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 29-Apr-2020]	55

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Results 55 of 55 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 29-Apr-2020]

1. Sustainability of quality improvement teams in selected regional referral hospitals in Tanzania.

Authors Kacholi, Godfrey; Mahomed, Ozayr H
Source International journal for quality in health care : journal of the International Society for Quality in Health Care; Apr 2020
Publication Date Apr 2020
Publication Type(s) Journal Article
PubMedID 32352146
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Available at International journal for quality in health care : journal of the International Society for Quality in Health Care from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at International journal for quality in health care : journal of the International Society for Quality 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.
Available at International journal for quality in health care : journal of the International Society for Quality in Health Care from Unpaywall

Abstract OBJECTIVEThe aim of this study was to determine the sustainability of hospital quality improvement teams and to assess factors influencing their sustainability in the regional referral hospital in Tanzania.DESIGNA cross-sectional study was conducted between April and August of 2018.SETTING AND PARTICIPANTSThe study was conducted in four selected regional referral hospitals in Tanzania. All members of the quality improvement teams available during the study period were recruited.INTERVENTIONQuality improvement teams and their activities.MAIN OUTCOME MEASUREThe primary outcome was sustainability total scores. The secondary outcomes were process, staff and organizational sustainability scores. The sustainability of quality improvement teams was assessed by using the National Health Service Institute for Innovation and Improvement Sustainability Model self-assessment tool.RESULTSThe overall mean sustainability score was 59.08 (95% CI: 53.69-64.46). Tanga Regional Referral Hospital had the highest mean sustainability score of 66.15 (95% CI: 55.12-77.18). Mbeya Regional Referral Hospital obtained the lowest mean sustainability score of 52.49 (95% CI: 42.96-62.01). The process domain had the highest proportionate mean sustainability score of 22.46 (95% CI: 20.58-24.33) across four hospitals. The staff domain recorded the lowest proportionate sustainability score of 27.28 (95% CI: 24.76-29.80).CONCLUSIONSPerceived less involvement of senior leadership (hospital management teams) and clinical leadership (heads of clinical departments) and infrastructure limitation appeared to negatively affect the sustainability of the hospital quality improvement teams. Our study underscores the importance of establishing a permanent and fully resourced Quality Improvement Unit-with team members employed as full-time staff.

2. Rapid implementation of virtual clinics due to COVID-19: report and early evaluation of a quality improvement initiative.

Authors Gilbert, Anthony William; Billany, Joe C T; Adam, Ruth; Martin, Luke; Tobin, Rebecca; Bagdai, Shiv; Galvin, Noreen; Farr, Ian; Allain, Adam; Davies, Lucy; Bateson, John
Source BMJ open quality; May 2020; vol. 9 (no. 2)
Publication Date May 2020
Publication Type(s) Journal Article
PubMedID 32439740
Database Medline

Abstract BACKGROUNDThe COVID-19 outbreak has placed the National Health Service under significant strain. Social distancing measures were introduced in the UK in March 2020 and virtual consultations (via telephone or video call) were identified as a potential alternative to face-to-face consultations at this time.LOCAL PROBLEMThe Royal National Orthopaedic Hospital (RNOH) sees on average 11 200 face-to-face consultations a month. On average 7% of these are delivered virtually via telephone. In response to the COVID-19 crisis, the RNOH set a target of reducing face-to-face consultations to 20% of all outpatient attendances. This report outlines a quality improvement initiative to rapidly implement virtual consultations at the RNOH.METHODSThe COVID-19 Action Team, a multidisciplinary group of healthcare professionals, was assembled to support the implementation of virtual clinics. The Institute for Healthcare Improvement approach to quality improvement was followed using the Plan-Do-Study-Act (PDSA) cycle. A process of enablement, process redesign, delivery support and evaluation were carried out, underpinned by Improvement principles.RESULTSFollowing the target of 80% virtual consultations being set, 87% of consultations were delivered virtually during the first 6 weeks. Satisfaction scores were high for virtual consultations (90/100 for patients and 78/100 for clinicians); however, outside of the COVID-19 pandemic, video consultations would be preferred less than 50% of the time. Information to support the future redesign of outpatient services was collected.CONCLUSIONSThis report demonstrates that virtual consultations can be rapidly implemented in response to COVID-19 and that they are largely acceptable. Further initiatives are required to support clinically appropriate and acceptable virtual consultations beyond COVID-19.REGISTRATIONThis project was submitted to the RNOH's Project Evaluation Panel and was classified as a service evaluation on 12 March 2020 (ref: SE20.09).

3. Use of a digital delirium pathway and quality improvement to improve delirium detection in the emergency department and outcomes in an acute hospital.

Authors Vardy, Emma; Collins, Niamh; Grover, Umang; Thompson, Rebecca; Bagnall, Alexandra; Clarke, Georgia; Heywood, Shelley; Thompson, Beverley; Wintle, Lesley; Nutt, Louise; Hulme, Sarah
Source Age and ageing; May 2020
Publication Date May 2020
Publication Type(s) Journal Article
PubMedID 32417926
Database Medline
Available at Age and ageing from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at Age and ageing from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.
Abstract BACKGROUNDdelirium is a common condition associated with hospital admission. Detection and diagnosis is important to identify the underlying precipitating cause and implement effective management and treatment. Quality improvement (QI) methodology has been applied in limited publications. There are even fewer publications of the role of development of the electronic health record (EHR) to enhance implementation.METHODSwe used QI methodology to improve delirium detection in the emergency department (ED). Plan Do Study Act (PDSA) cycles could be broadly categorised into technology, training and education and leadership. As part of the technology PDSA an electronic delirium pathway was developed as part of an NHS England digital systems improvement initiative (NHS England Global Digital Exemplar). The electronic pathway incorporated the 4AT screening tool, the Confusion Assessment Method, the TIME delirium management bundle, investigation order sets and automated coding of delirium as a health issue.RESULTSdevelopment of the EHR combined with education initiatives had benefit in terms of the number of people assessed for delirium on admission to the ED and the total number of people diagnosed with delirium across the organisation. The implementation of a delirium pathway as part of the EHR improved the use of 4AT in those 65 years and over from baseline of 3% completion in October 2017 to 43% in January 2018.CONCLUSIONwe showed that enhancement of the digital record can improve delirium assessment and diagnosis. Furthermore, the implementation of a delirium pathway is enhanced by staff education.

4. Global Tracheostomy Collaborative: data-driven improvements in patient safety through multidisciplinary teamwork, standardisation, education, and patient partnership.

Authors Brenner, Michael J; Pandian, Vinciya; Graham, Dionne A; Milliren, Carly E; Zaga, Charissa; Morris, Linda L; Bedwell, Joshua R; Das, Preety; Zhu, Hannah; Lee Y Allen, John; Peltz, Alon; Chin, Kimberly; Schiff, Bradley A; Randall, Diane M; Swords, Chloe; French, Darrin; Ward, Erin; Sweeney, Joanne M; Warrillow, Stephen J; Arora, Asit; Narula, Anthony; McGrath, Brendan A; Cameron, Tanis S; Roberson, David W
Source British journal of anaesthesia; May 2020
Publication Date May 2020
Publication Type(s) Journal Article Review
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Available at British Journal of Anaesthesia from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at British Journal of Anaesthesia from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract There is growing recognition of the need for a coordinated, systematic approach to caring for patients with a tracheostomy. Tracheostomy-related adverse events remain a pervasive global problem, accounting for half of all airway-related deaths and hypoxic brain damage in critical care units. The Global Tracheostomy Collaborative (GTC) was formed in 2012 to improve patient safety and quality of care, emphasising knowledge, skills, teamwork, and patient-centred approaches. Inspired by quality improvement leads in Australia, the UK, and the USA, the GTC implements and disseminates best practices across hospitals and healthcare trusts. Its database collects patient-level information on quality, safety, and organisational efficiencies. The GTC provides an organising structure for quality improvement efforts, promoting safety of paediatric and adult patients. Successful implementation requires instituting key drivers for change that include effective training for health professionals; multidisciplinary team collaboration; engagement and involvement of patients, their families, and carers; and data collection that allows tracking of outcomes. We report the history of the collaborative, its database infrastructure and analytics, and patient outcomes from more than 6500 patients globally. We characterise this patient population for the first time at such scale, reporting predictors of adverse events, mortality, and length of stay indexed to patient characteristics, co-morbidities, risk factors, and context. In one example, the database allowed identification of a previously unrecognised association between bleeding and mortality, reflecting ability to uncover latent risks and promote safety. The GTC provides the foundation for future risk-adjusted benchmarking and a learning community that drives ongoing quality improvement efforts worldwide.

5. Implementation of clinical decision support to manage acute kidney injury in secondary care: an ethnographic study.

Authors Bailey, Simon; Hunt, Carianne; Brisley, Adam; Howard, Susan; Sykes, Lynne; Blakeman, Thomas
Source BMJ quality & safety; May 2020; vol. 29 (no. 5); p. 382-389
Publication Date May 2020
Publication Type(s) Journal Article
PubMedID 31796574
Database Medline
Available at BMJ quality & safety from BMJ Journals - NHS
Available at BMJ quality & safety from Unpaywall

Abstract BACKGROUNDOver the past decade, acute kidney injury (AKI) has become a global priority for improving patient safety and health outcomes. In the UK, a confidential inquiry into AKI led to the publication of clinical guidance and a range of policy initiatives. National patient safety directives have focused on the mandatory establishment of clinical decision support systems (CDSSs) within all acute National Health Service (NHS) trusts to improve the detection, alerting and response to AKI. We studied the organisational work of implementing AKI CDSSs within routine hospital care.METHODSAn ethnographic study comprising non-participant observation and interviews was conducted in two NHS hospitals, delivering AKI quality improvement programmes, located in one region of England. Three researchers conducted a total of 49 interviews and 150 hours of observation over an 18-month period. Analysis was conducted collaboratively and iteratively around emergent themes, relating to the organisational work of technology adoption.RESULTSThe two hospitals developed and implemented AKI CDSSs using very different approaches. Nevertheless, both resulted in adaptive work and trade-offs relating to the technology, the users, the organisation and the wider system of care. A common tension was associated with attempts to maximise benefit while minimise additional burden. In both hospitals, resource pressures exacerbated the tensions of translating AKI recommendations into routine practice.CONCLUSIONSOur analysis highlights a conflicted relationship between external context (policy and resources), and organisational structure and culture (eg, digital capability, attitudes to quality improvement). Greater consideration is required to the long-term effectiveness of the approaches taken, particularly in light of the ongoing need for adaptation to incorporate new practices into routine work.

6. Surgeon presence and utilization of bariatric surgery in the United States.

Authors Billmeier, Sarah E; Atkinson, Rachel B; Adrales, Gina L
Source Surgical endoscopy; May 2020; vol. 34 (no. 5); p. 2136-2142
Publication Date May 2020
Publication Type(s) Journal Article
PubMedID 31363893
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Available at Surgical endoscopy from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at Surgical endoscopy from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract BACKGROUNDBariatric surgery is the most effective long-term treatment for morbid obesity; however, it is under-utilized. This study examines the association between morbid obesity rates, bariatric surgeon presence, and utilization of bariatric surgery in the United States.METHODSHealthcare Cost and Utilization Project's 2013 National Inpatient Sample was used to determine the incidence of inpatient bariatric procedures using ICD-9 codes. The Center for Disease Control's 2013 Behavioral Risk Factor Surveillance System survey was analyzed to determine estimates of bariatric surgery qualified adults, aged 18-70, with BMI ≥ 40 or ≥ 35 with diabetes. The number of bariatric surgeons was determined from four online sources: searches of Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program accredited bariatric programs, American Society for Metabolic and Bariatric Surgery membership, and two adjustable gastric band manufacturer "find a surgeon" search tools. Correlations between rates of morbid obesity, bariatric surgeon presence, and incidence of inpatient bariatric surgery were determined.RESULTSThe defined bariatric surgery eligible population comprised between 3.6% (New England) to 6.8% (East South Central) of the total division population ($p < 0.001$). Incident rates of bariatric surgery ranged from 0.9% in East South Central to 2.2% in New England ($p < 0.001$). 2124 bariatric surgeons were identified. The rate of bariatric surgery by division was negatively correlated with division morbid obesity rates ($r = - 0.65$) and strongly positively correlated with surgeon presence ($r = 0.91$). After adjusting for demographic differences between divisions, surgeon presence remained highly associated with surgery utilization ($p < 0.001$).CONCLUSIONSRates of bariatric surgery procedures in the U.S. are minimally correlated with rates of morbid obesity and are strongly correlated with the number of available bariatric surgeons. Effective therapy for the morbidly obese may be limited by the lack of qualified surgeons.

