

Abstract P383 Table 1

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

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 months 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.

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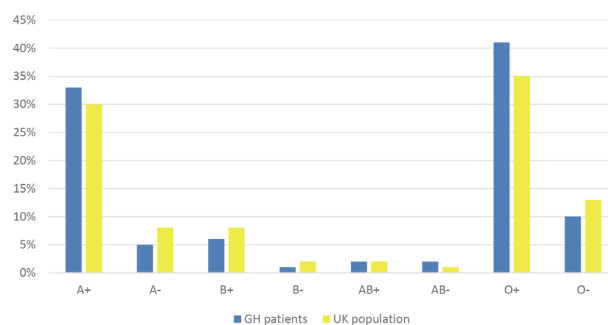
#### DOES BLOOD DONATION IN GENETIC HAEMOCHROMATOSIS MATCH THE DEMANDS OF THE UK BLOOD TRANSFUSION SERVICES?

<sup>1</sup>Thomas Rassam\*, <sup>2</sup>Jill Clarkson, <sup>1</sup>Steven Masson. <sup>1</sup>Newcastle Upon Tyne Hospitals Trust, Newcastle Upon Tyne, UK; <sup>2</sup>NHS Blood and Transplant Service, Newcastle upon Tyne, UK

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**Introduction** In patients with Genetic Haemochromatosis (GH) and iron overload, the mainstay of treatment is venesection. Current UK<sup>3</sup> and European<sup>4</sup> 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



Abstract P384 Figure 1 Blood type comparison – our GH cohort with UK population

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.<sup>3</sup>

**Results** Since implementation, 187 patients have been seen in the specialist clinic (117 male; median age 59). 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

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2. EASL Clinical Practice Guidelines for HFE Haemochromatosis. *J Hepatol* (2010). Doi:10.1016/j.jhep.2010.03.001
3. NHS Blood and Transplant, Dec 2018 [https://www.blood.co.uk/why-give-blood/blood-types/]

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#### NATIONAL SURVEY EVALUATING THE PROVISION OF GASTROENTEROLOGY DIETETIC SERVICES IN ENGLAND

<sup>1</sup>Anupam Rej\*, <sup>1</sup>Rachel L Buckle, <sup>1</sup>Charles C Shaw, <sup>1</sup>Nick Trott, <sup>2</sup>Heidi Urwin, <sup>2</sup>Norma McGough, <sup>1,3</sup>Imran Aziz, <sup>1,3</sup>David S Sanders. <sup>1</sup>Academic Unit of Gastroenterology, Royal Hallamshire Hospital, Sheffield Teaching Hospital NHS Foundation Trust, Sheffield, UK; <sup>2</sup>Coeliac UK, 3rd Floor, Apollo Centre, Desborough Avenue, High Wycombe, UK; <sup>3</sup>Academic Unit of Gastroenterology, Department of Infection, Immunity and Cardiovascular Disease, University of Sheffield, Sheffield, UK

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**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 their 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 the 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.

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

Rebecca Reynolds, Azhar Ansari\*, Anthony Aziz. *Surrey And Sussex NHS Foundation Trust, Surrey, UK*

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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 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.

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

Shaneel Shah\*, Robyn Howcroft, Bethan Green, Gary Constable. *Princess of Wales Hospital, Bridgend, Wales, Bridgend, UK*

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**Introduction** The British Society of Gastroenterology (BSG) recently published guidelines on the diagnosis and management of lower gastrointestinal bleed (LGIB) – the first UK national guideline to concentrate on LGIB. 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 LGIB 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 LGIBs. 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