Vol 24 No 1
Spring 2016

news

BRITISH SOCIETY OF GASTROENTEROLOGY

Message from the President

Your president has been round the block enough times to know that morale among doctors and nurses working in secondary care has waxed and waned over the years. However, years of underinvestment in healthcare and in under valuing its staff has now laid a framework for disenchantment that is more profound and widespread than one can recall. It has been extraordinary to have witnessed the depth of feeling of so many young doctors, yet I sense the Health Secretary is going to have to work a lot harder to discourage the vast majority of them from choosing to abandon their chosen career and specialty.

The latest census of consultants and trainees from the RCP has just landed on the presidential doormat, and the data continue to make pleasant reading for members of the BSG. Gastroenterology is now the largest organ based specialty, and is second only to geriatric medicine in terms of consultant numbers. Austerity is everywhere but the number of consultants in gastroenterology has grown by 5% in the past year, which exceeds the average growth across specialties in England of 3.2%, although Scotland has seen an 8.0% overall rise in consultant numbers and the rate in Wales (3.8%) has also exceeded that in England. I highly recommend members also look at the excellent analysis provided later in these pages from our Workforce Lead, Melanie Lockett. There are certainly some challenges for our specialty to address head on.

We do have fewer trainees than cardiology and respiratory medicine. This is good news for our present trainees as the job market is very much in their favour. But it is less good news for hospitals seeking to recruit gastroenterologists as the number of unfilled posts continues to be a serious concern. While the BSG has been presenting the powerful case for expansion of training numbers to Health Education England, one does not need the Wisdom of Solomon to identify the most likely major constraint in Health Education England agreeing to such expansion. It is hard to argue against the case for geographical redistribution of training posts more equitably, and BSG certainly recognises the desirability of taking posts from London and relocating them in areas of relative under provision. This could help the problem of recruitment as trainees are understandably influenced by their regional base in choosing where to apply for consultant posts.

The proportion of gastroenterology consultants and specialist trainees who always or often enjoy their job and find it satisfying remains at around the 80% mark.

I can now confirm that the councils of the Association of Upper Gastrointestinal Surgeons (AUGIS) and the Association of Coloproctology of Great Britain and Ireland (ACPGBI) do not wish to be partners in future Digestive Disorders Federation (DDF) meetings. This was as expected from earlier discussions and

Ian Forgacs, President

reflects not only their disappointment at the share of the proceeds but also the lower than usual numbers of their members attending. BASL (British Association for the Study of the Liver) council also feel they would want to hold their usual annual meeting in the year in which a future DDF might take place. BAPEN (British Association for Parenteral and Enteral Nutrition) council have yet to meet but, although they have been our most enthusiastic partner, it is now clear that there is insufficient critical mass for there to be a third federated meeting in 2018.

There is an appetite, however, for sustaining some form of joint meetings—one model might be a combined BSG/surgical or nutrition 1 day symposium at the annual BSG meeting. It would be sad to lose the concept of the partner societies being involved with the BSG annual meeting, not least because of the declining influence of surgeons within the BSG.

We continue to develop our partnered meetings with the specialist societies in the devolved nations. The BSG met with the Scottish Society of Gastroenterology on 4 March, and plans are well in hand for a meeting early in 2017 with the Ulster and Irish Societies in Belfast. Without a DDF in 2018, the door is then open to a 3 yearly cycle, as BSG could meet then (as it did in 2014) with the Welsh Association for Gastroenterology and Endoscopy.

The loss of the National Clinical Director (NCD) post in gastroenterology and hepatology is a blow. Graeme Alexander (president of BASL) and I made strong representations to NHS England, but it seems the decision had already been taken to axe 8 of the 24 NCDs. It is seemingly ridiculous that the largest of the major acute specialties in medicine should lose its representative within the higher reaches of NHS policy making. Graeme and I are seeking a meeting with Bruce Keogh to find out how specialist advice and input on health policy will be given in future.

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I worry about the fallout from the junior doctors' strike and whatever acrimony follows the related negotiations with consultants which will follow. BSG is a professional membership body and not a trade union. I was approached to sign a letter from the RCP in early February that in essence did little more than call for negotiations to continue—it seemed bland, almost neutral, and I felt neither that our trainee members would draw strength from such a letter nor would it really have any influence on the negotiators. That judgment has proved correct, but I have yet to meet a member of the BSG that does not support the cause for which the junior doctors have taken action.

