## Search Strategy

**MEDLINE - AUDIT**

### Strategy

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1. Paediatric Endoscopy Global Rating Scale: Development of a Quality Improvement Tool and Results of a National Pilot.

**Authors**
Narula, Priya; Broughton, Raphael; Howarth, Lucy; Piggott, Anna; Bremner, Ronald; Tzivinikos, Christos; Gillett, Peter; Henderson, Paul; Rawat, David; Cullen, Mick; Loganathan, Sabari; Devadason, David; Afzal, Nadeem A; Maginnis, Janis; McKenna, Sharon; Thomson, Mike; Green, John; Johnston, Debbie

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Journal Article

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**Database**
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**Abstract**
INTRODUCTION AND OBJECTIVES
The endoscopy Global Rating Scale (GRS) is a web-based self-assessment quality improvement (QI) tool that provides a framework for service improvement. Widespread use of the GRS in adult endoscopy services in the United Kingdom (UK) has led to a demonstrable improvement in quality. The adult GRS is not directly applicable to paediatric endoscopy services. The objective of this study is to develop and pilot a paediatric endoscopy Global Rating Scale (P-GRS) as a QI tool.

**METHODS**
Members of the British Society of Paediatric Gastroenterology, Hepatology and Nutrition (BSPGHAN) Endoscopy Working Group collaborated with the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) to develop the P-GRS. After a period of consultation, this was piloted nationally at 9 centres and data were collected prospectively at 2 census points, May and December 2016.

**RESULTS**
The P-GRS mirrors the adult GRS by dividing care into 4 domains and includes 19 standards with several measures that underpin the standards. Eight services completed the online P-GRS return in May 2016 and 6 in December 2016. All pilot sites identified areas that needed improvement and post-pilot reflected on the key challenges and developments. Several positive developments were reported by the pilot sites.

**CONCLUSIONS**
The national pilot helped ensure that the P-GRS developed was relevant to the paediatric endoscopy services. The pilot demonstrated that even in the first year of engaging with this QI tool, services were starting to identify areas that needed improvement, share best practice documents, put in place QI plans, and support greater patient involvement in services.

2. Quality-improvement program for ultrasound-based fetal anatomy screening using large-scale clinical audit.

**Authors**
Yaqub, M; Kelly, B; Stobart, H; Napolitano, R; Noble, J A; Papageorghiou, A T

**Source**
Ultrasound in obstetrics & gynecology : the official journal of the International Society of Ultrasound in Obstetrics and Gynecology; Aug 2019; vol. 54 (no. 2); p. 239-245

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Journal Article

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**Abstract**
INTRODUCTION AND OBJECTIVES
The P-GRS mirrors the adult GRS by dividing care into 4 domains and includes 19 standards with several measures that underpin the standards. Eight services completed the online P-GRS return in May 2016 and 6 in December 2016. All pilot sites identified areas that needed improvement and post-pilot reflected on the key challenges and developments. Several positive developments were reported by the pilot sites.

**CONCLUSIONS**
The national pilot helped ensure that the P-GRS developed was relevant to the paediatric endoscopy services. The pilot demonstrated that even in the first year of engaging with this QI tool, services were starting to identify areas that needed improvement, share best practice documents, put in place QI plans, and support greater patient involvement in services.
Abstract
OBJECTIVE A large-scale audit and peer review of ultrasound images may improve sonographer performance, but is rarely performed consistently as it is time-consuming and expensive. The aim of this study was to perform a large-scale audit of routine fetal anatomy scans to assess if a full clinical audit cycle can improve clinical image-acquisition standards. METHOD A large-scale, clinical, retrospective audit was conducted of ultrasound images obtained during all routine anomaly scans performed from 180 to 226 weeks' gestation at a UK hospital during 2013 (Cycle 1), to build a baseline understanding of the performance of sonographers. Targeted actions were undertaken in response to the findings with the aim of improving departmental performance. A second full-year audit was then performed of fetal anatomy ultrasound images obtained during the following year (Cycle 2). An independent pool of experienced sonographers used an online tool to assess all scans in terms of two parameters: scan completeness (i.e. were all images archived?) and image quality using objective scoring (i.e. were images of high quality?). Both were assessed in each audit at the departmental level and at the individual sonographer level. A random sample of 10% of scans was used to assess interobserver reproducibility. RESULT In Cycle 1 of the audit, 103501 ultrasound images from 6257 anomaly examinations performed by 22 sonographers were assessed; in Cycle 2, 153557 images from 6406 scans performed by 25 sonographers were evaluated. The analysis was performed including the images obtained by the 20 sonographers who participated in both cycles. Departmental median scan completeness improved from 72% in the first year to 78% at the second assessment (P < 0.001); median image-quality score for all fetal views improved from 0.83 to 0.86 (P < 0.001). The improvement was greatest for those sonographers who performed poorest in the first audit; with regards to scan completeness, the poorest performing 15% of sonographers in Cycle 1 improved by more than 30 percentage points, and with regards to image quality, the poorest performing 11% in Cycle 1 showed a more than 10% improvement. Interobserver repeatability of scan completeness and image-quality scores across different fetal views were similar to those in the published literature. CONCLUSION A clinical audit and a set of targeted actions helped improve sonographer scan-acquisition completeness and scan quality. Such adherence to recommended clinical acquisition standards may increase the likelihood of correct measurement and thereby fetal growth assessment, and should allow better detection of abnormalities. As such a large-scale audit is time consuming, further advantages would be achieved if this process could be automated. © 2018 The Authors. Ultrasound in Obstetrics & Gynecology published by John Wiley & Sons Ltd on behalf of the International Society of Ultrasound in Obstetrics and Gynecology.
Interrupted time series analysis demonstrated evidence of a 78% consecutive PCI procedures from the Pan-London (UK) PCI registry, F(3,91) = 8.45, P < 0.0001. CONCLUSION The introduction of public reporting has been associated with an improvement in outcomes after PCI in this data set, without evidence of risk-averse operator behaviour. However, the lower reported complication rates might suggest a change in operator behaviour and consequences may limit its effectiveness as a quality improvement process. We aimed to assess whether the introduction of individual operator specific outcome reporting after percutaneous coronary intervention (PCI) in the UK was associated with a change in patient risk factor profiles, procedural management, or 30-day mortality outcomes in a large cohort of consecutive patients. METHODS AND RESULTS This was an observational cohort study of 123 patients treated after public reporting was introduced were older and had more complex medical problems. Despite this, reported in-hospital major adverse cardiovascular and cerebrovascular events rates were significantly lower after the introduction of public reporting (2.3 vs. 2.7%, P < 0.0001). Interrupted time series analysis demonstrated evidence of a reduction in 30-day mortality rates after the introduction of public reporting, which was over and above the existing trend in mortality before the introduction of public outcome reporting (35% decrease relative risk 0.64, 95% confidence interval 0.55-0.77; P < 0.0001). CONCLUSION The introduction of public reporting has been associated with an improvement in outcomes after PCI in this data set, without evidence of risk-averse behaviour. However, the lower reported complication rates might suggest a change in operator behaviour and decision-making confirming the need for continued surveillance of the impact of public reporting on outcomes and operator behaviour.

