



# **UK IBD Audit 2<sup>nd</sup> Round (2008) Report**

## **Executive Summary of the National Results for the Organisation & Process of Adult IBD Care in the UK**

### **Generic Hospital Report**

**Prepared by the  
The UK IBD Audit Steering Group  
on behalf of**

- **Association of Coloproctology of Great Britain and Ireland**
- **British Society of Gastroenterology**
- **British Society of Paediatric Gastroenterology, Hepatology and Nutrition**
- **Clinical Effectiveness & Evaluation Unit, Royal College of Physicians of London**
- **National Association of Colitis and Crohn's Disease**

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The web based data collection tool was developed by Netsolving Ltd.

Thanks are due to the many people who have participated in the UK IBD Audit 2<sup>nd</sup> Round. The UK IBD Audit Steering Group recognise that this has involved many individuals spending time over and above an already heavy workload with no financial recompense.

Thanks are also due to

- The Health Foundation who funded the UK IBD Audit 1<sup>st</sup> and 2<sup>nd</sup> rounds
- The Association of Coloproctology of Great Britain and Ireland
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- British Society of Paediatric Gastroenterology, Hepatology and Nutrition
- The National Association for Colitis and Crohn's Disease (NACC)
- All hospital staff who contributed towards organising the collection, retrieval and inputting of data including Clinical Audit, IT and coding staff in addition to the members of the multidisciplinary clinical teams working in support of IBD patients.

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**\*Note on the term “site” used throughout this report**

Lead clinicians (in almost every instance a Consultant Gastroenterologist) that were initially contacted within each Trust/Health Board with a view to taking part in the UK IBD Audit 2<sup>nd</sup> round, were asked to register to participate and collect data on the basis of a unified IBD Service which would be registered as a named “site”. This was typically a single hospital within the Trust/Health Board. Where a Trust/Health Board had more than one hospital offering independent IBD Services they entered data for separate “sites”. Some institutions running a coordinated IBD Service across two or more hospitals with the same staff completed the audit as one Trust-wide site.

## UK IBD Audit 2<sup>nd</sup> Round (2008)

### Background

The Inflammatory Bowel Diseases, Ulcerative Colitis (UC) and Crohn's Disease (CD), are common causes of gastrointestinal morbidity. The total cost of IBD to the NHS has been estimated at £720 million, based on an average cost of £3,000 per patient per year with up to half of total costs for relapsing patients<sup>1</sup>.

The [UK Inflammatory Bowel Disease Audit 1st Round](#) was the first UK-wide audit performed within gastroenterology. It demonstrated a marked variation in the resources and quality of care for IBD patients across the UK with particular deficits in some fundamental aspects of IBD care. The 1st Round of the audit was widely supported by clinicians with 75% of applicable UK hospitals participating. Following dissemination of results, change implementation was supported by a series of regional meetings, a web based document repository and selected hospital visits.

The second round of the audit in autumn 2008 assessed changes to the organisation and processes of IBD care following these interventions.

Although IBD was not part of the National Service Framework program, results from the first round of the audit were a catalyst for the development of the National Service Standards for the healthcare of people who have Inflammatory Bowel Disease (IBD) that were published in February 2009 (<http://www.ibdstandards.org.uk>). These Standards were developed by a collaboration of six health professional societies and NACC, the IBD patients' organisation and it is recommended that IBD Services should meet these standards by September 2010.

The aim of the IBD National Service Standards is to ensure that IBD patients receive consistent, high-quality care and that IBD Services throughout the UK are knowledge-based, engaged in local and national networking, based on modern IT and that meet specific minimum standards. The UK IBD Audit Steering Group strongly endorses the new standards and whilst the UK IBD Audit 2<sup>nd</sup> round did not directly measure against these new standards we anticipate that further rounds of the IBD Audit will do so.

### Overall Summary

The results of the UK IBD Audit 2<sup>nd</sup> round (2008) demonstrate service improvements in many aspects of IBD care over a 2 year period. Some improvement has been seen in the provision of dedicated gastroenterology wards and there has been an increase in both the number of IBD Clinical Nurse Specialists and the time that they dedicate to IBD care. There has also been a considerable increase in the appropriate use of prophylactic heparin. Improvements have been seen in the collection of stool cultures and samples for Clostridium Difficile toxin but these are not yet at acceptable levels.

Meetings between physicians and surgeons are happening less and this may be a reflection of the time pressures imposed by other multi-disciplinary team meetings (MDTs), notably for cancer. Provision of dietetic services, toilet facilities and psychological support remain at unacceptably low levels and remain key priorities for improvement. There continues to be considerable variation across the United Kingdom.

This audit has demonstrated significant service change over a relatively short time period, although there is clearly still much to do. The implementation of the IBD National Service Standards is now needed and will, together with further rounds of audit, deliver improvements in the quality of care for IBD patients. The key action points are as follows:

- Health departments in England, Northern Ireland, Scotland and Wales must support future rounds of the UK IBD Audit in order that quality improvement in IBD care is sustained.
- All NHS Trusts/Health Boards should review their local audit results in relation to the new IBD National Service Standards and take any necessary action to improve their IBD Services.

## Key Findings and Recommendations for action

The UK IBD Audit was established and 2<sup>nd</sup> round datasets agreed, before the IBD National Service Standards were published. Therefore, we did not specifically audit against them for the 2<sup>nd</sup> round. In order to reflect support for this landmark document the UK IBD Audit Steering Group decided to group the Key Findings and Recommendations from the 2<sup>nd</sup> round results against the 6 core areas (A to F) of the new standards. Results quoted below in the key findings are from the national statistics stated in sections 4 -7 of the full report of the results of the UK IBD Audit 2<sup>nd</sup> round available via the Clinical Effectiveness & Evaluation Unit section of the Royal College of Physicians of London website: <http://www.rcplondon.ac.uk>. They compare data from the 2008 audit round with results from the 2006 audit.

### Standard A – High Quality Clinical Care

High quality, safe and integrated clinical care for IBD patients, based on multi-disciplinary team working and effective collaboration across NHS organisational structures and boundaries.

#### Key findings:

##### Organisation of IBD Services

- There are more IBD Clinical Nurse Specialists (a rise from 56% to 62% of sites) and more of the sessions that they work (median from 6 to 8) are dedicated to IBD. Over one third of sites (38%) still do not have an IBD Clinical Nurse Specialist.
- Designated specialist ward areas are more common: Now available in 75% of sites, becoming more common since 2006 (when it was 67%).
- Meetings between physicians and surgeons have become less common (taking place in 66% of sites, down from 74% in 2006).
- Psychological support for patients with IBD is available in only a small minority (<10%) of sites
- Toilet facilities have not improved and are below the required standard of a minimum of 1 easily accessible toilet per 3 beds.

##### Quality of Care

- The prescription of prophylactic heparin has improved considerably (Ulcerative Colitis 54% to 73%; Crohn's Disease 55% to 71%).
- Stool cultures are now collected in 64% of patients admitted with IBD with diarrhoea, an improvement from 55% in 2006. The minority (about 2%) are positive.
- The collection of stool specimens for C. Diff toxin has also improved by about 10% but is still only done in just over half of patients (55%). These are positive in about 3%.
- More patients (57% vs. 52%) with Crohn's Disease are being weighed on admission but the provision of dietetic services remains poor: only 33% of Crohn's patients were visited by a dietitian in 2008 (37% in 2006) with a median of 2 (IQR 1-6) dietetic sessions per week dedicated to gastroenterology, the same as in 2006.
- More surgery is being undertaken laparoscopically (Ulcerative Colitis 20% vs. 10%; Crohn's Disease 13% vs. 8%).
- 77% of IBD Services still perform pouch operations. The median number per year is 3.
- Fewer Crohn's Disease patients (38% vs. 46%) have received steroids continuously for greater than 3 months but there has been no significant increase in the use of bone protection agents (49% vs. 45%).

#### Key recommendations:

- *There should be a renewed focus on multidisciplinary working with units moving towards the development of the IBD team as outlined in the IBD National Service Standards.*
- *Improvement in provision of specialist nurses to levels recommended in the IBD National Service Standards.*
- *Dietetic service provision remains poor and efforts to develop this should be continued.*
- *Psychological support is notably lacking and should be improved.*
- *Trusts/Health Boards should provide appropriate levels of toilet facilities.*
- *Efforts should be made to continue to improve stool culture and CDT collection rates.*

**Standard B – Local delivery of care**

Care for IBD patients that is delivered as locally as possible, but with rapid access to more specialised services when needed.

**Key findings:**

- Monitoring of immunosuppressive therapy is usually done well (at least 3 monthly for 86%) and often takes place in primary care.

**Key recommendations:**

- *A system for sharing of information about test results or treatment changes should be in place through the use of IT, written communication or a patient held record.*
- *IBD Services must continue to develop shared care between hospitals and primary care.*

**Standard C – Maintaining a patient-centred service**

Care for IBD patients that is patient-centred, responsive to individual needs and offers choice of clinical care and management where possible and appropriate.

**Key findings:**

- 67% of sites would see relapsing patients within 5 working days. This has risen from 63% in the first round of the audit.
- Written information on who to contact in event of relapse is available in 68% of units. This figure was 64% in 2006.
- Patient panel or other patient meetings remain uncommon (28%).
- Direct telephone contact with an IBD Specialist (IBD Clinical Nurse/Stoma Care Nurse) is available in 85% of sites with many offering contact via email (41% - up from 28% in 2006) or drop in clinics (13%).

**Key recommendations:**

- *IBD Services should aim to see all relapsing patients within 5 working days.*
- *Patient involvement in service development should increase.*

**Standard D – Patient education and support**

Care for IBD patients that assists patients and their families in understanding Inflammatory Bowel Disease and how it is managed and that supports them in achieving the best quality of life possible within the constraints of the illness.

**Key findings:**

- Written information about IBD is available in almost all (97%) of UK hospitals. The most common literature is that developed by NACC.

**Key recommendations:**

- *Units should consistently provide written information, education and support.*

**Standard E – Information technology and audit**

An IBD Service that uses IT effectively to support patient care and to optimise clinical management through data collection and audit.

**Key findings:**

- A searchable IBD database is available in 39% of sites compared with 34% in round 1.
- Participation rates in the UK IBD Audit have improved since 2006 (87% vs. 75%).

**Key recommendations:**

- *Every IBD Service should develop a searchable IBD database.*
- *Participation in national audit is a requirement for all IBD Services.*

**Standard F – Evidence-based practice and research**

A service that is knowledge-based and actively supports service improvement and clinical research

**Key findings:**

- There is virtually no participation in clinical research. Only 2 patients from the entire audit were entered into clinical trials.

**Key recommendations:**

- *Participation in clinical research must increase substantially. The development of the UK comprehensive research network may help wider participation in clinical trials.*

1. Luces C, Bodger K. Economic burden of inflammatory bowel disease: a UK perspective. Expert Review of Pharmacoeconomics & Outcomes Research 2006; 6(4):471-482.

## **The Burden of Inflammatory Bowel Disease**

Although ignored by the National Service Framework program, the Inflammatory Bowel Diseases, Ulcerative Colitis (UC) and Crohn's Disease (CD), are common causes of gastrointestinal morbidity in the western world. The incidence of IBD has risen dramatically in recent decades with a combined incidence now of over 400/100 000. It is estimated that up to 0.5% of European and North American populations are affected.

IBD most commonly first presents in the second and third decade but much of the recent increase has been observed in childhood, with CD in children increasing 3 fold in 30 years. IBD is not curable, UC and CD are lifelong conditions following an unpredictable relapsing and remitting course. 25% of UC patients will require colectomy and approximately 80% of CD patients require surgery over their lifetime. The main symptoms are diarrhoea, abdominal pain and an overwhelming sense of fatigue but associated features such as arthritis, anal disease, fistulae, abscess and skin problems can also contribute to a poor quality of life. While overall mortality is low (<2% of inpatients) morbidity is considerable; there are wide ranging effects on growth and development, psychological health, work prospects, family life and pregnancy and conception. Effective multidisciplinary care can attenuate relapse, prolong remission, treat complications and improve quality of life.

## **UK IBD Audit Aims**

The UK IBD Audit seeks to improve the quality and safety of care for IBD patients in hospitals throughout the UK by auditing individual patient care and the provision and organisation of IBD service resources.

As with the 1<sup>st</sup> Round this 2<sup>nd</sup> Round Report enables each participating site to compare or benchmark their performance against national statistics. Between the two rounds the UK IBD Audit Steering Group looked to facilitate, develop and instigate intervention strategies to improve the provision and quality of IBD patient care. This comprised the widespread dissemination of results to participating sites through the registered site clinical leads (normally a Consultant Gastroenterologist) as well as hospital board management. The 1<sup>st</sup> Round National Report was available publicly via the UK IBD Audit web page within the Clinical Effectiveness and Evaluation Unit section of the Royal College of Physicians website. The UK IBD Audit hosted 8 very well-attended regional meetings throughout the UK between June and October 2007 to discuss the audit results. Data from the 1<sup>st</sup> round was also presented at key professional and patient national meetings including those of the: British Society of Gastroenterology, Association of Coloproctology of Great Britain & Ireland, British Dietetic Association, Royal College of Nursing (IBD Nurse Forum), National Association for Colitis and Crohn's Disease.

A number of participating sites collaborated with members of the UK IBD Audit Steering Group to develop a model "Action Plan" for IBD Services that addressed the key messages from the 1<sup>st</sup> round report. The model action plan was accessible via the internet and contained freely adaptable reference documents such as care pathways, model business cases for IBD Nurse posts and patient information leaflets that could be downloaded and edited to meet local requirements. We also piloted site visits to 23 of the hospitals that participated in the 1<sup>st</sup> round of the IBD Audit during which a clinical member of the IBD Audit Steering Group worked alongside the health professional team responsible for IBD care to develop an action plan for their IBD Service that would address areas identified in their 1<sup>st</sup> round site specific report as requiring improvement.

## **Audit Governance**

The audit is a collaborative partnership between Gastroenterologists (the British Society of Gastroenterology), Colorectal Surgeons (the Association of Coloproctology of Great Britain and Ireland), Patients (the National Association for Colitis and Crohn's Disease) and Physicians (the Royal College of Physicians of London).

Following the 1<sup>st</sup> round, members of the UK IBD Audit met with representatives of the British Society of Paediatric Gastroenterology, Hepatology and Nutrition and agreed to include Paediatric Gastroenterology (<16 years of age at the date of admission to hospital) in the 2<sup>nd</sup> round so that the UK IBD Audit could become a truly comprehensive audit to encompass IBD patients of all ages. As a consequence a separate report for the Organisation & Process of Paediatric IBD Care in the UK will be published by the UK IBD Audit Steering Group in April 2009.

