Results 929 patients were recruited to the study (425 (46%) male, median age of 58 years, range 17–92 years). Of these, 306 (33%) underwent an OGD, 304 (33%) had a colonoscopy, 100(11%) had a flexible sigmoidoscopy, 86 (9%) had an endoscopic ultrasound, 100 (11%) had an ERCP and 33 (4%) had a double balloon enteroscopy. 319 (34%) of the patients recruited had NRS scores > 5 for distress, with multivariate analysis identifying pre-procedure anxiety ($p < 0.0001$) as the only variable predictive of patient distress. Both endoscopist and nurse assessments of patient's distress moderately correlated with the patient's actual reported distress (Table 1), with significant correlation identified between each other.

Abstract PTH-119 Table 1 Table 1: Correlations between distress scores

	Correlation coefficient	Significance
Endoscopist - patient correlation	0.424	< 0.001
Nurse - patient correlation	0.405	< 0.001
Endoscopist - nurse correlation	0.651	< 0.001

Conclusion This study demonstrates that estimates of patient's distress during endoscopy are comparable between nurses and endoscopists. Whilst this finding is reassuring, procedural pain remains an important outcome measure better identified by nursing staff. We advocate that increased importance should be given to nursing assessments during endoscopic examinations.
Disclosure of Interest None Declared.

PTH-120 NURSING CHALLENGES OF IMPLEMENTING THE THREE SESSION DAY

doi:10.1136/gutjnl-2013-304907.607

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Introduction **Introduction:** Three session working day in endoscopy was implemented at the Royal Liverpool hospital (RLH) in October 2009: in order to increase capacity as there was no room for estate expansion. The main drivers for this were increased projected activity from Bowel Cancer Screening and the increased waiting times.
Methods Aim To discuss the nursing challenges when implementing three session days.
Results Initial steps: The three session day provides 18 extra lists per week. The business case provided a comprehensive breakdown of what would be achieved by the three session day, why it was necessary, what this would mean for the patients and what it would mean financially for the trust.
Workforce Challenges As nursing establishment increased, 10 WTE nursing staff/HCA, including one band seven Deputy Manager/Trainer. It is important that new staff are flexible. Workforce redesign, skill mix reviews, and altered contracts required careful negotiation and planning. Changing nursing rotas was a challenge as the new template did not marry well with traditional Monday – Friday 9–5pm nursing rotas. A creative and flexible approach to shift patterns was necessary, this allows maximum flexibility in rostering shifts but staff benefit from more time away from the department. Each staff member should be individually considered for each type of flexible working plan. It is important to robustly manage staff absence.
Training Challenges A culture developed of staff only feeling confident to do certain procedures, thus limiting the skill mix across the department. It was realised that so many new starters and an expanded workforce required further investment in training. It is essential to have a senior nurse to focus on training. Since then a full training programme has been implemented providing clear guidance and structure to all staff. Support is also provided in weekly training sessions and cascade training.
Leadership Steering a team through any organisational change required strong medical, managerial and nursing leadership, with key skills of problem solving, organisation, negotiation, and the ability to communicate the right messages to the team. Communication strategies include weekly activity meetings with the managers, senior nurses, admin manager and endoscopy leads. Monthly staff meetings, quarterly user group meetings, Glitch board, communication board and daily team brief were introduced to facilitate feedback and communication.
Conclusions The three session day benefitted the department greatly by increasing much needed capacity when there was no room for expansion. It has been challenging and has only been successful through effective communication, a team approach and a commitment to achieving a common goal.
Disclosure of Interest None Declared.

