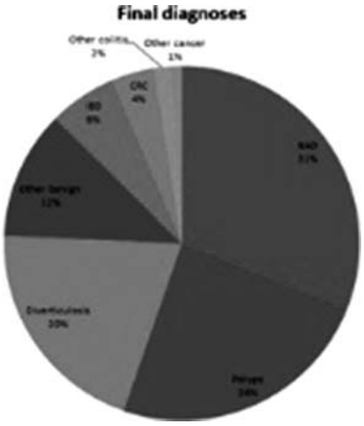

Abstract PTH-069 Figure 1

system. Physical colorectal clinic appointments were saved in four-fifths of new patients and in two-thirds of those with a normal colonoscopy, which could be allocated to newly diagnosed cancers, or those requiring treatment for benign conditions. The straight to endoscopy service resulted in an average reduction of 11 days in making a treatment plan for new colorectal cancers. This contributed towards a low rate of breaches of the 62 day treatment target. However one-third of new cancer patients still waited over a month for a decision to treat, highlighting the extra time required for ancillary investigations and MDT discussion. These can be addressed by triggering staging investigations and MDT discussion at the time of endoscopy.

Disclosure of Interest None Declared.

PTH-070 NURSE LED ONE STOP UPPER GI CLINICS ARE SAFE AND ALLOW RAPID ASSESSMENT OF PATIENTS WITH SUSPECTED GASTRO-OESOPHAGEAL MALIGNANCY

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Introduction Meeting 2 week referral targets presents a challenge to many hospitals. Commonly patients are seen in clinic prior to investigation with resultant additional delays in time to investigation. Nurse led one stop clinics where patients undergo clinical assessment and endoscopic and/or radiological assessment on the same day have the potential to shorten time to investigation, allow rapid complete clinical assessment and meet the demand for 2 week wait (2WW) referrals.

Methods

Aims

To assess the efficacy and safety of a nurse led one stop suspected upper GI cancer clinic in meeting 2 week targets. To determine outcomes for patients referred on a 2WW pathway.

Methods All patients referred to Whiston Hospital on a two week upper GI pathway within the 6 month period from November 2012 to April 2013 were assessed. Additionally all upper GI cancers diagnosed in the same period were separately analysed. Patients were identified using hospital IT systems and data collated on demographics, referring symptoms, investigations and patient outcomes. Analysis was performed using StatsDirect v2.6.8.

Results Complete data was available for 202 patients (61%). 40% of patients did not meet criteria for 2 week referral. One stop clinics enabled complete assessment and investigation of patients within 2 weeks (mean 11.6 ± 0.63 days). Time to first investigation was significantly quicker than patients seen in clinic (11.6 vs 18 days, $p < 0.005$, ANOVA) and was no different than open access endoscopy (11 days, $p = 0.96$). Cancers were identified in 15 (7.4%), of which only 8 (57%) were upper GI. No significant differences in patient outcome (time to investigation/pathology identified) were seen between nurse led and physician led clinics. In the same time period 53 upper GI cancers were diagnosed meaning only 15% were referred on a two week pathway. The presence of dysphagia was the commonest presenting symptom in upper GI malignancy (87%) but had a poor positive predictive value (15%).

Conclusion Nurse led one stop upper GI cancer clinics are safe, allow complete assessment and investigation of patients within 2 week wait (2WW) targets and improve time to test compared to standard clinics. Appropriateness of 2WW referrals remains low and many cancers are diagnosed outside this pathway. Further use of dedicated nurse led clinics may improve the ability for hospitals to meet service demands.

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PTH-071 AUDIT OF SUBSEQUENT OUTCOME IN PATIENTS ADMITTED TO HOSPITAL WITH ALCOHOL USE DISORDER (AUD)

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Introduction There are limited published data on subsequent outcome of patients admitted acutely to hospital with alcohol use disorders (AUDs), in regard to drinking relapse, hospital readmission and death.

Methods We conducted a prospective audit of 142 patients (105 men), aged (median (range) 46 (23–78) years) admitted with AUDs to a medical admission unit during Oct-Nov 2012 and Jan-March 2013. Information on hospital readmission, AandE attendance and death (from hospital electronic records), and on subsequent alcohol drinking (from records and from telephoning patients) was gathered up to 21/05/13. Data were analysed by life-table and Cox regression analysis.

Results Of the 142 patients, 80 (56%) lived alone and 121 (85%) were unemployed. 36 patients (25%) had liver disease (Child-Pugh Grade B/C). Of 92 patients with CT or MRI brain scan within 5 years, 49 (53%) had brain atrophy. 73 patients (51%) had another mental health problem (anxiety or depression in 68, schizophrenia in 5). Over the previous year, 71 (50%) had >1 previous AUD-related admission, and 24 (17%) had >3 such admissions. Out of 110 patients, 79% of patients said they intended to stop drinking. Length of stay during index admission was 6 (0–61 days). 51 patients experienced complications, 29 self-discharged early and 18 were verbally ± physically abusive. 5 patients died during admission, 4 from liver disease.

17 discharged patients were lost to follow up; of the remaining 120, 96 relapsed into drinking, 18 (0–168 days) after discharge. 100-day relapse rate was 78%. When asked the reason for relapse (n = 87), 53 patients cited "no particular reason", 22 depression, 5 a traumatic experience and 4 a celebratory event. Relapse was independently associated with self-discharge after index admission ($p < 0.001$).

