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Gastroenterology IN PRIMARY CARE

JOURNAL OF THE PRIMARY CARE SOCIETY FOR GASTROENTEROLOGY

Tackling alcohol abuse over the divide

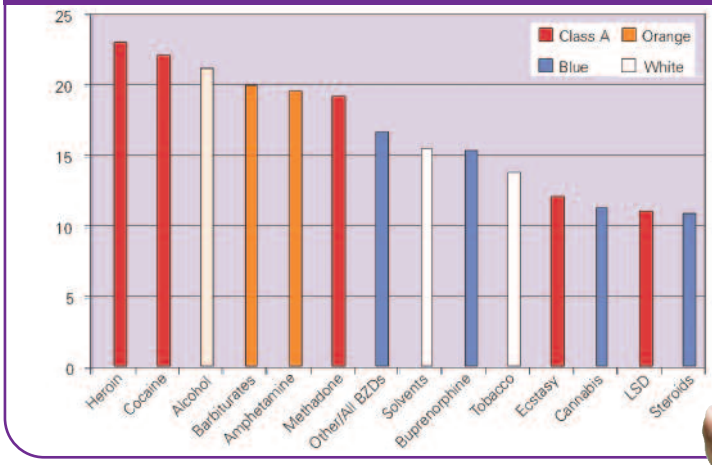
HOW CAN PRIMARY AND SECONDARY CARE WORK TOGETHER?

Professor Ian Gilmore, PRCP - Report by Mike Cohen

The current epidemic of alcohol-related disease was briefly discussed in a recent edition of GIP. Since becoming President of the Royal College of Physicians, Professor Ian Gilmore has been very vocal and active in high-lighting the current situation, so we were delighted when he accepted our invitation to speak at the recent PCSG symposium at the BSG in Glasgow.

He started by setting the background regarding global alcohol consumption and compared the habits of the UK with the rest of the world. Alcohol is undoubtedly still our favourite drug and is comes in third behind heroin and cocaine in terms of its relative harm.

RELATIVE HARM OF DRUGS



Europe and in particular, Eastern Europe are the greatest consumers of alcohol. In the UK we consume per capita on average 12-15 litres a year. The disability adjusted life years attributable to alcohol abuse are enormous. There are global differences regarding the consequences of alcohol misuse. In developing countries harm results mainly from accidents and violence, whereas in developed countries problems of dependence and chronic diseases predominate. The economic burden of alcohol misuse is enormous with respect to not only health and premature mortality, but also in terms of absenteeism, unemployment and criminal damage.

However, these costs need to be offset against the economic benefits to the manufacturing industry, retail industry and advertising industry as well benefits to tourism and leisure industry.

What has been happening in the UK over recent years?

The licensing laws in 1916 caused a drop in consumption which was timely. The last thing the country needed was munitions workers returning to their afternoon's labours in an inebriated state! In the last 20 years or so there has been a steady rise in alcohol consumption, and in particular, wine and ready to drink drinks such as 'Alcopops'.

The tax on cider is still relatively low and drinking white cider is still an inexpensive way to get drunk. Only 50% of the population drink within safe limits, with 30% of men and 15% of women drinking well over safer limits. Binge drinking is the order of the day and in this country there is a tendency

Continued on page 3

This issue...

"GOD is on the side of the heavy battalions"

said Voltaire (1694-1778, French author, humanist, rationalist, & satirist). But he made a large number of other famous pronouncements as well, including "A witty saying proves nothing", presumably to make sure he wasn't taken too seriously… For those of us attempting to maintain or mount new small scale operations of a specialism in primary care, the allocation of the diagnostics contracts in England to the seven cluster based independent sector procurements feels like the beginning of the takeover of the primary care ground and the new opportunities, by the heavy battalions.

