



HQIP

Healthcare Quality
Improvement Partnership

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

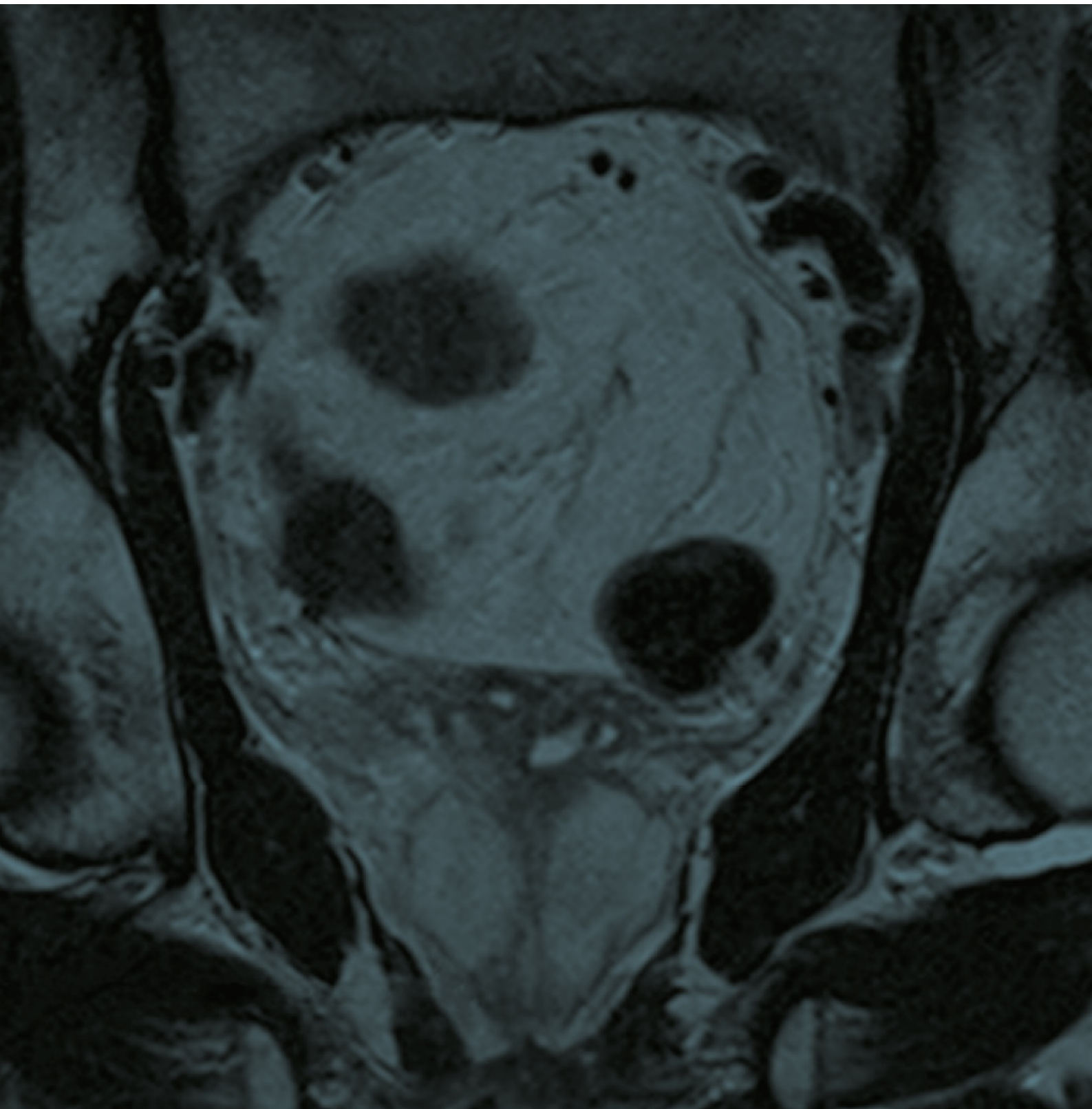
Q4 (January – March 2024), updated 18/03/2024