PTH-121 PRACTICALITIES OF IMPLEMENTING A THREE SESSION DAY IN ENDOSCOPY

doi:10.1136/gutjnl-2013-304907.608

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Introduction Introduction: The three session day (8.30–20.30) was implemented at the Royal Liverpool Hospital (RLH) October 2009; this was necessary to guarantee an increased capacity in order to meet current and predicted service needs to accommodate the increase in activity lower GI investigation including the bowel cancer screening programme (BCSP) and rise in complex endoscopy
Methods Aim This is a reflective look on how this programme of change was implemented, what was achieved by its implementation and what lessons have been learned through the process.
Results Prior to implementation 4 rooms were undertaking 12,000 procedures per year with 40% inpatients 60% day-case activity. Waiting times were urgents2–5 wks, routine 8–9 weeks, and surveillance 19 weeks
Workforce planning and implementation A collaborative approach between Trust (business case approval), Consultants, Nurse Managers, Administration and Human Resources and nursing unions was necessary to ensure full staff engagement as shift patterns had to be changed; job plans and contracts had to be altered. The increased workload required a long term investment of; 3X WTE Consultant Endoscopists (6 lists each), 1 X WTE Nurse Endoscopist (for training and 6 lists),10X WTE Nurses/HCAs, 1X WTE Admin Manager, 2 X WTE Admin staff, 1XWTE Medical secretary. 1xWTE Nurse Educator, 1 WTE: Unit Manager
List scheduling 3 rooms are simultaneously run in the evening; these are segmented into 1 upper, 1 colonoscopy and 1 in-patient list. The day-case lists are shorter at 3 hours; so either 4 colons, 10 OGDs, 4 EUS or 6 in-patients are schedule per list. No complex endoscopy is listed. Patients listed have been younger with less comorbidity thus reflecting the working population. Particular advantage for colonoscopy as all bowel prep can be taken on the day of procedure.
Results Activity has increased to 16,000 procedures per annum with > 85% being day-case. This is due to a work-force flexibility and continual stream of communication through the admin manager to achieve list utilisation > 95%. With full booking, DNA in evening is < 5%. In our patient survey, 85% reported that they do not mind, are willing or very willing to come in the evening list. Waiting times; all urgent are within 2 weeks, routine within 6 weeks and Surveillance within 6 weeks.
Conclusion 3 session day can improve capacity and reduce waiting times but needs workforce planning and significant capital

investment. It requires leadership, workforce and skill mix review, workforce flexibility and a dedicated team.

Disclosure of Interest None Declared.

PTH-122 A RETROSPECTIVE STUDY TO COMPARE THE EFFECTIVENESS OF REFERRAL METHODS TO ALCOHOL SERVICES FOR SPECIALIST TREATMENT FROM AN ACUTE HOSPITAL FOLLOWING BRIEF INTERVENTION

doi:10.1136/gutjnl-2013-304907.609

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Introduction Screening, brief intervention and referral to treatment (SBIRT) programmes have been advocated as having a preventive effect in non dependent drinkers and can provide a pathway to access specialist treatment for alcohol use disorders (AUD) for hospitalised patients who are contemplating changing their drinking behaviour. Little research into the effect of referral methods in hospitalised people treated for AUDs has been carried out.

Methods Patient data for 2007–2009 were retrospectively reviewed in order to compare two referral to treatment methods namely, referral to treatment by a specialist nurse (RTT group) or self referral supported by a specialist nurse (SSR). Attendances at offered appointments were compared to identify each referral methods efficacy in eliciting attendance at a community alcohol treatment service following a request for further treatment for AUD elicited during hospitalisation in an acute setting.

Results The sample size was 76; the most common reason for hospitalisation was deliberate overdose with alcohol (17.3%) followed by fall or collapse with alcohol (11.8%) Alcoholic Liver Disease with alcohol withdrawal (7.3%).

Of 76 Patients referred to treatment by both methods, 36 were in the SSR group and 40 in the RTT group, no significant difference in response to referral modality between the RTT and SSR group was detected.

Conclusion This study found no evidence of a difference in effectiveness of referral methods. This suggests that both referral methods were as effective as each other in eliciting attendance at a specialist alcohol treatment service after an offer of treatment had been made during acute hospitalisation. Further studies, with a larger population, are required to validate this finding

Disclosure of Interest None Declared.

