Strategy 432444/8

#	Database	Search term	Results
8	Medline	(((audit* OR "quality improvement*").ti,ab OR exp "CLINICAL AUDIT"/ OR exp "QUALITY IMPROVEMENT"/) AND ((NHS OR england OR UK OR "united kingdom" OR "national health service").ti,ab OR exp "UNITED KINGDOM"/)) [Since 27-Jun-2019]	32

Contents 32 of 32 results on Medline - (((audit* OR "quality improvement*").ti,ab OR exp "CLINICAL AUDIT"/ OR exp "QUALITY IMPROVEMENT"/) AND ((NHS OR england OR UK OR "united kingdom" OR "national health service").ti,ab OR exp "UNITED KINGDOM"/)) [Since 27-Jun-2019]

Results 32 of 32 results on Medline - (((audit* OR "quality improvement*").ti,ab OR exp "CLINICAL AUDIT"/ OR exp "QUALITY IMPROVEMENT"/) AND ((NHS OR england OR UK OR "united kingdom" OR "national health service").ti,ab OR exp "UNITED KINGDOM"/)) [Since 27-Jun-2019]

1. Quality improvement of prescribing safety: a pilot study in primary care using UK electronic health records.

Authors Booth, Helen P; Gallagher, Arlene M; Mullett, David; Carty, Lucy; Padmanabhan, Shivani; Myles, Puja R; Welburn, Stephen J; Hoghton, Matthew; Rafi, Imran; Valentine, Janet
Source The British journal of general practice : the journal of the Royal College of General Practitioners; Jul 2019
Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 31262845
Database Medline
Available at The British journal of general practice : the journal of the Royal College of General Practitioners from EBSCO (MEDLINE Complete)
Available at The British journal of general practice : the journal of the Royal College of General Practitioners from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at The British journal of general practice : the journal of the Royal College of General Practitioners from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.
Available at The British journal of general practice : the journal of the Royal College of General Practitioners from Unpaywall

Abstract BACKGROUNDQuality improvement (QI) is a priority for general practice, and GPs are expected to participate in and provide evidence of QI activity. There is growing interest in harnessing the potential of electronic health records (EHR) to improve patient care by supporting practices to find cases that could benefit from a medicines review.AIMTo develop scalable and reproducible prescribing safety reports using patient-level EHR data.DESIGN AND SETTINGUK general practices that contribute de-identified patient data to the Clinical Practice Research Datalink (CPRD).METHODA scoping phase used stakeholder consultations to identify primary care QI needs and potential indicators. QI reports containing real data were sent to 12 pilot practices that used Vision GP software and had expressed interest. The scale-up phase involved automating production and distribution of reports to all contributing practices that used both Vision and EMIS software systems. Benchmarking reports with patient-level case review lists for two prescribing safety indicators were sent to 457 practices in December 2017 following the initial scale-up (Figure 2).RESULTSTwo indicators were selected from the Royal College of General Practitioners Patient Safety Toolkit following stakeholder consultations for the pilot phase involving 12 GP practices. Pilot phase interviews showed that reports were used to review individual patient care, implement wider QI actions in the practice, and for appraisal and revalidation.CONCLUSIONElectronic health record data can be used to provide standardised, reproducible reports that can be delivered at scale with minimal resource requirements. These can be used in a national QI initiative that impacts directly on patient care.

2. Qualitative process evaluation of the Perioperative Quality Improvement Programme (PQIP): study protocol.

Authors Wagstaff, Duncan; Moonesinghe, S Ramani; Fulop, Naomi J; Vindrola-Padros, Cecilia
Source BMJ open; Jul 2019; vol. 9 (no. 7); p. e030214
Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 31296515
Database Medline
Available at BMJ open from Europe PubMed Central - Open Access
Available at BMJ open from HighWire - Free Full Text
Available at BMJ open from ProQuest (Health Research Premium) - NHS Version
Available at BMJ open from Unpaywall

Abstract INTRODUCTIONThe Perioperative Quality Improvement Programme (PQIP) is designed to measure complications after major elective surgery and improve these through feedback of data to clinicians. Previous research suggests that despite the significant resources which go into collecting data for national clinical audits, the information they contain is not always used effectively to improve local services.METHODS AND ANALYSISWe will conduct a formative process evaluation of PQIP comprising a multisited qualitative study to analyse PQIP's programme theory, barriers, facilitators and wider contextual factors that influence implementation. The research will be carried out with the PQIP project team and six National Health Service (NHS) Trusts in England, selected according to geographical location, type of hospital, size and level of engagement with PQIP. We will include one Trust which has not expressed interest in the PQIP for comparison and to explore the role of secular trend in any changes in practice. We will use semi-structured interviews (up to 144 in Trusts and 12 with the project team), non-participant observations (up to 150 hours) and documentary analysis. We will track the lifecycle of perioperative data, exploring the transformations it undergoes from creation to use. We will use framework analysis with categories both from our research questions and from themes emerging from the data.ETHICS AND DISSEMINATIONEthical approval has been granted from the University College London Research Ethics Committee (ref 10375/001). Permissions to conduct research at NHS Trusts have been granted by local Research and Development offices in coordination with the Health Research Authority. We will follow guidelines for data security, confidentiality and information governance. Findings will be shared at regular time points with the PQIP project team to inform the implementation of the programme, and with participating NHS Trusts to help them reflect on how they currently use data for improvement of perioperative services.

3. Pay for performance for hospitals.

Authors Mathes, Tim; Pieper, Dawid; Morche, Johannes; Polus, Stephanie; Jaschinski, Thomas; Eikermann, Michaela
Source The Cochrane database of systematic reviews; Jul 2019; vol. 7 ; p. CD011156
Publication Date Jul 2019
Publication Type(s) Journal Article Review
PubMedID 31276606
Database Medline
Available at Cochrane Database of Systematic Reviews from Cochrane Collaboration (Wiley)

Abstract BACKGROUNDPay-for-Performance (P4P) is a payment model that rewards health care providers for meeting pre-defined targets for quality indicators or efficacy parameters to increase the quality or efficacy of care.OBJECTIVESOur objective was to assess the impact of P4P for in-hospital delivered health care on the quality of care, resource use and equity. Our objective was not only to answer the question whether P4P works in general (simple perspective) but to provide a comprehensive and detailed overview of P4P with a focus on analyzing the intervention components, the context factors and their interrelation (more complex perspective).SEARCH METHODSWe searched CENTRAL, MEDLINE, Embase, three other databases and two trial registers on 27 June 2018. In addition, we searched conference proceedings, gray literature and web pages of relevant health care institutions, contacted experts in the field, conducted cited reference searches and performed cross-checks of included references and systematic reviews on the same topic.SELECTION CRITERIAWe included randomized trials, cluster randomized trials, non-randomized clustered trials, controlled before-after studies, interrupted time series and repeated measures studies that analyzed hospitals, hospital units or groups of hospitals and that compared any kind of P4P to a basic payment scheme (e.g. capitation) without P4P. Studies had to analyze at least one of the following outcomes to be eligible: patient outcomes; quality of care; utilization, coverage or access; resource use, costs and cost shifting; healthcare provider outcomes; equity; adverse effects or harms.DATA COLLECTION AND ANALYSISTwo review authors independently screened all citations for inclusion, extracted study data and assessed risk of bias for each included study. Study characteristics were extracted by one reviewer and verified by a second.We did not perform meta-analysis because the included studies were too heterogenous regarding hospital characteristics, the design of the P4P programs and study design. Instead we present a structured narrative synthesis considering the complexity as well as the context/setting of the intervention. We assessed the certainty of evidence using the GRADE approach and present the results narratively in 'Summary of findings' tables.MAIN RESULTSWe included 27 studies (20 CBA, 7 ITS) on six different P4P programs. Studies analyzed between 10 and 4267 centers. All P4P programs targeted acute or emergency physical conditions and compared a capitation-based payment scheme without P4P to the same capitation-based payment scheme combined with a P4P add-on. Two P4P program used rewards or penalties; one used first rewards and than penalties; two used penalties only and one used rewards only. Four P4P programs were established and evaluated in the USA, one in England and one in France.Most studies showed no difference or a very small effect in favor of the P4P program. The impact of each P4P program was as follows.Premier Hospital Quality Incentive Demonstration Program: It is uncertain whether this program, which used rewards for some hospitals and penalties for others, has an impact on mortality, adverse clinical events, quality of care, equity or resource use as the certainty of the evidence was very low.Value-Based Purchasing Program: It is uncertain whether this program, which used rewards for some hospitals and penalties for others, has an impact on mortality, adverse clinical events or quality of care as the certainty of the evidence was very low. Equity and resource use outcomes were not reported in the studies, which evaluated this program.Non-payment for Hospital-Acquired Conditions Program: It is uncertain whether this penalty-based program has an impact on adverse clinical events as the certainty of the evidence was very low. Mortality, quality of care, equity and resource use outcomes were not reported in the studies, which evaluated this program.Hospital Readmissions Reduction Program: None of the studies that examined this penalty-based program reported mortality, adverse clinical events, quality of care (process quality score), equity or resource use outcomes.Advancing Quality Program: It is uncertain whether this reward-/penalty-based program has an impact on mortality as the certainty of the evidence was very low. Adverse clinical events, quality of care, equity and resource use outcomes were not reported in any study.Financial Incentive to Quality Improvement Program: It is uncertain whether this reward-based program has an impact on quality of care, as the certainty of the evidence was very low. Mortality, adverse clinical events, equity and resource use outcomes were not reported in any study.Subgroup analysis (analysis of modifying design and context factors)Analysis of P4P design factors provides some hints that non-payments compared to additional payments and payments for quality attainment (e.g. falling below specified mortality threshold) compared to quality improvement (e.g. reduction of mortality by specified percent points within one year) may have a stronger impact on performance.AUTHORS' CONCLUSIONSIt is uncertain whether P4P, compared to capitation-based payments without P4P for hospitals, has an impact on patient outcomes, quality of care, equity or resource use as the certainty of the evidence was very low (or we found no studies on the outcome) for all P4P programs. The effects on patient outcomes of P4P in hospitals were at most small, regardless of design factors and context/setting. It seems that with additional payments only small short-term but non-sustainable effects can be achieved. Non-payments seem to be slightly more effective than bonuses and payments for quality attainment seem to be slightly more effective than payments for quality improvement.