The audit is funded by a grant from the Health Foundation as part of their [\*Engaging with Quality Initiative\*](#) which aims to improve the quality of clinical care by engaging clinicians in quality improvement. The audit is a four-year, UK-wide, full cycle comparative audit with initial audit, dissemination, change implementation and re-audit.

The audit is co-ordinated by the Clinical Effectiveness and Evaluation unit (CEEu) of the Royal College of Physicians of London. Each hospital identified an overall clinical lead who was responsible for data collection and entry for their IBD Service. Data were collected by hospitals using a standardised method. The audit was guided by a multidisciplinary UK IBD Audit Steering Group (Appendix 1) which oversaw the preparation, conduct, analysis and reporting of the audit.

## **Who participated in the 2<sup>nd</sup> Round?**

Hospitals were eligible if they routinely admit IBD patients acutely. 270 hospitals that admit patients with Inflammatory Bowel Disease (IBD) in England, Northern Ireland, Scotland and Wales (plus the Isle of Man and the Channel Islands) were invited to take part. 209 sites submitted data (England 165, Northern Ireland 10, Scotland 18, Wales 15, Channel Islands 1). Of these 209 sites, 184 were single hospital sites within a Trust, 24 were Trust-wide sites combining 2 hospitals and 1 was a Trust-wide site combining 3 hospitals with a total of 235 (87%) hospitals contributing data.

We achieved 93% (161/174) participation at a Trust/Health Board level. This response was achieved through the hard work and time-commitment of clinical teams involved in the management of patients with IBD.

The audit of the organisation of IBD services was intended to be 'as of 1st September 2008' (together with activity data for all admissions for IBD (including multiple admissions for IBD for the same patient) from 1<sup>st</sup> June 2007 through to 31<sup>st</sup> August 2008) and 207 sites submitted data.

For individual patient care, 40 consecutive inpatient case notes were audited (20 Crohn's Disease and 20 Ulcerative Colitis) admitted from 31st August 2008 working backwards as far as 1<sup>st</sup> September 2007. For both Ulcerative Colitis (UC) and Crohn's Disease (CD), inpatient details were audited and for CD the last outpatient visit prior to admission was audited (so long as that visit did not directly prompt an acute admission to hospital and that it was not the only outpatient visit during the specified 12 month period).

In total, data were collected for 2981 Ulcerative Colitis patients (from 197 sites), median (IQR) of 17 (11-20) per site, and for 3154 Crohn's Disease patients (from 200 sites), median (IQR) of 18 (12-20) per site.

## Presentation of Results

Sections 4 to 7 of the full UK IBD Audit 2<sup>nd</sup> Round Report present the complete results of the audit, showing UK data for the 2<sup>nd</sup> round of 2008 alongside UK data from the 1<sup>st</sup> round of 2006. There is a largely overlapping but slightly different mix of hospitals that participated in each round. The results from each round represent the best cross-sectional estimates available regarding the organisation and process of IBD care at these times.

The following pages 11 to 34 show Key Indicator data to emphasise Key Findings and Recommendations.

Key Indicator results are given for the Organisation & Structure of IBD Services, Ulcerative Colitis inpatient care, Crohn's Disease inpatient and Crohn's Disease outpatient care. A small number of indicators are given for all IBD patients (Ulcerative Colitis and Crohn's Disease patients combined).

Key indicator results:

- Indicate site variation in the 2008 UK audit data, including the use of histogram graphics and site medians and Inter-Quartile range (IQR) statistics. Alongside each summary we give the results from YOUR SITE.
- Compare key indicator data for 2008 for England, Northern Ireland, Scotland and Wales
- Compare key indicator data from the 1<sup>st</sup> (2006) and 2<sup>nd</sup> (2008) Audit rounds for those sites that participated in both rounds. This gives a better feel for the potential impact of the audit process than the overall results presented in sections 4-7.

The full report is also supported by the UK IBD Audit Steering Group.

## Key indicator results with YOUR SITE data

207 sites contributed organisational data to the audit.

### Your site

197 sites submitted 2981 Ulcerative Colitis cases to the audit, median 17

**Your site submitted - cases.**

200 sites submitted 3154 Crohn’s Disease cases to the audit, median 18

**Your site submitted - cases.**

## Organisational / Structure

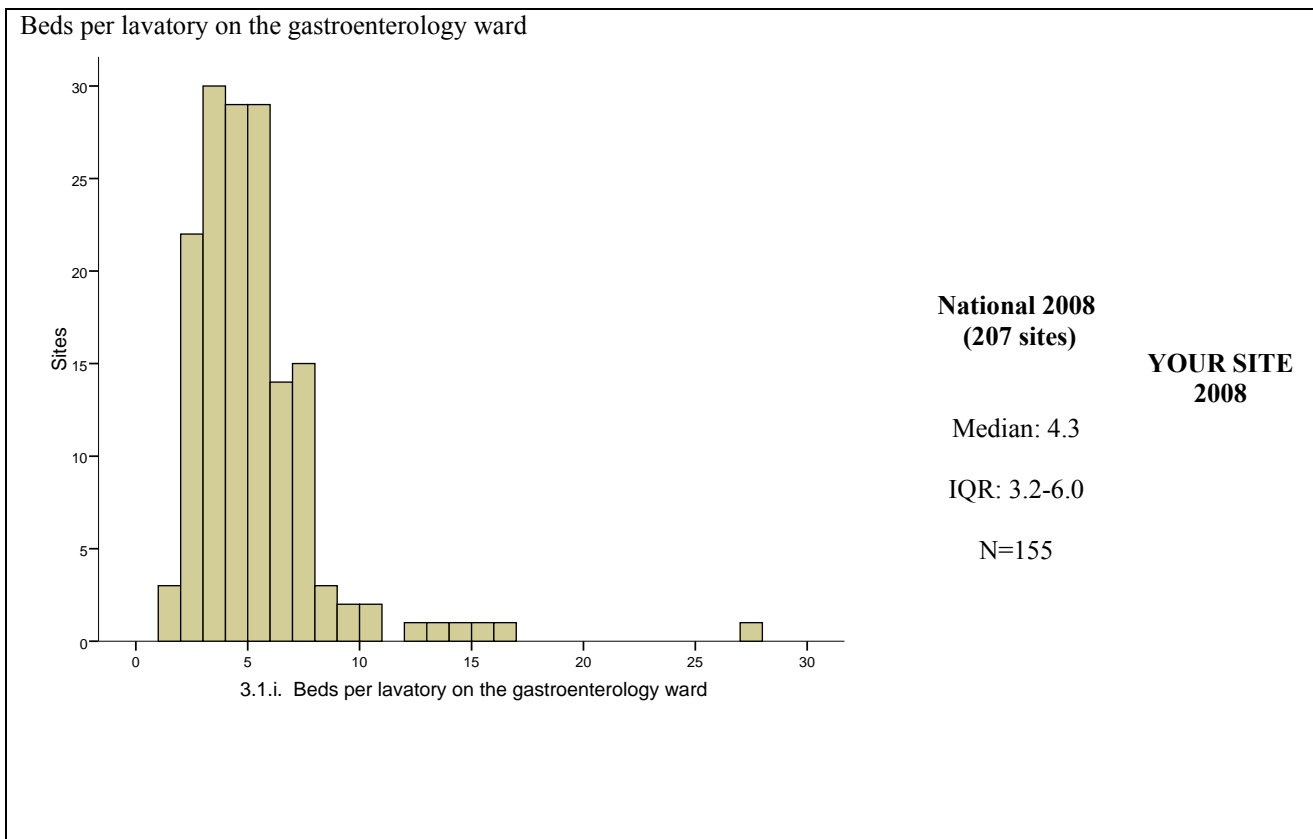
### 1. Timetabled meetings between Gastroenterologists and Colorectal Surgeons

	National 2008 (207 sites)	YOUR SITE 2008
5.2 Timetabled meetings (where IBD patients are discussed ) take place between Gastroenterologists and Colorectal Surgeons	66% (135/206)	

### 2. Gastro wards: dedicated gastroenterology ward (medical or surgical)

	National 2008 (207 sites)	YOUR SITE 2008
3.1 Is there a dedicated Gastroenterology ward?	75% (155)	

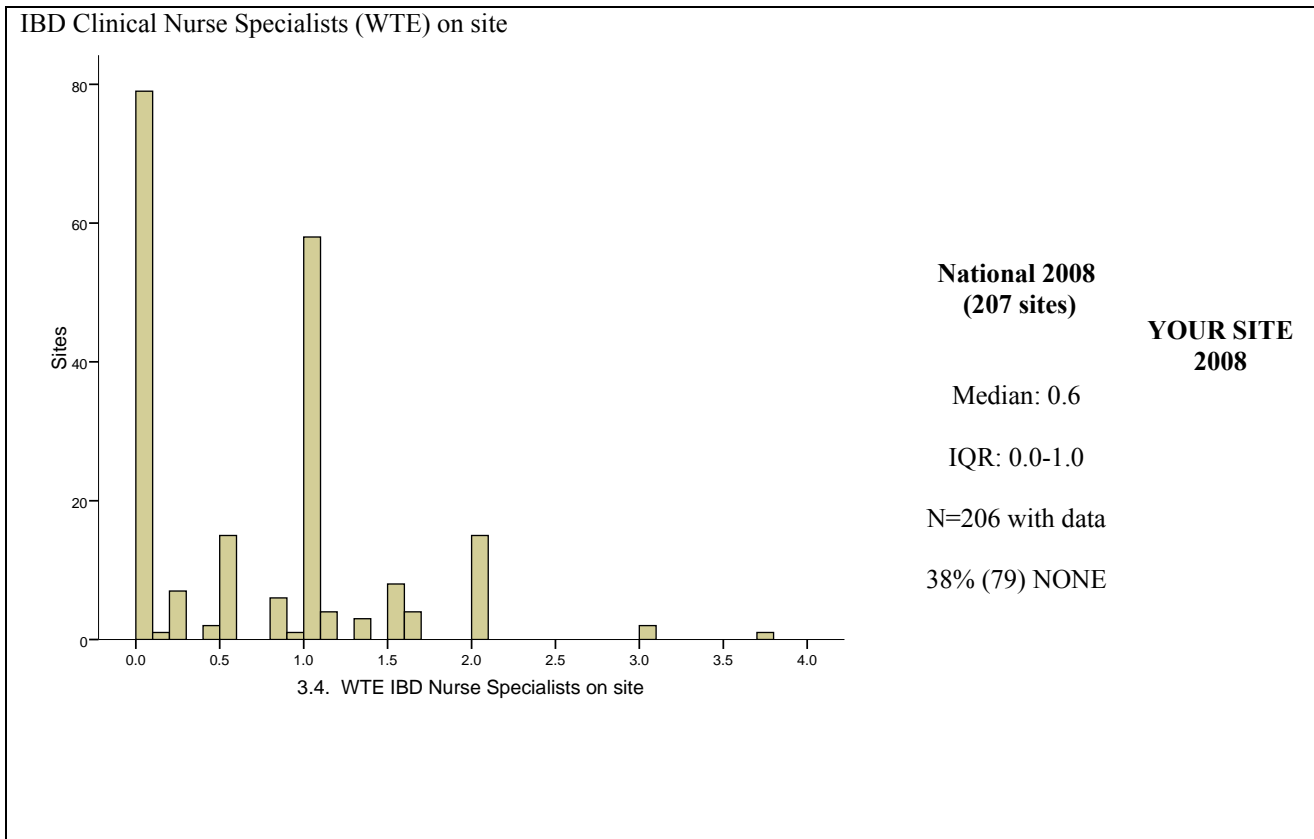
### 3. Toilets on dedicated gastroenterology ward

