Methods Data on consecutive patients who underwent endoscopic full thickness resection (eFTR) at two UK teaching hospitals in November - December 2019 were analysed. The procedure was undertaken using the endoscope mounted gastroduodenal FTRD®. Main outcome measures were technical success (target lesion resection with FTRD®), total procedural time, specimen size, R0 resection, and adverse events. Need for dilatation to facilitate passage of device past cricopharyngeus or the pylorus was also documented.

Results All cases were undertaken under general anaesthetic. It was possible to insert the device to the lesion in all cases; in two, dilatation of the pylorus with a 20 mm through the scope balloon was required to facilitate passage of the device to the duodenum. Technical success and histological diagnosis were achieved in 5/5 (100%) cases. Median total procedural time was 23 minutes (range 18–65). Baseline and outcome data of the cases can be seen in table 1.

Two patients were kept for overnight observation and three were discharge on same day as the procedure. One patient reported shivering post procedure, which was thought to be general anaesthesia related, otherwise there were no immediate or delayed complications.

Conclusions eFTR of SELs or heavily scarred lesions in the stomach and duodenum is feasible and safe with the gastroduodenal FTRD®. It facilitates acquisition of definite histology aiding diagnosis and R0 resection is possible, providing treatment or avoiding need for ongoing surveillance in selected patients. The device can be challenging to insert and in particular, pre-dilatation of the pylorus to facilitate insertion into the duodenum may be required.

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P15 **SHOULD POST COLONOSCOPY COLORECTAL CANCER BE ADDED TO INDIVIDUAL'S KEY PERFORMANCE INDICATORS?**

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Introduction Post colonoscopy colorectal cancer (PCCRC) is associated with a number of contributory factors, including poor endoscopist performance metrics. The JAG Global Rating Scale (GRS) tool currently only includes 8-day unplanned admission rates and 30-day mortality rates as a late outcome quality Key Performance Indicator (KPI) to feedback to individual endoscopists. Since 2016, units have been encouraged to subject each PCCRC to a root cause analysis (Rees CJ, et al. Gut 2016;65:1923–1929). We aimed to review PCCRC in our institution with a focus on KPI and specialty.

Methods This was a retrospective review of PCCRC over a 3-year period (Jan 2017-Dec 2019) at a 2-site hospital in North London serving a population of 500,000. All patients with an endoscopic diagnosis of colorectal cancer (CRC) were identified from the Unisoft GI reporting tool. Patients who had a prior colonoscopy within 3 and 5-years were identified (index colonoscopy). A definite missed cancer was considered as a

PCCRC within 3 years of the index scope, and a probable missed cancer was within 5 years.

Results CRC was diagnosed in 618 patients, of whom 3.7% (23) were identified as having a PCCRC [Female 48%; mean age 75 years; 56–90 years]. The 'definite miss rate' was 2.1% (13/618) and the 'probable miss rate' was 1.6% (10/618). The mean time lag from index scope to CRC was 34.4 months. The quality of the bowel prep in the index scope was 'less than good' in 61%. Index scopes were performed by surgeons in 65% (15) of cases. External providers and locums contributed to 22% (5) of PCCRC cases. Polyps were detected in 56% (13/23) of patients at the index scope, and the site of the polyps correlated with the CRC in 3 patients (surgical endoscopists). Curative treatment (surgery ± chemotherapy) was offered to 72% of patients (n=17).

Conclusions Our study demonstrates that our department meets quality standard for units which includes a target of <5% PCCRC at 3 years (Rees CJ, et al. Gut 2016;65:1923–1929). However, review of individual cases identified higher rates of PCCRC amongst endoscopists with lower volumes of procedures and sub-optimal Adenoma Detection Rates (ADR). At a previous BSG, we have suggested that polyps bigger than 1 cm should be removed only by recognised endoscopists in each unit to minimise the risk of poor polypectomy technique leading to PCCRC. This review endorses the needs for a root cause analysis for each case of PCCRC, but we also recommend that endoscopy leads feed back to individuals their own PCCRC data for ref.

P16 **ACCEPTABILITY OF KEY PERFORMANCE INDICATORS (KPI) IN THE NATIONAL ENDOSCOPY DATABASE (NED), A DELPHI PROCESS**

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Introduction Automated Performance Reports to Improve Quality Outcomes Trial (APRIQOT) uses NED to provide endoscopists feedback on colonic detection KPI. Traditional adenoma detection rate is dependent on unavailable histological data. Our aim was to gain expert consensus on which available KPI are acceptable to endoscopists.

Method A Delphi panel of UK expert endoscopists was recruited online, purposively for professional background. Panellists interacted using an online form. In round one we provided a summary and acceptability statement for each KPI, participants rated agreement with a 5 point Likert scale and free-text comments. Responses were analysed anonymously. In subsequent rounds participants reviewed all graded consensus statements and comments. Statements were accepted with ≥80% consensus or redrafted. Rounds ran January to April 2019.

