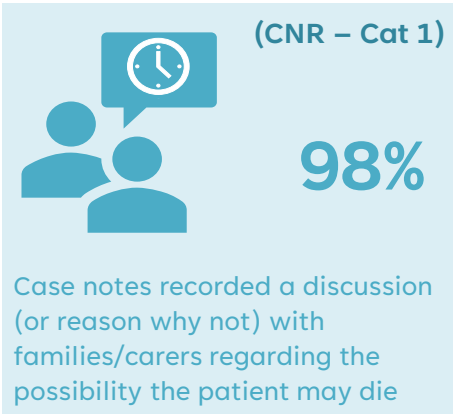
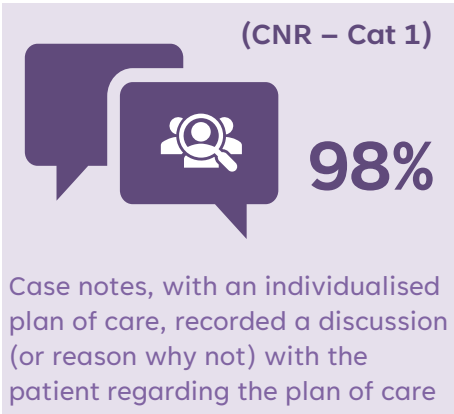
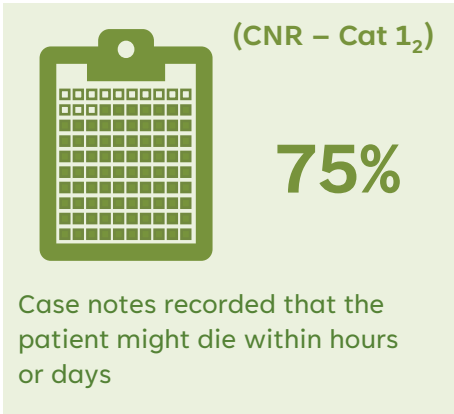
Mental Health Spotlight Audit Summary Report England and Wales (2021/22)



National Audit of Care at the End of Life 2021

Mental Health Spotlight Audit

Key findings at a glance



**Epilepsy12 2022 Combined
organisational and clinical audits:
Report for England and Wales
Round 3, Cohort 3 (2019-21)**

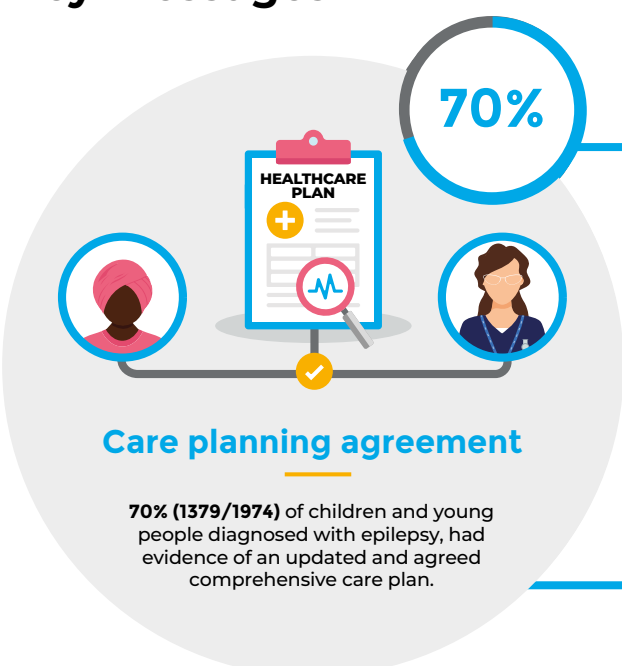
✧RCPCH Audits

EPILEPSY12

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

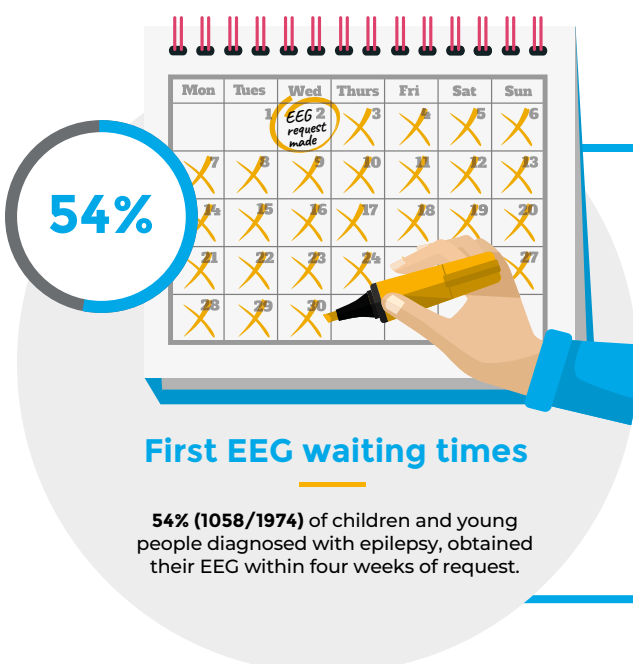
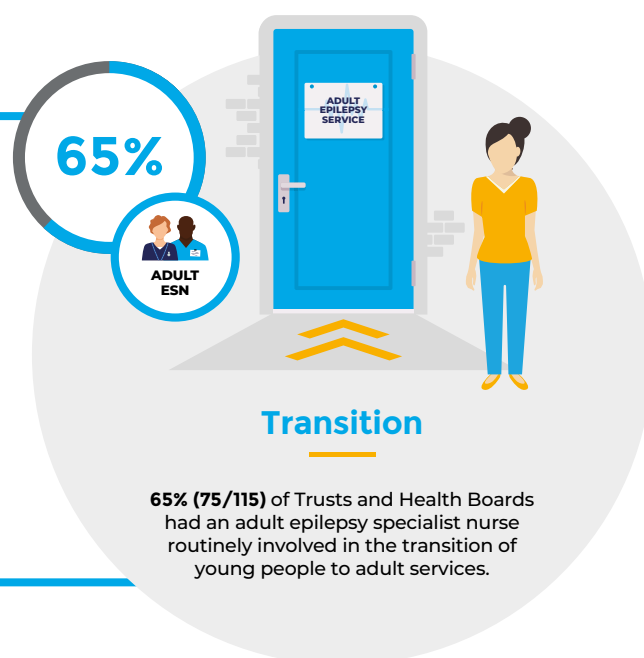
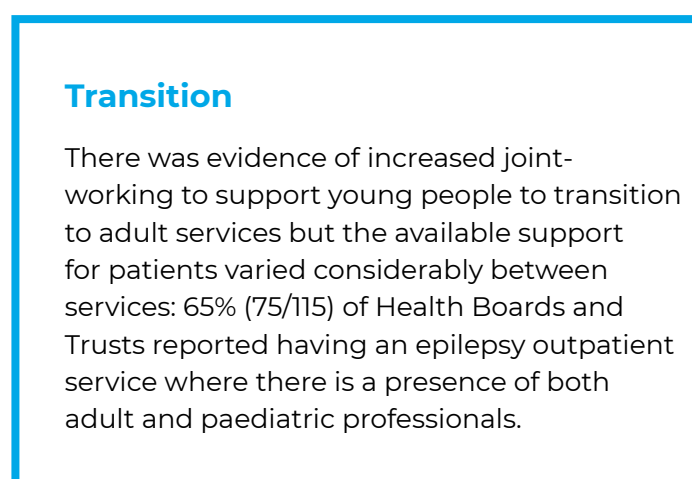


