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

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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 care[1]. 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 patienits, (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 seperated where possible into catagories 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 haves 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.

Disclosure of Interest None Declared.

REFERENCE

1. Impact of a nurse-led telephone clinic on quality of IBD care Sharon Gethins *et al.* Gastrointestinal Nursing, Vol. 5, Iss. 1, 18 Jan 2007, pp 34 – 39

PTH-154 THE OUTPATIENT BURDEN OF INFLAMMATORY BOWEL DISEASE: A 10 YEAR REVIEW

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Introduction Like many hospitals through out the UK the National IBD Standards (endorsed by the British Society of Gastroenterology) and the IBD (Global Rating Score) Quality Improvement Programme (endorsed by The Royal College of Physicians) have help highlighted areas of our inflammatory bowel disease (IBD) service that clearly need improving. In order to attract funding from our local primary care trust (PCT) to support the necessary service improvements, we set about establishing the total cost and demand made on our local hospital in managing these patients. We set about assessing 4 key areas; the endoscopy service, the radiology service, the hospital admissions and the outpatient service.

Objective of this study: To assess the demand on the outpatient services made by IBD patients.

Methods The Luton & Dunstable University Hospital has a database of 2680 local IBD patients. This is made up of 1425 patients with UC, 941 with Crohn's, 118 with proctitis, 113 with IBD unspecified, 53 with radiation proctitis, 13 with diversion colitis, 10 with ileo-anal pouchitis and 7 with microscopic colitis. Using the database the hospital coding system was used to analyse the total number of outpatient appointments (OPAs) made between 2001 and 2011 for these patients, and to which specialties they were referred. Total costs were calculated using a range of prices for the different specialties, depending on whether they were new (£210-£265) or follow up clinic visits (£83-£136).

Results Over the course of 10 years the 2680 IBD patients made 20,837 gastroenterology OPAs (2,053 new and 18,784 follow ups) (ie.2,084 per year), costing the local primary care trust (PCT) a total of £2,103,117. There were also 3474 OPAs made with the gastrointestinal (GI) surgeons (1,409 new and 2,065 follow ups) (ie. 347 per year), costing the local PCT a total of £603,524. In addition a further 42,276 (63%) OPAs were made with non-GI teams, costing the PCT an further £4,227,600.

Conclusion Over 10 years the 2680 patients made 66,007 outpatient clinic visits (24.6 per person, 2.46 per person per year) costings a total of £6,934,241. Of these, 24,311 (37%) were with the GI medics and surgeons, costing the PCT a total of £2,706,641. Many of the non-GI specialty appointments were made for IBD associated conditions eg. 1510 dermatology OPAs. The 3281 ophthalmology OPAs were predominantly for cataracts, which raised concerns about potential iatrogenic causes.

Disclosure of Interest None Declared.

PTH-155 THE HOSPITAL ADMISSION BURDEN OF INFLAMMATORY BOWEL DISEASE: A 10 YEAR REVIEW FROM A DISTRICT GENERAL HOSPITAL

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Introduction The National IBD Standards and IBD (Global Rating Score) Quality Improvement Programme have highlighted areas of our inflammatory bowel disease (IBD) service that need funding, in order to make the neccessary improvements. To facilitate this we set about establishing the total cost and demand of managing IBD patients in our local hospital, reviewing 4 key areas; the endoscopy, radiology, outpatients and hospital admissions services.

Study Objectives: To assess the average length of stay (LOS) and total number of hospital admissions made by IBD patients over 10y.

Methods The Luton & Dunstable University Hospital has a database of 2680 local IBD patients. This is made up of 1425 patients with UC, 941 with Crohn's, 118 with proctitis, 113 with IBD unspecified, 53 with radiation proctitis, 13 with diversion colitis, 10 with ileo-anal pouchitis and 7 with microscopic colitis. Using this database the hospital coding system was used to analyse the total number of hospital admissions made between 2001 and 2011 for these patients, and to which specialties they were being admitted.

Results Over the course of 10 years the 2680 IBD patients made a total of 6385 hospital admissions. Of these, UC patients accounted for 2524 admissions, whilst the Crohn's patients had a proportionally higher admission rate, accounting for 2504 admissions. The number of admissions per patient ranged from 1 to 134, and of those admitted they had a mean of 6.4 admissions each. These patients were being admitted by a range of specialties including 4361 by general medicine, 1260 by general surgery, 251 by elderly care, 103 by paediatrics, 101 by orthopaedics, 66 by urology, 29 by the ears, nose and throat team, 45 by obstetrics and gynaecology, 11 by medical oncology, 48 by haematology, 5 obstetrics, 32 by ophthalmology, 43 by the maxillary facial team, 4 by A+E, 1 by anaesthetic pain relief team, 24 by cardiology and 1 by dermatology. The type of admission ranged from being elective/planned admissions in 4457, A+E emergency admissions in 1,363, emergency admission from clinic in 116, emergency GP admissions in 420, and 9 patients transfers from other hospitals.

Conclusion Over the 10 year period 1724/2680 (64%) of all the IBD patients required at least 1 hospital admission. On average this cohort of patients required a mean of 2.4 hospital admissions, with Crohn's disease patients placing a greater demand on the hospital admission services (average = 2.66 admissions) as compared with the UC patients (average = 1.77). The average length of stay was 2.6 days (range = 1–278 days). Whilst it is clear that not all the hospital admissions were directly related to the underlying IBD, it is clear that there is a heavy demand placed on the local hospital admission services from this cohort of IBD patients.

Disclosure of Interest None Declared.

PTH-156 INFLAMMATORY BOWEL DISEASE: A 10 YEAR REVIEW OF THE COST AND DEMAND OF THIS CONDITION, ON A DISTRICT GENERAL ENDOSCOPY UNIT

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Introduction Like many hospitals through out the UK, the National IBD Standards (endorsed by the British Society of Gastroenterology) and the IBD (Global Rating Score) Quality Improvement Programme (endorsed by The Royal College of Physicians) have help highlighted areas of our inflammatory bowel disease (IBD) service that needed improving. In order to attract funding from our local primary care trust (PCT) to support the necessary service improvements, we set about establishing the total cost and demand made by this cohort of patients on 4 key services offered by our local hospital; the endoscopy, radiology, hospital admissions and outpatient services.

Objectives of this study: To assess the cost and demand for endoscopy originating from the management of IBD patients, over a 10 year period.

Methods The Luton & Dunstable University Hospital has a database of 2680 local IBD patients. This is made up of 1425 patients with UC, 941 with Crohn's, 118 with proctitis, 113 with IBD