# **HDAS** Export
# **Search Strategy** EMBASE - AUDIT

**17 May 18 - 10:39**

---

## **Strategy** 432448/9

See full search strategy

| # | Database | Search term | Results |
|---|---|---|---|
| 9 | 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"/)) [DT 2018-2018] [Since 17-May-2018] | 113 |

## **Contents** 100 of 113 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"/)) [DT 2018-2018] [Since 17-May-2018]

## **Results** 100 of 113 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"/)) [DT 2018-2018] [Since 17-May-2018]

### 1. Socioeconomic differences in selection for liver resection in metastatic colorectal cancer and the impact on survival

| | |
|---|---|
| **Authors** | Vallance A.E.; van der Meulen J.; Kuryba A.; Walker K.; Braun M.; Jayne D.G.; Hill J.; Cameron I.C. |
| **Source** | European Journal of Surgical Oncology; 2018 |
| **Publication Date** | 2018 |
| **Publication Type(s)** | Article In Press |
| **Database** | EMBASE |
| | Available at European journal of surgical oncology : the journal of the European Society of Surgical Oncology and the British Association of Surgical Oncology from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection<br>Available at European journal of surgical oncology : the journal of the European Society of Surgical Oncology and the British Association 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 |
| **Abstract** | Background: Socioeconomic inequalities in colorectal cancer (CRC) survival are well recognised. The aim of this study was to describe the impact of socioeconomic deprivation on survival in patients with synchronous CRC liver-limited metastases, and to investigate if any survival inequalities are explained by differences in liver resection rates. Methods: Patients in the National Bowel Cancer Audit diagnosed with CRC between 2010 and 2016 in the English National Health Service were included. Linked Hospital Episode Statistics data were used to identify the presence of liver metastases and whether a liver resection had been performed. Multivariable random-effects logistic regression was used to estimate the odds ratio (OR) of liver resection by Index of Multiple Deprivation (IMD) quintile. Cox-proportional hazards model was used to compare 3-year survival. Results: 13,656 patients were included, of whom 2213 (16.2%) underwent liver resection. Patients in the least deprived IMD quintile were more likely to undergo liver resection than those in the most deprived quintile (adjusted OR 1.42, 95% confidence interval (CI) 1.18-1.70). Patients in the least deprived quintile had better 3-year survival (least deprived vs. most deprived quintile, 22.3% vs. 17.4%; adjusted hazard ratio (HR) 1.20, 1.11-1.30). Adjusting for liver resection attenuated, but did not remove, this effect. There was no difference in survival between IMD quintile when restricted to patients who underwent liver resection (adjusted HR 0.97, 0.76-1.23). Conclusions: Deprived CRC patients with synchronous liver-limited metastases have worse survival than more affluent patients. Lower rates of liver resection in more deprived patients is a contributory factor. Copyright © 2018 |

### 2. A population-based audit of surgical practice and outcomes of oncoplastic breast conservations in Scotland - An analysis of 589 patients

| | |
|---|---|
| **Authors** | Romics L.; Macaskill E.J.; Pitsinis V.; Fernandez T.; Barber M.; Dixon J.M.; Simpson L.; Masannat Y.; Morrow E.; Tovey S.; Stallard S.; Doughty J.; Weiler-Mithoff E.; Malyon A.; Campbell E.J.; Mansell J. |
| **Source** | European Journal of Surgical Oncology; Jul 2018; vol. 44 (no. 7); p. 939-944 |
| **Publication Date** | Jul 2018 |
| **Publication Type(s)** | Article |
| **Database** | EMBASE |
| | Available at European journal of surgical oncology : the journal of the European Society of Surgical Oncology and the British Association of Surgical Oncology 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).<br>Available at European journal of surgical oncology : the journal of the European Society of Surgical Oncology and the British Association of Surgical Oncology from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article. |

| | |
|---|---|
| **Abstract** | Introduction: Current evidence for oncoplastic breast conservation (OBC) is based on single institutional series. Therefore, we carried out a population-based audit of OBC practice and outcomes in Scotland. Methods: A predefined database of patients treated with OBC was completed retrospectively in all breast units practicing OBC in Scotland. Results: 589 patients were included from 11 units. Patients were diagnosed between September 2005 and March 2017. High volume units performed a mean of 19.3 OBCs per year vs. low volume units who did 11.1 (p = 0.012). 23 different surgical techniques were used. High volume units offered a wider range of techniques (8-14) than low volume units (3-6) (p = 0.004). OBC was carried out as a joint operation involving a breast and a plastic surgeon in 389 patients. Immediate contralateral symmetrisation rate was significantly higher when OBC was performed as a joint operation (70.7% vs. not joint operations: 29.8%; p < 0.001). The incomplete excision rate was 10.4% and was significantly higher after surgery for invasive lobular carcinoma (18.9%; p = 0.0292), but was significantly lower after neoadjuvant chemotherapy (3%; p = 0.031). 9.2% of patients developed major complications requiring hospital admission. Overall the complication rate was significantly lower after neoadjuvant chemotherapy (p = 0.035). The 5 year local recurrence rate was 2.7%, which was higher after OBC for DCIS (8.3%) than invasive ductal cancer (1.6%; p = 0.026). 5-year disease-free survival was 91.7%, overall survival was 93.8%, and cancer-specific survival was 96.1%. Conclusion: This study demonstrated that measured outcomes of OBC in a population-based multi-centre setting can be comparable to the outcomes of large volume single centre series.<br>Copyright © 2018 Elsevier Ltd, BASO ~ The Association for Cancer Surgery, and the European Society of Surgical Oncology |

### 3. Variation in laparoscopic anti-reflux surgery across England: a 5-year review

| | |
|---|---|
| **Authors** | Palser T.R.; Bowrey D.J.; Ceney A.; Swift S.; Navarro A.; Beckingham I.J. |
| **Source** | Surgical Endoscopy and Other Interventional Techniques; Jul 2018; vol. 32 (no. 7); p. 3208-3214 |
| **Publication Date** | Jul 2018 |
| **Publication Type(s)** | Article |
| **Database** | EMBASE |
| | Available at Surgical endoscopy from Publishers' website (via doi.org) |
| | Available at Surgical endoscopy 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 Surgical endoscopy 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: Laparoscopic anti-reflux surgery (LARS) remains central to the management of gastro-oesophageal reflux disease but the scale and variation in provision in England is unknown. The aims of this study were firstly to examine the processes and outcomes of anti-reflux surgery in England and compare them to national guidelines and secondly to explore potential variations in practice nationally and establish peer benchmarks. Methods: All adult patients who underwent LARSin England during the Financial years FY 2011/2012-FY 2016/2017 were identified in the Surgeon's Workload Outcomes and Research Database (SWORD), which is based on the Hospital Episode Statistics (HES) data warehouse. Outcomes included activity volume, day-case rate, short-stay rate, 2- and 30-day readmission rates and 30-day re-operation rates. Funnel plots were used to identify national variation in practice. Results: In total, 12,086 patients underwent LARS in England during the study period. The operation rate decreased slightly over the study period from 5.2 to 4.6 per 100,000 people. Most outcomes were in line with national guidelines including the conversion rate (0.76%), 30-day re-operation rate (1.43%) and 2- and 30-day readmission rates (1.65 and 8.54%, respectively). The day-case rate was low but increased from 7.4 to 15.1% during the 5-year period. Significant variation was found, particularly in terms of hospital volume, and day-case, short-stay and conversion rates. Conclusion: Although overall outcomes are comparable to studies from other countries, there is significant variation in anti-reflux surgery activity and outcomes in England. We recommend that units use these data to drive local quality improvement efforts.<br>Copyright © 2018, The Author(s). |

### 4. Look, then leap: quality and improving maternity care

| | |
|---|---|
| **Authors** | Shah N.T. |
| **Source** | BJOG: An International Journal of Obstetrics and Gynaecology; Jun 2018; vol. 125 (no. 7); p. 866 |
| **Publication Date** | Jun 2018 |
| **Publication Type(s)** | Note |
| **Database** | EMBASE |
| | Available at BJOG : an international journal of obstetrics and gynaecology from Wiley Online Library Medicine and Nursing Collection 2018 - NHS |
| | Available at BJOG : an international journal of obstetrics and gynaecology 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 BJOG : an international journal of obstetrics and gynaecology 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. The increasing incidence and survival of thyroid malignancy in the west of Scotland

| | |
|---|---|
| **Authors** | Oozeer N.; Konstantinidis G.; Clark L.; Townsley R.; Reed N. |
| **Source** | Journal of Laryngology and Otology; 2018; vol. 132 (no. 4); p. 4-5 |
| **Publication Date** | 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at The Journal of Laryngology & Otology 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).<br>Available at The Journal of Laryngology & Otology 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 audit the incidence and survival of thyroid malignancy in the west of Scotland. Methods A prospectively held database of all thyroid malignancy treated in the west of Scotland between 1990 and 2011 was retrospectively reviewed. The incidence, overall survival and disease-free survival were calculated using the Kaplan-Meier method. Results Of the 1496 cases analysed, the majority were female with an average age of 58 years. Papillary cancer was more common in the younger patients. An increasing incidence of thyroid malignancy, especially papillary cancer, over the last 20 years was seen. The Kaplan-Meier survival and diseasefree curves for each histological subtype showed increasing survival. Conclusion Evolution in clinical practice may have played a role in the increased incidence of thyroid malignancy. Despite this increased incidence, there has been a decrease in overall mortality from thyroid malignancy, with improved survival estimates at 1, 5 and 10 years. |

### 6. Peri-operative management of paediatric obstructive sleep apnoea

| | |
|---|---|
| **Authors** | Vaughan E.; Fynn D.; Urquhart D.; Starritt N.E.; Montague M.-L.; Sharma A. |
| **Source** | Journal of Laryngology and Otology; 2018; vol. 132 (no. 4); p. 4 |
| **Publication Date** | 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at The Journal of Laryngology & Otology 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).<br>Available at The Journal of Laryngology & Otology 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 Polysomnography is the 'gold standard' for diagnosing obstructive sleep apnoea (OSA). In the UK, diagnosis (and the decision to proceed to adenotonsillectomy) is usually clinical as polysomnography is not widely available. The Sleep Service at our centre provides limited-channel cardiorespiratory sleep studies for children with suspected OSA. This affords categorisation of OSA severity and informs of the need for a high dependency unit bed post-operatively. This audit reviews sleep study outcomes at our centre, and examines their impact on operative management and the use of high dependency unit beds. Objectives The principal objectives were to determine whether there was a correlation between a clinical diagnosis of OSA and sleep study outcome at our centre, and to assess whether the high dependency unit beds requested were justified for children undergoing adenotonsillectomy for OSA. Method This study involved a retrospective analysis of non-syndromic children without co-morbidities who had undergone limited-channel cardiorespiratory sleep study at our centre from January 2009 to December 2012. Results A total of 271 children aged 2-13 years were included in the analysis. The sleep study showed no evidence of OSA in 45 per cent of children (n = 121). Thirty per cent of all children (n = 80) did not proceed to adenotonsillectomy on this basis. Of 191 children undergoing adenotonsillectomy, sleep study informed a request for a high dependency unit bed in 17 cases (8.9 per cent). Only five children (2.6 per cent) had post-operative airway sequelae that warranted high dependency unit care. Conclusion Cardiorespiratory sleep studies appeared to help avoid unnecessary surgery in 30 per cent of children. This finding requires further analysis. The low rate of airway sequelae suggests that high dependency unit level care is probably only indicated in cases of severe OSA. |

### 7. The Aberdeen video-linked tele-endoscopy clinic

| | |
|---|---|
| **Authors** | Bannister M.; Ah-See K. |
| **Source** | Journal of Laryngology and Otology; 2018; vol. 132 (no. 4); p. 4 |
| **Publication Date** | 2018 |
| **Publication Type(s)** | Conference Abstract |

| | |
|---|---|
| **Database** | EMBASE<br>Available at The Journal of Laryngology & Otology 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).<br>Available at The Journal of Laryngology & Otology 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 Demand for hospital out-patient appointments and for patients being treated closer to their home is increasing. We have previously reported the development of a videolinked tele-endoscopy clinic, which is offered to those in the Shetland Islands, UK. We present the audit findings of the first five years of the clinic's operation. This audit was conducted to assess the efficiency savings achieved by avoiding travel to Aberdeen from Shetland, whilst maintaining a safe, high-quality service. Materials and methods Prospective data were collected over a five-year period from 2007 to 2012. The principal outcome measure was the ability to manage the patient during a single consultation without the need for a review appointment. A secondary outcome measure was the overall cost savings of the service. Results In total, 160 patients were considered appropriate for consultation in the tele-endoscopy clinic. A total of 118 appointments were scheduled. Appointments were attended by 115 patients (97.5 per cent). Eighty-nine patients (77.4 per cent) were able to have their presenting complaint managed in a single consultation and were discharged. Nineteen patients (16.5 per cent) required further review principally in the visiting bi-monthly ENT clinic on Shetland. Seven patients (6.1 per cent) were scheduled for surgery. The initial capital cost of setting up and equipping the video clinic was 22 612. The staff costs per tele-endoscopy clinic are approximately 400, which totals at 8400 for the 5 years (21 clinics). The total cost of the clinic has been 31 012 since inception. The cost of a same-day return flight is approximately 400, totalling 46 000 for the 115 patients. Taxi transportation costs from Aberdeen airport to Aberdeen Royal Infirmary total 4600 for all 115 patients. The total cost of transportation for patients from Shetland to our hospital in Aberdeen is 50 600. Discussion The tele-endoscopy clinic is an efficient, safe and popular service. It is also cost-effective, saving travel costs and patients' time. This service would be applicable to other ENT centres who serve peripheral hospitals. |

### 8. ENT audit and research in the era of trainee collaboratives

| | |
|---|---|
| **Authors** | Smith M.E.; Hardman J.; Ellis M.; Williams R.J. |
| **Source** | European Archives of Oto-Rhino-Laryngology; Jul 2018; vol. 275 (no. 7); p. 1935-1938 |
| **Publication Date** | Jul 2018 |
| **Publication Type(s)** | Article |
| **Database** | EMBASE<br>Available at European archives of oto-rhino-laryngology : official journal of the European Federation of Oto-Rhino-Laryngological Societies (EUFOS) : affiliated with the German Society for Oto-Rhino-Laryngology - Head and Neck Surgery from Publishers' website (via doi.org)<br>Available at European archives of oto-rhino-laryngology : official journal of the European Federation of Oto-Rhino-Laryngological Societies (EUFOS) : affiliated with the German Society for Oto-Rhino-Laryngology - Head and Neck 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** | Large surgical audits and research projects are complex and costly to deliver, but increasingly surgical trainees are delivering these projects within formal collaboratives and research networks. Surgical trainee collaboratives are now recognised as a valuable part of the research infrastructure, with many perceived benefits for both the trainees and the wider surgical speciality. In this article, we describe the activity of ENT trainee research collaboratives within the UK, and summarise how INTEGRATE, the UK National ENT Trainee Research Network, successfully delivered a national audit of epistaxis management. The prospective audit collected high-quality data from 1826 individuals, representing 94% of all cases that met the inclusion criteria at the 113 participating sites over the 30-day audit period. It is hoped that the audit has provided a template for subsequent high-quality and cost-effective national studies, and we discuss the future possibilities for ENT trainee research collaboratives.<br>Copyright © 2018, The Author(s). |

### 9. Indications and complications of inpatient parenteral nutrition prescribed to children in a large tertiary referral hospital

| | |
|---|---|
| **Authors** | Mantegazza C.; Landy N.; Koglmeier J.; Zuccotti G.V. |
| **Source** | Italian Journal of Pediatrics; Jun 2018; vol. 44 (no. 1) |
| **Publication Date** | Jun 2018 |
| **Publication Type(s)** | Article |
| **Database** | EMBASE<br>Available at Italian journal of pediatrics from BioMed Central<br>Available at Italian journal of pediatrics from Europe PubMed Central - Open Access |

| | |
|---|---|
| **Abstract** | Background: Parenteral Nutrition (PN) is prescribed to children with intestinal failure. Although life saving, complications are common. Recommendations for indications and constituents of PN are made in the 2005 guidelines by the European Society of Paediatric Gastroenterology, Hepatology and Nutrition (ESPGHAN). The aim of this study was to establish if the indications for prescribing PN in a tertiary children's hospital were appropriate, and to identify complications encountered. Data were compared to those published by the National Confidential Enquiry into patient outcome and death (NCEPOD) carried out in the United Kingdom in 2010. Methods: Children and newborns receiving inpatient PN over a 6 months period were entered into the study and data was collected prospectively. The appropriate indications for the use of PN were based on the ESPGHAN guidelines. Recorded complications were divided into metabolic, central venous catheter (CVC) related, hepatobiliary and nutritional. Results: A total of 303 children (67 newborns) were entered into the study. The main indications for the start of PN were critical illness (66/303), surgery (63/303) and bone marrow transplantation (28/303). The ESPGHAN recommendations were followed in 91.7% (278/303) of cases (95.5% of newborns, 90.7% of children). PN was considered inappropriate in 12/303 patients and equivocal in 13. The mean PN duration was 18 days (1-160) and the incidence of complications correlated to the length of PN prescribed. Metabolic, hepatobiliary and CVC related complications affected 74.6, 24.4, 16.4% of newborns and 76.7, 37.7 and 24.6% of children respectively. In relation to the appropriate indications for the start of PN our results mirrored those reported by the NCEPOD audit (92.4% of newborns and 88.6% children). However, the incidence of metabolic disturbances was higher in our cohort (74.6% vs 30.4% in children, 76.7% vs 14.3% in newborns) but CVC related complications lower amongst our newborns (16,4% vs 25%). Conclusions: Although the indications for inpatient PN in children is mostly justified, there is still a proportion who is receiving PN unnecessarily. PN related complications remain common. There is a need for better education amongst health professionals prescribing PN and access to nutritional support teams to reduce unwanted side effects.<br>Copyright © 2018 The Author(s). |

**10. Guided self-help cognitive-behaviour Intervention for VoicEs (GiVE): Results from a pilot randomised controlled trial in a transdiagnostic sample**

| | |
|---|---|
| **Authors** | Hazell C.M.; Hayward M.; Cavanagh K.; Strauss C.; Jones A.-M. |
| **Source** | Schizophrenia Research; May 2018; vol. 195 ; p. 441-447 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Article |
| **Database** | EMBASE<br>Available at Schizophrenia 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: Few patients have access to cognitive behaviour therapy for psychosis (CBTp) even though at least 16 sessions of CBTp is recommended in treatment guidelines. Briefer CBTp could improve access as the same number of therapists could see more patients. In addition, focusing on single psychotic symptoms, such as auditory hallucinations ('voices'), rather than on psychosis more broadly, may yield greater benefits. Method: This pilot RCT recruited 28 participants (with a range of diagnoses) from NHS mental health services who were distressed by hearing voices. The study compared an 8-session guided self-help CBT intervention for distressing voices with a wait-list control. Data were collected at baseline and at 12 weeks with post-therapy assessments conducted blind to allocation. Voice-impact was the pre-determined primary outcome. Secondary outcomes were depression, anxiety, wellbeing and recovery. Mechanism measures were self-esteem, beliefs about self, beliefs about voices and voice-relating. Results: Recruitment and retention was feasible with low study (3.6%) and therapy (14.3%) dropout. There were large, statistically significant between-group effects on the primary outcome of voice-impact (d = 1.78; 95% CIs: 0.86-2.70), which exceeded the minimum clinically important difference. Large, statistically significant effects were found on a number of secondary and mechanism measures. Conclusions: Large effects on the pre-determined primary outcome of voice-impact are encouraging, and criteria for progressing to a definitive trial are met. Significant between-group effects on measures of self-esteem, negative beliefs about self and beliefs about voice omnipotence are consistent with these being mechanisms of change and this requires testing in a future trial.<br>Copyright © 2017 The Authors |

**11. Why participants in The United Kingdom Rotator Cuff Tear (UKUFF) trial did not remain in their allocated treatment arm: a qualitative study**

| | |
|---|---|
| **Authors** | Minns Lowe C.J.; Barker K.L.; Moser J. |
| **Source** | Physiotherapy (United Kingdom); Jun 2018; vol. 104 (no. 2); p. 224-231 |
| **Publication Date** | Jun 2018 |
| **Publication Type(s)** | Article |
| **Database** | EMBASE<br>Available at Physiotherapy from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection |

Available at Physiotherapy 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

**Abstract** Objective: The UKUFF trial was a three-way parallel group randomised trial comparing surgical and non-surgical treatments for people with rotator cuff tears of their shoulder. High crossover between arms in the UKUFF led to the original trial design being reconfigured; 'Rest then Exercise' was halted. This study explored why participants recruited did not remain within allocated treatment arms and explored crossover and surgical decision making. Design: A qualitative phenomenological approach. Participants: Purposive sampling (n = 18) included participants randomised to 'Rest then Exercise' arm considered least likely to proceed to surgery but who had surgery, plus participants from all arms not having surgery. Methods: In-depth, semi-structured interviews were recorded and transcribed. Field-notes, memos, member-checking and a reflexive diary were used. Data analyses: In accordance with Interpretative Phenomenological Analysis. Peer review, code-recode audits and constant comparison occurred throughout. Results: 1. Impact of symptoms and diagnosis: these influenced crossover; long durations of severe pain and failed conservative treatment increased eagerness for surgery. 2. Perceptions and expectations of treatment: surgery provided hope for participants, especially when "Rest then Exercise" was perceived as having previously failed. Surgeons were perceived to believe "tears need repairing". 3. Professionals know best: autonomy and communication: patients deciding not to have surgery had to actively leave the surgical waiting list. Increasing age, carer role, self-employment, co-morbidity and improving symptoms were reasons described for declining surgery. Conclusions: Most participants had failed conservative treatment before trial entry and described strong preferences regarding treatment. Trials should demonstrate patient and clinician equipoise but participants' rarely described equipoise. If conservative treatments are usually provided sequentially in clinical practice, it may be inappropriate to include them as comparators in surgical trials. This is a qualitative study and not eligible for trial registration since it was carried out independently of the UKUFF trial (UKUFF ISRCTN97804283 Date assigned 29/06/2007).
Copyright © 2017 Chartered Society of Physiotherapy

### 12. The clinical utility of genetic testing of tissues from pregnancy losses

**Authors** Waterman C.A.; Batstone P.; Bown N.; English C.J.; Cresswell L.; Delmege C.; Fews G.; McMullan D.; Grimsley L.; Imrie S.; Kulkarni A.; Johnson R.; Mann K.; Morgan S.M.; Roberts P.; Simonic I.; Trueman S.; Wall M.
**Source** BJOG: An International Journal of Obstetrics and Gynaecology; Jun 2018; vol. 125 (no. 7); p. 867-873
**Publication Date** Jun 2018
**Publication Type(s)** Article
**Database** EMBASE
Available at BJOG: An International Journal of Obstetrics & Gynaecology from Wiley Online Library Medicine and Nursing Collection 2018 - NHS
Available at BJOG: An International Journal of Obstetrics & Gynaecology from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection
Available at BJOG: An International Journal of Obstetrics & Gynaecology 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

**Abstract** Objective: To map the current testing being undertaken following pregnancy loss across the UK and to examine the clinical utility in terms of identifying a cause for the loss and in identifying couples at risk of an unbalanced liveborn child. Design: Retrospective audit. Setting: UK, for the year 2014. Population: An audit of 6465 referrals for genetic testing of tissue samples following pregnancy loss. Methods: Data were obtained by questionnaire from 15 UK regional genetics laboratories. Main outcome measures: Data were analysed with respect to gestational age, the presence of identified fetal anomalies, methodologies used, abnormality rates and the presence of a parental balanced rearrangement. Results: Of 6465 referrals a genetic cause was identified in 22% of cases (before 12 weeks' gestation, in 47%; at 12-24 weeks, in 14%; after 24 weeks, in 6%). In 0.4% of cases a balanced parental rearrangement was identified where there was a risk of an affected liveborn child in a future pregnancy. Eighty percent of genetic imbalances identified were aneuploidy or triploidy and could be identified by quantitative fluorescence polymerase chain reaction alone. There was significant variation across the UK in acceptance criteria, testing strategies and thus level of resolution of testing. Conclusions: Genetic testing of tissues following pregnancy loss identifies a probable cause of fetal demise in 22% of cases, but it is of low clinical utility in identifying couples at risk of a future unbalanced liveborn child. A comprehensive multidisciplinary review is needed to develop proposals for an affordable and equitable service. Tweetable abstract: UK audit of genetic testing of fetal loss shows variation in access to and resolution of analysis.
Copyright © 2016 Royal College of Obstetricians and Gynaecologists

### 13. Presenting symptoms and long-term survival in head and neck cancer

**Authors** Douglas C.M.; Ingarfield K.; McMahon A.D.; Conway D.I.; Savage S.A.; MacKenzie K.
**Source** Clinical Otolaryngology; Jun 2018; vol. 43 (no. 3); p. 795-804
**Publication Date** Jun 2018

**Publication Type(s)** Article
**Database** EMBASE
Available at Clinical otolaryngology : official journal of ENT-UK ; official journal of Netherlands Society for Oto-Rhino-Laryngology & Cervico-Facial Surgery from Wiley Online Library Medicine and Nursing Collection 2018 - NHS
Available at Clinical otolaryngology : official journal of ENT-UK ; official journal of Netherlands Society for Oto-Rhino-Laryngology & Cervico-Facial Surgery 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 Clinical otolaryngology : official journal of ENT-UK ; official journal of Netherlands Society for Oto-Rhino-Laryngology & Cervico-Facial 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** Objectives: To assess how type and number of symptoms are related to survival in patients with head and neck cancer. Design: Patients were followed up for over 10 years from the Scottish Audit of Head and Neck Cancer (national cohort of head and neck cancer patients in Scotland 1999-2001). September 2013, cohort was linked to national mortality data. First, second and third presenting symptoms were recorded at diagnosis. Setting: National prospective audit-Scotland. Participants: A subset of 1589 patients, from the original cohort of 1895, who had cancer arising from one of the four main subsites; larynx, oropharynx, oral cavity and hypopharynx. Main outcome measures: Median survival in relation to patients' presenting symptoms. Results: A total of 1146 (72%) males and 443 (28%) females, mean age at diagnosis 64 years (13-95). There was a significant difference in survival in relation to the number of the patient's presenting symptoms; one symptom had a median survival of 5.3 years compared with 1.1 years for three symptoms. Patients who presented with weight loss had a median survival of 0.8 years, compared to 4.2 years if they did not (P <.001). Patients who presented with hoarseness had a median survival of 5.9 years compared to 2.6 years without (P <.001). There was no significant difference in long-term survival for patients who presented with an ulcer, compared to those that did not (P =.105). Conclusions: This study highlights the importance of patients' presenting symptoms, giving valuable information in highlighting appropriate "red flag" symptoms and subsequent treatment planning and prognosis.
Copyright © 2017 John Wiley & Sons Ltd

### 14. Addressing the challenges of knowledge co-production in quality improvement: Learning from the implementation of the researcher-in-residence model

**Authors** Vindrola-Padros C.; Fulop N.J.; Eyre L.; Marshall M.; Baxter H.; Cramer H.; Wye L.; George B.; Utley M.; Phillips N.; Brindle P.
**Source** BMJ Quality and Safety; Jun 2018
**Publication Date** Jun 2018
**Publication Type(s)** Article In Press
**Database** EMBASE
Available at BMJ quality & safety from BMJ Journals - NHS
**Abstract** The concept of knowledge co-production is used in health services research to describe partnerships (which can involve researchers, practitioners, managers, commissioners or service users) with the purpose of creating, sharing and negotiating different knowledge types used to make improvements in health services. Several knowledge co-production models have been proposed to date, some involving intermediary roles. This paper explores one such model, researchers-in-residence (also known as embedded researchers'). In this model, researchers work inside healthcare organisations, operating as staff members while also maintaining an affiliation with academic institutions. As part of the local team, researchers negotiate the meaning and use of research-based knowledge to co-produce knowledge, which is sensitive to the local context. Even though this model is spreading and appears to have potential for using co-produced knowledge to make changes in practice, a number of challenges with its use are emerging. These include challenges experienced by the researchers in embedding themselves within the practice environment, preserving a clear focus within their host organisations and maintaining academic professional identity. In this paper, we provide an exploration of these challenges by examining three independent case studies implemented in the UK, each of which attempted to co-produce relevant research projects to improve the quality of care. We explore how these played out in practice and the strategies used by the researchers-in-residence to address them. In describing and analysing these strategies, we hope that participatory approaches to knowledge co-production can be used more effectively in the future.
Copyright © Article author(s) (or their employer(s) unless otherwise stated in the text of the article) 2018. All rights reserved. No commercial use is permitted unless otherwise expressly granted.

