

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](http://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

MW Johnson\*, K Lithgo, T Price. *Gastroenterology, Luton and Dunstable FT University Hospital, Luton, UK*

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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

MW Johnson\*, K Lithgo, T Price. *Gastroenterology, Luton and Dunstable FT University Hospital, Luton, UK*

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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