corroborating evidence of UGIB are very unlikely to have active bleeding and/or the need for endoscopic haemostasis. These patients could have an UGI capsule endoscopy in the emergency department as opposed to hospital admission and subsequent wait for an inpatient OGD. This could consequently have significant implications on admission rates, LOS and hospital associated morbidity.

P362 DEVELOPMENT OF THE FIRST UK LICENCED FAECAL MICROBIOTA TRANSPLANT SERVICE: RESULTS OF FIRST YEAR’S ACTIVITY

1S Shabir*, 2D Inglis*, 3S Manzoor, 1,2MN Quraishi, 1C Green, 1,2N Sharma, 1,2T Iqbal. 
1University of Birmingham Microbiome Treatment Centre, Birmingham, UK; 2Department of Gastroenterology, Queen Elizabeth Hospital, University Hospitals Birmingham NHS Foundation Trust, Birmingham, UK

Introduction The use of Faecal Microbiota Transplant (FMT) has become established practice for the treatment of recurrent or refractory Clostridiodes difficile infection (CDI). It involves the transplant of minimally processed donor faecal material into a recipient’s GI tract. Regulatory change in 2015 saw FMT classed as a medicinal product in The Human Medicines Regulations. As recognised by joint British Society of Gastroenterology and Healthcare Infection Society guidelines, these regulatory requirements are more readily fulfilled by a specialist centre, utilising a supply and satellite model - akin to that adopted by the Microbiome Treatment Centre (MTC). The MTC, supplies FMT on a named-patient basis under a Manufacturer’s Specials’ (MS) licence. FMT is supplied under the 2019–2020 NHS England Innovation and technology payment tariff, zero-cost model.

Methods The MTC strictly screens donors. Dedicated laboratory facilities are used for FMT production, minimising the risk of cross-contamination and allowing standardisation of the production process. FMT is stored frozen, allowing for multiple samples to be obtained immediately after donor screening. A numbering system is used in conjunction with a treatment directory to track FMT preparations. A multidisciplinary team approach is adopted, with screening, production and deployment overseen by a clinical gastroenterologist, microbiologist, service and production managers. Each FMT request is assessed for its clinical indication and then discussed with the requesting clinician.

Results From August 2018-January 2020, 181 FMT treatments have been given to 159 patients in 61 hospitals around the UK for recurrent or refractory CDI (Abstract P362 figure 1). 139 of these patients received a single FMT treatment with 20 patients receiving further transplants. Clinical follow up data has been received for 79% (n=110) of patients receiving a single FMT treatment. There has been an 81% (n=89) rate of reported resolution of CDI at 7 days post-transplant.

Of the 20 patients requiring more than 1 FMT, 4 had showed resolution of symptoms at 7 days post both first and second transplant, suggesting re-infection. All requested FMTs have been supplied to the clinical sites for the requested treatment date (25% were supplied in under 24 hours, 34% within 24–48 hours and 40% in over 48 hours.)

Conclusions The further development of the UK’s first FMT service has greatly improved NHS access to this novel technology, with 45 NHS trusts using the service in the past year, compared to 21 the year previously. FMT material is supplied expeditiously, with the majority arriving with the requesting clinician in under 48 hours.

P363 STARTING AZATHIOPRINE IN IBD: PRESCRIBE A THERAPEUTIC DOSE OR START LOW AND INCREASE SLOWLY?

Diluka Karunaratne*, Andrew Phillips, Francesca Melindo, Neil Hawkes, James Berrill. Royal Glamorgan Hospital, Llantrisant, UK

Introduction Azathioprine is frequently prescribed for the management of inflammatory bowel disease (IBD), however there is considerable variation in how it is initiated. It remains common practice to start patients on low dose Azathioprine and gradually increase the dose, with the belief that this approach will improve drug tolerance. However, this process can take several weeks or months to reach a therapeutic drug level, requiring multiple blood tests and patient contacts.

Since April 2018, patients attending our IBD clinic who require Azathioprine, have been started directly on a therapeutic 2 mg/kg dose. Outcomes from this ‘therapeutic dose group’ of patients (TDG), in terms of drug tolerability and safety, are compared to those from patients that started Azathioprine prior to April 2018, who were started on a low dose and increased gradually (LDG).

Methods In this single-centre, retrospective, observational study, adult IBD patients starting on Azathioprine between March 2016 and November 2019 were identified using pharmacy records. Patients with low thiopurine methyltransferase (TPMT) level, and patients who had taken thiopurine medication previously were excluded from the study.

The proportion of patients successfully established on Azathioprine was compared between the two groups, with a ‘success’ defined as continuing a therapeutic dose of medication beyond three months. Reasons for stopping Azathioprine prior to this were recorded.

Results The proportion of patients successfully established on Azathioprine was similar in both groups, with 34% in the LDG (n=63) compared to 66% in the TDG (n=29). There...
were no significant differences between groups in terms of gender, age, and IBD diagnosis.

