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1. Severe group A streptococcal infections in mothers and their newborns in London and the South East, 2010-2016: assessment of risk and audit of public health management

Authors Leonard A.; Wright A.; Saavedra-Campos M.; Balasegaram S.; Lamagni T.; Cordery R.; Nicholls M.; Domoney C.; Sriskandan S.
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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.

Abstract Objective: We describe cases of invasive group A Streptococcus (iGAS) in mothers or neonates and assess management according to national guidelines, which recommend administering antibiotics to both mother and neonate if either develops iGAS infection within 28 days of birth and investigation of clusters in maternity units. Design: Cross-sectional retrospective study. Setting and population: Notified confirmed iGAS cases in either mothers or neonates with onset within 28 days of birth in London and the South East of England between 2010 and 2016. Method: Review of public health records of notified cases. Main outcome measures: Incidence and onset time of iGAS in postpartum mothers and babies, proportion given prophylaxis, maternity unit clusters within 6 months. Results: We identified 134 maternal and 21 neonatal confirmed iGAS infections. The incidence (in 100 000 person years) of iGAS in women within 28 days postpartum was 109 (95% CI 90-127) compared with 1.3 in other females aged 15-44. For neonates the incidence was 1.5 (95% CI 9-23). The median onset time was 2 days postpartum [interquartile range (IQR) 0-5 days] for mothers and 12 days (IQR 7-15 days) for neonates. All eligible mothers and most (109, 89%) eligible neonates received chemoprophylaxis. Of 20 clusters (59 cases of GAS and iGAS) in maternity units, two clusters involved possible transmission. However, in 6 of 15 clusters, GAS isolates were not saved for comparison even after relevant guidance was issued. Conclusions: iGAS infection remains a potential postpartum risk. Prophylaxis among neonates and storage of isolates from maternity cases can be improved. Tweetable abstract: Are public health guidelines being followed in the management of mothers and their newborns to reduce the risk of iGAS infection?.

2. Spotlight on ... MBRRACE-UK

Authors Knight M.; Kurinczuk J.J.
Source Obstetrician and Gynaecologist; 2018; vol. 20 (no. 1); p. 5-6
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Available at The Obstetrician & Gynaecologist from Unpaywall

3. Development of a core outcome set capturing key concepts relevant to safe and efficient evaluation of innovative invasive procedures

Authors Avery K.; Potter S.; Wilson N.; Hinchliffe R.; Cousins S.; McNair A.
Source Clinical Trials; Aug 2018; vol. 15 ; p. 96-97
Publication Date Aug 2018

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Available at Clinical Trials 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 Methods for introducing invasive procedures (IP: surgicalprocedures without a device) into clinical practice are haphazard and largely ungoverned, with few RCTs and fewerwell designed and conducted early phase studies. Thiscontrasts the highly regulated research environment forintroducing new pharmaceutical products. Unregulatedintroduction of IPs has resulted in several scandals, suchas the recall of counterfeit spinal fusion screws in the US,removal of faulty silicone breast implants in Europe andongoing concerns over the use of vaginal mesh implantsin the UK, following association with previously unrecognised adverse events (AEs). While systems exist for reporting outcomes of some established IPs (e.g. AmericanJoint Replacement Registry, UK National Adult CardiacSurgery Audit, UK National Oesophago-Gastric CancerAudit), outcome definition, selection, measurement andreporting in early phase studies of innovative IPs lacksstandardisation. This prevents data syntheses from independent studies and delays identification of emergingproblems. Effective systems and mandatory requirementsfor surgeons to report outcomes when developing orimplementing new IPs are also lacking, meaning AEs arelikely under-reported.Development of a core outcome set (COS), a minimum mandated set of outcomes to be measured andreported in all early phase studies of innovative IPs, andaccompanied by transparent reporting guidelines mandated via regulatory agencies and publications, is necessary to promote uniform and evidence-based assessmentso that innovative IPs are introduced safely and efficiently.AimTo describe methods and early results (steps 1-2 below)of the identification of outcome domains for minimalreporting of innovative IPs.Methods1. Identify existing systems for reporting outcomes ofinnovative IPs;2. Categorise these outcomes (e.g. AEs, complications,symptoms, function) into 'conceptual' domains;3. Apply the conceptualised domains within casestudies of innovative IPs to refine them and establish how current AE reporting maps onto domains;4. Iteratively engage key stakeholders to consider theabove (e.g. surgeon innovators, patients, devicemanufacturers, regulators, journal editors) anddevelop guidelines for reporting of innovative IPs.ResultsExamples of outcome reporting systems identifiedinclude the US Food and Drug Administration DeviceRegulatory Strategy, Clavien-Dindo classification ofsurgical complications, UK NICE InterventionalProcedures Guidance and Medicines and Healthcare products Regulatory Agency. No single system provides detailed mandated guidance on outcome domainsrelevant to comprehensively evaluate innovative IPsspecifically. Early findings indicate that a broader conceptualisation of outcomes, beyond traditional outcomes such as AEs and complications, is needed tobegin to tackle the issues and provide transparent data.Conceptualised domains identified so far include:(i) Innovation delivered with intended effect;(ii) Innovation delivered with unintended effect;(iii) Innovation delivered and caused anticipated AE;(iv) Innovation delivered and caused unanticipatedAE;(v) Innovation abandoned (intraoperative postoperatively);(vi) Innovation associated with longer-term unintended/unanticipated effects/ AE.ConclusionsThere is an urgent need to develop and implement better methods for early phase evaluation of innovativeIPs. Identifying core outcome domains to inform selection of specific agreed outcomes for IPs is the first necessary step in this process. Further work is needed totest these conceptualised domains in specific innovations and with key stakeholders.

4. A systematic analysis of uk nationally-funded surgical pilot and feasibility study protocols from the last 10 years to inform and optimise future surgical trials

Authors Fairhurst K.; Blazeby J.; Avery K.
Source Clinical Trials; Aug 2018; vol. 15 ; p. 118-119
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Available at Clinical Trials 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 High quality randomised controlled trials are necessaryto inform evidence-based surgical practice. These may beoptimised by well performed pilot and feasibility studiesthat explore uncertainties around trial design and conduct. However, the published literature is littered withexamples of underpowered surgical trials, mislabelled aspilot studies. Detailed understanding of how and whento design and perform pilot and feasibility studies in surgery is lacking. The aim of this work is to identify keydesign features in successfully funded surgical pilot andfeasibility studies, to inform guidance in this area.MethodsPilot and feasibility studies of surgical interventionsfunded by the National Institute for Health Research(NIHR) Health Technology Assessment (HTA) andResearch for Patient Benefit (RfPB) programmes between2005 and 2015 were identified. Both are established majorUK programmes, funding studies up to 10m (HTA) and350k (RfPB). Original study protocols and associatedpublished outputs were sourced. Internal pilot studies,which are designed and funded as part of the main trialand should thus be considered separately (as other methodological work in this area has done), were excluded.Systematic reviews were also excluded as none met thedefinition of pilot/feasibility work by stating an intentionto inform a future main study. Data extracted from theprotocols included characteristics of the study type anddesign and the rationale cited for performing the work,including perceived uncertainties around conducting adefinitive main trial. Descriptive statistics are presented.ResultsOver the 10-year funding period, n=1,341 studies wereidentified. Of these, n=35/1,341 (2.6%: RfPB n=25/35, 71%; HTA n=10/35, 29%) were eligible for inclusion. Of the included studies, most (n=29/35, 83%)were randomised, with over half of these (n=15/29,52%) also including other types of pre-trial work, such as qualitative interviews, participant surveys and economic modelling. The n=6/35 (17%) non-randomisedstudies varied in design, including national audits, nonrandomised cohort studies, systematic reviews andquestionnaire surveys and/or qualitative work (e.g.interviews/focus groups) to explore stakeholders' opinions. Addressing uncertainties around recruitmentwas the most commonly cited rationale for conductingpre-trial work (n=30/35, 85.7%). Only one in fourstudies (n=9/35, 25.7%) sought to address uncertainties surrounding intervention stability, implementationor delivery. One in three studies (n=11/35, 31.4%)stated an intention to collect 'preliminary' data onsafety and/or effectiveness, of which n=8/11 (73%)specifically planned to statistically compare intervention(s) and/or control groups to test effectiveness and/or safety. Nearly half (n=14/35, 46%) of all studieshad not made their results publicly available to date.ConclusionsThis analysis of peer-reviewed nationally-funded surgicalpilot/feasibility studies indicates that, while methodological issues are explored to some extent, the full potentialof pre-trial work to inform and optimise definitive surgical studies is likely not being realised. In addition, muchpilot/feasibility work remains unreported. Future workshould focus on engaging key stakeholders to developrecommendations and guidance on the design and optimal use of pilot/feasibility work to inform surgical trials.

5. New paediatric drug chart as a means of quality improvement for antibiotic stewardship

Authors Arghode S.; Gupta R.
Source Pediatric Critical Care Medicine; Jun 2018; vol. 19 (no. 6); p. 102
Publication Date Jun 2018
Publication Type(s) Conference Abstract
Database EMBASE

Abstract Aims & Objectives:-To audit antibiotic prescriptions against expected standards set by Department of Health Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infections in UK.-To find ways to improve prescriptions and review of antibiotics to promote antibiotic stewardship.-Create awareness and education for antibiotic stewardship. Methods A) Over 3 weeks period paediatric drug cards were reviewed for-Indication and duration of antibiotic on drug chart prescription.-Review of intravenous antibiotics at 48 hours with culture results and clinical status.-Compliance to local antibiotic guidelines for choice of antibiotic.-Effects on patient care (prolonged course of intravenous antibiotic/ broader spectrum antibiotic). B) One day in each week during grand round the team was educated about antibiotic prescriptions and need to mention indication, duration and review of antibiotics on drug charts. Results-62 % of antibiotic prescriptions had no indications.-77 % of antibiotic prescriptions had no duration mentioned.-53 % of IV prescriptions had no clear documented review or plan at 48-72 hours.-27 % prescriptions were not compliant with antibiotic guidelines for choice of antibiotics. Impact on patient care-42% had prolonged IV antibiotics and had no indication to justify this.-11% were on broader spectrum antibiotics. Conclusions-There was no prompt for indication, duration and review of antibiotics on old drug chart. This affected quality of prescriptions.-Recognition of need for new drug chart with separate area for antibiotic prescriptions having mandatory fields for indication, duration & review of antibiotics.-Drug charts can be used as a quality improvement measure for antibiotic stewardship. Regular re-audits of antibiotic prescriptions can help maintain quality.

6. Establishment of paediatric intensive care registry in Latvia

Authors Vegeris I.; Daukste I.; Barzdina A.; Balmaks R.; Parslow R.
Source Pediatric Critical Care Medicine; Jun 2018; vol. 19 (no. 6); p. 161
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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 Aims & Objectives: Latvia is an Eastern European country with a population of just less than 2 million. There is a single eight-bed PICU where all critically ill children are admitted. A recent retrospective audit of paediatric critical care outcomes in Latvia revealed high number of unplanned extubations and excess crude mortality. In 2017 our centre joined UK and Ireland based Paediatric Intensive Care Audit Network (PICANet) as a pilot project for paediatric critical care registry. Methods Riga Stradins University Ethics Committee approved the study. Anonymized data of all patients admitted to our unit from 1st of June to 30th of November, 2017 were prospectively entered in PICANet WEB site. Results A total of 399 PICU admissions were analyzed; 43% of admissions were elective. The median length of stay was 0.94 days (IQR: 0.79-1.94). 20% required mechanical ventilation. There were 8.65 expected deaths as calculated by Paediatric Index of Mortality 3; 7 patients (1.8%) died. Emergency readmission rate within 48 hours after PICU discharge was 0.5%. There were 2.7 unplanned extubations per 100 invasive ventilation days. On 30-day follow-up 339 patients were alive and outside hospital, 45 were inpatients, 3 had died, 2 were lost to the follow-up. Conclusions This project explored possibility of paediatric critical care audit in Latvia by joining established international network. This allowed direct comparison of outcomes between the countries. Excess mortality was not observed during this short data collection period, however high rate of unplanned extubations was revealed. Different case mix, particularly, large proportion of low intensity care, complicated the comparison.

7. Paediatric airway management at referral hospitals in the north thames region of London: Complications associated with endotracheal intubation

Authors Matettore A.; O'Connor M.; Chigaru L.
Source Pediatric Critical Care Medicine; Jun 2018; vol. 19 (no. 6); p. 53-54
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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 Aims & Objectives: Acutely ill children often present to community hospitals. Local healthcare providers must provide initial resuscitative care, including airway management. Studies have shown an incidence of Tracheal Intubation Associated Events (TIAEs) of 19-54% in the paediatric population at referring hospitals (1,2,3). We sought to identify the rate of TIAEs at our referral centres. Methods The Children's Acute Transport Service gathered data prospectively over 15 months on all intubated patients transferred to Paediatric Intensive Care Units (PICUs) in the North Thames region of London. Results Our audit captured 713 paediatric intubations. The majority occurred in Emergency Departments (36.8%), done primarily by anaesthetists (69.4%). Ketamine and fentanyl were used most commonly (30%; 36.2%), and a paralytic was used in 78% of intubations. The complication rate was 29.3% and was higher in patients who did not receive a paralytic agent (38.9 % vs. 29.1%). 54.7% were intubated on the first attempt, 18.7% required 2 attempts and 12.5% required >= 3 attempts. Consultants had the highest rate of complications (36.4%) whereas trainees (4-8th year) had the lowest (19.7%). The most common TIAEs were endobronchial intubations (7.0%), hypoxia (4.8%), hypotension (4.1%), cardiac arrest (3.2%) and oesophageal intubation (2.8%)-Fig-1. Conclusions Our data suggest that TIAEs are common at our referral centres. Intubation checklists can improve patient safety (3). Our data support the need for widespread use of such a tool and focused strategies to prevent the most common adverse events during intubation especially in centres with a low volume of critically ill paediatric patients.

8. Use of continuous renal replacement therapy by paediatric intensive care units in the UK and the republic of Ireland

Authors Westrope C.; Kapetanstrataki M.; Parslow R.; Morris K.
Source Pediatric Critical Care Medicine; Jun 2018; vol. 19 (no. 6); p. 20-21
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Abstract Aims & Objectives: To better understand how extracorporeal methods of continuous renal replacement therapy (CRRT) are being employed across the UK and Republic of Ireland given the paucity of high level evidence and the need for future randomised controlled trials. Methods Data on a subset of children receiving CRRT and collected as a voluntary additional audit dataset were abstracted from the UK and Republic of Ireland Paediatric Intensive Care Audit Network (PICANet). All admissions collected by volunteer PICUs between April 2015 and October 2017 were reviewed. Results 478 admissions (447 children) received CRRT in 19 units; range 1-94 CRRT admissions per unit. The commonest mode of CRRT employed was haemofiltration (CVVH) (75%), followed by haemodialfiltration (CVVHDF) (16%). A combination of modalities was employed in 7% of cases. In 5/19 units CVVHDF was the preferred first line modality. 'Dose' of CRRT (ultrafiltration and/or dialysate rates) varied widely within and between units. CRRT was initiated early, median=18.3 (IQR=5.8-66) hours following PIC admission. Overall mortality in this cohort was 32% (152 admissions); higher in neonates (42/90 (46.7%)), than infants (30/78 (38.5%)) or older children (80/310(25.8%)). 57/310 (18.4%) of the older child cohort required ongoing RRT at the time of PICU discharge (neonates 5/90 (5.6%), infant 10/78 (12.8%)). Conclusions Addition of a renal dataset to the core PICANet dataset has provided valuable contemporary information on CRRT use. Significant variation in choice of modality and dose is evident. Mortality remains high in patients who receive CRRT, and a significant proportion are left with renal morbidity.

9. Move on ventilation early (MOVE): An early mobility quality improvement initiative

Authors Hills J.; Sharp K.; Johnstone B.
Source Pediatric Critical Care Medicine; Jun 2018; vol. 19 (no. 6); p. 198
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Abstract Aims & Objectives: To introduce the concept of early mobility as part of the clinical care delivered within a Paediatric Intensive Care Unit (PICU) in the United Kingdom (UK). The objective was to facilitate a change in culture within the PICU. Methods Move on Ventilation Early (MoVE) is a collaborative quality improvement (QI) initiative within the PICU at the Royal Hospital for Children in Glasgow. A baseline review was carried out to establish current practice in relation to activity and the barriers to activity within PICU. QI principles such as regular communication, stakeholder engagement and family centred care were utilised in the design process. The MoVE initiative set a goal for each patient to achieve 3 activities per day. Ongoing data collection throughout the initiative was analysed after 80 days and after 6 months. Results Graph 1 presents the barriers to activity. Data collected for the first 80 days of MoVE demonstrated the number of patients achieving 3 activities per days were 80%. 6 months following the launch of MoVE this increased to 95%. Parental involvement in at least one activity was 70% during the initial 80 days and after 6 months is continuing at 65%. The physio involvement in activities was maintained at 17% throughout the initial 80 days. Conclusions MoVE has successfully facilitated a change in culture within RHC PICU in regards to providing EM. No additional increase in physiotherapy staffing was required as it was a PICU wide patient initiative and adopted by staff and families into daily routine care. (Figure prsented).

10. Emergency intubations in under 1 year olds referred to north wales and north west paediatric transport service (NWTS)

Authors Garbarino J.; Mullen G.; Pritchard L.
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Abstract Aims & Objectives: The NWTS team give advice and transfer critically ill children from District General or adult only hospitals to Paediatric Intensive Care Units. Intubating babies is a procedure associated with anxiety, as a result we find that intubation can be delayed awaiting arrival of the NWTS team. This can be detrimental to patient care. Aims: To assess the procedure and any associated complications when intubating under 1 year olds in DGH/adult only hospitals. The information collected was to help guide advice and training to personnel who need to intubate babies in this setting. Methods Retrospective audit of 100 patients <1year old who were intubated in DGH's/adult only hospitals. These were consecutive patients and information was obtained retrospectively from clinical case notes. The information collected included patient demographics, grade and specialty of intubating clinician, drugs and equipment used, grade of laryngoscopy, number of attempts at intubation, whether CXR prompted tube re-positioning and any complications during the procedure. Results Please see attached results table (Figure prsented). Conclusions The results provide reassurance that critically ill children under 1 year are intubated safely and successfully in DGH's/adult only hospitals. Intubation therefore should not be delayed awaiting the NWTS team. The data guides a recipe card for successful intubation in an under 1 year old. Alongside teaching and training this simple tool should help reassure clinicians.

11. Epidemiology of sepis in children admitted to paediatric intensive care unit (PICU) in United Kingdom-a snapshot

Authors Christopher M.; Saxena R.; Ramanan A.
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Abstract Aims & Objectives: To study the epidemiology of children admitted with sepsis in a PICU in UK. Methods A retrospective, single centre study involving children admitted to a 17 bed, mixed PICU over 4.5 years (Jan 2012-June 2017).Information was accessed from the local database submitted to national Paediatric Intensive Care Audit Network,UK.105 read codes regarding infection reporting were available. Out of these, 44 codes thought to be most relevant to identify children with a final diagnosis of sepsis were applied. Results 64 children were identified with a final diagnosis of sepsis.29 and 35 children were <= 1 yr and > 1 yr old respectively. CNS and respiratory system were the most common primary site in <= 1 yr and >1 year old respectively(Figure 1). 51.7%(n=15) were culture positive in <= 1 yr group as compared to 45%(n=16) in >1 year old group.Out of these, gram positive infection was common in <= 1 yr group (60%) as compared to the gram negative infection (62%) in the older group (Figure 2).Mortality was 13.8%(n=4) in <= 1 yr as compared to 5.7%(n=2) in > 1 year old.There was no significant difference in the median length of stay(p=0.708). Figure 3 shows the variables with statistically significant difference at presentation between the children who died and survived. Conclusions Important differences exist between epidemiology of sepsis in these two age groups with respect to primary site of infection and organism types.Simplify coding /reporting methods on a global basis is required in order to understand the true load and disease trends enabling judicious use of resources. (Figure prsented).

12. Compassionate leadership from nursing staff enhances patient safety and staff well being

Authors Nicholls R.; Rosen C.
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Abstract Aims & Objectives: The aim of this initiative was to develop a template to improve communication and teamwork within the 'spheres' of critical care. The template outlines safety checks to improve compliance and acknowledge support required within the team. Methods The initiative used a SUDA recognised change methodology. Our sense was that junior staff required additional support and senior staff needed encouragement to demonstrate a leadership role. We understood following audit that compliance of checking emergency equipment and structuring of delegated tasks was poor. Results Initially there was a low completion rate of using the template during shifts and there was a lack of engagement with the initiative. Despite the sample size being low, it was evident there was a heightened awareness of the importance of safety checks and working together to achieve goals and delegate tasks. Therefore the projected impact was substantial and promising. Conclusions It was found that the initiative had to evolve from a task based focus to one of staff well-being and support. Staff required motivation and skills to become leaders themselves, learning from existing research regarding compassionate leadership.The challenge then widened to researching this topic and exploring how this is used within other trusts in the NHS and adapting this for staff nurses within critical care.

13. Initial challenges of establishing a stand-alone paediatric critical care transport service in England, UK

Authors Devanahalli Nagaraj C.; Mohammad Z.; Liveing L.; Hill A.; Saikia B.; Barry P.W.; Raffaj D.
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Abstract Aims & Objectives: The Children's Medical Emergency Transport service (CoMET) is a stand-alone paediatric critical care transport service established in March 2017. The service has been commissioned to provide an acute transport service 24/7, and a repatriation service during daytime hours. CoMET serves the East Midlands region of England, with a population of more than 4.5 million. Aim:-We report the initial challenges of establishing CoMET, in the current scenario of limited finance and availability of trained staff in UK. Methods We retrospectively analysed feedback from incidents, staff, stakeholder events and data from the PICANet. (Paediatric Intensive Care Audit Network-UK National Database). Results CoMET faces challenges regarding recruitment to enable the full establishment of the service. In order to launch a 24/7 acute service on 4th December 2017, the repatriation service offered had to become ad-hoc (only 38% of shifts covered between December 2017-March 2018) Ambulance provision was not commissioned and the team relies on front line emergency vehicles which serve the whole region. As a result, CoMET is only able to comply with the national standards of mobilising within 30 minutes of acceptance (acute transfers) in 21 % of occasions (March-December 2017). Ambulance delays making up the majority of the incidents reported. Conclusions Achieving adequate staffing and a dedicated ambulance remains a major challenge. Openness, transparency and a flexible mind-set to learn from the challenges faced will continue to be the key in developing this service during its first steps, and into the future.

14. Care of critically ill children in general (adult) intensive care units-a tale of three regions

Authors Mogan S.; Briggs A.; Saxena R.; Cooper A.; Kashyap A.
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Abstract Aims & Objectives: To study the demographics and epidemiology of children admitted to general (adult) intensive care units (GICUs) across the three regions in England, United Kingdom. Methods A retrospective analysis of paediatric data submitted to the Intensive Care Audit and National Research Centre as part of a case mix programme of adult critical care in UK over one year (Jan-Dec 2015). The three regions studied were South-West England and Wales,The Midlands and North-East England.These are each served by their own specialist paediatric transport service called WATCh,KIDS and NECTAR respectively. Results 21,13 and17 GICUs admitted 229(222), 19(19) and 34(33)(number of children) paediatric critical illness episodes in the catchment areas of WATCh, KIDS and NECTAR respectively.Respiratory followed by neurological pathology were the biggest reason for GICU admission.No statistical difference was found between the overall median time spent in GICUs across the three regions (p =0.898)(see figure 1,2).Specialist transport team unavailability (35%) followed by inaccessibility of PICU bed(18%) at the time of referral were the most common reasons for admission to the local GICU (WATCh data).No correlation was found between the time spent in GICU and patient's age (r=0.16) or distance of GICU from paediatric transport service base (r=0.152). Conclusions A significant number of critically ill children were treated at local GICUs. Unavailability of specialist transport teams and PICU bed were the major reasons for this stay. A national audit of GICUs against the current PICS standards should be performed while determining merits (cost effectiveness, patient outcomes and family dynamics) of local vs specialised care. (Figure prsented).

