

## GASTROENTEROLOGY RECONFIGURATION BRIEFING PAPER

<b>Project Title</b>	Gastroenterology Reconfiguration - Pilot: Gloucestershire Urgent and Emergency Care Sustainability Plan 2018/19
<b>Programme Title</b>	Centres of Excellence
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### 1. Purpose

The purpose of this paper is to outline the proposal to reconfigure inpatient Gastroenterology services onto Cheltenham General Hospital (CGH) as part of the Gloucestershire Urgent and Emergency Care Sustainability Plan 2018/19. The Gastroenterology service transferred from Hazleton ward (CGH) into Snowhill ward (CGH) on 28th June 2018. This proposal seeks to bring all gastroenterology inpatient activity into a single ward at CGH to optimise care quality and outcomes.

### 2. Background

As a Trust, we regularly have empty beds at CGH while we have escalation beds open at Gloucestershire Royal Hospital (GRH). GRH operates at higher bed occupancy than CGH, 96% vs. 88% (Annex A). Published evidence demonstrates that high bed occupancy has a negative impact on patient flow, mortality, safety, patient and staff experience.

Gastroenterology is a busy speciality that provides medical care (non-surgical) for patients with stomach, pancreas, bowel and liver problems. This includes the provision of endoscopy tests (diagnostic camera tests of either the upper or lower gut to diagnose a range of conditions including stomach and bowel cancer), as well as care for patients with illnesses like liver cirrhosis, coeliac disease, ulcerative colitis and Crohn's disease, Irritable Bowel Syndrome, stomach ulcers and indigestion. Much of the work is done in outpatients (approximately 11,480 appointments and 16,841 scopes performed last year), with a smaller number of patients requiring admission to hospital. The Gastroenterology team currently look after two wards, one at CGH and one at GRH. Only 30% of patients currently under the care of Gastroenterology need the skills and experience of the Gastroenterology team. The Gastroenterology team spend most of their time on wards caring for non-Gastroenterology patients and less of their time delivering endoscopy sessions and outpatient clinics, extending patient waiting times (Annex B).

The junior doctors supporting the inpatient Gastroenterology service have also been impacted by high workload which compromises their training experience and an impending Deanery review of training posts is expected to demand a reduction in patient load or run the risk of training status being removed.

### 3. Proposed Solution

It is proposed that specialised Gastroenterology is consolidated onto one ward at CGH (Snowhill ward, 18 beds) with a 2-bed, 'high acuity' Gastroenterology bed-base at GRH for acutely unwell patients. This will enable:

- 7-day acute Gastroenterology review at GRH and CGH;
- More inpatient endoscopy sessions delivered at CGH and GRH, speeding up decision making and reducing patient length of stay;
- The Gastroenterology ward at GRH will become a General Medicine ward, reducing medical outliers.

The vacated ward at GRH (ward 7A) will be taken over by the Renal service, helping to centralise the general medical patients that they currently look after on outlying wards and releasing specialised dialysis beds for acutely unwell patients.

## **4. Impact Analysis**

### **4.1 Electives**

The Consultant Gastroenterology time released from the ward round cover (that will be picked up by the Renal team), will be used to enhance the elective service. Outpatient and endoscopy services will continue to be provided on all sites, including a 7-day per week endoscopy service at both Cheltenham and Gloucester and endoscopy lists at Stroud and Cirencester Hospitals. This will enable 100% of patients to receive their endoscopy procedure within 24 hours of referral being made into the service on both Cheltenham and Gloucester sites (currently achieving 95%).

### **4.2 Impact on access to diagnostic and outpatient care**

The 350 consultant sessions released as a result of the proposed inpatient bed base changes will be transferred into Endoscopy theatre lists. This will translate into an additional 7 lists per week which will support the treatment of an additional 43 patients per week. This will ensure 100% achievement against the 6 week wait national diagnostic target and a reduction in overdue planned patients returning for a monitoring endoscopy procedure.

