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

Q3 (October 2023 – December 2023), updated 20/12/2023

PUBLICATION DATE	HEALTHCARE AREA	TYPE	PROJECT NAME	LEAD PROVIDER	FULL REPORT TITLE	HQIP WEBLINK TO REPORT	DOC NUMBER
2023/10/12	Long term conditions	Audit	NEIAA - National Early Inflammatory Arthritis Audit	BSR: British Society for Rheumatology	National Early Inflammatory Arthritis Audit (NEIAA) State of the Nation Report 2023 - Summary report Data collection period: 1 April 2022 – 31 March 2023	https://www.hqip.org.uk/resource/neiaa-state-of-the-nation-2023/	0.01
2023/10/12	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 State of the Nation Surveillance Report 2023 Surveillance findings from the UK Confidential Enquiries into Maternal Deaths 2019-21	https://www.hqip.org.uk/resource/mbrrace-surveillance-oct23/	0.02
2023/10/12	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 State of the Nation Themed Report Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths from infection, neurological, haematological, respiratory, endocrine, gastrointestinal and general surgical causes 2019-21	https://www.hqip.org.uk/resource/mbrrace-themed-report-2/	0.03
2023/10/12	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 State of the Nation Themed Report Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths from haemorrhage, amniotic fluid embolism and anaesthetic causes 2019-21 and morbidity following repeat caesarean birth	https://www.hqip.org.uk/resource/mbrrace-themed-report-1-oct23/	0.04
2023/10/12	Women and children	Audit	NNAP - National Neonatal Audit Programme	RCPCH: Royal College of Paediatrics and Child Health	National Neonatal Audit Programme (NNAP) - Summary report on 2022 data	https://www.hqip.org.uk/resource/nnap-summary-report-2022/	0.05
2023/10/12	Long term conditions	Audit	NDA - National Diabetes Audit	NHS Digital	National Diabetes Audit 2021-22, Report 1: Care Processes and Treatment Targets, Overview	https://www.hqip.org.uk/resource/nda-care-processes-and-treatment-targets-oct23/	0.06
2023/10/12	Long term conditions	Audit	NDA - National Diabetes Audit	NHS Digital	National Diabetes Audit 2021-22, Type 1 Diabetes - Overview	https://www.hqip.org.uk/resource/nda-type1-overview-oct23/	0.07
2023/10/12	Long term conditions	Audit	NDA - National Diabetes Audit	NHS Digital	National Diabetes Audit National Pregnancy in Diabetes Audit 2021 and 2022 (01 January 2021 to 31 December 2022)	https://www.hqip.org.uk/resource/nda-pregnancy-diabetes-oct23/	0.08
2023/11/09	Cardiovascular	Audit	NVR - National Vascular Registry	RCS: Royal College of Surgeons	National Vascular Registry - State of the Nation Report 2023 Results for patients who had vascular procedures during 2022 in NHS hospitals in England, Wales, Scotland and Northern Ireland	https://www.hqip.org.uk/resource/nvr-nov-2023/	0.09
2023/11/09	Long term conditions	Audit	SSNAP - Sentinel Stroke National Audit Programme	KCL: Kings College London	Sentinel Stroke National Audit Programme Annual Report 2023 Stroke care received between April 2022 to March 2023	https://www.hqip.org.uk/resource/ssnap-nov-2023/	0.10
2023/12/14	Long term conditions	Audit	NDA - National Diabetes Audit	NHS Digital	Non-Diabetic Hyperglycaemia, 2021-22, Diabetes Prevention Programme State of the Nation Report	https://www.hqip.org.uk/resource/diabetes-ndh-2021-22/	0.11
2023/12/14	Long term conditions	Audit	NDA - National Diabetes Audit	NHS Digital	National Diabetes Audit 2021-22, Young People with Type 2 Diabetes	https://www.hqip.org.uk/resource/nda-young-people-type-2-diabetes/	0.12
2023/12/14	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	A comparison of the care of Black and White women who have experienced a stillbirth or neonatal death - State of the Nation Report	https://www.hqip.org.uk/resource/mbrrace-perinatal-confidential-enquiry-black-white-women/	0.13
2023/12/14	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	A comparison of the care of Asian and White women who have experienced a stillbirth or neonatal death - State of the Nation Report	https://www.hqip.org.uk/resource/mbrrace-perinatal-confidential-enquiry-asian-white-women/	0.14
2023/12/14	Women and children	Audit	PICANet - Paediatric Intensive Care Audit	University of Leeds	National Paediatric Critical Care Audit (PICANet) State of the Nation Report 2023	https://www.hqip.org.uk/resource/picanet-paediatric-critical-care-2023/	0.15

National Early Inflammatory Arthritis Audit (NEIAA) State of the Nation Report 2023

Summary report
Data collection period: 1 April 2022 – 31 March 2023

October 2023
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HQIP
Healthcare Quality Improvement Partnership

National Early Inflammatory Arthritis Audit (NEIAA) State of the Nation Report 2023

Key findings

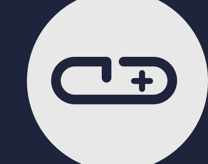
Patients enrolled per year

Audit participation has improved, however participation is still not at pre COVID-19 levels.

Quality metrics

Referral to specialist rheumatology services has improved with 56% of patients (vs 54% in year 4) being referred within three working days.
(QS33 2013: QS 1)

Assessment delay has increased with only 39% of patients (vs 41% in year 4) being seen for their first appointment within three weeks of receipt of referral.
(QS33 2013: QS 2)



Treatment delay has decreased with 56% of patients (vs 52% in year 4) receiving treatment within six weeks of receipt of referral.
(QS33 2013: QS 3)

Response to treatment has not changed with 36% of patients reporting a good response to treatment within three months of diagnosis.

Patient Reported Outcome Measures (PROMs)
Clinically meaningful improvements were recorded for all PROMs between baseline and 3-month follow-up:

- Quality of Life
- Functional and work impairment
- Anxiety and depression

Organisational metrics

Data over the five years of NEIAA have shown the presence of a dedicated EIA clinic and higher levels of staffing are associated with an increase chance of meeting quality statements 2 (assessment within three weeks) and 3 (treatment within six weeks).

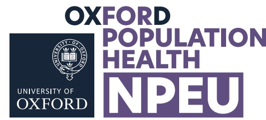
Maternal, Newborn and Infant Clinical Outcome Review Programme

Saving Lives, Improving Mothers' Care

State of the Nation Surveillance Report

Surveillance findings from the UK Confidential Enquiries into Maternal Deaths 2019-21

October 2023



Key messages

In 2019-21, **241 women died** during or up to six weeks after pregnancy among 2,066,997 women giving birth in the UK.

11.7 women per 100,000 died during pregnancy or up to six weeks after childbirth or the end of pregnancy.

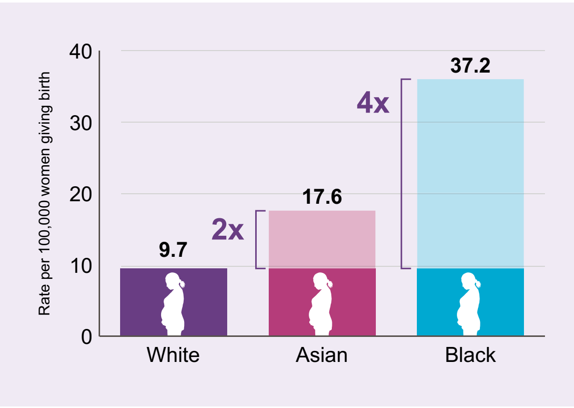
Causes of women's deaths

Women	Cause	%
33 women	COVID-19	14%
33 women	Cardiac disease	14%
33 women	Blood clots	14%
25 women	Mental health conditions	10%
23 women	Sepsis	10%
22 women	Epilepsy and stroke	9%
19 women	Other physical conditions	8%
17 women	Bleeding	7%
9 women	Pre-eclampsia	4%
4 women	Cancer	2%
23 women	Other	10%

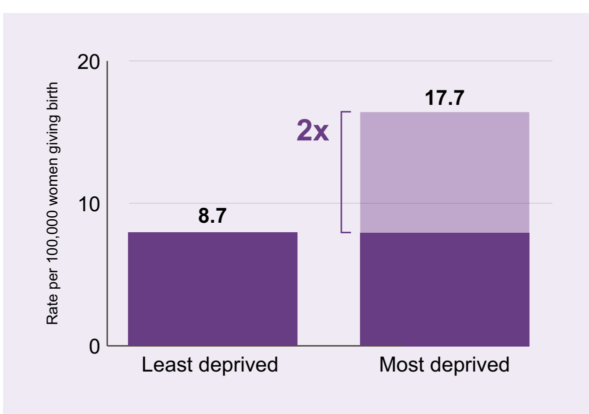
When maternal deaths due to COVID-19 are excluded, **10.1 women** per 100,000 died during pregnancy or up to six weeks after childbirth or the end of pregnancy

Inequalities in maternal mortality

Ethnic group



Living in more deprived areas



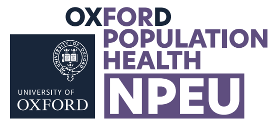
Maternal, Newborn and Infant Clinical Outcome Review Programme

Saving Lives, Improving Mothers' Care

State of the Nation Themed Report

Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths from infection, neurological, haematological, respiratory, endocrine, gastrointestinal and general surgical causes 2019-21

October 2023



Key messages

from the themed mortality enquiry report 2023

Treat pregnant, recently pregnant, and breastfeeding women the same as a non-pregnant person unless there is a very clear reason not to.

