

**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%)<sup>1</sup>. 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

<sup>1</sup> Janne van der Woude *et al.* J Crohns Colitis 2010;4:493–510

**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)

**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%

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.

## 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 <sup>1</sup>, 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

the Western General Hospital for colonoscopy and flexible sigmoidoscopy during the two periods were included. Cost effective analysis was also undertaken.

**Results** 1418 Colonoscopies and flexible sigmoidoscopies were carried out during period 1 and 1234 were carried out during period 2. 454 (32%) of the colonoscopies were carried out using Moviprep in period 1 and 973 (79%) in period 2. Poor quality preparation was significantly more common with PicoLax preparation when compared to Moviprep in both period 1: 12 vs. 7% ( $p = 0.0037$ ) and period 2: 13% vs. 5% ( $p < 0.0001$ ). Repeat endoscopic procedures and completion imaging due to poor preparation fell from 44 (3.1%) in period 1 to 21 (1.7%) ( $p = 0.03$ ) in period 2 following the change in default preparation to Moviprep. The estimated annual savings on repeat procedures and completion imaging across NHS Lothian of £89 000 offset the increased cost of Moviprep (£8.60 per patient vs. £3.65 for PicoLax) of £23 265 annually.

**Conclusion** Changing to Moviprep as the default preparation for colonoscopy in NHS Lothian has resulted in significantly better quality bowel preparation. Furthermore fewer repeat procedures have been required resulting in more efficient use of scarce capacity and cost savings.

#### REFERENCE

1 <http://www.nrls.npsa.nhs.uk/resources/?entryid45=59869>

**Disclosure of Interest** None Declared.

#### PTH-029 LIFESTYLE SCREENING AND BRIEF INTERVENTIONS IN A GASTROENTEROLOGY CLINIC

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**Introduction** Worcestershire Acute Hospitals NHS Trust currently have an Alcohol Liaison Nurse (ALN) Service. In response to NICE and Making Every Contact Count we wanted to implement a lifestyle screening tool within the out patients clinic, and be able to offer signposting and an opportunistic Brief Intervention (BI) service.

**Methods** Patients aged over 16 years attending a busy gastroenterology out-patients clinic were asked to complete a 'lifestyle' screening tool using the AUDIT-C (Babor 2001) to assess alcohol use and smoking status.

Individuals identified as smokers, were advised of the health risk by the a specially trained health care assistant and signposted to a smoking cessation service.

Individuals who were AUDIT-C positive ( $>5$ ) were referred by the consultant to the Alcohol Liaison Nurse (ALN) for further assessment and Brief Intervention.

**Results** 448 patients attended the clinic. 60% ( $n = 269$ ) were asked to complete the tool (2 refused).

32 (12%) individuals were identified as smokers. 13 males with a median age of 56 and 19 females with a median age of 49. 18 accepted an advice card.

82 (31%) AUDIT-C  $>5$ . 46 males with a median age of 53 and 36 females with a median age of 51. 27 accepted referral to ALN (3 unable to contact).

The highest reported motivating factors for change were improved physical and mental health, followed by better finances and weight loss. 75% of the sub-group receiving Brief

Intervention could not identify any costs of change. The sub-group also scored high in relation to readiness to change and confidence to change following the BI. Extended BI reported reduced AUDIT-C scores and reduced drinking days/unit consumption.

**Conclusion** The results suggests that lifestyle screening is a achievable and acceptable in a busy gastroenterology clinic. A significant proportion of patients attending a gastroenterology clinic are likely to be using alcohol at harmful levels or smoking and are therefore likely to benefit from opportunistic BI or signposting to smoking cessation services.

#### REFERENCES

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Babor T, Higgins-Biddle J, Saunders J, Monteiro M. The Alcohol Use Disorders Identification Test. Guidelines for use in primary care. 2nd ed. Geneva, Switzerland: WHO 2001  
The NHS's role in the public's health: A report from the NHS Future Forum. Accessed online [04/12/2013] [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/216423/dh\\_132114.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216423/dh_132114.pdf)

**Disclosure of Interest** None Declared.

#### PTH-030 CLINIC OUTCOMES FOR UNSELECTED PATIENTS REVIEWED BY DOCTORS AND ADVANCED NURSE CLINICIANS – IS THERE ANY DIFFERENCE?

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**Introduction** There is a well-established role of specialist nurses in on-going management of chronic diseases in specialist clinics. With the reduction in junior doctor hours, advanced nurse clinicians (ANC) are taking on increasing complex medical roles. We aimed to evaluate the effectiveness of ANC in managing unselected new patients (NP) in the general gastroenterology clinic in a district general hospital.

**Methods** Analysis was done on 76 consecutive NP seen in the gastroenterology clinic over one week which then generated a further 66 follow appointments over an 18 month follow up period. We compared the direct service costs, diagnosis, outcome and discharge rates for each clinician grade. IBD patients requiring regular follow were excluded from the analysis. Cost analysis was performed using current NHS tariffs for the investigations performed.

**Results** Forty new patients (53%) were seen by an ANC, 26 (34%) by a consultant gastroenterologist and 10% (13%) by a middle-grade doctor (MG) at the first appointment. Forty referrals were on the 'suspected cancer' pathway, of these 68% were seen by ANC, 13% by a consultant 19% and by MG. Of the 36 non-urgent referrals – 36% were seen by ANC, 55% by a consultant and 9% by MG. The mean number of follow up appointments generated was 1.9 (ANC), 1.8 (consultant) and 2.2 (MG). ANC's ultimately discharged 30 patients (39%), consultants 23 (30%), MG's 7 (9%). Sixteen patients (21%) required long-term follow-up or did not attend. Consultants requested 16 investigations on new patients (0.62 tests/patient) costing £161 per patient, MG 15 investigations (1.5 tests/patients) costing £337/patient and ANC's 50 investigations (1.25 tests/patient) costing £331/patient. Only 1 patient was referred back to clinic having been discharged and this was for a new and unrelated problem.

**Conclusion** In our hospital, nurse led and doctor led outpatient care was of equivalent effectiveness with no differences in