IBD Registry

IBD REGISTRY ROADSHOW 2017

THURSDAY 18TH MAY 2017
CARDIFF

These meetings have been funded by Celltrion Healthcare, Dr Falk Pharma UK Ltd, Janssen, Napp Pharmaceuticals Ltd, Takeda Ltd, Tillotts UK Pharma Ltd, with no input into the meeting programme.

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IBD Registry

Co-Chairs:

Barney Hawthorne & Helen Ludlow
University Hospital of Wales,
Cardiff

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Roadshow objectives

IBD Registry

- Update on biologics audit and QI programme using the IBD Registry
- Provide protected time for IBD teams to plan for Registry participation
- Offer support with the adoption process, wherever you are on the pathway
- Give the chance for you to contribute ideas and opinions on future Registry development

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Agenda

2.00pm	Welcome and introduction	Co-chairs: Barney Hawthorne & Helen Ludlow
2.15pm	The 2017 IBD landscape	Richard Driscoll
2.45pm	IBD Wales	Barney Hawthorne & Helen Ludlow
3.15pm	Where are we now and where do we want to get to?	Facilitated by Nicola Brett & Claire Munro
3.30pm	Working to embed Quality Improvement	Susan Murray
3.50pm	Practicalities of IBD Registry participation – ask the expert	Barney Hawthorne Helen Ludlow Susan Murray Richard Driscoll
4.10pm	***Tea break***	
4.30pm	Moving on up – how to get to the next step on the ladder	Facilitated by Nicola Brett & Claire Munro
5.30pm	Feedback and conclusions	Barney Hawthorne & Helen Ludlow
6.00pm	***Meeting close***	

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IBD Registry

@IBDRegistry

@BritSocGastro

@CrohnsColitisUK

@dovetail_health

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Logistics support has also been provided by Tillotts

None of the companies had any influence over programme content.

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IBD Registry

Making
information work
for **patients**,
their **clinical teams**
and the **NHS**

IBD Registry

The 2017 IBD Landscape

Richard Driscoll
Development Lead, IBD Registry

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Outline

- Audit & Registry – ongoing data collection for QI using the IBD Registry to collect the data
- Registry systems
- IBDR 2017 objectives
- What's in it for you and your patients?
- Research
- Support

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Outline

- Audit & Registry – ongoing data collection for QI using the IBD Registry to collect the data
- Registry systems
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- Research
- Support

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Aims of the IBD Registry

Creating a UK-wide repository of pseudonymised IBD adult and paediatric patient data for prospective quality assurance, audit and research purposes.

This will:

- Drive continuous improvement in patient care & access to care across the UK
- Provide local, regional & national data in order to better define the pattern of colitis and Crohn's disease
- Improve understanding of long term outcomes
- Inform commissioning and service design
- Support IBD research

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Previously in IBD:

- Focus was on collecting data for audit
  - Specified data collected in a defined time period.
  - Analysed nationally and results fed back in a report for local QA and to stimulate local QI.
- Biologics audit introduced continuing data collection, but still with an audit focus
  - Some IBD Teams used the system as their database for managing their biologics, but it was not the primary purpose.

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Registry Approach

- Local service development
  - Introducing the routine use of an electronic record holding IBD clinical data
  - Using that data to manage patient care and inform service delivery
- Registry – secondary use of the data
  - Audit (national benchmarking for QA))
  - Using the national data to support QI
  - Pharmacovigilance
  - Research
- *Enter data once and use for multiple purposes*

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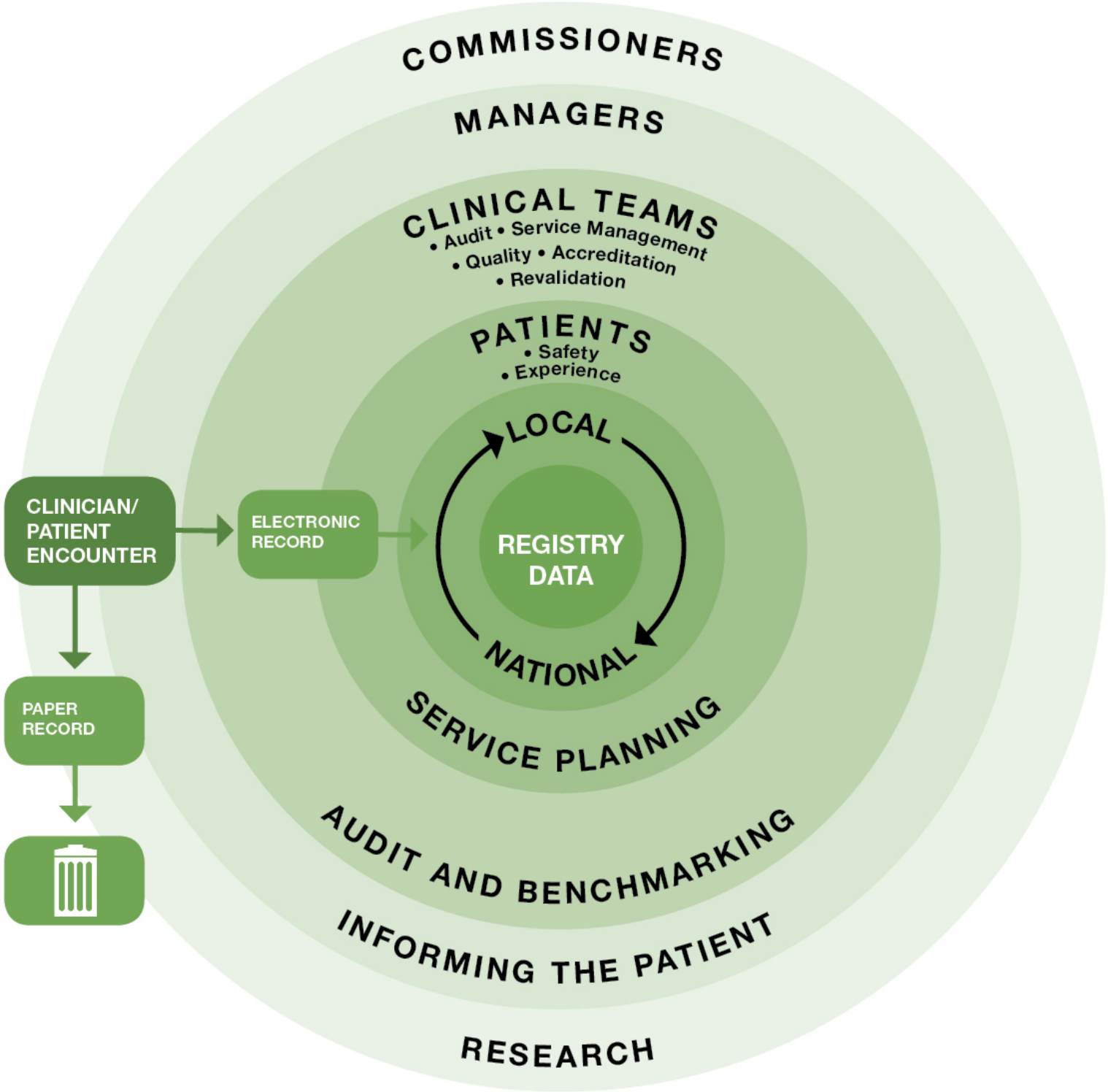
COMMISSIONERS
MANAGERS
CLINICAL TEAMS
• Audit • Service Management
• Quality • Accreditation
• Revalidation
PATIENTS
• Safety
• Experience
LOCAL
REGISTRY DATA
NATIONAL
SERVICE PLANNING
AUDIT AND BENCHMARKING
INFORMING THE PATIENT
RESEARCH
CLINICIAN/ PATIENT ENCOUNTER
ELECTRONIC RECORD
PAPER RECORD

IBD Audit > IBD Registry

2016/17 was the year of transition from the IBD Audit to the IBD Registry:

- Sites were asked to
  - establish a Registry-compatible system and
  - to take back their historic biologics data for transfer into the Registry system
- The final IBD Audit biological therapies report was published.
- RCP web tool was closed in January 2017.
- RCP QI work continues to September 2017.
- Registry re-launched the Biologics Audit (more later)