Richard Sharpe denied Voltaire's statement by saying "God is not on the side of the heavy battalions, but of the best shot" and this is where GPs need to place themselves in the new age of competition, grouping together as the NHS community's 'best shots' and providing the services that patients prefer. One cannot underestimate however, the complexities involved and difficulties likely to be encountered in setting up new services such as a primary care-led gastroenterology and endoscopy service, for example the service proposed in Bristol which has now been under consideration as part of the PCT's local development plan for many months and is still not finding final agreement despite ticking all the boxes. PCTs themselves face a more complex commissioning task than before and may be under instructions not to show favour and to let the market dictate who essentially 'wins'. One suspects that a PCT will not find any political favours if it is shown to be protective of local NHS service providers and quite possibly they are being told not to create over-capacity so that the new politically-inspired service developments can thrive. As a local GPwSI, you could be seeking some form of preferential contract or guaranteed activity by offering to provide a service based in the community, but it may be that you would have to consider offering the service in a purely competitive market as a suitable provider, but without any guarantee of a volume contract. An urban area with several alternative providers is a different scenario from (say) a rural area where a primary care proposal might be unopposed and where a PCT might encourage a single provider in the community as an alternative from a rather remote hospital.

In spite of the above caveat, models are springing up in most areas of services based on demand management and initial triage and assessment of patients hitherto referred to secondary care providers and in this arena the independent sector may not impact so directly. It may also be possible to provide various procedures which are performed at a tariff price in secondary care (and independent sector) at a reduced cost to commissioners, if the service can be run with lower overheads. So there is scope for proposing community based 'specialist' services which actually remain within the primary care envelope and do not reach the point of referral to secondary care. Diabetes, orthopaedics and dermatology are three examples of services now existing in primary care in different districts and there are the GP practice based community endoscopy services which have existed in England (although not Scotland or Wales) since the era of GP fundholding.

One of the principal drivers for change in the current climate is the 18 week referral to treatment target which is being rolled out across all three member countries of the UK. Meeting this target in Scotland is no problem since the Scots are aiming to produce a reduction in the current 9 week referral to treatment target. Scotland it seems invests a greater proportion of GDP in the NHS and is refreshingly unencumbered with the complexities of PCTs, PBC and PBR – quite simply, the Scots have none of these, but instead a simple central command structure via Health Boards, something like the English NHS 15 years ago! Until I joined a meeting north of the border in March, I had not realised the extent to which one is setting foot in a foreign land (even if it is the land of my own ancestors)! Andrew Summers, GP Endoscopist in Yeovil, Somerset is the GP member of the 18 Week Programme Team and has provided the article in this issue.

The PCSG continues to be grateful for the very busy colleagues, particularly Committee members, who somehow make some time to contribute the excellent articles that appear in this journal. This issue also contains articles drawn from expert presentations on Hepatitis C, alcoholism, upper GI cancers and IBS.

As Editor, I would like to apologise for the failure to name the authors of three of the outstanding articles in the last issue (April 2007) – they were:

Patient Safety – Dr John Galloway reporting Professor Mike Bramble's state of the art presentation on Safety in Endoscopy. This document should become a standard reference.

AspEct – The 10 year 5000 patient Aspirin Esomeprazole Chemoprevention Trial, presented for us by the Principal Investigator, Professor Janusz Jankowski

New Concepts in Gastro-oesophageal Reflux Disease – this outstanding original article was written for the journal by the PCSG President, Roger Jones, Wolfson Professor of Primary Care at Kings, Guys and St Thomas's.

Sincere thanks to these eminent colleagues for their time and contributions and sincere apologies from this editor for the failure to accredit.

I hope readers gain as much enjoyment from the present issue as the last; certainly as editor I have benefit enormously from the depth of the various contributions.

Richard Spence, Editor

Continued from front

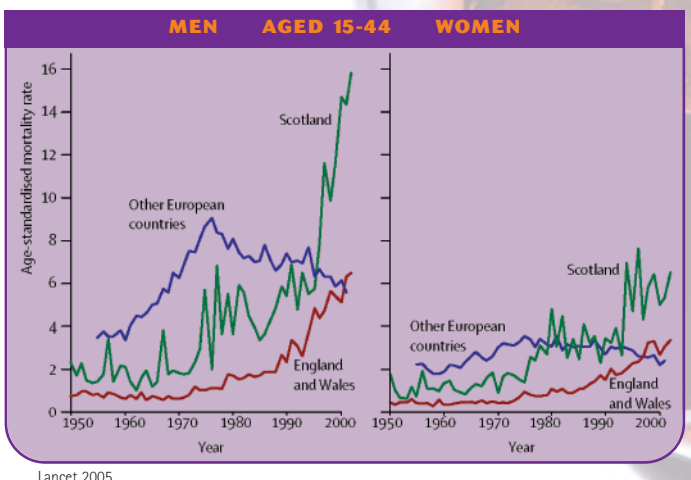
not to drink with food - causing a huge difference in peak alcohol levels. Reports between 1990 and 2002 suggest that children of school age are drinking more. Consumption in this age group has doubled-over 20% of 13 year olds admit to being drunk at some time.

