

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.

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| 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 |

Methods A retrospective analysis of colonoscopies performed at a single site across weekends for 12 months from Jan 2019 was conducted. Pseudo-anonymised data was extracted from the endoscopy reporting system and correlated with pathology. Confirmation of caecal intubation was independently verified by reviewing photo-documentation (P-D). Outcomes were defined by core KPIs and reporting standards. Chi square test was used to assess for associations between dichotomous variables and independent *t* test for continuous outcome variables.

Results 2157 procedures were performed, 55.9% were performed by the local team. Mean patient age was 54.9 years (SD 14.6) with no age difference between WLI and insourced endoscopists ($p = 0.81$). There were 28 local and 27 insourced endoscopists. Mean procedure count per endoscopist was 43.0 (SD 36.5) and 35.0 (SD 44.9) for local and insourced respectively.

The local team performed more procedures for surveillance (26.3%) or inflammatory bowel disease (21.4%). Insourced procedures were more likely to be for anaemia (25.2%) or change in bowel habit (33.1%). Table 1 highlights the KPIs assessed:

Conclusions The local team achieved significantly higher ADR, PDR and caecal P-D rates. Insourced procedures had lower sedation rates. In both cohorts, P-D did not support self-reported CIR. ADR was below the minimum standard for insourcing procedures, although this may reflect the difference in case mix observed and all other KPIs were achieved. More work is needed to establish whether findings are related to weekend working or effects of differing working environments.

P70 THE JAG SURVEY OF UK ENDOSCOPY SERVICES: RESULTS FROM THE 2019 CENSUS

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Introduction The Joint Advisory Group on Gastrointestinal endoscopy (JAG) conduct a biennial census to understand factors related to endoscopy quality, workforce and training across services in the UK. The study reports the results of the 2019 census.

Methods A census of all UK JAG-registered services was conducted in April 2019. Questions were devised by an expert panel covering domains of activity, workforce and waiting times. Question items were informed by results of the

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| List Type | DNA rate (mean ± SD) | UK region | Service type (acute, independent or non-acute) | Accreditation status |
|---|----------------------|-------------|--|----------------------|
| Standard (symptomatic, surveillance, therapeutic) | 3.48 ± 3.07 | $p < 0.001$ | $p < 0.001$ | $p = 0.48$ |
| Bowel cancer screening | 1.33 ± 2.81 | $p = 0.07$ | $p = 0.51$ | $p = 0.41$ |

previous census. Results were collated and analysed using Chi Square, Fisher's exact and Kruskal Wallis tests.

Results The response rate was 68.4%. A total of 2,133,541 endoscopic procedures were performed in 2018. In March 2019, 31,938 endoscopy lists were delivered (mean 99.2 ± 95.7 per service).

The responding services employed 5,578 endoscopists (mean 17.32 ± 10.13, 12% non-medical), 1,366 trainees (mean 4.24 ± 6.43) and 12,680 nurses and allied health professionals (AHP) (mean 39.94 ± 284.81). There was a nursing and AHP vacancy rate of 7.29%. Region ($p = 0.02$) and service type ($p < 0.001$) had a significant association with vacancy.

Out of the lists performed by trainees, 51.9% were for training only. An average of 7.46 (± 1.45) oesophago-gastro-duodenoscopies and 3.86 (± 0.85) colonoscopies were booked for each training list. There was a significant regional influence on number of trainee lists ($p < 0.001$).

In the first 3 months of 2019, waiting time targets were met by 73.7% of services for urgent cancer, 68.7% for routine waits and 63.4% for surveillance waits. There was a significant difference in meeting targets between region ($p < 0.01$) and service type ($p < 0.01$). The commonest reasons for this were endoscopist, physical and nursing capacity. JAG accredited services were more likely to meet routine and surveillance wait targets than unaccredited services ($p < 0.001$). The mean standard DNA (Did Not Attend) rate for March 2019 was 3.48 (± 3.07) as shown in table 1.

Conclusions This census reflects the most extensive data regarding current UK endoscopy practice. There is evidence of service pressure, affecting wait times and training opportunities with significant regional and service-specific variability.

P71 A NATIONAL SURVEY OF SAFETY ACROSS UK ENDOSCOPY SERVICES

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Introduction The 'Improving Safety and Reducing Error in Endoscopy' (ISREE) strategy has highlighted the need to improve our understanding of factors related to safety across UK endoscopy. This study assesses aspects of safety that were included in the Joint Advisory Group on Gastrointestinal endoscopy (JAG) biennial census of services.

Methods An expert panel devised questions across 7 themes that complemented JAG safety domains. These were incorporated into the census of UK JAG-registered services in April 2019. Census results were collated and analysed. Categorical data was analysed through Chi square, Fisher's Exact, Kruskal Wallis and Friedman's tests. Free text responses were analysed thematically.

Results The response rate was 68.4%. Across March 2019, a total of 1535 patient safety incidents (PSIs) were reported (per service mean 4.80, SD 11.87). There was a significant difference in reporting dependent on incident type ($p < 0.001$). Technical and training incidents were least likely to be reported (see figure 1). There was no effect of region,