the strength of evidence behind the standard and the strength of recommendation. Such that the most contentious standards with largest percentage of endoscopists not planning to adopt had weak evidence and were weak recommendations. Whilst it is important to improve training and practice in gastroscopy and develop minimal acceptable standards this survey would suggest that standards with weak recommendation and with weak evidence may need revision.

PTH-026 IMPROVEMENT OF AN ERCP SERVICE IN PRACTICE

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Introduction The NHS Tayside ERCP service performs around 450 procedures per annum, serving a population of 5 50 000. A review of our service identified that whilst responsive for emergency inpatient (IP) procedures we had a nine week wait for an elective out-patient (OP) procedures. We wish to describe the review and redesign of our service.

Method The patient pathway was mapped with key stakeholders and areas of variation were identified. A test of change was undertaken over 7 weeks to promote a more consistent approach as below:

1. A&C processes: A single point of booking for ERCP out-patients was created. Lists were adapted to support IP and OP demand. The ERCP referral form was updated.
2. Patient flow: Lists were distributed evenly throughout the week having been previously weighted at the start of the week. Defined ERCP beds were secured in our Clinical Investigations Unit (CIU) rather than clinical wards. Patients from external hospitals are also now booked into CIU.
3. Same day discharge: A 24 hour Stay Core Data Set was implemented and included criteria for Nurse Led Discharge and a Discharge Checklist enabling same day discharge of out-patients.
4. Patient information: The ERCP Patient Information Booklet was updated supporting postal consent.
5. All outpatients have a full medical clerk-in pre-procedure supported by a Physician's Associate.
6. An Endoscopy RN visits in-patients the day before their procedure. Out patients were given a patient satisfaction questionnaire.

Results

1. Waiting times: The wait for both IP and OP ERCP has reduced from 9 weeks to zero weeks. All patients are now booked 'real-time'.
2. Savings/efficiencies: 34 patients were booked into CIU. 21 were discharged home the same day. No patients were booked to come into hospital the day before the procedure. This resulted in a total saving of 40 overnight stays.
3. Patient experience: Patient Satisfaction Questionnaires were returned from 14 patients booked into CIU. Feedback was mainly positive. There have been no serious complications. 3 patients had mild pain post procedure but this did not prevent same day discharge.
4. Procedural Change: Patients no longer telephone pre admission to enquire about bed availability, patient admission time has changed from 8 am to 10 am for patients on the pm list, OPs receive an ERCP report and reports are sent to GP.

5. Impact and other services: Streamlining of the patient pathway has supported appropriate use of acute in-patient beds and avoided/reduced cancellations.
6. Impact on staff: It has encouraged disciplines to work together with exceptional staff engagement.

Conclusion An overview of an established service identified inefficiencies at several points which were rectified. The cumulative effect of these changes has transformed the patient journey and released resource in other areas.

PTH-028 USE OF PPI IN ACUTE NON-VARICEAL UPPER GI BLEEDS IN A UNIVERSITY TEACHING HOSPITAL

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Introduction Acute non-variceal upper GI bleeds are a common presentation to UK hospitals. NICE guidelines state patients should not receive treatment with proton pump inhibitors (PPI) prior to endoscopy¹, as the 2010 Cochrane review² showed no reduction in mortality, re-bleeding or need for surgery. The review did however show a reduction in the requirement for endoscopic therapy.²

Methods We carried out a retrospective review of 763 patients who received an upper GI endoscopy for non-variceal bleeding between September 2010 and September 2013 at Cardiff and Vale University health board. Patients were divided into 2 groups depending on the receipt of PPI's pre-endoscopy. We then compared outcomes for both groups including mortality, need for surgery, re-bleeding and need for intervention at endoscopy.

Results Our data showed 77% of patients were treated with a PPI pre-endoscopy despite NICE guidelines. There was not a significant difference in death rates (9% vs 14%, $p=0.91$), need for surgery (3% vs 2% $p=0.28$) or re-bleeding (6% vs 8% $p=0.37$) in these patients. Our data does show a significant reduction in the need for endoscopic intervention ($p=0.014$) in patients pre-treated with a PPI.

Abstract PTH-028 Table 1

Therapeutic procedure at endoscopy	PPI pre-endoscopy	No PPI pre-endoscopy	Total
Yes	94 (16%)	43 (24%)	137
No	491 (84%)	135 (76%)	626
Total	585	178	763
			($p=0.014$)

Conclusion Use of PPI pre-endoscopy is not detrimental to patient outcomes and our data supports the existing evidence base suggesting a reduction in the need for endoscopic intervention². Further study is needed to evaluate the cost effectiveness of PPI use pre-endoscopy.

REFERENCES

1. NICE Guidelines. <https://www.nice.org.uk/guidance/cg141/chapter/1-Guidance>
2. Sreedharan A, et al. Proton Pump Inhibitor treatment initiated prior to endoscopic diagnosis in upper GI bleeding, Cochrane review 2010.