DECEMBER 2007

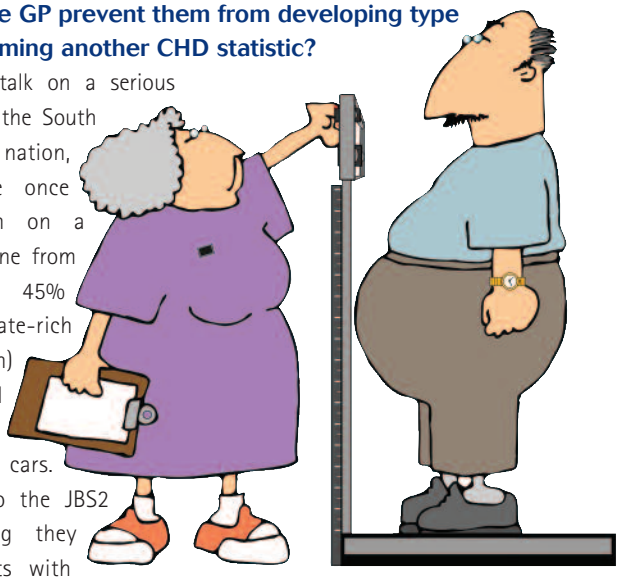
Gastroenterology IN PRIMARY CARE

JOURNAL OF THE PRIMARY CARE SOCIETY FOR GASTROENTEROLOGY

QOF totally misses target in UK obesity

DR RICHARD SPENCE

David Haslam told us that the single obesity target in the QOF is genuinely worse than useless. All you do is just register that the patient in front of you is fat to collect your 8 points and ask them to come back next year to register the same again. He underlined how unethical it is to turn a blind eye to all the other risk factors presenting in the overweight subject; what are the eating/drinking habits? Is the patient hypertensive? Smoking? Has cholesterol been checked? Can the GP prevent them from developing type 2 diabetes, becoming another CHD statistic?



His entertaining talk on a serious subject began with the South Pacific tiny island nation, Nauru, where the once healthy population on a natural diet had gone from zero obesity to 45% following phosphate-rich guano (bird pooh) export profits and the introduction of western food and cars. David subscribes to the JBS2 guidelines believing they offer better targets with cholesterol value at 4.0, LDL 2.0 mmol. So what to do with the patient who plonks down in front of you saying "I'm fat" and (or inferring) "You've got to sort it out".

He showed statistics which revealed that obesity in the UK has almost tripled since 1980 and believes that there is only a limited window of opportunity to do anything about the situation in this country before it reaches the appalling prevalence in the USA (37% men, 55% women). He showed that the evidence is good that a 10% loss in body weight results in a marked improvement in mortality statistics and a 30% reduction intra-abdominal fat (which is associated with damaging lipocytokines and with multiple morbidities including increased incidence of various cancers). There is value in weight loss programmes even when weight is regained so that even with an overall loss of only 1kg/year over 4 years there is a 58% reduction in new diagnoses of Type 2 diabetes - a truly astonishing statistic.

His most telling slide was a handwritten note from a boy called

Continued on back cover

His plan for a more meaningful QOF target would be

1. Adult obesity register
2. Child obesity register
3. Percentage figure for registering weight management advice/practice weight loss programme
4. BMI recorded in previous 15 months.
5. Fasting glucose recorded in previous 15 months.
6. BP recorded in previous 15 months.
7. Fasting lipids recorded in previous 15 months.

This issue...