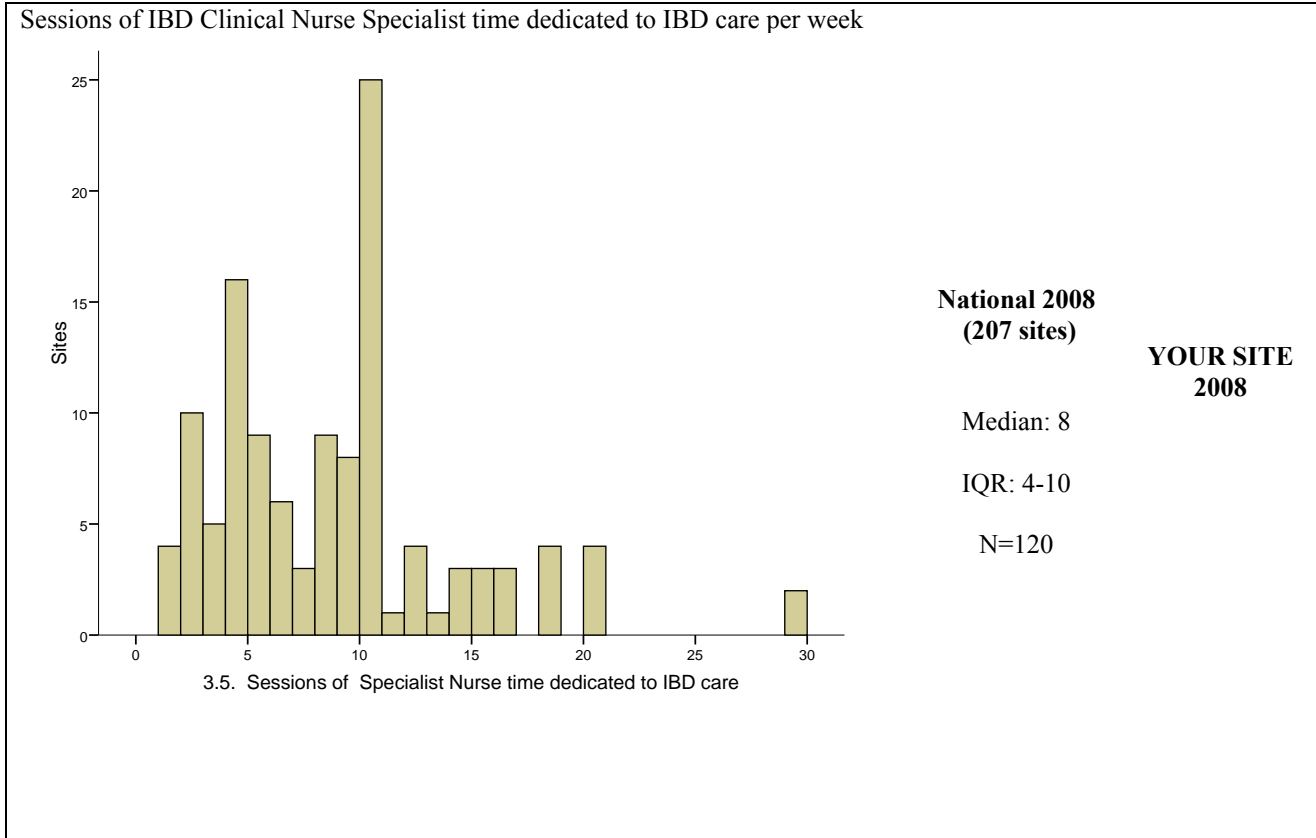


4. Yearly activity (Period 1/9/07 to 31/8/08)

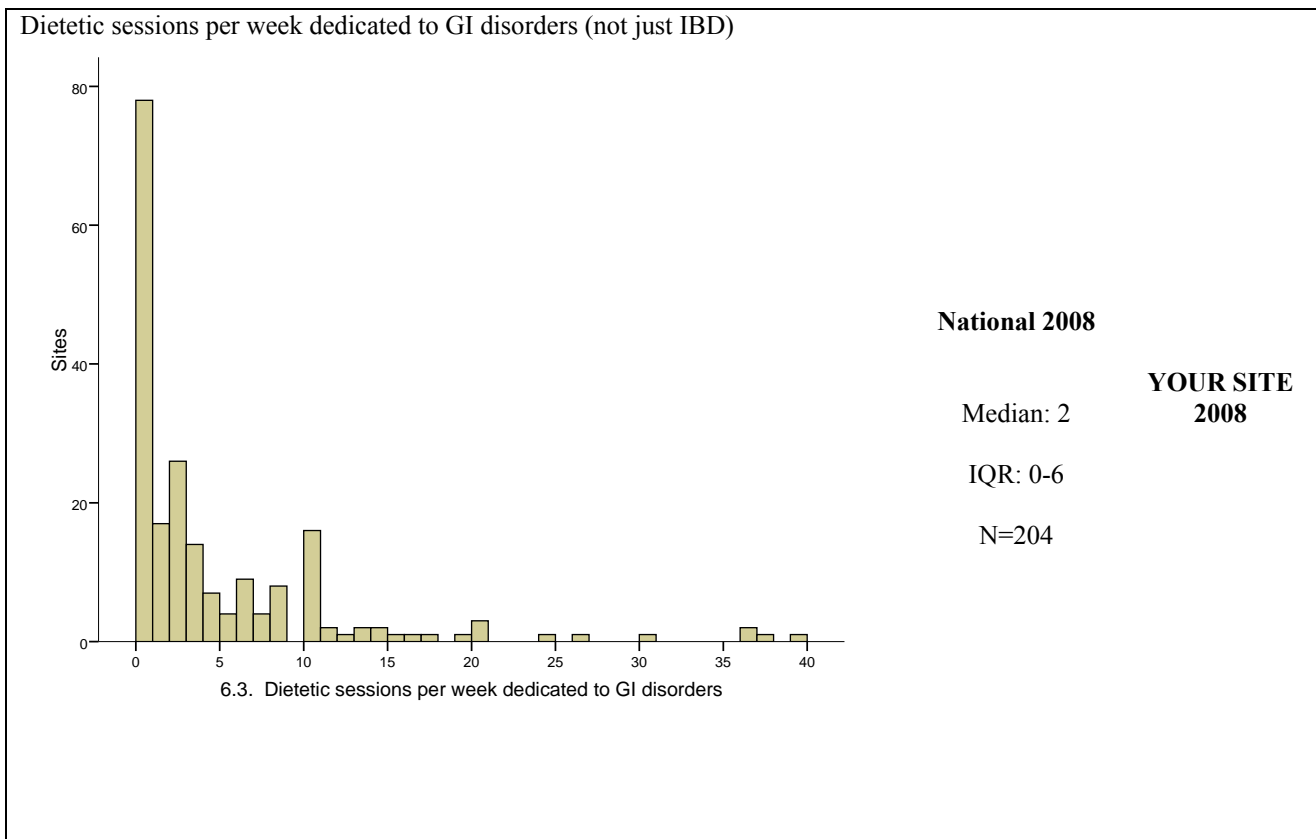
	National 2008 (207 sites)			YOUR SITE 2008
	Median	IQR	N	
Patients discharged with primary diagnosis of <b>Ulcerative Colitis</b>	47	24-90	199	
Patients discharged with primary diagnosis of <b>Crohn's Disease</b>	57	31-111	199	
Patients discharged having operation, primary indication <b>Ulcerative Colitis</b>	10	4-19	194	
Patients discharged having operation, primary indication <b>Crohn's Disease</b>	14	7-29	194	

5. IBD Clinical Nurse Specialists



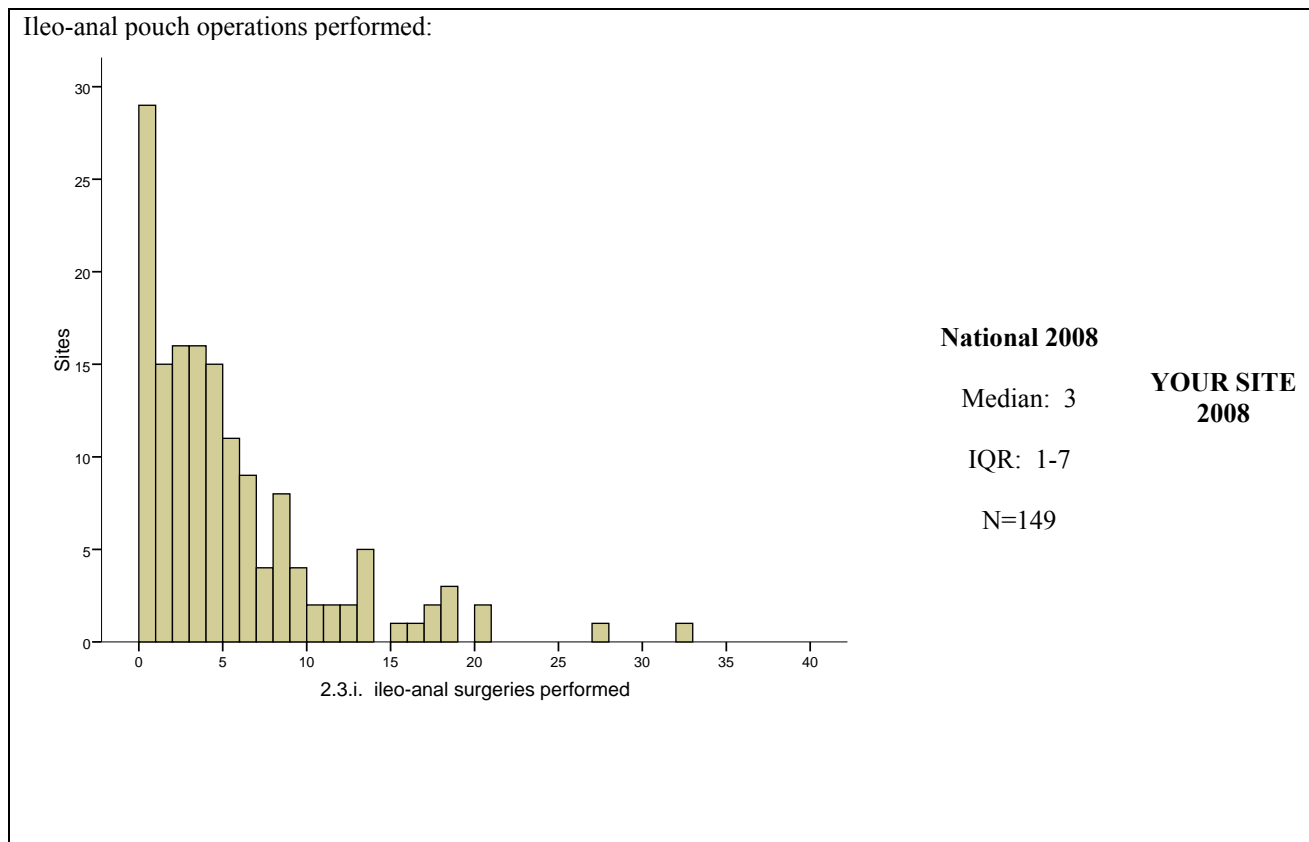


## 6. Dietetics



7. Pouch surgery on-site

	National 2008 (207 sites)	YOUR SITE 2008
Surgeons perform ileo-anal pouch surgery on site	77% (157/205)	



8. Searchable database of IBD patients on site

	National 2008 (207 sites)	YOUR SITE
5.1 Searchable database of IBD patients on site	39% (79/205)	

9. Patient meetings

	National 2008 (207 sites)	YOUR SITE
12.1 Hospital offers open forums or meetings for patients with IBD	28% (58/205)	
i. If yes, how often do these take place?		
a) Less than 4 monthly	17% (10)	
b) Every 4-8 months	43% (25)	
c) Every 8-12 months	33% (19)	

10. Psychological support

	National 2008 (207 sites)	YOUR SITE
10.3 Psychologists are attached to the Gastroenterology service	6% (12/205)	
10.4 Pathways exist for direct access to psychological support	21% (44/205)	

## 11. Joint or parallel clinics run on site

	<b>National 2008 (207 sites)</b>	<b>YOUR SITE</b>
7.4 Joint and/or parallel clinics run between Gastroenterologists and Surgeons	49% (101/206)	

## 12. Paediatric to adult handover clinic for young patients with IBD

	<b>National 2008 (207 sites)</b>	<b>YOUR SITE</b>
10.1 Paediatric to adult handover clinic for young patients with IBD	26% (54/205)	

## 13. Stoma Care Nurses

	<b>National 2008 Site variation</b>				<b>YOUR SITE 2008</b>
	Median	IQR	N	Sites with NONE	
4.3 Stoma Nurses on site	2	1-3	205	4% (8)	

## 14. Written guidelines for acute or severe UC

	<b>National 2008 (207 sites)</b>	<b>YOUR SITE</b>
11.1 Written Trust guidelines exist for the management of acute or severe Colitis	69% (141/205)	

## 15. Access to care

	<b>National 2008 (207 sites)</b>	<b>Your site</b>
7.1 There is written information for patients with IBD on whom to contact in the event of a relapse	68% (141/206)	
7.2 In general, how soon could a relapsed patient expect to be seen in clinic?		
a) Less than 7 days	67% (137/206)	
b) Between 7-14 days	30% (61/206)	
c) Other (please specify)*	4% (8/206)	
7.3 Do patients have access to an IBD specialist by any of the following methods (tick all that apply)		
a) Telephone	85% (175)	
b) Drop-in clinic	13% (26)	
c) Email	41% (84)	
d) None of these	13% (27)	

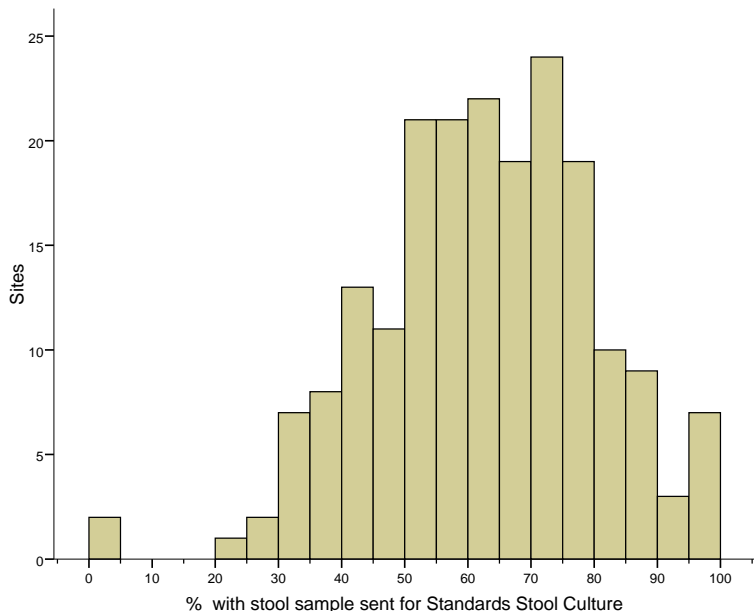
\* 2008 Other comprised 14-28 days (2), 21 days, 7-28 days, 14-28 days, as required, variable, 1 slot per week in IBD nurse clinic

## Results combined for Ulcerative Colitis & Crohn’s Disease patients

### 1. Stool samples

Site variation results are given for Ulcerative Colitis (non-elective) patients and Crohn’s Disease (non-elective, with diagnosis of diarrhoea) patients combined.

Site variation in % of stool sample sent for standards stool culture :



**National 2008  
Site variation**  
**Median: 62%**  
**IQR: 50-74%**  
**N=199**

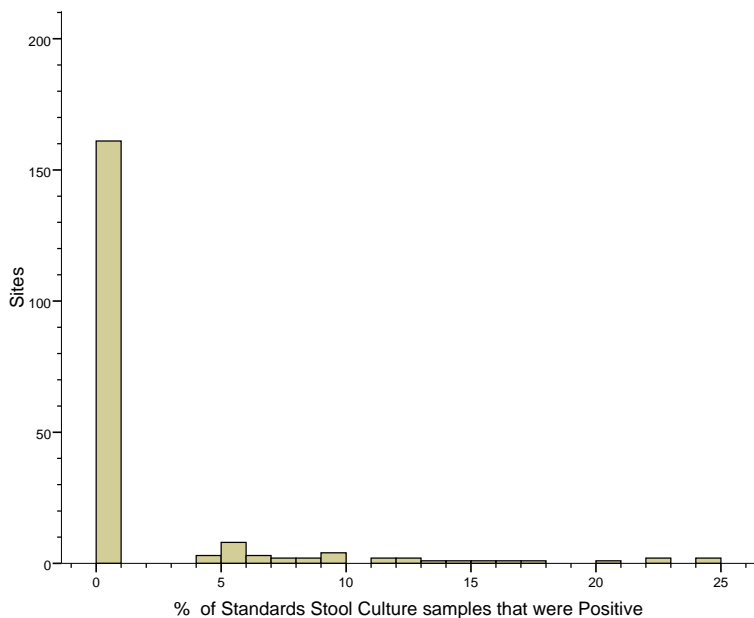
**YOUR SITE  
2008**

Overall  
non-elective  
patient results:

Ulcerative Colitis:  
67% (1628/2444)

Crohn’s Disease:  
53% (661/1237 with  
diarrhoea)

Site variation in % of standards stool culture samples that were positive :



