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1. MSSA Bacteraemia Can Be Eliminated in LVAD Patients

Authors Smith N.R.; Woods A.; Brown S.T.; MacGowan G.A.; Schueler S.; Samuel J.
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Abstract Purpose: The incidence of MSSA bacteraemia continues to plague clinicians, with trends continually rising in the UK (Darzi, 2018). This is echoed in the MCS community. We aim to demonstrate how we have significantly reduced the incidence of this infection at our centre.
Method(s): Following several root cause analyses exploring MSSA bacteraemia in our patient cohort, several practice developments were incorporated into our local and regional guidance, in conjunction with advice from our microbiologists. The changes included:Strategic: Root cause analysis for all VAD associated MSSA/MRSA bacteraemia, Review of health care acquired infections at Trust Serious Infection Review meetings.
Operational: VAD MSSA policy Introduction of MSSA screening at intervals of pre operatively, weekly for all inpatients, and at all clinic visits. MSSA Eradication therapy. Robust aseptic non touch technique training for all clinicians and competency assessments. Universal anti-microbial washes. Antibiotic suppression for MSSA colonised patients. Driveline management: regular reviews, change of dressings, audits of appropriate dressing, timely surgical intervention.
Result(s): 160 patient records were reviewed retrospectively, with a total of 31 MSSA bacteremia being identified between 2011-2017. (Table 1) As seen in Table 1, a peak in MSSA bacteraemia was identified in 2012-2013 prior to the introduction of the practice developments. In subsequent years our rate of MSSA bacteraemia has fallen sharply. The total number of annual LVAD implants have stayed consistent around 30 per annum. [Table presented]
Conclusion(s): With the introduction of our practice developments we have almost completely eliminated MSSA bacteremia in our LVAD community.
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2. EDTA contamination: Old FOE but still not resolved in the laboratory

Authors Marrington R.; French J.; Anderson M.; MacKenzie F.; Whitehead S.
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Abstract BACKGROUND-AIM: Potassium EDTA (Ethylenediaminetetracetic acid) K2EDTA is an anticoagulant used in blood collection tubes for many laboratory tests. Gross EDTA contamination, from blood sampling collection errors, is easily recognised with marked hyperkalemia and hypocalcaemia. More subtle contamination is not so easily identified, but can still affect patient management. A case is described where potassium is elevated above the phone limit at 6.51 mmol/L. Adjusted calcium, magnesium and ALP were normal. Repeat bloods showed potassium was 4.2 mmol/L. The first sample contained >0.5 mmol/L EDTA. The impact of subtle EDTA contamination on routine clinical chemistry assays has been assessed through the UK NEQAS for Clinical Chemistry EQA Scheme, as well as an audit of the handling of suspected EDTA contamination.
METHOD(S): Female non-clinical issue donations from NHSBT were pooled, and spiked with 0, 0.25 and 0.5 mmol/L K2EDTA. These three specimens were distributed to 628 participants in the UK NEQAS for Clinical Chemistry scheme at Distribution 1033 (February 2018).
RESULT(S): Results were returned by 614 participants, as expected serum potassium was elevated by 0.5 and 1.0 mmol/L, whilst the calcium and magnesium levels were affected by differing amounts dependent on method. Iron, copper and zinc showed method specific issues; however, no significant impact was seen on other analytes within the EQA Scheme including ALP. The participant audit showed a wide range in laboratory practices for identifying EDTA contamination, with 1.2% participants offering an EDTA service. 32 different protocols were given for which analytes are not reported if EDTA contamination is suspected (from 402 responses).
CONCLUSION(S): EDTA contamination is not a new concept, but despite evidence of a high prevalence in routine clinical laboratories, there is a wide range in practice on handling suspected EDTA contamination, with only a few laboratories routinely measuring EDTA concentrations.

3. Improving patient safety through optimisation of airway management strategies

Authors Nabecker S.; Greif R.; Kleine-Brueggeney M.; Riggenbach C.; Theiler L.
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Database EMBASE
Available at Swiss Medical Weekly from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Background: An UK Audit (NAP4) (1) estimated severe airway management-related complications in 1 of 5.500 anaesthesia cases. The incidence of minor complications remains unclear. Nonetheless, minor incidents have the potential to accumulate and lead to fatal events (2). Our goal is to improve patient safety through optimisation of airway management strategies. For this reason, we first obtained a baseline to estimate the incidence and nature of minor and major airway related events, followed by an intervention phase, and finally the re-analysis as a before and after cohort study to decrease severe and minor airway management-related complications.
Method(s): As a baseline benchmark, all general anaesthesia cases at the University Hospital of Bern, Switzerland were closely monitored during two months. Based on these results, 5 interventions were implemented in the 10 months until the next evaluation phase. The interventions were: 1. To not check proper facemask ventilation before inducing neuromuscular blockade. 2. To preoxygenate optimally. 3. To perform a standardised compulsory pre-anaesthesia check. 4. To change operator (to most experienced) after 2 unsuccessful attempts to secure the airway. 5. To use videolaryngoscopy whenever possible. This was followed by the re-analysis. Our primary outcome parameter was the incidence of airway management-related events.
Result(s): During baseline analysis, 3.681 general anaesthesia cases were closely monitored over a 2-months period. Airway managementrelated events occurred in 574 cases (15.6%). Most frequent problems included: difficult bag-valve-mask ventilation (16.9%), several attempts needed to secure the airway (14.5%), Cormack & Lehane Score >2 (12.7%) and hypoxia or desaturation <95% (12.3%). The re-analysis after the implementation of the interventions listed above started on May 1st 2016 and will continue until June 30th 2016.
Discussion(s): The baseline analysis revealed a surprisingly high number of desaturations. At the congress, we will be able to demonstrate whether the easy to apply interventions were effective in reducing the number of events occurring during airway management.

4. Are energy and protein requirements met in hospital?

Authors Pullen K.; Collins R.; Stone T.; Carter H.; Sadler H.; Collinson A.
Source Journal of human nutrition and dietetics : the official journal of the British Dietetic Association; Apr 2018; vol. 31 (no. 2); p. 178-187
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Available at Journal of human nutrition and dietetics : the official journal of the British Dietetic Association from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract BACKGROUND: Malnutrition is a problem within hospitals, which impacts upon clinical outcomes. The present audit assesses whether a hospital menu meets the energy and protein standards recommended by the British Dietetic Association's (BDA) Nutrition and Hydration Digest and determines the contribution of oral nutrition supplements (ONS) and additional snacks.
METHOD(S): Patients in a UK South West hospital were categorised as 'nutritionally well' or 'nutritionally vulnerable' in accordance with their Malnutrition Universal Screening Tool score. Energy and protein content of food selected from the menu ('menu choice'), menu food consumed ('hospital intake') and total food consumed including snacks ('overall intake') were calculated and compared with the standards.
RESULT(S): In total, 93 patients were included. For 'nutritionally well' patients (n = 81), energy and protein standards were met by 11.1% and 33.3% ('menu choice'); 7.4% and 22.2% ('hospital intake'); and 14.8% and 28.4% ('overall intake'). For 'nutritionally vulnerable' patients (n = 12), energy and protein standards were met by 0% and 8.3% ('menu choice'); 0% and 8.3% ('hospital intake'); and 8.3% and 16.7% ('overall intake'). Ten percent of patients consumed ONS. Patients who consumed hospital snacks (34%) were more likely to meet the nutrient standards (P <= 0.001).
CONCLUSION(S): The present audit demonstrated that most patients are not meeting the nutrient standards recommended by the BDA Nutrition and Hydration Digest. Recommendations include the provision of energy/protein-dense snacks, as well as menu, offering ONS where clinically indicated, in addition to training for staff. A food services dietitian is ideally placed to lead this, forming a vital link between patients, caterers and clinical teams.
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5. Awareness of alcohol marketing, ownership of alcohol branded merchandise, and the association with alcohol consumption, higher-risk drinking, and drinking susceptibility in adolescents and young adults: A cross-sectional survey in the UK

Authors Critchlow N.; MacKintosh A.M.; Thomas C.; Hooper L.; Vohra J.
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PubMedID 30872548
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Abstract Objectives To explore awareness of alcohol marketing and ownership of alcohol branded merchandise in adolescents and young adults in the UK, what factors are associated with awareness and ownership, and what association awareness and ownership have with alcohol consumption, higher-risk drinking and susceptibility. Design Online cross-sectional survey conducted during April-May 2017. Setting The UK. Participants Adolescents and young adults aged 11-19 years in the UK (n=3399). Main outcome measures Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) (0-12) and indication of higher-risk consumption (>5 AUDIT-C) in current drinkers. Susceptibility to drink (yes/no) in never drinkers. Results Eighty-two per cent of respondents were aware of at least one form of alcohol marketing in the past month and 17% owned branded merchandise. xi^2 tests found that awareness of marketing and ownership of branded merchandise varied within drinking variables. For example, higher awareness of alcohol marketing was associated with being a current drinker (xi^2 =114.04, p<0.001), higher-risk drinking (xi^2 =85.84, p<0.001), and perceived parental (xi^2 =63.06, p<0.001) and peer approval of consumption (xi^2 =73.08, p<0.001). Among current drinkers, multivariate regressions (controlling for demographics and covariates) found that marketing awareness and owning branded merchandise was positively associated with AUDIT-C score and higher-risk consumption. For example, current drinkers reporting medium marketing awareness were twice as likely to be higher-risk drinkers as those reporting low awareness (adjusted OR (AOR)=2.18, 95% CI 1.39 to 3.42, p<0.001). Among never drinkers, respondents who owned branded merchandise were twice as likely to be susceptible to drinking as those who did not (AOR=1.98, 95% CI 1.20 to 3.24, p<0.01). Conclusions Young people, above and below the legal purchasing age, are aware of a range of alcohol marketing and almost one in five own alcohol branded merchandise. In current drinkers, alcohol marketing awareness was associated with increased consumption and greater likelihood of higher-risk consumption. In never drinkers, ownership of branded merchandise was associated with susceptibility.
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6. The use of IVIg in the treatment of in ammatory polyneuropathies and myasthenia gravis at the Walton centre

Authors Kimyongur S.
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Available at Journal of the Royal College of Physicians of Edinburgh from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Background Immunoglobulin is a blood product used in a variety of medical disorders, usually delivered intravenously (IVIg). Neurology patients, particularly those with in ammatory polyneuropathy, utilise a lot of IVIg. There is a national shortage of immunoglobulin and, thus, pressing need to ensure minimum effective dosing as well as rigorous outcome assessments to assess benefit at treatment start and subsequently, as placebo effects can be strong. Methods Serial audit of IVIg use at The Walton Centre against national guidelines was carried out through analysis of clinical notes of day unit patients. Review of the national immunoglobulin database and of neurology outpatient notes to benchmark our practice and provide some comparison with the wider nation was also performed. Results Serial audit led to improved adherence to guidelines, and analysis of practice identi ed wide variation in IVIg use. Conclusion Local audit and benchmarking of practice can be used to promote quality and consistency of IVIg use across the NHS.
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7. Oncoplastic breast conservation occupies a niche between standard breast conservation and mastectomy - A population-based prospective audit in Scotland

Authors Morrow E.S.; Romics L.; Stallard S.; Doughty J.; Malyon A.; Barber M.; Dixon J.M.
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Available at European Journal of Surgical Oncology from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Introduction: The role of oncoplastic breast conservation (OBC) surgery is not fully defined in terms of whether it is equivalent to standard breast conservation (SBC), or more an alternative to mastectomy, or whether it occupies its own niche somewhere between the two. Therefore, we have carried out a population-based prospective audit of the current OBC practice in Scotland.
Method(s): All patients diagnosed with breast cancer in the whole of Scotland between 01/01/2014 and 31/12/2015 were prospectively recorded within the National Managed Clinical Networks databases. Patients treated with OBC were compared to patients who had SBC, mastectomy and mastectomy with immediate reconstruction (MIR).
Result(s): 8075 patients were included (OBC:217(2.7%); SBC:5241(64.9%); mastectomy:1907(23.6%); MIR:710(8.8%)). OBC patients were younger than SBC or mastectomy, but older than MIR ($p < 0.0001$). OBC patients were between SBC and mastectomy patients in terms of clinical and pathological tumour size (all $p < 0.001$), rates of lobular cancers (v.SBC:$p = 0.015$ and v.mastectomy:$p < 0.001$), high-grade tumours (v.SBC:$p = 0.030$ and v.mastectomy:$p = 0.008$), ER negative (v.SBC: $p = 0.042$) and HER-2 positive (v.SBC: $p = 0.003$) tumours, and nodal metastasis (v.mastectomy: $p < 0.001$). More OBC patients received (neo)adjuvant chemo- and hormonal therapy ($p <= 0.001$), adjuvant radiotherapy ($p = 0.005$), trastuzumab ($p < 0.001$) than SBC. More OBC patients presented through screening (v.mastectomy/MIR: $p < 0.0001$). Time to surgery from diagnosis was longer for OBC than SBC/mastectomy ($p < 0.0001$), but shorter than MIR ($p = 0.007$).
Conclusion(s): This national audit demonstrates that OBC occupies its own niche between SBC, mastectomy and MIR in the surgical treatment of breast cancer in Scotland. We recommend that OBC should be recorded separately in other national breast cancer registries.
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8. Pregnancy in prison, mental health and admission to prison mother and baby units

Authors Dolan R.; Edge D.; Shaw J.; Hann M.
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Available at Journal of Forensic Psychiatry and Psychology from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Little is known about the mental health of pregnant women in prison in England or the factors which impact admissions to prison mother and baby units (MBUs). Research from the UK suggests women with more 'stable' backgrounds and lower prevalence of mental disorder are more likely to be admitted to prison MBUs. Eighty-five pregnant women were interviewed in eight different prisons. Schedules for the Clinical Assessment of Neuropsychiatry (SCAN) and Edinburgh Postnatal Depression Scale (EPDS) were used to assess mental health; Severity of Dependence Questionnaire (SOD-Q) for drug misuse; Alcohol Use Identification Test (AUDIT) for hazardous drinking; and the Structured Clinical Interview for DSM-IV (SCID-II) to identify personality disorder. Fifty-one per cent of participants had depression and 57% had anxiety. Those who were working prior to imprisonment were more likely to be admitted to MBUs, and those with a prior social services involvement, diagnosis of personality disorder or history of suicidality were less likely to be admitted. The high levels of depression and anxiety can have negative impacts on both the mother and her unborn child. Factors which influence MBU admission suggest those who might benefit most from MBU placement are least likely to be admitted.
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9. Editorial: blood transfusion for lower gastrointestinal bleeding-authors' reply

Authors Kherad O.; Jairath V.
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10. Surgical techniques in breast cancer: an overview

Authors Critchley A.C.; Cain H.J.
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Available at Surgery (United Kingdom) from ScienceDirect Click on 'Athens' links to activate your UHL access to full text content, Please click on 'Sign in' and then on 'OpenAthens' for the site to recognise your Athens account and provide access to the full range of issues.
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Abstract Breast cancer is the most common female cancer and its incidence continues to increase. Ongoing advances in adjuvant treatments have resulted in declining mortality rates with increasing numbers of women surviving their breast cancer diagnosis. While the primary outcome of surgery remains oncological efficacy, the contemporary breast surgeon must consider the long-term aesthetic outcome of the procedure and the inevitable impact on body image and self-esteem. There has been a paradigm shift in breast surgery in the UK over the last 20 years with the widespread provision of oncoplastic breast surgery techniques now representing the standard of care. As the role of breast conserving surgery has been extended by therapeutic mammoplasty and the use of neoadjuvant treatments, mastectomy rates continue to decline. The widespread introduction of sentinel node biopsy has fostered an increasingly conservative approach to axillary surgery. Nationally, rates of immediate breast reconstruction following skin-sparing mastectomy continue to rise. Yet the National Mastectomy and Breast Reconstruction Audit highlighted the disparities in care and wide variation in practice that still exists in the UK. Whilst breast reconstruction is widely practiced, the adoption of the Oncoplastic Breast Surgery Best Practice Guidelines and engagement with long-term follow-up studies focusing on patient-reported outcome measures will hopefully result in a consistently high standard of care.
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11. Giant cell arteritis in patients of Indian Subcontinental descent in the UK

Authors Tan N.; Ali N.; Acheson J.
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Available at Eye (Basingstoke) from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Background: GCA in the Indian Subcontinent (ISC) is rare. Our centre in London, UK, serves an ethnically diverse population, including a significant population of patients of ISC descent. We hypothesise that patients of ISC descent are no less likely than others to present with symptoms suggestive of GCA and therefore to undergo temporal artery biopsy (TAB).
Method(s): A retrospective audit of all TABs performed at our institution over an 8 year period, to identify ethnicity (white, black, ISC, other, unknown) and biopsy result. We compared the proportion of all patients of ISC descent attending the ED to the proportion of ISC patients undergoing TAB. We compared the proportion of positive TABs among ISC patients with positive TABs among white patients. We also compared the proportion of TAB in ISC patients with all non-ISC ethnicities combined.
Result(s): The proportion of patients undergoing TAB who were of ISC descent (16.3% of 92) was comparable to the proportion of A&E attendances made up by ISC patients [p = 0.1339]. 3.8% (1/26) of positive biopsies were among patients of ISC descent. White patients were significantly more likely to have a positive biopsy than patients of ISC ethnicity (33% of 61 white patients vs. 7% of 15 ISC [p = 0.0456]), as were patients of non-ISC ethnicity (32.5% of 77 non-ISC patients vs. 7% of 15 ISC patients [p = 0.0464]).
Discussion(s): At our centre, biopsy proven GCA occurs in patients of ISC descent, but rarely. Full investigation for GCA continues to be appropriate where it is suspected, regardless of ethnicity.
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12. United Kingdom Continence Society: Minimum standards for urodynamic studies, 2018

Authors Abrams P.; Gammie A.; Eustice S.; Harding C.; Kearney R.; Rantell A.; Reid S.; Small D.; Toozs-Hobson P.; Woodward M.
Source Neurourology and Urodynamics; 2019; vol. 38 (no. 2); p. 838-856
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13. Outcomes following restrictive or liberal red blood cell transfusion in patients with lower gastrointestinal bleeding

Authors Kherad O.; Restellini S.; Martel M.; Barkun A.; Sey M.; Jairath V.; Murphy M.F.; Oakland K.

Source Alimentary Pharmacology and Therapeutics; Apr 2019; vol. 49 (no. 7); p. 919-925
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Abstract Background: Restrictive red blood cell (RBC) transfusion reduces mortality and rebleeding after upper gastrointestinal bleeding (UGIB). However, there is no evidence to guide transfusion strategies in lower gastrointestinal bleeding (LGIB).
Aim(s): To assess the association between RBC transfusion strategies and outcomes in patients with LGIB.
Method(s): This was a post hoc analysis of the UK National Comparative Audit of LGIB and the Use of Blood. The relationships between liberal RBC transfusion and clinical outcomes of rebleeding, mortality and a composite outcome for safe discharge were examined. Transfusion strategy was dichotomised and defined as "liberal" when transfusion was administered for haemoglobin (Hb) >=80 g/L (or >=90 g/L in patients with acute coronary syndrome) or major haemorrhage, and "restrictive" otherwise. Multivariable logistic regression models were used to assess the independent association between liberal RBC transfusion and outcomes.
Result(s): Of 2528 consecutive patients enrolled from 143 hospitals in the original study, 666 (26.3%) received RBC transfusion (mean age 73.3 +/- 16 years, 49% female, initial mean haemoglobin 90 +/- 24 g/L, 2.3% had haemodynamic instability). The rebleeding rate in transfused patients was 42.3%. After adjusting for potential confounders, there was no difference between liberal and restrictive RBC transfusion strategies for the odds of rebleeding (OR 0.89, 95% CI 0.6-1.22), in-hospital mortality (OR 0.54, 95% CI 0.3-1.1) or of achieving the composite outcome (OR 0.72, 95% CI 0.5-1.1).
Conclusion(s): Although these results could be due to residual confounding, they provide an important foundation for the design of randomised trials to evaluate transfusion strategies for LGIB.
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14. Coaching primary care clinics for HPV vaccination quality improvement: Comparing in-person and webinar implementation

Authors Calo W.A.; Gilkey M.B.; Heisler-MacKinnon J.; Brewer N.T.; Leeman J.; Averette C.; Sanchez S.; Kornides M.L.
Source Translational behavioral medicine; Jan 2019; vol. 9 (no. 1); p. 23-31
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Database EMBASE
Available at Translational behavioral medicine from Europe PubMed Central - Open Access
Abstract State health departments commonly use quality improvement coaching as an implementation strategy for improving low human papillomavirus (HPV) vaccination coverage, but such coaching can be resource intensive. To explore opportunities for improving efficiency, we compared in-person and webinar delivery of coaching sessions on implementation outcomes, including reach, acceptability, and delivery cost. In 2015, we randomly assigned 148 high-volume primary care clinics in Illinois, Michigan, and Washington State to receive either in-person or webinar coaching. Coaching sessions lasted about 1 hr and used our Immunization Report Card to facilitate assessment and feedback. Clinics served over 213,000 patients ages 11-17. We used provider surveys and delivery cost assessment to collect implementation data. This report is focused exclusively on the implementation aspects of the intervention. More providers attended in-person than webinar coaching sessions (mean 9 vs. 5 providers per clinic, respectively, p = .004). More providers shared the Immunization Report Card at clinic staff meetings in the in-person than webinar arm (49% vs. 20%; p = .029). In both arms, providers' belief that their clinics' HPV vaccination coverage was too low increased, as did their self-efficacy to help their clinics improve (p < .05). Providers rated coaching sessions in the two arms equally highly on acceptability. Delivery cost per clinic was $733 for in-person coaching versus $461 for webinar coaching. In-person and webinar coaching were well received and yielded improvements in provider beliefs and self-efficacy regarding HPV vaccine quality improvement. In summary, in-person coaching cost more than webinar coaching per clinic reached, but reached more providers. Further implementation research is needed to understand how and for whom webinar coaching may be appropriate.