Key messages



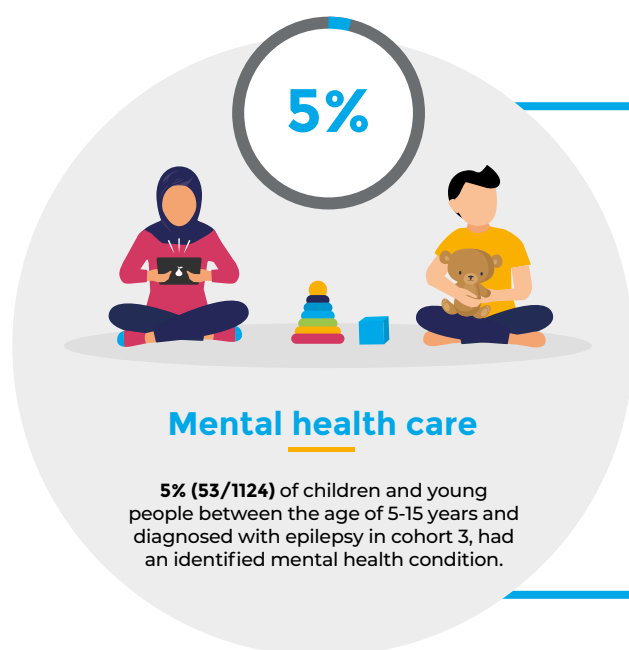
Care planning

There was evidence of wide-spread use of comprehensive, individual care planning for children with epilepsy. Most care plans were agreed and updated. The proportion of plans which contained all the required elements also increased to 75% (1487/1974) in cohort 3.



First EEG waiting times

There was an increase in children and young people waiting more than 16 weeks for an initial Electro-encephalogram (EEG) in cohort 3 (10%, 191/1974). NICE Quality Standard 27 (statement 2) states that children and young people having initial investigations for epilepsy undergo the tests within 4 weeks of being requested.

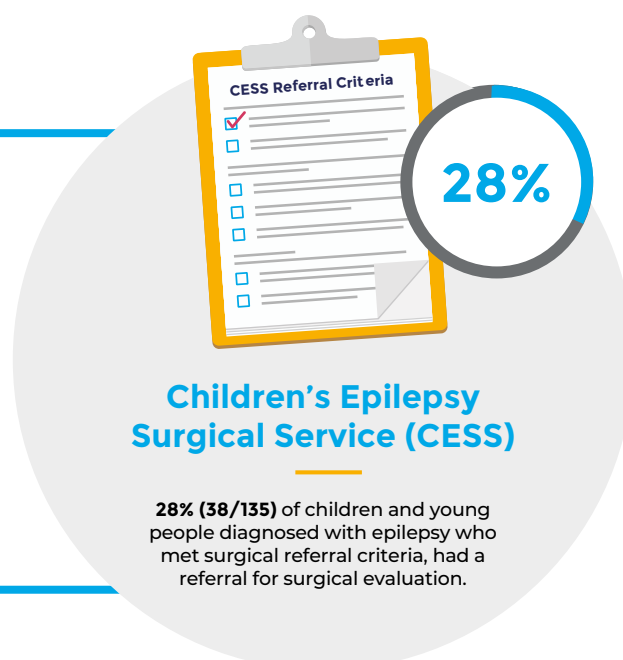


Mental health care

Research suggests there is a higher incidence of mental health problems among children and young people with long term conditions, but very few of the epilepsy patients had an identified mental health condition (5%, 53/1124). Few epilepsy services could provide co-located mental health provision as recommended within the Best Practice Criteria (18%, 12/115).

Children's Epilepsy Surgical Service (CESS)

Some children and young people with epilepsy may be missing out on, or having delayed referral to, epilepsy surgery assessments. 28% (38/135) of children and young people diagnosed with epilepsy who met surgical referral criteria had a referral for surgical evaluation during their first year of care.



Recommendations for improvement



EEG and epilepsy services continued to submit their data to Epilepsy12 despite significant challenges of the pandemic. We want to recognise the dedication to children with epilepsy that this shows.

The recommendations made in the report focus on areas for improvement, however the overall consistency of the results with those from pre-pandemic cohorts is a testament to how hard teams and individuals have worked to maintain services and care.