15. The relationship between lactate, base excess and mortality in paediatric intensive care

Authors Kapetanstrataki M.; Parslow R.C.; Morris K.; Wilkins B.; Ward V.; Slater A.; Straney L.
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Abstract Aims & Objectives: High lactate and base excess (BE) values are associated with higher mortality in adult and paediatric intensive care units. The absolute value of BE is currently used in the calculation of Paediatric Index of Mortality (PIM). We investigated the association between lactate and BE and determined which more accurately predicts mortality. Methods Data were abstracted from the UK and Republic of Ireland Paediatric Intensive Care Audit Network (PICANet) and the Australian and New Zealand Paediatric Intensive Care Registry (ANZPICR), for all admissions between 1st January 2012 and 31st December 2015 that had both a lactate and BE measurement (N=59,915) obtained within one hour of PIC admission. Spearman correlation coefficient, univariate logistic regression models and generalized additive modelling (GAM) functions were used. Results Lactate is moderately negatively correlated with BE (rho=-0.20 p<0.001) (Figure 1) and that correlation becomes stronger for those that died (rho=-0.62 p<0.001). High negative BE values are associated with higher mortality (OR=1.17, 95% CI (1.16, 1.18) than high positive BE values (OR=1.01, 95% CI (0.99, 1.02) (Figure 2). There is a stronger relationship between lactate and mortality than BE per unit increase (OR=1.32, 95% CI (1.31, 1.34)) (Figures 2 & 3), and a higher area under the Receiver Operating Characteristic (ROC) curve for lactate than BE (0.746 vs 0.669). Conclusions Lactate is a better predictor of mortality than BE. High negative BE values have a higher mortality trajectory than high positive values, suggesting that alternative approaches to modelling should be examined. (Figure prsented).

16. Improving mortality prediction using acid/base parameters in PIM2

Authors Kapetanstrataki M.; Parslow R.C.; Morris K.; Wilkins B.; Ward V.; Slater A.; Straney L.
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Abstract Aims & Objectives: Paediatric Index of Mortality 2 (PIM2) is used as a mortality predictor in PICU and includes absolute base excess (BE) along with other clinical and physiological variables. Small scale studies have shown that lactate is a better predictor than base excess (BE). We investigated the effect on PIM2 of a) utilising venous samples, which have historically been excluded, b) adding lactate to the model, with or without BE, c) utilising separate terms for positive and negative BE, and d) the treatment of missing values. Methods Data were abstracted from the UK and Republic of Ireland Paediatric Intensive Care Audit Network (PICANet) and the Australian and New Zealand Paediatric Intensive Care Registry (ANZPICR). All admissions between 1st January 2012 and 31st December 2015 were analysed (N= 123,252) using a series of logistic regression models. Area under the Receiver Operating Characteristic (ROC) Curve (AUROC) and the Akaike Information Criterion (AIC) were used to assess model fit. Results Addition of venous BE measurements improved the fit of PIM2 (AUROC improved by 0.0016). Addition of positive and negative BE as two separate terms didn't improve the model fit, but showed that negative BE is a stronger mortality predictor. A model with missing lactate values set to 1 gave a better fit than replacing with 0. Table shows results of the different models. Conclusions Lactate improves the fit of PIM2. Addition of two variables for BE, inclusion of lactate, and using only lactate measurements if both lactate and BE are obtained should be considered.

17. Audit of general intensive care units providing care to critically ill children against paediatric intensive care society (PICS) quality standards across three regions in UK

Authors Briggs A.; Mogan S.; Saxena R.; Cooper A.; Kashyap A.
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Abstract Aims & Objectives: 1.To assess the compliance with 2015 Paediatric Intensive Care Society (PICS) quality standards among adult general intensive care units (GICUs) in three regions across UK 2.To identify most common concerns of non-paediatric specialists caring for critically ill children Methods 51 general intensive care units (GICUs) across three UK regions were surveyed. Each GICU is linked to a specialist paediatric transport team-WATCh (South West England), NECTAR(North East) or KIDS(Midlands).Nursing and medical leads of each GICU were asked to complete a separate online questionnaire. Results Overall response rate was 53%(27/51) [62%,38%,53% for WATCh,KIDS and NECTAR respectively) for the medical questionnaire and 51% (26/51) [67%,31%,47% for WATCh,KIDS and NECTAR respectively] for the nursing questionnaire.The only standards met by all GICUs in any one region were 'anaesthetic consultant available within 30 minutes' (NECTAR region) (figure 1) and '24 hour parent access' (WATCh and KIDS regions).No region was 100% compliance with availability of a dedicated paediatric equipped area in GICU or adequate number of nurse cover with paediatric experience in the GICU(figure 2 and 3). Top concerns for caring children were lack of specialist skills,knowledge base and appropriate equipment. Conclusions None of the GICU's in these three regions comply with the recently published PICS 2015 standards in spite of a significant admission number (approximately 280 episodes across the three regions)1. An urgent active review of these services at a national level is required to improve these standards.Adequate training and resources should be provided to improve GICU staff confidence. (Figure prsented).

18. Adhrence to an oxygen saturation guideline for pre-term neonates within the paediatric intensive care setting

Authors Price K.; Menzies J.; Philpott A.; Winmill H.
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Abstract Aims & Objectives: Pre-term neonates (<=37 weeks gestation) require targeted oxygen saturations (pulse oximetry, SpO2) to help reduce the risk of ROP (Retinopathy of Prematurity) and Broncho-Pulmonary Dysplasia (BPD)1. Recommendations from BOOST II(91%-95%)2, have been amended within the PIC setting to produce a local guideline of targeting 92-96%. Aim was to retrospectively audit compliance to local guideline-targeted Sp02 and, where available, arterial O2 (SaO2) for infants <=36 weeks' gestation on a single-site UK PIC. Methods Audit. Included: neonates receiving oxygen via any mechanism admitted to PIC (01.01.2017-10.06.2017). Excluded: cyanotic cardiac patients. Data collection from PIC observation charts: hourly SpO2 and arterial SaO2 (where arterial line in situ) for the duration of oxygen therapy. Results 24/26 eligible patient notes were audited (2 unavailable). From SpO2 readings patients were at risk of hyperoxia, with 47% of recordings above 97% (see Table below). Where oxygen recordings from arterial lines (SaO2) were available (n=13) the percentage of hyperoxic readings was lower (18% of readings). However 44% of these patients were exposed to hypoxia, with SaO2 below 91%; below PIC recommendations. Conclusions Despite evidence-based PIC guidelines, only 47% of SpO2 results were within the recommended range. This appears to place patients at risk of BPD and ROP from hyperoxia. Where arterial lines are present, compliance to guidelines also remains an issue with SaO2 readings indicating patients are subjected to hypoxia. Further work is required to improve adherence to PIC guidelines through clinical education. Clinicians also need to review the efficacy and safety of an arterial line to aid clinical decision-making. (Table presented).

19. A three pronged approach to improving advance care planning and end of life decision making for patients with life limiting conditions admitted to picu

Authors Sidgwick P.; Randle E.; Petros A.
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Abstract Aims & Objectives: To develop three linked projects to enumerate, reflect upon and identify ways to improve the experience of children with life limiting conditions (LLC) admitted to PICU without previous contact with palliative care services or existing advance care plans (ACP). Methods Three projects included local education, regional data collection and contribution to national debate. An ACP in PICU simulation programme for clinicians in our large quaternary centre. A clinical audit to identify children with pre-existing LLCs with and without ACPs retrieved to PICU by a regional retrieval service in southeast England and who died during the admission for which they were transferred. A national review article engaging palliative care teams and intensivists in considering the current landscape for children with LLC in PICU and analysing the ACP as part of a means to improved care. Results All three projects identified significant areas for further work. The education project outcome was positive, identifying a particular need for ongoing training in handling complex conversations around death and dying. The clinical audit found that the overwhelming majority of patients with LLCs retrieved had no ACP in place. The review piece was more reflective and generated considerable debate amongst the PICU community. Conclusions ACP and end of life care planning is vital for children with LLCs, their families and those who care for them in PICU. There is significant unmet need and significant will to improve the quality of the conversations and services we offer these children and their families and to increase the numbers offered timely ACPs.

20. Prognostic factors for survival post cardiac arrest in kids: The netpack-2 audit

Authors Evans S.; Scholefield B.; Martin J.; Kapetanstrataki M.; Parslow R.C.
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Abstract Aims & Objectives: Paediatric cardiac arrest (CA) is associated with high mortality and morbidity. Despite significant advances in post-arrest intensive care, it is unclear who will benefit from invasive interventions and considerable prognostic uncertainty remains. We therefore aimed to identify prognostic factors in order to inform survival prediction within 1 hour after admission to paediatric intensive care units (PICU). Methods We used data prospectively collected as part of the Paediatric Intensive Care Audit Network (PICANet) on children admitted to PICU after CA in 23 PICUs in the UK and Republic of Ireland (August 2014-December 2015). Inclusion criteria were admission after >2 minutes of cardiopulmonary resuscitation and mechanical ventilation. We excluded CA within the PICU. Outcome was in-PICU mortality. Patient demographics, arrest characteristics and resuscitation interventions were included in a multivariable logistic regression analysis. Multiple imputation was performed for missing data. Results 313 patients were included, 64% were male. Median age was 1 year [IQR: 3 months-7 years]. 156 (49.8 %) patients had in-hospital and 157 (50.2%) outof-hospital CA. After adjustment for location of CA, factors associated with increased mortality were: blood lactate, female sex, requirement for vasoactive infusion, neurological co-morbidity, pupil reactivity to light, and secondary hospital transport for admission into a PICU (see table 1). Conclusions Identified prognostic factors provide additional information for clinicians and families on expectation of survival after CA. The association of inter-hospital transfer on survival may be a target for quality improvement initiatives. Further model development and validation is required.

21. Re-audit of management of sepsis-review of management at district general hospitals from north west north wales transport service (NWTS) experience

Authors Nguyen K.; Houltram C.; Barber R.; Pritchard L.
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Abstract Aims & Objectives: Over 100 children are referred to North West North Wales Transport Service (NWTS) every year with sepsis or septic shock. Approximately 50% are transferred to tertiary ICU for management. This audit aims: 1. To review management of fluid resuscitation and inotropic use in sepsis at district general hospitals (DGH) in accordance to NWTS and NICE guidelines 2. To complete audit cycle from a previous audit Methods Retrospective notes review of transferred patients over 1 year period 01/08/15-31/07/16 Data collected are categorised into different time frame focusing on 1. Management of DGH 2. Management following NWTS advice 3. Management by NWTS Results 56 patients were identified for results analysis At the point of referral 88% (49/56) patients had received fluid resuscitation with a mean bolus of 38.2 ml/kg. 12% (7/56) had not. Of those 7 patients, 3 had lactates >4 and 3 had lactates >2. 19% (9/56) received inotropic support with peripheral dopamine. Following NWTS advice, further 19 patients were initiated on inotropes. Mean inotrope score was 1.97 at point of referral compared to mean inotrope score 36.37 at pre departure point. Conclusions Mortality of sepsis in children in the North West is approximately 11% which is similar to the national average. Compared to previous audit, median time of referral had decreased from 2.3 hrs to 1.43 hrs indicating that DGH are escalating sooner. Overall there is an improvement in speed of escalation of care. However, there is still poor compliance with the Sepsis Six Bundle with regards to adequate fluid resuscitation and earlier consideration of inotropic support.

22. The detection of significant fractures in suspected infant abuse

Authors Raynor E.; Konala P.; Freemont A.
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Abstract Objective: Skeletal survey is a commonly used means of detecting fractures in infants, and is used as a screen in suspected cases of physical abuse. It is recognised that in live infants, a repeat survey some days after a suspected episode of injury will detect more fractures than one taken shortly after the suspected injury, indicating that the latter lacks sensitivity. In infants who die soon after a suspected episode of physical abuse, the managing clinicians do not have the option of a second survey; however there is the opportunity for the microscopic examination of bones removed at autopsy. Increasingly Osteoarticular Pathology at the Manchester University NHS Foundation Trust (MFT) is being sent samples of bones from infants suspected of inflicted injury for histological examination, both from bones with fractures detected at autopsy or skeletal survey and from posterior ribs and long bone metaphyses (sites of significance in assessing for abusive injury) when there is no evidence of fracture on skeletal survey or autopsy. Here we report the results of an audit of the anonymised data from a series of such cases, to establish the sensitivity of skeletal survey (SS) to detect fractures and to define the medico-legal value of submitting bones for histological examination. Methods: This was an audit of skeletal injuries in 38 infants aged <18 months presenting to MFT for specialist histopathological evaluation of suspected non-accidental fractures between January 2011 and June 2017. Histopathological examination was performed on all bones submitted and compared with contact radiography of isolated bones and post-mortem skeletal surveys undertaken by specialist paediatric or musculoskeletal radiologists for the presence of fracture. Results: A total of 318 fractures were detected histologically; of these, 178 (56%) were of the ribs, 119 (37.5%) were of major limb long bones, 10 (3%) were of the skull, and 11 (3.5%) were recorded as 'other'. Excluding refractures, skeletal survey detected 54% of the fractures recorded histologically. No fractures were detected radiologically that were not seen histologically. Generally, for skeletal survey, detection rates improved with the age of the lesion, and rib fractures were more difficult to detect than long bone fractures. Ribs 5-8 were the most frequently fractured ribs, and metaphyses around the knee accounted for most metaphyseal limb long bone fractures undetected by SS. Conclusion: In infants coming to post-mortem, histopathology is more sensitive than SS for the detection of clinically significant fractures. In children suspected of non-accidental injuries but with negative or equivocal SS, sampling of the anterior and posterior end of ribs 5-8 and the bones around the knee for histological examination could reveal clinically unsuspected fractures and significant evidence of physical abuse. 71% of infants showed evidence of old fractures typical of non-accidental injury.

23. Uptake of medical devices approved by NICE

Authors Leng G.; Williams S.; Partridge G.; Sanghvi S.; Hung I.
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Abstract Background: The UK is sometimes considered to be slow in adopting new technologies. The recent Accelerated Access Review examined adoption challenges and identified opportunities for improvements. This study aims to determine the rate of uptake of selected new medical devices approved by the National Institute for Health and Care Excellence over a 10-year period, and to consider what factors may have influenced their uptake. Methods: The selected devices were approved at least 10 years ago to ensure there was sufficient data to review uptake trends. The devices that met the selection criteria were drug-eluting coronary artery stents, the brush used in liquid-based cytology, and fluid-filled thermal balloon and microwave endometrial ablation. Data on uptake were collected from the National Audit of Percutaneous Coronary Interventions (drug-eluting stents), the national cervical screening programme (liquid-based cytology) and Hospital Episode Statistics (endometrial ablation). Results: The technologies illustrated different uptake scenarios. Liquid-based cytology showed rapid and complete uptake, probably because it was a nationally driven programme. Neither drug-eluting stents nor endometrial ablation technologies were part of a national programme, and their uptake was slower. The uptake of stents has gradually increased to 88.5% of percutaneous coronary intervention procedures in the most recent data. For both fluid-filled thermal balloon and microwave ablation, there was an increase and then decline in uptake as other technologies were developed. Conclusions: The data show excellent uptake when promoted through a nationally managed programme. Uptake was slower when left to local systems. Obtaining good, reliable data about the use of medical devices in the National Health Service (NHS) is challenging - collecting real-world data linked to electronic patient records would allow us to better track the impact of new technologies in the future. More robust implementation plans may also increase the uptake rate of cost-effective and potentially life-saving technologies into the NHS.

24. Using the pain self-efficacy questionnaire (PSEQ) as a service outcome measure for a community-based chronic pain service

Authors Theron J.
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Abstract Purpose The NHS in East Kent serves a population of 750 000, managed by five different Clinical Commissioning Groups (CCGs). Pain services consist of a comprehensive multidisciplinary service within primary care (offered by the Community Trust) and an interventional service within secondary care (East Kent Hospitals University Foundation Trust). They work collaboratively to support patients to develop self-management strategies. There is a single point of access for referral letters, where triage is managed by senior clinicians. The Musculoskeletal Services Framework document published in 2006, led to the remodelling of the pain services previously based solely in secondary care. The biopsychosocial component with medicines management, non-pharmacological therapies and pain management programmes takes place in the community across several regional sites. Annual audits were being performed on the different treatment modalities and patient satisfaction. Key Performance Indices were published monthly but there was no measure in place to demonstrate the global improvement of a patient in their journey through the community service. Guidelines, like the IMMPACT recommendations, exist for measuring changes in individual patients. It was less clear how global changes relating to a service should be measured. The chosen method also had to be fast, user-friendly and computer compatible. Local commissioners indicated that they wanted to see that patients became more self-sufficient when attending the service. It was thus decided to trial the Pain Self-efficacy Questionnaire (PSEQ) as a service outcome measure. This tool measures the confidence patients have to manage different areas of their lives, despite being in pain. The higher the score (out of a potential 60), the better a patient is coping. It was anticipated that patients would score lower on entry into the service and would demonstrate higher scores on exit. Methods From Monday, 2 July 2014, all new patients referred to the service were posted the questionnaire and asked to provide their scores within a two week time frame by phone, otherwise they were not offered an appointment. Exceptions were those patients unable to fill in a form, for instance due to dementia or language difficulties. Entry scores were recorded on computer within the Trust clinical informatics system by administrative triage staff and exit scores were captured by the discharging clinician. After one year, all scores were extracted from the system by the Trust IT department. Results 1602 entry scores and 115 exit scores were captured. On entry into the service, 87 per cent of patients score 30/60 or less, 64 per cent score 20/60 or less, 30 per cent scored 10/60 or less, three per cent scored zero. On exit from the service, none scored zero and 75 per cent scored more than 30/60. These scores can be regarded as a 'snapshot' of entry and exit scores, as most were not from the same patients. There were 39 patients who had both an entry and exit score, with an average increase of 17 points (range minus three to +41). Only one patient scored less on exit. Records revealed that he developed a large disc prolapse and was discharged to undergo spinal surgery. There were no scores captured for those who were discharged because of non-attendance, those who discharged themselves by phone or those discharged in the first appointment. This still left a gap between the number of patients with a planned discharge and those with a recorded exit score. Clinicians had to be reminded to always do the questionnaire. Conclusions First year data revealed a clear trend in increased levels of confidence and self-efficacy in patients after receiving treatment from the community-based chronic pain service and thereby potentially a higher likelihood to self-manage. Although numbers were still low, both commissioners and clinicians were satisfied that the PSEQ was a suitable way of measuring the outcome of the service itself.

25. Impact of a commercial order entry system on prescribing errors amenable to computerised decision support in the hospital setting: A prospective pre-post study

Authors Pontefract S.K.; Shah S.; Hodson J.; Coleman J.J.; Slee A.; Girling A.J.; Williams R.; Sheikh A.
Source BMJ Quality and Safety; Sep 2018; vol. 27 (no. 9); p. 725-736
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Abstract Background In this UK study, we investigated the impact of computerised physician order entry (CPOE) and clinical decision support (CDS) implementation on the rate of 78 high-risk prescribing errors amenable to CDS. Methods We conducted a preintervention/postintervention study in three acute hospitals in England. A predefined list of prescribing errors was incorporated into an audit tool. At each site, approximately 4000 prescriptions were reviewed both pre-CPOE and 6 months post-CPOE implementation. The number of opportunities for error and the number of errors that occurred were collated. Error rates were then calculated and compared between periods, as well as by the level of CDS. Results The prescriptions of 1244 patients were audited pre-CPOE and 1178 post-CPOE implementation. A total of 28 526 prescriptions were reviewed, with 21 138 opportunities for error identified based on 78 defined errors. Across the three sites, for those prescriptions where opportunities for error were identified, the error rate was found to reduce significantly post-CPOE implementation, from 5.0% to 4.0% (P<0.001). CDS implementation by error type was found to differ significantly between sites, ranging from 0% to 88% across clinical contraindication, dose/frequency, drug interactions and other error types (P<0.001). Overall, 43/78 (55%) of the errors had some degree of CDS implemented in at least one of the hospitals. Conclusions Implementation of CPOE with CDS was associated with clinically important reductions in the rate of high-risk prescribing errors. Given the pre-post design, these findings however need to be interpreted with caution. The occurrence of errors was found to be highly dependent on the level of restriction of CDS presented to the prescriber, with the effect that different configurations of the same CPOE system can produce very different results.

26. INTRAOPERATIVE AND POSTOPERATIVE COMPLICATIONS IN PHACOVITRECTOMY FOR EPIRETINAL MEMBRANE AND MACULAR HOLE: A Clinical Audit of 1,000 Consecutive Eyes

Authors Fajgenbaum M.A.P.; Wong R.S.; Laidlaw D.A.H.; Williamson T.H.; Neffendorf J.E.
Source Retina (Philadelphia, Pa.); Sep 2018; vol. 38 (no. 9); p. 1865-1872
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Database EMBASE

Abstract PURPOSE: The aim of this study was to report the intraoperative and postoperative complications of phacovitrectomy for epiretinal membrane (ERM) and macular hole (MH).METHODS: This was a retrospective audit of 1,052 phacovitrectomy operations (410 for ERM and 642 for MH) by the same surgical team between 1998 and 2017. Outcome measures included rates of intraoperative anterior segment and posterior segment complications such as posterior capsule rupture and retinal breaks. A subgroup analysis of 189 procedures in which postoperative complications were rigorously recorded was also undertaken.RESULTS: The rate of posterior capsule rupture was 2.2%, with no difference between ERM and MH (1.7 vs. 2.5%; P = 0.40). Iatrogenic retinal tears were more common in MH than in ERM surgery (15.6 vs. 6.8%; P < 0.001). The chance of one or more anterior segment or posterior segment intraoperative complications occurring (excluding iatrogenic retinal breaks) was not associated with: indication for surgery, grade of surgeon, gauge of surgery, surgical machine, diabetic status, patient sex, or patient age. Subgroup analysis showed postoperative events as follows: posterior capsular opacification 10.6% (20/189), posterior synechiae 4.2% (8/189), uveitis 2.1% (4/189), angle closure glaucoma 1.6% (3/189), and rhegmatogenous retinal detachment 1.1% (2/189).CONCLUSION: Phacovitrectomy seems to be safe in phakic patients with ERM or MH, performed either by fellows or consultants. It avoids the requirement for repeat surgery and is more cost and resource efficient.

27. Learning from errors: assessing final year medical students' reflection on safety improvement, five year cohort study

Authors Tully V.; Murphy D.; Fioratou E.; Davey P.; Chaudhuri A.; Shaw J.
Source BMC medical education; Apr 2018; vol. 18 (no. 1); p. 57
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Database EMBASE

Abstract BACKGROUND: Investigation of real incidents has been consistently identified by expert reviews and student surveys as a potentially valuable teaching resource for medical students. The aim of this study was to adapt a published method to measure resident doctors' reflection on quality improvement and evaluate this as an assessment tool for medical students.METHODS: The design is a cohort study. Medical students were prepared with a tutorial in team based learning format and an online Managing Incident Review course. The reliability of the modified Mayo Evaluation of Reflection on Improvement tool (mMERIT) was analysed with Generalizability G-theory. Long term sustainability of assessment of incident review with mMERIT was tested over five consecutive years.RESULTS: A total of 824 students have completed an incident review using 167 incidents from NHS Tayside's online reporting system. In order to address the academic practice gap students were supervised by Senior Charge Nurses or Consultants on the wards where the incidents had been reported. Inter-rater reliability was considered sufficiently high to have one assessor for each student report. There was no evidence of a gradient in student marks across the academic year. Marks were significantly higher for students who used Section Questions to structure their reports compared with those who did not. In Year 1 of the study 21 (14%) of 153 mMERIT reports were graded as concern. All 21 of these students achieved the required standard on resubmission. Rates of resubmission were lower (3% to 7%) in subsequent years.CONCLUSIONS: We have shown that mMERIT has high reliability with one rater. mMERIT can be used by students as part of a suite of feedback to help supplement their self-assessment on their learning needs and develop insightful practice to drive their development of quality, safety and person centred professional practice. Incident review addresses the need for workplace based learning and use of real life examples of mistakes, which has been identified by previous studies of education about patient safety in medical schools.