### 15. Content of clinical informatics in international training standards for emergency medicine specialists

**Authors** Holroyd B.R.; Beeson M.S.; Hughes T.; Kurland L.; Sherbino J.; Truesdale M.; Hersh W.
**Source** Canadian Journal of Emergency Medicine; May 2018; vol. 20
**Publication Date** May 2018

**Publication Type(s)** Conference Abstract
**Database** EMBASE
Available at CJEM 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 field of Clinical Informatics (CI) and specifically the electronic health record, has been identified as a key facilitator to achieve a sustainable evidence-based healthcare system for the future. International graduate medical education programs have been challenged to ensure their trainees are provided with appropriate skills to deliver effective and efficient healthcare in an evolving environment. This study explored how international Emergency Medicine (EM) specialist training standards address training in relevant areas of CI. Methods: A list of categories of CI competencies relative to EM was developed following a thematic review of published references documenting CI curriculum and competencies. Publically available, published documents outlining core content, curriculum and competencies from international organizations responsible for specialty graduate medical education and/or credentialing in EM for the United States, Canada, Australasia, the United Kingdom and Europe. These EM training standards were reviewed to identify inclusion of topics related to the relevant categories of CI competencies. Results: A total of 23 EM curriculum documents were included in the thematic analysis. Curricula content related to critical appraisal/evidence based medicine, leadership, quality improvement and privacy/security were included in all EM curricula. The CI topics related to fundamental computer skills, computerized provider order entry and patient-centered informatics were only included in the EM curricula documents for the United States and were absent for each other organization. Conclusion: There is variation in the CI related content of the international EM specialty training standards which were reviewed. Given the increasing importance of CI in the future delivery of healthcare, organizations responsible for training and credentialing specialist emergency physicians must ensure their training standards incorporate relevant CI content, thus ensuring their trainees gain competence in essential aspects of CI.

### 16. Comparing echocardiography and cardiac magnetic resonance measures of ejection fraction: Implications for HFMRF research

**Authors** Simpson R.; Bromage D.; Dancy L.; Monaghan M.; McDonagh T.; Sado D.; McDiarmid A.
**Source** Heart; May 2018; vol. 104
**Publication Date** May 2018
**Publication Type(s)** Conference Abstract
**Database** EMBASE
Available at Heart from BMJ Journals - NHS
Available at Heart 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 Heart 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 Cardiovascular MRI (CMR) is the gold standard for calculation of left ventricular ejection fraction (LVEF). Echocardiography (echo) has been shown to consistently underestimate LVEF when compared to CMR. However, this has not been demonstrated for different categories of LVEF. Methods This was an observational study of patients with both CMR and echo studies, between May and October 2017, identified via local UK National Heart Failure Audit data or CMR records. Patients were excluded if the imaging tests were performed >60 days apart or if they had a diagnosis that would predictably change between tests. LVEF categories were defined according to ESC guidelines. Results 103 cases with both imaging modalities were included. Overall, echo underestimated LVEF compared to CMR (CMR 46.5%+/-1.8%, echo 37.33%+/-1.4%, p<0.0001). There was no significant variation in discrepancy over time (r2 0.04). Subgroup analysis according to echo technique (Simpson's vs 3D) and underlying diagnosis (where at least n=10 available) did not alter the overall trend. Importantly, echo underestimated LVEF compared to CMR for all categories of LVEF (<40% CMR 34.0+/-1.7% vs echo 26.1%+/-1.0%, p<0.0001; 40%-50% CMR 60.1+/-2.8% vs 40%-50% echo 45.7% +/-0.7%, p<0.0001;>50% CMR 63.7+/-2.1% vs echo 56.4% +/-0.9%, p=0.0019). Using echo as the default measurement, CMR LVEF assessment would result in 36 patients (35.0%) being reclassified. Conclusion Echo underestimates LVEF compared to CMR across all LVEF subgroups and diagnoses, regardless of technique used. This is of interest in HFmrEF trials where, if echo is used for LVEF assessment, many included patients may have normal systolic function.

### 17. An analysis of capillary blood glucose levels in hospitalized patients with stroke

**Authors** Abduljabbar M.; Dawson J.; Jones G.; Sainsbury C.; McAlpine C.; McPherson S.; Walters M.
**Source** European Stroke Journal; May 2018; vol. 3 (no. 1); p. 619
**Publication Date** May 2018
**Publication Type(s)** Conference Abstract
**Database** EMBASE

**Abstract** Background and Aims: People with acute stroke and diabetes mellitus may have episodes of hypoglycaemia (capillary blood glucose (CBG)< 4mmol/l) and hyperglycaemia (CBG > 15 mmol/l). Capillary blood glucose (CBG) levels may also vary within these more extreme ranges. We aimed to examine the relationship between episodes of hypoglycaemia, hyperglycaemia and variability in CBG (CBGv) with outcome in hospitalised patients with diabetes and acute stroke. Method:We used routinely available clinical data from Scottish National Health Service records and from the Scottish Stroke Care Audit. All CBG measurements during a verified stroke admission were identified and episodes of hypoglycaemia and hyperglycaemia identified. CBGv was defined as the interquartile range (IQR) of all recorded CBG readings during the admission.We extracted outcome date for death, readmission to the hospital, and discharge destination and assessed the relationship with CBG measures using Cox-proportional hazards models and logistic regression. Results:We included 3551 patients. Hypoglycaemia, hyperglycaemia and CBGv were associated with increased risk of death (HR=1.3;1.05-1.6, HR=2.06;1.7-2.5, HR=1.13;1.09-1.17 respectively). Hypoglycaemia was associated with lower rate of readmission (HR=0.85;0.70-0.10, p0.04) and CBGv with an increase (HR=1.04,1.01-1.07, p<0.001). The number of hypoglycaemic episodes (+/-4) was associated with discharge to a destination other than (OR 2.25;1.45-3.5, p<0.001). Conclusion: Outcomes were worse in patients with stroke and diabetes who had episodes of hypoglycaemia, hyperglycaemia and greater CBGv. Close monitoring of blood glucose levels is needed along with strategies to minimise the number of episodes of hypoglycaemia and variability of blood glucose levels.

### 18. Stroke thrombectomy experience in a neurosciences unit covering a large non urban region

**Authors** Abdelgadir E.; Canvin T.; Ball K.; Leach O.; Mukonoweshuro W.; Adams W.; Mohd Nor A.; Weatherby S.
**Source** European Stroke Journal; May 2018; vol. 3 (no. 1); p. 193-194
**Publication Date** May 2018
**Publication Type(s)** Conference Abstract
**Database** EMBASE
**Abstract** Background and Aims: Plymouth Hospital NHS Trust is the Regional Neurosciences Unit in the Southwest of England. Its thrombectomy service covers a large area (6,375sq km) with a sparse population of 2m. It currently runs during weekday working hours and accepts inter-hospital transfers from other areas in the region. These are mostly by land, but due to the rural geography and often poor travel conditions, can be by air ambulance. We performed a retrospective review of our services. Method: Cases were collated between 2013-2017. Demographics, NIHSS scores and arterial puncture times were extracted from our Radiology & Sentinel Stroke National Audit Program database. Follow up calls were performed to administer a previously validated simplified Modified Rankin Score (smRS) assessment. Results: Forty cases were treated for proximal anterior circulation clots. Travel distance ranged from 1.3 to 66 miles. 7 deaths occurred in the first 30 days. 17 cases were available to follow up. sMRS was recorded an average 1.5 years after their stroke. Outcomes per smRS category were: 0 (17.6%), 1 (11.7%), 2 (5.9%), 3 (29.4%), 4 (5.9%), 5 (29.4%). The average door to puncture times reduced from 143min to 91 min in line with service changes in 2017. The average outcome smRS reduced 3.2 to 2.3. Conclusion: A change and streamlining of our thrombectomy services has led to shorter door to puncture times and a reduction in overall smRS. Our review shows the long term functional benefit of this treatment and that is feasible to deliver this service across a large geographical area.

### 19. Identifying stroke care pathways in the UK: The sentinel stroke national audit programme: Investigating and evaluating stoke therapy (ssnapiest)

**Authors** Gittins M.; Vail A.; Tyson S.; Paley L.; Bray B.; Lugo Palacios D.; Bowen A.
**Source** European Stroke Journal; May 2018; vol. 3 (no. 1); p. 282-283
**Publication Date** May 2018
**Publication Type(s)** Conference Abstract
**Database** EMBASE

| | |
|---|---|
| **Abstract** | Background and Aims: To further investigate in detail the organisation of post-acute care and multi-disciplinary stroke therapy we first needed to identify the routes (or pathways) that patients experienced through stroke services. Method: Data from the Stroke Sentinel National Audit Programme (SSNAP), a national stroke register for all strokes occurring in England and Wales, were extracted for July 2013-June 2015. An iterative step-bystep procedure using data driven factors and clinical experience then identified the common pathways patients undertook. Results: Based on 124,674 stroke patients, 874 possible routes were identified and then consolidated to nine common pathways. Eighty four percent stayed in a single stroke inpatient unit which were split across four pathways; Shorter-stay (<7dys stoke unit average) acute unit > no community rehabilitation (28.3%) or community rehabilitation (19.6%), Longer-stay acute unit > no community rehabilitation (20.6%) or community rehabilitation (16.2%). Fourteen percent transferred to a secondary in-patient rehab unit split into; Shorter-stay acute unit > other in-patient rehabilitation unit > no community rehabilitation (5.3%) or community rehabilitation (6.8%), Longer-stay acute unit > other inpatient rehabilitation unit > no community rehabilitation (0.9%) or community rehabilitation (1.4%). The remaining 1.1% of routes were classed asother'. Descriptive statistics of baseline demographics, stroke characteristics, and patient stay indicated differences in the patients present in these pathways. Conclusion: Though variation in the routes through a health care system experienced by stroke patients can seem numerous, common stroke pathways can be observed and help identify patients with similar characteristics and experiences. |

### 20. Treatment of ischaemic stroke with thrombectomy alone and with bridging therapy with intravenous thrombolysis (TPA)-UK national registry data

| | |
|---|---|
| **Authors** | McCurran V.; Paley L.; Dunn G.; Hoffman A.; Rudd A.; Bray B.; James M. |
| **Source** | European Stroke Journal; May 2018; vol. 3 (no. 1); p. 190 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE |
| **Abstract** | Background and Aims: We used real-world data from the Sentinel Stroke National Audit Programme (SSNAP), the UK national stroke register (excluding Scotland) to compare the characteristics and early outcomes of patients with acute ischaemic stroke treated with thrombectomy according to use of bridging therapy with tPA. Method: Patient-level data from 85,122 records in SSNAP were analysed for patients admitted between April 2016 and March 2017. We compared baseline characteristics and early outcomes of patients that had bridging therapy with tPA plus thrombectomy (n=369) versus thrombectomy alone (n=211). Results: Patient characteristics were generally similar between the two groups. Differences include lower prevalence of AF (15% versus 35%, p<0.001), shorter known onset to arrival time (73 minutes versus 155 minutes, p<0.001), and more severe stroke (median NIHSS 18 versus 16, p=0.004) in the tPA group. Patients receiving bridging tPA had shorter known onset to completion times (300 vs 331 minutes, p=0.006) but longer arrival to completion times (207 vs 177 minutes, p=0.016) for thrombectomy. Procedural times were similar in both groups. There were no differences in reperfusion rates (mTICI) or early outcomes (0-2 NIHSS at 24h, 19% with tPA vs 22%, p=0.443) between the two groups. Conclusion: There are some differences in casemix between patients receiving bridging tPA prior to thrombectomy, and those without. Arrival to completion times are longer in the group receiving tPA, presumably reflecting extra time spent on delivering tPA first. Reperfusion rates and early neurological outcomes were similar, which supports ongoing trials to understand the additional efficacy of bridging therapy in patients receiving thrombectomy. |

### 21. Association between onset-to-arrival time and functional outcome at discharge in acute ischaemic stroke

| | |
|---|---|
| **Authors** | Muruet W.; Wolfe C.; Bray B.; Paley L.; Hoffman A.; Rudd A. |
| **Source** | European Stroke Journal; May 2018; vol. 3 (no. 1); p. 385 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE |

**Abstract** Background and Aims: Few studies have examined the association between onset-to-arrival time and functional outcomes in acute ischaemic stroke, particularly in patients not receiving reperfusion therapy. Our study aims to investigate if early arrival to a hospital is associated with good functional outcome (mRS <= 1) at discharge. Method: Data were collected from the nationwide, registry-based Sentinel Stroke National Audit Programme.We included all adult patients aged >16 admitted to hospital with acute Ischaemic Stroke in England andWales between the 1st of April 2013 and the 31st of March 2017.We used a multilevel logistic regression analysis to adjust for potential demographic (age, sex, ethnicity) and clinical (pre-stroke functional status, comorbidities, stroke severity, arrival by ambulance and reperfusion therapy) confounders at the patient level, as well as potential differences between centres. Results: 165,301 patients with ischaemic stroke from 224 different hospitals were included in the analysis. 85,427 (52%) were male, 146,179 (88%) were white, median NIHSS was on arrival was 4 (IQR: 2-10), and median onset-to-arrival time was 156 minutes (IQR: 82-474), with 49,021 patients arriving within 1.5 hours of stroke onset. After adjustment, patients arriving within 1.5 hours and between 1.5 and 3 hours after stroke onset had slightly increased odds of having a good functional outcome at discharge (OR 1.21 [95%CI 1.15-1.27] and 1.08 [95%CI 1.03-1.13]) compared to those arriving after 24 hours. Conclusion: Early hospital arrival within 3.0 hours after ischaemic stroke onset is associated with good functional outcome at discharge even after adjusting for stroke severity and reperfusion therapy.

### 22. The impact of a dedicated orthoptist to our acute stroke unit (ASU) at ST. George's university hospital-london

| | |
|---|---|
| **Authors** | Venturi N.; Perera A.P.; Nitkunan A. |
| **Source** | European Stroke Journal; May 2018; vol. 3 (no. 1); p. 209-210 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE |
| **Abstract** | Background and Aims: The 2016 stroke national clinical guidelines emphasised the importance of orthoptic assessment for patients presenting to ASUs. The orthoptic society recommends orthoptic review within the acute admission. A local audit in 2014 showed 48% of patients with a visual problem saw an orthoptist. Method: A stroke orthoptist was appointed in January 2017. She accepted all referrals from the multidisciplinary team on the ASU for patients with a visual deficit. From September 18th to December 21st 2017 we reexamined the percentage of patients who received orthoptic input and issued a simplified VFQ-25 questionnaire to patients to examine the difference an orthoptic assessment made to patients' quality of life. Results: 61 patients were admitted to ASU. 16 (26%) of these had active visual symptoms. The percentage of patients seen by the orthoptist increased from 48% previously to 69%. 24 questionnaires were returned (39% response rate) with 29% reporting poor vision- this aligns with the 26% who had visual symptoms on review of their notes; 44% of the patients with visual concern who returned questionnaires were seen by the orthoptist and 75% of them stated an improved quality of life after orthoptic assessment. Conclusion: This audit shows that appointing a stroke orthoptist has had a significant positive impact on the visual symptoms of stroke patients - almost three-quarters are now seen and three quarters of those seen feel that their quality of life has been impacted on positively by this encounter. The key limitation of our study is the small sample size. |

### 23. Transient ischaemic attack (TIA) service improvement project as per national clinical guidelines for stroke, UK (RCP 2016)

| | |
|---|---|
| **Authors** | Rehan J.; Naqvi A. |
| **Source** | European Stroke Journal; May 2018; vol. 3 (no. 1); p. 280-281 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE |
| **Abstract** | Background and Aims: Recently Royal College of Physicians (RCP) updated guidelines for TIA. We created a TIA clinic standardised form in line with these guidelines to ensure provision of timely secondary preventative strategies after TIA. Aim of our project was to ensure TIA service is in compliance with RCP guidelines and is standardised seven days a week. Method: Patients were identified using our TIA clinic database between October-November 2017. Data collection tool was developed in line with RCP guidelines and notes reviewed. We compared our practice before and after introducing new TIA form. Results: Medication advice was given in 93.7% and 100% previously during weekday & weekends respectively which improved to 100% using new form all week. Follow up appointments were 100% before & after throughout the week. Life style and driving advice were given in 18.6% and 50% previously, 46.7% and 80% using new form respectively during weekdays while it was 0% & 50% previously, 50% & 75% using new form respectively at weekends. Information leaflets were given to 0% previously throughout the week which improved to 66.6% using new form during the week but remained 0% at weekends. Similarly information given to ring 999 was 6.25% and 0% previously which improved to 66.6% and 25% using new form during weekdays and weekends respectively. Conclusion: This audit and quality improvement project highlights areas of improvement and certainly showed good results since the introduction of new TIA forms. Given improvement in service with new form, we plan to introduce an electronic form. |

### 24. Using quality improvement methodology to improve intermittent pneumatic compression device use after acute stroke

| | |
|---|---|
| **Authors** | Elder-Gracie T.; Medwin M.; Visvanathan A.; Dennis M.; O'Brien R. |
| **Source** | European Stroke Journal; May 2018; vol. 3 (no. 1); p. 298-299 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE |
| **Abstract** | Background and Aims: Venous Thromboembolism (VTE) is a common complication of acute stroke. Evidence supports the use of Intermittent Pneumatic Compression (IPC) to reduce the risk of VTE and improve survival when used for immobile patients up to 30-days following stroke. IPC is recommended in UK and European Stroke Guidelines yet use in clinical practice has been inconsistent. In 2016 <50% of eligible patients in Scotland were offered IPC and so this remains a focus for Quality Improvement (QI) activity. We used QI methodology to identify interventions with the overall aim of improving use of IPC for immobile patients after acute stroke. Method: We constructed process maps, used the Pareto principle to identify interventions and iterative Plan Do Study Act (PDSA) cycles. Data were collected prospectively, monthly from a randomly sampled population of in-patients within our 44-bed Stroke Unit. We introduced checklists to improve patient identification, improved IPC prescribing and introduced patient information /leaflets to improve patient engagement. Results: Between September 2017 and January 2018 the proportion of sampled patients who met the criteria for IPC use remained stable (50- 70%). The use of checklists improved the identification of patients, and IPC sleeve sizing, from zero to 43% but this was not maintained. A preprepared prescription improved our prescribing of IPC from 14% to >90% for 3 consecutive months. Conclusion: Quality Improvement interventions can be helpful in ensuring the successful implementation of evidenced based medicine. Further work is required to ensure that improvements are maintained so that patients receive effective interventions in clinical practice. |

### 25. Dowomen receive equivalent acute stroke care to men? a national stroke registry study

| | |
|---|---|
| **Authors** | Dunn G.; Hoffman A.; Paley L.; Stanley K.; McCurran V.; Kavanagh M.; Bray B.; James M.; Rudd A. |
| **Source** | European Stroke Journal; May 2018; vol. 3 (no. 1); p. 55 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE |
| **Abstract** | Background and Aims: Analysis of a national register of stroke was undertaken to determine whether quality of care differs by gender. Method: 12 quality measures (representative of whole stroke pathway) were analysed using 2016/17 Sentinel Stroke National Audit Programme (SSNAP) data, a national quality register for England, Wales and Northern Ireland. Adjustment was made for age, stroke onset while inpatient, stroke type, modified Rankin Scale score, hypertension, atrialfibrillation (AF), diabetes, previous stroke/TIA and NIHSS-on-admission. Results: Using data for 83,484 patients between April 2016-March 2017 admitted to hospital with acute stroke, small differences were identified for whether patient attended a stroke unit within 4hrs (adjusted odds ratio 1.04, 95% CI 1.01-1.07), swallow screen within 4hrs (aOR 1.05, CI 1.01-1.10), received Early Supported Discharge (aOR 1.05, CI 1.01-1.08). More marked differences were present for receiving thrombolysis (aOR 1.10, CI 1.05-1.15), door-to-needle time within 60min (aOR 1.15, CI 1.05-1.25), physiotherapy within 72hrs (aOR 1.11, CI 1.03-1.19). No evidence of differences in care by gender were found for brain scanning within 1 hour, admitted on an anticoagulant if in AF, seen by stroke nurse within 24hrs, assessed by occupational therapist within 72hrs, swallow assessment within 72hrs, seen by speech and language therapist within 72hrs. Conclusion: Many aspects of care did not show differences between genders, however small differences were identified for the management of thrombolysis and access to physiotherapy. It is unclear why such differences might exist and care quality should be monitored to ensure that inequalities are identified and overcome. The possibility of incomplete adjustment for confounding requires further exploration. |

### 26. Does the ABC acute care bundle for intracerebral haemorrhage lead to sustained improvements in mortality and which aspects of treatment are important

| | |
|---|---|
| **Authors** | Parry-Jones A.; Sammut-Powell C.; Birleson E.; Paroutoglou K.; Patel H.; Emsley R.; Bray B. |
| **Source** | European Stroke Journal; May 2018; vol. 3 (no. 1); p. 69-70 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE |

| | |
|---|---|
| **Abstract** | Background and Aims: Our 'ABC' intracerebral haemorrhage (ICH) care bundle consists of (A):rapid anticoagulant reversal, (B):optimal blood pressure (BP) management, and (C):a care pathway for access to neurosurgery. Implementation at our centre from June 2015 was associated with a 33% relative reduction in 30-day case-fatality. We sought to test if this improvement was sustained, compare mortality rate to national trends, and determine which factors explain the increased survival. Method: We analysed prospective audit data for consecutive ICH patients before (01/07/13-31/05/15), during (01/06/15-31/05/16), and after (01/06/16-31/01/17) bundle implementation and determined factors associated with survival using a Cox regression model. Key process measures were added to the model to test for mediation. Differencein- difference analysis compared our centre with the rest of England & Wales using data from the Sentinel Stroke National Audit Programme (SSNAP). Results: 810 patients were admitted during our data collection period. Admission during (HR:0.46; 95%CI:0.27-0.77; p=0.003) and after (HR:0.33; 95%CI:0.17-0.64; p=0.001) bundle implementation (vs. before) was associated with a reduced hazard of death. The statistically significant mediating components were a reduction in acute (<24h) donot- resuscitate (DNR) orders (mediating 50.6% of association), and undergoing neurosurgery (mediating 19.6% of association). 30-day case fatality was 1.4 percentage points (pp) above national averages pre-implementation, but fell to 8.9pp below post-implementation (difference-indifference -10.3pp; 95%CI -2.9 to -17.7pp; p=0.009). Conclusion: Our ABC bundle is associated with a sustained reduction in 30-day ICH case fatality at our centre and is not accounted for by national trends. Reduced DNR orders and neurosurgery partially mediate this association. Further evaluation in a cluster-randomised trial is planned. |

