OTH-03 IMPACT OF DIRECT ACCESS IBD PHYSICIAN DELIVERED SIGMOIDOSCOPY FROM ACUTE IBD FLARE LINE CALL SERVICE

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Introduction Inflammatory bowel disease (IBD) patients calling our specialist nurse led IBD flare line with worsening symptoms were traditionally seen in outpatient clinics before being referred for endoscopy to evaluate disease activity. Non-IBD endoscopists often deferred treatment decisions until subsequent IBD outpatient appointments (OPA), leading to delays in treatment and pressure on IBD OPA workload.

Methods In January 2016 “flare slots” on dedicated IBD endoscopy lists were introduced. Patients with flare symptoms submitted stool for enteric pathogen exclusion and those subsequently deemed suitable were directly booked to a flare slot on an IBD endoscopy list, if available. Anonymised data was systematically extracted from clinical systems for the first 6 months of 2016, 2017 and 2018 regarding endoscopy outcomes leading to change in treatment and number of OPA in the respective years. Change in treatment was defined as start/stop of medication, urgent investigation to guide treatment or admission to hospital.

Abstract OTH-03 Figure 1 demonstrates the reduction of IBD OPA by 52.2% while increasing IBD nurse led OPA by 47.7%.

Results For the first six months of 2016, 2017 and 2018, data identified 90, 92 and 92 IBD flare line-triggered flexible sigmoidoscopies respectively. Overall 74.6% had ulcerative colitis and the remainder Crohn's disease (22.3%) or IBDU (1.3%). In 2016, 63.3% of procedures were performed by IBD physicians, which increased to 77.2% and 79.3% in 2017 and 2018 respectively. IBD endoscopists initiated change in treatment following their procedures in 70.2% (2016), 74.7% (2017) and 84.9% (2018) of cases, compared to 9.1%, 14.3% and 5.3% of non-IBD endoscopist procedures over the same period. Total gastroenterology outpatient appointments within the year in this population were 232 (2016), 214 (2017) and 111 (2018); a 52.2% decrease from 2016 to 2018. Nurse-led

outpatient appointments following IBD flare flexible sigmoidoscopy increased from 19 in 2016 to 51 in 2017 and 53 in 2018, when they constituted 47% of OPA in this group. This represented a 72.8% (155 OPA) reduction in consultant appointments from 2016 to 2018 (Figure 1).

Conclusion Changing the model of service delivery for acute IBD flares by combining IBD physician delivered endoscopy with proactive management decisions resulted in a change of management in 84.9% of patients. This reduced overall IBD OPA by 52.2%, while increasing nurse led follow up clinics in this cohort to 47% leading to a total 72.2% reduction in consultant OPA.

OTH-04 DEVELOPMENT OF A LICENCED FAECAL MICROBIOTA TRANSPLANT SERVICE FOR PATIENT TREATMENT IN THE NHS

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Introduction Faecal Microbiota Transplant (FMT) is an efficacious treatment for recurrent *Clostridium difficile* infection (CDI) and has shown encouraging signals for inflammatory bowel disease. Access to FMT services in the NHS has been limited by the regulation of FMT as a medicinal product in the UK. To enable inter-institution supply, FMT manufacturers are required to hold a Specials licence from The Medicines and Healthcare products Regulatory Agency.

Methods In 2017 the first licenced FMT service in UK was created at the University of Birmingham Microbiome Treatment Centre. Policies and procedures were developed using the Rules and Guidance for Pharmaceutical Manufacturers and Distributors (Orange Guide), which were used and maintained within a quality management system. The frozen FMT bank utilises anonymous unrelated healthy donors and provides FMT on a named patient basis for the treatment of CDI and supplies clinical trials via an investigational medicinal product (IMP) licence.

Results Since August 2018, 53 faecal microbiota transplants have been supplied for recurrent and refractory CDI to 21 NHS Trusts across England and Wales. Twelve of these Trusts did not have access or perform FMT prior to the introduction of this service. In 98% (52/53) of cases FMT was delivered either within 48 hours or on the day of request if >48 hours from request. Clinical response to treatment was observed in 76% (16/21) of patients, with 88% (14/16) of these patients remaining symptom free at 90 days. In 2018 the service became the sole supplier of FMT under the 201–019 NHS Innovation and Technology Tariff. Under the IMP licence the service has successfully supplied over 360 faecal microbiota transplants for the pilot stage of a multi-centre trial of FMT in UC (STOP-Colitis).

Conclusions Development of a licenced FMT facility at the University of Birmingham has improved equality of access to this novel treatment across the NHS. FMT has been provided within a zero cost model for CDI and is available generally within 48 hours of request. Patients with CDI benefit from improved care from this service, which limits morbidity and mortality from this severe infection. Supply via an IMP licence