The PHYSICIAN

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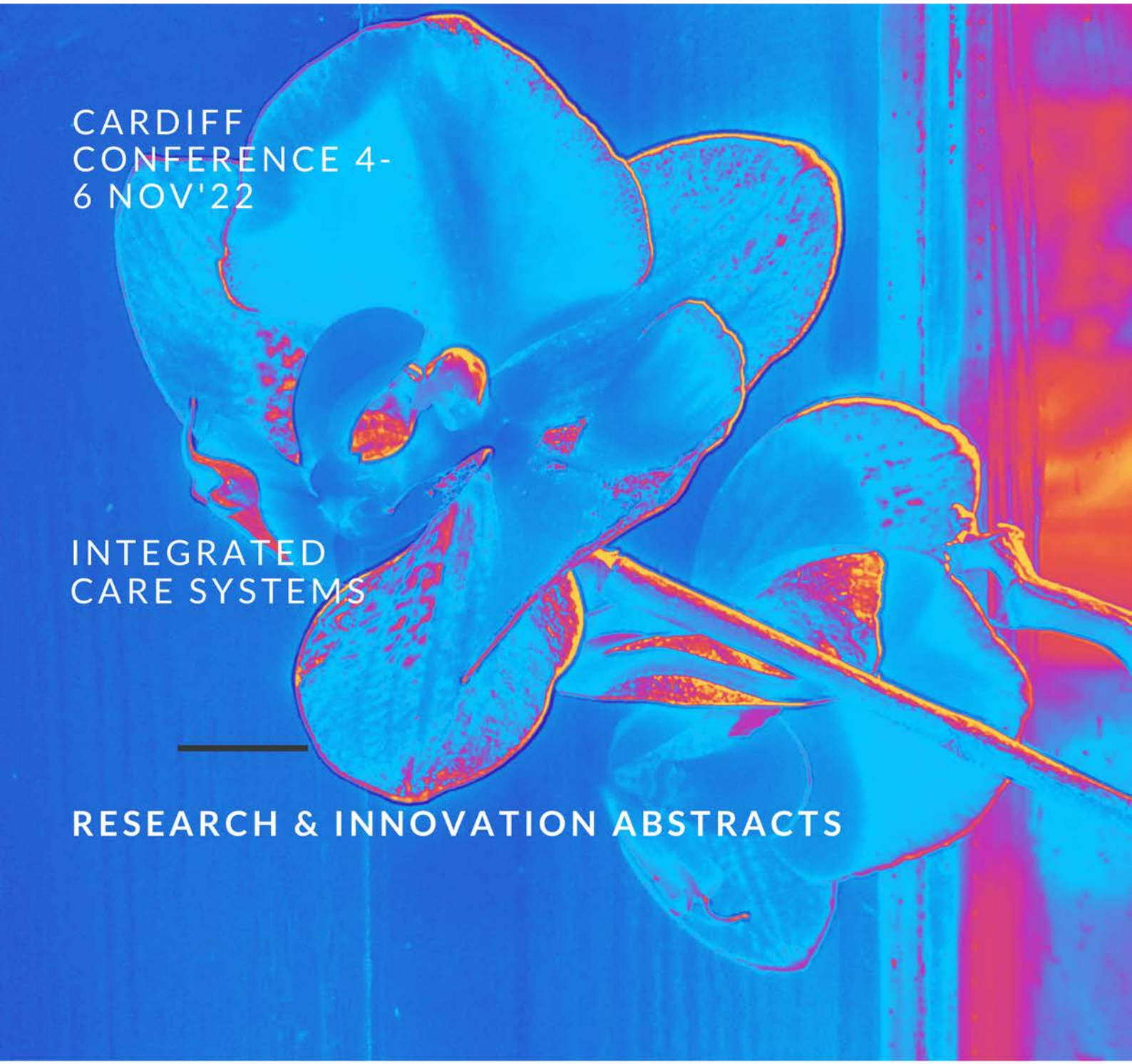

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About The Physician

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BAPIO Publications for
British Association of Physicians of Indian Origin,
Bedford, UK
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Additional content available at The Physician
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Online first - https://www.physicianjnl.net

Scope
The Physician will accept submissions from across the healthcare spectrum but is particularly interested in issues that impact the health of migrants, international medical/ nursing graduates, diaspora studies, and differential outcomes in patients and professionals based on ethnicity or other protected characteristics. The editorial board welcomes submissions from new or emerging researchers and early-career clinicians.

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Each print/ PDF whole issue has a current circulation of >10,000 among health professionals in the UK and is also available globally to download for free and purchase at a cost price from the website.

Indexing & Frequency
The Physician has been published since 2012 in print, previously in time with BAPIO national conferences, including conference abstracts. Since Jan'20, it has been published online and in regular print editions.
It is a member of Crossref, and all published articles are registered with DOI and cited in Google Scholar and ScienceOpen. It will be submitted for indexing in PUBMED in 2023; once accepted, all archived content will be available retrospectively.

Peer Review Policy
The Physician has moved from a traditional blind to an open, post-publication peer-review process in 2020. Once submitted by the Editor(s), all manuscripts are published online in the 'pre-print' format. The peer-review process continues, and all peer-review recommendations and revisions/author rebuttals are published online. A minimum of 2 peer reviews is required for final acceptance.

Where authors or co-authors may be part of the journal's Editorial Board, The Physician follows a transparent process of assigning the manuscript to an editor not connected with the article and seeking 2 external reviewers. The peer reviews are open and published alongside the article.

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- Allegations of misconduct
- Authorship and contributorship
- Complaints and appeals
- Conflicts of interest / Competing interests
- Journal management
- Post-publication discussions and corrections

Archiving
All published manuscripts are archived in OJS, BPL Cloud drive and will be permanently archived in CLOCKSS shortly.
Zero Article Processing Charges
The journal does not apply any charges to authors at present.
In 2020-2021, the journal offered to fully subsidise article processing charges for all submissions. In subsequent years, article processing charges will continue to be reasonable as BAPIO is a not-for-profit organisation and fully subsidised for BAPIO members and associates.

A NEW HOPE FOR BRITAIN

I am writing this message in the week Rishi Sunak, a person of Indian origin took over as the Prime Minister of the United Kingdom. It seems we have come a long way in respect of equality and inclusion since BAPIO was launched 25 years ago. However, I also know there is a long way to go before discrimination and racism in society, the workplace is eliminated, and the principles of equality and justice prevail.

We at BAPIO are committed to upholding the principles of equality, diversity, and justice for our patients and our colleagues. In this context, I am proud of our recent contributions. We undertook a project on Tackling Differential Attainment in the Medical Profession - 'Bridging the Gap'.

Over one year with contributions from 150 professionals, we critically considered what progress has been made and asked honest questions about changing the face of inherent hurdles that require intervention to make equity in medical careers, a reality. This project is set change the scope of DA in the next few years, and achieve one of our cardinal missions as an organisation.

We defined the gold standard for dignity in the workplace. 'The Dignity at Work Standards' was created with the help of over 50 stakeholders. This was followed by a Charter for 'Locally Employed Doctors'. We will continue our efforts to positively promote equity.

Our two academic journals, The Physician and the Sushruta are gaining global recognition under the supervision of a highly talented team of BAPIO Institute for Health Research.

The BAPIO Training Academy is growing by leaps and bounds. It has several International Fellowship programs to promote excellence in education and career progression and at the same time support staff shortages in the NHS.

The Medical Defence Shield continues to provide excellent support to doctors in difficulty with an excellent success rate at the MPTS hearing. British Indian Nurses Association is an 'arm's length body' of BAPIO. Just in two years of inception it has grown significantly and is providing pastoral care to newly arrived nurses from India and at the same time supporting the existing Indian nurses.

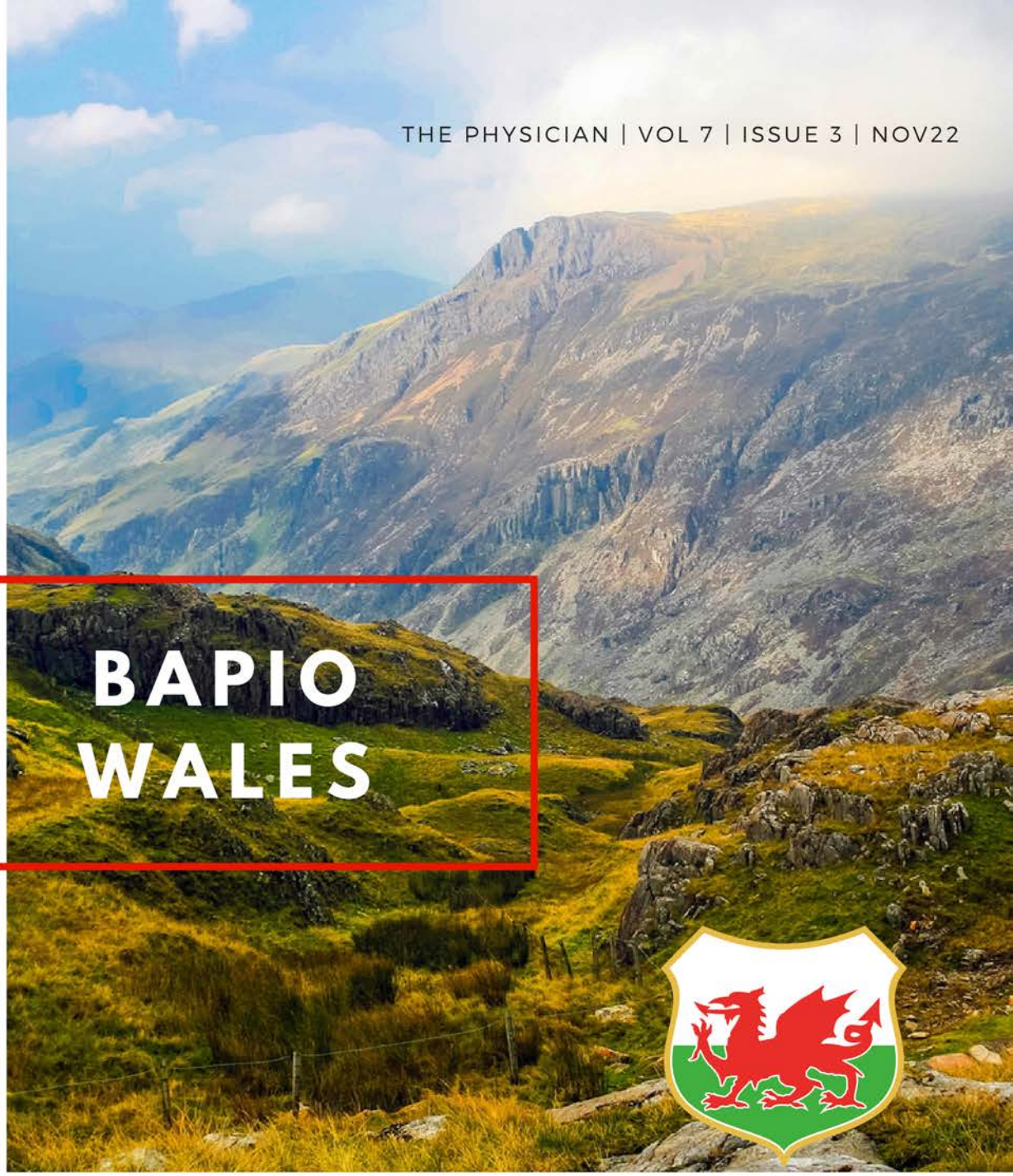
We continue to reach out to NHS Trusts to develop partnerships to assist with the EDI agenda but also provide support with recruitment, retention, and pastoral care for staff while promoting dignity at work. The dark clouds of the pandemic are lifting and it is a great feeling that after almost 2 years of being locked in the house we are now able to meet face-to-face and socially interact.

BAPIO Annual Conferences have evolved into an important national event in the UK medical calendar. BAPIO is now recognised as an important partner in the healthcare sector and our opinion at the national level is respectfully acknowledged. It is also a great event for networking and meeting who's who in the UK health sector.

I hope you have seen the BAPIO documentaries and the song commissioned to celebrate our silver jubilee. These are now available on BAPIO YouTube.

Finally, we have just finished the Diwali celebrations! May the message of Diwali fill your hearts with joy and peace. We are sending lots of love to you and your family. Take care of yourselves and stay safe.

Ramesh Mehta OBE
President, BAPIO
Annual Conference, Cardiff, November 2022



BAPIO WALES

A warm welcome to Cardiff, the capital city of Wales.

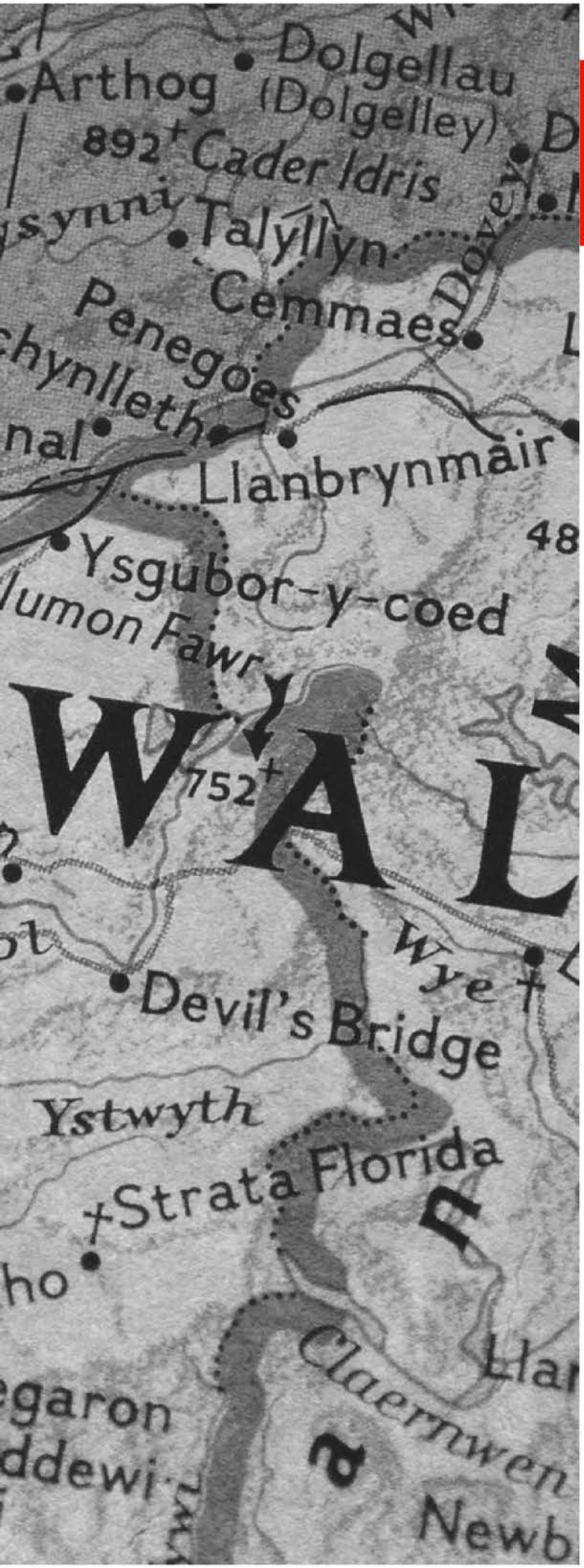
BAPIO Annual Conference this year brings us together at a time of many challenges and opportunities. We come together against the backdrop of dealing with the aftermath of the Covid-19 pandemic, the emerging worldwide financial situation, The workforce challenges of our NHS, and the increasing challenge of environmental sustainability and its effects on health.

The conference brings together the key themes and focuses on our members' contributions to help solve some of these critical issues.

Delegates, Cardiff is a vibrant city known for its diversity and multicultural communities and home to the Welsh parliament. Wales is a country steeped in its language and culture. We are a proud nation, the birthplace of Aneurin Bevan, founder of our NHS.

Modern Wales is welcoming, inclusive, and ambitious for all its people and our city. We look forward to welcoming you back in the future. We recognise the commitment and enthusiasm of our excellent organising committee led by Prof Keshav Singhal MBE; Without them, none of this would have happened. Thank you.

Hasmukh Shah
Secretary, BAPIO Wales



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ANNUAL CONFERENCE CARDIFF 4 NOV 2022

MERCURE HOTEL, LLANEDERYN

09:00 REGISTRATION

Coffee

09:20-09:40 BINA SESSION

- Welcome - H Shah
- Chairman's address - JS Bamrah

09:40-10:35 INTERNATIONAL NURSE RECRUITMENT

- Chairs - M Coumarassamy & H Powell
- Keynote: R Desir, Nursing Off, Wales- Priorities for a diverse NHS Workforce.
- Opportunities for int nurses in Public Health- R Beaumont-Wood, Exec Dir, Public Health Wales
- International Nurse Recruitment – Progress: J Roberts, Exec Dir Nursing, Cardiff & Vale Univ HB
- Support for Int Educated Nurses: R Metri, Exec Lead (Wales), BINA
- Q & A

10:35 - 11:30 PROFESSIONAL DEVELOPMENT IN NURSING

- KEYNOTE - Happy staff happy patients - D Burton, CNO, NHSE
- Nurturing through coaching - R Beaumont-Wood, Public Health Wales
- Supporting Higher Education - S Hunt, HEI consultant
- Developing a diverse workforce - R Desir, Nursing Officer
- Q&A

11:30 BREAK

Coffee

ANNUAL CONFERENCE CARDIFF 4 NOV 2022

MERCURE HOTEL, LLANEDERYN

11:45-12:00 NHSE/I & HEE- IMPACT OF THE MERGER

- Interview with Navina Evans by G Byrne & R Mehta

12:00-12:30 MIGRATION OF INDIAN HEALTH PROFESSIONALS

- Ethical migration pathways
- Global fellows in Emergency Medicine
- EMP Development for Medical Oncologists
- WYHCPB and ODEPC to recruit RNs in W Yorkshire
- Diagnostic Radiographers

12:30-13:00 ETHICAL PARTNERSHIP

What an ethical partnership may look like moving forward including tripartite relationships with other developing nations

13:00- 14:00 LUNCH

14:00-14:30 OPPORTUNITIES FOR INDIAN HEALTH PROFESSIONALS

14:30-15:30 WOMEN'S FORUM

Chairs - M Subramaniam, U Gordon & G Menon

- Gender & Climate Change - J Srinivas
- Women in Conferences - J Vasani
- Lift while climbing - S Kinra
- Panel discussion - L Gokhale, M Mitra

15:30-16:15 UNDERSTANDING NHS GOVERNANCE

- Interactive session with Prof Derek Bell, Past President, RCPE

16:15-17:00 SAFETY & WELLBEING

- Improving working lives
- Tackling bullying - N Kapoor
- Disciplinary processes - S Kumar
- Panel discussion- R Ananthakrishnan, R Singh, B Chawda, I Devi

ANNUAL CONFERENCE CARDIFF 5 NOV 2022

TOWN HALL, CARDIFF

07:30-08:30 WELLNESS YOGA

R Baikady, K Mehta & R Metri

09:00-09:30 REGISTRATION

09:30-09:45 WELCOME

- Welcome - H Shah
- President's address - R Mehta

09:45-11:30 PATHWAYS TO RECOVERY FROM COVID-19

Chairs - K Singhal & S Mathew

- 09:45 - Personal narratives - Patient & Doctor
- Mentimeter survey - Issues impacting recovery for the NHS- K Mukherjee & A Gaitonde
- 10:00 - NHS plans for recovery

Chairs S Hemmadi & S Daga

- Comments from professionals on the road to recovery
- Panel Discussion - N Wood, C Jones, B Simon, G Byrne
- Mentimeter survey - A Wagle, Y Nathdwarawala

10:45-11:00 KEYNOTE - MORALE OF THE NHS STAFF IS A PRIORITY

Chairs JS Bamrah & B Rao
Sir Frank Atherton, CMO, Wales

11:00 BREAK

Coffee

11:20 CHIEF GUEST - PROF MARK DRAKEFORD MS

First Minister of Wales
Chairs K Singhal & U Gordon

11:35-11:55 DEBATE

Overdiagnosis and overtreatment are causing the medicalisation of trivial illnesses
Murali Verma
Chairs - K Mehta & S Shah; Moderator K Singhal
Mentimeter survey - S Berry

ANNUAL CONFERENCE CARDIFF 5 NOV 2022

TOWN HALL, CARDIFF

11:55-12:25 GUEST LECTURE - UNA LANE - GMC IS RESPONDING TO MEMBERS' CONCERNS

- Director of Registration and Revalidation
- Panel discussion - A Shah, P Banfield, G Byrne
- Chairs - A Sharma & R Gupta

12:25-13:20 WELLBEING - HAPPY STAFF-HAPPY PATIENTS

- 12:25 Challenge of global healthcare staff shortage - N Simon

Chairs - S Bhatia & S Chakravorty

- 12:40 Keynote - Education and Training in the next decade - S Gregory, MD, Primary & Integrated Care, HEE
- Panel Discussion - P Banfield, I Collins, A Chopada, M Coumarassamy

Chairs - S Hosdurga & I Chopra

13:30- 14:15 LUNCH & POSTER VIEWING

14:15 - 17:00 PARALLEL SESSION- RESEARCH & QI PRESENTATIONS

BAPIO INSTITUTE FOR HEALTH RESEARCH

14:15 - 15:00 BAPIO TRAINING ACADEMY

Chairs - A Chandratreya & V Gupta

- BTA International Programs - P Singhal
- Panel Discussion - Making training count
- U Lane, P Singhal, I Singh, D Bell & S Barnwal

15:00-15:40 MEDICAL DEFENCE SHIELD

Professional indemnity in your hour of need
Chairs - R Katimada & S Mathew
The triple jeopardy of medical practice- J Grover
Panel discussion - Stress of being referred to the GMC

15:40-16:25 BAPIO INSTITUTE FOR HEALTH RESEARCH

Chairs - S Dave & MS Kamath

- Equality through evidence - I Chakravorty
- Dignity at Work Standards - C George
- Locally Employed Doctors - R Gajanan
- Panel discussion - Moderator S Sharma; CR Chandra, M Patel, I Chakravorty, C George, R Gajanan & A Latheef

16:25-17:10 FACULTY OF LEADERSHIP

Chairs - G Menon & V Nayar
Guest lecture - Kamaljeet K Bains, UK Weight lifting champion
Panel Discussion - A Dave, S Daga, C Nagpaul, S Gregory

ANNUAL CONFERENCE CARDIFF 6 NOV 2022
MERCURE HOTEL, LLANEDERYN

07:30-08:30 WELLNESS MORNING WALK

N Berry & A Miskin

09:00-09:25 REGISTRATION & WELCOME

N Byrappa

09:30-10:15 PAEDIATRIC FORUM

- Chairs - S Goyal & N Sharma
- The journey of a thousand miles - I Thakrar
- Buildind a sustainable NHS Workforce - A Ramachandran
- Panel discussion - S Hosdurga & A Dhelaria

10:00-13:00 BIHR PRACTICAL MASTERCLASS

10:00 – 10:30 Understanding stages of research
10:30 – 11:30 Transforming a research question into a study
11:30 – 12:30 How to write a good paper and get it published

10:15-11:00 GP FORUM

Chairs - C Nagpaul

- 10:45 - Journey from 'needing improvement to 'outstanding' - UA Tanvir Alam
- 11:00- Optimising practice resources - F Rizvi
- Panel discussion - KK Tumurugoti, H Shah, S Agrawal & M Nagpal

11:00 BREAK

Coffee

11:15-12:00 SAS-LED FORUM

Chair K Gajanan

- Panel discussion - Your voice matters-guiding the future for SAS doctors - A Kochar, M Hemadri
- Panel discussion - Challenges faced by LEDs - P Nageswaran

12:00 - 12:45 YDF & MEDICAL STUDENTS FORUM

- Origins of YDF - S Moudhgalya, C Dominic
- Overview of YDF work - N Natarajan, A Banerjee, C Mascarenhas, R Bharadwaj

13:00 VOTE OF THANKS

S Gaitonde

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MUSINGS ON THE MONARCHY

EDITORIAL

And the passing of HM QE II

INDRANIL CHAKRAVORTY

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The events that unfurled in the UK and around the world following the announcement from the Royal household on September 8, 2022, were of a scale hitherto unwitnessed in recent times. Before the cartoonists and their followers on the Twitter-sphere had time to milk the maximum footage from the apparent exchange between the Queen and her 15th prime minister (rumoured to include a reference to their names- one Liz to another) came the grim announcement that the Queen had died peacefully at Balmoral Castle. When she missed the Privy Council meeting the day before online, and the palace announced that her doctors had advised her to rest, many had started predicting the worst. On the day, as the BBC presenters changed to a dark theme and the nation's mood became sombre, we feared the worst. In between seeing patients in the clinic, eyebrows were raised, and furtive glances were exchanged as we waited for the inevitable.

There was a finality in the announcement that the Queen had died. We in the healthcare profession know this for sure and encourage people to accept the inevitable, to remain brave and, when counselling, advise the bereaved to focus on the good times that have come, the life and achievements of the deceased. When the whole nation (or the vast majority, as far as we know) are grieving, who do you turn to for comfort?

Death is often described as the only truth in the world by some. Those less poetic often equate the purpose of life with the end goal. Indeed, poets such as Rabindranath Tagore consider death to be the extinguishing of a candle and the harbinger of a new dawn. Growing up as children in a newly independent India, our parents learnt of the new dawn that had arrived but with much pain, anguish and destruction of millions of innocent lives due to the ill-planned partition of India. Yet, soon after, the crown was thrust upon a young princess as Queen Elizabeth II was coronated. She had little preparation for the role of a monarch of an empire that was going through the pangs of giving birth to independent nations.

And the passing of HM QE II

The Commonwealth was born to preserve the legacy of the empire, and many were not entirely enamoured by what the empire had done to its subjects. There were deep wounds to reckon with, a legacy that stretched over centuries of injustice, slavery, indenture, stories of trust and betrayal, of torture and repression and financial ruin as vast amounts of wealth were unfairly taken from the dominions.

The young Queen faced the unique challenge of having to come of her own while the gargantuan Commonwealth came into being. The Commonwealth was not the league of nations, nor could it be built in the aftermath of the World Wars; it had a different history. There was so much hurt in the world that it would have been natural for most countries that gained freedom from the Crown to violently reject any reference to the crown and shun everything associated with it. Yet, the opposite happened, and one wonders why?

In the next 70 years of her reign, Queen Elizabeth II visited over 120 countries. She managed to keep the Commonwealth of independent nations maintaining a connection with their shared history and their destiny, their virtual allegiance to the crown. Many post-colonial authors, historians, politicians and economists pointed out how the empire has destroyed centuries of potential growth, crippling financial ruin, the enormity of the human tragedy of slavery and indenture, and the terrible wounds of partition. Yet, the populace in the Commonwealth chose not to identify Queen Elizabeth II personally with any of these injustices.

To them, she was the embodiment of hope and glory, the nearest they could come to the promise. It is true that, as humans, many of us find comfort in the belief that we are not alone in times of our deepest despair and desperation; what keeps us going is the faith that there is someone above who will deliver us through our darkest hour.

Growing up in a scientific household, one has learned to question, observe, and rationalise. When visiting majestic temples, churches and grandiose mosques, one has often wondered what brings people to have faith in one that cannot be seen, heard, touched or experienced by application of any of our senses. Nor can be predicted or calculated by the application of scientific principles. What drives the creation of such masterpieces as Abu Simbel, the Inca places of worship, the cave paintings of Ajanta, the Buddha of Bamiyan, the Greek temple of Apollo and the Sistine chapel? As humans, we need a scaffolding with which to structure our lives, to make sense of the world around us and perhaps religion offers us that which brings peace to the soul.

There is no denying that however far back one cares to look in what can be gleaned from human history, there are clear examples of belief in such that we refer to as Gods, Goddesses or Holy spirits. This is not a treatise on religion, nor has the author any knowledge or authority to write about such elan ethereal subject matter. It is merely personal speculation on why a hereditary monarchy still captures the imagination of the vast majority of the populace, at least in the UK (if regular polls on the monarchy are to be trusted) and elsewhere in the world, within and beyond the virtual reach of the Commonwealth.

Queen Elizabeth II believed in divine right. Her divine right to be the rightful monarch and her duty to God and country. She took her duty seriously and delivered with sincerity that can only come from absolute belief. Yet, in 1649, Oliver Cromwell deposed the then King, removed the divine right to rule and established Parliamentary sovereignty. Even when King Charles II was restored as King of England in 1660, the divine right to rule was only returned nominally and severely restricted to only a virtual function at the mercy of the elected members of the House of Commons.

Throughout her long reign, the country, its intelligentsia, its people through their representatives and her erstwhile subjects across the Commonwealth have grappled with the role of the hereditary monarchy and the sanctity of the divine right to the throne. Somewhat remarkably, Queen Elizabeth II managed to keep herself endeared to her public, to keep her head above such controversies with the monarchy debate, and even when a severe challenge was presented in her personal household, she remained steadfast in her own resolve, her divine duty and steered the monarchy away from choppy waters. It is her personal legacy that the monarchy has survived to this day but, as is visible from the outpouring of public grief and affection, has gained immensely in strength.

As she lies in state in Westminster Palace, the queue stretches to 5 miles, and her subjects wait over 24 hours to pay their respect to her departed soul. They come, old and young, people of all colour, all religions and they file past her in silence, in solemnity and offer their affection. Some just want to be in her presence; not many have had the chance to be so close to her mortal self before as they do now.

Some of us are incredibly lucky to be invited to the funeral service in Westminster Abbey. A selection of people receiving her birthday honours is invited to share on the solemn occasion. As an Indian at heart and British by choice, having dedicated the best part of one's blood, sweat, toil and enterprise to Britain, one has to make sense of why this is such a privilege. The more I read of her reign, the more I try to make sense of the terrible injustices that are a direct consequence of the empire; one cannot associate Queen Elizabeth II personally with any of that. I find myself unknowingly shedding many tears as I think of her dedication to duty, of not taking a single false step all her life, except perhaps misjudging the affection that Diana commanded among her loyal subjects.

HM QE II

I can only feel love, affection and massive respect for her exemplary life in public and private. Yes, she did not once acknowledge nor apologise for the historic injustices carried out in the name of the crown before her time and also, as some will point out, during her reign. Perhaps she could have done more, engaged with her subjects, influenced some of her 15 premiers to change the course of history for her Commonwealth subjects, and offered reparation. Perhaps, the new King will change her hands-off approach to politics and engage with justice for humanity and climate change. It is a double-edged sword, as engagement may allow the Commons to remove the last vestiges of the monarchy if one loses step with the mood of the public. As we watch the outpouring of affection, the nearly million people who are predicted to file past her coffin, and billions more who watch around the world, one cannot help but wonder that the best lesson for the new King has to be the masterclass that Queen Elizabeth II demonstrated through her life.

May her soul rest in peace. Long live the King.

AN EQUAL BRITIAN

My personal experience is not unique. Over the years, I have come across many similar stories. Many deserving candidates have lost out for reasons often difficult to fathom. The NHS loses out if the best candidate does not get the job.

Vipin Zamvar, zamvarv@hotmail.com; Twitter: @VipinZamvar

As I travel to Cardiff for the BAPIO Annual Meeting, I am very excited at the prospect of visiting the hospitals where I worked more than two decades ago. I spent some of the best times of my professional life in Cardiff, and some of the most bitter too. I had completed my basic cardiac surgical training in Southampton and Manchester when I arrived as a numbered trainee in Cardiff.

As a trainee the hours were long, but the benefits were immense. There was a lot of theatre time and within a couple of years I became an independent operator. As fate would have it just after getting my CCST, a locum position opened up in the same unit which I was offered. For almost two years, I had some of the best times as a professional. I was able to develop my special interests in off-pump coronary surgery and arterial revascularisation.

But it was all fine as long as I was a locum. When the substantive post came up, it was not for me. Not because I had any less clinical experience; not because I had a less accomplished CV, and definitely not because there was anything lacking clinically during my time as a locum, (on the contrary, it was the other way round). Rather, my belief is that the substantive post was not for me for completely different reasons. Reasons that I have never been able to fathom. In my search for a substantive post, I attended many interviews. The feedback was always predictable.

When I had less operative experience, it was "someone else had more experience"; when I had more operative experience, it was "someone else had more research experience". And when I had more operative and research experience, it would be something else. The goalposts were never clearly defined for me. The feedback I received when applying for the Cardiff job was perhaps the most memorable: "Research and clinical experience are important, but we also look at potential". Well, no one can argue against that. This can be a very valid reason, but it requires those in positions of power to have unblinkered glasses. When there is subconscious bias, this type of excuse becomes a rubber-stamp for legitimising their racist opinions. Fate took to me to Edinburgh, where I found excellent and supportive colleagues and the opportunities to develop professionally. The bitterness of the Cardiff experience quickly diluted over time. Sometime later when a colleague from Cardiff called to say that there was talk of a surgeon (who had been appointed there) being asked to stop operating independently or to go elsewhere for re-training, the bitterness did not resurface. Nor was there an element of schadenfreude. All that I found in myself were feelings of indifference. How did I cope? My experience of attending more than 20 interviews and getting feedback (which in many cases I sincerely found difficult to believe) made me determined to just be a bit better next time. Those fateful years taught me to be more resilient. They also made me intensely determined to just get a little bit better for "tomorrow". I did consider complaining. After one particular rejection, I sought the help of the BMA, I was advised (quite rightly) that the cardiac surgical community is a very small one, and that I should not be in the limelight for the wrong reasons; I must definitely not rock the boat.

What is the purpose of writing this story today? This experience of mine could very well stay in the cobwebs of my personal diaries. The major players from more than 20 years ago have either retired or passed on; others would not care less. But I wanted this story to be heard. I wanted to write so that this experience of mine would be on record. Race equality in the NHS has come a long way in the last two decades. The overt racism of yesteryears has almost but disappeared. But still the unconscious bias that is deeply embedded in society needs to change. There is scope for progress to an equal, fair and just society for all. And for those still facing discrimination, it is important to talk and to seek help.

