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

Q2 (July – September 2023), updated 25/09/2023

PUBLICATION DATE	HEALTHCARE AREA	TYPE	PROJECT NAME	LEAD PROVIDER	FULL REPORT TITLE	HQIP WEBLINK TO REPORT	DOC NUMBER
2023/07/13	Women and children	Audit	NCMD - National Child Mortality Database	University of Bristol	NCMD: Deaths of children and young people due to traumatic incidents: Vehicle Collisions, Drownings, Violence and Maltreatment and Unintentional Injuries	https://www.hqip.org.uk/resource/ncmd-trauma-jul23/	0.01
2023/07/13	Long term conditions	Audit	NACEL - National Audit of Care at the End of Life	NHS Benchmarking	NACEL: Fourth round of the audit (2022/23) report	https://www.hqip.org.uk/resource/epilepsy12-july23/	0.02
2023/07/13	Acute	Clinical Outcome Review Programme	Medical and Surgical Clinical Outcome Review Programme	NCEPOD: National Confidential Enquiry into Patient Outcome and Death	Making the Cut? A review of the care received by patients undergoing surgery for Crohn's Disease	https://www.hqip.org.uk/resource/making-the-cut-crohns-ncepod/	0.03
2023/08/10	Long term conditions	Audit	NAD - National Audit of Dementia	Royal College of Psychiatrists	National Audit of Dementia - Care in General Hospitals 2022-2023 Round 5 Audit Report	https://www.hqip.org.uk/resource/nad-round5-aug2023/	0.04
2023/09/14	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	MBRRACE-UK Perinatal Mortality Surveillance: UK Perinatal Deaths for Births from January to December 2021 - State of the Nation Report	https://www.hqip.org.uk/resource/mbrrace-perinatal-mortality-sep23/	0.05

NCMD
National Child Mortality Database

Knowledge, understanding and learning to improve young lives

Deaths of children and young people due to traumatic incidents:

Vehicle Collisions, Drownings, Violence and Maltreatment and Unintentional Injuries

