bsg News

EVENTS | COMMENT | RESEARCH

SPRING 2022

I'VE LOOKED AT LIFE FROM BOTH SIDES NOW

Taking time for consent and making patients comfortable

MESSAGE FROM THE PRESIDENT ELECT

How can we tackle the backlog caused by COVID-19?

BSG ENDOSCOPY UPDATE

Safely reducing the burden of endoscopy following the pandemic

I've looked at life from both sides now.

Joni Mitchell is an icon of the 70s. Her songs have always been quirky with a message. A couple of months ago, she joined Neil Young and removed all of them from a well-known streaming service because, in her view, a series of podcasts that they had streamed had promoted ideas about COVID that were questionable. Integrity is about having the courage to stand by your convictions, both artistic as well as political.

Many of Joni Mitchell's songs seem, with hindsight, to be well ahead of their time. Who else would have written about putting up a parking lot in paradise? The comment on the environment and DDT "killing the birds and the bees" was half a century ahead of David Attenborough and Greta. The point about "Big Yellow Taxi" is that,

"You don't know what you've got till it's gone!"

She is also an accomplished poet.

"There was milk and toast and honey
and a bowl of oranges too
and the sun poured in like butterscotch
and stuck to all my senses".
"Chelsea Morning", Joni Mitchell

A celebration of sun and joy that we could all do with in the middle of a fairly dark winter. It is also an observation about memory, and the way that the simple tactile pleasure of a sunny morning can imprint itself forever. The toast and the honey are long gone, but the solar butterscotch remains. Darker memories also imprint. For our patients, it is not all sunlight. For me, her line "I've looked at life from both sides now" has been particularly apt.

I have not been entirely well. Nothing serious thankfully, but enough to make my GP raise a quizzical eyebrow and politely suggest that she should probably refer a 63-year-old male for a "few tests". So a few weeks ago, I ended up on the other side of the scope. Not a colonoscopy, but still rather narrow, and private enough to be uncomfortable.

The colleague who carried out the procedure did not actually ask for written consent. I think he had other things on his mind. Perhaps he assumed that as a doctor I was already well informed, a slightly optimistic assessment. The past few months have reinforced for me how desperately ignorant I am. He was, however, correct. I knew the procedure was required, and I definitely wanted it to go ahead, and I think, but I am not sure, that I may have signed a consent form a few weeks before. It is amazing what a little bit of stress does to your memory.

Interestingly, local anaesthetic does not work instantly, a point I have often emphasised to trainees when it comes to upper GI endoscopy, and which a number of patients have left me in no doubt about, when in the old days we used to do liver biopsies on the ward. My examination was not painful, but it was slightly eye watering. Enough to mean that, if I needed another one, I would definitely want a few more moments to let the lignocaine work. Even a rectal exam - please forgive me if this is all too much information - is not quite as comfortable as we tend to reassure ourselves and our patients. There was a great advert for bowel cancer screening in Scotland, in which a middle-aged man, lying in a fairly obviously foetal position, shouted "Auchtermuchty" as the gastroenterological finger reached its full extent. "Auchtermuchty" was not the word that immediately came to my mind at the time. The precise expression was too Anglo-Saxon to repeat. Billy Connolly might get away with it, but I cannot, at least in the pages of the BSG magazine.

It is also strange how some words change their meanings dependant on the context. "Probably" for example, in the context of "It's probably normal", should be reassuring, but somehow does not quite remove all the anxiety. Similarly, the conjunction "but" seems innocent. The statement, "but we should wait a few weeks and repeat the tests", slightly diminishes the joy.

I am struck by the similarity between "diagnoses" and "earworms"; those annoying tunes and lyrics that you cannot get out of your head, and which always come back more strongly, the more you try to rationalise them away. If I prompt you with, "I'll tell you what I want, what I really, really want", you will sing it all day. "Possible" diagnoses and worries get into people's heads, and only stop when someone can give them an honest and reliable answer. In passing, a medical degree does not confer protection from either earworms or "possible" diagnoses.