7. Costs of postoperative morbidity following paediatric cardiac surgery: observational study.

Authors Hudson, Emma; Brown, Katherine; Pagel, Christina; Wray, Jo; Barron, David; Rodrigues, Warren; Stoica, Serban; Tibby, Shane M; Tsang, Victor; Ridout, Deborah; Morris, Stephen
Source Archives of disease in childhood; May 2020
Publication Date May 2020
Publication Type(s) Journal Article
PubMedID 32381518
Database Medline
Available at Archives of Disease in Childhood from BMJ Journals - NHS
Available at Archives of Disease in Childhood from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at Archives of Disease in Childhood from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.
Available at Archives of Disease in Childhood from Unpaywall

Abstract OBJECTIVEEarly mortality rates for paediatric cardiac surgery have fallen due to advancements in care. Alternative indicators of care quality are needed. Postoperative morbidities are of particular interest. However, while health impacts have been reported, associated costs are unknown. Our objective was to calculate the costs of postoperative morbidities following paediatric cardiac surgery.DESIGNTwo methods of data collection were integrated into the main study: (1) case-matched cohort study of children with and without predetermined morbidities; (2) incidence rates of morbidity, measured prospectively.SETTINGFive specialist paediatric cardiac surgery centres, accounting for half of UK patients.PATIENTSCohort study included 666 children (340 with morbidities). Incidence rates were measured in 3090 consecutive procedures.METHODSRisk-adjusted regression modelling to determine marginal effects of morbidities on per-patient costs. Calculation of costs for hospital providers according to incidence rates. Extrapolation using mandatory audit data to report annual financial burden for the health service.OUTCOME MEASURESImpact of postoperative morbidities on per-patient costs, hospital costs and UK health service costs.RESULTSSeven of the 10 morbidity categories resulted in significant costs, with mean (95% CI) additional costs ranging from £7483 (£3-£17 289) to £66 784 (£40 609-£103 539) per patient. On average all morbidities combined increased hospital costs by 22.3%. Total burden to the UK health service exceeded £21 million each year.CONCLUSIONPostoperative morbidities are associated with a significant financial burden. Our findings could aid clinical teams and hospital providers to account for costs and contextualise quality improvement initiatives.

8. Reducing variation in hospital mortality for alcohol-related liver disease in North West England.

Authors Kallis, Constantinos; Dixon, Pete; Silberberg, Benjamin; Affarah, Lynn; Shawihdi, Mustafa; Grainger, Ruth; Prospero, Nancy; Pearson, Mike; Marson, Anthony; Ramakrishnan, Subramanian; Richardson, Paul; Hood, Steve; Bodger, Keith
Source Alimentary pharmacology & therapeutics; May 2020
Publication Date May 2020
Publication Type(s) Journal Article
PubMedID 32441393
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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.

Abstract BACKGROUNDVariations in emergency care quality for alcohol-related liver disease (ARLD) have been highlighted.AIMTo determine whether introduction of a regional quality improvement (QI) programme was associated with a reduction in potentially avoidable inpatient mortality.METHODRetrospective observational cohort study using hospital administrative data spanning a 1-year period before (2014/2015) and 3 years after a QI initiative at seven acute hospitals in North West England. The intervention included serial audit of a bundle of process metrics. An algorithm was developed to identify index ("first") emergency admissions for ARLD (n = 3887). We created a standardised mortality ratio (SMR) to compare relative mortality and regression models to examine risk-adjusted odds of death.RESULTSIn 2014/2015, three of seven hospitals had an SMR above the upper control limit ("outliers"). Adjusted odds of death for patients admitted to outlier hospitals was higher than non-outliers (OR 2.13, 95% CI 1.32-3.44, P = 0.002). Following the QI programme there was a step-wise reduction in outliers (none in 2017/2018). Odds of death was 67% lower in 2017/2018 compared to 2014/2015 at original outlier hospitals, but unchanged at other hospitals. Process audit performance of outliers was worse than non-outliers at baseline, but improved after intervention.CONCLUSIONSThere was a reduction in unexplained variation in hospital mortality following the QI intervention. This challenges the pessimism that is prevalent for achieving better outcomes for patients with ARLD. Notwithstanding the limitations of an uncontrolled observational study, these data provide hope that co-ordinated efforts to drive adoption of evidence-based practice can save lives.

9. Surveillance of Bloodstream Infections in Intensive Care Units in England, May 2016-April 2017: Epidemiology and Ecology.

Authors Gerver, Sarah M; Mihalkova, Miroslava; Bion, Julian F; Wilson, A Peter R; Chudasama, Dimple; Johnson, Alan P; Hope, Russell; Infection in Critical Care Quality Improvement Oversight Group
Source The Journal of hospital infection; May 2020
Publication Date May 2020
Publication Type(s) Journal Article
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Available at The Journal of hospital infection from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at The Journal of hospital infection from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract BACKGROUND/AIMBloodstream infections (BSI) in Intensive Care Unit (ICU) patients are associated with increased morbidity, mortality and economic costs. Many BSI are associated with central venous catheters (CVCs). We established the Infection in Critical Care Quality Improvement Programme (ICCQIP) to initiate surveillance of BSIs in English ICUs.METHODSA web-based data capture system was launched 01/05/2016 to collect all positive blood cultures (PBCs), patient-days and CVC-days. National Health Service (NHS) Trusts in England were invited to participate in the surveillance programme. Data were linked to the antimicrobial resistance dataset maintained by Public Health England and to mortality data.FINDINGSBetween 01/05/2016 and 30/04/2017, 84 ICUs (72 adult, seven paediatric, five neonatal) based in 57/147 NHS Trusts provided data. A total of 1,474 PBCs were reported, with coagulase-negative staphylococci, Escherichia coli, Staphylococcus aureus and Enterococcus faecium being the most commonly reported organisms. The rates of BSI and ICU-associated CVC-BSI were 5.7, 1.5 and 1.3/1,000 bed-days and 2.3, 1.0 and 1.5/1,000 ICU-CVC-days in adult, paediatric and neonatal ICUs, respectively. There was wide variation in BSI and CVC-BSI rates within ICU types, particularly in adult ICUs (0-44.0/1,000 bed-days and 0-18.3/1,000 ICU-CVC-days).CONCLUSIONSWhile the overall rates of ICU-associated CVC-BSIs were lower than 2.5/1,000 ICU-CVC-days across all age-ranges, large differences were observed between units, highlighting the importance of a national standardised surveillance system to identify opportunities for improvement. Data linkage provided clinically important information on resistance patterns and patient outcomes at no extra cost to participating Trusts.

10. Incidence of postpartum haemorrhage defined by quantitative blood loss measurement: a national cohort.

Authors Bell, Sarah F; Watkins, Adam; John, Miriam; Macgillivray, Elinore; Kitchen, Thomas L; James, Donna; Scarr, Cerys; Bailey, Christopher M; Kelly, Kevin P; James, Kathryn; Stevens, Jenna L; Edey, Tracey; Collis, Rachel E; Collins, Peter W
Source BMC pregnancy and childbirth; May 2020; vol. 20 (no. 1); p. 271
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Database Medline
Available at BMC Pregnancy and Childbirth from BioMed Central
Available at BMC Pregnancy and Childbirth from Europe PubMed Central - Open Access
Available at BMC Pregnancy and Childbirth from Unpaywall
Abstract BACKGROUNDVisual estimation of blood loss following delivery often under-reports actual bleed volume. To improve accuracy, quantitative blood loss measurement was introduced for all births in the 12 hospitals providing maternity care in Wales. This intervention was incorporated into a quality improvement programme (Obstetric Bleeding Strategy for Wales, OBS Cymru). We report the incidence of postpartum haemorrhage in Wales over a 1-year period using quantitative measurement.METHODSThis prospective, consecutive cohort included all 31,341 women giving birth in Wales in 2017. Standardised training was cascaded to maternity staff in all 12 hospitals in Wales. The training comprised mock-scenarios, a video and team drills. Uptake of quantitative blood loss measurement was audited at each centre. Data on postpartum haemorrhage of > 1000 mL were collected and analysed according to mode of delivery. Data on blood loss for all maternities was from the NHS Wales Informatics Service.RESULTSBiannual audit data demonstrated an increase in quantitative measurement from 52.1 to 87.8% (P < 0.001). The incidence (95% confidence intervals, CI) of postpartum haemorrhage of > 1000 mL, > 1500 mL and > 2000 mL was 8.6% (8.3 to 8.9), 3.3% (3.1 to 3.5) and 1.3% (1.2 to 1.4), respectively compared to 5%, 2% and 0.8% in the year before OBS Cymru. The incidence (95% CI) of bleeds of > 1000 mL was similar across the 12 hospitals despite widely varied size, staffing levels and case mix, median (25th to 75th centile) 8.6% (7.8-9.6). The incidence of PPH varied with mode of delivery and was mean (95% CI) 4.9% (4.6-5.2) for unassisted vaginal deliveries, 18.4 (17.1-19.8) for instrumental vaginal deliveries, 8.5 (7.7-9.4) for elective caesarean section and 19.8 (18.6-21.0) for non-elective caesarean sections.CONCLUSIONSQuantitative measurement of blood loss is feasible in all hospitals providing maternity care and is associated with detection of higher rates of postpartum haemorrhage. These results have implications for the definition of abnormal blood loss after childbirth and for management and research of postpartum haemorrhage.

11. Characterising the evidence base for advanced clinical practice in the UK: a scoping review protocol.

Authors Evans, Catrin; Poku, Brenda; Pearce, Ruth; Eldridge, Jeanette; Hendrick, Paul; Knaggs, Roger; McLuskey, John; Tomczak, Philippa; Thow, Ruaridh; Harris, Peter; Conway, Joy; Collier, Richard
Source BMJ open; May 2020; vol. 10 (no. 5); p. e036192
Publication Date May 2020
Publication Type(s) Journal Article
PubMedID 32439696
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Available at BMJ open from HighWire - Free Full Text

Abstract INTRODUCTIONA global health workforce crisis, coupled with ageing populations, wars and the rise of non-communicable diseases is prompting all countries to consider the optimal skill mix within their health workforce. The development of advanced clinical practice (ACP) roles for existing non-medical cadres is one potential strategy that is being pursued. In the UK, National Health Service (NHS) workforce transformation programmes are actively promoting the development of ACP roles across a wide range of non-medical professions. These efforts are currently hampered by a high level of variation in ACP role development, deployment, nomenclature, definition, governance and educational preparation across the professions and across different settings. This scoping review aims to support a more consistent approach to workforce development in the UK, by identifying and mapping the current evidence base underpinning multiprofessional advanced level practice in the UK from a workforce, clinical, service and patient perspective.METHODS AND ANALYSISThis scoping review is registered with the Open Science Framework (https://osf.io/tzpe5). The review will follow Joanna Briggs Institute guidance and involves a multidisciplinary and multiprofessional team, including a public representative. A wide range of electronic databases and grey literature sources will be searched from 2005 to the present. The review will include primary data from any relevant research, audit or evaluation studies. All review steps will involve two or more reviewers. Data extraction, charting and summary will be guided by a template derived from an established framework used internationally to evaluate ACP (the Participatory Evidence-Informed Patient-Centred Process-Plus framework).DISSEMINATIONThe review will produce important new information on existing activity, outcomes, implementation challenges and key areas for future research around ACP in the UK, which, in the context of global workforce transformations, will be of international, as well as local, significance. The findings will be disseminated through professional and NHS bodies, employer organisations, conferences and research papers.

12. Geo-temporal provision of pre-hospital emergency anaesthesia by UK Helicopter Emergency Medical Services: an observational cohort study.

Authors Bourn, Sebastian; Turner, Jake; Raitt, James; Tucker, Harriet; PHOTON (Pre-HOspital Trainee Operated research Network)
Source British journal of anaesthesia; May 2020; vol. 124 (no. 5); p. 571-578
Publication Date May 2020
Publication Type(s) Journal Article Observational Study
PubMedID 32307033
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Available at British journal of anaesthesia from Leicester General Hospital Library Local Print Collection [location] : Leicester General Library. [title_notes] : Issues before 2000 held in Archive.
Available at British journal of anaesthesia from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at British journal of anaesthesia from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.
Abstract BACKGROUNDPre-hospital emergency anaesthesia (PHEA) is frequently required for injured patients. National Institute for Health and Care Excellence (NICE) quality standards state that PHEA should be delivered within 45 min of an emergency call. We investigated whether there is geo-temporal variation in service provision to the UK population.METHODSWe retrospectivly audited the time of day when PHEA is provided by UK Helicopter Emergency Medical Services (HEMS), by recording PHEA provision on a randomly selected week and weekend day in 2018. Pre-hospital emergency anaesthesia in the United Kingdom: an observational cohort study retrospectively assessed the time from emergency call to pre-hospital emergency anaesthesia delivery by HEMS during a 1 yr period from April 2017 to March 2018. The population coverage likely to receive pre-hospital emergency anaesthesia in accord with NICE guidelines was estimated by integrating population data with the median time to PHEA, hours of service provision, geographic location, and transport modality.RESULTSOn a weekday 20 HEMS units (comprising from four to 31 enhanced care teams) were estimated to be able to meet NICE guidelines for delivery of PHEA to a poulation of 6.6-35.2 million individuals (at times of minimum and maximal staffing, respectively). At the weekend, 17 HEMS units (comprising from 5 to 28 enhanced care teams) were estimated to be able to meet NICE guidelines for PHEA deliveryto a population of 6.8-34.1 million individuals (minimum and maximal staffing, respectively).CONCLUSIONSThere is marked geo-temporal variation in the ability of HEMS organisations to deliver pre-hospital emergency anaesthesia in the UK.