4. Vulnerabilities in diabetic eye screening for children and young people in England.

Authors Ibanez-Bruron, Maria C; Solebo, Ameenat L; Cumberland, Phillippa M; Rahi, Jugnoo S; Diabetic Eye Disease in Childhood Study (DECS) group
Source Pediatric diabetes; Jul 2019
Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 31270908
Database Medline

Available at Pediatric Diabetes from Wiley Online Library Medicine and Nursing Collection 2019 - NHS
Available at Pediatric Diabetes from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection
Available at Pediatric Diabetes 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 BACKGROUNDChildren and young people (CYP) living with diabetes require integrated child-centered care. We hypothesized that suboptimal uptake to diabetic retinopathy screening in CYP may be partly related to the degree of services integration. We investigated the structure of the current pediatric diabetic eye care pathway and associations between service-level characteristics and screening uptake.METHODSA quality improvement project between January and May 2017 comprising a survey of practice of all 158 pediatric diabetes services (pediatric diabetes units, PDUs) across England and secondary data analysis of routinely collected service data. Generalized linear models for proportional responses were fitted to investigate associations between reported PDU characteristics and screening uptake.RESULTS124 PDUs (78%) responded. In 67% (n = 83), patients could be referred directly to screening programs; the remainder relied on primary care for onward referral. 97% (n = 120) considered eye screening results useful for counseling patients but only 65% (n = 81) reported it was "easy" to obtain them. Factors independently associated with higher screening uptake were a higher proportion of patients referred from primary care (OR = 1.005; 95%CI = 1.004-1.007 per 1% of increase), absence of "out-of-catchment area" patients (OR = 1.13; 95%CI = 1.04-1.22), and easy access to eye screening results (OR = 1.45; 95%CI = 1.34-1.56).CONCLUSIONSThere is limited direct communication between the services involved in diabetic eye care for CYP in England. This risks reducing the effectiveness of diabetic retinopathy screening. Similar vulnerabilities are likely to exist in other countries where retinopathy screening for CYP has been "bolted on" to provision for adults.

5. Diagnostic delay for superficial and deep endometriosis in the United Kingdom.

Authors Ghai, Vishalli; Jan, Haider; Shakir, Fevzi; Haines, Pat; Kent, Andrew
Source Journal of obstetrics and gynaecology : the journal of the Institute of Obstetrics and Gynaecology; Jul 2019 ; p. 1-7
Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 31328629
Database Medline

Available at Journal of obstetrics and gynaecology : the journal of the Institute 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 Journal of obstetrics and gynaecology : the journal of the Institute 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 A Cross-sectional study was undertaken at a specialist centre in the United Kingdom investigating duration and causes of delay in the diagnosis of endometriosis. One hundred and one women completed a self-reported questionnaire containing 20 items about their psychosocial, symptoms and experiences. The statistical analysis included a Mann-Whitney U test. A p value of .05 was considered statistically significant. The Spearman's rank correlation was also calculated. Overall, there was a median delay of 8 years (Q1-Q3: 3-14) from the onset of symptoms to a diagnosis of endometriosis. Factors such as menstrual cramps in adolescence, presence of rectovaginal endometriosis, normalisation of pain and the attitudes of health professionals contributed to a delayed diagnosis (p values<.05). There was a negative correlation indicating the earlier the onset of symptoms, the greater the delay to diagnosis (Spearman's Rank Correlation Coefficient -0.63, p<.01). The results of this study highlight a considerable diagnostic delay associated with endometriosis and the need for clinician education and public awareness. Impact statement What is already known on this subject? The diagnostic delay of 7-9 years with endometriosis has been reported globally. In an effort to standardise surgical treatment, improve outcomes, and shorten delays specialist endometriosis centres were introduced in 2011. There has been no recent quality improvement assessment since the establishment of such centres. What do the results of this study add? This is the most recent evaluation in the United Kingdom since the introduction of specialist endometriosis centres. There is a considerable diagnostic delay associated endometriosis in the United Kingdom with a median of 8 years. The delays seem not to have improved over the last two decades. We have identified medical and psychosocial factors that may contribute to such delays. These include factors such as menstrual cramps in adolescence, presence of rectovaginal endometriosis, normalisation of pain and attitudes of health professionals contribute to a delayed diagnosis. What are the implications of these findings for clinical practice and/or further research? The results of this study, highlight the need for clinician education and public awareness to decrease the long term-morbidity and complications that result from untreated endometriosis.

6. A 2-Year Pragmatic Trial of Antibiotic Stewardship in 27 Community Nursing Homes.

Authors	Sloane, Philip D; Zimmerman, Sheryl; Ward, Kimberly; Kistler, Christine E; Paone, Deborah; Weber, David J; Wretman, Christopher J; Preisser, John S
Source	Journal of the American Geriatrics Society; Jul 2019
Publication Date	Jul 2019
Publication Type(s)	Journal Article
PubMedID	31317534
Database	Medline
	Available at Journal of the American Geriatrics Society from Wiley Online Library Medicine and Nursing Collection 2019 - NHS
	Available at Journal of the American Geriatrics Society from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
	Available at Journal of the American Geriatrics 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	OBJECTIVESTo determine if antibiotic prescribing in community nursing homes (NHs) can be reduced by a multicomponent antibiotic stewardship intervention implemented by medical providers and nursing staff and whether implementation is more effective if performed by a NH chain or a medical provider group.DESIGNTwo-year quality improvement pragmatic implementation trial with two arms (NH chain and medical provider group).SETTINGA total of 27 community NHs in North Carolina that are typical of NHs statewide, conducted before announcement of the US Centers for Medicare and Medicaid Services antibiotic stewardship mandate.PARTICIPANTSNursing staff and medical care providers in the participating NHs.INTERVENTIONStandardized antibiotic stewardship quality improvement program, including training modules for nurses and medical providers, posters, algorithms, communication guidelines, quarterly information briefs, an annual quality improvement report, an informational brochure for residents and families, and free continuing education credit.MEASUREMENTSAntibiotic prescribing rates per 1000 resident days overall and by infection type; rate of urine test ordering; and incidence of Clostridium difficile and methicillin-resistant Staphylococcus aureus (MRSA) infections.RESULTSSystemic antibiotic prescription rates decreased from baseline by 18% at 12 months (incident rate ratio [IRR] = 0.82; 95% confidence interval [CI] = 0.69-0.98) and 23% at 24 months (IRR = 0.77; 95% CI = 0.65-0.90). A 10% increase in the proportion of residents with the medical director as primary physician was associated with a 4% reduction in prescribing (IRR = 0.96; 95% CI = 0.92-0.99). Incidence of C. difficile and MRSA infections, hospitalizations, and hospital readmissions did not change significantly. No adverse events from antibiotic nonprescription were reported. Estimated 2-year implementation costs per NH, exclusive of medical provider time, ranged from $354 to $3653.CONCLUSIONSAntibiotic stewardship programs can be successfully disseminated in community NHs through either NH administration or medical provider groups and can achieve significant reductions in antibiotic use for at least 2 years. Medical director involvement is an important element of program success.

