BOURNEMOUTH UNIVERSITY

2026 BU-NHS Conference

Moving Forwards Together

Fusion Building, Talbot Campus
16th April 2026

Programme D
FG06

Insights Actions Outcomes

Dorset Population Health Management & Health Inequalities

BU-NHS CONFERENCE

How good are you at taking care of your health?

Co-producing a Person Activation Model for Prevention in Dorset

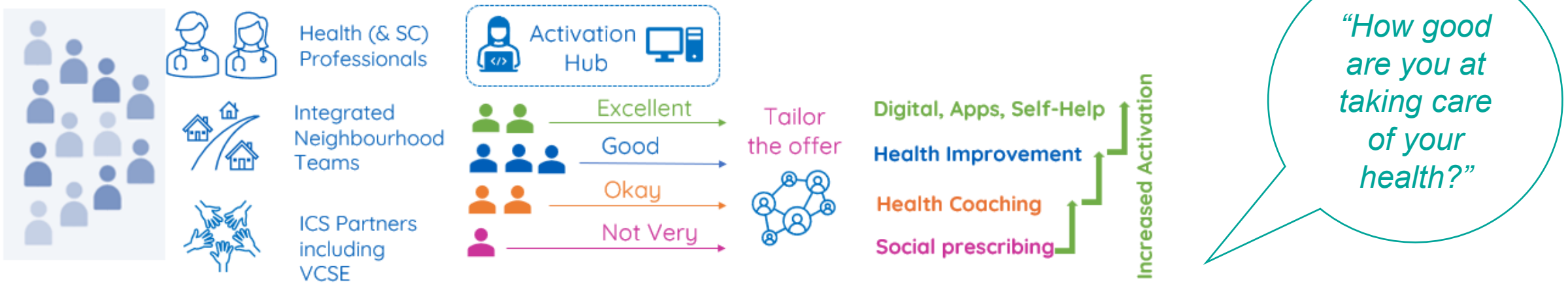
Thursday 16th April 2025

Jo Wilson, Strategic Lead for Prevention at NHS Dorset

Version: 01 Date: 16/04/2025 Author: Jo Wilson

Research Question and Methods

‘Patient activation’ describes the knowledge, skills and confidence a person has in managing their own health and care.’ People with higher activation have better health outcomes.



How do people feel about being asked the Activation question and our model of care?

We enlisted the help of four community organisations, who reached out to diverse populations across Dorset and BCP:

- Tea and toast, creative writing, online and in person questionnaires, social prescribing calls, engagement event with food, mixed martial arts group, 1-2-1 care conversations

NHSE – Patient Activation FAQ pa-prog-faqs.pdf

Results

- **Relational trust, face-to-face interaction, and personalised support** consistently emerged as significant factors for health and wellbeing
- From Primary Care there were mixed views on when to ask the question, with **over 50% preferring post consultation** and a **range of mediums being acceptable**, with **multi offer proposed**. Blend **human connection** with **digital convenience**.
- Through conversations it became clear that whilst **participants** may **rate themselves as managing their health well**, their **knowledge, skills and confidence did not always match**.
- **Self-care** was understood as **pragmatic, lived action within personal limits.** *What works for one person may not work for another.*
- Importance of **staff development** to ensure the question is asked confidently, responses are interpreted appropriately with proportionate support. **Skilled delivery and trauma informed approaches are needed**.
- **Framing the question to avoid judgement** was an expressed concern for some, with reflections on how the question may land differently depending on mood, confidence, and trust..
- Some participants were **sceptical whether asking would result in real support**. **Who asks and why matters.**
- **Groups, workshops and peer support are highly valued**, and consistently mentioned as ways to build confidence in managing health

Opportunities to collaborate

Some Next Steps

- A deeper dive into the feedback from our Patient Engagement partners and summarise themes
- Write up and publish a joint learning report on Patient Engagement from the four reports
- Share our findings with the Integrated Neighbourhood Co-production workstream
- Share our findings with the AHP Prevention Group

Question - How can we further embed a co-production approach into local Activation models?

Thank you to colleagues at the Lantern Trust, South Coast Medical, Help and Care and (CAN) Community Action Network, and most importantly to the people and patients who gave generously of their time and shared their experiences so we can improve local services for our communities and neighbourhoods.

Come and meet us in the Atrium to find out more about the Prevention Community of Practice!

Care of older people undergoing emergency surgery: meeting the standards of the National emergency laparotomy audit (NELA).

Dr Peter Robinson (POPS Clinical lead)
Presented by ACP Laura Gates POPS

NELA
National Emergency Laparotomy Audit

So what?

- NELA audit collects data and looks at reasons why people die following emergency abdominal surgery. It focuses on 13 key standards.
- 2019/20 21,846 patients had emergency bowel surgery- 30 day mortality rate 8.7%, average hospital stay 15 days.
- 55.4% > 65 years old and 18.1% >80 years old. Older patients , particularly frail have considerably worse outcomes.
- The least documented standards are Risk Documentation (risk scoring- frailty scoring) and Post op input from a care of the older person team.

Mortality – National (patients over 65)

Figure 7.1.1 Comparison of 30-day mortality in two groups of patients over time; patients over the age of 65 years and patients under the age of 65 years

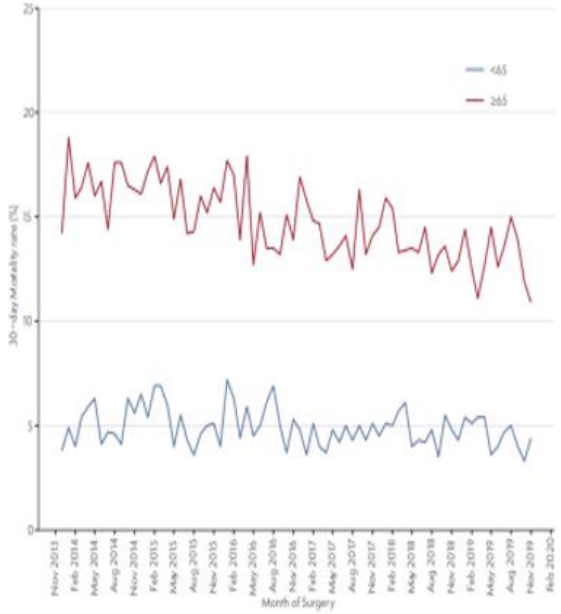
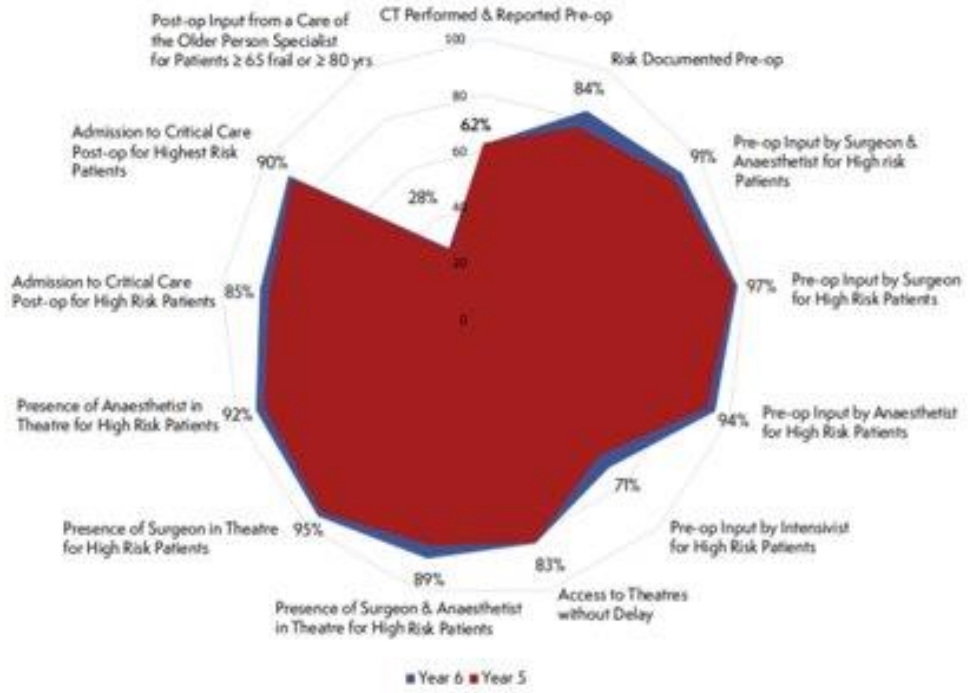
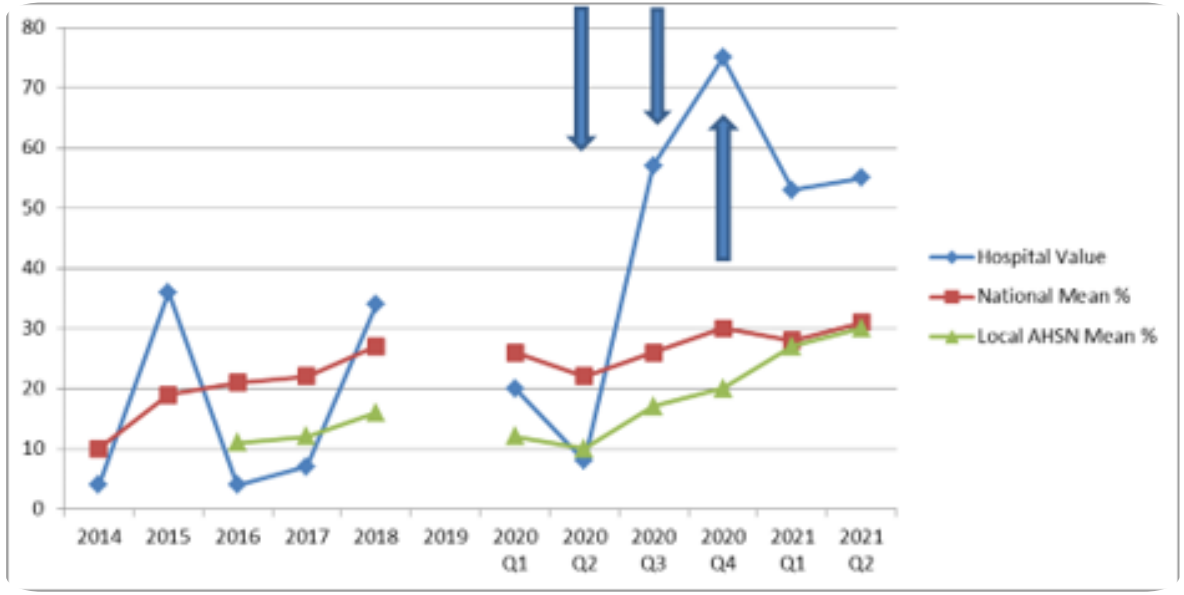


Figure 3.1.1 Proportion of all emergency laparotomy patients in Year 6 who had surgery between December 2018 and November 2019, who received key standards of care





1. New Consultant appointment
   - Engagement with NELA team
   - Focussed case finding
   - Emergency Surgery committee
2. Electronic referral system
3. Emergency Laparotomy pathway

WHAT HAPPENED?

- **Quality improvement**
- Aim - to improve local trust performance in meeting the NELA standard ‘ Perioperative assessment by a member of the
- geriatrician led MDT for frail patients 65 or older’
- **Method-**
- -proactive case finding
- -Engagement with the emergency surgical team
- -Improved referral system
- - Assist in development of electronic booking system with emergency laparotomy cases
- **Result**
- We demonstrated a significant improvement in meeting the standard. From 33% (red zone) to achieving 60% (amber
- zone). However remains below the NELA target.
- Conclusion – standards make a difference

What next?

- Build on the service POPS
- Education, service improvement
- Continue collecting Data
- Aim for > 90%
- Best practice tariff
- Trust wide goal

Thank you

Questions?

Improving Screening and Management of Iron Deficiency in Patients with Heart Failure with Reduced Ejection Fraction

A Two-Cycle Quality Improvement Project

Ibad ur Rehman

University Hospitals Dorset NHS

Project Aim: To improve compliance with ESC guidelines for iron deficiency screening and appropriate IV iron therapy in inpatients with HFrEF at University Hospitals Dorset NHS Foundation Trust.

Why? Iron deficiency is highly prevalent in patients with heart failure with reduced ejection fraction (HFrEF) and is associated with:

- *Poorer functional capacity and quality of life*
- *Worse outcomes irrespective of anaemia status*
- *Increased hospital admissions and mortality*

ESC Heart Failure Guidelines (2023) recommend routine screening eligible patients

Specific Objectives:

1. **Increase documentation** of iron studies (ferritin, TSAT) for all eligible patients
2. **Increase appropriate prescription** and administration of IV iron when indicated
3. **Improve documentation** of valid reasons for non-prescription
4. **Compare pre/post performance** across two QI cycles

Timeline & Methodology

Two-cycle QI approach: Baseline audit → Interventions → Re-audit

- **Cycle 1:** Retrospective data collection of adult inpatients with HFrEF
- **Interventions:** Junior doctor education, guideline summaries, ward reminders
- **Cycle 2:** Re-audit with identical methodology

Cycle 1
→
Intervention
→
Cycle 2-Ongoing

Eligibility Criteria

Target Population: Adult inpatients with documented HFrEF

1-LVEF ≤45%
Heart failure with reduced ejection fraction

2-Screening Required
Regardless of anemia status

Diagnostic Thresholds

1-Ferritin <100 µg/L
Iron deficiency confirmed

2-Ferritin 100-299 µg/L
+ TSAT <20%

Treatment >>> IV Ferric Derisomaltose (Monofer)

Indication: Patients meeting diagnostic criteria for iron deficiency
Dose: 1000mg single infusion or as per local protocol
Monitoring: Follow-up iron studies at 8-12 weeks

Baseline (Cycle 1) Findings

Overall: **Suboptimal rates of iron status assessment and appropriate supplementation in eligible patients with HFrEF**.

Gaps identified: Incomplete ordering of iron studies (ferritin/TSAT)

Missed opportunities: IV iron not administered despite eligibility

Documentation: Limited documentation of non-prescription reasons

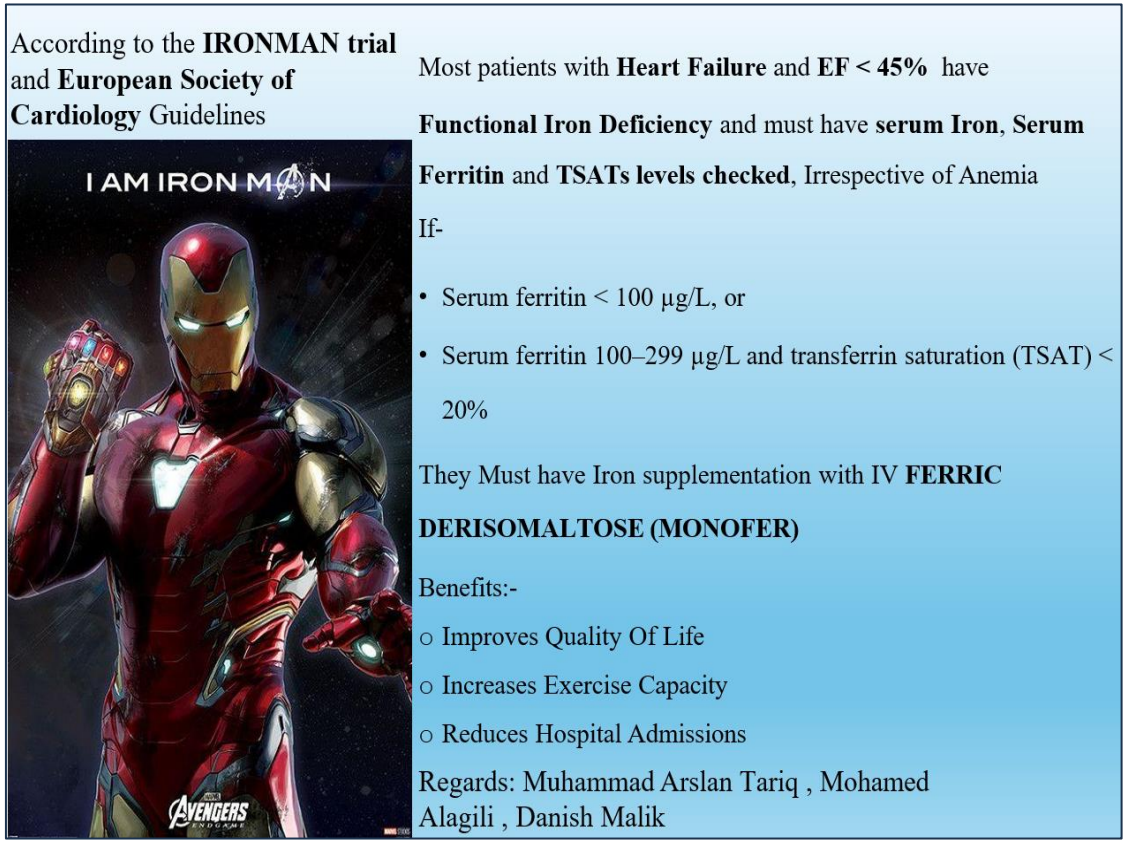
Compliance: Variable adherence to ESC guidelines

Results to date

- **Baseline low screening rates**
- **Post intervention improved awareness**
- **Better documentation observed**
- **Full cycle 2 results pending…**

Conclusion

- **Simple interventions drive change**
- **Bridges gap between guidelines & practice**
- **Sustainable and reproducible model**



Ward Poster

Next steps & Collaboration

- **Complete Cycle 2 & Assess sustainability**
- **We are open to multicentre collaboration**

Any Questions?