13. Introduction of standardized, cumulative quantitative measurement of blood loss into routine maternity care.

Authors Powell, E; James, D; Collis, R; Collins, P W; Pallmann, P; Bell, S
Source The journal of maternal-fetal & neonatal medicine : the official journal of the European Association of Perinatal Medicine, the Federation of Asia and Oceania Perinatal Societies, the International Society of Perinatal Obstetricians; May 2020 ; p. 1-7
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Available at The journal of maternal-fetal & neonatal medicine : the official journal of the European Association of Perinatal Medicine, the Federation of Asia and Oceania Perinatal Societies, the International Society of Perinatal Obstetricians 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: Postpartum hemorrhage (PPH) is the leading cause of maternal morbidity in the UK. Visual estimation of blood loss is unreliable yet remains common practice. As part of a national quality improvement project to improve care during PPH, standardized, quantitative measurement of blood loss (QBL) for all deliveries was introduced into a tertiary obstetric unit in Cardiff, Wales.Methods: Retrospective analysis of 875 consecutive maternities between December 2017 and February 2018 was undertaken. Of these, 372 mothers had both pre- and post-partum hemoglobin (Hb) were recorded. Regression analyses were performed to investigate the relationship between change in Hb adjusted for red cell transfusion and QBL.Results: The correlation coefficient between QBL and adjusted change in Hb for all deliveries (n = 372) was 0.57. This corresponded to an estimated fall of adjusted change in Hb of 15.3 g/L (95% CI: 13.1, 17.6) per 1000 mL blood loss.Discussion: QBL has been shown to be reliable across all maternity settings, with reproducible results in theater and delivery rooms (on the obstetric unit and alongside midwifery-led unit). QBL is moderately correlated with adjusted change in Hb for all volumes of bleeding and gives clinicians more accurate knowledge of blood loss than visual estimation. This low-cost, low-fidelity intervention can influence the timely escalation of clinical care and therefore patient outcome.

14. Determinants of Variation in the Use of Adjuvant Chemotherapy for Stage III Colon Cancer in England.

Authors Boyle, J M; Kuryba, A; Cowling, T E; Aggarwal, A; Hill, J; van der Meulen, J; Walker, K; Braun, M S
Source Clinical oncology (Royal College of Radiologists (Great Britain)); May 2020; vol. 32 (no. 5); p. e135
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Available at Clinical oncology (Royal College of Radiologists (Great Britain)) 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 AIMSAdjuvant chemotherapy (ACT) for stage III colon cancer is well-established. This study aimed to explore the determinants of ACT use and between-hospital variation within the English National Health Service (NHS).MATERIALS AND METHODSIn total, 11 932 patients (diagnosed 2014-2017) with pathological stage III colon cancer in the English NHS were identified from the National Bowel Cancer Audit. Records were linked to Systemic Anti-Cancer Therapy and Hospital Episode Statistics databases. Multi-level logistic regression analyses were carried out to estimate independent factors for ACT use, including age, sex, deprivation, comorbidities, performance status, American Society of Anaesthesiologists (ASA) grade, surgical urgency, surgical access, TNM staging, readmission and hospital-level factors (university teaching hospital, on-site chemotherapy and high-volume centre). A random intercept was modelled for each English NHS hospital (n = 142). Between-hospital variation was explored using funnel plot methodology. Fully adjusted random-intercept models were fitted separately in young (<70 years) and elderly (≥70 years) patients and intra-class correlation coefficients estimated.RESULTS60.7% of patients received ACT. Age was the strongest determinant. Compared with patients aged <60 years, those aged 60-64 (adjusted odds ratio [aOR] 0.76, 95% confidence interval 0.63-0.93), 65-69 (aOR 0.63, 95% confidence interval 0.54-0.74), 70-74 (aOR 0.53, 95% confidence interval 0.44-0.62), 75-79 (aOR 0.23, 95% confidence interval 0.19-0.27) and ≥80 years (aOR 0.05, 95% confidence interval 0.04-0.06) were significantly less likely to receive ACT. With adjustment for other factors, ACT use was more likely in patients with higher socioeconomic status, fewer comorbidities, better performance status, lower ASA grade, advanced disease, elective resections, laparoscopic procedures and no unplanned readmissions. Hospital-level factors were non-significant. The observed proportions of ACT administration in the young and elderly were 46-100% (80% of hospitals 74-90%) and 10-81% (80% of hospitals 33-65%), respectively. Risk adjustment did not reduce between-hospital variation. Despite adjustment, age accounted for 9.9% (7.2-13.4%) of between-hospital variation in the elderly compared with 2.7% (1.2-5.7%) in the young.CONCLUSIONSThere is significant between-hospital variation in ACT use for stage III colon cancer, especially for older patients. Advanced age alone seems to be a greater barrier to ACT use in some hospitals.

15. Positive predictive value of stroke identification by ambulance clinicians in North East England: a service evaluation.

Authors McClelland, Graham; Flynn, Darren; Rodgers, Helen; Price, Christopher

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

Abstract INTRODUCTION/BACKGROUNDAccurate prehospital identification of patients who had an acute stroke enables rapid conveyance to specialist units for time-dependent treatments such as thrombolysis and thrombectomy. Misidentification leads to patients who had a 'stroke mimic' (SM) being inappropriately triaged to specialist units. We evaluated the positive predictive value (PPV) of prehospital stroke identification by ambulance clinicians in the North East of England.METHODSThis service evaluation linked routinely collected records from a UK regional ambulance service identifying adults with any clinical impression of suspected stroke to diagnostic data from four National Health Service hospital trusts between 1 June 2013 and 31 May 2016. The reference standard for a confirmed stroke diagnosis was inclusion in Sentinel Stroke National Audit Programme data or a hospital diagnosis of stroke or transient ischaemic attack in Hospital Episode Statistics. PPV was calculated as a measure of diagnostic accuracy.RESULTSAmbulance clinicians in North East England identified 5645 patients who had a suspected stroke (mean age 73.2 years, 48% male). At least one Face Arm Speech Test (FAST) symptom was documented for 93% of patients who had a suspected stroke but a positive FAST was only documented for 51%. Stroke, or transient ischaemic attack, was the final diagnosis for 3483 (62%) patients. SM (false positives) accounted for 38% of suspected strokes identified by ambulance clinicians and included a wide range of non-stroke diagnoses including infections, seizures and migraine.DISCUSSIONIn this large multisite data set, identification of patients who had a stroke by ambulance clinicians had a PPV rate of 62% (95% CI 61 to 63). Most patients who had a suspected stroke had at least one FAST symptom, but failure to document a complete test was common. Training for stroke identification and SM rates need to be considered when planning service provision and capacity.

16. An evaluation of CT head reporting radiographers' scope of practice within the United Kingdom.

Authors Lockwood, P
Source Radiography (London, England : 1995); May 2020; vol. 26 (no. 2); p. 102-109
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Available at Radiography (London, England : 1995) 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 INTRODUCTIONThis study investigated the scope of practice of CT head reporting radiographers in the UK, and to compare adherence to professional body standards.METHODSAn online questionnaire was utilized applying both multiple-choice and response (closed questions), and qualitative open question free-text responses. The 30 questions covered four key areas of demographics, the scope of practice, referrals, and ongoing competence, as described in professional body national guidance standards. The questionnaire was disseminated (convenience sampling) via Twitter and email to the National CT Head Reporting Special Interest Group. Responses were transcribed and coded; the results applied descriptive statistics to summarise observations of the study sample.RESULTSThe sample of participant response data analysed was n = 54. Most respondents were from England, with a postgraduate certificate award in clinical reporting, and a mean length of 8.3 years of reporting experience. The accepted referral pathway included a wide range of medical and surgical specialities, including both in and outpatients and acute and chronic pathways. Furthermore, 96.2% of the sample had a scope of practice that authorised referral recommendations to a broad and inclusive group of medical and surgical teams, and if required further or repeat diagnostic imaging. To maintain quality and evidence of ongoing competency, all radiographers were involved in audit cycles.CONCLUSIONThe data collected confirmed the reporting practice within this sample group aligns to national recommended guidance. The data provided key information on the range and variation of individuals scope of practice within age restrictions of patients, examination types, referral teams, and ongoing competency practices.IMPLICATIONS FOR PRACTICEThis paper details the scope of practice of CT head reporting by radiographers and the contribution made to the healthcare sector.

17. National survey of enhanced recovery after thoracic surgery practice in the United Kingdom and Ireland.

Authors Budacan, Alina-Maria; Mehdi, Rana; Kerr, Amy Pamela; Kadiri, Salma Bibi; Batchelor, Timothy J P; Naidu, Babu
Source Journal of cardiothoracic surgery; May 2020; vol. 15 (no. 1); p. 95
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Available at Journal of cardiothoracic surgery from Unpaywall
Abstract BACKGROUNDEvidence that Enhanced Recovery After Thoracic Surgery (ERAS) improves clinical outcomes is growing. Following the recent publications of the international ERAS guidelines in Thoracic surgery, the aim of this audit was to capture variation and perceived difficulties to ERAS implementation, thus helping its development at a national level.METHODSWe designed an anonymous online survey and distributed it via email to all 36 centres that perform lung lobectomy surgery in the UK and Ireland. It included 38 closed, open and multiple-choice questions on the core elements of ERAS and took an average of 10 min to complete.RESULTSEighty-two healthcare professionals from 34 out of 36 centres completed the survey; majority were completed by consultant thoracic surgeons (57%). Smoking cessation support varied and only 37% of individuals implemented the recommended period for fluid fasting; 59% screen patients for malnutrition and 60% do not give preoperative carbohydrate loading. The compliance with nerve sparing techniques when a thoracotomy is performed was poor (22%). 66% of respondents apply suction on intercostal drains and although 91% refer all lobectomies for physiotherapeutic assessment, the physiotherapy adjuncts varied across centres. Perceived barriers to implementation were staffing levels, lack of teamwork/consistency, limited resources over weekend and the reduced access to smoking cessation services.CONCLUSIONCentres across the UK are working to develop the ERAS pathway. This survey aids this process by providing insight into "real life" ERAS, increasing exposure of staff to the ESTS- ERAS recommendations and identifying barriers to implementation.

18. The landscape of psoriasis provision in the UK.

Authors Smith, S P; Mohd Mustapa, M F; de Berker, D
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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 Psoriasis remains one of the commonest conditions seen in dermatological practice, and its treatment is one of the greatest cost burdens for the UK NHS. Treatment of psoriasis is complex with numerous overlapping lines and modalities of therapy employed in combination. This complexity reflects the underlying pathophysiology of the disease as well as the heterogenous population which it affects. NICE guidance for the treatment of psoriasis has been available since 2013 and has been the subject of 3 national audits conducted by the British Association of Dermatologists (BAD). This report synthesises the results of the most recent of those exercises and places it in the context of NICE guidance and previous audits. It clearly shows the significant burden of disease, issues with provision of services and long waiting times as well as the marked shift in therapeutic modalities towards targeted biologic therapies.

19. Qualitative interview study exploring frontline managers' contributions to hand hygiene standards and audit: Local knowledge can inform practice.

Authors Gould, Dinah J; McKnight, Jacob; Leaver, Meghan; Keene, Claire; Gaze, Sarah; Purssell, Edward
Source American journal of infection control; May 2020; vol. 48 (no. 5); p. 480-484

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Available at American journal of infection control 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 BACKGROUNDFrontline managers promote hand hygiene standards and adherence to hand hygiene protocols. Little is known about this aspect of their role.METHODSQualitative interview study with frontline managers on 2 acute admission wards in a large National Health Service Trust in the United Kingdom.RESULTSManagers reported that hand hygiene standards and audit were modeled on World Health Organization guidelines. Hand hygiene outside the immediate patient zone was not documented but managers could identify when additional indications for hand hygiene presented. They considered that audit was worthwhile to remind staff that hand hygiene is important but did not regard audit findings as a valid indicator of practice. Managers identified differences in the working patterns of nurses and doctors that affect the number and types of hand hygiene opportunities and barriers to hand hygiene. Ward managers were accepted as the custodians of hand-hygiene standards.CONCLUSIONSFrontline managers identified many of the issues currently emerging as important in contemporary infection prevention practice and research and could apply them locally. Their views should be represented when hand hygiene guidelines are reviewed and updated.