PUBLICATION DATE	HEALTHCARE AREA	TYPE	PROJECT NAME	LEAD PROVIDER	FULL REPORT TITLE	HQIP WEBLINK TO REPORT	DOC NUMBER
2024/01/11	Cancer	Audit	NPCA - National Prostate Cancer Audit	RCS: Royal College of Surgeons	NPCA State of the Nation Report An audit of the care received by people with prostate cancer in England and Wales from 01/01/2019 to 31/01/2023	https://www.hqip.org.uk/resource/npca-report/	0.01
2024/01/11	Cancer	Audit	NOGCA - National Oesophago-Gastric Cancer Audit	RCS: Royal College of Surgeons	National Oesophago-Gastric Cancer Audit State of the Nation Report	https://www.hqip.org.uk/resource/nogca-report/	0.02
2024/02/07	Mental Health	Clinical Outcome Review Programme	Mental Health Clinical Outcome Review Programme	University of Manchester	Suicide by people in contact with drug and alcohol services: a national study 2021 to 2022	https://www.hqip.org.uk/resource/ncish-drug-alcohol-services/	0.03
2024/02/07	Mental Health	Clinical Outcome Review Programme	Mental Health Clinical Outcome Review Programme	University of Manchester	National Confidential Inquiry into Suicide and Safety in Mental Health: Annual report 2024, England, Northern Ireland, Scotland and Wales	https://www.hqip.org.uk/resource/ncish-annual-report/	0.04
2024/02/07	Cancer	Audit	NBoCA - National Bowel Cancer Audit	RCS: Royal College of Surgeons	National Bowel Cancer Audit State of the Nation Report 2023	https://www.hqip.org.uk/resource/nboca-sotn-2023/	0.05
2024/02/07	Women and Children	CORP - Clinical Outcome Review Programme	Child Health Clinical Outcome Review Programme	NCEPOD: National Confidential Enquiry into Patient Outcome and Death	Twist and Shout: A review of the pathway and quality of care provided to children and young people aged 2-24 years who presented to hospital with testicular torsion	https://www.hqip.org.uk/resource/ncepod-twist-and-shout/	0.06

NPCA State of the Nation Report

An audit of the care received by people with prostate cancer in England and Wales from 01/01/2019 to 31/01/2023

Published January 2024



Diagnosis

For men diagnosed between January - December 2022 in England and between January - December 2021 in Wales

50,702 men were **diagnosed** with prostate cancer in England in 2022

2,168 men were **diagnosed** with prostate cancer in Wales in 2021

27% increase compared with 39,888 men in 2021

15% increase compared with 1,886 men in 2020

This may be explained by the reporting being in the Covid-19 recovery period

Disease presentation

For men diagnosed between April 2020 - March 2021 in England and between April 2021 - March 2022 in Wales

19% of men presented with **metastatic** disease in both England and Wales

Treatment allocation

For men diagnosed between April 2020 - March 2021 in England and between April 2021 - March 2022 in Wales

Low-risk*, localised disease

8%^E of men had radical treatments in England (E) and Wales (W)
9%^W

**Low-risk: T stage 1/2, Gleason ≤6, M/N 0 or missing*

High-risk/locally advanced disease

69%^E of men had radical treatments in England (E) and Wales (W)
69%^W

Treatment outcomes

For men undergoing surgery between April 2021 - March 2022 in England and Wales

13% of men were **readmitted** within 3 months **following surgery** in England

9% of men were **readmitted** within 3 months **following surgery** in Wales

For men undergoing radical treatment between September 2019 - August 2020 in England and Wales

7%^E of men experienced at least one **genitourinary** complication requiring a procedural/surgical intervention within two years after **radical prostatectomy** in England (E) and Wales (W)
8%^W

10%^E of men experienced at least one **gastrointestinal** complication requiring a procedural/surgical intervention within two years after **radical radiotherapy** in England (E) and Wales (W)
5%^W

National Oesophago-Gastric Cancer Audit

State of the Nation Report

**An audit of the
care received by
people with
oesophago-
gastric cancer in
England and
Wales**

**1 April 2020 – 31 March
2022**



Published January 2024


NOGCA | National Oesophago-Gastric Cancer Audit


State of the Nation Report

19,865

records of patients diagnosed with OG cancer in England and Wales between 2020-2022 were submitted to the Audit

