Results Abstract PTU-254 table 1 outlines GPs' confidence in managing gastroenterological conditions while Abstract PTU-254 table 2 outlines their rating of service developments in chronic disease management, referral pathways and other services. GPs commented on the need for *"clear referral pathways"* and *"rapid access clinics"* outside of the 2-Week Rule remit. They wanted *"clear plans"* for shared care with *"rapid access if problems"* as well as *"support from nurse specialists"* and *"access to telephone advice"* for both patients and themselves. GPs wanted *"workload implications to be recognised"* and *"money to follow the patient"* if more patients are managed in primary care.

Table 2. GPs rating of Gastroenterology service developments

Title	Average	Median
Referral and Follow Up pathways		
Patient access to SOS appointments	3.92	4
Rapid access service for Jaundice / Deranged LFTs	3.87	4
Community based GI service	3.79	4
Rapid access or IBD drop-in clinic	3.79	4
Clear referral pathway and proforma	3.57	4
Greater community hospital services (Endoscopy, Clinics)	3.55	4
Chronic Disease Management		
Individualised treatment plan for shared care of patients	4.00	4
Increased role of patients in managing chronic conditions	3.81	4
Community based education programme for patients	3.69	4
Increased monitoring / reviews of stable patients by GPs	3.48	4
Autonomous surveillance / screening programs	3.47	4
Other Services		
Improved Psychological support services	3.79	4
Improved Drug and Alcohol Services in Secondary and Primary Care	3.73	4
Single Drug Formulary across Primary and Secondary Care	3.58	4
Greater role and coverage for Clinical Nurse Specialists	3.13	4
Increased role of Patient Advocacy and Support Groups	2.46	2

Conclusion The survey has identified which conditions GPs are confident managing in primary care and those which need additional support from secondary care. Future service development is needed in areas of chronic disease management, referrals pathways and allied services. GPs value rapid access to secondary care as well as patient access to SOS appointments and nurse specialists. Developing local pathways, such as with Map of Medicine, can help with referrals and managing chronic conditions in primary care. Online surveys are an easy way to ask GPs about their own confidence in managing gastroenterological conditions as well as their opinion on service developments.

Competing interests None declared.

PTU-255 IS THE SERVICE PROVISION OF DIRECT ACCESS UPPER GI ENDOSCOPY BEING USED EFFECTIVELY BEYOND 2010?

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Introduction Upper GI Endoscopy can generate significant income through payment by results (PBR) in the UK. Primary care physicians have a direct access for endoscopy via open access (GPOA) or 2-week rule (2WR) systems and appropriateness of these lists have been long-debated. With the current financial cut backs within the NHS, it is worthwhile to re-evaluate their effectiveness.

Aim To assess the effectiveness of GPOA/2WR upper GI Endoscopy service.

Methods Retrospective audit of GPOA and 2WR lists between April and October 2011 was performed. 483 referrals were audited (n=400 2WR, n=83 GPOA) for patient demographics, indications, significant diagnosis, additional tests and patient outcomes.

Results 2WR—Patients: Audit capture rate 86%. Median age of the patient was 65 years (range 18—96), 58% were Females, with median ASA 2. NICE criteria for referrals was not met in 12% and a further 14% had a gastroscopy within 3 years. Outcomes: Significant diagnoses (cancer, oesophagitis, Barretts, PUD, Coeliac Disease, Stricture, *Helicobacter pylori* gastritis) were present in 44% (cancer diagnosis 3.4%). An endoscopy urease test was performed in 48%, with a 30% positivity rate. Biopsies were taken in 64%. 86% were discharged back to the GP, 4% were referred to clinic, 6% booked for a repeat endoscopy and 4% referred to cancer MDT. **GPOA Patients**: Audit capture rate was 96% referrals. Patients were younger than the 2WR with median age 52 years (range 17—86) (p=0.0001), and healthier with median ASA 1 (p=0.0001). 53% were females. 31% of patients did not meet NICE guidelines and 4% had a gastroscopy within 3 years. **Outcomes**: Significant diagnoses were made in 29.9% (cancer diagnosis 1.2%). While the cancer diagnoses with 2WR was comparable (p=0.2), there were less benign diagnoses (p=0.01). Additional tests included urease test in 19%, positivity rate 20% and biopsies 14%. Patient outcomes were similar to 2WR with 88% of patients discharged directly back to GP, 6% booked for a repeat endoscopy, 4% referred to Gastroenterology Clinic and 2% to a cancer MDT. Overall, 51 patients (12%) had a previous endoscopy within 3 years, none of which had cancer and 83 patients (19%) did not meet NICE guidelines that is, 31% were inappropriate.

Conclusion With 31% of patients being inappropriate and low cancer pick up rate, the value of these lists may be questionable. However, benign pathology was significant in both lists and therefore process mapping the patient to see if the endoscopy changed the patient's management would be useful given the very high discharge rate to the GP. There still remains significant room for improving the effective use of these services.

Competing interests None declared.

PTU-256 OPTIMISING BOWEL SCREENING COLONOSCOPY UPTAKE WITH NURSE-LED TELEPHONE ASSESSMENT CLINICS

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Introduction Bowel Screening Wales utilises nurse-led telephone assessments pre-colonoscopy for screening participants following a positive faecal occult blood test (FOBt) result. This approach has been shown to optimise colonoscopy uptake.

Methods A literature review was carried out to determine the cost effectiveness and efficiency of telephone assessment as indicated by overall screening colonoscopy appointment uptake. Nurse-led telephone assessment is an advanced practice. Nurses undertaking this form of assessment should have undergone suitable training and supervision, be competent in their practice and accountable for their actions. Advanced assessment is the detailed, systematic collection of relevant information about the patient's problems and health status which requires a specialist knowledge, skill and extensive experience to uncover the relevant information being given and discard the irrelevant.[1] Bowel Screening Wales was introduced nationally in October 2008 and operates from a single hub which is responsible for inviting participants, processing completed kits and providing results for participants. There are 13 Local Assessment Centres (LAC) which have a responsibility to provide endoscopy, pathology and radiology services for participants who have had a positive FOBt result. Specialist Screening Practitioners are based in each LAC. In Wales each Health Board covers a large geographical area therefore telephone assessments are a more effective method of pre-colonoscopy assessment in terms of cost, time and travel requirements. It has also been found that this approach results in a lower colonoscopy default rate due to improved participant involvement in the decision making process.