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news

BRITISH SOCIETY OF GASTROENTEROLOGY

Message from the President

In this anniversary year, I have been pondering how Shakespeare would have reacted late in life had he known that some 400 years after he had 'shuffled off this mortal coil' his name would be known by almost every educated person in the world, that every one of the plays he had written would still be performed and that several of them would be regarded as the greatest ever written.

The British Society of Gastroenterology was founded in 1937 by Sir Arthur Hurst as a club for what was then a small group of doctors who were eccentric enough to be fascinated not by diseases of the lung, the heart or the nervous system—like proper doctors ought to be—but by diseases of the gastrointestinal system. I do wonder what Sir Arthur would have thought had he been told that before the BSG had reached its 80th birthday, there would be more consultants in gastrointestinal and liver disease than in any other organ based specialty, and that it was seen by young doctors as an incredibly desirable specialty in which to train.

The BSG is a highly regarded professional membership organisation rather than a club—indeed, we are properly considered to be a learned society and that does sound rather grander than a mere club. Yet I would argue that the BSG does preserve many of the values of a club: we are an association of individuals from varying backgrounds yet united by a common interest and enthusiasm. We consider it worthwhile making a personal financial contribution (a sum which due to the great skill of our treasurer has been static for some years) to a central pool whose purpose is to enhance the collective professional lives we lead. There are some who remain on the outside, yet passively benefit from much that the Society does for those who choose to join. Nowhere are our societal values more in evidence than when we come together for our annual meeting which is now just days away. There are now several sub-specialist meetings with more focused specialised content than ours, and there are certainly larger general meetings that seem, like the dinosaurs, to be in danger of sinking under their own bulk. The BSG Annual Meeting is so carefully programmed that it presents clinical and research excellence in an arena that does not overwhelm but offers in a single venue the opportunity to learn and also make/renew/reaffirm friendships based on shared enthusiasms.

The summer solstice this year occurs late in the evening of Monday 20 June when many of us will have assembled in Liverpool. I have not yet had any apologies from members of the BSG who feel the need to be at Stonehenge around that time, but I was a little surprised that a senior member of the Society was unable to accept our invitation to speak on the final day of the meeting as he would be putting up his tent in a field in Glastonbury.....and the public thinks if we're not at work, we are all on the golf course.

Ian Forgacs,
BSG President

The days may be long at this time of year but time will just whizz past as the programme is so excellent. I am especially looking forward to the plenary on Tuesday 21 June which contains the lectures named in honour of Sir Arthur Hurst and Sir Francis Avery Jones, delivered by outstanding gastroenterologists at opposing phases of their careers. Yet the moment I am looking forward with the keenest anticipation is the presentation of the BSG Lifetime Achievement Award—do come along to see who has been chosen to be its very first recipient.

From many years' experience of attending conferences in our specialty, I have learned that gastroenterologists do know how to enjoy themselves. The social highlight of the annual meeting is the BSG Trainees' Conference Party which in only a few years of its existence has already moved into legend. Those who can remember being at the event in Manchester 2014 probably weren't really there. It is a ticket only event although all registrants are welcome at this year's party on Tuesday 21 June. This does happen to be the longest day and therefore the shortest night, but it is an evening when one's watch, together with one's inhibitions, are best left at home.

The impact of the progressive annual reductions in the proportion of the nation's wealth that the UK government spends on the health of its citizens is a major issue for a Society that dedicates itself to helping its members achieve the best outcomes for patients with gastrointestinal and liver diseases. It seems inappropriate for me even to mention the word 'Europe' just now but there will be many challenges for us to face as a profession as our share of spending on health among comparable European nations continues to dwindle towards the relative position we were in at the beginning of this century. Our role at the BSG is surely to marshal the evidence for delivering what constitutes best care and then present this as clearly, confidently and surely as we can. A great example has been making the successful case for ensuring delivery of antiviral therapy for those patients with hepatitis C virus infection where there is a strong body of evidence they would derive clear benefit, thus

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ensuring NHS England's challenge to a NICE decision was not upheld. We are currently working on a report with the King's Fund that should be immensely helpful to those who must argue for additional resources to meet the predicted year on year demand for endoscopy. BSG is committed to taking evidence based arguments forward to improve all of the elements (service, education, training, research) that go into delivery of high quality patient care and outcomes.

