



BRITISH SOCIETY OF
GASTROENTEROLOGY

Commissioning evidence-based care for Patients with Gastrointestinal and Liver Disease



The Authors

This guide has been written in partnership by professional and patient organisations relevant to gastroenterology and hepatology:

- British Society of Gastroenterology
- British Association for the Study of the Liver
- Primary Care Society for Gastroenterology
- British Association for Parenteral and Enteral Nutrition
- Crohn's and Colitis UK
- Coeliac UK
- The IBS Network
- British Liver Trust

The Aim

The aim of this document is to provide an evidence-base according to which good quality secondary care services should be commissioned for patients with symptoms and conditions related to the gastrointestinal tract and liver. Adherence to this should facilitate care that is:

- appropriate
- good quality
- cost effective
- coordinated across primary and secondary care

It is expected that implementation of these recommendations should:

- re-align resources to improve outcomes and provide better value
- reduce inequalities in care

The guidance given here focuses on provision of medical gastroenterology and hepatology services, including endoscopy, but does not cover emergency or elective surgery. It also does not cover the essential high quality support services that include specialist GI/liver pathology, diagnostic and interventional radiology, and microbiology, all of which need to be commissioned to ensure a good GI/hepatology service.

The new commissioning framework represents a great opportunity for colleagues in primary and secondary care to work together to re-evaluate patient needs, reduce activity that is outdated or of limited value, invest in high value services that meet patient needs and thereby achieve the overall objectives of improving value whilst modernising the service to meet the goals of the Outcomes Framework as it applies to gastrointestinal and liver diseases.

The impact of gastrointestinal and liver conditions

Gastrointestinal and liver conditions, together, account for nearly 14% of the total in-patient NHS budget. Gastrointestinal symptoms account for 10% of GP consultations, 10% of hospital specialist workload and 14% of the drug budget. [1] Gastrointestinal and liver conditions account for 11-14% of acute medical admissions. [2] 11.2% of deaths are related to GI and liver causes [ONS 2001].

In 2007 a systematic review of the literature found that gastrointestinal disease was “the third most common cause of death overall, the leading cause of cancer death (27% of cancer deaths), and the most common cause of hospital admission [3].”

Liver disease is the 5th highest cause of death in the U.K. and the only common cause of death that is still rising. The median age of death from liver disease is 59 years, compared to 82-84 years for heart & lung disease or stroke. In 2005 there were 43,694 episodes coded with liver disease as the primary diagnosis with a mortality rate of 15.5% per episode and deaths from liver disease in the UK have been rising at between 8-10% per year. Yet liver disease morbidity and mortality are largely preventable. Alcohol accounts for over 60% of liver deaths and there is a direct relationship between liver deaths and overall alcohol consumption.

	Total FCEs	Percentage of total FCEs	Total Costs (2009/10)	Percentage of total cost
The total number of In-patient episodes for one year (all conditions not just GI)	16,988,026		£18,264,119,957	
For luminal GI (includes all gastroenterology and gastrointestinal surgery); chapter F of ICD coding book	2,346,161	13.8%	£2,342,571,570	12.8%
Hepatic, biliary and pancreatic diseases, including surgery; chapter G of ICD coding book	315,956	1.9%	£509,836,275	2.8%
Outpatient procedures (only those OP that had procedures coded, and not all OP activity)	4,554,562		£500,736,600	
Luminal GI OP procedures;	188,237	4.1%	£42,093,014	8.4%
Hepatology, biliary and pancreatic OP procedures;	2,460	0.1%	£286,851	0.1%

References:

1. Jones R. Primary care research and clinical practice: gastroenterology. Postgrad Med J. 2008 Sep;84(995):454-8.
2. Moore S et al. Impact of specialist care on clinical outcomes for medical emergencies. Clinical Medicine 2006; 6:286-93.
3. Williams JG et al. Gastroenterology services in the UK. The burden of disease, and the organisation and delivery of services for gastrointestinal and liver disorders: a review of the evidence. Gut. 2007;56 Suppl 1:1-113

A good quality service for gastroenterology and hepatology should include:

1 An endoscopy service that participates in the Global Rating System, is accredited by the Joint Advisory Group on Endoscopy (JAG), participates in national audit, provides/participates in a network that provides 24 hour/7 day endoscopy service for gastrointestinal bleeding and ensures that all patients over 40 with recent onset rectal bleeding and/or persistent diarrhoea >3 weeks have access to flexible sigmoidoscopy or colonoscopy within 4 weeks. Efficient use of facilities should usually include evening and weekend lists. Commissioners should negotiate with Trusts to achieve a transparent shift of activity from unnecessary endoscopy in young patients with dyspepsia towards appropriately increased resources to meet appropriately increased demand for lower-GI endoscopy.

2 An inflammatory bowel disease service that is separately commissioned, conforms to the IBD Standards <http://www.ibdstandards.org.uk/>, and participates in national clinical audit.

