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GASTROENTEROLOGISTS DRAW UP BLUEPRINT FOR THE FUTURE

'STRATEGY FOR THE CARE OF PATIENTS WITH GASTROINTESTINAL DISORDERS'

A blueprint to provide a strategy for the future care of patients with gastrointestinal disorders, the third most common cause of death in the UK after circulatory and respiratory causes, has been drawn up by the British Society of Gastroenterology.

'Care of Patients with Gastrointestinal Disorders in the United Kingdom: A Strategy for the Future' says that without a clear strategy, the development of gastroenterology services would continue to be fragmentary, reactive and driven by uncoordinated Government initiatives, potentially to the disadvantage of the service overall.

The report will be used to negotiate improvements throughout the service and redress the disadvantage resulting from not being chosen as a priority area by the Government and National Service Frameworks, which would have brought with them the funding to implement changes.

The report tells how the UK is lagging behind Europe in saving lives. The UK's five year survival rate for gastric cancer is 12% - much lower than in Europe. Survival rates for pancreatic cancer and colorectal cancer are also lower than in Europe.

Gastrointestinal cancers are the most common type of cancer. Deaths from diseases of the digestive system have increased by 25% in the last ten years. In the year 2000, there were 59,685 deaths due to GI disease in England and Wales, accounting for 11.2% of deaths from all causes.

It calls for increased use of specialist nurses and a multidisciplinary approach. There should be appropriate specialist nurses to expedite the patient's journey through the pathway agreed by the multidisciplinary team and cancer network. "Nurse specialists are popular both with patients and doctors and their primary task is to offer quality and depth of service," says the report. "To provide these services, a minimum of two specialist nurses would be required within a gastroenterolological team."

The report envisages that 24 hour a day consultant cover will remain a requirement for the foreseeable future. A model provision of 1 consultant Gastroenterologist per 40,000 population and compliance with directives restricting working hours, requires units be staffed by a minimum of 6 whole time equivalent consultants.

Integrated multidisciplinary teams should be in place to treat cancer patients, led by appropriate clinicians and supported by a cancer specific coordinator. Two or more

specialists are required in each cancer area, such as gastroenterology, surgery and radiology and a full range of diagnostic methods should be available.

Incidence of colorectal cancer is increasing and accounted for 14,000 deaths in 2000. Incidence of oesophageal cancer has increased by 50% in the last 20 years the mortality rate from liver cancer has increased by 50% in ten years.

The report warns of the rising toll of alcohol related damage. Management of in-patients with alcoholic liver disease and its complications is the largest single workload that GI physicians face. The report predicts that the burden from alcohol, particularly alcoholic liver disease, is going to increase markedly over the coming decade or more. “As a nation, we are drinking more than for 90 years and there is a lag between consumption and cirrhosis. Already we have seen a 350% increase in cirrhosis between 1970 and 1998, and this figure is 900% for those under 45 years of age,” the report says.

It points out that patients with alcoholic cirrhosis and its complications are heavy users of expensive hospital resources. Managing the health consequences of the rising tide of alcohol misuse in the UK will be one of the key challenges of the future, and much of it will fall to the gastroenterology and hepatology services in acute hospitals.

The report recommends the provision of regional centres for complex liver disease including liver transplantation, while the overall emphasis for benign disease is on providing care close to the patient’s home. “We believe there are real dangers of a shift towards centralisation in destabilising the balance of services at the primary/secondary interface and impoverishing it,” says the report. “This would undermine the ability to provide services locally and would have a serious secondary effect on training.”

Work on the report started in 2003. “In 2003, aware of the fact that there was no National Service Framework for Gastroenterology or Hepatology services and the consequent disadvantage this has created for the specialty, the British Society of Gastroenterology (BSG) saw the need to write its own ‘Service document’. The aim was to produce a document which could be used to negotiate the improvement in provision of services at Trust, Strategic Health Authority (SHA) and national levels and at primary care level in the community,” says the report.

Dr Michael Hellier, Chair of the Strategy Group, authors of the report, says it should be considered alongside an earlier document written by Professor John Williams’ Unit at the Centre of Health Improvement Research in Swansea, a major database of Burden of GI Disease and Existing Service provision. The new report is based on the Williams report and on consensus view and expert opinion drawn widely from stakeholders in delivery of gastroenterological services. There is to be a third document, which will be a policy document, drawn up by the Council of the British Society of Gastroenterology.

A survey of BSG members found that three diseases were considered most important: colorectal cancer, alcohol-related liver disease and inflammatory bowel disease (IBD), which covers Crohn’s disease and ulcerative colitis. The report says that

multidisciplinary care is essential and a gastroenterologist specialising in IBD is essential to the service. Dietetic support should be integral to the IBD service.

Screening for colon cancer in the age group 60-69 is planned to start in England in April 2006, with the programme eventually being delivered through 100 centres over the next three years as expertise is built up.

The total non-NHS cost to the British economy of illness and death from GI disease is £7.8 billion a year, while total hospital costs for GI disorders are £1.4 billion. Drugs for the 60 million prescriptions cost £802 million and cost of GP consultations is put at £136 million.

The report highlights the overwhelming finding that there is a lack of good research or evaluation relating to initiatives in service delivery. It strongly recommends that this is systematically introduced and developed to inform future decision making.

The reports says that training "all round" gastroenterologists is no longer a sustainable option in the long term. Proposed progression to sub-specialty training could include three or four of the following: luminal gastroenterology, hepatology, advanced therapeutic endoscopy or academic gastroenterology in addition to an initial basic training in general gastroenterology.

An acute shortage of GI radiologists is reported, resulting from the rapid increase in the development of interventional radiology. "This critical manpower issue needs addressing," says the report.

General recommendations include:

- Patients' ready access to optimal care should be the overriding principle
- Assisted self management to include patient education and support
- Multidisciplinary team approach. e.g. alcohol induced disease
- Close integration between primary and secondary care
- Specialist nurses play an important and integral role, particularly at the primary/secondary care interface and in education, telephone access, monitoring and patient support.
- Trusts and clinical teams should review GI services to see where they could be shared locally
- Centralisation of some services is essential, e.g. complex liver disease, liver transplantation, home parenteral nutrition and certain complex cancers.
- Crucial that skills and services are maintained at a local level
- Urgent need for better information technology support for clinical care

The report also makes recommendations on the handling of paediatric gastroenterology, diverticular disease, pancreatic disease, obesity, nutrition, endoscopy services, GI haemorrhage, benign upper gastrointestinal disease, academic gastroenterology and research, and models of care.

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