Qs within pre-existing structured audit plans with allocated audit staff had greater compliance (83/93, 89.2%) in comparison to those without (14/32, 43.8%, $p < 0.05$). Several subspecialties had failed to continue to audit their service after termination of previously mandated national audits.

Conclusions The currently mandated audit of Qs is a significant burden, with overlap of published gastroenterology Qs and ambiguity in certain areas. The majority require some manual case-note review. Electronically audited Qs are more likely to be monitored. Audit activity is improved when clear audit plans exist. Audit wanes when compliance is not mandatory.

Consensus between professional bodies is recommended to devise a practical and comprehensive list of GI standards without duplication. Designing an integrated planned rolling audit programme should improve compliance with national Qs. Ideally all data should be collected electronically and prospectively to validate and simplify the process. Increased mandatory submission of data to professional bodies may promote improved continuous audit activity.

PTU-079 AMBULATORY MANAGEMENT OF SYMPTOMATIC ANAEMIA

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Introduction Current NICE guidance recommends restrictive blood transfusions to a target haemoglobin of 70–90 g/L.¹ In cases of symptomatic iron deficiency anaemia (IDA), parenteral iron is effective.² New IDA warrants urgent investigation. The financial burden of IDA is high rendering the introduction of an ambulatory management pathway at our trust beneficial.

Methods A single-centre retrospective analysis was undertaken of all patients with symptomatic anaemia, referred to ambulatory care between February and September 2017. Our aim was to assess pathway adherence and estimate cost savings.

Results 54 patients (26M; 28F) were referred to ambulatory care between 1/2/17 to 4/9/17 via the anaemia pathway. Mean age was 69 years (range 25 to 97). 44 (81%) were GP referrals whilst 10 (19%) were internal referrals. 72% (n=39) of patients were treated within 24 hours of referral; 17% (n=9) within 2–3 days; 11% (n=6) within 4–11 days.

81% (n=44) of these patients were ambulatory; 19% (n=10) required an in-patient stay for co-existing medical concerns. Causes of known anaemia included: GAVE – 7 (13%); Chronic illness – 9 (17%); Malignancy – 14 (26%); Gynaecological – 4 (7%). Of 20 (37%) patients with new anaemia, 15 (75%) patients were seen within 2 weeks by the relevant team. 2 (10%) delays occurred. 3 (15%) patients did not have IDA.

32 (59%) patients had IDA; 19 received intravenous iron alone (ferritin 3–57.7 ug/L, Hb 72–92 g/L); 13 received parenteral iron plus blood transfusion (ferritin 1.3–125.3 ug/L, Hb 56–80 g/L) and 22 had a transfusion alone (ferritin 12.8–3047.6 ug/L, Hb 53–82 g/L).

Conclusions The introduction of the anaemia pathway, has reduced emergency admissions of patients with symptomatic anaemia. Cancer fast track referrals of IDA have been effective and appropriately triaged and the anaemia pathway has been adhered to. IDA has been treated with parenteral iron,

enabling restrictive transfusion. Each emergency IDA admission is estimated to cost £1165 more than a day case (£1640 vs £475, respectively).³ Between February and September 2017, we estimate to have saved 44 such admissions, resulting in an estimated cost saving of £51 260.

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PTU-080 SUCCESSFUL IMPLEMENTATION OF REMOTE VIDEO CONSULTATIONS FOR PATIENTS RECEIVING HOME PARENTERAL NUTRITION

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Background Salford Royal NHS Foundation Trust National Intestinal Failure Unit (IFU) provides care for patients from across the UK and beyond. Type 3 IF patients are routinely reviewed at 3–6 month intervals. Between March 2007–2017 there was a 90% increase in type 3 patients attending our outpatient. Coping with the increasing demand whilst maintaining outpatient capacity and standards is a key component of IF care. Telemedicine provides a strategy for achieving this. Moreover, whilst doing so, such approaches can save patients' time, cost, lengthy and difficult journeys to the outpatient clinic. Thereby improving the patient experience.

Method Quality Improvement (QI) methodology was used to implement and evaluate remote video consultations. Implementation began Dec 2015 via patient consultation and small tests of change. All protocols and information sheets were approved through clinical governance and trust policy. Clinical data was obtained from a prospectively maintained database forming part of ESPEN audit standards.

A virtual clinic allows the clinician and the patient to see each other, holding a face to face discussion via the internet using the video call service Skype. An anonymous qualitative satisfaction questionnaire was subsequently completed by participating patients.

Results At the end of 2015, 246 patients were receiving HPN, this figure rose by 13.7% by 2017 to 285. Twenty-one patients used our telemedicine service, with a total of 55 contacts. Mean potential distance travelled by telemedicine cohort was 118.6 miles (range 10–441.8), mean cumulative miles saved since telemedicine initiated 8600 miles. Twelve patients used the service on multiple occasions. Seventy percentage of patients rated their satisfaction with the system at 90% and above, with the mean satisfaction of 83%. Despite the increase in number of HPN patients, the mean duration between outpatient appointment offered reduced from 103.7 days before telemedicine to 100.4 days in 2017, for the whole HPN cohort. One patient had a CRBSI following commencement of telemedicine. 9.5% of the telemedicine cohort were admitted with a HPN complication. This compares to an admission rate of 23.5% for the whole HPN cohort over the two years since telemedicine was initiated.

