



Prifysgol Cymru

Y Drindod Dewi Sant

University of Wales

Trinity Saint David

PROGRAMME: MSC PUBLIC HEALTH AND SOCIAL CARE IN PRACTICE

MODULE: COMMUNITY CARE AND MANAGEMENT OF LONG-TERM CONDITIONS

MODULE CODE: LCHS7003

ASSIGNMENT TITLE: COMPONENT 2

INDIVIDUAL PRESENTATION

TOPIC- IRRITABLE BOWEL SYNDROME (IBS)

TARGET GROUP- PRIMARY CARE NURSES

LECTURER- MOHAMMAD KHAN

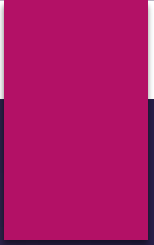
STUDENT NAME: IRENE ANNA PRADEESH

STUDENT ID: 2430629

DEADLINE: 10 DECEMBER 2025, 14:00 (2PM)

IRRITABLE BOWEL SYNDROME



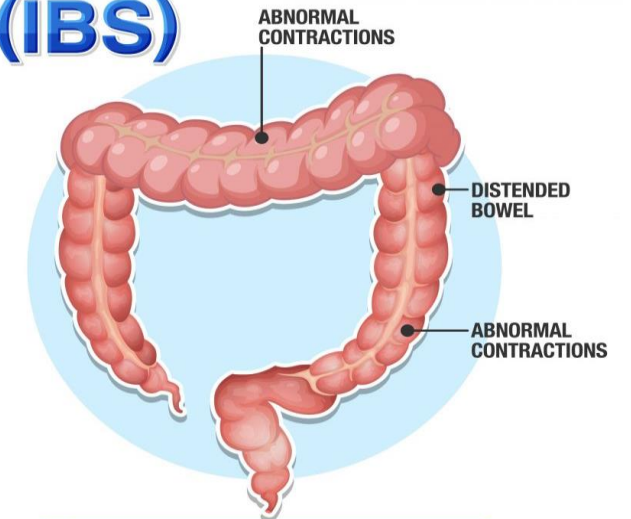


TARGET AUDIENCE-
PRIMARY CARE NURSES

OVERVIEW OF IRRITABLE BOWEL SYNDROME

- ▶ IBS is a chronic gut-brain disorder that presents as recurring abdominal pain associated with changed bowel habit (such as constipation, diarrhea, or a mixture of both). IBS has been regarded as a chronic illness because of fluctuating symptoms, impairment in daily life, and the need for the continuation of lifestyle management and personalised intervention (Drossman & Hasler, 2016; Lacy et al., 2021).
- ▶ IBS is categorized as Disorders of Gut–Brain Interaction (DGBI), laying stress on neurological and psychological elements thereof.
- ▶ It is a chronic relapsing condition requiring long-term lifestyle, dietary, and psychological support.
- ▶ IBS often co-occurs with other functional disorders, enhancing the need for integrated care (Chey et al., 2015). (BING.COM)
- ▶ Symptoms vary greatly among individuals; therefore, management has to be personalised.

IRRITABLE BOWEL SYNDROME (IBS)



○ Irritable Bowel Syndrome (IBS) is a chronic condition characterized by abdominal pain, bloating, and changes in bowel habits, without any underlying structural abnormalities.

(BING.COM)

SUBTYPES

1. IBS-C (Constipation-Predominant)

- ❖ Hard or lumpy stools $\geq 25\%$ of bowel movements
- ❖ Loose or watery stools $< 25\%$
- ❖ They usually manifest as bloating, straining, and less frequent bowel movements.

2. IBS-D (Diarrhea-Predominant)

- ❖ Looseness of stool/watery stools $\geq 25\%$ of bowel movements
- ❖ Hard stools $< 25\%$
- ❖ Presents with urgency, frequent bowel movements with abdominal cramping