Equity for pregnant and breastfeeding women

- Prepare a route for rapid delivery of advice and data on new vaccines and treatments
- Include in medicine and vaccine research
- Tailor care after pregnancy to a woman's individual needs
- Include in guidance for admission to ECMO* services
- Ensure staff in maternal medicine networks have the skills to care for complex physical, mental and social care needs
- Develop training resources to promote shared decision making and counselling on medication use

*ECMO = Extracorporeal membrane oxygenation

Maternal, Newborn and Infant Clinical Outcome Review Programme

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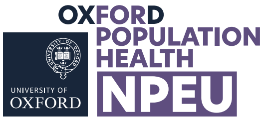
October 2023

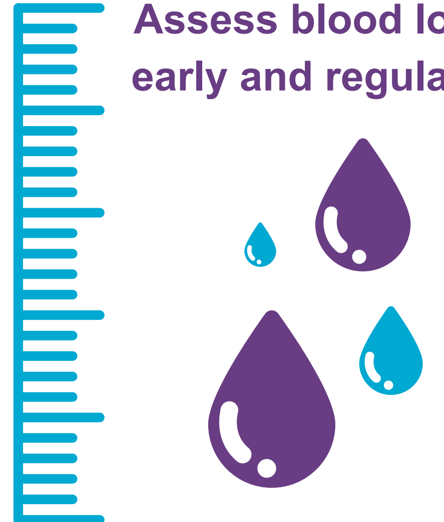


Key messages

from the themed morbidity enquiry report 2023

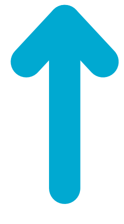
Recognition and management of bleeding

Assess blood loss early and regularly

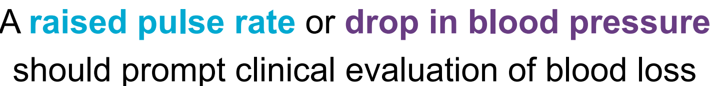


Don't rely on a single bedside measurement of clotting or haemoglobin

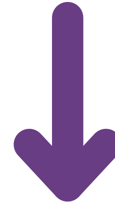
Consider and exclude concealed bleeding



Pulse rate and blood pressure are typically maintained until 30% of circulating volume is lost

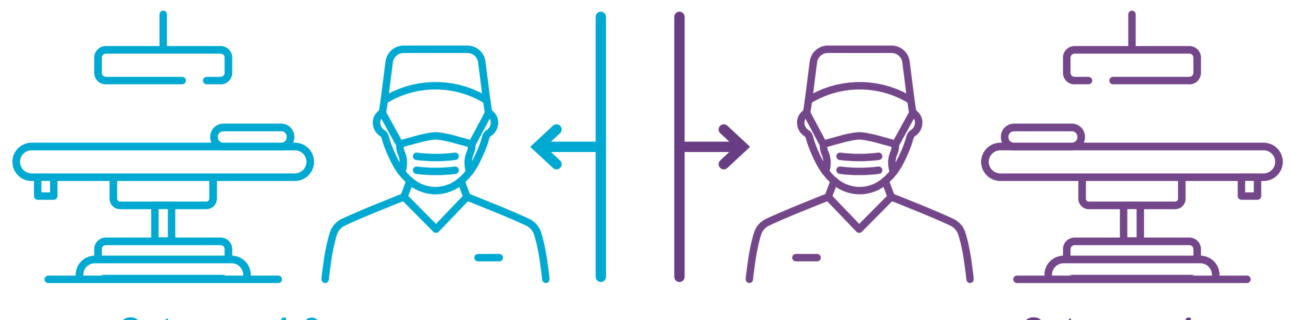


A **raised pulse rate** or **drop in blood pressure** should prompt clinical evaluation of blood loss

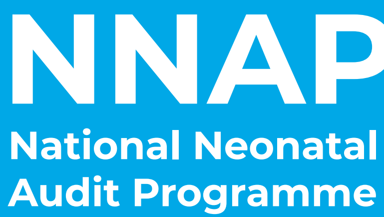


National recommendation

Manage operating teams for urgent and elective caesarean sections separately



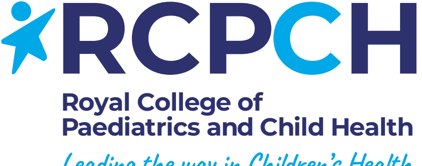
Category 1-3 **Category 4**



RCPCH Audits

National Neonatal Audit Programme (NNAP) Summary report on 2022 data

Photo courtesy of Maddy and Baljit Singh



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 admitted to neonatal care between January and December 2022[†], unless otherwise stated. Results displayed in the horizontal pink bars show the range of neonatal network proportions (lowest and highest) and the pink circle shows the overall audit (England, Scotland and Wales) proportion.

Outcomes of neonatal care

Mortality

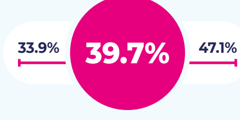
6.5% of babies born at less than 32 weeks* died before discharge home.

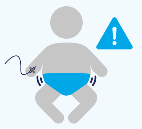
*born July 2019 to June 2022

Bronchopulmonary dysplasia

39.7% of babies born at less than 32 weeks* developed BPD or died.

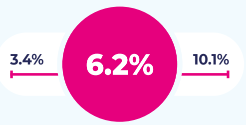
*discharged January 2020 to December 2022





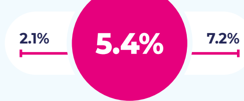
Necrotising enterocolitis

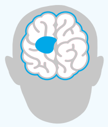
6.2% of babies born at less than 32 weeks developed necrotising enterocolitis.



Bloodstream infection

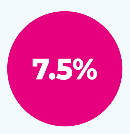
5.4% of babies born at less than 32 weeks had growth of a clearly pathogenic organism.

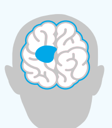




Preterm brain injury – Intraventricular haemorrhage (IVH)

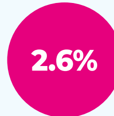
7.5% of babies born at less than 32 weeks experienced IVH. Missing data was high (13.9%).





Preterm brain injury – cystic periventricular leukomalacia (cPVL)

2.6% of babies born at less than 32 weeks experienced cPVL. Missing data was high (17.2%).



Optimal perinatal care

Antenatal steroids

52% of mothers of babies born at less than 34 weeks were given a full course of antenatal steroids in the week prior to delivery.

Born in a centre with a NICU

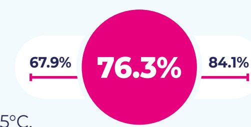
79% of babies born at less than 27 weeks were born in a centre with a NICU on site.

Deferred cord clamping

60.4% of babies born at less than 34 weeks had their cord clamped at or after one minute.

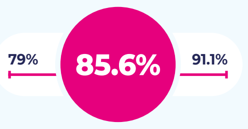
Temperature on admission

76.3% of babies born at less than 32 weeks were admitted with a temperature within the recommended range of 36.5°C-37.5°C.



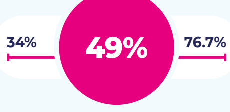
Antenatal magnesium sulphate

85.6% of mothers of babies born at less than 30 weeks were given antenatal magnesium sulphate.



Breastmilk feeding in first 2 days of life

49% of babies born at less than 34 weeks received their mother's milk in the first 2 days of life.



[†]For Scotland, results relate to babies admitted between April and December 2022.

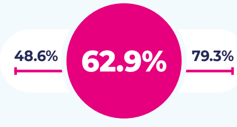
Parental partnership in care

Breastmilk feeding at 14 days of life

79% of babies born at less than 34 weeks received their mother's milk at 14 days of life.

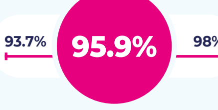
Breastmilk feeding at discharge

62.9% of babies born at less than 34 weeks received their mother's milk at discharge.



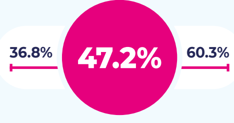
Parent consultation within 24 hours

95.9% of parents had a documented consultation with a senior member of the neonatal team within 24 hours of their baby's admission.

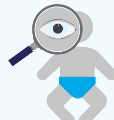


Parent inclusion in consultant ward rounds

47.2% of baby care days had a consultant-led ward round with at least one parent included.

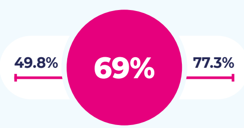


Care processes and nurse staffing



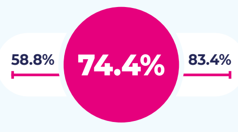
On-time screening for retinopathy of prematurity (ROP)

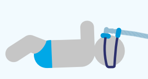
69% of eligible babies were screened on time for ROP.



Medical follow up at two years

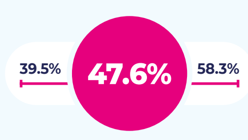
74.4% of babies born at less than 30 weeks had a documented medical follow up at the right time.

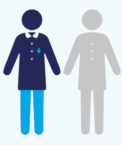




Non-invasive breathing support

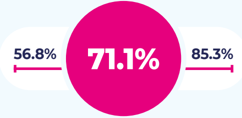
47.6% of babies born at less than 32 weeks received only non-invasive breathing support in the first seven days of life.





Neonatal nurse staffing

71.1% of nursing shifts were staffed according to recommended levels.



Further information and resources

For neonatal services, neonatal networks and NHS Health Boards/Trusts

Full annual results

Full annual results at neonatal unit and network levels, interactive reporting tools and unit posters are available on NNAP Online at: **www.nnap.rcpch.ac.uk**

Extended Analysis Report

The NNAP 2022 Data: Extended Analysis Report, providing in-depth results and a summary of findings by audit measure, along with full national recommendations, local quality improvement recommendations and links to case studies and useful resources is available at: **www.rcpch.ac.uk/nnap-report-2022-data**

For parents and families

Your Baby's Care Guide 2022

Parents and families can find more information about the NNAP and 2022 results in **Your Baby's Care**, a guide to the NNAP, while **NNAP Online** provides more in-depth results for each neonatal unit and network in England, Scotland 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 parents, visit **www.rcpch.ac.uk/your-babys-information** or scan the QR code with your phone to read our leaflet Your Baby's Information.

