Conclusion Patients with MC are diagnosed within a median of just over 3 months of symptom onset. Some patients are still referred and diagnosed long after symptom onset. There may be patients with chronic diarrhoea in the community who are undiagnosed. There is some variation in prescribing practice for MC. Standardisation of management pathway in the UK would assist with management (Münch A, et al. *Frontline Gastroenterology* 2020;11:228–234).

PTH-51 PATIENT SAFETY MATTERS: CARE CLOSER TO HOME IN GASTROENTEROLOGY HIGH COST DRUG MANAGEMENT DURING COVID-19

¹Sapna Gohil*, ¹Arti Soni, ¹Maimuna Ahmed, ¹Nikki Lovell, ²Duncan Loft, ²Esther Unitt, ¹Hardeep Bagga. ¹Pharmacy, University Hospitals Coventry and Warwickshire NHS Trust, Coventry, UK; ²Gastroenterology, University Hospitals Coventry and Warwickshire NHS Trust, Coventry, UK

10.1136/gutjnl-2021-BSG.366

Introduction The Covid-19 pandemic has been a strong catalyst in driving the reconfiguration of gastroenterology outpatient models of High Cost Drug (HCD) delivery. This service evaluation aims to explore the impact of multiple quality improvement initiatives synchronously implemented by the HCD pharmacists and the gastroenterology clinical team, to improve medication safety and HCD treatment access.

Methods The Plan-Do-Study-Act (PDSA) quality improvement methodology was applied to three key service areas, from March 2020 to May 2021: i) 95 Hepatitis B (HB) patients receiving FP10 HCD prescriptions were reviewed by the clinical team for switch to the hospital outpatient pharmacy model (HOP), enabling HCD collection from their local pharmacy. Conversely, Hepatitis C (HCV) patients struggled to reach the HOP. To improve treatment access, 29 eligible HCV patients were offered HCV HCD homecare (HC) delivery, enabling direct delivery to the patient's preferred address ii) development of a digital pharmacy database to record queries and pharmacist interventions supporting safety monitoring for 450 HC gastroenterology patients iii) exploration of alternative HCD formulations available via HC.

Results 100% of the eligible HCV patients agreed to the HC model and 100% of HB patients agreed to the HOP. HCD pharmacists helped to resolve 114 HC prescription queries in regard to incomplete blueteq proformas, delayed clinic follow-up reviews and blood monitoring. Subcutaneous (SC) formulations of vedolizumab and infliximab recently became available for self-administration (SA) via HC, as options for eligible inflammatory bowel disease (IBD) patients considered to be at-risk of Covid-19. 41 patients receiving intravenous (IV) vedolizumab at the hospital were eligible for switch to SC via HC. 26/41 patients agreed to switch. 2/26 patients switched back to IV as 1 patient = reported IBD flare and 1 patient = injection site reaction. 15/41 patients refused the switch. IV infliximab patients eligible for switch to SC are currently being reviewed. 72 new starter IBD patients were identified for potential commencement of the new cost-effective adalimumab biosimilar via HC.

Conclusions Gastroenterology HCD prescriptions are now being processed safely via two main outpatient delivery models, both governed by robust contractual arrangements. Improved clinical monitoring has helped to reduce the risk of adverse events, thereby improving medication safety. These

simple initiatives also delivered prescribing cost efficiencies in excess of £400,000 ensuring best use of NHS resources.

PTH-52 PBC MANAGEMENT IN A RURAL SETTING. HOW DO WE COMPARE TO NATIONAL STANDARDS?

Stewart McDonald*, Eugene Campbell. *Western Health and Social Care Trust, Enniskillen, UK*

10.1136/gutjnl-2021-BSG.367

Introduction The South West Acute Hospital (SWAH) serves the most rural population in Northern Ireland. The British Society of Gastroenterology (BSG) updated guidelines on the treatment and management of Primary Biliary Cholangitis (PBC) in 2018.¹ We audited our PBC patients to assess management of patients with PBC, and identify areas for improvement.

Methods Patients were identified by searching PAS and the Northern Ireland Electronic Care Record (NIECR). ICD-10 code K74.3 was used - 'Chronic nonsuppurative destructive cholangitis' - as primary and secondary diagnosis. We audited the notes of all patients who had a diagnosis of PBC in our hospital catchment area within the last 10 years based on recommendations from the 2018 BSG PBC guidelines.

Results A total of 51 patients with PBC were identified. Mean age 66 [age range 31 to 92], 11 male and 40 female [78% F; 22% M].

Of our patients, 84% were on Ursodeoxycholic Acid (UDCA), but only 54% were on the correct dose of 13-15mg/kg/day of UDCA.

6 patients considered high risk on their LFT results has not been referred for second line therapy. 3 UDCA intolerant patients had not been referred for second line therapy.

98% (50/51) had had baseline TFTs checked; 51% (26/51) had had coeliac serology checked. Bone densitometry (DEXA scan) had been performed on 63% of our patients with PBC.

14 patients reviewed during our audit had passed away over the last 10 years. Of these 50% (7/14) had died of PBC or a liver related illness.

Conclusions The majority of patients were on UDCA, but not all were on the correct dose. Of concern were the high risk patients and UDCA-intolerant patients who had not been referred onwards for consideration of second line therapy and consideration of liver transplant. COVID19 lockdown certainly negatively influenced the optimal management of PBC patient over the last 12 months. To improve our care, we have instituted a PBC proforma, to be used during clinics and aim to streamline all PBC patients into one specialist clinic, rather than the current multi-clinic, multi-consultant set up. The recent addition of a Fibroscan service will also benefit patient management.

