secondary care.[1] A community gastroenterology clinic was established in Sheffield in 2011 to deliver out-patient care closer to patients' homes while retaining access to specialist expertise. This study reports results from the first 8 months of the community clinic and compares with secondary care gastroenterology clinics.

Methods A single, weekly, consultant-delivered new patient community clinic (CC), designed as a "one touch", single consultation, was established in primary care for a Consortium of 27 General Practices. Data for the study period, March 2011–October 2011, was retrieved for the CC from referral proformas, letters and primary care records. This was compared to secondary care clinics for patients' referred from the same consortium during the study period and for the same time period the year prior to the CC (March 2010 to October 2010).

Results In March–October 2010, 579 patients from the consortium were seen in secondary care gastroenterology clinics. During March–October 2011, 896 patients were seen in gastroenterology clinics: 741 (82%) in secondary care and 155 (18%) in the newly established CC. Mean age was lower in the CC (50 vs 57.8 years, $p<0.001$), with 42/155 (27%) aged over 65 in the CC compared to 310/741 (42%) in the secondary care clinic ($p<0.01$). 67/741 (9.0%) patients did not attend appointments at the secondary care clinic compared to 9/155 (5.8%; $p=0.15$) in the CC. Median waits for CC appointments was 21 days at month 1 rising to 47.5 days in month 8. Presenting features were altered bowel habit (n=59 (38%)), abdominal pain (n=23 (15%)), reflux type dyspepsia (n=18 (12%)) and iron deficiency anaemia (n=16 (10%)). 144 patients (93%) attending the CC had had the specified pre-clinic investigations. 118/146 (81%) patients attending the CC were discharged back to the GP after one visit: of whom 111 (94%) had further tests recommended (33 blood tests, 56 gastroscopy, 53 colonoscopy, 16 ultrasound abdomen). In the 2010 period prior to the CC, 35/579 (6%) patients seen were discharged from their initial secondary care clinic review ($p<0.0001$).

Conclusion The new primary care gastroenterology clinic is associated with higher initial discharge rates, moving co-ordination of ongoing out-patient management to primary care. However, this was not associated with a reduction in patients seen in secondary care and attracted a younger cohort of patients. Additional follow-up is required to assess effects on overall healthcare resource utilisation.

Competing interests None declared.

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PTU-246 NHS BOWEL CANCER SCREENING PROGRAMME

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Introduction Background: The NHS Bowel Cancer Screening Programme (BCSP) in England was established following successful pilot screening programmes in England and Scotland.[1] The BCSPcommenced in 2006 with a 3-year phased implementation offering screening to men and women aged 60–69. The programme also enabled people aged 70 and over to self-refer into the screening programme.

Objectives:

–reduce mortality from bowel cancer by up to 16%.[2]

–offer men and women aged 60–69 a guaiac-based FOBt every 2 years.

–enable those over 70 to be screened on request.

–offer those with an abnormal screening result a colonoscopy as the investigation of choice.

–refer for treatment if cancer is found at screening colonoscopy.

–transfer to colonoscopic surveillance within BCSP where intermediate/high risk polyps are found.

Methods The programme comprises five regional programme hubs responsible for call and recall, laboratory processing of test kits and booking clinic appointments for participants with abnormal FOBt results. Participants with an abnormal FOBt result are referred to a local screening centre to discuss colonoscopy with a specialist screening practitioner (SSP) within 2 weeks and offered a screening colonoscopy within a further 2 weeks. General practitioners are not directly involved in the screening process, but do receive information to support their patients to make an informed choice.

Results All 58 screening centres have completed their prevalent round of screening, and the entire eligible population has received at least one invitation. The screening invitation age range is being extended to 75th birthday from 2010 in response to the government's Cancer Reform Strategy.

Conclusion Over twelve million invitations have been despatched. Data shows that uptake has increased from 47.73% in prevalent round to 87.41% in incident round and positivity has decreased from 2.19% in prevalent to 1.99% in incident round. Of these patients, prevalent round data showed 9.90% had a confirmed cancer diagnosis and in incident round this has reduced to 6.05%. Over 143 000 diagnostic tests have been carried out, of which 130 402 were screening colonoscopies. Episode outcomes also show a reduction in incident rounds of high risk polyps (10.21% to 7.65%) and intermediate risk polyps (17.95% to 14.33%). There has been an increase in low risk polyps (15.81% to 21.13%) and abnormal findings, not polyps (19.73% to 26.38%).

Competing interests None declared.

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PTU-247 ERCP—CAN A SMALL VOLUME UNIT PROVIDE A SATISFACTORY SERVICE?

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Introduction In recent years, systems grading ERCP technical difficulty have been introduced in UK clinical practice. According to these, small volume units are advised to refer complex cases to specialised centres. Conversely, in the US the American Society for Gastrointestinal Endoscopy (ASGE) has announced favourable results of community based hospitals ERCP success rates compared to university hospitals. Recommended competence rates are: 90% successful bile duct cannulation, 85% for bile duct stone removal and 90% for bile duct drainage of a blocked duct.[1] In the UK, the J.R. B. Green and the UK ERCP stakeholders working party and Joint Advisory Group (JAG) suggest an overall 80% success rate.[2] This study compares ERCP success rates in Nobles Hospital, a geographically isolated District General Hospital, to the competence rates of ASGE and JAG in order to assess whether ERCP can be performed successfully in district general hospitals in the UK.