3 A hepatology service that is separately commissioned and that ensures appropriate monitoring of patients with chronic liver disease for prophylactic treatment of varices and early diagnosis of hepatocellular carcinoma and that includes 7 day/week availability of appropriately trained specialist care for patients with acute jaundice and liver failure. The service should be provided by an appropriate multidisciplinary team as defined in the National Liver Plan <http://www.bsg.org.uk/sections/liver-news/the-national-plan-for-liver-services-uk-2009.html>

4 Provision of a consultant gastroenterology/hepatology ward round on each day including weekends and public holidays.

5 A multidisciplinary alcohol care team, integrated across primary and secondary care but with a hospital base, providing a 7 day/week service to support patients with alcohol-related problems, improve abstinence, and reduce re-admission rates.

6 Efficient use of outpatient services with low follow-up to new ratios eg 1:1 for patients excluding those with chronic disease (IBD and liver disease) and appropriate use of nurse-led clinics, telephone and email consultation. Efficient first consultation for new patients should be facilitated by the use of structured referral forms containing relevant data and pre-investigation results, agreed by local consultation between primary and secondary care. Secondary care Trusts should provide explicit information that allows targeted referral of patients to the most appropriate sub-speciality service.

7 A multidisciplinary nutrition service that provides daily input into the care of in-patients with nutritional problems, and provides specialist dietetic support in all settings for patients with special dietary requirements including patients with liver disease, inflammatory bowel disease, coeliac disease and patients with short bowel. A coeliac disease service conforming to NICE <http://www.nice.org.uk/CG86> and ESPGHAN <http://www.espgan.med.up.pt/> standards on diagnosis, national guidance on management and using cost efficient pharmacy supply schemes to manage prescriptions.

Outcome metrics are still under development but may include:

- (i) In-patient mortality for GI bleeding.
- (ii) In-patient mortality for patients with alcoholic liver disease.

- (iii) In-patient mortality for patients with biliary obstruction.
- (iv) In-patient bed days/patient/year for patients with inflammatory bowel disease.
- (v) Readmission rates for patients with alcohol-related problems.

Meeting the goals of the Outcomes Framework

1 Preventing people from dying prematurely

- 1.1 Reduction of premature deaths from liver disease.**
Liver disease has risen rapidly to be a major cause of avoidable mortality with a median age at death of only 59. More than 60% is alcohol-related but there are significant contributions from viral hepatitis (B and C) and obesity-related fatty liver disease.
- 1.1.1 Early detection of liver disease in Primary Care using blood testing supplemented by brief formal assessments of alcohol use, according to NICE guidelines 2011.**
<http://www.nice.org.uk/guidance/index.jsp?action=download&o=45489> – alcoholic liver disease.
The success of this goal will be maximized if done in the context of a multidisciplinary team integrated across primary and secondary care (see 1.1.2), with rapid access to clinics to investigate abnormal LFTs and deal with identified problems of alcohol or drug dependence.
- 1.1.2 Multidisciplinary alcohol care teams integrated across primary and secondary care** have been shown to improve abstinence and markedly reduce admissions to hospital for alcohol-related problems. They need to be commissioned to work across secondary and primary care, with a clearly defined senior leader e.g. nurse consultant or medical consultant, who should have a base within secondary care. According to NICE just 6 per cent of people in England who have an alcohol problem are receiving treatment for it. NICE has called for screening and better access to withdrawal services.
See “highly recommended” QIPP on Alcohol Care Teams: <http://www2.evidence.nhs.uk/qipp>
This should lead to substantial cost savings.

- 1.1.3 Preventing deaths from viral hepatitis.** Mortality and morbidity from chronic viral hepatitis is rising rapidly in England and accounts for over half of all referrals for liver transplantation – see HPA annual report – http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1309969907625.
Cost effective therapy is NICE recommended (Hepatitis C TA200) (Hepatitis B TA153 and TA173) and effective administration of antiviral therapy in a ‘trace and treat’ model will lead to very substantial cost savings in the medium term.
- 1.1.4 Preventing deaths from complications of chronic liver disease: patients with cirrhosis: by appropriate screening for varices and use of beta blockers to prevent deaths from variceal bleeding, and by appropriate screening of cirrhotic patients (by ultrasound and serology) to identify hepatocellular carcinoma at a treatable stage.**
<http://www.bsg.org.uk/clinical-guidelines/liver/uk-guidelines-on-the-management-of-variceal-haemorrhage-in-cirrhotic-patients.html>
<http://www.bsg.org.uk/clinical-guidelines/liver/guidelines-for-the-diagnosis-and-treatment-of-hepatocellular-carcinoma-hcc-in-adults.html>
- 1.1.5 Preventing deaths from Acute Jaundice and Liver Failure:** These are associated with an increased risk of death. Hospital trusts should have policies consistent with the National Liver Plan and ensuing policies that ensure *prompt availability 7 days/week of specialist MDT care for patients with liver disease.*
- 1.2 Reduction of deaths from upper GI bleeding.**
- 1.2.1** Hospital gastroenterology services should be commissioned to provide *24 hr 7 day endoscopic service for GI bleeding*, as recommended by the National Patient Safety Agency, – either through their own resources or by networking with other local hospitals. In-hospital mortality from upper GI bleeding generally runs at around 10% but can be reduced substantially with optimum care. Interventions (endoscopic and radiological as well as surgical) are available which can reduce mortality but these need to be accessible 7 days per week.
See: *GI bleeding toolkit*:
<http://aomrc.org.uk/projects/upper-gastrointestinal-bleeding-toolkit.html>