So we drink a lot but does this matter?

Well of course it does. The harmful effects of alcohol abuse are wide ranging having untoward affects with respect to crime, public disorder, family and social networks, there are also implications affecting health and work place productivity. The collateral third party damage is enormous and Professor Gilmore made an interesting comparison with the harmful effects of passive smoking. It was the damage from passive smoking which tipped the balance and enabled legislation to be brought in banning smoking in public places. The chronic effects of alcoholism are wide ranging causing physical disease - GI damage, cardiovascular damage, neuropsychiatric conditions, cancers, maternal and perinatal morbidity and behavioural problems leading to abuse, violence, crime and breakdown of relationships and family structure. Alcohol-related disease is increasing world wide. It is now the third commonest risk factor implicated in causes of preventable death in developed countries behind tobacco-related conditions and the harmful effects of hypertension.

As an aside, he did mention the benefits of a daily intake of 1-2 units of alcohol per day and the beneficial effect on lipid profiles.

The depressing situation we currently find ourselves in the UK is that standardized mortality rates from cirrhosis in England, Wales and Scotland in men and women are rising, whereas in other European countries they are falling.



Lancet 2005

On the brighter side considerable reductions in mortality can be achieved from relatively small reductions in alcohol intake (Norstom 2001)

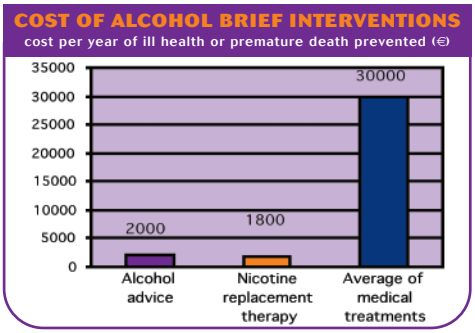
Can the NHS afford the current wave of alcohol-related disease?

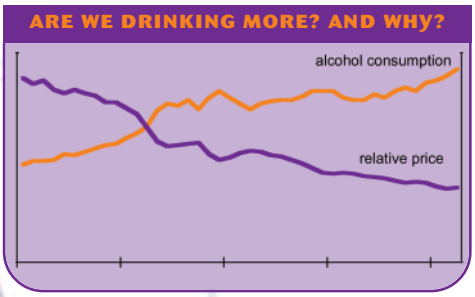
Of course it cannot so what can we do about it and how may we develop a coherent alcohol strategy for hospitals?

Alarmingly the current financial situation means that there is 100 times more funding for drug misuse compared to alcohol misuse. A National Strategy and a Director were introduced in 2004. Recommendations were made to improve education in undergraduate and post graduate training, as well as in the training of other health care workers. Each Trust should have a strategy for an early detection programme, provision of brief interventions, audited protocols for detoxification, established links with community alcohol services and mental health services. Trusts need senior members of medical staff and nursing staff to act as champions and one or more dedicated alcohol health workers. Each hospital should employ an alcohol specialist nurse. Nurse-led clinics do seem to make a difference and could they be the key to bridging primary and secondary care services? However, in a recent questionnaire survey of acute hospital Trusts few had alcohol specialist nurses in post. These nurses can deliver brief interventions and motivate patients to take responsibility for their drinking behaviour. This can enable patients to make appropriate changes.

Professor Gilmore told us that in Liverpool (where he works) more of these nurses have been moved into the community and that primary care is an ideal setting for brief intervention. They take 15-30 minutes on two or three occasions. Meta analyses of alcohol brief interventions show them to be cost effective with respect to cost per year of ill health or prevention of premature death. (NNT better than smoking cessation)

Perhaps practice based commissioning groups may wish to explore these services further?





Academy of Medical Sciences Report 2004

Finally - why are we drinking more?

