

collection has highlighted clearly what improvements are needed based upon facts and not assumptions.

Disclosure of Interest None Declared.

PTH-057 A STUDY OF NON-RESPONDENTS' PERSPECTIVES OF THE BARRIERS AFFECTING BOWEL CANCER SCREENING UPTAKE IN WALES FOR THE PURPOSES OF INFORMING PROGRAMME DELIVERY AND MANAGEMENT OF SCREENING

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Introduction Decreasing participation levels in the Welsh bowel screening programme are cause for concern for Bowel Screening Wales (BSW) and the Welsh Government. BSW, the population screening programme was launched in 2008 and was the first home-testing screening programme in Wales. The programme has successfully detected almost 700 cancers and identified a significant number of polyps for removal that may have otherwise developed into cancer. Despite this, participation in the programme has declined and was 52% during the last quarter of 2011/2012.

Methods The research aimed to seek the views of those who have not responded to their latest invitation to participate in bowel cancer screening (BCS). Methodology for the study included development of a questionnaire based around behavioural theories and qualitative interviews. The research was conducted using a mixed-methods design with a postal questionnaire to BCS non-respondents (quantitative) and semi-structured interviews with non-respondents and screening professionals (qualitative). These methods probed into attitudes and beliefs to find out to what extent these traits influenced behaviour. The research was also combined with a literature review.

The questionnaires were randomly sent to 988 participants with a 3 week deadline given for completion and return. In total 101 questionnaires were returned, 9 were not useable either because the individuals had other arrangements in place (like private healthcare) or declined to participate.

7 semi-structured telephone interviews were also undertaken with responders to the questionnaire who agreed to contact, together with service providers. The data from questionnaires was analysed for emerging themes and issues.

Results Findings show a wide range of factors preventing participation and that a 'one size fits all' approach to increasing uptake is unlikely to work. The evidence from primary and secondary research points to tailored interventions being a more effective approach. The findings from the questionnaire indicated a reasonable level of knowledge about the disease and its signs and symptoms. However, when tested during interviews, the responses showed that awareness levels were poor. Qualitative responses suggested that upfront key messages about the diseases prevalence and the benefits of early detection were needed.

Conclusion Based on the research undertaken, the following recommendations were made to increase the uptake of the screening programme: Raise levels of awareness of bowel cancer and the screening programme; review information to ensure upfront key messages and have sufficient information about the balance of harms and benefits to make an informed choice: pilot a range of small-scale process changes, particularly to the reminder processes.

Disclosure of Interest None Declared.

PTH-058 A CENTRES EXPERIENCE OF SETTING UP A NEW BOWEL CANCER SCREENING CENTRE AND PREPARING FOR BOWEL SCOPE

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Introduction The population served by the Merseyside and North Cheshire Programme was 1.7 million based at University Hospitals Aintree was asked to split because of the imminent introduction of Bowel scope. Authorisation for forming of new centre at the Royal Liverpool Hospital (RLH) by central office was granted in the summer 2013 and implementation was required by February 2014.

Methods The Liverpool and Wirral Bowel screening centre (LandW BSC) was formed with a 45% share of the in the population. The service was designed with the aim to run the FOBT service and then introduce the Bowel Scope (BS) as second wave for the serving population of 802,000.

Results Workforce: The current workforce at the Royal Liverpool (RLH) included 4x BCSP screening colonoscopists of which one became Clinical Director of the centre. The endoscopy service manager supportive for the nursing and operational aspects and the Endoscopy Admin manager supported the administration aspect. There was full managerial backing by the directorate manager. In addition, programme manager, Lead SSP, 3x New SSPs, 4x admin staff were appointed.

Collaborations and Engagement: The logistical issues and training of the new SSPs and Admin staff was heavily facilitated by the current Merseyside and Cheshire programme. Engagement and support also included the National Team, CCG, Local QA team and Screening and Immunisation Regional Team. Implementation group representation from all parties. A business was supported by the trust board. The strong collaboration was made with the team from Arrows Park Hospital (APH).

BowelScope: Strategically, new urology centre had spare capacity for 8 lists to include some evenings and weekends sessions at Broadgreen Hospital was identified as good access site for Liverpool. For the Wirral site, APH was identified as the site to deliver bowelscope and for the population would require 4 lists. Eight endoscopists were further identified (6 nurse endoscopists, 1 Fellow and 1 radiographer-also programme manager) as needing accreditation for bowelscope. All mentees were assigned a mentor (3 BCSP colonoscopists) and put on the pre-accreditation course at RLH. Exams were planned over 3, UKdays for all the endoscopists in April 2014. Prior to the exam, all endoscopists, had 2 flexi lists booked with their mentors at RLH as well as ad-hoc sessions to help with MCQ.

Outcome: The LandW BCSC got approval by national office in Jan 2014 with a go live date in Feb to take over FOBT service. Bowelscope is planned for September 2014.

Conclusion The setting up of a new centre in such a short period of time was extremely challenging but successful due to good team work, planning and collaboration.

Disclosure of Interest None Declared.

PTH-059 A MODEL DESIGNED TO CALCULATE THE COST OF CARE FOR INFLAMMATORY BOWEL DISEASE (IBD).

