AN AUDIT TO ASSESS FEASIBILITY AND EFFICACY OF
SETTING UP A HEPATOLOGY ECONSULT SERVICE

Introduction
A low FODMAP diet has demonstrated symptom improvement in patients with IBS when conducted during individual consultations. Structured dietetic group education is a well recognised medium for encouraging self-management and promoting confidence in patients with chronic illness. There is a lack of research in the use of low FODMAP dietary intervention in a group setting. This audit was conducted to assess the efficacy and feasibility of providing low FODMAP dietary advice in a group environment.

Methods
Data was collected using the ‘IBS satisfaction survey’ which was given to 17 patients with IBS on completion of the 8 week low FODMAP diet. The following question was used to monitor effectiveness of the low FODMAP diet: ‘Do you currently have satisfactory relief from your gut symptoms? This is a closed question, completed anonymously, with a choice response of ‘yes’ or ‘no’. Feasibility of a group format was measured via attendee’s feedback and non-attendance (DNA) rate. Feedback was collected using an evaluation questionnaire (6 point Likert scale – very satisfied, satisfied, acceptable, dissatisfied, very dissatisfied, unsure) after the group session.

Results
21 patients attended the initial session. 4 patients (19%) failed to attend the follow up session. 82% (14 /17) of patients who completed the education programme reported satisfactory relief of gut symptoms. 100% of patients were ‘satisfied’ or ‘very satisfied’ with the presentation and group discussion. 94% were ‘satisfied’ or ‘very satisfied’ with the organisation of the group session.

Conclusion
Group education for low FODMAP diet therapy is a feasible and effective method for promoting symptom improvement for IBS patients. Group education has the potential to be at least as effective as one-to-one low FODMAP IBS education. Further randomised control studies with large sample sizes are recommended.

References

Disclosure of Interest
None Declared.

PTH-065 SETTING UP A HEPATOLOGY ECONSULT SERVICE – BENEFICIAL FOR PATIENTS AND PRIMARY CARE, BUT PERHAPS A HARDSHIP FOR SECONDARY CARE?

SK Kinrade, RM Twamley*, L Fell, L Heald, A Healy, Nutrition and Dietetics, University Hospital South Manchester, Manchester, UK

Introduction
Due to the heavy burden of liver disease, new policies are required to improve information flow between primary care (PC) and secondary care (SC). Outpatient visits are costly to PC, time consuming for patients and not always appropriate. Developing interventions to increase care available in PC is desirable and likely cost effective. We developed a hepatology eConsult (eC) service, allowing PC clinicians to send a referral and share a patient’s medical record electronically with SC using a PC database.

Methods
Service set up: Discussions between PC and SC identified a need for the service, and thorough review of the current Hepatology service was undertaken, focussing on current and projected working practices, service demands as well as clinicians job plans. Once eC was agreed in principle, a price of £23 per eC and a timescale of 7 days for eC to be completed was agreed with the CCG. A risk assessment of the service was performed and a comprehensive set of guidelines devised for use in PC, ensuring that only appropriate and timely referrals are made. Prior to launching the service, IT systems were updated, and appropriate training delivered to clinicians. To ensure smooth running of eC, user guides and support documents were created and distributed.
Making and processing a referral using eC: Once a referral has been made in PC, it appears on-line and a hepatology secretary logs the referral, opening the episode of care and informs the designated hepatologist that a referral has been received. The eC takes approximately 15 min of consultant time to complete but varies depending on case complexity. On complete, the hepatologist informs the secretary and they log a ‘completed episode of care’ ensuring the trust is paid for the clinical encounter. Referrals are audited on a 6 monthly basis. Results Between March 2012 – Oct 2013, 81 eC were completed (12 in months 1–6, 16 in months 7–12, 40 in months 13–18, 13 in months 19–20). A SC appointment was avoided in 78% of patients (n = 63) resulting in a cost saving to PC of £16,443 [63 x eC (£23) = 1,449 vs 63 x new patient referrals (£181) = £11,403 + 1x follow up/patient (£103) = £6489]. Median response time for eC was 2 days, 43% were completed within the same working day. Conclusion Hepatology eC is beneficial for patient care, with specialist advice being provided within one working day in a substantial number of cases, and is clearly cost effective, making eC popular with PC. However, until a more slim-line IT system is developed reducing the number of steps involved in completing an eC, and the cost per eC increased, it appears to be beneficial for all parties except SC. Disclosure of Interest None Declared.

**PTH-069 NURSE TELEPHONE TRIAGED STRAIGHT TO TEST COLONOSCOPY**

A Thapar, S Rodney, D Hakobu, J Wilson, C Bhan, M Walsh, J Haddow, A Dohoo, H Mukhtar. Surgery, Whittington Hospital, London, UK; National Centre for Bowel Research and Surgical Innovation, Queen Mary University of London, London, UK.

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**Introduction** In 2011 patients referred with suspected colorectal cancer at our institution waited a median of 36 days (IQR 28–46) for a treatment plan. This resulted in 61% of colorectal cancer taking over 31 days to reach a decision to treat. We aimed to reduce the time spent in the diagnostic phase, which was perceived to be the main hold up in the fast track pathway.

**Methods** A quality improvement approach was employed to change the new pathway from the existing clinic-first service to a straight-to-test service. The new nurse-led telephone triage service confirmed symptoms and assessed fitness for colonoscopy, with higher-risk patients defaulting to flexible sigmoidoscopy or clinic. Results for the first year of the new service are presented.

**Results** 438 patients were referred between 1/10/2012 and 1/10/2013. 222 (50%) went straight to colonoscopy and 136 (31%) to flexible sigmoidoscopy, 46 (11%) went to clinic, 32 (7%) patients did not attend and data was missing for 2 (1%) patients. Final diagnoses are shown in the attached figure. Colorectal cancer was found in 14/358 patients (4%). Median time from receipt of referral to first endoscopy was 13 days (IQR 11–20), with 128/348 patients (29%) waiting more than 14 days. Median time to decision to treat colorectal cancer was 25 days (IQR 20–34) in straight to test patients, a significant reduction compared to 2010–2011 (p = 0.01), with 5/14 (36%) waiting more than 31 days. Median time to first oncological treatment was 40 days (IQR 28–44), with 1/14 (7%) waiting more than 62 days. 41/66 (62%) of patients with a normal colonoscopy were discharged directly from endoscopy back to their GP.

**Conclusion** The new straight to test service was applicable to the majority of new colorectal fast track patients and a high patient uptake was observed. Colorectal cancer was in fact uncommon, which is being fed back to those referring into the...