We invited Lailah Peel, a junior doctor in Scotland, to write for this issue of the Physician. She reflects on her heritage and I was sorry to read that at times she feels not part of the Indian diaspora. This just is not true. The Indian umbrella includes all those who have lived or been part of the Indian canvas at any time in the past. Rishi Sunak has just been sworn in as the UK Prime Minister. This is huge news. No doubt he was the best candidate amongst all those vying for the top job.

He has broken barriers, to be the first brown person to be the UK PM, the first of Indian heritage, and many more. I feel immensely proud to be British today, a country where anything is possible for anyone.

This is a watershed moment in British history and it speaks volumes for this country where anyone can aspire for the top job.

REFLECTIONS ON DIVERSITY & EXCLUSION

Meeting new people is great and can lead to interesting conversations. But as a brown woman of mixed race, there's often an apprehension at the back of my mind.

I have worked as a junior doctor in the NHS for over 10 years across England and Scotland and across a variety of specialties and hospital sites. I've had a full spectrum of experiences – some positive and some less so. We have all had those teams you instantly feel a part of, and those you struggle to feel accepted within. As a junior doctor this is a never-ending challenge with the constant rotations that make up our various training pathways across the UK.

I love what I do. Working in emergency medicine, no two shifts are the same. There is much I could write about why I love my job and my profession, but for me, the greatest inspiration about working in A&E is the variety of people you meet and interact with. I consider myself to be a people person, an extrovert many would say - I love to chat. Whether that be with colleagues, patients, or others along the way. I will nearly always end up finding someone to chat to, wherever I am. Most of the time it's a strength, and a pleasure, but there are times where it can become unpleasant and awkward.

Only recently have I begun to be less afraid of the question "where are you from?" This is mostly because, in Scotland this question seems to focus on my 'English accent' and a curiosity as to why I ventured north and made Scotland my home. My answer is almost universally accepted when I refer to my hometown of Birmingham, even if some may question the authenticity of my accent (my Brummie twang has mellowed over the years and merged with other influences as I've moved around). Very rarely, do I get the dreaded follow up "But where are you really from?" Although it does happen occasionally. The older I am, the braver I am in gently calling this out, refusing to be defined by other people's judgments or prejudices and them not accepting my own definition of where I am from. And at times it can really infuriate me.

As a brown woman, I am used to being a minority most of the time. As a mixed-race woman, I am sadly too used to feeling like an outsider, like I don't belong. There is a debate whenever I fill in a form as to which ethnic group I belong to – even now well into my 30s.

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Aged 14 years, I remember writing a short essay alongside one such question on a form, where I did not feel like I fitted into any of the prescribed categories, only to be faced with the same restrictive and feeling quite 'excluded' trying to fit into these socially constructed boxes, again and again regardless.

Growing up in Birmingham, the communities I was a part of were diverse – or appeared so at least. Even so, I was often at the receiving end of negative comments due to judgements people made about the colour of my skin and that of those around me. Conscious that people might look and 'tut' at me walking with my white father, or my brother with his paler complexion, or not believe I was related to many of my other white family members.

As a teenager, I remember difficulties with many peers from Asian backgrounds, being called a 'coconut' and other derogatory comments, being bullied, or simply just being made to feel different.

This trend, has sadly continued although not as much as before. I recognise now that although I look brown, I often receive interactions and behaviours similar to a privileged 'white' person - meaning I may escape overt racism in a lot of the circumstances. The variable way I get treated by others has, at times, has left me with my own racial biases as a personal defensive mechanism. I have evolved through the years. I have not always felt able to be open about my feelings on experiencing bias, and discrimination, because it's often tricky for people to understand that I have suffered racism from so many different ethnicities.

And if I am truly honest much of the worst racism I have suffered, has been from people who look like me, but can often make me feel very excluded.

When I was asked to write this piece, I was initially a little puzzled. Why would BAPIO want to hear from me? Is that a group that would include me? I hadn't ever really thought so before. I identify as British, as mixed race, as brown - but never Indian.

I was born in Birmingham and grew up there. My Dad is a proud Yorkshire man (my grandfather even more so). My Mum moved to the UK in the 1970s from Goa, where she spent most of her childhood and where I still have lots of family. The association with Portuguese is clear, and Catholicism too, but Indian is a label many of my family would feel uncomfortable with most of the time, myself included. Although it's hard to deny that I have Indian origins, too often both myself and my family have been made to feel different to a community that is technically ours too.

One of the things I love most about the NHS is its core principle to treat everyone based on their needs rather than anything else. The aim for equality runs through every part of the organisation. Sadly, right now it's clear that isn't always the case.

For us as staff or our patients – racism, sexism and other forms of discrimination are sadly too familiar to too many of us. The NHS is made up of diverse staff and patient groups, with people from many different walks of life coming together. I hope that moving forward we can appreciate that we have more in common than our differences and learn to celebrate both our diversity and what unites us, equally.

We are a team, and one I am incredibly proud to belong to. The last few years have been tough, and undoubtedly there's more tough times to come, but I have no doubt that together we can make it through.

AS A PERSON OF COLOUR AND A MINORITY IN BRITAIN, IS IT SAFE TO SPEAK UP?

Can we, as minority professionals, as people of colour, even have any hope to be treated with respect as an equal and be considered a citizen of 'modern multicultural Britain'?

A recent tweet by Nadine White[1] who writes for the Independent set me thinking. People of colour (POC), she wrote, had to be always careful about how they were perceived. This comment was related to the sacking of Kwasi Kwarteng as Chancellor of the Exchequer.[2] Even if POC were successful they had to temper their talk and actions because they would be judged by a different set of standards.

I reflected back on similar thoughts that have crossed my mind over the last many years. As an immigrant to the UK over 30 years ago, it did not really strike me initially that I was of a different colour, because I wasn't much aware of the concept of discrimination. Till then, if at any time, I didn't do as well in my career aspirations, examinations or in job interviews, as someone else, it was obviously because they were simply 'just better' than me. Thoughts of favouritism and discrimination, did not cross my mind.

Slowly over the years, I came to realise that there were double standards and when I have seen my white colleagues act or behave somewhat 'inappropriately' the usual lines quoted (by those in positions of authority) in defending by trivialising their misdemeanours as, 'they did not mean anything bad'. For me, I had to be careful and if I said something even slightly aggressively I was put into a corner and made to feel that I had done something grossly wrong.

I reflected on the impact of a recent interaction with some officials in positions of authority, even before I saw this tweet. I feel that when white people speak to brown or black people they can easily be more aggressive (sometimes labelled as "confidence") and get away with it. This is because deep within them there is a feeling of superiority that comes across, especially in a one to one conversation where it's one person's word against other. It is perhaps time to acknowledge that many minority ethnic staff do not feel they are operating in a 'level playing field'. [3]

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There is evidence that people from a minority background are progressing in nearly every walk of life. This is down to hard work, drive and a determination to succeed, a clear trait among many minority communities. But there are still some blockages and 'snowy white peaks' at the very top of business and in our public institutions.[4] I have noticed that successful brown and black individuals are extremely careful about how they speak up in society, especially for the under-privileged. In fact, they rarely do. They're usually the type of people who have crept their way to the top, often by remaining highly individualistic, focusing on their work, being non-controversial, and of course, extremely good at what they do.

Following the tweet by Nadine White it dawned on me that perhaps they may have a point. I suppose this reflects a choice between self-respect and success, where defining success is always a matter of personal opinion, while self-respect is exactly what it says on the tin. Having said this I do feel that it does not give licence to anyone to behave badly and that we must treat each other with respect and give everyone an element of privacy and private space to be allowed to say what they wish and make the occasional mistake. It is those who make repeated mistakes, behave inappropriately and cause offense or harm to their fellow humans, should and must be called out. Of course the price that one pays when one is a person of colour is a much higher price. In fact those who speak up will rarely be seen to be "successful" in the public domain unless they have started speaking up after they have obtained recognition.

A report by Baroness Casey into the harassment in the Met Police, showed that raising issues relating to racism, or other discrimination and wrongdoing often led to being labelled a trouble maker, which then led to unfair disciplinary action. There were reports that the misconduct system was not sufficiently robust with White officers who breach professional standards, but there was a lower threshold for minority ethnic officers and staff. [5]

Just to make sure that I wasn't getting completely the wrong end of the stick, I ran my perception of disparity in standards of behaviour, by leaders that I have great respect for. They agreed wholeheartedly that this tweet 'nailed it'. It was entirely true that people of colour had to be more careful of how they came across. I have always paid a high personal price for speaking up. I don't really care much because the first thing anyone needs to do is live with oneself and if self-respect means upsetting bad people in the upper echelons, then that is just too bad. The successful ones will say its all a matter of perspective and only end-points matter. Baroness Casey's investigation found that, Black and Asian officers and staff were more likely than their White colleagues to have a misconduct allegation given a case to answer decision, and therefore have sanction justified, while there were no disparity in complaints received from the public. [5] Analysis of data from cases of professional misconduct among medical professionals demonstrate clearly that minority ethnic doctors or nurses face a disproportionately higher risk of referral to the regulator and receiving harsher sanctions compared to their white peers. [6,7][8] They are frequently passed over for promotion and do not have equity of opportunity and the NHS Workforce Race Equality Standards reports do not show consistent improvement as there is a lack of accountability. [9]

No one is free of faults, of making errors of judgement, making unwise choices and certainly the adage, 'to err is human...' is true. Certainly in healthcare this is true regarding medical errors and their consequences, how staff interact with themselves - but effective organisations learn not by pointing fingers at caring health care professionals who make honest mistakes. The problem is not bad people- it is that good people working in unsupported and inadequate systems that need to be made safer. [10] To make this diatribe fair and balanced, we must put the boot on the other foot and have a really good look at ourselves.

We, as individuals whose first language is often not English may not understand the precise combination of words or nuances to express our thoughts fully and accurately. Language is more than a means of communication, it is linked to outcomes in trust, social capital and cultural identification or stereotyping. [11] For any individual, community or group, having assumptions about one's identity or have identities imposed upon can lead to inaccurate stereotyping, and undermining of self-worth. This understanding when it comes to diversity in culture and communication proves the need to better understand the language around it, especially considering its evolution through one's lives. [12] Many of us, 'Easterners', are used to wearing our hearts on our sleeve. It makes us more emotionally volatile, causing offence more easily, and therefore more vulnerable in a society ruled by the stiff, supercilious, and often disdainful upper lip. We often end up choosing the wrong words, or language that may be interpreted as harsh or even rude. Not just that but there are times when we are unable to use nuances which can easily soften the impact of our chosen words. Take this one step further, and our body language and facial expression can also work to our detriment. This is perhaps different for those who are brought up with English as their first language, as they may be able to navigate social interactions with greater flexibility and with better social insight. The pitch and tone of our voice also makes a difference and higher pitch and a higher tone definitely causes more trouble.

The basic issue is deep-seated bias and discrimination on the basis of being different – albeit due to race, ethnicity, religion, gender, colour or any of the other protected characteristics that both define and divide as people in spite of having a common purpose. This is illustrated in the public discourse that surrounds the resignation of Rt Hon Liz Truss as UK's shortest tenure as Prime Minister.

In response to such an exchange between a caller and talk radio host Sangita Myska (@SangitaMyska)[13] for the London Big Conversation Radio (@LBC) on why Tory voters would never vote for Rt Hon Rishi Sunak MP as a leader of the Conservative Party and future Prime Minister, because 'he is not even British' - Dr Ruby wrote on Twitter;

I repeat, racism in the UK is to the extent that white people will not vote in their best interest. They will choose whiteness over money, health and life. You absolutely should believe the assertion of this caller that many white people in the UK think and vote like him. (@PaperWhispers)[14]

This exchange perhaps sums up the problem in UK society, one of identity that equates 'Whiteness' to 'Britishness', and therefore goes on to confirm our worst suspicions. Can we, as minority professionals, as people of colour, even have any hope to be treated with respect as an equal and be considered a citizen of 'modern multicultural Britain'? For once, I feel despondent.

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"Let there be light, and there was light" – Tamaso Maa Jyotir Gamaya

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It gives us great pleasure to write about the first National LED Conference hosted by BAPIO UK on September 24, 2022 in Leicester, in collaboration with the BAPIO SAS LED forum. Locally employed doctors (LEDs) make up a sizable component of the NHS workforce. Unsung, undervalued, silent, and forgotten NHS heroes are LEDs. Despite their enormous numbers, they receive little help in addition their needs being unmet. In keeping with the long history of BAPIO, a conference was organised and carried out to draw attention to the system inequities and to influence system leader's ways of thinking. Colleagues from Leicester Hospital, St. George's Hospital in London, and Nottingham Hospital created the LED charter as a leading light to encourage change under the auspices of BAPIO UK. We hope and believe that the LED charter will illuminate the dark paths of injustice, paving the way for relationships built on trust and support that will result in exceptional patient care.

We thank the British Medical Association (BMA), General Medical Council (GMC), Health Education England (HEE) and Leicester Hospital (UHL) Board for their contributions. Over 200 people attended the conference overall, which had a spread-out presence across the United Kingdom with equal gender representation. More than 70% of conference registrants came from organisations other than BAPIO, demonstrating the outreach of the conference. The meeting was attended by International Medical Graduates (IMG) from different countries like Netherlands, Saudi Arabia, Nepal, Palestine, Bangladesh, Sudan, Myanmar. By gender and age distribution, the conference leadership was one of the most egalitarian. Delighted to note that mor than 70% of the conference's leadership represented by women, and podium spots were equally split.

We consider happiness to be the basis of healthy living. To serve this motto, the conference started with "Meditation and Wellness" exercises led by Brahmakumaris. Stress is a natural aspect of working in the medical field, and efficient stress management is crucial to a doctor's ability to control their emotions and give their patients the best care possible. The useful advice on how to control our emotions and promote tranquillity was quite beneficial. Astonishing links were found between breathing and emotions. The new mindfulness paradigm was supplied by a music-led guided meditation. Rejuvenated, calm, joyful, and contented delegates were good indicators of the session's success.

The HEE ethos recognised ad-hoc, fragmented, and irregular LED support systems. According to Prof. Menon, the difficulties of cultural, linguistic, and legal adaptation impair well-being and indirectly threaten the quality of patient care. Based on comments, HEE has taken proactive measures to introduce the induction of international medical graduates (IMGs). The merger of NHS England and HEE may serve to enhance the circumstances for the benefit of LEDs, the session noted. The current system supports the development of two different types of doctors, and there was an agreement to move toward a fair system that gives everyone the same opportunity to grow.

The GMC reflected that without sufficient support, LEDs were at risk of losing their ability to practise. 70% of LEDs and more than 60% of GMC medical registrants are graduates from other countries. In this group, more than one-third of the doctors work in a hostile environment without assistance. There was optimism for new Good Medical Practices (GMP) that would foster kindness, civility, inclusion, and equity for all. "Fair to refer" and "Caring for doctors caring for patients" are concepts that have gained traction.

The employment conditions and contracts for LEDs were discussed by industry specialists. The conversation was given a genuine, human touch by the experiences of persons at various professional stages. The chance to examine the laws and regulations from a union, executive and hiring perspective with an experiential dimension was notable. The panel decided that adjustments and alterations were required to provide a positive feel for the employees.

LEDs are considered vulnerable and are at a high risk of disciplinary action. Medical Defence Shield (MDS) conducted a workshop on dealing with disciplinary action using examples from real-world situations. A concurrent session on young doctors' mental health and well-being with the guidance and assistance needed to survive in real-world scenarios was organised by the BAPIO wellness forum.

The magnum opus was the LED Charter. The charter was created using practical solutions based on real-world experience for the advancement of LEDs. The charter serves as a lighthouse that point in the direction of greatness. The charter was presented to the world by Dr Afzal Lateef. The UHL board's decision to implement the recommendation was made promptly, demonstrating the charter's immediate impact.

We trust that the charter is a fire that not only illuminate the dim lanes of LED development but also strong enough to direct LEDs along the path to excellence. The charter may make the BAPIO leadership immortal by leaving a lasting impression on future generations. A light bright enough to reveal the truth inspiring us to pursue justice.

Asatoma Sadgamaya, Tamasoma Jyotirgamaya, Mrithyorma Amritamgamaya

LETTER

REFLECTIONS ON MY JOURNEY AS AN IMG

"Nearly 50% of our psychiatrists & physician associates are from BAME backgrounds - how can we recognise and learn from the experience they bring to benefit the organisation and our service users?" was a question on Twitter by a colleague.

I tried putting in a few succinct comments, as much as Twitter character counts would allow, but the thoughts brought back so many memories I could not help but write more. It is a multi-layered question which deserves multi-layered answers and complex thinking. But before we come to solutions, a bit of context will help the uninitiated reader.

Background

But here I am, writing an IMG's (International Medical Graduate) story. The term Black and minority ethnic (BAME) and IMG are not synonymous, but there is a significant overlap. And we cannot write IMG stories unless we talk about the BAME experience in tandem, as that underpins many of the facets of an IMG journey.

What did I struggle with most when I stepped into my first hospital accommodation in 2003? What took the most time to adjust to when I started working six months later? What and who helped the most? What was the moment I thought I could continue living in this country, be happy, and feel that I belonged?

There is a lot more consciousness of racial discrimination and awareness of what needs to be corrected and who needs to be supported now, than I had 40 years ago. My father was a doctor in the NHS in the 1970s. I was too young to remember it well, but I remember being called 'blackie' at school; the only girl who would play with me was a Sri Lankan.

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I was not sorry to return to India to grow up. My father used to talk about interview panels where it was perfectly normal to be asked, 'So why do you want to stay in the UK? Why don't you go back to where you came from?' I think my father answered his last interview panel to say he was not staying for more than a year. Not sure whether that was a factor in him getting his last UK job.

Back to the UK

So, in 2003, when I came to Scotland to start my life in the UK, my husband had already been working for over six months. I was luckier than most. There was a degree of financial stability, my husband had a job, and we had some good friends in the neighbourhood who spoke our mother tongue and understood our culture. I desperately missed my one-and-a-half-year-old daughter, who I had left with my parents in India while I prepared for PLAB (Professional and Linguistic Assessment Board).

The BAME/IMG struggle is not about discrimination alone. It is about homesickness, missing large extended families, and the lack of help with household chores that most middle-class people in India, at least, take for granted. It is about missing the colours, the smells, the street food, the sounds, and the hustle and bustle. It is about the crowds on the streets, someone to share your language, and celebrating festivities at home.

Retraining

The second shock was starting training all over again. Back home, I was already a specialist. I had done an MD (Doctor of Medicine) in psychiatry and an additional DNB (Diplomate of National Board) in India. Having passed two major psychiatry exams, completed a senior residency for six months, and been in independent private practice for a year, the realisation that I was back to a year one SHO (Senior House Officer), training with colleagues who had just finished their foundation year and had very little experience in psychiatry- was not easy. I had signed up for yet another set of major exams, this time with a young family to care for and a household to look after was sinking in deep.

I was lucky to get some very supportive consultants at work who trusted my skills, recognised that I was experienced and gave me a degree of responsibility higher than that of a year-one SHO. That helped immensely. At a time like this, some self-worth, some recognition of who I was, was something I needed deeply.

Support has to be the right type. When my supervisors made an effort to know my background, enquired how I was coping with childcare and no grandparents to help, showed curiosity and respect about my culture and told me it was okay if I turned up on the ward in a salwar kameez, it helped me settle.

An unfamiliar workplace and customs

Knowing psychiatry from back home in India, at least as far as the knowledge goes, is both an advantage and disadvantage in the NHS. In an unfamiliar work environment, knowledge is a strength. However, we all pick up specific ways of doing things in our own systems which do not work elsewhere. In India, I was grilled at every ward round about what I had written- the details of my history, the phenomenology I had identified, my formulation and diagnosis, and my treatment choice. It was like doing a long case every day. But the nurses called me 'mam', and I called my consultant 'sir' or 'mam'. Though the institute I worked and trained in taught me to work in multidisciplinary (MDT) teams with psychologists and social workers, that is hardly the case in many psychiatry departments in India. In the UK, it took a lot of effort to call my consultant by name- even by title. You learn to work in a non-hierarchal system, and the BAME doctor who settles fastest is the one who picks up the new system quickly. What might be mistaken in the new BAME doctor as rudeness to the MDT colleagues and subservience to their consultants might just be the system they are used to, with no intention to cause offence.

BAME doctors need mentoring by BAME doctors- people who have lived through these changes and challenges themselves. Most of all, they must find their community outside of work.

The best work environment does not make up for the fact that there is nowhere to go after work where you can discuss other things. A Bengali 'adda' (agenda-less discussion and discourse between friends) over a cup of cardamom tea and puffed rice- there was a yearning at times I cannot describe enough.

The turning point was finding a Bengali community in Leicester. The shops on Belgrave Road helped, no doubt, but when we found our community, we decided life in the UK was a choice we could live with happily.

Cultural Awareness

It is not just changing the work environment. BAME/IMG doctors need to find a life outside work, a cultural belonging. BAME doctors come with different experiences and different levels of expertise behind them. The MTI scheme has been excellent in taking in doctors at a more appropriate stage. A well-guided overseas CESR might even lead to a direct entry to the specialist register. Personalised and well-thought-out, flexible pathways tailored to individual experiences are needed. We need a flexible approach which focuses on competencies rather than time. Trainees with prior experience for years overseas or in SAS grades might feel stagnated if not challenged with more complex jobs; others might need longer than the 3 years we offer in Specialist training.

The efforts will be worth it. UK today is a flourishing and vibrant multicultural, multi-ethnic society. Our patients come from different backgrounds. I have done single clinics where I've had patients from as many as five countries. Having a diverse workforce to help our cultural understanding and approach is a great strength that needs to be nurtured and strengthened. Support for BAME doctors needs to combine an acknowledgement of skills, valuing experience and helping where they need it. Support is an over-arching word. We need to be careful not to inadvertently patronise in the process.

A multi-cultural Britain

When my parents visited in later 2003, bringing my daughter with them, they noticed changes. They said it was a different UK from the one they had left in 1978, in a good way. We are not there yet- but we are asking the right questions, we are seeking the correct answers, and we are in this together. The journey towards equality and non-discrimination is everybody's journey; the BAME questions are for the entire workforce. We need to believe that we can achieve what we are aiming for, and I genuinely believe that we can.

Milestones

MRCPsych

And to end the story of my journey, where do I stand now? At a place which I would not have imagined in my wildest dreams in 2003. Passing my MRCPsych exams was the most I could think about. An LTFT (less than full-time) trainee in Scotland, managing a 4-year-old daughter, jobs, and exam prep on my own, my husband in Leicester starting off his training rotation in gastroenterology, and no family around like many overseas doctors. Life had its joys, but the struggles were real.

Training

After exams, I moved to Leicester to join my husband, and the family was together again. The daughter started school. After a 6-month gap in job searching (2007 was when Modernising Medical Careers -MMC hit), a 6-month Associate Specialist job in Leicester was the start. A Local appointment for a training post in Leicester starting in December 2007 was my first job in Leicester. Six months later, I got a locum consultant stint thanks to someone who trusted an SpR after 6 months! And then finally, I entered higher training in general adult psychiatry in August 2008.

CESR

By then, I had been training in psychiatry for 11 years. Not to forget that psychiatry was all I had done since September 1997. I had considerable training experience from India - from the Central Institute of Psychiatry, and no less an MD and a DNB. A year of independent private practice. I sincerely did not feel I needed a full 3 years of general adult psychiatry training.

IMy 2006 CESR application had not been successful, but I had a clear list of what I had to do more, and it was not a long one. I needed my higher training to complete what was needed. Two months in my locum consultant post (before my ST!) had whetted my appetite. I needed to fly now. The list was made in early 2009, towards the end of my ST4 year, and I posted a 5 KG bundle of papers to PMETB. I was ready.

Consultant

A consultant post in EIP came vacant in the Trust in mid-2009, and a colleague encouraged me to go for it. I went for my ARCP (annual review of career progression) that year with a consultant job offer under my belt, but the wrong specialist training numbers. I still got outcome 1 from the panel but faced a separate panel of more senior educators from the Deanery to be told to reflect on my ambitions and aggressive attitudes. To cut a long story short- I got my CESR around the 9th of December 2009, was on the specialist register on the 11th of December, and joined my consultant job on the 14th of December 2009. The start of a new journey.

Additional Roles

In 2010 I took up my first College role- external advisor. Since then, I have visited deaneries around the UK to watch how different deaneries have very different ARCP panels. In 2011, I became a clinical director. That was also the year I first visited Nigeria as part of our Trust international links project, a labour of love that has continued. I have continued to deliver mhGAP training in rural Benue, got involved in 2 projects instead of one and now lead the project for our Trust.

In 2013, I became GA TPD (training program director) in the Deanery. In 2014 I also became the MRCPsych course organiser and continued both roles simultaneously for one year. In 2015, I left the TPD role when I became a PLAB part 2 examiner. In 2016, I left the MRCPsych course organiser role when I became Associate Dean for Equivalence at the Royal College of Psychiatrists. I was careful to make sure that I balanced my roles.

In the meantime, I continued to work full-time in EIP, had several publications and progressed through honorary titles at the University of Leicester. I was a SCAN trainer in the UK who had trained delegates from Denmark, Greenland, the Philippines, Taiwan, Nigeria and Ghana. I was now the secretary of the international panel. I had been on the Equivalence Committee of the College since 2012, 4 years before I became Associate Dean for Equivalence.

Fast forward to 2016 onwards- set up CESR training in the College and trained hundreds of potential CESR applicants throughout the country. I led the committee, trained more evaluators, and had regular meetings with the General Medical Council (GMC) and the Academy of Royal Medical Colleges to understand the broader picture of specialist registration. I continued my charity work in Nigeria and did several fundraising events. (one of them was climbing Mt Kilimanjaro in 2013 when I raised around £550 on my own). I became involved in various other committees in the College- quality assurance, ETC course, and curriculum revision. I have chaired judging panels for College awards. I became part of the task-and-finish groups looking at shaping the psychiatry workforce. I published guidance for CESR support for NHS Trusts. I answered dozens of individual emails asking for CESR advice, met medical directors and DMEs to advise on the same, and continued attending ARCP panels.

Somewhere along the way, I became a CASC examiner and a PLAB 1-panel member. I gathered yet another College role-member lead for CALC-operational. A role I share with Dr Raoof, the two of us taking over from Dr Lade Smith CBE.

Academic roles

So that is how in October 2020, I found myself Hon Prof of the University of Leicester and RCPsych Council elected nominee for the Dean elections. It had taken 14 years from that point when I was a trainee facing her final MRCPsych exams. 14 years in which I have lived every moment with a passion for psychiatry to drive me on.

Moving another year forward, and I have now finished my role as associate dean for Equivalence and started as the National Lead for Recruitment in Psychiatry, a joint appointment by RCPsych and HEE. I have picked up roles with various charities and volunteer organisations in the last year. Most notably, I am helping set up a community mental health ambassador programme with South Asian Health Action.

Life

There are more stories to share. I learnt Bharatanatyam in the UK, have performed widely, passed up to grade 6 ISTD exams, travelled widely (47 countries so far!) and now have my own travel newsletter. Being happy is not just about work; it is discovering every aspect of yourself.

My Reminisces

To all IMGs considering coming to the UK, the NHS is not perfect; like any other organisation, we have our problems. Relocating to another country is never easy. But you must follow your heart and do what is right for you. Hard work and determination always win in the end, more than academic brilliance. Believe in yourself is the motto I hold on to now because life has taught me to discover and nurture talents I never knew existed inside me.

Black isn't black as you think

– By Dr Rajeev Gupta, Consultant Paediatrician

Let's make a difference to the humanity
Let's not shame ourselves anymore with immorality
What was done wrong in past due to the race and colour
Shouldn't matter anymore with propaganda of equality and fervour
Black doesn't mean it's bad as black-spot or black-listed
Black mean here tolerance, to absorb, like colour black or tinted

It's an old slavery word for Africans and won laurels for old Americans
That conduct now for George Floyd, has brought shame for White Americans
In this era when we talk, we need to have respect and a lot more sense
We can't be judgemental, we need to be open and have no defence

We need to bring equity, fairness and sense of equality
We need to feel that there is no discrimination and duality
When we have courage and fix what is wrong,
We have inner satisfaction, we feel proud and strong
Let's work on the matter, raise profile and make use of our voice
So that even evil chiefs have to think and make a good choice.

If we can do that, we can make a difference to the humanity
We can stop wars, hatred, detestation and immorality

Strive for Equality and fairness

The BAPIO Institute for Health Research team at the National Conference in Birmingham, 2021

DIGNITY AT WORK STANDARDS

Proceedings from a consensus summit- October 2022

Background

With increasing pressures on the UK National Health Service, offering a supported environment where autonomy, dignity and respect go hand in hand with equity, recognising the diversity of background and promoting inclusion is vital for the recruitment and retention of a contented workforce is crucial in achieving the universal goal of achieving health for all. A mechanistic approach to policy and reactionary response when incidents of harassment are reported remains the mainstay of initiative for most UK NHS-employing organisations. Clearly, over the years, including the regular reporting of Workforce Race Equality Standards, the ambition to eradicate incivility in organisations has remained an impossible bridge to cross. While it may be impossible to tackle overt incidents of bullying and harassment by the draconian implementation of current policies, there is no evidence that such measures do anything to achieve a safe organisation and happy workforce. Neither do policies help to promote a positive workplace culture? The role of leaders is not only to define a vision for the organisation and to manage outcomes but to build teams who are empowered, engaged and work collaboratively to achieve the institutional goals, their own career aspirations and life goals.Treating members of the workforce (Our People) with value and respect helps to engage in a shared vision of excellence, the ambition for continual improvement and transparency of the process is fundamental to running an engaged and functioning workforce.

Much of the leadership of organisations do not have the emotional intelligence and the awareness of diversity to engage with their employees, nor do they have the training or tools to be compassionate leaders.

In many organisations, leaders are judged by financial and quantitative outcomes over qualitative ones, certainly not by what their staff think of their leadership styles. Recognising that a wholly different approach needs to be developed to tackle the rising dissatisfaction and burnout in the NHS healthcare workforce, BAPIO and its partners from the Alliance for Equality for Healthcare set out to develop consensus standards for the healthcare workplace. The summit was hosted at the Royal College of Surgeons of England, in London on 14 October, 2022.

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Dignity at Work Standards

The Dignity at Work Standards (1), published first in January 2022, highlighted the fundamental issues and critical areas of improvement needed within processes and policies. A national consensus meeting was convened at the Royal College of Surgeons of England to address these issues on 14th October 2022. The consensus panel comprised distinguished leads representing various healthcare organisations to review the proposed Dignity at Work Standards (1) and deliberate subsequent action.

The panel aimed to attain a consensus on the following topics:

1. Policies
2. Accountability
3. Benchmarking
4. Processes
5. Support

1. POLICIES

Healthcare workers encounter a multitude of policies, policies that are frequently ambiguous and questionable.

1.1 Many existing policies do not consistently acknowledge the 'person' concerned within them, and policies are not regularly reviewed and revised.

1.2 The 'Maintaining High Professional Standards (2), which guides processes to use where serious concerns involving conduct, clinical performance and health of dental and medical employees, published in 2005, is hugely outdated and consequently insufficient to support healthcare workers.

1.3 Reform of policies needs engagement from representatives from all levels and from Equality, Diversity and Inclusion (EDI) advisors to ensure they are not partisan.

1.4 Policies require consideration of prevention first and mediation second rather than advancing straight to sanctions.

1.5 Policies need to be transparent and promoted in an open learning culture.

1.6 The workforce should be appropriately directed to policies at induction and regular intervals.

1.7 Leaders need to implement policies compassionately and judiciously and promote a positive workforce culture.

1.8 Leaders and teams that promote a positive well-being culture should be recognised and act as exemplars, mentors or role models to initiate a broader impact.

2. ACCOUNTABILITY

Leaders play a crucial role in accountability by building trust among their teams and communicating the outcomes and objectives for individuals.

2.1 The leader's role is to define the common purpose, clear expectations, communicate appropriately, coach individuals and discuss the consequences to the team.

2.2 It is crucial that leaders take a compassionate approach when understanding any deviation in this as often issues arise inadvertently.

2.3 Accountability should not be about punishing, defaming or demoting individuals. Instead, leaders should use opportunities to review issues in the workforce and provide the appropriate support for all staff.

2.4 The workforce should be encouraged to respond to episodes of disrespect with no fear of speaking up.

2.5 Active bystanders should be empowered when advocating for colleagues during episodes of disrespect by providing formal training and supporting appropriately.

2.6 Leaders and teams promoting enhanced workplace culture should be rewarded and recognised accordingly.

2.7 Appraisals should consider including workplace culture as a separate domain.

3. BENCHMARKING

Organisations should use a growth mindset when reflecting on their progress and assessing their current state.

3.1 Benchmarking should not be a tick box exercise but an opportunity for organisations to reach a mutual ambition of elaborating the workplace and workforce.

3.2 Organisations should have a board-level director for EDI whose role is to ensure that EDI is included as a prerequisite during improvement on every occasion to appraise.

3.3 Learning drives outcome, and organisations should provide their root cause analysis data to all department members, including more junior members, to emphasise learning.

3.4 Organisations should provide 'Learning Meetings' to disseminate learning from errors anonymously and blamelessly.

3.5 Organisations should collaborate with one another by 'buddying up to guide and advise through the continual process of enhancement.

3.6 Organisations should create ambassadors whose role is to promote improvement within departments, encourage peer review of teams and advocate solution-focused.

3.7 All processes should include EDI to ensure changes are as equitable as possible.

4. PROCESSES

NHS Employers should reform processes to become transparent by providing a clear set of definitions that are consistent within all policies, organisations, departments and systems.

4.1 Processes should empathise with the workforce built in by promptly providing compassionate leadership and support.

4.2 The workforce should be appropriately signposted to available resources internally and externally, such as unions.

4.3 Leaders should be trained formally in promoting mediation within teams and being able to information resolve issues.

4.4 Leaders should use these opportunities to encourage learning within teams.

4.5 Leaders should understand that the culture of blaming is not proactive but demotivating and demoralising.

4.6 Organisations should evaluate everyday systems and processes that may need improvement from an efficiency perspective for the workforce and the workplace and undertake regular performance management.

