Strategy 432448/8

#	Database	Search term	Results
8	EMBASE	(((audit* OR "quality improvement").ti,ab OR exp "CLINICAL AUDIT"/) AND ((NHS OR england OR UK OR "united kingdom" OR "national health service").ti,ab OR exp "UNITED KINGDOM"/ OR exp "NATIONAL HEALTH SERVICE"/)) [Since 26-Apr-2019]	137

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Results 100 of 137 results on EMBASE - (((audit* OR "quality improvement").ti,ab OR exp "CLINICAL AUDIT"/) AND ((NHS OR england OR UK OR "united kingdom" OR "national health service").ti,ab OR exp "UNITED KINGDOM"/ OR exp "NATIONAL HEALTH SERVICE"/)) [Since 26-Apr-2019]

1. A review of primary biliary cholangitis practice in Wales: Time for specialist care

Authors Haboubi H.; Shenbagaraj L.; Harborne P.; Appanna G.; Abdul-Sattar A.; Philips A.; Yahya I.; Navaratnam J.; Edwards K.; Alrubaiy L.; Newbould R.; Vincent R.; Jennings V.; Mannem S.; Gardezi S.A.; Aslam U.; Samuel D.; Yousuf F.; Yeoman A.; Pembroke T.; Srivastava B.; Ch'ng C.L.
Source Journal of Hepatology; Apr 2019; vol. 70 (no. 1)
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Available at Journal of Hepatology 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 and aims: Therapeutic advances in primary biliary cirrhosis (PBC)make assessment of treatment response a critically important issue. We studied the clinical practice around PBC in Wales. Population of Wales is over 3 million people with rural/urban diversity. Clinical services reflect the diversity with small district hospitals and large liver units.
Method(s): We developed a clinical audit tool with UK-PBC and EASL guidelines. Data was retrospectively collected by specialist trainees in each health board, including demographic information, clinical management and differences in adherence to standards between clinicians. We interrogated ursodeoxycholic acid (UDCA)use, appropriate dosing, documentation of symptoms, prevalence of cirrhosis and referral for transplant.
Result(s): Total of 406 living patients with diagnosis of PBC were identified across five Welsh health boards. Out of 406 patients, majority were females (n = 297, 73%), mean age at diagnosis of 59.7 years (+/- 13.5). Serological testing for PBC (AMA > 1 /40)was present in 88.5% patients at time of diagnosis. Mean Alkaline Phosphatase (ALP)at diagnosis was 334U/L (56-2020). Liver biopsy was performed in 26.6% of patients and was more likely to be requested by a hepatologist than a general gastroenterologist, p = 0.039 (Chi Square). Mean follow-up since diagnosis was 7.9 +/- 6years. Symptoms of pruritus and fatigue were documented in 29.2% and 32.9% of recent clinic records respectively. Hepatologists followed PBC patients up more frequently with 70.7% of their patients seen at 6 monthly intervals whereas general gastroenterologists were more likely to follow-up patients annually, p < 0.001. Of 214 patients with recent clinic letters, 179 (83.6%)were on UDCA. Patients managed by hepatologists were more likely on the appropriate dose of UDCA (92.9%)compared to gastroenterologists (39.3%), p = 0.018. Hepatologists were better in recording assessment of response at 1 year (86.8%)compared to gastroenterologists (62.5%), p = 0.024. Of the total cohort, 47.8% patients had cirrhosis, with screening performed for hepatocellular cancer in 54.3% and varices in 38%. Out of 82 patients with documentation of conversation about transplant, 26 patients were considered with 12 undergoing liver transplant.
Conclusion(s): This study provides a unique insight into current services for PBC patients across Wales. Despite widely available guidelines, there were significant discrepancies in adherence to standards between hepatology and gastroenterology managed patients. In particular, patients managed by hepatology were likely to receive optimal UDCA dosing and have response documented at 1 year. This study has also uncovered areas requiring improvement like documentation of fatigue and pruritis. These findings will be used to review the PBC care pathway in Wales to improve adherence to standards and access to new therapies.

2. Newborn hearing screening at the Neonatal Intensive Care Unit and Auditory Brainstem Maturation in preterm infants

Authors Andrea C.; Stavros H.; Virginia C.; Cristina C.; Claudia A.; Chiara B.; Francesco S.; Stefano P.
Source International Journal of Pediatric Otorhinolaryngology; Aug 2019; vol. 123 ; p. 110-115
Publication Date Aug 2019
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Available at International Journal of Pediatric Otorhinolaryngology 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: Aim of this study is to report and discuss the results of 4 years of Newborn hearing screening (NHS)program at the Neonatal Intensive Care Unit (NICU), particularly evaluating the clinical ABR results.
Method(s): Retrospective study. NHS data from NICU newborns, admitted for >=5 days, in the period from January 1st, 2013 and December 31st, 2016, were retrieved and analyzed. NHS results were classified as following: (i)"pass" when both ears for both the a-TEOAE (automated Transient-Evoked Otoacoustic Emissions)and the a-ABR (automated Auditory Brainstem Response)protocol resulted as "pass"; (ii)"fail" when one ear, at either one of the two performed tests resulted as "fail"; (iii)"missing" when the newborns were not tested with both protocols. All "fail" and "missing" newborns were retested (with both tests): in the case of a second "fail" result, a clinical ABR was performed within a period of 3 months.
Result(s): A total of 1191 newborns were screened. From those, 1044/1191 resulted as "pass", 108/1191 as "fail", and 39/1191 as "missing". During the re-testing of these 147 newborns, 43 were assigned as "missing", 63 were assigned as "pass" (showing bilaterally a wave V identifiable within 30 dB nHL)and 25 failed the retest and/or did not present an identifiable wave V within 30 dB nHL. Among the 147 retested infants, we identified a group of 16 subjects who resulted as NHS "refer" and who, during the audiological follow-up, showed either: (i)a unilateral or bilateral wave V identifiable over 30 dB nHL, at the first clinical ABR assessment; or (ii)a bilateral wave V identifiable within 30 dB nHL, in a following clinical ABR test during the first year of life. These 16 subjects were defined to have an 'Auditory Brainstem Maturation' issue.
Conclusion(s): A possible "maturation" of the ABR response (and therefore of the auditory pathway)has been hypothesised in 16 out of 1191 infants (1.3%). A delay of the auditory pathway maturation in preterm babies compared to term newborns has already been suggested in the literature. A possible delay of the NHS retest could be considered, in selected cases, with significant savings in economic resources and parental anxiety.

3. Requirement for urgent tracheal intubation after traumatic injury: a retrospective analysis of 11,010 patients in the Trauma Audit Research Network database

Authors Crewdson K.; Lockey D.J.; Fragoso-Iniguez M.
Source Anaesthesia; 2019
Publication Date 2019
Publication Type(s) Article
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Available at Anaesthesia from Wiley Online Library
Available at Anaesthesia 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 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 Advanced airway management is a treatment priority in trauma care. It is likely that a proportion of patients who receive urgent airway management on arrival in the emergency department represent an unmet demand for airway intervention in the pre-hospital phase. This study aimed to investigate emergency airway practice in major trauma patients and establish any unmet demand in this patient group. A retrospective review of the Trauma Audit and Research Network database was performed to identify airway intervention(s) performed for patients admitted to major trauma centres in England from 01 April 2012 to 27 June 2016. In total, 11,010 patients had airway interventions: 4375 patients (43%) had their tracheas intubated in the pre-hospital setting compared with 5889 patients (57%) in the emergency department. Of the patients whose tracheas were intubated in the emergency department, this was done within 30 min of hospital arrival in 3264 patients (75%). Excluding tracheal intubation, 1593 patients had a pre-hospital airway intervention of which 881 (55%) subsequently had their trachea intubated in the emergency department; tracheal intubation was done within 30 min of arrival in the majority of these cases (805 patients (91%)). Over 70% of emergency department tracheal intubations in patients with traumatic injuries were performed within 30 min of hospital arrival; this suggests there may be an unmet demand in pre-hospital advanced airway management for trauma patients in England.

4. The referral and management process of patients sustaining peri-anaesthetic dento-alveolar trauma: an audit

Authors Wilson V.; Barclay S.; Pervin S.
Source British dental journal; Apr 2018; vol. 224 (no. 7); p. 513-516
Publication Date Apr 2018
Publication Type(s) Article

PubMedID 29576610
Database EMBASE
Available at British dental journal from ProQuest (Health Research Premium) - NHS Version
Available at British dental 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.

5. Paired surveys for patients and physiologists in echocardiography: A single-centre experience

Authors Roshen M.; John S.; Ahmet S.; Amersey R.; Gupta S.; Collins G.
Source Echo Research and Practice; 2019; vol. 6 (no. 1); p. 1-6
Publication Date 2019
Publication Type(s) Article
Database EMBASE
Available at Echo Research and Practice from Europe PubMed Central - Open Access
Available at Echo Research and Practice from Unpaywall
Abstract The British Society of Echocardiography (BSE) highlights the importance of patient questionnaires as part of the quality improvement process, To this end, we implemented a novel system whereby paired surveys were completed by patients and physiologists for transthoracic echocardiography scans, allowing for parallel comparison of the experiences of service providers and end users. Anonymised questionnaires were completed for each scan by the patient and physiologist for outpatient echocardiographic scans in a teaching hospital. In 26% of the responses, patient found the scans at least slightly painful, and in 24% of scans physiologists were in discomfort. The most common reason given by physiologists for technically difficult or inadequate scans was patient discomfort. In 38% of the scans at least one person (the patient or the physiologist) was in at least some discomfort. Comparative data showed that the scans reported as most painful by patients were also reported by the physiologists as difficult and uncomfortable. In summary, these results demonstrate the feasibility of implementing paired surveys. Patient information leaflets by the BSE and National Health Service (NHS) describe echocardiography as painless but the results here indicate this is not always the case.

6. Where are we now in perioperative medicine? Results from a repeated UK survey of geriatric medicine delivered services for older people

Authors Joughin A.L.; Partridge J.S.L.; O'Halloran T.; Dhesi J.K.
Source Age and ageing; May 2019; vol. 48 (no. 3); p. 458-462
Publication Date May 2019
Publication Type(s) Article
PubMedID 30624577
Database EMBASE
Available at Age and ageing from Ovid (Journals @ Ovid) - Remote Access
Available at Age and ageing 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 Age and ageing 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: national reports highlight deficiencies in the care of older patients undergoing surgery. A 2013 survey showed less than a third of NHS trusts had geriatrician-led perioperative medicine services for older surgical patients. Barriers to establishing services included funding, workforce and limited interspecialty collaboration. Since then, national initiatives have supported the expansion of geriatrician-led services for older surgical patients.This repeat survey describes geriatrician-led perioperative medicine services in comparison with 2013, exploring remaining barriers to developing perioperative medicine services for older patients.
METHOD(S): an electronic survey was sent to clinical leads for geriatric medicine at 152 acute NHS healthcare trusts in the UK. Reminders were sent on four occasions over an 8-week period. The survey examined the nature of the services provided, extent of collaborative working and barriers to service development. Responses were analysed descriptively.
RESULT(S): eighty-one (53.3%) respondents provide geriatric medicine services for older surgical patients, compared to 38 (29.2%) in 2013. Services exist across surgical specialties, especially in orthopaedics and general surgery. Fourteen geriatrician-led preoperative clinics now exist. Perceived barriers to service development remain workforce issues and funding. Interspecialty collaboration has increased, evidenced by joint audit meetings (33% from 20.8%) and collaborative guideline development (31% from 17%).
CONCLUSION(S): since 2013, an increase in whole-pathway geriatric medicine involvement is observed across surgical specialties. However, considerable variation persists across the UK with scope for wider adoption of services facilitated through a national network.

7. Improving cardiac rehabilitation uptake: Potential health gains by socioeconomic status

Authors Hinde S.; Bojke L.; Harrison A.; Doherty P.
Source European Journal of Preventive Cardiology; 2019
Publication Date 2019
Publication Type(s) Article
PubMedID 31067128
Database EMBASE
Abstract Background: Globally, cardiac rehabilitation (CR) is recommended as soon as possible after admission from an acute myocardial infarction (MI) or revascularisation. However, uptake is consistently poor internationally, ranging from 10% to 60%. The low level of uptake is compounded by variation across different socioeconomic groups. Policy recommendations continue to focus on increasing uptake and addressing inequalities in participation; however, to date, there is a paucity of economic evidence evaluating higher CR participation rates and their relevance to socioeconomic inequality.
Method(s): This study constructed a de-novo cost-effectiveness model of CR, utilising the results from the latest Cochrane review and national CR audit data. We explore the role of socioeconomic status by incorporating key deprivation parameters and determine the population health gains associated with achieving an uptake target of 65%.
Result(s): We find that the low cost of CR and the potential for reductions in subsequent MI and revascularisation rates combine to make it a highly cost-effective intervention. While CR is less cost-effective for more deprived groups, the lower level of uptake in these groups makes the potential health gains, from achieving the target, greater. Using England as a model, we estimate the expenditure that could be justified while maintaining the cost-effectiveness of CR at 68.4 m per year.
Conclusion(s): Increasing CR uptake is cost-effective and can also be implemented to reduce known socioeconomic inequalities. Using an estimation of potential population health gains and justifiable expenditure, we have produced tools with which policymakers and commissioners can encourage greater utilisation of CR services.

8. The incidence and clinical outcome of complications in 4,000 consecutive strabismus operations

Authors Ritchie A.E.; Ali N.
Source Journal of AAPOS : the official publication of the American Association for Pediatric Ophthalmology and Strabismus; May 2019
Publication Date May 2019
Publication Type(s) Article
PubMedID 31063810
Database EMBASE
Available at Journal of AAPOS : the official publication of the American Association for Pediatric Ophthalmology and Strabismus 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 test the validity of the British Ophthalmic Surveillance Unit (BOSU) study's incidence figure of severe complications following strabismus surgery and to determine the incidence, type, risk factors, and outcome of all strabismus surgery complications at a single institution.
METHOD(S): A prospective audit of consecutive strabismus operations performed by consultants or trainees was carried out between 2011 and 2016 at Moorfields Eye Hospital NHS Foundation Trust. Patient diagnosis, age, sex, surgical details, complications, and outcome were recorded from hospital records. We classified complications as minor, moderate, or severe. The outcome was graded using the Bradbury and Taylor grading system (I to IV), with a poor or very poor outcome meaning loss of corrected visual acuity or unexpected primary position diplopia.
RESULT(S): A total of 4,076 consecutive strabismus operations were performed during the study period. There were 46 (1.13%) complications, of which 28 (0.69%) were minor, 7 (0.17%) were moderate, and 9 (0.22%) were severe. Only 1 patient (0.02%) had a poor visual outcome. Two patients had nonocular postoperative complications (0.05%).
CONCLUSION(S): In this large, prospective series, we found the rate of severe complications of strabismus surgery to be 1 in 455 cases. Our results validate the findings of the BOSU study.

9. Exploring organizational support for the provision of structured self-management education for people with Type 2 diabetes: findings from a qualitative study

Authors Carey M.E.; Horne R.; Agarwal S.; Davies M.; Slevin M.; Coates V.
Source Diabetic Medicine; Jun 2019; vol. 36 (no. 6); p. 761-770
Publication Date Jun 2019
Publication Type(s) Article
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Available at Diabetic Medicine from Wiley Online Library Medicine and Nursing Collection 2019 - NHS
Available at Diabetic Medicine 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 Diabetic Medicine 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 explore the organizational context in which Type 2 diabetes structured group education is provided.
Method(s): Four Clinical Commissioning Groups in England providing Type 2 diabetes structured self-management education participated in a qualitative study exploring the context for provision of that education. Using UK National Diabetes Audit returns, two Clinical Commissioning Groups were selected that had non-attendance rates of <=25%, and two that had non-attendance rates of >=50%. Between May 2016 and August 2017, 20 interviews were conducted with Clinical Commissioning Group staff including: commissioners, healthcare professionals, managers, general practitioners and diabetes educators. Data gathering was prolonged as it proved challenging to engage with healthcare staff as a result of frequent local restructuring and service disruption.
Result(s): Local audits revealed discrepancies in basic data such as referral and attendance numbers compared with national audit data. There was a commonality in the themes identified from interviews: diabetes education was rarely embedded in service structure; where education uptake was poor, a lack of central support to delivery teams was noticeable; and where education uptake was positive, delivery teams were actively engaged, sometimes relying on enthusiastic individuals. Both situations put the local sustainability of diabetes education at risk.
Conclusion(s): There appears to be a link between attendance rates and organizational issues, therefore, when considering how to increase attendance rates, the state of the diabetes education infrastructure should be reviewed. Good uptake of diabetes education can be too reliant on the enthusiastic commitment of small teams or individuals delivering the education.

10. Quality improvement: referral radiographs

Authors Hamrang-Yousefi Y.; Pannu M.
Source International Journal of Oral and Maxillofacial Surgery; May 2019; vol. 48 ; p. 289
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Available at International 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 Background: Referrals received from the National Health Service (NHS)Referral System are printed then scanned as an upload onto Electrical Medical Records (EMR), which clinicians can access. It is during this transition that the quality drops below the Gold Standard. This often leads to overexposing patients unnecessarily, as well as lengthening clinic times whilst the patient goes for a repeat radiograph.
Objective(s): To measure the drop-in quality of radiographs from the NHS Referral System to EMR To implement changes to ensure radiograph quality does not drop during this transition.
Method(s): 100 radiographs were selected at random from NHS referrals & EMR and graded in accordance with the National Radiological Protection Board (NRPB)guidelines to measure the quality.
Finding(s): Grade 1: 74% NHS, 16% EMR Grade 2: 16% NHS, 48% EMR Grade 3: 9% NHS, 36% EMR from 80 patients, 47 (59%)were re-exposed.
Conclusion(s): Liaison with the IT department to allow training of staff enabled referrals to be directly transferred electronically to EMR. This prevented the drop in quality and re-audit results showed no drop-in quality: Grade 1: 72% for both Grade 2: 18% for both Grade 3: 10% for both As a result, less patients were re-exposed.

11. Antibiotic prophylaxis for mandible fractures

Authors Sheikh O.; Vempaty S.; Logan G.; Azizi M.; Shorafa M.
Source International Journal of Oral and Maxillofacial Surgery; May 2019; vol. 48 ; p. 203
Publication Date May 2019
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Available at International 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 Background: Antibiotics are prescribed prophylactically for open reduction and internal fixation (ORIF)of mandible fractures. Scottish Intercollegiate Guidelines Network (SIGN)on antibiotic prophylaxis in surgery provide evidence-based recommendations that suggest not giving more than 24 hours of antibiotic prophylaxis in ORIF of mandible fractures. A previous study was undertaken by the authors between January 2014 and August 2016 in a major United Kingdom district general hospital. A control group with only 24 hours or 3 post-operative intravenous doses was compared with those who also received 7 days of oral antibiotics to take away. The study found no significant difference in the rate of postoperative infection between both groups. Our department subsequently adopted the SIGN recommendation as our antibiotic prophylaxis local guideline for mandible fractures that required operation.
Objective(s): Antibiotic prescribing must be appropriate to minimise adverse effects as well as to reduce the incidence of resistant organisms.
Method(s): An audit was performed the determine adherence to the adopted guideline and local prescribing policy. Patient data was collected for those admitted with mandible fractures including patient demographics, length of stay in the hospital and antibiotic prescribing regime.
Finding(s): Our results show that we are 84% compliant with our local guideline. 4% of cases were immunocomprised and microbiology advice was for an additional 7 days of oral antibiotics post discharge.
Conclusion(s): There is a propensity for over-prescribing of prophylactic antibiotics following ORIF of mandible fractures. Although 88% compliance (including the 4% discussed with microbiology)is relatively high there is room for improvement.

12. Improving access to genetic testing for adults with intellectual disability: A literature review and lessons from a quality improvement project in East London

Authors Adlington K.; Smith J.; Crabtree J.; Win S.; Rennie J.; Khodatars K.; Hall I.; Rosser E.
Source American Journal of Medical Genetics, Part B: Neuropsychiatric Genetics; 2019
Publication Date 2019
Publication Type(s) Article
Database EMBASE

Available at American Journal of Medical Genetics, Part B: Neuropsychiatric Genetics 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 Recent advances in genetic research have led to an increased focus on genetic causes of intellectual disability (ID) and have raised new questions about how and when clinicians offer genetic testing and the nature of communication around this decision with patients and carers. Determining the right approach to such discussions is complicated by complexities of communication, consent, and capacity and ethical concerns about genetic testing in this population. In this article, we briefly discuss the recent advances in genetic research relevant to people with intellectual disability, highlighting the challenges that might arise when undertaking genetic testing in this population. We then describe how we have used a Quality Improvement methodology to develop a clinical pathway for routine genetic testing for adults with intellectual disability in a clinical setting in East London.

13. Urethral injury in major trauma

Authors Battaloglu E.; Porter K.; Figuero M.; Lecky F.; Moran C.
Source Injury; May 2019; vol. 50 (no. 5); p. 1053-1057
Publication Date May 2019
Publication Type(s) Article
Database EMBASE
Available at Injury 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 Injury 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 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.