- 1.2.2 *All patients admitted with acute upper or lower GI bleeding should have access to interventional endoscopy, interventional radiology and surgery*
Care for patients with GI bleeding should preferably be focused on centres that have these facilities.
- 1.2.3 Risk of GI bleeding will be reduced by *adherence to NICE guidelines (for osteoarthritis) for the use of PPI prophylaxis in all patients taking NSAIDs or COX-2 inhibitors*
<http://www.nice.org.uk/nicemedia/pdf/CG59NICEguideline.pdf>
These guidelines show there is a major dominant effect (reduced costs and reduced morbidity and mortality) from this strategy. District pharmacists should be required to implement these guidelines which would more than halve the harms from NSAIDs.
- 1.3 Reduction of deaths from acute GI and liver conditions (e.g. liver failure, GI bleeding, Inflammatory bowel disease) *out of hours, at weekends and public holidays.*
- 1.3.1 A marked increase in mortality has been noted from GI bleeding at weekends and on public holidays and reflects lack of specialist cover. Although less well documented, other potentially fatal conditions such as liver failure, biliary sepsis and severe colitis also require daily specialist input. A hospital providing care for people with these conditions should be *commissioned to ensure a consultant gastroenterology/hepatology ward round takes place on each day including weekends and public holidays.* See: Working for patients:
<http://www.rcplondon.ac.uk/resources/consultant-physicians-working-patients-gastroenterology-and-hepatology>
- 1.3.2 Hospital trusts should have policies consistent with the UK National IBD Standards that ensure *prompt availability of specialist MDT care for patients with inflammatory bowel disease.*
<http://www.ibdstandards.org.uk/>
- 1.4 Reduction of deaths from colorectal cancer. Three per cent of deaths in the UK are from colorectal cancer and survival for patients with this diagnosis currently lags behind other European countries. Delayed diagnosis is a major part of the problem.

- 1.4.1 Colonoscopy services should be commissioned so that *all patients over 40 with recent onset rectal bleeding and/or persistent diarrhoea >3 weeks should have access to flexible sigmoidoscopy or colonoscopy within 4 weeks.*

2 Enhancing quality of life for people with long-term conditions

- 2.1 Reducing morbidity, hospital admissions and unnecessary clinic visits for patients with inflammatory bowel disease (IBD).
- 2.1.1 The UK-wide IBD audit has revealed marked variations in quality of care and has led to definition of *agreed Standards of Care for IBD:*
<http://www.ibdstandards.org.uk/>
These include commissioning of a *multidisciplinary team that includes year round access to gastroenterologists, specialist colorectal surgeons, IBD specialist nurses, gastroenterology-specialist dietitians and psychological support.*
- 2.1.2 A separately commissioned outpatient service for IBD patients is recommended. This could be commissioned according to a “year of care” tariff.
- 2.1.3 Also, according to IBD Standards of Care (above) – *Patients suffering a flare should be able to self-refer and be seen in a specialist clinic within 7 days.*
- 2.1.4 Well patients should not be followed up by routine outpatient clinic visits more than once per year – *commissioning of telephone consultations for routine follow-up is encouraged.*
- 2.1.5 The purpose of the follow-up visits should be clearly defined e.g. monitoring of drug side effects, assessment of response to therapy, need for continued therapy (particularly immunosuppressives/biologics), compliance with surveillance.
- 2.1.6 *Commissioning of monitoring e.g. for drug toxicity, should ensure that patients are provided with the results of their monitoring tests* together with information about their interpretation e.g. by copy of the relevant protocol/information sheet.
- 2.2 Reducing morbidity, hospital admissions, and unnecessary clinic visits for patients with liver disease.

- 2.2.1 Multidisciplinary Alcohol care teams should be established as per 1.1.2 to improve abstinence and markedly reduce admissions to hospital for alcohol-related problems.
See “highly recommended” QIPP on Alcohol Care Teams: <http://www2.evidence.nhs.uk/qipp>
This should lead to substantial cost savings.
- 2.2.2 Appropriate monitoring of patients with chronic liver disease for prophylactic treatment of varices and early diagnosis of hepatocellular carcinoma as per:
<http://www.bsg.org.uk/clinical-guidelines/liver/uk-guidelines-on-the-management-of-variceal-haemorrhage-in-cirrhotic-patients.html> and <http://www.bsg.org.uk/clinical-guidelines/liver/guidelines-for-the-diagnosis-and-treatment-of-hepatocellular-carcinoma-hcc-in-adults.html>
- 2.2.3 The purpose of the follow-up visits should be clearly defined e.g. monitoring of drug side effects, assessment of response to therapy, need for continued therapy (particularly immunosuppressives/antivirals), compliance with surveillance.
- 2.2.4 A separately commissioned outpatient service for liver disease patients is recommended. This could be commissioned according to a “year of care” tariff.
- 2.2.5 Special monitoring arrangements are required for patients with viral hepatitis where cost effective care requires provision of specialist nurses (to support and monitor therapy) as well as provision of high quality, rapid turnaround virology services able to perform the sophisticated virological tests needed to monitor therapy. The treatment of viral hepatitis should only be performed in Trusts where there are at least two clinicians capable of delivering the service and where activity is at least 25 patients commencing therapy per year as per BASL guidelines.
- 2.3 Integrated care for patients with chronic conditions with an explicit, planned and transparent sharing of responsibilities between primary and secondary care:
- 2.3.1 *Care pathways that move between primary and secondary care are recommended for many of the conditions listed in this report – see appended tables.*

