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.

Introduction

The use of Faecal Microbiota Transplant (FMT) has become established practice for the treatment of recurrent or refractory Clostridioides 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 expediently, with the majority arriving with the requesting clinician in under 48 hours.

Abstract P362 Figure 1 Cumulative FMTs (by month)
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.

P365 GASTROENTEROLOGY OUTPATIENT TRANSFORMATION – CLINICAL ASSESSMENT SERVICE (CAS)


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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.