Royal College of Physicians | Inflammatory Bowel Disease Programme

# Organisational audit: round 4
# Adult services – audit tool *VERSION 2*

## Section 1: Demographics

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| DEM 1.1 | How many IBD patients does your service manage? | |
| DEM 1.2 | Is this figure: an estimate (enter 'e') or from a database/register (enter 'd')? | |
| DEM 1.3 | Of these IBD patients, how many have ulcerative colitis? | |
| DEM 1.4 | Of these IBD patients, how many have Crohn's disease? | |
| DEM 1.5 | Of these IBD patients, how many have IBD-unspecified? | |
| DEM 1.6 | How many new IBD patients have you seen in the last 12 months? | |
| DEM 1.7 | Is this figure: an estimate (enter 'e') or from a database/register (enter 'd')? | |
| DEM 1.8 | How many patients aged 17 and over at the date of admission, were discharged from the care of adult services between 1 January and 31 December 2013 with a primary diagnosis of ulcerative colitis? (with LOS >24hrs) | |
| DEM 1.9 | How many of these patients were readmitted within 30 days of discharge? (with LOS >24hrs) | |
| DEM 1.10 | How many patients aged 17 and over at the date of admission, were discharged from the care of adult services between 1 January and 31 December 2013 with a primary diagnosis of Crohn's disease? (with LOS >24hrs) | |
| DEM 1.11 | How many of these patients were readmitted within 30 days of discharge? (with LOS >24hrs) | |
| DEM 1.12 | Does your service look after patients aged <16 years old? | |
| DEM 1.13 | How many patients aged 16 and under at the date of admission, were discharged from the care of adult services between 1 January and 31 December 2013 with a primary diagnosis of ulcerative colitis? (with LOS >24hrs) | |
| DEM 1.14 | How many of these patients were readmitted within 30 days of discharge? (with LOS >24hrs) | |
| DEM 1.15 | How many patients aged 16 and under at the date of admission, were discharged from the care of adult services between 1 January and 31 December 2013 with a primary diagnosis of Crohn's disease? (with LOS >24hrs) | |
| DEM 1.16 | How many of these patients were readmitted within 30 days of discharge? (with LOS >24hrs) | |
| DEM 1.17 | How many patients aged 17 and over at the date of admission, discharged from the care of adult services between 1 January and 31 December 2013 had an operation where the primary indication was ulcerative colitis? (with LOS >24hrs) | |
| DEM 1.18 | How many patients aged 17 and over at the date of admission, discharged from the care of adult services between 1 January and 31 December 2013 had an operation where the primary indication was Crohn's disease? (with LOS >24hrs) | |
| DEM 1.19 | How many patients aged 16 and under at the date of admission, discharged from the care of adult services between 1 January and 31 December 2013 had an operation where the primary indication was ulcerative colitis? (with LOS >24hrs) | |
| DEM 1.20 | How many patients aged 16 and under at the date of admission, discharged from the care of adult services between 1 January and 31 December 2013 had an operation where the primary indication was Crohn's disease? (with LOS >24hrs) | |
| DEM 1.21 | Do surgeons perform ileo-anal pouch surgery on site? | |
| DEM 1.22 | How many ileo-anal pouch operations were performed between 1 January and 31 December 2013? | |
| DEM 1.23 | How many WTE gastroenterologists are there on site? | |
| DEM 1.24 | How many WTE colorectal surgeons are there on site? | |
| DEM 1.25 | How many WTE IBD nurse specialists are there on site? | |
| DEM 1.26 | How many WTE stoma nurses are there on site? | |
| DEM 1.27 | How many WTE dietitians are allocated to gastroenterology? | |
| DEM 1.28 | How many WTE administrators are attached to the IBD team? | |

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| DEM 1.29 | How many patients with Crohn's disease were newly-started on Infliximab between 1 January and 31 December 2013 (include patients of any age)? | |
| DEM 1.30 | How many patients with ulcerative colitis were newly-started on Infliximab between 1 January and 31 December 2013 (include patients of any age)? | |
| DEM 1.31 | How many patients with IBD-unspecified were newly-started on Infliximab between 1 January and 31 December 2013 (include patients of any age)? | |
| DEM 1.32 | How many patients with Crohn's disease were newly-started on Adalimumab between 1 January and 31 December 2013 (include patients of any age)? | |
| DEM 1.33 | How many patients with ulcerative colitis were newly-started on Adalimumab between 1 January and 31 December 2013 (include patients of any age)? | |
| DEM 1.34 | How many patients with IBD-unspecified were newly-started on Adalimumab between 1 January and 31 December 2013 (include patients of any age)? | |
| DEM 1.35 | Are the figures in DEM 29 and DEM 34 an estimate (enter 'e') or from a database/register (enter 'd')? | |
| DEM 1.36 | How many patients admitted primarily for treatment of their IBD between 1 January and 31 December 2013, died during that admission? | |