**National 2008  
Site variation**  
**82% (161/197) of  
sites had no positive  
samples in the audit**

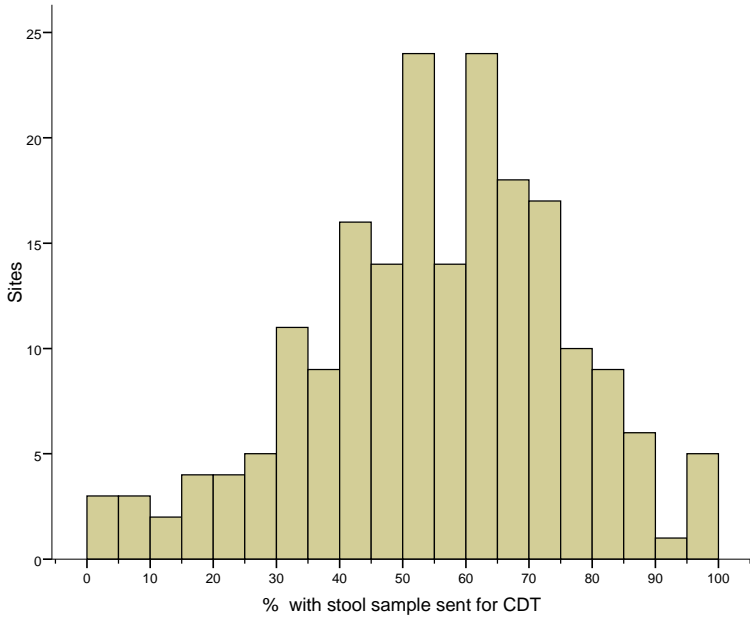
**YOUR SITE  
2008**

Overall  
non-elective  
patient results:

Ulcerative Colitis:  
2.1% (34/1627)  
were positive

Crohn’s Disease:  
1.7% (11/659)  
Were positive

Site variation in % of stool sample sent for CDT :



**National 2008  
Site variation**

**Median: 57%  
IQR: 42-69%  
N=199**

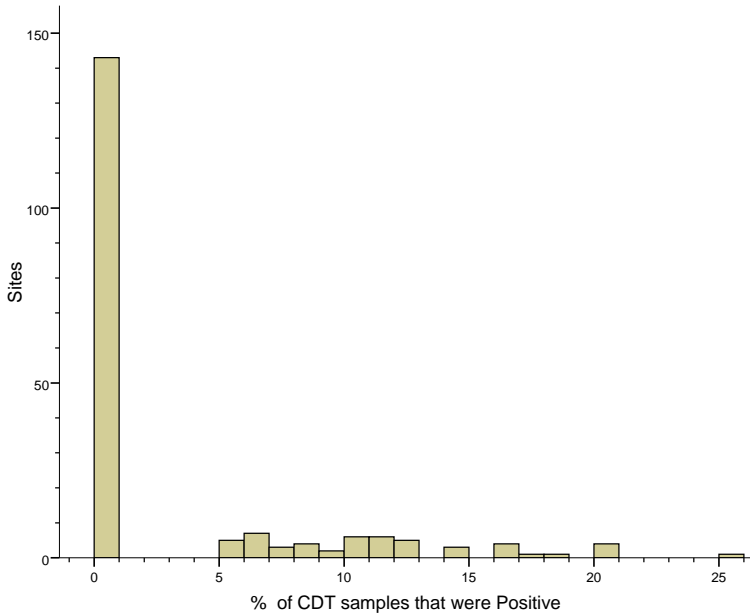
**YOUR SITE  
2008**

Overall  
non-elective  
patient results:

Ulcerative Colitis:  
59% (1439/2444)

Crohn's Disease:  
47% (580/1237 with  
diarrhoea)

Site variation in % of CDT samples that were positive :



**National 2008  
Site variation**

**73% (143/196) of  
sites had no positive  
CDT samples in the  
audit**

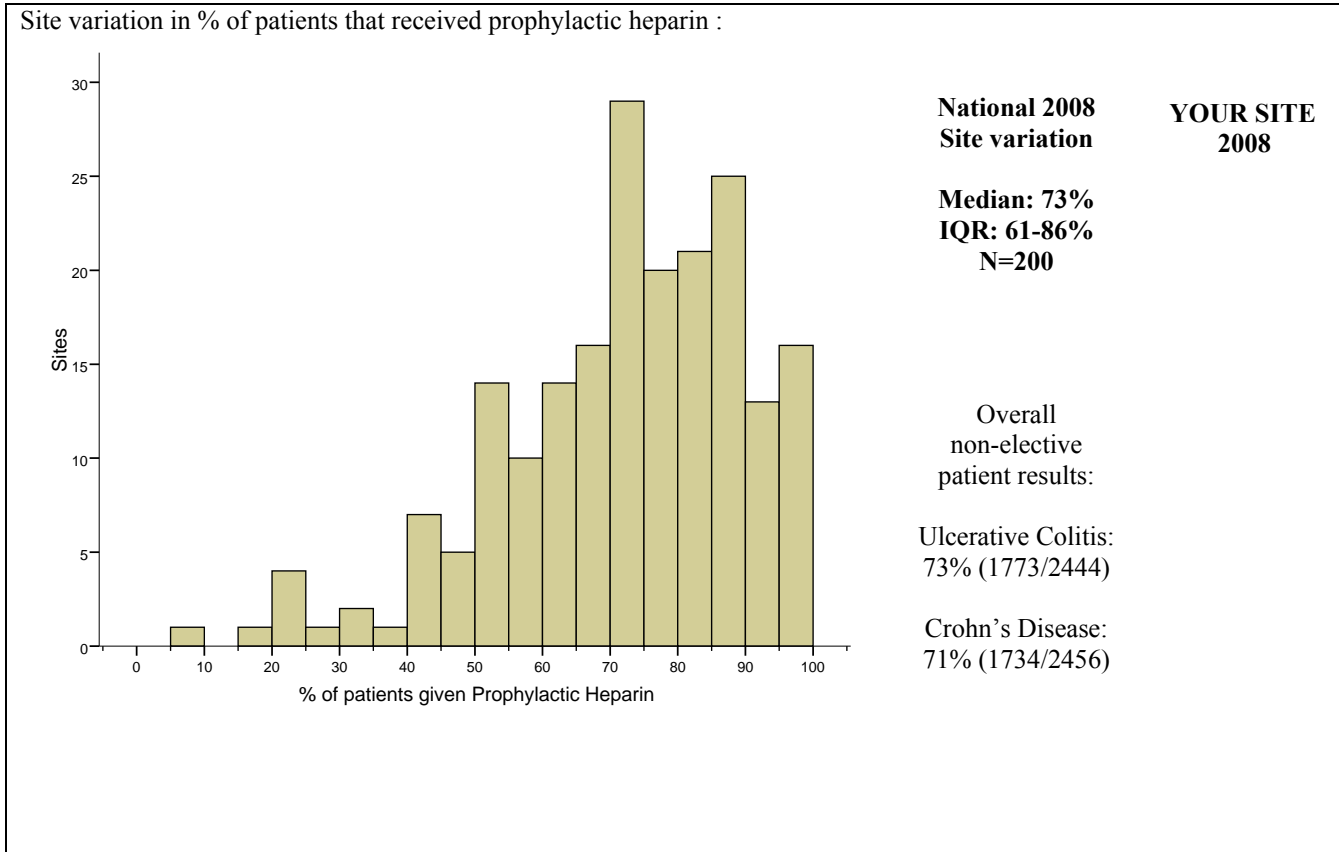
**YOUR SITE  
2008**

Overall  
non-elective  
patient results:

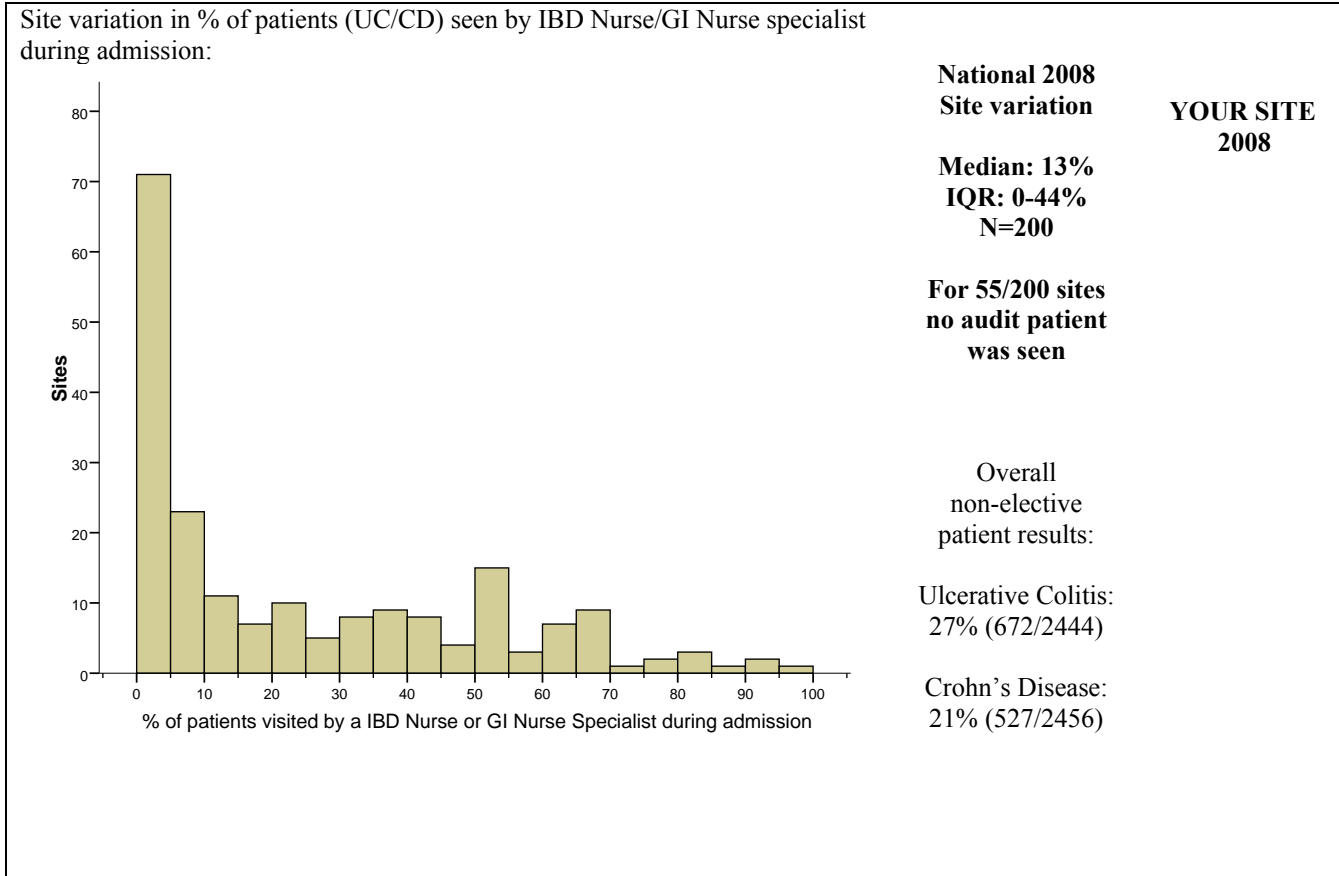
Ulcerative Colitis:  
3.5% (50/1439)

Crohn's Disease:  
2.6% (15/580)

2. Prophylactic heparin (non-elective patients)



3. Patient seen by IBD nurse practitioner during stay



## Results for Ulcerative Colitis

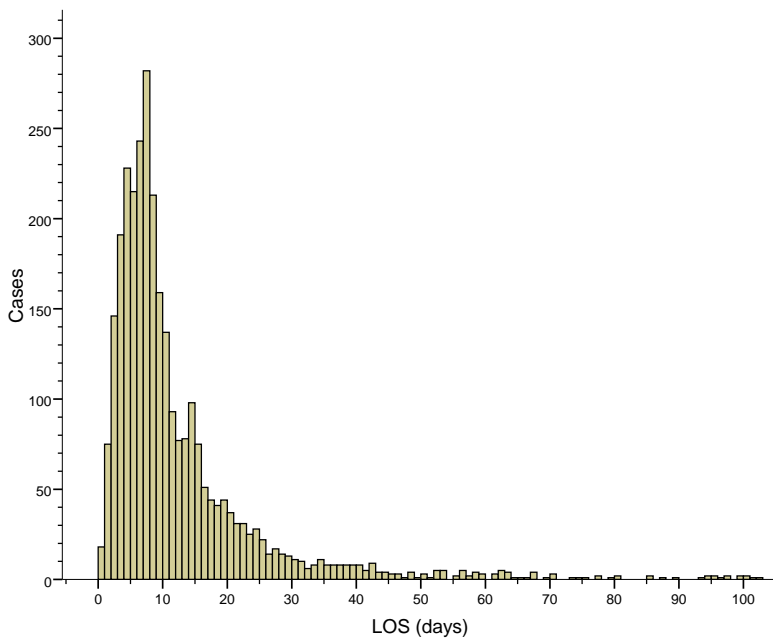
Results are for non-elective patients, apart from mortality and length of stay which refer to all patients.

### 1. Mortality

	<b>National 2008</b>	<b>YOUR SITE</b>
Patient died during admission	1.5% (46/2981)	38 sites had 1 death, 4 sites had two deaths in their audit sample.

### 2. Length of stay (LOS)

Discharged patient variation in LOS:



#### **National 2008**

Overall median (IQR) was 8 (5-14) days, N=2920.

