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40. Characteristics and outcome of acute heart failure patients according to the severity of peripheral oedema. Page 23
1. Effectiveness of a national quality improvement programme to improve survival after emergency abdominal surgery (EPOCH): a stepped-wedge cluster-randomised trial.

**Authors**
Peden, Carol J; Stephens, Tim; Martin, Graham; Kahan, Brennan C; Thomson, Ann; Rivett, Kate; Wells, Duncan; Richardson, Gerry; Kerry, Sally; Bion, Julian; Pearse, Rupert M; Enhanced Peri-Operative Care for High-risk patients (EPOCH) trial group

**Source**
Lancet (London, England); Jun 2019; vol. 393 (no. 10187); p. 2213-2221

**Publication Date**
Jun 2019

**Publication Type(s)**
Research Support, Non-u.s. Gov't Randomized Controlled Trial Multicenter Study Journal Article

**PubMedID**
31030986

**Database**
Medline

**Abstract**
BACKGROUND Emergency abdominal surgery is associated with poor patient outcomes. We studied the effectiveness of a national quality improvement (QI) programme to implement a care pathway to improve survival for these patients. METHODS We did a stepped-wedge cluster-randomised trial of patients aged 40 years or older undergoing emergency open major abdominal surgery. Eligible UK National Health Service (NHS) hospitals (those that had an emergency general surgical service, a substantial volume of emergency abdominal surgery cases, and contributed data to the National Emergency Laparotomy Audit) were organised into 15 geographical clusters and commenced the QI programme in a random order, based on a computer-generated random sequence, over an 85-week period with one geographical cluster commencing the intervention every 5 weeks from the second to the 16th time period. Patients were masked to the study group, but it was not possible to mask hospital staff or investigators. The primary outcome measure was mortality within 90 days of surgery. Analyses were done on an intention-to-treat basis. This study is registered with the ISRCTN registry, number ISRCTN80682973. FINDINGS Treatment took place between March 3, 2014, and Oct 19, 2015. 22 754 patients were assessed for eligibility. Of 15 873 eligible patients from 93 NHS hospitals, primary outcome data were analysed for 8482 patients in the usual care group and 7374 in the QI group. Eight patients in the usual care group and nine patients in the QI group were not included in the analysis because of missing primary outcome data. The primary outcome of 90-day mortality occurred in 1210 (16%) patients in the QI group compared with 1393 (16%) patients in the usual care group (HR 1·11, 0·96-1·28). INTERPRETATION No survival benefit was observed from this QI programme to implement a care pathway for patients undergoing emergency abdominal surgery. Future QI programmes should ensure that teams have both the time and resources needed to improve patient care. FUNDING National Institute for Health Research Health Services and Delivery Research Programme.

2. Patient experience feedback in UK hospitals: What types are available and what are their potential roles in quality improvement (QI)?

**Authors**
Marsh, Claire; Peacock, Rosemary; Sheard, Laura; Hughes, Lesley; Lawton, Rebecca

**Source**
Health expectations : an international journal of public participation in health care and health policy; Jun 2019; vol. 22 (no. 3); p. 317-326

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Jun 2019

**Publication Type(s)**
Journal Article Review

**PubMedID**
31016863

**Database**
Medline

Available at Health expectations : an international journal of public participation in health care and health policy from Europe PubMed Central - Open Access

Available at EBSCO (MEDLINE Complete)
3. Nursing and medical contribution to Defence Healthcare Engagement: initial experiences of the UK Defence Medical Services.

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

**Source** Journal of the Royal Army Medical Corps; Jun 2019; vol. 165 (no. 3); p. 143-146

**PubMedID** 30077975

**Database** Medline

**Abstract**

**INTRODUCTION** The WHO Constitution enshrines ‘...the highest attainable standard of health as a fundamental right of every human being.’ Strengthening delivery of health services confers benefits to individuals, families and communities, and can improve national and regional stability and security. In attempting to build international healthcare capability, UK Defence Medical Services (DMS) assets can contribute to the development of healthcare within overseas nations in a process that is known as Defence Healthcare Engagement (DHE). METHODS In the first bespoke DMS DHE tasking, a team of 12 DMS nurses and doctors deployed to a 1000-bedded urban hospital in a partner nation and worked alongside indigenous healthcare workers (doctors, nurses and paramedical staff) during April and May 2016. The DMS nurses focused on nursing hygiene skills by demonstrations of best practice and DMS care standards, clinical leadership and female empowerment. A Quality Improvement Programme was initiated that centred on hand hygiene (HH) compliance before and after patient contact, and the introduction of peripheral cannula care and surveillance. RESULTS After a brief induction on the ward, it was apparent that compliance with HH was poor. Peripheral cannulas were secured with adhesive zinc oxide tape and no active surveillance process (such as venous infusion phlebitis (VIP) scoring) was in place. After intensive education and training, initial week-long audits were undertaken and repeated after a further 2 weeks of training and coworking. In the second audit cycle, HH compliance had increased to 69% and VIP scoring compliance to 99%. In the final audit cycle, it was noted that nursing compliance with HH (75/98: 77%) was significantly higher than the doctors' HH compliance (76/202: 38%); p<0.0001. CONCLUSIONSDHE is a long-term collaborative process based on the establishment and development of comprehensive relationships that can help transform indigenous healthcare services towards patient-centred systems with a focus on safety and quality of care. Short deployments to allow clinical immersion of UK healthcare workers within indigenous teams can have an immediate impact. Coworking is a powerful method of demonstrating standards of care and empowering staff to institute transformative change. A multidisciplinary group of Quality Improvement Champions has been identified and a Hospital Oversight Committee established, which will offer the prospect of longer term sustainability and development.

Authors: Hull, Sally A; Rajabzadeh, Vian; Thomas, Nicola; Hoong, Sec; Dreyer, Gavin; Rainey, Helen; Ashman, Neil

Source: The British journal of general practice : the journal of the Royal College of General Practitioners; Jun 2019

Publication Date: Jun 2019

Publication Type(s): Journal Article

PubMedID: 31160369

Abstract:

BACKGROUND: The UK national chronic kidney disease (CKD) audit in primary care shows diagnostic coding in the electronic health record for CKD averages 70%, with wide practice variation. Coding is associated with improvements to risk factor management; CKD cases coded in primary care have lower rates of unplanned hospital admission.

AIM: To increase diagnostic coding of CKD (stages 3-5) and primary care management, including blood pressure to target and prescription of statins to reduce cardiovascular disease risk.

DESIGN AND SETTING: Controlled, cross-sectional study in four East London clinical commissioning groups (CCGs).

METHOD: Interventions to improve coding formed part of a larger system change to the delivery of renal services in both primary and secondary care in East London. Quarterly anonymised data on CKD coding, blood pressure values, and statin prescriptions were extracted from practice computer systems for 1-year pre- and post-initiation of the intervention.

RESULT: Three intervention CCGs showed significant coding improvement over a 1-year period following the intervention (regression for post-intervention trend P<0.001). The CCG with highest coding rates increased from 76-90% of CKD cases coded; the lowest coding CCG increased from 52-81%. The comparison CCG showed no change in coding rates. Combined data from all practices in the intervention CCGs showed a significant increase in the proportion of cases with blood pressure achieving target levels (difference in proportion P<0.001) over the 2-year study period. Differences in statin prescribing were not significant.

CONCLUSION: Clinically important improvements to coding and management of CKD in primary care can be achieved by quality improvement interventions that use shared data to track and monitor change supported by practice-based facilitation. Alignment of clinical and CCG priorities and the provision of clinical targets, financial incentives, and educational resource were additional important elements of the intervention.

5. Associations between daily air quality and hospitalisations for acute exacerbation of chronic obstructive pulmonary disease in Beijing, 2013-17: an ecological analysis.

Authors: Liang, Lirong; Cai, Yutong; Barratt, Benjamin; Lyu, Baolei; Chan, Queenie; Hansell, Anna L; Xie, Wuxiang; Zhang, Di; Kelly, Frank J; Tong, Zhaohui

Source: The Lancet. Planetary health; Jun 2019; vol. 3 (no. 6); p. e270

Publication Date: Jun 2019

Publication Type(s): Journal Article

PubMedID: 31229002

Database: Medline
BACKGROUND Air pollution in Beijing has been improving through implementation of the Air Pollution Prevention and Control Action Plan (2013–17), but its implications for respiratory morbidity have not been directly investigated. We aimed to assess the potential effects of air-quality improvements on respiratory health by investigating the number of cases of acute exacerbations of chronic obstructive pulmonary disease (COPD) advanced by air pollution each year.