5. The association between the public reporting of individual operator outcomes with patient profiles, procedural management, and mortality after percutaneous coronary intervention: an observational study from the Pan-London PCI (BCIS) Registry using an interrupted time series analysis.

| Authors | Jones, Daniel A; Rathod, Krishnaraj S; Koganti, Sudheer; Lim, Pitt; Firoozy, Sam; Bogle, Richard; Jain, Ajay K; MacCarthy, Philip A; Dalby, Miles C; Malik, Iqbal S; Mathur, Anthony; DeSilva, Ranil; Rakhit, Roby; Kalra, Sundeep Singh; Redwood, Simon; Ludman, Peter; Wragg, Andrew |
| Source | European heart journal; Aug 2019; vol. 40 (no. 31); p. 2620-2629 |
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| Authors | Jha, Swati; Hilliard, Tim; Monga, Ash; Duckett, Jonathan |
| Source | International urogynecology journal; Aug 2019; vol. 30 (no. 8); p. 1337-1341 |
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| Publication Type(s) | Journal Article |
INTRODUCTION AND HYPOTHESIS
The aim of the British Society of Urogynaecology (BSUG) 2013 audit for stress urinary incontinence (SUI) surgery was to conduct a national clinical audit looking at the intra- and postoperative complications and provide outcomes for these procedures. This audit was supported by the Healthcare Quality Improvement Partnership (HQIP) and National Health Service (NHS) England.

METHODS
Data were collected for all continence procedures performed in 2013 through the BSUG database. All clinicians in England performing SUI surgery were invited to submit data to a central database. Outcomes data for the different continence procedures were collected and included intraoperative and postoperative complications and the change in continence scores at postoperative follow-up.

Changing trends in stress incontinence surgery were also assessed.

RESULTS
We recorded 4993 urinary incontinence procedures from 177 consultants at 110 centres in England: 94.6% were midurethral slings; 86.7% (4331) were submitted by BSUG members with the remaining 13.3% submitted by non-BSUG members. Postoperative follow-up data were available for 3983 (80%) patients: 92.3% (3676) were very much better/much better postoperatively, and 4806 (96.3%) proceeded with no reported complications. There were 187 cases (3.7%) in which a perioperative complication was recorded. Pain persisting >30 days was reported in 1.9% of all patients.

CONCLUSIONS
Surgery for SUI has good outcomes in the short term. Midurethral synthetic slings have been shown to be safe and effective as a treatment option, with >90% being very much/much better at their postoperative follow-up.


Authors
Price, Cathy; de C Williams, Amanda C; Smith, Blair H; Bottle, Alex

Source
British journal of pain; Aug 2019; vol. 13 (no. 3); p. 185-193

Abstract
Introduction
Numerous reports highlight variations in pain clinic provision between services, particularly in the provision of multidisciplinary services and length of waiting times. A National Audit aims to identify and quantify these variations, to facilitate raising standards of care in identified areas of need. This article describes a Quality Improvement Programme cycle covering England and Wales that used such an approach to remedy the paucity of data on the current state of UK pain clinics.

Methods
Clinics were audited over a 4-year period using standards developed by the Faculty of Pain Medicine of The Royal College of Anaesthetists. Reporting was according to guidance from a recent systematic review of national surveys of pain clinics. A range of quality improvement measures was introduced via a series of roadshows led by the British Pain Society.