I represent the Society on the council of the RCP—as at the UN Security Council, the BSG has a permanent seat. Taking advantage of our proximity to the RCP, I have hosted a series of meetings with the presidents of the British Cardiovascular Society, British Thoracic Society and Association of British Neurologists as we get together for a 1 hour meeting before College Council. There is much we can learn from one another but we are also stronger as a collective voice when we express concerns about such issues as the relevance of medical specialties in the Future Hospital Concept or the threat to specialist training from the Shape of Training proposals.

I continue to feel the BSG's profile in gastrointestinal and liver cancer must be kept as high as possible. The decision making process within the NHS has become super-byzantine in its complexity, yet the key to the decision making doors seem to open more easily if it is cancer that is the issue about which we wish to talk. What is now widely appreciated is that so many of the BSG's membership is central to the diagnosis of cancer—most gastrointestinal and liver cancers in the UK are diagnosed by members of the Society. To pursue this, the Society has commissioned a report from the Kings Fund concerning the challenges to endoscopy services that both cancer screening and a lower threshold for referral from primary care will entail. A further feature of the report will be to provide guidance to members on how they might be able to enhance their own services. We are working on collaborations with the major cancer charities—especially Cancer Research UK—and with key players in primary care. Building linkages with surgical societies, cancer charities, policy makers, parliamentarians and indeed any responsible body committed to improving the care of people with gastrointestinal and liver problems is absolutely what the BSG should be doing.

Endoscopy matters

Gastrointestinal endoscopy in the UK continues to thrive despite huge pressure and demands. The BSG collaborates with many partners to try and meet those demands while working hard to ensure that quality is maintained. Training and education are essential to ensuring high quality endoscopy, and the UK contributes to these areas both at home and abroad. One important element of training is assessment with DOPS, providing the foundation for both formative and summative assessment in UK endoscopy practice. Under the leadership of JAG, existing DOPS forms are being revised with an increased focus on the technical aspects of endoscopy. Individual descriptors will now enable trainers to more easily identify when an individual is ready for independent practice. Summative DOPS are also being developed for JAG certification and other assessments. New DOPS have also been developed for management of upper gastrointestinal bleeding and for ERCP.

Endoscopy education is delivered in a variety of ways, with the BSG playing an increasing role in the delivery of live endoscopy. At the BSG annual meeting this year, a full day of live endoscopy will be delivered from Aintree hospital. The 2nd Endolive UK meeting on 2–3 March 2017 is now only a year away and plans for this meeting are at an advanced stage. The UK plays a leading role in paediatric endoscopy, and the 3rd tri-annual European ESPGHAN Paediatric Endoscopy Summer School was held in Sheffield in September 2015. This attracted delegates from 32 countries and was a major success, with high quality international faculty delivering hands on training.

In addition to the day of live endoscopy, the BSG annual meeting will offer a varied and informative programme of endoscopy education. Leading UK and international faculty will focus on high quality endoscopy with sessions covering each type of endoscopic procedure. Sessions will also cover bowel cancer screening and management of large colonic polyps. The 2016 Hopkins prize applications were of an extremely high standard, with many of the applications worthy of the award. I am delighted to announce that the eventual winner was Dr Kofi Oppong from Newcastle, and he will give his presentation on 'Advancing the diagnostic and therapeutic role of EUS in pancreaticobiliary disease'. BSG endoscopy continues to develop its quality agenda with a number of initiatives in development.

BSG endoscopy also continues to update and develop new guidelines to support UK endoscopists in their practice. The number and variety of antiplatelet and anticoagulant drugs has expanded greatly in recent years and there has been strong demand for updated guidance. The newer direct oral anticoagulants may have simplified anticoagulation regimens but come with an increased risk of gastrointestinal haemorrhage and a lack of easy reversibility. Dr Andy Veitch has led an innovative collaboration between BSG and the European Society of Gastrointestinal Endoscopy (ESGE) to produce joint guidelines on endoscopy in patients on antiplatelet or anticoagulant therapy. These will be published online simultaneously in *Gut* and *Endoscopy* journals. UK Endoscopy has a very good relationship with partners internationally, particularly in the rest of Europe. We are delighted to see Paul Fockens, recent president of the ESGE, appointed as UEG president elect.

