

Results - 675 new and 1622 follow up appointments were seen by Medical Staff (Consultant, Registrar or SHO) giving an overall NFR of 1:2.4

- 516 patients were seen in Nurse-led clinics
- NFR and diagnostic case-mix varied by Consultant team
- Table 1 shows the diagnostic case-mix and outcomes

Abstract PTH-151 Table 1

Primary diagnosis	% of follow up	% discharged by diagnosis
IBD	23.5	1.6
Chronic liver disease	15.0	2.1
IBS	5.9	39
GORD	3.4	51.85
Coeliac	3.1	6.1
IDA	2.9	30.19
Gallstones/biliary	2.8	13.6
Barrett's	2.2	0.0
Others	41.2	25.5

Conclusion Almost 40% of secondary care follow up patients are seen with IBD or chronic liver disease. Fewer of these patients are discharged than patients with other diagnoses. In order to improve NFRs we now have primary care discharge pathways for stable patients with coeliac disease and limited colitis. Additional pathways are planned but diagnostic case-mix appears to be a major determinant of NFRs and should be taken into consideration when NFR targets are set.

Disclosure of Interest None Declared.

REFERENCE

1. NHS Institute for Innovation and Improvement. Converting the potential into reality: 10 steps a provider can take to realise the benefits of Better Care, Better Value indicators.

PTH-152 NURSE DELIVERED DAY CASE PARACENTESIS - A SINGLE CENTRE EXPERIENCE

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Introduction Refractory ascites is a debilitating consequence of end stage liver and other diseases. Treatment options are limited and include recurrent large volume paracentesis (LVP). Admission for LVP requires usage of in-patient beds which are in high demand and have a high cost. Since 2009 we have introduced day case paracentesis and trained a Hepatology clinical nurse specialist (CNS) to perform LVP for stable patients as day cases.

Methods We aimed to evaluate our service development to assess the safety and success rate of day case LVP and particularly a nurse delivered day case LVP service. Initially, day case LVP was coordinated by the CNS with trainees in gastroenterology performing the procedure; subsequently we trained up and assessed the CNS in performing LVP independently. A retrospective audit, evaluating all day case LVP performed since the introduction of the service was performed. Aetiology of ascites and severity of liver disease (Child Pugh), volume drained and complications related to drainage were all recorded. The proportion of cases performed by doctors and the CNS were noted to determine relative outcomes. All cases of LVP for ascites due to cirrhosis were given 20% human albumin solution as per local protocol.

Results 108 LVP performed (in 42 patients). 62 (57.4%) performed by the CNS. The cause of ascites was cirrhosis in 36 patients (94 LVP) and malignancy in 6 patients (14 LVP). In cirrhotic patients, median Child Pugh score was 8 (range 7–11). 107 (99.1%) of

attempts at LVP were successful with 106 (98.1%) drains sited with a single needle pass. The volume of ascites drained typically was 12–16 litres (range 3–26). Complications included local skin infection requiring oral antibiotics in 1 case (0.9%) and leakage of ascites requiring suturing in 11 (10.2%) procedures. Most cases of local leakage were in those with malignant ascites (63.6%). There were no long term or serious complications and no unplanned admissions following on from day case LVP. There was no difference in success or complication rate between those LVP performed by the CNS or medical staff.

Conclusion Nurse delivered day case LVP is a safe and effective method of managing patients with refractory ascites. It is a method of relieving the burden on the hospital bed base in a sustainable and safe way. In addition, we would anticipate significant cost savings for this model compared to admission for LVP.

Disclosure of Interest None Declared.

PTH-153 THREE YEAR EXPERIENCE IN A NURSE LED TELEPHONE CLINIC: A RETROSPECTIVE STUDY OF A DISTRICT GENERAL GASTROENTEROLOGY CLINIC.

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Introduction With the demand for patient choice and increasing numbers of outpatients being reviewed in secondary care, a nurse led telephone clinic has proved to be an important part of patients care¹. Our clinic was first developed in 2009 as a way of providing more efficient follow up care to our patients post procedure.

The Aim of this study was to identify and analyse the current use of our telephone clinic and the type of patients and conditions that are managed by the nursing team.

Methods A retrospective study of all patients enrolled between May 2009 and November 2012 to the telephone clinic (TC) was completed. Demographics, procedure referral reason, attendance and outcome data were analysed. This was compared with our current face to face outpatients (FTFOP) data. Costs of care were estimated using data sourced from NHS tariff 2011–12.

Results There were 1021 individual appointments made of which 807 (79%) appointments were completed, 57 messages were left and 82 patients were unable to be contacted. FTFOP non attendance rate was 28% vs 20% for the telephone clinic. 54.3% of patients were female vs 63.7% in FTFOP. The majority of patients, (85%) were called with the primary reason of test results. 5.6% of patients were contacted with the primary objective of review and advice.

Patients problems were separated where possible into categories 3.4% hepatobiliary, 5.8% indeterminate, 42% Lower Gastrointestinal (GI), 49% upper GI. Particular common complaints being addressed included dyspepsia, 19.4% of total patient referral reasons and 7.4% change in bowel habit. 77% of patients were discharged after the telephone consultation with 3.3% given an open appointment. 9.3% required specific timed follow up in FTFOP. With current tariffs for non face to face out patient appointments at £55.15 vs FTFOP of £141.44 we expect initial annual savings based on an average of 235 consultations a year of £20,278.15.

Conclusion The telephone clinic has provided a useful adjunct in patient to provider care. The data has shown that a variety of conditions can be successfully managed and relatively few patients require subsequent follow up in a face to face consultation. The clinic seems to be particularly useful in dealing with clinical symptoms which have algorithmic management, such as dyspepsia. Non-attendance rates were comparable. Patients have anecdotally liked the service for its efficiency and time saving approach. Development of this service will include increased monitoring of patient symptoms as a primary reason for review and integration to the email helpline service established since 2008.