| **Section 2: Patient experience** | | | |
|---|---|---|---|
| **Information on the IBD service** | | **Yes** | **No** |
| PE1.1 | Patients are provided with written information on discharge or initial clinic visit, regarding how to access IBD services and arrangements for follow up | ◯ | ◯ |
| PE1.2 | All newly diagnosed patients are given educational material, either locally produced or from an established source eg CCUK | ◯ | ◯ |
| PE1.3 | All newly diagnosed patients are offered a 'patient education' session to enable them to understand their illness This can be either 1:1 or in clinic or as part of a group education programme | ◯ | ◯ |
| PE1.4 | Regular education opportunities are available for all IBD patients and their families, either as individuals or in groups | ◯ | ◯ |
| PE1.5 | There is clear guidance on how patients can seek a second opinion if they are unhappy with their care / need advice | ◯ | ◯ |
| **Rapid access to specialist advice** | | **Yes** | **No** |
| PE2.1 | There is written information for patients with IBD on whom to contact in the event of a relapse | ◯ | ◯ |
| PE2.2 | Patients have access to contact an IBD specialist via telephone | ◯ | ◯ |
| PE2.3 | Specialist review (face to face) for relapsed patients is available within 14 days | ◯ | ◯ |
| PE2.4 | Patients and carers are able to contact an IBD specialist via an email service | ◯ | ◯ |
| PE2.5 | Patients who contact the service via telephone or email are answered within 48 hours by an IBD specialist | ◯ | ◯ |
| PE2.6 | Specialist review (face to face) for relapsed patients is available within 7 days | ◯ | ◯ |
| PE2.7 | Specialist review (face to face) for relapsed patients is available within 5 working days | ◯ | ◯ |
| **Provision of information and supporting patients to exercise choice between treatments** | | **Yes** | **No** |
| PE3.1 | Written information about IBD and a range of treatments (eg Crohn's and Colitis UK booklets) is made available to all patients | ◯ | ◯ |
| PE3.2 | Written information about IBD and the range of treatments (eg Crohn's and Colitis UK booklets) is provided to patients as part of the consultation to support patient's decisions | ◯ | ◯ |

| | | Yes | No |
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| PE3.3 | There is access to a translator for all face to face and telephone contacts between patients and the IBD specialist | ◌ | ◌ |
| PE3.4 | Information is available that is appropriate to the age, understanding and communication needs of the patients attending the IBD service | ◌ | ◌ |
| PE3.5 | A selection of written information is available for patients in languages other than English, reflecting the major ethnic minority groups among patients | ◌ | ◌ |
| PE3.6 | Patients are actively involved in management decisions about care, with a clear structured pathway for the patient to discuss his or her treatment with the multidisciplinary team | ◌ | ◌ |
| **Involvement of patients in service improvement** | | **Yes** | **No** |
| PE4.1 | IBD patients are given the opportunity to provide feedback on their care | ◌ | ◌ |
| PE4.2 | At least one of the following means of assessing patient satisfaction is used: a) An annual survey of a significant number of patients b) IBD service subscribes to patient opinion or similar feedback service c) Comment cards given to randomly sampled outpatients and inpatients | ◌ | ◌ |
| PE4.3 | Patients are involved in service planning and improvement | ◌ | ◌ |
| PE4.4 | The service has an IBD patient panel or similar patient involvement group through which patients discuss with health professionals how the service might be improved | ◌ | ◌ |
| PE4.5 | There has been reporting, followed by action planning and change implemented that was carried out as a result of the patient feedback of their care within the last year | ◌ | ◌ |
| **Education of patients** | | **Yes** | **No** |
| PE5.1 | Newly-diagnosed patients are offered one-to-one education with an IBD nurse or dietitian | ◌ | ◌ |
| PE5.2 | Regular education opportunities (eg specialist nursing visits) are available for all IBD patients and their families as individuals or in groups, to enable them to understand their illness and the options for treatment and to support them in managing their own care | ◌ | ◌ |
| PE5.3 | The IBD service participates in an open forum meeting which meets at least annually | ◌ | ◌ |
| **Information and support for patient organisations** | | **Yes** | **No** |
| PE6.1 | Written information is made available to all new patients, providing details of relevant patient organisations | ◌ | ◌ |
| PE6.2 | All IBD patients are provided with information about their local patient support groups | ◌ | ◌ |
| PE6.3 | There is regular contact and support from the IBD team for educational activities for patients eg Crohn's and Colitis UK group meetings, Crohn's and Colitis UK or CICRA paediatric events, IA (The Ileostomy and Internal Pouch Support Group) meetings, local pouch support groups | ◌ | ◌ |

