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

Q3 (October- December 2022), updated 04/01/2023

PUBLICATION DATE	HEALTHCARE AREA	TYPE	PROJECT NAME	LEAD PROVIDER	FULL REPORT TITLE	HQIP WEBLINK TO REPORT	DOC NUMBER
13/10/2022	Long term conditions	Audit	NEIAA - National Early Inflammatory Arthritis Audit	BSR: British Society for Rheumatology	National Early Inflammatory Arthritis Audit - Year 4 Annual Report	https://www.hqip.org.uk/resource/national-early-inflammatory-arthritis-audit-year-4-annual-report/	0.01
10/11/2022	Cardiovascular	Audit	NVR - National Vascular Registry	RCS: Royal College of Surgeons	National Vascular Registry 2022 Annual Report	https://www.hqip.org.uk/resource/national-vascular-registry-2022-annual-report/#.Y2z-v3bP1PY	0.02
10/11/2022	Acute	Audit	FFFAP - Falls and Fragility Fracture Audit Programme	Royal College of Physicians	National Audit of Inpatient Falls (NAIF) Annual report 2022: Working together to improve inpatient falls prevention	https://www.hqip.org.uk/resource/national-audit-of-inpatient-falls-annual-report-2022/#.Y2z-knbP1PY	0.03
10/11/2022	Women and children	Clinical Outcome Review Programme	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK, University of Oxford	Maternal, Newborn and Infant Clinical Outcome Review Programme : Saving Lives, Improving Mothers' Care Report 2022	https://www.hqip.org.uk/resource/maternal-newborn-and-infant-clinical-outcome-review-programme-saving-lives-improving-mothers-care-report-2022/	0.04
10/11/2022	Women and children	Audit	NNAP - National Neonatal Audit Programme	RCPCH: Royal College of Paediatrics and Child Health	National Neonatal AuditProgramme (NNAP): Summary report on 2021 data	https://www.hqip.org.uk/resource/national-neonatal-audit-programme-summary-report-on-2021-data/	0.05
08/12/2022	Acute	Clinical Outcome Review Programme	Medical and Surgical Clinical Outcome Review Programme	NCEPOD: National Confidential Enquiry into Patient Outcome and Death	Disordered Activity? A review of the quality of epilepsy care provided to adult patients presenting to hospital with a seizure	https://www.hqip.org.uk/resource/ncepod-disordered-activity-2022/#.Y5G0IHbP1PY	0.06

British Society for Rheumatology

National Early Inflammatory Arthritis Audit (NEIAA)

Year 4 Annual Report
(Data collection: 1 April 2021 – 31 March 2022)

October 2022

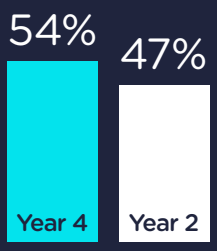
HQIP
Healthcare Quality Improvement Partnership

Key findings

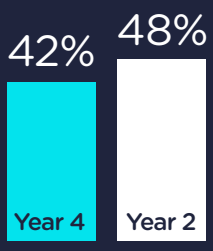
11,722

Key finding 1 – 11,722 patients were recruited with suspected inflammatory arthritis (vs 13,578 in year two).

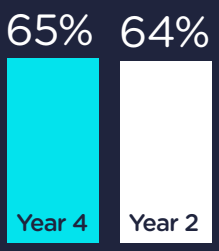
Quality statements



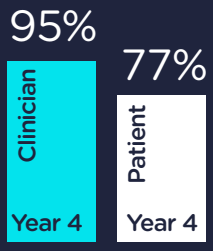
Key finding 2 – Speed of referral from primary care has improved with 54% of referrals meeting the three-day NICE target (vs 47% in year two).



Key finding 3 – First review by a specialist was achieved within three weeks of referral for 42% of patients (vs 48% in year two).



Key finding 4 – Conventional disease modifying anti-rheumatic drug (cDMARD) treatment delays remain stable with initiation within six weeks of referral in 65% of patients (vs 64% in year two).



Key finding 5 – According to clinician-reported data, 95% (vs 94% in year two) of patients received disease education and self-management support; however, 77% (vs 81% in year two) of patients submitting patient reported outcomes data reported receiving disease education and self-management support.

Key finding 6 – Most trust/health boards (90%) continue to engage with treat-to-target strategies (vs 89% in year two).

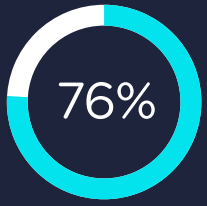
Key finding 7 – Whilst provision of telephone helplines for patients was still high (95%) (vs 92% in year two), only 51% of Trusts/Health Boards reported on the organisational form that they offer emergency access to rheumatology advice within 24 hours.

Three-month outcomes

Key finding 8 – Patient reported outcomes: Clinically meaningful improvements were recorded for all measures over the first three months of specialist care.

Key finding 9 – Disease remission was achieved in34% of patients by three months after diagnosis (vs 37% in year two).

Early arthritis clinics

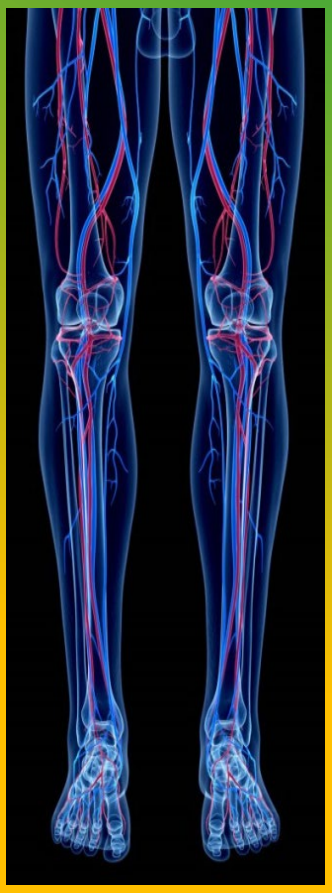


Key finding 10 – Early arthritis clinics were available in 76% of departments (vs 77% in year two).

Key finding 11 – Access to relevant AHP services remain suboptimal.

axSpA 5-year symptom duration prior to diagnosis

Key finding 12 – 32% of patients with axSpA had symptoms for over five years prior to assessment in comparison to 3% of patients with RA.