The BSG's horizons extend well beyond Europe. I feel we should all take great pride in our investment in taking our training expertise to low income countries. BSG has been a major partner in developing endoscopy training in Malawi, and the joint WGO/BSG training centre there was inaugurated last month. In March, I was asked to go to Swansea to meet my counterpart from Bangladesh over dinner—some dinner it turned out to be as it was a charitable event with over a hundred guests invited to thank the BSG for our support of the exchange training initiative established between South Wales and Bangladesh.

Thanks are due to all who have built our international bridges but if I were to mention by name these and so many others who do so much for the Society the list would, to quote the Bard, 'stretch out to the crack of doom'. Yet I do wish to acknowledge the huge contributions made by two senior outgoing officers: Steve Ryder, as VP Hepatology, and Simon Greenfield, as Chair of CSSC. They have both been magnificent, and I wish them both, and their respective successors, Mark Hudson and Dermot Gleeson, all the best. I close my last newsletter by wishing my successor, Martin Lombard, all best wishes for his term of office and hope that he will find serving the BSG as your President as enjoyable and rewarding as I have done. I think Sir Arthur would have been very proud of how his 'club' has developed.

Ian Forgacs, BSG President

Endoscopy matters

Endoscopy research

Endoscopy research is fundamental to improving the care we provide to our patients. The UK has played a leading role in endoscopy quality improvement and training for many years. Throughout this time we have continued to innovate in endoscopy and develop new research ideas. Most research has historically been delivered in a limited number of institutions, and multicentre endoscopy trials have been more limited. In the past few years this has begun to change, and led by the BSG, the UK is now delivering large scale endoscopy research with a collaborative network of endoscopy researchers delivering high quality research across the whole spectrum of gastrointestinal endoscopy. In the field of upper gastrointestinal endoscopy, a number of multicentre trials into minimally invasive endoscopy have been delivered. Rebecca Fitzgerald's team have led the highly acclaimed BEST 2 trial utilising the cytosponge to screen for Barrett's oesophagus. This work was the winner of the *BMJ* gastrointestinal team of the year award and plans are at an advanced stage for BEST 3—a trial studying the use of the cytosponge as a primary care screening tool (if you are interested in collaborating in this trial, contact Rebecca on RCF29@MRC-CU.cam.ac.uk). A number of high quality ERCP and EUS trials are underway evaluating the optimal use of novel technology and optimal endoscopic management of hepaticopancreaticobiliary pathology. Colonoscopy research is thriving. FIND-UC is a multicentre trial of novel endoscopic imaging for IBD surveillance, and the Discard 2 multicentre optical diagnosis trial has recently been published in *Gut*. Other successful endoscopy trials delivered recently include END-CAP, ADENOMA and BRIDE, with around 4000 patients recruited. The UK now has a strong endoscopy research infrastructure and a number of academic endoscopists running high quality research programmes and training researchers of the future. BSG is keen to develop and support those interested in endoscopy research, and if you would like further information on how to get involved in endoscopy research or how to develop an endoscopy research career, please contact Julie.solomon@bsg.org.uk.

Guidelines

In the 8 years since the last guidelines on consent for endoscopy were published, endoscopic practice has changed substantially. Many more patients are sent directly to test from primary care, and higher complexity, higher risk procedures are performed more frequently. On this background, the legal framework within the UK has altered. New guidelines on consent for gastrointestinal endoscopy, covering elective and acute procedures, have now been drawn up to replace the 2008 document and will be published shortly. These make specific recommendations that should be applicable to all practitioners involved in requesting and delivering endoscopy to our patients. Guidelines on management of patients on antiplatelets and anticoagulants have been published recently in *Gut*. These are the first guidelines jointly produced with ESGE.

Annual meeting

An exciting endoscopy programme will be delivered at this year's annual meeting. Sessions will focus on delivery of high quality endoscopy and cover a wide range of gastrointestinal endoscopy procedures, including colorectal cancer screening sessions. The Endoscopy Foundation letter will be delivered by Professor Nagi Reddy and the Hopkins lecture by Dr Kofi Oppong. In addition, on Wednesday 22 June, a day of live endoscopy will be delivered from Aintree Hospital. This will concentrate on how to deliver high quality diagnostic and therapeutic endoscopy.

