satisfaction survey to measure quality. A prospective study is warranted as our service expands.

Disclosure of Interest None Declared.

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PTH-076 UNIVERSITY HOSPITAL SOUTHAMPTON IBD PORTAL PILOT– AN INNOVATIVE IT TOOL TO PROMOTE PATIENT SELF-CARE

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Introduction Chronic disease management represents a big challenge to the NHS. The IBD standards specify the use of IT to support patient care and to optimise clinical management through data collection and audit. The development of innovative patient care pathways are required to meet these challenges as well as the Quality, Innovation, Productivity and Prevention (QIPP) agenda. 'My Health Record' is a secure web-based service built on the Microsoft HealthVault platform, which allows storage of health information from many sources in one secure online location. The IBD team and UHS IT department, in collaboration with web developers, GetReal, have designed this pilot website with the objective of improving patient access and care.

Methods The IBD portal aims to provide an email based 'Flareline', record current and past medication history, inform patients of upcoming outpatient and endoscopy appointments, allow patient access to verified relevant investigation results, food/stool/health diaries and to provide tailored care plans with email and SMS reminders. We are taking advantage of existing innovative technologies, such as Smartphones capable of 'Near Field Communication' (NFC) and NFC enabled weight scales. These weight scales upload data directly to patient records, where aims and parameters are set, which alert the clinician to the progress of the patient.

Results The pilot IBD portal was launched in September 2012. We have recruited n = 55 patients over 5 months, with n = 19 patients completing the registration process. The most commonly used function of the service to date has been the email 'Flareline' and messaging service. These enquiries were answered with in one day for 'Flareline' messages and 1.8 days for non-urgent messages. Three patients have been supplied with NFC enabled weight scales with all patients using the devices regularly. The data collected using the NFC devices has lead to reliable clinical data and timely changes in treatment, particularly dietetic input.

Conclusion IBD is a chronic disease with a spectrum of clinical activity effecting quality of life and occurs in a significant proportion of patients in working age. The development of a web-based IBD portal is an innovative addition to IBD services with a potential to improve patient care and will lead to the development of new patient care pathways in collaboration with local care commissioning groups. We aim to improve cost effectiveness by reducing outpatient visits, reducing work load from phone based flareline enquiries and, provide more information on local IBD services for patients. Challenges to the IBD pilot so far have been to engage patients in this new model of care for chronic disease management.

Disclosure of Interest None Declared.

PTH-077 THE CHANGING FACE OF CLOSTRIDIUM DIFFICILE INFECTION

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Introduction C.*difficile* infection (CDI) is the most common identified cause of antibiotic associated diarrhoea and carries a significant mortality. Several reports have demonstrated that exogenous infection plays an important role in the spread of CDI. Reports show that ribotype 027 has been responsible for large outbreaks of CDI and is associated with a poorer outcome.

Methods All cases of CDI over a 9 month period (ending August 2012) were cultured and typed by the London reference laboratory. For each case, retrospective data on patient demographics, admission dates, ward and clinical team were analysed.

Results 32 new cases of CDI occurred of which 22(69%) could be ribotyped. All cases had had antibiotic exposure. Average age: 67 years, 27% of cases were from patients admitted to critical care and 13% were under elderly care. 27% of all cases were community and 73% hospital acquired. 12 ribotypes were seen (table 1), 1 case of type 027. There were no cases of CDI of the same ribotype originating in the same clinical area or under the care of the same clinical team within 30 days of each other. 1 patient (ribotype 015) underwent colectomy for colonic perforation secondary to extensive pseudomembranous colitis with co-existing diverticular disease. There was 16% overall mortality on index admission with 1 death indirectly attributable to CDI (ribotype 020).

Abstract PTH-077 Table 1 No predominating ribotype was seen, 1 case of type 027

Ribotype	002	003	014	015	020	027	106	023,031,056,176,411
No of cases	4	2	3	2	3	1	2	1 case of each

Conclusion In contrast to previous literature, type 027 was not the predominant ribotype seen in our cohort. The case requiring colectomy was type 015 and the death indirectly attributed to CDI was also not caused by type 027. This demonstrates a possible shift in the epidemiology of CDI. The groups most at risk were patients admitted to critical care and those under the care of the elderly care physicians with an overall 16% mortality whilst still admitted. There was little evidence of cross-infection and most cases were endogenously acquired indicating that infection prevention and control methods being practised at our Trust are effective. These findings also suggest that the main cause of CDI in this study arises from selection pressure secondary to antimicrobial use and emphasises the importance of antibiotic stewardship in the prevention and control of this infection.

Disclosure of Interest None Declared.

Inflammatory bowel disease

PTH-078 A PROSPECTIVE EVALUATION OF THE PREDICTIVE VALUE OF FAECAL CALPROTECTIN IN QUIESCENT CROHN'S DISEASE

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Introduction Studies have suggested that faecal calprotectin (FC) levels may increase early in inflammatory bowel disease relapse before the patient is symptomatic and thus may be useful to identify patients at a higher risk of relapsing. The purpose of this study was to evaluate the role of FC in predicting relapse in patients followed up for a minimum of 12 months and to ascertain the best cut-off for this in our cohort of adult patients with quiescent Crohn's disease (CD).

Methods Patients with CD in clinical remission were recruited and followed up prospectively for a minimum of 12 months. Participants

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