28. The challenge pathway: A mixed methods evaluation of an innovative care model for the palliative and end-of-life care of people with dementia (Innovative practice)

Authors Harrop E.; Nelson A.; Noble S.; Rees H.; Harris D.
Source Dementia (London, England); Feb 2018; vol. 17 (no. 2); p. 252-257
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Available at Dementia from PubMed Central
Available at Dementia from Unpaywall
Abstract An innovative service for the palliative and end-of-life care of people with dementia was introduced at a UK hospice. This evaluation involved analysis of audit data, semi-structured interviews with project staff (n=3) and surveys of family carers (n=15) and professionals (n=20). The service has increased access to palliative, end-of-life care and other services. Improvements were reported in the knowledge, confidence and care skills of family carers and professionals. Carers felt better supported and it was perceived that the service enabled more patients to be cared for at home or in their usual place of care.

29. Association between age, deprivation and specific comorbid conditions and the receipt of major surgery in patients with non-small cell lung cancer in England: A population-based study

Authors Belot A.; Fowler H.; Njagi E.N.; Luque-Fernandez M.-A.; Maringe C.; Magadi W.; Exarchakou A.; Quaresma M.; Turculet A.; Rachet B.; Peake M.D.; Navani N.
Source Thorax; 2018
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Available at Thorax 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 Thorax from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Introduction: We investigated socioeconomic disparities and the role of the main prognostic factors in receiving major surgical treatment in patients with lung cancer in England. Methods: Our study comprised 31 351 patients diagnosed with non-small cell lung cancer in England in 2012. Data from the national population-based cancer registry were linked to Hospital Episode Statistics and National Lung Cancer Audit data to obtain information on stage, performance status and comorbidities, and to identify patients receiving major surgical treatment. To describe the association between prognostic factors and surgery, we performed two different analyses: one using multivariable logistic regression and one estimating cause-specific hazards for death and surgery. In both analyses, we used multiple imputation to deal with missing data. Results: We showed strong evidence that the comorbidities 'congestive heart failure', 'cerebrovascular disease' and 'chronic obstructive pulmonary disease' reduced the receipt of surgery in early stage patients. We also observed gender differences and substantial age differences in the receipt of surgery. Despite accounting for sex, age at diagnosis, comorbidities, stage at diagnosis, performance status and indication of having had a PET-CT scan, the socioeconomic differences persisted in both analyses: more deprived people had lower odds and lower rates of receiving surgery in early stage lung cancer. Discussion: Comorbidities play an important role in whether patients undergo surgery, but do not completely explain the socioeconomic difference observed in early stage patients. Future work investigating access to and distance from specialist hospitals, as well as patient perceptions and patient choice in receiving surgery, could help disentangle these persistent socioeconomic inequalities.

30. Post-mortem imaging in adults

Authors Smith A.P.; Traill Z.C.; Roberts I.S.
Source Diagnostic Histopathology; 2018
Publication Date 2018
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Database EMBASE
Available at Diagnostic Histopathology 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 Post-mortem computed tomography (PMCT), offers a non-destructive approach to the investigation of fatal injuries and the diagnosis of deaths from natural causes. Strengths of PMCT include the demonstration of fractures, internal haemorrhage, vascular disease and tumours. Imaging can be combined with minimally invasive techniques in the investigation of deaths secondary to sepsis, metabolic causes and drug toxicity. Unlike traditional invasive autopsy, PMCT creates an observer-independent permanent record of the findings that is amenable to audit, and may be used for courtroom or other demonstration. In the United Kingdom, PMCT is increasingly used as a first line technique in coronial investigation. The cause of death can be ascertained without open autopsy in the majority of cases. The use of PMCT in the UK is driven by religious and cultural objections to invasive autopsy, a shortage of autopsy pathologists and concerns regarding the quality of autopsies. Despite the backing of the Royal Colleges and the Chief Coroner, a number of logistical and financial challenges must be overcome in developing a national service.

31. Proceedings of the 2018 Spring Meeting of the Society of British Neurological Surgeons

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

Abstract The proceedings contain 117 papers. The topics discussed include: the impact of selective dorsal rhizotomy on the quality of life of ambulant children with diplegic cerebral palsy; conservative treatment of back pain: too much for too long; computer assisted trajectory planning for laser interstitial thermal therapy (LiTT) in mesial temporal lobe epilepsy; recruitment, safety and progress review; over halfway in the Dex-CSDH trial; glioblastoma resection surgery does not worsen pre-existing alexithymia (emotion recognition); early data from PRaM GBM patients using tablet-based cognitive testing; optimising trial recruitment using qualitative research methods: the ROAM (radiation versus observation following surgical resection of atypical meningioma) information study; MEMBRAIN project: update and provisional results of the UK national, prospective audit on the management evaluation of metastases in the brain; early radiotherapy impairs survival in glioblastoma; do standard prognostic scores for patients with brain metastases underestimate survival in a neurooncological practice?; boost radiotherapy for resected brain metastases; predictive factors for survival from breast cancer cerebral metastases: what should a neuro-oncology MDT look at?; safety and feasibility of a short stay protocol for patients undergoing craniotomy for gliomas and cerebral metastasis; new endocrine dysfunction following primary and revisional transphenoidal adenectomy; outcome of patients with near total excision of acoustic schwannomas, our experience; and the management of trigeminal neuralgia in patients with multiple sclerosis: a retrospective review from a tertiary referral centre.

32. CT scans for head injury - Are we NICE enough

Authors Harris L.; Axinte L.
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Available at British journal of neurosurgery from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Objectives: Head injury is a common presentation to the accident and emergency (A&E) department. It is important to differentiate between those who may suffer serious complications and those who can be safely discharged. Failure to do so can lead to disability and death. Adherence to guidelines is suboptimal and variable. Our study assesses adherence to NICE CT head guidelines at a large teaching hospital in the UK. It critically evaluates the efficacy of interventions designed to improve adherence. Design: We conducted a full-cycle clinical audit. Subjects: We examined medical records of patients requiring a CT head in A&E over a 1 month period in 2014, and in 2017. Methods: We focused on the indications for CT head, the time taken to scan, and the time to report. Interventions included an educational lecture to the multidisciplinary team, guideline checklists present in the A&E department for use as a reference or to attach to patient notes, and tri-annual education sessions aimed at each new intake of junior doctors. Results: Data was collected from 85 patients in cycle 1 and 86 in cycle 2. Following intervention, there was a statistically significant decrease of 23% in the number of CT heads requested with no clear indication ($p = 0.00027$). The mean time to scan for the one hour indications decreased from 73 to 55 minutes. The mean time to report all scans decreased from 89 to 57 minutes. Conclusions: This study shows that adherence to NICE guidelines for head injury is currently inadequate but can be improved by simple interventions.

33. MEMBRAIN project: Update and provisional results of the UK national, prospective audit on the management evaluation of metastases in the brain

Authors Jung J.; Ashkan K.; Vergani F.; Tailor J.
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Available at British journal of neurosurgery from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Objectives: To determine if brain metastasis referrals to the neurooncology MDT in UK & Ireland comply with current NICE guidelines and to understand how referrals are managed based on recursive partitioning analysis (RPA) and/or graded prognostic assessment (GPA). Design: A prospective multi-centre audit. Subjects: All adult patients referred to local MDT with 1 cerebral metastasis. Methods: After a 2 months trial at King's, neurosurgical units were invited to recruit patients prospectively for a period of 4 months from November 2017. Anonymised data on patient age, type/status of primary malignancy, performance status, location/ number of metastases, available imaging, treatment recommendation and length to decision making is entered into a secure online database. Results: A total of 25/32 units are participating. By end of November 2017, data on 25.8% of the target 500 patients had been submitted by 15/32 units; accrual rates predict completion by February 2018. Preliminary results from King's indicate mean of 7(range 5-9) referred cases per MDT. Median age of 66(range 36-91) years with 2:3 M:F ratio. Solitary metastases only comprise 45.07% of the referrals and surgery/SRS was recommended in 50.7% of cases. National results will be presented at the Autumn SBNS meeting. Conclusions: Preliminary prospective data fits with previous audit. This audit will help to draw up a national picture of brain metastases referrals and inform NICE on current work load and management.

34. Development of a ward round checklist to improve patient safety and flow on the neurosurgical ward

Authors Boissaud-Cooke M.; Jeffery T.; Mason T.; Sudhakar N.
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Available at British journal of neurosurgery from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.
Abstract Objectives: Efficient patient flow is essential to maintain operational capability of a tertiary neurosurgical service. The use of ward round structured checklists are increasingly used in surgical practice to reduce errors and improve safety but could have a role in improving flow. This project aims to develop a neurosurgical toolkit to improve documentation, facilitate early decision making and enhance multidisciplinary communication. Design: Plan-Do-Study-Act (PDSA) quality improvement methodology. Subjects: Neurosurgical ward patients in a single UK unit. Methods: Three consecutive ward round entries for each patient were reviewed before and after the intervention. Documentation of pre-defined key safety reviews were noted, as well as evidence of rehabilitation and discharge plans. Results: The introduction of a checklist improved documentation of: VTE prophylaxis (17% to 76%); resuscitation status (17% to 76%); review of lines (31% to 76%); dexamethasone weaning plan (20% to 83%); and antiepileptic drug duration (0% to 65%). Discharge and therapy planning also improved: fitness for discharge or repatriation (17% to 79%); outlier suitability (0% to 70%); therapy requirements (28% to 60%); and mobilisation plan (15% to 71%). Conclusions: The introduction of a ward round checklist has improved documentation and has been well received by members of the multidisciplinary team. Further review and development of the tool is required to optimise its implementation into regular practice and to assess its impact on safety and efficiency outcomes.

35. The British Association of Urological Surgeons radical cystectomy audit 2014/2015: An update on current practice, and an analysis of the effect of centre and surgeon case volume

Authors Khadhouri S.; Miller C.; McGrath J.S.; Cresswell J.; Rowe E.; Fowler S.; Housome L.
Source Journal of Clinical Urology; 2018
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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 Objective: The Consultant Outcomes Publication has made it mandatory to submit surgeon-level data on radical cystectomy (RC) practice in England. The current analysis describes contemporary surgical practice and compares this by surgeon and centre case volume. Materials and methods: Between 1 January 2014 and 31 December 2015, data on 3742 RCs performed by 161 surgeons over 84 centres were recorded on the British Association of Urological Surgeons audit and data platform. Centre case volumes were grouped as high (> 60), medium (30-60) and low (< 30), while surgeon case volumes were grouped as high (> 30), medium (8-30) and low (< 8). All data averages were for the combined 2-year period. Results: The median number of RCs performed was 16/surgeon and 31/centre; 45.4% of cases were performed for muscle-invasive transitional cell carcinoma (TCC). The commonest performed urinary diversion was ileal conduit (85.2%), followed by orthotopic bladder substitution (5.7%). Open radical cystectomy (ORC) was performed in 67.8%, robotically-assisted cystectomy (RARC) in 20.6% and laparoscopic cystectomy (LRC) in 9.1% of cases. RARC was more likely to be performed by high-volume surgeons and centres. The majority of patients underwent a lymph node dissection (LND), with rates varying from 79.5% to 90.3%. Reported rates of high-grade complication were generally low across all groups, suggesting under-reporting. There was a trend towards higher reported transfusion rates as centre volumes decreased. The median length of stay (LOS) was 7-9 days for minimally invasive approaches compared to open surgery, which was 11-12 days. Mortality rates were low across all groups. Conclusions: Compliance with the data registry is high. ORC remains the most common approach. High-case volume surgeons and centres more commonly offer RARC. The majority of patients undergo LND. There is a trend towards higher reported rates of transfusion as centre volume decreases. LOS is shorter in RARC and LRC in comparison to ORC, but is otherwise similar across centres and surgeons. Level of evidence: 2b.

36. UK & Ireland Prostate Brachytherapy Practice Survey 2014-2016

Authors Corey G.; Mitchell D.M.; Jain S.; Mohamed Yoosuf A.B.; Workman G.; Byrne M.
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Available at Journal of contemporary brachytherapy from PubMed Central

Abstract Purpose: To document the current prostate brachytherapy practice across the UK and Ireland and compare with previously published audit results. Material and methods: Participants from 25 centers attending the annual UK & Ireland Prostate Brachytherapy Conference were invited to complete an online survey. Sixty-three questions assessed the center's experience and staffing, clinician's experience, clinical selection criteria and scheduling, number of cases per modality in the preceding three years, low-dose-rate (LDR) pre- and post-implant technique and high-dose-rate (HDR) implant technique. Responses were collated, and descriptive statistical analysis performed. Results: Eighteen (72%) centers responded with 17 performing LDR only, 1 performing HDR only, and 6 performing both LDR and HDR. Seventy-one percent of centers have > 10 years of LDR brachytherapy experience, whereas 71% centers that perform HDR brachytherapy have > 5 years of experience. Thirteen centers have 2 or more clinicians performing brachytherapy with 61% of lead consultants performing > 25 cases (LDR + HDR) in 2016. The number of implants (range), that includes LDR and HDR, performed by individual practitioners in 2016 was > 50 by 21%, 25-50 by 38%, and < 25 by 41%. Eight centers reported a decline in LDR monotherapy case numbers in 2016. Number of center's performing HDR brachytherapy increased in last five years. Relative uniformity in patient selection is noted, and LDR pre- and post-implant dosimetry adheres to published quality guidelines, with an average post-implant D_{90} of > 145 Gy in 69% of centers in 2014 and 2015 compared to 63% in 2016. The median CT/US volume ratios were > 0.9 <= 1.0 (n = 4), > 1.0 <= 1.1 (n = 7), and > 1.1 (n = 2). Conclusion: There is considerable prostate brachytherapy experience in the UK and Ireland. An apparent fall in LDR case numbers is noted. Maintenance of case numbers and ongoing compliance with published quality guidelines is important to sustain high quality outcomes.

37. Improving emergency surgical care for patients with right iliac fossa pain at a regional scale: A quality improvement study using the Supported Champions implementation strategy

Authors Feinberg J.; Flynn L.; Woodward M.; Morgan L.; Tully P.; McCulloch P.; Higham H.; Holman L.; Pennell C.
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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 [location] : UHL Libraries On Request (Free).
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 [location] : British Library via UHL Libraries - please click link to request article.

Abstract Introduction: Methods to improve clinical systems safety suffer from significant difficulties in implementation and scaling up. We used an upscaling implementation strategy entitled Supported Champions in a quality and safety improvement programme for emergency surgery at regional level, focusing on patients with right iliac fossa pain. Methods: A before-after study was conducted across four acute NHS Trusts: A 6 month intervention phase was preceded and followed by 3 months of data collection. An established Human Factors intervention was led at each Trust by a small group of staff selected as Champions. Champions received training in teamwork and systems improvement and were supported by Human Factors experts. The primary improvement aim was to expedite surgery for patients with sepsis, using Royal College of Surgeons emergency surgery guidelines as the measure. Additional outcomes studied included length of inpatient stay and 30-day readmission rates. Results: Breaches of RCS urgency guidelines decreased markedly from 13.7% of operated patients pre-intervention to 3.5% post-intervention (p = 0.000). Mean time from booking to incision decreased in three of the four sites, whilst median length of stay increased in 3 of 4. Overall 30-day readmission rate remained stable (7.84% pre-intervention versus 7.31% post-intervention, p = 0.959). Discussion: The Supported Champions model allowed all surgical teams to reduce delay for septic patients by more than 50%, using distinct Quality Improvement strategies to address local issues. Improvement was implemented in 4 diverse settings with a quarter of the level of expert input previously used in a single hospital.

38. Why in Spain the kidney altruistic donation rate is lower that of other countries of our environment?

Authors Gracia M.; Martinez I.; Valentin M.; Ormeno M.; Dominguez-Gil B.
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Abstract Introduction: Spain has a national altruistic living kidney donation program since 2010. In this programthe evaluation of each candidate is structured in three consecutive steps, which must be overcome to advance the process: 1. Initial semi-structured telephone interview from the ONT. 2. Evaluation in a hospital with a kidney transplant program. 3. Evaluation in a hospital with crossover kidney exchange program. The real effectiveness of the Spanish programis lower than that published by neighboring countries such as: UK, Netherlands and USA. Objective: Describe the characteristics of potential candidates for altruistic renal donation in Spain and the causes of dismissal at each level of evaluation. Know the characteristics of those candidates who finally managed to donate their kidney. Method: Retrospective, descriptive study of the epidemiological, motivational and pathological characteristics of all candidates for altruistic kidney donation in Spain, between January 2010 and December 2016. Resulted: 182 people showed interest in the altruistic donation, 67% of these (n = 123) was rejected after the initial interview conducted from the ONT, and the main reasons were: Medical contraindication (35%) and loss of interest after receiving specific information about the process (27%). The candidates who passed this first interview (n = 59), had an average age of 51.3 years, they were Spanish (88%), with secondary or higher education (65%, n = 40), active in work (62%, n = 47), without a current partner (62%, n = 45), with children (56%, n = 46) and 100% (n = 44) recognized an altruistic life course (39% were blood donors; 29% NGO volunteers, 22% bone marrow donors, 20% organ donors after death). The main motivation recognized was: "Awareness of the need for society" (32%) and "Improve the quality of life of other people" (23%). In the first hospital evaluation, 39%(n=23) were dismissed, mainly as a result of detected medical and/or psychiatric contraindications (78%). In the second hospital evaluation, 44% candidateswere discarded (n=16), of which 65% were also due to medical and/or psychiatric contraindications. Finally, 13 of these candidates (7%total) satisfactorily surpassed the three levels of evaluation: 8 men and 5 women, with an average age of 49 years, with no medical history except overweight (2) and obesity (1). Conclusion: People, who present themselves as candidates for an altruistic kidney donation, have a history of helping others and a strong motivation towards donation. Asignificant number of candidates are rejected due to medical contraindications. It is necessary to perform an audit of medical contraindications to assess whether they are adequate.

39. Paediatric intensive care and neonatal intensive care airway management in the United Kingdom: the PIC-NIC survey

Authors Foy K.E.; Mew E.; Cook T.M.; Bower J.; Kelly F.E.; Knight P.; Dean S.; Herneman K.; Marden B.
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Available at Anaesthesia from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract In 2011, the Fourth National Audit Project (NAP4) reported high rates of airway complications in adult intensive care units (ICUs), including death or brain injury, and recommended preparation for airway difficulty, immediately available difficult airway equipment and routine use of waveform capnography monitoring. More than 80% of UK adult intensive care units have subsequently changed practice. Undetected oesophageal intubation has recently been listed as a 'Never Event' in UK practice, with capnography mandated. We investigated whether the NAP4 recommendations have been embedded into paediatric and neonatal intensive care practice by conducting a telephone survey of senior medical or nursing staff in UK paediatric intensive care units (PICUs) and neonatal intensive care units (NICUs). Response rates were 100% for paediatric intensive care units and 90% for neonatal intensive care units. A difficult airway policy existed in 67% of paediatric intensive care units and in 40% of neonatal intensive care units; a pre-intubation checklist was used in 70% of paediatric intensive care units and in 42% of neonatal intensive care units; a difficult intubation trolley was present in 96% of paediatric intensive care units and in 50% of neonatal intensive care units; a videolaryngoscope was available in 55% of paediatric intensive care units and in 29% of neonatal intensive care units; capnography was 'available' in 100% of paediatric intensive care units and in 46% of neonatal intensive care units, and 'always available' in 100% of paediatric intensive care units and in 18% of neonatal intensive care units. Death or serious harm occurring secondary to complications of airway management in the last 5 years was reported in 19% of paediatric intensive care units and in 26% of neonatal intensive care units. We conclude that major gaps in optimal airway management provision exist in UK paediatric intensive care units and especially in UK neonatal intensive care units. Wider implementation of waveform capnography is necessary to ensure compliance with the new 'Never Event' and has the potential to improve airway management.

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

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

41. Review of referral criteria to lipid clinics and outcomes of treatment in four UK centres

Authors Wierzbicki A.S.; Crook M.A.; Viljoen A.; Viljoen S.; Martin S.; Reynolds T.M.
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Available at International Journal of 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 [location] : British Library via UHL Libraries - please click link to request article.

Abstract Background: Little data exist on the referral patterns and effectiveness of lipid clinics. Methods: An audit was conducted in four clinics of 100 consecutive referrals each. Data were recorded on referral criteria, cardiovascular disease (CVD) risk factors, drug history, investigations, diagnoses, therapies, results and referrals. Results: Patients were aged 56 +/- 14 years, 47% were male and 87% were primary prevention. Risk factors included smoking (16%), type 2 diabetes (13%) and hypertension (13%). Referrals were made for hypercholesterolaemia (68%), diagnosis of FH (31%), statin intolerance (23%) and hypertriglyceridaemia (23%). Initial total cholesterol (TC) was 7.65 +/- 2.64 mmol/L, triglycerides (TG) 2.17 (0.41-76.9 mmol/L) mmol/L, HDL-C 1.53 +/- 0.71 mmol/L, LDL-C 4.57 +/- 1.66 mmol/L with non-HDL-C 5.90 +/- 2.09 mmol/L. Criteria for FH were met in 21% with genetic testing in 13% and lipid cascade testing in 30% of index cases. Triglycerides >20 mmol/L were present in 4%. The diagnosis was changed in 21%: hypercholesterolaemia (7%), mixed hyperlipidaemia (7%) and hypertriglyceridaemia (7%). Hepatic steatosis was identified in 14.5%. Lipoprotein(a) levels >125 nmol/L occurred in 41% in one clinic. Therapy changes included altered statins (40%), addition of a fibrate (11%) or ezetimibe (8%). These reduced TC by 1.92 mmol/L (19%; P = 0.0001), LDL-C 1.07 mmol/L (15%; P = 0.02), non-HDL-C 1.50 mmol/L (16%; P < 0.001), and TG 2.3 (-4 to 38) mmol/L (16%; P < 0.001) with 11% extra achieving TG <5 mmol/L while HDL-C increased by 7% (P = 0.37). Conclusions: Lipid clinics have diverse functions including diagnosis of FH, managing severe hypercholesterolaemia, mixed hyperlipidaemia and statin intolerance. Effectiveness criteria of average reductions of 1.5 mmol/L in TC or non-HDL-C, 1 mmol/L in LDL-C and 2 mmol/L in TG would be reasonable for newly referred patients.

