

Abstract PTH-161 Table 1

Group	Known IBD (%)	New IBD (%)	PUD (%)	NSI (%)	Cancer (%)	CRA (%)	Coeliac (%)	Unknown (%)	Other (%)
Age < 55 + FCP 60–100 (n = 15)	AB4 (26.7)	AB0 (0.0)	AB0 (0.0)	AB2 (13.3)	AB0 (0.0)	AB0 (0.0)	AB0 (0.0)	AB1 (6.7)	AB8 (53.3)
Age < 55 + FCP > 100 (n = 68)	AB39 (57.4)	AB6 (8.8)	AB2 (2.9)	AB3 (4.4)	AB0 (0.0)	AB0 (0.0)	AB1 (1.5)	AB4 (5.9)	AB13 (19.1)
Age > 55 + FCP 60–100 (n = 11)	AB3 (27.3)	AB0 (0.0)	AB0 (0.0)	AB0 (0.0)	AB0 (0.0)	AB1 (9.1)	AB0 (0.0)	AB0 (0.0)	AB7 (63.6)
Age > 55 + FCP > 100 (n = 42)	AB22 (52.3)	AB2 (4.8)	AB0 (0.0)	AB0 (0.0)	AB2 (4.8)	AB2 (4.8)	AB0 (0.0)	AB2 (4.8)	AB12 (28.5)

reviewed in addition to clinic letters to understand clinician interpretation of results when necessary. Patients were categorised by age and FCP result. Outcomes in patients without IBD were categorised as: new IBD, non-specific inflammation/ulceration (NSI), peptic ulcer disease (PUD), cancer, colorectal adenoma (CRA), coeliac disease, other (including irritable bowel syndrome, bile salt malabsorption) or unknown where no additional information was available.

Results 147 positive (of 391, 37.6%) FCP results were identified. 11 were excluded, as investigations were ongoing. The outcome of investigations per category are summarised in Table 1.

Conclusion The use of FCP is increasing. In our unit, the majority are used for assessment in patients with known IBD. In patients in whom FCP was used to aid diagnosis, those with a result < 100 had a 'benign' diagnosis following investigation in both age categories suggesting a considered approach in this group may be reasonable.

Disclosure of Interest None Declared.

PTH-162 THE CHALLENGES OF IMPLEMENTING EVIDENCE INTO ENDOSCOPIC PRACTICE: A QUALITATIVE STUDY

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Introduction The Quality Improvement in Colonoscopy (QIC) study was a region wide service improvement study that aimed to improve adenoma detection rate (ADR), and thusly quality in colonoscopy, through implementation of a 'bundle' of measures to routine colonoscopy practise. These were: withdrawal time ≥ 6 minutes; routine hyoscine butylbromide use; supine position to examine the transverse colon; rectal retroflexion. Each has been shown to improve adenoma detection. The implementation of evidence into clinical practise can be challenging. We performed a qualitative interview study to evaluate factors that influenced implementation of the 'bundle' in the QIC study.

Methods The study took place in 12 units who are members of the Northern Region Endoscopy Group, a research network in the north east of England. The study team held training sessions in each unit to introduce the 'bundle', supported by a nominated local lead colonoscopist and nurse. Posters were supplied for each endoscopy room to aid promotion. Following QIC study completion units and individuals were purposively sampled for the qualitative interview study ensuring a range of units (by size, bundle uptake) were included. Semi-structured interviews were conducted until saturation was reached. Data were evaluated using thematic analysis to code and categorise interviews.

Results 119 colonoscopists participated in the QIC study. Interviews were conducted with 11 participants. 8 were lead colonoscopists, 1 a lead nurse and 3 colonoscopists who weren't leads. Increased emphasis on examination time, increased awareness of ADR as a quality marker and empowerment of endoscopy nurses to encourage use of quality measures were seen as positive impacts of introducing the 'bundle'. The simple, highly visible posters were also reported as useful in aiding study promotion. Challenges included difficulty in arranging set up meetings and in engaging certain speciality groups.

Conclusion Implementation of evidence into clinical practise can be challenging. During the QIC study, challenges included arranging staff meetings and engaging all team members. Positive outcomes included increased awareness of colonoscopy quality, particularly slower withdrawal times, and empowerment of endoscopy nurses to promote quality measures. We demonstrate that emphasis on timing of meetings and strategies to engage speciality groups should be given consideration when planning implementation of evidence or guidelines into clinical practise.

Disclosure of Interest None Declared.

PTH-163 NURSE LED TELEPHONE CLINICS- THE NHS REVOLUTION IN MAKING

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Introduction Patients under the care of Gastroenterologists suffer from a wide variety of acute and chronic conditions which often need regular intensive monitoring. This often necessitates frequent outpatient visits and follows up blood tests.

To improve both patient care and efficiency, a telephone clinic led by nurse specialists was instigated.

The patients included those with follow ups of investigations into anaemia, abnormal liver function tests, coeliac disease, inflammatory bowel disease hepatitis B/C and irritable bowel disease.

Patients, who required drug monitoring, follow up of blood tests, histology and radiological investigations including flare ups of their inflammatory bowel condition were included.

Methods This initial consultation was in a consultant led clinic following which the results were communicated via the telephone clinic in 4–6 weeks. Depending on the initial results further investigations, treatment or follow up was arranged according to clinical need.

Patients with flares of IBD, follow up of treatment of Hepatitis B/C were now directly in contact with nurse led telephone clinics who in turn could give specialist advice and expedite treatment and investigations.

December 2009 were analysed. Similar data from 2005 was used as controlst January 2009 to 31stData regarding outpatient and telephone clinic activities from 1.

