Abstract PTH-57 Figure 1

Introduction A quality improvement project was carried out at a district general hospital focusing on the clinical management of patients presenting with decompensated liver cirrhosis.

Method A project group was formed comprising of three hepatologists, an advanced nurse practitioner (ANP) in hepatology, two acute medical consultants and a nurse acting as liver champions on the medical admissions unit (MAU) and a member from care quality improvement team. Quality Improvement principles, like driver diagram, were employed to narrow down focused interventions which would improve outcomes. Four key interventions were made; a) Educational sessions delivered by the hepatology team to consultants, junior doctors, physician associates and nurses on MAU b) Training of carrying out ascitic taps and drains, delivered by the Hepatology ANP to acute medical team, doctors in training and allied health professions c) Implementation of the BSG-BASL cirrhosis care bundle d) Provision of Specialist review within 24 hour of patients admitted on MAU. A 18-month worth of electronic documentary review and analysis of patients' health records pre- and post- intervention was carried out.

Results The interventions were started in July 2020 and Statistical Process Control charts were utilised to analyse and evaluate statistical significance which shows an improvement in key indicators.

Conclusion We have demonstrated that engagement of the appropriate teams with targeted training and support at an intensive level can significantly improve the delivery of care for decompensated cirrhosis patients by non-specialist/emergency care teams. This has the potential to dramatically improve the outcome of these patients.

PTH-58 PARTNERSHIP OF SPECIALIST NURSE AND SPECIALIST PHARMACIST ROLES IMPROVES QUALITY OF CARE OF IBD PATIENTS

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10.1136/gutjnl-2021-BSG.373

Introduction The role of the specialist pharmacist has added value and clinical oversight to the care of IBD patients as treatment with biologic therapy has become more prevalent.^{1,2} Despite this, specialist pharmacists seldom run independent drug monitoring virtual outpatients' clinics or routinely participate in IBD MDTs.³

The Department of Gastroenterology at Barnsley Hospital, developed the twin roles of a

Specialist Gastroenterology Pharmacist and an IBD Specialist Nurse/Non-medical endoscopist in 2012 to augment IBD care.⁴ Both roles require accreditation for independent prescribing. The pharmacist has responsibility for therapeutic drug monitoring, the prescription of biologic treatment following induction and immunosuppressants, patient support and patient education. The nurse oversees the clinical and endoscopic surveillance of patients including the running of the IBD telephone helpline service. This study is a patient survey that evaluates the quality of care afforded to our IBD patients.

Method This study assessed all IBD patients on biologic treatment who attended our biologic infusion unit or were part of the Homecare biologic service. A Linkert scale questionnaire was developed, piloted and locally validated before being submitted electronically to patients via text messaging.

Results Seventy-two patients responded to the survey, response rate 51.4% (Female, n=43, 59.7%; Male, n=29, 40.3%). Patients recorded the number of times that they had contacted the IBD helpline in the last 12 months: 22.2% (n=16) did not require support; 47.2% (n=34) made contact between 1 and 3 times; 22.2% (n=16) made contact between 4 and 6 times. 76.4% (n= 55) found the IBD helpline 'extremely helpful' or 'very helpful'. 63.9% (n=46) acknowledged the effectiveness of the therapeutic drug monitoring. 71.2% (n=47) were 'very satisfied' or 'satisfied' with the virtual pharmacist-led outpatients' clinics. 82.9% (n=58) of patients concluded that the partnership between the specialist nurse and specialist pharmacist was 'extremely helpful' or 'very helpful' for their IBD care. The overall score of the combined specialist nurse and specialist pharmacist service was rated as excellent, 4.5/5.

Conclusion Robust clinical, biochemical and endoscopic surveillance is crucial for the delivery of effective treatments and

quality of care in IBD. Telemedicine and virtual clinics have become part of mainstream clinical practice to allow IBD patients rapid access to healthcare services, pathway-driven treatment decision-making processes and endoscopy. Such initiatives allow efficient management of the Gastroenterology workload and show extremely high levels of patient acceptability.