Conclusion The introduction of telemedicine can release some HPN clinic capacity and help reduce the increasing pressure for patient access to HPN services. Importantly, compliance with NICE and ESPEN guidelines can be maintained. Whilst maintaining patient satisfaction and patient safety.

PTU-082 OPTIMISATION OF PATIENTS PRIOR TO IBD RELATED RESECTION USING A QUALITY IMPROVEMENT METHODOLOGY

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Introduction Up to 70% of patients with Crohn's disease and some 30% of patients with ulcerative colitis require abdominal surgery during their lifetime. Perioperative adverse events such as anastomotic leaks, intra-abdominal abscess and unplanned stoma formation are associated with potentially modifiable risk factors. Impaired recovery and complications cause considerable loss of quality of life in this population, who are often in a formative stage of life with considerable educational, professional and family commitments. In order to improve outcomes in elective or expedited IBD surgery, identification of these modifiable risk factors and their pre-operative optimisation in each individual patient is important, but preoperative management remains heterogeneous. We therefore aimed to implement a care bundle to systematically identify and optimise preoperative modifiable risk factors in IBD surgery.

Method A literature review identified five important modifiable pre-operative factors in IBD surgery: smoking, anaemia, malnutrition, steroid and immunosuppressant therapy, and intra-abdominal sepsis. From May 2017, a pre-operative patient optimisation bundle was developed to improve these risk factors. It was implemented using a continuous quality improvement (QI) methodology utilising the model for improvement, sequential plan-do-study-act cycles, tests of change and trust wide upscaling. The main outcome measure was days between failure, where failure was defined as non-compliance with one or more of the five components of the pathway. The care pathway was fully implemented from 1 September 2017, with a continuous QI approach.

Results 18 consecutive patients operated prior to the implementation date, were retrospectively assessed and 14 patients operated with the care bundle were prospectively studied. Mean days between compliance failure increased approximately 2-fold, from 11.7 to 26.1 days. From the first month of implementation, 100% compliance with the anaemia and smoking interventions were achieved, while full compliance with nutritional assessment and steroid weaning elements took longer time to achieve. Length of stay and incidence of Clavien-Dindo grade $\geq$ II morbidity remain unchanged in this preliminary data.

Conclusion Quality improvement methodologies including PDSA cycles, tests of change and trust-wide up-scaling are effective in implement a complex multidisciplinary pre-

operative optimisation care pathway for patients undergoing major IBD surgery.

PTU-083 ADVICE GIVEN TO PATIENTS WITH ALCOHOL EXCESS REGARDING FITNESS TO DRIVE

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Introduction In 2015, around 5740 accidents and 220 fatalities occurred on UK roads and involved drivers under the influence of alcohol.¹ Following discussions amongst the gastroenterology team and Hospital Alcohol Liaison Team (HALT), at Southport Hospital it appears that fitness to drive advice is inconsistently given to patients with excess alcohol intake.

Methods The aim was to firstly assess if patients with a history of alcohol excess were being informed about their fitness to drive in accordance with national Driver and Vehicle Licensing Agency (DVLA) guidelines. Then to introduce a simple aide memoire and document that the DVLA advice had been given. The standards used were the Current medical guidelines: DVLA guidance for professionals.² Clinical notes were assessed for evidence of a discussion regarding fitness to drive and DVLA guidance for all patients with alcohol excess presenting to Southport hospital over a 2 week period and reviewed by HALT, who also performed the data collection. A label was then designed for insertion into the clinical records. This demonstrates that a patient was advised about their fitness to drive by the HALT nurses. Re-audit was performed by the medical staff by reviewing the clinical records of 30 different patients for evidence of the label.

Results Initial audit showed of the patients with alcohol excess (n=30), 14 (46.7%) patients were currently driving with 0 being informed about their fitness to drive. During the re-audit of the total patients with a history of alcohol excess (n=30), 11 (36.7%) patients were currently driving. 11 (100%) patients had documented evidence being informed about their fitness to drive in accordance with national DVLA guidelines in the form of a label. Ongoing driving was verbally confirmed by HALT for each patient.

Conclusions Patients with alcohol excess were not being informed about their fitness to drive in accordance with national DVLA guidelines. Introduction of our label has since resulted in an improvement in the number of patients informed about their fitness to drive and adherence with national guidance. Therefore, the use of a simple aide memoire has demonstrated improved compliance with DVLA guidance and potentially reduced the risk of alcohol-related driving incidents.

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PTU-084 **BARRETT'S OESOPHAGUS: A QUALITATIVE STUDY OF PATIENT BURDEN AND FOLLOW UP NEEDS**

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Introduction The rising incidence of Barrett's oesophagus (BO) has implications on both service provision and patient burden. Few studies have assessed the impact on patients or engaged them in the design of care pathways. This qualitative study aims to: 1) identify factors impacting on BO patients' health-related quality of life; 2) explore their follow up needs and attitudes to new models of follow up care.

