assessment of incontinence although should probably not have been on a cancer pathway, 2 had a previous failed colonoscopy and 1 had learning difficulties. There was a single cancer in this patient group. Despite having a reasonable justification for exclusion from a STT examination 27/70(39%) patients still went on to have an endoscopic examination. We found no justification for exclusion from a STT examination in 34/104 (33%) patients of whom 31(91%) went on to have a colonoscopy following a clinic review and two of these patients had a colorectal cancer.

Conclusion Two-thirds of patients judged inappropriate for a STT examination were appropriately identified by primary care referrers. However, there was no justification for why a third of patients were excluded and the large majority of these proceeded to a colonoscopy. This data supports secondary care providers being the key decision makers in allocation of patients for 2ww STT colonoscopy examinations.

PTH-19 ASSESSING THE IMPACT OF SBAR PROFORMA AND GI BLEED ROTA IN MANAGING VARICEAL BLEED PATIENTS

¹Irfan Ullah*, ²Amir Hazizi Abdul Razak, ³Gireesh Kothegal Marimahadevappa, ⁴Peter Neville. ¹Nevill Hall Hospital, Abergavenny, UK; ²Prince Charles Hospital, Merthyr Tydfil, UK; ³Prince Charles Hospital, Merthyr Tydfil, UK; ⁴Prince Charles Hospital, Merthyr Tydfil, UK

10.1136/gutjnl-2021-BSG.334

Introduction Variceal bleeding in liver disease is associated with significant mortality and morbidity. Early recognition and appropriate interventions are crucial in managing patients with acute variceal bleeding.

Methods Patients presented with acute variceal haemorrhage to Prince Charles Hospital and Royal Glamorgan Hospital were retrospectively identified using our endoscopy database. Four locally agreed key performance factors including early endoscopy within 24 hours, use of prophylactic antibiotics, documentation of Glasgow Blatchford Score (GBS) and correct identification of upper gastrointestinal bleed (UGIB) on initial presentation were assessed in patients presented between February 2018 to February 2019 in the initial audit cycle. These factors were audited again for patients from March 2019 to December 2019, after the introduction of SBAR proforma and out-of-hours (OOH) GI bleed on call rota.

Results A total of 31 patients were included in initial audit and 13 patients in the reaudit. In the first audit it showed that compliance with endoscopy within 24 hours was 96%, prophylactic antibiotics was 74%, GBS documentation was 55% and identification of upper GI Bleed on admission was 100%. After the introduction of UGI bleed SBAR proforma and OOH GI bleed on call rota, the repeat audit of the same factors showed improvement in GBS documentation to 92% and prophylactic antibiotics use on admission to 85% while UGIB identification on admission remained 100%. Endoscopy within 24 hrs of admission was 85%, but this was due to the risk benefit review of a case and the need for urgent endoscopy by the team. Endoscopic procedures done OOH initially was 22% which rose to 31% after introduction of UGI bleed on call service. Additional information also showed that SBAR proforma was used in 62% of cases. It also showed better use of the in hours endoscopy services, as more cases were discussed appropriately with the on call Gastroenterologists.

Conclusion This audit concludes that there was better documentation of GBS, use of prophylactic antibiotics, appropriate

early recognition and management of variceal bleeding by using available endoscopy service and the appropriate use of on call service for these patients, who generally have significant morbidity due to their underlying liver disease. We recommended that repeating the audit cycle in 12-24 months would be valuable to see whether these improvements are sustained and to reassess the long term benefit of GI bleed on call service in effectively managing these patients. We also suggest that we should aim to achieve 100% compliance in these performance factors along with appropriate management of associated liver disease.

PTH-20 THE IMPACT OF COVID-19 PANDEMIC ON UPPER GI AND HEPATO-PANCREATO-BILIARY CANCERS – DIAGNOSIS AND STAGING

^{1,2}Ee Xuan Ngeyu*, ¹Palaniappan Jeyam-Suresh, ^{1,3}Anjan Dhar. ¹County Durham and Darlington Nhs Foundation Trust, Darlington, UK; ²Newcastle university Medical School, Newcastle, UK; ³School of Health and Life Sciences, Teesside University, Middlesbrough, UK

10.1136/gutjnl-2021-BSG.335

Introduction Cancer Charities and the BSG Endoscopic Section predict an increased GI cancer related mortality arising from reduced endoscopic activity and delays to cancer diagnosis during the COVID-19 pandemic. Initial modelling reports suggest up to a 58% reduction in weekly GI cancer detection. A real world analysis of the adverse impact of COVID-19 on Upper GI and hepato-pancreato-biliary (HPB) cancers has not been reported so far.