Colin Rees, BSG Vice President, Endoscopy

Liver matters

Clinical

Twenty-three hepatitis C operational delivery networks are now established in England but despite NICE ruling that all G1 patients should be treated with the new oral agents, NHS England has placed very significant restrictions on availability. The networks have been given a number of treatments per month with a financial penalty via a CQUIN scheme for any network that exceeds their 'run rate'. The run rate for some networks was lower than the previous rate of interferon based therapy and, given the 10 000 treatments available nationally by no means matching the patients that would benefit, there are likely to be clinicians facing significant problems in managing patient expectations. The devolved nations have restrictions too, based mainly on the degree of hepatic fibrosis. It is a reasonable expectation that access will improve as other companies' products enter the market, which will happen shortly. BSG continues to lobby strongly for adequate access to these drugs.

There have been major therapeutic advances in other areas of liver disease, particularly primary biliary cirrhosis, and it seems likely that NHS England will use the established networks to deliver therapy in these new areas too. These new therapeutics are the subject of a satellite symposium at the BSG Annual Meeting which I would encourage you all to attend.

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Research

The Lind Alliance alcohol related liver disease process, a partnership between BSG and NIHR to set the key research priorities, is nearing completion. 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 will feed into NIHR clinical trials calls next year.

Clinical trials study groups have continued to meet with some considerable success in terms of trial proposals and grant income. Subgroups are established in autoimmune liver disease, viral hepatitis, NAFLD, biomarkers and, most recently, portal hypertension. There have been two recent major grant awards from these groups, feeding into NIHR portfolio studies.

Consultations

BSG has provided commentary on two important NICE guidelines, cirrhosis and NAFLD. 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. To compliment these guidelines, BSG has produced its own guideline under Phil Newsome's lead to produce a management guideline for investigating abnormal liver function tests. This should be available in the next month and will compliment the two NICE guidelines which will jointly provide a complete template on the key issues on screening and earlier detection of liver disease.

HCV Therapies

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 shows no sign of slowing. 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. 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 Practitioners; this should be very timely in linking with the NICE guidelines on cirrhosis and NAFLD. 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

Cathryn Edwards appointed BSG President Elect

Taking the membership challenge!

"As a professional Society we need to be responsive to the needs of our membership, enacting 'change' at a pace that makes us professionally relevant to our members".

It is a pleasure and a privilege to be appointed to the role of President Elect. At a time of considerable challenge for the medical profession as a whole and for gastroenterology as a specialty, the BSG's role in the professional life of its members takes on an additional important relief.

The BSG is in its 79th year as a professional society. It has 3269 members, among whom number 1395 consultants (gastroenterologists and related surgical, pathology and radiology specialists), 589 trainees, 700 allied health professionals (mainly nurse associates and physiologists) and 239 students/pre-ST3 trainees. These along with our international, senior and honorary members complete a diverse membership constituency.

The rapidly changing landscape of the NHS throughout the UK and the increasing difficulties of delivering high quality clinical care to patients in a resource constrained environment places significant strain on our professional workforce. This is compounded by the unpredictable and likely changes to the nature of our professional contractual obligations, be these for consultants, junior doctors or nursing colleagues.

I am mindful that the BSG relies on this *same* workforce for the delivery of a vibrant professional network, a vocal interactive national lobby for gastrointestinal disease and hepatology, and the research, education and training for which the Society has deserved credibility and respect.

As a professional Society we need to be responsive to the needs of our membership, enacting 'change' at a pace that makes us professionally relevant to our members, even within the uncertainty of a changing national framework. This might be the need for change to our own Society's structures; changes to our contributions to clinical best practice or change to how we support the professional development of our members. Moreover, we need to ensure that any such change is supported by a strategy and vision of delivering best care for our patients.

Our key areas of influence (research, education and training) offer an opportunity to effect such change for patient benefit, to shape and support the integrity of the professional workforce and to impact on the wider political and public heath agenda. With many initiatives already started to support our members at all stages of their careers (not least mentoring, leadership and management, and our continued commitment to clinical best practice), the Society wants to harness your ongoing support to make the BSG's professional network an integral part of, and daily reality for, the quotidian professional lives of *all* of its members. Our incoming President, Professor Martin Lombard, will write further about the need for a coordinated approach to membership reform in the next issue, tasking us all to engage fully in this process!

