discover if using a cut-off value of $>100$ was adequate in diagnosing IBD.

Method A retrospective analysis was conducted for all patients in Chesterfield who had a FC requested by their GP between July and December 2017. The notes of those referred and seen in clinic were then analysed.

Results 498 patients had a FC performed by their GP. 107 patients were seen in clinic, 58 were female and 49 were male. Ages ranged from 16 years to 89 years with FC results from <8 to 1086. 9 patients in total were diagnosed with IBD. If a cut off FC $>100$ were used; 42 of these patients would have been referred with 6 being diagnosed with IBD. 65 would not have been referred but 3 would have IBD, giving a sensitivity of 66.67% (95% CI 29.93% to 92.51%) and a specificity of 63.27% (95% CI 52.93% to 72.78%). The positive predictive value of our test would therefore be 14.29% (95% CI 8.93% to 22.07%) with negative predictive value of 95.38% (95% CI 89.02% to 98.14%).

Conclusion Our study has shown that using a cut-off value of $>100$ for FC values will result in a lower sensitivity when compared to data from other groups. However, a larger cohort of patients will need to be retrospectively analysed to determine whether a cut off value for FC of 100 should be used or if it should be lowered in order to improve sensitivity and specificity in diagnosing patients with IBD. In addition, we have discovered that FC testing is being incorrectly performed in patients who meet other diagnostic pathways and so further advice and guidance needs to be given regarding its use.

**PTU-091** RIGHT HEMICOLECTOMY IN CROHN’S DISEASE – ARE WE FOLLOWING ECCO GUIDELINES?

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10.1136/gutjnl-2019-BSGAbstracts.450

Introduction Despite recent advances in medical therapy, approximately 80% of patients with Crohn’s disease will require surgery within 20 years of diagnosis. Surgery is not curative and clinical and/or endoscopic recurrence occurs in the majority of patients. Correct pre-operative planning and post-operative care has a major impact on the outcome of such treatment. The aim of this study was to compare local practice in the Countess of Chester Hospital with published ECCO guidelines, to identify opportunities to improve care.

Methods This was a retrospective analysis of all patients with Crohn’s disease that underwent a right hemicolectomy between January 2013 and December 2017 at the Countess of Chester Hospital. Patients were identified by obtaining a list of right-hemicolectomy specimens from the histopathology department. Patient notes were reviewed to ascertain patient demographics, pre- and post-operative treatment, and follow-up endoscopy.

Results A total of 14 patients were identified for this study. Age range was 2–5 with a male to female ratio of 4:3. The Montreal classification varied widely. Only 8/14 (57%) of patients had received an immunomodulator pre-operatively and 2/14 (14%) were on a biologic, 10/14 (71%) of patients were not given either an immunomodulator or biologic post-operatively. Follow-up endoscopy occurred in 7/14 (50%) patients. 3 of these were within 6 months and 4 were within 12 months of the operation date. 3/7 (42.9%) of patients had evidence of recurrence on endoscopy. None of the patients had a Rutgeerts’ score generated.

Conclusions This study demonstrates the variability of management of patients with Crohn’s disease post-operatively. Our results show that over 60% of patients were not on any medical treatment pre-operatively. In addition, over 75% of patients continued to remain on no maintenance after their operation. Only 50% of patients underwent a follow-up endoscopy within 12 months of their operation date and a Rutgeerts’ score was not generated in any of these patients.

**PTU-092** EXPLORING ACCESS TO SECONDARY CARE SERVICES FOR PATIENTS WITH ESTABLISHED INFLAMMATORY BOWEL DISEASE

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10.1136/gutjnl-2019-BSGAbstracts.451

Introduction The Inflammatory Bowel Disease (IBD) Standards of Care recommend that defined arrangements are in place to allow for direct admission or assessment to a gastroenterology unit for patients with UC or Crohn’s. Currently in Leicester there is no facility for rapid access or direct admission to inpatient GI services. The aim of this study was to establish how patients with (IBD) accessed secondary-care services when admission was required.

Methods Consecutive patients admitted to gastroenterology with an established diagnosis of IBD were asked to complete a questionnaire exploring their point of access, admission process, waiting times and treatment during admission before their discharge from hospital.

Results 50 patients were recruited (30 UC, 19 CD, 1 indeterminate). First point of access after admission was recommended included 30 pts arriving at A&EE, 11 via medical admission unit, 7 directly via gastroenterology services and 2 to other departments.

Other pathways once admitted involved 14 pts transferring to 2 wards and 29 pts to 3 wards.

32 patients were commenced Intravenous steroids in first 24 hours, 8 patients waited longer than 24 hours. 8 patients did not commence any treatment relating to an acute exacerbation of IBD.

Conclusions Patients were admitted to a number of different wards via a variety of routes. Many were waiting for longer periods of time & some patients did not require hospital admission. As a result of this evaluation we have established a ‘Hot Clinic’.

