

Pride and Prejudice – Compassion and Inequality in today's NHS

12th Annual Conference

London School of Obstetrics & Gynaecology
incorporating Community Sexual and
Reproductive Health



14th May 2021

Virtual Event on MS Teams

Welcome

We are pleased to welcome you to the 12th Annual Conference of the London Specialty School of Obstetrics and Gynaecology and Community and Sexual Reproductive Health.

This year's title is "**Pride and Prejudice - Compassion and Inequality in today's NHS**", which will motivate us to explore real and perceived inequalities in healthcare education and healthcare provision.

The opening session presentations by Professor Siddiqi and Dr Katherine Woolf will explore current knowledge and research about "differential attainment" in medical education and healthcare and how to address the issues. Closing the session, we are once again very privileged to have Dame Professor Lesley Regan, our immediate past President, give the keynote talk at our conference and inspire us with her journey in women's health.

Immediately prior to the oral presentations Miss Ranee Thakar, Senior Vice President of the RCOG, will discuss the work of the RCOG Race Equality Taskforce and how the need to make a change involves us all.

Trainees' research will be then presented, with prizes awarded this afternoon, for the best oral presentation and the best poster presentation. The presentations were originally to be presented at our 2020 conference which as you will be aware was called off at the last minute due to the pandemic. Two of our speakers have since been appointed as consultants and we hope this provides the incentive for everyone to submit abstracts next year. Please take the time to view the posters throughout the course of the day and participate in the GAMER experience.

Before lunch you will be given the opportunity to discuss further training and educational developments with your local TPDs.

The afternoon presentations by Dr Banerjee and Dr French address inequalities in maternity care and reproductive and sexual health and immediately prior to the Q&A session, Professor Catherine Nelson-Piercy will address the conference on the impact and management of Covid in pregnancy.

The pandemic has had a major impact on all of our lives and on the delivery of healthcare. It has also meant that we have had to adapt to the rapidly evolving technology which enables us to meet in this virtual world.

We would like to extend to you a very warm welcome to our 12th Annual Conference and sincerely hope that in 2022 we will be able to meet in person again.

Thank you for joining us in this fascinating and inspiring journey.

Greg and Sonji
London School of Obstetrics and Gynaecology

Programme

Conference will open at 8.45am Please use MS Teams log-in link here: Conference log-in	
Session 1 Chair: Sally Watkinson	
09:00- 09:10	Welcome Mr Greg Ward, Head of School
09:10 - 09:30	Differential Attainment - Training Attainment Dashboards Dr Farah Siddiqui, Consultant in Fetal and Maternal Medicine TPD South East Midlands, University of Leicester NHS Trust
09:30 - 10:30	Tackling Differential Attainment Dr Katherine Woolf, NIHR Career Development Fellow, Associate Professor in Medical Education
10:30 - 11:00	My Journey, My Passion Dame Professor Lesley Regan
11:00 - 11:15	Break/ E-posters viewing/ Covid reflections/ comments <i>Electronic copy of the E-posters/ Covid reflections presentation is available on the London HEE Website, Events page here: presentation</i>
Session 2 Chair: Shankar Visvanathan	
11:15 – 11:45	RCOG Race Equality Taskforce - We need to make a change Miss Raneer Thakar, Consultant Urogynaecologist, Croydon University Hospital Senior Vice President RCOG
11:45 – 12:45	Trainee Oral Presentations
11:45 -11:55	Universal versus selective aspirin prophylaxis: Pregnancy outcomes in women with chronic hypertension Ms Christina Coroyannakis, Consultant Obstetrician & Gynaecologist at Guy's and St Thomas Hospital NHS Foundation Trust
11:55 -12:05	Hyperemesis gravidarum and outpatient management: Does it really make a difference? Dr Asli Ucyigit, ST7 at King's College Hospital
12:05 – 12:15	Is routine urine dipstick testing justified in asymptomatic women in early pregnancy? Dr Jonathan Gaughran, Senior Research Fellow in Early Pregnancy & Acute Gynaecology
12:15 – 12:25	Implementation of routine first trimester screening for pre-eclampsia: A clinical effectiveness study Dr Gavin Guy, Consultant Obstetrician and Subspecialist in Feto-Maternal Medicine at Medway Maritime Hospital

12:25 – 12:35	Immediate postpartum contraception - London: A tale of two cities Dr Annette Thwaites, Academic Clinical Fellow at King's College Hospital
12:35 – 12:45	Voting for best trainee oral presentation Please join online voting at: www.slido.com with #T819
12:45 – 13:15	Session 3 Meet your TPDs and Trainee Reps Virtual MS Teams Break-out Rooms
	North Central and East London TPDs: Dilip Visvanathan, Charlotte Kingman and Vincent Oon Trainee Rep: Lauren Berg MS Teams Log-in: Click here to join the meeting
	North West London - Catriona, Sadaf and Shruti TPDs: Catriona Stalder, Sadaf Ghaem-Maghani and Shruti Mohan Trainee rep: Erna Bayar MS Teams Log-in: Click here to join the meeting
	South London TPDs: Sally Watkinson, Rowena Bevan and David Rose Trainee Rep: Simran Bansal MS Teams Log-in: Click here to join the meeting
	CSRH – no break out session available TPD: Janet Barter Trainee Rep: Ellen Adams If you have any queries for CSRH training programme, please kindly email to OandG.lase@hee.nhs.uk and we will forward it to Ms Barter
	Academic Trainees - - no break out session available TPD: Ranjit Manchanda If you have any queries for academic training programme, please kindly email to OandG.lase@hee.nhs.uk and we will forward it to Mr Manchanda
13:15 – 13:45	Break/ E-posters viewing/ Covid reflections/ comments <i>Electronic copy of the E-posters/ Covid reflections presentation is available on the London HEE Website, Events page here: presentation</i>

Session 4 Chair: Catriona Stalder	
13:45 – 14:05	Inequalities in Maternity Care and its consequences Dr Anita Banerjee Consultant Obstetric Physician, Diabetes and Endocrinology Consultant, Simulation Lead for Women's Health
14:05 – 14:25	Inequalities in Reproductive and Sexual Health NATSAL Dr Rebecca French, Chair of Clinical Studies FSRH, Associate Professor in Sexual & Reproductive Health Research, London School of Hygiene & Tropical Medicine
14:25-14:55	Covid and Pregnancy- What Obstetricians and Gynaecologists need to know Professor Catherine Nelson-Piercy, Consultant Obstetric Physician, Guy's and St. Thomas' Hospital trust and Queen Charlotte's and Chelsea Hospital in London
14:55 – 15:10	Break/ E-posters viewing/ Covid reflections/ comments <i>Electronic copy of the E-posters/ Covid reflections presentation is available on the London HEE Website, Events page here: presentation</i>
15:10 – 15:40	Session 5 School Panel – Trainees' questions
15:40 – 15:50	Closing Remarks and Thanks Mrs Sonji Clarke, Deputy Head of School
15:50	Conference Close

Conference Speakers

Dr Anita Banerjee FHEA, FRCP is an Obstetric Physician, General Medicine Physician and Diabetes and Endocrinology Consultant. She is an Honorary Reader in Obstetric Medicine, at King's College London and Deputy Director of Medical Education at Guys and St Thomas' Hospitals NHS Foundation Trust.