Results We recruited 21 UK expert endoscopists. 12 were female, 48% gastroenterology background, 29% nursing, 14% surgical and 9% trainees. All statements reached consensus by round 3 (Table 1). The panel agreed KPI adjusted for age, sex and indication were 'more acceptable'. Polyp measure had risks of 'gaming' and distal hyperplastic polyp over reporting, but encompass significant non-adenomatous polyps. Mean number of polyps (MNP) reached consensus after discussing reduction of the 'one and done' phenomenon and using a cap of 5 polyps/colon to mitigate skew from polyposis. Proximal

Abstract P16 Table 1

KPI	Definition	Statement Accepted	Round Consensus Reached	Agree/ Neutral/ Disagree
Polyp Detection Rate (PDR)	Procedures where at least 1 polyp is detected, displayed as%.	PDR is an acceptable detection measure in colonoscopy in the absence of a link to histological polyp data. Procedure adjusted polypectomy rate may be used to account for variables which may affect polyp detection, such as the procedure indication and patient demographics.	2	95%/0%/ 5%
Mean Number Polyps (MNP)	Number of polyps detected, displayed as rate per 100 colonoscopies.	MNP detected is an acceptable detection measure in colonoscopy. Procedure adjusted polypectomy rate may be used to account for variables which may affect polyp detection, such as the procedure indication and patient demographics.	3	81%/14%/ 5%
Proximal Polypectomy Rate (PPR)	Procedure where at least 1 polyp is removed proximal to the splenic flexure.	PPR is an acceptable secondary measure to the primary KPI. Procedure adjusted polypectomy rate may be used to account for variables which may affect polyp detection, such as the procedure indication and patient demographics.	3	86%/9%/ 5%

polypectomy rate (PPR) was accepted as a secondary 'tool to improve right sided detection' and reduce 'gaming', despite concerns around contraindications to polypectomy.

Conclusion All adjusted KPI were accepted, MNP was selected for trial with robust data to model case-mix.

SIERRA LEONE ENDOSCOPY, USING SOCIAL MEDIA TO ENGAGE WITH PATIENTS AND PHYSICIAN

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Introduction Sierra Leone is a resource poor country in Subsaharan Africa, medical services are rudimentary with no previous adult endoscopy services. Since 2016 our team of UK endoscopists and endoscopy nurses have developed a sustainable endoscopy service model in Freetown, through providing distance learning and in person training to local doctors and nurses, the team now provide upper GI endoscopy to international quality standards.

Access to mobile data and social media has increased in Serra Leone, with mobile phone data access increasing from 29% of the population in 2012 to 88% of in 2016,[1] with Facebook taking 64% of national social media market share.[2] Social media and mobile interfaces offer an efficient communication method to patients and referring physicians, promoting available healthcare services and providing information to those in the most to difficult to reach areas of the world.

We aimed to develop a social media campaign for our endoscopy services, to improve patient engagement during a clinical visit in November 2019.

Method We developed a Sierra Leone Endoscopy Facebook page providing information on endoscopy services, and a series of events promoting assessment clinics. Social media events were used to promote services at the end of November 2019, to coincide with a weeklong clinical visit and training from the UK team. These events were targeted at Facebook users in and around Freetown. We developed a google site providing more detailed information for patients on upper GI endoscopy, introducing the clinical team and the development of endoscopy in Sierra Leone.

Results The Facebook events were live from 19th October 2019 for one month, over this period events reached over 160 000 people in the Freetown area, with 1590 people interacting with the events online. Despite high online engagement in the week period from 18th – 22nd November 2019, three patients of the 12 undertaking GI endoscopy reported access to endoscopy prompted by social media engagement.

Conclusion Access to endoscopy was modestly improved with a targeted social media campaign, however the barriers to accessing healthcare and endoscopy in Sierra Leone remain very high. The Sierra Leone team continue to use the social media platform to provide information to patients and physicians, and expand to provide video information in both English and Krio.

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DEVELOPING A THEORY INFORMED BEHAVIOUR CHANGE INTERVENTION TO IMPROVE COLONIC POLYP DETECTION

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Introduction Colonoscopists with low polyp detection rates (PDR) have higher post colonoscopy colorectal cancer rates. Audit and feedback (A&F) interventions modestly improve performance in clinical contexts, but most interventions lack theoretical underpinnings so how they work is not understood. We aimed to develop a behaviour change intervention (BCI) giving endoscopists feedback to improve mean number of polyps (MNP) detected.

Methods An A&F literature review will inform a draft BCI: a report on endoscopist performance. Rounds of cognitive interviews were undertaken with independent colonoscopists, purposively sampled by professional role. Participants viewed the BCI and 'talked aloud' about content, followed by a semi-structured interview. The BCI was refined after each round, recruitment ceased when no new themes arose.

Results The BCI was based on the theory of planned behaviour and feedback intervention theory. 19 endoscopists participated in 6 interview rounds.

Case-mix adjusted MNP was endorsed as an acceptable performance metric after iterative refinement of explanatory text.