Methods KPIs between January 2017 and January 2018 were obtained from local ERS derived audit and endoscopists with KPIs below the minimum requirement were offered individual feedback by the clinical lead. Number of procedures, Polyp Detection Rate (PDR) and Caecal Intubation rate (CIR) were compared with data from colonoscopies performed between January 2019-January 2020 with data obtained from National Endoscopy Database. Opinion on individualised KPI reporting was measured across the department using Survey Monkey.

Results Nine endoscopists (seven gastroenterologists, one surgeon, and one nurse endoscopist) were offered feedback as minimum quality standards were not met, all of whom took part in the feedback process. Six endoscopists' CIR was below the minimum requirement. Three endoscopists' CIR and PDR were below the minimum requirement. Two endoscopists performing less than 10 procedures per year, elected to cease performing colonoscopy. Four endoscopists with inadequate CIR improved following feedback. 1 endoscopist with insufficient PDR improved with feedback.

11 endoscopists responded to the survey. 82% reported checking their KPI at least annually, with the majority (45%) feeling that this should be reported quarterly. A formal individualised KPI report was felt to be useful by 64% of respondees.

Conclusions Providing individualised feedback did help individuals' KPIs in this cohort. We have demonstrated that using the NED data KPIs can be monitored with ease. A larger study involving multiple sites would give greater power to whether this could lead to a significant improvement in outcomes. Majority of endoscopists feel that an individualised KPI report will be helpful.

P8 DOES AN EDUCATIONAL VIDEO IMPROVE BOWEL PREPARATION IN PATIENTS FIRST COLONOSCOPY? A UK MULTI-CENTRE RCT

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Introduction Colonoscopy is the gold standard for investigation of the large bowel. Adequate bowel preparation is vital to an effective procedure. A well-informed, motivated patient, who understands the process to prepare the bowel and will adhere to it, is more likely to have adequate bowel preparation. The aim of this study is to assess whether an educational video for patients undergoing colonoscopy can lead to an improvement in bowel preparation.

Methods Participants referred for their first colonoscopy and receiving Moviprep were eligible for recruitment. Those recruited, were randomised 1:1 to access to the educational video or the control group. All participants were also provided with standard written instructions. The educational video was developed in collaboration with Nottingham Trent University graphics department. Primary end point was adequacy of bowel preparation, defined as a Boston Bowel Preparation Scale (BBPS) of 2 or greater in each segment. BBPS was scored at the time of the examination by the endoscopist performing the examination. Endoscopists received training on BBPS via an online video.

Abstract P8 Table 1

Risk Factor	Adequate preparation	Inadequate preparation	P value
<3 motions/week	37/424 (9%)	13/89 (15%)	NS
Diabetes Mellitus	47/424 (11%)	20/89(22%)	<0.05
Parkinson's disease	8/424 (2%)	5/89 (6%)	<0.05
Cirrhosis	7/424 (2%)	4/89 (4%)	NS

Results 513 participants were recruited, from 6 centres, with 254 participants randomised to access to the education video. The mean age was 58 (range 18–88). 265 (52%) of whom were female. 54 patients in the control group had inadequate prep, compared with 35 participants in the intervention group (p value <0.05, CI 0.381 to 0.967). The rate of adequate bowel preparation was not significantly different between centres. There was no significant difference between recognised risk factors for poor bowel preparation between the two groups. The association of adequacy of bowel preparation and risk factors for poor bowel preparation is shown below.

Conclusions Many factors affect the quality of bowel preparation. This study demonstrates that an educational video leads to a greater proportion of adequate bowel preparation compared with standard instructions alone. The number needed to treat to prevent one excess inadequate bowel preparation in this study is 14. Widespread adoption of enhanced patient education, such as this educational video, could lead to improved adequacy of bowel preparation.

P9 OUTCOMES FROM THE UK PURASTAT® REGISTRY: MULTICENTRE OBSERVATIONAL STUDY OF PURASTAT® USE IN GASTROINTESTINAL BLEEDING

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Introduction PuraStat® is a novel haemostatic agent without the risk of thermal injury, perforation or loss of mucosal views associated with other treatments such as heat therapy, clips or haemostatic powders. Our aim was to evaluate the efficacy of PuraStat® in the prevention and treatment of gastro-intestinal bleeding.

Methods This is a prospective analysis of PuraStat® use in the UK, with 6 tertiary referral centres open to recruitment. Data was collected on procedure & lesion details, haemostasis management and complications for endoscopies where PuraStat® was used.

