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 LIKERT² 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.¹ 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