| **Section 3: Clinical quality** | | | |
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| **The IBD team** | | **Yes** | **No** |
| CQ1.1 | The IBD service has a named clinical lead for the IBD team | ◌ | ◌ |
| CQ1.2 | The IBD service is routinely supported by a histopathologist with an interest in gastroenterology | ◌ | ◌ |
| CQ1.3 | The IBD team is made up of at least a consultant gastroenterologist, an IBD nurse specialist, stoma nurse, dietitian, and a consultant colorectal surgeon. | ◌ | ◌ |
| CQ1.4 | There is a clear pathway for referring IBD patients to a rheumatologist | ◌ | ◌ |

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| CQ1.5 | The IBD service is routinely supported by a radiologist with a special interest in gastroenterology | ◌ | ◌ |
| CQ1.6 | The IBD service is routinely supported by a named pharmacist with a special interest in IBD or gastroenterology | ◌ | ◌ |
| CQ1.7 | There is defined access to a named ophthalmologist | ◌ | ◌ |
| CQ1.8 | The IBD service has 0.5WTE administrative support, per 250,000 population | ◌ | ◌ |
| CQ1.9 | There are 2 WTE consultant gastroenterologists, 2 WTE consultant colorectal surgeons, 1.5 WTE IBD nurse specialists, 1.5 WTE stoma nurse specialists and 0.5 WTE gastroenterology dietitians in the IBD service, per 250,000 population | ◌ | ◌ |
| **Inpatient monitoring** | | **Yes** | **No** |
| CQ2.1 | >50% of IBD patients have the following undertaken on admission to hospital: weight and nutritional risk assessment, such as the MUST score | ◌ | ◌ |
| CQ2.2 | >50% IBD patients with diarrhoea, have a stool sample sent for standard stool culture and clostridium difficile on admission | ◌ | ◌ |
| CQ2.3 | >50% IBD patients have regular stool chart documented during admission | ◌ | ◌ |
| CQ2.4 | >60% of IBD patients have the following undertaken on admission to hospital: weight and nutritional risk assessment, such as the MUST score | ◌ | ◌ |
| CQ2.5 | >60% IBD patients with diarrhoea, have a stool sample sent for standard stool culture and clostridium difficile on admission | ◌ | ◌ |
| CQ2.6 | >60% of IBD patients have regular stool chart documented during admission | ◌ | ◌ |
| CQ2.7 | >75%of IBD patients the following undertaken on admission to hospital: weight and nutritional risk assessment, such as the MUST score | ◌ | ◌ |
| CQ2.8 | >75% IBD patients with diarrhoea, have a stool sample sent for standard stool culture and clostridium difficile on admission | ◌ | ◌ |
| CQ2.9 | >75% of IBD patients have regular stool chart documented during admission | ◌ | ◌ |
| CQ2.10 | >90% of IBD patients have the following undertaken on admission to hospital: weight and nutritional risk assessment, such as the MUST score | ◌ | ◌ |
| CQ2.11 | >90% IBD patients with diarrhoea, have a stool sample sent for standard stool culture and clostridium difficile on admission | ◌ | ◌ |
| CQ2.12 | >90% of IBD patients have regular stool chart documented during admission | ◌ | ◌ |
| **Mental health services** | | **Yes** | **No** |
| CQ3.1 | IBD inpatients can receive specialist mental health assessment within the acute service, for an acute psychiatric emergency and will be seen within 48 hours. | ◌ | ◌ |
| CQ3.2 | Information is available for IBD patients about how they can access counselling support eg via local primary care funded service or patient group | ◌ | ◌ |
| CQ3.3 | IBD patients can be referred for specialist Clinical Psychological support on an ad hoc basis | ◌ | ◌ |
| CQ3.4 | Secure funding and a clear referral pathway is in place for IBD patients to be referred to clinical psychology or a counsellor with a specialist interest in IBD | ◌ | ◌ |
| **Sexual and reproductive health** | | **Yes** | **No** |
| CQ4.1 | Written information about IBD in pregnancy and its effects on fertility is available for patients | ◌ | ◌ |
| CQ4.2 | Patients and their partners are given advice, when required, on issues regarding sexuality and body image. Teams can refer for specialist support locally as appropriate | ◌ | ◌ |
| CQ4.3 | There is a medical disorders of pregnancy clinic (or named obstetrician with interest in management of medical disorders in pregnancy), to which all pregnant IBD patients on current medical treatment are referred | ◌ | ◌ |

