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.

P386 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*

10.1136/gutjnl-2020-bsgcampus.460

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 the 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.

P387 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*

10.1136/gutjnl-2020-bsgcampus.461

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