NATIONAL VASCULAR REGISTRY

2022 Annual Report

Royal College of Surgeons of England
ADVANCING SURGICAL CARE

VASCULAR SOCIETY
OF GREAT BRITAIN AND IRELAND

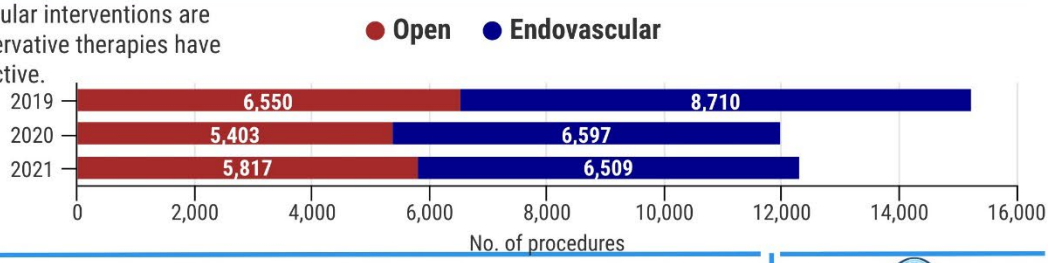
British Society of Interventional Radiology
Registered Charity No: 1084852

HQIP
Healthcare Quality Improvement Partnership

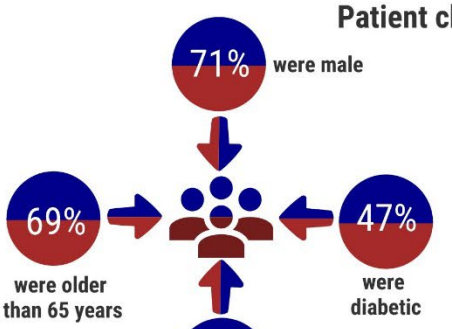
Lower limb revascularisation for peripheral arterial disease to prevent limb loss

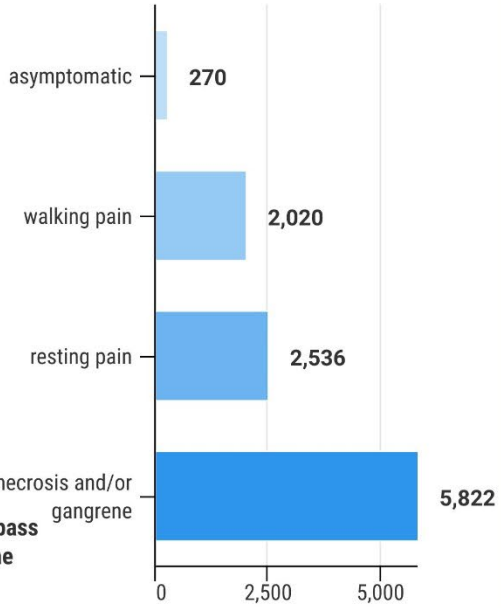
Peripheral arterial disease (PAD) is a restriction of the blood flow in the lower limb arteries that can severely affect a patient's quality of life, and risk their limb.

Open and endovascular interventions are options when conservative therapies have proved to be ineffective.



Patient characteristics in 2021

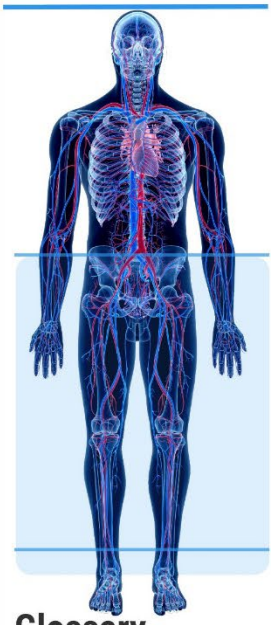




54% of patients admitted with CLTI had their bypass within 5 days, which is the recommended time

However for 9/64 vascular units, 25% of patients waited more than 10 days

In the NVR data, CLTI is defined as patients admitted in an emergency with either resting pain or necrosis and/or gangrene.

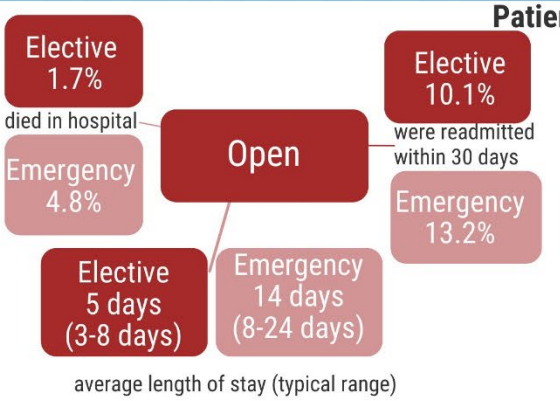


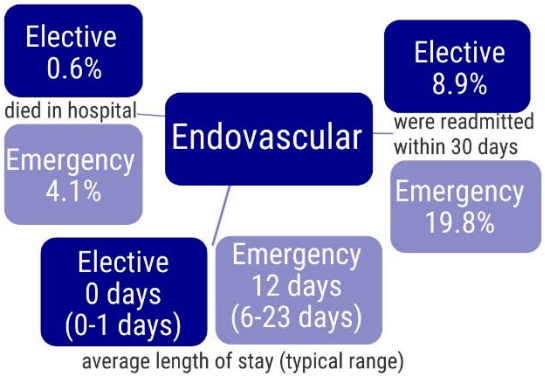
Glossary

The average is the median; "typical range" is the interquartile range.

Chronic limb-threatening ischaemia (CLTI) is the most severe form of PAD, where the blood flow to the legs becomes severely restricted.

Patient Outcomes





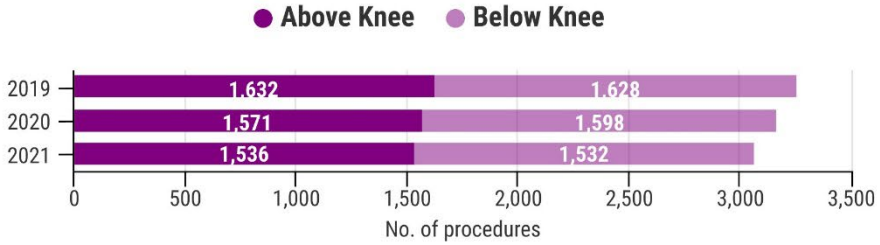
Lower limb major amputation for peripheral arterial disease

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.