Results In 2005 there were 1046 new patients and 3752 follow ups. In 2009 there were 1227 new patients and 3275 follow ups, 535 of which were seen by the telephone clinic services exclusively. There were no adverse events recorded in this cohort.

The number of follow ups reduced substantially saving clinic time, improving efficiency and allowing us to see extra 17.3% patients.

Conclusion The nurse led telephone clinics have improved efficiency, safety of the gastroenterology services and improved the new to follow up ratio from 0.27 to 0.37. Patient survey data suggests that they were not only happy with the telephone clinic service but would prefer that in order to save time and money.

Disclosure of Interest None Declared.

PTH-164 WHAT ISSUES NEED TO BE ADDRESSED REGARDING WORKFORCE PLANNING IN RELATION TO THE CHANGING DEMOGRAPHICS OF DOCTORS WITHIN THE FIELD OF GASTROENTEROLOGY?

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Introduction Many challenges lay ahead in the future development of the NHS including the changing workforce demographic, tighter funding and the prospect of increasing demands on services. Currently in the specialty of Gastroenterology 15% of consultants and 34% of trainees are female. To help realise the problems faced in workforce planning by this change of demographic we have tried to identify the current working patterns and perceptions of satisfaction and work-life balance amongst female Consultant Gastroenterologists.

Methods A survey was developed using previously validated questions, these were then piloted amongst a group of female hospital doctors to ensure that they were fit for purpose. A total of 110 Female Gastroenterologists were then emailed with a web based link to the survey along with information explaining what the survey was for. The responses were managed by RAND Europe, an independent non-profit organisation who have experience of similar projects.

Results There was a 63% response rate. The majority of respondents were between the ages of 41 to 50, and highly experienced of the NHS having worked for at least 15 years. 90% had achieved some form of higher degree, but only 2% worked in academic posts. 76% of respondents had had children, 73% of those felt that they provided the majority of childcare in comparison to their partner. 48% had delayed having children until they had become a consultant and 41% felt that they had had fewer children because of their career. A minority felt that their gender and parental status had negatively affected their career. The majority of respondents worked long hours with 30% working more than 49 hours per week. 11% of respondents worked part time, 19% were aware of a flexible working policy but not able to use it while 35% were not aware that one existed. Only 38% percent were satisfied with the recognition they got for their work. Almost 20% had experienced bullying from either managers or other colleagues in the preceding 12 months and 27% had received harassment from patients or patient's relatives. Almost 45% felt more stressed than usual and that their work life had a negative impact on their life. Although the majority of respondents felt happy with their current lifestyle, 10% were dissatisfied with their life, and 27% would change it if they could.

Conclusion Current female Gastroenterologists are competently educated but underrepresented in academic posts. They are more likely to be the main care giver at home but face inflexible working arrangements. They reported high levels of bullying as well as a perceived lack of value from their NHS employer. To maintain a committed and motivated medical workforce the issues highlighted in this survey will need to be addressed in future workforce planning.

Disclosure of Interest None Declared.

PTH-165 VALIDATING THE COLONOSCOPY WAITING LIST - CHALLENGING BUT REWARDING

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Introduction Endoscopy services within the UK are under pressure with increasing demand predicted and a need to maintain time-liness. The Department of Health for England and Wales wishes to improve outcomes for colorectal cancer and so increase the volume of lower GI endoscopy. Endoscopy services must increase efficiency to meet this challenge. We felt there was an opportunity to increase quality and reduce variation by ensuring all scheduled colonoscopies complied with National and departmental guidance. This is a key quality standard of the Global Rating Scale. We identified sessions in job plans of 3 nurse endoscopists within our trust. We then identified the guidance, informed endoscopists and the management team of the exercise we were undertaking and finally evaluated the intervention to be shared within our directorate team.

Methods Patients awaiting scheduled colonoscopy were identified from the Primary Targetted List database held by the trust to manage waiting and scheduled patients. Patients being followed up for colorectal cancer were excluded from the process and study as there was no single protocol being followed at the time of the study. The patient groups studied were therefore those on surveillance pathways for polyp follow up, family history or inflammatory bowel disease.

Clinical teams within the trust were informed by the clinical director of the process and that BSG guidelines for the conditions listed above were to be followed. The initial phase of the process was undertaken by a single Nurse Endoscopist. Following validation against guidelines, the case was reviewed by the clinical director and a letter addressed to the patient and copied to the patient's GP and secondary care consultant. The letter was co-signed by the nurse and the clinical director.

Following the establishment of the process as feasible, two other nurse endoscopists were trained in validating the procedures. Sessions were identified in job plans to ensure this process could be perpetuated long term.

Results

Abstract PTH-165 Table 1

2012	Total	Canc	Defer	Leave	Other
Apr	102	42	18	39	3
May	96	28	7	60	1
Jun	106	28	15	63	0
July	124	43	22	59	0
Aug	76	27	10	37	2
Sept	95	34	8	52	1
Oct	102	36	13	53	0
Total	701	238	93	363	6

Large numbers of surveillance colonoscopies are undertaken (73–124 per month). Many were listed on basis of colonoscopy findings and not checked for histology. A wide range of clinicians including non-endoscopists were listing patients. Guidelines were not adhered too. There was resistance to this standardisation from clinicians, GPs and patients initially.

Conclusion Wide variations in practise were observed. A large number of unnecessary colonoscopies were deferred to a more appropriate interval, producing benefits in quality and efficiency using existing resources.

Disclosure of Interest None Declared.

REFERENCE

BSG (2010) Guidelines for colorectal cancer screening and surveillance in moderate and high risk groups BSG (2002) Surveillance following Adenoma Removal