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

Q3 (October – December 2024), updated 16/12/2024

PUBLICATION DATE	HEALTHCARE AREA	TYPE	PROJECT NAME	LEAD PROVIDER	FULL REPORT TITLE	HQIP WEBLINK TO REPORT	DOC NUMBER
2024/10/10	Acute	Audit	NELA - National Emergency Laparotomy Audit	RCoA: Royal College of Anaesthetists	Ninth Patient Report of the National Emergency Laparotomy Audit	https://www.hqip.org.uk/resource/ninth-laparotomy-patient-report-nela/	0.01
2024/10/10	Long term conditions	Audit	NEIAA - National Early Inflammatory Arthritis Audit	BSR: British Society for Rheumatology	State of the Nation Summary Report 2024	https://www.hqip.org.uk/resource/neiaa-sotn-2024/	0.02
2024/10/10	Acute	Audit	FFFAP - Falls and Fragility Fracture Audit Programme	RCP: Royal College of Physicians	The 2024 National Audit of Inpatient Falls (NAIF) report on 2023 clinical data	https://www.hqip.org.uk/resource/naif-dont-stop-moving/	0.03
2024/10/10	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 2023 data	https://www.hqip.org.uk/resource/summary-2023-nnap/	0.04
2024/10/10	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	Saving Lives, Improving Mothers' Care - State of the Nation Report	https://www.hqip.org.uk/resource/improving-mothers-care-mbrrace/	0.05
2024/11/14	Long term conditions	Audit	NRAP - National Respiratory Audit Programme	RCP: Royal College of Physicians	Organisational Audit 2024	https://www.hqip.org.uk/resource/nrap-nov2024/	0.06
2024/11/14	Cardiovascular	audit	NVR - National Vascular Registry	RCS: Royal College of Surgeons	State of the Nation Report 2024	https://www.hqip.org.uk/resource/nvr-sotn-2024/	0.07
2024/11/14	Long term conditions	Audit	SSNAP - Sentinel Stroke National Audit Programme	KCL: Kings College London	State of the Nation Report 2024	https://www.hqip.org.uk/resource/ssnap-nov24/	0.08
2024/11/14	Acute	Clinical Outcome Review Programme	Medical and Surgical Clinical Outcome Review Programme	NCEPOD: National Confidential Enquiry into Patient Outcome and Death	Planning for the End- A review of the quality of care provided to adult patients towards the end of life	https://www.hqip.org.uk/resource/ncepod-nov24/	0.09
2024/11/14	Women and children	Audit	NPDA - National Paediatric Diabetes Audit	RCPCH: Royal College of Paediatrics and Child Health	First Year of Care Parent and Patient Reported Experience Measures (PREMs) 2024	https://www.hqip.org.uk/resource/npda-nov2024/	0.10
2024/12/12	Women and children	Clinical Outcome Review Programme	NCMD - National Child Mortality Database	University of Bristol	Child deaths due to Asthma or Anaphylaxis National Child Mortality Database Programme Thematic Report	https://www.hqip.org.uk/resource/ncmd-dec24/	0.11
2024/12/12	Cardiovascular	Audit	CVDPREVENT- Cardiovascular Disease Prevention Audit	NHS Benchmarking Network	Fourth Annual Report	https://www.hqip.org.uk/resource/cvdprevent-dec2024/	0.12
2024/12/12	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	Perinatal Confidential Enquiry - State of the Nation Report: The care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death	https://www.hqip.org.uk/resource/mbraceuk-dec24/	0.13
2024/12/12	Women and children	Audit	PICANet - Paediatric Intensive Care Audit	University of Leeds	National Paediatric Critical Care Audit State of the Nation Report 2024	https://www.hqip.org.uk/resource/picanet-dec24/	0.14

NELA
National Emergency Laparotomy Audit

Ninth Patient Report of the National Emergency Laparotomy Audit

December 2021 to March 2023

RCOA Royal College of Anaesthetists | CR&I Centre for Research and Improvement | Royal College of Surgeons of England | HQIP Healthcare Quality Improvement Partnership

October 2024

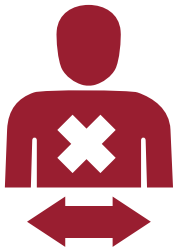
NELA
National Emergency Laparotomy Audit

Executive Summary

Results from 2021–2023 – the Ninth Year of the National Emergency Laparotomy Audit

1 **27,863 patients** who had emergency bowel surgery in England and Wales were included in the Year 9 audit from 173 hospitals.

2 Improvements in mortality have plateaued – **in-hospital mortality was 9.3%** compared to 9.2% in Year 8 and 9.1% in Year 7.

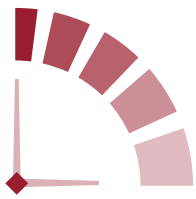


3 Preoperative assessment of risk **has dropped below target**, to 84.6% after peaking at 86.8% in Year 8.

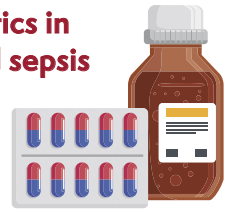
4 **86.1% of patients** with a high documented risk had **consultant surgeon** input before surgery.

71.4% of patients with a high documented risk had **consultant anaesthetist** input before surgery.

5 **Patients with sepsis** suspected at time of arrival in hospital waited a median of **15.5 hours from time of admission** until surgery.

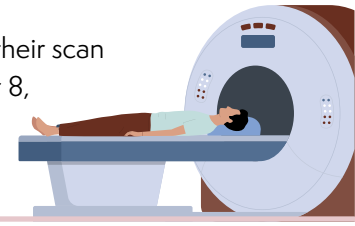


6 **Median time to antibiotics in patients with suspected sepsis** was 3.1 hours from arrival in hospital.



7 **91.1% of patients** received a preoperative CT scan

30.8% of patients had their scan outsourced (26.3% in Year 8, 19.1% in Year 7).



8 Presence of both **anaesthetic and surgical consultants** during surgery in high-risk patients was **90.4% (91.3% in Year 8)**.

9 **80.3% of high-risk patients** were admitted to critical care postoperatively (79.1% in Year 8).

13.9% of high-risk patients were admitted to a normal ward.

10 **33.2% of patients** aged 80 or over, or 65+ and frail, had geriatrician input (31.8% in Year 8).

11 Postoperative length of hospital stay (LOS) has not significantly changed over the last five years, **with a median in Year 9 of 11 days**.

Churchill House, 35 Red Lion Square, London WC1R 4SG
020 7092 1676 nela@rcoa.ac.uk data.nela.org.uk @NELANews

RCOA Royal College of Anaesthetists | CR&I Centre for Research and Improvement | Royal College of Surgeons of England | HQIP Healthcare Quality Improvement Partnership

British Society for Rheumatology

National Early Inflammatory Arthritis Audit

State of the Nation Summary Report 2024

Data Collection Period: 1 April 2023 – 31 March 2024

Geographic Coverage: England and Wales

Geographical Granularity: Countries, Integrated Care Boards, and Welsh Health Boards.

October 2024

HQIP
Healthcare Quality Improvement Partnership

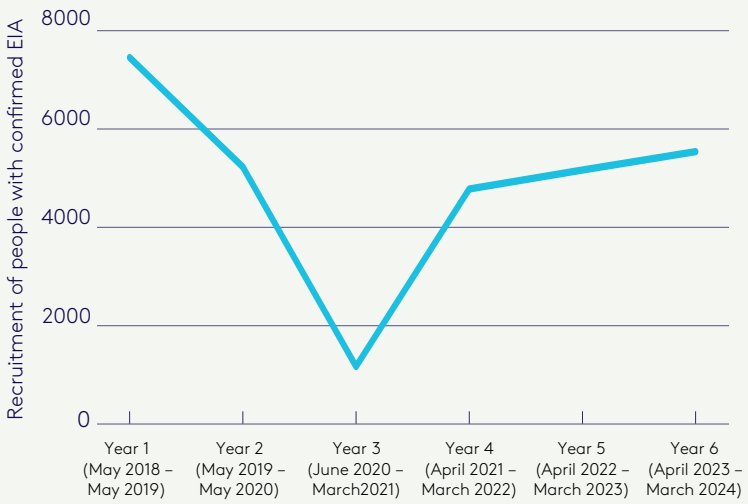
National Early Inflammatory Arthritis Audit

British Society for Rheumatology

State of the Nation Summary Report 2024 Infographic

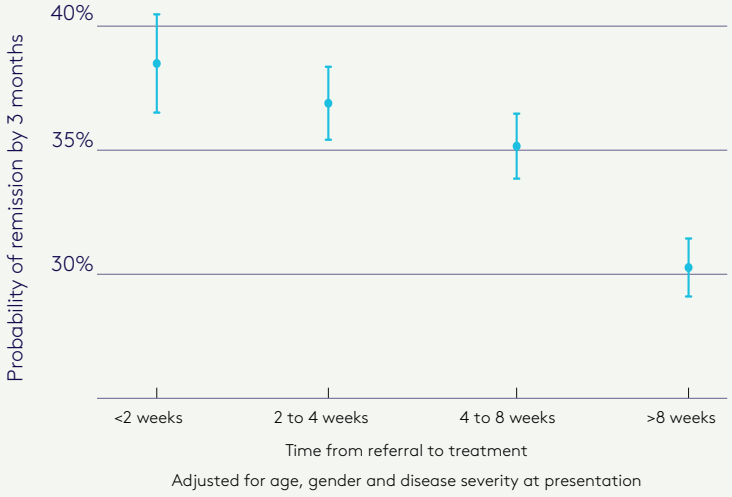
Recruitment rates continue to improve post-pandemic

All eligible units entered some data in year six.

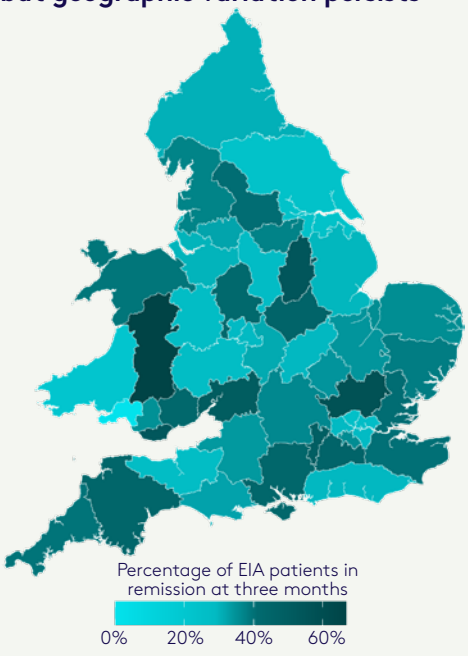


Treatment timeliness for early inflammatory arthritis has improved

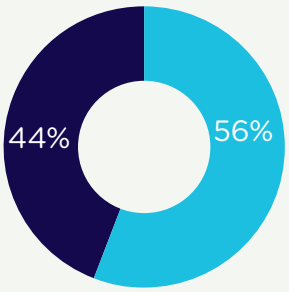
Relationship between remission rates and treatment timeliness



Remission rates remain stable at 35% but geographic variation persists



Most early inflammatory arthritis patients report that their symptoms significantly impact their employment