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| CQ4.4 | There is an agreed clinical care pathway between the women's health and IBD services, for shared care of IBD patients | ◌ | ◌ |

| **Multidisciplinary working** | | **Yes** | **No** |
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| CQ5.1 | There is a multidisciplinary meeting in which complex IBD cases can be discussed | ◌ | ◌ |
| CQ5.2 | There are joint or parallel clinics for patients requiring joint medical and surgical care, which take place at least 4 times per year. | ◌ | ◌ |
| CQ5.3 | The multidisciplinary team meetings occur at least every 2 weeks, are minuted and have an attendance register. These are regularly attended by medical, surgical and nursing representatives | ◌ | ◌ |
| CQ5.4 | There are joint or parallel clinics for patients requiring joint medical and surgical care, which take place at least monthly | ◌ | ◌ |
| CQ5.5 | Decisions from the multidisciplinary team meeting are documented in the patient notes and fed back to the patient | ◌ | ◌ |
| CQ5.6 | There is an attendance at multidisciplinary team meetings by a gastroenterology dietitian | ◌ | ◌ |
| CQ5.7 | There is an attendance at multidisciplinary team meetings by a pharmacist | ◌ | ◌ |
| CQ5.8 | There is an attendance at multidisciplinary team meetings by an administrator | ◌ | ◌ |
| CQ5.9 | There are joint or parallel clinics for patients requiring joint medical and surgical care, which take place at least weekly | ◌ | ◌ |
| **Access to nutritional support and therapy** | | **Yes** | **No** |
| CQ6.1 | >30% of IBD patients who require dietetic review  are reviewed by a dietitian during an inpatient stay | ◌ | ◌ |
| CQ6.2 | IBD patients can be referred to a dietitian experienced in the dietary management of IBD, for specialist dietary advice and nutritional support | ◌ | ◌ |
| CQ6.3 | Enteral nutrition as a primary treatment is available to patients with Crohn's disease, both as inpatients and outpatients | ◌ | ◌ |
| CQ6.4 | Information given to all new IBD patients includes nutritional advice | ◌ | ◌ |
| CQ6.5 | There is a multidisciplinary nutrition team available to IBD inpatients | ◌ | ◌ |
| CQ6.6 | >40% of IBD patients who require dietetic review (Crohn's disease, acute severe colitis, newly-diagnosed) are reviewed by a dietitian during an inpatient stay | ◌ | ◌ |
| CQ6.7 | Home enteral and, where applicable, home parenteral nutrition provision and monitoring is always available to patients either locally or by a regional centre | ◌ | ◌ |
| CQ6.8 | All new IBD patients have malnutrition screening (weight and BMI recorded at minimum) on their first outpatient appointment | ◌ | ◌ |
| CQ6.9 | The multidisciplinary nutrition team includes a specialist dietitian, specialist nutrition support nurse, consultant gastroenterologist and or a consultant colorectal surgeon | ◌ | ◌ |
| CQ6.10 | 60% of IBD patients who require dietetic review (Crohn's disease, acute severe colitis, newly-diagnosed) are reviewed by a dietitian during an inpatient stay | ◌ | ◌ |
| CQ6.11 | >75% of IBD patients who require dietetic review (Crohn's disease, acute severe colitis, newly-diagnosed) are reviewed by a dietitian during an inpatient stay | ◌ | ◌ |
| **Arrangements for use of immunosuppressives** | | **Yes** | **No** |
| CQ7.1 | Prior to starting biological therapies screening for tuberculosis and consideration of a vaccination programme are carried out. The patient is assessed for the risk of infections such as HIV, hepatitis B, varicella-zoster and herpes simplex | ◌ | ◌ |
| CQ7.2 | All patients and parents are counselled about the risk of malignancy and sepsis prior to starting immunosuppressive therapy and this is documented in the notes | ◌ | ◌ |