15. Failure demand: a concept evaluation in UK primary care

Authors Walley P.; Found P.; Williams S.
Source International journal of health care quality assurance; Feb 2019; vol. 32 (no. 1); p. 21-33
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Available at International journal of health care quality assurance from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract PURPOSE: The purpose of this paper is to assess failure demand as a lean concept that assists in waste analysis during quality improvement activity. The authors assess whether the concept's limited use is a missed opportunity to help us understand improvement priorities, given that a UK Government requirement for public service managers to report failure demand has been removed. DESIGN/METHODOLOGY/APPROACH: The authors look at the literature across the public sector and then apply the failure demand concept to the UK's primary healthcare system. The UK National Health Service (NHS) demand data are analysed and the impact on patient care is elicited from patient interviews. FINDINGS: The study highlighted the concept's value, showing how primary care systems often generate failure demand partly owing to existing demand and capacity management practices. This demand is deflected to other systems, such as the accident and emergency department, with a considerable detrimental impact on patient experience. RESEARCH LIMITATIONS/ IMPLICATIONS: More research is needed to fully understand how best to exploit the failure demand concept within wider healthcare as there are many potential barriers to its appropriate and successful application. PRACTICAL IMPLICATIONS: The authors highlight three practical barriers to using failure demand: first, demand within the healthcare system is poorly understood; second, systems improvement understanding is limited; and third, need to apply the concept for improvement and not just for reporting purposes. ORIGINALITY/VALUE: The authors provide an objective and independent insight into failure demand that has not previously been seen in the academic literature, specifically in relation to primary healthcare.

16. The impact of a combinatorial digital and organisational intervention on the management of long-term conditions in UK primary care: a non-randomised evaluation

Authors Lugo-Palacios D.G.; Allen T.; Hammond J.; Darley S.; McDonald R.; Blakeman T.; Bower P.
Source BMC health services research; Mar 2019; vol. 19 (no. 1); p. 159
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Available at BMC health services research from EBSCO (MEDLINE Complete)

Abstract BACKGROUND: Better management of long-term conditions remains a policy priority, with a focus on improving outcomes and reducing use of expensive hospital services. A number of interventions have been tested, but many have failed to show benefit in rigorous comparative research. In 2016, the NHS Test Beds scheme was launched to implement and test interventions combining digital technologies and pathway redesign in routine health care settings, with each intervention comprising multiple innovations to better realise benefit from their 'combinatorial' effect. We present the evaluation of one of the NHS Test Beds, which combined risk stratification algorithms, practice-based quality improvement and health monitoring and coaching to improve management of long-term conditions in a single health economy in the north-west of England.
METHOD(S): The NHS Test Bed was implemented in one clinical commissioning group in the north-west of England (patient population 235,800 served by 36 general practices). Routine administrative data on hospital use (the primary outcome) and a selection of secondary outcomes (data from both hospital and primary care) were collected in the intervention site, and from a comparator area in the same region. We used difference-in-differences analysis to compare outcomes in the NHS Test Bed area and the comparator after initiation of the combinatorial intervention.
RESULT(S): Tests confirmed the existence of parallel trends in the intervention and comparator sites for hospital outcomes for the period April 2016 to March 2017, and for some of the planned primary care outcomes. Based on 10months of post-intervention secondary care data and 13months post-intervention primary care data, we found no significant impact on primary outcomes between the intervention and comparator site, and a significant impact on only one secondary outcome.
CONCLUSION(S): A combinatorial digital and organisational intervention to improve the management of long-term conditions was implemented across a whole health economy, but we found no evidence of a positive impact on health care utilisation outcomes in hospital and primary care.

17. Patient perspectives on a national multidisciplinary team meeting for a rare cancer

Authors Bate J.; Donkin A.; Taylor R.; Whelan J.; Wingrove J.
Source European journal of cancer care; Mar 2019; vol. 28 (no. 2)
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Available at European journal of cancer care from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Multidisciplinary team meetings (MDTM) provide a regular forum for cancer teams to convene and discuss the diagnostic and treatment aspects of patient care. For some rare cancers, MDTMs may also occur at national level to pool expertise and to ensure more consistent decision-making. One such national MDTM exists in the UK for patients with a diagnosis of Ewing's sarcoma of the bone-the National Ewing's MDT (NEMDT). This study explored the patient perspective of this rare cancer national MDTM using focus group and survey methodology. Study participants used their experience to provide several recommendations: that their views should always inform the decision-making process, these views should be presented by someone who has met them such as a specialist nurse, MDT recommendations should be provided to them in plain English, and tools to improve patient choice and enhance communication should be implemented. These patient-centred recommendations will be used to improve the NEMDT but may be valid to inform quality improvement processes for other similar national panels.
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18. Creating sustainable health care systems

Authors Littlejohns P.; Kieslich K.; Weale A.; Tumilty E.; Richardson G.; Stokes T.; Gauld R.; Scuffham P.
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Available at Journal of health organization and management from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract PURPOSE: In order to create sustainable health systems, many countries are introducing ways to prioritise health services underpinned by a process of health technology assessment. While this approach requires technical judgements of clinical effectiveness and cost effectiveness, these are embedded in a wider set of social (societal) value judgements, including fairness, responsiveness to need, non-discrimination and obligations of accountability and transparency. Implementing controversial decisions faces legal, political and public challenge. To help generate acceptance for the need for health prioritisation and the resulting decisions, the purpose of this paper is to develop a novel way of encouraging key stakeholders, especially patients and the public, to become involved in the prioritisation process. DESIGN/METHODOLOGY/APPROACH: Through a multidisciplinary collaboration involving a series of international workshops, ethical and political theory (including accountability for reasonableness) have been applied to develop a practical way forward through the creation of a values framework. The authors have tested this framework in England and in New Zealand using a mixed-methods approach. FINDINGS: A social values framework that consists of content and process values has been developed and converted into an online decision-making audit tool. RESEARCH LIMITATIONS/ IMPLICATIONS: The authors have developed an easy to use method to help stakeholders (including the public) to understand the need for prioritisation of health services and to encourage their involvement. It provides a pragmatic way of harmonising different perspectives aimed at maximising health experience. PRACTICAL IMPLICATIONS: All health care systems are facing increasing demands within finite resources. Although many countries are introducing ways to prioritise health services, the decisions often face legal, political, commercial and ethical challenge. The research will help health systems to respond to these challenges. SOCIAL IMPLICATIONS: This study helps in increasing public involvement in complex health challenges. ORIGINALITY/ VALUE: No other groups have used this combination of approaches to address this issue.

19. The Future of penile prosthetic surgery in the UK

Authors Bates A.S.; Pearce I.; Terry T.R.
Source Journal of Clinical Urology; 2019
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Database EMBASE
Available at Journal of Clinical Urology from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).

Abstract Introduction: The provision of penile prosthetic surgery (PPS) in the United Kingdom needs to be reviewed given the twin popular philosophies of Centres of Excellence, as defined by high case volume yielding best outcomes, and Getting It Right First Time (GIRFT), defined as effective and efficient use of resources.
Method(s): To recognise centres of high volume of PPS and their location, we interrogated Hospital Episode Statistic (HES) data between 2014 and 2017. From this analysis we advance a model of the 10 British Association of Urological Surgeons (BAUS) regions in England providing PPS, working largely to recommendations made by National Health Service (NHS) England through its Clinical Commissioning Policy for Penile Prosthesis.
Result(s): Between 2014 and 2017, there were 2361 surgical procedures undertaken, and of these, primary implantations numbered 1330 and revisions 1031. University College London Hospitals performed more than 50% of all primary implantations and 52% of all revisions. Across England for the year 2017, there were 301 primary implantations and 442 revisions.
Discussion(s): We suggest that revision surgery for device mechanical failure should be within the remit of these centres but referral of complex revision surgery irrespective of aetiology may warrant referral to defined tertiary centres in London, the Midlands and the North of England.
Conclusion(s): Prospective data on patient outcomes from PPS are urgently needed, and NHS England should regard a national database of PPS as essential. We advance a model of the 10 BAUS regions in England providing PPS as a distributed and geographically equitable network for primary implantation. A regionalised network of revision surgery should be considered.
Level of Evidence: Not applicable for this multicentre audit.
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20. Physiotherapy provision to hospitalised stroke patients: Analysis from the UK Sentinel Stroke National Audit Programme

Authors McGlinchey M.P.; Rudd A.G.; Paley L.; Hoffman A.; Douiri A.
Source European Stroke Journal; Mar 2019; vol. 4 (no. 1); p. 75-84
Publication Date Mar 2019
Publication Type(s) Article
Database EMBASE

Abstract Introduction: The purpose of this study is to investigate which factors are associated with physiotherapy provision to hospitalised stroke patients.
Method(s): Data were analysed for stroke patients admitted to hospital in England and Wales between April 2013 and March 2017 recorded on the Sentinel Stroke National Audit Programme (SSNAP) national stroke register. Associations between different patient factors, and applicability for and intensity of physiotherapy were measured using multi-level logistic and regression models.
Finding(s): Data from 306,078 patients were included on the SSNAP register. Median age was 77 years (IQR 67-85) and 84.7% of patients with completed stroke severity data had a mild-moderate stroke. In all, 85.2% of patients recorded on SSNAP were deemed applicable for physiotherapy. Applicability for physiotherapy was 47% higher among thrombolysed patients (aOR 1.47, 95% CI 1.40-1.54), 36% lower in those with severe pre-morbid disability (aOR 0.64, 95% CI 0.58-0.71) and more than 2.5-fold higher among patients admitted to hospitals with greater availability of early supported discharge (aOR 2.62, 95% CI 1.28-5.37). Patients who were younger, male, had less pre-morbid disability, lower stroke severity, sustained an infarction, received thrombolysis, and had fewer medical complications were more likely to receive more intensive physiotherapy post-stroke.
Conclusion(s): Several patient and service organisational factors are associated with physiotherapy provision to stroke patients, some of which may not be justifiable. Physiotherapists should be aware of these factors when planning and delivering physiotherapy as well as any possible biases associated with physiotherapy provision to patients post-stroke.
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21. Impact of a physician-led pre-hospital critical care team on outcomes after major trauma

Authors Hepple D.J.; Durrand J.W.; Bouamra O.; Godfrey P.
Source Anaesthesia; Apr 2019; vol. 74 (no. 4); p. 473-479
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Available at Anaesthesia from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract The deployment of physician-led pre-hospital enhanced care teams capable of critical care interventions at the scene of injury may confer a survival benefit to victims of major trauma. However, the evidence base for this widely adopted model is disputed. Failure to identify a clear survival benefit has been attributed to several factors, including an inherently more severely injured patient group who are attended by these teams. We undertook a novel retrospective analysis of the impact of a regional enhanced care team on observed vs. predicted patient survival based on outcomes recorded by the UK Trauma Audit and Research Network (TARN). The null hypothesis of this study was that attendance of an enhanced care team would make no difference to the number of 'unexpected survivors'. Patients attended by an enhanced care team were more seriously injured. Analysis of Trauma Audit and Research Network patient outcomes did not demonstrate an improved adjusted survival rate for trauma patients who were treated by a physician-led enhanced care team, but confirmed differences in patient characteristics and severity of injury for those who were attended by the team. We conclude that a further prospective multicentre analysis is warranted. An essential prerequisite for this would be to address the current blind spot in the Trauma Audit and Research Network database - patients who die from trauma before ever reaching hospital. We speculate that early on-scene critical care may convert this cohort of invisible trauma deaths into patients who might survive to reach hospital. Routine collection of data from these patients is warranted to include them in future studies.
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22. Temporal trends in survival following ward-based NIV for acute hypercapnic respiratory failure in patients with COPD

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Source Clinical Respiratory Journal; Mar 2019; vol. 13 (no. 3); p. 184-188
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Available at Clinical Respiratory Journal from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection

Abstract Introduction: Non-invasive ventilation (NIV) is recommended for treatment of acute hypercapnic respiratory failure (AHRF) in acute exacerbations of COPD. National UK audit data suggests that mortality rates are rising in COPD patients treated with NIV.
Objective(s): To investigate temporal trends in in-hospital mortality in COPD patients undergoing a first episode of ward-based NIV for AHRF.
Method(s): Retrospective study of hospitalised COPD patients treated with a first episode of ward-based NIV at a large UK teaching hospital between 2004 and 2017. Patients were split into two cohorts based on year of admission, 2004-2010 (Cohort 1) and 2013-2017 (Cohort 2), to facilitate comparison of patient characteristics.
Result(s): In total, 547 unique patients were studied. There was no difference in in-hospital mortality rate between the time periods studied (17.6% vs 20.5%, P =.378). In Cohort 2 there were more females, a higher rate of co-morbid bronchiectasis and pneumonia on admission and more severe acidosis, hypercapnia and hypoxia. More patients in Cohort 2 had NIV as the ceiling of treatment. Patients in Cohort 2 experienced a longer time from AHRF diagnosis to application of NIV, higher maximum inspiratory positive airway pressure, lower maximum oxygen and shorter duration of NIV. Finally, patients in Cohort 2 experienced a shorter hospital length of stay (LOS), with no differences observed in rate of transfer to critical care or intubation.
Conclusion(s): In-hospital mortality remained stable and LOS decreased over time, despite greater comorbidity and more severe AHRF in COPD patients treated for the first time with ward-based NIV.
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23. Assessing quality of care in oesophago-gastric cancer surgery in Australia

Authors Burton P.R.; Shaw K.; Smith A.I.; Brown W.A.; Nottle P.D.; Ooi G.J.
Source ANZ journal of surgery; Apr 2018; vol. 88 (no. 4); p. 290-295
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Abstract BACKGROUND: Outcomes of oesophago-gastric cancer are poor and highly variable between centres. It is important that complex multimodal treatments are applied optimally. Low case volumes at Australian centres mean that the analysis of crude outcomes is an inadequate assessment of overall quality of care. Detailed analysis across a range of quality domains offers the opportunity to measure performance.
METHOD(S): We compared data from the UK National Oesophago-gastric Cancer Audit 2010 with the prospective Alfred Hospital oesophago-gastric cancer database.
RESULT(S): There were 314 Alfred and 17279 UK patients identified. The volume of patients assessed by the Alfred was equal to the second highest quartile in the UK trust (4-5 new cases per month). Case ascertainment was better, capturing 84% of all oesophago-gastric cancer within the Alfred prospective audit (P<0.001). The use of staging CT and PET scans was more common among Alfred patients (99% versus 89%, P<0.01 and 83.8% versus 17%, P<0.01, respectively). More patients embarked on a curative pathway (P<0.01), with greater use of neo-adjuvant therapies. Acceptable lymph node yields were less in oesophagectomies (88.2% versus 96.2%, P<0.01) and similar in gastrectomies (77.4% versus 74.6%, P=0.61). Higher overall complications were observed in Alfred patients (P<0.01), predominantly due to respiratory complications. Perioperative mortality after resection and 1-year survival was similar.
CONCLUSION(S): Comparing a range of quality domains as a means of identifying areas of deficiency is feasible. This allows for contemporaneous improvements in service quality and may be more appropriate in the Australian setting than focusing on volume.
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24. The relationship between unwarranted variation in optometric referrals and time since qualification

Authors Parkins D.J.; Benwell M.J.; Evans B.J.W.; Edgar D.F.
Source Ophthalmic & physiological optics : the journal of the British College of Ophthalmic Opticians (Optometrists); Sep 2018; vol. 38 (no. 5); p. 550-561
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Available at Ophthalmic & physiological optics : the journal of the British College of Ophthalmic Opticians (Optometrists) from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract PURPOSE: To investigate variation in optometric referral decision-making and the influence of experience and continuing education and training (CET).
METHOD(S): To gain insight into unwarranted variation in referral activity in the United Kingdom (UK): (1) triage data were audited to investigate source of referral, provisional diagnosis, and outcome; (2) an online system was developed to present two sets of 10 vignettes, designed to avoid prompting answers. Participating optometrists completed 10 pre-CET vignettes, recording their tests and management decisions. The main group of participants chose whatever CET they wished over a 6-month period and then completed another 10 post-CET vignettes. A second group of newly-qualified optometrists completed the vignettes before and after a CET course intervention, followed by a third group of pre-registered optometrists with an intervention of 6-months experience of their pre-registration year.
RESULT(S): The audit identified 1951 optometric referrals and 158 optometrists (211 referrals were from general medical practitioners), with 122 of the 158 optometrists making fewer than ten referrals. Two newly-qualified optometrists generated 12.5% of the total referrals in the audit (N = 2162). Many suspect glaucoma referrals were based on a single suspect measurement resulting in a high discharge rate after community review, as did referrals for certain fundus-related appearances for which no treatment was indicated. The intervention of gaining CET points appeared to have no significant impact (p = 0.37) on referral decision-making, although this part of the study was underpowered. Self-selection bias was confirmed in the main group. When the main group and newly-qualified practitioners were compared, the number of referrals was negatively associated with time since qualification (p = 0.005). When all 20 referral decisions were compared, all optometrists referring more than 10 vignette patients came from a group of newly-qualified practitioners up to 2 years post-qualification. Pre-registered optometrists generally referred more appropriately than newly-qualified. Upon qualification, there was a significant increase in the number of sight tests undertaken per day (p = <0.0005).
CONCLUSION(S): Gaining CET points alone is unlikely to significantly improve referral decision-making. Mentoring and targeted CET for the newly-qualified up to 2 years post-qualification should be considered. Ophthalmology replies to the referring newly-qualified optometrist are vital for moderating future referrals and developing clinical confidence.
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25. Evaluating the impact of the ICNET clinical decision support system for antimicrobial stewardship 11 Medical and Health Sciences 1117 Public Health and Health Services

Authors Heard K.L.; Hughes S.; Mughal N.; Azadian B.S.; Moore L.S.P.
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Available at Antimicrobial Resistance and Infection Control from BioMed Central
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Abstract Background: Antimicrobial resistance (AMR) is an ecological and economic crisis and stewardship of available antimicrobials is required. Electronic prescribing, where available, enables auditing of practice, yet in order to be efficient and effective in addressing inappropriate antimicrobial prescribing, better use of current and new technological interventions is needed. This retrospective observational evaluation looked at the impact of a commercial clinical decision support system (CDSS) on the workflow of an established antimicrobial stewardship (AMS) team. Material/methods: Clinical, workflow, and pharmaceutical data from 3 months post implementation of CDSS were collated, and compared to the same 3 month periods in preceding years. The evaluation considered total interventions made, the types of intervention made, impact of said interventions, and time spent executing interventions. All antimicrobial data were adjusted for total daily defined doses (DDD) of intravenous antimicrobials.
Result(s): Productivity: In the 3 month evaluation period (Jun-Aug 2016) a total of 264 case reviews resulting in 298 AMS interventions were made. Compared to preceding years where 138 and 169 interventions were made (2013 and 2014 respectively). In 2013 49% of interventions were stopping medication and 30% change of therapy based on cultures and sensitivities compared to 25 and 17% in 2016. In contrast to previous years', the CDSS instead enabled a greater number of dose/drug optimisation (13%), escalation of antimicrobials (12%) and intravenous (IV) to oral switch (11%) interventions. Patient Identification: Despite increased patient numbers post-CDSS, on average 46 min per day was spent compiling a patient list for review, compared to 59 min in 2014. The use of CDSS facilitated 15 interventions/1000DDD, compared to pre-intervention (9.4/ 1000DDD in 2013; 11.5/1000DDD in 2014).
Conclusion(s): Initial evaluation of the impact of this CDSS on AMS at the organisation has demonstrated effectiveness in terms of case finding, AMS team productivity, and workflow auditing. More importantly, patient infection management has been optimised with a shift in the emphasis of AMS interventions. It has contributed to the success of the healthcare provider achieving nationally set remunerated AMS targets.
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26. Safety of meningococcal group B vaccination in hospitalised premature infants