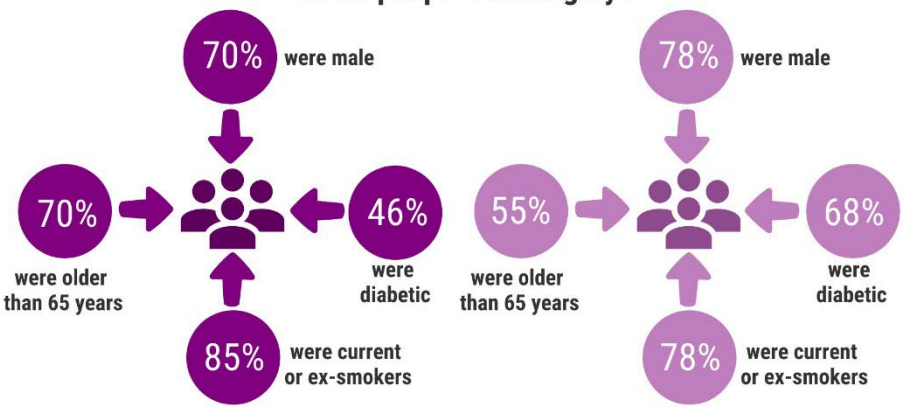
PAD can gradually progress in some patients and an operation to improve blood flow may no longer be possible. In these situations, people will require amputation of the lower limb. Additionally, patients without PAD but with a complication of diabetes may require a major amputation.

Impact of COVID-19

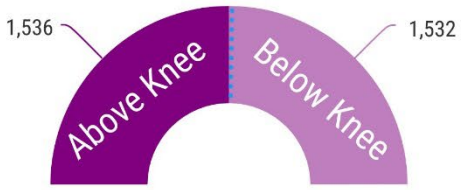
There has only been a slight reduction in the number of procedures submitted on the NVR from 2019 to 2021.

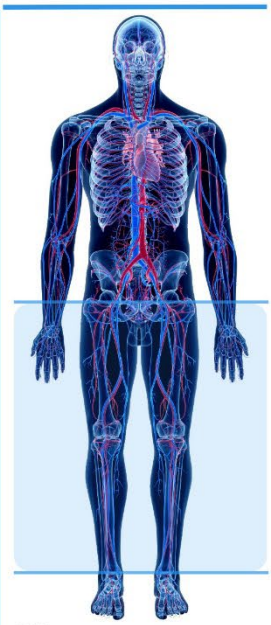


Which people had surgery?



Hospitals should aim to have an above knee amputation to below knee amputation ratio below 1. In 2021, the national ratio was 1.00, but it varied greatly across the country. 29 hospitals had a ratio above 1, and of these, 5 were above 2.

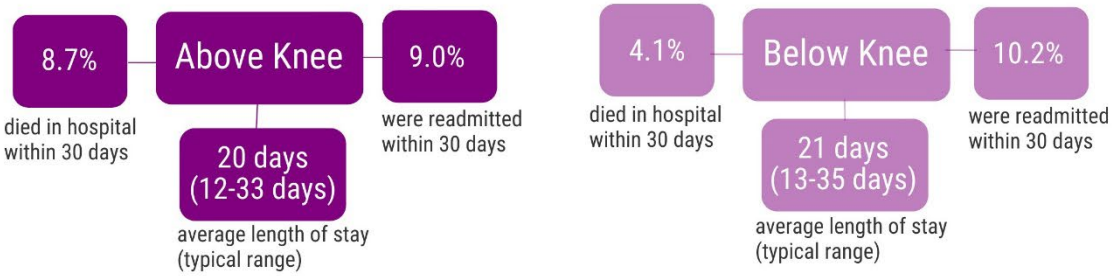




Glossary

The average is the median; "typical range" is the interquartile range.

Patient outcomes after surgery

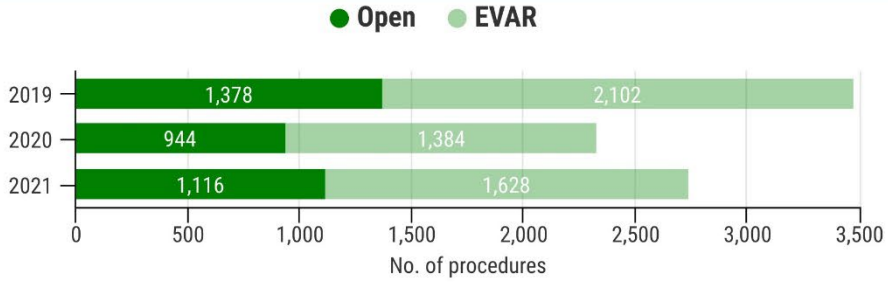


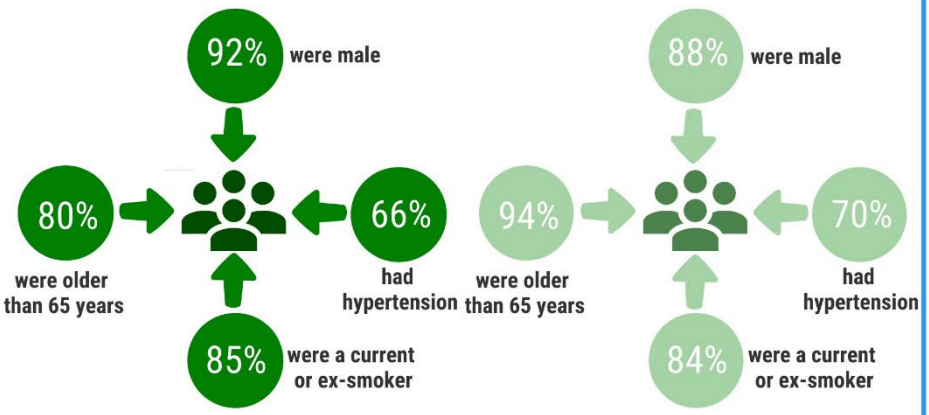
Repair of abdominal aortic aneurysm (AAA) to prevent rupture

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.