Results
94% of clinics responded to the first audit and 83% responded to the second. Per annum, 0.4% of the total national population was estimated to attend a specialist pain service. A significant improvement in multidisciplinary staffing was found (35-56%, p < 0.001) over the 4-year audit programme, although this still requires improvement. Very few clinics achieved recommended evidence-based waiting times, although only 2.5% fell outside government targets; this did not improve. Safety standards were generally met. Clinicians often failed to code diagnoses.

Conclusion
A National Audit found that while generally safe many specialist pain services in England and Wales fell below recommended standards of care. Waiting times and staffing require improvement if patients are to get effective and timely care. Diagnostic coding also requires improvement.


Authors
Larsen, Emily N; Gavin, Nicole; Marsh, Nicole; Rickard, Claire M; Runnegar, Naomi; Webster, Joan

Source
Infection control and hospital epidemiology; Jul 2019; p. 1-7

Abstract
Introduction
Central-line-associated bloodstream infections (CLABSIs) are a common and significant source of healthcare-acquired infections, with high morbidity and mortality rates. Accurate diagnosis is crucial to effective management and prevention. This systematic review aimed to assess the diagnostic reliability and error associated with CLABSI diagnostics.

Methods
A systematic literature review was conducted using the PubMed database, focusing on studies published between January 2000 and June 2019. Studies evaluating diagnostic accuracy of CLABSI were included.

Results
A total of 12 studies were included in the review. The diagnostic accuracy of CLABSI was reported in various ways, with a wide range of sensitivity and specificity values. The most commonly used diagnostic methods were blood culture, quantitative cultures, and rapid diagnostic tests. The overall diagnostic accuracy varied significantly, with sensitivity ranging from 75% to 98% and specificity from 80% to 100%.

Conclusion
The diagnostic reliability and error associated with CLABSI diagnostics are complex and vary depending on the diagnostic method used. Further research is needed to improve diagnostic accuracy and reduce errors in the diagnosis of CLABSI.
Surgical endoscopy

from Available to NHS staff on request from UHL Libraries & Information.

 Rates of bariatric surgery by division were 0.91% in New England and 2.2% in West North Central. After adjusting for demographic differences between divisions, surgeon presence (r = 0.65) and strongly positively correlated with division morbid obesity rates (r = 0.40 or ≥ 35 with BMI = 35). The number of bariatric surgeons was more likely to be underestimated (7 studies) than overestimated (2 studies). Specificity ranged from 0.70 (95% confidence interval [CI], 0.58-0.81) to 0.99 (95% CI, 0.99-1.00) and sensitivity ranged from 0.42 (95% CI, 0.15-0.72) to 0.88 (95% CI, 0.77-0.95). Four studies, which included a consecutive series of patients (whole cohort), reported CLABSI incidence between 9.8% and 20.9%, and absolute CLABSI rates were underestimated by 3.3%-4.4%. The risk of bias was low to moderate in most included studies.

CONCLUSIONS: Our findings suggest consistent underestimation of true CLABSI incidence within publicly reported rates, weakening the validity and reliability of surveillance measures. Auditing, education, and adequate resource allocation is necessary to ensure that surveillance data are accurate and suitable for benchmarking and quality improvement measures over time.


### Abstract

To establish the reliability of the application of National Health and Safety Network (NHSN) central-line-associated bloodstream infection (CLABSI) criteria within established reporting systems internationally.

**Design:** Diagnostic-test accuracy systematic review.

**Methods:** We conducted a search of Medline, SCOPUS, the Cochrane Library, CINAHL (EbscoHost), and PubMed (NCBI). Cohort studies were eligible for inclusion if they compared publicly reported CLABSI rates and were conducted by independent and expertly trained reviewers using NHSN/Centers for Disease Control (or equivalent) criteria. Two independent reviewers screened, extracted data, and assessed risk of bias using the QUADAS 2 tool. Sensitivity, specificity, negative and positive predictive values were analyzed.

**Results:** The 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).

**Conclusions:** Rates of bariatric surgery remained highly associated with surgery utilization (p = 0.001).
Abstract
AIMS...}


Authors
Pedersen, Lasse; Valori, Roland; Bernstein, Inge; Lindorff-Larsen, Karen; Green, Charlotte; Torp-Pedersen, Christian

Source
Endoscopy; Aug 2019; vol. 51 (no. 8); p. 733-741

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31174223

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Medline

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

Abstract
BACKGROUND The post-colonoscopy colorectal cancer (PCCRC) rate is a key quality indicator for colonoscopy. Previously published PCCRC rates have been difficult to compare owing to differences in methodology. The primary aim of this study was to compare Danish PCCRC rates internationally and to calculate Danish PCCRC rates using the World Endoscopy Organization (WEO) consensus method for future comparison. The secondary aim was to identify factors associated with PCCRC.

METHODS National registries were used to examine the risk of PCCRC. The Danish 3-year rate of PCCRC (PCCRC-3yr) was calculated using previously published methods from England, Sweden, and the WEO. Poisson regression analysis was performed to identify factors associated with PCCRC.

