

This checklist was modified and used for all endoscopic procedures performed in our trust.

**The Aim** of the survey was to gather opinions from endoscopy staff about the recently introduced team debrief and the modified WHO checklist for endoscopy in our trust. We aimed to assess the staff's perception of the impact of the checklists (positive or negative) on patient safety, communication and team behaviour, staff satisfaction and their general effectiveness. We also aimed to assess the need for training on the use of the checklists and their potential to drive improvement with an additional section for their comments. Responses were obtained from the different grades of staff including nurses, health care assistants, trainees and consultants.

**Methods** We designed a questionnaire according to the LIKERT<sup>2</sup> scale, where the respondent could choose between five options including one neutral stance and the other four with varying degrees of agreement or disagreement with sixteen questions covering the above mentioned key categories. Participation in the survey was anonymous and voluntary.

**Results** 78 staff across two hospitals of the trust responded to the survey, of which two were incomplete and hence excluded from analysis. Respondents included consultants (20), Specialist Registrars (8), nurses (29), health care assistants (12) and unknown (7).

81% perceived an improvement in patient safety and 75% in team communication. 75% were satisfied with the checklists. 80% believed that the checklists have the potential to drive improvement with 96% of them wanting to continue using these. The only negative aspect from the survey was that almost a half of the respondents (48%) felt that their feedback was not acted upon. 100% agreed that all staff needed to participate actively in the checklist and team briefs.

**Conclusion** Our results suggest that the introduction of the adapted WHO checklist has been a positive experience based on this staff survey, enhancing patient safety and staff communication. This adapted checklist will continue to evolve based on staff feedback. We suggest that all endoscopy units should introduce an adapted WHO checklist and we understand that the BSG is developing one currently.

**Disclosure of Interest** None Declared.

## REFERENCES

1. Safe Surgery Save Lives - WHO/IER/PSP/2008.07
2. Public Opinion and the Individual. Gardner Murphy and Rensis Likert. New York: Harper & Brothers, 1938

## PTH-174 DEVELOPMENT OF A NETWORK MULTIDISCIPLINARY TEAM AND NATIONAL REFERRAL CENTRE FOR TREATMENT OF COMPLEX BENIGN COLORECTAL POLYPS

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**Introduction** Large flat or sessile lesions are not uncommon on a screening colonoscopy list and endoscopic removal is often technically challenging. The assessment process for screening colonoscopists in Wales does not assess therapeutic skill and variation in rates of referral to surgery suggest that clinician skill level may influence management decisions. A Network Multi Disciplinary Team (NMDT) and National Referral Centre (NRC) pilot was established to offer the opportunity for expert opinion and discussion of therapeutic options for participants of the welsh bowel screening programme.

**Methods** The six month pilot began in October 2011 by taking referrals from Screening Colonoscopists and local MDT's. The aim was to provide a service that would reduce variation of practise with potential value for education on lesion recognition, EMR technique and decision making.

Expressions of interest were invited and expert advisors appointed for Colonoscopy, Pathology, Radiology and Surgery. Specialist Screening Practitioners and management staff were appointed and the NMDT established as a virtual group to meet biweekly.

Referral criteria were agreed based on a composite of size, morphology and accessibility of lesion. Participants with lesions satisfying the criteria were referred to the NMDT electronically. Local Assessment Centres were provided with image capture devices and staff trained to record and edit video clips which were subsequently saved on a share drive, reviewed by expert advisors and discussed at NMDT meetings.

Expertise in complex polypectomy is often limited to few centres and the NRC was designated in a unit accessible to colonoscopists with appropriate skills. It was established in Cardiff at University Hospital Llandough via an agreement with Public Health Wales. Depending on outcomes of NMDT discussions participants were given the option of accessing local surgery or travelling to the NRC for therapeutic endoscopy where appropriate.

**Results** During the initial pilot phase 13 meetings were held. No meeting was cancelled due to availability of advisors, 1 was cancelled on a bank holiday and 1 because of technical difficulties. Thirty eight cases were referred for discussion and 15 of them referred to the NRC for therapeutic procedures.