Assessment of the Optimal Use of Rate Control Medications in CT Coronary Angiography

Ibad ur Rehman & Khurram Shehzad ·

University Hospitals Dorset NHS Foundation Trust

Uswa Zeb- Sherwood Forest NHS Foundation Trust

Background, Objectives & Methods

Background

Adequate heart rate control (<65 bpm) is essential for diagnostic-quality CTCA images. Motion artefact from elevated heart rates reduces accuracy and risks unnecessary invasive procedures 4 yet consistent achievement in district general hospitals remains challenging.

Objective

Evaluate use and effectiveness of rate control medications, and their impact on heart rate reduction and image quality.

Methods

Cross-sectional study of **49 patients** undergoing CTCA at Queen Elizabeth Hospital, Lewisham & Greenwich NHS Trust (July–September 2023). Data collected: demographics, referral source, prescribing practices, pre/intra-scan heart rates, and image quality (standardised 5- point scale).

Results

35%

Inadequately Controlled

17 of 49 patients scanned with heart rate ≥65 bpm

10

No Medication Given

Half from rapid access chest pain clinic where prescriptions were not issued

61.6

Mean HR with IV Metoprolol

vs. 65.4 bpm with oral beta-blockers

3.22

Image Quality (IV)

vs. 3.09/5 with oral beta-blockers

Conclusion & Next Steps

Conclusion

IV metoprolol demonstrates superior heart rate reduction and image quality.

Standardised prescribing pathways and improved referral coordination could meaningfully enhance CTCA diagnostic quality in district general hospital settings.

Impact & Next Steps

Optimising rate control can reduce repeat imaging and lower the need for invasive coronary investigations. We welcome collaborators interested in developing standardised on-table rate control protocols across NHS trusts.

Interested in collaboration? Please do speak with us 4 we'd love to connect!

Platelets and their death

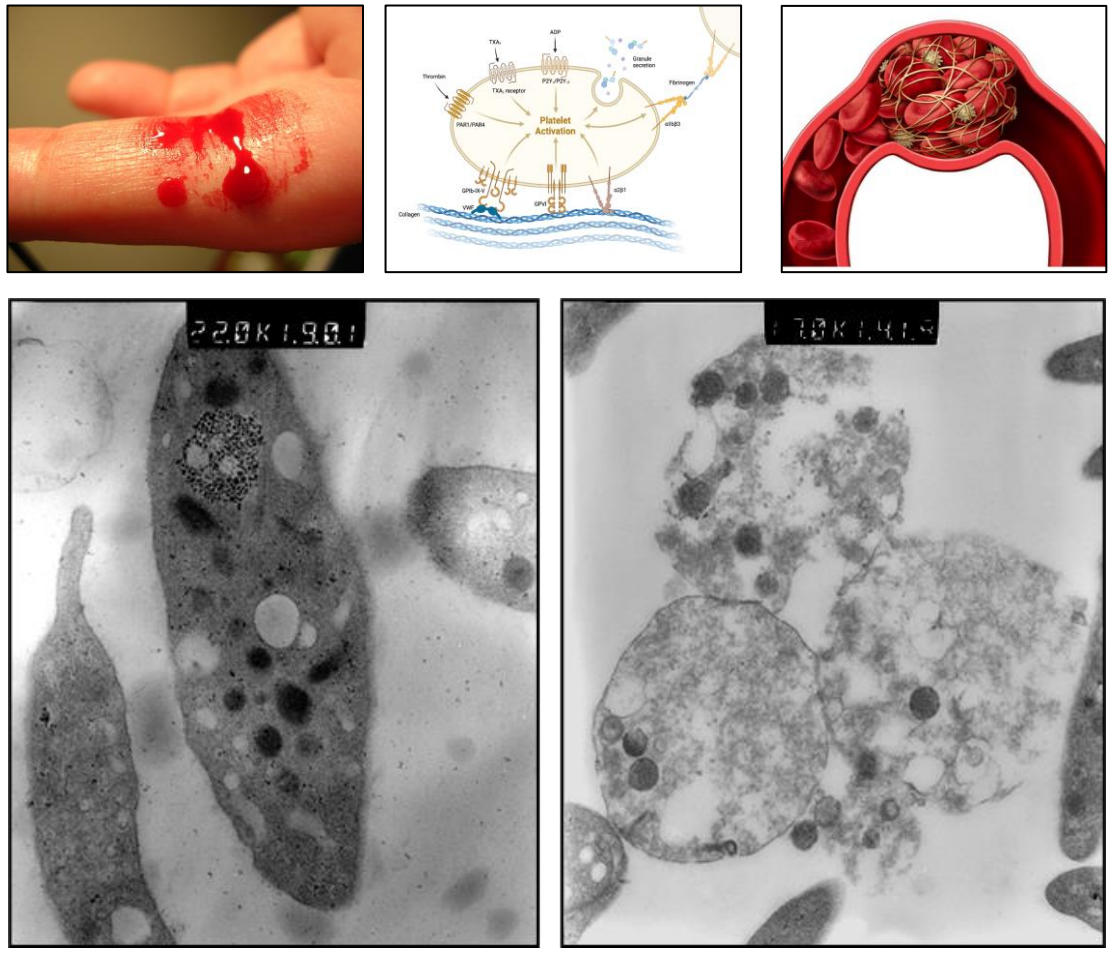
Dr. Paul Hartley (Faculty of Health Environment and Medical Science)

Platelets are critical for **haemostasis** and have huge clinical significance due to their role in **stroke** and **thrombosis**.

Platelets have a finite lifespan (~10 days in circulation).

It is predicted that dying platelets contribute to abnormal haemostasis and alter the risk of stroke and thrombosis

Understanding platelet turnover and what triggers their death is therefore important.

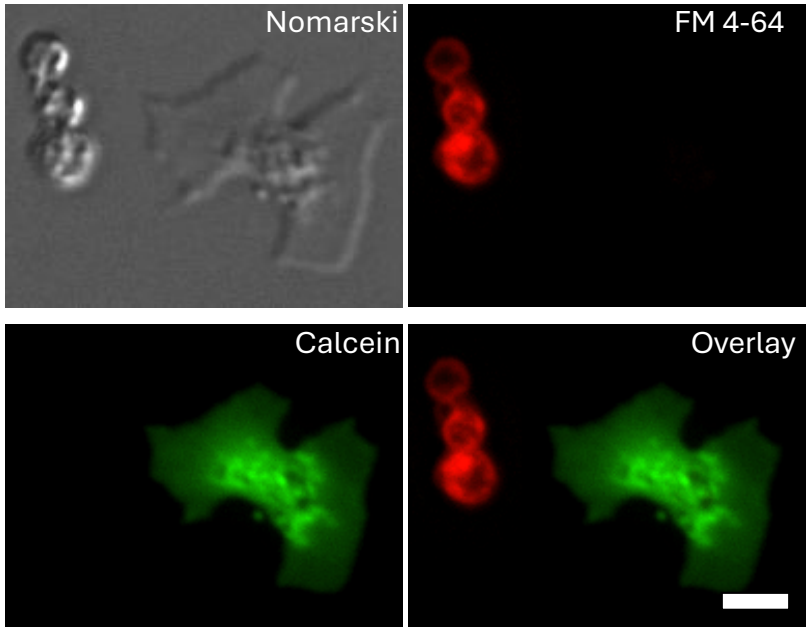


Platelets undergo programmed death and become necrotic independent of being activated during injury responses. Dying involves loss of surface receptors (e.g. CD42b – part of the von Willbrand receptor) and sensitivity to pro-coagulant agonists.

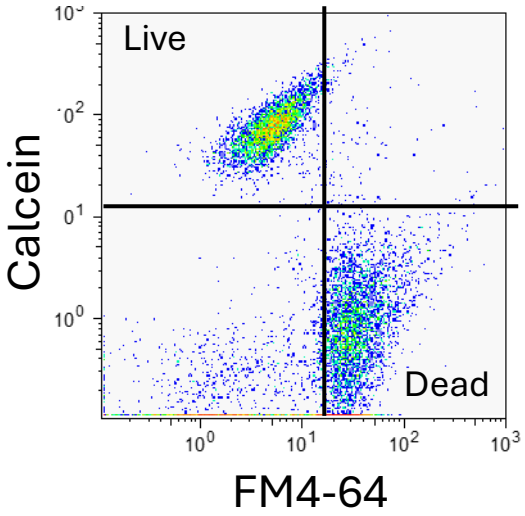
Identifying dead and dying platelets is possible and we know they die by different mechanisms:

- **Intrinsically** during their 10-day lifespan in circulation.
- **activation-dependent** during thrombus formation.
- **'storage lesion'** (in platelets stored for transfusion.

During death, platelet function is affected in different and complex ways. For example, they can form metalloproteinase-dependent aggregates but can also become primed for coagulation.



Bar = 5µm



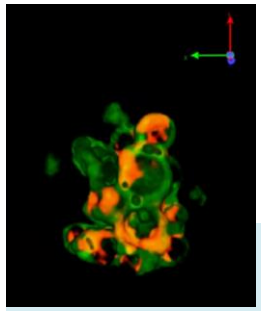
Dead platelets can be identified by microscopy and cytometry using calcien-AM and FM4-64.

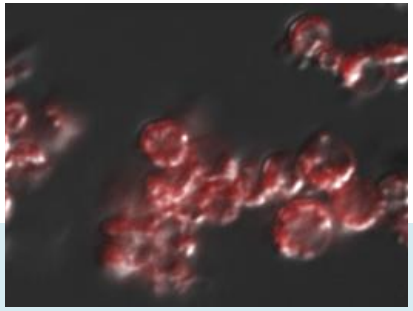
Dying platelets can be identified using the mitochondrial membrane potential (JC-1) but death itself seems abrupt.

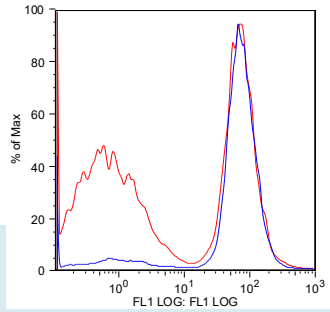
Translating the work…

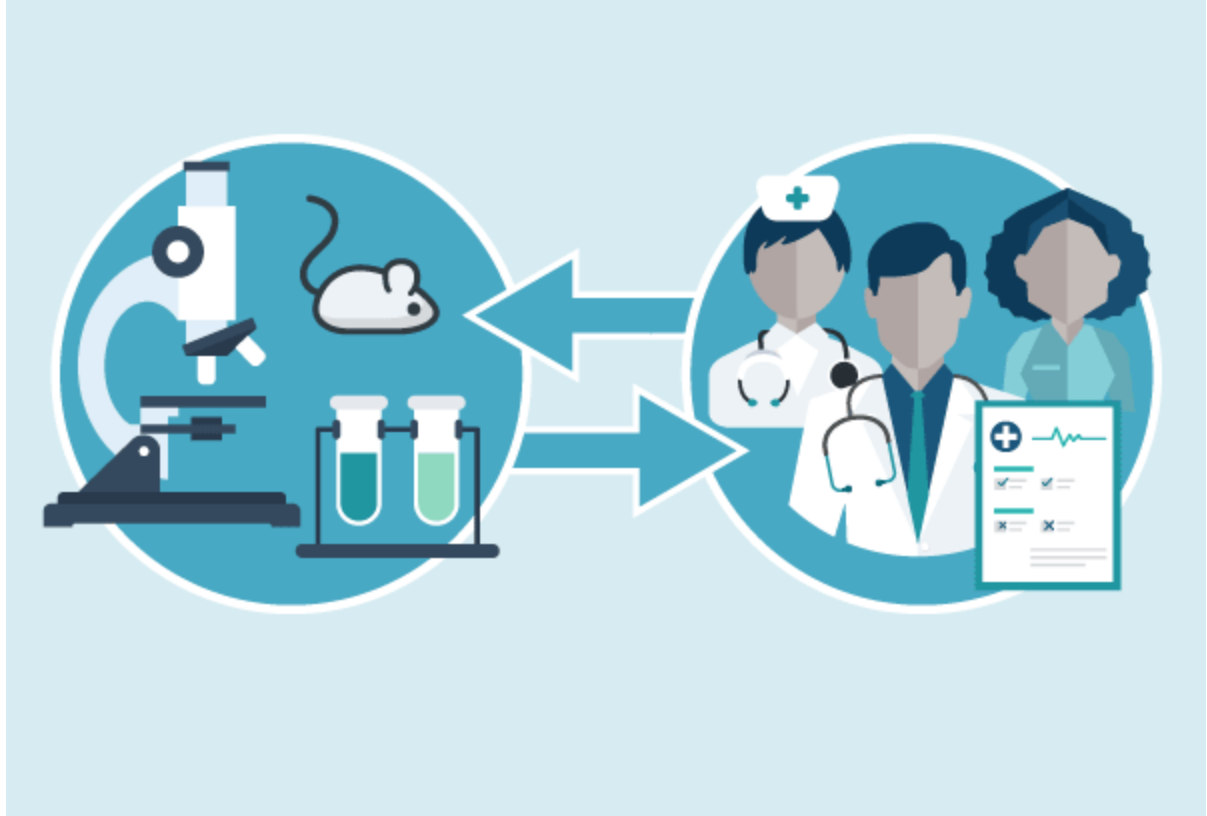
We're interested in where dead and dying platelets might feature in people / patient groups:

- **Hypoxia** – low $SP0_2$ is linked to platelet death – athletes, sleep apnoea, ageing?
- **Toxicology** – what pharmacological agents and environmental pollutants drive platelet death?
- **Biomarker** – do they accumulate in people with abnormal immune clearance & (sub-clinical) inflammation?
- **Working with anyone interested in platelets and blood…**









Medical Research Council

British Heart Foundation

University Hospitals Dorset
NHS Foundation Trust

A Multidisciplinary Decompensated Cirrhosis Discharge Clinic is Both Possible and Effective in Reducing Total Number of Bed Days and Length of Stay

Andrew Wellstead
Department of Gastroenterology, University Hospitals Dorset

Introduction

Decompensated cirrhosis (DC) is associated with frequent hospital admissions and prolonged inpatient stays, contributing to significant healthcare resource utilisation. The British Society of Gastroenterology (BSG) has emphasised the importance of structured outpatient care pathways, including multidisciplinary team (MDT) approaches, to improve patient outcomes and reduce hospital dependency in this population. This study evaluates the practicality and impact of a dedicated MDT clinic on healthcare utilisation among patients with decompensated cirrhosis.

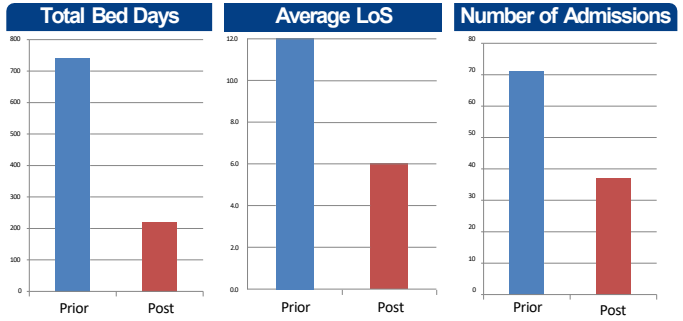
A dedicated MDT clinic was established at a district general hospital (DGH), comprising a consultant hepatologist, advanced nurse practitioner (ANP), dietician, physiotherapist, palliative care specialist, and assertive alcohol outreach worker. All patients were discussed in an MDT immediately prior to clinic and were then reviewed by the appropriate members of the team. Patients were referred to the clinic for comprehensive outpatient management following an admission with decompensated cirrhosis, or if they had decompensated as an outpatient, aligning with BSG recommendations.

A retrospective analysis of 79 patients who had attended clinic compared total bed days, number of admissions (excluding day case admissions), and mean length of hospital stay during the 90 days before and after the initial clinic attendance.

1. Mansour D, Masson S, Corless L, et al. British Society of Gastroenterology Best Practice Guidance: outpatient management of cirrhosis - part 2: decompensated cirrhosis. Frontline Gastroenterology. 2023;14(6):462-473. doi:10.1136/flgastro-2023-102431

Results

In the 90 days preceding clinic attendance, 79 patients accounted for 743 hospital bed days, which decreased to 220 bed days in the 90 days following clinic attendance - a reduction of 523 bed days (70.4%). The number of admissions longer than one day decreased from 71 to 37 (47.9% reduction). The mean length of hospital stay per admission reduced from 10.5 to 5.95 days (43.1% reduction). Elective day case activities, such as paracentesis, continued to be supported through outpatient services.



Local data demonstrating the pre and post clinic intervention metrics, including actual number and percentage changes for a number of key KPIs

Metric	90 Day Admissions Pre Clinic	90 Days Admissions Post Clinic	Reduction	% Reduction
Total Admissions	71	37	34	47.9%
Bed Days (Total)	743	220	523	70.4%
Total Estimated Cost (£)*	£593,942.80	£175,912.00	£418,030.80	
Average LOS (days)	10.46	5.95	4.51	43.1%
Cost Per Admission (£)	£8362.62	£4755.62	£3607.00	

* All cost estimates are based on a business-accounting verified cost of £799.60 per bed day, calculated from a sample of 10 randomly selected patients with decompensated cirrhosis.

** The Mean average of the 10 patients was 15.1, and median 7. These values are relating to individual admissions from the pre clinic period.

