# Database | Search term | Results
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9 | 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")) [DT 2018-2018] [Since 18-Jul-2018] | 26

## Contents

26 of 26 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")) [DT 2018-2018] [Since 18-Jul-2018]

1. Paediatric intensive care and neonatal intensive care airway management in the United Kingdom: the PIC-NIC survey. page 3
2. Implementing and evaluating a primary care service for oral surgery: a case study. page 3
3. Evaluation of the cost-effectiveness of rifaximin-α for the management of patients with hepatic encephalopathy in the United Kingdom. page 4
4. A multi-centre quality improvement project to reduce the incidence of obstetric anal sphincter injury (OASI): study protocol. page 4
6. National guidance contributes to the high incidence of inpatient hypoglycaemia. page 5
7. Audit cycle of the provision of compression garments on prescription. page 6
8. How can end of life care excellence be normalized in hospitals? Lessons from a qualitative framework study. page 6
10. Nursing and medical contribution to Defence Healthcare Engagement: initial experiences of the UK Defence Medical Services. page 8
11. The Cleft Multidisciplinary Collaborative: Establishing a Network to Support Cleft Lip and Palate Research in the United Kingdom. page 8
12. Transforming Improving Access to Psychological Therapies. page 9
13. Feasibility of early discharge following vaginal hysterectomy with a bipolar electrocoagulation device. page 9
14. Implementing a standardised discharge analgesia guideline to reduce paediatric post tonsillectomy pain. page 10
15. Prospective real-world analysis of OnabotulinumtoxinA in chronic migraine post-National Institute for Health and Care Excellence UK technology appraisal. page 10
16. Using population-based routinely collected data from the Sentinel Stroke National Audit Programme to investigate factors associated with discharge to care home after rehabilitation. page 10
17. 20 years of researching stroke through audit. page 11
18. Identifying antibiotic stewardship interventions to meet the NHS England CQUIN: an evaluation of antibiotic prescribing against published evidence-based antibiotic audit tools. page 12

20. Attempts to reduce alcohol intake and treatment needs among people with probable alcohol dependence in England: a general population survey..................................................................................................................................................................Page 13


22. Feasibility of data linkage in the PARAMEDIC trial: a cluster randomised trial of mechanical chest compression in out-of-hospital cardiac arrest........................................................................................................................................Page 14

23. A review of asthma care in 50 general practices in Bedfordshire, United Kingdom..................................................................................................................................................................Page 14

24. The Impact of Accreditation for 10 Years on Inpatient Units for Adults of Working Age in the United Kingdom..............................Page 15

25. National survey of gastric emptying studies in the UK..................................................................................................................................................................................Page 15


Full search strategy .................................................................................................................................................................................................Page 18
1. Paediatric intensive care and neonatal intensive care airway management in the United Kingdom: the PIC-NIC survey.

Authors: Foy, K E; Mew, E; Cook, T M; Bower, J; Knight, P; Dean, S; Herneman, K; Marden, B; Kelly, F E

Source: Anaesthesia; Aug 2018

Publication Date: Aug 2018

Publication Type(s): Journal Article

PubMedID: 30112809

Database: Medline

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

2. Implementing and evaluating a primary care service for oral surgery: a case study.

Authors: Goldthorpe, Joanna; Sanders, Caroline; Gough, Lesley; Rogers, Jean; Bridgman, Colette; Tickle, Martin; Pretty, Iain

Source: BMC health services research; Aug 2018; vol. 18 (no. 1); p. 636

Publication Date: Aug 2018

Publication Type(s): Journal Article

PubMedID: 30107796

Database: Medline

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

**Authors**
Berni, Ellen; Murphy, Daniel; Whitehouse, James; Conway, Pete; Di Maggio, Paola; Currie, Craig J; Poole, Chris

**Source**
Current medical research and opinion; Aug 2018 ; p. 1-8

**Publication Date**
Aug 2018

**Publication Type(s)**
Journal Article

**PubMedID**
29995455

**Database**
Medline

**Abstract**
OBJECTIVE Rifaximin-\(\alpha\) 550 mg twice daily plus lactulose has demonstrated efficacy in reducing recurrence of episodes of overt hepatic encephalopathy (OHE) and the risk of hepatic encephalopathy (HE)-related hospitalizations compared with lactulose alone. This analysis estimated the cost effectiveness of rifaximin-\(\alpha\) 550 mg twice daily plus lactulose versus lactulose alone in United Kingdom (UK) cirrhotic patients with OHE. METHOD A Markov model was built to estimate the incremental cost-effectiveness ratio (ICER). The perspective was that of the UK National Health Service (NHS). Clinical data was sourced from a randomized controlled trial (RCT) and an open-label maintenance study in cirrhotic patients in remission from recurrent episodes of OHE. Health-related utility was estimated indirectly from disease-specific quality of life RCT data. Resource use data describing the impact of rifaximin-\(\alpha\) on hospital admissions and length of stay for cirrhotic patients with OHE was from four single-center UK audits. Costs (2012) were derived from published sources; costs and benefits were discounted at 3.5%. The base-case time horizon was 5 years. RESULTS The average cost per patient was £22,971 in the rifaximin-\(\alpha\) plus lactulose arm and £23,545 in the lactulose arm, a saving of £573. The corresponding values for benefit were 2.35 quality adjusted life years (QALYs) and 1.83 QALYs per person, a difference of 0.52 QALYs. This translated into a dominant base-case ICER. Key parameters that impacted the ICER included number of hospital admissions and length of stay. CONCLUSION Rifaximin-\(\alpha\) 550 mg twice daily in patients with recurrent episodes of OHE was estimated to generate cost savings and improved clinical outcomes compared to standard care over 5 years.