**Methods**

Daily city-wide concentrations of PM10, PM2·5, PMcoarse (particulate matter > 2·5–10 μm diameter), nitrogen dioxide (NO2), sulphur dioxide (SO2), carbon monoxide (CO), and ozone (O3) in 2013–17 were averaged from 35 monitoring stations across Beijing. A generalised additive Poisson time-series model was applied to estimate the relative risks (RRs) and 95% CIs for hospitalisation for acute exacerbation of COPD associated with pollutant concentrations.

**Findings**

From Jan 18, 2013, to Dec 31, 2017, 161 613 hospitalisations for acute exacerbation of COPD were recorded. Mean ambient concentrations of SO2 decreased by 68% and PM2·5 decreased by 33% over this 5-year period. For each IQR increase in pollutant concentration, RRs for same-day hospitalisation for acute exacerbation of COPD were 1·029 (95% CI 1·023–1·035) for PM10, 1·028 (1·021–1·034) for PM2·5, 1·018 (1·013–1·022) for PMcoarse, 1·036 (1·028–1·044) for NO2, 1·019 (1·013–1·024) for SO2, 1·024 (1·018–1·029) for CO, and 1·027 (1·010–1·044) for O3 in the warm season (May to October). Women and patients aged 65 years or older were more susceptible to the effects of these pollutants on hospitalisation risk than were men and patients younger than 65 years. In 2013, there were 12 679 acute exacerbations of COPD cases that were advanced by PM2·5 pollution above the expected number of cases if daily PM2·5 concentrations had not exceeded the WHO target (25 μg/m3), whereas the respective figure in 2017 was 7377 cases.

**Interpretation**

Despite improvement in overall air quality, increased acute air pollution episodes were significantly associated with increased hospitalisations for acute exacerbations of COPD in Beijing. Stringent air pollution control policies are important and effective for reducing COPD morbidity, and long-term multidimensional policies to safeguard public health are indicated.

FUNDING

UK Medical Research Council.


**Authors**

Acharya, Shamasunder; Philcox, Annalise N; Parsons, Martha; Suthers, Belinda; Luu, Judy; Lynch, Margaret; Jones, Mark; Attia, John

**Source**

Australian journal of primary health; Jun 2019

**Publication Date**

Jun 2019

**Publication Type(s)**

Journal Article

**PubMedID**

31221243

**Abstract**

Evidence-based standardised diabetes care is difficult to achieve in the community due to resource limitations, and lack of equitable access to specialist care leads to poor clinical outcomes. This study reports a quality improvement program in diabetes health care across a large health district challenged with significant rural and remote geography and limited specialist workforce. An integrated diabetes care model was implemented, linking specialist teams with primary care teams through capacity enhancing case-conferencing in general practice supported by comprehensive performance feedback with regular educational sessions. Initially, 20 practices were recruited and 456 patients were seen over 14 months, with significant improvements in clinical parameters. To date 80 practices, 307 general practitioners, 100 practice nurses and 1400 patients have participated in the Diabetes Alliance program and the program envisages enrolling 40 new practices per year, with a view to engage all 314 practices in the health district over time. Diabetes care in general practice appears suboptimal with significant variation in process measures. An integrated care model where specialist teams are engaged collaboratively with primary care teams in providing education, capacity enhancing case-conferences and performance monitoring may achieve improved health outcomes for people with diabetes.

7. Financialising acute kidney injury: from the practices of care to the numbers of improvement.

**Authors**

Bailey, Simon; Pierides, Dean; Brisley, Adam; Weisshaar, Clara; Blakeman, Thomas

**Source**

Sociology of health & illness; Jun 2019; vol. 41 (no. 5); p. 882-899

**Publication Date**

Jun 2019

**Publication Type(s)**

Journal Article

**PubMedID**

30756403

**Database**

Medline

Available at Sociology of health & illness from Wiley Online Library

Available at Sociology of health & illness from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information.

Local Print Collection [location]: UHL Libraries On Request (Free).
Abstract

Although sociological studies of quality and safety have identified competing epistemologies in the attempt to measure and improve care, there are gaps in our understanding of how finance and accounting practices are being used to organise this field. This analysis draws on what others have elsewhere called ‘financialisation’ in order to explore the quantification of qualitatively complex care practices. We make our argument using ethnographic data of a quality improvement programme for acute kidney injury (AKI) in a publicly funded hospital in England. Our study is thus concerned with tracing the effects of financialisation in the emergence and assembly of AKI as an object of concern within the hospital. We describe three linked mechanisms through which this occurs: (1) representing and intervening in kidney care; (2) making caring practices count and (3) decision-making using kidney numbers. Together these stages transform care practices first into risks and then from risks into costs. We argue that this calculative process reinforces a separation between practice and organisational decision-making made on the basis of numbers. This elevates the status of numbers while diminishing the work of practitioners and managers. We conclude by signalling possible future avenues of research that can take up these processes.


Authors
Chunara, M H; McLeavy, C M; Kesavanarayanan, V; Paton, D; Ganguly, A

Source
Clinical radiology; Jun 2019; vol. 74 (no. 6); p. 450-455

Publication Date
Jun 2019

Publication Type(s)
Journal Article

PubMedID
30952360

Database
Medline

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

Abstract
AIMTo assess the current practice of scaphoid fracture imaging (where initial scaphoid radiographs are normal) in the UK. MATERIALS AND METHODS A survey monkey questionnaire was sent to 140 eligible NHS trusts derived from the NHS England database following exclusion of all non-acute and specialist centres. Four questions were asked regarding the provision of magnetic resonance imaging (MRI) for radiographically occult scaphoid fractures, time to MRI, number of departmental MRI scanners, and alternative imaging offered. RESULTS Responses were received from 74 trusts (53%). Thirty-eight offered MRI as a first-line test in plain-film occult scaphoid injury, 25 preferred computed tomography (CT), and 11 opted for repeat plain radiographs. Of the 38 trusts who offered MRI, 26 provided this within 1 week; the rest within 2 weeks. No trends were identified based on the size of the hospital or its geographical location. Statistical analysis of the data revealed no significant relationship between the number of MRI scanners and the provision of MRI, nor between the numbers of MRI scanners and the time to MRI. CONCLUSIONS MRI has been recognised in the literature as a highly specific, highly sensitive, and cost-effective tool, yet only 51% of trusts provide this service in the UK. For those who cannot offer MRI first-line, CT remains a very accurate and reliable alternative.


Authors
Mari, Lorenzo; Freeman, Julia; Van Dijk, Jan; De Risio, Luisa

Source
Journal of veterinary internal medicine; May 2019

Publication Date
May 2019

Publication Type(s)
Journal Article

PubMedID
31144374

Database
Medline

Available at Journal of Veterinary Internal Medicine from Europe PubMed Central - Open Access

Available at Journal of Veterinary Internal Medicine from Wiley Online Library - Free Content - NHS

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

Available at Journal of Veterinary Internal Medicine from Unpaywall
BACKGROUND Data about congenital sensorineural deafness (CSD) in white blue-eyed cats derive mainly from research colonies, and information about client-owned cats is limited.

OBJECTIVE To describe the prevalence of CSD in a client-owned population of white purebred kittens and colored littermates in the United Kingdom.

ANIMALS One hundred thirty-two solid white client-owned purebred kittens and 61 colored littermates, 6 to 21 weeks of age.

METHODS Retrospective (56 cases) and prospective (137 cases) study. Hearing was assessed by brainstem auditory evoked response testing, and the entire litter was tested.

RESULTS Congenital sensorineural deafness was diagnosed only in solid white kittens, with a prevalence of 30.3% (15.9% bilateral, 14.4% unilateral). The prevalence of CSD was significantly higher in white kittens with 1 (44.4%) or 2 (50%) blue irises than in those without blue irises (22.2%). Kittens with at least 1 blue iris were 3.2 times more likely to have CSD than kittens without blue irises. In solid white kittens, CSD was diagnosed in 7 of 15 (46.7%) Turkish Vankedisi, 8 of 18 (44.0%) Maine Coon, 18 of 41 (43.9%) Norwegian Forest, 3 of 11 (27.3%) British Shorthair, 2 of 12 (16.7%) Devon Rex, 2 of 12 (8.3%) Persian, 1 of 21 (4.8%) Russian, and 0 of 2 Sphinx. The prevalence of CSD was significantly different in Norwegian Forest, Maine Coon, and Turkish Vankedisi kittens compared with Persian or Russian kittens.

