other GOPD changes in order to achieve CCG targets and further improve patient flow. Options being appraised include a liver CNS (to provide a similar service to IBD), virtual IBD clinics, better use of direct-to-test pathways, nurse-led protocol-driven clinics (e.g. anaemia), and virtual review clinics.

PTU-095 FRONT DOOR PRESENTATION WITH IRON DEFICIENCY ANAEMIA MANAGEMENT PATHWAY

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Introduction This project aimed to improve the care of patients presenting via their general practitioner (GP) or emergency department (ED) with new iron deficiency anaemia (IDA) by reducing unnecessary blood transfusions; reducing unnecessary admissions for blood transfusion; arrange iron infusions in the ambulatory care ward (ACW) and streamline investigations.

Methods An audit between 7th March and 7th April 2016 identified 28 patients who were admitted and had blood transfusions, 9 of these could have potentially been managed in ambulatory care with an iron infusion. 6 patients had blood in the ambulatory care ward receiving 14 units in total. Pathology started to automatically test B12, folate and ferritin in all blood tests from ED and GPs with new potential IDA. A pathway for ED and GPs was set up to enable patients to be booked into ACW for iron infusions, or given oral iron, rather than admitted to medical assessment (MAU) for blood transfusion. Criteria for further investigation were set. A costing estimate was developed for the cost of the iron infusion vs blood transfusion; including nursing time and consumables. Training was delivered to the ambulatory care nursing staff in administration of iron infusions and a pathway developed with pharmacy to ensure timely delivery of the iron infusion.

Results The project was launched on 1st August 2016. Over 12 months to 31st July 2017, 65 patients, median age 70 (23–91) years, received an iron infusion in ACW. Median Hb 75 (40–130) g/dl, follow up Hb median 112 (75–155) g/dl a median of 34 (1–133) days post iron infusion. 10 patients additionally received blood, median 2 (1–6) units.

There was an overall reduction in units of blood transfused in MAU from 841 to 552 comprising of mostly of a reduction in ACW units transfused from 768 to 319.

There were 15 new diagnoses as a direct result of the incident presentation, 7 cancer, 7 non-cancer gastric ulcers and 1 recurrent metastatic ovarian cancer. There was an established diagnosis in 21 patients, 6 cancers and 13 non-cancer of which 6 were gastrointestinal causes. In 28 patients, no diagnosis was made. In 10 patients investigations were normal. In 9 patients it was decided they were not appropriate for further investigation. 4 were not iron deficient, 4 had an unknown outcome and 1 patient was pregnant 2 months post iron infusion and not investigated further.

Conclusions This was the successful development and implementation of a pathway to streamline the care of patients presenting acutely with IDA. There has been a reduction in the number of units of blood transfused in MAU and a 58% reduction in the number of units of blood transfused in ACW. 65 patients have been treated with an iron infusion with an overall improvement in their Hb, with 23% receiving significant new diagnosis.

PTU-096 THE USE OF A SIMPLE BESPOKE IT TOOL SIGNIFICANTLY IMPROVES PATIENT COMPLIANCE WITH IMMUNOSUPPRESSANT MONITORING

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Introduction Immunosuppressant monitoring is a vital function of the multidisciplinary IBD team. However, it remains a difficult process to undertake safely and effectively in an NHS setting, consequently often incurring a significant governance risk. To address this the IBD team developed a simple immunosuppressant monitoring tool (IMT). We report the initial results from this compared with a historical cohort.

Methods Using a simple Excel algorithm we developed a database that automatically populated blood monitoring dates highlighting individual patient's status using a traffic light system. Patients were followed up in secondary care for the first 12 weeks with stable patients then handed over to primary care using a shared-care protocol. All immunosuppressant prescriptions were initiated through a specific IBD nurse/pharmacist clinic and prospectively monitored with data recorded on the IMT. Results were compared to a retrospective cohort of patients monitored prior to the introduction of the IMT.

Results 65 patients starting on immunosuppression were prospectively monitored using the IMT. These patients were compared with 30 historical controls. In the IMT group 335 blood tests were required for 100% compliance over the first 12 weeks of monitoring. 298/335 (88.9%) of blood tests were taken, compared with 123/175 (70%) of blood tests taken in the control group initiated prior to the IMT ($p=0.01$). 100% of the 335 requested bloods were logged in the IMT with actions recorded for the 37 missing tests (28 missed blood tests chased via phone, 3 discontinued treatment, 2 delayed starters and 4 pending that week). Comments on abnormal bloods or metabolites were logged in 186 (55.5%) of cases. This data was not routinely collected prior to implementation of the IMT. Compliance with monitoring at all time points was better in the IMT than control group (week 1 95.4% v 93.3%, week 2 95.1% v 75.9%, week 4 93% v 72.4%, week 6 85.7% v 72.4%, week 8 86.0% v 55.2%, week 12 73.9 v 51.7%).

Conclusions Implementation of a simple bespoke IT monitoring tool using a traffic light system significantly improves compliance with blood monitoring in patients initiating immunosuppressant treatment. The development of an IT trail dramatically improved documentation and clinical governance surrounding monitoring. Feedback has been universally positive with the new system markedly reducing the nursing burden associated with monitoring. The IBD team has identified areas where compliance can be improved, which are now being actively investigated. We are happy to make the software available to other teams on request.

PTU-097 NEAR HOSPITAL ACCOMMODATION AS AN ALTERNATIVE TO ADMISSION FOR PATIENTS UNDERGOING COMPLEX ENDOSCOPY

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