- 2.3.2 Most patients with potentially long term gastrointestinal conditions, such as *dyspepsia, gastro-oesophageal reflux, and irritable bowel syndrome (IBS) should be managed in primary care. Coeliac disease patients can also be managed in primary care once diagnosed and established on a gluten free diet but should have ready access to secondary care if troubled by recurrent or persistent symptoms. Patients with chronic conditions, whether managed in primary or secondary care, should have ready access to psychological and dietetic treatment or intervention.*
- 2.3.3 By contrast, less common complex diseases, like *inflammatory bowel disease and viral hepatitis, benefit from input from secondary care, though there is scope for blood and symptom monitoring in primary care and liaison with specialist units.*
In either case there must be flexibility for patient choice with clear delineation of responsibilities and avoidance of duplication.
- 2.4 Improving capacity for self-care and self-directed care amongst GI patients:
- 2.4.1 *Self-directed care:* Commissioning should facilitate patient self management of chronic conditions such as inflammatory bowel disease, chronic liver disease, irritable bowel syndrome and coeliac disease; the informed patient guided and supported by health professionals to determine optimum treatment. *Communication by phone and email can facilitate this but needs to be properly commissioned.*
- 2.4.2 *Self-care: Commissioning should include training of primary care staff (e.g. using secondary care staff as trainers) so that they can facilitate self-care* for long term functional conditions such as irritable bowel syndrome and dyspepsia.
- 2.4.3 Commissioners should involve patients in designing locally agreed pathways of care and service provision. There are well established patients charities that can facilitate this process including *British Liver Trust, Coeliac UK, Crohn's and Colitis (UK), The Hepatitis C Trust and The IBS Network.*

- 3 Helping people to recover from episodes of ill-health**
- 3.1 Reducing readmissions for patients with alcohol-related problems.**
- 3.1.1** Commissioning of an *appropriate multidisciplinary alcohol care team* (see 2.2.1) will substantially reduce hospital readmissions.
- 3.2 Reducing admissions for patients with inflammatory bowel disease.**
- 3.2.1** The recent UK IBD audit has shown substantially lower admission rates in hospitals where patients have *access to IBD specialist nurses*.
www.rcplondon.ac.uk/resources/inflammatory-bowel-disease-audit
- 3.2.2** *Access to anti-TNF treatments according to NICE guidelines. Appropriate anti-TNF treatment has been shown to reduce hospitalization substantially* in patients with Crohn's disease and may also reduce colectomy rates in patients with ulcerative colitis. Recent audit suggested major regional differences in access to anti-TNF treatment. NICE guidelines currently recommend anti-TNF treatment for approximately 10% of patients with Crohn's disease.
<http://guidance.nice.org.uk/TA187>
- 3.3 Access to therapy for viral hepatitis according to NICE guidelines.**
Access to therapy for viral hepatitis cures the infection and prevents admissions from decompensated cirrhosis and liver cancer. Very substantial cost savings can be made in this area by increasing provision of antiviral therapy in a 'trace and treat' model.
- 3.4 Provision of a multidisciplinary nutrition service** that provides daily input into the care of in-patients with nutritional problems, and provides specialist dietetic support for outpatients with special dietary requirements including patients with liver disease, inflammatory bowel disease, coeliac disease, irritable bowel syndrome, and patients with short bowel. Specialist dietetics support should also be available in the community for patients with coeliac disease.

- 4 Ensuring that people have a positive experience of care**
- 4.1 Organisation of Outpatient Services.**
- 4.1.1** *Improving efficiency by ensuring that first consultation for new patients is facilitated by the use of structured referral forms* containing relevant data and pre-investigation results, according to a referral pathway agreed by local consultation between primary and secondary care. Trusts should provide explicit information that allows targeted referral of patients to the most appropriate sub-speciality service.
- 4.1.2** *Allocation of patient referrals to the most appropriate specialist:*
Referral management and triage services should be commissioned and resourced to ensure referral of new patients to the most appropriate specialist: "Right patient, right place". Patients with chronic organic conditions such as inflammatory bowel disease and liver disease are best managed in disease-specific clinics attended by various members of the appropriate multi-disciplinary teams.
- 4.1.3** *Avoidance of unnecessary follow-up/clinic attendance.*
Provided that patients with IBD and liver diseases are managed in separately commissioned clinics as per 4.1.5, other patients who do not have chronic organic diseases should be managed in a general clinic that should be able to operate with a follow-up: new ratio approaching 1:1. **'One-stop' multidisciplinary services:** Delivery of high quality effective services for certain conditions can often be done as a 'one-stop' clinic, whereby both clinical assessment and diagnostic or therapeutic intervention all takes place during the same outpatient visit, often within the same departmental setting. This 'one-stop model' of service delivery is appropriate for patients with rectal bleeding, dyspepsia or abnormal liver function tests. The 'one-stop' concept could be used more widely with more careful planning from Hospital Trusts, to align for example GI and gynaecological clinics (abdominal discomfort), hepatology, addiction and liaison psychiatry (alcohol dependence) or GI and haematologist (anaemia). **Alternatives to new patient referrals:** There should be greater use of email advice, between primary and secondary care (appropriately timetabled and funded). **Alternatives to routine follow-up appointments:**