Apparently as laudable as education is there is limited evidence that it works and maybe that is why the drinks industry is happy to back it?! Alcohol is now more affordable than ever and the price of cider and alcopops is very low.

Alcohol is now available at all sorts of outlets such as supermarkets and garages. Licensing hours increase availability.

Professor Gilmore concluded that the best way to reduce alcohol-related harm across primary-secondary care was to:

- Acknowledge the problem
- Detect early and implement brief interventions
- Reduce per capita consumption through price and access

This was a very illuminating and entertaining talk. There were a couple of questions and then we retired to the bar for a couple of glasses of mineral water!

Mike Cohen
GPwSI Gastroenterology Bristol

18 WEEK PATHWAY PROJECT GI WORK IN PROGRESS

It is Government and therefore Department of Health policy that by December 2008 no patients should wait longer than 18 weeks from referral to receiving their first definitive treatment. The underlying principle is that patients should receive excellent care without unnecessary delay.

It was against this background that a Clinical Advisory Group (CAG) was assembled in early December 2006. The members were drawn from twelve clinical specialties known to be high volume users of NHS resources. Each team comprised representatives from Secondary and Primary Care with a non clinical project leader ensuring fair play. The CAG was to discuss with and give advice to the Implementation Director, Phillippa Robinson, on the development of commissioning pathways.

A generic template had been prepared into which we were asked to shoehorn guidelines against which commissioners of health care could measure the services delivered by service providers. The template is essentially a flow chart offering decision points and supplementary clinical information. The CAG has been at great pains to ensure that the pathways are seen to be commissioning pathways and not clinical guidelines. The 18 week pathway is intended to guide commissioners and show the various points at which the 18-week clock starts and stops.

Any referral from Primary Care starts the 18-week clock if it is expected that:

- The patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring health professional; and
- Any treatment will or might be carried out by a medical or surgical consultant-led service irrespective of setting.

A referral to a General Practitioner with a Special Interest will start an 18-week clock if that practitioner has been commissioned as part of a referral-management arrangement. Along the way there are various clock stopping points including for example a diagnostic colonoscopy which becomes therapeutic. To allow for the inevitable complex cases and "legitimate delays" there can also be clock pauses. A decision to employ "watchful waiting" also counts as a clock stopper. The full guidance is available on the website.

The gastroenterology team comprises:
Team leader Sue Kong
Primary Care Andrew Summers
Secondary Care Adrian Manning (Endoscopy)
Robert Logan (Gastroenterologisy)
Basil Fozzard (colorectal surgeon)
Public Health Steve Laitner

We developed three pathways covering dyspepsia, altered bowel habit and rectal bleeding. The pathways can be viewed on the 18 Week website www.18weeks.nhs.uk and comments are still welcome before the final versions are agreed.

It is fair to say that we were not always clear about how these templates were to be used and all members of the CAG have been anxious to stress that we have not tried to rewrite clinical guidance. In order to consult with a wider body of opinion there will be a "Consensus Day" when invited clinicians will gather to discuss the pathways and make suggestions for final alterations before the finished products are published on the website and delivered to commissioning bodies.

The gastroenterology consensus day will be May 21 in London and PCSG committee members will be invited to attend or nominate participants to provide the Primary Care voice.

Dr Andrew Summers is a GP in Yeovil and Endoscopist at Yeovil Hospital NHS Foundation Trust. He is a Steering Committee Member of the PCSG and newly appointed as RCGP representative on the JAG committee.

Upper Gastro-intestinal Cancers

IS IT TIME F

The Quality and Outcome Framework (QOF) element of the new GP contract has been immensely influential in changing the behaviour of general practitioners. Essentially it is programme for resourcing and rewarding systematic care for a selection of chronic diseases through the setting up of registers and quality targets. As money earned through the QOF is one of the only ways practices can increase their earnings they have invested in staff, systems, education and effort in the diseases covered by it.

One result of this that for disease areas not included in the QOF, like gastroenterology, the effect has been positively detrimental. Attention and investment is directed away and towards those areas that are included in the QOF. These areas were chosen on political as much as public health grounds. Government priority areas such as cardiovascular disease and mental health were included and a range of equally important

At the last PCSG Annual Scientific Meeting we were treated to a number of talks on gastrointestinal cancers. The following is a summary of the talk by Dr Alan Ireland, Consultant Gastroenetrologist in Brighton.