7. Validation of the acute cholecystectomy rate as a quality indicator for emergency general surgery using the SWORD database.

Authors	Palser, T R; Navarro, A P; Swift, S; Beckingham, I J
Source	Annals of the Royal College of Surgeons of England; Jul 2019; vol. 101 (no. 6); p. 422-427
Publication Date	Jul 2019
Publication Type(s)	Journal Article
PubMedID	31155890
Database	Medline
	Available at Annals of the Royal College of Surgeons of England from Ovid (Journals @ Ovid) - Remote Access
	Available at Annals of the Royal College of Surgeons of England from EBSCO (MEDLINE Complete)
	Available at Annals of the Royal College of Surgeons of 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 Annals of the Royal College of Surgeons of England from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract INTRODUCTIONDespite an increasing emphasis on data-driven quality improvement, few validated quality indicators for emergency surgical services have been published. The aims of this study therefore were: 1) to investigate whether the acute cholecystectomy rate is a valid process indicator; and 2) to use this rate to examine variation in the provision of acute cholecystectomy in England.MATERIALS AND METHODSThe Surgical Workload and Outcomes Research Database (SWORD), derived from the Hospital Episode Statistics database, was interrogated for the 2012-2017 financial years. All adult patients admitted with acute biliary pancreatitis, cholecystitis or biliary colic to hospitals in England were included and the acute cholecystectomy rate in each one examined.RESULTSA total of 328,789 patients were included, of whom 42,642 (12.9%) underwent an acute cholecystectomy. The acute cholecystectomy rate varied significantly between hospitals, with the overall rate ranging from 1.2% to 36.5%. This variation was consistent across all disease groupings and time periods, and was independent of the annual number of procedures performed by each NHS trust. In 41 (29.9%) trusts, fewer than one in ten patients with acute gallbladder disease underwent cholecystectomy within two weeks.CONCLUSIONSThe acute cholecystectomy rate is easily measurable using routine administrative datasets, modifiable by local services and has a strong evidence base linking it to patient outcomes. We therefore advocate that it is an ideal process indicator that should be used in quality monitoring and improvement. Using it, we identified significant variation in the quality of care for acute biliary disease in England.

8. Impact of secondary care financial incentives on the quality of physical healthcare for people with psychosis: a longitudinal controlled study.

Authors Crawford, Mike J; Huddart, Daniel; Craig, Eleanor; Zalewska, Krysia; Quirk, Alan; Shiers, David; Strathdee, Geraldine; Cooper, Stephen J
Source The British journal of psychiatry : the journal of mental science; Jul 2019 ; p. 1-6
Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 31272513
Database Medline
Available at The British journal of psychiatry : the journal of mental science from Glenfield Hospital Library Local Print Collection [location] : Glenfield Library.
Available at The British journal of psychiatry : the journal of mental science from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at The British journal of psychiatry : the journal of mental science from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract BACKGROUNDConcerns have repeatedly been expressed about the quality of physical healthcare that people with psychosis receive.AimsTo examine whether the introduction of a financial incentive for secondary care services led to improvements in the quality of physical healthcare for people with psychosis.METHODLongitudinal data were collected over an 8-year period on the quality of physical healthcare that people with psychosis received from 56 trusts in England before and after the introduction of the financial incentive. Control data were also collected from six health boards in Wales where a financial incentive was not introduced. We calculated the proportion of patients whose clinical records indicated that they had been screened for seven key aspects of physical health and whether they were offered interventions for problems identified during screening.RESULTSData from 17 947 people collected prior to (2011 and 2013) and following (2017) the introduction of the financial incentive in 2014 showed that the proportion of patients who received high-quality physical healthcare in England rose from 12.85% to 31.65% (difference 18.80, 95% CI 17.37-20.21). The proportion of patients who received high-quality physical healthcare in Wales during this period rose from 8.40% to 13.96% (difference 5.56, 95% CI 1.33-10.10).CONCLUSIONSThe results of this study suggest that financial incentives for secondary care mental health services are associated with marked improvements in the quality of care that patients receive. Further research is needed to examine their impact on aspects of care that are not incentivised.Declaration of interestD.S. is an expert advisor to the National Institute for Health and Care Excellence (NICE) centre for guidelines and a member of the current NICE guideline development group for rehabilitation in adults with complex psychosis and related severe mental health conditions; a board member of the National Collaborating Centre for Mental Health (NCCMH); views are personal and not those of NICE or NCCMH. G.S. was the National Clinical Director for Mental Health at NHS England and played a lead role in setting up the physical health CQUIN (Commissioning for Quality and Innovation framework) for people with psychosis. M.J.C. is Director of the College Centre for Quality Improvement which was commissioned by NHS England to collect data for the CQUIN and commissioned by HQIP to conduct the National Clinical Audit of Psychosis. S.J.C. is Clinical Lead for the National Clinical Audit of Psychosis. E.C., K.Z. and A.Q. are employed by the Royal College of Psychiatrists which was commissioned by NHS England to collect data for the CQUIN and commissioned by HQIP to conduct the National Clinical Audit of Psychosis.

9. Improving coding and primary care management for patients with chronic kidney disease: an observational controlled study in East London.

Authors Hull, Sally A; Rajabzadeh, Vian; Thomas, Nicola; Hoong, Sec; Dreyer, Gavin; Rainey, Helen; Ashman, Neil
Source The British journal of general practice : the journal of the Royal College of General Practitioners; Jul 2019; vol. 69 (no. 684); p. e454
Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 31160369
Database Medline
Available at The British journal of general practice : the journal of the Royal College of General Practitioners from EBSCO (MEDLINE Complete)
Available at The British journal of general practice : the journal of the Royal College of General Practitioners from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at The British journal of general practice : the journal of the Royal College of General Practitioners from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract BACKGROUNDThe UK national chronic kidney disease (CKD) audit in primary care shows diagnostic coding in the electronic health record for CKD averages 70%, with wide practice variation. Coding is associated with improvements to risk factor management; CKD cases coded in primary care have lower rates of unplanned hospital admission.AIMTo increase diagnostic coding of CKD (stages 3-5) and primary care management, including blood pressure to target and prescription of statins to reduce cardiovascular disease risk.DESIGN AND SETTINGControlled, cross-sectional study in four East London clinical commissioning groups (CCGs).METHODInterventions to improve coding formed part of a larger system change to the delivery of renal services in both primary and secondary care in East London. Quarterly anonymised data on CKD coding, blood pressure values, and statin prescriptions were extracted from practice computer systems for 1-year pre- and post-initiation of the intervention.RESULTSThree intervention CCGs showed significant coding improvement over a 1 year period following the intervention (regression for post-intervention trend P<0.001). The CCG with highest coding rates increased from 76-90% of CKD cases coded; the lowest coding CCG increased from 52-81%. The comparison CCG showed no change in coding rates. Combined data from all practices in the intervention CCGs showed a significant increase in the proportion of cases with blood pressure achieving target levels (difference in proportion P<0.001) over the 2-year study period. Differences in statin prescribing were not significant.CONCLUSIONClinically important improvements to coding and management of CKD in primary care can be achieved by quality improvement interventions that use shared data to track and monitor change supported by practice-based facilitation. Alignment of clinical and CCG priorities and the provision of clinical targets, financial incentives, and educational resource were additional important elements of the intervention.

10. Seven steps to mapping health service provision: lessons learned from mapping services for adults with Attention-Deficit/Hyperactivity Disorder (ADHD) in the UK.

Authors Price, Anna; Janssens, Astrid; Dunn-Morua, Susan; Eke, Helen; Asherson, Philip; Lloyd, Tony; Ford, Tamsin
Source BMC health services research; Jul 2019; vol. 19 (no. 1); p. 468
Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 31288805
Database Medline
Available at BMC health services research from BioMed Central
Available at BMC health services research from Europe PubMed Central - Open Access
Available at BMC health services research from EBSCO (MEDLINE Complete)
Available at BMC health services research from ProQuest (Health Research Premium) - NHS Version
Available at BMC health services research from Unpaywall

Abstract BACKGROUNDADHD affects some individuals throughout their lifespan, yet service provision for adults in the United Kingdom (UK) is patchy. Current methods for mapping health service provision are resource intensive, do not map specialist ADHD teams separately from generic mental health services, and often fail to triangulate government data with accounts from service users and clinicians. Without a national audit that maps adult ADHD provision, it is difficult to quantify current gaps in provision and make the case for change. This paper describes the development of a seven step approach to map adult ADHD service provision in the UK.METHODSA mapping method was piloted in 2016 and run definitively in 2018. A seven step method was developed: 1. Defining the target service 2. Identifying key informants 3. Designing the survey 4. Data collection 5. Data analysis 6. Communicating findings 7. Hosting/updating the service map. Patients and members of the public (including clinicians and commissioners) were involved with design, data collection and dissemination of findings.RESULTSUsing a broad definition of adult ADHD services resulted in an inclusive list of identified services, and allowed the definition to be narrowed to National Health Service (NHS) funded specialist ADHD services at data analysis, with confidence that few relevant services would be missed. Key informants included patients, carers, a range of health workers, and commissioners. A brief online survey, written using lay terms, appeared acceptable to informants. Emails sent using national organisations' mailing lists were the most effective way to access informants on a large scale. Adaptations to the methodology in 2018 were associated with 64% more responses (2371 vs 1446) collected in 83% less time (5 vs 30 weeks) than the pilot. The 2016 map of adult ADHD services was viewed 13,688 times in 17 weeks, indicating effective communication of findings.CONCLUSIONThis seven step pragmatic method was effective for collating and communicating national service data about UK adult ADHD service provision. Patient and public involvement and engagement from partner organisations was crucial throughout. Lessons learned may be transferable to mapping service provision for other health conditions and in other locations.