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

Pulmonary rehabilitation 2021 organisational audit

Resourcing and organisation of care in services
in England and Wales

Summary report

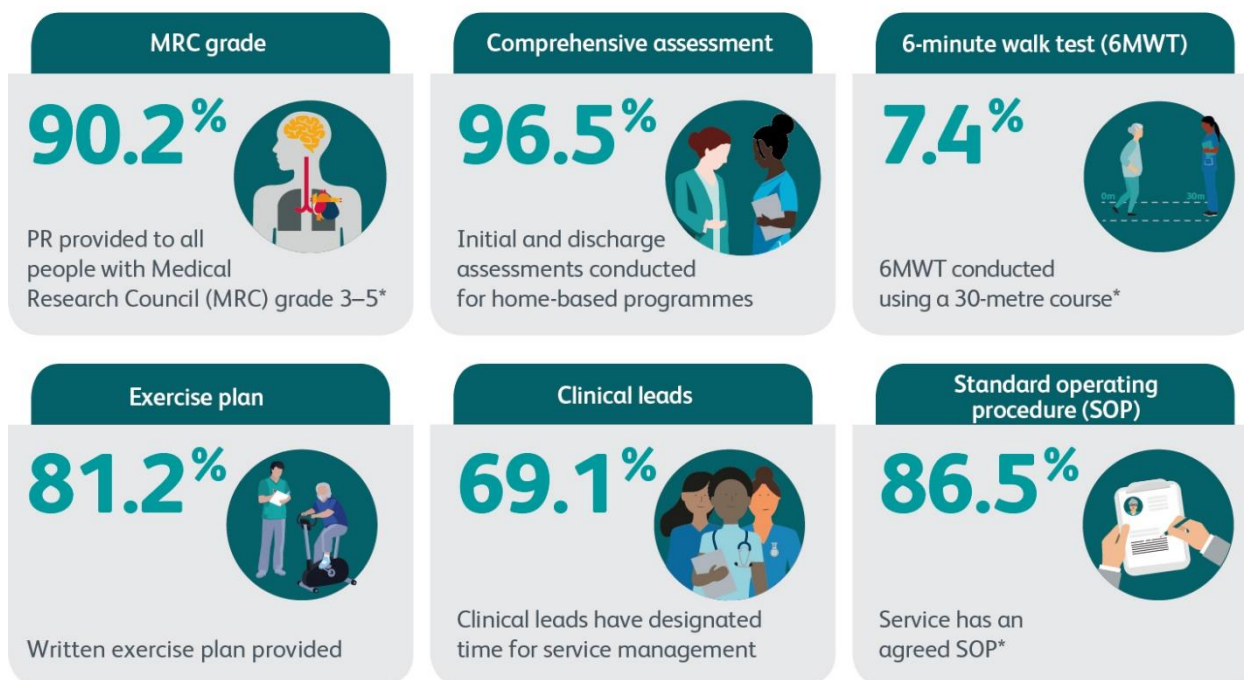
Published 14 July 2022



In association with:

Commissioned by:

Summary of performance against KPIs



*improvement priority

The infographic summarises the national position of services against NACAP's KPIs. Data demonstrate variation in service provision across England and Wales. Related data from [NACAP's first organisational audit of PR services](#) in 2019⁵ are presented where available:

- > **94%** of services provide PR to people with MRC grade 4 (**92.4%** in 2019) and **90.1% to grade 5 (88.5%** in 2019)
- > **86.5%** of PR services offer home-based programmes (**34%** in 2019)
- > Of **60.9%** of services conducting the 6MWT, **7.4%** do so using a 30m course (in 2019, **62.5%** were conducting the 6MWT and of these **11.1%** were using a 30m course)

- > **81.2%** of services provide written plans for ongoing exercise maintenance (**82.6%** in 2019)
- > **69.1%** of services provide clinical leads with dedicated sessional time for service development (**65.9%** in 2019)
- > **86.5%** have a standard operating procedure (SOP) which sets out a delivery framework for the service (**84%** in 2019).

COVID-19 has impacted the way pulmonary rehabilitation is delivered, and PR teams should be congratulated for all that they achieved throughout this period. Moving forwards, it is important that services are restored to continue to deliver high-quality care to ensure the best outcomes for people with COPD and other lung conditions.

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

Wales primary care clinical audit 2021

(asthma and COPD data extracted
from 314 general practices in
Wales to capture activity up
to 31 July 2021)

Clinical audit report

Published July 2022



Report at a glance

All Wales results data obtained from 314/389 general practices capturing activity up to 31 July 2021

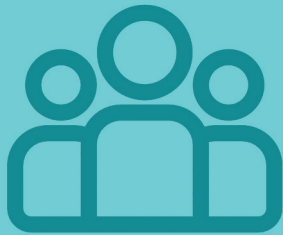


National report for England Early Intervention in Psychosis Audit



Key Findings

Key findings of this audit should be considered in context of the COVID-19 pandemic over the last two years. Teams are commended for maintaining Early Intervention in Psychosis (EIP) service delivery at high level in the context of the pandemic.



66%

of teams had an increase in staff in post last year



Children and Young People (CYP) improvements in:

- ✓ Clozapine prescribing
- ✓ Physical health screening and interventions
- ✓ Carer focused education and support programmes

10%
INCREASE FROM PREVIOUS

80%

of people with first episode psychosis (FEP) received all 7 physical health screens

71%

of people with FEP received all relevant interventions for their physical health

10%
INCREASE FROM PREVIOUS

Recording of outcome measures increased by 5% to **60%**

Health of the Nation Outcome Scale (HoNOS) scores on all 3 targeted items showed improvements from baseline to repeat assessment for the following % of individuals:

19%

drinking or drug-taking

44%

psychotic symptoms

29%

activities of daily living

National report for Wales Early Intervention in Psychosis Audit



Key Findings

Key findings of this audit should be considered in context of the COVID-19 pandemic over the last two years. Teams are commended for maintaining Early Intervention in Psychosis (EIP) service delivery in the context of the pandemic.

85%



of people with first episode psychosis (FEP) who had not responded adequately to treatment with at least 2 antipsychotic drugs were offered clozapine

36%



of people with FEP who were **not** in work/education took up a supported employment and education programme

51%

of people with FEP received all 7 physical health screens

27%
INCREASE FROM
PREVIOUS AUDIT

30%

of people with FEP received all relevant interventions for their physical health

17%
INCREASE FROM
PREVIOUS AUDIT

Children and Young People (CYP) improvements in:

- ✓ All teams have CYP EIP provision (44% increase)
- ✓ 66% of teams have a shared protocol between the EIP team and CYP mental health service
- ✓ Improvements in medication management and prescribing arrangements for CYP

Recording of outcome measures **increased by 8%** to 15%

National Audit of Dementia

Memory Assessment Services Spotlight

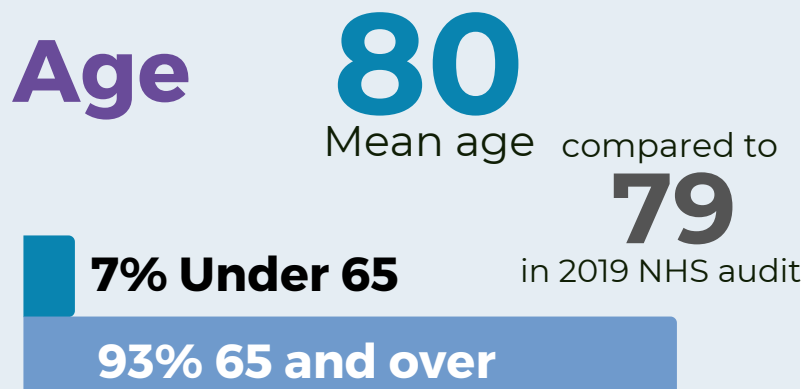
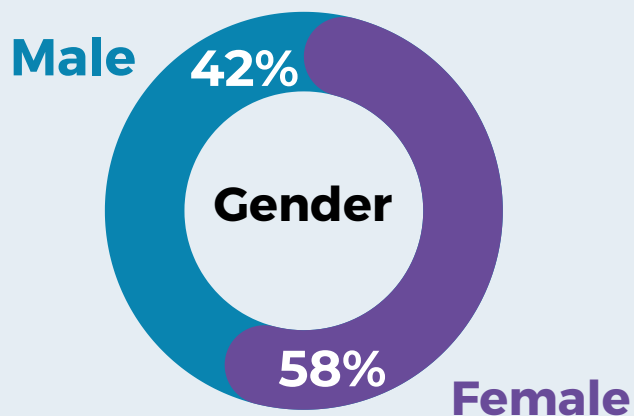
Audit 2021