Gastro-oesophageal cancers cause approximately 14,000 deaths per year and there is a rising incidence of oesophageal cancer and poor outcomes are the rule once alarm symptoms present.

Gastric Cancer.

The UK incidence is 12-15/100,000, while in Japan it is 90/100,000. Screening is justified in Japan because of the high incidence and the five-year survival figure is greater than 90% if the diagnosis is made early; submucosal endoscopic resection is often an effective and life-saving treatment. In contrast, the median five-year survival for both the UK and the USA is 30%.

There is undoubtedly a link between helicobacter infection and the development of gastric cancer and the postulated sequence is from infection to gastritis, atrophy, intestinal metaplasia, dysplasia and on to frank cancer. Uemura et al (New England Journal of Medicine pp 784-789, Sep 2001) followed up a series of patients post endoscopy and testing for HP and the mean follow-up time was 7.8 years. In the HP positive group 53% developed moderate atrophy, 17% severe atrophy and 37% intestinal metaplasia. Cancer developed in 36/1246 patients who were HP positive. No HP negative patients developed cancer. It is still too early to be able to assess the effect of HP elimination.

An analysis of symptoms in those referred with alarm symptoms showed that dysphagia, weight loss, and age >55 were the only symptoms of significant predictive value.

Oesophageal Cancer

There has been a 6 to 8 fold increase in the incidence of oesophageal cancer in the past 15 years and this is almost completely accounted for by a rising incidence of adeno-carcinoma. There has been a 6 fold increase in the incidence of Barrett's oesophagus diagnosed at endoscopy. There is also a statistical link to increasing incidence of reflux and/or obesity. Studies indicate their over the past 15 years there has been an increased survival and one-year that virtually no change in five and ten-year survival.

Barrett's Oesophagus

In patients with Barrett's mucosal change there is a 30 fold increased risk of carcinoma and those at greatest risk are males, age >45, with long segment changes and a >10year history of reflux. Despite this 95% of those with Barrett's will not developed cancer. Barrett's will remain a hidden problem while the current NICE guidelines stand. Screening patients with reflux is not recommended by the BSG - their guidelines suggest that discussion should take place with each patient and in those who wish it two-yearly endoscopic follow-up should take place with quadrantic biopsies every 2 cm above the squamo-columnar junction. A health economic assessment suggests that such two-yearly assessment will have a cost of £19,000 per life saved.

Against these depressing figures, prevention seems the only answer and there are currently 2 studies seeking answers. The BOSS study (Barrettt's Oesophagus Surveillance Study) is recruiting in 2500 patients with Barrett's and in follow-up will stratify them by aspirin use. The AspECT study is comparing high and low dose Esomeprazole with or without aspirin. Both these large and very important studies will need a full 10 years to report. There is an urgent need to increase recruitment to the AspECT study, and GPs with a GI interest are urged to participate. Please contact the chief investigator, Professor Janusz Jankowsi.

OR A GASTRENTEROLOGICAL QOF?

and debilitating conditions were not.

The next round of negotiations for changes to the QOF has started. Interested parties have been invited to submit new areas for potential inclusion together with supporting evidence. As has become usual, the deadline was short and the process obscure. It seems submissions are checked for quality and strength of evidence and then become part of the negotiations between the General Practice Committee of the British Medical Association and the NHS employers on behalf of the Government. How these negotiations work in deciding what factors might affect inclusion or exclusion in the new framework is unknown. The process gets murkier as it is rumoured (at the time of writing) that the NHS employers have withdrawn from the process and the BMA is now dealing directly with the Department of Health. If this correct then we can expect an even more political QOF.

Gastroenterological conditions account for about 10% of the workload in both primary and secondary care and a disproportionately greater amount of the budget. A number of the conditions seen are long-term. Mindful of the fact that not being in the QOF is positively detrimental to the attention given to a disease area, the PCSG has submitted proposals for inclusion in the new framework.