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Introduction The rising incidence of IBD, young age of onset and chronic nature mean that IBD has significant cost implications with the National IBD Audit estimating that cost to the National Health Service (NHS) exceeded £1 billion in 2010. The recent introduction of Clinical Commissioning Groups has also changed the way in which healthcare is paid for. This model is designed to be used by both commissioners and individual gastroenterology units to calculate the annual cost per patient of treating Ulcerative Colitis (UC) and Crohns Disease (CD) and to enable areas of potential cost savings to be explored.

Methods The cost of care for IBD was calculated by summing the costs of treatment, treatment side effects and disease-related complications, accounting for the proportions of patients incurring these costs. Default input values for costs, the percentage of patients receiving each treatment, and the percentage of patients experiencing side effects or complications were determined from sources such as the British National Formulary (BNF), National Institute for Clinical Excellence (NICE), NHS trusts and published literature. However, an important feature of the model was its customisability allowing users to input local data, thereby generating costs which were unique and precise for that unit.

Results Using default input values, the annual cost of treating any UC patient was estimated to be £3,084. For a UC patient in remission, in relapse with mild-to-moderate UC or in relapse with severe UC, annual cost per patient was estimated to be £1,693, £2,903 and £10,760, respectively. The annual cost for any CD patient was estimated to be £6,156 (£1,800 for patients in remission; £10,513 for patients in relapse). However, inputting local data would show some variability in the costs from trust to trust.

Annually £743.65 was spent per UC patient on mesalazines. The model allows exploration of the cost savings if the percentage of patients on each brand of mesalazine was altered.

When the percentage of relapsing CD patients on adalimumab was increased from 5% to 10%, the annual cost per relapsing CD patient rose from £10,513 to £11,032. The overall annual cost for any CD patient rose from £6,156 to £6,416.

Increasing the percentage of mild-to-moderate UC patients on leukapheresis from 0.5 to 8% increased the annual cost per mild-to-moderate patient from £2,903 to £3,352, and the annual cost for any UC patient from £3,083 to £3,263. However, assuming that increased use of leukapheresis would cause a decrease from 20% to 15% in the annual proportion of patients experiencing acute severe flares, the annual cost for any UC patient fell to £3,078.

Conclusion This model facilitates calculation of local annual costs per UC and CD patient, and allows areas to be identified where savings could be made.

Disclosure of Interest: None Declared.

PTH-060 EVALUATION OF AN ESTABLISHED COMMUNITY GASTROENTEROLOGY CLINIC WITH COMPARISON TO SECONDARY CARE

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Introduction Community based specialist clinics improve patient experience and access to healthcare whilst improving GP-Specialist communication.¹ Commissioning dictates that future

management of chronic gastro-intestinal conditions needs to involve integrated care. We reviewed the outcomes of an established gastroenterology community clinic run for 3 years by two General Practitioners with a specialist interest in gastroenterology (GPwSIs) and a consultant gastroenterologist from the local hospital.

Methods A weekly gastroenterology community clinic in primary care was established to service 35 local General Practices. Data was collected from January-September 2013 using referral letters and an electronic database and compared to the local hospital general gastroenterology clinics.

Results Of 490 patients referred 284 (58%) were triaged to community, 188 (38%) referred onwards to secondary care and 18 (4%) were returned to the referring GP. 37% of appointments were conducted by the consultant.

The proportion of patients that did not attend was lower in the community (10%) than secondary care (22%). 86% were discharged back to their referring GP; 16% after the 1st appointment and 84% after one further follow up appointment. Others were directly referred to relevant secondary care. 80% had further investigations (39% Gastroscopy, 24% Colonoscopy, 22% CT scan, 12% Ultrasound abdomen, 9% flexible sigmoidoscopy, 1% Oesophageal manometry) all performed in the local hospital.

Median wait time from referral to 1st clinic appointment was 28 days in the community (56 days in the local hospital). Intra-clinic wait time in community was an average of 3 min (38 min in secondary care). A community patient satisfaction survey (N=102) revealed that 88% would definitely recommend the clinic to a friend, with high levels of satisfaction. A secondary care satisfaction survey (N=214) showed that although overall satisfaction was similar, there was relative dissatisfaction of waiting times, waiting area and communication.

Conclusion This novel gastroenterology community clinic delivers high quality care closer to patients. It is associated with shorter refer, UKrral waiting times, high discharge rates and excellent patient satisfaction scores. Additional benefits include enhancement of primary/secondary care links, mentoring and teaching of GPwSIs, continuity of care and direct access to onward referral to secondary care for further management across specialties. Further follow up is necessary to evaluate the effect on local healthcare delivery.

REFERENCE

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Disclosure of Interest None Declared.

PTH-061 THE MANAGEMENT OF ACUTE UPPER GASTROINTESTINAL BLEEDING IN PAEDIATRIC PRACTICE: A NATIONAL SURVEY

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Introduction Acute upper gastrointestinal (GI) haemorrhage is rare in paediatric practice but continues to cause significant morbidity and mortality. Guidelines for the management of GI bleeding in children exist but their evidence base is limited and their implementation in the UK is unknown. We aimed to determine the provision for paediatric upper GI bleeding in the UK with regard to access to services and management using a national survey.