4.7 Organisations should be consistent in their approach to all processes.

5. SUPPORT

Organisations and teams should encourage an active environment and culture to raise concerns and provide appropriate support for all involved.

5.1 Concerns may arise inadvertently as an impact of pressures, and perpetrators may not be aware of the problem.

5.2 Those alleged perpetrators should be provided coaching as a means for improvement and should be seen as a strength, not a weakness.

5.3 All members should be allowed to resolve issues informally with mediation and without repercussions.

5.4 Freedom to Speak Up Guardians should sit independent of Human Resources.

5.5 Whistle blowers should be provided with protection and all members should be provided with appropriate support in the form of trained 'allies'.

5.6 Forums for psychological safety should be provided for all those involved in a concern, including victims, perpetrators and bystanders.

5.7 Induction should incorporate the expected workplace culture and signpost the relevant resources available in the trust. Spaced-out inductions should take place to ensure the workforce are guided and encouraged to use resources.

5.8 Leaders should empower and promote the raising of concerns in order to work on the mutual goal of enhancing the workplace and workforce collectively.

FUTURE DIRECTIONS

The panel discussed extensively on the current workplace culture and how to remodel this accordingly with the roles of leaders being crucial in this improvement. The panel agreed to pilot the Dignity at Work Standards (1) at four trusts: 1) King's College Hospital NHS Foundation Trust, 2) St. Georges and Epsom and St Helier University Hospitals, 3) University Hospitals of Leicester NHS Trust and 4) Integrated Care Service Birmingham with the opportunity for feedback and learning. Implementation toolkits will be developed for the standards through workshops.

ACKNOWLEDGEMENTS

Our preliminary vision of the 'Dignity at Work Standards' (1) was to create a document that defines the gold standard for dignity in a diverse workplace with consideration to intersectionality. Our aim in organising the summit was to bring together distinguished leads of notable health organisations whose members would be directly impacted by these standards in order to help materialise our vision. We are grateful to Sir Stephen Powis, National Medical Director for chairing the summit. We thank all of the attendees at the consensus meeting who have helped guide the proposed implementation of these standards.

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WORKING GROUP ATTENDEES

Dr Ananta Dave – Chief Medical Officer designate, Black Country Integrated Care System
Dr Beryl De Souza – Vice Chair, BAPIO London Division
Dr Chaand Nagpaul – Past Chair, BMA
Dr Kantappa Gajanan – Chair, BAPIO SAS & LED Forum
Dr Oge Ilozue – Executive Council, Medical Association Of Nigerians Across Great Britain
Dr Priyanka Nageswaran – Vice Chair – BAPIO SAS & LED Forum
Dr Raja Nadeem Sajjad – Treasurer, Association of Pakistani Physicians of Northern Europe
Dr Ramesh Mehta – President of BAPIO
Dr Satheesh Mathew – Vice President, BAPIO
Dr Vinod Nargund – Co-Chair, BAPIO London Division
Mr Abhay Chopada – Co-Chair, BAPIO London Division
Mr Ashok Khandelwal - Director of Operations & International affairs, BAPIO
Mr Mark Swindells - Assistant Director for the Standards and Ethics team GMC
Mr Paul Da Gama - Chief People Officer at St. Georges and Epsom and St Helier University Hospitals
Ms Aishnine Benjamin - Head of Equality Inclusion and Culture, BMA
Ms Carron Ceesay – Deputy People Officer, University Hospital Leicester
Ms Sandy Zavery - Equality and Diversity Advisor, NHS Leicestershire County and Rutland
Prof Ajay Shah - Dean, Faculty of Life Sciences & Medicine King's College London
Prof Andrew Reed – Chief Executive, Royal College of Surgeons of England
Prof Clive Kay - Chief Executive Officer, King's College Hospital NHS Foundation Trust
Prof Geeta Menon - Postgraduate Dean, HEE South London
Dame Prof Helen Stokes Lampard – Chair, Academy of Medical Royal Colleges
Prof Indranil Chakravorty – Chair of BAPIO Institute for Health Research
Prof Neil Mortensen – President of Royal College of Surgeons of England
Sir Andrew Goddard – Past President, Royal College of Physicians
Sir Stephen Powis – National Medical Director, NHS England
Sir Terence Stephenson – Chair, Health Research Authority (HRA), Past Chair, GMC and Academy of Medical Royal Colleges

EMPOWERING & EMBEDDING LOCALLY EMPLOYED DOCTORS IN UK HEALTHCARE

Conference Proceedings from the First National Conference for Locally Employed Doctors, September 2022, Leicester, UK
This is Just the Beginning - By LEDs, for LEDs

Abstract

Recognising the changes in career pathways with the growth in the Locally Employed Doctor cohort who are diverse in their composition from the UK and International Medical Graduates at various stages of their working life and with a whole host of aspirations, BAPIO SAS & LED Forum designed and delivered the novel National LED Conference in Leicester in September 2022.

This conference provided a collaborative platform to discuss and debate the LED doctors' aspirations and challenges with a spectrum of national healthcare leaders and stakeholders. The proceedings included keynote sessions, interactive workshops, and presentations on research and innovation.

The LED Charter was unveiled at the penultimate session of the conference highlighting a framework for development and parity in experience and progression with other doctors. The delegates represented the true diversity of LEDs and system leaders from across the UK, including people of various nationalities and stages of their careers. The enthusiasm from people wanting to participate in future SAS and LED forum surveys and conferences will help us organise future events.

The positive enthusiasm from people wanting to participate in future SAS and LED forum surveys and conferences will help us organise future events with greater enthusiasm.

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Background

Even before the world was changed forever by the devastation wreaked by the COVID-19 pandemic, the UK National Health Service (NHS), often considered the jewel in the crown of UK public institutions was reeling under the scourge of perpetual staff shortages, placing a tremendous pressure on the safe delivery of care. Although it has now survived over seven decades since its inception, the future sustainability of the NHS is often considered to be at risk as each government grapples with the almost impossible task of matching spiralling costs, high expectations from the public and the shrinking public purse yet with an inherent unwillingness to increase National Insurance contributions. The Covid-19 pandemic added the unpredictability of staff sickness, increased pressures on the infrastructure due to pandemic surges, and broke the morale of staff reporting posttraumatic stress disorder and burnout.

While careful workforce planning is essential, predicting with any degree of accuracy what the needs of the service will be a decade in advance is fraught with disaster. Any expansion of the medical professional pool is not only a long drawn out affair but also involving huge cost to the public. Staff recruitment and retention are crucial in recovering and sustaining healthcare services. UK NHS has particular challenges as the local systems of training of new doctors has always been much lower than the numbers needed, primarily because of the high cost to the public. It is estimated that to train each doctor costs between £100- 250k GBP. It is much cheaper therefore to import fully trained staff from abroad at a fraction of this cost. Hence, there has been a perpetual dependence on IMGs to provide safe staffing in the NHS despite periodic declaration of a 'hostile immigration environment' by government ministers.

The General Medical Council's (GMC) workforce data not only shows that IMGs now outnumber UK trained medical graduates in new registrations and also that there is a change in career pathways. Between 2015 and 2022, there are increasing numbers of Locally Employed Doctors (LEDs) within the UK workforce, as many doctors both UK graduates and IMGs are choosing not to join regimented, prescriptive, formal training programs. Nearly two thirds of foundation doctors are choosing not to join training and take 1-2 years doing selected jobs and pursuing alternative career paths. As they remain outside the scope of 'training surveys' and supervision or progression assessments, little is reliably known about them. It is a missing piece in the workforce and health service sustainability puzzle. The report states that over the past five years the collective group of SAS and LEDs have grown by 40% emphasising their value in the workforce.(1) The 2019 GMC Survey of SAS and LEDs demonstrated that 60% are IMGs and around a quarter reported that they are not treated fairly or have experienced bullying within the past year. Other challenges include hurdles in accessing opportunities for professional development and unsupportive working environments.(2) Professor Dame Carrie MacEwan, Chair of the GMC, said, 'LE doctors are a valuable asset: we are fortunate to have access to their knowledge and expertise. But the system does not always make the most of their talents'.(1)

This is probably an understatement, knowing what we know from the reports on their experiences.

It is imperative upon all of us in the healthcare business to provide a platform to hear the experiences of these doctors, understand their aspirations, their motivations and drivers. It is necessary to ensure that the career and lifestyle aspirations of this burgeoning group of doctors is understood and healthcare education and training systems respond to meet their needs.

SAS & LED Forum

As an initiative to support and advocate for LEDs, the SAS & LED Forum of BAPIO (British Association of Physicians of Indian Origin) was rejuvenated in December 2020. BAPIO, a voluntary professional organisation in its 26TH year, supports IMGs from across the world with its partner organisations, with the overarching mission to achieve equity, celebrate diversity and promote inclusion for all. The BAPIO SAS and LED Forum hosted the first-ever National LED Conference on September 24th 2022 in Leicester. The conference was organised to provide a platform for connecting LEDs from across the UK and hosting a systemwide discourse about the challenges they face. The conference provided a much needed space, for the very first time in the history of the NHS exclusively for LEDs to explore their experiences and career choices, engaging the full spectrum of organisations from healthcare employers, medical royal colleges, higher educational institutions, to trade unions as well as the regulator.

Mission & Stakeholders

The ultimate aim of the conference was to provide the framework for all healthcare organisations to achieve equality in experiences and career opportunity for all LEDs as integral part of a valued workforce. The LED Charter developed by the Forum provides the framework for organisations to self-assess their progress for all LEDs. The conference was also unique in being conceived, designed, organised and delivered by LEDs, for LEDS.

The conference was supported by the various arms-length bodies of BAPIO and external healthcare organisations. Notable representatives were present from the British Medical Association, Health Education England, and the General Medical Council. Other leading representatives included University Hospitals of Leicester NHS Trust, BAPIO Faculty of Leadership, BAPIO Institute of Health and Research (BIHR), BAPIO Training Academy (BTA) BAPIO Health and Wellbeing Forum, Association of Pakistani Physicians of Northern Europe (APPNE), Nepalese Doctors Association UK (NDA UK), Medical Association of Nigerian Doctors Across Great Britain (MANSAG), National Overseas Doctors Family (NODFA), British Egyptian Medical Association (BEMA).

Proceedings

Wellbeing

The conference started with a meditation and wellbeing session conducted by Brahmakumaris, a worldwide spiritual movement dedicated to personal transformation and world renewal. The session highlighted the importance of developing a personal mindset. Stress is a part of any doctor's daily life, and it is critical that doctors manage it effectively in order to provide the best care for themselves and their patients. The Brahmakumaris helped the delegates in identifying the impact within themselves of various situations and why 'how we choose to respond is what matters'.

Enhanced Induction & Support

The first keynote session covered Health Education England's strategy for providing equal opportunities for LEDs by Professor Geeta Menon, Postgraduate Dean of HEE South London. With a huge number of LEDs coming from an IMG background, Professor Menon explained the steps HEE have taken to introduce the IMG induction programme, developed with LEDs and by listening carefully to their needs. This programme sets minimum standards of induction including aims of mentoring, supervision, tackling inexperience of a new environment with peer groups and a buddying system.

The induction toolkit can be used by trusts to roll out policies to support LEDs. Professor Menon recognised the huge challenges faced by LEDs including adapting to a new culture, language barriers, understanding the medicolegal framework and the different experiences LEDs face at different trusts. Programmes such as the Overseas Doctor Development, at King's College Hospitals in London, highlight the work being done at specific sites. The aim of supporting IMGs and LEDs should be to recognise their strengths and celebrate diversity. The merger of NHS England and HEE, due in 2023, Professor Menon believed should help in steering a development strategy, reframe policies and create the governance environment to implement the LED Charter goals and help in achieving equal opportunities.

Regulating the Work Environ

The second keynote session, 'Ensuring locally employed doctors are supported to provide patient care' was presented by Dr Tista Chakravarty-Gannon, Head of Outreach Operations, for the GMC. Dr Chakravarty-Gannon believed that LEDs are potentially the most vulnerable, often at risk of relinquishing their license to practice, if there exists inadequate support and a unfamiliar or under-resourced work environment. Nearly a third of LEDs report an unsupportive and negative work environment. The GMC outreach service focuses on epitomising upstream intervention thereby providing support to doctors before any potential harm to colleagues and patients happens.

Although the GMC works in a continuum in setting standards to prevent harassment and bullying, there is still a considerable gap. The proposals for the revision of the Good Medical Practice (GMP) addresses new areas such as promoting compassion, civility, inclusivity and fairness for all. Dr Chakravarty-Gannon explained there was a need for organisations to deliver standards as described in GMC's reports such as 'Fair to Refer' and 'Caring for Doctors, Caring for Patients'. (3-4)

Workshops

LEDs are still technically considered to be out of training and miss out on access to career progression. The purpose of the morning workshops was to highlight the options available through three parallel sessions. Delegates were able to attend either a session in

·Medical Education led by BTA,

·Leadership led by BAPIO Faculty of Leadership or

·Research led by BIHR.

The sessions provided the delegates with the space to understand key roles that healthcare staff may also contribute to and how they could get involved. The aim was to provide an introduction to these career paths so that delegates had someone welcome them to these options.

Employment Matters

The session on, Employment terms and conditions for LEDs was presented by Professor Philip Bansfield, Chair of the BMA. The session highlighted what LEDs should expect from contracts, how to negotiate these and specific support the BMA can provide during this stage. He discussed how he is often told of the challenges faced by LEDs and is currently in the process of designing an implementation toolkit. Professor Bansfield felt that organisations and Trusts should work on improving equality, diversity, and inclusion. He also discussed issues faced by doctors in the private sector which ranged from long working hours, filling rota gaps without breaks and how it not only causes issues for LEDs but affects patient care. Professor Bansfield reassured the delegates that the BMA will work in collaboration with the BAPIO SAS & LED Forum to implement the LED charter recommendations.

LED Charter

The LED charter was presented to the conference by Professor Indranil Chakravorty, the chair of Bapio Institute of Health Research, and unveiled by the president of BAPIO Dr Ramesh Mehta jointly with representatives from the partner organisations (MANSAG, APPNE), BMA, NHS Trusts, the GMC and medical royal colleges.

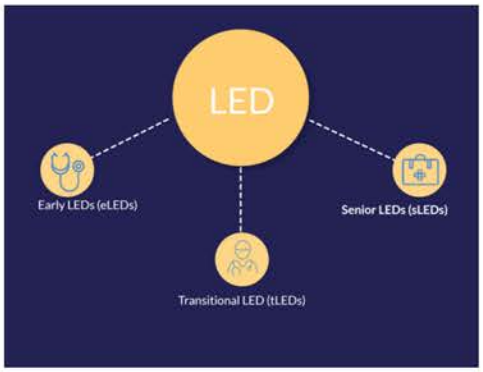
The LED charter was developed by LEDs following a thematic review of survey data, their lived experiences, career aspirations and learning from the effectiveness ofinterventions from exemplar organisations. The purpose of the LED charter was to provide a consensus framework for employers to aspire to achieve a level playing field, by recognising the diversity of backgrounds, career choices, challenges faced by IMGs and the need to implement equal opportunities in working conditions, supervision and career progression. Dr Afzal Lateef elaborated how the charter was designed and developed with contributions from LEDs. He discussed the ten recommendation headings set out in the charter which included the entire spectrum from employment contracts, induction, study leave, to supervision and career progression. With a large proportion of LEDs being from an IMG background, their family, friends and social support system may be limited, especially in challenging times.

Avoiding Pitfalls - MDS

The afternoon session included workshops providing practical knowledge and skills in how to avoid and seek support when facing disciplinary action in the NHS (by MDS) and protecting the, mental health and wellbeing of young doctors (by BAPIO Health and Wellbeing Forum).

Research & Innovation

Research and quality improvement projects were presented as posters and oral presentations representing the diversity of roles and multidisciplinary workplace settings.



Delegates

The conference venue had a cap of 200 delegates and so many were unable to attend. Only a third of delegates were members of BAPIO. Participants from various grades attended the conference, with the highest representation from SHO/Trust Grade/Clinical Fellow posts (39%), followed by 12% from SpR/ST3/ST4 Registrars. There were delegates from various international backgrounds including 59% Indian, 10% Pakistani, 6% Bangladeshi, Sudanese, White British, 4% from Myanmar and 1.5% individually from Saudi Arabia, Nepal, Palestine, and the Netherlands.

Over 84% of delegates agreed to initiate discussions with their respective employers in implementing the charter recommendations and 46% agreed to take part in additional research Feedback was excellent (70%), and 87% were willing to participate in future conferences.

Conclusions

The delegates represented the true diversity of LEDs and system leaders from across the UK, including people of various nationalities and stages of their careers. The positive enthusiasm from people wanting to participate in future SAS and LED forum surveys and conferences will help us organise future events with greater enthusiasm.

Reflecting on the experiences of LEDs with people of all levels exhibits the work that needs to be done to support these doctors in the workforce. With evidence of more doctors choosing to be LEDs and IMGs joining the workforce, we should be making it a priority to not only celebrate this diverse and growing group but also encourage, empower, and embed them to work in an environment that is provides safety and job satisfaction. The BAPIO SAS & LED Forum will continue to work alongside organisations to ensure LEDs are always considered fairly.

Future directions and next steps

The introduction of the conference and the LED charter was the first step in taking the actions of supporting LEDs further. We appreciate that actions should always follow words. The panel discussed the implementation of the charter at the University Hospitals of Leicester NHS FT. The BIHR and BAPIO SAS & LED Forum will formulate a new implementation toolkit for organisations to measure performance, develop business plans and gain stakeholder support.

Acknowledgements

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COMMENTARY

EFFICACY OF PRIMARY PREVENTION IN THE COVID-19 PANDEMIC

ABSTRACT

Background: The COVID-19 treatment protocol has consistently been under modification since its inception, from the omission of drugs once considered lifesavers such as hydroxychloroquine to the addition of newer medications e.g.: remdesivir. In such situations, it is crucial that we reinforce the importance of primary prevention, especially in low-income countries, where issues exist of shortage of resources such as oxygen and ventilators. We demonstrate how primary prevention holds good against the emergence of new variants, and future pandemics.

Discussion: Articles predating and postdating the COVID-19 pandemic were analysed.

The articles predating the pandemic included those relating to primary preventive methods used during the H1N1 pandemic of 2009, and articles postdating the pandemic included studies which demonstrate higher mortality of COVID-19 in smokers shed light on the importance of primary prevention, and demonstrate how primary prevention and good health education could have saved countless lives.

Conclusion: It is essential that Primary prevention be employed, not only in the case of chronic lifestyle conditions such as hypertension and diabetes mellitus but also in the cases of pandemics, where prevention before the chain of infection starts can prove to be lifesaving. As healthcare providers, the responsibility lies with us to emphasize on the importance of primary prevention and comprehensively propagate information.

Keywords : COVID-19, Primary prevention, Health education, pandemic, Mask usage, Ventilation

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Introduction

The COVID-19 pandemic, caused by SARS-CoV-2, the most recently identified strain of the coronavirus, had its index case reported in Wuhan, China, in December 2019.[1] Symptoms of SARS-CoV-2 range from mild discomfort, to more grievous symptoms such as breathing difficulties, cough ,fatigue, fever, loss of taste and smell.[2] The pathophysiology behind breathing difficulties has been identified as being due to Acute Respiratory Distress Syndrome (ARDS), caused by a multitude of cascading factors such as cytokine storm and hypercoagulability leading to multiple organ failure and septic shock.[3][4]The spread of the virus is mainly through airborne routes. aerosol spread, and less often due to fomites.

Primary prevention : A definition

Primary prevention refers to the act of intervening before health effects occur, [5] through measures such as vaccinations, altering risky behaviours (poor eating habits, tobacco use), and banning substances known to be associated with a disease or health condition. Primary prevention has recently gained much traction in healthcare. In terms of chronic conditions such as Diabetes mellitus, and hypertension, primary and primordial prevention, not only help us identifying those at risk of these chronic conditions, and implement changes to one's lifestyle, such as increased physical exercise, and changes to a diet with lower glycaemic index , but such measures also help us to eliminate the occurrence of dire complications of such chronic lifestyle diseases, such as diabetic ulcers, strokes, nephropathies and retinopathies to name a few. The World Health organisation, in January 2020, after confirming the spread of SARS-CoV-2 via human-to-human contact, released an advisory document relating to measures of primary prevention, to help curb the spread of the Coronavirus. These included measures such as wearing masks, hand hygiene, social distancing, and etiquette regarding coughing and sneezing. [6]

Methods of Primary Prevention

While the role of primary prevention in terms of chronic conditions has been well established, the emergence of the COVID-19 pandemic demonstrated that primary prevention in terms of an acute outbreak, such as a pandemic, is not as well implemented in many countries as we would expect. The following points based on published studies highlight the importance of primary prevention[7] Vaccination is an important pillar of primary prevention. In recent months we have seen the advent of several vaccines to protect against SARS-CoV-2. Vaccination protects populations by stopping the chain of infection, and preventing transmission and adverse health effects. The importance of vaccination can be seen on a global scale in the case of Israel, whose government started an aggressive national program in December 2020, to vaccinate patients above the age of 70, healthcare workers, and patients with chronic medical conditions. Prior to the start of the program, a daily average of 84 Covid-positive patients above the age of 70 were started on mechanical ventilation as compared to a daily average of 15 Covid-positive patients under the age of 50, which is a ratio of about 6:1. However, three months after the start of the program, this ratio dropped to 2:1. [8] However, this model is an ideal one and is very difficult in countries where there are large populations and shortage of resources. The inequality in vaccine distribution also makes this a difficult model to execute. Hence it is necessary to look at other viable methods of primary prevention.

Hand hygiene in the form of washing hands and using sanitizers was one of the first line defences that announced to the general public to fight the Coronavirus infection. Even prior to the advent of the COVID-19 pandemic, studies confirmed the efficacy of washing hands with soap and using ethanol-based sanitizers against enveloped viruses with a lipid bilayer.

Diligent washing and hand sanitizing was proven to reduce infections by 20%-95%. In addition to this, a 95% ethanol-based rub was shown to reduce the influenza virus to undetectable levels after 30 seconds of use. [9] [10]. To demonstrate the importance of hand hygiene, researchers from the University of Birmingham, used data regarding hand washing culture, obtained from surveys carried out by BVA France Sarl, Worldwide Independent Network of Market Research and GALLUP International from 63 countries. It was noted that at least 50% of the population did not practice hand hygiene in countries such as China, Japan, South Korea and the Netherlands. [11] Researchers used this data and obtained a strong correlation between exposure to the SARS-CoV-2 and handwashing culture. This correlation can be clearly evidenced in the worst hit countries of the COVID-19 Pandemic. According to the survey, the percentage of people who do not practice regular handwashing is 23% in the USA, whereas 40% of the population did not practice adequate hand hygiene in India, followed by 27% of the population in Brazil. France, which is currently the 4th worst hit nation in terms of active cases [12], showed a percentage of 38% of individuals who did not practice regular hand hygiene.

There is also emphasis placed upon the importance of good ventilation in hospitals and homes. Qian et al. [13] in their study of 318 Coronavirus outbreaks with at least three or more transmissions, noticed that transmission of the virus occurred in indoor spaces, in all of the 318 cases except for one, demonstrating a strong relationship between COVID-19 spread and poor ventilation in indoor spaces. In addition to this, Park et al. [14] studied the spread of Coronavirus, in an eleventh-floor call centre, in South Korea. It was observed that 43.5% of the staff was found to be infected, however, the percentage of secondary infections of the household members of the infected staff members was only found to be 16.2%, implying an increase in spread of SARS-CoV-2, with decreased ventilation in crowded workspaces.

The concept of ventilation used in the battle against respiratory illnesses is not new. One of the very important risk factors for Tuberculosis, is living spaces with decreased amounts of ventilation. Cross ventilation has been an effective and inexpensive method in dealing with patients of respiratory illnesses such as Tuberculosis. Equipment such as High-efficiency particulate air (HEPA) filters, typically costing $100, work in most homes, and can remove nearly 98% of particles >0.3 µm. [15] Such filters can help to eliminate biological aerosols ranging in size from 0.5 to 3 microns. A more affordable solution, such as facing a fan outside the window, in rooms with influenza patients, was also found to be effective, creating a negative pressure, and thereby transporting the air from the room towards the outside, a principle that is being increasingly used in infective disease wards, for respiratory conditions, in the UK.

There has been an influx of modern technological appliances that offer promise in dealing with SARS-CoV-2. An example of such devices used in the past is the usage of UV lights against the influenza virus. A hospital study on Influenza A (H5N1) found 2% and 19% rates of influenza in 2 similar buildings with and without UV lights. The effectiveness doubles when there is a continuous source of cold air at the ceiling, which sinks as warmer air rises and thus increases air circulation, and hence creates greater exposure to the UV light. A ceiling fan can help facilitate this. [16] These previously used successful models have paved the way for more evidence based studies that may help to prove the success of UV lights irradiation to combat the COVID-19 pandemic.

An in vitro experiment conducted to study the effects of Deep UV irradiation on SARS-CoV-2 infected cells has yielded positive results. [17] SARS-CoV-2 was isolated from a patient who contracted COVID-19 aboard the Diamond Princess cruise ship in Japan. The virus, was then propagated in vero cells, and stock cultures were obtained which were then subject to Deep UV irradiation for a short period of time.

Marked cytopathic effects were observed in the irradiated cells, with infectious titre reduction rate of 84.7% in cells irradiated for 1s, and 99% in cells irradiated for 10 s. [17] Such studies can help develop technologies that could be indispensable to hospital environments as well as for large scale disinfection and sterilisation.

A model to demonstrate the efficacy of mask-usage

In July 2020, the director of the CDC, Robert Redfield claimed that if everyone in the United States wore a mask, they could drastically reduce infection rates in 4-8 weeks[18]. While some saw this claim as mainly conjecture, A computer scientist by the name of De Kai, from UC Berkeley decided to test the theory by developing a computer-based simulation that helps to compare infection rates between populations that largely wore masks, and populations that had reduced mask usage. The simulator by the name of MasksimTM takes sophisticated programming used by epidemiologists to track outbreaks and pathogens like COVID-19, Ebola, and SARS, and integrates this with other models that are used in artificial intelligence to take into account the role of chance and unpredictability. [19]According to the simulator, If 80% of a closed population were to don a mask, COVID-19 infection rates would statistically drop to approximately one twelfth the number of infections, implying the strong relationship between adequate mask usage and a drop in COVID-19 infections.

Conclusion

The fact that such information is available to us, which could help curb the rise of coronavirus cases, not only amongst the general public but also among healthcare workers in hospitals, leads one to the conclusion that an important pillar of primary prevention is also health education and health promotion. The ongoing pandemic will always be known as one that was plagued by disinformation at all levels. Confusion regarding mask usage, and the types of masks to be used was rampant.

In some cases, disinformation led to worse consequences. Some examples are that of self-medication with various unlicensed drugs, improper usage of masks, and misinformation regarding vaccines. Such examples lead us to believe that health information, and its responsible propagation to the masses should be the cornerstone of primary prevention.

As healthcare providers the onus lies on us to propagate information in correct and comprehensible terms. Health education is of the utmost importance since simple measures at the most basic of levels may help to dictate the outcome of a COVID-19 infection. Advice given to the public regarding mask usage, hand sanitization, and social distancing may seem very elementary but are indeed the greatest of defences against SARS-CoV-2. Advice to stop smoking is also of paramount importance, since smoking affects ACE-2 expression and is considered a risk factor since ACE-2 receptors have been reported as being a route of entry for the virus. Further, Smoking is also an independent risk factor for the development of pneumonia that may affect the outcome of COVID-19 on the respiratory system.[20] Advice regarding caloric intake and weight management is also of the utmost importance. Decreased immune responses against Influenza and decreased immunogenicity of the Influenza vaccine has been in obese patients.[21] Obesity is also a risk factor for increased mortality in COVID-19 cases. In the present clinical scenario, where treatment protocol change rapidly, primary prevention is important to prevent transmission and resulting mortality and morbidity. The model of primary prevention must be employed when dealing with outbreaks with a timeline more rapid than those of chronic conditions. The implementation of such a model is of utmost importance, since it is imperative that we must be prepared to deal with such a situation in the future, with the age-old adage in mind - Prevention is always better than cure.

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IMPACT OF COVID-19 ON MENTAL HEALTH, WELL-BEING AND QUALITY OF LIFE OF WOMEN IN RURAL MAHARASHTRA

ABSTRACT

In Maharashtra, Mahila Aarthik Vikas Mandal (MAVIM), a non-profit initiative of the Government of Maharashtra, India, works to build the overall capacities of women. It acts as a nodal agency to implement various female-empowerment schemes of central and state governments.

The general observation of MAVIM was that post-COVID-19, women from rural sectors experienced high rates of depression and anxiety. Hence, to understand the extent of the mental well-being of rural women, a cross-sectional field study was planned in the two worst-affected rural sectors of the Vidarbha region, located in central India.

Women not in formal employment, and those widows, are sub-groups of concern for whom immediate action plans are needed from MAVIM for their mental health restoration. Some skill development programs should be designed explicitly for this subset of women that would help them to achieve a better quality of life for better livelihood.

Keywords; mental health, COVID-19, rural health, women's health

Introduction

COVID-19 outbreak originated in December 2020, and soon became pandemic, affecting humanity in many ways for last two years. Every country followed strict public health measures to combat the disease, by imposing lockdowns, travel bans, closing of educational institutions, restrictions on other public and private services etc. In India, the first case was detected in February 2020 and later the occurrences scaled up exponentially. The Indian government also developed and implemented stringent protocols to curb the spread of the disease. There was not only a fear about physical health, but also the surrounding situations impacted the mental health of individuals.

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The situation became worse during second wave in India in early months of 2021. States such as Maharashtra, Kerala, Karnataka and Andhra Pradesh were the worst hit during this wave. The mortality rates were as high as 0.035%, which created panic in the country. Due to unpredictable swing in the disease pattern, there was confusion in the civic administration in policy making, as a result the livelihood of many individuals was at stake. The health infrastructure collapsed and was unable to cope with the growing requirements in some states, despite the best possible efforts from the government. The unforeseen loss of dear ones shattered many families across the nation, leading to immense economical, and mental stress. The pandemic-related stressors affected nearly everyone, but women suffered disproportionally [1].

In last two years, women, especially those from rural sectors, were the worst hit from socio-economic view point. Due to lack of educational and social opportunities, they were more vulnerable and faced issues such as isolation, loneliness, loss of income and economic hardship. COVID-19 had its repercussions on the well-being of women and surviving widows in part due to social isolation.

In Maharashtra, Mahila Aarthik Vikas Mandal (MAVIM), a non-profit initiative of Government of Maharashtra, India, works for building overall capacities of women. It acts as a nodal agency to implement various female-empowerment schemes of central and state government. The general observation of MAVIM was that post-COVID-19, women from rural sectors experienced high rates of depression and anxiety. Hence, to understand the extent of mental wellbeing of rural women, a cross-sectional field study was planned in two worst affected rural sectors of Vidarbha region, located in central India. The study was supported by British Association of Physicians of Indian Origin (BAPIO) UK, which is a national voluntary organization with a commitment to provide high quality patient care through National Health Service (NHS) UK.

Materials and Methods

This was a cross-sectional observational study aimed at physical, social and mental well-being of women from rural Maharashtra, planned during March – May 2022 in selected villages from Nagpur and Yavatmal districts. The respondents were women, either married or widowed, registered at MAVIM in these districts. All the blocks from both the districts were considered and the list of members from each village in each block was obtained. Women were selected for the study following simple random sampling technique. It was ensured that the villages have adequate representation in the sample proportionate to the population. Assuming that the mental wellbeing is affected in nearly 50% of the female population, a sample of 384 was obtained with 95% confidence level. A list of 384 women was drawn, with 232 from Nagpur and 152 from Yavatmal district. Two survey instruments viz., Patient Health Questionnaire-9 (PHQ-9) and WHO-QOL (World Health Organization – Quality of Life) were used to determine the level of depression and quality of life of women. PHQ-9 is a well-known questionnaire for measurement of depression in patient, with a score ranging from 1 to 27. WHO-QOL measures individual's perception about their position in life in the context of culture, their goals, expectations, standards and concerns. It highlights the effects of disease and health interventions on the quality of life of individuals. The recognition of multi-dimensional nature of quality of life gets reflected through the questionnaire. The sessions were organized for social health workers to familiarize them with the survey instruments and train them to obtain reliable information through these interview-assisted questionnaires. The village wise list of sampled women was handed over to the respective village health workers. Both the survey questionnaires were utilized simultaneously during the interview session. Additionally, the details such as age, education level, marital status, occupational details were also obtained for each respondent. Formal consent was taken from each female respondent before interview session.

Statistical analysis

Descriptive statistics such as mean, standard deviation were obtained for continuous variables in the study, while frequencies and percentages were obtained for categorical variables. The statistical significance of association of PHQ-9 score categories and education level, occupational status and marital status were determined using Pearson's chi-square test. The domain wise WHO-QOL scores were compared across the categories of demographic variables using Mann-Whitney U test or Kruskal-Wallis test. The correlation between PHQ-9 score and domain wise score on WHO scale was obtained using Spearman rank correlation. All the analyses were performed using SPSS ver 26.0 (IBM Corp., ARMONK USA) and the statistical significance was evaluated at 5% level.

Results

Out of total 384 identified women, 36 could not be traced or not available at the time of interview, while data on 24 women were incomplete. Hence, the final analyses involved data on 324 respondents from two districts. Both PHQ-9 and WHO-QOL questionnaires were used to obtain their mental, physical, social and environmental health status, after second wave of COVID-19 outbreak.

Table 1 provides the descriptive statistics for various demographic characteristics of respondents. The mean age of women was 42.52 (SD: 8.99) years. Majority of women had completed higher secondary education [171 (52.8%)], while only 25 (7.7%) were graduates. There were 125 (38.6%) married women living with a husband, while 199 (61.4%) were widows. There were 243 (75%) working women with the occupation distribution as given in Figure 1. The majority of women i.e. 175 (54%) were labourers, while 30 (9.26%) worked in farming.