Publication date: August 2022

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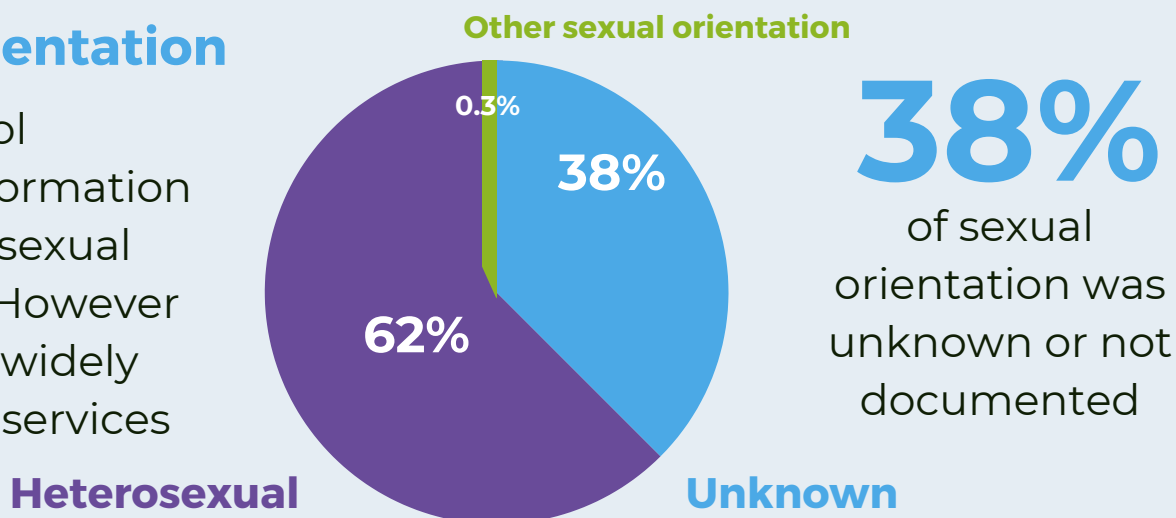
DEMOGRAPHICS

*figures are rounded to the nearest percentage and may not add to 100%



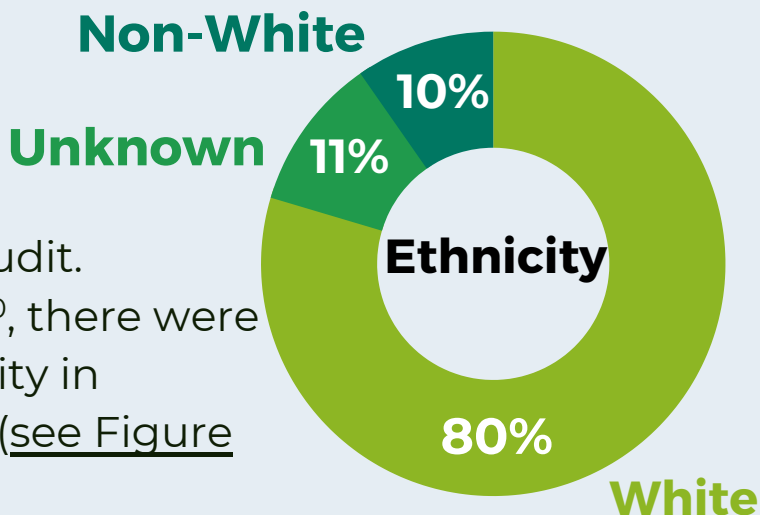
Sexual Orientation

The audit tool collected information about other sexual orientation. However this was not widely collected by services



11% patients with undocumented or unknown ethnicity

compared to **6%** in 2019 NHS audit. Although analysis was conducted¹⁰, there were no significant differences in ethnicity in relation to the audit's key findings (see Figure A in appendix III).



85%

patients spoke English as their first language

4%

patients needed an interpreter

36%

patients lived alone

COVID-19 RECOVERY AND IMPACT

119

services were
either closed or
had staff
redeployed



Service Closure and Redeployment

83%



services
had staff
redeployed
during the
first
national
lockdown

66% of
services
experienced
both closure
and
redeployment

72%

services were
closed or
paused

2021: 17.7 weeks

2019: 13 weeks

Mean wait time between
referral to diagnosis
increased by **4.7 weeks**



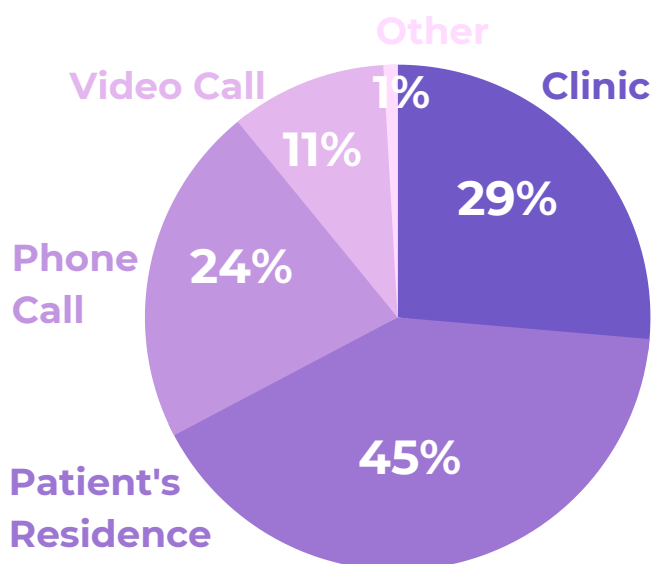
Overall Wait Time



Place of Assessment

35%

patients received
a virtual initial
assessment



See
recommendations
1 and 2 regarding
overall wait times
and service
provisions

ASSESSMENTS

92%

patients had **at least one** in-clinic routine assessment:



