PTU-074 **ENDOSCOPY ENIGMA – CRACKING CLINICAL CODING IN ERCP & EUS**

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Introduction The coding department uses clinical information in endoscopy reports to assign a healthcare resource group tariff. The accuracy of information is important to ensure correct remuneration as well as reflecting the complexity of the procedures delivered and comorbidity of the population. We aimed to assess whether our endoscopy unit's activity is coded accurately.

Methods A list of ERCP and EUS procedures for September 2017 was generated using the 'Auditor's Tool' on Unisoft. A senior clinician and a dedicated coder examined the Unisoft reports, discharge summaries and the codes that had been assigned to each case. The findings were presented and discussed at the department meeting. The first intervention was to generate a list of 'favourite' procedures for endoscopists to include in endoscopy reports and discharge summaries. These corresponded to a set of accurate codes for the coders to use. In the second PDSA cycle, the Endoscopy QI fellow met with the dedicated coder to review the previous month's ERCP cases and adjust the codes as applicable. The aim was to assess whether regular review could further reduce inaccurate coding.

In the third PDSA cycle, EUS coding was also reviewed. During this time, the 'Auditor's Tool' on Unisoft was unavailable and instead, a list of procedures coded on Cerner was generated.

Results The baseline measurement showed that 86.6% of ERCPs and 73.3% of EUS were inaccurately coded. In the second and third cycles, the percentage of coding changes for ERCPs continued to improve leading to an average of £752 increase in remuneration per month. For EUS, the changes tended to be less marked. Following the first intervention, the corrections were mainly adding plastic or metal stent codes,

adding assessment of the pancreatic duct where relevant and ensuring accurate primary diagnosis codes.

Conclusion Our QIP showed continual improvement in accuracy of coding of ERCP and EUS with time. While there is benefit in having a clinician review coding monthly, the one-off educational session for both clinicians and coders and development of formal guidance had the largest impact on coding accuracy. The improved income generated from this work has helped fund the Endoscopy QI Fellowship, ensuring the sustainability of this intervention.

PTU-075 **RECONFIGURING A GASTROENTEROLOGY INPATIENT SERVICE – A SUCCESS STORY**

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Introduction Studies have demonstrated that consultant delivered care can lead to; increases in productivity, reducing length of stay, and increasing patient satisfaction. ¹ The Gastroenterology inpatient (IP) service at Kettering General Hospital was reconfigured to implement NHS improvement's SAFER patient flow bundle. ²

The incumbent arrangements on Deene C Ward (DCW); 29 patients under the care of three Consultants doing twice weekly ward rounds (WR) not prospectively covered, newly admitted and unwell patients reviewed by any WR as a safety net arrangement.

This was transformed to a Digestive Diseases Unit (DDU), bed base reduced from 29 beds (3 side rooms, 3 x 6 bedded bays, a 5 bedded bay, & a 3 bedded bay), to 20 beds, by reducing 6 bedded bays to 4 beds, and converting the 3 bedded bay to a nurse-led Gastroenterology Treatment Area (GTA) for daycase ambulatory patients. This facilitated the introduction of a Consultant of the Week (CotW) model in November 2017.

Abstract PTU-074 Table 1

Month	ERCP				EUS			
	No of patients	No of patient with changes to code	Change in codes (%)	Change in remuneration (pounds)	No of patients	No of patient with changes to code	Change in codes (%)	Change in remuneration (pounds)
PDSA 1								
Sept 17	15	13	86.6		15	6	40	
Oct 17	13	7	53.8					
PDSA 2								
March 18	19	9	47.4					
April 18	11	7	63.6	281				
May 18	13	6	46.1	1380				
PDSA 3								
Sept 18	18	7	38.8	-657	5	1	20	-305
Oct 18	8	3	37.5	0	6	1	16	-461
Nov 18	10	4	40	2623	6	1	16	-146
Dec 18	12	4	33.3	889	4	1	25	0

The CotW, for 2 weeks (prospectively covered), is responsible for daily DDU WRs of all 20 patients under their care, review of IP referrals, inreach into urgent care wards, and support of GTA. There is minimal outpatient (OP) commitment (no endoscopy lists or OP clinics). Outcomes were analysed at 12 months to assess the impact on patient care.

