Methods A retrospective review of medical notes was performed of patients seen in the clinic. Information was gathered on diagnosis, previous surgery for IBD, parity, outcomes of previous pregnancies, medication preconception and during pregnancy, disease activity preconception and during pregnancy and outcome of pregnancy.

Results Data was collected on 20 patients. 8 had Crohns disease (CD), 12 had ulcerative colitis (UC). Surgery: In the UC group 3/12 had previous surgery:2 ileoanal pouch, 1 subtotal colectomy. In CD group 4/8 had an ileocolonic resection. Parity: 5=para 1, 8=para 2, 6=para 3, 1=para 4. Medication: 11/20 were on no medication (6 UC, 5 CD). 3 were on infliximab, last infusion 20/40, 3 were on azathioprine, 5 were on a 5ASA. Disease activity: 19/20 were well preconception, 1 was unwell around time of conception (miscarriage at 11/40). 10/20 had a flare of disease activity during pregnancy: 1 settled with topical treatment, 1 settled with 5ASA, 8 required oral steroids. All 3 patients on infliximab had a flare after stopping it and required oral steroids. 1 of these had a stillbirth shortly after commencing steroids for a flare. Outcomes: 10/20 have not yet delivered, 3 are planned for elective CS (1 perianal disease, 1 previous CS, 1 previous forceps delivery). 3 had CS (2 had ileoanal pouches and 1 had perianal disease), 1 stillbirth, 1 miscarriage, 5 had normal vaginal delivery (NVD). No preterm births or low birth weights reported.

Conclusion Those with ileoanal pouches and perianal disease are being appropriately considered for a planned CS. 50% of our patients have a NVD which as expected is lower than the general population. 50% of our patients had a flare in disease during pregnancy which is higher than literature (30%)[1]. 80% required oral prednisolone to settle and both adverse outcomes appear to be related to a flare in disease. Those on infliximab appear to be at high risk of flaring after their last dose around 20 weeks.

REFERENCE

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Disclosure of Interest None Declared.

PTH-027 ANAESTHESIA-LED PROPOFOL SEDATION FOR COMPLEX ENDOSCOPY: CLIMBING HIGHER

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Introduction NHS indicators for quality improvement (QI) are divided into key domains - safety, experience, outcome and effectiveness. Patient experience has been shown to be positively related to clinical effectiveness and safety and should not be overlooked when assessing the effectiveness of a service. The introduction of a new Anaesthesia-Led Propofol Sedation (ALPS) service in 2012 was pivotal in managing patients undergoing complex endoscopic procedures. Our aim was to establish a continuous quality improvement programme to take an already successful service and pursue excellence.

Methods Measures and scores were agreed within the domains of patient optimisation, outcome and experience, and service efficiency. A composite score was used as an Excellence Score. All patient episodes were scored by the same anaesthetist using a 3-point qualitative scale; fully (>95% complete, 2 points), largely (75–95% complete, 1 point) and partially/not achieved (<75% complete, 0 points). Individual domain scores and the Excellence Score were presented as a percentage, in terms of the current service and "What If" scores to show the impact of changing practice. Patient experience was measured indirectly and with a telephone questionnaire at one-week post-discharge. Results were discussed in an MDT focus group, interventions instigated and the data recollected three months later and re-discussed.

Results 40 consecutive patients attending for complex endoscopic procedures from January to June 2013 were reviewed. Table 1 shows scores during the first three months and the influence of implemented changes. Across all scores, improvement was seen, particularly in the Efficiency Score which increased by 22%.

A patient optimisation score reflected a guideline-compliant service, but was initially low due to a lack of pre-assessment and individualised patient preparation, and sporadic use of an adapted WHO Surgical Safety Checklist. A "What If" score of 82% was presented, showing the potential service gains in the presence of these additions. Consequently managers agreed to fund use of the Hospital Preoperative Assessment Service and clinical staff agreed to implement regular use of an adapted WHO Safe Surgery Checklist.

Conclusion Achieving excellence depends upon acknowledging weaknesses in practice that may already be very good. This study has shown the value of a quality improvement programme in improving a new, innovative service. Often adoption of care elements used routinely elsewhere within the hospital setting can lead to significant improvements in patient care and the efficiency of the service.

Disclosure of Interest None Declared.

Abstract PTH-027 Table 1 Domain and excellence scores over the six-month QI period

	Jan-Mar	Apr-Jun
Outcome score	93%	97%
Experience score	86%	93%
Efficiency score	62%	85%
Excellence score	68%	75%

PTH-028 ANALYSIS OF QUALITY OUTCOMES FOLLOWING CHANGING BOWEL PREPARATION FOR COLONOSCOPY FROM PICOLAX TO MOVIPREP IN NHS LOTHIAN

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Introduction Using our global rating scale data from 2010 we observed that the quality of preparation for colonoscopy using Moviprep was superior to Picolax. Given this and the National patient safety alert issued in 2009 regarding bowel preparation [1], we decided to change the default bowel preparation from Picolax to Moviprep in NHS Lothian in 2012.

Methods The aim of this study was to prospectively audit the quality of Moviprep and Picolax preparation for colonoscopy and flexible sigmoidoscopy during two 3 month periods-before (March-May 2012, period 1) and after (November-January 2013, period 2) Moviprep was changed to the default preparation in NHS Lothian for colonoscopy. All patients who attended