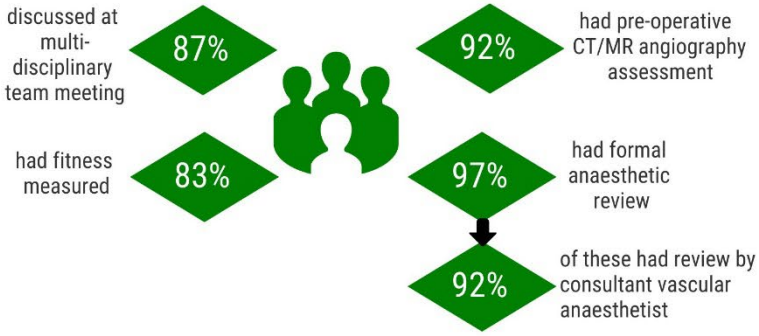
Impact of COVID-19

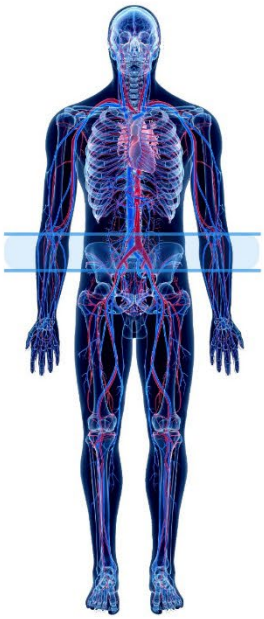
There was an increase in procedures in 2021, but the numbers were still not back up to the pre-COVID-19 levels in 2019.





How were patients assessed?





Glossary

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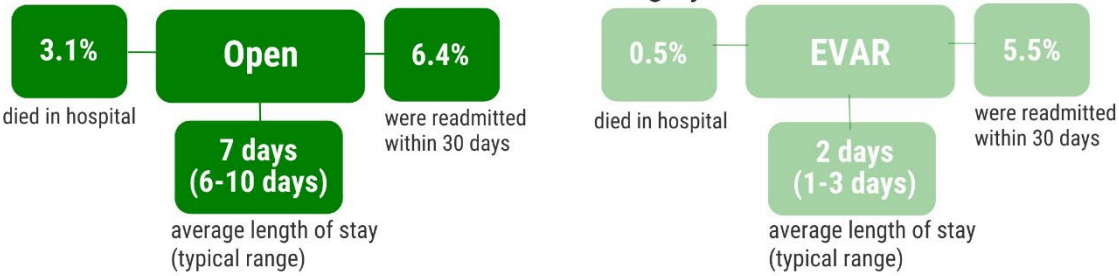
Patient outcomes after surgery in 2021

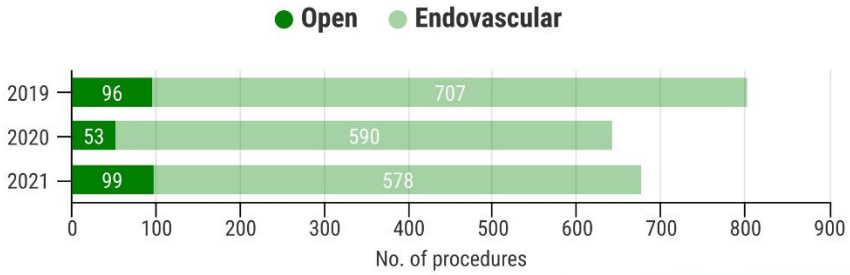


Repair of elective complex aortic aneurysms to prevent rupture

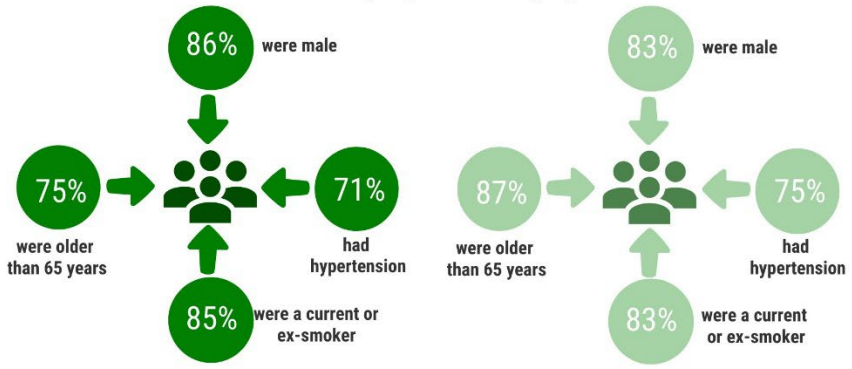
The term complex is used to describe those aneurysms that occur above the level of the renal (kidney) arteries. These are more complicated that the standard infra-renal repairs and require specialist teams, often within a specialist hospital.

Impact of COVID-19

The numbers have fluctuated over recent years with 803 procedures in 2019, 643 in 2020 and 677 in 2021. This represented a reduction of around 16% between 2019 and 2021.

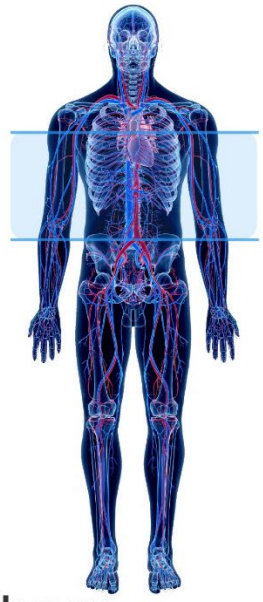


Which people had surgery?



The most common complex endovascular 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), which involves a repair of the aorta within the chest region of the body.



