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## Conference Information

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### Conference Organising Committee

London Surgical Research Group are proud to be organising this year's conference.

Committee: Nick Symons, James Haddow, Giles Bond-Smith, Sarantos Kaptanis, Milan Makwana, Charles Knowles.

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### Attendance Certificates

These will be emailed to you after the conference. For those attending in person, please be sure that you've been checked in on the Eventbrite system by one of the organisers (yellow lanyards). Unfortunately we cannot retrospectively check you in after the event. Virtual delegates will automatically be checked in.

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### Virtual Conference Area

All delegates and virtual delegates have access to the virtual conference area. If you have not received an email with access details please contact us.

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### WiFi

Select RCS-PUBLIC network. No password, just accept the terms and conditions pop-up.

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### Twitter

You can ask questions and provide discussion using [#nrcm2013](#). A Twitter DJ will be reading out the highlights in each session.

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### Acknowledgements

We are very grateful to our sponsors LAP Research UK and LifeCell for making this event possible. Thank you also to the Royal College of Surgeons of England for their support and hosting the event. And thank you especially to all the speakers and facilitators for their invaluable contributions.

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### Venue

The Royal College of Surgeons of England, 35-43 Lincoln's Inn Fields, London WC2A 3PE. Nearest tube: Holborn.  
Tel: 020 7405 3474.

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### Contact

Enquiries on the day to

[info@nationalresearch.org.uk](mailto:info@nationalresearch.org.uk)

Website: [www.nationalresearch.org.uk](http://www.nationalresearch.org.uk)

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# National Research Collaborative Meeting

Friday 6th December 2013, The Royal College of Surgeons of England, London

- 
- 08.30 **Registration and Coffee**  
Inner Hall and Edward Lumley Hall
- 
- 08.50 **Welcome Speech: Mr Nick Symons**  
Vandervell Lecture Theatre
- 
- 09.00 **Project Presentations**  
Chaired by Prof Charles Knowles  
Vandervell Lecture Theatre
- 
- 10.30 **Coffee**  
Edward Lumley Hall
- 
- 11.00 **Research Workshop: Prof Dion Morton**  
Facilitated by Prof Charles Knowles (QMUL), Prof Rupert Pearse (QMUL), Prof Karim Brohi (QMUL), Dr Andrew Cook (NETSCC), Ms Charlotte Wilson (RDS London), Dr Richard Hooper (RDS London), Prof Ian Russell (WORTH CTU), Mr Toby Hammond and Dr Trish Groves (BMJ)  
Edward Lumley Hall
- 
- Specialty Presentations and Prof Peter McCulloch**  
Chaired by Mr Aneel Bhangu and Mr Angelos Koliass  
Vandervell Lecture Theatre
- 
- 13.00 **Lunch, Research Clinics and Stands**  
Edward Lumley Hall
- 
- 14.00 **Debate "This house believes that centralization of surgery is better"**  
Chaired by Dr Trish Groves; Proposed by Mr Peter Holt and Dame Ruth Carnall; Opposed by Prof John MacFie and Dr John Coakley  
Vandervell Lecture Theatre
- 
- 15.30 **Coffee and Poster Judging**  
Edward Lumley Hall
- 
- 16.00 **Keynote Lecture: Prof Ian Roberts**  
Vandervell Lecture Theatre
- 
- 16.30 **Keynote Lecture: Prof Norman Williams**  
Vandervell Lecture Theatre
- 
- 17.00 **Prize-giving and Wrap-up**  
Vandervell Lecture Theatre
- 
- 17.10 **Close**  
Informal drinks at the College Bar



### Dame Ruth Carnall

Ruth was responsible for the NHS in London as Chief Executive of NHS London. In this capacity, she oversaw an extensive programme of performance improvement and strategic change. The results of this work are widely recognised in the UK and internationally. Prior to joining NHS London, Ruth worked as an independent consultant with public and private sector clients including Department of Health, Monitor, Health Authorities, NHS Trusts and Glaxo as well as the Prime Minister's Delivery Unit, the Cabinet Office, the Home Office and the Ministry of Justice. Ruth also has experience as a non executive director of a Public company, chair of a private company and trustee of a charity. She has also provided coaching support to senior executives.

Ruth has a strong reputation in leadership development and the creation of high performing teams. She is frequently asked to speak about her experience in the UK and abroad. In 2011, Ruth was made a Dame Commander of the British Empire for her achievements in healthcare.



### Dr John Coakley

John Coakley trained in medicine at Liverpool University, qualifying in 1980. His postgraduate training posts were in Merseyside and London. He was appointed as a consultant in intensive care medicine at St Bartholomew's and Homerton Hospitals in 1992. He has been Medical Director of Homerton Hospital since 1998.



### Dr Trish Groves

Trish Groves trained in medicine and psychiatry before going to the BMJ, where she is deputy editor and Head of Research. She is also editor-in-chief of the online only journal BMJ Open. While at the BMJ Trish has been a part time honorary research fellow at the School for Public Policy, University College London (UCL); has contributed to European Science Foundation proposals for revising the EU Clinical Trials Directive; served on the council of the Committee on Publication Ethics (COPE); and helped develop research reporting statements including CONSORT 2010, SPIRIT, and PRISMA extensions. Trish has presented for TV and radio in the UK and for the BBC World Service, and she was first author of the HarperCollins Consumer's Guide to Mental Health (1996).



### Mr Peter Holt

Peter Holt is a senior lecturer and consultant vascular surgeon at St George's Vascular Institute, London, UK. He is widely published through both peer-reviewed journals and book chapters in his specialist field of health services and outcomes research. His major contribution to date in the vascular surgical literature is through his persistent work on optimising the configuration of vascular surgical services to improve patient outcomes. This body of work is on-going, but includes multi-national evidence synthesis studies and national benchmarking studies.

In the UK, his work has benchmarked the outcomes for each index vascular surgical procedure. Subsequent modelling of health services based on national outcomes data has led to the centralisation of vascular surgical services in the UK, with the results of his work being adopted by the Department of Health. Service modelling has been complemented by analysis of patients' preferences and the implications to patients of travel on the proposed service changes. Peter also sits on a number of national committees to improve the delivery of care to vascular surgical patients. Alongside his research Peter has aided the development of international guidelines for AAA repair and sits as on the editorial board of several medical journals, including as section editor for outcomes research.



### Professor John MacFie

John MacFie is a Consultant Surgeon employed by the York Foundation Teaching Hospital Trust and based in Scarborough. He has a personal Chair with the University of Hull and is affiliated to the Academic Surgical Unit, Castle Hill, Cottingham, Hull. He was President of the Association of Surgeons of GB and Ireland (ASGBI) from 2010 to 2012. His specialty interest is colorectal with a specific commitment to the management of patients with intestinal failure and those with inflammatory bowel disease. He maintains an active interest in nutrition and metabolism, ethics and the care of the critically ill. John MacFie has received a number of prizes and research grants over the years, including a Hunterian Professorship by the Royal College of Surgeons of England, the John F Kinney prize

# Biographies

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for Nutrition and Metabolism, and the ASGBI Moynihan prize. He has written over 200 papers and many book chapters. Particular research interests include energy metabolism in surgical patients, the utilisation of fat emulsions, the definition of gut function, the ethics of nutritional support and gut barrier function. He has also worked in many roles including Regional Advisor and Programme Director for General Surgery in Yorkshire, and was recently elected a Fellow of the James IV Association.



**Professor Dion Morton**

Dion received his degree in Medicine from Bristol University in 1985. He was given an honorary consultant appointment at the University Hospital Birmingham in 1996, and was appointed Professor of Surgery in 2006. He is Director of the Birmingham Experimental Cancer Medicine Centre, Director of Clinical Research at the Royal College of Surgeons of England since October 2011 and Deputy Head (Clinical) at the School of Cancer Sciences since December 2012. He is also Research Committee Chair at the European Society of Coloproctology. His research interests are predominantly in clinical and translational research in colorectal cancer, but also encompassing the development of clinical trials in surgery.



**Professor Ian Roberts**

Ian Roberts is Professor of Epidemiology & Public Health at the London School of Hygiene & Tropical Medicine. His main research interests are the prevention and treatment of trauma and the links between energy and health. He trained as a paediatrician and then in epidemiology at the University of Auckland, New Zealand and at McGill University, Canada. He established and is co-ordinating editor of the Cochrane Injuries Group, an international network of individuals that prepares and maintains systematic reviews of the effectiveness of interventions in the prevention, treatment and rehabilitation of injury. He is principal investigator of the CRASH trials, large international randomised controlled trials that seek better ways to treat seriously injured trauma patients. The MRC CRASH trial, which included 10,000 patients with head injury from around the world, showed that corticosteroids, which were widely used in the management of head injury, did not improve patient outcome after head injury but increased the risk of death. The CRASH-2 trial has shown that tranexamic acid, an inexpensive and widely practicable treatment, safely reduces mortality in bleeding trauma patients. He is the author with Phil Edwards of *The Energy Glut: the politics of fatness in an overheating world*.