Introducing once-daily Mezavant XL for ulcerative colitis (UC)

Mezavant® XL in the morning

The rest of the day for them

The first and only once-daily 5-ASA tablets approved in the UK for the induction of clinical and endoscopic remission, in active, mild to moderate UC patients, and maintenance of remission[1]

Prescribing information: (Please refer to full Summary of Product Characteristics [SPC] before prescribing).
Mezavant® XL 1200mg, gastro-resistant, prolonged release tablets. Presentation: Mesalazine (5-ASA) provided as 1200mg gastro-resistant, prolonged release tablets debossed on one side with S476. **Uses:** For the induction of clinical and endoscopic remission in patients with mild to moderate, active ulcerative colitis. For maintenance of remission. **Dosage and administration:** Oral. Tablets to be taken once daily (o.d.). Tablets must not be crushed or chewed and should be taken with food. ***Adults/Elderly:*** For induction of remission: 2.4 to 4.8g (two to four tablets) should be taken once daily. The highest dose of 4.8g/day is recommended for patients not responding to lower doses of mesalazine. When using the highest dose (4.8g/day), the effect of the treatment should be evaluated at 8 weeks. For maintenance of remission: 2.4g (two tablets) should be taken once daily. ***Children:*** Not recommended. **Contraindications:** History of hypersensitivity to salicylates (including mesalazine) or any of the excipients of Mezavant XL. Severe renal impairment (GFR <30ml/min/1.73m^2) and/or severe hepatic impairment. **Special Warnings and Precautions:** Use with caution in patients with confirmed mild to moderate renal impairment. All patients should have an evaluation of renal function prior to initiation of therapy and at least twice a year. If there is suspicion of blood dyscrasia, treatment should be terminated. If acute intolerance syndrome is suspected, prompt withdrawal of mesalazine is required. Caution should be used in prescribing to patients with hepatic impairment, patients with chronic lung function impairment, especially asthma (due to risk of hypersensitivity reactions), patients allergic to sulphasalazine, or patients with conditions predisposing to myo- or pericarditis. Organic or functional obstruction in the upper gastrointestinal tract may delay onset of action. See SPC for full details on warning and precautions. **Interactions:** Caution is recommended with concomitant use of known nephrotoxic agents including non-steroidal anti-inflammatory drugs (NSAIDS). Mesalazine inhibits thiopurine methyltransferase and caution is recommended for concurrent use of mesalazine with azathioprine or 6-mercaptopurine. Administration with coumarin type anticoagulants could result in decreased anticoagulant activity. **Pregnancy and Lactation:** Only use during pregnancy when clearly indicated, using caution with high doses. Caution should be exercised if using mesalazine whilst breastfeeding. **Undesirable Effects:** Approximately 14% subjects experienced treatment emergent adverse drug reactions in clinical trials with Mezavant XL, the majority being transient and mild or moderate in severity. Events reported as common (>1% and <10%) were flatulence, nausea or headache. Uncommon events (>0.1% and <1%) to Mezavant XL were: decreased platelet count, dizziness, somnolence, tremor, ear pain, tachycardia, hypertension, hypotension, pharyngolaryngeal pain, abdominal distension, abdominal pain, colitis, diarrhoea, dyspepsia, pancreatitis, rectal polyp, vomiting, increased alanine aminotransferase, abnormal liver function test, acne, alopecia, prurigo, pruritus, rash, urticaria, arthralgia, back pain, asthenia, face oedema, fatigue, pyrexia. Mesalazine has also been associated with the following; agranulocytosis, aplastic anaemia, leukopenia, neutropenia, pancytopenia, thrombocytopenia, neuropathy, myocarditis, pericarditis, allergic alveolitis, bronchospasm, cholelithiasis, hepatitis, angioedema, systemic-lupus erythematosus-like syndrome, myalgia, interstitial nephritis, nephrotic syndrome. **Overdose:** Conventional therapy for salicylate toxicity. Hypoglycaemia, fluid and electrolyte imbalance should be corrected and adequate renal function maintained. **Basic NHS price:** £62.44 **Legal category:** POM. **Marketing Authorisation number:** PL 08081/0040. **Marketing Authorisation holder:** Shire Pharmaceuticals Contracts Limited, Hampshire International Business Park, Chineham, Basingstoke, Hampshire, RG24 8EP, UK. **Date of revision:** October 2007. Further information is available from: Shire Pharmaceuticals Limited, Hampshire International Business Park, Chineham, Basingstoke, Hampshire, RG24 8EP, UK. Tel: 01256 894000. MEZAVANT is a trademark of Shire LLC in the UK.