Routine follow up for well patients could be avoided by monitoring and testing by practice nurses, open rapid access follow up appointments when necessary, telephone and email follow up. *Nurse-led follow-up clinics are particularly appropriate for IBD and hepatitis B and C.*

4.1.4 Referrals for specific conditions:

- (i) *Dyspepsia should be managed in Primary Care (> 95%) by a policy of (H.pylori) test and treat, supplemented by (generic) PPI prescriptions.*
- (ii) *Chronic diarrhoeal illness: pre-referral screening of chronic diarrhoea as per 4.1.1 should include:*
- (a) *faecal calprotectin to identify intestinal inflammation*
- (ii) *TTG antibody to identify coeliac disease*
- to increase the speed and precision of appropriate referral and to reduce the volume of inappropriate referral.
- (iii) *Anaemia: Referral to gastroenterology for anaemia should be restricted to patients with iron, B12 or folate deficiency that is not explained by dietary deficiency or menorrhagia.* Haematological referral is appropriate for most other cases of anaemia. Combined one-stop GI/Haematology clinics facilitate getting patients on the right pathway.
- (iv) *Abnormal LFTs and jaundice: One stop referral clinics should be commissioned for patients with abnormal LFTs and jaundice,* to achieve early diagnosis according to the *National Liver Plan:*
- (v) For patients with *viral hepatitis who are using illicit drugs* community services are very effective and improve quality of care whilst reducing onward transmission of infections Aliment Pharmacol Ther. 2009 Jan;29(1):29-37. Community-based treatment for chronic hepatitis C in drug users: high rates of compliance with therapy despite ongoing drug use. Wilkinson M et al. Aliment Pharmacol Ther. 2009 Jan;29:38-45. Clinical trial: a primary-care-based model for the delivery of anti-viral treatment to injecting drug users infected with hepatitis C. Jack K et al *These are highly cost effective*
<http://www.bsg.org.uk/sections/liver-news/the-national-plan-for-liver-services-uk-2009.html>

- (vi) *Outpatient and diagnostic services for other specific conditions:* Advice on how to apply these principles to the commissioning and provision of out-patient and diagnostic services for other common specific symptoms and presentations is detailed in the appended tables.

4.1.5 Time Allocation:

At least 50% of new referrals to a GI clinic are likely to have functional problems such as irritable bowel syndrome, dyspepsia or GERD. *Most of these patients with functional problems can usually be diagnosed and managed in a single visit providing that pre-clinic investigations are performed and that adequate time is taken in clinic* to take a full history and give the patient appropriate information. *This will usually require an average of 30 minutes allocated per new patient* as advocated in the RCP 'Working for patients' document.

4.2 Audit.

- 4.2.1** *Where national audits/registries exist for specific GI/hepatology conditions or services participation should be considered mandatory. For example: NHS Trusts providing care for patients with IBD must participate in the UK IBD Audit and Registry.*
www.rcplondon.ac.uk/resources/inflammatory-bowel-disease-audit

This will ensure compliance with the IBD standards and help greatly to reduce the previous marked geographical variations in quality of care.

4.3 Commissioning High Quality Endoscopy Services.

4.3.1 Providing Patient needs and feedback by:

- (i) Ensuring that *Endoscopy services and activity are organized according to the needs of the local patient population.*
- (ii) *Commissioned Endoscopy Services must participate in the UK Global Rating System (GRS) for Endoscopy – this includes monitoring of patient experience and outcome.*
www.grs.nhs.uk/
This has driven up standards of care in endoscopy substantially.
- (iii) *Trusts should be required to show that they act on patient feedback.*

4.3.2 Models of Service Delivery:

Commissioning should encourage *a reduction in unnecessary diagnostic endoscopy*, e.g.

- (i) *endoscopy should be avoided in patients <55 with dyspepsia without alarm symptoms.*
- (ii) *Funds released by reduced endoscopy of dyspepsia should be used for the procurement of modern endoscopes with enhanced imaging capacity that can be effective in the early diagnosis of dysplastic and neoplastic lesions in the oesophagus, stomach and colon, allowing endoscopic treatment at an early stage.* Barrett's oesophagus is prototypic for this approach. Methods for focused screening for Barrett's oesophagus will soon be available.

4.3.3 Endoscopy in the community.

- (i) *In most areas, routine endoscopy will be provided in a hospital Trust but it can also be conducted in the community providing appropriate quality and training standards (GRS and JAG) are met.*
- (ii) *All endoscopy units should ensure efficient use of equipment – with routine lists 6 days/week encouraged.*

4.3.4 Commissioning endoscopic services for specific procedures and indications.

- (i) *Referral for endoscopy in patients with dyspepsia should be in accordance with the NICE Guidelines:*
<http://www.nice.org.uk/guidance/cg17>
- (ii) *Endoscopy for acute GI bleeding should be commissioned as a 7 day, 24 hour service using an appropriate model from the GI bleeding toolkit:*
<http://aomrc.org.uk/projects/uppergastrointestinal-bleeding-toolkit.html>

(iii) *Implications of increased Bowel cancer screening and surveillance for commissioning of colonoscopy and flexible sigmoidoscopy.*

Gastroenterologists are the mainstay of the bowel cancer screening programme which has been successful in reducing cancer mortality and will be leading the roll out of an *expansion of this scheme over the next five years through the implementation of flexible sigmoidoscopy*. This, coupled with campaigns to increase awareness of early symptoms, will have implications for increased colonoscopy workload and *DoH data currently estimates a need for a 5-10% year on year sustained increase in colonoscopy, at least for the next 5 years* (letter to all Trust Chief Executives from Sir Bruce Keogh, Medical Director DH, August 2011. Gateway reference 16390).