### 27. How do outcomes differ between patients with mild stroke, more severe stroke and a final non-stroke diagnosis who are thrombolysed? a retrospective data analysis

| | |
|---|---|
| **Authors** | Turner M.; Langhorne P.; Macleod M.J. |
| **Source** | European Stroke Journal; May 2018; vol. 3 (no. 1); p. 146 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE |
| **Abstract** | Background and Aims: Thrombolysis in minor ischaemic stroke is controversial. We explored the effect of stroke severity and a final non-stroke diagnosis on outcomes following thrombolysis. Method: Data was extracted from the Scottish Stroke Care Audit (SSCA) and linked to deaths recorded by National Records Scotland (NRS) for all patients thrombolysed between 2010-2015. Outcomes were compared between mild stroke, more severe stroke and non-stroke. Results: 3116 patients were included in the analysis. 492 (15.8%) had minor stroke, 2569 (82.4%) had more severe stroke and 55 (1.8%) non-stroke. Less than 5% of mild strokes had haemorrhage on repeat imaging compared with 13.9% for more severe strokes and 19.6% for non-strokes. In the whole population there were<0.3% deaths at 7 days and<0.4% deaths at 30 days from haemorrhagic stroke. The percentages across each of the three patient groups were similar. Conclusion: In this population based study thrombolysis outcomes compare favourably to published data. Milder strokes are less likely to have post-thrombolysis haemorrhage and the risk of stroke related death is low. Further work is required to explore the diagnoses underlying the presentation of patients who are thrombolysed and have a non-stroke final diagnosis. |

### 28. Is post-acute, community based rehabilitation in scotland evidence based?

| | |
|---|---|
| **Authors** | Fisher R.; Walker M.; Baylan S.; Muir N.; Brennan K.; Quinn T.; Langhorne P.; Reid L. |
| **Source** | European Stroke Journal; May 2018; vol. 3 (no. 1); p. 292 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE |

| | |
|---|---|
| **Abstract** | Background and Aims: Stroke is a clinical priority in Scotland, yet it is unclear whether the recommendations for implementing evidence based post-acute care in national clinical guidelines have been acted upon. The aims of this study were to determine the type of community stroke rehabilitation services that stroke patients are referred to on hospital discharge. Method: Additional questions were included in the 2017 organisational Scottish Stroke Care Audit (SSCA) asking Managed Clinical Network managers and clinical audit co-ordinators in Scottish health boards to specify whether patients were referred to: a) Early Supported Discharge (ESD) b) Stroke Specific ESD c) Community Rehabilitation (CR) or d) Stroke Specific CR. Semi-structured interviews with 44 multidisciplinary stakeholders involved in the delivery of ESD or CR were then conducted across three case study sites to further investigate the types of service models. Results: Seven out of fourteen health boards reported provision of ESD, with one reporting partial stroke-specific ESD. Twelve reported provision of CR with two regarding themselves as stroke-specific. Framework analysis of qualitative data revealed key themes relating to intervention delivery, monitoring, training and drivers for future service implementation. Strengths and challenges were highlighted. This revealed differences in the adopted models and service fragmentation, together with a variety of factors driving future development. Evidence of stroke education was present across sites. Conclusion: Findings highlight inequality in the provision of post-acute care in Scotland. This raises questions about the challenges faced in implementing evidence based community stroke care that require further investigation. Opportunities for improving evidence based care were identified. |

**29. A review of the mechanical thrombectomy service at a large UK Teaching Hospital**

| | |
|---|---|
| **Authors** | Blythe R.; Blank C. |
| **Source** | European Stroke Journal; May 2018; vol. 3 (no. 1); p. 273-274 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE |
| **Abstract** | Background and Aims: An intra-venous thrombolysis (IVT) service has been established at Sheffield Teaching Hospitals for several years. Mechanical thrombectomy (MT) for acute ischaemic stroke in selected patients has been shown to produce favourable outcomes. Therefore, a new collaborative pathway was created to provide MT for selected patients within working hours. Method: After several patients have undergone MT we have retrospectively audited against standards taken from The British Association of Stroke Physicians. Results: 12 patients underwent MT between January 2016 and July 2017. 2 patients were excluded as they were clear outliers. 3 of the remaining 10 patients only had MT and did not have IVT due to contraindications. 100% had large vessel occlusions with symptom onset to MT <5hr (mean3hrs19mins, range 1hrs47mins-4hrs35mins). The IVT to groin puncture time was achieved at<90mins with mean 1hr 4mins (range 57mins-1hr21mins). Mean groin puncture time to start of revascularisation was 28.9mins (Range 9-65mins). This represents 90% patients meeting the standard of <45mins. Median groin puncture time to end of revascularisation was 66mins (Range 30-163mins). Revascularisation achievement was 70% TICI-grade 2b or above. One patient suffered haemorrhagic transformation but did not meet the SICH criteria. Conclusion: We have demonstrated that a MT pathway can be created alongside an established IVT pathway. Our patients were appropriately selected as they had proximal vessel occlusion, received MT within the recommended time and revascularisation rate was high. Areas for ongoing improvement include a customised assessment area within the radiology department, MT flowcharts and a dedicated MT coordinator to improve communication. |

**30. Thrombolysis use and outcomes in young patients (16-29 years) with ischaemic stroke in England, Wales and Northern Ireland. Data from national stroke registry**

| | |
|---|---|
| **Authors** | Meredith G.; Paley L.; Hoffman A.; Bray B.; Rudd A. |
| **Source** | European Stroke Journal; May 2018; vol. 3 (no. 1); p. 27-28 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE |
| **Abstract** | Background and Aims: Alteplase is licensed for patients 18-80 years across Europe. No patients under 18 years and few under 30 years are reported or participated in the randomised control trials in the cochrane review. Method: Data were extracted from the national stroke register (Sentinel Stroke National Audit Programme (SSNAP)) of adults with acute ischaemic stroke treated in all hospitals in England and Wales from July 2013-November 2017. Results: 322218 adults with acute ischaemic stroke were admitted to 202 hospitals, 1460 (0.5%) were aged between 16-29 years. Of these 230 (15.5%) were treated with intravenous alteplase (IV-tPA). (Table Presented) Conclusion: The treatment of younger patients with IV-tPA appears safe, with no reported symptomatic intracranial haemorrhage in the 1460 patients less than 30 years receiving treatment. Improvement in NIHSS 24 hours after treatment was comparable to those over 30 years. (data not presented). Despite no randomised control trial evidence these data suggest that, where appropriate, IV-tPA should not be withheld for patients under 18 years. |

**31. Modelling length of stay for thrombectomy in a comprhensive UK stroke unit**

| | |
|---|---|
| **Authors** | McGee J.; Day D.; Elizabeth W. |

| | |
|---|---|
| **Source** | European Stroke Journal; May 2018; vol. 3 (no. 1); p. 104 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE |
| **Abstract** | Background and Aims: Since Mr CLEAN and 5 other trials demonstrating benefit of endovascular therapy, discussion continues around optimal service delivery across the UK. Modelling the reduction in length of stay (LOS) outside of a trial setting is required, to calculate beds days to deliver a comprehensive regional service. The NHS (UK) is working at capacity, accurate costs are central to building effective services. Locally we deliver a 9-5 service, expanding to 24/7 regional service as resources are available. Method: We conducted a seven month retrospective audit of LOS in 2017: Patient receiving thrombectomy versus those suitable for thrombectomy but out of service hours, including both catchment and satellite hospital patients. National guideline criteria was used. All included patients received thrombolysis. Results: There was no statistical difference in age or severity between the groups. Mean LOS for catchment thrombectomy patients: nine days. For suitable patient without thromectomy: mean LOS 34.5 days. Patients repatriated to our satellite hospital thrombectomy=five days, no thrombectomy =six days (table1). This data demonstrates large cost savings in LOS in a non-trial setting, enabling services to invest and rapidly recoup costs, alongside improved patient outcome. Acknowledged bias: only thrombolysed patients were included. Conclusion: Bed availability should not delay service delivery, as capacity will delivered by shorter LOS, improved patient outcome and large cost savings to health economy. (Table presented) . |

### 32. A performance audit of the transient ischaemic attack (TIA) service at pennine acute hospitals NHS trust

| | |
|---|---|
| **Authors** | Lim C.K.; Ng C.; Sett A.; Oates R. |
| **Source** | European Stroke Journal; May 2018; vol. 3 (no. 1); p. 269 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE |
| **Abstract** | Background and Aims: Approximately 46,000 people in the UK have their first TIA every year (Stroke association, 2012). Timely assessments and appropriate delivery of treatments for TIA patients in the outpatient setting could significantly reduce the risk of developing stroke by 80%. (Johnston SC, 2006) Method: A retrospective review of all referrals to the Neurovascular Clinics across all four hospital sites (North Manchester, Bury, Oldham and Rochdale) from 1st July 2014 to 1st September 2014 was carried out, with a re-audit in 2017 after changes were implemented. These looked at reasons for referrals and time frame from referral to seeing patients in the clinics. The changes were of a new community TIA referral proforma and trust online referral proforma to guide non-stroke physicians in making appropriate referrals. Following this, we also designed a simple patient information leaflet to provide adequate information to patients with suspected TIA. Results: 93% of patients were referred using the new TIA referral proforma. The appropriateness of referrals increased from 66.2% to 74.2%. It also showed that the percentage of patients seen within the recommended time frame by the National Institute of Clinical Excellence (NICE) has increased to 78.95% from 68.64%. Conclusion: This quality improvement project showed significant improvements in the time taken to see patients with suspected TIA in the outpatient setting. Recent changes in the NICE guidelines have significantly increased the number of TIA patients who should be seen within 24 hours, hence an increasing need to maximise the effective use of Neurovascular Clinics. |

### 33. Current, future and avoidable costs of stroke in the United Kingdom: A societal cost of illness study

| | |
|---|---|
| **Authors** | Patel A.; Berdunov V.; Quayyum Z.; Wittenberg R.; King D.; Knapp M. |
| **Source** | European Stroke Journal; May 2018; vol. 3 (no. 1); p. 286 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE |

| | |
|---|---|
| **Abstract** | Background and Aims: Despite significant progress in prevention, treatment and rehabilitation, stroke generates significant economic burdens. We estimated its societal costs in the UK to gain a better understanding of current burden (2015), its future trajectory (to 2025 and 2035), and potential for alleviating future costs. Method: We focused on adults aged >=45 years. Current average health/ social care costs (2015 prices) were estimated using Xu et al.'s (2017) discrete event simulation model which incorporated national stroke audit and regional stroke register data. We estimated informal care and lost employment costs using data from two UK-wide randomised controlled trials. We applied literature estimates of stroke incidence/ prevalence for extrapolations to national UK population level. Future cost projections accounted for likely changes in demography, formal care wages, and stroke incidence/prevalence. Incidence/prevalence trajectories and research priorities were elicited from a survey of UK stroke experts. Results: Current societal costs are 25.6 billion, dominated by informal care costs. Between 2015 and 2035, we estimate increases in: first-time strokes from 117,600 to 187,000 (+59%); stroke survivors from 950,000 to 2,120,000 (+123%); and societal costs from 25.6 billion to 75 billion (+194%). Of experts' top-five research priorities, improving stroke prevention offered greatest scope for savings (4 billion). Conclusion: Numbers of stroke survivors and costs in the UK could more than double in the next 20 years. Investing in priority research areas could alleviate the burden on both formal and informal care sectors. |

### 34. Does patients' perception of improvement following a pain management programme, match reported minimally clinically important differences?

| | |
|---|---|
| **Authors** | Heelas L.; Wiltshire S.; Wall A.; Barker K. |
| **Source** | British Journal of Pain; May 2018; vol. 12 (no. 2); p. 30-31 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at British Journal of Pain from Europe PubMed Central - Open Access |
| **Abstract** | Background Effectiveness of pain management programmes for chronic pain is well established. Large samples attending highly intensive programmes have been evaluated to determine clinically reliable change, but patients' impression of change has not been recorded. Lack of measurement of factors important to patients, such as relationships and social interaction, has been highlighted (C de C Williams, 2017). Morley and Thorne (2009) suggested a mean change of 2.09 in pain interference, as measured by the Brief Pain Inventory (BPI), could be considered acceptable to patients. Currently data is unavailable for changes in pain acceptance. A greater understanding of the percentage of patients that perceive improvement following treatment, may assist with patient decision making and informed consent for treatment. Furthermore, changes on outcome measures for this 'improved' cohort may assist with benchmarking services nationally, especially since the inception of the King's Fund's Getting It Right First Time (GIRFT, 2017) model in the NHS. Aims To evaluate clinical outcomes for patients attending a pain management programme to determine whether patients who rated an improvement on a Global Impression of Change Score, achieved mean changes in BPI that were consistent with 'acceptable' change, and to determine mean changes on other outcomes in this population. Methods A battery of validated questionnaires were completed by patients attending a 36 hour (standard) interdisciplinary pain management programme at pre-treatment and three months post rehabilitation, between 2015-2017. The programme was based on the Acceptance and Commitment Therapy psychological model, with emphasis on enhancing psychological flexibility, present-moment awareness, and a willingness to pursue values based goals. The percentage of patients that scored between 5 and 7 (improved) on the Global Impression of Change Score was calculated. Pre and post mean and standard deviations (SD) were calculated on the Brief Pain Inventory-Interference Scale (BPI), Chronic Pain Acceptance Questionnaire (CPAQ-8), Generalised Anxiety Scale (GAD-7), Patient Health Questionnaire (PHQ-9) and the Tampa Scale of Kinesiophobia (TSK). Effect sizes were calculated, using a correlation co-efficient for inter-related measures. Ethical Approval: All patients consented to their outcome data being used for service evaluation. The Joint Research and Development Committee LREC was not required. results Complete 3 month data was available for 164 patients (62% of the total cohort) who received treatment. 79 patients (48%) reported an improvement. Mean pre-post changes (SD) in the improved/ complete cohort were: PHQ-9 13.5 (5.6)-10.1 (6)/13.9 (5.8)-11.0 (6.5) GAD-7 9.6 (5.7)-6.8 (5)/10.3 (5.8)-7.5 (5.4) BPI 7.3 (1.7)-5.1 (2.2)/7.5 (1.9)-5.4 (2.4) TSK 37.5 (9.4)-31.2 (9.4)/38.4 99.4)-33.2 (10.1) CPAQ 19.6 (8.9)-24.5 (9.4)/18.8 (8.2)-23.2 (9) Effect sizes in the improved/complete cohort for the PMP were: PHQ-9 (0.7/ 0.5) GAD-7 (0.6/0.5), BPI (1.2/0.9), TSK (0.8/0.5), CPAQ (0.8/0.5) conclusion Mean changes on the BPI in the improved cohorts of the PMP were 2.2 which mirrors the acceptable change cited by Thorne and Morley (2009). Although effect sizes in the total cohorts were generally moderate to large, less than 50% of patients considered these changes as acceptable. Clinical Importance: Clinicians may consider revising the previously considered estimate of a 1 point change on the BPI post treatment as clinically meaningful (National Pain Audit 2012). An understanding of changes expected following a standard pain management programme may assist clinicians when advising patients of the risks and benefits of treatment. |

### 35. Painful vulvodynia alleviated by topical gabapentin: A two-centre survey of treatment safety and efficacy

| | |
|---|---|
| **Authors** | Keevil E.; Khot S.; Nunns D.; Hodgkinson V.; Patel G.; Hiom S. |

| | |
|---|---|
| **Source** | British Journal of Pain; May 2018; vol. 12 (no. 2); p. 27 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at British Journal of Pain from Europe PubMed Central - Open Access |
| **Abstract** | Background Vulvodynia is a devastating condition that significantly affects a woman's quality of life and emotional well-being. The prevalence of vulvodynia has been estimated as 9-18%. It is one of the most common causes of sexual pain in premenopausal women, with associated low conception rates. The International Society for the Study of Vulvovaginal Diseases defines vulvodynia as vulvar pain of at least three months duration, without clear identifiable cause, which may have potential associated factors. It is thought to present as a neuropathic pain syndrome and is treated with systemic neuropathic pain medications. The use of systemic medications is associated with intolerable side effects, insufficient long-term pain relief and drug interactions. Topical analgesia may offer an alternative treatment option. Aims Topical gabapentin has been reported to be effective in the treatment of vulvodynia, although the numbers involved in these studies were small. The purpose of this patient survey was to determine the impact of topical gabapentin use on self-reported pain, patient functioning and patient satisfaction in patients presenting with vulvodynia. Methods The survey was conducted at Cardiff and Vale University Health Board (Cardiff) and Nottingham University Hospitals NHS Trust (Nottingham). Patients prescribed topical gabapentin from 2014-2016 were identified from databases held by the pain clinic (Cardiff) and gynaecology outpatients (Nottingham). Ethics approval was not required as this was a service evaluation as confirmed by the respective audit departments. Patients were assessed using a ten point numerical scale to quantify pain relief immediately after commencing the treatment, pain relief after 6 months of treatment and overall satisfaction with the product. Patients were also questioned on a ten point numerical scale (-5 to 5) to assess the effect of topical gabapentin on their mood, sleep and activity levels. Additionally, patients were asked for qualitative feedback on the product and any adverse effects. results A total of 54 patients received treatment with gabapentin gel (Cardiff 24, Nottingham 30). Of these, 27 patients were successfully contacted (Cardiff 17, Nottingham 10). Improved pain was reported by 14 of 27 patients (Cardiff 7/17, Nottingham 7/10). After 6 months of treatment 12 patients continued to experience pain relief (Cardiff 5, Nottingham 7). The mean reduction in pain among those responsive to treatment was 66% immediately (Cardiff 74%, Nottingham 58%) and 49% after 6 months (Cardiff 48%, Nottingham 50%). Amongst those who reported a benefit, mean satisfaction scores were 7.6/10 (Cardiff 8.2/10, Nottingham 7/10). Improved sleep was reported by 5 patients, improved mood by 10 patients and increased activity by 8 patients. Decreased sleep was reported by 1 patient, decreased mood by 2 patients and decreased activity by 1 patient. Reasons for discontinuing the treatment were lack of efficacy (12 patients) and local irritation (2 patients). conclusion The findings of improved symptoms, along with the corroboration of results from two trusts, support the efficacy of topical gabapentin in the treatment of vulvodynia. Women report satisfaction with the quality of the product and improvement in quality of life indicators such as mood, sleep and activity levels. |

### 36. BJP ASM Poster Abstracts 2018

| | |
|---|---|
| **Authors** | anonymous |
| **Source** | British Journal of Pain; May 2018; vol. 12 (no. 2) |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Review |
| **Database** | EMBASE |
| **Abstract** | The proceedings contain 75 papers. The topics discussed include: assessment of pain in adults who have a learning disability a snapshot survey of practice in secondary care NHS trusts across the united kingdom; impact of brief psychological interventions for patients with complex needs: the role of the clinical psychologist within the inpatient pain team; prescribing opioids for chronic pain in primary care: a qualitative metasynthesis; what do people with persistent pain think about when they complete the Tampa scale of kinesiophobia (TSK)? a qualitative study; exploring perceptions of pain relief strategies as masculine and feminine gender norms and stereotypes using Q-methodology; and chronic and complex pain workload of inpatient pain services (Chips) - a national audit. |

### 37. Chronic pain following breast cancer surgery

| | |
|---|---|
| **Authors** | Suleiman T.; Goodman B.; Womack J. |
| **Source** | British Journal of Pain; May 2018; vol. 12 (no. 2); p. 21-22 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at British Journal of Pain from Europe PubMed Central - Open Access |

| | |
|---|---|
| **Abstract** | Background Breast cancer is the second commonest cancer worldwide, affecting >55,000 women each year in the UK. The outcomes of treatment are very good, with 78% surviving over 10 years. Chronic post-surgical pain affects 14-60% of breast cancer patients, and is a major cause of morbidity after oncological cure. Identified risk factors for its development include younger age, more invasive surgery, adjuvant radiotherapy and poor post-operative pain control. Regional anaesthetic techniques have become commonplace in our institution, allowing for procedures such as mastectomies to be undertaken as day cases. However, once patients leave hospital, we know little about how their pain is affecting them. In an era of excellent oncological outcomes for breast cancer, improving long term quality of life by investigating the incidence and modifiable risk factors for chronic post-surgical pain is imperative. Aims We aimed to investigate the prevalence and associations of chronic pain following breast surgery in our hospital. We estimated that a target sample size of approximately 100 would give us a snapshot of the incidence of pain, and might allow identification of modifiable risk factors for quality improvement. Methods Following ethical and institutional approval, patients attending eight consecutive breast review clinics in March 2017 were asked to complete a Modified McGill Pain questionnaire. Additional clinical details were collected by a junior doctor. Exclusion criteria were: surgery within 8 weeks of clinic, significant missing information in patient notes, and non-cancer surgery. GraphPad Prism 7 software was used for statistical analysis. The Chi squared test was used to investigate associations of chronic pain with patient and treatment factors. Student's t-test was used for analysis of differences in age between the two groups. results Of 297 patients given questionnaires, 98 (33%) were returned. After application of the exclusion criteria, data from 93 patients remained for analysis. Fifty (53.8%) described persistent pain following surgery. The mean age of the cohort was 60 years. Three factors were associated with an increased incidence of chronic pain: younger age (p=0.02), breast pain prior to surgery (p=0.015) and suboptimal postoperative pain control (p=0.019). The incidence of pain was similar following mastectomy (47%) and wide local excision (56%). Use of regional anaesthetic techniques (n=24) and adjuvant cancer therapy (n=89) was not associated with differences in chronic pain in this sample. 47% of patients rated their pain as severe, with 58% reporting it impacted on at least one of sleep, ADLs, QOL or anxiety. Of the patients describing chronic pain, 28% required regular analgesia. conclusion In keeping with published literature, our data identified younger age, breast pain prior to surgery, and poor postoperative pain control as risk factors for the occurrence of chronic pain following breast cancer surgery. However, our sample size was insufficient to draw firm conclusions on all risk factors. Furthermore, convenience sampling methodology might have impacted the results, as patients with pain might be more likely to complete the questionnaire. Our data confirm the significant burden chronic pain has on patients' quality of life. We aim to undertake further prospective work to identify patients with modifiable risk factors for chronic post-surgical pain. |

### 38. Bundles of care: Standardisation of care in an NHS pain management service

| | |
|---|---|
| **Authors** | Willcocks C.; Price C.; Harding J.; Snushall E. |
| **Source** | British Journal of Pain; May 2018; vol. 12 (no. 2); p. 54 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at British Journal of Pain from Europe PubMed Central - Open Access |

| | |
|---|---|
| **Abstract** | Background At present local NHS pain services are working over clinical capacity, with a high volume of referrals and increasing patient complexity. Due to this demand it is essential that services are efficiently coordinated. However, multidisciplinary practice can lead to a lack of standardization and poorly defined management pathways, resulting in variable care throughout the service. Care bundles are coordinated packages of care formed from individual building blocks (elements of service). These ensure a patient receives consistent high level care throughout their journey. Each care bundle is evidence-based and contains three to four stages, which have been reliably shown to improve patient outcomes. A care bundles approach was proposed to tackle both variation and efficiency. We were unable to find examples of this in pain management although they are widely used in other clinical areas. Aims To create and establish effective care bundles within a pain management service, aiming to increase standardisation of practice and to improve service efficiency. Methods The multidisciplinary pain team identified areas of patient care where it was felt the care bundle approach (a package of interventions that must be followed for every patient, every time) could improve service consistency and efficiency. A subsequent prioritisation exercise gave rise to three preliminary bundles; Medication Review, Pain Education and Discharge. These three areas were examined in further detail to elucidate the core elements deemed most vital to a successful patient care episode. Three or four elements for each bundle were identified. Following this, baseline data was collected for each of these bundles, examining how current practice compared to the proposed ideal. Twenty patient records were retrospectively reviewed against the new bundle standards, to identify how these elements of service were being delivered and documented. results Twenty records were reviewed from patients who had completed their journey within the pain service, and placed on SOS discharge. There were 6 male and 14 female patients, average age was 55.4 and they had been under the care of the pain team for an average of 9.3 months. During current practice we complete all elements of the three care bundles 62% of the time. Analysis of individual bundles showed; Overall completion rate of the medication review bundle is 70%, ranging from 0% to 100% on individual elements. Overall completion rate of the pain education bundle is 54%, ranging from 25% to 70% on individual elements. Overall completion rate of the discharge bundle is 61%, ranging from 45% to 100% on individual elements. conclusion Currently the service is working at a varying level of consistency within patient care, an area which clearly requires improvement. Findings of the baseline review were presented to the multidisciplinary team. The individual elements of the bundles were examined in detail and suggestions taken as to any practical steps to improve adherence. These included education of all members of the pain team and adjustments to the online patient record system. Re-audit of further patient records following implementation of these bundles is planned to determine whether standardisation of recording may be improved. Alongside this, further work to improve efficiency is required. |

### 39. Moving forwards with fibromyalgia: An evidence-based clinical pathway

| | |
|---|---|
| **Authors** | Margetts L.; Newton P.; Chasey R.; Burrows D.; Howell A. |
| **Source** | British Journal of Pain; May 2018; vol. 12 (no. 2); p. 53-54 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at British Journal of Pain from Europe PubMed Central - Open Access |

| | |
|---|---|
| **Abstract** | Background Audit showed that 45% of patients seen in outpatient clinics by Pain Consultants at Torbay and South Devon NHS Foundation Trust between 1st July 2015 and 30th June 2016 had a diagnosis of Fibromyalgia. The European League Against Rheumatism (EULAR) released new guidance in 2016 for the management of Fibromyalgia strongly recommending the provision of education and exercise early in the course of the condition. (1) Medication is not recommended as a first line treatment. Learning self-management has the potential to improve patient activation, quality of life and psychological distress.(2) Aims To create a new clinical pathway for patients with Fibromyalgia to enable early access to education about their condition and the role of medication in the management of Fibromyalgia. To facilitate early use of appropriate self-management interventions. Methods A multidisciplinary working group comprising a senior doctor, specialist pain physiotherapist, specialist pain psychologist and a chronic pain nurse devised the pathway in collaboration with local commissioners and patient representative group 'Involve'. GPs diagnose Fibromyalgia and then provide details of how to access group education in the form of seminars and workshops. Patients opt-in to the initial education sessions. Having attended these, screening tools (Brief Pain Inventory, Psychological Inflexibility in Pain Scale, Patient Activation Measure) are used to guide patients along the pathway to access matched care. Multidisciplinary paper triage is required for patients with longstanding Fibromyalgia or complex presentations for whom group education is not suitable. Local GPs, physiotherapists and mental health professionals were given guidance on making the diagnosis and accessing the pathway. The pathway was introduced gradually to allow modification where required, and to incorporate service user feedback. Referral data was collected between March 2017 and December 2017 and feedback was collected after all seminars and workshops. results 300 patients were referred onto the new pathway between March 2017 and December 2017.10% of referrals were returned to their GP. 12% were triaged to a consultant or specialist nurse. 72% of patients were diverted from usual medical care. 34% of patients were offered group education, 38% were offered matched care in the form of pain physiotherapy, pain psychology or joint therapies clinics. Patients were asked to rate seminars and workshops on a scale of 1-10 where 10 was very helpful. 80% rated the "Understanding Fibromyalgia" Seminar 8/10 or higher 80% rated the "Moving Forwards with Fibromyalgia" Workshop 8/10 or higher. conclusion This pathway was designed to provide early access to education and facilitate self-management. 72% of patients with Fibromyalgia were diverted from usual medical care onto this pathway. Patient feedback was positive. "Moving Forwards with Fibromyalgia" is now the clinical pathway for patients with Fibromyalgia in South Devon. It represents an evidence-based, patient-centred move away from the traditional medical model of care. It enables prompt, matched care. Patients are empowered to self-manage their condition. |

