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

Q1 (April – June 2026), updated 12/06/2026

PUBLICATION DATE	HEALTHCARE AREA	TYPE	PROJECT NAME	LEAD PROVIDER	FULL REPORT TITLE	HQIP WEBLINK TO REPORT	DOC NUMBER
2026/05/14	Long term conditions	Audit	NRAP - National Respiratory Audit Programme	RCP: Royal College of Physicians	Wales primary care clinical audit report 2023 - 25	https://www.hqip.org.uk/report/nrap-ref651/	0.01
2026/05/14	Acute	Audit	NELA - National Emergency Laparotomy Audit	RCoA: Royal College of Anaesthetists	2026 Patient Report of the National Emergency Laparotomy Audit around Standards of Care for Patients who do not Undergo Emergency Laparotomy ('NoLap' cohort)	https://www.hqip.org.uk/report/nela-ref715/	0.02
2026/06/11	Long term conditions	Audit	NAD - National Audit of Dementia	RCPsych: Royal College of Psychiatrists	Survey of Memory Assessment Services in England, Wales and Jersey 2025	https://www.hqip.org.uk/report/nad-730/	0.03
2026/06/11	Acute	Clinical Outcome Review Programme	Medical and Surgical Clinical Outcome Review Programme	NCEPOD: National Confidential Enquiry into Patient Outcome and Death	Learning TogetherLearning Together, A review of the quality of care provided to adults with a learning disability when admitted to hospital acutely unwell.	https://www.hqip.org.uk/report/ncepod-720/	0.04
2026/06/11	Cancer	Audit	NOCA - National Ovarian Cancer Audit	NATCAN: National Cancer Audit Collaborating Centre	National Ovarian Cancer Audit State of the Nation Report 2026	https://www.hqip.org.uk/report/noca-natcan-719/	0.05
2026/06/11	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 of babies born in 2024, State of the nation report	https://www.hqip.org.uk/report/mbrrace-705/	0.06

Royal College of Physicians

National Respiratory Audit Programme (NRAP)

Wales primary care clinical audit report 2023–25

Publication year: 2026

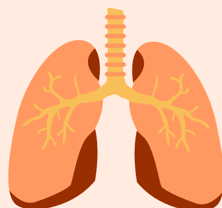
Report at a glance

COPD

During 2023–25

Patients diagnosed with COPD in the last 2 years who have a post-bronchodilator spirometry code available in the last 2 years

23.5%

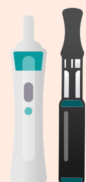


Patients with COPD who are breathless (MRC score 3–5) and have been referred to pulmonary rehabilitation in the last 3 years

16.4%

Patients with COPD **who did not have a record of their smoking status** in the last 15 months

29.6%



Patients with COPD **who did not have a record of their vaping status** in the last 15 months

98.1%

Adult asthma

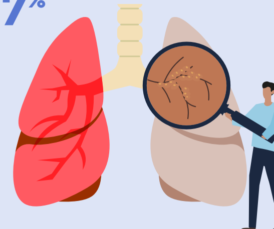
During 2023–25

Adults diagnosed with asthma who have a record of at least one objective measurement* in the last 2 years

62.1%

Adults with asthma who had a personalised asthma action plan (PAAP) in the last 15 months

28.7%

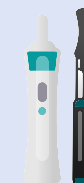


Adults with asthma **who did not have a record of their smoking status** in the last 15 months

35.5%

Adults with asthma **who did not have a record of their vaping status** in the last 15 months

98.2%



CYP asthma

During 2023–25

Children and young people (CYP) diagnosed with asthma who have a record of at least one objective measurement* in the last 2 years

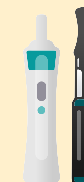
47.4%

CYP (aged 14–18 years) with asthma **who did not have a record of their smoking status** in the last 15 months

65.4%

CYP with asthma who had a personalised asthma action plan (PAAP) in the last 15 months

24.0%



CYP (aged 14–18 years) with asthma **who did not have a record of their vaping status** in the last 15 months

98.6%

*One objective measurement includes spirometry, peak flow with greater than one reading, or evidence of peak flow diary or recorded FeNO

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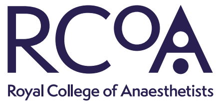

2026 Patient Report of the National Emergency Laparotomy Audit around Standards of Care for Patients who do not Undergo Emergency Laparotomy ('NoLap' cohort)

April 2024 to April 2025

May 2026

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Overview

In its first year, the NoLap audit includes records on 943 patients from 91 hospitals (826 [87.6%] from England, 44 [4.7%] from Wales and 73 [7.7%] from Northern Ireland) representing approximately 50.6% of sites submitting operative NELA data. Among these patients, 58.6% were women and 41.4% were men.