43%

patients had **all 4** in-clinic routine assessments:



76%

patients had their falls history recorded



71%

in 2019 NHS audit

61%

patients had discussions around eyesight/vision, the same percentage as the 2019 NHS audit



78%

patients discussed their alcohol consumption

50%

in 2019 NHS audit



58%

patients discussed their hearing, including the use of hearing aids

57%

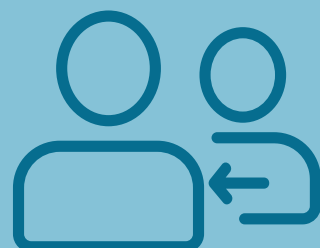
in 2019 NHS audit

See recommendation 3 regarding in-clinic routine assessments



20%

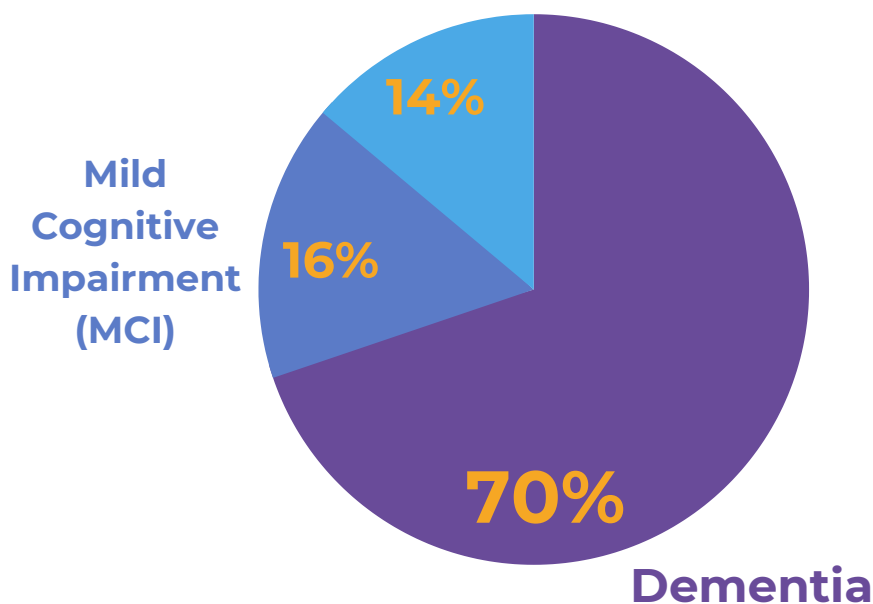
patients were referred to occupational therapy or a diagnostic neuropsychological assessment



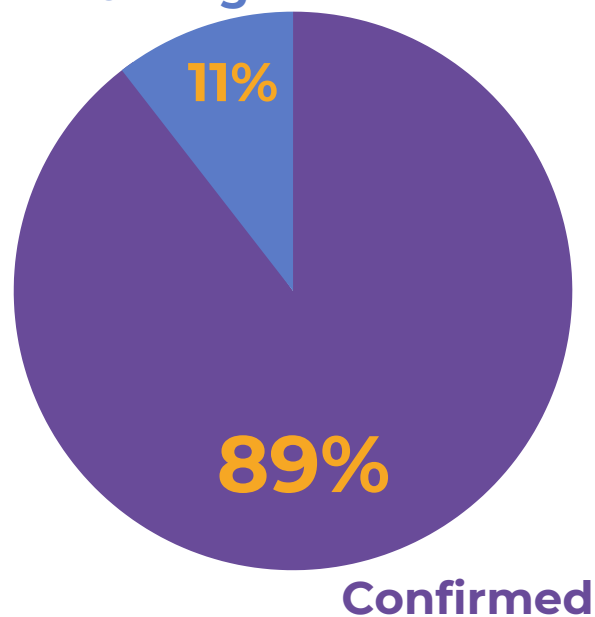
DIAGNOSIS AND TREATMENT

Diagnosis

Other (Not Dementia)



Working



100%

patients were offered medication who were deemed clinically appropriate



Medication

56%

patients with dementia received medication

83%

 in 2019 NHS Audit

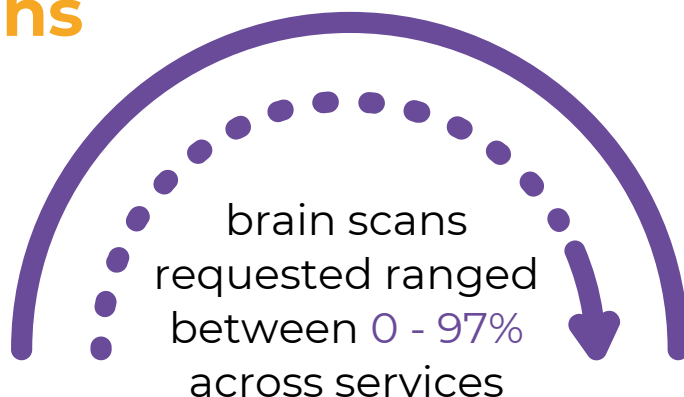
Investigations



See [recommendation 4](#) regarding [neuroimaging](#)

25%

services perform ECGs routinely



POST DIAGNOSTIC INTERVENTIONS

Any Post Diagnostic Intervention

84%

patients were offered any post diagnostic intervention (excluding signposting)

Occupational therapy

is the most common intervention provided (excluding signposting)

134

services offer at least one intervention

Cognitive Stimulation Therapy (CST)