CONCLUSION AND CLINICAL IMPORTANCE We identified a high prevalence of CSD in a population of client-owned purebred white kittens in the United Kingdom and suggest differences in breed-specific prevalence of CSD.
Abstract
It is important for safe practice in radiology that junior doctors are aware of the guidelines and legislation surrounding ionising radiation; however, it has been demonstrated over many years that knowledge in these areas is poor with potential impacts on patient safety. As the reliance of the National Health Service (NHS) on radiological imaging increases, it is vital that lasting intervention is implemented to prevent harm. This commentary highlights key issues in this area with results from a recent audit and suggests potential solutions.


Authors
Ferris, John D; Donachie, Paul H; Johnston, Robert L; Barnes, Beth; Olaitan, Martina; Sparrow, John M

Source
The British journal of ophthalmology; May 2019

Publication Date
May 2019

Publication Type(s)
Journal Article

PubMedID
31142463

Database
Medline

Abstract
OBJECTIVE To investigate the impact of EyeSi surgical simulators on posterior capsule rupture (PCR) rates of cataract surgery performed by first and second year trainee surgeons.

DESIGN A Royal College of Ophthalmologists’ National Ophthalmology Database audit study of first and second year surgeons’ PCR rates over seven consecutive National Health Service (NHS) years. Participating centres were contacted to ascertain the date when their surgeons had access to an EyeSi machine and whether this was on-site or off-site.

OPERATIONS were classified as before, after or no access to EyeSi.

SETTING The study took place in 29 NHS Ophthalmology Units in a secondary care setting.

RESULTS Two-hundred and sixty five first and second year trainee surgeons performed 17,831 cataract operations. 6919 (38.8%) operations were performed before access to an EyeSi, 8648 (48.5%) after access to an EyeSi and 2264 (12.7%) operations by surgeons with no access to an EyeSi. Overall, there was a 38% reduction in the first and second year surgeon’s unadjusted PCR rates from 4.2% in 2009 to 2.6% in 2015 for surgeons with access to an EyeSi, and a 3% reduction from 2.9% to 2.8% for surgeons without access to an EyeSi. The overall first and second year unadjusted PCR rates for before, after and no access to an EyeSi were 3.5%, 2.6% and 3.8%, respectively. The decrease in the with-access to an EyeSi group PCR rate was similar for surgeons with access to an EyeSi ‘on site’ or ‘off site’.

CONCLUSIONS First and second year trainee surgeons’ unadjusted PCR rates have decreased since 2009 which has significant benefits for patients undergoing cataract surgery. This 38% reduction in complication rates aligns with the introduction of EyeSi simulator training.


Authors
Shepherd, Sheila; Saraff, Vrinda; Shaw, Nick; Banerjee, Indraneel; Patel, Leena

Source
Archives of disease in childhood; Jun 2019; vol. 104 (no. 6); p. 583-587

Publication Date
Jun 2019

Publication Type(s)
Journal Article

PubMedID
30567827

Database
Medline

Abstract
OBJECTIVE To investigate growth hormone prescribing patterns in the UK, 2013-2016.

RESULTS Growth hormone prescribing patterns in the UK, 2013-2016 are presented.

CONCLUSIONS Growth hormone prescribing patterns in the UK, 2013-2016 are discussed.
INTRODUCTION Prescribing of recombinant human growth hormone (rhGH) for growth failure in UK children is based on guidance from the National Institute for Health and Care Excellence. In 2013, the British Society for Paediatric Endocrinology and Diabetes initiated a national audit of newly prescribed rhGH treatment for children and adolescents. In this review, we have examined prescribing practices between 2013 and 2016.

METHODS All patients ≥16.0 years of age starting rhGH for licensed and unlicensed conditions in the UK were included. Anonymised data on indication and patient demographics were analysed.

RESULTS During the 4 years, 3757 patients from 76 of 85 (89%) centres started rhGH. For each licensed indication, proportions remained stable over this period: 56% growth hormone deficiency (GHD), 17% small for gestational age (SGA), 10% Turner syndrome, 6% Prader-Willi syndrome (PWS), 3% chronic renal insufficiency (CRI) and 2% short stature homeobox deficiency (SHOXd). However, the unlicensed category decreased from 10% (n=94) in 2013 to 5% (n=50) in 2016. The median age of patients starting rhGH was 7.6 years (range 0.1-16.0). Patients with PWS were significantly younger (median 2.2 years, range 0.2-15.1) compared with other indications (p<0.0001) and were followed by the SGA group (median 6.2 years, range 1.3-15.6, p<0.0001). Boys predominated in all groups except for PWS and SHOXd.

CONCLUSION We demonstrate significant engagement of prescribing centres in this audit and a decline in unlicensed prescribing by half in this 4-year period. Patients in the PWS group were younger at initiation of rhGH compared with other indications and had no male predominance unlike GHD, SGA and CRI.

14. How do information sources influence the reported Cerebral Performance Category (CPC) for in-hospital cardiac arrest survivors? An observational study from the UK National Cardiac Arrest Audit (NCAA).

Authors Reynolds, Emily C; Zenasni, Zohra; Harrison, David A; Rowan, Kathryn M; Nolan, Jerry P; Soar, Jasmeet; National Cardiac Arrest Audit

Source Resuscitation: Jun 2019; vol. 141 ; p. 19-23

Publication Date Jun 2019

Publication Type(s) Journal Article

PubMedID 31199943

Database Medline

Available at Resuscitation 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 - request (Free).

Available at Resuscitation 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.

AIM Cerebral Performance Category (CPC) can be used to categorise neurological outcome after cardiac arrest. There is no consensus on what information sources can be used to derive the CPC. This study describes the information sources used by hospitals participating in the UK National Cardiac Arrest Audit (NCAA) and their impact on the CPC reported for individuals surviving an in-hospital cardiac arrest (IHCA).

METHODS Data on the CPCs and on the information source used to assess the CPC (either case note review, communication with the clinical team or direct patient assessment) were abstracted for individual adult patients who survived to discharge following an IHCA in an acute hospital participating in NCAA between 1 May 2014 and 30 April 2016.

RESULTS Data for 33,114 IHCA (in 31,783 patients) from 195 hospitals were reported to NCAA, of whom 6093 (18.4%) survived to hospital discharge. Of these hospital survivors, 5492 (90.1%) had both the CPC and information source reported: case note review (3989 patients, 72.6%), communication with the clinical team (1053 patients, 19.2%); and direct patient assessment (450 patients, 8.2%). Most (96.6%) survivors were abstracted for CPC scores 1 or 2.

CONCLUSION In the UK IHCA audit, the most commonly used information source for CPC assessment is case notes. Most survivors of IHCA are reported as having a CPC score of 1 or a good outcome (CPC scores 1 or 2).

15. Patients with in-situ metallic coils and Amplatzer vascular plugs used to treat pulmonary arteriovenous malformations since 1984 can safely undergo magnetic resonance imaging.

Authors Alsafi, Ali; Jackson, James E; Fatania, Gavin; Patel, Maneesh C; Glover, Alan; Shovlin, Claire L

Source The British journal of radiology; Jun 2019; vol. 92 (no. 1098); p. 20180752

Publication Date Jun 2019

Publication Type(s) Journal Article

PubMedID 30894022

Database Medline

Available at British Journal of Radiology from Wiley Online Library Medicine and Nursing Collection 2019 - NHS Available at British Journal of Radiology 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.
OBJECTIVE To examine the MRI safety of metallic coils and Amplatzer vascular plugs. Currently, concern regarding MR safety of devices used to treat pulmonary arteriovenous malformations (PAVMs) causes delays in performing emergency MRI in patients presenting with acute neurological symptoms.

METHODS A retrospective audit was performed on all patients who underwent PAVM embolization at Hammersmith Hospital, London UK between 1984 and 2017. Outcomes of all MRI studies performed at our institution were recorded. In addition, known outcomes of all known MRI studies performed on patients treated with the earliest steel coils (1984-1995) were recorded.

RESULTS At our institution, 20 patients underwent 1.5 T MRI after the insertion of 100 steel coils (15.5 - 28.6, median 22 years later), 140 coils designated MR-conditional (0.42 - 12.7, median 9.3 years later), and 54 MRI-conditional Amplatzer vascular plugs (0.17 - 8.0, median 0.75 years later), many in combination. The majority of scans were for cerebral indications, but other body regions scanned included spinal, thoracic, and pelvic regions. No adverse events were reported. Similarly, there were no adverse events in any MR scan known to have been performed in other institutions in seven further patients treated with the earliest steel coils (1984-1995). Again, the majority of scans were for cerebral indications.