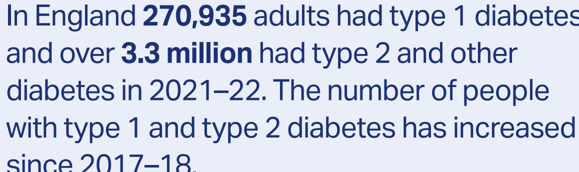
Publication, Part of National Diabetes Audit

National Diabetes Audit 2021-22, Report 1: Care Processes and Treatment Targets, Overview

Audit, Survey, Other reports and statistics

Publication Date: 12 Oct 2023
Geographic Coverage: England, Wales
Geographical Granularity: NHS Trusts, GP practices, Integrated Care Boards, Regions
Date Range: 01 Jan 2021 to 31 Mar 2022

National Diabetes Audit 2021-22, England



In England **270,935** adults had type 1 diabetes and over **3.3 million** had type 2 and other diabetes in 2021–22. The number of people with type 1 and type 2 diabetes has increased since 2017–18.

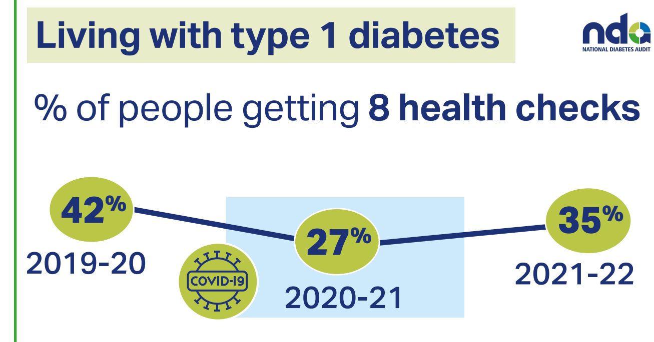
Diabetes is a serious condition. When you've got type 1 diabetes, you can't make insulin. If you've got type 2 diabetes you have some insulin but either you can't produce enough or it doesn't work effectively.

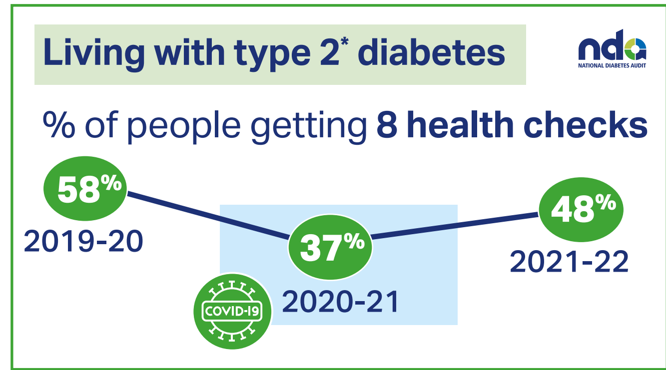
Diabetes can lead to health complications such as blindness, kidney failure and heart disease. But these complications can be prevented.

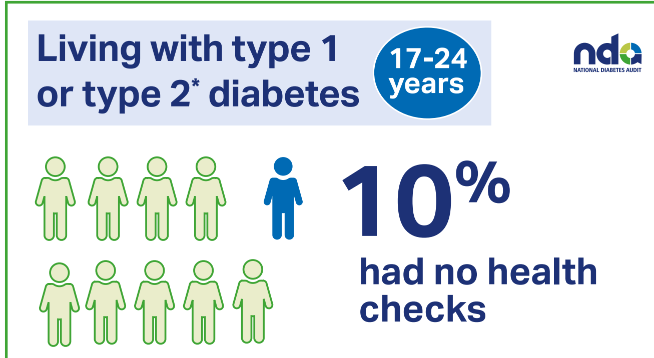
Everyone with diabetes should have healthcare checks at least once a year. Treatments may be adjusted to achieve recommended targets for HbA1c and blood pressure. Those with high heart risk should be prescribed a statin.

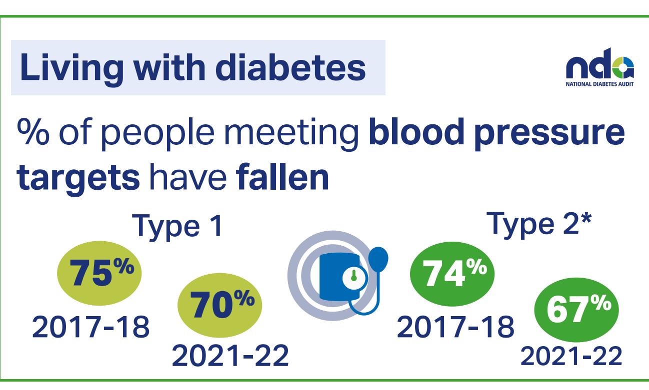
Completing all health checks and achieving the three treatment targets are the key to preventing complications.

Findings









* For this report type 2 diabetes refers to those with a diagnosis of type 2 diabetes and other rarer forms of diabetes such as MODY (Maturity Onset Diabetes of the Young) and LADA (Latent Autoimmune Diabetes in Adults) or unspecified diabetes

Find out more

1. National Diabetes Audit

2. Audit results for your local services
National Diabetes Audit dashboards

National Diabetes Audit 2021-22, Wales

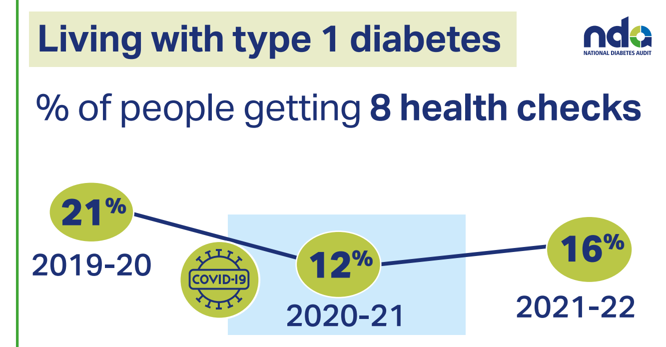
In Wales **16,090** adults had type 1 diabetes and **191,205** had type 2 and other diabetes in 2021-22. The number of people with type 1 and type 2 diabetes have increased since 2017-18.

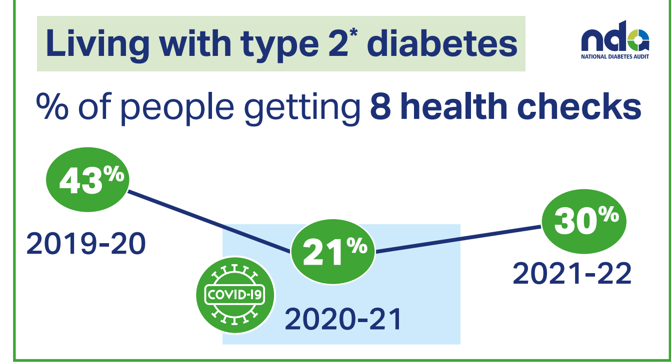
Diabetes is a serious condition. When you've got type 1 diabetes, you can't make insulin. If you've got type 2 diabetes you have some insulin but either you can't produce enough or it doesn't work effectively.

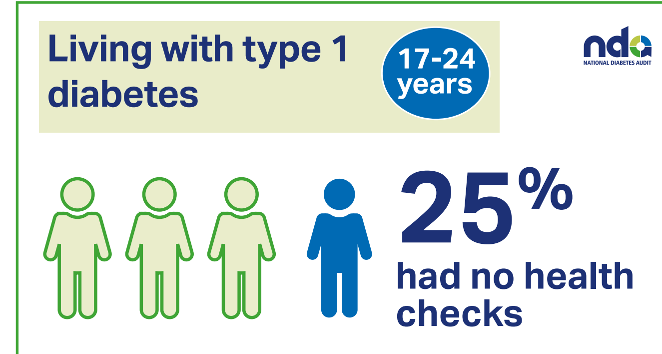
Diabetes can lead to health complications such as blindness, kidney failure and heart disease. But these complications can be prevented.

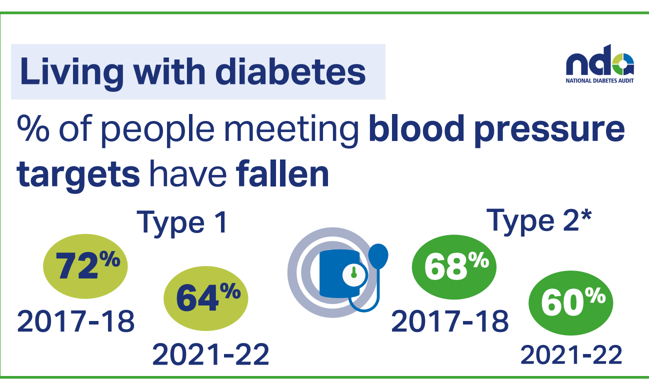
Everyone with diabetes should have healthcare checks at least once a year. Treatments may be adjusted to achieve recommended targets for HbA1c and blood pressure. Those with high heart risk should be prescribed a statin.

Completing all health checks and achieving the three treatment targets are the key to preventing complications.









* For this report type 2 diabetes refers to those with a diagnosis of type 2 diabetes and other rarer forms of diabetes such as MODY (Maturity Onset Diabetes of the Young) and LADA (Latent Autoimmune Diabetes in Adults) or unspecified diabetes

Find out more

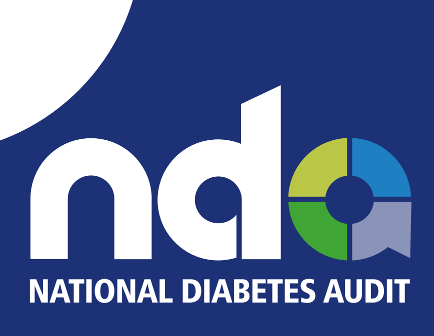
1. National Diabetes Audit

2. Audit results for your local services
National Diabetes Audit dashboards

Publication, Part of National Diabetes Audit, Type 1 Diabetes

National Diabetes Audit 2021-22, Type 1 Diabetes - Overview

Publication Date: 12 Oct 2023
Geographic Coverage: England, Wales
Geographical Granularity: Regions, Clinical Commissioning Groups, Integrated Care Boards
Date Range: 01 Jan 2021 to 31 Mar 2022



National Type 1 Diabetes Audit 2021-22, England and Wales

Type 1 diabetes is a serious condition where your blood glucose (sugar) level is too high because your body can't make a hormone called insulin.