Routes to diagnosis

13%  of patients were diagnosed after emergency admission

44%  of patients had Stage 4 cancer at diagnosis (up from 37% in 2012/13)

Treatments & outcomes

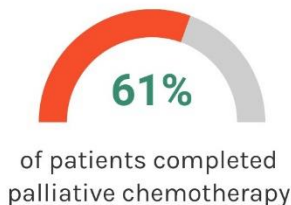
37% of patients had a treatment plan with curative intent

Surgical outcomes

	Oesophagectomy	Gastrectomy
90-day mortality*	3.0%	2.5%
+ longitudinal margins*	4.9%	9.8%

	1 year	2 year	3 year
% of patients alive after surgery**	85.3	71.4	62.7

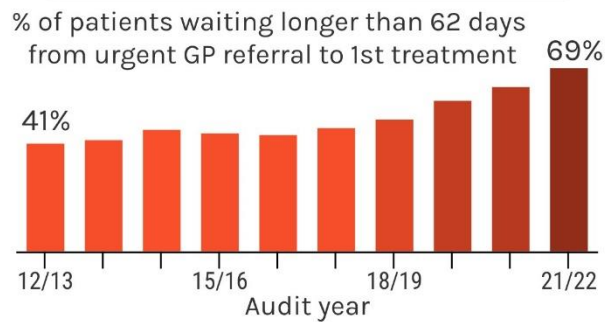
Non-curative treatments



Patient profile at diagnosis

	% male	% female	Median age (years)
Oes SCC	48	52	72
Oes ACA	80	20	72
Stomach	66	34	74

Waiting times





Nutritional support


76% of patients received dietetic support between diagnosis and treatment 


93% of patients had ongoing nutritional management following curative surgery

High grade dysplasia

 **92%** of people had diagnosis confirmed by 2nd pathologist

 **91%** of people had their treatment plan agreed at an upper GI MDT meeting

 **80%** of patients had a plan for active treatment

 **98%** of active treatment plans involved endoscopy

Arrows indicate increase compared to first years of audit (2012-2014)[^]

BSC: Best supportive care
OG: Oesophago-Gastric
Oes SCC: Oesophageal squamous cell carcinoma
Oes ACA: Oesophageal adenocarcinoma

^{*}3 years' of data (2019-22) used for surgical outcomes to ensure enough procedures to produce robust statistics; results are the % of patients undergoing surgery
^{**}Analysis of patients diagnosed between 2017-22
[^]Compared to 2012-2014 cohort to highlight changes over 10 years of HGD data collection

Suicide by people in contact with drug and alcohol services: a national study 2021 to 2022



National Confidential Inquiry into Suicide and Safety in Mental Health

8%

of all people who died by **suicide** had **recent** contact with **drug and alcohol services**