11. Prevalence of congenital sensorineural deafness in a population of client-owned purebred kittens in the United Kingdom.

Authors Mari, Lorenzo; Freeman, Julia; Van Dijk, Jan; De Risio, Luisa
Source Journal of veterinary internal medicine; Jul 2019; vol. 33 (no. 4); p. 1707-1713
Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 31144374
Database Medline
Available at Journal of veterinary internal medicine from Europe PubMed Central - Open Access
Available at Journal of veterinary internal medicine from Wiley Online Library Free Content - NHS
Available at Journal of veterinary internal 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.
Available at Journal of veterinary internal medicine from Unpaywall
Abstract BACKGROUNDData about congenital sensorineural deafness (CSD) in white blue-eyed cats derive mainly from research colonies, and information about client-owned cats is limited.OBJECTIVESTo describe the prevalence of CSD in a client-owned population of white purebred kittens and colored littermates in the United Kingdom.ANIMALSOne hundred thirty-two solid white client-owned purebred kittens and 61 colored littermates, 6 to 21 weeks of age.METHODSRetrospective (56 cases) and prospective (137 cases) study. Hearing was assessed by brainstem auditory evoked response testing, and the entire litter was tested.RESULTSCongenital sensorineural deafness was diagnosed only in solid white kittens, with a prevalence of 30.3% (15.9% bilateral, 14.4% unilateral). The prevalence of CSD was significantly higher in white kittens with 1 (44.4%) or 2 (50%) blue irises than in those without blue irises (22.2%). Kittens with at least 1 blue iris were 3.2 times more likely to have CSD than kittens without blue irises. In solid white kittens, CSD was diagnosed in 7 of 15 (46.7%) Turkish Vankedisi, 8 of 18 (44.0%) Maine Coon, 18 of 41 (43.9%) Norwegian Forest, 3 of 11 (27.3%) British Shorthair, 2 of 12 (16.7%) Devon Rex, 2 of 12 (8.3%) Persian, 1 of 21 (4.8%) Russian, and 0 of 2 Sphinx. The prevalence of CSD was significantly different in Norwegian Forest, Maine Coon, and Turkish Vankedisi kittens compared with Persian or Russian kittens.CONCLUSION AND CLINICAL IMPORTANCEWe identified a high prevalence of CSD in a population of client-owned purebred white kittens in the United Kingdom and suggest differences in breed-specific prevalence of CSD.

12. Prescribing dronedarone for paroxysmal atrial fibrillation: how is it done across the UK and is it safe?

Authors Yones, Eron; Mullan, Jennifer; Horwood, Andrew; Connell, Nicola; Odams, Sarah; Maloney, Jean; Kyriacou, Andreas L; Sahu, Jonathan; Lee, Justin M; Kelland, Nicholas F
Source European journal of hospital pharmacy. Science and practice; Jul 2019; vol. 26 (no. 4); p. 220-222
Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 31338172
Database Medline

Abstract Dronedarone, a useful treatment for paroxysmal atrial fibrillation, is often only prescribed in secondary care. To support a protocol shared between primary and secondary care, dronedarone use was audited in our centre and prescribing practices across UK secondary care centres were reviewed. From 2010 to 2015, a total of 181 patients were started on dronedarone. There were no deaths or serious adverse events. Median cessation time due to adverse effects was 52 days and 88% stopped dronedarone within 6 months. Of 17 local prescribing protocols across the UK, 12 involved shared care and 5 purely secondary care follow-up. In our review, dronedarone was safe and well tolerated. The use of shared care protocols is well established in other UK centres. The development of a local shared care protocol between primary and secondary care is feasible with existing systems in place to support its introduction.

13. Type A Aortic Dissection in the UK: The Untold Facts.

Authors Bashir, Mohamad; Harky, Amer; Howard, Callum; Bartram, Thomas
Source Seminars in thoracic and cardiovascular surgery; Jul 2019
Publication Date Jul 2019
Publication Type(s) Editorial
PubMedID 31283988
Database Medline
Available at Seminars in thoracic and cardiovascular surgery from ScienceDirect Please click on 'Sign in' and then on 'OpenAthens' for the site to recognise your Athens account and provide access to the full range of issues.
Available at Seminars in thoracic and cardiovascular surgery from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract BACKGROUNDThere is a lack of evidence on multitude level for appropriate recognition, management and outcome results in Type A Aortic Dissection management in the UK. A huge amount of retrospective data exists in the literature which provides non meaningful prospect to a service that meets the current era.METHODSElectronic searches were performed on PubMed and Cochrane databases with no limits placed on dates. Search terms were charted to MeSH terms and combined using Boolean operations, and also used as key words. Papers were selected on the basis of title and abstract. The reference lists of selected papers were reviewed to identify any relevant papers that might be suitable for inclusion in the study. Papers were selected based on providing primary end points of death, rupture, or dissection and/or information regarding aortic aneurysm growth. Papers were not excluded based on patient population age.RESULTSWe demonstrated the lack of evidence for quality outcomes in Type A aortic dissection in the UK. This highlighted the unwarranted variation seen in this entity and the caveats needed to improve structuring of Type A aortic dissection from early identification in emergency departments to arrival at destination site for optimum intervention.CONCLUSIONEmergency services should be restructured to meet the immediate affirmation of diagnosis with gold standard imaging modality available. Management of this dire disease should be instituted at local hospitals prior to transportation and results should be audited regularly to improve quality outcomes. Attempts should be made to create local area networks to improve the efficiencies and outcomes of the service and transfer to centres with concentration of expertise. Recognition of regional networks by the UK Government Care Quality Commission, should in part based on cumulative evidence sought after from virtual MDTs. Unwarranted variation is an avenue that requires to be addressed to rise with service provision that meets our patients aspiration and be of current evidence in 21st era.

14. Increasing the incidence of drain-free day-case mastectomies with the use of a fibrin tissue sealant; data from a single surgical center in the United Kingdom.

Authors Harrison, Conrad; Remoundos, Dionysios D; Harvey, Kate L; Stoker, Gill V; MacLean, Gael; Adwani, Asha; Roy, Pankaj G
Source The breast journal; Jul 2019
Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 31338929
Database Medline
Available at The breast journal from Wiley Online Library Medicine and Nursing Collection 2019 - NHS
Available at The breast 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 Day-case mastectomy surgery provides benefits to both patients and hospitals. Key barriers are the use of a drain and the risk of postoperative seroma formation. We introduced the use of a tissue sealant (Artiss) into the surgical site (post-mastectomy without immediate reconstruction and postaxillary clearance) and evaluated its effect on our practice, particularly day-case rates. A prospective audit of 177 patients who underwent a simple mastectomy with or without axillary surgery, or axillary node clearance with or without breast-conserving surgery was conducted at a single surgical center in the UK between November 2015 and November 2016. Artiss was used in all operations and, where appropriate, the drain was omitted to facilitate day-case surgery. The clinical outcomes were compared between patients undergoing different operations and duration of hospital stay. There was no statistically significant difference between day-case patients and inpatients in seroma aspiration rates (24.5% and 21.7%, respectively; P = 0.381) or other complications (22.4% and 16.1%, respectively; P = 0.106). The day-case mastectomy rate increased from 3.9% in the first quarter to 45.5% in the final quarter, which was a significant increase reaching well beyond the national target. The use of Artiss enabled us to increase the drain-free day-case surgery rates over a 1-year period, exceeding the 30% target recommended by the British Association of Day Surgery. We did not observe any increase in patient morbidity, and the change was cost-effective. We have now implemented the routine use of Artiss in women undergoing simple mastectomy with or without axillary surgery and stand-alone axillary node clearances as part of enhanced recovery clinical pathways.

