remaining 21.5% reported improvement in severity of disease. Thus, we strongly advocate that nutrition therapy should at least be offered as a treatment modality to every Crohn's patient during gastroenterology consultations.

PTH-29 INTENTIONAL FOREIGN BODY INGESTION DURING THE COVID-19 CRISIS: A CRY FOR HELP?

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Introduction Endoscopy was significantly affected by the COVID-19 pandemic in the past year, meaning any increased demand placed significant strains on services. Rising rates of intentional foreign body ingestion (IFBI) requiring urgent endoscopy impacted on our centre in this period leading us to compare rates with pre-pandemic levels and analyse it against key dates in the UK coronavirus timeline.

Methods Endoscopic records in a large acute NHS trust in South England were examined retrospectively between 01/01/2019 - 31/12/2020 to identify gastroscopies for foreign body removal. Procedures were reviewed and individuals' records interrogated to identify information on their backgrounds and prior behaviours. Rates of IFBI were examined against contemporary events of the COVID pandemic.

Results 122 endoscopies were identified for foreign body removal. Of these: 46 (37.7%) were for IFBI, 69 (56.6%) for food bolus removal, and 7 (5.7%) for accidental foreign body ingestion. Whilst rates for food bolus dropped by almost a third in 2020 (compared to 2019), we noted an 8.2 times increase in IFBI procedures for the same period. 8 individual patients contributed to the IFBI workload. 54.3% of IFBI endoscopies required general anaesthetic and 95% involved sharp or dangerous objects.

Rates were analysed against the COVID timeline (*Table 1*). Between 01/01/2020 – 23/03/2020, when global COVID alerts were rising, levels of IFBI were relatively high with 5 procedures performed (equal to total 2019 number). From 23/03/2020-10/05/2020, when the UK was in its 1st lockdown, numbers dropped with only one case recorded. After this point levels rose dramatically with 1.13 procedures a week logged until 31/10/2020, when the UK re-entered lockdown. The 2nd lockdown, and later tiered system, did not see dramatic reductions in activity as cases continued at 0.80 week until the end of 2020.

Conclusions There has been a large increase in IFBI requiring emergency endoscopy in 2020. Mental health stresses during the pandemic seem to have had a role in susceptible individuals reaching crises point in this behaviour. Sustained effects of increased anxiety, in combination with patchy access to mental

health services, may have led to this manifestation of self-harm. This represents yet another unforeseen consequence of the COVID pandemic that has affected the utilisation of endoscopy services locally.

PTH-30 THE FIRST UK DIETITIANS PROVIDING ADVANCED PRACTITIONER GI SERVICES

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Introduction Clinical demand for gastrointestinal (GI) services in the United Kingdom (UK) has grown exponentially and the mean annual consultant expansion of 5% over the last 10 years has still not dealt with the unmet need.¹ As a result 43% of new consultant appointments are vacant and private contractors are filling this space.¹ We provide data on the first UK GI dietitians to deliver an advanced practitioner role using a payment by results model (PbR).

Methods Two Band 6 dietitians were trained by a physician over a 12-month period (cost £40,500 per dietitian per annum) to undertake outpatient medical gastroenterology clinics. In addition, they were enrolled into a MSc in advanced clinical practice (cost £8490 per dietitian). Outpatient clinics assessing patients with symptoms compatible with irritable bowel syndrome (IBS) were performed, initially physician-led, followed by dietetic-led. Patients were invited to assess their clinic satisfaction on a scale from 0-10. Clinical notes were reviewed subsequently to see the diagnostic outcomes of these patients. Cost analysis of income generation from clinics was also performed.

Results 91 clinical notes were reviewed (mean age 38 years, 66% female [n=60]), with 73% (n=66) having a diagnosis of IBS, 12% [n=11] bile acid diarrhoea, 4% [n=4] functional diarrhoea, 2% [n=2] microscopic colitis and 9% [n=8] having another diagnosis. 62% [n=56] had been seen by a physician, with 38% [n=35] being seen by a dietitian. There was no statistically significant difference in clinic satisfaction between physician and dietetic-led clinics (physician-led mean 9.2±1.5 vs dietitian-led mean 9.4±1.1, p=0.50). Annual income generation was calculated on the basis of 84 clinics annually per dietitian, with 3 new patients and 7 follow ups (total income generation of £68.2k [£35.3k new patients, £32.9k follow ups]). The cost to employ a band 7 dietitian to deliver this service is £53.5k (midpoint of scale), providing an estimated net surplus of £14.7k based on the 2020/21 PbR tariff to the directorate.

Conclusions Dietetic-led outpatient clinics for IBS patients can lead to an annual surplus of £14.7k per dietitian, with no difference in patient satisfaction between physician and dietitian-

Abstract PTH-29 Table 1 IFBI endoscopies against COVID timeline

Endoscopies for IFBI	Total year 2019	Jan-Dec 2020				Total year 2020
		01/01/20-23/03/20 (pre-lockdown)	23/03/20-10/05/20 (1st lockdown)	10/05/20-31/10/20 (variable easing of restrictions)	31/10/20-31/12/20 (2nd national lockdown + tiered restrictions)	
Total number	5	5	1	28	7	41
Procedures per week	0.10	0.43	0.15	1.13	0.80	0.79

led clinics. This reduces the number of premium rate sessions required to be delivered by consultants, being potentially transferable to other Trusts.