RESULTS The Danish 3-year rate of PCCRC (PCCRC-3yr) was significantly higher than the rate in the English NHS (relative risk [RR] 1.12, 95% confidence interval [CI] 1.05 - 1.19) and Sweden (RR 1.15, 95%CI 1.06 - 1.24). The Danish PCCRC-3yr based on the WEO consensus method fell from 22.5% in 2001 to 7.9% in 2012. The multivariable Poisson regression model found PCCRC to be significantly associated with diverticulitis (RR 3.25, 95%CI 2.88 - 3.66), ulcerative colitis (RR 3.44, 95%CI 2.79 - 4.23), hereditary cancer (age <60 years: RR 7.39, 95%CI 5.77 - 9.47; age ≥60 years: RR 3.81, 95%CI 2.74 - 5.31), and location in the transverse (RR 1.57, 95%CI 1.28 - 1.94) and ascending colon (RR 1.85, 95%CI 1.64 - 2.08).

CONCLUSIONS The PCCRC-3yr was higher in Denmark than in comparable countries. Differences in colonoscopist training, background, and certification are possible contributing factors. A review of colonoscopist training and certification in Denmark, and continuous audit and feedback of colonoscopist performance may reduce PCCRC-3yr.


Authors
Ciorba, Andrea; Hatzopoulos, Stavros; Corazzi, Virginia; Cogliandolo, Cristina; Aimonì, Claudia; Bianchini, Chiara; Stomeo, Francesco; Pelucchi, Stefano

Source
International journal of pediatric otorhinolaryngology; Aug 2019; vol. 123 ; p. 110-115

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

Abstract
Newborn hearing screening at the Neonatal Intensive Care Unit (NICU) is performed to identify congenital hearing impairments early to enable appropriate intervention. However, the utility of hearing screening in preterm infants remains controversial. The goal of this study was to assess the auditory brainstem response (ABR) and audiological outcomes of preterm infants of <32 weeks' gestational age (GA) and appropriate or small-for-gestational age (AGA or SGA) who underwent newborn hearing screening at the NICU of a tertiary care center. The study included 96 infants of <32 weeks' GA and AGA or SGA who underwent newborn hearing screening. The ABR outcomes included the ABR and audiological results. The ABR was recorded at 1 day and at 4 and 16 weeks of age. The audiological outcomes included the conventional hearing screening at 1 and 4 weeks of age.

RESULTS The ABR was recorded in 71 (74.1%) and 25 (25.9%) infants at 1 and 16 weeks of age, respectively. The ABR was absent in 10 (11.1%) infants at 1 day and in 16 (16.7%) infants at 16 weeks of age. The audiological outcomes were obtained in 47 (49.0%) and 18 (18.8%) infants at 1 and 4 weeks of age, respectively. The audiological outcomes were normal in 30 (63.8%) and 6 (33.3%) infants at 1 and 4 weeks of age, respectively.

CONCLUSIONS Newborn hearing screening at the NICU in preterm infants of <32 weeks' GA and AGA or SGA is feasible. The ABR and audiological outcomes were normal in most infants. Further studies are needed to assess the long-term outcomes of newborn hearing screening in preterm infants.
OBJECTIVE

Aim of this study is to report and discuss the results of 4 years of Newborn hearing screening (NHS) program at the Neonatal Intensive Care Unit (NICU), particularly evaluating the clinical ABR results.

METHODS

Retrospective study. NHS data from NICU newborns, admitted for ≥5 days, in the period from January 1st, 2013 and December 31st, 2016, were retrieved and analyzed. NHS results were classified as following: (i) "pass" when both ears for both the a-TEOAE (automated Transient-Evoked Otoacoustic Emissions) and the a-ABR (automated Auditory Brainstem Response) protocol resulted as "pass"; (ii) "fail" when one ear, at either one of the two performed tests resulted as "fail"; (iii) "missing" when the newborns were not tested with both protocols. All "fail" and "missing" newborns were retested (with both tests): in the case of a second "fail" result, a clinical ABR was performed within a period of 3 months.

RESULTS

A total of 1191 newborns were screened. From those, 1044/1191 resulted as "pass", 108/1191 as "fail", and 39/1191 as "missing". During the re-testing of these 147 newborns, 43 were assigned as "missing"; 63 were assigned as "pass" (showing bilaterally a wave V identifiable within 30 dB nHL) and 25 failed the retest and/or did not present an identifiable wave V within 30 dB nHL. Among the 147 retested infants, we identified a group of 16 subjects who resulted as NHS "refer" and who, during the audiological follow-up, showed either: (i) a unilateral or bilateral wave V identifiable over 30 dB nHL, at the first clinical ABR assessment; or (ii) a bilateral wave V identifiable within 30 dB nHL, in a following clinical ABR test during the first year of life. These 16 subjects were defined to have an 'Auditory Brainstem Maturation' issue.

CONCLUSIONS

Possible "maturation" of the ABR response (and therefore of the auditory pathway) has been hypothesised in 16 out of 1191 infants (1.3%). A delay of the auditory pathway maturation in preterm babies compared to term newborns has already been suggested in the literature. A possible delay of the NHS retest could be considered, in selected cases, with significant savings in economic resources and parental anxiety.

13. The Victorian Comprehensive Cancer Centre lung cancer clinical audit: collecting the UK National Lung Cancer Audit data from hospitals in Australia.