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

Authors Parry, Matthew G; Sujenthiran, Arunan; Cowling, Thomas E; Nossiter, Julie; Cathcart, Paul; Clarke, Noel W; Payne, Heather; Aggarwal, Ajay; van der Meulen, Jan
Source International journal of cancer; Jul 2019; vol. 145 (no. 1); p. 40-48
Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 30549266
Database Medline
Available at International journal of cancer from Wiley Online Library
Available at International journal of cancer from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection
Available at International journal of cancer from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.
Available at International journal of cancer from Unpaywall

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

16. British Association of Dermatologists (BAD) National Audit on Non-Melanoma Skin Cancer Excision 2016 in collaboration with the Royal College of Pathologists.

Authors Keith, D J; Bray, A P; Brain, A; Mohd Mustapa, M F; Barrett, H E; Lane, S; Emmerich, M; Jakes, A; Barrett, P D; de Berker, D A R
Source Clinical and experimental dermatology; Jul 2019
Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 31265150
Database Medline
Available at Clinical and experimental dermatology from Wiley Online Library Medicine and Nursing Collection 2019 - NHS
Available at Clinical and experimental dermatology from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).

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

Abstract BACKGROUNDWe conducted a re-audit of the surgical practice of United Kingdom (UK) dermatologists in the treatment of non-melanoma skin cancer and examined changes with reference to our previous audit in 2014. The audit was supplemented by a detailed assessment of completeness of the histopathology reports for each tumour.METHODSUK dermatologists collected data on 10 consecutive non-micrographic excisions for basal cell carcinoma and 5 for squamous cell carcinoma. Data was collected on site, pre- operative diagnosis, histological diagnosis, proximity to previous scars, histological deep and peripheral margins.RESULTSWe received 222 responses from 135 centres of 3290 excisions. Excisions from the head and neck accounted for 56.7% of cases. The mean tumour diameter was 11.4 mm (SD 7.1 mm, maximum 100 mm) and 97% of cases were primary excisions. BCCs accounted for 65.7% of total cases and SCCs 26.8%. Of the suspected BCCs, 95.8% were confirmed histologically and for suspected SCCs 80.4%. All margins for any tumour were clear in 97.0%. Complication rate in the audit was <1%. Of the 2864 histology reports evaluated only 706 (24.6%) contained all core data items. 95% of these were synoptic reports. Commonly omitted items were level of invasion, risk and T stage, absent in 35.7%, 64.2% and 44.1% of reports respectively.CONCLUSIONSDiagnostic accuracy and complete excision rates remain high. Complication rates may be under-reported due to lack of follow up. Histopathology reporting has a greater chance of being complete if reports are generated on a field based platform (synoptic reporting). This article is protected by copyright. All rights reserved.

17. Association of quality of paediatric epilepsy care with mortality and unplanned hospital admissions among children and young people with epilepsy in England: a national longitudinal data linkage study.

Authors Hargreaves, Dougal S; Arora, Sandeepa; Viveiro, Carolina; Hale, Daniel R; Ward, Joseph L; Sherlaw-Johnson, Christopher; Viner, Russell M; Dunkley, Colin; Cross, J Helen
Source The Lancet. Child & adolescent health; Jul 2019
Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 31281027
Database Medline
Abstract BACKGROUNDConcerns have been raised about variation in care quality and outcomes among children and young people with epilepsies in England. We aimed to investigate the association between quality of paediatric care, hospital admissions, and all-cause deaths among epilepsy patients.METHODSIn this longitudinal data linkage study of paediatric epilepsy services in England, we linked unit-level data from round 1 (2009-11) and round 2 (2013-14) of the Epilepsy12 national clinical audit, with death registrations from the UK Office for National Statistics and data for unplanned hospital admissions from Hospital Episode Statistics. We investigated the association between unit-level performance in involving a paediatrician with epilepsy expertise, an epilepsy specialist nurse, and a paediatric neurologist (where appropriate) in round 1 and the proportion of adolescents (aged 10-18 years) with epilepsy admitted to each unit who subsequently died during the study period (April 1, 2009, to March 31, 2015). We also investigated whether change in Epilepsy12 performance between the two audit rounds was associated with changes in the standardised ratio of observed-to-expected unplanned epilepsy admissions over the same period.FINDINGSIn 99 units with data for the analyses relating to paediatricians with epilepsy expertise and epilepsy specialist nurses, 134 (7%) of 1795 patients died during the study period, 88 (5%) of whom died after the transition to adult service. In 55 units with data for the analyses relating to paediatric neurologists, 79 (7%) of 1164 patients died, 54 (5%) of whom did so after the transition. In regression models adjusting for population, unit, and hospital activity characteristics, absolute reductions in total mortality risk (6·4 percentage points, 95% CI 0·1-12·7) and mortality risk after transition (5·7 percentage points, 0·6-10·8) were found when comparing units where all versus no eligible patients were seen by a paediatric neurologist. Units where all eligible patients were seen by a paediatric neurologist were estimated to have absolute reductions of 4·6 percentage points (0·3-8·9) in total mortality and of 4·6 percentage points (1·2-8·0) in post-transition mortality, compared with units where no or some eligible patients were seen by a paediatric neurologist. There was no significant association between performance on being seen by an epilepsy specialist nurse or by a paediatrician with epilepsy expertise and mortality. In units where access to an epilepsy specialist nurse decreased, the standardised ratio of epilepsy admissions increased by a mean of 0·21 (0·01-0·42).INTERPRETATIONAmong adolescents with epilepsy, greater involvement of tertiary specialists in paediatric care is associated with decreased all-cause mortality in the period after transition to adult services. Reduced access to an epilepsy specialist nurse was associated with an increase in paediatric epilepsy admissions.FUNDINGThe Health Foundation.

18. Inequalities in glycaemic control in childhood onset type 2 diabetes in England and Wales - A national population-based longitudinal study.

Authors Khanolkar, Amal R; Amin, Rakesh; Taylor-Robinson, David; Viner, Russell M; Warner, Justin; Stephenson, Terence
Source Pediatric diabetes; Jul 2019

Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 31329349
Database Medline
Available at Pediatric diabetes from Wiley Online Library Medicine and Nursing Collection 2019 - NHS
Available at Pediatric diabetes from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection
Available at Pediatric diabetes 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 BACKGROUNDNot much is known about glycaemic-control trajectories in childhood-onset type 2 diabetes (T2D). We investigated characteristics of children and young people (CYP) with T2D and inequalities in glycaemic control.METHODSWe studied 747 CYP with T2D, <19 years old in 2009-2016 (from the total population-based National Paediatric Diabetes Audit [>95% diabetes cases in England/Wales]). Linear mixed-effects modelling was used to assess socioeconomic and ethnic differences in longitudinal glycated haemoglobin (HbA1c) trajectories during four years post-diagnosis (3,326 HbA1c datapoints, mean 4.5 datapoints/subject). Self-identified ethnicity was grouped into six categories. Index of Multiple Deprivation (a small geographical area-level deprivation measure) was grouped into SES quintiles for analysis.RESULTS58% were non-White, 66% were female and 41% were in the most disadvantaged SES quintile. Mean age and HbA1c at diagnosis were 13.4 years and 68mmol/mol respectively. Following an initial decrease between diagnosis and end of year 1 (-15.2mmol/mol 95%CI, -19.2, -11.2), HbA1c trajectories increased between years 1 and 3 (10mmol/mol, 7.6, 12.4), followed by slight gradual decrease subsequently (-1.6mmol/mol, -2, -1.1). Compared to White CYP, Pakistani children had higher HbA1c at diagnosis (13.2 mmol/mol, 5.6-20.9). During follow-up, mixed-ethnicity and Pakistani CYP had poorer glycaemic control. Compared to children in the most disadvantaged quintile, those in the most advantaged had lower HbA1c at diagnosis (-6.3mmol, -12.6, -0.1). Differences by SES remained during follow-up. Mutual adjustment for SES and ethnicity did not substantially alter the above estimates.CONCLUSIONSAbout two thirds of children with childhood-onset T2D were non-White, female adolescents, just under half of whom live in the most disadvantaged areas of England and Wales. Additionally, there are substantial socioeconomic and ethnic inequalities in diabetes control. This article is protected by copyright. All rights reserved.

19. Study protocol for the validation of a new patient-reported outcome measure (PROM) of listening effort in cochlear implantation: the Listening Effort Questionnaire-Cochlear Implant (LEQ-CI).