**Professor Norman Williams**

Consultant colorectal surgeon Professor Norman Williams became College President in July 2011. He is Professor of Surgery and Director of Innovation at the Academic Surgical Unit of Barts and The London, Queen Mary's School of Medicine and Dentistry and National Centre for Bowel Research and Surgical Innovation. His main clinical interests are sphincter preservation and reconstructive surgery, and his scientific interests are concentrated on GI motility and anorectal physiology.

Professor Williams was elected as a Council Member and Trustee of the College in 2005; chaired the Research and Academic Board and the Invited Review Mechanism; and was Lead for the National Fellowship Scheme. Prior to being elected as College President, he was President of the Society of Academic & Research Surgery and President of the Ileostomy & Internal Pouch Support Group, the national patient charity. Professor Williams has also been Chairman of the UKCCCR committee on Colorectal Cancer, President of European Digestive Surgery, President of The International Surgical Group and Vice Chairman of The British Journal of Surgery.

Professor Williams is joint editor of *Bailey and Love's Short Practice of Surgery*, co-author of *Surgery of the Anus, Rectum and Colon*, and is a founding trustee and Chairman of Bowel & Cancer Research. He was a Fulbright Scholar (1980-2), and was awarded the Patey Prize of the SRS (1978), the Moynihan Travelling Fellowship (1985), the Society of Authors Prize (Jointly 1995) the Nessim Habif Prize, University of Geneva (1995), the Galen Medal of the Worshipful Company of Apothecaries (2003) and the Cutler's Surgical Prize (2011). He is a Fellow of the Academy of Medical Sciences and the Royal College of Physicians, and in 2011 he gave the prestigious Hunterian Oration at the College, and in 2013 he became an Honorary Fellow of the American College of Surgery.



Advancing Research through Collaboration

gical Research Network (UKNPN). Our network is open to all trainees and junior staff interested in undertaking high-quality neurosurgical research. The BNTRC achieved a number of important milestones in just 12 months since its inception: a launch meeting, which was held at the RCS in October 2012, was attended by trainees from 21 UK units, senior academics and SBNS representatives; start-up funding was secured (£10,000 grant awarded by the SBNS); the first UK-wide, prospective, protocol-driven study of the BNTRC (national audit of chronic subdural haematoma) was launched in May 2013. Trainees and senior academics from 17 different units were engaged in a collaborative process which led to the development of the protocol for the national audit of chronic subdural haematoma. The vast majority of adult UK neurosurgical units (27/31) have signed up to the audit, which has already become the largest multi-centre prospective study of chronic subdural haematomas worldwide. Two randomised multi-centre trials and a further prospective cohort study are currently in development. For more information, including how to get involved, please visit [www.bntrc.org.uk](http://www.bntrc.org.uk).

## Collaborative Orthopaedic Research NETWORK



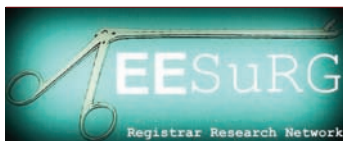
### Collaborative Orthopaedic Research NETWORK

The Collaborative Orthopaedic Research NETWORK (CORNET) was established in January 2013. It currently covers 10 hospitals undertaking both elective and emergency orthopaedic care in the North East of England. CORNET was successfully launched at a research day held in Durham in June 2013 which included guest presentations by Prof Dion Morton (Royal College of Surgeons), Prof Amar Rangan (British Orthopaedic Association) and Prof David Torgerson (York Trials Unit). During the last 12 months it has gained the support of 55 local orthopaedic trainees as well as the region's training program director, SAC chair and local consultant faculty. CORNET is currently running a number of regional projects. These include a regional audit of the use and barriers to use of total hip replacements in the management of hip fracture patients, a review of the evidence for the management of grade 3 acromioclavicular joint injuries alongside an evaluation of current practice, and an examination of regional variation in enhanced recovery / peri-operative management protocols and their influence upon pain, nausea and time to mobilisation following elective hip and knee replacement. CORNET is also looking to co-ordinate regional involvement in national orthopaedic trials. Further information can be accessed at [www.cometresearch.co.uk](http://www.cometresearch.co.uk) or by emailing [administrator@cometresearch.co.uk](mailto:administrator@cometresearch.co.uk).



### Cardiothoracic Research Trainees Collaborative

The cardiothoracic research trainees collaborative (CTRC) was founded in 2011. Our Aims are to promote research amongst trainees, facilitate trainee led research projects and encourage collaboration between Cardiothoracic Units across the UK. Our strength is in our geographic spread, with trainees from Cardiothoracic Units across the UK getting involved. We focus on producing multi-centre studies, taking advantage of our network to collect data on large cohorts. Our intention is to carry out research that produces meaningful results, representative of UK practice. All studies run by our group are badged as coming from the collaborative. The emphasis is on trainees having the opportunity to develop research skills and experience. Each project is run by a trainee (the project lead), often with the backing of a consultant at their local centre. Trainees from across the UK can then participate by collecting and submitting data. Whilst we are trainee led, we value the advice and support of our senior colleagues, and many studies will also involve a consultant 'sponsor' at each site. We aim to have a very fair and transparent policy to ensure that all those participating are acknowledged for their hard work. The authorship policy is clearly defined at the start of each project. Activity in 2013: May: CTRC presentation at Cardiothoracic Clinical Study Group (Royal College of Surgeons of England), CTRC presentation at London Core Review Course; April 2013: CTRC presentation at ASiT conference; March 2013: Annual CTRC meeting at SCTS at which we welcomed new members (minutes will be available on the CTRC website which is to be launched within the next month). [www.ctrc-uk.com](http://www.ctrc-uk.com).



### East of England Surgical Research Group

The East of England Surgical Research Group (EESuRG) was established in October 2011 with the aim of providing high quality research and discussion forums for projects conceived within the region. Membership is open to all general surgical trainees and we are considering specific CT and FY appointments to the management committee. We have completed a survey of general surgical trainees about the adequacy of vascular training in preparing them to work as Consultant General Surgeons which was selected for a poster presentation at the recent ASGBI conference. Data collection has been completed for our current regional multi-centre studies (listed below) and we are preparing manuscripts and abstracts for submission. EESuRG has co-ordinated local recruitment to both The National Appendectomy Audit and the current SPARCS Sepsis Audit on behalf of the National Collaborative. Details of all projects can be found on our website [www.eesurg.org.uk](http://www.eesurg.org.uk) and ideas can be emailed directly to [chair@eesurg.org.uk](mailto:chair@eesurg.org.uk). We are discussing proposals for future prospective studies into the pre-operative management of diabetes mellitus and analgesic techniques for laparoscopic colorectal surgery. Over the next twelve months we aim to disseminate the results of current projects whilst continuing to grow our core membership and developing our IT capabilities to overcome the difficulties posed by the vast geographical area that represents our region. Current Projects: A Regional Assessment of Perineal Wound Complications after Abdomino-Perineal Excision of the Rectum, A Study into the Significance of Anaemia in patients receiving Short-course Radiotherapy for Rectal Cancer.

# Collaborative Reports



## East Midlands Surgical Academic Network

The East Midlands Surgical Academic Network is now two years old. So far it has collaborated successfully with the recent National Appendicectomy Audit and the SPARCS Sepsis Audit. It's first independent project, a regional study examining the outcomes of patients admitted with rectal bleeding, has been completed and is being prepared for submission. Two further projects are in their infancy currently but are planned for the middle of next year, on both of which we would be keen to work with other collaboratives. Although currently just in the North of the Deanery (centred around Nottingham), the hope is to extend into the South (centred on Leicester) at the beginning of next year. For further info go to [www.emsan.org.uk](http://www.emsan.org.uk), contact [tompalser@doctors.net.uk](mailto:tompalser@doctors.net.uk) or [info@emsan.org.uk](mailto:info@emsan.org.uk).

