Paediatric Organisational Audit

Health Information Coding

Responses for this section require data for the period between 1/12/13 - 30/11/14.

[Infliximab was introduced for the treatment of ulcerative colitis under the PBS arrangements on 1st December 2014]

Q1.1 to Q1.17 require ICD-10 coding data that should be sourced from your health information staff using the guide 'Health Information Data Request' available in the resources tab on the homepage

1.1. For the specified time period (above) How many multi-day separations (LOS>24 hours) total were there at your hospital for all diagnoses (not limited to IBD)?

Crohn's disease

1.2. How many multi-day separations (LOS>24 hours) were there for Crohn's disease (ICD-10 codes K50.0 Crohn's disease of small intestine,K50.1 Crohn's disease of large intestine, K50.8 Other Crohn's disease, K50.9 Crohn's disease, unspecified)?

1.3. What was the average length of stay for the multi-day Crohn's disease separations? (days)

1.4. How many were unplanned admissions?

1.5. How many were admitted for an elective surgical procedure?

1.6. How many of the multi-day Crohn's disease episodes were unplanned readmissions i.e were discharged less than 28 days previously with no intention to readmit?

1.7. How many of the multi-day Crohn's disease patients died during the admission?

1.8 How many of the multiday Crohn's disease episodes had procedure codes for:

a. 32060-00: Restorative proctectomy

b. 32051-00/01 Total proctocolectomy with ileo-anal anastomosis (including formation of temporary ileostomy)

c. 32030-00/01 Rectosigmoidectomy with formation of stoma stoma -Hartmann's procedure

d. 32039-00: Abdominoperineal proctectomy (APR)

e. 32024-00: High anterior resection of rectum

f. 32025-00: Low anterior resection of rectum

g. 32026-00: Ultra low anterior resection of rectum

h. 32047-00: Perineal proctectomy

i. 32006-00 to -03 Left hemicolectomy with anastomosis (incl. formation of stoma)

j. 32003-00/02 Limited excision of large intestine with anastomosis

k. 32000-00/02 Limited excision of large intestine with formation of stoma

l. 32003-01/03 Right hemicolectomy with anastomosis

m. 32000-01/03 Right hemicolectomy with formation of stoma

n. 32005-0: Extended right hemicolectomy with anastomosis

o. 32004-0: Extended right hemicolectomy with formation of stoma

p. 32009-00/01: Total colectomy with ileostomy

q. 32012-00/01: Total colectomy with ileorectal anastomosis

r. 30564: Strictureplasty of small intestine

s. 30565: Resection of small intestine with formation of stoma

t. 30566: Resection of small intestine with anastomosis

1.9. How many multi-day separations (LOS>24 hours) were there for people with an admission age <18 years at their admission date for Crohn's disease?

Ulcerative colitis (including indeterminate colitis)

1.10. How many multi-day separations (LOS>24 hours) were there for ulcerative colitis (ICD-10 codes K51.0 Ulcerative (chronic) pancolitis, K51.2 Ulcerative (chronic) proctitis, K51.3Ulcerative (chronic) rectosigmoiditis, K51.4 Inflammatory polyps, K51.5 Left hemicolitis, K51.8 Other ulcerative colitis K51.9 Ulcerative colitis, unspecified, K52.3 indeterminate colitis)?

1.11. What was the average length of stay for the multi-day ulcerative colitis separations? (days)

1.12. How many were unplanned admissions?

1.13. How many were admitted for an elective surgical procedure?

1.14. How many of the multi-day ulcerative colitis episodes were unplanned readmissions i.e were discharged less than 28 days previously with no intention to readmit?