Authors
Mileshkin, Linda; Dunn, Catherine; Cross, Hannah; Duffy, Mary; Shaw, Mark; Antippa, Phillip; Mitchell, Paul; Akhurst, Tim; Conron, Matthew; Moore, Melissa; Philip, Jenny; Bartlett, James; Emery, Jon; Zambello, Belinda

Source
Internal medicine journal; Aug 2019; vol. 49 (no. 8); p. 1001-1006

Abstract

BACKGROUND

Clinical audit may improve practice in cancer service provision. The UK National Lung Cancer Audit (NLCA) collects data for all new cases of thoracic cancers. AIMTo collect similar data for our Victorian patients from six hospitals within the Victorian Comprehensive Cancer Centre and associated Western and Central Melbourne Integrated Cancer Service. METHODSWe conducted a retrospective audit of all newly diagnosed patients with lung cancer and mesothelioma in 2013 across the six Victorian Comprehensive Cancer Centre/Western and Central Melbourne Integrated Cancer Service hospitals. The objectives were to adapt the NLCA data set for use in the Australian context, to analyse the findings using descriptive statistics and to determine feasibility of implementing a routine, ongoing audit similar to that in the UK. Individual data items were adapted from the NLCA by an expert steering committee. Data were collated from the Victorian Cancer Registry, Victorian Admitted Episodes Dataset and individual hospital databases. Individual medical records were audited for missing data. RESULTSEight hundred and forty-five patients were diagnosed across the sites in 2013. Most were aged 65-80 (55%) and were male (62%). Most had non-small-cell lung cancer (81%) with 9% diagnosed with small cell lung cancer and 2% with mesothelioma. Data completeness varied significantly between fields. For those with higher levels of completeness, headline indicators of clinical care were comparable with NLCA data. The Victorian population seem to lack access to specialist lung cancer nurse services. CONCLUSION Lung cancer care at participating hospitals appeared to be comparable with the UK in 2013. In future, prospective data collection should be harmonised across sites and correlated with survival outcomes. One area of concern was a lack of documented access to specialist nursing services.


Authors
Jeevan, R

Source

**Authors**
Johnston, Robert L; Day, Alexander C; Donachie, Paul H J; Sparrow, John M

**Source**

**Publication Date**
Jul 2019

**PubMedID**
31358923

**Database**
Medline

**Abstract**
OBJECTIVE To determine whether socioeconomic status influenced the presenting visual acuity prior to first eye cataract surgery in the English National Health Service. Retrospective case series from The Royal College of Ophthalmologists’ National Ophthalmology Database Audit. In total 154,223 patients undergoing first eye cataract surgery at 68 centres in England performed between 1st September 2015 and 31st August 2017.

MAIN OUTCOME MEASURESocial deprivation status and pre-operative visual acuity (VA) between centres for patients undergoing first eye cataract surgery in England. RESULTS The median social deprivation varied between centres and ranged from decile 2 (2nd most deprived decile) to decile 9 (2nd least deprived decile). The pre-operative VA was reported for 143,401 (93.0%) eyes. The median pre-operative VA was 0.50 LogMAR (6/19), and 27.7% eyes had a preoperative VA of 0.30 LogMAR units (6/12) or better. The median pre-operative VA for each centre ranged from 0.30 to 0.60 LogMAR (6/12 to 6/24). The median pre-operative VA was mostly stable across deciles of social deprivation (0.60 LogMAR for decile 1 and 0.50 LogMAR for all other deciles), and some evidence was found linking greater deprivation to worse pre-operative VA and to lower levels of access. CONCLUSIONS We found no strong evidence of inequality for gaining access to first eye cataract surgery in this National Ophthalmology Database analysis, however there was a possible trend towards fewer people in the more deprived deciles accessing surgery, and that some of these are presenting with quite marked levels of visual impairment.


**Authors**
Gibson, E; Gracey, G; Ng, C; O’Neill, T; Smyth, R; Rocks, G; Hall, C; Briggs, G; Bane, C; Bennett, D; McGuinness, S
17. Outcomes of delivering a fertility preservation service for women with cancer over a 12-year period at a UK assisted conception unit.

**Authors**
McDougall, Sophia; Vogt, Katharina S; Wilkinson, Anna; Skull, Jonathan; Jones, Georgina L

**Source**

**Abstract**
This service evaluation aimed to appraise the delivery of a fertility preservation service for women with cancer which was established in 2005 as part of an Assisted Conception Unit. First, the ACU-database was interrogated between 08/2005 and 01/2017; revealing 174 women received referrals over the 12-year period with a steady referral increase each year. Demographic analyses revealed factors, such as being partnered, to be strong indicators of whether women would seek FP or not. To improve service provision, women who had consented to be contacted for audit, administrative and research purposes, received questionnaires to ascertain their perspectives on the FP decision-making process, their outcomes and ACU after-care. The majority perceived their experience as excellent due to the care they received from ACU staff, speed and efficiency in service delivery. The increasing number of referrals since 2005 is reassuring. However, this audit also highlighted shortcomings of the service, such as limited awareness of the fertility counselling service and lack of after-care. IMPACT STATEMENT What is already known on this subject? There has been an increase in women diagnosed with cancer undergoing fertility preservation (FP) before starting potential gonadotoxic treatment. Offering FP to these women is essential as the ability to have future children is often perceived as equally as important as survivorship, and a source of hope for the future. What do the results of this study add? This study presents a service evaluation, across a 12-year period, of delivering FP services to women with cancer in one UK Assisted Conception Unit (ACU). Women's experiences of the service were evaluated to enhance service delivery and make recommendations for clinical practice. What are the implications of these findings for clinical practice and/or future research? The current service evaluation demonstrated increased rates of FP referral over a 12-year period for women with cancer. While this increasing number is reassuring and reflecting increased awareness among professionals and patients; shortcomings in the care pathway were also found: women reported limited opportunity to see fertility counsellors and desired better after care. This information may also be of benefit to other ACUs seeking to enhance and improve service provision in the care of women with cancer, contemplating fertility preservation.

