achieved through dedicated lists, and regular audits. Including summary of the guidelines in endoscopists' induction might also improve new BO diagnosis.

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PTU-107 VIDEO OUTPATIENT SERVICES: CAN PATIENT CHOICE IN HOW TO ATTEND BE A SUCCESS?

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Introduction Recent technological advancements have created the opportunity to radically transform how outpatient services are delivered. Citizens with chronic relapsing/remitting disease such as Inflammatory Bowel Disease (IBD) are often required to attend regular follow up clinic appointments with the associated travel and time off work creating considerable effects on carbon emissions and the wider economy.

Methods As part of a wider program of work to establish a patient focussed outpatient service a pilot study was instigated where all patients were offered the option of attending their IBD appointment using a video clinic platform (Attend Anywhere®). This abstract describes the evaluation phase of patient initiated video appointments from patient and clinician viewpoints. The uptake of video appointments was recorded from the Patient Administration System along with demographics of the tele-medicine (video) and anchi-medicine (traditional clinic) groups. Patient perspectives were captured by an online questionnaire presented to them on concluding the video appointment and clinician perspective was captured with the clinic documentation.

Results During the 7 month study period 194 (12%) opted for a video appointment of which 85 (41%) completed the patient questionnaire. There were no significant differences in demographics or proportion of did not attend (DNA) appointments between the groups. However, 77% of the video group were noted to have minimal symptoms. In the patient questionnaire, 85 (100%) indicated they would use video again, 80 (94%) found it more convenient than attending the hospital and 54 (64%) indicated they had not had to take time off work. The average travel saved was 117 miles per appointment. However, 33% experienced technical issues during the consultation.

The clinician data indicated that 80% of the video consultations had been entirely successful with the majority of unsuccessful video consultations being completed by telephone. Two patients required a further anchi-medicine appointment for examination and three required to attend for blood tests only available at the clinic.

Conclusions In line with the increasing use of technology in our society, this study has indicated that the patient can successfully make the choice of how to attend the clinic with little, if any, impact on the wider clinic service. However, such changes must be planned and prepared for so that other clinic

processes such as booking and blood investigations procedures can be accommodated in the new clinic model. As with all technology adoption there is a curve of uptake, as the technology underpinning video clinics becomes mainstream it is anticipated that video will become an increasingly popular method of outpatient review technology with patients and clinicians.

PTU-108 PROSPECTIVE COHORT TO IDENTIFY FACTORS ASSOCIATED WITH DIAGNOSTIC DELAY IN PATIENTS WITH INFLAMMATORY BOWEL DISEASE

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Background International cohort studies have previously identified Crohn's disease (CD), ileal disease, smoking, and age (<40 years old) as factors associated with a delay in diagnosis of patients with inflammatory bowel disease (IBD). Currently, there is a paucity of data looking at the factors influencing diagnostic delay specific to a UK population, where healthcare system is free at point-of-access. Hence, we conducted a prospective observational cohort study of patients referred to secondary care between January 2014 to December 2017.

Methods In total, 163 patients between the age of 18 and 46 years who first presented to their general practitioner (GP) with gastrointestinal symptoms from January 2014 were included in this study. Patients above the age of 46 were excluded due to the increased risk of colorectal cancer with increasing age. This was also the upper age limit recommended for faecal calprotectin use in the investigation of suspected IBD. In addition to baseline demographic data, our main outcome measure was time to overall diagnosis including time from onset of symptoms to GP presentation (patient delay), time of GP presentation to referral (primary care delay), and time of referral to diagnosis (secondary care delay).

Results The median time to diagnosis was 6.7 months [IQR 3.3–14.1], with no significant difference in time to diagnosis for IBD sub-types [CD, 9.8 months [IQR 5.5–18.5]; IBD-Unclassified, 7.0 months [IQR 4.5–8.5] and ulcerative colitis (UC), 5.2 months [IQR 2.9–12.3] ($p = 0.56$)]. The median time it took patients to present to their GP was 3.0 months [IQR 1.4–6.0]; median time for GP to refer to a gastroenterologist was 0.6 months [IQR 0.2–1.7]; and the median time from GP referral to diagnosis was 1.5 months [IQR 0.8–2.5]. On multivariable analysis, rectal bleeding (OR 0.33, 95% CI 0.15–0.71, $p = 0.005$) and abdominal pain (OR 2.49; 95% CI 1.13–5.89, $p = 0.029$) was negatively and positively associated with being in the upper quartile of patient delay. Urgent GP referrals (OR 0.14; 95% CI 0.05–0.36, $p < 0.001$) and triage by surgeons (OR 5.61; 95% CI 2.29–14.38, $p < 0.001$) had a negative and positive association with being in the upper quartile of secondary care delay, respectively. The use of faecal calprotectin or being triaged straight-to-test did not reach statistical significance.

Conclusion Referrals triaged urgently and by a gastroenterologist were associated with a reduction in secondary care diagnostic delay. Adopting a combination of primary care faecal