77 patients (56%) were readmitted to hospital, 66 (86%) for clearly alcohol-related reasons. 13 more patients re-attended the AandE Department without readmission. 100 day readmission rate was 50%. 19 patients were readmitted twice and 23 patients >3 times. Readmission was independently associated with unemployment (p = 0.043), self-discharge after index admission (p = 0.011), relapse into drinking (p = 0.028), and (surprisingly) with having received a brief intervention regarding alcohol consumption during the index admission from a dedicated alcohol worker (n = 61, p = 0.009). Seven more patients had died by 21/05/13, 5 from liver disease.

Conclusion Patients admitted to hospital with AUDs tend to be socially deprived, frequent hospital attenders with major physical and mental co-morbidity. They have high subsequent alcohol relapse and hospital readmission rates. Reduction of these is not achieved by interventions during the index admission and will require more pro-active measures post-discharge.

Disclosure of Interest None Declared.

PTH-072 IMPROVING THE QUALITY OF AN ACUTE GI BLEEDING SERVICE: IMPACT OF INTERVENTIONS. RESULTS OF THREE PROSPECTIVE AUDITS IN A TERTIARY CENTRE

SM Alam*, N Chauhan, K Sager, A Bond, P Collins. *Gastroenterology, Royal Liverpool and Broadgreen University Hospital Liverpool UK, Liverpool, UK*

10.1136/gutjnl-2014-307263.518

Introduction National guidelines for the management of upper gastrointestinal (GI) bleeding exist and are based on conclusive evidence for effective clinical practice[1]. A mortality rate in acute admissions of 7% was reported in a national audit of upper GI bleeding[2]. This is an area of high volume, high risk and high cost where improvements can be made.

Methods Three prospective audits of all acute admissions with upper GI bleed were undertaken for 4 week periods in 2009 (Audit 1), 2011 (Audit 2) and 2013 (Audit 3). After Audit 1, a new GI bleed proforma was introduced,a rolling,targeted educational programme for Accident and Emergency (AandE) and Medical Admissions Unit (AMAU) trainees was started,mandatory fields for risk scoring were included in the electronic requests and additional evening inpatient endoscopy lists were started. After Audit 2, Saturday and Sunday inpatient endoscopy lists were introduced and a dedicated endoscopy co-ordinator supervised triaging of patients to appropriate lists.

Results A total of 115 patients were included in the three audits. 88% were admitted through AandE. There were no deaths and no patients underwent surgery in each of the three audit periods. 13% of all patients had lesions at endoscopy requiring therapy (6% band ligation for variceal bleeding, 7% endotherapy for peptic ulcer bleeding). The proportion of patients in whom a risk score was calculated in the 2009, 2011 and 2013 audits improved with each audit period with completion rates of 0%. 39% and 94%, respectively. (P < 0.001 for comparison of 2009 to 2011, and 2011 to 2013). However, the risk scores were inaccurately calculated by the admitting doctors in 46% and 33% of cases in Audit 1 and Audit 2. The improvement in accuracy between the audit periods was not statistically significant (p = 0.64). There was a statistically significant improvement in the time from admission to endoscopy between the audit periods 2009 and 2013 (median 33.5 h (range 15 to 214 h) versus 23.25 h (range 1.5 to 92 h) (p = 0.0017). The proportion of patients having endoscopy within 24 h of admission improved between audit 1 and Audit 3 (23% and 46%, respectively (P = 0.04)).

Conclusion Targeted interventions have been associated with incremental improvements in the quality of care for patients admitted acutely with acute GI bleeding in the last 4 years. Mortality rates have been consistently well below the national average. Further interventions will include targeted education to improve the accuracy of risk stratification of patients admitted with upper GI blood loss and changes to the mechanism of triage to inpatient endoscopy lists to improve the time from admission to endoscopy.

REFERENCES

1 NICE(Clinical guideline 141.) 2012
2 Hearnshaw SA, *et al*. *Gut* 2010;59:1022–1029

Disclosure of Interest None Declared.

PTH-073 UNITED KINGDOM NATIONAL BOWEL CANCER AWARENESS PROGRAMME – MORE PAIN, NO GAIN?

[1]T Khong*, [2]K Naik, [1]R Sivakumar, [3]S Shah. *[1]Deparment of Surgery, Pinderfields Hospital, Mid Yorkshire NHS Trust, Wakefield, UK; [2]Department of Radiology, Pinderfields Hospital, Mid Yorkshire NHS Trust, Wakefield, UK; [3]Department of Gastroenterology, Pinderfields Hospital, Mid Yorkshire NHS Trust, Wakefield, UK*

10.1136/gutjnl-2014-307263.519

Introduction The UK government embarked on two National Bowel Cancer Awareness Campaigns in 2012 to raise public awareness of colorectal cancer (CRC) and to prompt symptomatic individuals to visit their primary care physicians early. A pilot programme in 2011 failed to demonstrate neither increased numbers, nor earlier stage of new CRC diagnosed, despite significant rise in 2WW referrals[1]. It is unclear whether such findings would translate to other regions of the UK during a nationwide awareness campaign.

Aims/Objectives

1. To determine the effects of the bowel awareness campaigns on 2WW referrals.
2. Comparison of the number of CRC cases diagnosed during the campaigns to a comparable period in 2011.
3. Stage of disease and survival for patients diagnosed during the campaigns.

Methods Retrospective study of over 1439 consecutive patients referred through the 2WW colorectal pathway to Mid-Yorkshire Hospital NHS Trust during the campaigns between 1/2/2012 to 30/4/2012 and 1/9/2013 to 31/10/2012. Total number of referrals, newly diagnosed cases of CRC and non-CRC, with their respective staging were determined and compared with a comparable group in 2011. One year survival for the two groups was evaluated by Kaplan-Meier.

Results Referrals through the 2WW pathway increased by 55–60% during the bowel awareness campaigns, but there was no significant relative increase in CRC or non-CRC diagnoses. Positive diagnostic yield for CRC remained low at 5.6% and 6.1%. The bowel awareness campaigns did not affect the stage at which CRC patients were diagnosed, as over 50% presented with Stage 3 and 4 disease, and similarly there was overall no difference in 1 year survival.

Conclusion The UK bowel awareness campaign has increased public awareness of CRC and prompted symptomatic individuals to seek medical attention. This study shows the increase in 2WW referrals has not translated to better outcomes for patients. Furthermore the study highlights the difficulty in assessing a symptomatic individual's risk for CRC in primary care, despite current guidelines which carry poor positive predictive value.