77 patients (56%) were readmitted to hospital, 66 (86%) for clearly alcohol-related reasons. 13 more patients re-attended the AandE Department without readmission. 100 day readmission rate was 50%. 19 patients were readmitted twice and 23 patients >3 times. Readmission was independently associated with unemployment (p = 0.043), self-discharge after index admission (p = 0.011), relapse into drinking (p = 0.028), and (surprisingly) with having received a brief intervention regarding alcohol consumption during the index admission from a dedicated alcohol worker (n = 61, p = 0.009). Seven more patients had died by 21/05/13, 5 from liver disease.

Conclusion Patients admitted to hospital with AUDs tend to be socially deprived, frequent hospital attenders with major physical and mental co-morbidity. They have high subsequent alcohol relapse and hospital readmission rates. Reduction of these is not achieved by interventions during the index admission and will require more pro-active measures post-discharge.

Disclosure of Interest None Declared.

PTH-072 IMPROVING THE QUALITY OF AN ACUTE GI BLEEDING SERVICE: IMPACT OF INTERVENTIONS. RESULTS OF THREE PROSPECTIVE AUDITS IN A TERTIARY CENTRE

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Introduction National guidelines for the management of upper gastrointestinal (GI) bleeding exist and are based on conclusive evidence for effective clinical practice[1]. A mortality rate in acute admissions of 7% was reported in a national audit of upper GI bleeding[2]. This is an area of high volume, high risk and high cost where improvements can be made.

Methods Three prospective audits of all acute admissions with upper GI bleed were undertaken for 4 week periods in 2009 (Audit 1), 2011 (Audit 2) and 2013 (Audit 3). After Audit 1, a new GI bleed proforma was introduced,a rolling,targeted educational programme for Accident and Emergency (AandE) and Medical Admissions Unit (AMAU) trainees was started,mandatory fields for risk scoring were included in the electronic requests and additional evening inpatient endoscopy lists were started. After Audit 2, Saturday and Sunday inpatient endoscopy lists were introduced and a dedicated endoscopy co-ordinator supervised triaging of patients to appropriate lists.

Results A total of 115 patients were included in the three audits. 88% were admitted through AandE. There were no deaths and no patients underwent surgery in each of the three audit periods. 13% of all patients had lesions at endoscopy requiring therapy (6% band ligation for variceal bleeding, 7% endotherapy for peptic ulcer bleeding). The proportion of patients in whom a risk score was calculated in the 2009, 2011 and 2013 audits improved with each audit period with completion rates of 0%. 39% and 94%, respectively. (P < 0.001 for comparison of 2009 to 2011, and 2011 to 2013). However, the risk scores were inaccurately calculated by the admitting doctors in 46% and 33% of cases in Audit 1 and Audit 2. The improvement in accuracy between the audit periods was not statistically significant (p = 0.64). There was a statistically significant improvement in the time from admission to endoscopy between the audit periods 2009 and 2013 (median 33.5 h (range 15 to 214 h) versus 23.25 h (range 1.5 to 92 h) (p = 0.0017). The proportion of patients having endoscopy within 24 h of admission improved between audit 1 and Audit 3 (23% and 46%, respectively (P = 0.04)).

Conclusion Targeted interventions have been associated with incremental improvements in the quality of care for patients admitted acutely with acute GI bleeding in the last 4 years. Mortality rates have been consistently well below the national average. Further interventions will include targeted education to improve the accuracy of risk stratification of patients admitted with upper GI blood loss and changes to the mechanism of triage to inpatient endoscopy lists to improve the time from admission to endoscopy.

REFERENCES

1 NICE(Clinical guideline 141.) 2012
2 Hearnshaw SA, *et al*. *Gut* 2010;59:1022–1029

Disclosure of Interest None Declared.

PTH-073 UNITED KINGDOM NATIONAL BOWEL CANCER AWARENESS PROGRAMME – MORE PAIN, NO GAIN?

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Introduction The UK government embarked on two National Bowel Cancer Awareness Campaigns in 2012 to raise public awareness of colorectal cancer (CRC) and to prompt symptomatic individuals to visit their primary care physicians early. A pilot programme in 2011 failed to demonstrate neither increased numbers, nor earlier stage of new CRC diagnosed, despite significant rise in 2WW referrals[1]. It is unclear whether such findings would translate to other regions of the UK during a nationwide awareness campaign.

Aims/Objectives

1. To determine the effects of the bowel awareness campaigns on 2WW referrals.
2. Comparison of the number of CRC cases diagnosed during the campaigns to a comparable period in 2011.
3. Stage of disease and survival for patients diagnosed during the campaigns.

Methods Retrospective study of over 1439 consecutive patients referred through the 2WW colorectal pathway to Mid-Yorkshire Hospital NHS Trust during the campaigns between 1/2/2012 to 30/4/2012 and 1/9/2013 to 31/10/2012. Total number of referrals, newly diagnosed cases of CRC and non-CRC, with their respective staging were determined and compared with a comparable group in 2011. One year survival for the two groups was evaluated by Kaplan-Meier.

Results Referrals through the 2WW pathway increased by 55–60% during the bowel awareness campaigns, but there was no significant relative increase in CRC or non-CRC diagnoses. Positive diagnostic yield for CRC remained low at 5.6% and 6.1%. The bowel awareness campaigns did not affect the stage at which CRC patients were diagnosed, as over 50% presented with Stage 3 and 4 disease, and similarly there was overall no difference in 1 year survival.

Conclusion The UK bowel awareness campaign has increased public awareness of CRC and prompted symptomatic individuals to seek medical attention. This study shows the increase in 2WW referrals has not translated to better outcomes for patients. Furthermore the study highlights the difficulty in assessing a symptomatic individual's risk for CRC in primary care, despite current guidelines which carry poor positive predictive value.