20. An antenatal alcohol service evaluation of the north-east of England and north Cumbria.

Authors Howlett, Helen
Source Journal of public health (Oxford, England); May 2020; vol. 42 (no. 2); p. 374-387
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Available at Journal of public health (Oxford, England) from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract BACKGROUNDNHS England's 'Better Births' strategy aims to improve maternal and infant health outcomes. A strategic priority identified in the north-east local maternity system is to reduce alcohol consumption in pregnancy due to the documented diverse risks of harm to mother and baby, including foetal alcohol spectrum disorder.AIMSTo evaluate current alcohol prevention, screening and treatment service provision in maternity care across the region, and inform future recommendations.METHODSA service evaluation survey was developed to systematically consult strategic stakeholders across all nine maternity trusts in the region over a 2-month period in 2018. Content analysis was employed to identify fundamental themes and inform recommendations for practice.RESULTSHigh variation was reported throughout regional clinical practices, service provision and staff training. For example, a number of alcohol screening tools were identified, each with diverse thresholds for referral; reported data collection and documentation practices were multifarious, incomparable and unquantifiable; audit was rare and guidelines were primarily influenced by local commissioning agreements.DISCUSSIONStandardized patient pathways involving alcohol screening and management practices are required, and sharing best practices will facilitate referrals and support regardless of location. The implementation of these recommendations requires appropriate leadership, commissioning and training strategies.

21. Evaluating outcomes following emergency laparotomy in the North of England and the impact of the National Emergency Laparotomy Audit - A retrospective cohort study.

Authors McLean, Ross C; Brown, Leo R; Baldock, Thomas E; O'Loughlin, Paul; McCallum, Iain Jd
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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 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 BACKGROUNDEmergency laparotomy is associated with high morbidity and mortality. Current trends suggest improvements have been made in recent years, with increased survival and shorter lengths of stay in hospital. The National Emergency Laparotomy Audit (NELA) has evaluated participating hospitals in England and Wales and their individual outcomes since 2013. This study aims to establish temporal trends for patients undergoing emergency laparotomy and evaluate the influence of NELA.METHODSData for emergency laparotomies admitted to NHS hospitals in the Northern Deanery between 2001 and 2016 were collected, including demographics, co-morbidities, diagnoses, operations undertaken and outcomes. The primary outcome of interest was in-hospital death within 30 days of admission. Cox-regression analysis was undertaken with adjustment for covariates.RESULTSThere were 2828 in-hospital deaths from 24,291 laparotomies within 30 days of admission (11.6%). Overall 30-day mortality significantly reduced during the 15-year period studied from 16.3% (2001-04), to 8.1% during 2013-16 ($p < 0.001$). After multivariate adjustment, laparotomies undertaken in more recent years were associated with a lower mortality risk compared to earlier years (2013-16: HR 0.73, $p < 0.001$). There was a significant improvement in 30-day postoperative mortality year-on-year during the NELA period (from 9.1 to 7.1%, $p = 0.039$). However, there was no difference in postoperative mortality for patients who underwent laparotomy during NELA (2013-16) compared with the preceding three years (both 8.1%, $p = 0.526$).DISCUSSION30 day postoperative mortality for emergency laparotomy has improved over the past 15-years, with significantly reduced mortality risk in recent years. However, it is unclear if NELA has yet had a measurable effect on 30-day post-operative mortality.

22. Radiology reporting of osteoporotic vertebral fragility fractures on computed tomography studies: results of a UK national audit.

Authors Howlett, David C; Drinkwater, Karl J; Mahmood, Nadia; Illes, Jozsef; Griffin, Jill; Javaid, Kassim
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Abstract OBJECTIVESTo evaluate organisational reporting infrastructure and patient-related reporting data in the diagnosis of vertebral fragility fractures (VFFs) as demonstrated on computed tomography (CT).METHODSOrganisational and patient-specific questionnaires were developed by consensus between The Royal College of Radiologists, the Royal College of Physicians, and the Royal Osteoporosis Society. The patient-specific component of the audit involved analysis of CT reporting data acquired from 50 consecutive non-traumatic studies including the thoracolumbar spine. Ethical approval for this type of study is not required in the UK. All UK radiology departments with an audit lead (auditor) registered with The Royal College of Radiologists (RCR) were invited to participate in this retrospective audit.RESULTSIn total, 127 out of 202 departments (63%) supplied data to the study, with inclusion of 6357 patients. Overall, 1362/6357 patients (21.4%) had a fracture present on auditor review of the CT imaging. There was a lack of compliance with all audit standards: 79% of reports commented on the vertebrae (target 100%), fracture severity was mentioned in 26.2% (target 100%), the recommended terminology 'vertebral fracture' was used in 60.1% (target 100%), and appropriate onward referral was recommended in 2.6% (target 100%).CONCLUSIONSThe findings from this study should be used to provide impetus to improve the diagnosis and care for patients with osteoporotic VFFs. Solutions are multifactorial, but radiologist and local osteoporosis/fracture liaison service engagement is fundamental, combined with necessary development of electronic report notification systems and expansion of supporting fracture services.KEY POINTS• Early detection and diagnosis of vertebral fragility fractures (VFFs) significantly reduce patient morbidity and mortality. This study describes the results of a retrospective UK-wide audit evaluating current radiology reporting practice in the opportunistic diagnosis of VFFs as demonstrated on computed tomography (CT) studies including the spine. • Key audit standards included comment made on bone integrity in primary report (target 100%), comment made on severity of fractures (90%), report used recommended terminology 'fracture' (100%), and report made appropriate recommendations for referral/further assessment (100%). The audit results demonstrated a lack of compliance with all audit standards; lack of compliance was most marked in the use of recommended terminology (achieved 60.3%), in relation to comment on fracture severity (achieved 26.2%) and for recommendation for referral/further assessment (achieved 2.6%). • Solutions are challenging and multifactorial but the opportunity exists for all radiologists to examine their practice and directly improve patient care.

23. Multispecialty tracheostomy experience.

Authors Lipton, G; Stewart, M; McDermid, R; Docking, R; Urquhart, C; Morrison, M; Montgomery, J

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Available at Annals of the Royal College of Surgeons of England from Available to NHS staff on request from UHL Libraries & Information Services (from 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 INTRODUCTIONTracheostomy is a common surgical procedure used to create a secure airway in patients, now performed by a variety of specialties, with a notable rise in critical care environments. It is unclear whether this rise is seen in units with large head and neck surgery departments, and how practice in such units compares with the rest of the UK.METHODSA three-year retrospective audit was carried out between anaesthetic, surgical and critical care departments. All tracheostomy procedures were recorded anonymously.RESULTSA total of 523 tracheostomies were performed, 66% of which were in men. The mean patient age was 60 years. The majority (83%) were elective, performed for various indications, while the remaining 17% were emergency tracheostomies performed for pending airway obstruction. A fifth of the tracheostomies were percutaneous procedures. Most emergency tracheostomies (78%) were performed by otolaryngology. Three cricothyroidotomies were performed within critical care and theatres. Complications related to tracheostomy occurred in 47 cases (9%), most commonly lower respiratory tract infection. The mean time to decannulation was 12.8 days.CONCLUSIONSThis paper discusses the findings of a comprehensive, multispecialty audit of tracheostomy experience in a large health board, with over 150 tracheostomies performed annually. Elective cases form the majority although there is a significant case series of emergency tracheostomies performed for a range of pathologies. Around a quarter of those requiring tracheostomy ultimately died, mostly as a result of advanced cancer.

24. Cost of hospital treatment of type 1 diabetes (T1DM) and type 2 diabetes (T2DM) compared to the non-diabetes population: a detailed economic evaluation.

Authors Stedman, Mike; Lunt, Mark; Davies, Mark; Livingston, Mark; Duff, Christopher; Fryer, Anthony; Anderson, Simon George; Gadsby, Roger; Gibson, Martin; Rayman, Gerry; Heald, Adrian
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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 OBJECTIVESOther than age, diabetes is the largest contributor to overall healthcare costs and reduced life expectancy in Europe. This paper aims to more exactly quantify the net impact of diabetes on different aspects of healthcare provision in hospitals in England, building on previous work that looked at the determinants of outcome in type 1 diabetes (T1DM) and type 2 diabetes (T2DM).SETTINGNHS Digital Hospital Episode Statistics (HES) in England was combined with the National Diabetes Audit (NDA) to provide the total number in practice of people with T1DM/T2DM.OUTCOME MEASURESWe compared differences between T1DM/T2DM and non-diabetes individuals in relation to hospital activity and associated cost.RESULTSThe study captured 90% of hospital activity and £36 billion/year of hospital spend. The NDA Register showed that out of a total reported population of 58 million, 2.9 million (6.5%) had T2DM and 240 000 (0.6%) had T1DM. Bed-day analysis showed 17% of beds are occupied by T2DM and 3% by T1DM. The overall cost of hospital care for people with diabetes is £5.5 billion/year. Once the normally expected costs including the older age of T2DM hospital attenders are allowed for this fell to £3.0 billion/year or 8% of the total captured secondary care costs. This equates to £560/non-diabetes person compared with £3280/person with T1DM and £1686/person with T2DM. For people with diabetes, the net excess impact on non-elective/emergency work is £1.2 billion with additional estimated diabetes-related accident & emergency attendances at 440 000 costing the NHS £70 million/year. T1DM individuals required five times more secondary care support than non-diabetes individuals. T2DM individuals, even allowing for the age, require twice as much support as non-diabetes individuals.CONCLUSIONSThis analysis shows that additional cost of provision of hospital services due to their diabetes comorbidities is £3 billion above that for non-diabetes, and that within this, T1DM has three times as much cost impact as T2DM. We suggest that supporting patients in diabetes management may significantly reduce hospital activity.

25. Gastric emptying: methodology and normal ranges for two commonly used meals in the UK.

Authors Hansrod, Shazmeen; James, Gregory; Notghi, Alp; Croasdale, Jilly; O'Brien, Joseph; Thomson, William H
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Available at Nuclear medicine communications from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract AIMA recent audit has highlighted that there is a large variation in the way gastric emptying scintigraphy is performed, analysed and reported in the UK. In this study, we have established a comprehensive protocol on how to perform gastric emptying including normal ranges for two of the most widely used meals. A standardized scrambled egg sandwich was used as the main meal. Normal ranges were also established for oat porridge as an alternative gluten-free meal. We have calculated normal ranges for several functional parameters which may be used to assess gastric emptying. We hope that establishing a reliable normal range for these two simple and commonly used meals will encourage adoption of a universally accepted protocol for measurement of solid gastric emptying in the UK.METHODA total of 42 volunteers (20 male, 22 female, age range 22-68) with no history of gastrointestinal symptoms or diabetes were studied. Each volunteer fasted overnight and consumed two meals with similar nutritional composition on two separate days: scrambled eggs with two slices of bread were consumed on one day and gluten-free porridge (40 g in 200 mL whole milk) was consumed on a different day. Each meal was radiolabelled with 10 MBq of Tc-DTPA. Simultaneous anterior-posterior 2-min static images were acquired with the patient standing between the gamma camera detectors. Images were acquired every 5 min over a 2 hour period, followed by a single image at 3 hour. The data were modelled using a power-exponential function that allowed measurements of gastric emptying functional parameters including lag time, half-emptying time (HET), peak emptying rate, time-to-peak emptying (TPE) and exponential half-life (EHL). Three-hour retention was also calculated. Paired t-tests were used to compare the two meals and two-sample t-tests were used to assess gender-related differences. Regression analysis was used to assess correlation of the functional parameters with age and body habitus (body surface area, BSA).RESULTSAll gastric emptying functional parameters were significantly different between the two meals ($P < 0.001$). The normal range for lag time was 0-13 min for porridge and 1-34 min for scrambled egg. The normal range for HET was 18-73 min for porridge and 44-116 min for scrambled egg. The normal range for EHL was 21-57 min for porridge and 20-82 min for scrambled egg. The normal range for 3 hour retention was <7% for porridge and <17% for scrambled egg. Only weak significance was found for gender-related differences in gastric function for the two meals ($0.05 < P < 0.10$). Weak correlation was also observed for some functional parameters when plotted against age and BSA ($0.05 < P < 0.10$).CONCLUSIONWe have established gastric emptying normal ranges for the two most commonly used meals in the UK. The normal ranges are meal specific and not interchangeable, with porridge showing significantly faster transit than scrambled egg for all measured parameters. Scrambled egg sandwich is the recommended meal for solid gastric emptying studies as it is more reproducible and more comparable to a normally consumed solid meal for our population. Porridge would be a suitable alternative for patients who are unable to eat egg sandwiches, for example, patients with egg allergy or gluten intolerance.