75%

of those who were unemployed at diagnosis said this was due to their arthritis

20%

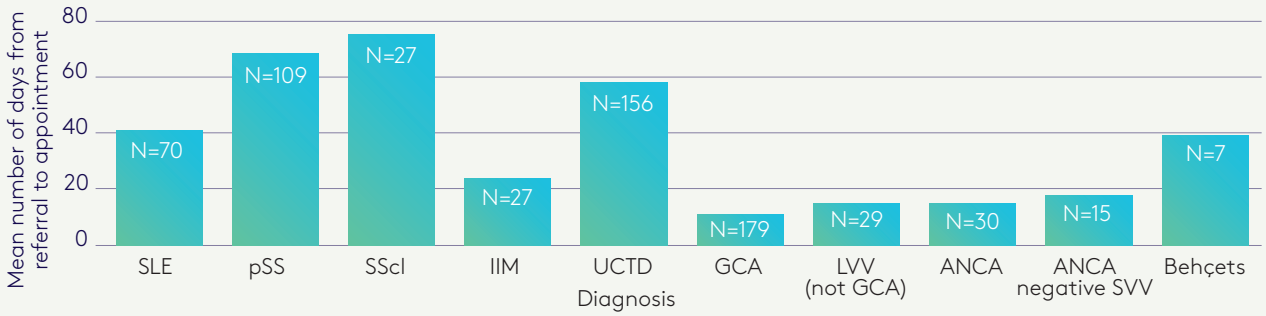
of those who were employed at diagnosis said they had to change their work after diagnosis

National Early Inflammatory Arthritis Audit

British Society for Rheumatology

State of the Nation Summary Report 2024 Infographic

Waiting times for Rare Autoimmune Rheumatic Diseases are highly variable (see list of diagnoses)



Diagnosis	
SLE	Systemic lupus erythematosus
pSS	Primary Sjögren's syndrome
SScl	Systemic sclerosis
IIM	Idiopathic inflammatory myopathies
UCTD	Undifferentiated/other connective tissue disease or overlap syndrome
GCA	Giant cell arteritis
LVV (not GCA)	Large vessel vasculitides (not giant cell arteritis)
ANCA	ANCA-associated vasculitis
ANCA negative SVV	Other small/medium vessel vasculitides (ANCA-negative)
Behçets	Behçet's syndrome

Recommendations

1. Royal College of Physicians:
Ensure consultant job plan guidance includes allocated time for triage and pre-referral specialist advice.

2. Integrated Care Boards and Welsh Health Boards:
Ensure commissioned rheumatology services include protected EIA clinics.

3. British Society for Rheumatology:
Produce a national guideline recommending that people living with EIA are offered a DMARD on the day of their diagnosis.

4. Care Quality Commission and Health Inspectorate Wales:
Improve regulatory oversight of individual healthcare providers by utilising routine NEIAA data to assess standards of care and ensure compliance with quality standards.

5. Department for Works and Pensions, Department of Health and Social Care, NHS England and Welsh Health Boards:
Improve timely access to employment and mental health support programmes for people living with EIA.

Royal College of Physicians

National Audit of Inpatient Falls (NAIF)

Don't stop moving

Optimising safety while staying active in hospital

The 2024 National Audit of Inpatient Falls (NAIF) report on 2023 clinical data

1 January – 31 December 2023

In association with

British Geriatrics Society
Improving healthcare for older people

British Orthopaedic Association

Royal Osteoporosis Society
Better bone health for everybody

Commissioned by

HQIP
Healthcare Quality Improvement Partnership

Report at a glance

In 2023, 1,959 people sustained a femoral fracture as an inpatient; 1,609 (82%) were due to a fall and included as cases in the National Audit of Inpatient Falls.

Proportion of patients with risk factor assessment

In this report, to address the potential for harm caused by hospital-acquired deconditioning, we present a new approach that focuses on promoting activity using assessments to ensure each patient is fit to move as safely as possible. As such, the name of KPI 1 will be changing from multifactorial falls risk assessment (MFRA) to multifactorial assessment to optimise safe activity (MASA).

High-quality MASA

In 2023: **39%** of patients had 5 or more risk factors assessed

In 2022: **37%**

Vision

In 2023: **57%**

In 2022: **45%**
In 2021: **52%**

LSBP

In 2023: **42%**

In 2022: **39%**
In 2021: **39%**

Medication review

In 2023: **78%**

In 2022: **74%**
In 2021: **74%**

Delirium

In 2023: **52%**

In 2022: **52%**
In 2021: **66%**

Mobility

In 2023: **92%**

In 2022: **92%**
In 2021: **92%**

Continence

In 2023: **84%**

In 2022: **82%**
In 2021: **83%**

Post-fall management

Checked for injury

In 2023: **77%**

In 2022: **74%**
In 2021: **77%**
In 2020: **71%**

Safe method for moving from the floor

In 2023: **33%**

In 2022: **32%**
In 2021: **29%**
In 2020: **26%**

Medical assessment within 30 minutes

In 2023: **65%** (30 mins)

In 2022: **74%**
In 2021: **60%**
In 2020: **62%**

Recommendations

1. Trusts and health boards (HBs) should review their policies and practice to ensure older hospital inpatients are enabled to be as active as possible.
2. NHS England and Welsh Government should implement national drivers to ensure that all older people are screened for delirium upon hospital admission using the 4AT and reviewed for changes suggestive of a new onset of delirium for the duration of their admission.
3. Trusts and health boards should ensure that there are robust governance processes in place to understand when post-fall checks fail to correctly identify a fall-related injury.
4. Trusts and health boards should have processes in place to hasten time to administration of analgesia after an injurious fall, to ensure patients who sustain a femoral fracture in hospital are given analgesia within 30 minutes of falling.
5. Trusts and health boards are encouraged to prepare for the audit expansion in January 2025.

The full FFFAP glossary is available on the RCP website.

NNAP
National Neonatal Audit Programme

RCPCH Audits

National Neonatal Audit Programme (NNAP) Summary report on 2023 data

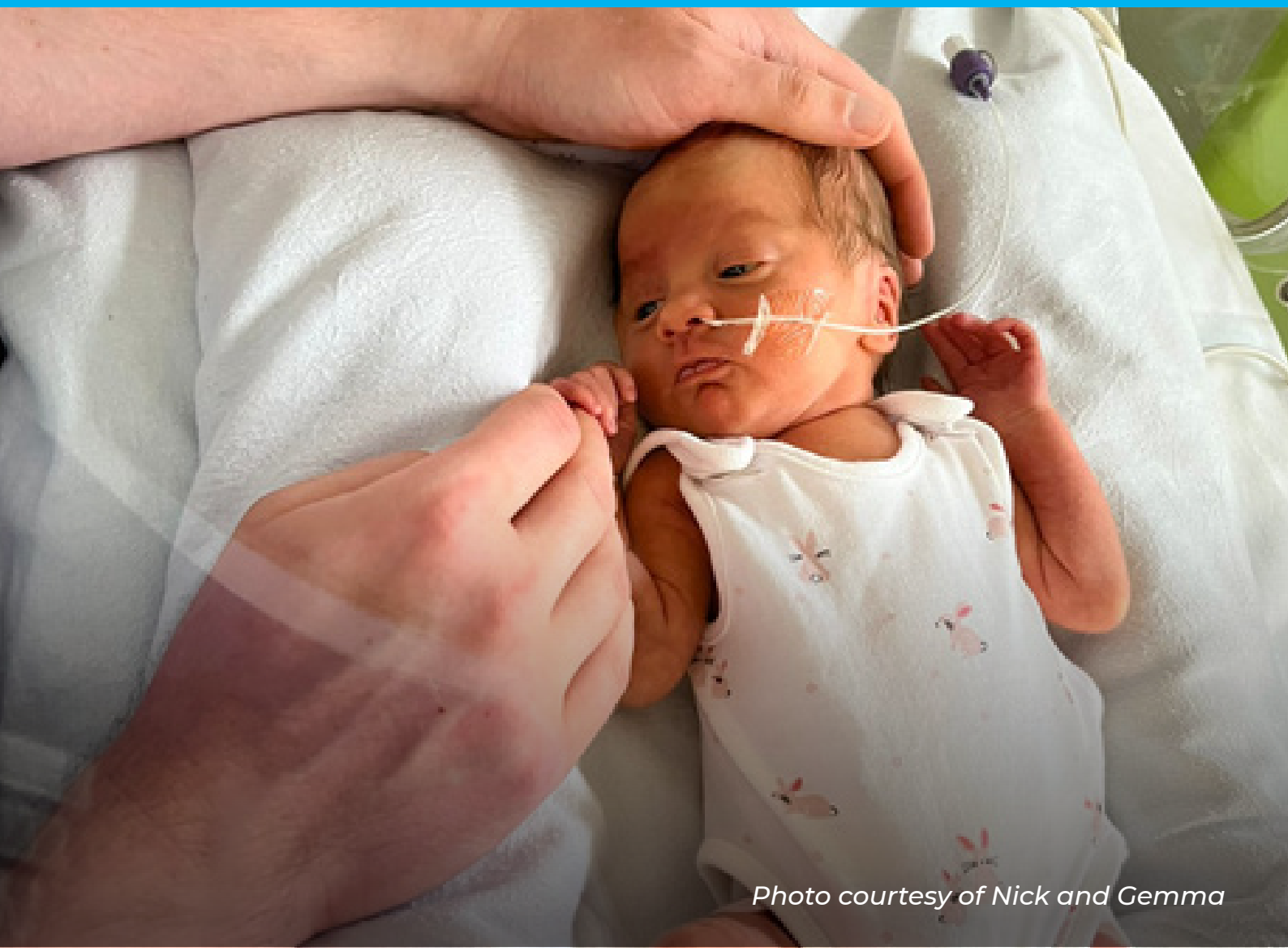


Photo courtesy of Nick and Gemma

HQIP
Healthcare Quality Improvement Partnership

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

Results at a glance

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

This poster summarises the results based on NNAP data relating to babies admitted to neonatal care between January and December 2023, unless otherwise stated. Results displayed in the horizontal pink bars show the range of neonatal network proportions (lowest and highest) and the pink circles shows the overall audit proportion.

Outcomes of neonatal care

Mortality

6.4% of babies born at less than 32 weeks died before discharge home.

0.1% decrease from previous year (2022: 6.5%)

3.3% — **6.4%** — 8.2%

Bronchopulmonary dysplasia (BPD)

31.5% of babies born at less than 32 weeks developed BPD or died.

0.2% increase from previous year (2022: 31.3%)

25.6% — **31.5%** — 39.1%

Necrotising enterocolitis

5.5% of babies born at less than 32 weeks developed necrotising enterocolitis.

0.7% decrease from previous year (2022: 6.2%)

3.8% — **5.5%** — 8.3%

Bloodstream infection

4.6% of babies born at less than 32 weeks had growth of a clearly pathogenic organism.

0.8% decrease from previous year (2022: 5.4%)

1.9% — **4.6%** — 9.6%

Preterm brain injury – Intraventricular haemorrhage (IVH)

6.6% of babies born at less than 32 weeks experienced IVH.

0.9% decrease from previous year (2022: 7.5%)

4.1% — **6.6%** — 9.6%

Preterm brain injury – cystic periventricular leukomalacia (cPVL)

2.6% of babies born at less than 32 weeks experienced cPVL.

0% change from previous year (2022: 2.6%)

1.2% — **2.6%** — 3.9%

Optimal perinatal care

Antenatal steroids

52.9% of mothers of babies born at less than 34 weeks' were given a full course of antenatal steroids in the week prior to delivery.