1.15. How many of the multi-day ulcerative colitis patients died during the admission?

1.16 How many of the multiday ulcerative colitis episodes had procedure codes for:

a. 32060-00 : Restorative proctectomy

b. 32051-00/01 Total proctocolectomy with ileo-anal anastomosis (including formation of temporary ileostomy)

c. 32030-00/01 Rectosigmoidectomy with formation of stoma - Hartmann’s Procedure

d. 32039-00: Abdominoperineal proctectomy (APR)

e. 32024-00: High anterior resection of rectum

f. 32025-00: Low anterior resection of rectum

g. 32026-00: Ultra low anterior resection of rectum

h. 32047-00: Perineal proctectomy

i. 32006-00 to -03 Left hemicolectomy with anastomosis (incl. formation of stoma)

j. 32003-00/02 Limited excision of large intestine with anastomosis

k. 32000-00/02 Limited excision of large intestine with formation of stoma

l. 32003-01/03: Right hemicolectomy with anastomosis

m. 32000-01/03: Right hemicolectomy with formation of stoma

n. 32005-0: Extended right hemicolectomy with anastomosis

o. 32004-0: Extended right hemicolectomy with formation of stoma

p. 32009-00/01: Total colectomy with ileostomy

q. 32012-00/01: Total colectomy with ileorectal anastomosis

r. 30564: Strictureplasty of small intestine

s. 30565: Resection of small intestine with formation of stoma

t. 30566: Resection of small intestine with anastomosis

1.17. How many multi-day separations (LOS>24 hours) were there for people with an admission age <18 years at their admission date for ulcerative colitis?

Both Crohn's disease and Ulcerative colitis (including indeterminate colitis)

1.18. For the specified time period how many IBD patients did your service manage i.e. known to your service through inpatient admission, outpatient service or emergency department ?

a. Is this figure: an estimate or from a database/register? ☐Estimate ☐Database

1.19. How many IBD patients were seen in outpatients or associated clinics?

a. Is this figure: an estimate or from a database/register? ☐Estimate ☐Database

1.20. How many new IBD patients has your centre seen for the specified period?

a. Is this figure: an estimate or from a database/register? Estimate Database

1.21. Up to what age are patients cared for in your service?

Demographics

Responses for all remaining sections should be for a snapshot at 30/11/14

2.1. Does your hospital have a Gastroenterology Clinic? Yes No

2.2. Does your hospital have a specific IBD Clinic? Yes No

2.3. Do surgeons perform ileo-anal pouch surgery on site? Yes No

2.4. Were the majority of these ileo-anal pouch operations carried out by a paediatric surgeon in conjunction with an adult colorectal surgeon? Yes No

2.5. How many FTE paediatric gastroenterologists are there on site?

2.6. How many general paediatricians with an interest in gastroenterology are there on site?

2.7. How many paediatric gastroenterologists fractional appointment/VMO/substantive appointment = 0.5 FTE or above.

2.8. How many FTE paediatric gastroenterologists in the unit have a clinical focus on/responsibility for IBD?

2.9. How many FTE paediatric colorectal surgeons are there on site?

2.10. How many FTE paediatric IBD nurse specialists (excluding clinical trial nurses) are there on site?

2.11. How many FTE paediatric IBD nurse specialists have ongoing secure funded positions

2.12. How many FTE paediatric clinical trial nurses are there on site?

2.13. How many FTE paediatric stoma nurses are there on site?

2.14. How many FTE paediatric dietitians or dietitians with suitable paediatric experience are allocated to gastroenterology?

2.15. How many FTE administrators are attached to the IBD team?

2.16. What percentage of your patients with Crohn's disease were on infliximab?

2.17. What percentage of your patients with ulcerative colitis were on infliximab?

2.18. What percentage of your patients with IBD-unspecified were on infliximab?

2.19. What percentage of your patients with Crohn's disease were on adalimumab?

2.20. What percentage of your patients with ulcerative colitis were on adalimumab?

2.21. What percentage of your patients with IBD-unspecified were on adalimumab?

2.22. What percentage of your patients with Crohn's disease were on immunomodulators such as azathioprine, mercaptopurine, thioguanine, methotrexate, mycophenolate, sirolimus, cyclosporine, tacrolimus

2.23. What percentage of your patients with ulcerative colitis were on immunomodulators?

2.24. What percentage of your patients with IBD-unspecified were on immunomodulators?

2.24.1. Are the figures in 2.16 to 2.24 an estimate or from a database/register? EstimateDatabase

Clinical Quality

The IBD Team

3.1. There is a defined access to a consultant paediatric gastroenterologist Yes No

3.2. The IBD Service has a named clinical lead who is a paediatric gastroenterologist Yes No

3.3. There is a clear pathway for referring IBD patients to a paediatric rheumatologist Yes No

3.4. The IBD Service is supported by a radiologist with a special interest in paediatric gastroenterology Yes No

3.5. The IBD Service is supported by a named pharmacist with a special interest in IBD or paediatric gastroenterology Yes No