National Child Mortality Database Programme Thematic Report

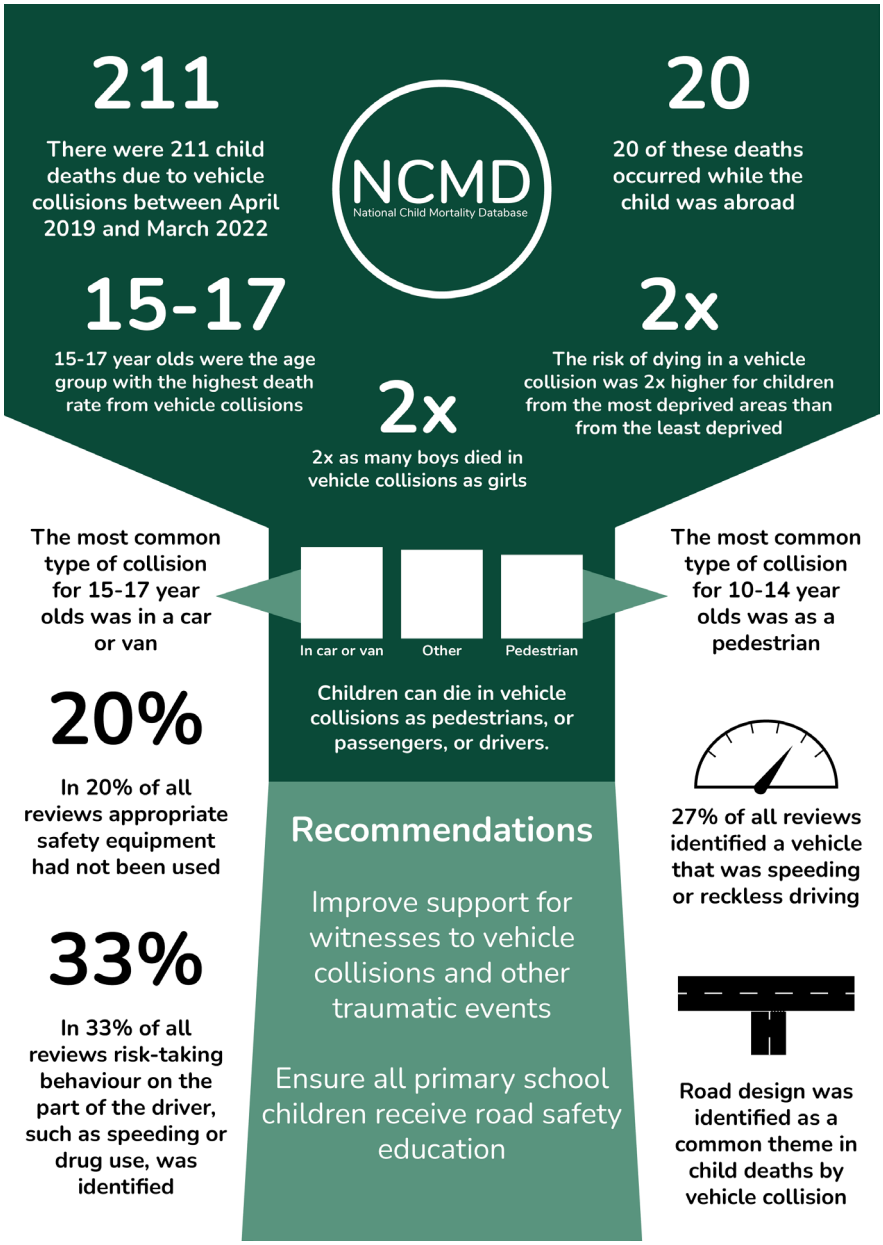
Data from April 2019 to March 2022

Published July 2023

www.ncmd.info

HQIP

Deaths due to vehicle collisions



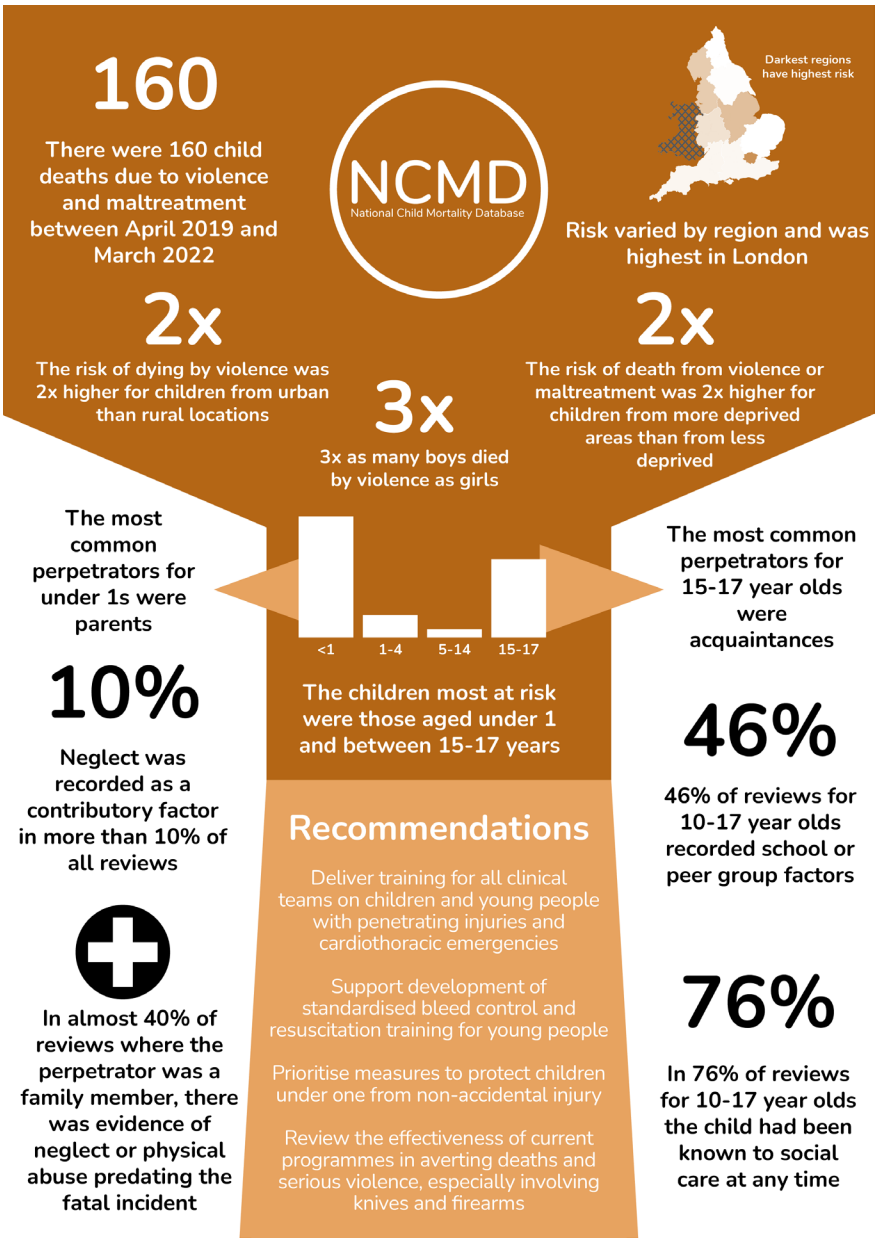
Introduction

Globally, road traffic accidents are the leading cause of death among children and young people aged 5-29 years[4]. This report uses the term “collisions” rather than “accidents” since most injuries and their precipitating events are predictable and preventable[5]. Children and young people can be involved in vehicle collisions in a number of ways, for example, as a pedestrian, as the driver of a vehicle or as a passenger in a vehicle.

Road danger is a strong disincentive to active transport (i.e., walking and cycling). A survey of parents of primary school children in inner London in 1998 found that 90% of parents were worried about the safety of their children as pedestrians on the school–home journey[6]. Fear of pedestrian injury may encourage greater car use, leading to higher motorised traffic volumes and greater risks to pedestrians.

