

nature of incident. Trained QA assessors and mentors are required to provide detailed observation of performance in the context of colonoscopist's usual working environment, using validated DOPS methodology (incorporating discussion around decision-making). The final step involves the colonoscopist agreeing a tailored training plan based on feedback from BSW QA advisors, assessors and mentors. This states 1) the nature of the concerns identified; 2) specific goals to be achieved; 3) timetabling and 4) tools to be employed to measure progress. Where there is serious concern for participant safety the BSW Colonoscopy Panel may consider suspension pending appropriate investigation and training. The outcome of training will be reviewed by this Panel to determine ongoing suitability to perform as a screening colonoscopist.

Conclusion A pragmatic Performance Management Framework for BSW Colonoscopists has been developed. It seeks to provide a safe and supportive environment for both patients and colonoscopists respectively undergoing and performing complex therapeutic interventions, aiming to provide early identification of problems through central data analysis and specific, targeted training interventions where required.

Disclosure of Interest None Declared.

PWE-051 BOWELSCOPE: EARLY RESULTS FROM THE PILOT SITES

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Introduction UK population colorectal cancer (CRC) screening has been successfully implemented with Bowel Cancer Screening Programme (BCSP) faecal occult blood testing biannually from age 60–75.

A large UK study of once-only flexible sigmoidoscopy (FSIG) demonstrated a reductions in CRC incidence of 33% and death rates of 43% (1). This, with the screening centre infrastructure developed for the FOB programme, allowed provision of a new arm of BCSP, offering FSIG to 55 year olds in England, known as BowelScope screening.

BowelScope screening began May 2013, with 6 pilot sites performing FSIGs in the first 7 months.

Methods We aim to describe procedural data from the early months of BowelScope screening.

Data were obtained from The Bowel Cancer Screening System (BCSS) database for all participants invited and participating

in BowelScope FSIGs May-Dec 2013. Procedural data were recorded, including insertion depth, FSIG length, adenoma detection rates (ADR), cancer detection, discomfort levels, entonox usage and colonoscopy conversion rates.

Results 13927 people were invited or opted in to BowelScope screening at 6 centres. Overall uptake is 43.5% (range 37.0–51.9%). 4 cancers were detected. Polyps were detected in 16.4–23.8% of FSIGs (mean 20.7%). Mean ADR 8.4%. One centre has a significantly higher ADR than the other five sites ($p < 0.05$) (see Table 1).

Most (53%) procedures took 6–10 min.

79% of procedures were reported as causing no or minimal pain only, with only 34 procedures (1%) reporting severe pain.

Conclusion Uptake has varied between centres, but is lower than for the FOB arm of BCSP. Average ADR is 8.4% (range 6.1–12.1%), lower than in the UK flexible sigmoidoscopy screening trial (12.1%¹) although the age range studied in the trial differs from the cohort described here.

Further work will be required to investigate the variation in uptake rates and to improve these rates. ADR variations may also need to be addressed; further analysis of patient groups may explain these differences.

REFERENCE

1 Atkin *et al.* *Lancet* 2010;375:1624–1633

Disclosure of Interest None Declared.

PWE-052 BOWELSCOPE SCREENING – THE SOUTH OF TYNE AND WEAR EXPERIENCE

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Introduction The National Bowel Cancer Screening Programme has been extended to include a one-off flexible sigmoidoscopy (FSIG) to all aged 55, after a large UK study demonstrated reduction in colorectal cancer incidence and death rates when FSIG is performed and adenomas removed.

BowelScope screening is being piloted in 6 centres – South of Tyne and Wear (SOTW), Norwich, St Mark's, Surrey, Kent and Medway, and Wolverhampton. SOTW was the first centre to offer screening.

Methods We describe delivery of BowelScope at SOTW.

The Bowel Cancer Screening System (BCSS) database was interrogated for procedural data. A study was performed recording timings of lists. Patients complete a satisfaction survey the morning after the procedure; anonymised results are provided to the centre.

Abstract PWE-051 Table 1 Outcomes by anonymised centre

Screening centre	Invitees*	Attended*	Uptake [†] %	FSIG with adenomas	ADR%	Cancer	Colonoscopy required (%)
1	3125	1128	(51.9)	100	8.9%	1	39 (3.5)
2	1866	524	37.0	64	12.1%	0	23 (4.4)
3	3779	1070	40.9	90	8.4%	0	50 (4.7)
4	986	311	46.6	25	8.0%	0	12 (3.9)
5	1970	625	47.4	38	6.1%	2	21 (3.4)
6	2181	479	37.2	30	6.2%	1	18 (3.8)
Total	13927	4135	43.5	347	8.4%	4	163 (3.9)

*as of 20.12.13.

[†]Uptake is calculated from invitees invited ≥ 16 weeks before 20.12.13 to allow time to respond to invitations and attend for screening.

Abstract PWE-052 Table 1

Invitees	1866
Attended	524
Uptake*	37.0%
FSIGs with adenomas (adenoma detection rate,%)	64 (12.2)
Colonoscopy required (%)	23 (4.4)
Extent (%) [†]	
Transverse	351 (67.0)
Descending	130 (24.8)
Sigmoid	34 (6.5)
Rectum	4 (0.8)
Entonox (%)	94 (17.9)

*Uptake calculated from those invited ≥ 16 weeks before 20.12.13 to allow response to invitation and attendance.
[†]missing data in 5.