42. Diagnosis, presentation and initial severity of Autoimmune Hepatitis (AIH) in patients attending 28 hospitals in the UK

Authors Gordon V.; Gleeson D.; Adhikary R.; Appleby V.; Das D.; Day J.; Delahooke T.; Dixon S.; Elphick D.; Hardie C.; Hoeroldt B.; Hooper P.; Hutchinson J.; Jones R.; Khan F.; Aithal G.P.; McGonigle J.; Nelson A.; Nkhoma A.; Pelitari S.; Prince M.; Prosser A.; Sathanarayana V.; Savva S.; Shah N.; Saksena S.; Thayalasekaran S.; Vani D.; Yeoman A.
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Abstract Background & Aims: There is limited information regarding patients with AIH outside relatively few large centres. We describe here the presenting features of patients with AIH, collected as part of an audit involving 28 UK hospitals. Methods: Patients (incident since 1/1/2007 or prevalent since 1/1/2000) were >=18 years and either met 1999 International AIH Group (IAIHG) diagnostic criteria (n = 1164), or received immunosuppressive therapy for clinically diagnosed AIH (n = 103). Results: Of 1267 patients (80% women, 91% Caucasian, age (median(range)) 55(8-86) years, 0.5% had acute viral hepatitis (CMV/EBV/HEV); 2% were taking Nitrofurantoin and 0.7% Khat. Twenty-one percent had clinical decompensation and/or a MELD score of >15. Time from first abnormal liver tests to diagnosis was >=1 year in 19% and was longer in jaundiced vs non-jaundiced patients. HBV and HCV serology were undocumented in 4%, serum immunoglobulins in 31% and autoantibodies in 11%-27%. When documented, >=1 antibody was present in 83%. LKM-1-positive and autoantibody-negative patients had more severe disease. Histological cirrhosis was reported in 23%, interface hepatitis 88%, predominant lymphocytes/plasma cells 75%, rosettes 19% and emperipolesis 0.4%. Only 65% of those meeting 1999 IAIHG criteria also met simplified IAIHG criteria. University Hospitals compared to District General Hospitals, were more likely to report histological features of AIH. Conclusions: This cohort from across the UK is older than other multicentre AIH cohorts. One-fifth had decompensation or MELD >15. Diagnosis was delayed in 19%, diagnostic testing was incomplete in one-third and rosettes and emperipolesis were infrequently reported.

43. Improving weekend review for trauma and elective orthopaedic patients in the post-operative period

Authors Khoury A.; Williamson M.; Slater G.; Jones M.; Buckle C.
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Abstract Purpose: Weekend surgery carries higher mortality than weekday surgery, with complications most commonly arising within the first 48 hours. There is a reduced ability to identify complications at the weekend, with early signs going undetected in the absence of thorough early patient review, particularly in the elderly with multiple co-morbidities. Weekend working practices vary amongst UK hospitals and specialties. The weekend effect has been a prominent feature in the literature over the past decade. The purpose of this paper is to identify the number of patients undergoing weekend surgery who receive a Day 1 post-operative review and improve this outcome by implementing an effective change. Design/methodology/approach: It was observed that not all patients undergoing surgery on a Friday or Saturday at the authors' District General Hospital were receiving Day 1 post-operative review by a clinician. A retrospective audit was carried out to identify percentage of patients reviewed on post-operative Day 1 at the weekend. A change in handover practice was implemented before re-audit. Findings: In Phase 1, 54 per cent of patients received Day 1 post-operative reviews at the weekend against a set standard of 100 per cent. A simple change to handover practice was implemented to improve patient safety in the immediate post-operative period resulting in 96 per cent of patients reviewed on Day 1 post-operatively at re-audit. Originality/value: This study confirms that simple changes in handover practices can produce effective and translatable improvements to weekend working. This further contributes to the body of literature that acknowledges the existence of a weekend effect, but aims to evolve weekend working practices to accommodate improvement within current staffing and resource availability by maximising efficiency and communication.

44. Prehospital emergency anaesthesia: An updated survey of UK practice with emphasis on the role of standardisation and checklists

Authors Burgess M.R.; Lockey D.J.; Perkins Z.B.; Crewdson K.
Source Emergency Medicine Journal; Sep 2018; vol. 35 (no. 9); p. 532-537
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Available at Emergency medicine journal : EMJ 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 Prehospital emergency anaesthesia (PHEA or 'prehospital rapid sequence intubation') is a high-risk procedure. Standard operating procedures (SOPs) and checklists within healthcare systems have been demonstrated to reduce human error and improve patient safety. We aimed to describe the current practice of PHEA in the UK, determine the use of checklists for PHEA and describe the content, format and layout of any such checklists currently used in the UK. Method A survey of UK prehospital teams was conducted to establish the incidence and conduct of PHEA practice. Results were grouped into systems delivering a high volume of PHEA per year (>50 PHEAs) and low volume (<=50 PHEAs per annum). Standard and 'crash' (immediate) induction checklists were reviewed for length, content and layout. Results 59 UK physician-led prehospital services were identified of which 43 (74%) participated. Thirty services (70%) provide PHEA and perform approximately 1629 PHEAs annually. Ten 'high volume' services deliver 84% of PHEAs per year with PHEA being performed on a median of 11% of active missions. The most common indication for PHEA was trauma. 25 of the 30 services (83%) used a PHEA checklist prior to induction of anaesthesia and 24 (80%) had an SOP for the procedure. 19 (76%) of the 'standard' checklists and 5 (50%) of the 'crash' induction checklists used were analysed. On average, standard checklists contained 169 (range: 52-286) words and 41 (range: 28-70) individual checks. The style and language complexity varied significantly between different checklists. Conclusion PHEA is now performed commonly in the UK. The use of checklists for PHEA is relatively common among prehospital systems delivering this intervention. Care must be taken to limit checklist length and to use simple, unambiguous language in order to maximise the safety of this high-risk intervention.

45. Trabeculectomy bleb needling and antimetabolite administration practices in the UK: A glaucoma specialist national survey

Authors Mercieca K.; Drury B.; Fenerty C.; Bhargava A.
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Available at The British journal of ophthalmology from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Aims To evaluate, describe and quantify the diversity in postoperative antimetabolite administration and bleb needling practices among glaucoma specialists performing trabeculectomy surgery within the UK and Ireland. Methods A cross-sectional online survey was distributed to all consultant glaucoma specialists who are on the United Kingdom and Eire Glaucoma Society (UKEGS) contact list. Participants were asked specific questions about their current practices for post-trabeculectomy antimetabolite administration followed by questions directly related to bleb needling procedures. Results 60 (83%) of UKEGS glaucoma subspecialty consultants completed the survey. 70% of respondents administered 5-fluorouracil (5-FU) in their clinic room while 30% used a separate treatment room. Doses of 5-FU varied considerably but 70% used 5 mg as standard. Techniques used to reduce corneal toxicity included precipitation with amethocaine (44%) or benoxinate (14%), saline wash (14%) and modified injection technique (8%). Topical antibiotics and/or betadine were used to prevent infection following 5-FU injection in just over 50%. Bleb needling was exclusively performed in operating theatre by 56% of respondents and solely at the slit lamp in the clinic room by 12%. A further 30% used a combination of both theatre and outpatient clinic rooms. Anti-metabolites used were 5-FU (72%) and mitomycin C (22%) with 12% using either of the two substances. Conclusions There is a significantly wide variety of current practices for antimetabolite administration and bleb needling within the UK and Ireland. This may be influenced by a glaucoma surgeon's specific experience and audit results as well as particular clinical set-up, availability of antimetabolite and clinic room space.

46. Validity of neurodevelopmental outcomes of children born very preterm assessed during routine clinical follow-up in England

Authors Wong H.S.; Cowan F.M.; Modi N.

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Abstract Objective To determine the validity of assessing and recording the neurodevelopmental outcome of very preterm infants during routine clinical follow-up in England. Design Children born <30 weeks gestation, attending routine clinical follow-up at post-term ages 20-28 months, were recruited. Data on neurodevelopmental outcomes were recorded by the reviewing clinician in a standardised format in the child's electronic patient record, based on a set of key questions designed to be used without formal training or developmental testing. Using a predefined algorithm, each participant was classified as having 'no', 'mild/moderate' or 'severe' impairment in cognitive, communication and motor domains. All participants also received a research assessment by a single assessor using the Bayley Scales of Infant Development, third edition (Bayley-III). The sensitivity and specificity of routine data in capturing impairment (any Bayley-III score <85) or severe impairment (any Bayley-III score <70) was calculated. Results 190 children participated. The validity of routine assessments in identifying children with no impairment and no severe impairment was high across all domains (specificities 83.9%-100.0% and 96.6%-100.0%, respectively). However, identification of impairments, particularly in the cognitive (sensitivity 69.7% (55.1%-84.3%)) and communication (sensitivity (53.2% (42.0%-64.5%)) domains, was poor. Conclusions Neurodevelopmental status determined during routine clinical assessment lacks adequate sensitivity in cognitive and communication domains. It is uncertain whether this reflects the assessment or/and the recording of findings. As early intervention may improve education and social outcomes, this is an important area for healthcare quality improvement research.

47. Audit of safety and quality of selfexpanding metallic stent (SEMS) insertion in patients with dysphagia

Authors Lim E.L.P.; Davies A.H.G.
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Abstract Introduction: Dysphagia is a common symptom in late stages of upper gastrointestinal(GI) malignancy. The main aim in palliative treatment is to achieve patency of the digestive tract. In patients with oesophageal cancer and life expectancy of less than 3 months the best therapeutic option would be for oesophageal stenting. Material and Methods: A retrospective audit was performed in patients who had an endoscopic stent insertion in 2015 across a trust in the UK. The British Society of Gastroenterology(BSG) guidelines were used to outline the measures of this audit. Information from case notes were extracted electronically. Results: 19 patients were found to have had endoscopic stent insertions but 1 patient was excluded due to a GI bleed related stent insertion. Out of the 18 patients all patients had a malignant cause (oesophageal gastric pancreatic duodenal). The median time from diagnosis to stent insertion was 21(IQR 7-192) days. All patients had a radiographic confirmation post-stent insertion to ensure satisfactory stent position. Only one patient (5.5%) required radiographic assistance throughout the procedure. All patients had the procedure within working hours with full surgical access for possible complications. Only 1 patient (5.5%) was found to have a stent insertion preceding their MDT discussion. However none of these patients had any documentation of dysphagia scores. There were 7 complications identified in 5 patients (27.7%) (immediate = 1 early = 3 late = 3). Re-intervention was noted in 2 patients (11.1%) (dilatation = 1 restenting = 2). The 30-day mortality rate was n = 3 (16.7%) with 1 patient remaining alive and the median survival rate of 150(IQR 4-480) days. Conclusion: The use of SEMS in palliative patients with dysphagia in our trust has been satisfactory against the set guidelines by the BSG and comparable to previous studies. However we need to incorporate dysphagia scores pre and post SEMS to identify improvement of symptoms.

48. The malnutrition universal screening tool (MUST) identifies nutritional and clinical outcome in stroke patients

Authors Hamdy S.; Kama Y.; Lal S.; Smith C.; Burden S.
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Available at Dysphagia 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: Malnutrition is commonly seen in patients after a stroke. In addition malnutrition is associated with poor clinical outcome in these people (1 2) with a prevalence that varies widely from 6.1 to 62% (3). This study aimed to establish the true prevalence of malnutrition is among patients after stroke and whether the malnutrition universal screening tool (MUST) can be used as an independent predictor of clinical outcome in stroke victims. Method: This is a retrospective observational cohort study using patients' records who have been admitted to stroke unit at a large teaching hospital in the North West of England and who have had MUST as part of routine care from January 2013 to March 2016. The cohort data utilised information obtained from the Sentinel Stroke National Audit Programme (SSNAP). Results: Of 1101 patients 51% were women the mean age of 73.6 years and 88.7% had an ischemic stroke. Of these while the majority of patients (78.5%) had no risk of malnutrition 17.3% had high risk and 4.1% had medium risk.Additionally the association between risk of malnutrition and clinical outcomes was both significant and proportional (i.e. the greater the risk of malnutrition the higher the possibility of poorer outcomes). For those who had greater risk of malnutrition (high vs.medium) their hospital stay was longer (P B 0.023 vs. P B 0.033). In the high risk group mortality was higher both within the hospital admission (P<0.001) and at 6 months follow-up (P<0.001) and infectionsmore prevalent (P<0.001). Conclusion: Malnutrition is prevalent in the stroke population. Furthermore the application of the MUST as an independent predictor of clinical outcomes can be used in health care settings in acute stroke. Early identification of risk of malnutrition in stroke and provision of early nutritional interventions are likely to become an important priority for health services with potential improved clinical outcomes and resources saving.

49. Are morbidity and mortality case review practices in Scottish intensive care units aligned to national standards?

Authors Al-Haddad M.F.; Cadamy A.; Black E.; Slade K.
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Available at Journal of the Intensive Care Society from PubMed Central
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Abstract Introduction: Both Scottish and UK standards guidelines recommend that intensive care units should hold regular, structured, multidisciplinary morbidity and mortality meetings. The aim of this survey was to ascertain the nature of current practice with regards to morbidity and mortality case reviews and meetings in all intensive care units in Scotland. Methods: Semi-structured telephone interviews were conducted with a consultant from all Scottish intensive care units. A list of intensive care units in Scotland was obtained from the Scottish Intensive Care Society Audit Group annual report. Results: All 24 intensive care units (100%) in Scotland were surveyed. The interviews took an average of 20 min. The three cardiac intensive care units were excluded from analysis. All other intensive care units had morbidity and mortality meetings and 18 units had a morbidity and mortality clinical lead. Nineteen intensive care units held joint morbidity and mortality meetings, eight of which were regular. In all intensive care units, meetings were attended by consultants and trainees. In 14 intensive care units, meetings were attended by nurses, seven by allied health professionals, 1 by a manager and 11 by other professionals. All mortality cases in intensive care unit were discussed in 19 intensive care units, in the other two intensive care units, 10-20% of mortality cases were discussed. Conclusion: There is a wide variation in the processes of reviewing mortality cases and significant events in intensive care units across Scotland, and in the way morbidity and mortality meetings are organised and held. Based on this survey, there is scope for improving the consistency of approach to morbidity and mortality case reviews and meetings in order to improve education and facilitate shared learning.

50. Advancing quality in sepsis management: A large-scale programme for improving sepsis recognition and management in the North West region of England

Authors Nsutebu E.F.; French N.; Ibarz-Pavon A.B.; Kanwar E.; Prospero N.; McGrath C.
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Available at Postgraduate 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 Objective: To evaluate the impact of a collaborative programme for the early recognition and management of patients admitted with sepsis in the northwest of England. Setting: 14 hospitals in the northwest of England. Intervention: A quality improvement programme (Advancing Quality (AQ) Sepsis) that promoted a sepsis care bundle including time-based recording of early warning scores, documenting systemic inflammatory response syndrome criteria and suspected source of infection, taking of blood cultures, measuring serum lactate levels, administration of intravenous antibiotics, administration of oxygen, fluid resuscitation, measurement of fluid balance and senior review. Main outcome measures: Inpatient mortality, 30-day readmission rates and duration of hospital >=10 days. Results: Data for 7776 patients were included in this study between 1 July 2014 and 29 December 2015. Participation in the AQ Sepsis programme was associated with a reduction in readmissions within 30 days (OR 0.81 (0.69-0.95)) and hospital stays over 10 days (OR 0.69 (0.60-0.78)). However, there was no reduction in mortality. Administration of a second litre of intravenous fluid within 2 hours, oxygen therapy and review by a senior clinician were associated with increased mortality. Starting a fluid balance chart within 4 hours was the only clinical process measure that did not affect mortality. Taking a blood culture sample, administering antibiotic therapy and measuring serum lactate within 3 hours of hospital arrival were all associated with reduced mortality (OR 0.69 (0.59-0.81), OR 0.77 (0.67-0.89) and OR 0.64 (0.54-0.77), respectively) and shorter hospitalisations (OR 0.58 (0.49-0.69), OR0.81 (0.70-0.94) and OR 0.54 (0.45-0.66), respectively). However, none of these measures had an impact on the risk of readmission to hospital within 30 days. Conclusions: The AQ Sepsis collaborative in northwest of England improved readmission and length of stay for patients admitted with sepsis but did not affect mortality. Further cost-effectiveness evaluation of the programme is needed.

51. 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.
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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.

52. 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.
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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.

53. Jugglers and tightrope walkers: The challenge of delivering quality community pharmacy services

Authors Watson M.C.; Skea Z.C.
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Abstract Introduction This is the first exploration of service providers' attitudes and beliefs of quality and quality improvement in the community pharmacy setting in the UK. Materials and methods A series of interviews and focus groups was conducted with stakeholders from the pharmacy profession in the UK. Interviews were semi-structured and conducted face-to-face or by telephone. Focus groups were conducted with naturally-occurring groups i.e. at pharmacy conferences. Interviews and focus groups were audio-recorded, transcribed and analysed systematically using an interpretive approach. Results Forty-two individuals participated across four focus groups and four interviews. A maximum variation sample was achieved in terms of pharmacist and pharmacy characteristics. Participants were generally positive about the need for quality and quality improvement and provided multifaceted and interlinked interpretations of quality and acknowledged its dynamic nature "quality moves forward". The challenge of standardising practice whilst providing person-centred care emerged: "you don't want to lose the personal touch, but you can't have people having a variable experience and one day it's fantastic and the next day it isn't". A variety of quality measurement methods were identified including direct observation (by internal and external agents) and feedback (mystery shoppers, colleagues, regulatory inspectors, service users), suggesting that standardisation was also needed in terms of future quality measurement. There was a tendency to report negative events as triggers for improvement. Future initiatives could adopt more positive approaches including positive deviants "There's nothing more powerful than people who've come up with something really good sharing it with their other colleagues". Discussion The results are being used to develop and evaluate future quality improvement initiatives in this sector. These are likely to be targeted at organisational, team and individual levels.

54. Evaluation of the cost-effectiveness of rifaximin-alpha for the management of patients with hepatic encephalopathy in the United Kingdom

Authors Berni E.; Conway P.; Currie C.J.; Murphy D.; Whitehouse J.; Di Maggio P.; Poole C.
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Publication Type(s) Article In Press
Database EMBASE
Available at Current Medical Research and Opinion 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: Rifaximin-alpha 550 mg twice daily plus lactulose has demonstrated efficacy in reducing recurrence of episodes of overt hepatic encephalopathy (OHE) and the risk of hepatic encephalopathy (HE)-related hospitalizations compared with lactulose alone. This analysis estimated the cost effectiveness of rifaximin-alpha 550 mg twice daily plus lactulose versus lactulose alone in United Kingdom (UK) cirrhotic patients with OHE. Method: A Markov model was built to estimate the incremental cost-effectiveness ratio (ICER). The perspective was that of the UK National Health Service (NHS). Clinical data was sourced from a randomized controlled trial (RCT) and an open-label maintenance study in cirrhotic patients in remission from recurrent episodes of OHE. Health-related utility was estimated indirectly from disease-specific quality of life RCT data. Resource use data describing the impact of rifaximin-alpha on hospital admissions and length of stay for cirrhotic patients with OHE was from four single-center UK audits. Costs (2012) were derived from published sources; costs and benefits were discounted at 3.5%. The base-case time horizon was 5 years. Results: The average cost per patient was 22,971 in the rifaximin-alpha plus lactulose arm and 23,545 in the lactulose arm, a saving of 573. The corresponding values for benefit were 2.35 quality adjusted life years (QALYs) and 1.83 QALYs per person, a difference of 0.52 QALYs. This translated into a dominant base-case ICER. Key parameters that impacted the ICER included number of hospital admissions and length of stay. Conclusion: Rifaximin-alpha 550 mg twice daily in patients with recurrent episodes of OHE was estimated to generate cost savings and improved clinical outcomes compared to standard care over 5 years.

55. Happy hour on the stroke unit at POWH

Authors Douglas C.; Holyday M.; Collier A.; Meletis M.
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Available at International journal of stroke : official journal of the International Stroke Society 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 swallowing difficulties, particularly those reliant on thickened fluids, are at an increased risk of dehydration. A recent audit at Prince of Wales Hospital (POWH) showed that patients requiring thickened fluids were only meeting 30% of their fluid requirements. Method: A 'Happy Hour' Service was trialled on the Stroke Unit of POWH. It offered non alcoholic beer and wine and mocktails which could be thickened if required. Results: It proved to be an effective method to improve the fluid intake of all patients on the POWH Stroke Unit, including a 44% increase at afternoon tea for patients requiring mildly thick fluids. The service was timely and all consumables were easily attainable. It provided a greater variety of drink options which, according to the patient satisfaction survey, both looked and tasted better when compared to the normal tea trolley service. Feedback collected from both nursing staff and patients during the Trolley Service indicated a positive change in ward atmosphere. Conclusion: For the Happy Hour Trolley to continue, a sustainable work force is required. It is feasible for the trolley to be run by one person per service who has been trained in the provision of thickened fluids. Options of suitable personnel for this role include Allied Health staff, nursing staff or volunteers. In the future we hope to implement a Happy Hour Service on the stroke unit at POWH with a vision to expand to other wards in need.

56. Audit of patients attending optometry led diabetic retinopathy screening slit-lamp clinic in braid valley health & care centre (NHSCT)

Authors Foster M.; Moore J.; McKeown B.; Peto T.
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Abstract DESIGN. Retrospective Audit PURPOSE. This audit analyses patient attendance and outcomes for the first 6-months of the Optometry led Slitlamp clinic of the Diabetic Eye Screening Programme Northern Ireland (NIDESP). METHODS. Patients attending the newly established Optometry led NIDESP Slit-lamp Clinic, between June- December 2017 were reviewed for accuracy of referrals, attendance and patient outcomes. RESULTS. Altogether, 158 patients were invited, of which 143 (90.5%) attended the Slit-Lamp Clinic in Braid Valley Health & Care Centre. Of those attending, 113 (79%) were referred for cataract; 8 (5.6%) for learning disability or poor compliance; 6 (4.2%) for small pupils; 6 (4.2%) for posterior capsular opacification; 4 (2.8%) for asteroid hyalosis; 6 (4.2%) for other conditions: keratoconus, ptosis, epi-retinal membrane, corneal dystrophy, extensive laser photocoagulation, myopic retinal degeneration. Following Slit lamp clinic assessment and grading; 17 (11.9%) were referred to hospital eye services (HES) for inadequate retinal view: [10 (7%) cataract; 4 (2.8%) posterior capsular opacification; 2 (1.5%) asteroid hyalosis; 1 (0.7%) learning disability]. Thirteen (9.1%) patients were returned to annual photography screening, while 4 (2.8%) were placed in digital surveillance for close monitoring. The remaining 109 patients were retained in the Slit-lamp clinic. CONCLUSIONS. The vast majority of the patients (88.1%) required no further referral to HES and could safely be retained in the Optometry led Slit-lamp clinics within NIDESP. These patients remain under the care of specialist Optometrist-led clinical monitoring, which is the correct pathway to ensure their clinical needs are met in one appointment. This reduces the burden on both the patient and upon ophthalmology services. The evidence shows that increased availability of this clinical pathway, should further enhance the efficiency and specificity of the Northern Ireland Diabetic Screening Services' patient management.

57. No longer diabetic according to the diabetic eye screening programme northern Ireland database: Myth or truth?

Authors Robinson R.; Robinson R.S.; McElduff P.; Jelly A.; Peto T.
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Abstract DESIGN. Retrospective Audit PURPOSE. The aim of the audit was to identify patients that are classified as "no longer diabetic" and as such are excluded from the annual Diabetic Retinopathy Screening Programme of Norther Ireland (NIDESP). The timeframe for the audit was the year 2016, as NIDESP implemented the national screening pathway in that year. METHODS. NIDESP's database is run on that nationally approved software Optomize where patients are marked as "Off Register - No longer Diabetic" when such a patient is either found during screening or reported by various sources from community healthcare. In any case, the patients' GPs must confirm that the patient does not suffer from diabetes any longer. Those patients who had pancreas transplant and are off insulin should still be screened. All patients who were on this exclusion list were audited by checking their data against the national database and their general practitioners (GPs) were contacted to confirm the diabetic status of each patient. RESULTS. In the calendar year of 2016, 46 patients (0.1% of total screened) were flagged as "Off Register - No longer diabetic". Of these, 21 (46%) were male. Patients aged 60 and over made up the majority of the patients in this group (83%). Reporting sources were patients, relatives, and GP surgeries. After seeking confirmation by the relevant GPs, 25 (54%) patients were found to have diabetes and 19 (41%) were confirmed not to have diabetes warranting re-screening anymore (gestational diabetes and coding error being the most common reason), while 2 (5%) deceased in the interim. Of those who still had diabetes and had been screened 25% had diabetic retinopathy. One exclusion was due to combined kidney-pancreas transplant, the patient subsequently developed vitreous haemorrhage in the lasertreated eyes. CONCLUSIONS. More than half of the patients deemed "no longer diabetic" and excluded from screening were found to still have diabetes and some diabetic eye disease at the time of re-screening.