(iv) ERCP: this is integral to HPB services and *should usually be commissioned in close association with Endoscopic ultrasound (EUS)*. It should only be performed in Trusts where there are at least two clinicians capable of delivering the service and where activity is at least 75 procedures/year/endoscopist as per JAG/BSG guidelines.
<http://www.thejag.org.uk/downloads%5CUnit%20Resources%5CBSG%20Quality%20and%20Safety%20Indicators.pdf>(v) *Some less common procedures are not covered by tariffs and will need to be locally negotiated. These may include for example endoscopic mucosal resection and radio frequency ablation. Surveillance for cancer and pre-cancer (dysplasia) in patients with colitis should only be commissioned from units that use image enhancement and systematic biopsy protocols.*
<http://guidance.nice.org.uk/CG/Wave21/3>(vi) Advanced Imaging:
Use of *autofluorescence, narrow band or other post-processing techniques, which have emerging advantage in specific areas should be focussed on a limited number of specialist centres.*

4.3.5 People:

- (i) *Endoscopists should all be able to demonstrate standards of care with activity and outcome data.*
- (iii) *Each unit should be JAG Accredited*
<http://www.thejag.org.uk/>

4.3.6 Finance:

- (i) Although the national tariff determines average costs associated with individual endoscopy procedures in NHS Trusts *commissioners will need to assess the cost effectiveness of any given endoscopy service*. This will be influenced by the case-mix of the population needing procedures. "Cherry-picking" of services should be avoided.
- (ii) *The tariff structure is not currently sophisticated enough to reward consultation with procedures together* (i.e. one stop service) and local arrangements should be considered to fund this activity.
- (iii) The detailed data on HRG and tariffs for each trust which are made available to commissioners via SUS (Secondary users service) should be discussed directly with the lead clinician for GI/hepatology services to identify anomalies and if necessary cap some services and increase others to drive quality and value.

For detailed advice on costings refer to the relevant Payment By Results (PBR) tariffs.

<http://data.gov.uk/dataset/payment-by-results-2010-11-national-tariff-information>

5 Treating and caring for people in a safe environment

5.1 Commissioning safe endoscopy:

- (i) *Endoscopy Services must obtain training accreditation from the Joint Advisory Panel on GI Endoscopy (JAG)*
<http://www.thejag.org.uk/>
- (ii) *Endoscopy services must participate in the UK Global Rating System (GRS) for Endoscopy*
www.grs.nhs.uk/
- (iii) *All complications from endoscopy must be continuously logged and regularly reviewed at a multidisciplinary team meeting.*
- (iv) *Decontamination of endoscopic equipment must comply with national standards (HTM-01-06)*
<http://www.nice.org.uk/guidance/index.jsp?action=byID&r=true&o=11332>

5.2 Monitoring Outcomes.

A list of conditions for which relevant standards are/will become available (from the latest DoH list as at June 2011) follows below:

Acute upper GI bleeding
Gastroesophageal reflux disease
Ulcerative colitis
Crohn's disease
Irritable bowel syndrome
Coeliac disease
Liver disease (non-alcoholic)
Cirrhosis
Hepatitis B
Hepatitis C
Pancreatitis
Alcohol dependence and harmful alcohol use
Faecal incontinence
Nutritional support in adults
Nutrition in hospital, including young people
Nutrition support in adults
Constipation (children and young people)
Colorectal cancer
Referral for suspected cancer

It is expected that all/most of these will be backed up by outcome metrics that will need to be routinely collected.

Mechanisms to re-align resources for improvement of outcomes and value.

Specific mechanisms for using commissioning to improve efficiency.

We have framed our recommendations in the light of the current financial circumstances and the Nicholson challenge to the health service to make £20 billion of efficiency savings. We think that our recommendations are cost neutral and based on the principle of reducing spending on established activities that may now be of low value in order to invest in those that are of higher value and/or where investment can lead to savings. Some of the major mechanisms for improving efficiency are as follows:

1 Interface Services

- a) Specialist support for primary care. Many patients with functional problems are currently referred to secondary specialist GI services. Such referrals could be reduced by using Interface services to allow GPs to assess appropriateness of referral through the Advice and Guidance functionality of Choose and Book. Alternatives include secure e.mail exchange or telephone help lines, but these require local implementation and process measures to support service improvement or local SLAs.
- b) Clinical Assessment Service. Gastrointestinal symptoms are often multiple (abdominal pain AND rectal bleeding AND bloating) for which several patient pathways maybe available. To avoid multiple or duplicate referral commissioners should consider implementing a RMS/CAS services to stream patients to the most appropriate clinical service or diagnostic

pathway. Telephone assessment and/or pre-investigation maximises the value of the new patient consultant visit. CAS can be set up within Choose & Book which captures activity for monitoring SLA.