26. The optimal time to test for sero-reversion in HIV-exposed uninfected infants: the later the better?

Authors Hindocha, A; Randell, P; Seery, P; Rahimi, T; Kirkhope, N; Raghunanan, S; Foster, C; Tudor-Wiliiams, G; Lyall, H
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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 OBJECTIVESHIV-exposed uninfected (HEU) infants are tested for loss of maternal antibody (sero-reversion) at 18 months of age. Highly sensitive fourth-generation antigen/antibody assays can detect very low levels of antibody, leading to retesting. We audited serological screening outcomes in HEU infants at two National Health Service (NHS) Trusts.METHODSHEU infants born between January 2013 and August 2016 were identified via case records. Data collected included gestation; age at testing; test results and assay type.RESULTSOne hundred and forty-two infants were identified, of whom 21 were excluded from analysis. One hundred and one (83%) were born at term and 20 (17%) preterm (< 37/40 weeks of gestation), and the median age at first serology was 19.1 [interquartile range (IQR) 18.1; 21.4] months. Initial serology was positive in 10 of 121 infants (8.3%), and the median age of these 10 infants was 18.3 (IQR 18.1; 18.8) months, whereas those with negative serology (n = 111) had a median age of 19.2 (IQR 18.1; 21.5) months (P = 0.12). All infants with positive HIV serology were born at term. Seven of 10 infants had reactive serology on two fourth-generation assays. Subsequent serology was available for eight of 10 infants, with a median age of 21.3 months. Five of the eight (63%) were negative. One was reactive but HIV RNA polymerase chain reaction (PCR) was negative, and one was reactive on screening but negative on confirmatory testing. The remaining child was still seropositive at 24.7 months but had a non-reactive result at 29.4 months.CONCLUSIONSOverall, 8.3% of HEU infants required repeat testing to confirm loss of antibody. Delaying testing until 22 months of age reduces retesting to < 2%, with associated resource and emotional implications. Positive serology at 22 months should prompt an HIV RNA PCR to exclude infection.

27. Differences in management of isolated spinal fractures between neurosurgery and orthopaedics: a 6-year retrospective study.

Authors Myers, Matthew; Hall, Samuel; Sadek, Ahmed-Ramadan; Dare, Christopher; Griffith, Colin; Shenouda, Emad; Nader-Sepahi, Ali
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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 Introduction: The acute management of spinal fractures is traditionally split between neurosurgeons and orthopaedic surgeons and the specialities have varying approaches to management. This study investigates differences between neurosurgeons and spinal orthopaedic surgeons in the management of spinal fractures at a single trauma centre in the United Kingdom.Methods: A retrospective study at a single trauma centre of patients identified using the Trauma Audit and Research Network (TARN). Case notes and radiological investigations were reviewed for demographics, fracture classification, clinical management and outcomes. Polytrauma cases and patients managed by non-neurosurgical/orthopaedic specialties were excluded.Results: A total of 465 patients were included in this study (neurosurgery n = 266, orthopaedics n = 199). There were no significant differences between groups for age, gender, Charlson co-morbidity score or distribution of fractures using the AO spine classification. Patients admitted and managed under the orthopaedic surgeons were more likely to undergo a surgical procedure when compared to those admitted under the neurosurgeons (n = 71; 35.7% vs n = 71; 26.8%, p = 0.042, OR 1.56 95%CI 1.056 to 2.31). The median overall length of stay was 8 days and there was no significant difference between teams; however, the neurosurgical cohort were more likely to be admitted to an intensive care unit (24.3% vs 16.2%, p = 0.04).Conclusion: This study is the first in the United Kingdom to compare neurosurgical and orthopaedic teams in their management of spinal fractures. It demonstrates that differences may exist both in operating rates and outcomes.

28. Association of prevalence of active transport to work and incidence of myocardial infarction: A nationwide ecological study.

Authors Munyombwe, Theresa; Lovelace, Robin; Green, Mark; Norman, Paul; Walpole, Sarah; Hall, Marlous; Timmis, Adam; Batin, Phil; Brownlee, Alistair; Brownlee, Jonathan; Oliver, Ged; Gale, Chris P
Source European journal of preventive cardiology; May 2020; vol. 27 (no. 8); p. 822-829
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Abstract BACKGROUNDThere is a paucity of population-based geospatial data about the association between active transport and myocardial infarction. We investigated the association between active transport to work and incidence of myocardial infarction.DESIGNThis ecological study of 325 local authorities in England included 43,077,039 employed individuals aged 25-74 years (UK Census, 2011), and 117,521 individuals with myocardial infarction (Myocardial Ischaemia National Audit Project, 2011-2013).METHODSBayesian negative binomial regression models were used to investigate the association of active transport to work and incidence of myocardial infarction adjusting for local levels of deprivation, obesity, smoking, diabetes and physical activity.RESULTSIn 2011, the prevalence of active transportation to work for people in employment in England aged 25-74 years was 11.4% (4,531,182 active transporters; 8.6% walking and 2.8% cycling). Active transport in 2011 was associated with a reduced incidence of myocardial infarction in 2012 amongst men cycling to work (incidence rate ratio (95% credible interval) 0.983 (0.967-0.999); and women walking to work (0.983 (0.967-0.999)) after full adjustments. However, the prevalence of active transport for men and women was not significantly associated with the combined incidence of myocardial infarction between 2011-2013 after adjusting for physical activity, smoking and diabetes.CONCLUSIONSIn England, the prevalence of active transportation was associated with a reduced incidence of myocardial infarction for women walking and men cycling to work in corresponding local geographic areas. The overall association of active transport with myocardial infarction was, however, explained by local area levels of smoking, diabetes and physical activity.

29. Paediatric antimicrobial stewardship programmes in the UK's regional children's hospitals.

Authors Vergnano, S; Bamford, A; Bandi, S; Chappel, F; Demirjian, A; Doerholt, K; Emonts, M; Antolin, L F; Goenka, A; Jones, L; J Herberg; Hinds, L; McGarrity, O; P Moriarty; O'Riordan, S; Patel, M; Paulus, S; Porter, D; Stock, K; S Patel
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Available at The Journal of hospital infection from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.
Abstract A survey was conducted in UK regional children's hospitals with paediatric intensive care and paediatric infectious disease (PID) departments to describe the characteristics of paediatric antimicrobial stewardship (PAS) programmes. A structured questionnaire was sent to PAS coordinators. 'Audit and feedback' was implemented in 13 out of 17 centres. Microbiology-led services were more likely to implement antimicrobial restriction (75% vs 33% in PID-led services), to focus on broad-spectrum antibiotics, and to review patients with positive blood cultures. PID-led services were more likely to identify patients from e-prescribing or drug charts and review all antimicrobials. A PAS network has been established.

30. The impact of the Tracey judgment on the rates and outcomes of in-hospital cardiac arrests in UK hospitals participating in the National Cardiac Arrest Audit.

Authors Zenasni, Zohra; Reynolds, Emily C; Harrison, David A; Rowan, Kathryn M; Nolan, Jerry P; Soar, Jasmeet; Smith, Gary B
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Available at Clinical medicine (London, England) from Unpaywall

Abstract AIMSThe aim was to determine if the 17 June 2014 Tracey judgment regarding 'do not attempt cardiopulmonary resuscitation' decisions led to increases in the rate of in-hospital cardiac arrests resulting in a resuscitation attempt (IHCA) and/or proportion of resuscitation attempts deemed futile.METHODUsing UK National Cardiac Arrest Audit data, the IHCA rate and proportion of resuscitation attempts deemed futile were compared for two periods (pre-judgment (01 July 2012 - 16 June 2014, inclusive) and post-judgment (01 July 2014 - 30 June 2016, inclusive)) using interrupted time series analyses.RESULTSA total of 43,109 IHCAs (115 hospitals) were analysed. There were fewer IHCAs post- than pre-judgment (21,324 vs 21,785, respectively). The IHCA rate was declining over time before the judgment but there was an abrupt and statistically significant increase in the period immediately following the judgment (p<0.001). This was not sustained post-judgment. The proportion of resuscitation attempts deemed futile was smaller post-judgment than pre-judgment (8.2% vs 14.9%, respectively). The rate of attempts deemed futile decreased post-judgment (p<0.001).CONCLUSIONThe IHCA rate increased immediately after the Tracey judgment while the proportion of resuscitation attempts deemed futile decreased. The precise mechanisms for these changes are unclear.

31. Prevalence of HCV in prisons in Wales, UK and the impact of moving to opt-out HCV testing.

Authors Perrett, Stephanie E; Plimmer, Amy; Shankar, Ananda Giri; Craine, Noel
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Available at Journal of public health (Oxford, England) from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract BACKGROUNDViral hepatitis is a leading cause of death worldwide. The World Health Organisation introduced a target to reduce hepatitis C virus (HCV) as a public health threat by 2030. Testing and treatment of those at elevated risk of infection in prison is key to achieving disease elimination. An opt-out testing policy for those in prison was introduced in Wales, UK, in 2016.METHODSWe analysed all Wales laboratory data where the testing site was a prison. We analysed numbers tested and positivity for a 14-month period before and after the introduction of opt-out testing policy.RESULTSBetween September 2015 and December 2017, 6949 HCV tests were from prison settings in Wales, equating to 29% of admissions to prison (P < 0.001). All but one prison increased testing following the introduction of opt-out policy. Percentage positivity for HCV remained at 11% before and after opt-out policy (P = 0.572). Short-stay prisons saw higher rates of HCV positivity than long stay.CONCLUSIONData suggest implementation of opt-out policy improved uptake and diagnosis of HCV amongst those in prison; however, further effort is required to fully embed screening for all. Positivity remains high amongst those in prison, particularly in short-stay prisons. Laboratory data can support audit of opt-out policy.

32. The incidence and effect of resternotomy following cardiac surgery on morbidity and mortality: a 1-year national audit on behalf of the Association of Cardiothoracic Anaesthesia and Critical Care.

Authors Agarwal, S; Choi, S W; Fletcher, S N; Klein, A A; Gill, R; Contributors
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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.
Available at Anaesthesia from Unpaywall

Abstract Over 30,000 adult cardiac operations are carried out in the UK annually. A small number of these patients need to return to theatre in the first few days after the initial surgery, but the exact proportion is unknown. The majority of these resternotomies are for bleeding or cardiac tamponade. The Association of Cardiothoracic Anaesthesia and Critical Care carried out a 1-year national audit of resternotomy in 2018. Twenty-three of the 35 centres that were eligible participated. The overall resternotomy rate (95%CI) within the period of admission for the initial operation in these centres was 3.6% (3.37-3.85). The rate varied between centres from 0.69% to 7.6%. Of the 849 patients who required resternotomy, 127 subsequently died, giving a mortality rate (95%CI) of 15.0% (12.7-17.5). In patients who underwent resternotomy, the median (IQR [range]) length of stay on ICU was 5 (2-10 [0-335]) days, and time to tracheal extubation was 20 (12-48 [0-2880]) hours. A total of 89.3% of patients who underwent resternotomy were transfused red cells, with a median (IQR [range]) of 4 (2-7 [1-1144]) units of red blood cells. The rate (95%CI) of needing renal replacement therapy was 23.4% (20.6-26.5). This UK-wide audit has demonstrated that resternotomy after cardiac surgery is associated with prolonged intensive care stay, high rates of blood transfusion, renal replacement therapy and very high mortality. Further research into this area is required to try to improve patient care and outcomes in patients who require resternotomy in the first 24 h after cardiac surgery.

33. Evaluation of the MCAST, a multidisciplinary toolkit to improve mental capacity assessment.

Authors Jayes, Mark; Palmer, Rebecca; Enderby, Pamela
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Available at Disability and rehabilitation from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Purpose: To evaluate the usability and acceptability of the Mental Capacity Assessment Support Toolkit (MCAST) in healthcare settings and whether its use was associated with increased legal compliance and assessor confidence.Materials and methods: A mixed methods convergence triangulation model was used. Multidisciplinary professionals used the MCAST during mental capacity assessments for UK hospital patients with diagnoses of stroke or acute or chronic cognitive impairment. Changes in legal compliance were investigated by comparing scores on case note audits before and after implementation of the MCAST. Changes in assessor confidence and professionals' perceptions of the MCAST's usability and acceptability were explored using surveys. Patients' and family members' views on acceptability were determined using semi-structured interviews. Data were integrated using triangulation.Results: Twenty-one professionals, 17 patients and two family members participated. Use of the MCAST was associated with significant increases in legal compliance and assessor confidence. Most professionals found the MCAST easy to use and beneficial to their practice and patients. Patients and family members found the MCAST materials acceptable.Conclusions: The MCAST is the first toolkit to support the needs of individuals with communication disabilities during mental capacity assessments. It enables assessors to deliver high quality, legally compliant and confident practice.IMPLICATIONS FOR REHABILITATIONMental capacity assessment practice needs to be improved to maximise patient autonomy, safety and well-being.The MCAST is a paper-based toolkit designed to facilitate and improve mental capacity practice in England and Wales.This study suggests the MCAST would be easy and acceptable to use in healthcare settings and could lead to improvements in assessment quality and assessor confidence.