4 RCPCH (2020)
5 Davis et al (2001)
6 Sonkin et al (2006)

Deaths due to violence and maltreatment



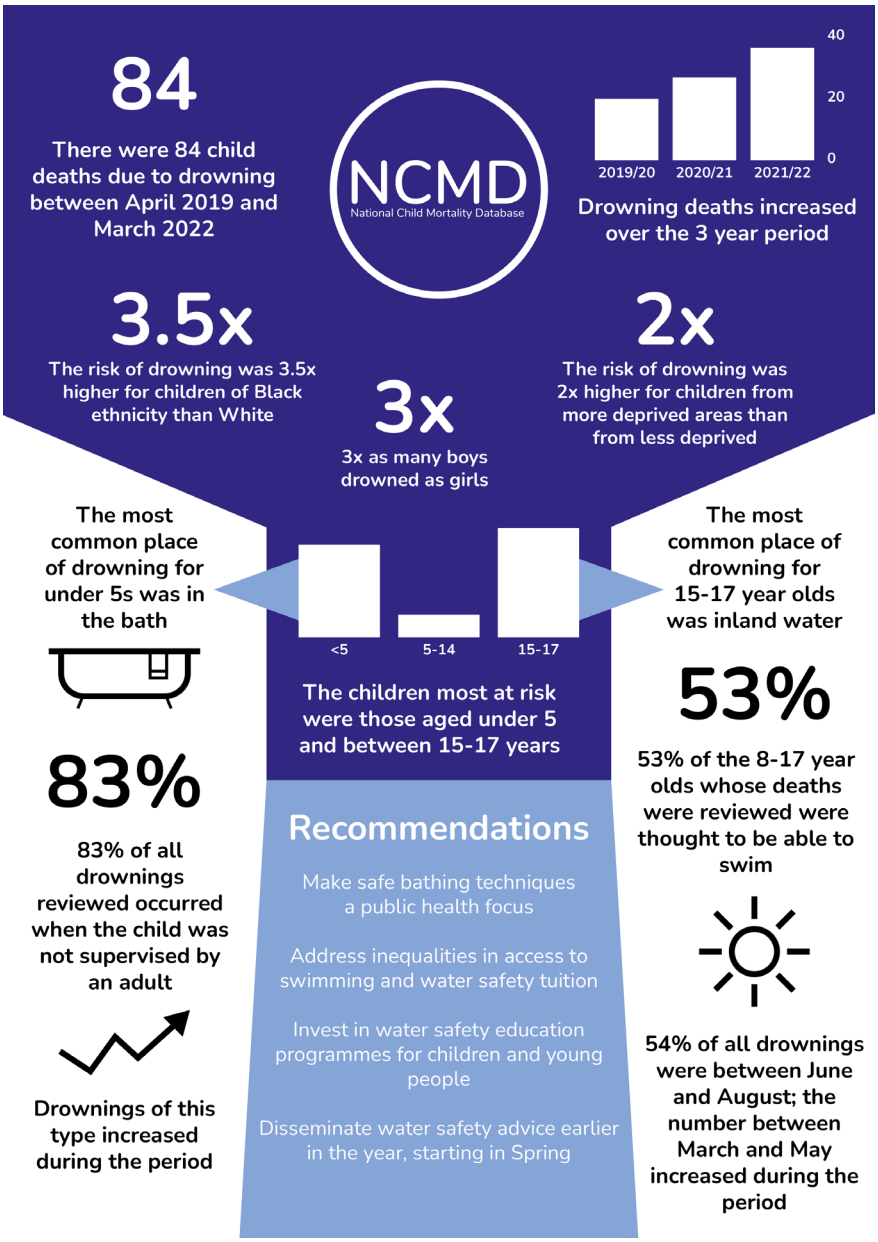
Introduction

The 2030 Agenda for Sustainable Development adopted by all United Nations member states in 2015 is centred around 17 Sustainable Development Goals (SDGs) for urgent action by all countries. SDG target 16.2 aims to end violence against children.

Globally, over half of all children aged 2-17 years have experienced violence in the past year[12]. The World Health Organisation Global Status Report on preventing violence against children (2020) highlights that over the course of their lifetime, children exposed to violence are at increased risk of: mental illness and anxiety disorders; high-risk behaviours like alcohol and drug abuse, smoking and unsafe sex; chronic diseases such as cancers, diabetes and heart disease; infectious diseases like HIV; and social problems including educational under attainment and further involvement in violence, and crime.

12 Babinski et al (2016)

Deaths due to drowning



Introduction

The World Health Organisation Global Report on Drowning (2014) highlights that drowning is among the 10 leading causes of death of children and young people in every region of the world, with children aged under 5 years disproportionately at risk. In Australia, drowning is the leading cause of unintentional injury death in children aged between 1-3 years and in the United States of America, drowning is the second leading cause of unintentional injury death in children aged between 1-14 years.

Drowning is consistently recognised as a highly preventable public health challenge, with mostly low-cost solutions, such as installing barriers to control access to water hazards, supervision for younger children and teaching school-age children basic water competency.

Effective policies and legislation are also important for drowning prevention including a national water safety strategy. The UK recognised the importance of a national drowning strategy in 2015, when the National Water Safety Forum published "A future without drowning: the UK Drowning Prevention Strategy 2016-2026" to contribute to a

National Audit of Care at the End of Life

Fourth round of the audit (2022/23) report

England and Wales

Published 2023

Benchmarking Network

HQIP
Healthcare Quality Improvement Partnership

National Audit of Care at the End of Life 2022
Key findings at a glance

214 Hospital/site overviews (H/S)

7,620 Case Note Reviews (CNR)

3,600 Quality Surveys (QS)

11,143 Staff Reported Measures (SRM)

(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)

87%

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

(CNR – Cat 1)

76%

Case notes recorded an individualised plan of care

(CNR – Cat 1)

79%

Case notes recorded patient's hydration status assessed daily once dying phase recognised

(QS)

54%

Families/carers were asked about their needs

(QS)

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

66% Care provided to families/carers

71% Care provided to the patient

(H/S)

60%

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

(SRM)

85%

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

82%

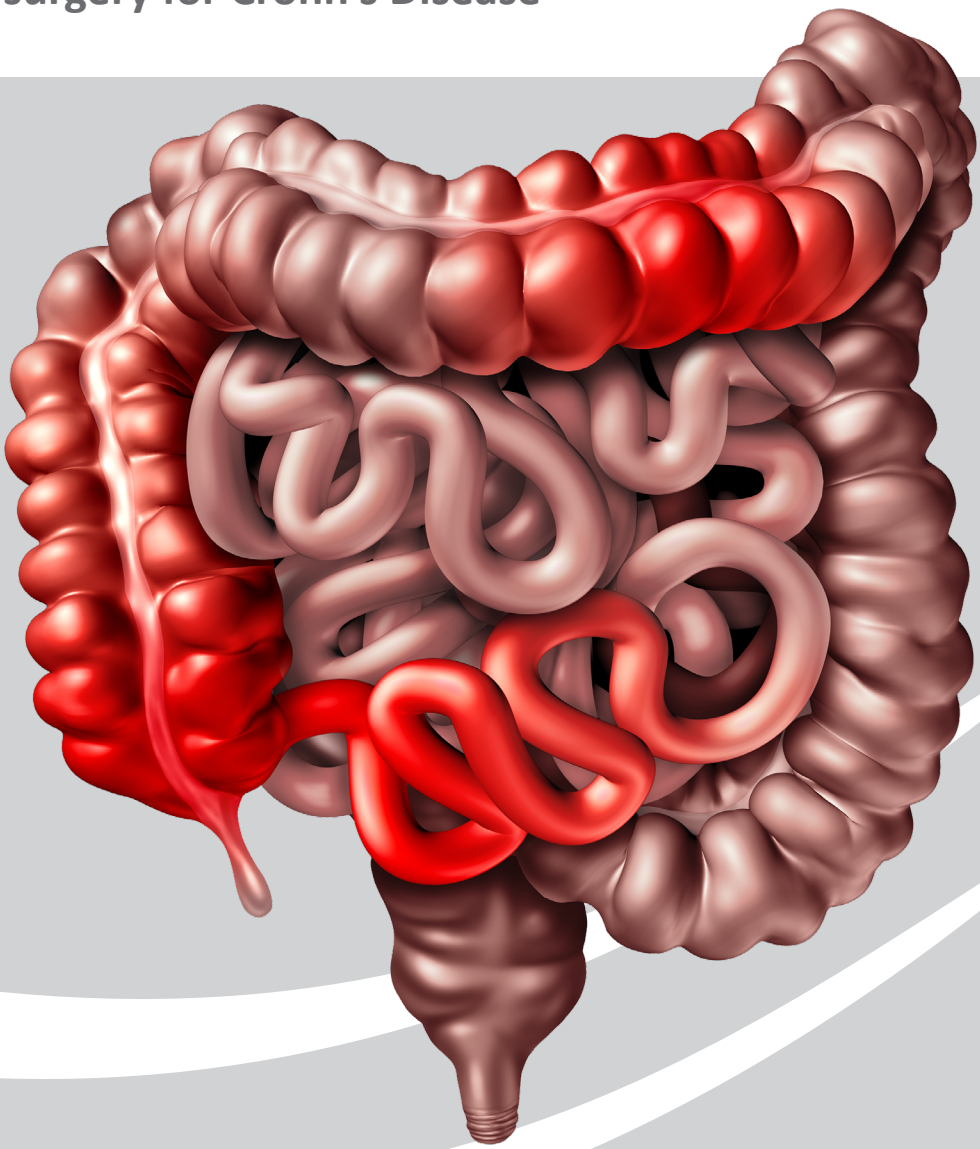
Staff feel supported by their specialist palliative care team

83%

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

Making the Cut?