Cathryn Edwards, BSG President Elect 2016–2018

Simon Greenfield steps down as Clinical Services and Standards Committee Chair

As my 6 year association with CSSC is shortly to come to an end, I thought it would be appropriate to reflect on my time in office.

BSG guidelines have worldwide renown and continue to be produced to an exacting standard, and we are fortunate that there are many busy individuals working for the section committees and CSSC who are willing to give up their spare time to help produce and review them. My time as editor of the guidelines was a period of enormous self-education and a very good way of filling up the CPD diary! We can be delighted that our guidelines are now recognised

by NICE, and special mention must go to Dermot Gleeson who helped achieve this. However, clinicians also need quality support, and I must acknowledge the help of all the backroom staff during my tenure and in particular Simone Cort who coped admirably with the email traffic!

Acute upper gastrointestinal bleeding (AUGIB) remains high on the agenda of the CSSC. In 2014–2015, the BSG and NHS England surveyed access to out of hours endoscopy for patients with AUGIB. Acute gastrointestinal bleed rotas are available in about 80% of units surveyed but only 60% of stable gastrointestinal bleeds are offered an endoscopy within 24 hours. As a result of this survey and the NCEPOD report, the BSG will ensure that AUGIB has a high profile with senior NHS clinicians.

Our regional and national CSSC representatives are assiduous in their efforts to provide the CSSC with a clear picture of services throughout the country. We can be delighted that many hospitals in the UK have well developed endoscopy, outpatient and inpatient services, and we receive reports of first class specialist services. However, a number of hospitals in the UK are struggling with the workload that is compounded by difficulties in consultant recruitment. There are increasing struggles to meet OP waiting times and 2 week wait targets. I have been in contact with some of these units to provide support and show that the BSG recognises their difficulties. Can I urge anyone who is facing significant service issues within their department to contact their regional representative so that this can be fed on to CSSC. We cannot promise to solve all the issues but we will take your problems seriously and follow them up. Ongoing GIM commitment also increases the pressure on individuals, and at the forthcoming BSG conference the CSSC will run a debate that 'This house believes gastroenterologists should stop doing GIM on call'. We look forward to seeing you at the most important referendum of that particular week in June!

Of course one of the keys to improving our units is to lay down standards for a service that can then be accredited against those standards. JAG has revolutionised how endoscopy services are run, and it is hoped that the IBD standards framework will do the same. Currently, the BSG and CSSC have been in preliminary discussions with Roland Valori, at the accreditation unit of the RCP, as to how there can be further accreditation of gastrointestinal services. Much work is still to be done but wouldn't it be nice to think that in 10 years' time the management of our outpatients and inpatients is run to the same high standard as a JAG accredited endoscopy unit.

Simon Greenfield, Chair, BSG Clinical Services and Standards Committee

Andy Douds appointed CSSC Secretary

The BSG is delighted to announce that Dr Andy Douds has been appointed as the next Secretary of the BSG's Clinical Services and Standards Committee and the guidelines editor for *Gut*. He takes over this role following the annual meeting in June and will work closely with Dr Tony Tham who now becomes Deputy Chair and with Professor Dermot Gleeson as the new Chair of the CSSC. Andy has been the BSG's regional representative on CSSC on two occasions for the East of England region and is a consultant gastroenterologist at the Queen Elizabeth Hospital Kings Lynn NHS Trust. We welcome Andy to this important role in the BSG.

Mark Hudson appointed BSG Vice President of Hepatology

I am delighted and honoured to have been appointed Vice President of Hepatology. Dr Steve Ryder is a difficult act to follow; he has effectively led the BSG in a wide range of areas in the past 3 years, including implementation of the new direct acting antiviral agents and as a senior member of the *Lancet* Commission. It is my role to build on this and other challenges in hepatology. The *Lancet* Commission has highlighted the crisis in liver disease and I want the BSG to work towards delivering the 10 main recommendations within the commission. This will require coordinating liver services and enhancing services in areas of greatest need.

The BSG, along with BASL, is currently in the process of identifying what liver services are being delivered and where. We would appreciate your support in completing questionnaires that may arrive in your inbox and thank you to the many who have already completed this on behalf of your hospital or trust. We do appreciate that you are now asked to fill out many such surveys but this really does help make a difference. There are many initiatives in hepatology at present: Liver QuEST, NICE guidelines in cirrhosis and NAFLD, the cirrhosis care bundle and the CQUIN to deliver in hepatitis C. I want BSG members to understand how these initiatives may benefit you and your patients in everyday practice. For instance, the operational delivery networks (ODNs) for hepatitis C form not only a natural network for hepatitis C treatment delivery but they also form a potential network infrastructure for the delivery of liver services in England.

