Abstract P383 Table 1

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Followed (%)</th>
<th>Not Followed (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discussed at MDT</td>
<td>92</td>
<td>8</td>
</tr>
<tr>
<td>Baseline bloods within 1 month of starting</td>
<td>90</td>
<td>10</td>
</tr>
<tr>
<td>Blood borne virus screen within 6 months of starting</td>
<td>70</td>
<td>30</td>
</tr>
<tr>
<td>CXR prior to starting</td>
<td>72</td>
<td>28</td>
</tr>
<tr>
<td>Quantiferon prior to starting</td>
<td>80</td>
<td>20</td>
</tr>
<tr>
<td>3 month clinic appointment on time</td>
<td>46</td>
<td>54</td>
</tr>
<tr>
<td>3 month consultant review</td>
<td>76</td>
<td>24</td>
</tr>
<tr>
<td>Clear decision made to stop or continue</td>
<td>76</td>
<td>24</td>
</tr>
<tr>
<td>Discussion about continuing biologic at 1 year?</td>
<td>64</td>
<td>36</td>
</tr>
<tr>
<td>Drug level check at 1 year</td>
<td>36</td>
<td>64</td>
</tr>
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</table>

Following patients up:

- 54% did not have appropriate 1st follow-up appointment (32% early, 22% late)
- 24% had initial treatment response inadequately recorded
- 36% had annual inadequate recording at annual review of treatment response and plan to continue biologics
- 4% had their new biologic stopped at 1 year

Conclusions

Results show that we are not following our local guidelines in a significant minority of cases. Some of this may be due to lack of recording or a consistent approach to assessments. Lack of outpatient resource prevents timely reassessment of patients and opportunities for dose titration or appropriate change of treatment are missed. The finding that 95% of patients were maintained on biologics after 12 month is at odds with published response rates & it is possible that patients are continuing treatment which is not effective.

To address the failures shown by this audit we propose alternative models including virtual review. Annual review will consist of a consultant led remote review of response to biologic & a decision on ongoing treatment. A proposed IBD pharmacist will aid with optimal dosing and adherence to protocol.

P384 DOES BLOOD DONATION IN GENETIC HAEMOCROMATOSIS MATCH THE DEMANDS OF THE UK BLOOD TRANSFUSION SERVICES?

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Introduction

In patients with Genetic Haemochromatosis (GH) and iron overload, the mainstay of treatment is venesection. Current UK3 and European4 guidelines recommend that, in uncomplicated haemochromatosis, therapeutic venesection should be undertaken at a blood donor centre in order that blood can be utilised by transfusion service. However, given that GH occurs almost exclusively amongst North European Caucasians, we aimed to determine whether the blood donated from our GH cohort matched the needs of the blood donation service.

Methods

A specialist haemochromatosis clinic was established in a tertiary liver centre to standardise care and facilitate blood donation amongst this cohort. Data on all those attending was collected along with blood type, where available. Data was collected on new referrals to the local blood donor service along with blood type of those donating. Population blood type data was sourced from NHS Blood and Transplant.

Results

Since implementation, 187 patients have been seen in the specialist clinic (117 male; median age 39). Of these, 50 are now blood donors. Overall, blood type was available in 114. Distribution of blood types amongst our GH cohort was very similar to the UK donor population (figure 1). The commonest type in both was O+ (41% GH; 35% UK) followed by A+ (33% GH; 30%) then O- ['universal donors'] (10% GH; 13% UK). Rh genotyping had been done on some donors to enable better matching of blood products to patients. The Ro subtype of RhD+ was identified in 1 patient.

Conclusion

The blood types of our North-East GH cohort were almost identical to that of the UK donor population which is less ethnically diverse than the general UK population. Whilst each donation is beneficial, there are higher demands for certain blood types. Priority blood groups are O+, the 'universal donor', and the Ro subtype of RhD+; the latter needed for increased demand patients with sickle cell disease. These blood types constituted only a small number of our cohort. However, there is a willingness to donate amongst GH patients. Implementing a service to facilitate blood donation for GH patients more widely would proportionally increase the availability of all blood types whilst also affording the opportunity to maximise communication with and recruitment of 'Priority Blood Group' donors.

REFERENCES

3. NHS Blood and Transplant, Dec 2018 [https://www.blood.co.uk/why-give-blood/blood-types/]

P385 NATIONAL SURVEY EVALUATING THE PROVISION OF GASTROENTEROLOGY DIETIC SERVICES IN ENGLAND

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Introduction

In England there were 143 gastroenterology dietetic services (GDS) in 2019. The number of GDS per million population varied from 0.01 to 0.40. This variation in the availability of GDS may impact upon the ability of patients to access dietetic services.

Aim

To explore the availability of dietetic services across England.

Methods

A questionnaire was sent to all gastroenterology dietitians across England. This included questions on service provision, consultant support, independence, experience and capacity.

Results

42% of dietitians responded. There was wide variation in the availability of dietetic services with more services in urban areas. The majority of dietitians spent a third of their time on dietetic issues, with 29% spending more than half of their time. Consultant support was more common in urban areas. A quarter had been trained in gastroenterology and 26% had no formal training. 16% felt that capacity was an issue. 71% did not feel that they were able to provide an optimal service.