0.9% increase from previous year (2022: 52%)

40.7% — **52.9%** — 61.1%

Born in a centre with a NICU

79.6% of babies born at less than 27 weeks' were born in a centre with a NICU on site.

0.6% increase from previous year (2022: 79%)

61.6% — **79.6%** — 89.9%

Deferred cord clamping

68.3% of babies born at less than 34 weeks' had their cord clamped at or after one minute.

7.9% increase from previous year (2022: 60.4%)

62.1% — **68.3%** — 77.1%

Temperature on admission

80.4% of babies born at less than 34 weeks' were admitted with a temperature within the recommended range of 36.5°C-37.5°C.

4.1% increase from previous year (2022: 76.3%)

75.5% — **80.4%** — 85.1%

Antenatal magnesium sulphate

85.1% of mothers of babies born at less than 30 weeks' were given antenatal magnesium sulphate.

0.4% decrease from previous year (2022: 85.6%)

78.3% — **85.1%** — 89%

Breastmilk feeding in first 2 days of life

62% of babies born at less than 34 weeks' received their mother's milk in the first 2 days of life.

13% increase from previous year (2022: 49%)

41.4% — **62%** — 78.3%

Parental partnership in care

Breastmilk feeding at 14 days of life

79.6% of babies born at less than 34 weeks' received their mother's milk at 14 days of life.

0.6% increase from previous year (2022: 79%)

70.4% **79.6%** 90.3%

Breastmilk feeding at discharge

63% of babies born at less than 34 weeks' received their mother's milk at discharge.

0.1% increase from previous year (2022: 62.9%)

47.4% **63%** 82%

Parent consultation within 24 hours

95.2% of parents had a documented consultation with a senior member of the neonatal team within 24 hours of their baby's admission.

0.7% decrease from previous year (2022: 95.2%)

92.6% **95.2%** 97.4%

Parent inclusion in consultant ward rounds

38.7% of baby care days had a consultant-led ward round with at least one parent included.

8.5% decrease from previous year (2022: 47.2%)

25.7% **38.7%** 62.3%

Care processes and nurse staffing

On-time screening for retinopathy of prematurity (ROP)

78.4% of eligible babies were screened on time for ROP.

9.4% increase from previous year (2022: 69%)

65.4% **78.4%** 86.4%

Medical follow up at two years

77% of babies born at less than 30 weeks' had a documented medical follow up at the right time.

2.6% increase from previous year (2022: 74.4%)

61.7% **77%** 90.1%

Non-invasive breathing support

49.3% of babies born at less than 32 weeks' received only non-invasive breathing support in the first seven days of life.

1.7% increase from previous year (2022: 47.6%)

41.1% **49.3%** 57.3%

Neonatal nurse staffing

79.3% of nursing shifts were staffed according to recommended levels.

8.2% increase from previous year (2022: 71.1%)

69.3% **79.3%** 91.2%

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

Further information and resources

For neonatal services, neonatal networks and trusts/health boards

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 2023 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**

For parents and families

Your Baby's Care Guide 2023

Parents and families can find more information about the NNAP and 2023 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 and Wales.

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

How we use information

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

Maternal, Newborn and Infant Clinical Outcome Review Programme

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

Saving Lives, Improving Mothers' Care

State of the Nation Report

Surveillance findings and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths from thrombosis and thromboembolism, malignancy and ectopic pregnancy 2020-2022, and morbidity findings for recent migrants with language difficulties.

October 2024

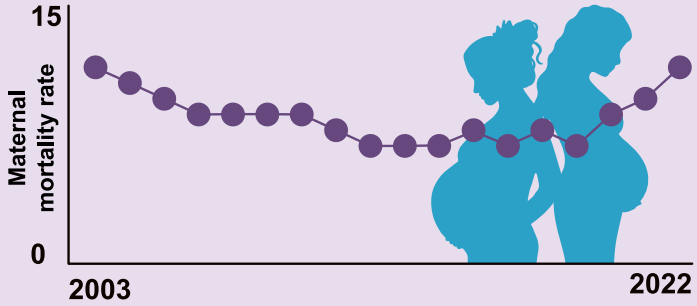
HQIP Healthcare Quality Improvement Partnership
University of Leicester
University of Birmingham
The Newcastle upon Tyne Hospitals NHS Foundation Trust
TIMMS
Sands Stillbirth & neonatal death charity
Chelsea and Westminster Hospital NHS Foundation Trust
University of Oxford
Oxford Population Health
NPEU

Key messages
from the report 2024

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

275 women died during pregnancy or up to six weeks after pregnancy in 2020-2022

13.56 women per 100,000 died during pregnancy or up to six weeks after pregnancy



Causes of women's deaths

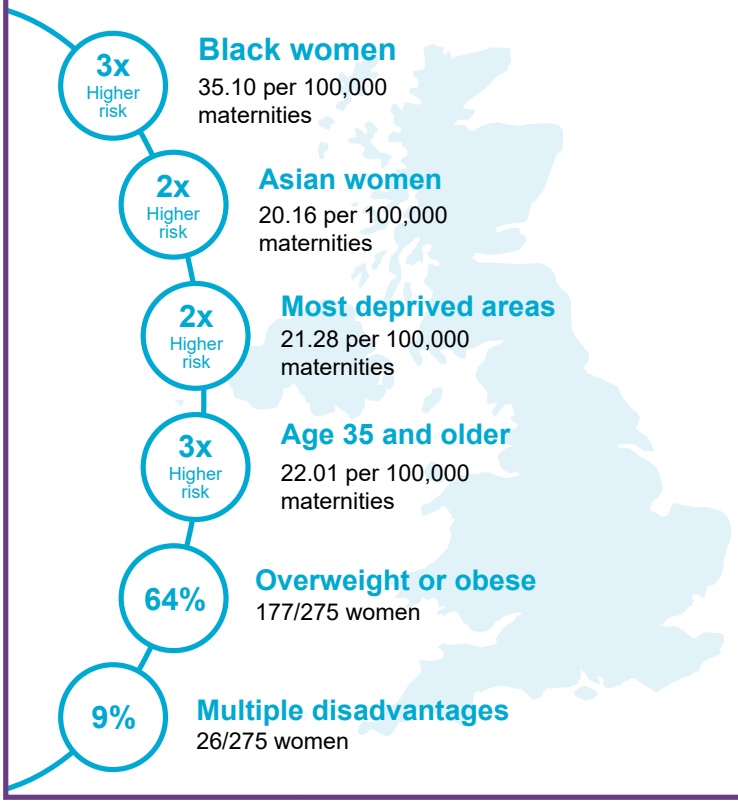
The **national risk assessment tool** must be evidence-based, clear and accurate

Consider the effects of vomiting, dehydration, immobility and other **symptoms** that can increase risk

Risk happens early - define pathways so women who need medication to prevent blood clots can access it when they need it, including in the first trimester

Blood clots	16%
COVID-19	14%
Cardiac disease	13%
Mental health conditions	11%
Sepsis	9%
Epilepsy and stroke	9%
Other physical conditions	7%
Obstetric bleeding	7%
Early pregnancy disorders	5%
Other direct causes	4%
Cancer	3%
Pre-eclampsia	3%

Inequalities in maternal mortality



3x Higher risk — **Black women**
35.10 per 100,000 maternities

2x Higher risk — **Asian women**
20.16 per 100,000 maternities

2x Higher risk — **Most deprived areas**
21.28 per 100,000 maternities

3x Higher risk — **Age 35 and older**
22.01 per 100,000 maternities

64% — **Overweight or obese**
177/275 women

9% — **Multiple disadvantages**
26/275 women

Royal College of Physicians

National Respiratory Audit Programme (NRAP)

Organisational audit 2024

Resourcing and organisation of asthma and COPD care in hospitals, and PR services in England and Wales

Based on data from 2022–24

Publication year: 2024

Organisational audit 2024 – at a glance

425 hospitals/services in England and Wales providing asthma, COPD and PR healthcare participated in the audit

The report is based on data from 2022 to 2024

Appropriate workforce-to-patient ratios should be achieved across England and Wales by 2026

Adult asthma

74.3%

of hospitals met the minimum ratio of one respiratory nurse specialist per 300 admissions

COPD

46.3%

of hospitals met the minimum ratio of one respiratory nurse specialist per 300 admissions

Asthma transition services should be available to all young people transferring to adult services in England and Wales by 2026

CYP asthma

61.2%

of hospitals have at least one element of formal transition in place

Adult asthma

40.4%

of hospitals have at least one element of formal transition in place

Access to respiratory consultant and respiratory nurse specialist to be made available 7 days a week in hospitals in England and Wales by 2026

CYP asthma

0.8%

of hospitals have weekend respiratory nurse availability

Adult asthma

22.1%

of hospitals have weekend respiratory nurse availability

COPD

32.4%

of hospitals have weekend respiratory nurse availability

Access for CYP with asthma to tobacco dependence treatment and support

CYP asthma

44.4% England

20.0% Wales

Provision of tobacco dependence service for CYPA patients

CYP asthma

71.0% England

60.0% Wales

Provision of tobacco dependence service for CYPA parents / carers

Ensure that pulmonary rehabilitation (PR) services are resourced to accept referrals for all eligible respiratory conditions by 2026

PR

100%

of services fund PR for COPD

PR

88.8%

of services fund PR for interstitial lung disease

PR

89.4%

of services fund PR for bronchiectasis

PR

75.0%

of services fund PR for asthma

Royal College of Physicians | National Respiratory Audit Programme (NRAP)

National Vascular Registry

State of the Nation Report 2024

Results for people who had vascular procedures during 2023 in NHS hospitals **in England, Wales, Scotland and Northern Ireland**

November 2024

Commissioned by:

Royal College of Surgeons of England
ADVANCING SURGICAL CARE

VASCULAR SOCIETY
OF GREAT BRITAIN AND IRELAND

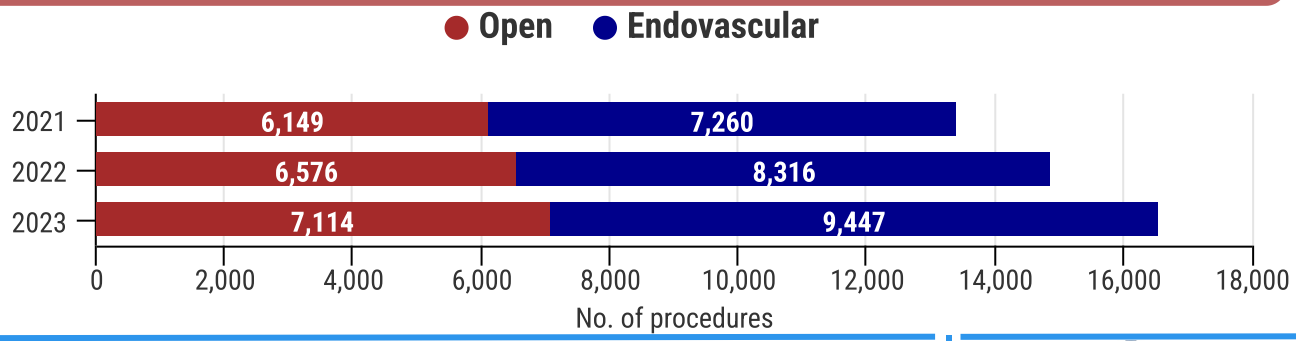
BSIR British Society of Interventional Radiology

HQIP Healthcare Quality Improvement Partnership

Lower limb revascularisation for peripheral arterial disease (PAD) to prevent limb loss

Peripheral arterial disease (PAD) is a condition caused by narrowing of the blood vessels that supply the legs. This causes severe pain on walking and can lead to amputation.