34. Enhancer Locus in ch14q23.1 Modulates Brain Asymmetric Temporal Regions Involved in Language Processing.

Authors Le Guen, Yann; Leroy, François; Philippe, Cathy; IMAGEN Consortium; Mangin, Jean-François; Dehaene-Lambertz, Ghislaine; Frouin, Vincent
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Available at Cerebral cortex (New York, N.Y. : 1991) 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 Identifying the genes that contribute to the variability in brain regions involved in language processing may shed light on the evolution of brain structures essential to the emergence of language in Homo sapiens. The superior temporal asymmetrical pit (STAP), which is not observed in chimpanzees, represents an ideal phenotype to investigate the genetic variations that support human communication. The left STAP depth was significantly associated with a predicted enhancer annotation located in the 14q23.1 locus, between DACT1 and KIAA0586, in the UK Biobank British discovery sample (N = 16 515). This association was replicated in the IMAGEN cohort (N = 1726) and the UK Biobank non-British validation sample (N = 2161). This genomic region was also associated to a lesser extent with the right STAP depth and the formation of sulcal interruptions, "plis de passage," in the bilateral STAP but not with other structural brain MRI phenotypes, highlighting its notable association with the superior temporal regions. Diffusion MRI emphasized an association with the fractional anisotropy of the left auditory fibers of the corpus callosum and with networks involved in linguistic processing in resting-state functional MRI. Overall, this evidence demonstrates a specific relationship between this locus and the establishment of the superior temporal regions that support human communication.

35. Autologous breast reconstruction in older women: A retrospective single-centre analysis of complications and uptake of secondary reconstructive procedures.

Authors Brendler-Spaeth, C I; Jacklin, C; See, J L; Roseman, G; Kalu, P U
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Available at Journal of plastic, reconstructive & aesthetic surgery : JPRAS 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 BACKGROUNDWomen aged ≥65 years have the highest age-specific rates of breast cancer incidence in the UK. However, national audit results demonstrate that the rates of post-mastectomy breast reconstruction offered to and performed on this age group are considerably lower than in younger women (Jeevan, 2009). This discrepancy may arise from unsubstantiated concerns over greater medical and surgical risk in older patients (James, 2015). In the present study, the first of its kind in the UK, we sought to evaluate potential differences in postoperative complications following autologous breast reconstruction between young and older patient populations.METHODSWe conducted a retrospective review of 59 patients (31 'younger' <65 years; 28 'older' ≥65 years) who underwent autologous breast reconstruction at Oxford University Hospitals, between 2008 and 2017. Clinical, operative, and outcome variables were compared across the two age groups. To examine the complete multi-stage process of breast reconstruction as a whole, we also compared rates of uptake of multiple secondary reconstructive and revisional procedures across age groups.KEY RESULTSMajor surgical, minor surgical, and medical complication rates, as well as length of stay, did not differ significantly by age group. The scar revision rate (at the flap donor site) was higher in the <65 group (19.4% vs. 0.0%; p = 0.025). Otherwise, rates of secondary reconstructive and revisional procedures were comparable across both groups.CONCLUSIONPatients aged ≥65 years were not at a significantly greater risk of complications following autologous breast reconstruction compared to younger patients. Chronological age, in itself, should not influence treatment decisions surrounding breast reconstruction.

36. Cardiopulmonary resuscitation discussions with patients admitted to acute oncology wards: A national audit of current practice.

Authors Tol, Isabel; Cumber, Elspeth; Nakakande, Daphne; Wijaya, Silvana; Turberfield, Catherine; Badran, Abdul; Siddiqui, Safia; Srivastava, Prakhar; Chung, Bethany; Dineen, Molly; Devlin, Cariosa; Worrall, Claire; Green, Rebecca; Bennett, Emily; Golding, Elizabeth; Lillis, Ashling; Sabharwal, Ami; Protheroe, Andrew S; Watson, Robert A
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Available at European journal of cancer care from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract OBJECTIVESTo map current practice regarding discussions around resuscitation across England and Scotland in patients with cancer admitted acutely to hospital and to demonstrate the value of medical students in rapidly collecting national audit data.METHODSCollaborators from the Macmillan medical student network collected data from 251 patient encounters across eight hospitals in England and Scotland. Data were collected to identify whether discussion regarding resuscitation was documented as having taken place during inpatient admission to acute oncology. As an audit standard, it was expected that all patients should be invited to discuss resuscitation within 24 hr of admission.RESULTSResuscitation discussions were had in 43.1% of admissions and of these 64.0% were within 24 hr; 27.6% of all admissions. 6.5% of patients had a "do not attempt resuscitation" order prior to admission with a difference noted between patients receiving palliative and curative treatment (8.5% and 0.39%, respectively, p < .05). Discussions regarding escalation of care took place in only 29.3% of admissions.CONCLUSIONSThese data highlight deficiencies in the number of discussions regarding resuscitation that are being conducted with cancer patients that become acutely unwell. It also demonstrates the value of medical student collaboration in rapidly collecting national audit data.

37. Cancer diagnosis in Scottish primary care: Results from the National Cancer Diagnosis Audit.

Authors Murchie, Peter; Adam, Rosalind; McNair, Emma; Swann, Ruth; Witt, Jana; Wood, Rose; Weller, David
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Available at European journal of cancer care from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Available at European journal of cancer care from Unpaywall

Abstract OBJECTIVETo characterize cancer diagnosis in Scottish primary care and draw comparisons with cancer diagnostic activity in England.METHODA national audit of cancer diagnosis was conducted in Scottish and English general practices. Participating GPs collected diagnostic pathway data on patients diagnosed in 2014 from medical records. Data were supplemented by linkage to national cancer registries. Analysis explored and compared patient characteristics, diagnostic intervals, and routes to diagnosis.RESULTS7.7% of all Scottish general practices in 2017 provided data on 2,014 cancer diagnoses. 71.5% of cases presented to GPs and 37.4% were referred using the "Urgent-Suspected Cancer" route. The median primary care interval was 5 days (IQR 0-23 days) and median diagnostic interval was 30 days (IQR 13-68). Both varied by cancer-site. Diagnostic intervals were longer in the most remote patients and those with more comorbidities. Scottish and English samples corresponded closely in key characteristics.CONCLUSIONSMost people diagnosed with cancer in Scotland present to a GP first. Most are referred and diagnosed quickly, with variations by cancer-site. Intervals were longest for the most remote patients. GPs in Scotland and England appear to perform equally but, in view of growing differences between health systems, future comparative audits may be informative.

38. Higher ICU Capacity Strain Is Associated With Increased Acute Mortality in Closed ICUs.

Authors Wilcox, M Elizabeth; Harrison, David A; Patel, Akshay; Rowan, Kathryn M
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Available at 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 OBJECTIVESTo determine whether patients admitted to an ICU during times of strain, when compared with its own norm (i.e. accommodating a greater number of patients, higher acuity of illness, or frequent turnover), is associated with a higher risk of death in ICUs with closed models of intensivist staffing.DESIGNWe conducted a large, multicenter, observational cohort study. Multilevel mixed effects logistic regression was used to examine relationships for three measures of ICU strain (bed census, severity-weighted bed census, and activity-weighted bed census) on the day of admission with risk-adjusted acute hospital mortality.SETTINGPooled case mix and outcome database of adult general ICUs participating in the Intensive Care National Audit and Research Centre Case Mix Programme.MEASUREMENTS AND MAIN RESULTSThe analysis included 149,310 patients admitted to 215 adult general ICUs in 213 hospitals in United Kingdom, Wales, and Northern Ireland. A relative lower strain in ICU capacity as measured by bed census on the calendar day (daytime hours) of admission was associated with decreased risk-adjusted acute hospital mortality (odds ratio, 0.94; 95% CI, 0.90-0.99; p = 0.01), whereas a nonsignificant association was seen between higher strain and increased acute hospital mortality (odds ratio, 1.04; 95% CI, 1.00-1.10; p = 0.07). The relationship between periods of high ICU strain and acute hospital mortality was strongest when bed census was composed of higher acuity patients (odds ratio, 1.05; 95% CI, 1.01-1.10; p = 0.03). No relationship was seen between high strain and ICU mortality.CONCLUSIONSIn closed staffing models of care, variations in bed census within individual ICUs was associated with patient's predicted risk of acute hospital mortality, particularly when its standardized bed census consisted of sicker patients.

39. A novel method to teach and assess the sterility of donning sterile gloves.

Authors Lloyd, R; Ruiz-Herrero, A
Source Journal of perioperative practice; May 2020; vol. 30 (no. 5); p. 124-129
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Available at Journal of perioperative 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 Sterility is of utmost importance during surgery, particularly orthopaedic surgery. The literature suggests sterility, when compromised, is frequently contaminated at the point of donning sterile gowns and gloves. We describe a novel method to assess the compliance of sterility whilst applying surgical gloves using an ultraviolet lightbox and an ultraviolet-sensitive 'Germ paint'. We carried out an audit of 'sterility' using this method with our surgical trainees. A subsequent educational programme described methods of glove-donning. Repeat assessment yielded significantly improved results. Educating staff using this method may improve sterility in theatre. We believe this is a novel method to teach and assess sterility during glove-donning. The equipment is readily accessible within each NHS hospital. Medical and theatre staff should use this as part of training and departmental induction programmes.

40. Identifying support mechanisms to overcome barriers to food safety scheme certification in the food and drink manufacturing industry in Wales, UK.

Authors Evans, Ellen W; Lacey, Jessica; Taylor, Helen R
Source International journal of environmental health research; May 2020 ; p. 1-16
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Available at International journal of environmental health research from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Obtaining food safety certification is essential for food manufacturers. Potential barriers to obtaining certification are complex, interrelated and broadly relate to, 'knowledge and skills', 'time, cost and resources', and 'communication and access to information'. This study aimed to explore requirements for support to enable food manufacturers in Wales to overcome identified barriers. Food manufacturers (n = 37) participated in group discussions (n = 2) and completed online-questionnaires (n = 29). Support mechanisms, perceived necessary to obtain food safety certification included; funding for training and audit-fees, support for implementing food safety scheme documentation, on-site support through mentoring/coaching and pre-audits. Findings identify the need for a food safety scheme certification support package pathway incorporating online, off-site, on-site and financial support to assist food and drink manufacturers obtain third-party food safety certification. Such assistance would support three critical areas. Findings may inform development of support mechanisms to increase uptake of food safety certification and accelerate food-sector growth.

41. A nationwide causal mediation analysis of survival following ST-elevation myocardial infarction.

Authors Dondo, Tatendashe Bernadette; Hall, Marlous; Munyombwe, Theresa; Wilkinson, Chris; Yadegarfar, Mohammad E; Timmis, Adam; Batin, Philip D; Jernberg, Tomas; Fox, Keith Aa; Gale, Chris P
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Abstract OBJECTIVEInternational studies report a decline in mortality following ST-elevation myocardial infarction (STEMI). The extent to which the observed improvements in STEMI survival are explained by temporal changes in patient characteristics and utilisation of treatments is unknown.METHODSCohort study using national registry data from the Myocardial Ischaemia National Audit Project between first January 2004 and 30th June 2013. 232 353 survivors of hospitalisation with STEMI as recorded in 247 hospitals in England and Wales. Flexible parametric survival modelling and causal mediation analysis were used to estimate the relative contribution of temporal changes in treatments and patient characteristics on improved STEMI survival.RESULTSOver the study period, unadjusted survival at 6 months and 1 year improved by 0.9% and 1.0% on average per year (HR: 0.991, 95% CI: 0.988 to 0.994 and HR: 0.990, 95% CI: 0.987 to 0.993, respectively). The uptake of primary percutaneous coronary intervention (PCI) (HR: 1.025, 95% CI: 1.021 to 1.028) and increased prescription of P2Y12 inhibitors (HR: 1.035, 95% CI: 1.031 to 1.039) were significantly associated with improvements in 1-year survival. Primary PCI explained 16.8% (95% CI: 10.8% to 31.6%) and 13.2% (9.2% to 21.9%) of the temporal survival improvements at 6 months and 1 year, respectively, whereas P2Y12 inhibitor prescription explained 5.3% (3.6% to 8.8%) of the temporal improvements at 6 months but not at 1 year.CONCLUSIONSFor STEMI in England and Wales, improvements in survival between 2004 and 2013 were significantly explained by the uptake of primary PCI and increased use of P2Y12 inhibitors at 6 months and primary PCI only at 1 year.TRIAL REGISTRATION NUMBERNCT03749694.

