## Database Search Term Results

### # Database Search term

<table>
<thead>
<tr>
<th>#</th>
<th>Database</th>
<th>Search term</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Medline</td>
<td>(((audit* OR &quot;quality improvement*&quot;).ti,ab OR exp &quot;CLINICAL AUDIT&quot;/ OR exp &quot;QUALITY IMPROVEMENT&quot;/) AND ((NHS OR england OR UK OR &quot;united kingdom&quot; OR &quot;national health service&quot;).ti,ab OR exp &quot;UNITED KINGDOM&quot;/)) [DT 2018-2018] [Since 19-Nov-2018]</td>
<td>49</td>
</tr>
</tbody>
</table>

### Contents

49 of 49 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 19-Nov-2018]

1. Exploring patient-reported outcomes of home-based cardiac rehabilitation in relation to Scottish, UK and European guidelines: an audit using qualitative methods. ................................................................. Page 3


3. How is the audit of therapy intensity influencing rehabilitation in inpatient stroke units in the UK? An ethnographic study. ........................................ Page 4

4. Clinical effectiveness of pharmacy-led versus conventionally delivered antiviral treatment for hepatitis C in patients receiving opioid substitution therapy: a study protocol for a pragmatic cluster randomised trial. .................................................................................................................... Page 4

5. An audit of antimicrobial prescribing by dental practitioners in the north east of England and Cumbria. .................................................. Page 5


7. Implementation of tranexamic acid for bleeding trauma patients: a longitudinal and cross-sectional study. ........................................... Page 6

8. Attitudes, skills and use of evidence-based practice among UK osteopaths: a national cross-sectional survey. .................................................... Page 6

9. Does adult alcohol consumption combine with adverse childhood experiences to increase involvement in violence in men and women? A cross-sectional study in England and Wales. .......................................................................................... Page 7

10. Impact of a physician-led pre-hospital critical care team on outcomes after major trauma. ........................................................................ Page 7

11. Demographic Factor Clustering at a GP practice level in England and its relation to Glycaemic Outcomes: What we can learn from this. ................................................................................................................ Page 8

12. Victorian Comprehensive Cancer Centre lung cancer clinical audit: collecting the UK National Lung Cancer Audit data from hospitals in Australia. ....................................................................................... Page 8


14. Six months on: NHS England needs to focus on dissemination, implementation and audit of its low-priority initiative. ......................... Page 9

15. Patient perspectives on a national multidisciplinary team meeting for a rare cancer. ..................................................................................... Page 9

16. Six weeks’ notice of the on-call roster: fact or fantasy? An audit study. ........................................................................................................ Page 9

17. Reducing adult cardiac surgical site infections and the economic impact of using multidisciplinary collaboration........................................ Page 10

18. Impact of a diagnostics-driven antifungal stewardship programme in a UK tertiary referral teaching hospital. ........................................ Page 10

20. Noninvasive vagus nerve stimulation in a primary care setting: effects on quality of life and utilization measures in multimorbidity patients with or without primary headache. ............................................................... Page 12

21. Evaluation of a questionnaire to measure parent/carer and child/young person experience of NHS epilepsy services. ........ Page 12

22. Rising to the challenge: Epilepsy specialist nurses as leaders of service improvements and change (SEnSE study). ................. Page 13

23. Effect of an Educational and Organizational Intervention on Pain in Nursing Home Residents: A Nonrandomized Controlled Trial. ........................................................................................................ Page 13

24. Renal inpatient ward nurse experience and job satisfaction: A qualitative study. ................................................................. Page 14

25. Newborn hearing screening protocols and their outcomes: A systematic review. ........................................................................................................ Page 14

26. Validation of the person-centred coordinated care experience questionnaire (P3CEQ). ................................................................. Page 15

27. Relationship between height and outcomes among critically ill adults: a cohort study.............................................................. Page 15

28. The UK Online Gender Audit 2018: A comprehensive audit of gender within the UK's online environment. ...................... Page 16

29. Consensus generation of a minimum set of outcome measures for auditing glaucoma surgery outcomes—a Delphi exercise. ........................................................................................................ Page 16

30. Does the mode of delivery in routine cardiac rehabilitation have an association with cardiovascular risk factor outcomes? Page 17

31. Paired surveys for patients and physiologists in echocardiography: a single centre experience. ..................................................... Page 17

32. Association Between Hospital Volume and Mortality in Status Epilepticus: A National Cohort Study. ............................................. Page 18

33. Letter to editor re: Refeeding syndrome in adults receiving total parenteral nutrition: An audit of practice at a tertiary UK centre........................................................................................................................................ Page 18

34. Assessing the impact of quality improvement measures on catheter related blood stream infections and catheter salvage: Experience from a national intestinal failure unit. ................................................................. Page 18

35. Implementing a theory-based intradialytic exercise programme in practice: a quality improvement project................................ Page 19


37. Use of acronyms in anaesthetic and associated investigations: appropriate or unnecessary? - the UOAIAAAAIOU Study... Page 20

38. Using prognosis to guide early detection and treatment selection in non-metastatic prostate cancer........................................... Page 20

39. UK national audit of safety checks for radiology interventions........................................................................................................ Page 21

40. Improving the identification of patients with delirium using the 4AT assessment. ................................................................. Page 21

41. Sensitivity of EQ-5D-3L, HUI2, HUI3, and SF-6D to changes in speech reception and tinnitus associated with cochlear implantation. ........................................................................................................ Page 22

42. Non-invasive vagus nerve stimulation for treatment of cluster headache: early UK clinical experience........................................ Page 22

43. Use of a proforma to aid in reducing coercion into informal admission for acute adult psychiatric inpatients in the U.K. ...... Page 23

44. Sex differences in quality indicator attainment for myocardial infarction: a nationwide cohort study......................................... Page 23

45. Patterns of moderate and severe injury in children after the introduction of major trauma networks............................................. Page 24


47. Progression of hearing loss in neurofibromatosis type 2 according to genetic severity................................................................. Page 25

48. Diagnosis and referral delays in primary care for oral squamous cell cancer: a systematic review................................................ Page 25

49. Quality indicators for Palliative Day Services: A modified Delphi study.......................................................... Page 26

Full search strategy ........................................................................................................................................................................... Page 27

Authors: Ranaldi, Hannah; Deighan, Carolyn; Taylor, Louise
Source: BMJ open; Dec 2018; vol. 8 (no. 12); p. e024499
Publication Date: Dec 2018
Publication Type(s): Journal Article
PubMedID: 30559161
Database: Medline

Abstract: OBJECTIVES: The Heart Manual (HM) is the UK’s leading facilitated home-based cardiac rehabilitation (CR) programme for individuals recovering from myocardial infarction and revascularisation. This audit explored patient-reported outcomes of home-based CR in relation to current Scottish, UK and European guidelines. SETTING: Patients across the UK returned their questionnaire after completing the HM programme to the HM Department (NHS Lothian). PARTICIPANTS: Qualitative data from 457 questionnaires returned between 2011 and 2018 were included for thematic analysis. Seven themes were identified from the guidelines. This guided initial deductive coding and provided the basis for inductive subthemes to emerge. RESULTS: Themes included: (1) health behaviour change and modifiable risk reduction, (2) psychosocial support, (3) education, (4) social support, (5) medical risk management, (6) vocational rehabilitation and (7) long-term strategies and maintenance. Both (1) and (2) were reported as having the greatest impact on patients’ daily lives. Subthemes for (1) included: guidance, engagement, awareness, consequences, attitude, no change and motivation. Psychosocial support comprised: stress management, pacing, relaxation, increased self-efficacy, validation, mental health and self-perception. This was followed by (3) and (4). Patients less frequently referred to (5), (6) and (7). Additional themes highlighted the impact of the HM programme and that patients attributed the greatest impact to a combination of all the above themes. CONCLUSION: This audit highlighted the HM as comprehensive and inclusive of key elements proposed by Scottish, UK and EU guidelines. Patients reported this had a profound impact on their daily lives and proved advantageous for CR.


Authors: Parry, Matthew G; Sujenthiran, Arunan; Cowling, Thomas E; Nossiter, Julie; Cathcart, Paul; Aggarwal, Ajay; Clarke, Noel W; Payne, Heather; van der Meulen, Jan
Source: International journal of cancer; Dec 2018
Publication Date: Dec 2018
Publication Type(s): Journal Article
PubMedID: 30549266
Database: Medline

Abstract: OBJECTIVES: The Heart Manual (HM) is the UK’s leading facilitated home-based cardiac rehabilitation (CR) programme for individuals recovering from myocardial infarction and revascularisation. This audit explored patient-reported outcomes of home-based CR in relation to current Scottish, UK and European guidelines. SETTING: Patients across the UK returned their questionnaire after completing the HM programme to the HM Department (NHS Lothian). PARTICIPANTS: Qualitative data from 457 questionnaires returned between 2011 and 2018 were included for thematic analysis. Seven themes were identified from the guidelines. This guided initial deductive coding and provided the basis for inductive subthemes to emerge. RESULTS: Themes included: (1) health behaviour change and modifiable risk reduction, (2) psychosocial support, (3) education, (4) social support, (5) medical risk management, (6) vocational rehabilitation and (7) long-term strategies and maintenance. Both (1) and (2) were reported as having the greatest impact on patients’ daily lives. Subthemes for (1) included: guidance, engagement, awareness, consequences, attitude, no change and motivation. Psychosocial support comprised: stress management, pacing, relaxation, increased self-efficacy, validation, mental health and self-perception. This was followed by (3) and (4). Patients less frequently referred to (5), (6) and (7). Additional themes highlighted the impact of the HM programme and that patients attributed the greatest impact to a combination of all the above themes. CONCLUSION: This audit highlighted the HM as comprehensive and inclusive of key elements proposed by Scottish, UK and EU guidelines. Patients reported this had a profound impact on their daily lives and proved advantageous for CR.
Abstract

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

3. How is the audit of therapy intensity influencing rehabilitation in inpatient stroke units in the UK? An ethnographic study.

Authors
Taylor, Elizabeth; Jones, Fiona; McKevitt, Christopher

Source
BMJ open; Dec 2018; vol. 8 (no. 12); p. e023676

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Dec 2018

Publication Type(s)
Journal Article

PubMedID
30552266

Database
Medline
Available at BMJ open from Europe PubMed Central - Open Access
Available at BMJ open from HighWire - Free Full Text

Abstract

OBJECTIVESOccupational therapy, physiotherapy and speech and language therapy are central to rehabilitation after a stroke. The UK has introduced an audited performance target: that 45 min of each therapy should be provided to patients deemed appropriate. We sought to understand how this has influenced delivery of stroke unit therapy, DESIGNEthnographic study, including observation and interviews. The theoretical framework drew on the work of Lipsky and Power, framing therapists as ‘street level bureaucrats’ in an ‘audit society’. SETTINGStroke units in three English hospitals. PARTICIPANTSForty-three participants were interviewed, including patients, therapists and other staff. RESULTSThere was wide variation in how therapy time was recorded and in decision-making regarding which patients were ‘appropriate for therapy’ or auditable. Therapists interpreted their roles differently in each stroke unit. Therapists doubted the validity of the audit results and did not believe their results reflected the quality of services they provided. Some assumed their audit results would inform commissioning decisions. Senior therapy leaders shaped priorities and practices in each therapy team. Patients were inactive outside therapy sessions. Patients differed regarding the quantity of therapy they felt they needed but consistently wanted to be more involved in decisions and treated as individuals.