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| CQ7.3 | There are written local protocols for the administration of biological therapies | ◌ | ◌ |
| CQ7.4 | Patients on immunosuppressive treatment have their white blood count measured at least 3 monthly. | ◌ | ◌ |
| CQ7.5 | Clinicians involved in the management of patients on immunosuppressants have access to a pharmacist with specialist knowledge / interest | ◌ | ◌ |
| CQ7.6 | Local protocols for the administration of biological therapies include pre-treatment, actions for infusion reactions and accelerated infusions | ◌ | ◌ |
| CQ7.7 | There is a clear guidance written guidance on action if white cell counts are low and a named individual who acts on abnormal results and communicates with GP's and patients if appropriate | ◌ | ◌ |
| CQ7.8 | Patients on immunosuppressive therapy have the choice of whether their treatment is monitored by the hospital or in the community by a GP | ◌ | ◌ |
| CQ7.9 | The decision to start anti-TNF therapy is usually made after discussion in a multidisciplinary team meeting | ◌ | ◌ |
| CQ7.10 | Patients receiving biological therapy are reviewed at least 3 monthly (either directly or by email/telephone) to monitor efficacy and adverse effects | ◌ | ◌ |
| CQ7.11 | There is a local patient information sheet that includes advice on the action required if adverse events occur, that is given to all patients on immunosuppressive and biological treatments | ◌ | ◌ |
| CQ7.12 | Clear shared care arrangements for the monitoring and prescribing of immunosuppressive drugs are in place between primary and secondary care, including advice on the frequency of monitoring and what to do in the event of abnormal results | ◌ | ◌ |
| CQ7.13 | Patients have a choice of appointment times for anti-TNF infusions (ie morning, afternoon, or evening) | ◌ | ◌ |
| CQ7.14 | IBD patients on both immunomodulator and biological therapy are subject to regular audit for outcome monitoring | ◌ | ◌ |
| **Surgery for IBD** | | **Yes** | **No** |
| CQ8.1 | Consent is fully informed and supported by written information on related risks and benefits | ◌<br>◌ NA | ◌ |
| CQ8.2 | Consent is routinely taken by the surgeon who will be carrying out the operation or who has carried out the procedure before. Patients have access to independent advocates if required | ◌<br>◌ NA | ◌ |
| CQ8.3 | Patients undergoing ileal pouch surgery are entered onto the Association of Coloproctology of Great Britain and Ireland (ACPGBI) Ileal Pouch Registry | ◌<br>◌ NA | ◌ |
| CQ8.4 | There is a formal regular governance process to review surgical morbidity and mortality within the trust/health board/network, including review or audit of postoperative complications | ◌<br>◌ NA | ◌ |
| CQ8.5 | There are facilities and trained surgeons to offer laparoscopic / laparoscopically-assisted surgery where possible and if appropriate | ◌<br>◌ NA | ◌ |
| CQ8.6 | Complex surgical procedures are usually undertaken following joint discussion between medical/surgical and other MDT members, in a formal IBD MDT meeting | ◌<br>◌ NA | ◌ |
| CQ8.7 | Patients being considered for pouch surgery are referred for expert pathological assessment where diagnostic uncertainty exists | ◌<br>◌ NA | ◌ |

