Abstract PTH-161 Table 1

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

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 specialty groups should be given consideration when planning implementation of evidence or guidelines into clinical practise.

Disclosure of Interest None Declared.

---

**PTH-162**

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

doi:10.1136/gutjnl-2013-304907.649

1–5 T Rajasekhar, 6 Brown, 7 Nixon, 8 Bramble, 9 East, 10 Rutter, 11 Saunders, 12 Rees on behalf of The Quality in Colonoscopy Study Group, 13 Gastroenterology, South Tyneside District Hospital, South Shields; 14 Evaluation Research Development Unit, Durham University, Stockton-on-Tees; 15 Department of Social Science, Sunderland University, Sunderland; 16 School of Medicine and Health Science, Durham University, Stockton-on-Tees; 17 Gastroenterology, John Radcliffe Hospital, Oxford; 18 Gastroenterology, University Hospital of North Tees, Stockton-on-Tees; 19 Gastroenterology, St Marks Hospital, Harrow, UK

**Introduction**
The Quality Improvement in Colonoscopy (QIC) study was a region wide service improvement study that aimed to improve adenoma detection rate (ADR), and thus 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**
19 patients with flares of IBD, follow up of treatment of Hepatitis B/C and irritable bowel disease. Patients, who required drug monitoring, follow up of blood tests, need regular intensive monitoring. This often necessitates frequent outpatient visits and follows up blood tests.

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

The patients included those with follow up 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 advise and expedite treatment and investigations.

December 2009 were analysed. Similar data from 2005 was used as control.

**Disclosure of Interest**
None Declared.

---

**PTH-163**

NURSE LED TELEPHONE CLINICS: THE NHS REVOLUTION IN MAKING

doi:10.1136/gutjnl-2013-304907.650

1–5 R Shah, 6 T Tan, 7 G Lim, 8 Gastroenterology, NHS, Farnborough, 9 Gastroenterology, NHS, Epsom, UK

**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.

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

The patients included those with follow up 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.

**Results**
19 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 advise and expedite treatment and investigations.

December 2009 were analysed. Similar data from 2005 was used as control. A January 2009 to 31 Data 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, 555 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 VALIDATING THE COLONOSCOPY WAITING LIST - CHALLENGING BUT REWARDING**

doi:10.1136/gutjnl-2013-304907.651

1 R Prudham, 1 A Boyer. 1 Gastroenterology, Pennine Acute NHS Trust, Bury, UK

Introduction  Endoscopy services within the UK are under pressure with increasing demand predicted and a need to maintain timeliness. 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 polyph 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

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

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  