3.6. There is defined access to a named paediatric ophthalmologist Yes No

3.7. The IBD Service is supported by a histopathologist with an interest in paediatric gastroenterology Yes No

Mental Health Services

3.8. The IBD Service includes a paediatric mental health clinician Yes No

3.9. Paediatric patients with IBD can be referred to appropriate mental health services Yes No

3.10. Families and carers of paediatric patients with IBD can be referred to appropriate mental health services Yes No

3.11. Information is available for IBD patients who wish to access counselling support, e.g. via GP patient care plans Yes No

Sexual and Reproductive Health

3.12. Age appropriate written information about IBD in pregnancy and its effects on fertility is available for patients Yes No

3.13. Patients are given age-appropriate advice, when required, on issues regarding sexuality and body image. Teams can refer for specialist support locally as appropriate Yes No

3.14. There is an agreed clinical pathway between adolescent gynaecology services and IBD Services for shared care Yes No

Multidisciplinary Working

3.15. There is a multidisciplinary meeting in which complex IBD cases can be discussed
Yes No

3.16. How often do the multidisciplinary meetings occur? (evey x weeks)

3.17. Decisions from the multidisciplinary team are documented in the patient notes and fed back to the patient Yes No

3.18. There is an attendance at multidisciplinary team meetings by a paediatric gastroenterology dietitian AlwaysSometimesNever

3.19. There is an attendance at multidisciplinary team meetings by a paediatric pharmacist

AlwaysSometimesNever

3.20. There is an attendance at multidisciplinary team meetings by an administrator

AlwaysSometimesNever

3.21. There are joint or parallel outpatient clinics for patients requiring joint medical and surgical care, which take place YesNo

3.22. How often do the joint or parallel clinics occur? (Every X weeks)

Referral of suspected IBD patients

3.23. Suspected IBD patients can be referred to either paediatric gastroenterology, paediatric IBD or paediatric surgical clinics Yes No

3.24. There is an agreed referral pathway for urgent paediatric out-patients between GPs and hospitals Yes No

3.25. All urgent referrals are seen within 4 weeks or more rapidly if clinically necessary

 Yes No

3.26. Guidance has been developed to help GPs identify and refer symptomatic patients in whom IBD is suspected and when a review of diagnosis of patients with unresponsive, atypical or troublesome abdominal symptoms should occur Yes No

Access to nutritional support and therapy

3.27. IBD patients can be referred to a paediatric dietitian experienced in the dietary management of IBD Yes, public service Yes, private service No

3.28. Exclusive enteral nutrition as a primary treatment is available to patients with Crohn's disease, both as inpatients and outpatients Yes No

3.29. Information given to all new IBD patients includes nutritional advice Yes No

3.30. Regular assessment (minimum 4 monthly) occurs to ensure that nutritional intake is appropriate to facilitate normal growth and pubertal development Yes No

3.31. Home enteral and, where applicable, home parenteral nutrition provision and monitoring is always available to patients either locally or by a regional centre Yes No

Arrangements for use of immunosuppressives and biologicals

3.32. The hospital has a policy / protocol for screening for tuberculosis, hepatitis B and other relevant infections. Yes No

3.33. A vaccination program for infections such as hepatitis B and Varicella zoster is considered before starting biological therapies. Yes No

3.34. All patients and, when relevant, parents are counselled about the risk of malignancy and sepsis prior to starting immunosuppressive therapy. Yes No

3.35. There are local protocols for the administration of biological therapies Yes No

3.36. There is a process to ensure that patients on immunosuppressive treatment have their white blood count measured at least 3 monthly. Yes No

3.37. Clinicians involved in the management of patients on immunosuppressives have access to a pharmacist with specialist knowledge/interest. Yes No

3.38. Local protocols for the administration of biological therapies include pre-treatment, actions for infusion reactions and accelerated infusions Yes No

3.39. A policy/protocol is available to guide the response of the IBD Service staff if white cell counts are low or other blood test abnormalities are observed; a named individual acts on abnormal results and communicates with GPs and patients, if appropriate Yes No