58. Acute angle closure glaucoma in the Northern Ireland diabetic retinopathy screening programme

Authors Lagan M.; O'Gallagher M.; Johnston S.; Peto T.
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Available at European journal of ophthalmology 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 DESIGN. Retrospective audit of all acute ophthalmic centres in Northern Ireland. PURPOSE. Is diabetic screening associated with angle closure glaucoma from dilated mydriasis? METHODS. The care of acute ophthalmic emergencies in Northern Ireland is co-ordinated by 2 centres. We identified using clinical coding all presentations of acute angle closure from January 2007 to December 2010. We cross referenced patient details with NIDRSP records, identifying cases where the diagnosis or procedure occurred within 14 days of a screening episode. RESULTS. The risk of angle closure was 1 in 31755. CONCLUSIONS. Acute angle closure within the diabetic screening service is rare. The patients presented promptly, 2 within 24 hours. None has suffered severe vision loss as a result. Patients should be informed of the symptoms and advised to represent promptly.

59. The power of words: Letters from a diabetic retinopathy screening programme

Authors Wright S.; Bowles R.; O'Hare P.; Peto T.; Findlay-White F.
Source European Journal of Ophthalmology; May 2018; vol. 28 ; p. 10-11
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Abstract DESIGN. Prospective audit of patient letters in the Diabetic Eye Screening Programme in Northern Ireland (NIDESP). PURPOSE. NIDESP adopted the nationally approved Optomize Diabetic Retinopathy Screening Software in February 2017, patient and healthcare professional letters have been sent since. The purpose of this audit was to evaluate time taken to generate the letters, their acceptance to the patients, Diabetes UK patient groups and if the correct letters have been generated by the software. METHODS. Altogether 98,428 patients are knows to NIDESP, of these 69.2% have been screened in the past year. Letters are automatically generated by Optomize at the end of each appropriate pathway, but the wording of the letters can be modified locally. National criterion is that 99% of the letters should be sent within 6-weeks of screening. The letters' wording must be acceptable locally and appropriate letters are expected to be generated. Twelve different outcome letters were chosen, and 655 individual patient letters were audited. The wording of these was discussed at Diabetes UK Focus groups and with ophthalmologists, and subsequently the timing and the correctness of the letters were checked manually. RESULTS. The outcomes of the 12 letters audited were for different levels of diabetic retinopathy (DR) including ungradables and those referred for other-than-DR. All but one letter type were sent within 5 days of grading (2.8-4.7 days), and patients groups approved 7/12 as they stood. For the other 5 letters most suggestions were minor comments. The proliferative DR letter was deemed to have alarming wording and was requested to be rewritten. Thirty-two of the 655 audited letters were adequate but not wholly accurate, and 12/655 were completely incorrect despite the patient being in the appropriate clinical pathway. CONCLUSIONS. NIDESP sent letters within the recommended guidelines, however in some cases incorrect letters were generated, much to the alarm of patients and healthcare-professionals. Patient groups provided absolutely invaluable input into wording of letters. Close collaboration with Diabetes UK and detailed analysis of the pathways shed light on issues never thought to exist.

60. Audit of attendance and disease severity in paediatric type 1 diabetes mellitus patients in the belfast trust

Authors Davison R.; Peto T.
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Abstract DESIGN. Audit of all paediatric patients with type 1 diabetes mellitus aged 12 and over. PURPOSE. To audit if all paediatric patients with Type 1 diabetes mellitus aged 12 and over (PPwT1DM) are present on the Northern Ireland Diabetic Eye Screening Programme (NIDESP) database and that they are receiving appropriate diabetic retinopathy (DR) screening and if required, ophthalmic care when compared to relevant UK DESP standard care (Standard DES-PS-1: 100% of patients over the age of 12 are on the DESP database). METHODS. Altogether 113 such patients were identified by the Paediatric Diabetes Clinic at the Belfast Trust on the 11th June 2017 and subsequently the NIDESP records of these patients were scrutinized for attendance, DR severity and ophthalmic care. RESULTS. Seven patients were not known to NIDESP, six of them were between the age of 12 and 13 at the time of data collection. Of those known to NIDESP, 20.8% (22 patients) failed to attend or respond to NIDESP screening invitation. Of those who attended, 88.6% (70 patients) had no DR in either eye on the images. The rest (9 patients) had mild-moderate DR. No PPwT1DM had referable DR or maculopathy according to the UK DESP DR or maculopathy grading criteria. Two non-attenders had complex medical problems and were subsequently seen in eye-clinic and appropriately excluded from NIDESP. CONCLUSIONS. Our audit shows that there is a delay in referral to NIDESP once patients turn 12. Of those known to NIDESP, about 1 in 5 does not attend the appointment offered, and of those attending, 1:10 already has DR at such a young age. While our results are similar to those of other UK programmes, it is imperative that better collaboration is built between paediatric diabetes and eye care services in NI. As a result of this audit, direct email based referral from the paediatric diabetes clinic to NIDESP has been instituted without having to go through the patients' GP; this resulted in immediate referral at the age of 12 in 7 cases since inception of this service.

61. Accuracy of hospital eye service discharge list: Transfer from clinic to diabetic retinopathy screening in northern Ireland

Authors McKeown B.; Peto T.
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Abstract DESIGN. Retrospective cohort study PURPOSE. This audit investigated that no patients were lost as they were discharged from hospital eye service (HES) to the Northern Irish Diabetic Retinopathy Screening Programme (NIDESP) and that patients were subsequently screened in a timely manner. Patients were discharged either due to their treatment being complete or due to non-attendance/no contact with HES. As there was no systematic electronic discharge letter from HES/ hospital administrator to NIDESP, it was deemed possible that patients were discharged from HES, but not screened. METHODS. Patients with diabetes mellitus (PwDM) discharged between September 2015 and October 2016 from the Belfast Health and Social Care Trust were identified using the hospital's database. These patients were then cross-referenced with NIDESP's Optomize database. Those not found on the database were investigated further and where appropriate, an appointment at NIDESP was supplied. RESULTS. Altogether 2485 PwDM were identified on the HES discharge list, of these 123 could not be matched to the NIDESP's database and were deemed to be "potentially not transferred". For this cohort of PwDM a detailed search was conducted on the Northern Irish Electronic Care Record (NIECR). Seventy-four of these PwDM were identified as deceased and not investigated further. Of the remaining 49 patients, 18 were not known to NIDESP and had no known address and GP on NIECR and therefore were non-contactable. The remaining 31 patients were matched using detailed demographic search and were found to be in the correct clinical pathway on NIDESP. The outcome of these 31 patients: 15 no diabetic retinopathy (DR), 6 mild DR, 8 cancelled, 1 patient could not be contacted and 1 passed away in the interim. CONCLUSIONS. There was a small, but not insignificant number of patients who were identified as not transferred to NIDESP. The vast majority of these patients were either deceased or non-contactable. Of those screened subsequently, none required treatment. This audit highlighted the importance of good communication between HES and NIDESP and the importance of NIECR as an essential method of tracking patients.

62. Audit of those patients with no perception of light recorded in the northern Irish diabetic eye screening programme (NIDESP)

Authors McElduff P.; Jelly A.J.; Peto T.
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Available at European journal of ophthalmology 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 DESIGN. Retrospective Cohort Study PURPOSE. To ensure all patients with vision better than NPL in at least one eye were re-invited for screening. To ensure patients are correctly registered as sight impaired/severely sight impaired and receive appropriate Low Vision support. METHODS. Information was collected from the Northern Ireland Electronic Care Record (NIECR), Medisoft and the five Northern Ireland Sensory Support Teams and inputted in an Excel database. RESULTS. Of the 53 patients (28 females; age range of 33-95 years) recorded as having NPL on NIDESP's database, altogether, 14 were confirmed to have NPL in both eyes, 21 had better than NPL in at least one eye, the rest of the patients had no information available on their vision in any of the electronic databases (6 since deceased and 7 are not contactable at present). There were 35 patients registered as Severely Sight Impaired (SSI) and 2 patients as Sight Impaired (SI), but eligible for SSI. Three patients were eligible for SSI registration but not registered. Of those registered the causes were Diabetic Retinopathy in 34% of cases, Glaucoma 11%, Retinal Dystrophy 11%, Trauma 9%, ARMD 3%, Other 12% and no information 20%. CONCLUSIONS. All patients with vision better than NPL in at least one eye were re-invited for screening and are now in the appropriate clinical pathway. All those who could be registered as SI/SSI but have not done so are being seen in eye clinics to discuss the benefits of registration. There is further education needed so all clinical/ administrative staff understands this exclusion criteria so it is applied correctly.

63. Reduction in blindness rates since the introduction of digital photographic screening in an English diabetic eye screening programme

Authors Dale A.; Stratton I.M.; Aldington S.J.; Price K.; Scanlon P.H.
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Abstract DESIGN. Retrospective audit PURPOSE. To determine changes in rates of blindness in an area covered by an English diabetic eye screening programme METHODS. A systematic retinal screening programme for people with diabetes was introduced in 1998. Causes of blindness have been recorded since August 2005 RESULTS. Between August 2005 and July 2008, 16 people were registered with Seriously Sight Impairment (SSI) or blind with principal cause diabetic retinopathy (DR) (annual rate 25.4 per 100,000 of those with diabetes (95% confidence intervals 15.0 to 40.4) and a further 26 registered as Sight Impaired (SI) or partially sighted with principal cause DR (annual rate 41.3 per 100,000 of those with diabetes (95% c.i. 27.6 to 59.6). Between April 2014 and March 2017, there were 2 notifications of SSI or blindness due to DR (annual rate 2.0 per 100,000 with diabetes, 95% c.i. 0.3 to 6.7) and 10 notifications of SI or partial sight (10 per 100,000 with diabetes (95% c.i. 5.1 to 17.9). The reductions in rates of SSI or blindness and in SI were significant (p<0.0001 for both). CONCLUSIONS. The relative reductions in vision loss in this area of England due to systematic screening, treatment for diabetic eye disease, tighter control of glycaemia and hypertension and earlier diagnosis of diabetes cannot be estimated from these data but all are likely to have contributed to this welcome change.

64. Risks associated with delayed transfusion

Authors Bolton-Maggs P.H.B.
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Abstract

Haemovigilance schemes have focused on adverse reactions and events in donors and recipients following transfusion of blood and its components. However, patients may also suffer adverse consequences if transfusion does not take place in a timely manner. The UK national patient safety agency (NPSA) was set up in 2001 to identify trends and patterns in patient safety problems through a national reporting and learning system (NRLS)1. Hospitals were encouraged to report any unintended or unexpected incident that could have or did lead to harm. This scheme issued national warnings and alerts from sentinel events. Between 2005 and 2010 reports were received of 11 deaths and 83 incidents in which patients were harmed as a result of delayed provision of blood in an emergency. A "Rapid Response Report" (RRR) followed in October 20102 requiring immediate action by hospitals to be completed by April 2011, including review of major haemorrhage protocols (MHP) and instruction to report any incidents of death or harm from delays to the haemovigilance scheme, SHOT (Serious Hazards of Transfusion). Hospitals were advised to review their local practices for requesting and obtaining blood in an emergency. This should include training and regular drills similar to those used in training for cardiac arrest calls. The protocol should be activated using an easily recognised trigger phrase, and a local team member nominated to co-ordinate communication. Hospital transfusion committees are recommended to review all incidents to ensure activation is appropriate and effective. Major haemorrhage packs (usually made up of 4 units of red cells with 4 units of fresh frozen plasma (FFP), and repeated including platelets in a second pack if necessary), are now advocated for management of severe bleeding on the basis of good results in military settings where the principle is early and adequate transfusion for major trauma. UK regional transfusion committees have undertaken several audits of major haemorrhage3. These local audits have shown that the majority of MHP calls in the civilian setting are not triggered by major trauma but by other serious bleeding events-particularly upper gastrointestinal bleeding, obstetric haemorrhage and vascular bleeding or surgery. Three years after the RRR not all hospitals had instituted dedicated telephone lines or drills for major haemorrhage. Within regions, hospitals have worked together to standardise their MHPs4. Overall, the use of the emergency pack use may result in significant wastage of FFP. A meta-analysis of plasma to red cell ratios in trauma has demonstrated that a ratio of 1:2 is as good as 1:15. Analysis of 442 cases of major haemorrhage in trauma from 22 UK hospitals demonstrated that only 2% received optimal resuscitation within the first hour, and delivery of platelets and cryoprecipitate was slow or absent6. There is still work to do. The SHOT haemovigilance scheme has collected transfusion incidents since 1996 and reports of delays or inadequate transfusion since publication of the RRR in 2010. Currently 100% UK National Health Service hospitals report to this scheme. Although the NPSA recommendation related only to emergency transfusion, the SHOT scheme will accept any report where the clinician noted "delay" that impacted on patient care, for example delay resulting from reluctance to transfuse overnight despite clear clinical indications. This can result when guidelines (best not to transfuse at night unless essential) are inappropriately converted to "rules" e.g. "we never transfuse at night". Other SHOT-reportable adverse events contribute to delays such as sample mix-ups, poor labelling and ultimately such errors may lead to wrong components transfused including ABO-incompatible red cells. Reports to SHOT of delayed transfusion have increased each year, from 2 in 2010, to 101 in 2016 with a total of 314 (age range birth to 100 years of age). These are seriously ill patients with a high mortality (109/314, 34.7%) and in some cases (26/109, 23.9%) this was related to the delayed transfusion. The majority of delays occurred in emergency situations. Many lessons have been learned. A death in 2011 resulted from inadequate transfusion after obstetric haemorrhage in a 34-yearold woman. In this instance 6 units of blood were available within 5 minutes of the MHP call, the bleeding was quickly controlled and the MHP stood down, but there was failure to recognise and correct the large volume haemorrhage that had occurred, compounded by shift changes and confusion over who was in charge. In two cases reported in 2013 junior doctors did not recognise and act on basic signs of haemorrhagic shock, resulting in death in one case and cardiac arrest followed by serious brain damage in the other. Key features identified from these 314 cases included lack of knowledge about MHPs (when and how to trigger), but also serious errors: short cuts in procedures resulting in failure of correct identification of patients, poor sample labelling so that repeat samples were required, selection of wrong blood components and transfusion without the final bedside checks. Poor communication and understanding between clinical and laboratory staff contributed to delay when the laboratory staff were not informed that this was an emergency. Clinical staff need to be clear about, and state the urgency of transfusion; immediate, urgent or after standard sample processing, particularly where transfusion is urgent but the clinical situation did not warrant activation of the MHP. Delay resulted from poor handover where patients were transferred between departments and hospitals. A patient with acute myeloid leukaemia was admitted with a Hb of 40g/L, but the unit of blood prescribed in the emergency department was not administered for 28 hours because the ward and then specialist hospital to which he was transferred assumed that it had been given. There were unexpected lessons. A major bleeding event began during an interventional radiology procedure which revealed that none of the radiology medical or other staff knew about MHPs and none had received any transfusion training. Indeed, transfusion training was not included in the national training programme for interventional radiology. There were 2 unrelated incidents where the MHP was activated but fire alarms involving the laboratory meant no laboratory facilities were available. These reporters were put in touch with each other and shared their root cause analyses and solutions with benefit. Delays were also reported where Blood Services sent components (platelets or specially-selected red cells) to the wrong hospitals. Patients who have irregular (non-ABO) red cell antibodies may experience delayed transfusion while compatible units are sourced locally or from remote Blood Centres. Transfusion laboratories

should have a protocol for managing such patients in association with their consultant haematologists. The patient should not die from anaemia or bleeding and may need to receive incompatible red cells with appropriate caution (close supervision of renal function and possible pre-emptive use of steroids or intravenous immunoglobulin). Haemolytic transfusion reactions may occur after use of emergency O D-negative units which are not suitable for everybody7; in particular, if a patient is known to have anti-c the transfusion staff will be able to provide appropriate units very quickly (O D-positive). The probability (estimated from a review of 14 studies) that a patient will develop an acute haemolytic transfusion reaction after receiving uncrossmatched units in an emergency was found to be 2/3,398, or less than 1/1,000, although 3.7% of patients had an identifiable antibody7. It is clear that further education and training is needed, particularly to ensure junior medical staff can recognise haemodynamic compromise and are facilitated to escalate to senior colleagues. The initiation and operation of MHPs will

65. Assessing the impact of prescribing antiosteoporosis medication after an index fracture as part of a national clinical audit

Authors Javaid M.K.; Gallagher C.; Vasilakis N.J.; Judge A.
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Abstract Objective: To identify what proportion of patients over 50 years are initiated on bone protection therapy following a fragility fracture. Material and Methods: Each FLS in the audit was asked to submit data on all patients they saw who were aged 50 or over and who had sustained a fragility fracture that was diagnosed in the NHS between 1 January and 30 December 2016. As part of the audit we asked whether the patient was recommended bone therapy by the FLS. Anti-osteoporosi s medication included were : alendronate, risedronate, ibandronate, raloxifene, teriparatide, strontium, denosumab, zoledronate, systemic oestrogens, systemic oestrogen and progesterone, calcitriol and alfacalcidol. There were a few cases where more than one drug was submitted. To identify the recommended drug, a hierarchy was used to select the one drug: oral bisphosphonate > denosumab > zoledronate, then teriparatide or raloxifene or strontium or activated vitamin D or oestrogen therapy. Results: 50 FLS submitted data on 42,000 patients. Of the patients who have a recorded treatment outcome, 23% were recommended for bone therapy and 11% required further clinical input (either by a GP or another clinician). However, there was considerable variation at FLS level, firstly the decision to treat and then the specific type of bone therapy recommended by FLSs. Conclusions: NICE technology assessments (TAs) 161/204 have provided recommendations for first and second-line bone therapies after a fragility fracture for FLSs to follow. This audit has demonstrated marked variation between FLSs in the decision to treat and the type of bone therapy. Bone therapies vary in cost but also adherence and potentially effectiveness. These data suggest that local interpretation of national recommendations is significantly impacting therapeutic options offered to patients in the NHS. Better understanding of the contributory factors for this variation will inform future FLS delivery and more effective and efficient medicines management. (Table Presented).

66. Assessing the prevalence of glucocorticoid prescription, fracture risk factors and bone health management in a prospective, unselected, neuro-oncology patient population

Authors Puvaneswaralingam S.; Rashed A.; Higham C.E.; Mcbain C.
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Abstract Objectives: To determine prevalence of treatment dose glucocorticoid (GC) prescription, calculate fracture risk (FR) and review bone health management in an unselected, prospectively evaluated, neuro-oncology outpatient population. Methods: Prospective data from 100 (41 female, mean(range) age 50 (26-86) yrs) unselected, sequential, neuro-oncology outpatients at a tertiary oncology centre were collected in Nov 2017 using patient questionnaires (demographics, oncology diagnosis, past/present GC treatment and risk factors for FR). FRAX score and NOGG 2017 assessment thresholds (NOGG-AT) (lifestyle/measure BMD/treat) were calculated where appropriate (n=26 <40yrs). In addition, patients declining the questionnaire (n=47) were reviewed for diagnosis and prevalence of GCs. Project approval obtained from local QIP/audit committee. Results: 74 patients had gliomas (32 grade 3, 24 grade 2). Other diagnoses: spinal cord tumours (6), schwannomas (4), others (16). Oncology treatments: 42 first-line, 46 follow-up and 13 relapsed disease. 34/100 patients were receiving current GCs (30 dexamethasone; mean (+/-sd) dose 3 (1.6)mg od, 16 had been on GCs for >3 months). In addition, 11 had received >3 months GC treatment previously; 39 had received some GC (at time of surgery or<3 months in total). 12/74 evaluable patients had hip FR >4% or major osteoporotic FR>20%. According to NOGG-AT, 8 were in "treat" category (2/8 were receiving bisphosphonate therapy), 29 were in "measure BMD" (5/29 had BMD measured) and 35 "lifestyle/reassurance". 12/100 patients had history of fragility fracture: 8/12 had undergone DXA; 3/12 were treated with bisphosphonates. In total 15/100 patients had undergone DXA and 6/ 100 were receiving bisphosphonate therapy. 12/47 patients declining the patient questionnaire were receiving GCs (10) or had previously received GCs (2). Conclusions: There is a high prevalence ofGCprescription in this patient group. They are a high-risk group for poor bone health and fracture. Current management does not align with UK NOGG guidelines.

67. Improving fundamentals of care for hip fracture patients and facilitating quality improvement

Authors Jones C.; Gupta A.
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Abstract Objective: To identify gaps between current and best practice in fundamentals of patient care, establish priorities and facilitate quality Improvement. The 22 Health and Care Standards (April 2015) are core Standards for NHS Wales, UK(UK) for organisations to provide high quality patient care and to comply with legislation and guidance. Methods: Setting-teaching hospital acute hip fracture unit in UK. Subjects-hospitalised patients following hip fracture. A trained nurse collected data about clinical care of 5 randomly selected patients from documents (nursing, food/fluid/drug charts), by observing clinical care, checking manual handling aids. 'Health and Care Standards Audit Tool October 2017 version' was used which is 114 item questionnaire based upon 7 quality themes-staff resources, staying healthy, Individual care, timely care, dignified care, effective care, safe care. Responses generated were compared with Standard and scored on 5 point scale or Yes/No answers. Results: High compliance with standards and areas of good practice noted were on smoking cessation advice, manual handling, pressure sore prevention, falls assessment and prevention, infection control, supporting nutrition, hydration/ food/ medication charts/trolley compliance, safeguarding systems in place, care of patients who lack capacity, DOLS applications, communication about care with patient, pain/toilet/ hygiene/butterfly care plans, discharge assessment and care plan. Standards requiring further attention noted were alcohol risk care plan, assessment of carer needs, oral healthcare plan, wearing of ID badges by all staff. Following the study, frontline staff were given feedback, education and were facilitated to use a range of quality Improvement Standards and Guidelines and this Improvement program is ongoing. The next step is encouraging other wards/departments/hospitals to identify and deliver high quality fundamentals of Care for all patients. Conclusion: Good compliance with majority of standards of fundamental care implies that high quality care is being delivered in acute hip unit. Evidence gathered from current practice and patient care has provided a basis for improving quality and safety of healthcare services for hip fracture patients.

68. What matters most? Promoting patient centred hip fracture care

Authors Jones C.; Gupta A.
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Abstract Objectives: Patient experience and feedback can improve clinical effectiveness, patient care and outcomes. Aim of this study was to work in partnership with patients, measure patient experience, interpret patient feedback to implement quality improvement in hip fracture care. Methods: Setting-A teaching hospital Acute Hip fracture unit in UK. A 'Health and Care Standards National Audit patient Feedback Tool' 2016 version was used. Anonymised responses were collected by a trained professional from hospitalised cognitively intact hip fracture patients using a standard questionnaire containing 34 both open and closed ended questions. Results: 7 female 9 Male patients Age range 60-90 years. Some responses out of 34 item questionnaire' Overall experience-10/10 (31%) 9/10(25%) 8/10(25%) 7/10(12%) Treated with dignity-always (69%) usually(19%) sometimes(12%) Given enough privacy-always (75%), usually (25%) Kept pain free-always(62%) usually(38%) Given help for feeding-always (75%) usually(25%) Responding quickly for toilet-always(56%) usually (25%) sometimes(19%) Given help to become independent-always(100%) Able to get enough rest/sleep-always(25%), usually (25%) sometimes(50%) Given information always(56%) usually(38%) sometimes(6%) Most patients acknowledged they had excellent care from hardworking, kind nurses, good support for recovery after hip operation. Shortcomings reported-more bedside assistance, special food items needed,more meals assistance, care-staff shortage, reassess pillows and mattresses. Data from this survey enabled a nursing champion to organise staff engagement, training and support for improvements which have been implemented and are ongoing. Conclusions: Hospital patient experience and feedback program has offered valuable insight and understanding where care is meeting expectations and where it is deficient. This enabled healthcare providers develop and implement targeted Improvement plans and thereby have raised standards of care for elderly hip fracture patients. A patient partnership and patient-centred culture has been promoted locally for this vulnerable group.

