

072 RE-CAPTURING A LOST POPULATION – THE BENEFITS OF A NURSE-DELIVERED HCV COMMUNITY CIRRHOSIS CLINIC

Maryam Noeman, Sehar Farooq, Lourdes Cumlat, Rajan N Patel*, William Blad, Indrajit Ghosh, Deepak Suri. *The Whittington Hospital NHS Trust, London, UK*

10.1136/gutjnl-2020-bsgcampus.72

Introduction The current landscape of service provision for patients with liver disease does not match that of disease burden. A North London-based drug and alcohol dependency unit ('Better Lives') provides blood borne virus (BBV) screening and opioid substitution therapy (OST) as well as Hepatitis C Virus (HCV) treatment. These patients are often complex with marginalised social needs, have chaotic lifestyles and don't engage with conventional care models. We aimed to describe the demographics of a cohort of patients seen in a novel community outreach clinic (OC).

Methods Approximately 1000 patients per year receive OST from 'Better Lives' via a multidisciplinary clinic with doctors, nurses and recovery workers. 117 (11.7%) screened positive for chronic HCV. 22 (18.8% of chronic HCV patients, 2.2% of those receiving OST) with advanced liver fibrosis or cirrhosis (F3/F4) were referred to OC between November 2018 and September 2019. We used electronic hospital records to assess 'Did Not Attend' (DNA) rates to outpatient appointments (OPA) and emergency department (ED) attendances prior to review in OC and completion of key investigations afterward.

Results 22 patients referred to OC in the study period (median age 52 (IQR 46.3 – 57), 81.8% male, 40.9% white). 14 patients (63.6%) attended. Chronic HCV primary aetiology in 12 (54.5%), 11 (50%) self-reported ongoing alcohol intake and 4 (18%) were people who inject drugs (PWID). Median liver stiffness 19 kPa (IQR 12.95 – 36.1). 12 (54.5%) did not have registered GPs. 15 (68.2%) DNA hospital appointments prior to OC clinic.

Conclusion This is the first UK-based nurse-delivered community liver cirrhosis outreach clinic aimed to improve treatment and supportive medical care and offer a link to hospital cirrhosis services. We re-engaged two-thirds of complex marginalised patients with advanced fibrosis via OC that would otherwise have been lost to follow up. Patients attending OC had an average of 2 prior DNA to hospital OPA and 6 ED attendances. 35% and almost 50% of patients had their surveillance US abdomen and gastroscopies, respectively, following

Abstract 072 Table 1 Comparison between patients attending outreach clinic and not attending

	All F3/F4 patients referred (n = 22)	Patients attending OC (n = 14)	Patients not attending OC (n = 8)
HCV Aetiology, n (%)	12 (54.5)	9 (64.2)	3 (37.5)
Prior DNA OPAs, mean (SD)	2.14 (2.14)	2.07 (1.64)	2.25 (2.96)
Prior ED attendances, mean (SD)	5.05 (6.94)	6 (7.2)	3.38 (6.57)
US Abdomen after OC, n, (%)	7 (31.8)	6 (42.86)	1 (12.5)
Gastroscopy after OC, n (%)	6 (27.3)	5 (35.71)	1 (12.5)

attendance to OC compared with only 12% who did not attend. Further work to investigate if a community based liver outreach clinic can improve the trajectory of marginalised patients is required.

073 INTRODUCING A CLINICAL NURSE ENDOSCOPIST LED BARRETT'S SURVEILLANCE PROGRAMME IN A TERTIARY REFERRAL CENTRE

Sara Elizabeth May Brogden*, Rehan Haidry. *Uclh, London, UK*

10.1136/gutjnl-2020-bsgcampus.73

Introduction Endoscopic eradication therapy (EET) is established as the first line therapy for patients with Barrett's oesophagus (BE) related dysplasia to avoid progression to invasive cancer. Success rates for disease reversal are high but there is an appreciable risk of recurrence. Periodic endoscopic surveillance is mandated to detect disease recurrence early so further curative EET is possible.

After successful EE, endoscopic surveillance is mandated by all international societies to detect recurrence. This can however be time and resource intensive and can impact on already busy therapeutic endoscopy services. Therefore exploring how to divert these patients to other bespoke sessions is needed, thereby allowing the specialist consultant operators to focus on delivering therapeutic endoscopy to maximise resources and enhance patient care.

Aim and Methods Consecutive patients with BE at a London specialist tertiary hospital with over 10 years' experience in delivering EET were analysed. All patients had achieved successful EET for BE neoplasia and were entered in a post treatment surveillance programme.

Gastroscopies were performed on a dedicated Clinical Nurse Endoscopist (CNE) BE surveillance sessions.

The CNEs had at least 5 years expertise in BE surveillance and specialist ongoing training by the clinical lead. Three dedicated surveillance sessions were performed weekly with an average of 4–5 patients per endoscopy session.

Data was collected over a three year period 2016- 2019, a total of 456 patients were analysed.

All procedures were carried out using white-light, NBI endoscopy and acetic acid chromoscopy where indicated and biopsies performed as per post EET surveillance protocols and reviewed by dedicated pathologist with an interest in BE.

All patients with relevant histopathology changes or concerning features were discussed in dedicated multidisciplinary meetings.

Results 456 patients were analysed (x males, x female, median age xxx)

Over a 36 month period the dedicated CNE programme was able to detect low grade dysplasia (LGD) in 26 patients, high grade dysplasia (HGD) 14 patients, Indefinite for dysplasia (ID) 34 patients and inter mucosal carcinoma (IMC) in 2 patients.

Overall dysplasia recurrence was 15.7% in this cohort of patients and all were offered retreatment with EET

The data also shows that out of 456 patients undergoing a gastroscopy only 1 needed repeating by a consultant due to abandoning the procedure.

