

lower haemorrhage related mortality in the OTSC group (4.5% vs 1.4%, $p=0.02$).

Conclusions This is one of the largest series of patients treated with OTSC for upper GI haemorrhage, demonstrating a significant reduction in both early and late rebleeding in addition to haemorrhage related mortality and thus needs to part of the treatment armamentarium.

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COLD PIECEMEAL ENDOSCOPIC MUCOSAL RESECTION (EMR) FOR LARGE ADENOMAS/SERRATED POLYPS ARE SAFE AND FEASIBLE

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Background Conventional EMR carries a risk of delayed bleeding, perforation and post polypectomy syndrome. Incomplete polyp resection could lead to recurrence and post colonoscopy cancer.

Methodology Prospective databases from our institution including 113 consecutive patients with 149 polyps (>1 cm in size) resected by cold EMR between 2016 and 2018 were included. Demographics, clinicopathological and polyp characteristics, surveillance and recurrence data were analysed.

Results Male: female was 2:1 with a median age of 65 years (35–83). Median polyp size was 19 mm (10–40 mm). one hundred and seventeen polyps (78%) were in the proximal colon. Histology of resected polyps were :47 adenomas (32%) and 102 sessile serrated polyps of which 3 had dysplasia (2.9%).

Most common sites were transverse colon (23.5%), caecum (20.8%) and ascending colon (17.4%). 78.8% of polyps were found proximal to splenic flexure.

Intra procedural oozing was witnessed during resection and settled without any haemostatic interventions in 98.6% of cases. 2 cases needed application of clips to achieve haemostasis. One patient was admitted following the procedure with abdominal pain and managed conservatively. There were no delayed bleeding or perforation. A surveillance colonoscopy (6–36 months) were carried out in 80 patients (71%) and the remainder of the patients either awaiting a planned surveillance or discharged from surveillance programme.

Overall recurrence rate following cold EMR was 3.7% (4/108) and successfully treated with cold snare resection.

Conclusions Cold EMR for large adenomas and serrated polyps appears to be safe and feasible without any immediate or delayed complications.

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10% POUIG LITTLE TOO MUCH – 6YR DGH EXPERIENCE

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Introduction An upper Gastro-Intestinal (GI) cancer detected within 3 years of Oesophago-Gastro-Duodenoscopy (OGD) is considered as a failure to diagnose cancer earlier, termed Post OGD Upper GI Cancer (POUGIC). POUIG rates of less than 10% are now auditable key performance indicator (KPIs) set out in quality standards.¹ Our aim was to examine

Abstract P67 Table 1

		2014– 2016	2017– 2019	Total in 6 years
Diagnosed Upper GI	Overall	148	205	353
Cancer	Missed	6 (4%)	13 (6.3%)	19 (5.3%)
Oesophageal	Overall	78	83	161 (45.6%)
	Missed	2	5	7
GOJ	Overall	10	16	26(7.3%)
	Missed	1	1	2
Gastric	Overall	57	100	157(44.4%)
	Missed	3	7	10
Duodenal	Overall	3	6	9(2.5%)
	Missed	0	0	0

POUGIC rates over two consecutive 3-year periods (2014–2016 and 2017–2019).

Methods A retrospective review into all diagnosed upper GI cancer patients, identified from upper GI cancer database, was carried out between 01/01/2014 -31/12/2016 and 01/01/2017 -31/12/2019. Data was extracted using electronic records on patients who had standard light gastroscopy within 3-year period prior to diagnosis at both study intervals. Three independent endoscopists ratified missed cancers.

Results A total of 353 patients had newly diagnosed upper GI cancers in the time period 2014–2019. There was male preponderance (69%) with a median age of 73.5 at diagnosis. The results from two consecutive 3-year periods are shown in following Table 1.

Of the missed cancers, index gastroscopy was performed by consultant grade in 15, nurse endoscopist in 3 and supervised trainee in 1 patient.

42% (8/19) of these patients did not have photographs of the cancer site, 6 patients had photographs showing normal areas, which subsequently developed cancer. 5 had photographs but were difficult to ascertain whether those areas were the ones developing malignancy later.

Conclusions Missed cancer rate at our centre is 4% and 6.3%, over 2 consecutive 3-year period. Our observation is lower than the published acceptable rates¹ and comparable to other centres.^{2 3 4} There is argument to revise the standard in line with national average and mandate photographic evidence of landmark as a quality control of diagnostic OGD.¹

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ACCREDITATION DEFERRAL AT JAG ASSESSMENT: WHERE DO ENDOSCOPY SERVICES NEED TO IMPROVE?