Aims and Methods Patients with a new diagnosis of upper GI (oesophageal and gastric) or HPB cancer at County Durham over two 4-month periods of June-September 2019 (pre-COVID) and 2020 (peri-COVID) were selected for this analysis. Data collected from electronic patient notes and Somerset Cancer MDT electronic database included: 1) patient demographics and co-morbidities; 2) Pathway parameters - duration of symptoms prior to presentation, 2WW timeframes, interval between referral and endoscopy, performance status, elective vs emergency presentation, and 3) Tumour parameters - cancer site, TNM staging, 90-day mortality, where available was also recorded.

Results 163 patients were included – 82 patients in pre-COVID (2019) and 81 in peri-COVID (2020) cohorts. In the pre-COVID group, 25 were oesophageal cancers, 8 gastric, 21 pancreatic, and 26 liver cancers. In the peri-COVID group, 31 were oesophageal cancers, 13 gastric, 17 pancreatic, and 18 liver cancers. An absolute increase of 17.5% was seen in emergency presentation of UGI cancers to A&E in 2020 (35.8% v 18.3%). In the peri-COVID group, 87.1% of patients had advanced (TNM staging of T3/4, N2 or M1) oesophageal and gastric cancer, 7.1% more than in pre-COVID group. A similar increase of 6.4% was identified in metastatic pancreatic cancers (58.8% in 2020 v 52.4% in 2019). There was a significant reduction in the number of endoscopies performed within 3 weeks of referral - 56.8% pre-COVID, compared with only 20% peri-COVID. There was no significant difference between 60-day mortality (pre-COVID 25.61% and peri-COVID group 25.91%) and 90-day mortality (34.15% and 32.10% respectively), between the two groups.

Conclusion Although the impact of COVID-19 on endoscopy activity resulted in a 17.5% increase in emergency presentations of UGI and HPB cancers and nearly 10% increase in

advanced cancer diagnosis with a 37% reduction in endoscopy activity in County Durham, we were unable to show a significant increase in short term cancer related mortality. We believe a similar phenomenon is occurring across the NHS leading to an indirect increase in COVID-19 related cancer diagnosis. Measures to mitigate this are urgently needed.

PTH-21 CAPNOGRAPHY MONITORING OF PHYSICIAN-LED PROCEDURAL SEDATION FOR GASTROINTESTINAL SERVICES AT A UK TEACHING HOSPITAL

¹Gareth Corbett, ¹Peter Pugh, ¹Jurgen Herre, ¹Teik Choon See, ¹David de Monteverde Robb, ²Rafael Torrejon Torres*, ²Rhodri Saunders, ³Catherine Leonard, ¹Amit Prakash. ¹Cambridge University Hospital NHS Trust, Cambridge, UK; ²Coreva Scientific, Koeningwinter, Germany; ³Medtronic UK, Watford, UK

10.1136/gutjnl-2021-BSG.336

Introduction Physician-led sedation is commonly employed for selected endoscopic procedures. There is still an open question around the optimal patient monitoring strategy during such procedures. Use of additional capnography has been shown to be associated with fewer patient respiratory compromise events than pulse oximetry alone. To quantify and explore the impact of capnography on patient safety, a quality improvement initiative was undertaken for gastrointestinal (GI), interventional cardiology (IC), vascular access (VA), and respiratory medicine (RM) clinical services at a large UK teaching hospital.

Methods Four target events as defined by the world Society for Intravenous Anaesthesia (SIVA) tool were determined as the cumulative primary outcome after a review of available literature. These events were: Oxygen desaturation (75-90%) for <60s, severe (<75% at any time) or prolonged (<90% for >60s) oxygen desaturation, bradycardia (>25% increase from baseline), and tachycardia (>25% decrease from baseline). The design was pre- and post-implementation of capnography monitoring. A 20% reduction in this cumulative endpoint was agreed upon to be the quality improvement threshold. Data on procedures featuring procedural sedation were collected as a convenience sample between December 2017 and January 2020. The results were entered on-site in an Excel based data collection tool. No patient identifiers were recorded.