69. Audit of boast guidelines concerning fracture liaison services at a district general hospital (DGH)

Authors Zhang Y.; Ross R.; Swaminathan R.S.
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Abstract Objectives: Fragility fractures (Ff), caused by underlying osteoporosis, are a leading cause of mortality and morbidity in the UK (UK), resulting in a great financial burden on the National Health Service (NHS). These injuries are often progressive, highlighting the importance of secondary prevention. Fracture liaison services (FLS) are effective at reducing the risk of subsequent fragility fractures in the elderly. The British Orthopaedic Association Standards for Trauma (BOAST) out l i n e guidance for FLS organi sation and implementation. Methods: This audit focused on measures applicable in a fracture clinic setting. Over 4 weeks, patients aged over 50 presenting to fracture clinic with fragility fracture were tracked for the following outcomes: GP awareness, patient education or any other action. Results: From 31 patients included, only 3% of GPs had been informed. No patient had been given any information on osteoporosis or fragility fractures. Only 1 patient's letter made reference to concerns regarding balance to be addressed by the GP but no other initiated intervention had been documented. Conclusion: There is definite room to improve the secondary prevention of Ff at this DGH. The fracture clinic setting is normally busy and frantic, but it is an ideal opportunity for simple measures to implemented, or at least as a feeder into a formal FLS. Currently this service is lacking, and is in discussion to be implemented. Until then, GP awareness and patient education should be a minimum, which will look to be addressed before re-audit.

70. Fracture liaison services (FLSS) in england and wales: Inequity of access and quality of care after a fragility fracture

Authors Javaid K.; Gallagher C.; Vasilakis N.
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Abstract Objectives: The Fracture Liaison Service Database (FLSDB) aims to measure the volume and quality of care in secondary fracture prevention delivery across England and Wales. Methods: In 2015 a facilities audit of all acute trusts and LHBs in England and Wales was completed in order to establish where fracture liaison services are commissioned, the services they provide and how they are resourced. In 2016 the FLSDB started to collect patient level data on a continuous basis. We looked at the number of patients seen by an FLS between January 2016 and December 2016. Results: 56 FLSs are currently participating in the FLSDB and have entered over 89,000 patient records to date. Based on 2016 data, this represents an estimated 40% of all fragility fractures that should have been submitted by the participating FLSs, from a total of 107,745 fractures. Nationally only around 1/3 ofNHS trusts and LHBs in England and Wales participate in the audit, therefore only an estimated 13% of all fragility fractures in the NHS are being identified and entered on to the FLSDB. Of those submitted, there was marked variability in the performance of key indicators of quality secondary fracture prevention with some FLSs able to deliver high quality care for specific indicators. Conclusion: This audit has enabled unprecedented insight into secondary fracture prevention in England and Wales, with over 89000 patient records currently included in the audit. The initial findings have highlighted the marked great variation in the availability and delivery of secondary fracture prevention by FLSs in England andWales. The FLSDB has gone some way to achieve its objective to highlight inequity of access to FLSs. Importantly; the audit has demonstrated the need for continuous service measurement to inform a) the components of the pathway to prioritise both locally and nationally and b) provide the necessary data feedback to measure the impact of service improvement initiatives. Already the findings of the audit have led to more services being commissioned and this is increasing awareness of the benefits of participating in the FLSDB. The implications of this study are that more needs to be done to improve the equity of access to secondary fracture prevention services for patients across England and Wales.

71. Multi-site opportunistic diagnosis of vertebral fragility fractures in computed tomography scans

Authors Staal J.; Kariki E.; Hyatt R.; Javaid M.K.; Russell E.; aO'Neill T.; Poole K.; Chappell D.; Rajak R.
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Abstract Objective: Vertebral fragility fractures (VFFs) are an early manifestation of osteoporosis. VFFs may triple the risk of future hip fracture1 yet VFF patients are often underrepresented in Fracture Liaison Services (FLSs). We assessed the rate of VFFs in computed tomography (CT) scans of the thorax, abdomen and pelvis and reviewed whether they had been previously reported. We also investigated whether the identified VFF patients had been referred to an FLS. Methods: We retrospectively audited pseudonymised CT scans of patients 50 years and older, containing the spine, and performed over a 12-month period at 5 NHS hospitals in the UK (Cambridge, Croydon, East Lancashire, Oxford and Salford). We used the Optasia Medical ASPIRETM service, a commercial casefinding service combining machine learning with radiologist overread (EK). VFFs were classified using the Genant-SQ method and only moderate and severe VFFs were included. We compared our findings with the original radiology reports. Results:We collected 47,889 scans (50.1%) and used a sample of 1638 scans for analysis. Of these, 237 patients (53.4%) had VFFs (14.5%+/-1.7%, 95%CI). VFF prevalence between sites was not significantly different. Four sites (Ca., Cr., E.L., Ox.) checked the original radiology reports and FLS referral. The median reporting rate was 67.7% (IQR 55.7%, 74.5%) and the median FLS referral was 13.3% (IQR 10.8%, 22.0%). Conclusions: On average, 1 in 7 patients had at least one moderate VFF with a median of 13.3% being seen by the FLS. Whilst men are underrepresented in FLSs2, nearly as many men as women were found to have VFFs. Opportunistic diagnosis of VFF can greatly increase the number of patients referred to FLSs, potentially protecting the patients' quality of life and decreasing the economic burden of osteoporosis.

72. Interventions to increase access to or uptake of physical health screening in people with severe mental illness: a realist review

Authors Lamontagne-Godwin F.; Manyande A.; Barley E.; Burgess C.; Clement S.; Gasston-Hales M.; Greene C.; Taylor D.; Walters P.
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Abstract OBJECTIVES: To identify and evaluate interventions aimed at increasing uptake of, or access to, physical health screening by adults with severe mental illness; to examine why interventions might work.DESIGN: Realist review.SETTING: Primary, secondary and tertiary care.RESULTS: A systematic search identified 1448 studies, of which 22 met the inclusion criteria. Studies were from Australia (n=3), Canada (n=1), Hong Kong (n=1), UK (n=11) and USA (n=6). The studies focused on breast cancer screening, infection preventive services and metabolic syndrome (MS) screening by targeting MS-related risk factors. The interventions could be divided into those focusing on (1) health service delivery changes (12 studies), using quality improvement, randomised controlled trial, cluster randomised feasibility trial, retrospective audit, cross-sectional study and satisfaction survey designs and (2) tests of tools designed to facilitate screening (10 studies) using consecutive case series, quality improvement, retrospective evaluation and pre-post audit study designs. All studies reported improved uptake of screening, or that patients had received screening they would not have had without the intervention. No estimation of overall effect size was possible due to heterogeneity in study design and quality. The following factors may contribute to intervention success: staff and stakeholder involvement in screening, staff flexibility when taking physical measurements (eg, using adapted equipment), strong links with primary care and having a pharmacist on the ward.CONCLUSIONS: A range of interventions may be effective, but better quality research is needed to determine any effect size. Researchers should consider how interventions may work when designing and testing them in order to target better the specific needs of this population in the most appropriate setting. Behaviour-change interventions to reduce identified barriers of patient and health professional resistance to screening this population are required. Resource constraints, clarity over professional roles and better coordination with primary care need to be addressed.

73. Right Iliac Fossa Pain Treatment (RIFT) Study: protocol for an international, multicentre, prospective observational study

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Abstract INTRODUCTION: Patients presenting with right iliac fossa (RIF) pain are a common challenge for acute general surgical services. Given the range of potential pathologies, RIF pain creates diagnostic uncertainty and there is subsequent variation in investigation and management. Appendicitis is a diagnosis which must be considered in all patients with RIF pain; however, over a fifth of patients undergoing appendicectomy, in the UK, have been proven to have a histologically normal appendix (negative appendicectomy). The primary aim of this study is to determine the contemporary negative appendicectomy rate. The study's secondary aims are to determine the rate of laparoscopy for appendicitis and to validate the Appendicitis Inflammatory Response (AIR) and Alvarado prediction scores.METHODS AND ANALYSIS: This multicentre, international prospective observational study will include all patients referred to surgical specialists with either RIF pain or suspected appendicitis. Consecutive patients presenting within 2-week long data collection periods will be included. Centres will be invited to participate in up to four data collection periods between February and August 2017. Data will be captured using a secure online data management system. A centre survey will profile local policy and service delivery for management of RIF pain.ETHICS AND DISSEMINATION: Research ethics are not required for this study in the UK, as determined using the National Research Ethics Service decision tool. This study will be registered as a clinical audit in participating UK centres. National leads in countries outside the UK will oversee appropriate registration and study approval, which may include completing full ethical review. The study will be disseminated by trainee-led research collaboratives and through social media. Peer-reviewed publications will be published under corporate authorship including 'RIFT Study Group' and 'West Midlands Research Collaborative'.

74. Hip fracture audit: Creating a 'critical mass of expertise and enthusiasm for hip fracture care'?

Authors Currie C.
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Abstract The care of frail older people admitted with hip fracture has improved greatly over the last half-century, largely as a result of combined medical care and surgical care and the rise - over the last four decades - of large-scale hip fracture audit. A series of European initiatives evolved. The first national hip fracture audit was the Swedish Rikshoft in the late 1980s, and the largest so far is the UK National Hip Fracture Database (NHFD), launched in 2007. An external evaluation of the NHFD demonstrated statistically significant increases in survival at up to 1 year associated with improved early care: with rising geriatrician involvement and falling delays to surgery, and from which lessons have been learned. Comparable national audits have emerged since in northern Europe and in Australia and New Zealand, and most recently in Spain and Japan. Like the NHFD, these use the synergy of agreed clinical standards and regular - ideally continuous - audit feedback that can prompt and monitor clinical and service developments, often demonstrating both rising quality and improved cost effectiveness. In addition, important benchmarking studies of hip fracture care have been reported from India and China, both of which face huge challenges in providing care of fragility fractures in populations characterised by first-generation mass ageing. The 'halo effect' of the impact of growing expertise in hip fracture care on the care of other fragility fractures is noteworthy and now relevant globally. Although many national audits have now published encouraging reports of progress, the details of context and process determinants of the initiation and development of effective hip fracture audit have received relatively little attention. To address this, an extended discussion section - based on the author's experience of participation in several substantial audits, variously supporting and observing many others, and from his numerous discussions with audit colleagues over the years - may be of value in offering practical advice on some obvious and less obvious practical issues that arise in the setting up of large-scale hip fracture audits in a variety of healthcare contexts.

75. A multi-centre quality improvement project to reduce the incidence of obstetric anal sphincter injury (OASI): Study protocol

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Abstract Background: Third and fourth degree perineal tears, or obstetric anal sphincter injuries (OASI), sustained during childbirth can result in anal incontinence and psychosocial problems which require ongoing treatment. Within the English National Health System (NHS) reported rates of OASI have gradually increased. In response, a care bundle was developed incorporating four elements: 1) antenatal information to women, 2) manual perineal protection during all vaginal births, 3) episiotomy to be performed with a 60degree mediolateral angle at crowning (when clinically indicated) and 4) perineal examination (including per rectum) after childbirth. Implementation of the OASI Care Bundle is aided by a skills development module and an awareness campaign. The project is a collaboration between two national professional bodies, an NHS hospital trust and an academic institution. Methods: Implementation of the OASI Care Bundle will be evaluated using a stepped-wedge design. From January 2017 sixteen maternity units across England, Wales and Scotland will participate in the study over a 15-month period, with sequential roll-out of the intervention in four blocks (regions) of four units. The primary clinical outcome is OASI rate. Regression analysis will adjust for differences in organisational characteristics and obstetric risk factors in women who gave birth before and after implementation of the care bundle. Focus group discussions and in-depth interviews with clinicians will evaluate the feasibility of integrating the care bundle into routine practice. Interviews with women will explore the acceptability of the intervention. Discussion: This protocol outlines the evaluation of our quality improvement project which aims to prevent OASI using a bundle of evidence-based interventions that are each widely used in practice. The OASI project aims to 1) standardise practice to prevent OASI in a way that is acceptable to clinicians and women and 2) identify the barriers and enablers associated with upscaling interventions within maternity units. If found to be effective, feasible and acceptable, the OASI Care Bundle will be shared with a range of audiences using the communication channels available to the professional bodies.

76. The clinical effectiveness of the nutrition support team-an acute district general hospital experience

Authors Coyle J.; Gensale O.; Finney C.; Daniel N.; Sung E.
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Available at Gut 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 George Eliot Hospital NHS Trust is a 310 bed acute district general hospital. The Nutrition Support Team consisting of a consultant gastroenterologist, nutrition nurse, speech and language therapist and a dietitian were established in 2011. This audit explores the safety and effectiveness of a multi-disciplinary nutrition support team (NST) in enteral and PN delivery. Data on 30 day mortality rates for gastrostomy feeding tubes and, line sepsis rates and appropriateness of patients receiving parenteral nutrition (PN) were analysed for both before and after the establishment of the NST. Methods Prospective and retrospective data was collected from medical notes, dietetic records and NST meeting documentation. Two Separate audits were completed including mortality rates post-PEG placements with and without NST input and parenteral feeding venous line sepsis rates with and without NST input. Data was collected for patients who underwent PEG insertions and PN. 30 day mortality from PEG insertions and prevalence of line sepsis was analysed for period of 2010-2011 (before NST was established) and 2014 onwards (after establishment of NST). The data collected were compared to the findings from the NCEPOD report (2010). Results Enteral Feeding In 2010-11, prior to the formation of the NST, 61 patients had gastrostomy feeding tubes placed within the hospital; of which 19 of those patients died within 30 days. This would equate to a 31% 30 day mortality rate. Data from three years with NST input covering 2014-16 showed that 63 gastrostomy tubes were placed, of which only 3 patients died within 30 days which equates to a 5% mortality rate. Parenteral Feeding Data collected from a report by NCEPOD (2011) which looked into the national average prevalence of line sepsis associated with PN showed a confirmed sepsis of 6% and a sus-pected line sepsis of 9.4%. Data collected from a two year period 2014-16 since NST had been established included 72 patients that showed confirmed line sepsis of 2.7% and a suspected line sepsis rate of 2.7%. Conclusions The NST has improved the safety and efficacy of enteral and PN therapy in our trust. NST which has managed to decrease line sepsis and mortality rate of gastrostomy placements since its formation in 2011. Prior to 2011, individual professionals worked in isolation with inconsistent communication between them. Patients were assessed by a nutrition nurse with focus on fitness for tube placement. The cohesive multidisciplinary team (MDT) approach to nutrition allows a more holistic assessment and treatment of the patient. Specialists within their fields discuss up to date information of the patient's medical and nutritional status which can allow best interest decisions to be made alongside family members and other healthcare professionals as appropriate. This has ensured that placement of gastrostomy tubes is appropriate and within the window of opportunity in patients with progressive neurological conditions, preventing crisis in later stages of disease. PN associated line sepsis has decreased since the formation of NST who have clinical ownership of the initiation and monitoring within the hospital. The NST has initiated proto-cols and has developed guidelines which advise on ways to maintain patient safety including PN specific wards, bedside PICC insertion service and establishing training for ward nursing teams.

77. Prospective multi-site audit of acute upper gastrointestinal bleeding delivered across multiple regions by trainee-led networks

Authors Ingram R.J.M.; Baxter A.A.; White C.; Siau K.; Widlak M.M.; Nixon K.
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Abstract Introduction Trainee-led networks were developed to support improvements in patient care by delivering audit, quality improvement and research projects across multiple sites. The Midlands was the first UK region to establish gastroenterology trainee research networks: WMRIG in 2015 and the GARNet in North West trainees established GasTRIN NoW in 2017. Here, we report the first project in the UK to be delivered simultaneously by trainee physicians through multiple networks. Methods We audited the care of patients with acute upper GI bleeding (AUGIB) against national quality standards (NICE QS38 and JAG GRS) and collected data on patient and proc-ess outcomes. Patients aged >16 years admitted with suspected AUGIB who underwent an inpatient OGD were prospectively identified in a consecutive 30 day window from November Anonymised data and outcomes to 30 d were collected using common proformas and protocols. Results 471 patients were identified across 30 sites (EM: 157, 8 sites, WM: 193, 12 sites, NW: 121, 10 sites). We report the population characteristics and selected audit and outcome measures for 455/471 (97%) with complete data available. The mean age was 65 years (SD 18.1, range 17-100) and 54% were male. 45% presented on weekdays 7am-7pm, 32% on weekdays outside these hours and 23% at weekends. The median time from presentation to OGD was 22.5 hour (IQR 12.7-43.9 hour), with 54% performed within 24 hour (range at sites 22%-88%;>50%: 18 sites,>75%: 5 sites). Glasgow Blatchford scores were recorded pre-OGD in 47% (range at sites 8%-100%), with median score 7 (IQR 1-12;>8: 46%,>12: 26%). Endoscopic findings were: 63% non-variceal, 11% variceal, 8% other, 18% no lesion identified. 116 patients required endotherapy (25%; 80 non-variceal, 34 oesophageal and 4 gastric varices). A rebleed plan was documented in 36% (range at sites 0%-81%). Rebleeding within 8 d occurred in 36 patients (7.9%). 29 died (6.3%) within 30 d of OGD. Median length of stay was 5 d (IQR 3-9 d). Conclusions Collaboration between gastroenterology trainee-led research networks can successfully deliver projects across multiple sites and regions. This audit shows wide variations in practice. Local action plans are still needed to meet JAG quality measures. However, we propose to harness the enthusiasm of trainees to drive improvements in the quality of care received by patients with GI bleeding-regionally, through the BSG national QI agenda, and in partnership with patients via Core. We encourage our peers to establish their own trainee-led research networks.

78. UGI cancers-are we looking?

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Abstract Introduction Oesophago-gastric (OG) cancers in the UK often present at an advanced stage, and hence reduced chance of curative therapy. A recent meta-analysis involving 3787 patients with OG cancer has shown that 11.3% OG cancers are missed at endoscopy 3 years before diagnosis. Recent guidelines from the BSG recommend that endoscopy units should audit for potential missed pathology in those diagnosed who have undergone an endoscopy in the preceding 3 years. Methods This was a retrospective audit at a regional upper gastrointestinal centre reviewing all cases presenting with OG cancer over a 2 year period between Sept 2015 and Sept 2017. Data was collected from the electronic database, case notes and the GI reporting tool, in all patients to ascertain if an OGD was performed within 3 years prior to diagnosis. This included site of cancer, stage, endoscopist, probable reason for missed pathology and assessment of certain KPPs pertaining to the endoscopy. Results 105 patients were diagnosed with OG cancers during this period. Median age 74 years; M:F 69:31; Oesophageal 60%:stomach 40%. Twenty-two patients (21%) had an OGD in the 3 years prior to their index (diagnostic) OGD; 11 (10.5%) were deemed 'not missed' cancers because there were valid reasons for repeating an endoscopy; and 11 (10.5%) were thought to represent 'missed' opportunities of diagnosing cancer in the preceding 3 years. The median time interval between the 1 st OGD and index OGD were 20 and 270 days for 'not-missed' and 'missed' groups respectively. Possible reasons for missed cancer were lack of lesion recognition (5/46%), dual pathology (1/9%), technical limitations of OGD (1/9%) or a combination of factors (4/36%). Adequacy of mucosal visualisation was not photo-documented in 64% of cases. The main reason for early repeat endoscopy in the 'non-missed' group was a high index of suspicion of pathology on initial OGD without any histological confirmation. Conclusions A missed cancer rate of 10.5% in a regional upper GI centre is similar to published rates in a recent metaanalysis but does not achieve the minimal standard of <10% set by the BSG. These results were discussed at the EUGM and various measures being undertaken to reduce this include: modifications to optimise visualisation (simethicone pre-proce-dure), rigorous photo-documentation, dedicated surveillance lists eg. Barretts. This will be re-audited in 3 years.

79. Managing acute severe colitis in a district general hospital

Authors Oxenburgh S.; Wells C.
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Abstract Introduction Following a critical incident in the care of a patient with acute severe colitis (ASC) we audited practice against the European Crohn's and Colitis Organisation (ECCO) standards for ASC. Performance was compared to the 2014 Inflammatory Bowel Disease (IBD) Audit. Since 2014 gastroenterology inpatient care changed to consultant of week instead of a single consultant. This improved discharge rates (top 4 in England for acute admission targets) but may have disrupted quality of care for more complex conditions like IBD. Methods Adult coding database searched for 'colitis' from 01/01/2016-31/10/2017. Admissions<48 hours excluded. Discharge letters were searched for ASC cases and notes then reviewed. Admissions with ASC were audited against the ECCO standards. Results 40 admissions with ASC (30 patients-2 had 3 and 8 had 2 admissions) 17 saw gastroenterologist day 1 (median day 2, range 1-4) 39 went to gastro ward 32 had abdominal xray on day 1 1 had flexi sig day 1, 12 had lower GI scope pre-admission, 18 during admission (median day 3, range 1-11) and 9 had none 34 had IV hydrocortisone on day 1 (median day 3, range 1-6) 26 had Ca/vit D All had low molecular weight heparin (LMWH) 14 saw dietician, 33 had MUST scored 24 saw IBD nurse 13 saw stoma nurse 6 saw surgeon on day 1 (median day 2, range 1-14) and 15 did not get referred 10 required surgery-7 done by a colorectal surgeon (6 laparoscopically, 4 open) Median surgery day 9 (range 2-23 from admission) 1 on biologic pre-admission 2 had surgery on readmission 3 based on clinical features 3 not responded to biologic 1 not clear Biologies given to 10 patients-2 day 3, 1 day 4, 6 day 5 and 1 day 6 (2:8 between adalimumab:infliximab). No ciclosporin. 90% did not need surgery. Conclusion In 2014 our trust data showed we performed on par with National audit. In 2017 we were equivalent to or outperformed the National figures for: Care on a specialist ward (98% vs 69%) Nutritional assessment (80% vs 82%) Dietician review (45% v 40%) Prescribing LMWH (100%) IBD nurse review (60% vs 66%) We performed below the IBD audit for: Sigmoidoscopy in 72 hours (28% vs 99%) Prescribing Ca/vit D (65% vs 74%) Median time to surgery (9 vs 7.5 days) Important standards of IBD nurse and dietician review maintained. Delay in endoscopic evaluation and therefore time to surgery indicate there has been a slipping of standards in ASC care. This may be related to less direct ward continuity. Our data show a drop in performance (access to endoscopy and time to surgery). They have allowed us to critically appraise our acute IBD service thus leading to care delivery change and an education package for medical and surgical directorates. A repeat audit is planned in 24 months to demonstrate quality improvement as a result of this.

80. Advice given to patients with alcohol excess regarding fitness to drive

Authors Braniff J.; Taylor N.; Sager K.; Butcher G.
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Abstract Introduction In 2015, around 5740 accidents and 220 fatalities occurred on UK roads and involved drivers under the influence of alcohol.[1] Following discussions amongst the gastroenterology team and Hospital Alcohol Liaison Team (HALT), at Southport Hospital it appears that fitness to drive advice is inconsistently given to patients with excess alcohol intake. Methods The aim was to firstly assess if patients with a history of alcohol excess were being informed about their fitness to drive in accordance with national Driver and Vehicle Licensing Agency (DVLA) guidelines. Then to introduce a simple aide memoire and document that the DVLA advice had been given. The standards used were the Current medical guidelines: DVLA guidance for professionals.[2] Clinical notes were assessed for evidence of a discussion regarding fitness to drive and DVLA guidance for all patients with alcohol excess presenting to Southport hospital over a 2 week period and reviewed by HALT, who also performed the data collection. A label was then designed for insertion into the clinical records. This demonstrates that a patient was advised about their fitness to drive by the HALT nurses. Re-audit was performed by the medical staff by reviewing the clinical records of 30 different patients for evidence of the label. Results Initial audit showed of the patients with alcohol excess (n=30), 14 (46.7%) patients were currently driving with 0 being informed about their fitness to drive. During the re-audit of the total patients with a history of alcohol excess (n=30), 11 (36.7%) patients were currently driving. 11 (100%) patients had documented evidence being informed about their fitness to drive in accordance with national DVLA guidelines in the form of a label. Ongoing driving was verbally confirmed by HALT for each patient. Conclusions Patients with alcohol excess were not being informed about their fitness to drive in accordance with national DVLA guidelines. Introduction of our label has since resulted in an improvement in the number of patients informed about their fitness to drive and adherence with national guidance. Therefore, the use of a simple aide memoire has demonstrated improved compliance with DVLA guidance and potentially reduced the risk of alcohol-related driving incidents.