*** n=79 individual patients, data taken from the first attendance to the decompensated MDT clinic

Discussion

In the 90 days preceding clinic attendance, 79 patients accounted for 743 hospital bed days The implementation of a multidisciplinary clinic for patients with decompensated cirrhosis, in line with BSG outpatient care guidelines, resulted in significant reductions in hospital bed days, admission frequency, and length of stay. The integration of hepatology, nursing, allied health, palliative care, and addiction services facilitated proactive management of complications and reduced hospital dependency. These findings support the efficacy of structured MDT outpatient models in improving care quality and reducing healthcare burden in advanced liver disease and demonstrate its practicality in a DGH setting.

Next Steps

The creation of a strategic business proposal which fully appreciates the cost analysis of job planned roles for each of the MDT members to provide a stable and long-term future for the clinic. Given the alignment with the NHS 10-year plan and Trust objective's we see the potential for significant benefits.

Future Work

Alongside this work is the expansion of an ACP-led ambulatory pathway which bridges the gap between inpatient and MDT clinic offering a same day service to streamline patients to an ambulatory pathway which avoids admission and further strengthens the reduction in bed days, admissions, readmissions, whilst providing care closer to home – An exciting project with clear cost effectiveness if supported.

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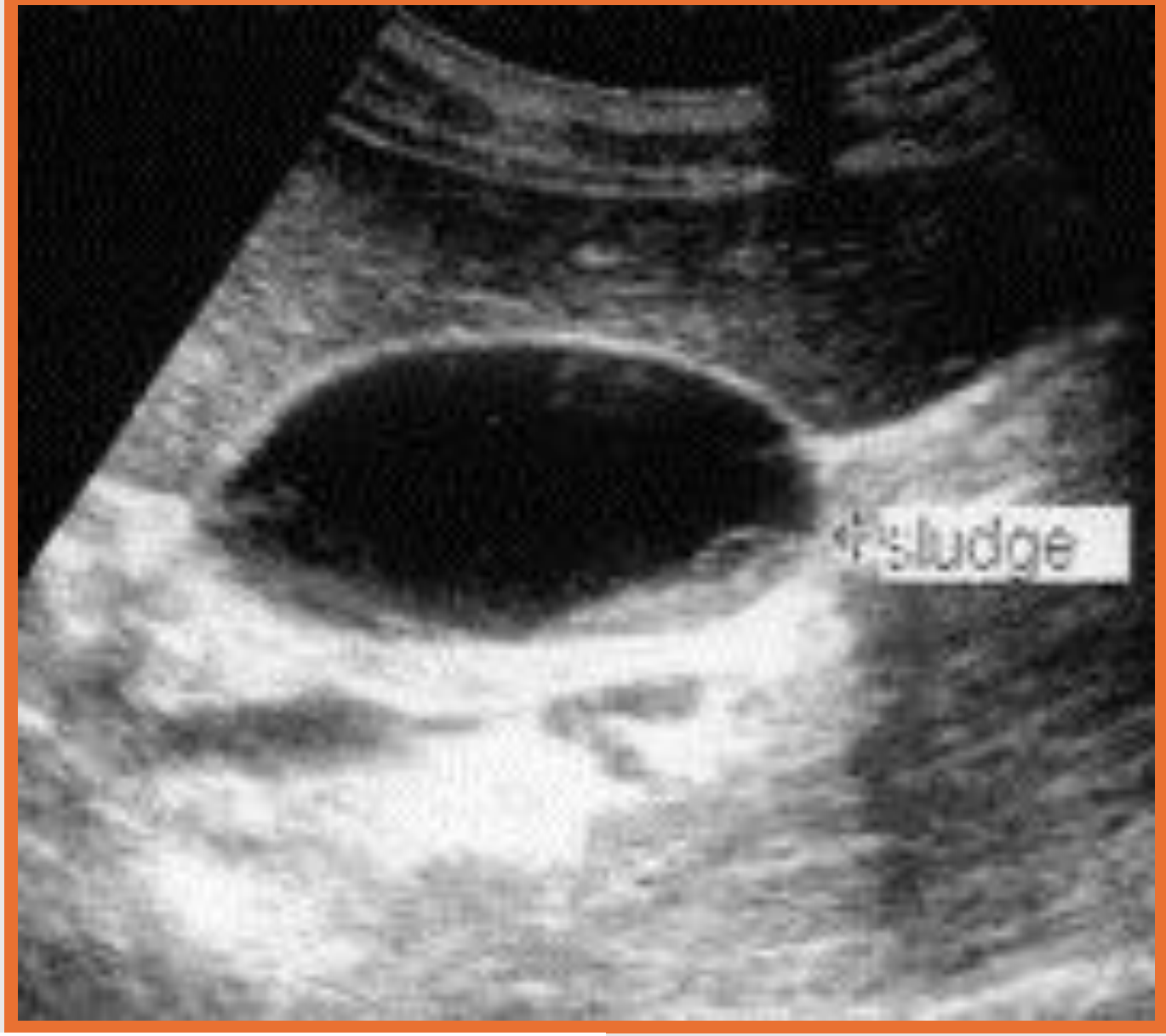
Any Questions

Any Questions?

Towards validation of MRI in the quantification of biliary microlithiasis burden

Dr Hannah Rickman

Bournemouth University



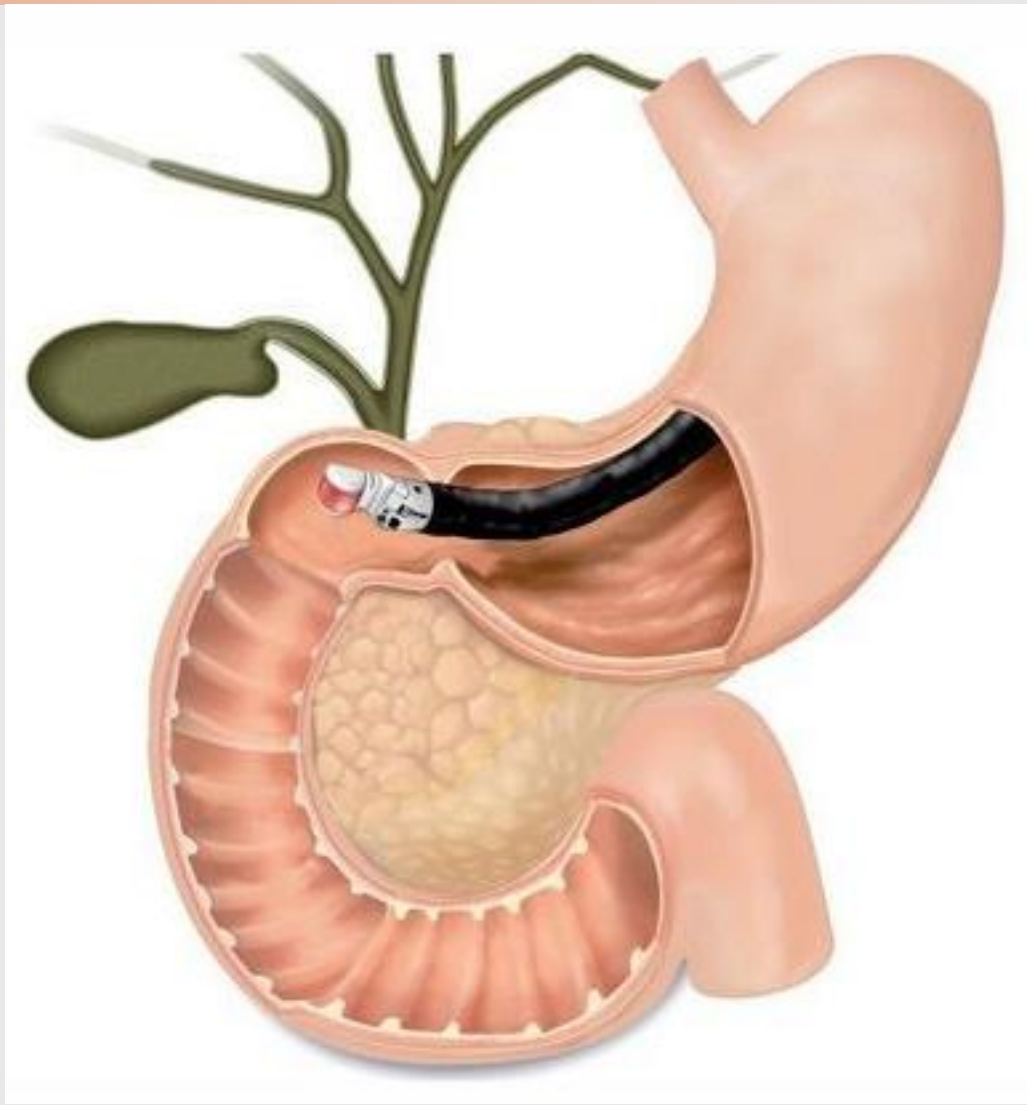
Jüngst et al. (2006) *Best Practice & Research Clinical Gastroenterology*, **20**, 6, 1053

Gallbladders: the problem

Biliary microlithiasis: presence of **small stones** or ‘sludge’ in the **gallbladder**.

- Can cause **pain**, **inflammation** and **acute pancreatitis**.
- Treatment is removal of the gallbladder.
- >60,000 gallbladders removed in the UK each year.

Diagnosis: **endoscopic ultrasound** is favoured by 93% clinicians.[1]



www.pacehospital.com/endoscopic-ultrasound-eus-procedure

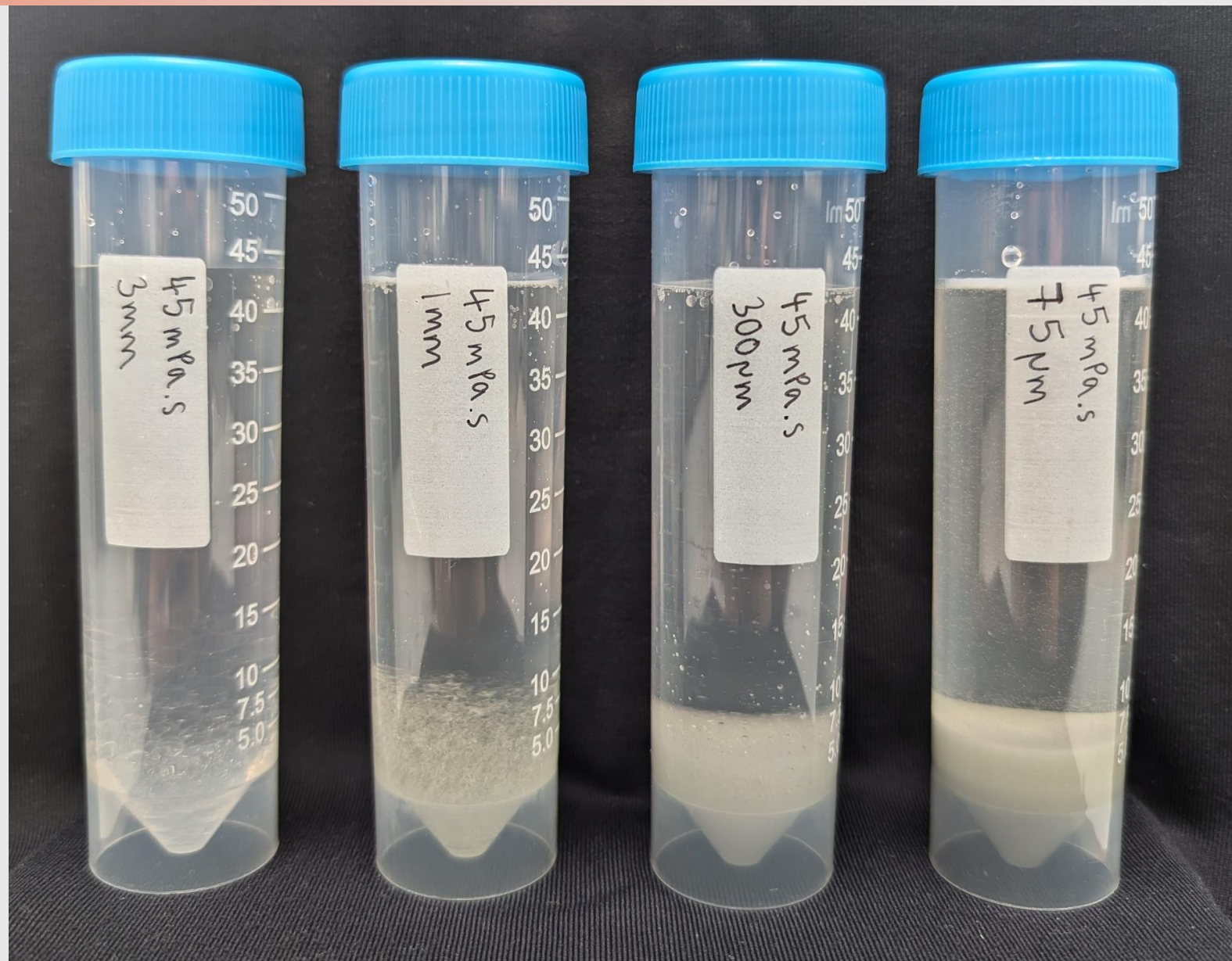
1. M. Żorniak et al. (2023), *Gut*, **72**, 1919-1926.

Research aim

MRI is not yet validated for the diagnosis of biliary microlithiasis.

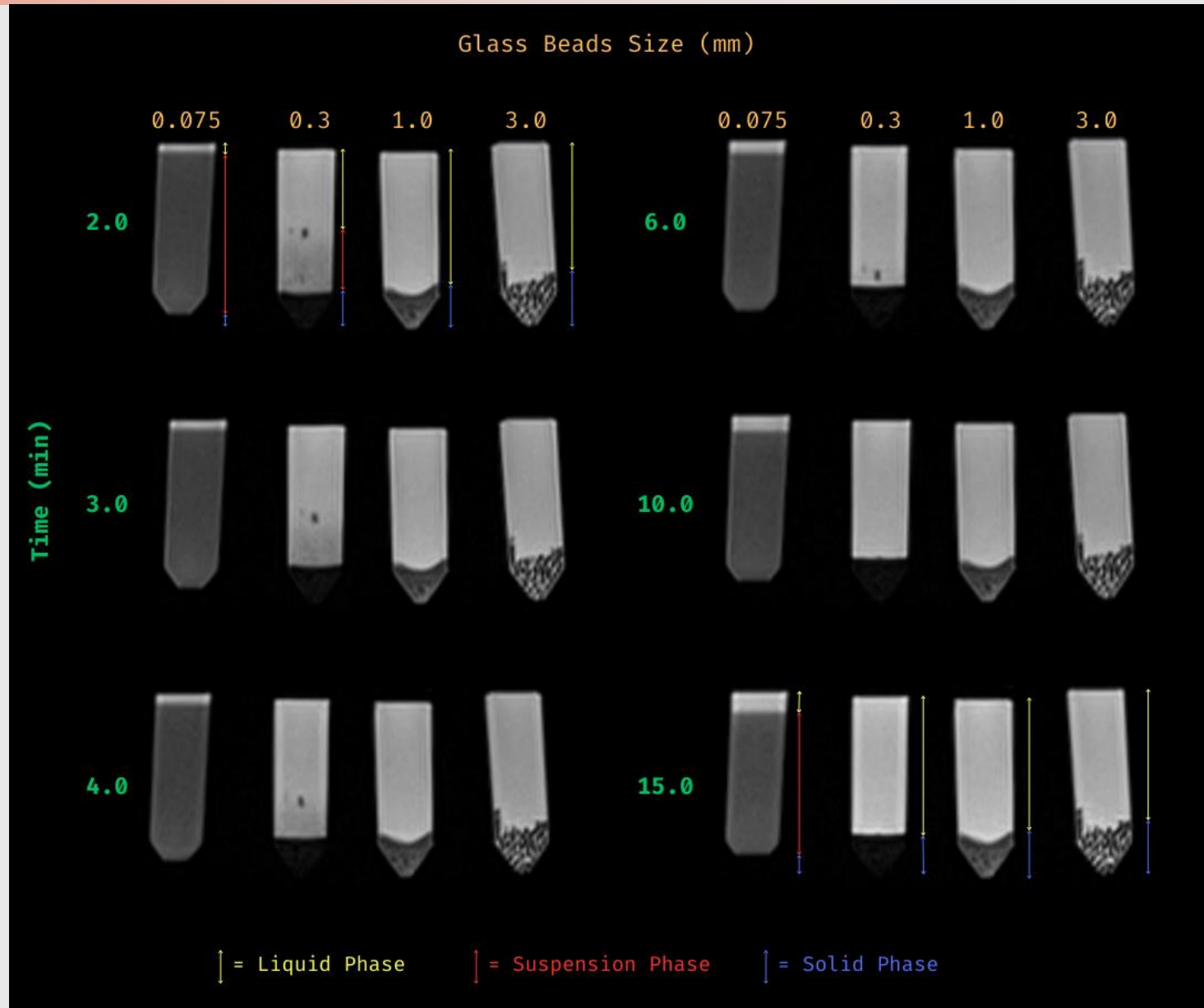
We aim to demonstrate that the gradient seen across gallbladders in MRI scans is caused by the **settling of particles.**

So that this observation can be used to diagnose biliary microlithiasis.