3. IBS-M (mixed type)

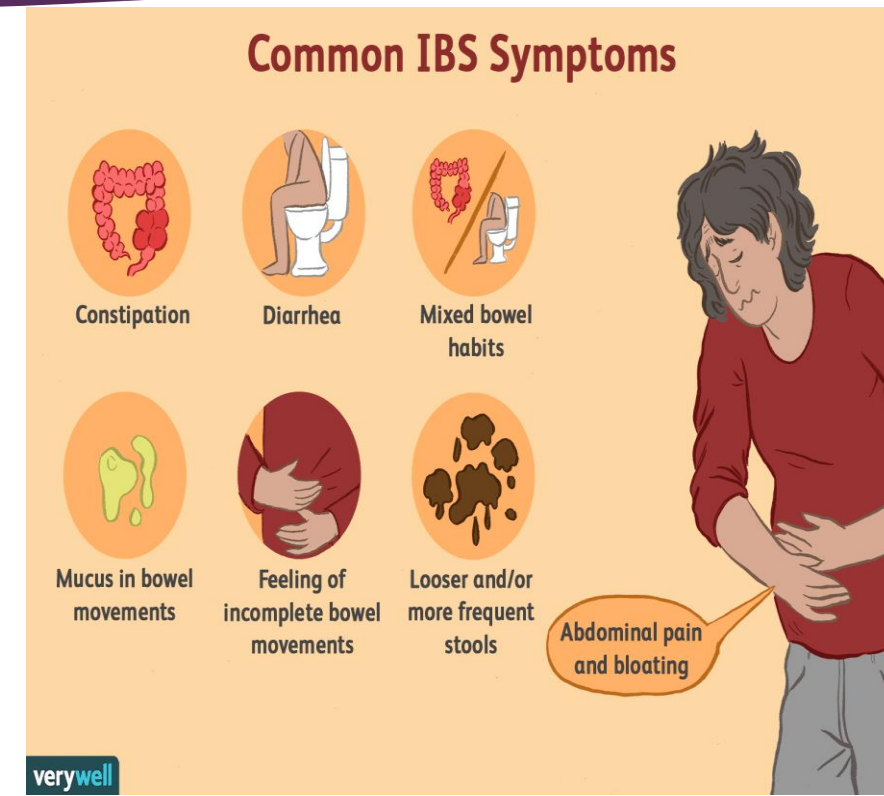
- ❖ Both hard/lumpy stools and loose/watery stools $\geq 25\%$ of bowel movements
- ❖ Symptoms tend to fluctuate between constipation and diarrhea
- ❖ Often associated with increased unpredictability

4. IBS-U (unclassified)

- ❖ Symptoms meet the diagnosis of IBS
- ❖ Stool pattern does not fit IBS-C, IBS-D or IBS-M criteria
- ❖ Less common but clinically important

SYMPTOMS

- ▶ Symptoms associated with IBS usually include abdominal pain, bloating, increased gas, constipation, diarrhea, mucus in stools, and urgency. Symptoms have been classified into IBS-C (constipation-dominant), IBS-D (diarrhea-dominant), IBS-M (mixed type) and IBS-U (unclassified). Symptoms may greatly interfere with eating, working, travelling, and social routines (Harvard Health Publishing (2024) Irritable Bowel Syndrome (IBS)).
- ▶ Symptoms often wax and wane in severity, often worsening during periods of stress or hormonal change (Simrén et al., 2022).
- ▶ The large proportion of individuals with IBS report postprandial discomfort - worse after meals (Chey et al., 2015).
- ▶ Extra-intestinal symptoms that may occur in IBS include complaints of fatigue, back ache and genitourinary discomfort.
- ▶ Symptoms are usually unpredictable in nature and can lead to avoidance behaviours affecting social and work activities (Gracie & Ford, 2017).



(www.verywellhealth.com)