Glossary

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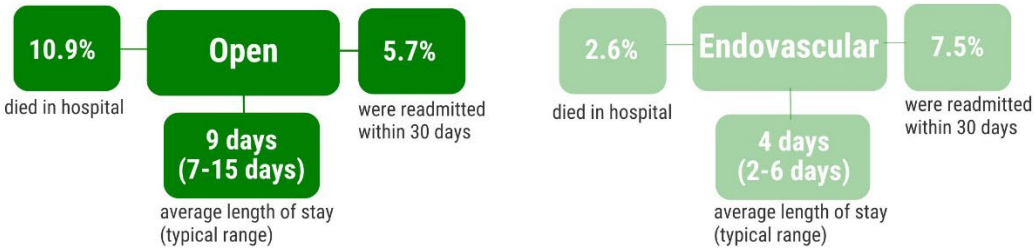
Patient outcomes after surgery in 2019-21

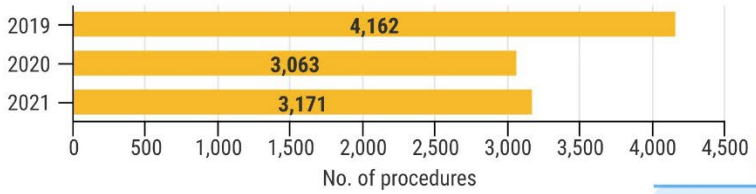


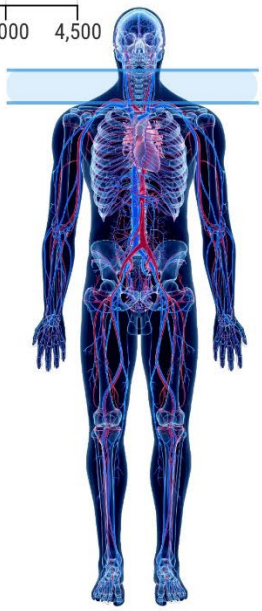
Carotid artery surgery to prevent stroke

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

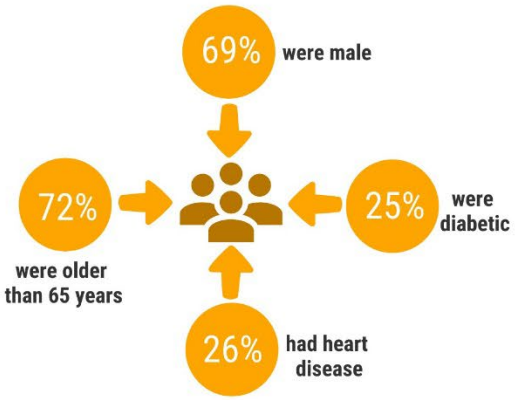
Impact of COVID-19

There was a large decrease in the number of CEAs carried out in 2020, compared to 2019. This number only slightly increased in 2021.

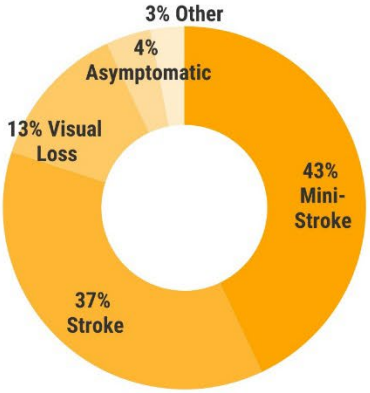




Which people had surgery?

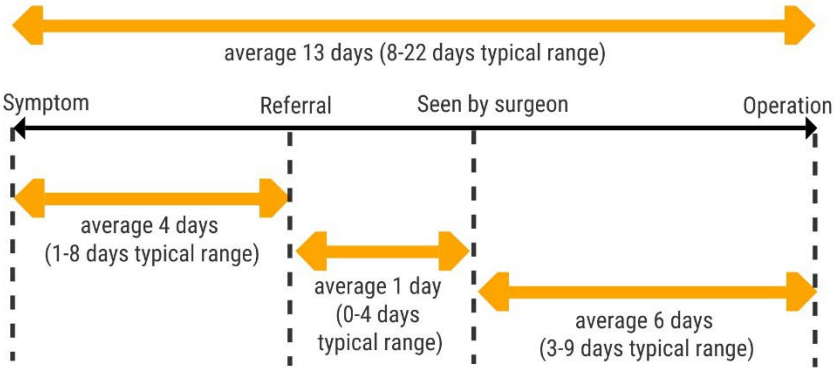


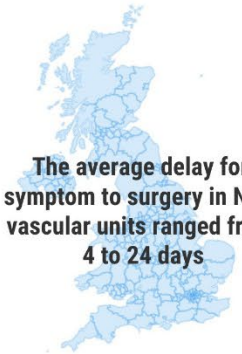
Reasons for surgery



Treatment times for symptomatic patients

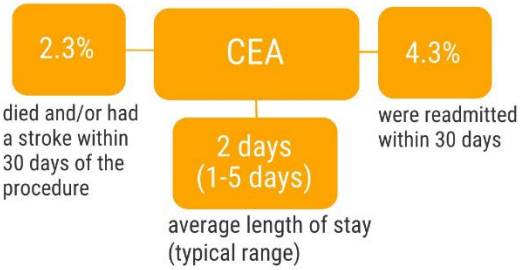
Recommended time from symptom to surgery is within 14 days





The average delay for symptom to surgery in NHS vascular units ranged from 4 to 24 days