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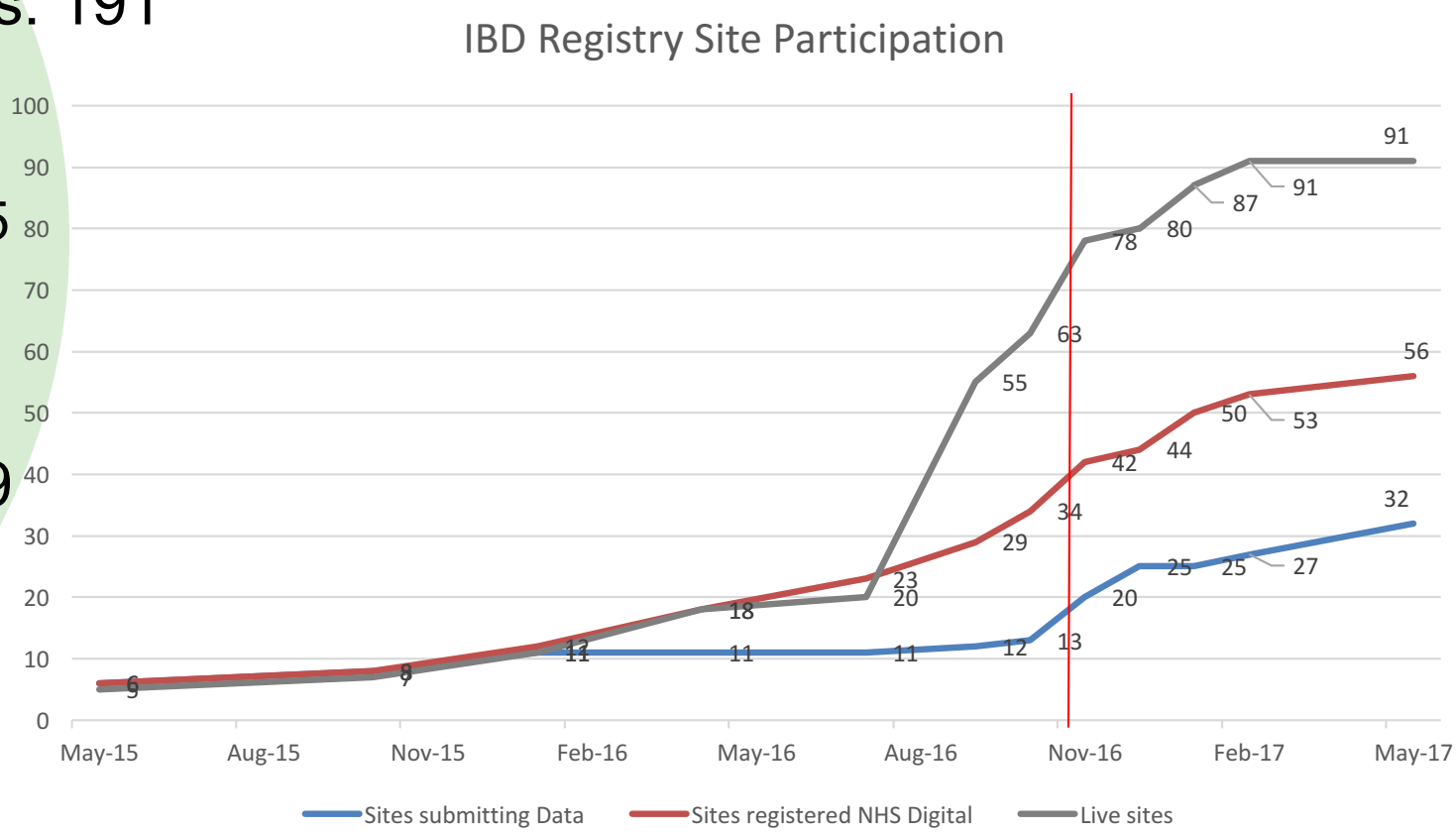
Current participation

- Registered sites: 191
- Live sites: 91
  - Web Tool = 55
  - PMS = 22
  - Other = 13
- Pipeline sites: 9
  - Web Tool = 2
  - PMS = 5
  - Other = 2



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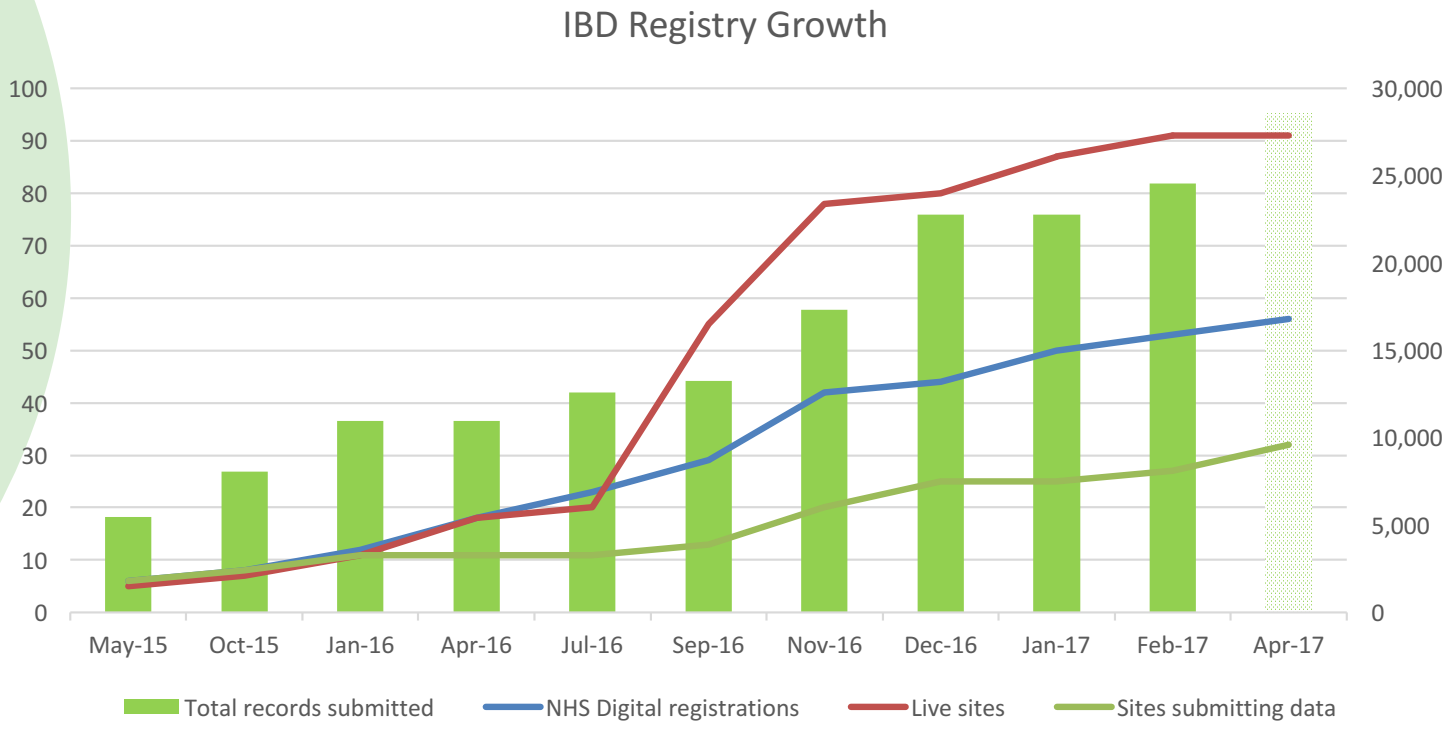
Data submission status

- NHS Digital registrations: 56
  - Web Tool = 29
  - PMS = 17
  - Other = 10
- Data submitted:
  - ~24,500



* further ~5,000 to be submitted

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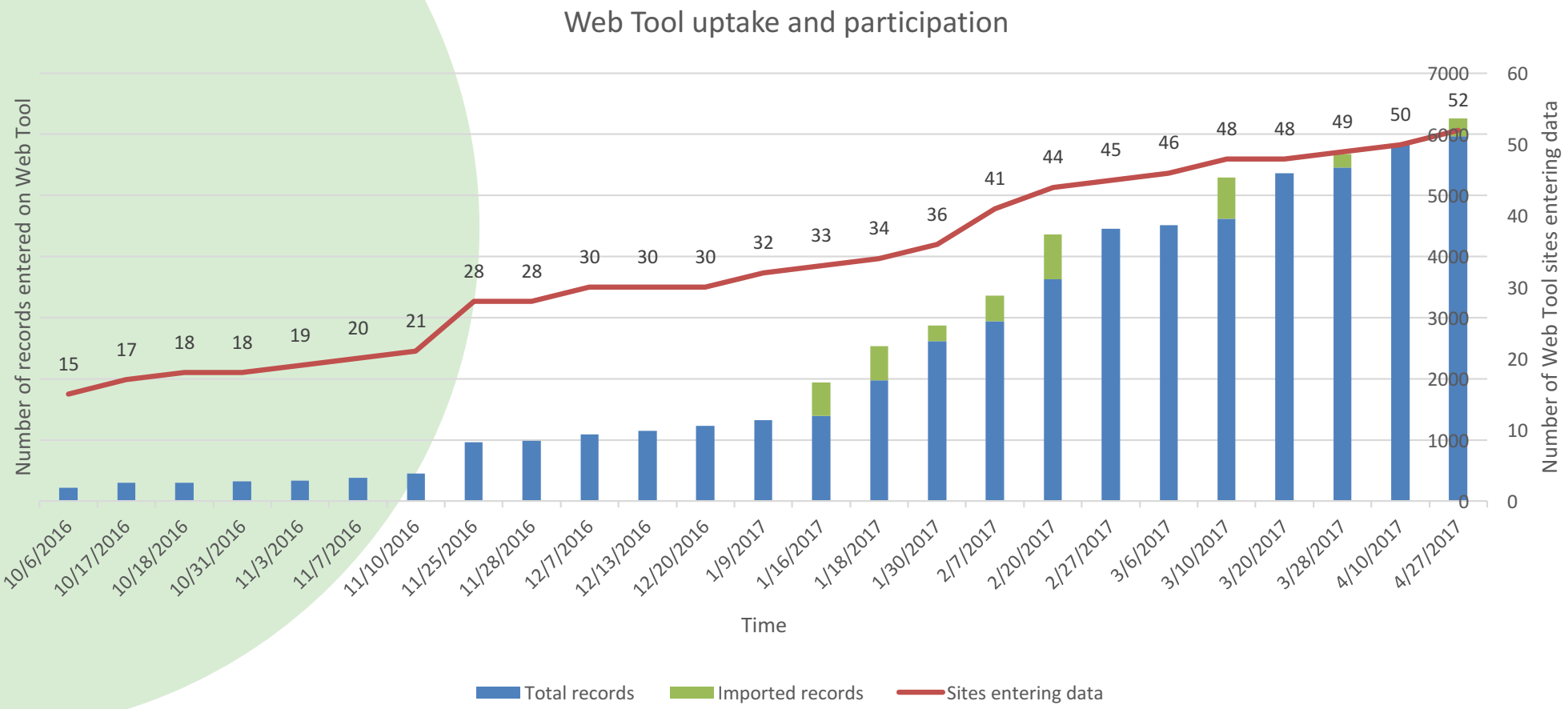
Web Tool uptake



