Care of patients with gastrointestinal disorders

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It is hard to plan a strategy for healthcare delivery against a background of the present turmoil in the reconfiguration of the NHS. This, however, has been the challenge faced by the British Society of Gastroenterology (BSG) over the last two years, culminating in the March 2006 launch of its strategy document, *Care of patients with gastrointestinal disorders in the United Kingdom: a strategy for the future.*[1]

The development of gastroenterological services has suffered from the lack of a national service framework. At the same time, the balance of service delivery has been distorted by various Government initiatives such as the guidelines for the management of upper gastrointestinal (GI) cancers and the two-week waiting time directive. Whilst admirable in their own right, these initiatives failed to take into account the impact they would have on the balance of overall GI service provision. It is apparent that the burden of gastrointestinal disease is not fully appreciated. GI disease is the third most common cause of death after circulatory and respiratory disease and, in the working population mortality is equal to that of respiratory disease. Gastrointestinal cancer is the most common type of cancer in Europe and the most prevalent cause of cancer death, constituting 27% of all cancer deaths. The estimated cost of early death due to GI disease is £3.23 billion. Total hospital cost due to GI disorders was £1.4 billion in 2001 and there were 60 million prescriptions for GI disorders in 2002, the net ingredient cost of these drugs being £802 million.

The BSG took the view that, regardless of the healthcare delivery structure, patient's easy access to optimal care should be the overriding principle governing their management. The needs of the patient should be the starting point from which the strategy for service delivery should develop and, where possible, care should be delivered close to the patient.

Although there are obvious areas of the specialty where there is need for centralisation of service, for example complex hepatobiliary disease, liver transplantation and home parenteral nutrition, a great deal relates to chronic disorders, for example inflammatory bowel disease (IBD), irritable bowel syndrome (IBS) and chronic liver disease. These lend themselves to an integrated delivery of care starting with assisted self-management of the patient in the community through support at primary care level to specialist supervision by the specialist unit in the secondary care setting. The smooth transition of care between these various levels must be safeguarded by carefully constructed and strictly applied care pathways, guidelines and clinical governance. Good communication is of the essence and specialist nurses are increasingly playing an essential role in assuring integration of care, particularly at the primary/secondary care interface, and in education, telephone access, monitoring and patient support.

Inflammatory bowel disease, the major part of a specialist gastroenterologist's workload, is a paradigm for chronic disease management and illustrates these points well. Multidisciplinary care is essential and should bring together gastroenterologists, colorectal surgeons, radiologists, histopathologists, specialist nurses, dietitians and pharmacists. Multidisciplinary gastroenterology team meetings (MDT) for benign disease should have similar priority to the cancer MDT meeting. A gastroenterologist specialising in IBD is central to the service. Self-management is appropriate for some patients but the needs of the IBD patient vary greatly. The IBD service should therefore provide support for the range of care options including assisted self-management (the word assisted is used advisedly), shared care with primary care and hospital care. With the increasing development of GPs with a special interest, more of the routine management of IBD patients can be carried out in the primary care setting. Patient support groups should also be involved in the planning of local IBD services. A similar model can be applied to patients with IBS. This is a condition which has been rather neglected and yet it affects 10–20% of the UK population and constitutes 20–50% of the outpatient gastroenterological workload.

For a strategy document of this sort to carry weight when used in negotiations with health service commissioners, it needs to be evidence based. With this in mind, the BSG appointed Professor John Williams at the Centre for Health Improvement Research and Evaluation (CHIRAL), University of Wales, Swansea, to research the data which would constitute the backbone of the document. The evidence-based review of the burden of disease and the organisation and delivery of services is available online.[2] An overwhelming finding of this review was the lack of good research or evaluation relating to initiatives in service delivery. A strong recommendation was that systematic development of research

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into service delivery must be introduced to inform future decision making. The lack of reliable data to support large areas of clinical practice meant that much of the strategy document recommendations relied on wide-ranging consultations with all those involved in the delivery of gastroenterological services together with expert opinion and consensus view.

While centralisation of certain specific services is essential, the BSG believes that total centralisation would destabilise and impoverish the balance of service at the primary/secondary care interface. This would not only undermine the ability to provide local services but would also have a serious secondary effect on training. It is therefore crucial to define the essential service at a local level for a population of 250,000 and to maintain the recommended services as already described. A functional GI unit is required in which expertise relevant to the broad spectrum of the specialty is represented: gastroenterologists, upper and lower GI surgeons, diagnostic and interventional radiologists, pathologists, nutritionists, dietitians, GI physiologists, psychologists and geneticists.

From a medical standpoint, it is envisaged that 24 hour a day consultant cover will remain a requirement for the foreseeable future. Based on the 2005 Royal College of Physicians recommendations a model provision of one consultant gastroenterologist per 40,000 population and complying with directives restricting working hours, a unit requires a minimum of six whole time equivalent consultants.[3] This would provide cross cover and allow for an experienced consultant to be available on-call for life-threatening emergencies, such as GI haemorrhage, and advise on other urgent situations.

The BSG strategy document lays down principles for the optimum care of patients. It does not attempt to make judgements on the various government proposals for outsourcing to the private sector. The essential features necessary for optimal care, eg a seamless service between primary and secondary care, quality, communication, integrated teamwork, standard/clinical governance and training, would be seriously threatened by a fragmented service delivery, however attractive that might seem from a market or economic perspective.

References

1 British Society of Gastroenterology. *Care of patients with gastrointestinal disorders in the United Kingdom: a strategy for the future*. London: BSG, 2006. www.bsg.org

2 The Centre for Health Improvement Research and Evaluation. *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*. Swansea: CHIRAL, 2006. www.medicine.swan.ac.uk/giservicesreview

3 Royal College of Physicians. *Consultant physicians working with patients: the duties, responsibilities and practice of physicians in general medicine and the specialties*, 3rd edn. London: RCP, 2005.