SO, WHAT HAVE I LEARNED?

Consent is important and worth the time (see my previous blog on our discussions with the GMC).

Lignocaine is a miracle drug, but it does not work instantly as we sometimes assume. Taking time is important and, as our governments quite rightly, rack up the pressure to do more procedures, more quickly, we need to think about the comfort of our patients. Unpleasant memories imprint themselves every bit as much as sunlight and butterscotch.

"Taking time is important and, as our governments quite rightly, rack up the pressure to do more procedures, more quickly, we need to think about the comfort of our patients"

Our health is something that we need to think about at all stages of our lives. "You don't know what you've got till it's gone". Fortunately, I still appear to have mine.

To quote Ms Mitchell again,

"I've looked at life from both sides now"
and it is very educational.

Stay well. Stay sharp. Stay kind.

ALASTAIR MCKINLAY BSG President

REGISTRATION OPENS FOR BSG LIVE 2022

Registration is now live for our Annual Meeting; BSG LIVE, taking place 20th – 23rd June at the ICC, Birmingham. This is the first face-to-face annual meeting in 2 years, make sure you register by 14th April to catch the early bird rate!

ACUTE UPPER GI BLEEDING AUDIT

The 2022 UK wide acute upper gastrointestinal bleed audit is due to commence on 3rd May and data collection will close on 2nd August. Please participate in this pivotal piece of work, register your interest here.

INTRODUCING THE BSG TRAINING STRATEGY 2021-2024

The Training Strategy 2021-24 provides members with an introduction from the President and Training Committee Chair, a background of the committee, recent achievements and current challenges, and a summary of the strategic priorities.

MENTORING PROGRAMME RELAUNCHING IN 2022

The BSG will be asking for mentors to register their interest in the coming weeks. Training will be provided in May and the platform will launch in June when mentees will be asked to register their interest.

A MESSAGE FROM THE PRESIDENT ELECT ON TACKLING THE BACKLOG

As I write, the Prime Minister has announced, surprisingly to many in the medical profession, that all Covid restrictions in England are likely to become only guidance rather than legally required in the near future.

The numbers of cases remain very high, though fortunately we have escaped the feared "tsunami" that might have overwhelmed the NHS. Nevertheless, there are huge pressures in emergency departments and acute medical wards. Our members are feeling this pressure too, with the conflicting demands of the hospital "front door" versus the specialist outpatient and elective work we are trained to do well. High levels of stress and burnout have been identified amongst consultant gastroenterologists, and these conflicting demands on our time and attention are contributory. While we all, I think, wish to help our colleagues with the demands of acute medicine during staff shortages due to Covid in the short term, we are rightly concerned to maintain diagnostic, therapeutic, and outpatient services, not only for cancer, but for inflammatory bowel disease and chronic liver disease. Failure to do so will only lead to more acute admissions with complications of these conditions, and "feed the fire" at the front door.

In England, the NHS has published a Delivery Plan for Tackling the Covid-19 Backlog of Elective Care (February 2022). I recommend reading at least the executive summary, but the detail will help in planning care, and perhaps in local negotiations regarding your working patterns.

> **"More than 2 million patients are waiting over 18 weeks for elective care, and more than 300,000 are waiting over a year"**

The plan includes targets to eliminate waits longer than one year for elective care by 2025, and to deliver 95% of diagnostic tests to within 6 weeks in the same timeframe. These timescales give some idea of the mountain to climb to achieve this, and the hard figures show how ambitious this is. More than 2 million patients are waiting over 18 weeks for elective care, and more than 300,000 are waiting over a year. Cancer remains a priority and the "ambition" is to diagnose or rule out cancer in 75% of patients within 28 days by March 2024. Pertinent to my initial comments regarding conflicting work pressures on BSG members, the plan clearly highlights the need to "prioritise diagnosis and treatment" and to have a separation between urgent and elective care.