Results 2 endoscopists were accredited in March 2013– 1 medical research fellow, and 1 staff grade surgeon. 2 existing BCSP colonoscopists also support the BowelScope lists as required.

First invitations were sent from the Northern Hub on 21.03.13, and first screening list held on 07.05.13.

Lists are held on Tuesday and Thursday evenings, recently increasing to include Saturday lists. Lists initially had 12 slots available, but were reduced to 10 in light of over-running lists. Average list length 229 min (11/12 points) vs 199 min (≤ 10 points).

248 FSIGs were completed in ≤ 110 min, 172 in 11–15 min, and 88 in > 115 min (data missing in 7).

Comfort was recorded by SSPs as none/minimal/mild discomfort in 484 cases, and moderate/severe in 35. Entonox was used by 94 screenees. Patient surveys showed patient reported moderate/severe pain in 44%.

Failure to attend– 52 (9%).

As of 20.12.2013:

Conclusion We demonstrate that BowelScope screening can be adequately delivered by existing screening centres. Adjustments may need to be made to list templates in order to ensure minimal waiting for patients. Uptake is less than for the FOB programme but is higher than in early pilots. Some slots are wasted with the 9% FTA rate; a new text messaging reminder service has been developed to address this. Patient reported pain levels are higher than those recorded by the SSPs, highlighting a need for accurate assessment of patient experience.

Disclosure of Interest None Declared.

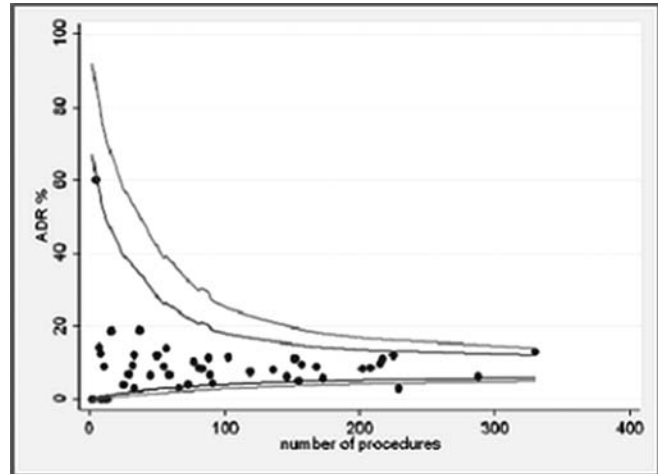
PWE-053 VARIATION IN ADENOMA DETECTION RATE IN BOWELSCOPE SCREENING

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Abstract PWE-053 Table 1 ADR by centre and volume

	Centre 1	Centre 2	Centre 3	Centre 4	Centre 5	Centre 6	All centres	
Endoscopist procedure counts	ADR%	ADR%	ADR%	ADR%	ADR%	ADR%	ADR%	ADR range%
All	8.8	11.7	8.9	7.6	6.5	7.3	8.6	0.0–60.0
≥ 50	8.9	11.3	8.1	8.6	6.4	6.4	8.6	3.1–14.0
≥ 100	9.0	11.3	8.9	8.6	3.1	5.2	8.7	3.1–13.0



Abstract PWE-053 Figure 1

Introduction The English Bowel Cancer Screening Programme has been expanded to include a one-off flexible sigmoidoscopy offered to all 55 year olds, called BowelScope Screening. Screening commenced in May 2013, with 6 pilot sites performing flexible sigmoidoscopies in the first 8 months of screening.

Methods The NHS Bowel Cancer Screening System database was interrogated and ADRs reviewed for each screening centre and screening endoscopist. A funnel plot was constructed using the log odds method.

Results 49 endoscopists have performed 4444 sigmoidoscopies at 6 screening centres. Endoscopists had performed 2–330 procedures (median 66, mean 91), 29 endoscopists had performed ≥ 50 procedures, of these, 17 had performed ≥ 100 procedures. Overall BowelScope ADR is 8.6%. ADR by centre is shown in Table 1.

Centre 2 has a higher ADR than the other centres. When considering all procedures, this difference reaches statistical significance when compared to centres 3, 5, and 6 ($p < 0.05$), and approaches significance when compared to centre 1 ($p = 0.0687$) and centre 4 ($p = 0.0548$). When considering procedures done by endoscopists who have performed ≥ 50 or ≥ 100 sigmoidoscopies, there remains a significant difference ($p < 0.05$) between centre 2 compared to centres 5 and 6, but not to the other centres. Creating a funnel plot of individual endoscopist ADRs, demonstrates one endoscopist below the 99.8% control limit (Figure 1).

Conclusion Adenoma detection rates within BowelScope screening show variation between centres. There is also variation between endoscopists in terms of individual ADRs, although all but 1 endoscopist are above the 99.8% lower control level on funnel plot. These variations require further exploration at both centre and individual level; feedback and education methods will be used to improve ADRs. Consideration should be given to establishing an ADR standard.

Disclosure of Interest None Declared.