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52/58 sites entered data using the Web To

Outline

- Audit & Registry – ongoing data collection for QI using the IBD Registry to collect the data
- Registry systems
- IBDR 2017 objectives
- What's in it for you and your patients?
- Research
- Support

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IBD Registry System(s)

- Maximising the value of the IBD clinical data
- Meeting NHS Standards for patient privacy and data security
- Aligning with NHS IT across the UK enabling local choice of EPR system for IBD
- Aligning with NHS national plans

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IBD Registry

Step 1

IBD Registry

Core IBD dataset

- Demographics
- Consent
- Diagnosis
- Contacts
- Disease Classifi
- Disease Scores
- Medication
- Biologics
- Surgery

NHS Number
Date of birth
Gender
Postcode
GP Practice code
Date of death
IBD involvement in death
Date of Current Diagnosis
Current diagnosis
Date of onset of symptoms
Earliest Diagnosis
Date of Earliest Diagnosis
Local unit code
IBD Audit code
Date consent last recorded
Informed consent for registry
Informed consent for linkage
Informed consent for research
Consent to be contacted for future research
Date of contact
Contact type
Adult or paediatric service patient
Postcode at time of contact
AgeOfOnsetAdult(Montreal)
Extent of UC Adult (Montreal)
Behaviour Crohns Adult (Montreal)
Location Crohns Adult (Montreal)
Disease Proximal to terminal Ileum (Montreal L4)
AgeOfOnsetPaediatric(Paris)
Extent of UC Paediatric(Paris)
Behaviour Crohns Paediatric(Paris)
LocationCDPaediatric(Paris)
Disease Proximal to terminal Ileum (Paris L4a L4b)
Perianal Crohn's Disease
HBI Total Score
Modified UCDAI
weightedPCDAI
PUCDAI
SCCAI
Smoking status
Local unit code
IBD Audit code
Date of hospital admission for IBD management
Type of admission
Reason for admission
Date of discharge
Local unit code
IBD Audit code
Date of surgery
Hospital where surgery took place

Hospital where surgery took place
Main Surgical Procedure
Other Surgical Procedure
Surgery performed laparoscopically
Local unit code
IBD Audit code
Date of diagnosis of cancer
Site of cancer
Local unit code
IBD Audit code
Date of measurement
Height (m)
Weight (kg)
Local unit code
IBD Audit code
Date Occupation Status Recorded
Primary Occupation Status
Year Type
Relevant Year
Days lost - number
Days lost - range
Local unit code
IBD Audit code
Date of Control PROM
Question1a
Question1b
Question2
Question3a
Question3b
Question3c
Question3d
Question3e
Question 3f
Question4a
Question4b
Question4c
Question4d
Question5Vas
IBDCTRL-8SCORE
Local unit code
IBD Audit code
Drug Code
Drug Start Date
Drug End Date
Dose
Unit
Frequency
Route of Administration
Biologics Drug End Reason
Local unit code
IBD Audit code
IBD Biologics Audit site code

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IBD Registry

Existing EPRs if Registry-compliant

Local EPRs and Databases
Bioresource system

Local IBD Patient Management Systems

InfoFlex Patient Management System
EMIS Gastroenterology (was Ascribe)

Web Tool

Web-based Tool (InfoFlex)

NHS Digital

Pseudonymisation of patient data

England only

NHS Digital

Linking to NHS routine activity data - HES

Quarterly

Annually

IBD Registry

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Choosing a system

Locally-installed PMS:

- Greater functionality
- Can be interfaced with hospital systems (e.g. PAS, letters, pathology etc)
- Can be adapted to local wishes to some extent
- Upfront cost and IT often slow to implement

Registry Web Tool:

- Less functionality
- Cannot be interfaced with local hospital systems
- Speed dependent on local internet
- No customisation possible
- Quick to implement and lower cost

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EPR system costs

- Locally installed system:
  - InfoFlex PMS from CIMS – approx £13,250* covering installation, PAS integration, 3-year licence)

    [**There are sometimes additional local costs]*
  - EMIS for Gastroenterology – ask for quote

- Registry Web Tool:
  - Minimal IT requirement - £1,000 pa

    (data usually transferable to InfoFlex or EMIS)

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Outline

- Audit & Registry – ongoing data collection for QI using the IBD Registry to collect the data
- Registry systems
- IBDR 2017 objectives
  - Establish funding model
  - Focus on biologics data collection
  - Focus on reporting to IBD Teams
- What's in it for you and your patients?
- Research
- Support

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Registry Funding model

- Subscription for Audit participation and a cost recovery charge for use of the Web Tool
- Registry-initiated research projects
- Charitable Grants (e.g.CCUK)
- Projects using the Registry for data capture and analysis
  - Professional/academic (e.g. BSPGHAN Pinpoint)
  - Investigator-led/Industry-funded (e.g. VEST)
- Industry Grant Support

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2017/18 rationale for biologics focus

- Registry data will have real statistical value when we have near complete data on a given set of patients with a common set of data points
- Data on biologics has real value for clinical teams, managers and commissioners, patients and potential funders
- Our aim is to build on the success of the IBD Audit biologics data collection

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2017/18 objective

- A near complete register of patients on biological therapies in as many IBD units as possible
  - with their historic data from RCP audit
  - with all new patients being entered routinely
  - with a realistic set of data points common to all patients
  - KPIs focused on the improvement messages from the last RCP report

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2017/18 Biologics Audit/QI

- Selection of 7 KPIs for benchmarking based on findings in final report.
- Data collection on all current biologics patients.
- Quarterly cycle:
  - Data submitted by IBD Teams June/Sept/Dec/March
  - Registry feedback back to IBD Teams/Boards each quarter.
- Audit remains in Quality Accounts in England
- Trusts/Boards must pay a subscription to participate

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Biological therapy KPIs

Pre-treatment checks

- Was the patient screened before starting on a biological therapy?
- Was a formal assessment of disease activity recorded at the point the decision was made to commence a biological therapy?
- Is there a record of Registry consent being discussed with the patient?

Post-induction review (approximately 3 months after the date of the initial treatment)

- Did a post-induction review take place?
- Was a formal assessment of disease activity recorded at this time?

12-month review (approximately 12 months after the date of the initial treatment)

- Did a 12-month review take place?
- Was a formal assessment of disease activity recorded at this time?

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The benefits of an EPR

- Patient information more readily accessible than in the paper notes
  - Summary page for each patient
  - Information does not get lost
  - Information available in multiple places
- EPR supports efficient working and safety
  - processes such as MDT, blood monitoring, cancer surveillance etc
- Patient can receive instant summary or GP letter
- Potential for patient portal access

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Registry Reporting

- All participating sites:
  - Quarterly reporting on patient data and Biologics KPIs with national comparators (for Quality Accounts)
  - Annual reporting of HES data on unplanned admissions and A&E attendances initially (England)
- Web Tool only (at present):
  - will have instantly available charts from May 2017:
    - Basic profile of all patients entered
    - Run charts on KPIs comparing participating site to the average of all sites using the web tool.

