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PTH-23 CONSULTANT TRIAGE OF ENDOSCOPY WAITING LISTS DURING THE COVID-19 PANDEMIC SAVES MONEY AND REDUCES WORKLOAD

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Introduction The Covid-19 pandemic continues to cause delays nationally in provision of endoscopy services. As recommended by the BSG, triage of 'Planned' and 'Routine' endoscopy waiting lists was conducted within a hospital serving a population of 166,257.

This study aimed to see if consultant led triage resulted in cost savings and/or a reduction in endoscopy workload.

Methods The 'Planned' endoscopy waiting list included patients on a surveillance pathway or awaiting a follow up procedure. The 'Routine' endoscopy waiting list referred to all other outpatient endoscopy requests. Patient records were reviewed on iSOFT Clinical Manager 2.0. Patients were telephoned if further information was needed.

Each endoscopy request was assigned to one of four categories; 'no longer required', 'no change to request', 'upgrade request to urgent', and 'change request to alternative planned interval'. Outcomes were recorded in an Excel spreadsheet. Patients were informed of any important change in management plan.

Procedures that were deemed no longer required were reviewed in more detail to establish the reason for this. Potential savings made as a result of not carrying out procedures that were categorised as 'no longer required' were based on the 2018/19 National Tariff for the procedure with biopsies.

Results A total of 589 patients were on the endoscopy waiting lists; 326 on the 'Planned' list, and 263 on the 'Routine' list.

157 (27%) of endoscopy requests were categorised as not required. Reasons for this included updated or incorrect adherence to surveillance guidelines (26%), clinical judgement deeming it no longer necessary (62%), or a change in the patient's clinical status or unclear indication (12%).

Conclusions 1. 27% of endoscopy waiting list procedures were judged unnecessary.

- Consultant led triage of endoscopy waiting lists resulted in an estimated cost saving of £67,993 (a 25% cost reduction) and a reduction in endoscopy work load.

- Potential savings nationally from endoscopy waiting list triage are considerable.

Abstract PTH-23 Table 1 Numbers of endoscopy requests triaged into each category across planned and routine waiting lists

Outcome after consultant triage of endoscopy request	Planned	Routine
No longer required	79	78
No change to request	202	159
Upgrade request to urgent	14	9
Change request to alternative planned interval	31	17
Total	326	263

- Triage theoretically increased training opportunities by reducing workload.

Greater awareness of current guidelines could reduce the number of endoscopies scheduled.

PTH-24 THE IMPACT OF PEG COMPLICATIONS PRESENTING TO ED – A DGH EXPERIENCE

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Introduction Percutaneous endoscopic gastrostomy (PEG) tube and Radiologically inserted percutaneous gastrostomy (RIG) tube feeding is widely used for providing enteral nutrition to patients with impaired swallowing or cannot meet their nutritional requirements by oral route. At a district general hospital (DGH), patients present with complications of gastrostomy tubes to the emergency department (ED). I analysed the data to determine the impact of these patients on acute services including length of stay (LOS) in hospital and associated costs.

Methods A list of patients who attended ED with gastrostomy related problems from April 2018 to August 2019 was obtained and analysed. Indication for referrals, length of stay in hospital and outcomes with regards to the feeding tubes were analysed. Cost analysis was conducted using the 2017/18 NHS tariffs.

Results Based on coding, 80 patients were identified of which 3 were paediatric patients, 1 had nasojunal tube problems, another's details could not be verified and 1 had an unrelated admission - these were excluded from analysis. Of the 74 patients, there were 45 attendances in the first year and 29 in the 5 months from April 2019. Mean age was 62 years (22-84). The reasons for presentation included dislodged tubes (n=38, 51%), blocked tubes (n=16, 22%), to check PEG position replaced in community/sent with a deflated balloon (n=6), infection/pain/bleeding at insertion site (n=7), split tubes (n=2), clamp problems (n=1) and suspected buried bumper (n=3).

LOS varied from 2 to 47 days (n=39) with a mean of 9.3 days and a cumulative total of 353 bed days. 35 patients (47%) were managed in ED, 13 (18%) in 2 days, 1 in 3 days, 4 on day 4 while 22 patients (30%) stayed beyond 5 days. 2 patients died during hospital stay. 14 patients (19%) attended more than once, with 2 patients attending 6 and 7 times respectively. Most of the blocked and dislodged feeding tubes were replaced by ED doctors or the gastroenterology team. 12 patients had gastrostomy tubes insertion by Interventional radiology (usually with tract dilatation) with a mean delay of 6.6 days (1-31). 2 patients had endoscopic gastrostomy insertion on day 9 and 11 after admission. With an estimate of £160 for ED attendance and £346 for each bed day, the cost for managing patients with PEG complications was £133,978.

Conclusions Care of gastrostomy tubes in the community needs improvement to avoid distress to patients/carers and reduce pressure on acute services as well as prevent repeat attendances. This requires greater support, expertise and training of community healthcare professionals. A focused outreach gastroenterology specialist advice service can help in reducing ED attendances, thus saving bed days and reducing costs to the NHS.