P394 BENEFITS OF A VBIC TO BOTH PATIENTS AND THE LOCAL HEALTH ECONOMY

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Introduction Virtual Biologics and Immunosuppressives Clinics (VBICs) assess inflammatory bowel disease (IBD) patients who are on biologics with a view to optimising treatments whilst also delivering cost savings through the withdrawal of high cost drugs. Darent Valley Hospital(DVH) is a district general hospital without an IBD Nurse. A VBIC was set up for the 1st time in July 2019 to assess the 112 patients on infliximab (IFX) to reassess patients' treatment regularly but also with a view to demonstrating how an IBD nurse could be utilised to deliver cost savings.

Methods Patients were assessed in VBIC by 2 IBD consultants, a pharmacy technician and an IBD administrator and categorised into 5 groups based on their recent investigations: to continue biologics, to reassess before offering withdrawal, to switch, to dose-escalate, or dose de-escalate. Letters were written to the patients' consultant advising next management.

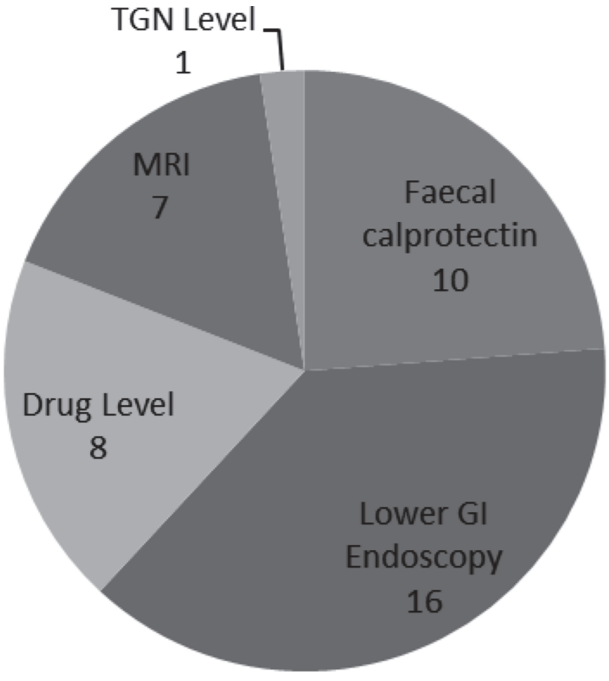
Patients were analysed for: the group that they were assigned to, whether next management was performed and the number of patients offered withdrawal. Potential cost savings were estimated on the assumption that patients in the 'reassess before offering withdrawal' category, were likely to be in remission and would agree to withdraw. Costs were based on the price of IFX being £120/100 mg vial.

Results 63 patients were analysed (62% male, 59% with Crohn's, 41% on concomitant therapy, 13% had previous loss of response to adalimumab). The mean duration patients had been on IFX was 40 months (SD 32, range 1–140 months) and the mean time to their last disease assessment was 19 months (SD 15, range 1–69 months) of whom 33% were in remission at that time.

Of the 40 (63%) patients in the 'reassess before offering withdrawal' category only 11 had all the investigations proposed by VBIC performed (see figure 1); only 5(8%) patients were withdrawn. If all patients in this category had been withdrawn, the savings would have been £162,480 in the 1st year and £324,960 in the 2nd year.

Of the remaining 23 patients analysed, 3 were switched biologic, 5 were dose-escalated, 1 was de-escalated and 14 continued at their current dose. Overall, 19% of all the patients had subtherapeutic drug levels.

Conclusions Before VBIC, a significant proportion of our patients had neither been reassessed regularly, nor offered withdrawn when in remission. However, although our VBIC was able to optimise therapy for some patients, it was unable to deliver the predicted cost savings. The reason for this was that it relied on the consultant in charge of the patient's care performing the next management step; an issue that having an IBD nurse would resolve.



Abstract P394 Figure 1 How patients in the reassess before offering withdrawal category were due to be reassessed

Education and training

P395 UTILISING A DAY-CASE PARACENTESIS UNIT TO DEVELOP A NEAR-PEER TRAINING PROGRAMME FOR JUNIOR DOCTORS

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Introduction Junior doctors traditionally lack confidence in performing diagnostic paracentesis on the medical take. This project explores a near-peer training programme in diagnostic paracentesis, with an aim to improve junior doctors' confidence and subsequent adherence to the national liver care bundle (British Association for the Study of the Liver). It also explores the safety of near-peer training in large volume paracentesis in a day case setting within the gastroenterology team.

Methods A training programme was developed, in which junior doctors interested in learning diagnostic paracentesis were enrolled via email and posters. Training was delivered by four gastroenterology junior doctors, with the consent of patients attending for elective large-volume paracentesis. Trainee survey and clinical audits were used to assess effectiveness and safety of this programme.

Results Feedback showed significant improvement in trainees' confidence in performing the skill. The controlled environment of a day-case setting and interaction with real patients contributed to all trainees finding the setting highly suitable for procedure training. Core trainees also noted that this programme saved them a significant amount of time seeking training opportunities ad-hoc. Re-audit of the liver care bundle showed improvement in the rates of diagnostic paracentesis being performed within 24 hours of admission, from 57.9% to 65.5%. Over a twelve-month period, gastroenterology junior doctors performed 109 large volume paracenteses. Detailed study of 57 of these cases showed no complications requiring hospital admission.

Conclusion Whilst there may be trends in moving paracentesis towards a specialist nurse-led service with ultrasound guidance, this training programme shows near-peer junior doctor

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