Methods KPIs between January 2017 and January 2018 were obtained from local ERS derived audit and endoscopists with KPIs below the minimum requirement were offered individual feedback by the clinical lead. Number of procedures, Polyp Detection Rate (PDR) and Caecal Intubation rate (CIR) were compared with data from colonoscopies performed between January 2019-January 2020 with data obtained from National Endoscopy Database. Opinion on individualised KPI reporting was measured across the department using Survey Monkey.

Results Nine endoscopists (seven gastroenterologists, one surgeon, and one nurse endoscopist) were offered feedback as minimum quality standards were not met, all of whom took part in the feedback process. Six endoscopists’ CIR was below the minimum requirement. Three endoscopists’ CIR and PDR were below the minimum requirement. Two endoscopists performing less than 10 procedures per year, elected to cease performing colonoscopy. Four endoscopists with inadequate CIR improved following feedback. 1 endoscopist with insufficient PDR improved with feedback.

11 endoscopists responded to the survey. 82% reported checking their KPI at least annually, with the majority (45%) feeling that this should be reported quarterly. A formal individualised KPI report was felt to be useful by 64% of respondents.

Conclusions Providing individualised feedback did help individuals’ KPIs in this cohort. We have demonstrated that using the NED data KPIs can be monitored with ease. A larger study involving multiple sites would give greater power to whether this could lead to a significant improvement in outcomes. Majority of endoscopists feel that an individualised KPI report will be helpful.

Abstract P8 Table 1

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Adequate preparation</th>
<th>Inadequate preparation</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;3 motions/week</td>
<td>37/424 (9%)</td>
<td>13/89 (15%)</td>
<td>NS</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>47/424 (11%)</td>
<td>20/89(22%)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Parkinson’s disease</td>
<td>8/424 (2%)</td>
<td>5/89 (6%)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Cirrhosis</td>
<td>7/424 (2%)</td>
<td>4/89 (4%)</td>
<td>NS</td>
</tr>
</tbody>
</table>

P9 OUTCOMES FROM THE UK PURASTAT® REGISTRY: MULTICENTRE OBSERVATIONAL STUDY OF PURASTAT® USE IN GASTROINTESTINAL BLEEDING

1Sophie Arndt*, 2Shamila Subramaniam, 1Ejaz Hossain, 3Mohamed Abdelrahim, 2Yong Ang, 4Iosif Beintaris, 5Massimiliano di Pietro, 6Marietta Iacucci, 7Brian Saunders, 4Noriko Suzuki, 8Praadeep Bhandari, 1Queen Alexandra Hospital, Portsmouth, UK; 2Salford Hospital, Salford Royal NHS Foundation Trust, UK; 3North Tees and Hartlepool NHS Foundation Trust, North Tees, UK; 4Addenbrooke’s Hospital, Cambridge, UK; 5University Hospitals Birmingham NHS Foundation Trust, Birmingham, UK; 6St Mark’s Hospital, Harrow, UK

Introduction PuraStat® is a novel haemostatic agent without the risk of thermal injury, perforation or loss of mucosal views associated with other treatments such as heat therapy, clips or haemostatic powders. Our aim was to evaluate the efficacy of PuraStat® in the prevention and treatment of gastrointestinal bleeding.

Methods This was a prospective analysis of PuraStat® use in the UK, with 6 tertiary referral centres open to recruitment. Data was collected on procedure & lesion details, haemostasis management and complications for endoscopies where PuraStat® was used.

Results 226 procedures were included across 3 indications: 198 high risk resection, 6 upper gastro-intestinal bleeding (UGIB) and 22 radiation proctopathy. PuraStat® was used for immediate haemostasis in 100 bleeding episodes, of which 92 were as primary agent and 8 as secondary agent (after failure of alternative initial therapy) and for prevention of delayed bleeding.
bleeding in 177 cases (see Table 1). PuraStat® was additionally used in 22 radiation proctopathy cases, as sole therapy in 14 and secondary therapy in 8, with improvement in patient reported symptom score and haemoglobin. The average volume of PuraStat® used across all indications was 0.43 mls for haemostasis and 2.33 mls for prevention of delayed bleeding. No PuraStat® related complications were reported.

Conclusions Our data shows PuraStat® is safe and effective for a range of indications, with most use within high risk resections. It shows high efficacy in both immediate haemostasis and prevention of delayed bleeding. We believe PuraStat® is a promising new agent in the prevention and management of gastro-intestinal bleeding.

P10 IS PRE-ENDOSCOPY FASTING ADVICE CONSISTENT ACROSS ENDOSCOPY UNITS IN ENGLAND?