81. Post-colonoscopy colorectal cancer rates in IBD are high and vary by nhs trust in england

Authors Burr N.; Subramanian V.; Hull M.; Smith A.; Morris E.; Valori R.; Shelton J.; Pearson C.; Rutter M.
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Abstract Introduction Colorectal cancer (CRC) risk is increased in those with inflammatory bowel disease (IBD). Guidelines advocate surveillance colonoscopy for patients with longstanding IBD. Post-colonoscopy colorectal cancer (PCCRC) is a key quality indicator of colonoscopy. There is limited data exploring the rate of PCCRC in those with IBD and potential risk factors associated with IBD-related PCCRC. This study explored national and individual hospital rates of IBD-related PCCRC in England since 2006. Further analysis explored potential associations with IBD-related PCCRC in order to inform future quality improvement interventions. Methods We identified all those who had undergone a colonoscopy between 1/1/2006 and 31/12/2012 and developed a CRC before 31/12/2015 using linked national Hospital Episode Statistics and National Cancer Registration and Analysis Service data. IBD cases were identified by relevant ICD-10 codes. Using international consensus guidelines[1,2] the rate of PCCRC within 3 years (PCCRC-3 yr) was calculated as the number of false negative colonoscopies (within 6-36 months of CRC) divided by the sum of the true positive (within 6 months of CRC) and false negative colonoscopies. The IBD-associated PCCRC-3 yr rate in each NHS hospital trust in England was ranked and trusts were separated into quintiles. Factors associated with IBD-related PCCRC were investigated. Results Between 2006 and 2012 we identified 7781 PCCRC, 800 (10%) with a diagnosis of IBD. Nationally, the IBD-PCCRC-3 yr rate was 35%, and varied between hospital trusts with those in the lowest quintile having a mean, unadjusted rate of 19% (SD +/-7%) compared to 52% (SD +/-7%) in the highest quintile. PCCRC cases were younger at diagnosis (60 years compared to 66 years), were less likely to have diverticular disease (10% compared to 16%), and had undergone more previous colonoscopies when compared to detected cases (within 6 months of colonoscopy). There was no significant difference for sex, bowel location, deprivation score, or metachronous tumours. Conclusion PCCRC-3 yr in those with IBD is high, and accounted for 10% of all PCCRC-3 yr in England between 2006 and 2012. There is a wide variation in the unadjusted rates between NHS trusts in England that is unlikely to be explained by natural variation. There is an urgent need to investigate avoidable reasons for cancers in those with IBD to optimise surveillance and prevention of CRC in IBD.

82. Near hospital accommodation as an alternative to admission for patients undergoing complex endoscopy

Authors Goodchild G.; Odedra P.; Potts J.R.; Keane M.G.; Chapman M.H.; Johnson G.J.; Pereira S.P.; Webster G.J.
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Abstract Introduction Use of hospital beds as pre/post procedure accommodation places a strain upon resources and risks 'on the day' cancellation. Nevertheless 'day case then home' may be a poor option for patients undergoing complex endoscopy who live many miles away. Our centre offers Near Hospital Accommodation (NHA) in a bespoke 35-roomed hotel 100 metres from the hospital at a cost of 120/night (versus 380 per inpatient bed). We aimed to assess the safety and utility of NHA for patients within our pancreatobiliary (PB) service. Methods We undertook a retrospective audit of all PB patients who stayed in the NHA from Jan '15-Dec '17. Data collected from the endoscopy database and electronic records included: procedure type, distance travelled, type of hotel room, length of stay and unplanned post-procedural hospital admissions from the NHA. Results Over a 3 year period 152 patients stayed in NHA for 169 nights, ninety-three (61%) female with median age of 62 years (range 24-81). All patients underwent therapeutic ERCP, EUS, or cholangioscopy The decision to use NHA was based upon case complexity and travel logistics. Most patients (89%) stayed one night and 11% stayed two nights (pre and postprocedure). Median one-way distance travelled was 107 miles (range 3-299 miles) (figure 1). The total cost of NHA was 23,660, saving 40 560 over the equivalent inpatient beds. <50 miles-50-100 miles-100-150 miles 150-200 miles >200 miles Abstract PTU-097 Figure 1 Distances travelled to UCLH for treatment There were five unplanned admissions (3.3%), summarised in table 1. Abstract PTU-097 Table 1 Unplanned readmissions from NHA Patient and Procedure Reason for Outcome readmission 42 year female ERCP Abdominal pain Normal investigations, +sphincterotomy discharged<48 hours 40 year female ERCP Rectal bleeding Normal investigations, +spfiincterotomy discharged<4 hours 39 year female ERCP Abdominal pain Mild acute pancreatitis, +cholangioscopy discharged<72 hours 36 year female ERCP, Abdominal pain Normal investigations, sphincterotomy and fcSEMS discharged<48 hours 59 year female ERCP Rectal bleeding Blood transfusion, +sphincterotomy discharged<72 hours Conclusion NHA is a safe, cost-effective alternative to hospital admission for selected patients undergoing complex endoscopy. The unplanned readmission rate was low, with no serious complications. The immediate cost saving was considerable, in addition to efficiency savings from the extra bed capacity generated and reduced late cancellations. Benefits to patients include visitor-friendly, hotel-standard accommodation, reduced travelling time on the day of the procedure and saving of private hotels fees. Further studies are needed to assess if this translates into increased patient satisfaction. With increasing centralisation of specialist services and ongoing financial pressures throughout the NHS, the NHA model of care offers advantages to hospitals and patients.

83. Growth in participation, registrations and data maturity in the UK IBD registry: Focus on biologics

Authors Shawihdi M.; Razanskaite V.; Bodger K.; Cummings F.; Bloom S.
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Abstract Introduction The UK IBD Registry (IBD-R) provides a standardised dataset and alternative methods for local teams to record structured electronic data in routine care. The infrastructure enables collection of data for local use and upload of anonymized data centrally (each quarter). Registry participation allows sites to demonstrate engagement with national audit (e.g. Biologies Audit, listed on the NHS Quality Accounts) and access to centrally-developed analytics and reporting. Methods To evaluate growth in establishment of local biologies registers using the IBD-R, we analysed three uploads of data (March, June and Sept 2017) with a focus on key data items required for producing site-level reports for patients treated with these agents (from a basic to more granular-level detail, using the 'biologies events' dataset). We generated Quarterly Reports and distributed to centres, seeking feedback to inform future iterations. Results Participating centres grew by 59% (32 to 51) and number of sites contributing biologies events more than doubled (16 to 37). Total registered patients in the IBD-R increased from 24 633 to 31 613. Biologies Events For adults with CD, submitted initiation events increased >6 fold (472 to 3126 patients), post-induction review ~3 fold (709 to 2,022) and 12 month review >19 fold (22 to 437). Agents used for adult CD [UC]: Remicade 1423 [450]; Humira 1675 [311]; Inflectra 345 [236]; Remsima 398 [225]; Vedolizumab 186 [201]; Ustekinu-mab 16 [0]. Data completeness varied by item, e.g. recording of 'naive' status (y or n) was static at-50%; categorization of clinical indication consistently high at >80% of cases. Outcome measures By Sept 17, Physician Global Assessment (PGA) was reported at 1053 initiation events for CD (62%) and UC 940 (66%); and at 1537 (97%) and 1248 (80%) post-induction reviews showing rapid adoption, but data for disease activity indices (HBI or SCCAI) remained static at around 10%. The next upload (Feb 2018) contains almost 40 000 records from 63 sites and confirms continuing growth (analysis in progress). Conclusions There has been significant increase in participation and in the breadth and depth of data being submitted to the UK IBD-R, particularly for biological therapies. Patterns of outcome data collection suggest clinical teams favour simple global outcome measures to formal activity indices-likely reflecting the added burden of administering and recording the data. However, the feasibility of site-level reporting to support local biologies registries is now established. Funded by Crohn's and Colitis UK.

84. Impact of improved access to biologic therapies and physician engagement on excess steroid exposure

Authors Parkes G.; Selinger C.; Bassi A.; Smith M.; Lindi J.; Ludlow H.; Patel P.; Salunke S.; Hall V.; George B.; Saunders J.; Adamson M.; Donovan F.; Parisi L.; Gray L.; Fraser A.; Pollock R.; Scott G.; Raine T.
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Abstract Background Steroid free remission is an important goal of IBD therapy. The aim of this study was to evaluate temporal changes in steroid prescribing in UK IBD outpatients in the context of major changes in UK prescribing guidelines and physician participation in audit and tailored service changes. Methods Steroid use over the previous 12 months was recorded for unselected outpatient attenders against a definition of excess from ECCO guidelines. Data were collected from 7 centres that had completed a steroid assessment audit cycle in 2015, as well as from 12 new matched centres. Results Data was collected for 2385 patients May-July 2017 and compared with 2015 data from 1176 patients. Overall disease distribution was 47.1% CD, 49.6% UC and 3.3% IBD-U, whilst 77.7% of patients were in clinical remission at the time of assessment. There was only a modest increase in patient exposure to anti-TNF from 2015 to 2017: 30.6% to 37.2% in CD (p = 0.009) and 9.9% to 12.0% in UC (p=NS). Anti-integrin usage increased from 0.8% to 3.3% in CD (p = 0.002) and from 1.6% to 2.4% in UC (p=NS). For centres taking part in the 2015 audit, steroid exposure rates fell from 30% to 23.8% (p = 0.003) and steroid excess from 13.7% to 11.5% (p=NS). Steroid exposure and excess rates for sites that had not been part of the previous audit were significantly higher (31.0% excess, 17.1% exposure, p = 0.0001 for both). There were no significant differences in important baseline characteristics of 2 groups of sites. Logistic regression analysis revealed independent predictors of reduced risk of steroid excess, after correction for disease severity. For CD these included treatment with anti-TNF therapy (p = 0.04), treatment in a centre with regular IBD multidisciplinary team (MDT) meetings (p = 0.01) and treatment in an original 2015 centre (p = 0.02). For UC treatment in a 2015 centre was also significant predictor of protection (p = 0.04) and treatment with thi-opurine monotherapy a predictor of risk of excess (p = 0.01); usage of anti-TNF therapy in UC did not reach significance for protection from excess. Conclusions Changes in biologic access in the UK have resulted in only modest changes in prescribing behaviour and have not yet impacted significantly on excess steroid exposure in UC, unlike in CD. Participation in an audit cycle of steroid usage was associated with a meaningful reduction in steroid excess. These data support the concept that steroid excess could be used as a key performance indicator in IBD and physicians should be engaged in this process.

85. Improving new to follow-up ratios in a district general hospital gastroenterology service

Authors Frank M.; Phillips R.
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Abstract Introduction The NHS 5 year forward view emphasises the need to develop new models of care. In 2004 an audit showed our new (N) to follow-up (FU) ratio for patients attending the gastroenterology outpatient department (GOPD) at Princess Alexandra Hospital (PAH) was 1:2.52. Since then there have been changes in our service: 2 IBD clinical nurse specialists (CNS) have been appointed (providing telephone and nurse-led clinics); an irritable bowel syndrome (IBS) primary care pathway intro-duced, and an adhoc telephone service implemented to deliver test results and interim management. This service evaluation assessed the current N:FU ratio for patients attending GOPD at PAH to determine whether we now meet our Clinical Commissioning Groups (CCG) contract N:FU ratio of 1:1.24 and British Society of Gastroenterology (BSG) commissioning recommendation advice to have 'efficient use of OPD services with low FU:N ratios e.g. 1:1 for patients excluding those with chronic disease (inflammatory bowel disease (IBD) and liver disease(CLD))'. Methods Data was collected for consecutive patients seen in GOPD from April 2016 for 3 months. Data collected included diagnosis (or symptom where a diagnosis not yet made), whether they were N or FU and the clinic outcome (discharged or FU). The N:FU ratio was calculated and compared with CCG and BSG targets. Results Total number of patients seen by doctorsl,347 (593 N, 754 FUs). The N:FU ratio was 1:1.27. If the IBD and CLD patients were excluded (as per BSG) our N:FU ratio was 1:1.00. Commonest symptoms/diagnoses for N and FU patients are shown in Tables 1 and 2. Of N patients 26% discharged and 61% had FU. For FU, 30% discharged and 57% had FU. Others did not attend their appointment, or no outcome specified. Abstract PTU-094 Table 1 Top 10 symptoms/diagnoses for new patients Symptom/N % Diagnosis GORD* 75 14 Abdominal pain 53 10 IBD 48 9 IBS** 39 7 Dysphagia 32 6 Diarrhoea 25 5 ALD 22 4 Weight loss 21 4 Barrett's 20 4 oesophagus Viral hepatitis 19 3.5 *Gastro-oesophageal reflux disease **Irritable bowel syndrome Abstract PTU-094 Table 2 Top 10 symptoms/diagnoses for follow-up patients Symptom/N % Diagnosis IBD 243 29 (48% UC, 43% CD) Liver disease 90 11 Abdominal pain 68 8 Diarrhoea 56 7 GORD 55 6 Anaemia 47 6 IBS 44 5 Weight loss 17 2 Diverticular disease 16 2 Barrett's oesophagus 14 1.5 Ulcerative colitis **Crohns disease Conclusions A significant improvement in N:FU ratio (1:1.27) since last audit in 2004 (1:2.52). CCG targets (1:1.24) were almost met and excluding IBD and CLD from N and FU figures the BSG target of 1:1 was met. We aim to implement other GOPD changes in order to achieve CCG targets and further improve patient flow. Options being appraised include a liver CNS (to provide a similar service to IBD), virtual IBD clinics, better use of direct-to-test pathways, nurse-led protocol-driven clinics (e.g. anaemia), and virtual review clinics.

86. An audit tool to evaluate post-colonoscopy colorectal cancer (PCCRC) rates in endoscopy units

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Abstract Introduction Colorectal cancer (CRC) is the third most common cancer globally and the third most common cause of cancer death. Early diagnosis at stages where disease can be treated, significantly improves survival rates justifying the need for CRC screening programs by 'gold standard' colonoscopy. Given the concern for significant numbers of missed lesions, the new JAG Global Rating Scale (GRS) requires all endoscopy units to develop an audit for post-colonoscopy colorectal cancer (PCCRC). Our aim was to provide a template for performing this audit at a major teaching hospital. Methods We retrospectively reviewed our electronic patient records and collected data on all new CRC diagnoses made over a three-year period (1 st September 2014-31 st August 2017). We looked for evidence of colonoscopy performed in the three years prior to diagnosis and applied the following exclusion criteria: No colonoscopy within the 3 years prior to diagnosis Diagnosis of CRC made at different hospital hindering access to patient records Previous flexible sigmoidoscopy only and subsequent CRC diagnosis in transverse/ascending colon Unsatisfactory bowel preparation necessitating repeat endoscopy Alternative investigation/referral arranged by endoscopist (e.g. due to technical difficulty leading to incomplete endoscopy procedure). PCCRC rate was defined as the proportion of PCCRC diagnoses amongst all CRC cases. For CRC cases, we also analysed patient demographics, timeframe between colonoscopies and individual endoscopist PCCRC rate. Results Out of a total 944 CRC cases, 691 were eligible for analysis (Figure 1). There were a total of 12 cases of PCCRC, giving our hospital a PCCRC of 1.74%. The average age of patients with a PCCRC diagnosis was 65.25 years (29-80). The average time between initial and diagnostic colonoscopies in PCCRC cases was 14.33% months (range, 1-34) with ini-tial-to-diagnostic colonoscopies separated by <12 months in 5 cases (41.67%), 12-24 months in 5 cases (41.47%) and >24 months in 2 cases (16.67%). Physician endoscopist miss rate ranged from 0.11%-0.21%. Conclusions Results from our audit show our hospital is within the BSG, JAG and the Association of Coloproctology of Great Britain and Ireland (ACPGBI) quality assurance target of <5% PCCRC at 3 years. Ideally, endoscopy units will use similar methods for the mandatory JAG GRS audit, allowing comparison between different endoscopy units to improve quality of CRC screening. Our work provides a guidance tool on performing the audit in the hope of achieving this aim. CRC database Sept 14-Aug 17 (n=944) >> Excluded patients (n=253) i Remaining patients (n=691) 7\ CRC diagnosis on initial PCCRC colonoscopy n=12 n=673 j I Abstract PTU-042 Figure 1 Flow chart summarising identification of cases included for analysis.

87. Gastrin now: Establishing a trainee LED research network

Authors Nixon K.; White K.; Gashau W.; Morris L.; Kalla R.; Borg-Bartolo S.
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Abstract Introduction Research, quality improvement and audit are essential parts of effective personal and professional development. Increasing clinical demands and the proposed shortening of training time may limit trainees' involvement in clinical research. Trainee LED research and improvement networks (TLRINs) allow us to develop large, cost-effective, multi-site quality improvement and research projects without necessitating time out of programme. They also provide opportunities for tailored input dependent on personal clinical interest. Aims To assess the feasibility of a new TLRIN, GasTRIN NoW, within Health Education England North West, by conducting a multi-site clinical audit. We aimed to recruit trainee members from 75% of 16 potential hospital sites, and from these obtain 75% complete data. Methods Membership was offered to all gastroenterology specialty trainees in the North West Deanery. All consultants were offered honorary membership. We replicated an audit proforma from the West Midlands TLRIN (GARnet) to assess the management of acute upper gastrointestinal bleeds, collecting prospective data over a one month period. Members were required to sign a constitution to ensure fair acknowledgment of work. Video conferencing enabled regular committee meetings with additional updates to members at regional gastroenterology teaching days. Results LED by a committee of 6 trainee members, 27 trainees, supported by 25 consultants, from 13 sites (81%) were recruited to GasTRIN NoW Complete audit data were received from 10 sites (77%). Conclusion The need for and utilisation of TLRINs is increasing in gastroenterology. TLRINs offer trainees the opportunity to experience research and quality improvement in a peer-supported environment alongside clinical work. This will allow them to achieve competencies required for successful attainment of CCT and become more rounded consultants of the future. TLRINs provide a cost effective approach to answer questions of clinical importance and provide innovative change in a coordinated manner. Continuity for data collection and project structure exists even when trainees rotate hospital placements. Our current model has produced encouraging results, building a comprehensive and comparable picture of practice throughout the region with no financial requirements in initial set up.

88. Neighbourhood deprivation and quality of life among people with diabetes in England

Authors Abubakari A.-R.
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Abstract Background: Income levels and Socio-economic status at the individual level are known to be associated with adverse health outcomes including risk of diabetes and its complications. However it is unclear how neighborhood deprivation levels influence perceived quality of life among people with diabetes. This study investigated the relationship between neighborhood deprivation and quality of life among people with diabetes attending two hospital trusts in Liverpool, England. Methods: eligible participants completed a set of study questionnaires including demographic characteristics and the Audit of Diabetes Dependent Quality of Life questionnaire. Postcode based neighborhood deprivation data were obtained from the UK's Department for Communities and Local Government website. Relevant statistical analyses were undertaken using SPSS version 22. Results: a total of 123 people with type 1 and type 2 diabetes participated in the study. Majority of participants were type 2 diabetes patients (53%) and about half were men (51%). Overall 20% of participants reported poor quality of life. Compared to those with type 2 diabetes, a higher proportion of people with type 1 diabetes reported good quality of life (58% vs. 61%; p<0.05). Poor neighborhood deprivation was associated with poor quality of life, both in univariate and multivariate analysis (p<0.05). However, there was no significant association between neighborhood deprivation and patients' perceptions of how diabetes affected their quality of life (p>0.05). Conclusion: Neighborhood deprivation levels are significantly associated with quality of life among people with diabetes and could potentially be used to guide interventions aimed at promoting their health and well-being.

89. Use of insulin degludec in type 1 diabetes clinical practice in the U. K.-General Practice Data from two english regions and data from the association of british clinical diabetologists (ABCD) Nationwide Degludec Audit

Authors Lumb A.N.; Gallen I.W.; Bickerton A.; Abraham R.R.; Bain S.C.; Harper R.; Ryder R.E.
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Abstract In clinical trials insulin degludec (Tresiba) was associated with less hypoglycaemia and less day to day glucose variability than older basal insulins. This study assessed the use of insulin degludec in type 1 diabetes in real clinical practice in the UK. Data were extracted from General Practice records in 2 areas of England for people with type 1 diabetes, prescribed insulin degludec, who had weight and HbA1c measurements at baseline and at least 3 months into treatment. 77 eligible people were identified (43M, 44F). Mean age was 53.3 years (SD 19.9). In this unselected group, there was a significant reduction in HbA1c from 9.5% to 8.9% (p<.001), associated with a significant rise in weight from 78.4 to 80.7kg (P<.005). For individuals, there was no significant association between the change in HbA1c and change in weight. These data were considered alongside data from the ABCD Nationwide Degludec Audit. In this audit, there were 144 people with type 1 diabetes who had weight and HbA1c measurements at baseline and at least 3 months into treatment at the time of the analysis (65M, 79F). Mean age was 44.1 years (SD 15.7). There was no significant reduction in HbA1c with degludec treatment (8.9% to 8.7%), and no significant increase in weight (77.2 to 77.7 kg). We have previously shown in the ABCD Nationwide Degludec Audit that there is no significant change in HbA1c or weight in those switched to insulin degludec for reasons of hypoglycaemia (n=88), although hypoglycaemia is significantly improved. A significant reduction in HbA1c and significant increase in weight is seen in those switched to insulin degludec for reasons other than hypoglycaemia (n=56). If the majority of those in the General Practice database were switched to degludec for reasons other than hypoglycaemia, such as to reduce day to day glucose variability, this may explain the observed results.

90. Barrett's surveillance in a district general hospital: Do we follow guidelines for non-dysplastic barrett's?

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Abstract Introduction BSG 2013 guidelines for diagnosis and management of Barrett's oesophagus (BE) recommend surveillance intervals based on the length of BE, histology, and presence of intestinal metaplasia. Practice for BE surveillance varies nationally. East and North Hertfordshire NHS Trust is a district general hospital with a population of approx. 6 00 000. Since the 2013 guidelines most BE surveillance is done by 2 consultants and a specialist nurse. Methods A retrospective review of all gastroscopies performed for the indication of BE surveillance from 1/1/16-31/12/16. These were audited against BSG 2013 guidelines specifically looking at use of Prague criteria (PC), histology and selection of surveillance intervals. All endoscopies were performed using high definition video-endoscopes. Results 207 OGDs for BE surveillance were reviewed (median age 68 [29-90], 75% males). 144 (70%) recorded BE length using the PC. 23 (11%) had either no or minimal Barrett's (<1 cm), of whom 15 (65%) were discharged. In the remain-ing 40 OGDs (19%) length of BE was unclear in 11 reports, able to be partially deduced from the free text in 20 cases, and fully deduced in 9 cases. Analysis of surveillance intervals was performed only on the 144 OGDs where length of BE was documented fully using PC. Amongst these were 17 cases of dysplasia (12%: 6 indefinite for dysplasia, 7 low grade dysplasia, 4 high grade dysplasia). The remaining 127 cases (88%) were non-dysplas-tic. Distribution of length of BE is displayed in figure 1. Of the non-dysplastic cases, 46 (36%) had a BE length of <3 cm of whom 20 (43%) had surveillance interval of 3-5 years, 18 (40%) were discharged and 8 (17%) had a surveillance interval of 2 years. 81 (64%) had a BE length of >3 cm, of whom 74 (92%) had surveillance interval of 2-3 years, 1 (1%) for 1 year, 4 (5%) for 4-5 years, 1 (1%) was discharged and 1 (1%) died. Conclusions Whilst we reported 70% of our BE length using PC, a measure now recommended as a quality standard, a further 19% could have been reported this way. Our data show that only 10% (13) of our 127 non-dysplastic BE cases had an incorrect surveillance interval chosen, less than the figures suggested by JAG who estimate that 30% of patients undergo surveillance at incorrect intervals or where not indicated at all. Of the 207 OGDs analysed, 135 (65%) were carried out by one of our 2 consultants with specialist interest in BE or our BE specialist nurse endoscopist. We therefore support the advice that BE surveillance should be performed on dedicated lists in order to improve endoscopic quality reporting and choice of correct surveillance interval. [Figure Presented] Abstract PTH-023 Figure 1 Non-dysplastic cases depicated by blue bars with number of cases as each length corresponding to height of the bar. Each individual case of dysplasia is depicted as illustrated in the key above.