I am very keen to understand how the BSG can help develop hepatology in your everyday practice. How can we do this? What is required? Is it a clinical guideline, training, educational events? Let us know. I want to hear your ideas as to how best to improve liver services; how we can best support colleagues with limited resources. I also want to know how we get the message of the benefit of early identification of potential liver disease into the community and primary care. I look forward to meeting many of you at the BSG Annual Meeting in Liverpool in June and in the months ahead

Mark Hudson, BSG Vice President, Hepatology 2016-2018

BSG Annual Meeting 2016

The BSG is taking its Annual Meeting to Liverpool's ACC from Monday 20 June to Thursday 23 June, and it affords all those involved in gastroenterology and hepatology the opportunity to learn, refresh, share information and socialise!

On Monday we have world renowned UK speakers delivering cutting edge updates in the postgraduate masterclass. Interactive sessions on how to manage endoscopic challenges and complications feature heavily throughout the day as experts show delegates what they would do in tricky situations! You will also be able to hear about gastroenterology in war zones, as the trainees section have linked up with military doctors to provide an exciting insight into real 'frontline' gastroenterology!

The main scientific conference commences on Tuesday, with free paper sessions followed by the BSG plenary. We are particularly excited to have Professor Jane Dacre, President of the Royal College of Physicians, delivering the new perspectives lecture on 'Interesting times'. The plenary will also see Professor Michael Camilleri (President of the AGA) give the prestigious Sir Arthur Hurst lecture, and for the first time the BSG is presenting a lifetime achievement award.

I would like to thank all sections of the programme committee who have worked hard to guarantee that there is something for everyone, ensuring all interests are covered and nobody is disappointed. IBD features on all days and includes updates in the latest research advances, optimising therapy and tips on how to develop your IBD service. The liver section also features heavily and looks at diagnosing and managing cognitive changes, non-invasive fibrosis markers, how the microbiome influences liver disease and how to save money while still providing best care in the era of service accreditation.

The UK has a world class colorectal cancer screening programme, and the endoscopy section do this justice by devoting a whole afternoon to analysing its quality and effectiveness, and discussing whether/what changes are needed. The small bowel and nutrition section are throwing the spotlight on end of life nutrition and what we can learn from nutrition in other animals,

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while the gastroduodenal section are spotting and stopping stomach cancer. There is also a focus on nutrition on Wednesday with symposia on coeliac disease, adolescent gut allergies and the tsunami of obesity. The colorectal section are looking at what lurks beneath and unusual colorectal tumours in addition to advising delegates on how to make a dedicated polyp service happen. The pancreatologists symposium focuses on pancreatic cancer and the oesophageal section will advise on non-malignant dysphagia in addition to covering endoscopic therapy with EMR, ESD and RFA.

Live endoscopy will focus on getting the basics right. Too often it is assumed that everyone knows how to do routine everyday procedures competently. But we can develop bad habits, or perhaps for the more established gastroenterologists they were not taught in the same way that today's SpR's benefit from. It is always good to either check your technique or, for trainees, learn how to perform endoscopy to the highest standards at the beginning of your career. Experts will demonstrate to everyone 'how to do it', from carrying out a basic gastroscopy to stone extraction at ERCP.

Wednesday also sees the Clinical Services and Standards Committee (CSSC) providing guidance on developing your alcohol and gastrointestinal bleed services. They are also hosting a debate on whether gastroenterologists should stop doing medicine on call, and this is followed by the independent practice committee symposium on navigating the private sector. More help is at hand on Thursday morning with another CSSC symposium giving advice on how to develop a successful business case and a win:win with CCGs.

Neurogastroenterologists will enjoy hearing about enteric dysmotility, narcotic bowel syndrome and pseudo-obstruction, along with a functional disorders symposium featuring a state of the art lecture from Professor Nicholas Talley. Managing severe gastrointestinal bleeding and dealing with the implications of the NCEPOD report will be the focus of the radiology section, while the supporting women in the gastroenterology symposium includes a debate seeing Professor Parveen Kumar and Professor Erika Denton going head to head on whether there should be fixed quotas to promote women in the specialty.