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IBD Registry

NHS Digital

teams and the NHS

The minimum dataset

- ❑ **Current diagnosis** (UC, CD or IBD-U)
- ❑ **Date of diagnosis**
- ❑ **Consent status** (from May 2017)

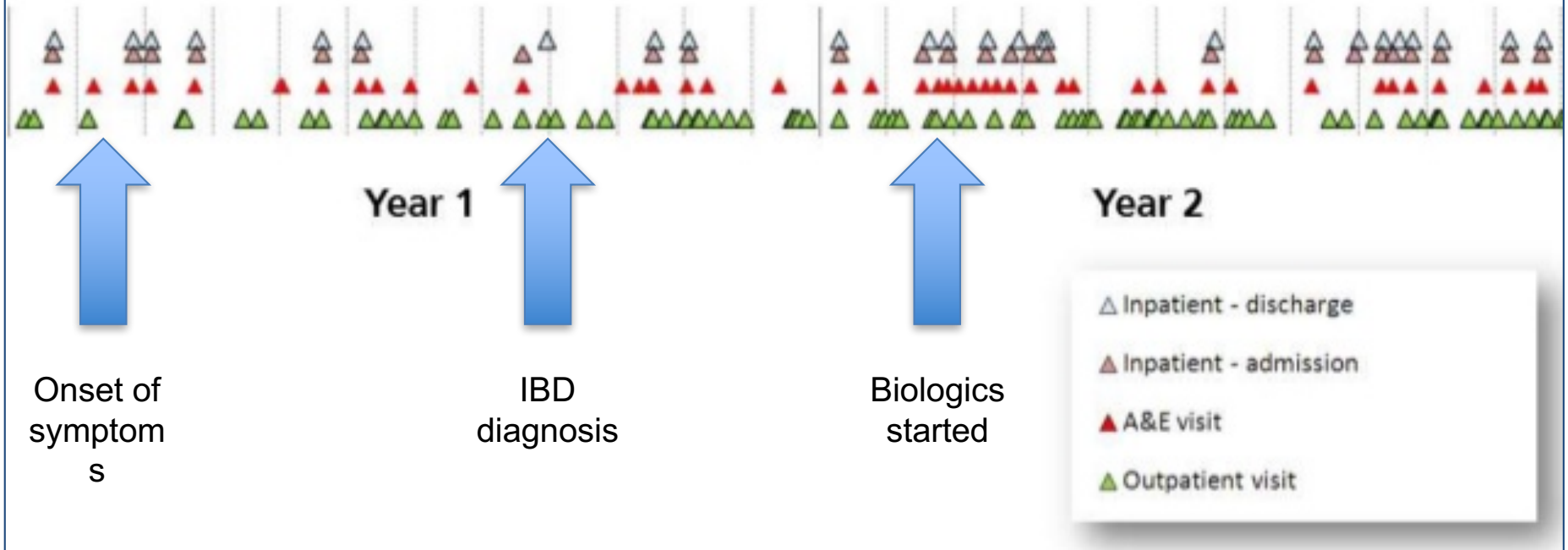
Hospital Episode Statistics

- ❑ **Inpatient & Day Case Episodes**
- ❑ **Outpatient attendance**
- ❑ **Accident & Emergency attendance**

Equivalent in Wales is the Patient Episode Database for Wales (PEDW)

One person's HES record

- with IBD events added



Registry and HES data

- Crohn's and Colitis UK funded project at University of Liverpool (Keith Bodger)
  - Developing the methodologies for analysing this data down to Trust level
  - Current focus is unplanned admissions
- In May 2017, sending a questionnaire and an example of HES data output for IBD Teams to give feedback
- Later in 2017 – bringing together HES and Registry clinical data

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How to progress locally?

- Choose a system
  - *Registry support available by telephone or attending team meeting*
- Receive the appropriate Registry starter pack
  - Obtain the necessary local approvals (also funding and IT support if choosing the locally-installed PMS)
- Arrange for your RCP biologics data to be imported or converted to make data entry easier
- Consider your IBD Service priorities and plan how you will approach entering the data
  - Backfill
  - Routine data entry
  - Will you start with the Biologics Audit data?
  - Do you have other priorities?

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Other possibilities?

- Aim for a complete local register?
  - Just demographics and diagnosis?
  - This will maximise the value you can gain from future HES analysis
- Focusing on other sub-groups of patients?
  - Managing surveillance
  - Monitoring blood tests
  - Managing the most ‘active’ patients

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Information Governance

- Consent is not required for the primary purpose data collection
- Consent is required for the secondary use.

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Existing EPRs if Registry-compliant

Local EPRs and Databases
Bioresource system

Local IBD Patient Management Systems

InfoFlex Patient Management System
EMIS Gastroenterology (was Ascribe)

IBD Registry

Web Tool

Web-based Tool (InfoFlex)

Primary purpose: Consent not required

England only

NHS Digital

Pseudonymisation of patient data

NHS Digital

Linking to NHS routine activity data - HES

Quarterly

Annually

IBD Registry

Secondary purpose: Consent required

Section 251

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Information Governance

- At present there is a s251 exemption and patient data can be submitted to the Registry provided the consent posters and information leaflets are displayed (= opt out)

BUT

- obtaining consent during the coming year is important

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Rationale for PID

- Some registries use fully anonymised data without need for consent.
- Why use Patient Identifiable Data (PID)?
  - Prevent two registry records for the same patient treated in two different hospitals
  - Enables linkage to HES data
    - *(HES = Hospital Episodes Statistics)*
  - Facilitates identification of patients for research projects (longer-term goal)

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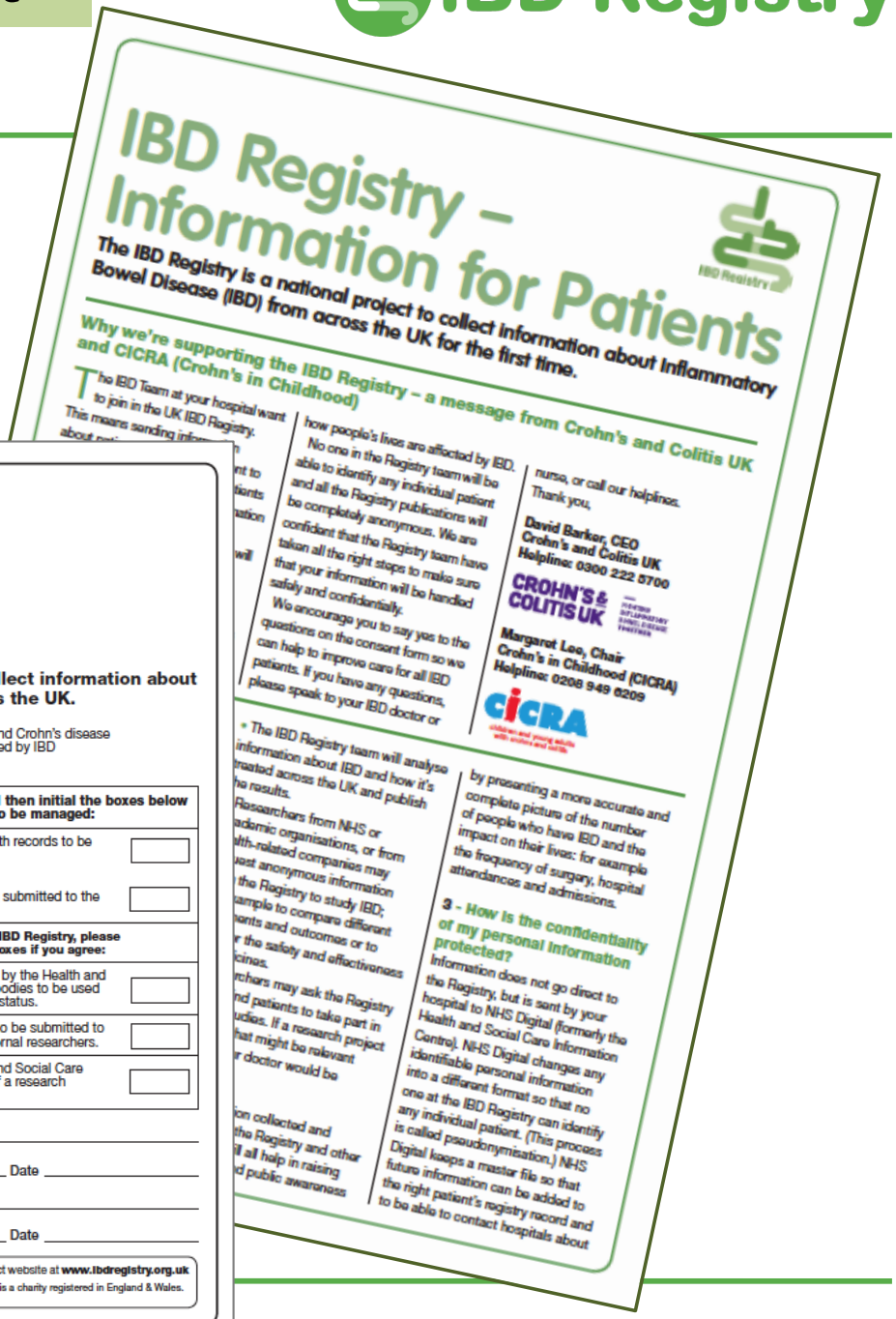
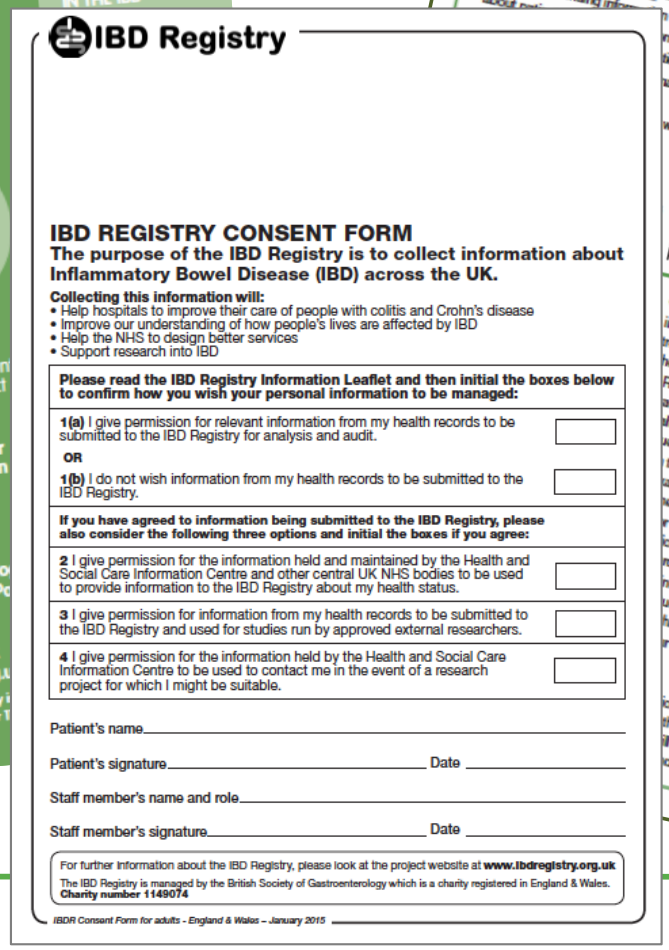
Please use the Registry consent pack