227,435 adults in England and Wales have a diagnosis of type 1 diabetes. This report covers the period 1 January 2021 to 31 March 2022.

Having diabetes can lead to health complications such as blindness, kidney failure, heart disease and stroke. It is essential that everyone with diabetes receives certain healthcare checks every year.

The results of the checks can show whether someone is at risk of developing health complications.

Treatment should be adjusted where needed to achieve recommended HbA1c (average blood glucose) and blood pressure levels. Those with high heart risk should be prescribed a statin. These are known as the three treatment targets. Improvements are needed so all people receive the care that they need.

Findings

Since 2019-20 achievement of **blood glucose targets** has **improved**

of people in England were using wearable **glucose monitors** by March 2022*

Since 2019–20 achievement of **blood pressure targets** has **declined**

Type 1

Care, treatment and outcomes are dependent on **geography**, **age**, **ethnicity** and **deprivation**

*Data on wearable glucose monitors are not currently available for Wales

Find out more

1. National Type 1 Diabetes Audit

2. Audit results for your local services
   National Diabetes Audit dashboards

Publication, Part of National Pregnancy in Diabetes Audit

National Pregnancy in Diabetes Audit 2021 and 2022 (01 January 2021 to 31 December 2022)

Audit

Publication Date: 12 Oct 2023
Geographic Coverage: England, Wales
Geographical Granularity: Hospital and Community Health Services, Hospital Trusts, NHS Trusts

National Pregnancy in Diabetes Audit 2021 and 2022, England and Wales*

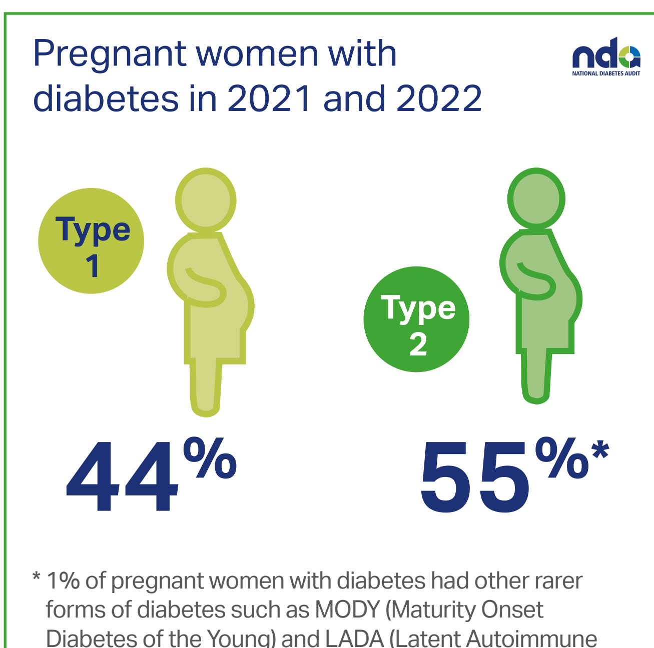
* This audit does not include pregnancies in women with gestational diabetes (diabetes that develops in pregnancy)

Diabetes is a serious condition where your blood glucose level is too high. When you've got type 1 diabetes, you can't make any insulin at all. If you've got type 2 diabetes you have some insulin but either you can't produce enough or it doesn't work effectively.

In 2021 and 2022 there were **10,055 pregnancies recorded for women with type 1 diabetes and type 2 diabetes**.

Most women with diabetes have a healthy baby, but having diabetes means that you and your baby are more at risk of serious health complications during pregnancy and childbirth. Planning for pregnancy when you have diabetes, and getting support from your healthcare team means you can really reduce the risks involved. Getting the right care at the right time and understanding how you can look after yourself means you're more likely to enjoy a healthy pregnancy and give birth to a healthy baby.

Findings



* 1% of pregnant women with diabetes had other rarer forms of diabetes such as MODY (Maturity Onset Diabetes of the Young) and LADA (Latent Autoimmune Diabetes in Adults) or unspecified diabetes

95% of women with type 1 diabetes wore **continuous glucose monitors** in 2022*

improving:

glucose levels for mothers

outcomes for women and babies

* Accurate data on CGM use has only been available since 2022

continued >

National Pregnancy in Diabetes Audit 2021 and 2022, England and Wales*

* This audit does not include pregnancies in women with gestational diabetes (diabetes that develops in pregnancy)

Findings continued

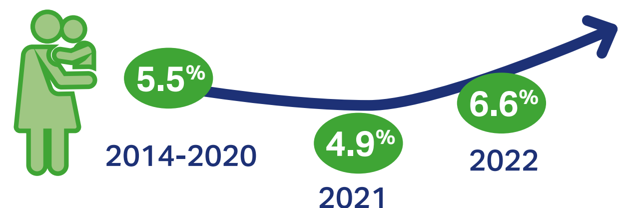
Pregnant women with **type 2 diabetes** are more likely than those with type 1 to be:

From ethnic minorities

Living in deprived areas

and to experience **health inequalities** before and during pregnancy. This finding is unchanged since 2014.

Rates of **serious outcomes** for women with **type 2** diabetes and their babies increased in 2022*



* Serious outcomes include miscarriage, stillbirth or neonatal death, or birth defect. It's important to remember that these outcomes are rare and there are many things you can do to reduce the risk

Find out more

1. National Pregnancy in Diabetes Audit 2021 and 2022 (01 January 2021 to 31 December 2022

2. Pregnancy and diabetes
3. Audit results for your local services National Diabetes Audit dashboards

National Vascular Registry

State of the Nation Report 2023

Results for patients who had vascular procedures during 2022 in NHS hospitals **in England, Wales, Scotland and Northern Ireland**

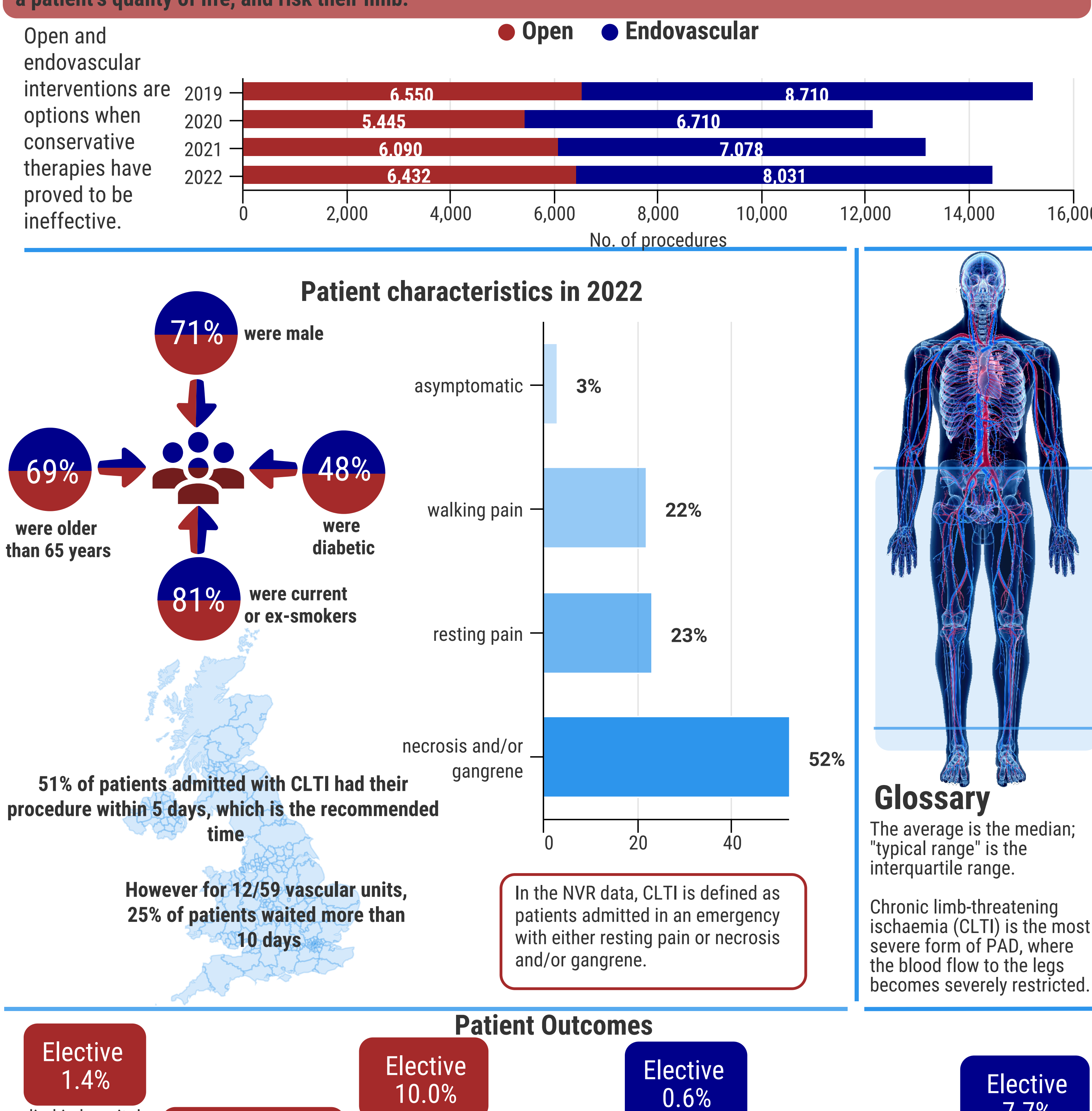
November 2023

Commissioned by:

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.