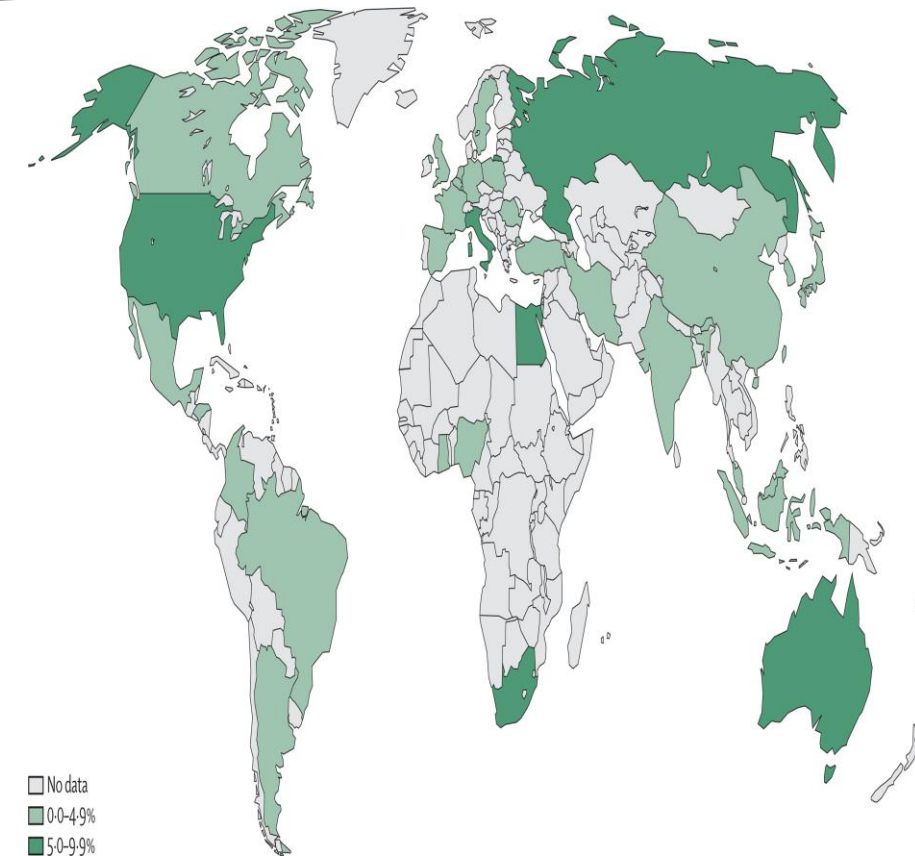
AETIOLOGY OF IBS

- ▶ IBS has a multifactorial origin that involves gut-brain axis dysregulation, abnormalities in intestinal motility, changes in gut microbiota, visceral hypersensitivity, and immune dysfunction. Symptoms may also be aggravated by psychological factors like anxiety, trauma, and chronic stress through increased sensitivity of the gut. (Simrén et al., 2022; Quigley, 2017; Löwe, 2008)
- ▶ Altered serotonin signaling affects gut motility and pain regulation, contributing to IBS pathology. (Spiller & Major, 2016).
- ▶ Food sensitivities to food components, such as fermentable carbohydrates, can be responsible for the development of symptoms caused by rapid fermentation.
- ▶ Previous gastrointestinal infections can cause inflammation and long-lasting changes in gut function.
- ▶ Early life stress and adverse experiences are strongly linked with the development of IBS (Psychological factors).



PREVALENCE OF IBS

- ▶ IBS affects an estimated 10-20% of the population in the UK and about 10% worldwide. Women are more commonly affected, especially between the ages of 20 and 40 years. IBS accounts for about 10% of all GI consultations in UK primary care (NICE, 2021; Barberio, Savarino & Black, 2021; Wong, Palsson & Whitehead, 2018).
- ▶ Prevalence varies according to the different diagnostic criteria but is consistently high across the world.
- ▶ IBS is one of the most common chronic gastrointestinal conditions seen by both GPs and nurses (Wong et al., 2018).
- ▶ Most cases go undiagnosed due to stigma or self-management (Black & Ford, 2020).
- ▶ The burden is disproportionately high in young adult females because of hormonal influences.



(thelancet.com)

ECONOMIC BURDEN

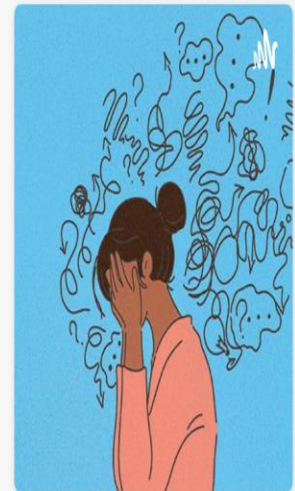
- ▶ A recent UK study estimated the annual direct healthcare cost per person with IBS at £556.65 (for Rome IV IBS) and £474.16 (for Rome III IBS). Extrapolating to the whole UK, this corresponds to a total direct annual healthcare cost of ~£1.27 billion (Rome IV) — up to ~£2.07 billion if Rome III criteria are used.
- ▶ For individuals, cost components include: consultations with healthcare professionals, diagnostic investigations, unplanned hospital attendances, and medications. In Europe (for moderate-to-severe IBS-C), direct cost to healthcare systems has been estimated at €937.1–€2,108.0 per patient per year.
- ▶ IBS makes a major contribution to the direct costs of the NHS through repeated consultations and investigations.
- ▶ Indirect costs due to absenteeism and presenteeism are estimated to surpass direct medical costs (Black & Ford, 2020). Social functioning is often affected, as many patients avoid traveling and eating socially. The psychological toll exacerbates symptoms, making this an anxiety-ridden cycle of declining gut function.



(gettyimages)

SOCIAL BURDEN

- ▶ Some of the social impacts associated with IBS are self-esteem, social participation, relationships, and psychological well-being.
- ▶ IBS patients have often significantly lower health-related quality of life (HR-QoL), and increased time off work compared to non-IBS individuals. One UK study noted that IBS patients had greater annual NHS costs plus more days off work than controls.
- ▶ In European IBS-C study: of employed patients, 21.4–50.8% took sick leave, with mean sick leave between 11.6 and 64.1 days/year, reflecting considerable productivity loss.
- ▶ Indirect costs account for much of the societal burden: lost work days, reduced work capacity, absenteeism/ presenteeism.
- ▶ IBS also impacts social life, relationships, travel, and eating habits and, overall, impacts mental health—all contributing to a reduced quality of life and social participation. Clinical reviews have underlined the psychological and social impact as substantial.