CONCLUSION The findings demonstrate MR safety at 1.5 T of all PAVM embolization devices inserted in a main UK centre since inception in 1984. ADVANCES IN KNOWLEDGE MRI of patients who have had PAVMs treated by embolization can be implemented without contacting specialist pulmonary arteriovenous malformation treatment centres for approval.

16. The health behaviour status of teenage and young adult cancer patients and survivors in the United Kingdom.

Authors Pugh, G; Hough, R; Gravestock, H; Fisher, A
Source Supportive care in cancer : official journal of the Multinational Association of Supportive Care in Cancer; May 2019
Publication Date May 2019
Publication Type(s) Journal Article
PubMedID 31144171
Database Medline

Abstract The primary aim of this study was to investigate the health behaviour status of teenage and young adult (TYA) cancer patients and survivors; the secondary aim was to determine if TYA cancer patients and survivors health behaviour differs to general population controls.

METHODS Two hundred sixty-seven young people with cancer (n =83 cancer patients receiving active treatment: n =174 cancer survivors, 57.1% >1 year since treatment completion) and 321 controls completed a health and lifestyle questionnaire which included validated measures of physical activity (PA) (Godin Leisure Time Exercise Questionnaire), diet (Dietary Instrument for Nutrition Education, DINE), smoking status, and alcohol consumption (AUDIT-C).

RESULTS General population controls and cancer survivors were more likely to meet current (PA) recommendations (p <0.001) than TYA cancer patients undergoing treatment (54.8% vs 52.3% vs 30.1%, respectively). Less than 40% of young people with cancer and controls met fat intake, sugar intake, fibre intake or current fruit and vegetable recommendations. TYA cancer survivors were more likely to report binge drinking than controls (OR=3.26, 95% CI 2.12-5.02, p <0.001). Very few young people with in the study were current smokers. The majority of TYA cancer patients and survivors reported a desire to make positive changes to their health behaviour.

CONCLUSION Consideration should be given to whether existing health behaviour change interventions which have demonstrated positive effects among the general TYA population could be adapted for young people with cancer.

17. Diabetic foot ulcer incidence and survival with improved diabetic foot services: an 18-year study.

Authors Paisey, R B; Abbott, A; Paisey, C F; Walker, D
Source Diabetic medicine : a journal of the British Diabetic Association; May 2019
Publication Date May 2019
Publication Type(s) Journal Article
PubMedID 31150130
Database Medline

Abstract The primary aim of this study was to investigate the incidence and survival of diabetic foot ulcers (DFUs) and their association with diabetic foot services.

METHODS A retrospective analysis of 1748 DFUs in 1122 patients was performed. Patients were divided into three groups based on the level of diabetic foot services available at the time of ulceration. The primary outcome was DFU incidence and survival.

RESULTS The incidence of DFUs was 0.35% per person-year in the lowest service group, 0.15% per person-year in the medium service group, and 0.08% per person-year in the highest service group. The survival of DFUs was 70% at 1 year and 50% at 2 years in the lowest service group, 80% at 1 year and 60% at 2 years in the medium service group, and 90% at 1 year and 70% at 2 years in the highest service group.

CONCLUSION Improving diabetic foot services can reduce DFU incidence and improve DFU survival.
Heart (British Cardiac Society) 65 years, 50% for those aged 65-74 years and 25% for those aged 75-81 years (P < 0.0001). In those with Heart (British Cardiac Society) 068) compared with Israel (n=5647) were older, more likely to be Heart (British Cardiac Society) Available at [location] : British Library via UHL Libraries - please click link to request article. Heart (British Cardiac Society) Available at [location] : British Library via UHL Libraries - please click link to request article. Heart (British Cardiac Society) Available at [location] : British Library via UHL Libraries - please click link to request article. Heart (British Cardiac Society) Available at [location] : British Library via UHL Libraries - please click link to request article. Heart (British Cardiac Society) Available at [location] : British Library via UHL Libraries - please click link to request article. Heart (British Cardiac Society) Available at [location] : British Library via UHL Libraries - please click link to request article. Heart (British Cardiac Society) Available at [location] : British Library via UHL Libraries - please click link to request article. Heart (British Cardiac Society) Available at [location] : British Library via UHL Libraries - please click link to request article. Heart (British Cardiac Society) Available at [location] : British Library via UHL Libraries - please click link to request article. Heart (British Cardiac Society) Available at [location] : British Library via UHL Libraries - please click link to request article. Heart (British Cardiac Society) Available at [location] : British Library via UHL Libraries - please click link to request article. Heart (British Cardiac Society) Available at [location] : British Library via UHL Libraries - please click link to request article. Heart (British Cardiac Society) Available at [location] : British Library via UHL Libraries - please click link to request article. Heart (British Cardiac Society) Available at [location] : British Library via UHL Libraries - please click link to request article. Heart (British Cardiac Society) Available at [location] : British Library via UHL Libraries - please click link to request article. Heart (British Cardiac Society) Available at [location] : British Library via UHL Libraries - please click link to request article. Heart (British Cardiac Society) Available at [location] : British Library via UHL Libraries - please click link to request article. Heart (British Cardiac Society) Available at [location] : British Library via UHL Libraries - please click link to request article. Heart (British Cardiac Society) Available at [location] : British Library via UHL Libraries - please click link to request article. Heart (British Cardiac Society) Available at [location] : British Library via UHL Libraries - please click link to request article. Heart (British Cardiac Society) Available at [location] : British Library via UHL Libraries - please click link to request article. Heart (British Cardiac Society) Available at [location] : British Library via UHL Libraries - please click link to request article. Heart (British Cardiac Society) Available at [location] : British Library via UHL Libraries - please click link to request article. Heart (British Cardiac Society) Available at [location] : British Library via UHL Libraries - please click link to request article.
Abstract
AIM To evaluate the outcomes of higher risk screening in Northern Ireland (NI) and compare with the UK National Health Service Breast Screening Programme (NHSBSP).

MATERIALS AND METHODS Higher risk breast screening commenced in NI in April 2013. Data on the programme were audited retrospectively through the Higher Risk screening centre. As there are no national standards for attendance rates and cancer detection rates, screening data and standards from the NHSBSP were used as a baseline for comparison.

RESULTS Attendance rates for the higher risk screening population have increased each of the last 3 years up to 77.7%. Recall rates have improved year on year from initial 14.2%-8.6%. Cancer detection rates have varied each year with a range from 21.5 per 1,000 women screened to 30.9 per 1,000 women screened.

CONCLUSION The Higher Risk Breast Screening Programme in NI represents a success story in risk stratified screening. Performance outcomes are excellent. The data outcomes may be used to inform standards of acceptable practice in the wider NHSBSP.


Authors Juniat, Valerie; Athwal, Sarju; Khandwala, Mona
Source Eye (London, England); Jun 2019
Publication Date Jun 2019
Publication Type(s) Journal Article
PubMedID 31160703
Database Medline

Abstract
INTRODUCTION Hospitals in England are reimbursed via national tariffs set out by NHS England. The tariffs payable to hospitals are determined by the activity coded for each patient’s hospital visit. There are no national standards or publications within oculoplastics for coding accuracy. Our audit aimed to determine the accuracy of coding oculoplastic procedures carried out in theatres and to assess the financial implications of any discrepancies.

METHODS We carried out a prospective audit of consecutive oculoplastic procedures performed at one hospital site over a 6-week period. We subsequently created a coding proforma and performed a re-audit using the same methods.

RESULTS In the first cycle, clinical coding was ‘correct’ in 30.7% of cases, ‘incomplete’ for 12.9% and ‘incorrect’ for 56.5%. Of the ‘incorrect’ codes, 54.3% were coded as non-oculoplastic procedures (e.g. extraocular muscle surgery). We discussed our findings with the coding team in order to address the sources of error. We also created a ‘tick box’ coding proforma, for completion by surgeons. Our re-audit results showed an improvement of ‘correct’ coding to 85.7%.

CONCLUSION Clinical coding is complex and vulnerable to inaccuracy. Our audit showed a high rate of coding error, which improved following collaboration with our coding team to address the sources of error and by creating a coding proforma to improve accuracy. Accurate clinical coding has financial implications for hospital trusts and consequently Clinical Commissioning Groups. In times of severe financial pressures, this could be a valuable tool, if rolled out over all specialties, to make much needed savings.

21. Evaluating possible intended and unintended consequences of the implementation of alcohol minimum unit pricing (MUP) in Scotland: a natural experiment protocol.