### 40. Patient safety in chronic pain practice: An evaluation of incidents and complications in a multidisciplinary chronic musculoskeletal pain centre

| | |
|---|---|
| **Authors** | Schutzer J.; Mihaylov D.; Zarnegar R.; Pritchard D. |
| **Source** | British Journal of Pain; May 2018; vol. 12 (no. 2); p. 52-53 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at British Journal of Pain from Europe PubMed Central - Open Access |

**Abstract**

Background The Chronic Pain Centre at the Royal National Orthopaedic Hospital (RNOH) holds monthly multidisciplinary Risk, Incidents and Complex Case Meetings in which clinical and non-clinical incidents, hazards and complex cases are reflectively discussed. The Centre has a written policy on managing untoward events. In line with this policy all incidents following procedures which necessitate an additional clinical assessment, investigation or intervention, and therefore by definition cause moderate or severe harm (NPSA definitions), should be discussed at the meeting as well as all cases of missed or incorrect diagnosis, actual or attempted patient suicide, prescribing errors and all incidents submitted to the RNOH incident reporting system that are related to chronic pain practice. The records from these meetings provide quantitative information on complications of interventional procedures and a picture of quality and patient safety issues encountered in a musculoskeletal pain service. Aims To determine the rate of incidents after interventional procedures for chronic pain treatment and compare these against published literature, where possible. To identify commonly occurring patterns in clinical incidents related to chronic pain practice. To audit responses to incidents against current standards of practice. Methods Meeting minutes from March 2016 to July 2017 inclusive were quantitatively and qualitatively reviewed by two investigators for data on the type of incident, severity of harm and follow up actions. Medical records were accessed for additional information where needed. Records of total number of procedures done in the same time frame were accessed from the hospital's operational data for comparison. Incidents were categorized in broad categories of clinical and non-clinical. results No incidents caused severe harm. Thirty-two events were discussed over the 17 month evaluation period. Twenty were complications of interventional procedures. General procedure complication rates were 0.8% (14/1836) for all non-neuromodulation, 1.87% (9/482) for spinal injections and 3.6% (6/168) for neuromodulation. The commonest post-procedural complications were transient increased pain (5) and weakness (3) after spinal injection. Neuromodulation-related complications included a drug error (epidural injection of metronidazole instead of saline), antibiotic allergy (2), CSF leak (2) and respiratory depression during conscious sedation (1). Most (7) non-procedural incidents were related to information governance and information technology issues including incorrect filing, use of e-mail and loss of a dictaphone. Follow-up and reporting protocols were adhered to and incidents were documented well in the medical notes. Discussions recorded in minutes contained examples of effecting change to improve service provision, reduce documentation errors and refine consent and interventional processes towards reducing variations in practice. conclusion Incident reporting, clinical audit and quality improvement are core standards for UK Pain services. This audit shows that departmental meetings in which incidents are discussed enhance service quality and allow audit and benchmarking. With the exception of spinal injections, there is limited published data on chronic pain procedure complications. Post-procedure complication rates in this series are, as expected, lower than published case series which include all complications. Arguably reporting rates of moderate-severe complications is more clinically relevant and more suitable for benchmarking. Our data supports existing literature on the rarity of severe complications following procedures.

### 41. Survey of opioid medications beyond the recommended dose in a secondary care pain clinic

| | |
|---|---|
| **Authors** | Dailami C.; Gadiyar V.; Adedokun J. |
| **Source** | British Journal of Pain; May 2018; vol. 12 (no. 2); p. 15-16 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE |
| | Available at British Journal of Pain from Europe PubMed Central - Open Access |

| | |
|---|---|
| **Abstract** | Background There has been a sharp rise in the prescription of opioids for chronic pain in the United Kingdom. With the rise of opioid use and subsequent rise in opioid related side effects such as dependence, greater attention has been drawn to the safe prescribing of these medications. The Royal College of Anaesthetists (RCoA) states 'the risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day, but there is no increased benefit'. This audit is important as it sheds light on the relevant topic of overuse of opioid analgesia in the UK and whether patients themselves are aware of the side effects and have a desire to reduce or discontinue opioid use altogether. Aims The aim of this audit was to investigate the use of opioids in patients attending pain clinics at our Trust. The purpose was to investigate how many patients are taking more than the RCoA recommended amount of opioids and whether they have a desire to reduce or discontinue opioid use. Methods Paper questionnaires were designed for patients to complete at their pain clinic appointment, before they saw the Consultant. The questionnaires, consisting of 5 questions, were distributed over a period of 5 months (July-November 2017). The questions included which medications were being used for analgesia, the duration of use and where such medications were initially prescribed. More detailed questions on patients' awareness of opioid side effects and their desire to reduce or discontinue opioid medications were also asked. These details were verified by the Pain Consultant during the consultation. Only patients who use opioid analgesia were focussed on for this study. The data from these patients were coded and analysed in SPSS version 24. results Of the 292 patients who completed the questionnaire,180(61.6%) were taking opioid analgesia. The most common opioids taken were codeine (40.6%) followed by tramadol (23.3%) and morphine (22.2%). Of the 180 opioid taking patients, 32(17.8%)were on more than 120mg of morphine or the morphine equivalent per day. The median dose was 164mg. 98 patients (54.4%) have been taking opioids for 12 months or longer, 28 patients have been on opioids for more than 5 years. The majority of patients, 76.1%, had opioids initially prescribed by their general practitioner. Of the 180 patients using opioids 64.4% were aware that dependence is one of the side effects. Patient awareness was less than 33% for 5 other common side effects of opioids. 24.4% of patients were not aware of any of the listed opioid side effects despite taking them. 58.3% patients indicated they would like to reduce or discontinue their opioid use. conclusion 17.8% of patients in this audit are on more than the RCoA recommended daily limit of opioid consumption for chronic pain, with median dose of 164mg and maximum dose of 960 mg of morphine equivalent. Alarmingly few patients are aware of the common opioid side effects and 40% of patients would not like to reduce or discontinue opioids. We recommend that the opioid use be discussed in the clinic. Information needs to be provided and the patients on higher dose be actively encouraged to reduce the dose with support from the pain clinic. |

### 42. The opioid legacy patients: 18 months experience of a specialised opioid reduction clinic within a secondary care pain clinic

| | |
|---|---|
| **Authors** | Ullrich K.; Gallagher J.; Alamgir A. |
| **Source** | British Journal of Pain; May 2018; vol. 12 (no. 2); p. 14 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at British Journal of Pain from Europe PubMed Central - Open Access |

| | |
|---|---|
| **Abstract** | Background UK pain clinics are adopting responsible opioid prescribing for patients with persistent non-cancer pain in recent years. The British Pain Society helped to raise the Opioids Aware campaign that included recommendations on opioid prescribing for non-cancer pain as well as resources for education and pain management. However due to the legacy of overprescribing of strong opioids since the 1990s a substantial number of chronic pain sufferers continue to take high dose opioids despite their deleterious effects. In 2015 a local audit in our pain clinic showed that 27% of patients were prescribed strong opioids for persistent non-cancer pain and that some patients were taking excessively high doses. That audit concluded that a targeted approach to address the problem of high dose opioid prescribing was necessary and suggested the implementation of a multi-professional specialised clinic. Here we audit the outcomes from the first 18 months of this specialised opioid reduction clinic. Aims 1. To describe the patient population referred to a specialised multi-professional pain clinic for patients who require opioid dose reduction. 2. To evaluate clinical outcomes after the first 18 months of the clinic's existence. 3. To benchmark the results against the recommendations of Opioids Aware. Methods This is a retrospective audit of routinely obtained patient-reported outcomes. All clinicians in our secondary and tertiary care pain clinics were able to refer patients who had a variety of medication-related issues, including overuse, addiction, difficulties with dose reduction. The clinics were usually staffed by two health professionals, one of whom was a pain consultant. Demographic descriptors were age and gender, we recorded the main pain diagnoses. Morphine equivalent doses of the patients' opioid intake were calculated using BNF conversion tables. Analysis included median, quartiles, and range of opioid dose at first and most recent contact. We collected the following patient-reported outcomes on the day of the first opioid reduction clinic appointment: Pain Detect Questionnaire, Health related Quality of Life questionnaire EQ5D-3L, Pain Self Efficacy Questionnaire (PSEQ), Hospital Anxiety and Depression Scale (HADS). At follow up appointments patients were asked to fill in EQ5D-3L and PSEQ. results 30 patients were seen at least once in the specialist clinic. 57% were female, median age 49 years. The most common pain diagnoses were widespread pain (40%), failed back surgery (27%), and Ehlers Danlos Syndrome (13%). At the first appointment patients were taking a median opioid dose of 300mg (range 70-4100mg) oral morphine equivalent per day. 83% of patients were taking more than 120mg morphine equivalent per day. 37% of patients also had overuse problems with other drugs, e.g. benzodiazepines. Patientreported outcomes indicated very poor quality of life and self-efficacy and high incidence of clinical depression and anxiety. At follow up 85% of patients had achieved a reduction of their opioid intake. The median reduction in morphine equivalent daily dose was 26% (range +10% to-75%). Patient-reported outcomes were no worse than at the first appointment. 53% of patients continue in the opioid reduction clinic aiming for further reduction. conclusion Patients referred to this opioid reduction clinic take extraordinarily high doses of opioids and other centrally acting medications. By comparison, in previous snapshot audit of our primary and secondary care pain clinics the median opioid dose of the group on strong opioids was 67.5mg daily. These patients report very poor healthrelated quality of life and extremely low self-efficacy regarding their pain management. Due to the very high prevalence of clinically relevant anxiety and depression the clinic was supported by a Clinical Psychologist during recent months. An individualised strategy to reduce the intake of opioids is required for these complex patients. |

### 43. The creation of a peri-operative analgesia protocol for major hepatobiliary surgery in a tertiary referral hospital

| | |
|---|---|
| **Authors** | Parry J.; Melikian C.; Pemberton P. |
| **Source** | British Journal of Pain; May 2018; vol. 12 (no. 2); p. 12 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at British Journal of Pain from Europe PubMed Central - Open Access |

| | |
|---|---|
| **Abstract** | Background Standardisation of practice is a proven way to streamline systems, improve efficiency and potentially patient care. There is a multitude of analgesic regimes that can be utilised intra and post-operatively for hepatobiliary (HPB) surgery including the use of lignocaine intravenous infusion (IVI), intrathecal opioids, epidural anaesthesia and patient controlled analgesia (PCA). Adequate analgesia has a major impact on patient satisfaction, can potentially aid earlier mobilisation, reduce short term complications and reduce chronic post-surgical pain. Anecdotal reports from the hospital's acute pain team has found difficulty in managing pain in major HPB surgery patients on the wards. Aims We initiated a quality improvement project. Our aim was to standardise analgesic regimes for major hepatobiliary surgery to reduce post-operative pain scores in 12 months at the Royal Free Hospital NHS Trust. Methods We performed an analysis to identify key stakeholders (anaesthetists, surgeons, intensive care team, acute pain team, patients, management). Baseline data was collected prospectively via a paper proforma reviewing adult major HPB patients over a two month period between September and November 2017. The outcome measure was pain scores, the process measures were analgesia used and duration, complications and patient satisfaction. To guide protocol creation, we established current practice nationwide amongst other HPB units via an online survey sent to 32 departmental secretaries and distributed accordingly to HPB anaesthetic consultants. Data was input into Microsoft Excel©. Data was analysed as medians for daily pain scores and percentages for proportions of analgesics used across the patient cohort. Following data analysis, we developed an analgesic protocol including a flowchart for major HPB surgery. results 22 cases were analysed, 59% male, 45% 61-80 years old. Intraoperative analgesia use was: Paracetamol (90%), Fentanyl (77%), spinal diamorphine (50%), ketamine (50%), lignocaine IVI (27%), magnesium (18%), epidural (14%). Post-operative analgesia use was: Paracetamol (72%), Fentanyl PCA (68%), epidural (9%). Median daily pain scores (0-3) were day 0: 1, day 1: 2.5, day 2: 2, day 3: 1, day 4: 1, day 5: 1, day 6: 1. Two patients had chronic pain and there were three analgesia-related complications. Fentanyl PCA use ranged from 100mcg/24 hours to 5mg/24 hours, median duration was 1.5 days. Regarding the national survey, 91 anaesthetists from 22 units responded. 60% use an enhanced recovery program, 50% an analgesic protocol. Intra-operative analgesia use was: Paracetamol (71%), epidural (55%), Fentanyl (55%), morphine (20%), spinal diamorphine (15%), ketamine (12%), lignocaine (10%). Post-operative analgesia use was: Paracetamol (80%), epidural (59%), wound catheter (34%), Fentanyl PCA (21%), Morphine PCA (21%). conclusion There was varied practice nationally and locally indicating the need for standardisation, especially as simple analgesia was not always given. The first cycle demonstrated areas for improvement. PCA use was varied and short, with apparent trends demonstrating a peak of pain scores at 24 hours post-operatively, falling at day three, potentially indicating a need for longer PCA use. A protocol has been introduced with multi-disciplinary input. Cycles are ongoing to review and adapt the protocol to enable improved pain scores. A preoperative information video to help reduce patient anxiety and manage pain expectations is also in production. |

### 44. Chronic and complex pain workload of inpatient pain services (CHIPS)-a national audit

| | |
|---|---|
| **Authors** | Rockett M. |
| **Source** | British Journal of Pain; May 2018; vol. 12 (no. 2); p. 8-9 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at British Journal of Pain from Europe PubMed Central - Open Access |

---

| | |
|---|---|
| **Abstract** | Background Despite evidence that inpatient pain services can be cost effective, they have been generally under resourced in the UK and are at risk from decommissioning in many areas. It is imperative that these services demonstrate added value in a cash limited NHS. Two areas where benefit to patients and savings may be achieved are in the management of inpatients with exacerbations of chronic pain and those with complex pain problems who have undergone surgery or trauma. Both these groups often have prolonged and costly inpatient stays. These patients do not fit within enhanced recovery programmes without support from effective inpatient pain services and account for approximately 15% of the surgical workload. Published single centre audit has revealed the significant extent of this workload and this poster presents findings from the pilot to a national audit. Aims The aim of this national audit is to reveal the workload of managing inpatients with chronic and complex pain. We aim to collect data on diagnoses and referral patterns, length of hospital stay, organisational data and impact of intervention. National level data will inform NHS resource use. Methods The dataset was selected following local audit and review by members of the acute pain specialist interest group of the British Pain Society. A pilot audit was carried out in two centres and the dataset modified based on these findings. Sites for the national audit were identified from previously published acute pain service census data and via advertising on the National Acute Pain Symposium website. To date 63 hospitals have agreed to carry out the audit throughout the UK. Data collection spreadsheets will be sent to all participating hospitals in January 2018 and each will begin a staggered eight-week data collection period up to mid-May 2018. Data collection will be complete by late summer 2018. Following analysis, the findings on the two key patient groups will be published in peer-reviewed journals. Each hospital will also be able to benchmark its own data against national data to facilitate local commissioning discussions. results Pilot data were available for one month. These data included time spent managing patients with exacerbations of chronic pain only. National data on acute pain management in patients with chronic pain will be presented in the poster. 25 patients were identified. 68% of the patients were female with a mean age of 62.6yrs (SD 18.9). Male patients mean age was 47.5 (16.7), not significantly different from the female patients (p=0.06). The median length of stay was 7 days, with a range of 1-44 days. Patients were seen a median of 2 days after admission and discharged a median of 3 days later. The data were skewed by outliers. 72% of referrals were from acute medicine, the remainder from surgical specialties. 56% of the patients had chronic back or neck pain and 20% had exacerbations of chronic abdominal pain. Other diagnoses included medical pain, chronic widespread pain and chronic infection. conclusion Given these figures, we conservatively expect 1550 datasets nationally from 63 sites for exacerbations of chronic pain and a similar number for complex pain management. The pilot audit has demonstrated that we can collect data reliably from multiple sites. The data reveal high levels of inpatient service use by patients with exacerbations of chronic pain. National data may reveal which models of care result in reduced length of stay in these patients and help to inform future investment in inpatient pain services. |

### 45. Fasting and sedation for elective pain procedures: A comparison between Ipswich Hospital and national practices

| | |
|---|---|
| **Authors** | Laba D.; Dhillon P. |
| **Source** | British Journal of Pain; May 2018; vol. 12 (no. 2); p. 41 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at British Journal of Pain from Europe PubMed Central - Open Access |

| | |
|---|---|
| **Abstract** | Background There is a wide variation in sedation practice in pain procedures ranging from no sedation to routine use. In the United Kingdom, deep sedation requires the same level of care as general anaesthesia, and many practitioners follow standard 2-4-6 hour fasting guidance to avoid potential loss of airways and pulmonary aspiration. However, pre-operative fasting for sedation is controversial and considered unnecessary by some authorities. Potential downsides of fasting include discomfort for the patient and potential risks of hypoglycaemia in diabetics. Moreover, NICE guidance on children's sedation accepts no fasting before sedation if the sedation is minimal or moderate and the patient will maintain verbal contact with the practitioner. It is also recognised that clinicians choosing to sedate patients without fasting should be prepared to justify this choice. Aims This study examines local and national practices for fasting and sedation in pain procedures. It also assesses whether there is scope for developing separate guidance in our Trust where no fasting is permitted in selected groups of patients where minimal sedation is used. Methods In the first instance, we performed an audit in our Trust during 3 consecutive weeks. The audit proforma included several questions related to fasting and sedation. Regarding fasting, patients were asked whether they followed standard written pre-op instructions where rules 2-4-6 applied, or were given different (verbal) instructions. Diabetic patients were asked if they experienced symptoms of hypoglycaemia. Concerning sedation, questions included: drugs, dose and whether patients were offered sedation or asked for it. Finally, the time between leaving the theatre and time 'ready-for-discharge' was recorded for sedated and non-sedated patients. In the national survey, an online questionnaire was sent via professional group email to pain physicians containing similar questions regarding fasting protocols, sedation and diabetic considerations. results All audit patients (n=53) were sent written instructions to fast prior to procedure. However, 7 patients (13%) received verbal instructions advising not to fast. 26 patients (49%) received sedation, where 22 were given anxiolysis with Midazolam (average dose 2.8 mg) and 4 received a combination of Midazolam and Fentanyl. Six patients (11%) were diabetic and 2 of them had symptoms of hypoglycaemia. The average 'ready-for-discharge' time in sedated patients was 62 minutes and non-sedated 52 minutes. The national survey (n=52) revealed that 20% of clinicians do not use sedation at all. Sedation use depends almost exclusively on patient and surgical factors. Minimal and conscious sedation stands for 94% of sedation procedures. 25% of clinicians instruct not to fast prior to procedure even where sedation is considered. Only 12% use separate guidelines specific to pain procedures. 74% of clinicians use Midazolam. 33% of clinicians use separate guidance for diabetic patients. conclusion The survey and the local audit showed that practices regarding sedation and fasting vary. The pre-op instruction with 2-4-6 rules is the most common. A proportion of clinicians advise their patients not to fast prior to sedation. The minimal or conscious sedation with Midazolam is the most common level of sedation. Insulin diabetic patients remain at risk of symptomatic hypoglycaemia after the starvation period. The study rationalises a change in current protocol on fasting for pain procedures with minimal sedation in selected group of patients. |

### 46. Assessment of pain in adults who have a learning disability a snapshot survey of practice in secondary care nhs trusts across the united kingdom

| | |
|---|---|
| **Authors** | De Gray L.; Seth B.; Black S. |
| **Source** | British Journal of Pain; May 2018; vol. 12 (no. 2); p. 5 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at British Journal of Pain from Europe PubMed Central - Open Access |

| | |
|---|---|
| **Abstract** | Background In the UK there are currently various guidelines which specifically promote the assessment and management of pain in adults who have a learning disability. The NICE guideline, NG11, published in May 2015 on "Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges" specifically states that "there should be an agreed and shared care plan for managing any physical health problems (including pain)." The Royal College of Anaesthetists guidelines on acute pain management state that "Tools such as the Abbey pain scale may be appropriate for non-verbal adults. However as with all guidelines and recommendations, what happens in practice may be very much dictated by resources both in terms of man power as well as staff training. A survey of published literature reveals various publications which have pointed towards significant lack of adequate care for patients who have a learning disability. Aims With this view in mind, a survey has been conducted on behalf of the Faculty of Pain medicine to analyse assessment of pain in adults with learning disability across secondary care NHS Trusts in the United Kingdom. Methods One hundred and three NHS Trusts across the United Kingdom were randomly picked. A further random analysis of around twenty websites, revealed that most did not name a specific person who was designated Safeguarding Lead for Adult patients with Learning Disabilities. A postal survey was therefore sent out and simply addressed to the "Safe guarding Lead for Adult patients with Learning Disabilities". The survey specifically asked for details of the responsible Lead, mandatory training of staff, assessment tools used, audit performed to assess the management of such patients and whether these patients were being appropriately assessed and managed. Eight weeks were allowed to pass before all data received was collated and analysed. results Although the return of surveys was low at 23%, we believe our data is a reasonably accurate representation of current practice in the United Kingdom. The survey confirms that there is appreciation of the fact that there is a population of adults with learning disabilities that maybe admitted to acute hospital Trusts. However training of medical and nursing staff to deal with these patients is surprisingly low with only 39% of Trusts providing mandatory training. Only 87% of Trusts have a named Lead for Safeguarding adults with Learning disabilities. There appears to be a reasonable understanding and use of communication tools suitable for pain assessment in this population of patients with only thirteen percent of Trusts apparently not using any specific recognised or bespoke tools. The response to our question as to whether this population of patients is being appropriately assessed and managed well suggests that their assessment and management remains a challenge. Only 39% of Trusts were actively involved in auditing measures and outcomes being used in this group of patients. conclusion All health professionals need to have a greater awareness of learning disability, how to increase opportunities for effective communication and be very familiar with the issue and guidelines relating to this group of patients. It appears likely that pain continues to be underrecognised and under-treated, particularly in those with severe and profound intellectual disabilities and impaired capacity to communicate. These patients depend on their care givers to interpret behavioural responses to pain, to recognize their pain and at the end of the day, to relieve their pain. Despite increasing awareness of the need for safeguarding this vulnerable group of patients, there appears to remain a significant need for improvement in both assessment and delivery of pain management in particular in the acute care setting. |

### 47. A national quality incentive scheme to reduce antibiotic overuse in hospitals: Evaluation of perceptions and impact

| | |
|---|---|
| **Authors** | Islam J.; Llewelyn M.J.; Ashiru-Oredope D.; Budd E.; Hopkins S.; Howard P.; Walker A.S. |
| **Source** | Journal of Antimicrobial Chemotherapy; Jun 2018; vol. 73 (no. 6); p. 1708-1713 |
| **Publication Date** | Jun 2018 |
| **Publication Type(s)** | Article |
| **Database** | EMBASE<br>Available at The Journal of antimicrobial chemotherapy 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 |

| | |
|---|---|
| **Abstract** | Background: In 2016/2017, a financially linked antibiotic prescribing quality improvement initiative Commissioning for Quality and Innovation (AMR-CQUIN) was introduced across acute hospitals in England. This aimed for > 1% reductions in DDDs/1000 admissions of total antibiotics, piperacillin/tazobactam and carbapenems compared with 2013/2014 and improved review of empirical antibiotic prescriptions. Objectives: To assess perceptions of staff leading antimicrobial stewardship activity regarding the AMR-CQUIN, the investments made by hospitals to achieve it and how these related to achieving reductions in antibiotic use. Methods: We invited antimicrobial stewardship leads at acute hospitals across England to complete a webbased survey. Antibiotic prescribing data were downloaded from the PHE Antimicrobial Resistance Local Indicators resource. Results: Responses were received from 116/155 (75%) acute hospitals. Owing to yearly increases in antibiotic use, most trusts needed to make > 5% reductions in antibiotic consumption to achieve the AMR-CQUIN goal of 1%reduction. Additional funding wasmade available at 23/113 (20%) trusts and, in 18 (78%), this was < 10%of the AMR-CQUIN value. Nationally, the annual trend for increased antibiotic use reversed in 2016/2017. In 2014/2015, year-on-year changeswere+3.7%(IQR-0.8%,+8.4%),+9.4%(+0.2%,+19.5%) and+5.8%(-6.2%,+18.2%) for total antibiotics, piperacillin/tazobactam and carbapenems, respectively, and +0.1% (-5.4%, +4.0%), -4.8% (-16.9%,+3.2%) and-8.0%(-20.2%,+4.0%) in 2016/2017. Hospitalswhere staff believed they could reduce antibioticuseweremore likely todo so (P < 0.001). Conclusions: Introducing the AMR-CQUIN was associated with a reduction in antibiotic use. For individual hospitals, achieving the AMR-CQUIN was associated with favourable perceptions of staff and not availability of funding.<br>Copyright © The Author(s) 2018. Published by Oxford University Press on behalf of the British Society for Antimicrobial Chemotherapy. All rights reserved. |

### 48. The establishment of a managed clinical network to enhance collaborative provision of service for haemophilia in Scotland

| | |
|---|---|
| **Authors** | Brodie N. |
| **Source** | Haemophilia; May 2018; vol. 24 ; p. 126 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE |
| | Available at Haemophilia : the official journal of the World Federation of Hemophilia from Wiley Online Library Medicine and Nursing Collection 2018 - NHS |
| | Available at Haemophilia : the official journal of the World Federation of Hemophilia 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** | Haemophilia services in Scotland have a track record of working on a collaborative basis for the benefit of patients and to provide high quality and equitable health care for people with inherited bleeding disorders. Following years of informal collaboration between all professional groups a National Managed Clinical Network (NMCN) for inherited bleeding disorders was commissioned in 2016. The Scottish Inherited Bleeding Disorders Network (SIBDN) includes two comprehensive care centres (Glasgow and Edinburgh) and three Haemophilia Centres (Aberdeen, Inverness and Dundee). The new network is part of a group of over 20 other NMCNs in Scotland. Each network brings together everyone involved in providing specialist care for particular groups of patients with the rarest and/or complex healthcare needs. All NMCNs also have a remit to include patients and third sector groups. SIBDN encompasses a variety of personnel from multidisciplinary teams within the haemophilia centres in Scotland (medical staff, nurses, data managers, allied health professionals etc) as well as colleagues from NHS National Services Scotland who manage and fund recombinant and commercial concentrates for people with inherited bleeding disorders. It also includes representatives from patient groups as well as individual patient and carer representatives. Overall network strategy is set by a steering committee made up of a clinical lead, multidisciplinary staff from treatments centres across Scotland, with representatives from the network's work streams which also include patient group representatives. The network activities fall into three broad areas or work streams: Communication and Patient Engagement, Best Practice Policies and Protocols, and Quality Improvement, Data and Audit. Overall, the activities over the last 2 years of the MNCNs designation have proven to be valuable and inclusive though not without challenges. Moving forward the experience gained in this time can only ensure ongoing improvements in provision of quality haemophilia care in Scotland. |

### 49. What impact has tendering had on trainees? Results of a national survey by British association for sexual health and HIV trainees' collaborative for audit, research and quality improvement projects

| | |
|---|---|
| **Authors** | Wiggins H.; Hartley A.; Clarke E.; Foley E.; Nandwani R.; Carlin E.; Waters L.; Ahmed N. |
| **Source** | International Journal of STD and AIDS; 2018; vol. 29 (no. 1); p. 38-43 |
| **Publication Date** | 2018 |
| **Publication Type(s)** | Article |
| **PubMedID** | 28669323 |
| **Database** | EMBASE |

Available at International Journal of STD & AIDS 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 International Journal of STD & AIDS 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 April 2013, local authorities gained responsibility for commissioning sexual health services in England. With many services going out to tender and resultant change in services or service provider, there is anecdotal evidence that this has impacted on the education, training and morale of genitourinary medicine (GUM) trainees. The aim of this study was to evaluate the impact of tendering on GUM trainees. An electronic survey designed by the British Association for Sexual Health and HIV Trainees' Collaborative for Audit, Research and Quality Improvement Projects (T-CARQ) was distributed to GUM trainees and newly appointed consultants. Eighty-two individuals responded (74% GUM trainees, 25% newly appointed consultants, 1% locum appointed for service). Sixty-three per cent (45/72) had experience of training within a service which was being tendered. of these, 59% (24/41) felt their training was not considered during the tendering process and 20% (8/41) felt that it was. Forty-four per cent (18/41) felt adequately supported. Thirty per cent (12/40) reported active participation in the tendering process. On a scale of 0 (no impact) to 5 (major impact), the median score for impact of tendering on training was 2. The positive/negative impact of tendering on different training elements was rated: other than management experience the overall impact on all parameters was negative, namely morale, senior support and education. In conclusion, this survey describes the variable impact of service tendering on GUM training. Our recommendations for maintaining training standards despite tendering include actively involving trainees and education partners, inclusion of specialist GUM training in service specifications, development of guidance for commissioners and services for the management of GUM training within tendering.
Copyright © The Author(s) 2017.