## ENTTRC ENT Trainee Research Collaborative - West Midlands

The ENTTRC-WM held its founding meeting on 16th October 2013 at the Queen Elizabeth Hospital Birmingham. 55 attendees, ranging from medical students to Professors, met to establish the first trainee led collaborative in ENT surgery in England. Professor Dion Morton spoke to regional ENT trainees about the future of research in surgery and how integral the trainee collaboratives will be to successful development and deployment of clinical trials. We also heard from the chairman of the West Midlands Research Collaborative about the projects they have run and how they have run a successful trainee-led organisation. We are fortunate to have the support of Professor Hisham Mehanna as honorary president of the collaborative. The ENTTRC-WM will be working over the next few months to develop our first multicentre prospective audit of peritonsillar abscess management. Regular monthly meeting will be adopting an educational element with invited talks from trial methodologists, statisticians and researchers. We are keen to encourage the formation of trainee-led research collaboratives in ENT across the UK and will be making a draft constitution available on our website to facilitate regional adoption. We hope this regional model will allow rapid generation of projects that may be rolled out nationally. If you would like to get involved, or set up a collaborative in your region, please get in touch. Web: [www.enttrc.com](http://www.enttrc.com) Email: [enquiries@enttrc.com](mailto:enquiries@enttrc.com) Twitter: [@enttrc](https://twitter.com/enttrc) Facebook: [www.facebook.com/enttrc](http://www.facebook.com/enttrc)



## London Surgical Research Group

The LSRG is the host of this year's National Research Collaborative Meeting at the Royal College of Surgeons of England. We cover all trainees in the London Deanery and we aim to design and run a wide variety of projects from simple surveys to randomised controlled trials. Our membership list is currently 600 strong and, of these, 162 members have participated in past projects. LSRG projects include PRIME, a RCT of ischaemic preconditioning prior to major surgery to reduce the incidence of perioperative myocardial injury; ESAP, assessing quality of care for emergency general surgical admissions; SAS, examining the predictive ability of the post-operative Surgical Apgar Score; and SHAPE, looking at beliefs and prescribing practices around antibiotic prophylaxis for hernia repair. Upcoming projects include a new study to investigate the epidemiology of diverticulosis and its relationship with diet. We will also be participating and promoting the International Surgical Outcomes Study, a project from Queen Mary University of London that aims to collect worldwide data on elective surgical outcomes. The LSRG has also been involved in a number of projects in collaboration with other research groups. These include the current national Surviving Sepsis audit and completed projects such as the national appendicectomy audit, CHARMS, SWIFT and ROSSINI. New members can sign up, get further details of our current and past projects and find out about upcoming meetings and events at our website [www.lsrp.co.uk](http://www.lsrp.co.uk). You can also email the committee with your ideas for surgical research studies at [lsrgcommittee@googlegroups.com](mailto:lsrgcommittee@googlegroups.com) or tweet us @lsrguk.

## NoSTRA Northern Surgical Trainee Research Association

NoSTRA has remained active over the last year with the main focus on completing projects started shortly after the group formed in June 2012. The main successes: GIFTASUP project, a baseline audit of fluid prescribing across 11 hospitals was completed in October 2012 and presented at ASiT and ASGBI in 2013. A follow up F1 educational intervention and poster campaign was developed and delivered in several units. Re-audit shows significant improvements in fluid prescribing. The results of this project will be formally prepared as a paper once enough units are completed. This is a very well developed audit which completes the audit cycle and delivers clinical practice improvement and could be rolled out on a larger scale to interested research collaboratives. Diverticulitis systematic review: a systematic review has been completed into the management of Hinchey 0-2 diverticulitis; as yet awaiting publication. Cochrane review into antibiotic coated sutures: protocol submitted and awaiting peer review. The main challenge for the group has been a lack of mentorship and momentum. This has resulted in the reduction in frequency of group meetings due to frequent poor attendance. It is hoped that once the above projects yield more substantive recognition and when key members of the committee return from current out of region fellowships productivity will increase. The diverticulitis review has been particularly useful in generating ideas for possible future clinical trials however at present the group needs to take a systematic approach to completing existing projects rather than divert energies elsewhere. [www.nostragroup.co.uk](http://www.nostragroup.co.uk)



## Paediatric Surgical Trainee Research Network

The PSTRN was established in 2011 to facilitate and encourage multicentre studies in paediatric surgery. We aim to engage trainees in research, provide a platform for multicentre studies and to foster a culture of research within our speciality. We are a national group with 96 members at present. Trainees at all levels are welcome; a career dedication to paediatric surgery is not essential. We meet annually at our National Speciality Annual Meeting (BAPS). We participated in the hugely successful National Appendicectomy Audit (NAA) and our members are involved in the CHildren's INterval Appendicectomy (CHINA) study. 19 of the 26 UK specialist paediatric units contributed to date to the NAA. Two exciting projects are planned for the coming year; both are open to all UK surgical centres, not restricted to specialist paediatric centres. Cross collaborative collaboration is actively encouraged! Projects: 1) a prospective multicentre audit of orchidopexy with a particular focus on testicular outcomes in relation to age at which orchidopexy is performed. This is an ambitious but timely

project given a recent change in national guidance on optimum age of orchidopexy. More information will be presented at this meeting and non-specialist centres where paediatric orchidopexy is performed are particularly welcome to participate. 2) an observational study of handlebar injuries in children led by a trainee with a particular interest in injury prevention. We hope to collect data on precise mechanism of injury and exact type of handlebar. We hope to influence policy to reduce injuries in the future. To participate in these studies or for further information please contact the collaborative lead, Nigel Hall at [nigel.hall@ucl.ac.uk](mailto:nigel.hall@ucl.ac.uk).

## RSTN

### Reconstructive Surgery Trials Network

### Reconstructive Surgery Trials Network

The Reconstructive Surgery Trials Network was established at the start of 2013. It serves as the trials network for the British Association of Plastic, Reconstructive and Aesthetic Surgery and The British Society for Surgery of the Hand. It is led by Abhilash Jain, the Surgical Specialty Lead for Hand and Plastic Surgery. The mission is to foster a trials culture within plastic and hand surgery as well as support collaborative audits and projects. Our website [www.reconstructivesurgerytrials.net](http://www.reconstructivesurgerytrials.net) enables members to sign up to our newsletter and provides information on how to access the network. We currently have close to 150 members and over 70 attended our first Trials Day in September. Follow us @Surgery\_Trials.



### Scottish Surgical Research Group

SSRG was started in early 2012 by a few trainees from each of the regional sectors of Scotland. There are 12 Core Committee members representing our four sectors and roughly thirty people on our mailing list. We wished to harness the power of the large number of surgical trainees in Scotland and work together, promoting and facilitating research and audit to trainees who might have previously felt it wasn't for them, or that they worked in too small a hospital to make research possible. SSRG has unique logistical issues due to the geographical remoteness of each sector and this has led to most meetings being via Skype video-calling, with face-to-face meetings quarterly. Currently projects include looking at prevalence and indication for Hartmann's procedure. We also facilitated recruitment of nearly all Scottish hospitals to the SPARCS sepsis project, and helped with the WMRC WPBA project. We are involved with the Scottish Emergency Laparotomy Interest Group (SELIG), complementing our anaesthetic colleagues' input. Completed projects – a national audit of Inguinal Hernia which has been presented at this Autumn's West of Scotland Surgical Association and also at the Edinburgh Audit Symposium. We also conducted an electronic survey of Attitudes to Smartphones amongst surgical trainees in Scotland. This work has been submitted for publication. We welcome any input from interested trainees regionally, and nationally from fellow collaboratives. Website: [www.scottishsurgeons.com](http://www.scottishsurgeons.com) Email: [info@scottishsurgeons.com](mailto:info@scottishsurgeons.com) Twitter: @ScotSRG Postal address: The SSRG, c/o Alice Brown, Secretariat, Royal College of Surgeons of Edinburgh, Nicolson Street, Edinburgh, EH8 9DW.