(podcast,.apple.com)

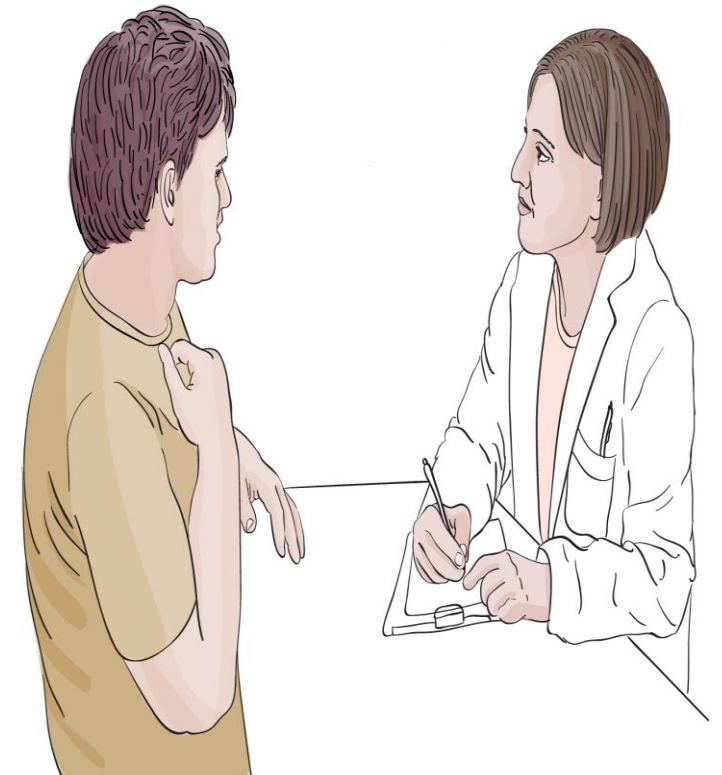
DIAGNOSIS

- ▶ IBS is a clinical diagnosis according to the Rome IV criteria, which includes the requirement for abdominal pain at least once a week, associated with a change in stool frequency or appearance (Drossman & Hasler, 2016). NICE recommends basic testing to rule out other conditions: full blood count, CRP or ESR, celiac screening, and fecal calprotectin to exclude inflammatory bowel disease (NICE, 2021; WGO, 2018).
- ▶ Imaging and colonoscopy are not undertaken routinely; diagnosis is based on skilled clinical assessment (NICE, 2021; NICE Diagnostics Committee, 2013).
- ▶ Red flag symptoms-rectal bleeding, unintentional weight loss, or anemia-should be excluded (NICE, 2021).
- ▶ Early diagnosis decreases anxiety for patients and prevents unnecessary tests (Ford et al., 2017). Communication is necessary in confirming the patient's experience and clearing stigma from it. (Williams et al., 2022).



INITIAL ASSESSMENT IN PRIMARY CARE

- ▶ Primary Care Nurses perform holistic assessment of IBS by symptom pattern review, diet, hydration, sleep, stress levels, and psychological well-being, followed by inquiry into social circumstances, daily functioning, impact on work, and comorbidities. In addition, patient triggers, lifestyle habits, and need for support will all be considered in a truly patient-centered approach (Chey et al., 2015; Löwe, 2008).
- ▶ Holistic assessment therefore includes diet, bowel routine, hydration, activity levels, sleep quality (Chey et al., 2015).
- ▶ Psychological diagnostics can reveal the triggers, such as anxiety, panic, or traumatic stress (Löwe 2008).
- ▶ PCNs explore the condition's impact on work, relationships and social participation (Gracie & Ford 2017).
- ▶ Early identification of red flags ensures timely referral to secondary care when necessary (NICE, 2021).



(bmc1.utm.utoronto.ca)

MODEL OF CARE FOR IBS

- ▶ A number of models inform the long-term management of IBS, which include the House of Care Model, the Year of Care Approach, the Biopsychosocial Model, the Chronic Care Model, and the WHO ICCC framework. Each model underlines an aspect of the holistic, coordinated, person-centered care that is central to functional conditions such as IBS.
- ▶ These models emphasize long-term self-management and collaborative working.
- ▶ The Biopsychosocial Model underpins the NICE guidelines for IBS treatment.
- ▶ Chronic Care Model principles center on early intervention and patient involvement.
- ▶ All these models allow for continuity and being patient-centred, which is important due to symptoms that are in flux.

MODEL : HOUSE OF CARE

- ▶ The House of Care Framework is a whole-system approach developed by NHS England to improve care for people living with long-term conditions.
- ▶ It emphasises co-production, where patients and professionals work together to create personalised care and support plans. The framework visualises care as a “house,” with four essential components:-
 - Engaged and informed individuals
 - Health and care professionals committed to partnership working
 - Organisational and system enablers
 - Supportive community resources.

The roof represents personalised care planning, supported by strong foundations and structures. It focuses on empowering patients, coordinated multidisciplinary care and self-management.

The House of Care:



The House of Care describes four key interdependent components that, if implemented together, will achieve patient centred, coordinated service for people living with long term conditions and their carers.

FRAMEWORK

- ▶ This best fits with IBS since the House of Care model allows one to focus on personalized care and support planning, shared decision-making, and supported self-management. In the case of IBS, its management largely rests on lifestyle guidance, psychological interventions, and collaborative planning on the part of clinicians and patients, which is a key constituent of this model.
- ▶ It encourages shared responsibility of the patient and health professionals.
- ▶ It supports adaptable care plans updated when symptoms change as suggested by NHS England.
- ▶ Promotes integration between dietitians, psychological therapies, and primary care.
- ▶ Enhances patient activation with consequent improved adherence and confidence (Williams et al., 2022).