Initial observations

- Phantoms containing the smallest particles separated into three phases:
  - Liquid
  - Suspension
  - Solid
- **Suspension intensity appears to correlate with total particle mass**
- **Used to quantify biliary microlithiasis burden?**



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- Karen Hau
- Lorna Smith

Volatile Organic Compounds as Diagnostic Biomarkers of Skin Cancer

Research Team

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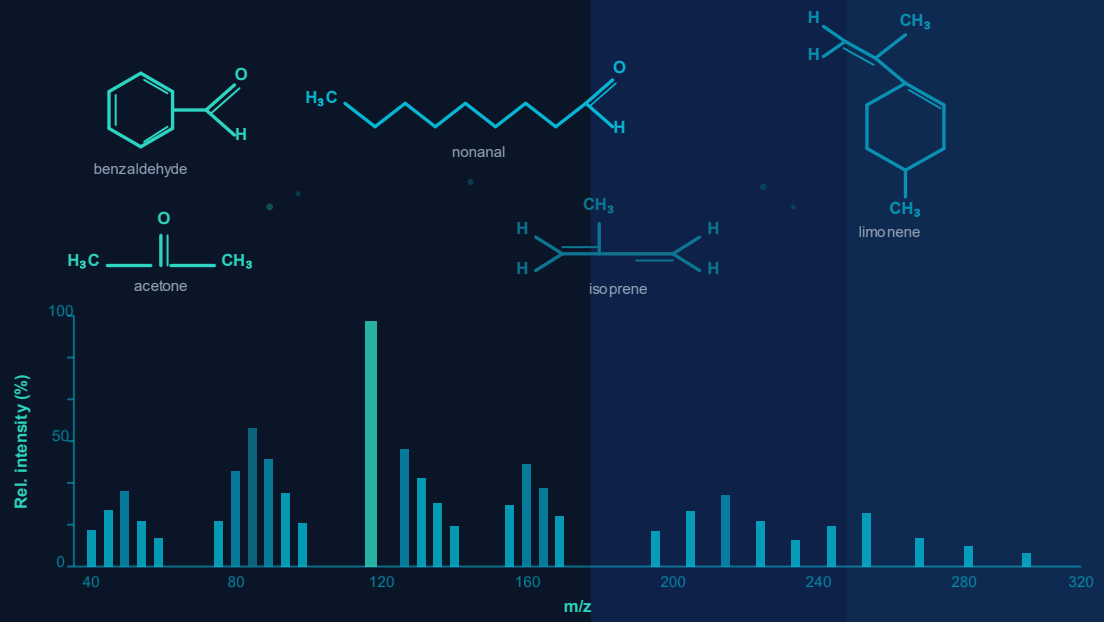

Skin Cancer Detection - Current status

Current Diagnosis Challenge

Diagnosis currently relies on GP visual assessment of skin abnormalities, followed by specialist referral for biopsy. This process is:

- Time consuming and over-reliant on visual analysis
- Biopsy is painful and invasive
- Early-stage cancers have varying visual presentations, raising mis-diagnosis risk

Early detection, particularly for cSCC is critical.

200,000

people diagnosed with skin cancer each year in the UK

500,000

referrals to dermatologist for suspected skin cancer annually

High referral rates create backlogs in specialist care

Efficient and effective triage of potential skin cancers is required in primary care

Our research: From pilot study to 3 year trial

VOC Sampling Technology - Biomarker validation - Sensor development

Skin cancer sites release odorous volatile organic chemicals (VOCs). These can be collected and analysed to chemically profile skin cancers. We developed a portable, non-invasive sampling process to collect a wide range of skin cancer biomarkers, tested on cancerous and healthy skin in a clinical study.

1 Phase 1

- Develop portable VOC sampling method
- Prove concept in pilot clinical study
- Discover initial biomarkers
- EJC Skin Cancer 2025*

2 Phase 2

- Validate biomarker discovery
- Large cohort (n=576) clinical study
- Within patient control group
- Healthy control group
- Benign lesion control group

3 Phase 3

- Multiple platform sensor development
- Selective detection of multiple VOCs
- Device integration & clinical validation

* Paul, Richard, et al. "Potential biomarkers of skin cancer diagnosis revealed through volatile metabolomics–A prospective research study." *EJC Skin Cancer* (2025): 100740.

The Vision

Point-of-Care Sensor for Rapid Skin Cancer Detection

Contact:
rpaul@bournemouth.ac.uk

Improving patient triage for skin cancers

Development of a selective cancer VOC sensor, deployed in primary care, could transform how skin cancer is detected — earlier, faster, and non-invasively. Initial results have already revealed volatile organic compounds as promising diagnostic biomarkers.

New insights

Our VOC sampling technique reveals a wider range of markers providing insight into skin cancer metabolomics

Non-invasive

VOC sampling is non-invasive and comfortable for patients

Improving triage

Referral rates to specialist care are high. More effective triage is required

Improving outcomes

Poor outcomes are associated with late or misdiagnosis of SCC in particular.

Outcomes are good when skin cancers are caught early.

A collaborative research study made possible through BU & UHD collaboration

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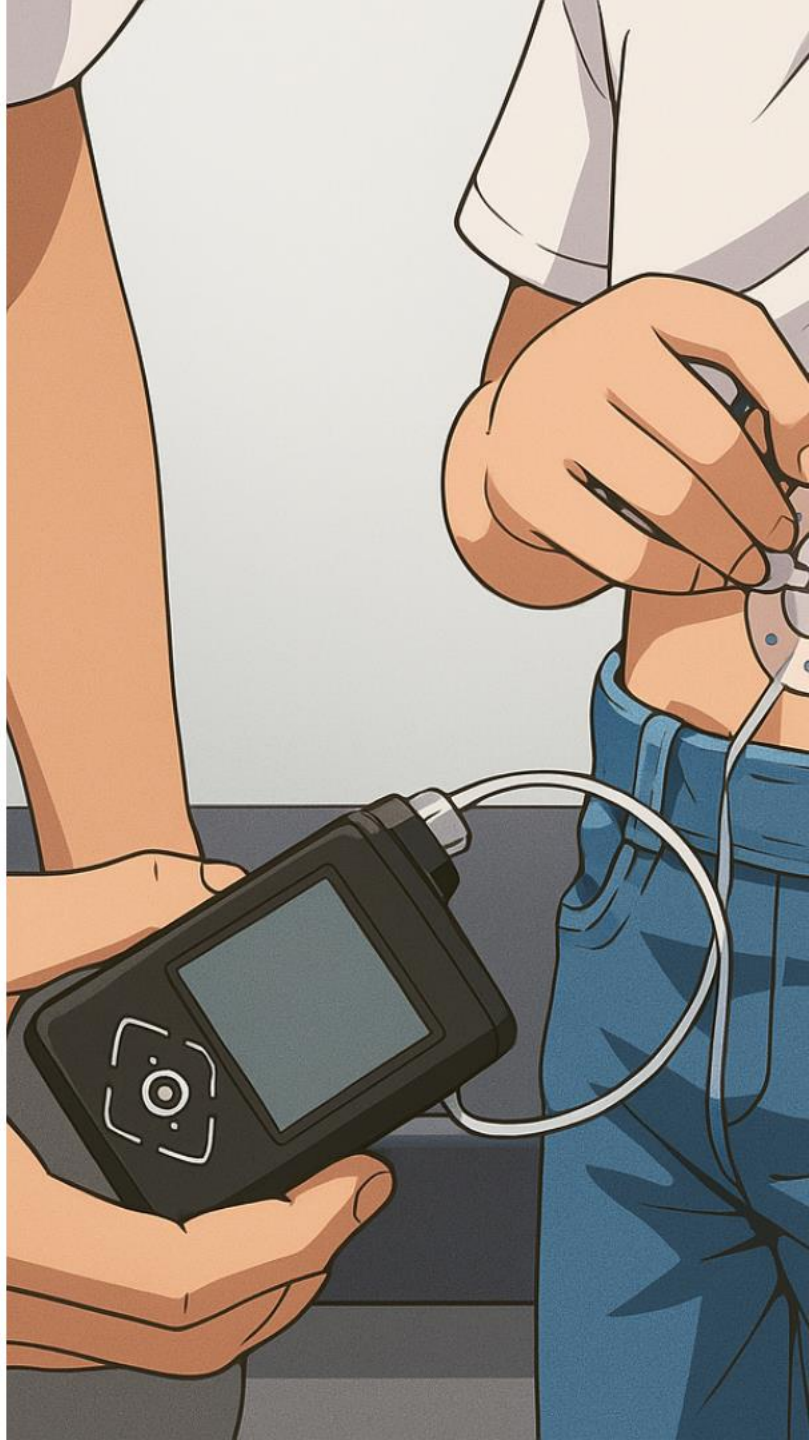
Comparing Glycaemic Outcomes in Pump-Naïve and Experienced Users Starting Hybrid Closed-Loop Therapy

Thomas Behan, Emma Jenkins, Helen Partridge, Jo Kunzi
University Hospitals Dorset

Does prior insulin pump experience influence glycaemic outcomes following initiation of hybrid closed-loop (HCL) therapy in adults with type 1 diabetes?



Methods

Study Design
Observational cohort study
Adults with type 1 diabetes initiating HCL therapy

Participants
- 97 participants included in analysis
- Pump-experienced (“Onboard”): n = 44
- Pump-naïve: n = 53

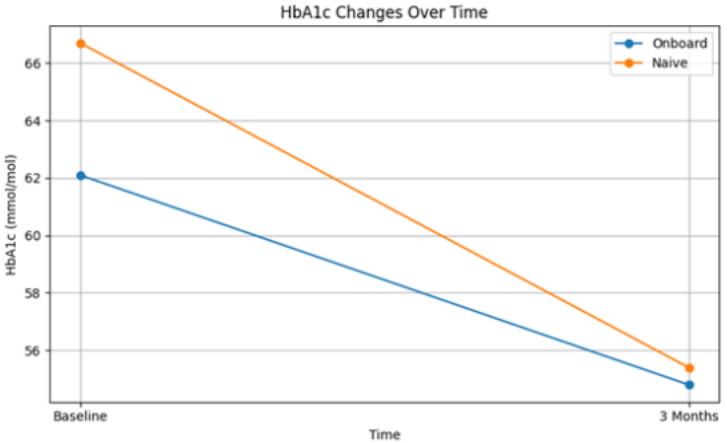
Outcomes (baseline → 3 months)
- HbA1c
- Time in Range
- Glucose variability (CV)

Analysis
Linear mixed-effects models

Results

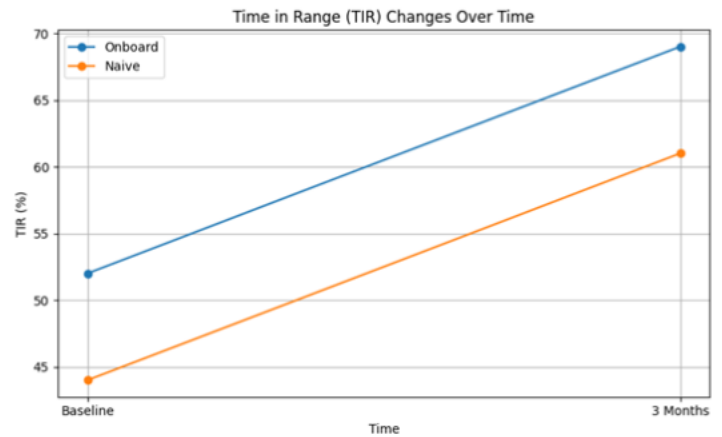
HbA1c
HbA1c improved in both groups

- Onboard: 62.1 → 54.8
- Pump-naïve: 66.7 → 55.4
- No difference in rate of change



Time in Range
Time in Range increased by 17% in both groups

- Onboard: 52% → 69%
- Pump-naïve: 44% → 61%



Glucose variability
CV improved in onboard users (38% to 36%) but remained unchanged in pump naive participants (37%).

Conclusion

- Hybrid closed-loop therapy leads to improvements in HbA1c and TIR for both pump-naïve and experienced users
- Pump-naïve individuals achieve outcomes comparable to existing pump users, supporting equitable access to HCL
- Findings help optimise clinical pathways and support expansion of structured education at HCL initiation
- Broader HCL adoption may improve safety, reduce complications, and enhance patient experience

Any Questions?

IMPACT OF MODE OF BIRTH AND PERINATAL ANTIBIOTICS ON INFANT GUT MICROBIOTA AND HEALTH

PRESENTED BY DR HEIDI SINGLETON

BACKGROUND

RESEARCH OBJECTIVE

To evaluate how mode of birth and perinatal antibiotic exposure, independently and together, influence infant gut-microbiota composition, diversity, and early health outcomes.