A review of the care received by patients undergoing surgery for Crohn's Disease



NCEPOD

Improving the quality of healthcare

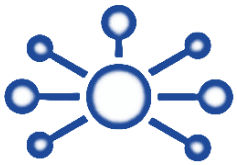
EXECUTIVE SUMMARY

To assess the quality of care provided to patients aged 16 years and over, who had a diagnosis of Crohn's disease and who underwent an operation, data were collected from two sample periods: 1st September 2019 to 29th February 2020 and 1st September 2020 to 28th February 2021 inclusive to account for influence of the COVID-19 pandemic. Analysis was undertaken on questionnaires from 553 clinicians, 414 sets of case notes, and 138 organisational questionnaires, supported by qualitative data from patient surveys and focus groups.

CONCLUSION

Surgery for patients with drug resistant Crohn's disease surgery should be considered earlier in the treatment pathway for patients, instead of surgery being perceived as a failure of medical care. Once a decision to perform surgery has been made it should be undertaken within a month to prevent patients on elective waiting lists deteriorating and requiring emergency surgery. Furthermore, closer working between all members of the multidisciplinary team would benefit patients, to reduce delays as well as providing all the holistic care that patients with Crohn's disease need.

1. PROVIDE HOLISTIC SUPPORT FOR ALL PATIENTS WITH CROHN'S DISEASE



Patients with Crohn's disease have many wider health needs e.g. psychological, dietary and peer support.

The reviewers found evidence of psychological support across the care pathway in just 30/332 (9.0%) cases reviewed, even though patients had undergone major surgery.

Services that the patients would have liked but did not receive included psychological support (132/310; 42.6%) and dietetic support (108/310; 34.8%).

2. MEDICATION FOR CROHN'S DISEASE SHOULD BE MANAGED EFFECTIVELY AT ALL STAGES OF THE PATHWAY

This would ensure patients are taking the correct medication before, during and after surgery.

253/414 (61.1%) patients were taking medications for their Crohn's disease, and of these, complications or side effects of the medication were recorded in 38/253 (15.0%).

There was room for improvement in the management of medication for 45/222 (20.3%) patients e.g. the use of prophylaxis (15) and/or a delay in starting/reviewing medication (10).

3. CONSIDER SURGERY AS A POTENTIAL TREATMENT OPTION FOR PATIENTS WITH CROHN'S DISEASE

Surgery should not be perceived as a failure of medical management and could be undertaken sooner.

Reviewers reported that referral for a colorectal surgical opinion should have occurred earlier in 41/218 (18.8%) patients.

56/278 (20.1%) patients, identified in the reviews, encountered more than one delay in the elective surgery pathway and 14/34 patients had adverse outcomes due to complications and the need for a stoma.

4. PERFORM SURGERY PROMPTLY ONCE A DECISION TO OPERATE HAS BEEN MADE

This would prevent elective patients becoming emergencies and reduce the risk of a Crohn's flare when medications are altered pre-operatively.

128/301 (42.5%) patients waited more than 18 weeks (126 days) before their operation was carried out (unknown for 63 patients) and 30/311 (10.0%) patients waited more than six months for surgery.

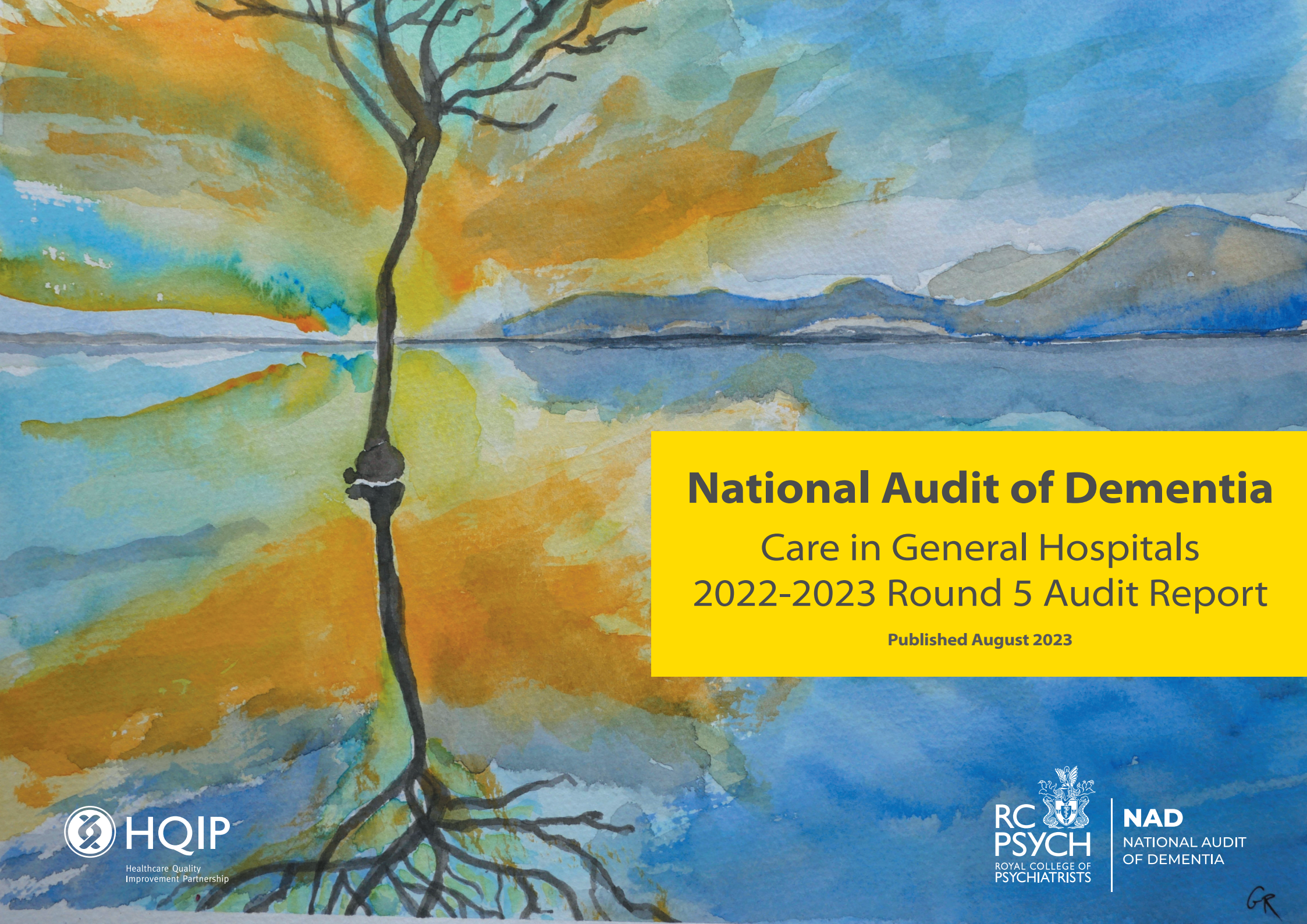
Only 18/138 (13.0%) hospitals reported local targets in place for the scheduling of Crohn's disease surgery.