75%

services offer CST across England



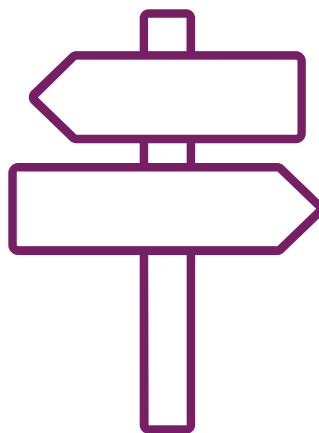
72%

services commissioned to provide CST

Signposting

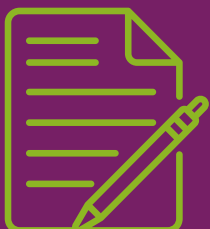
93%

services offer signposting as a post diagnostic intervention



47%

patients received signposting as intervention

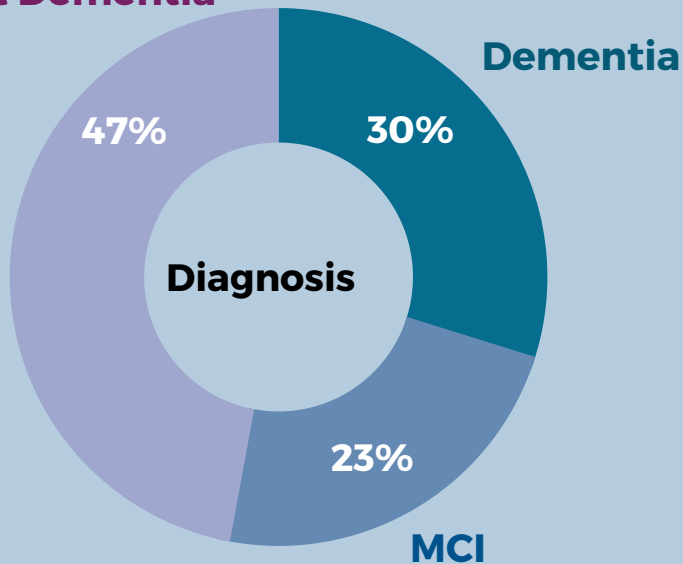


See recommendation 5 regarding cognitive stimulation therapy.