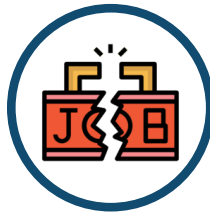
428

registered deaths by suicide between 1 October 2021 and 30 September 2022

Social and demographic features



50% **men**
aged **35-54**



47%
unemployed



34% lived in
deprived areas

Clinical factors



48% **alcohol** was
main substance



25% **completed**
treatment



Less **treatment** for
mental health

Common themes from serious incident reports



Interpersonal
problems

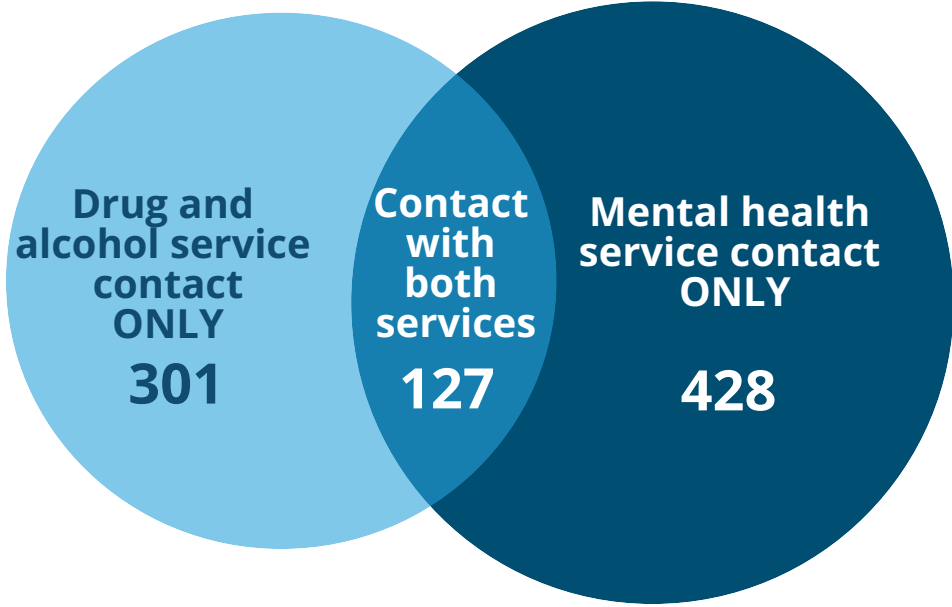


Recent contact



Self-harm and
suicidal ideation

People under the care of mental health services



Few people receiving both **mental health** and **substance misuse** care



76% had previous **self-harm**



20% **missed last** appointment with services



14% **non-adherent** with medication

Opportunities for prevention for drug and alcohol services



Signpost to financial support



Awareness of changing risks



Frontline staff training



Joint working with mental health services



Continued monitoring of trends



The University of Manchester



HQIP

Healthcare Quality
Improvement Partnership

National Confidential Inquiry

into Suicide and Safety
in Mental Health

ANNUAL REPORT 2024:

England, Northern Ireland, Scotland and Wales

UK patient and general population data 2011-2021

1,597

suicides by people under recent (within 12 months) mental health care in 2021

26%

of all people who died by **suicide** in 2011-2021 had **recent** contact with **mental health services**

Clinical care



48% lived **alone**



47% had **alcohol misuse**



54% had more than one **mental health diagnosis**

Clinical prevention should target these common risk factors

Acute mental health care settings

433 deaths per year

deaths per year

28%

In-patients died under **enhanced nursing observation**



Highest risk 1-2 weeks after discharge

Prevention should focus on ward environment and careful transition to community

Autistic people or those with ADHD

44 deaths per year

deaths per year



Younger and more likely to identify as **LGBT**



Suicide-related internet use common

Services should be aware of risks of online experience

In-patients under 25

11

deaths per year

Mostly **female**; almost half had experienced **childhood abuse**



More **died on the ward** than in-patients aged 25+

Attention is needed to potential ligatures and ligature points

Students aged 18-21 under mental health care (England and Wales)

9

deaths per year

Fewer students under mental health care



More **depression** than other young patients

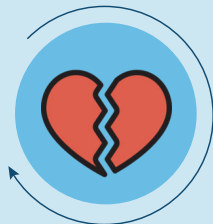
A clear pathway to NHS services is needed

Patients with a one-off assessment

167

deaths per year

Recent adverse **life events** common



Many had **no further follow-up**

Awareness of risk needed after single assessments

Patients who died in public locations

354

deaths per year

Younger, more acutely unwell



Increased use of **parks/woodland**

Local suicide prevention plans should address high risk locations

State of the Nation Report

An audit of the care received by people with bowel cancer in England and Wales focusing on people diagnosed between 1 April 2021 and 31 March 2022.

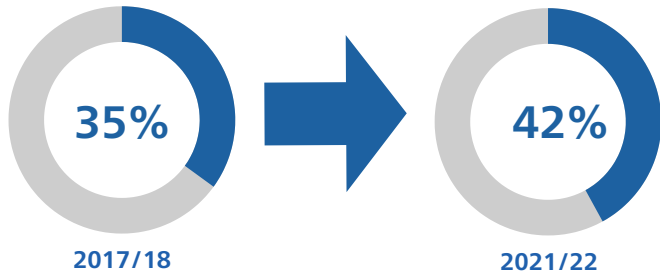
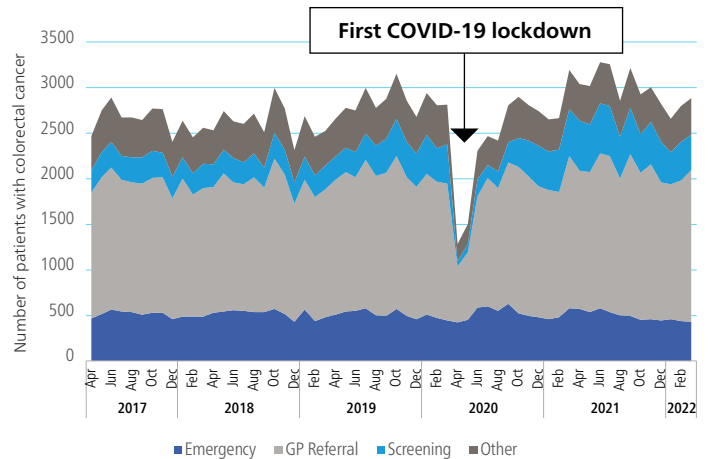
Published 8 February 2024.