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

**Authors**
Bidwell, Posy; Thakar, Ranee; Sevdalis, Nick; Silverton, Louise; Novis, Vivienne; Hellyer, Alexandra; Kelsey, Megan; van der Meulen, Jan; Gurol-Urganci, Ipek

**Source**
BMC pregnancy and childbirth; Aug 2018; vol. 18 (no. 1); p. 331

**Publication Date**
Aug 2018

**Publication Type(s)**
Journal Article

**PubMedID**
30103734

**Database**
Medline

**Abstract**
BACKGROUND A primary care oral surgery service was commissioned alongside an electronic referral management system in England, in response to rising demand for Oral Surgery services in secondary care. It is important to ensure that standards of quality and safety are similar to those in existing secondary care services, and that the new service is acceptable to stakeholders. The aim of this study is therefore to conduct an in-depth case study to explore safety, quality, acceptability and implementation of the new service. METHOD This case study draws on multiple sources of evidence to report on the commissioning process, implementation, treatment outcomes and acceptability to patients relating to a new oral surgery service in a primary care setting. A combination of audit data and interviews were analysed. RESULTS Most referrals to the new service consisted of tooth extractions of appropriate complexity for the service. There were issues with lack of awareness of the new service in a primary care setting within referring primary care practices and patients at the start of implementation, however over time the service became a fully integrated part of the service landscape. Complications reported following surgery were low. CONCLUSION Patients liked the convenience of the new service in terms of shorter waiting time and geographical location and their patient reported experience measures and outcomes were similar to those reported in secondary care. Providing appropriate clinical governance was in place, oral surgery could safely be provided in a primary care setting for patients without complex medical needs. Attention needs to be paid to communication with general dental practices around changes to the service pathway during the early implementation period to ensure all patients can receive care in the most appropriate setting.

Authors
Belot, Aurélien; Fowler, Helen; Njagi, Edmund Njeru; Luque-Fernandez, Miguel-Angel; Maringe, Camille; Magadi, Winnie; Exarchakou, Aimilia; Quaresma, Manuela; Turculet, Adrian; Peake, Michael D; Navani, Neal; Rachet, Bernard

Source
Thorax; Aug 2018

Publication Date
Aug 2018

Publication Type(s)
Journal Article

PubMedID
30100577

Database
Medline

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

Abstract
INTRODUCTION
We investigated socioeconomic disparities and the role of the main prognostic factors in receiving major surgical treatment in patients with lung cancer in England.

METHODS
Our study comprised 31,351 patients diagnosed with non-small cell lung cancer in England in 2012. Data from the national population-based cancer registry were linked to Hospital Episode Statistics and National Lung Cancer Audit data to obtain information on stage, performance status and comorbidities, and to identify patients receiving major surgical treatment. To describe the association between prognostic factors and surgery, we performed two different analyses: one using multivariable logistic regression and one estimating cause-specific hazards for death and surgery. In both analyses, we used multiple imputation to deal with missing data.

RESULTS
We showed strong evidence that the comorbidities ‘congestive heart failure’, ‘cerebrovascular disease’ and ‘chronic obstructive pulmonary disease’ reduced the receipt of surgery in early stage patients. We also observed gender differences and substantial age differences in the receipt of surgery. Despite accounting for sex, age at diagnosis, comorbidities, stage at diagnosis, performance status and indication of having had a PET-CT scan, the socioeconomic differences persisted in both analyses: more deprived people had lower odds and lower rates of receiving surgery in early stage lung cancer.

DISCUSSION
Comorbidities play an important role in whether patients undergo surgery, but do not completely explain the socioeconomic difference observed in early stage patients. Future work investigating access to and distance from specialist hospitals, as well as patient perceptions and patient choice in receiving surgery, could help disentangle these persistent socioeconomic inequalities.

6. National guidance contributes to the high incidence of inpatient hypoglycaemia.

Authors
Levy, N; Hall, G M

Source
Diabetic medicine : a journal of the British Diabetic Association; Aug 2018

Publication Date
Aug 2018
Abstract
The seventh National Diabetes Inpatient Audit (NaDIA) 2017 was published in March 2018, NaDIA is the annual snapshot audit of diabetes inpatient care in England and Wales. NaDIA 2017 found that 18% of hospital beds were occupied by a person with diabetes, an absolute increase of 3% from 2011. Moreover, the report identified that 4% of people with Type 1 diabetes mellitus developed the serious and preventable disorder of hospital-acquired diabetic ketoacidosis. Medication errors were common: 31% of people had at least one medication error, and this increased to 40% in those receiving insulin. Some 18% of inpatients with diabetes experienced at least one episode of hypoglycaemia (defined as a blood glucose of < 4.0 mmol/l). The incidence of severe hypoglycaemia was 7% (defined as a blood glucose < 3.0 mmol/l), but this increased to 26% in those with Type 1 diabetes [1]. Hypoglycaemia is not innocuous; there is considerable evidence that a blood glucose < 4.0 mmol/l is a risk factor for death in hospitalized persons [2-4]. This article is protected by copyright. All rights reserved.