Conclusion We retrospectively analysed consecutive cases with BE following successive EET in a dedicated and specialist CNE led surveillance service in a tertiary referral centre.

Our data show that that with regimented training and a protocolised and standardized approached we can improve the pickup recurrent disease in patients post EET on dedicated sessions in order to offer retreatment.

Our aim is to introduce this across the country by supporting and monitoring other CNEs and specialist units to follow our model to provide a standardized model which is easy to follow and provide a national training programme for both therapeutic and diagnostic procedures.

Education & training

074 EXPERIENCE OF A PILOT TRAINING THE COLONOSCOPY TRAINERS COURSE IN INDIA

¹Pandurangan Basumani, ²Mark Donnelly*, ²Stuart Riley, ²Mo Thoufeeq, ¹R Ravi. ¹Dr Rela Institute and Medical Centre, Chennai, India; ²Sheffield Teaching Hospitals, Sheffield, UK

10.1136/gutjnl-2020-bsgcampus.74

Introduction Training the Colonoscopy Trainers (TCT) courses have become a key resource in improving colonoscopy training in the UK and elsewhere around the globe. To our knowledge, such courses have never taken place in India. Endoscopy in India is believed to be of a high standard but the training of endoscopists is variable with little structure or standardisation. Indian and UK colleagues were keen to explore whether TCT courses would be effective and well received in the Indian endoscopic setting.

Methods A team of three UK based experienced TCT faculty visited the Dr Rela Institute and Medical Centre (DRIMC) in Chennai, India in January 2020. Over the course of 4 days, two 2 day TCTs were delivered to a total of 12 delegates. All of the delegates were independent consultant colonoscopists with a training role in their base hospital. Years of independent colonoscopy median 3 years (range 1 - 9). Number of colonoscopies performed independently median 800 (range 100 - >5000). Each delegate had been nominated to attend by their home unit in an area encompassing much of South India. The courses delivered were slightly modified standard UK courses. Day 1: educational theory, role play; Day 2: hands on training of peers. Delegates were asked to retrospectively evaluate the impact the course had on their training style and techniques using a pre- and post-course 1–10 scale in the following specific areas: applying structured training interventions; segmenting training; SMART (Specific, measurable, Achievable, Realistic, Timely) objective setting; understanding conscious competence; avoiding dual task interference;

Abstract 074 Table 1

	Pre-course score [median and (range)]	Post-course score [median and (range)]	p-value (Wilcoxon)
Structured interventions	3 (1–5)	8 (6–9)	<0.01
Segmenting	3 (1–6)	8 (7–9)	<0.01
SMART objectives	1 (1–4)	8 (7–9)	<0.01
Conscious competence	2 (1–5)	8 (7–9)	<0.01
Dual task interference	2 (1–7)	9 (1–7)	<0.01
Effective feedback	3 (1–5)	8 (8–9)	<0.01
Reflection	3 (1–4)	8 (7–9)	<0.01

using performance enhancing feedback; critical self-reflection on teaching.

Results

Conclusions This is an account of the first ever TCT courses, to our knowledge, delivered in India. The courses were very positively and enthusiastically received. Delegates knowledge of and ability to deliver effective colonoscopy training were significantly improved across a range of measures. We plan to deliver further courses with an eventual aim to enable Indian colleagues to become effective TCT faculty to deliver their own courses.

075 TRAINING IN CLINICAL RESEARCH FOR THE ANY, NOT THE FEW: A PILOT PROGRAMME IN HEPATOLOGY

¹Lynsey Corless*, ²Ryan Buchanan, ³Louise China, ⁴Aftab Ala, ²William Rosenberg. ¹Hull University Teaching Hospitals, Hull, UK; ²University of Southampton, Southampton, UK; ³University College London, London, UK; ⁴Royal Surrey County Hospital, Guildford, UK

10.1136/gutjnl-2020-bsgcampus.75

Introduction Everyone working in frontline NHS services is trained to deliver clinical care, but few are trained to conduct research. To ensure research remains accessible to all patients, there is a need to train future generations in the skills required to deliver it. The NIHR hepatology National Specialty Group (NSG) developed a national programme to empower trainees to use, conduct, design and lead clinical research as an NHS Consultant. Through participation in a year-long programme, trainees learn core competencies against a curriculum comprising: Good Clinical Practice (GCP), Evidence-Based Medicine (EBM), Clinical Research Methodology, Research Governance, and Conduct of Clinical Research.

Methods We established a team of trainers and trainees to develop the programme. It is based on the principles of EBM and delivered through a mix of residential learning, on-line materials, and supervised participation in clinical research. The programme begins with a 2-day residential course and is completed at work and on-line. Online materials - developed in collaboration with NIHR Learn - include: GCP training, Evidence-based hepatology videos, critical appraisal worksheets and a forum for networking and giving feedback. Assessment is via completion of Workplace Based Assessments, coursework and a satisfactory educational supervisors report. From the outset we worked with specialty societies and the Hepatology NSG. We engaged the Specialist Advisory Committee at the Royal College of Physicians, and the NIHR Academy and CRN during development to ensure that they were fully aware of the initiative.

Results The first cohort of 27 trainees recently completed the course, and a second similar-sized group began in September 2019. Feedback was sought from the year 1 cohort. The majority felt more robust research training was important and necessary. Everyone said the course was extremely useful or useful. Participants were empowered to be research active, and to build it into their clinical work: most were on a trial delegation log and had been involved with more than one aspect of the study. Some have also continued to recruit into studies in their current placement. Crucially, several registrars are now leading research. One obtained funding and opened a portfolio study which has recruited over 300 participants; one is a co-applicant on an NIHR grant; and another leads an industry funded study and is a co-applicant on grants from the Academy of Medical Sciences and NIHR.