Outcomes of surgery



Glossary

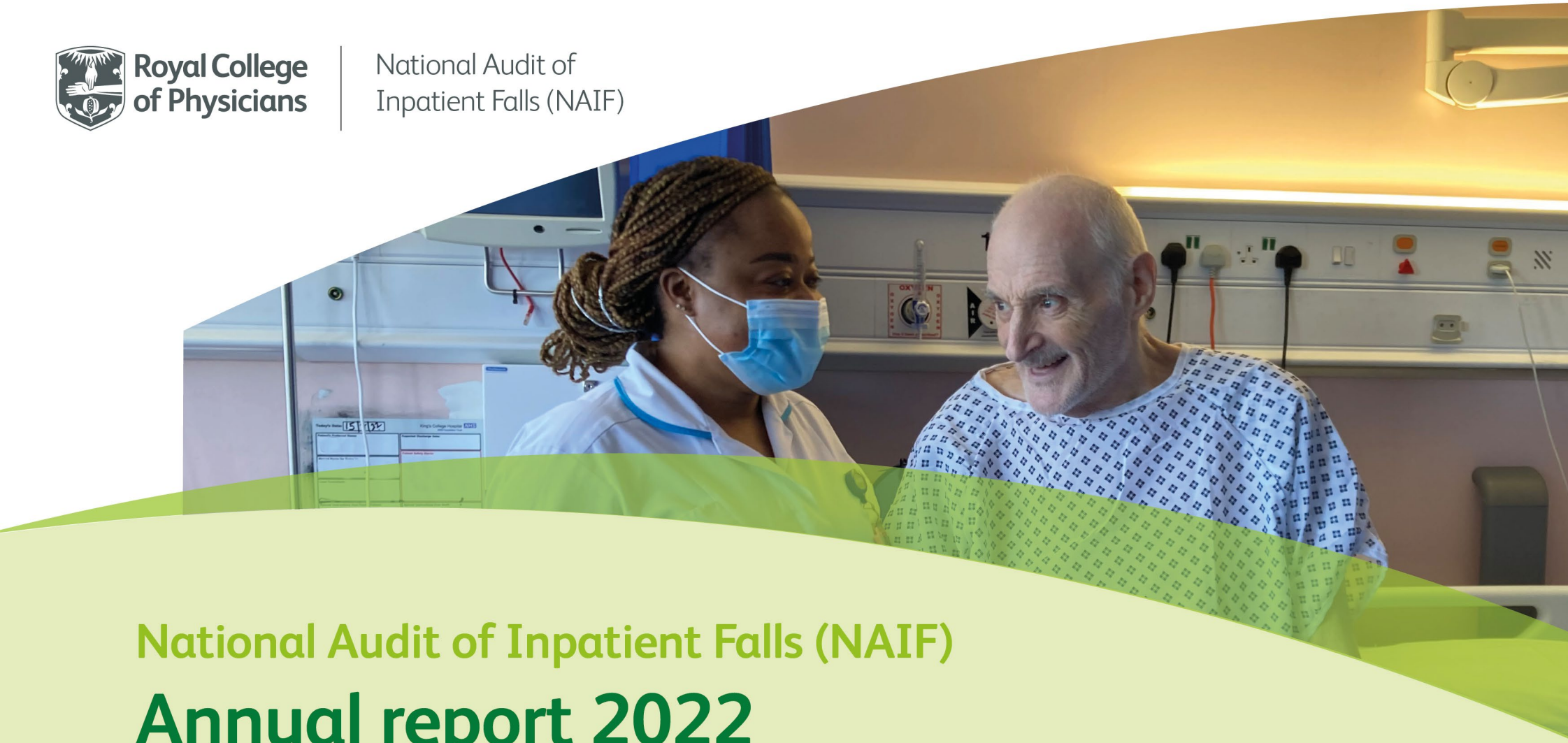
A mini stroke, also known as a transient ischaemic attack (TIA), resolves completely within 24 hours.

Visual loss (amaurosis fugax) is the loss of vision in one eye due to an interruption of blood flow to the retina.

The average is the median; "typical range" is the interquartile range.

A patient showing symptoms is known to be symptomatic.

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



National Audit of Inpatient Falls (NAIF)

Annual report 2022

Working together to improve inpatient falls prevention (2021 clinical and 2022 facilities audit data)

Autumn 2022

In association with

BGS British Geriatrics Society Improving healthcare for older people

British Orthopaedic Association

Royal Osteoporosis Society Better bone health for everybody

Commissioned by

HQIP Healthcare Quality Improvement Partnership

Report at a glance – key messages

Femoral fractures sustained in inpatient settings result in poorer patient experience and worse outcomes compared with fractures that occur outside of hospital.

Femoral fractures can occur on any ward – not just on older people's wards.
There is only one chance to get things right – most (80%) femoral fractures occur on the first inpatient fall.

The records of inpatients who had a femoral fracture as a result of a fall were audited for the presence of multifactorial falls risk assessment (MFRA) prior to the fracture and post-fall management immediately afterwards.

85%

of trusts and local health boards (LHBs) in England and Wales participated in the audit this year.

Vision
52%
In 2020: **44%**

LSBP
39%
In 2020: **35%**

Medication review
74%
In 2020: **69%**

Delirium
66%
In 2020: **73%**

Mobility
92%
In 2020: **73%**

Continence
83%
In 2020: **74%**

There have been improvements in the proportion of patients receiving MFRA component assessments, the exception being delirium assessment. However, completion of lying and standing blood pressure assessment remains below 50%. Two-thirds of MFRAs included fewer than five of these six component assessments.

Checked for injury
77%
↓ In 2020: **71%**
↓ In 2019: 69%

Safe method for moving from the floor
29%
↓ In 2020: **26%**
↓ In 2019: **22%**

Medical assessment within 30 minutes
60%
30 mins
↑ In 2020: **62%**
↓ In 2019: **52%**

Post-fall management KPIs continue to gradually improve, but only one-third of patients with a femoral fracture are moved from the floor using flat lifting equipment. Using flat lifting equipment reduces the risk of pain and distress for patients who have sustained a femoral fracture.

Next steps for trusts/LHBs:

- review local data on webtool and in the trust report
- identify areas for action in your organisation
- use quality improvement methods to find out why it is a problem, design an improvement intervention to address the problem, measure the impact of the intervention and ensure changes are sustained.

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

Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20

November 2022

HQIP Healthcare Quality Improvement Partnership
University of Leicester
University of Birmingham
The Newcastle upon Tyne Hospitals NHS Foundation Trust
TIMMS
Sands Stillbirth & neonatal death charity
Chelsea and Westminster Hospital NHS Foundation Trust
University of Oxford
Oxford Population Health
NPEU

Missing Voices

Key messages from the report 2022

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

229 women died during or up to six weeks after the end of pregnancy in 2018-20

10.9 women per 100,000 giving birth

24% higher than 2017-19

27 of their babies died

366 motherless children remain

A further **289 women** died between six weeks and a year after the end of pregnancy in 2018-20

13.8 women per 100,000 giving birth

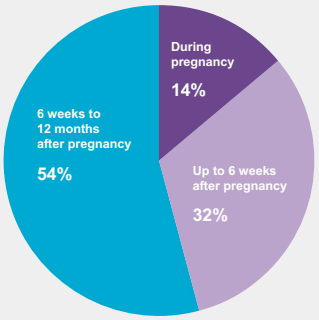
9 women died from covid-19

Excluding their deaths, **10.5 women** died per 100,000 giving birth

19% higher than 2017-19

1 in 9 women who died had severe and multiple disadvantage

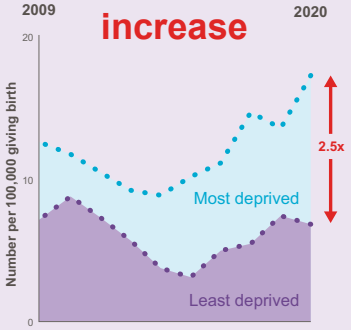
Most women died in the postnatal period **86%**



Black women were **3.7x** more likely to die than white women (**34 women** per 100,000 giving birth)

Asian women were **1.8x** more likely to die than white women (**16 women** per 100,000 giving birth)

More women from **deprived areas** are dying and this continues to **increase**



In 2020, women were **3x** more likely to die by **suicide** during or up to six weeks after the end of pregnancy compared to 2017-19

1.5 women per 100,000 giving birth

NNAP
National Neonatal Audit Programme

RCPCH Audits

National Neonatal Audit Programme (NNAP) Summary report on 2021 data

Photo of Olivia-Grace
Courtesy of Danielle Benedict

HQIP
Healthcare Quality Improvement Partnership

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

Results at a glance

The National Neonatal Audit Programme (NNAP) assesses whether babies admitted to neonatal units receive consistent high-quality care and identifies areas for improvement.