2 Shared Care

Monitoring of Immunosuppressant Drugs.

Patients with IBD and auto-immune hepatitis are often treated with powerful immunosuppressant drugs which can, rarely, have severe life-threatening complications. However the 3 monthly monitoring is often done by secondary care at inconvenience to the patient and cost to primary care. Commissioners should ensure local clinical governance processes (via local pharmacy and DT committees) to support prescribing, mandate blood testing in primary care and ensure appropriate IT to allow secondary care to review and action results (www.nhsleadership.org.uk/images/library/files/POSTERS/immunosuppressant.pdf).

3 Organisation and configuration of Outpatient services

Focus on summary KPIs (e.g. new to follow-up ratios) does not support useful analysis and fails to capture the detail and granularity required. Dedicated IBD or chronic liver disease clinics should be coded separately and excluded from pathway specific new to follow-up ratios. Many patients, if given adequate time (reference RCP working for patients) at their initial visit will prefer virtual clinic follow-up. Likewise, open follow-up arrangements allow for clinical uncertainty and will be cost-saving.

4 Organisation and configuration of Endoscopy services

Commissioners should review key endoscopy activity data from atlas of variation in context of local GI cancer outcomes. Outlying activity should prompt review of following local service provision:

- a) Direct access to low risk endoscopic procedures should only be provided as part of RMS/CAS with process measures to capture demand and activity. For most cases of oesophageal reflux pragmatic treatment with long-term PPIs without endoscopy is appropriate. Endoscopy remains appropriate where there are alarm symptoms, especially in older people. For non-reflux dyspepsia without alarm symptoms H pylori test and treat strategies remain currently more appropriate.
- b) One stop services should be actively supported, particularly for providing diagnostics for rectal bleeding pathway; tariffs need to be locally negotiated to appropriately resource clinical and therapeutic elements.
- c) Surveillance: commissioners and providers should ensure robust systems are in place to clinically validate surveillance lists for colonoscopy and OGD.
- d) Named consultant vs pooled lists: commissioners and providers should recognise risks of pooling and loss of clinical responsibility generating multiple steps in patients pathways. In contrast named lists add value and deliver high quality/high efficiency care. (reference JAG guidance).

5 Alcohol Care Teams

Spending on the medical consequences of alcohol is enormous and in many instances futile. Patients with an alcohol-related admission have been identified as one of the main sources of spending during in-patient medical admissions, and can be associated with frequent re-presentation. Modelling exercises and pilot studies have shown that Alcohol Care teams, as well as representing an improvement in service, can achieve substantial cost savings, particularly by improving abstinence and reducing re-admission. An integrated approach should include facilities for community care and detoxification, early detection and brief advice and community outreach and rapid effective access to psychiatric services where appropriate.

6 Use of faecal calprotectin pre-screening

Most patients referred to hospital with ongoing diarrhoea turn out to have Irritable Bowel Syndrome but frequently incur investigation by upper and lower endoscopy at significant cost. Conversely there is an unacceptable lag before patients with Inflammatory Bowel Disease are seen. Pre-screening by faecal calprotectin will save significant funds by reducing inappropriate referral and investigation, whilst ensuring that those with Inflammatory Bowel Disease are diagnosed at an earlier stage.

Recommended structure for GI/Hepatology Commissioning and detailed tables for commissioning specific conditions.

DIAGNOSIS: Access to tests and to expert opinion

- Dyspepsia and dysphagia
- Abdominal discomfort and altered bowel habit
- Rectal bleeding
- Anaemia
- Abnormal Liver Function Test

ACUTE MANAGEMENT

- GI bleeding
- IBD
- Jaundice
- Liver failure
- Gallstones and pancreatitis
- Nutritional problems

CHRONIC MANAGEMENT

- Alcohol dependency
- Chronic GI morbidity after cancer treatment
- Coeliac
- Barretts
- IBS/Functional symptoms
- IBD
- Alcoholic Liver disease
- Viral Hepatitis
- NASH/non-alcoholic fatty liver disease

Further detailed information in respect to commissioning for each of these areas is given in the linked tables:

Acknowledgments to authors:

We are very grateful to the many people who have input into this guidance including the writing committee and particularly to co-chairs Robert Logan and Tawfique Daneshmend and to Jon Rhodes, Nick Read, Phil Newsome, Mark Hudson, Chris Hawkey, Tom Smith, Richard Driscoll and Sarah Sleet. We are also grateful to the people who have commented on previous drafts.

Tables for the BSG Commissioning Guide

Section 1: diagnosis

i) Dyspepsia and Dysphagia

BACKGROUND

- Indigestion, heartburn, upper abdominal pain related to eating are experienced by one-third of the population at least once a year. The vast majority of the population self medicate with OTC remedies.
- Associated conditions include peptic ulcer disease (related to H.pylori and use of NSAIDs/aspirin) and GastroOesophageal Reflux Disease (GORD).
- Dyspepsia often triggers endoscopy but management yields are low and costly compared to testing for and treating *H. pylori* or empirical use of PPIs.
- Difficulty swallowing (dysphagia) and significant weight loss are alarm symptoms which merit prompt investigation, usually including upper GI endoscopy, along Two Week Wait Pathway.
- The incidence of oesophageal cancer (>6000 cases pa in UK) is one of the highest in the world and rising and exceeds gastric cancer where rates continue to fall due to decreasing rate of H.pylori infection and use of Hp eradication therapy.
- No robust evidence exists to support current strategies for managing patients with Barrett's oesophagus.