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

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


Abstract
The wearing of compression garments is an essential aspect of the management of lymphoedema. Patients however, do not always receive the requested garment on an NHS prescription from their general practitioner (GP). Through an audit cycle over 3 years, necessary changes in clinical practice were identified and introduced. The aim was to improve the number of patients obtaining the correct garment on an NHS prescription. The audit standard was not met in any of the audits and the conclusion made is that compression garments are difficult to find on NHS electronic prescribing systems leading to a delay in patients receiving their prescription and a risk of error due to the wide range of options available. Further work is necessary to ensure that electronic prescribing systems address the problem of product recognition for compression garments so that the process of obtaining compression garments is smooth, accurate and timely for patients and their GPs.
BACKGROUND There is a pressing need to improve end-of-life care in acute settings. This requires meeting the learning needs of all acute care healthcare professionals to develop broader clinical expertise and bring about positive change. The UK experience with the Liverpool Care of the Dying Pathway (LCP), also demonstrates a greater focus on implementation processes and daily working practices is necessary.

METHODS This qualitative study, informed by Normalisation Process Theory (NPT), investigates how a tool for end-of-life care was embedded in a large Australian teaching hospital. The study identified contextual barriers and facilitators captured in real time, as the ‘Clinical Guidelines for Dying Patients’ (CgDp) were implemented. A purposive sample of 28 acute ward (allied health 7 [including occupational therapist, pharmacists, physiotherapist, psychologist, speech pathologist], nursing 10, medical 8) and palliative care (medical 2, nursing 1) staff participated. Interviews (n = 18) and focus groups (n = 2), were audio-recorded and transcribed verbatim. Data were analysed using an a priori framework of NPT constructs; coherence, cognitive participation, collective action and reflexive monitoring.

RESULTS The CgDp afforded staff support, but the reality of the clinical process was invariably perceived as more complex than the guidelines suggested. The CgDp ‘made sense’ to nursing and medical staff, but, because allied health staff were not ward-based, they were not as engaged (coherence). Implementation was challenged by competing concerns in the acute setting where most patients required a different care approach (cognitive participation). The CgDp is designed to start when a patient is dying, yet staff found it difficult to diagnose dying. Staff were concerned that they lacked ready access to experts (collective action) to support this. Participants believed using CgDp improved patient care, but there was an absence of participation in real time monitoring or quality improvement activity.

CONCLUSIONS We propose a model, which addresses the risks and barriers identified, to guide implementation of end-of-life care tools in acute settings. The model promotes interprofessional and interdisciplinary working and learning strategies to develop capabilities for embedding end of life (EOL) care excellence whilst guided by experienced palliative care teams. Further research is needed to determine if this model can be prospectively applied to positively influence EOL practices.

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10. Nursing and medical contribution to Defence Healthcare Engagement: initial experiences of the UK Defence Medical Services.

**Authors**
Bowley, Douglas M; Lamb, D; Rumbold, P; Hunt, P; Kayani, J; Sukhera, A M

**Source**
Journal of the Royal Army Medical Corps; Aug 2018

**Publication Date**
Aug 2018

**Publication Type(s)**
Journal Article

**PubMedID**
30077975

**Database**
Medline

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

Available at Journal of the Royal Army Medical Corps 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 WHO Constitution enshrines ‘...the highest attainable standard of health as a fundamental right of every human being.' Strengthening delivery of health services confers benefits to individuals, families and communities, and can improve national and regional stability and security. In attempting to build international healthcare capability, UK Defence Medical Services (DMS) assets can contribute to the development of healthcare within overseas nations in a process that is known as Defence Healthcare Engagement (DHE).

**METHODS**
In the first bespoke DMS DHE tasking, a team of 12 DMS nurses and doctors deployed to a 1000-bedded urban hospital in a partner nation and worked alongside indigenous healthcare workers (doctors, nurses and paramedical staff) during April and May 2016. The DMS nurses focused on nursing hygiene skills by demonstrations of best practice and DMS care standards, clinical leadership and female empowerment. A Quality Improvement Programme was initiated that centred on hand hygiene (HH) compliance before and after patient contact, and the introduction of peripheral cannula care and surveillance.

**RESULTS**
After a brief induction on the ward, it was apparent that compliance with HH was poor. Peripheral cannulas were secured with adhesive zinc oxide tape and no active surveillance process (such as venous infusion phlebitis (VIP) scoring) was in place. After intensive education and training, initial week-long audits were undertaken and repeated after a further 2 weeks of training and coworking. In the second audit cycle, HH compliance had increased to 69% and VIP scoring compliance to 99%. In the final audit cycle, it was noted that nursing compliance with HH (75/98: 77%) was significantly higher than the doctors’ HH compliance (76/200: 38%); p<0.0001.