As regards to depression, the majority i.e. 131 (40.4%) women had mild depression, while 96 (29.6%) had moderate depression. Overall, approximately 84% of women had depression in the mild to moderate range.

The domain wise WHO-QOL score showed a median of 56 for physical domain, while other domains had a median score of 50 each.

Table 2 provides the association of various respondent characteristics with level of depression. The association of age with depression was statistically non-significant (p=0.668), suggesting that age of women was not associated with the of level of depression. Similarly, education level was also not associated with level of depression (p=0.089). Occupation showed significant association with level of depression, as indicated by p-value < 0.0001. Marital status was also independent of the level of depression (p=0.183).

The comparison of WHO-QOL scores was performed across educational levels for each domain independently, as shown in Table 3. It shows that the median scores for social domain differed significantly across age categories with a p-value of 0.034. Also, the median score for this domain differed significantly across educational categories with a p-value of 0.004. The median scores for primary and secondary levels were significantly smaller than that of higher secondary and graduate levels, suggesting inferior quality of life on social front for women with primary and secondary level education. The proportion of mild to moderate depression was significantly higher for working women. In other words, working women had lower severity of depression as compared to non-working women. The median scores on psychological, social and environmental domains of WHO-QOL scale were significantly more for working women as compared to non-working women, with p-values 0.015, 0.01 and 0.046 respectively. The median scores for widows on physical, psychological, social and environmental domains were significantly smaller than that of married women staying with their husband, with p-values 0.004, 0.001, < 0.0001 and < 0.0001 respectively. The proportion of widows with any level of depression was higher than married women, as a result, the WHO scores were smaller for widows than married category.

Table 1: Descriptive statistics for various characteristics of participants

Characteristic	Level	Statistic
Age in years [Mean (SD); Median]		42.52 (8.99); 42
Education [n (%)]	Illiterate	44 (13.6%)
	Primary	41 (12.7%)
	Secondary	43 (13.3%)
	Higher secondary	171 (52.8%)
	Graduate	25 (7.7%)
Marital status [n (%)]	Married*	125 (38.6%)
	Widow	199 (61.4%)
Occupation code [n (%)]	Non-working	81 (25.0%)
	Working	243 (75.0%)
PHQ-9 category [n (%)]	Mild depression	131 (40.4%)
	Minimal depression	44 (13.6%)
	Moderate depression	96 (29.6%)
	Mod Severe depression	42 (13.0%)
	Severe depression	11 (3.4%)
WHO-QOL [Mean (SD); Median]	Physical domain	52.91 (14.67); 56
	Psychological domain	50.53 (19.51); 50
	Social domain	48.85 (26.33); 50
	Environmental domain	50.58 (18.91); 50

Figure 1: Horizontal bar chart showing number of participants according to occupation

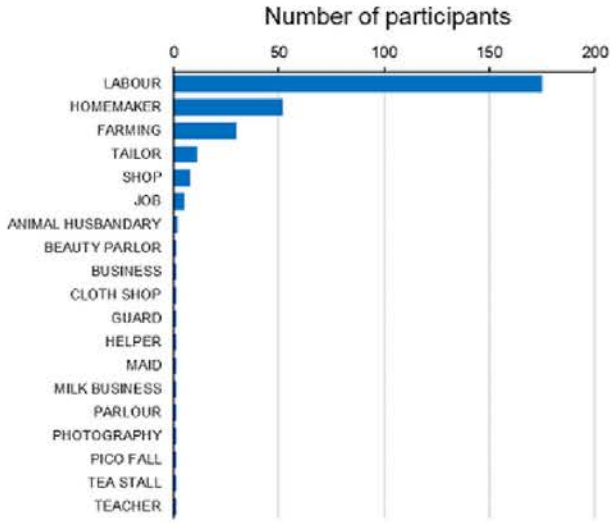

Figure 2: Scatter plot showing relationship between PHQ-9 score and WHO-QOL domains.

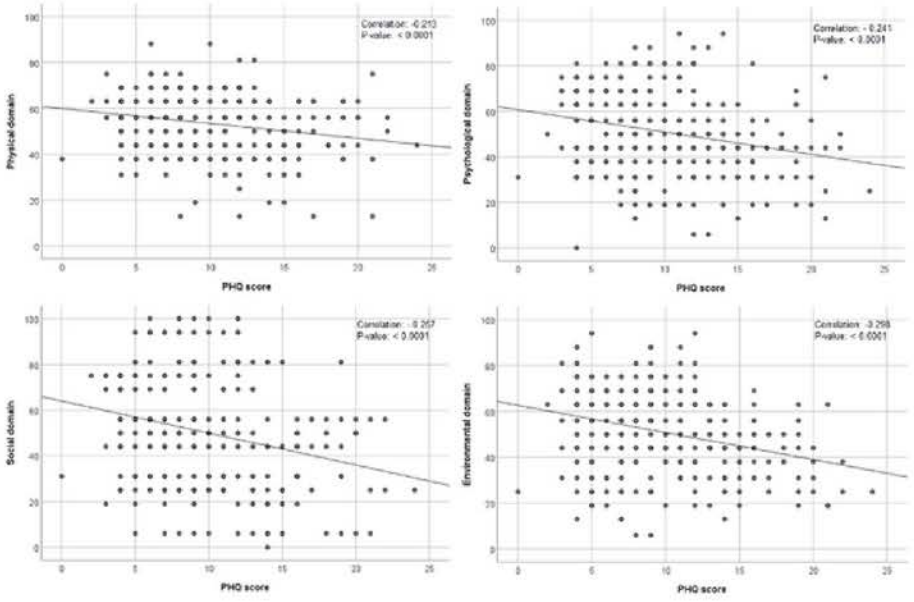

Table 2A: Association of educational level with level of depression using PHQ-9 scale

		PHQ-9 category					Total
		Mild depression	Minimal depression	Moderate depression	Mod Severe depression	Severe depression	
Education	Illiterate	11	9	17	6	1	44
	Primary	19	2	13	4	3	41
	Secondary	13	6	17	7	0	43
	Higher secondary	79	24	43	21	4	171
	Graduate	9	3	6	4	3	25
	Total	131	44	96	42	11	324

P-value: 0.089 using Pearson's chi-square test

Table 2B: Comparison of WHO-QOL scores for each domain across educational levels

Education level		WHO-QOL			
		Physical domain	Psychological domain	Social domain	Environmental domain
Illiterate	n	44	44	44	44
	Mean	53.818	51.295	49.318	52.818
	SD	10.493	19.138	22.216	17.562
	Median	56.000	44.000	47.000	53.000
Primary	n	41	41	41	41
	Mean	53.925	51.600	42.450	49.575
	SD	14.127	19.330	24.562	17.814
	Median	56.000	50.000	37.500	50.000
Secondary	n	43	43	43	43
	Mean	50.047	48.907	42.558	46.419
	SD	12.040	19.960	20.215	18.007
	Median	50.000	50.000	31.000	44.000
Higher secondary	n	171	171	171	171
	Mean	53.612	50.712	52.527	51.376
	SD	13.402	17.963	25.044	17.514
	Median	56.000	50.000	50.000	50.000
Graduate	n	25	25	25	25
	Mean	58.458	56.583	62.792	55.875
	SD	13.749	18.563	25.399	18.660
	Median	59.500	53.000	56.000	56.000
P-value*		0.122	0.604	**0.004**	0.273

*Obtained using Kruskal-Wallis test; Bold p-value indicate statistical significance

For physical domain, the median scores were same, although the distribution of scores differed significantly between two groups.

Figure 2 shows the scatter plot of relationship between PHQ-9 scores and domain wise scores of respondents. The relationship of PHQ-9 score was negative with all the domains and statistically significant with p-value < 0.0001. The higher the PHQ-9 score, the higher the level of depression, and lower the score on WHO-QOL scale for any domain, poorer is the well-being of the individual. The scatters reveal that as the PHQ-9 score increases, the domain score decreases. In other words, the responses obtained on both the scales suggested that as the severity of depression increases, the QOL deteriorates.

Table 3A: Association of occupational status with level of depression using PHQ-9 scale

		PHQ-9 categories					Total
		Mild depression	Minimal depression	Moderate depression	Mod. severe depression	Severe depression	
Occupation status	Non working	20	7	34	14	6	81
	Working	111	37	62	28	5	243
	Total	131	44	96	42	11	324

P-value < 0.0001 using Pearson's chi-square test

Table 3B: Comparison of WHO-QOL scores for each domain between occupation status

Occupation code		Physical domain	Psychological domain	Social domain	Environmental domain
Non-working	n	81	81	81	81
	Mean	52.864	47.160	44.025	47.827
	SD	12.062	19.691	23.181	16.204
	Median	56.000	44.000	44.000	44.000
Working	N	243	243	243	243
	Mean	53.800	52.429	52.367	52.100
	SD	13.371	18.040	24.645	18.148
	Median	56.000	50.000	50.000	56.000
P-value*		0.35	**0.015**	**0.01**	**0.046**

*Obtained using Mann-Whitney U test; Bold p-values indicate statistical significance

Table 4B: Comparison of WHO-QOL scores for each domain between marital status

Marital status	Parameter	Physical domain	Psychological domain	Social domain	Environmental domain
Married	n	120	120	120	120
	Mean	55.758	55.108	63.735	56.600
	SD	14.640	19.607	23.930	18.156
	Median	56.000	56.000	69.000	63.000
Widow	n	199	199	199	199
	Mean	52.434	49.051	42.801	47.913
	SD	11.874	17.559	21.101	16.623
	Median	56.000	44.000	44.000	47.000
P-value*		**0.004**	**0.001**	**< 0.0001**	**< 0.0001**

*Obtained using Mann-Whitney U test; Bold p-values indicate statistical significance

Discussion

This study was primarily aimed at assessing the depression level and its effect on quality of life of women in rural settings, as a consequence of COVID-19 pandemic. Various research studies have shown that women are more prone to developing metal health problems due to infectious disease outbreaks [2-5]. The authorities of MAVIM believed that such problems exists among women in villages, and conducted this study in order to discern their types and severity.

The interest was also to understand the socio-demographic factors influencing such problems. Accordingly, two survey instruments i.e. PHQ-9 questionnaire and WHO-QOL were used to assess depression level and quality of life of women, registered under MAVIM in two districts of Vidarbha region.

The study revealed that nearly 46% of the women had depression (moderate to severe) due to recent events related to pandemic. The severity of depression was similar across age groups (p=0.668). Our observation corroborates with some of the previous studies [6-9].

However, in some other studies, the authors observed significant association of age with severity of depression, with high levels in young adult groups [10-12]. The differences in the findings could be attributed to the context and the sample population. In our study, level of education also showed non-significant association with depression (p=0.089). Around 50% of the respondents had moderate to severe depression in each educational category. However, this result was in contrast to that observed in the Karachi study. [12] In this study, reported higher depression levels in respondents with lower education levels. In another study by Sagar SK et al. from Bangladesh, the authors reported significantly increased odds of depression among women with higher educational level. [13] Thus, there was no specific conclusion regarding education and level of depression across studies. The variable occupation, i.e. working or non-working showed statistically significant association with level of depression. Nearly 67% of the not-working women had moderate to severe depression level, as compared to 39% of working women.

A significant association between lack of occupation and depression has been reported in few studies [7, 9, 12]. The marital status and depression had no association (p=0.183); although, around 50% of widows showed moderate to severe depression, which was higher than the proportion of married women i.e. 42%. The quality of life of these women was also assessed to understand the influence of the disease on various quality of life domains. The older women indicated social insecurity especially in terms of personal relationships and social support. Even the lower education background led to such insecurity among women.

The psychological impact of the situation was pronounced among non-working women as compared to working women. This observation matches with the depression assessment based on PHQ-9 scale. Further, social and environmental impact was more on women not in formal employment, compared to employed women.

This is expected because monotonous living style, lack of opportunities to learn new skills and unhealthy domestic environment were major concerns of these women. These problems were more distinct among widows as observed through the study. The QOL scores were significantly lower on all the domains for widows as compared to women staying with their husband.

The mental health of women was evaluated using PHQ-9 questionnaire as well as through psychological assessment using WHO-QOL questionnaire. The two scores showed statistically significant correlation, although weakly related. Further, as the depression level increased on PHQ-9 scale, the quality of life related to physical, social and environmental domain indicated deterioration, which is justified.

One of the major limitation of the study was the sample size and the geographical representation. The study was restricted to only two districts; rather a wider geographical coverage with more districts would reveal the real mental health status pattern in the population. Nevertheless, this study provides insight into the mental status of women and the factors influencing the status.

Conclusion

The study explores the extent of depression among women from rural setting after COVID-19 pandemic. Women not in formal employment, and those who are widows, are sub-groups of concern for whom immediate action plans are needed from MAVIM for their mental health restoration. Some skill development programs should be specifically designed for this subset of women that would help them to achieve a better quality of life for better livelihood.

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IMPACT OF HELP OR CRISIS LINES FOR MENTAL HEALTH

Proposal for a systematic review using PRISMA-2020 statement

Abstract

Helplines and crisis lines for mental health exist in different formats throughout the world [1, 2] as a form of intervention which appears to be intuitively supportive and useful to people in distress. It also has the advantage of being widely accessible, approachable, and bypasses the waiting times and bureaucracies of referral systems for accessing secondary mental health services.

The authors were curious about the existing evidence regarding measurable outcomes for helplines and crisis lines, beyond subjectively reported caller satisfaction. Is there evidence to suggest that the existence of helplines reduce suicide rates, or emergency attendances or referrals to the local mental health services? What outcomes have been studied for mental health helplines and crisis lines in terms of efficacy, effectiveness, and efficiency?

The authors explore the background and rationale for a systematic review to answer these questions.

Keywords: mental health, helpline, crisis line, outcomes, efficacy, effectiveness, efficiency.

Introduction

A possible intervention for people in mental health distress is a helpline or crisis line, where someone in need of help can connect with and talk to a person trained to offer psychological support in such situations. Such helplines are currently operational in various parts of the world [2]. The outcomes of this intervention have been studied in different ways but is mostly based on caller satisfaction and subjectively reported improvement in wellbeing.

Many helplines being anonymous, have inherent challenges in assessing outcomes in efficacy, efficiency and effectiveness on long term follow up.

Aim

The authors aim to conduct a systematic review of evidence for mental health outcomes of service users of helplines and crisis lines.

Research question and Methods

The research question was, 'What outcomes are evidenced in published literature for mental health helplines and/or crisis lines in terms of efficacy, effectiveness or efficiency?'

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The method proposed is a systematic review of literature using the PRISMA-2020 statement [3]. The literature search would be done based on the PICOS [4] (Population-Intervention-Comparator-Outcome-Setting) framework to select keywords, inclusion, and exclusion criteria for our search. (Table-1)

Population included:
We propose to include the broad population experiencing any form of mental health distress. This includes subgroups that are suicidal or in crisis. We also intend to include papers studying services for specific target populations (such as veterans).

Intervention reviewed:
Helplines are different from ongoing talk therapy, since they are typically meant to be used for an immediate and one-time intervention in a crisis situation and may be staffed by volunteers or paid workers who have received short term training for specific scenarios, rather than licensed professionals. However, it has been found that callers sometimes use helplines repeatedly, and in various situations of distress (such as isolation) rather than just crises [5]. Helplines have traditionally been phone lines; however, in recent times, digital platforms such as chat or text have also been used to provide this service [6]. We will include all modes of delivery of service of a helpline in this analysis. Different publications have referred to this type of service by various names, as helpline, help-line, crisis line, hotline, or lifeline. We will include the variations in the nomenclature of this type of service all these terms in our search.

Comparison versus alternative:
In places where helplines are unavailable, there is typically no intervention until a more advanced stage of distress (such as a suicide attempt) necessitates medical intervention. Hence, this project compares the outcomes of helpline usage versus no intervention.

Outcomes studied:
One of the challenges in measuring the efficacy of helplines is that they are frequently anonymous, so outcomes after the call has ended cannot be tracked. Hence it is difficult to find data related to quantitative or long-term outcomes of helpline services. The efficacy of these services is often tracked based on caller or volunteer perceptions. Though our particular interest is on quantitative outcomes, we do not expect there will be numerous papers. Hence, to include a wide spectrum of evidence we intend to include both qualitative and quantitative outcomes, subjective and objective data to have a broad overview of the work that has been done so that future research proposals can be focused on areas where there is less evidence.

Setting:
Primary research publications pertaining to the qualitative or quantitative outcomes of helplines and crisis lines are included in this review. Only full publications (not just conference abstracts), in English, will be included. No other restrictions will be applied.

Databases included:
We would run literature searches using Web of Science, Ovid, PubMed and Scopus databases. Cross-checking against references in available literature would be done to improve the output.
Search strategy:
Based on the PICOS framework shown, the search strategy would be as follows:
Topic: "mental health" OR distress OR psychological OR psychosocial OR psychiatric OR suicid* OR anxiety OR depression OR stress*
AND Topic: helpline OR help-line OR crisis line OR hotline OR lifeline
AND Title: effic* OR outcome OR effec*

Exclusion criteria:
1.Reviews, editorials, case studies, opinion pieces, book chapters, letters
2.Ongoing talking therapies
3.Published in a language other than English
4.Only published as abstract (conference posters and presentations)
5.Papers looking at staff perceptions or caller demographics, reasons for calling rather than outcomes for callers
6.COVID related helplines. We decided to exclude these as they would have been temporary set ups and not likely to continue in future as the pandemic runs its course. We would like to concentrate on the data which has more long-term viability.

The literature search will be reported using the PRISMA-S statement. [Rethlefsen ML, Kirtley S, Waffenschmidt S, Ayala AP, Moher D, Page MJ, Koffel JB; PRISMA-S Group. PRISMA-S: an extension to the PRISMA Statement for Reporting Literature Searches in Systematic Reviews. Syst Rev. 2021;10(1):39. PMID: 33499930]

Once the papers have been identified using the above search strategy from all the databases, they will be merged, and de-duplicated to remove to make a final list. Two of the authors (MG, NC) will then go through the list and through the inclusion and exclusion criteria, select a final list of papers which will be included in the final analysis. Any disagreements will be resolved by co-author DD. Whether we would be able to do a meta-analysis, or just draw themes from the publications will depend on the results of the final search output. The authors look forward to publishing these results in future.

Discussion
Previous publications include a systematic review on the effectiveness of crisis lines [7] covering publications up to 2018, and another on the effectiveness of youth helplines [8] covering publications up to 2020.
Hoffberg et al [7] studied the literature published between 1990 and 2018 and concluded that there was a dearth of high-quality evidence demonstrating effectiveness of crisis lines. This review was possibly the closest to our proposed methodology. However, we have a wider scope in not restricting the date of publication.

Mathieu et al [8] also concluded that there was indeed lack of controlled trials in the existing evidence and methodological/ethical barriers preventing such trials. They voiced the need for more research before conclusions regarding effectiveness of such services to the youth population can be made.

In an era of restricted resources and economic crunch, it is important to understand how funds and resources are utilised in providing effective and efficient services to people in mental health crises I the most cost-effective way. In preparation for continued funding or expansion of such services, the existing literature needs to be studied for evidence so that improvements can be made, and the right focus can be achieved.

We hope that our review in addition to the existing ones can also make the case for more rigorous trials which provide reliable evidence based on which important policy and planning decisions can be made.

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Table-1

PICOS framework for the systematic review

Population	Intervention	Comparator	Outcome	Setting
mental health distress	helpline	no intervention	quantitative	papers published in English
psychological distress	crisis line		qualitative	original research
suicidal	hotline			full publication
depression	lifeline			
anxiety	help-line			
stress				

IMPACT OF COVID-19 ON ORGAN DONATION AND TRANSPLANTATION IN THE UK

Lessons learnt and opportunities for future

Abstract

The COVID-19 pandemic has placed considerable strain on the allocation of healthcare resources. In this research, we explored the views of healthcare professionals in the UK on the countrywide management of organ donation and transplantation during the first COVID-19 surge in spring 2020.

Methods: An internet based survey was developed and
distributed over a 2 week period in May/June 2020.

Results: Three hundred and fourteen professionals responded, covering all organ donation and transplant regions across the UK. Data suggest a considerable degree of scaling back of activity in all but one region (Northern Ireland). A range of absolute criteria for organ donation and transplantation were highlighted that have since been implemented in practice.

Notable strengths of the countrywide response included the donation and transplant community acting responsibly and proportionately (51.6%), providing access to up to date information and data (43.9%,) and communicating risk (40.8%). Mixed views were expressed on equity in resource allocation with 32% aligning to inequity, 28% to equity and 17% of respondents stating that issues of equity are not relevant in a crisis.

Conclusion: Findings highlight that managing scarcity is complex during a pandemic. Embedding ethical values in recovery and future preparedness for threats should be a priority.

Key words: Transplantation; Healthcare professionals; Viewpoint; COVID-19; Mixed-methods

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INTRODUCTION

The World Health Organisation (WHO) declared the novel coronavirus (SARS-CoV-2) a pandemic in March 2020. The UK has seen particularly high rates of transmission and death from the disease. As of 11th February 2021, there had been over 3.9 million confirmed cases and 115,529 fatalities [1]. The National Health Service (NHS) responded by reconfiguring to increase capacity for COVID-19 positive cases and to minimise further risk of transmission [2]. Inevitably, this has impacted how patients are treated for a range of other conditions [3-5]. During the first surge of COVID-19 infections in April 2020, organ donation and transplant programme activity was selectively paused or suspended. Living donor transplantation was completely stopped. Overall there was a 72% reduction in transplants from deceased donors [6]. Estimates suggest this has increased the number of people waiting for a solid organ transplant by 16% and significantly lengthened the median time to intervention [6]. As the UK progressed through its 3rd case surge, challenges continued for donation and transplant programmes. The huge effect of the pandemic on patients raises important questions about how the organ donation and transplant community has responded, and how the increased urgency and demand for transplants should be managed.

Through an online survey, we explored the views of organ donation and transplantation healthcare and administrative/management staff in the UK on the countrywide response to COVID-19. Importantly, we also considered the circumstances under which the community felt that organ donation and transplantation activity should continue, so as to map findings to practice.

MATERIALS and METHODS

Survey Design

This was an online cross-sectional study involving a survey designed to explore healthcare and administrative/management staff views on organ donation and transplantation during the first surge of the COVID-19 pandemic in the UK.

The survey was developed using a Delphi methodology [8]. The authors specified the scope of the survey. They include a mix of healthcare professionals with expertise in organ donation, organ retrieval and implantation, pre and post-transplant care of patients, and general research methodology.

Questions were devised around five key areas:

·respondent demographics and job characteristics;

·impact of COVID-19 on organ donation and transplant programmes in employing NHS Trusts;

·views on equitable access to healthcare resources during the pandemic;

·absolute conditions under which transplant activity should resume;

·and what the community has done well in response to the pandemic.

Two free text comment boxes were also included to allow respondents to elaborate on their views about equity and learning during the pandemic. Overall, there were 22 items. Prior to the online launch, the survey underwent expert review by professionals in national positions of responsibility in relation to organ donation and transplantation. This resulted in some questions being refined to make the survey fully inclusive of donor and transplant side issues.

Dissemination of Survey

To facilitate a rapid response, the survey was disseminated electronically via the weekly NHS Blood and Transplant (NHSBT) Organ Donation and Transplantation Directorate (NHSBT ODT) bulletin. The survey was also distributed to the membership of the British Transplantation Society, the Renal Association, and the mailing list of the British Renal Society. The Renal Association facilitated dissemination of the survey to the Clinical Leads of all Transplanting Centres across the UK and the British Renal Society facilitated dissemination to allied professional groups, including the UK Renal Pharmacy Group. The UK National Clinical Lead for Organ Donation facilitated dissemination to all UK Clinical Leads for Organ Donation (CLODs) and Regional Leads for Specialist Nurses in Organ Donation (SNODs).

Multiple networks were used so as to capture diverse views and to ensure a spread of responses across different regions. Responses were collected over a two week period in May/June 2020, with no follow-up reminders since evidence suggests that this is less effective for web-based surveys [9]. Ethical approval was granted by the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority (LMS/SF/UH/04170).

ANALYSES

The data were explored in descriptive terms using frequencies and percentages in SPSS (version 26). Free text comments were analysed in NVivo (version 12) and using thematic analysis as described by Braun and Clarke [10]. An inductive approach was used with coding and the development of themes driven by the semantic content of the comments. One of the authors (AH) analysed all comments using a structured approach. We segregated comments by the two free text items and analysed the data separately. Analyses then progressed to review the data more holistically in the generation of overall themes. Quality assurance involved the first author (SS) reviewing a random sample of 25% of all comments and discussing coding with AH. Discrepancies were resolved through discussion and related exclusively to the specific alignment of comments to sub-themes within the master themes.

RESULTS

Survey respondents

Three hundred and fourteen people accessed the survey and engaged with at least 50% of items. Of the total sample, 266 (85%) respondents completed all items. Figure 1 illustrates the number of responses mapped to the 12 regions/zones of NHSBT ODT activity. Survey respondents collectively covered all regions across the UK, with a largest number of responses based in London (26%), Scotland (12%) and the Midlands (11%).

Table 1 includes an overview of respondent characteristics. The majority of respondent were employed as nurses (nurse, specialist nurse, transplant nurse) (30%), transplant physicians (24.2%) and doctors (referring, ICU, emergency medicine) (22.3%). Most were involved with care related to kidney transplantation (57%) and based in a transplant centre offering single (24.2%) or multi-organ provision (36.3%). The respondents were experienced professionals, with most citing years in service over 11 (36.3%) or 21 years+ (48.7%).

Impact of COVID-19 on regional organ donation and transplantation

Figure 2 illustrates the proportion of organ donation and transplant programmes that were reported to be completely or partly paused at the time of the survey. Respondents based in most NHSBT ODT regions reported a considerable degree of scaling back of activity. The least impact was reported in Northern Ireland.

Views on resource allocation

Table 2 displays respondent views in relation to whether or not resource allocation for transplantation has been equitable during the pandemic. There was a lack of consensus in responses to this item. Just over 32% of the study sample aligned to an inequitable response for resource allocation, with 28% stating that allocation had been equitable. There was a cluster of respondents who felt that issues related to equity are not relevant in a pandemic situation (17%), with a further cluster undecided or not providing a response to this item. Table 3 further illustrates the most important principles of equity to respondents themselves for resource allocation during the pandemic. Overall, there were distinct priorities related to maximizing the number of quality adjusted life years (QALYs) (37.9%); saving the greatest number of lives (37.6%); proportionate rationing for life saving intervention regardless of COVID status (24.8%); and saving the greatest number of life years (21.7%).

TABLE 1

	N (%)
Job role	
Nurse/Specialist Nurse/Transplant Nurse	94 (30)
Transplant Surgeon	30 (9.5)
Transplant Physician	76 (24.2)
Transplant Anaesthetist	2 (0.6)
Doctor (Referring/ICU/Emergency Medicine)	70 (22.3)
Infectious Disease Specialist	1 (0.3)
Pharmacist	4 (1.3)
Management/Administrative	1 (0.3)
Other	36 (11.5)
Organ areas	
Heart	2 (0.6)
Kidney	179 (57)
Liver	12 (3.8)
Lung	2 (0.6)
Pancreas	3 (1.0)
Small bowel	0
Deceased organ donation	69 (22)
Not applicable	36 (11.5)
Other	11 (3.5)
Years of service	
<5 years	8 (2.5)
6-10 years	39 (12.4)
11-20 years	114 (36.3)
21+ years	153 (48.7)
Type of hospital	
Transplanting centre (single organ)	76 (24.2)
Transplanting centre (multiple organ)	114 (36.3)
Non transplanting centre with transplant follow up	65 (20.7)
Non transplanting centre	59 (18.8)

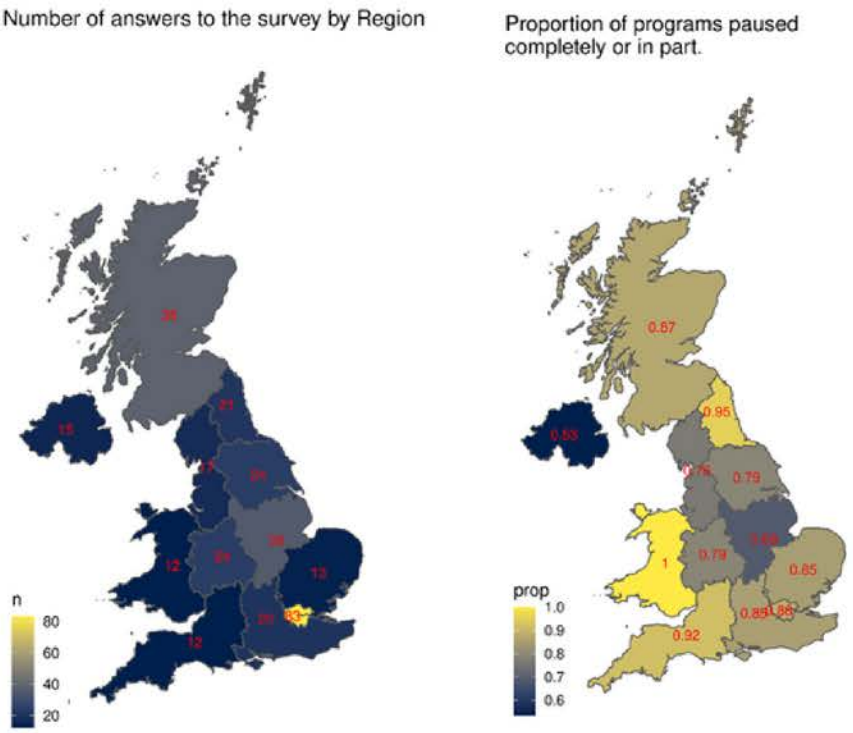

Table 2: Views on equity in resource allocation

	N (%)
Inequitable. The needs of critical non-COVID patients have been overlooked.	21 (6.7)
Inequitable, but transparent. Pandemic planning reasonably and transparently prioritises "saving the greatest number of lives".	80 (25.5)
Equitable. Health systems are designed to be responsive to the needs of society.	14 (4.5)
Equitable. Health care planning in a pandemic fairly, reasonably and transparently prioritises "saving the greatest number of lives".	74 (23.6)
In a pandemic, issues of equity are not relevant. We need to manage the crisis.	53 (16.9)
Undecided	27 (8.6)
Missing	45 (14.3)

Table 3: Principles of equity important to respondents personally

	N (%)
Saving the greatest number of lives.	118 (37.6)
Saving the greatest number of life years.	68 (21.7)
Maximising the number of quality adjusted life years (QALYs).	119 (37.9)
Prioritising those who have particular instrumental value to others during the pandemic.	17 (5.4)
Reciprocity. Prioritising those who have given to society.	6 (1.9)
Prioritising those who experience inequalities in access to healthcare.	12 (3.8)
First-come-first served.	3 (1.0)
Sickest first.	61 (19.4)
Youngest first.	21 (6.7)
Proportionate rationing for life-saving interventions regardless of Covid-19 status.	78 (24.8)
Random selection when considering patients with similar prognosis.	5 (1.6)
Other	8 (2.5)

Table 4: Endorsement of absolute criteria for organ donation and transplantation

	N (%)
Low transmission rate of Covid-19 in region where transplant is taking place	140 (44.6)
Transplanting hospital has a Covid-19 free pathway	213 (67.8)
Transplanting hospital is a "green site"	55 (17.5)
Post-operative critical care capacity	224 (71.3)
Availability of segregated workforce	114 (36.3)
Potential transplant recipient has low post-operative risk	154 (49)
Potential transplant recipient has high risk of waitlist mortality	114 (36.3)
Donor Covid-19 infection screen negative	244 (77.7)
Recipient Covid-19 infection screen negative	235 (74.8)
Healthcare staff Covid-19 infection screen negative	102 (32.5)
Carer/family in the same home as recipient Covid-19 infection screen negative at the time of grafting	96 (30.6)
Availability of point of care testing for Covid-19	140 (44.6)
Availability of effective treatment for Covid-19	29 (9.2)
Availability of Covid-19 vaccine	10 (3.2)
Don't know	7 (2.2)
Other	15 (4.8)

Table 5: Strengths of countrywide response to COVID-19

	N (%)
The transplant community has communicated risk associated with Covid-19 and solid organ transplant	128 (40.8)
The transplant community has provided access to up to date information	138 (43.9)
The transplant community has provided access to informative webinars	114 (36.3)
The transplant community has acted decisively	81 (25.8)
The transplant community has acted responsibly and proportionately	162 (51.6)
The transplant community has acted regionally	86 (27.4)
National oversight of transplantation has been responsible and decisive	74 (23.6)
The transplant community has supported research into Covid-19	81 (25.8)
Don't know	19 (6.1)
Other	26 (8.3)

Absolute criteria for organ donation and transplantation during COVID-19

Table 4 displays responses to absolute criteria that respondents felt were necessary for organ donation and transplantation to continue during COVID-19. The most common criteria included the donor (77.7%) and recipient (74.8%) screening negative for COVID-19 infection, post-operative critical care capacity (71.3%) and the transplanting hospital having a COVID-19 free pathway (67.8%). It is notable that a range of other criteria were important to at least 30% of respondents such as rate of transmission in the region where the transplant is taking place (44.6%), point of care testing (44.6%), segregated workforce (36.3%) and family residing in the same house screening negative for COVID infection at the time of grafting (30.6%).

Organ donation and transplant community response during the pandemic Table 5 includes responses to key learning about what the organ donation and transplant community has done well during the pandemic. Statements with the highest endorsement included that the community had acted responsibly and proportionately (51.6%), provided access to up to date information and data (43.9%), communicated risk (40.8%), and provided access to information through webinars (36.3%). To a lesser extent, respondents agreed that national oversight of transplantation was responsible and decisive (23.6%), the transplant community overall was decisive (25.8%), the community has acted regionally (27.4%) and supported research into COVID-19 (25.8%).