42. Management of reduced fetal movement: A comparative analysis of two audits at a tertiary care clinical service.

Authors Kapaya, Habiba; Almeida, Joana; Karouni, Faris; Anumba, Dilly
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Abstract OBJECTIVESReduced fetal movement (RFM) is a commonly presenting worrisome complaint, both for mothers and attending clinicians. The aim of this study was to review the management of RFM before and following the implementation of new hospital guideline and to determine pregnancy outcomes following single vs repeated consultations with complaints of RFM. We also compared the standards in our old and new trust guidelines against published guidance from the Royal College of Obstetricians and Gynaecologists (RCOG).STUDY DESIGNThis retrospective cohort study was conducted between June -November 2016 (audit 1) and July-December 2018 (audit 2). All women with a non-anomalous singleton pregnancy, attending the Day Assessment Unit of the Jessop Wing Hospital Sheffield UK with a primary presentation of perceived RFM after 24 weeks of gestation were included. The electronic maternity database was used to collect information regarding their presentations and pregnancy outcomes. Adherence to the old and the new local guidelines for the respective epochs of the assessment were reviewed by two independent observers using the Appraisal of Guidelines for Research and Evaluation (AGREE) 11 tool.RESULTSA total of 1775 women presented with RFM during the two study periods. Of these, 632 attended with more than 1 presentation of RFM (35.6 %). There were 3 stillbirths; all diagnosed at the first presentation with RFM. In the second audit, prevalence of RFM increased by 10 %, CTG documentation improved by 1% and ultrasound scan requests decreased by 6.6 %. Women with more than one episode of RFM were more likely to be younger, smokers, nulliparous, have raised BMI, had a higher IOL rate and had more ultrasound scans compared to those with one episode. However, neonatal outcome, onset of labour and mode of delivery remained unchanged between the two groups. While the RCOG guideline was superior to both (old and new) guidelines, the overall scores increased in the new guideline by 22 %.CONCLUSIONAfter implementing the new guideline, the re-audit demonstrates a reduction in the number of requested ultrasound scans without any compromise on the perinatal outcome.

43. Patient-initiated follow-up after treatment for low risk endometrial cancer: a prospective audit of outcomes and cost benefits.

Authors Coleridge, Sarah; Morrison, Jo
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Abstract OBJECTIVERecurrence of low-risk endometrioid endometrial cancer is rare, and traditional hospital follow-up has a cost to both the patient and the healthcare system, without evidence of benefit. We examined the uptake of patient-initiated follow-up, pattern of recurrences, and survival for women following surgical treatment of low-risk endometrial cancer and compared estimated costs with hospital follow-up.METHODSThis study was a prospective audit of outcomes following implementation of a patient-initiated follow-up policy in a UK-based gynecological cancer center for women with low-risk endometrial cancer treated surgically (International Federation of Gynecology and Obstetrics (FIGO) stage 1A, G1-2) from January 2010 to December 2015. Women were identified following multidisciplinary team meetings and data were collected from the electronic cancer register, paper, and electronic clinical records. Health service costs were calculated based on standard tariffs for follow-up appointments; patient costs were estimated from mileage traveled from home postcode and parking charges. Progression-free survival and overall survival were assessed. Estimated financial costs to the health service and patients of hospital follow-up were compared with actual patient-initiated follow-up costs.RESULTSA total of 129 women were offered patient-initiated follow-up (declined by four; accepted by another 11 after hospital follow-up for 6 months to 3.5 years) with median follow-up of 60.7 months (range 1.4-109.1 months). Ten women recurred: four vaginal vault recurrences (all salvaged), three pelvic recurrences (all salvaged), and three distant metastatic disease (all died). Five-year disease-specific survival was 97.3%. Ten women in the cohort died: three from endometrial cancer and seven from unrelated causes. The cost saving to the health service of patient-initiated follow-up compared with a traditional hospital follow-up regimen was £116 403 (median £988.60 per patient,range £0-£1071). Patients saved an estimated £7122 in transport and parking costs (median £57.22 per patient,range £4.98-£147.70).CONCLUSIONPatient-initiated follow-up for low risk endometrial cancer has cost benefits to both health service and patients. Those with pelvic or vault recurrence had salvageable disease, despite patient-initiated follow-up.

44. A building concern? The health needs of families in temporary accommodation.

Authors Croft, Laura Austin; Marossy, Agnes; Wilson, Tracey; Atabong, Alice
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Available at Journal of public health (Oxford, England) from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract BACKGROUNDThe number of families living in temporary accommodation in the UK is increasing. International evidence suggests that family homelessness contributes to poor mental health outcomes for both child and parent/carer, yet there is no routine way of understanding these health impacts at a local area level.METHODSA homeless health needs audit was adapted to include questions about family health and completed in survey form by 33 people living in temporary accommodation in the London Borough of Bromley. Data were supplemented through an engagement event with 23 health and community care practitioners.RESULTSThe small population sample surveyed showed high levels of poor mental health in addition to behaviours that increase the risk of physical ill health (such as smoking) and a high use of secondary healthcare services. Engagement with practitioners showed awareness of poor health amongst this population group and challenges with regard to providing appropriate support.CONCLUSIONSThere needs to be a sustainable and representative way of understanding the health needs of this population group including a comparison of the health needs of people placed in temporary accommodation in and out of their resident area.

45. Accidental dural puncture and post-dural puncture headache: a retrospective review in an Irish maternity hospital.

Authors Abela, Glenn Paul; Tan, Terry
Source Irish journal of medical science; May 2020; vol. 189 (no. 2); p. 657-660
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Available at Irish journal of medical science from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract BACKGROUNDAccidental dural puncture (ADP) during epidural catheter insertion and the possible consequent post-dural puncture headache (PDPH) remain challenging complications in obstetric anaesthesia. ADP/PDPH can represent a considerable degree of morbidity for the parturient and require immediate diagnosis and appropriate management to ensure recovery and avoid complications.AIMThis retrospective audit was carried out to identify the accidental dural puncture and post-dural puncture headache rates at the Coombe Women and Infant University Hospital in Dublin.METHODSCases of ADP and PDPH were identified retrospectively from a register used to record these cases. Demographic and obstetric data was retrieved using the patients' medical records. Analysis was carried using MS Excel.RESULTSIn 1 year (June 1, 2018 to June 1, 2019), there were 25 cases of ADP during epidural catheter insertion and this is 0.78% of epidurals done in this period. Seventeen of these (68%) subsequently developed PDPH. In total, there are 32 cases of PDPH: 27 after epidural analgesia using an 18G Touhy needle and 5 after a spinal anaesthetic using a 25G Whitacre needle. All PDPH cases received first-line conservative treatment and 9 (28.1%) required an epidural blood patch (EBP). No-one required a second EBP.DISCUSSIONThe incidence of ADP at our hospital (0.78%) is within the range quoted in the literature (0.1-1.5%) and below the UK standard of 1%. The incidence of PDPH after recognized ADP (68%) is also consistent with other published reports.

46. The Psychosocial Adjustment of Children Born With a Cleft Lip and/or Palate: Cross-Sectional and Longitudinal Analyses.

Authors Pinckston, Molly; Dalton, Louise; Farrar, Stephanie; Hotton, Matthew T
Source The Cleft palate-craniofacial journal : official publication of the American Cleft Palate-Craniofacial Association; May 2020 ; p. 1055665620921669
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Available at The Cleft palate-craniofacial journal : official publication of the American Cleft Palate-Craniofacial Association from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).

Available at The Cleft palate-craniofacial journal : official publication of the American Cleft Palate-Craniofacial Association from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract OBJECTIVETo determine the psychosocial adjustment of children born with a cleft lip and/or palate (CL/P).DESIGNLongitudinal analyses of psychosocial outcomes and cross-sectional comparison with published norms.SETTINGRetrospective clinical audit at a UK cleft center.PARTICIPANTSData available for 1174 participants born with a CL/P at ages 5 (n = 658), 10 (n = 415), and 15 (n = 171), with longitudinal data for a subset of the sample at 5 and 10 (n = 168) and 10 and 15 (n = 49).MAIN OUTCOME MEASUREParental-report Strengths and Difficulties Questionnaire (SDQ).RESULTSThe majority of children scored in the average range for overall adjustment. Children born with CL/P had significantly higher mean overall SDQ scores relative to normative data at ages 5 and 10. Longitudinal analysis highlighted that adjustment at age 5 was a significant predictor of adjustment at age 10. Gender was another significant predictor of adjustment at age 5 and 10, with boys reporting more problems than girls. However, effect sizes for the impact of age and gender were small. Cleft type was not a significant predictor of SDQ score at any age.CONCLUSIONSChildren aged 5 and 10 years of age born with a cleft may experience greater overall psychosocial difficulties than the general population. The domains on the SDQ on which children experience difficulty may be influenced by age and gender. Future research should focus on the specific impact of cleft-related issues, including speech, language, and hearing difficulties, on psychosocial adjustment.

47. Hospital deaths dashboard: care indicators.

Authors Minton, Ollie; Ede, Charlotte; Bass, Stephen; Tavabie, Simon; Bourne, Amy; Hiresche, Andreas
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Abstract OBJECTIVESWe wanted to create a medical/nursing led data collection tool to allow for an ongoing audit of the quality of deaths in a teaching hospital. We wanted to be able to produce a visual summary to monitor our involvement, use of PRN medication, recognition of death, treatment escalation plans and communication aspects. We feel these are good surrogate indicators for quality end-of-life care.METHODSWe designed a purpose built spreadsheet which we have designed as an abbreviated version of the UK national audit tools. We involved a number of our core medical trainees to iterate the data collection so it could be done in a timely manner with a simple training guide. Our collective approach meant we have made this as straightforward as possible to roll out and maintain data collection.RESULTSWe collected 100 cases over a period of 6 months (August 2019 to January 2020). We created a dashboard looking at the core elements of end-of-life care and found bar treatment escalation planning all aspects were completed the majority of the time with near 100% communication to relevant family and friends.CONCLUSIONSOur sample collection tool provides a useful ongoing indicator for the quality of end-of-life care in the trust and to provide a timely infographic quarterly to feedback to interested members of the trust. We hope to be able to continue over some years to collate themes and trends. We would encourage other hospital teams to adopt our approach.

48. Clinical outcomes of patients with chronic pulmonary aspergillosis managed surgically.

Authors Setianingrum, Findra; Rautemaa-Richardson, Riina; Shah, Rajesh; Denning, David W
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Available at European journal of cardio-thoracic surgery : official journal of the European Association for Cardio-thoracic 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.
Available at European journal of cardio-thoracic surgery : official journal of the European Association for Cardio-thoracic Surgery from Unpaywall

Abstract OBJECTIVESSurgical resection is one treatment modality for chronic pulmonary aspergillosis (CPA), and sometimes a preoperative presumption of lung cancer turns out to be CPA. We have audited our surgical experience with regard to risk factors for relapse, and the value of postoperative monitoring of Aspergillus-immunogolubulin G (IgG) titres.METHODSAll patients with CPA surgically treated at National Aspergillosis Centre (NAC), Manchester, UK (2007-2018), were retrospectively evaluated. Surgical procedures, underlying disorders, Aspergillus-IgG titres (ImmunoCap) and antifungal therapy were evaluated for symptom control, operative complications, CPA relapse and mortality.RESULTSA total of 61 patients with CPA (28 males, 33 females) were operated on primarily for antifungal therapy failure (51%, n = 31) and presumed lung malignancies (38%, n = 23). Procedures included lobectomy (64%, n = 39), wedge resection (28%, n = 17), segmentectomy (n = 3), pneumonectomy (n = 3) and decortication (n = 2). Overall, 25 (41%) patients relapsed, 26 months (standard deviation: 24.8 months) after surgery. Antifungal therapy before surgery (P = 0.002) or both before and after surgery (P = 0.005) were protective for relapse. The relapse rate within 3 years after surgery (33%, n = 20) was higher than the 3-10 years after surgery (8%, n = 5). At the end of follow-up, the median Aspergillus-IgG titre was lower than at relapse in 12 patients (67 vs 126 mg/l) (P = 0.016).CONCLUSIONSSurgery in these selected patients with CPA resulted in favourable outcomes. Relapse is common after surgical treatment of CPA but can be minimized with antifungal therapy, emphasizing the importance of an accurate diagnosis prior to surgery.