Authors Katikireddi, Srinivasa Vittal; Beeston, Clare; Millard, Andrew; Forsyth, Ross; Deluca, Paolo; Drummond, Colin; Eadie, Douglas; Graham, Lesley; Hilton, Shona; Ludbrook, Anne; McCartney, Gerry; Phillips, Thomas; Stead, Martine; Ford, Allison; Bond, Lyndal; Leyland, Alastair H
Source BMJ open; Jun 2019; vol. 9 (no. 6); p. e028482
Publication Date Jun 2019
Publication Type(s) Journal Article
PubMedID 31221890
Database Medline

Abstract
HDAS Export
Search Strategy MEDLINE - AUDIT
Page 13 of 24

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Local Print Collection [location]: UHL Libraries On Request (Free).

Available at Clinical Radiology 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.
22. A balanced randomised placebo controlled blinded phase IIa multi-centre study to investigate the efficacy and safety of AUT00063 versus placebo in subjective tinnitus: The QUIET-1 trial.

Authors: Hall, Deborah A; Ray, Jaydip; Watson, Jeannette; Sharman, Alice; Hutchinson, John; Harris, Peter; Daniel, Matija; Millar, Bonnie; Large, Charles H

Source: Hearing research; Jun 2019; vol. 377; p. 153-166

Abstract: AUT00063 is an experimental new medicine that has been demonstrated to suppress spontaneous hyperactivity by modulating the action of voltage-gated potassium-channels in central auditory cortical neurons of a rodent model. This neurobiological property makes it a good candidate for treating the central component of subjective tinnitus but this has not yet been tested in humans. The main purpose of the QUIET-1 (QUest In Eliminating Tinnitus) trial was to examine the effect of AUT00063 on the severity of tinnitus symptoms in people with subjective tinnitus. The trial was a randomised, placebo-controlled, observer, physician and participant blinded multi-centre superiority trial with two parallel groups and a primary endpoint of functional impact on tinnitus 28 days after the first drug dosing day. The trial design overcame the scale and logistical challenges of delivering a scientifically robust, statistically powered multi-centre study for subjective tinnitus within the National Health Service in England. The trial was terminated early for futility. Overall, 212 participants consented across 18 sites with 91 participants randomised to groups using age, gender, tinnitus symptom severity and hearing status as minimisation factors. While the pharmacokinetic markers confirm the uptake of AUT00063 in the body, within the expected therapeutic range, with respect to clinical benefit findings indicated that AUT00063 was not effective in alleviating tinnitus symptoms (1.56 point change in Tinnitus Functional Index). In terms of clinical harms, results indicated that a daily dose of 800 mg capsules of AUT00063 taken for 28 days was safe and well tolerated. These findings provide significant advances in the drug development field for hearing sciences, but raise questions about the potential unintended effects of MUP on alcohol source and drug use. Using a natural experiment design and repeated cross-sectional audit, difference between Scotland (intervention) and North England (control) will be tested for outcomes using regression adjusting for differences at baseline. Differential impacts by age, gender and socioeconomic position will be investigated. Component 3 used focus groups with young people and heavy drinkers and interviews with stakeholders before and after MUP implementation. The focus groups will allow exploration of attitudes, experiences and behaviours and the potential mechanisms by which impacts arise. The interviews will help characterise the implementation process.

ETHICS AND DISSEMINATION: Study components 1 and 2 have been ethically approved by the NHS, and component 3 by the University of Stirling. Dissemination plans include peer-reviewed journal articles, presentations, policy maker briefings and, in view of high public interest and the high political profile of this flagship policy, communication with the public via media engagement and plain language summaries.

TRIAL REGISTRATION NUMBER: ISRCTN16039407; Pre-results.


Authors: Ramjeeawon, Natalie; Lecky, Fiona; Burke, Derek P; Ramlakhan, Shammi

Source: European journal of emergency medicine : official journal of the European Society for Emergency Medicine; Jun 2019; vol. 26 (no. 3); p. 158-162

Abstract: Scotland is the first country to carry out a national implementation of minimum unit pricing (MUP) for alcohol. MUP aims to reduce alcohol-related harms, which are high in Scotland compared with Western Europe, and to improve health equalities. MUP is a minimum retail price per unit of alcohol. That approach targets high-risk alcohol users. This work is key to a wider evaluation that will determine whether MUP continues. There are three study components.

METHODS AND ANALYSIS: Component 1 sampled an estimated 2800 interviewees at a baseline and each of two follow-ups from four Emergency Departments in Scotland and Northern England. Research nurses administered a standardised survey to assess alcohol consumption and the proportion of attendances that were alcohol-related. Component 2 covered six Sexual Health Clinics with similar timings and country allocation. A self-completion survey gathered information on potential unintended effects of MUP on alcohol source and drug use. Using a natural experiment design and repeated cross-sectional audit, difference between Scotland (intervention) and North England (control) will be tested for outcomes using regression adjusting for differences at baseline. Differential impacts by age, gender and socioeconomic position will be investigated. Component 3 used focus groups with young people and heavy drinkers and interviews with stakeholders before and after MUP implementation. The focus groups will allow exploration of attitudes, experiences and behaviours and the potential mechanisms by which impacts arise. The interviews will help characterise the implementation process.

ETHICS AND DISSEMINATION: Study components 1 and 2 have been ethically approved by the NHS, and component 3 by the University of Stirling. Dissemination plans include peer-reviewed journal articles, presentations, policy maker briefings and, in view of high public interest and the high political profile of this flagship policy, communication with the public via media engagement and plain language summaries.

TRIAL REGISTRATION NUMBER: ISRCTN16039407; Pre-results.
OBJECTIVES AND BACKGROUND Head injury is a common paediatric emergency department presentation. The National Institute for Health and Clinical Excellence updated its guidance in January 2014 regarding imaging required for adults and children following a head injury (CG176). This study looked at the rates of computed tomography (CT) head scans performed and adherence rates to CG176. PATIENTS AND METHODS A single-centre audit was carried out, examining imaging practice in children with head injuries. CG176 was implemented formally in August 2014 to the new trainee doctors. The primary outcome was adherence to CG176. As the data were binary, 95% confidence intervals were used for comparison. RESULTS In all, 1797 patients were identified as having a head injury. Implementation at the Sheffield’s Children NHS Foundation Trust resulted in a statistically significant increase in guideline adherence from 79.2% [95% confidence interval (CI): 76.4-81.9%] to 85.1% [95% CI: 82.9-87.4%]. The greatest impact in adherence was found in CT head scans, from 95.8% [95% CI: 94.5-97.2%] to 97.7% [95% CI: 96.7-98.6%]. CONCLUSION The implementation at the Sheffield’s Children NHS Foundation Trust was successful in satisfying the aim of CG176 by increasing adherence and decreasing CT head scans. This success could be explained by the formal implementation to the new cohort of doctors and better physician agreement with the guidelines. The increase in adherence is contrary to the previous studies.


Authors
Shawihdi, Mustafa; Dodd, Susanna; Kallis, Constantinios; Dixon, Pete; Grainger, Ruth; Bloom, Stuart; Cummings, Fraser; Pearson, Mike; Bodger, Keith

Source
Alimentary pharmacology & therapeutics; May 2019

Publication Date
May 2019

Publication Type(s)
Journal Article

PubMedID
31135073

Database
Medline

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


Authors
Emmott, E H; Mc Grath-Lone, L; Harron, K; Woodman, J

Source
Journal of public health (Oxford, England); Jun 2019

Publication Date
Jun 2019

Publication Type(s)
Journal Article

PubMedID
31211394
26. Exploring organizational support for the provision of structured self-management education for people with Type 2 diabetes: findings from a qualitative study.

**Authors**
Carey, M E; Agarwal, S; Horne, R; Davies, M; Slevin, M; Coates, V

**Source**
Diabetic medicine : a journal of the British Diabetic Association; Jun 2019; vol. 36 (no. 6); p. 761-770

**Publication Date**
Jun 2019

**PubMedID**
30868654

**Database**
Available at Diabetic Medicine from Wiley Online Library Medicine and Nursing Collection 2019 - NHS
Available at Diabetic 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).

