

This involved the triage of patients (including UGI Bleeds and ERCPs), coordinating with the wards and listing of patients. As the focal point of contact for ward teams, advice is given to teams about preparation of patients, as well as consenting patients on the wards ready for lists. Attending ward rounds on a daily basis to AandE, medical admissions unit and Gastroenterology wards means patients are actively listed. The effect was audited with outcomes of list utilisation, improvement patient waiting times and back-filling of lists.

Results Satisfaction Feedback from the ward staff, doctors and specialist nurses were extremely positive with the role.

ERCPs were managed more effectively with reductions in cancellations of patients that did not require them and effective triage to EUS. Also access of patients needing urgent ERCP was much easier due to the value of coordination.

UGI Bleeds Were managed more effectively which led to a reduction in the patients that required in-hours and out of hours theatre.

Interventional Endoscopy Listing in-patients for complex therapeutic interventions such as stenting and getting tertiary referrals in form other hospitals was significantly improved.

Efficiency The list utilisation improved greatly from 64 to 86% in just 8 months. The waiting times (patient scoped within 24 h of referral) improved by 32% for upper GI endoscopy and by 16% for sigmoidoscopy despite a substantial increase in the number of referrals (OGD increase by 13% and sigmoidoscopy by 20%).

Conclusion An in-patient liaison nurse has been pivotal for improving the quality, and efficiency, of the endoscopy service we offer to in-patients.

Disclosure of Interest None Declared.

OC-055 IBD PASSPORT-DEVELOPING AN EVIDENCE-BASED INTERNET TRAVEL RESOURCE FOR INFLAMMATORY BOWEL DISEASE: A REPORT OF THE INITIAL STAGES OF IMPLEMENTATION

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Introduction Travellers with Inflammatory bowel disease (IBD) are at greater risk of travel-related morbidity^[1], with ECCO recommending expert consultation prior to travel, particularly for those on immunosuppression². The travel consult and patients pre-travel preparation have been found to be deficient¹. Here we present the development of a dedicated IBD travel advice website to enable informed, safe travel with IBD.

Methods We conducted a literature review using Ovid databases and a search of existing online material using major internet search engines to identify existing research and resources regarding IBD and travel. Data was extracted from a recently reported prospective survey³ of 136 IBD patients which examined pre-travel preparation and experiences of travelling with IBD.

Results The database and Internet search revealed a paucity of research and resources available for IBD patients and professionals regarding travel and IBD. Our survey of 136 patients found 60% [82/136] reported IBD affected travel, however; pre-travel medical advice was only sought by 24% [32/136]. Disease-related travel knowledge was poor with 52% of immunosuppressed patients unaware of the need to avoid live vaccines; only 53/136 (39%) buy travel insurance covering

their IBD and the majority of these (70%) pay a premium. 91% (124/136) would find a dedicated IBD travel website useful. As a result of this, IBDPassport™ was developed for both patients and professionals as non-commercial, IBD-specific travel resource, aimed at providing evidence-based information on all aspects of travel and IBD. The functionality of the website includes an interactive map of country specific advice including vaccinations and a 'search and refer' service for IBD professionals to refer to other IBD centres globally. Features also include practical information for travelling with IBD and specific information for the immunocompromised traveller.

Conclusion We present the first comprehensive web-based travel resource created for both IBD patients and professionals to obtain evidence-based IBD and country specific travel information. IBDPassport™ needs to be formally evaluated by patients and healthcare professionals as part of a larger study and to inform further development.

REFERENCES

- 1 Rahir *et al.* ECCO 2009
- 2 Soonawala *et al.* *Inflamm Bowel Dis* 2012
- 3 Greveson *et al.* A Recent Flare of Disease does not Prohibit Travel: Early Results of a Single Centre Study in Inflammatory Bowel Disease and Travel. Abstract Number: A-1908. ECCO 9th congress Copenhagen 2014

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OC-056 STRAIGHT TO TEST COLONOSCOPY – A VIABLE MEANS OF SHORTENING TIME TO A DEFINITIVE DIAGNOSIS

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Introduction Endoscopy units face an increasing demand on their ability to meet timeliness targets. One way of managing demand is to work differently – and straight to test (STT) offers this. Patients with lower gastrointestinal (LGI) symptoms are telephone triaged by a trained specialist nurse direct to the appropriate endoscopic investigation, rather than attending clinic first. Clear benefits to the patient are a reduction in time to wait until definitive (endoscopic) diagnosis, to the Trust in freeing up out-patient staff to work elsewhere, and finally to the local health economy in terms of reduction in clinic costs

Methods We followed a protocol outlined previously by the Dorset group¹. Briefly, a specialist nurse assessed patients by phone and completed a symptom questionnaire. Patients were triaged according to symptoms and age; flexible sigmoidoscopy (<40 yrs, anorectal symptoms only) or clinic (>80 yrs and comorbidity, or major co-morbidity) or colonoscopy (everyone else). Appointments occurred within 2 weeks for 2WW patients, or within 6 weeks for 18WW patients. The endoscopist was allowed to arrange further clinic review as was seen fit. A prospective database allowed capture of patient outcomes and demographic details, an estimate of financial benefit was made on the basis of standard charges for surgical (£172) or medical (£220) out-patient clinics.

Results 89 patients passed through the pathway in the first three months, 64% female. Mean age 61 (range 32–88) yrs, 76% were on the 2WW pathway. Only 2% of the patients were triaged to flexible sigmoidoscopy, no patients required