3.40. Patients on immunosuppressive therapy have a choice as to whether their treatment is monitored by the hospital or in the community □ Yes □ No

3.41. Patients receiving biological therapy are reviewed at least 3 monthly (either directly or by email/telephone) to monitor efficacy and adverse effects □ Yes □ No

3.42. 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 □ Yes □ No

3.43. 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 □ Yes □ No

3.44. IBD patients on both immunomodulator and biological therapy are subject to regular audit for outcome monitoring □ Yes □ No

Surgery for IBD

3.45. There is a formal regular governance process to review surgical morbidity and mortality within the hospital/health network, including review or audit of post-operative complications □ Yes □ No

3.46. There are facilities and trained surgeons to offer laparoscopic /laparoscopically-assisted surgery where possible and if appropriate □ Yes □ No

3.47. Complex surgical procedures are undertaken following joint discussion between medical/surgical and other multidisciplinary team members in a formal IBD Multidisciplinary Team Meeting or joint outpatient clinic. □ Yes □ No

3.48. Patients being considered for pouch surgery are referred for expert pathological assessment where diagnostic uncertainty exists. □ Yes □ No

3.49. Anaesthesia for IBD surgery is carried out by accredited paediatric anaesthetists □ Yes □ No

3.50. One consultant surgeon with dedicated Paediatric IBD experience is the nominated lead for IBD surgery within the hospital/network. They support decision-making and/or surgery for complex IBD cases □ Yes □ No

3.51. Pouch failure (and salvage) is managed in, or routinely referred to an agreed regional specialist unit, with appropriate expertise in re-operative pouch surgery YesNo ?

3.52. There is annual review of IBD surgical service with review of activity, mortality and morbidity. □ Yes □ No

Inpatient facilities

3.53. There is an identifiable gastroenterology ward ☐ Yes ☐ No

3.54. There is a paediatric intensive care unit (ICU) and a mixed medical/surgical high dependency unit (HDU). ☐ Yes ☐ No

3.55. On the main ward that gastroenterology patients are managed, there is at least one toilet per 3 beds. ☐ Yes ☐ No

3.56. Gastroenterology and colorectal surgical facilities are on the same site ☐ Yes ☐ No

3.57. IBD or suspected IBD patients are usually triaged to the gastroenterology ward on admission ☐ Yes ☐ No

3.58. The toilets have floor to ceiling partitions, full height doors and good ventilation ☐ Yes ☐ No

Access to diagnostic services

3.59. There is a 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 YesNoUncertain

3.60. For inpatients there is access to on-site ultrasound within 24 hours where required ☐ Yes ☐ No

3.61. For inpatients there is access to on-site CT within 24 hours where required in a child friendly and suitably equipped environment ☐ Yes ☐ No

3.62. For inpatients there is access to on-site MR within 24 hours where required a child friendly and suitably equipped environment ☐ Yes ☐ No

3.63. It is routine practice for patients with acute severe ulcerative colitis to have a plain abdominal x-ray on admission ☐ Yes ☐ No

3.64. X-ray reports of presence of toxic megacolon(transverse>4cm in children under10 years and >6cm in children over 10 years) are documented in the notes or on radiology report. Documentation is by the most senior member of the team who comments on initial X-ray ☐ Yes ☐ No

3.65. Paediatric patients undergo endoscopy in an age-appropriate environment, carried out by someone with training or extensive experience in paediatric endoscopy and appropriate training recognized by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy (CCRTGE) ☐ Yes ☐ No

3.66. There is a process for urgent access to endoscopy, so that patients admitted with relapse can be scoped within 72 hours of admission ☐ Yes ☐ No

3.67. All histological reports are available within 5 working days ☐ Yes ☐ No

3.68. Urgent histology biopsies can be reported within 2 days Yes No

3.69. When required, drainage of an abscess can be carried out by interventional radiology
 Yes No

3.70. There is outpatient access to ultrasound/CT/MR studies and endoscopic assessment within 4 weeks Yes No

3.71. Small bowel MRI is available as an alternative to CT scans Yes No

3.72. There is a consultant radiologist who primarily reports all paediatric gastrointestinal radiology in the hospital Yes No

