86.7% of patients were satisfied with the process. The department is planning to increase the number of CAS clinics in future.

P366

MANAGEMENT OF COMPLEX ENDOSCOPIC LESIONS THROUGH AN ADVANCED-ENDOSCOPY MULTIDISCIPLINARY TEAM-MEETING: EXPERIENCE FROM A TERTIARY CENTRE

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Optimisation of patient care through multidisciplinary team (MDT) meetings is now established as the standard of care in cancer pathways. Cases presented at MDTs are discussed by a panel of experts in order to provide optimal management. An 'Advanced-endoscopy MDT' may help to achieve consensus on decision-making, clinical outcomes and patient satisfaction.

In our tertiary referral institution, we developed and adopted an 'Advanced-Endoscopy MDT' to evaluate complex cases. A bi-weekly meeting was established with the presence of expert interventional endoscopists, radiologists, histopathologists, dedicated gastrointestinal surgeons and nurse endoscopists. Depending on the cases discussed, additional experts were also in attendance. Endoscopic images, radiological scans and histopathology reports were assessed in order to decide treatment options and surveillance intervals. We retrospectively reviewed all patients that were discussed. Demographic, clinical, endoscopic findings and outcome data were analysed.

Over 20 months, 35 meetings were conducted; 463 cases were discussed for a total of 323 patients. The main reasons for MDT referral were for consideration of double-balloon enteroscopy (DBE) (107 patients) and for appropriate endoscopic or surgical management of mucosal/submucosal GI lesions. Through MDT discussion, 9 patients were referred for surgical management; 34 patients were treated with endoscopic submucosal dissection (ESD) and 72 patients with endoscopic mucosal resection (EMR). One ESD procedure was abandoned due to high suspicion of deep invasion and was referred for surgery. From the remaining 33 cases, R0 margins were reported for 32/33 patients. Eight patients referred for DBE did not require endoscopic input and 29 cases were reviewed twice as additional radiological investigations or small bowel capsule endoscopy were deemed necessary. No major adverse event including perforation, severe delayed GI bleed or sepsis occurred after any endoscopic procedure discussed at the MDT.

Based on our preliminary experience of an 'Advanced-Endoscopy MDT' is a useful platform for the safe, effective and efficient management of complex advanced endoscopic procedures.

P367

DEVELOPING THE GASTROENTEROLOGY/ENDOSCOPY WORKFORCE FOR 2025 AND BEYOND: IMPLICATIONS FOR ENDOSCOPY AND BOWEL CANCER SCREENING

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Introduction Delivering better outcomes for cancer is a major part of the Long Term Plan for the NHS. For colo-rectal cancer (CRC) better outcomes will mainly come from earlier diagnosis of CRC and polyps via the bowel cancer screening programme (BCSP). However more CRC screening has implications for the Bowel Cancer screening workforce. Currently there is no data to inform how much additional screening can be undertaken. The aim of this survey was to assess workforce career intentions with regards to screening and non-screening endoscopy.

Methods A questionnaire survey, developed by the core stakeholders, sent to all members of the BSG, ACPGB&I and JAG between Feb-April 2020.

Results Responses were received from 352 endoscopists (age 25–74 yr old) most of whom worked in England. Respondents were non-screening colonoscopists (40%), screening colonoscopists (24%), nurse endoscopists (19%) and trainees (17%). Amongst current screening colonoscopists, most undertook 2 lists per week, one of which was for screening. However many were keen to do an additional screening list each week, if they were able to relinquish emergency care (71%), ward cover (45%) or an outpatient clinic (41%). Importantly, 40% of the current screening workforce were planning to stop screening in the next 2–5 yrs due to retirement/pension issues. Of non-screening consultants 36% were considering becoming JAG accredited if they could give up emergency care (83%), ward cover (67%) or an outpatient clinic (43%). Interests outside of screening (42%) was the most common reason for not wanting to become a screener. In addition, there was little enthusiasm for undertaking more endoscopy. However amongst trainees, 72% wanted to contribute to the BCSP, particularly if they did not participate in acute medicine or GIM ward cover. Their ideal job plan would have 1–2 BCSP lists per week, as did 48% of the nurse endoscopists who wanted to become BSCP colonoscopists.

Conclusions Amongst the current consultant workforce there is some appetite to contribute to the BCSP, particularly if allowed to step away from emergency/acute care. However, the impact of early retirement and pensions needs to be considered within the plans to develop the screening workforce. Many trainees and nurse endoscopists would like to become BCSP colonoscopists.

P368

SERVICE EVALUATION OF AN IBD HELP LINE

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Introduction Dedicated specialist advice lines for patients with IBD (Inflammatory bowel disease) are recommended by the BSG [Lamb CA, *et al.* Gut 2019;0:1–106] to help prioritise rapid access to advice and specialist clinical input. This project evaluated the efficacy of the service in a tertiary London