### 50. Implementing a standardised discharge analgesia guideline to reduce paediatric post tonsillectomy pain

**Authors** Shelton F.R.; Ishii H.; Mella S.; Chew D.; Winterbottom J.; Walijee H.; Chisholm E.J.; Brown R.
**Source** International Journal of Pediatric Otorhinolaryngology; Aug 2018; vol. 111 ; p. 54-58
**Publication Date** Aug 2018
**Publication Type(s)** Article
**Database** EMBASE

Available at International Journal of Pediatric Otorhinolaryngology 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 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: To reduce readmission for pain control post-paediatric tonsillectomy. Introduction: Paediatric tonsillectomy is a common procedure in the UK. Uncontrolled pain at home is a common reason for re-admission and therefore adequate analgesic control following paediatric tonsillectomy is vital for a smooth post-operative recovery. Analgesic regimens at a district general hospital in England were audited and a standardised protocol was subsequently implemented. Methods: A retrospective audit from September 2014 to August 2015 was completed. Discharge analgesic regimens and readmission rates post-tonsillectomy for recurrent tonsillitis in 2-17 year-old children were studied in a large general hospital in the United Kingdom. A standardised weight-based algorithm was used to dose scheduled regular paracetamol for 2 weeks. Second cycle prospective audit ran from December 2015 to November 2016. Results: In cycle 1, 151 children (mean age, 7.9 years) underwent tonsillectomy for tonsillitis, 25 (16.6%) of whom were readmitted. 12 (7.9%) experienced postoperative haemorrhage, 13 (8.6%) required pain control, and one (1.2%) had infection. The discharging analgesic regimen varied widely and often included purchase of over-the-counter ibuprofen and paracetamol. In cycle 2, 118 children (mean age, 8.8 years) underwent tonsillectomy, 17 (14.4%) were readmitted; 12 (10.2%) had post-operative haemorrhage, 0 needed pain control, 5 (4.2%) had other problems. There was a significant reduction in readmission for pain control (p = 0.0027) from 7.3% to 0% in the study. There was no significant change in overall readmission rate (16.6%-14.4%) or postoperative haemorrhage rate (8.9% overall). Discussion: Analgesia prescription post tonsillectomy varies widely and over the counter prescriptions of ibuprofen and paracetamol is based on age rather than weight with patients receiving inadequate analgesic doses. A readily available standardised postoperative analgesic protocol can significantly reduce readmission rates for pain control following paediatric tonsillectomy.
Copyright © 2018

### 51. Renal replacement therapy in the critically ill child

**Authors** Westrope C.A.; Fleming S.; Kapetanstrataki M.; Parslow R.C.; Morris K.P.
**Source** Pediatric Critical Care Medicine; Mar 2018; vol. 19 (no. 3); p. 210-217

| | |
|---|---|
| **Publication Date** | Mar 2018 |
| **Publication Type(s)** | Article |
| **Database** | EMBASE<br>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).<br>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: Although renal replacement therapy is widely used in critically ill children, there have been few comprehensive population-based studies of its use. This article describes renal replacement therapy use, and associated outcomes, in critically ill children across the United Kingdom in the largest cohort study of this patient group. Design: A retrospective observational study using prospectively collected data. Setting: Data from the Pediatric Intensive Care Audit Network database which collects data on all children admitted to U.K. PICUs. Patients: Children (< 16 yr) in PICU who received renal replacement therapy between January 1, 2005, and December 31, 2012, were identified. Interventions: Individual-level data including age, underlying diagnosis, modality (peritoneal dialysis and continuous extracorporeal techniques [continuous renal replacement therapy]), duration of renal replacement therapy, PICU length of stay, and survival were extracted. Measurements and Main Results: Three-thousand eight-hundred twenty-five of 129,809 PICU admissions (2.9%) received renal replacement therapy in 30 of 33 centers. Volumes of renal replacement therapy varied considerably from 0% to 8.6% of PICU admissions per unit, but volume was not associated with patient survival. Overall survival to PICU discharge (73.8%) was higher than previous reports. Mortality risk was related to age, with lower risk in older children compared with neonates (odds ratio, 0.6; 95% CI, 0.5-0.8) although mortality did not increase over the age of 1 year; mode of renal replacement therapy, with lower risk in peritoneal dialysis than continuous renal replacement therapy methodologies (odds ratio, 0.7; 0.5-0.9); duration of renal replacement therapy (odds ratio, 1.02/d; 95% CI, 1.01-1.04); and primary diagnosis, with the lowest survival in liver disease patients (53.9%). Conclusions: This study describes current renal replacement therapy use across the United Kingdom and associated outcomes. We describe a number of factors associated with outcome, including age, underlying diagnosis, and renal replacement therapy modality which will need to be factored into future trial design.<br>Copyright © 2018 by the Society of Critical Care Medicine and the World Federation of Pediatric Intensive and Critical Care Societies. |

### 52. Optimization of the CT component of SPECT-CT and establishment of local CT diagnostic reference levels for clinical practice

| | |
|---|---|
| **Authors** | Dennis J.L.; Gemmell A.J.; Nicol A.J. |
| **Source** | Nuclear Medicine Communications; 2018; vol. 39 (no. 6); p. 493-499 |
| **Publication Date** | 2018 |
| **Publication Type(s)** | Article |
| **Database** | EMBASE<br>Available at Nuclear Medicine Communications 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 |
| **Abstract** | Objective The aim of this study was to perform a process of optimization and establish local diagnostic reference levels (DRLs) for the computed tomography (CT) component of single-photon emission computed tomography (SPECT)-CT imaging, for use in clinical practice. Methods A multidisciplinary group defined categories for the clinical purpose of the CT component of local SPECT-CT examinations. Each of the examinations were assigned a category, and optimization of acquisition and reconstruction parameters was performed to achieve the required image quality. Dose data were collated for 754 SPECT-CT scans performed on three systems over 10 months. The third quartile values for volume CT dose index and dose length product were calculated and established as local DRLs. Results Four categories of CT examinations were defined: Attenuation correction; localization and attenuation correction; localization, characterization and attenuation correction; and diagnostic and attenuation correction. Local DRLs were established for 11 examinations. Reference was made to the proposed national DRLs set by a recent UK survey. Conclusion This work describes a process of optimization and the creation of practical and effective local DRLs. These can be used in local audit of practice. In future, improved descriptors and standardization of SPECT-CT use would allow more practicable UK national DRLs to be created.<br>Copyright © 2018 Wolters Kluwer Health, Inc. All rights reserved. |

### 53. Reducing adult cardiac surgical site infections and the economic impact of using multidisciplinary collaboration

| | |
|---|---|
| **Authors** | Chiwera L.; Wigglesworth N.; Newsholme W.; McCoskery C.; Lucchese G. |
| **Source** | Journal of Hospital Infection; 2018 |
| **Publication Date** | 2018 |
| **Publication Type(s)** | Article In Press |

---

**Database** EMBASE
Available at Journal of Hospital Infection 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 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** Background: Cardiac surgical site infections (SSIs) have devastating consequences and present several challenges for patients and healthcare providers. Adult cardiac SSI surveillance commenced in 2009 at our hospitals, Guy's & St Thomas' NHS Foundation Trust, London, as a patient safety initiative amid reported increased incidence of SSIs. Before this time, infection incidence was unclear because data collection was not standardized. Aim: To standardize SSI data collection and establish baseline SSI rates to facilitate deployment of evidence-based targeted interventions within clinical governance structures to improve quality, safety, and efficiency in line with our organizational targets. Methods: We standardized local data collection protocols in line with Public Health England recommendations and identified local champions. We undertook prospective SSI surveillance collaboratively to enable us to identify potential practice concerns and address them more effectively through a series of initiatives. Clinical staff completed dedicated surveillance forms intraoperatively and postoperatively. Findings: Overall adult cardiac SSI rates fell from 5.4% in 2009 to 1.2% in 2016 and coronary artery bypass graft rates from 6.5% in 2009 to 1.7% in 2016 ($P < 0.001$). Gram-negative bacteria were recognized as important SSI causative organisms and were better controlled after introducing stringent infection control measures. Conclusion: Comprehensive, evidence-based infection control practices were successfully implemented through a multidisciplinary collaborative approach, which may have great potential to reduce Gram-negative, Staphylococcus aureus, polymicrobial and overall SSI burden and/or associated costs. We now investigate all SSIs using an established SSI detailed investigation protocol to promote continual quality improvement that aligns us perfectly with global efforts to fight antimicrobial resistance.
Copyright © 2018 The Healthcare Infection Society

### 54. Exploring variation in glycemic control across and within eight high-income countries: A cross sectional analysis of 64,666 children and adolescents with type 1 diabetes

**Authors** Charalampopoulos D.; Stephenson T.; Amin R.; Hermann J.M.; Holl R.W.; Svensson J.; Fredheim S.; Skrivarhaug T.; Drivvoll A.K.; Kummernes S.J.; Maahs D.M.; Akesson K.; Warner J.T.; Birkebaek N.H.; Miller K.M.; Foster N.; Svensson A.-M.; Hofer S.E.; Hanberger L.; Rami-Merhar B.; Johansen A.; Dahl-Jorgensen K.; Clements M.; Hanas R.
**Source** Diabetes Care; Jun 2018; vol. 41 (no. 6); p. 1180-1187
**Publication Date** Jun 2018
**Publication Type(s)** Conference Paper
**Database** EMBASE
Available at Diabetes 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

**Abstract** OBJECTIVE International studies on childhood type 1 diabetes (T1D) have focused on wholecountrymean $HbA_{1c}$ levels, thereby concealing potential variations within countries. We aimed to explore the variations in $HbA_{1c}$ across and within eight high-income countries to best inform international benchmarking and policy recommendations. RESEARCH DESIGN AND METHODS Data were collected between 2013 and 2014 from 64,666 children with T1D who were <18 years of age across 528 centers in Germany, Austria, England, Wales, U.S., Sweden,Denmark, and Norway.We used fixed- and random-effectsmodels adjusted for age, sex, diabetes duration, and minority status to describe differences between center means and to calculate the proportion of total variation in $HbA_{1c}$ levels that is attributable to between-center differences (intraclass correlation [ICC]). We also explored the association between within-center variation and children's glycemic control. RESULTS Sweden had the lowestmean$HbA_{1c}$ (59mmol/mol [7.6%]) and togetherwithNorway andDenmark showed the lowest between-center variations (ICC <=4%). Germany and Austria had the next lowest mean $HbA_{1c}$ (61-62 mmol/mol [7.7-7.8%]) but showed the largest center variations (ICC ~15%). Centers in England, Wales, and the U.S. showed low-to-moderate variation around high mean values. In pooled analysis, differences between counties remained significant after adjustment for children characteristics and center effects (P value <0.001). Across all countries, children attending centers withmore variable glycemic results had higher $HbA_{1c}$ levels (5.6mmol/mol [0.5%] per 5mmol/mol [0.5%] increase in centerSD of $HbA_{1c}$ values of all children attending a specific center). CONCLUSIONS Atsimilaraveragelevels of$HbA_{1c}$, countriesdisplaydifferentlevelsofcentervariation. The distribution of glycemic achievement within countries should be considered in developing informed policies that drive quality improvement.
Copyright © 2018 by the American Diabetes Association.

### 55. Venous Thrombo-Embolic Prophylaxis in Aesthetic Surgery: A National Audit of Practices in the United Kingdom

**Authors** Patel L.; Gupta R.D.
**Source** Aesthetic Surgery Journal; May 2018; vol. 38 (no. 6); p. 88-91

| | |
|---|---|
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Letter |
| **Database** | EMBASE |
| | Available at Aesthetic Surgery Journal from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free). |
| | Available at Aesthetic Surgery 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. |

### 56. Management of gout by UK rheumatologists: a British Society for Rheumatology national audit

| | |
|---|---|
| **Authors** | Roddy E.; Packham J.; Obrenovic K.; Rivett A.; Ledingham J.M. |
| **Source** | Rheumatology (Oxford, England); May 2018; vol. 57 (no. 5); p. 826-830 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Article |
| **PubMedID** | 29447370 |
| **Database** | EMBASE |
| | Available at Rheumatology (Oxford, 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 Rheumatology (Oxford, 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** | Objectives: To assess the concordance of gout management by UK rheumatologists with evidence-based best-practice recommendations.Methods: Data were collected on patients newly referred to UK rheumatology out-patient departments over an 8-week period. Baseline data included demographics, method of diagnosis, clinical features, comorbidities, urate-lowering therapy (ULT), prophylaxis and blood tests. Twelve months later, the most recent serum uric acid level was collected. Management was compared with audit standards derived from the 2006 EULAR recommendations, 2007 British Society for Rheumatology/British Health Professionals in Rheumatology guideline and the National Institute for Health and Care Excellence febuxostat technology appraisal.Results: Data were collected for 434 patients from 91 rheumatology departments (mean age 59.8 years, 82% male). Diagnosis was crystal-proven in 13%. Of 106 taking a diuretic, this was reduced/stopped in 29%. ULT was continued/initiated in 76% of those with one or more indication for ULT. One hundred and fifty-eight patients started allopurinol: the starting dose was most commonly 100 mg daily (82%); in those with estimated glomerular filtration rate <60 ml/min the highest starting dose was 100 mg daily. Of 199 who started ULT, prophylaxis was co-prescribed for 94%. Fifty patients started a uricosuric or febuxostat: 84% had taken allopurinol previously. Of 44 commenced on febuxostat, 18% had a history of heart disease. By 12 months, serum uric acid levels 360 and <300 mumol/l were achieved by 45 and 25%, respectively.Conclusion: Gout management by UK rheumatologists concords well with guidelines for most audit standards. However, fewer than half of patients achieved a target serum uric level over 12 months. Rheumatologists should help ensure that ULT is optimized to achieve target serum uric acid levels to benefit patients. |

### 57. Closing the loop on centralization of cleft care in the United Kingdom

| | |
|---|---|
| **Authors** | Ness A.R.; Wills A.R.; Waylen A.; Smallridge J.; Sell D.; Sandy J.R.; Hall A.J. |
| **Source** | Cleft Palate-Craniofacial Journal; 2018; vol. 55 (no. 2); p. 248-251 |
| **Publication Date** | 2018 |
| **Publication Type(s)** | Article |
| **Database** | EMBASE |
| | Available at The Cleft palate-craniofacial journal : official publication of the American Cleft Palate-Craniofacial Association 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 Cleft palate-craniofacial journal : official publication of the American Cleft Palate-Craniofacial Association from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article. |

| | |
|---|---|
| **Abstract** | Objective: We highlight a major study that investigated the impact of reconfigured cleft care in the United Kingdom some 15 years after centralization. We argue that centralization as an intervention has a major impact on outcomes. Setting: Audit clinics held in Cleft Centers in the United Kingdom. Patients, Participants: Five-year-olds born between April 1, 2005, and March 31, 2007, with nonsyndromic unilateral cleft lip and palate. Interventions: Centralization of cleft care. Main Outcome Measure(s): We collected routine clinical measures (speech recordings, hearing, photographs, models, oral health, psychosocial factors) in a very similar way to a previous survey. Results: We identified 359 eligible children and recruited 268 (74.7%) to the study. Overall, their outcomes were better postcentralization. There have been marked improvements in dentoalveolar arch relationships and in speech whereas the prevalence of dental caries and hearing loss are unchanged. Conclusions: Centralized cleft care has changed UK outcomes considerably and there is no argument for returning to a dispersed model of treatment.<br>Copyright © The Author(s) 2017. |

**58. Prospective real-world analysis of OnabotulinumtoxinA in chronic migraine post-National Institute for Health and Care Excellence UK technology appraisal**

| | |
|---|---|
| **Authors** | Andreou A.P.; Trimboli M.; Al-Kaisy A.; Murphy M.; Palmisani S.; Fenech C.; Smith T.; Lambru G. |
| **Source** | European Journal of Neurology; 2018 |
| **Publication Date** | 2018 |
| **Publication Type(s)** | Article In Press |
| **Database** | EMBASE<br>Available at European Journal of Neurology from Wiley Online Library Medicine and Nursing Collection 2018 - NHS |
| **Abstract** | Background and purpose: The National Institute for Health and Care Excellence (NICE) in the UK recommends the use of OnabotulinumtoxinA (BoNTA, Botox) in the management of chronic migraine (CM) following specific guidelines within the National Health Service. In view of the lack of data on the efficacy of this therapy following implementation of these guidelines in clinical practice and on the evaluation of guidance compliance, we aimed to evaluate the effectiveness and safety of BoNTA in patients with CM following the NICE guidelines. Methods: This was a prospective real-life audit study. Results: After two treatments, 127 of 200 patients (63.5%) obtained at least a 30% reduction in headache days. Those who continued the treatment up to 3 years reported a stable beneficial effect compared with baseline. Amongst responders, 68 patients (53.5%) were reclassified as episodic migraineurs. A total of 57 of these patients (83.8%) converted to an episodic migraine pattern at 6-month follow-up. The majority of those whose migraine became episodic after BoNTA extended the treatment intervals beyond 3 months (range 4-8 months) before noticing any worsening of headache. We observed no significant differences in the efficacy measures in patients treated with 155 U BoNTA compared with those treated with >155 U BoNTA. Conclusions: When administered according to the NICE guidance, BoNTA produced a clinically meaningful effect in the long-term management of CM with and without medication overuse headache. Treatment discontinuation when CM becomes episodic may be useful in clinical practice to identify those who may benefit from extended treatment intervals. Our clinical experience indicates a lack of additional benefit from using the 'follow-the-pain' paradigm.<br>Copyright © 2018 European Federation of Neurological Societies. |

**59. Contact tracing for chronic hepatitis B in primary care? A 'snapshot' audit in Grampian, Northeast Scotland**

| | |
|---|---|
| **Authors** | Phillips B.; Corrigan H.; Okpo E. |
| **Source** | Scottish Medical Journal; 2018 |
| **Publication Date** | 2018 |
| **Publication Type(s)** | Article In Press |
| **Database** | EMBASE<br>Available at Scottish Medical Journal from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article. |

| | |
|---|---|
| **Abstract** | Introduction: Contact tracing for chronic hepatitis B infection is an important activity for preventing the spread of hepatitis B infection. In the UK, the 'Green Book' recommends that all sexual and household contacts of individuals with chronic hepatitis B should be tested and vaccinated if required. This audit aimed to evaluate contact tracing in primary care. Barriers to effective follow-up of contacts of patients with chronic hepatitis B were explored and recommendations made. Methods and results: Mixed method, including a survey of general practitioners and review of hepatitis B surveillance data from 1 June 2015 to 31 December 2015 held by NHS Grampian Health Protection Team. The audit was carried out in August 2016. Contact tracing was mainly by patient referral. Only 20% (4/20) of identified close contacts were tested. No contact eligible for vaccination was vaccinated, and 57% (8/14) of general practitioners who completed the audit questionnaire suggested that general practitioners do not have a role in contact tracing. Barriers identified were: lack of time, lack of resources and contacts being registered with a different practice. Conclusions: This audit suggests that contact tracing for chronic hepatitis B in primary care is largely incomplete. Moving contact tracing from general practice to health protection teams in Boards may be a pragmatic way of improving follow-up activities.<br>Copyright © 2018, The Author(s) 2018. |

### 60. Can Sepsis Be Detected in the Nursing Home Prior to the Need for Hospital Transfer?

| | |
|---|---|
| **Authors** | Sloane P.D.; Ward K.; Kistler C.E.; Zimmerman S.; Weber D.J.; Brown B.; Davis K. |
| **Source** | Journal of the American Medical Directors Association; Jun 2018; vol. 19 (no. 6); p. 492 |
| **Publication Date** | Jun 2018 |
| **Publication Type(s)** | Article |
| **Database** | EMBASE<br>Available at Journal of the American Medical Directors Association from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection |
| **Abstract** | Objectives: To determine whether and to what extent simple screening tools might identify nursing home (NH) residents who are at high risk of becoming septic. Design: Retrospective chart audit of all residents who had been hospitalized and returned to participating NHs during the study period. Setting and Participants: A total of 236 NH residents, 59 of whom returned from hospitals with a diagnosis of sepsis and 177 who had nonsepsis discharge diagnoses, from 31 community NHs that are typical of US nursing homes overall. Measures: NH documentation of vital signs, mental status change, and medical provider visits 0-12 and 13-72 hours prior to the hospitalization. The specificity and sensitivity of 5 screening tools were evaluated for their ability to detect residents with incipient sepsis during 0-12 and 13-72 hours prior to hospitalization: The Systemic Inflammatory Response Syndrome criteria, the quick Sequential Organ Failure Assessment (SOFA), the 100-100-100 Early Detection Tool, and temperature thresholds of 99.0degreeF and 100.2degreeF. In addition, to validate the hospital diagnosis of sepsis, hospital discharge records in the NHs were audited to calculate SOFA scores. Results: Documentation of 1 or more vital signs was absent in 26%-34% of cases. Among persons with complete vital sign documentation, during the 12 hours prior to hospitalization, the most sensitive screening tools were the 100-100-100 Criteria (79%) and an oral temperature >99.0degreeF (51%); and the most specific tools being a temperature >100.2degreeF (93%), the quick SOFA (88%), the Systemic Inflammatory Response Syndrome criteria (86%), and a temperature >99.0degreeF (85%). Many SOFA data points were missing from the record; in spite of this, 65% of cases met criteria for sepsis. Conclusions: NHs need better systems to monitor NH residents whose status is changing, and to present that information to medical providers in real time, either through rapid medical response programs or telemetry.<br>Copyright © 2018 AMDA - The Society for Post-Acute and Long-Term Care Medicine |

### 61. Management of children and young people (CYP) with asthma: A clinical audit report

| | |
|---|---|
| **Authors** | Levy M.L.; Ward A.; Nelson S. |
| **Source** | npj Primary Care Respiratory Medicine; Dec 2018; vol. 28 (no. 1) |
| **Publication Date** | Dec 2018 |
| **Publication Type(s)** | Article |
| **Database** | EMBASE<br>Available at npj Primary Care Respiratory Medicine from Nature Publishing Group - Open Access<br>Available at npj Primary Care Respiratory Medicine from Europe PubMed Central - Open Access<br>Available at npj Primary Care Respiratory Medicine from EBSCO (MEDLINE with Full Text)<br>Available at npj Primary Care Respiratory Medicine from PubMed Central |

**Abstract** An asthma attack or exacerbation signals treatment failure. Most attacks are preventable and failure to recognize risk of asthma attacks are well recognized as risk factors for future attacks and even death. Of the 19 recommendations made by the United Kingdom National Review of Asthma Deaths (NRAD) (1) only one has been partially implemented - a National Asthma Audit; however, this hasn't reported yet. The Harrow Clinical Commissioning Group (CCG) in London implemented a clinical asthma audit on 291 children and young people aged under 19 years (CYP) who had been treated for asthma attacks in 2016. This was funded as a Local Incentive Scheme (LIS) aimed at improving quality health care delivery. Two years after the publication of the NRAD report it is surprising that risks for future attacks were not recognized, that few patients were assessed objectively during attacks and only 10% of attacks were followed up within 2 days. However, it is encouraging that CYP hospital admissions following the audit were reduced by 16%, with clear benefit for patients, their families and the local health economy. This audit has provided an example of how clinicians can focus learning on patients who have had asthma attacks and utilize these events as a catalyst for active reflection in particular on modifiable risk factors. Through identification of these risks and active optimization of management, preventable asthma attacks could become 'never events'.
Copyright © 2018 The Author(s).