NEW ONCE-DAILY mezavant® XL mesalazine 1200mg gastro-resistant, prolonged release tablets

Once daily for remission.

Adverse events should be reported to the Yellow Card Scheme. Information about adverse event reporting via this scheme can be found at www.yellowcard. gov.uk. Adverse events may also be reported to Shire Pharmaceuticals Ltd on 01256 894000.

Reference: 1. Mezavant XL. Summary of Product Characteristics. January 2007.

Shire

Trailblazers

or wild goose chase?

Those of you that attended the PCSG endoscopy meeting in Brighton at the end of June will remember the dreadful weather; it was truly horrible with heavy rain and lashing winds. You may also recall the storm occurring inside the meeting room caused by the issue of appraisal and accreditation of GP endoscopists. Roland Valori, National Endoscopy clinical lead, proposed that the PCSG should be at the forefront of revalidation by setting its own criteria and standards and start the process off. A draft proposal was presented and Prospero himself would have been proud of the result.

At present there is no process by which endoscopists are appraised and revalidated. Training has been formalised through JAG and all endoscopists, regardless of background, are trained to the same standard, no distinction being made between physicians, surgeons, nurses or GPs. The latest JAG document published recently highlights the need for revalidation of all endoscopists especially in the wake of what is happening with the assessment of competence of screening colonoscopists for the National Bowel Cancer Screening Programme. They are having to submit an audit of recent performance, do an MCQ and have a direct observation of procedural skills (DOPS) assessment before being let loose on the public. As GPs we have annual appraisal and endoscopy is assessed as part of that. It is highly likely that the person doing it is a non-endoscopist and therefore not necessarily the best person to appraise that aspect of our work. The proposed endoscopy appraisal would include the submission of a CV, description of working environment, case mix, discussion cases, list of critical events, evidence of learning, feedback, perceived learning needs and agreed objectives for the coming year. There would also be a DOPS exercise looking at consent, sedation, endoscopic skills and management of the patients. What isn't clear is how often endoscopy appraisal would take place (yearly or biannually), who would set the standards, what would the policy be on endoscopists failing to meet those standards, who does the assessments (consultants or peers) and who's going to pay for it all? It would also appear that the National Endoscopy team are having the nurse endoscopists jump through similar hoops to invent their own appraisal and revalidation criteria so they can be at the forefront of this process as well. Is this a case of first group to come up with their own plan wins? The big difference is there is money and support for the nurses from the National team and from JAG. Speaking at Brighton, Roland Valori implied there might be funding available for a GP pilot but this has not been forthcoming thus far. My view is we have a regulatory body that treats all groups the same for training that it is in the middle of setting the standards for appraisal. We have representation on that group. Let's see what JAG comes up with rather than spend valuable time on a wild goose chase just to end up getting stuffed at the end of it.

Dr Mark C. Follows
BM MRCP(UK) MRCGP,
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The Society would like to acknowledge support from the following members of the Corporate Membership Scheme:

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Obesity epidemic: is surgery an option?

Mr Roger Ackroyd, Consultant Surgeon, Royal Hallamshire Hospital, Sheffield delivered a most illuminating and entertaining talk on Bariatric surgery (surgery for severe and refractory obesity) at the Annual Scientific Meeting held in October at the RCP in London.

People with BMI over 35 have **morbid obesity**; over 50 are **super obese** and over 60 **super super obese**.

Indications for surgery

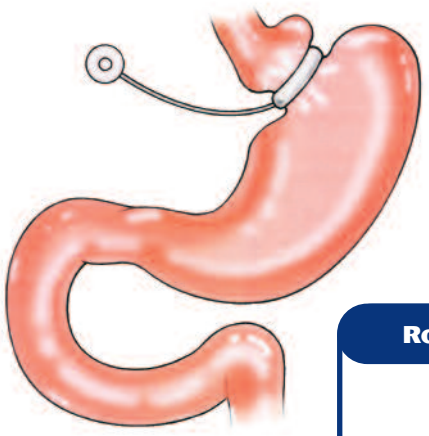
- Revised NICE guidelines on management of obesity recommend that those with BMI of over 50 can be referred directly for surgery
- BMI >40 or >35 with at least one co-morbidity and age >18 (should have tried all other "appropriate" treatment first