Methods An exploratory qualitative approach was utilised using 20 semi-structured, in-depth one-to-one interviews, audio recorded and transcribed verbatim. Patients undergoing BO surveillance at a single district general hospital were recruited using purposive sampling with the aim of achieving maximum variation in terms of age, sex and disease duration. Interviews focused on the impact of surveillance, physical and psychological symptoms, experiences of follow-up care, follow-up needs and new models of follow-up care. New models of care included a dedicated BO service and patient-initiated consultation by means of telephone or virtual clinic. Data were analysed using Framework approach, supported by NVivo Pro 11.

Results Data saturation occurred after 20 participant interviews. Median age was 63 years (range 42–77 years) and median disease duration was 5.6 years (range 1–15 years). 10 subthemes and three main themes emerged from data analysis: 1) Burden of disease – symptom control, worry of oesophageal cancer and surveillance endoscopy; 2) Follow up experiences – historic and current follow up care, at this DGH, was found to be inconsistent and often inadequate to meet patients' needs and expectations. In particular, a lack of disease specific information; 3) Follow up needs – participants sought enhanced communication, organisation and structure of care. They valued face to face interaction with a specialist and were more likely to follow their advice. The concept of direct secondary care access in-between endoscopies was reassuring to participants. There was a strong preference towards a telephone patient-initiated consultation over an 'impersonal' online system.

Conclusions This qualitative research provides an in-depth account of the patients' perspective of BO in an NHS setting. The potential burden to patients must be considered when implementing future care pathways or when designing a BO specific patient reported outcome measure. To improve patient experiences we recommend the implementation and prospective assessment of a complex care intervention, which encompasses dedicated BO surveillance, outpatient clinic and telephone direct access line.

PTU-085 **A DEDICATED SERVICE IMPROVES THE ACCURACY OF BARRETT'S OESOPHAGUS SURVEILLANCE: A PROSPECTIVE COMPARATIVE COHORT STUDY**

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Introduction This study aims to assess the quality of current Barrett's Oesophagus surveillance delivery against a dedicated service in the post BSG guideline era.

Methods All patients undergoing BO surveillance between January 2016 and July 2017 at a single NHS district general hospital (DGH) were included. Patients had their endoscopy conducted on a dedicated BO endoscopy list or a generic service list. Data were collected prospectively against the BSG guidelines. Prospective surveillance data were also compared to each patient's prior surveillance endoscopy experience.

Results 361 patients were scheduled for surveillance of which 217 attended a dedicated list (29 discharged, 13.4%), 78 attended a non-dedicated list (7 discharged, 9%) and 66 did not have their endoscopy. The cohorts were comparable in terms of age, sex and co-morbidity prevalence. The dedicated list adhered more closely to the BSG guidelines (table 1). Histology results from the dedicated list cohort revealed higher rates of intestinal metaplasia (79.8% vs 73.1%, $p=0.1155$) and dysplasia/OAC (4.3% vs 2.6%, $p=0.4082$) when compared to the non-dedicated, although statistical significance was not reached.

Abstract PTU-085 Table 1 Adherence to BSG Standards for endoscopy surveillance

BSG Standards	Dedicated BO endoscopy (n=188)^	Non-dedicated endoscopy (n=71)^	P value Dedicated vs Non-dedicated	Prior endoscopy (post BSG guideline, n=229)	P Value Dedicated vs Prior
Prague Classification	100% (n=188)	87.3% (n=62)	$P<0.0001$	82.5% (n=189)	$P<0.0001$
Barrett's island description	96.6% (n=28/29)	0% (n=0)	$P<0.0001$	17.6% (n=3/17)	$P<0.0001$
Hiatus hernia delineation	100% (n=188)	64.8% (n=46)	$P<0.0001$	63.3% (n=145)	$P<0.0001$
Visible lesion documentation(yes or no)	100% (n=188)	94.4% (n=67)	$P=0.0053$	89.9% (n=206)	$P<0.0001$
Visible lesion description(distance from incisors + Paris classification)	94.4% (n=17/18)	0% (n=0/6)	$P<0.0001$	0% (n=0/11)	$P<0.0001$
Biopsy documentation (location and n)	99.5% (n=187)	5.6% (n=4)	$P<0.0001$	6.9% (n=16)	$P<0.0001$
Seattle Protocol Adherence	72% (n=135/188)	42% (n=26/62)	$P<0.0001$	50% (n=94/189)	$P<0.0001$
Surveillance Interval Adherence	100% (n=188)	*	*	75% (n=147)	$P<0.0001$

Conclusions The post-BSG guideline era of BO surveillance remains suboptimal in this DGH. A dedicated service can improve the accuracy and consistency of surveillance care pathways in line with current best practice, although the clinical significance of this remains to be determined.

PTU-086 **IMPROVING ENDOSCOPY EFFICIENCY BY REDUCING TURNAROUND TIME BETWEEN CASES**

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