14. Socioeconomic inequalities in the delivery of brief interventions for smoking and excessive drinking: Findings from a cross-sectional household survey in England

Authors Angus C.; Gillespie D.; Buykx P.; Meier P.; Brown J.; Beard E.; Kaner E.F.S.; Michie S.
Source BMJ Open; Apr 2019; vol. 9 (no. 4)
Publication Date Apr 2019
Publication Type(s) Article
PubMedID 31048422
Database EMBASE
Available at BMJ Open from Europe PubMed Central - Open Access
Available at BMJ Open from HighWire - Free Full Text
Available at BMJ Open from ProQuest (Health Research Premium) - NHS Version

Abstract Objectives Brief interventions (BI) for smoking and risky drinking are effective and cost-effective policy approaches to reducing alcohol harm currently used in primary care in England; however, little is known about their contribution to health inequalities. This paper aims to investigate whether self-reported receipt of BI is associated with socioeconomic position (SEP) and whether this differs for smoking or alcohol. Design Population survey of 8978 smokers or risky drinkers in England aged 16+ taking part in the Alcohol and Smoking Toolkit Studies. Measures Survey participants answered questions regarding whether they had received advice and support to cut down their drinking or smoking from a primary healthcare professional in the past 12 months as well as their SEP, demographic details, whether they smoke and their motivation to cut down their smoking and/or drinking. Respondents also completed the Alcohol Use Disorders Identification Test (AUDIT). Smokers were defined as those reporting any smoking in the past year. Risky drinkers were defined as those scoring eight or more on the AUDIT. Results After adjusting for demographic factors and patterns in smoking and drinking, BI delivery was highest in lower socioeconomic groups. Smokers in the lowest social grade had 30% (95% CI 5% to 61%) greater odds of reporting receipt of a BI than those in the highest grade. The relationship for risky drinking appeared stronger, with those in the lowest social grade having 111% (95% CI 27% to 252%) greater odds of reporting BI receipt than the highest grade. Rates of BI delivery were eight times greater among smokers than risky drinkers (48.3% vs 6.1%). Conclusions Current delivery of BI for smoking and drinking in primary care in England may be contributing to a reduction in socioeconomic inequalities in health. This effect could be increased if intervention rates, particularly for drinking, were raised.

15. Audit of antipsychotic prescribing in people with learning disability

Authors Wighe A.; Ward F.
Source Australian and New Zealand Journal of Psychiatry; Apr 2019; vol. 53 ; p. 154-155
Publication Date Apr 2019
Publication Type(s) Conference Abstract
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Available at Australian and New Zealand Journal of Psychiatry 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: Individuals with learning disability have higher mental health co-morbidities and have an increased risk of side effects from antipsychotic medications. National guidelines recommend standards for prescribing and monitoring of antipsychotic medications for people with a learning disability. An initial audit in March 2015 identified areas of improvement: enquiring about side effects and monitoring requirements in clinic letters. Subsequently, changes in psychiatry appointment and clinic letters were recommended and the use of a side-effect checklist.
Objective(s): This session aims to describe re-auditing practice in relation to prescribing and monitoring of antipsychotic medication in people with learning disabilities and evaluating the impact of the initial recommendations.
Method(s): A sample of 10 outpatients open to the learning disability psychiatry service who were currently prescribed antipsychotic medication were included. The Prescribing Observatory for Mental Health (POHM-UK) data collection tool was completed for each case.
Finding(s): Co-morbidity with learning disability remained high (95%), reflecting the consistency with good practice recommendations and National Institute for Health and Care Excellence (NICE) guidance. Positive improvements included a clearer indication for the use of an antipsychotic and prescribing for 'behavioural' problems was consistent with the last audit. A significant improvement (90% versus 50%) in the recording of side effects and movement disorder (55% versus 15%) was evidenced. Improvements in recording of actual values of metabolic parameters was also observed.
Conclusion(s): Improvement in practice was evidenced across all parameters. Amendments to appointment letters and recording of monitoring requirements in clinic letters was agreed to be an effective measure. Modifications to clinic letters to include monitoring of weight and blood pressure was agreed. Current practice was agreed as acceptable.

16. Non-invasive ventilation: Making changes and demonstrating improvement using quality improvement methodology

Authors Mummery V.; Lin F.; Ritchie L.; McNicholas C.; Bloch S.; Adeleke Y.; Matthew D.; Woodcock T.
Source Thorax; Dec 2018; vol. 73
Publication Date Dec 2018
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Abstract Introduction and objectives The BTS audit and NCEPOD report on Non-Invasive Ventilation (NIV) demonstrate significant failings in the care of acute NIV patients. NIV has the potential to reduce mortality by 50% when delivered appropriately, but can do significant harm if poorly managed. Quality improvement (QI) is a relatively new and rapidly increasing discipline in the clinical field. Demonstrating that changes result in improvement can be difficult. However, when improvement can be robustly shown, the data are powerful and can help to ensure stakeholder engagement and continued motivation. As part of a NIHR CLAHRC Northwest London funded QI initiative (April 2017-March 2018), aiming to improve care for acute NIV patients, we used QI methodology and a patient centred approach to develop an NIV bundle, algorithm, standardise training and develop a competency framework. We aimed to demonstrate that these interventions resulted in improved care by using a 'measures for improvement' approach. Method An Action-Effect Diagram was developed to identify and articulate the aims of the project and how they might be achieved. Stakeholder engagement, process mapping and iterative PDSA cycles to test change were some of the QI methods used. A measurement plan defined our process, outcome and balancing measures. Data were collected prospectively, analysed using Statistical Process Control (SPC) charts and used to inform decision-making, reporting on a fortnightly basis. Results Since implementation (July 2017), 111 NIV carebundles have been completed from a possible 185. 535 staff were trained using the updated education framework. SPC charts demonstrated improvements in care, for example in the documentation of NIV parameters (figure 1) we also began to see improvement in the percentage of patients receiving all five points on our COPD treatment algorithm (controlled oxygen, steroids, nebulisers, antibiotics and chest xray prior to NIV), and patients having a ceiling of care discussion prior to NIV. Conclusions We have demonstrated that by using a robust QI approach, approaching improvement in an evidence-based, systematic and patient centred way we were able to make improvements. Future challenges include efficiently sustaining these improvements to ensure that the new BTS quality standards are met. (Figure Presented).

17. Frailty in hospitalised COPD patients

Authors Fei L.; Fraser J.; Padmanaban V.; Boniface A.; Wyman E.; Maguire M.; Stone M.; Elkin S.; Mallia P.
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Abstract Background Chronic obstructive pulmonary disease (COPD) patients have multiple comorbidities and a high prevalence of frailty. Frailty is associated with increased hospital readmissions. Frailty increases length of stay (LOS) in patients admitted to acute medical units but has not been studied in COPD. There are conflicting results with regards to the effects of comorbidities on LOS in COPD. We examined relationships between frailty, comorbidities and LOS in COPD patients admitted to a London hospital trust with an acute exacerbation (AECOPD). Methods The Rockwood Clinical Frailty score was recorded for 222 patients admitted with AECOPD between February 2017 and December 2017. This data was collated and referenced via the National COPD auditing tools. The medical records of a subset of 70 patients were examined to investigate whether the Frailty/Care of the Elderly medical teams were involved in their care. Results 222 COPD patients (48% male) with an age range from 43-94 years were admitted during this time period. LOS ranged from 0-50 days (mean LOS 6.1 days, median LOS 5 days). The median Rockwood score was 5 (1 subject had a score of 1 and 4 subjects had a score of 9). LOS increased with increasing Rockwood score (figure 1), mean LOS was 3.27 days in patients with a score of 2 compared with 10.86 in patients with a score of 8 ($p=0.038$). There were weak but significant correlations between Rockwood score and LOS ($r=0.26$, $p<0.0001$) and number of comorbidities ($r=0.19$, $p=0.025$). Out of 70 patients, only 22 (31.4%) were reviewed by Frailty/ Care of the Elderly team. The median Rockwood score of those not reviewed was 4, and 5 in those reviewed ($p=0.06$). Discussion There is a correlation between Rockwood frailty score and LOS in hospitalised COPD patients. Patients admitted with COPD exacerbation are not routinely seen by physicians with expertise in frailty and it is not clear how decisions are made as to which patients are seen. The Rockwood Frailty Score can identify those patients that may require greater integrated health and social care interventions and service adaption to facilitate Frailty Team review may improve outcomes for these patients.

18. The true cost of switching to low globalwarming potential inhalers. An analysis of NHS prescription data in England

Authors Braggins R.; Smith J.; Wilkinson A.J.K.

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Abstract Introduction and objectives The hydrofluorocarbons that replaced CFCs in MDIs have global warming potentials (GWPs) thousands of times greater than CO_2, so MDIs are a major contributor to NHS greenhouse gas emissions. 1 Dry powder inhalers (DPIs) are a low GWP alternative to MDIs recommended by BTS and UK government.1 2 Other European countries use DPIs far more than the UK, however the financial cost of DPIs is considered a barrier to their use in the UK.1 We investigated the financial implications for the NHS of switching from MDIs to DPIs. Methods We analysed Net Ingredient Cost (NIC) data for England 2017 to calculate the 'NIC per day of typical use' for each inhaler and the total annual NIC in several scenarios where MDIs were replaced with clinically equivalent DPIs. Results and conclusions More than <=8.24 million and 68.6 kilotonnes of CO_2 equivalent could be saved for every 10% of MDIs that are replaced with the cheapest clinically equivalent DPI. The cost of switching ICS, SABA and ICS/LABA/LAMA MDIs for the cheapest equivalent DPIs is overwhelmed by savings from switching LABA and ICS/LABA MDIs for the cheapest equivalent DPIs. Additionally greater uptake and greater efficiency of DPIs could further reduce their cost in the longer term. If at least 58% of the MDIs that are replaced are switched for the cheapest clinically equivalent DPI then the transition from MDIs to DPIs would be cost neutral, assuming that the remaining MDIs are replaced with DPIs in the same proportions that DPIs were prescribed in 2017. Given the potential for both financial and environmental savings, the recommendations of the Environmental Audit Committee2 and the BTS Position Statement on The Environment and Lung Health,1 we anticipate a change in NHS policy. Every effort must be made to minimise greenhouse gas release to protect current and future generations from the worst effects of climate change. Patients, clinicians and policy makers should act now facilitate this change. (Figure Presented).

19. Chronic thromboembolic pulmonary hypertension (CTEPH)-is it chronically underdiagnosed?

Authors Suntharalingam J.; MacKenzie Ross R.; Robinson G.; Hall T.; Hudson B.; Redman S.; Graham R.; Little D.; Easaw J.; Augustine D.; Carson K.; Coghlan G.J.
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Abstract Introduction Chronic Thromboembolic Pulmonary Hypertension (CTEPH) is a potentially curable form of Pulmonary Hypertension (PH), thought to develop as a rare complication of acute pulmonary embolic disease. Although treatable, it is estimated that only 7%-29% of cases are diagnosed. This abstract examines the impact of developing a regional specialist PH service within our District General Hospital (DGH) on our local incidence of CTEPH, compared with national figures. Methods Since 2007 the Royal United Hospital (RUH) Bath has offered a regional shared care PH service to the South West, in collaboration with the Royal Free. The service now involves staff from several specialties within the hospital, increasing local awareness of PH. A retrospective analysis was carried out of all CTEPH patients diagnosed within our local DGH catchment area of 4 50 000 between 2007 and 2018, from which annual incidence figures were calculated. A further analysis was carried out of patients with Chronic Thromboembolic Disease (CTED) ie those with persistent thrombus but no associated PH. Results 43 local patients (58% male, 60.4 years) were diagnosed with CTEPH between 2007-2018, resulting in an average annual incidence 8.3 cases/million (95% CI 4.8, 11.8) and prevalence 68.9 cases/million. This is higher than UK-wide figures extrapolated from the 2017 National PH audit (annual incidence 4.7 cases/million and prevalence 32 cases/million). Referrals were received from 9 different specialties. Average Pulmonary Vascular Resistance (PVR) at presentation fell over time (R^2 0.3022) (figure 1) suggesting patients diagnosed more recently were picked up at an earlier stage in their disease process. All patients were discussed at the national pulmonary endarterectomy MDT at Papworth. 38/43 received active treatment-30/43 (70%) had technically operable disease, with 19/30 undergoing surgery, whilst 22/43 received medical therapy, including 3 patients post-surgery. In addition, a further 33 patients were diagnosed with CTED and were managed with anticoagulation alone. During the same timescale the service diagnosed 162 CTEPH and 100 CTED cases from the wider regional catchment area. Conclusions Developing a specialist PH service has increased our local diagnoses of CTEPH above national rates. The data supports the literature that this potentially treatable condition is currently under-diagnosed. (Table Presented) .

20. Impact of national optimal lung cancer pathway-can we meet the 28 day standard by 2020?

Authors Kutubudin F.; Robinson R.; Deus P.; Hughes K.; Wight A.G.
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Abstract Introduction and objectives The relationship between early cancer stage and patient outcome is well recognised. It is suggested that streamlined diagnostic pathways could improve this. UK cancer targets are being redefined by publication 'Achieving World Class Cancer Outcomes'. This includes the target of 95% of patients being definitely diagnosed or excluded of cancer and the results communicated to the patient within 28 days by 2020. The National Optimal Lung Cancer Pathway (NOLCP) was published in 2017 defining a timed framework for lung cancer investigation to meet this goal. WUTH introduced an IT driven local version of the NOLCP in October 2017. Using radiology requests from primary care it is a paperless system linking primary care with secondary care radiology, respiratory and outpatient booking services (including endoscopy). A daily consultant virtual clinic forms diagnostic plan from CT scan (day 0), all further diagnostic investigations are pre-arranged (including PET) and where required first method of contact is telephone communication from lung CNS. Information is linked real time to primary care. Methods Post NOLCP implementation comparison study of pathway timescales over 3 months (January- March 2018) with 3 month baseline September-November 2014 (traditional one-stop clinic) Results Total patients- 210, 69/210 triage to cancer OPD, 61/ 210 discharged to primary care, 70/210 downgraded with cancer excluded, 4 referred to other tumour group. Those triaged to cancer clinic 34/69 (49%) confirmed lung cancer, 11/69 (16%) other malignancy, 24/69 benign (total 65% conversion to malignancy). Time from virtual review to formal cancer OPD- mean 5.8 days (target 5 days). Time Flagged CXR (or CT request) to MDT discussion (target 21 days)- 23.9 days (median 22), comparison 2014-38.9 days (median 32). 85% patients informed of treatment plan within 28 days (2014%- 39%) Conclusion Three months following adoption of electronic trackable NOLCP and virtual clinic we have seen shortened diagnostic timeframe by average of 15 days and are on target to meet the 95% target by 2020. We are now completing real-time audit for areas of delay. We feel that 28 day target is achievable even outside tertiary centers.

21. Impact of a local incentive scheme on implementation of nice guidance on smoking cessation in secondary care and a smoke free hospital in an inner city teaching hospital setting

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Abstract Introduction Senior NHS leaders and organisations such as RCP and ASH have recently placed increased emphasis on the need to identify and treat tobacco dependence in healthcare settings. We report on the feasibility and lessons learnt from developing a system wide approach to implementing NICE guidance on smoking cessation in secondary care in an inner London teaching hospital, and the impact of a 3 year local incentive scheme on this. Method King's College Hospital is a tertiary teaching hospital with 82 wards/1670 inpatient beds/12,000 staff. A Smoke Free Strategy Group convened in 2013, led by BTS smoking cessation champion/consultant and involving key stakeholders. A 3 year local incentive scheme worth <=2.5 million/year ran from 2014-2017 with incremental targets for recording smoking status, offering very brief advice and onward referral for inpatients plus staff training. An auditable electronic order was developed, linked to the National Referral System (NRS) for automated referral of smokers to their local service. 1 WTE hospital based tobacco liaison specialist was appointed in 2014 to support implementation and training. A Smoke Free Policy including smoke free grounds and inpatient nicotine withdrawal treatment algorithm were introduced in 2015. Results Baseline data in 2013 showed that 40% of inpatients were current smokers and were highly tobacco dependent with 68% needing a cigarette within 30 min of waking. 64% wished to stop smoking and 77% expected help during their admission. Only 32% were offered NRT and 58% were given no information on smoking cessation. From 2014-2017 numbers of patients/year with smoking status recorded increased from 9770 to 16 231 to 22 101 and were 31 034 in 2017/18. Smoking prevalence ranged from 20%-25% with 90% smokers given very brief advice/offered treatment in year 1% and 76% in years 2/3. 34% smokers accepted smoking cessation referral in Year 1; 32% in year 2% and 21% in year 3. 62%, 45% and 57% respectively of these patients subsequently quit. 83% of nursing staff on inpatient wards completed appropriate training. Conclusion System wide implementation of a smoke free hospital is challenging but feasible and successful. Financial incentivisation and clinical leadership are key facilitators.

22. British Thoracic Society Winter Meeting 2018

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Abstract The proceedings contain 455 papers. The topics discussed include: the utilisation of a 'pleural procedures' whatsapp group to alert medical trainees to the availability of pleural procedures; learning-needs focused hands-on workshops on chest drain insertion and post-insertion chest drain management: how we addressed and identified patient safety issues in our hospital; respiratory medicine trainees experience with large bore chest drains: results from a UK wide national survey; medical thoracoscopy training at a tertiary referral center; confidence and aptitude of healthcare professionals at demonstrating inhaler technique; acute non-invasive ventilation: a survey of medical registrars; non-invasive ventilation: making changes and demonstrating improvement using quality improvement methodology; the effect of a training session on health care professionals confidence in withdrawal of mechanical ventilation in motor neurone disease; INTU: improving non-invasive ventilation (NIV) through understanding. using patient experience to improve acute NIV provision as part of a quality improvement project; understanding the experience of adults living with pulmonary hypertension; and incision-free removal of indwelling pleural catheters.

23. Understanding death: The use of a standardised mortality assessment by a UK TB network

Authors Goldman N.; Lipman M.; Anaraki S.; Anderson S.; Lalor M.; Morgan G.; Dekoningh J.; White J.
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Abstract Background Reducing TB deaths is an END TB WHO Target. However, in England drug sensitive TB deaths increased from 4.7% in 2013 to 6.1% in 2016. We reviewed TB-related deaths in a large metropolitan TB network to improve care and develop strategies to reduce mortality. Method A mortality audit form was developed to capture relevant clinical and healthcare information in people with TB who had died during their episode of care. This was completed on all deaths by the TB case manager. Results In 2016/17, 691 TB cases were notified. Of the 27 (3.9%) deaths reported, in 22 (81%) TB diagnosis was made in hospital. Age at death ranged from 20-89 years (median 64 years). 52% (14) had pulmonary, 11% (3) pulmonary with extra-pulmonary and 37% (10) extra-pulmonary TB. In 41% (11) death occurred within 4 weeks of starting treatment (table 1). In the 21 patients with drug sensitivity information available, 18 had drug-sensitive and 3 isoniazidresistant TB. 96% (26) had significant medical co-morbidities. These included: diabetes (8), immune-compromise (4 non-HIV, 2 HIV), chronic respiratory (6), kidney (3) and liver diseases (2). 3 (11%) had one or more social risks for TB (homelessness, alcohol or drug misuse or imprisonment). Reviewing possible system factors contributing to death, treatment was reported as delayed in 7 (26%): 5 due to patient-related and 2 healthcare-related issues. Drug toxicity was noted in 26% (7) - though this was felt to have contributed to only 2 (7%) deaths. Poor treatment adherence was reported in 2 patients. Information on a patient's death certificate and post-mortem case manager assessment indicated a similar proportion of cases where TB was felt to have caused or contributed to death. For case managers, this was 'TB caused death' in 19% (5), and 'contributed to death' in 44% (12). Conclusion Diagnostic delays appear to contribute to 1 in 4 deaths. However the majority of people dying with TB have major co-morbidities, and often die early in treatment. This suggests that TB deaths may be unavoidable, and may explain why TB is often not recorded as the primary cause of death on death certificates.

24. Improving curative-intent treatment rates in early stage lung cancer-results from 775 patients in the NLCA spotlight audit

Authors Navani N.; Harden S.; Woolhouse I.; Beckett P.; Khakwani A.; Wood N.
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Abstract Background One possible explanation for poor survival in lung cancer patients in the UK is under-utilisation of curativeintent treatment. We carried out a spotlight audit to understand why eligible patients do not receive surgical treatment and whether national guidelines for assessment of early-stage lung cancer were being adhered to. Methods Details of patients in England with stage I/II NSCLC and a performance status of 0-1 who did not undergo surgical treatment were extracted from the NLCA dataset and used to populate a web-based portal developed in conjunction with the National Cancer Registration and Analysis Service (NCRAS). Trusts were invited to populate their cases with additional data. Results 82 of 142 trusts in England took part in the audit and data on 775 patients was suitable for analysis (67% stage I and 33% stage II). 46% of patients did receive treatment with curative intent in the form of SABR or radical radiotherapy (including CHART). 8% received other anti-cancer therapy, and 46% received best supportive care. As expected, age over 75 independently predicted best supportive care, even after other factors associated with age (such as co-morbidity and PS) are taken into account. 31% of patients did not have surgery owing to patient choice and, of these, 66% preferred SABR or other radical radiotherapy, while the remainder elected for no treatment. Only 2% of patients had a second surgical opinion, 14% had a CPEX, 34% had an echocardiogram and 11% had a V/ Q scan. Very few patients had a shuttle walk test, or had thoracoscore or a formal cardiac risk assessed. 1 year survival for patients having best supportive care was 37%, for SABR it was 67%, for radical radiotherapy it was 45% and for those undergoing palliative radiotherapy was 27%. After adjustment for age, PS, stage, deprivation index and comorbidity index (ACE-27), both SABR and radical radiotherapy improved survival compared with best supportive care. Conclusions Although nearly half the patients did receive an alternative treatment with curative intent, patient choice is a common reason for not receiving surgery. It is crucial that patients are assessed according to best practice and that information about their options is delivered and discussed appropriately.