Authors Kent A.; Braccio S.; Heath P.T.; Ladhani S.; Beebeejaun K.; Kadambari S.; Clarke P.
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Available at Archives of Disease in Childhood: Fetal and Neonatal Edition from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information
Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.
Available at Archives of Disease in Childhood: Fetal and Neonatal Edition from Unpaywall

Abstract Objectives To assess the risk of significant adverse events in premature infants receiving the novel 4-component group B meningococcal vaccine (4CMenB) with their routine immunisations at 2 months of age. Participants, design and setting In December 2015, Public Health England requested neonatal units across England to voluntarily participate in a national audit; 19 units agreed to participate. Anonymised questionnaires were completed for infants receiving 4CMenB alongside their routine immunisations. For comparison, a historical cohort of premature infants receiving their primary immunisations without 4CMenB or paracetamol prophylaxis was used. Main outcome measures Paracetamol use; temperature, cardiovascular, respiratory and neurological status before and after vaccination; and management and investigations postvaccination, including serum C reactive protein levels, infection screens and antibiotic use. Results Complete questionnaires were returned for 133 premature infants (<35 weeks' gestation) who received their first dose of 4CMenB at 8 weeks of age, including 108 who received prophylactic paracetamol according to national recommendations. Overall, 7% (8/108) of infants receiving 4CMenB with paracetamol had fever (>38degreeC) after vaccination compared with 20% (5/25) of those receiving 4CMenB without paracetamol (P=0.06) and none of those in the historical cohort. There were no significant differences between cohorts in the proportion of infants with apnoea, bradycardia, desaturation and receiving respiratory support after vaccination. Conclusions 4CMenB does not increase the risk of serious adverse events in hospitalised premature infants. This audit supports the current national recommendations to offer 4CMenB with other routine vaccinations and prophylactic paracetamol to premature infants at their chronological age.
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27. A qualitative study exploring how routinely collected Medication Safety Thermometer data have been used for quality improvement purposes using case studies from three UK hospitals

Authors Rostami P.; Ashcroft D.; Tully M.P.; Harrison A.; Parry G.
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Abstract Objectives The Medication Safety Thermometer (MedsST) is a medication safety data collection tool, which has been used by over 100 UK healthcare organisations to enable measurement of medication safety for improvement purposes. This study aimed to explore whether, and how, data collected by the MedsST have been used in organisations to facilitate medication safety improvements. Design Routine MedsST data collected between October 2013 and July 2016 were analysed using Run charts. Identified changes were investigated using interviews with staff from each hospital trust. The interviews were analysed using a framework based on Normalisation Process Theory, focusing on use of the MedsST and its data. Setting Three National Health Service hospital trusts in the North West of England, which have used the MedsST for the longest period. Participants Eight interview participants, purposely sampled based on their involvement with the MedsST, included pharmacists, pharmacy technicians and nurses. Results Improvement was often at ward level and focused on particular areas of medication safety, led by clinical champions. The most sustainable improvements involved changes to systems, such as introducing new guidelines. Although some improvement occurred, internal communication about improvements was poor, and large amounts of data remained unused, often due to a lack of ownership of data review and use. Conclusions Simply collecting data is not sufficient; a system of data collection, review and use for improvement is required. Issues with such systems may have been recognised and averted if implementation theory had been used in the early stages of national development and implementation. However, implementation theory could be used within organisations to fix issues locally, particularly to increase ward-level ownership of this system, which could lead to considerable improvements.
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28. Exploring preceptorship programmes: Implications for future design

Authors Taylor L.M.; Eost-Telling C.L.; Ellerton A.
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Available at Journal of clinical nursing from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract AIMS AND OBJECTIVES: To review and analyse current preceptorship programmes within NHS trusts in the North West of England. To evaluate the pedagogic rigour of the programme and suggest recommendations to inform the future design of preceptorship programmes. BACKGROUND: Enhancing the retention of newly qualified staff is of particular importance given that the journey from a new registrant to a competent healthcare professional poses a number of challenges, for both the individual staff member and organisations. DESIGN: A mixed methods evaluative approach was employed, using online questionnaires and content analysis of preceptorship documentation.
METHOD(S): Forty-one NHS trusts across the North West region employing newly qualified nurses were invited to participate in the completion of an online questionnaire. In addition, preceptorship programme documentation was requested for inclusion in the content analysis. This study used the SQUIRE (Standards for Quality Improvement Reporting Excellence) guidelines.
RESULT(S): The response rate for the questionnaire was 56.1% (n = 23). Eighteen trusts (43.9%) forwarded their programme documentation. Findings highlighted the wide variation in preceptorship programmes across the geographical footprint.
CONCLUSION(S): There were instances of outstanding preceptorship and preceptorship programmes where there was a clear link between the strategic vision, that is, trust policy, and its delivery, that is, preceptorship offering. There was no one framework that would universally meet the needs of all trusts; yet, there are key components which should be included in all preceptorship programmes. Therefore, we would encourage innovation and creativity in preceptorship programmes, cognisant of local context. RELEVANCE TO CLINICAL PRACTICE: The significant shortage of nursing staff in England is an ongoing issue. Recruitment and retention are key to ameliorating the shortfall, and formal support mechanisms like preceptorship, can improve the retention of newly qualified staff. Understanding current preceptorship programmes is an important first step in establishing the fundamental building blocks of successful preceptorship programmes and enabling the sharing of exemplary good practice across organisations.
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29. Deep sedation and anaesthesia in complex gastrointestinal endoscopy: A joint position statement endorsed by the British Society of Gastroenterology (BSG), Joint Advisory Group (JAG) and Royal College of Anaesthetists (RCoA)

Authors Sidhu R.; Sanders D.S.; Turnbull D.; Newton M.; Thomas-Gibson S.; Hebbar S.; Haidry R.J.; Webster G.; Smith G.
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Abstract In the UK, more than 2.5 million endoscopic procedures are carried out each year. Most are performed under conscious sedation with benzodiazepines and opioids administered by the endoscopist. However, in prolonged and complex procedures, this form of sedation may provide inadequate patient comfort or result in oversedation. As a result, this may have a negative impact on procedural success and patient outcome. In addition, there have been safety concerns on the high doses of benzodiazepines and opioids used particularly in prolonged and complex procedures such as endoscopic retrograde cholangiopancreatography. Diagnostic and therapeutic endoscopy has evolved rapidly over the past 5 years with advances in technical skills and equipment allowing interventions and procedural capabilities that are moving closer to minimally invasive endoscopic surgery. It is vital that safe and appropriate sedation practices follow the inevitable expansion of this portfolio to accommodate safe and high-quality clinical outcomes. This position statement outlines the current use of sedation in the UK and highlights the role for anaesthetist-led deep sedation practice with a focus on propofol sedation although the choice of sedative or anaesthetic agent is ultimately the choice of the anaesthetist. It outlines the indication for deep sedation and anaesthesia, patient selection and assessment and procedural details. It considers the setup for a deep sedation and anaesthesia list, including the equipment required, the environment, staffing and monitoring requirements. Considerations for different endoscopic procedures in both emergency and elective setting are also detailed. The role for training, audit, compliance and future developments are discussed.
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30. Re: RCR audit of compliance with UK guidelines for the prevention and detection of acute kidney injury in adult patients undergoing iodinated contrast media injections for CT. A reply

Authors Cope L.H.; Drinkwater K.J.; Howlett D.C.
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31. Assessing the deprivation gap in stillbirths and neonatal deaths by cause of death: A national population-based study

Authors Best K.E.; Seaton S.E.; Draper E.S.; Field D.J.; Manktelow B.N.; Smith L.K.; Kurinczuk J.J.
Source Archives of Disease in Childhood: Fetal and Neonatal Edition; 2019
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Available at Archives of Disease in Childhood: Fetal and Neonatal Edition from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at Archives of Disease in Childhood: Fetal and Neonatal Edition from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Objective: To investigate socioeconomic inequalities in cause-specific stillbirth and neonatal mortality to identify key areas of focus for future intervention strategies to achieve government ambitions to reduce mortality rates.
Design(s): Retrospective cohort study.
Setting(s): England, Wales, Scotland and the UK Crown Dependencies.
Participant(s): All singleton births between 1 January 2014 and 31 December 2015 at >=24 weeks' gestation.
Main Outcome Measure(s): Cause-specific stillbirth or neonatal death (0-27 days after birth) per 10 000 births by deprivation quintile.
Result(s): Data on 5694 stillbirths (38.1 per 10 000 total births) and 2368 neonatal deaths (15.9 per 10 000 live births) were obtained from Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK). Women from the most deprived areas were 1.68 (95% CI 1.56 to 1.81) times more likely to experience a stillbirth and 1.67 (95% CI 1.48 to 1.87) times more likely to experience a neonatal death than those from the least deprived areas, equating to an excess of 690 stillbirths and 231 neonatal deaths per year associated with deprivation. Small for gestational age (SGA) unexplained antepartum stillbirth was the greatest contributor to excess stillbirths accounting for 33% of the deprivation gap in stillbirths. Congenital anomalies accounted for the majority (59%) of the deprivation gap in neonatal deaths, followed by preterm birth not SGA (24-27 weeks, 27%).
Conclusion(s): Cause-specific mortality rates at a national level allow identification of key areas of focus for future intervention strategies to reduce mortality. Despite a reduction in the deprivation gap for stillbirths and neonatal deaths, public health interventions should primarily focus on socioeconomic determinants of SGA stillbirth and congenital anomalies.
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32. Causes of renal allograft failure in the UK: Trends in UK renal registry and national health service blood and transplant data from 2000 to 2013

Authors Burton H.; Hilton R.; Perisanidou L.I.; Steenkamp R.; Evans R.; Evans K.M.; Caskey F.J.; Mumford L.
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Available at Nephrology Dialysis Transplantation from Unpaywall

Abstract Background: Improvement in long-term renal allograft survival is impeded by incomplete or erroneous coding of causes of allograft loss. This study reports 13-year trends in causes of graft failure across the UK.
Method(s): National Health Service Blood and Transplant (NHSBT) and UK Renal Registry data were linked to describe UK kidney patients transplanted in 2000-13. NHSBT graft failure categories were used, with 'other' recoded when free text was available. Adjusted analyses examined the influence of age, ethnicity and donor type on causes of graft failure.
Result(s): In 22 730 recipients, 5389 (23.7%) grafts failed within a median follow-up of 5 years. The two most frequent causes were death with a functioning graft (40.8%) and alloimmune pathology (25.0%). Graft survival was higher in recipients who were younger (mean 47.3 versus 50.7 years), received a preemptive transplant (20.2% versus 10.4%), spent less time on dialysis (median 1.6 versus 2.4 years) and received a living donor transplant (36.3% versus 22.2%), with no differences by sex, ethnicity or human leucocyte antigen mismatch. Allograft failure within 2 years of transplantation fell from 12.5% (2000-4) to 9.8% (2009-13). Surgical- and alloimmune-related failures decreased over time while death with a functioning graft became more common. Age, ethnicity and donor type were factors in recurrent primary disease and alloimmune pathology.
Conclusion(s): Since 2000 there have been reductions in surgical and alloimmune graft failures in the UK. However, graft failure codes need to be revised if they are to remain useful and effective in epidemiological and quality improvement trials.
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33. The current status of clinical trials in emergency gastrointestinal surgery: A systematic analysis of contemporary clinical trials

Authors Milton A.; Lee M.J.; Drake T.M.
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Abstract BACKGROUND Emergency gastrointestinal surgery (EGS) conditions represent a significant healthcare burden globally requiring emergency operations that are associated with mortality rates as high as 80%. EGS is currently focused on quality improvement and internal audits, which occurs at a national or local level. An appreciation of what EGS trials are being conducted is important to reduce research wastage and develop coordinated research strategies in surgery. The primary aim of this study was to identify and quantify recent and active trials in EGS. The secondary aim was to identify conditions of interest and which aspects of care were being modified. METHODS A systematic search of WHO, UK, US, Australian, and Canadian trials databases was undertaken using broad terms to identify studies addressing emergency abdominal surgery and specific high-risk diagnoses. Studies registered between 2013 and 2018 were eligible for inclusion. Data on study topic, design, and funding body were collected. Interventions were classified into "perioperative", "procedural", "postoperative", "non-surgical", and "other" categories. RESULTS Searches identified 5603 registered trials. After removal of duplicates, 4492 studies remained and 42 were eligible for inclusion. Almost 50% of trials were located in Europe and 17% (n = 7) in the United States. The most common condition addressed was acute appendicitis (n = 11), with the most common intervention being procedure based (n = 23). Hospital-based funding was the most common funder (n = 30). CONCLUSION There is large disparity in the number of surgical trials in emergency surgery, which are primarily focused on high-volume conditions. More research is needed into high-mortality conditions. LEVEL OF EVIDENCE Systematic review, level III.
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34. Basic and Advanced EMS Providers Are Equally Effective in Naloxone Administration for Opioid Overdose in Northern New England

Authors Gulec N.; Lahey J.; Suozzi J.C.; Sholl M.; MacLean C.D.; Wolfson D.L.
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Abstract OBJECTIVE: Overdose mortality from illicit and prescription opioids has reached epidemic proportions in the United States, especially in rural areas. Naloxone is a safe and effective agent that has been shown to successfully reverse the effects of opioid overdose in the prehospital setting. The National EMS Scope of Practice Model currently only recommends advanced life support (ALS) providers to administer naloxone; however, some individual states have expanded this scope of practice to include intranasal (IN) administration of naloxone by basic life support (BLS) providers, including the Northern New England states. This study compares the effectiveness and appropriateness of naloxone administration between BLS and ALS providers.
METHOD(S): All Vermont, New Hampshire, and Maine EMS patient encounters between April 1, 2014 and December 31, 2016 where naloxone was administered were examined and 3,219 patients were identified. The proportion of successful reversals of opioid overdose, based on improvement in the Glasgow Coma Scale (GCS), respiratory rate (RR), and provider global assessment (GA) of response to medication was compared between BLS and ALS providers using a Chi-Squared statistic, Fisher's exact or Wilcoxon rank-sum test.
RESULT(S): There was no significant difference in the percent improvement in GCS between BLS and ALS (64% and 64% $P = 0.94$). There was no significant difference in the percentage of improvement in RR between BLS and ALS (45% and 48% $P = 0.43$). There was a significant difference in the percentage of improvement of GA between BLS and ALS (80% and 67% $P < 0.001$). There was no significant difference in determining appropriate cases to administer naloxone where RR < 12 and GCS < 15 between BLS and ALS (42% and 43% $P = 0.94$).
CONCLUSION(S): BLS providers were as effective as ALS providers in improving patient outcome measures after naloxone administration and in identifying patients for whom administration of naloxone is appropriate. These findings support expanding the National EMS Scope of Practice Model to include BLS administration of intranasal naloxone for suspected opioid overdoses.

35. Inequalities in glycaemic control in children and young people with type 1 diabetes-a national population-based cohort study in England and Wales

Authors Khanolkar A.R.; Amin R.; De Stavola B.; Viner R.; Stephenson T.; Taylor-Robinson D.; Warner J.
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Abstract Objectives: To investigate ethnic and socioeconomic (SES) differences in glycaemic control in children and young people (CYP) with type 1 diabetes.
Method(s): We undertook a longitudinal population-based cohort study of 20,777 CYP<19 years old and included in the National Pediatric Diabetes Audit (>95% of diabetes cases in England/Wales) attending 178 diabetes clinics between 2011-2015. Piecewise linear spline multilevel models were used to analyze ethnic differences in glycaemic control (HbA1c) trajectories up to 5 years post-diagnosis (156,679 HbA1c datapoints, mean 7.5 datapoints/subject), adjusting for sex, age and SES. The best fitting model allowed for changes in slopes at 2, 8, 16 and 28 months post-diagnosis. Ethnicity was self-identified and SES based on area-level indices of deprivation (grouped into quintiles).
Result(s): Mean age at diagnosis was 9 years, 47% of CYP were female and 78% were White. Mean HbA1c at diagnosis was 97 mmol/mol. On average, HbA1c decreased by 35 mmol/mol during the first two months, followed by a gradual increase (0.5 mmol/mol/month between 8 to 16 months, 0.6 mmol/mol/month between 16 to 28 months and 0.1 mmol/mol/month thereafter). After adjustment for all covariates, mixed-ethnicity (mean difference 4 mmol/mol, 95% CI 3-6), Pakistani (2 mmol/mol, 1-3), Indian (2 mmol/mol, 1-4), and Black (6mmol/mol, 5-8) CYP had higher HbA1c at diagnosis compared to White CYP (Figure). Compared to CYP in the poorest SES quintile, CYP in all other quintiles had on average lower HbA1c at diagnosis with a dose-response relationship (-6 mmol/ mol, 95% CI -6 to -5 for the richest SES quintile). Ethnic differences in HbA1c trajectories remained constant during follow-up.
Conclusion(s): Large ethnic and socioeconomic inequalities in glycaemic control persist from diagnosis onwards. This is of concern as poor glycaemic control tracks into adulthood increasing risk for acute and chronic outcomes across the lifecourse.

36. Care of adolescents with type 2 diabetes across the North West London pediatric diabetes network

Authors Kyprianou N.; Ivey E.; Ray N.; Bhandari J.; Rangasami J.
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Abstract Introduction: SWEET study revealed that although Type 1 Diabetes is more prevalent in children, those with Type 2DM suffer higher rate of complications.
Objective(s): Our aim was to assess individual services in 5 hospitals across our network, using ISPAD and AAP guidelines as benchmark and use our findings to instigate changes in our clinical practice to ensure better management for this patient cohort.
Method(s): Data was collected using electronic and paper records, anonymized and compared to ISPAD and AAP guidelines.
Result(s): Our cohort comprises of 48 patients(32 females, median age 14,range 9.0-17.7years)who have been under follow-up for a median of 1.5years.96% were diagnosed appropriately using an HbA1c or fasting glucose but 42% did not have autoantibody testing to preclude Type 1 diabetes. Strikingly, none of the patients had a comprehensive assessment of all diabetes-related comorbidities at presentation, with the most significant shortfalls seen with obstructive sleep apnoea, PCOS, depression and renal disease.88% were treated appropriately with either metformin or insulin monotherapy or both, along with lifestyle advice and dietician input. None had complete assessment of comorbidities at annual review, with particularly low rates of checking albumin-creatinine ratio and triglycerides. Median frequency of HbA1c monitoring was 3monthly,only 33% reaching less than 48mmol/mol at latest follow-up. The main reason for not achieving HbA1c targets is poor compliance with treatment and lack of community-based lifestyle intervention programs.
Conclusion(s): This audit reveals weaknesses at assessing comorbidities at presentation across most hospitals in the Network, vast majority of patients subsequently not achieving optimal HbA1c.Clinic proformas serve as aide memoir to improve management. Vital support can be provided by Community lifestyle intervention programs to engage this difficult age group of children. Wider choice of medications and innovative diets are needed.

37. The current law of diminishing returns with lower gastrointestinal imaging

Authors Mohammed A.M.A.; Aawsaj Y.M.; Bradburn M.D.; Mills S.J.
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Available at Colorectal Disease from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at Colorectal Disease from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Purpose: To investigate whether the steady increase in lower gastrointestinal (LGI) tract imaging is benefiting a single NHS Trust's referral base in respect of ascertainment of diagnosed colorectal cancers (CRC), proportion of cases presenting as an emergency, stage at diagnosis and crude survival.
Method(s): A retrospective analysis of a prospectively populated dataset of all cases of CRC with a date of diagnosis 1/4/10 - 31/3/17, correlated against the number of colonoscopy, flexible sigmoidoscopy and CT colonography (CTC) performed during the same period. Survival was compared using a Kaplan Meyer analysis and the correlation between the total number of cancer cases diagnosed each year and the volume of investigative procedures was studied using Pearson's coefficient.
Result(s): The volume of investigative work increased by 33% between audit years 2010/11 and 2016/17 while the number of CRC cases diagnosed dropped by 4.7%, the Pearson correlation coefficient between the two variables was -0.289 (P 0. 530). The number of cases requiring urgent or emergent treatment at presentation rose from 12.3% to 23.8% and cases staged as Duke's D rose from 21.8% to 32.1% for the same period. Chi-square for the survival analysis was 10.499 (P 0.105).
Conclusion(s): The increase in LGI imaging has not benefited this Trust's referral base with any increase in CRC ascertainment, nor any reduction in emergency presentation, earlier stage at diagnosis or survival. There is interest locally in whether faecal immunochemical testing in the symptomatic population in primary care could better target referrals and investigations.