Coeliac disease is a long-term condition whose care can be delivered or arranged from primary care. It is relatively easy to envisage incentives and resources being provided for setting up a practice register and ensuring reviews which could include checking such things as understanding and concordance with diet, blood tests and where appropriate and supported by the evidence, DEXA scanning. Although it is often felt that coeliac disease is a 'minority' condition the latest prevalence figure for it is around 1% of the population which puts it on a par with epilepsy and not that far behind diabetes.

Dyspepsia is more difficult area because of the looser definition and large numbers of patients. However as the NICE dyspepsia guidelines become more wisely used there is a strong argument that uninvestigated dyspeptic patients on long-term acid suppression need an occasional review to check that they have not developed alarm symptoms. All this could easily be incorporated in a structure for systematic care.

Other possible areas that could be included in a new framework are the care of Inflammatory Bowel Disease patients and case finding in high risk populations for Hepatitis C.

Although the submissions made are of strong clinical merit we cannot know how they will fare in the melee of financial and political negotiations. We await events.

Richard Stevens,
PCSG Chairman

FIFTEEN THINGS YOU MIGHT NOT KNOW ABOUT
Irritable Bowel Syndrome

Irritable bowel syndrome affects 10 to 15% of the adult population in the UK, with female predominance. Patients typically report abdominal pain or discomfort, bloating or distension, disordered bowel habit that is diarrhoeal, constipated or mixed.

1 Extracolonic symptoms may also be present including: low backache; lethargy; nausea; thigh pain; urinary frequency, urgency or urge incontinence; dysmenorrhoea and dysparaenia.

2 It is tradition to describe the diagnosis of IBS as a diagnosis made by exclusion but this is an outdated concept. By employing the diagnostic criteria including the Manning criteria, Rome I, Rome II criteria and soon to be published, Rome III criteria, a positive diagnosis can be made safely, in the absence of 'red flag' symptoms. However, this diagnosis can make less certainly in those over the age 50 years, in particular, if the symptoms are of recent onset. Patients with diarrhoea predominant symptoms pose more of a challenge than those with constipation predominant IBS. Inflammatory bowel disease has to be considered when diarrhoea is present particularly if this accompanied by perianal soreness.

3 The presence of 'red flag' symptoms (rectal bleeding, anaemia, weight loss, late age of onset, acute onset, family history of cancer, family history of IBD, and signs of infection) should prompt the search for alternative diagnoses including IBD and bowel cancer. Diverticulosis is often present in the older patient with a diagnosis of IBS but it is often difficult to differentiate between the two conditions or even which is responsible for any current symptoms.

4 In general, investigations should be kept to a minimum but a full blood count and ESR should exclude most realistic alternatives. There is uncertainty whether screening for Coeliac disease is worthwhile however there is growing evidence to suggest that this is a valuable investigation particularly in diarrhoea predominant IBS.

5 Abdominal examination should be normal but right or left iliac fossa tenderness is occasionally present and the caecum may be palpable.

6 Traditionally, fibre is recommended in the treatment of IBS; there is little evidence to support the use of supplemental dietary fibre. Insoluble fibre such as bran often exacerbates bloating and pain making the condition worse. Fibre may help constipation type IBS; commercially available soluble fibre is least likely to exacerbate symptoms.

7 Certain food substances can exacerbate the symptoms of IBS. These include; coffee, chocolate and sugar substitutes such as sorbitol or fructose. Any food suspected of causing IBS should be excluded for one month and only one food type excluded at a time. Strict exclusion diets have shown to be helpful in some cases but are best managed under strict supervision of a dietician with an interest in IBS.

8 Antibiotics and non-steroidal inflammatories often exacerbate the symptoms of IBS; erythromycin is particularly prone to worsen IBS symptoms.

9 Drug treatment has not changed markedly over the past 20 years. The main stay of treatment is antispasmodics; the two main classes are anticholingerics and smooth muscle relaxants. Both worthwhile prescribing in combination if either class is individually ineffective. These should be taken as required which should minimise tachyphylaxis.

10 Antidiarrhoeals and laxatives have their place in the treatment of IBS. Loperamide is particularly useful as an antidiarrhoeal as it tends to increase the anal tone. The dosage should be titrated to the individual's need and the patient reassured that long-term treatment would not affect their bowel.