Colin Rees, BSG Vice President, Endoscopy

Liver matters

Research

The James Lind Alliance alcohol related liver disease process is moving on as a partnership between BSG and the National Institute for Health Research (NIHR). Over 1000 potential research questions have been submitted from a wide range of stakeholders and have been categorised. The next step is checking the evidence base and then prioritising the key questions. This should be complete later this year and be able to feed into NIHR clinical trials calls next year.

Clinical trials study groups have continued to meet with some success. Subgroups are established in autoimmune liver disease, viral hepatitis, non-alcoholic fatty liver disease, biomarkers and, most recently, portal hypertension. There have been two recent major grant awards from these groups feeding into NIHR portfolio studies.

Clinical

Twenty-two hepatitis C operational delivery networks are now established in England, and the implementation of NICE guidance for all oral therapy for G1 hepatitis C virus is due very shortly. BSG framed the professional response to NHS England's attempt to challenge NICE on the grounds of affordability, and it is gratifying to see the new therapeutics moving into practice without restriction by NICE. The mode of delivery and price of drugs will vary in England and the devolved nations but all now have access.

Consultations

BSG has provided commentary on two important NICE guidelines: cirrhosis (https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0683) and

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non-alcoholic fatty liver disease (https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0692). These are important documents with a major potential impact on liver services and the links with primary care. Both guidelines recommend an approach of fibrosis screening in high risk groups to identify those at high risk of having advanced liver disease which will change local pathways from primary care and require much wider availability of tests of fibrosis. The current draft recommends ELF markers but it is likely that other methods will have similar utility (fibroscan, ARFIE). The major challenge will be that none of these fibrosis assessing methodologies is in routine clinical use so local investment is likely to be required to implement them.

TAGs

The tidal wave of new hepatitis C virus therapies in particular has required a huge investment of time from liver section committee members and other nominees to provide expert input to NICE, and I remain very grateful to those BSG members who have put in substantial amounts of time and effort into this. BSG (via the Royal College) has always submitted clear and timely input which I know is appreciated by NICE.

Lancet commission

BSG continues to contribute to the *Lancet* Commission which published an update to its initial plan for liver services in November 2015. This report gave progress reports in all areas of liver services; there has been clear progress in hepatitis C with the new therapeutics and establishment of ODNs in England. A major step forward was also achieved with the establishment of liver disease as a major area of focus for the Royal College of General Practice—this should be very timely in linking with the NICE guidelines on cirrhosis and non-alcoholic fatty liver disease. Alcohol remains conspicuous by an absence of new policy although in the light of the European Court judgement on minimum unit pricing, Scotland seems set to take forward legislation.

Training

The change to national appointment of specialty trainees in hepatology seems to be working well, with all of the hepatology posts filled. Hepatology remains an area where consultant numbers will need to increase in the next few years, and it remains attractive to trainees.

Stephen D Ryder, BSG Vice President, Hepatology

Key new appointments

The Society is pleased to announce that Professor Rebecca Fitzgerald has agreed to chair the BSG's Academic Development Committee. She will be supported by Professor Simon Leedham as deputy chair to push forward the crucial agenda of academic gastroenterology nationally. We are delighted that two such eminent academics in our specialty are leading our work in this area.

Dr Jessica Williams has been appointed as chair of the BSG's Education Committee, succeeding Dr Gavin Johnson. Jessica is a consultant gastroenterologist at the Derby Teaching Hospitals NHS Trust and took up the role with effect from January 2016. She has a proven track record and strong interest in training and education, and we warmly welcome her to the role.

BSG Senior Secretary, Dr Jayne Eaden, has been elected to the UEG Meeting of Members as a National Society representative. The Meeting of Members (formerly called General Assembly) is composed of members of the UEG and is the highest governing body of the UEG. Our congratulations to Jayne on this success.