Types of surgical procedures

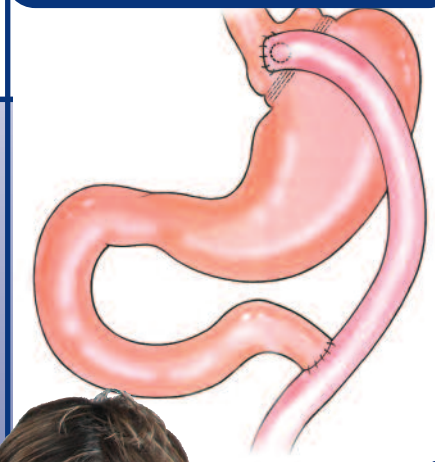
The two most commonly used are gastric bypass (malabsorptive) and laparoscopic banding (restrictive). Gastric by pass procedures currently account for 50 to 60% and LapBand 40-50% of all bariatric operations.

Mortality rate is 1% (6 deaths of 1400 operations performed by Mr Ackroyd). Complications include slippage, erosion, leakage and infection. Metabolic effects with bypass procedure may cause diarrhoea, malabsorption and liver failure.

LapBand



Roux-en-y gastric bypass



Considering the epidemic scourge of obesity in the UK at the present time it is estimated that up to 1 million people may be eligible for bariatric surgery. The speaker concluded by pointing out that despite the technical difficulties of surgery, very limited number of Bariatric Surgeons (15 to 20 in UK) and significant complications, Bariatric Surgery is economically viable and set to rapidly expand. He also asserted that in 5 to 10 years from now patients with non-insulin dependent diabetes may opt for bariatric surgery to "cure" their illness.

Dr Raghu Raghunath

Raghu is a full-time GP in an inner-city practice in Hull. His interests include training, teaching, primary care and inter-face research. His research link is with Professor Pali Hungin's academic unit at the Durham University. Raghu completed his PhD on H. pylori and GORD last year. He has been a clinical assistant performing upper and lower GI endoscopies at the local Castle Hill hospital for nearly 10 years.

Lecture by Professor Qasim Aziz, Professor of Neurogastroenterology, Barts and The London

Professor Aziz presented a very interesting lecture describing his research into how the mind and body interact. His research is aimed at trying to understand how psychological factors can modulate viceral pain pathways (in health and disease), and demonstrates changes at a biochemical level driven by these psychological "suggestions". This has many implications in the so called functional gastroenterological problems (e.g. irritable bowel syndrome) and he has shown demonstrably different patterns of biochemical changes in the brain when the same physical stimulus is modulated by different emotional states.

Functional brain imaging techniques - eg functional MRI - can be used to identify which areas of the brain become more active in response to viceral stimuli, and magneto-encephalography has followed these activations over time. These studies have shown that the cortical processing of viceral information occurs in the primary and secondary somatosensory cortex (sensory discrimination) and is subsequently further processed in the anterior cingulate (emotional response) and pre-frontal cortex (cognition). His research has been able to localise areas of activation from an initial gut stimulus, and can assign emotional valence to it.

The project arranged groups of volunteers to receive non painful oesophageal stimulus (OS), and mapped the patterns of change in the areas of the brain mentioned above. Volunteers were then shown images of faces with increasingly more fearful expressions, and his researchers were able to show that as the emotional context became more negative, the same stimuli was perceived as being "amplified" ie being interpreted as more noxious. There was, in addition, a progressive increase in activity in the dorsal anterior cingulate (emotional area) and the anterior insula, whereas the primary processing (somatosensory cortex) area showed no change in activity. **Fig 1**

This work is definitely relevant to our understanding of functional bowel disorders. It shows how patient's negative emotional states may contribute towards a state of "viceral hypersensitivity" and result in non-noxious sensation being perceived as noxious, and conversely how helping patients achieve a better emotional state may deminish patient's symptoms.