The plan comes with additional funding and includes innovative ideas, such as Surgical Hubs and Community Diagnostic Centres, but the crux is that there is a finite workforce in the NHS, and it is already under strain. The BSG have recently submitted data to a Health and Social Care Committee scrutinising the government's delivery of cancer services, highlighting the pressures on our workforce and diagnostic services, and giving positive examples of innovative practice that we have initiated or championed. We will continue to support our members and patients through the on-going challenges ahead throughout the United Kingdom.

ANDY VEITCH
President Elect

BSG ENDOSCOPY UPDATE

The road to catch up with the backlog of endoscopic procedures will be long and winding. Demand management through rigorous senior triage to target limited resources to patients with time critical conditions and the most to gain will remain a difficult but essential task.

Surely the time is nigh to embrace 'realistic endoscopy' and adopt new alternative diagnostic and risk stratification tools? There is promising data and more to come that will bolster the evidence base, to allow us to safely reduce the burden of endoscopy and create the room we need for more bowel screening, high risk surveillance, and planned therapy.

Adequate time for high-quality training, education, research, and career development is also vital. I hope you've enjoyed our monthly webinars which have proven very successful, especially the "clinical controversies" series and I'm grateful to Srisha Hebbar for his hard work in developing these. Members can also watch them on catch up – my thanks go to the superb faculty of speakers that have covered a broad range of fascinating topics. Webinars will pause after March as we prepare for the annual meeting in Birmingham in June. I do hope as many as possible will attend in person: remote conferencing has many benefits, but it's also important we meet, as face-to-face discussion, networking, and socialising are essential ingredients of our careers and lie at the heart of what makes the BSG such a successful and friendly organisation. We have a fantastic programme including live endoscopy from Leeds, the return of Endo Village, and we welcome Professor Evelien Dekker as our Foundation lecturer and a host of expert speakers during sessions on difficult upper GI bleeding, surveillance of high-risk conditions (warning - genetics for endoscopists!), as well as a joint session with the IBD section. There will also be the Hopkins prize lecture and oral abstract presentations.

We've had productive discussions with the GMC about the importance of personalised consent and proportionality post Montgomery. Simon Everett, who produced our consent guideline in 2016, has kindly agreed to update this and members should use our guidance in conjunction with that of the GMC, published in 2020.

As part of the ongoing EQIP programme, we are preparing a comprehensive audit of ERCP practice in the UK to inform and embed important KPIs into practice, so watch out for this and, while I appreciate the burden of taking part in audits and surveys, please do contribute to this one when it comes out later in 2022. Other ongoing important EQIP projects include excellent workshops for clinical and nurse endoscopists, led by Sanchoy Sarkar, GI bleeding therapy workshops, led by Mo Thoufeeq, and imminent guidance on training in EUS.

It's important that, where local capacity allows, endoscopy clinical trials and research studies resume after being paused early in the pandemic. The Endoscopy CRG has been highly productive under the leadership of Colin Rees, and I thank him for his enthusiasm and drive over the years as he demits this role and hands over to Pradeep Bhandari. I'm sure Pradeep will continue in the same vein, and I'd encourage everyone to consider taking part in ongoing endoscopic research studies. Finally, progress on our new sedation guideline has been good and my thanks go to Reena Sidhu for her tireless work as it nears completion.

Pace yourselves for the long and winding road ahead and conserve some energy for a fabulous time at the Annual Meeting – I look forward to saying hello to as many of you as possible (and also farewell, as I will be handing over to John Morris as our incoming VP Endoscopy).