IBD Registry





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- What's in it for you and your patients?
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- Support

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How can you be involved?

- All data contributes to IBD research –
  - Healthcare utilisation and economics
  - Outcomes and value of biologics
- All data contributors will be acknowledged.
- FUTURE: When the Registry has matured, any researchers can apply to access the data.
- NOW: Research projects using the Registry infrastructure to capture data – e.g. anaemia and VEST studies, BSPGHAN's Pinpoint study.

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Registry support

General support – implementation, IG, software etc

- support@ibdregistry.org.uk
  - Mark Allan – Data Manager
  - Simone Cort – Registry Admin Support
  - www.ibdregistry.org.uk

Technical support

- Infoflex PMS users:
  - InfoFlex CIMS HELP DESK on 01923 890700
- For users of other systems:
  - Contact your supplier's help desk

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Funding support for IBD Teams

- Data entry grants from industry fund

Round 1:

- 12 sites awarded £2,000 each to fund data entry over 20 week period – mostly biologics but some aiming for complete register of demographics and diagnosis.

Round2:

- Application form available now

email: support@ibdregistry.org.uk

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IBDR Industry Working Group

- Industry Working Group was set up June 2016 to co-design solutions and develop framework for collaboration.
- The group has been looking at how industry partners can help to accelerate the uptake of the Registry as well as identifying local challenges.
- Setting up a small network of field based personnel to support IBD teams with Registry queries.

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IBD Registry

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IBD Registry

IBD Wales

Barney Hawthorne & Helen Ludlow
University Hospital of Wales,
Cardiff

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IBD Wales

Driving up standards of care for IBD patients across Wales

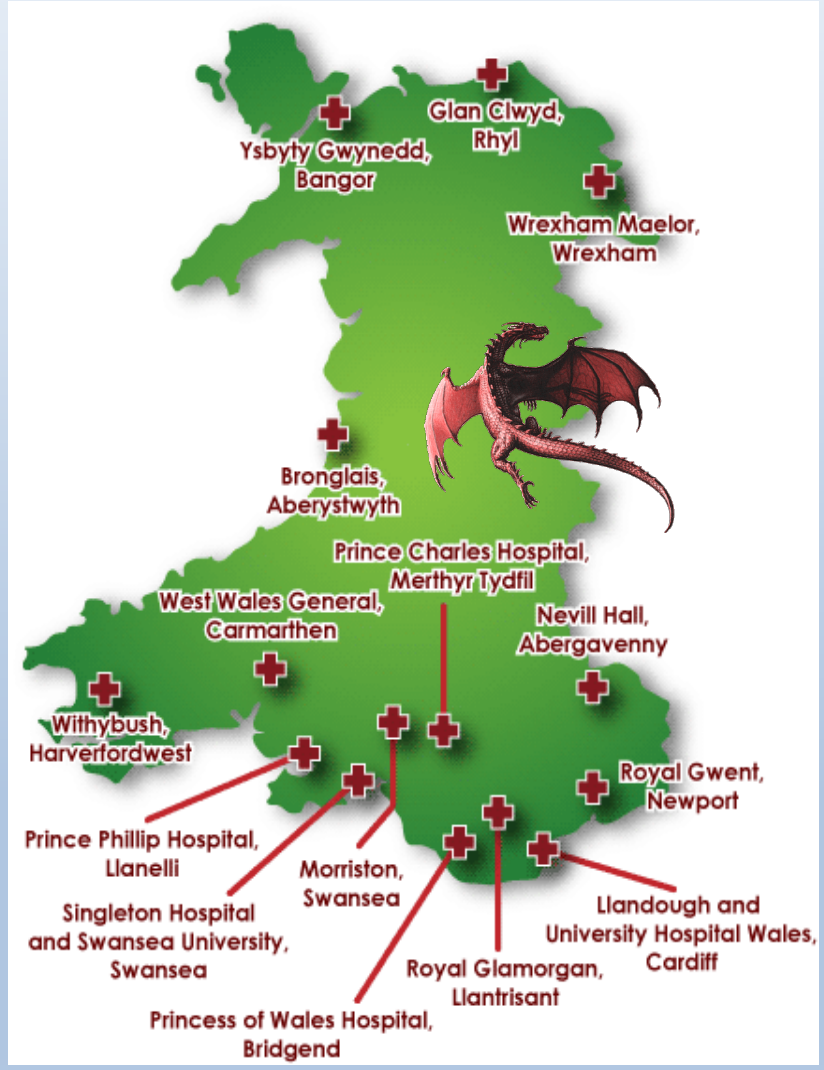
Welsh Association for Gastroenterology and Endoscopy
Cymdeithas Gastroenteroleg ac Endosgopi Cymru

CROHN'S & COLITIS UK
FIGHTING INFLAMMATORY BOWEL DISEASE TOGETHER

GIG CYMRU NHS WALES

What is IBD Wales?

- A group of patients and healthcare professionals (nurses, physicians, surgeons, paediatricians, dieticians, pharmacists) involved with IBD care
- Representing all areas of Wales
- Supported by Crohn's Colitis UK
- Accountable to WAGE