Authors
Radley, Andrew; de Bruin, Marijn; Inglis, Sarah K; Donnan, Peter T; Dillon, John F

Source
BMJ open; Dec 2018; vol. 8 (no. 12); p. e021443

Publication Date
Dec 2018

Publication Type(s)
Journal Article

PubMedID
30552244

Database
Medline
Available at BMJ open from Europe PubMed Central - Open Access
Available at BMJ open from HighWire - Free Full Text
Abstract

INTRODUCTION
Hepatitis C virus (HCV) infection affects 0.7% of the general population, and up to 40% of people prescribed opioid substitution therapy (OST) in Scotland. In conventional care, less than 10% of OST users are tested for HCV and less than 25% of these initiate treatment. Community pharmacists see this group frequently to provide OST supervision. This study examines whether a pharmacist-led 'test & treat' pathway increases cure rates for HCV.METHODS AND ANALYSIS
This protocol describes a cluster-randomised trial where 60 community pharmacies provide either conventional or pharmacy-led care. All pharmacies offer dried blood spot testing (DBST) for HCV. Participants have attended the pharmacy for OST for 3 months; are positive for HCV genotype 1 or 3; are not co-infected with HIV and/or hepatitis B; have no decompensated liver disease; are not pregnant. For conventional care, pharmacists refer HCV-positive participants to a local centre for assessment. In the pharmacy-led arm, pharmacists assess participants themselves in the pharmacy. Drug prescribing is by nurse prescribers (conventional arm) or pharmacist prescribers (pharmacy-led arm). Treatment in both arms is delivered as daily modified directly observed therapy in a pharmacy. Primary trial outcome is number of sustained virological responses at 12 weeks after treatment completion. Secondary trial outcomes are number of tests taken; treatment uptake; completion; adherence; re-infection. An economic evaluation will assess potential cost-effectiveness. Qualitative research interviews with clients and health professionals assess acceptability of a pharmacist-led pathway.ETHICS AND DISSEMINATION
This protocol has been ethically approved by the East of Scotland Research Ethics Committee 2 (15/ES/0086) and complies with the Declaration of Helsinki and principles of Good Clinical Practice. Caldicott guardian approval was given on 16 December 2016 to allow NHS Tayside to pass information to the cluster community pharmacies about the HCV test status of patients that they are seeing to provide OST supervision. NHS R&D approvals have been obtained from each health board taking part in the study. Informed consent is obtained before study enrolment and only anonymised data are stored in a secured database, enabling an audit trail. Results will be submitted to international peer-reviewed journals and presented at international conferences.TRIAL REGISTRATION NCT02706223; Pre-results.

5. An audit of antimicrobial prescribing by dental practitioners in the north east of England and Cumbria.

Authors
Sturrock, A; Landes, D; Robson, T; Bird, L; Ojelabi, A; Ling, J

Source
BMC oral health; Dec 2018; vol. 18 (no. 1); p. 206

Abstract
BACKGROUND
Inappropriate prescribing of antimicrobials is a significant threat to global public health. In England, approximately 5% of all antimicrobial items are prescribed by dentists, despite the limited indications for their use in the treatment of oral infections in published clinical guidelines. The objective of this study was to survey antimicrobial prescribing by dental practitioners in North East England and Cumbria, identify educational and training needs and develop a self-assessment tool that can be used for Continued Professional Development by individual practitioners.

METHODS
During October 2016, 275 dental practitioners used a standardised form to record anonymous information about patients who had been prescribed antimicrobials. Clinical information and prescribing details were compared against clinical guidelines published by the Faculty of General Dental Practitioners UK.

RESULTS
Dental practitioners provided data on 1893 antimicrobial prescriptions. There was documented evidence of systemic spread, such as pyrexia in 18% of patients. Dentists recorded patients’ pain (91.1% of patients), local lymph gland involvement (41.5%) gross diffuse swelling (55.5%) dysphagia (7.2%) and trismus (13.6%). Reasons for prescribing antimicrobials included patient expectations (25.8%), patient preference (24.8%), time pressures (10.9%), and patients uncooperative with other treatments (10.4%). The most commonly prescribed antimicrobials were amoxicillin, accounting for 61.2% of prescriptions, followed by metronidazole (29.9%). Most prescriptions for amoxicillin were for either 5 days (66.8%) or 7 days (29.6%) and most prescriptions for metronidazole were for a 5-day course (65.2%) or 7-day (18.6%) course.

CONCLUSION
In most cases, when an antimicrobial was prescribed, practitioners used the correct choice of agents and usually prescribed these at the correct dose. However, some evidence of suboptimal prescribing practices when compared to the Faculty of General Dental Practitioner guidelines were identified. The audit has identified training needs across the region and aided the development of Continued Professional Development sessions. Further work to identify barriers and facilitators for improving antimicrobial prescribing and determining appropriate methods to improve clinical practice are required.


Authors
Engelhardt, T; Ayansina, D; Bell, G T; Oshan, V; Rutherford, J S; Morton, N S; APRICOT Group of the European Society of Anaesthesiology Clinical Trial Network

Source
Anaesthesia; Dec 2018
Anaesthesia. Comparison of TNF-α is not significantly different between the TXA and control groups. The proportion of patients with a positive end expiratory pressure (PEEP) requirement was lower in the TXA group (p < 0.05). There was no difference in the proportion of patients requiring mechanical ventilation between the two groups. The proportion of patients with a haematocrit below 0.2 was significantly lower in the TXA group (p < 0.001). There was no difference in the proportion of patients with a platelet count below 50 x 10⁹/L between the two groups. The proportion of patients with a haemoglobin concentration below 80 g/L was lower in the TXA group (p < 0.001). There was no difference in the proportion of patients with a pH below 7.35 between the two groups. The proportion of patients with a respiratory rate above 20 breaths per minute was lower in the TXA group (p < 0.001). There was no difference in the proportion of patients with a Glasgow Coma Scale score below 8 between the two groups.

Abstract

The anaesthesia practice in children observational trial of 31,127 patients in 261 European hospitals revealed a high (5.2%) incidence of severe critical events in the peri-operative period and wide variability in practice. A sub-analysis of the UK data was undertaken to investigate differences compared with the non-UK cohort in the incidence and nature of peri-operative severe critical events and to attempt to identify areas for quality improvement. In the UK cohort of 7040 paediatric patients from 43 hospitals, the overall incidence of peri-operative severe critical events was lower than in the non-UK cohort (3.3%, 95%CI: 2.9-3.8 vs. 5.8%, 95%CI: 5.5-6.1, RR 0.57, p < 0.001). There was a lower rate of bronchospasm (RR 0.22, 95%CI: 0.14-0.33; p < 0.001), stridor (RR 0.42, 95%CI: 0.28-0.65; p < 0.001) and cardiovascular instability (RR 0.69, 95%CI: 0.55-0.86; p = 0.001) than in the non-UK cohort. The proportion of sicker patients where less experienced teams were managing care was lower in the UK than in the non-UK cohort (10.4% vs. 20.4% of the ASA physical status 3 and 9% vs. 12.9% of the ASA physical status 4 patients). Differences in work-load between centres did not affect the incidence and outcomes of severe critical events when stratified for age and ASA physical status. The lower incidence of cardiovascular and respiratory complications could be partly attributed to more experienced dedicated paediatric anaesthesia providers managing the higher risk patients in the UK. Areas for quality improvement include: standardisation of serious critical event definitions; increased reporting; development of evidence-based protocols for management of serious critical events; development and rational use of paediatric peri-operative risk assessment scores; implementation of current best practice in provision of competent paediatric anaesthesia services in Europe; development of specific training in the management of severe peri-operative critical events; and implementation of systems for ensuring maintenance of skills.


Authors

Coats, Timothy J; Fragoso-Iñiguez, Marisol; Roberts, Ian

Source

Emergency medicine journal : EMJ; Dec 2018

Publication Date

Dec 2018

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30530744

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Available at Emergency medicine journal : EMJ from BMJ Journals - NHS

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

Abstract

OBJECTIVE To describe the use of tranexamic acid (TXA) in trauma care in England and Wales since the Clinical Randomization of an Antifibrinolytic in Significant Hemorrhage (CRASH-2) trial results were published in 2010.METHODS A national longitudinal and cross-sectional study using data collected through the Trauma Audit and Research Network (TARN), the clinical audit of major trauma care for England and Wales. All patients in the TARN database injured in England and Wales were included apart from those with an isolated traumatic brain injury, with a primary outcome of the proportion of patients given TXA and the secondary outcome of time to treatment.RESULTS Among 228,250 patients, the proportion of trauma patients treated with TXA increased from near zero in 2010 to 10% (4593) in 2016. In 2016, most patients (82%) who received TXA did so within 3 hours of injury, however, only 30% of patients received TXA within an hour of injury. Most (80%) of the patients who had an early blood transfusion were given TXA. Patients treated with TXA by an ambulance paramedic received treatment at a median of 49 min (IQR 33-72) compared with 111 min (IQR 77-162) for patients treated in hospital.CONCLUSION There is a low proportion of patients treated with TXA across the range of injury severity and the range of physiological indicators of severity of bleeding. Most patients receive treatment within the existing target of 3 hours from injury, however there remains the potential to further improve major trauma outcomes by the earlier treatment of a wider patient group.


Authors

Sundberg, Tobias; Leach, Matthew J; Thomson, Oliver P; Austin, Philip; Fryer, Gary; Adams, Jon
9. Does adult alcohol consumption combine with adverse childhood experiences to increase involvement in violence in men and women? A cross-sectional study in England and Wales.

Authors: Bellis, Mark A; Hughes, Karen; Ford, Kat; Edwards, Sara; Sharples, Olivia; Hardcastle, Katie; Wood, Sara

Source: BMJ open; Dec 2018; vol. 8 (no. 12); p. e020591

Abstract: OBJECTIVES To examine if, and to what extent, a history of adverse childhood experiences (ACEs) combines with adult alcohol consumption to predict recent violence perpetration and victimisation. DESIGN Representative face-to-face survey (n=12 669) delivered using computer-assisted personal interviewing and self-interviewing. SETTING Domiciles of individuals living in England and Wales. PARTICIPANTS Individuals aged 18–69 years resident within randomly selected locations. 12 669 surveys were completed with participants within our defined age range. MAIN OUTCOME MEASURES Alcohol consumption was measured using the Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) and childhood adversity using the short ACEs tool. Violence was measured using questions on perpetration and victimisation in the last 12 months. RESULTS Compliance was 55.7%. There were strong positive relationships between numbers of ACEs and recent violence perpetration and victimisation in both sexes. Recent violence was also strongly related to positive AUDIT-C (≥5) scores. In males, heavier drinking and ≥4ACEs had a strong multiplicative relationship with adjusted prevalence of recent violent perpetration rising from 1.3% (95% CIs 0.9% to 1.9%) to 0 ACEs, negative AUDIT-C to 3.6% (95% CIs 2.7% to 4.9%); 0 ACEs, positive AUDIT-C and 8.5% (95% CI 5.6% to 12.7%); ≥4ACEs, negative AUDIT-C to 28.3% (95% CI 22.5% to 34.8%); ≥4ACEs, positive AUDIT-C. In both sexes, violence perpetration and victimisation reduced with age independently of ACE count and AUDIT-C status. The combination of young age (18–29 years), ≥4ACEs and positive AUDIT-C resulted in the highest adjusted prevalence for both perpetration and victimisation in males (61.9%, 64.9%) and females (24.1%, 27.2%). CONCLUSIONS Those suffering multiple adverse experiences in childhood are also more likely to be heavier alcohol users. Especially for males, this combination results in substantially increased risks of violence. Addressing ACEs and heavy drinking together is rarely a feature of public health policy, but a combined approach may help reduce the vast costs associated with both.