Open and endovascular (minimally invasive) procedures can be carried out to increase the blood flow to the legs and feet.



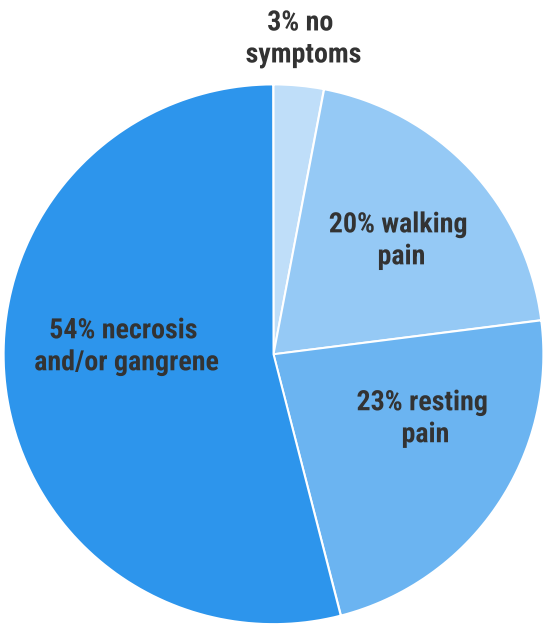
Patient characteristics in 2023

72% were male

70% were older than 65 years

50% were diabetic

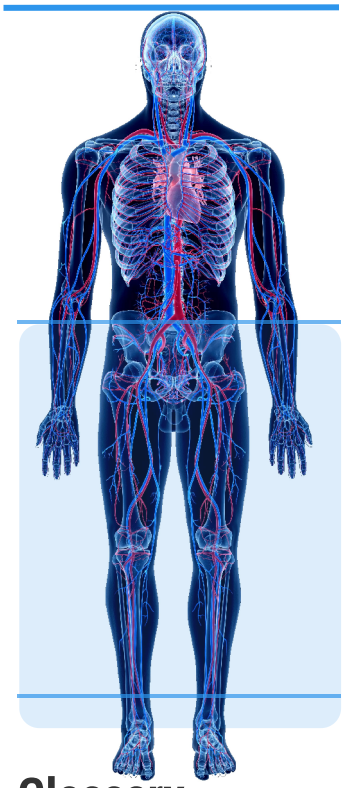
80% were current or ex-smokers



50% of patients admitted with CLTI had their procedure within 5 days, which is the recommended time

However for 16/60 hospitals, 25% of patients waited more than 10 days

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

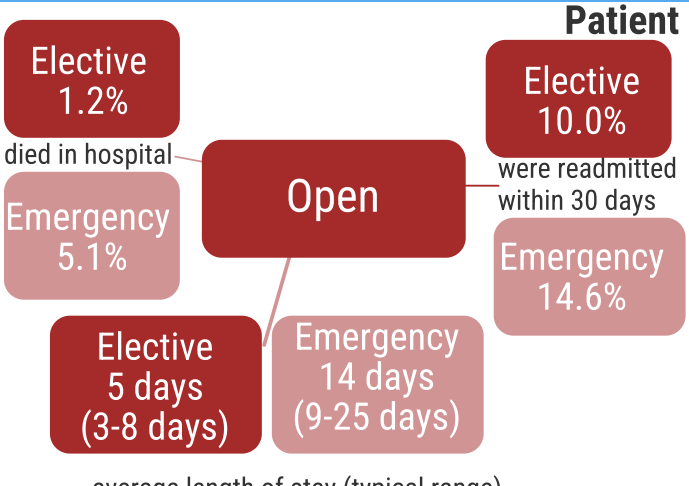


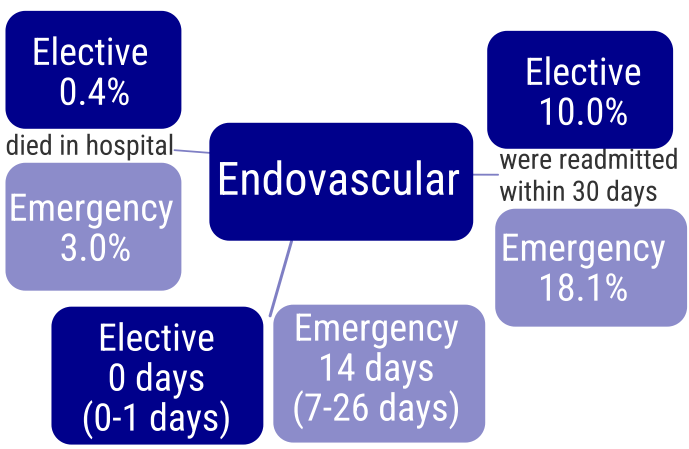
Glossary

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 in 2023

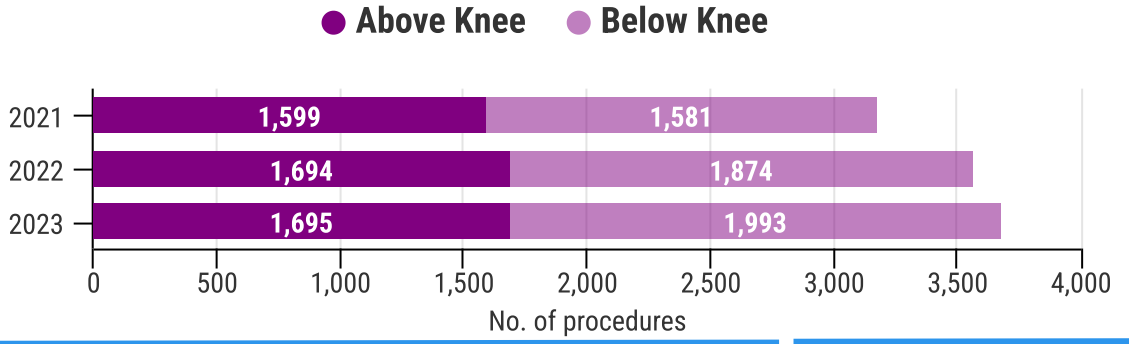




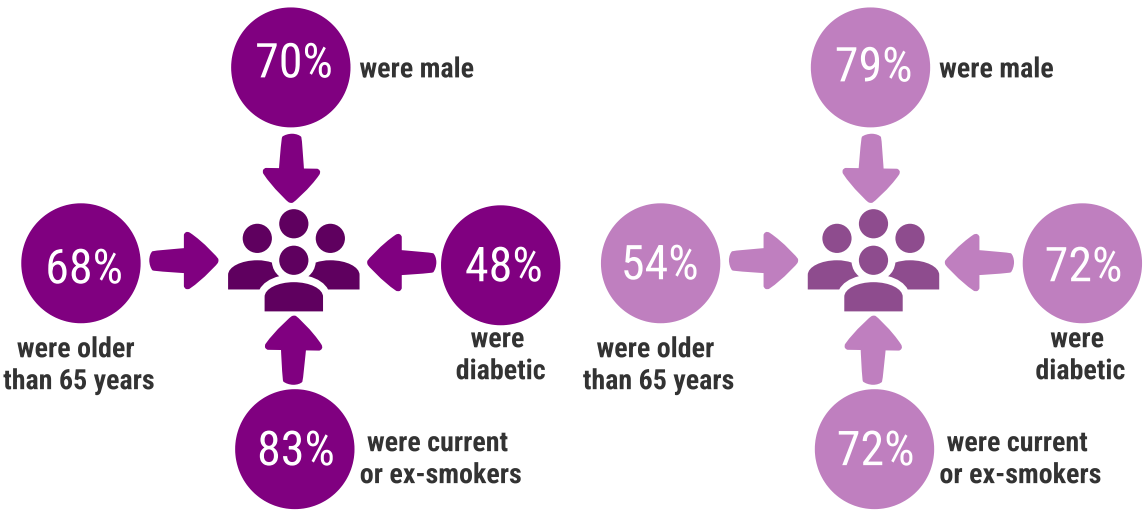
Lower limb major amputation for peripheral arterial disease (PAD)

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.

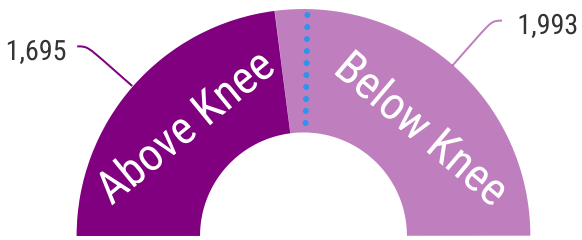
PAD can gradually progress in some patients and an operation to improve blood flow may no longer be possible. In these situations, people will require amputation of the lower limb. Additionally, patients without PAD but with a complication of diabetes may require a major amputation.

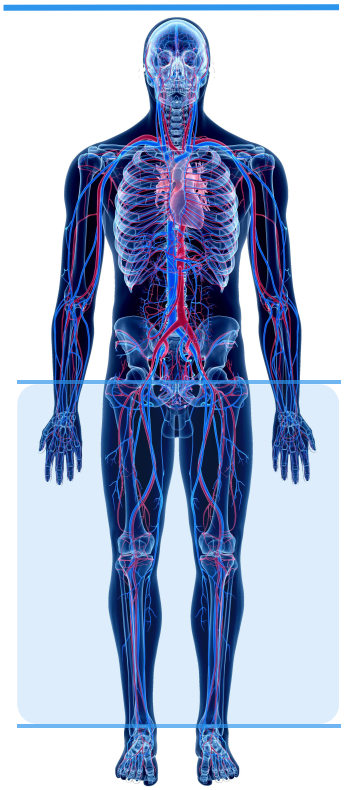


Which people had surgery in 2023?



Hospitals should aim to have an above knee amputation to below knee amputation ratio less than 1. In 2023, the national ratio was 0.85, but it varied across the country. 18/61 (30%) of hospitals had a ratio above 1.

