Results 21 patients received infliximab during the study period. 12 patients were emergency admissions who had failed to respond to intravenous steroid therapy (acute group). Nine patients had failed to respond to maximum oral therapy, which included immunomodulators and oral prednisolone (sub-acute group). In the acute group, 42% (n=5) of patients had avoided a colectomy at a median follow-up of 467 days (IQR 370–612). The other 58% (n=7) proceeded to colectomy after a median of 69 days (IQR 30–136). Of the patients who proceeded to colectomy, 57% had been prescribed immunomodulator therapy prior to infliximab usage. However, all the patients who avoided colectomy were immunomodulator naive prior to infliximab. In the sub-acute group, only 33% (n=3) of patients required a colectomy after a median follow-up of 153 days (IQR 110–180). The remaining 67% (n=6) were well and off steroids after a median of 303 days (IQR 209–400).

Conclusion This review of patient outcomes shows the potential benefits of infliximab for treating both acute and sub-acute UC. After a maximum of three doses of infliximab, 42% of acute and 67% of sub-acute UC patients were able to avoid a colectomy. Our results are comparable to those of Oxford (1 to 7 doses of infliximab as needed) who reported that 43% of acute and 50% of sub-acute were able to avoid a colectomy.[1] Furthermore, our results confirm the greater potential benefit of infliximab in acute, immunomodulator naive patients. In addition, all sub-acute patients, who avoided colectomy, were well and off steroids at the end-of follow-up, compared to only 38% from the Oxford group, suggesting additional benefit from planned infliximab doses.[1]

Competing interests None declared.

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PMO-253 IMPACT OF INFLAMMATORY BOWEL DISEASE NURSE SPECIALIST ON QUALITY OF PATIENT CARE AND MEETING STRATEGIC NATIONAL AIMS

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[1]E Fernandez,* [2]K Kemp. *[1]Clinical Standards Department, Royal College of Physicians, London, UK; [2]Department of Gastroenterology, Manchester Royal Infirmary, Manchester, UK*

Introduction The UK IBD Audit has now completed its 3rd round with continued marked variation in the resource and quality of care for IBD patients. This analysis of the national data aims to measure the quality of care for patients in centres with: a IBD nurse >1 WTE, IBD nurse <1 WTE and those with no IBD nurse; to demonstrate the impact of the IBD nurse in terms of quality of care; and how the role assists in meeting specific aims of the White Paper (Equity and excellence: Liberating the NHS, 2010).

Methods A comparison was carried out of the 2010 audit results of hospitals with no IBD nurse, <1 WTE nurse and those with ≥1 nurses. It cannot directly be inferred that the IBD nurse is the causative factor in the reduction in hospital admissions or improvements in care. The results also do not reflect the number of nurse sessions per week dedicated to IBD care or long the IBD nurse had been in post.

Results There was a significant reduction in the number of patients admitted to hospital with an IBD nurse in post and a difference in the range and choice of care delivery. More patient education was offered in the presence of the IBD nurse (28%, 60%, 74%, p<0.001), more patient involvement in service development (12%, 20%, 39%, p<0.001), clearer guidance for patients to seek a 2nd opinion (93%, 20%, 45%, p<0.009) and clinical data more likely to be captured (23%, 50%, 61%, p<0.001).

Conclusion The NHS White paper states reducing avoidable hospital admissions, increasing the proportion of people with a long term condition to self care and the ability to offer choice of care are High Level Outcomes which lead to commissionable services. The presence of an IBD nurse, within the IBD team, correlates with fewer admissions, the availability of self management programmes and greater overall choice in care provision and new modes of care delivery.

Competing interests None declared.

PMO-254 COMPARISON OF IBDQIP SCORES FOR TWO SERVICES WITHIN ONE TRUST

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[1]E Fernandez,* [2]D Hall. *[1]Clinical Standards Department, Royal College of Physicians, London, UK; [2]Department of Gastroenterology, Birmingham Heartlands Hospital, Birmingham, UK*

Introduction The Heart of England NHS Foundation Trust is one of the largest in England, with over 1200 beds and serves over a million people throughout north and east Birmingham and surrounding areas. It has three sites: Birmingham Heartlands, Good Hope Hospital and Solihull Hospital.

Methods Good Hope Hospital and Heartland & Solihull Hospitals entered data separately into IBD Quality Improvement Project. Services were asked to meet as a team to enter data about their service. The majority teams were able to complete data entry within 2–3 h. Each team comprised of two Consultant gastroenterologists a Consultant Colorectal surgeon and an IBD CNS. Results were not discussed between services at the time of data entry. After completion the sites requested comparative results and arranged a joint meeting to discuss the outputs.

Results As a response to this the teams reviewed their data together and agreed the following action points: (1) Good Hope Hospital will join Heartlands and Solihull's Transition Clinic at Birmingham Children's Hospital. This takes place twice a year and a joint team from both sites will attend. (2) A shared care agreement for patient's on immunosuppressive, between primary and secondary care is being devised for use across the Trust. (3) Nutritional support, which was initially available at Heartlands but has been extended to Good Hope. (4) Heartlands hospital have recently trialled a changed on-call system, to provide daily Gastroenterology ward rounds, to improve appropriate patient flow to specialist gastroenterology beds.

Conclusion (1) There are significant differences in service provision between the two services within the same Trust (2) The Trust

Abstract PMO-253 Table 1

	No IBD CNS	<1 WTE IBD CNS	1 or more WTE IBD CNS	p Value
% Patients admitted to hospital 1 September 2009–31 August 2011	19% (10.8–34.0)	10% (5.1–23.3)	11% (7.2–19.4)	<0.001
The site offers a range of arrangements for outpatient care including email, drop—in, telephone	61% (35/57)	85% (34/40)	84% (88/105)	0.002
The service offers guided self—management with access to support when needed.	34% (12/35)	62% (21/34)	63% (55/88)	0.013
Expedited specialist review of relapsed patients	83% (47/57)	98% (39/40)	98% (103/105)	0.002
A clear structured pathway for the patient to discuss their treatment with the multidisciplinary team	16% (9/57)	45% (18/40)	57% (60/105)	<0.0001
There is written information for patients on whom to contact in the event of a relapse.	42% (24/57)	88% (35/40)	95% (100/105)	<0.0001