10. Impact of a physician-led pre-hospital critical care team on outcomes after major trauma.

Authors: Hepple, D J; Durrand, J W; Bouamra, O; Godfrey, P

Source: Anaesthesia; Dec 2018

Abstract: BACKGROUND Evidence-based practice (EBP) is a clinical decision-making framework that supports quality improvement in healthcare. While osteopaths are key providers of musculoskeletal healthcare, the extent to which osteopaths engage in EBP is unclear. Thus, the aim of this cross-sectional study was to investigate UK osteopaths' attitudes, skills and use of EBP, and perceived barriers and facilitators of EBP uptake. METHODS UK-registered osteopaths were invited to complete the Evidence-Based Practice Attitude and Utilisation Survey (EBASE) online. RESULTS Of the 5200 registered osteopaths in the UK, 9.9% (517/5200) responded to the invitation, and 7.2% (375/5200) completed the EBASE (<20% incomplete answers). The demographic characteristics of the survey sample were largely similar to those of the UK osteopathy workforce. The osteopaths reported overall positive attitudes towards EBP, with most agreeing that EBP improves the quality of patient care (69.3%) and is necessary for osteopathy practice (76.5%). The majority reported moderate-level skills in EBP, and most (80.8%) were interested in improving these skills. Participating osteopaths typically engaged in EBP activities 1–5 times over the last month. Barriers to EBP uptake included a lack of time and clinical evidence in osteopathy. Main facilitators of EBP included having access to online databases, internet at work, full-text articles, and EBP education materials. CONCLUSIONS UK osteopaths were generally supportive of evidence-based practice, had moderate-level skills in EBP and engaged in EBP activities infrequently. The development of effective interventions that improve osteopaths' skills and the incorporation of EBP into clinical practice should be the focus of future research.
The deployment of physician-led pre-hospital enhanced care teams capable of critical care interventions at the scene of injury may confer a survival benefit to victims of major trauma. However, the evidence base for this widely adopted model is disputed. Failure to identify a clear survival benefit has been attributed to several factors, including an inherently more severely injured patient group who are attended by these teams. We undertook a novel retrospective analysis of the impact of a regional enhanced care team on observed vs. predicted patient survival based on outcomes recorded by the UK Trauma Audit and Research Network (TARN). The null hypothesis of this study was that attendance of an enhanced care team would make no difference to the number of 'unexpected survivors'. Patients attended by an enhanced care team were more seriously injured. Analysis of Trauma Audit and Research Network patient outcomes did not demonstrate an improved adjusted survival rate for trauma patients who were treated by a physician-led enhanced care team, but confirmed differences in patient characteristics and severity of injury for those who were attended by the team. We conclude that a further prospective multicentre analysis is warranted. An essential prerequisite for this would be to address the current blind spot in the Trauma Audit and Research Network database - patients who die from trauma before ever reaching hospital. We speculate that early on-scene critical care may convert this cohort of invisible trauma deaths into patients who might survive to reach hospital. Routine collection of data from these patients is warranted to include them in future studies.

11. Demographic Factor Clustering at a GP practice level in England and its relation to Glycaemic Outcomes: What we can learn from this.

Authors
Stedman, M; Lunt, M; Livingston, M; Fryer, A; Moreno, G; Anderson, S; Gadsby, R; Heald, A

Source
International journal of clinical practice; Dec 2018 ; p. e13303

Publication Date
Dec 2018

Publication Type(s)
Journal Article

PubMedID
30515926

Database
Medline

Available at International Journal of Clinical Practice from Wiley Online Library Medicine and Nursing Collection 2018 - NHS

Abstract
As described in our previous papers (1,2,3), a multiplicity of factors determine the outcome for people with both type 1 diabetes (T1DM) and type 2 diabetes (T2DM) when seen from the perspective of general practitioner (GP) practice level data as reported by the National Diabetes Audit (NDA) (4). This article is protected by copyright. All rights reserved.


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; Dec 2018

Publication Date
Dec 2018

Publication Type(s)
Journal Article

PubMedID
30515932

Database
Medline

Available at Internal Medicine Journal from Wiley Online Library Medicine and Nursing Collection 2018 - NHS
Abstract

INTRODUCTION 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. We aimed to collect similar data for our Victorian patients from six hospitals within the Victorian Comprehensive Cancer Centre (VCCC) and associated Western and Central Melbourne Integrated Cancer Service (WCMICS). METHODS We conducted a retrospective audit of all newly diagnosed patients with lung cancer and mesothelioma in 2013 across the 6 VCCC/WCMICS hospitals. The objectives were to adapt the NLCA dataset 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. RESULTS 845 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 to 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 to the UK in 2013. In future, prospective data collection should be harmonized across sites and correlated with survival outcomes. One area of concern was a lack of documented access to specialist nursing services. This article is protected by copyright. All rights reserved.


Authors Pyles, Putney; Pelland, Kimberly; Crowningshield, Vicki; Jenkins, Brenda; Capizzo, Lauren
Source Rhode Island medical journal (2013); Dec 2018; vol. 101 (no. 10); p. 24-27
Publication Date Dec 2018
Publication Type(s) Journal Article
PubMedID 30509002
Database Medline
Abstract Healthcare reform efforts implemented to optimize primary and specialty care delivery require practices to undertake considerable transformation. To support change efforts, many private insurers and federal and state health-reform efforts provide practices and clinicians with access to practice-transformation facilitators. Healthcentric Advisors provides practice-transformation support and technical assistance to practices in Rhode Island and across New England. From this work we know that strategies and approaches to support transformation and achievement of program recognitions differ by practice characteristics, resource access, and patient panels. Understanding practice attitudes and beliefs about change, recognizing that change occurs on a spectrum, acknowledging that program recognition is only the beginning, and aligning quality-improvement initiatives, are domains that support success regardless of practice type. However, working with a facilitator who engages your entire care team to integrate a culture of quality improvement and process ownership, has the greatest impact on overall transformation.

14. Six months on: NHS England needs to focus on dissemination, implementation and audit of its low-priority initiative.

Authors Walker, Alex J; Bacon, Seb; Curtis, Helen; Croker, Richard; MacKenna, Brian; Goldacre, Ben
Source Journal of the Royal Society of Medicine; Dec 2018 ; p. 141076818808429
Publication Date Dec 2018
Publication Type(s) Journal Article
PubMedID 30507285
Database Medline
Abstract Available at Journal of the Royal Society of Medicine from Leicester General Hospital Library Local Print Collection [location] : Leicester General Library. [title_notes] : Issues before 2000 held in Archive. Available at Journal of the Royal Society of 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.

15. Patient perspectives on a national multidisciplinary team meeting for a rare cancer.

Authors Bate, Jessica; Wingrove, Jane; Donkin, Alexandra; Taylor, Rachel; Whelan, Jeremy
Source European journal of cancer care; Dec 2018 ; p. e12971
Publication Date Dec 2018
Publication Type(s) Journal Article
PubMedID 30507003
Database Medline
Abstract Available at European Journal of Cancer Care from Wiley Online Library Medicine and Nursing Collection 2018 - NHS Available at European Journal of Cancer Care from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).

**Authors** Pepper, Thomas; Hicks, Georgina

**Source** British journal of hospital medicine (London, England : 2005); Dec 2018; vol. 79 (no. 12); p. 708-710

**Database** Medline

**PubMedID** 30526113

**Abstract** The duty roster should be made available 6 weeks before commencement of post. The duty roster is the first step towards achieving any work-life balance, and anecdotally doctors frequently receive very little notice of this. This audit assessed NHS trusts' compliance with the Code of Practice, with specific reference to advance notification of duty rosters.

**METHOD:** The duty roster should be made available 6 weeks before commencement of post. The initial audit comprised a survey sent to all London surgical CT1s starting in October 2016. The interventions introduced following this were creation of a shared spreadsheet containing roster coordinator contact details, reminder emails sent to roster coordinators and distribution of results to NHS Improvement. A repeat survey was sent to all London surgical CT1s and CT2s starting in October 2017.

**RESULTS:** In the initial audit 48/88 (55%) responded, of whom 4/48 (8%) received their duty roster in accordance with the standard and 9/48 (19%) did not receive the roster at all before starting. A total of 40/48 (83%) of trainees had to make specific contact with their future NHS trust in order to obtain their roster. In this initial audit 12/48 (25%) of trainees were satisfied or very satisfied with the amount of notice given. In the reaudit 133/178 (75%) responded, of whom 4/48 (8%) received their duty roster in accordance with the standard and 9/48 (19%) did not receive the roster at all before starting. A total of 97/133 (73%) of trainees had to make specific contact with their future NHS trust in order to obtain their roster. In the reaudit 56/133 (42%) of trainees were satisfied or very satisfied with the amount of notice given.

**CONCLUSIONS:** This closed loop audit led to a doubling in the proportion of trainees receiving their rosters in accordance with the standard, and this was associated with an increase in trainee satisfaction levels. However, adherence to the standard remained low in both phases of the audit, and a significant proportion of trainees continue to commence jobs without any knowledge of their on-call roster. A range of measures is proposed to address this.

17. Reducing adult cardiac surgical site infections and the economic impact of using multidisciplinary collaboration.

**Authors** Chiwera, L; Wigglesworth, N; McCoskery, C; Lucchese, G; Newsholme, W

**Source** The Journal of hospital infection; Dec 2018; vol. 100 (no. 4); p. 428-436

**Database** Medline

**PubMedID** 29604297

**Abstract** Multidisciplinary team meetings (MDTM) provide a regular forum for cancer teams to convene and discuss the diagnostic and treatment aspects of patient care. For some rare cancers, MDTMs may also occur at national level to pool expertise and to ensure more consistent decision-making. One such national MDT exists in the UK for patients with a diagnosis of Ewing's sarcoma of the bone—the National Ewing's MDT (NEMDT). This study explored the patient perspective of this rare cancer national MDTM using focus group and survey methodology. Study participants used their experience to provide several recommendations: that their views should always inform the decision-making process, these views should be presented by someone who has met them such as a specialist nurse, MDT recommendations should be provided to them in plain English, and tools to improve patient choice and enhance communication should be implemented. These patient-centred recommendations will be used to improve the NEMDT but may be valid to inform quality improvement processes for other similar national panels.
BACKGROUND Cardiac surgical site infections (SSIs) have devastating consequences and present several challenges for patients and healthcare providers. Adult cardiac SSI surveillance commenced in 2009 at our hospitals, Guy’s & St Thomas’ NHS Foundation Trust, London, as a patient safety initiative amid reported increased incidence of SSIs. Before this time, infection incidence was unclear because data collection was not standardized. AIM To standardize SSI data collection and establish baseline SSI rates to facilitate deployment of evidence-based targeted interventions within clinical governance structures to improve quality, safety, and efficiency in line with our organizational targets. METHODS We standardized local data collection protocols in line with Public Health England recommendations and identified local champions. We undertook prospective SSI surveillance collaboratively to enable us to identify potential practice concerns and address them more effectively through a series of initiatives. Clinical staff completed dedicated surveillance forms intraoperatively and postoperatively.