In the second part of his lecture Professor Aziz went on to describe current research into the role of stress itself having an influence on the gut immune system, either by altered release or response to neuroendocrine factors. **Fig 2**

Thus in simplest terms emotional stress can cause inflammation in the bowel, so truly a vicious circle.

Dr Huw Thomas

FIG 1 Relationship between the brain and immune system is reciprocal

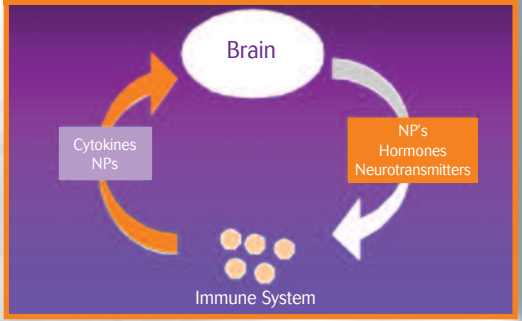
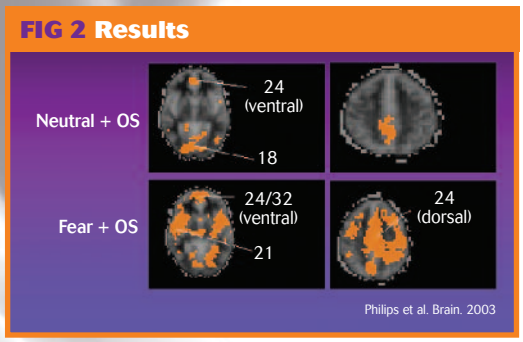


FIG 2 Results



MIND & BODY

From IBD Audit to IBD Standards

The results of the first UK-wide audit of Inflammatory Bowel Disease (IBD) were published in February 2007 and showed a wide variation in the resourcing and organisation of secondary care IBD services and significant deficits in some aspects of clinical care for IBD patients.[1] Since then a Working Group has been established to develop National Standards for IBD Services and these will be published as a Guide to Commissioning an IBD Service in mid-2009.

The IBD Audit

The IBD Audit is a four-year project funded by a grant from the Health Foundation and involves four partner organisations - the Royal College of Physicians, the British Society of Gastroenterology, the Association of Coloproctology and NACC, the National Association for Colitis and Crohn's Disease. The audit has been conducted by the Clinical Effectiveness Unit at the RCP.

The aims of the project are to improve the quality and safety of care for IBD patients throughout the UK by involving professional groups and patients in a national audit of individual patient care and of service resources and organisation in all hospitals in the UK.

There were three key reasons for proposing a national IBD Audit:

1 the absence of any NHS national plans or targets for GI services in relation to IBD, despite the fact that IBD is a serious benign disease which leads to approximately 20,000 admissions per year for exacerbation of disease.

2 some evidence of significant variation in mortality between centres with an increased death rate around the time of surgery.

3 a strong patient agenda for improving the quality of services.

In the absence of agreed national standards for IBD Services, presumptive standards were developed by the Audit Steering Group, based on clinical management guidelines for IBD published by the BSG and a consensus view on organisational service standards.

All acute hospitals in the UK were invited to participate and 181 sites (75% of those invited) did so. A web-based data entry system was developed and the audit covered aspects of service organisation and resources, plus the clinical care of 20 consecutive patients admitted due to Ulcerative Colitis and 20 admitted due to Crohn's Disease. In total 2767 Ulcerative Colitis and 2914 Crohn's Disease admissions were audited. (It is estimated there are approximately 27,000 admissions annually.)

