PTU-099 EVALUATION TO SUPPORT SERVICE IMPROVEMENT FOR PATIENTS WITH INFLAMMATORY BOWEL DISEASE AT ST MARK'S HOSPITAL

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Introduction As a centre for excellence for Inflammatory Bowel Disease (IBD), St Mark's Hospital in North-West London attracts worldwide referrals while also treating local patients. As demand increases, yet NHS resource remains limited, pressure has heightened on the IBD service to improve capacity and reduce waiting times. This local service evaluation (SE) aimed to describe the current management of IBD outpatients, and patient and staff experience with the service, so that barriers to efficient care delivery could be identified and addressed.

Methods A SE involving the collection of retrospective and prospective clinic and patient level data was conducted in 2015 for patients attending outpatient clinics over one year. Data collected included numbers of patients attending clinics, disease characteristics, type of healthcare professional (HCP) seen and time from decision to prescribe a biologic to first dose (n=31). Surveys were conducted with patients with IBD (n=66) and HCPs (n=46). Key personnel were interviewed in 2017 to determine how results could be used to drive specific service changes.

Results A mean of 18 patients were seen per clinic (with a maximum of 41 patients); 73% patients were in follow-up and attending for routine review. Of 51 patients followed prospectively, 8% had a joint visit involving multiple HCPs and 59% were judged to be in remission by the care team. Median time from decision to prescribe biologic therapy to first dose was 13.6 weeks. While 80% patients reported clinic management was 'good'/'very good', patients and HCPs were concerned about clinic space, patient volume and waiting times. Following the SE, a more integrated approach to treating patients and allocating staff resource was implemented to improve the pathway of care for patients (e.g. joint IBD multi-disciplinary clinics).

Conclusions Of the high number of patients attending clinics, many had stable disease or were in follow-up. Many patients were reviewed by different HCPs on different days, driving a plan for joint clinics to improve the patient journey. There were delays accessing parts of the service (e.g. biologic therapy). Patients and staff reported dissatisfaction with clinic space and capacity. These findings helped generate an action plan for specific service-level changes such as specialist IBD/joint multidisciplinary clinics, new administrative processes, and facilitation of patient self-management. This project can be used as a model for others to identify and address barriers to quality and efficiency within their own services.

PTU-100 INPATIENT ENDOSCOPY: A 'HOT SITE' EXPERIENCE

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Introduction Access to inpatient endoscopy is important for both patient management and flow within acute NHS Trusts. A daily dedicated weekday inpatient endoscopy list was introduced at Barnet Hospital, Royal Free London NHS Trust, to enhance

service provision in line with NICE guidance (CG141, 2016). We report on our initial 'hot site' experience.

Method A single centre retrospective study involving of all consecutive inpatients requiring endoscopy at a large district general hospital (445 beds) serving a population 5 00 000 during a 5 month period (January – May 2016). All patients were identified from the endoscopy procedure log. Additional data including endoscopy type, indication, therapeutic intervention and hospital discharge within 24 hours of endoscopy were collected using electronic patient records and the 'Unisoft GI Reporting Tool'.

Results In total 440 inpatient endoscopies were performed; 322 (73%) gastroscopies, 82 (19%) flexible sigmoidoscopies and 36 (8%) colonoscopies. Median age was 76 years [interquartile range (IQR) 55–86], 53% were male. Gastrointestinal bleeds (GIB) accounted for 192/440 (44%) procedures. 40/192 (21%) lower gastrointestinal and 152/192 (79%) upper gastrointestinal bleeds (UGIB). Additional indications included 48/440 (11%) abnormal imaging, 48/440 (11%) dysphagia, 47/440 (11%) iron deficiency anaemia, 40/440 (9%) diarrhoea, 26/440 (6%) percutaneous endoscopic gastrostomy (PEG) tube insertion, 17/440 (4%) abdominal pain, 17/440 (4%) weight loss, 4/440 (1%) volvulus and 1/440 (<1%) for dyspepsia. Sedation was used in 315/440 (72%) cases, median midazolam dose was 2.5 mg [IQR 1–5 mg] and fentanyl 25mcg (IQR 0–50mcg). Median (IQR) procedure time for gastroscopy, flexible sigmoidoscopy and colonoscopy were 20 (IQR 15–25), 15 (IQR 10–20) and 30 (IQR 25–40) min, respectively. Colonoscopy completion rate was 31/36 (86%). Therapeutic intervention occurred in 88/440 (20%). In total 259/440 (59%) procedures were undertaken within 24 hours of request, 110/152 (73%) UGIB and 30/40 (75%) lower GI bleeds. Overall 30 day mortality was 47/440 (11%) and 114/440 (26%) patients were discharged within 24 hours.

Conclusion Gastrointestinal bleeding is the most common indication for inpatient endoscopy. A dedicated inpatient endoscopy list improves both patient management and flow with >70% GIB scoped within 24 hours and a quarter of all patients discharged within 24 hour. Therapeutic procedures are expected in a fifth of all inpatient endoscopy. Optimal list timing merits further exploration, as does the prospect of extending the service to further improve outcomes.

PTU-101 FIRST DEMONSTRATION OF TRAINEE-LED NETWORKS DELIVERING QUALITY IMPROVEMENTS IN GASTROENTEROLOGY SERVICES: A CALL TO ACTION

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Introduction The GARNet was the first trainee-led gastroenterology network to complete a multi-site audit. We focussed on standards of care and outcomes in acute upper GI bleeding (AUGIB). Here, we present our regional experience with quality improvement (QI) and our subsequent re-audit.

Methods We audited patient care against national standards (NICE CG141 and QS38). Patients aged ≥16 years admitted with suspected AUGIB who underwent an inpatient OGD were prospectively identified between 01–30/11/16 and 01–30/11/17. QI focused on reducing time from presentation to endoscopy, using process mapping and staff questionnaires, to develop local action plans at each site. Fishers, Mann-Whitney and Wilcoxon