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

Open

- Died in hospital: Elective 1.4%; Emergency 4.6%
- Were readmitted within 30 days: Elective 10.0%; Emergency 13.6%
- Average length of stay (typical range): Elective 5 days (3-8 days); Emergency 14 days (9-26 days)

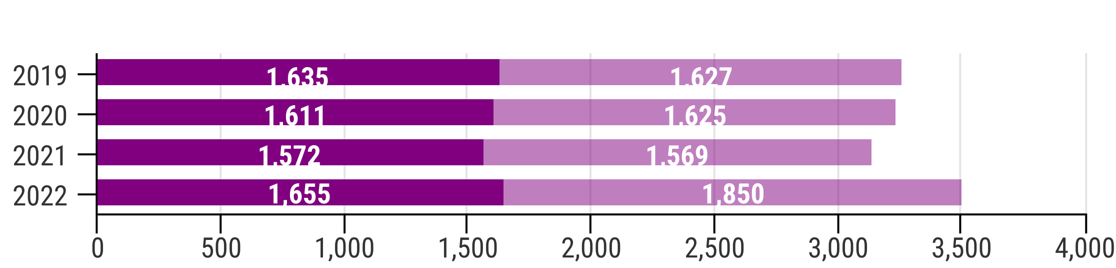
Endovascular

- Died in hospital: Elective 0.6%; Emergency 4.2%
- Were readmitted within 30 days: Elective 7.7%; Emergency 16.8%
- Average length of stay (typical range): Elective 0 days (0-1 days); Emergency 14 days (7-27 days)

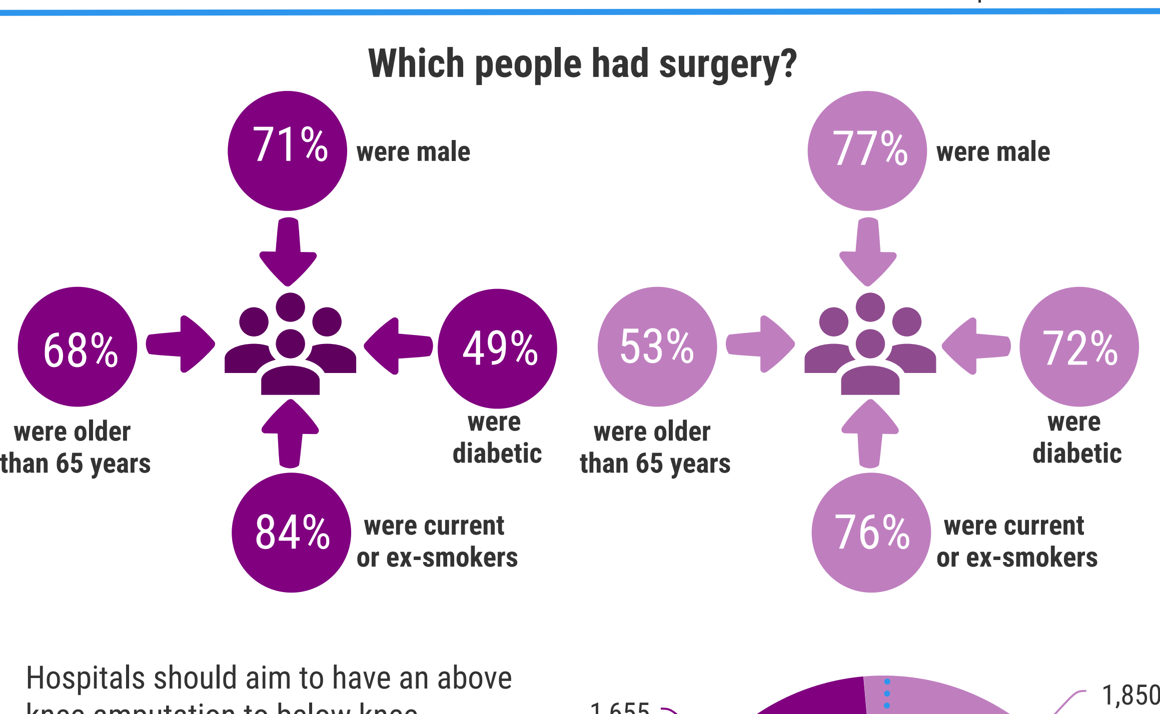
Lower limb major amputation for peripheral arterial disease

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.

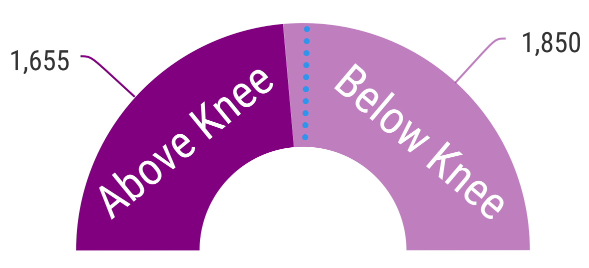
PAD can gradually progress in some patients and an operation to improve blood flow may no longer be possible. In these situations, people will require amputation of the lower limb. Additionally, patients without PAD but with a complication of diabetes may require a major amputation.

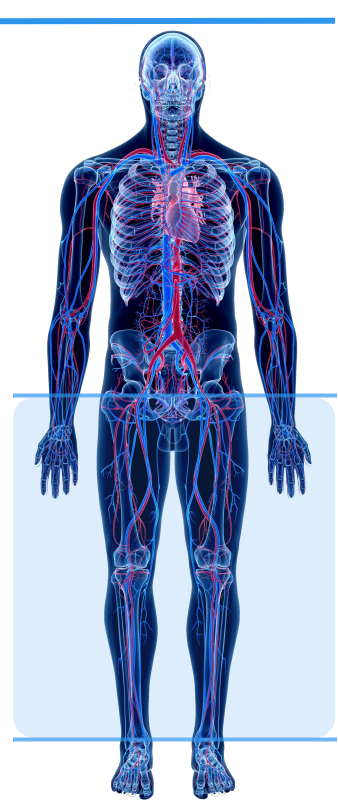


Which people had surgery?



Hospitals should aim to have an above knee amputation to below knee amputation ratio below 1. In 2022, the national ratio was 0.89, but it varied greatly across the country. 24 hospitals had a ratio above 1, and of these, 6 were above 2.

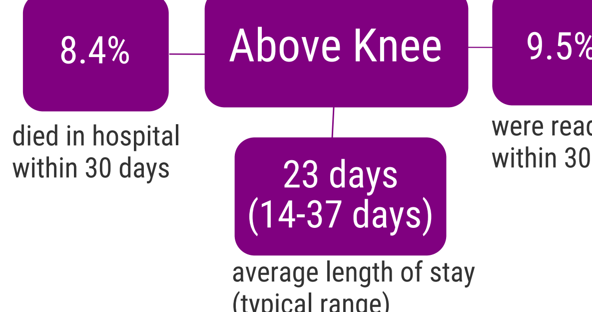




Glossary

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

Patient outcomes after surgery



Below Knee

4.4% died in hospital within 30 days

9.8% were readmitted within 30 days

22 days (14-38 days) average length of stay (typical range)

Repair of abdominal aortic aneurysm (AAA) to prevent rupture

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

● Open ● EVAR

Year	Open	EVAR
2019	1,378	2,173
2020	945	1,454
2021	1,128	1,730
2022	1,144	1,689

0 500 1,000 1,500 2,000 2,500 3,000 3,500 4,000

No. of procedures

Open

- 93% were male
- 79% were older than 65 years
- 64% had hypertension
- 85% were a current or ex-smoker

EVAR

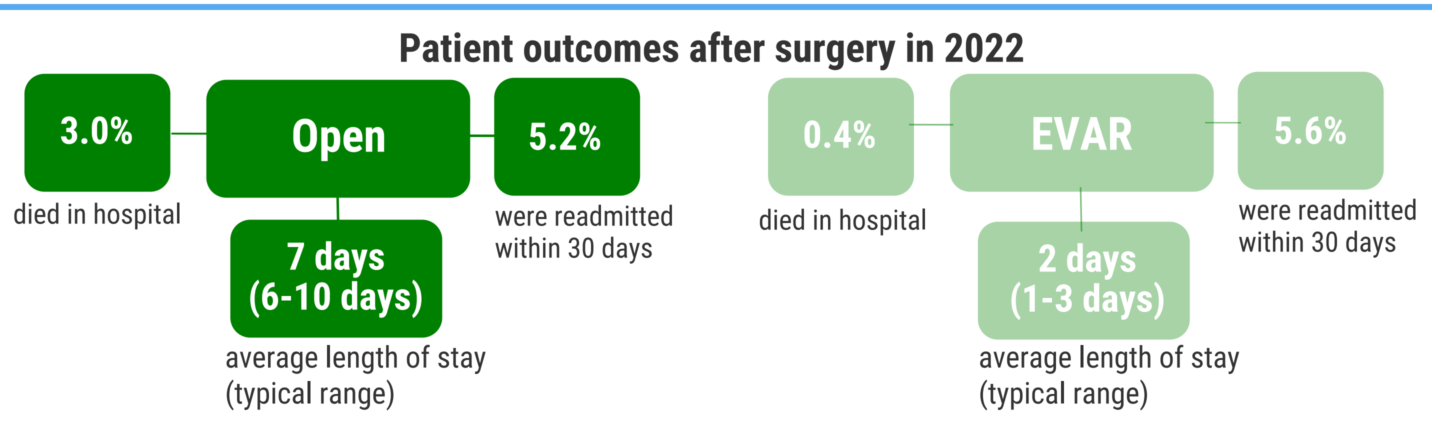
- 91% were male
- 95% were older than 65 years
- 68% had hypertension
- 83% were a current or ex-smoker

How were patients assessed?