The BSG's nursing section have put together an exciting programme for both experienced and more junior nurses (on Tuesday and Thursday, respectively), covering topics for clinical nurse specialists and endoscopy nurses, including hepatobiliary, gastrointestinal bleeding, liver transplant, decontamination, and career progression and motivation. Their plenary sees Dr Peter Carter (previous chief executive of the Royal College of Nursing) and Professor Dickon Weir-Hughes (former CEO and registrar of the NMC) take to the podium to discuss contemporary issues in nursing.

The final day sees the Scientific Translational Masterclass concentrating on the gut neuroendocrine system. The focus for the endoscopy section is all about providing high quality examinations. So, in addition to the live endoscopy sessions, they include detecting early neoplasia in the stomach, quality standards for advanced endoscopic therapy and improving ERCP and EUS. The small bowel is not forgotten, with a review of capsule endoscopy and the popular dragons den returns! Also on Thursday is a 'Best of BSG' session which will cover the highlights of the conference from leaders in their areas. The international section will showcase projects from around the world. Last but not least, our vibrant trainees section has a stellar line up of speakers for their symposium entitled gastroenterology movers, shakers, innovators and educators.

We have new awards this year for the best abstracts presented at the conference which have been generously sponsored by *Gut*, *Frontline Gastroenterology* and *BMJ Open Gastroenterology*. These are of course in addition to the annual awards for best in category oral and poster presentations (judged during the lunchtime poster rounds) and all of the trainees' section 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 trainee section organised conference party on Tuesday evening at the PanAm bar.

More detail can be found on the conference website (http://www.bsg2016.org.uk/). You can go online now and start personalising your agenda using the full interactive programme. This links seamlessly with the conference app which went live in May. Live Twitter feeds will be displayed around the conference centre, and the BSG stand will be hosting workshops on using Twitter for those novices who would like to become savvier! Also make sure you follow @BritSocGastro on Twitter to find daily information and highlights in the build up to the conference. Fees have been held at 2014 prices, so whether you plan to attend the whole conference or just a couple of days, it offers fantastic value for money. I look forward to seeing you all there.

Jayne Eaden, BSG Senior Secretary and Chair of the Programme Committee

Inauguration of the BSG/JAG/WGO Blantyre International Training Centre, Malawi, May 2016

Malawi is one of Africa's poorest, least developed and most densely populated countries. Since 2008, the Mersey School of Endoscopy, at the Royal Liverpool University Hospital, led by Dr Paul O'Toole, has been partnering with local institutions in Malawi to deliver sustainable locally relevant endoscopy training. They have developed a hub and spoke training model in which the Queen Elizabeth Central Hospital (QECH) 'hub' in Blantyre functions as a training centre, to train and support endoscopists and endoscopy nurses from within QECH, and also from the three other hospital 'spokes' in Malawi (Lilongwe, Zomba and Mzuzu). This work has been led by Professor Melita Gordon from the University of Liverpool and the Malawi–Liverpool–Wellcome Trust (MLW) Major Overseas Centre, and developed and supported over the years by links with a number of UK endoscopy and nurse trainers from other UK hospitals, including Glasgow Royal Infirmary, Torbay, Southport and Belfast. Regular locally bespoke JAG style training courses, including a foundation course, basic skills, nursing, and therapeutic upper gastrointestinal courses have been delivered and, importantly, train the trainers courses for both endoscopists and nurses to ensure a local sustainable training programme.

JAG training in endoscopy has an excellent international reputation, and this has been recognised and appreciated by the World Gastroenterology Organisation (WGO) which has a global network of endoscopy and gastroenterology training centres. The excellent results and reputation of the Malawi endoscopy training centre and its local network has been jointly acknowledged by BSG, JAG and WGO, with a formal partnership established to further develop the training programme for the local population and ultimately for other African nations. Training will be developed to also include gastroenterology and hepatology, and will be supported by UK and international faculty. The Blantyre International Training Centre was formally inaugurated on 10 May 2016. Representatives from the local partners (the University of Malawi College of Medicine, the Malawi Ministry of

Left to right: Sr Malamba, Sr Lineley the Queen's Hospital chief matron, Dr Andrew Gonani the Queen's Hospital director, Dr Mwapatsa mIpando, the principal of the College of Medicine Medical School, Professor Melita Gordon, Malawi–Liverpool–Wellcome Trust Major Overseas Centre and training centre director, Professor David Bjorkman, President of the WGO and Andy Veitch, BSG.