PTH-123 THE EFFECTIVENESS OF AN ALCOHOL LIAISON NURSE SERVICE AT REDUCING FUTURE ALCOHOL RELATED ATTENDANCES TO A COUNTY'S ACCIDENT & EMERGENCY DEPARTMENTS

doi:10.1136/gutjnl-2013-304907.610

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Introduction Worcestershire Acute NHS Trust has an Alcohol Liaison Nurse Service (ALN) based in two Emergency Departments; this provides assessments including screening, brief interventions and referrals into treatment. They function during office hours only. We wanted to evaluate how effective these roles are in reducing the trend in future alcohol related attendances.

Methods Patients were identified by either non-specialist clinicians or the ALN, where alcohol had been a factor in their attendance at A&E, Emergency Decisions Unit (EDU) or Medical Assessment Unit (MAU). They were seen by the ALN who delivered a Brief Intervention (BI).

Their attendances to A+E were compared for the period 12 months before and after the brief intervention to identify whether their attendance patterns varied.

The comparison was carried out by visual audit of patient records on Patient First A+E records system.

Results Since the inception of the ALN service, year on year the figures show a reduced number of re-attendance. Since the inception of the ALN service 1688 patients received a brief intervention, the number of attendances 12 months pre BI were 3814, with 2155 in the 12 months following BI. This shows a reduction of 43%. Based on National Indicators on average, each alcohol related A&E attendance costs £80 (NHS evidence ID:10/0021 2012), this suggests a Trust saving of £132,720.00 over a four year period.

Conclusion These results confirm the efficacy of BI delivered by an ALN service in district general hospital based emergency departments. As a result of these findings other departments within our Trust are developing identification of Alcohol use disorders and Brief Interventions.

Disclosure of Interest None Declared.

PTH-124 ACTION LEARNING SETS TO SUPPORT SPECIALIST SCREENING PRACTITIONERS

doi:10.1136/gutjnl-2013-304907.611

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Introduction Bowel Screening Wales (BSW) have undertaken a pilot to provide evidence which will consider the benefits of Action Learning Sets to Support Specialist Screening Practitioners.

Methods Action Learning Sets (ALS) are a powerful problem-solving process widely used in nursing and other organisations to help staff develop their own skills in resolving workplace issues by using enhanced communication in a group setting. It can help build teams, support individuals, develop self awareness, promote professional development and improve leadership skills. Allocating time for one-to-one meetings for clinical supervision can be difficult to maintain. ALS could be developed to enable SSP peer-group learning. A pilot will commence in one LAC in January 2013 and will create a mechanism for setting up action learning, enabling discussion of the options and the practicalities of setting up ALS. A Bowel Screening Wales, Regional Nurse would take on the initial facilitator role. This would help to ensure progress is maintained and to encourage and shape ALS, with a view totraining up internal facilitators for future sets in other LACs. The ALS would become self facilitating but this would only be done once the SSP's are experienced in the methodology. Those involved in the pilot would need to agree how the ALS pilot will be evaluated, one possibility would be to ask members to write a reflective account of their experience of participating and how it influenced their practise and professional development.

Results The feedback from the results will be considered and the process consent process modified accordingly. The results of the pilot will help BSW focus on finding out how ALS could enable SSP peer-group learning, development and support providing peer supervision, identifying strategies for leading service developments and providing a focus for problem solving and reflection workplace issues. Also needing consideration is how the pilot, if successful, could be conveyed to other SSP's working within Bowel Screening Wales, SSP's working within other UK Bowel Screening Programmes and other Specialist Nurses working within the symptomatic service.

Conclusion ALS for SSP's would ensure continuous professional development and could represent an empowering approach for SSP's advanced practise, helping them to develop their own practical solutions to workplace problems and issues. ALS is a dynamic and evolving group process. The approach would require commitment but ALS is a relatively straight forward way of