BSG Annual Scientific Meeting, Liverpool, 20–23 June 2016: early bird registration closes 18 March

There's something for everyone at BSG 2016 in Liverpool, 20–23 June. The conference begins with the postgraduate master class and includes updates in several areas of gastroenterology and hepatology, interactive sessions on how to manage your endoscopic complications (although of course you won't have many of these!) and there's a state of the art lecture on the basics and benefits of the microbiome. The trainees' symposium ends the day with three great lectures from the military on gastroenterology in war zones.

The main conference, including industry sponsored exhibition and lunchtime poster rounds, runs from Tuesday to Thursday. Every section of the BSG has worked very hard to produce an exciting programme with state of the art lectures, basic and clinical science symposia, and several sections have collaborated on innovative joint symposia. There are too many sessions to list and so rather than only mention a few (and offend those I miss) I would encourage you to check out the interactive programme for yourselves at http://www.bsg2016.org.uk/. However, I cannot omit to let you know that Wednesday sees live endoscopy return to the conference, and Thursday's highlights include the basic science translational master class on the gut neuroendocrine system. There are also breakfast, lunchtime and evening industry sponsored symposia.

For the first time the BSG will be presenting a lifetime achievement award at the plenary session on Tuesday morning. The identity of the worthy recipient will remain a secret until the day of the presentation! There are also new prizes this year for the best abstracts in three separate categories, which are sponsored by *Gut*, *Frontline Gastroenterology* and *BMJ Open Gastroenterology*, in addition to all the usual oral abstract and poster prizes.

The conference is a great opportunity to catch up with old friends and make new ones. For those Beatles fans, we have The Cheatles, who will be playing at the conference party on Tuesday evening. If you're a cyclist, why not join like-minded friends and get on your bike to raise money for Core! Details can be found at http://www.gastro-cycle.co.uk/

So, if you haven't already registered I would encourage you to do so before 18 March to take advantage of the early bird rate. I look forward to seeing you all there.

Jayne A Eaden, BSG Senior Secretary

BSG Workforce report

On 30 September 2015, there were 1414 substantive gastroenterologists and hepatologists in the UK, a 6.6% expansion from 30 September 2014. Gastroenterology and hepatology represents the second largest medical specialty (with geriatric medicine the largest). Most consultants are aged 45 and 49.9 years. Nearly 1 in 5 (18%) consultants are women, with a higher proportion of women among younger consultants (28.0% of 35–39.9 year olds, 10% of 55–59.9 year olds) and regional variation. Consultants are contracted for 11 PAs on average but actually work 12 PAs. Consultants working less than whole time (LTWT) comprise 14% of the workforce (31% of women and 11% of men) and, on average, are contracted for 7 PAs but work 8 PAs per week. This compares with 18% of all medical specialties (39% of women and 6% of men) working LTWT. Over three-quarters (80%) of gastroenterologists have a commitment to acute general internal medicine (but only 52% of hepatologists) compared with 63% of medical specialties overall. The remainder support the acute take by seeing patients with gastroenterology or hepatology problems in the medical admissions unit.

It is estimated that we need 6 whole time equivalent consultant gastroenterologists (doing GIM) working 11.5 PAs per week for a population of 250 000, or 1:41 700; or 1:39 200 adjusted for 14% LTWT working (1610 in total, 196 more). This should be achievable in 2–3 years with 5% expansion per year. While two parts of the UK already have this level of consultant cover (London and the North East), other areas have a much lower number for an equivalent population (eg, South East Coast/South Central). Gastroenterologists and hepatologists typically retire at 64 years. Gastroenterology has had an average CCT output of 99 per year over the past 5 years, sufficient for 5.6% expansion in 2016. It is predicted that there will be an average of 17 retirements per year over the next 5 years. It is unclear what effect a new consultant contract and the new pension rules will have on this number. Retirements are predicted to increase by 31, 41 and 59 per year at 5 yearly intervals, ultimately only enabling expansion of 1% per year by 2039.

There are many recent service changes that have resulted in increased demand for more gastroenterology and hepatology consultants such as: out of hours gastrointestinal bleed on-call rotas, 7 day services, increased hepatology burden, bowel scope screening, change to FiT testing in bowel cancer screening, the desire for increased access to endoscopy, and an expanding and aging population who are high service users. Trusts are trying to appoint new consultants to meet this demand. In England and Wales (data for Scotland and Northern Ireland are unavailable), 178 substantive consultant appointments were attempted from 1 October 2014 to 30 September 2015, but 90 (51%) were unfilled.