25. Effect of pulmonary rehabilitation in patients with co-existing COPD and heart failure: data from the 2015 national COPD audit programme

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Abstract Introduction and objectives Little is known on the uptake and completion of pulmonary rehabilitation (PR) in adults with COPD and either left or right heart failure (HF) (cor pulmonale [CP]). Furthermore, the responsiveness related to PR is unknown. The objectives were to explore completion rates and outcome measures in patients with COPD and co-existing HF or not, that were assessed for PR, using data from the 2015 National COPD Audit Programme, Royal College of Physicians. Methods PR services across England and Wales provided data for all consenting patients assessed for PR between Jan and April 2015. Descriptive statistics, t-tests and chi-square were used to explore data from patients with COPD +HF (collected as either left heart failure [LVF] or CP). Mixed 2 x 2 ANOVA's were used to compare data between patients with COPD (with or without HF), before and after PR. Results 232/7134 (3.3%) patients with COPD+HF (32% females, mean [SD] age 74.5 [10.0] years; males 72.2 [9.2] years) were assessed for PR. Of those, 85% (n=196) enrolled into PR and of these 196, 65% (n=128) completed. In those with co-existing HF, there was no difference in age or gender between PR completers and non-completers (73.1+9.1 vs 72.7 +10.1 years p=0.74, and 66% vs 71% males, respectively). Exercise capacity (assessed by the ISWT) increased after PR (mean[SD] 41.8 [49.8]m) in patients with COPD+HF (n=66) (t(65)=-6.8, p<0.0005) but a significant group*time interaction (F(1,2253)=5.1, p=0.02) revealed patients with COPD +HF made a smaller improvement after PR than those without HF (n=2189) ([pre PR 153.6 m] vs 64.2 m [pre PR 209.5 m]). Improvements in the 6 MWT occurred after PR (33.0 [61.2]m) in patients with COPD+HF (n=43) (t(42)=- 3.5, p<0.001), however, there was no difference in the improvement gained between those with COPD+HF and those without (F(1,1683)=3.5, p=0.06). There were significant mean improvements in each domain of the Chronic Respiratory Questionnaire after PR; these did not differ between groups. Conclusion Nationally, 3.3% of patients with COPD assessed for PR had documented HF. Over half (55%) of those assessed with COPD +HF completed PR. Those without HF improved their exercise capacity (ISWT) more compared to those with HF. The improvements in HRQOL and functional capacity were similar.

26. Outcomes from acute NIV: Are British thoracic society quality standards realistic?

Authors Burns J.E.; Faulkner J.; Brabbs R.; Hornsby J.; Lowe D.; Carlin C.
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Abstract Background Acute non-invasive ventilation (NIV) for lifethreatening acidotic exacerbations of COPD is an effective treatment, with a number needed to treat of 8 to prevent 1 death in Cochrane meta-analysis. Recent NCEPOD publication highlighted shortfalls in UK acute NIV practice with poorer outcomes, resulting in publication of UK Quality Standards for Acute NIV. The evidence-base for some of these is limited, ability to achieve these standards is uncertain and it is unclear whether impaired acute NIV outcomes reflect shortfalls in care, case-mix of patients in routine practice, or a combination. We have established an acute NIV audit, quality improvement and innovation programme to address these issues, and can present the first dataset from this. Methods Fifty acute NIV episodes were identified from resuscitation room and acute respiratory unit records. Data was reviewed using NCEPOD audit toolkit with analysis of interrater agreeability between two data to evaluate the toolkit's reliability. Inpatient mortality and readmission rates was also noted. Results Incomplete recognition of patients receiving acute NIV was noted. Performance against two NCEPOD recommendations was graded green (100% compliance), three amber (50%-99%), and five red (0%-49%). Inter-rater agreeability with NCEPOD audit tool was low. ABG sampling during NIV (50% at 30-90 mins, 44% at 3-5 hours) was inconsistent. 38.8% of individuals were judged to have received suboptimal NIV. Inpatient mortality was 32.0% overall (vs 10% in Cochrane review) but there was no improvement in those who received optimal NIV. 6 month readmission rates (61.8%, of whom 28.6% were within 2 weeks) and mortality rates (32.4%) were similar to national published data. Conclusions The validity of the NCEPOD toolkit and UK Acute NIV Quality Standards is questioned based on the subjectivity of some toolkit variables, low inter-rater agreeability, limited evidence base and lack of consideration for realistic medicine and documentation challenges. High mortality and readmission rates in this cohort emphasise a need to standardise and improve management of patients with hypercapnic respiratory failure. Lack of improvement in overall outcome of patients judged to have had optimal acute NIV suggests that striving to achieve NCEPOD derived standards may not address these challenges.

27. The role of a regional mesothelioma MDT in improving prognostication

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Abstract Introduction Malignant pleural mesothelioma (MPM) is primarily associated with asbestos exposure. Prognosis is poor, with median survival quoted as 6-12 months. Although uncommon, incidence has been steadily increasing and is predicted to peak in 2020. The National Lung Cancer Audit report on MPM (2015), demonstrated significant variation in management and outcomes across the UK and subsequently lead to the production of the British Thoracic Society Guideline for the investigation and management of MPM (2017). This included the recommendation for regional mesothelioma MDTs. We present the findings from the first 15 months of the regional MDT in Oxford and its impact on other recommendations contained within the guidelines. Method Complete follow up data was collected prospectively from all patients with MPM treated at the Oxford Pleural Unit since 2005. Following the establishment of a mesothelioma MDT in March 2017, 39 patients have been diagnosed and discussed at this meeting. These cases were compared with the 39 preceding cases to assess the impact of the introduction of a specialist MDT. Results Demographics between both groups were similar. Average age was 77.4 in the MDT group versus 73.8. Sex showed a male predominance in both groups of 82.5%. There was some variation in the distribution of histological subtypes within the groups, however there was an improvement in the number of patients with a clinical diagnosis, no histological subtype or those requiring post-mortem, although sample size was inadequate to achieve significance (table 1). There was no difference in the number of patients being considered for enrolment in clinical trials (33% versus 36%) however there were significant increases in the number of patients who had prognostic scores calculated (54% versus 0%) and those who had formal staging documented (56% versus 21%, p=0.001). Discussion Mesothelioma MDTs appear to improve documentation and communication of disease stage and prognosis. Further improvement in this area and in the consideration of enrolment in clinical trials may be possible with the introduction of an MDT proforma. Further work is required to assess the impact on diagnostic accuracy which might be best achieved by joint MDT working to obtain required numbers (Table Presented) .

28. Understanding the impact of introducing a best practice tariff on clinical process standards in the national COPD audit programme

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Abstract Background On 1/2/17, the National COPD Audit moved to continuous data collection for a small number of clinical process items with real time feedback presented as run charts designed to support site level quality improvement initiatives. In addition, a best practice tariff (BPT) for COPD admissions was agreed with NHSE to promote hospital management and Board engagement with audit improvement aims. We hypothesised that there would be differences observed in the compliance of clinical process standards for the 2 process items aligned to the BPT compared with the 4 that were not. Methods Data were entered by each site for all eligible cases in hospitals in England and Wales to a bespoke web tool hosted by Crown Informatics. Data on the following key indicators were collected: Patients receiving NIV within 3 hours of arrival, Current smokers prescribed smoking cessation pharmacotherapy, Patients with spirometry result available, Patients prescribed oxygen to target saturation, Patients receiving a discharge bundle, Patients receiving respiratory review by a member of the respiratory team within 24 hours of admission, Patients where care meets best practice tariff (BPT) for COPD; the latter three being related to the BPT. The BPT was launched on 1 st April 2017. Compliance with clinical process standards was calculated for all cases discharged during the month of February 2017; pre BPT launch, and at the end of the observation period (June 2018), after the BPT had been introduced. The proportion of hospital discharges where the clinical process standard was met were measured. Results Data on 98,506 COPD hospital admissions were entered by 186 hospitals over the 17 months. 4797 cases were discharged in February 2017 and 2804 in June 2018. There were improvements in compliance with all the clinical process standards measured (table 1). Conclusions Clinical process standards linked to the BPT demonstrated a much larger degree of improvement than those not linked to the tariff. Evidence from previous studies suggests that improvement linked to financial incentives may not be sustained in the long term. Further monitoring will be required to determine if this has been a useful improvement tool for COPD care. (Figure Presented) .

29. Developing a public benchmarking table aligned with national audit quality improvement priorities in pulmonary rehabilitation

Authors Mortier K.; McMillan V.; Holzhauer-Barrie J.; Lowe D.; Roberts C.M.; Steiner M.
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Available at Thorax 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 National COPD Audit Programme conducted an audit aiming to capture all patients enrolled on to a pulmonary rehabilitation (PR) course between 3 January and 31 March 2017 in England and Wales. Alongside this an audit of the resources and organisation of PR services was conducted in England and Wales between 3 January and 28 April 2017. Public benchmarking was developed in order to summarise each service's performance against its peers, in order to identify areas of focus for quality improvement activities. Methods In order to create a meaningful benchmarking table six key indicators were identified and categorised into process and outcome performance indicators. These indicators were selected as they were objective and easily recordable, mapped to accepted quality standards and discriminatory in the audit cycle. Results 7476 patients (79% of those eligible) were included in the clinical audit submitted from 184 services. 187 (96%) services participated in the organisational audit. Services results for the six key indicators were split according to the national median. An additional column was added referring to case ascertainment for PR services derived from the total number of cases submitted by services to the clinical audit divided by the number of eligible patients reported by services in the organisational audit. Each of the quartiles both above and below the median were colour coded to assist in identifying their performance nationally compared to their peers. This enabled services at a glance to identify areas of focus that required improvement. Conclusion The benchmarking of results is a clear and efficient way to show both variations and similarities across services. Using the three main colours services are able to quickly identify both best performance and gaps in processes. Benchmarking can help to set performance expectations enable a culture of continuous improvement.

30. Which factors predict early discontinuation of antifibrotics in idiopathic pulmonary fibrosis?

Authors Bhomra P.S.; Burge G.A.; Turner A.M.; Burge P.S.; Walters G.I.
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Available at Thorax 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 UK guidelines recommend pirfenidone and nintedanib as antifibrotic therapy in idiopathic pulmonary fibrosis (IPF); both are effective in slowing disease progression. Randomised controlled trials have shown discontinuation rates of 14%-33% due to adverse events (including side-effects, disease progression and death); clinical audit in our regional centre for IPF showed a rate of 18.4%. We aimed to establish the main clinical, diagnostic and social factors, which predict early discontinuation of antifibrotic therapy using a mixed methodology approach. Methods We collected data on 170 patients with MDT-diagnosed IPF (2012-16) prescribed either pirfenidone (n=139) or nintedanib (n=31). Retrospective data was collected from electronic records and telephone interviews. Data included demographics, social factors (eg. access to social support, distance from hospital, socio-economic status and level of education), diagnostic tests (HRCT result, pulmonary function tests, broncheoalveolar lavage and biopsy results), which antifibrotic was prescribed, treatment duration and side-effects. We undertook focus groups and patient interviews, which were analysed thematically. Results Commonest side-effects were nausea and vomiting (50%) and appetite loss (40%; pirfenidone) and diarrhoea (79%) and weight loss (25%; nintedanib). Factors associated with early discontinuation at 30 days on univariate analysis included age >=60 (p=0.03), female gender (p=<=0.001), DLCO<=40% at diagnosis (p=0.001), gastrointestinal (p=0.007) and skin side-effects (p=0.004), with similar results at 90 days. In multivariate analysis, DLCO<=40% at diagnosis (OR=2.44) showed increased risk of early discontinuation at 30 days, with male gender (OR=0.39) and skin side-effects (OR=0.09) both associated with reduced risk. At 90 days, systemic side effects (OR=2.50) increased the risk of early discontinuation, whereas male gender (OR=0.39) and gastrointestinal side effects (OR=0.42) reduced the risk. Thematic analysis of interview scripts suggested side-effects were tolerable with support, and social factors (eg. distance to hospital, barriers to travel) were not considered barriers by patients. Conclusion Age, female gender and DL_{CO}<=40% at diagnosis were strong predictors of early discontinuation, when compared with social factors and side-effects. Given low DLCO has previously been shown to predict increased mortality, it follows that progressive disease would increase the risk of early discontinuation. Side effects were usually manageable, in keeping with previously reported trial outcomes.

31. Mortality following assessment for pulmonary rehabilitation (PR) in patients with COPD: A preliminary analysis from the 2015 national COPD: Pr audit

Authors Evans R.A.; Greening N.J.; Steiner M.C.; Lowe D.; McMillan V.; Blakey J.; Beckford K.; Bolton C.E.; Elkin S.; Man W.D.C.; Sewell L.; Singh S.J.; Walker P.; Roberts M.C.
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Available at Thorax 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 The recent National COPD Audit: Pulmonary Rehabilitation (PR) report1 indicated completion of PR was associated with a survival advantage at 180 days. We investigated whether this was related to the effects of PR or to confounding due to differences in case-mix severity. Methods PR services across England and Wales provided data for all consenting patients assessed for PR between Jan and April 2015. Mortality data were extracted from the Office for National Statistics (ONS) from Jan 2015 - Jan 2017. Time to event analysis was performed until Jan 2017 using Cox proportional hazards model adjusted for baseline gender, age [yr], FEV1 [L], Body Mass Index (BMI) category, MRC dyspnoea grade, smoking status, presence of co-morbidities and Incremental Shuttle Walk distance (ISWT) [m]. Results 1755 patients had complete datasets for all components of the model: 53% male, mean [SD] age 69 [9] yrs, FEV11.38 [0.59] L, median BMI category 'overweight', MRC 1: 2%, 2: 21%, 3: 38%, 4: 32%, 5: 7%, 7% never smokers, 71% ex-smokers, 22% current smokers, 92% other co-morbidity, ISWT 212 (135) m. n=67 patients who likely died before completion of PR were removed (date of death Jan - May 2015). The unadjusted mortality rate was 7.2% for those who completed PR vs 7.8% for those who did not, p=0.74 [figure 1]. Completion of PR was not significantly associated with mortality after adjustment, HR (95% CI) 1.03 (0.69 to 1.05, p=0.88) whereas older age 1.03 (1.01 to 1.05, p=0.008), male gender 1.87 (1.30 to 2.70, p=0.001), higher FEV10.69 (0.48 to 0.98, p=0.04), higher BMI category 0.72 (0.62 to 0.92, p<0.001), higher ISWT distance 0.99 (0.995 to 0.997, p<0.001) were all prognostic indicators in the final model. Conclusion Cumulative mortality following PR is not significantly different between completers and non-completers after adjustment for baseline case-mix severity. However, exercise performance remains a modifiable prognostic indicator. (Figure Presented) .

32. Scale up of a multi-strategic intervention to increase implementation of a school healthy canteen policy: findings of an intervention trial

Authors Reilly K.L.; Nathan N.; Wiggers J.; Yoong S.L.; Wolfenden L.
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Abstract BACKGROUND: Implementation interventions delivered in schools to improve food provision have been found to improve student diet and reduce child obesity risk. If the health benefits of food availability policies are to be realised, interventions that are effective need to be implemented at scale, across an entire population of schools. This study aims to assess the potential effectiveness of an intervention in increasing the implementation, at scale, of a healthy canteen policy by Australian primary schools.
METHOD(S): A non-controlled before and after study was conducted in primary schools located in the Hunter New England region of New South Wales, Australia. Schools received a multi-component intervention adapted from a previous efficacious and cost-effective randomised control trial. The primary trial outcome was the proportion of canteen menus compliant with the state healthy canteen policy, assessed via menu audit at baseline and follow-up by dietitians. Secondary outcomes included policy reach and adoption and maintenance policy implementation.
RESULT(S): Of the 173 schools eligible for inclusion in the trial, 168 provided menus at baseline and 157 menus were collected at follow-up. At follow-up, multiple imputation analysis found 35% (55/157) of schools compared to 17% (29/168) at baseline (OR=2.8 (1.6-4.7), p=<0.001) had menus compliant with the state healthy canteen policy. As an assessment of the impact of the intervention on policy reach, canteen manager and principal knowledge of the policy increased from 64% (n=76) and 38% (n=44) respectively at baseline to 69% (n=89) and 60% (n=70) at follow-up (p=0.393, p=0.026). Adoption of the policy increased from 80% (n=93) at baseline to 90% (n=104) at follow-up (p=0.005) for principals, and from 86% (n=105) to 96% (n=124) (p=0.0001) for canteen managers. Multiple imputation analysis showed intervention effects were maintained six-months post intervention (33% of menus compliant OR=2.6 (1.5-4.5), p=<0.001 compared to baseline).
CONCLUSION(S): This study found school canteen compliance with a healthy food policy increased in association with a multi-strategy intervention delivered at scale. The study provides evidence for public health policy makers and practitioners regarding strategies and modes of support required to support improvement in nutrition policy implementation across entire populations of schools.

33. 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.
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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.

34. Refeeding syndrome in adults receiving total parenteral nutrition: An audit of practice at a tertiary UK centre

Authors Pantoja F.; Fragkos K.C.; Patel P.S.; Keane N.; Samaan M.A.; Barnova I.; Di Caro S.; Mehta S.J.; Rahman F.
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Abstract Background & aims: The key to preventing refeeding syndrome (RS) is identifying and appropriately managing patients at risk. We evaluated our clinical management of RS risk in patients starting total parenteral nutrition (TPN).
Method(s): Patients commencing TPN at University College London Hospital between January and July 2015 were prospectively followed-up for 7-days. Eighty patients were risk assessed for RS and categorized into risk groups. High and low risk RS groups were compared focussing on the onset of biochemical features of RS (hypophosphatemia, hypokalaemia and hypomagnesemia) and initial clinical assessment. Statistical analysis was conducted using t-tests and Mann-Whitney U tests.
Result(s): Sixty patients (75%) were identified as high-risk for RS and received lower initial calories (12.8 kcal/kg/day, $p < 0.05$). All high-risk patients received a high potency vitamin preparation compared to 35% in the low risk group ($p < 0.05$). Daily phosphate, magnesium and potassium plasma levels were monitored for seven days in 25%, 30% and 53.8% of patients, respectively. Hypophosphatemia developed in 30% and hypomagnesaemia and hypokalaemia in 27.5% of all patients. Approximately 84% of patients had one or more electrolyte abnormalities, which occurred more frequently in high-risk RS patients ($p < 0.05$). Low risk patients developed mild hypophosphatemia at a much lower percentage than high-risk RS (20% vs 33.3%, respectively).
Conclusion(s): A significant proportion of patients commencing TPN developed biochemical features of RS (but no more serious complications) despite nutritional assessment, treatment, and follow up in accordance with national recommendations. High vs low risk RS patients were more likely to have electrolyte abnormalities after receiving TPN regardless of preventative measures. Additional research is required to further optimise the initial nutritional approach to prevent RS in high-risk patients.

35. Current imaging practice for suspected scaphoid fracture in patients with normal initial radiographs: UK-wide national audit

Authors Chunara M.H.; McLeavy C.M.; Kesavanarayanan V.; Ganguly A.; Paton D.
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Abstract AIM: To assess the current practice of scaphoid fracture imaging (where initial scaphoid radiographs are normal) in the UK. MATERIALS AND METHODS: A survey monkey questionnaire was sent to 140 eligible NHS trusts derived from the NHS England database following exclusion of all non-acute and specialist centres. Four questions were asked regarding the provision of magnetic resonance imaging (MRI) for radiographically occult scaphoid fractures, time to MRI, number of departmental MRI scanners, and alternative imaging offered.
RESULT(S): Responses were received from 74 trusts (53%). Thirty-eight offered MRI as a first-line test in plain-film occult scaphoid injury, 25 preferred computed tomography (CT), and 11 opted for repeat plain radiographs. Of the 38 trusts who offered MRI, 26 provided this within 1 week; the rest within 2 weeks. No trends were identified based on the size of the hospital or its geographical location. Statistical analysis of the data revealed no significant relationship between the number of MRI scanners and the provision of MRI, nor between the numbers of MRI scanners and the time to MRI.
CONCLUSION(S): MRI has been recognised in the literature as a highly specific, highly sensitive, and cost-effective tool, yet only 51% of trusts provide this service in the UK. For those who cannot offer MRI first-line, CT remains a very accurate and reliable alternative.