Table 6: Thematic analysis of free text comments

Master Theme	Sub-themes	Quotes exemplifying meaning
Pandemic preparedness	Clarity in healthcare stewardship	*"There has been a lack of direction at a national level, with much of the responsibility being left to local units to determine."*
		"I think that some of the decisions could and should have been more centralised -this would have saved time in units all writing their own policies and letters and also would have provided greater equality for access to transplantation."
		"It is an ever changing situation and people are required to be flexible to move quickly with the changes but this requires clear communication."
	Responsive adaptation of practice	*"Think of areas within a selected transplant centre or a transplant centre that can be kept free of admissions from infectious disease of concern. Plan this at the beginning of the outbreak."*
		"Aim to keep local hospital/transplanting centre within regions COVID free. Allows potential transplantation to take place."
	Power in mobilising knowledge	*"The webinars have provided good anecdotal personal experience that helps support and educate staff in less affected areas."*
		"The webinars and teleconferences have been informative and influential in our decision making'.
Inequity in resource allocation	Collateral damage from all eyes on COVID	*"People are now dying of the wrong disease. We have become so focused on COVID that the mortality of those with organ failure is bound to become excessive."*
		"The hidden cost of the COVID pandemic will be all life threatening conditions which will have increased their mortality rates and the lack of transplantation for end organ failure as a treatment."
	Consensus on fair access and allocation	*"We over resourced care towards COVID-19 at the cost of donation and transplantation."* *"I am interested in how certain centres have continued renal transplantation from donation after circulatory death at a time when other units across the UK have halted all but nonurgent transplantation due to the massive risk of outbreak. Is this resource allocation fair?"*
		"If another surge happens, units in areas with low prevalence should not be allowed to transplant as many of their "own" patients as possible whilst other units are closed - they should offer to transplant prioritised patients from all UK units; these patients were at a complete disadvantage during the first surge."
Personalised care	Individual need	*"Consideration on a personalised level for each individual in light of the unique donor offer at that point in time is crucial. For some, but not all patients transplanting during an infectious disease outbreak will be appropriate for them."* *"Keeping transplantation going at a small scale for truly needy sicker recipients has been very helpful to the institution and to these patients."*
	Patient consent and risk acceptance	*"Risk cannot be removed and provided patients are appropriately consented it is up to them to decide."* *"A degree of increased risk needs to be accepted and fully informed consent principles should be applied."* *"Importance of communicating clearly with patients regarding the risk and benefits, particularly with regards to risk of covid 19 on immunosuppression as part of consent process."*

Free text analysis

We analysed 158 free text comments overall drawn from 115 individual respondents. Three themes emerged from the data. Table 6 details the master themes and their associated sub-themes further. 'Pandemic preparedness' highlighted respondent perceptions about the need for clear political stewardship to drive consistency in clinical practice. There was a sense that many decisions and practices were being implemented locally though centralised directives may have been time efficient and led to more consistency in patient management. Related to this, respondents felt that services could have been reconfigured more rapidly to preserve activity. Sharing knowledge was seen as a significant strength to navigate uncertainty.

The second theme related to 'inequity in resource allocation' driven by a perception of disproportionate resource distribution to COVID-19 leaving patients impacted by end stage organ failure marginalised. There was also recognition that where transplantation was being supported, there is potential for disparity since these centres may be prioritising their own patients as opposed to looking collectively at fair access and allocation.

The third theme related to 'personalised care' and referred to both the risk-benefit approach to organ donation and transplantation to address the tension of disadvantaging those in need of urgent intervention balanced with ensuring that patients are fully aware of added risks during the COVID pandemic.

DISCUSSION

This study was undertaken during May/June 2020 when the UK had implemented national restrictions and was passing through its first surge in daily COVID-19 cases. Through an online survey we aimed to explore the perspectives of healthcare and administrative/managerial professionals working in organ donation and transplantation on the countrywide response. Our findings evidence the immediacy of impact on patients awaiting a solid organ transplant, and this is reflected worldwide [11-13]. Survey respondents covered all NHSBT ODT regions and reported either completely pausing activity, or a marked scaling back. The only notable exception was Northern Ireland, where data have since shown a record number of kidney transplants by September 2020. This mainly reflects the rapid set up of post-operative care within a new location to reduce risk to patients during this critical period; allowing healthcare teams to divert organs to local waitlist patients. This exemplifies the effective implementation of at least two of the absolute criteria for organ donation and transplantation that were also identified by the survey respondents, namely post-operative care capacity as well as a COVID-free pathway. Additionally, as the pandemic has progressed, the other major criteria suggested by our respondents have already transpired in emerging guidelines and practice [14-16].

Importantly, respondents expressed mixed views as to whether resource allocation for organ donation and transplantation had been equitable. Emanuel et al [17] state that there a four ethical values that drive resource allocation in times of scarcity. They relate to maximisation of benefit, treating people equally, instrumental value and priority for the worst off. Respondents in our study predominantly aligned to the ethical value of maximising benefit, which is advanced as the most important feature of responsible stewardship through a crisis [17]. Qualitative comments suggest that perceptions of how this is achieved likely reflect whether or not resource allocation was deemed as equitable or not.

Inequity centred around the hidden cost or collateral damage from prioritising patients with COVID infections and concerns over disparity in decisions that allow location based priority where transplantation is viable. In other words, reservations about how the value of maximisation applies fairly across patients. Whilst it is recognised that health services acted quickly to create capacity for an unanticipated threat [18], the NHS has a responsibility incumbent upon it to address disparity and avoid the widening of health inequalities [19]. Pandemics rarely affect all people in the same way [19,20,21]. As a consequence of the response, not only is essential life-saving care interrupted but so also are programmes and interventions focussed on improving equity, diversity and inclusivity. As we progress with a national vaccination roll-out programme, it is imperative that organ donation and transplantation professionals think through the possible ways in which equitable access to organs for transplants can be restored. This is likely to involve developing new pathways of care that take account of and respond to the additional risks that COVID-19 brings to particular age groups and communities. It is essential that any such pathways are developed collaboratively and are transparent without jeopardising trust and the enterprise of transplantation as a whole.

The transplant community can be better prepared in future by learning from this pandemic, monitoring the effect, actively intervening to redress imbalances and thereby building a stronger, more equitable future, which is more resilient to new threats. For example, in relation to patients on the waitlist for a kidney transplant, COVID infection rates are markedly lower in those dialysing at home as compared to in-centre due to the advantage of shielding [22]. There is a socioeconomic gradient to uptake of home dialysis modalities [23,24] and so programmes aimed at addressing this disparity will yield better preparedness for different patient communities when faced with challenges in future. The specific strengths of the countrywide response should be drawn on to share knowledge of effective initiatives to address disparity and to evidence sustained commitment to acting responsibly.

Whilst our survey offered rapid insight into the views of professionals involved in organ donation and transplantation, we recognise the self-selecting nature of participation and particularly that a quarter of responses were from professionals based in London, a region with high morbidity and mortality from COVID-19 [25]. Furthermore, the majority of respondents (57%) were involved in the care of kidney patients. Both of these factors affect the extent to which the pattern of responses can be generalised to donation and transplantation overall. Notwithstanding these limitations, our data reflect issues related to resource allocation that have been raised about the care of non-COVID patients in other health settings [26,27] and so highlight learning for future crisis situations. Data particularly signal the need for transparent frameworks for guiding decisions in allocating health resources that evidence responsible stewardship as well as advocacy for patients.

In conclusion, organ donation and transplant activity was immediately impacted by the COVID-19 pandemic. Important lessons have been learnt to inform both recovery plans and the response to future threats so that we are better able to preserve essential non-COVID related care. Ethical values should be embedded to avoid the widening of disparity in an enterprise already grappling with the limited supply of donor organs as a constraint to allocating health resources.

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PROGRESS ON RECOMMENDATIONS FOR AN EQUAL EXPERIENCE OF CQC REGULATION FOR ETHNIC MINORITY-LED GP PRACTICES

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Background

Majority of General Practices are rated as either good or outstanding by the Care Quality Commission (CQC). However, concerns were raised in 2020 from ethnic minority-led GP Practices that they do not receive fair regulatory outcomes from CQC, as providers led by GPs of a White background. This resulted in a programme exploring the experience of ethnic minority-led GP practices, and how the CQC could improve methods to address any inequalities in its processes.

The research found various factors that may affect the experience of ethnic minority-led GP practices – some relating to CQC's own regulatory processes and other wider systemic factors that disproportionately affect ethnic minority-led practices.

Aim

Regulation should be based on fairness for all those that CQC regulate and for the people who use services. As CQC's new National Professional Advisor for Equality and Diversity in Primary Care, and an ethnic minority GP, it is my duty to ensure we carry forward the actions identified in 'Ethnic minority-led GP practices: Impact and experience of CQC regulation'.

Reform

CQC is currently going through a period of major change. This brings opportunities to embed the recommendations from the research into a new regulatory model. However, it also means that some of these changes will need to happen in line with progress towards a new regulatory model. CQC leaders understand any frustration relating to the time it is taking to implement the improvements, but does wish to reassure GPs that this is a key priority for CQC, and doing it alongside this work means any changes needed are properly embedded in its approach and made in the most effective way. CQC believes it has made significant progress already in addressing this vital issue.

Here is a summary of the key findings from CQC's research into the impact and experiences of regulation among ethnic minority-led GP practices, and the progress in addressing them:

- The review highlighted a need for improvement in robust, meaningful data collection on ethnicity. Collecting ethnicity data is sensitive, and often people are reluctant to divulge this information lest they are victimised. However, the primary purpose of obtaining this data is to understand how different groups experience regulation. To implement this, CQC is developing the best approach to capturing this valuable information, having also explored the available data already being collected in the wider system.
- The review highlighted contextual factors: for example, being a single-handed practice, working in a socio-economically deprived area, external system pressures, a lack of support from external bodies. These can disproportionally affect ethnic minority-led practices and their ability to demonstrate how they provide good care. CQC has developed a training webinar to ensure inspectors understand these contextual factors and the challenges faced by ethnic minority-led GP practices. The regulatory model needs to acknowledge and reflect the context in which a practice operates in decision-making, without compromising on expected standards of care for people. CQC is currently determining the best way to incorporate this contextual data into the new framework in a safe, supportive and objective manner.
- CQC understands that many GP practices working under additional pressures, particularly those serving people in a more deprived area, are developing innovative ways of working to combat the impact. Supported by funding from the Regulators' Pioneer Fund, CQC set out to identify how it could recognise and share innovative practice by NHS GP providers to reduce health inequalities as part of its routine regulatory processes, assessments and engagement. As a first step, CQC will be publishing key findings from this project to the benefit of both GP practices and inspectors. This will help recognise responsive care and good leadership where a GP practice is operating in more challenging circumstances.
- Everyone, wherever they are, has the right to safe, high-quality care and GPs should be supported appropriately to achieve this. CQC is aware that support for GP practices needs to improve. CQC's strategy outlines how it will enable increased access to improvement support across health and social care, working with partners and through strong relationships at local level. CQC's new online Provider Portal will make it easier to engage, share information and keep details up-to-date. CQC will develop better guidance for providers about what the regulator – and the public – expect of them in meeting the regulations and providing good quality care. CQC is also developing training events to support practices.
- A whole regulatory approach – including the CQC regulates GP practices – is moving away from the old key lines of enquiry to a single assessment framework. This uses quality statements, which place a greater emphasis on a provider's understanding of the diverse needs of their community, addressing equity in access and experience and tackling inequalities in health outcomes, as well as a stronger emphasis on learning and innovation. This will help both address inequalities and give greater emphasis to the areas of work that GP practices, in areas of deprivation, are likely to be doing well.
- Projects are under way to increase the feedback CQC receives from patients who face barriers when communicating with the regulator to help ensure feedback is more representative. This includes building a People's Experience Framework to ensure robust and consistent consideration of the diversity of people's views, developing outreach and engagement in local areas, and producing videos in different languages to encourage people to give feedback on their care, linked to promotion of our interpreting arrangements. The way it collects information from both providers and the public, and how it is used in assessments, will be more transparent, and how decisions and judgements are made will be more structured, rounded and consistent.
- There is a new duty on CQC to review and assess integrated care systems (ICSs). It is currently in the 'test and learn' stage and developing high-level interview quality statements to ensure ICSs support their GPs and proactively tackle health inequalities in their communities. CQC is working with other key organisations to ensure GPs are supported to deliver safe, high-quality care.

CQC understands that GPs want to make these changes as soon as possible. While it will endeavour to do this, CQC must also ensure each workstream is thoroughly reviewed and analysed to ensure the change has the desired effects. CQC anticipates that most of these workstreams will be completed in time to embed into the new regulatory model throughout 2023.

In the future, CQC will continue to measure fairness in our regulation, reflect on feedback received, and work with providers and people using services to develop how it works where needed.

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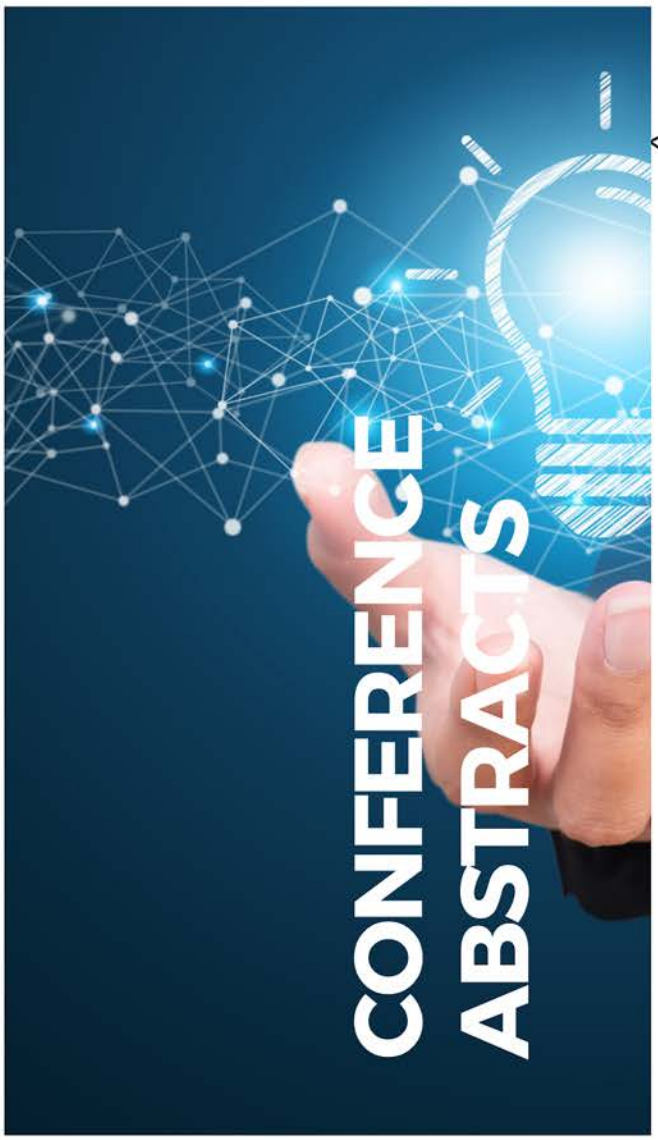

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1. **Outcomes Of Home Isolated COVID-19 Patients And Risk Factors Associated With The Adverse Outcomes: Longitudinal Retrospective Study In Shimoga, Karnataka**

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Background: COVID-19 is a current global pandemic caused by the newly discovered novel SARS-COV-2. According to studies in comparison to those who have recovered, patients who have died thus far were older, more likely to be male, and to have comorbidity such as hypertension, diabetes, cardiovascular disease, or lung disease, thus necessitating the assessment of risk variables in various demographic groups or contexts.
Aims: To estimate the proportion of different outcomes such as recovery, hospitalization, and mortality among home isolated covid-19 patients. To estimate the proportion and to determine various risk factors associated with COVID-19 adverse outcomes.
Methods: The study was carried out at Shimoga Institute of Medical Sciences, Shivamogga, Karnataka. Data were collected by telephone Interview.
Study Design: Longitudinal Retrospective study on home-isolated COVID-19 patients. All the patients reported in Mcgann triage from April 20th-June 20th, 2021. The patients' basic information and phone numbers were collected from the triage.
Results: A total of 168 people participated in this study, with 93 men (55.3%) and 75 women (44.7%). More than 90% of Home Isolated Covid 19 patients recovered, 10.75% required hospitalisation, and 3% died. One-third of the patients (37%) had one or more comorbidities.
Conclusion: Our systematic overview of the results to determine the relationship between COVID-19 infection and outcomes such as hospitalisation, death, and recovery shows that older age, male gender and comorbidities have higher hospitalisation rates. Comorbidities and older age were associated with a higher risk of death in hospitalised patients. Even though the recovery rate is very high, a significant (10.75%) home isolated patients need hospital admission during the disease course. So, properly monitoring isolated home patients can save the lives of many COVID-19 patients.

2. **Fracture clinic daycare Orthopaedic surgery: A novel model**

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Background: Daycare surgery is a cost-effective and safe orthopaedic surgery model. The arduous and challenging times during the Covid-19 pandemic ushered in need for a new practical, safe and cost-effective model to continue daycare surgery for treating patients with Orthopaedic injuries.
Methods: Fracture clinic inpatient beds were set up following safety assessment for daycare surgery. The patients were seen in the fracture clinic by a senior clinician and consented. Patients were screened for surgery safely by the preoperative assessment team and were given dates for surgery. These patients were monitored by an Orthopaedic trauma nurse and clinic nurses with supervision by doctors in the fracture clinic postoperatively. Discharged safely on the same day after a doctor review, safety netting advice and given follow-up clinic appointments. The data were analysed retrospectively and compared to ward-based daycare orthopaedic surgery over 2 months from October-November 2020 & February-March 2021, respectively.
Results: 39-day cases each were planned on ward-based daycare surgery and a new fracture clinic daycare model. There was a saving of 75 inpatient bed days with the new model. Same-day successful discharge was attained at 82.05% with the new model compared to 38.5% with the previous model. This accounted for a cost-effectiveness of 90,155 pounds. Additionally, there were no complications during the hospital stays or failed discharges & re-admissions.
Conclusion: Fracture clinic daycare model is safe and cost-effective during times of pandemic & winter pressures. It can be utilised regularly in strained NHS systems.

3. **Mental Health-Related Quality of Life at Baseline Predicts Dementia: findings from the EPIC-Norfolk prospective population-based study**

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Background: Lower Health-Related Quality of Life (HRQoL) predicts dementia in older adults in the USA. It is unknown if this association persists in other populations or mid-life when interventions to prevent or delay cognitive decline may benefit.
Methods: 7,452 community-dwelling participants (57% women; mean age 69.3) attended the European Prospective Investigation of Cancer-Norfolk study's third health examination and answered the Short-Form Health Survey (SF-36), measuring HRQoL. Longitudinal associations between standard deviation differences in Physical Component (PCS) and Mental Component Summary (MCS) scores, as well as eight SF-36 sub-scales (physical functioning, role-physical, bodily pain, general health, vitality, social functioning, role-emotional, mental health), and incident dementia over ten years were explored using Cox Proportional Hazard regression. Additionally, cross-sectional relationships between HRQoL and global cognitive function were explored using Logistic regression (n=4435). The cohort was examined as a whole and by age groups (50-69, >70), considering socio-demographics and co-morbidity.
Results: Higher MCS scores predicted lower dementia risk (HR= 0.75, 95% CI 0.69-0.81; p<0.001) and odds of poor cognitive function (OR 0.82, 95%CI 0.76-0.89), with similar observations across age-groups (e.g., incident dementia: 50-69yrs- HR 0.75, p=0.005; >70yrs- HR 0.75, p<0.001). Associations between higher scores on subscales about mental but not physical health and lower dementia risk were also observed. Higher PCS scores were associated with poor cognitive function in younger (OR 0.81, 95%CI 0.72-0.92) but not older participants. All associations with incident dementia attenuated with adjustment (50-69yrs- HR 0.89, 95%CI 0.69-1.16; >70yrs- HR 0.94 95%CI 0.83-1.06).
Conclusions: Lower mental HRQoL may help identify mid and late-life adults at risk of cognitive decline.

4. **Training In Foetal Monitoring – A Game Changer**

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Background: Intrapartum fetal surveillance is routinely offered to women in labour to reduce adverse neonatal outcomes.

Aims: In this study, we aim to look at the reduction in the Hypoxic Ischaemic Encephalopathy (HIE) rate after the dissemination of mandatory CTG training in the obstetric unit at a tertiary care centre in Wales.
Methods: In this comparative study, we reviewed the incidence of adverse neonatal outcomes, i.e. HIE, over 8 years, i.e. 4 years before and after the commencement of formal CTG training. From 2019 onwards, various themed training sessions were organised yearly, as outlined in Table 1.
Results: After analysing the 8-year data-set, we concluded that these sessions with an attendance compliance rate of over 95% each year have significantly reduced the mean incidence of HIE from 18.5 to 10.5. Discussion: We did receive positive feedback from the attendees. Over 90% of the attendees felt that the training was informative and interactive, helping them translate the acquired knowledge into clinical practice.
Conclusion: The significant change in the incidence of HIE justifies how building a robust CTG training framework is imperative and practical over self-directed e-learning to identify foetal hypoxia appropriately, thereby improving neonatal outcomes.

Content for CTG Training over the years		
2019/2020	2021	2022
Fetal Physiology	Revision	Revision Loss of Contact Acute Hypoxia, DFM, Cord Blood Analysis
Intermittent Auscultation	Non-Hypoxic CTG – Meconium, Infection, DKA	Antenatal CTG - Effect of maternal drug, Diabetes, cardiac Arrythmia Computerised NST Antenatal CTG
Human Factors – Dirty Dozen, SBAR, Learning Conversation	Human Factors - Learning Conversation, Psychological Safety	Human Factors - Learning Conversation, Psychological Safety, Civility
Reflections		

5. 'Does Every Patient With Post-Menopausal Bleeding And Endometrial Thickness< 4mm Need Hysteroscopy?' A Retrospective study

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Aims: To assess the safety and efficacy of the standard operating procedure for patients with postmenopausal bleeding who present with a low-risk history and typical radiological and clinical features at Swansea Bay UHB during a covid pandemic.
Methods: The clinical data were analysed in the Welsh Clinical Portal of 1007 patients. They were referred for hysteroscopy as urgent suspected cancer over 6 months (Nov 2020 to April 2021). Inclusion criteria were patients who did not undergo outpatient hysteroscopy as part of their evaluation. According to the standard operating procedure, patients with a low-risk history and a USS report confirming ET< 4 mm, normal contour endometrium that was completely visualised and with typical clinical findings do not need an endometrial sample performed.
Results and Discussion: 1007 patients were referred for hysteroscopy over 6 months. Among them, 290 patients were included in the study with Endometrial Thickness less than 4 mm in US Scan.
Among 290 patients, a total of 115 underwent hysteroscopy to evaluate PMB as they had associated risk factors or irregularity in the US scan. 1.74% of patients were on tamoxifen, 37.39% had BMI>35,45.21% were diabetic,6% had PCOS,6% was nulliparous/ late menopause, 2.6% had previous endometrial hyperplasia, and 11.3% had scan abnormality. Among 290 patients, 175 did not have a hysteroscopy and were managed conservatively. Among them, 1 patient was later on diagnosed with endometrial cancer. But this patient should have a hysteroscopy as she had an associated risk factor (Nulliparity).
Conclusion: Women with ET < 4mm, a low-risk history, a USS report confirming no abnormalities and a regular contour endometrium that is completely visualised do not need OPH or endometrial sampling and can be examined & discharged as clinically appropriate. This has significantly reduced the waiting list in outpatient hysteroscopy clinics.

6. Assessment of administration of VTE prophylaxis within 14 hours of hospital admission

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Background: Hospital-acquired thrombosis (HAT)accounts for 50-60% of all VTEs seen. As per NICE guidelines, inpatients aged 16 and above should have pharmacological VTE prophylaxis administered within 14 hours of hospital admission to reduce the risk of HAT.
Aim: To assess whether the guidelines were being followed or not in the HPB ward at Glenfield hospital.
Method: We excluded pre-op and post-op patients in whom prophylaxis was not needed or contraindicated as per the VTE assessment.
Results: Around 39.2%patients didn't receive the treatment within 14 hours.
Conclusion: There were 2 main reasons: a) Fixed schedule (73%), b) Patient refusal (27%). In Glenfield hospital, patients are given VTE prophylaxis at 17:00, irrespective of when they arrive. Hence, patients arriving after 22:00 at night received treatment on next day at 17:00. This was the leading cause of the delayed treatment.

7. DVLA driving advice to Cardiology Patients

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Background: Doctors at St Georges Hospital tend to see intervention, EP, non-invasive and heart failure patients. We need to ensure that clinicians looking after patients know the importance of giving sound and accurate advice and are responsible for guiding these patients regarding any driving restrictions to ensure patient safety beyond hospital doors. This is particularly important following specific procedures. The Driving and Vehicle Licensing Agency guides medical doctors to aid in assessing their patients concerning driving.
A three-step QIP project was undertaken to evaluate the accuracy of documenting driving advice on electronic discharge summaries and to counteract any lack of proper advice or documentation.

Method: Data were collected retrospectively from electronic discharge summaries of patients admitted over three months from 1st March- 30th April 2022.Implementation of change through setting up posters and giving verbal advice to colleague doctors. Assessment of improvement in documentation of driving advice through reviewing electronic discharge letters over the period from 3rd May -26th July 2022
Results: 53 patients were interventional, 34 were EP, and 13 were HF. Of these, 46% had documented driving advice, and 54% had no discharge advice on their discharge summaries. Furthermore, only 76.4 % of the driving advice given was accurate. To assess the documentation improvement, During the second review, 62% had driving advice documented, and 98% of the advice was accurate.
Conclusion: The Driving and Vehicle Licensing Agency gives precise guidance to all patients undergoing cardiac intervention about resuming driving or not. Clinicians are responsible for ensuring all patients are given accurate driving advice, which is directly related to patients and people on the road. Continuous education for doctors is crucial, either through posters, lectures, or induction programs.

8. **A&E management of AUR**

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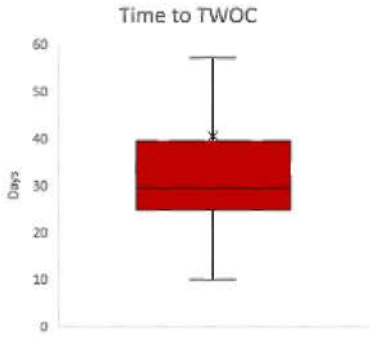
Background: AUR is a common problem encountered in the A&E. It presents a sudden inability to voluntarily void. Its aetiology can be varied and multifactorial. Treatment of AUR aims to relieve the obstruction and mitigate the underlying cause of retention. This can generally be accomplished in the ED without immediate urologic consultation.
Aims: We assessed the quality of referrals to the TWOC clinic directly from A&E. The aim was to measure the quality of the initial management of AUR patients presenting to A&E, the quality of the documentation being fed back to the Urology department, and the appropriateness of referrals.
Methods: A urinary retention proforma was provided, which included the patient's details, history and examination, urine dipstick and blood tests. Common causes of urinary retention were included, along with specific admission and discharge criteria. In addition, the size and type of catheter and urine drained in 15 minutes, 1 hour, and 2 hours drained in ml were all included. 48 cases were added in the period from June 2021 until November 2021.
Results: 50% of patients had size 14Fr inserted, and in 77% of the cases, a silicone catheter was inserted. The mean time of TWOC was 40 days. Surprisingly, only 50% of the cases were offered an alpha blocker before TWOC, and in 20% of the cases, DRE was documented. The overall recording of urine output was adequate in most patients. 96% of the proformas performed were incomplete. The TWOC pass rate was 57% compared to the national average of 20-40%.
Conclusion: DRE documentation among ED physicians should be encouraged. Silicone catheters should be the catheter of choice, as the follow-up time could exceed the lifespan of PTFE catheters. Consideration of Tamsulosin should be established if there are no contraindications. Finally, admission should be considered if the urinary output drained is >1500ml.



9. **The diagnosis and long-term management of AVNRT as an initial presentation of COVID- 19 infection in the absence of cardiovascular disease**

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Atrial tachyarrhythmia is associated with severe COVID illness and is commonly seen in the ICU setting. Many patients will also have a history of arrhythmia. Yet, this case reports SVT in the context of undiagnosed COVID infection with the clinical and biochemical absence of significant infection or previous cardiac disease. The outpatient investigation demonstrated long runs of narrow complex tachycardia persisting after viral resolution. This case raises questions about the pathophysiology of the virus and viral-associated inflammation of the heart, both acutely and long-term. It raises questions about the outpatient care requirements for cases such as these.

10. Multidisciplinary acute knee clinic, cost-effective model for managing knee injuries

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Background: Acute knee injuries can be time-critical and need specialist input according to to BOAST/BASK guidelines. These injuries used to be referred to the fracture clinic for assessment, then to the knee specialist. This delayed management and affected outcomes. During the COVID pandemic, we established an MDT "Acute Knee Clinic" service to reduce the number of patient visits while maintaining an efficient service and speeding up the definitive management. A pathway was designed to assist ED staff, and 2 experienced physiotherapists were allocated to ED.
Aims: We assess this service through the number of visits, time to see a specialist and definitive management and cost implications.
Methods: The notes for all patients attending AKC between Feb 2021 – July 2022 were assessed regarding time to review by a specialist, time to operative management, appropriateness of referral and of MRI request and cost implications.

Results: We had 365 patient visits for a total of 205 patients. 84.4% of the referrals to the clinic were appropriate. 162 MRIs were ordered (positive in 87.7%, average 42.6 days). The average time to see a specialist was 36.7 days. 80 patients (39%) were listed for surgery, of which 43 had their surgery (average 128.6 days). The patient's average visit was 2.08, with an estimated cost of £294.48 per. Physiotherapists in ED saw 83 patients with 71 MRI requests (94.4% appropriate) in 33.7 days on average). The average time to AKC was 40.25, and to listing for surgery was 69.5 days. The average patient visit was 1.71 (average cost of £242.44 per patient)
Conclusion: Establishing an Acute Knee Clinic is a cost-effective and safe way to reduce the time to definitive management of acute knee injuries, reducing patients' footprint and the number of unnecessary MRIs. The MDT nature of the clinic improves outcomes as well.

	Within protocol	Outside protocol
Pt number	144 Pts	61 Pts
Appropriate referrals	126 (87.5%)	47 (77%)
Number of MRI requests	111 (77.1%)	49 (80%)
Time to MRI	36.7 days	59.9 days
Time to MRI (Critical conditions)	24.5 days	26.4
Appropriate MRI	103 (92.8%)	40 (81.6%)
Time to seeing a specialist	28.6 days	55.5 days
Time to listing for surgery	55.4 days	99 days
Time to listing for surgery (critical conditions)	29.75 days	39.6 days
Time to having surgery	135.8 days	104.7 days
Time to having surgery (critical conditions)	38 days	70.9 days
Average OPD visits per patient	1.83 visit	2.6 visits
Average cost per patient	£259.32	£367.99
Number of operations (% of patients referred)	29 (21%)	14 (22.58%)

11. **The efficacy of ENT elective surgical post-operative information leaflets to improve health literacy**

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Background: An adverse event in an elective ENT post-operative patient post-discharge led to the introduction of procedure-specific patient information leaflets. This was done to improve patient knowledge and to signpost appropriately when there are concerns.
Objectives: To evaluate the effectiveness of providing information leaflets post elective ENT surgery in improving patients' health literacy.
Method: The survey was carried out over 6 months. Information leaflets were handed out before discharge. We created a questionnaire to be completed at the patient's first appointment post-surgery. The survey assessed patient experience, health literacy, understanding and retention qualitatively and via Likert scales.
Results: We collected 33 completed questionnaires. The introduction of post-operative information leaflets had positive patient feedback. There were no post-surgical complications. 70% of patients felt involved in the plans to care for themselves post-surgery, and 88% reported retention of care information. The questionnaire reported a health literacy of 73% among patients, and 88% of patients felt they were aware of the emergency services available. 22% of patients preferred an electronic version of the leaflet alongside a paper copy.
Conclusions: The introduction of post-surgical information leaflets has led to patients being more informed and aware of how to deal with complications arising from the surgery.
Recommendations: To further improve the accessibility of leaflets, it would be valuable for the patients to have online PDF versions available to be downloaded via QR codes.

12. Day Case Partial And Total Knee Replacement- A District General Hospital Experience.

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Background: There has been a significant increase in the demand for arthroplasty due to the Covid 19 pandemic and the lack of beds on the green pathway. The average length of in-hospital stay following knee replacements has been successfully reduced over the years following the introduction and adoption of enhanced recovery protocols.
Aim: Day-case arthroplasty has the potential to be efficient as well as cost-effective. We present our day case pathway for elective knee arthroplasty and its early adoption results at a district general hospital.
Methodology: Our pathway was developed through multidisciplinary input from surgeons, anaesthetists, physiotherapists, nursing staff, administrative staff, surgical care practitioners and pharmacists. Inclusion criteria were defined to identify patients suitable for cay case arthroplasty. Results of 32 patients who underwent day-case partial and total knee replacement at our institution are presented.
Results:31 out of 32 (97%) were discharged safely on the day of surgery. These patients were compared to 38knee replacements undertaken as in-patients over 2 years. DSU patients were discharged at a mean of 7 hours following surgery, while in-patient TKR were discharged at an average of 2.7 days. There were no readmissions following discharge in the DSU group. DSU group: There were no surgical complications at a mean follow-up of 2 years. Patient feedback revealed high satisfaction levels and that they would recommend the pathway to others. Cost analysis revealed savings towards bed costs.
Conclusion: Our early results demonstrate day-case knee arthroplasty to be safe and cost-effective. With limited resources to tackle the enormous backlog of arthroplasty, it offers the potential to make theatre utilization efficient.