FINDINGS Overall adult cardiac SSI rates fell from 5.4% in 2009 to 1.2% in 2016 and coronary artery bypass graft rates from 6.5% in 2009 to 1.7% in 2016 (P < 0.001). Gram-negative bacteria were recognized as important SSI causative organisms and were better controlled after introducing stringent infection control measures. CONCLUSION Comprehensive, evidence-based infection control practices were successfully implemented through a multidisciplinary collaborative approach, which may have great potential to reduce Gram-negative, Staphylococcus aureus, polymicrobial and overall SSI burden and/or associated costs. We now investigate all SSIs using an established SSI detailed investigation protocol to promote continual quality improvement that aligns us perfectly with global efforts to fight antimicrobial resistance.

18. Impact of a diagnostics-driven antifungal stewardship programme in a UK tertiary referral teaching hospital.

Authors
Rautemaar-Richardson, R; Rautemaar, V; Al-Wathiqi, F; Moore, C B; Craig, L; Felton, T W; Muldoon, E G

Source
The Journal of antimicrobial chemotherapy; Dec 2018; vol. 68 (no. 677); p. e869

Abstract
Objectives A concise invasive candidosis guideline (based on the ESCMID candidaemia guideline) utilizing an informative biomarker [serum β-1-3-d-glucan (BDG)] was developed in 2013 by an antifungal stewardship (AFS) team and implemented with the help of an AFS champion in 2014. The main aims of the AFS programme were to reduce inappropriate use of antifungals and improve patient outcomes. The aim of this project was to evaluate the compliance of the ICU teams with the invasive candidosis guideline and the impact of the AFS programme on mortality and antifungal consumption on the ICUs (total of 71 beds).

METHODS All patients who were prescribed micafungin for suspected or proven invasive candidosis during 4 month audit periods in 2014 and 2016 were included. Prescriptions and patient records were reviewed against the guideline. Antifungal consumption and mortality data were analysed.

RESULTS The number of patients treated for invasive candidosis decreased from 39 in 2014 to 29 in 2016. This was mainly due to the reduction in patients initiated on antifungal therapy inappropriately: 18 in 2014 and 2 in 2016. Antifungal therapy was stopped following negative biomarker results in 12 patients in 2014 and 10 patients in 2016. Crude mortality due to proven or probable invasive candidosis decreased to 19% from 45% over the period 2003-07. Antifungal consumption reduced by 49% from 2014 to 2016. Conclusions The AFS programme was successful in reducing the number of inappropriate initiations of antifungals by 90%. Concurrently, mortality due to invasive candidosis was reduced by 58%. BDG testing can guide safe cessation of antifungals in ICU patients at risk of invasive candidosis.


Authors
Maskell, Katherine; McDonald, Paula; Paudyal, Priyamvada

Source
The British journal of general practice : the journal of the Royal College of General Practitioners; Dec 2018; vol. 68 (no. 677); p. e869

Abstract
The British journal of general practice : the journal of the Royal College of General Practitioners from EBSCO (MEDLINE Complete) Available at The British journal of general practice : the journal of the Royal College of General Practitioners from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.
Abstract

BACKGROUND
Health education materials (HEMs) are widely used in general practice. However, there is little information on the variety of HEMS currently available to patients in the UK, or their preferences for accessing educational materials.

AIM
To assess patients’ perceptions of HEMs, and the variety and accessibility of these materials.

DESIGN AND SETTING
Cross-sectional study conducted in general practices in Brighton and Hove.

METHOD
An anonymous questionnaire was distributed to patients in the waiting room (WR). Additionally, an audit was conducted to measure the variety of the HEMs. Results were analysed using binary multiple logistic regression.

RESULTS
In all, 556 participants (response rate 83.1%) from 19 practices took part. The mean age of participants was 49.3 years (SD ±18.9) and 63% were female. Perceived usefulness of HEMs was associated with reading in the WR using written HEMs, and not having a university degree; noticeability was associated with reading in the WR, and being female; attractiveness was associated with not having a university degree and shorter waiting time. On average, WRs contained 72 posters covering 23 topics, and 53 leaflets covering 24 topics, with many outdated and poorly presented materials of limited accessibility.

CONCLUSION
This study found substantial variation in the amount, topicality, and quality of material available in WRs. As most patients notice HEMs and find them useful, available technology could be better utilised to widen access to HEMs. The introduction of wireless free internet (Wi-Fi) to waiting rooms should provide an opportunity to update this area.

20. Noninvasive vagus nerve stimulation in a primary care setting: effects on quality of life and utilization measures in multimorbidity patients with or without primary headache.

Authors
Strickland, Iain; Mwamburi, Mkaya; Davis, Steven; Ward, James C R; Day, Janet; Tenaglia, Andrew T; Leibler, Eric J; Staats, Peter S

Source
The American journal of managed care; Dec 2018; vol. 24 (no. 24)

Publication Date
Dec 2018

Publication Type(s)
Journal Article

PubMedID
30543269

Database
Medline

Abstract
A patient audit was conducted in the UK to evaluate the impact of gammaCore use in multimorbidity patients on quality of life and healthcare resources utilization measures. A total of 233 patients were enrolled and their data was examined over a 1-year period after their gammaCore prescription. Of these patients, 132 (56%) had primary headache disorders while 101 (44%) were patients without a headache disorder (nonheadache patients). The mean age was 49 years, 169 (72%) were female, the mean number of comorbid conditions was 3.1, and the mean baseline EQ-5D score was 0.581. The mean paired difference in EQ-5D index for persistent gammaCore users (ie patients who used gammaCore for at least 40 weeks) was +0.156 at week 40. The mean percentage reductions in number of general practice consults (doctor’s office appointments) was -28.5% from baseline mean of 7.31 and, 40.0% from baseline mean of 3.52 for medical codes used. This evidence demonstrates that a significant proportion of these multimorbidity patients on gammaCore remained compliant with the prescribed treatment regimen for an extended period. GammaCore use in multimorbidity patients may be associated with lower costs of care and provide opportunities for pay-for-performance coverage policies.

21. Evaluation of a questionnaire to measure parent/carer and child/young person experience of NHS epilepsy services.

Authors
Maini, Rishma; Kirkpatrick, Martin; McCafferty, Aileen; Dunkley, Colin; Ogston, Simon; Williams, Fiona

Source
Seizure; Dec 2018; vol. 63 ; p. 71-78

Publication Date
Dec 2018

Publication Type(s)
Journal Article Validation Studies

PubMedID
30445294

Database
Medline

Abstract
A patient audit was conducted in the UK to evaluate the impact of gammaCore use in multimorbidity patients on quality of life and healthcare resources utilization measures. A total of 233 patients were enrolled and their data was examined over a 1-year period after their gammaCore prescription. Of these patients, 132 (56%) had primary headache disorders while 101 (44%) were patients without a headache disorder (nonheadache patients). The mean age was 49 years, 169 (72%) were female, the mean number of comorbid conditions was 3.1, and the mean baseline EQ-5D score was 0.581. The mean paired difference in EQ-5D index for persistent gammaCore users (ie patients who used gammaCore for at least 40 weeks) was +0.156 at week 40. The mean percentage reductions in number of general practice consults (doctor’s office appointments) was -28.5% from baseline mean of 7.31 and, 40.0% from baseline mean of 3.52 for medical codes used. This evidence demonstrates that a significant proportion of these multimorbidity patients on gammaCore remained compliant with the prescribed treatment regimen for an extended period. GammaCore use in multimorbidity patients may be associated with lower costs of care and provide opportunities for pay-for-performance coverage policies.
Abstract

PURPOSE To validate a patient-reported-experience-measure, PREM, of the NHS paediatric epilepsy service. METHODS Section 1 of the PREM recorded demographic and clinical characteristics, and Section 2 collected information about the users’ experience with the service. Section 2 included eighteen statements around three constructs: communication and provision of information to service users, interpersonal skills of staff, and clinic visits and accessibility to the services. Face validity, construct validity, internal reliability, and internal consistency were used to examine the robustness of these statements. The PREM was completed by parents/carers and also children/young people. RESULTS PREMs were received from 145 of the 192 audit units; 2335 completed forms were returned; the attitude statements were completed by 750 children/young people and 1550 parents/carers. Face validity of the PREM was good. Construct validity was indecisive; confirmatory factor analysis of the hypothesised construct was weak. Exploratory factor analysis identified a four factor solution for the parent/carers dataset and a five factor solution for the children/young people’s dataset. Internal reliability was good for the parent/carers dataset but less good for the children/young people. Internal consistency was moderately good for both datasets. CONCLUSION These findings indicate that the PREM is likely to be a valid tool with the potential to elicit a wide variety of reliable views from parents/carers of children with epilepsy. The construct validity for the PREM should be reassessed with confirmatory factor analysis in a new dataset. More work needs to be undertaken with children/young people to design statements that capture their specific needs.

22. Rising to the challenge: Epilepsy specialist nurses as leaders of service improvements and change (SENsE study).

Authors Higgins, Agnes; Downes, Carmel; Varley, Jarleth; Doherty, Colin P; Begley, Cecily; Elliott, Naomi

Source Seizure; Dec 2018; vol. 63 ; p. 40-47

Publication Date Dec 2018

Publication Type(s) Journal Article

PubMedID 30399460

Database Medline

Abstract

PURPOSE To report the leadership role and change activities of epilepsy specialist nurses (ESNs) in Ireland; findings from the SENsE study. METHODS A mixed methods study design was used, involving 12 epilepsy specialist nurses working in five units in Ireland, 24 multidisciplinary team members working with them, and 35 people with epilepsy and their family members. Data were collected using individual and focus group interviews, observation and documentary analysis. RESULTS Five key areas in which ESNs demonstrated leading on the change agenda were identified. These included: Initiating new clinical practice developments; Building capability within the multidisciplinary team; Developing education programmes and resources for people with epilepsy, family and the public; Exerting influence through membership of committees and lobbying; and Advancing the ESN role. CONCLUSION Though the epilepsy specialist nurse role was first established in the UK in 1988, much of the literature that discusses or describes the ESN role is founded on anecdotal evidence, or focusses on their clinical expertise. Findings from this study provide empirical evidence that the ESNs were involved as key players in leading changes within the services, in the education of others, and the continuous advancement of epilepsy care.

23. Effect of an Educational and Organizational Intervention on Pain in Nursing Home Residents: A Nonrandomized Controlled Trial.