Results 226 procedures were included across 3 indications: 198 high risk resection, 6 upper gastro-intestinal bleeding (UGIB) and 22 radiation proctopathy. PuraStat® was used for immediate haemostasis in 100 bleeding episodes, of which 92 were as primary agent and 8 as secondary agent (after failure of alternative initial therapy) and for prevention of delayed

Abstract P9 Table 1 Haemostatic efficacy of PuraStat®

Indication	Procedures n=204 (n)	Immediate haemostasis n=100 (n,%)	Prevention of delayed bleeding n=177 (n,%)
High risk resection	198	90/98 (91.8%)	169/173 (97.7%)
UGIB	6	2/2 (100%)	4/4 (100%)
Overall	204	92/100 (92.0%)	173/177 (97.7%)

bleeding in 177 cases (see Table 1). PuraStat® was additionally used in 22 radiation proctopathy cases, as sole therapy in 14 and secondary therapy in 8, with improvement in patient reported symptom score and haemoglobin. The average volume of PuraStat® used across all indications was 0.43 mls for haemostasis and 2.33 mls for prevention of delayed bleeding. No PuraStat® related complications were reported.

Conclusions Our data shows PuraStat® is safe and effective for a range of indications, with most use within high risk resections. It shows high efficacy in both immediate haemostasis and prevention of delayed bleeding. We believe PuraStat® is a promising new agent in the prevention and management of gastro-intestinal bleeding.

P10 IS PRE-ENDOSCOPY FASTING ADVICE CONSISTENT ACROSS ENDOSCOPY UNITS IN ENGLAND?

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Introduction There is a lack of guidance regarding the recommended duration of fasting pre-gastroscopy. Endoscopy guidelines advise a low fibre diet the day before colonoscopy and continuing bowel preparation up to 2 hours pre-procedure. Current practice in England regarding pre-endoscopy fasting advice is unclear.

Methods Data on pre-endoscopy fasting advice for fluids and solids were sought from all English endoscopy units by accessing online patient information leaflets (PIL) and direct contact with the units.

Results Data were obtained from 137 of 143 (96%) endoscopy units. 54 Trusts (38%) had online PIL.

Most instructions used specific timings, but some were vague (e.g. lunch).

Gastroscopy

89% of Trusts stopped solid food 6 hours prior to gastroscopy.

11% advised a longer fasting period, range 8 to >12 hours.

58% of Trusts stopped clear fluids 2 hours before.

42% advised longer periods, range 3 to 8 hours.

Colonoscopy

Moviprep was used by 85% of Trusts. 17% followed the company's leaflet instructions with regards to solid foods. 77% had longer fasting periods (hourly intervals from 7 am). 6% stopped solid foods the entire day before. 6% had a shorter fasting period.

68% of Trusts stopped clear fluids 2 hours before.

12% had longer periods, range 3 to 6 hours.

20% had shorter periods, 18% allowing clear fluids until the procedure.

Conclusions Anaesthetic guidelines recommend stopping clear fluids 2 hours before and solid food 6 hours before an elective procedure to reduce the risk of aspiration. These guidelines are probably relevant for gastroscopy, however 11% of Trusts had a longer fasting period (>6 hours) for solid foods and 46% (>2 hours) for clear fluids. 77% of Trusts had a longer fasting period than required for Moviprep. Unnecessary prolonged fasting has adverse consequences such as dehydration and patient discomfort. Conversely 18% allowed clear fluids up until a colonoscopy, which in a sedated patient may increase the risk of aspiration.

Guidelines recommend completing bowel preparation within 2–5 hours of the colonoscopy to optimise the quality of bowel cleanliness; this was only true for 3% of Trusts.

We have demonstrated wide variation in pre-endoscopy fasting advice across endoscopy units in England, with many units using fasting advice inconsistent with guideline recommendations.

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P11 UTILISATION AND REPRODUCIBILITY OF WEO PCCRC ALGORITHMS IN A REAL-WORLD SETTING

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Introduction Colorectal cancer (CRC) diagnosed following a colonoscopy in which no CRC is found is termed Post-Colonoscopy CRC (PCCRC). The World Endoscopy Organisation (WEO) consensus statements recommend review of individual PCCRC cases, including categorisation of cases into interval/non-interval CRCs, and root cause analysis (RCA) to determine most plausible explanation.

Our study aim was to test the usability, reproducibility and outcomes of the WEO categorisation.

Methods All CRC cases diagnosed from January 2015 to December 2016 in a single NHS trust were identified. Each was cross-referenced with local endoscopy and pathology databases. Cases where non-diagnostic colonoscopy was performed prior to CRC diagnosis were included. All colonoscopies going back to 2007 (when endoscopy reporting system introduced) were reviewed.

Each CRC was entered into a spreadsheet, with headings based on WEO RCA checklist for PCCRCs. We performed 2 separate assessments: (1) RCA to identify WEO most plausible explanation for PCCRC; and (2) WEO PCCRC subtype categorisation, which looks at screening/surveillance intervals (table 1).

Inter-observer agreement was measured using Cohen's kappa (k). Cases with inter-rater variation were analysed further using patient notes and then discussed by a panel to determine causes of variation and attempt to reach consensus.

Results Among 527 patients with CRC, 48 PCCRCs were identified. In 32 cases, the prior colonoscopy occurred within