**Abstract**
AIMTo explore the organizational context in which Type 2 diabetes structured group education is provided.

METHODSFour Clinical Commissioning Groups in England providing Type 2 diabetes structured self-management education participated in a qualitative study exploring the context for provision of that education. Using UK National Diabetes Audit returns, two Clinical Commissioning Groups were selected that had non-attendance rates of ≤25%, and two that had non-attendance rates of ≥50%. Between May 2016 and August 2017, 20 interviews were conducted with Clinical Commissioning Group staff including: commissioners, healthcare professionals, managers, general practitioners and diabetes educators. Data gathering was prolonged as it proved challenging to engage with healthcare staff as a result of frequent local restructuring and service disruption. RESULTSLocal audits revealed discrepancies in basic data such as referral and attendance numbers compared with national audit data. There was a commonality in the themes identified from interviews: diabetes education was rarely embedded in service structure; where education uptake was poor, a lack of central support to delivery teams was noticeable; and where education uptake was positive, delivery teams were actively engaged, sometimes relying on enthusiastic individuals. Both situations put the local sustainability of diabetes education at risk. CONCLUSIONSThere appears to be a link between attendance rates and organizational issues, therefore, when considering how to increase attendance rates, the state of the diabetes education infrastructure should be reviewed. Good uptake of diabetes education can be too reliant on the enthusiastic commitment of small teams or individuals delivering the education.

27. British Society of Interventional Radiology Iliac Angioplasty and Stent Registry: fourth report on an additional 8,294 procedures.

**Authors**
Miller, C; Frood, R; See, T C; Hammond, C J

**Source**
Clinical radiology; Jun 2019; vol. 74 (no. 6); p. 429-434

**Publication Date**
Jun 2019

**PubMedID**
30846190

**Abstract**
BACKGROUNDReferral rates from Health service to Children's Social Care (CSC) services vary across England. In 2019, the National Audit Office (re)iterated the urgent need to understand the drivers of such variation.

METHODSUsing administrative data (Children in Need Census, 2013-16), we calculated annual referral rates from Health to CSC services (Health referral rate) by Local Authority (LA) areas. We used multilevel linear regression to investigate the relationship between age-adjusted Health referral rates and local need (demand factors) and local practice/systems (supply factors). We present a tool to compare unadjusted and adjusted LA rates.

RESULTSThere was high LA variation in Health referral rates, particularly for infants (mean = 29.0/1000 children < 1 y; range = 6.5-101.8; sd = 12.4). LA variation persisted after age-adjustment. Child poverty (local need) and overall referral rate (local practice/systems) explained 60% of variation in age-adjusted Health referral rates. Overall referral rate was the strongest predictor. Adjusted referral rates were substantially different from unadjusted rates. After adjustment, 57.7% of LAs had higher/lower Health referral rates than expected.

CONCLUSIONSWhile higher levels of local need are associated with higher Health referrals, some areas have high Health referrals irrespective of local need. Our tool demonstrates the benefits of using adjusted rates to compare LAs.

**Authors** Wilson, Ceri; King, Matthew; Russell, Jessica

**Source** Health & social care in the community; Jun 2019

**Publication Date** Jun 2019

**Publication Type(s)** Journal Article

**PubMedID** 31157937

**Abstract** Recovery Colleges aim to assist people with mental health difficulties in the journey to recovery through education. They bring together professional and lived experience of mental health challenges in a non-stigmatising college environment and operate on college principles. All courses are designed to contribute towards well-being and recovery. Despite the ever-growing number of Recovery Colleges (both in the UK and internationally), the evaluative evidence is limited; comprising mostly non-peer-reviewed evaluations, audits and case studies. The present article comprises a mixed-methods evaluation of a newly established Recovery College in South East Essex, UK. The evaluation comprised questionnaires of mental well-being and social inclusion at baseline and 3 and 6 month follow-up, in addition to three focus groups. There were significant improvements in both mental well-being and social inclusion from baseline to 6 month follow-up (25 participants completed the measure of well-being at both time points and 19 completed the measure of social inclusion). This was supported by additional free-text questionnaire comments and focus group findings (17 participants participated across the focus groups), with reports of increased confidence, reduced anxiety and increased social inclusion/reduced social isolation. Additionally, at 6 month follow-up a majority of respondents were planning on attending courses external to the Recovery College, volunteering and/or gaining paid employment. Challenges and recommendations identified through the focus groups indicate the importance for standardisation of processes (which is particularly important when multiple organisations are involved in the running of a Recovery College), as well as consideration of longer-running courses. Funders should continue to invest in the Recovery College movement as the growing evidence-base is demonstrating how these colleges can help address the high prevalence of mental health difficulties, by promoting mental well-being and social inclusion.

29. Refeeding syndrome in adults receiving total parenteral nutrition: An audit of practice at a tertiary UK centre.

**Authors** Pantoja, Felipe; Fragkos, Konstantinos C; Patel, Pinal S; Keane, Niamh; Samaan, Mark A; Barnova, Ivana; Di Caro, Simona; Mehta, Shameer J; Rahman, Farooq

**Source** Clinical nutrition (Edinburgh, Scotland); Jun 2019; vol. 38 (no. 3); p. 1457-1463
All high-risk patients were identified as high-risk for RS and received lower initial calories (12.8 kcal/kg/day, p < 0.05). All high-risk patients received a high potency vitamin preparation compared to 35% in the low risk group (p < 0.05). Daily phosphate, magnesium and potassium plasma levels were monitored for seven days in 25%, 30% and 53.8% of patients, respectively. Hypophosphatemia developed in 30% and hypomagnesaemia and hypokalaemia in 27.5% of all patients. Approximately 84% of patients had one or more electrolyte abnormalities, which occurred more frequently in high-risk RS patients (p < 0.05). Low risk patients developed mild hypophosphatemia at a much lower percentage than high-risk RS (20% vs 33.3%, respectively).

CONCLUSION
A significant proportion of patients commencing TPN developed biochemical features of RS (but no more serious complications) despite nutritional assessment, treatment, and follow up in accordance with national recommendations. High vs low risk RS patients were more likely to have electrolyte abnormalities after receiving TPN regardless of preventative measures. Additional research is required to further optimise the initial nutritional approach to prevent RS in high-risk patients.

30. To MSNAP or not to MSNAP? Testing a small regional memory clinic against the UK Memory Service National Accreditation Program (MSNAP).

Authors
Sweeney, E B; Foley, J E; Fitzsimons, S; Denihan, A

Source
Irish journal of psychological medicine; Jun 2019; vol. 36 (no. 2); p. 145-151

Abstract
AimTo investigate whether a small regional memory clinic would benefit from engaging with a structured external audit process such as the Royal College of Psychiatrists’ Memory Service National Accreditation Program (MSNAP). BACKGROUND The Psychiatry of Old Age service in Navan operates a public cognitive clinic. Despite the publication of the 2014 National Dementia Strategy, there are currently no national standards for memory clinics in Ireland. It may be beneficial to link in with an external quality control system as part of routine clinical governance. METHODS Published data from the MSNAP group was reviewed and a set of audit materials extrapolated to replicate the MSNAP self-review process. The audit cycle involved (1) retrospective case review, (2) institution of a range of interventions and (3) a prospective audit, which included service user feedback. RESULTS Overall the results demonstrated a high standard of service, especially in the areas of accessibility, assessment and communication of diagnosis. The clinic performed well against MSNAP key performance indicators. Patient and carer satisfaction with the service was very high. Clinic policies needed further development, particularly in the areas of referral, consent and data protection. CONCLUSION The process was useful, providing clear pointers for action. It highlighted the need to formalise organisational and practice policies, patient support and education, audit and outreach. Although accreditation is a laborious process requiring financial investment, it provides a strong scaffold to maintain and improve standards and is likely to be a valuable learning experience, where national guidelines are lacking.

31. What is the impact of large-scale implementation of stroke Early Supported Discharge? A mixed methods realist evaluation study protocol.

Authors
Fisher, Rebecca; Chouliara, Niki; Byrne, Adrian; Lewis, Sarah; Langhorne, Peter; Robinson, Thompson; Waring, Justin; Geue, Claudia; Hoffman, Alex; Paley, Lizz; Rudd, Anthony; Walker, Marion

Source
Implementation science : IS; Jun 2019; vol. 14 (no. 1); p. 61
32. Comprehensive Geriatric Assessment in the perioperative setting; where next?

Authors: Dhesi, Jugdeep; Moonesinghe, S Ramani; Partridge, Judith

Source: Age and ageing; May 2019

Publication Date: May 2019

Publication Type(s): Journal Article

PubMedID: 31147709

Abstract: Comprehensive Geriatric Assessment (CGA) is being employed in the perioperative setting to improve outcomes for older surgical patients. Traditionally CGA is delivered by a geriatrician led multidisciplinary team but with the acknowledged workforce challenges in geriatric medicine, it has been suggested that non-geriatricians may be able to deliver CGA. HOW-CGA developed a toolkit to facilitate the delivery of CGA by non-geriatricians in the perioperative setting. Across two hospital sites uptake and implementation of this toolkit was limited by a potential lack of face validity, behavioural and cultural barriers and an acknowledgement that geriatric medicine expertise is key to CGA and optimisation. In-keeping with this finding there has been an observed expansion in geriatrician led CGA services for older surgical patients in the UK. In order to demonstrate the effectiveness of perioperative CGA services, implementation science should be combined with health services research methodology and the use of big data through linked national audit.