Bowel condition	Number of patients, n (%)
Bowel perforation	459 (48.7)
Bowel ischaemia	330 (35.0)
Bowel perforation and ischaemia	58 (6.2)
Not stated*	96 (10.2)

*Not explicitly indicated by user in Q6.15

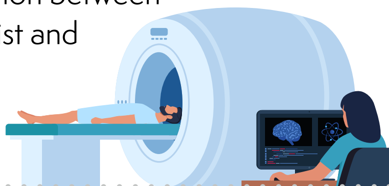
OUTCOMES

Median **length of stay** from date of hospital admission was **10 days** (range 0–384 [IQR 5–20] days).

Mortality at 30 days following admission was **80.2%**.

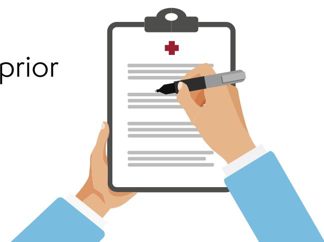
CT SCANNING

Overall, **919 (97.5%) patients had a CT scan** following admission. In 48.1% of patients, a report was issued within one hour of scanning. For **36.6%** of patients, there was a record of direct communication between reporting radiologist and a member of the referring team.



RISK ASSESSMENT

72.3% received a formal assessment of mortality risk prior to a decision not to proceed with surgery.



CARE OF THE OLDER PERSON

85.8% of patients aged 65 or older had a formal assessment of frailty performed.

ADVANCE CARE PLANNING

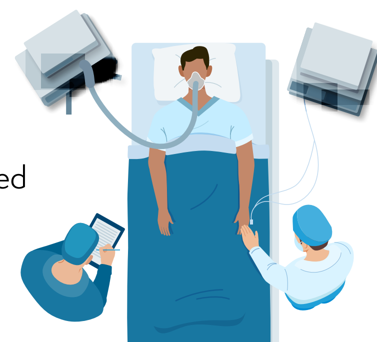
579 (61.4%) NoLap patients did not have any form of pre-existing advance care plan available prior to the decision not to operate.

While 160 (72.1%) patients discharged from hospital alive had a do not attempt cardiopulmonary resuscitation (DNACPR) in place, only around a third **(83, 37.4%)**, had any type of formal advance care plan documented.

END-OF-LIFE CARE

80.3% of patients who died in hospital had a documented end-of-life care plan.

59.7% of patients who died in hospital received direct input from a member of the palliative care team.



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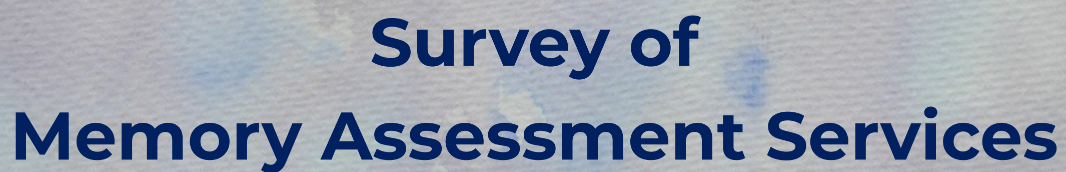
020 7092 1676 nela@rcoa.ac.uk data.nela.org.uk @NELANews



Survey of Memory Assessment Services

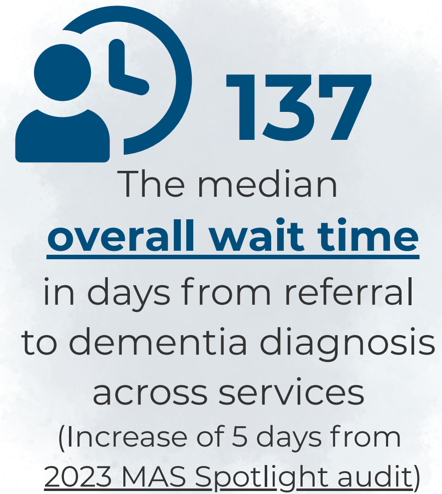
in England, Wales and
Jersey 2025

June 2026

Survey of Memory Assessment Service in England, Wales, and Jersey

Key Findings

Service demand rises proportionally with population (an increase in investigations size) - approximately **2 additional referrals** for every **1,000 people** covered



