Abstract P357 Figure 1 Numbers of referrals and descriptions

161 patients have been offered assessment and patient uptake is high with only 23 (14%) declining assessment. 52 (32%) patients were offered group therapy and the rest received individual therapy or declined ongoing support. Patients have been keen to access the service and feedback from those who have accessed it has been positive.

Conclusions There is high demand for an IBD psychology service with high patient uptake. This has led to pressure on the service and development of a long waiting list.

Within the IBD team there is improved understanding of what psychology can offer but the wide variation in referrals between individuals would suggest that further education as to the role of psychological input is required. This is supported by the observation that the greatest numbers of referrals come from sources where psychologist has most interaction.

As referrals increase the service will have to adapt to manage them as a 5 month waiting list is inappropriate for certain referrals.

Provision of this service has allowed the team to move closer to meeting IBD standards (IBDUK, 2019).

P358 INTRODUCTION OF THE NEW POLYPECTOMY GUIDELINES – WHAT'S THE COST?

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Introduction New guidelines have been issued for dictating surveillance post-polypectomy and post colorectal cancer, which estimate a reduction of the surveillance workload to 20% of current levels. These represent a challenge to patients, clinicians and organisationally to deliver a review of the surveillance workload. We recorded the time, cost and success of this process.

Methods The first 1000 cases on the UCLH surveillance pathway were reviewed. The new guidelines were applied to each case and a new recommendation for surveillance made by a team of three band 7 and 8 nurse endoscopists, with oversight by the endoscopy clinical lead. The first 20 cases were interpreted together to assist learning and have been omitted from this analysis. A letter was sent to every patient explaining the decision, if a patient complained the case was investigated by the clinical lead, a decision made and fed back to both the

patient and nurse endoscopist. Costs were assigned as per internal accounting agreements.

Results 512 patients were discharged from the pathway (51%). 106 (21%) of these were >75 years, 231 were discharged from 5 year surveillance. 58 patients (6%) were young enough to require 5 year surveillance as they were >10 years below screening age. 110 patients had surveillance upheld based solely on family history (11%) in the absence of a Lynch diagnosis. 45 patients were assessed on average per 4 hour session at a cost of £120/session, total cost of assessing surveillance list £2667. There were a total of 16 objections from patients (3%), of which 1 was upheld (multiple hyperplastic polyps). Diagnostic colonoscopy tariff is set at £433, representing a net saving of £219K and 102 surveillance lists over the next 5 years.

Conclusions The new guidelines represent an enormous opportunity for hard pressed endoscopy units to free up surveillance time and both save money as well as improving the timeliness. Assessment of the surveillance list can be efficaciously performed by nurse endoscopists, appeals of surveillance decisions are relatively low. 11% of patients had surveillance arranged purely on family history not always apparent from the electronic patient record – it may be that better documentation can reduce this figure in the future. Our discharge rate was lower than suggested, better documentation of reasons for ongoing surveillance may improve this figure in the future.

P359 TOWARDS A GREENER ENDOSCOPY: ESTIMATING THE AMOUNT OF SINGLE USE PLASTIC BOTTLES IN ENDOSCOPY

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Introduction A significant amount of plastic is being used in endoscopy. We believed that plastic polypropylene water bottles for the transport of sterile water generates significant amount of plastic/cost and strategies need to be employed to reduce its use. In this study, we aimed to assess the amount of plastic generated by 1L single-use polypropylene water bottles in a year for a number of endoscopic procedures.

Methods Data was obtained from the Endoscopy Database (Unisoft) regarding the number/type of procedures performed throughout 2019. We prospectively assessed the volume of sterile water used for a dedicated endoscopy list: oesophago-gastroscopy (OGD), sigmoidoscopy and colonoscopy. For each type of procedure, the volume of sterile water/plastic was estimated for a minimum of 20 procedures. The weight of plastic was measured using a Salter-Arc Electronic scale after leaving the bottle to dry for 48 hrs.

Results In our endoscopy unit, we estimated that we used 336 ml of sterile water per gastroscopy (7.05L for 21 OGDs); 241 ml per sigmoidoscopy (5.3L for 24 sigmoidoscopies); and 782 ml per colonoscopy (17.2L for 22 colonoscopies). For 2019, we performed 4436 OGDs, 2251 sigmoidoscopies and 3135 colonoscopies, which equates to a total estimated volume of sterile water of 4,485L (1490.5L for OGD; 542.49L for sigmoidoscopy; 2451.57L for colonoscopy). The dry weight of a single-use 1L plastic water bottle was 65 g while the cost of 1L of sterile water was 80p. Hence, the amount of plastic generated from water bottles in a year was approximated to