91. Successful implementation of remote video consultations for patients receiving home parenteral nutrition

Authors Bond A.; Taylor M.; Abraham A.; Abblet J.; Teubner A.; Slater C.; Leahy G.; Lai S.
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Abstract Background Salford Royal NHS Foundation Trust National Intestinal Failure Unit (IFU) provides care for patients from across the UK and beyond. Type 3 IF patients are routinely reviewed at 3-6 month intervals. Between March 2007-2017 there was a 90% increase in type 3 patients attending our outpatient. Coping with the increasing demand whilst maintaining outpatient capacity and standards is a key component of IF care. Telemedicine provides a strategy for achieving this. Moreover, whilst doing so, such approaches can save patients' time, cost, lengthy and difficult journeys to the outpatient clinic.Thereby improving the patient experience. Method Quality Improvement (QI) methodology was used to implement and evaluate remote video consultations. Implementation began Dec 2015 via patient consultation and small tests of change. All protocols and information sheets were approved through clinical governance and trust policy. Clinical data was obtained from a prospectively maintained database forming part of ESPEN audit standards. A virtual clinic allows the clinician and the patient to see each other, holding a face to face discussion via the internet using the video call service Skype. An anonymous qualitative satisfaction questionnaire was subsequently completed by participating patients. Results At the end of 2015, 246 patients were receiving HPN, this figure rose by 13.7% by 2017 to 285. Twenty-one patients used our telemedicine service, with a total of 55 contacts. Mean potential distance travelled by telemedicine cohort was 118.6 miles (range 10-441.8), mean cumulative miles saved since telemedicine initiated 8600 miles. Twelve patients used the service on multiple occasions. Seventy percentage of patients rated their satisfaction with the system at 90% and above, with the mean satisfaction of 83%. Despite the increase in number of HPN patients, the mean duration between outpatient appointment offered reduced from 103.7 days before telemedicine to 100.4 days in 2017, for the whole HPN cohort. One patient had a CRBSI following commencement of telemedicine. 9.5% of the telemedicine cohort were admitted with a HPN complication. This compares to an admission rate of 23.5% for the whole HPN cohort over the two years since telemedicine was initiated. Conclusion The introduction of telemedicine can release some HPN clinic capacity and help reduce the increasing pressure for patient access to HPN services. Importantly, compliance with NICE and ESPEN guidelines can be maintained.Whilst maintaining patient satisfaction and patient safety.

92. A model of good inpatient diabetes care with consistently low levels of medication errors

Authors Parsad M.; Lambert K.D.; Ardern D.; Mezzullo A.C.
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Abstract The National Diabetes Inpatient Audit is a yearly audit aimed at providing a snapshot view on various aspects of diabetes care across hospitals in England. Results are provided for each hospital and are shown in comparison to other hospitals. Since 2011, our 450-bedded hospital has been in the first quartile with regards to medication errors, prescription errors, medicine management errors and insulin errors. In the 2016 audit, we had 11.6% medication errors whereas across England, there were 44.6% medication errors. Our service is exemplary on many fronts. Foundation year doctors get formal training in diabetes care. Information Technology is key in providing the fail-proof electronic prescribing software, access to General Practitioner's Health records, safe insulin prescribing e-module, and up-to-date online clinical guidelines. We have Pharmacists and Pharmacist Technicians who check electronic prescriptions on a daily basis. We also benefit from the service of a Diabetes Specialist Pharmacist. We provide a twice-weekly specialist diabetes ward round across the whole hospital and patients are usually identified from the Electronic Patients Record software. The Diabetes Specialist Nurses are additionally available for one-to-one education Monday to Friday 0900 to 1700. Finally, we run a comprehensive diabetes education day for nurses and other allied health care professionals twice a year.

93. Does a direct-to-scope pathway significantly reduce time to diagnosis for patients with positive coeliac serology?

Authors Penman D.; Trotter R.; Thuraisingam A.
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Abstract Introduction NICE Coeliac Disease Quality Standard 134 (QS134) states that: Patients with suspected coeliac disease (CD) should undergo endoscopic (OGD) intestinal biopsy within 42 days of referral and, if confirmed, should receive specialist dietary advice. Given that UK incidence of CD is 19:100,000, our trust would expect 60 new cases of CD per year. In October 2017, a direct-to-scope referral was introduced to streamline the diagnostic pathway. We sought to evaluate the impact of this pathway on the time to histological diagnosis and dietitian review. Methods All adults referred with positive coeliac serology initiated in primary care from April-September 2017 were compared to those referred following the introduction of the new pathway. Data for the two cohorts was collected from e-case notes using a standard audit tool. This included time from referral to: OGD; confirmation of diagnosis; clinic review; dietician review and vaccination advice. Results 27 patients (cohort A) were identified in the 6 months prior to October and 17 patients (cohort B) in the following 4 months. In cohort A 2 patients did not attend their appointment and 5 patients underwent OGD prior to referral. From April-September we also identified 10 patients with positive coeliac serology that, to date, have not been referred. The results are shown in table 1. Abstract PTU-127 Table 1 mean range mean range (days) (days) Result-GP referral 30 7-159 29 9-140 0.98 GP referral-OGD 39 4-89 24 4-43 0.010 GP referral-clinic 43 13-81 49 27-67 0.22 GP referral-confirmation of CD 68 12-39 21-69 0.0012 189 GP referral-dietician review 104 98-52 30-71 0.0035 230 Patients discharged after initial 30.4% 92.3% review Patients given vaccination advice 25.0% 69.2% Conclusions The use of a direct-to-scope pathway significantly reduces time to diagnosis. This change in the pathway allows clinic and dietician review to occur simultaneously, resulting in referral to treatment time within 18 weeks. The only patient in cohort B outside the 6 week target to endoscopy did not tolerate their index OGD and required a repeat endoscopy. Written confirmation of diagnosis now occurs prior to the initial clinic review, helping reduce unnecessary follow-up for patients with uncomplicated CD. We hope continued use of this pathway may also reduce the number of patients with positive serology not referred from primary care.

94. Outcomes of an anaemia service evaluation using the IBD registry

Authors Waddingham W.; Bloom S.; McCluskey L.; Haukenes K.; Crooks B.; Davies V.; Knight P.; Dharmasiri S.; Silva A.C.; Cummings F.; Abbott J.; Oliver D.; Johnson M.
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Abstract Introduction Iron deficiency (ID) and iron deficiency anaemia (IDA) are frequent complications of Crohn's disease (CD) and Ulcerative Colitis (UC). Assessing iron status in IBD patients can be challenging as tests may be unreliable in the presence of inflammation. European Crohn's and Colitis Organisation (ECCO) guidelines state FBC, CRP and ferritin are the minimum to detect IDA. The UK IBD audit of inpatient care found 56% of those with IDA did not receive iron, but the standard of care for IBD outpatients is unknown. IBD patients with IDA rarely have an iron deficit of <1000 mg iron and effective treatment for ID/IDA requires correct and sufficient dosing of iron. This project compares current practice with the ECCO guidelines. Initial pilot data on ID/IDA diagnosis is presented from a Joint Working project using an adapted Webtool with anaemia specific parameters to determine the standard of care for IBD outpatients. Methods 20 consecutive consented patients (10 CD, 10 UC) were recruited at 5 sites and followed for around 12 months. Anaemia: Hb <120 g/L $ or <130 g/L 3 ID: MCV <80 fl AND/OR ferritin <30 ug/L if CRP <5 mg/L OR ferritin >30 ug/L to < 100 ug/L if CRP >5 mg/ml AND/OR TSAT <20% IDA: Anaemia and ID Results Baseline data were available for 94 patients: 45 (48%) male and 49 (52%) female, 47 (50%) with CD and 45 (48%) with UC (2 patients with unidentified IBD) mean age 46.5 years. 82 patients had >1 recorded haematinic and 18 of these (22%) had 26 anaemic episodes, with 10 (56%, 5 UC and 5 CD) and 14 (54%) of these patients and episodes being IDA. 23 (28%, 8 CD, 14 UC, 1 undefined IBD) patients experienced 34 episodes of ID. 136 Hb results were recorded, but only 78 (57%) were combined with ferritin plus CRP. Conclusions Most cases of anaemia were IDA, and more episodes of ID than IDA were found. An equal number of CD and UC patients had IDA, but non-anaemic ID was more common in UC than CD patients. As only 57% of haematinic tests fulfilled the minimum requirement to detect ID in anaemic IBD patients (Hb combined with ferritin plus CRP) ID/IDA may be significantly underdiagnosed conditions in IBD. However, these findings are limited due to the small, real-world, dataset. An adapted Registry Webtool may allow easy data collection though there are challenges in completing data input during consultations. Iron status could therefore be better monitored if haematinics were a default part of the IBD Registry dataset, allowing for quality improvement.

95. Endoscopic management of early neoplasia in barrett's oesophagus-an outcome analysis from North-East England

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Abstract Background Barrett's Oesophagus (BO) is a pre-malignant condition associated with progression to dysplasia and oesophageal adenocarcinoma (OAC) and surveillance startegies are aimed at detecting early neoplasia (low and high grade dysplasia), which can be treated by endoscopic resection(ER) and radiofrequency ablation(RFA). The British Society of Gastroen-terology Guidelines for management of Barrett's Oesophagus (Gut 2014) and NICE pathway (2014) recommend that all units carrying out these procedures should audit their performance to national standards. The North-east of England is an area of high prevalence and poor outcomes related to OAC. Aim of this study This study was aimed at analysing the combined outcomes of the treatment of Barrett's related early neoplasia in the two centres that provided this treatment in 2015-2016. The population covered by these two centres is approximately 3.0 million, with two regional tertiary MDTs. Methods A retrospective review of endoscopy, MDT and case notes for all patients with Barrett's related early neoplasia (defined as either low grade (LGD) or high grade (HGD) dysplasia) between January 2015-December 2016 was under-taken. All histology was reviewed by two specialist GI Pathologists, and endoscopic resection and RFA treatment carried out by two endoscopists (AD, DN). A limited number of endoscopic resections in the early phases were carried out by surgical endoscopists. RFA was done using the HALO 360 or 360 express balloons for circumferential ablation or the HALO 90 or TTS devices for focal ablation. 12 month outcomes for complete response for intestinal metaplasia (CE-IM) were analysed. Results A total of 49 patients with Barrett's oesophagus related dysplasia were treated, median age 68 years (range 43-85), M:F=3.5:1. 56% patients were current smokers and 15% ex-smokers. 4% patients had a family history of OAC. 52% patients were not obese. 71% pts had a Barrett's segment <8 cm long. 24 pts (52%) had high grade dysplasia, 17 of which were in a Barrett's segment of <8 cm length. Of 22 patients with LGD, only 7 pts had a Barrett's segment of >8 cm. 3/12 pts with LGD were treated by EMR followed by RFA, while 9 pts received RFA alone (the remaining LGD pts were either downgraded or kept on surveillance). In the HGD group, after MDT discussion, 4 pts opted for oesopha-gectomy, 7 had EMR and RFA and 7 had RFA alone. Post EMR histology confirmed dysplasia in 83%, and intramucosal adenocarcinoma in 5%. CE-IM was achieved in 15 pts (78%) at the end of 1 year, with 2 pts (9%) showing LGD and 1 (4%) showing HGD and 1 indefinite for dysplasia. Conclusions In this real world analysis of Endotherapy for Barrett's oesophagus in an area of high prevalence of OAC, we have shown that EMR rates are 50% for HGD and 25% for LGD and CE-IM rates of 78% achieved at 12 months. This is comparable to national outcomes, although the EMR rates for LGD are considerably lower.

96. Improving quality and reducing frequency of hospital care for alcohol-use disorder patients: A multi-disciplinary-team approach

Authors Owens L.; Kullu C.; Byrne D.; Lewis E.; Richardson P.; Patterson K.
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Abstract Introduction Patients with alcohol dependence often have complex health and social care needs resulting in frequent attendance at hospital. All too often care is aimed at optimising medical treatment of presenting conditions with little attention to, and planning for mitigation of causes, frequently exacerbated by non-medical problems. This failure to address the wider determinants of health often leads to a cycle of readmission. Therefore we aimed to improve the overall management of this patient group by bringing together a multidisciplinary team (MDT) to develop personalised multi-service, multi-professional care pathways. Methods We developed a core multidisciplinary group with representation from our hospital hepatology team, our alcohol service, liaison psychiatry, occupational therapy, and our partners in primary care and homeless services. Other professionals and services were invited to the MDT meeting based on individual patient needs; this included the patient and or family and carers as appropriate. The purpose of this group was to develop a bespoke pathway of care with all current and future care providers, and foster an atmosphere for collaboration and mutual support. Our patients were often being cared for by multiple services, however much of this work was happening in isolation and was at times conflicting. Importantly, the patients were unclear where to go for what, and were uti-lising the ED as a failsafe when they were troubled. Results MDT facilitated communication between services, professionals and the patient. This helped us provide planned rather than reactive care. For our 46 patients who have been presented at MDT, at six month follow-up we were able to demonstrate a significant reduction in hospital attendance and admission, resulting in ~120 less admissions and ~434 ED attendances across the acute trust; this equates to a saving within the last 6 months of an estimated 63 600 on ED attendance alone. Conclusions MDT meetings are a familiar element of system delivery within acute hospitals. What is unique about our approach, and has resulted in significant quality improvement is that we invested time building relationships with people from organisations not traditionally included in acute hospital care planning. This included those working in homeless shelters, probation services, voluntary agencies, families and patients. We believe our success could provide the confidence for other acute care teams across the NHS to replicate our model.

97. A prospective audit of the 2017 espen guidelines on micronutrient testing in quiescent IBD patients

Authors MacMaster M.; Gaya D.; Thomson C.; Gerasimidis K.; Talwar D.; Stefanowicz F.
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Abstract Introduction ESPEN guidelines advise regular screening for micronutrient deficiencies in patients with inflammatory bowel disease (IBD). This is rarely undertaken in UK and in the presence of active disease and systemic inflammation, plasma micronutrient concentration is complicated by the influence of acute phase response. We prospectively audited the micronutrient profile in an IBD cohort in clinical remission attending the OPC. Methods 54 IBD patients in remission were identified between September 2017 and January 2018 with a Harvey Bradshaw Index<4 or partial Mayo score <2. Micronutrient screen was performed for Vitamin Bl, B2, B6 and B12, Vitamin A, Vitamin E, Vitamin C, Vitamin D, Vitamin K, Selenium, Magnesium, Copper, Ferritin, Zinc, Manganese and Folate. Serum albumin and CRP were measured and faecal calprotectin was also tested. Results 33 patients had Crohn's disease with the majority Montreal A2 (15), L2 (15), Bl (23). 21 patients had UC or IBDU with majority Montreal A2 (12), E2 (10). Low levels of Vitamin B2 were identified in 1 (2%); Vitamin B6 in 10 (19%); Vitamin B12 in 6 (11%), Vitamin A in 1 (2%); Vitamin C in 9 (17%); Vitamin D in 39 (72%); Ferritin in 3 (6%); Zinc in 10 (20%) and Folate in 4 (8%). 3 (6%) patients had low levels of Selenium, Magnesium and Copper. Vitamin E, Vitamin Bl and Manganese were within normal range in all patients. To rule out the effect of acute phase response on blood micronutrient levels, a subgroup of 27 (50%) patients with albumin >34 g/L, CRP <20 mg/L and faecal calprotectin <250 mg/kg were analysed. Low levels of Vitamin B2 were identified in 1 (4%); Vitamin B6 in 4 (15%); Vitamin B12 in 2 (8%), Vitamin A in 1 (4%); Vitamin C in 2 (7%); Vitamin D in 20 (74%); Copper in 2 (7%); Ferritin in 1 (4%); Zinc in 4 (15%) and Folate in 2 (7%). Mag-nesium was within normal range in all patients. A few patients had high Vitamin Bl (1), Selenium (1) and Manganese (3). Spearman' rank correlation analysis showed positive significant correlations between faecal calprotectin with Vitamin B2, Magnesium, Copper, Ferritin and manganese; CRP with serum Selenium and Copper; and Albumin with Vitamin B2, Vitamin A, Vitamin D, serum Selenium, Copper, Ferritin and Zinc. Conclusions While we identified a substantial number of IBD patients with micronutrient deficiencies, a proportion of these may be an epiphenomenon of the acute phase response. We propose that micronutrient screening only be performed in IBD patients with disease in 'deep' remission.

98. Hypoglycemia in patients with diabetes in an Australian public hospital setting

Authors Piya M.K.; Zarora R.; Fletcher T.; Simmons D.
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Abstract Background: Diabetes is a common co-morbidity among hospital inpatients, particularly in medical wards. Diabetes is linked to increased length of stay and mortality in hospital inpatients, and hypoglycemia (hypo) is considered a contributory factor. We sought to determine the prevalence of diabetes in medical wards and the prevalence and patterns of hypo during their hospital stay. Methods: A daily census on three medical wards (79 beds) was conducted over a 4 month period from June 2017 in a 306 bed tertiary Sydney hospital. Charts and medications for inpatients with diabetes were audited each Friday using a questionnaire based on the UK National Diabetes Inpatient Audit. Patients admitted under the care of the diabetes team were excluded. Readmissions were counted as separate episodes. Results: The mean prevalence of diabetes was 27%, of which 2.4% had T1DM, with 212 patient episodes audited in 196 patients (16 readmissions). Mean age (SD) was 71 years (11.2), 54% male. Only 5.6% had a diabetes related admission. Insulin use was 34% on admission but 52% during hospital stay. There were 74 events of hypo (<72 mg/dL) in 38 patients (18%), with 10 episodes of severe hypo (<54 mg/dL) in 9 patients (4.3%). Within the first week of admission, 50 of these hypo events occurred (8 severe) in 29 patients. Insulin was prescribed in 82% of the patients who had hypo (31/38), and 89% of those who had severe hypo (8/9), with only 50% of them admitted on insulin. A smaller number of hypo events occurred 8am-5pm compared to 5pm-8am (29 vs. 45), with no significant difference between days of the week. Conclusion: Hypoglycemia is a major burden in patients with diabetes in hospital, particularly in the first week of admission, even when patients are not admitted due to diabetes related problems. Insulin use was the major risk factor and many patients had multiple hypo events. We recommend early involvement of the diabetes inpatient team as well as centralized point of care testing of glucose to allow early identification of patients at risk.

99. Cecal withdrawal time: Assessing standards of colonoscopy in district general hospital

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Abstract Introduction The British Society of Gastroenterology, the UK Joint Advisory Group on GI Endoscopy, and the Association of Coloproctology of Great Britain and Ireland have developed quality assurance measures and key performance indicators for the delivery of colonoscopy within the UK. However, studies have suggested that high variations in the quality of colonoscopy among different endoscopists are reflected in surrogate measures such as adenoma detection, cecal intubation rates, withdrawal times, and incidence of complications. This documents identifies the unacceptable variation in practice and measures adopted to improve quality of care. Method A prospective, observational colonoscopy practice audit was conducted of cecal withdrawal time at Glangwili General Hospital, Carmarthem for patients who presented for colonoscopy between August 2017 to January 2018. Diagnostic procedures were included in the study comprising two cycles 8 months apart. Patients with history of colonic surgery were eliminated. Same endoscopy nurse manually collected the data from 5 different endoscopist using stopwatch without them knowing. Both the cycles were 3 months apart during which different measures were taken to improve with-drawal time including sending individual feedback to endoscopists, one to one discussions between endoscopy consultant lead and involved endoscopist and keeping a timer in endoscopy room to keep tract of time. [Figure Presented] Results We reviewed 10 colonoscopies performed by each endoscopist in each cycle of audit and mean cecal withdrawal time is shown below. After taking appropriate measure to improve quality of care following results were obtained. Following graph shows variation in mean withdrawal time between two cycles compared against set standards. Below shows the comparison of 1 st and 2nd cycle showing rectal retroflexion performed and imaging of cecal landmarks recording done by each endoscopist [Figure Presented] Conclusion Practice among endoscopists varied with majority providing good standard of care. Weak points identified during 1 st stem of audit cycle and changes implemented lead to improvement in quality of care but still there is further room for improvement. Regular audits are important to make sure that colonoscopy practice meets key performance indicators outlined by JAG and BSG in order to increase polyp detection rate.

100. Introduction of sems for malignant distal biliary strictures at a large london district general hospital

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Abstract Introduction Biliary stents are commonly used to treat malignant biliary obstruction. Compared to plastic stents, self-expanding metal stents (SEMS) have a wider diameter and therefore offer enhanced biliary decompression and a longer duration of patency. In addition, biliary decompression with SEMS insertion at ERCP commands a significantly higher level of reimbursement than if a plastic stent is employed. For these reasons, at our hospital since 2015, plastic stents have been abandoned in favour of uncovered or covered SEMS (60 mm XlO mm) in patients with unresectable disease or potentially resectable disease respectively. Herein, we report the first 2 years of this change in endoscopic practice at a large DGH in East London. Methods Patients diagnosed with either pancreatic or biliary tract cancer between April 2015 and April 2017 and who underwent endoscopic biliary stenting were prospectively audited. Retrospective Data collection was performed from electronic systems including Somerset, CRS, EPR and unisoft GI reporting from this prospective cohort. Results Of 86 patients diagnosed with pancreatic or bile duct cancer, 45 patients (52%) underwent biliary stenting (37 distal biliary stricture, 9 with a perihilar stricture). Of the 37 with a distal stricture, CBD cannulation rate was 92%, the remainder required a rendezvous procedure to access the CBD. A SEMS was deployed across the stricture in all cases. A fully covered and uncovered SEMS was deployed in 27 and 12 patient respectively. A>50% reduction in bilirubin was identified in 94% of cases with this effect similar in both covered and uncovered SEMS. Following SEMS insertion 77% of patients achieved a bilirubin <50 umol/L. In total, 24 patients required repeat ERCP due to tumour progression with an average of 2.2 interventions per patient. During re-intervention, a new SEMS was deployed within the previous SEMS. 30 mortality post ERCP was 9%. Mortality at 6 months was 19%. Distal stent migration was not identified in any patient. Four patients (3 covered and 1 uncovered) suffered cholecystitis due to gallbladder contrast retention after occlusion of the cystic duct orifice. Whereas this was treated with stent removal in patients with covered SEMS, cholecystostomy drainage was required in the patient with uncovered SEMS. Conclusions In our unit the introduction of SEMS for the management of distal biliary strictures has resulted in excellent rates of biliary decompression with stent occlusion due to tumour progression managed by SEMS insertion within SEMS. Whereas distal stent migration was not identified in our series, 10% of patients suffered the gallbladder complications highlighting the need try to avoid SEMS deployment over the cystic duct orifice.

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 18-Aug-2018]	115
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