137

The median **overall wait time** in days from referral to dementia diagnosis across services

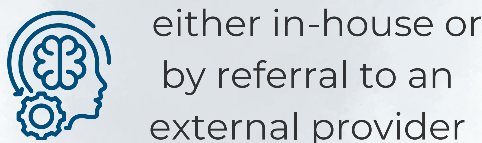
(Increase of 5 days from 2023 MAS Spotlight audit)

Low Staff Vacancies

50% of services reported **no vacancies**

42% of services reported **0-10% vacancies**

95% of services offer **post-diagnostic medication review** at 3 months



77% of services **can provide cognitive stimulation therapy** either in-house or by referral to an external provider

23% of services **do not provide CST**

Incomplete Data Issues

Many services could not return all requested data, in particular **diagnostic data**

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RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

NAD NATIONAL AUDIT OF DEMENTIA

Learning Together

A review of the quality of care provided to adults with a learning disability when admitted to hospital acutely unwell.

NCEPOD

Improving the quality of healthcare

IMPROVING THE CARE PROVIDED TO PATIENTS WITH A LEARNING DISABILITY ADMITTED TO HOSPITAL

NCEPOD reviewed the care of adults with a diagnosed learning disability who attended/were admitted to hospital as an emergency between 1st July and 30th September 2024. Care was reviewed using 666 clinician questionnaires, 366 sets of case notes, 144 primary care questionnaires, 199 organisational questionnaires, 832 healthcare professional survey responses and 82 patient/carer surveys.

Use the correct terminology. LEARNING DISABILITY and LEARNING DIFFICULTY are not the same and using 'LD' does not help.

119/366 (32.5%) patients were described as having a learning difficulty rather than a learning disability and the two terms were often used interchangeably.

LEARNING DISABILITY

Describes a significant impairment of intellectual and social functioning, both arising before adulthood

LEARNING DIFFICULTY

Describes the way a person learns specific skills or processes information

Accurately record a person's identified learning disability in the electronic patient record/clinical notes and in learning disability registers/lists.

175/196 (89.7%) organisations reported using alerts or flags on electronic patient records. However, only **310/583 (53.2%)** patients had such alerts.

Assess and implement reasonable adjustments for patients with a learning disability – ideally proactively.

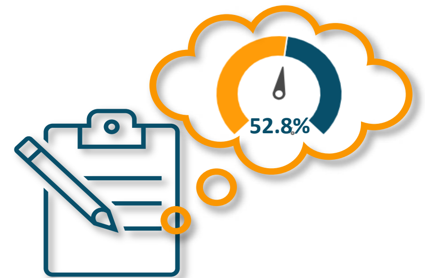
Only **292/666 (43.8%)** patients and/or their carer were asked if any reasonable adjustments were needed during the admission.

Reasonable adjustments were more likely if there was an alert on the patient's record.

Use decision support tools to aid healthcare professionals assessing mental capacity in patients with a learning disability.

121/229 (52.8%) patients who did not have a formal assessment **should have** received one.

Only **169/277 (61.0%)** healthcare professionals reported being confident in undertaking mental capacity assessments in patients with a learning disability.



Consistently and continuously involve people with a learning disability in their care during a hospital admission.

200/366 (54.6%) patients were involved in **decisions regarding their care** in the acute setting and in **148/353 (41.9%)** cases there was **no involvement** of the patient or the patient's carer **at discharge.**

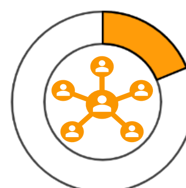
54.6% of patients involved during their stay

41.9% of patients/carers involved at discharge

Commission equitable acute hospital learning disability services.

Only **35/186 (18.8%)** learning disability services were **multidisciplinary, 69/186 (37.1%)** were a **single profession** and **82/186 (44.1%) a single individual.**

Multidisciplinary team



Single profession team

One person

NOCA

National Ovarian Cancer Audit

NATCAN

National Cancer Audit Collaborating Centre

National Ovarian Cancer Audit State of the Nation Report 2026

An audit of care received by women diagnosed with ovarian cancer between 1 January 2022 and 31 December 2023 in England and 1 January 2022 and 31 December 2024 in Wales.

