

and patients were identified for safe and early discharge with early community follow up. A total of 641 bed days were saved over the time period analysed.

**Conclusion** Implementation of a 7-day HALS team covering two acute hospital sites has significantly improved the quality of care provided to patients with alcohol-related disorders. In addition there has been a very positive impact on reducing length of stay and bed occupancy. Plans are in place to develop and audit the HALS team further and strengthen working relationships with community partners.

**Disclosure of Interest** None Declared.

### OC-039 IMPROVING QUALITY IN A NATIONAL INTESTINAL FAILURE UNIT: GREATER EFFICIENCY, IMPROVED ACCESS, REDUCED MORTALITY

<sup>1</sup>E Donaldson\*, <sup>2</sup>M Taylor, <sup>2</sup>A Abraham, <sup>2</sup>G Carlson, <sup>2</sup>O Fletcher, <sup>2</sup>V Jacqui, <sup>2</sup>A Teubner, <sup>2</sup>S Lal. <sup>1</sup>Gastroenterology/Quality Improvement, Salford Royal NHS Foundation Trust, Salford, UK; <sup>2</sup>Intestinal Failure Unit, Salford Royal NHS Foundation Trust, Salford, UK

10.1136/gutjnl-2014-307263.39

**Introduction** In 2010, there was a significant waiting list for admission to the Intestinal Failure Unit (IFU) at Salford, one of two current nationally-accredited centres. There had also been a steady increase in referrals to the IFU (89 patients in 2005; 152 patients in 2012) and the number of established patients requiring home parenteral nutrition (HPN) (135 patients in 2005; 206 patients in 2012). The impact of the long waiting list for these complex patients was that patient deaths occurred in those awaiting admission. Furthermore, the 'Strategic Framework for IF and HPN Services' in England had earlier highlighted the need for services to 'foster equity of access'.<sup>1</sup> The SRFT IFU team therefore conducted a rigorous assessment of its processes in order to improve patient flow and access to the IFU. The primary aim was to reduce inpatient length of stay (LOS) by 10%.

**Methods** We employed continuous improvement methodology, utilising the Model for Improvement and running sequential Plan-Do-Study-Act cycles. In addition to the key flow data, such as LOS and referral times, process data were collected, including time to intravenous feeding line insertion, time to radiology studies etc., when looking to streamline specific areas of practice. Data were analysed using statistical process control charts produced using QI Macros (KnowWare International, INC.). Statistically significant shifts were determined 'a priori' according to standard operating principals for special cause variation.<sup>2</sup>

**Results** Process improvements yielded a 20.8% reduction in average length of stay on the IFU from 55.7 to 44.1 days and a reduction of 70.7% in the average length of time spent on the waiting list for admission from 65.1 to 19.1 days. These changes were associated with concomitant reduction in 30-day readmission rates from 12.1 to 4.5% and early suggestions of reduced waiting list mortality. The number of inpatient deaths did not increase; indeed, there was a sustained increase in the number of complete discharge episodes between inpatient deaths (mean increase from 13 to 44).

**Conclusion** A quality improvement model is an effective means of enhancing the efficiency of a large National centre dealing with complex medical and surgical patients. Improvements in inpatient efficiency can reduce waiting times for admission, thus improving access and reducing waiting list mortality. The improvements in efficiency can be achieved without compromising patient safety.

### REFERENCES

- 1 Strategic Framework for Intestinal Failure and Home Parenteral Nutrition Services for Adults in England 2008
- 2 Langley, G *et al.* 2009. The improvement guide: a practical approach to enhancing organizational performance. John Wiley & Sons

**Disclosure of Interest** None Declared.

### OC-040 COMMUNITY-BASED ENDOSCOPY IN A CAR PARK. FANTASY OR REALITY?

A Hitchen, B Kompo\*, P Phillips, E Price, G Deans, NK Ahluwalia. *Gastroenterology, Care UK, Manchester, UK*

10.1136/gutjnl-2014-307263.40

**Introduction** Owing to safety and quality concerns raised by BSG in 1990s, Community Based Endoscopy (CBE) rapidly declined. In 2014 CBE is back on the agenda with CCGs demanding a safe, high-quality, sub-tariff, 7 day endoscopy service close to the patient's home, at a time of the patient's choosing. We describe 5 years experience of a fully JAG accredited consultant-delivered completely mobile endoscopy service provided in shopping centre car parks throughout Greater Manchester (GM).