METHODS

ELIGIBILITY CRITERIA

FOR A SYSTEMATIC REVIEW AND META-ANALYSIS

STUDY TYPES

- Randomized Controlled Trials
- Cohort Studies
- Case-Control Studies

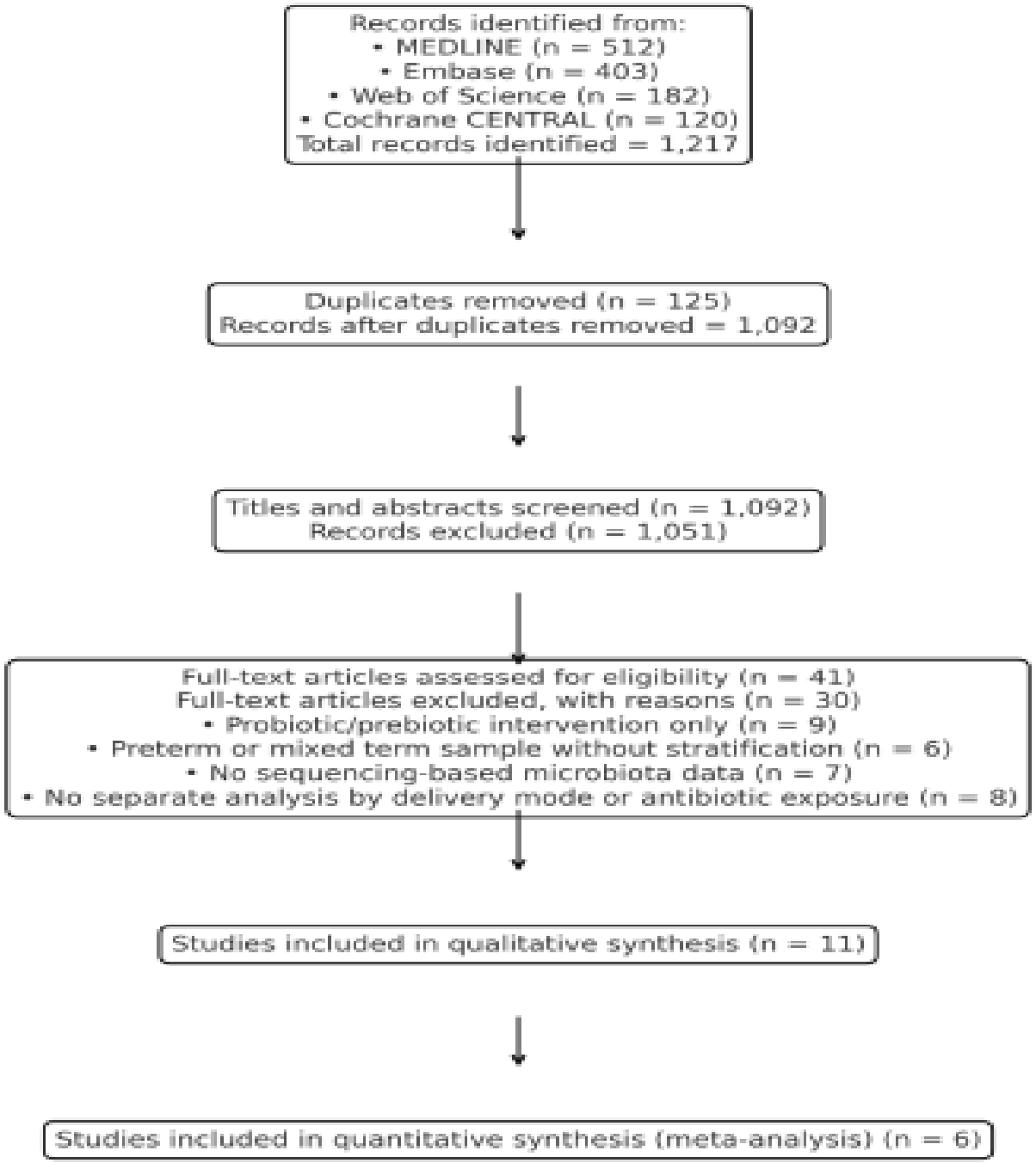
POPULATION

Healthy Term Infants

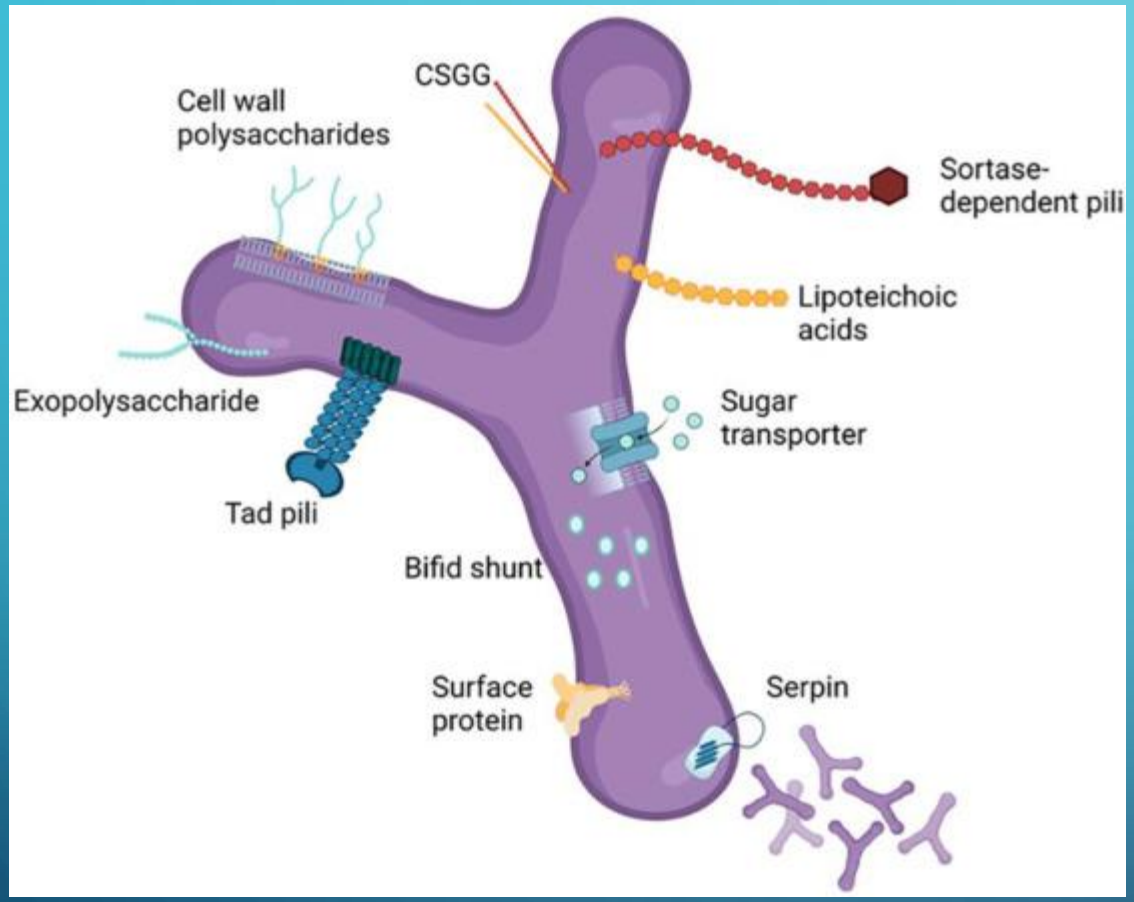
FOCUS AREAS

Birth vs. Cesarean Birth

RESULTS


Records identified from:
• MEDLINE (n = 512)
• Embase (n = 403)
• Web of Science (n = 182)
• Cochrane CENTRAL (n = 120)
Total records identified = 1,217
Duplicates removed (n = 125)
Records after duplicates removed = 1,092
Titles and abstracts screened (n = 1,092)
Records excluded (n = 1,051)
Full-text articles assessed for eligibility (n = 41)
Full-text articles excluded, with reasons (n = 30)
• Probiotic/prebiotic intervention only (n = 9)
• Preterm or mixed term sample without stratification (n = 6)
• No sequencing-based microbiota data (n = 7)
• No separate analysis by delivery mode or antibiotic exposure (n = 8)
Studies included in qualitative synthesis (n = 11)
Studies included in quantitative synthesis (meta-analysis) (n = 6)

QUANTITATIVE & NARRATIVE SYNTHESIS



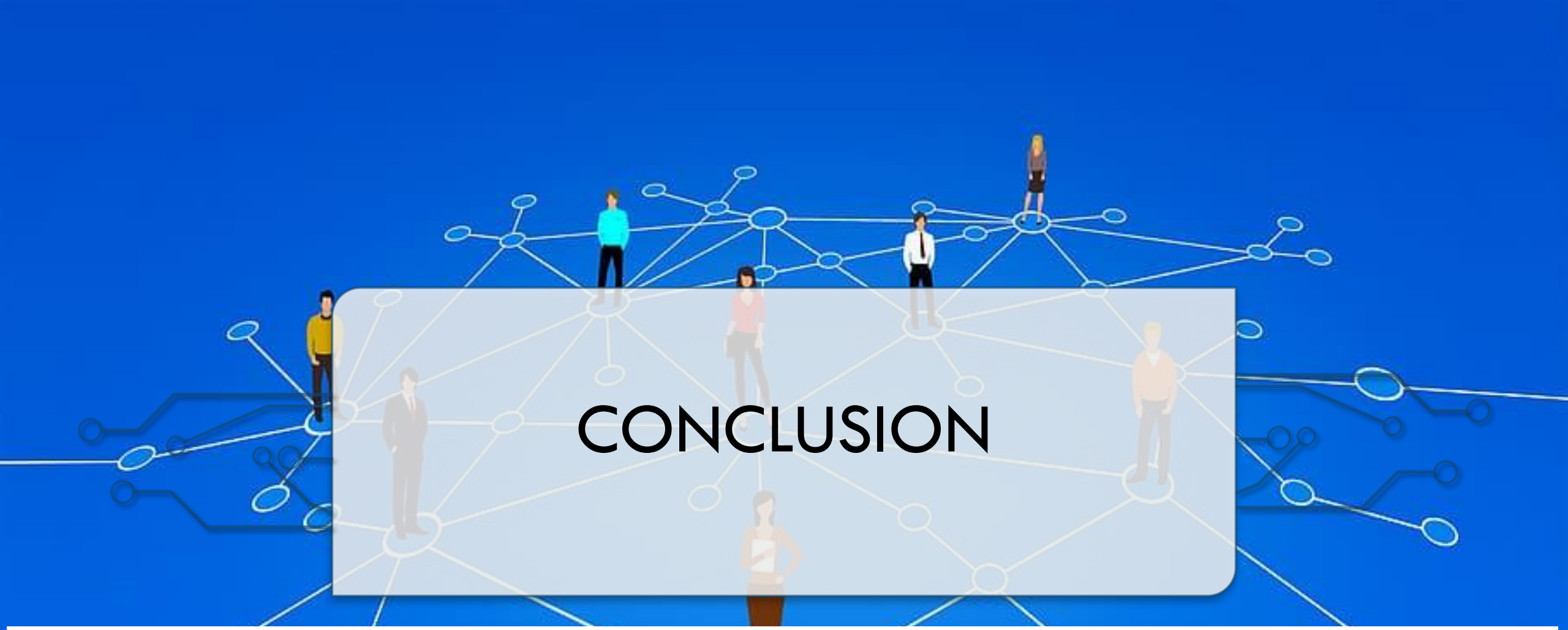
Trend towards higher bacterial abundance in vaginally delivered infants (where no antibiotics were given)

BREASTFEEDING AND INFANT OUTCOMES

Exclusive breastfeeding beyond 12 weeks strongly predicted microbial recovery.

DISCUSSION POINTS

Timing of administering antibiotics must be considered more carefully



Guyatt GH, Oxman AD, Vist GE, Kunz R, Falck-Ytter Y, Alonso-Coello P, et al. GRADE: An emerging consensus on rating quality of evidence and strength of recommendations. BMJ. 2008 Apr 26;336(7650):924-6.

National Institute for Health and Care Excellence. Intrapartum care for women with existing medical conditions or obstetric complications and their babies (NG121). London: NICE; 2021.

Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. BMJ. 2021 Mar 29;372:n71

Any Questions?

BOURNEMOUTH UNIVERSITY

2026 BU-NHS Conference

Moving Forwards Together

Fusion Building, Talbot Campus
16th April 2026

NHS

Afternoon Break

Exploring the experiences of people with type 1 diabetes and disordered eating (T1DE) when engaging with diabetes management information

Ariella Thompson

BU / UHD

Research focus and approach

Context

- Management of type 1 diabetes (T1D) is challenging and involves engaging with a lot of information
- Eating disorders are substantially more common among people with T1D – the co-morbidity is called **T1DE**
- Inherent tension between eating disorders and diabetes management

So, how do people with T1DE experience and engage with the diabetes management information upon which they depend?

Approach

- Person-centred, exploratory
- Qualitative
- Preliminary mixed-method questionnaire > sources and engagement
- Primary unstructured interviews > in-depth experiences

Findings

- Personal diabetes information ecosystems comprised of similar information source categories – peers (largely via social media), specialist and non-specialist healthcare professionals, and diabetes content from charities or other websites – but engaged with in highly individualised ways.
- Engagement with diabetes information constitutes a form of emotional and cognitive labour.
- Recognition of lived-experience complexity makes information usable.
- Past or present experiences of T1DE exacerbate informational vulnerability > recognition less likely + more emotional and cognitive labour. But participants demonstrated marked agency in engagement.

What does this mean for practice?

- Agency-supportive, co-created information environments.

NHS
Dorset County Hospital
NHS Foundation Trust

Patient survey of Hydrotherapy services

Hannah Williams
Specialist Physiotherapist

Healthier lives Empowered citizens Thriving communities

Background and Methods

Dorset County Hospital
NHS Foundation Trust

NHS Hydrotherapy (aquatic physiotherapy) services have seen a growing and worrying trend of pool closures in recent years. At Dorset County Hospital (DCH) we are fortunate to have a hydrotherapy pool and service running providing hydrotherapy for numerous patient groups.

- **Research question:** The aim of this audit was to survey patients who had completed a course of hydrotherapy to gather their experience of the service to help guide service improvement and capture the patient voice.
- **Method:** 100 patients identified who had completed hydrotherapy were sent a survey co created with the patient experience team.

1	How would you rate the service you received during your course of hydrotherapy treatment?	5 (best service)
		4
		3
		2
		1 (worst service)
2	Please tell us why you gave this number	Comment
3	How would you rate the facilities within the hydrotherapy department?	5 (excellent)
		4
		3
		2
		1 (poor)
4	Please tell us why you gave this number	Comment
5	Was your course of hydrotherapy treatment effective in helping you with the reason you were referred (EG pain reduction, increase strength etc)	Yes
		No
		other
6	Following your course of hydrotherapy have you returned to your normal day to day activities and/or recreational exercise?	Yes
		No
		Other
7	Following your course of hydrotherapy have you increased your daily activity and/or exercise levels?	Yes
		No
		Other

Results

Dorset County Hospital
NHS Foundation Trust

We received 36 responses out of 99 through both paper copies and electronically.

Results
97% of patient rated the service they received as excellent.
50% of patients rated the facilities as excellent.
92% of patients reported that hydrotherapy was effective in treating their condition.
56% of patients reported that they had returned to their day-to-day activities/and or recreational exercise.
69% of patients reported that they increased their activity levels after a course of hydrotherapy.

Common themes in patients written feedback included **long waiting lists** and then **too long in between appointments**, **outdated and old facilities** and felt needed **more appointments**.

Conclusion/next steps

Dorset County Hospital
NHS Foundation Trust

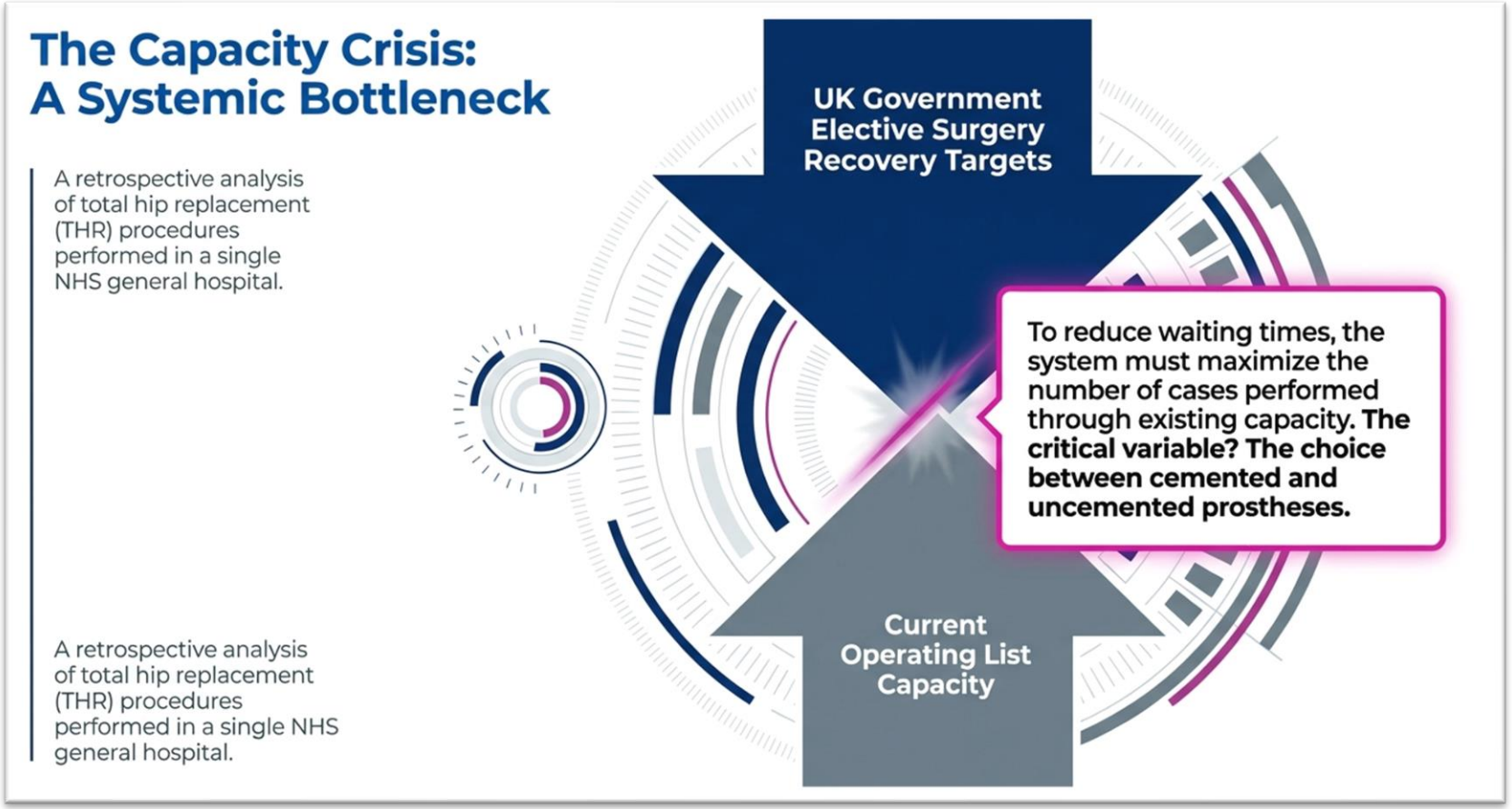
Actions following results • New shower panels fitted. • Increase in clinical staff 0.2 WTE. • Trialling 'block' booking patients to ensure frequent appointments.	**Conclusion** • Patients reported high levels of satisfaction within the hydrotherapy service at DCH.. • Patient reported clinical effectiveness was 92%. • Results suggest an increase in patient activity levels following hydrotherapy.
Reflections and Learning • The survey will be reviewed prior to a second roll out, including clearer wording on activity related questions and include demographic data to enhance interpretation of findings	**Next steps** • Refine survey and repeat. • **Implement use of a standardised outcome measure to all patients pre and post hydrotherapy treatment to assess the clinical effectiveness of hydrotherapy.**

Cemented vs. Uncemented Total Hip Replacements using Routinely Collected Hospital Data

Tom Wainwright, Richard Matko, Tikki Immins, Robert Middleton

ORIBU Orthopaedic Research Institute Bournemouth University

Background



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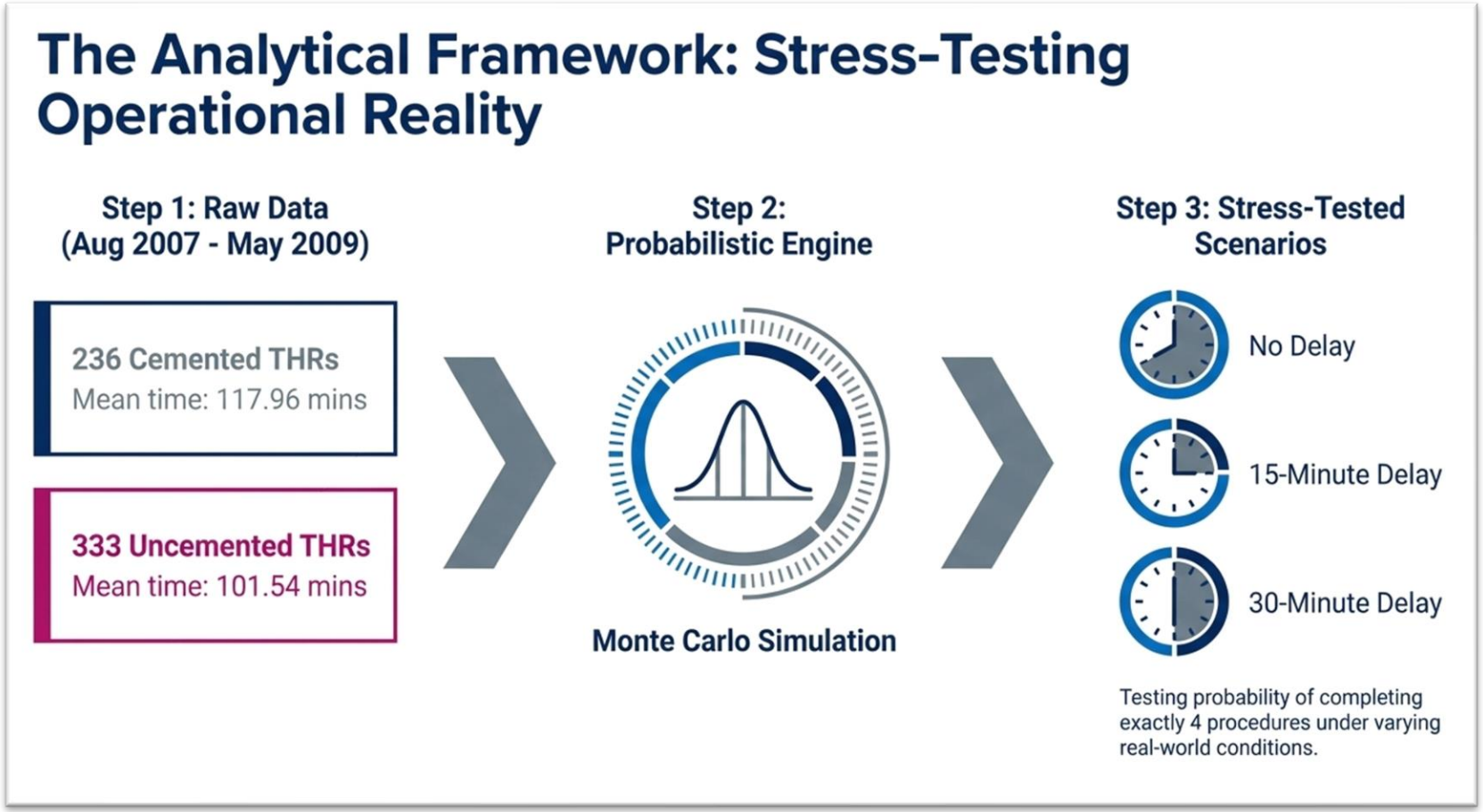
Methods



