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

96.92 kg for OGD (21.85 g per OGD); 35.30 kg for sigmoidoscopy (15.68 g per sigmoidoscopy); and 159.38 kg for colonoscopy (50.84 g per colonoscopy). In 1 year, the total plastic generated from sterile water bottles alone for these procedures was 291.6 kg. The total cost for sterile water was £3588.80 (£1192.80 for OGD, £434.40 for sigmoidoscopy and £1961.60 for colonoscopy).

Conclusion We conclude that significantly large volumes of sterile water and single use plastic are being used in endoscopy. This practice is not only costly but also has a detrimental impact on the environment due to the large amount of plastic generated. Reduction of single use plastic needs to be a priority for a greener and more sustainable practice of endoscopy.

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PILOT INTRODUCTION OF A TRIAGE SYSTEM REDUCES THE WORKLOAD OF THE HPB MDT

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Introduction The East Midlands Hepatobiliary Multidisciplinary Team (HPB MDT) serves a population of 2.4 million people. The high volume of referrals and increasing complexity of cases has consistently led to significant time constraint for case discussion and potential delay in timely delivery of care. Therefore, a triage system was introduced to identify cases where a full discussion was unnecessary or premature. The aim was to improve the operation of MDT meetings (MDTM) and deliver a streamlined, transparent pathway for all patients.

Methods A triage system was piloted in two of four regional trusts from January 2019. The triage team included two hepatologists, a HPB surgeon, a specialist nurse and an administrator. In line with national guidelines and local policies, triage pathways were developed for cases for which discussion in the main MDTM would not result in additional benefit. These include (1) registration only (2) probable benign pancreatic/liver lesions under surveillance (3) HCC on established treatment (4) advanced HPB cancers on established chemotherapy (5) patients with inadequate investigations (6) post-operative histology. Pathways were reviewed and approved at relevant governance meetings. All referrals were reviewed by the triage team 48 hours prior to the MDTM and two lists were created; one for triage and one for full discussion. Outcomes for those on the triage list were given after review and approval from the radiologist and/or histopathologist. For the first 4 weeks of implementation, all triage decisions were also reviewed at the MDTM. Data on the triage process were prospectively collected from January to December 2019. These were compared with the number of patients who were discussed in the previous 4 years. All statistical analyses were performed using GraphPad Prism 8 (San Diego, CA).

Results A total 2,686 referrals were received in 2019, which was comparable to the previous 4 years ($p=0.11$, figure 1). Adoption of the triage system led to a mean reduction of 37 patients/month to the MDTM ($p<0.0001$, figure 1). This was a 15% reduction in workload for the overall MDT and a 25% reduction for the 2 trusts that participated. All triaged patients were given a recommendation for further management

within the same time period for full MDT discussion. There were no reports of harm or complaints attributable to the triage system during this period.

Conclusions The above results confirm that streamlining of the HPB MDT pathway is feasible and significantly reduces the numbers discussed in the full MDTM without compromising patient care.

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THE RELIABILITY OF 'COFFEE-GROUND' VOMITING AS AN INDICATOR OF ACTIVE UGIB: A TERTIARY CENTRE EXPERIENCE

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Introduction Acute Upper GI Bleeds (UGIB) are a common medical emergency and account for significant morbidity and mortality. 'Coffee-ground' vomiting is considered indicative of UGIB however its reliability as an indicator of active bleeding is contentious. OGD is the current gold standard in the diagnosis and management of UGIB however UGI capsule endoscopy is an emerging alternative which can rapidly screen for bleeding and has benefits over OGD in terms of invasiveness, patient tolerance, rapid deployment anywhere and thus reduced hospital admission rates and ultimately cost-effectiveness. The aim of this study was to establish whether coffee-ground vomiting is a reliable indicator of active UGIB.

Methods Electronic referrals for OGD, which contained the phrase 'coffee-ground vomiting', were analysed and endoscopy reports assessed to identify whether active UGIB was identified.

Results During a 12-month period; 552 electronic endoscopy referrals for UGIB were submitted. 62 referrals contained the specific phrase 'coffee-ground vomiting'; 9 patients were excluded. 33/53 referrals came from inpatient medical wards. 35 patients were male, mean age at time of referral was 67.5 years (22.0 – 90.0). Mean Glasgow Blatchford Score at referral was 7.4 (1.0 – 15.0). Mean time between referral and endoscopy was 1.3 days (0.0 – 12.0).

The most common endoscopic diagnoses were oesophagitis (16/53 cases) and gastritis (9/53 cases). OGD findings were normal in 10 cases. Active bleeding was identified in 6 patients and in 2 patients a visible vessel was visualised without evidence of active bleeding at endoscopy. 4 patients required endotherapy namely injection and clipping, 1 patient required variceal banding. All 6 patients with confirmed active bleeding on endoscopy had melaena on presentation.

Mean length of stay (LOS) was 8 days (1.0 – 203.0) and in 1 case a repeat OGD was required during the same admission.

Conclusions The results of this study demonstrate that only a minority of OGDs performed for the indication of 'coffee-ground' vomiting demonstrated active UGIB. In addition, a significant proportion of the cohort had a normal study. No patients with coffee ground vomiting without melaena had active UGIB and none of these patients required endotherapy.

This study could be used to support the proposal that patients with coffee-ground vomitus without other