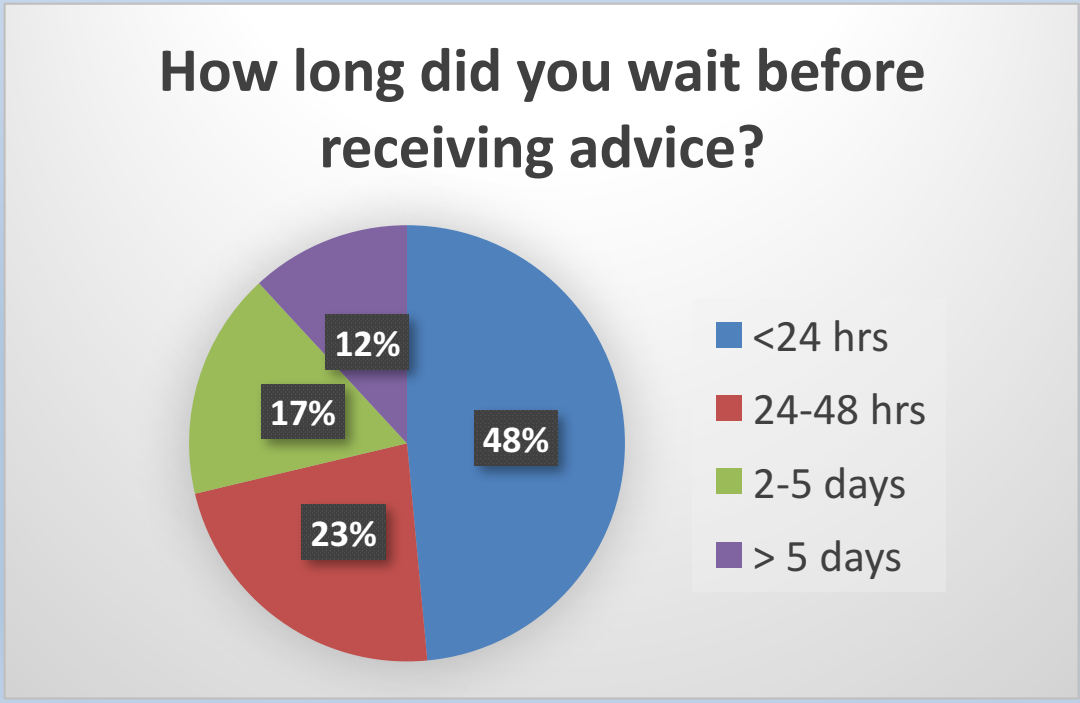


AIM

To drive up Standards of Care for IBD patients of all ages across Wales

Welsh patient survey 2015 (Crohn's Colitis UK) 447 respondents

- Female 70%, age 16-85, median age 26-35
- 42% had no access to IBD specialist nurse
- Of patients having a flare who sought advice from healthcare professionals (GP, IBD nurse, gastroenterologist):



Satisfaction with advice received	
Very satisfied	35%
Quite satisfied	44%
Not satisfied	12%
Very unsatisfied	9%

IBD Wales – key targets (A)

- Improve IBD diagnosis & care in Primary Care
  - Earlier referral & diagnosis (Calprotectin)
  - Manage flares in the community
  - *Access to hospital (28 days new, 5 days flare)*

RCGP spotlight project (IBD)

- Improve Paediatric IBD Services
  - Resources to meet RCPCH/BSPGHAN standards 2017
  - Paediatric IBD nurses
  - Access to appropriate surgical assessment/facilities when needed

IBD Wales – key targets (B)

- Improve IBD Patient Education and Support
  - Access to all forms of information
  - Support in self-management
  - Dietary information from specialist IBD dietician

- Improve Surgical Care
  - All elective surgery discussed at MDT
  - Timely elective surgery
  - All Acute Severe UC jointly managed (GI & colorectal)

IBD Wales – key targets (C)

- Improve IBD specialist nursing support
  - Adequate nos. (National IBD Nursing Modelling Caseload Standards Report 2017)
  - Response to emails/advice line by end next working day

- Improve Informatics to support:
  - Desktop disease summary
  - Data access for local/national audit/QI
  - Organisation of drug monitoring/surveillance etc

IBD Registry

Building support and involvement

LISTEN MEASURE SHARE PUBLICISE

We need your help

- We will be a contactable group that encourages your input and involvement
- We will produce regular communications to the IBD community to keep you informed

We need to gain Health Board support for implementing changes

- We will reach out to Health Board management and local policymakers to secure their involvement and facilitate change

We need national support

- We will campaign to national policymakers and Assembly Members to bolster support and drive initiatives

We need Government support

- We will demonstrate that IBD Wales activities help deliver Prudent Healthcare principles

BSG
Quality Improvement targets

- Targets across major disease areas of gastroenterology (liver disease/IBD/nutrition/IBS and functional disorders)
- For Quality Improvement (?future service accreditation)

<u>IBD draft targets in development</u>

- Simple
- Where data is needed: recordable through registry
- Examples:
  - Waiting time new referral to clinic appt
  - Elective surgical waiting times
  - Pre-biologics screening completed
  - Thiopurine-induced leucopaenia
  - IBD-control PROM

IBD-control PROM

1	Do you believe that:-				
Your IBD has been controlled in the last two weeks?	Yes	2	No	0
Your current treatment is useful in controlling your IBD?	Yes	2	No	0
2	Over the last 2 weeks:				
Over the past 2 weeks, have your bowel symptoms been getting better, worse or not changed?				
3	In the past 2 weeks, did you:-				
Miss any planned activities because of IBD?	Yes	0	No	2
Wake up at night because of symptoms of IBD?	Yes	0	No	2
Suffer from significant pain or discomfort?	Yes	0	No	2
Often feel lacking in energy?	Yes	0	No	2
Feel anxious or depressed because of your IBD?	Yes	0	No	2
Think you needed a change to your treatment?	Yes	0	No	2
4	At your next clinic visit would you like to discuss:-				
Alternative types of drug for controlling IBD?	Yes		No	
Ways to adjust your own treatment?	Yes		No	
Side effects or difficulties with using your medicines?	Yes		No	
New symptoms that have developed since your last visit?	Yes		No	
				TOTAL /16
5 How would you rate the overall control of your IBD in the past two weeks? (Worst Control = 0, Best Control = 100)		Score		

IBD Registry

Making
information work
for **patients**,
their **clinical teams**
and the **NHS**

IBD Registry

Where are we now and where do we want to get to?

Nicola Brett & Claire Munro
Dovetail

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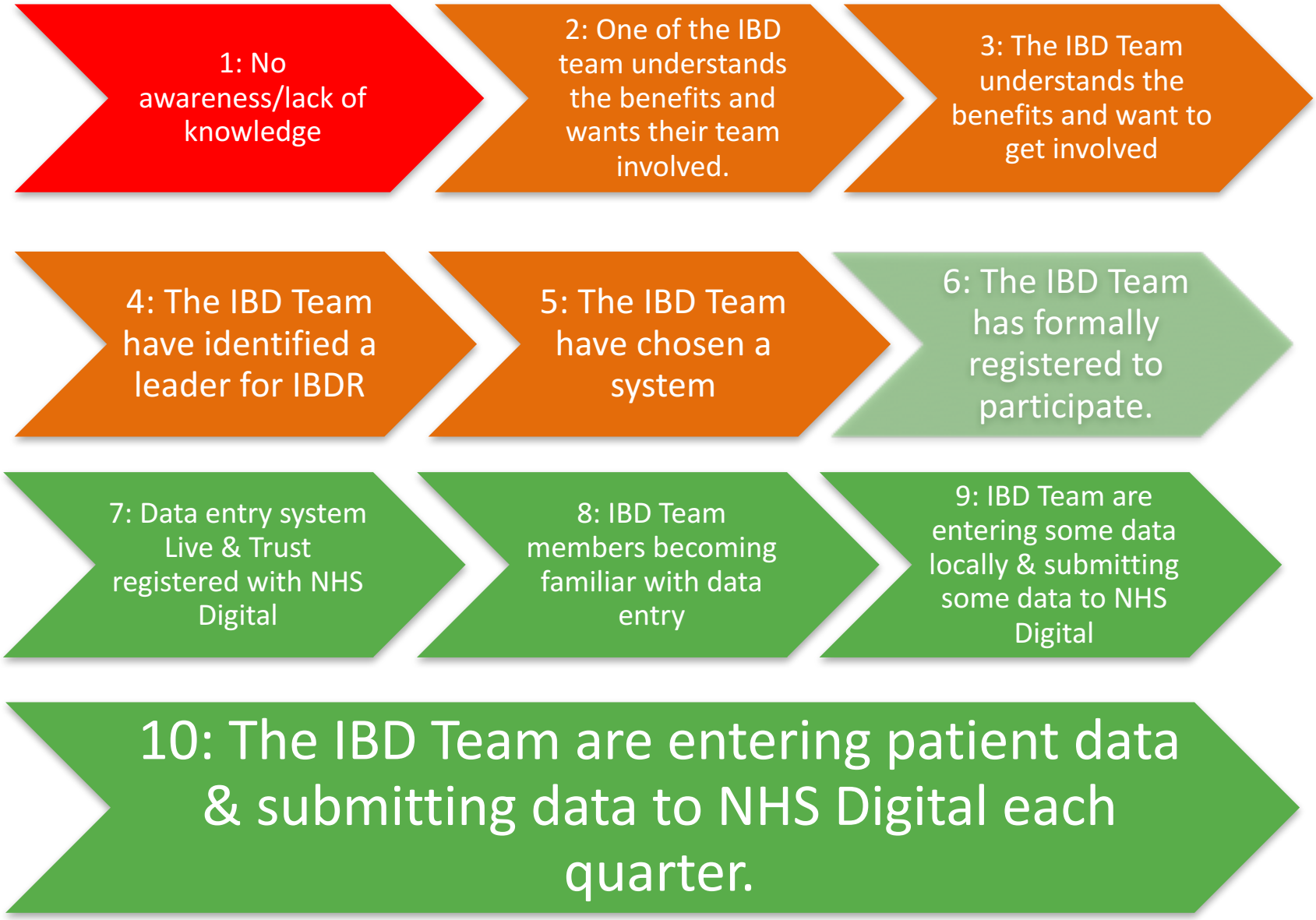
The IBD Registry Adoption Ladder