38. The changing association between socioeconomic deprivation and outcome in patients diagnosed with colorectal cancer in the west of Scotland; evidence from the post screening era

Authors Mansouri D.; McMillan D.C.; Horgan P.G.
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Available at Colorectal Disease from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Introduction: It has previously been shown that socioeconomically deprived patients with colorectal cancer (CRC) have poorer outcome. The impact of screening on this is unclear. The present study aims to assess the association between deprivation and outcome in CRC patients in the post-screening era.
Method(s): Data on all patients diagnosed with CRC (January 2011 - December 2014) was extracted from a prospective regional audit database. Deprivation was assessed using the Scottish Index of Multiple Deprivation. Post operative (90-day), cancer specific (CS) and overall survival (OS) was assessed.
Result(s): 6475 incident cases of CRC were identified, 3344 (52%) were in the two most deprived quintiles of deprivation. Deprived patients were more likely to be younger ($P = 0.05$), present as an emergency ($P < 0.001$), have advanced TNMstage ($P < 0.001$) and less likely to undergo surgery with a curative intent ($P = 0.01$). On univariate analysis, increased deprivation was associated with both poorer OS and CS ($P < 0.05$) however, when adjusting for age, sex, emergency presentation, TNM-stage and intent of surgery. on multivariate analysis, this failed to retain significance. In those undergoing a formal resection (n = 4289), 90-day mortality was 3.0%. On multivariate analysis age, higher ASA grade, emergency presentation and palliative intent of surgery were associated with poorer 90-day mortality (all $P < 0.05$) however socioeconomic deprivation was not.
Conclusion(s): Deprived patients with CRC have higher levels of adverse factors associated with poorer outcome, however deprivation itself does not confer independent risk. Interventions aimed at reducing these factors, such as emergency presentation rates, should be targeted at deprived cohorts.

39. A feasibility study of reporting patient reported outcome measures as part of a national colorectal cancer audit

Authors Vallance A.; Boyle J.; Hill J.; Braun M.; Walker K.; Kuryba A.; Van Der Meulen J.
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Available at Colorectal Disease from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Survival from colorectal cancer is improving but treatments can affect quality of life (QoL). NHS England's 2013 National Survivorship Initiative collected Patient Reported Outcome Measures (PROMS) for colorectal cancer patients including QoL measures (assessed by EQ-5D instrument). This study aimed to establish the feasibility of reporting PROMS as part of the National Bowel Cancer Audit (NBOCA) by linking PROMS to NBOCA data. NHS England's PROMS survey was distributed to all surviving patients with colorectal cancer (diagnosed 2010-2011). 21 802 patients (63.3%) responded. PROMS data was linked to NBOCA and Hospital Episode Statistics (HES) data to assess validity of measures; characteristics of responders compared to non-responders; representativeness of responders at different time points; and hospital trust response rate. 18 004 respondents were linked successfully. Agreement of self-reported and clinical measures was excellent (e.g. 95% patients reporting major surgery had concordant data in NBOCA). Respondents were more likely to be younger, fitter, less deprived (Index of Multiple Deprivation), and have undergone major surgery. Response rate did not change with time from diagnosis. Significant variation in trust response rate was identified (64/142 trusts outside 95% funnel limits). Trusts with lower response rates had higher deprivation rates. EQ- 5D scores showed expected correlation with patient characteristics, with lower QoL associated with old age (>75 years), deprivation, emergency presentation, advanced disease and stoma presence. This study supports the accuracy and validity of national PROMS. Variation in trust response rate and lack of responder representativeness must be considered if PROMS data is used to monitor provider performance.

40. Current practice & outcomes within NHS England in the use of self-expandable metal stents for the management of malignant obstruction of the left colon in the palliative setting

Authors Boyle J.; Vallance A.E.; Hill J.; Walker K.; Kuryba A.; Van Der Meulen J.; Braun M.
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Available at Colorectal Disease from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract The management of acute left-sided large bowel obstruction (LBO) remains contentious with options including self-expandable metal stents (SEMS), proximal diversion or primary resection. SEMS can provide alternative treatment for patients with disseminated disease or unacceptable surgical risk. NICE recommends consideration of SEMS within the palliative setting. This national study describes current use of SEMS in malignant obstruction of the left colon for palliative patients. National Bowel Cancer Audit data (2013-2015) was linked to Hospital Episodes Statistics data. Patients recorded as having emergency palliative procedures for leftsided colonic cancer as their index procedure were assumed to have acute LBO and included. Perforations were excluded. Outcomes included length of stay (LOS) following primary procedure, 30-day and 1-year re-intervention rate, hospitalisation, and 30-day and 1-year mortality. 369 patients had SEMS at 82/146 English hospitals. Median age was 77 years (range 67-84 years). Median LOS was 4 days (range 2-9). 30-day and 1-year reintervention were 9.2% and 17.1% respectively including laparotomy with colorectal resection and stoma formation. 10% patients required additional SEMS at 1 year. 28.6% patients with SEMS were hospitalised at any one point between 30 days to 1 year from intervention. 30-day and 1-year mortality were 15.7% and 63.4% respectively. SEMS is used infrequently in the palliative setting. A short initial LOS may enable earlier chemotherapy administration. The majority of patients treated with SEMS for palliation avoid further hospital admissions and procedures. High mortality rates reflect advanced disease at the time of SEMS insertion.

41. No volume-outcome relationship is observed in key performance indicators for rectal cancer surgery published in the NBCA annual report 2017

Authors Watson H.; Luo X.; Mahon C.C.W.
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Abstract Purpose: Case-volume outcome relationships in surgery are the subject of much discussion. The UK National Bowel Cancer Audit (NBCA) has identified CRM involvement, APER rate, and 18-month stoma rate as important outcomes in rectal cancer surgery. These outcomes are published in NBCA Annual reports for units reporting 10 or more major operations for rectal cancer during each audit cycle. The aim of this study was to identify whether there is any relationship between case-volume and these outcome measures for rectal cancer surgery as published by NBCA.
Method(s): Data extracted from NBCA Report 2017 were entered into an Excel database. Separate scatter plots were created for case-volume vs CRM involvement, APER rate, and 18-month stoma rate respectively and r values were obtained. Units where margin status involvement was not available for more than 50% of reported cases were excluded from analysis of CRM involvement.
Result(s): Data from 148 Trusts were included in the analysis. 28 Trusts were excluded from analysis of CRM involvement. The median number of patients undergoing major surgery for rectal cancer was 25 (range 10-97). No correlation between case-volume and CRM involvement was apparent (r = -0.057). No correlation between case-volume and APER rate was apparent (r = 0.034). No correlation between case-volume and 18-month stoma rate was apparent (r = -0.039).
Conclusion(s): Data published by NBCA do not suggest that a volume-outcome relationship in rectal cancer surgery exists for the key performance indicators of CRM involvement, APER rate, or 18-month stoma rate.

42. Role of emergency laparoscopic colectomy for colorectal cancer: A population-based study in England

Authors Vallance A.; Kuryba A.; Vander Meulen J.; Walker K.; Keller D.S.; Chand M.; Hill J.; Braun M.
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Available at Colorectal Disease from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Background: Laparoscopy is increasingly used for elective colorectal cancer (CRC) surgery, but uptake has been limited in the emergency setting. The aim of this study was to evaluate factors associated with the use of laparoscopic surgery and the associated post-operative outcomes following emergency resection of CRC in the English National Health Service.
Method(s): Patients recorded in the National Bowel Cancer Audit who underwent urgent or emergency CRC resection between April 2010 and March 2016 were included. A multivariable multilevel logistic regression model was used to estimate odds ratios (OR) of undergoing laparoscopic resection, and post-operative outcome according to approach.
Result(s): There were 15 516 patients included. Laparoscopy use doubled from 15.1% in 2010 to 30.2% in 2016. Laparoscopy was less common in patients with poorer physical status (ASA 4/5 vs 1, OR 0.29 (95% CI 0.23-0.37), P < 0.001) and more advanced T-stage (T4 vs T0-T2, OR 0.28 (0.23-0.34), P < 0.001) and M-stage (M1 vs M0, OR 0.85 (0.75-0.96), P < 0.001). Age, socio-economic deprivation, nodal stage, and hospital volume, were not associated with laparoscopy. Laparoscopic patients had a shorter length of stay (median 8 days (interquartile range (IQR) 5-15) vs 12 (IQR 8-21), adjusted mean difference -3.67 (-4.60-2.74), P < 0.001) and lower 90-day mortality (8.1% vs 13.0%; adjusted OR 0.78 (0.66-0.91), P = 0.004) than open patients. There was no significant difference in rates of readmission or reoperation by approach.
Conclusion(s): The use of laparoscopic approach in the emergency resection of CRC is linked to a shorter length of hospital stay and reduced postoperative mortality.

43. Patient outcomes following banding/injection sclerotherapy for haemorrhoidal disease, is follow up for everyone necessary?

Authors Khan K.A.; Richters M.; Norman K.; Thorn C.; Alexander R.J.
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Abstract Introduction: Hemorrhoids are abnormally swollen vascular mucosal cushions that are present in the anal canal. Community-based studies in the UK reported that hemorrhoids affect 13-36% of the general population1. This study looks at short-term patient outcomes following banding/injectionsclerotherapy for hemorrhoidal disease and determine whether follow up is necessary for everyone. Primary parameter was continuing symptoms within four months following treatment. Secondary parameters were: time to follow up, previous treatment for hemorrhoids, and follow up arranged from treatment or re-referral from community.
Study Design: Retrospective analysis of 151 patients undergoing flexible sigmiodoscopy for banding or injection-sclerotherapy for hemorrhoidal disease at a busy DGH, from June 2015-2016. Data collected from hospital database.
Result(s): * 151 banding/injection-sclerotherapy performed during one year period; average age was 54.5; of which: 81 male/70 female. * 94 underwent banding while 52 had injection-sclerotherapy; 16 patients had previous treatments for hemorrhoids. * 90 patients were followed up; median time to follow up was 4.3 months. 14 were re-referred from community. * 29 patients had continued symptoms; of which 4 were scheduled for further surgery.
Discussion(s): Considering NHS waiting times for outpatient appointment, it is prudent to explore ways to minimize unnecessary follow up to improve the system efficiency. Patient Initiated Follow-Up (PIFU) is an alternative system to address the situation. The findings of this audit will be presented at the Gastro-Intestinal Clinical Governance meeting; with an example patient leaflet containing: symptom related and appointment contact information; that will be introduced. Repeated audit: 6 months.

44. Management of acute diverticulitis in a large dedicated emergency surgical unit: An audit of current practice and recommendations for the future

Authors Kedrzycki M.; Kashyap J.; Liasis L.; Watfah J.; Hodgkinson J.D.; Leo C.A.
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Abstract Objective: To evaluate current practice in the management of acute diverticulitis in a large emergency surgical unit.
Method(s): The departmental prospectively maintained clinical database was searched for all patients presenting between January and December 2017 with acute diverticulitis. Case notes were retrospectively reviewed to extract data including blood results and length of stay.
Result(s): In the study period, 148 patients were treated for acute diverticulitis. The mean age was 61.7 years; 68 (45.9%) were males. CT scan confirmed the diagnosis in 124 (83.8%) patients. Of the remaining 24, 5 had a known history of diverticulitis and were treated clinically; 18 were treated according to clinical signs. 1 had a CT later in admission due to an acute kidney injury at presentation. Uncomplicated acute diverticulitis was diagnosed in 108 patients. For those with complications, 27 were Hinchey Grade 1, 6 Grade 2, 7 Grade 3 and 0 Grade 4. Three patients required radiological drainage of intra-abdominal abscess and 11 required surgical intervention with no post-operative mortality. Median length of stay was 3 days (1-34). Sixty-two patients (41.9%) stayed in hospital for <48 hours, 90% of whom had uncomplicated disease. Only 22 patients (14.9%) required a hospital stay of more than 1 week.
Conclusion(s): We describe the practice of a UK emergency surgical unit treating acute diverticulitis. Diagnostic CT scanning allows for rapid and accurate diagnosis. Most patients with uncomplicated disease do not required prolonged hospital stay. Improvement in ambulatory care services for this group could reduce hospital stay and costs.

45. Socioeconomic differences in survival in metastatic colorectal cancer

Authors Vallance A.E.; Van Der Meulen J.; Kuryba A.; Walker K.; Braun M.I.; Jayne D.G.; Hill J.; Cameron I.C.
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Abstract Background: Socioeconomic inequalities in colorectal cancer (CRC) survival are well recognised. The aim of this study was to describe the impact of socioeconomic deprivation on survival in patients with synchronous CRC liver-limited metastases, and to investigate if survival inequalities are explained by differences in liver resection rates.
Method(s): Patients in the National Bowel Cancer Audit diagnosed with CRC between 2010 and 2016 in the English National Health Service were included. Hospital Episode Statistics data were used to identify the presence of liver metastases and liver resection procedures. Multivariable random-effects logistic regression was used to estimate the odds ratio (OR) of liver resection by Index of Multiple Deprivation (IMD) quintile. Cox-proportional hazards model was used to compare 3-year survival.
Result(s): 13 656 patients were included, of whom 2213 (16.2%) underwent liver resection. Patients in the least deprived IMD quintile were more likely to undergo liver resection than those in the most deprived quintile (adjusted OR 1.42, 95% CI 1.18-1.70). Patients in the least deprived quintile had better 3-year survival (least vs most deprived, 22.3% vs 17.4%; adjusted hazard ratio (HR) 1.20, 1.11-1.30). Adjusting for liver resection attenuated this effect. There was no difference in survival between IMD quintile when restricted to patients who underwent liver resection (adjusted HR 0.97, 0.76-1.23).
Conclusion(s): Lower rates of liver resection contributes to poorer survival in deprived CRC patients with synchronous liver-limited metastases. There should be targeted efforts by CRC multi-disciplinary teams to ensure equitable access to specialist care for this cohort.

46. The use of IVIg in the treatment of inflammatory polyneuropathies and myasthenia gravis at The Walton Centre

Authors Kimyongur S.; Hywel B.; Holt J.

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Available at The journal of the Royal College of Physicians of Edinburgh from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.
Abstract BACKGROUND: Immunoglobulin is a blood product used in a variety of medical disorders, usually delivered intravenously (IVIg). Neurology patients, particularly those with inflammatory polyneuropathy, utilise a lot of IVIg. There is a national shortage of immunoglobulin and, thus, pressing need to ensure minimum effective dosing as well as rigorous outcome assessments to assess benefit at treatment start and subsequently, as placebo effects can be strong.
METHOD(S): Serial audit of IVIg use at The Walton Centre against national guidelines was carried out through analysis of clinical notes of day unit patients. Review of the national immunoglobulin database and of neurology outpatient notes to benchmark our practice and provide some comparison with the wider nation was also performed.
RESULT(S): Serial audit led to improved adherence to guidelines, and analysis of practice identified wide variation in IVIg use.
CONCLUSION(S): Local audit and benchmarking of practice can be used to promote quality and consistency of IVIg use across the NHS.

47. Motivation to reduce alcohol consumption and subsequent attempts at reduction and changes in consumption in increasing and higher-risk drinkers in England: a prospective population survey

Authors de Vocht F.; Brown J.; Beard E.; Michie S.; Campbell R.; Hickman M.; West R.
Source Addiction (Abingdon, England); May 2018; vol. 113 (no. 5); p. 817-827
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Database EMBASE
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Available at Addiction (Abingdon, England) from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Abstract AIMS: To assess how far motivation to reduce alcohol consumption in increasing and higher-risk drinkers in England predicts self-reported attempts to reduce alcohol consumption and changes in alcohol intake during the following 6 months.
METHOD(S): This study used self-reported data from 2928 higher-risk drinkers in the Alcohol Toolkit Study (ATS): a series of monthly cross-sectional household surveys of adults aged 16+ years of age in England. Alcohol consumption was measured in an initial survey and in a 6-month telephone follow-up interview using the Alcohol Use Disorders Identification Test (AUDIT)-C questionnaire. Motivation was measured in the initial survey using the Motivation to Reduce Alcohol Consumption (MRAC) scale. Attempts to reduce alcohol consumption during the past 6 months were recorded at follow-up. Data were analysed using repeated-measures difference-in-differences and logistic regression models.
RESULT(S): Participants with higher initial motivation to reduce alcohol consumption were more likely to report that they had made an attempt to reduce consumption at follow-up [adjusted odds ratio (ORadj) = 2.39, 95% confidence interval (CI) = 1.75-3.29]. There was an overall reduction in alcohol consumption between initial survey and follow-up (ORadj = 0.72, 95% CI = 0.65-0.79), but there was insufficient evidence of an additional effect of motivation to reduce consumption on subsequent changes in alcohol consumption, with the difference-in-differences effect instead suggesting an average increase (ORadj = 1.37, 95% CI = 1.00-1.88).
CONCLUSION(S): Increasing and higher-risk drinkers in England who report greater motivation to reduce their consumption are more likely to report making an attempt to reduce during the next 6 months, but this may not be associated with a reduction in alcohol consumption.
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48. Senescent Changes in Sensitivity to Binaural Temporal Fine Structure

Authors Fullgrabe C.; Sek A.P.; Moore B.C.J.
Source Trends in hearing; Jan 2018; vol. 22

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Publication Type(s) Article
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Available at Trends in hearing from Europe PubMed Central - Open Access

Abstract Differences in the temporal fine structure (TFS) of sounds at the two ears are used for sound localization and for the perceptual analysis of complex auditory scenes. The ability to process this binaural TFS information is poorer for older than for younger participants, and this may contribute to age-related declines in the ability to understand speech in noisy situations. However, it is unclear how sensitivity to binaural TFS changes across the older age range. This article presents data for a test of binaural sensitivity to TFS, the "TFS-adaptive frequency" (AF) test, for 118 listeners aged 60 to 96 years with normal or near-normal low-frequency hearing, but a variety of patterns of hearing loss at higher frequencies. TFS-AF scores were significantly lower (i.e., poorer) than those for young adults. On average, scores decreased by about 162Hz for each 10-year increase in age over the range 60 to 85 years. Individual variability increased with increasing age. Scores also declined as low-frequency audiometric thresholds worsened. The results illustrate the range of scores that can be obtained as a function of age and may be useful for the diagnosis and management of age-related hearing difficulties.

49. Identifying MAIS 3+ injury severity collisions in UK police collision records

Authors Nunn J.; Barnes J.; Morris A.; Petherick E.; Mackenzie R.; Staton M.
Source Traffic injury prevention; 2018; vol. 19
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Database EMBASE
Available at Traffic injury prevention from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract OBJECTIVE: This study represents the first stage of a project to identify serious injury, at the level of Maximum Abbreviated Injury Scale (MAIS) 3+(excluding fatal collisions) from within the police collision data. The resulting data will then be used to identify the vehicle drivers concerned and in later studies these will be culpability scored and profiled to allow targeting of interventions.
METHOD(S): UK police collision data known as STATS19 for the county of Cambridgeshire were linked using Stata with Trauma Audit and Research Network (TARN) hospital trauma patient data for the same geographical area for the period April 2012 to March 2017. Linking was 2-stage: A deterministic process followed by a probabilistic process.
RESULT(S): The linked records represent an individual trauma patient from TARN data linked to an individual trauma casualty from STATS19 data. Full collision data for the incident resulting in the trauma casualty were extracted. The resulting subset of collisions has the MAIS 3+ injury criteria applied. From the 10,498 recorded collisions, the deterministic linking process was successful in linking 257 MAIS 3+ trauma patients to collision injury subjects from 232 separate collisions with the probabilistic process linking a further 22 MAIS 3+ subjects from 21 collision events. The combined collision data for the 253 collisions involved 434 motor vehicle drivers.
CONCLUSION(S): We produced viable results from the available data to identify MAIS 3+ collisions from the overall collision data.

50. Angle-Dependent Distortions in the Perceptual Topology of Acoustic Space

Authors Brimijoin W.O.
Source Trends in hearing; Jan 2018; vol. 22
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Abstract By moving sounds around the head and asking listeners to report which ones moved more, it was found that sound sources at the side of a listener must move at least twice as much as ones in front to be judged as moving the same amount. A relative expansion of space in the front and compression at the side has consequences for spatial perception of moving sounds by both static and moving listeners. An accompanying prediction that the apparent location of static sound sources ought to also be distorted agrees with previous work and suggests that this is a general perceptual phenomenon that is not limited to moving signals. A mathematical model that mimics the measured expansion of space can be used to successfully capture several previous findings in spatial auditory perception. The inverse of this function could be used alongside individualized head-related transfer functions and motion tracking to produce hyperstable virtual acoustic environments.