She is the Secretary of the MacDonald Obstetric Medicine Society. She is one of the central physician assessors for the UK Confidential maternal deaths enquiry. She has published articles, guidelines and book chapters on a wide variety of medical conditions in pregnancy. She is one of the leading authors of the RCP Acute Care Toolkit on managing acute medical problems in pregnancy. She is on the steering committee for mMOET, as the lead advisor for medical problems in pregnancy. Her main interests are high risk pregnancies, the management of the deteriorating pregnant woman and education.



Dr Sonji Clarke is a Deputy Head of School and consultant obstetrician with an interest in high risk obstetrics, including neurological diseases in pregnancy and pregnancy with complex social factors.

She has wide ranging educational interests, including contributing to careers programmes in secondary schools and providing PHSE materials for both primary school children and their parents. She is an honorary senior lecture and King's College London with some responsibility for pastoral care of medical students as well as teaching. She recently completed a Masters programme in Academic Practice and works together with Greg Ward as his deputy for the London School of Obstetrics and Gynaecology.

As the lead Training Programme Director for the South of London, her particular focus is providing the tools during training to develop consultants appropriate for the 21st century.

Sonji has 2 teenage children and one at university. She also has 2 cats that her children think she's obsessed with. She is a strong believer in laughter being good medicine.



Dr Rebecca French, Associate Professor in Sexual & Reproductive Health Research (SRHR), LSHTM. She is a Public Health researcher with experience of policy-related research, intervention development and evaluation. Interests include how preferences affect choice in healthcare, specifically around fertility-related decision-making, and how new technologies can be used to promote better SRH. Current projects include an NIHR-funded study to examine how health services be best configured in response to the decriminalisation, deregulation and de-medicalisation of abortion to provide quality, evidence-based care for women in the UK and, with Public Health England (PHE), the development and piloting of a

national survey to assess women's reproductive health and well-being. She has an honorary contract with PHE. Chair of the RCOG Clinical Studies Group on SRH and member of the Natsal Reproductive Health Working Group.



Professor Catherine Nelson-Piercy MA FRCP FRCOG

Catherine Nelson-Piercy is a Consultant Obstetric Physician at Guy's and St. Thomas' Hospitals Trust and Queen Charlotte's and Chelsea Hospital in London. In 2010 she was awarded the title of Professor of Obstetric Medicine at King's College London. Her undergraduate studies were at King's College, Cambridge University and St Bartholomew's Hospital. She trained as a physician, and was taught Obstetric Medicine by Professor Michael de Swiet.

Professor Nelson-Piercy is past President of the International Society of Obstetric Medicine (ISOM). She was founding co-editor in chief of the journal '*Obstetric Medicine: the medicine of pregnancy.*'

Professor Nelson-Piercy has been involved in the development of several evidence-based National Guidelines notably for "Contraception in Women with Heart Disease", BTS / SIGN "Asthma in Pregnancy" and RCOG Green top guidelines on "Reducing the risk of thromboembolism during pregnancy, birth & the puerperium" and 'Management of nausea vomiting of pregnancy and hyperemesis gravidarum'. She has over 250 publications and has edited five books and written the successful *Handbook of Obstetric Medicine*, now in its sixth edition. She is also one of the central physician assessors for the UK Confidential maternal deaths enquiry.



Professor Dame Lesley Regan is a Professor of Obstetrics & Gynaecology at Imperial College London and Consultant at St Mary's Hospital in London. She is also Secretary General of FIGO, a member of the NHS Assembly and Chair of the Charity Wellbeing of Women.

She was the 30th President of Royal College of Obstetricians and Gynaecologists (2016-2019) and only the second woman to be elected to this position and the first in 64 years. During her tenure as RCOG she co-chaired the National Women's Health Task Force with Jackie Doyle-Price MP (then Health Minister) and authored "[Better for Women](#)", a hard hitting RCOG report which promotes a life-course approach to the delivery of women's health services.

Having graduated from the Royal Free Hospital School of Medicine, London in 1980, Professor Regan pursued her training at Addenbrooke's Hospital, Cambridge, where she first became enthused by clinical and laboratory research, completing her MD on miscarriage. She went on to set up the world's largest recurrent miscarriage clinic at St Mary's Hospital in London.

In 2015 she received a Doctorate of Science from University College London for her contribution to women's health. In 2020 she was awarded a DBE for her services to women's health in the Queen's New Year's Honours List.

Dr Farah Siddiqui

University of Dundee graduate

Research MD in diabetic pregnancies in Nottingham

NTN Trainee NW London

Subspec training in Fetal and maternal medicine in Nottingham

Consultant in University Hospitals of Leicester subspecialist in fetal maternal medicine

TPD for the South East Midlands

Currently completing an Apprenticeship in Senior Leadership and management at the University Hospitals of Leicester (CMI level 7)

Race Equality Taskforce member and RCOG Workforce planning- chairing the Numbers workstream

Member of the Leicester Maternity Commissioning group looking at reducing morbidity in the Ethnic diverse population of Leicester.



Miss Ranee Thakar is a Consultant Obstetrician and Gynaecologist and a Subspecialist in Urogynaecology at Croydon University Hospital as well as being a Honorary Senior Lecturer at St George's University of London. She is the Urogynaecology Lead and has previously served as the Clinical Business Unit Lead in her trust. Ranee is the Director of the Urogynaecology Subspecialty Training Programme at Croydon University Hospital and the clinical lead of the community-based, NHS England funded National Female Genital Mutilation support clinic in Croydon.

Ranee completed her basic medical training in India prior to moving to the United Kingdom. She obtained her MRCOG degree in 1994 and subsequently took up a research post in St George's Hospital and Medical School, London. This research led to a landmark paper which was published in the New England Journal of Medicine and a Doctorate (MD) from the University of London.

She is passionate about research and recognises its vital role in advancing health. Her publications include many original papers in peer reviewed journals and chapters in books. She has edited three textbooks. Having previously focused on the diagnosis and repair of obstetric anal sphincter injuries (OASI) through research and training, she is currently leading on a joint Royal College of Obstetricians and Gynaecologists and Royal College of Midwifery national prevention project funded by the Health Foundation, which has demonstrated a significant reduction in OASI rates. She has extensive experience in various posts in the RCOG, the most recent being the International Fellows Representative for South Asia on the RCOG Council. Other past leadership roles include secretary of the British Society of Urogynaecology and several roles in the International Urogynecological Association (IUGA). She is currently the President of IUGA thereby influencing Urogynaecology internationally.