Reasons for stopping azathioprine were drug-related symptoms (33% in LDG v 24% in TDG), abnormal liver function tests (8% in LDG v 3% in TDG), and pancreatitis (3% in LDG v 3% in TDG). Significant leucopenic episodes (defined as white cell count <3.5 × 10^9/l) occurred in 2 LDG patients and 1 TDG patient. In the TDG patient this was transient and resolved before any dose adjustment was required.

In TDG patients, thiopurine metabolites were checked at week 4 and showed median thioguanine nucleotides level = 379 pmol/8 × 10^8 cells (range 176 – 520), and median methylercaptopurine (MMP) level = 2438 pmol/8 × 10^8 cells (range 794 – 7277). Four patients in this group had their dose adjusted due to high MMP levels.

Conclusions Starting Azathioprine at a therapeutic 2 mg/kg dose, in IBD patients with normal TPMT level, appears to be as safe and well tolerated compared to using a low dose approach with gradual increase. This more direct approach has clear benefits in terms of achieving therapeutic response earlier, reducing the number of patient contacts, and saving IBD nurse or pharmacist time.

Methods IBD biologics MDT was initiated along the principles of QI. The aims, drivers and personnel were agreed via driver diagram. The criteria to include patients in the MDT were agreed- Longest wait (Patients who were furthest away from their last clinical review), Clinical Need or Complex Biosimilar switch. The MDT met for 90 minutes twice monthly. At least 3 Consultants were required to make quorate decisions. Outcomes were agreed and recorded, a copy of which would be sent to the GP and the patient. The data was recorded on a new biologics database. The process underwent ‘PDSA cycles’. Patient feedback was received.

Results Over the 1st 12 months, of the initial 225 patients on biologics (n) 113 (50%) were discussed (patients on biologics rose to 284, an increase of 26%, during this period). Four different biologics were being used in these patients (Biosimilar infliximab, originator or biosimilar Adalimumab, Vedolizumab and Ustekinumab). The longest waiting time between clinical review reduced from 80 to 31 weeks. The MDT altered management in 60 (53%) of patients It also led to further investigations in 49 (43%). Drug cost savings of £72206 was noted. 74% of patients surveyed were satisfied with MDT discussion, with the remaining 26% indifferent to discussion.

Conclusions The Biologic MDT can provide a safe and effective framework for IBD patients on biologic agents.

P364 THE IBD BIOLOGICS MDT: IMPROVING PATIENT SAFETY, GOVERNANCE, WAITING TIMES AND EFFICIENCY SAVINGS

Christopher Kelly, Nicole Hagarty, Ann Muir, Gillian Richardson, Pauline Morrison, Iain Morrison, Laura Clark, Stuart Paterson, Santoshkumar Salunke*. NHS Forth Valley, Larbert, UK

Introduction Biologic therapies have an ever-increasing evidence base to support their use in treatment of inflammatory bowel disease (IBD). Increasing number of patients on such treatments coupled with reduction in outpatient capacity coupled with availability of newer and multiple biologic drugs can often lead to challenges in decision making regarding best biologic and difficulty in safely monitoring this effective, but potentially toxic therapy. It was hypothesized that a Biologic Multi-Disciplinary Team (MDT) meeting could make dramatic improvements in quality of care, improve safety and establish governance around use of biologics in our district general hospital. The project was carried out in partnership with Royal College of Physicians, London, IBD Quality Improvement (QI) collaborative.

P365 GASTROENTEROLOGY OUTPATIENT TRANSFORMATION – CLINICAL ASSESSMENT SERVICE (CAS)


Introduction Increasing referrals lead to prolonged waiting time for patients to be seen in the clinic, creating pressure to comply with national guidance on referral to treatment time and raised appointment slot issue.

Method Clinical assessment service clinic was introduced to assess and manage patients remotely without face to face appointments.

Currently we are running 2 Virtual Gastroenterology clinics per week, where 40 patients are reviewed.

New referral in CAS clinic results in the following 5 outcomes; inappropriate referral, face to face appointment, appointment with/after results, review remotely after investigations, advice to GP and discharge.

Results 1254 patients have been reviewed in CAS clinic in 9 months. 21.1% of those patients were discharged with advice to GP on first assessment of the referral, including inappropriate referrals. Out of remaining 937 patients, 64.7% went directly for investigations and 113 patients were discharged after investigations, following a remote review.

Conclusion CAS clinic faced challenges initially, such as familiarizing GPs and staff to the system. This was dealt with, by reaching out to them, conducting awareness seminars and teaching sessions run by the Consultants. CCG and administration were supportive.

DNA (did not attend) rate fell to 0% and the process helped save new and follow up appointment slots. The Trust gained a financial benefit of £117,259 in 9 months.