Most laxatives are effective in IBS and again long term use is not a problem. However, lactulose should be avoided as this can cause excessive flatus and exacerbate bloating symptoms. A sufficient dose taken regularly is preferable to an intermittent cathartic purging.

11 Probiotics (lactobacilli or bifodobacteria) are being used with some success in IBS but firm evidence is lacking. Combinations of probiotics are not recommended as they can inhibit one another. A probiotic strain needs to be taken for at least 4 weeks before an alternative strain is attempted. Bifidobacterium infantis 35624 has been used with a good effect in women with both diarrhoea and constipation IBS.

12 In diarrhoea-predominant IBS, a trial with cholestyramine is sometimes very effective and is worthwhile trying in resistant cases. Success with cholestyramine suggests that the diagnosis may not be IBS!

13 Newer treatments are available these include Type 3 serotonin antagonists and Type 4 serotonin receptor agonists but have been dogged with restriction to gender and type of IBS. In addition, ischaemic colitis has been reported with Type 3 serotonin antagonists.

14 Behavioural therapies including psychotherapy, CBT and hypnotherapy have been shown to be effective in IBS. There is no reason why CBT could not be provided in primary care for the most resistant cases.

15 In summary, most patients will respond to a combination of an explanation of their symptoms, medication as required, a review (and often reduction) of their fibre intake. Referral to secondary care should be considered when the symptoms pose a significant effect on the patient's quality of life.

Jamie Dalrymple, Secretary PCSG

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PAYMENT BY RESULTS (THE NATIONAL TARIFF) by Scott McKenzie and Huw England

At the heart of the UK Government's NHS reforms is a new way of paying for hospital episodes; Payment by Results (PbR) sometimes known as The National Tariff. The Department of Health has drawn up a long list of procedures, such as hip replacements, treatment for stroke or treatment for heart attack; each with its own Healthcare Resource Groups (HRG) code. The HRG code represents the prices paid to Acute Trusts and Foundation Trusts for much of the activity they undertake.

There are more than 1,000 HRG codes, designed to capture all the treatments and procedures that a patient might have while in hospital for a particular condition or operation. Each GP Practice is strongly urged to have a copy of the National Tariff and start to understand what each procedure costs in real terms. (Anyone wishing a copy should email info@me-consultancy.com and we will be happy to supply an up-to-date copy).

Successful roll out of Payment by Results nationally is crucial to system reform. The financial regime, through Payment by Results, offers opportunities for the development of alternative services; indeed, PbR actually creates incentives for increasing productivity and making efficient use of resources.

While the new system is designed to get the price 'right' for services, by paying a price that ensures value for money for the taxpayer and incentivises the provision of innovative, high quality patient care; the system for coding the activity is far from perfect. It is widely accepted that the invoices sent to the PCTs, have coding errors in the order of 30%+; which represents many thousands of £'s from the indicative budgets held by Primary Care.

With the invoices containing such a high error rate the key for Primary Care lies in the robust analysis and tracking, of the data associated with episodes of hospital care. Once identified the errors need to be challenged by the PCTs, with the hospital providers, in order to claim a refund.

In terms of the data; Practices absolutely must ensure the HRG billed was both relevant and appropriate. Practices need to be aware that hospitals can, and will "game" the system.

As an example, there are two prices for an elective admission for COPD, £594 for treatment of patients without medical complications; £1,508 for those with complications. The risk is that hospitals will over code, using the £1,508 when the £594 would be correct. Worse still, the tariff offers perverse incentives to hospitals to give unnecessary treatment in order to make more money.

In addition you will also find straightforward errors; two examples seen recently:

1 The date of discharge should have been 11/7/2006 but was input as 7/11/2006 significantly increasing the number of days in hospital and in turn the value of the invoice.

2 A day case procedure costing £118,000; the hospital coder had input 118 days instead of 1 day.

Neither error had been picked up by the Practices but was picked up when the data was closely scrutinised as part of planning for Practice Based Commissioning.

Summary

Within the current Government's NHS reforms Payment by Results is a major change in the NHS financing regime; it is also a key component of the Government's Modernisation Programme for the NHS.

Payment by Results offers both significant opportunities, for the development of alternative services and also many challenges for the NHS; not least in the potential for errors in the coding of invoices which can have significant detrimental impacts on Primary Care indicative budgets if not picked up and challenged.