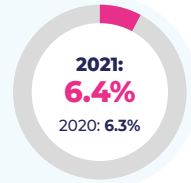
This poster summarises the results based on NNAP data relating to babies discharged from neonatal care between January and December 2021, unless otherwise stated.

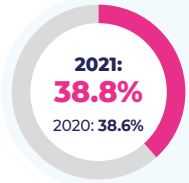
1. Outcomes of neonatal care

Mortality

6.4% of very preterm babies* died before discharge home, ranging from 4% to 8% between networks (observed proportion).

*born July 2018 to July 2021

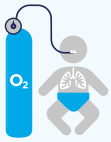




Bronchopulmonary dysplasia

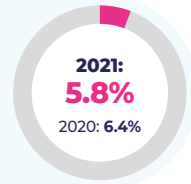
38.8% of very preterm babies* developed BPD or died, ranging from 33.5% to 46% between networks (observed proportion).

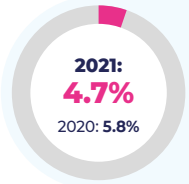
*discharged January 2019 to December 2021



Necrotising enterocolitis

5.8% of very preterm babies developed necrotising enterocolitis, ranging from 3.1% to 8.9% between networks (observed proportion).





Bloodstream infection

4.7% of very preterm babies had growth of a clearly pathogenic organism, ranging from 2.5% to 7.6% between neonatal networks.

2. Optimal perinatal care

Antenatal steroids

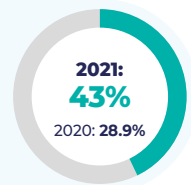
92.1% of mothers of babies born at less than 34 weeks' were given antenatal steroids, ranging from 89.2% to 95.8% between networks.

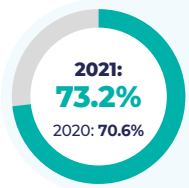
Born in a centre with a NICU

78.9% of babies born at less than 27 weeks' gestation were born in a centre with a NICU on site, ranging from 67.6% to 86.3% between networks.

Deferred cord clamping

43% of very preterm babies had their cord clamped at or after one minute, ranging from 13.9% to 68.1% between networks.



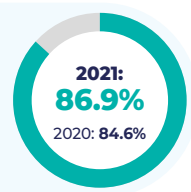


Temperature on admission

73.2% of very preterm babies were admitted with a temperature within the recommended range of 36.5-37.5°C, ranging from 63.8% to 82.9% between networks.

Antenatal magnesium sulphate

86.9% of eligible mothers were given antenatal magnesium sulphate, ranging from 83.6% to 91.7% between networks.



3. Parental partnership in care

Breastmilk feeding at 14 days

80.5% of very preterm babies received their mother's milk at 14 days of life, ranging from 75.9% to 86.3% between neonatal networks.

Breastmilk feeding at discharge

60.6% of very preterm babies received their mother's milk at discharge home, ranging from 52% to 75.6% between neonatal networks.

Parental consultation within 24 hours of admission

96.3% of parents had a documented consultation with a senior member of the neonatal team within 24 hours of their baby's admission.

Parental presence at consultant ward rounds

A parent was present on the consultant ward round at least once during the admission for **85.8%** of admissions. The proportion of ward rounds with at least one parent present was **44.1%**.

4. Care processes

On time screening of retinopathy of prematurity (ROP)

95.4% of eligible babies were screened on time for ROP, ranging from 81.4% to 98.1% between networks.

Medical follow up at two years

72.6% of eligible babies had a documented medical follow up at the right time, ranging from 52.8% to 85.1% between networks.

5. Neonatal nurse staffing

Neonatal nurse staffing

73.9% of nursing shifts were staffed according to recommended levels, ranging from 61.2% to 89.2% between networks.

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Further information & resources

Neonatal services and trusts/health boards

Local quality improvement recommendations

A summary of all recommendations, including additional local quality improvement recommendations made to neonatal services, is available at:

www.rcpch.ac.uk/nnap-report-2021-data

Next steps and resources for improvement

Neonatal services and Trusts/Health Boards can access their full results at unit and network level, interactive reporting tools and unit posters on **NNAP Online** at **www.nnap.rcpch.ac.uk**

The **Appendix A: NNAP 2021 data – results** provides in-depth results and a summary of findings by audit measure, along with next steps and resources.

Download it here:
www.rcpch.ac.uk/nnap-report-2021-data

Parents and families

Your Baby's Care Guide 2021

Parents and families can find more information about the NNAP and 2021 results in **Your Baby's Care**, while **NNAP Online** provides more in-depth results for each neonatal unit and network in England and Wales.