IAN PENMAN BSG VP Endoscopy

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OCTASA 400mg, 800mg & 1600mg Modified Release Tablets (mesalazine) - Prescribing Information

Presentation: Modified Release tablets containing 400mg, 800mg or 1600mg mesalazine. **Indications:** All strengths: *Ulcerative Colitis* - Treatment of mild to moderate acute exacerbations. Maintenance of remission. 400mg & 800mg only: *Crohn's ileocolitis* - Maintenance of remission. **Dosage and administration:** *400mg & 800mg tablets – Adults:* Mild acute disease: 2.4g once daily or in divided doses, with concomitant steroid therapy where indicated. Moderate acute disease: 2.4g – 4.8g daily. 2.4g may be taken once daily or in divided doses, higher doses should be taken in divided doses. Maintenance therapy: 1.2g – 2.4g once daily or in divided doses. *1600mg tablets – Adults:* Acute exacerbations: up to 4.8g, once daily or in divided doses. Maintenance: 1600mg daily. Tablets must be swallowed whole. *Elderly:* 400mg & 800mg - normal adult dose may be used unless liver or renal function is severely impaired. 1600mg - no studies in elderly patients have been conducted. *Children:* 400mg & 800mg - limited documentation of efficacy in children >6 years old. Dose to be determined individually. Generally recommended that half the adult dose may be given to children up to a body weight of 40 kg; and the normal adult dose to those above 40 kg. 1600mg – safety and efficacy not established in children. **Contra-indications:** Hypersensitivity to salicylates, mesalazine or any of the excipients, severe impairment of hepatic or renal function (GFR less than 30 ml/min/1.73m^2). **Warnings and Precautions:** Urinary status (dip sticks) should be determined prior to and during treatment, at discretion of treating physician. Caution in patients with raised serum creatinine or proteinuria. Stop treatment immediately if renal impairment is evident. Cases of nephrolithiasis have been reported with mesalazine treatment. Ensure adequate fluid intake during treatment. Severe cutaneous adverse reactions including Stevens-Johnson Syndrome and toxic epidermal necrolysis have been reported. Stop treatment immediately if signs and symptoms of severe skin reactions are seen. Haematological investigations are recommended prior to and during treatment, at discretion of treating physician. Stop treatment immediately if blood dyscrasias are suspected or evident. Caution in patients with impaired hepatic function. Liver function should be determined prior to and during treatment, at the discretion of the treating physician. Do not use in patients with previous mesalazine-induced cardiac hypersensitivity and use caution in patients with previous myo- or pericarditis of allergic background. Monitor patients with pulmonary disease, in particular asthma, very carefully. In patients with a history of adverse drug reactions to sulphasalazine, discontinue immediately if acute intolerance reactions occur (e.g. abdominal cramps, acute abdominal pain, fever, severe headache and rash). Use with caution in patients with gastric or duodenal ulcers. Intact 400mg & 800mg tablets in the stool may be largely empty shells. If this occurs repeatedly patients should consult their physician. Use with caution in the elderly, subject to patients having normal or non-severely impaired renal and liver function. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption, should not take the 400mg or 800mg tablets. **Interactions:** No interaction studies have been performed. May decrease the anticoagulant activity of warfarin. Caution when used with known nephrotoxic agents such as NSAIDs, methotrexate and azathioprine. May increase the myelosuppressive effects of azathioprine, 6-mercaptopurine or thioguanine. Monitoring of blood cell counts is recommended if these are used concomitantly. **Fertility, pregnancy and lactation:** Only to be used during pregnancy and lactation when the potential benefit outweighs the possible risk. No effects on fertility have been observed. **Adverse reactions:** *Common:* dyspepsia, rash. *Uncommon:* eosinophilia (as part of an allergic reaction), paraesthesia, urticaria, pruritus, pyrexia, chest pain. *Rare:* headache, dizziness, myocarditis, pericarditis, abdominal pain, diarrhoea, flatulence, nausea, vomiting, photosensitivity. *Very rare:* altered blood counts (aplastic anemia, agranulocytosis, pancytopenia, neutropenia, leucopenia, thrombocytopenia), blood dyscrasia, hypersensitivity reactions (such as allergic exanthema, drug fever, lupus erythematosus syndrome, pancolitis), peripheral neuropathy, allergic and fibrotic lung reactions (including dyspnoea, cough, bronchospasm, alveolitis, pulmonary eosinophilia, lung infiltration, pneumonitis), interstitial pneumonia, eosinophilic pneumonia, lung disorder, acute pancreatitis, changes in liver function parameters (increase in transaminases and cholestasis parameters), hepatitis, cholestatic hepatitis, alopecia, myalgia, arthralgia, impairment of renal function including acute and chronic interstitial nephritis and renal insufficiency, renal failure which may be reversible on withdrawal, nephrotic syndrome, oligospermia (reversible). *Not known:* Stevens-Johnson Syndrome, toxic epidermal necrolysis, pleurisy, lupus-like syndrome with pericarditis and pleuropericarditis as prominent symptoms as well as rash and arthralgia, nephrolithiasis, intolerance to mesalazine with C-reactive protein increased and/or exacerbation of symptoms of underlying disease, blood creatinine increased, weight decreased, creatinine clearance decreased, amylase increased, red blood cell sedimentation rate increased, lipase increased, BUN increased. Consult the Summary of Product Characteristics in relation to other adverse reactions. **Marketing Authorisation Numbers, Package Quantities and basic NHS price:** 400mg - PL36633/0002; packs of 90 tablets (£16.58) and 120 tablets (£22.10). 800mg - PL36633/0001; packs of 90 tablets (£40.38) and 180 tablets (£80.75). 1600mg – PL36633/0009; packs of 30 tablets (£30.08). **Legal category:** POM. **Marketing Authorisation Holder:** Tillotts Pharma UK Ltd, The Larbourne Suite, The Stables, Wellingore Hall, Wellingore, Lincolnshire, LN5 0HX, UK. Octasa is a trademark. Further Information is available from the Marketing Authorisation Holder. Date of preparation of PI: March 2021