Authors Hughes, Sarah E; Rapport, Frances; Watkins, Alan; Boisvert, Isabelle; McMahon, Catherine M; Hutchings, Hayley A
Source BMJ open; Jul 2019; vol. 9 (no. 7); p. e028881
Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 31289085
Database Medline
Available at BMJ Open from Europe PubMed Central - Open Access
Available at BMJ Open from HighWire - Free Full Text
Available at BMJ Open from ProQuest (Health Research Premium) - NHS Version
Available at BMJ Open from Unpaywall

Abstract INTRODUCTIONListening effort may be defined as the cognitive resources needed to understand an auditory message. A sustained requirement for listening effort is known to have a negative impact on individuals' sense of social connectedness, well-being and quality of life. A number of hearing-specific patient-reported outcome measures (PROMs) exist currently; however, none adequately assess listening effort as it is experienced in the listening situations of everyday life. The Listening Effort Questionnaire-Cochlear Implant (LEQ-CI) is a new, hearing-specific PROM designed to assess perceived listening effort as experienced by adult CI patients. It is the aim of this study to conduct the first psychometric evaluation of the LEQ-CI's measurement properties.METHODS AND ANALYSISThis study is a phased, prospective, multi-site validation study in a UK population of adults with severe-profound sensorineural hearing loss who meet local candidacy criteria for CI. In phase 1, 250 CI patients from four National Health Service CI centres will self-complete a paper version of the LEQ-CI. Factor analysis will establish unidimensionality and Rasch analysis will evaluate item fit, differential item functioning, response scale ordering, targeting of persons and items, and reliability. Classical test theory methods will assess acceptability/data completeness, scaling assumptions, targeting and internal consistency reliability. Phase 1 results will inform refinements to the LEQ-CI. In phase 2, a new sample of adult CI patients (n=100) will self-complete the refined LEQ-CI, the Speech, Spatial and Qualities of Hearing Scale, the Nijmegen Cochlear Implant Questionnaire and the Fatigue Assessment Scale to assess construct validity.ETHICS AND DISSEMINATIONThis study was approved by the Abertawe Bro Morgannwg University Health Board/Swansea University Joint Study Review Committee and the Newcastle and North Tyneside 2 Research Ethics Committee, Ref: 18/NE/0320. Dissemination will be in high-quality journals, conference presentations and SEH's doctoral dissertation.

20. Trends in surgical and catheter interventions for isolated congenital shunt lesions in the UK and Ireland.

Authors	Farooqi, Mehreen; Stickley, John; Dhillon, Rami; Barron, David J; Stumper, Oliver; Jones, Timothy J; Clift, Paul F; Brawn, William J; Drury, Nigel E
Source	Heart (British Cardiac Society); Jul 2019; vol. 105 (no. 14); p. 1103-1108
Publication Date	Jul 2019
Publication Type(s)	Journal Article
PubMedID	30772822
Database	Medline Available at Heart from BMJ Journals - NHS Available at Heart from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free). Available at Heart from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article. Available at Heart from Unpaywall
Abstract	OBJECTIVETo evaluate time trends in the use of catheter and surgical procedures, and associated survival in isolated congenital shunt lesions.METHODSNationwide, retrospective observational study of the UK National Congenital Heart Disease Audit database from 2000 to 2016. Patients undergoing surgical or catheter procedures for atrial septal defect (including sinus venosus defect), patent foramen ovale, ventricular septal defect and patent arterial duct were included. Temporal changes in the frequency of procedures, and survival at 30 days and 1 year were determined.RESULTS40 911 procedures were performed, 16 604 surgical operations and 24 307 catheter-based interventions. Transcatheter procedures increased over time, overtaking surgical repair in 2003-2004, while the number of operations remained stable. Trends in interventions differed according to defect type and patient age. Catheter closure of atrial septal defects is now more common in children and adults, although surgical interventions have also increased. Patent foramen ovale closure in adults peaked in 2009-2010 before falling significantly since. Surgery remains the mainstay for ventricular septal defect in infants and children. Duct ligation is most common in neonates and infants, while transcatheter intervention is predominant in older children. Excluding duct ligation, survival following surgery was 99.4% and ≈98.7%, and following catheter interventions was 99.7% and ≈99.2%, at 30 days and 1 year, respectively.CONCLUSIONSTrends in catheter and surgical techniques for isolated congenital shunt lesions plot the evolution of the specialty over the last 16 years, reflecting changes in clinical guidelines, technology, expertise and reimbursement, with distinct patterns according to lesion and patient age.

21. Systematic exploration of local reviews of the care of maternal deaths in the UK and Ireland between 2012 and 2014: a case note review study.

Authors	Cross-Sudworth, Fiona; Knight, Marian; Goodwin, Laura; Kenyon, Sara
Source	BMJ open; Jun 2019; vol. 9 (no. 6); p. e029552
Publication Date	Jun 2019
Publication Type(s)	Journal Article
PubMedID	31256038
Database	Medline Available at BMJ Open from Europe PubMed Central - Open Access Available at BMJ Open from HighWire - Free Full Text Available at BMJ Open from ProQuest (Health Research Premium) - NHS Version Available at BMJ Open from Unpaywall

Abstract OBJECTIVESLocal reviews of the care of women who die in pregnancy and post-birth should be undertaken. We investigated the quantity and quality of hospital reviews.DESIGNAnonymised case notes review.PARTICIPANTSAll 233 women in the UK and Ireland who died during or up to 6 weeks after pregnancy from any cause related to or aggravated by pregnancy or its management in 2012-2014.MAIN OUTCOME MEASURESThe number of local reviews undertaken. Quality was assessed by the composition of the review panel, whether root causes were systematically assessed and actions detailed.RESULTSThe care of 177/233 (76%) women who died was reviewed locally. The care of women who died in early pregnancy and after 28 days post-birth was less likely to be reviewed as was the care of women who died outside maternity services and who died from mental health-related causes. 140 local reviews were available for assessment. Multidisciplinary review was undertaken for 65% (91/140). External involvement in review occurred in 12% (17/140) and of the family in 14% (19/140). The root causes of deaths were systematically assessed according to national guidance in 13% (18/140). In 88% (123/140) actions were recommended to improve future care, with a timeline and person responsible identified in 55% (77/140). Audit to monitor implementation of changes was recommended in 14% (19/140).CONCLUSIONSThis systematic assessment of local reviews of care demonstrated that not all hospitals undertake a review of care of women who die during or after pregnancy and in the majority quality is lacking. The care of these women should be reviewed using a standardised robust process including root cause analysis to maximise learning and undertaken by an appropriate multidisciplinary team who are given training, support and adequate time.

22. Context-Specific Economic Evaluation for Molecular Pathology Tests: An Application in Colorectal Cancer in the West of Scotland.

Authors Bouttell, Janet; Tan, Yun Yi; Creed, David; McGaffin, Gillian; Hawkins, Neil; McLaughlin, Ruth; Smith, Graeme; Westwood, Paul; Williams, Nicola; Graham, Janet
Source International journal of technology assessment in health care; Jul 2019 ; p. 1-7
Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 31292015
Database Medline
Available at International Journal of Technology Assessment in Health Care from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.
Abstract OBJECTIVESThe cost-effectiveness of molecular pathology testing is highly context dependent. The field is fast-moving, and national health technology assessment may not be relevant or timely for local decision makers. This study illustrates a method of context-specific economic evaluation that can be carried out in a limited timescale without extensive resources.METHODSWe established a multi-disciplinary group including an oncologist, pathologists and a health economist. We set out diagnostic and treatment pathways and costs using registry data, health technology assessments, guidelines, audit data, and estimates from the group. Sensitivity analysis varied input parameters across plausible ranges. The evaluation setting was the West of Scotland and UK NHS perspective was adopted. The evaluation was assessed against the AdHopHTA checklist for hospital-based health technology assessment.RESULTSA context-specific economic evaluation could be carried out on a timely basis using limited resources. The evaluation met all relevant criteria in the AdHopHTA checklist. Health outcomes were expected to be at least equal to the current strategy. Annual cost savings of £637,000 were estimated resulting primarily from a reduction in the proportion of patients receiving intravenous infusional chemotherapy regimens. The result was not sensitive to any parameter. The data driving the main cost saving came from a small clinical audit. We recommended this finding was confirmed in a larger population.CONCLUSIONSThe method could be used to evaluate testing changes elsewhere. The results of the case study may be transferable to other jurisdictions where the organization of cancer services is fragmented.