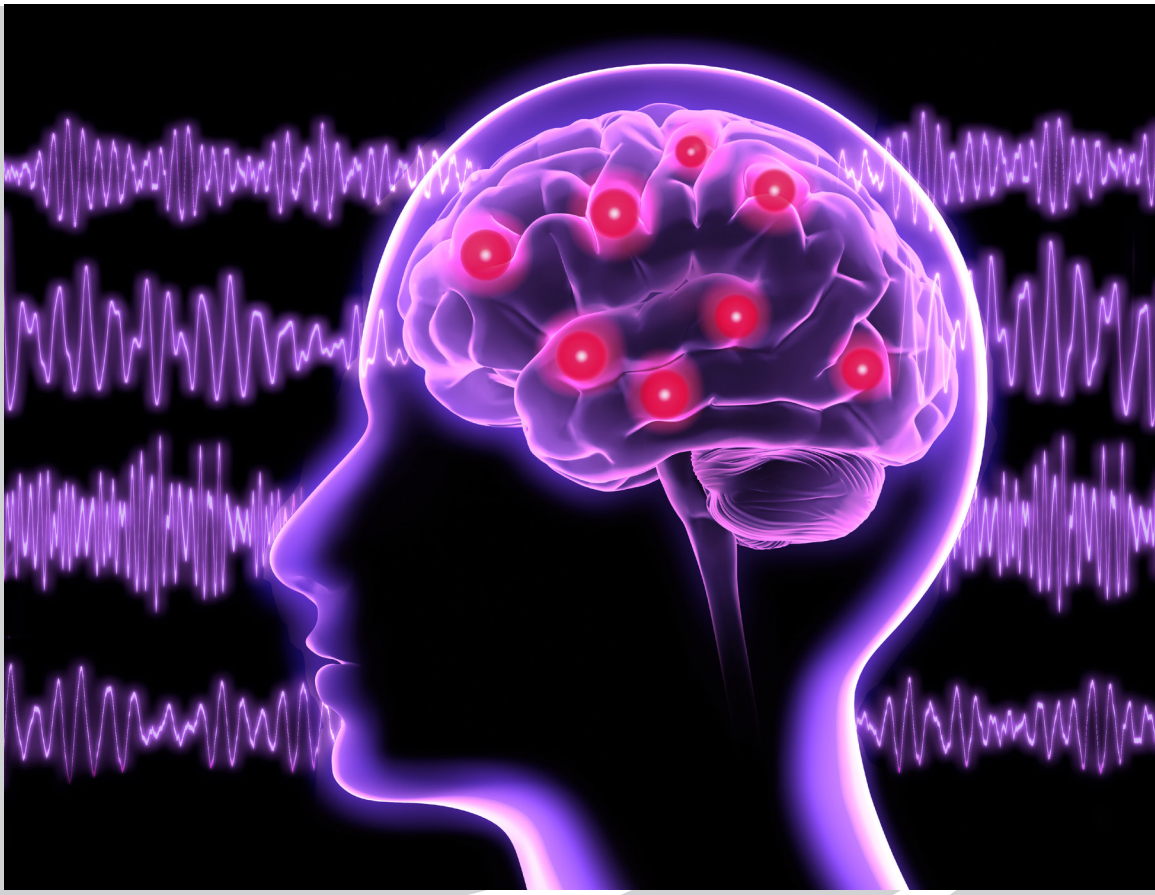
Your Baby's Care: **www.rcpch.ac.uk/your-babys-care**
NNAP Online: **www.nnap.rcpch.ac.uk**

How we use information

To find out more about how we use information about babies experiencing neonatal care and their mothers, please visit **www.rcpch.ac.uk/your-babys-information** or scan the QR code with your phone to read our leaflet Your Baby's Information.

Disordered Activity?

A review of the quality of epilepsy care provided to adult patients presenting to hospital with a seizure



NCEPOD

Improving the quality of healthcare

EXECUTIVE SUMMARY

Data from 610 clinical questionnaires, 264 sets of case notes and 158 organisational questionnaires were used to assess the quality of care provided to adult patients with a pre-existing epilepsy disorder or who were subsequently diagnosed with epilepsy and presented to hospital following a seizure, between 1st January and 31st December 2020.

CONCLUSION

It was identified that action could be taken at all points of the patient pathway to improve the quality of care. Beginning with telling the patient's usual epilepsy team if they had been admitted, making sure anti-seizure medications were checked and ensuring the correct investigations were done. Continuing through to more input from the neurology team, as needed, particularly utilising the role of the epilepsy specialist nurse. Finally, planning and communication at discharge to make sure patients and their families/carers understand the risks associated with seizures and epilepsy so that they know what to do if they have a further seizure.

1. ALERT A PATIENT'S 'USUAL' EPILEPSY TEAM, WHEREVER BASED, WHEN A PATIENT PRESENTS WITH A SEIZURE

This provides an opportunity to discuss the patient's needs and undertake an inpatient review if appropriate.

133/315 (42.2%) patients with epilepsy did not have their admission discussed with their usual secondary care team.

45/143 (31.5%) hospitals reported that there was a policy for the emergency department to contact the epilepsy team when patients with known epilepsy were seen.

2. DOCUMENT ANTI-SEIZURE MEDICATIONS AND ACTION A CLEAR PLAN FOR ANY INVESTIGATIONS NEEDED

This ensures the information is clear in the notes, acted upon and flows through to discharge and follow-up.

47/180 (26.1%) patients did not have their anti-seizure medication (ASM) written in their notes.

119/158 (75.3%) hospitals had the facility to perform an ASM blood screen on-site.

58/252 (23.0%) patients should have had additional investigations in the emergency department.

3. MAKE NEUROLOGY ADVICE AVAILABLE WHEN NEEDED FOR PATIENTS PRESENTING WITH A SEIZURE

This supports the admitting team and therefore the patient, when seizures are hard to control.

175/503 (34.8%) patients were reviewed by a neurologist during their admission and a further 109/503 (21.7%) had their epilepsy management discussed with a neurologist, leaving 219/503 (43.5%) patients without input.

Neurology input was inadequate for 61/217 (28.1%) patients.

Only 36/494 (7.3%) patients were reviewed by an epilepsy specialist nurse.

4. EXPLAIN THE RISKS ASSOCIATED WITH SEIZURES AND EPILEPSY TO PATIENTS AND THEIR FAMILY/CARERS

Gently making people aware of risks associated with seizures will help keep them safe.

In 52/135 (38.5%) hospitals, specific information or education regarding epilepsy was not routinely provided to patients until their first clinic appointment, which may be many weeks after discharge.

Only 40/317 (12.6%) patients had any evidence in their notes that the risk of SUDEP had been considered and discussed with them.

5. COMMUNICATE DISCHARGE/FOLLOW-UP PLANS TO THE PATIENT, THEIR FAMILY/CARERS & HEALTHCARE TEAMS

This would help patients, their families/carers and healthcare team manage their epilepsy together.

Only 23/85 (27.1%) hospitals reported the waiting time for first seizure clinics to be within two-weeks following a first seizure.

42/212 (19.8%) discharge letters were poor.

Follow-up was less likely to be arranged prior to discharge if the ongoing epilepsy care was led solely by a GP (18/93; 19.4%) compared to secondary care teams (36/47; 76.6%).