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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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?'

Comments received included 'Great service' 'Kept in touch- keeps your mind on it'

'Found the health psychology input helpful. Having someone to talk to who was interested in me cheered me up'' Really useful to have someone to report back to in terms of achieving weight loss goals "Extremely helpful in terms of explaining why weight loss was so important"

Think it is really helped having someone who is supportive and willing to listen is a big help. You don't feel you're achieving anything if you've got nobody to bounce it off'.

'I feel more confident that I can make changes'

'First Class Service -, I feel a lot more positive'

'The support I received at the NAFLD clinic was useful, it was good to talk about weight and why it was important to change things. Made me realise I needed to start making changes for myself and my family. We have all lost weight'

'Felt supported from the team. Telephone support really worked for me. Made me feel good and realise the progress I had made'

Conclusions The results have identified that patients who attended the multi-disciplinary clinic made substantial improvements to their lifestyle. Average daily step count increased over the 6 month period, from 1635 to 5958. 82% patients reported an increase in activity levels; 27% patients had been shielding but reported doing home based exercise programmes. Average self-reported weight loss at 6 months was 5.5kg (range 0.5kg- 23kg). There were also a reduction in the average anxiety and depression scores using HADS, from 7.4 to 6 for anxiety and 6.3 to 3.3 for depression.

The majority of patients, who engaged reported an increase in self-efficacy in terms of achieving weight loss. An important outcome (measured via patient's qualitative feedback) was around self-confidence and recognition that small changes were a great step in the right direction.

A learning point when we are able to fully resume normal service delivery is to try and increase the number of patients benefitting from this service. We see scope to potentially access patients earlier in primary care before they are referred to the Gastroenterology Team thus reducing waiting times and freeing up secondary care medical staff for more complex cases.

Although the Liver Nurse Specialist team were fully on board with identifying suitable patients, not all eligible patients took the service up. We are not sure the reason for this, although we are aware that the cohort of patients with NAFLD are often considered the 'hard to reach' patients, faced with multiple challenges, which may mean 'health' can slip down their priority list. It is worth noting that the majority of patients seen had complex long standing issues contributing to their poor health. Aspects of family functioning including conflict and divorce; emotional eating, insomnia, depression, anxiety were highlighted and in most cases were worked with throughout the support sessions from the psychologist.

Overall, it is considered that this new pathway and multi-disciplinary clinic has been very worthwhile. There have been noticeable improvements identified through the use of appropriate assessment tools and from positive qualitative patient and clinician feedback. In terms of future plans funding has been secured to work with innovation colleagues to provide a virtual version of supported self-management for less complex patients. This will allow a greater through put of patients and help further implement the new NAFLD pathway and multi-disciplinary approach.

PTH-60

IMPACT OF SARS-COV-2 PANDEMIC ON THE IBD ADVICE LINE – A SINGLE CENTRE EXPERIENCE

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SARS-CoV-2 pandemic has significantly affected delivery of gastroenterology services across UK. Transition to telephone clinics, redeployment of clinical staff and reduction in endoscopy capacity have resulted in additional pressures on the IBD advice line. We retrospectively analysed Chelsea and Westminster Hospital NHS Foundation trust's IBD advice line to evaluate the impact of the pandemic and to identify areas to improve upon.

Method Phone calls to IBD advice line are recorded on an excel sheet by the IBD nurses; this was used to identify list of patients who called the advice line between January – February 2021. Electronic operating system, Cerner, was used to mine data relevant to each phone call. Outcome parameters audited include patient demographics, reasons for call, outcomes from call, faecal calprotectin levels in documented flares, time since last clinic appointment and time to next outpatient appointment. This project was locally registered with the hospital's clinical audit team.

Results 209 patients contacted the service between 4/1/2021 to 04/02/2021. We were able to interrogate notes for 199 patients. 55% (n=109) of patients had Crohn's disease, 39% had ulcerative colitis and 6% had indeterminate colitis. 55% of patients were female (n=109) and median age was 32 years (youngest=18, oldest = 72). 90% (n=179) of the phone calls were from patients and remaining phone calls were from GPs and allied health care professionals. 10% of patients needed more than one attempt to call them back. 26.6% (n= 53) of the phone calls were related to flares, 13.6% (n= 27) of the phone calls were directly related to COVID-19 and 13.6% (n= 27) were related to further guidance on treatment. 22.6% of the phone calls needed IBD sisters to chase investigations, liaise with secretaries to chase appointments and convey results of investigations.

Phone calls directly related to COVID-19 include advice regarding shielding, implications for medications during periods of acute illness and advice regarding vaccinations.

Of the 53 patients who had documented flare, 27 had a raised faecal calprotectin of >250ug/g. 28.1% (n= 56) phone calls resulted in telephone advice from IBD nurses and 14.1% (n= 28) needed escalation to a gastroenterology consultant or team.

26% (n=51) of the patients were spoken to in an outpatient telephone clinic with in the last 4 weeks and 31% (n= 61) patients had an appointment coming up in the next 4 weeks.

Discussion SARS-CoV-2 pandemic has put additional pressures on the IBD advice line. In January 2021, there were 20% more phone calls than January 2020 at our centre. It is reassuring that there is no gender predominance in who accesses the advice line. Younger median age is consistent with peak incident age but with aging population and increasing prevalence of IBD in this cohort, more need to be done to ensure that there are no barriers to older population accessing the helpline. As intended, significant proportion of the phone calls were related to disease flares, however IBD nurses were only able to offer advice to 28.1% of the patients. This highlights