The number of attempted consultant appointments has increased from an average of 88 in 2008–2011 to 156 in 2014 (77% increase). This has not been matched by the 21% increase in successful appointments in the same time frame, and therefore the number of unfilled posts has risen dramatically from an average of 17 in 2008–2011 to 70 in 2014 (312% increase) with a large regional variation. This trend has been seen in the other specialties that dual accredit with GIM. The abolition of locum appointment for training (LAT) posts on 1 January 2016 by Health Education England may result in a lower CCT output by encouraging unsuccessful trainees to take a national training number (NTN) in their second choice specialty rather than a service post in gastroenterology. This could exacerbate consultant recruitment difficulties further, unless additional gastroenterology NTNs are recruited to compensate for the 17% of trainees who are out of program at any one time. Geography is the most important factor for trainees when choosing a consultant post, with only a third willing to move from the region in which they trained. Over a quarter (26%) of trainees are in London. NTN posts should therefore be redistributed from areas with recommended consultant numbers to those with under provision and recruitment difficulties.

For more details, please refer to the full Workforce report on the BSG website.

Melanie Lockett, BSG Workforce Lead

BSGNA at the BSG Annual Meeting 2016

Liverpool 2016 will be an exciting conference for nurses and allied health professionals. Make sure you keep the dates in your diary and come along to the BSG Nurses Association (BSGNA) conference sessions on Tuesday 21 June and Thursday 23 June; we have something for everyone at every level, from staff new to endoscopy and gastrointestinal disease to professionals with interests in specialist practice and management of patient services.

Live endoscopy will be part of the conference on Wednesday 22 June, where we will have the opportunity to ask questions to the nurse experts working within the live sessions. You will be able to tweet your questions to our panel of experts. Specialist sessions will also be available within the Wednesday medical programme.

We are delighted to announce that our key note speakers for the nurse plenary session on Tuesday morning will be Dr Peter Carter and Professor Dickon Weir-Hughes. Both have held some of the most influential nursing positions within the UK.

Dr Peter Carter, OBE, was the chief executive of the Royal College of Nursing from January 2007 to August 2015. The Royal College of Nursing is the world's largest professional union of nurses, with a membership of over 430 000 nurses, midwives, health visitors, nursing students, cadets and healthcare assistants. Dr Carter is probably one of the most recognised nurses in the UK; he will give us an overview of the contemporary issues in nursing. Dr Carter has served the NHS as a psychiatric nurse, general nurse and as chief executive of the Central and North West London NHS Trust, one of the largest mental health trusts in the UK. He was awarded the OBE for services to the NHS in 2006. During his extensive career, he has written numerous articles and papers relating to healthcare, and has also appeared on many TV and radio programmes, in addition to extensive work with national and local newspapers. In February 2015 he announced that he would be leaving the Royal College of Nursing. He is now working as an independent management consultant.

Professor Dickon Weir-Hughes will be joining the conference to speak about 'Improving patient care by valuing the knowledge of nursing'. Dickon is the former CEO and registrar of the Nursing and Midwifery Council (NMC), and has been chief nurse for three organisations, including the Royal Marsden NHSFT and Nuffield Health. Since leaving the NMC, his work now involves supporting Oxford University Hospitals and King Saud Medical City, Riyadh, with Magnet Hospital recognition together with being chair of Nursing Diagnostic Development and Taxonomy for NANDA (the International Society of Nursing Knowledge). He is also supporting nurses in Indonesia and Rwanda and speaks internationally on a range of nursing topics. He is author of *Clinical Leadership: from A-Z*.

The BSGNA conference sessions have something for everyone; there will be lots to learn and will give you plenty of opportunity to gain evidence for NMC revalidation. Sessions include:

Plenary session

- Contemporary issues in nursing
- Improving patient care by valuing the knowledge of nursing.

Hepatic biliary disease

- The burden of metabolic and alcoholic liver disease in the UK
- Management of chronic pancreatitis and the role of nurses.

Free paper sessions

- We have been very proud of the work of our nurses in recent years—this is an opportunity to showcase your work. Please submit your abstract via the conference portal at http://www.bsg2016.org.uk/

Gastrointestinal bleeds

- Response the NCEPOD publication 2015—what can we do to improve outcomes for patients with gastrointestinal bleeds?

