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, Koenigswinter, Germany; ³Medtronic UK, Watford, UK

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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

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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.