BIOPSYCHOSOCIAL MODEL

- ▶ The Biopsychosocial Model of IBS underlines the interaction between biological factors, such as motility and sensitivity; psychological influences, such as stress and anxiety; and social contributors, including work stresses and stigma. This model works well for IBS because stress, emotion, and social setting can powerfully influence gut symptoms. Williams, Blackshaw & Spiller, 2022
- ▶ A paper by Simrén et al. (2022) recognizes that chronic stress changes gut motility and microbiota.
- ▶ Social factors such as stigma, work stress, or social isolation can be the major driving elements in symptom flare-ups.
- ▶ It provides the basis for combining CBT and mindfulness-based interventions into IBS treatment.
- ▶ Supports NICE recommendations for psychological interventions (NICE, 2021).

TREATMENT: PSYCHOLOGICAL

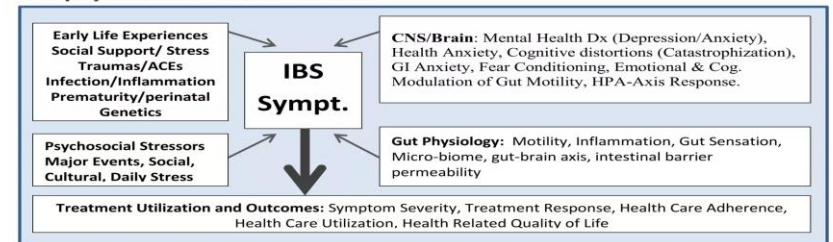
- ▶ Effective psychological interventions for IBS include Cognitive Behavioural Therapy (CBT), mindfulness-based stress reduction, and gut-directed hypnotherapy. These therapies improve coping, reduce anxiety and alter maladaptive gut-brain signalling, resulting in reduced pain and improved bowel habits (Lackner et al., 2018; Gracie & Ford, 2017).
- ▶ Cognitive behavioural therapy reduces symptom-related fear and catastrophising (Lackner et al., 2018).
- ▶ Gut-directed hypnotherapy has proven long-term symptom improvement (Gracie & Ford, 2017).
- ▶ Mindfulness regulates stress and reduces flare-ups.
- ▶ Psychological approaches are recommended when diet and medication alone are insufficient (NICE, 2021).

Health Psych IBS Tx.

Irritable Bowl Syndrome (IBS): Has a wide range of symptoms that impact a person's functioning. There are three kinds of IBS. IBS-C (Constipation), IBS-D (Diarrhea), IBS-M (Mixed Diarrhea and Constipation).



Biopsychosocial Model of IBS

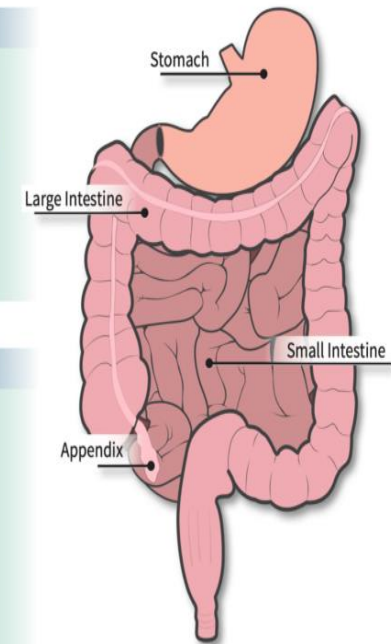
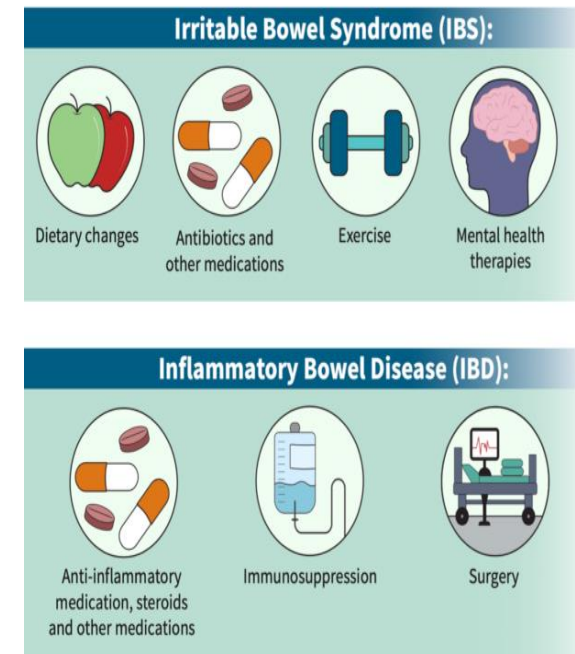


(aboutibs.org)