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Decontamination

- The why, what and how. Lots of hints and tips to protect our patients and to improve endoscopy services.

Career progression

- Compassion in nursing
- Career opportunities
- Improve your portfolio.

Liver transplant

- Patient experience of liver transplant; patient stories help to give us insight into how NHS services look from the patient perspective and ways we can improve the patient pathway to make healthcare easier for our patients.

We will have our Annual General Meeting on Tuesday 21 June—this is for BSGNA members only. If you would like to become a member, please complete the application form on the BSG website https://members.bsg.org.uk/mybsg/NewUser

For those of you who are BSGNA members and would like to be part of the committee, please contact Irene.Dunkley@nhs.net.

Irene Dunkley, BSGNA Chairperson

Devolution: your country needs you

The Devolution Committee is a subgroup of the much larger Clinical Services and Standards Committee. It consists principally of representatives from the three devolved nations of Northern Ireland, Wales and Scotland who meet with members of the BSG executive.

The three devolved nations have a population of around 10 million people and account for 16% of the total UK population. This is a sizeable minority but would still raise questions as to why three UK 'regions' should be singled out for special treatment.

The main factor that separates the devolved nations from England is that they have fully elected parliaments or assemblies. In contrast with Westminster, polling is usually by proportional representation rather than 'first past the post'. Each of the nations also has a government or executive to enact policy.

The legislation governing devolution is complicated, but certain matters such as defence and foreign policy are reserved for Westminster. Other issues such as health and education are fully devolved, and the UK government has no role in making policy. This leads to very significant differences in the way that services are provided in Scotland, Northern Ireland and Wales. BSG members in the devolved nations, therefore, have to interact with completely different parties, health departments and political philosophies.

Part of the role of the Devolution Committee is to make sure that these differences are reflected when the BSG drafts guidance, or expresses views on national concerns such as training and accreditation, that cross UK boundaries.

Not only are the devolved health services different from NHS England, but they are also increasingly different from each other because health policy is different in each of the nations. In Scotland, for example, the responsibility for inspecting hospitals, setting standards and investigating issues of care lies entirely with Health Improvement Scotland and not with NICE or the Care Quality Commission.

In the devolved nations the process of commissioning services is entirely different from that in England. Health boards usually both commission and provide care. In Northern Ireland, healthcare and social care are already integrated, and from 2017 this will also apply to Scotland.

These differences are important. A document that is directed solely at commissioners in NHS England may be rejected by the devolved governments because their commissioning processes are different and it is not seen as 'relevant'.

At times the differences may sound petty or unimportant, particularly as most of the BSG membership is based in England. This is a view that I completely understand, and as the outgoing chair of the Devolution Committee, feel some sympathy towards. There are, however, reasons why I think it is important that the BSG does not ignore devolution and continues to maintain a truly *British* perspective.

Firstly, there is strength in numbers, and the BSG can speak with authority, because it represents gastroenterologists across the whole of the UK. The medical problems that affect our patients are the same in all four countries, as are most of the training, manpower and recruitment issues.

Secondly, we can use differences between the health services in each of the four constituent nations to drive change. Governments are sensitive to local discrepancies and do not like publicity that suggests health is better managed in other areas of the country.

Finally, it seems likely that England will experience its own form of health devolution, as has already been promised to Manchester and the 'northern powerhouse'. NHS England is increasingly orientated around four major regions, each of which is larger than the devolved nations collectively. What would make a difference would be if this translated into a willingness to grant English regions greater powers to formulate their own local health policy, along with greater fiscal autonomy.

The people of Wales, Northern Ireland and Scotland seem to be happy with the autonomy that has come with devolution. There is virtually no desire to align policy with that in England. The fact that all three devolved governments have rejected the new junior doctors' contract and have avoided industrial action if anything strengthens this view.

Certainly food for thought.