**CONCLUSIONS**
DHE is a long-term collaborative process based on the establishment and development of comprehensive relationships that can help transform indigenous healthcare services towards patient-centred systems with a focus on safety and quality of care. Short deployments to allow clinical immersion of UK healthcare workers within indigenous teams can have an immediate impact. Coworking is a powerful method of demonstrating standards of care and empowering staff to institute transformative change. A multidisciplinary group of Quality Improvement Champions has been identified and a Hospital Oversight Committee established, which will offer the prospect of longer term sustainability and development.


**Authors**
Sainsbury, David C G; Davies, Amy; Wren, Yvonne; Southby, Lucy; Chadha, Ambika; Slator, Rona; Stock, Nicola Marie; Cleft Multidisciplinary Collaborative

**Source**
The Cleft palate-craniofacial journal : official publication of the American Cleft Palate-Craniofacial Association; Aug 2018 ; p. 1055665618790174

**Publication Date**
Aug 2018

**Publication Type(s)**
Journal Article

**PubMedID**
30068232

**Database**
Medline

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

BACKGROUND As a growing paradigm of health research, trainee collaboratives can influence clinical practice through the generation of cost-effective multicenter audit and research projects. The aims of the present article are to outline and discuss the establishment of a multidisciplinary collaborative in the context of cleft lip and/or palate (CL/P).

METHODS The Cleft Multidisciplinary Collaborative (CMC) was formed in April 2016 under the overarching supervision of the National Institute for Health Research. Membership of the CMC is open to all members of the CL/P multidisciplinary team, who are encouraged to submit ideas for new research projects that will benefit clinical practice.

RESULTS To date, 48 clinical participants are involved in the CMC. These participants represent all 17 cleft teams from the United Kingdom and encompass a wide range of disciplines. The CMC has undertaken 2 major projects so far. The first involved collection of phenotype data to support a national cohort study. The second, still in progress, is a systematic review investigating factors associated with outcomes for velopharyngeal competence following cleft palate repair.

CONCLUSIONS The concept of a multidisciplinary collaborative in CL/P has been demonstrated through the generation of a United Kingdom-wide network of committed clinicians and researchers and the effective undertaking of 2 large research projects. As the CMC gathers momentum, it hopes to attract funding to support its activities, to promote more involvement from the allied health and nursing professions, to encourage a more ingrained research culture within the CL/P community, and to promote the wider ambition of a global collaborative.

12. Transforming Improving Access to Psychological Therapies.

Authors Scott, Michael J
Source Journal of health psychology; Aug 2018; vol. 23 (no. 9); p. 1163-1172
Publication Date Aug 2018
Publication Type(s) Journal Article
PubMedID 29895206
Database Medline

Abstract

The three commentaries on my paper 'IAPT - The Need for Radical Reform' are agreed that Improving Access to Psychological Therapies cannot be regarded as the 'gold standard' for the delivery of psychological therapy services. Furthermore, they agreed that Improving Access to Psychological Therapies should not continue to mark its 'own homework' and should be subjected to rigorous independent evaluation scrutiny. It is a matter for a public enquiry to ascertain why £1 billion has been spent on Improving Access to Psychological Therapies without any such an independent evaluation. What is interesting is that no commentary has been forthcoming from the UK Improving Access to Psychological Therapies service nor have they shared a platform to discuss these issues. It is regrettable that the UK Government's National Audit Office has chosen, to date, not to publish its own investigation into the integrity of Improving Access to Psychological Therapies data. Openness would be an excellent starting point for the necessary transformation of Improving Access to Psychological Therapies.

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

Authors Cassis, Charlotte; Mukhopadhyay, Sambit; Sule, Medha M; Kuruba, Neeraja
Source International journal of gynaecology and obstetrics: the official organ of the International Federation of Gynaecology and Obstetrics; Aug 2018; vol. 142 (no. 2); p. 182-186
Publication Date Aug 2018
Publication Type(s) Journal Article
PubMedID 29718559
Database Medline

Abstract

Available at International Journal of Gynecology & Obstetrics from Wiley Online Library Medicine and Nursing Collection 2018 - NHS
Available at International Journal of Gynecology & Obstetrics from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location]: British Library via UHL Libraries - please click link to request article.
Abstract

OBJECTIVE To evaluate the safety and efficacy of vaginal hysterectomy for benign conditions (excluding prolapse) using the BiClamp (Erbe Elektromedizin, Tübingen, Germany) bipolar electrocoagulation system. METHODS The present study was a prospective audit of a consecutive case series of patients who underwent vaginal hysterectomy for benign conditions, performed using the BiClamp between March 1, 2015, and June 30, 2016, at Norfolk and Norwich University Hospital, Norwich, UK. Surgeries performed for benign conditions were eligible, excluding prolapse; severe endometriosis with pelvic adhesions was an exclusion criterion. Patient demographics and past history were recorded, along with intraoperative findings and adverse events. Follow-up data were obtained via telephone interviews 24 hours after surgery and a nurse-led postoperative clinic 8 weeks postoperatively. RESULTS The series included 75 patients; 32 (43%) were discharged on the same day as surgery and 70 (93%) within 23 hours. There were two patients who experienced vault hematomas and remained admitted for more than 24 hours. There was one intraoperative bladder injury that was repaired vaginally. No delayed adverse events occurred within 8 weeks. No patient required patient-controlled analgesia or an epidural injection for postoperative analgesia. CONCLUSION Patients experienced low postoperative pain following BiClamp treatment and 93% were discharged within 23 hours.


