- 21% - complaints about procedure duration

Specific narrative responses included:

- 'Give real-world examples of meals that are acceptable as part of the low-fibre diet' 'better diet advice'
- 'I do prefer it to the colonoscopy' 'capsule was fantastic' 'good service'
- 'I would recommend having a chaperone and avoiding public transport'
- 'communication was confusing and often contradictory'

Conclusions CCE was well received with most patients giving positive feedback. Of those who had experienced CC prior to CCE, over half found CCE 'much more comfortable'. However, despite having ample opportunity to ask questions and being highly satisfied with the answers and communication, some patients still found CCE confusing. Thematic narrative analysis was informative, indicating the standard pre-test written information caused confusion (in contrast to the positive Likert Scale responses) and highlighted specific areas for improvement. The difficult bowel preparation, unpleasant laxative regimen, lengthy pre-test diet and test duration present further challenges. These results highlight the need for clearer expectation setting and improved patient education and pre-test material. Implementation of the lessons learned here offer the opportunity to improve patient experience of CCE.

P44 MAKING ILFT SMARTER – ADDING THE ENHANCED LIVER FIBROSIS SCORE TO INTELLIGENT LIVER FUNCTION TESTING

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Introduction The intelligent Liver Function Testing (iLFT) pathway was introduced to NHS Tayside primary care in 2018. iLFT reflexes an aetiology screen and fibrosis scores if initial LFTs are abnormal. The results are combined with clinical details to provide automated interpretation and specialist referral recommendation. Initially, referral necessity was often dictated by risk of advanced fibrosis/cirrhosis based on indeterminate or elevated FIB-4 or NAFLD Fibrosis Score (NFS).

Increasing chronic liver disease (CLD) prevalence and the COVID-19 pandemic led to growing waiting lists for hepatology clinics. Here, we describe the introduction of Enhanced Liver Fibrosis (ELF) testing into the iLFT pathway to reduce unnecessary referral.

Method A pilot study was performed in 2019 to assess the potential impact of adding ELF for patients with indeterminate indirect fibrosis scores (FIB-4: 1.45–3.25/2.00–3.25 if <65/≥65 years; NFS: -1.455–0.675/0.120–0.675 if <65/≥65 years) who would ordinarily be recommended for specialist referral. A waiting list initiative (WLI) followed; ELF was measured on stored serum of iLFT patients on hepatology waiting lists due to indeterminate FIB-4/NFS to identify those who could safely be managed in primary care. Finally, ELF was incorporated into the iLFT algorithm, reflexing for all patients with indeterminate or elevated FIB-4/NFS.

Results 102 patients with multi-aetiology CLD were included in the pilot, with median ELF 9.9 (range 7.4–14.1). ELF ≥9.8, the manufacturer's 'significant fibrosis' threshold, was deemed by an expert group of hepatologists to warrant referral. 46.1% of pilot patients had ELF <9.8.

The WLI included 602 patients with indeterminate FIB-4/NFS awaiting clinic appointment, with median ELF 10.0 (range 7.1–15.6). 40.6% had ELF <9.8 and were removed from the waiting list (with option to be reinstated at patient request).

Between the incorporation of ELF into routine iLFT in July 2020 and August 2023, 3,130 iLFT with indeterminate or elevated FIB-4/NFS reflexed ELF (median ELF 10.2, range 7.1–18.8). ELF was <9.8 in 34.7%. Where ELF is <9.8 but FIB-4/NFS are elevated, iLFT 'fails safe' and referral is still recommended. Even accounting for this, the addition of ELF has reduced iLFT hepatology referral recommendations by 31.9%.

The addition of ELF to iLFT has allowed assessment of ELF as a prognostic marker; data review demonstrated ELF ≥13 is associated with rapid hepatic decompensation and high mortality. This group are now recommended for urgent clinic referral.

Conclusion The addition of reflexive ELF testing for two-step fibrosis assessment in a multi-aetiology primary care cohort has reduced referral by almost one-third and provides useful prognostic information.

P45 GREEN ENDOSCOPY: AN IMPROVEMENT PROJECT TO REDUCE AND RECYCLE IN ENDOSCOPY

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Introduction There is a growing call for endoscopy departments to challenge unsustainable practices to reduce their environmental impact. Currently, there are a paucity of sustainability measures in place within endoscopy at University Hospitals Coventry and Warwickshire NHS Trust (UHCW). This project aimed to trial two environmental initiatives within UHCW endoscopy. These were introducing recycling into a procedure room, and the use of quick response (QR) codes for patient information post-endoscopy. It was hoped that carbon and cost savings would be realised.

Methods Both initiatives were piloted at the Willow Endoscopy Unit, Hospital of St Cross, Rugby. Data collection occurred over a two-week period in October 2023, divided into a pre-intervention and post-intervention phase. The weight of infectious waste produced before and after recycling bags were introduced was recorded. Additionally, the uptake of QR codes and paper leaflets was compared. Carbon dioxide equivalents and cost information were utilised to calculate carbon and cost savings. Activity data was used to forecast annual savings that could be achieved if the changes were adopted departmentally.