Alastair McKinlay, outgoing chair of Devolution Committee, and elected member of BSG Council

Advisory Committee on Clinical Excellence Awards

Each year the BSG is asked to make nominations of meritorious gastroenterologists to the Advisory Committee on Clinical Excellence Awards (ACCEA) in support of their applications for National Level Clinical Excellence Awards. There are many worthy candidates each year but the number of nominations we can make is strictly limited, and competition for our support—especially at silver level—is intense. In 2015, there were over 2000 applications to ACCEA from consultants in all specialties for a total of only 300 new awards at all levels. In view of that intense competition where only one in seven applicants succeed, the BSG was delighted to learn that 9 of its 16 nominees were successful (2 at gold level, 3 at silver level and 4 at bronze level).

The 2016 award round will open on Friday 11th March and close on Monday 16th May. Further detailed advice and guidance about our role in the process will be available on the BSG website or from Janet Bassett (J.Bassett@bsg.org.uk), but act fast to meet the ever tighter deadlines imposed on us by ACCEA.

Every individual who receives BSG support is worthy, and while warm congratulations are due to those who received their awards in 2015, we commiserate with those whose merit was recognised by their specialist society but who did not quite make the cut with ACCEA. All of those who did not quite make it last year should not hesitate to reapply both to us and ACCEA again, as indeed should others among the many members of the Society who consider themselves deserving. Please read the rules about applying for national awards (https://www.gov.uk/government/organisations/advisory-committee-on-clinical-excellence-awards). If your contribution is on a wide scale (and you feel underappreciated in your institution), please note that, at least in recent years, it has not been necessary to have reached the top of the local CEA scale to put yourself in the frame nationally.

Ian Forgacs, BSG President

RCP Excellence in Patient Care Awards: shortlist announced

The shortlist for the debut RCP Excellence in Patient Care Awards has now been announced. The winners will be revealed at the awards ceremony and dinner on the first day of Medicine 2016: RCP Annual Conference, on Tuesday 15 March 2016.

The mission of the awards is to recognise and promote the impressive work that physicians are doing around the world to deliver patient centred care through education, policy, clinical practice and research.

We are pleased to note that the award for outstanding clinical activity that contributes to excellent patient care by a UK trainee in higher specialty training includes a gastroenterology trainee. Our congratulations go to Dr Matt Kurien and the other shortlisted individuals.

- Dr Daniel Cooper—improving the clinical and holistic care of patients with Ebola virus disease.
- Dr Charlotte Hall—developing a service of isoniazid preventive therapy for children aged <5 years who have been exposed to bacteriologically confirmed TB in Timor-Leste.
- Dr Matt Kurien—raising the standards for percutaneous endoscopic gastrostomy feeding across the UK.
- Dr Alexander Wilkinson—improving smoking cessation services and training.

Notices

New Appointments

Jennifer Addley
Lagan Valley Hospital
Ghazanfar Anwar
Sunderland Royal Hospital
Vinod Audimoolam
Worthing Hospital
Lachlan Ayres
Poole General Hospital
Philip Berry
St Thomas' Hospital
Shivaram Bhat
Craigavon Area Hospital
Uthayanan Chelvaratnam
Southmead Hospital
Deepika Chilkunda
Derbyshire Royal Infirmary
Said Din
Derbyshire Royal Infirmary
Benjamin Disney
James Cook University Hospital
Affifi Farrukh
Hereford County Hospital
Robert Fearn
Homerton University Hospital
Tamsin Gledhill
University Hospital Aintree
Victoria Gordon
Walsgrave Hospital
James Howson
Charing Cross Hospital
Arun Karthikeyakurup
Royal Stoke Hospital
Ian London
Countess of Chester Hospital
Stephen McGoldrick
Countess of Chester Hospital
Christopher Meaden
Blackpool Victoria Hospital
Sam Murray
Homerton University Hospital
Jonathan Nolan
East Surrey Hospital
Hari Padmanabhan
New Cross Hospital
Sarveson Rajkumar
Royal Stoke Hospital
Rakesh Sringeri Manjunath
Royal Stoke Hospital
Panagiotis Stamoulos
Croydon University Hospital
Philip Woodland
St Bart's and Royal London School of Medicine

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Published by the BMJ Publishing Group
In conjunction with the BSG
Executive Editor: Richard Gardner (r.gardner@bsg.org.uk)
Production Editor: Christopher O'Shea (Christopher.oshea@bsg.org.uk)
Howard Ellison (h.ellison@bsg.org.uk)
Production Manager: Isaac Jones (ijones@bmj.com)