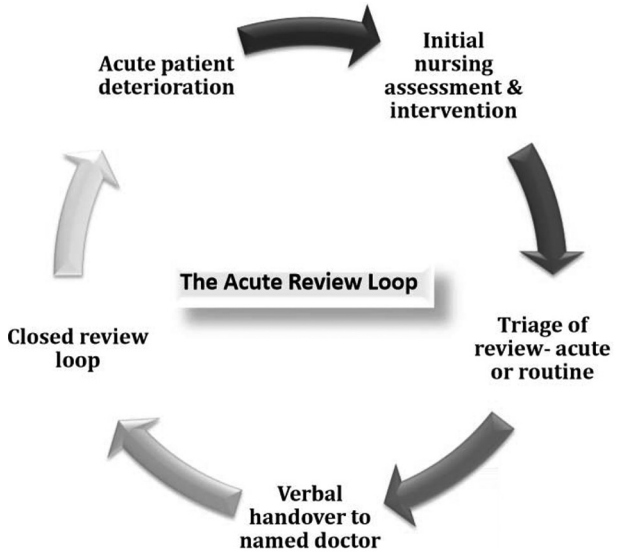

Abstract 104 Figure 1 The acute review loop

Results After analysing the preliminary data, we requested that the Hospital-at-day-team call F1 doctors with acute reviews, reverting to text only if unable to reach the F1. We trialled this intervention for 3 weeks and improved verbal handovers of acute reviews from 5.6% (1/18 verbal) to 71% (22/31 verbal). This ensured a closed acute review loop could be created in 71% of cases. We define a closed acute review loop as a system in which a named doctor is aware of an acutely unwell patient (figure 1).

Conclusions Due to our intervention, a named F1 was made aware acutely unwell patient within a short, known period, and thus could arrive in a timelier fashion ultimately improving patient care efficiency and safety. During this trial, we found that incomplete verbal SBARs were given to F1s, and routine reviews were inappropriately sent out as acute reviews.

The Out of hours taskforce at the hospital trialled a weekend of clinical staff giving advice to nurses and HCAs requesting acute reviews to facilitate the initiation of nursing level interventions at an earlier stage in the acute review process; they also gave the F1 doctor a verbal handover of acute reviews. We are working with the clinical site managers to triage reviews, ensure continuity of verbal handovers.

105 WHY TRANS HEALTH MATTERS IN GENERAL PRACTICE

Kamilla Kamaruddin. *GP principal, East One Health Surgery,London*

10.1136/leader-2019-FMLM.105

I am a transgender GP and I would like to share my experience as a transgender GP and a patient to highlight the difficulties that a trans person negotiating their health care through the NHS. My journey has not been straight forward but eventually it was fulfilling and I hope my story will raise trans awareness about gender identity, improving care for trans people and inclusivity. As a trans GP, transgender issues have been close to my heart, but it seems that they have only recently risen to prominence across the society - as well as in the press, sometimes for the better, and sometimes for the worse I will present two articles which was published to highlight trans health.

1. What's it like to be a transgender patient and a GP. 313.BJGP, July 2017
2. Why Trans Care Matters. RCGP Bulletin Spring 2019

I am grateful to this country and the NHS for giving me the opportunity and protection to be what I am. I am from a vulnerable group ; a trans person, an immigrant and people of colour and I am very lucky to work in an institution like the NHS, who welcomes everyone who is willing to work hard irrespective of their gender, race and sexual orientation.

106 DEVELOPING A HIGH QUALITY BARRETT'S OESOPHAGUS SURVEILLANCE PROGRAM OUTSIDE A TERTIARY CENTRE

Lovesh Dyall, Georgina Chadwick. *West Middlesex University Hospital, Chelsea and Westminster NHS Foundation Trust, UK*

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Introduction The importance of early recognition of dysplasia within a segment of Barrett's oesophagus (BO) is well recognised, due to the risk of progression to oesophageal cancer. National guidelines on endoscopic surveillance are published in Gut 2014.

Method A retrospective audit of endoscopies for all patients with BO between January and November 2018 was conducted.

Data collected included the number of endoscopists involved, patient characteristics, and adherence to the Prague and Seattle biopsy protocol. The histology data was extracted from the pathology reporting system and follow up was checked using endoscopy reports and clinic letters.

Results 136 cases of BO were identified by 17 different endoscopists. 47% had known a diagnosis of BO, and the remaining patients had a new diagnosis. 88% cases were reported using Prague Classification. The Seattle biopsy protocol was adhered to in 82 66% cases.

Only 2/8 cases of dysplasia were confirmed by a second independent pathologist. The BSG guidance states that all cases must be reviewed by a second pathologist.

The plan for follow up varied: 47% outpatient clinic, 25% virtual clinic, 5% GP, 4% MDT and 19% unclear.

Conclusions This audit highlighted the need for a structured surveillance program for detection and management of dysplasia in patients with BO.

Key issues highlighted were large number of endoscopists involved and lack of a standard approach to tissue sampling, reporting and follow up. Booking of surveillance was variable and inadequate. Patients were also unnecessarily being booked into clinics- suggesting that resources were not being used the most effectively.

Results were presented at a local department meeting and the following changes agreed;

1. Introduction of regular BO surveillance lists by a dedicated endoscopist to standardise reporting, improve on dysplasia detection.
2. Follow up with initial clinic appointment to discuss diagnosis and surveillance, thereafter via virtual clinic.