33. Audit of the two-week pathway for patients with suspected cancer of the head and neck and the influence of socioeconomic status.

Authors: Rogers, S N; Staunton, A; Girach, R; Langton, S; Lowe, D

Source: The British journal of oral & maxillofacial surgery; Jun 2019; vol. 57 (no. 5); p. 419-424

Publication Date: Jun 2019

Publication Type(s): Journal Article

PubMedID: 31159975

Abstract: Background: The two-week pathway for suspected cancer (TWP) is a service innovation that facilitates discharge from hospital and delivery of specialist rehabilitation in patients’ homes. There is currently widespread implementation of TWP services in many countries, driven by robust clinical trial evidence. In England, the type of TWP service patients receive on the ground is variable, and in some regions, ESD is still not offered at all. This protocol presents a study designed to investigate the mechanisms and outcomes of implementing ESD at scale in real-world conditions. This will help to establish which models of ESD are most effective and in what context.

Methods: A realist evaluation approach composed of two interlinking work packages will be adopted to investigate how and why ESD works, for whom and in what circumstances. Work package 1 (WP1) will begin with a rapid evidence synthesis to formulate preliminary realist hypotheses. Quantitative analyses of historical prospective Sentinel Stroke National Audit Programme (SSNAP) data will be performed to evaluate service outcomes based on the degree to which evidence-based ESD has been implemented. Work package 2 (WP2) will involve the qualitative investigation of purposely selected case study sites featuring in WP1 and covering different regions in England. The perspectives of clinicians, managers, commissioners, and service users will be explored qualitatively. Cost implications of ESD models will be examined using a cost-consequence analysis. Cross-case comparisons and triangulation of the data sources from both work packages will be performed to test, revise, and refine initial programme theories and address research aims.

Discussion: This study will investigate whether and how current large-scale implementation of ESD is achieving the outcomes suggested by the evidence base. The theory-driven evaluation approach will highlight key mechanisms and contextual conditions necessary to optimise outcomes and allow us to draw transferable lessons to inform the effective implementation and sustainability of ESD in clinical practice.

In addition, the methodological framework will progress the theoretical understanding of implementation and evaluation of complex rehabilitation interventions in stroke care.

Trial Registration: ISRCTN: 15568163, registration date: 26 October 2018.
1. CONCLUSION

These results show that whole body CT in trauma has a high sensitivity and a low rate of missed injuries (2.4%). However, our study only evaluated a subgroup of patients with ISS > 15 and further work is required to assess the use of this investigation for all major trauma patients.

34. Assessment of sensitivity of whole body CT for major trauma.

**Authors**

Yoong, Susan; Kothari, Ravi; Brooks, Adam

**Source**

European journal of trauma and emergency surgery : official publication of the European Trauma Society; Jun 2019; vol. 45 (no. 3); p. 489-492

**Publication Date**

Jun 2019

**Publication Type(s)**

Journal Article

**PubMedID**

29520416

**Database**

Medline

**Abstract**

**INTRODUCTION**

Whole body computed tomography has become standard practice in many centres in the management of severely injured trauma patients, however, the evidence for its diagnostic accuracy is limited. AIM To assess the sensitivity of whole body CT in major trauma. METHOD Retrospective review of all patients with injury severity score (ISS) > 15 presenting with blunt trauma to a UK Major Trauma Centre between May 2012 and April 2014. Injuries were classified as per ISS score: 1 = head and neck 2 = face 3 = chest 4 = abdomen. The authors reviewed patient’s electronic charts, radiological results; interventional procedure records, discharge letters and outpatient follow up documentation and referenced this with Trauma Audit and Research Network data. RESULTS 407 patients with ISS > 15 presented to the Trauma centre during May 2012 and April 2014. Of these, 337 (82.8%) had a whole body CT scan. 246 pts were male, 91 were female. 74 (21.9%) were due to a fall from > 2 m, 41 (12.2%) due to a fall from < 2 m, 208 (61.7%) were due to motor vehicle crashes, 1 (0.3%) due to a blast injury, 5 (1.5%) due to blows, and 8 (2.4%) due to crush injuries. Sensitivity for spinal injuries (21.9%) were due to a fall from > 2 m. 41 (12.2%) due to a fall from < 2 m, 208 (61.7%) were due to motor vehicle crashes, 1 (0.3%) due to a blast injury, 5 (1.5%) due to blows, and 8 (2.4%) due to crush injuries. Sensitivity for Region 1 was 0.98, Region 2 = 0.98, Region 3 = 0.98 and Region 4 was 0.95. Overall sensitivity was 0.98. 15 injuries (2.4%) were not identified on initial CT (false -ve). These injuries were: colonic perforation = 1, splenic contusion = 1, pneumothorax = 1, liver laceration = 1, intracranial haemorrhage = 1, cerebral contusions = 1, spinal injuries = 7, canal haemorrhage = 1, maxilla fracture = 1. CONCLUSION These results show that whole body CT in trauma has a high sensitivity and a low rate of missed injuries (2.4%). However, our study only evaluated a subgroup of patients with ISS > 15 and further work is required to assess the use of this investigation for all major trauma patients.

35. Do multidisciplinary cancer care teams suffer decision-making fatigue: an observational, longitudinal team improvement study.

**Authors**

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**Abstract**

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OBJECTIVE: The objective of this study was to examine effectiveness of codesigned quality-improving interventions with a multidisciplinary team (MDT) with high workload and prolonged meetings to ascertain: (1) presence and impact of decision-making (DM) fatigue on team performance in the weekly MDT meeting and (2) impact of a short meeting break as a countermeasure of DM fatigue. DESIGN AND INTERVENTION: This is a longitudinal multiphase study with a codesigned intervention bundle assessed within team audit and feedback cycles. The interventions comprised short meeting breaks, as well as change of room layout and appointing a meeting chair.

SETTING AND PARTICIPANTS: A breast cancer MDT with 15 members was recruited between 2013 and 2015 from a teaching hospital of the London (UK) metropolitan area. MEASURES: A validated observational tool (Metric for the Observation of Decision-making) was used by trained raters to assess quality of DM during 1335 patient reviews. The tool scores quality of information and team contributions to reviews by individual disciplines (Likert-based scores), which represent our two primary outcome measures. RESULTS: Data were analysed using multivariate analysis of variance. DM fatigue was present in the MDT meetings: quality of information (M=16.36 to M=15.10) and contribution scores (M=27.67 to M=21.52) declined from first to second half of meetings at baseline. Of the improvement bundle, we found breaks reduced the effect of fatigue: following introduction of breaks (but not other interventions) information quality remained stable between first and second half of meetings (M=16.00 to M=15.94), and contributions to team DM improved overall (M=17.66 to M=19.85). CONCLUSION: Quality of cancer team DM is affected by fatigue due to sequential case review over often prolonged periods of time. This detrimental effect can be reversed by introducing a break in the middle of the meeting. The study offers a methodology based on ‘team audit and feedback’ principle for codesigning interventions to improve teamwork in cancer care.

36. Complications related to peri-operative transoesophageal echocardiography - a one-year prospective national audit by the Association of Cardiothoracic Anaesthesia and Critical Care.

Authors: Ramalingam, G; Choi, S-W; Agarwal, S; Kunst, G; Gill, R; Fletcher, S N; Klein, A A; Association of Cardiothoracic Anaesthesia and Critical Care

Source: Anaesthesia; Jun 2019

Abstract: Previous studies on the safety of peri-operative transoesophageal echocardiography seem to suggest a low rate of associated morbidity and mortality. That said, there has been a paucity of prospective multicentre studies in this important area of clinical practice. We carried out a one-year prospective study in 2017, co-ordinated by the Association of Cardiothoracic Anaesthesia and Critical Care, to determine the rate and severity of complications associated with peri-operative transoesophageal echocardiography in anaesthetised cardiology and cardiac surgical patients. With the help of clinicians from 28 centres across the UK and Ireland, we recorded the total number of examinations conducted in anaesthetised patients during the study period. All major complications at each centre were prospectively reported and recorded. Of the 22,314 examinations, there were 17 patients diagnosed with a major complication which caused either palatal injury or gastro-oesophageal disruption. This corresponds to an incidence of 0.08% (95% CI 0.05-0.13%) or approximately 1:1300 examinations. There were seven deaths reported during the study period which were directly attributed to these complications, corresponding to an incidence of 0.03% (95% CI 0.01-0.07%) or approximately 1:3000. These figures are higher than previously reported and suggest a high probability of death following the development of a complication (~40%). Most complications occurred in patients without known risk factors for transoesophageal echocardiography associated gastro-oesophageal injury. We suggest clinicians and departments review their procedural guidelines, especially in relation to probe insertion techniques, together with the information communicated to patients when the risks and benefits of such examinations are discussed.