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OCTASA 1g Suppositories (mesalazine) - Prescribing Information **Presentation:** Suppository containing 1g mesalazine. **Indications:** Treatment of acute mild to moderate ulcerative proctitis. Maintenance of remission of ulcerative proctitis **Dosage and administration:** *Adults and older people:* Acute treatment - one Octasa 1 g Suppository once daily (equivalent to 1 g mesalazine daily) inserted into the rectum. Maintenance treatment - one Octasa 1 g Suppository once daily (equivalent to 1 g mesalazine daily) inserted into the rectum. *Children:* Limited experience and data for use in children. *Method of administration:* for rectal use, preferably at bedtime. Duration of use to be determined by the physician. **Contra-indications:** Hypersensitivity to salicylates or any of the excipients, severe impairment of hepatic or renal function. **Warnings and Precautions:** Blood tests and urinary status (dip sticks) should be determined prior to and during treatment, at discretion of treating physician. Caution in patients with impaired hepatic function. Do not use in patients with impaired renal function. Consider renal toxicity if renal function deteriorates during treatment. Cases of nephrolithiasis have been reported with mesalazine treatment. Ensure adequate fluid intake during treatment. Monitor patients with pulmonary disease, in particular asthma, very carefully. Patients with a history of adverse drug reactions to sulphasalazine should be kept under close medical surveillance on commencement of therapy, discontinue immediately if acute intolerance reactions occur (e.g. abdominal cramps, acute abdominal pain, fever, severe headache and rash). Severe cutaneous adverse reactions including Stevens-Johnson Syndrome and toxic epidermal necrolysis have been reported. Stop treatment immediately if signs and symptoms of severe skin reactions are seen. **Interactions:** No interaction studies have been performed. May increase the myelosuppressive effects of azathioprine, 6-mercaptopurine or thioguanine. May decrease the anticoagulant activity of warfarin. **Fertility, pregnancy and lactation:** Only to be used during pregnancy and lactation when the potential benefit outweighs the possible risk. No effects on fertility have been observed. **Adverse reactions:** *Rare:* Headache, dizziness, myocarditis, pericarditis, abdominal pain, diarrhoea, flatulence, nausea, vomiting, constipation, photosensitivity, *Very rare:* Altered blood counts (aplastic anaemia, agranulocytosis, pancytopenia, neutropenia, leukopenia, thrombocytopenia), peripheral neuropathy, allergic and fibrotic lung reactions (including dyspnoea, cough, bronchospasm, alveolitis, pulmonary eosinophilia, lung infiltration, pneumonitis), acute pancreatitis, impairment of renal function including acute and chronic interstitial nephritis and renal insufficiency, alopecia, myalgia, arthralgia, hypersensitivity reactions (such as allergic exanthema, drug fever, lupus erythematosus syndrome, pancolitis), changes in liver function parameters (increase in transaminases and parameters of cholestasis), hepatitis, cholestatic hepatitis, oligospermia (reversible). Consult the Summary of Product Characteristics in relation to other adverse reactions. **Marketing Authorisation Numbers, Package Quantities and basic NHS price:** PL36633/0011; packs of 10 suppositories (£9.87) and 30 suppositories (£29.62). **Legal category:** POM. **Marketing Authorisation Holder:** Tillotts Pharma UK Ltd, The Larbourne Suite, The Stables, Wellingore Hall, Wellingore, Lincolnshire, LN5 0HX, UK. Octasa is a trademark. Further Information is available from the Marketing Authorisation Holder. Date of preparation of PI: February 2021