She has a lifelong commitment to the improvement of women's health globally and intends to pursue new initiatives in global health in her capacity as the Vice President of the RCOG. Ranee's priorities are to support the membership of the College to deliver high quality healthcare to women by honing in on recruitment, attrition, rota gaps and consultant burnout. Other priorities include implementing strategies to ensure that the RCOG members and fellows across the world, feel engaged and empowered.



Mr Greg Ward FRCOG, Cert Hum (Open) is Head of the London Specialty School of Obstetrics and Gynaecology, Associate Postgraduate Dean and Consultant Obstetrician & Gynaecologist at Croydon University Hospital.

His clinical interests include maternal medicine, gynaecological oncology, and ethics. He has a long-term interest and involvement in both undergraduate and postgraduate medical education and has been Chairman of the London South/KSS STC (2005-2012) and RCOG Regional Assessor for the Confidential Enquiry into Maternal and Child Health (2003-2014). He sits on the Specialty Education Advisory Committee of the RCOG and examines for the MRCOG.

He teaches in Faculty Development courses for the Professional Support Unit and is a trained mentor/ coach using his expertise to support and develop specialty trainees, including doctors in difficulty.



Dr Katherine Woolf is Associate Professor in Medical Education and Honorary Research Fellow in Psychology at UCL.

Dr Woolf's research is about understanding and addressing inequalities in medicine and education, notably differential attainment by ethnicity, and more recently socio-demographic differences in selection into medical school. She has recently been working to understand ethnic differences in COVID-19 outcomes among healthcare workers. Her research has been used by the General Medical Council, Health Education England, and Medical Schools Council to improve the fairness of medical training at postgraduate and undergraduate levels.

Trainee Oral Presentations

Oral Presentation 1

Abstract Title: Universal versus selective aspirin prophylaxis: Pregnancy outcomes in women with chronic hypertension

Abstract Author(s): Christina Coroyannakis, Matthew Cauldwell, Basky Thaliganathan, Ingrid Watt-Coote, Dagmar Krueger, Gavin Guy, Elaine Sheehan, Trudy Williams

Please indicate type of project: Retrospective cohort study

Institution: St George's University Hospitals NHS Foundation Trust

Background/ Purpose: Current UK guidance recommends all women with chronic hypertension (CHTN) are treated with aspirin from 12 weeks to reduce the risk of developing pre-eclampsia. Recent data from an aspirin to prevent preeclampsia (ASPRES) trial suggested aspirin was ineffective in reducing preeclampsia in women with CHTN. Based on the latter evidence, we changed from universal to selective aspirin prophylaxis in ASPRES screen-positive women with CHTN.

Materials and Methods: Women with known CHTN managed in our unit: 95 in the 18 months prior (controls) and 41 in the nine months following ASPRES screening. High risk was defined as risk of $>1:50$ for preterm preeclampsia using ASPRES algorithm. Outcomes recorded included rates of aspirin prescription as well as prevalence of pre-eclampsia.

Results: Aspirin prophylaxis was 95.7% (91/95) in controls versus 100% in the 31/41 chronic hypertensive women screened high-risk in ASPRES cohort. None of the CHTN women screened as ASPRES low risk developed preeclampsia despite not taking aspirin prophylaxis. Preeclampsia at any gestation occurred in 27.4% (n=26) of controls versus 24.4% (n=10) of ASPRES women (p=0.718). Incidence of preterm preeclampsia was 8.4% (n=8) and 9.7% (n=8) in controls and ASPRES cohorts, respectively (p=0.801).

Conclusions: This study supports the non-inferiority of a policy of ASPRES screening with targeted aspirin prophylaxis in women with CHTN. Such a policy is likely to focus clinical resource use, improve monitoring, adherence by clinicians and compliance by women to targeted intervention to prevent preeclampsia.

Oral Presentation 2

Abstract Title: Hyperemesis gravidarum and outpatient management: Does it really make a difference?

Abstract Author(s): Dr Asli Ucyigit

Please indicate type of project: Retrospective observational study

Institution: King's College Hospital, London

Background/ Purpose: Since the publication of the Royal College's Guideline in 2016, there has been increased emphasis on the provision of outpatient services for the treatment of

hyperemesis gravidarum (HG). Such units are associated with increased cost effectiveness and high patient satisfaction rates.

Materials and Methods: A retrospective observational analysis was undertaken to assess the impact of the ambulatory hyperemesis unit at King's College Hospital, London. Data were collected from the admissions database spanning a 12 year period, both before and after the unit opened. The number of inpatient spells per year and length of stay were analysed (unpaired t-test).

Results: The average number of inpatient spells per year before and after the unit opened were 243.25 and 254.13 respectively ($p=0.6128$). The average number of inpatient nights per year were 424.5 vs. 227.38 respectively ($p<0.0001$). The estimated average cost of inpatient stay per year was £199,535 vs. £106,866 respectively ($p<0.0001$).

Conclusions: Although the overall number of annual inpatient admissions for HG did not fall following the introduction of ambulatory services, the average length of stay, and thus cost of care, were significantly reduced, suggesting that the aftercare provided by the unit has the most beneficial impact.

Oral Presentation 3

Abstract Title: Is routine urine dipstick testing justified in asymptomatic women in early pregnancy?

Abstract Author(s): Jonathan Gaughran, Bethany Chung, Daniel Field, Tom Lyne, Nuhaat Syeda and Judith Hamilton

Please indicate type of project: Service improvement

Institution: St Thomas' Hospital Early Pregnancy Unit

Background/ Purpose: Many Early Pregnancy Units (EPU) perform routine urinalysis due to a suggested correlation between bacteriuria and adverse birth outcomes. The aim of this study is to assess the cost and diagnostic yield of this.

Materials and Methods: In a tertiary referral EPU all patients have urinalysis at presentation. A retrospective analysis was undertaken of consecutive pregnant patients between July 2017 and July 2018.

Results: 10,490 urinalyses were performed at a cost of £40,386.50. 68 were positive for nitrites (0.6%). 179 MSU were sent (erroneously sending of leucocyte 3+ or 4+ but nitrite negative samples) at a further cost of £2593.71. 65 of the 179 MSUs were culture positive (36%) - a proven bacteriuria rate of 0.6%. In nitrite positive samples 41 had proven bacteriuria. This is a positive predictive value (PPV) of 63%. In the nitrite negative samples, 24 of the 123 had proven bacteriuria. This is a PPV of 20. There was appropriate antibiotic prescription in 61 of the 65 culture positive and no pyelonephritis. There was no statistical significance in mid-trimester loss rate, pre-term birth rate or low birth rate between MSU positive and negative.

Conclusions: Routine urinalysis has significant cost and low diagnostic yield. There was not proven link between bacteriuria and adverse birth outcomes. We believe there is no role for screening of asymptomatic women in this setting.