23. Nationwide improvement in outcomes of emergency admission for ulcerative colitis in England, 2005-2013.

Authors Shawihdi, Mustafa; Dodd, Susanna; Kallis, Constantinos; Dixon, Pete; Grainger, Ruth; Bloom, Stuart; Cummings, Fraser; Pearson, Mike; Bodger, Keith
Source Alimentary pharmacology & therapeutics; Jul 2019; vol. 50 (no. 2); p. 176-192
Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 31135073
Database Medline
Available at Alimentary Pharmacology and Therapeutics from Wiley Online Library
Available at Alimentary Pharmacology and Therapeutics 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 Alimentary Pharmacology and Therapeutics from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Available at Alimentary Pharmacology and Therapeutics from Unpaywall

Abstract BACKGROUNDThe UK IBD Audit Programme reported improved inpatient care processes for ulcerative colitis (UC) between 2005 and 2013. There are no independent data describing national or institutional trends in patient outcomes over this period.AIMTo assess the association between the outcome of emergency admission for UC and year of treatment.METHODSRetrospective analysis of hospital administrative data, focused on all emergency admissions to English public hospitals with a discharge diagnosis of UC. We extracted case mix factors (age, sex, co-morbidity, emergency bed days in last year, deprivation status), outcomes of index admission (death and first surgery), 30-day emergency readmissions (all-cause, and selected causes) and outcome of readmission.RESULTSThere were 765 deaths and 3837 unplanned first operations in 44 882 emergency admissions, with 5311 emergency readmissions (with a further 171 deaths and 517 first operations). Case mix adjusted odds of death for any given year were 9% lower (OR 0.91, 95% CI: 0.89-0.94), and that for emergency surgery 3% lower (OR 0.97, 95% CI: 0.95-0.98) than the preceding year. Results were robust to sensitivity analysis (admissions lasting ≥4 days). There was no reduction in odds for all-cause readmission, but rates for venous thromboembolism declined significantly. Analysis of institutional-level metrics across 136 providers showed a stepwise reduction in outliers for mortality and unplanned surgery.CONCLUSIONSRisk of death and unplanned surgery for UC patients admitted as emergencies declined consistently, as did unexplained variation between hospitals. Risk of readmission was unchanged (over 1 in 10). Multiple factors are likely to explain these nationwide trends.

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

Authors Parry, S; Curtis, H; Chadwick, D; British HIV Association Audit and Standards Sub-Committee
Source HIV medicine; Jul 2019; vol. 20 (no. 6); p. 424-427
Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 31006960
Database Medline
Available at HIV medicine from Wiley Online Library
Available at HIV medicine from IngentaConnect
Available at HIV 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 OBJECTIVESThe aim of this national audit was to assess adherence of services providing HIV care in the UK to national standards and guidelines regarding psychological support and the assessment of alcohol and recreational drug use (including chemsex drugs) in people living with HIV (PLWH).METHODSParticipating sites completed a survey of their services' care pathways relating to psychological support and substance use. They performed a case-note review of up to 40 adult PLWH per service, reviewing sociodemographic and clinical information and assessment of psychological wellbeing, drug use and alcohol use. The surveys and case notes were assessed against relevant British HIV Association (BHIVA) guidelines and standards.RESULTSThe survey was completed by 112 services. Of these, 73%, 82% and 73% had formal annual processes for assessing the psychological wellbeing, alcohol use and drug use, respectively, of PLWH. Case-note data were provided for 4486 PLWH from 119 sites. Audited rates of assessment of PLWH were 66.0% for psychological wellbeing, 68.0% for alcohol use, 58.4% for recreational drug use and 16.8% for chemsex drug use. Variation between clinical services was wide, with ranges from < 10% to 100% routinely assessing PLWH for each of these domains. Services using assessment tools performed better.CONCLUSIONSAssessment of PLWH for psychological wellbeing and alcohol and recreational drug use is variable in UK clinics, with a significant minority of services not documenting that they assessed these factors routinely. Wider adoption of assessment tools or proformas to assess PLWH in these areas is likely to improve surveillance for psychological morbidity and problematic alcohol or drug use.

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

Authors Naqvi, Anie; Raynor, Emma; Freemont, Anthony J
Source Histopathology; Jul 2019; vol. 75 (no. 1); p. 74-80
Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 30820979
Database Medline
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Abstract AIMSThis study is the first to systematically document histological features of fractures of known age in infants (≦12 months). It has been used to develop a tabulated database specifically to guide histopathologists to age fractures in children considered to have suffered accidental or non-accidental injury (NAI). Currently in the United Kingdom there are insufficient pathologists with experience in histological ageing of fractures to meet the medicolegal need for this examination. This study provides a practical tool that will allow those skilled paediatric and forensic pathologists currently involved in assessing infants for evidence of accidental or non-accidental injury a basis for extending their assessment into this area of unmet need.METHODS AND RESULTSOne hundred and sixty-nine fractures of known age at death were obtained from 52 anonymised infants over a period of 32 years (1985-2016 inclusive). Sections stained using haematoxylin and eosin (H&E) and Martius scarlet blue (MSB) were used to identify specific histological features and to relate them to fracture age. In 1999 the data were entered into a tabulated database for fractures accumulated between from 1985 to 1998 inclusive. Thereafter cases were added, and at 2-yearly intervals the accumulated data were audited against the previous database and adjustments made.CONCLUSIONSThis paper describes the final data set from the 2017 audit. The study was terminated at the end of 2016, as there had been no material changes in the data set for three consecutive audits.

26. Differences in access to Emergency Paediatric Intensive Care and care during Transport (DEPICT): study protocol for a mixed methods study.

Authors Ramnarayan, Padmanabhan; Evans, Ruth; Draper, Elizabeth S; Seaton, Sarah E; Wray, Jo; Morris, Stephen; Pagel, Christina; DEPICT Study Investigators
Source BMJ open; Jul 2019; vol. 9 (no. 7); p. e028000
Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 31315865
Database Medline
Available at BMJ Open from Europe PubMed Central - Open Access
Available at BMJ Open from HighWire - Free Full Text
Available at BMJ Open from ProQuest (Health Research Premium) - NHS Version
Available at BMJ Open from Unpaywall

Abstract INTRODUCTIONFollowing centralisation of UK paediatric intensive care, specialist retrieval teams were established who travel to general hospitals to stabilise and transport sick children to regional paediatric intensive care units (PICUs). There is national variation among these PICU retrieval teams (PICRTs) in terms of how quickly they reach the patient's bedside and in the care provided during transport. The impact of these variations on clinical outcomes and the experience of stakeholders (patients, families and healthcare staff) is however unknown. The primary objective of this study is to address this evidence gap.METHODS AND ANALYSISThis mixed-methods project involves the following: (1) retrospective analysis of linked data from routine clinical audits (2014-2016) to assess the impact of service variations on 30-day mortality and other secondary clinical outcomes; (2) a prospective questionnaire study conducted at 24 PICUs and 9 associated PICRTs in England and Wales over a 12-month period in 2018 to collect experience data from parents of transported children as well as qualitative analysis of in-depth interviews with a purposive sample of patients, parents and staff to assess the impact of service variations on patient/family experience; (3) health economic evaluation analysing transport service costs (and other associated costs) against lives saved and longer term measurements of quality of life at 12 months in transported children and (4) mathematical modelling evaluating the costs and potential impact of different service configurations. A final work stream involves a series of stakeholder workshops to synthesise study findings and generate recommendations.ETHICS AND DISSEMINATIONThe study has been reviewed and approved by the Health Research Authority, ref: 2 18 569. Study results will be actively disseminated through peer-reviewed journals, conference presentations, social media, print and broadcast media, the internet and stakeholder workshops.

27. Oxygen alert wristbands (OxyBand) and controlled oxygen: a pilot study.

Authors Rickards, Emma; Wat, Dennis; Kelly, Carol Ann; Sibley, Sarah
Source British journal of community nursing; Jul 2019; vol. 24 (no. 7); p. 310-314
Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 31265343
Database Medline
Available at British journal of community nursing 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).

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Abstract Despite the introduction of Oxygen Alert Cards, guidelines and audits, oxygen therapy remains overused in NHS practice, and this may lead to iatrogenic mortality. This pilot study aimed to examine the use of Oxygen Alert Wristbands (OxyBand) designed to alert health professionals who are delivering oxygen to patients to ensure that the oxygen is administered and titrated safely to the appropriate target saturations. Patients at risk of hypercapnic acidosis were asked to wear OxyBands while presenting to paramedics and health professionals in hospitals. Inappropriate prescription of oxygen reduced significantly after the OxyBands were used. A questionnaire-based assessment showed that the clinicians involved had a good understanding of the risks of uncontrolled oxygen. Forty-two patients found the wrist band comfortable to wear, and only two did not. OxyBands may have the potential to improve patient safety over Oxygen Alert Cards.

28. Sensitivity of Administrative Coding in Identifying Inpatient Acute Strokes Complicating Procedures or Other Diseases in UK Hospitals.

