

procedure and implement a proforma to help improve both confidence in performing the procedure and documentation.

Method Foundation doctors and Core Medical Trainees were surveyed about their attitudes towards abdominal paracentesis both before and after the implementation of a multi-disciplinary proforma. The survey consisted of four questions with free text responses: trainees' confidence in performing the procedure, common worries about the procedure, what has previously gone wrong and whether a proforma would be useful. Documentation of important steps in the procedure and results were audited both before and after implementation of the proforma.

Results Only 25 percent of respondents were confident in performing abdominal paracentesis independently and 67 percent of respondents felt a proforma would be useful. Common areas of uncertainty were surrounding bleeding risk and regimes of albumin replacement. Documentation of many key steps in the process of abdominal paracentesis was poor; following the introduction of the proforma documentation rates hit 100% for steps including informed written consent, number of passes to insert the drain and assessment of bleeding risk. The proforma was well received with 100% of respondents, both medical and nursing colleagues, agreeing it was a useful addition.

Conclusion Introduction of a simple, multi-disciplinary proforma has improved documentation in abdominal paracentesis. In addition, it clearly sets out best practice and addresses many of the concerns identified by junior doctors.

Disclosure of interest None Declared.

REFERENCES

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- 2 Specialty Training Curriculum for Core Medical Training, JRCPTB <http://www.mrcpuk.org/sites/default/files/documents/2009-CMT-Curriculum>

PTU-288 TAKING THE IBD STANDARDS FORWARD IN SCOTLAND: A NATIONAL PATIENT SURVEY

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Introduction Crohns and Colitis UK, working with Scottish Government, have committed to a project to raise the standards of care for patients with Inflammatory Bowel Disease (IBD) in Scotland. The programme's objective is to develop a national strategy for IBD service improvement, led by a national steering group supported by the findings from pilots in two diverse Health Boards. As part of the process, a large national survey was commissioned. The aim of the study, therefore, was to present the data generated from 777 participants who responded to the survey.

Method An on line questionnaire was developed and completed by people living in Scotland who have IBD. The survey was a snap shot of their views and experiences of their NHS health care provision, with a particular focus on their most recent flare up. The survey contained a combination of quantitative and qualitative (reported separately) questions. The survey was designed to be completed on-line (Survey Monkey) and was distributed through the Crohns and Colitis UK website and membership database. Social digital networks were also used to promote the survey. The survey was conducted between March and May 2013.

Results 777 participants responded to the survey (68% female). The majority of respondents were aged 16–65 (88%). 64% said that they had an IBD nurse. 79% of patients had an annual review. This review was principally by a gastroenterologist (78%). 50% of patients had suffered a disease flare in the previous 6 months. Principal symptoms of the last flare will be presented. 19% of patients self-treated during their last flare, 41% contacted their GP and 33% contacted their IBD nurse. Patients would like to have had a referral to an Occupational therapist, careers adviser and social worker. over 328 patients took time off during their last flare, with 40% taking over a week off.

Conclusion This survey provides confirmation that there are many people with IBD living in Scotland whose NHS service provision falls below that outlined in the IBD Standards. Prompt diagnosis, readily available information, quick access to advice and support are issues that are frequently raised. The results of the survey have informed the pilot Health Boards, who have developed workstreams to address areas of deficiencies,

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PTU-289 EMBEDDING PHARMACEUTICAL CARE INTO THE MULTIDISCIPLINARY TEAM

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Introduction Pharmacists traditionally do not get involved in the long-term management of patients with chronic disease.

This service development aimed to integrate pharmacy-lead IBD medication optimisation into the IBD Multi Disciplinary Team (MDT).

We report our experience of extending our specialist pharmacist's remit.

Method

1. A weekly pharmacist outpatient clinic was established, to initiate immunomodulating drugs and undertake biochemical monitoring. The pharmacist optimised therapy according to blood levels, adverse drug reactions (ADRs) and concordance.
2. Strategic and operational management of the biologics infusion clinic was transferred to the pharmacist.
3. A new blood and therapeutic drug monitoring (TDM) service for immunomodulators and biologics was introduced to optimise therapy decisions.
4. The rapid access (helpline) service was reviewed to see whether the pharmacist could add value.
5. The pharmacist facilitated MDT-approved pathways to initiate and review immunomodulators.
6. A workload and prescription audit was conducted over four months with financial impact assessment.
7. Patient and anonymous colleague feedback was sought.

Results

1. In the four months analysed, 14 pharmacist clinics were held, serving 138 patients. 382 patients had blood monitoring, ensuring clinical governance.
2. The biologics infusion clinic expanded to include a cross-speciality services.
3. 65 patients had their immunosuppressant therapy adjusted in the TDM service. The pharmacist is gatekeeper for testing and is responsible for optimising therapies (as a non-medical prescriber).
4. The advice sought from the rapid access service was primarily nurse-orientated and the service remains nurse-lead, with

pharmacist deputising to maximise resources. In 4 months 142 of 1032 queries were answered by the pharmacist.

- The MDT reviewed 42 patients on biologics according to the new pathways.
- The TDM service resulted in a minimum of £60,000 savings for the health economy.
- 6 of 6 peer-assessors returned overwhelmingly positive reviews of the service and patient feedback was fa.

Conclusion Involving the pharmacist in all aspects of the long-term care of patients with IBD enhanced patient safety and standardised treatment and monitoring protocols, whilst individualising therapy.