Oral Presentation 4

Abstract Title: Implementation of routine first trimester combined screening for preeclampsia: a clinical effectiveness study

Abstract Author(s): Gavin P Guy^{1,2}, Karin Leslie^{1,3}, David Diaz Gomez¹, Kinga Forenc¹, Eleanor Buck¹, Asma Khalil^{1,2}, Basky Thilaganathan^{1,2,4}

1. Fetal Medicine Unit, St George's University Hospitals NHS Foundation Trust, Blackshaw Road, London SW17 0RE, UK
2. Vascular Biology Research Centre, Molecular and Clinical Sciences Research Institute, St George's University of London, Cranmer Terrace, London SW17 0RE, UK
3. Department of Obstetrics and Gynaecology, Ashford and St Peter's NHS Foundation Trust, Guildford Road, Lyne, Chertsey, KT16 0PZ, UK
4. Tommy's National Centre for Maternity Improvement, Royal College of Obstetrics and Gynaecology, 10-18 Union Street, London SE1 1SZ

Objective: Evaluate clinical effectiveness of the first trimester combined (FMF) preeclampsia screening programme when implemented in a public healthcare setting.

Design: Retrospective cohort study.

Setting: London tertiary hospital from January 2017 to March 2019.

Methods: 7720 screened for preeclampsia according to NICE risk-based guidance and 4841 by the FMF algorithm which combined maternal risk factors, blood pressure, PAPP-A and uterine artery Doppler indices in the first trimester. High-risk was defined by standard NICE criteria in the pre-intervention cohort (prescribed 75mg aspirin) or a risk of $\geq 1:50$ for preterm preeclampsia from the FMF algorithm in the post-intervention cohort (prescribed 150mg aspirin).

Main outcome measures: Screening effectiveness, rates of preeclampsia.

Results: The FMF screening programme resulted in a significant reduction in the screen positive rate (16.1% vs 8.2%, OR 0.50, 95%CI 0.41-0.53) with a concurrent increase in targeted aspirin use in women classified as high-risk for preeclampsia (28.9% vs 99.0%, OR 241.6, 95%CI 89.6–652.0). Screening indices were uniformly improved for the FMF algorithm with ROC analysis demonstrating excellent discrimination for preterm preeclampsia (AUC=0.846, 95%CI 0.778–0.915, p-value= <0.001). Interrupted time series analysis showed that the FMF screening programme resulted in a significant 21 month relative effect reduction of 80% (p=0.025) and 89% (p=0.017), for preterm and early preeclampsia, respectively.

Conclusions: First trimester combined screening for preeclampsia is both feasible and effective in a public healthcare setting. Such an approach results in a two-fold de-escalation of risk, doubling of preeclampsia detection, near total physician compliance of aspirin use and a significant reduction in the prevalence of preterm preeclampsia.

Oral Presentation 5

Abstract Title: Immediate postpartum contraception - London: A tale of two cities

Abstract Author(s): A Thwaites, J Fleminger, D Reisel, S Chawla

Please indicate type of project: research

Institution: UCLH

Background/ Purpose: A cross-sectional survey of women on a postnatal ward reported that women would welcome provision of contraception, including long-acting reversible contraception (LARC) [1]. This study aims to test the generalisability of these results in a highly contrasting postnatal population in the same city.

Materials and Methods: An anonymous, confidential and voluntary survey was self-administered on iPads by women on the postnatal ward of a large teaching hospital 7-14/02/19. Qualtrix software was used for data collection and analysis. All postnatal women admitted to the ward were eligible with exclusion criteria preidentified as those unable to read English or subject to infection control restrictions.

Results: 99 women were surveyed (81% uptake). 8% had never used any contraception and 27% had used LARC. 13% recalled a health professional discussing contraception during pregnancy; 49% were undecided or needed more information to decide on their postnatal method. 46% overestimated when it is possible to conceive post-delivery and 51% underestimated or did not know the recommended interpregnancy interval. 40% thought no hormonal options were safe immediately postnatally rising to 55% if breastfeeding. 74% thought no LARC is safe immediately postnatally or if breastfeeding. However, 48% said they would prefer to get their contraception on the postnatal ward and 25% said they were likely to accept LARC in this setting.

Conclusions: Despite marked differences in population demographics, poor knowledge yet good acceptability of immediate postnatal contraception and LARC were seen across both studies. This suggests a universal need for effective, tailored contraceptive counselling antenatally and integrated postnatal provision.

Trainee E-Poster Presentations

Poster 1

Abstract Title: Intra-uterine Contraceptive Device Expulsion with Menstrual Cup Use: A Case Series

Abstract Author(s): Alexandra Edwards

Please indicate type of project: Case Series

Institution: Wolverton Centre for Sexual Health

Background/ Purpose: Reusable menstrual cup use has increased in popularity by 98% in 5 years with consumer environmental and financial concerns fuelling this trend.¹ Over the same time, intra-uterine contraception device (IUCD) use has also increased.² A recent meta-analysis reported 13 cases of dislodgment of IUCDs and there is little evidence-based guidance into how we should be counseling users choosing to use these two methods concurrently.

Materials and Methods: We report on three cases of IUCD expulsion when removing menstrual cups during menses presenting to an integrated sexual health clinic requesting IUCD replacement over two months.

Results: All were nulliparous, between the ages of 23 and 28 years and expelled copper-containing IUCDs. One reported complete expulsion and two reported partial expulsions more than 6 weeks following insertion. On replacement of the IUCD, two had uterine anteversion and one retroversion. Cavity lengths were within the normal range.

Conclusions: The characteristics of the cases are reflective of the demographic using menstrual cups and would be considered otherwise low-risk for expulsion. All expulsions occurred more than 6 weeks following IUCD insertion and therefore within the FSRH guidelines.³ Targeted counselling is required to instruct users how to remove menstrual cups in the presence of an IUCD to minimize risk of dislodgement.

Poster 2

Abstract Title: Management of unsatisfactory Colposcopy at Western Sussex Hospitals - Colposcopy units

Abstract Author(s): Hend Hadawi, Miss Peggy Khine

Please indicate type of project: Audit

Institution: Western Sussex Hospitals Foundation Trusts (WSHFT) (Worthing hospital and St Richard's hospital)

Background/ Purpose: Colposcopy is designed to diagnose premalignant cervical neoplasia with main goal is to prevent cervical cancer. Transformation zone (TZ) is critical area on the cervix where many premalignant and malignant lesions most often arise in > 90% of cases. TZ is area between mature squamous epithelium distally and columnar epithelium proximally. If the full SCJ can be seen, the colposcopy is deemed satisfactory. If the SCJ cannot be seen fully, the colposcopy is termed unsatisfactory. Aim is to evaluate decision-making in women with unsatisfactory Colposcopy.

Materials and Methods: It was retrospective audit covering 4 years "1st Jan 2015 - 31st Dec 2018". Data were collected from WSHFT – Regional Colposcopy database. 222 patients were identified had unsatisfactory Colposcopy.