3.73. Histology reporting times and outpatient waiting times for CT/MR and endoscopy are audited Yes No

Inpatient Monitoring

3.74. PUCAI (paediatric UC disease activity index score) is used at day 3 and 5 for assessment of patients with acute severe ulcerative colitis Yes No

3.75. The hospital has a policy / protocol that IBD patients have a weight and nutritional risk assessment, such as the STAMP, STRONGkids or PYMS score, on admission to hospital

 Yes No

3.76. The hospital has a policy / protocol that IBD patients who have diarrhoea, have a stool sample sent for standard stool culture and Clostridium difficile toxin on admission

 Yes No

3.77. The hospital has a policy / protocol that IBD patients have a stool chart recorded during hospitalisation Yes No

3.78. The hospital has a policy / protocol for suspected new IBD presentation Yes No

3.79. The hospital has a policy / protocol for flare of ulcerative colitis Yes No

3.80. The hospital has a policy / protocol for flare of Crohn's disease Yes No

3.81. The hospital has a policy / protocol for acute severe ulcerative colitis Yes No

Inpatient care

3.82. There is an acute pain management team available on site Yes No

3.83. Pain scores are routinely included in nursing observations for IBD patients Yes No

3.84. Inpatients have access to an IBD nurse during their admission Yes No

3.85. It is usual practice to refer an inpatient with severe pain (measured by pain scores) to the a cute pain management team Yes No

3.86. There is access to a stoma nurse during hospitalization Yes No

3.87. A named pharmacist with special interest in IBD is available to carry out inpatient drug reviews Yes No

Outpatient care

3.88. All of the following are usually documented for all patients at clinic review: number of liquid stools per day, abdominal pain, weight loss, general well-being, psychological concerns, pubertal growth (Tanner staging) where required and height and weight recorded on appropriate percentile charts. Yes No

3.89. Systems are in place to ensure that all patients currently under hospital review are identified and offered surveillance colonoscopy in accordance with guidelines. Yes No

3.90. Steroid usage is recorded to ensure that patients who have had 3 months or continuous steroid use are identified Yes No

3.91. All children with ulcerative colitis who have had the disease for more than 8 years are formally identified and a surveillance plan made and shared with adult services Yes No

3.92. Bone densitometry is offered routinely to all patients who have received more than 3 months of corticosteroids. Yes No

3.93. 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 (e.g. immunosuppressives, anti-TNF or surgery). Yes No

Transitional care

3.94. There is a transitional care service within the hospital to support young people being transferred from a paediatric service. A coordinator is responsible for the preparation and oversight of such transitional care(eg IBD nurse specialist) Yes No

3.95. Each young person with IBD has an individual transition plan Yes No

3.96. Age-appropriate written and verbal advice is provided on day-to-day management of symptoms and treatment Yes No

3.97. Support and education is provided on lifestyle issues (e.g.sexual health, smoking, alcohol, recreational drug use) in young people with IBD Yes No

3.98. The IBD service has a specific paediatric-to-adult transition policy Yes No

3.99. Staff can refer young people to appropriate mental health services Yes No

3.100. There is a close working relationship with appropriate mental health services in clinics and on the ward ☐ Yes ☐ No

3.101. The IBD service has a joint transition clinic with adult services ☐ Yes ☐ No

Patient Experience

Information on the IBD Service

4.1. Patients and carers are provided with written information regarding how to access IBD services and arrangements for follow up. ☐ Yes ☐ No

4.2. All newly diagnosed patients and carers are given educational material routinely.

☐ Yes ☐ No

4.3. All newly diagnosed patients and carers are offered a 'patient education' session routinely

☐ Yes ☐ No

4.4. Your hospital routinely offers regular education opportunities for all IBD patients and their families, either as individuals or in groups. ☐ Yes ☐ No

4.5. There is clear guidance as to how patients and carers can seek a second opinion if they wish. ☐ Yes ☐ No

Rapid access to specialist service

4.6. There is written information for patients and carers with IBD on whom to contact in the event of a relapse ☐ Yes ☐ No

4.7. Patients and carers have access to contact an IBD specialist nurse or doctor by telephone

☐ Yes ☐ No

4.8. Patients and carers are able to contact an IBD specialist nurse or doctor via an email service ☐ Yes ☐ No

4.9. Patients who contact the service via telephone or email are answered within 48 hours by an IBD specialist nurse or doctor ☐ Yes ☐ No

4.10. Specialist review (face-to-face) for relapsed patients is available

Within 7 working days

8 to 14 working days

Greater than 14 working days

Provision of information and supporting patients to exercise choice between treatments

4.11. Written information about IBD and a range of treatments (e.g. CCA booklets) is available to all patients and carers Yes No

4.12. Written information about IBD and the range of treatments (eg CCA booklets) is provided to patients and carers as part of the consultation to support the patient's decisions.

