Conclusions Implementation of the VAS pathway in Croydon demonstrated a 4% cancer conversion rate and a 29% conversion rate for clinically significant benign pathology although it did not reduce time to diagnosis.

Integration of a VAS pathway in existing clinical services should be considered for diagnosis of benign but relevant symptomatic conditions.

A VAS pathway could potentially assist GPs in referring patients early which should translate into early diagnosis of cancers not necessarily confined only to the gastrointestinal tract although more data is required to support this.

P390 MENTAL HEALTH DISORDERS AND LENGTH OF STAY IN GASTROENTEROLOGY INPATIENTS AT A UNIVERSITY TEACHING HOSPITAL

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Introduction University Hospital Southampton (UHS) NHS Foundation Trust provides services to over 1.3 million people. Mental health disorders (MHDs) affect over 40% of hospital inpatients,[1] but the prevalence in gastroenterology inpatients is not known. A 2017 NICE consultation on Liaison Psychiatry Services[2] highlighted reduced length of stay as an important outcome for medical patients with a MHD. We explored the prevalence of psychiatric comorbidities in our gastroenterology inpatients, contact with psychiatric services, and the associated length of stay (LoS), providing a rationale for dedicated specialized gastroenterology inpatient psychiatric liaison support.

Methods Electronic health records for 200 consecutive gastroenterology admissions between January and December 2018 were retrospectively interrogated. Demographic data, diagnosis, co-morbidities, psychiatric input and LoS were recorded.

Results 82/200 (41%) gastroenterology inpatients had a pre-existing MHD. Depression was most prevalent condition (59%), followed by alcohol dependency (20%) and anxiety (19%). Patients admitted with exacerbations of chronic conditions (e.g. inflammatory bowel disease (IBD), gut dysmotility) had a higher prevalence of MHD (46%) versus patients with acute gastrointestinal illness (e.g. gastroenteritis, GI bleeding) without a pre-existing MHD diagnosis (35%). Patients with nutritional failure had the highest mental health burden of all GI diagnoses with a MHD prevalence of 44%, closely followed by IBD at 42%. Mean LoS with or without psychiatric co-morbidity were 12.9 and 8.9 days respectively. 17/200 (8.5%) patients were assessed by the hospital psychiatric liaison service (7 consultant reviews, 3 junior doctor, 4 mental health nurse and 2 psychologist). Mean LoS in this group was 17 days. 4 patients had no pre-existing diagnosis of MHD and following review 3 of these patients (75%) received a new MHD diagnosis.

Conclusion Psychiatric co-morbidities were very prevalent in our gastroenterology inpatient cohort and were associated with an increased LoS versus patients without MHD. Those who received general psychiatry liaison input had a longer LoS which may reflect disease complexity or delay to psychiatry review due to limited resources. Early identification of patients with known MHD and provision of a dedicated gastrointestinal psychology service is important to provide holistic care to a complex group of patients and aim to reduce inpatient stay. A new dedicated psychiatric liaison service has consequently been implemented at UHS with plans to reassess impact upon LoS and patient outcomes.

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P391 AN EVALUATION OF A NURSE ENDOSCOPIST LED VIRTUAL CLINIC FOR MANAGEMENT OF COLONIC POLYP SURVEILLANCE

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An evaluation of the nurse endoscopist led virtual polyp surveillance clinic for the implementation of the British Society of Gastroenterology (BSG) 2019 Post polypectomy and post colorectal cancer resection surveillance guidelines, assessing the impact on patient safety and satisfaction, colonoscopy capacity and colonoscopy surveillance waiting times.

Methods A protocol was designed to manage colonoscopy polyp surveillance in a virtual nurse led clinic with two aims:

- Retrospectively review all patients currently undergoing colonoscopy surveillance for sporadic polyps and post colonoscopy cancer surveillance to determine the correct surveillance intervals or discharge.
- Prospectively review all new post colonoscopy polypectomy referrals to determine the correct surveillance intervals or discharge.

Exclusion criteria

- Family history of cancer patients – under the care of Family Cancer Clinic.
- Lynch syndrome patients – under care of Family Cancer Clinic
- FAP and any polyposis syndromes – under care of Polyposis Registry

The virtual clinic started in October 2019; all colonoscopy and histology results were reviewed and recorded from the index procedure. The administration team identified all patients requiring polyp and post colon cancer resection surveillance for the following 4 months (700 patients in total) .A prospective virtual clinic was also set up to review polyp histology from colonoscopies performed in the preceding 30 days. A patient and GP letter was designed; all reviews and outcomes were recorded on the hospital reporting systems and a helpline and email address were identified for patient and GP queries.

Results 2934 patients were identified on a polyp surveillance programme with a recall of 1, 3 or 5 yearly colonoscopy. Between October and December 2019, 629 retrospective reviews were performed for patients who were due for colonoscopy within the next 4 months. After review, 335 were discharged from surveillance (53%) 274 remained on surveillance (44%) and 20 patients had surveillance dates altered, from 1 -3 years (3%). There were 5 patient queries and 2 GP

queries during this time. Only one patient from this group had a further colonoscopy having exhibited new symptoms. The total waiting times for all colonoscopy surveillance programmes reduced by 6 weeks. All new polypectomy referrals to the clinic were actioned within 7 days of receipt of histology.

