

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

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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

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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

urgent inpatient colonoscopy. Average time till patients received urgent inpatient endoscopy was 2.88 days. Of 15 patients who required transfusion, 12 were correctly transfused. 57.80% of patients had warfarin or DOAC stopped at presentation. 5.26% of patients had anticoagulation correctly restarted following haemostasis. Similarly 40.00% of patients had aspirin stopped at presentation and 0.00% and 15.38% of patients had aspirin restarted correctly for primary and secondary prevention respectively.

Conclusions Auditing against a new standard has revealed worrying data and highlights the importance of change to practice that these guideline provide. This is best seen with the improper management of patients on anticoagulant and anti-platelet agents. However, the guideline is arguably overly cautious and strict adherence would place significant strain on a DGH. We propose several amendments to the guideline such as redefining admission criteria and the approach to managing unstable LGIB. Our modified guideline shows minimum expected clinical practice that is conducive to high quality patient care within the limits of hospital resources.

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COGNITIVE IMPAIRMENT PREDICTS MORTALITY AND LONGER ADMISSIONS FOR INDEX PRESENTATIONS OF ALCOHOL-RELATED LIVER DISEASE

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Introduction Alcohol-related liver disease (ARLD) can present with neuropsychiatric complications. Epidemiological studies have not investigated the impact of confusional states on patient journeys. As part of the Connected Health Cities programme, we retrospectively investigated coding data from a regional administrative dataset to identify the burden of recognised cognitive impairment (CI) in a pre-identified cohort of patients during their index admission of ARLD (fiscal years 2014–18).

Methodology Inpatient spells for a cohort of 3,887 index ARLD admissions were screened for ICD-10 codes indicative of acute and chronic CI. Descriptive analytics and stepwise multivariate logistic regression models were generated using Stata 15 (StataCorp, 2017) for predefined outcomes: inpatient mortality, length of stay, all-cause outpatient attendance and all-cause A&E attendance. These were casemix-adjusted for age, sex, co-morbidity, deprivation and variables associated with severity of liver decompensation.

Results 20 codes corresponded to acute or chronic CI, most frequently encoding encephalopathy and alcohol-related amnesiac syndrome respectively. Codes for intoxication and withdrawal were excluded and adjusted for. 277 spells (7.1%) were coded with ≥ 1 ICD code for acute CI, and 78 (2.0%) for chronic CI, with minimal overlap (0.6%). Comparisons were made with patients without relevant codes. Overall, these patients were older (mean age 57.5 and 64.1 respectively) with higher levels of co-morbidity (mean Charlson index 16.4 and 12.6 respectively) with median bed-days of 13 and 14. Multivariate logistic regression models demonstrated patients with acute CI had higher odds of inpatient mortality (OR 2.13) and long admission ≥ 21 days (OR 2.30). Patients coded with chronic CI had higher odds of long admission (OR 3.09) and A&E attendance within 90 days (OR 2.01), and were less

likely to attend an outpatient clinic at 14-day (OR 0.28) and 30-day (OR 0.4) intervals post-discharge. CI did not predict risk of readmission.

Conclusion In terms of mortality, acute CI is likely to reflect higher disease severity, particularly as encephalopathy is a poor prognosticator in this group of patients. The evidence suggests that chronic CI in patients with ARLD is under-detected in clinical practice. Our analysis demonstrates patients with recognised chronic CI experience extended admissions, are more likely to experience unplanned care and less likely to engage with outpatient care up to 90 days post-discharge. This suggests that current care models may not be appropriate for this subgroup, and alternative pathways integrating prompt identification and supported discharge mechanisms should be developed.

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VAGUE ABDOMINAL SYMPTOMS PATHWAY: IS IT WORTH IT?

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Introduction The time to diagnosis for patients with suspected cancer in the NHS is often excessive leading to unnecessary distress for patients and contributing to the poor survival rates in the UK compared to Europe. The Accelerate, Coordinate, Evaluate (ACE) Programme is an early diagnosis of cancer initiative focused on testing innovations that either identify individuals at high risk of cancer earlier or streamline diagnostic pathways.

Croydon University Hospital was chosen as one of three hospital sites across West London to participate in this pilot project. The aim was to implement and evaluate a vague abdominal symptoms (VAS) referral pathway from general practice to acute oncology within Croydon in order to reduce emergency admissions and late presentation of cancer.

Methods The pathway was implemented from April 2017 to March 2018. The pathway required GP practices to refer according to defined eligibility criteria. All referrals were triaged by an Acute Oncology Nurse specialist and reviewed in a dedicated gastroenterology clinic. All patients underwent initial investigations within 14 days of clinic review. Virtual clinic and feedback was provided to GPs and patients after completion of investigations.

Results 60 patients were referred of which 51 were assessed on the pathway (7 did not meet eligibility criteria and 2 refused to be seen) with a median age of 56 years. Commonest referral indication was abdominal pain (73%). 33% of patients had visited their GP at least three times for symptoms meeting the eligibility criteria of the pathway.

34 (67%) patients had endoscopy and 41 (80%) had radiology investigations. 23 (45%) of patients had more than 3 tests. Metastatic cancer was detected in 2 patients-splenic sarcoma and squamous lung carcinoma. 15 (29%) of patients had significant benign conditions including mesenteric ischaemia, Crohn's disease, granulomatous gastritis, intraductal papillary mucinous neoplasm, lymphocytic enteritis, gallstones, gallbladder polyps, colonic polyps and hydrosalpinx. 34 (67%) patients had other benign conditions. Median time to final diagnosis was 57 days (the 2 cancers were diagnosed at 7 and 34 days).