**Methods** In 2007, concept emerged out of a tender from 10 PCTs demanding safe and high quality endoscopy in the community. A linked-3-trailer unit with spacious waiting area for patients/relatives, consent-counselling, preparation, examination, decontamination and recovery areas. with its own – water, electricity, waste disposal, e-communications and administration network was commissioned with integral office, staff kitchen/rest room and changing area. All staff undergo rigorous mandatory induction and regular updates, CPD, audits as per JAG. Emergency scenarios are regularly rehearsed and audited. Full complement of ALS certified staff support consultants 8 am–8 pm, 7/7 [360] days in diagnostic UGI and LGI endoscopies [including polypectomies] and deliver 36 units/day. All patients undergo JAG-standard monitoring of pulse, BP, O<sub>2</sub> saturation, sedation and pain scores. All records are paperless, live and e-MAXIM and UNISOFT-based. All patients are contacted within 24 h by an experienced nurse to record any untoward incident. Patient and family feedback and regular meetings with GP allows total quality management in service delivery. Though no age limit, patients with IDDM, BMI >40, >25st and ASA≥3+ are excluded. Quarterly audits are shared with commissioners. Unit relocates biweekly to 7 convenient locations with adjacent free parking.

**Results** Of 26599 (10539 UGI, 10583 Flexi-Sig, 5477 Colonoscopy) procedures, 1 in 3 patients opted for out-of-hours or weekend as first choice.

LGI- 93% good-bowel prep, 91% caecal intubation, 8.8% adenoma detection, 97% polyp recovery and 100% Bx for diarrhoea. UGI- 98% D2 intubation, 100% 6 week repeat for GU, 84% unsedated. Biannual JAG-GRS compliant audits showed 0% 30 day mortality, 0% UGI SAE and 5 (0.018%) unplanned hospital admissions 4 requiring surgery due to colon perforation [one post-flexi detected in the unit (diverticular disease), 1 from polypectomy, 2 diagnostic colonoscopy] and fifth due to hyponatremia (CitraFleet – now discontinued) requiring electrolyte correction.

**Conclusion** CBE is ready for prime time, just at the right time, as commissioners are now seeking more care in the community

wherever safely possible. We however, recommend caution as model for sub-tariff CBE endoscopy from static sites needs to be first piloted.

**Disclosure of Interest** None Declared.

#### OC-041 REDUCED HOSPITAL ADMISSION AND RAPID ACCESS TO SPECIALIST SERVICES THROUGH THE INTRODUCTION OF A GASTROENTEROLOGY AND HEPATOLOGY AMBULATORY CARE SERVICE

<sup>1</sup>J Fielding\*, <sup>1</sup>A Hawley, <sup>1</sup>S Hardcastle, <sup>1</sup>K Drew, <sup>2</sup>D Gleeson, <sup>2</sup>M Karajeh, <sup>1</sup>D Sanders, <sup>1</sup>A Hopper, <sup>1</sup>R Sidhu, <sup>1</sup>M McAlindon, <sup>1</sup>AJ Lobo. <sup>1</sup>Gastroenterology, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield, UK; <sup>2</sup>Hepatology, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield, UK

10.1136/gutjnl-2014-307263.41

**Introduction** Ambulatory care sensitive conditions are those where intervention may limit hospital admissions. Improvements in the management of these conditions may save the NHS £96–£238 million per annum and alleviate pressures on Accident and Emergency. This is directly applicable in Gastroenterology but few gastrointestinal (GI) conditions are conventionally listed as suitable for this approach. This study examined the effect of such a service providing rapid access to specialist services in a UK Gastroenterology Unit.

**Methods** A Gastroenterology ambulatory care service was established as part of an investigation unit with on-ward endoscopy facilities. General practitioners (GPs) were given written guidelines and referred to a senior nurse via telephone. Patients considered suitable were those requiring urgent assessment but where admission might be avoided. Exclusion criteria: hypotension, suspected acute abdomen, or GP concern about potential for deterioration.

**Results** 224 patients were referred by their GP from June 2011 to January 2013. 12 did not attend.

Presentation and outcome are described in Table 1. 179 patients (84%) were seen on arrival by a consultant. 96 patients (45%) were admitted; 116 were discharged on the same day – of whom 94 (91%) were offered either same day (n = 67 (58%)) or outpatient (n = 27 (23%)) investigations. 30 day readmission rate was only 4% (n = 5).