ASSESSMENTS FOR WORKING AGE PATIENTS

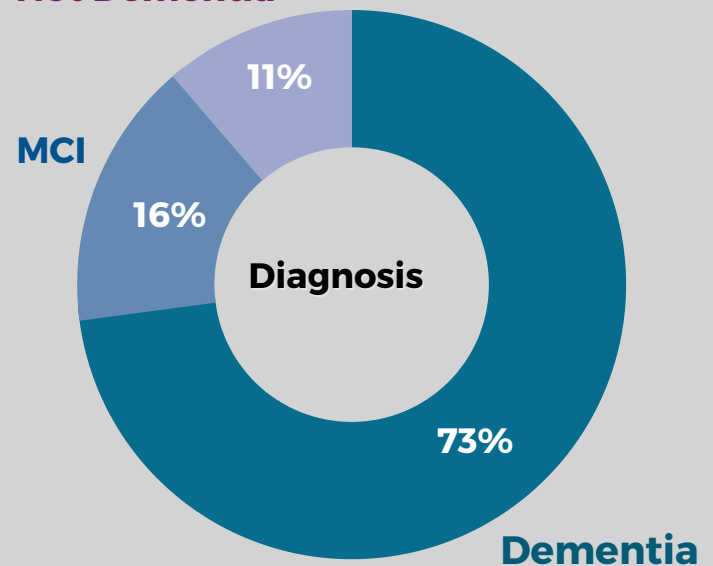
UNDER 65

Not Dementia

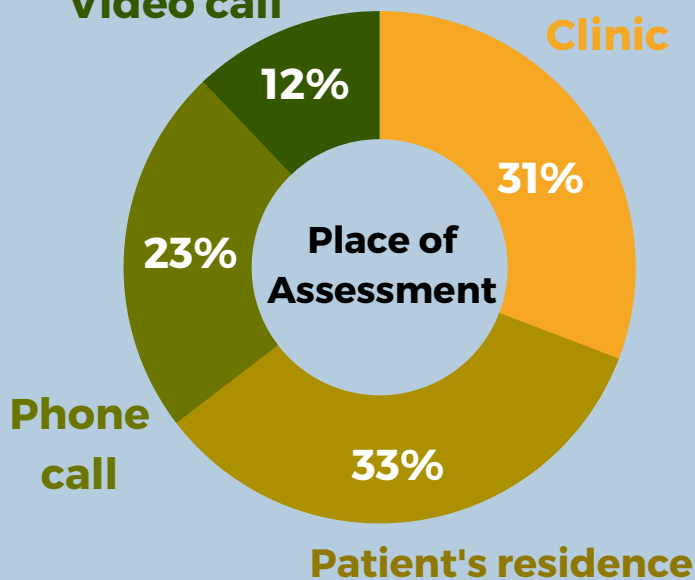


65 AND OVER

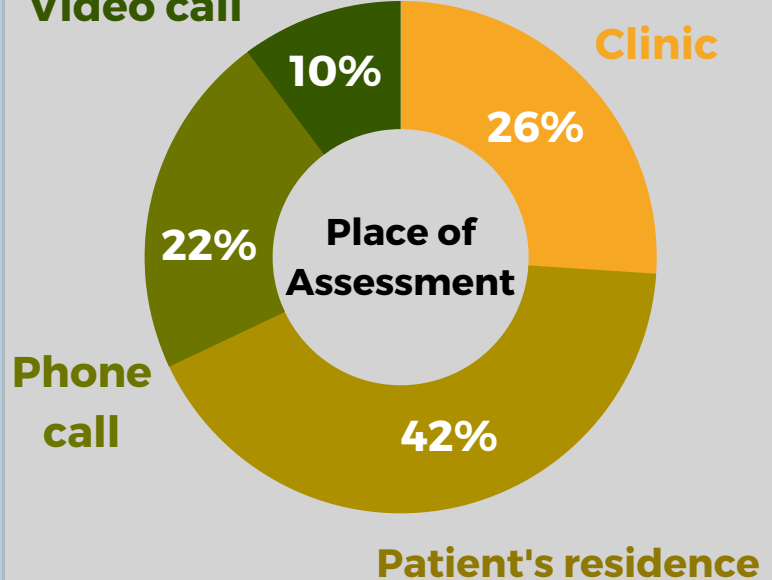
Not Dementia



Video call



Video call



55%

patients discussed
eyesight



62%

patients discussed
eyesight

49%

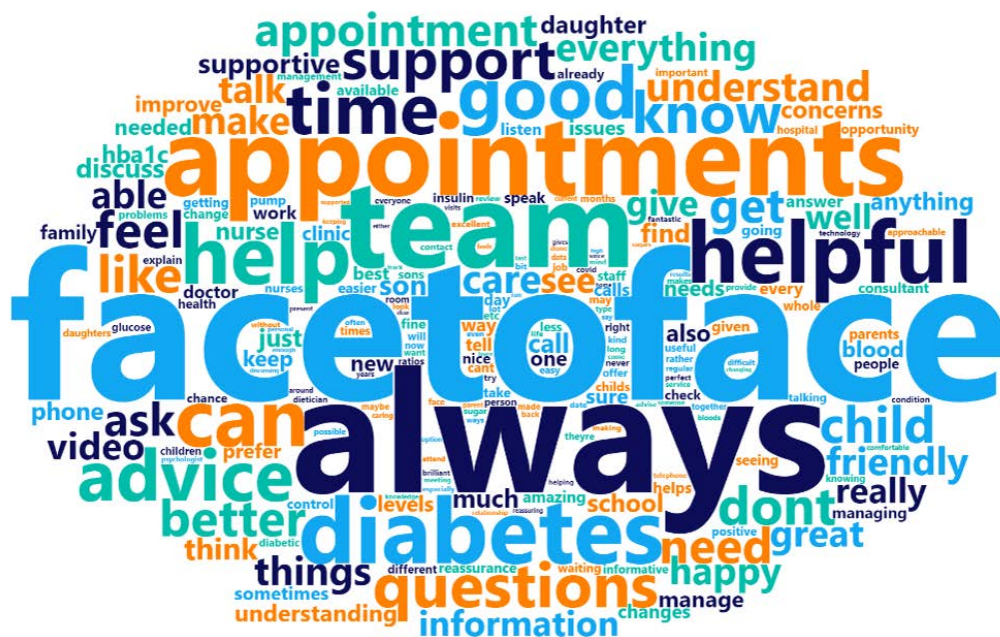
patients discussed
hearing



59%

patients discussed
hearing

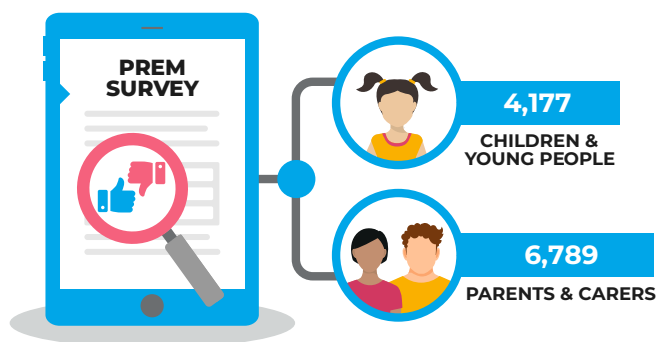
Parent and Patient Reported Experience Measures (PREMs) 2021



Key findings

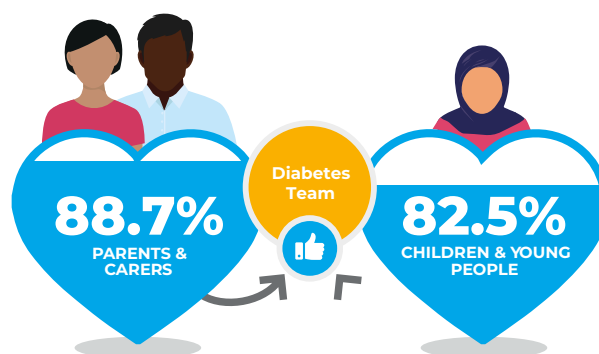
Quantitative analysis

Analysis of responses from children and young people with diabetes and their parents showed that:



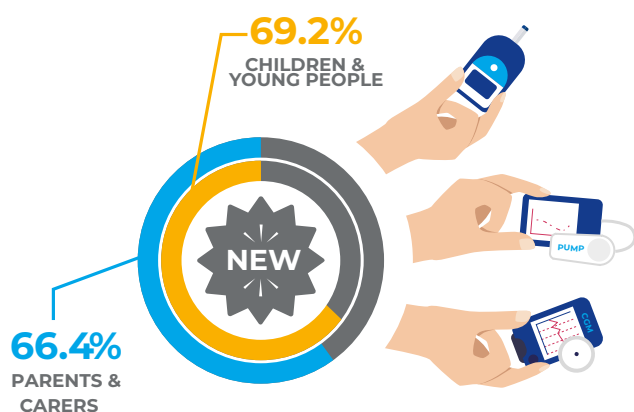
PREM survey completion

4,177 children and young people and **6,789 parents and carers** attending paediatric diabetes services in England and Wales completed a Patient Reported Experience Measure (PREM) survey in 2021, when 31,615 children and young people were receiving care from paediatric diabetes services.



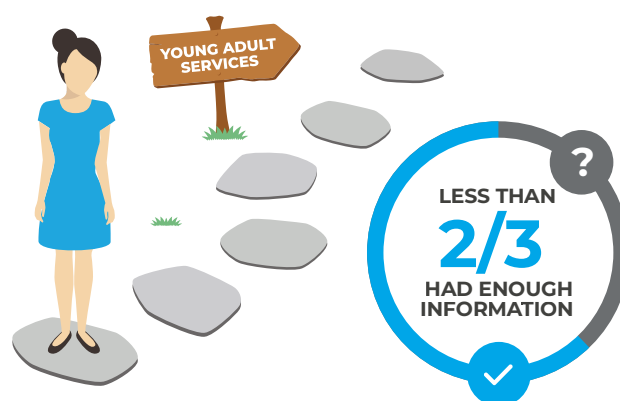
Relationship with diabetes teams

82.5% of children and young people and **88.7% of parents and carers** reported that they **always had a positive relationship** with their diabetes team. In 2019, similar percentages agreed the same: 79.9% of children and young people and 90.0% of parents and carers.



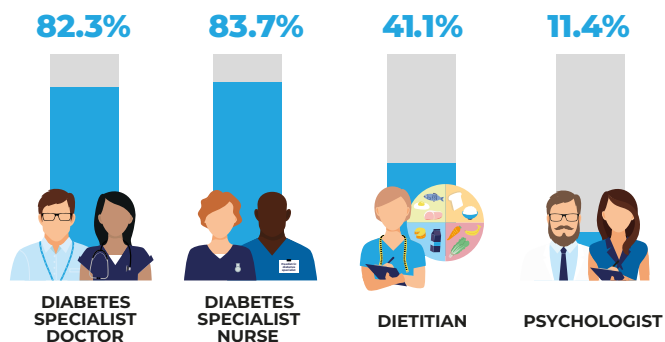
Diabetes-related technologies

66.4% of parents and carers and **69.2% of children and young people** agreed that their diabetes team **always kept them up to date with new diabetes-related technologies**. These were increases from 63.7% and 61.8%, respectively, in 2019.