37. Effectiveness of behavioural interventions to reduce urinary tract infections and Escherichia coli bacteraemia for older adults across all care settings: a systematic review.

Authors: Jones, L F; Meyrick, J; Bath, J; Dunham, O; McNulty, C A M

Source: The Journal of hospital infection; Jun 2019; vol. 102 (no. 2); p. 200-218
BACKGROUND Escherichia coli bacteraemia rates in the UK have risen; rates are highest among older adults. Previous urinary tract infections (UTIs) and catheterization are risk factors.

AIM To examine effectiveness of behavioural interventions to reduce E. coli bacteraemia and/or symptomatic UTIs for older adults.

METHODS Sixteen databases, grey literature, and reference lists were searched. Titles and/or abstracts were scanned and selected papers were read fully to confirm suitability. Quality was assessed using Critical Appraisal Skills Programme guidelines and Scottish Intercollegiate Guidelines Network grading.

FINDINGS Twenty-one studies were reviewed, and all lacked methodological quality. Six multi-faceted hospital interventions including education, with audit and feedback or reminders reduced UTIs but only three supplied statements of significance. One study reported decreasing catheter-associated UTI (CAUTI) by 88% (F(1,20) = 7.25). Another study reported reductions in CAUTI from 11.17 to 10.53 during Phase I and by 0.39 during Phase II (χ² = 254). A third study reported fewer UTIs per patient week (risk ratio = 0.39). Two hospital studies of online training and catheter insertion and care simulations decreased CAUTIs from 33 to 14 and from 10.40 to 0. Increasing nursing staff, community continence nurses, and catheter removal reminder stickers reduced infection. There were no studies examining prevention of E. coli bacteraemias.

CONCLUSION The heterogeneity of studies means that one effective intervention cannot be recommended. We suggest that feedback should be considered because it facilitated reductions in UTI when used alone or in multi-faceted interventions including education, audit or catheter removal protocols. Multi-faceted education is likely to be effective. Catheter removal protocols, increased staffing, and patient education require further evaluation.

38. National prospective observational study of inpatient management of adults with epistaxis - a National Trainee Research Collaborative delivered investigation.

Authors
INTEGRATE (UK National ENT research trainee network) on its behalf; Mehta, Nishchay; Stevens, Kara; Smith, Matthew E; Williams, Richard J; Ellis, Matthew; Hardman, John C; Hopkins, Claire

Source Rhinology; Jun 2019; vol. 57 (no. 3); p. 180-189

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Available at Rhinology 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 There is a paucity of high-quality evidence relating to the management of epistaxis severe enough to require admission to a hospital. Previous studies of interventions for epistaxis have suffered from small sample sizes. They lacked the power to allow analysis of the effect of an intervention on epistaxis control that is independent of the condition severity or additional interventions given. OBJECTIVE To determine the effect of specialist treatments on the successful management of severe epistaxis. METHODOLOGY: Secondary analysis of data collected from a national multi-centre audit of patients with epistaxis over 30 days in 2016. Data were entered prospectively, and patients were followed up for 30 days following hospital discharge. 1402 adults admitted for inpatient management of epistaxis were identified in 113 participating UK hospitals, with data entered prospectively during the 30-day audit window. Exposure variables assessed included treatment instigated at first ENT review, intervention strategy during hospitalization, disease factors (e.g. severity), patient risk factors (e.g. co-morbidities, medications) and treatment factors (grade of doctor, therapies initiated during hospital stay). Main Outcomes include treatment time (time from first ENT review to time haemostasis was achieved and patient was safe for hospital discharge) and 30-day hospital readmission rate. RESULTS 834 patients had sufficient data for inclusion. Patients who did not receive nasal cautery at first specialist review had a treatment time greater than double the time of those who were cauterised: Adjusted ratio (aR) 2.5 (95% CI 1.7-3.3), after controlling for age, bleeding severity, and whether they received a nasal pack or not. Only 30% of patients received treatment that complied with new national guidance, but those that did were 87% more likely to achieve haemostasis before those that did not, even after controlling for bleeding severity. Type of treatment, whether initial intervention or management strategy, did not affect 30-day re-attendance. CONCLUSIONS Analysis of national audit data suggest that cautery at first specialist review, and management according to national guidance can reduce hospital treatment times without compromising 30-day re-attendance. Future work should investigate why early nasal cautery is infrequently used, and how service delivery can be optimised to allow widespread implementation of evidence-based management for epistaxis.

39. Association between surgeon special interest and mortality after emergency laparotomy.

Authors
Boyd-Carson, H; Doleman, B; Herrod, P J J; Anderson, I D; Williams, J P; Lund, J N; Tierney, G M; NELA Collaboration

Source
The British journal of surgery; Jun 2019; vol. 106 (no. 7); p. 940-948

Abstract

BACKGROUND There are 30,000 emergency laparotomies performed each year in England and Wales. Patients with pathology of the gastrointestinal tract requiring emergency laparotomy are managed by general surgeons with an elective special interest focused on the upper or lower gastrointestinal tract. This study investigated the impact of special interest on mortality after emergency laparotomy. METHODS Adult patients having emergency laparotomy with either colorectal or gastroduodenal pathology were identified from the National Emergency Laparotomy Audit database and grouped according to operative procedure. Outcomes included all-cause 30-day mortality, length of hospital stay and return to theatre. Logistic and Poisson regression were used to analyse the association between consultant special interest and the three outcomes. RESULTS A total of 33,819 patients (28,546 colorectal, 5,273 upper gastrointestinal (UGI)) were included. Patients who had colorectal procedures performed by a consultant without a special interest in colorectal surgery had an increased adjusted 30-day mortality risk (odds ratio (OR) 1.23, 95 per cent c.i. 1.13 to 1.33). Return to theatre also increased in this group (OR 1.13, 1.05 to 1.20). UGI procedures performed by non-UGI special interest surgeons carried an increased adjusted risk of 30-day mortality (OR 1.24, 1.02 to 1.53). The risk of return to theatre was not increased (OR 0.89, 0.70 to 1.2). CONCLUSION Emergency laparotomy performed by a surgeon whose special interest is not in the area of the pathology carries an increased risk of death at 30 days. This finding potentially has significant implications for emergency service configuration, training and workforce provision, and should stimulate discussion among all stakeholders.

40. Characteristics and outcome of acute heart failure patients according to the severity of peripheral oedema.
BACKGROUND Most trials of patients hospitalized for heart failure focus on breathlessness (alveolar pulmonary oedema) but worsening peripheral oedema is also an important presentation. We investigated the relationship between the severity of peripheral oedema on admission and outcome amongst patients with a primary discharge death or diagnosis of heart failure.

OBJECTIVES We tested the hypothesis that severity of peripheral oedema is associated with length of hospital stay and mortality.

METHODS Patient variables reported to the National Heart Failure Audit for England & Wales between April 2008 and March 2013 were included in this analysis. Peripheral oedema was classified as ‘none’, ‘mild’, ‘moderate’ or ‘severe’. Length of stay, mortality during the index admission and for up to three years after discharge are reported.

RESULTS Of 121,214 patients, peripheral oedema on admission was absent in 24%, mild in 24%, moderate in 33% and severe in 18%. Median length of stay was, respectively, 6, 7, 9 and 12 days ($P < 0.001$), index admission mortality was 7%, 8%, 10% and 16% ($P < 0.001$) and mortality at a median follow-up of 344 (IQR 94–766) days was 39%, 46%, 52% and 59%. In an adjusted multi-variable Cox model, the hazard ratio for death was 1.51 for severe ($P < 0.001$, CI 1.50–1.53), 1.21 for moderate ($P < 0.001$, CI 1.20–1.22) and 1.04 (CI 1.02–1.05) for mild peripheral oedema compared to patients without peripheral oedema at presentation.

CONCLUSION Length of hospital stay and mortality during index admission and after discharge increased progressively with increasing severity of peripheral oedema at admission.