Authors Li, Linxin; Binney, Lucy E; Carter, Samantha; Gutnikov, Sergei A; Beebe, Sally; Bowsher-Brown, Karen; Silver, Louise E; Rothwell, Peter M; Oxford Vascular Study
Source Journal of the American Heart Association; Jul 2019; vol. 8 (no. 14); p. e012995
Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 31266385
Database Medline
Available at Journal of the American Heart Association from Europe PubMed Central - Open Access
Available at Journal of the American Heart Association from HighWire - Free Full Text
Available at Journal of the American Heart Association from Wiley Online Library Free Content - NHS
Available at Journal of the American Heart Association from Unpaywall

Abstract Background Administrative hospital diagnostic coding data are increasingly used in "big data" research and to assess complication rates after surgery or acute medical conditions. Acute stroke is a common complication of several procedures/conditions, such as carotid interventions, but data are lacking on the sensitivity of administrative coding in identifying acute stroke during inpatient stay. Methods and Results Using all acute strokes ascertained in a population-based cohort (2002-2017) as the reference, we determined the sensitivity of hospital administrative diagnostic codes (International Classification of Diseases, Tenth Revision; ICD-10) for identifying acute strokes that occurred during hospital admission for other reasons, stratified by coding strategies, study periods, and stroke severity (National Institutes of Health Stroke Score

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

Authors Bentley, Rebecca; O'Cathail, Micheal; Aznar-Garcia, Luis; Crosby, Vincent; Wilcock, Andrew; Christian, Judith
Source European journal of cancer care; Jul 2019; vol. 28 (no. 4); p. e13059
Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 30993779
Database Medline
Available at European journal of cancer care from Wiley Online Library Medicine and Nursing Collection 2019 - NHS
Available at European journal of cancer care from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
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Abstract AIMSThe role of selected treatments for brain metastases (BM) is well documented; however, the prevalence of these is not. We report on the patterns of care in the management of BM in a large oncology centre.MATERIALS AND METHODSWe retrospectively audited 236 cases of newly diagnosed BM from January 2016 to December 2017 by looking at 2 years of radiology reports and gathered data on primary site, survival, treatment received, palliative care input and brain metastases-related admissions.RESULTSEighty-two per cent of cases were related to lung, breast and melanoma primaries. Half of patients received a form of treatment with the other half receiving best supportive care. Of these, whole-brain radiotherapy (39%) and stereotactic radiosurgery (40%) were the most common treatment modalities. Most common reasons for admissions were headaches, seizures, weakness and confusion.CONCLUSIONThis is the first study in the UK that gives an in-depth overview of the real-world management of brain metastases. We have demonstrated the prevalence of treatment across the spectrum of brain metastases patients. Radiotherapy is the mainstay of treatment in nearly 80% of cases; however, care needs to be taken in ensuring that SRS is offered to those who are suitable.

30. Do infants with transposition of the great arteries born outside a specialist centre have different outcomes?

Authors Veal, Colin; Hunt, Richard; Tume, Lyvonne N
Source Cardiology in the young; Jul 2019 ; p. 1-6
Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 31272514
Database Medline
Available at Cardiology in the young 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).
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Abstract BACKGROUNDInfants born with undiagnosed transposition of the great arteries continue to be born in district general hospitals despite the improvements made in antenatal scanning. Evidence indicates improved outcomes with early definitive treatment after birth, hence the recommendation of delivery in a tertiary centre. The role of specialist paediatric and neonatal transport teams, to advise, stabilise, and transport the infants to a tertiary centre in a timely manner, is critical for those infants born in a district general hospital. This pilot study aims to compare outcomes between infants born in district general hospitals and those who were born in a tertiary maternity unit in South West England and South Wales.METHODSThis was a secondary data analysis of data collected from the local Paediatric Intensive Care Audit Network and the local transport database. Infants born with a confirmed diagnosis of transposition of the great arteries, that required an arterial switch operation as the definitive procedure between April, 2012 and March 2018 were included.RESULTSForty-five infants with a confirmed diagnosis of transposition of the great arteries were included. Statistical analysis demonstrated there were no significant differences in the time to balloon atrial septostomy (p = 0.095), time to arterial switch operation (p = 0.461), length of paediatric ICU stay (p = 0.353), and hospital stay (p = 0.095) or mortality between the two groups.CONCLUSIONSWe found no significant differences in outcomes between infants delivered outside the specialist centre, who were transferred in by a specialist team.

31. An intracerebral hemorrhage care bundle is associated with lower case-fatality.

Authors Parry-Jones, Adrian R; Sammut-Powell, Camilla; Paroutoglou, Kyriaki; Birleson, Emily; Rowland, Joshua; Lee, Stephanie; Cecchini, Luca; Massyn, Mark; Emsley, Richard; Bray, Benjamin; Patel, Hiren
Source Annals of neurology; Jul 2019
Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 31291031
Database Medline
Available at Annals of neurology from Wiley Online Library Medicine and Nursing Collection 2019 - NHS
Available at Annals of neurology from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
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Abstract OBJECTIVEAnticoagulation reversal, intensive blood pressure lowering, neurosurgery and access to critical care might all be beneficial in acute intracerebral hemorrhage (ICH). We combined and implemented these as the 'ABC' hyperacute care bundle and sought to determine whether the implementation was associated with lower case fatality.METHODSThe ABC bundle was implemented from 1 June 2015 to 31 May 2016. Key process targets were set and a registry captured consecutive patients. We compared 30-day case fatality before, during and after bundle implementation with multivariable logistic regression and used mediation analysis to determine which care process measures mediated any association. Difference-in-difference analysis compared 30-day case fatality with 32,295 patients with ICH from 214 other hospitals in England and Wales using Sentinel Stroke National Audit Programme data.RESULTS973 ICH patients were admitted in the study period. Compared to before implementation, the adjusted odds of death by 30 days were lower in the implementation period (odds ratio [OR] 0·62; 95% confidence interval [CI] 0·38 to 0·97; p=0·03) and this was sustained after implementation (OR 0·40; 95%CI: 0·24 to 0·61; p<0·0001). Implementation of the bundle was associated with a 10·8 pp (95%CI -17·9 to -3·7; p=0·003) reduction in 30-day case fatality in difference-in-difference analysis. The total effect of the care bundle was mediated by a reduction in do-not-resuscitate orders within 24 h (52·8%) and increased admission to critical care (11·1%).INTERPRETATIONImplementation of the ABC care bundle was significantly associated with lower 30-day case fatality after ICH. This article is protected by copyright. All rights reserved.

32. Impact of achieving primary care targets in type 2 diabetes on health outcomes and healthcare costs.

Authors Keng, Mi Jun; Tsiachristas, Apostolos; Leal, Jose; Gray, Alastair; Mihaylova, Borislava
Source Diabetes, obesity & metabolism; Jul 2019
Publication Date Jul 2019
Publication Type(s) Journal Article
PubMedID 31264761
Database Medline
Available at Diabetes, obesity & metabolism from Wiley Online Library Medicine and Nursing Collection 2019 - NHS
Available at Diabetes, obesity & metabolism from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection
Available at Diabetes, obesity & metabolism 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 AIMSIn England and Wales, the National Diabetes Audit (NDA) assesses the quality of management of type 2 diabetes (T2D) in primary care using treatment targets for HbA1c ≤58 mmol/mol, total cholesterol <5 mmol/L and blood pressure ≤140/80 mm Hg. We quantified the impact of variation in achieving these targets on health outcomes and healthcare costs across general practitioners' (GP) practices.METHODSSummary of characteristics of T2D patients from the 2015-2016 NDA were used to generate representative populations of T2D patients. The UKPDS Outcomes Model 2 was used to estimate long-term health outcomes and healthcare costs. The effects of achieving treatment targets on these outcomes were evaluated using regression models.RESULTSAchieving more of the HbA1c, cholesterol and blood pressure targets led to a lower incidence of diabetes-related complications. Approximately 0.5 (95% CI, 0.4-0.6) quality-adjusted life years (QALYs) and 0.6 (95% CI, 0.4-0.7) years of life (LYs) were gained by T2D patients over a lifetime for each additional target met. The projected healthcare cost savings arising from fewer diabetes-related complications as the result of achieving one, two or three targets compared to none were £859 (95% CI, £553-£1165), £940 (95% CI, £485-£1395) and £1037 (95% CI, £414-£1660) over a patient's lifetime. A typical GP practice in the lowest performing decile (average, 371 T2D patients per practice, with 27% achieving all targets) is projected to gain 201 (95% CI, 123-279) QALYs and 231 (95% CI, 133-329) LYs, if all T2D patients achieved all three targets.CONCLUSIONSSubstantial gains in health outcomes and reductions in healthcare costs could be achieved with further improvements in attainment of HbA1c, cholesterol and blood pressure targets for T2D patients.