Challenges including image quality, video transmission and interface with local MDT's were discussed at a multidisciplinary workshop and solutions identified for future development. Evaluation of the pilot indicates that the service has been well received by participants, NMDT members and local teams.

**Conclusion** This development has been logistically feasible, safe and successful in providing an equitable service for participants of the bowel screening programme in Wales and has contributed to a reduction in referrals for surgery for benign lesions.

**Disclosure of Interest** None Declared.

## PTH-175 NATIONAL ANALYSIS OF EMERGENCY ADMISSIONS FOR ALCOHOL-RELATED CONDITIONS BY HOSPITAL SPECIALTY

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**Introduction** Harmful alcohol use is associated with substantial health and economic burden.<sup>1</sup> Patients with alcohol-related conditions (ARCs) present acutely to hospital with a wide spectrum of disorders, impacting a range of medical & surgical specialties - a major challenge to the organisation and delivery of effective care within a hospital. Public health metrics derived from hospital (coding) data provide useful top-level indicators but do not provide clinically-relevant information for hospital teams. Gastroenterologists are seen increasingly as potential leaders in alcohol services. The aim of this project is to develop clinically-meaningful analyses and metrics that allow clinicians to better-understand alcohol-related emergency admission data to help in service planning.

**Methods** We analysed a 2-year download of HES data (~24M. care episodes) for acute NHS Trusts in England in IBM-SPSS stats package. Emergency admissions containing any alcohol code were extracted, all recorded diagnoses were tabulated and reviewed by clinical steering group. Logical baskets of conditions were generated, reflecting common clinical presentations and allocated to specialties. The resulting coding rules and hierarchies were applied to the national data to label each admission and summary data generated.

**Results** Of 7,440,546 emergency admissions to 150 trusts, ARCs accounted for 228,994 (3%). 12 diagnostic-specialty categories of admission were defined, of which Hepatology (alcoholic liver disease) and Gastroenterology (other GI conditions) ranked 1st and 3rd for admissions (17.4% and 13.8%) with alcohol withdrawal/intoxication

ranked 2nd (17.3%). Remaining categories fall within medical specialties (e.g. general neurology, cardiology, respiratory) with only 3.9% of admissions attributable to surgical conditions or trauma. Shortest mean LOS were Poisoning/Psychiatry admissions (1.97 days). Greatest single contributor to total bed days was Hepatology at 240,576 per year and (excluding cancer) this had highest inpatient mortality (18.2%).

**Conclusion** 3% of emergency admissions to English hospitals were for ARCs and the majority (95.7%) of admissions fall within the remit of physicians rather than surgeons. Half the recorded diagnoses for admitted patients are within the sub-specialties of hepatology or gastroenterology and these contribute the highest share of both bed days and mortality. This system of classifying hospital data provides a basis for re-design of services, manpower planning and potential metrics for performance.

**Disclosure of Interest** None Declared.

#### REFERENCE

1. Moriarty KJ, Platt H, Crompton S *et al*. Collaborative care for alcohol-related liver disease. *Clin Med*. 2007 Apr; 7(2):125–8.

#### PTH-176 AUDIT TO EVALUATE THE GASTROENTEROLOGY REGISTRAR OF THE WEEK SERVICE IN UNIVERSITY HOSPITALS OF LEICESTER

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**Introduction** The 'Registrar of the Week' service initially started in response to a Primary Care Trust initiative for Gastroenterology advice to GP's. This started as project 'Batphone'. The Gastroenterology department saw an ideal opportunity to start a Gastroenterology phone advice service which would be manned by an allocated Gastroenterology Registrar of the week, running Monday to Friday, 9–5pm excluding bank holidays. This started in August 2011. We give advice and see patients within the Leicester Royal Infirmary (LRI) as well as give advice to GP's and across site at the Leicester General Hospital (LGH) and Glenfield General Hospital (GGH).

**Methods** We collected data using a designed proforma to document all calls including origin, date time and also a summary sheet for the day. 262 days documentation was reviewed as these were complete. These were analysed.

**Results** The number of calls in 262 days was 2652. The range was 1–36 calls per day, but on average 10 per day. 512 patients were identified for a Gastroenterology ward. There were 607 patients physically reviewed. 1870 calls came from the LRI, 165 from LGH, 195 from GGH and 276 GP calls. This works out roughly 1 call per day from each of the latter.