PATIENT VIEW

- Most patients see medical advice from their GP because of troublesome symptoms or anxiety about serious underlying disease, which can trigger health seeking behaviour (and make their symptoms worse).

CURRENT PRACTICE

- Management should be based upon the age of patient and presence/absence of alarm symptoms.
- Young patients <55 without alarm features should usually be managed in primary care using *H. Pylori* test and treat and empirical PPI strategies.
- Young patients with GORD symptoms may warrant laparoscopic surgery to avoid long term drug use.
- Patients with alarm symptoms (dysphagia, early satiety, weight loss, anaemia) need prompt investigation, as do those > 55 with genuinely new significant dyspepsia.

OPPORTUNITIES FOR INTEGRATED WORKING

- With the decline of *H. Pylori* and the effectiveness of empirical treatment the dividend from endoscopy for dyspepsia has become limited.
- Patients on NSAIDs or coxibs chronically require PPI prophylaxis: <http://www.nice.org.uk/CG017>
- Diagnosis of upper GI malignancy at a stage sufficiently early to cure is rewarding but uncommon and often a chance finding and is seldom achieved by systematic endoscopy of symptomatic patients.
- However, it will remain important for high risk groups to have rapid access through structured pathways even though the therapeutic gain is limited.

OPPORTUNITIES FOR SAVINGS

- Endoscopy has little value in the modern management of simple dyspepsia and reflux.
- Devising and enforcing precise local algorithms based on but with greater specificity than national ones represents a major opportunity for primary and secondary care to work together to free resources for other more valuable activity.
- Feedback on referral practice is commonly given in many primary care settings but joint primary/secondary care discussion may also help in rationalising activity.
- Wherever possible outpatient clinics should be based on the principle of one stop investigation and management.

QUALITY INDICATORS / OUTCOME MEASURES

- Referral rates of individual practitioners for uncomplicated dyspepsia compared to local norms, with feed back and self directed moderation of behaviour. Rate of specialist referral for uncomplicated dyspepsia (i.e. not adequately managed in primary care).
- Proportion of occasions where the management of patients undergoing endoscopy for dyspepsia is changed following the procedure.
- Conversion rates of TWW compared to rate of cancer diagnosis with previous inappropriately un-investigated symptoms.

SOCIAL POLICY & UNDERSTANDING

- Numerous different systems and pathways to access OGD and USS, with risk that limiting access will drive inappropriate referral along TWW pathways.
- N/A to majority of patients with dyspepsia. Natural history of gastric cancer predicts that patients may only be diagnosed after attending A Long term management of GORD and appropriate consideration for surgical management.

REFERENCES

- NICE guidelines on dyspepsia: <http://www.nice.org.uk/CG017>
- Map of Medicine for dyspepsia: <http://eng.mapofmedicine.com/evidence/map/dyspepsia1.html>
- Map of Medicine for dysphagia: <http://eng.mapofmedicine.com/evidence/map/dysphagia1.html>
- British Society of Gastroenterology: Guidelines for oesophageal manometry and pH monitoring (2006) – www.bsg.org.uk/pdf_word_docs/oesp_man.pdf
- British Society of Gastroenterology: Guidelines on the use of oesophageal dilatation in clinical practice (2004) – www.bsg.org.uk/pdf_word_docs/oes_dil.pdf



CLINICAL

Clinical Menu

In this section...

News

Guidelines

Guidance

Publications

Clinical Services

Articles

Survey Corner

BSG Ballots

Resources

Commissioning
Report >

Diagnosis

Acute management

Chronic
managementIndependent Practice
Committee

Commissioning report

This commissioning guide has been produced in partnership with professional and patient associations. There are 2 aspects to this guidance. The first is the main document (picture to the right) which is a 15 page overview of the key elements of a good quality gastroenterology and hepatology service. The second aspect are the more detailed tables on which this guidance is based. These can be accessed via the links below. The guidance is currently in draft form and we welcome your comments on the document which should be emailed to t.smith@bsg.org.uk. Please send comments before Friday the 20th of April 2012.

Diagnosis

- > Dyspepsia and Dysphagia
- > Chonic Abdominal discomfort, Diarrhoea and Constipation
- > Rectal bleeding
- > Anaemia
- > Jaundice and Abnormal Liver Function Tests
- > Faecal Incontinence

Acute management

- > GI Bleeding
- > Inflammatory Bowel Disease
- > Acute Jaundice
- > Nutritional problems

Chronic management

- > Alcohol Dependency
- > Chronic GI morbidity after cancer treatment
- > Coeliac Disease
- > Barrett's Oesophagus
- > NASH and non-alcoholic fatty liver disease
- > IBS/Functional symptoms
- > Inflammatory Bowel Disease
- > Management of patients with Chronic Liver Diseases
- > Viral Hepatitis
- > Chronic pancreatitis


 Download commissioning report


Get Adobe Reader