13. Reducing the length of stay in the National Health Service.

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Background: The increasing waiting times in the NHS is a burning issue that has gradually worsened over the past few years, particularly following the Covid-19 pandemic. As well as delayed hospital discharges, prolonged waiting times in the Emergency Department (ED) are becoming incessant. The latest data from NHS England (2021/2022) shows that over 900,000 people waited more than 12 hours in ED from arrival to transfer, admission or discharge. NHS England also reported over 350,000 extended hospital stays per year, associated with higher patient costs and risks.
Methods: A literature review was undertaken to explore the reasons behind the increased waiting times and length of stay and to find practical and tested solutions in various NHS organisations to these problems.
Results: There is a paucity of high-quality evidence describing proven effective ways of reducing the length of stay. However, several initiatives and ideas have been successful in different areas.

We have incorporated some of these ideas into a 6-step plan to address some factors that lead to long waits in the NHS.
1. Prehospital: Paramedic and nurse care, consultant-led pre-hospital admission prevention. 2. ED: Consultant-led triage, virtual wards, hot clinics, spinal and head injury middle-grade doctors. 3. Inpatient: Discharge to assess model, winter field hospitals, enhanced recovery programmes.4. Rehabilitation: Needs-based rather than condition-based services, therapeutic gardens, faster access.5. Elective procedures: Patient hotels or care homes, proactive infection control, backup plans for cancellation. 6. Prevention: Screening programmes, food and exercise incentives.
Conclusion: Long waits in the NHS are a multifactorial problem. We have summarised some healthcare innovations that have proven valid; however, further research is needed in this area.

14. Risk Stratification of developmental dysplasia of the hip using the presence of multiple risk factors in a neonatal population: a prospective registry study.

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Background: Early detection of developmental dysplasia of the hip (DDH) is associated with improved outcomes from conservative treatment.
Aims: To evaluate the impact of multiple risk factors on the predictive value of a national screening program in detecting DDH.
Methods: A 5-year prospective cohort study of all live births in the study's catchment area (n=27,731), of whom 4,016 underwent ultrasonographic screening for DDH. Each child was evaluated prospectively for the presence of risk factors, and findings were documented in a prospective registry. Multivariate odds ratios following regression evaluation of variables were used to evaluate statistical significance.
Results: The prevalence of DDH (Graf type IIb-IV) within the study population was 5.3/1000 live births. The rate of missed presentation of DDH was 0.43/1000 live births. The presence of multiple risk factors demonstrated a significantly increased association for DDH than for patients with primary risk factors alone. The presence of any primary risk factor had a positive predictive value (PPV) of 9.6%. In comparison, those with multiple risk factors had a PPV of 18.4% (p=0.014) and a significant increase in odds ratio (p=0.048). When these same groups were compared alongside an abnormal examination with a single risk factor against those with multiple risk factors, those with multiple risk factors demonstrated a significant increase in the PPV from 16.4 to 28.6 (p=0.045).
Discussion: This novel paper demonstrates a need to risk-stratify children based on multiple risk factors to ensure early detection of DDH. In doing so, we may avoid system pressures that cause late diagnosis, and by screening those at high risk earlier, we can ensure adequate treatment of DDH is given through early detection.
Conclusion: There is a significantly increased association between children with multiple risk factors and the likelihood of the presence of pathological DDH.

15. 2 Hole DHS fixation of Garden I and II neck of femur fractures-Radiological outcomes and predictive factors of AVN

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Background: Garden I and II NOF fractures are traditionally known for reduced incidence of AVN
Aim: This study analyses the radiological outcomes and predictors of AVN following 2-hole DHS in Garden I and II neck of femur fractures in patients over 60 years of age with a minimum follow-up of one year.
Methods: We retrospectively reviewed 51 consecutive patients older than 60 years who underwent DHS fixation for Garden I and II fractures. Demographics, fracture classification, time to surgery, pre-operative AMTS, preoperative posterior tilt angle, quality of reduction, pre and post-operative haemoglobin(Hb), creatinine and comorbidities were analysed for correlation with AVN using Chi-Square test, Independent Sample and paired-t-test.
Results: There were 40 (78.4%) females, and the mean age of the cohort was 77 years. Union was observed in all our patients except one. (kappa =1). 12/51(23.5%) developed AVN of the femoral head. Statistically significant higher incidence of AVN was noted in patients with a pre-op tilt angle > 200 (p = 0.006). The mean drop in Hb was higher in patients who developed AVN (21.5 g/L) versus the non-AVN group (15.9 g/L) (p = 0.001). There was no difference in AVN rates concerning laterality, mean time to surgery, pre-op AMTS and Charlson comorbidity index. 4/52 (7.6%) had re-operations (one hardware prominence, two conversions to arthroplasty, and one fixation failure during the immediate post-op period). The 30-day and one-year mortality rates were 1.9 % and 11.7 %, respectively.
Conclusion: A preoperative posterior tilt angle of >200 and a more significant difference in pre and post-operative haemoglobin were found to correlate positively with the progression to AVN following 2-hole DHS fixation in undisplaced NOF fractures. No correlation was observed between AVN, time to surgery, laterality, quality of reduction, and comorbidities.

15. Clinical Assessment Preparation with 360-Degree Films: A Future-Proof Approach for Medical Students

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Background: COVID-19 changed the landscape of clinical teaching. In its aftermath, novel Medtech resources can target gaps in struggling medical students' clinical knowledge in preparation for Observed Structured Clinical Examinations (OSCEs). Livestreamed ward rounds allow pre-clinical students to prepare for the next phase of medical education, which involves more patient interaction. Students experience the clinical environment and can practice their consultation skills in preparation for assessments.
Aims: A new virtual learning initiative delivers immersive exam preparation. It partners student-led 360-degree-filmed mock OSCEs, with Professional OSCE Examiners' feedback. In providing immersive exam simulations, we aim to increase students' confidence and preparedness and impart crucial clinical history and examination skills.

Methods: 1. Students film mock 360-degree OSCEs. 2. Student participants watch videos and read an examiner's commentary. 3. Participants engage in a live-streamed ward round where they take a history from several patients. 4. Participants were quizzed to check confidence and awareness of how OSCEs run. 5. Participants join focus groups to examine the learning value of videos, ward round and contextual teaching. 6. Participants' comments were analysed for emerging themes.

Results: 360-degree films, posted on YouTube and watched on computers, phones or Google Cardboard, provide immersive clinical learning anywhere without exposing patient data- a future-proofing aspect.

Discussion: 1. Students appreciated the immersive and authenticity, enabling flexible and engaging learning. 2. 360-degree videos help students learn empathy, professionalism, and equitable attitudes.

Conclusion: Students commented that technology-themed learning improved confidence in communication skills with patients.

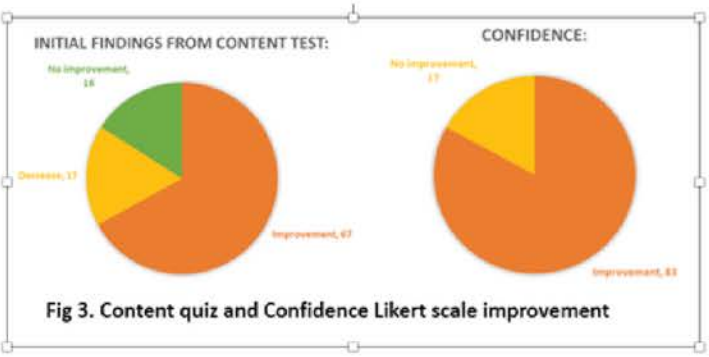

Fig 3. Content quiz and Confidence Likert scale improvement

17. Do trainees need more senior support to help with post-pandemic recovery?

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Background and Aim: The COVID pandemic significantly disrupted trainees throughout the country. This project aimed to assess the impact this has had on trainees' experiences at The Christie NHS Foundation Trust.

Method: A prospective study looking at data from end-of-rotation surveys in the 18 months following the start of the COVID-19 pandemic, using a 5-point Likert Scale. Comparisons were then made with data in the 18 months before the pandemic. The surveys were completed by junior medical staff.

Results: A total of 80 surveys were included in this study, 38 in the Pre-COVID group and 42 in the Post-COVID group. The results showed that 33.3% of trainees reported a good level of Consultant support and supervision after the pandemic's start, a fall from 47.1%. The number of trainees who thought they were receiving adequate feedback fell, with 41.5% rating their feedback as poor, compared with 27.1% before the pandemic. No difference in workload intensity was reported between the two periods.

Discussion: The Christie Hospital is a specialist cancer care centre and took steps to minimise the impact of COVID-19 on running routine services and delivering care to patients. The results of these surveys show that despite these efforts, juniors received less supervision and feedback than before the pandemic. This has led to a project, which is currently underway, exploring the potential impact this will have on the quality of training being delivered and identifying areas for improvement as we move past the pandemic.

18. An Evaluation of Bone Health in Paediatric Neurodisability

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Background: Children with neurodisability (conditions caused by impairment in the nervous or musculoskeletal systems) who have decreased ambulation or who have been prescribed certain medications are at higher risk of having low bone mineral density (BMD). This increases the risk of osteoporosis and fragility fractures. Identifying the risk factors associated with low BMD and their effects can help us create individualised care plans for children to improve their bone health.

Aims: To evaluate the risk factors associated with neurodisability and explore bone protection medication use.

Methods: Data was collected by a retrospective review of 110 patients (age range 3-20 years), under the Paediatric Orthopaedic team, using the Welsh Clinical Portal. Factors analysed include biochemical biomarkers, nutritional status, and weight-bearing activity.

Results: 63.3% of patients were classified as non-ambulatory, and 21.1% sustained fragility fractures. 40.4% of patients did not have a vitamin-D measurement and 60.9% of patients who had fractures were not on vitamin-D supplements. Most patients who sustained fractures (52%) had feeding difficulties requiring feeding adjuncts. 83% of patients who had fractures were caused either by non-traumatic injury or as an incidental finding. None of the patients with multiple fractures was assessed using a DEXA scan, and only 2/23 patients were prescribed bisphosphonates.

Conclusions: Bone health is affected by the cumulative effect that results from all the risk factors together. A new management pathway can help prevent low BMD and secondary complications. Preventative measures are essential in future practice by ensuring vitamin-D supplements are provided to all patients and raising awareness among staff, carers, and family to help handle patients and earlier recognition of fractures. Considering the early involvement of DEXA scans and bisphosphonates can be helpful alongside the other measures.

19. Do other injuries affect the outcomes of flexor tendon repair in the hand?

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Background: Limited data is reporting on the influence of concurrent injuries on outcomes of upper limb flexor tendon repairs (1). We aimed to compare Strickland and Glogovac's (2) TAM classification of flexor tendon repair outcomes in patients with and without concurrent neurovascular injury, fracture and extensor tendon divisions.

Methods: A retrospective case note review of a prospectively maintained hand therapy database from 1st Jan 2016 to 31st Dec 2020 was undertaken. The clinical notes were interrogated to determine the zone of flexor tendon injury, rupture rate, TAM outcomes and complications.

Results: Overall, 386 digits in 337 patients were available for analysis. Concurrent injuries included: 23 fractures, 10 extensor tendon lacerations and 138 neurovascular injuries. Concurrent injuries were associated with more significant fair/poor outcomes (46%) compared to patients with isolated injuries (33%). Patients with fractures had the most significant incidence of fair/poor outcomes (57%) compared with neurovascular injury (56%) and extensor tendon injury (44%).

Conclusions: Patients with concurrent hand injuries have reduced functional outcomes after flexor tendon repairs. The effects of extensor tendon injury on postoperative outcomes have not been addressed. A better understanding of rehabilitation strategies is needed to improve functional outcomes in these patient groups.

20. Incidence And Management Of Intraoperative Fractures Around Knee Joint During Primary Total Knee Arthroplasty – A Systematic Review.

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Background: Intra-operative fracture is one of the complications associated with TKA. Due to the low incidence rates, a lack of research evidence about the complications associated with TKA has been indicated.
Aim: This systematic review aims to analyze intra-operative fracture during primary TKA to establish its incidence rate, risk factors, the stage during the surgery, clinical outcome and management.
Method: The report adopts a systematic literature review strategy.
Result: 17 research articles were screened and identified for this systematic review. Only ten out of the 17 identified literature met the eligibility criteria.
Discussion and conclusion: The intra-operative incidence rate fell below 2%; its consequences are distressing since it may lead to TKA revision. Further research on the topic is recommended to increase the body of literature available.

21. The epidemiology of developmental dysplasia of the hip and a metanalytical evaluation of the impact of selective screenings in the United Kingdom.

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Background: Developmental dysplasia (DDH) of the hip is a common disease however its true incidence remains unknown. DDH can be managed effectively with non-surgical interventions when diagnosed early; however, with age, there is less likelihood of successful conservative intervention and the need for complex surgery increases. Hence, an effective screening program for DDH is essential to reduce the morbidity of late diagnoses in the population.
Methods: A systematic review and meta-analysis of the epidemiological literature from the last 25 years in the UK. Articles were selected from databases searches using MEDLINE, EMBASE, OVID and Cochrane. 13 papers met the inclusion criteria. Standard meta-analytic models utilising the MOOSE protocol were used to produce the results.
Results: The incidence of DDH within the UK over the last 25 years is 7.3/1000 live births, with females making up 86% of the DDH population (OR 6.14, CI 3.3, 11.5 $p<0.0001$). The incidence of DDH significantly increased following the change in NIPE guidance from 6.5/1000 to 9.4/1000 live births ($p<0.001$). The rate of late presentation also increased following the changes to the NIPE guidance, rising from 0.7/1000 to 1.2/1000 live births ($p<0.001$), however, despite this increase in late presenting cases there was no change in the rates of surgical intervention (0.8/1000 live births, $p=0.94$).
Conclusion: The literature demonstrates that implementing a selective screening program has increased the rate of DDH in the UK. It has led to increased rates of late presentation whilst failing in its primary goal of reducing rates of surgical intervention. The increase in late presentation without a subsequent increase in surgery is likely due to the lack of clarity in the literature when defining a late and missed case. This study suggests a requirement to reconsider defining terminology and compartmentalising the late (>12 weeks) and 'missed' cases>24 weeks.

22. Prehabilitation: A Patient's Perspective

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Background: Prehabilitation is a growing concept and proven effective tool, demonstrated by multiple studies 1. Most of the Prehabilitation research focuses on exercise-based interventions and clinical outcomes. In this study, I have attempted to improve our Prehabilitation service and gain a general view from patients on the idea of Prehabilitation.
Methods: To develop the breadth of our Prehabilitation service, I produced a leaflet aimed at colorectal cancer patients, providing advice on diet, exercise, well-being, smoking, alcohol and the concept of Prehabilitation. After publication on the trust website, I presented the leaflet to our pre-assessment nurses and asked them to give it to patients undergoing colorectal surgery. I then collected feedback from the team. The nurses would pass on the patients' details, with their consent, so I may call them to find out their views on the leaflet.
To structure the feedback, I wrote a short survey (figure 1).
Results: I contacted four patients in the first two weeks. Each patient had the leaflet for around one week and gave in-depth feedback. Patients had many constructive comments – including considering patients whose first language isn't English and use of technical terms; a more prominent font version; querying the use of referencing for patients and exercises for patients who may have disabilities. The patients had different areas they were most interested in, giving evidence for a holistic service. Interestingly, all four patients thought written information was more valuable than the links.
Conclusion: Most of all, the leaflet impacted patients' perspectives; patients know that a healthy diet and keeping fit is beneficial, but each one described a new motivation after reading the leaflet. They all expressed that the leaflet gave them confidence that making a change before surgery would result in a smoother recovery.

Figure 1

Prehabilitation Survey	
1.	How long have you had the leaflet?
2.	Which of the lifestyle topics of the leaflet would you feel most engaged around improving?
3.	Is the concept of prehabilitation something you considered before reading this leaflet?
4.	Which did you find most useful on the leaflet; links/ QR codes or written information on the leaflet?
5.	Are there any areas of this leaflet you feel could be improved?
6.	Are there any areas of this leaflet you thought worked well?

23. The Virtual Trauma Meeting – Adapting To The New Normal In The Wake Of COVID-19

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Background: COVID-19 has changed the NHS. Hospitals have had to adapt to meet the ever-changing strain of safety measures necessary to keep the workforce running and, more importantly, safe. Our orthopaedic department has implemented a virtual trauma meeting (VTM) using the Microsoft Teams conferencing platform. This ensures adequate social distancing, safety and efficient running of the morning trauma meeting. Objectives We aim to explore whether a VTM is a viable alternative to the traditional face-to-face trauma meeting and aim to demonstrate not just increased efficiency but elevated satisfaction amongst staff.
Study Design & Methods: A questionnaire was distributed amongst involved staff members using a purposeful convenience sampling technique. The questionnaire was organised into Likert-type and free-text questions. These were subsequently analysed via tabulation and thematic analysis.
Results: A total of 47 responses were received with completed questionnaires. All members of the multidisciplinary team were represented. An overall positive satisfaction rating of 98% was demonstrated. Staff felt that a VTM increased departmental organisation and facilitated safe attendance whilst maintaining efficiency compared to traditional trauma meetings. The educational value of the meeting has remained the same. Only 22% of those in attendance experienced log-on issues. 87% of users did not have an issue technically with the format. 87% of study participants would like the VTM to continue in its existing format, and 77% felt its implementation improved the standard of care delivery.
Conclusions: A VTM is a viable replacement for the traditional face-to-face trauma meeting. More staff can attend safely and facilitates all multi-disciplinary team members to be aware of the upcoming day's events. Our VTM has demonstrated excellent satisfaction levels. However, efforts must be made to maintain the educational/business balance of the meeting.

24. Spinal Injury Management In Trauma Units In South Wales

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Background: The South Wales Trauma Network was established in September 2020. The Major Trauma Centre (MTC) is based in Cardiff, with designated Trauma Units (TU) in other hospitals throughout South Wales. These include Morriston Hospital (MH) in Swansea Bay and West Wales General Hospital (WWGH) in Hywel Dda. Patients with Spinal Injury (SI) are often repatriated back from the MTC after completing specialist treatment. Until recently, these patients were admitted to various wards depending on bed availability. Cohorting patients on a single ward, or landing pad, has several advantages. Spinal Injury leads to complex problems, and a trained, experienced multidisciplinary team is vital to provide a good standard of care.
Aim: To provide centralised, timely care to patients with SI admitted to TU in Swansea Bay and Hywel Dda health boards by designating a specific ward as a landing pad where all their needs are met.
Methods: Using data from the significant trauma teams, a retrospective review of the patients with traumatic SI treated at MH and WWGH between February and September 2022.
Results: Since February 2022, there has been an attempt to cohort patients with SI on designated landing pads. So far, 24 ward nurses in MH and 14 nurses in WWGH have received specific training to provide holistic care to these patients. The total number of patients with SI admitted to MH and WWGH in the timeframe was 20 and 7, respectively.
Conclusion: Establishing a clear pathway and designated landing pads ensures smooth patient flow and trained, experienced staff, managing a cohort of patients with often complex needs. Further work is planned to examine the effects on patient experience and length of stay.

25. Von Hippel Lindau Retinal Screening in Oxford: A Quality-Improvement Project and Full-Cycle Audit

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Background and Aims: Von Hippel Lindau Disease (VHL) requires regular retinal screening due to the risk of developing capillary haemangioblastoma. There was no database of VHL patients requiring retinal screening in Oxford University Hospitals (OUH). This quality improvement project (QIP) sought to create, audit, and re-audit a database of patients requiring retinal screening to ensure safe and timely follow-up, particularly important during COVID-19, which posed a risk of loss of face-to-face follow-up.
Methods: VHL clinic lists across two years were consulted to identify all patients. Electronic patient records were used to identify appointment dates and outcomes. The database was created and password protected; 'standard' data were collected at the creation time. The database was re-audited after four months.

Results: 85 patients were included in the original database, of whom 75 (88%) had a clear follow-up plan, with a screening appointment already booked, not requiring an appointment for several (≥3) months, or only requiring follow-up in the genetics clinic. Nine patients were overdue for an appointment, and one did not have sufficient information to determine whether they were being screened correctly. Upon re-audit, 45 patients were included in the updated database. All were being screened appropriately, with appointments already booked, a clear follow-up plan, or several (≥3) months until their next appointment.
Conclusion: Most patients received optimal VHL retinal screening before the creation of the database; all received optimal screening upon re-audit. Implementing this QIP has helped to ensure that all patients receive appropriate and timely retinal screening.
The authors recommend re-audit the database after a longer duration of use (e.g., one year) to determine whether there has been any change in the screening process.

26. Delays in Accident and Emergency services

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Background: The Accident and Emergency (A&E) 'four-hour' waiting time standard has been among the highest profile NHS targets. But, it has declined from 95% (reaching the standard) to a mere 60% in a decade, with over 900,000 people having to wait over 12 hours from arrival, according to data published by NHS England (2021/2022). A study by Simon Jones et al. on 26,738,514 patients has shown an increase in all-cause 30-day mortality in patients with a delay of more than 5 hours from arrival in A&E to admission.
Methodology: A literature review has been undertaken to determine the gravity of the problem and explore practical, tested solutions.
Results: Proven effective ways of reducing waiting times in A&E are scanty. However, several initiatives have been proposed and thriving in various regions. We have derived the following list from integrating such models and experts' ideas. An increase in out-of-hospital care and primary care, Patient awareness campaigns, and Consultant led Triage has proven to decrease the need for investigations and waiting times, with over 50% being discharged back home from triage, Spinal and head injury middle grade or nurse practitioners input, Basic diagnostic training for A&E staff, Specialist frailty assessment unit, Virtual wards, Hot clinics, Avoid co-existing Minor injury units, balance demand and capacity by identifying patterns, compensating excess demand with increased capacity by rescheduling or re-allocating, and the evident need to increase staffing and beds.
Conclusion: This substantial problem of A&E doesn't have a straightforward solution but rather multiple interventions at various stages. The focus should be shifted to the whole patient pathway to identify and address bottlenecks along with further studies and regular audits.

27. Covid in pregnancy: are we following the guidelines?

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Background: Covid-19 was first detected in the UK in February 2020, originating in Wuhan, China. According to MBRRACE rapid report, 10 Pregnant women died from Covid between 1/3/2020 and 31/5/2020. Since very little was known about the disease and the safety of the vaccination could not be proved when it was introduced, it was very important to get the right treatment during pregnancy to prevent maternal morbidity and mortality. We aimed to audit the symptomatic and preventative treatment of Covid in pregnancy.
Methods: Retrospective audit of all pregnant women diagnosed with Covid from February 2020 until July 2021. We compared maternal corticosteroid use, VTE compliance (Clexane injections for at least 10 days) and steroid use for fetal lung maturation (in deliveries <38 weeks) with the published guidelines at the time.
Results: 73 patients had symptomatic Covid-19 infection during the study period. Compliance with maternal corticosteroid use was 89% (target 90%). VTE compliance was 88% in severe disease and 60% in moderate disease (target >90%). Results for steroid use for fetal lung maturation were inconclusive since it was unclear at what gestation steroids were given and whether these were given for fetal lung maturation or not (target 100% in deliveries <38 weeks).
Conclusions: Overall, the audit showed reasonable compliance with guidelines, especially considering guidelines for Covid in pregnancy changed several times during the study period. Clinician documentation could be improved in digital health records to help more accurately assess steroid use in pregnancy, which would help obstetric doctors understand this better when considering fetal lung maturation.

28. Longitudinal Analysis of Childhood Body Weight Trajectories and the Determinants of Weight Gain

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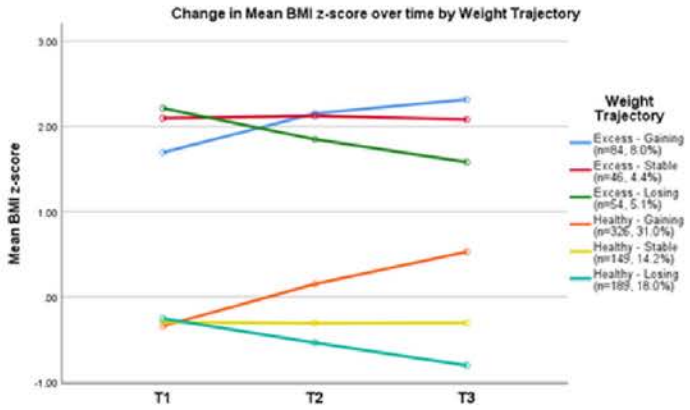
Objectives: To describe the change in BMI z-score over time among a cohort of UK primary school children and to identify differences between weight trajectories by socioeconomic and behavioural characteristics. Ultimately, to help identify groups of children at higher risk of gaining weight to aid obesity prevention strategies in the UK and similar high-income countries.
Methods: Secondary data analysis of WAVES study data; 1052 primary school children aged 5-9 in 2017 from 54 primary schools across the West Midlands, UK. BMI z-score calculated at three-time points, T1 (baseline), T2 (15 months), and T3 (30 months), are described by weight trajectory as a combination of their baseline weight status and subsequent weight change. Combined weight trajectories are compared using Pearson's Chi2 and SPSS logistic regression to identify significant differences by demographic factors and behavioural patterns.

Results: Mean BMI z-score increased with time, with 1-in-5 participants (20.9%) classed as overweight or obese at T1, increasing to almost 1-in-3 (31.2%) by T3. "Sex", "Deprivation", and "meeting guideline portions of fruit and vegetables" were not statistically significant determinants for weight gain in either baseline weight group. Significant associations with weight gain included being of "South Asian" or "Other" ethnicity when healthy or underweight at baseline, alongside "not meeting recommended levels of physical activity" when overweight or obese at baseline.
Conclusions: Carrying excess weight is prevalent in the study population, with participants displaying a tendency for weight gain throughout their primary school years. Multilevel prevention strategies should target the susceptible demographics identified. Public health campaigns encouraging healthy lifestyles are required to help tackle the UK's obesity crisis, prevent its from tracking into adulthood, and reduce the public health burden of childhood obesity.



29. Creating a standardised drug chart for a continuous intravenous infusion of Omeprazole for use after successful endoscopic haemostasis of bleeding peptic ulcers

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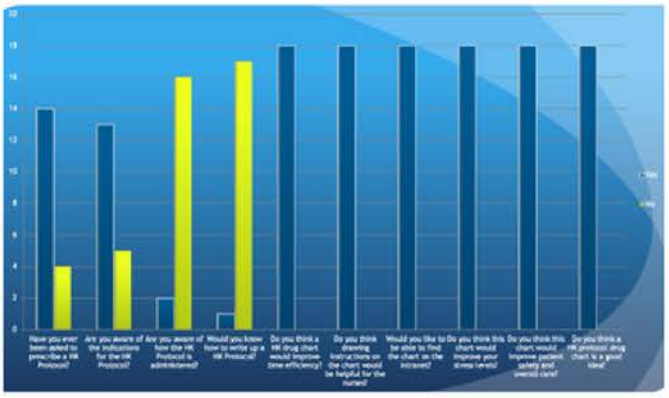
Background and Aims: There is high-quality evidence that a continuous PPI infusion (CPPII) over 72 hours following successful haemostasis in bleeding peptic ulcers at endoscopy can decrease rebleeding and improve mortality. Anecdotally, healthcare professionals (HCPs) have limited experience prescribing and administering a CPPII which can create confusion and force prescribing errors. My QIP aimed to create a standardised drug chart for a CPPII to help HCPs prescribe and administer it confidently and to ensure that Helicobacter Pylori (HP) eradication therapy is appropriate.
Methods: Two PDSA cycles were performed. A pre-QIP questionnaire was distributed to 18 doctors from 08/02/21-19/02/21 to ascertain the background knowledge regarding the rationale of a CPPII and whether a standardised drug chart would be beneficial. Their answers helped create the drug chart, which had to be approved by the Drug and Therapeutics Group (DTG) for official use across the health board. Following its approval on 05/05/21, a post-QIP questionnaire was distributed to 13 doctors from 24/05/21-28/05/21 to assess its effectiveness.
Results: The pre-QIP questionnaire demonstrated a poor understanding of the indications for a CPPII, with nearly 40% being unaware of the indications, 95% stating they did not know how to prescribe it and 90% being unaware of how it was administered. I 100% thought the QIP was worthwhile and would help improve overall patient safety and care. 100% of responses from the post-QIP questionnaire showed improved understanding and confidence in prescribing CPPII and HP eradication.
Conclusion: A standardised drug chart for CPPII has been shown to improve knowledge and confidence for HCPs to provide optimal care to a subset of patients who are critically unwell and with high mortality. It will theoretically reduce prescribing errors and by implementing best practices, improve patient safety.



30. Impact of COVID-19-related delays to arthroplasty surgery on patient-reported outcomes and quality of life measures

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Objectives: To describe the impact of COVID-related delays to arthroplasty surgery on patient-reported outcomes measures (PROMs), pain, and quality of life (QoL). The hope is to highlight the importance of attending to these patients' needs promptly and potentially informing and facilitating change at a regional level in response to such unprecedented times.
Methods: This patient-based service evaluation looked at a random selection of urgent arthroplasty patients from multi-surgeon waiting lists at the Royal Gwent Hospital, South Wales. The cohort was consented to, assessed, and listed for surgical treatment in the pre-COVID era and subsequently could not have their required treatment due to COVID-related delays. Patients were listed for Total Hip Arthroplasty, Total Knee Arthroplasty, and Uni-Compartmental Knee Replacement. Validated patient-reported outcomes (Oxford Hip or Knee Scores) and QoL tools (EuroQol) assessed at Pre-COVID. Current intervals are used to identify the impact of delays in hip or knee replacements attributed to the first year of the COVID-19 pandemic.
Results: Mean Oxford Score worsened from 27.2 at the Pre-COVID level to 40.7 at the current level, with the percentage of patients exhibiting a clinically significant worsening of Oxford Score at 85.3%. All five dimensions of quality of life reported maintained or worsened outcomes, with the worst affected being Usual Activities (53.0%), Pain or Discomfort (44.1%), and Anxiety or Depression (32.4%).

Conclusions: Findings illustrate the overwhelmingly negative impact of COVID-related delays to arthroplasty surgery on patient-reported outcomes measures (PROMs), pain, and quality of life (QoL), as well as prompting research into expanding post-procedure outcome measuring alongside larger sample sizes.

			Oxford T1		Oxford T2		Oxford Change			
Mean			27.2		40.7		13.5			
SD			9.9		7.1		8.8			
EQ-5D-3L	Mobility		Self-Care		Usual Activities		Pain / Discomfort		Anxiety / Depression	
	T1	T2	T1	T2	T1	T2	T1	T2	T1	T2
Mean (SD)	1.9 (0.4)	2.1 (0.3)	1.5 (0.6)	1.8 (0.6)	1.9 (0.6)	2.4 (0.6)	2.2 (0.6)	2.7 (0.5)	1.5 (0.7)	1.8 (0.8)
Maintained	25 (73.5%)		24 (70.6%)		16 (47.1%)		19 (55.9%)		23 (67.6%)	
Worsened	9 (26.5%)		10 (29.4%)		18 (53.0%)		15 (44.1%)		11 (32.4%)	
Rank	5		4		1		2		3	

31. Comparing the Outcomes of Traditional Growing Rods and Magnetically Controlled Growing Rods at Graduation

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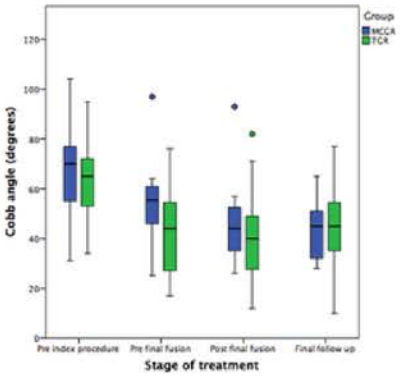
Objectives: To compare the clinical and radiological outcomes in patients with early-onset scoliosis who have undergone spinal fusion (graduation) following distraction-based spinal growth modulation through either traditional (TGRs) or magnetically-controlled growing rods (MCGRs).
Methods: A retrospective single-centre review of skeletally mature EOS patients treated with either TGR or MCGR. Measured outcomes included sequential coronal T1-S1 height and significant curve (Cobb) angle on plain radiographs from pre-operative to the latest follow-up and any complications requiring unplanned operations before final fusion.
Results: 43 patients were identified (63% female) with a mean age of 6.4 ±2.6 years at index procedure and 12.2 ±2.2 years at final fusion. The mean follow-up was 8.1 ± 3.4 years. 16 patients were treated with MCGR and 27 with TGRs. The mean number of distractions in MCGR group was 7.5 vs 10 in TGR group (p=0.47), with 3.4 months versus 8.6 months in between each distraction in the respective groups (p <0.001). The mean Cobb angle improved by 25.1° in the MCGR and 23.2° in TGR group (p=0.66) at the final follow-up. The mean coronal T1-S1 height increased by 16% in the MCGR and 32.9% in TGR group (p=0.001), although the mean T1-S1 height achieved at the final follow-up was similar in both groups. Unplanned operations occurred in 43.8% of MCGR and 51.2% of TGR cases (p=0.422)
Conclusion: In this retrospective single-centre review of MCGR and TGR graduates, there were no significant differences in major curve correction or gain in spinal height at fusion. Although the number of planned procedures was fewer with MCGR, rates of implant-related complications necessitating unplanned revision surgery were similar in the two groups.



32. Characteristics and outcomes of patients with hospital-related venous thrombo-embolism: A retrospective hospital study

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Background: Venous thromboembolism (VTE) is a preventable cause of death and occurs during the immediate period post-hospitalisation. Early risk assessment and adequate prophylaxis can reduce mortality.
Methods: We screened hospital records for radiologically confirmed deep vein thrombosis (DVT) or pulmonary embolism (PE) among adult hospitalised patients in the preceding 3 months. We interrogated hospital and GP records for mortality-related outcomes 3 months after diagnosis.
Results: Among 2907 records screened, there were 298 VTE events (10.3%), of which 64 (21.5%) were hospitalisation related. The median age was 73 years, and 62.5% (n = 40) were female. The most common presentation was PE (n = 35, 54.7%), and an equal proportion of people had hospital VTE during hospitalisation and three months post-discharge. Hospital VTE were higher among emergency medical admissions, 65.6% (n = 42). The median duration of hospitalisation was 9 days, and the median duration from admission to the diagnosis of VTE was 13 days. 98.5% (n = 63) were VTE risk assessed and 82.2% (n = 53) received prophylaxis. 76.6% (n = 49) received pharmacological and 18.8% (n = 12) mechanical prophylaxis. 95.3% (n = 61) of patients were discharged and 4.7% (n = 3) died. Cumulative mortality, 3 months post-VTE, was 25% (n = 16). Post-VTE mortality was significantly higher among medical patients and those aged more than 60 years.
Conclusion: Among hospitalised patients, significant VTE burdens occur in medical patients. VTE appears to be a strong determinant of mortality, although other factors, including COVID-19 infections and co-morbidities, may have contributed.