- 88% discussed at multi-disciplinary team meeting
- 83% had fitness measured
- 94% had pre-operative CT/MR angiography assessment
- 97% had formal anaesthetic review
  - 92% of these had review by consultant vascular anaesthetist

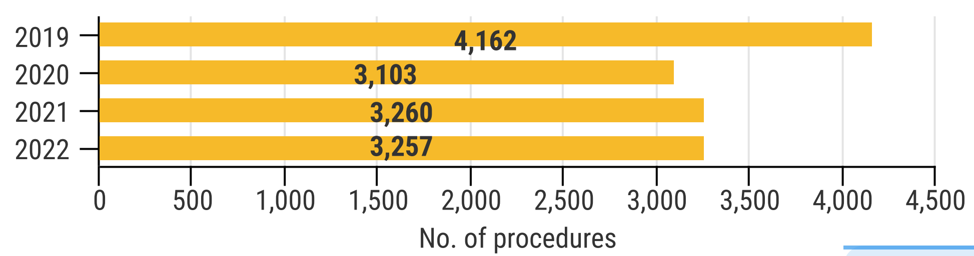
Glossary

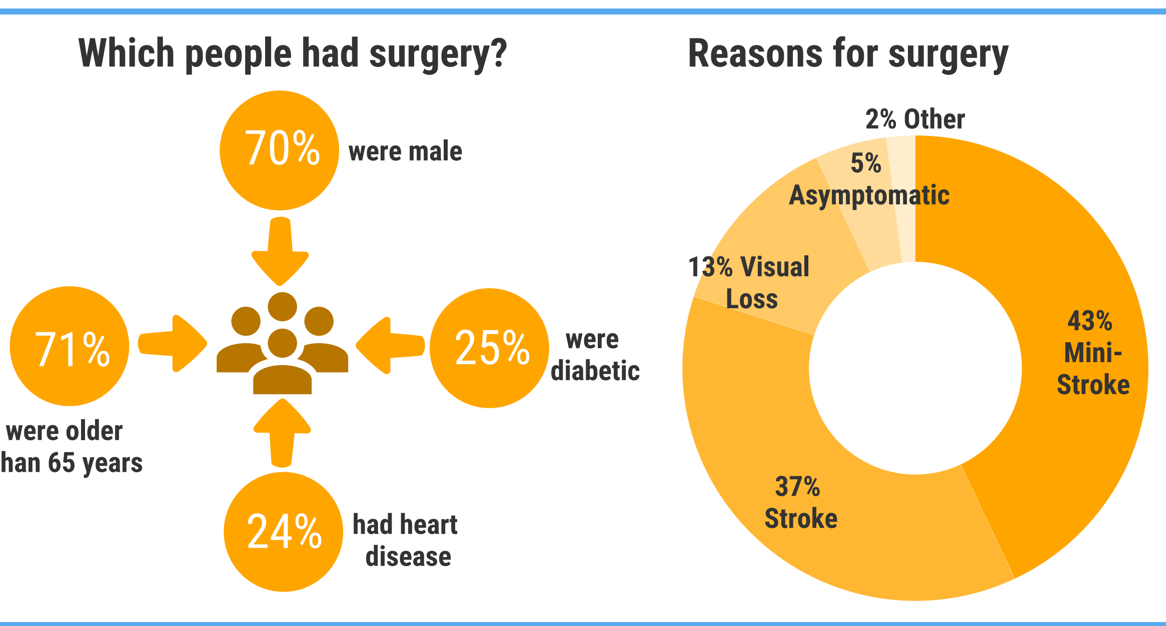
The average is the median; "typical range" is the interquartile range.

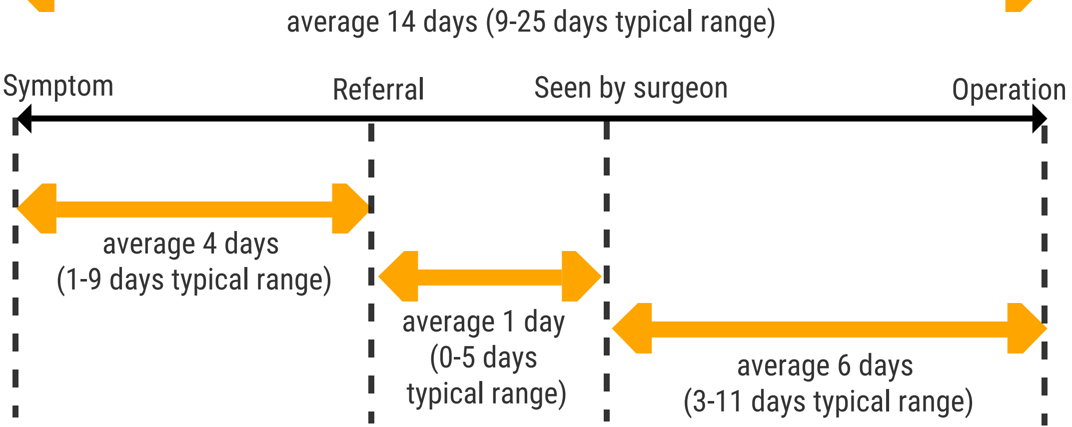


Carotid artery surgery to prevent stroke

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







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.

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

Outcomes of surgery

CEA

2.1% died and/or had a stroke within 30 days of the procedure

4.5% were readmitted within 30 days

2 days (1-4 days) average length of stay (typical range)

SSNAP Annual Report 2023

Stroke care received between April 2022 to March 2023

SSNAP
Sentinel Stroke National Audit Programme

Commissioned by

Summary of results for people admitted to hospital with stroke

High Quality Specialist Stroke Care

73% of patients spent at least 90% of hospital stay on a specialist stroke unit ↓ ***(77% 2021/22)***	**89%** of patients received stroke specialist nursing assessment within 24hrs of admission ↓ ***(90% 2021/22)***	**72%** of applicable patients received swallow screening within 4hrs of admission ***= (72% 2021/22)***

Seven Day Priority Clinical Standards of Stroke Care

40% of patients were directly admitted to a stroke unit within 4hrs of hospital arrival ↓ ***(44% 2021/22)***	**83%** of patients were assessed by a stroke specialist within 24hrs of admission ↓ ***(84% 2021/22)***	**57%** of patients received brain imaging within 1hr of hospital arrival ↑ ***(55% 2021/22)***

Reperfusion Treatment

54 minutes median time from arrival at hospital to thrombolysis treatment ↑ ***(53 minutes 2021/22)***	**10.7%** of all stroke patients received thrombolysis ↑ ***(10.4% 2021/22)***	**3.1%** of all stroke patients underwent a thrombectomy ↑ ***(2.5% 2021/22)***

Delivery of Inpatient Rehabilitation

% of applicable patients receiving the equivalent of 45 minutes of therapy 5 days a week

25% physiotherapy ↓ ***(27% 2021/22)***	**30%** occupational therapy ↓ ***(32% 2021/22)***	**14%** speech and language therapy ↓ ***(15% 2021/22)***

Community Rehabilitation

61% of patients discharged to a stroke/neurology specific community rehabilitation service ↑ ***(60% 2021/22)***	**49%** of community rehabilitation services registered as a combined ESD-CRT services ↑ ***(26% 2021/22)***	**6%** of patients were working full-time 6 months after stroke compared with 15% prior to stroke ***= (6% and 14% 2021/22)***

Longer Term Outcomes

37% of applicable patients received a 6 month follow-up ↓ ***(41% 2021/22)***	**17%** of patients at 6 months reported moderate or severe anxiety or depression ↓ ***(18% 2021/22)***	**3%** of patients had a recurrent stroke within 6 months ↑ ***(2.8% 2021/22)***

Publication, Part of National Diabetes Audit: Non-Diabetic Hyperglycaemia, Diabetes Prevention Programme

Non-Diabetic Hyperglycaemia, 2021-22, Diabetes Prevention Programme, Overview

Publication Date: 14 Dec 2023

Geographic Coverage: England

Geographical Granularity: Country, Provider

Date Range: 01 Jan 2021 to 31 Mar 2022

Non-diabetic hyperglycaemia (NDH) and the Diabetes Prevention Programme audit 2021-22, England

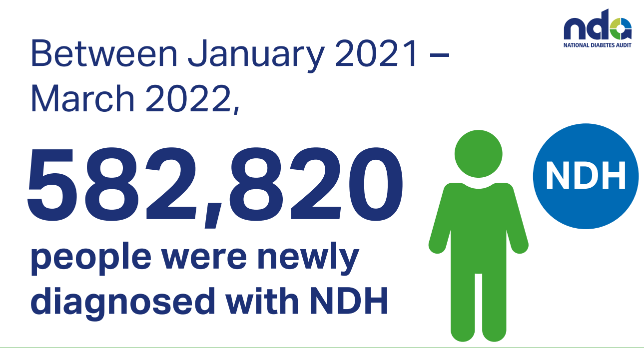
NDH (also referred to as prediabetes) means your blood glucose is higher than usual, but not high enough for you to be diagnosed with type 2 diabetes. NDH is a warning sign that you are at high risk of developing type 2 diabetes.

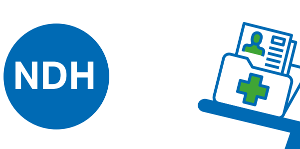
If you are identified as being high risk, your GP or nurse can refer you on to the NHS Diabetes Prevention Programme (DPP). The DPP is a behaviour change programme that supports people to maintain a healthy weight, improve nutrition and be more active. These things have been proven to reduce the risk of developing type 2 diabetes.

Every year people with NDH should have a blood test to check blood glucose levels and a weight measurement taken.

This report covers people with a diagnosis of NDH between 1 January 2021 and 31 March 2022.