TREATMENT: CLINICAL

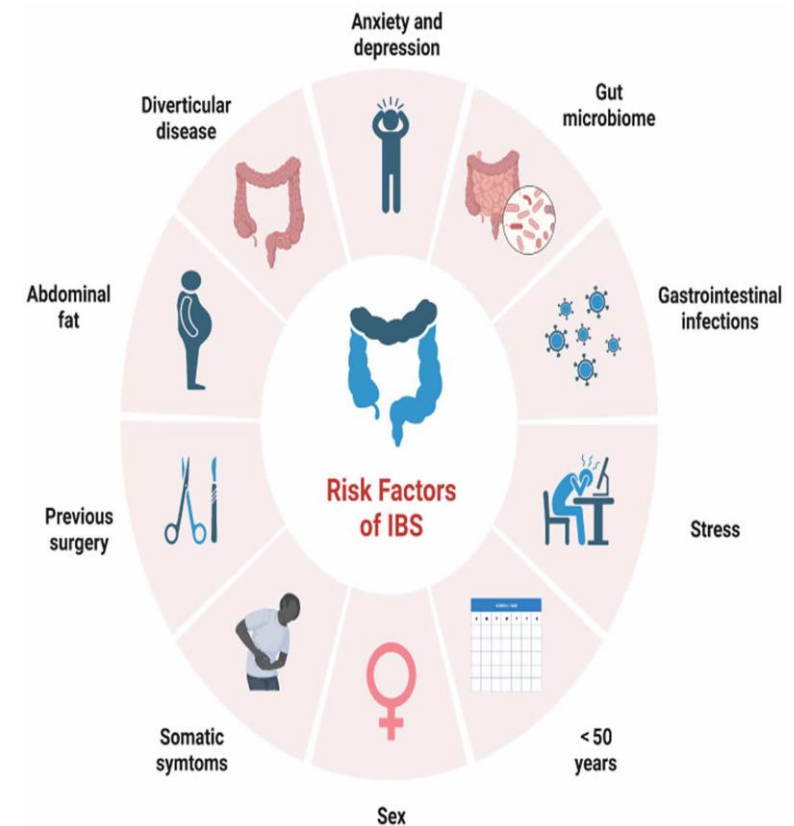
- ▶ Pharmacological treatments are tailored according to IBS subtype (Lacy et al., 2021)
- ▶ Antispasmodics are used for abdominal pain (Ford et al., 2017)
- ▶ Loperamide for diarrhoea (NICE, 2021)
- ▶ Osmotic laxatives for constipation and low-dose tricyclic antidepressants for chronic pain related to visceral hypersensitivity (Lacy et al., 2021).
- ▶ Peppermint oil has been shown to help with stomach pain and bloating because it relaxes muscles (Ford et al., 2017).
- ▶ Clinical management is most effective when integrated with psychological and lifestyle interventions. (surgery.wustl.edu)

Treatment:



COMORBIDITIES

- ▶ IBS often happens along with anxiety, depression, fibromyalgia, chronic fatigue syndrome, and migraines. These comorbid conditions often make IBS symptoms worse and more frequent, so people need both medical and psychological care (Löwe, 2008; Black & Ford, 2020; Kim et al., 2023; Lee et al., 2021).
- ▶ People with IBS are three times more likely to have anxiety or depression. (Löwe, 2008).
- ▶ Overlapping pathophysiology is what causes fibromyalgia and chronic pain disorders to have similar neurobiological pathways (Simrén et al., 2022).
- ▶ Comorbid conditions worsen severity and frequency of flares (Kim et al., 2023; Black & Ford, 2020).
- ▶ MDT care ensures that psychological and physical symptoms are treated together. (Williams, Blackshaw & Spiller, 2022; Gracie & Ford, 2017).



PREVENTING IBS FLARES

- ▶ It is possible to avoid IBS flare-ups by regularizing one's routine, being well-hydrated, consuming more soluble fiber, finding out one's food and stress triggers, and learning how to relax.
- ▶ Mindful eating and physical activity round off behavioral interventions that help maintain symptoms in a stable state over a long period.
- ▶ Symptom tracking with diaries or apps may help in the identification of patterns.
- ▶ IBS-friendly meal planning helps maintain dietary consistency.
- ▶ Breathing exercises reduce sympathetic nervous system activation.
- ▶ Caffeine and alcohol reduction may decrease flare frequency.



(mindsethealth.com)

SKILLS, VALUES AND BEHAVIOURS FOR CO-PRODUCTIVE CARE

SKILLS

- Active listening
- Clear, open communication
- Motivational interviewing
- Holistic bio-psycho-social assessment
- Collaborative decision-making
- Multidisciplinary working
- Coaching and behaviour-change skills

VALUES

- Empathy
- Compassion
- Respect
- Cultural sensitivity
- Person-centredness
- Non-judgement
- Partnership working

BEHAVIOURS

- Shared decision-making
- Power-sharing with patients
- Encouraging self-management
- Reflective practice
- Consistent follow-up and continuity
- Supporting patient autonomy
- Collaborative care planning

COMPREHENSIVE MODEL OF PERSONALISED CARE

- ▶ The Comprehensive Model of Personalised Care is based on six evidence-based components designed to give people choice, control, and support in managing long-term conditions such as IBS.