5. MAKE SURE THAT THE HANDOVER OF CARE FROM THE SURGICAL TEAM TO THE MEDICAL TEAM IS ROBUST

Early involvement by the inflammatory bowel disease team would promote joined up care after surgery.

299/553 (54.1%) patients saw neither an inflammatory bowel disease (IBD) nurse nor a gastroenterologist postoperatively.

Re-adjustments of Crohn's disease medication may be required after surgery to reduce the postoperative risks of immunosuppression, yet a pharmacist was only involved for 258/553 (46.7%) patients.



National Audit of Dementia

Care in General Hospitals 2022-2023 Round 5 Audit Report

Published August 2023

HQIP
Healthcare Quality Improvement Partnership

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

NAD
NATIONAL AUDIT OF DEMENTIA

Key Findings

Delirium Screening

87% patients received an initial screen for delirium

Up from 58% in previous round

Pain Assessment and Reassessment

61% patients only had questioning as a pain assessment

92% received any pain assessment

92% received a pain reassessment

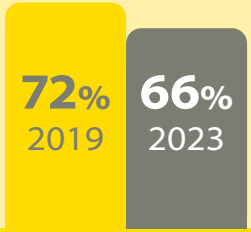
Discharge

39% patients had a discharge plan initiated within 24 hours of admission

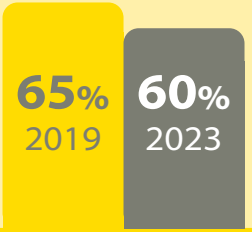
Median length of stay days 10

Feedback from carers

Rating for overall quality of care decreased



Rating for quality of communication decreased



Positive responses **decreased** from previous round for **all questions**

Key Findings

Identifying People with Dementia

Unverifiable figures returned by hospitals for total number of patients with dementia identified per year, ranging from

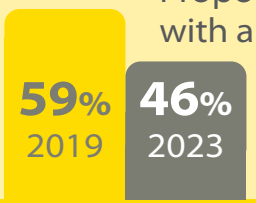
33 – 29,769

with proportion of patients with dementia varying from

0% – 15%

Personal Information Document

Proportion of patients with a personal information document decreased



Staff Expertise

20 hospitals reported having **no lead nurse** for dementia

Staff Training

Large variations of training reported, with

0% – 100%

hospital staff with **tier 1 training**

80% hospitals were able to provide figures for staff with **tier 1 training**

58% hospitals were able to provide figures for staff with **tier 2 training**

Dementia Friendly Environment Review

51% reviews taken place **throughout the hospital/all adult wards**

11% hospital review status' were **unknown or not taken place**

12% environmental review changes were **completed**

Information about Patients

Age

Average age

84 (no change from 2019)

with a range of **30-106**

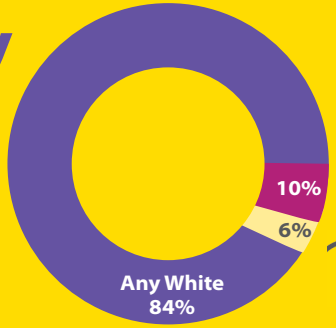
Gender

8% unknown/ not documented

2023 Female - 52%	Male - 40%

2019 Female - 59%	Male - 41%

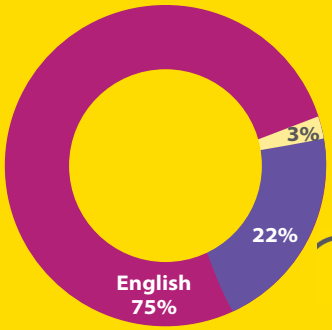
Ethnicity



Unknown/not documented

Any Other Background

First Language



Any Other Language

Unknown/ not documented

Dementia Status

25%	Known Dementia - 75%

Patients with suspected dementia or concerns about cognition

Place of Residence & Care

Own Home or Short Term Care - 71%	Long Term Care - 29%

There were no significant differences in level of care between demographic groups and audit key metrics. See Appendix VIII