CARE PATHWAYS

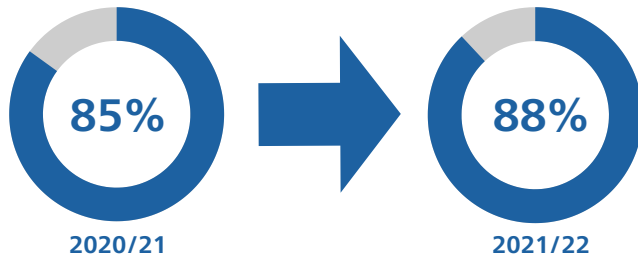
35,779 patients

were diagnosed with bowel cancer in England and Wales between 1 April 2021 and 31 March 2022.



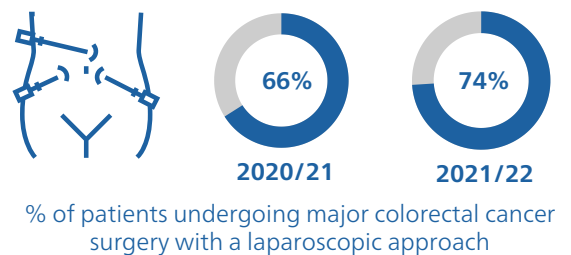
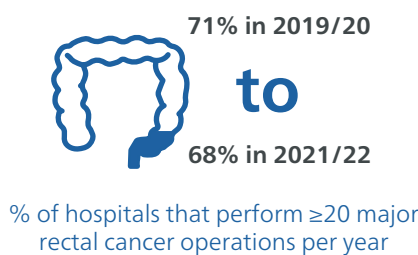
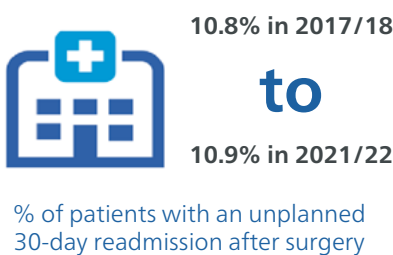
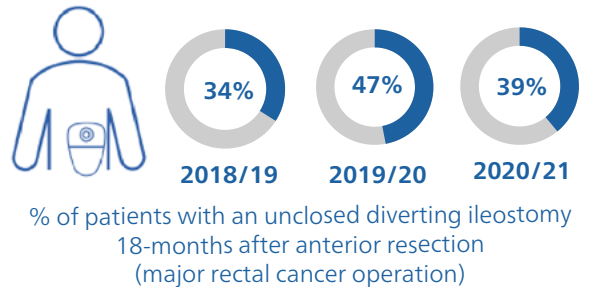
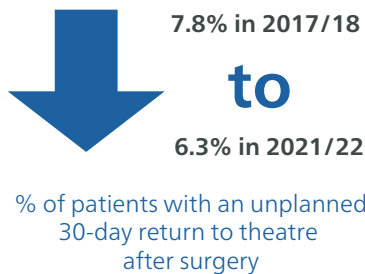
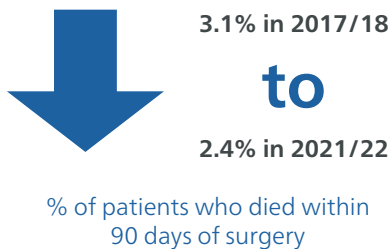
Increase in the proportion of patients presenting with stage I or II disease

Number of patients presenting with colorectal cancer returned to pre-pandemic levels