Authors Shelton, Fenella R; Ishii, Hirotaka; Mella, Sophie; Chew, Dylan; Winterbottom, Jemma; Walijee, Hussein; Brown, Rachel; Chisholm, Edward J

Source International journal of pediatric otorhinolaryngology; Aug 2018; vol. 111; p. 54-58

Publication Date Aug 2018

Publication Type(s) Journal Article

PubMedID 29958614

Database Medline

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

Abstract

OBJECTIVE To reduce readmission for pain control post-paediatric tonsillectomy. INTRODUCTION Paediatric tonsillectomy is a common procedure in the UK. Uncontrolled pain at home is a common reason for readmission and therefore adequate analgesic control following paediatric tonsillectomy is vital for a smooth post-operative recovery. Analgesic regimens at a district general hospital in England were audited and a standardised protocol was subsequently implemented. METHODS A retrospective audit from September 2014 to August 2015 was completed. Discharge analgesic regimens and readmission rates post-tonsillectomy for recurrent tonsillitis in 2-17 year-old children were studied in a large general hospital in the United Kingdom. A standardised weight-based algorithm was used to dose scheduled regular paracetamol for 2 weeks. Second cycle prospective audit ran from December 2015 to November 2016. RESULTS In cycle 1, 151 children (mean age, 7.9 years) underwent tonsillectomy for tonsillitis, 25 (16.6%) of whom were readmitted. 12 (7.9%) experienced postoperative haemorrhage, 13 (8.6%) required pain control, and one (1.2%) had infection. The discharging analgesic regimen varied widely and often included purchase of over-the-counter ibuprofen and paracetamol. In cycle 2, 118 children (mean age, 8.8 years) underwent tonsillectomy, 17 (14.4%) were readmitted; 12 (10.2%) had post-operative haemorrhage, 0 needed pain control, 5 (4.2%) had other problems. There was a significant reduction in readmission for pain control (p = 0.0027) from 7.3% to 0% in the study. DISCUSSION Analgesia prescription post tonsillectomy varies widely and over the counter prescriptions of ibuprofen and paracetamol is based on age rather than weight with patients receiving inadequate analgesic doses. A readily available standardised postoperative analgesic protocol can significantly reduce readmission rates for pain control following paediatric tonsillectomy.


Authors Andreou, A P; Trimboli, M; Al-Kaisy, A; Murphy, M; Palmisani, S; Fenech, C; Smith, T; Lambru, G

Source European journal of neurology; Aug 2018; vol. 25 (no. 8); p. 1069

Publication Date Aug 2018

Publication Type(s) Journal Article

PubMedID 29617060

Database Medline

Available at European Journal of Neurology from Wiley Online Library Medicine and Nursing Collection 2018 - NHS
Abstract

BACKGROUND AND PURPOSE: The National Institute for Health and Care Excellence (NICE) in the UK recommends the use of OnabotulinumtoxinA (BoNTA, Botox®) in the management of chronic migraine (CM) following specific guidelines within the National Health Service. In view of the lack of data on the efficacy of this therapy following implementation of these guidelines in clinical practice and on the evaluation of guidance compliance, we aimed to evaluate the effectiveness and safety of BoNTA in patients with CM following the NICE guidelines.

METHODS: This was a prospective real-life audit study.

RESULTS: After two treatments, 127 of 200 patients (63.5%) obtained at least a 30% reduction in headache days. Those who continued the treatment up to 3 years reported a stable beneficial effect compared with baseline. Amongst responders, 68 patients (53.5%) were reclassified as episodic migraineurs. A total of 57 of these patients (83.8%) converted to an episodic migraine pattern at 6-month follow-up. The majority of those whose migraine became episodic after BoNTA extended the treatment intervals beyond 3 months (range 4-8 months) before noticing any worsening of headache. We observed no significant differences in the efficacy measures in patients treated with 155 U BoNTA compared with those treated with >155 U BoNTA.

CONCLUSIONS: When administered according to the NICE guidance, BoNTA produced a clinically meaningful effect in the long-term management of CM with and without medication overuse headache. Treatment discontinuation when CM becomes episodic may be useful in clinical practice to identify those who may benefit from extended treatment intervals. Our clinical experience indicates a lack of additional benefit from using the 'follow-the-pain' paradigm.

16. Using population-based routinely collected data from the Sentinel Stroke National Audit Programme to investigate factors associated with discharge to care home after rehabilitation.

Authors
Dutta, Dipankar; Thornton, Daniel; Bowen, Emily

Source
Clinical rehabilitation; Aug 2018; vol. 32 (no. 8); p. 1108-1118

Abstract
OBJECTIVES: We investigated factors associated with Care Home (CH) discharge following stroke using routinely collected data in unselected patients and assessed the relevance of previous research findings to such patients seen in routine clinical practice.

DESIGN: Retrospective analysis of data from the Sentinel Stroke National Audit Programme using univariate analysis and logistic regression.

SETTING: A large acute and rehabilitation UK stroke unit with access to early supported discharge.

SUBJECTS: All patients with stroke treated from 1 January 2014 to 1 January 2017.

MAIN MEASURES: National Institutes of Health Stroke Scale (NIHSS) and modified Rankin Scale (mRS).