Identifying People with Dementia

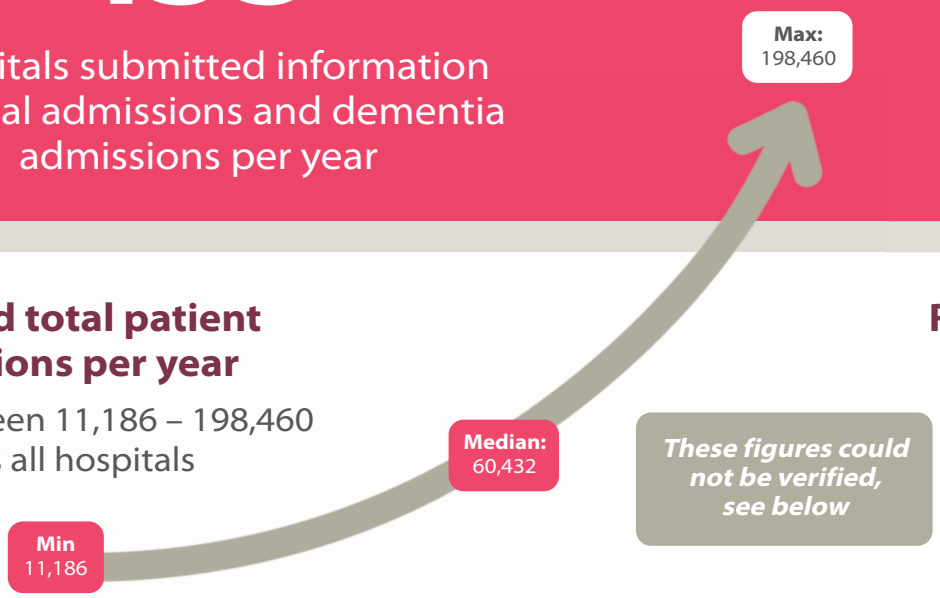
155

hospitals submitted information on total admissions and dementia admissions per year

> ***No use of the butterflies [identification] system... as a family we felt we had to be there as much as possible.***
>
> *CARER*

Reported total patient admissions per year

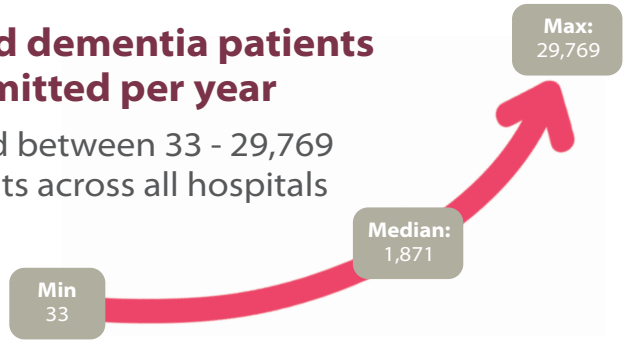
ranged between 11,186 – 198,460 across all hospitals



These figures could not be verified, see below

Reported dementia patients admitted per year

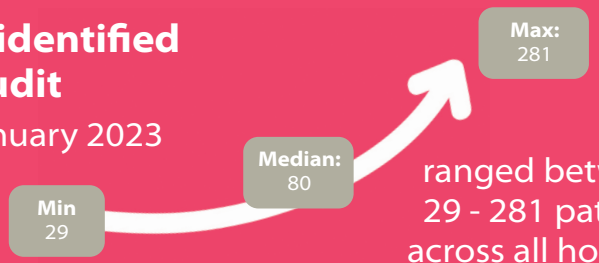
ranged between 33 - 29,769 patients across all hospitals



Refer to Recommendations

Dementia patients identified within this audit

September 2022 - January 2023



ranged between 29 - 281 patients across all hospitals

Governance and Monitoring Care of People with Dementia

168 hospitals submitted governance information

Refer to Recommendations

Proportion of patients with a Personal Information Document

2023: 46%

2019: 59%

Decrease from previous round

% hospitals with information systems that can identify people with dementia experiencing:

Falls	Readmissions	Delayed Discharge	Pressure Ulcers	Violent Incidents
64%	**46%**	**37%**	**49%**	**58%**

Staff Training

Out of **168** hospitals

33 hospitals were unable to provide figures for staff with **Tier 1 training**

Tier 1 training

ranged between 0% - 100% across all hospitals

Out of **168** hospitals

71 hospitals were unable to provide figures for staff with **Tier 2 training**

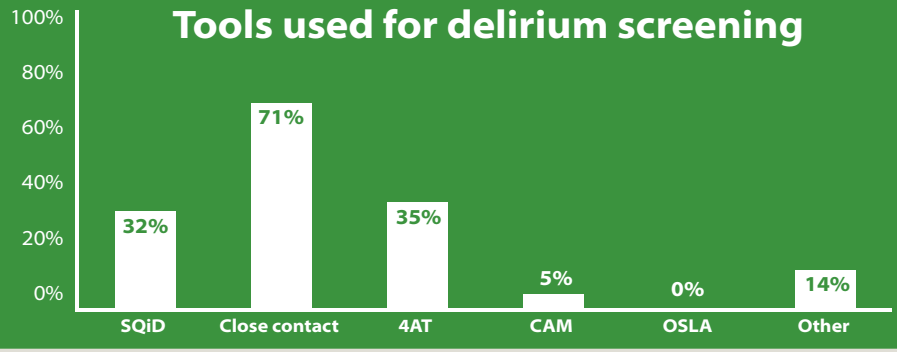
Delirium Screening & Assessment

An Improvement...

Patients who received an initial delirium screen, up from

58% in 2019 to **87%** in 2023

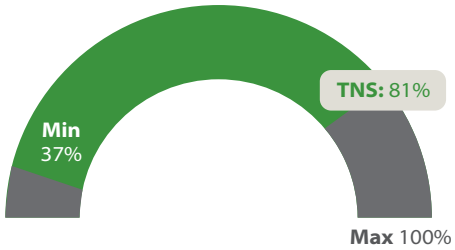
Tools used for delirium screening



87% patients received an initial delirium screen

No initial delirium screen

81% patients received a delirium screen within 24 hours of admission



Delirium screen within 24 hours

ranged between 37% - 100% across all hospitals

Delirium Diagnosis

72% patients were diagnosed with delirium

15%

13%

No further investigations took place

No delirium confirmed

93% patients received a delirium medical management plan

50% patients received a delirium nursing care plan

Pain Assessment

Pain assessments

ranged between 3% – 100% across all hospitals

> ***[RELATIVE] given a bell to press if he was in pain, but having dementia meant he mostly forgot what it was for and I often visited the hospital to find him in pain.***
>
> *CARER*

92% patients received any pain assessment

Patients who did not receive a pain assessment

85% patients received a pain assessment within 24 hours of admission

Refer to Recommendations

61% patients received only questioning as a pain assessment

> ***All of the ward staff, doctors and nurses were very professional and caring towards my [RELATIVE]. Ensuring he was kept pain free and comfortable at all times.***
>
> *CARER*

Pain Reassessment

60% patients received only questioning as a pain reassessment

Patients who did not receive a pain reassessment

92% patients received any pain reassessment

83% patients received a pain reassessment within 24 hours of the first assessment

