low with no mortality within 28-days. Post-drain removal instructions and documentation of ascitic fluid results require improvement. Increasing awareness on the importance of these sections in minimal standards of care amongst doctors and nurses will be the key factor in ensuring continual improvement in the quality of patient care.

PTH-55 **NEXT AVAILABLE PLEASE: REAL WORLD WAITING TIMES AND AVAILABILITY OF ENDOSCOPY FOR LOWER GASTROINTESTINAL BLEEDING**

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Introduction Current British Society of Gastroenterology (BSG) guidelines recommend all patients admitted to hospital with lower gastrointestinal bleeding (LGIB) undergo an inpatient colonoscopy on the next available list as part of providing a 7-day endoscopy service. The real-world availability of a 7-day service and adherence to this guidance is unknown.

Methods Patients aged ≥ 16 years admitted with LGIB to 7 hospital trusts from June 1st–Aug 31st 2019 were included. Data on presentation, endoscopy, time to procedure and outcomes were recorded. We established data from participating Trusts on their current endoscopy services in relation to BSG guidance.

Results 407 patients across 7 NHS Trusts presenting with LGIB were included. Mean age was 59.8 (17–96), with a mean Oakland score of 14.5 (SD 6.78). 14.7% received a LGI endoscopic investigation during admission (3.4% colonoscopy, 11.8% flexible sigmoidoscopy), with 25.7% of admitted patients undergoing their LGI endoscopy as an outpatient. Median time from admission to inpatient flexible sigmoidoscopy and colonoscopy was 2.5 days (58 hours) and >3 days (80 hours) respectively. 43% (3/7) of Trusts provided daily inpatient endoscopy lists able to accommodate inpatient colonoscopies, with colonoscopies being ad hoc/no regular slots in a further 43% of Trusts. At weekends, 86% (6/7) of hospitals provided endoscopy lists, however of these, 83% stated colonoscopies were not routinely performed at weekends.

Conclusions Current real-world practice is not in keeping with BSG guidelines. The majority of patients admitted with LGIB do not undergo inpatient LGI endoscopy (colonoscopy or flexible sigmoidoscopy) and the waiting time for a 'next available' slot can be several days. LGI endoscopic assessment for LGIB is more commonly performed as an outpatient. Most Trusts do not currently provide a 7-day endoscopy service, the majority with no regular weekend or weekday colonoscopy slots for patients with LGIB.

PTH-56 **ASSESSMENT OF HIGH-RISK RECTAL POLYPS : LESSONS FROM A SPECIALIST MDT**

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Introduction Recent guidelines have emphasised the importance of avoiding piecemeal resection of polyps that might contain malignancy. Moreover, superficial T1 cancers can be cured by local resection, avoiding the need for surgery. Evaluation of significant polyps and early colorectal cancers (SPECC) to determine the depth of invasion is of upmost importance. Assessment is difficult and no gold standard exists. In this study we evaluate the performance of our specialist MDT and, where sub-optimal assessment resulted in a poor outcome, we attempt to derive lessons that might be learnt.

Methods Referrals to the Specialist Early Rectal Cancer MDT were reviewed from Jan 2014 – Dec 2019. At the time of referral, they were categorised into: Confirmed early rectal cancers, referred for a primary treatment decision; inadvertently excised cancers, referred for possible adjuvant treatment and SPECC lesions, referred for a primary treatment decision. Each SPECC lesion was retrospectively split into 4 categories based on the MDT's risk of submucosal invasion: Low (category A), suitable for piecemeal resection; intermediate (B), suitable for en-bloc resection; high (C), suitable for TEMS and very high (D), not suitable for local excision. Where not explicit, an expert consensus was reached. Each assessment modality was compared to the MDT recommendation and final histological staging.

Results 581 referrals were made, 69 didn't meet referral criteria and 5 patients didn't engage or died before assessment. 57 patients were referred to consider adjuvant treatment for an inadvertently resected cancer. Of the remaining 450, 100 lesions were judged to be definite cancers and the remaining 350 were classed as SPECC lesions. Patients with SPECC lesions had a median age of 70 years, 2:1 male. The median and mean size of lesions was 38mm and 42.8mm respectively, range 10–150mm. Just over 20% of the lesions referred were larger than 60mm. Category A contained 174 lesions with a 4.8% cancer rate (CR). Cat B: 108 lesions, 8.3% CR. Cat C: 59 lesions, 54.2% CR. Cat D 9 lesions, 57.1% CR. 20% of the lesions reported as mucosal (or not seen) on MRI were malignant compared with 10% on EUS. 8 malignant lesions were assigned to the low-risk category and subjected to pEMR. Adequate EUS staging was only available in 4 of these lesions. 4 out of the 11 lesions referred for surgery were benign.