T Avades*, A Thurasaisingam. Wirral University Teaching Hospital, Wirral, UK

10.1136/gutjnl-2020-bsgcampus.85

Introduction There is a lack of guidance regarding the recommended duration of fasting pre-gastroscopy. Endoscopy guidelines advise a low fibre diet the day before colonoscopy and continuing bowel preparation up to 2 hours pre-procedure. Current practice in England regarding pre-endoscopy fasting advice is unclear.

Methods Data on pre-endoscopy fasting advice for fluids and solids were sought from all English endoscopy units by accessing online patient information leaflets (PIL) and direct contact with the units.

Results Data were obtained from 137 of 143 (96%) endoscopy units. 54 Trusts (38%) had online PIL. Most instructions used specific timings, but some were vague (e.g. lunch).

Gastroscopy
89% of Trusts stopped solid food 6 hours prior to gastroscopy.
11% advised a longer fasting period, range 8 to >12 hours.
58% of Trusts stopped clear fluids 2 hours before.
42% advised longer periods, range 3 to 8 hours.

Colonoscopy
Moviprep was used by 85% of Trusts. 17% followed the company’s leaflet instructions with regards to solid foods. 77% had longer fasting periods (hourly intervals from 7 am), 6% stopped solid foods the entire day before. 6% had a shorter fasting period.
68% of Trusts stopped clear fluids 2 hours before.
12% had longer periods, range 3 to 6 hours.
20% had shorter periods, 18% allowing clear fluids until the procedure.

Conclusions Anaesthetic guidelines recommend stopping clear fluids 2 hours before and solid food 6 hours before an elective procedure to reduce the risk of aspiration. These guidelines are probably relevant for gastroscopy, however 11% of Trusts had a longer fasting period (>6 hours) for solid foods and 46% (>2 hours) for clear fluids. 77% of Trusts had a longer fasting period than required for Moviprep. Unnecessary prolonged fasting has adverse consequences such as dehydration and patient discomfort. Conversely 18% allowed clear fluids up until a colonoscopy, which in a sedated patient may increase the risk of aspiration.

Guidelines recommend completing bowel preparation within 2–5 hours of the colonoscopy to optimise the quality of bowel cleanliness; this was only true for 3% of Trusts.

We have demonstrated wide variation in pre-endoscopy fasting advice across endoscopy units in England, with many units using fasting advice inconsistent with guideline recommendations.

REFERENCES
1. Practice Guidelines for Preoperative Fasting and the Use of Pharmacologic agents to reduce the risk of pulmonary aspiration: application to healthy patients undergoing elective procedures. An updated report by the American Society of Anesthesiologists. Anesthesiology 2017; 126:376–93

P11 UTILISATION AND REPRODUCIBILITY OF WEO PCCRC ALGORITHMS IN A REAL-WORLD SETTING

David Beaton*, Matt Rutter, Iosif Beintaris. North Tees and Hartlepool NHS Trust, Stockton-on-Tees, UK

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Introduction Colorectal cancer (CRC) diagnosed following a colonoscopy in which no CRC is found is termed Post-Colonoscopy CRC (PCCRC). The World Endoscopy Organisation (WEO) consensus statements recommend review of individual PCCRC cases, including categorisation of cases into interval/non-interval CRCs, and root cause analysis (RCA) to determine most plausible explanation.

Our study aim was to test the usability, reproducibility and outcomes of the WEO categorisation.

Methods All CRC cases diagnosed from January 2015 to December 2016 in a single NHS trust were identified. Each was cross-referenced with local endoscopy and pathology databases. Cases where non-diagnostic colonoscopy was performed prior to CRC diagnosis were included. All colonoscopies going back to 2007 (when endoscopy reporting system introduced) were reviewed.

Each CRC was entered into a spreadsheet, with headings based on WEO RCA checklist for PCCRCs. We performed 2 separate assessments: (1) RCA to identify WEO most plausible explanation for PCCRC; and (2) WEO PCCRC subtype categorisation, which looks at screening/surveillance intervals (table 1).

Inter-observer agreement was measured using Cohen’s kappa (k). Cases with inter-rater variation were analysed further using patient notes and then discussed by a panel to determine causes of variation and attempt to reach consensus.

Results Among 527 patients with CRC, 48 PCCRCs were identified. In 32 cases, the prior colonoscopy occurred within

<table>
<thead>
<tr>
<th>Indication</th>
<th>Procedures</th>
<th>Immediate haemostasis</th>
<th>Prevention of delayed bleeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk resection</td>
<td>198</td>
<td>90/98 (91.8%)</td>
<td>168/173 (97.7%)</td>
</tr>
<tr>
<td>UGB</td>
<td>6</td>
<td>22 (100%)</td>
<td>4/4 (100%)</td>
</tr>
<tr>
<td>Overall</td>
<td>204</td>
<td>92/100 (92.0%)</td>
<td>173/177 (97.7%)</td>
</tr>
</tbody>
</table>