Authors Guion, Vincent; De Souto Barreto, Philippe; Sourdet, Sandrine; Rolland, Yves

Source Journal of the American Medical Directors Association; Dec 2018; vol. 19 (no. 12); p. 1118

Publication Date Dec 2018

Publication Type(s) Journal Article

PubMedID 30471802

Database Medline

Abstract

PURPOSE To report the leadership role and change activities of epilepsy specialist nurses (ESNs) in Ireland; findings from the SENsE study. METHODS A mixed methods study design was used, involving 12 epilepsy specialist nurses working in five units in Ireland, 24 multidisciplinary team members working with them, and 35 people with epilepsy and their family members. Data were collected using individual and focus group interviews, observation and documentary analysis. RESULTS Five key areas in which ESNs demonstrated leading on the change agenda were identified. These included: Initiating new clinical practice developments; Building capability within the multidisciplinary team; Developing education programmes and resources for people with epilepsy, family and the public; Exerting influence through membership of committees and lobbying; and Advancing the ESN role. CONCLUSION Though the epilepsy specialist nurse role was first established in the UK in 1988, much of the literature that discusses or describes the ESN role is founded on anecdotal evidence, or focusses on their clinical expertise. Findings from this study provide empirical evidence that the ESNs were involved as key players in leading changes within the services, in the education of others, and the continuous advancement of epilepsy care.

Available at Journal of the American Medical Directors 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.
OBJECTIVES To determine whether an intervention based on education and professional support to nursing home (NH) staff would decrease the number of residents with a pain complaint, and to determine whether the intervention would improve pain management.

DESIGN Nonrandomized controlled trial.

NHS were nonrandomly allocated either to a strong intervention group consisting in audit, feedback, and collaborative work on quality indicators with a hospital geriatrician, or to a light intervention group (LIG) consisting in audit and feedback only.

SETTING One hundred fifty-nine NHs located in France.

PARTICIPANTS A subgroup of 3722 residents.

MEASURES Information on pain complaint and pain-related covariates at the resident-related and at the NH level were recorded by NH staff at baseline and 18 months later. These covariates were included in a mixed-effects logistic regression on resident’s pain complaint. Pain management was compared between intervention groups by chi-square tests.

RESULTS A greater reduction of residents with a pain complaint after the strong intervention (odds ratio 0.69, 95% confidence interval 0.53, 0.90) and a better pain management (47.6% gold standard, vs 30.6% in the LIG, P < .001) than controls.

CONCLUSION/IMPLICATIONS Combining educational and organizational measures, evaluating pain as a patient-reported outcome and as a process endpoint, and implementing a broad-spectrum intervention were original approaches to improve quality of care in NHs. Our results support nonspecific, collaborative, educational, and organizational interventions in NHs to decrease residents’ pain complaint and improve pain management.
26. Validation of the person-centred coordinated care experience questionnaire (P3CEQ).

**Authors**
Lloyd, Helen; Fosh, Ben; Whalley, Ben; Byng, Richard; Close, James

**Source**
International journal for quality in health care : journal of the International Society for Quality in Health Care; Dec 2018

**Publication Date**
Dec 2018

**Publication Type(s)**
Journal Article

**PubMedID**
30508089

**Database**
Medline

**Abstract**
Background Measuring patient experiences of healthcare is increasingly emphasized as a mechanism to measure, benchmark and drive quality improvement, clinical effectiveness and patient safety at both national and local NHS level. Person-centred coordinated care (P3C) is the conjunction of two constructs; person-centred care and care coordination. It is a complex intervention requiring support for changes to organizational structure and the behaviour of professionals and patients. P3C can be defined as: ‘care and support that is guided by and organized effectively around the needs and preferences of individuals’. Despite the vast array of PRMS available, remarkably few tools have been designed that efficiently probe the core domains of P3C. This paper presents the psychometric properties of a newly developed PREM to evaluate P3C from a patient perspective. Methods A customized EMIS search was conducted at 72 GP practices across the South West (Somerset, Devon and Cornwall) to identify 100 patients with 1 or more LTCs, and are frequent users of primary healthcare services. Partial Credit Rasch Modelling was conducted to identify dimensionality and internal consistency. Ecological validity and sensitivity to change were assessed as part of intervention designed to improve P3C in adults with multiple long-term conditions; comparisons were drawn between the P3CEQ and qualitative data. Results Response rate for the P3CEQ was 32.82%. A two-factor model was identified. Rasch analysis confirmed unidimensionality of each factor (using infit MQS values between 0.5 and 1.5). High internal consistency was established for both factors; For the Person-centred scale Cronbach’s Alpha = 0.829, Person separation = 0.756 and for the coordination scale Cronbach’s alpha = 0.783, person separation = 0.756. Conclusion The P3CEQ is a valid and reliable measure of P3C. The P3C is considered to have strong face, construct and ecological validity, with demonstrable sensitivity to change in a primary healthcare intervention.

27. Relationship between height and outcomes among critically ill adults: a cohort study.

**Authors**
Vail, Emily A; Harrison, David A; Wunsch, Hannah

**Source**
Intensive care medicine; Dec 2018; vol. 44 (no. 12); p. 2122-2133

**Publication Date**
Dec 2018

**Publication Type(s)**
Journal Article

**PubMedID**
30421257
Abstract

PURPOSE Many diagnostic and therapeutic interventions for critically ill adult patients are not performed according to patient size, but are standardized for an idealized 174-cm man (ideal body weight 70 kg). This study aims to determine whether critically ill patients with heights significantly different from a standardized patient have higher hospital mortality or greater resource utilization.

METHODS Retrospective cohort study of consecutive patients admitted to 210 intensive care units (ICUs) in the United Kingdom participating in the Intensive Care National Audit and Research Centre’s Case Mix Programme Database from April 1, 2009, to March 31, 2015. Primary outcome was hospital mortality, adjusted for age, comorbid disease, severity of illness, socioeconomic status and body mass index, using hierarchical modeling to account for clustering by ICU. Data were stratified by sex, and the effect of height was modeled continuously using restricted cubic splines.

RESULTSThe cohort included 233,308 men and 184,070 women, with overall hospital mortality of 22.5% and 20.6%, respectively. After adjustment for potential confounders, hospital mortality decreased with increasing height; predicted mortality (holding all other covariates at their mean value) decreased from 24.1 to 17.1% for women and from 29.2 to 21.0% for men across the range of heights. Similar patterns were observed for ICU mortality and several additional secondary outcomes.

CONCLUSIONSShort stature may be a risk factor for mortality in critically ill patients. Further work is needed to determine which unmeasured patient characteristics and processes of care may contribute to the increased risk observed.

28. The UK Online Gender Audit 2018: A comprehensive audit of gender within the UK’s online environment.

Authors Huluba, Ana-Maria; Kingdon, Jason; McLaren, Iain
Source Heliyon; Dec 2018; vol. 4 (no. 12); p. e01001
Publication Date Dec 2018
Publication Type(s) Journal Article
PubMedID 3056209
Database Medline

Abstract

Gender inequality has exploded as a recent issue within mainstream media across US and UK cultural commentary. High-profile scandals of sexual harassment and gender pay differences have focused attention on the on-going disparity between sexes and political status. This paper presents a novel experiment in the application of so-called ”big data” to analyse gender inequality. Using Artificial Intelligence (AI) techniques in the form of Natural Language Processing, a web crawler is used to audit the whole.uk online domain, and to measure the United Kingdom’s (UK’s) online economic presence for gender representation in terms of: prominence, job roles, and leadership within and across economic sectors. The procedure scans over 200 million web pages, and harvests 157,032 organisations and over 2.3 million people. The results reveal material bias (60%+) towards the representation of men over the majority of economic sectors, and across representation of power and status within job roles and professional titles. The experiment highlights not only new levels of gender bias but also the use of the Internet as a valuable source of plentiful data for social and economic analysis.

29. Consensus generation of a minimum set of outcome measures for auditing glaucoma surgery outcomes—a Delphi exercise.

Authors Somner, J E A; Ismail, R; Froud, R; Azaaara-Blanco, A; King, A J
Source Graefe’s archive for clinical and experimental ophthalmology = Albrecht von Graefes Archiv fur klinische und experimentelle Ophthalmologie; Dec 2018; vol. 256 (no. 12); p. 2407-2411
Publication Date Dec 2018
Publication Type(s) Multicenter Study Journal Article
PubMedID 30251199
Database Medline

Abstract

Available at Graefe's archive for clinical and experimental ophthalmology = Albrecht von Graefes Archiv fur klinische und experimentelle Ophthalmologie from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location]: British Library via UHL Libraries - please click link to request article.
Abstract

PURPOSE To identify the key set of glaucoma surgery outcome measures considered most important and practical to collect by glaucoma specialists. METHODS One hundred two glaucoma specialists (57 members of the UK and Eire Glaucoma Society (UKEGS) and 45 members of the European Glaucoma Society (EGS)) took part in an Online Delphi exercise. The RAND/UCLA appropriateness method was used analyse data from each round and generate a disagreement index. RESULTS Participants agreed on 13 baseline data points and 12 outcomes that were considered important and practical to collect. For intraocular pressure (IOP) percentage reduction in IOP from baseline (last three IOP readings pre-op) and reduction below a specified target were considered important. For visual fields, change in a global visual field index, e.g. MD, and development of progression as assessed by linear regression were considered important. From a safety perspective, any visual loss resulting in a doubling of the minimal angle of resolution, loss of 5 dB or more of visual field or development of advanced field loss (Hodapp Parrish Anderson Stage 4) was considered important. The importance of routines using patient reported outcome measures (PROMs) was highlighted. Consensus suggested that outcomes of glaucoma treatments should be reported at 1, 5 and 10 years. CONCLUSION There was broad consensus on a minimum dataset for reporting the outcomes of glaucoma surgery and outcome measurement intervals.

30. Does the mode of delivery in routine cardiac rehabilitation have an association with cardiovascular risk factor outcomes?

Authors Harrison, Alex S; Doherty, Patrick
Source European journal of preventive cardiology; Dec 2018; vol. 25 (no. 18); p. 1925-1933
Publication Date Dec 2018
Publication Type(s) Journal Article
PubMedID 30188178
Database Medline
Abstract AIMSCardiac rehabilitation is one of the most cost-effective interventions for patients with cardiovascular disease. Worldwide supervised group-based cardiac rehabilitation is the dominant mode of delivery followed by facilitated self-managed (FSM), which is emerging as part of a cardiac rehabilitation menu. Modern research evidence, using trials and well-resourced interventions, suggests FSM is comparable to supervised rehabilitation in its outcomes for patients; however, this is yet to be established using routine clinical practice data. METHODS Including 81,626 patients from routine clinical data in the National Audit of Cardiac Rehabilitation, this observational study investigated whether mode of delivery, supervised or FSM, was associated with similar cardiac rehabilitation outcomes. Hierarchical regression models included patient and service covariates such as age, gender, cardiac rehabilitation duration and programme staff type. RESULTS The results showed 85% of the population received supervised cardiac rehabilitation. The FSM group were significantly older, female and predominantly in lower socioeconomic groups. The results showed that all patients on average benefit from cardiac rehabilitation, independently of mode of delivery, across all risk factors. Additional benefit of 13% and 11.4% increased likelihood of achieving the target state for physical activity and body mass index respectively when using FSM approaches. CONCLUSION This is the first study to investigate traditional cardiovascular risk factors with cardiac rehabilitation mode of delivery using routine clinical data. Both modes of delivery were associated with comparable statistically significant positive outcomes. Despite having equivalent outcomes, FSM cardiac rehabilitation continues to be underutilised, with less than 20% of patients receiving this mode of delivery in the UK.


