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 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 established so that the referral process is not disjointed, eC will need to be used in parallel with the existing clinic-first service to reduce the time spent in the diagnostic phase, which was perceived to be the main hold up in the fast track pathway.

Disclosure of Interest None Declared.

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

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Introduction In 2011 patients referred with suspected colorectal cancer at our institution waited a median of 36 days (IQR28–46) for a treatment plan. This resulted in 61% of colorectal cancer being missed 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...
NURSE LED ONE STOP UPPER GI CLINICS ARE SAFE
AUDIT OF SUBSEQUENT OUTCOME IN PATIENTS
Gut A240

Methods determine outcomes for patients referred on a 2WW pathway. To
expected upper GI cancer clinic in meeting 2 week targets. To
Aims

Introduction Meeting 2 week referral targets presents a chal-

Conclusion Nurse led one stop upper GI cancer clinics are safe,

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

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Introduction Meeting 2 week referral targets presents a chal-

enge 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 investiga-
tion, allow rapid complete clinical assessment and meet the

Demand for 2 week wait (2WW) referrals.

system. Physical colorectal clinic appointments were saved in
four-fifths of new patients and in two-thirds of those with a nor-
mal 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 discus-
These can be addressed by triggering staging investigations and

Disclosure of Interest None Declared.

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

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10.1136/gutjnl-2014-307263.517

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, A
dattendance 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 remain-
ing 120, 96 relapsed into drinking, 18 (0–168 days) after dis-
charge. 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).

Abstract PTH-069 Figure 1