Results: 78% of unsatisfactory Colposcopy (UC) was noted at Worthing hospital while 22% was reported at St Richard's hospital. The highest record of UC was noted in 2018 at 30.8%. 64% of women were multiparous and 36% were nulliparous. 70% of patients were smoking. The referral cytology: low- grade and HPV positive reported in 45.5% whilst high grade cytology was found in 15%. 41% of patients had previous cervical treatment. 58% of UC was performed by Colposcopist nurses while 44% of UC was performed by medical Colposcopist. 5% required referral to MDT (MDT outcome 7 had hysterectomy, 2 had LLETZ and 2 had repeated smear), 18% had treatment with LLETZ while 29% discharge to repeat smear with GP in a year. 24% was given vaginal E2 & scheduled to repeat Colposcopy. 5% had cervical biopsy and 8.4% listed for Colposcopy surveillance. Outcome of high grade cytology (29 had LLETZ and 3 had hysterectomy)

Conclusions: Appropriate MDT discussion particularly when hysterectomy was the option. Excisional method/hysterectomy used in particular women with high risk factors. Higher number of cases discharged to community for repeat smear at 12 months. Unsatisfactory (inadequate) Colposcopy is a common area of clinical uncertainty due to the lack of clear evidences and guidance and challenging for all practising colposcopists. Experience of colposcopists is likely to have a significant effect on the decision.

Poster 3

Abstract Title: A national survey of immediate postpartum contraception in the UK: where are we now?

Abstract Author(s): Annette Thwaites, Felicia Yeung

Please indicate type of project: Research

Institution: University College London

Background/ Purpose: Immediate postnatal contraception (IPC) is a key strategy to reduce unplanned, rapid repeat pregnancies, which are associated with worse maternal and child outcomes. IPC at the place of delivery is safe, effective and highly acceptable to women. We provide a timely update on IPC services across the UK.

Materials and Methods: 15-item survey sent to all 38 current Community Sexual & Reproductive Health Trainees across 26 NHS Trusts. Responses collected October–December 2019.

Results: 29 responses received, covering every Trust with a CSRH Trainee. 21 Trusts offered at least one method of IPC; five offered none. 19 Trusts (73%) are at planning, proposal or pilot stages, with only four (15%) reporting sustainable funding. Most financing is a fragmented mix of maternity and sexual health budgets, with individual methods being supplied by different parties. Scottish and Welsh Trusts are leading the way, with government and public health funding.

Conclusions: IPC provision across the UK is heterogeneous, with most surveyed Trusts at early planning stages, and targeted, limited or ad-hoc provision. Commissioning in England was consistently highlighted as a barrier. We need coordinated, national sharing and evaluation of IPC commissioning and delivery models to make universal IPC a reality for women in the UK.

Poster 4

Abstract Title: Reducing caesarean birth rates: Audit of counselling regarding birth options provided to pregnant women with one previous caesarean birth at University College London Hospital (UCLH)

Abstract Author(s): Ellie Bard, Jo Modder

Please indicate type of project: Audit

Institution: Women's Health Division, University College London Hospitals NHS Foundation Trust

Background/ Purpose: In 2016, 45% of elective caesareans (ELCS) at UCLH were due to previous caesarean.

Materials and Methods: We obtained a list of births at UCLH in 2016 where the woman had one previous caesarean and no other children (n=631). After excluding contraindications to VBAC, we randomly selected 150 women, examined 113 maternity notes and collected information pertaining to the UCLH VBAC guideline.

Results: Women expressing a preference for ELCS before counselling were more often seen by obstetricians while those preferring VBAC were seen in midwife-led birth options clinics (BOC) ($p=0.03$). Women seen in BOC had higher rates of intended ($p=0.02$) and actual ($p=0.03$) VBAC. There was a low intended (38%) and actual (20%) VBAC rate overall. The VBAC success rate was 56% amongst the 36 women attempting VBAC. Documentation of information given was poor. 37% were given the recommended leaflet. 23% of women attending BOC, and none seeing obstetricians, had a VBAC counselling checklist completed. Women seen in BOC were given more information due to use of the checklist.

Conclusions: UCLH has a low VBAC rate. Women should have access to the same pathway regardless of their initial preference for birth mode. Counselling is poor and the counselling checklist should be used for all women.

Poster 5

Abstract Title: GP referrals to colposcopy – indications and outcomes

Abstract Author(s): Dr Priyanka Patel, Mr Eric Nyarko

Please indicate type of project: Quality Improvement

Institution: Homerton Hospital

Background/ Purpose: There are two sources of referral into Homerton Colposcopy clinic, direct referrals from the laboratory and referrals from GPs.

Materials and Methods: 100 GP referrals to colposcopy in October 2019 were analysed.

Results: Age: 54% were age 34 or younger. •Referral indication: The majority (44%) were referred with postcoital bleeding and/or intermenstrual bleeding; 29% had a previous abnormal smear or biopsy; 13% had a clinically suspicious cervix/contact bleeding; and 11% had a cervical polyp/inadequate or difficult smear. •Referral smear or histology status: The majority (44%) were negative and only 2% had high grade changes. •20% patients were referred as urgent.

Colposcopy impression: 33% didn't have a colposcopy (DNA/cancellations); 24% had no abnormality seen; and 4% were thought to have high grade disease. •Colposcopy smear/biopsy results: 26% had no tests taken due to normal colposcopies; 25% had negative/benign results; and 6% had high grade results. •Outcome: 48% were discharged. •Test results from the 44 patients referred for PCB/IMB: DNA/cancellations 14 Benign pathology/negative results/none taken 21 HPV only 4 Low grade 4 Unsatisfactory biopsy 1 • Test results from the 13 patients referred with clinically suspicious cervix/contact bleeding: DNA 1 None taken 6 Negative 5 HPV only 1

Conclusions: In this sample, purely clinical indications for colposcopy, in the absence of an abnormal smear, yielded no significant pathology.

Poster 6

Abstract Title: VTE assessment in Surgical Management of Miscarriage

Abstract Author(s): R.Dwyer, V.Wong, D.Borlase

Please indicate type of project: Audit

Institution: Queen Elizabeth Hospital, Woolwich

Background/ Purpose: VTE is a leading cause of maternal death representing around 1.39 per 100,000 maternities. Although the majority of these occur in the 3rd trimester and post partum, still 10.1% occur in the 1st trimester. Further 16% of deaths occur in the 1st trimester alone. This highlights the need for obstetric VTE assessment for surgical management of miscarriage (SMM).

Materials and Methods: We reviewed 102 cases of SMM between August and December 2019 to see if we appropriately VTE risk assessed them.

Results: 25% were incorrectly VTE assessed. Of those deemed intermediate or high risk VTE 86% were not given clexane. For example a case of a lady who underwent SMM with a BMI 46 and smoker was not given LMWH for discharge. Of all the patients that were not given LMWH there was no documented evidence of representation with VTE.

Conclusions: This review highlighted the need for a clear VTE obstetric assessment to add to our units' SMM care bundle. We also have recently educated all juniors to remember to do the obstetric VTE assessment.

Poster 7

Abstract Title: Induction of labour – Is there a role for mechanical induction?