### Severn and Peninsula Audit and Research Collaborative for Surgeons

SPARCS represents a group of like-minded surgical trainees in the South West of England. We are striving to change the culture of surgical research from competition to collaboration by encouraging trainees to participate in multicentre studies that change clinical practice. We are currently leading the 2013 national multicentre audit of sepsis in general surgery emergency admissions and have successfully recruited 120 national and international centres for this exciting project. Data collection is due to complete in November and we aim to publish results in early 2014. In collaboration with the Northwest Research Collaborative we have undertaken a snap shot audit of current surgical ward round practices, which has highlighted issues regarding consultant and nursing presence on ward rounds and is in the process of being submitted to BMJ Quality and Safety. In collaboration with the Bristol Surgical Trials Centre, SPARCS have successfully obtained HTA funding for a feasibility study to determine if a full trial comparing simple, complex and no dressings after elective surgery, is possible. Please contact us if you are interested in participating in any of these projects, or for more information. Email: [sparcsexec@gmail.com](mailto:sparcsexec@gmail.com) Sepsis study: [sparcsepsis@gmail.com](mailto:sparcsepsis@gmail.com) Website: [www.sparcs.org.uk](http://www.sparcs.org.uk) Twitter: @SPARCsexec

## START Student Audit & Research Training

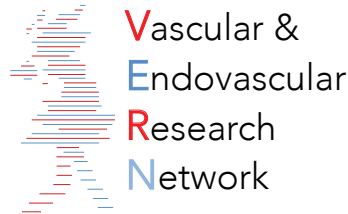
The Student Audit & Research Training (START) network is a national student collaborative group operating throughout the UK. START aims to foster academic potential in medical students by facilitating student-led multi-centre audit and research projects. Launched at the Royal College of Surgeons in September 2013, START recently completed its first national project, the STARSurgUK audit. Over 400 medical students and foundation doctors collected data at 110 hospital sites on the use of post-operative NSAIDs following bowel resection as part of the Enhanced Recovery after Surgery (ERAS) programme. This was a great success and demonstrated the feasibility of student-led multi-centre research. Following this astounding response from UK medical students and foundation doctors, START is already planning its next venture, due to launch in 2014. This project will push the boundaries of student-driven research further by linking medical students from across Europe. START will also invite students to an international collaborators' meeting in London during early-mid 2014. The vigour with which auditors have approached this venture has been exceptional and it has demonstrated the value of initiatives which aim to engage students in research at an early stage. Here at the START network we hope our activities will contribute to building a culture of collaboration and facilitate future integration into trainee-led collaborative groups.





### South Yorkshire Surgical Research Group

The South Yorkshire Surgical Research Group (SYSuRG) was created in May 2013. We aim to enhance the experience of surgical training in the region and conduct high quality research by establishing a network of surgical trainees and medical students willing to collaborate and undertake multi-centre audit and research in the generality of surgery. Despite being in our formative months over fifty surgical trainees and medical students in South Yorkshire have been involved in research projects through SYSuRG so far, undertaking studies on a far range of topics, such as sepsis, surgical training, simulation, ethics, surgical outcomes and assessment. Current/future projects: recruiting for - National Sepsis Audit, WPBA study, STARSurg, ROCSS, ISOS. SYSuRG lead for - NOTSS, EthiCheck, Trainee Operative Outcomes Project Get involved – the more the merrier! We meet on the last Tuesday in every month at 7pm at Sheffield Medical School to discuss current and future projects. If you have an idea for a project or want to get involved in any ongoing projects then visit our website: [www.sysurg.co.uk](http://www.sysurg.co.uk), email [sysurg@gmail.com](mailto:sysurg@gmail.com) or get in touch via twitter [@sysurg](https://twitter.com/sysurg).



### Vascular & Endovascular Research Network

#### Vascular & Endovascular Research Network

The Vascular & Endovascular Research Network (VERN) is a UK-wide interdisciplinary research network which unifies vascular surgeons, interventional radiologists, vascular anaesthetists, vascular scientists and vascular nurses to produce high quality large scale research output. Anyone who wants to get involved is welcome to do so, no membership is required to be part of this newly announced research network. VERN is in its infancy with the first study is underway, and involves mapping follow-up protocols following endovascular aneurysm repair at each vascular unit in the UK. The second study will look at the natural history of popliteal artery aneurysms. To get in touch, to get involved, or to submit an idea visit us at [vascular-research.net](http://vascular-research.net), email us at [info@vascular-research.net](mailto:info@vascular-research.net), follow us on Twitter [@VascResNet](https://twitter.com/VascResNet), or like us on [facebook.com/VascularResearchNet](https://facebook.com/VascularResearchNet).



### Welsh Barbers Research Group

#### Welsh Barbers Research Group

The Welsh Barbers Research Group was founded by surgical trainees in the Welsh deanery in 2009 and can be joined by any Welsh surgical trainee or medical student with an interest in surgery. We now have more than 160 members. We have been actively involved in both of the national audits and our members are keen to help you in your studies. If you have any trials that you would like to open across Wales please contact us on; [research@welshbarbers.org](mailto:research@welshbarbers.org). Our first randomised controlled trial, the Hughes Abdominal Repair Trial (HART) is now open for recruiting for the feasibility study. Trial Design: HART is a 2 stage trial i) a feasibility study ii) a phase IV RCT. Patients undergoing colorectal cancer resection with a midline incision will be randomised 1:1 to mass closure or Hughes repair. The trial aims to recruit 800 patients over two years with a 13% reduction (33% to 20%) in incisional hernias at 80% power. Primary outcome measure: The prevalence of incisional hernia one year after surgery in patients with colorectal cancer, as evaluated by clinical examination and computerised tomography (CT), in patients undergoing standard mass closure compared with the Hughes Repair. Secondary outcomes include: quality of life(QoL), cost analysis, demographic patient details and specific post operative complications. Recruitments and sites: Aim to start pilot study in January 2014 across 7 sites and the full study across the UK in 20 sites following this. Contact us if you are interested in participating: Email: [hart@welshbarbers.org](mailto:hart@welshbarbers.org) Website: [www.welshbarbers.org](http://www.welshbarbers.org)

#### Other Collaboratives

KMRC Kent and Medway Research Collaborative  
MeRGS Mersey Research Group for General Surgery [www.mergsurgery.co.uk](http://www.mergsurgery.co.uk)  
NURC Northern Urology Research Collaborative  
NWRC North West Research Collaborative [www.nwresearch.org](http://www.nwresearch.org)  
OSCAR Oswestry and Stoke Collaborative for Audit and Research [theoscar.co.uk](http://theoscar.co.uk)  
STORC South Yorkshire Trainees' Orthopaedic Research Collaborative  
WMRC West Midlands Research Collaborative [www.wmresearch.org.uk](http://www.wmresearch.org.uk)  
WMURAC West Midlands Urology Regional Audit Collaborative  
WSRG Warwickshire Surgical Research Group [warwickshiresrg.webs.com](http://warwickshiresrg.webs.com)  
YSRC Yorkshire Surgical Research Collaborative [www.ysrc.org.uk](http://www.ysrc.org.uk)

## Project Presentations

### 09.05 National Sepsis Audit: preliminary report

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*Severn and Peninsula Audit and Research Collaborative for Surgeons*

### 09.16 The Surgical Training & Education (STAGE) Planner, a Universal Checklist for Improving Training in Operative Surgery

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The Association of Surgeons in Training*

**Background:** Today's surgical trainee faces a constant challenge to maximise the educational value of every operative procedure. The benefits of checklists in healthcare are well known and a sharp increase in their uptake has been observed in recent years, the high profile WHO Surgical Checklist achieving worldwide adoption. ASIT has developed the "STAGE" checklist as a systematic and universal approach to improve the trainee's educational experience in operative surgery. It encompasses evidence-based strategies for the pre-, intra- and post-operative periods. We aim to determine the perceived educational value of the STEP checklist among surgical trainees across different regions of the UK and internationally.

**Methods:** The STAGE checklist was designed in line with principles from Stufflebeam's context, input, process, product (CIPP) evaluation model, ensuring that appropriate results and conclusions can be drawn from its prospective evaluation. A feedback questionnaire will be designed, aligned to the CIPP model, to assess its educational value.

Trainees will be recruited from all surgical specialties to pilot the STAGE checklist across at least ten centres in the United Kingdom and additional centres in North America, Australia and South Africa. A Specialty Registrar, Core Trainee, or local equivalent, will be identified in each centre as local investigator. This individual will coordinate recruitment of participants, checklist rollout and feedback collection. Analysis will be conducted by a team identified from the research collaborative. The success of the National Appendicectomy Audit, serves as an example of efficient multicentre data collection, collation and analysis with rapid complete project turnaround.

### 09.27 Clinical Variation in Practice of Laparoscopic Cholecystectomy and Surgical Outcomes: a multi-centre, prospective, population-based cohort study (CholeS Study)

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**Background:** Cholecystectomy is one of the most common general surgical operations performed in the UK. Increasing proportions of patients have surgery in the acute setting for severe biliary colic, cholecystitis and following gallstone pancreatitis. Randomised clinical trials in acute cholecystitis and gallstone pancreatitis suggest early laparoscopic surgery performed in specialist units is safe. Despite this, management differs between surgeons and centres across the UK and the impact of this variation on outcome are unclear.

The aim of this study is to investigate surgical outcomes following acute, 'delayed' and elective cholecystectomies in a population-based cohort.