Results A reduction in infectious waste by 13.4% was achieved through the introduction of recycling bags. There was a modest reduction in cost and carbon dioxide equivalents. Potential savings of approximately £641 and 859 kgCO2e annually could be realised if there was wider implementation across the department. 38.1% of patient information leaflets were given out digitally, after introducing QR codes. Questionnaire feedback from patients was mixed, with digital literacy and access to an appropriate device key barriers to QR code use.

Abstract P45 Table 1 Summary of results

	Pre-intervention	Post-intervention
Endoscopies, n	53	37
Aim 1: Recycling		
Total waste, kg	68.4	41.7
Mean waste per procedure, kg	1.3	1.1
Infectious waste, kg (%)	68.4 (100)	36.1 (86.6)
Recycling waste, kg (%)	n/a	5.6 (13.4)
Aim 2: Patient Information Leaflets (PIL)		
Patients who received a PIL, n	19	18
Total PILs, n	24	21
Paper PILs, n (%)	24 (100)	13 (61.9)
Digital PILs, n (%)	n/a	8 (38.1)

Conclusions This quality improvement project was successful in trialling two simple measures to reduce the environmental impact of UHCW endoscopy. Although the aims of the project were achieved, cost and carbon savings were modest. This indicates the need to combine these initiatives within a suite of other environmental measures. Savings could be enhanced by increasing staff awareness of waste segregation and identifying other areas for QR code use. Offering paper leaflets as a choice for patient information will need to be maintained to ensure accessibility. Further work is needed to scale up the changes across the department.

P46 A RE-AUDIT ON THE INVESTIGATIONS AND FIRST LINE TREATMENT FOR PATIENTS REFERRED TO A SPECIALIST IRRITABLE BOWEL SYNDROME CLINIC

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Introduction This two-cycle clinical audit evaluates the appropriateness of investigations and first-line treatments for patients referred to a specialist Irritable Bowel Syndrome (IBS) clinic. The audit aims to assess adherence to clinical guidelines, identify areas for improvement, and enhance the overall management of IBS patients, with a focus on reducing associated NHS costs.[1]

Methods A retrospective review of online medical records was conducted for confirmed IBS patients referred to the specialist IBS clinic our Trust. The first audit (Jan-Dec 2022, 118 patients) assessed adherence to guidelines and deviations. Interventions, such as sending British Dietetic Association (BDA) guidance letters and minimizing repeated investigations post-clinic to reduce wastage, were implemented. A re-audit (Aug 2023-Jan 2024, 49 patients) was then performed to evaluate the impact of these changes.

Results The first cycle showed that **18% of patients was not tested pre-clinic for coeliac disease (CD) and only 1 of these was tested post-clinic. Pre-clinic, there were 7 patients (24%) in whom faecal calprotectin was indicated but not performed, and 5 others who were tested that who did not require testing. Conversely, only 3 patients out of 118 had colonoscopies all of which were justified. Dietary modifications, such as the first line BDA advice, were prescribed to only 65% of patients.**

The reaudit reported a 10% improvement in the number of patients who had no pre-clinic coeliac serology. 100% of patients with indications for faecal calprotectin were tested pre-clinic. Hence, there were no patients presenting to secondary care who required inflammatory bowel disease testing as opposed to 24% which were missed pre-intervention. No post-clinic colonoscopies were requested.

There was only a 2% improvement in the prescription **of dietary modifications, such as the first line BDA advice with appropriate guidance from dietitians.**

Conclusion This re-audit suggests that there are still IBS patients in primary care who are not routinely tested for coeliac disease. Whilst there is an improvement in the appropriate investigations and reduction in the unnecessary tests done in the specialist clinic, documentation of first line dietary advice remains patchy. Recommendations include a formal action plan to improve adherence to best practices in IBS management.

REFERENCE

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P47 MANAGING IRON DEFICIENCY ANAEMIA (IDA): A DISTRICT GENERAL HOSPITAL EXPERIENCE

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Introduction IDA is a commonly encountered clinical entity. It may be precipitated by different causes including dietary deficiency and malabsorption but may be caused by a significant GI pathology in 1/3 of men and postmenopausal women. British Society of Gastroenterology (BSG) guidelines for IDA in adults recommends that gastrointestinal investigation should be considered on an urgent basis for IDA.

Methods A retrospective review of patients referred via 2-week wait pathways to our hospital with IDA. Review included demographics, comorbidities, primary care investigations and management in the secondary care settings.

Results 184 patients (89Female) referred with IDA between Sep2022 – Sep2023 were reviewed. On referral, 105/184 (57%) had no haematinics done, only 31(17%) had coeliac screening, urine analysis wasn't done in 125 (68%) but 104 (57%) patients did have oral iron commenced. The average time between GP referral and clinic review was 15 days. After review in the clinic, 21/184 (11%) had extra blood tests. 95 (51%) had both OGD and colonoscopy, 37 (19%) had OGD alone of whom 2/37 had CT colonoscopy and 15 had full body CT. Colonoscopy was the only investigation offered to 42/184 (23%) whilst 4 (2%) had imaging alone. Endoscopic investigations were performed in 36 without ferritin checked to confirm IDA. Cancer was found in 17/184 (9%), non-cancer GI pathology was identified in 91 others (49%) and no cause was found in 75 (40%). Of these 75, 65 were discharged whilst 10 required further investigations. One patient was referred with an MCV>100 and raised ferritin who underwent endoscopy. Dietary history was documented for 3 patients only.