Conclusion 83% of malignant polyps were triaged to an *en-bloc* excision. The risk of malignancy reinforces the importance of evaluating SPECC lesions carefully. Exactly how the depth of invasion was predicted by the MDT is difficult to determine retrospectively. However, endoscopic evaluation, pre-resection dysplasia grade and EUS findings carry the greatest sway. MRI evaluation appears to be poor in predicting the depth of invasion for tumours $<T2$. Ila+Ilc morphology and high grade dysplasia were the two greatest predictors of malignancy, 44% and 35% respectively.

PTH-57 **COLLABORATION BETWEEN ACUTE MEDICAL AND HEPATOLOGY TEAM SIGNIFICANTLY IMPROVES OUTCOMES OF PATIENTS WITH DECOMPENSATED CIRRHOSIS**

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Abstract PTH-57 Figure 1

Introduction A quality improvement project was carried out at a district general hospital focusing on the clinical management of patients presenting with decompensated liver cirrhosis.

Method A project group was formed comprising of three hepatologists, an advanced nurse practitioner (ANP) in hepatology, two acute medical consultants and a nurse acting as liver champions on the medical admissions unit (MAU) and a member from care quality improvement team. Quality Improvement principles, like driver diagram, were employed to narrow down focused interventions which would improve outcomes. Four key interventions were made; a) Educational sessions delivered by the hepatology team to consultants, junior doctors, physician associates and nurses on MAU b) Training of carrying out ascitic taps and drains, delivered by the Hepatology ANP to acute medical team, doctors in training and allied health professions c) Implementation of the BSG-BASL cirrhosis care bundle d) Provision of Specialist review within 24 hour of patients admitted on MAU. A 18-month worth of electronic documentary review and analysis of patients' health records pre- and post- intervention was carried out.

Results The interventions were started in July 2020 and Statistical Process Control charts were utilised to analyse and evaluate statistical significance which shows an improvement in key indicators.

Conclusion We have demonstrated that engagement of the appropriate teams with targeted training and support at an intensive level can significantly improve the delivery of care for decompensated cirrhosis patients by non-specialist/emergency care teams. This has the potential to dramatically improve the outcome of these patients.

PTH-58 PARTNERSHIP OF SPECIALIST NURSE AND SPECIALIST PHARMACIST ROLES IMPROVES QUALITY OF CARE OF IBD PATIENTS

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Introduction The role of the specialist pharmacist has added value and clinical oversight to the care of IBD patients as treatment with biologic therapy has become more prevalent.^{1,2} Despite this, specialist pharmacists seldom run independent drug monitoring virtual outpatients' clinics or routinely participate in IBD MDTs.³

The Department of Gastroenterology at Barnsley Hospital, developed the twin roles of a

Specialist Gastroenterology Pharmacist and an IBD Specialist Nurse/Non-medical endoscopist in 2012 to augment IBD care.⁴ Both roles require accreditation for independent prescribing. The pharmacist has responsibility for therapeutic drug monitoring, the prescription of biologic treatment following induction and immunosuppressants, patient support and patient education. The nurse oversees the clinical and endoscopic surveillance of patients including the running of the IBD telephone helpline service. This study is a patient survey that evaluates the quality of care afforded to our IBD patients.

Method This study assessed all IBD patients on biologic treatment who attended our biologic infusion unit or were part of the Homecare biologic service. A Linkert scale questionnaire was developed, piloted and locally validated before being submitted electronically to patients via text messaging.

Results Seventy-two patients responded to the survey, response rate 51.4% (Female, n=43, 59.7%; Male, n=29, 40.3%). Patients recorded the number of times that they had contacted the IBD helpline in the last 12 months: 22.2% (n=16) did not require support; 47.2% (n=34) made contact between 1 and 3 times; 22.2% (n=16) made contact between 4 and 6 times. 76.4% (n= 55) found the IBD helpline 'extremely helpful' or 'very helpful'. 63.9% (n=46) acknowledged the effectiveness of the therapeutic drug monitoring. 71.2% (n=47) were 'very satisfied' or 'satisfied' with the virtual pharmacist-led outpatients' clinics. 82.9% (n=58) of patients concluded that the partnership between the specialist nurse and specialist pharmacist was 'extremely helpful' or 'very helpful' for their IBD care. The overall score of the combined specialist nurse and specialist pharmacist service was rated as excellent, 4.5/5.

Conclusion Robust clinical, biochemical and endoscopic surveillance is crucial for the delivery of effective treatments and