### **4.3 Impact on access to inpatient beds**

The centralisation of Gastroenterology onto the Cheltenham site will allow provision of a 365 day acute Gastroenterology review service to GRH, starting with an Acute Medical Unit (AMU) triage round at 8am each day. This is in addition to a daily ward round at Cheltenham hospital where the inpatient ward will be located. There will also be increased support for ambulatory services – Acute Medical Initial Assessment (AMIA), helping to reduce admission for patients who can be managed via an alternative outpatient pathway. Inpatient endoscopy provision will also be improved, so that patients requiring an inpatient endoscopy for diagnosis or treatment can be seen quickly, avoiding diagnostic delay and contributing to a reduced length of stay.

Secondary to this will be the positive impact to general medicine patients who can receive consistent treatment on ward 7A, releasing dialysis beds on ward 7B to be used for acutely unwell renal patients by giving greater ability to flex capacity across the entire seventh floor as needed.

### **4.4 Impact on patient experience**

It is anticipated that by optimising the gastroenterology service there will be several benefits for patients:

- a) Improved specialist care for inpatients (Gastroenterology specialist support on Snowhill ward to treat acutely unwell patients in the most appropriate setting) leading to an anticipated reduced length of stay for Gastroenterology patients on Snowhill. This will be measured as part of the evaluation.
- b) Patients requiring planned admission will be admitted directly to Snowhill ward where the consultant of the week will ensure rapid review and treatment. Pathways will also be established to direct patients to CGH within hours, enabling specialist review within 14 hours for all patients thus meeting the national 7 day working standard (see Annex D).

Out of hours (e.g. after 8pm where Cheltenham ED reverts to a nurse led service) patients will be admitted to AMU at GRH and transferred across at the earliest opportunity the next morning. All patients who cannot be transferred before 8am will receive specialist Gastroenterology review on AMU, with triage to identify those who require ongoing speciality care and those who can be treated at GRH, or discharged home (Annex C).

- Approximately **520 patients that walk-in** per year to GRH would need to be transported (*either making their own way or hospital-provided transport*) (average 1-2 patients per day);
  - Approximately **270 patients that arrive at GRH by Ambulances between 6pm and 8am** per year would need to be transported to CGH (average 0 - 1 patient per day);
  - Approximately **243 patients that arrive at GRH by Ambulances between 8am and 6pm** per year would be directed to CGH via GPs and SWAST in the future model.
- c) More responsive inpatient endoscopy care with 100% of patients receiving their endoscopy procedure within 24 hours of referral being made into the service on both Cheltenham and Gloucester sites.
- d) Shorter waits for Gastroenterology endoscopy appointments due to increased Consultant availability to deliver specialist activity. Specifically patients will receive fewer delays in diagnostic testing along the Colorectal Cancer 2 week wait pathway and improved surveillance post-diagnosis through increased access to planned surveillance endoscopy..