**Methods:** The study will be performed over a three-month period, following a two-week, five centre pilot. Participation from 20 centres in the West Midlands

is estimated to recruit 2,000 patients. The study will be performed using a standardised database at each centre. Inclusion criteria will be: All patients undergoing cholecystectomy will be categorised into one of three groups: (1) Acute Cholecystectomy (first acute admission with biliary disease through A&E or GP and cholecystectomy performed during that index admission); (2) Elective Cholecystectomy (planned elective admission for cholecystectomy who have been referred from their GP and added to the routine surgical waiting list from the outpatient department only and (3) Delayed Cholecystectomy (all other planned cholecystectomies). Variation in practice will be assessed by all-cause 30-day re-admission rates, by centre. In addition, the influence of pre-operative factors and effects on peri- and post-operative measures will be investigated. The primary endpoint is all-cause 30-day readmission rate following cholecystectomy performed during a three month period. Secondary outcome measures are: pre-operative (demographics, admission type, diagnostic tests) peri-operative (conversion rates of laparoscopy to open surgery, complications,) and post-operative (length of stay, in-hospital morbidity) factors.

**Discussion:** This multi-centre, prospective, population-based cohort study will be delivered by a trainee-led collaborative research networks to ensure high volume without compromising quality.

### 09.38 Acute Uncomplicated Diverticulitis: In-patient vs Out-patient management? (AUDIO)

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**Background:** Diverticular disease is common. The most frequent complication is diverticulitis, either uncomplicated or complicated. Most patients with uncomplicated diverticulitis and can be managed conservatively. ACPGBI recommends early CT, to confirm diagnosis and severity, identifying patients likely to respond to conservative treatment.

Traditionally, patients are admitted for bowel rest, intravenous fluids and antibiotics. A recent multi-centre RCT comparing antibiotics with no antibiotics showed, however, no difference in outcome. Additionally, dietary restriction may prolong time to recovery and discharge. In 2011-2012, uncomplicated diverticulitis accounted for 87,202 admissions. Mean length of stay was 5.6 days. Early discharge therefore offers a potential large cost saving for the NHS.

The aim of this study is to compare an evidence-based out-patient treatment protocol versus standard management of acute uncomplicated diverticulitis in terms of safety, efficacy, the patient experience and cost-effectiveness.

**Methods:** All patients with suspected diverticulitis, if suitable, will be invited to participate. They enter a common management pathway, including a CT within 24 hours (ideally same day). Randomisation occurs if diagnosis/severity are confirmed.

**Out-patient treatment:** Discharge within 24 hours of admission, oral analgesia, unrestricted diet, contact information in case of deterioration. **In-patient treatment arm:** routine care undertaken for any patient diagnosed with uncomplicated diverticulitis by the responsible surgical team locally. **Outcome measures and on recruitment, at 48 hours, 7 & 30 days:** analgesia use and pain severity, diet diary, quality

of life (EQ-5D-5L Health Questionnaire), patient experience & satisfaction, out-patient colonoscopy or CT colonography (unless contraindicated) at 6-8 weeks (ACPGBI guidelines). A standardized case record form (CRF) will be used for each subject. This CRF will be web-based via a secured internet module and include demographics, medical history, presenting symptoms, examination and laboratory results, CT findings, VAS and QoL scores, and data on patient satisfaction & experience.

### 09.49 A prospective observational study of the diversity of management in acute complicated diverticulitis

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Yorkshire Surgical Research Collaborative, University of Leeds, Dewsbury District Hospital*

**Background:** Acute complicated diverticulitis (ACD) is a common surgical emergency with significant implications for the patients. A proportion of patients could end up with a life-long stoma and yet others undergo major surgical intervention and may need intensive care support. However, there is currently no standardization of care and no unified national guidelines. The NICE guidelines pertaining to diverticulitis stop short at when to refer patients with potential diverticulitis to hospital. Although there are various studies published relating to several management aspects of diverticulitis, yet some good level 1 evidence is conspicuous by its absence. There is a strong need design good randomized controlled studies addressing various management issues in ACD and for these to be of a sufficiently high quality to inform practice it is essential define the current scale of the problem and variability in management trends. This observational study aims to provide landmark data on the national incidence, management strategies, short-term patient outcomes, stoma rates and the role of surgical and radiological intervention.

**Methods:** A national study aimed to commence on the 01/01/2014 for 3 months collecting information on patient demographics, presenting symptoms, number of previous admissions, biochemistry, radiological imaging/intervention, surgical intervention, length and course of hospital stay in ACD. This would be followed up by a one-off follow-up at 6 months from the date of admission to assess the further proposed management with respect to diverticulitis.

**Discussion:** As stated above, there are several unanswered questions relating to the management of ACD, the most pressing of these are roles of and even the need for radiological and surgical intervention with respect to drainage of sepsis and washout, the role of major surgical resection with or without primary anastomosis and stoma formation. All these parameters may differ with the age of the patients who are now increasingly presenting at a younger age. The implications or whether or not to intervene and the degree of intervention are even higher in younger patients. There is a pressing need to define these problems, design trials which could define and refine and streamline the currently diverse practice in this widely prevalent illness.

### 10.00 Hughes Abdominal Repair Trial

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# Presentations

Welsh Barbers Research Group, University Hospital of Wales, WORTH

**Background:** Incisional hernias are common complications of midline closure following major abdominal surgery and cause significant morbidity, impaired quality of life and increased cost. The Hughes Repair is an alternative technique of abdominal wall closure (to standard mass closure) using 'near and far' sutures.

**Methods:** HART is a 2 stage trial i) a feasibility study ii) a phase IV RCT. Patients undergoing colorectal cancer resection with a midline incision will be randomised 1:1 to mass closure or Hughes repair. The trial aims to recruit 800 patients over two years (20 sites recruiting 40 patients) with a 13% reduction (33% to 20%) in incisional hernias at 80% power. HART will use adaptive randomisation to allocate patients to groups of similar size, with stratifications for elective/emergency, open/lap assisted, surgeon closure suture. Primary outcome measure: Incidence of IH at one year of patients with incisional hernia following colorectal cancer surgery. Secondary outcomes: Radiological incidence of incisional hernia (using CT). Quality of life (SF12, FACT C) Cost Analysis at one year and further follow up (Client Service Receipt Inventory). Demographic patient details and specific post operative complications; surgical site infection (SSI) and 'burst abdomens', or full thickness abdominal wall dehiscence. Incidence of incisional hernia at further follow-up of up to 5 years postop.

**Discussion:** Feasibility study started Sept 2013. Currently eight sites in pilot study due to start recruitment Jan 2014 and expanding to full trial with a total of 20 centres by July 2014. Aiming to recruit 40 patients per centre, with a view to recruiting 800 patients in total.

**10.11** A randomised controlled trial of Reinforcement of Closure of Stoma Site using a biological mesh: the ROCSS trials  
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**Background:** Hernia at the site of stoma closure occurs in up to 30% of patients and is associated with adverse effects on quality of life. In up to 10% of cases, patients are submitted to complex re-operation which carries significant morbidity. If there is a measurable benefit from mesh insertion, elective use of a collagen mesh would warrant consideration in the closure of other difficult, contaminated abdominal wounds. ROCSS will use stoma site closure as a model for biological mesh placement during any difficult contaminated abdominal wall closures. The aim of this study is to assess whether a biological mesh (collagen tissue matrix) reduces the incidence of clinically detectable stoma closure site hernias at two years compared to standard closure techniques.

**Methods:** Multicentre, patient and reviewer blinded, randomised controlled trial. The primary outcome is occurrence of clinically detectable hernias at two years post closure. Surgical complications is a key secondary outcome and an exploratory analysis will also be conducted to investigate the use of CT scan at one year as an early surrogate marker of late clinical herniation. This could then be used in future

abdominal wall studies as a surrogate endpoint for clinical hernia.

**Discussion:** The pilot study has recruited 71 patients from 6 centres, and is proving the safety of the surgical technique and feasibility of the trial protocol. These centres will recruit to complete the pilot of 90 patients. Completion of the pilot will run seamlessly into a full phase III trial. This will need a further 470 patients, for which a further 20 centres are required from the UK and Europe. Cost benefit analysis and quality of life analysis will be performed at 2 years.

## Specialty Presentations

**11.12** The national chronic subdural haematoma audit: An update and provisional results

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**Background:** Evacuation of a chronic subdural haematoma (CSDH) is a common neurosurgical procedure, however the optimal preoperative management, surgical technique and postoperative care are controversial. We proposed a prospective multicentre audit in order to establish current practices, national benchmarks and areas for future study by the network.