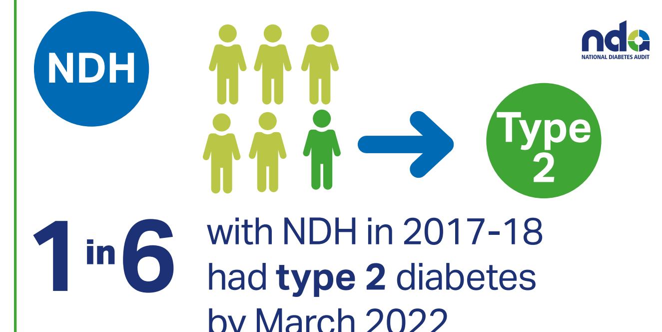
Findings





% of people getting the **two checks*** varies due to **geography**, **sex**, **age**, **ethnicity** and **deprivation**

* blood test to check glucose levels and weight measurements



Completing the DPP reduced the rate of progression to **type 2 diabetes**

Referred, but **did not attend DPP**	**21%**	developed **type 2** diabetes
Completed DPP	**15%**	developed **type 2** diabetes

Find out more

1. National Diabetes Audit

2. Audit results for your local services National Diabetes Audit dashboards

Publication, Part of National Diabetes Audit: Young People with Type 2 Diabetes

National Diabetes Audit 2021-22, Young People with Type 2 Diabetes - Overview

Publication Date: 14 Dec 2023
Geographic Coverage: England, Wales
Date Range: 01 Jan 2021 to 31 Mar 2022

National Diabetes Audit: Young people with type 2 diabetes 2021–22, England and Wales

Type 2 diabetes is a serious condition where your pancreas can't make enough insulin. This means your blood glucose (sugar) levels keep rising.

In the period January 2021 to March 2022 139,255 children, young people and adults under 40 in England and Wales had type 2 diabetes. The number of people with type 2 diabetes rose faster in this age group than in those aged 40-79.

Having diabetes can lead to complications such as blindness, kidney failure and heart disease. Everyone with diabetes should receive certain health checks every year. The results of these show whether someone is at risk of developing health complications.

Treatment should be adjusted to help achieve recommended targets for blood glucose and blood pressure. Those with heart risk should be prescribed a statin.

Findings

People **under 40 with type 2 diabetes** were more likely to be:

- Asian or mixed ethnicity
- Living in deprived areas
- Female

than people 40 and over with type 2 diabetes

Compared to people with **type 2** diabetes aged 40 and over, those **under 40** were **less likely to:**

Receive all the healthcare checks they need

Those under 40 were **less likely** to achieve **blood glucose targets** if they:

Lived in deprived areas

Had diabetes for longer

Find out more

1. National Diabetes Audit: Young Type 2

2. Audit results for your local services National Diabetes Audit dashboards

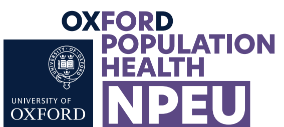
Maternal, Newborn and Infant Clinical Outcome Review Programme

MBRRACE-UK Perinatal Confidential Enquiry

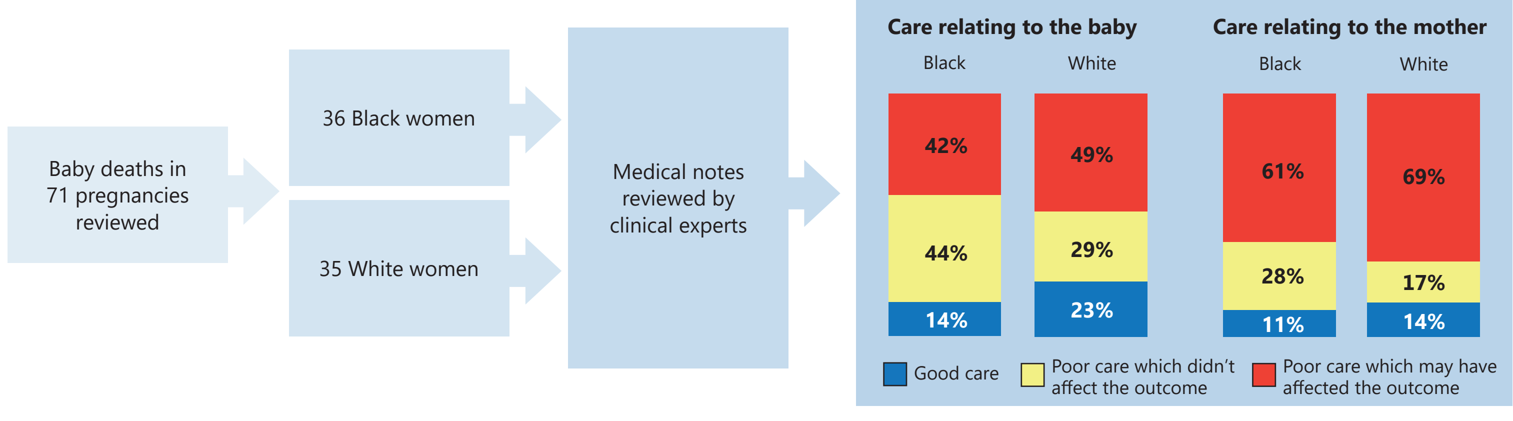
A comparison of the care of Black and White women who have experienced a stillbirth or neonatal death

State of the Nation Report

December 2023



Comparing the care of Black and White women whose babies died



Finding	Recommendation
Women's ethnicity, nationality and citizenship status was not always recorded well.	All women should be asked about their ethnicity, nationality and citizenship status, to help provide care that is tailored to their specific needs.

Finding	Recommendation
When a woman's first language wasn't English and she needed an interpreter, this wasn't always provided.	Women should be offered information about maternity care in different ways. An interpreter should be offered at each appointment, if the woman needs it to understand the information she is given or to talk to her doctor or midwife.

Finding	Recommendation
Some women faced challenges in their personal lives which were not always recognised or taken into account when planning their care. These challenges were more common for White women.	Information about women's personal and social risk factors should be recorded, and updated throughout the pregnancy, so that extra support can be provided if it is needed.

Finding	Recommendation
Some Black women found it difficult to get certain types of care or advice, even if it was offered to them.	Maternity care should be personalised to the needs of each woman. Women should be helped to overcome any problems that make it hard for them to get the care they need.

Finding	Recommendation
Blood tests to check for gestational diabetes were not offered to 1 in 3 Black women. Almost all White women who should have been tested were offered a test.	All women with risk factors for gestational diabetes, which includes all Black women, should be offered a test between 24 and 28 weeks of pregnancy.

Finding	Recommendation
All the Black women should have been offered a high dose of Vitamin D to take during their pregnancy, but none of them were.	All women should be offered Vitamin D to take during pregnancy, and women with darker skin or a BMI over 30 should be offered a higher dose.

Finding	Recommendation
Bereavement care was good for most parents.	Family-centred bereavement care, in line with the National Bereavement Care Pathway, should be offered to all parents.

Finding	Recommendation
Almost all baby deaths were reviewed using the Perinatal Mortality Review Tool. The hospital reviews were more positive than the conclusions reached by the confidential enquiry panels.	Hospitals should make sure that reviews are carried out by enough people from the right specialties. At least one of these people should be from another hospital.

Finding	Recommendation
When a review did take place, most parents didn't have any questions or talk about their experience, especially if they didn't speak English.	As part of the review process, parents should be supported to ask questions and talk about their experience, to ensure they receive answers about why their baby died.

Finding	Recommendation
Most parents had a follow-up meeting with their consultant to review their care, but not all had a letter summarising what they talked about. Black parents were less likely to receive a letter than White parents.	All parents should have a follow-up meeting (jointly with their obstetrician and neonatal doctor, if appropriate) to review their and their baby's care, and a clear and personalised written summary should be given to the parents.

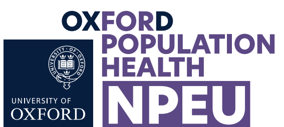
Maternal, Newborn and Infant Clinical Outcome Review Programme

MBRRACE-UK Perinatal Confidential Enquiry

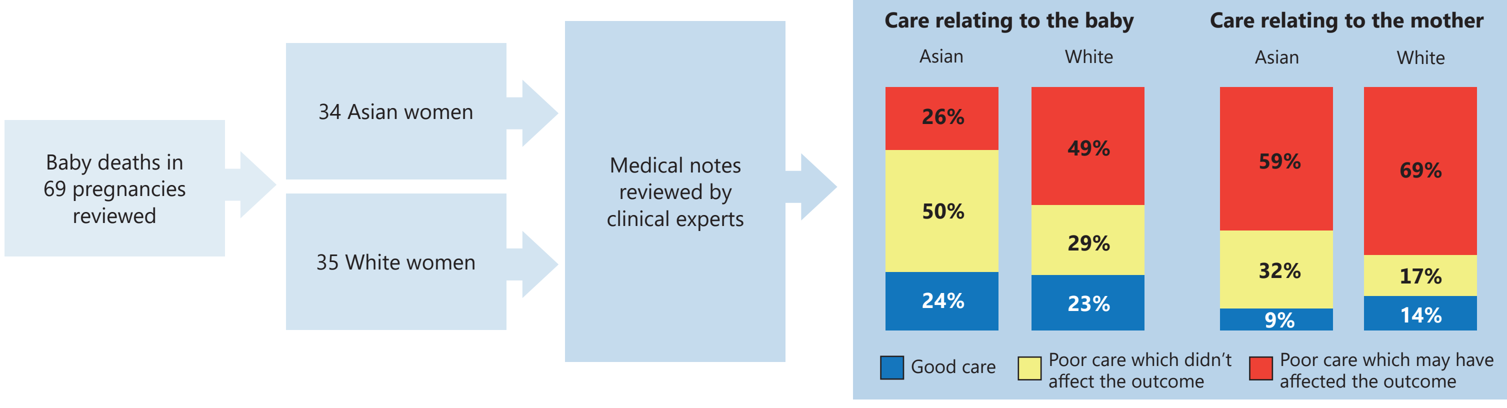
A comparison of the care of Asian and White women who have experienced a stillbirth or neonatal death

State of the Nation Report

December 2023



Comparing the care of Asian and White women whose babies died



Women's ethnicity, nationality and citizenship status was not always correctly written in the notes.

All women should be asked about their ethnicity, nationality and citizenship status, and it should be written in the her notes. Care should be planned based on each woman's specific needs.

When a woman's first language wasn't English and she needed an interpreter, this wasn't always provided. More Asian women needed an interpreter.

Women should be offered information about maternity care in different ways. An interpreter should be offered at each appointment, if the woman needs one to understand the information she is given or to talk to her doctor or midwife.

Some women faced challenges in their personal lives which were not always recognised or taken into account when planning their care. These challenges were more common for White women.