Methods Between December 2010 and January 2012, 42 ERCPs were performed on 36 patients (F:M 24:12, Mean age: 69.8). All procedures were done for therapeutic purposes. Indications were divided to two categories: jaundice-stones identified in biliary ducts on pre procedural imaging (n=21) and jaundice-causes besides stones were identified in pre procedural imaging (n=21). χ^2 Test was used to compare success ratios between Nobles Hospital and ASGE and JAG recommended levels.

Results Desired duct cannulation success rate was 88.1% (n=37). Success rate for stone removal was 80.95% (n=17). For bile duct drainage of a blocked duct was 85.7% (n=18). Had ASGE recommended rates been applied to our hospital's cases, the results would be: 38 out of 42, 18 out of 21 and 19 out of 21 respectively. No statistically significant difference was found between Nobles Hospital and ASGE figures (Successful cannulation p value=0.72, successful stone removal p value=0.68, successful blocked duct drainage=0.63). Overall success rate for Nobles was 83.3% (n=35).

Conclusion ERCP success rates in Nobles Hospital are equivalent to the ASGE/ACG Task Force recommended competency levels and exceed JAG recommended success rates. This study provides evidence that ERCP can be successfully performed in a non-specialised environment within the British National Health System.

Competing interests None declared.

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PTU-248 A SPECIALIST CIRRHOSIS CLINIC IMPROVES SCREENING, PATIENT SATISFACTION AND ATTENDANCE OF PATIENTS WITH ADVANCED LIVER DISEASE

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Introduction Cirrhosis represents the end stage of progressive liver disease and is associated with potentially lethal complications. Early detection and management of these complications can improve outcome. In July 2008, a dedicated Cirrhosis Clinic was instigated at St. Mary's Hospital, London, with the aim of enhancing the standard of care by improving the diagnosis and management of liver complications. We investigated the clinical impact of this novel clinic dedicated for patients with cirrhosis.

Methods We compared the demographics, clinical outcomes and patient satisfaction among 50 patients attending the Cirrhosis Clinic and 30 patients with cirrhosis attending a general Hepatology outpatient clinic. Clinical information and rates of screening for complications were assessed from the case notes and the hospital databases. Attendance rates were collected prospectively and patient satisfaction assessed with a standardised questionnaire.

Results The mean age, gender and ethnicity of patients in the Cirrhosis Clinic were identical to those in the general Hepatology clinic (57 years; 70% male; 62% Caucasian). Patients in the Cirrhosis Clinic were more likely to have alcoholic liver disease (58% vs 23%; p<0.05). Cirrhosis Clinic patients were more likely to have ascites (56% vs 17%; p<0.05), varices (60% vs 26%; p<0.05), encephalopathy (20% vs 3%; p<0.05), Child stage B or C (52% vs 19%; p<0.05) and had higher UKELD (47 vs 43; p<0.05). Screening rates were higher in the Cirrhosis Clinic patients for hepatocellular carcinoma (70% vs 57%; p<0.05), vitamin D deficiency (86% vs 40%; p<0.05) and varices (90% vs 77%; p=0.11). Attendance rates in the Cirrhosis Clinic improved substantially after the introduction of a telephone reminder (86% vs 64%; p<0.05). Attendance rates were better than the general clinic (86% vs 77%) but this was not statistically significant (p=0.27). The Cirrhosis Clinic was rated excellent by 67% of patients vs 34% of patients in the general clinic (p=0.06).

Conclusion A dedicated clinic serving patients with cirrhosis improved screening rates for complications, boosted attendance rates and led to increased patient satisfaction. Further work is required to evaluate the impact on long-term outcomes and cost-effectiveness.

Competing interests None declared.

PTU-249 KEY WORKER ALERTS IN EMERGENCY ADMISSIONS OF PATIENTS WITH GASTROINTESTINAL CANCER SUBSTANTIALLY SHORTEN LENGTH OF STAY AND READMISSION RATES

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Introduction A retrospective audit of data from 2007 to 2009 revealed that patients known to have gastrointestinal (GI) cancer admitted as an emergency to our trust had long median length of stays (LOS) of 13 days, despite coding in 80% indicating no procedural intervention was undertaken or limited to diagnostic testing. 50% of such GI cancer patients were admitted for symptom management or disease progression and only 18% had documented interaction with their key worker (clinical nurse specialist) during their admission.

Methods A pilot study of alerting the patient's key worker, when a patient known to have GI cancer was admitted as an emergency, was organised to establish whether early key worker intervention could shorten LOS and lower 30-day re-admission rates. Patients with GI cancer were flagged on Lorenzo (IPM) and an email and text message to the key worker generated via an ADT HL7 message to the Rhapsody Interface Engine, when a GI cancer patient was admitted as an emergency. The study initially involved patients with colorectal cancer but patients with upper GI cancer were also subsequently included.

Results During the 10-month study period, 146 colorectal alerts were received, 52 related to the patient's cancer, and during 8 months 57 upper GI cancer alerts were received, 42 related to the patient's cancer. Key worker intervention reduced LOS for colorectal patients admitted as an emergency from a median of 13 to 2 days and upper GI cancer from 7 to 1 day. Re-admittance rates were reduced from 28 to 8% for colorectal cancer patients and 35 to 23% for upper GI cancer. The principal interventions undertaken included symptom control and referral to specialist palliative care teams. Projections for 2011/2012 suggest that key worker alerts for GI cancer emergency admissions based on 260 colorectal and 146 upper GI cancer emergency admissions will save 3654 bed days.

Conclusion Key worker alerts are an inexpensive intervention that shortens LOS, prevents re-admission, does not adversely affect key worker workload and improves patient experience. The system has obvious potential benefits for patients with other cancer sites and patients with inflammatory bowel disease admitted as an emergency.

Competing interests None declared.