36. Antimicrobial resistance patterns of urine culture specimens from 27 nursing homes: Impact of a two-year antimicrobial stewardship intervention

Authors Tandan M.; Vellinga A.; Sloane P.D.; Kistler C.E.; Ward K.; Zimmerman S.; Weber D.J.
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Abstract Objective:Identify changes in the prevalence and antimicrobial resistance patterns of potentially pathogenic bacteria in urine cultures during a 2-year antimicrobial stewardship intervention program in nursing homes (NHs).
Design(s):Before-and-after intervention study.
Setting(s):The study included 27 NHs in North Carolina.
Method(s):We audited all urine cultures ordered before and during an antimicrobial stewardship intervention. Analyses compared culture rates, culture positive rates, and pathogen antimicrobial resistance patterns.
Result(s):Of 6,718 total urine cultures collected, 68% were positive for potentially pathogenic bacteria. During the intervention, significant reductions in the urine culture and positive culture rates were observed (P =.014). Most of the identified potentially uropathogenic isolates were Escherichia coli (38%), Proteus spp (13%), and Klebsiella pneumoniae (12%). A significant decrease was observed during the intervention period in nitrofurantoin resistance among E. coli (P <=.001) and ciprofloxacin resistance among Proteus spp (P <=.001); however carbapenem resistance increased for Proteus spp (P <=.001). Multidrug resistance also increased for Proteus spp compared to the baseline. The high baseline resistance of E. coli to the commonly prescribed antimicrobials ciprofloxacin and trimethoprim-sulfamethoxazole (TMP/SMX) did not change during the intervention.
Conclusion(s):The antimicrobial stewardship intervention program significantly reduced urine culture and culture-positive rates. Overall, very high proportions of antimicrobial resistance were observed among common pathogens; however, antimicrobial resistance trended downward but reductions were too small and scattered to conclude that the intervention significantly changed antimicrobial resistance. Longer intervention periods may be needed to effect change in resistance patterns.

37. Measurement of lying and standing blood pressure in hospital

Authors O'Riordan S.; Vasilakis N.; Schoo R.; Martin F.; Hussain L.; Whitney J.; Windsor J.; Horton K.
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Available at Nursing older people from Unpaywall

Abstract Measuring lying and standing blood pressure (BP) is an important clinical observation in older hospital inpatients. This is because a drop in BP on standing, known as orthostatic hypotension (OH) is common in older people and in acute illness and, therefore, in hospital patients. OH increases the risk of a fall in hospital. Simple measures such as changes in medication or rehydration can reduce this drop in BP and reduce the risk of falls. In a recent snapshot audit in England and Wales of 179 acute hospitals and 4,846 patients aged 65 years and over admitted with an acute illness, only 16% had a lying and standing BP recorded within 48 hours. A review of the literature showed that existing advice on how to measure and interpret lying and standing BP was often not appropriate for use on the ward with frail and unwell inpatients. An online survey of 275 clinicians' usual practice highlighted variation and the need for clarity and pragmatism. In the light of the survey findings, a clinical guide has been developed on when to measure lying and standing BP, how to measure it and what is considered a significant result.

38. British Cardiovascular Intervention Society registry framework: a quality improvement initiative on behalf of the National Institute of Cardiovascular Outcomes Research (NICOR)

Authors Rashid M.; Mamas M.A.; Ludman P.F.
Source European heart journal. Quality of care & clinical outcomes; May 2019
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Database EMBASE
Abstract AIMS: The British Cardiovascular Intervention Society (BCIS) percutaneous coronary intervention (PCI) registry is hosted by the National Institute of Cardiovascular Outcomes Research (NICOR) at Bart's Heart Centre and collects clinical characteristics, indications, procedural details and outcomes of all patients undergoing PCI in the United Kingdom. The data are used for audit and research to monitor and improve PCI practices and patient outcomes. INTERVENTIONS: Bespoke live data analysis and structured monthly reports are used to provide real time feedback to all participating hospitals about the provision of care. Risk-adjusted analyses are used as a quality metric and benchmarking PCI practices. POPULATIODN & SETTINGS: Consecutive patients undergoing PCI in all PCI performing hospitals in the UK. YEARS: From 1994 to present. BASELINE DATA: 113 variables encompassing patient demographics, indication, procedural details, complications and in-hospital outcomes are recorded. DATA CAPTURE: Prospective data is collected electronically and encrypted before transfer to central database servers. DATA QUALITY: Data is validated locally and further range checks, sense checks and assessments of internal consistency are applied during data uploads. Analyses of uploaded data including an assessment of data completeness are provided to all hospitals for validation, with repeat validation rounds prior to public reporting. ENDPOINTS: In-hospital PCI complications, bleeding and mortality. All-cause mortality is obtained via linkage to the Office of National Statistics. No other linkages are available at present. DATA ACCESS: Available for research by application to NICOR at http://www.nicor.org.uk/ using a data sharing agreement.

39. UK trainee-led paediatric governance collaboratives: Improving the lives of both trainees and children

Authors McDermott H.; Vawda H.; Harvey K.C.; Kirk J.; Lloyd S.; Course C.W.; Broomfield R.; Greenwood A.; Mason T.
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Abstract Research is vital to paediatrics; however, many trainees feel there is a deficit in their opportunities, experience and exposure in this area. Three training regions in the UK, the West Midlands, Wales and Peninsula, have recently started region-wide, trainee-led research and governance collaboratives aimed at improving trainee access and education in research, undertaking good quality, multicentre audit, quality improvement and pilot projects in collaboration across the regions and implementing change. We report on the experiences, benefits and challenges of these trainee collaboratives (Paediatric Research Across the Midlands, Wales Research and Education Network and Peninsula Trainee Research Audit and Innovation Network) including a trainee survey looking at how these initiatives have improved skills in conducting multicentre prospective studies, team working skills, leadership, understanding of statistics and manuscripts and presentation skills. We also describe how collaboration with colleagues and participation in projects can benefit trainees in a wider sense of purpose and help to encourage morale, as well as what can be learnt as paediatric training moves forward.

40. Examining the pathophysiology of short bowel syndrome and glucagon-like peptide 2 analogue suitability in chronic intestinal failure: experience from a national intestinal failure unit

Authors Bond A.; Taylor M.; Abraham A.; Teubner A.; Soop M.; Carlson G.; Lal S.
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Abstract Introduction: Short bowel syndrome (SBS) is a leading cause of intestinal failure (IF). Home parenteral nutrition (HPN) remains the standard treatment, with small intestinal transplantation reserved for cases with severe complications to HPN. There have recently been significant developments in growth factor therapy. We aimed to develop a greater contemporary understanding of our SBS-IF subset.
Method(s): We performed a retrospective observational study of a prospectively maintained HPN audit database in October 2017. Intestinal anatomical details and parenteral requirements were recorded. Each case was assessed for eligibility for growth factor therapy using recently published trials.
Result(s): Of 273 patients receiving HPN, 152 (55.7%) had type three IF as a result of SBS (SBS-IF), with a mean duration of HPN of 61 months (range 4-416). Mean length of small intestine was 98 cm. Furthermore, 114 (41.8%) patients had an end jejunostomy (SBS-J), 18 (6.6%) had an end ileostomy, and 7.3% of patients had all or part of the colon-in-continuity. Crohn's disease was the most common underlying pathology. Univariate analysis for the whole HPN cohort demonstrated SBS-IF and a longer duration of HPN to be associated with higher PN energy requirements, p <= 0.0001. Of all, 73 (48%) patients with SBS-IF were deemed suitable for GLP-2 analogue therapy, with co-morbidity being the most frequent cause of non-suitability (29.1%).
Conclusion(s): We describe a large U.K. HPN cohort using ESPEN pathophysiological and clinical severity classification. The majority of patients with SBS-IF had a jejunostomy and relatively few had colon-in-continuity. Co-morbidity is the most common contra-indication to GLP-2 analogue therapy. Clinical relevancy: GLP-2 analogues are emerging as an important treatment for patients with short bowel syndrome. Our study explores patient suitability in a large HPN cohort managed in a national IF centre. Furthermore, the international variation in the pathophysiology of SBS-IF varies significantly, which can have a bearing on PN requirements and outcomes when GLP-2 analogues are used.

41. Clinical practice guideline monitoring children and young people with, or at risk of developing autosomal dominant polycystic kidney disease (ADPKD)

Authors Dudley J.; Winyard P.; Marlais M.; Gale D.P.; Cuthell O.; Harris T.; Chong J.; Sayer J.; Burrows S.; Sandford R.; Moore L.; Turner K.
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Abstract Autosomal Dominant Polycystic Kidney Disease (ADPKD) is thought to affect about 1 in 1000 people in the UK. ADPKD causes a progressive decline in kidney function, with kidney failure tending to occur in middle age. Children and young people with ADPKD may not have any symptoms. However they may have high blood pressure, which may accelerate progression to later stages of chronic kidney disease. There is uncertainty and variation in how health professionals manage children and young people with confirmed or a family history of ADPKD, because of a lack of evidence. For example, health professionals may be unsure about when to test children's blood pressure and how often to monitor it in the hospital clinic or at the GP. They may have different approaches in recommending scanning or genetic testing for ADPKD in childhood, with some recommending waiting until the young person is mature enough to make this decision his or herself. This guideline is intended to help families affected by ADPKD by making sure that: health professionals with specialist knowledge in ADPKD offer you information on inheritance and potential benefits and harms of testing for ADPKD. the decision to test and the method of testing for ADPKD in children and young people is shared between you or your family and the health professionals blood pressure assessment is undertaken regularly in children and young people at risk of developing ADPKD

42. Sentinel node biopsy for malignant melanoma: Our experience using a modifed eortc protocol

Authors Ligory C.; Low S.E.; Sharma N.
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Abstract Malignant melanoma is the 6th most common cancer in the UK with aggressive biological behaviour in a signifcant number of cases. Sentinel lymph node biopsy (SLNB) is a very strong prognostic determinant in melanoma. Our hospital was chosen as the designated hub for melanoma SLNBs for a regional network in 2009. The evidence base for the SLNB EORTC protocol is one of the strongest currently available and currently UK trials incorporating SLNB are likely to be European Organisation for Research and Treatment of Cancer (EORTC) based. Alternative protocols are also acceptable outwith EORTC clinical trials provided there is evidence of a detection rate equivalent to that of the EORTC protocol of at least 25%. The EORTC protocol involves a combination of H&Es with multiple levels and immunohistochemistry (6 pairs of sections for H&E and S100 with 8 spares). We fnalised a modifed version in 2017 after various audits-5 pairs of sections for H&E and Melan A with an S100 at L2. Present auditing has shown there has been a very signifcant improvement in the positive detection rates in SLNB to 27%. This is in accordance with the stated desired positive detection rate required to prove equivalence with the full EORTC protocol.

43. Axillary node fine needle aspiration cytology in nhsbsp-is it a useful adjunct? correlation with histology and outcomes

Authors Bhagwat P.; Riley C.
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Abstract Breast cancer patients in the NHS Breast Screening Programme (NHSBSP) are subjected to fne needle aspiration (FNA) of suspicious lymph nodes found by ultrasound. This is typically performed by Radiologists as per guidelines in the NHSBSP. We wanted to look at the sensitivity, specifcity and positive predictive value of cytology by looking at the fnal histology of the nodes and clinical outcomes, especially focusing on the inadequate samples. To do this, we retrieved all the axillary aspirate samples in one year (from April 2017 to March 2018) and looked at the fnal outcomes. We had 115 samples, of which 16 were inadequate, 65 reactive, 4 suspicious for malignancy and 30 showed metastatic carcinoma. Final histology was available for 68/115 patients. Of these, 31 had metastatic involvement (9 cases only showed chemotherapy efect, complete response) and 37 were reactive on histology. The sensitivity was 80.56% and specifcity was 100%. The positive predictive value was calculated at 81%. These values compare favourably with the existing literature. In the 16 cases that were non-diagnostic on cytology, a possibility of human error and equipment was raised, as most cases had the same operator. An interesting feature was 9 cases of positive cytology, which had neoadjuvant chemotherapy in the interval between FNA and surgery which were negative on histology. Complete response was noted on histology, which raised an interesting question for our analysis-should these be classifed as negative or positive on histology? This potentially confounds statistical analysis. As there was clear indication of therapy efect, we decided to keep them in the metastatic involvement category. In summary, our study shows that axillary FNA is a useful adjunct with good sensitivity and excellent specifcity. Regular cytology-histology correlation is helpful to audit FNA processes. Neo-adjuvant chemotherapy can raise difculties for analysis of cyto-histo correlation.

44. EROSS: Enhanced recovery for obstetric surgery in Scotland, compliance and outcomes

Authors Clark A.; Litchfield K.; McDonald D.; Sparks L.; Perkins N.
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Abstract Objectives: To assess the impact of a national enhanced recovery for planned caesarean delivery by assessing pathway compliance and length of hospital stay. In 2011, the National Institute for Health and Care Excellence suggested mothers who are recovering well following caesarean section should be offered discharge after 24 hours.[1] In 2015, prior to the start of EROSS, less than five percent of mothers returned home on the day following surgery in Scotland.[2] Methods: A national network was inaugurated to facilitate improvement of recovery for all families following elective caesarean sections in Scotland. Thirteen hospitals across all of Scotland's mainland health boards combined to deliver a standardised national pathway. This included a novel multidisciplinary (midwifery, anaesthetic and physiotherapy)preparation class, to deliver high quality preoperative education and engage expectant families in their anticipated recovery and a perioperative care bundle, incorporating: early return to oral diet; prompt discontinuation of intravenous fluids, early mobilisation; and timely removal of urinary catheter. Data were collected for all elective caesarean sections and made available through a national dashboard to guide quality improvement and assess impact.
Result(s): 5,504 cases were reviewed. National hospital length of stay fell from an average of 2.22 to 2.05 days and the percentage of day one discharges rose from 24.3 to 34.8 ($p < 0.001$)comparing the last financial quarter of 2017 and 2018. Bundle compliance was associated with length of hospital stay (see table), $p < 0.05$ by Kruskal-Wallis test. [Figure presented]Conclusion: Delivering the whole bundle of care has a significant impact on patient length of stay. However, only 13.2% of mothers currently achieve all five bundle elements. The EROSS working group are making efforts to improve bundle compliance across Scotland through shared learning and use of this data. References 1. Information Services Division. Births in Scottish Hospitals. Year ending 31st March 2015. Publication date-26th August 2015. 2. Gholitabar M, Ullman R, James D, Griffiths M. GUIDELINES: Caesarean section: summary of updated NICE guidance. BMJ: British Medical Journal. 2011 Nov 26;343(7833):1111-4. Disclosure of Interest: None declared.

45. Adoption of a proven quality improvement bundle for eras in emergency general surgery in a us healthcare system

Authors Rothstein W.B.; Navarrete S.; Goldberg S.; Scott M.; Peden C.; Quiney N.
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Database EMBASE
Abstract Objectives: Emergency general surgery (EGS)is a major source of morbidity and mortality in the United States. EGS patients account for 50% of surgical mortality, and care expenditures in this population are expected to exceed $40 billion by 2040. The US has no nationally recommended EGS care bundle, with highly variable outcomes between hospitals. The UK ELPQuic study used an evidence based bundle to significantly reduce mortality. We sought to implement such a bundle at an academic US healthcare system.
Method(s): We did a current state analysis of all components of EGS care in reference to the ELPQuic bundle. We obtained the approval of key stakeholders, including Emergency Medicine, Radiology, Anesthesiology, Surgery, Critical Care, and nursing. A comprehensive fluid and hemodynamic management framework was introduced to begin on patient presentation to the Emergency Department and continue through ICU management. All key bundle elements were integrated into a powerplan within our health system's electronic medical record to facilitate implementation.
Result(s): After implementation, time to delivery of antibiotics decreased from over 2 hours to under 1. Operating room policies changed to ensure time to surgery in under 2 hours. Comprehensive management of fluid and hemodynamics, including early initiation of vasopressors and goal-directed fluid therapy, became standard of care where there had previously been no standardization. Several differences between UK and US process measures were noted. In the UK, barriers to optimal care included time to CT scanning and time to consultation, whereas US barriers consisted of time to antibiotic therapy and absence of standardized fluid management.
Conclusion(s): Our efforts demonstrated that an evidence based quality improvement bundle in the model of ELPQuic can be implemented in a US healthcare system with good compliance. Different challenges exist between healthcare systems. In the US, heavy use of electronic medical records requires a robust engagement with information technology solutions. US emergency department infrastructure and the presence of dedicated emergency general surgeons facilitated rapid assessment of patients, but adoption of a comprehensive fluid and hemodynamic strategy lags behind the UK. Disclosure of Interest: W. Rothstein: None declared, S. Navarrete: None declared, S. Goldberg: None declared, C. Peden: None declared, N. Quiney: None declared, M. Scott Consultant for: Edwards Lifesciences, Deltex Medical, Other: Executive Board Member ERAS Society.

46. Prehabilitation in the UK: Outcomes of a national survey

Authors Carter F.; Davies J.; Barlow R.; Francis N.; McDonald D.; Grocott M.
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Publication Type(s) Conference Abstract

Database EMBASE
Abstract Objectives: Prehabilitation is a collection of measures that aim to optimise a patient's physical and psychological wellbeing before treatment. This survey, run on behalf of the Enhanced Recovery after Surgery Society (UK), aimed to map the current status of prehabilitation.
Method(s): An online survey was designed to capture the current status of prehabilitation and shared through ERAS UK and Macmillan Cancer Support. Responses were anonymous, with each participant asked for their job role and place of work. Skip logic was used to interrogate difference perspectives, dependent on the current level of prehabilitation experience. Questions covered the different elements of prehabilitation, compliance, outcomes measures and barriers to adoption. The survey was available online (via SurveyMonkey TM)between 5.10.18 and 18.12.18.
Result(s): 232 complete responses were received (England 101; Northern Ireland 6; Scotland 21; Wales 96). Prehabilitation is routinely offered by 46.1% of respondents, however only 7.7% have wide implementation. Over half of respondents who routinely offer prehabilitation have more than 12months experience, but 55% of this group could not identify a specific person as the lead for their programme. This care package is most commonly offered to surgical patients (68.8%)but also offered with neoadjuvant oncology treatment (22.9%)and palliative care (9.2%). The care package includes the following elements: structured physical exercise programme (49.5%), nutritional optimisation (49.5%), psychological support (33%), support for smoking cessation (49.5%), support for alcohol cessation (28.4%), management of anaemia (34.9%), cardiopulmonary exercise testing (39.4%). Only seven respondents indicated that their programme offers all of these elements. Few centres undertake data collection and audit of these programmes (20.2%)with a very wide variety of outcome measured used. The most common reported challenges are lack of funding (28.4%), no consensus between colleagues (13.8%)and insufficient time in the preoperative period (10.1%).
Conclusion(s): This survey provides a snapshot of the provision of prehabilitation in the UK, which is far from widespread. Whilst providing additional funding could overcome some of the barriers to adoption of prehabilitation, it will be equally important to audit outcomes in order to increase consensus on the benefits of prehabilitation. Disclosure of Interest: None declared

47. Key factors to achieving International Organization for Standardisation (ISO)22870 accreditation with a broad point-of-care-testing (POCT)program

Authors Miller M.; Patel D.; Hobman R.
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Available at Clinica Chimica Acta 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-aim: When the Biochemistry department on the Wythenshawe site of Manchester University NHS Foundation Trust first achieved ISO 15189 laboratory accreditation in 2016, this was a big step towards extending the standards to our POCT program. Wythenshawe achieved 22870 accreditation in September 2018, making the department only the second NHS trust to be awarded POCT accreditation in the UK. Based on interest from peer institutions, we propose a roadmap for achieving ISO 22870, using our blood gas testing program as an example.
Method(s): Wythenshawe is a 900-bed teaching hospital providing acute care services to adult and paediatric patients. POCT service includes more than 300 devices-29 blood gas analysers, 180 hand-held glucose, ketone, tHb and chemistry devices- equating over 2million individual patient tests each year. Achieving ISO 22870 involved the efforts of the POCT team, clinical teams, learning and development, the main laboratory and our supplier partners to establish: e-learning, a Quality Management System (QMS), define Key Performance Indicators (KPI), and audit for improvement opportunities. The blood gas testing service at Wythenshawe includes 29 GEM PremierTM 5000 with iQM2 (Instrumentation Laboratory)analysers interfaced into GEMweb Plus which is a key element to the POCT program.
Result(s): The efforts performed for the blood gas testing can be used as a model for other institutions to achieve ISO 22870: 1. Build e-learning program - standardised analyser platform with Operator Competency modules in GEMweb Plus 2. Establish standardised documentation within the QMS system - Maintenance-free analysers simplify staff-time, documentation and elevate quality 3. Identify KPIs for POCT dashboard - built-in KPIs and iQM2 risk-management features facilitate monitoring for continuous improvement 4. Set up monitoring process - sample handling reports in GEMweb Plus enable monitoring for operator training
Conclusion(s): Seeking accreditation aligns with the Wythenshawe objectives to grow our clinical expertise and expand our research programs. Being awarded ISO 22870 validated the quality of our comprehensive POCT service. The built-in features of the GEM Premier 5000 with iQM2 and GEMweb Plus not only facilitated ISO quality requirements automatically, but also helped free up POCT staff to focus on the broader framework of the overall accreditation program.