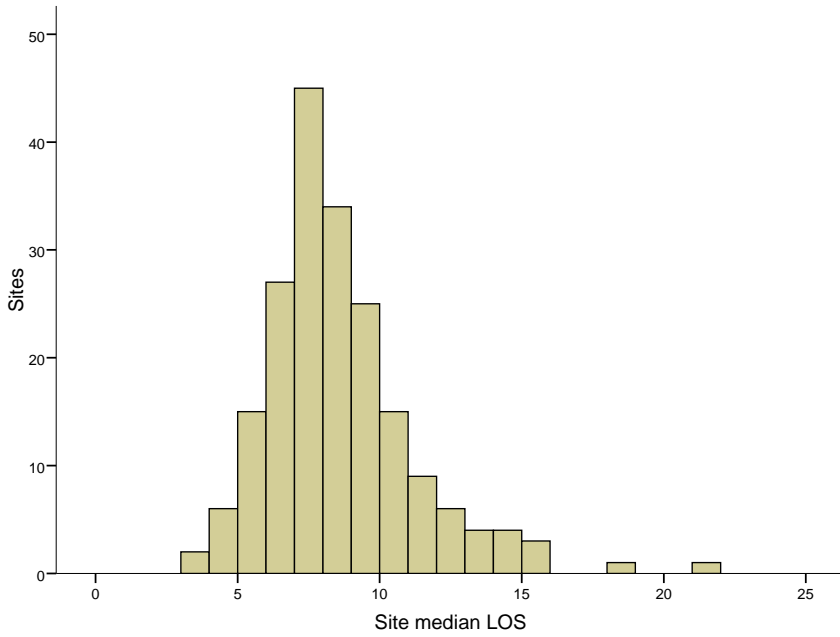
62% (1814/2920) had LOS of 7 or more days

27% (781/2920) had LOS of 14 or more days

Note that 21 outliers of >100 days were excluded from the histogram

#### **YOUR SITE 2008**

Variation in site median LOS:

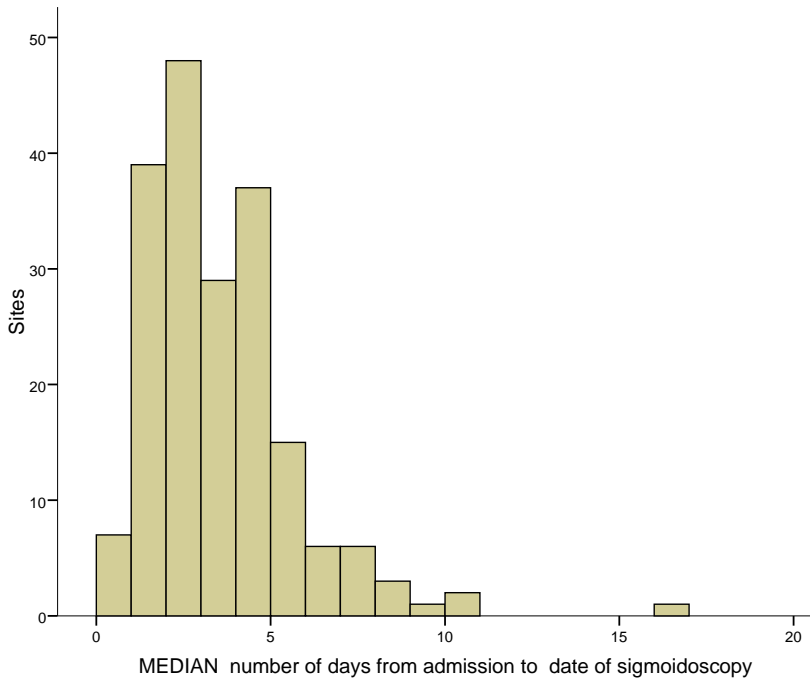


**National 2008**  
 The inter-quartile  
 range for the site  
 median LOS was  
 7- 9 days.

**YOUR SITE  
 2008**

### 3. Endoscopy (non-elective)

Site variation in median number of days from admission to sigmoidoscopy:



**National 2008**  
 Site variation  
 Median: 3 days  
 IQR: 2-4 days  
 N=194

**YOUR SITE  
 2008**

4. Abdominal X-ray (non-elective)

	National 2008 Site variation			Overall non-elective patient results	YOUR SITE 2008
	Median	IQR	N		
% with plain abdominal X-Ray performed	86%	71-93%	197	82% (2002/2444)	
% of plain abdominal X-Ray performed on same day as admission:	74%	60-84%	196	Same day: 71% (1430/2001)	

5. Acute severe UC (high stool frequency and high CRP) non-electives

Overall there were 205 patients (10% of non-electives) who were known to have high CRP (>45) and high stool frequency (>8 per day). 124 sites had 1 or more acute severe case within their UC audit sample, range 1-5.

	National audit (205 with acute severe UC)	Your site
Ciclosporin	24% (50)	
Infliximab	7% (15)	
Surgery	43% (88)	
Days to surgery	Median (IQR): 10 (7-14) days from admission	
Mortality	2.9% (6)	

6. Clinical trials

No Ulcerative Colitis patients were entered into a clinical trial.

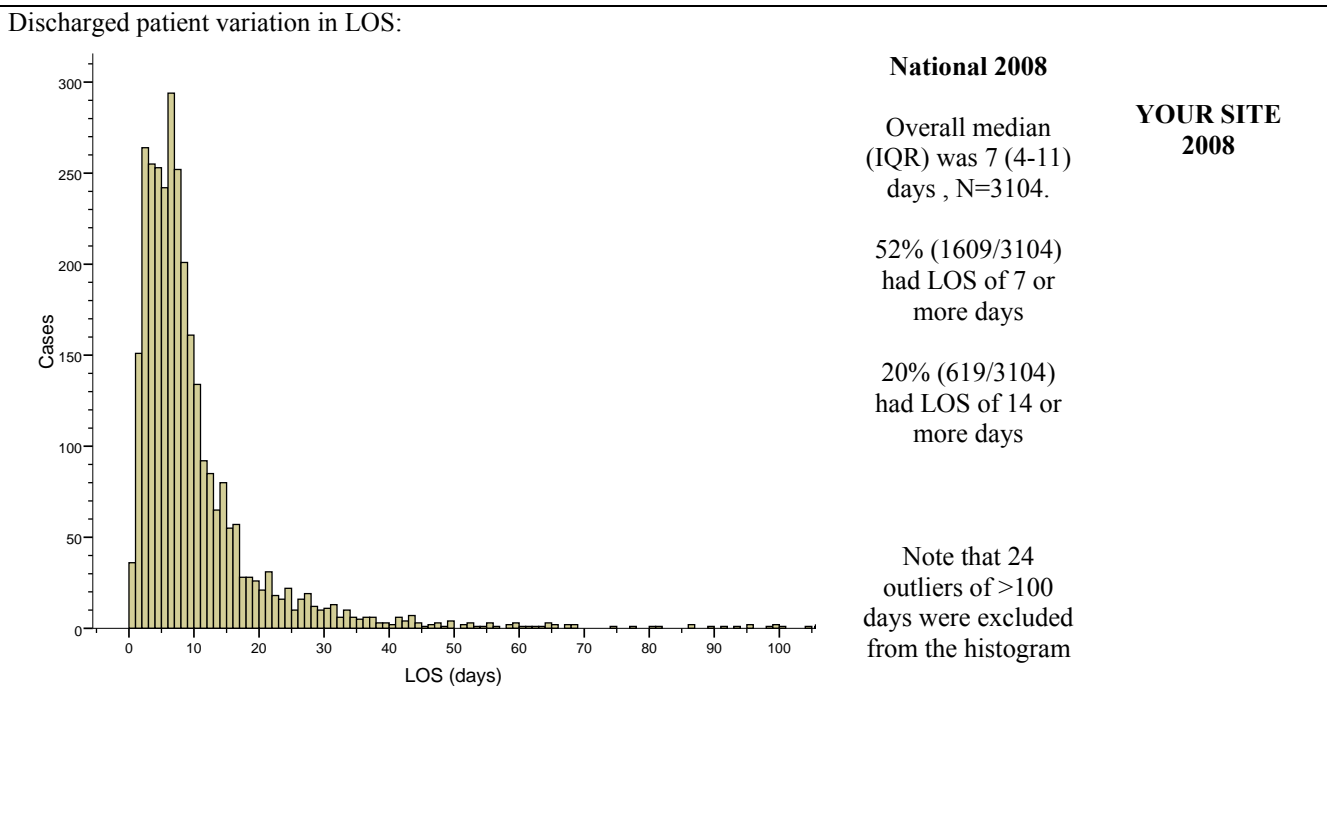
## Results for Crohn’s Disease

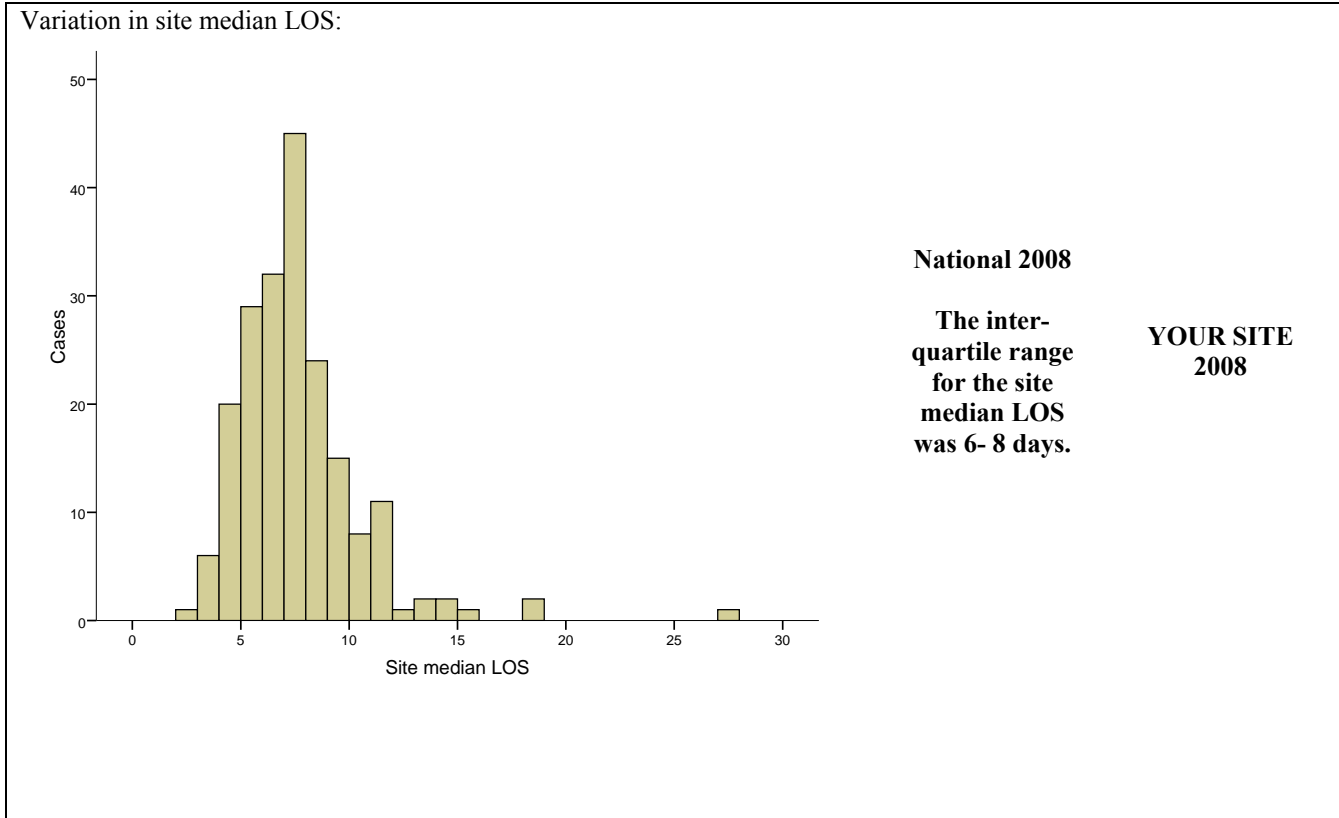
Inpatient results are for all patients, apart from weight and dietetics which refer to non-elective patients. Outpatient results are for all patients having an outpatient visit in the 12 months prior to the audit admission that did not directly initiate the audit admission.

### 1. Mortality

	National 2008	YOUR SITE
Patient died during admission	1.1% (34/3154)	28 sites had 1 death, 3 sites had two deaths in their audit sample.

### 2. Length of stay (LOS)

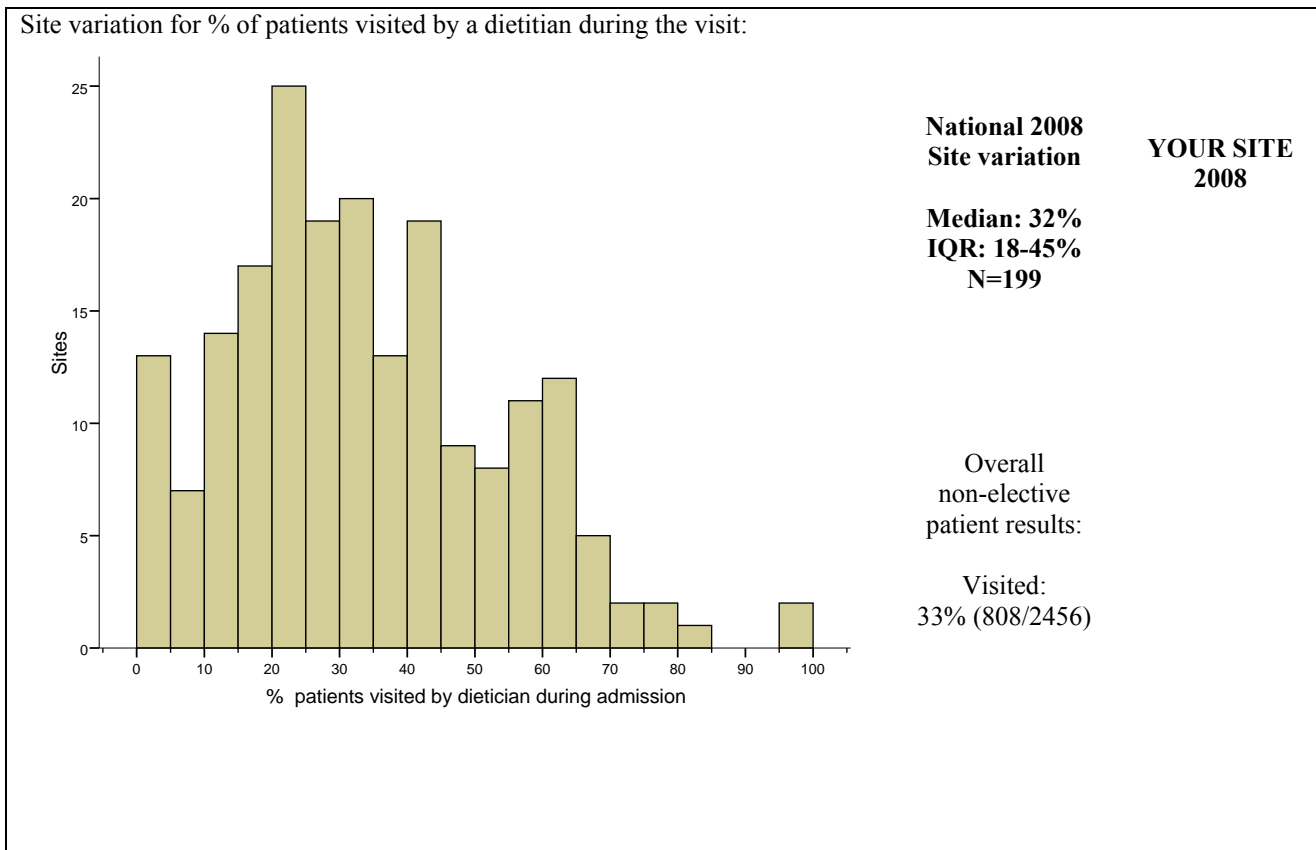
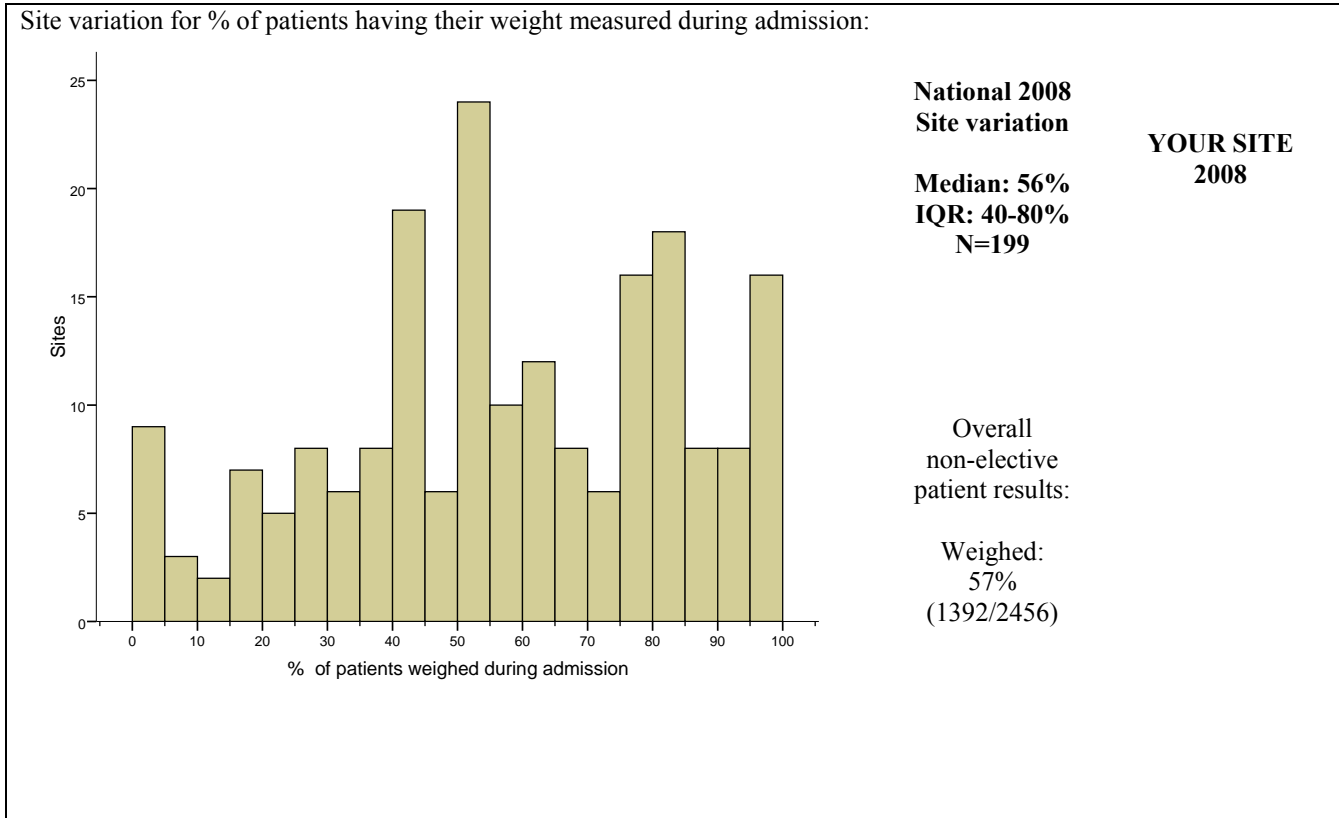