Service aspects generally done well:

- Multidisciplinary meetings in most sites
- IBD surgery is a consultant colorectal led and consultant delivered service
- Immunosuppressive monitoring generally done well (about 90% FBC at least 3 monthly)
- Rapid access to IBD specialists (60% sites see within 7 days of patient contacting)
- 95% sites provide written information to patients with IBD

Service aspects needing improvement:

- IBD Clinical Nurse Specialists (44% had no sessions)
- Dietitians (median 2 sessions per week dedicated to GI)
- Gastroenterology Wards (33% had no dedicated ward area)
- Joint or parallel medical/surgical clinics (53% did not do this)
- IBD databases (only 33% of sites had one)
- Pouch surgery and follow up (median operations per year 4 per site)
- Open forum or other meetings with patient groups (70% did not hold such meetings)
- Direct referral pathways should be available for IBD teams to refer directly to psychological support services (very few had these in place)

Where we need to improve individual care for patients with Ulcerative Colitis:

- Stool culture and CDT (recorded for only 45% of admissions)
- Prophylactic heparin (given for only 60% patients)
- Histology reports on patients with suspected IBD within 5 days
- Increase the use of second line therapy in steroid non-responsive acute severe UC (42% went straight to surgery)

Where we need to improve individual care for patients with Crohn's Disease:

- All patients admitted with CD should be weighed (only 52% recorded)
- Prolonged use of oral steroids should be avoided (46% over 3 months - all patients with Crohn's having steroids for >3 months should be reviewed by the IBD Team)
- Bone protection agents (should achieve >90% particularly in CD on steroids - currently 40%)

For both Colitis and Crohn's Disease it is clear that we need to increase participation in clinical trials (<0.5% currently on any trial medication).

Overall the Audit demonstrated an unacceptable variation in service provision and significant deficits in important aspects of care, but encouragingly showed a real willingness on the part of IBD Teams to participate and benchmark their IBD service and standards of care against the national picture.

The Audit Project is essentially a quality improvement initiative and so the first audit round has been followed not only by feedback of results to individual hospitals, but by a series of regional meetings and a number of individual visits to look at how services might be improved. Each hospital has been encouraged to identify several specific improvement actions and a national Action Plan Resource has been created on a website to enable good practice ideas and examples to be shared throughout the IBD community.[2] At the moment this is covering secondary care services, but it would be very useful to extend this with examples of good practice from a primary care perspective.[3]

Defining national standards for IBD

The audit showed that although there were evidence-based guidelines for most aspects of clinical care, there were no agreed standards for the organisational aspects of IBD care - staffing levels, facilities, organisation of services. Recognition of this has led to the formation of a working group on National IBD Service Standards, which aims to

- develop standards for IBD encompassing secondary and primary care and including paediatric gastroenterology
- focus on standards that can inform those commissioning IBD services and define standards for ongoing audit
- produce a briefing document for commissioning authorities that sets out the key standards that they should commission services to meet

The working group has been chaired by NACC and has representation from all the professional societies involved in IBD care, including the PCSG. It is intended that the document will be circulated to all members of these societies for comment before seeking formal endorsement and publication.

The standards will include definition of the core IBD team and essential supporting services, the need for a designated GI ward area with adequate toilet facilities, arrangements for Multidisciplinary working, referral of patients with suspected IBD, Emergency Admissions (into specialist care) and Paediatric/adolescent care

Continued on back cover

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Mesren® mesalazine

Information about adverse event reporting can be found at www.yellowcard.gov.uk. Adverse events should be reported to Teva UK Limited.

Please refer to the full Summary of Product Characteristics for further information before prescribing.

Presentation: Modified release tablets containing 400 mg mesalazine per tablet. **Uses:** In ulcerative colitis - treatment of mild to moderate acute exacerbations and maintenance of remission. In Crohn's ileo-colitis - for the maintenance of remission. **Dosage and Administration:** Oral administration. **Adults:** In acute disease - six tablets a day in divided doses, with concomitant corticosteroid therapy where clinically indicated. In maintenance therapy - three to six tablets a day in divided doses. **Elderly:** The normal adult dosage may be used unless renal function is impaired. **Children:** Not recommended. **Contra-indications:** Patients with a history of allergy to salicylates, or hypersensitivity to any ingredient. Patients with severe renal impairment (GFR less than 20 ml/min), severe hepatic impairment, gastric or duodenal ulcer, haemorrhagic tendency.