- ▶ 1. Shared Decision-Making

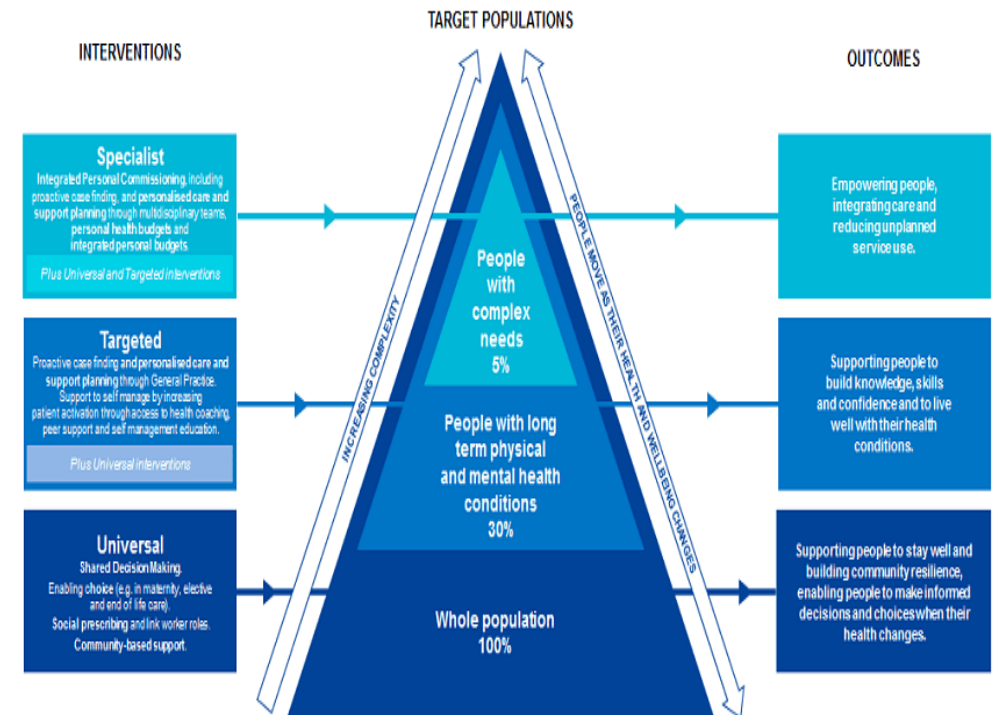
Decisions are made by patients and professionals together, based on clinical evidence and patient preferences.

- ▶ 2. Personalised Care & Support Planning

Everyone receives a care plan that is individualized according to symptoms, triggers, goals, and daily life needs.

Comprehensive Personalised Care Model

All age, whole population approach to Personalised Care



▶ **3. Supported Self-Management**

Patients have been given knowledge, skills, and confidence for self-management of their conditions.

▶ **4. Social Prescribing & Community Support**

Non-medical community resources, such as wellbeing groups, exercise, and stress-reduction programmes are utilized to support health.

▶ **5. Personal Health Budgets**

Where appropriate, individuals can have access to budgets for paying for personalized support, including psychological therapy or digital tools.

▶ **6. Enabling choices**

Providing Choice Patients are provided with real choices regarding treatments, services, and how their care is delivered.

CO-PRODUCTIVE CARE SKILLS FOR NURSES

- ▶ The required interpersonal skills of Primary Care Nurses include empathy, active listening, motivational interviewing, and shared decision-making. Such values support patient empowerment and the building of trust for collaborative engagement in the self-management of IBS (NICE, 2021).
- ▶ Cultural sensitivity is important given diet patterns vary between populations.
- ▶ Clear communication reduces misunderstandings around the fact that IBS is a “psychological only” condition. This encourages patient reflection and commitment to self-management.
- ▶ Primary care nurses can make a significant difference in reducing stigma and empowering patients regarding their condition.



(fernandocollege.com)

CRITICAL EVALUATION OF CURRENT PRACTICE

- Current IBS management in the UK is challenged by limited PCN training in IBS, restricted access to Primary care nurses can make a significant difference in reducing stigma and empowering patients regarding their condition. specialist dietitians, long waits for accessing psychological therapies, and ongoing stigma associated with functional gut disorders.(Wong et al., 2018; Gracie & Ford, 2017)
- ▶ There is underestimation of the severity of IBS by many healthcare professionals, which affects patient satisfaction.
- ▶ Poor outcomes are associated with delays in referrals for mental health services.
- ▶ Lack of integration between dietetics and primary care leads to inconsistency in advice. • Digital tools exist but are underutilized because of training gaps.

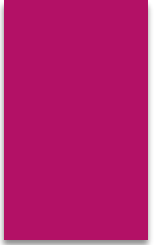
RECOMMENDATIONS

- ▶ Future improvements include enhancing IBS training for nurses, expanding dietetic and psychological support, developing nurse-led IBS clinics, integrating digital symptom-tracking tools and applying personalised care plans for all IBS patients. These changes align with the NHS Long Term Plan and universal personalised care framework (NHS England, 2020).
- ▶ Standardised primary care pathways could improve continuity of care.
- ▶ Increasing digital access to CBT could reduce waiting times (NHS England, 2020).
- ▶ Community-based support groups may help reduce isolation.
- ▶ Continuous professional development on IBS should be available for nurses.