Published June 2026

2. Infographic

NOCA
National Ovarian Cancer Audit

Summary of results for women diagnosed with ovarian cancer in England (2022-2023) and Wales (2022-2024)

Diagnosis

5,601

diagnoses of ovarian cancer in England in 2023

274

diagnoses of ovarian cancer in Wales in 2024

(excluding borderline ovarian tumours)

Stage at diagnosis

England in 2023

Wales in 2024

Approximately three out of four women in England and seven out of ten women in Wales with ovarian cancer were diagnosed with stage 2-4 disease.

(based on those with complete staging information - 76.4% in England and 85.4% in Wales)

Emergency admissions

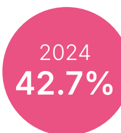
Approximately four out of ten women diagnosed in England in 2023 and in Wales in 2024 had an emergency admission within 28 days prior to diagnosis.

England

2022 **40.1%**

2021 **41.4%**

Wales



2023 **41.3%**

2022 **40.6%**

Receipt of any treatment (surgery and/or chemotherapy) for women with emergency admission prior to diagnosis*

59.7% E **England** 2022 **61.3%**

70.1% W **Wales** 2023 **71.0%**

of women who had an emergency admission prior to ovarian cancer diagnosis in England (E) in 2023 and in Wales (W) in 2024 had any treatment recorded within three months of diagnosis.

Receipt of any treatment (surgery and/or chemotherapy)

73.5% E **England** 2022 **74.2%** 2021 **72.7%**

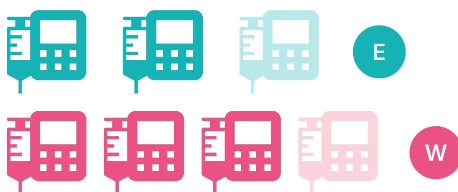
76.0% W **Wales** 2023 **80.3%** 2022 **76.7%**

of women diagnosed with stage 2-4 or unstaged ovarian cancer in England in 2023 and in Wales in 2024 had any treatment recorded within nine months of diagnosis.

Surgery

Approximately one out of two women diagnosed with stage 2-4 or unstaged ovarian cancer in England in 2023 and in Wales in 2024 had any surgery recorded within nine months of diagnosis.

Chemotherapy



Approximately two out of three women newly diagnosed with stage 2-4 or unstaged ovarian cancer in England in 2023, and three in four in Wales in 2024, had any chemotherapy recorded within nine months of diagnosis.

Platinum-based chemotherapy*

Approximately two out of three women diagnosed in England in 2023 with stage 2-4 or unstaged epithelial ovarian cancer had platinum-based chemotherapy recorded within three months of diagnosis.

Information about type of chemotherapy was not available for Wales.

England

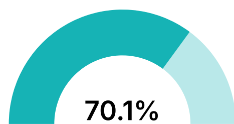
2023 **64.3%**

66.0% in 2022

65.7% in 2021

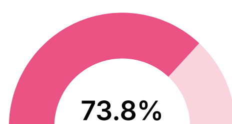
Survival

One-year survival



70.1%
England

2022 **70.2%**
2021 **69.4%**

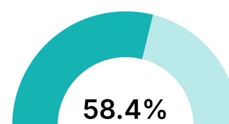


73.8%
Wales

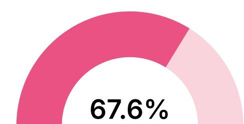
2022 **74.4%**

of women diagnosed with ovarian cancer in England and in Wales in 2023 survived at least one year after the diagnosis.

Two-year survival



58.4%
England



67.6%
Wales

of women diagnosed with ovarian cancer in England and in Wales in 2022 survived at least two years after the diagnosis.

(Results in this infographic are based on crude estimates and do not account for differences in case-mix)

* These indicators aim to capture timeliness as well, which is why a 3-month time period is used.