Authors Roshen, Michael; John, Sophia; Ahmet, Selda; Amersey, Rajiv; Gupta, Sandy; Collins, George
Source Echo research and practice; Dec 2018
Publication Date Dec 2018
Publication Type(s) Journal Article
PubMedID 30540562
Database Medline
Abstract Available at Echo research and practice from Europe PubMed Central - Open Access

The British Society of Echocardiography (BSE) highlights the importance of patient questionnaires as part of the quality improvement process. To this end, we implemented a novel system whereby paired surveys were completed by patients and physiologists for transthoracic echocardiography scans, allowing for parallel comparison of the experiences of service providers and end users. Anonymised questionnaires were completed for each scan by the patient and physiologist for outpatient echocardiographic scans in a teaching hospital. In 26% of the responses, patient found the scans at least slightly painful, and in 24% of scans physiologists were in discomfort. The most common reason given by physiologists for technically difficult or inadequate scans was patient discomfort. In 38% of the scans at least one person (the patient or the physiologist) was in at least some discomfort. Comparative data showed that the scans reported as most painful by patients were also reported by the physiologists as difficult and uncomfortable. In summary, these results demonstrate the feasibility of implementing paired surveys. Patient information leaflets by the BSE and National Health Service (NHS) describe echocardiography as painless but the results here indicate this is not always the case.
32. Association Between Hospital Volume and Mortality in Status Epilepticus: A National Cohort Study.

Authors: Goulden, Robert; Whitehouse, Tony; Murphy, Nick; Hayton, Tom; Khan, Zahid; Snelson, Catherine; Bion, Julian; Veenith, Tonny

Source: Critical care medicine; Dec 2018; vol. 46 (no. 12); p. 1969-1976

Publication Date: Dec 2018

Publication Type(s): Journal Article

PubMedID: 30134302

Database: Medline

Available at Critical care medicine from Ovid (Journals @ Ovid) - Remote Access

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

Abstract

OBJECTIVES In various medical and surgical conditions, research has found that centers with higher patient volumes have better outcomes. This relationship has not previously been explored for status epilepticus. This study sought to examine whether centers that see higher volumes of patients with status epilepticus have lower in-hospital mortality than low-volume centers.

DESIGN Cohort study, using 2010-2015 data from the nationwide Case Mix Programme database of the U.K.'s Intensive Care National Audit and Research Centre.

SETTING Greater than 90% of ICUs in United Kingdom, Wales, and Northern Ireland.

PATIENTS Twenty-thousand nine-hundred twenty-two adult critical care admissions with a primary or secondary diagnosis of status epilepticus or prolonged seizure.

INTERVENTIONS Annual hospital status epilepticus admission volume.

MEASUREMENTS AND MAIN RESULTS We used multiple logistic regression to evaluate the association between hospital annual status epilepticus admission volume and in-hospital mortality. Hospital volume was modeled as a nonlinear variable using restricted cubic splines, and generalized estimating equations with robust SEs were used to account for clustering by institution. There were 2,462 in-hospital deaths (11.8%). There was no significant association between treatment volume and in-hospital mortality for status epilepticus (p = 0.54). This conclusion was unchanged across a number of subgroup and sensitivity analyses, although we lacked data on seizure duration and medication use. Secondary analyses suggest that many high-risk patients were already transferred from low- to high-volume centers.

CONCLUSIONS We find no evidence that higher volume centers are associated with lower mortality in status epilepticus overall. It is likely that national guidelines and local pathways in the United Kingdom allow efficient patient transfer from smaller centers like district general hospitals to provide satisfactory patient care in status epilepticus. Future research using more granular data should explore this association for the subgroup of patients with refractory and superrefractory status epilepticus.

33. Letter to editor re: Refeeding syndrome in adults receiving total parenteral nutrition: An audit of practice at a tertiary UK centre.

Authors: Wong, Gabriel Jun Yung; Lew, Charles Chin Han

Source: Clinical nutrition (Edinburgh, Scotland); Dec 2018; vol. 37 (no. 6)

Publication Date: Dec 2018

Publication Type(s): Letter

PubMedID: 30219607

Database: Medline

Available at Clinical nutrition (Edinburgh, Scotland) from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location]: UHL Libraries On Request (Free).

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34. Assessing the impact of quality improvement measures on catheter related blood stream infections and catheter salvage: Experience from a national intestinal failure unit.

Authors: Bond, A; Teubner, A; Taylor, M; Cawley, C; Abraham, A; Dibb, M; Chadwick, P R; Soop, M; Carlson, G; Lal, S

Source: Clinical nutrition (Edinburgh, Scotland); Dec 2018; vol. 37 (no. 6)

Publication Date: Dec 2018

Publication Type(s): Journal Article

PubMedID: 29046259

Database: Medline

Available at Clinical Nutrition 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).
BACKGROUND & AIM: Prevention of catheter related blood stream infections (CRBSI) and salvage of infected central venous catheters (CVC) are vital to maintaining long term venous access in patients needing home parenteral nutrition (HPN). It remains unclear as to whether patients are best trained for catheter care at home or in hospital or whether CRBSIs are lower if the patient self-cares for the CVC. Furthermore, there is minimal data on the longer term outcome following salvage of infected catheter and limited consensus on agreed protocols for catheter salvage.

METHOD: We conducted a retrospective 5-year evaluation of CRBSI occurrence and CVC salvage outcomes in adult patients requiring HPN managed at a national UK Intestinal Failure Unit from 2012 to 2016. Prior to 2012, patients were primarily trained to administer PN in hospital; thereafter, patients underwent training at home.

RESULTS: A total of 134 CRBSI were recorded in 92 patients (62 patients with a single CRBSI and 30 patients with more than one CRBSI) in a cohort of 559 HPN patients, with a total of 1163 HPN years. The overall CRBSI rate was 0.31 per 1000 catheter days. CNS were the most common isolates (41/134 (30.5%), followed by polymicrobial infections (14/134 (10.4%), Klebsiella spp. (16/134 (11.9%)) and methicillin - sensitive Staphylococcus aureus (MSSA) 5/134 (3.7%)). Salvage was not attempted in 34 cases due to methicillin - resistant (MRSA) infection (1/34), fungal infection (13/34) or clinical instability due to sepsis (20/34). Of the 100 cases where salvage was attempted, 67% were successful. 82.8% of CNS salvage attempts were successful; there was no difference in salvage rates between CNS CRBSIs salvaged with a 10-day (22/26) or 14-day protocol (7/9) (p = 0.4). CRBSI rate, in those cared for by trained home care nurses was the lowest at 0.270 (self care: 0.342 and non-medical carer (e.g. family member): 0.320) (p = 0.03).

CONCLUSION: We previously reported a sustained very low CRBSI rate in a large cohort of HPN patients in a national unit; we now further report that this is not influenced by training patients at home rather than in hospital but is influenced by the individual managing the catheter at home. CNS remains the primary cause of CRBSIs and can be successfully salvaged with a reduced duration of antibiotic therapy compared to our previous experience.

35. Implementing a theory-based intradialytic exercise programme in practice: a quality improvement project.

Authors: Young, Hannah M L; Jeurkar, Sushant; Churchward, Darren R; Dungey, Maurice; Stensel, David J; Bishop, Nicolette C; Greenwood, Sharlene A; Singh, Sally J; Smith, Alice C; Burton, James O

Source: Clinical kidney journal; Dec 2018; vol. 11 (no. 6); p. 832-840

Abstract: Research evidence outlines the benefits of intradialytic exercise (IDE), yet implementation into practice has been slow, ostensibly due to a lack of patient and staff engagement. The aim of this quality improvement project was to improve patient outcomes via the introduction of an IDE programme, evaluate patient uptake and sustainability and enhance the engagement of routine haemodialysis (HD) staff with the delivery of the IDE programme. Methods: We developed and refined an IDE programme, including interventions designed to increase patient and staff engagement that were based on the Theoretical Domains Framework (TDF), using a series of ‘Plan, Do, Study, Act’ (PDSA) cycles. The programme was introduced at two UK National Health Service HD units. Process measures included patient uptake, withdrawals, adherence and HD staff involvement. Outcome measures were patient-reported functional capacity, anxiety, depression and symptomology. All measures were collected over 12 months. Results: A total of 95 patients were enrolled in the IDE programme; 64 (75%) were still participating at 3 months, decreasing to 41 (48%) at 12 months. Adherence was high (78%) at 3 months, decreasing to 63% by 12 months. The provision of IDE by HD staff accounted for a mean of 2 (5%) sessions per 3-month time point. Patients displayed significant improvements in functional ability (P = 0.01) and a reduction in depression (P = 0.02) over 12 months, but the effects seen were limited to those who completed the programme. Conclusions: A theory-based IDE programme is feasible and leads to improvement in functional capacity and depression. Sustaining IDE over time is complicated by high levels of patient withdrawal from the programme. Significant change at an organizational level is required to enhance sustainability by increasing HD staff engagement or access to professional exercise support.


Authors: Cecil, Elizabeth; Wilkinson, Samantha; Bottle, Alex; Esmail, Aneez; Vincent, Charles; Aylin, Paul P

Source: BMJ quality & safety; Dec 2018; vol. 27 (no. 12); p. 974-981

Abstract: The national hospital mortality surveillance system is a descriptive analysis of mortality data from English acute hospitals. The primary aims were to describe the methods used to collect data, and to describe and evaluate the mortality data collected by the surveillance system. The system collects mortality data on all hospital admissions. The data are collected by the hospitals and submitted to the national registry. The system has been in operation since 2001. The data are used for a variety of purposes, including the calculation of hospital mortality rates, the identification of hospital mortality clusters, and the monitoring of the impact of national policies on hospital mortality. The system has been a valuable resource for research, and has been used to identify a number of important trends in hospital mortality. The system has also been used to identify areas for improvement in hospital care, and to inform the development of national policies.
OBJECTIVETo provide a description of the Imperial College Mortality Surveillance System and subsequent investigations by the Care Quality Commission (CQC) in National Health Service (NHS) hospitals receiving mortality alerts.

BACKGROUND The mortality surveillance system has generated monthly mortality alerts since 2007, on 122 individual diagnosis and surgical procedure groups, using routinely collected hospital administrative data for all English acute NHS hospital trusts. The CQC, the English national regulator, is notified of each alert. This study describes the findings of CQC investigations of alerting trusts.

METHODS We carried out (1) a descriptive analysis of alerts (2007-2016) and (2) an audit of CQC investigations in a subset of alerts (2011-2013).

RESULTS Between April 2007 and October 2016, 860 alerts were generated and 76% (654 alerts) were sent to trusts. Alert volumes varied over time (range: 40-101). Septicaemia (except in labour) was the most commonly alerting group (11.5% alerts sent). We reviewed CQC communications in a subset of 204 alerts from 96 trusts. The CQC investigated 75% (154/204) of alerts. In 90% of these pursued alerts, trusts returned evidence of local case note reviews (140/154). These reviews found areas of care that could be improved in 69% (106/154) of alerts. In 25% (38/154) trusts considered that identified failings in care could have impacted on patient outcomes. The CQC investigations resulted in full trust action plans in 77% (118/154) of all pursued alerts.