48. Mortality for emergency laparotomy is not affected by the weekend effect: a multicentre study

Authors Nageswaran H.; Davies M.; Jones H.; Evans M.; Rajalingam V.; Sharma A.; Joseph A.O.
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Available at Annals of the Royal College of Surgeons of England 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 'weekend effect' describes variation in outcomes of patients treated over the weekend compared with those treated during weekdays. This study examines whether a weekend effect exists for patients who undergo emergency laparotomy. MATERIALS AND METHODS: Data entered into the National Emergency Laparotomy Audit between 2014 and 2017 at four NHS trusts in England and Wales were analysed. Patients were grouped into those admitted on weekdays and those on weekends (Friday 5pm to Monday 8am). Patient factors, markers of quality of care and patient outcomes were compared. Secondary analysis was performed according to the day of surgery.
RESULT(S): After exclusion of patients who underwent laparotomy more than one week after admission to hospital, a total of 1717 patients (1138 patients admitted on weekdays and 579 admitted on weekends) were analysed. Age, preoperative lactate and P-POSSUM scores were not significantly different between the two groups. Time from admission to consultant review, decision to operate, commencement of antibiotics and theatre were not significantly different. Grades of operating surgeon were also similar in both groups. Inpatient 60-day mortality was 12.5% on weekdays and 12.8% on weekends (P = 0.878). Median length of postoperative stay was 12 days in both groups. When analysed according to day of surgery, only number of hours from admission to antibiotics (12.8 weekday vs 9.4 weekend, P = 0.046) and number of hours to theatre (26.5 weekday vs 24.1 hours weekend, P = 0.020) were significantly different. DISCUSSION: Quality of care and clinical outcomes for patients undergoing emergency laparotomy during the weekend are not significantly different to those carried out during weekdays.

49. Making an IMPACT: A priority setting consultation exercise to improve outcomes in patients with locally advanced, recurrent and metastatic colorectal cancer

Authors Vallance A.E.; Harji D.; Fearnhead N.S.; Acheson A.; Maxwell-Armstrong C.; Simpson A.; Adams K.; Adams R.; Alsina D.; Antoniou A.; Clark S.; Jenkins J.; Taylor C.; Arnott R.; Rowbottom P.; Bach S.; Bedford M.; McArthur D.; Battersby N.; Beggs A.; Belcher E.; Boulstridge L.; Boyle K.; Bradbury J.; Braun M.; Brown E.; Brown G.; Burling D.; Cameron I.; Campbell K.; Polignano F.; Carney K.; Coyne P.; Griffiths B.; Cecil T.; Mohamed F.; Moran B.; Welsh F.; Chapman M.; Chapman S.; Sagar P.; Seligmann J.; Tiernan J.; Toogood G.; Chong P.; Crane S.; Daniels I.; McDermott F.; Davies J.; McDermott U.; Wheeler J.; Whitley S.; Davies L.; Hargest R.; Kumar N.; Powell C.; Davies M.; Evans M.; Dawson C.; Norris C.; Dawson P.; Duff M.; Demick A.; Elavia K.; Gardner R.; Fenwick S.; Galbraith S.; Good J.; Gilbert D.; Hill J.; Hompes R.; Huguet E.; Kapur S.; Karandikar S.; Youssef H.; Katte C.; Langman G.; Lim M.; Lopes de Azevedo-Gilbert R.; Morris M.; Macdonald A.; Machesney M.; Mathur P.; Mirnezami A.; Mitchell P.; Murphy J.; Wasan H.; Nakas A.; O'Dwyer S.; Renehan A.; Wilson M.; Panagiotopoulou I.; Samuel L.; Shaikh I.; Skaife P.; Skarrot P.; Speake W.; Stearns A.; Stylianides N.A.; Sutton P.; Swarnkar K.; Tebala G.; Thorpe G.; Vimalchandran D.; Walker K.; Pellino G.; Walsh C.; Warren O.; Winter D.
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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 Aim: The IMPACT (Improving the Management of Patients with Advanced Colorectal Tumours) initiative was established by the Association of Coloproctology of Great Britain and Ireland in 2017 as a consortium of surgeons (colorectal, hepatobiliary, thoracic), oncologists, radiologists, pathologists, palliative care physicians, patients, carers and charity stakeholders who will work together to improve outcomes in patients with advanced and metastatic colorectal cancer. To establish this initiative, better information is required to establish how further intervention is focused. This paper details the approaches used, and outcomes generated, from a priority setting exercise to inform the design of the IMPACT initiative.
Method(s): A mixed method approach was employed to set the priorities of patients, clinicians and other key stakeholders in the delivery of optimal care. This consisted of two patient centered consultation events and a questionnaire.
Result(s): A total of 128 participants took part in the consultation exercise; 15 patients, 5 carers/family members, 5 charity representatives and 113 healthcare professionals. Nine key themes for focus were identified, these were: current service provision, specialist services, communication, education, access to care, definitions and standardisation, research and audit, outcome measures, and funding of specialist care.
Conclusion(s): These future priorities will be developed with collaborative engagement in a systematic manner to produce an overall cohesive programme which will deliver a sustainable and efficient clinical and academic service to improving the management of patients with advanced colorectal tumours.
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50. What are the barriers and challenges faced by adolescents when searching for sexual health information on the internet? Implications for policy and practice from a qualitative study

Authors Patterson S.P.; Hilton S.; Flowers P.; McDaid L.M.
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Abstract Objectives: As sexual health information is increasingly presented digitally, and adolescents are increasingly seeking sexual health information on the internet, it is important to explore the challenges presented by this developing source of information provision. This study examined the key barriers and challenges faced by young people when accessing and using sexual health information online.
Method(s): A novel qualitative approach was used which combined paired interviews with real-time online activities. A purposive sample of 49 young people aged between 16 and 19 years and diverse in terms of gender, sexuality, religion and socio-demographic background were recruited from areas across Scotland. Data analysis comprised framework analysis of conversational data (including pair interactions), descriptive analysis of observational data, and data integration.
Result(s): This study highlighted practical and socio-cultural barriers to engagement with online sexual health content. Key practical barriers included difficulty filtering overabundant content; limited awareness of specific, relevant, trusted online sources; difficulties in finding locally relevant information about services; and difficulties in navigating large organisations' websites. Key socio-cultural barriers included fear of being observed; wariness about engaging with visual and auditory content; concern about unintentionally accessing sexually explicit content; and reticence to access sexual health information on social networking platforms or through smartphone applications. These practical and socio-cultural barriers restricted access to information and influenced searching practices.
Conclusion(s): This study provides insights into some of the key barriers faced by young people in accessing and engaging with sexual health information and support online. Reducing such challenges is essential. We highlight the need for sexual health information providers and intervention developers to produce online information that is accurate and accessible; to increase awareness of and promote reliable, accessible sources; and to be sensitive to young people's concerns about 'being seen' accessing sexual health information regarding audio-visual content and platform choice.
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51. An organisational participatory research study of the feasibility of the behaviour change wheel to support clinical teams implementing new models of care

Authors Bull E.R.; Hart J.K.; Joseph S.; Byrne-Davis L.M.T.; Swift J.; Baxter K.; McLauchlan N.
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Abstract BACKGROUND: Health and social care organisations globally are moving towards prevention-focussed community-based, integrated care. The success of this depends on professionals changing practice behaviours. This study explored the feasibility of applying a behavioural science approach to help staff teams from health organisations overcome psychological barriers to change and implement new models of care.
METHOD(S): An Organisational Participatory Research study was conducted with health organisations from North West England, health psychologists and health workforce education commissioners. The Behaviour Change Wheel (BCW) was applied with teams of professionals seeking help to overcome barriers to practice change. A mixed-methods data collection strategy was planned, including qualitative stakeholder interview and focus groups to explore feasibility factors and quantitative pre-post questionnaires and audits measuring team practice and psychological change barriers. Qualitative data were analysed with thematic analysis; pre-post quantitative data were limited and thus analysed descriptively.
RESULT(S): Four clinical teams from paediatrics, midwifery, heart failure and older adult mental health specialties in four organisations enrolled, seeking help to move care to the community, deliver preventative healthcare tasks, or become more integrated. Eighty-one managers, medical doctors, nurses, physiotherapists, midwives and other professionals contributed data. Three teams successfully designed a BCW intervention; two implemented and evaluated this. Five feasibility themes emerged from the thematic analysis of qualitative data. Optimising the BCW in an organisational change context meant 1) qualitative over quantitative data collection, 2) making behavioural science attractive, 3) co-development and a behavioural focus, 4) effective ongoing communication and 5) support from engaged leaders. Pre-post quantitative data collected suggested some positive changes in staff practice behaviours and psychological determinants following the intervention.
CONCLUSION(S): Behavioural science approaches such as the BCW can be optimised to support teams within health and social care organisations implementing complex new models of care. The efficacy of this approach should now be trialled.

52. 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.

53. 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.
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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.

54. Severity and Outcome Assessment score: a useful tool for auditing orthognathic surgery

Authors Geddes A.; Laverick S.; McBride A.; McIntyre G.T.
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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.

55. Vitamin D and foot and ankle trauma: An individual or societal problem

Authors Ribbans W.J.; Aujla R.S.; Allen P.E.; Ashour R.; Wood E.V.
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Available at Foot 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: Vitamin D deficiency is a worldwide health concern. Hypovitaminosis D may adversely affect recovery from bone injury. The authors aimed to perform an audit of the Vitamin D status of patients in three centres in the United Kingdom presenting with foot and ankle osseous damage.
Method(s): Serum 25-hydroxyvitamin-D (vitamin D) levels were obtained in patients presenting with imaging confirmed foot and ankle osseous trauma. Variables including age, gender, ethnicity, location, season, month, anatomical location and type of bone injury were recorded.
Result(s): 308 patients were included from three different centres. 66.6% were female. The average age was 47.7 (range; 10-85). The mean hydroxyvitamin-D levels were 52.0 nmol/L (SD 28.5). 18.8% were grossly deficient, 23.7% deficient, 34.7% insufficient and 22.7% within normal range. 351 separate bone injuries were identified of which 104 were categorised as stress reactions, 134 as stress fractures, 105 as fractures and 8 non-unions. Age, gender, anatomical location and fracture type did not statistically affect vitamin D levels. Ethnicity did affect Vitamin D levels: non-Caucasians mean levels were 32.4 nmols/L compared to Caucasian levels of 53.2 nmol/L (p = 0.0026).
Conclusion(s): Only 18.8% of our trauma patients had a normal Vitamin D level and 22.7% were grossly deficient. Patient age, gender, anatomical location and injury type did not statistically affect vitamin D levels. No difference between trauma and elective patients were found. Hypovitaminosis D is a problem of society in general rather than specific to certain foot and ankle injury patterns or particular patient groups sustaining trauma.
Level of Evidence: 2b.

56. Pregnancy in prison, mental health and admission to prison mother and baby units

Authors Dolan R.; Edge D.; Shaw J.; Hann M.
Source Journal of Forensic Psychiatry and Psychology; May 2019; vol. 30 (no. 3); p. 448-466
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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.

57. Pilot Teledermatology Service for Assessing Solitary Skin Lesions in a Tertiary London Dermatology Center

Authors Cheung C.-M.M.; Muttardi K.; Chinthapalli S.; Ismail F.
Source Journal for Healthcare Quality; Jan 2019; vol. 41 (no. 1)
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Available at Journal for Healthcare Quality 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:Efficient clinical pathways are needed to meet the growing pressures in dermatology due to the significant rise in the number of suspected skin cancer referrals. Our hospital serves a wide geographical area and receives a large number of 2-week-wait (2WW) suspected skin cancer referrals. In the United Kingdom, approximately 10-12% of 2WW referrals are diagnosed as skin cancers fulfilling the 2WW criteria.
Purpose(s):We sought to assess the role of teledermatology in reducing hospital consultations for patients referred via the dermatology 2WW pathway.
Method(s):We piloted a teledermatology service and detailed the clinical outcomes of patients with solitary skin lesions of uncertain diagnosis triaged through this pathway. Seventy-six primary care referrals were reviewed by consultant dermatologists and analyzed against the British Association of Dermatologists' teledermatology audit standards.
Result(s):In 52/76 (68%) of patients, confident benign diagnoses were made, avoiding the need for a face-to-face (FTF) consultation.
Conclusion(s):Our results showed that with adequate image quality, teledermatology can be used to accurately diagnose skin lesions.Implications:Teledermatology can significantly reduce the number of urgent referrals necessitating FTF appointments, therefore providing a new solution to streamline care delivery.

58. Clipping aneurysms improves outcomes for patients undergoing coiling

Authors Anderson I.A.; Kailaya-Vasan A.; Tolias C.M.; Nelson R.J.
Source Journal of Neurosurgery; May 2019; vol. 130 (no. 5); p. 1491-1497
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Available at Journal of Neurosurgery 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 Most intracranial aneurysms are now treated by endovascular rather than by microsurgical procedures. There is evidence to demonstrate superior outcomes for patients with aneurysmal subarachnoid hemorrhage (aSAH) treated by endovascular techniques. However, some cases continue to require microsurgery. The authors have examined the relationship between the number of aneurysms treated by microsurgery and outcome for patients undergoing treatment for aSAH at neurosurgical centers in England. METHODS The Neurosurgical National Audit Programme (NNAP) database was used to identify aSAH cases and to provide associated 30-day mortality rates for each of the 24 neurosurgical centers in England. Data were compared for association by regression analysis using the Pearson product-moment correlation coefficient and any associations were tested for statistical significance using the one-way ANOVA test. The NNAP data were validated utilizing a second, independent registry: the British Neurovascular Group's (BNVG) National Subarachnoid Haemorrhage Database. RESULTS Increasing numbers of microsurgical cases in a center are associated with lower 30-day mortality rates for all patients treated for aSAH, irrespective of treatment modality (Pearson r = 0.42, p = 0.04), and for patients treated for aSAH by endovascular procedures (Pearson r = 0.42, p = 0.04). The correlations are stronger if all (elective and acute) microsurgical cases are compared with outcome. The BNVG data validated the NNAP data set for patients with aSAH. CONCLUSIONS There is a statistically significant association between local microsurgical activity and center outcomes for patients with aSAH, even for patients treated endovascularly. The authors postulate that the number of microsurgical cases performed may be a surrogate indicator of closer neurosurgical involvement in the overall management of neurovascular patients and of optimal case selection.

59. Accuracy of pharmacist electronic discharge medicines review information transmitted to primary care at discharge

Authors Wilcock M.; Hill A.; Wynn A.; Kelly L.
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Available at International Journal of Clinical Pharmacy 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 The poor quality of discharge summaries following admission to hospital, especially in relation to information on medication changes, is well documented. Hospital pharmacists can record changes to medications in the electronic discharge note to improve the quality of this information for primary care. Objective To audit the pharmacist-completed notes describing changes to admission medication, and to identify improvement opportunities. Setting 750-bed teaching district general hospital in England. Methods An evaluation of pharmacist written notes was conducted at a 750-bed teaching district general hospital in England. A sample of notes was analysed in three consecutive years, 2016-2018. Analyses were performed using descriptive statistics. Main outcome measure The number of discrepancies in the note compared to the discharge summary medication list. Results Notes were analysed for 125, 120 and 120 patients in 2016-2018 respectively. We saw an overall improvement in the accuracy of our notes from 12% of patients having an inaccurate note in 2016 to 4.2% in 2017 and 5.8% in 2018. The percentage of discharge medicines affected by these discrepancies reduced from 1.7% (2016) to 0.6% (2017) and 0.9% (2018). Conclusion Discrepancies were due to changes in the patient's medicines journey not being fully captured and documented. The overall reduction of discrepancies over the three consecutive audits was felt to be largely due to formalisation of the discharge medicines reconciliation process and reminding staff on how to complete a note. We are planning to utilise informatics surveillance tools along with system developments to sustain this elimination of out of date notes being transmitted to primary care.

60. New evidence-based A1, A2, A3 alarm time zones for transferring thrombolysed patients to hyper-acute stroke units: faster is better

Authors Han T.S.; Sharma S.; Sharma P.; Gulli G.; Affley B.; Fluck D.; Fry C.H.; Barrett C.; Kakar P.
Source Neurological Sciences; 2019
Publication Date 2019
Publication Type(s) Article
PubMedID 31030369
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Abstract Objectives: The National Institute of Health and Clinical Excellence and The Royal College of Physicians recommend transferring thrombolysed patients with stroke to a hyperacute stroke unit (HASU) within 4 h from hospital arrival ($T_{Arrival-HASU}$), but there is paucity of evidence to support this cut-off. We assessed if a shorter interval within this target threshold conferred a significant improvement in patient mortality.
Design(s): We conducted a retrospective analysis of prospectively collected data from the Sentinel Stroke National Audit Programme.
Setting(s): Four major UK hyperacute stroke centres between 2014 and 2016.
Participant(s): A total of 183 men (median age = 75 years, IQR = 66-83) and 169 women (median age = 81 years, IQR = 72.5-88) admitted with acute ischaemic stroke.
Main Outcome Measure(s): We evaluated $T_{Arrival-HASU}$ in relation to inpatient mortality, adjusted for age, sex, co-morbidities, stroke severity, time between procedures, time and day on arrival.
Result(s): There were 51 (14.5%) inpatient deaths. On ROC analysis, the AUC (area under the curve) was 61.1% (52.9-69.4%, p = 0.01) and the cut-off of $T_{Arrival-HASU}$ where sensitivity equalled specificity was 2 h/15 min (intermediate range = 30 min to 3 h/15 min) for predicting mortality. On logistic regression, compared with the fastest $T_{Arrival-HASU}$ group within 2 h/15 min, the slowest $T_{Arrival-HASU}$ group beyond upper limit of intermediate range (>= 3 h/15 min) had an increased risk of mortality: 5.6% vs. 19.6%, adjusted OR = 5.6 (95%CI:1.5-20.6, p = 0.010).
Conclusion(s): We propose three new alarm time zones (A1, A2 and A3) to improve stroke survival: "A1 Zone" ($T_{Arrival-HASU}$< 2 h/15 min) indicates that a desirable target, "A2 Zone" ($T_{Arrival-HASU}$ = 2 h/15 min to 3 h/15 min), indicates increasing risk and should not delay any further, and "A3 Zone" ($T_{Arrival-HASU}$>= 3 h/15 min) indicates high risk and should be avoided.

61. Forty years of referrals and outcomes to a UK Child Development Centre (CDC): Has demand plateaued?

Authors Williams A.N.; Mold B.; Kilbey L.; Naganna P.
Source Child: care, health and development; May 2018; vol. 44 (no. 3); p. 364-369
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Available at Child: care, health and development from Wiley Online Library Medicine and Nursing Collection 2019 - NHS
Available at Child: care, health and development from EBSCO (Psychology and Behavioral Sciences Collection)
Available at Child: care, health and development 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 explore 40 years of Child Development Centre (CDC) activity and outcomes at Northampton General Hospital 1974-2014.
METHOD(S): The study comprises 3 data sets: a published report from 1974 to 1999, an internal audit from 2001 to 2004, and more recent data collected from 2005 to 2014. The medical notes of all children who were assessed by the CDC in 2014 were reviewed, along with referral data collected by the CDC manager from this year and the preceding 10 years.
RESULT(S): From January 1, 1974 to December 31, 2014, 3,786 children were assessed. The male to female ratio is 2.8:1 from 2005 to 2014. Referrals for behavioural difficulties increased from 10% (10/100 referrals) in 1999-2004 to 17.8% (18/101 referrals) in 2014. Similarly, referrals for social and communication problems, "interaction" increased two and a half fold from 10% (10/100 referrals) in 1999-2004 to 26.7% (27/101 referrals) in 2014. Between 2004 and 2014, numbers of referrals for "developmental delay" halved (22.2% to 12%).
CONCLUSION(S): We are aware of no other comparable extant UK CDC database. Services should plan for a referral rate of 6.5 per 1,000 preschool children. Between 1974 and 2014, there has clearly been a change in recorded assessment outcomes. From the mid-1980s, this reflects the change to a preschool assessment role and a shift away from purely educational outcome to include medical conditions. Covering 1974-2014, we demonstrate a clear increase in the number of referrals together with an increasing demand for assessments for social interaction and behavioural difficulties. This reflects the increased awareness of these neurodevelopmental difficulties and the changing diagnostic criteria which will now more likely result in an Autistic Spectrum Disorder diagnosis than previously. Together, these two features are most likely to have considerable implications for service development within Child Development Centres (CDCs) and Child Development Teams (CDTs).

62. Mortality in patients with spinal muscular atrophy over the last 10 years in the Northeast of the UK

Authors Specht S.; Eglon G.; Turner M.; Straub V.; Bettolo C.M.
Source Journal of Neuromuscular Diseases; 2019; vol. 6

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Publication Type(s) Conference Abstract
Database EMBASE
Available at Journal of Neuromuscular Diseases from Unpaywall
Abstract Background: Infantile onset SMA is the most common genetic cause of death in infants (Kolb et al Ann Neurol 2017). Since the introduction of Standards of Care (Wang et al Consensus Statement for Standard of Care in Spinal Muscular Atrophy 2007), a more proactive approach to care for SMA resulted in improvements in the natural history of the disease. However, for SMA I infants the approach has been in most cases palliative until more recently with the introduction of novel treatments like anti-sense nucleotide and gene therapy.
Aim(s): In view of this dramatic change in the care of SMA patients, from a palliative approach to causal therapies, an audit was conducted to identify the mortality of SMA patients in the Northeast population over the last 10 years.
Result(s): In our cohort of neuromuscular patients, 77 were diagnosed with SMA 0, I, II or III. Currently 53 SMA patients are followed up in our service; of these 4 SMA I children are receiving intrathecal injection of Nursinersen. Twenty-four SMA patients died of the disease. Of this latter group, 2 patients had SMA 0 and died within their first month of life. Seventeen suffered from SMA I, 2 patients from SMA II and 3 from SMA III respectively. Four patients died while receiving Nursinersen treatment, at the age of 6, 7, 20 and 26 months after their second or third intrathecal injection. The causes of death were respiratory arrest, hypoxic ischaemic brain injury secondary to out of hospital cardio-respiratory arrest and pneumonia. Two of those patients were followed up out of area after having initiated Nursinersen at our site. Prior to the introduction of Nursinersen, all 13 patients with SMA I died at the mean age of 8 months. The age of the deceased patients with SMA II varied greatly between 3 years and 56 years. As for SMAIII, patients died aged on an average of 61 years.
Conclusion(s): Over the past 10 years 25% SMA 0-I patients died at an average age of 8.4 months (age range 0-20), 6% SMA II-III patients died at mean age of 47 years (age range 3-75), cardiorespiratory failure being the most common cause of death in all cases.