**PTU-093** EVALUATING A NURSE LED INFLAMMATORY BOWEL DISEASE HOT CLINIC

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10.1136/gutjnl-2019-BSGAbstracts.452

Introduction Inflammatory Bowel Disease (IBD) can be an unpredictable condition with relapses requiring escalation of therapy and possible admission to hospital. The IBD Standards of Care recommend that patients with Crohn’s disease and Ulcerative colitis have rapid access to specialist doctors and
nurses so an appropriate and prompt plan of care can be implemented. Due to pressure on consultant Gastroenterology outpatient clinics, it is often difficult to see patients urgently who are acutely unwell. We recently evaluated referral pathways at the University Hospitals of Leicester (UHL) & identified a number of patients who were admitted that could potentially have been managed as outpatients. As a result, of this finding we implemented two IBD Nurse-Led ‘Hot Clinic’ s per week.

Methods The criteria for referral were an established or new diagnosis of IBD with significant exacerbation of symptoms potentially requiring admission. On referral, the IBD nursing team made an initial phone assessment to confirm severity. All patients with on-going symptoms were then offered an appointment within 5 working days.

Results Over a 12-month period, 67 patients were referred to the Hot Clinic. 37 (55%) self-referred via the IBD helpline, 11 (16%) were referred from endoscopy with active disease (6 from the 2 week-wait pathway) and 13 (19%) direct from General Practice (GPs), 55 (82%) had a face-to-face consultation. 3 (5%) patients required admission to hospital and were admitted directly to a Gastroenterology ward; 2 (3%) patients were treated with oral prednisolone but were admitted two weeks after the Hot Clinic review via Urgent care, and their admission was expedited to Gastroenterology within twenty-four hours. 2 (3%) patients recently discharged following an admission contacted the helpline due to recurring symptoms and assessed in the Hot Clinic, and alteration in treatment prevented a readmission. A further 2 (3%) patients admitted in the Medical Admissions Unit were assessed by the In-reach Gastroenterology team and were able to be discharged early with urgent review in a Hot Clinic appointment. Nine (13%) patients were assessed over the phone, treatment was arranged which prevented a face-to-face consultation, and a plan of care was sent to both the patient and their GP. One patient declined an OPD and two never replied to calls or letters to contact the team.

Conclusion The introduction of ‘IBD Hot Clinics’ have allowed symptomatic patients with established IBD or newly diagnosed patients requiring urgent treatment, to be rapidly assessed by a specialist IBD nurse who can initiate appropriate treatments. This has shown to prevent admissions and fewer than 10% required admission in our cohort. The cost effectiveness of this service now requires further evaluation, with plans to expand this service.

**PTU-094 IS THE ROLE OF A GASTROENTEROLOGY ADVANCED NURSE PRACTITIONER VALUED?**

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10.1136/gutjnl-2019-BSGAbstracts.453

Introduction The Advanced Nurse Practitioner (ANP) is an established role within many hospitals and can be found in all aspects of health organisations. This new role has equipped nurses to take on more procedures as well as tasks traditionally associated with junior doctors, including the ability to diagnose and prescribe, whilst still retaining their foundation nursing roles. Previous research has focused on the ANP role within the community setting or emergency departments. This innovative study aimed to examine perceptions from the nursing and medical teams of an ANP working on a gastroenterology ward.

Methods A qualitative study was conducted at the Royal United Hospital Bath using three separate focus groups, each comprising of five gastroenterology doctors (FY1 to registrar), five gastroenterology nurses (grades –) and six ANP’s. Each focus group lasted between 4–0 minutes and consisted of a set format of questions to guide discussions and aid with moderation of the group (eg. perceptions of the value of the ANP role within the ward environment, advantages of an ANP and how the ANP assists with a doctor’s role). Transcripts of the interviews were analysed and the data was reduced into themes.

Results Thematic analysis identified three positive themes related to the perception of an ANP working of a gastroenterology ward; (1) Assisting with work load, (2) Team work and (3) Leadership. It was highlighted that due to the ANP’s understanding of the processes of patient flow, tasks were pre-empted and performed in advance, improving efficiency and reducing the work load of other team members. Within the analysis there was an overriding theme of consistency; quotes from doctors included, “the ANP is an absolute ‘life line’ at the start of a new rotation. Their consistency allowed things not to get missed and acted as a safety net for us all, patients alike”. There were several sub-themes relevant to gastroenterology particularly; ‘sharing of applied skills and knowledge’. This was relevant for ascitic paracentesis, NG tube insertion, implementation of the liver care bundle and application of gastroenterology algorithms for complex patients which included GI bleeding.

Conclusions The study demonstrated that an ANP is a great asset to a gastroenterology ward and a valued member of the team. They provide consistency within the department, to both the nursing and medical teams. This is deemed vital, due to the ongoing four monthly rotations of junior medical staff, which is perceived as disruptive to team work and affecting consistency of patient care. The results have also identified how the ANP role appears to be more than just a ‘work gap’ solving role, they are paramount in sharing skills and knowledge with junior doctors as well as contributing to and enhancing team work, which is essential in health care transformation.

**PTU-095 UK QUALITATIVE FOCUS GROUP STUDY INVESTIGATING CURRENT PROVISION OF CARE FOR PEOPLE WITH MICROSCOPIC COLITIS**

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10.1136/gutjnl-2019-BSGAbstracts.454

Introduction Microscopic colitis (MC) is a common cause of chronic, non-bloody watery diarrhoea that impacts health-related quality of life. No UK guidelines currently exist for MC. This has potential negative sequelae to patients as misdiagnoses and use of inappropriate treatments have been reported. This study examines UK provision of care for MC