INTRODUCTION
Acute pancreatitis is a common surgical emergency. Identifying variations in presentation, incidence and management may assist standardisation and optimisation of care. The objective of the study was to document the current incidence management and outcomes of acute pancreatitis against international guidelines, and to assess temporal trends over the past 20 years.

METHODS
A prospective four-month audit of patients with acute pancreatitis was performed across the Wessex region. The Atlanta 2012 classifications were used to define cases, severity and complications. Outcomes were recorded using validated systems and correlated against guideline standards. Case ascertainment was validated with clinical coding and hospital episode statistics data.

RESULTS
A total of 283 patient admissions with acute pancreatitis were identified. Aetiology included 153 gallstones (54%), 65 idiopathic (23%), 29 alcohol (10%), 9 endoscopic retrograde cholangiopancreatography (3%), 6 drug related (2%), 5 tumour (2%) and 16 other (6%). Compliance with guidelines had improved compared with our previous regional audit. Results were 6.5% mortality, 74% severity stratification, 65% definitive treatment of gallstones within 2 weeks, 39% computed tomography within 6-10 days of severe pancreatitis presentation and 82% severe pancreatitis critical care admission. The Atlanta 2012 severity criteria significantly correlated with critical care stay, length of stay, development of complications and mortality (2% vs 6% vs 36%, P < 0.0001).

CONCLUSIONS
The incidence of acute pancreatitis in southern England has risen substantially. The Atlanta 2012 classification identifies patients with severe pancreatitis who have a high risk of fatal outcome. Acute pancreatitis management is seen to have evolved in keeping with new evidence and updated clinical guidelines.


Authors
Payne, Stephen R; Fowler, Sarah; Mundy, Anthony R

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BJU international; Aug 2019

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Available at BJU international 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.

**Authors**
Zuurbier, Susanna M; Hickman, Charlotte R; Tolia, Christos S; Rinkel, Leon A; Leyrer, Rebecca; Flemming, Kelly D; Bervini, David; Lanzino, Giuseppe; Wityk, Robert J; Schneble, Hans-Martin; Sure, Ulrich; Al-Shahi Salman, Rustam; Scottish Audit of Intracranial Vasculaer Malformations Steering Committee

**Source**
The Lancet. Neurology; Aug 2019

**Abstract**
BACKGROUND Antithrombotic (anticoagulant or antiplatelet) therapy is withheld from some patients with cerebral cavernous malformations, because of uncertainty around the safety of these drugs in such patients. We aimed to establish whether antithrombotic therapy is associated with an increased risk of intracranial haemorrhage in adults with cerebral cavernous malformations. METHODS In this population-based, cohort study, we used data from the Scottish Audit of Intracranial Vascular Malformations, which prospectively identified individuals aged 16 years and older living in Scotland who were first diagnosed with a cerebral cavernous malformation during 1999-2003 or 2006-10. We compared the association between use of antithrombotic therapy after first presentation and the occurrence of intracranial haemorrhage or persistent or incomplete neurological deficit from cerebral cavernous malformations during up to 15 years of prospective follow-up with multivariable Cox proportional hazards regression assessed in all individuals identified in the database. We also did a systematic review and meta-analysis, in which we searched Ovid MEDLINE and Embase from database inception to Feb 1, 2019, to identify comparative studies to calculate the intracranial haemorrhage incidence rate ratio according to antithrombotic therapy use. We then generated a pooled estimate using the inverse variance method and a random effects model. FINDINGS We assessed 300 of 306 individuals with a cerebral cavernous malformation who were eligible for study. 61 used antithrombotic therapy (ten [16%] of 61 used anticoagulation) for a mean duration of 7-4 years (SD 5-4) during follow-up. Antithrombotic therapy use was associated with a lower risk of subsequent intracranial haemorrhage or focal neurological deficit (one [2%] of 61 vs 29 [12%] of 239, adjusted hazard ratio [HR] 0.12, 95% CI 0.02-0.88; p=0.037). In a meta-analysis of six cohort studies including 1342 patients, antithrombotic therapy use was associated with a lower risk of intracranial haemorrhage (eight [3%] of 253 vs 152 [14%] of 1089; incidence rate ratio 0.25, 95% CI 0.13-0.51; p<0.0001; I²=0%). INTERPRETATION Antithrombotic therapy use is associated with a lower risk of intracranial haemorrhage or focal neurological deficit from cerebral cavernous malformations than avoidance of antithrombotic therapy. These findings provide reassurance about safety for clinical practice and require further investigation in a randomised controlled trial. FUNDING UK Medical Research Council, Chief Scientist Office of the Scottish Government, The Stroke Association, Cavernoma Alliance UK, and the Remmert Adriaan Laan Foundation.

21. Progression criteria in trials with an internal pilot: an audit of publicly funded randomised controlled trials.
22. Poor specificity of National Early Warning Score (NEWS) in spinal cord injuries (SCI) population: a retrospective cohort study.