Special warnings and precautions for use: Renal function should be monitored and treatment with mesalazine discontinued if renal function deteriorates. Best avoided in patients with mild to moderate renal impairment but, if necessary, use with extreme caution. If dehydration develops, normal electrolyte levels and fluid balance should be restored as soon as possible. In case of lung function impairment, especially asthma, patients need to be very closely monitored. In patients with a history of sensitivity to sulfasalazine, therapy should be initiated only under close medical supervision. Treatment must be stopped immediately if acute symptoms of intolerance occur such as cramps, abdominal pain, fever, severe headache, or rash.

Haematological investigations including a complete blood count should be performed prior to initiation and whilst on therapy according to the physician's judgement especially if a patient develops signs and symptoms suggestive of blood dyscrasia during treatment, such as unexplained bleeding, haematoma, purpura, anaemia, persistent fever, or a sore throat. Stop treatment immediately with Mesren MR 400 mg tablets if there is a suspicion or evidence of blood dyscrasia and patients should seek immediate medical advice.

Use in the elderly should be cautious and subject to normal renal function.

Contains lactose - patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine.

Interaction with other medicinal products and other forms of interaction: Concurrent use of known nephrotoxic agents may increase the risk of renal reactions. Mesalazine decreases the absorption of digoxin. Mesalazine can increase the immunosuppressive effects of azathioprine and 6-mercaptopurine. The uricosuric activity of probenecid and sulfinpyrazone, the diuretic effect of furosemide and the activity of spironolactone can be reduced. Gastrointestinal side-effects of glucocorticoids can be increased.

Pregnancy and lactation: Mesalazine should only be used during pregnancy if the potential benefit outweighs the possible risk. N-acetyl-mesalazine and, to a lesser degree, mesalazine are excreted in breast milk. Therefore, mesalazine should only be used during breast feeding if the potential benefit outweighs the possible risk. If the suckling neonate develops diarrhoea, the breast feeding should be discontinued.

Undesirable effects: Side effects are rare and predominantly gastrointestinal; diarrhoea, abdominal pain, bloating, alopecia, fever. Very rarely: Blood dyscrasia, thrombocytopenia, leucopenia, neutropenia, pancytopenia, anaemia, aplastic anaemia, agranulocytosis, bone marrow depression, headache, peripheral neuropathy, vertigo, myocarditis, pericarditis, allergic lung reactions, bronchospasm, eosinophilic pneumonia, pancreatitis, nausea, vomiting, exacerbation of the symptoms of colitis, abnormalities of hepatic function / transitory abnormal liver function tests, hepatitis, rash, urticaria, bulbous skin reactions, erythema multiforme, Stevens Johnson syndrome, lupus-erythematosus-like syndrome, myalgia, arthralgia, renal failure, which may be reversible on withdrawal, interstitial nephritis, nephrotic syndrome.

Marketing Authorisation Number and basic NHS price: Mesren MR 400 mg Tablets PL 00530/0681, blister packs of 90 (£20.29) or 120 (£27.05) tablets. Mesren is a registered trademark in the UK. Marketing Authorisation Holder: Norton Healthcare Ltd. (trading as IVAX Pharmaceuticals UK), Royal Docks, London, E16 2QJ, UK. Legal Category: POM. Date of Preparation: July 2007.

Date of Preparation: July 2007

MES/07/010

References

1. MIMS July 2007.
2. IMS British Pharmaceutical Index.
3. Mesren, Summary of Product Characteristics.
4. Asacol, Summary of Product Characteristics.
5. Data on file, Tillotts Pharma AG 2003.