If the NHS is to remain "within the available resources", and maximise the use of budgets, a successful implementation of Payment by Results will underpin those outcomes.

Editor: *McKenzie England Consultancy was established in 2005 and is a two-man partnership delivering innovative services in the healthcare sector. They specialise particularly in implementing policy around the drivers for change within the NHS by working with Practice Based Commissioning consortia, developing robust governance arrangements and commissioning plans. This has led to the effective implementation of Practice Based Commissioning across England, within our client base. They work with groups ranging from single handed practices to consortia with 24 practices and 150,000 patients.*

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Hepatitis C UPDATE

Although there are a number of voices warning about the impending crisis of Hepatitis C and its consequences not much seems to be being done on the ground. A clear and sound review of the issues was given by Dr Sushma Saksena, Consultant Gastroenterologist in Durham, at the PCSG Regional Meeting in York.

The Hepatitis C virus was only identified in 1989. It mutates easily and there are known to be six genotypes and over fifty subtypes. This is important as the different genotypes have differing virulence and differing treatment lengths. It may also be an important factor in the emergence of resistance in a patient group not always known for their compliance with treatment.

The natural history of the disease presented to the meeting was that after exposure fewer than 20% of people spontaneously clear the virus. The remainder go on to become chronically infected. Of these 50% develop chronic hepatitis and after some twenty or thirty years, 20% will develop cirrhosis. Of these 5% will develop liver cancer. It seems there was an epidemic starting in the 1970s which we are just appreciating as the result of long-term infection becomes clinically apparent. The increasing incidence seems to be a real effect and not an artefact of increased testing.

In the UK past or current intravenous drug users (IVDU) make up the biggest single group of sufferers.

Mode of Hepatitis C acquisition in the UK
IVDU 87%
Blood transfusion (pre-1991) 4%
Sexual contact 2%
Vertical transmission 0.8%
Occupational 0.1%
Others 6%

Testing for Hepatitis C only started in1991 and people receiving blood products before that date are at risk (Anita Ruddock of the Bodyshop being a famous example). Estimates of the prevalence of infection in the UK vary from 0.5%-0.8% of the population (200,000 to 500.000 people). The wide range in the estimate is due to the differing populations used to in the surveys that are often pregnant women or patients attending genitourinary clinics and from whom it may be difficult to extrapolate to the general population. In any event there seems to be an exponential rise in the number of cases and it can be inferred, a likely rise in future cases of cirrhosis and liver cancer.

The economic issues around screening for and treating Hepatitis C are debated. Many specialists maintain that cost of not intervening will be more costly in terms of treating the sequelae of long-term infection than a programme of case finding and offering treatment. In France there is not only such a programme but also the stigma of being infected seems to have been removed.

Initial screening with an ELISA test is estimated to be £10. Any positive results would need to be repeated and then confirmed and sub-typed by PCR. (£92). Knowing the virus genotype is important as this dictates the length of treatment and of it being successful. Infections with genotypes 2 and 3 require shorter (and therefore cheaper at £6,000) treatments with an 80% success rate than genotypes 1,4,5,6 (£12,000 with 45% success rate).

For the GP the message would seem to be to be aware of the potential size of the problem and offer counselling and testing to the at risk groups. Harm reduction by reducing infected patients' alcohol intake is also important. Familiarisation with local pathways would also be prudent as this is a diagnosis that is going to be made increasingly often.

Richard Stevens, Chairman PCSG

Event Diary

Sat 30 June - Sun 1 July 2007
Endoscopy Meeting,
Hilton Metropole,
Brighton
Contact: pcsg@pcsg.org.uk

12 October 2007
Annual Scientific Meeting/AGM,
RCP, London
Contact: pcsg@pcsg.org.uk

Sat 27 - Weds 31 October 2007
UEGW
Paris
Contact: www.uegw.org.uk

8 February 2008
PCSG Regional Meeting
Peterbrough – tbc
Contact: pcsg@pcsg.org.uk

Mon 10 - Thurs 13 March 2008
BSG Annual Scientific Meeting
ICC, Birmingham
Contact: www.bsg.org.uk

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