The focus of the MDT shifted to early medicines optimisation, realising considerable cost savings. Interprofessional relationships profited from working closely together / deputising for each other.

Embedding pharmaceutical skills into the multidisciplinary team influenced therapeutic decision making, ensuring that services incorporated good medicine management and medicine optimisation principles at conception to guarantee high-quality, compassionate care and strong governance.

Disclosure of interest None Declared.

PTU-290 WHAT'S ON OFFER FOR PATIENTS PRESENTING TO A GIANT (GI AND NUTRITION TEAM) CLINIC IN A SPECIALIST CANCER CENTRE?

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Introduction GI toxicity experienced by patients related to cancer therapy has been largely ignored by gastroenterologists.

Method A prospective evaluation was conducted of patients referred with chronic changes in GI function after cancer therapy after discharge from our clinic. All patients complete a Gastrointestinal Symptom Rating Scale recording 30 symptoms and a Bristol Stool Chart at every clinic visit. Patient characteristics, symptom incidence, severity, investigations and diagnoses were recorded.

Results From April 2013 to March 2014, there were 1266 clinic appointments, 398 new patients and 868 follow-ups, 326 patients were discharged. 62% referred by in-house oncology teams, 24% tertiary and 14% GP referrals. Median age was 68 years (20–90), the majority were male (56%). Time from cancer diagnosis to referral was 3.3 years (median, range 0–42). The majority were treated for urology (43%) or gynaecological malignancy (21%), 12% for colorectal, 10% for GI and 14% for other cancers. 94% had more than one troublesome symptom. The most commonly reported GI symptoms (diarrhoea, urgency, flatulence, tenesmus, bloating, abdominal pain, faecal incontinence, borborygmi, nocturnal defaecation, perianal pain and steatorrhoea) all improved by discharge. Only 4% had symptoms that required only endoscopic investigation. 84% reported ongoing fatigue, 45% urinary and 36% sexual concerns. Following an algorithm proven to be effective, 86% required blood tests, 58% OGD+ duodenal aspirate, 53% breath tests, 51% SeHCAT scanning, 48% flexible sigmoidoscopy, 20% colonoscopy, 45% stool faecal elastase and 3% other radiological imaging. Six investigations (median 0–10) were requested. 62% had 3 or more diagnoses made which included 46% small bowel bacterial overgrowth, 38% vitamin D deficiency, bile acid malabsorption 28%, gastritis 22%, radiation-induced bleeding 20%,

vitamin B12 deficiency 17%, weak pelvic floor 17%, 13% had polyp requiring removal, 5% pancreatic insufficiency. 3 visits were required (median, 1–16) before discharge. Those requiring more than 1 visit (n = 256) were followed up for 6 months (median, 0.4–142 months). 36% were referred for dietetic assessment and targeted dietary interventions as part of management. Referrals to other teams included: psychological support (4%), urology (2%), psychosexual counselling (1%), physiotherapy (1%) and endocrinology (1%).

Conclusion Many GI causes contribute to chronic change in bowel function after cancer treatment, endoscopic evaluation without addressing other GI symptoms is only appropriate in a small minority. Most can be discharged after a small number of consultations with significant improvement or resolution of symptoms if a systematic investigational and treatment approach is adopted.

Disclosure of interest None Declared.

PTU-291 MANAGING GI CONSEQUENCES OF CANCER TREATMENT- WHAT DOES IT COST?

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Introduction The considerable GI toxicity experienced by patients during and after cancer therapy is an increasing problem as more patients survive cancer, yet struggle to obtain adequate assessment or treatment.

Method A financial model was derived from a prospective evaluation of patients referred to a GI consequences of cancer treatment clinic, where patients are investigated and treated using an algorithm proven to be effective. The costs of assessment, investigations and prescriptions was calculated using the National Tariffs 2013/14. The clinical team includes a Consultant Gastroenterologist, a Nurse Consultant and a specialist dietetic service. This model does not include overhead costs such as administrative support, clinic space and laboratory staff costs.

Results The figures are based on the profiles of 326 consecutive patients discharged from our GI and Nutrition Team service between 01 April 2013 and 31 March 2014. This was a mixed cohort of men and women previously treated for urological (43%), gynaecological (21%), colorectal (12%), upper GI (10%) and other (14%) cancers.

Initial out-patient consultation costs £192, investigations with related prescription costs (e.g. bowel preparation, SeHCAT capsule) £890 and follow up and treatment costs £438 (mean £1520 per patient).

Annual NHS costs for cancer services are £5 billion, but the cost to society as a whole – including loss of productivity – is £18.3 billion (DoH, 2013). The NHS tariff for a person diagnosed with prostate cancer and treated with radiotherapy lies between £6,000 and £9,000. The tariff paid per woman treated with chemoradiation for cervical cancer is £14,800. Treatment for colon cancer with a right hemicolectomy followed by adjuvant capecitabine costs £8,300; anterior resection costs £10,800; long course chemoradiation (capecitabine and oxaliplatin) followed by surgery and adjuvant chemotherapy (capecitabine) costs >£45,000. Surgery for upper GI cancer costs £10,500 while additional chemotherapy adds £2,000–£6,000. A pylorus preserving Whipple procedure followed by adjuvant chemoradiation with epirubicin, cisplatin and capecitabine for pancreatic

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