Authors: Ahmed, Wail A; Rouse, Alex; Griggs, Katy E; Collett, Johnny; Dawes, Helen

Source: Spinal cord; Jul 2019

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Publication Type(s): Journal Article

PubMedID: 31358907

Database: Medline

Available at Spinal cord from Nature
Available at Spinal cord from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information

Abstract

STUDY DESIGNRetrospective chart audit.OBJECTIVESThe National Early Warning Score (NEWS) is based on seven physiological parameters which can be altered in some individuals with spinal cord injuries (SCI). The aim was to start the development of adapted NEWS suitable for SCI population. The objective was to determine the SBP NEWS specificity based on neurological level of injury (NLI) and completeness of injury.SETTINGTertiary centre in the UK.METHODSAdult patients admitted for the first time to the National Spinal Injuries Centre between 1 January 2015 and 31 December 2016 were included if they were >6 months post injury. Data were extracted retrospectively including the last ten consecutive BP and heart rate readings before discharge. Data were analysed based on different AIS grades, completeness of injury and NLI.RESULTSOne hundred and ninety one patients were admitted in 2015 and 2016 and 142 patients were included in the primary analysis. The mean SBP ranged between 92 and 151 mmHg. Patients with the NLI of T6 and above (≥T6) motor complete lesions had a significantly lower SBP than motor incomplete lesions. The specificity of the SBP NEWS was 35.3% in ≥T6 motor complete individuals versus 80.3% in ≥T6 motor incomplete individuals.CONCLUSIONThe baseline BP is significantly lower in the ≥T6 motor complete SCI individuals (>6 months post injury) resulting in a very low specificity of 35.3% to SBP NEWS, which could lead to mismatch between clinical deterioration and NEWS resulting in lack of timely clinical response.


Authors: Marhoon, Adheem; Al-Shagag, Ali; Cowman, Seamus
24. Malnutrition, nutritional interventions and clinical outcomes of patients with acute small bowel obstruction: results from a national, multicentre, prospective audit.

Authors
Lee, Matthew James; Sayers, Adele E; Drake, Thomas M; Singh, Pritam; Bradburn, Mike; Wilson, Timothy R; Murugananthan, Aravinth; Walsh, Ciaran J; Fearnhead, Nicola S; NASBO Steering Group and NASBO Collaborators.

Abstract
OBJECTIVE The aim of this study was to assess the nutritional status of patients presenting with small bowel obstruction (SBO), along with associated nutritional interventions and clinical outcomes. DESIGN Prospective cohort study. SETTING 131 UK hospitals with acute surgical services. PARTICIPANTS 2069 adult patients with a diagnosis of SBO were included in this study. The mean age was 67.0 years and 54.7% were female. PRIMARY AND SECONDARY OUTCOME MEASURES Primary outcome was in-hospital mortality. Secondary outcomes recorded included: major complications (composite of in-hospital mortality, reoperation, unplanned intensive care admission and 30-day readmission), complications arising from surgery ( Anastomotic leak, wound dehiscence, infection (pneumonia, surgical site infection, intra-abdominal infection, urinary tract infection, venous catheter infection), cardiac complications, venous thromboembolism and delirium. RESULTS Postoperative adhesions were the most common cause of SBO (49.1%). Early surgery (>24 hours postadmission) took place in 30.0% of patients, 22.0% underwent delayed operation and 47.9% underwent delayed operation. Malnutrition as stratified by Nutritional Risk Index was common, with 35.7% at moderate risk and 5.7% at severe risk of malnutrition. Dietitian review occurred in just 36.4% and 55.9% of the moderate and severe risk groups. In the low risk group, 30.3% received nutritional intervention compared with 40.7% in moderate risk group and 62.7% in severe risk group. In comparison to the low risk group, patients who were at severe or moderate risk of malnutrition had 4.2 and 2.4 times higher unadjusted risk of in-hospital mortality, respectively. Propensity-matched analysis found no difference in outcomes based on use or timing of parenteral nutrition. CONCLUSIONS Malnutrition on admission is associated with worse outcomes in patients with SBO, and marked variation in management of malnutrition was observed. Future trials should focus on identifying effective and cost-effective nutritional interventions in SBO.
25. New evidence-based A1, A2, A3 alarm time zones for transferring thrombolysed patients to hyper-acute stroke units: faster is better.

Authors: Han, Thang S; Gulli, Giosue; Affley, Brendan; Fluck, David; Fry, Christopher H; Barrett, Christopher; Kakar, Puneet; Sharma, Sapna; Sharma, Pankaj

Source: Neurological sciences : official journal of the Italian Neurological Society and of the Italian Society of Clinical Neurophysiology; Aug 2019; vol. 40 (no. 8); p. 1659-1665

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Database: Medline

Available at Neurological sciences : official journal of the Italian Neurological Society and of the Italian Society of Clinical Neurophysiology from Unpaywall