51. The effect of re-audit and education on antibiotic prescribing practice at Causeway Hospital, Northern Ireland

Authors Johnston D.N.; Keshtkar F.; Campbell W.
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Available at Irish Journal of Medical Science from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Background: Antimicrobial resistance is a growing global problem. There has been increasing emphasis on promoting antimicrobial stewardship. Accurate completion of antibiotic prescriptions, such as documentation of clinical indication and a stop/review date, helps promote antimicrobial stewardship.
Aim(s): To investigate the impact of educational interventions on the completeness of antibiotic prescriptions at Causeway Hospital surgical unit.
Method(s): Inpatient drug prescription charts were audited to monitor the completeness of antibiotic prescriptions on the surgical unit. Two educational interventions were implemented, with a subsequent prospective re-audit carried out.
Result(s): The completion of (1) "Stop date/Review date", (2) "What infection are you treating?", (3) "Cultures sent?", (4) "Printed name", (5) "Professional number", and (6) "Bleep number" fields within the inpatient drug charts increased noticeably in the re-audit. A paired t test, comparing all of the initial audit completion proportions with the re-audit completion proportions, demonstrated a statistically significant improvement ($p < 0.05$).
Conclusion(s): Educational interventions led to an improvement in the completeness of antibiotic prescriptions. This highlights the important role that continued audit and education play in the promotion of antimicrobial stewardship.
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52. Open tibial fractures in major trauma centres: A national prospective cohort study of current practice

Authors Young K.; Aquilina A.; Costa M.L.; Chesser T.J.S.; Kelly M.B.; Hettiaratchy S.; Moran C.G.; Pallister I.; Woodford M.
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Abstract Aims: To assess current national practice in the management of severe open tibial fractures against national standards, using data collected by the Trauma and Audit Research Network.
Material(s) and Method(s): Demographic, injury-specific, and outcome data were obtained for all grade IIIB/C fractures admitted to Major Trauma Centres in England from October 2014 to January 2016.
Result(s): Data was available for 646 patients with recorded grade IIIB/C fractures. The male to female ratio was 2.3:1, mean age 47 years. 77% received antibiotics within 3 h of admission, 82% were debrided within 24 h. Soft tissue coverage was achieved within 72 h of admission in 71%. The amputation rate was 8.7%. 4.3% of patients required further theatre visits for infection during the index admission. The timing of antibiotics and surgery could not be correlated with returns to theatre for early infection. There were significant differences in the management and outcomes of patients aged 65 and over, with an increase in mortality and amputation rates.
Conclusion(s): Good outcomes are reported from the management of IIIB/C fractures in Major Trauma Centres in England. Overall compliance with national standards is particularly poor in the elderly. Compliance did not appear to affect rates of returning to theatre or early infection. Appropriately applied patient reported outcome measures are needed to enhance the evidence-base for management of these injuries.
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53. Registration audit of clinical trials given a favourable opinion by UK research ethics committees

Authors Denneny C.; Bourne S.; Kolstoe S.E.
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Abstract Objective To determine levels of public registration for a cohort of clinical trials reviewed and given a favourable opinion by research ethics committees in the United Kingdom. Study design Audit of records. Setting Clinical trials receiving a favourable ethics opinion between 1 January 2016 and 30 June 2016. Main outcome measures Correlation between trials on the UK research ethics committee database and any primary registry entry on the WHO International Clinical Trials Registry Platform or clinicaltrials.gov as of 29 August 2017 (14 to 20 months after the favourable ethics committee opinion). Results Over the study period 1014 trials received a favourable ethics opinion, with 397 (39%) registered on the European Union Drug Regulating Authorities Clinical Trials database, and 18 with an agreed clinical trial registration deferral. Excluding these trials, the total number subsequently requiring registration was 599, and of these 405 (40% of total) were found to be registered. Follow-up with the 194 investigators or sponsors of trials not found to be registered produced 121 responses with a further 10 (1%) trials having already registered, 55 commitments to register and a variety of other responses. The overall registration rate was therefore 80%. Conclusions Despite researchers and sponsors being reminded that registration of clinical trials is a condition of the research ethics committee (REC) favourable opinion, one-fifth of clinical trials either had not been registered, or their registration could not easily be found, 14 to 20 months after receiving the favourable opinion letter. The methodology trialled here proved effective, and although there are positive indications of a culture change towards greater registration, our results show that more still needs to be done to increase trial registration.
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54. Urethral injury in major trauma

Authors Battaloglu E.; Porter K.; Figuero M.; Lecky F.; Moran C.
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Abstract Urethral injury in major trauma is infrequent, with complex problems of diagnosis and treatment. The aims of this study are to determine the incidence and epidemiological factors relating to urethral injury in major trauma, as well as determine if any additional prognostic factors are evident within this cohort of patients. A retrospective review of patients sustaining urethral injury following major trauma was made over a 6-year period, from 2010 to 2015. Quantitative analysis was made using the national trauma registry for England and Wales, the Trauma Audit and Research Network (TARN) database, identifying all patients with injury codes for urethral injury. 165 patients with urethral injuries were identified, over 90% were male, most commonly injured during road traffic accidents and with an associated overall mortality of 12%. Urethral injury in association with pelvic fracture occurred in 136 patients (82%), representing 0.6% of all pelvic fractures, and was associated with double the rate of mortality. Urethral injury was associated with unstable pelvic fractures (LC2, LC3, APC3, VS, CM) but not with a specific pelvic fracture type. This study confirms the rare incidence of this injury in major trauma at 1 per 2 million population per year.
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55. An audit review of safety and complication rates, of rigid bronchoscopy and large airways intervention, in a London tertiary centre

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Abstract Introduction: Rigid bronchoscopy permits endobronchial laser therapy, tracheal and bronchial stenting, airway dilatation and proximal tumour biopsy. Though some can be performed at flexible bronchoscopy, rigid bronchoscopy allows for improved airway control, wide bore suction and ventilation and lung isolation capabilities. Limited studies illustrating its safety and complication rates are available.
Aim(s): To audit our practice against previously reported complications and review indications.
Method(s): All rigid bronchoscopies, during the study period were retrospectively reviewed.
Result(s): 1711 rigid bronchoscopies were performed. Indication for rigid bronchoscopy was: Nd Yag laser 578 (34%), stent insertion 399 (23%), proximal tumour biopsy 358 (21%), diagnostic inspection of airways 186 (11%), dilatation of proximal stricture 100 (6%), removal of foreign body 28 (2%), removal of stent 21 (1%), percutaneous tracheostomy insertion 16 (1%), application of bioglue 19 (1%) and application of mitomycin C 6 (0.04%). Complications were noted in 18 (1.1%) patients. There was 1 fatality (0.06%) due to tumour erosion and massive haemorrhage, prior to intervention. 7 (0.4%) patients had haemorrhage of >=100mls and haemostasis was achieved in all endobronchially. Pneumothoraces in 7(0.4%), 5 of whom required chest drain insertion. 3 patients were admitted to the intensive care unit and subsequently discharged home.
Conclusion(s): Large airway intervention using rigid bronchoscopy under general anaesthetic within the confines of a multidisciplinary team is safe, successful and well tolerated. Rigid bronchoscopy at our centre is progressively increasing.

56. Management of children and young people (CYP) in London with asthma: A clinical audit report

Authors Levy M.L.; Ward A.; Nelson S.
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Abstract An asthma attack is a signal that treatment has failed: most attacks are preventable and there is a failure to recognise these as a future risk of attacks and even death.(1) The Harrow Clinical Commissioning Group (CCG) in North London, caring for about 250000 National Health patients, initiated a retrospective clinical asthma audit on children and young people (CYP) treated for asthma attacks in 2016. This was funded as a Local Incentive Scheme for general practices (GPs) to improve quality health care delivery.
Method(s): Standards included preattack treatment (< 6 SABAs) and action plans in previous year; PEF and SaO2 during attack; post attack reviews (for details see http://bit.ly/1Snt9Dd) Individual reports were presented to participating GPs.
Result(s): 29/33(87%) of GPs included data on 333 asthma attacks in 291 CYP. 15% of CYP had been prescribed excess numbers of SABA reliever inhalers; 2/3s of those on preventer inhalers had collected insufficient prescriptions; 1/3 of the records had evidence of CYP being provided with a personal asthma action plan; only 32/333 (10%) of the attacks were followed up within 2 days as recommended in the UK guideline. Individual reports for each of the GPs provided clear guidance for management of individual cases, and recommendations for change in managing asthma. Of note: subsequent CYP hospital admissions during the year after implementing the audit reduced by 16%.
Conclusion(s): This learning exercise resulted in reduced asthma admissions with clear benefit for patients, their families and the local health economy.

57. A review of asthma care in 50 general practices in Bedfordshire, United Kingdom

Authors Levy M.L.; Garnett F.; Kuku A.; Pertsovskaya I.; McKnight E.; Haughney J.
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Abstract The United Kingdom (UK) National Review of Asthma Deaths (NRAD) (20112014) identified a number of contributory risk factors which had not previously been recognized by those caring for people with asthma. Only one of the 19 NRAD recommendations has so far been implemented nationally, and as yet systems are not in place to identify patients at risk of attacks and dying from asthma. In 2015/2016 Bedfordshire Clinical Commissioning Group (CCG) in England, UK, initiated a quality asthma audit of people with asthma to identify some of the risk factors identified in the NRAD report with the aim of optimising patient care. Fifty (89%) of the General Practices caring for 415,152 patients (27,587 diagnosed with asthma (prevalence 7%;range 412%)), participated. Results identified a wide variation in process of care and presence of risk factors including: excess short acting reliever and insufficient preventer prescriptions, failure to issue personal asthma action plans and to perform annual reviews or check inhaler technique. Identification of these patients involved high intensity input by trained asthma nurses using sophisticated data extraction software. GP computer systems used in UK primary care currently do not have the functionally, without the need for manual audit, to implement the NRAD recommendations, starting with the identification of patients at risk. Modifications to existing systems within both primary and secondary care are required in order to prevent unnecessary deaths related to asthma. There is a pressing need to move towards a more proactive model of care.

58. Effects on CPAP use of a patient support mobile app

Authors Engleman H.; Stitt C.; Creswick L.; Cachada N.; Thomas M.; Leahy J.; Martin S.; Derashri N.; Kelly T.
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Abstract Introduction: A recent audit of Philips Sleep Support Service (PSSS) (1) showed an extra half-hour in nightly CPAP use after the 2016 roll-out of enhanced technology, including DreamStation (DS) devices, remote monitoring via modem and the DreamMapper (DM) patient support mobile app. Audit data was here used to explore DM's potential influence on CPAP use.
Method(s): The audit drew two 6m cohorts of all new CPAP users, from before (SysOne) and after (DS) new technology was implemented. CPAP use data over patients' first 12 weeks were collected in 6, 2-week 'bins'. DS patients were split into those downloading DM or not, though extent of DM use was not known. CPAP use was compared by oneway ANOVA of the three groups(SysOne, DS without DM, DS with DM), with post-hoc Dunnett's test.
Result(s): Average nightly CPAP use and sample sizes for each group and timepoint are shown in Figure. CPAP use by DS with DM patients was higher than in SysOne patients ($p<=0.01$) at each timepoint. Over 12 weeks, this difference in CPAP use averaged 1.1 hrs/nt, or a 27% increment.
Conclusion(s): In a UK audit, downloading DM was associated with higher average CPAP use. While exploratory, findings support DM's value in enhancing patient adherence and outcomes, through better engagement in and patient empowerment with therapy.

59. No single system of pulmonary rehabilitation delivers for all patients with COPD ?

Authors Apps M.; Keeling K.-A.; Goodrich C.; Olympio-Anang H.; Young I.; Kopacz A.; Sanger K.; Minter J.; Gisby T.
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Abstract Introduction: Group based courses of Pulmonary Rehabilitation(PR) lead to improvement in mortality, morbidity and quality for life for those who complete them. But studies show only 40-60% complete. In the UK completion rates vary between 17-59%. Our PR service is a part of an Integrated Community Respiratory Service since April 2015 serving 450,000. We try to identify patients (MRC3) who would benefit from PR whether referred directly for PR or to the service as a whole.
Method(s): We have carried out a series of nested audits to examine PR referral, nature of respiratory disease and outcomes after PR.
Result(s): In 2014-5, 300 patients received PR. In 2015-6 there were 799 PR referrals with 94% COPD. In 2017 the service excluding PR received 997 referrals, including 664 after hospital admission for COPD and 64% were identified for potential PR at triage. Between Apr-Nov 2017 there were 376 referrals to PR (14% after in patients stay) equivalent to 564/yr. At initial telephone consultation 156 declined the service. There were 2441 group attendances and 224 patients commenced PR. For 122 booked for inital clinical assessment (Jun-Aug), 108 attended. 99 started PR and 75 completed all sessions (61%). Reasons for non completion included deterioration of respiratory or non-respiratory disease(13%), moved away/ too busy (5%). 71% showed increased walking distance, 53% reduced CAT score by =or>2, 45% reduced HAD anxiety/depression scores.
Conclusion(s): Group PR works well but many decline the service or are unable to attend or complete. We need to look at other options especially for those who are MRC2 or unable to attend sessions or too ill to attend including home based and internet supported PR where possible.

60. A multidisciplinary approach to post intensive care tracheostomy weaning and the impact of a dedicated team on decannulation rates and outcome in a regional UK major trauma centre

Authors Moses R.; Pulsford J.; Bunting S.; Stevens L.; Al-Nufoury H.; Fishburn A.; Slinger C.; Vyas A.; Spencer C.
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Abstract Background: Percutaneous tracheosotmies are commonly performed in intensive care to expedite weaning from mechanical ventilation especially following major trauma, acquired brain injury or severe respiratory failure. Often patients are discharged from the intensive care unit (ICU) to a ward environment with no specialist follow up Aim: To evaluate the effectiveness of a multi-disciplinary tracheostomy team (MDT) at reducing the total length of hospital stay and improving decannulation rates in tracheostomy patients once discharged from ICU Method: The team consisted of a Consultant, Physiotherapist, Speech and Language Therapist, a Head & Neck Specialist Nurse and a Critical Care Outreach Nurse. The team met weekly on the neurosurgery and respiratory wards and may prescribe treatments or therapies, offer advice to ward staff or carry out interventions. Audit data was gathered for 6 months preceding the establishment of the team and during the 6 month pilot period.
Result(s): Based on around 62 patients being discharged to neurosurgical and respiratory wards per year, the permanent introduction of a Trust Tracheostomy MDT has the potential to reduce the time patients spend with a temporary tracheostomy in situ by 50% and in patient bed use by 911 days per year. View inline
Conclusion(s): A Tracheostomy MDT is an essential service to ensure timely decannulation as well as reducing hospital length of stay and improving overall outcome.

61. Developing datasets for a national audit of hospital asthma care and organisation in england and wales

Authors Andrews R.; McMillan V.; Roberts C.M.; Nasser S.
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Abstract Introduction: A national review of asthma deaths found that asthma management and care was inadequate in 26% of cases reviewed. The Asthma Audit Development Project was established to develop and test audit methods and datasets for a National Asthma Audit to address shortfalls in asthma care.
Method(s): A multidisciplinary group of experts, including asthma patients, was formed and used as a source of governance and guidance. A review of asthma literature and guidelines was undertaken to identify areas of poor and variable asthma care which, if improved, could lead to better patient outcomes. Areas identified were mapped to specific guidelines and standards to develop datasets covering adult and paediatric care and organisation. Dataset development also comprised: expert review public consultation to seek broad stakeholder opinion a focus group to seek views and feedback on what areas of asthma care were important to asthma patients and carers. Datasets were tested within a clinical setting by adult and paediatric hospitals in England and Wales. Participating hospitals were asked to comment and feedback on the practicalities of collecting the information needed.
Result(s): Feedback and patient views were used to inform and develop five datasets covering adult and paediatric asthma care. Datasets were designed for continuous clinical audit, with a snapshot organisational audit component. Hospitals testing confirmed that the necessary information could be collected and the data collection process could be incorporated into existing hospital processes.
Conclusion(s): This describes the approach followed and the activities undertaken to develop hospital datasets for a National Asthma Audit.

62. Quality performance indicators in lung cancer; Learning and reflecting on mortality data

Authors Hardavella G.; Hobart C.; Turner R.; Warwick G.; Hadley L.; Heitmann A.; Edmonds P.
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Abstract Introduction: In response to our hospital's routine review of data relating to mortality, an internal investigation was undertaken to our performance for the 2015 UK National Lung Cancer Audit, where survival, at 32.4% was reported to be worse than the regional average of 46.5%.
Aim(s):1). To provide assurance of the local quality of care for patients who died following a diagnosis of lung cancer in 2015.2) To identify variables unrelated to quality of care which might explain the apparent high rates of local mortality.
Material(s) and Method(s): A detailed review of patient records by senior doctors specialising in lung cancer.
Result(s): Of 203 patients diagnosed with lung cancer in 2015,136 patients had died as of the end of 2016, of who 131 had evidence of lung cancer diagnosis.66% were male;mean age 76(range 47-92) yrs. Only 66% had a pathological diagnosis, but the remainder all had clinic-radiological evidence of advanced lung cancer. Only 34% presented via primary care;69% had stage IV disease at diagnosis.76% had significant comorbidities, and 60% had a performance status>=3 at diagnosis.62% had palliative care as their primary treatment. The average time from diagnosis to death was 117 days.98 deaths were recorded as definitely unavoidable;2 with slight evidence of avoidability; and in the remainder there was insufficient data for such an assessment. No concerns of the quality of care or case mix were identified.
Conclusion(s): The characteristics of the patient population are likely to have affected the higher than predicted mortality from lung cancer. Our cohort was older than the national average, more likely to present as an emergency and had more advanced disease and poorer performance status at presentation.

63. The impact of late presentation of acidotic hypercapnic respiratory failure in hospitalised COPD patients on outcome following noninvasive ventilation

Authors Trethewey S.; Edgar R.; Morlet J.; Mukherjee R.; Turner A.
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Abstract Introduction: Noninvasive ventilation (NIV) is recommended for treatment of acidotic hypercapnic respiratory failure (AHRF) refractory to optimal medical management in patients with acute exacerbation of COPD. The UK national COPD audit revealed a potentially poor prognostic group - those who present with AHRF some time after initial admission.
Aim(s): To evaluate the relationship between time from hospital presentation to diagnosis of AHRF and inhospital mortality in COPD patients who have undergone wardbased NIV.
Method(s): Retrospective analysis of hospitalised COPD patients receiving wardbased NIV for AHRF between 2013 and 2017. Data collected prospectively as part of NIV service evaluation at a single centre. Multivariate analysis performed. Primary outcome was inhospital mortality.
Result(s): In total, 376 individual episodes of NIV were studied; 139 males (37%), median age 69.7 years, median FEV1 % predicted 35%, median FEV1/FVC ratio 42%. Overall inhospital mortality was 18% (n=68). A longer time between hospital presentation to diagnosis of AHRF was associated with inhospital mortality [median(IQR): 19.6(77) hours vs 3.3(23) hours, p=0.0001]. Patients who died in hospital were also older [median(IQR): 76.5(14) years vs 68.6(12) years, p<0.0001] however there were no significant differences in gender, FEV1 % predicted or FEV1/FVC ratio between groups.
Conclusion(s): Patients with COPD who present with AHRF later during hospital admission may have increased inhospital mortality. Further research is required to elucidate clinically relevant time points and their relationship with mortality to inform clinical decision making.

64. Skin integrity in domiciliary noninvasive ventilation: A clinical audit

Authors Ewles S.; Cozens S.; Worsley P.R.; Ewings S.; Conway J.
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Abstract We conducted a clinical audit on all domiciliary patients using the noninvasive (NIV) service as part of the Southampton (UK) Respiratory Centre. We aimed to identify the incidence of skin issues related to mask use in our patient groups, and potential risk factors. All electronic and written records for those using NIV were reviewed. The following data were recorded: patient demographics, comorbidities, type of NIV and mask/ interface, hours per day on NIV, selffitting of mask or not, presence of any skin issues, use of barrier dressing and oral steroid use.
Result(s): There were 278 patients on NIV, with an average age of 55.3 yr. There were a large number of diagnoses and comorbidities. Of these, 34 patients had skin issues (12%) and 19 patients needed barrier dressing (7%). Of those with skin issues all skin issues were at Stage 1 of the www.reacttoredskin.co.uk classification/grading system. Nine people (26% of those with a skin issue) had only a barrier dressing issued and five (15%) had an alternative mask, while ten (29%) more people had both a barrier and an alternative mask. 61% of patients with skin issues had a diagnosis of NMD, 18% a diagnosis of COPD, 9% OSA/OHS and 12% other various conditions. A relationship between hours on NIV and skin issues could not be determined. 82% of patients with skin issues had a primary interface issued as a full face mask, 6% minimalcontact full face mask, 6% nasal mask and 6% nasal pillows. Steroid use may be associated with a slightly higher incidence of skin issues for those with COPD.
Conclusion(s): Of our total domiciliary NIV patient population we found a 12% incidence of skin issues. Those with MND may develop issues at a higher rate than other conditions.

65. A comparison of outcomes from a regional Mesothelioma MDT against the National Lung Cancer Audit (NLCA) Mesothelioma standards

Authors Ahmed M.; Lyons J.; Jackson S.; Holme J.; Evison M.; Sharman A.; Dixon M.; Taylor P.
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Abstract Background: Malignant mesothelioma (MM) is an incurable malignancy with a poor prognosis. In 2014, 43% of patients survived to one year following diagnosis in the UK. There is evidence of patient benefit from regional mesothelioma multidisciplinary team meetings . The 2016 NLCA Pleural Mesothelioma report defined key recommendations for patients diagnosed with MM in England in 2014.
Aim(s): To evaluate and compare outcomes of patients managed through the Greater Manchester Regional Mesothelioma MDT against the 2016 NLCA findings.
Method(s): Retrospective review of MM cases discussed at our MDT meeting between April 2016 and February 2018 using data from electronic MDT proformas.
Result(s):
Conclusion(s): Outcomes from our MDT are encouraging and may help build evidence in favour of regional mesothelioma MDTs. In particular, active treatment rates and ensuring equity of access to clinical research appears higher than national figures within this specialist service..

