The CotW, for 2 weeks (prospectively covered), is responsible for daily DDU WRs of all 20 patients under their care, review of IP referrals, inreach into urgent care wards, and support of GTA. There is minimal outpatient (OP) commitment (no endoscopy lists or OP clinics). Outcomes were analysed at 12 months to assess the impact on patient care.

Methods A retrospective observational study was conducted to benchmark and evaluate changes in consultant led care. Patients were identified through electronic records. Data was collected from electronic discharge letters and paper notes. Statistical analysis was performed using Microsoft Excel.

Results

	DCW	DDU	Delta	P value
Median Length of stay (hours)	141	104	"37, 26.2%	< 0.01
Discharges per week	22.8	21.1	"1.7, 7.5%	
Discharges per week per bed	0.79	1.06	"0.27, 34.2%	< 0.01
Consultant reviews per week	0.63	1.16	"0.53, 84.1%	< 0.01

GTA treating >90 patients & generating > £35K each month.

Gastroenterology IP services SAFER compliant.

Conclusion The reconfiguration of Gastroenterology IP services has been a great success. A reduction in bed base (which many at management level were reticent about) has facilitated a CotW model of care to be implemented. The IP service is now SAFER compliant. Length of stay has significantly reduced by 26.2%. Weekly discharges per bed, and Consultant reviews, has significantly increased by 34.2% & 84.1% respectively. In addition, GTA treats >90 patients per month, generating income, preventing admissions, facilitating earlier discharges, and freeing capacity in the main hospital ambulatory unit.

This reconfiguration shows that a CotW model of care is optimal, successful, and SAFER compliant, even if a bed base reduction is required to facilitate this.

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PTU-076 MYENDOSCOPY.CO.UK, AN ONLINE RESOURCE FOR PATIENTS UNDERGOING ENDOSCOPY

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Introduction Prior to an endoscopy procedure, consent has to be sought from the patient. For consent to be valid, it must be voluntary, informed, and the person consenting must have the capacity to make the decision. The BSG *Guideline for obtaining valid consent for gastrointestinal endoscopy procedures*, recommends; "written information should be provided in advance of the procedure with sufficient time for the patient to read, evaluate and seek further information if required".¹

The General Medical Council's consent guidance states: "Before accepting a patient's consent, you must consider whether they have been given the information they want or need, and how well they understand the details and implications of what is proposed."²

To meet these regulatory requirements, endoscopy units give information to patients via printed leaflets, to outline; what to expect, what is involved, what preparation is required, and the benefits & risks. This gives sufficient information for a patient to give informed consent.

Information provided via an online platform would also meet regulatory requirements and may be preferred by many patients. An internet search shows that there is an NHS web resource for endoscopy which provides basic information, with limited media (a few images, no videos).³ Images and videos of endoscopy procedures are abundant online but there is limited resources for patients that combines the detail of a pre-procedure information leaflet, with illustrative media.

Methods Using the current printed information resources for patients used at Kettering General Hospital (KGH), this information was transferred onto a webpage, and was illustrated with media taken from KGH's endoscopy unit.

Results In February 2019, a website was published: www.myEndoscopy.co.uk

This website has a generic web address, minimal KGH branding, and is designed to be used by *any* patient undergoing a Gastroscopy, Sigmoidoscopy, or Colonoscopy (not just for KGH patients). It is accessible on PCs, laptops, tablets, and smartphones. The website has been promoted as a resource via direct email to colleagues across the UK, and via Social Media.

Conclusion This web resource is a big step forward in providing information to patients prior to having an endoscopic procedure. It has been designed to use generically by any patient irrespective of which hospital they are having their procedure. It has built in features to allow users to rate the website with comments so that we can evolve the content to meet the patient's needs. Over time, we will add more media, and information on ERCP, and capsule endoscopy.

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PTU-077 FIT-HB PATHWAY FOR PRIMARY CARE IN HEREFORDSHIRE: THE FIRST 6 MONTHS

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Introduction NICE guidance recommended FIT-Hb for routine use in Primary Care to "guide referral of symptomatic patients with LGI symptoms in absence of LGI red flag symptoms (NICE NG12/DG30)

FIT-Hb offers a negative predictive value $\geq 99\%$ for the exclusion of Colorectal Cancer and High Risk Polyps

BCSP age-extension is anticipated to increase LGI endoscopy demand by 8–00%. FIT-Hb testing may reduce unnecessary investigations

A primary care FIT-Hb diagnostic pathway has recently been launched in Herefordshire. We present the first 6 month data

Patients with unexplained LGI symptoms who do not meet the criteria for a suspected LGI cancer pathway triaged using FIT-Hb pathway and proforma request form

Indication for FIT-Hb (inclusion criteria)

1- Aged ≥ 50 yrs with:

- Change in Bowel Habit OR
- Unexplained Abdominal pain OR
- Unexplained Weight loss alone OR

2- Aged ≥ 60 yrs with:

- Anaemia (without iron deficiency)

FIT cut-off (Alpha-Labs):

POSITIVE ≥ 10 μg Hb/g faeces = Referral via 2WW Pathway

NEGATIVE < 10 μg Hb/g faeces = Consider URGENT Gastroenterology referral if clinical concerns/persistent symptoms

Methods Prospective data collection (July to December 2018).