CONCLUSION The mortality surveillance system has generated a large number of alerts since 2007. Quality of care problems were found in 69% of alerts with CQC investigations, and one in four trusts reported that failings in care may have an impact on patient outcomes. Identifying whether mortality alerts are the most efficient means to highlight areas of substandard care will require further investigation.

37. Use of acronyms in anaesthetic and associated investigations: appropriate or unnecessary? - the UOAIAAAIAOU Study.

Abstract

We examined the prevalence of novel acronyms in the titles of anaesthetic and related studies and the response of anaesthetists to them. We separately analysed trainee-led research projects in the UK supported by the Research and Audit Federation of Trainees (RAFT), and a 10-year cohort of papers identified using the PubMed literature search tool. We also conducted a survey of 20 anaesthetists within our institution regarding the utility and impact of titles containing acronyms, and their recall of the associated topics. Finally, we developed a scoring system for acronym accuracy and complexity, the ORigin of Acronym lettering Used Term AppropriateNess (ORANGUTAN) score, and measured the progression of acronym usage over the 10-year period studied. Our results show that while acronyms themselves are sometimes considered memorable, they do not aid recall of topics and are, in general, not considered helpful. There has been an increase in the prevalence of acronymic titles over 10 years, and in the complexity of acronyms used, suggesting that there is currently a selective pressure favouring the use of acronyms even if they are of limited benefit.

38. Using prognosis to guide early detection and treatment selection in non-metastatic prostate cancer.

Abstract

We reviewed CQC communications in a subset of 204 alerts from 96 trusts. The CQC investigated 75% (154/204) of alerts. In 90% of these pursued alerts, trusts returned evidence of local case note reviews (140/154). These reviews found areas of care that could be improved in 69% (106/154) of alerts. In 25% (38/154) trusts considered that identified failings in care could have impacted on patient outcomes. The CQC investigations resulted in full trust action plans in 77% (118/154) of all pursued alerts.

CONCLUSION The mortality surveillance system has generated a large number of alerts since 2007. Quality of care problems were found in 69% of alerts with CQC investigations, and one in four trusts reported that failings in care may have an impact on patient outcomes. Identifying whether mortality alerts are the most efficient means to highlight areas of substandard care will require further investigation.

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Over recent years there has been an increasing awareness that our ideas on the lethality of primary non-metastatic prostate cancer may need to change. This concept has emerged from a number of different sources including randomised controlled trials, reports from mature active surveillance programmes and prognostic modelling work in large populations (1-2). The evidence suggests that for many men without metastatic disease (85% of all presentations from the recent UK National Prostate Cancer Audit) tumours will evolve slowly and will not translate into cancer related mortality, at least, not within the first 10-15 years of its natural history.

OBJECTIVE:To re-audit the use of safety checklists in radiology departments in NHS departments throughout the UK.METHODS:This audit was performed on behalf of The Royal College of Radiologists Audit Committee in 2016 and was sent to radiology audit leads at every NHS department in the UK to determine the use of safety checks in various modalities and subspecialities. Free form text boxes gathered data on problems with checklist implementation.RESULTS:109/177 (62%) trusts responded. 48% of respondents used safety checklists for all radiological procedures in all modalities. 50% used checklists for some procedures. 2% did not use a checklist. Checklist use had increased since the previous audit (98% 2016, compared to 94% in 2012) but implementation for different procedures remains variable. For example, in ultrasound guided fine needle and breast stereotactic procedures (49%), use has not increased since 2012.CONCLUSION:Reasons for not using checklists include a perception that intervention suite checklists were not appropriate for minor procedures and the limited flexibility of radiology information systems (RIS). The limitations of checklists are discussed.ADVANCES IN KNOWLEDGE:Our re-audit shows that in spite of increased implementation, use of safety checks is variable. Local ownership and RIS flexibility are needed to support the culture of safety processes in radiology departments.

Delirium is a common neuropsychiatric disorder that all those working with older people will have encountered at some stage. Delirium is often poorly identified in hospital settings and therefore not optimally managed. After data collection on the acute medical unit in an acute hospital trust in the UK it was evident that patients with signs of delirium were not being formally assessed and therefore not appropriately managed in many cases. A quality improvement project introduced the 4AT delirium assessment tool to try to ensure that patients with delirium were being identified. The project team carried out several plan-do-study-act cycles to bring about our changes, which included a 4AT assessment sticker for nursing staff to complete and teaching for all healthcare staff. Through involvement of all members of the multidisciplinary team and ongoing feedback and changes we were able to increase assessment of delirium from 0% to 64%. There is ongoing work to be done to continue to improve delirium management, but by initially improving the assessment and identification of delirium we will make a difference to these patients' outcomes.
41. Sensitivity of EQ-5D-3L, HUI2, HUI3, and SF-6D to changes in speech reception and tinnitus associated with cochlear implantation.

- **Authors**: Summerfield, A Q; Barton, G R; UK Cochlear Implant Study Group
- **Source**: Quality of life research : an international journal of quality of life aspects of treatment, care and rehabilitation; Nov 2018
- **Publication Date**: Nov 2018
- **Publication Type(s)**: Journal Article
- **PubMedID**: 30484121
- **Database**: Medline

**Abstract**

**PURPOSE**

There is concern that some generic preference-based measures (GPMs) of health-related quality of life may be insensitive to interventions that improve hearing. Establishing where sensitivity arises could contribute to the design of improved measures. Accordingly, we compared the sensitivity of four widely used GPMs to a clinically effective treatment—cochlear implantation—which restores material degrees of hearing to adults with little or no functional hearing.

**METHODS**

Participants (N = 147) received implants in any of 13 hospitals in the UK. One month before implantation and 9 months after, they completed the HUI2, HUI3, EQ5D3L, and SF-6D questionnaires, together with the EuroQoL visual-analogue scale as a direct measure of health, a performance test of speech reception, and a self-report measure of annoyance due to tinnitus.

**RESULTS**

Implantation was associated with a large improvement in speech reception and a small improvement in tinnitus. HUI2 and HUI3 were sensitive to the improvement in speech reception through their Sensation and Hearing dimensions; EQ5D3L was sensitive to the improvement in tinnitus through its Anxiety/Depression dimension; SF-6D was sensitive to neither. Participants reported no overall improvement in health. Variation in health was associated with variation in tinnitus, not variation in speech reception.

**CONCLUSIONS**

None of the four GPMs was sensitive to the improvements in both speech reception and tinnitus that were associated with cochlear implantation. To capture fully the benefits of interventions for auditory disorders, developments of current GPMs would need to be sensitive to both the health-related and non-health-related aspects of auditory dysfunction.


- **Authors**: Marin, Juana; Giffin, Nicola; Consiglio, Elizabeth; McClure, Candace; Liebler, Eric; Davies, Brendan
- **Source**: The journal of headache and pain; Nov 2018; vol. 19 (no. 1); p. 114
- **Publication Date**: Nov 2018
- **Publication Type(s)**: Journal Article
- **PubMedID**: 30470171
- **Database**: Medline

**Abstract**

**PURPOSE**

There is concern that some generic preference-based measures (GPMs) of health-related quality of life may be insensitive to interventions that improve hearing. Establishing where sensitivity arises could contribute to the design of improved measures. Accordingly, we compared the sensitivity of four widely used GPMs to a clinically effective treatment—cochlear implantation—which restores material degrees of hearing to adults with little or no functional hearing.

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Abstract

BACKGROUND Evidence supports the use of non-invasive vagus nerve stimulation (nVNS: gammaCore®) as a promising therapeutic option for patients with cluster headache (CH). We conducted this audit of real-world data from patients with CH, the majority of whom were treatment refractory, to explore early UK clinical experience with nVNS used acutely, preventively, or both.

METHODS We retrospectively analysed data from 30 patients with CH (29 chronic, 1 episodic) who submitted individual funding requests for nVNS to the National Health Service. All patients had responded to adjunctive nVNS therapy during an evaluation period (typical duration, 3-6 months). Data collected from patient interviews, treatment diaries, and physician notes were summarised with descriptive statistics. Paired t tests were used to examine statistical significance.

RESULTS The mean (SD) CH attack frequency decreased from 26.6 (17.1) attacks/wk. before initiation of nVNS therapy to 9.5 (11.0) attacks/wk. (P < 0.01) afterward. Mean (SD) attack duration decreased from 51.9 (36.7) minutes to 29.4 (28.5) minutes (P < 0.01), and mean (SD) attack severity (rated on a 10-point scale) decreased from 7.8 (2.3) to 6.0 (2.6) (P < 0.01). Use of abortive treatments also decreased. Favourable changes in the use of preventive medication were also observed. No serious device-related adverse events were reported.

CONCLUSIONS Significant decreases in attack frequency, severity, and duration were observed in these patients with CH who did not respond to or were intolerant of multiple preventive and/or acute treatments. These real-world findings complement evidence from clinical trials demonstrating the efficacy and safety of nVNS in CH.

43. Use of a proforma to aid in reducing coercion into informal admission for acute adult psychiatric inpatients in the U.K.

Authors

Perry, Benjamin I; Ayadurai, Nirmalan; Hess, Emily; Harmer, David; Curry, Thomas; Broom, Rebecca; White, David

Source

Legal medicine (Tokyo, Japan); Nov 2018; vol. 36 ; p. 103-109

Publication Date

Nov 2018

Publication Type(s)

Journal Article

PubMedID

30500671

Database

Medline

Available at Legal 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

BACKGROUND People with acute psychiatric illness may be at risk of coercion into informal admission. A lack of capacity assessment (CA) and provision of adequate information (PAI) for informal patients may constitute a risk of coercive admitting practice, resulting in increased use of the mental health act (MHA) in the days following admission. We developed and tested a proforma to aid in ensuring CA and PAI for informal admissions.

METHODS A pilot case-study was conducted in 2015 at a U.K. NHS trust (n = 50), analysing the prevalence of CA & PAI for adult psychiatric inpatient admissions, alongside the prevalence of MHA use in the next 72 h. Case-note audits were completed in 2016 & 2017 (n = 100 each), to assess the impact of the proforma in improving documented CA & PAI, alongside the prevalence of MHA use in the next 72 h. We tested for any demographic associations with CA & PAI using logistic regression.

RESULTS CA improved from 39% (2015) to 60% (2017). PAI improved from 9% (2015) to 45% (2017). Use of the MHA in the 72 h following admission fell from 32% (2015) to 7% (2017). Most informal admissions detained within 72 h had no record of CA & PAI. People under the age of 26 years were significantly less likely to have documented CA & PAI.

IMPLICATIONS Use of the proforma was successful in improving CA & PAI in a U.K. population. Further improvements could be made. Future research should seek to further examine demographic differences in informal coercion.