66. Noninvasive ventilation in motor neurone disease patients attending the West of Scotland LongTerm Ventilation Unit (WoSLTVU)

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Abstract Introduction: Motor Neurone Disease (MND) results in progressive respiratory failure (RF). Survival and quality of life are both improved with NonInvasive Ventilation (NIV)[1,2]. Multidisciplinary team management is recommended[2].
Aim(s): to evaluate current practice of MND patients in the WoSLTVU Methods: Retrospective audit from 20132017. Data collected from electronic records: presence of RF, age, sex, length of survival, NIV uptake, cough assessment and physiotherapy referral.
Result(s): 188 patients referred: 53 had RF at first respiratory review and 39 developed RF during followup. Overall 78% RF patients were commenced on NIV. NIV lengthened survival by 12 months.
Conclusion(s): Referrals to WoSLTVU continue to increase. The survival benefits of NIV appear to be confirmed in real life practice. Early referral was not seen to further improve survival. Respiratory management has increased physiotherapy involvement with cough assessment and augmentation. Further work to assess the impact of this change on patient outcomes is required. References: 1. Bourke SC, Tomlinson M, Williams TL et al. Effects of noninvasive ventilation on survival and quality of life in patients with amyotrophic lateral sclerosis: a randomised controlled trial. Lancet Neurol 2006 Feb; 5(2):140147. 2. National Institute for Health and Care Excellence (2016) Motor neurone disease: assessment and management.

67. What's in a postcode? Socioeconomic deprivation in the primary care 201517 COPD audit

Authors Stone P.; McMillan V.; Holzhauer-Barrie J.; Baxter N.; Roberts C.M.; Quint J.
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Abstract Introduction: There is evidence that people from more deprived socioeconomic groups are less likely to receive appropriate health care (Gershon A.S. et al. COPD 2012; 9(3):216-226).
Aim(s): Investigate the impact of socioeconomic deprivation on the care received by COPD patients.
Method(s): The National COPD Audit Programme conducted an audit of general practice in Wales. The audit extracted data directly from GP systems, covering the period 1 April 2015 to 31 March 2017. Extracted patient postcodes were mapped to the Welsh Index of Multiple Deprivation (WIMD), a rank of relative deprivation between Welsh regions. Deprivation was categorised as follows: 10% most deprived, 1020% most deprived, 20%30% most deprived, 30%50% most deprived, and 50% least deprived.
Result(s): The audit captured 82,696 patients from 407 general practices (94% of all Welsh practices). The 10% most deprived patients relative to the 50% least deprived were: 29% more likely (OR: 1.29 (95% CI: 1.14-1.46)) to have had a referral to a behavioural change intervention and had a stop smoking drug prescribed if they were
Conclusion(s): Reasons for the differences in care received by different socioeconomic groups needs exploring. Studies to investigate if apparent differences in care are explained by differences in smoking or other habits would be a useful next step.

68. Outcomes of a coordinated MDT approach to the delivery of acute NIV

Authors Free R.; Curry L.; Rossall C.; Pulford L.; Valero I.; D'Sa S.; Walton R.; Grew T.; Woltmann G.; Evans R.
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Abstract Background: We implemented a series of quality improvement (QI) initiatives for patients requiring acute NIV and reviewed mortality and hospital length of stay (LOS).
Method(s): An acute NIV steering group was formed across our local NHS trust. We implemented a combined new guideline and proforma, a troubleshooting guide and a rolling MDT education programme over 201416. We analysed all documented admissions from Apr 2013 to Mar 2016 linked to local hospital data for LOS and mortality. Trends over time for mortality and LOS were assessed with time series regression.
Result(s): 555 patients (734 admissions) required acute NIV: 47% male, mean [SD] age 71.1 [11.6] yrs, Charlson Index (CI) 6.7 [7.6]. Primary diagnoses: COPD (47%), COPD with pneumonia (14%), pneumonia alone (14%), sleep disordered breathing (9%), heart failure (8%), other (6%), and bronchiectasis (1%). Overall inpatient mortality and 1year mortality were 13.1% and 49.3%, respectively. There was no change in inpatient mortality over time (Figure 1a) (p=0.33), but a small change in 1year mortality (p=0.017). Inpatient and 1year mortality were significantly increased for patients with CI >5 compared to <=5 (both p<0.001). The mean LOS was 17.5 days with a trend to a reduction over time (p=0.052) (Figure 1b).
Conclusion(s): A series of QI initiatives may help reduce hospital LOS but inpatient mortality remains variable. The 1year mortality rate is high.

69. Performance of endobronchial ultrasound transbronchial needle aspiration (EBUS-TBNA) with rapid on-site evaluation (ROSE) in the pathological subtyping and molecular testing of non-small cell lung cancer (NSCLC) at a UK institute

Authors Craig C.; Bailey S.; Narine N.; Shelton D.; Thiryayi S.; Rana D.; Al-Najjar H.
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Abstract Background: Differentiating NSCLC pathological subtypes as well as molecular testing is paramount to guide choice of chemotherapy and targeted EGFR and ALK therapies. The 2017 National Lung Cancer Audit(1) highlighted the need to minimise the rate of NSCLC not otherwise specified (NSCLC-NOS). The objective of our study was to determine whether samples obtained by EBUS-TBNA in the presence of ROSE could be used to subtype NSCLC and provide sufficient material for molecular testing.
Method(s): A prospective database from a regional thoracic oncology centre was evaluated. All patients diagnosed with NSCLC by EBUS-TBNA cytology between January 2016 and January 2017 were included. Our institute performs reflex testing for EGFR and ALK on all adenocarcinoma or NSCLC-NOS cases.
Result(s): A total of 128 patients were diagnosed with NSCLC via EBUS-TBNA. 11 were NSCLC-NOS (8.6%), 55 were squamous (43%), 56 adenocarcinoma (43.8%), 4 were large cell neuroendocrine (3.1%)and 2 were other NSCLC. 66 appropriate non-squamous lung cancer samples were sent for molecular analysis. For EGFR mutation, 62/66(94%) had sufficient material and 3 were positive (4.5%). For ALK, 63/66 (95%) had sufficient material and 2 (3%) were positive.
Conclusion(s): Our study has illustrated EBUS-TBNA cytology with ROSE can achieve accurate subtyping of NSCLC and a high proportion of sufficient material for molecular analysis. In addition our NSCLC-NOS rate (8.6%)is lower than UK national average (9%) in 2017.

70. Pneumocystis jirovecii pneumonia (PJP) in lymphoma patients, a tertiary cancer centre review

Authors Adderley H.; Covesmith L.; Syed J.; Linton K.
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Available at European Respiratory Journal from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at European Respiratory Journal from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Background: PJP causes atypical pneumonia in immunocompromised patients with significant morbidity and mortality. There are no PJP management guidelines for non HIV populations and mortality is significantly higher in patients without HIV (34-39%) compared to HIV patients (6-7%). Aims and Objectives: To describe risk factors for PJP in lymphoma patients, management and clinical outcomes.
Method(s): We performed a retrospective case note review of PJP positive lymphoma patients at the Christie Hospital NHS Foundation Trust from January 2010-January 2016. Standards identified were that all patients receiving > 2 weeks of >= 20mg prednisolone daily should receive prophylaxis. All hypoxic patients with confirmed PJP should receive appropriate steroids.
Result(s): 41 patients were identified: 27% Hodgkin lymphoma, 73% non Hodgkin lymphoma. Potential identifiable risks were lymphopenia (all grades = 95%; grade 3-4 = 38%), steroid use (61% of patients, majority for <1 week), recent immunochemotherapy (60% on treatment at diagnosis of PJP), and lack of required prophylaxis (20% of patients). 32% developed PJP despite use of prophylactic co-trimoxazole or azithromycin. 64% completed 21 days of treatment and 30- day mortality was 10%.
Conclusion(s): PJP occurs in lymphoma patients despite prophylaxis and risks are unclear, especially as most patients are lymphopenic and/ or treated with short course steroids. We developed extended guidelines for patients recommending PJP prophylaxis for those receiving purine analogue chemotherapy, >=20mg prednisolone or equivalent daily for > 2 weeks and patients with lymphopenia <=0.5 and CD4 <=200. Results will be prospectively evaluated with scope for a national audit.

71. Patterns of Use of Heated Humidified High-Flow Nasal Cannula Therapy in PICUs in the United Kingdom and Republic of Ireland

Authors Morris J.V.; Kapetanstrataki M.; Parslow R.C.; Davis P.J.; Ramnarayan P.
Source Pediatric critical care medicine : a journal of the Society of Critical Care Medicine and the World Federation of Pediatric Intensive and Critical Care Societies; Mar 2019; vol. 20 (no. 3); p. 223-232
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Available at Pediatric critical care medicine : a journal of the Society of Critical Care Medicine and the World Federation of Pediatric Intensive and Critical Care Societies from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract OBJECTIVES: To 1) describe patterns of use of high-flow nasal cannula therapy, 2) examine differences between patients started on high-flow nasal cannula and those started on noninvasive ventilation, and 3) explore whether patients who failed high-flow nasal cannula therapy were different from those who did not. DESIGN: Retrospective analysis of data collected prospectively by the Paediatric Intensive Care Audit Network. SETTING: All PICUs in the United Kingdom and Republic of Ireland (n = 34). PATIENTS: Admissions to study PICUs (2015-2016) receiving any form of respiratory support at any time during PICU stay.None. MEASUREMENTS AND MAIN RESULTS: Eligible admissions were classified into nine groups based on the combination of the first-line and second-line respiratory support modes. Uni- and multivariate analyses were performed to test the association between PICU and patient characteristics and two outcomes: 1) use of high-flow nasal cannula versus noninvasive ventilation as first-line mode and 2) high-flow nasal cannula failure, requiring escalation to noninvasive ventilation and/or invasive ventilation. We analyzed data from 26,423 admissions; high-flow nasal cannula was used in 5,951 (22.5%) at some point during the PICU stay. High-flow nasal cannula was used for first-line support in 2,080 (7.9%) and postextubation support in 978 admissions (4.5% of patients extubated after first-line invasive ventilation). High-flow nasal cannula failure occurred in 559 of 2,080 admissions (26.9%) when used for first-line support. Uni- and multivariate analyses showed that PICU characteristics as well as patient age, primary diagnostic group, and admission type had a significant influence on the choice of first-line mode (high-flow nasal cannula or noninvasive ventilation). Younger age, unplanned admission, and higher admission severity of illness were independent predictors of high-flow nasal cannula failure.
CONCLUSION(S): The use of high-flow nasal cannula is common in PICUs in the United Kingdom and Republic of Ireland. Variation in the choice of first-line respiratory support mode (high-flow nasal cannula or noninvasive ventilation) between PICUs reflects the need for clinical trial evidence to guide future practice.

72. Reflective Practice for Patient Benefit: An Analysis of Doctors' Appraisal Portfolios in Scotland

Authors Wakeling J.; Holmes S.; Boyd A.; Tredinnick-Rowe J.; Cameron N.; Marshall M.; Bryce M.; Archer J.
Source The Journal of continuing education in the health professions; Dec 2019; vol. 39 (no. 1); p. 13-20
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Abstract INTRODUCTION: Reflective practice has become the cornerstone of continuing professional development for doctors, with the expectation that it helps to develop and sustain the workforce for patient benefit. Annual appraisal is mandatory for all practicing doctors in the United Kingdom as part of medical revalidation. Doctors submit a portfolio of supporting information forming the basis of their appraisal discussion where reflection on the information is mandated and evaluated by a colleague, acting as an appraiser.
METHOD(S): Using an in-depth case study approach, 18 online portfolios in Scotland were examined with a template developed to record the types of supporting information submitted and how far these showed reflection and/or changes to practice. Data from semistructured interviews with the doctors (n = 17) and their appraisers (n = 9) were used to contextualize and broaden our understanding of the portfolios.
RESULT(S): Portfolios generally showed little written reflection, and most doctors were unenthusiastic about documenting reflective practice. Appraisals provided a forum for verbal reflection, which was often detailed in the appraisal summary. Portfolio examples showed that reflecting on continued professional development, audits, significant events, and colleague multisource feedback were sometimes considered to be useful. Reflecting on patient feedback was seen as less valuable because feedback tended to be uncritical.
DISCUSSION: The written reflection element of educational portfolios needs to be carefully considered because it is clear that many doctors do not find it a helpful exercise. Instead, using the portfolio to record topics covered by a reflective discussion with a facilitator would not only prove more amenable to many doctors but would also allay fears of documentary evidence being used in litigation.

73. Venous thromboembolism risk and prophylaxis prescription in surgical patients at a tertiary hospital in Eastern Cape Province, South Africa

Authors Rocher W.D.; Page T.; Rocher M.; Nel D.
Source South African medical journal = Suid-Afrikaanse tydskrif vir geneeskunde; Feb 2019; vol. 109 (no. 3); p. 178-181
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Available at South African medical journal = Suid-Afrikaanse tydskrif vir geneeskunde from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract BACKGROUND: Venous thromboembolism (VTE) is a common complication during and after hospitalisation, and is regarded as the most common cause of preventable death in hospitalised patients worldwide. Despite its importance, there are few data on VTE risk and adherence to prophylaxis prescription guidelines in surgical patients from the South African (SA) public sector, especially from low-resource environments such as Eastern Cape Province.
OBJECTIVE(S): To evaluate the risk and prescription of VTE prophylaxis to surgical patients at a tertiary government hospital in the Eastern Cape.
METHOD(S): A cross-sectional clinical audit of general surgical inpatients was performed on two dates during July and August 2017. Patients' VTE risk was calculated by using the Caprini risk assessment model (RAM) and thromboprophylaxis prescription evaluated accordingly.
RESULT(S): A total of 179 patients were included in the study, of whom 56% were male and 44% female. The average age was 45 (range 18 - 83) years. Of the total number of participants, 33% were elective cases and 67% were emergency admissions. With application of RAM, 77% of patients were at risk of VTE (Caprini score >=2), with 81% of elective and 74% of emergency patients being at risk. The most prevalent risk factors for VTE were major surgery (34%), age 41 - 60 years (30%), age 61 - 74 years (20%) and sepsis during the previous month (27%). A contraindication to chemoprophylaxis was recorded in 30% of patients, with the most prevalent being renal dysfunction (40%), peptic ulcer disease (34%), active bleeding (17%), liver dysfunction (17%), coagulopathy (6%) and recent cerebral haemorrhage (6%). With regard to VTE risk profile and contraindications to chemoprophylaxis, the correct thromboprophylactic treatment was prescribed to 26% of at-risk patients, with 21% of elective and 27% of emergency admission patients receiving the correct therapy.
CONCLUSION(S): Despite a high proportion of patients being at risk of VTE, the rate of adequate thromboprophylaxis prescription for surgical inpatients at Frere Hospital, East London, SA is very low. Increased availability of mechanical prophylaxis, as well as interventions to improve the rate of adequate prophylaxis prescription, needs to be evaluated for feasibility and effect in this hospital and other SA public hospitals.

74. Quality of handwritten surgical operative notes from surgical trainees: a noteworthy issue

Authors Nzenza T.C.; Manning T.; Perera M.; Sengupta S.; Bolton D.; Lawrentschuk N.; Ngweso S.
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Available at ANZ journal of surgery from Wiley Online Library Medicine and Nursing Collection 2018 - NHS
Available at ANZ journal of surgery from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract BACKGROUND: Surgical operation notes are crucial for medical record keeping and information flow in continued patient care. In addition to inherent medical implications, the quality of operative notes also has important economic and medico-legal ramifications. Further, well-documented records can also be useful for audit purposes and propagation of research, facilitating the improvement of delivery of care to patients. We aimed to assess the quality of surgical operation notes written by junior doctors and trainees against a set standard, to ascertain whether these standards were met.
METHOD(S): We undertook an audit of Urology and General Surgery operation notes handwritten by junior doctors and surgical trainees in a tertiary teaching hospital over a month period both in 2014 and 2015. Individual operative notes were assessed for quality based on parameters described by the Royal College of Surgeons of England guidelines.
RESULT(S): Based on the Royal College of Surgeons of England guidelines, a significant proportion of analysed surgical operative notes were incomplete, with information pertaining to the time of surgery, name of anaesthetist and deep vein thrombosis prophylaxis in particular being recorded less than 50% of the time (22.42, 36.36 and 43.03%, respectively).Overall, 80% compliance was achieved in 14/20 standards and 100% compliance was attained in only one standard.
CONCLUSION(S): The quality of surgical operation notes written by junior doctors and trainees demonstrated significant deficiencies when compared against a set standard. There is a clear need to educate junior medical staff and to provide systems and ongoing education to improve quality. This would involve leadership from senior staff, ongoing audit and the development of systems that are part of the normal workflow to improve quality and compliance.
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75. Hospital Readmissions Among Post-acute Nursing Home Residents: Does Obesity Matter?

Authors Cai S.; Wang S.; Temkin-Greener H.; Mukamel D.B.; Caprio T.
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Abstract Objectives: To explore profiles of obese residents who receive post-acute care in nursing homes (NHs) and to assess the relationship between obesity and hospital readmissions and how it is modified by individual comorbidities, age, and type of index hospitalizations.
Design(s): Retrospective cohort study. Setting and participants: Medicare fee-for-service beneficiaries who were newly admitted to free-standing US NHs after an acute inpatient episode between 2011 and 2014 (N = 2,323,019). Measures: The Minimum Data Set 3.0 were linked with Medicare data. The outcome variable was 30-day hospital readmission from an NH. Residents were categorized into 3 groups based on their body mass index (BMI): nonobese, mildly obese, moderate-to-severely obese. We tested the relationship between obesity and 30-day readmissions by fixed-effects logit models and stratified analyses by the type of index hospitalization and residents' age.
Result(s): Forty percent of the identified residents were admitted after a surgical episode, and the rest were admitted after a medical episode. The overall relationship between obesity and readmissions suggested that obesity was associated with higher risks of readmission among the oldest old (>=85 years) residents but with lower risks of readmission among the youngest group (65-74 years). After accounting for individual co-covariates, the association between obesity and readmissions among the oldest old residents became weaker; the adjusted odds ratio was 1.061 (P =.049) and 1.004 (P =.829) for moderate-to-severely obese patients with surgical and medical index hospitalizations, respectively. The protective effect of obesity among younger residents reduced after adjusting for covariates. Conclusions/Relevance: The relationship between obesity and hospital readmission among post-acute residents could be affected by comorbidities, age, and the type of index hospitalization. Further studies are also warranted to understand how to effectively measure NH quality outcomes, including hospital readmissions, so that policies targeting at quality improvement can successfully achieve their goals without unintended consequences.
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76. The impact of advancing age on incidence of hepatectomy and post-operative outcomes in patients with colorectal cancer liver metastases: a population-based cohort study

Authors Vallance A.E.; Kuryba A.; van der Meulen J.; Walker K.; Young A.L.; Lodge J.P.; Braun M.; Hill J.; Jayne D.G.
Source HPB; Feb 2019; vol. 21 (no. 2); p. 167-174
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Available at HPB from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Background: Clinical outcomes for elderly patients undergoing liver resection for colorectal cancer (CRC) liver metastases are poorly characterised. This study aimed to investigate the impact of advancing age on the incidence of liver resection and post-operative outcomes.
Method(s): Patients in the National Bowel Cancer Audit undergoing major CRC resection from 2010 to 2016 in England were included. Liver resection was identified from linked Hospital Episode Statistics data. A Cox-proportional hazards model was used to compare 3-year mortality.
Result(s): Of 117,005 patients, 6081 underwent liver resection. For patients <65 years there was 1 liver resection per 12 cases, 65-74, 1 per 17, and >=75, 1 per 40. 90-day mortality after liver resection increased with advancing age (<65 0.9% (26/2829), 65-74 2.8% (57/2070), >=75 4.0% (47/1182); P < 0.001). Age was an independent risk factor for 3-year mortality. Patients 65-74 did not have adjusted mortality higher than those <65, yet age >=75 was associated with increased overall mortality (Hazard ratio (HR) 1.47 (95% CI 1.30-1.68)) and cancer-specific mortality (HR 1.30 (95% CI 1.13-1.49)).
Conclusion(s): Although advancing age was associated with higher rates of 90-day mortality following liver resection, 3-year mortality for patients 65-74 years was comparable to younger patients. These results will aid clinicians and patients in pre-operative decision-making.
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77. Verbal abuse during pregnancy increases frequency of newborn hearing screening referral: The Japan Environment and Children's Study