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| CQ8.8 | One consultant surgeon with dedicated IBD experience is the nominated lead for IBD surgery within the trust/health board. They support decision-making and / or surgery for complex IBD cases | ◯ ◯ ◯ NA | |
| CQ8.9 | Pouch failure (and salvage) is managed in, or routinely referred to an agreed regional specialist unit, with appropriate expertise in re-operative pouch surgery | ◯ ◯ ◯ NA | |
| CQ8.10 | There is annual review of IBD surgical service with review of activity, mortality and morbidity. There is also an action plan which is regularly reviewed (at least yearly) for implementation | ◯ ◯ ◯ NA | |
| **Inpatient facilities** | | **Yes** | **No** |
| CQ9.1 | There is an identifiable gastroenterology ward | ◯ | ◯ |
| CQ9.2 | There is an intensive therapy unit (ITU) and a mixed medical/surgical high dependency unit (HDU). | ◯ | ◯ |
| CQ9.3 | There is at least one toilet per 6 patients | ◯ | ◯ |
| CQ9.4 | Gastroenterology and colorectal surgical facilities are on the same site | ◯ | ◯ |
| CQ9.5 | IBD or suspected IBD patients are usually triaged to the gastroenterology ward on admission | ◯ | ◯ |
| CQ9.6 | There is at least one toilet per 4 patients | ◯ | ◯ |
| CQ9.7 | The toilets have floor to ceiling partitions, full height doors and good ventilation | ◯ | ◯ |
| CQ9.8 | There is one toilet per 3 IBD patients | ◯ | ◯ |
| **Access to diagnostic services** | | **Yes** | **No** |
| CQ10.1 | There is gastrointestinal pathologist assessment available before surgery, which may involve referral of cases to a nationally recognised expert in the diagnosis and differential diagnosis, of chronic inflammatory bowel disease. | ◯ | ◯ |
| CQ10.2 | There is access to ultrasound/CT/contrast studies for inpatients within 24 hours | ◯ | ◯ |
| CQ10.3 | It is routine practice for patients with ulcerative colitis to have a plain abdominal x-ray on admission | ◯ | ◯ |
| CQ10.4 | There is a process for urgent access to endoscopy, so that patients admitted with relapse can be scoped within 72 hours of admission | ◯ | ◯ |
| CQ10.5 | All histological reports are available within 5 working days | ◯ | ◯ |
| CQ10.6 | Urgent histology biopsies can be reported within 2 days | ◯ | ◯ |
| CQ10.7 | When required drainage of an abscess can be carried out by interventional radiology | ◯ | ◯ |
| CQ10.8 | There is outpatient access to ultrasound/CT/contrast studies and endoscopic assessment within 4 weeks | ◯ | ◯ |
| CQ10.9 | Small bowel MRI is available as an alternative to repeated CT scans or barium enema | ◯ | ◯ |
| CQ10.10 | There is a consultant radiologist who primarily reports all gastrointestinal radiology in the hospital | ◯ | ◯ |
| CQ10.11 | Histology reporting times and outpatient waiting times for IBD patients for CT/MR and endoscopy have been recently audited | ◯ | ◯ |
| **Inpatient care** | | **Yes** | **No** |
| CQ11.1 | >30%of IBD patients are seen within 24 hours of admission by an IBD specialist | ◯ | ◯ |
| CQ11.2 | >50% compliance with risk assessment and prescribing of thromboprophylaxis | ◯ | ◯ |

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| CQ11.3 | There is an acute pain management team available on site | ◌ | ◌ |
| CQ11.4 | >50% of patients who are receiving steroids on discharge from hospital, are placed on a steroid reduction programme and covered with bone protection agents | ◌ | ◌ |
| CQ11.5 | >90% of IBD inpatients have their medication history reconciled by a pharmacist shortly after their admission | ◌ | ◌ |
| CQ11.6 | Inpatients have access to an IBD nurse during their admission | ◌ | ◌ |
| CQ11.7 | There are Trust/Health Board guidelines for the management of acute severe colitis | ◌ | ◌ |
| CQ11.8 | >50%of IBD patients are seen within 24 hours of admission by an IBD specialist | ◌ | ◌ |
| CQ11.9 | >65% compliance with risk assessment, prescribing of thromboprophylaxis | ◌ | ◌ |
| CQ11.10 | Pain scores are routinely included in nursing observations for IBD patients | ◌ | ◌ |
| CQ11.11 | >65% of patients who are receiving steroids on discharge from hospital, are placed on a steroid reduction programme and covered with bone protection agents | ◌ | ◌ |
| CQ11.12 | >50% of IBD inpatients are seen by an IBD nurse during their admission | ◌ | ◌ |
| CQ11.13 | >75% of IBD patients are seen within 24 hours of admission by an IBD specialist | ◌ | ◌ |
| CQ11.14 | > 75% of IBD patients are placed in a gastroenterology ward or on a named surgical ward within 24 hours of admission | ◌ | ◌ |
| CQ11.15 | >75% compliance with risk assessment and prescribing of thromboprophylaxis | ◌ | ◌ |
| CQ11.16 | It is usual practice to refer an inpatient with severe pain (measured by pain scores) to the acute pain management team | ◌ | ◌ |
| CQ11.17 | 75% of patients who are receiving steroids on discharge from hospital, are placed on a steroid reduction programme and covered with bone protection agents | ◌ | ◌ |
| CQ11.18 | All patients due to have, or who do have a stoma can be seen by a stoma nurse during their admission if required | ◌ | ◌ |
| CQ11.19 | >90% of IBD patients are seen within 24 hours of admission by an IBD specialist. | ◌ | ◌ |
| CQ11.20 | >75% of IBD inpatients are seen by an IBD nurse during their admission | ◌ | ◌ |
| CQ11.21 | A named pharmacist with special interest in IBD is available to carry out inpatient drug reviews of IBD patients | ◌ | ◌ |
| CQ11.22 | >90% compliance with risk assessment and prescribing of thromboprophylaxis | ◌ | ◌ |
| CQ11.23 | >90% of patients who are receiving steroids on discharge from hospital, are placed on a steroid reduction programme and covered with bone protection agents | ◌ | ◌ |