63. Effectiveness of a national quality improvement programme to improve survival after emergency abdominal surgery (EPOCH): a stepped-wedge cluster-randomised trial

Authors Peden C.J.; Stephens T.; Pearse R.M.; Martin G.; Kahan B.C.; Thomson A.; Kerry S.; Rivett K.; Wells D.; Richardson G.; Bion J.
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Available at Lancet (London, 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).
Available at Lancet (London, England) from LRI Library Local Full Text Collection [location] : LRI Library.
Available at Lancet (London, England) 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: Emergency abdominal surgery is associated with poor patient outcomes. We studied the effectiveness of a national quality improvement (QI) programme to implement a care pathway to improve survival for these patients.
METHOD(S): We did a stepped-wedge cluster-randomised trial of patients aged 40 years or older undergoing emergency open major abdominal surgery. Eligible UK National Health Service (NHS) hospitals (those that had an emergency general surgical service, a substantial volume of emergency abdominal surgery cases, and contributed data to the National Emergency Laparotomy Audit) were organised into 15 geographical clusters and commenced the QI programme in a random order, based on a computer-generated random sequence, over an 85-week period with one geographical cluster commencing the intervention every 5 weeks from the second to the 16th time period. Patients were masked to the study group, but it was not possible to mask hospital staff or investigators. The primary outcome measure was mortality within 90 days of surgery. Analyses were done on an intention-to-treat basis. This study is registered with the ISRCTN registry, number ISRCTN80682973.
FINDINGS: Treatment took place between March 3, 2014, and Oct 19, 2015. 22 754 patients were assessed for elegibility. Of 15 873 eligible patients from 93 NHS hospitals, primary outcome data were analysed for 8482 patients in the usual care group and 7374 in the QI group. Eight patients in the usual care group and nine patients in the QI group were not included in the analysis because of missing primary outcome data. The primary outcome of 90-day mortality occurred in 1210 (16%) patients in the QI group compared with 1393 (16%) patients in the usual care group (HR 1.11, 0.96-1.28). INTERPRETATION: No survival benefit was observed from this QI programme to implement a care pathway for patients undergoing emergency abdominal surgery. Future QI programmes should ensure that teams have both the time and resources needed to improve patient care. FUNDING: National Institute for Health Research Health Services and Delivery Research Programme.

64. Impact of cancer service centralisation on the radical treatment of men with high-risk and locally advanced prostate cancer: A national cross-sectional analysis in England

Authors Parry M.G.; Sujenthiran A.; Nossiter J.; Cowling T.E.; van der Meulen J.; Cathcart P.; Clarke N.W.; Payne H.; Aggarwal A.
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Available at International Journal of Cancer 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 In many countries, specialist cancer services are centralised to improve outcomes. We explored how centralisation affects the radical treatment of high-risk and locally advanced prostate cancer in the English NHS. 79,085 patients diagnosed with high-risk and locally advanced prostate cancer in England (April 2014 to March 2016) were identified in the National Prostate Cancer Audit database. Poisson models were used to estimate risk ratios (RR) for undergoing radical treatment by whether men were diagnosed at a regional co-ordinating centre ('hub'), for having surgery by the presence of surgical services on-site, and for receiving high dose-rate brachytherapy (HDR-BT) in addition to external beam radiotherapy by its regional availability. Men were equally likely to receive radical treatment, irrespective of whether they were diagnosed in a hub (RR 0.99, 95% CI 0.91-1.08). Men were more likely to have surgery if they were diagnosed at a hospital with surgical services on site (RR 1.24, 1.10-1.40), and more likely to receive additional HDR-BT if they were diagnosed at a hospital with direct regional access to this service (RR 6.16, 2.94-12.92). Centralisation of specialist cancer services does not affect whether men receive radical treatment, but it does affect treatment modality. Centralisation may have a negative impact on access to specific treatment modalities.

65. Increased mortality in patients with primary hyperparathyroidism: Does surgery make a difference?

Authors Collier A.; Ghosh S.; Nowell S.; Clark D.
Source Endocrine Practice; Apr 2019; vol. 25 (no. 4); p. 335-339
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PubMedID 30995426
Database EMBASE

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Abstract Objective: Primary hyperparathyroidism (PHPT) is functionally characterized by an inappropriately raised secretion of parathyroid hormone, leading to raised serum calcium levels. Some patients are referred for parathyroidectomy, and some are managed conservatively. The aim of the audit was to compare the mortality outcomes between the two groups.
Method(s): We retrospectively identified a cohort of inpatients with a main or secondary diagnosis of PHPT between 1986 and 2010 and followed them up to the end of 2011. The risk of mortality in PHPT patients compared to the background general population was estimated by calculating standardized mortality ratios (SMRs), adjusting for age, sex, and person-years at risk. Mortality in surgically treated patients was compared to conservatively treated patients using Cox regression, taking account of the Charlson Comorbidity Index.
Result(s): A total of 2,589 patients (77.9% females) were diagnosed with PHPT in Scotland over this period. Of patients diagnosed with PHPT, 41.6% (1,077/2,589) had died by the end of 2011. The SMR was 1.58 (95% confidence interval [CI], 1.48 to 1.67). A total of 54.8% of the patients underwent surgery (SMR, 1.30; 95% CI, 1.18 to 1.43), while the rest were treated "conservatively" (SMR, 1.88; 95% CI, 1.73 to 2.03) (P<.001). When other significant variables including the Charlson Comorbidity Index were taken into account in the final model, the hazard ratio for the "conservatively" managed group was reduced to 1.49 (95% CI, 1.30 to 1.70; P<.0001).
Conclusion(s): Our study confirmed that inpatients diagnosed with PHPT have increased mortality. The risk of mortality was lower in those treated surgically compared with patients treated conservatively.

66. Transmission of multi-drug resistant Pseudomonas aeruginosa between two flexible ureteroscopes and an outbreak of urinary tract infection: the fragility of endoscope decontamination

Authors Kumarage J.; Khonyongwa K.; Desai N.; Taori S.K.; Khan A.; Hoffman P.
Source Journal of Hospital Infection; May 2019; vol. 102 (no. 1); p. 89-94
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Available at Journal of Hospital Infection 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: Flexible endoscopes are difficult to decontaminate, and endoscope-associated infections are increasing. This report describes an outbreak of multi-drug resistant Pseudomonas aeruginosa identified following an increase in incidence of clinical infections associated with flexible ureteroscopy at a tertiary care centre in the UK.
Method(s): Clinical, laboratory and central decontamination unit (CDU) records were reviewed to determine the extent of the problem, and links to the used endoscopes. Audits of the ureteroscopy procedure, endoscopy unit and CDU were performed. Endoscopes were sampled, cultured and examined for structural integrity. All available isolates were typed.
Result(s): Thirteen patients developed clinical infections linked to two flexible ureteroscopes. The first ureteroscope was likely colonized from a known infected patient and the second ureteroscope after use on another patient infected by the first. Risk factors identified include surface cuts, stretching and puckering of the outer cover in both ureteroscopes, absence of bedside cleaning, overnight delay between the ureteroscopy and decontamination, inadequate drying after decontamination and non-traceability of connector valves.
Conclusion(s): The adequacy of flexible endoscope decontamination depends on numerous steps. With the increasing global incidence of multi-drug resistant organisms, stringent monitoring of the flexible endoscopy process by users and decontamination units is essential.

67. Investigating associations between the built environment and physical activity among older people in 20 UK towns

Authors Hawkesworth S.; Armstrong B.; Pliakas T.; Nanchalal K.; Lock K.; Silverwood R.J.; Jefferis B.J.; Sartini C.; Wannamethee S.G.; Ramsay S.E.; Amuzu A.A.; Casas J.-P.; Morris R.W.; Whincup P.H.
Source Journal of epidemiology and community health; Feb 2018; vol. 72 (no. 2); p. 121-131
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Available at Journal of epidemiology and community health from BMJ Journals - NHS

Available at Journal of epidemiology and community health from ProQuest (Health Research Premium) - NHS Version
Available at Journal of epidemiology and community health 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 BACKGROUND: Policy initiatives such as WHO Age Friendly Cities recognise the importance of the urban environment for improving health of older people, who have both low physical activity (PA) levels and greater dependence on local neighbourhoods. Previous research in this age group is limited and rarely uses objective measures of either PA or the environment.
METHOD(S): We investigated the association between objectively measured PA (Actigraph GT3x accelerometers) and multiple dimensions of the built environment, using a cross-sectional multilevel linear regression analysis. Exposures were captured by a novel foot-based audit tool that recorded fine-detail neighbourhood features relevant to PA in older adults, and routine data.
RESULT(S): 795 men and 638 women aged 69-92 years from two national cohorts, covering 20 British towns, were included in the analysis. Median time in moderate to vigorous PA (MVPA) was 27.9 (lower quartile: 13.8, upper quartile: 50.4) minutes per day. There was little evidence of associations between any of the physical environmental domains (eg, road and path quality defined by latent class analysis; number of bus stops; area aesthetics; density of shops and services; amount of green space) and MVPA. However, analysis of area-level income deprivation suggests that the social environment may be associated with PA in this age group.
CONCLUSION(S): Although small effect sizes cannot be discounted, this study suggests that older individuals are less affected by their local physical environment and more by social environmental factors, reflecting both the functional heterogeneity of this age group and the varying nature of their activity spaces.

68. Poorer Speech Reception Threshold in Noise Is Associated With Lower Brain Volume in Auditory and Cognitive Processing Regions

Authors Rudner M.; Ronnberg J.; Seeto M.; Keidser G.; Johnson B.
Source Journal of speech, language, and hearing research : JSLHR; Apr 2019; vol. 62 (no. 4); p. 1117-1130
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Available at Journal of speech, language, and hearing research : JSLHR from EBSCO (MEDLINE Complete)
Available at Journal of speech, language, and hearing research : JSLHR from ProQuest (Health Research Premium) - NHS Version
Available at Journal of speech, language, and hearing research : JSLHR from ProQuest (MEDLINE with Full Text) - NHS Version
Available at Journal of speech, language, and hearing research : JSLHR 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 Purpose Hearing loss is associated with changes in brain volume in regions supporting auditory and cognitive processing. The purpose of this study was to determine whether there is a systematic association between hearing ability and brain volume in cross-sectional data from a large nonclinical cohort of middle-aged adults available from the UK Biobank Resource (http://www.ukbiobank.ac.uk). Method We performed a set of regression analyses to determine the association between speech reception threshold in noise (SRTn) and global brain volume as well as predefined regions of interest (ROIs) based on T1-weighted structural images, controlling for hearing-related comorbidities and cognition as well as demographic factors. In a 2nd set of analyses, we additionally controlled for hearing aid (HA) use. We predicted statistically significant associations globally and in ROIs including auditory and cognitive processing regions, possibly modulated by HA use. Results Whole-brain gray matter volume was significantly lower for individuals with poorer SRTn. Furthermore, the volume of 9 predicted ROIs including both auditory and cognitive processing regions was lower for individuals with poorer SRTn. The greatest percentage difference (-0.57%) in ROI volume relating to a 1 SD worsening of SRTn was found in the left superior temporal gyrus. HA use did not substantially modulate the pattern of association between brain volume and SRTn. Conclusions In a large middle-aged nonclinical population, poorer hearing ability is associated with lower brain volume globally as well as in cortical and subcortical regions involved in auditory and cognitive processing, but there was no conclusive evidence that this effect is moderated by HA use. This pattern of results supports the notion that poor hearing leads to reduced volume in brain regions recruited during speech understanding under challenging conditions. These findings should be tested in future longitudinal, experimental studies. Supplemental Material https://doi.org/10.23641/asha.7949357.

69. A method for measuring continuity of care in day-to-day general practice: a quantitative analysis of appointment data

Authors Sidaway-Lee K.; Gray D.P.; Evans P.
Source The British journal of general practice : the journal of the Royal College of General Practitioners; May 2019; vol. 69 (no. 682)
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Available at The British journal of general practice : the journal of the Royal College of General Practitioners 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 The British journal of general practice : the journal of the Royal College of General Practitioners 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: Despite patient preference and many known benefits, continuity of care is in decline in general practice. The most common method of measuring continuity is the Usual Provider of Care (UPC) index. This requires a number of appointments per patient and a relatively long timeframe for accuracy, reducing its applicability for day-to-day performance management. AIM: To describe the St Leonard's Index of Continuity of Care (SLICC) for measuring GP continuity regularly, and demonstrate how it has been used in service in general practice. DESIGN AND SETTING: Analysis of appointment audit data from 2016-2017 in a general practice with 8823-9409 patients and seven part-time partners, in Exeter, UK.
METHOD(S): The percentage of face-to-face appointments for patients on each doctor's list, with the patient's personal doctor (the SLICC), was calculated monthly. The SLICC for different demographic groupings of patients (for example, sex and frequency of attendance) was compared. The UPC index over the 2 years was also calculated, allowing comparisons between indices.
RESULT(S): In the 2-year study period, there were 35 622 GP face-to-face appointments; 1.96 per patient per year. Overall, 51.7% (95% confidence interval = 51.2 to 52.2) of GP appointments were with the patients' personal doctor. Patients aged >=65 years had a higher level of continuity with 64.9% of appointments being with their personal doctor. The mean whole-practice UPC score was 0.61 (standard deviation 0.23), with 'usual provider' being the personal GP for 52.8% and a trainee or locum for 8.1% of patients.
CONCLUSION(S): This method could provide working GPs with a simple way to track continuity of care and inform practice management and decision making.

70. Patient experience feedback in UK hospitals: What types are available and what are their potential roles in quality improvement (QI)?

Authors Marsh C.; Peacock R.; Sheard L.; Hughes L.; Lawton R.
Source Health expectations : an international journal of public participation in health care and health policy; Apr 2019
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Available at Health expectations : an international journal of public participation in health care and health policy from Europe PubMed Central - Open Access
Available at Health expectations : an international journal of public participation in health care and health policy from EBSCO (MEDLINE Complete)
Available at Health expectations : an international journal of public participation in health care and health policy 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 & OBJECTIVES: The comparative uses of different types of patient experience (PE) feedback as data within quality improvement (QI) are poorly understood. This paper reviews what types are currently available and categorizes them by their characteristics in order to better understand their roles in QI.
METHOD(S): A scoping review of types of feedback currently available to hospital staff in the UK was undertaken. This comprised academic database searches for "measures of PE outcomes" (2000-2016), and grey literature and websites for all types of "PE feedback" potentially available (2005-2016). Through an iterative consensus process, we developed a list of characteristics and used this to present categories of similar types.
MAIN RESULTS: The scoping review returned 37 feedback types. A list of 12 characteristics was developed and applied, enabling identification of 4 categories that help understand potential use within QI-(1) Hospital-initiated (validated) quantitative surveys: for example the NHS Adult Inpatient Survey; (2) Patient-initiated qualitative feedback: for example complaints or twitter comments; (3) Hospital-initiated qualitative feedback: for example Experience Based Co-Design; (4) Other: for example Friends & Family Test. Of those routinely collected, few elicit "ready-to-use" data and those that do elicit data most suitable for measuring accountability, not for informing ward-based improvement. Guidance does exist for linking collection of feedback to QI for some feedback types in Category 3 but these types are not routinely used.
CONCLUSION(S): If feedback is to be used more frequently within QI, more attention must be paid to obtaining and making available the most appropriate types.

71. Patterns of practice in palliative radiotherapy for bone metastases in UK centres

Authors Khan N.; Green D.
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Available at Journal of Radiotherapy in Practice 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 Journal of Radiotherapy in Practice 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 There is abundant evidence of the comparative efficacy of single-fraction (SF) radiotherapy and multi-fraction (MF) radiotherapy when treating patients with bone metastases. Despite this, previous surveys have shown SF schedules to be underutilised.Aim To determine current patterns of practice in patients with bone metastasis and to investigate the factors that influence practice.Method An electronic audit was performed amongst 46 physicians, within 7 hospital trusts in the UK. The audit comprised of four hypothetical cases in which consultants and registrars chose which dose and fractionation they would recommend and their reasons for this recommendation.Results SF radiotherapy was the most common radiotherapy schedule in hypothetical cases 1, 3 and 4. SF radiotherapy was recommended by 65% of respondents in case 1, 47% in case 2, 89% in case 3 and 46% in case 4. For case 2, 50% proposed MF radiotherapy. For case 4, 22% of respondents recommended Stereotactic Body Radiotherapy (SABR). The following deciding factors were cited as influencing choice of an SF schedule: prognosis, published evidence, performance status and spinal cord compression.Conclusion The most common radiotherapy schedule selected was SF. However, there were inter-institution differences regarding the use of SF radiotherapy. Furthermore, the survey had shown that a third of respondents recommended an MF regime, despite evidence supporting the efficacy of an SF schedule.

72. Histological ageing of fractures in infants: a practical algorithm for assessing infants suspected of accidental or non-accidental injury

Authors Naqvi A.; Raynor E.; Freemont A.J.
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Available at Histopathology from Unpaywall

Abstract Aims: This study is the first to systematically document histological features of fractures of known age in infants (12 months). It has been used to develop a tabulated database specifically to guide histopathologists to age fractures in children considered to have suffered accidental or non-accidental injury (NAI). Currently in the United Kingdom there are insufficient pathologists with experience in histological ageing of fractures to meet the medicolegal need for this examination. This study provides a practical tool that will allow those skilled paediatric and forensic pathologists currently involved in assessing infants for evidence of accidental or non-accidental injury a basis for extending their assessment into this area of unmet need.
Methods and Results: One hundred and sixty-nine fractures of known age at death were obtained from 52 anonymised infants over a period of 32 years (1985-2016 inclusive). Sections stained using haematoxylin and eosin (H&E) and Martius scarlet blue (MSB) were used to identify specific histological features and to relate them to fracture age. In 1999 the data were entered into a tabulated database for fractures accumulated between from 1985 to 1998 inclusive. Thereafter cases were added, and at 2-yearly intervals the accumulated data were audited against the previous database and adjustments made.
Conclusion(s): This paper describes the final data set from the 2017 audit. The study was terminated at the end of 2016, as there had been no material changes in the data set for three consecutive audits.

73. Antibiotic resistance and antibiotic prescribing by dentists in England 2007-2016

Authors Bunce J.T.; Hellyer P.
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Abstract The early prescribers of penicillin realised that antibiotics should be used wisely and as an adjunct to traditional surgical provision. They predicted that inappropriate use would increase sensitisation to the drug. National Health Service dentists prescribed almost 10% of antibiotics issued in NHS general practice in 2016 and an audit shows that many of these may have been prescribed inappropriately. One of the causes of antimicrobial resistance is over prescription of the drugs. This paper recalls the recommendations of some early users of penicillin, reports on the current prescription patterns of dentists in England, describes the mechanism of acquisition of anti-microbial resistance and discusses dentists' role in attempting to reduce the problem.

74. High-Dose Chemotherapy in Relapsed or Refractory Metastatic Germ-Cell Cancer: The Scotland Experience

Authors Tan Y.Y.; Al-Bubseeree B.; Waterston A.; White J.; Irvine D.; McQuaker G.; Parker A.; MacDonald G.
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Abstract This retrospective audit investigated outcomes of high-dose chemotherapy and autologous stem-cell transplantation in relapsed or refractory metastatic germ-cell patients in Scotland. The overall survival and progression-free survival at 2 years for our cohort of 18 patients were comparable to the literature, suggesting the feasibility of successful recruitment into the TIGER trial (NCT02375204), which will compare this treatment to conventional-dose chemotherapy.Purpose: To report outcomes from high-dose chemotherapy (HDCT) and autologous stem-cell transplantation (ASCT) for metastatic germ-cell cancer in Scotland.
Patients and Methods: All patients who underwent this treatment between the years 2001 and 2016 at the Beatson West of Scotland Cancer Centre in Glasgow were identified. Information regarding baseline patient and tumor characteristics, prognostic features, HDCT delivery, and survival outcomes were obtained retrospectively from patients' medical records.
Result(s): Eighteen patients (15 male and 3 female subjects) received HDCT and ASCT in the salvage setting. Of the 14 male patients who had relapsed disease, 8 (57%) were high or very high risk according to the International Prognostic Factor Study Group (IPFSG) risk categorization. The mean time interval between HDCT cycles was 8.6 weeks, which is longer than the specified 3 to 4 weeks in the literature. A total of 67% of patients had no biochemical or radiologic evidence of disease after salvage treatment, including surgery. Progression-free survival and overall survival rates at 2 years were 67% and 72%, respectively. However, 12 patients (67%) and 6 patients (39%) had long-term neurotoxicity and ototoxicity, respectively.
Conclusion(s): Delivery of HDCT and ASCT as salvage treatment for metastatic germ-cell cancer is feasible within a tertiary cancer center with survival outcomes comparable to published literature, although maintaining dose intensity is a challenge. We hope to recruit subjects to the international TIGER trial (ClinicalTrials.gov, NCT02375204), which will attempt to clarify if HDCT is superior to conventional-dose chemotherapy in the salvage setting.