### 62. Cytological and histological assessment of pancreatic lesions in a tertiary hepatobiliary unit

**Authors** Masood M.; Baxendine-Jones J.; Di Palma S.; Bagwan I.
**Source** Journal of Pathology; Apr 2018; vol. 245
**Publication Date** Apr 2018
**Publication Type(s)** Conference Abstract
**Database** EMBASE
Available at The Journal of pathology from Wiley Online Library Medicine and Nursing Collection 2018 - NHS
Available at The Journal of pathology 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: Whilst there has been a steady improvement in mortality rates for patients with pancreatic cancer, it still remains the fifth most common cause of cancer death in the UK. With late diagnosis of the disease and substantial post-operative morbidity rates, the role of cytology in pancreatic lesions has been on the incline. The current study aims to assess correlation between pancreatic histological and cytological specimens, and respective turnaround times. Methods: All patients undergoing pancreatic Fine Needle Aspiration (FNA), biopsies and resections between September 2015 and 2016 were identified from a WinPath database. Dates of specimen reception and authorisation were noted, and both reports were analysed for concordance. Results: Out of 208 patients, 234 pancreatic FNAs were performed, and thirty five patients (16%) also had histological reports (either a core biopsy or a resection). Eighty percent of cytology was reported within 7 days, 78% of core biopsies and 42% of histology within 10 days. A 74% correlation was present between cytology and histology reports. The vast majority of non-correlating cases were due to non-representative cytology specimens, as commented upon on the reports. Conclusion: This audit has highlighted good correlation between histological and cytological findings. Non-concordance was mostly due to non-representative cytology specimens. Recent literature shows usage of a larger bore needle and high negative pressure when sampling may increase adequacy of cytological specimens. Factors influencing turnaround times will be assessed prior to re-auditing.

### 63. Grade of breast carcinoma in symptomatic patients-what are the golden standards to audit against

**Authors** Hashim H.; Alchami F.
**Source** Journal of Pathology; Apr 2018; vol. 245
**Publication Date** Apr 2018
**Publication Type(s)** Conference Abstract
**Database** EMBASE
Available at The Journal of pathology from Wiley Online Library Medicine and Nursing Collection 2018 - NHS
Available at The Journal of pathology 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: Histological grading provides a powerful prognostic and therapeutic factor in breast cancer. Nottingham Grading System is the most commonly used grading system in breast cancer assessment. The current benchmark ratio for symptomatic invasive breast cancer proposed by Royal College of Pathologist (RCPATH) is 2 : 3 : 5, (grade 1:grade 2:grade 3) referencing a paper by Elston and Ellis studying a population studied in the period between 1973-1989 in England and West Midlands. Materials and Methods: Google Scholars search was conducted for publications between 1991 to 2016. The following keywords were included during the search: Invasive breast cancer, screen-detected breast cancer, symptomatic breast cancer, histological grade and histological grade ratio. Internal audit of grades in 2200 breast cancer in the University Hospital of Wales UHW was conducted. Results: Audit results of UHW showed the ratio of histological grade of screen-detected subgroup is similar to NHS Breast Screening Programme yearly audit Ratio of 2 : 5: 3. The symptomatic group displays a ratio of 1 : 5 : 4. Both screen-detected and symptomatic subgroup shows a combination ratio of 1.6 : 5.1 : 3.3. The literature search of reported breast cancer grade ratio showed only two papers separating symptomatic from screening patients. The reported ratios varied between 0.6:3.4:6.1 and 1.8:5.1:3.1, and varied widely against country of origin and years studied. Discussion: There is wide variation in the reported ratio of breast cancer grade in the UK. Whilst auditing the grade of symptomatic breast cancer is a requirement by the Royal College of Pathologists, such audit results are not available or even discussed at national level in contrary to the screening detected breast cancer. A cross centre study is required in order to establish a more up to date ratio of breast cancer grade; which will provide a gold standard for future audits.

### 64. B3 diagnosis in core breast biopsies-evaluation of the outcome and positive predictive value relative to the royal college of pathologists dataset

**Authors** Al-Janabi Y.; Lower S.; Davis P.
**Source** Journal of Pathology; Apr 2018; vol. 245
**Publication Date** Apr 2018
**Publication Type(s)** Conference Abstract
**Database** EMBASE
Available at The Journal of pathology from Wiley Online Library Medicine and Nursing Collection 2018 - NHS
Available at The Journal of pathology 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 of Study: This quality improvement project was undertaken to evaluate the breast core biopsies graded as B3, lesions of uncertain malignant potential, at one NHS trust over a period of one year. The results were compared with the Royal College of Pathologists dataset recommendations regarding the suggested rate for B3 lesions and their positive predictive value, with an overall aim to explore potential points for improvement in the diagnosis of B3 lesions. Methods: Data from all core breast biopsy reports at the trust from August 2015 to August 2016 were used to identify the total number graded as B3. All B3 cases were followed up to evaluate, after excision biopsy or vacuum-assisted biopsy, how many lesions were upgraded to malignant and how many were downgraded, in order to find the positive predictive value for B3 lesions. Summary of Results: In total, 34 cases were identified as B3, making up 4% of all core breast biopsy cases, compared to the Royal College of Pathologists recommendation of 4.5 - 8.5%. On subsequent investigation, 10 of these cases were upgraded and were found to be cancerous, giving a positive predictive value of 32%, compared to the current national median of 15%. Conclusions: Compared to the guidelines from the Royal College of Pathologists, the proportion of lesions diagnosed as B3 in the trust was slightly under the recommended threshold, and the positive predictive value of B3 lesions in the trust was more than double the national median. These results suggest there should be a lower threshold for diagnosing B3 breast lesions to increase the likelihood of identifying those B3 lesions that are subsequently found to be cancerous. Potential points to implement are suggested to help achieve this including education, multidisciplinary team cases review and team discussions on B3 diagnoses.

### 65. An audit of the lower limit of DNA concentration for clonality testing in haematological malignancies

**Authors** Medley B.; Gilroy L.; Al-Qsous W.
**Source** Journal of Pathology; Apr 2018; vol. 245
**Publication Date** Apr 2018
**Publication Type(s)** Conference Abstract
**Database** EMBASE
Available at The Journal of pathology from Wiley Online Library Medicine and Nursing Collection 2018 - NHS
Available at The Journal of pathology 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** A clinical audit was performed on all Identiclone gene clonality assays carried out in NHS Lothian over a 24 month period. The results were reviewed to determine the numbers of failed samples and whether there was a correlation between failure and DNA concentration. The aim of this work was to determine the lower limit of DNA concentration acceptable for a successful assay. Of 195 samples assessed, 42 failed analysis and 18 yielded partial results. Of the 42 samples which failed analysis, 36 contained less that 2 ng/mul DNA, 2 contained less than 3 ng/mul DNA, and 4 contained more than 3 ng/mul DNA. Of the 18 samples which yielded partial results, 6 contained less than 2 ng/mul DNA, 2 contained less than 3 ng/mul DNA, and 10 contained more than 3 ng/mul DNA. Full results were obtained for 135 samples, of which 13 had less than 2 ng/mul DNA. Of these 13 samples, 8 needed repeat testing prior to reporting, 3 samples failed analysis of at least one tube, and 2 samples had a DNA ladder amplified up to 300 nucleotides suggestive of low quality samples. The Biomed II guidelines recommend a minimum of 50 ng/mul DNA for testing. However, only 19/195 samples (10%) had 50 ng/mul or more of DNA. This is possibly due to the majority of DNA samples tested in NHS Lothian being extracted from formalin fixed and paraffin embedded (FFPE) tissue samples, rather than peripheral blood. Formalin fixation is known to degrade DNA and with routine diagnostic samples often being scanty in size it is important to set a threshold for the lower limit of DNA quantity which still ensures good quality results. This audit resulted in the following recommendations and change of practice; samples with less that 2 ng/mul DNA are not tested, and samples with between 2-5 ng/mul DNA or size ladder amplification below 300 nucleotides are reported with a cautionary proviso.

### 66. Feasibility of early discharge following vaginal hysterectomy with a bipolar electrocoagulation device

| | |
|---|---|
| **Authors** | Cassis C.; Mukhopadhyay S.; Sule M.M.; Kuruba N. |
| **Source** | International Journal of Gynecology and Obstetrics; 2018 |
| **Publication Date** | 2018 |
| **Publication Type(s)** | Article In Press |
| **Database** | EMBASE<br>Available at International Journal of Gynecology & Obstetrics from Wiley Online Library Medicine and Nursing Collection 2018 - NHS<br>Available at International Journal of Gynecology & Obstetrics 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 evaluate the safety and efficacy of vaginal hysterectomy for benign conditions (excluding prolapse) using the BiClamp (Erbe Elektromedizin, Tubingen, Germany) bipolar electrocoagulation system. Methods: The present study was a prospective audit of a consecutive case series of patients who underwent vaginal hysterectomy for benign conditions, performed using the BiClamp between March 1, 2015, and June 30, 2016, at Norfolk and Norwich University Hospital, Norwich, UK. Surgeries performed for benign conditions were eligible, excluding prolapse; severe endometriosis with pelvic adhesions was an exclusion criterion. Patient demographics and past history were recorded, along with intraoperative findings and adverse events. Follow-up data were obtained via telephone interviews 24 hours after surgery and a nurse-led postoperative clinic 8 weeks postoperatively. Results: The series included 75 patients; 32 (43%) were discharged on the same day as surgery and 70 (93%) within 23 hours. There were two patients who experienced vault hematomas and remained admitted for more than 24 hours. There was one intraoperative bladder injury that was repaired vaginally. No delayed adverse events occurred within 8 weeks. No patient required patient-controlled analgesia or an epidural injection for postoperative analgesia. Conclusion: Patients experienced low postoperative pain following BiClamp treatment and 93% were was discharged within 23 hours.<br>Copyright © 2018 International Federation of Gynecology and Obstetrics. |

### 67. Evaluating the implementation of a quality improvement process in General Practice using a realist evaluation framework

| | |
|---|---|
| **Authors** | Moule P.; Clompus S.; Fieldhouse J.; Ellis-Jones J.; Barker J. |
| **Source** | Journal of Evaluation in Clinical Practice; 2018 |
| **Publication Date** | 2018 |
| **Publication Type(s)** | Article In Press |
| **Database** | EMBASE<br>Available at Journal of evaluation in clinical practice from Wiley Online Library Medicine and Nursing Collection 2018 - NHS<br>Available at Journal of evaluation in clinical 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 |

**Abstract** Rationale, aims, and objectives: Underuse of anticoagulants in atrial fibrillation is known to increase the risk of stroke and is an international problem. The National Institute for Health Care and Excellence guidance CG180 seeks to reduce atrial fibrillation related strokes through prescriptions of Non-vitamin K antagonist Oral Anticoagulants. A quality improvement programme was established by the West of England Academic Health Science Network (West of England AHSN) to implement this guidance into General Practice. A realist evaluation identified whether the quality improvement programme worked, determining how and in what circumstances. Methods: Six General Practices in 1 region, became the case study sites. Quality improvement team, doctor, and pharmacist meetings within each of the General Practices were recorded at 3 stages: initial planning, review, and final. Additionally, 15 interviews conducted with the practice leads explored experiences of the quality improvement process. Observation and interview data were analysed and compared against the initial programme theory. Results: The quality improvement resources available were used variably, with the training being valued by all. The initial programme theories were refined. In particular, local workload pressures and individual General Practitioner experiences and pre-conceived ideas were acknowledged. Where key motivators were in place, such as prior experience, the programme achieved optimal outcomes and secured a lasting quality improvement legacy. Conclusion: The employment of a quality improvement programme can deliver practice change and improvement legacy outcomes when particular mechanisms are employed and in contexts where there is a commitment to improve service.
Copyright © 2018 John Wiley & Sons, Ltd.

**68. Looking the truth in the eye-Benchmarking care and outcomes against the world's largest paediatric IBD registry**

**Authors** Hensel K.; Cunion D.; Gasparetto M.; Brennan M.; Folan A.; Lee C.; Torrente F.; Zilbauer M.; Heuschkel R.
**Source** Journal of Pediatric Gastroenterology and Nutrition; Apr 2018; vol. 66 ; p. 59
**Publication Date** Apr 2018
**Publication Type(s)** Conference Abstract
**Database** EMBASE
Available at Journal of Pediatric Gastroenterology and Nutrition 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 and Study: Medical management of children with inflammatory bowel disease (IBD) is challenging, complex and informed by numerous guidelines. Despite the well-described benefits of benchmarking clinical practice, the vast majority of paediatric IBD centres in the UK do not measure clinical outcomes. ImproveCareNow (ICN) is a US health-learning network that includes data on over 25,000 children. It includes monthly webinars to share learning and innovation, offers access to an extensive online 'exchange' of ideas, and supports improvement initiatives to improve individual care and population outcomes. Membership also provides units with monthly data on their patient population, benchmarked against over 100 other paediatric IBD centres. The aim of this study is to assess outcomes of care and identify areas for improvement in children with IBD managed at Addenbrookes Hospital, Cambridge. Method: We report IBD related outcome data of 164 children currently active within the ICN2 Registry (> 75% of all children eligible for enrolment in Cambridge). 54% have Crohn's disease (CD), 31% ulcerative colitis (UC) and 15% with IBD-unclassified (IBD-U). Data is presented as % of eligible patients, compared to the average of all participating centres with >=75% of patients enrolled, versus the network's defined targets (control numbers given in brackets). We await data from ICN network on the correlation between % remission rates and biologic use. Results: Currently, 70% (ICN control group 81%; declared network target 83%) of all eligible paediatric IBD patients are in clinical remission. 94% (96%; 95%) are currently not taking prednisone. 74% of our patients with CD (and 82% in the control group) are in clinical remission. 69% (78%) of the UC patients are in clinical remission. 85% (90%; 90%) of all children with IBD feature a satisfactory nutritional status and 98% (93%) show a satisfactory growth status. TPMT activity was measured in 100% (83%; 90%) of all IBD patients when treatment with thiopurine was started and thiopurine dose was administered according to ICN model care guidelines in 97% (64%; 80%) of patients. Conclusion: Children with IBD managed in Cambridge appear to fall below US peer group and network targets for clinical remission. Having identified such gaps, work is now underway to understand the drivers for this disparity. We will clarify whether or not the major driver for an improved remission rate in the best US centres is due to earlier / more frequent use of biologic medication. Without accurate, population-based measures, improvements in clinical outcome cannot be documented. Embedding quality improvement and benchmarking of clinical outcomes in children with IBD allows i) identification of areas for improvement, and ii) impact of any change in management. Such large health-learning networks provide substantial advantages over standard audit / registry data. Assessment of the key drivers for differences in clinical outcomes between US and European PIBD units, may lead to beneficial changes in practice.

**69. Improvements in medical treatment and surgical outcome of children and adolescents with ulcerative colitis in the United Kingdom**

**Authors** Auth M.; Bunn S.K.; Protheroe A.; Williams L.; Fell J.; Muhammed R.; Croft N.; Beattie R.M.; Wilmott A.; Spray C.; Vadamalayan B.; Rodrigues A.; Puntis J.; Pigott A.; Wilson D.C.; Mitton S.; Furman M.; Chong S.; Charlton C.; Russell R.K.

**Source** Journal of Pediatric Gastroenterology and Nutrition; Apr 2018; vol. 66 ; p. 49-50
**Publication Date** Apr 2018
**Publication Type(s)** Conference Abstract
**Database** EMBASE
Available at Journal of Pediatric Gastroenterology and Nutrition 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 and Study: Children with ulcerative colitis are affected by steroid dependency, anaemia, and complications of surgery. To improve these nationwide, we examined the efficacy of steroid sparing strategies and surgical outcomes by a coordinated approach to all national leads for inflammatory bowel disease. We examined morbidity and escalation treatment for children with active UC, steroid sparing strategies, proportion of second line treatment and surgical outcome, highlighting geographical differences, areas of improving practice and areas for future development. Method: The 4th round of our national prospective audit was conducted for the inpatient period of all children with ulcerative colitis for medical or surgical treatment in the UK from 1.1.-31.12.2013. Of 34 centres invited 32 participated and recruited 224 children in 298 admissions. We compared results with two previous paediatric audit rounds. Results: Over six years, recording of PUCAI score (median 65)(23% to 55%, p< 0.001), guidelines for acute severe colitis (43% to 77%, p 0.04), and ileal pouch surgery registration (4% to 56%, p< 0.001) have increased. Corticosteroids were given in 183/298 episodes (61%) with 61/183 (33%) not responding and requiring second line therapy or surgery. Of those treated with anti-TNFalpha (16/61, 26%), 3/16 (18.8%) failed to respond and required colectomy. Prescription of rescue therapy (26% to 49%, p=0.04) and proportion of anti-TNFalpha (20% to 53%, p=0.03) had increased, the reduction of the colectomy rate (23.7% to 15%) did not reach statistical significance (p=0.5). Subtotal colectomy was the most common surgery performed (n=40), and surgical complications from all procedures occurred in 33%. In 215/224 (96%) iron deficiency anaemia was detected and in 51% treated, orally (50.2%) or intravenously (49.8%). Conclusion: Our national audit programme has proven effective to reduce steroid side-effects and iron deficiency anaemia in children with UC. Although over 6 years in the era of biologics there was a trend of decreasing colectomy rates, nearly half of children requiring colectomy had to be operated non-electively, indicating the importance of early recognition, optimising treatment, and collaborative gastro-surgical assessment. Oral and intravenous iron therapy was efficient and safe. More than half children with rescue therapy received anti-TNFalpha, and nearly 20% of those failed to respond and required colectomy. Subtotal colectomy was required in 13.7% of patients admitted, and complications occurred in one third of surgical patients with UC. Our audit highlights collaborative progress made to implement steroid reduction strategies, prevent iron deficiency anaemia, and to perform elective colectomy in specialised centres.

### 70. Audit of referral to Leicester Children's Hospital for suspected Inflammatory Bowel Disease (standard 5 of new BSPGHAN / RCPCH quality standards<sup>1</sup>

**Authors** Willmott A.
**Source** Journal of Pediatric Gastroenterology and Nutrition; Apr 2018; vol. 66 ; p. 609
**Publication Date** Apr 2018
**Publication Type(s)** Conference Abstract
**Database** EMBASE
Available at Journal of Pediatric Gastroenterology and Nutrition 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 and Study: In January 2017 the new BSPGHAN / RCPCH quality standards were published for paediatric gastroenterology, hepatology and nutrition. The first step to implementation is to audit current practice. We present an audit of Standard 5 "Children with suspected inflammatory bowel disease are seen by a specialist service within four weeks in an age appropriate facility by a multi-disciplinary team" The aim of the audit was to see how we performed during 2016-2017 compared to this standard of care, in order to see what changes we may need to make to improve. Methods: We used our IBD database to identify children diagnosed with IBD over 2016 and 2017. We used the HISS system to note the date the original referral was received, the date they were seen either as an inpatient or in outpatients Information about all suspected cases is not easy to obtain, so a decision was made to start with those cases we confirmed with IBD in 2016 and 2017 (up to November, December data to follow) to see how we performed with these cases in the first instance. We aimed to look at the cases where there was most delay to see how we can reduce this. Cases diagnosed in the private sector, or those with incomplete information, were excluded. Results: In Leicester Royal Infirmary, in 2016-2017:-Total patients diagnosed with IBD = 62 Incomplete information 1, diagnosed privately 4, leaving 57 patients Summary: Out of 57 patients diagnosed with IBD in 2016-2017 in NHS 72% met the new quality standard, with 91% seen within 6 weeks. 5 patients waited longer. None were felt very unwell when first seen. Conclusions: 1) In our centre we meet the suggested standard in 72% of cases, and are close to this in a further 19% 2) This was achieved by consultants doing many extra adhoc clinics. The appointment of a 4th consultant should help us to get even closer to the standard 4) The children who waited were felt not to be so unwell according to the information on the referral letter, or family cancelled appointment initially, so we will consider education to GPs and general paediatricians regarding information we would find helpful in referral letters 5) The next step would be to audit all suspected cases, but this information is not easy to obtain retrospectively.

### 71. A review of copper deficiency in paediatric patients on long-term jejunal nutrition

**Authors** Gardner T.; Spencer R.; Ross K.; Walker S.; Kishore S.
**Source** Journal of Pediatric Gastroenterology and Nutrition; Apr 2018; vol. 66 ; p. 998
**Publication Date** Apr 2018
**Publication Type(s)** Conference Abstract
**Database** EMBASE
Available at Journal of Pediatric Gastroenterology and Nutrition 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 and Study: Copper is a trace element essential for a number of vital processes within the body. It is mainly absorbed in the duodenum. Copper deficiency is a rare but potentially serious condition, manifesting as haematological derangement, sensory impairment and neuropathies. It is most commonly seen in patients who have had bariatric surgery. Patients who are jejunally-fed longterm will logically be at risk of copper deficiency due to where their nutrition enters the GI Tract, as feed is delivered beyond the site of copper absorption. Aims: 1. To review the detection and management of copper deficiency in jejunally fed patients managed at a single tertiary care centre. 2. To investigate feeding tube position as a potential contributor to copper malabsorption. 3. To close the loop on a previous audit performed in our department, which found that 40% of jejunally fed patients were copper deficient. Methods: Case notes of all patients on long-term jejunal nutrition were reviewed. Type of Jejunal feeding was noted. Results from trace element screens were recorded and imaging was checked by specialist radiologists to assess tube position. These results were then correlated with serum copper levels, to look for any links to low copper and an inadequately positioned tube. Results: 22 patients were included in this study, (14 Males, 8 Females, mean age 8 years (range 1-21 years)). 7 of these patients had a Roux-en-Y Jejunostomy, 12 had a PEGJ, 2 had a GJ Button, and 1 had an NJ tube. Nearly half of the patients were suffering from Cerebral Palsy. 2 patients had never had copper levels checked. There was no relationship between type of feed, its copper content, and serum copper levels. 3 of these patients (13.6%) had been diagnosed with a low serum copper level, down from 40% in our previous audit. 1 patient had a low serum copper and was receiving copper sulphate solution as treatment. 1 patient had previously low copper levels with normalisation on recent testing, but remained on treatment. The third patient was on a lower than standard maintenance dose for previous low copper that had subsequently normalised. As an additional point, 4 patients also had low zinc picked up on their micronutrient screen, one of whom was documented as being prescribed supplements. Tube position was generally found to be good; we did notice that a poorly positioned tube of any type, or a tube requiring regular adjustment/change resulted in poorer micronutrient absorption. Assessment of neurological complications from copper deficiency was difficult given the co-morbidities of this patient cohort. No obvious haematological derangement was observed. Conclusion: The number of enterally-fed patients is increasing in the UK, both in the adult and paediatric populations. Micronutrient management is becoming an increasingly recognised part of care. Copper deficiency is under-recognised in children on jejunal nutrition. When detected, treatment was established and successful. Work must be done in implementing guidance on the screening of micronutrient deficiencies as a whole, however there are obvious practicality issues with achieving this in such a population.