Conclusion

There is wide variation in the availability of dietetic services with more services in urban areas. Consultant support is more common in urban areas. A quarter had been trained in gastroenterology and 26% had no formal training. 16% felt that capacity was an issue. 71% did not feel that they were able to provide an optimal service.
Introduction The aim of this study was to assess the current provision of dietetic services for coeliac disease (CD), irritable bowel syndrome (IBS) and inflammatory bowel disease (IBD) in England.

Methods Hospitals within all NHS trusts in England were approached (n=209). A custom-designed web-based questionnaire was circulated via e-mail, post or telephone. Individuals/teams with knowledge of gastrointestinal (GI) dietetic services within the trust were invited to complete the questionnaire.

Results 76% of trusts (n=158) provided GI dietetic services, with responses received from 78% of these trusts (n=123). The median number of dietitians per 100,000 population was 3.64 (range 0.15–16.60), which differed significantly between regions (p=0.03). The commonest individual consultation time for patients with CD, IBS and IBD was 15–30 mins (43%, 44% and 54% respectively). GI dietetic services were delivered both via individual and group counselling, with individual counselling being more frequent delivery method available (93% individual vs 34% group). A significant proportion of trusts did not deliver any specialist dietetic clinics for CD, IBS and IBD (49% [n=60], 50% [n=61] and 72% [n=88] respectively).

Conclusions There are a variable number of dietitians per head of population across the UK. Allocated time for clinics appears to be insufficient compared to time advocated in the literature. Many trusts do not deliver specialist dietetic clinics, impacting on the optimal delivery of dietary therapies. Group clinics are becoming a more common method of dietetic service delivery (in order to cope with demand). National guidelines are required to ensure equity of dietetic services across England.

Abstracts

A POPULATION-BASED MODEL OF CARE FOR PEOPLE WITH INFLAMMATORY BOWEL DISEASE – PATIENT-REPORTED OUTCOMES

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Introduction Inflammatory bowel disease is characterised by remission and flare. Flares of IBD are common and often require unscheduled care. However, OPD slots can become filled with stable, diarised appointments which are often not tailored to clinical need. In contrast, East Surrey Hospital offers a broad open access non-face to face (NFTF) service including telephone, email and a web-based portal (Patients Know Best). When offered to all patients it allows identification of both stability and flare of condition to tailor the service to the patient.

Methods Patients in the IBD clinic were recruited to a prospective study over a 2 month period. Data from 35 patients was taken using two questionnaires prior to and then 4 months after introduction to NFTF service. The Patient Activation Measure® (PAM®) survey of 13 questions focuses on the knowledge, skills and confidence that individuals have to manage their health. The score correlates with clinical outcomes which are further categorised into a four tier scale. The four levels of activation are shown as ‘Low’ (Levels 1 & 2), ‘Moderate’ (Level 3), and ‘High’ (Level 4). A second questionnaire, the IBD-Control questionnaire measures the overall disease control from the patient perspective. The questionnaires were combined to see if the NFTF IBD service provides timely care, improves self-efficacy and has a positive impact on patient-reported outcomes. This prospective data was compared with that collected from 35 patients in a retrospective cohort with over 12 months already using the NFTF service.

Results There was 100% response in both cohorts. In the prospective cohort, 17 of 35 were male compared to 13 of 35 in the retrospective cohort. Two questions in the IBD-Q determine patient’s personal perception of IBD control.

At baseline, 60% of prospective study were well controlled, increasing to 71% at 4 months, 83% of retrospective respondents reported good IBD control.

At baseline 89% of the prospective cohort had low activation levels. This reduced to 63% at 4 months, with 37% having medium or high levels of activation, compared to 11% at baseline. 66% of the retrospective cohort had medium or high levels of activation. Of the retrospective cohort, 68% said the NFTF service had a positive impact on their IBD, 77% said the it helped them feel more confident in managing their own health and 57% said it improved their quality of life.

Conclusions Our new model of care promotes patients as authors of their own health, enabling access to specialist support and guidance appropriate to their situation. We should consider the widespread adoption of NFTF structures in IBD and other long-term conditions with multi-method prospective evaluation including patient activation, patient experience and clinical outcomes.

P387 MANAGING EXPECTATIONS: A DGH’S APPROACH TO BSG 2019 GUIDELINES ON MANAGEMENT OF LOWER GASTROINTESTINAL BLEED

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Introduction The British Society of Gastroenterology (BSG) recently published guidelines on the diagnosis and management of lower gastrointestinal bleed (LGB) – the first UK national guideline to concentrate on LGB. Although comprehensive, these guidelines are demanding and pose a number of challenges to a district general hospital (DGH).

Methods Over a 6 month period we reviewed the cases of all patients who presented to emergency department with LGB and retrospectively applied the new guidelines to evaluate our current performance against the new BSG standards. We intended to expose which aspects of diagnosis and/or management a typical DGH may struggle with. Using the data in conjunction with the existing literature base and the experience of senior medical staff, we reconstructed a modified version of the guidelines with a view to implement them locally.

Results In total, 113 patients met our selection criteria. Patients had an average Oakland risk score of 13. According to the BSG guidelines 54.87% of patients were correctly admitted or discharged. Of those correctly discharged, 30.43% received urgent outpatient endoscopic investigation. The average time till patients received outpatient investigation was 8 weeks. Of the 113, 5 patients were stratified as unstable LGBs, 0.00% of these patients received CT angiography. In the absence of CTA, 2 of the 5 received urgent inpatient endoscopy. Of those correctly admitted, 20.51% received urgent inpatient investigation.