49. Does declared surgeon specialist interest influence the outcome of emergency laparotomy?

Authors Hallam, S; Bickley, M; Phelan, L; Dilworth, M; Bowley, D M
Source Annals of the Royal College of Surgeons of England; May 2020 ; p. 1-5
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Available at Annals of the Royal College of Surgeons of England from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract INTRODUCTIONIn the UK, general surgeons must demonstrate competency in emergency general surgery before obtaining a certificate of completion of training. Subsequently, many consultants develop focused elective specialist interests which may not mirror the breadth of procedures encountered during emergency practice. Recent National Emergency Laparotomy Audit analysis found that declared surgeon special interest impacted emergency laparotomy outcomes, which has implications for emergency general surgery service configuration. We sought to establish whether local declared surgeon special interest impacts emergency laparotomy outcomes.METHODSAdult patients having emergency laparotomy were identified from our prospective National Emergency Laparotomy Audit database from May 2016 to May 2019 and categorised as colorectal or oesophagogastric according to operative procedure. Outcomes included 30-day mortality, return to theatre and length of stay. Binomial logistic regression was used to identify any association between declared consultant specialist interest and outcomes.RESULTSOf 600 laparotomies, 358 (58.6%) were classifiable as specialist procedures: 287 (80%) colorectal and 71 (20%) oesophagogastric. Discordance between declared specialty and operation undertaken occurred in 25% of procedures. For colorectal emergency laparotomy, there was an increased risk of 30-day mortality when performed by a non-colorectal consultant (unadjusted odds ratio 2.34; 95% confidence interval 1.10-5.00; p = 0.003); however, when adjusted for confounders within multivariate analysis declared surgeon specialty had no impact on mortality, return to theatre or length of stay.CONCLUSIONSurgeon-declared specialty does not impact emergency laparotomy outcomes in this cohort of undifferentiated emergency laparotomies. This may reflect the on-call structure at Birmingham Heartlands Hospital, where a colorectal and oesophagogastric consultant are paired on call and provide cross-cover when needed.

50. What factors determine specimen quality in colon cancer surgery? A cohort study.

Authors Ng, Kheng-Seong; West, Nicholas P; Scott, Nigel; Holzgang, Melanie; Quirke, Phil; Jayne, David G
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Abstract PURPOSETenets of 'good quality' colon cancer surgery include mesocolic plane dissection to preserve an intact mesocolic fascia/peritoneum, and excision of sufficient mesocolon for adequate lymphadenectomy. However, it remains controversial what clinicopathological factors determine 'good quality' surgery, and whether quality of surgery influences morbidity/mortality. This study documents the quality of colon cancer surgery at a quaternary referral centre and identifies factors that influence quality of surgery and post-operative outcomes.METHODSConsecutive patients who underwent resection for colon adenocarcinoma at St. James's University Hospital, Leeds, UK (2015-2017), were included. Primary outcome measures included (i) plane of mesocolic dissection, prospectively assessed; and (ii) tissue morphometry (area of mesentery and vascular pedicle length). Other histopathological data were extracted from a prospective database. Clinical data were obtained from the National Bowel Cancer Audit and individual records.RESULTSFour hundred five patients were included (mean 69.6 years). The majority (67.4%) of specimens were mesocolic plane dissections. Median area of mesentery excised was 12,085.4 mm2. Median vascular pedicle length was 89.3 mm. Post-operative complication was recorded in one-third of patients. Mesocolic plane excision was associated with open surgery (OR 1.80, 95% CI 1.05-3.09), especially in emergency colectomy. Open resections also had a greater mesentery excised (P = 0.002), but incurred more post-operative complication (OR 2.11, 95% CI 1.12-3.99). Post-operative complication was not associated with plane of excision or tissue morphometry.CONCLUSIONMajority of resections were 'optimal' mesocolic plane dissections. Open resections yielded better quality specimens, but incurred more morbidity. There is room for improvement in the quality of laparoscopic colon cancer surgery, particularly those performed as emergency.

51. Ultrasound Surveillance of Common Iliac Artery Aneurysms.

Authors Dhanji, Aliya; Murray, Hilary E; Downing, Richard
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Abstract BACKGROUNDThe surveillance of patients with common iliac artery aneurysms (CIAA) does not follow a defined protocol such as the one adopted for the management of abdominal aortic aneurysms. This study explores CIAA growth rate, and seeks to determine correlations with related parameters which may serve to influence aneurysm expansion with the view of devising an effective local surveillance protocol.METHODSVascular laboratories across the UK were invited to participate in an online survey. Questions were designed to assess current clinical practice in regards to the surveillance of patients with CIAA. Additionally, a retrospective audit was performed using the clinical reports of patients attending a regional vascular laboratory to undergo an aorto-iliac duplex scan (USS). Expansion rate of aneurysms was studied in patients who had ≥2 USS scans; data was recorded at 6 and/or 12 monthly intervals up to 5 years. Kaplan Meier estimates of patient mortality (all cause) and intervention rate during the surveillance period were performed. Patient age, initial CIAA diameter, bilateral/unilateral CIAA and coinciding aortic aneurysm diameter were recorded to determine if these specific features were associated with CIAA growth rates. Pearson's correlation coefficient was used to determine the strength of association between variables.RESULTSNine hundred and ninety-five of one thousand and sixty patient records were suitable for review: 21.6% (215/995) of patients had a CIAA. Isolated CIAA accounted for 23% (50/215). Mean CIAA growth was 1.5 ± 0.3 mm/year. A strong correlation was found between CIAA diameter versus time from diagnosis (r = 0.820; P = 0.004); CIAA with smaller initial diameters (15-20 mm) expanded more rapidly than those of larger diameter at diagnosis (r = 0.871; P = 0.005). CIAA measured at >30 mm demonstrated an unpredictable growth trajectory which was also evident in those CIAA coinciding with larger AAA (>50 mm; r = 0.208; P = 0.655).CONCLUSIONSThe results obtained in this study may form the basis for a dedicated CIAA surveillance protocol.

52. An injury audit in high-level male youth soccer players from English, Spanish, Uruguayan and Brazilian academies.

Authors Hall, Elliott C R; Larruskain, Jon; Gil, Susana M; Lekue, Jose A; Baumert, Philipp; Rienzi, Edgardo; Moreno, Sacha; Tannure, Marcio; Murtagh, Conall F; Ade, Jack D; Squires, Paul; Orme, Patrick; Anderson, Liam; Whitworth-Turner, Craig M; Morton, James P; Drust, Barry; Williams, Alun G; Erskine, Robert M
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Available at Physical therapy in sport : official journal of the Association of Chartered Physiotherapists in Sports 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 OBJECTIVESTo identify the most common injury types/locations in high-level male youth soccer players (YSP).DESIGNProspective cohort surveillance study.SETTINGProfessional soccer club academies.PARTICIPANTSSix hundred and twenty-four high-level male YSP [Under 9 (U9) to U23 year-old age groups] from academies in England, Spain, Uruguay and Brazil.MAIN OUTCOME MEASURESInjury type, location and severity were recorded during one season. Injury severity was compared between age groups, while injury type and location were compared between nations.RESULTSFour hundred and forty-three training or match injuries were recorded, giving an injury rate of 0.71 per player. Non-contact injuries were most common (58.5%), with most (44.2%) resolved between 8 and 28 days. Most injuries (75.4%) occurred in the lower limbs, with muscle (29.6%) the most commonly injured tissue. U14 and U16 suffered a greater number of severe injuries relative to U12 and U19/U20/U23/Reserves. Tendon injury rate was higher in Brazil vs. Spain ($p < 0.05$), with low back/sacrum/pelvis injury rate highest in Spain ($p < 0.05$).CONCLUSIONSThe proportion of severe injuries in U14 and U16 suggests YSP injury risk is maturation-dependent. Minimal differences in type and location between high-level YSP from four different countries suggest injury rates in this population are geographically similar.

53. Maternal Risk Modeling in Critical Care-Development of a Multivariable Risk Prediction Model for Death and Prolonged Intensive Care.

Authors Simpson, Nicholas B; Shankar-Hari, Manu; Rowan, Kathryn M; Cecconi, Maurizio; von Dadelszen, Peter; Huning, Emily Y-S; Magee, Laura A; Payne, Beth A; Quinn, Audrey C; Harrison, David A
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Available at 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 OBJECTIVESWe aimed to develop and validate an accurate risk prediction model for both mortality and a combined outcome of mortality and morbidity for maternal admissions to critical care.DESIGNWe used data from a high-quality prospectively collected national database, supported with literature review and expert opinion. We tested univariable associations between each risk factor and outcome. We then developed two separate multivariable logistic regression models for the outcomes of acute hospital mortality and death or prolonged ICU length of stay. We validated two parsimonious risk prediction models specific for a maternal population.SETTINGThe Intensive Care National Audit and Research Centre Case Mix Programme is the national clinical audit for adult critical care in England, Wales, and Northern Ireland.PATIENTSAll female admissions to adult general critical care units, for the period January 1, 2007-December 31, 2016, 16-50 years old, and admitted either while pregnant or within 42 days of delivery-a cohort of 15,480 women.INTERVENTIONSNone.MEASUREMENTS AND MAIN RESULTSWe aimed to develop and validate an accurate risk prediction model for both mortality and a combined outcome of mortality and morbidity for maternal admissions to critical care. For the primary outcome of acute hospital mortality, our parsimonious risk model consisting of eight variables had an area under the receiver operating characteristic of 0.96 (95% CI, 0.91-1.00); these variables are commonly available for all maternal admissions. For the secondary composite outcome of death or ICU length of stay greater than 48 hours, the risk model consisting of 17 variables had an area under the receiver operating characteristic of 0.80 (95% CI, 0.78-0.83).CONCLUSIONSWe developed risk prediction models specific to the maternal critical care population. The models compare favorably against general adult ICU risk prediction models in current use within this population.

54. Impact of co-morbid personality disorder on quality of inpatient mental health services for people with anxiety and depression.

Authors Williams, Ryan; Farquharson, Lorna; Rhodes, Ellen; Dang, Mary; Fitzpatrick, Naomi; Quirk, Alan; Baldwin, David S; Crawford, Mike J

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Abstract INTRODUCTIONConcerns have been raised about the quality of inpatient care received by patients with a diagnosis of personality disorder.OBJECTIVESThe aim of this study was to examine the quality of care received by inpatients with an anxiety or depressive disorder, comparing subgroups with or without a co-morbid personality disorder.METHODWe used a retrospective case-note review of 3 795 patients admitted to inpatient psychiatric wards in England, utilizing data from the National Clinical Audit of Anxiety and Depression. Data were gathered on all acute admissions with an anxiety or depressive disorder over a 6-month period, for a number of measures reflecting quality of care derived from national standards. Association of coexisting personality disorder with quality of care was investigated using multivariable regression analyses.RESULTSFour hundred sixteen (11.0%) of the patients had a co-co-morbid diagnosis of personality disorder. Patients with personality disorder were less likely to have been asked about prior responses to treatment in their initial assessment (odds ratio (OR) = 0.67, 95% confidence interval (CI) 0.50 to 0.89, p = 0.007). They were less likely to receive adequate notice in advance of their discharge (OR = 0.87, 95% CI 0.65 to 0.98, p = 0.046). They were more likely to be prescribed medication at the point of discharge (OR = 1.52, 95% CI 1.02 to 2.09, p = 0.012) and less likely to have been provided with information about the medicines they were taking (OR = 0.86, 95% CI 0.69 to 0.94, p = 0.048). In addition, the carers of patients with co-morbid personality disorder were less likely to have been provided with information about available support services (OR = 0.73, 95% CI 0.51 to 0.93, p = 0.045).CONCLUSIONWe found evidence of poorer quality of care for patients with co-morbid personality disorder who were admitted to psychiatric hospital for treatment of anxiety or depressive disorders, highlighting the need for improved clinical care in this patient group. © 2020 John Wiley & Sons, Ltd.

55. Exploring medicines reconciliation in the emergency assessment unit: staff perceptions and actual waiting times.

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Abstract

BACKGROUNDMedicines reconciliation is the process of creating and maintaining the most accurate list possible of all medicines a patient is taking. If medicines reconciliation cannot be completed in a timely manner in hospital emergency assessment units (EAUs), delays in treatment can occur, potentially leading to deterioration of long-term and acute conditions, patient distress and complaints.AIMTo obtain the perspectives of staff working on an EAU regarding the time patients wait for their medicines to be prescribed, including their awareness of practice and protocols. To determine the time from admission to the EAU until medicines reconciliation, and to identify if there was any time difference in medicines reconciliation according to the day of admission.METHODThis was a service evaluation in which staff working in one EAU in a teaching hospital in the north east of England were asked to complete a survey in December 2017. The staff survey aimed to ascertain: whether staff were aware of any guidance relating to medicines reconciliation times; how long they thought the average waiting time was for medicines reconciliation; and if they thought there were implications for patients or staff as a result of time spent waiting for medicines reconciliation. In addition, an audit was performed analysing medicines reconciliation times for all patients admitted to the EAU during the month of December 2017.RESULTSA total of 30 staff members responded to the survey. While 40% (n =12) of respondents believed that the EAU had an efficient system in place for timely medicines reconciliation, 90% (n =27) believed the unit could still improve. Almost half the respondents (47%, n =14) perceived a delay in medicines reconciliation could result in exacerbation of patients' physical conditions. The clinical audit identified considerable variation in medicines reconciliation times, ranging from seven minutes to almost 24 hours. However, most medicines (82%) were reconciled within six hours.CONCLUSIONThis service evaluation found that the median time after arrival in the EAU until completion of medicines reconciliation was two hours 48 minutes. However, almost one fifth of patients had to wait for more than six hours, and in one instance almost 24 hours. One potential solution could be increasing the involvement of hospital pharmacists or pharmacy technicians in medicines reconciliation.