Abstract Author(s): Sobanakumari Jeyapala, Kimberley Kok, Maya Al-Memar, Kiren Gill, Iris Derwig

Please indicate type of project: Review of practice

Institution: Chelsea and Westminster

Background/ Purpose: Agents used to induce labour include prostaglandins, amniotomy and mechanical induction. We performed an audit looking at agents used in our practice in order to help guide clinicians when personalising patient's IOL care plans.

Materials and Methods: Prospective audit reviewing the notes of randomly selected patients between July 2019 to October 2019 on the IOL pathway. Information was collected using hospital records. The agents used for IOL and mode of delivery were reviewed.

Results: 64% of patients had propress as their first line agent; 10% used prostin; 1 patient had a balloon. 17% of patients required a second agent and 44% of these patients required a 3rd agent. All patients requiring a 3rd agent subsequently had an 'Emergency caesarean section' (EMCS). 11% of patients had hyperstimulation and 5% had tachysystole following prostaglandin use.

Conclusions: Recommendations following this audit include:

1. Consider using mechanical balloon induction as a primary method or subsequent to prostaglandins to reduce the risk of hyperstimulation/ tachysystole. This additionally allows outpatient IOL, relieving pressures on inpatient workload.
2. Consider offering caesarean section to patients requiring a 3rd prostaglandin. To reduce the morbidity associated with EMCS later in labour.

Poster 8

Abstract Title: When should we offer a postdates induction of labour?

Abstract Author(s): Sobanakumari Jeyapala, Kimberley Kok, Maya Al-Memar, Kiren Gill, Iris Derwig

Please indicate type of project: Review of practice

Institution: Chelsea and Westminster Hospital

Background/ Purpose: The 2019 SWEPIs study compared the outcomes of postdate 'Induction of Labour' (IOL) offered at 41 versus 42 weeks; there was significant neonatal mortality in the latter group. Therefore, the recommendation was to offer IOL at 41 weeks. We reviewed our own IOL pathway to assess if changes could be made.

Materials and Methods: Prospective audit reviewing the notes of randomly selected IOL patients between July 2019 - October 2019. Information collected using hospital records. The indication for IOL and mode of delivery was reviewed.

Results: 22% of patients had an IOL for postdate pregnancies, this was the most common indication. 50% of postdate inductions had an emergency caesarean section. 39% of patients had an emergency IOL; 38% of these were for reduced fetal movements (RFM).

Conclusions: The results show that IOL at a later gestation may not correlate to a reduced caesarean section risk and therefore supports an earlier induction. Offering elective IOL at 41 weeks could also reduce emergency IOL for RFM at later gestations; allowing people to be counselled appropriately by managing expectations, whilst also reducing birth trauma. This would relieve the pressures associated with inpatient emergency IOL.

Poster 9

Abstract Title: A quality improvement project to standardise care for women with pregnancy of unknown location in Croydon University Hospital using the M6 prediction model

Abstract Author(s): Amokrane, N., Warren, D., Rose, D.

Please indicate type of project: QIP

Institution: Croydon University Hospital

Background/ Purpose: Women who are given an outcome of pregnancy of unknown location at our Early Pregnancy Unit have not had standardised care. A new prediction model to stratify the risk of these patients having high risk outcomes ie ectopics or persistent PUL vs low risk outcomes such as failing PUL or intrauterine pregnancy has been developed and tested in two large multicentre studies. A pilot study was tested in our unit using this model for a trial period of 1 month to see if we could safely use this model to risk assess our patients and standardise care.

Materials and Methods: All women who had an outcome of PUL at their initial scan were triaged in a 2-step protocol including M6 model as proposed by Bodiwala et al. Data was collected and analysed using Excel and electronic patient records..

Results: During a month period, 29 patients had a first scan outcome showing PUL. 7

patients were suitable for immediate discharge following step 1 and 4/7 (57%) were correctly discharged at this point. 22 patients proceeded to step 2 in the model and of these 10 were flagged as high risk. 4/10 patients had ectopic pregnancies in this group. 1 out of 4 ectopic pregnancies was ruptured prior to the final diagnosis being made. 12 patients were flagged as low risk at step 2 and no ectopics or persistent PUL were eventually diagnosed in this group.

Conclusions: Overall, staff had good feedback on using the model. All high risk patients were correctly predicted and no high risk patients were found in the low risk group.

Poster 10

Abstract Title: Case report: An unlikely twist

Abstract Author(s): Dr Ishak (ST3) and Miss Sally Watkinson

A 35-year-old pregnant woman was brought in by ambulance to labour ward triage with a history of dizziness, vomiting and collapse; blood pressure was 90/50. On arrival she complained of severe groin pain. She'd delivered her previous child by caesarean section for breech, and despite appearing full-term (symphysis-fundal height: 41cm), she was only 30+1 weeks pregnant, with no history of gestational diabetes or polyhydramnios. The fetal heart was abnormal; ranging from 120bpm to 80bpm. Soon a fetal bradycardia necessitated a category 1 caesarean section on the suspicion of uterine scar rupture. The baby was born in a good condition and received resuscitation. During the operation the uterus appeared congested; it was large, boggy and a deep red/purple colour. There was no rupture. Reflecting the bladder was difficult. Following delivery the uterus was exteriorised and in fact the uterus had spontaneously torqued 180 degrees (see images).

On reflection, a tell-tale sign from this case could be the groin pain and inappropriately large symphysis-fundal height for gestation; perhaps created by the obstruction of venous return despite cumulative inflow of high-pressure arterial blood. The tension on the round ligament would also contribute to the pain.

Spontaneous uterine torsion is a rare occurrence, with minimal cases in the literature. It remains a rare but important differential in the cause of groin pain, maternal collapse and fetal bradycardia. Prompt consideration this rare cause should trigger urgent delivery to better resuscitate the mother and neonate.

Poster 11

Abstract Title: Mode of delivery of DCDA twin pregnancy: maternal and neonatal outcomes

Abstract Author(s): Madeleine Trowsdale Stannard

Please indicate type of project: QIP

Institution: Kingston Hospital NHS Foundation Trust

Background/ Purpose: Kingston Hospital cares for more than 120 DCDA twin pregnancies every year. Twin pregnancies are associated with higher maternal and neonatal morbidity and mortality than singleton pregnancies, with many complications relating to mode of delivery. Given this increased risk, it is essential to choose the appropriate mode of delivery.

Materials and Methods: Data were collected for 126 women with DCDA twin pregnancies who delivered at Kingston Hospital in 2019. Information regarding estimated blood loss (EBL),

maternal postnatal complication and neonatal unit (NNU) admission was collected from the digital records and handheld patient notes.

Results: Maternal postnatal complication rate was 11% following vaginal delivery, 0% following instrumental delivery, and 24% and 35% following ELCS and EMCS respectively. EBL was highest following EMCS and lowest following vaginal delivery. Conversely, 27% of babies born by vaginal delivery required NNU admission, whilst only 12% and 15% of babies born by ELCS and EMCS were admitted to NNU.