Data collected from FIT request forms, endoscopy, pathology, radiology system and clinic correspondence.

Data collected on demographics, indication and adherence to inclusion criteria, result and clinical outcome.

Results 13 GP practices enrolled in pilot.

97 patients underwent FIT-Hb testing (87% had complete data).

All patients were ≥ 50 years (average 70y, 33% male).

Inclusion criteria were met in all patients, change in bowel habit (51%), unexplained abdominal pain (39%), 16% ≥ 1 indication.

FIT-Hb positive in 20 patients (24%, range 1–93 $\mu\text{gHb/g}$). All patients were referred for 2WW GI investigation, 75% colonoscopy, 20% CT-Colonography, 5% no investigation to date.

Diagnostic outcomes: Colorectal cancer (2), colonic polyps (3, all low risk polyps), diverticular disease (2), colitis (1)

Despite a negative FIT-Hb result, 2 patients (4%) ultimately had colonoscopy (1 low risk polyp detected).

No FIT-Hb-negative patients diagnosed with LGI malignancies during the limited follow-up period ($\sim$ months).

Conclusions Assuming all FIT-Hb tested patients would have been referred to secondary care for lower GI investigation, the data suggests 72% reduction in outpatient referral and colonoscopy/CTC. No CRC diagnoses were missed by a negative FIT-Hb during the limited follow-up period.

Direct verbal feedback suggests the enrolled GP practices have confidence in the pathway. Prospective data collection continues, but based on the limited pilot data and recent NICE recommendation, a FIT-Hb pathway has been formally commissioned by the Herefordshire CCG.

PTU-078 DOES COMPLEX POLYPS MULTI-DISCIPLINARY TEAM CHANGE PATIENTS' OUTCOME? DISTRICT GENERAL HOSPITAL EXPERIENCE

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Introduction The management of advanced non-cancerous GI polyps can be challenging. Data on the impact of complex polyps Multi-disciplinary Team (ComP MDT) is lacking. Our aim is to evaluate the outcomes of ComP MDT in our hospital.

Methods ComP MDT was established in Barnsley Hospital in April 2018 & held monthly. Data prospectively collected (Apr2018-Jan2019). ComP MDT team included advanced endoscopists, gastroenterologists and colorectal surgeon. All referrals were received internally with an initial plan. The outcome is approved after discussing each case to reach a consensus.

Results 53 cases discussed in 10 meetings. There were 29 males vs 24 females with a mean age of 68.1 years. 46/53 (87%) were colonic polyps (CP) compared to 7/53 (13%) upper GI polyps (UGIP). The most common indications for referring CP were: multiple polyps ranged from $\sim$ 0 polyps (33%), polyp size ranged 2–0mm (20%), morphology; flat & uncertain pit pattern (20%), difficult colonoscopy; long, loopy & fixed colons (15%) & difficult location (22%). CP were situated mainly in the rectosigmoid 19/46 (41%) vs 17/46 (37%) in the right colon (caecum & ascending colon).

ComP MDT agreement with initial endoscopist lesion assessment was observed in 41/53 (78%). However, changes to proposed resection plan were recommended in 21/53 (40%). The range of SMSA score for CP was -4 . 26/46 (57%) were level – polyps. Endoscopic mucosal resection (EMR) was approved and achieved in 25/46 (54%). Only one patient had complication with mild postpolypectomy bleeding that was managed conservatively as an inpatient. 6/46 (13%) were referred directly for surgical resection, 3/46 (7%) referred to tertiary centre, 7/46 (15%) were not fit for resection & 5/46 (11%) are awaiting EMR. Recommendations for type of bowel preparation, time dedicated to EMR, type of colonoscope & operating endoscopist were also advised.

Out of all CP reviewed at ComP MDT, two found to be cancerous polyps, one successfully removed surgically (confirmed adenocarcinoma) & the other managed conservatively.

Polyp type uncertainty was the reason for referring UGIP (5 gastric & 2 duodenal polyps). One gastric polyp resected successfully, three proven hyperplastic histologically & one referred for endoscopic ultrasonography. One duodenal polyp was resected & one directed to cancer pathway.

Conclusion ComP MDT changes the patients' outcome in a significant number of referrals by directing patients to the appropriate intervention. Safe & successful resection of all advanced polyps which deemed resectable on ComP MDT was achieved. ComP MDT was able to pick up some cancerous lesions that were initially misdiagnosed as benign polyps.

PTU-079 ASSESSING GLUTEN FREE DIET ADHERENCE USING CDAT AND BIAGI QUESTIONNAIRES IN PATIENTS WITH COELIAC DISEASE

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Introduction The gold standard currently for assessing adherence in individuals with coeliac disease is via duodenal biopsies, which is invasive and costly. In view of this, we assessed the utility of the CDAT and Biagi questionnaires for non-invasive assessment of gluten free adherence.

Methods Patients with an established diagnosis of coeliac disease, referred for further evaluation of dietary adherence and disease remission were assessed between January 2016 to December 2018. Patients were prospectively recruited, and