REFERENCES

- Barberio, B., Savarino, E.V. & Black, C.J. (2021). Epidemiology of irritable bowel syndrome: A global perspective. *Gastroenterology*, 160, pp.99–114. 2.
- Black, C.J. & Ford, A.C. (2020). Global burden of irritable bowel syndrome. *Nature Reviews Gastroenterology & Hepatology*, 17, pp.473–486.
- Böhn, L., Störsrud, S. & Simrén, M. (2013). Nutritional guidance for patients with irritable bowel syndrome. *Clinical Gastroenterology and Hepatology*, 11, pp.41–48.
- Chey, W.D., Kurlander, J. & Eswaran, S. (2015). Irritable bowel syndrome: A clinical review. *JAMA*, 313(9), pp.949–958.
- Drossman, D.A. & Hasler, W.L. (2016). Rome IV—Functional gastrointestinal disorders: Disorders of gut–brain interaction. *Gastroenterology*, 150, pp.1257–1261.
- Ford, A.C. et al. (2017). Efficacy of pharmacological therapies in irritable bowel syndrome: Systematic review and network meta-analysis. *The Lancet Gastroenterology & Hepatology*, 3, pp.1–10.
- Gracie, D.J. & Ford, A.C. (2017). IBS and the role of psychological co-morbidity. *Clinical Medicine*, 17(3), pp.263–267.
- Harvard Health Publishing. (2024). Irritable Bowel Syndrome (IBS). Harvard Medical School
- Kim, Y.S. et al. (2023). Comorbid central sensitisation conditions worsen irritable bowel syndrome. *Journal of Gastroenterology and Hepatology*, 38(2), pp.244–252.
- Drossman, D.A. & Hasler, W.L. (2016). Rome IV—Functional GI disorders: Disorders of gut–brain interaction. *Gastroenterology*.
- Chey, W.D., Kurlander, J. & Eswaran, S. (2015). Irritable bowel syndrome: A clinical review. *JAMA*.

- 
- Lackner, J.M. et al. (2018). Improvement in IBS symptoms after CBT. *Gastroenterology*, 155, pp.47–57.
 - Lacy, B.E. et al. (2021). ACG Clinical Guideline: Management of irritable bowel syndrome. *American Journal of Gastroenterology*, 116, pp.17–44.
 - Lee, Y.J. et al. (2021). Physical and psychological comorbidities associated with IBS: A systematic review. *Journal of Psychosomatic Research*, 140, 110287.
 - Löwe, B. (2008). Somatisation and IBS: Psychological perspectives. *Psychosomatic Medicine*, 70, pp.903–910.
 - Mindset Health. (2022). IBS flare-up management guide. Mindset Health.
 - NICE. (2021). Irritable bowel syndrome in adults: diagnosis and management (NG1). National Institute for Health and Care Excellence.

 - NICE Diagnostics Committee. (2013). Faecal calprotectin diagnostic guidance. NICE DG11.
 - NHS England. (2020). Universal Personalised Care: Implementing the Comprehensive Model.
 - NHS England. (2019). House of Care Model: Long-Term Conditions Framework.
 - Pickett-Blakely, O. (2014). Diet and lifestyle management in IBS. *Current Gastroenterology Reports*, 16, p.379.
 - Quigley, E.M. (2017). Gut microbiota in IBS. *Journal of Gastroenterology and Hepatology*, 32, pp.27–31.
 - Shah, E.D. & Day, L.W. (2014). Economic burden of IBS on healthcare. *American Journal of Managed Care*, 20(4), pp.E1–E8.
 - Simrén, M. et al. (2022). Mechanisms of gut–brain interaction in IBS. *Nature Reviews Gastroenterology & Hepatology*, 19, pp.427–445.
 - Spiller, R. & Major, G. (2016). IBS and serotonin signalling. *Neurogastroenterology & Motility*, 28, pp.443–453.
 - WGO. (2018). Global Guidelines: Irritable Bowel Syndrome. World Gastroenterology Organisation.
 - Williams, C., Blackshaw, L. & Spiller, R. (2022). Psychological and social factors influencing IBS. *Frontline Gastroenterology*, 13, pp.1–8.
 - Wong, R.K., Palsson, O.S. & Whitehead, W.E. (2018). Prevalence, burden, and healthcare use in IBS. *Alimentary Pharmacology & Therapeutics*, 47, pp.351–360.
 - Verywell Health. (2023). IBS symptom overview. [VerywellHealth.com](https://www.verywellhealth.com/ibs-symptom-overview/).
 - World Health Organization. (2002). Innovative care for chronic conditions (ICCC) framework.
 - Sleepio. (2021). Sleep disturbance and IBS: relationships and triggers.
 - European Medicines Agency. (2020). IBS treatment overview and safety guidance.