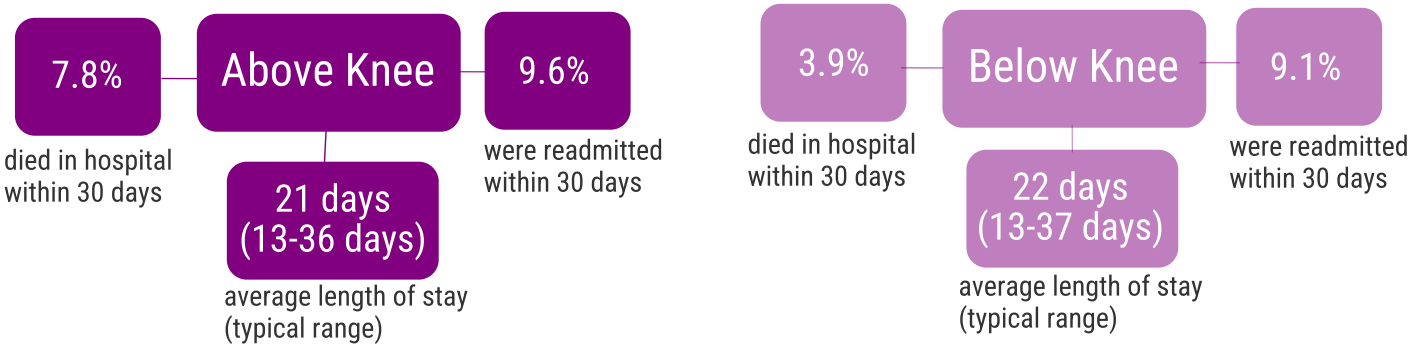




Glossary

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

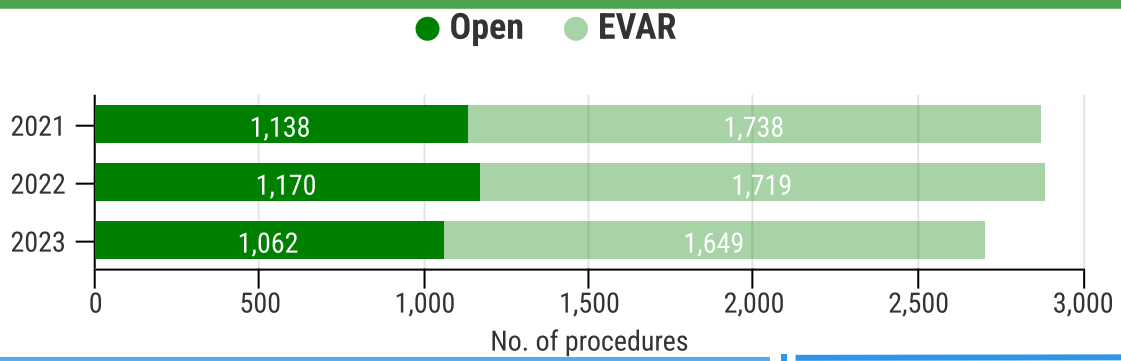
Patient outcomes after amputation in 2023



Repair of abdominal aortic aneurysm (AAA) to prevent rupture/bursting

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. A procedure for AAA can be repaired by traditional open surgery through the belly or by less invasive endovascular (keyhole) surgery (EVAR) using a stent.

The number of AAAs carried out each year has remained fairly stable over the last few years, although they are much less than the numbers carried out 10 years ago.



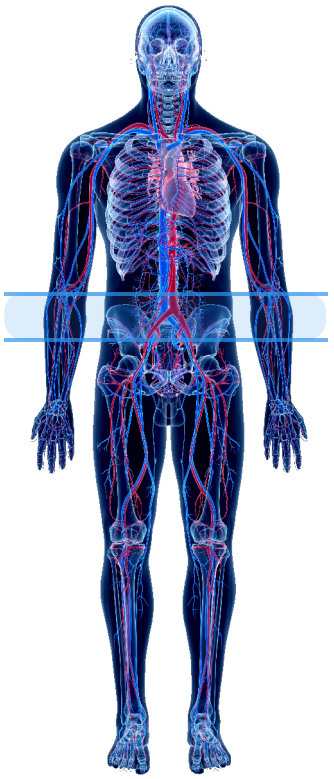
Patient characteristics in 2023

Open

- 93% were male
- 79% were older than 65 years
- 64% had high blood pressure
- 86% were a current or ex-smoker

EVAR

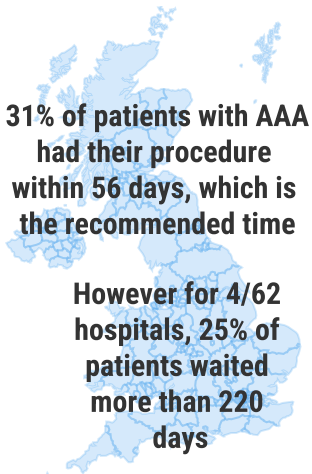
- 91% were male
- 93% were older than 65 years
- 66% had high blood pressure
- 81% were a current or ex-smoker



How were patients assessed?

- 87% discussed at MDT meeting
- 94% had pre-operative CT or MRI scan date recorded
- 84% had fitness measured
- 98% had formal anaesthetic review
- 91% of these had review by consultant vascular anaesthetist

Waiting Times



31% of patients with AAA had their procedure within 56 days, which is the recommended time

However for 4/62 hospitals, 25% of patients waited more than 220 days

Glossary

MDT is a multi-disciplinary team.
The average is the median; "typical range" is the interquartile range.

Patient outcomes after surgery in 2023

Open

- 2.7% died in hospital
- 3.9% were readmitted within 30 days
- 7 days (6-10 days) average length of stay (typical range)

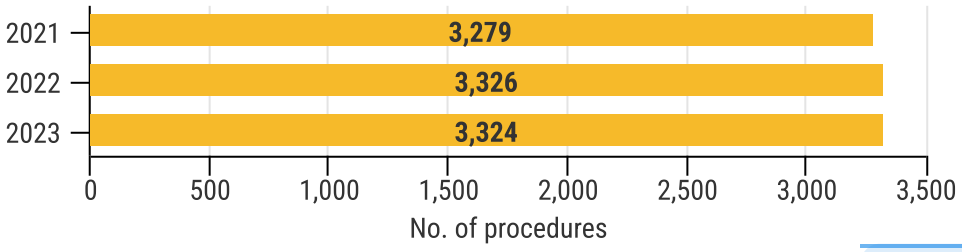
EVAR

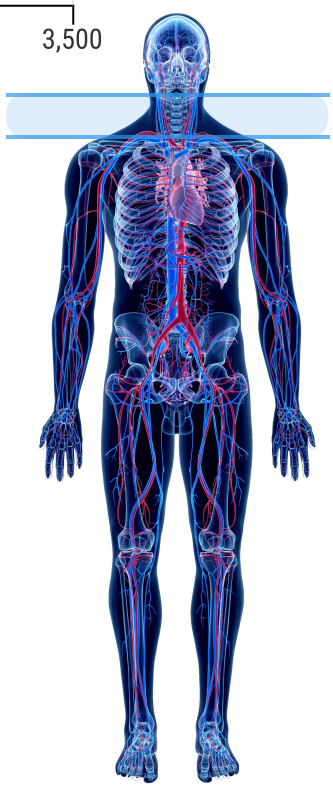
- 0.3% died in hospital
- 4.9% were readmitted within 30 days
- 2 days (1-2 days) average length of stay (typical range)

Carotid artery surgery to prevent stroke

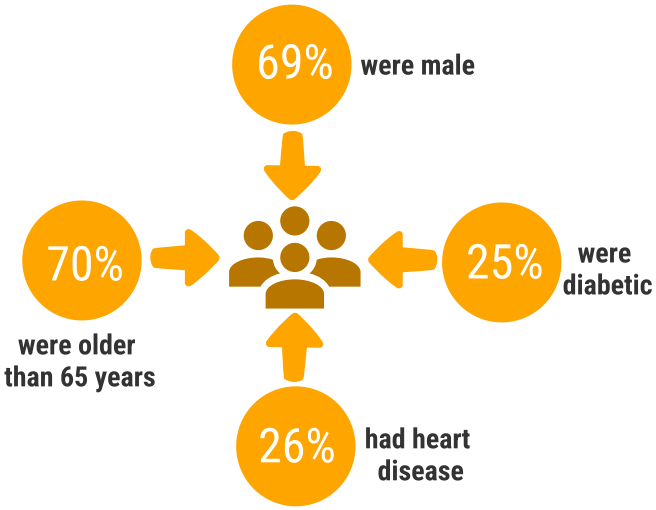
A procedure in which build-up of plaque is removed from the carotid artery in the neck is called a carotid endarterectomy (CEA).

The number of CEAs carried out each year has remained fairly stable over the last few years. The numbers are almost half those carried out 10 years ago.

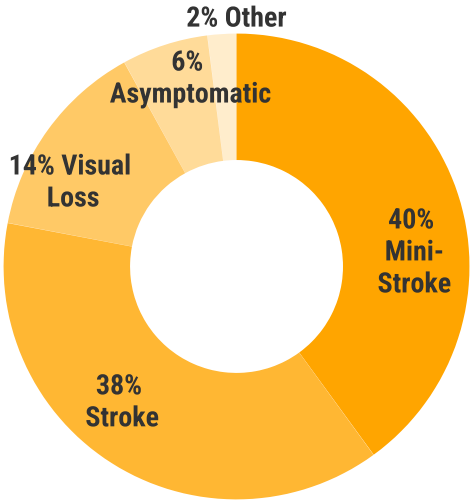




Which people had surgery?

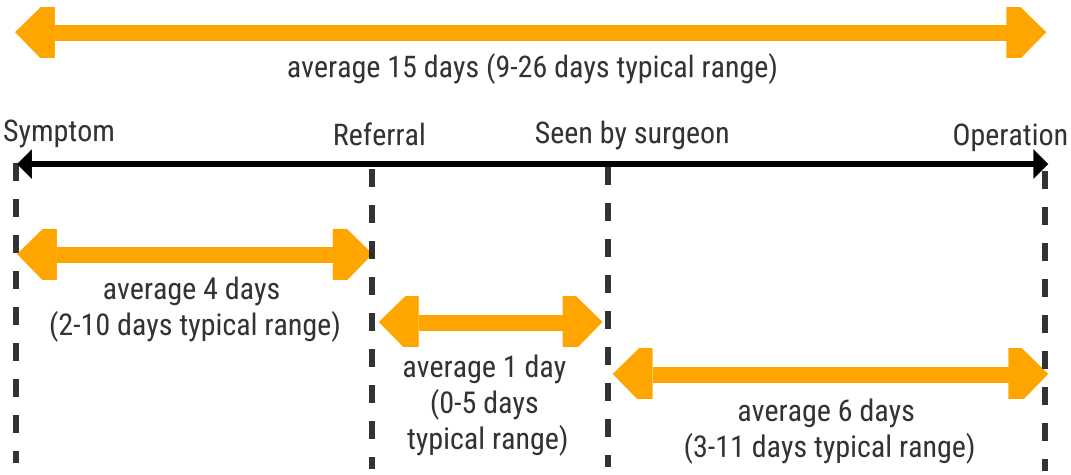


Reasons for surgery



Treatment times for symptomatic patients

Recommended time from symptom to surgery is within 14 days



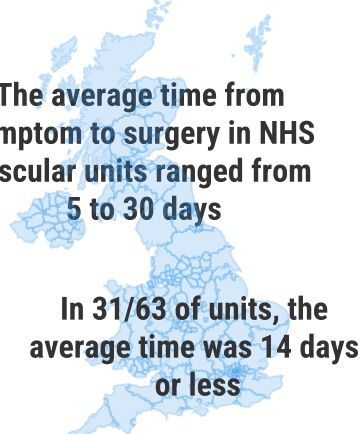
Glossary

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.

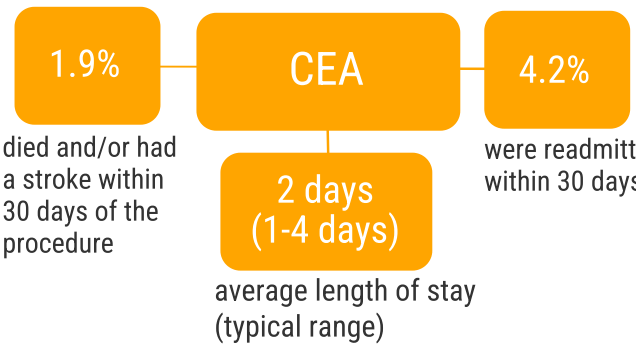
A patient showing symptoms is known to be symptomatic.