Discharge Planning

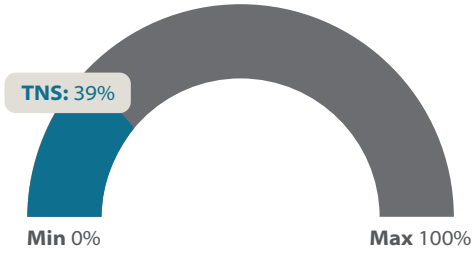
> *The hospital put in place things to make sure my friend was discharged safely and with a package of care in place. They were fantastic really*
>
> CARER

72% patients had named staff coordinate their discharge

64% patients had an expected date of discharge

86% patients received a discharge plan

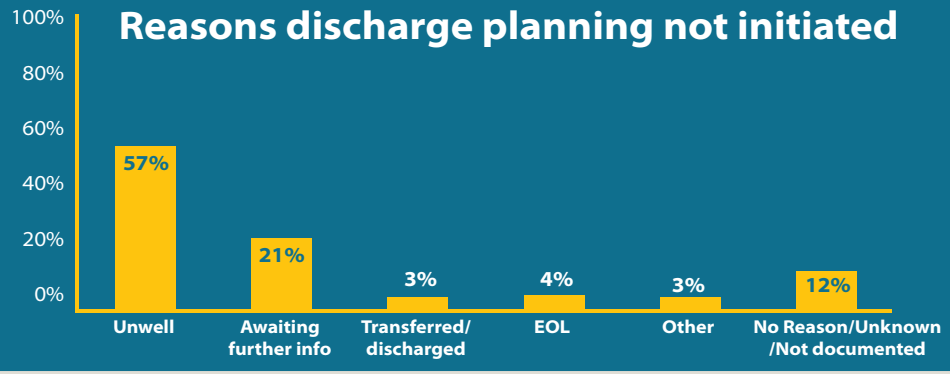
39% patients received a discharge plan within 24 hours of admission



discharge planning within 24 hours

ranged between 0% - 100% across all hospitals

Reasons discharge planning not initiated



> *I was contacted out of the blue and told my [AGE] [RELATIVE] would be discharged to a Travelodge... The discharge team did not take into account her night time needs and I was distraught*
>
> CARER

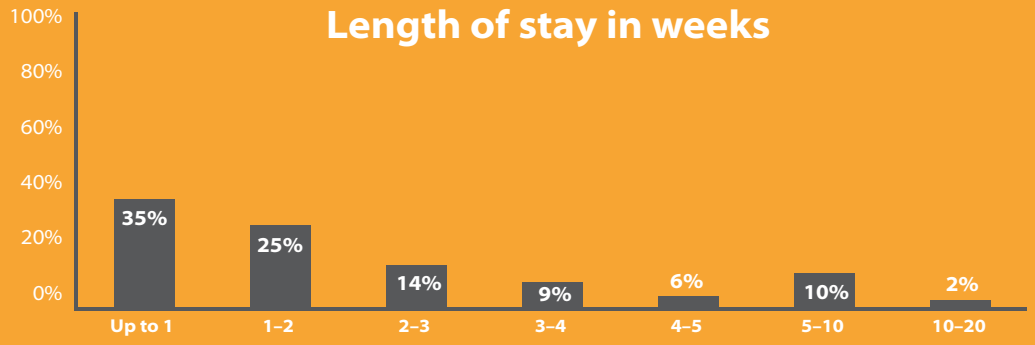
Discharge Information

86%
patients were discharged by the end of audit period

92%
patients were on the right ward for their consultant specialty at point of discharge

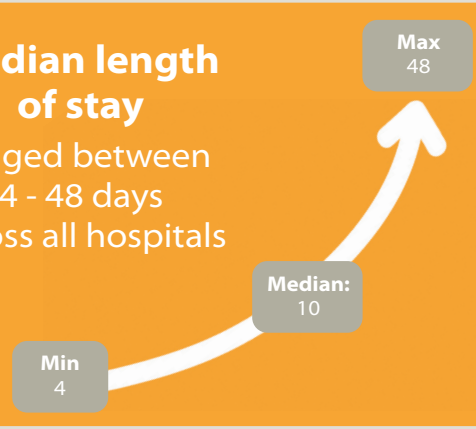
81%
patients who died received an end of life care plan

Length of stay in weeks



10
Median days length of stay

Median length of stay
ranged between 4 - 48 days across all hospitals



Change of Place of Residence/Care

13% patients had a change in care location after discharge from **own home/short term to long term care** compared to **8%** in 2019

60%
patients were discharged to their own home or short term care

Nutrition and Environment

Wards with finger foods available

ranged between
0% - 100%
across all hospitals

Wards with snack foods available

ranged between
0% - 100%
across all hospitals

'Dementia Friendly' Environment Review

36% reviews taken place **throughout the hospital**

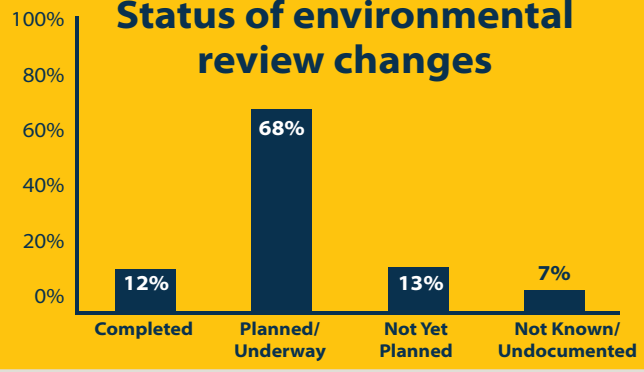
15% reviews taken place on **all adult wards**

39% reviews taken place **some wards**

11% hospital review status' were **unknown or not taken place**

Refer to Recommendations

Status of environmental review changes



> *I think there could be more assistance with feeding and drinking. The food and drink is just out on the table and left. Elderly people and those with dementia do not always understand how to eat.*
>
> CARER

> *The dementia team always helped me at meal times*
>
> PATIENT

Feedback from Carers

Participation
2,223
responses across
160 hospitals

Carer Rating of Overall Care Quality

66%
compared to **72%** in 2019

Positive responses
decreased
from previous round for
all questions

Refer to Recommendations

Carer Rating of Communication

60%
compared to **65%** in 2019

> ***Very happy with the consistent empathy & patience shown by everyone from the cleaner to the Dr, nurses, physicians...***
>
> *CARER*