Conclusion The development and implementation of the nurse endoscopist led virtual polyp surveillance clinic has led to a reduction in polyp and post colorectal cancer surveillance colonoscopies, prevented unnecessary procedures, reduced colon surveillance waiting times for all patients and has been widely accepted by patients, GPs and referring clinicians.

P392 HOW HAS THE TRANSITION FROM FOBT TO FIT CHANGED THE BCSP COLONOSCOPY SERVICE?

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Introduction In 2019, the national bowel cancer screening programme (BCSP) switched its home stool test kit from a six windowed guaiac faecal occult blood test (FOBt), to a single sample semi-quantitive faecal immunochemical test (FIT). The FIT test is superior to FOBt,[1] the transition to a single sample was expected to increase returns (uptake). A FIT cut-off = 120 µg/g was introduced so that endoscopy services weren't overwhelmed. We evaluate the impact of this switch on the colonoscopy service.

Methods Northamptonshire patients who returned a positive stool testing kit in 2019 had their data collated and analysed.

Results Of 565 patients, 356 (63.0%) were male. 52 (9.2%) had colorectal cancer (CRC), 308 had polyps (54.5%). Overall; 340 (60.2%) had CRC &/or polyps.

Conclusion The switch from FOBt to FIT has changed the profile of patients returning a positive test. The convenience of a single sample has presumably driven an increase in returns (uptake), the 120 µg/g FIT test threshold has increased positivity. The age & gender profiles, and CRC detection rate, are similar. There is a higher ADR, with a significantly higher number of larger (>10 mm) polyps detected & removed. In cases where polyps were identified, the mean number of adenomas removed is also significantly higher, and more likely be in the left side of the colon. This suggests that colonoscopists need to be prepared to perform more polypectomies, especially of larger polyps.

Interestingly, 25.5% of the FIT test positive cases were patients who had not previously returned a FOBt kit. This group were younger, and were significantly more likely to be male, have more adenomas (especially larger ones), which were more likely to be in the left colon. CRC detection was slightly lower – this may be due to those patients with cancer presenting symptomatically having not had the protection of BCSP.[2]

Abstract P392 Table 1

	FOBt	FIT	FIT (1st return)
Number	294	271	69
Uptake	62% *	66.6% *	
Positivity	1.86% *	2.29% *	
Male/Female	62.6/37.4%	63.5/36.5%	68.1/31.9%
Median age (yrs)	68	68	66
CRC	26 (8.8%)	26 (9.6%)	5 (7.2%)
Adenoma detection rate (ADR)	154 (52.4%)	153 (56.5%)	44 (63.8%)
>10 mm	68 (23.1%) †‡	91 (33.6%) †	26 (37.7%) ‡
>20 mm	23 (7.8%)	28 (10.3%)	10 (14.5%)
Left sided polyps	52.2%	58.5%	65.6%
Mean adenomas removed	1.9 #	2.3 #	2.2

* Comparing Oct/Nov 2018 with Oct/Nov 2019. † p = 0.006, ‡ p = 0.01
# Number of adenomas removed in cases with polyps, p = 0.03,

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P393 CAN TELEDIETETICS IMPROVE ACCESS TO SPECIALIST DIETITIANS FOR PATIENTS WITH IBD?

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Background Specialist dietitian input, while an important part of IBD management, is often difficult for patients to access due to long wait times. Moreover, a number of dietitians are interested in part-time work, which is often not feasible in a hospital environment. We have developed a virtual dietetics platform, Mangetoo, as a way to increase flexibility for dietitians and improve patient access to IBD specialists.

Methods We performed a patient and public involvement (PPI) exercise with IBD patients sampled from Crohn's and Colitis UK to demonstrate the functionality of the platform. Following the exercise, attendants were sent a questionnaire about their views on dietetics, and whether they would be open to using the teledietetics service.

Results We received a total of 46 responses to our questionnaire. Of the patients who had previously seen a dietitian (52%), only 20% found the interaction helpful, mostly due to seeing a generalist rather than an IBD specialist. The majority of patients (70%) listed access to an IBD subspecialist as their most important factor in choosing a dietitian, ahead of location/access (15%) and reputation (9%).

80% of respondents said they were interested in using a teledietetics service, with their main concerns being availability of a specialist dietitian, accessibility, and cost.

Conclusions Our exercise has shown that the top priority for IBD patients in engaging with dietetics was access to a subspecialist IBD dietitian. As long as a virtual dietetic platform could provide access to specialist dietitians, IBD patients would be interested in engaging with the service.

Having determined IBD patients are interested in the service in principle, we will now trial the platform, Mangetoo, using actual IBD patients and dietitians to evaluate its efficacy in replacing face-to-face dietetics consultations in practice.