| **Section 4: Organisation and choice of care** | | | |
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| **Referral of suspected IBD patients** | | **Yes** | **No** |
| OC1.1 | Newly-referred IBD patients can go to either gastroenterology or surgical clinics | ◌ | ◌ |
| OC1.2 | There an agreed referral pathway for urgent OPD referrals between GP's and secondary care | ◌ | ◌ |
| OC1.3 | All urgent referrals are seen within 4 weeks or more rapidly if clinically necessary | ◌ | ◌ |
| OC1.4 | Guidance has been developed to guide GP's in the referral and identification of symptomatic patients in whom IBD is suspected and when a review of diagnosis of patients with unresponsive, atypical or troublesome abdominal symptoms should occur | ◌ | ◌ |

| Supporting patients to exercise choice between care strategies for outpatient management | | Yes | No |
|---|---|---|---|
| OC2.1 | All patients under secondary care are reviewed annually | ◌ | ◌ |
| OC2.2 | Stable patients who are referred back to primary care are given a clear plan about what to do in the event of flare up | ◌ | ◌ |
| OC2.3 | When a patient is discharged back to primary care, the GP is routinely given clear instruction about the need and criteria for annual review , including assessment of the need for colorectal cancer surveillance, renal function and bone densitometry | ◌ | ◌ |
| OC2.4 | Patients are offered a choice of annual review including hospital clinic, telephone clinic or review in primary care | ◌ | ◌ |
| **Outpatient care** | | **Yes** | **No** |
| OC3.1 | All of the following are usually documented for all patients at clinic review: number of liquid stools per day, abdominal pain, weight loss. | ◌ | ◌ |
| OC3.2 | Systems are in place to ensure that all patients currently under hospital review are identified and are offered surveillance colonoscopy, as required (in accordance with BSG guidelines) | ◌ | ◌ |
| OC3.3 | Steroid usage is recorded to ensure that patients who have had 3 months or continuous steroid use are identified | ◌ | ◌ |
| OC3.4 | The following are documented in outpatient review : number of liquid stools per day, abdominal pain or mass, general well-being, psychological concerns, weight loss, smoking status | ◌ | ◌ |
| OC3.5 | Bone densitometry is routinely offered to all patients who have received more than 3 months of corticosteroids | ◌ | ◌ |
| OC3.6 | Annual data is collected and presented on: the percentage of patients who remain on steroids continuously for 3 months, the percentage of these patients discussed at MDT and the percentage started on additional therapy (eg immunosuppressives, anti TNF or surgery) | ◌ | ◌ |
| **Care of patients aged 16 years and younger within adult services** | | **Yes** | **No** |
| OC4.1 | There is a defined access to a consultant paediatric gastroenterologist or a consultant paediatrican with an interest in gastroenterology, working with an adult consultant gastroenterologist with an interest in adolescents | ◌<br>◌ NA | ◌ |
| OC4.2 | Inpatients are looked after in an age-appropriate environment | ◌<br>◌ NA | ◌ |
| OC4.3 | Patients have access to IBD nurse specialist with suitable paediatric experience | ◌<br>◌ NA | ◌ |
| OC4.4 | The team providing care for patients 16 years or younger, work within a paediatric clinical network | ◌<br>◌ NA | ◌ |
| OC4.5 | Paediatric patients undergo endoscopy in an age-appropriate environment, carried out by someone with training or extensive experience in paediatric endoscopy | ◌<br>◌ NA | ◌ |
| OC4.6 | The team providing care for patients 16 years or younger have access to a surgeon and anaesthetist with appropriate paediatric training | ◌<br>◌ NA | ◌ |
| OC4.7 | There is defined access to a dietitian with suitable paediatric experience, including use of exclusive enteral feeding | ◌<br>◌ NA | ◌ |