33. Rural-Mobile Based Rehabilitation Program. (Access to early intervention therapy for children with disabilities)

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Background: According to WHO," if children with developmental delays are not provided with appropriate early intervention, their difficulties can lead to lifetime consequences, increased poverty and profound exclusion. There are more than 102,600 in the Eastern region of Uganda with disabilities in age 0-6.85% of these have no access to EI therapy because of a lack of rehab specialists in rural areas and long distances. Therefore, bringing therapy to a child's home through Community Rehabilitation Workers with GPS monitoring systems guided by rehabilitation specialists provides a high-fidelity solution that rural children can access.
Aims: Enable parents and caregivers to support their children's overall development and prepare them for primary school through exploration and early literacy skills. Methods: We hire and train local women in the community to become Community Rehabilitation Workers through a 3-week intensive training program. All children in our surrounding community aged 0-6 are screened for developmental delays in health centres and nursery schools using a validated tool in our app. Our team of Rehab specialists then assesses children identified with disabilities. Community Rehab workers provide the EI therapy in the child's home (guided by the therapy program set out in the App). Impact evaluation and management through periodic evaluation of children is done. Reach: Our monitoring and evaluation of the program have revealed high engagement, with 87% of completed therapy visits. As of date, we have managed to screen 22,000 children.55 health workers and nursery teachers have been trained to use our RmBRP app, and finally, we have provided therapy for 1240 children. Results: Parents:- Decreased strain(74%), increased engagement(73%) and improved child interaction (62%) through the Canadian occupation performance measure tool. Improved children's development:- cognitive speech model, social development and improved child interaction. School enrollment:- increased enrollment (55% to 79%) through the family empowerment scale.

34. Audit of the Assessment of patient management in the Department of Acute Medicine compared to the latest NICE AF guidelines

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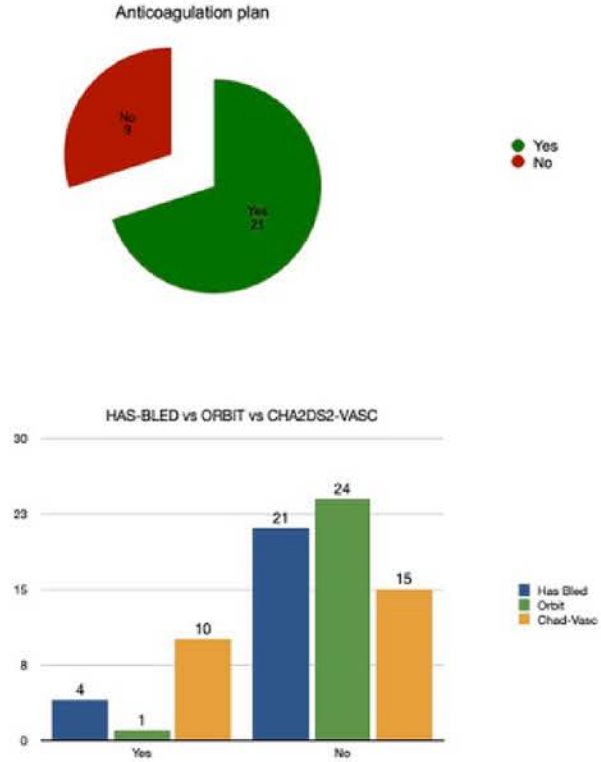
Background: Atrial fibrillation (AF) is the most common heart rhythm disorder detected as an irregular pulse or rhythm on an Electrocardiogram. Drug treatment includes anticoagulants and anti-arrhythmic. ORBIT and HAS-BLED scores have been recommended to assess the bleeding risk in patients while offering anticoagulation.
Aim: This audit aims to evaluate the patient management standards of AF compared to the latest NICE AF guidelines at a single centre.
Methods: Data were collected retrospectively from patients' notes and discharge letters of patients discharged with primary or secondary diagnoses of AF from the Department of Acute Medicine, Good Hope Hospital, over 2 months from January to February 2022 and compared against the latest NICE AF guidelines.
Results: The NICE standards are 100% documentation of the discussion, including ORBIT & HAS-BLED score while offering anticoagulation with a direct-acting oral anticoagulant to people with AF and a CHA2DS2-VASc score of 2 or above.
A total of 25 patients were selected, of which 21 (84%) patients were initiated on anticoagulation with a direct-acting oral anticoagulant.10 (40%), 4 (16%), and 1 (4%) patients had their CHA2DS2-VASc, HAS-BLED and ORBIT scores documented respectively.
Conclusion: Results of the audit showed that although 21 out of 25 patients were started on a form of Anticoagulation, there was an inadequacy in the documentation of the discussions along with the ORBIT, HAS-BLED and CHA2DS2-VASc scores before initiating the treatment. A departmental meeting was conducted to improve awareness among doctors, following which frequent messages on social media were forwarded to ensure adherence to the guidelines. A re-audit of the same will be performed in October 2022, and the target is to attain 100% compliance with the NICE guidelines.

Documentation of ORBIT, HAS-BLED and CHA2DS2-VASc scores before initiating treatment for Atrial Fibrillation



35. Did the COVID Pandemic affect outcomes for patients having total hip arthroplasty for hip fracture?

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Background: The COVID-19 Pandemic caused widespread changes to healthcare delivery worldwide. Hip fractures continued to be prevalent despite otherwise decreasing trauma trends. For inappropriate hip fracture patients, total hip arthroplasty (THA) can provide superior clinical and functional outcomes to other operations.

Aims This study aimed to observe changes in outcomes in the THA patient cohort compared to the previous year. The primary outcome measure was the length of stay (LOS), with secondary outcome measures including mortality, discharge destination, follow-up time, and complication rate.
Methods: Data was collected for one year in 2020 during COVID and an equivalent period in 2019 using the National Hip Fracture Database. This data was further examined using local IT systems. Only patients treated with THA were included.
Results: 59 patients had THA pre-COVID vs 47 during. Gender and ASA distribution were equivalents; however, the patients operated on were significantly younger at 73 vs 77 (P=0.05) during the pandemic. 2 patients developed asymptomatic COVID-19 infection. Average LOS during COVID was 13.2 days vs 10.8 pre-COVID. However, this was not statistically significant (P=0.167). Zero mortalities happened during COVID compared with 3 pre-COVID (P=0.116). 100% of patients returned to their pre-hospital discharge destination during COVID compared with 87.7% the previous year, which was significant (P=0.0126). Mean time to follow-up was less during COVID, averaging 27.7 vs 44.4 days before (P=0.015), with a similar follow-up rate (78% during vs 79% before). Complication rates were not significantly different at 27% pre-COVID vs 21% during (P=0.5). 1 Re-operation occurred pre-COVID vs 0 during the pandemic (P=0.3).
Conclusion: Despite numerous regulations being introduced, patients receiving THA during COVID experienced slightly better secondary outcomes. We should seek to employ lessons learned during COVID to continue improving the care offered to our patients as practice returns to normal.

36. Patient attitudes towards re-use of orthopaedic braces

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Background: Climate change poses the greatest danger to global health in the 21st century. Paradoxically, healthcare contributes enormously to climate change, from manufacturing pharmaceuticals to disposing waste products. Healthcare facilities produce 660 tonnes of waste daily. The rising use of disposable materials has led to a progressive annual increase in waste since 1992. The evidence regarding “green orthopaedics” has mainly examined waste generated perioperatively.
Aims: This study aimed to examine patient attitudes toward recycling orthopaedic braces in fracture clinics.
Methods: Brace-wearing patients in the fracture clinic were invited to complete a questionnaire examining personal attitudes to climate change, single-use plastics and the reuse of orthopaedic braces. The importance of climate change and recycling was recorded using a Likert scale (0, no importance- 10, very important). The degree of agreement to personal use of a recycled brace was assessed using a 4-point Likert scale.
Results: 211 patients attended the clinic, of whom 93 were wearing orthopaedic braces (44.1%). 40 responses were collected (response rate 43%). Of the respondents, 22 were female patients (55%) with a mean age of 49 (range 16-82). 38 patients (95%) were aware of the issue of climate change, whilst 37 (92.5%) were aware of the issues of single-use plastics. 22 patients (55%) described the issue of climate change as a Likert scale of 8,9 or 10, whilst 24 (60%) described the issue of single-use plastic as a Likert scale of 8,9 or 10. 36 patients (90%) were in strong or very strong agreement that braces should be reused.
Conclusion: Orthopaedic trauma patients are mindful of the importance of climate change and brace reuse. Our data suggest positive attitudes towards the reuse of braces. Orthopaedic surgeons and the orthotics industry should aim to develop sustainable, reusable orthopaedic braces.

37. A Comparative Analysis Of Inter-Observer Reliability And Intra-Observer Reproducibility Of Oswestry Bristol Classification And The Dejour Classification For Trochlear Dysplasia Of The Knee

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Background: Classifying trochlear dysplasia (TD) helps determine the treatment options for patients suffering from patellofemoral instability (PFI). There is no consensus on which classification system is more reliable and reproducible to guide clinicians in treating PFI. There are also concerns about the validity of the Dejour classification (DJC), which is the most widely used classification for TD, having only a fair reliability score. The Oswestry-Bristol classification (OBC) is a recently proposed classification system of TD. The authors report a fair-to-good interobserver agreement and good-to-excellent intra-observer agreement in the assessment of TD. This study aimed to compare the reliability and reproducibility of these two classifications.
Methods: 6 assessors (4 consultants and 2 registrars) independently evaluated 100 magnetic resonance axial images of the patella-femoral joint for TD and classified them according to OBC and DJC. All raters again repeated these assessments after 4 weeks. The inter and intra-observer reliability scores were calculated using Cohen’s kappa and Cronbach’s alpha.
Discussion: Both classifications showed good interobserver reliability with high alpha scores. The OBC classification showed a substantial intra-observer agreement (mean kappa 0.628)[p<0.005], whereas the DJC showed a moderate agreement (mean kappa 0.572) [p<0.005]. There was no significant difference in the kappa values when comparing the assessments by consultants to those by registrars in either classification system.
Conclusion: This large study from a non-founding institute shows both classification systems to be reliable for classifying TD based on magnetic resonance axial images of the patella-femoral joint, with the simple-to-use OBC having a higher intra-observer reliability score compared to the DJC.


Table I and II show assessor wise intra-observer agreement for the two classifications

Table I
Agreement between Assessment 1 and Assessment 2 for Oswestry Bristol Classification

	Kappa	p-value
Assessor 1	0.612	<.001
Assessor 2	0.673	<.001
Assessor 3	0.629	<.001
Assessor 4	0.581	<.001
Assessor 5	0.658	<.001
Assessor 6	0.755	<.001
Mean kappa	0.628	

Table II
Agreement between Assessment 1 and Assessment 2 for Dejour Classification

	Kappa	p-value
Assessor 1	0.625	<.001
Assessor 2	0.585	<.001
Assessor 3	0.534	<.001
Assessor 4	0.621	<.001
Assessor 5	0.618	<.001
Assessor 6	0.446	<.001
Mean kappa	0.572	

38. Early Management of Paediatric Forearm Fractures in Cardiff A&E

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Background and Aims: The forearm is the most common site of fractures in children. Casting is the gold standard for most fractures, as children have a greater remodelling capacity than adults. For most forearm fractures that exceed remodelling potential, early closed reduction by manipulation, avoiding the need for admission, and general anaesthesia are the treatment of choice. The British Orthopaedic Association (BOAST) released guidelines in May 2021 on 'Early Management of Paediatric Forearm Fractures.' This audit compares the early management of paediatric forearm fractures in Cardiff with the BOAST guidelines.
Methods: A retrospective audit was conducted on data between January 2020 to December 2020 was collected. Patients aged 16 or less at presentation with an angulated (but not off-ended) forearm fracture were included. Patients with complex fractures not suitable for manipulation were excluded. Information was collected through radiology imaging software and clinic letters. Data were collected on patient demographics, mechanism of injury, time to a first clinic appointment, management and outcome.
Results: 168 patients with forearm fractures were identified. 106 were managed conservatively, 56 were manipulated in A&E, and 6 were under general anaesthetic. Of the 56 manipulated in A+E, only 2 required further intervention. Of the 12 standards set by BOAST, 8 were met, and 3 were partially met.
Conclusion: The current management of early paediatric forearm fractures in Cardiff meets most of the standards set by BOAST. In 2020, 54 patients that required manipulation avoided hospital admission and general anaesthetic. As a result of this audit, a formal pathway was created and displayed in A&E, and a re-audit is in progress.

39. Incidence And Management Of Intra-Operative Fractures Occurring Around The Hip During Primary Total Hip Arthroplasty-A Systematic Review

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Background: Intraoperative fractures, although rare, is one of the complications known to occur while performing a total hip arthroplasty (THA). However, due to lower incidence rates, there is currently a gap in this area of literature that systematically reviews this critical issue of complications associated with THA.
Aim: This systematic review analyses the incidence and management of intra-operative fractures occurring during primary THA and establishes the risk factors and the exact stage of occurrence during the procedure.
Method: We looked into Electronic databases published in any language that evaluated intra-operative fractures occurring during total hip arthroplasty from 1950-2020. The screening, data extraction and quality assessment were carried out by two researchers, and if there was any discrepancy, a third reviewer was involved.
Results: Fourteen studies were identified. The reported fracture occurrence range while performing hip replacement surgery was found to be 0.4-7.6%.Major risk factors identified were surgical approaches, Elderly age, less Metaphyseal-Diaphyseal Index score, change in resistance while insertion of the femur implants, inexperienced surgeons, uncemented femoral components, use of monoblock elliptical components, implantation of the acetabular components, patients with ankylosing spondylitis, female gender, abnormal proximal femoral anatomy, different stem designs, heterogeneous fracture patterns and toothed design. Intraoperative fractures during THA were managed with cerclage wire techniques, femoral revision, the use of an intramedullary nail and cerclage wires and internal fixation plates and screws for management of intraoperative femur and acetabular fractures.
Discussion: The main reason for intraoperative fracture was found to be the use of cementless implants, but planning and timely recognition of risk factors and evaluating them is essential in managing intraoperative fractures. Adequate surgical site exposure is critical, especially during the dislocation of the hip, reaming of the acetabulum, impaction of the implant and preparing the femoral canal for stem insertion.

40. Enhanced International Medical Graduates (IMG) Induction Programme at St George's Hospital and Its Outcomes.

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Aim: To explore the challenges IMGs at St George's Hospital, London and provide the appropriate framework and support to adapt to the NHS system.
Background: The National Health Service (NHS), from its inception, depended on its international workforce. IMGs are doctors who have obtained a primary medical qualification from outside the UK and migrated to join the NHS. Acclimatisation to a new environment could be challenging, given their varied backgrounds and experiences. IMGs without induction or supervision could take longer to adapt to the NHS culture. The enhanced induction programme is designed to provide clinical and lifestyle support to these doctors.
Methods: An anonymised online survey was undertaken among the IMGs via Google forms looking at their confidence in communication, portfolio development assistance, work-based assessments, and career and educational opportunities awareness. We then delivered a bespoke induction day for IMGs and weekly modules to address these issues. A post-programme survey was also done.
Results: Of the 110 IMGs at the Trust, 41.2% were new. Out of 40 responses, 67% lacked confidence in professional communication. 34% were dissatisfied with the Trust's portfolio development and career guidance support. 12.5% were unfamiliar with General Medical Council's Good Practice or medico-legal aspects. On the post-programme survey, 96% of the IMGs affirmed that enhanced induction, mentorship programme, and IMG forum have positively influenced their confidence in improving access to career guidance, education and research opportunities.
Conclusion: The enhanced induction, mentorship programme and IMG forum helped with the transition into the new working system, boosted confidence, and ameliorated the required skills of the IMGs at St. George's. We recommend that this be a standard pathway at all NHS trusts.

41. An Evaluation Of The Effects Of Deprivation On DDH Screening

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Background: Developmental dysplasia of the hip (DDH) encompasses a spectrum of conditions that can lead to childhood disability and premature arthritis in adulthood. Early detection (through screening programmes) is essential in minimising the risks of these complications. There are well-documented links between lower socioeconomic status and poorer health outcomes.
Aims: This project aimed to study the link between socioeconomic status, DDH outcomes, and the effectiveness of screening programmes.
Methods/design: A cohort study studying live births from a single tertiary centre between 2011 and 2020. Various demographic variables were collected and stored in a secure database. We then collected data from the DDH screening programme and identified the number of diagnosed cases. We also collected data on the number of late presenting cases (presenting after 24 weeks of age). We then collected data on the socioeconomic status of screening-identified cases and missed cases using the Welsh Index of Multiple Deprivation (2019) (WIMD).
Results: There were significant links between missed DDH cases and the total WIMD score, income, employment, health and education scores. This indicates that individuals who live in a more deprived area are less likely to have been picked up by DDH screening programmes. Interestingly, residing in an area with a worse physical environment score led to higher DDH detection rates.
Discussion: Missed DDH cases increase the likelihood of more invasive treatment for patients. There is also a significant financial cost associated with treating missed DDH cases compared to early identified cases. Further analysis is needed to determine whether there is a need for an enhanced screening programme to detect as many cases as possible.
Conclusions: Our preliminary data suggest that those who live in a more deprived area are more likely to have a late diagnosis of DDH.

42. Positive Impact Of Walk In Trauma Clinics On The NHS Post Covid-19

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Background: The NHS faced extreme pressures during the pandemic, most notably in Emergency Departments. To reduce the burden on ED and provide quick, easy access to Orthopedic specialist services, this busy District General Hospital introduced a Specialty Doctor and Consultant led walk-in Trauma Clinic running on weekdays from 9 am-5 pm.
Aims and Methods: Data were collected from 100 patients randomly in October 2019 (Before Covid 19) compared to when these clinics were introduced in April 2020. Patients admitted to the ward directly or referred to other specialities were removed from the total. We aimed to evaluate this service's impact by focusing on three measurable factors. Firstly, the average time spent in ED; secondly, the average time taken for patients to receive essential radiographic imaging and finally, the availability of a fracture clinic appointment.
Results: The results show the average time spent in ED reduced by 86% from 197 to 27 minutes. The average time to receive an X-ray was reduced by 18.5% from 81 minutes to 66 minutes. Looking at the data in depth we concluded that 56% of patients who attended the walk-in trauma clinic were discharged on the same day with no further follow up hence relieving pressures on fracture clinics. This was reflected by the fact that since the introduction of these clinics, a patient can be seen by a Consultant in a fracture clinic the next working day.
Discussion: These results show that these clinics have proven to positively impact all aspects of patient care. Furthermore, walk-in trauma clinics can deal with inappropriate referrals sooner and prevent unnecessary admissions, reducing unnecessary costs for the NHS. To conclude, Walk-in Trauma clinics have proven to be an invaluable service during this challenging period.

43. Audit Of Quality Of Communication Between ED And Radiology Departments, Leicester Royal Infirmary, UK 2022.

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Background: The department of radiology raised concerns regarding inadequate referrals from ED. We investigated requests for suspected Neck of femur (NOF) fractures which lacked information that allowed the radiographer to perform a patient-centred imaging strategy. Different imaging is usually required for existing metalwork/prostheses and patients with a history of malignancy.
Aim: To evaluate x-ray requests made for NOF fracture from ED, particularly looking at the adequacy of clinical information. We aimed to make improvements in requesting that result in less time wastage, less radiation dose for patients and reduced workload for the radiology department.
Methodology: Data was collected from a cohort of 30 randomly selected patients from ED at Leicester Royal Infirmary who were admitted with a NOF fracture between May and June. This data was carefully reviewed and compared to the set targets during the planning of the audit. 1. History and Clinical examination findings, 2. Previous metalwork/prosthesis in situ, 3. History of any primary malignancy
Result: The data showed the requests for x-ray lacked information on all three questions.
Less than 50% of the request had a clinical background with examination findings.
Only 40% of the request had information regarding any prostheses or implants. Unfortunately, none of the requests had any information regarding any malignancies.
Conclusion: With the advent of technology and electronic requests for imaging, there lies a communication gap which leads to under-diagnosis, inappropriate use of resources and a poorer quality of care. We aim to highlight this issue and improve on it by educating the requester and implementing a prompt-based request system, asking for all the relevant information.

44. Migrant Workers In The United Kingdom And Their Mental Health: A Systematic Mixed Studies Review

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Aim: This systematic mixed studies review aims to identify the mental disorders manifested by migrant workers in the United Kingdom and to highlight preventative strategies to help combat the issues identified. Migrant workers form a significant number of migrants in the United Kingdom.
Methods: Six electronic databases were searched. In addition, reference lists of selected papers were screened to identify other relevant papers that were not present in the databases. The search included published articles in the last twenty-one years (2000-2021). The Critical Appraisal Skills Program checklist was used to assess the quality of primary qualitative studies, and the AXIS critical appraisal tool was used to appraise primary quantitative studies. The most recent version of the Mixed Method Appraisal Tool was used to assess the quality of the mixed method studies.
Result: The search yielded a total of 1050 potentially eligible publications. Of these, 12 articles met the inclusion criteria for this systematic mixed studies review (7 Qualitative studies, 4 quantitative studies and 1 mixed methods study). Based on the findings from this review, the primary mental health outcomes among migrant workers are work-related stress, somatization, depression, anxiety, paranoia, social exclusion, suicidal attempt, and schizophrenia.
Conclusion: Globally, migration benefits both the host country and the country of origin. Migrant workers are at risk of health inequalities. This may be due to several factors, including working conditions, immigration policies, and language and cultural barriers. Findings from this review will guide policymakers in implementing laws that may help reduce distress among migrant workers, making workplaces safe and healthy for migrant workers.

45. A Closed Loop Two Cycle Audit Assessing The Adherence To NICE Guidelines In MRI IAM Referrals For Investigation Of Hearing Loss And Tinnitus

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Background: MRI IAMs are requested for various otological conditions. NICE guidelines recommend MRI IAM for the investigation of 1) asymmetrical sensorineural hearing loss (defined as ≥15db at two or more contiguous frequencies), 2) unilateral tinnitus, 3) pulsatile tinnitus, 4) hearing loss with localising symptoms (tinnitus/facial palsy).
Aim: To assess the adherence to NICE guidelines in requesting MRI IAM in patients with hearing loss and tinnitus
Methods: We performed a retrospective analysis of the MRI IAM requests and their indications from the ENT department of a DGH from July 2019 to December 2019 and assessed their appropriateness as per NICE guidelines. Following intervention in the form of a re-discussion of guidelines and laminated prompts for consultation rooms, we re-audited the MRI IAM requests from June 2022 to August 2022.
Results: In the first cycle, we found adherence to NICE guidelines in 60.75 per cent of requests, with 39.25 percent being inappropriate. The second cycle revealed adherence to guidelines in 92.5 % of cases.
Conclusion: Our closed-loop audit significantly improved compliance with guidelines from 60.75 % to 92.5 % (p-value <0.0001) following the intervention. This shows massive implications on cost saving for NHS and reduction of burden on radiological services. Re-education of guidelines every 4-6 months, especially in departments with a high turnover of doctors, will ensure future adherence to guidelines. A 100% adherence would lead to a potential saving of £39,360 per year.

46. Diversity And Inclusivity In The NHS

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Background: Racism costs lives, careers and prevents people from reaching their full potential to make a meaningful contribution to society. Despite many efforts to address racial discrimination against ethnic minority doctors in NHS, the problem remains. According to a recent survey published by BMA in 2022, among 2030 respondents, 84% of overseas doctors experienced racist incidents in their workplace in the last two years, compared to 69% who trained in the UK. 60% of respondents from Asian backgrounds, 57% from Black backgrounds and 45% from Mixed backgrounds felt racism had been a barrier to their career progression, compared to 4% of White British respondents. Of those who reported experiences of racism, nearly 58% said that doing so hurt them. Another BMA survey published in 2018 reported that 55% of ethnic minority doctors felt included in the workplace, compared to 75% of white doctors.
The aim, Methodology: A review of literature from various journals was used to identify and understand the extent of racial inequality experienced by medical personnel at the workplace and different approaches that can be used to tackle this problem.
Results: Although many surveys were conducted over the years and research was published on ways to tackle this issue; it remains clear that much more is required to tackle racial disparities against medical professionals. No single intervention can make a difference.
Conclusion: It's important to practice different approaches to create a lasting effect. The cornerstone is creating an independent body that can address the problem should it not be resolved locally. It can be prevented by education and implementation of anti-discriminatory strategies and managed by 3R's approach, which involves, Recording the incident, Recording the witnesses Reporting the incident and providing due support later on.

47. Factors Impacting Junior Doctor Attendance In Weekly Teachings Taking Place In Acute Medicine At A North-West Hospital

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Background: The AMU is one of the busiest departments in the hospital, which means it is one of the best places to learn things. (1) Keeping that in mind, teaching sessions are a great way of staying up to date during the busy week.

Method: A survey was sent to all AMU juniors in the department (n=18), including FY1/FY2, GPST/IMT, and Trust grade ST1/2 doctors. There was an 88.8% response rate.
Teaching sessions were held once a week, and this study was used to analyse different variables, including understanding ideas from a presenter's and an audience's point of view.
Results: 81% of responses were from trainees/trust-grade doctors. Unfortunately, only 18% of participants attended weekly teaching weekly, whereas 31% said they did not attend the sessions. From those attending, 50-60% said they found the topics relevant, kept them up to date, appreciated fixed timing, and found the presenters engaging. Up to 75% said the teaching sessions have positively impacted their clinical practice. 75% said they enjoyed sponsored pharmaceutical input as it helped keep them up to date with new medicines.
81% of junior doctors said they found it difficult to attend due to the workload in the wards, and similarly, 61% said they did not present actively due to difficulty in finding time to make presentations; 93% said they would be interested in improving their teaching skills by taking courses.
Conclusion: This survey helped us identify the positives and gaps that need bridging. Protected teaching time needs to establish for continuing medical education, and encouragement is needed to bring in presenters. Incentives, such as teaching/attendance certificates, can be provided, and recorded lectures can be made available for later watch.

48. An Audit Cycle On Improving New Heart Failure Diagnosis And Management

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Background: Heart failure is an increasingly prevalent condition in the UK. It is a condition where the heart develops structural and functional abnormality resulting in its inadequacy. Diagnosing heart failure involves not only clinical judgement by doctors and specialist nurses, it also involves quantitative assessment via tests such as echocardiography and pro-NT-BNP, all of which should be done within specific timeframes. In this audit, we reviewed the patients presenting with undiagnosed heart failure symptoms against the guidelines provided by the Trust for managing suspected heart failure patients.
Method: We gathered data from 28 patients who presented with heart failure symptoms at Blackpool Victoria Hospital and recorded if the heart failure investigations and referrals were being done according to Trust guidelines. The significant aspects measured were the utilisation of PRO-NT-BNP levels, involvement of heart failure teams within 24 hours, conducting echocardiography within 48 hours of presentation, and appropriate outpatient follow-up arrangements after discharge.
Results: We found that the rate of complete adherence to the guidelines was much lower than expected. While all 28 patients with suspected heart failure had pro-NT-BNP done (all patients had proNT BNP levels >400 ng/L), the biggest challenge faced in heart failure management was with the time frames involved. We found that only 7 out of 17 echocardiographs were done within 48 hours, and only 1 out of 9 patients reviewed by the heart failure team were within 24 hours of presentation.
Discussion: This audit cycle recognises shortcomings in managing heart failure in medical wards. The time frames can help us optimise inpatient management, reduce the workload on the GPs, and overall reduce the duration of inpatient stay. The second cycle is due in October 2022.

49. Formative Assessment In A Post-Covid-19 Era: The Value Of A Peer-Led Virtual Mock Assessment In Blackpool Victoria Hospital, NHS Foundation Trust Undergraduate Medical Students

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Background and aims: Active learning strategies, such as formative assessment, have been associated with more robust academic performance. Moreover, the COVID-19 pandemic has widely demonstrated the positive impact of blended learning methods through the appropriate use of the virtual platform. Peer-led education has also become widely accepted as a powerful adjunctive teaching tool. To capitalise on these educational strategies, we delivered a peer-led virtual mock assessment as a university finals assessment preparation method for UK undergraduate medical students. We subsequently evaluated student perceptions of this mock assessment.
Methods: Vevox is a cloud-based interaction tool used to deliver the examination. Zoom was used to coordinate information with live participants. Thirty single-best-answer questions, testing core clinical knowledge, were added to the platform as a series of live polling options that participants could answer remotely on their mobile/laptop devices. Ninety seconds were allocated per question. A cross-sectional survey with Likert-type options was disseminated.
Results: 198 students completed the survey. Most students agreed the assessment aided their preparation for university finals assessments (median:8, IQR: 7–9). The assessment was perceived as helpful preparation for both written and online assessments (median:10, IQR: 8-10). Most participants (n=104, 52.5%) felt the total number of questions and time allocation per question was ideal for a mock assessment. Vevox was regarded as an effective platform for delivering the assessment (median:9, IQR: 8–10) and was agreed as superior to other live polling software (n=129, 65.2%).
Conclusion: The virtual mock assessment was implemented to simulate a controlled summative assessment environment and was perceived as a pedagogical educational experience. The designated number of questions with limited answering time allowed time-pressured evaluation of knowledge, with little opportunity for cheating.

50. Burn Out Amongst LED-IMGs Working In The AMU/General Medical Departments In A North West Hospital

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Background: Doctors worldwide face burnout. Koutsimani et al. define burnout as a psychological syndrome characterized by emotional exhaustion, feelings of cynicism and reduced personal accomplishment. In 2021, about 1/3rd of trainee doctors in the UK reported feeling burned out as per GMC National Training Survey; however, there is no data regarding LED doctors.

Aim: This study aimed to identify how many LED-IMG doctors at this hospital experienced burnout on average, relevant factors, and whether this has impacted their decision to come to the UK.
Methods: During August 2022, 26 LED IMGs were working in AMU/GenMed at a North West Hospital – a survey was shared, consisting of questions regarding experiences with burnout. There was a 96.1% response rate.
Results: The majority of the responses (64%) were from doctors between the ages of 26-30. Most doctors (48%) had been working in the trust between 6-12 months, stating it took them 3-6 months to adjust to the UK culture. 60% managed to develop work friendships within 3 months. 48% said they were able to adjust to the NHS. However, 80% said they felt burned out. Burn-out was experienced at least once a week by 52.2% of doctors, with staffing, workload, and the attitude of co-workers being the top reasons.
48% felt they could not speak up about their problems, and 76% stated they try to be optimistic about stress. 40% said they felt moderately homesick. However, the majority (64%) said they were happy with their decision to come to the UK.
Conclusion: Working in the NHS is a vastly diverse experience for many new doctors. There is a rise in burnout amongst many doctors coming to the UK, and despite showing resilience in the face of adversity, much more support needs to be garnered.

51. Maintaining Student Engagement In A Post-Covid-19 Era: The Value Of Using 'Simpsons' Characters To Teach Jaundice To Undergraduate Medical Students

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Background and aims: The use of popular culture as a vehicle for knowledge delivery and enhancing engagement has excellent potential. However, its educational value has not been extensively evaluated. Moreover, there are concerns regarding learning fatigue from excessive use of video conferencing platforms in the aftermath of the pandemic. Innovative solutions are mandated to ensure effective learning during online teaching sessions that enhance audience understanding while maintaining attention span. To address this, we evaluated the use of popular culture in an online near-peer teaching session.
Methods: An online teaching session, titled 'Jaundice for Finals', consisted of clinical vignettes and single-best answer questions (SBAs). Characters from 'The Simpsons' were utilised to deliver knowledge on jaundice through a series of carefully designed clinical vignettes. The vignettes were written using 'Simpsons' characters as context for the different causes of jaundice. No prior knowledge of the 'Simpsons' TV show was necessary to correctly answer the SBAs. A cross-sectional survey, with 7-point Likert questions, was disseminated.
Results: 53 survey responses were collected. 92.5% of participants had heard of the Simpsons TV show before the session. The participants reported understanding of jaundice after the session was significantly higher than before the session [median:6 (IQR:5-6) vs median: 4 (IQR:3-4.5), $p<0.0001$)]. Participants agreed the addition of 'Simpsons' characters improved their knowledge of jaundice and made the teaching more memorable and engaging [Knowledge (median:5, IQR:4-6), Memorability (median: 6, IQR: 5-7), Engagement (median: 6, IQR: 5-7), $p < 0.01$].
Conclusion: If appropriately integrated, popular culture can effectively engage students while increasing self-perceived knowledge retention. 'Simpsons' characters can be pedagogically and professionally utilised as patient analogies to deliver teaching on the topic of jaundice.

52. Tuberculosis In Immigrants In The United Kingdom

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Background: According to Tuberculosis (TB) in England report 2021, TB rates in the UK continue to be highest among the immigrant population accounting for 72.8% of total cases in 2020. It has also been observed that the incidence of Multidrug-resistant TB (MDR TB) is higher among immigrants than the native population. The TB risk among migrants has been noted to be highest within 2-5 years following immigration. Various factors have contributed to the increased risk of TB infection or reactivation of latent tuberculosis infection in immigrants.
Methods: A review of the literature published in different journals were used to understand the factors contributing to the increased incidence of TB infection in immigrants and devise preventive measures to decrease the TB rates.
Results: A broad variety of contributing factors such as differential pathogen exposure, transnational movements, BCG vaccination, genetic susceptibility, vitamin D deficiency, co-morbidities, socioeconomic status, experiences of migration, and differential treatment seeking have been identified and have contributed to increased incidence of TB in immigrants. NHS also has access to faster diagnostic methods like the use of polymerase chain reaction techniques in detecting MDT TB
Conclusion: Pre-entry tuberculosis testing, early primary care registration by increasing awareness, and latent tuberculosis infection screening can help in effective diagnosis and reduce the risk of progression to active disease among immigrants.