Conclusions: Women who had ELCS had higher rates of postnatal maternal complication and a higher EBL, but lower rates of NNU admission. Balancing the risk to mother and baby is clearly critical, hence decision-making regarding mode of delivery should be patient centred and involve the multidisciplinary team and the patient.

Poster 12

Abstract Title: Diagnostic and therapeutic laparoscopy performed in the Day Surgery Unit at Croydon University Hospital: Indications, pre-surgical managements, investigations and outcomes.

Abstract Author(s): Amokrane, N., Le Bas, A., Collaris, R.

Please indicate type of project: AUDIT

Institution: Croydon University Hospital

Background/ Purpose: Laparoscopy remains the gold standard for diagnosis of endometriosis but is not without its inherent risks. NICE gives clear guidance regarding the investigation and management of suspected or confirmed endometriosis. This audit aimed to establish national guideline adherence.

Materials and Methods: We performed a retrospective audit of 50 laparoscopies in our day surgery unit over a three-month period. Data collection occurred via electronic notes and was analysed with Excel.

Results: The most common presenting symptoms were chronic pelvic pain (56%) and dysmenorrhoea (60%), with 60% having 2 or more symptoms. 24% had a documented pelvic examination prior to surgery and 78% had an ultrasound. 0.5% had a symptom diary, with 54% having a trial of analgesia and 39% of those suitable, having a trial of hormonal management. The negative laparoscopy rate was 24%. Ultrasound features correlated with laparoscopy findings in 51% with the remainder discovering further pathology surgically. Follow up and further management offered was variable, not correlating with surgical findings or treatment. 64% were offered follow up. 28% patients were not offered any further management or follow up, including some with a new diagnosis of endometriosis.

Conclusions: Correct preoperative assessment and management of patients with suspected endometriosis could help reduce the number of procedures required, thereby the total number of complications, and our negative laparoscopy rate going forward. A local patient pathway will be developed to facilitate this and to ensure postoperative counselling and follow up is arranged. This will enable optimal patient care, with potential for safety and financial benefits.

Poster 13

Abstract Title: Outpatient Hysteroscopy: An audit of pain management before and after OPH at Croydon University Hospital, including self-assessed patient experience feedback.

Abstract Author(s): Le Bas, A., Amokrane, N., Ajay, B.

Please indicate type of project: Patient survey and audit

Institution: Croydon University Hospital

Background/ Purpose: NICE recommends outpatient hysteroscopy (OPH) or ultrasound as a first-line investigation for dysfunctional uterine bleeding. Best practice includes advising patients to take analgesia pre-procedure and vaginoscopic techniques with miniature hysteroscopes.

Materials and Methods: We audited our pain management and patient experience of pain. All patients who attended OPH in one month were asked to evaluate their experience anonymously.

Results: 72 patients completed this questionnaire. Pre-procedure, 72% felt well-informed and 61% took analgesia. 45% reported adequate time to discuss analgesia during the consultation. 53% deemed OPH 'slightly' painful, with 4% feeling pain 'constantly'. 85% deemed the overall experience as 'excellent', the remaining 15% considering it 'good'. 55 consecutive OPH cases were then audited using patient notes and Excel to assess our pain management. The main OPH indications were postmenopausal bleeding (35%) and heavy menstrual bleeding (40%). 19% of patients had documentation of having taken analgesia pre-procedure. Miniature hysteroscopes were used in 85% of cases and 5mm scopes were used in 13%. Failure rates, use of anaesthetic and dilatation of cervix rates were higher for these cases.

Conclusions: This audit confirms miniature hysteroscopes are vital to reduce OPH failure rates and the need for further procedures, which furthers the proposal for purchasing more miniature scopes in our unit. We have instigated a new practice of calling patients pre-appointment to advise of analgesia use before OPH.

Poster 14

Abstract Title: Management of ectopic pregnancy at University Hospital Lewisham

Abstract Author(s): Geddes-Barton, M; Mehra, H; Morgan, S

Please indicate type of project: Audit

Institution: University Hospital Lewisham

Background/ Purpose: To assess whether the ectopic pregnancy management at University Hospital Lewisham was in line with local and national guidelines and to compare to a previous audit from 2017-2018

Materials and Methods: We identified cases coming through EPU and A&E from a 7 month period of June 2020 - December 2020 and then collected data using Icare and Astria and used Excel for data entry. We recorded age, parity, history of previous ectopic, presenting bhcg and progesterone, management (surgical, medical, conservative), success of management, time to definitive management and follow up plan and documentation

Results: We looked at a total of 41 cases. 42% of these were managed conservatively, 2% medically and 57% surgically. 95% had a baseline bhcg and progesterone at presentation. 81% of those who opted for surgical management had their surgery with 24 hours. 83% had successful conservative management. 85% were given advise re future pregnancies on

discharge. As a trust we still have some areas to improve on our management of ectopic pregnancy. 6 of the women who had a previous salpingectomy had another salpingectomy with no reason documented in the notes why not a salpingotomy. 20% failure of conservative management and 20% of conservatively managed women were lost to follow up. Only 84% of the conservatively managed women were discussed with a consultant and only 66% had a documented discussion of options as per the guideline.

Conclusions: As a trust there are areas that we need to improve on for management of ectopic pregnancy. We need better documentation of discussion of options, advice re pregnancy test follow up if salpingectomy, appropriate selection of conservative management, better training in salpingostomy/ better documentation for reason for salpingectomy and to address theatre delays. Also from the range of bhcg's at presentation we have noted that they range from 95 - 105000 so no bhcg can rule out an ectopic pregnancy.

Poster 15

Abstract Title: Developing a new Postpartum Contraception (PPC) service in Obstetrics during the Covid19 pandemic.

Abstract Author(s): Amelie Morin, Elisabeth Kostov, Alexandra Cann, Anwen Gorry

Please indicate type of project: QIP/Audit

Institution: Whipps Cross Hospital

Background/ Purpose: 45% pregnancies in the UK are unplanned and 20% women who present to local abortion services had a baby within a year. PHE estimates that every £1 spent on contraception saves £9 to the public sector. The "Better for Women" report advocates one-stop services for women's health. Access to sexual health services further reduced during the Covid19 pandemic. We decided to set up a PPC service and we audit the first year of use.

Materials and Methods: Patient questionnaires on attitudes to contraception were undertaken in maternity to assess patients' interest and knowledge. Training sessions on contraception counselling were given to midwives, GPs and junior doctors. We have built a partnership with the nearest sexual health department to secure funding, facilitate staff training and patient follow-up. We review our service use and women's feedback after one year.

Results: 80% stated they planned to use contraception, but only 26% had discussed contraception with a healthcare professional during pregnancy. 28% were interested in immediate IUCD or implant insertion postnatally. We identified misconceptions about hormonal contraception and addressed them by improving women's awareness. 5% of women were discharged from maternity with contraception: 43% subdermal implant, 32% IUCD, 24% POP. No IUCD expulsion or perforation were reported and 91% of users were very satisfied.

