OC-027 DOES THE ORGANISATION OF SERVICES IN A GEOGRAPHICALLY DIVERSE REGION HAVE IMPACT UPON DELIVERY OF END OF LIFE CARE FOR PATIENTS WITH UPPER GI CANCER?

doi:10.1136/gutjnl-2012-302514a.27

A Jones,* R Coggins, J Godsman. *NHS Highland, Inverness, UK*

Introduction The Scottish government "Living and Dying Well" action plan aims to ensure that end of life care needs are recognised in all care settings. This study aims to examine end of life care for Upper GI cancer patients, diagnosed within the geographically diverse region that comprises NHS Highland. Following diagnosis, do we get patients home, and do they die at home?

Methods E-Case Cancer Audit, Cancer Waiting Times Submissions, General Register Office Death and Cancer Registry databases were searched using ICD10 codes for upper GI cancer (ICD10 C15–C17 and C22–C25) for years 2005–2010. Place of death for patients diagnosed within NHS Highland was identified and recorded as one of: home, hospital, hospice or "other institution". This data were then compared with Scottish national data for all cancers, compiled and published by Information Services Division, Scotland.

Results 978 patients were diagnosed with upper GI cancer in the study period. Place of death was not known in 298 patients and these were therefore excluded from further analysis. Of the remaining 680 patients 237 (34.9%) died at home, 295 (43.4%) died in hospital, 96 (14.1%) died in hospice and 49 (7.2%) died in another institution. Of 75 522 cancer deaths in Scotland between 2004 and 2008 24.3% died at home, 51.9% died in hospital, 17.6% died in hospice and 6.2% died in another institution. Using χ^2 testing with Yates' correction, differences between NHS Highland and national data show highly significant differences in both "at home" and "in hospital" deaths ($p<0.0001$).

Conclusion Despite government initiatives, over half of cancer patients in Scotland still die in hospital and just under a quarter die at home. In our study group fewer patients die in hospital and more—over one third—die at home. Despite the challenges of geography and transport links in the north of Scotland, the ability to deliver complex care and end of life planning for patients with Upper GI cancer is not adversely affected.

Competing interests None declared.

REFERENCE

1. **Information Services Division**. *Living and Dying Well: A National Action Plan For Palliative And End Of Life Care In Scotland*. Scotland: NHS National Services, 2008. http://www isdscotland.org. ISBN 9780755958894.

OC-028 DEVELOPING SUSTAINABLE GI ENDOSCOPY TRAINING IN MALAWI

doi:10.1136/gutjnl-2012-302514a.28

[1]J Geraghty,* [2]A Kankwatira, [3]M Feeney, [4]M Hendrickse, [5]L Kalongolera, [2]R Malamba, [2]N Mtunthama, [6]H Mwandumba, [1]P O'Toole, [1]M Gordon. *[1]Department of Gastroenterology, Royal Liverpool University Hospital, Liverpool, UK; [2]Clinical Investigation Unit, Queen Elizabeth Central Hospital, Blantyre, Malawi; [3]Department of Gastroenterology, South Devon Healthcare, Torbay; [4]Department of Gastroenterology, Blackpool Victoria Hospital, Blackpool, UK; [5]Department of Surgery, Queen Elizabeth Central Hospital, Blantyre, Malawi; [6]Department of Medicine, Queen Elizabeth Central Hospital, Blantyre, Malawi*

Introduction Sustainable endoscopy services could improve management of upper gastrointestinal malignancy and haemorrhage, both common in Malawi. Since 2008 we have committed to improving endoscopy training through an International Health Link (IHL) partnership with Malawi. We aimed to (1) develop a sustainable training "hub" with locally-trained Trainers in Blantyre (2) develop locally-relevant training courses, (3) extend training support to regional hospital "spokes".

Methods We partnered in five training visits to Malawi, funded by the Tropical Health Education Trust and the British Society of Gastroenterology. We ran 14 courses (Basic Skills, Skills Enhancement, Training the Gastroscopy Trainers (TGT) and Endoscopy Nurses) involving 52 delegate-training-episodes (29 local doctors, 12 clinical officers (COs), three expatriate doctors, eight nurses). Outcomes were monitored by JAG-format DOPS and course evaluations. Progress over time towards the three aims was assessed.

Results Aim 1) Training models and audit, reporting and assessment tools were introduced in Blantyre. The mean number of delegate-episodes increased from 6.3 during the first four visits, to 20 during the last two visits. During the first four visits the local faculty was four expatriate doctors and one CO, increasing to seven local doctors, five COs, two nurses and one expatriate doctor during the last two visits. In the first four visits, 16/21 delegate-episodes involved only skills learning and 5/21 (24%) were as mentored or local faculty, while in the last two visits, 25/40 involved only skills learning and 15/40 (38%) were as mentored or local faculty. In 2011 we ran and evaluated the first TGT within Malawi. Aim 2) We developed a Basic Skills in Gastroscopy course appropriate to local circumstances, which was delivered, evaluated and modified over each visit, and ultimately delivered by two locally-trained Trainers. Aim 3) The delegates' region of origin for the first four visits was 18/19 from Blantyre, and for the last two visits was 15/40 Blantyre, 13/40 Lilongwe, 7/40 Zomba, 3/40 Mzuzu and 2/40 Zambia. The origin of UK external faculty increased from 1 to 3 sites, and two new IHLs were established with Lilongwe and Zomba.

Conclusion IHL partnerships represent a sustainable means of improving GI endoscopy training. Modified JAG-format courses, assessments and evaluations were useful even in a resource-limited setting. A hub-and-spoke model helped to support other regions. Future training priorities include training in therapy and further development of local trainers. Local reporting tools should allow audit of outcomes across regions.

Competing interests None declared.

OC-029 DYSPEPSIA MANAGEMENT IN MALAWI: A PROSPECTIVE AUDIT

doi:10.1136/gutjnl-2012-302514a.29

[1]M G Keane,* [2]A Thumbs, [2]K Hellberg, [2]T Allain, [2]A Kankwatira, [2]W Howson, [3]J Geraghty, [2]R Malamba, [4]M A Gordon, [3]P O'Toole. *[1]Department of Gastroenterology, UCLH, London, UK; [2]College of Medicine, QECH, Blantyre, Malawi; [3]Department of Gastroenterology, Royal Liverpool University Hospital, UK; [4]Department of Gastroenterology, University of Liverpool, Liverpool, UK*

Introduction Dyspepsia is a very common symptom world wide. Unless managed effectively it can burden endoscopy services and create high treatment costs. Management algorithms are widely used in developed countries but have not been validated in sub-Saharan Africa. In Malawi, *Helicobacter pylori* (HP) infection rates are high, endoscopy facilities are scarce and proton pump inhibitors (PPIs) expensive. In addition the region has extremely high rates of oesophageal cancer and HIV. The incidence of gastric cancer is not known. These conditions make dyspepsia management particularly challenging. Queen Elizabeth Central Hospital (QECH) in Blantyre is Malawi's tertiary hospital, and provides endoscopy services for a large part of the Southern Region.

Methods A prospective audit of all patients presenting routinely to the outpatient department or endoscopy unit at QECH with dyspeptic symptoms over a 4-week period between August and September 2010. Patients were interviewed and health records and prescriptions reviewed.