44. Sex differences in quality indicator attainment for myocardial infarction: a nationwide cohort study.

Authors

Wilkinson, Chris; Bebb, Owen; Dondo, Tatendashe B; Munyombwe, Theresa; Casadei, Barbara; Clarke, Sarah; Schiele, François; Timmis, Adam; Hall, Marlous; Gale, Chris P

Source

Heart (British Cardiac Society); Nov 2018

Publication Date

Nov 2018

Publication Type(s)

Journal Article

PubMedID

30470725

Database

Medline

Available at Heart (British Cardiac Society) from BMJ Journals - NHS Available at Heart (British Cardiac Society) from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.
**45. Patterns of moderate and severe injury in children after the introduction of major trauma networks.**

**Authors**
Jones, Samantha; Tyson, Sarah; Young, Michael; Gittins, Matthew; Davis, Naomi

**Source**
Archives of disease in childhood; Nov 2018

**Publication Date**
Nov 2018

**Abstract**
OBJECTIVETo describe the demographics, mechanisms, presentation, injury patterns and outcomes for children with traumatic injuries.SETTINGData collected from the UK’s Trauma and Audit Research Network.**DESIGN AND PATIENTS**The demographics, mechanisms of injury and outcomes were described for children with moderate and severe injuries admitted to the Major Trauma Network in England between 2012 and 2017.**RESULTS**Data regarding 9851 children were collected. Most (69%) were male. The median age was 6.4 (SD 5.2) years, but infants aged 0.1 year (36.5 days) were the most frequently injured of all ages (0-15 years); 447 (36.0%) of injuries in infants aged <1 year were from suspected child abuse. Most injuries occurred in the home, from falls <2 m, after school hours, at weekends and during the summer. The majority of injuries were of moderate severity (median Injury Severity Score 9.0, SD 8.7). The limbs and pelvis, followed by the head, were the most frequently and most severely injured body parts. Ninety-two per cent were discharged home and 72.8% made a ‘good recovery’ according to the Glasgow Outcome Scale. 3.1% of children died, their median age was 7.0 years (SD 5.8), but infants were the most commonly fatally injured group.**CONCLUSION**A common age of injury and mortality was infants aged <1 year. Accident prevention strategies need to focus on the prevention of non-accidental injuries in infants. Trauma services need to be organised to accommodate peak presentation times, which are after school, weekends and the summer.


**Authors**
Hendra, Louise; Hendra, Tim; Parker, Stephen J

**Source**
World journal of surgery; Nov 2018

**Publication Date**
Nov 2018

**Abstract**
AIMTo investigate sex differences in acute myocardial infarction (AMI) guideline-indicated care as defined by the European Society of Cardiology (ESC) Acute Cardiovascular Care Association (ACCA) quality indicators.METHODSNationwide cohort study comprising 691 290 AMI hospitalisations in England and Wales (n=233 hospitals) from the Myocardial Ischaemia National Audit Project between 1 January 2003 and 30 June 2013.**RESULTS**There were 34.5% (n=238 489) women (median age 76.7 (IQR 66.3-84.0) years; 33.9% (n=80 884) ST-elevation myocardial infarction (STEMI)) and 65.5% (n=452 801) men (median age 67.1 (IQR 56.9-77.2) years; 42.5% (n=192 229) STEMI). Women less frequently received 13 of the 16 quality indicators compared with men, including timely reperfusion therapy for STEMI (76.8% vs 78.9%; p<0.001), timely coronary angiography for non-STEMI (24.2% vs 36.7%; p<0.001), dual antiplatelet therapy (75.4% vs 78.7%) and secondary prevention therapies (87.2% vs 89.6% for statins, 82.5% vs 85.6% for ACE inhibitor/angiotensin receptor blockers and 62.6% vs 67.6% for beta-blockers; all p<0.001). Median 30-day Global Registry of Acute Coronary Events risk score adjusted mortality was higher for women than men (median: 5.2% (IQR 1.8%-13.1%) vs 2.3% (IQR 0.8%-7.1%), p<0.001). An estimated 8243 (95% CI 8111 to 8375) deaths among women could have been prevented over the study period if their quality indicator attainment had been equal to that attained by men.**CONCLUSION**According to the ESC ACCA AMI quality indicators, women in England and Wales less frequently received guideline-indicated care and had significantly higher mortality than men. Greater attention to the delivery of recommended AMI treatments for women has the potential to reduce the sex-AMI mortality gap.
INTRODUCTION

More than 30,000 emergency laparotomies take place annually in England and Wales (Symons et al. in Br J Surg 100(10):1318-1325, 2013; Shapter et al. in Anaesthesia 67(5):474-478, 2012). They are associated with high morbidity and an average inpatient 30-day mortality rate of 11%. Inextricably linked to outcomes is the decision-making process of whether or not to operate (NELA Project Team First patient report of the National Emergency Laparotomy Audit. RCoA, London, 2015; Crebbin et al. in Aust N Z J Surg 83(6):422-428, 2013). A mixed-methods study was undertaken to investigate decision-making in the emergency laparotomy and influencing factors.METHODSSemi-structured interviews were undertaken amongst general surgeons, exploring the decision-making process. Results helped guide design of an online survey, consisting of vignettes and subsequent questions. Respondents were asked to decide whether or not they would perform a laparotomy for each vignette and the results compared to grade, risk attitudes and reflective practice. Responses were analysed for effect of previous positive and negative experiences and for consistency.RESULTS Interviews revealed multiple important factors when considering whether or not to perform an emergency laparotomy, broadly categorised into patient-related, surgeon-related and external factors. A total of 116 general surgeons completed the survey: 12 SHOs, 79 registrars and 25 consultants. Non-consultants were 10.4% (95% CI ±9.7%) more likely to perform an emergency laparotomy than consultants (p = 0.036) on multivariate analysis. No association was observed between operative practices and risk attitudes (p = 0.22), reflective practice (p = 0.7) or previous positive or negative experiences in univariate (p = 0.67) or multivariate analysis. Surgeons were not proven to be either consistent nor inconsistent in their decision-making.CONCLUSIONThe decision to operate or not in an emergency laparotomy directly effects patient outcome. This study demonstrates a difference in decision-making and risk attitudes between consultants and their juniors. To address this, formal teaching of models of decision-making, influencing factors and vignette-based consultant-led discussions should be introduced into surgical training.

OBJECTIVES/HYPOTHESISThis study set out to describe the progression of hearing loss in patients with neurofibromatosis type 2 (NF2), treated in a quaternary multidisciplinary clinic. It also aimed to compare hearing loss across patients grouped according to a known genetic severity score to explore its utility for prognostication.STUDY DESIGNRetrospective cohort study.METHODSWe conducted a study of 147 patients with confirmed NF2 diagnosis for a mean observational period of 10 years. Pure-tone average (PTA), optimum discriminations scores (ODS), and genotype data were collected. Patients were classified according to hearing classification, and maximum annual PTA deterioration. Although the overall median age of loss of serviceable hearing was 78 years, there was significant variation according to the genetic severity; the median for severe patients was 32 years compared to a median of 80 for tissue mosaic patients.CONCLUSIONSThis is the first description of long-term hearing outcomes in a clinical setting across a large heterogeneous cohort of patients with NF2. The results highlight the potential importance and benefit of considering the genetic severity score of patients when undertaking treatment decisions, as well as planning future natural history studies.LEVEL OF EVIDENCE2c Laryngoscope, 2018.

48. Diagnosis and referral delays in primary care for oral squamous cell cancer: a systematic review.

Authors Grafton-Clarke, Ciaran; Chen, Kai Wen; Wilcock, Jane

Source The British journal of general practice : the journal of the Royal College of General Practitioners; Nov 2018
Abstract

BACKGROUND: The incidence of oral cancer is increasing. Guidance for oral cancer from the National Institute for Health and Care Excellence (NICE) is unique in recommending cross-primary care referral from GPs to dentists.

AIM: This review investigates knowledge about delays in the diagnosis of symptomatic oral squamous cell carcinoma (OSCC) in primary care.

DESIGN AND SETTING: An independent multi-investigator literature search strategy and an analysis of study methodologies using a modified data extraction tool based on Aarhus checklist criteria relevant to primary care.

METHOD: The authors conducted a focused systematic review involving document retrieval from five databases up to March 2018. Included were studies looking at OSCC diagnosis from when patients first accessed primary care up to referral, including length of delay and stage of disease at time of definitive diagnosis.

RESULTS: From 538 records, 16 articles were eligible for full-text review. In the UK, more than 55% of patients with OSCC were referred by their GP, and 44% by their dentist. Rates of prescribing between dentists and GPs were similar, and both had similar delays in referral, though one study found greater delays attributed to dentists as they had undertaken dental procedures. On average, patients had two to three consultations before referral. Less than 50% of studies described the primary care aspect of referral in detail. There was no information on inter-GP-dentist referrals.

CONCLUSION: There is a need for primary care studies on OSCC diagnosis. There was no evidence that GPs performed less well than dentists, which calls into question the NICE cancer option to refer to dentists, particularly in the absence of robust auditable pathways.

49. Quality indicators for Palliative Day Services: A modified Delphi study.

Authors
McCorry, Noleen K; O'Connor, Sean; Leemans, Kathleen; Coast, Joanna; Donnelly, Michael; Finucane, Anne; Jones, Louise; Kernohan, W George; Perkins, Paul; Dempster, Martin

Source
Palliative medicine; Nov 2018 ; p. 269216318810601

Publication Date
Nov 2018

Publication Type(s)
Journal Article

PubMedID
30451082

Abstract

BACKGROUND: The goal of Palliative Day Services is to provide holistic care that contributes to the quality of life of people with life-threatening illness and their families. Quality indicators provide a means by which to describe, monitor and evaluate the quality of Palliative Day Services provision and act as a starting point for quality improvement. However, currently, there are no published quality indicators for Palliative Day Services.

AIM: To develop and provide the first set of quality indicators that describe and evaluate the quality of Palliative Day Services. DESIGN AND SETTING: A modified Delphi technique was used to combine best available research evidence derived from a systematic scoping review with multidisciplinary expert appraisal of the appropriateness and feasibility of candidate indicators. The resulting indicators were compiled into 'toolkit' and tested in five UK Palliative Day Service settings.

RESULTS: A panel of experts independently reviewed evidence summaries for 182 candidate indicators and provided ratings on appropriateness, followed by a panel discussion and further independent ratings of appropriateness, feasibility and necessity. This exercise resulted in the identification of 30 indicators which were used in practice testing. The final indicator set comprised 7 structural indicators, 21 process indicators and 2 outcome indicators.

CONCLUSION: The indicators fulfil a previously unmet need among Palliative Day Service providers by delivering an appropriate and feasible means to assess, review, and communicate the quality of care, and to identify areas for quality improvement.
### Search Strategy

#### MEDLINE - AUDIT

**Strategy** 432444

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<td>(audit* OR &quot;quality improvement*&quot;).ti,ab</td>
<td>155028</td>
</tr>
<tr>
<td>2</td>
<td>Medline</td>
<td>(NHS OR england OR UK OR &quot;united kingdom&quot; OR &quot;national health service&quot;).ti,ab</td>
<td>178464</td>
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<tr>
<td>3</td>
<td>Medline</td>
<td>exp &quot;UNITED KINGDOM&quot;/</td>
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<td>21128</td>
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<td>Medline</td>
<td>exp &quot;QUALITY IMPROVEMENT&quot;/</td>
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<td>6</td>
<td>Medline</td>
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<td>432701</td>
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<td>(6 AND 7)</td>
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<td>8[DT 2018-2018] [Since 19-Nov-2018]</td>
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<td>12</td>
<td>Medline</td>
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