75. Epidemiology and aetiology of paediatric traumatic cardiac arrest in England and Wales

Authors Vassallo J.; Barnard E.B.G.; Smith J.E.; Webster M.; Lyttle M.D.
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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 Objective To describe the epidemiology and aetiology of paediatric traumatic cardiac arrest (TCA) in England and Wales. Design Population-based analysis of the UK Trauma Audit and Research Network (TARN) database. Patients and setting All paediatric and adolescent patients with TCA recorded on the TARN database for a 10-year period (2006-2015). Measures Patient demographics, Injury Severity Score (ISS), location of TCA ('prehospital only', 'in-hospital only' or 'both'), interventions performed and outcome. Results 21 710 paediatric patients were included in the database; 129 (0.6%) sustained TCA meeting study inclusion criteria. The majority, 103 (79.8%), had a prehospital TCA. 62.8% were male, with a median age of 11.7 (3.4-16.6) years, and a median ISS of 34 (25-45). 110 (85.3%) had blunt injuries, with road-traffic collision the most common mechanism (n=73, 56.6%). 123 (95.3%) had severe haemorrhage and/or traumatic brain injury. Overall 30-day survival was 5.4% ((95% CI 2.6 to 10.8), n=7). 'Pre-hospital only' TCA was associated with significantly higher survival (n=6) than those with TCA in both 'pre-hospital and in-hospital' (n=1) - 13.0% (95% CI 6.1% to 25.7%) and 1.2% (95% CI 0.1% to 6.4%), respectively, p<0.05. The greatest survival (n=6, 10.3% (95% CI 4.8% to 20.8%)) was observed in those transported to a paediatric major trauma centre (MTC) (defined as either a paediatric-only MTC or combined adult-paediatric MTC). Conclusions Survival is possible from the resuscitation of children in TCA, with overall survival comparable to that reported in adults. The highest survival was observed in those with a pre-hospital only TCA, and those who were transported to an MTC. Early identification and aggressive management of paediatric TCA is advocated.

76. Sensitivity of EQ-5D-3L, HUI2, HUI3, and SF-6D to changes in speech reception and tinnitus associated with cochlear implantation

Authors Summerfield A.Q.; Barton G.R.
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Available at Quality of Life Research 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: There is concern that some generic preference-based measures (GPMs) of health-related quality of life may be insensitive to interventions that improve hearing. Establishing where sensitivity arises could contribute to the design of improved measures. Accordingly, we compared the sensitivity of four widely used GPMs to a clinically effective treatment-cochlear implantation-which restores material degrees of hearing to adults with little or no functional hearing.
Method(s): Participants (N = 147) received implants in any of 13 hospitals in the UK. One month before implantation and 9 months after, they completed the HUI2, HUI3, EQ5D3L, and SF-6D questionnaires, together with the EuroQoL visual-analogue scale as a direct measure of health, a performance test of speech reception, and a self-report measure of annoyance due to tinnitus.
Result(s): Implantation was associated with a large improvement in speech reception and a small improvement in tinnitus. HUI2 and HUI3 were sensitive to the improvement in speech reception through their Sensation and Hearing dimensions; EQ5D3L was sensitive to the improvement in tinnitus through its Anxiety/Depression dimension; SF-6D was sensitive to neither. Participants reported no overall improvement in health. Variation in health was associated with variation in tinnitus, not variation in speech reception.
Conclusion(s): None of the four GPMs was sensitive to the improvements in both speech reception and tinnitus that were associated with cochlear implantation. To capture fully the benefits of interventions for auditory disorders, developments of current GPMs would need to be sensitive to both the health-related and non-health-related aspects of auditory dysfunction.

77. 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; Mar 2019; vol. 20 (no. 3); p. 223-232
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Available at Pediatric Critical Care Medicine 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 Pediatric Critical Care Medicine 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(s): Retrospective analysis of data collected prospectively by the Paediatric Intensive Care Audit Network.
Setting(s): All PICUs in the United Kingdom and Republic of Ireland (n = 34).
Patient(s): Admissions to study PICUs (2015-2016) receiving any form of respiratory support at any time during PICU stay.
Intervention(s): 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.

78. A Comparison of Mortality From Sepsis in Brazil and England: The Impact of Heterogeneity in General and Sepsis-Specific Patient Characteristics

Authors Ranzani O.T.; Shankar-Hari M.; Harrison D.A.; Rowan K.M.; Rabello L.S.; Salluh J.I.F.; Soares M.
Source Critical Care Medicine; Jan 2019; vol. 47 (no. 1); p. 76-84
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Abstract Objectives: To test whether differences in both general and sepsis-specific patient characteristics explain the observed differences in sepsis mortality between countries, using two national critical care (ICU) databases.
Design(s): Cohort study.
Setting(s): We analyzed 62 and 164 ICUs in Brazil and England, respectively.
Patient(s): Twenty-two-thousand four-hundred twenty-six adult ICU admissions from January 2013 to December 2013.
Intervention(s): None.
Measurements and Main Results: After harmonizing relevant variables, we merged the first ICU episode of adult medical admissions from Brazil (ORganizational CHaractEeriSTics in cRitical cAre study) and England (Intensive Care National Audit & Research Centre Case Mix Programme). Sepsis-3 definition was used, and the primary outcome was hospital mortality. We used multilevel logistic regression models to evaluate the impact of country (Brazil vs England) on mortality, after adjustment for general (age, sex, comorbidities, functional status, admission source, time to admission) and sepsis-specific (site of infection, organ dysfunction type and number) patient characteristics. Of medical ICU admissions, 13.2% (4,505/34,150) in Brazil and 30.7% (17,921/58,316) in England met the sepsis definition. The Brazil cohort was older, had greater prevalence of severe comorbidities and dependency compared with England. Respiratory was the most common infection site in both countries. The most common organ dysfunction was cardiovascular in Brazil (41.2%) and respiratory in England (85.8%). Crude hospital mortality was similar (Brazil 41.4% vs England 39.3%; odds ratio, 1.12 [0.98-1.30]). After adjusting for general patient characteristics, there was an important change in the point-estimate of the odds ratio (0.88 [0.75-1.02]). However, after adjusting for sepsis-specific patient characteristics, the direction of effect reversed again with Brazil having higher risk-adjusted mortality (odds ratio, 1.22 [1.05-1.43]).
Conclusion(s): Patients with sepsis admitted to ICUs in Brazil and England have important differences in general and sepsis-specific characteristics, from source of admission to organ dysfunctions. We show that comparing crude mortality from sepsis patients admitted to the ICU between countries, as currently performed, is not reliable and that the adjustment for both general and sepsis-specific patient characteristics is essential for valid international comparisons of mortality amongst sepsis patients admitted to critical care units.

79. Fibreoptic intubation in airway management: a review article

Authors Wong J.; Lee J.S.E.; Wong T.G.L.; Wong P.; Iqbal R.
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Abstract Since the first use of the flexible fibreoptic bronchoscope, a plethora of new airway equipment has become available. It is essential for clinicians to understand the role and limitations of the available equipment to make appropriate choices. The recent 4th National Audit Project conducted in the United Kingdom found that poor judgement with inappropriate choice of equipment was a contributory factor in airway morbidity and mortality. Given the many modern airway adjuncts that are available, we aimed to define the role of flexible fibreoptic intubation in decision-making and management of anticipated and unanticipated difficult airways. We also reviewed the recent literature regarding the role of flexible fibreoptic intubation in specific patient groups who may present with difficult intubation, and concluded that the flexible fibrescope maintains its important role in difficult airway management.

80. Recommendation to include hydroxyethyl (meth)acrylate in the British baseline patch test series

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Available at British Journal of Dermatology 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: (Meth)acrylates are potent sensitizers and a common cause of allergic contact dermatitis (ACD). The frequency of (meth)acrylate ACD has increased with soaring demand for acrylic nails. A preliminary audit has suggested a significant rate of positive patch tests to (meth)acrylates using aimed testing in patients providing a clear history of exposure. To date, (meth)acrylates have not been routinely tested in the baseline patch test series in the U.K. and Europe.
Objective(s): To determine whether inclusion of 2-hydroxyethyl methacrylate (2-HEMA) 2% in petrolatum (pet.) in the baseline series detects cases of treatable (meth)acrylate ACD.
Method(s): During 2016-2017, 15 U.K. dermatology centres included 2-HEMA in the extended baseline patch test series. Patients with a history of (meth)acrylate exposure, or who tested positive to 2-HEMA, were selectively tested with a short series of eight (meth)acrylate allergens.
Result(s): In total 5920 patients were consecutively patch tested with the baseline series, of whom 669 were also tested with the (meth)acrylate series. Overall, 102 of 5920 (1.7%) tested positive to 2-HEMA and 140 (2.4%) to at least one (meth)acrylate. Had 2-HEMA been excluded from the baseline series, (meth)acrylate allergy would have been missed in 36 of 5920 (0.6% of all patients). The top (meth)acrylates eliciting a positive reaction were 2-HEMA (n = 102, 1.7%), 2-hydroxypropyl methacrylate (n = 61, 1.0%) and 2-hydroxyethyl acrylate (n = 57, 1.0%).
Conclusion(s): We recommend that 2-HEMA 2% pet. be added to the British baseline patch test series. We also suggest a standardized short (meth)acrylate series, which is likely to detect most cases of (meth)acrylate allergy.

81. Psychological wellbeing and use of alcohol and recreational drugs: results of the British HIV Association (BHIVA) national audit 2017

Authors Parry S.; Curtis H.; Chadwick D.
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Abstract Objectives: The aim of this national audit was to assess adherence of services providing HIV care in the UK to national standards and guidelines regarding psychological support and the assessment of alcohol and recreational drug use (including chemsex drugs) in people living with HIV (PLWH).
Method(s): Participating sites completed a survey of their services' care pathways relating to psychological support and substance use. They performed a case-note review of up to 40 adult PLWH per service, reviewing sociodemographic and clinical information and assessment of psychological wellbeing, drug use and alcohol use. The surveys and case notes were assessed against relevant British HIV Association (BHIVA) guidelines and standards.
Result(s): The survey was completed by 112 services. Of these, 73%, 82% and 73% had formal annual processes for assessing the psychological wellbeing, alcohol use and drug use, respectively, of PLWH. Case-note data were provided for 4486 PLWH from 119 sites. Audited rates of assessment of PLWH were 66.0% for psychological wellbeing, 68.0% for alcohol use, 58.4% for recreational drug use and 16.8% for chemsex drug use. Variation between clinical services was wide, with ranges from < 10% to 100% routinely assessing PLWH for each of these domains. Services using assessment tools performed better.
Conclusion(s): Assessment of PLWH for psychological wellbeing and alcohol and recreational drug use is variable in UK clinics, with a significant minority of services not documenting that they assessed these factors routinely. Wider adoption of assessment tools or proformas to assess PLWH in these areas is likely to improve surveillance for psychological morbidity and problematic alcohol or drug use.

82. Improving care at scale: process evaluation of a multi-component quality improvement intervention to reduce mortality after emergency abdominal surgery (EPOCH trial)

Authors Stephens T.J.; Pearse R.M.; Abbott T.E.F.; Peden C.J.; Shaw S.E.; Jones E.L.; Kocman D.; Martin G.

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Abstract BACKGROUND: Improving the quality and safety of perioperative care is a global priority. The Enhanced Peri-Operative Care for High-risk patients (EPOCH) trial was a stepped-wedge cluster randomised trial of a quality improvement (QI) programme to improve 90-day survival for patients undergoing emergency abdominal surgery in 93 hospitals in the UK National Health Service.
METHOD(S): The aim of this process evaluation is to describe how the EPOCH intervention was planned, delivered and received, at both cluster and local hospital levels. The QI programme comprised of two interventions: a care pathway and a QI intervention to aid pathway implementation, focussed on stakeholder engagement, QI teamwork, data analysis and feedback and applying the model for improvement. Face-to-face training and online resources were provided to support senior clinicians in each hospital (QI leads) to lead improvement. For this evaluation, we collated programme activity data, administered an exit questionnaire to QI leads and collected ethnographic data in six hospitals. Qualitative data were analysed with thematic or comparative analysis; quantitative data were analysed using descriptive statistics.
RESULT(S): The EPOCH trial did not demonstrate any improvement in survival or length of hospital stay. Whilst the QI programme was delivered as planned at the cluster level, self-assessed intervention fidelity at the hospital level was variable. Seventy-seven of 93 hospitals responded to the exit questionnaire (60 from a single QI lead response on behalf of the team); 33 respondents described following the QI intervention closely (35%) and there were only 11 of 37 care pathway processes that >50% of respondents reported attempting to improve. Analysis of qualitative data suggests QI leads were often attempting to deliver the intervention in challenging contexts: the social aspects of change such as engaging colleagues were identified as important but often difficult and clinicians frequently attempted to lead change with limited time or organisational resources.
CONCLUSION(S): Significant organisational challenges faced by QI leads shaped their choice of pathway components to focus on and implementation approaches taken. Adaptation causing loss of intervention fidelity was therefore due to rational choices made by those implementing change within constrained contexts. Future large-scale QI programmes will need to focus on dedicating local time and resources to improvement as well as on training to develop QI capabilities. EPOCH TRIAL REGISTRATION: ISRCTN80682973 https://doi.org/10.1186/ISRCTN80682973 Registered 27 February 2014 and Lancet protocol 13PRT/7655.

83. Public self-consciousness, pre-loading and drinking harms among university students

Authors Davies E.L.; Paltoglou A.E.
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Abstract BACKGROUND: Social anxiety and self-consciousness are associated with alcohol-related problems in students. The practice of pre-loading is one avenue for exploration regarding this relationship. Individuals may pre-load to reduce social anxiety and feel more confident when socializing, which could lead to the increased harms experienced. The current study aimed to explore reasons for pre-loading, and whether public and private self-consciousness and social anxiety were related to pre-loading, increased drinking, and harms.
OBJECTIVE(S): Prospective study with four-week follow up of 325 UK students aged 18--30 years old. Participants completed measures of private and public self-consciousness, social anxiety, alcohol consumption, alcohol-related harms, and pre-loading.
RESULT(S): Financial motives and mood-related reasons, such as gaining confidence were reported as reasons for pre-loading. Pre-loading predicted hazardous alcohol consumption, but social anxiety, and public and private self-consciousness did not. However, pre-loading, public self-consciousness, and social anxiety predicted alcohol-related harms. Furthermore, public self-consciousness mediated the relationship between pre-loading and harms in a positive direction and this appeared to be more relevant in high-risk (AUDIT 8+) than low-risk drinkers.
CONCLUSION(S): Students who scored higher in public self-consciousness appeared to be at greater risk of harms from pre-loading. Further research should examine this relationship with particular attention to high-risk drinkers, and explore which aspects of a night out are related to heightened self-consciousness. Interventions could incorporate measures to reduce public self-consciousness, in order to reduce the negative impacts of pre-loading.

84. Audit cycle of the provision of compression garments on prescription

Authors Woods M.
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Available at British journal of nursing (Mark Allen Publishing) 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 wearing of compression garments is an essential aspect of the management of lymphoedema. Patients however, do not always receive the requested garment on an NHS prescription from their general practitioner (GP). Through an audit cycle over 3 years, necessary changes in clinical practice were identified and introduced. The aim was to improve the number of patients obtaining the correct garment on an NHS prescription. The audit standard was not met in any of the audits and the conclusion made is that compression garments are difficult to find on NHS electronic prescribing systems leading to a delay in patients receiving their prescription and a risk of error due to the wide range of options available. Further work is necessary to ensure that electronic prescribing systems address the problem of product recognition for compression garments so that the process of obtaining compression garments is smooth, accurate and timely for patients and their GPs.

85. Writing for publication: Sharing your clinical knowledge and skills

Authors Wood C.
Source British journal of community nursing; Jan 2018; vol. 23 (no. 1); p. 20-23
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Available at British journal of community 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 Clinical nurses are ideally placed to write for publication in addition to those who work in academia who have this as an accepted part of their role. Nurses generate new evidence from their work in practice by carrying out research and audits and being involved in practice development projects, for example. This resource of knowledge needs to be shared with others, ideally in an international arena so that nurses can learn from each other. Nursing in the United Kingdom is now an all graduate profession and many nurses go on to study at both Masters and PhD level, providing writing from all levels of academic study that can be adapted for publication. It seems wrong to undertake a study and obtain findings and then choose not share this widely. Both a lack of confidence and time are cited as reasons why nurses do not write; however, to share knowledge with others is a duty as part of any nursing role for the improvement of staff working practices and patient care. All nurses need knowledge that is practical, experiential, and scientific; clinical nurses who write for publication can provide this.

86. The use of acuity and frailty measures for district nursing workforce plans

Authors David A.; Saunders M.
Source British journal of community nursing; Feb 2018; vol. 23 (no. 2); p. 86-92
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Available at British journal of community 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 This article discusses the use of Quest acuity and frailty measures for community nursing interventions to quantify and qualify the contributions of district nursing teams. It describes the use of a suite of acuity and frailty tools tested in 8 UK community service trusts over the past 5years. In addition, a competency assessment tool was used to gauge both capacity and capability of individual nurses. The consistency of the results obtained from the Quest audits offer significant evidence and potential for realigning community nursing services to offer improvements in efficiency and cost-effectiveness. The National Quality Board (NQB) improvement resource for the district nursing services (NQB, 2017) recommends a robust method for classifying patient acuity/frailty/dependency. It is contended the Quest tools and their usage articulated here offer a suitable methodology.

87. Establishing an allied health professional delivered selective laser trabeculoplasty service in Scotland

Authors Chadwick O.; Chia S.N.; Rotchford A.
Source Ophthalmic & physiological optics : the journal of the British College of Ophthalmic Opticians (Optometrists); May 2019; vol. 39 (no. 3); p. 216-223
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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 describe the process of establishing a selective laser trabeculoplasty (SLT) service delivered by experienced allied health professionals (AHP) in a Scottish NHS Hospital Eye Service, and assess the safety and efficacy in comparison with SLT performed by ophthalmologists.
METHOD(S): A training scheme for AHPs who were experienced in extended roles within the glaucoma service was developed, consisting of supervised training by a consultant ophthalmologist specialising in glaucoma leading to the AHPs independently delivering SLT. A prospective audit of consecutive SLT procedures performed by AHPs between November 2015 and April 2017 was performed. Data were analysed and compared to a previous intradepartmental audit of SLT performed by ophthalmologists (consultants and trainees).
RESULT(S): A total of 325 eyes of 208 patients underwent SLT, of which 117 patients had bilateral SLT in a single session. The overall rate of complications was 3.9%, however these were minor and/or self-limiting (this compared to a 3.8% complication rate in the ophthalmologist delivered SLT series). The rate of intraocular pressure (IOP) spike was 0.3%, compared to 1.4% in the ophthalmologist delivered SLT series. Mean IOP at listing was 20.9 +/- 5.1 mmHg, 17.3 +/- 4.5 mmHg at 3 months post SLT and 17.6 +/- 3.7 mmHg at 12 months-a median reduction of 16.7% at 3 months and 17.4% at 12 months. There was no statistically significant difference between the percentage reduction in IOP in the AHP and ophthalmologist delivered SLT groups at 3 or 12 months.
CONCLUSION(S): This is the first service of its kind in Scotland and the outcomes of this study demonstrate that the AHP delivered SLT service is at least as safe as the previous ophthalmologist delivered SLT service. The data demonstrate a similar efficacy between AHP and ophthalmologist delivered SLT. In the face of increasing demand and workload, this is a practical model in service commissioning to free up medical clinicians for more complex glaucoma management.

88. Sharing the results of a patient satisfaction audit

Authors Walker K.; Osborne D.; Milton S.; Watkins R.; Newman S.; Pullen J.; Davies T.
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Abstract Regular service audits since 2008 gave a stoma care department confidence in the service it provides. In 2016 the department undertook a new audit to benchmark its services, using the Association of Stoma Care Nurses (ASCN) UK Revised Stoma Care Nursing Standards and Audit Tool (2015) . Of the 60 questionnaires given out, 43 were returned (71%). The results highlighted areas of good practice with positive patient feedback. However, it also identified that the team needed to improve documentation when offering patients the opportunity to meet a former patient with a stoma preoperatively and when discussing lifestyle issues. The results demonstrated poor preoperative compliance; this was lower than expected and did not concur with department statistics. The audit highlights the importance of clarity when developing a questionnaire to ensure all respondents not only interpret its meaning in the same way, but also only answer the questions specific to them.

89. Managing dysfunctional central venous access devices: a practical approach to urokinase thrombolysis

Authors Kumwenda M.; Dougherty L.; Spooner H.; Jackson V.; Mitra S.; Inston N.
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Available at British journal of nursing (Mark Allen Publishing) 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 Tunnelled central venous access devices (CVADs) are defined as any intravenous multipurpose catheters placed within the central veins for use in haemodialysis and administration of blood products or chemotherapy in oncology and haematological conditions. Frequent complications include thrombosis and catheter-related infection, which may lead to significant adverse patient outcomes. Once thrombosis is suspected correction should be attempted empirically with thrombolytic agents. Commonly available thrombolytic agents in the UK include urokinase (Syner-Kinase) and alteplase (Cathflo). It is well recognised that urokinase usage differs widely and concerns were raised by clinicians about the variation of dose regimens nationally. The objective of the CVAD Focus Group was to address this issue and offer guidance in the management of suspected thrombosis of CVAD with urokinase using two algorithms for renal and non-renal dysfunctional CVAD and to audit prospectively the outcomes of intervention.