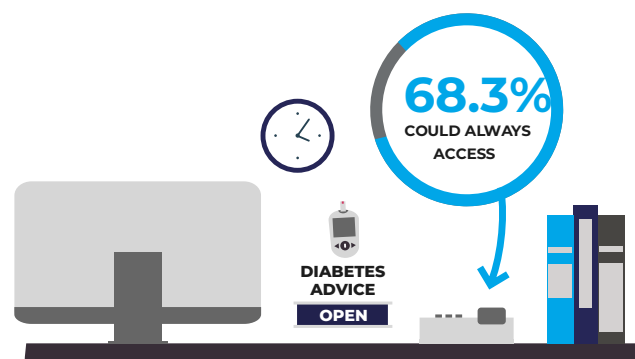
Transfer to adult care

Less than two thirds of parents and carers (**64.2%**) and children and young people (**62.3%**) agreed their diabetes team were providing them with the **information, resources and support needed to prepare for their transfer to adult care**. These results are similar to those reported in 2019 (64.0% of parents and carers and 58.2% of children and young people).



Availability of specialists

82.3% of parents and carers reported that they could see a diabetes specialist doctor at each visit, 83.7% could see a paediatric diabetes specialist nurse at each visit, 41.1% could see a dietitian at each visit, and 11.4% could see a psychologist at each visit. Percentages were smaller for each staffing group compared to 2019.



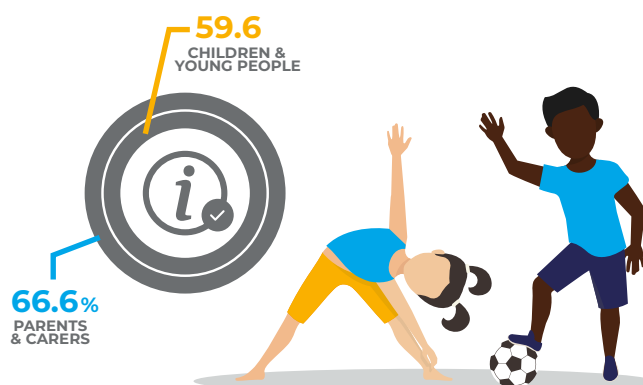
Access to specialist diabetes advice

81.1% of parents and carers said they could always access specialist diabetes advice during core hours. This was similar to 2019 (81.3%). However, **only 68.3% said they could always receive advice 24 hours a day.** This was also similar to 2019 (68.8%).



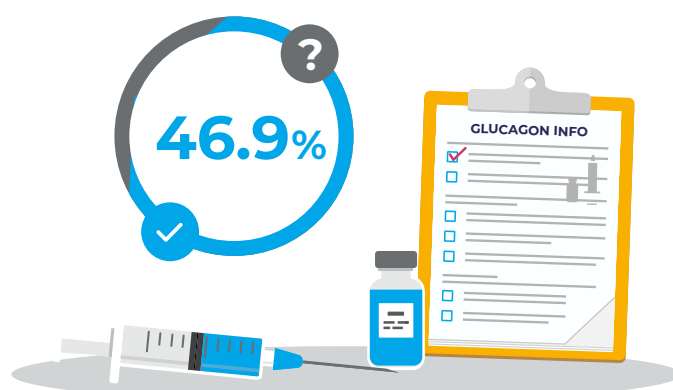
Managing diabetes at school

72.3% of children and young people and 71.9% of parents and carers agreed their diabetes team always gave them enough information to effectively manage their/child's diabetes at school/college, down from 74.1% and 75.2%, respectively, in 2019.



Information about exercise

59.6% of children and young people and 66.6% of parents and carers agreed their diabetes team always gave them enough information to manage exercise. These percentages were similar to 2019.



Glucagon preparation & administration

Only half (46.9%) of parents and carers agreed they always received enough information on the preparation and administration of glucagon, similarly to 2019.



National Perinatal Mortality Review Tool

Learning from Standardised Reviews When Babies Die

National Perinatal Mortality Review Tool

Fourth Annual Report



September 2022



Learning from Standardised Reviews When Babies Die – 2021 Annual Report



Key Messages – September 2022

Since the launch of the national Perinatal Mortality Tool (PMRT) in early 2018 over 18,000 reviews have been started. This fourth annual report presents the findings for reviews completed from March 2021 to February 2022 coinciding with the second year of the SARS-CoV-2 global pandemic. Here are the key messages from the 4,199 reviews completed during this period.

Multi-disciplinary group review is essential



Issue with care and areas for improvement identified at review

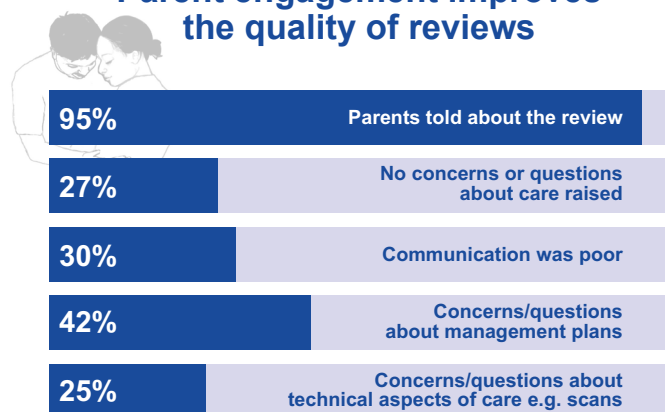


Over 19 out of 20 reviews identified areas for improvement



3 out of 20 issues identified may have made a difference to the outcome

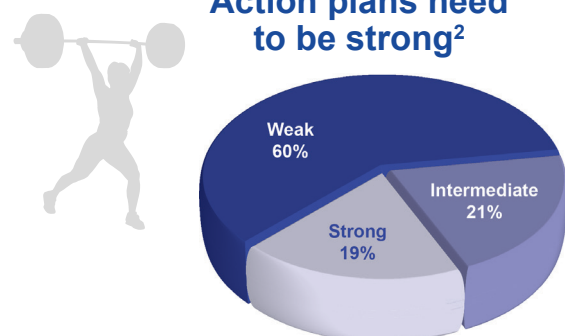
Parent engagement improves the quality of reviews



Comments, question and concerns raised by parents



Action plans need to be strong²



Examples of the strength² of actions planned

Weak

“ Individual debrief and staff education. Present case at perinatal mortality and morbidity meeting. ”

A reminder for individual action without any controls

Intermediate

“ SGA and Grow guidelines to be amalgamated to make the process clearer for serial scans. ”

A new system in place but still requires individuals to act without any controls

Strong

“ Incubators were reviewed and a different type of incubator was needed to admit extreme preterm babies; commissioned and operational. ”

A system level design to eliminate human error

1. A relevant professional external to the trust/health board to provide a 'fresh eyes' independent perspective of care.
2. Strong actions are system changes which remove the reliance on individuals to choose the correct action. They use standardised and permanent physical or digital designs to eliminate human error and are sometimes referred to as 'forcing actions'.