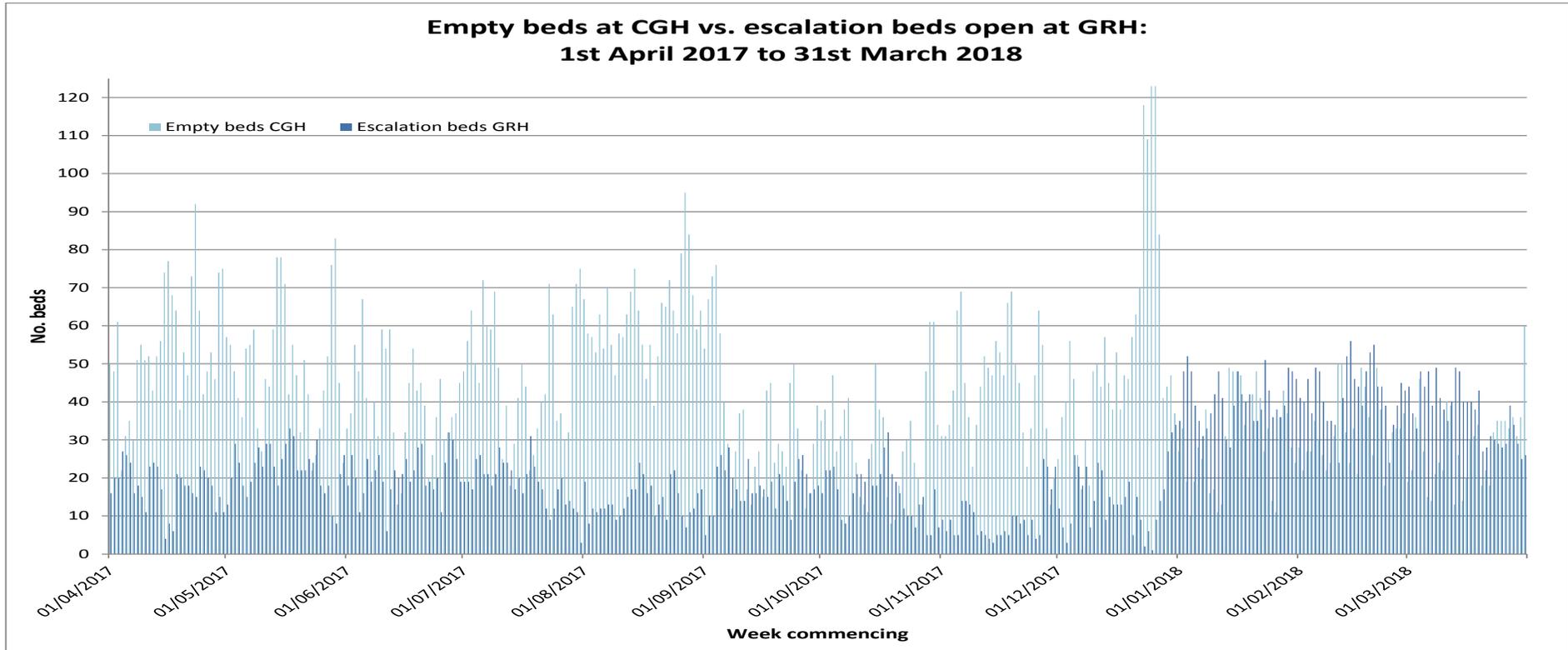
## 5. Implementation and evaluation

This service change will initially be run as a pilot. The metrics shown in the table below will be baselined and tracked to ensure the benefits described in this paper are achieved.

If approved by HSOSC, GHFT would like to implement the change by 1<sup>st</sup> November 2018, as part of the Gloucestershire Urgent and Emergency Care Sustainability Plan 2018/19.