RESULTS: Of 2584 patients (median age 78 years, interquartile range (IQR) 69-86; 50.6% male; 86.7% infarcts; median admission NIHSS 4, IQR 2-9), 401 (15.5%) died in hospital and 203 patients (7.9%) were permanently discharged to CH for the first time. Most had pre-discharge mRS scores of 4/5. Factors (odds ratios; 95% confidence intervals) associated with CH discharge included age (1.07; 1.05-1.10), incontinence (11.5; 7.13-19.25), dysphagia (2.13; 1.39-3.29), severe weakness (1.93; 1.28-2.92), pneumonia (1.68; 1.13-2.50), urinary tract infection (UTI) (1.70; 1.04-2.75) and depression (1.65; 1.00-2.72). In a subgroup of all patients with a pre-discharge mRS of 4/5, age (1.04; 1.02-1.06), incontinence (4.87; 2.39-11.02), UTI (2.0; 1.09-3.71) and pneumonia (1.59; 1.02-2.50) were the only factors associated with CH discharge.

CONCLUSION: Potentially modifiable variables like incontinence, UTI and pneumonia were associated with CH discharge, particularly in the severely disabled.

17. 20 years of researching stroke through audit.

Authors
Rudd, Anthony G; Hoffman, Alex; Paley, Lizz; Bray, Benjamin

Source
Clinical rehabilitation; Aug 2018; vol. 32 (no. 8); p. 997-1006

Abstract
OBJECTIVES: We investigated factors associated with Care Home (CH) discharge following stroke using routinely collected data in unselected patients and assessed the relevance of previous research findings to such patients seen in routine clinical practice.

DESIGN: Retrospective analysis of data from the Sentinel Stroke National Audit Programme using univariate analysis and logistic regression.

SETTING: A large acute and rehabilitation UK stroke unit with access to early supported discharge.

SUBJECTS: All patients with stroke treated from 1 January 2014 to 1 January 2017.

MAIN MEASURES: National Institutes of Health Stroke Scale (NIHSS) and modified Rankin Scale (mRS).

RESULTS: Of 2584 patients (median age 78 years, interquartile range (IQR) 69-86; 50.6% male; 86.7% infarcts; median admission NIHSS 4, IQR 2-9), 401 (15.5%) died in hospital and 203 patients (7.9%) were permanently discharged to CH for the first time. Most had pre-discharge mRS scores of 4/5. Factors (odds ratios; 95% confidence intervals) associated with CH discharge included age (1.07; 1.05-1.10), incontinence (11.5; 7.13-19.25), dysphagia (2.13; 1.39-3.29), severe weakness (1.93; 1.28-2.92), pneumonia (1.68; 1.13-2.50), urinary tract infection (UTI) (1.70; 1.04-2.75) and depression (1.65; 1.00-2.72). In a subgroup of all patients with a pre-discharge mRS of 4/5, age (1.04; 1.02-1.06), incontinence (4.87; 2.39-11.02), UTI (2.0; 1.09-3.71) and pneumonia (1.59; 1.02-2.50) were the only factors associated with CH discharge.

CONCLUSION: Potentially modifiable variables like incontinence, UTI and pneumonia were associated with CH discharge, particularly in the severely disabled.
17. Identifying antibiotic stewardship interventions to meet the NHS England CQUIN: an evaluation of antibiotic-prescribing against published evidence-based antibiotic audit tools.

**Authors**
Powell, Neil; McGraw-Allen, Kate; Menzies, Alasdair; Peet, Bradley; Simmonds, Callie; Wild, Abigail

**Source**
Clinical medicine (London, England); Aug 2018; vol. 18 (no. 4); p. 276-281

**Publication Date**
Aug 2018

**Publication Type(s)**
Journal Article

**Medline**
Available at Clinical Medicine from ProQuest (Hospital Premium Collection) - NHS Version
Available at Clinical Medicine from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at Clinical 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**
Evidence-based audit tools were used to identify the antibiotic stewardship improvements necessary to meet the NHS England targets in a 750-bed teaching hospital. Antibiotic prescribing was reviewed against published evidence-based audit tools for 139 patients treated with antibiotics. Severe community-acquired pneumonia (CAP) median course length was 8.5 days. Ninety-six percent of non-severe CAP patients were initiated on intravenous antibiotics (IV); median antibiotic course length 9 days. Twenty-six percent of urinary tract infection (UTI) patients without an indwelling catheter met the UTI diagnostic criteria. IV antibiotics initiated in 79% patients with other infections. Of these, 17% met the IV to oral switch criteria at 72 hours but were not switched. On average, antibiotic courses were 19% longer than recommended. Three key areas for improvement consist of: (a) implement the National Institute of Health and Care Excellence UTI Quality Standard - only 38% of patients treated for UTI met the UTI definition; (b) ensure antibiotic course lengths are in line with local prescribing guidelines - antibiotics were continued for 14% longer than recommended in local guidelines; (c) switch antibiotic therapy to oral when switch criteria met - 17% percent of patients initiated on IV antibiotics were eligible for oral switch by 72 hours and were not switched.