**Methods:** A prospective multi-centre audit. All adult patients aged 16 years and over with a primary or recurrent CSDH were eligible for inclusion. Neurosurgical units (NSU) in the United Kingdom and Ireland were invited to recruit patients prospectively for a period of 4 months from June 2013. Data on various aspects of patient care were entered into a secure online database and analysed by the study's management group.

**Results:** Audit standards were determined from published systematic reviews and a randomised controlled trial. These include: clinical recurrence rate < 20%; unfavourable modified Rankin Scale (mRS) (4-6) at discharge from NSU < 30%; mortality rate in NSU < 5 %; morbidity rate in NSU < 10%. The outcome measures were: (1) clinical recurrence requiring re-operation within 60 days; (2) modified Rankin scale (mRS) score at discharge from NSU; (3) morbidity and mortality in the NSU; (4) destination at discharge from NSU; (5) length of stay in the NSU. More than 200 patients have been enrolled as of 15th August 2013. Provisional results of the audit will be presented at the research meeting.

**Discussion:** The audit will elucidate the contemporary management and outcomes of patients with CSDH in the United Kingdom and Ireland. It will inform national guidelines, clinical practice and future studies in order to improve the outcome of patients.

**11.19** Multicentre Audit of Quinsies (MAQ). A multicentre audit of peritonsillar abscess management and outcomes.

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ENT Trainee Research Collaborative

**Background:** Peritonsillar abscess is the second most common emergency presentation in ENT surgery. Current management strategies include aspiration or incision and drainage, followed by empirical antibiotic therapy to cover common causative

organisms. The use of steroids has limited evidence and new techniques such as intraoral ultrasound remain poorly adopted. The primary aim of this audit is to describe variations in management and outcome of peritonsillar abscesses following acute presentation.

**Methods:** The audit will look at consecutive patients presenting with peritonsillar abscesses to ENT on call services in multiple centres. Data will be collected regarding the referral context, patient demographics, initial management, discharge, follow up and complications. A pilot study will be implemented trialling a secure web-based audit tool (SWAT). This novel tool has been developed by the ENT Trainee Research Collaborative to allow centralised data collection with real time appreciation of patient recruitment and data completeness. A second phase of the audit will commence in January 2014 to include any acute ENT service that has registered to take part. A third audit phase is planned for January 2015 to measure the impact of the MAQ report. The primary outcome measure is an adverse event within 30 days of presentation; a composite measure including re-presentation to hospital and repeated attempt at drainage. Secondary outcome measures include rates of ambulatory management, drainage technique, steroid usage, and utilisation of investigations.

**Discussion:** We expect to show significant heterogeneity in the acute management of peritonsillar abscesses. In particular, current rates of inpatient management seem inappropriately high and initial management with corticosteroids inconsistent. Inappropriate admissions and poor symptom control may lead to increased costs for trusts and expose patients to unnecessary inconvenience and hospital pathogens. MAQ will describe current practice and record patient outcomes to help rationalise variations in management of patients with peritonsillar abscesses.

**11.26** Multi-centre assessment of NSAIDs as risk factors for post-operative adverse events: a student-led network

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**Background:** Medical students form a natural network across the United Kingdom. They are encouraged and frequently required to participate in audit during their training. Developing a tangible and sustainable student-led collaborative may help develop a future generation of research-active surgeons. This study will test the feasibility of this network for engaging in multi-centre audit, whilst answering an important clinical question. Non-steroid anti-inflammatory drugs (NSAIDs) are commonly used in the post-operative setting as a safe adjunct for analgesia. However conflicting evidence gained from recent population-level studies implicates them with an increased risk of anastomotic leak. Further evidence is needed, including their association with a wider range of adverse events.

**Methods:** Multi-centre, prospective, student-led audit. Centres will prospectively audit patients over three possible 14-day periods within a month time-span starting from 24th September to Monday 21st October, 2013. Consecutive patients undergoing upper or lower gastrointestinal bowel resection in both the elective and emergency settings, >18 years old will be included. Any centre in the UK performing bowel resection is eligible for inclusion. Those undergoing

appendicectomy will be excluded. The primary outcome measure is the 30-day adverse event rate. Local leads at each medical school have been established to help develop local networks. We expect a minimum of 45 centres. With an average of 20 emergency and elective bowel resections over a 14 day period, 900 patients provides adequate power to detect a difference of 10% in adverse event rates (2:1 control:experimental matching).

**Discussion:** We expect complete results available for presentation by the time of the National Research Collaborative meeting. This study will develop and test the feasibility of a UK-wide, student-led network. It will also deliver an audit with an important clinical question, which is neglected in current literature.

## 11.33 Improving Hip Care through Local Quality Improvement Programmes: the Past, the Present and the Future

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North Western

**Background:** Hip fractures occur frequently and they are associated with high morbidity and mortality. It is estimated that there are more than 60,000 cases of hip fracture each year and more than a third of these patients die within a year of the fracture. The National Hip Fracture Database (NHFD) was introduced as a tool to aid hip fracture care. Since its launch in 2007 contribution to the database has steadily grown and it now estimated that as much as 95% treated annually is captured by the database<sup>1</sup>. The benefits of using NHFD for research purposes are; that it has a large number of cases, which enables even small effect sizes to be detected and it has multicentre participation with generalisability of the results. The usefulness of the NHFD, like other clinical databases is limited by the quality of its data. Although the quality of the data in the NHFD is unknown, data in NHFD has been used to make alterations to hip fracture services and it has been used to answer research questions.

**Methods:** At our centre, the quality of data submitted to the NHFD was reviewed. The hip fracture type data was used as a marker of the overall quality. The admission radiographs were reviewed by an orthopaedic SpR to determine the hip fracture type. The quality of the data was determined by comparing the orthopaedic SpR's diagnoses with the data in the NHFD.

**Results:** Worthing, the data was accurate in only 50% of the case. Subsequently, a programme of change was implemented. Our quality has now improved to 83%.

**Discussion:** If further centres were to implement local quality improvement programmes this will improve the overall quality of data in NHFD. Ultimately this will result in improved care of patients with hip fracture.

## 11.40 Cardiothoracic Surgery Update

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## 11.47 Improving the quality of surgical research and innovation: help from the IDEAL Collaboration

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## 12.04 Does the age of orchidopexy influence early surgical outcomes and testicular atrophy rate?

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Paediatric Surgical Trainee Research Network

**Background:** The guidelines for the optimal age at orchidopexy have changed over time. In September 2011, following recent evidence which suggests operating earlier will improve long term function and reduce malignancy risk, the British Association of Paediatric Urologists (BAPU) recommended that orchidopexy should be performed as early as 3 months of age, although between 6 and 12 months is acceptable. This audit will establish the uptake of these guidelines and compare early surgical outcomes between patients operated on either before or after 1 year of age.

**Methods:** This will be a prospective, multicentre audit to establish current practice and outcomes for orchidopexy. The primary surgical outcome will be testicular atrophy post orchidopexy. The audit standard of less than 5% atrophy rate post orchidopexy is taken from published literature<sup>1</sup>. Sample size calculation of 185 patients in each group is based on detecting an increased atrophy rate of 10%. The secondary surgical outcomes will include intra-operative complications, operation time, anaesthetic complications/ overnight stays, rate of re-operation/testicular ascent and wound infection rates. Patient recruitment will run over a 4 month period. Participation from at least 10 paediatric surgical centres and 20 district general hospitals performing general surgery of childhood is estimated to recruit 400 patients.

**Discussion:** Reducing the age of orchidopexy may have positive long term benefits however operating on younger patients may increase the rate of short term complications. This audit seeks to establish whether the recent recommendations have been implemented and whether there is any evidence that short term outcomes are affected.

## 12.11 Reconstructive Surgery Update

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## 12.18 Are MRI scans more accurate in diagnosing parotid tumours than FNAs?

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**Background:** Current NICE and ENT UK guidelines advocate the use of FNA for diagnosing parotid tumours. We decided to investigate the accuracy of Magnetic Resonance Imaging (MRI) versus Fine Needle Aspiration (FNA) in correctly diagnosing parotid tumours.

**Methods:** We identified all patients from Jan 2012 to June 2013 who had undergone a parotidectomy and obtained the parotid sample list from the pathology department. We used the histology findings from the samples as our definitive diagnosis for the parotid tumour in question. Only parotidectomies carried out for primary tumour removal were considered. All parotidectomies performed as part of a complete dissection for other primary malignancies were excluded.

Retrospective analysis was undertaken to identify the investigations that took place prior to surgery. In

order to determine the accuracy of each investigation, the results of each test was compared to the definitive pathology result as the 'gold standard'.