Information about women's personal and social risk factors should be written in the notes, and updated throughout the pregnancy, so that extra support can be offered if it is needed.

Asian women were more likely to decline screening for chromosomal conditions when it was offered. Almost all White women chose to accept the offer of screening.

Women should be given information about antenatal screening tests, translated where necessary. If a woman chooses to have any of the tests, she should be offered an appointment to talk about the results and her future choices.

Blood tests to check for gestational diabetes were not offered to 1 in 5 Asian women. Almost all White women who should have been tested were offered a test.

All women with risk factors for gestational diabetes, which includes all Asian women, should be offered a test between 24 and 28 weeks of pregnancy.

All the Asian women should have been offered a high dose of Vitamin D to take during their pregnancy, but only 1 in 10 were.

All women should be offered Vitamin D to take during pregnancy, and women with darker skin or a BMI over 30 should be offered a higher dose.

Bereavement care was good for most parents, but White women were more likely to be seen by a midwife once they had left hospital.

Family-centred bereavement care, in line with the National Bereavement Care Pathway, should be offered to all parents.

Almost all baby deaths were reviewed using the Perinatal Mortality Review Tool. The hospital reviews were more positive than the conclusions reached by the confidential enquiry panels.

Hospitals should make sure that reviews are carried out by enough people from the right specialties. At least one of these people should be from another hospital.

When a review did take place, most parents didn't have any questions or talk about their experience, especially if they didn't speak English.

As part of the review process, parents should be supported to ask questions and talk about their experience, to ensure they receive answers about why their baby died.

Most parents had a follow-up meeting with their consultant to review their care, but not all had a personalised letter summarising what they talked about. Asian parents were less likely to receive a letter than White parents.

All parents should have a follow-up meeting (jointly with their obstetrician and neonatal doctor, if appropriate) to review their and their baby's care, and a clear and personalised written summary should be given to the parents.

Paediatric Intensive Care Audit Network

National Paediatric Critical Care Audit

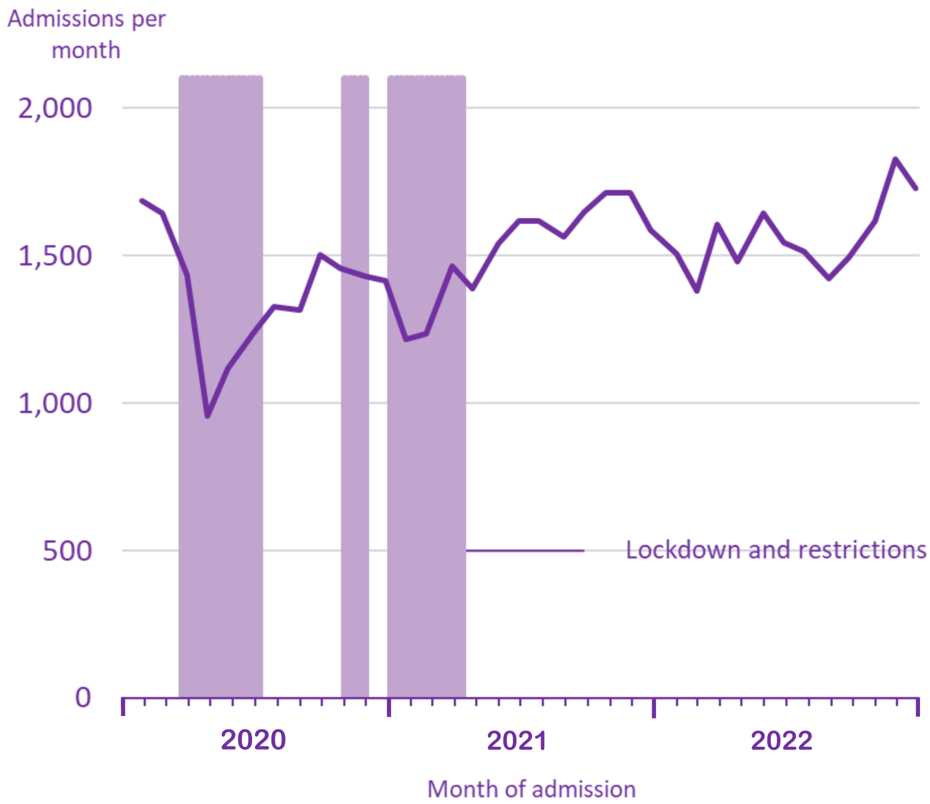
State of the Nation Report 2023

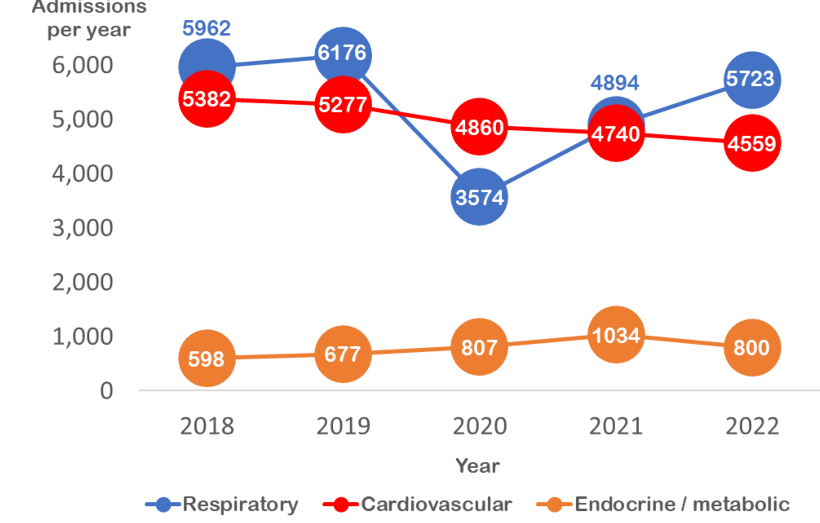
Summary Report

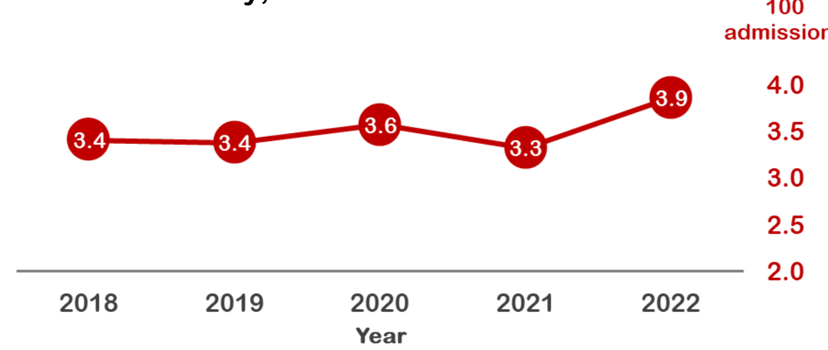
Data collection period: January 2020 – December 2022

Published 2023

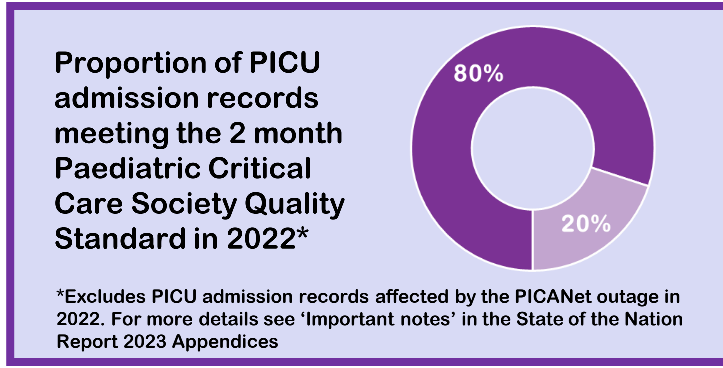
State of the Nation Report 2023



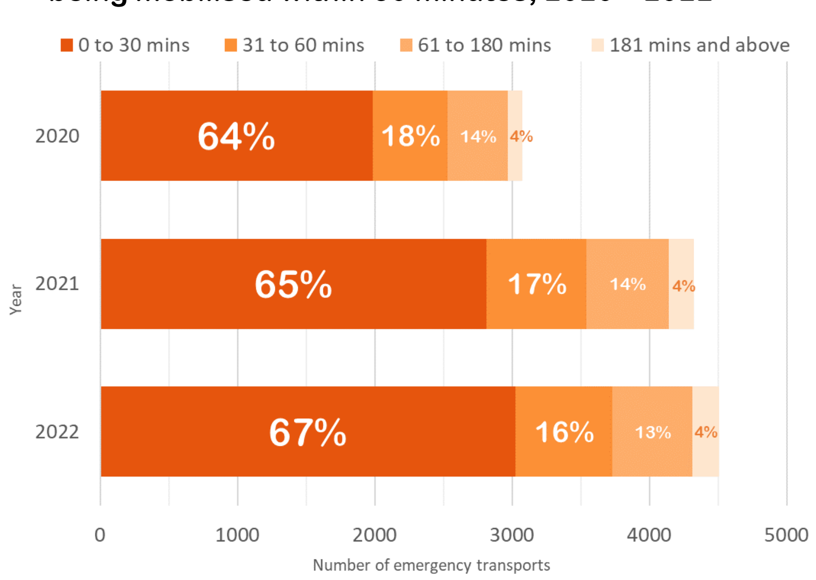




Key Metrics



Increase in the proportion of emergency transports being mobilised within 30 minutes, 2020 – 2022



Ethnic distribution of PICU admissions

Legend: Not stated or unknown; Black, African, Caribbean or Black British; White; Other ethnic group; Asian or Asian British; Mixed or multiple ethnic groups

	2019	2020	2021
Not stated or unknown	14%	12%	11%

Axis: 0%, 10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%, 100%

PICU admissions by deprivation level

Least deprived → Most deprived

General population	20%	20%	20%	20%	20%
PICU admissions	14%	15%	18%	22%	31%

Deprivation level

Admissions to PICU are more likely to be from the most deprived areas when compared to the general population