The average time from symptom to surgery in NHS vascular units ranged from 5 to 30 days

In 31/63 of units, the average time was 14 days or less

Outcomes of surgery in 2023



State of the Nation Report 2024

Stroke care received between April 2023 to March 2024

KING'S College LONDON

SSNAP
Sentinel Stroke National Audit Programme

Commissioned by
HQIP
Healthcare Quality Improvement Partnership

Summary of results for people admitted to hospital with stroke

Stroke care providers

95,222
stroke admissions

250
hospitals

195
community services

184
6 month follow-up providers

Arrival at hospital

4h00m
median time from onset to arrival at first hospital
3h55m 2022/23

Acute interventions

11.6%
of all stroke patients received thrombolysis
10.7% 2022/23

Click here to see country rates

3.9%
of all stroke patients received a thrombectomy
3.1% 2022/23

Click here to see country rates

24.9%
of eligible patients received hyperacute intervention for intracerebral haemorrhage within 1 hour of hospital arrival
22.8% 2022/23

6 month follow-up

38.8%
of applicable patients received a 6 month follow-up
38.7% 2022/23

Hyperacute assessment

26.5%
of patients received brain imaging within 20 minutes of hospital arrival
24.9% 2022/23

22.5%
of patients were assessed by a stroke specialist consultant within 1 hour of hospital arrival
19.3% 2022/23

Specialist pathway

46.7%
of patients were directly admitted to a stroke unit within 4 hours of hospital arrival
40.2% 2022/23

75.9%
of patients spent at least 90% of their hospital stay on a specialist stroke unit
72.8% 2022/23

63.4%
of patients were discharged to a stroke/neurology specific community rehabilitation service
61.1% 2022/23

22.9%
of patients were discharged to a stroke/neurology specific combined ESD-CRT service

***Hyperacute intervention for intracerebral haemorrhage**: for patients on anticoagulants eligible for reversal, given reversal agents within 1hr of arrival OR for patients with elevated systolic blood pressure (>150mmHg) on admission, given anti-hypertensives within 1hr of arrival.*

***Discharge to a combined ESD-CRT service** can only be measured for the 2023/24 year and so there is no comparative data for 2022/23.*

*From 2024/25, a new metric for the proportion of patients assessed by a **stroke-skilled clinician** within 1hr of arrival will be reported. In this report, the proportion of patients assessed by a **stroke specialist consultant** within 1hr of arrival has been used.*

***Key:** green icons show improvement against previous year, orange no change, and red worsening. Technical guidance on metrics available here.*

Planning for the End

A review of the quality of care provided to adult patients towards the end of life

NCEPOD

Improving the quality of healthcare

EXECUTIVE SUMMARY

Each year over 600,000 people die in the United Kingdom and many of these deaths occur in hospital, despite the majority of people saying that they would prefer not to die there. Approximately 70% of people die from long-term health conditions that often follow a predictable course, with death anticipated well in advance of the event. The annual number of deaths in the United Kingdom is predicted to rise to 736,000 by mid-2035. Therefore, the provision of care at the end of life must meet the needs of the population.

The quality of care provided towards the end of life for adults with a diagnosis of dementia, heart failure, lung cancer or liver disease were reviewed. The sampling period of death or final admission (for community deaths) was between 1st April 22 and 30th September 22. Data included 701 clinician questionnaires and the assessment of 350 sets of case notes. In addition, organisational data were kindly supplied by the National Audit of Care at the End of Life (NACEL).

★ Palliative care is not just about end of life care

Not enough patients had access to early palliative care alongside existing treatments to improve symptoms and quality of life.

135/439 (30.8%) patients had parallel planning.

During the final admission, the specialist palliative care team were involved in the care of 230/446 (51.6%) patients.

Where a parallel planning approach was not taken, this linked to room for improved clinical care for 58/140 (41.4%) patients.

★ Normalise conversations about death and dying

Death and dying was not discussed as often as it could have been. More people need to have their end of life care wishes recorded.

169/233 (72.5%) patients did not have their preferences for care at the end of their life recorded.

Communication was an area for improvement and of good practice. This included how patients and their families were included in decisions about care being provided, and advance care plans.

★ Have a named care co-ordinator

Care co-ordinators are an accepted standard in cancer services but were less common for other advanced chronic conditions.

There was documentation of a lead person in the records of 257/396 (64.9%) patients.

When a lead person was documented, specific end of life documentation was used in 162/243 (66.7%) patients, compared with 44/134 (32.8%) where there was no lead person documented.

★ Provide specialist palliative care services in hospitals and in the community

Specialist palliative care services were not always available in hospitals nor involved when needed.

Seven-day specialist palliative care services were available in 125/210 (59.5%) hospitals.

120/290 (41.4%) patients without parallel planning had specialist palliative care input, compared with 94/130 (72.3%) who did.

For 77/444 (17.3%) patients specialist palliative/end of life care input could have been better.

★ Palliative and end of life care should be a core competency for all healthcare staff

Training to identify when palliative or end of life care will help was not always provided or available.

Training in end of life care was included in the induction programme in only 137/214 (64.0%) hospitals and in mandatory or priority training in 110/214 (51.4%) hospitals.

Training in end of life care for all healthcare staff is needed to recognise who would benefit from specialist palliative care to treat the symptoms of advanced chronic disease.

NPDA
National Paediatric Diabetes Audit

RCPCH Audits

First Year of Care Parent and Patient Reported Experience Measures (PREMs) 2024

July 2023 – January 2024

HQIP
Healthcare Quality Improvement Partnership

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

NPDA National Paediatric Diabetes Audit

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

NPDA First Year of Care Parent and Patient Reported Experience Measures (PREM) 2024

The National Paediatric diabetes audit monitors the care received and diabetes outcomes achieved by children and young people with diabetes in England and Wales, and helps support paediatric diabetes teams, local health systems, and policy makers to make continuing improvements to care.

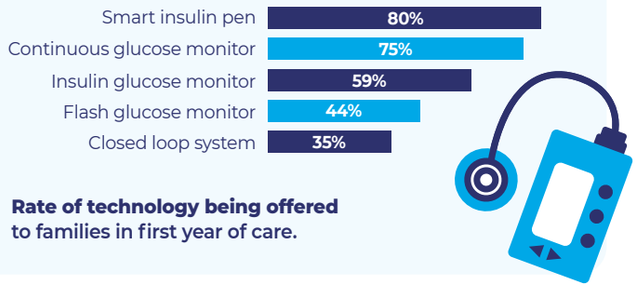
This poster summarises the results reported in the 2024 PREM report, and is based on data from July 2023 to January 2024.

Who took part?

2,712 responses

726 were from children and young people and **1986** from parents and carers.

Access to technology



Rate of technology being offered to families in first year of care.

Availability of Specialist Advice

Almost all (**97%**) respondents received face-to-face support, while **85%** of parents and carers and **60%** of children and young people received support via telephone.

82%
Could always contact their diabetes team during **core 9am – 5pm hours**

71%
Could always access appropriate advice **24 hours a day**

Diabetic Ketoacidosis (DKA) at Diagnosis

DKA is a life-threatening complication of diabetes where **there is a severe lack of insulin** in the body.

44%
of parents and carers stated that their child had DKA at diagnosis. **15%** didn't know whether they or their child had DKA at diagnosis.

Input from Data Professionals

Percentage of parents and carers who were able to **see diabetes team members at every visit:**

Impact on Parents' Employment and Sleep

11%
reported that they or their **partner left employment due to their child's diabetes care needs.** 30% reduced their hours.

47%
had **disrupted sleep over 3 times a week** due to attending to their child's diabetes care needs.

Further Information and Resources

NPDA national reports and recommendations:

The NPDA First Year of Care Parent and Patient Reported Experience Measures (PREMs) 2024 report includes the key messages and recommendations based on the data. Extended analyses of the data have also been made available. These are available at **www.rcpch.ac.uk/NPDA-PREM-Report**

More on the NPDA:

The NPDA also publishes an annual report into the care received and outcomes achieved by children and young people in England, Wales, and Jersey. These can be found at: **www.rcpch.ac.uk/resources/npda-annual-reports**

How we use information:

To find out more about how we use data submitted to the NPDA, please see our privacy notice. Please visit: **www.rcpch.ac.uk/resources/national-paediatric-diabetes-audit-transparency-open-data** or scan the QR code with your phone.

