Following implementation of these changes, we carried out a re-audit from October to December 2018. Results from both audit cycles are shown below.

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	Audit cycle 1 (n=37)	Audit cycle 2 (n=16)		
	Median (range) days	Mean±SD days	Median (range) days	Mean±SD days
2WW - CT	9 (0-34)	9±10	8 (0-48)	11±13
2WW - spirometry	0 (0-7)	0±2	0 (0)	0
2WW - TLCO	7 (0-118)	15±25	8 (0-58)	10±15
2WW - PET	15 (2-121)	28±33	9 (2-44)	15±11
2WW - decision	25 (3-125)	36±35	24 (10-46)	25±11
2WW - surgery	73 (48-88)	69±14	37 (30-55)	38±10

Conclusions: These minor amendments resulted in improvement and ultimately marginal gains from each stage resulted in a significantly shorter pathway for patients to undergo radical treatment for lung cancer.

100.
SIMULATION TO MEASURE DRUG TO PATIENT TIMES IN CATASTROPHIC HEAD AND NECK HAEMORRHAGE; CURRENT PROTOCOL VS NEW PROTOCOL

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Background: Catastrophic haemorrhage is a terminal and distressing complication of head and neck cancer. Patients can be prescribed anticipatory analgesia and sedation. However, there exists anecdotal evidence that these drugs may never reach the patient. We aim to record the drug to patient administration times in simulated catastrophic haemorrhage scenarios using the current NHS Ayrshire and Arran protocol and a newly proposed protocol.
Method: 32 scenarios were simulated on the head and neck ward. 16 simulations involved drawing up medications (marked saline vials) from the controlled drug cupboard. 16 simulations involved using pre-drawn up medications (containing saline) placed in a grab bag. Staff were informed of planned scenarios, and scenarios were initiated by lead investigators pulling the emergency buzzer in the ENT treatment room. Times were measured from when staff were made aware, to the saline being delivered to a cannula representing a patient in the ENT treatment room experiencing a catastrophic haemorrhage.
Results: The mean time for administration for the current policy was 124 seconds, while the grab bag was 48 seconds, $P < 0.01$ (Wilcoxon ranked test). There was also a reduction in the variance of times when using the grab bag; 33-53 seconds vs 78-202 seconds.
Conclusion: The proposed 'grab bag' approach demonstrated a reduction in variability and overall drug-to-patient time. Nursing staff also stated that they felt the new protocol would improve patient/family experiences and improve advance decision planning. We aim to implement this new approach on the head and neck ward.

101.
LOOKING AT THE QUALITY & APPROPRIATENESS OF REFERRALS SENT ON THE 2WW PATHWAY TO THE MAXILLOFACIAL DEPARTMENT AT UNIVERSITY HOSPITAL SOUTHAMPTON SEPTEMBER 2017-AUGUST 2018

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Background: The 'two week wait (2WW)' pathway for head and neck cancer was introduced to streamline the diagnosis and treatment of patients presenting with possible cancer. Processing of patients on a 2WW pathway places considerable stress on the available resources within the NHS. We analysed the appropriateness of referrals to a single unit and highlighted outliers making inappropriate referrals on the 2WW pathway. The plan was then to engage with GDPs to develop more efficient and effective referral pathways.
Method: A retrospective study of 500 referrals to OMFS in 2018 using the 2WW pathway were reviewed. These were analysed for quality using a 14-point scoring system looking at demographic and clinical data. The appropriateness was decided on the clinical and social history and the applicability to the use of the 2WW form. Practices with large numbers of inappropriate referrals were highlighted as outliers.
Results: Of the 500 referrals 281 were from GDPs, 209 from GPs and 10 from other referrers. The mean quality score was 6 out of 14. The number of inappropriate referrals was 301. The most common diagnosis was of fibroepithelial polyps (35 cases) and hyperkeratosis (35 cases). In 30 of the 500 referrals a malignancy was identified.
Conclusion: Amongst the 2WW referrals there were many poor quality and inappropriate referrals. Referrers who repeatedly made poor referrals may benefit from targeted training. A new referral system may be required and if this is to be developed successfully will need input from those in practice and the hospital setting.

102.
SUCCESSFUL INTRODUCTION OF A ROBOTIC MULTISPECIALTY PROGRAM AT PORTSMOUTH HOSPITALS NHS TRUST

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Background: Robotic surgery has gained momentum in general surgery over the last decade. Better view/instruments and full autonomy for the surgeon make this a very valuable tool for surgeons performing complex procedures. However, the safe introduction of new practice needs support from a well-functioning multidisciplinary team.
Methods: A review of robotic surgical practice was taken to understand the prerequisites, essentials of team selection, training and recruitment to provide safe surgery. A training program for the robotic surgical team was developed at Portsmouth hospital (PHT) and assessed retrospectively.
Results: Robotic surgery was introduced at PHT in 2013 - no prior staff/team training in place. A core group of staff received system training and dry/wet lab training. A robotic surgery user group was created: all surgeons performing robotic surgery, anaesthetics lead, theatre manager, nursing lead. This led to a standard operating procedure for patient positioning and pressure points care during robotic surgery. This led to a designated robotic theatre with booking of lists by specialties. With over 1800 procedures performed in total by 4 specialty teams, there was no incidence of perioperative mortality/reported cases of emergency undocking/massive intraoperative bleeding. Since its inception, the robotic theatre team has 28 members:12 scrub nurses of which 2 team leaders, 5 healthcare support workers and 11 surgeons.
Conclusion: Team training and recruitment remain important aspects of a successful robotic program. A systematic approach to the introduction of robotic surgery can lead to a safe practice with good outcomes, and a culture of collaborative team working.