90. Defining patterns of care in the management of patients with brain metastases in a large oncology centre: A single-centre retrospective audit of 236 cases

Authors Bentley R.; Crosby V.; Wilcock A.; O'Cathail M.; Aznar-Garcia L.; Christian J.
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Available at European journal of cancer care 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 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 AIMS: The role of selected treatments for brain metastases (BM) is well documented; however, the prevalence of these is not. We report on the patterns of care in the management of BM in a large oncology centre.
MATERIALS AND METHODS: We retrospectively audited 236 cases of newly diagnosed BM from January 2016 to December 2017 by looking at 2 years of radiology reports and gathered data on primary site, survival, treatment received, palliative care input and brain metastases-related admissions.
RESULT(S): Eighty-two per cent of cases were related to lung, breast and melanoma primaries. Half of patients received a form of treatment with the other half receiving best supportive care. Of these, whole-brain radiotherapy (39%) and stereotactic radiosurgery (40%) were the most common treatment modalities. Most common reasons for admissions were headaches, seizures, weakness and confusion.
CONCLUSION(S): This is the first study in the UK that gives an in-depth overview of the real-world management of brain metastases. We have demonstrated the prevalence of treatment across the spectrum of brain metastases patients. Radiotherapy is the mainstay of treatment in nearly 80% of cases; however, care needs to be taken in ensuring that SRS is offered to those who are suitable.

91. Joanna Bircher: quality improvement evangelist

Authors anonymous
Source BMJ (Clinical research ed.); Feb 2019; vol. 364
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Database EMBASE
Available at BMJ (Clinical research ed.) from BMJ Journals - NHS

92. Comparison of post chemotherapy retroperitoneal lymph node dissection (PC-RPLND) outcomes from a single high volume UK centre with national registry outcomes

Authors Pearce A.; Reid A.; Huddart R.; Mayer E.; Nicol D.
Source BJU International; Apr 2019; vol. 123 ; p. 79
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Available at BJU International from Leicester General Hospital Library Local Print Collection [location] : Leicester General Library. [title_notes] : Issues before 2000 held in Archive.
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Available at BJU International 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 and Objectives: According to UK national registry figures, 151 open RPLNDs are performed annually for testicular tumours, centralised to 17 specialist centres. The median operation time is 3- 4 h, median length of stay is 6 days and transfusion rate 22.5%. Our centre receives referrals from within our Testis Cancer Supra-Network, as well as complex cases (massive or growing teratomas) and redo RPLNDs referred from centres. We aimed to review our outcomes and compare them with a 12-month national data registry of this procedure in the UK (BAUS RPLND National Registry) to which all 17 centres contributed.
Method(s): We analysed the electronic records of all open RPLNDs performed for testicular tumours at our institution under two lead surgeons between July 2012 and October 2018. Indications for surgery, length of stay, transfusion rate, Clavien graded complications and histology. Our second monthly morbidity and mortality audit records were cross-checked for completeness of complication capture. Data were compared to that of the BAUS registry. Chisquared testing was used to assess for statistical significance between two percentages.
Result(s): Transfusion rates were significantly lower than registry data (p = 0.0107).
Conclusion(s): Despite a greater number of vascular procedures and visceral resections, reflective of the complex caseload at our high-volume centre, our peri-operative outcomes are comparable to that of registry data with low Clavien III+ complication rate. Our transfusion rate is significantly lower that registry figures. At both our centre and the UK national cohort the histological findings of necrosis/ fibrosis only was substantially lower than reported in other large series worldwide, possibly reflecting selection criteria for post-chemotherapy surgery.

93. Post-mastectomy radiotherapy following immediate implant based reconstruction: A possible solution to a reconstructive challenge

Authors Chaichanavichkij P.; Arun K.S.; Conibear J.; Ullah M.Z.
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Available at Cancer Research 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: The National Mastectomy and Breast Reconstruction Audit report (NMBRA, 2011)1 revealed that immediate implant-based breast reconstruction (IIBR) was the most common type of primary reconstruction performed in the UK (37%). The main reason given by clinicians for not offering immediate breast reconstruction was the need for adjuvant radiotherapy. Post-mastectomy radiotherapy (PMRT) decreases the rate of local recurrence as well as increase the long-term survival in patients who demonstrate intermediate to high-risk features2,3 but has been shown to increase the risk of implant complications in IIBR by up to 24% (Berry et al, 2010)4. Cordeiro et al (2004)5 showed the incidence of capsular contracture was 28% higher in the PMRT group compared with non-irradiated patients. Most patients in the UK receive hypofractionated PMRT of 40.05Gy in 15 fractions over 3 weeks based on the UK Standardisation of Breast Radiotherapy (START) trial6, which demonstrated that hypofractionated PMRT is as safe and effective as the conventional PMRT of 50Gy in 25 fractions over 5 weeks. The aim of this study was to determine whether the conventional PMRT of 50Gy in 25 fractions over 5 weeks (2Gy per fraction) was associated with a reduced risk of implant complications in patients undergoing mastectomy with IIBR compared with hypofractionated PMRT regiment of 40.05Gy in 15 fractions over 3 weeks (2.67Gy per fraction).
Method(s): A single centre retrospective review of data on patients who underwent IIBR followed by PMRT between September 2012 and May 2017 was conducted. Radiotherapy-related complications (surgical site infection, contracture, implant rupture or leakage, wound breakdown) were compared between the two groups of patients receiving conventional and hypofractionated PMRT.
Result(s): Fifty-nine patients underwent IIBR followed by PMRT. Twenty-six patients received hypofractionated PMRT and thirty-three patients received conventional PMRT. Radiotherapy-related complications occurred in 62% of patients in the hypofractionated PMRT group compared with 45% in the conventional PMRT group (p = 0.30). The incidence of capsular contracture (31% in vs. 21%, p = 0.55) and wound breakdown (23% vs. 15%, p = 0.51) was higher in the hypofractionated PMRT group, but surgical site infection (SSI) was more common in the conventional group (4% vs. 6%, p = 1.00).
Discussion(s): Possible confounding factors (BMI, smoking status, and adjuvant chemotherapy) were not analysed due to the small sample size and limitations of the retrospective nature of this study. However, our overall rate of SSI is low in comparison with national data from the NMBRA (2011), which states the SSI rate of 25% in patients who underwent breast reconstruction surgery.
Conclusion(s): This study suggests that the rate of radiotherapy-related complications is lower in patients treated with conventional PMRT compared with hypofractionated PMRT, however the sample size is too small to demonstrate statistical significance. Further research is required to evaluate the effectiveness of conventional PMRT as an option to facilitate immediate implant-based reconstruction following mastectomy.

94. Prepectoral immediate implant-based reconstruction using Braxon acellular dermal matrix-National audit from the United Kingdom

Authors Chandarana M.; Harries S.
Source Cancer Research; Feb 2019; vol. 79 (no. 4)
Publication Date Feb 2019
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Available at Cancer Research 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 Implant based reconstruction is the most common method of reconstruction in the United Kingdom (UK) for women having a mastectomy for breast cancer or as a risk reducing procedure. Prepectoral reconstruction with full implant coverage using an acellular dermal matrix (ADM) - BRAXON - is a relatively new technique. Prepectoral reconstruction has the advantages of a better aesthetic outcome, less postoperative pain, quicker return to normal activities and no postoperative problems with animation. We report on the outcomes of prepectoral immediate breast reconstruction (IBR) using BraxonADM from a National audit. Methods A retrospective multi-centre audit of all direct-to-implant reconstructions using Braxonin the United Kingdom was carried out . The demographic details, treatment details, short-term and long-term outcomes were evaluated. Factors affecting complication rates were analysed. Results Data from 406 Braxon reconstructions in 324 patients across 20 centres in the UK were collated. Mean age of the cohort was 50.48 (SD - 11.11, range - 20-82) years with a mean BMI of 26.05 (SD - 4.87, range - 18-42) kg/m^2. Demographic and treatment characteristics are given in Table 1. The mean follow-up period was 10.94 months (0.3 to 34.8 months). The overall complication rate was 32% with a readmission rate of 16% and an implant loss rate of 9%. Of the factors evaluated for their effect on complication rates, patient age (p = 0.005), therapeutic mastectomy (p = 0.001), specimen weight (p < 0.005) and axillary nodal clearance (p = 0.006) were significantly associated with higher complication rate on univariate analysis. Patient demographics and treatment details View inline Conclusion Implant-based prepectoral breast reconstruction with Braxonhas satisfactory short-term and long-term operative outcomes, comparable to the National Mastectomy Audit data from the United Kingdom. Patient-reported outcomes, aesthetic outcomes and post operative pain need to be evaluated. Further studies with larger numbers of patients and longer follow-up have been planned.

95. Anaesthesia for open abdominal aortic surgery

Authors Duncan A.; Pichel A.
Source Anaesthesia and Intensive Care Medicine; May 2019; vol. 20 (no. 5); p. 281-286
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Available at Anaesthesia and Intensive Care Medicine 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 prevalence of abdominal aortic aneurysm (AAA)and the number of patients undergoing aneurysm repair is increasing. The UK has worked tirelessly to reduce its operative mortality rates for elective open AAA repair with the introduction of a quality improvement programme. Reducing death from ruptured aortic aneurysm has been the focus of the national screening programme. Despite the increased prevalence of disease and intervention, the popularity of open repair has diminished since the advent of endovascular repair (EVAR). The short-term benefits of EVAR when compared to open repair are well described; however, the long-term survival benefits, freedom form re-intervention and cost effectiveness of EVAR are not proven. The choice of technique for emergency AAA repair is contentious, with the more traditional approach of open repair being rapidly overtaken by endovascular options. In this article we provide an overview of the evidence supporting the different treatment options, outline current approaches to risk stratification, describe the key physiological changes that occur during open repair and describe an overview of the approach to perioperative management.

96. Case Series of a Knowledge Translation Intervention to Increase Upper Limb Exercise in Stroke Rehabilitation

Authors Connell L.A.; McMahon N.E.; Tyson S.F.; Watkins C.L.; Eng J.J.
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Available at Physical therapy 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 AND PURPOSE: Current approaches to upper limb rehabilitation are not sufficient to drive neural reorganization and maximize recovery after stroke. To address this evidence-practice gap, a knowledge translation intervention using the Behaviour Change Wheel was developed. The intervention involves collaboratively working with stroke therapy teams to change their practice and increase therapy intensity by therapists prescribing supplementary self-directed arm exercise. The purposes of this case series are: (1) to provide an illustrative example of how a research-informed process changed clinical practice and (2) to report on staff members' and patients' perceptions of the utility of the developed intervention. CASE DESCRIPTIONS: A participatory action research approach was used in 3 stroke rehabilitation units in the United Kingdom. The intervention aimed to change 4 therapist-level behaviors: (1) screening patients for suitability for supplementary self-directed arm exercise, (2) provision of exercises, (3) involving family and caregivers in assisting with exercises, and (4) monitoring and progressing exercises. Data on changes in practice were collected by therapy teams using a bespoke audit tool. Utility of the intervention was explored in qualitative interviews with patients and staff.
OUTCOME(S): Components of the intervention were successfully embedded in 2 of the 3 stroke units. At these sites, almost all admitted patients were screened for suitability for supplementary self-directed exercise. Exercises were provided to 77%, 70%, and 88% of suitable patients across the 3 sites. Involving family and caregivers and monitoring and progressing exercises were not performed consistently.
CONCLUSION(S): This case series is an example of how a rigorous research-informed knowledge translation process resulted in practice change. Research is needed to demonstrate that these changes can translate into increased intensity of upper limb exercise and affect patient outcomes.

97. Alternative Fistula Risk Score for Pancreatoduodenectomy (a-FRS): Design and International External Validation

Authors Mungroop T.H.; van Rijssen L.B.; Klompmaker S.; van Dieren S.; Busch O.R.; Besselink M.G.; van Klaveren D.; Smits F.J.; Molenaar I.Q.; van Woerden V.; van Dam R.M.; Linnemann R.J.; Nieuwenhuijs V.B.; de Pastena M.; Marchegiani G.; Bassi C.; Ecker B.L.; Bonsing B.; Vollmer C.M.; Erdmann J.; van Eijck C.H.; Steyerberg E.W.; Groot Koerkamp B.; Gerhards M.F.; van Goor H.; van der Harst E.; de Hingh I.H.; Luyer M.; de Jong K.P.; Kazemier G.; Shamali A.; Barbaro S.; Armstrong T.; Takhar A.; Hamady Z.; Abu Hilal M.; Klaase J.; Lips D.J.; Rupert C.; van Santvoort H.C.; Scheepers J.J.; van der Schelling G.P.

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Abstract OBJECTIVE: The aim of this study was to develop an alternative fistula risk score (a-FRS) for postoperative pancreatic fistula (POPF) after pancreatoduodenectomy, without blood loss as a predictor. BACKGROUND: Blood loss, one of the predictors of the original-FRS, was not a significant factor during 2 recent external validations.
METHOD(S): The a-FRS was developed in 2 databases: the Dutch Pancreatic Cancer Audit (18 centers) and the University Hospital Southampton NHS. Primary outcome was grade B/C POPF according to the 2005 International Study Group on Pancreatic Surgery (ISGPS) definition. The score was externally validated in 2 independent databases (University Hospital of Verona and University Hospital of Pennsylvania), using both 2005 and 2016 ISGPS definitions. The a-FRS was also compared with the original-FRS.
RESULT(S): For model design, 1924 patients were included of whom 12% developed POPF. Three predictors were strongly associated with POPF: soft pancreatic texture [odds ratio (OR) 2.58, 95% confidence interval (95% CI) 1.80-3.69], small pancreatic duct diameter (per mm increase, OR: 0.68, 95% CI: 0.61-0.76), and high body mass index (BMI) (per kg/m increase, OR: 1.07, 95% CI: 1.04-1.11). Discrimination was adequate with an area under curve (AUC) of 0.75 (95% CI: 0.71-0.78) after internal validation, and 0.78 (0.74-0.82) after external validation. The predictive capacity of a-FRS was comparable with the original-FRS, both for the 2005 definition (AUC 0.78 vs 0.75, P = 0.03), and 2016 definition (AUC 0.72 vs 0.70, P = 0.05).
CONCLUSION(S): The a-FRS predicts POPF after pancreatoduodenectomy based on 3 easily available variables (pancreatic texture, duct diameter, BMI) without blood loss and pathology, and was successfully validated for both the 2005 and 2016 POPF definition. The online calculator is available at www.pancreascalculator.com.

98. Improving the Usefulness and Use of Patient Survey Programs: National Health Service Interview Study

Authors	Flott K.; Darzi A.; Mayer E.; Gancarczyk S.
Source	Journal of medical Internet research; Apr 2018; vol. 20 (no. 4)
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PubMedID	29691207
Database	EMBASE
	Available at Journal of medical Internet research from Europe PubMed Central - Open Access
	Available at Journal of medical Internet research from EBSCO (MEDLINE Complete)
Abstract	BACKGROUND: A growing body of evidence suggests a concerning lag between collection of patient experience data and its application in service improvement. This study aims to identify what health care staff perceive to be the barriers and facilitators to using patient-reported feedback and showcase successful examples of doing so. OBJECTIVE(S): This study aimed to apply a systems perspective to suggest policy improvements that could support efforts to use data on the frontlines. METHOD(S): Qualitative interviews were conducted in eight National Health Service provider locations in the United Kingdom, which were selected based on National Inpatient Survey scores. Eighteen patient-experience leads were interviewed about using patient-reported feedback with relevant staff. Interviews were transcribed and underwent thematic analysis. Staff-identified barriers and facilitators to using patient experience feedback were obtained. RESULT(S): The most frequently cited barriers to using patient reported feedback pertained to interpreting results, understanding survey methodology, presentation of data in both national Care Quality Commission and contractor reports, inability to link data to other sources, and organizational structure. In terms of a wish list for improved practice, staff desired more intuitive survey methodologies, the ability to link patient experience data to other sources, and more examples of best practice in patient experience improvement. Three organizations also provided examples of how they successfully used feedback to improve care. CONCLUSION(S): Staff feedback provides a roadmap for policy makers to reconsider how data is collected and whether or not the national regulations on surveys and patient experience data are meeting the quality improvement needs of local organizations. Copyright ©Kelsey Flott, Ara Darzi, Sarah Gancarczyk, Erik Mayer. Originally published in the Journal of Medical Internet Research (http://www.jmir.org), 24.04.2018.

99. The menopause experience: A quality improvement project

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Abstract Background: In 2016, 10,350 women living with HIV aged 45-56 attended HIV clinics in the UK. The BHIVA/ BASHH/FSRH Guidelines for sexual and reproductive health (2017) state that all women between the ages 45-56 should have an annual menopausal review and given information about the perimenopause/menopause along with information around the use of HRT.
Aim(s): Approximately 13% (153/1200) of our HIV cohort are women aged between 45-56. Our aim was to review these women attending our services and assess if they have ever discussed menopause, have menopausal symptoms and whether they might benefit from a discussion about or initiating HRT.
Method(s): A comprehensive questionnaire looking at contraception, menopausal symptoms, comorbidities, medications and lifestyle risk factors was developed and information obtained. Case note review was undertaken following completion of the questionnaire and information gathered around clinical review, FRAX and cardiovascular scores were calculated and their antiretroviral (ARV) regime was reviewed.
Result(s): 20 women between age 45-56 completed the questionnaire. 80% were Black African/Black Caribbean, 15% White British and 5% Asian in Ethnicity. 90% were are on HIV treatment and all had an undetectable viral load. Of these women, none of them had a menopause review in their visits with a HIV physician but 40% had menopausal symptoms which would have been identified if questioned. 20% had heard of HRT and only half of them had been given this information from a healthcare professional, otherwise had heard about it through word of mouth and no information had been given/sought about whether they would be eligible or would help with their menopausal symptoms. The remaining 60% who had no symptoms, were still having regular periods but given their age, are likely to reach menopause in the near future so would be worth discussing symptoms/signs in advance and information around Hormone Replacement Therapy (HRT). Only 1 of these symptomatic women had discussed the menopause with their GP and started HRT which they found beneficial. Women with HIV are more likely to undergo pre-mature menopause and hence it is very important to enquire about menopause at least once a year in their annual review. A comprehensive review to include their FRAX, cardiovascular risk scores, their current anti-retroviral regimen, pharmacological review to identify any drug-drug interactions in women of this age group is crucial to minimise any drug related side effects. Information on HRT should be made readily available for these women. Every unit should have a specialist interested in menopausal issues to improve the quality of care provided, as HIV now is more about living long and living healthy.
Conclusion(s): This survey has highlighted that menopausal symptoms are extremely common in women of the specified age group. Based on our survey, we aim to improve 'menopausal awareness' by not only identifying the issues in our annual review but also providing information and guidance to deal with menopause.

100. Mortality and causes of death among HIV patients in London in 2017

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Abstract

Background: Since 2013, the London Mortality Study Review Group has conducted annual reviews of deaths among people with HIV to reduce avoidable mortality and improve patient care.
Method(s): London trusts commissioned by NHS England to provide HIV care were invited to report 2017 data on patient deaths. Data were submitted to Public Health England using a modified Causes of Death in HIV reporting form. Cause of death was categorised by an epidemiologist and two HIV clinicians.
Result(s): All 17 trusts provided data, reporting 166 deaths; 75% (124) deaths were among men and median age of death was 52 years (IQR: 44-64). Cause of death was ascertained for 88% (146) of patients, with the most common cause being non-AIDS cancers (28%) followed by AIDS (20%), non-AIDS infections (18%), substance misuse (9%), cardiovascular disease (CVD)/stroke (8%), accident/suicide (7%), respiratory disease (4%), liver disease (1%) and other causes (4%). Death was expected for 66% (98) of patients and of these, 72% (71) had a prior end-of-life care discussion. Median time from diagnosis to death was 13 years (IQR: 7-19); 13 patients died within a year of diagnosis (at diagnosis: CD4 <350 cells/ mm^3: 69%; AIDS: 54%). Reported risk factors in the year prior to death included: tobacco smoking (29%; 38), excessive alcohol consumption (18%; 25), injecting (10%; 14) and non-injecting (14%; 20) drug use. Several co-morbidities were reported: CVD (39%; 53), mental illness (36%; 47), cancer (33%; 51), liver disease (30%; 39), respiratory conditions (26%; 31), diabetes mellitus (23%; 30), renal disease (21%; 26) and other chronic conditions (43%; 46). Common mental illnesses included: depression (39), psychosis (10) and anxiety (11), while the most common cancers were non-Hodgkin's lymphoma (13) and lung cancer (11). Treatment coverage (95%; 157) and viral suppression <200 copies/ml (73%; 116) among patients were high.
Conclusion(s): Despite free care and treatment, HIV patients continue to die from AIDS in 2017, as a direct result of late diagnosis; HIV testing must increase to reduce these preventable deaths. However, encouragingly, most deaths among HIV patients reported as part of the audit were not directly HIVrelated. For people living with HIV longer term, health promotion must be improved through risk reduction, including modifying cardiovascular risk factors and addressing psychological needs and substance misuse.