NCMD
National Child Mortality Database

Knowledge, understanding and learning to improve young lives

Child deaths due to Asthma or Anaphylaxis

National Child Mortality Database Programme Thematic Report

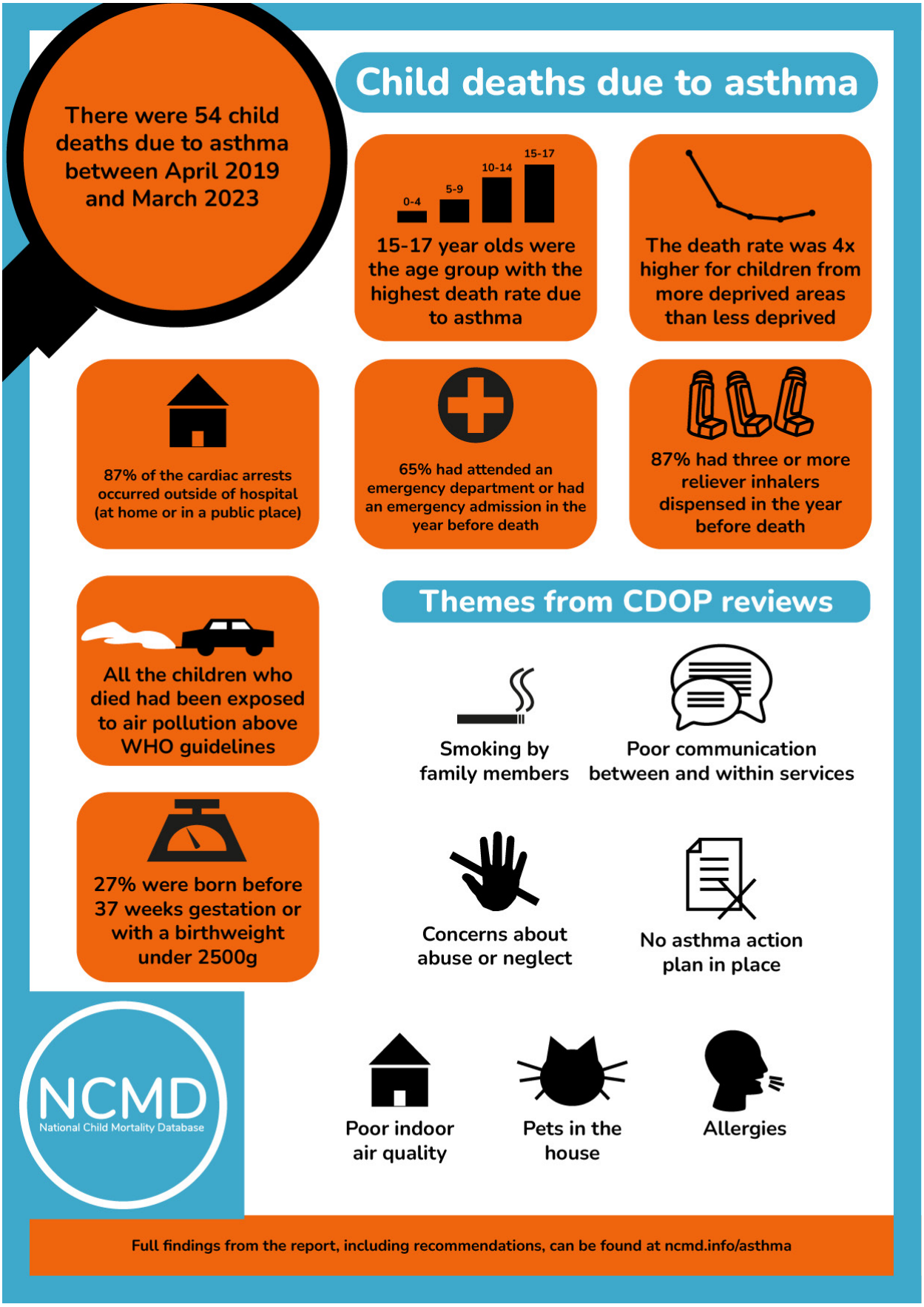
Data from April 2019 to March 2023

Published December 2024

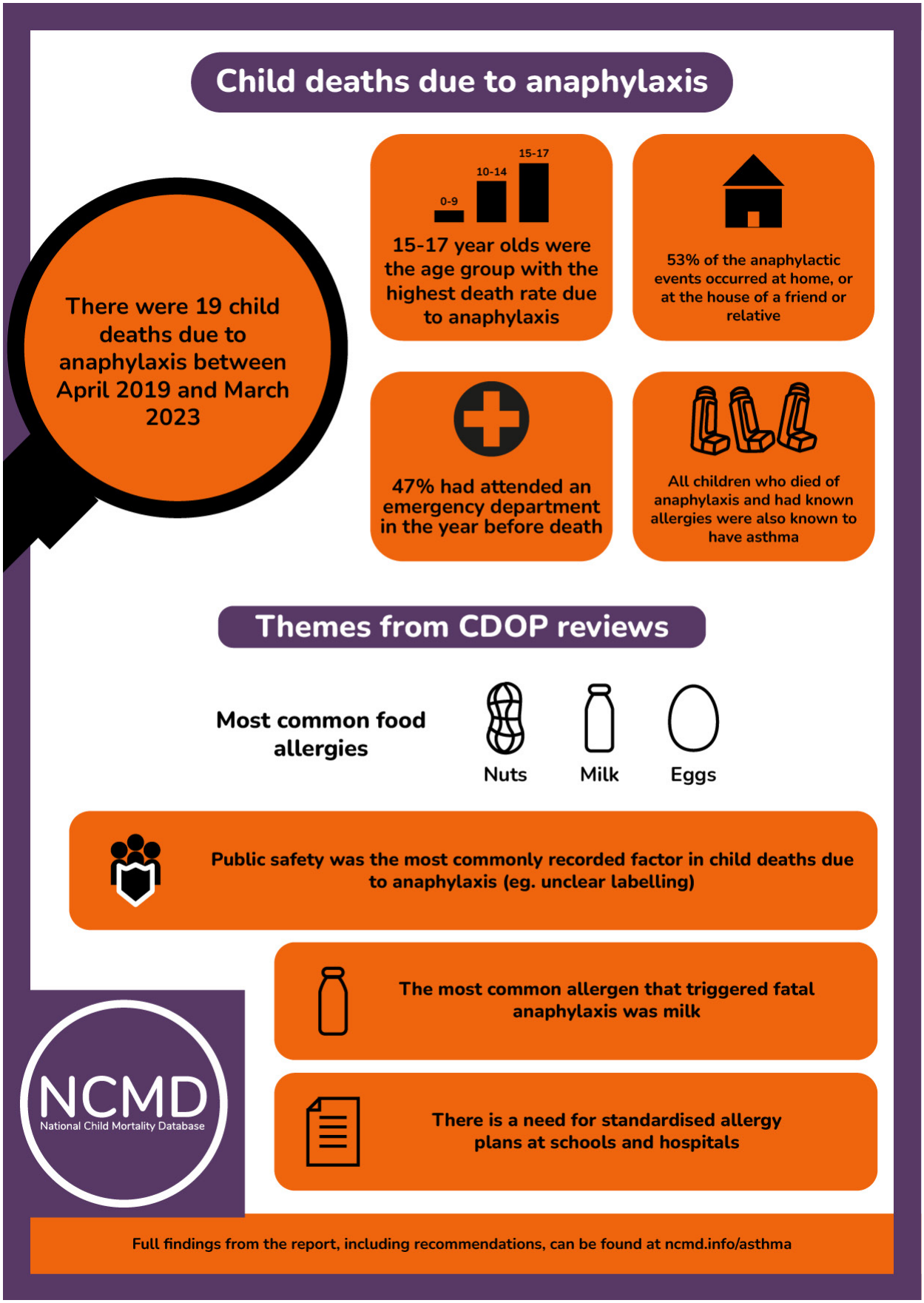
www.ncmd.info

HQIP

Child deaths due to asthma – key findings



Child deaths due to anaphylaxis – key findings



CVDP ANNUAL AUDIT REPORT 2024

Department of Health & Social Care

CVDPREVENT

(Audit Period to March 2024)

Using data to drive cardiovascular disease prevention

HQIP
Healthcare Quality Improvement Partnership

CVDPREVENT

Check out the Data & Improvement Tool

CVDPREVENT Annual Audit Report 2024 – Key findings

Data up to 31st March 2024

CVDPREVENT is a national primary care audit that automatically extracts routinely held GP data about the prevention of cardiovascular disease, for more information click here. This infographic summarises the key findings from the 2024 annual report which can be found here, highlighting key pieces of the data from March 2024.

HYPERTENSION

Key finding 1

499,314 patients need to be treated to meet the 77% ambition[1] set by NHS England

71% of patients with hypertension were treated to the recommended blood pressure (BP) threshold, this compares to 69% in March 2023

69% March 2023

Key finding 2

1 in 4 people with hypertension were aged 18 – 59 years

They were less likely than people in older age groups to be treated to recommended BP threshold

ATRIAL FIBRILLATION (AF)

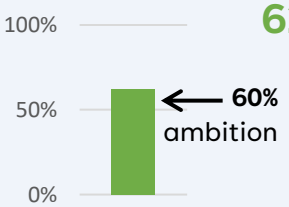
Key finding 8

90% ambition set by NHS England

92% of patients with AF at high-risk of stroke were prescribed an anticoagulant, meeting the 90% ambition[2]

CHOLESTEROL

Key finding 5



62% of patients with no cardiovascular disease (CVD) and a QRISK score over 20% had a prescription for lipid lowering therapy (LLT), hitting the 60% ambition set by NHS England

Key finding 6

37% of patients with CVD had their cholesterol lowered to threshold[3]

24% March 2022

37% March 2024

This compares to 24% in March 2022 when this indicator was first reported

Key finding 7

Looking at patients with diagnosed CVD

8 in 10 people in the black ethnic group

compared to

9 in 10 people in the Asian ethnic group

had a current prescription for LLT

(1) NHS priorities and operational planning guidance 2023/24
(2) Public Health England, 2019
(3) Threshold refers to the 2023/24 QOF threshold of non-HDL cholesterol less than 2.5mmol/l or LDL-cholesterol less than 1.8mmol/l.
(4) Blood pressure over 160/100mmHg
(5) Mortality rates calculated for people as per CVDPREVENT outcomes analysis. For more information, please read our guidance.

NHS England | Department of Health & Social Care | HQIP Healthcare Quality Improvement Partnership

CVDPREVENT Annual Audit Report 2024 – Key findings

Data up to 31st March 2024

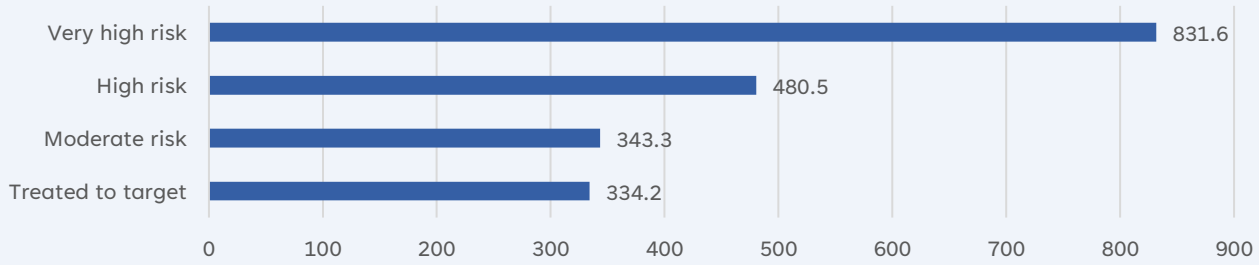
In February 2024 the CVDPREVENT audit data was linked to hospital and deaths records to better understand the health outcomes of its patients. Using this linked dataset, outcomes indicators were developed and are now being reported on by the audit. Click here to find out more about these indicators and view key findings around mortality and health inequalities below, as identified in the CVDPREVENT 2024 Annual Audit Report.

MORTALITY & INEQUALITIES

Key finding 3

People with hypertension with 'high' and 'very high' BPs(4) on 1st April 2023 were more likely to die(5) from CVD than those with lower risk blood pressures, measured 1st April 2023 – 31st March 2024

Mortality from cardiovascular disease among patients with hypertension aged 18 to 79 (Age-standardised rate per 100,000 person years)



Key finding 4

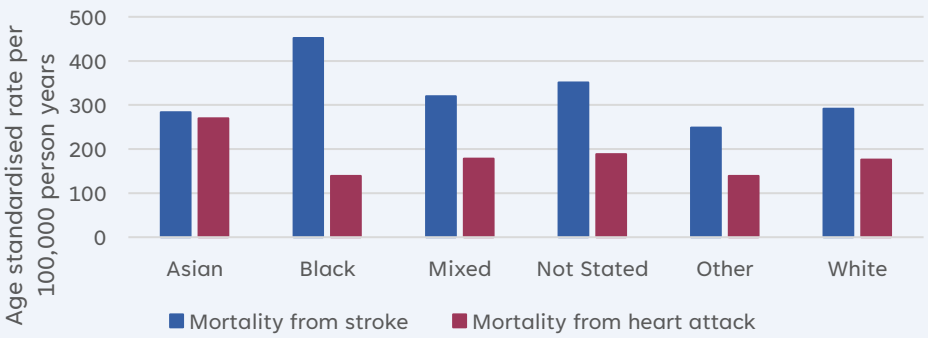
Looking at patients who had a diagnosis of hypertension as of 1st January 2023

The CVD mortality rate(5) for the most deprived quintile was **2 TIMES HIGHER** when compared to CVD mortality rate for the least deprived quintile

Key finding 9

Looking at patients with CVD, mortality from stroke(5) was highest in the black ethnic group and mortality from heart attack(5) was highest in the Asian ethnic group

Mortality from stroke/heart attack among patients with CVD by ethnicity



(1) NHS priorities and operational planning guidance 2023/24
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(3) Threshold refers to the 2023/24 QOF threshold of non-HDL cholesterol less than 2.5mmol/l or LDL-cholesterol less than 1.8mmol/l.
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Maternal, Newborn and Infant Clinical Outcome Review Programme

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

MBRRACE-UK Perinatal confidential enquiry

The care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death

State of the nation report

December 2024

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

The care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death

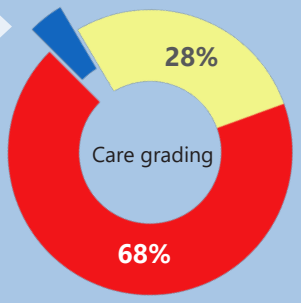
MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

The care of 25 women and their babies was reviewed

The women arrived in the UK less than two years prior to giving birth and had a preferred language other than English

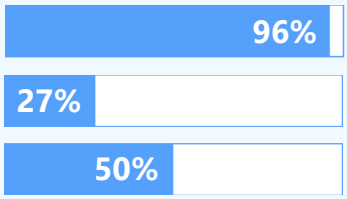
Medical notes reviewed by clinical experts

Only 1 out of 25 (4%) mother-baby pairs received care graded as 'Good'



- Good care; no improvements identified
- Care improvements identified that didn't affect the outcome
- Care improvements identified that may have affected the outcome

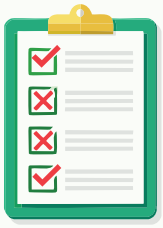
1 Language barriers and interpretation



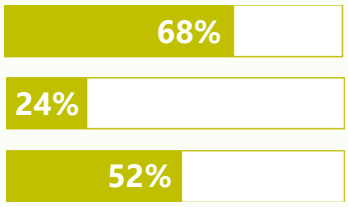
Almost all of the women had a documented need for an interpreter.