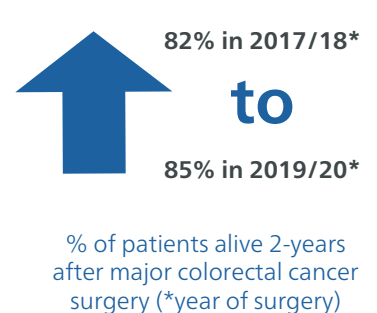
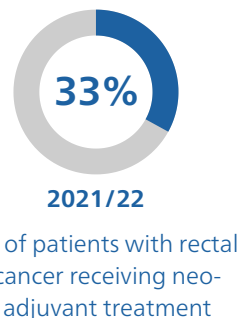
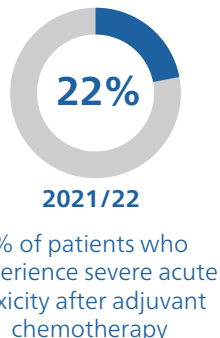
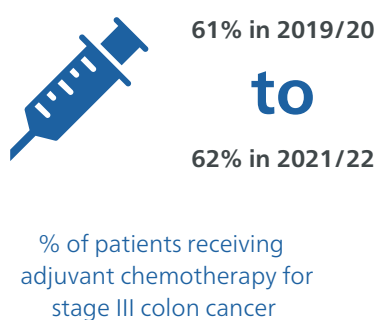


