050 INTRODUCTION OF A QUALITY OF TRAUMA CARE PATIENT REPORTED EXPERIENCE MEASURE DURING WEEKLY TRAUMA GOVERNANCE REVIEW MEETINGS

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The 2005 Darzi Report stated that Patient Safety, Clinical Effectiveness and Patient Experience should be afforded parity when evaluating services. Positive Patient Experience (PEx) is correlated with improved outcomes across a wide range of conditions. In our hospital, we conduct weekly governance review of trauma cases, but no PEx element was previously included.

This pilot study has the primary aim of evaluating PEx and incorporating this into weekly trauma meetings, specifically identifying strengths and vulnerabilities in service provision. A secondary aim was to stimulate improvement of the trauma system based on feedback received.

The setting for this pilot study was the Peninsula Trauma Network Major Trauma Centre at University Hospitals Plymouth NHS Trust. The 13-item validated Short Form Quality of Trauma Care Patient Reported Experience Measure (SF-QTACPREM), originally developed by Bobrovitz *et al*, was directly administered to trauma patients able to provide informed consent from November 2018 onwards. Items are equally weighted. A positive response is assigned 7.69%, a neutral response 3.85% and a negative response, 0%. By consensus, a target overall PEx score of >90% has been determined.

PEx data have been successfully incorporated into trauma meetings. Data are presented in meetings via a visual dashboard (figure 1). Cumulative data are compiled into an aggregate PEx data slide (figure 2).

Current mean average PEx Score (n=30) is 81.79% (Range 46.15%–100%). Aggregate data reveal that communication domains tend to score lower whereas technical domains involving medical care score more highly. Provision of mental health support following injury has been identified as a priority area for improvement.

As a direct result of negative reported experience or a low PEx score, specialist trauma nurses return to address patient concerns, increasing service responsiveness in real-time. In the future, it is hoped that this pilot will be expanded to include all network trauma patients.

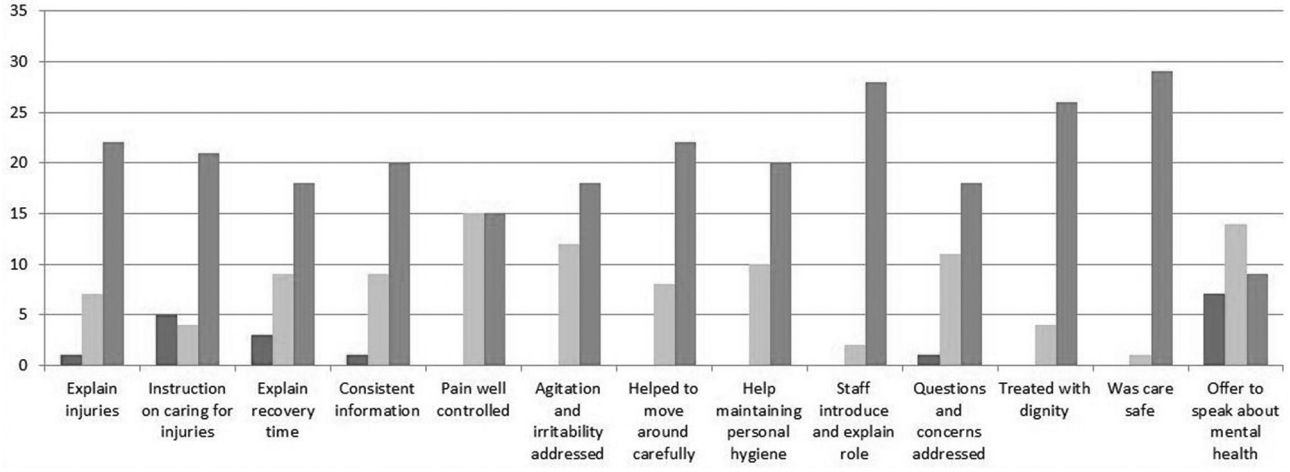
Individual Experience Dashboard

Red	<60%	Overall Experience Measure	84.62%	Green	>90%

Explain all **injuries** clearly		'Individual teams explained their injuries'
Instruction on **caring** for **injuries**		'Received all the information I needed for now'
Explain recovery time from injuries		'Individually, but not together'
Information received was **consistent**		'Yes, just nobody overall in charge of care'
Pain well **controlled**		'Usually'
Agitation and **irritability** addressed		'I felt very well looked after'
Helped to **move** around **carefully**		
Help maintain **personal hygiene**		
Staff **introduce** and **explain role**		'Always'
Questions and **concerns** addressed		'Yes, but hard to track down relevant person'
Treated with **dignity**		
Was **care safe**		
Offer to speak about **mental health**		'No, I don't think I need support though'

Green	+7.69%	Amber	+3.85%	Red	+0%

Abstract 050 Figure 1 Patient experience dashboard



Abstract 050 Figure 2 Aggregate data

051 THE ACUTE (AMBULANCE CPAP: USE, TREATMENT EFFECT AND ECONOMICS) FEASIBILITY STUDY: A PILOT RANDOMISED CONTROLLED TRIAL OF PREHOSPITAL CPAP FOR ACUTE RESPIRATORY FAILURE

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Background Acute respiratory failure (ARF) is a common and life-threatening medical emergency. Continuous positive airway pressure (CPAP) is a potentially beneficial prehospital

treatment, but it is uncertain whether this could improve important outcomes in NHS ambulance services.

Methods An individually randomised, external pilot study was conducted to test the feasibility of a definitive pragmatic trial. Adults with respiratory distress and peripheral oxygen saturations below British Thoracic Society target levels were recruited from the West Midlands Ambulance Service between August 2017 and July 2018. Participants were randomised 1:1 to prehospital CPAP or standard oxygen therapy. Feasibility objectives estimated the: incidence of eligible patients; proportion recruited and allocated to treatment appropriately; adherence to allocated treatment; retention and data completeness; and 30-day mortality, as a potential primary outcome for a definitive trial.

Results Over 12 months, 77 patients were enrolled (CPAP arm 42, standard oxygen arm 35 cases, target 120). CPAP was fully delivered as planned in 74% (target 75%). There were no major protocol violations/non-compliances (target 0%). Full data were available for key outcomes (target $\geq$90%). Mortality was higher than expected (overall 27.3%, CPAP arm 28.6% n=12/42, standard care arm 25.7% n=9/35). Of deceased patients, 14/21 (68%) either did not have a respiratory condition or had ceiling of treatment decisions excluding hospital non-invasive ventilation and critical care. Two patients required emergency department treatment for a pneumothorax, neither having received prehospital CPAP. There were no other serious adverse events.

Conclusions The lower than expected recruitment rate, limited compliance with CPAP, and the difficulty in identifying patients who could benefit from CPAP, indicate limited potential for prehospital CPAP to reduce mortality. A definitive effectiveness trial is therefore not recommended. These findings also argue against routine implementation of CPAP into NHS ambulance services.