 Yes No

4.13. There is access to a translator for all face-to-face and telephone contacts between patients and carers and the IBD specialist. Only answer 'yes' if a translator is available for ALL face-to-face and telephone contact. Yes No

4.14. Information is available that is appropriate to the age, understanding and communication needs of patients Yes No

4.15. A selection of written information is available for patients and carers in languages other than English Yes No

4.16. Patients and carers are actively involved in management decisions about care, with a clear structured pathway for the patient to discuss his or her treatment with the gastroenterology, surgical, dietetics and other members of the multidisciplinary team

 Yes No

Supporting patients to exercise choice between care strategies for outpatient management

4.17. Stable patients who are referred back to primary care are given a clear plan about what to do in the event of a flare up Yes No

4.18 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: (select all that apply)

Colorectal cancer surveillance

Renal function

Bone densitometry

None

4.19 Patients are offered a choice of annual review including: (select all that apply)

Hospital clinic

Telephone clinic

Review in primary care

None

4.20. If your service has a referral or communication relationship with another IBD service (either as provider or receiver of specialist advice) describe your communication process eg. email, telephone, video conference, shared data network/patient management system, personal electronic health record or hardcopy patient held file.

Involvement of patients in service improvement

4.21. IBD patients are given the opportunity to provide feedback on their care

 Yes No

4.22. At least one of the following means of assessing patient satisfaction is used:

- An annual survey of a significant number of patients

- IBD service subscribes to patient opinion or similar feedback service

- Comment cards given to randomly sampled outpatients and inpatients

 Yes No

4.23. Patients and carers are involved in service planning and improvement Yes No

4.24. The service has an IBD patient panel or similar patient involvement group through which patients and carers discuss how the service might be improved with health professionals

 Yes No

4.25. 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

 Yes No

Information and support for patient organisations

4.26. Written information is made available to all new patients and carers, providing details of relevant patient organisations Yes No

4.27. All IBD patients and carers are provided with information about their local patient support groups Yes No

4.28. The IBD team circulate information about local support groups regularly e.g Crohn's and Colitis Australia, pouch and ostomy support groups. Yes No

Research, Education and Audit

Register of patients under the care of the IBD service

5.1. The IBD service has a searchable database or registry of adult and paediatric IBD patients
 Yes No

5.2. The database is updated with clinical data about IBD patients receiving hospital care

 Yes No

5.3. The database is updated with patients on biological therapy Yes No

5.4. The database is updated with patients on all immunosuppressives (including biological therapies) Yes No

5.5. The database is updated with clinical data about all patients with a diagnosis of IBD

 Yes No

Participation in audit

5.6. All IBD inpatient deaths are reviewed by the IBD team, an action plan is formulated and action plan implementation is reviewed at least annually Yes No

5.7. 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. Yes No

Training and education

5.8. There are education opportunities focussed on IBD for all medical and nursing staff Yes No

5.9. The IBD team provides IBD training for GPs on an ad hoc basis Yes No

Research

5.10. The IBD service provides access to age appropriate clinical trials Yes No

5.11. How many patients were entered into a clinical trial for UC/CD in the last year?

5.12. Do you collaborate on clinical trials with other sites? Yes No

5.13. All members of service are encouraged to participate in research, which is supported by the service with monetary support and/or flexible working arrangements Yes No

5.13.1. If 'yes' is this externally funded? Yes No

Service development

5.14. An annual review of the IBD Service is carried out Yes No

5.15. The annual review is attended by a multidisciplinary team of relevant professionals and there is a reflection on the Service ☐ Yes ☐ No

5.16. An annual action plan is completed as a result of the review and achievement of the actions is reviewed as part of the organisational Quality Plan. ☐ Yes ☐ No