**Results:** FNA demonstrated a sensitivity of 57% and a specificity of 66%. MRI scan results demonstrated a sensitivity of 83% and specificity of 80%. The accuracy of MRI in diagnosing parotid malignancy was 86%, significantly higher than FNA.

**Discussion:** Our results highlighted the accuracy of MRI as a diagnostic tool in the identification of parotid tumours.

In order to explore this accuracy in greater depth, we would like to extend this audit further, by retrospectively analysing five years worth of data for malignant parotid tumours across a multitude of trusts in the UK and recruit fellow Head & Neck trainees to take part in order to answer the research question asked in the title.

There may be a substantial role for MRI over FNA in diagnosing parotid tumours that requires further research, the outcomes of which may have a potentially significant impact on changing current recommended practice in the UK.

## 12.25 Vascular Surgery Update

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## 12.32 Anaesthetics Update

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## 12.39 General Surgery Update

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## Poster Presentations

### 01 Safety of short, in-hospital delays before surgery for acute appendicitis: multicentre cohort study, systematic review and meta-analysis

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**Background:** Short organisational delays before appendicectomy may safely improve provision of acute surgical services. Further information is needed to support the most appropriate evidence based strategy. The aim of this study was to determine whether delaying appendicectomy by over 12 hours increased the rate of complex appendicitis.

**Methods:** The primary endpoint was the rate of complex appendicitis (perforation, gangrene and/or abscess). The main explanatory variable was timing of surgery, using <12 hours from admission as the reference. The first part of this study analysed primary data from a multicentre study on appendicectomy from 95 centres. The second part combined this data with a systematic review and meta-analysis of published data.

**Results:** The cohort study included 2510 patients with acute appendicitis, of whom 812 (32.4%) had complex findings. Adjusted multivariable binary regression modelling showed that timing of operation was not related to risk of complex appendicitis (12-24 hours odds ratio [OR] 0.98 [p=0.869]; 24-48 hours OR 0.88 [p=0.329]; 48+ hours OR 0.82 [p=0.317]). However after 48 hours, the risk of surgical site infection and 30-day adverse events both increased (adjusted OR 2.24 [p=0.039] and 1.71 [p=0.024] respectively). Meta-analysis of 11 non-randomised studies (8858 patients) revealed that delay of 12-24 hours after admission did not

increase the risk of complex appendicitis (OR 0.97, p=0.750).

**Discussion:** Short delays of <24 hours prior to appendectomy did not affect the rate of complex pathology in selected patients. These organisational delays may aid service provision, but planned delay beyond this should be avoided. However, where optimal surgical systems allow for expeditious surgery, prompt appendectomy will still aid fastest resolution of pain for the individual patient.

## 04 The Economic Burden of Incisional Hernia Repair

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Welsh Barbers Research Group

**Background:** Incisional hernia (IH) is an endemic complication of abdominal surgery. Rates of abdominal IH have been quoted between 4.7%-33%. They are associated with reduced QoL, although their subsequent cost to the health service is poorly understood. This retrospective review aims to quantify the cost of repairing IH in our institution, a university hospital serving a population of 2.5 million, during the 2011-2012 financial year.

**Methods:** Data collection took place from 1st April 2011 to 31st March 2012. A list of all patients who had undergone primary or recurrent IH repairs during this period was obtained from the clinical coding department. Patient information regarding clinics attended, investigations undertaken, inpatient admissions and operations performed (laparoscopic/open and suture/mesh repair) were obtained from the Clinical Portal system. Operation times were obtained from the IT department. Calculated costs included the cost of outpatient clinics, radiological investigations (ultrasound and computed tomography), overnight hospital stay and the cost of open and laparoscopic surgical repair. Data analysis was performed in partnership with a specialist health economist.

**Results:** Eighty-five patients were admitted for either primary or recurrent incisional hernia repair. Thirty-three patients are currently on waiting lists to undergo repair. Five patients were cancelled due to bed shortages or co-morbidities preventing operation. Sixty-seven primary repairs and 14 recurrent repairs were performed (1 patient underwent 2 recurrent repairs in the study period.) The mean age was 56 years. The number of theatre sessions utilised solely for incisional hernia repair was 39.8 half day sessions in the 12 month period. The total cost was £225,889.65.

**Discussion:** In our institution IH repairs represent a significant proportion of the yearly budget as well as taking up valuable theatre and surgeon time. Extrapolating these local results to the UK as a whole, IH repairs cost in excess of £5.5 million per year.

## 11 Feedback on Feedback: an Objective Assessment of the Feedback Provided to Junior Surgical Trainees

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**Background:** WBAs are intended to be used as formative assessments in which students are provided with effective feedback. Effective feedback enables trainees to develop and progress by; motivating them, raising their self-esteem, encouraging deep learning and understanding and offering specific suggestions for improvement. However, emerging evidence suggests the quality of the feed-

back is poor. Ali et al. 2011 investigated the quality of feedback received by urology trainees. They discovered a worrying lack of good quality feedback. It is unclear whether this is a urology specific problem or in fact it is a problem that plagues other surgical specialities as well. It is imperative that this question is answered so that corrective measures can be taken. Failure to do so will limit the educational value of WBAs and limit their long-term usefulness. Hence, a wonderful opportunity to improve the quality of surgical training would have been missed and wasted. The aim of this study is: to determine the quality of feedback provided to junior surgical trainees.

**Methods:** All DOPS undertaken by core surgical trainees between Aug 2012 – July 2013 will be included. Three DOPs will be selected at random for each placement undertaken by every trainee. Data will be collected on the; surgical speciality, deanery, grade of trainer, global score and the quality of feedback. The quality of feedback will be compared to established guidelines for effective feedback. Three assessors will independently review the feedback for each DOP.

**Discussion:** This study will help to gain an insight the current quality of surgical feedback. This will be feedback to the stakeholders to reinforce positive behaviors and identify areas for improvement.

## 24 A study to determine whether it is feasible to perform a phase III double blind, randomised, placebo controlled, multicentre trial to evaluate whether chlorhexidine mouthwash, before and after oesophagectomy for cancer, Prevents Post-Operative Pneumonia (P-POP study)

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**Background:** Pneumonia is the most common postoperative complication. It normally occurs due to bacterial contamination of the lungs originating from the mouth and throat and loss of natural defence mechanisms when a tracheal tube is used for ventilation. Postoperative pneumonia (POP) results in increased NHS hospital costs, longer hospital stay and is a major cause of death. The highest risk group for developing POP are patients undergoing combined thorax and abdominal procedures such as an oesophagectomy. Chlorhexidine mouthwash is cheap, safe and commonly used to treat mouth infections by reducing the concentration of oral bacteria. There is evidence that oral decontamination with chlorhexidine (ODC) reduces the incidence of POP following cardiac surgery. In addition, evidence from the research literature and the National Institute of Health and Clinical Excellence (NICE) support the use of ODC as a way of reducing pneumonia in ventilated patients in intensive care; the cause of which is similar to POP. To date there is no robust evidence testing the effect of ODC on POP in patients undergoing high risk thorax-abdominal procedures.

**Methods:** The proposed study aims to determine whether it is feasible to perform a phase III trial to evaluate whether ODC given before and after oesophagectomy for cancer prevents POP. The design of the feasibility study mirrors that of the phase III trial. Patients will be randomised to receive 2 days pre-operative and 5 days postoperative ODC (treatment arm) or placebo (control arm). Compliance with treatment, ability to recruit patients and issues pertinent to the design of the phase III trial will be

assessed. If these criteria are favourable a phase III trial will be performed.

**Discussion:** If a phase III trial were to prove that ODC is beneficial these important findings could have a major impact on all patients undergoing surgery within the NHS.

## 28 Assessing The Non-Technical Skills of Surgical Trainees

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**Background:** The launch of the Intercollegiate Surgical Curriculum Programme (ISCP) ([www.iscp.ac.uk](http://www.iscp.ac.uk)) had a major impact on surgical training in the last few years. This web-based system describes a comprehensive syllabus content of all surgical specialities and provides a platform for workplace based assessments (WBAs). However, the curriculum still lacks a formative method of assessing non-technical skills of trainees, namely situation awareness, teamwork, leadership and decision-making within the theatre environment. These skills are frequently implicated in surgical adverse events as they are vitally important to ensure patient safety. Our proposed study aims at exploring the current views amongst the members of the surgical theatre team regarding the need to introduce an assessment tool of non-technical skills of surgical trainees (NOTSS) in the theatre environment, which the ISCP currently lacks. In addition, the previous training and familiarity of the members of the surgical theatre team with the concept of NOTSS will be evaluated.