51 patients had low risk GI bleeds (Rockall score 0–1). 30 (59%) of these were discharged the same day and 90% (n = 27) had an OGD within 24 h of assessment, either same day or returning the following morning.

**Conclusion** The Ambulatory Care Service provides direct, rapid access to specialist opinion and investigation for a range of GI

presentations, avoiding hospital admission for the majority referred. In contrast to other UK studies those with low risk GI bleeding were managed as out-patients but with gastroscopy undertaken. This is a model for a tiered approach to emergency care in Gastroenterology.

**Disclosure of Interest** None Declared.

#### OC-042 SENSITIVITY OF ANNUAL FAECAL IMMUNOCHEMICAL TESTS FOR HAEMOGLOBIN (FIT) FOR DETECTING ADVANCED NEOPLASIA IN PATIENTS UNDERGOING THREE-YEARLY SURVEILLANCE COLONOSCOPY – THE FIT FOR FOLLOW-UP STUDY

<sup>1</sup>E MacRae\*, <sup>1</sup>A Brenner, <sup>1</sup>J Martin, <sup>2</sup>S Pearson, <sup>2</sup>C Piggott, <sup>3</sup>H Bowyer, <sup>3</sup>G Vart, <sup>3</sup>C von Wagner, <sup>3</sup>J Wardle, <sup>2,4</sup>S Halloran, <sup>1</sup>W Atkin. <sup>1</sup>Imperial College, London, UK; <sup>2</sup>NHS BCSP, Guildford, UK; <sup>3</sup>UCL, London, UK; <sup>4</sup>University of Surrey, Guildford, UK

10.1136/gutjnl-2014-307263.42

**Introduction** With increasing demand for colonoscopy in the NHS Bowel Cancer Screening Programme (BCSP) in England, there is a need for effective non-colonoscopy approaches to surveillance. We have undertaken a study to compare the sensitivity and specificity of a faecal immunochemical test for haemoglobin (FIT) annually for three years with colonoscopy surveillance, in patients diagnosed with intermediate-risk adenomas following a positive faecal occult blood test in the BCSP.

**Methods** Participants are invited to complete a FIT (OC-SENSOR, Eiken Chemical Co. Ltd.) annually while awaiting their first surveillance colonoscopy. Those testing positive (>40 µg Hb/g faeces) are invited to have their three-year colonoscopy brought forward, while those testing negative are sent another FIT a year later until they have completed three rounds of testing. We aim to determine the sensitivity of FIT in detecting colorectal cancer or advanced adenomas (≥10 mm, or with tubulovillous or villous histology, or with high-grade dysplasia), using colonoscopy as the reference standard.

**Results** We invited 8009 people to participate in the study, of whom 5840 (72.9%) consented. The positivity rate in Round 1 was 5.8% (336/5840). To date, 265/303 (87.5%) have had an early colonoscopy: 62/265 (23.4%) had advanced adenomas and five (1.9%) had cancer. 33/336 (9.8%) declined an early colonoscopy.

To date, in Round 2 we have invited 2800 patients who tested FIT negative in Round 1: 2560 (91.4%) completed a second FIT and 115/2560 (4.5%) tested positive. 85/106 (80.2%) have received an early colonoscopy: 13/85 (15.3%) had

**Abstract OC-041 Table 1** Summary of admissions and discharges

Diagnosis	Number	Admitted	Discharged	Discharged: same day investigation (% of discharged)	Discharged: OP investigation (% of discharged)	Discharged: 30 day readmit
GI Bleed	51	21 (41%)	30 (59%)	25 (83%)	2 (7%)	0
PR bleed	16	8 (50%)	8 (50%)	4 (50%)	3 (37.5%)	0
Anaemia	18	9 (50%)	9 (50%)	3 (33%)	4 (44%)	0
Abdo pain	36	16 (44%)	20 (56%)	9 (45%)	8 (40%)	2 (10%)
IBD flare	30	14 (47%)	16 (53%)	8 (50%)	2 (12%)	0
Deranged LFTs/ jaundice	20	9 (45%)	11 (55%)	6 (55%)	3 (27%)	1 (9%)
Diarrhoea/vomiting	15	5 (33%)	10 (67%)	5 (50%)	3 (30%)	1 (10%)
Other	26	14 (54%)	12 (46%)	7 (58%)	2 (17%)	1 (8%)
Total	212	96 (45%)	116 (55%)	67 (58%)	27 (23%)	5 (4%)