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PTH-59 A PATIENT CENTRED PATHWAY TO SUPPORT SELF MANAGEMENT FOR PATIENTS WITH NON-ALCOHOLIC FATTY LIVER DISEASE

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10.1136/gutjnl-2021-BSG.374

Introduction The aim of this project was to implement the new pathway 'Transforming the care of patients with non-alcoholic fatty liver disease' in the secondary care Gastroenterology Clinic with a view to reducing the number of patients requiring medical review, meet waiting time targets and promote supported self-management

Non-alcoholic fatty liver disease (NAFLD) is a spectrum of liver pathology, strongly associated with obesity and diabetes. Lifestyle change aimed at weight loss through diet and physical activity is the mainstay of clinical management guidelines for NAFLD (NICE 2016). Only 34% of people link being overweight to liver disease (versus over 80% understanding the link between excess weight and heart disease, high blood pressure and diabetes).

Evidence highlights just providing NAFLD patients with information and advice to change behaviour is an insufficient intervention. Readiness to change weight-related behaviours (both physical activity and eating habits) is often low and not associated with severity of liver disease. Being diagnosed with NAFLD is insufficient to propel people into the 'preparation/action' stage of change. This is not surprising given that NAFLD is often asymptomatic. Patients do not 'see' their condition. (Stewart et al 2014).

A multi-disciplinary approach promoting supported self-management is recommended. A review by Taylor et al (2014) stated that all healthcare organisations should be providing self-management as an integral component of care.

Methods Local health intelligence data was reviewed to justify rationale for establishing a new pathway for patients with NAFLD. According to health intelligence figures, 862 patients were admitted to hospital with NAFLD and NASH as either their main reason for admission or a secondary reason during a 12 month period (1st October 2018 - 30 September 2019).

Prior to the new pathway the majority of patients with abnormal Liver Function Test (LFT) were referred to hospital

and saw medical staff at their first appointment. Due to the volume of patients this led to a long waiting list to be seen. GPs were unsure when to refer patients and which bloods/investigations should be performed beforehand. There was no dedicated input from Health Psychology or Diabetes Specialists.

The Lead Clinician and Lead Hepatology Nurse Specialist led on development of a new pathway. They agreed input and way forward for a multidisciplinary approach with General Practitioners, dietetic and psychology departments. It was agreed GPs would perform chronic liver disease screen, ultrasound and FIB4. If ultrasound suggested NAFLD patients would be referred to the new multi-disciplinary clinic. Each patient was seen by a Liver Nurse for a fibroscan and if required they also saw a Consultant in the same clinic. All appropriate patients were referred for psychology assessment in the same clinic slot. Dietetic support was available asynchronously.

Following the initial clinic appointment all review appointments were offered by psychology (4-8 review virtual review appointments). Repeat bloods were done at blood hubs set up locally. Patients were only brought back into clinic if they required more tests, a repeat fibroscan and for 6 month review.

Over a 15 month period 101 patients received a brief low intensity psychology intervention. Participants were encouraged to change their health behaviour. Each participant was seen for an assessment (and up to 8 weekly follow-up consultations via email, telephone or video call). Each patient was reviewed by the Health Psychologist at three and six months. At each contact participants were asked to complete A Hospital Anxiety and Depression Scale (HADs) fourteen item scale (Zigmond and Snaith, 1983) commonly used to determine the levels of anxiety and depression that a person is experiencing.

Each participant was provided with a Fitbit Inspire fitness tracker at their baseline appointment and were asked to record and report back their seven day average step count to the Health Psychologist. A goal setting booklet and four week walking plan was provided to assist with this.

Results 101 patients, (53% Males and 47% Females) agreed to participate. The BMI of patients assessed was 40.1 (113.5kg). Almost all patients were not meeting guidelines of 150mins of physical activity per week. Baseline step count was 1635. The majority presented with two or more long term conditions alongside NAFLD. Most common being Type 2 Diabetes (44%) and anxiety/depression (27%). Average Fib 4 score was 1.4, KPa 14.4, HbA1c 58.8, Cholesterol 5.0, ALT 81.4, AST 58.4.

91% of patients were followed up (9% drop out). Average weight loss 5.5kg (range 0.5kg- 23kg). 82% increased daily step count (1635 to 5958). Anxiety scores (HADs) decreased from (7.4 to 6) and Depression scores reduced 6.3 to 3.3.

Due to Covid 19 restrictions we don't have repeat measures on medical markers for all patients. However some case studies are encouraging.

At the end of their 6 month follow-up appointment, participants were asked to provide free text qualitative feedback on their thoughts about the new pathway and multi-disciplinary approach.

Questions asked included 'What happened?', 'How did you feel?', 'What was good?' and 'What could be improved?'