

the Western General Hospital for colonoscopy and flexible sigmoidoscopy during the two periods were included. Cost effective analysis was also undertaken.

Results 1418 Colonoscopies and flexible sigmoidoscopies were carried out during period 1 and 1234 were carried out during period 2. 454 (32%) of the colonoscopies were carried out using Moviprep in period 1 and 973 (79%) in period 2. Poor quality preparation was significantly more common with PicoLax preparation when compared to Moviprep in both period 1: 12 vs. 7% ($p = 0.0037$) and period 2: 13% vs. 5% ($p < 0.0001$). Repeat endoscopic procedures and completion imaging due to poor preparation fell from 44 (3.1%) in period 1 to 21 (1.7%) ($p = 0.03$) in period 2 following the change in default preparation to Moviprep. The estimated annual savings on repeat procedures and completion imaging across NHS Lothian of £89 000 offset the increased cost of Moviprep (£8.60 per patient vs. £3.65 for PicoLax) of £23 265 annually.

Conclusion Changing to Moviprep as the default preparation for colonoscopy in NHS Lothian has resulted in significantly better quality bowel preparation. Furthermore fewer repeat procedures have been required resulting in more efficient use of scarce capacity and cost savings.

REFERENCE

1 <http://www.nrls.npsa.nhs.uk/resources/?entryid45=59869>

Disclosure of Interest None Declared.

PTH-029 LIFESTYLE SCREENING AND BRIEF INTERVENTIONS IN A GASTROENTEROLOGY CLINIC

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Introduction Worcestershire Acute Hospitals NHS Trust currently have an Alcohol Liaison Nurse (ALN) Service. In response to NICE and Making Every Contact Count we wanted to implement a lifestyle screening tool within the out patients clinic, and be able to offer signposting and an opportunistic Brief Intervention (BI) service.

Methods Patients aged over 16 years attending a busy gastroenterology out-patients clinic were asked to complete a 'lifestyle' screening tool using the AUDIT-C (Babor 2001) to assess alcohol use and smoking status.

Individuals identified as smokers, were advised of the health risk by the a specially trained health care assistant and signposted to a smoking cessation service.

Individuals who were AUDIT-C positive (>5) were referred by the consultant to the Alcohol Liaison Nurse (ALN) for further assessment and Brief Intervention.

Results 448 patients attended the clinic. 60% ($n = 269$) were asked to complete the tool (2 refused).

32 (12%) individuals were identified as smokers. 13 males with a median age of 56 and 19 females with a median age of 49. 18 accepted an advice card.

82 (31%) AUDIT-C >5 . 46 males with a median age of 53 and 36 females with a median age of 51. 27 accepted referral to ALN (3 unable to contact).

The highest reported motivating factors for change were improved physical and mental health, followed by better finances and weight loss. 75% of the sub-group receiving Brief

Intervention could not identify any costs of change. The sub-group also scored high in relation to readiness to change and confidence to change following the BI. Extended BI reported reduced AUDIT-C scores and reduced drinking days/unit consumption.

Conclusion The results suggests that lifestyle screening is a achievable and acceptable in a busy gastroenterology clinic. A significant proportion of patients attending a gastroenterology clinic are likely to be using alcohol at harmful levels or smoking and are therefore likely to benefit from opportunistic BI or signposting to smoking cessation services.

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PTH-030 CLINIC OUTCOMES FOR UNSELECTED PATIENTS REVIEWED BY DOCTORS AND ADVANCED NURSE CLINICIANS – IS THERE ANY DIFFERENCE?

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Introduction There is a well-established role of specialist nurses in on-going management of chronic diseases in specialist clinics. With the reduction in junior doctor hours, advanced nurse clinicians (ANC) are taking on increasing complex medical roles. We aimed to evaluate the effectiveness of ANC in managing unselected new patients (NP) in the general gastroenterology clinic in a district general hospital.

Methods Analysis was done on 76 consecutive NP seen in the gastroenterology clinic over one week which then generated a further 66 follow appointments over an 18 month follow up period. We compared the direct service costs, diagnosis, outcome and discharge rates for each clinician grade. IBD patients requiring regular follow were excluded from the analysis. Cost analysis was performed using current NHS tariffs for the investigations performed.

Results Forty new patients (53%) were seen by an ANC, 26 (34%) by a consultant gastroenterologist and 10% (13%) by a middle-grade doctor (MG) at the first appointment. Forty referrals were on the 'suspected cancer' pathway, of these 68% were seen by ANC, 13% by a consultant 19% and by MG. Of the 36 non-urgent referrals – 36% were seen by ANC, 55% by a consultant and 9% by MG. The mean number of follow up appointments generated was 1.9 (ANC), 1.8 (consultant) and 2.2 (MG). ANC's ultimately discharged 30 patients (39%), consultants 23 (30%), MG's 7 (9%). Sixteen patients (21%) required long-term follow-up or did not attend. Consultants requested 16 investigations on new patients (0.62 tests/patient) costing £161 per patient, MG 15 investigations (1.5 tests/patients) costing £337/patient and ANC's 50 investigations (1.25 tests/patient) costing £331/patient. Only 1 patient was referred back to clinic having been discharged and this was for a new and unrelated problem.

Conclusion In our hospital, nurse led and doctor led outpatient care was of equivalent effectiveness with no differences in