Health and the MLW Major Overseas Centre) officiated at the inauguration ceremony, and the event was well received and covered by local press and television. WGO was represented by its president, Professor David Bjorkman, and BSG and JAG by Dr Andy Veitch. BSG and JAG are also collaborating with WGO to disseminate UK style training throughout the other WGO centres and this is further recognition of the excellent standards and methods of training developed in the UK.

Andy Veitch, BSG

Save the date—BSG Endolive 2017—Birmingham, 2–3 March 2017

Endolive 2015 was the largest live endoscopy course to be held in the UK, with more than 500 consultants, trainees and nurses gathering in Birmingham to watch, discuss and debate best practice in endoscopy. Feedback was excellent, and as endoscopic technique and technology advances so rapidly, we are doing it again! As well as demonstrating a full range of diagnostic and therapeutic endoscopy (transmitted live from Glasgow and London St Mark's) the expert UK and international faculty will provide clinical updates and lead debate from the ICC in Birmingham. This will be an event not to be missed!

George Webster, Endolive 2017 Lead

BSG Oesophageal Section Symposium

The Oesophageal Section held a very successful standalone symposium at the RCP London in March 2016 to discuss the revision of two clinical guidelines—oesophageal stricture dilatation (led by Stephen Attwood) and oesophageal physiology testing (led by Nigel Trudgill), including high resolution manometry with and without impedence, and prolonged pH/impedence monitoring. The draft guidelines were well received and actively discussed by the membership, who represented a wide range of disciplines—medical, nursing, physiologists and patients. The constructive comments and questions will feed into the final versions of the guidelines to be published next year. We were privileged to have international expert panellists Professor Peter Siersema and Professor Guy Boekxstaens whose comments were thought provoking and constructive, and will also feed into the final drafts. Mimi McCord provided useful insight and comments from a patient perspective.

Each guideline development group has a panel of 8–10 BSG members. We have been fortunate in having the help and expertise of two gastrointestinal trainees, Sarmed Sami from Nottingham and Hasan Haboubi from Swansea, who introduced the panel members to Mendeley as a means of sharing and screening abstracts. Feedback from the meeting has been very positive, with particular value seen in the discussions of the questions and the clear expertise of the speakers

Stephen Attwood, Secretary, Oesophageal Section Committee

What is Liver QuEST?

Liver QuEST is a project that aims to improve the care of patients with liver disease. It asks services to improve themselves against six core standards:

1. Leadership and organisation
2. Service planning and definition
3. Safety
4. Clinical effectiveness
5. Person centred care
6. Staffing a clinical service

Services undergo self-assessment followed by peer review visits during the improvement process. The team conducting these visits include a patient, doctor, nurse and a quality assurance specialist. Ultimately the aim is for liver services to be accredited against these standards.

The project is funded by the Royal College of Physicians of London and has the backing of the patient groups, BSG, the British Association for the Study of the Liver and the *Lancet* Commission.

We have a number of services involved in the project and have so far visited six sites in the pilot stage. Two key themes emerged from the visits. Firstly, most services were poor at demonstrating what services they provided and how to access them via the internet. Secondly, units struggled to measure key performance indicators linked to the recently published cirrhosis care bundle http://www.bsg.org.uk/care-bundles/care-bundles-general/decompensated-cirrhosis-care-bundle-first-24-hours.html

Key performance indicators

- Antibiotic prescription in acute variceal bleeding 24 hours either side of the procedure.
- Ascitic tap in emergency admissions with ascites (within 12 hours).
- Albumin and antibiotic prescription in patients diagnosed with SBP within 12 hours of diagnosis.
- Per cent of acute admissions with decompensated liver disease seen by a gastroenterologist/hepatologist within 24 hours of admission.

A recent national meeting reviewed the project's progress so far and was a great success. We now plan to roll the project out to more sites and utilise regional networks to promote Liver QuEST. Our ultimate aim is to provide an improvement and accreditation scheme for all liver services in the UK that will improve the care for patients with liver disease.

James Ferguson

BRITISH SOCIETY OF GASTROENTEROLOGY

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