### 72. Surgical consent practice in the UK following the Montgomery ruling: A national cross-sectional questionnaire study

| | |
|---|---|
| **Authors** | McKinnon C.; Finn R.; Jeyaretna D.S.; Williams A.P.; Loughran D.; Coxwell-Matthewman M. |
| **Source** | International Journal of Surgery; Jul 2018; vol. 55 ; p. 66-72 |
| **Publication Date** | Jul 2018 |
| **Publication Type(s)** | Article |
| **Database** | EMBASE<br>Available at International journal of surgery (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<br>Available at International journal of surgery (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 |
| **Abstract** | Background: The Supreme Court case of Montgomery vs Lanarkshire Health Board in 2015 was a landmark case for consent practice in the UK which shifted focus from a traditional paternalistic model of consent towards a more patient-centered approach. Widely recognised as the most significant legal judgment on informed consent in the last 30 years, the case was predicted to have a major impact on the everyday practice of surgeons working in the UK National Health Service (NHS). Two years after the legal definition of informed consent was redefined, we carried out an audit of surgical consent practice across the UK to establish the impact of the Montgomery ruling on clinical practice. Materials & methods: Data was collected by distribution of an electronic questionnaire to NHS doctors working in surgical specialities with a total of 550 respondents. Results: 81% of surgical doctors were aware of the recent change in consent law, yet only 35% reported a noticeable change in the local consent process. Important barriers to modernisation included limited consent training, a lack of protected time for discussions with patients and minimal uptake of technology to aid decision-making/documentation. Conclusions: On the basis of these findings, we identify a need to develop strategies to improve the consent process across the NHS and limit the predicted rise in litigation claims.<br>Copyright © 2018 IJS Publishing Group Ltd |

### 73. Mitochondrial genetic diagnostics in Oxford: A 25-year journey of service developments and novel findings

| | |
|---|---|
| **Authors** | Fratter C.; Sergeant K.; Smith C.; Brown R.; Seller A.; Brown G.; Poulton J. |
| **Source** | Neuromuscular Disorders; Apr 2018; vol. 28 |
| **Publication Date** | Apr 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at Neuromuscular Disorders 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: Mitochondrial disorders, due to defects in cellular energy production, are phenotypically and genetically heterogeneous, and hence diagnosis is notoriously challenging. Aims: To review and audit mitochondrial genetic diagnostics in Oxford. Patients and methods: We have provided a service for 25 years, testing over 10,000 probands. The service has developed from testing a handful of common mitochondrial DNA (mtDNA) mutations in the pre-sequencing era to whole mtDNA next generation sequencing and exome sequencing. Although the field of genetic/genomic testing remains largely qualitative, development of quantitative approaches to assess mtDNA copy number and mtDNA heteroplasmy has been critical for this service. In 2007, NHS Highly Specialised Services (HSS) for rare mitochondrial disorders were established with centres in Oxford, London and Newcastle. Results and conclusions: A genetic diagnosis was made in approximately 700 of the 10,000 probands. MtDNA maintenance disorders and pyruvate dehydrogenase (PDH) deficiency are particular areas of expertise; rare and novel findings include a case of germline mosaicism for SLC25A4 associated mtDNA depletion syndrome, and several cases of mosaicism in PDHA1 associated PDH deficiency. Collaboration between the three HSS centres has been key to developing the service and enhancing knowledge. Recent examples include characterisation of RRM2B mutations as a common cause of PEO, description of RNASEH1-related mitochondrial disease, and identification of NDUFA6 as a novel disease gene associated with complex I deficiency. |

### 74. Delivering outcomes from a joint supportive care and acute oncology service

| | |
|---|---|
| **Authors** | La Mola L.; Berman R.; Clare H.; Campbell G.; Cooksley T.; Hacker L. |
| **Source** | Supportive Care in Cancer; 2018; vol. 26 (no. 2) |
| **Publication Date** | 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at Supportive care in cancer : official journal of the Multinational Association of Supportive Care in Cancer 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 Supportive care in cancer : official journal of the Multinational Association of Supportive Care in 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** | Introduction Enhanced supportive care (ESC) has transformed existing palliative care services in cancer centres. Joint working with oncologists, rebranding of palliative care and provision of a rapid access clinic delivered jointly by palliative care and acute oncology have all proved beneficial in preventing crises leading to admission, ultimately improving patient satisfaction whilst delivering cost savings. Objectives Initially our aims were to remove barriers to palliative care, provide patients with the right information to allow them to make the most appropriate decisions about their treatment and enhance communication between primary and secondary care. Methods We rebranded "palliative care" to "supportive care". Supportive care services were embedded within 3 oncology disease groups to enhance practice of all team members and provide specialist support for patients developing problems at a much earlier stage. Audit and collection of patient and oncologist feedback was conducted throughout. Phase 2 widened the scope of the service. We developed a "rapid access clinic" in collaboration with acute oncology to better address the problems faced by any cancer patient or cancer survivor without delay. Results Phase 1 demonstrated almost 600 avoided admissions over a three year period, reducing emergency admissions by more than 20%. A 6 month pilot of Phase 2 demonstrated 49 prevented admissions, 59 patients discharged early from hospital, and 101 patients with enhanced symptom control. NHS England adopted this initiative and phase 1 is currently being rolled out as a CQUIN in 23 cancer centres nationwide. Conclusions Enhanced supportive care can positively impact on emergency admissions and patient outcomes. |

### 75. Reducing unplanned hospital admissions in patients with neuromuscular diseases: An NHS re-audit

| | |
|---|---|
| **Authors** | Scalco R.S.; Nastasi L.; Hanna M.G.; Quinlivan R. |
| **Source** | Neuromuscular Disorders; Apr 2018; vol. 28 |
| **Publication Date** | Apr 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at Neuromuscular Disorders 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: Patients with neuromuscular diseases (NMDs) require long-term multi-disciplinary care. Access to specialised NMD services is still variable across the UK. In 2012, an audit showed a high frequency of emergency admissions in this patient population, which were more likely to happen if care was poorly coordinated and not proactive in preventing NMDs complications. The audit was followed by several recommendations and a partnership approach project. Aims: To assess the impact of the previous audit Methods:A re-audit was undertaken across the same specialised commissioning groups in Central and South-East England. Results: More patients were known to specialised centres in NMDs, and the majority of admissions were under the care of Neurosciences (77%) as compared to 2012 when only 14.9% were admitted under Neuroscience. Improvements included a reduction in preventable admissions directly related to known NMDs (from 63% to 32.8%) and reduction in re-admissions (from 25.1% to 12.4%). The mortality rate dropped from 4.5% to 0.3%. Patients known to a NMD specialised service had shorter hospital stay and fewer ITU admissions than patients who were not known to specialised services. Conclusion: The re-audit on unplanned hospital admissions in England highlighted the importance of co-ordination of care at specialised services for patients with neuromuscular disorders. It successfully documented improvements in the care provided to patients with NMDs in the assessed regions. |

### 76. Auditofhomeparenteral nutrition in palliative care patients

| | |
|---|---|
| **Authors** | Shaw C.; Eldridge L.; Droney J.; Halley A. |
| **Source** | Supportive Care in Cancer; 2018; vol. 26 (no. 2) |
| **Publication Date** | 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at Supportive care in cancer : official journal of the Multinational Association of Supportive Care in Cancer 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).<br>Available at Supportive care in cancer : official journal of the Multinational Association of Supportive Care in 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** | Introduction The provision of parenteral nutrition in palliative care is controversial in the United Kingdom. Home Parenteral Nutrition (HPN) is not recommended for patients with incurable disease and a short life-expectancy. HPN may be considered for patients with malignant obstruction, a prognosis of more than 3 months and a WHO performance status of less than 2. Objectives To determine whether the provision of home parenteral nutrition for palliative patients at a tertiary cancer centre in the UK was in accordance with European guidance (Bozzetti et al, 2009). Methods A retrospective audit of patient records was undertaken at a tertiary cancer treatment centre. Results Between June 2012 and May 2017, 34 patients were considered for home parenteral nutrition with 22 patients being discharged on HPN. The average age was 56.5 years with range 31-84 years with the majority of patients either having gastrointestinal (45%) or gynaecological (40%) cancers. PN was used appropriately in patients who were unable to eat (100%) and in median survival time of longer than 2 - 3 months (median survival 121 days). However, the standard was not met in terms of documentation of prognosis with 27% recorded and performance status with 45% having this documented in the electronic patient records. Conclusions The provision of home parenteral nutrition is complex, requires specialist management and appropriate patient selection. Recommendations have been made following the audit regarding patient selection, documentation of prognosis and performance status and improvements to methods of communication with the patient and specialist services. |

### 77. A retrospective audit, using a holistic needs questionnaire, to identify the unmet needs of uveal melanoma survivors that are undergoing regular liver surveillance

| | |
|---|---|
| **Authors** | Upton J. |
| **Source** | Supportive Care in Cancer; 2018; vol. 26 (no. 2) |
| **Publication Date** | 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at Supportive care in cancer : official journal of the Multinational Association of Supportive Care in Cancer 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).<br>Available at Supportive care in cancer : official journal of the Multinational Association of Supportive Care in 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** | Introduction In the UK there are around 500 new cases of uveal melanoma diagnosed each year. Around 30%of these cases will die of distantmetastases before 5 years after diagnosis and around 45%at 15 years after diagnosis. Unlike cutaneous melanoma, approximately 90%of distant metastases fromUM occur in the liver. National guidance recommends life-long liver surveillance to enable early detection of metastases. Research studying anxiety for patients enrolled in cancer screening programmes is variable, however, all studies concur that anxiety is a common problem observed in patients undergoing surveillance for cancers. This presentation reports the findings of an audit that has studied the unmet needs of cancer survivors who are undergoing regular liver surveillance having previously been diagnosed with uveal melanoma. Objectives * Identify patterns between unmet needs and time points within the patient's surveillance journey * Identify statistically significant trends in the unmet needs of the patients Methods Using the National Cancer Survivorship Initiative Holistic Needs Assessment questionnaire (2012), a retrospective audit of 119 uveal melanoma survivors undergoing regular liver surveillance was conducted. Results Unmet needs were identified in 43% of patients, with 52% of patients reporting emotional concerns. An average of 41% reported physical concerns throughout the trajectory. Baseline visits showed higher levels of unmet physical and emotional needs with the level of concern reported as higher. Conclusions In most of the categories concerns and unmet need improved with the elapse of time, however, some physical symptoms presented later and could be late effects of primary treatment or reflect an ageing population. |

### 78. Clinical relevance of regular blood monitoring in long-term immunoglobulin treatment

| | |
|---|---|
| **Authors** | Compton L.; Kapoor M.; Nihoyannopoulos L.; Rossor A.; Manji H.; Reilly M.M.; Lunn M.P.; Carr A.S.; Groves J.; Cade R.; Morrow S.; Gosal D.; Lavin T. |
| **Source** | Neuromuscular Disorders; Apr 2018; vol. 28 |
| **Publication Date** | Apr 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at Neuromuscular Disorders 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: National guidelines for the use of immunoglobulin (Ig) in immunomodulatory therapy advise routine monitoring of FBC and U&E and pretreatment screening for IgA deficiency. However, autoimmune haematological complications are typically subclinical. Acute kidney injury (AKI) is no longer a risk since the replacement of sucrose as Ig-stabilising agent. And absolute IgA deficiency may complicate immunoreplacement therapy but is irrelevant in the inflammatory neuromuscular disease population. Aims: We audited guideline compliance to IgA pre-treatment and regular FBC, U&E monitoring in inflammatory neuropathy patients on long-term IVIg treatment in two UK Neurology departments with specialist peripheral nerve services (Manchester and London). We examined the data for evidence of clinically relevant IgA deficiency, haematological or AKI Ig-related events. Methods: Data was collected by database and retrospective case note review on all treatment episodes from Jan 2015 and Dec 2017. Patients were identified at random over a 2-month study period in both institutions. Accepted definitions for clinically significant and biochemically significant haemolysis, neutropenia, thrombocytopenia and AKI were used. Results: 885 treatment episodes in 58 inflammatory neuropathy patients were analysed. Mean (SD) age: 55.5 (16.3) years; 68% male; 86% CIDP (14% MMN); 94% IVIg (6% SCIg). Mean dose: 1.46 (0.56) g/kg/month or 91 (34.5) g/infusion; mean frequency: 3.6 (1.0) weeks. No clinically significant episodes of haemolysis, neutropenia, thrombocytopenia or AKI occurred in relation to Ig treatment. An asymptomatic drop >100 mg/L Hb occurred in 23/885 episodes in 22 individuals; mean reduction: 17.7 (7.4) mu g/L; lowest Hb: 99 mu g/L. One patient on weekly SCIg with Type 1 DM developed AKI after Igunrelated DKA. Renal function remained stable (Cr: 200-300) on weekly SCIg over 1 year. One individual with relative IgA deficiency (0.38 g/L) received 16 infusions over 1.5 years without complication. Conclusions: Regular monitoring of FBC and U&E in inflammatory neuropathy patients therapy identified subclinical haemolysis in 2.5% of infusions but no clinically significant events in this representative population. This analysis suggests current monitoring recommendations are superfluous to safety requirements. We suggest pre-treatment FBC, U&E and HBV followed by clinically indicated retesting only. |

### 79. Towards reliably good sustainable care, teaching and research in care homes: A paradigm shift

| | |
|---|---|
| **Authors** | Hockley J.; Murray S.A. |
| **Source** | Palliative Medicine; May 2018; vol. 32 (no. 1); p. 57 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at Palliative medicine from EBSCOhost EJS<br>Available at Palliative 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).<br>Available at Palliative 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** | Nursing care homes are now viewed as the hospices of yesterday. In the UK, 22% population die in care homes (four times the number dying in hospices); a figure projected to rise to 40% by 2040. The public and professional perception of care homes remains poor. Quality improvement palliative care 'in-reach' programmes to care homes are often short term with no long-term solution. At a time of unprecedented increase in people 80+ years requiring 24-hour care and fears of a lack of an appropriate workforce there is a need for re-visioning such care. Aim: To scope the feasibility for a teaching/research-based care home (TRCH) as a centre for excellence and community engagement to support and empower all care homes across a region. Methods: Three stages included: a review of the international literature on TRCHs; a visioning afternoon with local stakeholders (health/social care, universities, care home organisations, third party organisations); interviews with residents/families and care staff/managers (14); and, face-to-face meetings with: policy/government (28); academia (16); clinical (19); hospices (12); international organisations (15). A template was used to capture important information after each meeting. Interviews were transcribed and themes developed across both interviews and faceto-face meetings. Results: Five core objectives for the TRCH were identified, namely: innovative 'household' service provision to showcase expert holistic care; knowledge and skills development to improve the competency of care home staff; undergraduate/postgraduate student training for students from different disciplines; research to increase the evidence-base for care home work; and, community engagement encouraging intergenerational volunteerism. Targeted face-to-face meetings not only provided important insights from different organisations but also offered names of further people to speak to until saturation was reached. Discussion is underway for the provision of a site for the Centre. Meanwhile a variety of student placement work will commence in 'satellite' nursing care homes across the region. Conclusion: Undertaking a yearlong feasibility study embracing all stakeholders has galvanised support (including health/social care) in this important area. Just as hospices brought a sea-change to the end-of-life care needs for cancer patients, it is hoped that the TRCH will bring a seachange to the professional and public perception of care homes. |

### 80. Using normalisation process theory (NPT) to inform an implementation toolkit for a carer-centred process of assessment and support within palliative care

| | |
|---|---|
| **Authors** | Diffin J.; Grande G.; Ewing G. |
| **Source** | Palliative Medicine; May 2018; vol. 32 (no. 1); p. 116-117 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at Palliative medicine from EBSCOhost EJS<br>Available at Palliative 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).<br>Available at Palliative 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** | Introduction: The Carer Support Needs Assessment Tool (CSNAT) intervention is a carer-centred process of assessment and support for use in palliative care. Face-to-face training to assist palliative services to implement the intervention is being replaced with an internationally accessible online implementation toolkit, prompting revision of content. Aim: To study implementation of the CSNAT intervention through the lens of NPT to produce pragmatic lessons for an implementation toolkit. Methods: Qualitative: 38 practitioners (intervention champions) in 32 UK palliative care services interviewed three-and six-month post-CSNAT implementation. Focus groups with staff in three services six months postimplementation. The four core constructs of NPT (Coherence, Cognitive Participation, Collective Action, Reflexive Monitoring) were used as an analysis framework. Results: NPT constructs were valuable for extracting main learning points from palliative practice implementation: "Coherence" (how individuals make sense of a new practice): support needed to (i) distinguish the CSNAT intervention from practitioner-led and more informal approaches; (ii) help staff plan for how they will integrate the CSNAT into their practice to ensure it is not an 'add-on'. "Cognitive Participation" (engagement work done to generate 'buy in' for a new practice): guidance needed on (i) ensuring managerial support for provision of protected time for preimplementation planning and on-going audit and review; (ii) developing/refining a carer strategy to provide clear rationale for implementation of the CSNAT intervention; (iii) collecting and sharing positive examples of when the intervention produced meaningful outcomes. "Collective Action" (work done to put the intervention into practice): support needed to (i) adapt the use of the intervention to meet the nature of the service; (ii) develop staff confidence and help them to make their first assessment. "Reflexive monitoring" (work of appraising a new set of practices): advice needed on (i) managing expectations around the length of time needed for implementation planning; (ii) goal setting, monitoring progress, and planning for audit and evaluation. Conclusions: These findings have direct implications for practice and will assist palliative services (nationally and internationally) to implement and sustain carer-centred assessment and support for family carers. |

### 81. How continuous are our continuous subcutaneous syringe driver infusions?

| | |
|---|---|
| **Authors** | Brosnan A.; Coleman O.; Wilcox E.; Ambrose R. |
| **Source** | Palliative Medicine; May 2018; vol. 32 (no. 1); p. 224 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at Palliative medicine from EBSCOhost EJS<br>Available at Palliative 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).<br>Available at Palliative 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: The purpose of the quality improvement initiative was to measure delays in the administration of the T34 ambulatory continuous syringe driver infusion pump (CSCI) and improve the standard of care provided to patients in the Specialist Palliative Care Unit (SPC).(NHS Scottish Guidelines 2011). Methods: An assessment tool was completed by the Registered General Nurses(RGNs) in the SPC Unit over a two week period .A total of thirty CSCI pumps were assessed at the allocated administration time. The main objective of the tool was to identify if there was a delay in administration of the CSCI pump and length of time of same. The tool also reviewed the rationale for the delay. The tool explored if the prescription was unavailable, patient or staff were unavailable or any other reason noted.Data was analysed by the Clinical Nurse Manager of the SPC Unit. Results: Our tool noted a compliance of 83.33% with international best practice(NHS Scottish Guidelines 2011).16.66% of the CSCI pumps were delayed in administration. 10%of these were delayed between 0-30 minutes.The remainding 6.66% were delayed between 1-2hrs. The rationale for the delays of 6.66% of CSCI pumps between 1-2 hours in administration was that the prescriptions were unavailable as the Multidisciplinary Team (MDT)Meetings were ongoing. 10% of the CSCI pumps were delayed because RGNs were unavailable as they were attending to patients physical and symptom management in the SPC Unit. Conclusion: Compliance of 100 % is achievable if the SPC unit implements the following Plan-Do-Study-Act quality improvement initiative and remeasures the assessment tool in six months (Adapted from Deming 1982 :Langley et al. 2009). Plan: All key stakeholders of the initiative plan to gather and review the results of the assessment tool.(Stakeholders refers to team members in pharmacy, medical, supportive care workers). Do: All key stakeholders should be informed of the quality improvement initiative in order for overall success and prioritisation of same is essential. If MDT meetings are anticipated to be lengthy in duration then prescription of the CSCI should be prioritized.Support workers to attend to patients physical needs at administration times of CSCI. Study: Review current literature on delays in CSCI pumps. Act: Remeasure the quality improvement initiative in six months.

### 82. The sustainability of in-reach end-of-life care programmes into care homes

**Authors** Kinley J.; Hockley J.
**Source** Palliative Medicine; May 2018; vol. 32 (no. 1); p. 66
**Publication Date** May 2018
**Publication Type(s)** Conference Abstract
**Database** EMBASE
Available at Palliative medicine from EBSCOhost EJS
Available at Palliative 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 Palliative 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**

Background: Frail older people are now admitted to European care homes (CHs) with a mean life expectancy of about 18 months. In the UK, nursing care homes (NCHs) are being seen as the hospices of yesterday. Undertaking and sustaining quality improvement in relation to end-oflife care (EoLC) in CHs is difficult because of the relatively 'low' context (lack of multi-disciplinary team and organisational learning) and high staff turnover. Previously, we have reported on 4 sequential research studies that followed the MRC complex intervention outline (development, feasibility, and evaluation of a cluster RCT). The studies highlighted the importance of 'high facilitation' when implementing initiatives in NCHs and the active involvement of their managers. We now present the MRC fourth category: implementation. Aims: To evaluate the dissemination, surveillance and monitoring of a sustainability initiative in NCHs completing the Gold Standards Framework programme. Methods: The sustainability initiative was set up in 2012 in 24 NCHs. It consisted of: a day on palliative care for all new staff; a four-day palliative care course for nurses/care staff; and, 'action learning' sets for managers to encourage critical thinking. Audit data was collected on: place of death, bereaved relatives' perceptions of care in the last month of life, and validated assessment tools/end-of-life care documentation. Five years on the current sustainability model is compared to the original alongside its dissemination, surveillance and monitoring. Results: Dissemination: The research-based model of practice has been extensively shared in publications/presentations and helped to shape further European research. Surveillance and monitoring: Subsequent research highlighted the requirement to provide multi-layered learning to: targeted individuals, organisations, and in appreciative learning systems. We have learnt that, whilst CHs require different programmes, 'high' facilitation alongside supporting the CH managers results in a cost-effective model that sustains the delivery of high quality EoLC in this setting. Conclusion: A structured sustainability initiative created at the outset of a quality improvement initiative is likely to mean the culture of the care home will change. Whilst not without cost, sustainability can be cost effective. The increasing use of technology supporting staff training within their work place facilitates staff becoming part of a wider appreciative learning system.

### 83. The barriers and facilitators to implementing the carer support needs assessment tool (CSNAT) in a community palliative care setting

| | |
|---|---|
| **Authors** | Horseman Z.; Finucane A.; Milton L. |
| **Source** | Palliative Medicine; May 2018; vol. 32 (no. 1); p. 61-62 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at Palliative medicine from EBSCOhost EJS<br>Available at Palliative 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).<br>Available at Palliative 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** | Introduction: Family carers play a central role in community-based palliative care. However, caring for a terminally ill person puts the carer at increased risk of physical and mental morbidity, which is detrimental for both carer and patient (Williams & McCorkle, 2011). The validated Carer Support Needs Assessment Tool (CSNAT) provides a comprehensive measure of carer support needs and is intended for use in community palliative care (Ewing & Grande, 2013). The CSNAT creates an opportunity for carers to discuss their needs with healthcare professionals, facilitating the provision of appropriate support. A recent audit demonstrated poor use of the CSNAT in a Scottish community specialist palliative care service despite training and support. Aim: To identify barriers and facilitators to implementation of the CSNAT in a community specialist palliative care service. Methods: A qualitative study was undertaken, involving interviews with 12 palliative care nurse specialists from two community nursing teams in Lothian, Scotland. Data was audio-recorded, transcribed and thematically analysed using a framework approach. Results: This study found palliative care nurse specialists to be passionate and enthusiastic about carer support practices. It revealed an overarching acceptance and appreciation of the CSNAT by nurses. However, it demonstrated that nurses feel there is potential for the CSNAT to be used more effectively in this setting. The study identifies factors which enable and prevent the use of the CSNAT in a community palliative care setting. Recommendations are made for improving the use, acceptability and uptake of the CSNAT in practice. Conclusion: Findings from this study have the potential to enhance engagement with the CSNAT, make it more congruent with current nursing practice, and improve the experience of carers of people approaching the end-of-life. |

### 84. New Zealand Patient safety perspective

| | |
|---|---|
| **Authors** | Bensemann C.; Tapsell R. |
| **Source** | Australian and New Zealand Journal of Psychiatry; Apr 2018; vol. 52 (no. 1); p. 25 |
| **Publication Date** | Apr 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at Australian & 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: The Health Quality Safety Commission (the Commission) is leading a 5-year national program to improve quality and safety in the mental health and addictions services. Objectives: * Implement a national program of quality improvement using proven improvement methodology. * Build improvement science capability in the sector. * Engage sector leadership in quality improvement and building a quality and safety culture. Methods: * In 2016, two national sector-wide workshops defined five priority domains. In 2017, four regional workshops followed to develop these domains. * A national consultation with M nat was led by the Commission Cultural Adviser/Kaumatua. * A sector leadership group was established and a work plan developed. * A training program for quality improvement facilitators from across the sector was established. Findings: Five priority domains are defined: 1 Minimizing restrictive care 2 Improving medication management and prescribing 3 Improving transitions of care 4 Maximizing physical health of consumers 5 Learning from serious adverse events and consumer experience The work plan will include both national and regional 'collaboratives' that use methodology similar to the Institute for Healthcare Improvement Breakthrough Series (Collaborative) and the Scottish Patient Safety Programme (SPSP; Healthcare Improvement Scotland, 2016) with whom a partnership is established. Consumer engagement, co-design, Maori participation and equity are critical to success. The sector has engaged enthusiastically with the first national training program for improvement facilitators. conclusions: This 5-year improvement program provides the opportunity to put quality and safety at the centre of mental health and addictions service delivery. |

### 85. The organisation of critical care for burn patients in the UK: Epidemiology and comparison of mortality prediction models

| | |
|---|---|
| **Authors** | Toft-Petersen A.P.; Ferrando-Vivas P.; Harrison D.A.; Rowan K.M.; Dunn K. |
| **Source** | Anaesthesia; 2018 |

**Publication Date** 2018
**Publication Type(s)** Article In Press
**Database** EMBASE
Available at Anaesthesia from Wiley Online Library Medicine and Nursing Collection 2018 - NHS
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** In the UK, a network of specialist centres has been set up to provide critical care for burn patients. However, some burn patients are admitted to general intensive care units. Little is known about the casemix of these patients and how it compares with patients in specialist burn centres. It is not known whether burn-specific or generic risk prediction models perform better when applied to patients managed in intensive care units. We examined admissions for burns in the Case Mix Programme Database from April 2010 to March 2016. The casemix, activity and outcome in general and specialist burn intensive care units were compared and the fit of two burn-specific risk prediction models (revised Baux and Belgian Outcome in Burn Injury models) and one generic model (Intensive Care National Audit and Research Centre model) were compared. Patients in burn intensive care units had more extensive injuries compared with patients in general intensive care units (median (IQR [range]) burn surface area 16 (7-32 [0-98])% vs. 8 (1-18 [0-100])%, respectively) but in-hospital mortality was similar (22.8% vs. 19.0%, respectively). The discrimination and calibration of the generic Intensive Care National Audit and Research Centre model was superior to the revised Baux and Belgian Outcome in Burn Injury burn-specific models for patients managed on both specialist burn and general intensive care units.