REFERENCE

1. Rutter C. British Society of Gastroenterology Workforce Report October 2019. Available at <https://www.bsg.org.uk/wp-content/uploads/2020/02/British-Society-of-Gastroenterology-Workforce-Report-2019-.pdf>

PTH-31 THE ROLE OF FIT IN TRIAGING COLONOSCOPY REQUESTS: LESSONS LEARNT DURING FIRST WAVE OF COVID

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Introduction The role of faecal immunochemical testing (FIT) in the symptomatic pathway for suspected colorectal cancer (CRC) has been growing in importance. NICE guidance (NG 12) recommends using FIT in the diagnostic pathway to assess for CRC in adults with low risk of CRC (≥ 50 years with change in bowel habit (CIBH) or iron deficiency anaemia (IDA) and no rectal bleeding; or ≥ 60 years with anaemia with no rectal bleeding). Owing to increasing pressure on endoscopy services over the last few years, the role of FIT as a tool for triaging colonoscopy referrals has been growing in importance. This has been particularly pertinent over the COVID-19 coronavirus pandemic period where endoscopy services have been severely affected. We present our experience of the use of FIT in the symptomatic CRC pathway over the initial COVID-19 coronavirus wave (April-July 2020). **Methods** FIT was introduced into our service in late April 2020 and was used to triage and manage patients who had been placed on a waiting list when endoscopy services ceased at the end of March 2020 during the first wave of COVID-19 coronavirus. All patients referred into the symptomatic CRC pathway underwent investigations (colonoscopy/CTC) as we wanted to understand and audit the impact of FIT on outcomes. A lower FIT cut-off of $4\mu\text{g/g}$ was used for triage, based on DG30 data (NICE NG12) for the OC Sensor assay. Patients with FIT $< 4\mu\text{g/g}$ were deemed at very low risk of malignancy and underwent a non-urgent colonoscopy or CTC. All patients with FIT $> 4\mu\text{g/g}$ were prioritised for colonoscopy or urgent CTC during the initial recovery phase of our colonoscopy services in May 2020. Colonoscopy and CTC activity from April to July 2020 through the CRC pathway was retrospectively analysed.

Results Between May-July 2020, 751 patients (393 females, 358 males, mean age 64 years) underwent lower gastrointestinal endoscopy (606 colonoscopy, 145 flexible sigmoidoscopy). 477 patients with low-risk CRC history were triaged using FIT. 359 (75%) of patients with FIT $< 4\mu\text{g/g}$ underwent non-urgent colonoscopy and none of these patients had CRC diagnosed at colonoscopy. Out of 73 CRC diagnosed during April-July 2020, 8 (11%) were in the FIT group and 5 (63%) had FIT levels of $400\mu\text{g/g}$ (χ^2 , $\text{df}=1$, $n=477$), 6.54 , $p=0.01$, and underwent urgent colonoscopy that led to diagnosis. Three of these patients had FIT $< 4\mu\text{g/g}$ and underwent non-urgent colonoscopy at a mean of 8 weeks after their FIT test. FIT $< 4\mu\text{g/g}$ had a sensitivity of 62.5%, a specificity of 77%, a PPV of 4.3% and an NPV of 99.2% in our series. In the CTC group, 18/23 (78%) had FIT $< 4\mu\text{g/g}$ and none of the

patients in this group had CRC on imaging. 15 patients were admitted during the first COVID-19 coronavirus wave with bowel obstruction and underwent successful urgent colonic stenting due to suspension of the CRC surgical pathway at the time. FIT has now been incorporated into our symptomatic suspected CRC pathway.

Conclusions Our data confirms the utility of FIT in triaging patients for CRC and highlights our successful triage strategy using FIT to inform prioritising procedures during the first wave of the COVID-19 coronavirus pandemic.

PTH-32 DEVELOPMENT OF A NOVEL ELECTRONIC REFERRAL GRADING & TRIAGE SYSTEM

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Introduction Prior to Covid-19, demand for secondary care appointments continued to rise year on year suggesting unsustainable future post-pandemic demand. Now is thus the right time to invest in triage and clinical pathway innovation.

Methods A new fully-integrated digital triage system was built at our institution allowing for document upload and electronic triage. Data pertaining to referral time, triage decision, outpatient appointments and direct-to-test was extracted from the backend to plot empirical cumulative distribution functions, interquartile ranges and allow statistical comparison using the Kruskal-Wallis' test.

Results We analysed the first 704 luminal Gastroenterology referrals through the new triage system with the following sub-specialty classifications: Iron deficiency anaemia (IDA) – 200, Upper gastrointestinal symptoms (UGI) – 152, Inflammatory bowel disease (IBD) – 116, Irritable bowel syndrome (IBS/Functional) – 95, Lower gastrointestinal symptoms/change in bowel habit alone (LGI/CIBH) – 59, Coeliac – 27, Surgical – 25, Complex Functional – 12, Intestinal failure (IF/Nutrition) – 12, Hepatology – 4. 664 (95%) of referrals were accepted with 179 (27%) being sent direct to test. Of these only 42 (23.5%) had a subsequent clinic appointment booked,

Abstract PTH-32 Figure 1 Subspecialty Referrals vs Direct-To-Test Numbers