3. Smoking status documented (all patients)

	National 2008 Site variation			Overall patient results	YOUR SITE 2008
	Median	IQR	N		
% with smoking status documented	90%	80-100%	200	86% (2722/3154)	

4. Weight and dietetics (non-electives)



	National 2008 Site variation			Overall non-elective patient results	YOUR SITE 2008
	Median	IQR	N		
% of patients having dietary treatment initiated (by dietitian)	27%	11-40%	199	Initiated: 28% (698/2456)	
% of patients prescribed exclusive liquid enteral nutrition therapy (by dietitian)	0%	0-13%	199	Therapy: 8% (204/2456)	
	98/199 sites prescribed such therapy to at least 1 audit patient				

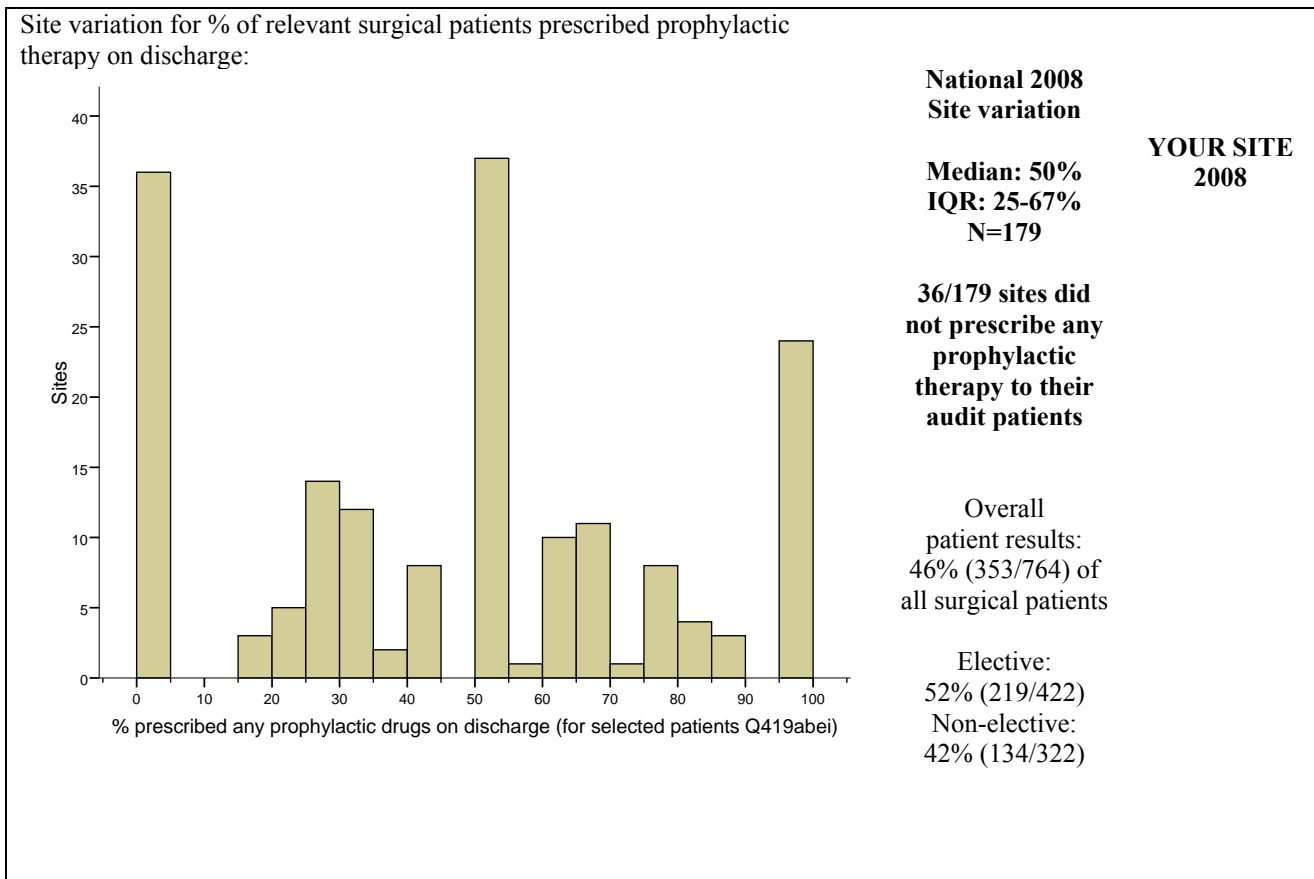
5. Laparoscopy (elective and non-elective)

	National 2008 Site variation			Overall patient results	YOUR SITE 2008
	Median	IQR	N		
% of surgical patients having surgery done laparoscopically or laparoscopically-assisted	13%	0-33%	186	20% (235/1184) of all surgical patients Elective: 24% (164/685) Non-elective: 14% (71/499)	

6. Post operative therapy

Included in the following results are those surgical patients having segmental/extended colectomy, subtotal colectomy, ileal/jejunal resection and ileocolonic resection.

Prophylactic therapy was taken as being any of the following drugs on discharge: Azathioprine, Mercaptopurine, Metronidazole, 5-ASA, Methotrexate. 179 sites had from 1 to 11 such patients, median 4 patients



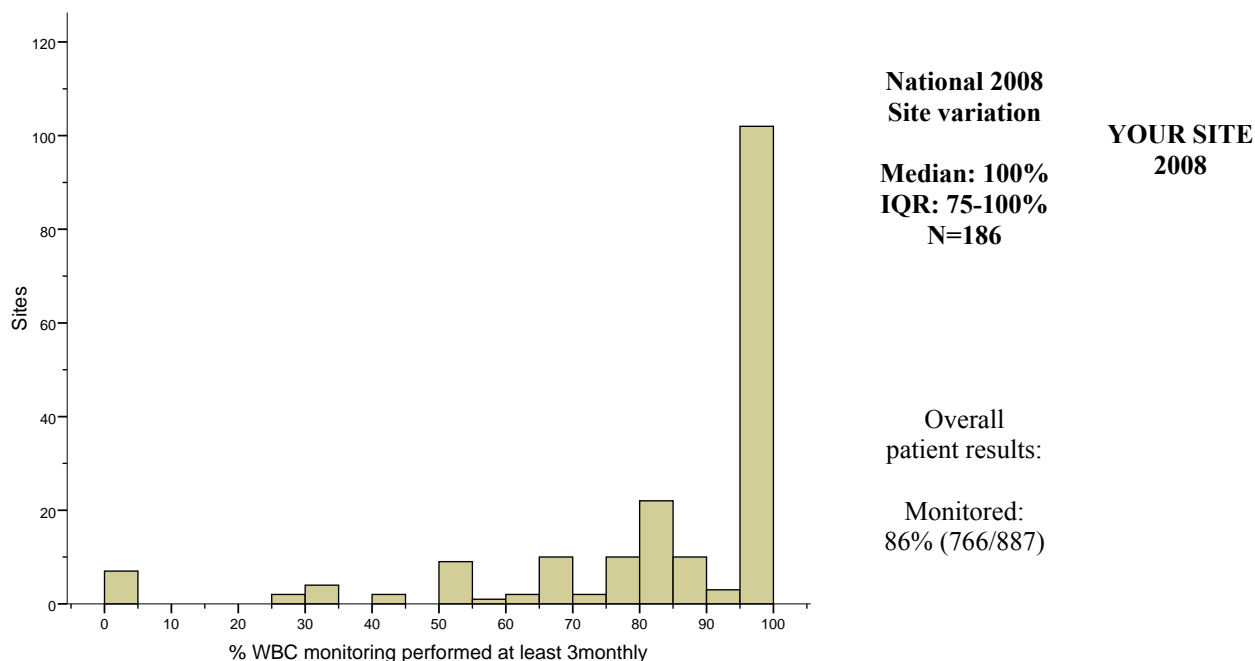
## Crohn's Outpatient data

63% (1976/3154) had previous outpatient visits for Crohn's Disease in the previous 12 months. 1797 of these were visits that did not directly initiate the admission being audited, and these form the basic denominator for Crohn's outpatient results.

### 7. Immunosuppressive monitoring (Outpatient Data)

Denominator comprises 887 patients (from 1797) taking any of Azathioprine, Mercaptopurine or Methotrexate (Q6.4.1) in the 12 months prior to the start date of the audited admission.

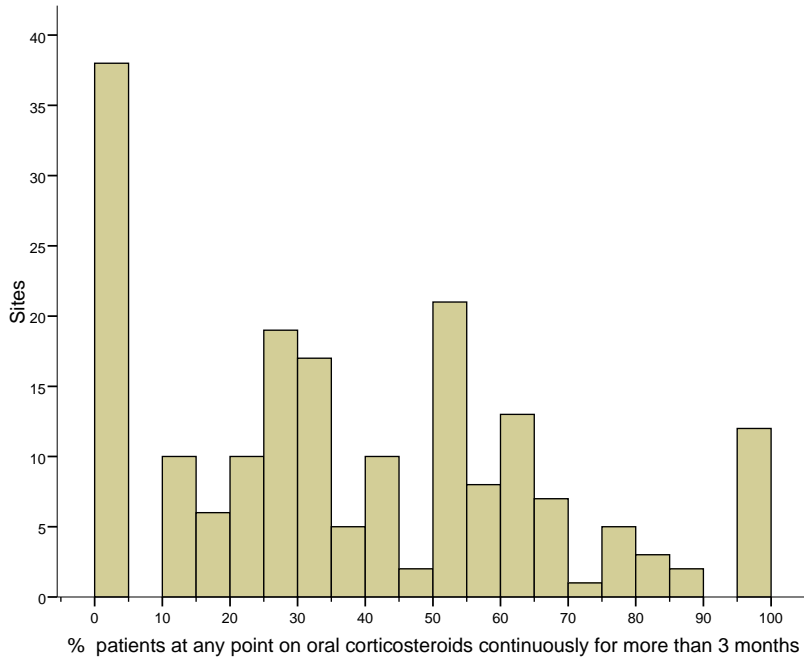
Site variation for % of patients having WBC monitoring performed at least every 3 months:



### 8. Steroid therapy

	National 2008 Site variation			Overall patient results	YOUR SITE 2008
	Median	IQR	N		
% of patients taking corticosteroids for their Crohn's Disease in 12 months prior to admission	55%	38-73%	1895	Therapy: 55% (982/1797)	

Site variation for % of patients at any point taking oral corticosteroids continuously for more than 3 months:



**National 2008  
Site variation**

**Median: 33%  
IQR: 14-56%  
N=189**

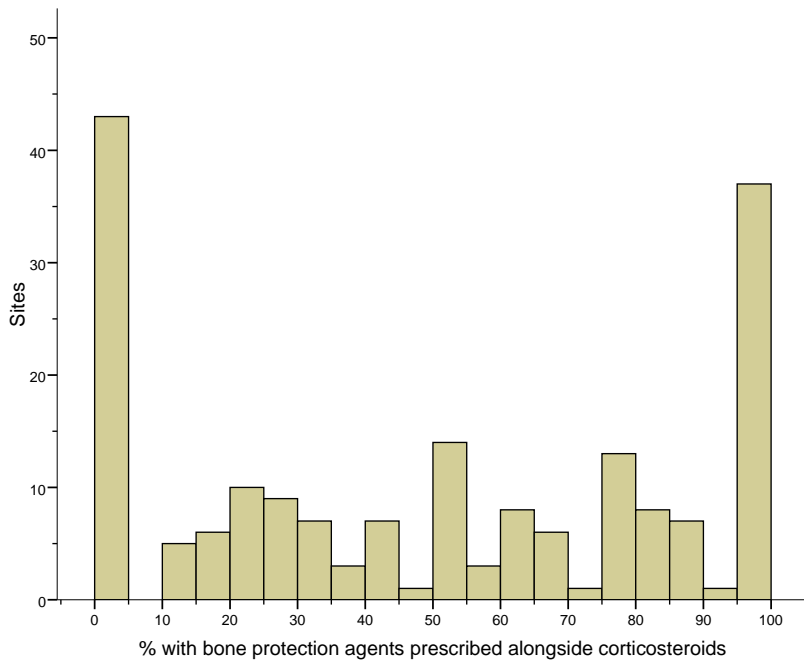
**YOUR SITE  
2008**

Overall  
patient results:

>3 months:  
38% (370/982)

## 9. Bone protection

Site variation for % of patients prescribed bone protection agents alongside corticosteroids



**National 2008  
Site variation**

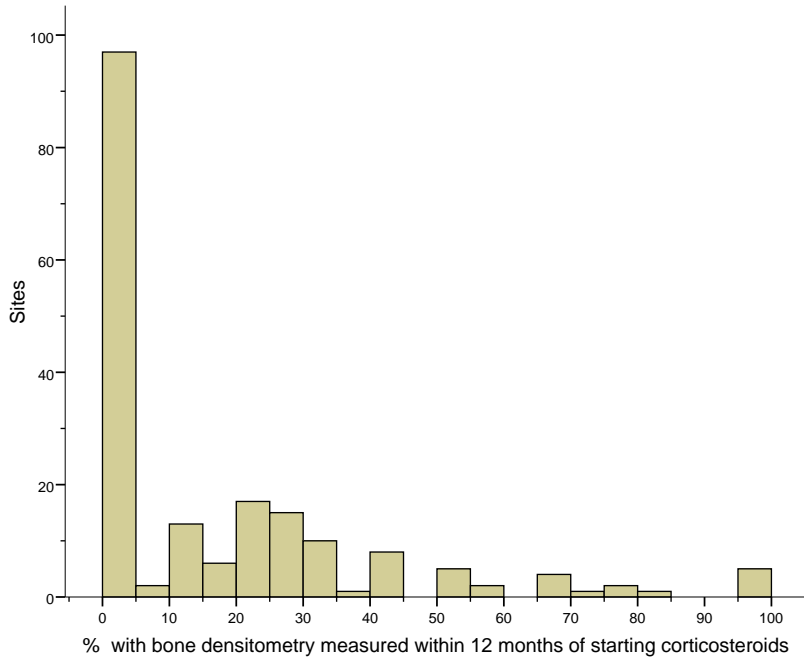
**Median: 50%  
IQR: 14-83%  
N=189**

**YOUR SITE  
2008**

Overall  
patient results:

Agents:  
49% (484/982)

Site variation for % of patients with bone densitometry measured within 12 months of starting corticosteroids



**National 2008  
Site variation**

**Median: 0%  
IQR: 0-25%  
N=189**

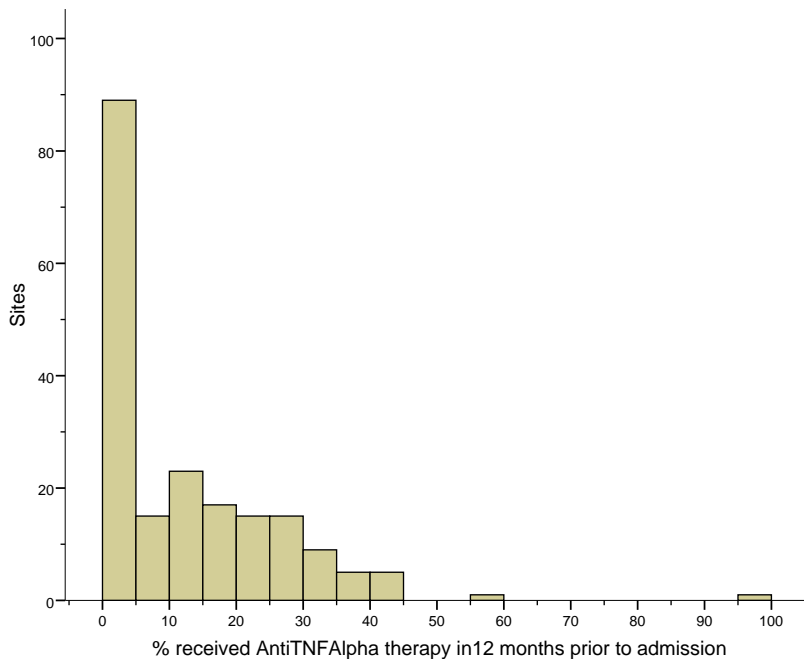
**YOUR SITE  
2008**

Overall  
patient results:

Densitometry:  
17% (165/982)

### 10. Anti-TNF $\alpha$ therapy

Site variation for % of patients receiving anti-TNF- $\alpha$  therapy in the 12 months prior to admission



**National 2008  
Site variation**

**Median: 8%  
IQR: 0-20%  
N=195**

**YOUR SITE  
2008**

**For 89/195 sites  
there were no  
audit patients  
receiving anti-  
TNF- $\alpha$  therapy**

Overall  
patient results:

Therapy:  
12% (224/1797)

Overall there were 224 patients who had received anti-TNF- $\alpha$  therapy in the 12 months prior to admission. The number per site ranged from 1 to 9, median 2 patients. These 224 form the starting denominator for the following results:

	<b>National audit (224 received therapy)</b>	<b>Your site</b>
6.6.2 Anti-TNF- $\alpha$ therapy given for very first time at any point in 12 months before audited admission	58% (131/224)	
6.6.3 Patient had severely active Crohn's Disease at the time anti-TNF- $\alpha$ therapy was initiated.	95% (124/131)	
6.6.6 Fistulating disease was primary reason for decision to initiate anti-TNF- $\alpha$ therapy	27% (36/131)	
6.6.7 Patient had chest X-ray to exclude TB in 3 months before of initiating anti-TNF- $\alpha$ therapy	89% (116/131)	

## 11. Clinical Trials

Only 2 Crohn's Disease patients were entered into a clinical trial on the audited admission.

## Key indicator results 2008 for England, Northern Ireland, Scotland & Wales

These exclude data from 1 “Island’s” site.

### Organisational / Structure

	England (163)	Northern Ireland (10)	Scotland (18)	Wales (15)
2.1 Patients discharged with a primary diagnosis of <b>Ulcerative Colitis</b> : Median (IQR)	52 (26-98), n=157	36 (10-55), n=9	48 (29-103), n=16	29 (16-49), n=15
2.1 Patients discharged with a primary diagnosis of <b>Crohn’s Disease</b> : Median (IQR)	62 (33-112), n=157	37 (19-53), n=9	86 (51-169), n=16	33 (20-63), n=15
2.2 Patients discharged having had an operation where the primary indication was <b>Ulcerative Colitis</b> : Median (IQR)	10 (4-19), n=157	11 (2-18), n=7	6 (2-35), n=13	9 (3-21), n=15
2.2 Patients discharged having had an operation where the primary indication was <b>Crohn’s Disease</b> : Median (IQR)	15 (7-28), n=157	10 (3-21), n=7	9 (4-55), n=13	8 (7-22), n=15
2.3 Surgeons perform ileo-anal pouch surgery on site	81% (131/161)	50% (5/10)	67% (12/18)	53% (8/15)
If yes, ileo-anal pouch operations performed: Median (IQR)	4 (1-6), n=126	1 (range 1-4)	7 (3-13), n=9	2 (0-7), n=8
3.1 Dedicated Gastroenterology ward	79% (129/163)	30% (3/10)	67% (12/18)	73% (11/15)
If yes, Beds per lavatory on the ward: Median (IQR)	4.5 (3.4-6.0), n=129	Values 2.5, 3.2 & 5.0	3.0 (2.4-6.0), n=12	4.0 (3.5-6.0), n=11
3.4 IBD Nurse Specialists on site (WTE): Median (IQR)	1 (0-1), n=162 36% (59) NONE	0.3 WTE, n=1 90% (9/10) NONE	1 (0-1), n=18 17% (3/18) NONE	0 (0-1), n=15 47% (7/15) NONE
3.5 Sessions of Specialist Nurse time dedicated to IBD care per week?: Median (IQR)	8 (4-10), n=99	3 sessions, n=1	10 (3-10), n=12	6 (2-12), n=8
5.1 Searchable database of IBD patients on site	39% (63/161)	40% (4/10)	39% (7/18)	27% (4/15)
5.2 Timetabled meetings (where IBD patients are discussed ) take place between Gastroenterologists and Colorectal Surgeons	71% (115/162)	20% (2/10)	44% (8/18)	60% (9/15)
6.3 Dietetic sessions per week dedicated to GI disorders (not just IBD): Median (IQR)	2 (0-8), n=161	0 (0-1), n=9	2 (1-5), n=18	1 (0-6), n=15
7.1 Is there written information for patients with IBD on whom to contact in the event of a relapse?	69% (112/162)	40% (4/10)	67% (12/18)	80% (12/15)
7.2 In general, a relapsed patient expected to be seen in clinic in less than 7 days	70% (114/162)	80% (8/10)	44% (8/18)	40% (6/15)
7.3 Patients have access to an IBD specialist by :				
a) Telephone	87% (142/163)	70% (7/10)	72% (13/18)	80% (12/15)
b) Drop-in clinic	13% (21/163)	0% (0/10)	17% (3/18)	13% (2/15)
c) Email	47% (77/163)	0% (0/10)	28% (5/18)	13% (2/15)
7.4 Joint or parallel clinics run between Gastroenterologists and Surgeons	50% (81/162)	10% (1/10)	44% (8/18)	73% (11/15)
10.1 Paediatric to adult handover clinic for young patients with IBD	28% (45/161)	10% (1/10)	33% (6/18)	13% (2/15)
10.3 Psychologists attached to the Gastroenterology service	6% (10/161)	10% (1/10)	0% (0/18)	7% (1/13)
10.4 Pathways exist for direct access to psychological support	24% (39/161)	0% (0/10)	28% (5/18)	0% (0/15)
11.1 Written trust guidelines exist for management of acute or severe colitis	73% (117/161)	30% (3/10)	61% (11/18)	67% (10/15)
12.1 Hospital offers open forums or meetings for patients with IBD	33% (53/161)	20% (2/10)	6% (1/18)	13% (2/15)
a) Less than 4 monthly	13% (7/53)	50% (1/2)	100% (1/1)	50% (1/2)
b) Every 4-8 months	47% (25/53)	0% (0/2)	-	-
c) Every 8-12 months	36% (19/53)	0% (0/2)	-	-

## Results combined for Ulcerative Colitis & Crohn's Disease patients

Stool sample results are given for Ulcerative Colitis (non-elective) patients and Crohn's Disease (non-elective, with diagnosis of diarrhoea) patients combined. Results for heparin and IBD nurse specialists are given for non-elective Ulcerative Colitis and Crohn's Disease patients combined.

	England	Northern Ireland	Scotland	Wales
Stool sample sent for Standard Stool Culture	63% (1894/3024)	64% (93/146)	58% (164/282)	61% (133/219)
Stool sample was positive	2.1% (39/1891)	0% (0/93)	2.4% (4/164)	1.5% (2/133)
Stool sample sent for CDT	56% (1688/3024)	53% (77/146)	52% (148/282)	47% (102/219)
Stool sample was positive	3.3% (55/1687)	3.9% (3/77)	3.4% (5/148)	2.0% (2/102)
Patient given Prophylactic heparin	72% (2904/4017)	76% (163/214)	68% (249/365)	62% (177/286)
Patient visited by IBD Nurse/GI Nurse specialist during admission	26% (1044/4017)	11% (23/214)	22% (80/365)	18% (52/286)

## Results for Ulcerative Colitis

Results below are for non-elective patients, apart from mortality & length of stay which refer to all patients.

	England	Northern Ireland	Scotland	Wales
1.3.1 Patient died during admission	1.5% (37/2481)	2.7% (3/110)	1.4% (3/208)	1.7% (3/179)
1.3.2 Length of stay (discharges)      Median (IQR)	8 (5-14), n=2429	12,14,19 days n=3	7 (3-13), n=205	8 (5-12), n=176
2.3.1 Patient had sigmoidoscopy (Rigid/Flexible)	46% (931/2036)	41% (41/101)	43% (71/164)	46% (65/140)
Admission to sigmoidoscopy (days): median (IQR)	3 (1-5), n=931	2 (2-4), n=41	2 (1-4), n=71	2 (1-5), n=65
3.2.1. Plain abdominal X-ray performed	83% (1680/2036)	81% (82/101)	71% (117/164)	86% (121/140)
Performed same day as admission	71% (1192/1679)	73% (60/82)	76% (87/114)	75% (91/121)
Patients with acute/severe Ulcerative Colitis:*	176	10	12	4
• Ciclosporin	25% (44/176)	10% (1/10)	17% (2/12)	75% (3/4)
• Infliximab	7% (13/176)	10% (1/10)	8% (1/12)	0% (0/4)
• Surgery	47% (83/176)	30% (3/10)	8% (1/12)	25% (1/4)
• Days to surgery:      Median (IQR)	10 (7-14), n=83	6,7,10 days, n=3	9 days, n=1	12 days, n=1
• Mortality	2.8% (5/176)	0% (0/10)	8% (1/12)	0% (0/4)

\* Non-elective patients known to have high CRP (>45) and high stool frequency (>8 per day) during first 72 hours of steroid therapy

## Results for Crohn's Disease

Inpatient results below are for all patients, apart from weight & dietetics which refer to non-elective patients.

	England	Northern Ireland	Scotland	Wales
1.3.1 Patient died during admission	1.0% (27/2575)	0% (0/133)	1.6% (4/246)	1.6% (3/188)
1.3.2 Length of stay      Median (IQR)	7 (4-12), n=2533	7 (4-12), n=133	6 (3-12), n=241	7 (4-10), n=185
1.6.1 Smoking status documented	86% (2203/2575)	83% (111/133)	94% (231/246)	88% (166/188)
2.5.1 Patient weight measured	56% (1121/1986)	53% (60/113)	62% (125/201)	56% (82/146)
2.5.2 Patient visited by dietitian	32% (636/1986)	42% (48/113)	35% (71/201)	35% (51/146)
2.5.3 Dietary treatment was initiated	28% (564/1986)	33% (37/113)	26% (53/201)	29% (43/146)
Exclusive liquid enteral nutrition therapy prescribed	8% (168/1986)	7% (8/113)	8% (17/201)	8% (11/146)
4.1.9 Surgery done laparoscopically/laparoscopically-assisted	20% (201/989)	8% (3/37)	22% (19/86)	18% (12/68)
4.3.1 Prophylactic therapy* on discharge	46% (291/634)	36% (8/22)	51% (28/55)	46% (23/50)

\* Azathioprine, Mercaptopurine, Metronidazole, 5-ASA or Methotrexate for patients having segmental/extended colectomy, subtotal colectomy, ileal/jejunal resection and ileocolonic resection.