For correspondence contact:

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JOURNAL OF THE PRIMARY CARE SOCIETY FOR GASTROENTEROLOGY

Event Diary

19 February 2008
PCSG Regional Meeting
Barnham Broom, Norwich
Contact: pcsg@pcsg.org.uk

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

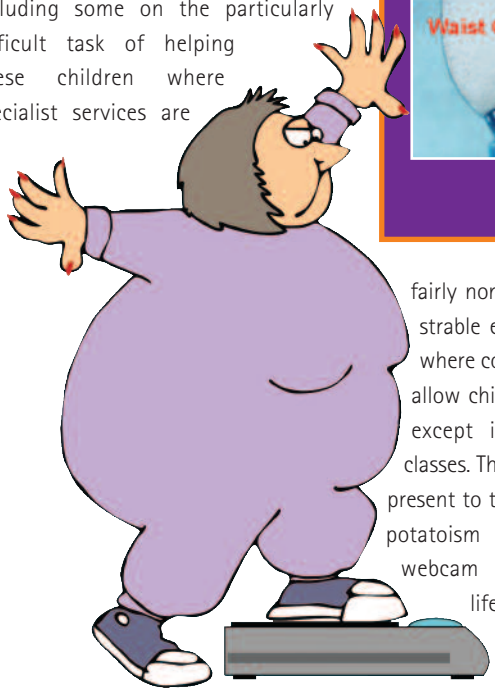
10 March 2008
PCSG Seminar
9.00–12.00
BSG, ICC, Birmingham
Contact: pcsg@pcsg.org.uk

12 September 2008
Annual Scientific Meeting/AGM
RCP, London
Contact: pcsg@pcsg.org.uk

26 November 2008
Endoscopy Meeting
East Midlands Conference Centre, Nottingham
Contact: pcsg@pcsg.org.uk

ISSN 1752-8763

David who needed him to do something about his sister who was fat and slept in the bunk above him and he was "scared"! A lot of questions and discussion followed David's talk including some on the particularly difficult task of helping obese children where specialist services are fairly non-existent without demonstrable endocrine abnormality and where community gymnasia do not allow children under 16 to exercise except in infrequent supervised classes. There is no useful antidote at present to the new epidemic of couch potatoism driven by IT Messenger/webcam and multi-channel TV lifestyle. (MEND programme from Great Ormond Street). The website is www.nationalobesityforum.org.uk



Abdominal obesity and the cardiometabolic risk

David Haslam says "We are a charity, membership is free and open to HCPs; everything on the website is free to download, and we work on behalf of GPs Nurses, Dietitians, Health Visitors etc, and also with Parliamentarians and the DOH".

Dr Richard Spence

From IBD Audit to IBD Standards

Continued from page 6

Standards currently suggested that relate to primary care include:

- IBD Team to have an established link with a GP for a liaison and educational role
- All patients with a confirmed diagnosis of IBD to be on a local IBD Registry
- All patients to have an annual review which could be done by a GP with a defined competency
- A protocol to be agreed for the identification and referral for investigation of patients with suspected IBD
- A pathway to be agreed for rapid access in relapse

The intention of the working group is to publish the document as a Guide to Commissioning IBD Services and to seek formal acceptance and endorsement of the Guide by the Dept of Health for England, the Scottish Government, Welsh Assembly Govt etc. This national endorsement would then provide a supportive background to local bids for improved resources with backing from IBD patients and professionals at the local level.

The key to gaining acceptance and successful implementation will be effective collaboration between all those who make up the IBD community - professionals and patients - so that there is a unified voice in support of the proposals.

Endorsement and implementation will not happen without political backing and NACC has begun a campaign to raise awareness and understanding of IBD with politicians at Westminster and in the devolved governments, and also with relevant officials and NHS managers.

It is anticipated that the draft document will be circulated to PCSG members for comment in February 2008.

Richard Driscoll
Director of NACC, the National Association for Colitis and Crohn's Disease, and Chairman of the Working Group on IBD Service Standards

1 The IBD Audit Report can be found at www.rcplondon.ac.uk/college/ceeu/ceeu_uk_ibd_audit.htm
2 The IBD Audit Action Plan Resource can also be found at the RCP website
3 The RCP contact for information or submission of good practice examples is calvin.down@rcplondon.ac.uk .
4 Richard Driscoll can be contacted at richard.driscoll@nacc.org.uk

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