Authors Komori K.; Eitoku M.; Joelle Muchanga S.M.; Suganuma N.; Komori M.; Kobayashi T.; Ninomiya H.
Source Child Abuse and Neglect; Apr 2019; vol. 90 ; p. 193-201
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Available at Child Abuse and Neglect from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Background: Verbal abuse during pregnancy has a greater impact than physical and sexual violence on the incidence of postnatal depression and maternal abuse behavior towards their children. In addition, exposure of children (aged 12 months to adolescence) to verbal abuse from their parents exerts an adverse impact to the children's auditory function. However, the effect of verbal abuse during pregnancy on fetal auditory function has not yet been thoroughly investigated.
Objective(s): The objective of the study was to examine the relationship between intimate partner verbal abuse during pregnancy and newborn hearing screening (NHS) referral, which indicates immature or impaired auditory function. Participants and setting: The Japan Environment and Children's Study is an ongoing nationwide population-based birth-cohort study designed to determine environmental factors during and after pregnancy that affect the development, health, or wellbeing of children. Pregnant women living in 15 areas of Japan were recruited between January 2011 and March 2014.
Method(s): Multiple imputation for missing data was performed, followed by multiple logistic regression using 16 confounding variables.
Result(s): Of 104,102 records in the dataset, 79,985 mother-infant pairs submitted complete data for questions related to verbal and physical abuse and the results of NHS. Of 79,985 pregnant women, 10,786 (13.5%) experienced verbal abuse and 978 (1.2%) experienced physical abuse. Of 79,985 newborns, 787 (0.98%) received a NHS referral. Verbal abuse was significantly associated with NHS referral (adjusted odds ratio: 1.44; 95% confidence interval: 1.05-1.98).
Conclusion(s): Verbal abuse should be avoided during pregnancy to preserve the newborn's auditory function.
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78. Severity and Outcome Assessment score: a useful tool for auditing orthognathic surgery

Authors Geddes A.; Laverick S.; McBride A.; McIntyre G.T.
Source British Journal of Oral and Maxillofacial Surgery; 2019
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Available at British Journal of Oral and Maxillofacial Surgery from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Many indices and scoring systems exist for assessing skeletal patterns and malocclusion but none have been universally adopted by teams providing orthognathic surgery in the UK. Using a standardised objective measure of a patient's condition is important both for service provision, treatment allocation, and other clinical governance domains. The Severity and Outcome Assessment tool (SOA) developed by the British Orthodontic Society (BOS) and British Association of Oral and Maxillofacial Surgeons (BAOMS) provides a standardised method of assessing patients throughout the orthognathic pathway and lends itself to case selection, resource allocation and auditing treatment outcomes. The SOA uses 7 cephalometric skeletal, dental and soft tissue measures to produce an overall score.The SOA has been used by the current NHS Tayside orthognathic team since August 2006 to audit treatment outcomes. While we recognise that cephalometric analysis forms only one part of orthognathic treatment we believe that having an objective measure on which to assess treatment is useful. We present our experience of using this quick, simple and reproducible tool in auditing orthognathic treatment outcomes.
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79. British Society of Interventional Radiology Iliac Angioplasty and Stent Registry: fourth report on an additional 8,294 procedures

Authors Miller C.; Frood R.; Hammond C.J.; See T.C.
Source Clinical Radiology; 2019
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Available at Clinical Radiology from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract AIM: To provide an update of current practice in iliac artery intervention in the UK. MATERIALS AND METHODS: Ninety-nine interventional units across the UK completed online submission forms for iliac angioplasty and stent procedures between 2011 and 2014 (inclusive) for the British Iliac Angioplasty and Stenting (BIAS) IV registry.
RESULT(S): Data for 8,294 procedures were submitted during the study period. A total of 12,253 iliac segments were treated in 10,311 legs. The commonest indication was claudication (n=5219, 64.4%). Of the cases performed, 6,582 (80.8%) were performed electively with 3,548 (44.8%) of the procedures performed as a day-case and 6,586 (54%) of the lesions were treated with stents. Successful endovascular intervention (residual stenosis <=49%) was achieved in 11,847 (97%) of treated segments, with residual stenosis in 1.5%. One point five percent of lesions could not be crossed with a wire. Limb complications were recorded in 366 (3.5%), resulting in 141 patients undergoing an unplanned intervention and 173 (2.2%) patients had a systemic complication. There were 84 deaths prior to discharge, of which 13 (15%) were procedure related. Both systemic and limb complication rates were higher in patients undergoing treatment for critical ischaemia.
CONCLUSION(S): Iliac stenting and angioplasty are associated with high technical success with a low complication rate. These data provide up-to-date statistics for patient information and future audit and benchmarking purposes.
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80. Ethnic-specific mortality of infants undergoing congenital heart surgery in England and Wales

Authors Knowles R.L.; Ridout D.; Crowe S.; Bull C.; Wray J.; Tregay J.; Franklin R.C.G.; Barron D.J.; Parslow R.C.; Brown K.
Source Archives of Disease in Childhood; 2019
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Available at Archives of Disease in Childhood from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).

Available at Archives of Disease in Childhood from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Purpose: To investigate ethnic differences in mortality for infants with congenital heart defects (CHDs) undergoing cardiac surgery or interventional catheterisation.
Design(s): Observational study of survival to age 1 year using linked records from routine national paediatric cardiac surgery and intensive care audits. Mortality risk was investigated using multivariable Poisson models with multiple imputation. Predictors included sex, ethnicity, preterm birth, deprivation, comorbidities, prenatal diagnosis, age and weight at surgery, preprocedure deterioration and cardiac diagnosis.
Setting(s): All paediatric cardiac surgery centres in England and Wales.
Patient(s): 5350 infants with CHDs born from 2006 to 2009.
Main Outcome Measure(s): Survival at age 1 year.
Result(s): Mortality was 83.9 (95% CI 76.3 to 92.1) per 1000 infants, with variation by ethnic group. Compared with those of white ethnicity, infants in British Asian (Indian, Pakistani and Bangladeshi) and 'all other' (Chinese, mixed and other) categories experienced significantly higher mortality by age 1 year (relative risk [RR] 1.52[95% CI 1.19 to 1.95]; 1.62[95% CI 1.20 to 2.20], respectively), specifically during index hospital admission (RR 1.55 [95% CI 1.07 to 2.26]; 1.64 [95% CI 1.05 to 2.57], respectively). Further predictors of mortality included non-cardiac comorbidities, prenatal diagnosis, older age at surgery, preprocedure deterioration and cardiac diagnosis. British Asian infants had higher mortality risk during elective hospital readmission (RR 1.86 [95% CI 1.02 to 3.39]).
Conclusion(s): Infants of British Asian and 'all other' non-white ethnicity experienced higher postoperative mortality risk, which was only partly explained by socioeconomic deprivation and access to care. Further investigation of case-mix and timing of risk may provide important insights into potential mechanisms underlying ethnic disparities.
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81. Endometrial Carcinoma Follow-up: Time for a Change?

Authors Saxby H.; Essapen S.; Tailor A.
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Available at Clinical Oncology from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

82. Surgical versus balloon valvotomy in neonates and infants: Results from the UK National Audit

Authors Dorobantu D.M.; Taliotis D.; Tulloh R.M.; Angelini G.D.; Stoica S.C.; Mohamed Ahmed E.; Sharabiani M.T.A.
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Publication Date Feb 2019
Publication Type(s) Article
Database EMBASE
Available at Open Heart from Europe PubMed Central - Open Access
Available at Open Heart from HighWire - Free Full Text

Abstract Objective: There are conflicting data on choosing balloon aortic valvoplasty (BAV) or surgical aortic valvotomy (SAV) in neonates and infants requiring intervention for aortic valve stenosis. We aim to report the outcome of both techniques based on results from the UK national registry.
Method(s): This is a retrospective study, including all patients under 1 year undergoing BAV/SAV between 2000 and 2012. A modulated renewal approach was used to examine the effect of reinterventions on outcomes.
Result(s): A total of 647 patients (488 BAV, 159 SAV, 292 neonates) undergoing 888 aortic valve procedures were included, with a median age of 40 days. Unadjusted survival at 10 years was 90.6% after initial BAV and 84.9% after initial SAV. Unadjusted aortic valve replacement (AVR) rate at 10 years was 78% after initial BAV and 80.3% after initial SAV. Initial BAV and SAV had comparable outcomes at 10 years when adjusted by covariates (p>0.4). AVR rates were higher after BAV and SAV reinterventions compared with initial valvoplasty without reinterventions (reference BAV, HR=3 and 3.8, respectively, p<0.001). Neonates accounted for 29/35 of early deaths after the initial procedure, without significant differences between BAV and SAV, with all late outcomes being worse compared with infants (p<0.005).
Conclusion(s): In a group of consecutive neonates and infants, BAV and SAV had comparable survival and freedom from reintervention as initial procedures and when performed as reinterventions. These findings support a treatment choice based on patient characteristics and centre expertise, and further research into the best patient profile for each choice.
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83. SMASH! The Salford medication safety dashboard

Authors Williams R.; Keers R.; Gude W.T.; Jeffries M.; Ashcroft D.M.; Davies C.; Brown B.; Peek N.; Kontopantelis E.; Avery A.J.
Source Journal of innovation in health informatics; Oct 2018; vol. 25 (no. 3); p. 183-193
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PubMedID 30398462
Database EMBASE

Abstract BACKGROUND: Patient safety is vital to well-functioning health systems. A key component is safe prescribing, particularly in primary care where most medications are prescribed. Previous research demonstrated that the number of patients exposed to potentially hazardous prescribing can be reduced by interrogating the electronic health record (EHR) database of general practices and providing feedback to general practitioners in a pharmacist-led intervention. We aimed to develop and roll out an online dashboard application that delivers this audit and feedback intervention in a continuous fashion.
METHOD(S): Based on initial system requirements we designed the dashboard's user interface over 3 iterations with 6 general practitioners (GPs), 7 pharmacists and a member of the public. Prescribing safety indicators from previous work were implemented in the dashboard. Pharmacists were trained to use the intervention and deliver it to general practices.
RESULT(S): A web-based electronic dashboard was developed and linked to shared care records in Salford, UK. The completed dashboard was deployed in all but one (n=43) general practices in the region. By November 2017, 36 pharmacists had been trained in delivering the intervention to practices. There were 135 registered users of the dashboard, with an average of 91 user sessions a week.
CONCLUSION(S): We have developed and successfully rolled out of a complex, pharmacist-led dashboard intervention in Salford, UK. System usage statistics indicate broad and sustained uptake of the intervention. The use of systems that provide regularly updated audit information may be an important contributor towards medication safety in primary care.

84. Successful second language learning is tied to robust domain-general auditory processing and stable neural representation of sound

Authors Kachlicka M.; Tierney A.; Saito K.
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Abstract There is a great deal of individual variability in outcome in second language learning, the sources of which are still poorly understood. We hypothesized that individual differences in auditory processing may account for some variability in second language learning. We tested this hypothesis by examining psychoacoustic thresholds, auditory-motor temporal integration, and auditory neural encoding in adult native Polish speakers living in the UK. We found that precise English vowel perception and accurate English grammatical judgment were linked to lower psychoacoustic thresholds, better auditory-motor integration, and more consistent frequency-following responses to sound. Psychoacoustic thresholds and neural sound encoding explained independent variance in vowel perception, suggesting that they are dissociable indexes of sound processing. These results suggest that individual differences in second language acquisition success stem at least in part from domain-general difficulties with auditory perception, and that auditory training could help facilitate language learning in some individuals with specific auditory impairments.
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85. To what extent is the variation in cardiac rehabilitation quality associated with patient characteristics?

Authors Salman A.; Doherty P.
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Abstract BACKGROUND: Huge variability in quality of service delivery of cardiac rehabilitation (CR) in the UK. This study aimed to ascertain whether the variation in quality of CR delivery is associated with participants' characteristics.
METHOD(S): Individual patient data from 1 April 2013 to 31 March 2014 were collected electronically from the UK's National Audit of Cardiac Rehabilitation database. Quality of CR delivery is categorised as low, middle, and high based on six service-level criteria. The study included a range of patient variables: patient demographics, cardiovascular risk factors, comorbidities, physical and psychosocial health measures, and index of multiple deprivation.
RESULT(S): The chance that a CR patient with more comorbidities attended a high-quality programme was 2.13 and 1.85 times higher than the chance that the same patient attended a low- or middle-quality programme, respectively. Patients who participated in high-quality CR programmes tended to be at high risk (e.g. increased waist size and high blood pressure); high BMI, low physical activity levels and high Hospital Anxiety and Depression Scale scores; and were more likely to be smokers, and be in more socially deprived groups than patients in low-quality programmes.
CONCLUSION(S): These findings show that the quality of CR delivery can be improved and meet national standards by serving a more multi-morbid population which is important for patients, health providers and commissioners of healthcare. In order for low-quality programmes to meet clinical standards, CR services need to be more inclusive in respect of patients' characteristics identified in the study. Evaluation and dissemination of information about the populations served by CR programmes may help low-quality programmes to be more inclusive.

86. Improving the identification of patients with delirium using the 4AT assessment

Authors Bearn A.; Lea W.; Kusznir J.
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Available at Nursing older people from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Delirium is a common neuropsychiatric disorder that all those working with older people will have encountered at some stage. Delirium is often poorly identified in hospital settings and therefore not optimally managed. After data collection on the acute medical unit in an acute hospital trust in the UK it was evident that patients with signs of delirium were not being formally assessed and therefore not appropriately managed in many cases. A quality improvement project introduced the 4AT delirium assessment tool to try to ensure that patients with delirium were being identified. The project team carried out several plan-do-studyact cycles to bring about our changes, which included a 4AT assessment sticker for nursing staff to complete and teaching for all healthcare staff. Through involvement of all members of the multidisciplinary team and ongoing feedback and changes we were able to increase assessment of delirium from 0% to 64%. There is ongoing work to be done to continue to improve delirium management, but by initially improving the assessment and identification of delirium we will make a difference to these patients' outcomes.
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87. Penicillin allergy status in primary and secondary care

Authors Barrett S.; Baqir W.; Campbell D.; Ellis S.; Premchand N.
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Abstract Background: Among all allergic reactions to antibiotics, penicillin is one of the most commonly reported with 5%-10% of patients having a documented allergy to penicillin.[1] However, incidence of penicillin-related anaphylaxis has been reported to be in the region of 0.01% to 0.04%.[2] A debate is growing on the nature of reported allergy status, highlighting the association between reported allergy status and a history of clinically significant IgE-mediated reactions.[1] Whilst work has demonstrated that clinicians considered history and severity of allergy when selecting antibiotics in patients with an allergy to penicillin recorded,[3] some authors suggest that half of allergies reported by patients may not have an immunological origin.[4] This raises concern in that patients with a documented penicillin allergy may not receive first-line penicillin-containing treatments and instead may be treated with second-line agents. Second-line agents may be less cost-effective, and the unnecessary overuse of these agents may represent opportunities to improve patient treatment outcomes. This study aimed to explore reported levels of penicillin allergy across primary and secondary care.
Method(s): Over a period of 1 week, all patients admitted to one hospital were audited for penicillin allergy status. A second study was carried out to identify the number of patients with reported penicillin allergy in electronic primary care records.
Result(s): An audit of hospital admissions (across Northumbria Healthcare NHS Foundation Trust) over 4 weeks found 12% (n = 326) of 2720 of patients had a documented penicillin allergy whilst within primary care records, penicillin allergy status was recorded in 6.2% (n = 77) of 1237 patients.
Conclusion(s): Across both settings, almost one in 10 patients are recorded to be allergic to penicillin, thus being at risk of not receiving optimal treatment if they needed it. Urgent work is needed to assess these patients to identify those truly allergic. By doing so, we reduce risk of harm, reduce healthcare costs, and protect limited antibiotic agents against resistance.

88. Use of CLOPIXOL ACUPHASE (ZUCLOPENTHIXOL acetate) on the inpatient care wards within Northumberland Tyne and Wear (NTW) NHS FOUNDATION trust

Authors Ayre R.; Thomas C.; Morsy M.
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Available at Pharmacoepidemiology and Drug Safety from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Aims/ObjectivesThe main objectives of the audit were to:Determine if the rationale for prescribing Acuphase was documented in the patient record (RiO) and if this was in line with the NTW policy. Determine if monitoring was undertaken post Acuphase administration in line with the NTW policy. Compare the use of Acuphase across NTW, identifying any differences in clinical practice needing further investigation. There was limited assurance of compliance with the audit standards for the use of Acuphase: 97% of prescriptions were complaint with licenced indications for the prescribing of Acuphase, but two patients received greater than the licenced maximum dose over the 14-day treatment period. 35% of patients did not have the rationale for use of Acuphase documented; 28% were in accordance with Trust policy. Only 10% received complete monitoring as required by the Trust policy. One area of the trust accounted for 62% of the prescribing of Acuphase. 75% of patients were accepting regular or PRN oral medication on the day of Acuphase administration. Three patients received Acuphase who were naive to antipsychotic treatment. A medical review of the patient before a dose was prescribed only occurred in 50% of the administrations of Acuphase.
Conclusion(s): Significant variations were found in the prescribing, administration, and monitoring of Acuphase, and an improvement is required. The audit results have been disseminated and discussed at all levels of the trust. Awareness and training are occurring for all members of the clinical team and specific clinical guidance on the use of Acuphase to meet prescribing, and good clinical practice standards have been developed in collaboration with key prescribers identified by the audit. A re-audit on the use of Acuphase will occur after implementation of the clinical guidance.

89. Changing epidemiology of motor neurone disease in Scotland

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Abstract Objectives: Scotland benefits from an integrated national healthcare team for motor neurone disease (MND) and a tradition of rich clinical data capture using the Scottish MND Register (launched in 1989; one of the first national registers). The Scottish register was re-launched in 2015 as Clinical Audit Research and Evaluation of MND (CARE-MND), an electronic platform for prospective, population-based research. We aimed to determine if incidence of MND is changing over time.
Method(s): Capture-recapture methods determined the incidence of MND in 2015-2016. Incidence rates for 2015-2016 and 1989-1998 were direct age and sex standardised to allow time-period comparison. Phenotypic characteristics and socioeconomic status of the cohort are described.
Result(s): Coverage of the CARE-MND platform was 99%. Crude incidence in the 2015-2017 period was 3.83/100,000 person-years (95% CI 3.53-4.14). Direct age-standardised incidence in 2015 was 3.42/100,000 (95% CI 2.99-3.91); in 2016, it was 2.89/100,000 (95% CI 2.50-3.34). The 1989-1998 direct standardised annual incidence estimate was 2.32/100,000 (95% CI 2.26-2.37). 2015-2016 standardised incidence was 66.9% higher than Northern European estimates. Socioeconomic status was not associated with MND.
Conclusion(s): Our data show a changing landscape of MND in Scotland, with a rise in incidence by 36.0% over a 25-year period. This is likely attributable to ascertainment in the context of improved neurological services in Scotland. Our data suggest that CARE-MND is a reliable national resource and findings can be extrapolated to the other Northern European populations.
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90. A retrospective regional audit of compliance with urinary tract infection: Treatment guidelines in secondary care

Authors Hagan L.; Brady A.; Mallon C.
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Abstract Background and objective: Recent strategies to tackle antimicrobial resistance have identified antimicrobial stewardship as a means to encourage prudent prescribing. Furthermore, Public Health initiatives such as the Strategy for Tackling Antimicrobial Resistance (STAR 2012-2017) cite the establishment and maintenance of systems to monitor antimicrobial usage and surveillance of resistance as a key objective1. As such, this study focuses on urinary tract infections (UTI), at present the second most common indication for empirical antimicrobial treatment in both primary and secondary care2.
Design(s): The study is a retrospective audit across the five Health and Social Care Trusts in Northern Ireland. A total of 303 patients, with a diagnosis of uncomplicated, complicated or catheter associated UTI, were randomly selected from all patients admitted from January to August 2016. The primary aim was to assess compliance with empirical guidelines for the treatment of uncomplicated, complicated and catheter associated UTI. Secondary aims focussed on documentation of clinical symptoms, obtaining and recording of appropriate cultures and documenting intended duration or review date of antibiotic therapy.
Result(s): Overall Trust-wide compliance with regional guidelines was 31% (n = 95). Of 303 patients reviewed 57% (n = 173) were prescribed an antibiotic compliant with regional guidelines. Two of the hospital trusts met the Trust-wide target of 95% compliance for correctly prescribed dose of antibiotic. Of 303 patients reviewed, 54% had a documented review date or duration on their Kardex and 42% (n = 129) had a documented review or duration in their medical notes.
Conclusion(s): In conclusion, none of the five Trusts met the Trust-wide agreed target of 95% compliance to regional guidelines. Based on the findings of this audit the following recommendations are proposed to improve compliance to the guidelines, promotion of the regional guidelines, revising the regional Kardex to include a dedicated section for recording intended duration of antibiotic, development of regional evidence based algorithm to aid diagnosis and classification of UTI, education for the management of asymptomatic bacteria, and education on using urinalysis and culture results to guide treatment.