Methods A retrospective observational study was conducted to benchmark and evaluate changes in consultant led care. Patients were identified through electronic records. Data was collected from electronic discharge letters and paper notes. Statistical analysis was performed using Microsoft Excel.

Results

	DCW	DDU	Delta	P value
Median Length of stay (hours)	141	104	"37, 26.2%	< 0.01
Discharges per week	22.8	21.1	"1.7, 7.5%	
Discharges per week per bed	0.79	1.06	"0.27, 34.2%	< 0.01
Consultant reviews per week	0.63	1.16	"0.53, 84.1%	< 0.01

GTA treating >90 patients & generating > £35K each month.

Gastroenterology IP services SAFER compliant.

Conclusion The reconfiguration of Gastroenterology IP services has been a great success. A reduction in bed base (which many at management level were reticent about) has facilitated a CotW model of care to be implemented. The IP service is now SAFER compliant. Length of stay has significantly reduced by 26.2%. Weekly discharges per bed, and Consultant reviews, has significantly increased by 34.2% & 84.1% respectively. In addition, GTA treats >90 patients per month, generating income, preventing admissions, facilitating earlier discharges, and freeing capacity in the main hospital ambulatory unit.

This reconfiguration shows that a CotW model of care is optimal, successful, and SAFER compliant, even if a bed base reduction is required to facilitate this.

REFERENCES

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PTU-076 MYENDOSCOPY.CO.UK, AN ONLINE RESOURCE FOR PATIENTS UNDERGOING ENDOSCOPY

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Introduction Prior to an endoscopy procedure, consent has to be sought from the patient. For consent to be valid, it must be voluntary, informed, and the person consenting must have the capacity to make the decision. The BSG *Guideline for obtaining valid consent for gastrointestinal endoscopy procedures*, recommends; "written information should be provided in advance of the procedure with sufficient time for the patient to read, evaluate and seek further information if required".¹

The General Medical Council's consent guidance states: "Before accepting a patient's consent, you must consider whether they have been given the information they want or need, and how well they understand the details and implications of what is proposed."²

To meet these regulatory requirements, endoscopy units give information to patients via printed leaflets, to outline; what to expect, what is involved, what preparation is required, and the benefits & risks. This gives sufficient information for a patient to give informed consent.

Information provided via an online platform would also meet regulatory requirements and may be preferred by many patients. An internet search shows that there is an NHS web resource for endoscopy which provides basic information, with limited media (a few images, no videos).³ Images and videos of endoscopy procedures are abundant online but there is limited resources for patients that combines the detail of a pre-procedure information leaflet, with illustrative media.

Methods Using the current printed information resources for patients used at Kettering General Hospital (KGH), this information was transferred onto a webpage, and was illustrated with media taken from KGH's endoscopy unit.

Results In February 2019, a website was published: www.myEndoscopy.co.uk

This website has a generic web address, minimal KGH branding, and is designed to be used by *any* patient undergoing a Gastroscopy, Sigmoidoscopy, or Colonoscopy (not just for KGH patients). It is accessible on PCs, laptops, tablets, and smartphones. The website has been promoted as a resource via direct email to colleagues across the UK, and via Social Media.

Conclusion This web resource is a big step forward in providing information to patients prior to having an endoscopic procedure. It has been designed to use generically by any patient irrespective of which hospital they are having their procedure. It has built in features to allow users to rate the website with comments so that we can evolve the content to meet the patient's needs. Over time, we will add more media, and information on ERCP, and capsule endoscopy.

REFERENCES

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PTU-077 FIT-HB PATHWAY FOR PRIMARY CARE IN HEREFORDSHIRE: THE FIRST 6 MONTHS

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Introduction NICE guidance recommended FIT-Hb for routine use in Primary Care to "guide referral of symptomatic patients with LGI symptoms in absence of LGI red flag symptoms (NICE NG12/DG30)

FIT-Hb offers a negative predictive value $\geq 99\%$ for the exclusion of Colorectal Cancer and High Risk Polyps

BCSP age-extension is anticipated to increase LGI endoscopy demand by 8–00%. FIT-Hb testing may reduce unnecessary investigations

A primary care FIT-Hb diagnostic pathway has recently been launched in Herefordshire. We present the first 6 month data