Increase in the proportion of patients seen by a clinical nurse specialist

PERI-OPERATIVE CARE

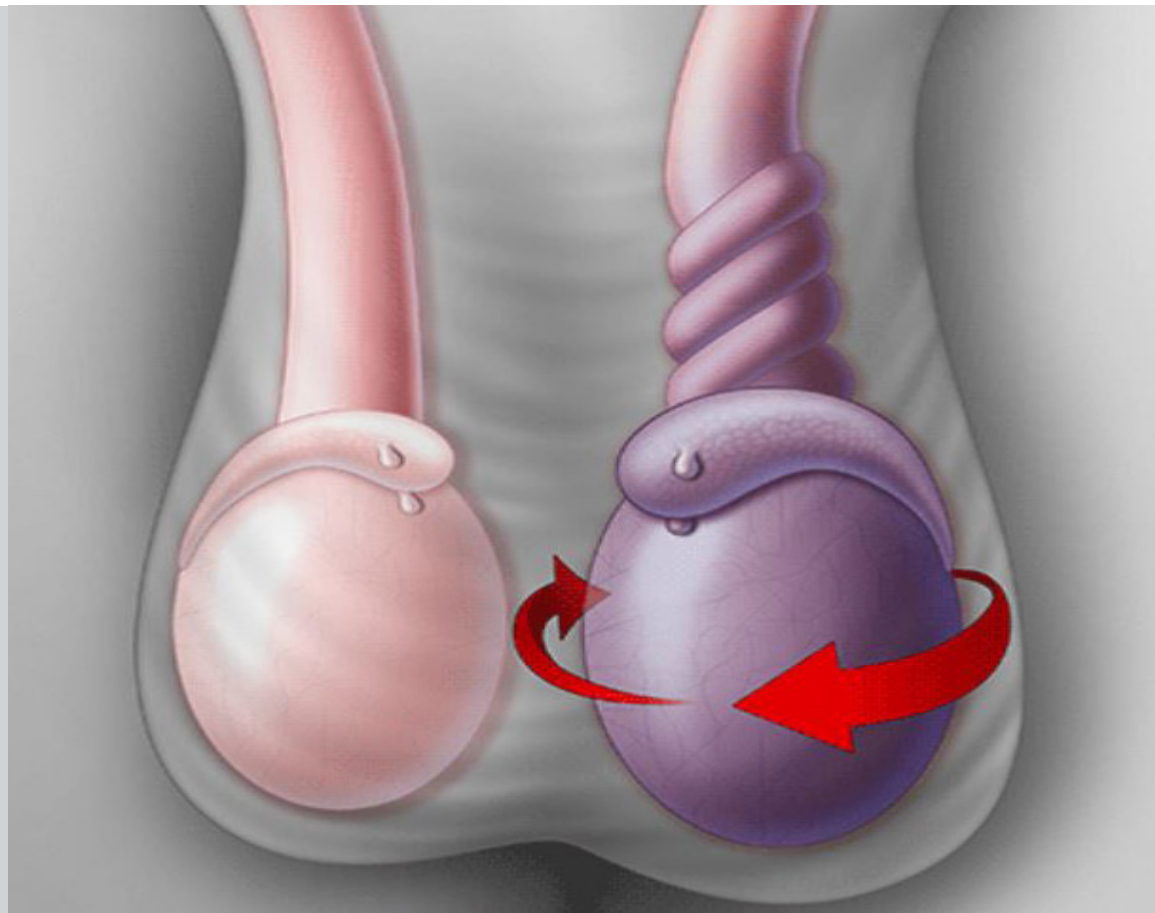


ONCOLOGICAL MANAGEMENT



Twist and Shout

A review of the pathway and quality of care provided to children and young people aged 2-24 years who presented to hospital with testicular torsion



EXECUTIVE SUMMARY

Testicular torsion occurs when the spermatic cord twists and cuts off the blood supply to the testicle. Testicular torsion is a surgical emergency requiring prompt diagnosis and surgical intervention to preserve the testicle. Delay in recognising testicular torsion and delay in presenting to hospital is known to lead to poorer outcomes.

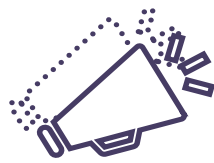
There needs to be greater public awareness about testicular torsion. Hospitals need to be equipped to deal with testicular torsion as an emergency operation, with senior clinicians able to decide whether surgery is needed and to be able to perform the surgery/anaesthetise the patient. If these services are not available, then there needs to be robust transfer arrangements in place to get the patient to theatre. Patients will need good information at discharge, and the option to return for further follow-up should they need psychological support or wish to discuss the use of a prosthesis.

IN THIS STUDY

The pathway and quality of care provided to patients aged 2-24 years who presented to hospital with testicular torsion was reviewed. The sampling period of 1st April 2021 to 31st March 2022 was used and data were included from 574 clinician questionnaires, 143 organisational questionnaires and the assessment of 635 sets of case notes.

1. INCREASE PUBLIC AWARENESS

Increased awareness and education may reduce embarrassment and get people talking.

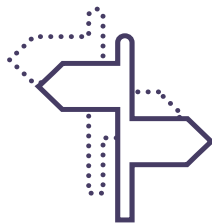


Testicular torsion was not recognised by 157/239 (65.7%) patients or 83/239 (34.7%) parents/carers.

Only 294/403 (73.0%) patients had contacted a healthcare professional within six hours of developing symptoms.

2. ENSURE PATHWAYS MINIMISE THE NEED FOR TRANSFERS

Directing patients to hospitals where surgery for testicular torsion can be undertaken will minimise the need for transfer and reduce the risk of delay to theatre.



60/475 (12.6%) patients were referred by a GP, 34/475 (7.2%) from an urgent treatment centre and 25/475 (5.3%) NHS 111.

91/143 (63.6%) hospitals reported that patients were transferred out of the hospital for treatment on occasions.

Patients not on a pathway were more likely to have their testicle removed (154/389; 39.6%) compared with those who were (16/67; 23.9%).

3. URGENT SENIOR REVIEW, DECISION-MAKING AND OPERATION

Urgent review by senior decision-makers and access to senior specialists in urology, paediatric surgery, or general surgery for urgent surgery is essential for prompt treatment.



136/435 (31.3%) patients had their first assessment on arrival at hospital performed by a junior specialist trainee.

113/422 (26.8%) patients had not had their first ST3+ surgical review within two hours of arrival and 40/422 (9.5%) patients waited more than four hours.

There was a delay in making a diagnosis in 116/635 (18.3%) patients which impacted their care in 69/116 (59.5%) cases.

4. EXTENDED FOLLOW-UP

Patient-initiated follow-up after surgery may encourage patients to seek psychological support and/or the use of prosthetic implants.



Information on prosthetic replacements could only be found in the case notes of 139/534 (26.0%) patients who had a testicle removed, with an explanation recorded for 83/139 (59.7%) patients.

Adequate written information given to the patient and family at discharge could only be found in the case notes of 123/233 (52.8%) patients.