Outpatient results are for all patients having an outpatient visit in the 12 months prior to the audit admission that did not directly initiate the audit admission.

	England	Northern Ireland	Scotland	Wales
Outpatient visits in previous 12 months	63% (1626/2575)	56% (75/133)	65% (159/246)	57% (107/188)
Visit did not directly initiate the audit admission	91% (1479/1626)	88% (66/75)	91% (145/159)	92% (98/107)
6.4.1 Taking Azathioprine, Mercaptopurine or Methotrexate in the 12 months before admission.	46% (679/1479)	39% (26/66)	50% (73/145)	56% (55/98)
6.4.3 WBC monitoring performed at least 3 monthly	91% (620/679)	88% (23/26)	93% (68/73)	93% (51/55)
6.5.1 Oral corticosteroids for Crohn's in 12 months before admission	54% (795/1479)	52% (34/66)	57% (82/145)	64% (63/98)
6.5.2 Oral corticosteroids taken at some point continuously for more than three months	37% (291/795)	38% (13/34)	38% (31/82)	48% (30/63)
6.5.3 Bone protection agents prescribed alongside corticosteroids	50% (395/795)	68 (23/34)	28% (23/82)	67% (42/63)
6.5.4 Bone densitometry measured within 12 months of initiation of corticosteroid therapy	17% (136/795)	21% (7/34)	16% (13/82)	14% (9/63)
6.6.1 Patient received anti-TNF- $\alpha$ therapy in the 12 months prior to admission	12% (181/1479)	20% (13/66)	13% (19/145)	8% (8/98)
6.6.2 Anti-TNF- $\alpha$ therapy given for very first time at any point in 12 months before audited admission	57% (103/181)	69% (9/13)	63% (12/19)	75% (6/8)
6.6.3 Patient had severely active Crohn's Disease at the time anti-TNF- $\alpha$ therapy was initiated.	95% (98/103)	89% (8/9)	100% (12/12)	100% (6/6)
6.6.6 Fistulating disease was primary reason for decision to initiate anti-TNF- $\alpha$ therapy	25% (26/103)	22% (2/9)	33% (4/12)	50% (3/6)
6.6.7 Patient had chest X-ray to exclude TB in 3 months before of initiating anti-TNF- $\alpha$ therapy	87% (90/103)	89% (8/9)	92% (11/12)	100% (6/6)

## Key indicator results (2006 and 2008) for sites participating in both rounds

The following tables compare the national audit results from 2008 with the national audit results from 2006 for those sites taking part in both audits. This will give a better indication of the potential impact of the audit process than the overall results presented in sections 4-7 of the full report. Due to changes in Trust configuration and changes in site definition the total number of sites differs slightly between audit rounds. The number of sites submitting data is shown below:

	National 2006	National 2008
Organisational	155 sites	150 sites
Ulcerative Colitis cases	2325 from 145 sites	2293 from 144 sites
Crohn's Disease cases	2429 from 145 sites	2353 from 146 sites

### Organisational / Structure

		National 2006 (155)	National 2008 (150)
2.1 Patients discharged with a primary diagnosis of <b>Ulcerative Colitis</b> :	Median (IQR)	50 (24-100), n=147	47 (26-85), n=143
2.1 Patients discharged with a primary diagnosis of <b>Crohn's Disease</b> :	Median (IQR)	61 (30-110), n=147	55 (33-109), n=143
2.2 Patients discharged having had an operation, primary indication <b>Ulcerative Colitis</b> :	Median (IQR)	12 (5-30), n=140	10 (5-21), n=141
2.2 Patients discharged having had an operation, primary indication <b>Crohn's Disease</b> :	Median (IQR)	17 (9-39), n=140	15 (8-29), n=141
2.3 Surgeons perform ileo-anal pouch surgery on site		76% (117/154)	77% (115/149)
If yes, how many ileo-anal pouch operations performed:	Median (IQR)	4 (2-7), n=111	4 (2-8), n=111
3.1 Dedicated Gastroenterology ward		70% (108/155)	80% (120/150)
If yes, Beds per lavatory on the ward:	Median (IQR)	4.5 (3.0-6.0), n=105	4.2 (3.0-6.0), n=120
3.4 IBD Nurse Specialists on site (WTE):		1 (0-1), n=154	1 (0-1), n=150
Median (IQR)		41% (63) NONE	33% (50) NONE
3.5 Sessions of Specialist Nurse time dedicated to IBD care per week?:	Median (IQR)	6 (4-10), n=82	8 (4-10), n=95
5.1 Searchable database of IBD patients on site		37% (57/154)	47% (70/149)
5.2 Timetabled meetings (where IBD patients are discussed) take place between Gastroenterologists and Colorectal Surgeons		76% (118/155)	73% (109/150)
6.3 Dietetic sessions per week dedicated to GI disorders (not just IBD):	Median (IQR)	2 (0-7), n=149	2 (0-8), n=148
7.1 Written information for patients with IBD on whom to contact in the event of a relapse		68% (104/154)	73% (110/150)
7.2 In general, a relapsed patient expected to be seen in clinic in less than 7 days		64% (99/155)	72% (108/150)
7.3 Patients have access to an IBD specialist by :			
a) Telephone		77% (119/155)	87% (131/150)
b) Drop-in clinic		15% (24/155)	15% (22/150)
c) Email		30% (47/155)	47% (70/150)
7.4 Joint or parallel clinics run between Gastroenterologists and Surgeons		47% (73/155)	55% (82/150)
10.1 Paediatric to adult handover clinic for young patients with IBD		23% (35/154)	28% (41/149)
10.3 Psychologists attached to the Gastroenterology service		8% (12/154)	7% (11/149)
10.4 Pathways exist for direct access to psychological support		22% (34/154)	26% (38/149)
11.1 Written trust guidelines exist for management of acute or severe colitis		50% (77/154)	72% (108/149)
12.1 Hospital offers open forums or meetings for patients with IBD		30% (47/155)	35% (52/149)
a) Less than 4 monthly		15% (7/47)	19% (10/52)
b) Every 4-8 months		38% (18/47)	42% (22/52)
c) Every 8-12 months		36% (17/47)	33% (17/52)

## Results combined for Ulcerative Colitis & Crohn's Disease patients

Stool sample results are given for Ulcerative Colitis (non-elective) patients and Crohn's Disease (non-elective, with diagnosis of diarrhoea) patients combined. Results for heparin and IBD nurse specialists are given for non-elective Ulcerative Colitis and Crohn's Disease patients combined.

	National 2006	National 2008
Stool sample sent for Standard Stool Culture	55% 1670/3022	63% (1765/2799)
Stool sample was positive	Not asked	1.8% (32/1765)
Stool sample sent for CDT	44% 1318/3022	55% (1544/2799)
Stool sample was positive	Not asked	3.4% (52/1544)
Patient given Prophylactic heparin	56% 2225/3975	73% (2708/3687)
Patient visited by IBD Nurse/GI Nurse specialist during admission	21% 843/3974	28% (1032/3687)

## Results for Ulcerative Colitis

Results below are for non-elective patients, apart from mortality & length of stay which refer to all patients.

	National 2006	National 2008
1.3.1 Patient died during admission	1.4% (33/2325)	1.5% (34/2293)
1.3.2 Length of stay      Median (IQR)	8 (5-15), n=2274	8 (5-14), n=2250
2.3.1 Patient had sigmoidoscopy (Rigid/Flexible)	43% (868/2003)	45% (844/1875)
Admission to sigmoidoscopy (days): median (IQR)	3 (1-6), n=868	3 (1-5), n=844
3.2.1. Plain abdominal X-ray performed	80% (1603/2001)	83% (1552/1875)
Performed same day as admission	67% (1072/1603)	72% (1121/1552)
Patients with acute/severe Ulcerative Colitis:*	179	156
• Ciclosporin	28% (51/179)	26% (41/156)
• Infliximab	4% (8/179)	8% (13/156)
• Surgery	42% (76/179)	45% (70/156)
• Days to surgery:      Median (IQR)	11 (8-17), n=76	10 (7-13), n=70
• Mortality	2.2% (4/179)	2.6% (4/156)

\* Non-electives who were known to have high CRP (>45) and high stool frequency (>8 per day).

## Results for Crohn's Disease

Inpatient results are for all patients, apart from weight & dietetics which refer to non-elective patients.

	National 2006	National 2008
1.3.1 Patient died during admission	1.2% (29/2429)	1.0% (24/2353)
1.3.2 Length of stay      Median (IQR)	8 (4-13), n=2382	7 (4-11), n=2326
1.6.1 Smoking status documented	85% (2073/2429)	88% (2060/2353)
2.5.1 Patient weight measured	53% (1052/1972)	58% (1046/1812)
2.5.2 Patient visited by dietitian	37% (726/1972)	34% (612/1812)
2.5.3 Dietary treatment was initiated	30% (598/1972)	29% (529/1812)
Exclusive liquid enteral nutrition therapy prescribed	6% (113/1972)**	8% (141/1812)
4.1.9 Surgery done laparoscopically/laparoscopically-assisted	10% (85/844)	19% (171/889)
4.3.1 Prophylactic therapy* on discharge	48% (320/670)	46% (264/573)

\* Azathioprine, Mercaptopurine, Metronidazole, 5-ASA or Methotrexate for patients having segmental/extended colectomy, subtotal colectomy, ileal/jejunal resection and ileocolonic resection.

\*\* 2006 question asked if parenteral nutrition was required.

Outpatient results are for all patients having an outpatient visit in the 12 months prior to the audit admission that did not directly initiate the audit admission.

	<b>National 2006</b>	<b>National 2008</b>
Outpatient visits in previous 12 months	65% (1571/2429)	63% (1483/2353)
Visit did not directly initiate the audit admission	Not asked	91% (1349/1483)
6.4.1 Taking Azathioprine, Mercaptopurine or Methotrexate in 12 months before admission.	46% (679/1479)	50% (669/1349)
6.4.3 WBC monitoring performed at least 3 monthly	84% (573/679)	87% (585/669)
6.5.1 Oral corticosteroids for Crohn's in 12 months before admission	57% (890/1571)	55% (746/1349)
6.5.2 Oral corticosteroids taken at some point continuously for more than three months	47% (416/890)	37% (273/746)
6.5.3 Bone protection agents prescribed alongside corticosteroids	47% (414/890)	55% (407/746)
6.5.4 Bone densitometry measured within 12 months of initiation of corticosteroid therapy	18% (160/890)	17% (128/746)
6.6.1 Patient received anti-TNF- $\alpha$ therapy in the 12 months prior to admission	7% (105/1456)	13% (169/1349)
6.6.2 Anti-TNF- $\alpha$ therapy given for very first time at any point in 12 months before audited admission	74% (78/105)	57% (97/169)
6.6.3 Patient had severely active Crohn's Disease at the time anti-TNF- $\alpha$ therapy was initiated.	82% (64/78)	97% (94/97)
6.6.6 Fistulating disease was primary reason for decision to initiate anti-TNF- $\alpha$ therapy	29% (23/78)	24% (23/97)
6.6.7 Patient had chest X-ray to exclude TB in 3 months before of initiating anti-TNF- $\alpha$ therapy	82% (64/78)	88% (85/97)

Appendix 1

**UK IBD Audit Steering Group – February 2008**

**Chair & UK IBD Audit Clinical Director**

Dr Ian Arnott, Consultant Gastroenterologist, Western General Hospital, Edinburgh, NHS Lothian

**Association of Coloproctology of Great Britain and Ireland**

Miss Asha Senapati, Consultant Surgeon, Portsmouth Hospitals NHS Trust

**British Dietetic Association**

Dr Miranda Lomer, Locum Consultant Dietitian in Gastroenterology, Guy's and St Thomas' NHS Foundation Trust

**British Society of Gastroenterology**

Dr Stuart Bloom, Consultant Physician and London Gastroenterologist, University College London Hospitals NHS Foundation Trust.

**British Society of Gastroenterology**

Dr Keith Leiper, Consultant Gastroenterologist, Royal Liverpool and Broadgreen University Hospitals NHS Trust & UK IBD Audit Clinical Director

**British Society of Gastroenterology**

Professor Jonathan Rhodes, Professor of Medicine, University of Liverpool

**British Society of Gastroenterology**

Mrs Chris Romaya, Executive Secretary

**British Society of Gastroenterology**

Dr Simon Travis, Clinical Director of Gastroenterology & Endoscopy, Oxford Radcliffe Hospitals NHS Trust

**British Society of Gastroenterology**

Dr Ian Shaw, Consultant Gastroenterologist, Gloucestershire Hospitals NHS Foundation Trust

**British Society of Gastroenterology**

Dr Abraham Varghese, Consultant Gastroenterologist, Causeway Hospital, Northern Health and Social Care Trust

**British Society of Paediatric Gastroenterology Hepatology and Nutrition**

Dr Sally Mitton, Consultant / Senior Lecturer Paediatric Gastroenterology, St George's Hospital, Paediatric Gastroenterology Unit.

**British Society of Paediatric Gastroenterology Hepatology and Nutrition**

Dr Richard Russell, Consultant Paediatric Gastroenterologist, Royal Hospital for Sick Children (Yorkhill), NHS Greater Glasgow & Clyde

**National Association for Colitis and Crohn's Disease (NACC)**

Mr Richard Driscoll, Chief Executive (NACC)

**Newport Local Health Board**

Mr John Frankish, Head of Service Modernisation, Newport Local Health Board

**Royal College of Nursing Crohn's and Colitis Special Interest Group**

Ms Lindsey Hurst, IBD Clinical Nurse Specialist, North Tees and Hartlepool NHS Foundation Trust

**Royal College of Nursing Crohn's and Colitis Special Interest Group**

Ms Karen Kemp, IBD Clinical Nurse Specialist, Central Manchester University Hospitals NHS Foundation Trust

**Royal College of Nursing Crohn's and Colitis Special Interest Group**

Ms Allison Nightingale, IBD Clinical Nurse Specialist, Cambridge University Hospitals NHS Foundation Trust

**Royal College of Physicians**

Ms Rhona Buckingham, Manager, Clinical Effectiveness and Evaluation Unit

**Royal College of Physicians**

Mr Calvin Down, Project Manager, UK IBD Audit

**Royal College of Physicians**

Dr Barney Hawthorne, Consultant Gastroenterologist, Cardiff and Vale NHS Trust

**Royal College of Physicians**

Ms Jane Ingham, Director of Clinical Standards

**Royal College of Physicians**

Ms Clare Moloney, Project Co-ordinator, UK IBD Audit

**Royal College of Physicians**

Dr Jonathan Potter, Clinical Director, Clinical Effectiveness and Evaluation Unit

**Royal Pharmaceutical Society of Great Britain**

Ms Jackie Eastwood, Senior Specialist Gastroenterology Pharmacist, St. Mark's Hospital