### 86. Assessment of non-motor symptoms and cognitive functions in patients with isolated adult-onset cervical dystonia previously not treated with botulinum toxin: A single-centre case-controled study

**Authors** Relja M.; Miletic V.
**Source** Neurology; Apr 2018; vol. 90 (no. 15)
**Publication Date** Apr 2018
**Publication Type(s)** Conference Abstract
**Database** EMBASE
Available at Neurology 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 Neurology from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

**Abstract** Objective: To investigate non-motor symptoms (NMS) functions in patients with isolated adult-onset cervical dystonia (IAOCD)previously not treated with botulinum toxin. Background: Traditionally, IAOCD is considered as a motor disorder. However, NMS are increasingly recognized as a part of IAOCD phenotype. Cognitive functions in IAOCD were rarely investigated and poorly undrstood making this issue a matter of debate. Design/Methods: We studied 51 IAOCD patinets (29 male/22 female; mean age 442.31) and 90 matched healthy controls (50 male/40 female; mean age 45.26). Severity of motor symptoms, disability, and pain were assessed with Thoronto Western Severity Torticollis Rating Scale (TWSTRS). Psychiatric assessment included: Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), Starkstein Apathy Scale (AS). Sleep quality andfatigue were determined with Pitsburg Sleep Quality Index (PSQI) and Fatigue Severity Scale (FSS). Cognitive functions were assesses using Cogtest, a computerized neurocognitive battery set of 5 tests examining several cognitive domains: Auditory Number Sequencing (ANS), Spatial Working memory (SWM), Strategic Target Detection (STD), Continuous Performance Test (Flanker CPT) and Tower of London (ToL). Results: Overall, 44 (86.2%) IAOCD patients had at least one investigated psychiatric disorder in comparison to 29 (32.2%) healthy controls. Mean BDI-II score, BAI score and AS score were significantly higher in IAOCD patients R than in healthy controls (12.59+/-6.28 vs. 6.11+/-4.26, p<0.001; 13.59+/-6.78 vs. 7.76+/-4.95, p<0.001; 10.27+/-5.09 vs.7.68+/-4.35, p=0.002, respectively). Mean PSQI and FSS score were higher in IAOCD patients (4.90+/-1.7 vs. 4.08+/-1.44, p=0.003; 4.17+/-1.2 vs. 3.50+/-0.95; p<0,001, respectively). There were no differences between IAOCD patients and controls in determined variables of ANS and SWM tests (p>0.05). However, IAOCD patients had worse performance in STD, ToL, and Flanker CPT test (p<0.05). Conclusions: Spectrum of IAOCD symptoms includes psychiatric comorbidities, impaired sleep quality, pathological fatigue, and cognitive dysfunction, especially in the domains of attention and executive functioning, thus implicating shared neurobiology of motor and NMS.

### 87. Presence of NMDA-r antibodies in schizophrenia

**Authors** Vernino S.; Kim M.; Ivleva E.; Tamminga C.; Gershon E.; Keedy S.

| | |
|---|---|
| **Source** | Neurology; Apr 2018; vol. 90 (no. 15) |
| **Publication Date** | Apr 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at Neurology 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).<br>Available at Neurology 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: Evaluate for encephalitis autoantibodies in a group of wellcharacterized psychosis patients. Background: Autoimmune encephalitis (AE) commonly presents with psychosis. A recent study from UK identified NMDA-R antibodies in 3% of patients with first-episode of psychosis. Younger patients may be incorrectly diagnosed as schizophrenia if other features of AE are not present. Design/Methods: As part of an ongoing multicenter study on psychosis biomarkers (B-SNIP consortium) over 3,000 probands with psychotic disorders, their biological relatives, and healthy subjects have been characterized using a broad battery of brain-based biomarkers (EEG, eye tracking, cognition, neuroimaging). We utilized this resource to investigate the possibility that autoimmune encephalitis may present as schizophrenia. As a pilot study, we tested all females in the study who had plasma samples available - 68 subjects with schizophrenia or schizoaffective disorder (mean age: 43.3+/-10.4y/o; mean age at first diagnosis: 20.1+/-9.8y/o) and 36 controls (mean age: 33.3+/-10.6y/o). Plasma samples were coded to ensure blinding and tested (at 1:10 screening dilution) for a panel of encephalitis antibodies (NMDAR, LGI1, CASPR2, AMPAR, GABABR, DPPX) using cellbased assay. Positive results were confirmed by an independent reference laboratory using live cell NMDA-R assay. Results: Three African American subjects (2 schizophrenia, 1 control) were found to have NMDA-R antibodies. No other encephalitis antibodies were found in these samples. One 38y/o patient had sudden onset auditory hallucinations at age 19 which have persisted for 20 years. She denied other thought disorder but was unable to work. The other patient was 28y/o with sudden onset auditory hallucinations at around age 21 along with visual and tactile hallucinations and delusions of control and thought broadcasting. The control subject was a healthy 43y/o. Conclusions: NMDA-R antibodies are found in a small number of patients with psychosis who otherwise meet the criteria for diagnosis of schizophrenia. |

### 88. Psychology: A truth in neglect in neuromuscular clinics. A metaanalysis of mood disorders in myasthenia gravis clinics

| | |
|---|---|
| **Authors** | Bandyopadhyay S.; Altiero A. |
| **Source** | Neurology; Apr 2018; vol. 90 (no. 15) |
| **Publication Date** | Apr 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at Neurology 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).<br>Available at Neurology 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 study the relatively leftout psychological aspects of Myasthenia gravis. Background: The usual approach of neuromuscular neurologists treating patients with Myasthenia is dominated by the spree of looking for somatic aspects of the disease only, with psychological aspects heaping up in the blind spots. Psychological factors such as depression, anxiety, or stress can trigger myasthenia, influence under-diagnosis or overdiagnosis by causing physical fatigue, or influence the overall quality of life. Available data in this field is scattered, by no means ample, or satisfying. Scattered annual reports of quality improvement projects from reputable institutions have reported unexpected high prevalence of mood disorders in Myasthenia. Design/Methods: A meta-analysis of Pub med and Ovid articles published in original or translated English between 1980 and 2016 from five continents sourcing from Australia, Brazil, China, England, Germany, Japan, Serbia, and USA, was done. Results: Over 2600 patients were studied, highest being from Europe, especially Germany. Important revelations were: mood disorders, present in about a third of the patients, were higher in the late-onset disease forms. Emotional stress was a trigger of myasthenia aggravation especially with older age of onset, lower educational level, more severe and longer duration disease. Depression was a powerful quality of life affecting factor second only to decreased mobility, influenced by the doses of oral corticosteroid. Plasma exchange treatment failed to improve mood in spite of uplifted muscle power and ambulation, suggesting that mood disorders were not solely due to decreased somatic abilities. Conclusions: This study, involving five continents for 35 years, indicate the unappreciated high prevalence of mood disorders in neuromuscular clinics addressing Myasthenia. Very few clinics, even among the respected ones, use available tools to detect unsolicited mood disorders. Such determination, followed by outcome measures may justify the necessity of changing the paradigm, presently in practice countrywide.. |

### 89. Intravenous lidociane infusion for patients with chronic pain conditions. How are we doing?

| | |
|---|---|
| **Authors** | Al-Shather H.; Nash P.; Khatibi S. |
| **Source** | Pain Practice; Apr 2018; vol. 18 ; p. 53 |
| **Publication Date** | Apr 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at Pain 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: Intravenous Lidocaine Infusion Protocol (ILIP) for Chronic Pain Conditions in Royal Berkshire NHS Foundation Trust was introduced in 2008. This protocol was set to provide a safe environment as well as ensuring that patients always receive best possible care at the right time. Objectives: In this audit, we aimed to measure the compliance with the ILIP and to deter-mine the clinical outcome of ILIP in Chronic Pain Conditions that are not re-sponding to conventional treatments. Methods: After departmental and Hospital approval, we undertook a retrospective analy-sis of 100 patients who underwent two or more intravenous Lidocaine infusion between March and November 2017. We looked at the patients' demographics, indication of Lidocaine infusion, dose of Lidocaine, duration of procedure, pos-sible side effects and complications after intravenous Lidocaine. Post-procedure outcomes including patients' experience and overall value of care were also col-lected. Results: The average patient age was 48 years. 87% of patients were females and 13% were males. Noninvasive monitoring (ECG, BP, SPO2 and Temperature) was performed in 100% of cases. Lidocaine (2%) was used in all patients, with an average dose of 4.8 mg/kg. The average length of procedure was 68.5 minutes. During the procedure, intravenous Plasma-Lyte 148 (pH 7.4) solution was used in all cases. The majority of patients had Fibromyalgia or Widespread Pain (81/100). 100% of infusions were performed by Consultant Pain Specialist and fully trained Specialist Nurses supervised all procedures. 82% of patients had no complication or side effect. The most common side effects were generalised numbness and tingling sensation (12%). There was no significant side effect or complication documented during or after the infusion. Conclusions: Most of intravenous Lidocaine infusion protocol elements for chronic pain con-ditions were being followed appropriately. Our audit demonstrated that adher-ence to ILIP for a chronic pain condition was associated with significant satisfac-tion among patients and staff with minimal side effects. |

### 90. An audit of the volunteer unrelated donor search process in support of allogeneic HSCT over a 5 year period

| | |
|---|---|
| **Authors** | Sage D.A.; Hemmatpour S.; Richardson D.; Orchard K. |
| **Source** | HLA; May 2018; vol. 91 (no. 5); p. 405-406 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Conference Abstract |
| **Database** | EMBASE<br>Available at HLA from Wiley Online Library Medicine and Nursing Collection 2018 - NHS |
| **Abstract** | An audit of the unrelated donor search process in support of allogeneic HSCT performed over 5 years (2012-2016) was undertaken at the Wessex Blood and Marrow Transplant Unit, England. The transplant unit's policy requires CMV matching and ABO compatibility where possible. A total of 226 transplants were performed, of which 123 (54%) used a UK donor. There was an increase in the use of UK donors across the audit period, from 40% in 2012, to a peak of 62% in 2015. Of the international donors used, 66 (29%) were from the German Registry, 19 (9%) from the NMDP and 18 (8%) from other international registries. The number of verification typing samples tested per patient decreased across the audit period from 4.2 in 2012 to 3.4 in 2015 and 2016. One hundred and sixty (71%) transplants were undertaken using a 10/10 HLA matched donor (matching at high resolution for HLA-A, -B, -C, -DRB1 and -DQB1), whilst 64 (28%) transplants used a 9/10 HLA matched donor. CMV matching was achieved for 205 (91%) transplants and 198 (88%) were undertaken using a blood group matched or compatible donor. We looked at the time taken to identify the final donor for transplant, i.e. the time between initiation of search and receipt of verification typing sample from the donor selected for transplant. In 2012, the time taken had a median of 31 days (range 8-86) days. This figure had improved to 14 days (range 4-60 days) during 2016, the last year of the audit period. During the final two years of the audit (2015 and 2016), the search process involved identifying an alternative donor for transplant in 21/104 (20%) cases due to the final donor selected for transplant subsequently not being available for donation. This occurred due to a variety of reasons including donor withdrawal, failing medical or deferral due to medical reasons. These audit data reflect the strategy of utilizing UK donors where possible and improvements in HLA data on the UK registry. |

### 91. Good Practice in Radiography: Dos and Don'ts

| | |
|---|---|
| **Authors** | Eaton K.; Toy A. |
| **Source** | Primary dental journal; Mar 2018; vol. 7 (no. 1); p. 38-43 |
| **Publication Date** | Mar 2018 |
| **Publication Type(s)** | Article |
| **PubMedID** | 29609669 |

| | |
|---|---|
| **Database** | EMBASE<br>Available at Primary dental journal from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection |

### 92. Postdischarge Unscheduled Care Burden After Lower Limb Arthroplasty

| | |
|---|---|
| **Authors** | Tucker A.; Hill J.C.; O'Brien S.; Walls A.; Leckey B.; Beverland D.E.; Phair G.; Bennett D.B. |
| **Source** | Journal of Arthroplasty; 2018 |
| **Publication Date** | 2018 |
| **Publication Type(s)** | Article In Press |
| **Database** | EMBASE<br>Available at The Journal of Arthroplasty 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).<br>Available at The Journal of Arthroplasty 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: In contrast to postdischarge arthroplasty readmission rates, the unscheduled reattendance burden to primary care is under-reported. Understanding reasons for reattendance would allow for implementation of strategies to reduce this burden. The present study aims to quantify the out-of-hours (OOH) general practitioner and emergency department (ED) service reattendance burden and readmission rate after primary total hip arthroplasty and total knee arthroplasty, with estimation of the associated costs. Methods: This is a prospective consecutive cohort study. A prospective audit of all total hip arthroplasty and total knee arthroplasty patients in 2016 in a single high-volume UK arthroplasty unit was performed. Incidence and reasons for reattendance to OOH and ED service, as well as readmission rates, at both 30 and 90 days following discharge are reported. A multivariate analysis was performed to determine patient characteristics, which results in increased reattendance and readmission rates. Results: A total of 2351 procedures resulted in 374 attendances of OOH service and 665 to ED with a total estimated cost of 190,000 within 90 days. The readmission rate was 6.8%. Risk factors for reattendance and readmission were increasing age and a prolonged length of stay. The use of a 5-day postdischarge phone call and a dedicated Arthroplasty Care Practitioner favors reduced reattendances but not the readmission rate, with the additional benefit of being cost-effective. Conclusion: The postdischarge arthroplasty reattendance burden is associated with significant costs, and strategies to reduce this should be developed. Further research is required to assess the effectiveness and cost-effectiveness of multicomponent strategies to reduce reattendance operating at scale.<br>Copyright © 2018 Elsevier Inc. |

### 93. Does length of time spent on the waiting list for TURP influence the outcome?

| | |
|---|---|
| **Authors** | Parsons S.R.; Carey M.M.; Jenkins J.E.T.; Davenport K. |
| **Source** | Journal of Clinical Urology; May 2018; vol. 11 (no. 3); p. 184-191 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Article |
| **Database** | EMBASE<br>Available at Journal of Clinical Urology from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free). |
| **Abstract** | With an ever increasing demand for operative procedures within the NHS but little increase in capacity, waiting lists are lengthening, particularly for benign procedures. We sought to determine whether increasing time on a waiting list influences the outcome from a transurethral resection of prostate (TURP), with a primary outcome measure of success at inpatient trial without catheter (TWOC) and pre-operative, peri-operative and post-operative secondary outcome measures. Data was collected from four separate retrospective TURP audits performed between 2009-2015. A total of 379 TURP procedures were included with the time on the waiting list ranging from 8 to 384 days. In patients who were not catheterised pre-operatively success at in patient TWOC by 30 day intervals (in 30 day intervals from 1-30 days to over 151 days) was 79%, 83%, 88%, 87%, 100% and 83%; in those with a catheter, success was 46%, 71%, 75%, 100%, 50% and 86%. In conclusion waiting longer for a TURP does not adversely affect the outcome of inpatient TWOC. Level of evidence: Not applicable - this is a single centre audit over multiple time points.<br>Copyright © 2018, © British Association of Urological Surgeons 2018. |

### 94. Comparison of European guidelines on paediatric urology against current British best practice

| | |
|---|---|
| **Authors** | Gill N.W.; Jones P. |
| **Source** | Journal of Clinical Urology; May 2018; vol. 11 (no. 3); p. 215-219 |
| **Publication Date** | May 2018 |
| **Publication Type(s)** | Article |
| **Database** | EMBASE |

Available at Journal of Clinical Urology from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).

**Abstract** A comparison of European Association of Urology paediatric urology guidelines with British guidelines and best practice. Level of evidence: Not applicable for this multicentre audit.
Copyright © 2017, © British Association of Urological Surgeons 2017.

### 95. Prostate cancer diagnostics: A review of practice across the northwest of England

**Authors** Broome J.D.; Oates J.
**Source** Journal of Clinical Urology; May 2018; vol. 11 (no. 3); p. 220-225
**Publication Date** May 2018
**Publication Type(s)** Review
**Database** EMBASE

Available at Journal of Clinical Urology from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).

**Abstract** Introduction: The aim of this regional audit was to gain an understanding of the different approaches to prostate cancer diagnosis across the northwest of England. This often complicated area of urological practice has undergone many changes in recent years and this audit will attempt to evaluate the degree of diversity in diagnostic pathway across one region. Methods: Electronic questionnaires were distributed to consultant urologists across the northwest. Over a 2-week data collection period 48 responses were received from 19 urology units. Responses were grouped by centre to evaluate practice per urology unit. Results: Written consent was taken for transrectal ultrasound and biopsy in 54% of centres. All centres used a prophylactic antibiotic regime that included ciprofloxacin; however, the duration varied across the region. Units used a 3-day course, 1-day course and single dose at the time of biopsy in 69%, 5% and 21%, respectively. Rectal swabs to detect fluoroquinolone-resistant organisms were not used in 15 of 19 units (79%). Magnetic resonance imaging was not used before the first biopsy in 42% of units. Twenty-one per cent used this study on all men undergoing a first biopsy, while 37% of centres used a more targeted approach. All centres routinely sampled 12 cores during TRUS and biopsy. The majority (74%) sent cores for histology in two containers by side (left/right). The remaining sent two samples from each geographical area in one container. For repeat biopsy indications 42% of units reported they would proceed straight to transrectal ultrasound and biopsy. The remaining 58% utilised another modality such as multiparametric magnetic resonance imaging or transperineal template biopsy in the first instance. Conclusion: This audit has highlighted a wide variation in practice within one UK region. Although there have been measurable advances in prostate cancer management, more standardisation of diagnostic pathways may facilitate data collection and reduce variation in outcomes. Level of evidence: Not applicable in this multicentre audit.
Copyright © 2017, © British Association of Urological Surgeons 2017.

### 96. Is there a solution to PONV after craniotomy?

**Authors** Tong C.; Mohan S.; Papageorgiou P.; Hell J.; Thomas B.
**Source** Journal of Neurosurgical Anesthesiology; Jan 2018; vol. 30 (no. 1); p. 97
**Publication Date** Jan 2018
**Publication Type(s)** Conference Abstract
**Database** EMBASE

Available at Journal of Neurosurgical Anesthesiology 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 Neurosurgical Anesthesiology 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: Postoperative nausea and vomiting (PONV) occurs frequently after craniotomy; a recent UK audit found an incidence of 28% at 48 hours. We audited PONV to determine the rate and any specific risk factors in our center. Methods: We audited 54 patients over a 10-month period. A questionnaire was completed by the anesthetist and patients were followed-up by the authors up to 48 hours. We recorded patient demographics, operative approach, anesthetic type, PONV risk factors, as well as timings of PONV ranging from recovery, 4 to 8 hours, 24 hours, and 48 hours. Results: In total, 54 patients were audited (25 males: 29 females) with a mean (range) age of 56 years (26 to 85). Seven patients were lost to followup after the recovery room. Follow-up was complicated by many patients being discharged within 36 hours. All patients were anesthetised with total intravenous anaesthesia. Peak PONV rates were found at 4 to 8 hours (nausea 14/47 [30%] and vomiting 6/47 [13%]). The incidence of PONV at 24 hours was well predicted by the Apfel score (average predicted PONV 40% and average incidence of PONV 43%). The PONV rate at 48 hours was much lower (nausea 8/47 [17%] and vomiting 2/47 [4%]). There was an increased incidence of PONV with posterior fossa and pterional approaches when compared with other craniotomy incisions (Fig. 1). There was delayed and sustained nausea following a pterional incision (rates at 24 and 48 h were 40% and 33%, respectively). This correlated with an increased use of IV morphine. Patients who received magnesium intraoperatively used less opioid in the 24 to 48 hours period. Conclusions: This audit demonstrated a lower rate of PONV in our center than previously described at both 24 and 48 hours.1,2 Operative site and continued opioid use were identified as significant risk factors for PONV. We plan to introduce a PONV guideline, which includes the site of operation as a risk factor and recommends regular antiemetics for the first 48 hours after postfossa and pterional approaches. This will be reaudited thereafter. (Figure Presented).

### 97. Anaesthesia, surgery, and life-threatening allergic reactions: epidemiology and clinical features of perioperative anaphylaxis in the 6th National Audit Project (NAP6)

| | |
|---|---|
| **Authors** | Harper N.J.N.; Farmer L.; Hitchman J.; Cook T.M.; Garcez T.; Floss K.; Marinho S.; Warner A.; Ferguson K.; Egner W.; Kemp H.; Thomas M.; Lucas D.N.; Nasser S.; Karanam S.; Kong K.-L.; Farooque S.; Bellamy M.; McGuire N.; Torevell H. |
| **Source** | British Journal of Anaesthesia; 2018 |
| **Publication Date** | 2018 |
| **Publication Type(s)** | Article In Press |
| **Database** | EMBASE<br>Available at British Journal of Anaesthesia from Leicester General Hospital Library Local Print Collection [location] : Leicester General Library. [title_notes] : Issues before 2000 held in Archive.<br>Available at British Journal of 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).<br>Available at British Journal of 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** | Background: Anaphylaxis during anaesthesia is a serious complication for patients and anaesthetists. Methods: The 6th National Audit Project (NAP6) on perioperative anaphylaxis collected and reviewed 266 reports of Grades 3-5 anaphylaxis over 1 yr from all NHS hospitals in the UK. Results: The estimated incidence was =1:10 000 anaesthetics. Case exclusion because of reporting delays or incomplete data means true incidence might be =70% higher. The distribution of 199 identified culprit agents included antibiotics (94), neuromuscular blocking agents (65), chlorhexidine (18), and Patent Blue dye (9). Teicoplanin comprised 12% of antibiotic exposures, but caused 38% of antibiotic-induced anaphylaxis. Eighteen patients reacted to an antibiotic test dose. Succinylcholine-induced anaphylaxis, mainly presenting with bronchospasm, was two-fold more likely than other neuromuscular blocking agents. Atracurium-induced anaphylaxis mainly presented with hypotension. Non-depolarising neuromuscular blocking agents had similar incidences to each other. There were no reports of local anaesthetic or latex-induced anaphylaxis. The commonest presenting features were hypotension (46%), bronchospasm (18%), tachycardia (9.8%), oxygen desaturation (4.7%), bradycardia (3%), and reduced/absent capnography trace (2.3%). All patients were hypotensive during the episode. Onset was rapid for neuromuscular blocking agents and antibiotics, but delayed with chlorhexidine and Patent Blue dye. There were 10 deaths and 40 cardiac arrests. Pulseless electrical activity was the usual type of cardiac arrest, often with bradycardia. Poor outcomes were associated with increased ASA, obesity, beta blocker, and angiotensin-converting enzyme inhibitor medication. Seventy per cent of cases were reported to the hospital incident reporting system, and only 24% to Medicines and Healthcare products Regulatory Agency via the Yellow Card Scheme. Conclusions: The overall incidence of perioperative anaphylaxis was estimated to be 1 in 10 000 anaesthetics.<br>Copyright © 2018 British Journal of Anaesthesia |

### 98. Fetal growth surveillance - Current guidelines, practices and challenges

| | |
|---|---|
| **Authors** | Williams M.; Turner S.; Butler E.; Gardosi J. |
| **Source** | Ultrasound; May 2018; vol. 26 (no. 2); p. 69-79 |

**Publication Date** May 2018
**Publication Type(s)** Review
**Database** EMBASE
Available at Ultrasound 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** Antenatal surveillance of fetal growth is an essential part of good maternity care, as lack of detection of fetal growth restriction is directly associated with stillbirth and perinatal morbidity. New algorithms and guidelines provide care pathways which rely on regular third trimester ultrasound biometry and plotting of estimated fetal weight in pregnancies considered to be at increased risk, and their implementation has increased pressures on ultrasound resources. Customised growth charts have improved the distinction between constitutional and pathological smallness and reduced unnecessary referrals. Their introduction, together with clinicians' training, e-learning and audit as the key elements of the growth assessment protocol, has resulted in increased antenatal detection of small for gestational age babies and a reduction in avoidable stillbirths. However, missed case audits highlight that further improvements are needed, and point to the need to address quality assurance and resource issues in ultrasound services.

### 99. Delayed coronary obstruction after transcatheter aortic valve implantation is not the structural equivalent of late stent thrombosis after percutaneous coronary intervention

**Authors** Kennon S.
**Source** Interventional Cardiology Review; Jun 2018; vol. 13 (no. 2); p. 60-61
**Publication Date** Jun 2018
**Publication Type(s)** Editorial
**Database** EMBASE

### 100. The use of process mapping in healthcare quality improvement projects

**Authors** Antonacci G.; Reed J.E.; Lennox L.; Barlow J.
**Source** Health Services Management Research; May 2018; vol. 31 (no. 2); p. 74-84
**Publication Date** May 2018
**Publication Type(s)** Article
**Database** EMBASE
Available at Health services management research 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 Health services management 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** Introduction: Process mapping provides insight into systems and processes in which improvement interventions are introduced and is seen as useful in healthcare quality improvement projects. There is little empirical evidence on the use of process mapping in healthcare practice. This study advances understanding of the benefits and success factors of process mapping within quality improvement projects. Methods: Eight quality improvement projects were purposively selected from different healthcare settings within the UK's National Health Service. Data were gathered from multiple data-sources, including interviews exploring participants' experience of using process mapping in their projects and perceptions of benefits and challenges related to its use. These were analysed using inductive analysis. Results: Eight key benefits related to process mapping use were reported by participants (gathering a shared understanding of the reality; identifying improvement opportunities; engaging stakeholders in the project; defining project's objectives; monitoring project progress; learning; increased empathy; simplicity of the method) and five factors related to successful process mapping exercises (simple and appropriate visual representation, information gathered from multiple stakeholders, facilitator's experience and soft skills, basic training, iterative use of process mapping throughout the project). Conclusions: Findings highlight benefits and versatility of process mapping and provide practical suggestions to improve its use in practice.

## **Strategy** 432448

| # | Database | Search term | Results |
|---|---|---|---|
| 1 | EMBASE | (audit* OR "quality improvement").ti,ab | 217423 |
| 2 | EMBASE | (NHS OR england OR UK OR "united kingdom" OR "national health service").ti,ab | 309023 |
| 3 | EMBASE | exp "CLINICAL AUDIT"/ | 2146 |
| 4 | EMBASE | exp "UNITED KINGDOM"/ | 407871 |
| 5 | EMBASE | exp "NATIONAL HEALTH SERVICE"/ | 65431 |
| 6 | EMBASE | (1 OR 3) | 217930 |
| 7 | EMBASE | (2 OR 4 OR 5) | 575560 |
| 8 | EMBASE | (6 AND 7) | 19773 |
| 9 | EMBASE | 8 [DT 2018-2018] [Since 17-May-2018] | 113 |
| 10 | EMBASE | (audit*).ti,ab | 180804 |
| 11 | EMBASE | (3 OR 10) | 181336 |
| 12 | EMBASE | (7 AND 11) | 18283 |
| 13 | EMBASE | 12 [DT 2018-2018] | 365 |