Adverse events should be reported.
Reporting forms and information can be found at https://yellowcard.mhra.gov.uk. Adverse events should also be reported to Tillotts Pharma UK Ltd. (address as above) Tel: 01522 813500.

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Date of preparation: April 2021. PU-00464.

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THE SHAPE OF GASTROENTEROLOGY TRAINING IN 2022

All those involved in medical education will be acutely aware of the unprecedented challenges that the community has been through recently.

Covid has hit gastroenterologists in training particularly hard with first the collapse of endoscopy training, and now a recovery hampered by record service pressures and the continued need to cover Covid rotas. The virtual outpatient clinic comes with a need to understand how best to train in and assess performance at this new skill. At the same time, both junior and senior gastroenterologists are experiencing the cumulative effects of two years of upheaval with levels of burn out higher than other specialties.

As this happens, we are about to step into a new Shape of Training, with a revamped curriculum and the contraction of training time from five to four years. It could be the worst possible time to contemplate such a move, but if Covid has taught us anything, it is that we are perfectly capable of accomplishing meaningful change in a world of limited resources. The new curriculum offers real improvements in how we train and assess the gastroenterologists of tomorrow. The pathway to hepatology subspecialisation is much clearer with two defined years of subspecialty training after an initial two generic years. For the first time, colonoscopy will be mandated for luminal gastroenterologists permitting leverage to protect endoscopy training. Annual appraisal will stop being a long list of symptoms and conditions to be ticked off in a kind of medical stamp collecting to a few "Competences in Practice" (CiP). These high-level descriptors are simple statements summarising the necessary skills of a gastroenterologist, including "managing care of gastroenterology and hepatology patients in an outpatient setting", or the "ability to practice upper GI endoscopy". Supervisors will be asked to assign entrustment decisions with the expectation that trainees will be able to undertake each CiP independently to attain CCT.

Another exciting opportunity progressing with almost indecent haste are Endoscopy Academies. Seven English superregional Academies have been set up to provide oversight of multi-professional training with similar initiatives in the devolved nations. This is the first centralised opportunity to match training to service needs. The Academies have also been tasked with providing accelerated or immersive training that should mitigate the reduction in training time.

The BSG has been and will continue to be an important voice in developing and improving the quality of gastroenterology training. As an independent charity with a broad membership, we are able to influence national stakeholders in postgraduate education. The BSG Training Committee will be looking to support the wider community as the new training landscape evolves, and ensure that we continue to produce a skilled consultant workforce capable of delivering the best possible standards of care for our patients of the future.

MATT COWAN Training Committee Chair

BSG 2022 ELECTIONS LAUNCH SOON

Trainee Elections will run first over the course of March and April, with the Main Elections running through April and May, with results announced in June. Keep an eye out for more information on available roles, coming soon!

CATCH UP ON WEBINARS ON DEMAND

Check out our new video hub for BSG webinars. As a member, you can access replays of our previous virtual events, alongside supporting documents and resources.