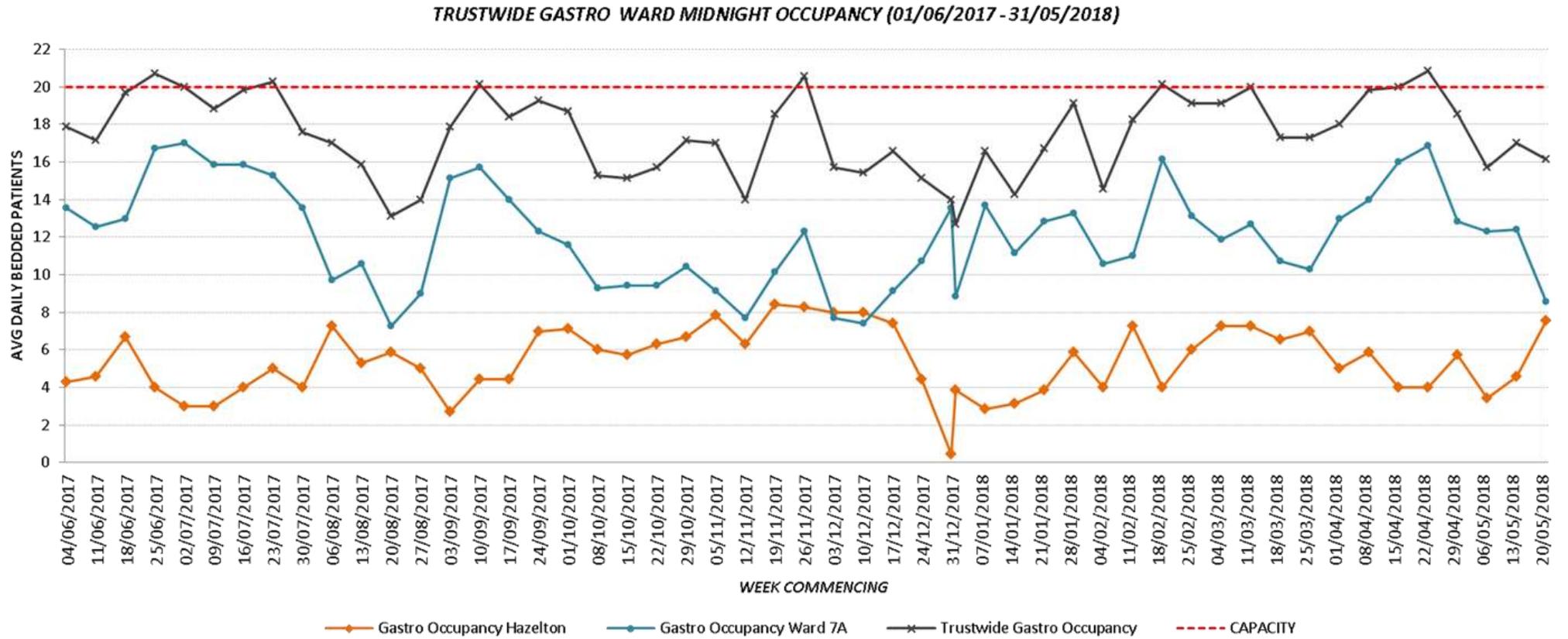
<b>Table 1 – Key performance metrics</b>			
<b>Metric</b>	<b>Measured by</b>	<b>Frequency</b>	<b>Monitored by</b>
100% Inpatient diagnostic endoscopy procedures completed within 24 hours of referral	Audit	Weekly	Cross-site weekly telconference.
Patient experience	Reduce number of complaints and increase compliments	Weekly	PALs team
Reduction in length of stay General Medicine inpatients on 7A	Bespoke Trakcare report	Weekly	Management team
Reduction in length of stay for Gastroenterology patients on Snowhill Ward	Bespoke Trakcare report	Weekly	Management team
Zero patient breaches for 6ww diagnostic target	6ww Diagnostic report	Weekly	Assistant General Manager
Zero exception reports raised by Gastroenterology deanery appointed junior doctors	Monthly Guardian report	Monthly	Trust Leadership Team
100% of patients repatriated to Snowhill ward from AMU within 14 hours of admission	Audit	Weekly	Site Management Team

Annex A



## Annex B

Analysis of ward 7A at GRH over a 12-month period, demonstrates an average of 12 beds out of 28 are actually Gastroenterology patients:



## Annex C

**Table 2- Total Admissions split by site and mode of arrival (01-06-2017 to 31-05-2018)**

Source	Cheltenham General			Gloucestershire Royal		
	In Hours (08:00 - 18:00)	Out of Hours (18:00 - 08:00)	TOTAL	In Hours (08:00 - 18:00)	Out of Hours (18:00 - 08:00)	TOTAL
Walk-In	166	65	231	345	174	519
Ambulance	31	28	59	243	271	514
Unknown	130	14	144	21	33	54
<b>Total</b>	<b>327</b>	<b>107</b>	<b>434</b>	<b>609</b>	<b>478</b>	<b>1087</b>

**Table 3 - Total Admissions per day (split by site and mode of arrival)**

Source	Cheltenham General			Gloucestershire Royal		
	In Hours (08:00 - 18:00)	Out of Hours (18:00 - 08:00)	TOTAL	In Hours (08:00 - 18:00)	Out of Hours (18:00 - 08:00)	TOTAL
Walk-In	0.45	0.18	0.63	0.95	0.48	1.42
Ambulance	0.08	0.08	0.16	0.67	0.74	1.41
Unknown	0.36	0.04	0.39	0.06	0.09	0.15
<b>Total</b>	<b>0.90</b>	<b>0.29</b>	<b>1.19</b>	<b>1.67</b>	<b>1.31</b>	<b>2.98</b>

Requires transfer to CGH

Requires directing to CGH in new model

## Annex D – Patient pathways