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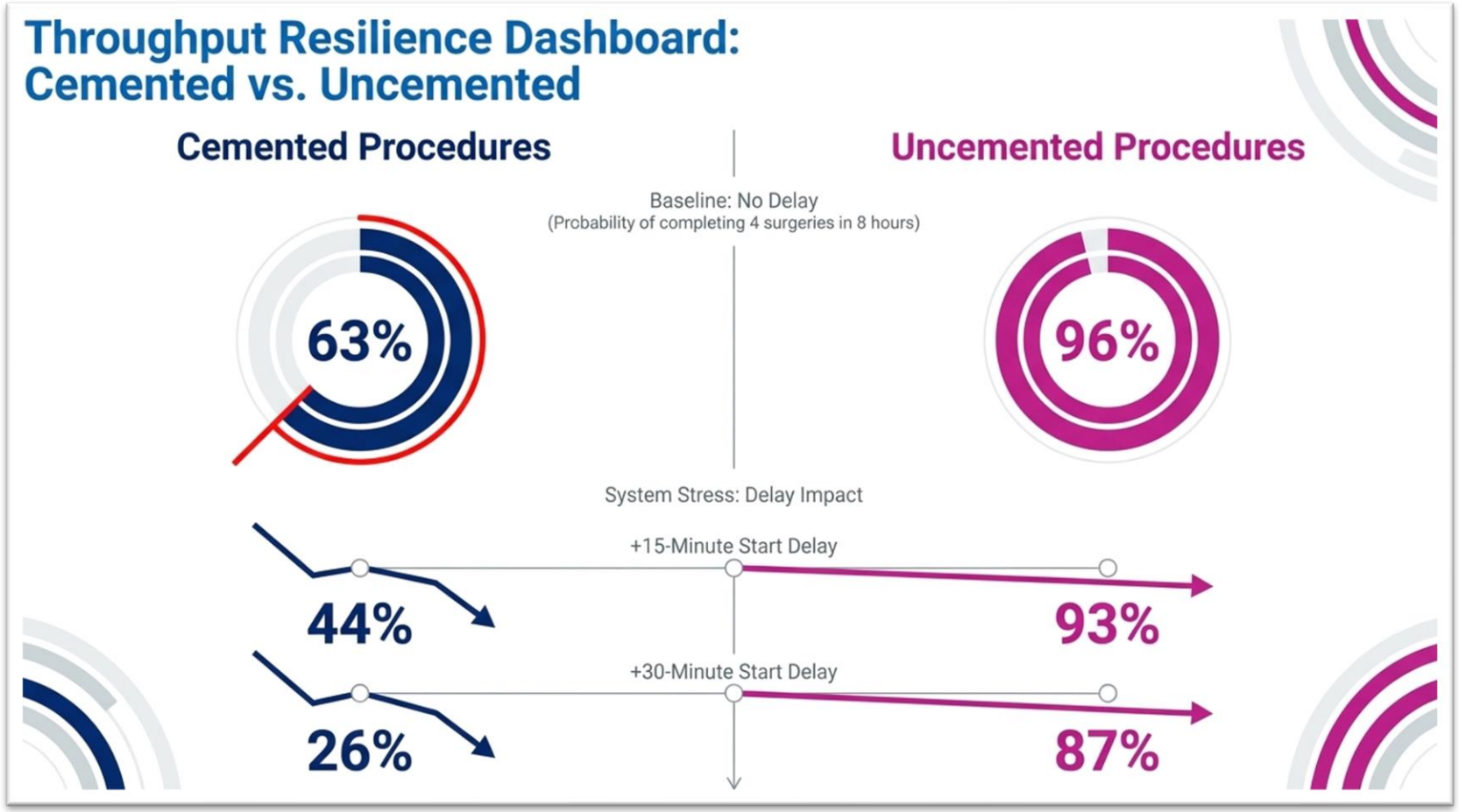
Findings



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Conclusion

The Systemic Solution for Elective Recovery

Clinically Suitable Uncemented Prostheses

Existing 8-Hour Operating Capacity

Increased Throughput & Reduced NHS Waitlists

Uncemented procedures act as an operational shock absorber. By adopting uncemented prostheses where clinically appropriate, hospitals can drastically increase case completion rates and effectively tackle the capacity crisis without requiring additional theatre time.

Professor Robert Middleton
Consultant Orthopaedic Surgeon, University Hospitals Dorset
Professor of Orthopaedics and Head of ORI

robert.middleton6@nhs.net
rmiddleton@bournemouth.ac.uk

ORIBU Orthopaedic Research Institute Bournemouth University

Any Questions?

Dorset County Hospital
NHS Foundation Trust

Is Patient-Initiated Follow-Up (PIFU) the future for Urology Outpatient Appointments (OPA)?

Dr Suraiya van den Bos

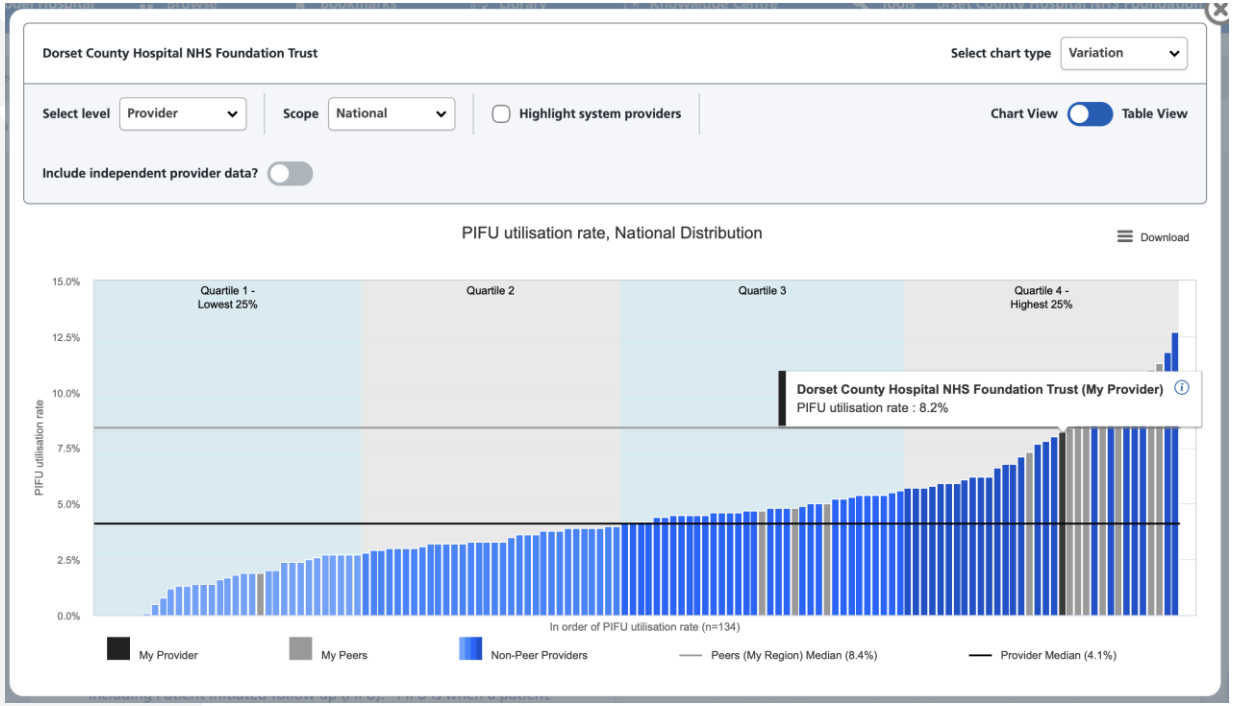
Background

7.5 million patients currently waiting for OPA [1]

Dorset County Hospital (DCH) is leading nationally in utilising PIFU [2]

Patient initiates appointment when needed, based on symptoms and individual circumstances [3]

Give patients and carers flexibility to arrange their follow-up appointment



GOV·UK

Home > Health and social care

Press release

PM sets out plan to end waiting list backlogs through millions more appointments

Millions of patients will be able to access more appointments closer to home and get the treatment they need faster under a new plan to tackle hospital backlogs.

Aim

Assess the effectiveness of PIFU in improving clinic waiting times

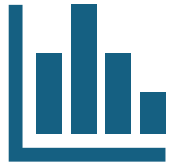
Identify patients suitable for this service

