

list) and from January-April 2013 (once IB list established). The IB list set aside 3 slots every Monday-Friday from 8–9 am for inpatient AUGIB. Each week a designated consultant gastroenterologist was responsible for performing endoscopies on the IB list. AUGIB cases were identified from endoscopy indications being 'haematemesis' and/or 'melaena'. Patients who developed AUGIB after admission were excluded. For each patient, the endoscopy date, admission and discharge dates were collected from electronic discharge summaries and patient records. The time (in days) to endoscopy (from admission) and length of hospital stay (LOS) was calculated for all cases.

Results The longest wait to OGD was for patients admitted on a weekend (Friday-Sunday) with a mean waiting time of 3.04 days pre IB list though this figure reduced to 1.88 days with the introduction of the IB list.

Conclusion The introduction of the 5 day IB list enabled our gastroenterology service to improve compliance with the NICE guidelines for AUGIB as the mean number of days to OGD decreased from 2.15 to 1.78, with over 50% of patients having an OGD within 24 h under the new system. The median LOS was also reduced from 5 to 4 days with the IB list. We expect that an extension of the IB list from a 5 to 7 day service would further reduce waiting times to OGD and LOS. The use of a dedicated 'bleeders' list prior to the start of elective endoscopy lists is an efficient and safe method of meeting targets in AUGIB and we would recommend its use particularly in a district general hospital setting with limited access to a 24/7 emergency AUGIB endoscopy service.

REFERENCE

- 1 Acuteupper gastrointestinal bleeding: management'; Issued June 2012; NICE clinical guidance 141; guidance.nice.org.uk/cg141

Disclosure of Interest None Declared.

PTH-051 THE FIRST YEARS OUTCOME DATA FROM IBD-SSHAMP; UK'S FIRST REMOTE WEB-BASED SELF MANAGEMENT PROGRAMME FOR STABLE INFLAMMATORY BOWEL DISEASE PATIENTS

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Introduction In February 2012 the Luton and Dunstable University Hospital, became the first hospital in UK to use a remote (web-based) programme to help manage stable inflammatory bowel disease (IBD) patients. IBD-SSHAMP (Supported, Self Help And Management Programme) aimed to transfer the care of stable IBD patients from hospital based outpatient appointments (OPAs), to effective community based monitoring + management, co-ordinated by specialist IBD nurses.

Objective To improve cost efficiency by reducing the number of unnecessary routine OPAs + thereby improve OPA waiting times.

Methods The LandD manages 2420 active IBD patients, most of which are seen twice a year in routine OPAs. 26 lack mental capacity and 117 do not have internet access. Using Patient Knows Best we developed individualised websites for all of our IBD patients, to offer them a direct communication portal and a symptomatic assessment tool that provides appropriate management advice via a traffic light system. If a patient scores badly, an alert is sent out to the specialist team. The websites have a library of self help advice sheets and upload the patients hospital

results in graphical form. The system can be converted into 6 different languages and has both iPhone or Android apps. Patients can access this service from the comfort of their own homes or (like a health passport) whilst on the move/abroad. A proportion of our more stable patients can be transferred to community based care via IBD-SSHAMP and receive twice yearly virtual (telephone) clinics with blood and faecal (calprotectin) inflammatory marker assessments. By freeing up OPA space we can accommodate emergency patients usually within 24–48 hrs.

Results We are steadily inviting the 2,277 IBD patients who have internet access to a personalised website, and have successfully transferred 420 onto IBD-SSHAMP. We plan to transfer a further 400 to community based IBD-SSHAMP by the end of 2014. Confidence is such that this second wave will primarily contain patients stable on immunosuppressants eg. azathioprine. So far IBD-SSHAMP has saved our CCG approx £68,000 (400 × 2 × £85), whilst reducing our OPA waiting times. Only 7 of our IBD-SSHAMP patients have required an emergency hospital OPA. We have received positive feedback from the patients, who feel more supported and appreciate that they are not being discharged.

Conclusion IBD-SSHAMP is the UK's first internet based remote management system for managing stable IBD patients. This proof of concept project, has proven to be effective, safe and cost efficient. Our CCG have fully supported the concept and outcome, funding 2 additional IBD nurses to support the system. The Regional CCG are now keen to roll this concept out through the East of England.

Disclosure of Interest None Declared.

PTH-052 HOW THE NEW INFLAMMATORY BOWEL DISEASE REGISTRY AND PATIENT MANAGEMENT SYSTEM (IBD-R/PMS) HAS HELP DEFINE THE FUTURE OF OUR DISTRICT GENERAL IBD SERVICE

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Introduction In 2013 the Luton and Dunstable (LandD) University Hospital, became the first hospital in UK to pilot the new IBD-R/PMS. The PMS was designed by clinicians to be quick and easy to use, at the point of care, to facilitate best clinical practice. The system is live with PAS details, accessible throughout the Trust and provides up-to-date information consolidated in one place with real-time data collection. The IBD-Registry aims to provide the UK with its first ever national IBD statistics, by pooling some of this anonymised data centrally.

Objective To reviewed the effects of IBD-R/PMS on a DGH's IBD Service.

Methods The LandD looks after 2780 IBD patients. Data from 2571 of these patients has been uploaded, with pre-existing data on 1200 being ported over from an old Rotherham database. The IBD-R/PMS can analyse the service and individuals workloads, to help provide service reports and evidence of self worth for the IBD nurse specialists role. The new National IBD Standards (E2) advocates the use of electronic clinical management systems. When patients phoned up "out of the blue", clinical staff can quickly access clinical summary sheets, just by using a name search. To-date we have had no complaints or concerns about data inputting or security issues. Instead patients felt reassured and confident that staff were well informed about their

condition. The instant generated clinic letters have been a particular success with both patients and GPs.