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Maternal, Newborn and Infant Clinical Outcome Review Programme

MBRRACE-UK
Perinatal mortality surveillance

UK perinatal deaths of babies born in 2024

State of the nation report

June 2026

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University of Leicester
NHS The Newcastle upon Tyne Hospitals NHS Foundation Trust
TIMMS
sands Saving babies' lives. Supporting bereaved families.
NHS Chelsea and Westminster Hospital NHS Foundation Trust
NPEU
Women's & Reproductive Health
University of Oxford

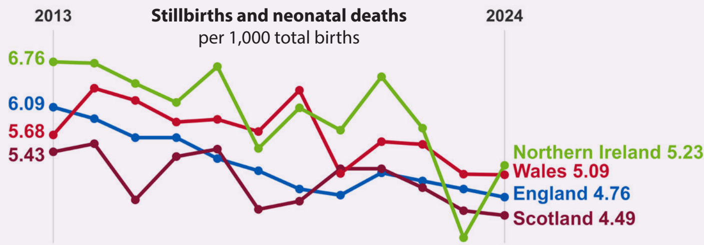
State of the nation report

UK perinatal deaths of babies born in 2024

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

Fewer babies are dying than in the past

- Since 2013, the number of babies who die shortly before, during, or soon after birth has fallen across the UK. In 2024, rates continued to decrease.



Rates were more consistent for stillbirths than for neonatal deaths

Stillbirth rates

Lower ← Average → Higher

Neonatal mortality rates

- When trusts and health boards were grouped by the level of care they provide, they all had a stillbirth rate which was **around the average** for their group.
- Neonatal mortality rates varied more, particularly in the group of trusts and health boards providing the most complex care.

Where families live still makes a big difference

- Babies born to mothers who live in the most deprived areas continue to face much higher risks, despite recent improvements.

	Stillbirths per 1,000 total births (2020)	Stillbirths per 1,000 total births (2024)	Neonatal deaths per 1,000 live births (2020)	Neonatal deaths per 1,000 live births (2024)
Most deprived areas	4.29	4.16	1.98	2.14
Least deprived areas	2.60	2.19	1.05	1.18

2020 2021 2022 2023 2024

Being born early remains the highest risk

- Outcomes have improved, particularly for babies born later in pregnancy.
- The highest rates of stillbirths and neonatal deaths occur before 37 weeks of pregnancy, especially at the earliest gestations.

Stillbirths/late fetal losses per 1,000 total births	Gestational age in weeks	Neonatal deaths per 1,000 live births
414.0	22 to 23	606.2
205.3	24 to 27	150.2
69.3	28 to 31	23.4
12.1	32 to 36	5.0
1.0	37 to 41	0.6

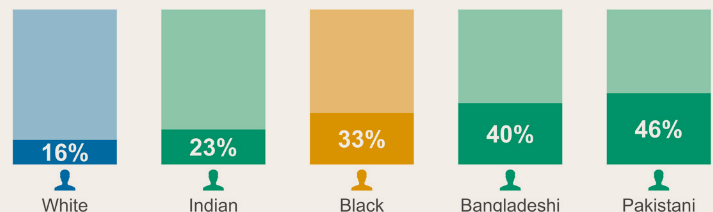
Not all ethnic groups are affected in the same way

- Babies of Black and Asian ethnicity continue to experience higher mortality rates.

Stillbirths per 1,000 total births		Neonatal deaths per 1,000 live births	
White	2.67	White	1.44
Indian	3.54	Indian	1.92
Pakistani	5.12	Bangladeshi	2.13
Bangladeshi	5.29	Black	2.43
Black	5.58	Pakistani	2.54

- A higher proportion of Black and Asian families live in the most deprived areas.

How many babies are born to mothers who live in the most deprived areas?



The main causes of baby death have remained the same

Main causes of stillbirth

Cause	%
Unknown causes	36%
Placental problems	34%
Congenital anomalies	7%
Infections	5%
Umbilical cord issues	5%

Main causes of neonatal death

Cause	%
Congenital anomalies	35%
Extreme prematurity	13%
Brain or nervous system problems	13%
Heart or lung complications	8%
Infections	8%

Congenital anomalies make up a large share of deaths

- Congenital anomalies contribute to deaths in all ethnic groups, but account for a particularly large share of neonatal deaths among Bangladeshi, Pakistani and Black babies.

Neonatal deaths
per 1,000 live births (2022 to 2024)

	Excluding deaths due to congenital anomalies	All deaths
Indian	1.03	1.54
White	1.05	1.50
Bangladeshi	1.24	2.36
Black	1.40	2.37
Pakistani	1.49	3.20

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