Patients & Methods

Single-centre, retrospective data of 121/1687 adult urology patients

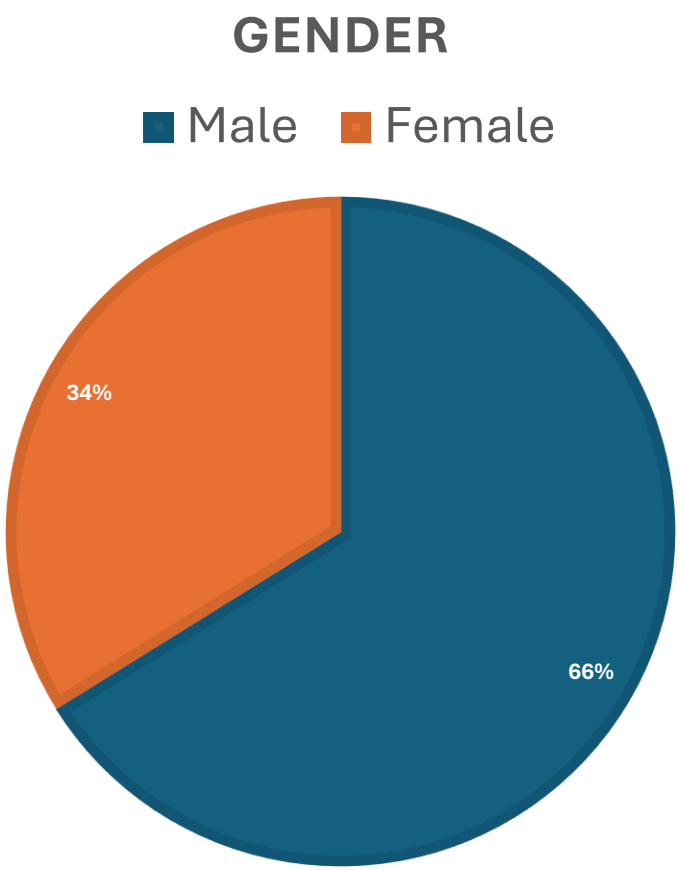
Offered PIFU

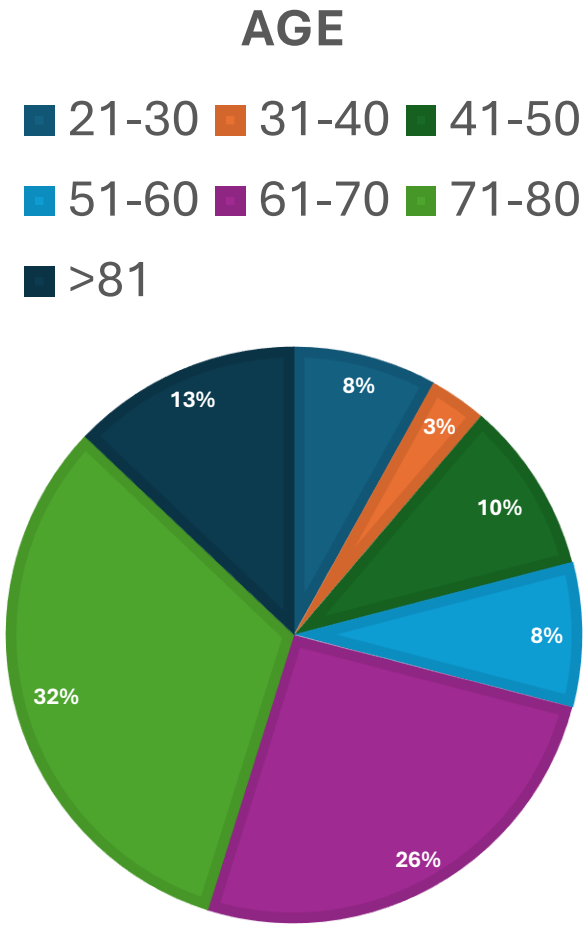
1st May to 30th June 2025



62/121 analysed

Patients & Methods

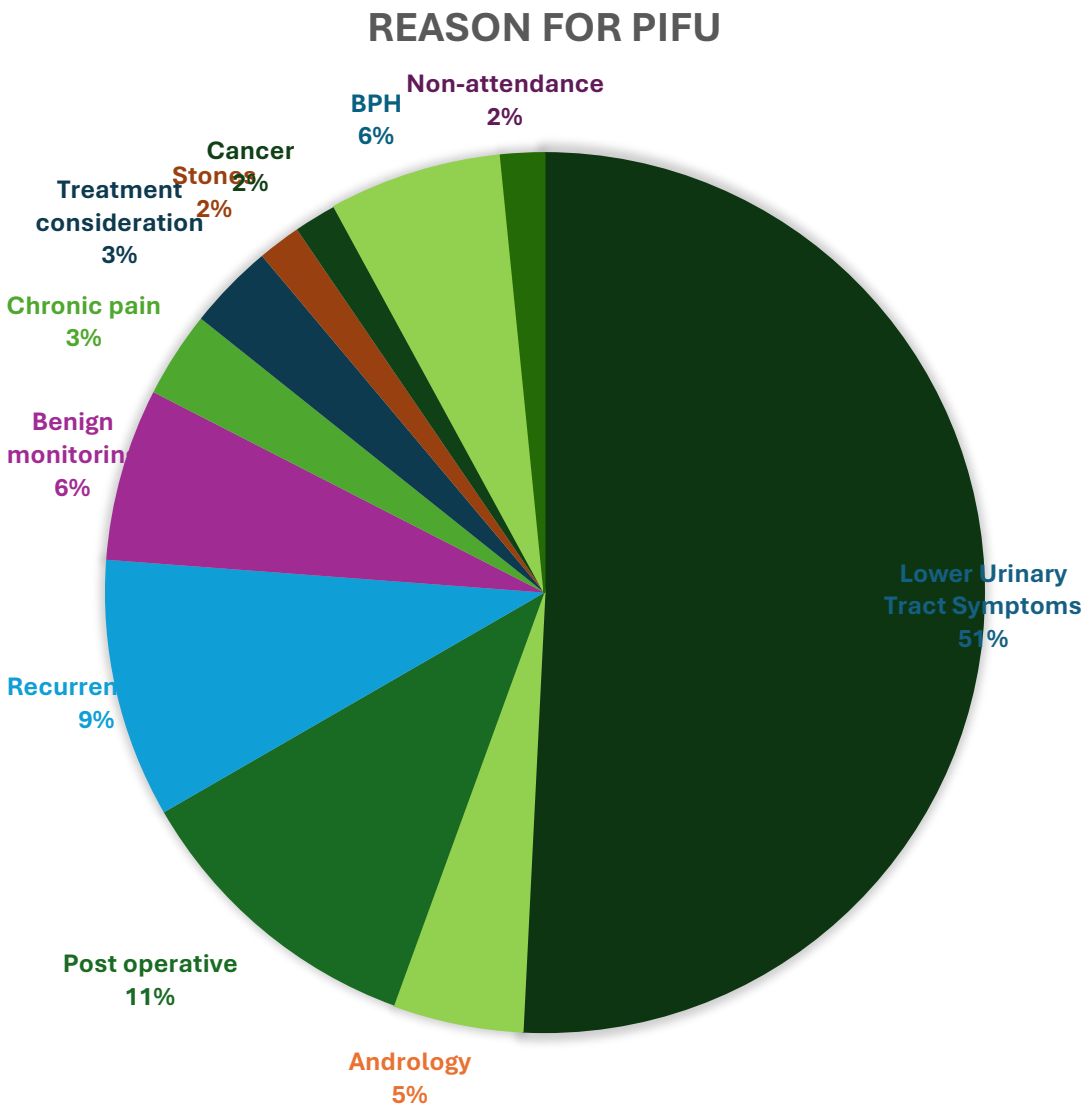




Results

7.2% (n=121) of all urology patients were offered PIFU

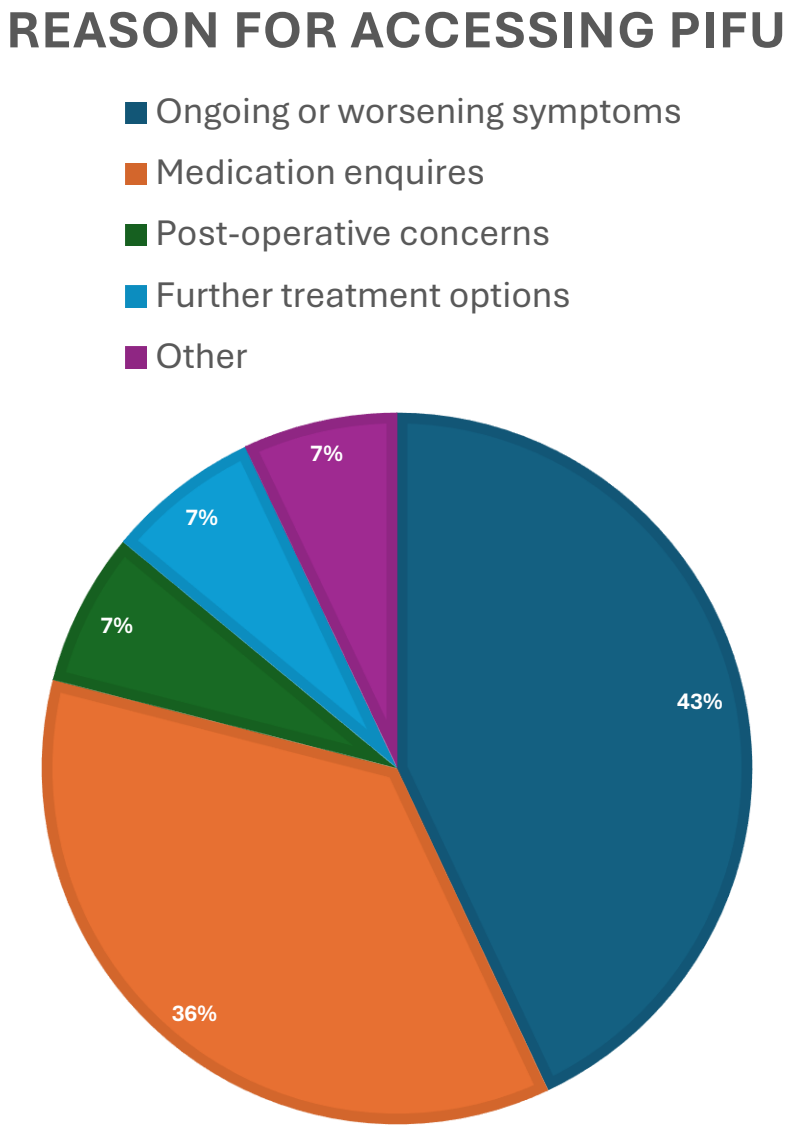
32 were diagnosed with LUTS, 10% with recurrent UTIs, and 11% for post-operative concerns, remaining 27% for surveillance reasons (n = 62/121)



Results

25% of patients utilised PIFU in 6 months

Females more likely to access service, 29% to 20%, respectively



Conclusion

PIFU is a realistic option in suitable patients with benign conditions in addressing NHS waiting times

Preliminary data provided regarding patient suitability

Benefit from a larger national service evaluation to provide advice for all trusts accessing this platform safely

Thank you!

References

1. https://www.gov.uk/government/news/pm-sets-out-plan-to-end-waiting-list-backlogs-through-millions-more-appointments#:~:text=Tackling%20the%207.5million%20strong,inefficiencies%20or%20inconsistencies%20in%20care

2. https://model.nhs.uk/compartments/43e2cd1a-c59e-4c7f-bc86-2a5d8db9830e/subcompartments/07e19170-231c-4c01-9648-7e0592eae01a

3. https://www.england.nhs.uk/outpatient-transformation-programme/patient-initiated-follow-up-giving-patients-greater-control-over-their-hospital-follow-up-care/

Any Questions?

Developing One NHS in Dorset

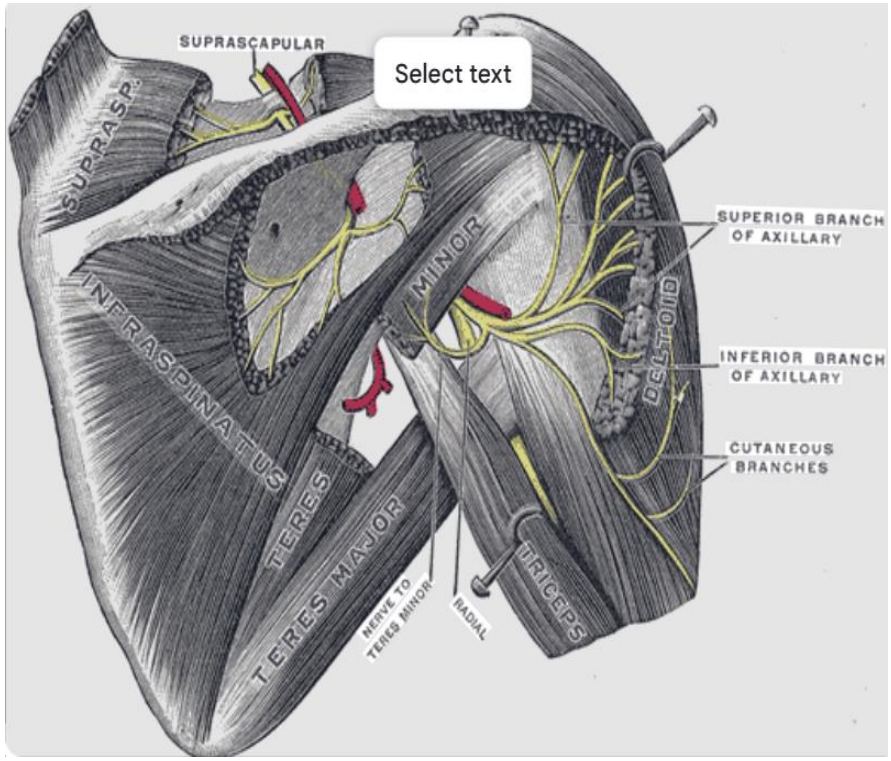
Suprascapular Nerve Blocks; A system wide approach

NHS University Hospitals Dorset NHS Foundation Trust

NHS Dorset County Hospital Dorset HealthCare

The Problem

Patients living in Dorset with chronic inoperable shoulder pain faced up to 2 years wait for an ultrasound guided suprascapular nerve block (SSNB) to be administered in the Dorset Pain Management Service (DPMS).



The Aim

To upskill advanced practitioners and orthopaedic consultants from all Dorset NHS Trusts to deliver a landmark guided SSNB in a high-volume, low complexity clinic, achieving competency to provide a new service to patients across the MSK pathway in both community and acute care across Dorset. From hospital to community NHS England » Fit for the Future: 10 Year Health Plan for England

Emily Middleton ACP, Nikki Sharp Service Manager, Greg Bicker ACP

NHS Dorset County Hospital
Dorset HealthCare

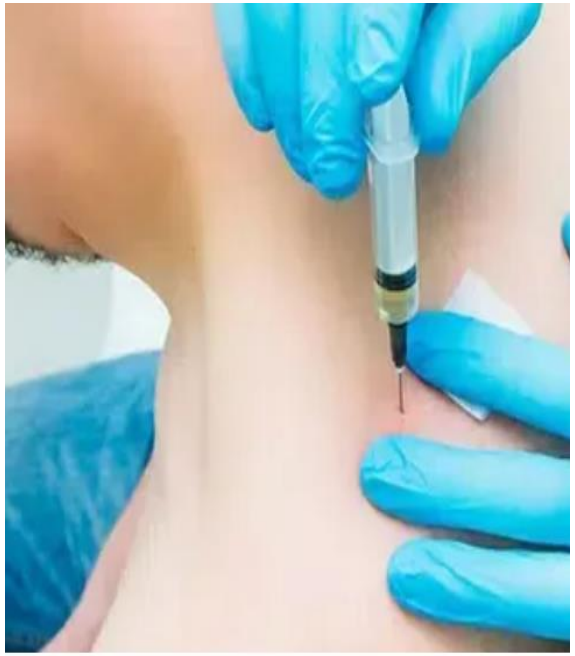
The Dorset Multi-Disciplinary Team

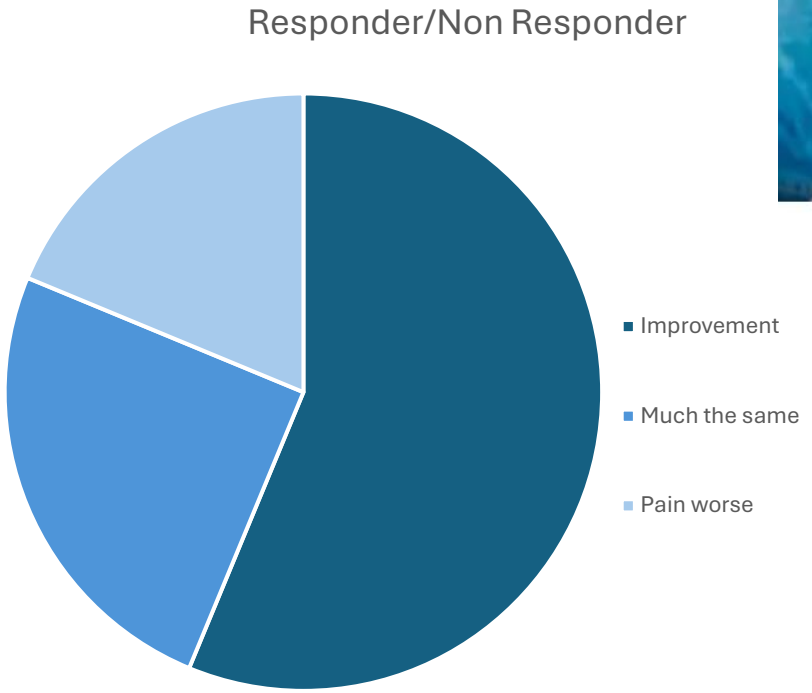
Consultant Orthopaedic Surgeons from UHD and DCH
Advanced MSK Practitioners from UHD and DHC
The Dorset Pain Management Service (DHC)

NHS
University Hospitals Dorset
NHS Foundation Trust

Results

56% felt improvement.
Patients can be referred for guided or ablation procedure for longer lasting results where clinically indicated.





Learning and Next Steps

- Chronicity and co-morbidity of patient cohort influences results at a pilot stage. Ongoing collaboration between stakeholders continues to shape the embedding of SSNB's into current community care, adding to patient choice, reducing avoidable delays in care and preventing chronic pain (Batten et al 2022) Suprascapular nerve blockage for painful shoulder pathology – a systematic review and meta-analysis of treatment techniques | The Annals of The Royal College of Surgeons of England
- 6-month impact data shown significant drop-in referral rate to pain management team from both acute trusts as technique embedded into clinics.
- Dorset wide referral pathway created to use in community services (DMSK) with broader pathology inclusion criteria.

Contact for further info
Emily.middleton4@nhs.net, nikki.sharp@nhs.net, greg.bicker@nhs.net

Impact of obesity on outcomes after total hip and knee replacement: A study on hospital length of stay and readmission rates in NHS Scotland

Presenter

Wissem Tafat

Supervisors

Prof. Tom Wainwright, Prof. Marcin Budka, Dr. David McDonald

ORIBU Orthopaedic Research Institute Bournemouth University

Introduction

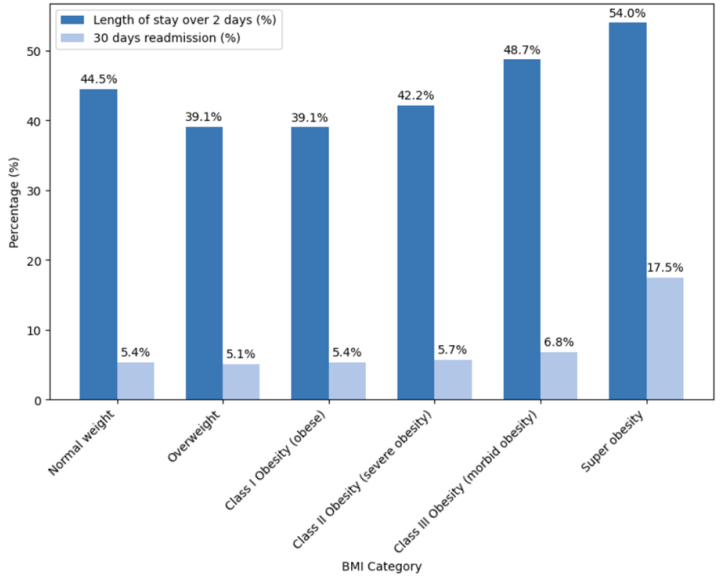
- Obesity is increasingly common among patients undergoing total hip replacement (THR) and total knee replacement (TKR).
- Higher BMI may affect postoperative recovery and place greater demand on hospital resources.
- This study examined whether higher BMI is associated with longer LOS and increased 30-day readmission in NHS Scotland.

Methodology

- Retrospective cohort study using anonymised NHS Scotland data.
- 48,705 primary THR and TKR patients from 22 hospitals.
- BMI analysed by category and using a clinically important threshold of BMI ≥ 40.
- **Study period**: July 2019 to February 2025.
- **Outcomes**: hospital LOS and 30-day readmission.
- **Analysis**: descriptive statistics, visualisation, and logistic regression.

Results

- Most patients were overweight or obese.
- Patients with BMI ≥ 40 had longer hospital stays.
- Odds of prolonged stay increased with rising BMI.
- 30-day readmission rates were highest in patients with severe obesity.



Length of Stay Over 2 Days and 30-Day Readmission Across BMI Categories

	Length of Stay				30 Days Readmission			
	Odds Ratio	95% CI Lower	95% CI Upper	p-value	Odds Ratio	95% CI Lower	95% CI Upper	p-value
40 ≤ BMI < 45	1.369	1.261	1.487	<0.001	1.289	1.011	1.643	<0.05
45 ≤ BMI < 50	1.578	1.305	1.908	<0.001	1.363	0.829	2.241	0.2
BMI ≤ 50	1.750	1.130	2.711	<0.001	2.784	1.174	6.601	<0.05

Odds Ratios for Length of Stay and 30-Day Readmission at Higher BMI Thresholds

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Conclusion

- Higher BMI, particularly BMI ≥ 40, is associated with poorer postoperative outcomes after THR and TKR.
- Patients with morbid and super obesity were more likely to experience prolonged LOS and higher readmission.
- These findings support more tailored perioperative planning for higher-risk patients in NHS Scotland.

Key numeric findings

Mean LOS

3.44 vs 3.02 days

BMI >= 40 vs BMI < 40

Long-stay odds

1.37 to 1.75x

from BMI 40-45 up to BMI >= 50

Readmission risk

2.78x odds

for BMI >= 50 compared with BMI < 40

ORIBU Orthopaedic Research Institute Bournemouth University

Thank you

Scan to read the paper

ORIBU Orthopaedic Research Institute Bournemouth University

Audit of MRI and bladder scanning for suspected Cauda Equina cases compared with GIRFT/NICE standards

February 2026

Dr. Omran Alkhatib, Dr. Bethany Mumby

Has the patient developed any of the following in the last 14 days?