53. A Case Of Bilateral Adrenal Haemorrhages

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Background: Adrenal haemorrhage is a rare clinical presentation with an incidence of only 5 in 1,000,000 [1]. 10% of these are bilateral adrenal haemorrhages, which has a very high mortality rate of 15 % [2]
Case summary: 22-year-old female had C-section for persistent breech presentation at term. She has a history of preterm delivery due to chorioamnionitis during her previous pregnancy. The patient had about 1.2L post-partum haemorrhage. She deteriorated after 24 hours of C-section, with hypotension, pyrexia, and decreased urinary output. The blood result showed acute kidney injury (AKI), raised INR, raised procalcitonin>100ng/ml, severely deranged liver function tests, hyperkalaemia (K+ 6.9mmol/L) and hyponatremia (Na+ 129mmol/L). CT- abdomen showed bilateral acute adrenal haemorrhages. In critical care, she was started on IV hydrocortisone and treatment for post-partum haemorrhage, sepsis, and AKI.

Following clinical improvement, the hydrocortisone dose was reduced. She had a short Synacthen test which showed a subnormal response to Cosyntropin (cortisol of 207 nmol/L and 192 nmol/l) with raised ACTH of 102 ng/L.
She was discharged on hydrocortisone 10/5/5 dose with outpatient endocrine follow-up.
Discussion: Bilateral adrenal haemorrhages have been reported in patients with infection, trauma and anticoagulants [3]. Due to the high mortality rate, it is essential to have a very high index of suspicion for treatment. IV steroids are the key if there is a suspicion of adrenal insufficiency in patients. In this case, the aetiology of bilateral adrenal haemorrhage is likely multifactorial, including postpartum haemorrhage and sepsis. In such cases, it is also essential to distinguish whether the adrenal insufficiency is not due to a central cause, as postpartum haemorrhages were also noted. In this case, the anterior Pituitary hormones were normal, and ACTH was raised.

54. A Case Of Severe Insulin Resistance And Insulin Allergy

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Background: A 63-year-old gentleman diagnosed with type 2 diabetes in 2004 started insulin in 2010. Has a background of diabetic peripheral neuropathy, retinopathy, hyperlipidaemia, hypertension, ischaemic heart disease, and obstructive sleep apnoea. The patient had reasonable diabetes control with HbA1c between 50 to 57mmol/ml. Referred to diabetes clinic due to allergic reactions to Humalog Mix30. The patient tolerated Bovine Insulin with a modest effect on blood sugars but discontinued it due to lack of availability. An immunology review confirmed multiple insulin allergies. IgG antibodies for insulin and autoantibody screen were negative. The patient seemed to tolerate Humulin R u500 and Toujeo with no overt allergic reactions. However, the requirement for insulin was increasing with seemingly little effect on blood sugars, requiring 900 units of insulin/day with Metformin and SGL21, with blood sugars in the twenties. The HbA1c was 115mmol/mol. To assess adherence and response to IV insulin, the patient was admitted. SC insulin given under supervision had no discernible effect on blood sugars. With IV insulin, the blood sugars improved immediately, requiring less than 0.5units/kg/day to achieve euglycaemia. A trial of high-dose prednisolone given did not make any change. A trial of continuous subcutaneous insulin infusion, CSII (Onmipod pump with Novorapid) showed dramatic improvement in glycaemic control (75% time in target, on 1.1u/hr basal rate and bolus 1:10) with the latest HbA1c 49mmol/mol.
Discussion: This patient showed features of severe subcutaneous insulin resistance (SIR) and insulin allergy. SIR is rare and was first reported in the 1970s by Schneider (1) and Paulsen (2). There are reports of SIR treated with CSII with limited long-term success, requiring inhaled insulin, intraperitoneal or, in some cases, islet cell transplant3. Insulin allergies, however, are managed by avoidance, alternative insulins, CSII or immune suppression4. This case shows successful treatment of these two syndromes with CSII.

55. Case Report Of Melioidisis /Whitmore's Disease

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Background: Melioidosis, caused by the gram-negative saprophyte Burkholderia pseudomallei, is a disease of public health importance in southeast Asia with high case-fatality rates in animals and humans.1
Case History: A 62 year/ MALE presented with C/o Fever x 2 weeks (high grade, intermittent, No diurnal variation) and generalized tiredness for 2 weeks; he complained of Decreased Appetite since 2 weeks he had H/ o passing dark-coloured stools with the foul smell for 3 days, H/o Vomiting for 3 days (dark coloured contents). The patient had h/o travel to Sri Lanka.
Past History: Patient was K/C/O Diabetes Mellitus and HTN for 10 yrs
Clinical Findings: HbA1c - 8.4%, INR:1.44 , D-DIMER: 3.39. No other clinically significant finding was seen.
CT – Abdomen: Showed Hyperdensity within the gastric antrum, D1 and D2 segments of duodenum -? Haemorrhage/clots, Cholelithiasis B/L Mild perinephric fat stranding with thickening of pararenal fascia seen
CT - Chest Suggestive of Small Airway Disease.
Course In Hospital: The patient was evaluated for the cause of sepsis/ Disseminated Intravascular coagulation. Empirical antibiotics were started after sending cultures. Hypotension was managed with fluid resuscitation, transfusion and inotrope support; UGI endoscopy showed pooling of altered blood in the body and fundus of the stomach. Blood Cultures grew Burkholderia pseudomallei (S-Imipenem, Meropenem, Ceftazidime). Antibiotics changed to Imipenem and doxycycline and later de-escalated to Ceftazidime + Doxycycline. The patient's complaints of fever subsided on day 5 of the hospital stay.
I/V/O persistently elevated WBC counts. A relook Endoscopy was done due to a drop in Hemoglobin- which showed a duodenal ulcer. Managed by injection sclerotherapy

56. Predicting the amount of cement required while performing a cemented ETS hemiarthroplasty and its cost implications

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Background: Cemented hemiarthroplasty is one of the most everyday operations in orthopaedics; hence, predicting the amount of cement used can be cost-effective in the long run.
Aim: Predict the amount of cement required while performing a cemented hemiarthroplasty.
Methods: Retrospective analysis of consecutive series of 51patients undergoing cemented hemiarthroplasty with Exeter monoblock stem from November 2021 to April 2022. The volume of a cylinder(femoral-canal) is 3.14xR2xH. The 'H'(Length) was standardized using a 150cms ETS and a Hardinge restrictor sunk at 17cms from the GT allowing for a 2cms cement tail. The residual cement was weighed to ascertain the amount of cement wasted. Palacos-R cement was used in all cases (single mix consisting of 40mg-polymer+10mg-monomer).

Results: Mean age was 79(61-99). All operations were performed using a modified Hardinge approach, monoblock-ETS, Palacos-R cement and Hardinge restrictor. Number of Dorr-A femurs were 4(8%), Dorr-B femurs- 14(28%) and Dorr-C femurs were 33(64%). The average amount of residual cement when using 2-mixes was 33grams, using 1.5-mixes was 22grams and with a single mix was 5grams. There is a tendency to use 2-mixes of cement as a default, resulting in unnecessary wastage.
Conclusion: Keeping the length(height of 17cms) constant, the volume of cement (in terms of the number of cement mixes) can be predicted by ascertaining the radius of the femoral canal. This femoral canal radius depends upon the Dorr type and the size of the femur. Considering that the majority of femurs are Dorr-C at that age, predicting the femur size is vital. This femur size tends to be larger in tall males (requiring 2 mixes) in contrast to the other spectrum of petite females (requiring a single mix). Not wasting an average of 33grams (almost a whole mix) with 2-mixes(when not required) can be a substantial cost-saving factor in the long run.

57. The sustainability of analgesics: Could the adoption of oral pre-operative analgesia reduce the need for analgesics, reducing the environmental and economic impact of IV drug use on the NHS?

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Background: The current UK NHS carbon footprint is 24.9 million tonnes CO2e annually. The main contributors are medical equipment and pharmaceuticals, and thus, the scrutinisation of these areas to help deliver a net-zero NHS by 2050. As pharmaceuticals are the most significant GHG emitter within the NHS, with paracetamol being the most clinically used analgesic, it represents an ideal target to determine the magnitude of GHG emissions attributable to its different delivery formats.
Method: To assess carbon dioxide equivalents (kgCO2e) and price per1g of paracetamol use pre or intra-operatively between Intravenous (IV), suppository, oral tablets, oral effervescent and suspension preparation. Life cycle assessment(LCA) was calculated from 'cradle-to-grave', applying the Inventory of Carbon & Energy database to attain the embodied carbon factor to enable a total kgCO2e for each preparation(DEFRA.2021)
Results: The IV preparation has a significantly higher total kgCO2(9.233), suspension(2.797), suppository(0.70537), effervescent(0.385), and oral tablets(0.0847) of kgCO2e per 1g paracetamol used as surgical analgesia. Representing a 110X increase comparing the use of 1g IV to oral paracetamol. The most energy-demanding sub-section was cradle to gate(98%), with travel and waste contributing under 2% to the total GHG emissions. Oral tablets had the lowest cost (£0.0249)/ 1g paracetamol, effervescent(£0.182), suspension(£0.523), IV(£1.20),with suppositories the highest at £11.04. IV paracetamol is 48x more expensive than oral tablets.
Discussion: On assessing the carbon footprint, clinical efficiency, and price, this study has evaluated the sustainability value of each paracetamol preparation. It shows a considerable carbon footprint in IV preparations over its oral alternative. The clinical use of IV paracetamol must be questioned, with oral preparations having the same efficiency with a significantly lower GHG emission total and price per use. It highlights the sustainable alternatives to oral tablets concerning specific patient populations, with effervescence and suspensions still superior to IV environmentally and economically.

58. An audit on preoperative antibiotic prophylaxis in patients undergoing laparoscopic cholecystectomy and inguinal hernia repairs in Kingsway hospitals, Nagpur.

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Background: Patients who develop surgical site infections are five times more likely to be readmitted to the hospital. Antibiotic prophylaxis is the administration of antibiotics before surgery to reduce the risk of postoperative infections, the need for which is compelling.
Aim: To answer the following questions about the preoperative antibiotic prophylaxis (PAP) being followed at Kingsway – (A) Was the agent appropriate? (B) Was the time of administration appropriate? (C) Was the dose correct? (D) Was the route correct?
Methods: Data was collected prospectively using a google form from August 1 to December 31, 2021. The audit was done at Kingsway Hospitals in Nagpur, India. In an excel sheet, relevant data was entered. Our practices were assessed against a set of WHO guidelines. A strategy was developed and shared with the consultants.
Results: There were 30 patients in total. A lag was found in the agent being used, and 87% of the patients received an alternate agent. In 100% of the instances, the administration was 30-60 minutes before the incision. An intravenous route is recommended, which was the case in 100% of our patients. Both procedures employed mostly first-line medicines, but because of the discrepancy in the agent being used, only 13% times the dose was correct.
Conclusion: A gap was discovered between practice and recommendations at Kingsway Hospitals. The consultants involved were notified of the findings, and a strategy was devised to adhere to the WHO criteria more closely. The re-audit will be done in February 2023 to assess if the gap between practices and standards has been closed.

59. Hydroxyurea-induced oral, nail, and cutaneous hyperpigmentation.

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Background: Hydroxyurea (HU) is an antineoplastic and antimetabolite commonly used in treating sickle cell disease, essential thrombocythemia (ET), Psoriasis, and solid tumours. We present a case of a 73-year-old female diagnosed with ET who developed rare adverse effects of HU, such as oral, nail, and cutaneous pigmentation. HU-induced hyperpigmentation and melanonychia are not commonly reported. The physician should be aware of such rare adverse effects and closely monitor them to avoid further drug toxicity.

Case description: A 73-year-old female patient diagnosed with ET and past medical history of sacroiliitis, coronary artery disease, and left renal calculi. The patient was diagnosed with ET on ~ 18/06/2022. Hence HU was prescribed. On 22/09/2022, the patient presented with hyperpigmentation in the tongue, all 20 nails, palm, and sole however, the medication was well tolerated. The patient was anxious about hyperpigmentation and was worried about skin malignancy. HU's rare adverse effects were identified and explained to the patient. The patient agreed to continue HU after an explanation. However, HU's dose was reduced from 500mg BD to OD. On 13/10/2022, lesser pigmentation was identified compared to the previous hyperpigmentation. Moreover, HU was discontinued as the patient platelet count was within normal range. The patient was advised to follow up after one month with a platelet count report.
Conclusion: The adverse reaction of HU should be explained to the patient before prescribing HU to reduce the risk of anxiety. The physician should be aware of the adverse reactions of HU to avoid unnecessary intervention. However, continuous monitoring and follow-up can help avoid the drug's toxicity.
Highlight: As physicians, we want to spread awareness about these rare side effects and early mention of adverse effects to the patient to alleviate anxiety and avoid unnecessary intervention.

60. Clinical audit on breaking the bad news to patients and relatives in diagnosed cancer patients as per SPIKES protocol at Kingsway hospitals, Nagpur

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Background and aim: Breaking bad news is an essential and often difficult task faced by nearly all healthcare professionals. The audit aims to close the gap by formulating proformas and bringing changes to existing guidelines to make the difficult task performable, thereby increasing healthcare quality.
Methods: Study design- Prospective study.
Period of study- February to April 2022
Place of study and data collection- Oncology OPD, chemotherapy wards, and patients' consent were taken before data collection.
Sample size- 40 diagnosed cancer patients were studied. Forms- A proforma was formulated.
Results: Was the news broken- 77.5%? Where was the news broken- 70%? Who broke the news- 82.5%. Patient's understanding and other relatives informed- 75%. Next plan of action and treatment options discussed- 86.5%.
Documentation of breaking the news- 40%
Discussion about prognosis- 72.5%. Patients requests noted- 95%
Conclusion: An audit tool to break the bad news allows better psychological adjustment by the patient. Reduces stress among healthcare professionals. Facilitates an open discussion among patients, relatives and doctors. The audit showed considerable adherence to the formulated protocol.

61. An audit on treatment compliance of patients receiving Paclitaxel and carboplatin therapy in Kingsway Hospitals, Nagpur, India.

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Background: Paclitaxel and carboplatin are two essential anticancer agents. Compliance with therapy is critical, especially in therapies with curative intent. Reduced adherence leads to poor outcomes, including an increase in morbidity and mortality.
Aim: To assess patient adherence to paclitaxel and carboplatin therapies in cancer patients and to - Analyze the compliance rate and identify gaps in adherence, complications, and problem resolution.
Method: Over four months, a prospective audit encompassing audit and re-audit cycles was carried out. Patients' notes, discharge summaries, attendance, complications, and compliance issues were collected from 50 patients receiving Paclitaxel and Carboplatin. The data were analysed using Excel sheets.
Result: The initial audit cycle indicated a 24% non-compliance rate. Financial issues, forgetfulness, travel constraints owing to covid norms, and illness were all noted. Financial struggles and forgetfulness accounted for 66% of the total. Patients and staff were educated on the significance of chemotherapy adherence, a record-keeping and attendance registry was established, reminder calls and messages were initiated, and patients were provided financial incentives. A re-audit was performed, and a 16% improvement non-compliance rate was observed, regarded as acceptable.
Conclusion: Patient compliance with chemotherapy is critical, especially for those treated with curative intent. Compliance can be significantly enhanced and complications prevented by educating staff and patients, motivating them, and using appropriate tools. This audit demonstrates the same.

62. Clinical audit- Thyroid function testing in patients with hypothyroidism receiving replacement thyroxine

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Background and aim: The aim is to provide timely monitoring of thyroid function testing in hypothyroidism patients receiving replacement thyroxine and appropriate treatment.
The study was conducted in Kingsway hospitals, Nagpur, India
Methods: Sample size: 50, Study type: Retrospective study, Duration of study: 1 month (April 2022), Data sampling: Outpatients with hypothyroidism
Inclusion criteria: Adult patients diagnosed with hypothyroidism and receiving thyroxine
Exclusion criteria: Newly diagnosed patients in current visit, Pregnant women, Children
Source: Recommendation 13, ATA/AACE Guidelines for Hypothyroidism in Adults, 2012
Results: Timely testing - 21 (42%), Too frequent testing - 12 (24%), Too late testing- 17 (34%)
Conclusion: Awareness about ATA/AACE guidelines. Importance of audits to improve patient care. 42% of the patients got timely testing even in times of pandemic. Considerably good sample size

63. An audit on premedication compliance in patients receiving Paclitaxel and Carboplatin therapy in Kingsway Hospitals, Nagpur, India.

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Background: Paclitaxel and carboplatin are commonly used as chemotherapy agents and are notoriously known to cause fatal hypersensitivity reactions. Dexamethasone, a glucocorticoid and Ranitidine, a Histamine 2 antagonist, are used as premedications to prevent adverse reactions to this chemotherapy regime. Numerous research and meta-analyses have highlighted their efficacy and significance.
Aim: To evaluate premedication therapy adherence in cancer patients receiving paclitaxel and carboplatin.
To discover gaps in premedication adherence.
To record any complications.
To resolve compliance issues and bridge the gap.
Method: 50 patients were included in a prospective audit that lasted five months. Using tools such as patients' notes, history, discharge summaries, and medication charts, data were generated and analysed using Excel sheets. The dose, route and timing of premeditation were noted and compared with the local guideline. The issues were fixed, the gap was reduced, and a re-audit was performed.
Results: During the audit cycle, 20% of patients were non-compliant with their premedication. According to analysis and history, the most common reasons were inattention and hyperglycemia. Patients and staff were taught the necessity of premedication, and reminder calls and messages were initiated to remind patients about medication time, dosage, and route, and an endocrinologist's opinion was taken to address steroid-induced hyperglycaemia. These findings were presented locally, and recommendations were implemented. The re-audit found that the deficit had been significantly reduced as only two of the twenty-five patients were noncompliant. The results were deemed acceptable, and the audit was closed.
Conclusion: Adverse reactions, including fatal hypersensitivity reactions, are common complications in chemotherapy patients. They can be successfully avoided with the right premedication. This audit demonstrates that strict adherence improves outcomes and prevents deadly consequences.

64. Impact of virtual consultations on carbon footprint and health economics in neurosurgery: could the COVID-19 pandemic have a silver lining?

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Background: The COVID-19 pandemic created an urgent need to protect patients and clinicians by replacing traditional outpatient appointments with remote consultations. Benefits for patients and the environment, including reduced travel time and costs, greater patient choice, and improved CO2 emissions, have been poorly explored. We examined these savings from our neurosurgical outpatient clinic, which serves urban and rural areas, during UK's first COVID-19 peak.
Methods: All planned adult neurosurgical outpatients' appointments in Wales from 1st April to 30th May 2020 were included. A successful 'remote appointment' was defined as when the replacement enabled onward clinical management for the patient by phone, video, or letter.
For these patients, estimated savings in total mileage, travel time and petrol costs were derived using web mapping software and UK government databases. Carbon emissions were approximated based on UK's most popular car.
Results: 81 remote clinics were conducted over the above-described period, with 552 face-to-face appointments re-scheduled. 77.2% (426) were completed virtually (388 telephones, 32 letters, 6 videos), 12.1% were rearranged, and 10.7% were deemed insufficient, similar to a 'Did Not Attend' outcome. These consultations translated into the following potential savings: total road mileage (21,292 miles), petrol costs (£3,492), cumulative travel time (592 hours) and carbon emissions (2.9 tonnes of CO2 equivalents in g/km).
Conclusion: We show the potential savings that remote consultations can offer patients and the environment. Other benefits include increased patient choice and access, especially for those who live far away or in rural areas. Therefore, while virtual clinics do not replace F2F appointments entirely, they may have a significant role in a future hybrid outpatients model.

65. Prevalence and predictors of low birth weight in India: Findings from the 2015-2016 National Family Health Survey (NFHS-4), Professional publication framework

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Background: The main factor for the survival, growth, and development of a newborn is the birth weight. Low birth weight (LBW) infants are likely to be born with congenital heart anomalies and prone to more severe problems like sepsis and respiratory, metabolic and neurodevelopmental disorders. According to the National Family Health Survey (NFHS) of India 2015-16, the prevalence of LBW is at 18.2% of all live births. No proper data accounts for the LBW prevalence at the national level in either birth certificates or hospital discharge data forms, even though India has the highest reported rates for LBW globally. Aim: This paper determines the prevalence of LBW and the factors influencing it in India, also mapped distribution by state. The study will help understand the main factors causing LBW and contribute to developing interventions and policies to reduce the incidence of LBW. Methods: This study consists of the secondary analysis of India's NFHS-4 data. The descriptive results were obtained through chi-square and t-test. Univariate and multivariable logistic regression results obtained predictors causing LBW in India. The causal diagram was drawn using Directed-Acyclic-graph to obtain the potential confounders of the association between maternal age at the time of delivery and LBW. Results: Predictors causing LBW in India are the mother's age at the time of delivery, female child, birth interval less than 24 months, mother's low educational level, poor wealth index, rural residence, no insurance coverage, history of infant death, mother's low BMI, being anaemic, and inadequate ANC visits during pregnancy. Maternal age at the time of delivery is significantly associated with LBW after controlling for confounders. Mothers aged below 18 at the time of delivery are at higher risk of having an LBW child than other women (OR: 1.212, 95% CI: 1.172 - 1.303).

66. An Audit Of Time Taken From First Medical Contact In ER To Treatment In Patients Suffering From ST Elevation MI

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Background: This was an audit done in Kingsway Hospital, Nagpur, from January 2022 – May 2022. The aim was to study the time taken for medical intervention in treating patients suffering from ST-elevation Myocardial infarction from the point of first medical contact in the Emergency Room (ER) . The objective was also to determine compliance with treatment guidelines in such patients as per NICE guidelines.
Method: It was a retrospective & prospective study with a sample size of 25 patients. The resources included patient case files and NICE guidelines. The data was collected using questionnaires and entered into an excel sheet, and the results were interpreted using various graphs and tables.
Results:21/25 patients included in the study were more than 50 years old, and the majority were males. 76% of the patients had comorbidities like Diabetes Mellitus, Hypertension. The doctor saw 52% of the patients within 5 minutes of arrival in ER. Most patients had their ECG done within 15 minutes of arrival in ER. Regarding management, 64% of patients with ST-elevation MI underwent primary percutaneous intervention (PCI), and 36% were treated by thrombolysis. 25 % of the patients had their primary PCI done within 12 hours of the onset of symptoms. Thrombolysis for all patients was done within 100 minutes from the time of arrival in ER.
Conclusion: As far as thrombolysis was concerned,100% compliance with NICE guidelines was observed amongst the patients included in the study. As per the NICE guidelines, among the 4 patients who received primary PCI within 12 hours from symptom onset, only 2 underwent PCI within 120 minutes. Mortality /Morbidity rates post-intervention and until discharge was minimal/nil for all the patients studied.

67. Outcome of Multimodal treatment algorithm for Management of Necrotising pancreatitis

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Background: Infection of pancreatic necrosis is the most critical risk factor contributing to death in severe acute pancreatitis, and it is generally accepted that infected pancreatitis should be managed surgically. Acute necrotising pancreatitis accounts for 10% of acute pancreatitis cases. Less than 4 weeks of disease onset: Acute necrotic collection (ANC) Greater than 4 weeks of disease onset: Walled-off Pancreatic Necrosis (WOPN)
Aim: To devise a multidisciplinary approach for managing Acute Necrotising Pancreatitis.
Methods: A prospective observational study was conducted on 11 patients with biochemical and radiological evidence of Acute necrotising pancreatitis. The study was conducted at a tertiary care centre, Kingsway hospital in Nagpur, for 6 months and the results obtained were systematically tabulated in respective proportions.
Results: Out of 11 cases, less than 2% of patients required intervention after treatment. Multimodal management was effective in about 95% of patients. Less than 5% of patients reported adverse effects related to management. No mortality was reported.
Conclusion: A multidisciplinary conservative approach should be considered for patient stabilization before any surgical intervention, such as an open necrosectomy, as it drastically reduces mortality. Patient-centric management should be considered, and minimally invasive techniques such as endoscopic and laparoscopic/Video-assisted retroperitoneal debridement should be implemented wherever indicated.

68. Gentamicin Antibiotic Dosing in Acute Surgical Patients

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Background: Gentamicin is a broad-spectrum aminoglycoside commonly used to treat intrabdominal sepsis. Despite its significant side effect profile, its clinical use is commonly missed or insufficiently monitored. A quality improvement project was carried out to investigate contributing factors and ratify this.
Methods: Patients admitted to Surgical Decision Making Unit (SDMU) at Morriston Hospital started on Gentamicin were identified. Data was prospectively gathered for height, weight, Gentamicin dose, the timing of the initial dose, the timing of level taken, adjustment and timing of the second dose, and compared with guidelines.
A poster was made summarising essential guidelines with a nomogram for dosing and displayed on computers in SDMU, and surgical wards and attached to new patients' drug charts. Re-audit of the Gentamicin prescription was then completed to assess improvement in compliance.
Results: Of 43 patients in the pre-intervention group, 16 (37.2%) were started on an incorrect dose, of which 5 were changed. 17 (39.5%) were missing key parameters to dose Gentamicin, and 28 (65.1%) had their Gentamicin level taken at an inappropriate time, causing a delay of the second dose in 11 cases.
51 post-intervention patients were analysed. 21 (41.2%) were started on an incorrect dose, of which 11 (52.4%) were changed, a 67.6% improvement. 16 (31.4%) had their level taken inappropriately, 8 of whom had delayed treatment; a 51.8% reduction in inappropriate level taking.
Conclusions: Weight measurement was the main factor for incorrect dosing. The intervention included adding weight recording to doctors clerking, which reduced inaccurate dosages. Pharmacists were invaluable in identifying inaccurate dosing however, further education of junior doctors is needed to streamline Gentamicin prescription. Despite improvement in level timing, levels taken >24 hours post-dose still proved problematic. Further improvement in communication is needed to ensure timely administration.

69. Patients' recollection of post-procedure complications for a local anaesthetic procedure with written and signed consent as compared to verbal consent

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Aim : To analyse the efficacy of taking verbal consent for flexible cystoscopy as opposed to taking written consent and whether it affected patient recall of complications.

Methodology: Flexible cystoscopy has 3 main complications we mention to the patients – Dysuria, hematuria and Infection. The month-long study from August to September 2022 involved 40 patients who had an elective flexible cystoscopy in Aberdeen Royal Infirmary and were randomly selected. 20 patients had verbal consent before the procedure, and the other 20 had a written and signed consent form. We then asked these patients, post-procedure, if they recollected the 3 significant complications mentioned earlier.
Results: All patients recalled that dysuria would be expected post-procedure. However, 65% of the patients who had written and signed consent recalled haematuria as a complication compared to 45% of the patients who had verbal consent. 40% of the patients who had a written and signed consent recollected that they might have dysuria post-procedure. This was 25% of the group that had verbal consent.
Discussion: Putting pen to paper in a written consent form significantly impacts a patient's recollection post-flexible cystoscopy. However, given the quick and relatively rapid turnover of patients, is there a better way to ensure patient recollection by perhaps explaining with a pre-prepared visual aid to assist patients with quick procedures like flexible cystoscopies?
Conclusion: At present, verbal consent does not supersede written consent when it comes to patient recall post-flexible cystoscopy

70. To see or not to see: Quality improvement project on patient feedback forms

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Aim: To assess the need for larger fonts for patient feedback forms for patients attending the Ophthalmology clinic.
Methodology: We selected 85 patients in the Ophthalmology clinic at Aberdeen Royal Infirmary. All patients were shown 2 feedback forms. They were given a feedback form used for years to collect their views and recommendations regarding the service. In September 2022, we introduced a feedback form with a larger font size. We collected the data from the feedback forms to analyse the following parameters- ability to read the text, their visual acuity, and reasons why the patient could not read the standard form.
Results: A total of 85 patients were involved in this study. 35.3% of the patients could read the pre-existing form. However, 64.7% of patients could read the enhanced form. The remainder of the patients could not read either because of pupil dilation or because they did not have their spectacles in hand. We also assessed the visual acuity of all subjects and compared it with DVLA standards for driving (6/12 or better). All the patients who could read the standard forms had 6/7.5 or better vision, whereas only 70.90% of patients who could read the larger print had 6/12 vision or better vision.
Conclusion: Many patients who present to an Ophthalmology clinic have impaired vision. As such, it would be imperative to provide magnified forms so they can read and understand. This would have a significant impact on patient confidence and subsequent treatment.

72. A review of the first month of transitioning to a fully paperless Electronic Patient Record system

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Background: On 8th September 2022, the largest NHS Foundation Trust, Manchester University NHS Foundation Trust (MFT), switched to an entirely paperless Electronic Patient Record (EPR) system.
Aim: This is an insight into how the first month went from a plastic surgery tertiary referral service perspective.
Method: The plastic surgery team operate across four main sites in Manchester. A survey of 50 staff members comprised of nursing staff, doctors and administrative staff aimed to highlight any benefits that have come from the transition, any negatives and any incidences of patient harm that occurred.
Results: All 50 staff members were recruited.
All administrative staff disliked the current system, with responses mainly focusing on simple tasks taking longer and a lack of oversight or reassurance that the process undertaken was correct. Junior doctors were mainly in favour of the new system making most of their work easier and quicker.
Consultants all disliked the new system. The main reason was the lack of information or training given to staff, the number of significant incidences that had occurred due to the global rollout of the system overnight and the rapid increase in adverse patient-safety-related events.
Conclusions: There were two distinctive groups: inpatient services and outpatient services.
Most inpatient work has been made clearer, safer, and more universal, except for medication administration and anaesthetic care. This was slower and full of administration and prescription errors making daily tasks more difficult. All outpatient clinics had become more complex with a lack of previously recorded information, either unavailable or more difficult to access. All doctors are now required to write their letters and book outpatient follow-up appointments, which has caused numerous problems and countless hours of extra work for senior clinicians slowing down the number of patients they can see and treat safely.

72. **Multiple Myeloma**

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Background: Multiple myeloma (MM) is a clonal plasma cell proliferative disorder characterized by the abnormal increase of monoclonal immunoglobulins. Unchecked, the excess production of these plasma cells can ultimately lead to specific end-organ damage. Most commonly, this is seen when at least one of the following clinical manifestations is present: hypercalcemia, renal dysfunction, anaemia, or bone pain accompanied by lytic lesions. The differential is broad with any of these symptoms and/or findings. Still, MM must be kept in mind as part of the differential as management is unique and improved outcomes are available with timely intervention.
Methods/Design: case report.
Conclusion: 1- Multiple myeloma is an important differential diagnosis for recurrent mouth ulcers. 2- CT skeletal survey with no bony lesions does not rule out multiple myeloma. 3- oral ulcer biopsy with no malignancy does not rule out multiple myeloma. 4- Cardiac ECHO is essential to look for possible cardiac amyloidosis. 5- Bone marrow biopsy is the primary confirmative test of multiple myeloma. 6- Amyloidosis is one of the main complications of multiple myeloma.

73. Pre-existing diabetes causing neovascular glaucoma and its impact on Trabeculectomy with Mitomycin C.

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Aim: To evaluate the surgical outcomes for patients undergoing Trabeculectomy with Mitomycin C with pre-existing diabetes causing neovascular diabetes.
Methods: We did a retrospective hospital-based analysis of the electronic medical records of patients with Neovascular glaucoma. Some had pre-existing diabetes and underwent Trabeculectomy with Mitomycin C from 2010 to 2020. The objective was to analyse the impact of diabetes on the outcome of the trabeculectomies.
Results: We analysed 52 eyes of 50 people with neovascular glaucoma who underwent Trabeculectomy with Mitomycin C. Of these 15 procedures - 15 eyes (28.8%) recorded an adverse outcome. An adverse outcome included patients with an Intraocular pressure of more than 21 mmHg and patients who encountered the need to reinstate medical therapy postoperatively.
Of these 15 patients, 11 (73.3%) had pre-existing diabetes documented in their pre-operative assessment.
Conclusion: As seen in the above study, diabetes significantly affects operative success. Neo-vascular glaucoma is an increasing disease with the changes in lifestyle and a growing number of diabetics worldwide. Hence, early recognition that diabetes is a significant prognostic indicator would aid in better managing these patients and encourage further research into the optimisation of diabetics for ophthalmological procedures such as trabeculectomies.

74. COVID-19: to double test or not to double test the paediatric patient for semi-elective surgery?

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Background: The COVID-19 pandemic has resulted in a significant reduction in the number of elective and semi-elective operations being performed. All semi-elective (minor day case trauma) patients in our paediatric plastic surgery department currently require a viral polymerase chain reaction (PCR) COVID-19 test at the time of booking to secure a day case bed on the elective admission unit. On the day of the surgery, all patients were tested again using a lateral flow test (LFT) to ensure no patients with active COVID-19 infection were admitted to the ward. A positive result of COVID-19 mandates a side room being organised for the patient in a different ward. This significant administrative burn was often not perfectly executed and resulted in frequent delays. This audit looked at the number of paediatric patients testing positive for COVID-19 to see if this two-step process is still required.
Aims: Establish the number of positive COVID-19 results in the month of September 2022 for all semi-elective paediatric trauma patients presenting through the plastic surgery department at the Royal Manchester Children's Hospital.
Methods: Viral PCR and lateral flow tests were retrospectively reviewed for every trauma patient presenting during one month to ascertain if the pre-operative viral PCR test is still required and whether a single lateral flow test on the day of surgery should be considered instead.
Results: 68 patients presented during the month of September 2022. None of the 68 patients had either a positive lateral flow test or a viral PCR test.
Conclusion: This audit has demonstrated that lateral flow testing would be sufficient on admission on the day of surgery, given the low incidence of recorded positive results in the paediatric plastic surgery population.

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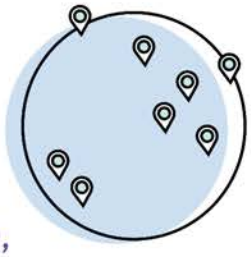

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