Results The dashboard facility gives an instant overview of our local IBD cohort, revealing 2571 (as of Jan 2014), 1280 with UC, 934 with Crohn's, 77 with IBD unclassified and 59 with microscopic colitis. It takes 4–5 min to upload the basic details in clinic, although complex histories take longer. There were 1072 telephone and virtual clinic contacts recorded between Jan–Nov 2013. The time spent on the IBD phone line was 943 min, with a further 940 min spent dealing with these issues. This work saved 149 clinic visits. Data reports sent to our CCG provided evidence of this service and enabled an income generation not previously claimed for. The IBD-R/PMS identified 913 clinic visits and 173 inpatient reviews. Experience using the worklist functions now allow us to better monitor colonoscopy surveillance, schedule MDT patients and regulate azathioprine reviews.

Conclusion The IBD-R/PMS has been a huge success, with relatively little effort on our behalf. It would be difficult now to go back to paper based reporting. There are still benefits yet to be fully appreciated. The service reports have been easy to generate and strongly assisted in our bid to fund 2 additional IBD nurses. Further integration is expected to reduce duplication with our own IBD-SSHAMP project, IBD-GRS and the Biologics Audit.

Disclosure of Interest. None Declared.

PTH-053 OPEN ACCESS TO COLONOSCOPY: ONE YEAR OF EXPERIENCE IN A DISTRICT GENERAL HOSPITAL

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Introduction Open access endoscopy allows non-gastroenterologists to schedule elective endoscopies without prior consultation with a specialist and is widely used for upper gastrointestinal endoscopy. Our hospital has provided an open access service for colonoscopy (OAC) since May 2011. We analyse our initial data to determine the appropriateness of referral and proportion of clinically significant diagnoses found.

Methods We retrospectively reviewed endoscopy reports from all open access colonoscopies between 01/05/2011 and 30/04/2012 performed in a local district general hospital. Patient demographic data was collected alongside indication for examination, completion rates and final diagnosis. Further information from all colonoscopies performed during this period was retrieved from our endoscopy database system for comparison. Appropriateness of

Abstract PTH-053 Table 1

EPAGE referral status	Appropriate/Uncertain	Inappropriate
Diagnosis		
Diverticular Disease	77	1
Polyp (s)	53	-
Haemorrhoids	19	2
Inflammatory Bowel Disease	13	1
Anal fissure	2	-
Colorectal cancer	2	-
Angiodysplasia	1	-

open access colonoscopy was graded using the European Panel on the Appropriateness of Gastrointestinal Endoscopy criteria (EPAGE II). Primary endpoint: appropriateness of colonoscopy. Secondary endpoint: clinically significant diagnosis.

Results 2895 colonoscopies were performed in total during the study period of which OAC accounted for 14% (407). 57% (231) patients were female, age range 24–89 years (median 56 years). Caecal intubation was achieved in 96% (389 patients). OAC had the lowest diagnostic yield for all outpatient referrals to colonoscopy compared to bowel cancer screening (86%), medical outpatients (61%) and surgical outpatients (57%). The indication was designated appropriate in 69% (279 patients), inappropriate in 6% (25 patients) and uncertain in 25% (103 patients) based on the EPAGE II criteria. Patients with appropriate or uncertain indications had more relevant endoscopic findings than those with inappropriate indications (45.8 vs 19.0% $p = 0.005$). Sensitivity and negative predictive value of the EPAGE II criteria for detecting clinically significant pathology were 97.7 and 83.3% respectively. The most common diagnosis was diverticular disease, followed by polyps and haemorrhoids (Table 1). Colorectal cancer was found in 0.5% (2 patients), both in the appropriate/uncertain EPAGE group based on indication.

Conclusion Open access to colonoscopy is useful to avoid delay in investigation of symptomatic patients but is associated with a low proportion of clinically significant findings compared to standard referral routes. Inclusion of the EPAGE II criteria in the referral form may help to avoid unnecessary examinations.

Disclosure of Interest None Declared.

PTH-054 IS TIME ALLOCATED FOR COLONOSCOPIC ENDOSCOPIC MUCOSAL RESECTION ENOUGH?

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Introduction Colorectal cancer is the third commonest cancer in the United Kingdom with 35000 patients newly diagnosed per annum Evidence has shown that resection of adenomatous colonic polyps decreases the occurrence of malignancy by upto 90%. Endoscopic mucosal resection of polyps has been very effective in removing polyps.

Methods A retrospective case study of lower GI EMR procedures done by a single endoscopist (colonoscopy/ sigmoidoscopy) at a district general hospital from September 2012 and January 2013 was performed. The data was extracted from endbase reporting system.

Data collected included size, location and morphology of polyp. Procedural data collected included type of EMR and procedural time.

Results 95 EMRs were included in the study. 1 unit time point was assumed to be 15 min. Procedures were allocated between 2 and 4 units.

All the procedures were performed by a consultant gastroenterologist with experience in EMRS. The mean time for 95 procedures was 52 min, whilst the mean allocated time was 43 min. There was a significant correlation between the time taken to complete EMR polypectomy and age (mean age = 66.6 years, $p = 0.02$ and polyp size (mean diameter = 25.3 mm) $p < 0.0001$.

Morphology of the polyps did not cause significant variation in time taken (sessile/flat-elevated Vs semi-pedunculated/pedunculated: mean duration = 51 mins vs. 54 mins mean time difference = 3 mins $p = 0.28$).