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Introduction Endoscopy services are expected to meet standards in four domains to achieve JAG accreditation: clinical quality, patient experience, training and workforce. At a JAG

Abstract P68 Table 1

Domain	NHS				IS			
	Deferral likely		Deferral unlikely		Deferral likely		Deferral unlikely	
	Standard	% deferrals	Standard	% deferrals	Standard	% deferrals	Standard	% deferrals
Clinical Quality	Quality (CQ 4.2)	2.9	Results (CQ 6.1/6.3)	0.1	Quality (CQ 4.2)	3.9	Results (CQ 6.1)	0
Quality of patient experience	Respect & dignity (QP 1.3)	5.5	Aftercare (QP 6.1)	0.3	Respect & dignity (QP 1.1)	3.6	Patient environment & equipment (QP 3.7)	0.3
Training	Environment, training opportunity & resources (TR 1.1)	1.7	Assessment & appraisal (TR 3.3)	0.1	N/A			
Workforce	Workforce delivery (WR 2.1)	2.4	Professional development (WR 3.5)	0.1	Teamwork (WR 1.2)	2.5	Workforce delivery (WR 2.4)	0

assessment, accreditation is 'deferred' if the service does not achieve the standards. The aim of this study was to analyse the standards on which NHS and independent sector (IS) services have their accreditation deferred to highlight themes for improvement and identify where support is needed.

Methods A retrospective analysis of accreditation assessments from Nov 2016 to Jan 2020 was performed. Services were included if they had a deferral based on one or more standards. Where services had multiple reasons for deferral under one standard, records were de-duplicated. The proportion of deferrals per standard was calculated. Wilcoxon signed-rank test was used to compare deferral proportions between NHS and IS services.

Results 276 services underwent assessment, 90 services had reasons for deferral, across 1255 standards. 73% of services included in the analysis were NHS. Table 1 shows the standards that were most and least likely to cause deferral across each domain:

When NHS and IS services were compared, there were significant differences for deferral reasons in the clinical quality ($p < 0.01$) and quality of patient experience domains ($p = 0.02$) but no difference across the workforce domain ($p = 0.20$). Comparing individual standards, NHS services were more likely to be deferred over patient environment ($p = 0.02$) and IS services over leadership ($p = 0.03$) and professional development ($p = 0.04$).

Conclusions This study provides insights into reasons for accreditation deferral between NHS and IS services. There are clear differences with NHS services more likely to defer on patient experience standards and IS services on clinical quality standards. Further work will focus on qualitative studies to investigate these findings further with the aim of supporting services seeking accreditation.

P69 INSOURCING COLONOSCOPY – IS THERE A DIFFERENCE?

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Introduction Gastrointestinal endoscopy services are under increasing pressure to meet demand. Subcontracting procedures to external providers - 'insourcing', is increasing and often used in addition to waiting list initiative (WLI) lists by local teams. Guidance suggests the quality of provision is assessed through core key performance indicators (KPIs). This study assesses the quality of weekend colonoscopy by endoscopists from a single insourcing provider compared to equivalent weekend WLI lists performed by the local hospital team.

Abstract P69 Table 1

KPI	Local team	Insourced	Standard	P value
Caecal intubation rate (CIR)	96.3% (1160/1205)	96.4% (918/952)	Minimum >90%	0.91
Adenoma detection rate (ADR)	20.6% (210/1020)	12.5% (91/729)	Minimum 15%	<0.001
ADR adjusted for age > 50	27.2% (185/679)	14.3% (72/503)		<0.001
Polyp detection rate (PDR)	34.4% (414/1205)	21.6% (206/952)		<0.001
Polyp retrieval success	91.3% (378/414)	89.3% (184/206)	Minimum 90%	0.47
Moderate/severe patient discomfort	5.5% (66/1202)	5.8% (54/936)	<10%	0.85
Adequacy bowel prep	94.9% (1117/1177)	93.5% (879/940)	Minimum 90%	0.19
Unsedated procedures	18.2% (219/1199)	22.3% (209/936)	-	0.02
P-D confirmation of caecum	86.0% (872/985)	82.2% (581/707)	-	<0.001