Conclusions: The antenatal period involves regular contact with women including high risk and vulnerable patients. There is a substantial unmet patient demand for immediate LARC, which could lead to improved pregnancy spacing and reduce unplanned pregnancy and abortions.

Poster 16

Abstract Title: Intracorporeal laparoscopic suturing training during Covid19 pandemic: Computers Vs the Instructor

Abstract Author(s): Lazaridis, Iliodromiti, Navaratnarajah, Odejinmi

Please indicate type of project: A prospective pilot control study

Institution: Barts Health NHS Trust

Background/ Purpose: Our recent experience suggests that current and future generations of surgical trainees will have less opportunity for traditional face to face surgical and to an extension laparoscopic simulation training because of social distancing and limitations in travelling due to prolonged Covid19 restrictions. We designed a computer-based video instruction (CBVI) package to test the training potential (primary outcome) and effectiveness (secondary outcome) of CBVI when compared to the traditional instructor-guided simulation training (IGST) for intracorporeal laparoscopic suturing.

Materials and Methods: Twenty 3rd and 4th year medical students from Barts Medical School; who had no previous laparoscopic experience, volunteered to attend a 60min training session followed by a performance assessment at the end of their session and after 4 weeks. They were randomized in two groups of 10 participants. The groups were matched for gender, right/left hand dominance, previous knowledge of a musical instrument and/or video games exposure and surgical career aspirations.

Results: Both groups showed similar performance outcomes for task completion, an intracorporeal laparoscopic knot, confirming our primary outcome that CBVI has comparable training potential. Nine out of 10 participants of the CBVI group successfully completed the task, with only one dropout; while in the IGST group only 7 out of 10 participants successfully completed the task with three dropouts. ($P = 0.267$). Regarding the secondary outcomes (time and precision), both CBVI and IGST groups had similar performance without substantial difference for all three key steps of laparoscopic suturing (needle loading, needle driving, knot tying). On the 4-week skills retention assessment individuals of the CBVI group performed significantly better compared to the IGST for needle loading ($F = 9.758$, $P = .014$).

Conclusions: CBVI participants completed the task and showed lower time in needle loading than their IGST counterparts, therefore supporting the hypothesis that CBVI training for laparoscopic intracorporeal suturing seems to be reliable and effective. Moreover, when we take into account costs for travelling and hiring of training facilities as well as considerable faculty time commitments, which can also result to clinical time scheduling conflicts, then the video-only training is a more effective training approach for laparoscopic suturing and potentially other complex laparoscopic skills training; especially during Covid19 restrictions.

Poster 17

Abstract Title: "Can you hear me?" - virtual antenatal appointments in the COVID era and beyond

Abstract Author(s): Dr Christina Tavener, Dr Christopher Kyriacou, Imene Elmascri, Antenatal Big Room, Ms Sabrina Das

Please indicate type of project: Quality Improvement Project

Institution: Queen Charlotte's and Chelsea Hospital, Imperial College Healthcare NHS Trust

Background/ Purpose: The COVID-19 pandemic called for a rapid change in the running of hospital outpatient services. Coupled with a longstanding problem of long waiting times in the

Consultant-led antenatal clinic, our team aimed to reduce face-to-face patient consultations in order to limit potential viral exposure and improve patient satisfaction. Multiple specialities have successfully and safely introduced virtual consultations in order to reduce hospital footfall and facilitate remote work, for example in individuals who are shielding or self-isolating.

Materials and Methods: In March 2020, clinics were pre-vetted by the responsible Consultant, to select suitable patients to be reviewed remotely, via video or telephone. Our aim was to review 15% of patients virtually and reduce waiting times to an average of 30 minutes. Clinic templates were altered, to increase appointment times from 20 to 25 minutes and 'AccuRx' software was used to communicate meeting details and conduct consultations. Data collected from March to June 2020 detailed numbers of consultations of each type and face-to-face clinic waiting times, along with qualitative patient feedback.

Results: We successfully met our target to review 15% of patients remotely, reducing our average face-to-face clinic waiting time from 45 to 30 minutes. Significant advantages were highlighted by our patient population, including convenience for childcare, allowing partner involvement and comfort of waiting for appointments at home. However, internet connection issues, time required to pre-vet clinics and need to streamline the administration process are all areas for further development.

Conclusions: We have shown that virtual appointments can be introduced to the antenatal clinic with ease; reducing contact with a patient population vulnerable to COVID-19 and reducing face-to-face waiting times to improve patient satisfaction. We suggest that this straightforward approach could be adopted by other maternity services to offer similar benefits.

Poster 18

Abstract Title: Interventions available during pandemics for heavy menstrual bleeding

Abstract Author(s): Thomas Mitchell, James MN Duffy

Please indicate type of project: Systematic Review of evidence and creation of patient information tool for use by clinicians discussing treatment options for women with menstrual bleeding during the COVID-19 pandemic.

Institution: Cochrane Gynaecology and Fertility Group, University of Auckland, New Zealand

Background/ Purpose: The COVID-19 pandemic caused significant disruption to access to specialist assessment and treatment for gynaecological problems including heavy menstrual bleeding. This systematic review aimed to evaluate the effectiveness and side effects of commonly available treatments for heavy menstrual bleeding available in a pandemic. The evidence was used to create a shared decision making tool to aid patients and clinicians in making informed decisions for treatment options in this context.

Materials and Methods: We sought published Cochrane Reviews, evaluating interventions that can continue during pandemics for women with heavy menstrual bleeding with no known underlying cause. We identified Cochrane Reviews by searching the Cochrane Database of Systematic Reviews in June 2020. The primary outcome was menstrual bleeding. Secondary outcomes included quality of life, patient satisfaction, side effects, and serious adverse events. We undertook the selection of systematic reviews, data extraction, and quality assessment in duplicate. We resolved any disagreements by discussion. We assessed review quality using the Assessing the Methodological Quality of Systematic Reviews (AMSTAR) 2 tool, and the certainty of the evidence for each outcome using GRADE methods.

Results: Four Cochrane Reviews, with 11 comparisons, data from 44 randomised controlled trials (RCTs), and 3196 women were included in the review which informed the decision making tool. We assessed all the reviews to be high quality. Key results: There is moderate-certainty evidence that antifibrinolytics and combined hormonal contraceptives reduce heavy menstrual bleeding compared with placebo. There is low-certainty evidence that non-steroidal anti-inflammatory drugs (NSAIDs) reduce heavy bleeding compared with placebo. There is low-certainty evidence that antifibrinolytics are more effective in reducing heavy menstrual bleeding when compared with NSAIDs and short-cycle progestogens.

Conclusions: Antifibrinolytics, non-steroidal anti-inflammatory drugs and combined oral contraceptive pills are effective treatment options for heavy menstrual bleeding, available in the context of pandemics. Women's values, preferences and circumstances should be taken into account when making shared decisions for treatment. A decision aid can assist with the process of shared decision making.