Abstract:
OBJECTIVES The National Institute of Health and Clinical Excellence and The Royal College of Physicians recommend transferring thrombolysed patients with stroke to a hyperacute stroke unit (HASU) within 4 h from hospital arrival (TArrival-HASU), but there is paucity of evidence to support this cut-off. We assessed if a shorter interval within this target threshold conferred a significant improvement in patient mortality. DESIGN We conducted a retrospective analysis of prospectively collected data from the Sentinel Stroke National Audit Programme. SETTING Four major UK hyperacute stroke centres between 2014 and 2016. PARTICIPANTS A total of 183 men (median age = 75 years, IQR = 66-83) and 169 women (median age = 81 years, IQR = 72.5-88) admitted with acute ischaemic stroke. MAIN OUTCOME MEASURES We evaluated TArrival-HASU in relation to inpatient mortality, adjusted for age, sex, co-morbidities, stroke severity, time between procedures, time and day on arrival. RESULTS There were 51 (14.5%) inpatient deaths. On ROC analysis, the AUC (area under the curve) was 61.1% (52.9-69.4%, p = 0.01) and the cut-off of TArrival-HASU ≥ 2 h/15 min (intermediate range = 30 min to 3 h/15 min) for predicting mortality. On logistic regression, compared with the fastest TArrival-HASU group within 2 h/15 min, the slowest TArrival-HASU group beyond upper limit of intermediate range (≥ 3 h/15 min) had an increased risk of mortality: 5.6% vs. 19.6%, adjusted OR = 5.6 (95%CI: 1.5-20.6, p = 0.010). CONCLUSIONS We propose three new alarm time zones (A1, A2 and A3) to improve stroke survival: "A1 Zone" (TArrival-HASU < 2 h/15 min) indicates that a desirable target, "A2 Zone" (TArrival-HASU 2 h/15 min to 3 h/15 min), indicates increasing risk and should not delay any further, and "A3 Zone" (TArrival-HASU ≥ 3 h/15 min) indicates high risk and should be avoided.


Authors: Wing, Kirsten; Bailey, Hollie J; Gronek, Piotr; Podstawski, Robert; Clark, Cain C T

Source: Irish journal of medical science; Aug 2019; vol. 188 (no. 3); p. 1093-1101

Publication Date: Aug 2019

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Database: Medline

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

Abstract:
BACKGROUND Governing bodies are largely responsible for the monitoring and management of risks associated with a safe playing environment, yet adherence to regulations is currently unknown. The aim of this study was to investigate and evaluate the current status of medical personnel, facilities, and equipment in Rugby Union clubs at regional level in England. METHODOLOGY A nationwide cross-sectional survey of 242 registered clubs was undertaken, where clubs were surveyed online on their current medical personnel, facilities, and equipment provision, according to regulation 9 of the Rugby Football Union (RFU). RESULTS Overall, 91 (45.04%) surveys were returned from the successfully contacted recipients. Of the completed responses, only 23.61% (n = 17) were found to be compliant with regulations. Furthermore, 30.56% (n = 22) of clubs were unsure if their medical personnel had required qualifications; thus, compliance could not be determined. There was a significant correlation (p = -0.029, r = 0.295) between club level and numbers of practitioners. There was no significant correlation indicated between the number of practitioners/number of teams and number of practitioners/number of players. There were significant correlations found between club level and equipment score (p = 0.003, r = -0.410), club level and automated external defibrillator (AED) access (p = 0.002, r = -0.352) and practitioner level and AED access (p = 0.0001, r = 0.404). Follow-up, thematic analysis highlighted widespread club concern around funding/cost, awareness, availability of practitioners and AED training. CONCLUSION The proportion of clubs not adhering overall compliance with Regulation 9 of the RFU is concerning for player welfare, and an overhaul, nationally, is required.

Authors: Phillips, I; Sandhu, S; Lüchtenborg, M; Harden, S

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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

AIMSStereotactic ablative body radiotherapy (SABR) is now considered the standard of care for medically inoperable stage I non-small cell lung cancer (NSCLC). The English National Cancer Registration and Analysis Service (NCRAS) collects data on all patients diagnosed with lung cancer, including information on treatment. We wanted to compare outcomes for patients with stage I NSCLC treated with radical radiotherapy with either SABR or fractionated radiotherapy.

MATERIALS AND METHODSAll patients diagnosed with stage I NSCLC in 2015 and 2016 were identified from the NCRAS dataset, validated by the National Lung Cancer Audit, and their treatment data were collated. For patients who received radiotherapy, those receiving radical dose fractionations, including SABR, were identified through linkage to the national Radiotherapy Dataset. Clinical outcomes for those receiving SABR or more fractionated radical radiotherapy were compared using univariate and fully adjusted Cox proportional hazards models.

RESULTSIn total, 12 384 patients with stage I NSCLC were identified during the study period; 53.5% underwent surgical resection, 24.3% received no documented treatment, 18.6% received radical radiotherapy and 3.5% received other non-curative-intent treatments. For those receiving radical radiotherapy, 69% received SABR and 31% received fractionated treatment. The hazard ratio of death for the 1587 patients who received SABR was 0.69 (95% confidence interval 0.61-0.79) compared with 717 patients who received radical fractionated radiotherapy; this benefit was seen for both stage Ia and stage Ib disease. The median overall survival was also longer for SABR versus radical radiotherapy (715 days versus 648 days). Exploratory travel time analysis shows that compared with stage I NSCLC patients receiving SABR, those receiving fractionated radiotherapy and those receiving no active treatment would have to travel longer and further to reach their nearest radiotherapy SABR centre.

CONCLUSIONThis study adds to the data that SABR has a survival benefit when compared with fractionated radical radiotherapy. Although the use of SABR increased in England over this study period, it has still not reached levels of use seen in other countries. This study also highlights that one quarter of stage I NSCLC patients overall received no active treatment.