**Conclusion** We have seen a great increase in the usage of our service. We think that the audit data may well be an under reflection of the work done as people forget to fill the sheets in. The intensity is unpredictable. The number of GP calls is far lower than the number of hospital calls. It was felt overall the service was being avidly utilised by mainly medical and surgical teams and that it was also good experience for our Gastroenterology specialist Registrars.

There were misuses of the telephone for example patients and relatives being put through. We are hoping to reduce this by education and circulation of further guidelines. The things we intend to change are the actual telephone as the reception is poor. Referrals that need to be seen the same day should be referred before 12pm. Guidelines for referral will be circulated. There will be more formalised consultant back-up in the future. We believe our service has been a success especially in the sense that we are able to know about and manage patients earlier although we think the efficiency of the service could be improved. We intend on re-auditing this service in the future so that we can continually improve it.

**Disclosure of Interest** None Declared.

#### PTH-177 A NEW PANCREATOBILIARY TELEPHONE CLINIC SERVICE – IMPROVED SERVICE DELIVERY, EFFICIENCY AND PATIENT EXPERIENCE

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**Introduction** Following the establishment of specialist cancer centres (and other centralised services), increasing numbers of patients are referred for tertiary care. This may have implications for travel, particularly as patients now have to pay travel costs. As a tertiary referral centre for pancreaticobiliary (PB) medicine we are referred patients from across the UK for a specialist opinion on complex benign and malignant PB problems. The established system of an initial face-to-face clinic visit often then requires return visits for investigations or endoscopic intervention, with significant inconvenience and travel costs for the patient. In response to this, we developed a novel, consultant-led telephone clinic (TC) service. The aims of this service were to improve efficiency and patient satisfaction.

**Methods** A TC service was commenced with prospective data entry into a database over a 12-week period. Data was obtained on the following: patient demographics; postcode; clinical indication; round distances patients would have otherwise travelled if visiting UCLH. The time and cost incurred for visiting UCLH was calculated using the cheapest return train fare to London Euston (nearest train station). Patients were contacted some time after their consultation by an uninvolved member of non-clinical staff to obtain feedback based on a 9-point questionnaire.

**Results** 77 patients were listed for consultation in 10 separate TC's. 17 (22%) were excluded (9 did not answer their original TC; 8 did not answer for feedback). Of the 60 patients analysed (35 female, median age 52.5 years), 12 (20%) were new referrals and 48 (80%) follow-ups. The average round distance if otherwise travelling to UCLH was 96 (3–606) miles. The average time and cost for a return trip to UCLH was 155 (8–593) minutes and £27.60 (£7.30–105). Clinical indications were suspected Sphincter of Oddi dysfunction 18 (30%); acute or chronic pancreatitis 12 (20%); cholangiopathy 6 (10%); choledocholithiasis 5 (8%); non-PB gastrointestinal disease 9 (15%). 14 (23%) had formal out patient clinic review following their TC consultation. In 22 (37%) a repeat TC appointment was sufficient and 7 (12%) were discharged. The remaining 17 (28%) were referred for further endoscopic or radiological imaging at UCLH with TC follow up afterwards. All 60 patients either 'strongly agreed' (52, 86%) or 'agreed' (8, 13%) that the TC service was efficient. 29 (48%) expressed concerns regarding travel costs if visiting UCLH. Only 4 (6.7%) would have preferred to have seen a doctor in person for their initial consultation.

**Conclusion** We have demonstrated that a TC service is a useful adjunct in helping to deliver an efficient and convenient tertiary PB service, with excellent patient satisfaction.

**Disclosure of Interest** None Declared.

#### PTH-178 WHO CALLS THE LIVER REGISTRAR AT KING'S?

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**Introduction** Delivering excellent healthcare in today's NHS involves multiple agencies and depends on accurate communication between professionals in different locations. King's College Hospital is a leading Hepatology centre that receives tertiary and quaternary referrals from across the UK and Europe. Frequently, the first point of contact with the Unit is via a telephone call to a Specialist Registrar, for whom no case notes are available in which to record information. Until recently,