Results The data from 1,401 procedures across the GI, IC, and RM services were collected. The first 666 procedures were pre-capnography (baseline), with the subsequent 735 post-capnography implementation (capnography). GI represented 601 of the procedures, with 262 collected at baseline and 339 with capnography. Over the 1,401 procedures, a 42% reduction in the incidence of the composite endpoint was recorded. The adjusted odds ratio was estimated at 0.57 (95% confidence interval (CI): 0.42 - 0.77).

For the department of GI, 20 events were observed in the baseline procedures (0.076 events per procedure), and for the capnography arm 12 (0.035 events per procedure), corresponding with a 53.9% percent reduction in the composite endpoint. Odds ratios were decreased for all American Society of Anesthesiologists (ASA) levels, with ASA III patients receiving capnography being associated with the lowest odds ratio [0.24 (95% CI: 0.06-0.94)] for the composite primary outcome compared to baseline.

Conclusions Implementing capnography monitoring led to a 42% overall and a 53.9% GI-specific reduction in the composite outcome patient safety events. Participating services support capnography monitoring being added to the hospital's

sedation guidelines. More data are required to explore whether reduction in more rare but severe patient outcomes can be realised with use of capnography monitoring.

PTH-22 BENCHMARKING IBD PHARMACY SERVICES TO OPTIMISE, STRENGTHEN AND ALIGN IBD EXPERT PHARMACY PRACTICE

^{1,2}Anja St*, ^{2,3}Uchu Meade. ¹Brighton and Sussex University Hospitals NHS Trust, Brighton, UK; ²IBDUK, Hatfield, UK; ³St Mark's Hospital, Harrow, UK

10.1136/gutjnl-2021-BSG.337

Introduction UK IBD Standards 2019 (ibduk.org) for the first time embed and describe Specialist Pharmacy Services (SPS) as an integral part of the IBD multidisciplinary team (MDT) and enable recognition and commissioning of expert pharmacy practice¹. The IBD UK National Service Standards Audit 2020 provides a benchmark of IBD pharmacy standards.

Methods The benchmarking tool developed and agreed by IBD UK to drive quality defines A-D descriptors for all standards (A='excellent, proactive' to D='minimal, inadequate' care). Descriptors for the 4 (7%) IBD Standards describing SPS were developed in 2 consensus workshops by IBD UK with expert pharmacy representation. Royal Pharmaceutical Society (RPS) standards and SPS feedback were used to define descriptors for pharmacy leadership, medicines expert role and MDT working. All UK IBD services were asked to complete the self-assessment between Oct 2019 and Jan 2020.

Results 166 (72%) paediatric and adult IBD services took part across the UK.

MDT Standard 46% (n=81/166) of all IBD Services have pharmacist input to the IBD MDT, but only 27% (n=18/66) of adult IBD Services met or exceeded the IBD Standard of 0.6 WTE Expert Pharmacist in IBD (EPharmIBD)/250,000 population.

Leadership role 76% (n=98/129) of services with an IBD leadership team work with a pharmacist of which 48% (n=47/98) work with an EPharmIBD on the annual formulary review and of these teams 66% (n=31/47) work with an EPharmIBD on annual protocol/policy review, with actions and outcomes, to actively develop pharmacy services within IBD.

Medicines expert role Ward pharmacists in 95% (n=157/166) of IBD Services have access to an advanced generalist pharmacist for advice and of these services 54% (n=84/157) are supported by an EPharmIBD but in only 41% (n=34/84) of these services patients and ward pharmacists have access to an EPharmIBD on admission and during their stay for medication review, optimisation and personalised consultation.

Conclusions Benchmarking shows a low level of pharmacy IBD expertise in the UK with a minority of services, ward pharmacists and patients having access to an EPharmIBD. Less than half of IBD leadership teams work with an EPharmIBD and a small number of services have adequate WTE of EPharmIBDs commissioned.

With new treatments becoming available the role will become more essential. The benchmarking tool highlights the high need for EPharmIBDs, advanced competencies in pharmacy IBD practice, training pathways to develop future EPharmIBDs and prioritisation of service commissioning. The pharmacy profession needs to respond to this challenge urgently to ensure high quality pharmaceutical care for IBD patients.