

REFERENCE

1. St.Clair Jones A, Meade U. UK IBD Standards: a roadmap to IBD pharmacy work-force transformation. BSG Campus 2021, Poster 223

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.

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PTH-25 IS THE QUALITY OF A COLONOSCOPY AFFECTED BY THE DAY OF THE WEEK?

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Introduction In 2016 the BSG and JAG published the 'key performance indicators and quality assurance standards for colonoscopy'. This includes a series of measures that can be used to assess endoscopy standards and ensure that there is a high level of practice. With a greater demand for colonoscopies and weekend lists, our study aimed to assess whether these standards are affected by the day of the week the exam is performed on.

Methods Data was collected for 494 patients between January 2019 and March 2019 using our electronic booking calendar and reporting software (EPR and Unisoft). Our four outcome measures were: caecal intubation, polyp detection and whether or not greater than 50mcg of Fentanyl or 2mg of Midazolam had been used for sedation. These are all standards included in the BSG/JAG guidance highlighted above. Our six independent variables were the days of the week that colonoscopy is currently performed on, Monday through to Saturday. The statistical analysis began with descriptive statistics, including a Chi-Squared test, followed by a multivariate logistic regression, all using the SPSS statistical programme.

Results In our Chi-squared analysis, Polyp detection ($p < 0.001$) and the amount of Midazolam given ($p < 0.001$) were not independent of the day of the week, whereas both caecal intubation and the amount of fentanyl given were. Following on from this, in the multivariate analysis, we have shown that you are significantly ($p < 0.05$) less likely to have a polyp detected on a Monday (adjusted OR = 0.44, 95% CI 0.21-0.89), Friday (0.31, 0.14-0.72) and Saturday (0.43, 0.21-0.88). You are significantly ($p < 0.01$) more likely to be given greater than 2mg of Midazolam on a Tuesday (adjusted OR = 3.13, CI 1.33-7.4), Friday (3.51, 1.37 - 9.02) and Saturday (4.03, 1.65 - 9.84).

Conclusions Our results suggest that caecal intubation rate is consistent irrespective of the day of the week, however, other colonoscopy standards are affected. We have shown that you are less likely to have a polyp detected and more likely to be given greater amounts of Midazolam on some days compared to others. For both groups Friday and Saturday were the most strongly associated with a poor outcome, suggesting that there may be a 'weekend effect' in colonoscopy standards. Two limitations of the study are that we cannot account of individual performance and there may be other variables such as training lists which are not accounted for; this provides opportunity for further research.

This study highlights discrepancies in patient care that can hopefully be addressed through education and cultural change. Understanding that the day of the week can affect the quality of colonoscopies is very important, especially as we aim to increase the weekend workload and move towards a 7-day NHS.

PTH-26 AUDITING TARGET UPPER GI REFERRALS – UTILISING A DEDICATED UPPER GI CLINICAL NURSE SPECIALIST TRIAGE

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Introduction Target referrals for suspected Upper Gastrointestinal (UGI) cancer constitute a large proportion of any Gastroenterology service workload – and failure to refer via the correct pathway can prove costly in terms of both time and money. As Gastroenterology is an interventional specialty, formulating a robust management plan often necessitates investigations. Straightforward patients may be investigated via 'Straight to Test' (STT) pathways (through endoscopic assessment or imaging), following which it is decided if an outpatient clinic appointment (OPA) is needed. Complex or comorbid patients require clinic assessment first.

Here, we sought to establish the benefit of utilising a dedicated UGI cancer Clinical Nurse Specialist (CNS) to triage target UGI referrals.

Methods Using Electronic Patient Records (EPR), we collated data for all target referrals to Barnet and Chase Farm Hospitals (BCFH) during a 1-month period (February 2019); each was triaged by a Gastroenterology consultant, who assigned patients to receive an OPA or undergo STT assessment. We then asked our UGI CNS to state, for each patient, what they would have done (i.e. request an OPA or arrange STT assessment). This was blinded – our CNS was unaware which option the triage consultant had chosen. We then recorded – regardless of whether our CNS and the consultant had agreed with regards to OPA vs STT assessment – whether or not the investigations eventually requested via OPA were nonetheless in keeping with the STT investigations our CNS suggested.

Results During February 2019, there were 164 target referrals to BCFH, 8 of which were later withdrawn (3 were also referred to, and instead seen by, the Lower GI service; 2 were seen in different trusts; 1 was instead seen by ENT; 1 was rejected; 1 did not attend an OPA).

Of 156 referrals analysed, our UGI CNS agreed with the triage consultant's choice of OPA vs STT investigation in 63.5% ($n = 99$).

We also assessed whether our CNS agreed with the consultant's choice of investigations (whether requested via an OPA or the STT pathway). Here, we excluded a further 8 cases due to lack of available data. Of 148 referrals included in this subsequent analysis, there was 93.9% ($n = 139$) agreement as regards the investigations chosen by our CNS and the triage consultant.

Conclusions Whilst our UGI CNS agreed with the consultant selection of OPA vs STT investigation in only 63.5% of cases, they ultimately selected the same investigations in 93.9% of cases. This corroborates the notion that often, an OPA is unnecessary prior to investigation, and may not be required at all. These findings strongly support having a dedicated UGI CNS to triage target referrals. Benefits include streamlining of the process, faster outcomes for patients, monetary savings, and reduced demand for OPA slots.