91. Laboratory performance of serum B12 assay in the United Kingdom (UK) as assessed by the UK national external quality assessment scheme for haematinics: Implications for clinical interpretation

Authors MacKenzie F.; Devalia V.
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Abstract Serum B1 2 assay is the most commonly used routine test for assessing cobalamin status in the body. In the United Kingdom, there are around 350 laboratories performing the assay using seven different platforms. External quality assessment of the assays is organised by UK NEQAS for Haematinics by sending a serum sample every 3 months. An 'all participants' consensus mean is calculated and used as the target value and the results analysed with respect to intra-and inter-group variation. The percentage bias from the target value is used to assess performance. We present data on one such assessment to demonstrate the problems of the serum B1 2 assay (Survey number 248, April 201 8) and also how it is interpreted by the laboratory for clinical use. Method A serum sample with a B1 2 target value of approximately 1 73 ng/L was sent to participating laboratories for analysis. Laboratories were also asked for an interpretation of their result which would be reported to the requesting clinician, namely from low to high. Results Fig 1 shows an individual laboratory's result (indicated by the arrow) in relation to all laboratories using the same technology (shaded histogram) or all methods (open histogram). There is a significant variation ranging from 86 to 258 ng/L depending on the assay used, with an overall standard deviation of 28 and co-efficient of variation of 16%. Fig 2 shows the distribution of results in the different methodologies used and how each laboratory interpreted its result. It demonstrates the bias of results obtained by the different methods. The assays using Beckman Coulter Access/Dxl (SF5 and SF6) gave much lower results than other methods. In the group SF5, three laboratories interpreted the result as 'normal' and one as 'indeterminate'. In the groups Abbot Architect (AB1 3) and Roche Cobas/Modular (BO5), although having higher results than other groups, there is a significant number of laboratories interpreting the result as 'low' and also 'normal' or 'indeterminate'. Fig 3 shows a graphical representation of an individual laboratory's performance bias and the consistency of its individual and group bias over a period of 6 months. The Bias score (B score on y axis) is how far the result obtained deviated from the target value. The C score (on x axis) informs on consistency of the bias over the past 6 months. Hence, ideally both B score and C score should be as low as possible, and therefore all methodologies would harmonise towards similar results. Discussion These data demonstrate the limitations of the serum B1 2 assay in assessing body B1 2 status. The numerical value obtained of any sample can vary considerably between the different methodologies used. In addition, the interpretation provided by the laboratory can also be highly variabl may have profound implications for clinical assessment and management. In addition, this is compounded by the fact that it is not quite cle would be regarded as the normal or reference range. Laboratories in the United Kingdom use the manufacturers ranges and clinicians may c the British Society for Haematology Guidelines (Devalia V et al (2014) BCSH Guidelines for the diagnosis and treatment of cobalamin and folate disorders. British Journal of Haematology, 166, 496-513) for help in clinical interpretation. Our data shows that the different reference ranges quoted by the kit manufacturers do not correspond to their assay bias, ie there is no simple direct correlation between the ranges provided against the bias of their particular assay. Conclusion The UK NEQAS Haematinics Programme demonstrates problems associated with the serum B12 assay with data on variation of results obtained, bias and interpretation of results in a style that is unique across currently available Proficiency Testing/External Quality Assessment schemes. Laboratories need to be aware of their performance in assessing serum B12 level in order to provide appropriate clinical advice. This needs collection of feedback and audit of data of the clinical situation for which the request was made. Clinicians need to be aware of the performance of their laboratories in order that they can interpret the result provided in a meaningful way in relation to the clinical picture.

92. Forty percent of mds patients wish they received red blood cell transfusions at higher hemoglobin thresholds than they currently are: A multinational transfusion audit

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Abstract Background: Red blood cell transfusion dependence (RBC-TD) is a reality for most MDS patients at some point during their disease trajectory. RBC-TD has been associated with inferior quality of life, iron overload and inferior overall survival. Alongside a focus on new therapies to abrogate or diminish the dependence on RBC units, optimizing quality of life while on transfusions may also have value. Our objective was to better understand the transfusion experience and what patients value, in order to inform future research initiatives.
Method(s): We designed a web-based survey (using SurveyMonkey) in the USA, Canada and UK that was disseminated by the international MDS Foundation, the Leukemia Lymphoma Society of Canada, the Aplastic Anemia and MDS Association of Canada (AAMAC), the University of York, the MDS registry of Canada and the MDS UK Patient Support Group. The survey consisted of 57 questions and was completed by willing patients who received at least 1 unit of blood in the previous 8 weeks. The anonymized survey was completed from 8/27/17 to 2/18/2018.
Result(s): Of 712 responses, 475 (67%) were RBC-TD and eligible for the survey. 55% were male with a median age of 72 years, 77% lived in urban or suburban communities. 75%, 12% and 12% of respondents were from USA, Canada and the UK; 93% were Caucasian. 45% and 27% reported lower and higher risk MDS respectively while 28% did not know. Patients reported having lived with MDS for a median of 3 years, 52% became transfusion dependent within 6 months of diagnosis and 37% > 12 months after diagnosis. 80% knew the haemoglobin (Hb) threshold at which they were transfused (Figure 1). 14%, 30% and 54% received 1, 1-2 or 2 units at a time and the median number of units/month was 2 (Figure 2). The most common symptoms pretransfusion were fatigue (91%), weakness (69%), shortness of breath (SOB, 72%), dizziness (43%) and headache (22%) with fatigue and SOB having the most negative impact on their lives. 25%, 53% and 12% felt better after a transfusion within 1 day, 1-2 days and 3-4 days respectively and 20% felt worse for 1-2 days post transfusion. 64% reported feeling symptomatic for 5+ days before their next transfusion was organized, but 65% were able to organize a blood transfusion within 1- 2 days of reaching their Hb threshold. 61% had a crossmatch on a different day from their transfusion and 30% of these patients indicated that they would have preferred to have a same day crossmatch even if it demanded more time at the transfusion centre. 42% were driven to their transfusions by friends or family. Travel time to the transfusion centre was < 1 hour for 93% of patients and did not have a negative impact on quality of life for 81% of respondents. 47% spent 4-6 hours at the clinic on the day of their transfusions and 19% spent 6-7+ hours. 31% faced economic hardship ('significantly' 12%, 'somewhat' 20%) due to their transfusion dependence. 24% experienced negative side effects consisting of, allergic reactions (32%), fever (16%), circulatory overload (9%), and other (39%). 57% patients reported iron overload. When presented with scenarios, 45% indicated that receiving less frequent transfusions (for example, by receiving 3 units at a time instead of 2) and 74% indicated that having home Hb point of care testing (to facilitate organizing transfusions before symptoms) would improve their QOL. Only 20% felt that receiving more frequent transfusions would improve their QOL, but 40% preferred to be transfused at a higher threshold than currently ordered by their physician. The ideal 'aspired-to' Hb thresholds for transfusion by these patients are indicated in figure 1, and 66% indicated a Hb of > 85g/L.
Conclusion(s): It is well known that transfusion dependence has a negative impact on the QOL of MDS patients but this survey revealed that it also presents an economic hardship and significant time commitment. Patient feedback from this survey suggests some approaches that might improve the experience of TD MDS patients. These might include strategies to reduce the time for the transfusion pathway (eg. same day crossmatches) and point of care testing for Hb at home. Studies are needed to address a lack of evidence on optimal or higher Hb thresholds for red cell transfusion in outpatients as no trials have been conducted. 2 clinical trials (RBC-Enhance, NCT 02099669 and REDDS, ISRCTN26088319) are ongoing. More transfusion clinical trials with primary endpoints of patient reported outcomes are needed in MDS.

93. Investigating the effects of under-triage by existing major incident triage tools

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Available at European journal of emergency medicine : official journal of the European Society for Emergency Medicine from Unpaywall

Abstract OBJECTIVES: Triage is a key principle in the effective management of a major incident. Its effectiveness is a balance between identifying those in need of life-saving intervention, and those triaged incorrectly as either needing/not needing a life-saving intervention. The primary aim of this study was to report mortality in those under-triaged by existing major incident triage tools. Secondary aims were to report the ability of triage tools at identifying serious injury by body region (defined as an Abbreviated Injury Scale severity score>=3).
PATIENTS AND METHODS: Retrospective database analysis of the UK Trauma Audit Research Network for all adult patients (>=18 years) between 2006 and 2014. Patients were defined as priority one using a previously published list. Using the first recorded hospital physiology, patients were categorized by the Modified Physiological Triage Tool (MPTT), National Ambulance Resilience Unit (NARU) Sieve and the Major Incident Medical Management and Support (MIMMS) Triage Sieve. Categorical and continuous data were analyzed using a chi-test and Mann-Whitney U-test respectively.
RESULT(S): During the study period, 218985 adult patients met the Trauma Audit Research Network inclusion criteria, with 24791 (19.5%) priority one patients, of which 70% were male with a median age of 51 (33-71) years and injury severity score of 16 (9-25). The MPTT showed the lowest rate of under-triage (42.4%, P<0.001). Compared with existing methods, the MPTT under-triage population had significantly lower mortality (5.7%, P<0.001) with significantly fewer serious thorax and head injuries under-triaged than both the NARU Sieve and MIMMS Triage Sieve (P<0.001).
CONCLUSION(S): This study has defined the implications of under-triage in the context of a major trauma population. The MPTT misses fewer severely injured patients, with a significant reduction in mortality. We suggest the MPTT to be considered as an alternative to existing primary major incident triage tools.

94. Current epidemiology and antenatal presentation of posterior urethral valves: Outcome of BAPS CASS National Audit

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Available at Journal of Pediatric Surgery from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Aim: Posterior urethral valves (PUVs) are the most common cause of congenital bladder outlet obstruction (BOO) in boys and end-stage renal failure (ESRF) in childhood. In the 1980s, 1 in 4000 boys had PUV. Presentation was 1/3 antenatal/neonatally, 1/3 postnatal, 1/3 late (> 1 year). This study aimed to describe the current proportions in a contemporary cohort.
Method(s): A national audit (BAPS CASS) of referrals in the UK and Ireland of boys diagnosed with suspected or confirmed PUV in a year was conducted. National registration data provided the male birth-rate. Data were presented as number (%), analysed by Mann-Whitney U-test and Chi-square test, with P < 0.05 taken as significant. The study was approved by a national ethics committee (NRES Committee South Central Oxford A (12/SC/0416)).
Result(s): Data were collected from 1st October 2014 to 30th September 2015 from 25/26 centres on 121 cases of suspected bladder outlet obstruction (BOO), of which 113 (93%) were because of PUV. The male birth rate during the period was 432,806/year. The calculated incidence of BOO was 1/3580 and for PUV was 1/3800 per-annum. The proportion of PUV presenting according to age was: antenatally (n = 40, 35%), infancy (n = 47, 42%), and late (n = 26, 23%). Plasma creatinine was higher in antenatally-diagnosed BOO vs. postnatal, 54 (39.5-109.5) mumol/l vs. 34(21-47) mumol/l, P = 0.0005. Hydronephrosis and ureteric dilatation were significantly greater in antenatally diagnosed BOO vs. postnatal vs. late. Renal dysplasia (cortical thinning, poor corticomedullary differentiation, or renal cysts) was significantly more likely in antenatally diagnosed BOO.
Conclusion(s): Neither the incidence (~ 1/4000) nor the proportion antenatally diagnosed (~ 1/3) of boys with PUV appears to have changed in the past 30 years. Those boys who were antenatally diagnosed have significantly higher postnatal plasma creatinine, more hydroureteronephrosis, and renal dysplasia than those diagnosed in infancy or later. It may be hypothesized that this is the reason they are detected antenatally.
Level of Evidence: Prognosis study - Level I - prospective national cohort study.
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95. Evaluation of Costings in the Orthoplastic Management of Open Lower Limb Fractures

Authors Alexander Tan Y.P.; Wong J.K.F.; Pillai A.; Ogden A.; Pearson D.; Brooks A.; Reid A.J.
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Abstract Objectives: To perform a cost-analysis of the management of open lower limb patients within a regional OrthoPlastic surgery unit.
Method(s): 37 and 35 patients suffering from Type-IIIB Gustillo-Anderson fractures that were treated at the Manchester University Foundation Trust (Wythenshawe) Orthoplastic Surgery Unit were identified in 2016 and 2017 respectively. Each patient was carefully assessed based on medical notes, imaging, lab results, and other investigations to ensure that medical documentation was complete. Costing was determined based on 2 different levels:1. True remuneration: Real income received for service provision as determined per HRG remuneration. 2. Patient level costing: cost of treating patients based on Patient-Level Information Costing Systems (PLICS) data. PLICS data was derived from the direct, indirect and overhead costs related to a patient admission spell including theatre, ward, equipment and staffing costs. Coding accuracy was assessed by clinician involvement with a senior coder in an audit of 2016 patients and continued for 2017 patients. The impact of HRG4+ introduction in April 2017 was determined by simulation of 2016 patients through the HRG4+ 2017/18 Local Payment Grouper.
Result(s): The cost of managing open lower limb fractures was 13,959/patient in 2016 and 12,005/patient in 2017. Remuneration in 2016 was 5,196/patient; whilst remuneration in 2017 was 10,707/patient. The clinically dominant procedure determined by HRG4+ was in orthopaedic surgery 70.3% in 2016 and 44.1% in 2017; yet, they received 40.5% of the income in 2016 and 44.2% in 2017. Simulation revealed that income under new HRG4+ tariffs increased by 25.1%, where improving coding accuracy yielded a further increase of 29.1% in income.
Conclusion(s): Providing complex lower limb reconstruction for open fractures in a multidisciplinary unit is resource intensive and associated with high costs. Current hospital remuneration for providing orthoplastic services is insufficient and inadequate. To ensure that orthoplastic units across NHS England can operate efficiently and to improve patient care, more accurate coding and an increase in national tariffs are essential. Remuneration goes to a single clinical specialty despite a multidisciplinary service provision and local assessment of parity is required.
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96. Implementing a theory-based intradialytic exercise programme in practice: A quality improvement project

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Abstract Background. Research evidence outlines the benefits of intradialytic exercise (IDE), yet implementation into practice has been slow, ostensibly due to a lack of patient and staff engagement. The aim of this quality improvement project was to improve patient outcomes via the introduction of an IDE programme, evaluate patient uptake and sustainability and enhance the engagement of routine haemodialysis (HD) staff with the delivery of the IDE programme. Methods. We developed and refined an IDE programme, including interventions designed to increase patient and staff engagement that were based on the Theoretical Domains Framework (TDF), using a series of 'Plan, Do, Study, Act' (PDSA) cycles. The programme was introduced at two UK National Health Service HD units. Process measures included patient uptake, withdrawals, adherence and HD staff involvement. Outcome measures were patient-reported functional capacity, anxiety, depression and symptomology. All measures were collected over 12 months. Results. A total of 95 patients were enrolled in the IDE programme; 64 (75%) were still participating at 3 months, decreasing to 41 (48%) at 12 months. Adherence was high (78%) at 3 months, decreasing to 63% by 12 months. The provision of IDE by HD staff accounted for a mean of 2 (5%) sessions per 3-month time point. Patients displayed significant improvements in functional ability (P 1/4 0.01) and a reduction in depression (P 1/4 0.02) over 12 months, but the effects seen were limited to those who completed the programme. Conclusions. A theory-based IDE programme is feasible and leads to improvement in functional capacity and depression. Sustaining IDE over time is complicated by high levels of patient withdrawal from the programme. Significant change at an organizational level is required to enhance sustainability by increasing HD staff engagement or access to professional exercise support.
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97. Standardised reports with a template format are superior to free text reports: the case for rectal cancer reporting in clinical practice

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Abstract Purpose: Rectal cancer staging with magnetic resonance imaging (MRI) allows accurate assessment and preoperative staging of rectal cancers. Therefore, complete MRI reports are vital to treatment planning. Significant variability may exist in their content and completeness. Template-style reporting can improve reporting standards, but its use is not widespread. Given the implications for treatment, we have evaluated current clinical practice amongst specialist gastrointestinal (GI) radiologists to measure the quality of rectal cancer staging MRI reports.
Material(s) and Method(s): Sixteen United Kingdom (UK) colorectal cancer multi-disciplinary teams (CRC-MDTs) serving a population over 5 million were invited to submit up to 10 consecutive rectal cancer primary staging MRI reports from January 2016 for each radiologist participating in the CRC-MDT. Reports were compared to a reference standard based on recognised staging and prognostic factors influencing case management Results: Four hundred ten primary staging reports were submitted from 41 of 42 (97.6%) eligible radiologists. Three hundred sixty reports met the inclusion criteria, of these, 81 (22.5%) used a template. Template report usage significantly increased recording of key data points versus non-template reports for extra-mural venous invasion (EMVI) status (98.8% v 51.6%, $p < 0.01$) and circumferential resection margin (CRM) status (96.3% v 65.9%, $p < 0.01$). Local tumour stage (97.5% v 93.5%, NS) and nodal status (98.8% v 96.1%, NS) were reported and with similar frequency.
Conclusion(s): Rectal cancer primary staging reports do not meet published standards. Template-style reports have significant increases in the inclusion of key tumour descriptors. This study provides further support for their use to improve reporting standards and outcomes in rectal cancer. Key Points: * MRI primary staging of rectal cancer requires detailed tumour descriptions as these alter the neoadjuvant and surgical treatments. * Currently, rectal cancer MRI reports in clinical practice do not provide sufficient detail on these tumour descriptors. * The use of template-style reports for primary staging of rectal cancer significantly improves report quality compared to free-text reports.
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98. Impact of surgical site infection (SSI) following gynaecological cancer surgery in the UK: A trainee-led multicentre audit and service evaluation

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Abstract Objectives Surgical site infection (SSI) complicates 5% of all surgical procedures in the UK and is a major cause of postoperative morbidity and a substantial drain on healthcare resources. Little is known about the incidence of SSI and its consequences in women undergoing surgery for gynaecological cancer. Our aim was to perform the first national audit of SSI following gynaecological cancer surgery through the establishment of a UK-wide trainee-led research network. Design and setting In a prospective audit, we collected data from all women undergoing laparotomy for suspected gynaecological cancer at 12 specialist oncology centres in the UK during an 8-week period in 2015. Clinicopathological data were collected, and wound complications and their sequelae were recorded during the 30 days following surgery. Results In total, 339 women underwent laparotomy for suspected gynaecological cancer during the study period. A clinical diagnosis of SSI was made in 54 (16%) women. 33% (18/54) of women with SSI had prolonged hospital stays, and 11/37 (29%) had their adjuvant treatment delayed or cancelled. Multivariate analysis found body mass index (BMI) was the strongest risk factor for SSI (OR 1.08[95% CI 1.03 to 1.14] per 1 kg/m 2 increase in BMI [p=0.001]). Wound drains (OR 2.92[95% CI 1.41 to 6.04], p=0.004) and staple closure (OR 3.13[95% CI 1.50 to 6.56], p=0.002) were also associated with increased risk of SSI. Conclusions SSI is common in women undergoing surgery for gynaecological cancer leading to delays in discharge and adjuvant treatment. Resultant delays in adjuvant treatment may impact cancer-specific survival rates. Modifiable factors, such as choice of wound closure material, offer opportunities for reducing SSI and reducing morbidity in these women. There is a clear need for new trials in SSI prevention in this patient group; our trainee-led initiative provides a platform for their successful completion.
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99. Effectiveness of an antifungal stewardship programme at a London teaching hospital 2010-16

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Abstract The need for antifungal stewardship is gaining recognition with increasing incidence of invasive fungal infection (IFI) and antifungal resistance alongside the high cost of antifungal drugs. Following an audit showing suboptimal practice we initiated an antifungal stewardship programme and prospectively evaluated its impact on clinical and financial outcomes.
Patients and Methods: From October 2010 to September 2016, adult inpatients receiving amphotericin B, echinocandins, intravenous fluconazole, flucytosine or voriconazole were reviewed weekly by an infectious diseases consultant and antimicrobial pharmacist. Demographics, diagnosis by European Organization for Research and Treatment of Cancer (EORTC) criteria, drug, indication, advice, acceptance and in-hospital mortality were recorded. Antifungal consumption and expenditure, and candidaemia species and susceptibility data were extracted from pharmacy and microbiology databases.
Result(s): A total of 432 patients were reviewed, most commonly receiving AmBisomeVR (35%) or intravenous fluconazole (29%). Empirical treatment was often unnecessary, with 82% having no evidence of IFI. Advice was given in 64% of reviews (most commonly de-escalating or stopping treatment) and was followed in 84%. Annual antifungal expenditure initially reduced by 30% (0.98 million to 0.73 million), then increased to 20% above baseline over a 5 year period; this was a significantly lower rise compared with national figures, which showed a doubling of expenditure over the same period. Inpatient mortality, Candida species distribution and rates of resistance were not adversely affected by the intervention.
Conclusion(s): Provision of specialist input to optimize antifungal prescribing resulted in significant cost savings without compromising on microbiological or clinical outcomes. Our model is readily implementable by hospitals with high numbers of at-risk patients and antifungal expenditure.
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