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Inflammatory Bowel Disease programme

Working to embed quality improvement

Susan Murray
Programme manager

May – June 2017

Royal College of Physicians

Setting higher standards

Outline

- IBD audit 10yrs and the need for continued improvements
- Current quality improvement projects
- IBD registry - data visualisation

IBD audit : Improvements

	Round 1 06-08	Round 3 10-12
Inpatient care audit		
UC mortality rates have halved over 3 rounds of audit	1.7%	0.8%
Significantly fewer readmissions for UC over 3 rounds of audit	51.1%	33.6%
Organisational audit		
Sites with at least some IBD nurse specialist provision	56%	78%
Sites with a designated Gastroenterology ward on site	67%	93%
Biological therapies audit		
Patients entering remission (at first follow up after 12 weeks)	62%	73%
Number of adverse events reported by patients (at any follow up treatment)	6%	5%

Summary of the past

- 10yrs IBD audit at RCP
- IBD audit to IBD Registry -1st Mar ‘17
- Biologics audit data made available for transfer to IBD Registry

Essential that we continue to improve quality of care

Current QI projects @RCPLondon

- Developing QI champions for IBD
- Improve screening rates (Biologics)
- IBD Registry - data visualisation
- Supporting materials /Webinars

Developing QI champions training

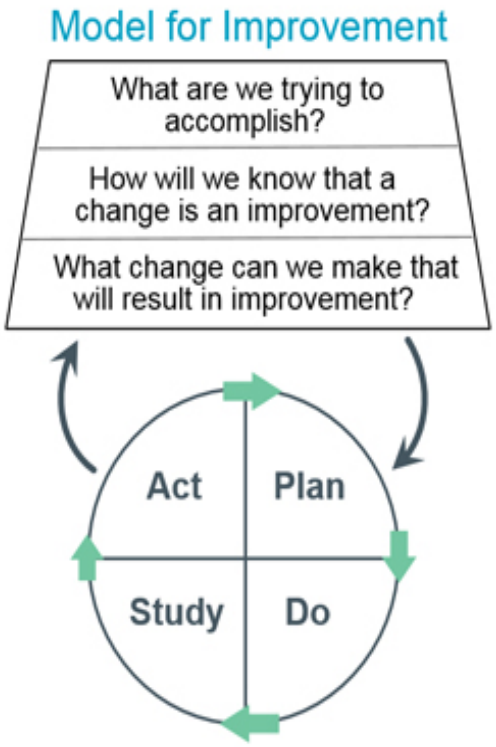
QI hub @RCP

June – Nov
3 x1 day face to face

Webinars/coaching

8 IBD teams across UK

QI hub training course



More training opportunities to come

Managing barriers

Leadership and networking

Improving screening for biologics

Biologics 2016 report

- 60% of patients adequately screened

- Identifying processes set up to ensure adequate screening
- Sharing some case studies from across the UK

An example of achieving an adequate process for pre treatment screening for biological therapies

Dr decides patient need
Bgx
HBI score ?

Dr prints out electronic form and stickers for specific blood tests HIV, Hep B, Hep C, Varicella and Chest Xray. Form is signed by Dr.

Patient has tests same day and books appointment to see nurse within 2 weeks

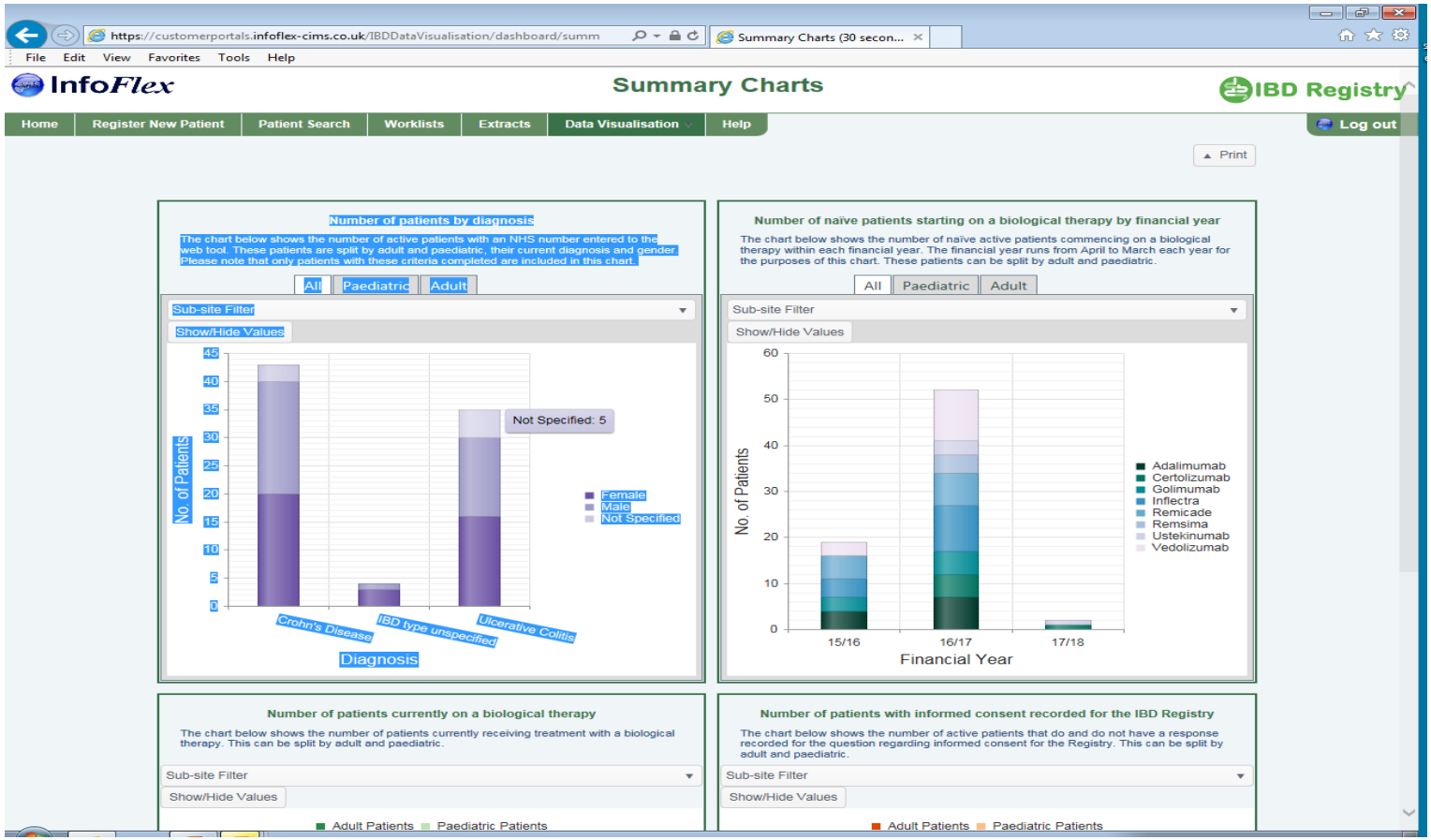
Nurse counselling and review of results for appropriateness to start Bgx. If screening adequate – appointment for infusion clinic