**Authors**
Leonard, Anusha; Wright, Amanda; Saavedra-Campos, Maria; Lamagni, Theresa; Cordery, Rebecca; Nicholls, Margot; Domoney, Claudine; Sriskandan, Shiranee; Balasegaram, Soorja

**Source**
BJOG : an international journal of obstetrics and gynaecology; Aug 2018; vol. 18 (no. 4); p. 276-281

**Publication Date**
Aug 2018

**Publication Type(s)**
Journal Article

**Medline**
Available at BJOG : an international journal of obstetrics and gynaecology from Wiley Online Library Medicine and Nursing Collection 2018 - NHS
Available at BJOG : an international journal of obstetrics and gynaecology from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at BJOG : an international journal of obstetrics and gynaecology from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.
OBJECTIVEWe describe cases of invasive group A Streptococcus (iGAS) in mothers or neonates and assess management according to national guidelines, which recommend administering antibiotics to both mother and neonate if either develops iGAS infection within 28 days of birth and investigation of clusters in maternity units.DESIGNCross-sectional retrospective study.SETTING AND POPULATIONNotified confirmed iGAS cases in either mothers or neonates with onset within 28 days of birth in London and the South East of England between 2010 and 2016.METHOD OUTFROMeasureSEncidence and onset time of iGAS in post-partum mothers and babies, proportion given prophylaxis, maternal unit clusters within six months.RESULTSWe identified 134 maternal and 21 neonatal confirmed iGAS infections. The incidence (in 100 000 person years) of iGAS infections in women within 28 days post-partum was 109 (95% CI 90-127) compared to 1.3 in other females aged 15-44. For neonates the incidence was 1.5 (95% CI 9-23). The median onset time was two days post-partum (IQR 0-5 days) for mothers and 12 days (IQR 7-15 days) for neonates. All eligible mothers and most (109, 89%) eligible neonates received chemoprophylaxis. Of 20 clusters (59 cases of GAS and iGAS) in maternity units, two clusters involved possible transmission. However, in six of fifteen clusters, GAS isolates were not saved for comparison even after relevant guidance was issued.CONCLUSIONSiGAS infection remains a potential post-partum risk. Prophylaxis among neonates and storage of isolates from maternity cases can be improved. This article is protected by copyright. All rights reserved.

**Authors**
Ji, Chen; Quinn, Tom; Gavalova, Lucia; Lall, Ranjit; Scomparin, Charlotte; Horton, Jessica; Deakin, Charles D; Pocock, Helen; Smyth, Michael A; Rees, Nigel; Brace-McDonnell, Samantha J; Gates, Simon; Perkins, Gavin D

**Source**
BMJ open; Jul 2018; vol. 8 (no. 7); p. e021519

**Abstract**
OBJECTIVES There is considerable interest in reducing the cost of clinical trials. Linkage of trial data to administrative datasets and disease-specific registries may improve trial efficiency, but it has not been reported in resuscitation trials conducted in the UK. To assess the feasibility of using national administrative and clinical datasets to follow up patients transported to hospital following attempted resuscitation in a cluster randomised trial of a mechanical chest compression device in out-of-hospital cardiac arrest.METHODS Hospital data on trial participants were requested from Hospital Episode Statistics (HES), the Intensive Care National Audit and Research Centre, and Myocardial Ischaemia National Audit Project and National Audit of Percutaneous Coronary Interventions, using unique patient identifiers. Linked data were received between June 2014 and June 2015. RESULTS So 4471 patients randomised in the pre-hospital randomised assessment of a mechanical compression device in cardiac arrest (PARAMEDIC) trial, 2398 (53.6%) were not known to be deceased at hospital emergency department arrival and were eligible for linkage. We achieved an overall match rate of 86.7% in the combined HES accident and emergency, inpatient and critical care dataset, with variable match rates (4.2%-80.4%) in individual datasets. Patient demographics, cardiac arrest-related characteristics and major outcomes were predominantly similar between HES matched and unmatched groups, in the linkage apart from location, response time and return of spontaneous circulation (ROSC) at handover. CONCLUSION Although advancing age was associated with higher rates of 90-day mortality following liver resection, 3-year mortality for patients 65-74 years was comparable to younger patients. These results will aid clinicians and patients in pre-operative decision-making.

23. A review of asthma care in 50 general practices in Bedfordshire, United Kingdom.

**Authors**
Levy, Mark L; Garnett, Fiona; Kuku, Adedayo; Pertssovskaya, Inna; McKnight, Eddie; Haughney, John

**Source**
npj primary care respiratory medicine; Jul 2018; vol. 28 (no. 1); p. 29

**Abstract**
BACKGROUND Clinical outcomes for elderly patients undergoing liver resection for colorectal cancer (CRC) liver metastases are poorly characterised. This study aimed to investigate the impact of advancing age on the incidence of liver resection and post-operative outcomes.METHODS Patients in the National Bowel Cancer Audit undergoing major CRC resection from 2010 to 2016 in England were included. Liver resection was identified from linked Hospital Episode Statistics data. A Cox-proportional hazards model was used to compare 3-year mortality.