> ***I constantly reminded both staff and doctors to phone anytime to ask anything. No one ever phoned and we were rarely spoken to on the ward***
>
> *CARER*

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

UK Perinatal Deaths for Births from January to December 2021

State of the Nation Report

September 2023

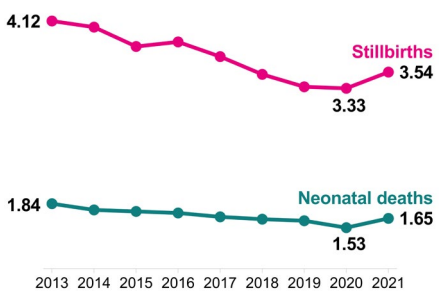
HQIP Healthcare Quality Improvement Partnership
University of Leicester
University of Birmingham
The Newcastle upon Tyne Hospitals NHS Foundation Trust
TIMMS
Sands Stillbirth & neonatal death charity
Chelsea and Westminster Hospital NHS Foundation Trust
University of Oxford
Oxford Population Health
NPEU

State of the Nation Report

UK Perinatal Deaths for Births from January to December 2021

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

1. Perinatal mortality rates increased across the UK in 2021



Stillbirths per 1,000 total births

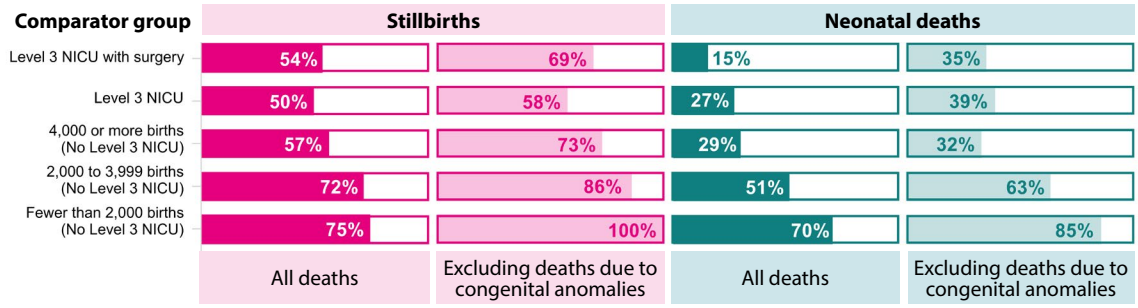
Country	2020	2021
UK	**3.33**	**3.54**
England	3.29	3.52
Scotland	3.72	3.27
Wales	3.48	3.88
Northern Ireland	3.38	4.09

Neonatal deaths per 1,000 live births

Country	2020	2021
UK	**1.53**	**1.65**
England	1.50	1.60
Scotland	1.47	1.91
Wales	1.64	1.70
Northern Ireland	2.37	2.46

2. There was wide variation in stillbirth and neonatal mortality rates

Percentage of organisations with mortality rates within 5% of the group average



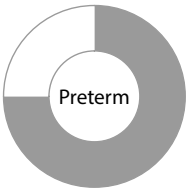
3. Stillbirth and neonatal mortality rates increased in almost all gestational age groups

Stillbirths per 1,000 total births

Gestational age	Rate	Change since 2020
22 to 23 weeks	472.7	4% increase
24 to 27 weeks	212.1	7% increase
28 to 31 weeks	81.7	**12% increase**
32 to 36 weeks	16.4	6% increase
37 to 41 weeks	1.19	**3% decrease**

Neonatal deaths per 1,000 live births

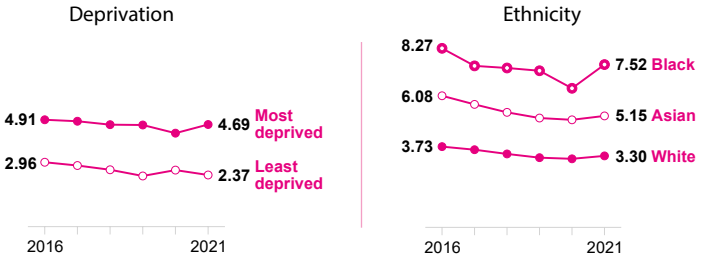
Gestational age	Rate	Change since 2020
22 to 23 weeks	660.5	2% increase
24 to 27 weeks	160.0	**18% increase**
28 to 31 weeks	34.0	11% increase
32 to 36 weeks	5.35	No change
37 to 41 weeks	0.66	2% increase



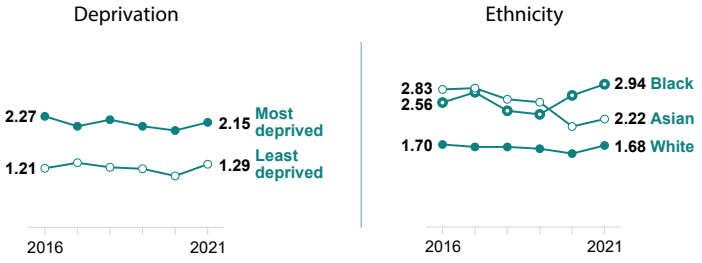
Births before 37 completed weeks' gestational age accounted for 75% of stillbirths and late fetal losses and 73% of neonatal deaths

4. Inequalities in mortality rates by deprivation and ethnicity remain

Stillbirths per 1,000 total births

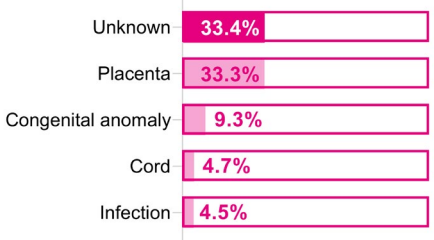


Neonatal deaths per 1,000 live births

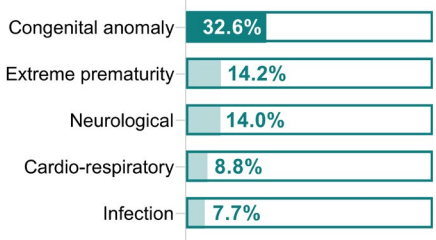


5. The most common causes of stillbirth and neonatal death are unchanged

Most common causes of stillbirth



Most common causes of neonatal death



Congenital anomalies continue to contribute to a significant proportion of perinatal deaths