| | | | |
|---|---|---|---|
| OC4.8 | There is defined access to a radiologist with suitable paediatric experience | ◌ ◌ NA | ◌ |
| **Transitional care** | | **Yes** | **No** |
| OC5.1 | There is a transitional care service within the Trust / Health Board for young people to support their transfer to adult services by 18-19 years | ◌ | ◌ |
| OC5.2 | A named coordinator is responsible for the preparation and oversight of transitional care, from child to adult services (eg IBD nurse specialist) | ◌ | ◌ |
| OC5.3 | The IBD service has a joint transition clinic with paediatric services | ◌ | ◌ |
| OC5.4 | Direct referral (not via GP) is available for a specialist endocrinology review regarding concerns about growth and/or pubertal status | ◌ | ◌ |
| OC5.5 | The IBD service has a specific paediatric to adult transition policy | ◌ | ◌ |
| OC5.6 | Staff can refer to psychological services (eg CAMHS) for any psychological problems | ◌ | ◌ |
| OC5.7 | There is a close working relationship with psychological services in clinics and on the ward | ◌ | ◌ |
| OC5.8 | Each young person with IBD has an individual transition plan | ◌ | ◌ |
| OC5.9 | Age-appropriate written and verbal advice is provided on day to day management of symptoms and treatment | ◌ | ◌ |
| OC5.10 | Support and education is provided on sexual health in young people with IBD | ◌ | ◌ |

## Section 5: Research, education and audit

| **Register of patients under the care of the IBD service** | | **Yes** | **No** |
|---|---|---|---|
| RE1.1 | The IBD service has a searchable database or registry of adult IBD patients | ◌ | ◌ |
| RE1.2 | The database is updated with clinical data about IBD patients receiving hospital care | ◌ | ◌ |
| RE1.3 | The database is updated with patients on biological therapy | ◌ | ◌ |
| RE1.4 | The database is updated with patients on all immunosuppressants (including biological therapies) | ◌ | ◌ |
| RE1.5 | The database is updated with clinical data about all patients with a diagnosis of IBD | ◌ | ◌ |

| **Participation in audit** | | **Yes** | **No** |
|---|---|---|---|
| RE2.1 | Service participates in the national IBD audit | ◌ | ◌ |
| RE2.2 | Service participates in the national IBD audit and results are fed back to the service. An action plan is completed | ◌ | ◌ |
| RE2.3 | Patient surveys are carried out annually | ◌ | ◌ |
| RE2.4 | All IBD inpatient deaths are reviewed by the IBD team, an action plan is formulated and action plan implementation is reviewed at least annually | ◌ | ◌ |
| RE2.5 | The service participates in the national IBD audit, completes an action plan and ensures monitoring of actions or changes | ◌ | ◌ |
| RE2.6 | There are mortality and morbidity meetings that are attended by a multidisciplinary team, to discuss any deaths and outcomes of surgery. These are minuted and have attendance registers | ◌ | ◌ |
| RE2.7 | A regular patient survey is carried out, an action plan is produced and any required changes to the service are completed | ◌ | ◌ |

| Training and education | | Yes | No |
|---|---|---|---|
| RE3.1 | There are education opportunities for all medical and nursing staff | ◯ | ◯ |
| RE3.2 | The IBD team provides IBD training for primary care on an ad hoc basis | ◯ | ◯ |
| RE3.3 | Advanced nursing practitioners within the IBD team have a regular, multidisciplinary training schedule. Attendance is audited and protected time for training is provided | ◯<br>◯ NA | ◯ |
| RE3.4 | Primary care practitioners wishing to provide IBD services are named members of the IBD team | ◯ | ◯ |
| **Research** | | **Yes** | **No** |
| RE4.1 | The IBD service is part of a clinical trials network (UKCRN) | ◯ | ◯ |
| RE4.2 | The IBD service has enrolled patients in an IBD trial in the last two years | ◯ | ◯ |
| RE4.3 | All members of service are encouraged to participate in research, which is supported by the service with monetary support and/or flexible working | ◯ | ◯ |
| **Service development** | | **Yes** | **No** |
| RE5.1 | An annual review of the IBD service is carried out | ◯ | ◯ |
| RE5.2 | The IBD team has been involved in one or more clinical network arrangements or events with neighbouring IBD services, in the last year (eg IBD audit meetings) | ◯ | ◯ |
| RE5.3 | The annual review is attended by a multidisciplinary team of relevant professionals and there is a reflection on the service | ◯<br>◯ NA | ◯ |
| RE5.4 | An annual action plan is completed as a result of the review and achievement of the actions is reviewed | ◯<br>◯ NA | ◯ |