BSG ENDOSCOPY QUALITY IMPROVEMENT PROGRAMME UPDATE

The BSG Endoscopy Quality Improvement Programme seeks to support endoscopists in improving their practice. A number of national and regional programmes have been developed including mentoring and upskilling programmes and production of endoscopy standards where they were not available.

As the BSG representative for the North-West EQIP programme, Dr Sanchoy Sarkar developed a study day for clinical/nurse endoscopists. Within the Mersey School of Endoscopy, with help from senior clinical nurse endoscopists and specialist consultant endoscopists, the team designed an interactive course called 'Give Us a CLUE' update, where CLUE was an acronym for Clinical Lower & Upper Endoscopists.

The course was established as a 1-day event to cover both upper and lower GI topics with course objectives to improve lesion recognition & characterisation, to help improve KPIs, to discuss common dilemmas facing clinical endoscopists, and updates on latest best practice. The initial event was a face-to-face event pre-covid (September 2019) for the North-West Clinical Endoscopists supported by the BSG and Industry (Boston). The course was designed to be interactive with delegate voting devices. 52 delegates attended and the course was extremely well received with excellent feedback.

On 12th January 2022, a modified virtual course was delivered by ZOOM to allow national coverage for the BSG EQIP programme. On this occasion, 42 delegates participated using an interactive voting app to ensure maximum interaction with the delegates. This allowed delegates to vote on clinical scenarios from a range of options to keep them engaged. The feedback was again excellent with 5 out of 5 stars for each session and overwhelming positive narrative from all delegates.

BSG EQIP are extremely grateful to Sanchoy and the team (including Howard Smart, Paul O'Toole, Scott Hambleton, Carol Pierpoint, and Ian Jevons) for delivering this important Quality Improvement Initiative. Further courses will be delivered subject to demand.

BSG EQIP continues to develop new ways to improve the quality of endoscopy. Current developments include producing videos to assist with difficult elements of colonoscopy technique, and a forthcoming ERCP survey to understand how ERCP quality can be improved.

If you would like to find out more about BSG EQIP, please email colin.rees@newcastle.

JOIN US AT THE FIRST FACE-TO-FACE ANNUAL MEETING IN TWO YEARS!

It is with great pleasure that we invite you to join the BSG for our Annual Meeting; BSG LIVE at the ICC, Birmingham on the 20th – 23rd of June 2022.

After over two years without a face-to-face meeting, we are excited to be able to bring the gastroenterology and hepatology community to Birmingham for an in-person event so that together, we can look forward to the future of our speciality. The aims of this meeting are:

- To educate our members on state-of-the-art investigation and management, as well as new developments in all fields of gastroenterology and hepatology
- To provide high quality CPD for our members
- To allow researchers in all gastroenterology-related fields to present, share, and discuss their findings
- To encourage and enable collaborative working and research in all fields of gastroenterology and hepatology

We are bringing back popular features such as the Monday Masterclass, Endoscopy Village, and Meet the Experts sessions. A number of exciting new initiatives such as a Wellbeing zone and a dedicated space for Digital Health and Innovation will also be launched. In addition to our Plenary and section-based sessions covering the breadth of our speciality, we will also run several major new symposia, including Sustainability in Gastroenterology, Mentoring, and "How to avoid Burnout".

After two years like no other, we are delighted to welcome you to BSG LIVE next year and hope you will join us as we come together to make this the very best BSG Meeting yet.

PROF ADRIAN STANLEY
BSG Senior Secretary

We're proud to have members all over the world with a huge range of experiences and backgrounds. Our "meet our members" initiative interviews them about their work and what they value about their membership. Take part here.

BRITISH SOCIETY OF GASTROENTEROLOGY

The BSG is an organisation focused on the promotion of gastroenterology and hepatology within the United Kingdom. It has over three thousand members drawn from the ranks of physicians, surgeons, pathologists, radiologists, scientists, nurses, dietitians, and others interested in the field.

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