Patient receives Bgx at infusion clinic and reviewed in 12 weeks

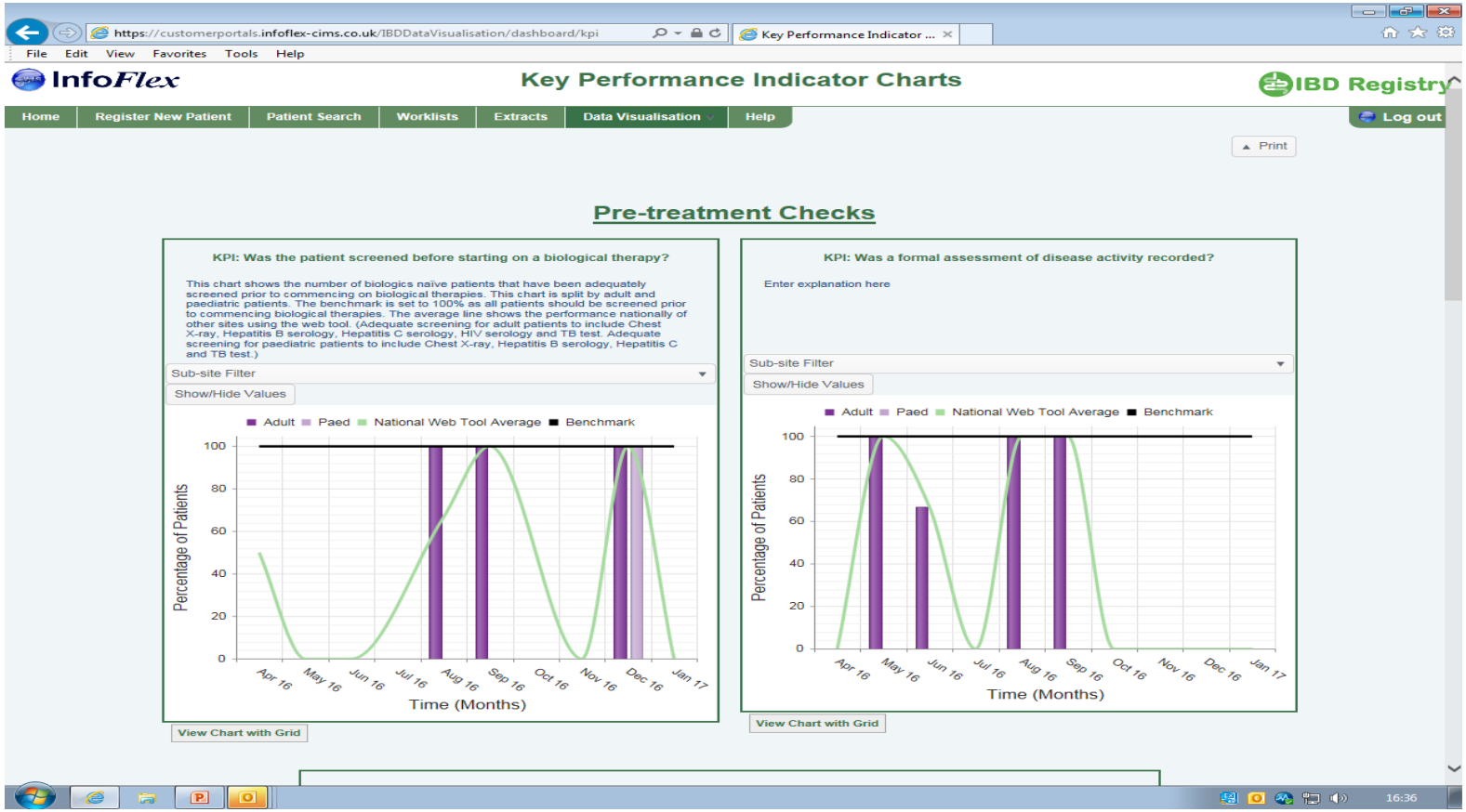
Next up….Data visualisation on web tool

- Delivered first through the IBD Registry Web tool. (Infoflex platform)
- Will be trialled via the IBD Registry web tool
- Not yet available on the PMS

What does it look like?



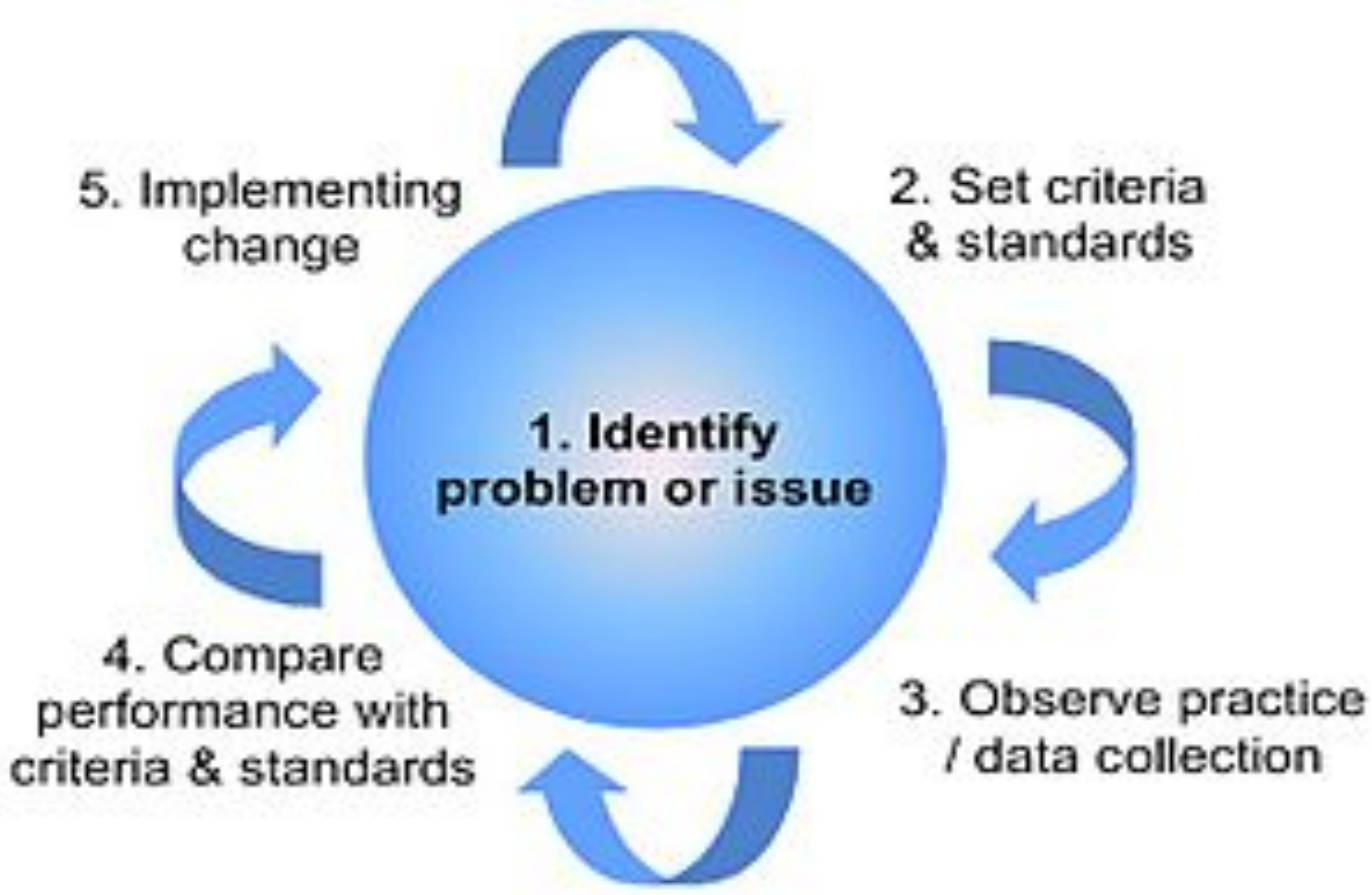
What does it do?
Performance against standards



Why data visualisation?

- Provides feedback on performance against standards
- Highlights performance over time
- Ability to track, identify ups and downs
- Prompt review of practice and improvement in process
- New in IBD – well established in other diseases

Making improvements



Learning from other audits…

- National Hip fracture data base (NHFD) http://www.nhfd.co.uk/20/hipfractureR.nsf/welcome?readform

- National Emergency Laparotomy audit (NELA) https://www.youtube.com/watch?v=vByhUM2de4Q&feature=youtu.be&list=PLmIDe-j6iZk5N7U2gmD0iTFYZYXgdawA2

Find out more

Opportunity to view on Registry web

Feedback (survey)

Webinars to support

Tweet @IBDQI

Remembering the team……

Royal College of Physicians

Setting higher standards

Current KPI's – a focus to improve

- Was the patient screened before starting on a biological therapy?
- Was a formal assessment of disease activity recorded?
- Is there a record of Registry consent being discussed with the patient?

Current KPI's – a focus to improve

At 3 and 12 months…..

- Did a post induction review take place?
- Was a formal assessment of disease activity recorded at this time?

How the IBD audit captured improvements

	Round 1 06-08	Round 2 08-10	Round 3 10-12	Round 4 12-14	Round 5 14-16
Organisation of services	✓	✓	✓	✓	
Inpatient care	✓	✓	✓	✓	
Paediatric patients included		✓	✓	✓	✓
Primary care perspective of IBD			✓		
Inpatient experience			✓	✓	
Biological therapies			✓	✓	✓
Focus on quality improvement					✓

IBD Registry

Making
information work
for **patients**,
their **clinical teams**
and the **NHS**

IBD Registry

Practicalities of Registry participation – ask the experts

Barney Hawthorne
Helen Ludlow
Susan Murray
Richard Driscoll

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Moving on up: how to get to the next step on the ladder

Nicola Brett & Claire Munro
Dovetail

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Feedback and discussion

Barney Hawthorne &
Helen Ludlow

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IBD Roadshow continues at:

- EXETER Monday 15th May
  Chairs: Dr Nick Kennedy & Pearl Avery
- CARDIFF Thursday 18th May
  Chairs: Dr Barney Hawthorne & Helen Ludlow
- WARRINGTON Monday 22nd May
  Chairs: Dr Keith Bodger & Andrew Kneebone
- DARLINGTON Tuesday 23rd May
  Chairs: Dr John Mansfield
- LONDON Friday 2nd June
  Chairs: Dr Stuart Bloom & Kay Greveson
- BIRMINGHAM Friday 9th June
  Chairs: Dr Matt Brookes & Mel Love
- GLASGOW Autumn 2017
  Chair: Dr Ian Arnott

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