There were 589 separate contacts with healthcare services, but only 27% took place with a documented professional interpreter.

50% of contacts took place without any documented interpreter.



2 Gaps in antenatal care



68% of women didn't book their pregnancy, or booked late in their pregnancy.

24% of women who booked their pregnancy received antenatal care in line with national guidance.

52% of women had an opportunity to talk about their mental health during the antenatal period.

3 Bereavement care in the community

59% of women whose baby died received documented bereavement care in the community.

4 Research and service development gaps

- Lack of research to inform service development for women new to the UK and non-English speakers.
- Services do not meet the needs of these women effectively.

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

Paediatric Intensive Care Audit Network

National Paediatric Critical Care Audit
State of the Nation Report 2024

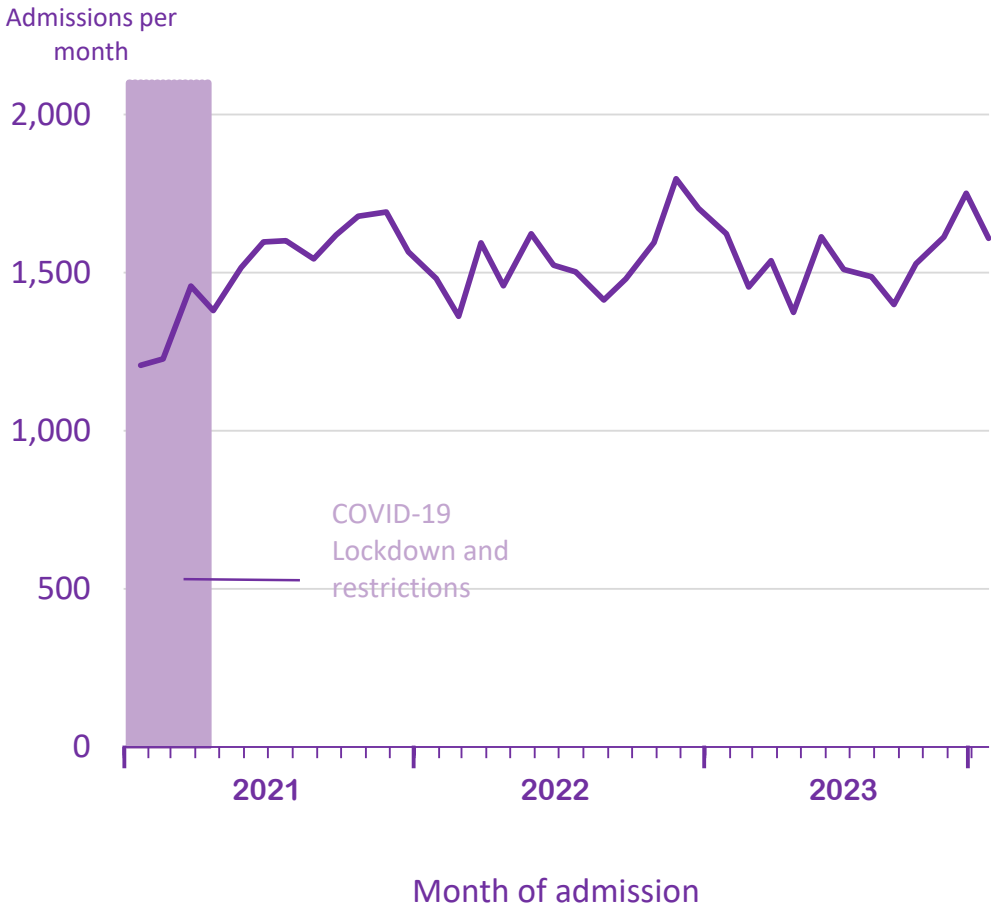
Summary Report

Data Collection Period: January 2021 - December 2023
Published 2024

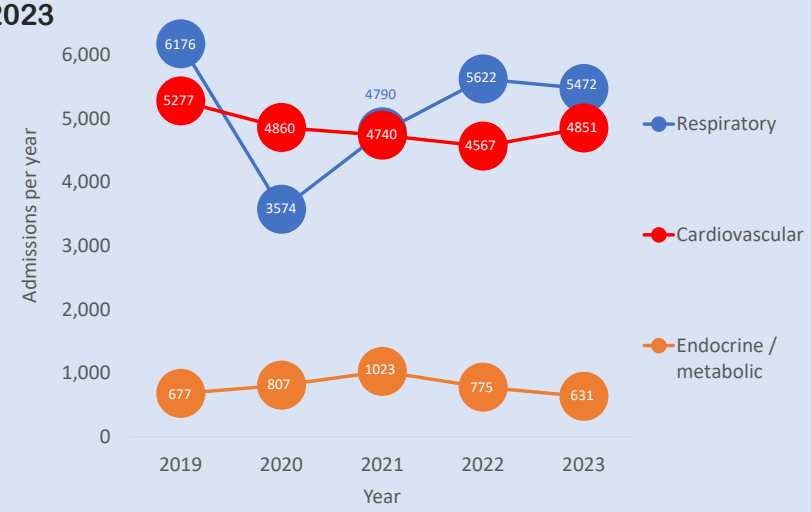
Paediatric Intensive Care Audit Network
Level 3 National Paediatric Critical Care Audit
picanet.org.uk · picanet@leeds.ac.uk

State of the Nation Report 2024

Admissions to paediatric intensive care across the UK and Republic of Ireland, 2021 – 2023

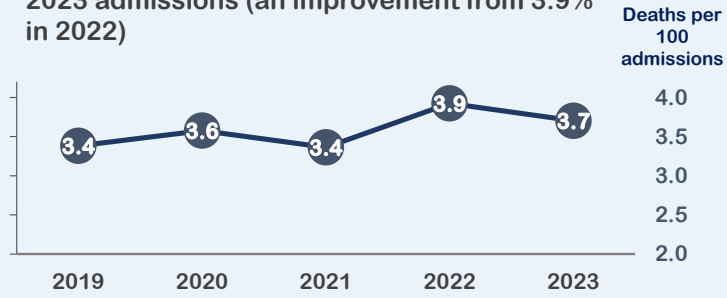


Respiratory admissions were the most common primary diagnosis, making up just under 30% of all PICU admissions in 2023



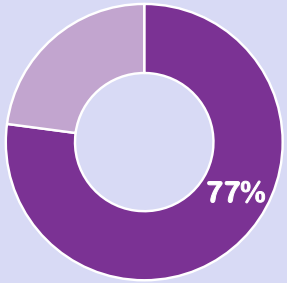
In-PICU mortality, 2019 - 2023

Mortality for children in PICU was 3.7% of 2023 admissions (an improvement from 3.9% in 2022)

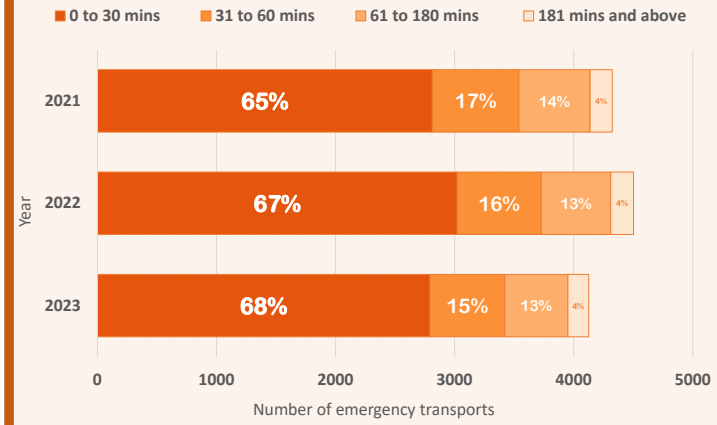


Key Metrics

77% of PICU admission records met the 2-month Paediatric Critical Care Society Quality Standard in 2023

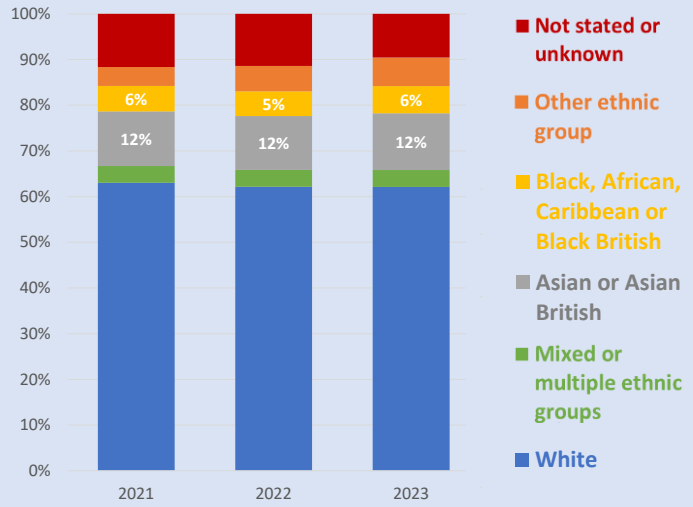


The percentage of emergency transports being mobilised within 30 minutes increased year on year from 2021 to 2023

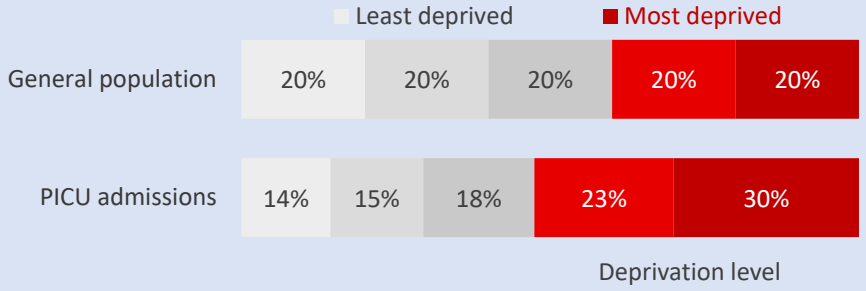


Ethnic distribution of PICU admissions 2021 – 2023

The percentage of admission from Asian and Black ethnicities increased in 2023 to 18.3% from 17.1% in 2022



PICU admissions by deprivation level 2021 – 2023



Children living in the highest areas of deprivation were more likely to be admitted to a PICU