incomplete resection rates at colonoscopy was noted for such polyps at local units. We hence established a National Clinical Network of specialist expert advisors, meeting every fortnight via videoconference to review endoscopy, radiology, pathology and clinical data of cases referred through specific criteria for complex lesions. We also established a National referral centre (NRC) at Llandough with the requisite skills and expertise in complex Endoscopic Mucosal Resection and Dissection (EMR, ESD) where appropriate polyps that met the referral criteria after a Network Multidisciplinary Team meeting discussion (NMDT) could undergo advanced therapy. An NMDT and NRC pilot was established in Oct 2011 to offer the opportunity to access expert opinion and discussion of therapeutic options for Welsh participants of the BCSF. We present our preliminary results.

Methods Referral criteria for complex polyps were agreed based on a composite of site, size, morphology and accessibility. Polyps satisfying the criteria were referred to the NMDT electronically along with relevant images and video. Depending on outcomes of NMDT discussion participants were given the option of accessing local surgery or travelling to the NRC for therapeutic endoscopy. Over a 2 year period, 140 referrals were made from 14 different Welsh BCS centres to the NMDT.

Results The various management decisions taken in 126 benign complex polyps and the 14 cancers detected is illustrated in figure 1. Polyps that had incomplete resection (22) often had piecemeal EMR or repeated attempts at EMR at LAC causing failure of lifting in polyps. It is noteworthy that in the first 1 year of NMDT and NRC establishment;16 such cases were referred in contrast to 6 in the subsequent year with most cases in the 1st year needing surgery. This is an encouraging trend as awareness through discussion in the NMDT has streamlined management and decreased the incidence of incomplete resections allowing definitive management in the first instance and reduction in inappropriate referral to surgery for benign disease.

Conclusion Establishing a clinical network for standardised decision making for complex polyps appears to have a significant effect on clinical outcomes.

Disclosure of Interest None Declared.

REFERENCE


Disclosure of Interest None Declared.

PTh-067 SETTING UP A HEPATOLOGY ECONSULT SERVICE – BENEFICIAL FOR PATIENTS AND PRIMARY CARE, BUT PERHAPS A HARDSHIP FOR SECONDARY CARE?

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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. Once completed, 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 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. The eC takes approximately 15 min of consultant time to complete (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.

OGD

Introduction The two week wait (2WW) referral leads to significant burden on outpatient clinics. This delays appointments for patients that may not fit the 2WW criteria. Only 5% of patients referred as 2WW will have an upper GI malignancy and it may not be necessary for all these patients to be reviewed urgently in clinic. Previously at our hospital, most upper GI 2WW referrals were booked an OGD (performed by any available endoscopist) in addition to a clinic appointment on receipt of the referral. In order to streamline the service, in January 2013 patients were triaged to either an OGD or a clinic appointment. The index OGD’s are now done on consultant’s list (Gastroenterologist and Upper GI Surgeon) with a clinical assessment at their OGD appointment. Further management is protocol based and dependant upon the assessment and OGD findings. The aim of this study was to determine if this change in practice is effective and safe.

Methods Patients referred as a 2WW in January and February 2012 were compared to those referred in January, February, August and September 2013. Only patients triaged directly to OGD were included (77/143 (54%) in 2012 and 180/291 (62%) in 2013). 14 patients were excluded from further analysis due to non-attendance.

Results Total cancer detection for all referrals was 8% in 2012 and 9% in 2013. In patients selected for a direct OGD referral, 7 upper GI cancers were diagnosed in 2012 and 14 in 2013. After the OGD, 4 (5%) patients in 2012 were immediately discharged back to the GP, compared to 33 (20%) in 2013 (p = 0.003). Of those attending clinic post OGD, 9 patients (13%) were given a routine appointment in 2012 compared to 50 (37%) in 2013 (p = 0.0002). Comparing the two years, there was a 32% reduction in the requirement of urgent outpatient appointments (83% had urgent OPD in 2012 compared to 51% in 2013, p = 0.0001). Of those discharged in 2013, 85% had documentation of the current symptoms at time of OGD and in 94%, treatment advice was provided to the GP. One patient was discharged after an OGD showing grade B oesophagitis and symptom improvement with PPI. Unfortunately, a re-referral 8 weeks later for worsening symptoms found oesophageal cancer on OGD.

Conclusion The introduction of consultant assessment as a first contact for all OGD 2WW referrals has led to a significant reduction in the requirement of urgent outpatient clinic appointments by one third. Waiting times for all clinic referrals have reduced significantly, amounting to 54% reduction in the number of patients waiting more than 9 weeks for a first appointment. Cancer detection is comparable to the previous model of care. Patients with ongoing symptoms at the time of endoscopy need follow up. In hindsight the missed cancer should have had an oesophageal biopsy, but this is clinical judgement and we do not believe the new service accounted for this delay.

Disclosure of Interest None Declared.