- **New (≤ 14 days) or deteriorating** difficulty initiating micturition or impaired sensation of urinary flow
- **New (≤ 14 days) or deteriorating** altered perianal, perineal or genital sensation S2-S5 dermatomes – area may be small or as big as a horses' saddle (subjectively reports or objectively tested)
- Severe or progressive neurological deficit of both legs, such as major motor weakness with knee extension, ankle eversion, or foot dorsiflexion
- **New (≤ 14 days) or deteriorating** loss of sensation of rectal fullness
- **New (≤ 14 days) or deteriorating** sexual dysfunction (achievement of erection or ability to ejaculate, loss of genital sensation)

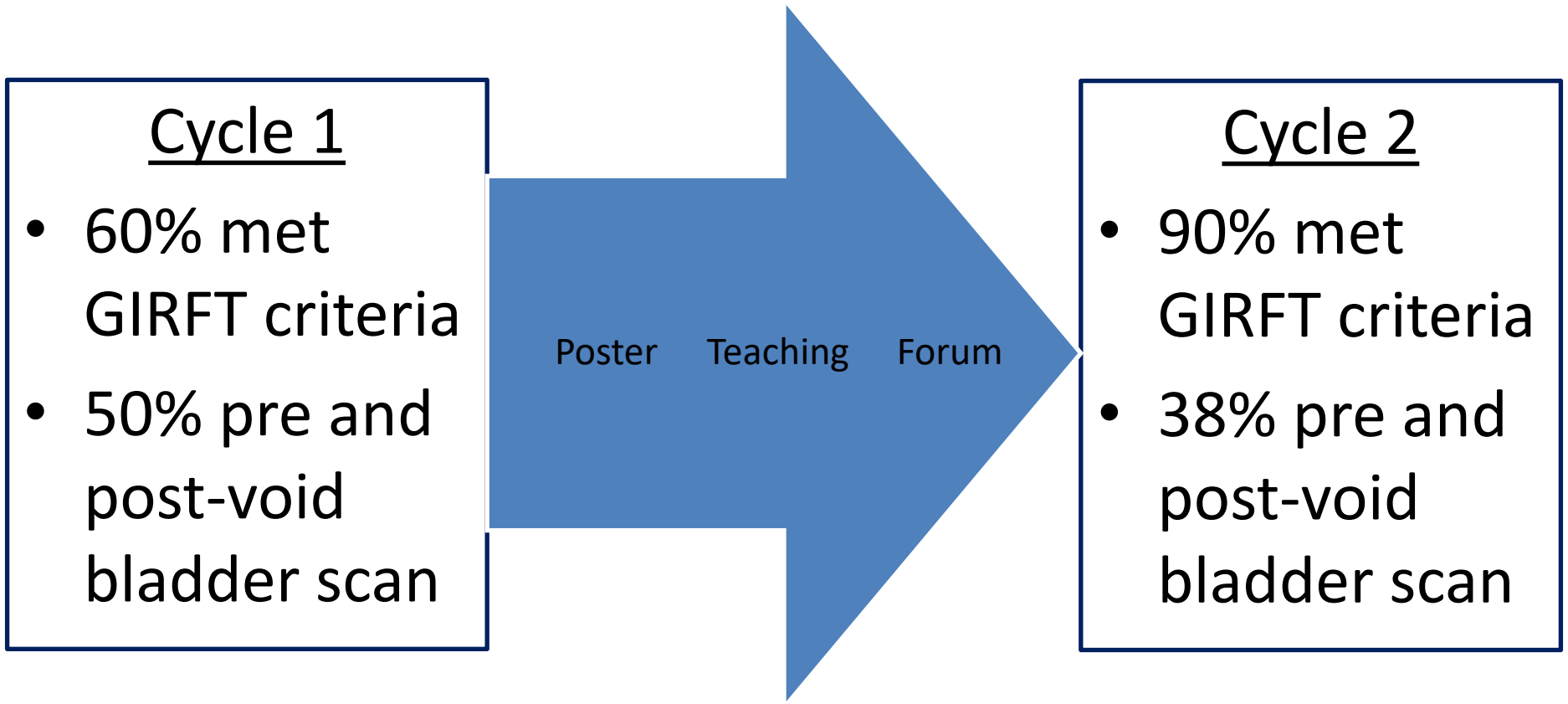
Has the patient developed any of the following?

- Sudden onset bilateral radicular pain or unilateral radicular leg pain that has progressed to bilateral
- **14 days or more** difficulty initiating micturition or impaired sensation of urinary flow
- **14 days or more** altered perianal, perineal or genital sensation S2-S5 dermatomes – area may be small or as big as a horses' saddle (subjectively reports or objectively tested)
- **14 days or more** loss of sensation of rectal fullness
- **14 days or more** sexual dysfunction (achievement of erection or ability to ejaculate, loss of genital sensation)

New or deteriorating CES symptoms

Bladder scan and emergency MRI

Results


Cycle 1
• 60% met GIRFT criteria
• 50% pre and post-void bladder scan
Poster
Teaching
Forum
Cycle 2
• 90% met GIRFT criteria
• 38% pre and post-void bladder scan

Recommendations & Action Plan

- Reinforce documentation of ALL CES red flags
- Ensure bladder scans (pre- and post-void) are routinely performed in all suspected CES cases and documented
- Presentations
- Posters
- Re-audit

Any Questions?

An integrated teams approach to complex lower limb wound project

Claire Thomson AP lead vascular
Caroline Pye Deputy CL UHD outpatients
Jenna Martin leg ulcer nurse Adam Practice

Why and How

- Fragmented care pathways
- Inappropriate referrals to secondary care,lack of guidance
- Reduced cross disciplinary approach to wound care
- Gap in joined up approaches/sharing knowledge identified

- East and West Dorset collaboration
- Pilot project at outset
- Manage patients with complex lower limb wounds
- Governance
- Escalation routes
- Key stakeholders
- Documentation, standards and reporting processes

Collaboration

- Collective working across primary and secondary care has strengthened professional relationships and communication
- Shared learning and training opportunities have been provided (eg equipment discussion, vascular study day), enhancing staff knowledge and workforce skill
- Learning is supported indirectly through case discussions and evidence-based practice, benefiting both staff and patients. Empowering professionals in their clinical decision-making skills
- Flexible multidisciplinary team approach allowing patient specific input eg lymphoedema specialist
- Improved the referral process by ensuring referrals are more appropriate and timely.
- *From a patient experience perspective, care has been enhanced through a more coordinated and consistent approach. There has been a shift from 'just treating my wound' with a greater emphasis on prevention and early intervention, aiming to reduce recurrence rates. Patients have also felt more involved in their care plans, as they have received feedback from the multidisciplinary team.*

- UK Government (2025) *Fit for the Future: 10 Year Health Plan for England*. Available at: https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future
- NHS England (2018) *National Wound Care Strategy Programme*. Available at: https://www.nationalwoundcarestrategy.net/

Outcomes and Evaluation

- Evaluation and audit will look at data: relevant referrals received, healing rates, reduced secondary care attendance, work force and patient experience.
- West Dorset MDT has quantitative evidence already seen a reduction in referrals received for lower limb patients.
- Discussions and outcomes are documented on EPR.
- Learning opportunities and the ripple effect of learning eg. Lymphodema, toe pressures and incompressible arteries. For future studies and understanding between professionals improving competence.
- Reduces the stress for patients requiring hospital transport and reducing the need for hospital visits/parking.
- Positive project but is reliant on funding from Wider Dorset ICB Funding.
- Looking at Secondary care visits to leg clubs from vascular team.
- Wiltshire/Salisbury team to start looking at developing the same as can see benefits.

Reducing Postoperative Hyponatraemia in Hip Replacement: A Four-Cycle Quality Improvement Approach

Lauren Thornley, James Craig, Thomas Wainwright, Robert Middleton

ORIBU Orthopaedic Research Institute Bournemouth University

Introduction

- Postoperative hyponatraemia (POH) occurs in 20-40% of patients following elective total hip replacement (THR)
- It is associated with increased mortality, prolonged hospital stay, and delayed recovery.
- Even mild POH can impair adherence to enhanced recovery protocols.
- Despite its prevalence, there is limited interventional research addressing this issue.

Methods

- We conducted a four-cycle PDSA quality improvement project at a single centre to assess and reduce POH incidence in elective THR patients.
- POH was defined as serum sodium <135 mmol/L.
- Interventions were introduced sequentially:
  - Cycle 1: unrestricted oral fluid intake
  - Cycle 2: fluid restriction
  - Cycle 3: weight-based (20 ml/kg) postoperative oral fluid protocol
  - Cycle 4: weight-based (20 ml/kg) postoperative oral fluid protocol, with added oral sodium chloride and 2L intraoperative isotonic IV fluids

Results and Discussion

- A total of 438 patients were included.
- No cases of severe hyponatraemia were observed.
- POH incidence decreased across cycles:
  - Cycle 1: 40.69% (mild 72.29%, moderate 27.71%)
  - Cycle 2: 27.63% (mild 85.71%, moderate 14.29%)
  - Cycle 3: 30.61% (mild 80%, moderate 20%)
  - Cycle 4: 18.33% (mild 72.73%, moderate 27.27%)

This likely reflects routine sodium testing on postoperative day 1, enabling early detection and intervention.

Structured, low-cost perioperative fluid and electrolyte protocols significantly reduced POH incidence.

Incorporating sodium monitoring and standardised fluid strategies into enhanced recovery pathways may support improved outcomes and timely discharge following THR.

Thank you

Lauren Thornley
lauren.thornley3@nhs.net

IV Zoledronate recommended as first line secondary prevention of osteoporosis in femur fractures (NOGG 2021)

No provision for bone protection for > 75

No inpatient provision for IV bisphosphonates

Vitamin D loading schedules over 6-7 weeks – big delays to treatment

Unable to retest vitamin D levels within 3 months

Logistical complications of orthopaedic patients returning as an outpatient

Vitamin D

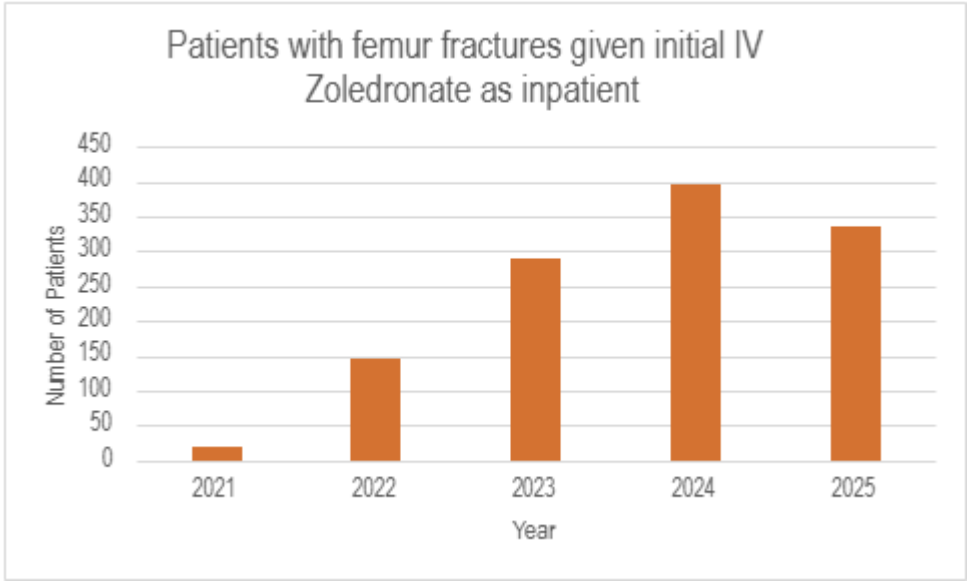
- ‘Fast Loading’ schedules
- EPMA Protocols

Decision Aids

- Treatment algorithms – Fragility Fracture: Secondary Prevention of Osteoporosis
- Femur and non-femur fragility fractures – recent update
- Cross speciality use

National Guidance

- 1 vs 3 annual infusions
- Call to Action: A Five Nations Consensus (British Geriatric Society 2023)
- Off license use IV Zoledronate 4mg
- Administration within 2 weeks surgery
- Single doses in frail patients



Vitamin D Replacement Guidance

University Hospitals Dorset NHS Foundation Trust

Only for patients receiving inpatient parenteral treatment for Osteoporosis

Vitamin D replacement: 'Fast' Loading (CrCl >20 mL/min)

<30 nmol/L
Colecalciferol 60,000 units PO OD for 4 days

30-50 nmol/L
Colecalciferol 40,000 units PO OD for 4 days

Followed by

CrCl > 30 mL/min
Maintenance Vitamin D and Calcium supplement (as per formulary) for duration of parenteral therapy

CrCl 20-30 mL/min
Colecalciferol only—avoid calcium supplements

For patients Vitamin D deplete/ receiving outpatient parenteral Osteoporosis treatment

Vitamin D replacement: 'Slow' Loading (CrCl >20 mL/min)

> 50 nmol/L
No replacement vitamin d required

30-50 nmol/L
Maintenance colecalciferol 800 units OD only

<30 nmol/L
Colecalciferol 40,000 unit PO OW for 7 weeks (as per formulary)
Followed by maintenance colecalciferol 800 units OD

Vitamin D replacement CrCl < 20 mL/min

Seek advice from renal team

Vit D Replacement guideline v1 Approved by MOG Dec 25 Review date Dec 28

Fragility Fractures: Secondary Prevention in the Under 75s & Over 75s CFS ≤ 5

(All low trauma fractures excluding digits)

University Hospitals Dorset NHS Foundation Trust

Bloods: FBC, U+Es, Bone profile, Vitamin D (if not tested within last 3 months), Creatinine Clearance (CrCl)

Additional tests if indicated: TSH, ESR, myeloma screen, breast exam, CXR, Serum testosterone (9am sample), PTH (if Calcium abnormal), Coeliac Screen

Vitamin D level

<50 nmol/L

CrCL > 20 mL/min
Vitamin D < 30 nmol/L
Colecalciferol 40,000 units once weekly for 7 weeks

Followed by
Maintenance vitamin D

Consider calcium supplementation if low corrected calcium*

Vitamin D 30-50 nmol/L
Maintenance colecalciferol 800 units OD

>50 nmol/L

Advise Over The Counter Vitamin D 800 units OD minimum

Fracture Liaison Service for FRAX and bone health assessment

Refer via email if > 75 years

Check entry on EPR to confirm follow up

*1st line Adcal D3 tablets 1 PO BD, 2nd line Adcal D3 caplets 2 PO BD

NOTE: Patients on **primidone, phenytoin, carbamazepine, phenobarbital, or sodium valproate** need high dose vitamin D supplementation— Colecalciferol 3200 unit capsules 1 PO OD
CrCl should be calculated using MdCalc online calculator. Patients with BMI ≥ 30, please use adjusted body weight figure

Fragility Fractures under 75s and over 75s CFS =<5 v2. Approved by MOG Dec 2025. Review Date Dec 2028

Fragility Fractures: Secondary Prevention in the Over 85s & Over 75's CFS ≥ 6— Not on current Osteoporosis Treatment

University Hospitals Dorset NHS Foundation Trust

Bloods: Bone profile, Vitamin D (if not tested within last 3 months), if Creatinine clearance (CrCl) <30 mL/min include PTH & Phosphate

Additional tests if indicated: ESR, TSH, myeloma screen, breast exam, CXR and Males: PSA, 9am testosterone, Females: FSH, coeliac screen (TTG)

Not suitable if
Unlikely to benefit—Patient in last year of life
Unable to comply with daily calcium/vitamin D regime
CrCl < 20 ml/min
NB: osteoporosis treatment can be delayed if patients have planned dental work within 3 months

Femur Fracture?

Yes

No

History of; oesophagitis, oesophageal dysmotility, hiatus hernia, reflux > 1 episode per week, Barrett's oesophagus, oesophageal stricture or varices, adequate trial of 2x PO bisphosphonates

Swallowing difficulties

CrCL < 30 mL/min

No to all

CrCl >35mL/min
Alendronic Acid 70mg PO once weekly for 10 yrs
Maintenance vitamin d/calcium therapy as per formulary

CrCl 30-35mL/min or intolerant of Alendronic Acid
Risedronate 35mg PO once weekly for 10 yrs
Maintenance vitamin d/calcium therapy as per formulary

Advise re atypical pain; ear, jaw, groin, femur and indigestion

Yes to 1 or more

Consider injectable therapy
Ensure vitamin d replete see vitamin d guidance

Attends routine dental checks*
Encourage regular visits and counsel for Osteonecrosis of the jaw

CrCl >35 mL/min
CrCl 30-35 mL/min**

Consent for 4mg IV Zoledronate - 1* v 3x annual infusions
Discuss benefit v risk
Advise re atypical pain; ear, jaw, groin and femur
First dose 5 days post-op or 3 months post planned dental treatment
Assess if appropriate for TIU
Maintenance vitamin d and calcium supplement as per formulary
Ensure eDischarge update re plan for GP information

CrCl 20-35 mL/min

Consent for 60mg SC Denosumab/biosimilar Denosumab
6 monthly injections up to 10 yrs/lifelong
Cholecalciferol maintenance as per formulary
Discuss benefit v risk including risk of rebound fracture
Advise re atypical pain; ear, jaw, groin and femur
Ensure eDischarge updated re plan for GP information

One-off dose (off label use agreed by Trust)
*a single dose of IV Zoledronate may be considered for patients with impaired dentition, advancing age; advanced dementia and care home residents
**For impaired but stable renal function (CrCl 30-35), a single dose of IV Zoledronate may be considered with Consultant discussion

CrCl should be calculated using MdCalc online calculator. Patients with BMI ≥ 30, please use adjusted body weight figure
Routine blood tests after Zoledronic Acid are not required unless there are concerns about hypocalcaemia
Routine bloods tests after Denousmab are not required but monitor calcium 2 weeks after treatment in patients at risk of hypocalcaemia eg with a CrCl < 30 ml/min

Fragility Fractures over 75s New OP treatment v2. Approved by MOG Dec 2025. Review Date Dec 2028

Documentation

- Comprehensive Electronic Bone Health Proforma
- Cross specialty access and use
- Promoting multi-disciplinary collaboration and improved patient safety
- Improve communication with primary care colleagues

County Wide Approach to Secondary Prevention of Osteoporosis

- “The Vision”
- Consistent approach to secondary prevention of osteoporosis
- Dorset wide

- National Osteoporosis Guidance Group UK (2024), Clinical Guideline for the Prevention and Treatment of Osteoporosis [online] available from: https://www.nogg.org..uk/full-guidance
- Johansen A, Sahota O, Dockery F, Black AJ, MacLullich AMJ, Javaid MK, Ahern E, Gregson CL. (2024) Call to action: a five nations consensus on the use of intravenous zoledronate after hip fracture. [online] Erratum in: Age Ageing. 3(1)
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- University Hospital Dorset (2021) Fragility Fractures: Secondary Prevention in the Under 75's and over 75's with CFS , 5
- Univeristy Hospital Dorset (2023) Calcium and Vitamin D [online] available from: Calcium and Vitamin D
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Any Questions?

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Moving Forwards Together

PLEASE JOIN US FOR AWARD PRESENTATIONS IN SHARE LECTURE THEATRE