REFERENCE

1. Hirschfield GM, Dyson JK, Alexander GJM et al. 2018, *Gut*, e-publication, 2018, page0-27.

PTH-53 EVALUATING THE EFFECT OF COVID ON AN UPPER GI TWO WEEK WAIT PATHWAY

Amy Woods*, Sabina Beg, Anum Javed. *Imperial College Healthcare Nhs Trust, London, UK*

10.1136/gutjnl-2021-BSG.368

Introduction The covid-19 pandemic has necessitated a change in how healthcare provision is delivered. As such

there has been an almost instantaneous transition from face-to-face doctor-patient consultations to the use of tele-medicine. The aim of this study was to evaluate outcomes from referrals via the upper gastrointestinal two week wait pathway (UGI TWW) made by GPs using telephone assessment during the covid era.

Methods This was a retrospective database review of all patients referred via the UGI TWW pathway between 1st March 2019 - 28 Feb 2020 pre-covid (PC) and during the covid era (CE) during 1st March 2020 - 28 Feb 2021.

All referrals received by Imperial Healthcare trust were included in this study. The standardised referral proforma was reviewed to determine patient characteristics and symptoms. Investigations undertaken and subsequent diagnoses were recorded.

Results A total of 153 referrals were included in this study, 83 PC and 70 during CE.

GP consultations PC were conducted in over 95% of patients, compared to 16% in CE, where the remaining 84% were handled virtually or by telephone. PC the average age of patients referred was 66 (range 34-92) with a M:F ratio of 0.77:1, this compared to CE 60 which was a significant difference (p value = 0.025226) (range 19-86) with a M:F ratio of 0.79:1. Language based demographic data showed patients coded as having a non-english primary language made up 21.69% of the pre-covid cohort and 25.71% of patients in the covid era cohort.

When the outcomes of investigations were examined, we found that GI cancer was found in 4% PC compared to 13% CE. The diagnosis of benign pathologies was 86% PC compared to 41% CE (p value < 0.00001 which is significant), while no pathology was detected in 10% PC compared to 39% CE (p value = 0.000022 which is significant). 6% were unknown as these patients were either referred to their local hospitals or we lost follow up.

Abstract PTH-53 Figure 1 Breakdown of diagnosis

Conclusion GP telephone consultation for upper gastrointestinal symptoms results did not result in a change to the rate of cancer detection. It was however noted that a greater proportion of patients with no pathology underwent investigation.

PTH-54 AN AUDIT ON THE USE OF LARGE VOLUME PARACENTESIS CHECKLIST IN PATIENTS WITH CIRRHOSIS

Aye Myat Noe Khin*, Hsu Yadana, Wai Yan Htet Tin, Lin Lee Wong. Royal Devon And Exeter NHS Foundation Trust, Exeter, UK

10.1136/gutjnl-2021-BSG.369

Introduction Standardised procedure checklist for large volume paracentesis (LVP) has been shown to improve rates of documentation and reduce procedure related complications (Fyson et al; 2018). A modified LVP checklist from the British Society of Gastroenterology was implemented at Exeter Hospital in September 2019 as a patient-safety measure. An audit pre and post checklist was conducted to assess uptake and outcomes.

Methods 48 patients with ascites due to decompensated cirrhosis who had LVP were reviewed retrospectively through case note interrogation (24 pre- and 24 post-LVP checklist introduction). Malignant ascites was excluded. Patient demographics, procedure documentation and outcomes were collected. Data was analysed using SPSS. The chi-square test and Fisher's exact value were used to compare percentages between groups.

Results The patient characteristics in both groups are shown in Table 1. The majority of patients had alcohol-related cirrhosis (71% in both groups). About 2/3 cases in both groups were acute inpatient procedures. Documentation of informed consent using consent forms improved significantly from 8% pre-checklist to 63% ($p=0.0002$). Other areas of improvement included: procedural documentation of aseptic technique use (67% to 92%, $p=0.07$), instrument used (29% to 83%, $p<0.0001$) and drain removal at 6 hours (67% to 88%, $p=0.168$). Post-drain removal instructions documentation worsened from 54% (pre) to 42% (post). Documentation of fluid polymorph count only occurred in 3 (13%) pre- and 9 (38%) post-checklist ($p=0.093$). Complications within 24 hours were minor; hypotension and minor bleeding in pre- and abdominal pain in post-checklist group ($p=1.00$). No patients developed spontaneous bacterial peritonitis or died within 28 days. Overall mortality was 5 (21%) and 4 (17%) in the pre- and post-checklist group ($p=1.00$).

Conclusions The LVP checklist resulted in overall improvement in documentation with significant improvement of documenting procedural informed consent. The complication rate was

Abstract PTH-54 Table 1 Patient characteristics

Characteristics	Pre Checklist n=24	Post Checklist n=24
Male	20 (83%)	17 (71%)
Age (median, range)	61 (49-81) years	60 (39-87) years
Platelet (median, range)	152 (44-315) $\times 10^9/L$	157 (39-400) $\times 10^9/L$
INR (median, range)	1.3 (1.0-3.6)	1.3 (1.0-3.1)
Volume drained	7 (1.2 - 13.5) L	6.3 (1.7 - 15) L
20% HAS prescribed for every 3 Litres drained	21 (88%)	24 (100%)
	3 – missing fluid charts	