RESULTS So 117,005 patients, 6081 underwent liver resection. For patients <65 years there was 1 liver resection per 12 cases, 65-74, 1 per 17, and ≥75, 1 per 40. 90-day mortality after liver resection increased with advancing age (+65 0.9% (26/2829), 65-74 2.8% (57/2070), ≥75 4.0% (47/1182); P < 0.001). Age was an independent risk factor for 3-year mortality. Patients 65-74 did not have adjusted mortality higher than those <65, yet age ≥75 was associated with increased overall mortality (Hazard ratio (HR) 1.47 (95% CI 1.30-1.68)) and cancer-specific mortality (HR 1.30 (95% CI 1.13-1.49)).

CONCLUSION Although advancing age was associated with higher rates of 90-day mortality following liver resection, 3-year mortality for patients 65-74 years was comparable to younger patients. These results will aid clinicians and patients in pre-operative decision-making.
Abstract

The United Kingdom (UK) National Review of Asthma Deaths (NRAD) (2011-2014) identified a number of contributory risk factors which had not previously been recognized by those caring for people with asthma. Only one of the 19 NRAD recommendations has so far been implemented nationally, and that only partially, and as yet systems are not in place to identify patients at risk of attacks and dying from asthma. In 2015/2016 Bedfordshire Clinical Commissioning Group (CCG) in England, UK, initiated a quality asthma audit of people with asthma to identify some of the risk factors identified in the NRAD report with the aim of optimizing patient care. Fifty (89%) of the General Practices caring for 415,152 patients (27,587 diagnosed with asthma (prevalence 7%; range 4-12%)), participated and the results identified a wide variation in process of care and presence of risk factors including: excess short acting reliever and insufficient preventer prescriptions, failure to issue personal asthma action plans, and to perform annual reviews or check inhaler technique. Identification of these patients involved high-intensity input by trained asthma nurses using sophisticated data extraction software. GP computer systems used in primary care currently do not have the functionally, without the need for manual audit, to implement the NRAD recommendations, starting with the identification of patients at risk. Modifications to existing systems within both primary and secondary care are required in order to prevent unnecessary deaths related to asthma. There is a pressing need to move towards a more pro-active model of care.

24. The Impact of Accreditation for 10 Years on Inpatient Units for Adults of Working Age in the United Kingdom.

Authors
Chaplin, Robert; Raphael, Hannah; Beavon, Mark

Source
Psychiatric services (Washington, D.C.); Jul 2018 ; p. appips201700567

Publication Date
Jul 2018

Publication Type(s)
Journal Article

PubMedID
30041590

Database
Medline

Abstract
Psychiatric inpatient units in the United Kingdom have been criticized for having falling bed numbers, staff shortages, and brief compulsory admissions. This column describes the impact over 10 years of a voluntary U.K. quality improvement program to provide accreditation for inpatient wards. Performance on evidence-based standards was assessed during peer review visits, and 92 of the 140 wards participating are currently accredited. Improvement was found in patient contact, access to therapies, safety, crisis planning, ability among staff to take breaks, and doctor availability. Availability of activities outside working hours needs improvement. Further work is needed to incorporate clinical outcomes in the accreditation program.

25. National survey of gastric emptying studies in the UK.

Authors
Notghi, Alp; Hansrod, Shazmeen

Source
Nuclear medicine communications; Jul 2018

Publication Date
Jul 2018

Publication Type(s)
Journal Article

PubMedID
30044332

Database
Medline

Abstract
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.
26. An evaluation of the TARGET (Treat Antibiotics Responsibly; Guidance, Education, Tools) Antibiotics Toolkit to improve antimicrobial stewardship in primary care—is it fit for purpose?

Authors

Jones, Leah; Ffion; Hawking, Meredith K D; Owens, Rebecca; Lecky, Donna; Francis, Nick A; Butler, Chris; Gal, Micaela; McNulty, Cliodna A M

Source

Family practice; Jul 2018; vol. 35 (no. 4); p. 461-467

Abstract

BACKGROUND The TARGET (Treat Antibiotics Responsibly; Guidance, Education, Tools) Antibiotics Toolkit aims to improve antimicrobial prescribing in primary care through guidance, interactive workshops with action planning, patient facing educational and audit materials. OBJECTIVE To explore GPs', nurses' and other stakeholders' views of TARGET. DESIGN Mixed methods. METHOD In 2014, 40 UK GP staff and 13 stakeholders participated in interviews or focus groups. We analysed data using a thematic framework and normalization process theory (NPT). RESULTS Two hundred and sixty-nine workshop participants completed evaluation forms, and 40 GP staff, 4 trainers and 9 relevant stakeholders participated in interviews (29) or focus groups (24). GP staffs were aware of the issues around antimicrobial resistance (AMR) and how it related to their prescribing. Most participants stated that TARGET as a whole was useful. Participants suggested the workshop needed less background on AMR, be centred around clinical cases and allow more action planning time. Participants particularly valued comparison of their practice antibiotic prescribing with others and the TARGET Treating Your Infection leaflet. The leaflet needed greater accessibility via GP computer systems. Due to time, cost, accessibility and competing priorities, many GP staff had not fully utilized all resources, especially the audit and educational materials. CONCLUSIONS We found evidence that the workshop is likely to be more acceptable and engaging if based around clinical scenarios, with less on AMR and more time on action planning. Greater promotion of TARGET through Clinical Commissioning Group's (CCG's) and professional bodies, may improve uptake. Patient facing resources should be made accessible through computer shortcuts built into general practice software.
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