**Methods:** A regional survey amongst the members of the theatre surgical team in two hospitals in South Yorkshire will be performed in order to provide data on the participants' view regarding the need for assessing the NOTSS of surgical trainees. Each participant can respond only once.

The target participants are surgical consultants, surgical trainees, consultants anaesthetists, theatre sisters and staff nurses/ODPs who scrub for operations in all surgical specialities. Any other ancillary theatre staff that does not scrub will be excluded. The participants will be contacted directly and asked to fill the questionnaires in theatres. The selection process will be solely dependent on the availability of the staff during the study period.

**Discussion:** If the acceptability amongst trainees and assessors is positive for the introduction of NOTSS into surgical training, the next stage would be to conduct a pilot study in order to assess the utility of the NOTSS instrument as part of the WBA framework of the ISCP. Hence, this survey can be a major step towards incorporation of NOTSS into the ISCP curriculum.

## 31 Workplace based assessments (WPBA) in General Surgery: Do they represent a chance to learn?

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**Background:** WPBA are assessments of junior doctors' performance in the clinical workplace performed by senior colleagues. These assessments

require a significant amount of time, may be a source of stress and lack an evidential basis. WPBA are said to have a dual purpose; formative (to help trainees learn) and summative (to assess trainees to allow them to progress in their careers). This dual meaning creates uncertainty and therefore individuals infer their own meaning. We are interested in the formative (feedback) role of WPBA. Systematic review data has shown that feedback is an important influence on subsequent clinical performance (6) and there is some evidence that trainees and trainers find this beneficial though the literature also describes many problems with giving and receiving feedback in practice.

This project aims to determine surgical trainees' and trainers' perceptions of WPBA along a learning-to-assessment scale and to explore whether WPBA promote or hinder feedback between surgical trainees and trainers.

**Methods:** Mixed methods sequential explanatory design with initial quantitative (questionnaire using validated instruments) and subsequent qualitative data (focus groups). Study participants include surgical trainers; individuals who complete WPBA for surgical trainees, and trainees; who utilise WPBA through the ISCP (CT1 – ST7). 16+ sites. Data will be analysed using SPSS v.15 (quantitative) and basic thematic analysis using nVivo 10 (qualitative).

**Results:** The results of the pilot data have been presented at ASGBI 2013 and the results of the main study will be ready to present in December 2013.

**Discussion:** Pilot data showed that surgical trainees and trainers had differing perceptions of whether WPBA represent an opportunity to learn in the workplace or not. The majority of trainers felt they provided feedback to trainees but only half trainees thought they received feedback in the same encounters.

### 34 Use of antibiotic prophylaxis in elective inguinal hernia repair in adults in London and south-east England: a cross-sectional survey

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**Background:** Evidence regarding whether or not antibiotic prophylaxis is beneficial in preventing post-operative surgical site infection in adult inguinal hernia repair is conflicting. A recent Cochrane review based on 17 randomised trials did not reach a conclusion on this subject. This study aimed to describe the current practice and determine whether clinical equipoise is prevalent.

**Methods:** Surgeons in training were recruited to administer the Survey of Hernia Antibiotic Prophylaxis usE survey to consultant-level general surgeons in London and the south-east of England on their practices and beliefs regarding antibiotic prophylaxis in adult elective inguinal hernia repair. Local prophylaxis guidelines for the participating hospital sites were also determined.

**Results:** The study was conducted at 34 different sites and received completed surveys from 229 out of a possible 245 surgeons, a 93 % response rate. Overall, a large majority of hospital guidelines

(22/28) and surgeons' personal beliefs (192/229, 84 %) supported the use of single-dose pre-operative intravenous antibiotic prophylaxis in inguinal hernia repair, although there was considerable variation in the regimens in use. The most widely used regimen was intravenous co-amoxiclav (1.2 g). Less than half of surgeons were adherent to their own hospital antibiotic guidelines for this procedure, although many incorrectly believed that they were following these.

**Discussion:** In the south-east of England, there is a strong majority of surgical opinion in favour of the use of antibiotic prophylaxis in this procedure. It is therefore likely to be extremely difficult to conduct further randomised studies in the UK to support or refute the effectiveness of prophylaxis in this commonly performed procedure.

### 35 Use of the Surgical Apgar Score to guide postoperative care: a pilot impact study

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**Background:** The Surgical Apgar Score (SAS) can predict 30-day major complications or death after surgery. Studies have validated the score in different patient populations and suggest its use to objective guide postoperative care. In this pilot impact study, we determined if using the SAS in a decisive approach in a future randomized controlled trial (RCT) would be likely to demonstrate an effect on postoperative care and clinical outcome.

**Methods:** Adults undergoing general or vascular surgery in nine centres were recruited. Participants were randomized to a control group – standard postoperative care; or an intervention group – care influenced, but not mandated, by the SAS (decisive approach). The notional primary outcome was 30-day major complications or death.

**Results:** Data from 139 patients were analysed. Incidence of major complications was similar in both groups (control, 20/69 (29%); intervention, 23/70 (33%);  $P=0.622$ ). Immediate admissions to critical care was higher in the intervention group especially in the SAS 0–4 subgroup (4/6 versus 2/7), although not statistically significant ( $P=0.310$ ). Validity was confirmed in AUROC analysis ( $C=0.77$ ).

**Discussion:** This pilot found that, although a future RCT to study the effect of using the SAS in a decisive approach might demonstrate a difference in postoperative care, there is a substantial risk that it would not show any difference in clinical outcome, namely major complications or death within 30 days of surgery. Features including compulsory critical care admission for poorly scoring patients, tighter inclusion criteria and a stepped wedge cluster design need to be considered.

### 36 Improving fluid prescribing in the Northern Deanery

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**Background:** Inappropriate IV fluid prescribing contributes significantly to inpatient morbidity and mortality amongst surgical patients. The 2011 GIFTASUP guidelines made clear recommendations regarding fluid prescription choice, volumes and composition to improve this area of concern.

**Methods:** Baseline audit of fluid prescribing was performed in 11 hospitals throughout the northern

deanery. Following this an educational intervention and awareness campaign was developed and delivered to Foundation doctors within the region. A reaudit of fluid prescribing was performed to assess the impact of the educational program. (This has been completed in 1 hospital with regional roll out in October.)

**Results:** Data was collected on 221 patients as part of the baseline audit. Compliance with guidelines for fluid prescribing was poor. Compliance with volume recommendations was achieved in 34%, Sodium maintenance in 6.3% and potassium in 6.8%. Following educational intervention overall compliance with the 3 categories improved from 10% to 29%. The mean patient hourly urine volume dropped from 87ml/hr to 71ml/hr showing a reduction in the over-prescription of fluid, there were no cases of renal failure to indicate under prescription. The proportion of types of fluid prescribed changed from baseline Saline 34% to 11% after intervention, Hartmanns 62% to 37%, Dextrose Saline 3% to 52%. Prior to intervention only 30% of hypokalemic patients were prescribed additional potassium, this rose to 100% after education.

**Discussion:** Significant improvements in fluid prescribing can be made by appropriate educating foundation doctors in key principles that underline fluid prescribing guidelines. We recommend that this intervention should be disseminated to all Foundation doctors and regular audit of quality of prescribing be undertaken.

### 38 Surgical ward rounds in England: A trainee-led multi-centre study of current practice

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**Background:** Recent guidance advocates daily consultant-led ward rounds which are conducted in the morning, with the presence of senior nursing staff and minimising patients on outlying wards. These recommendations aim to improve patient management through timely investigations, treatment and discharge. This study sought to establish current surgical ward round practices in England.

**Methods:** Information regarding timing and staffing levels of surgical ward rounds was collected prospectively over a one-week period. The location of each patient was also documented. Two surgical trainee collaboratives coordinated data collection from 19 hospitals and 13 surgical subspecialties.

**Results:** Data from 471 ward rounds involving 5622 patient encounters was obtained. 367 (77.9%) ward rounds commenced before 9am. Of 422 weekday rounds, 190 (45%) were consultant-led compared with 33 of the 49 (67%) weekend rounds. Forty seven of the 51 (92%) post-take ward rounds were consultant-led. 2474 (44%) patients were seen with a nurse present. 1518 patients (27%) were classified as outliers, with 361 ward rounds (67%) reporting at least one outlying patient.

**Conclusion:** Recommendations for daily consultant-led multi disciplinary ward rounds are not consistently implemented in surgical practice, and patients continue to be managed on outlying wards. Although strategies may be employed to improve nursing attendance on ward rounds, substantial changes to medical workforce planning would be required to deliver daily consultant-led care. An increasing political focus on patient outcomes at weekends may prompt changes in these areas.



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