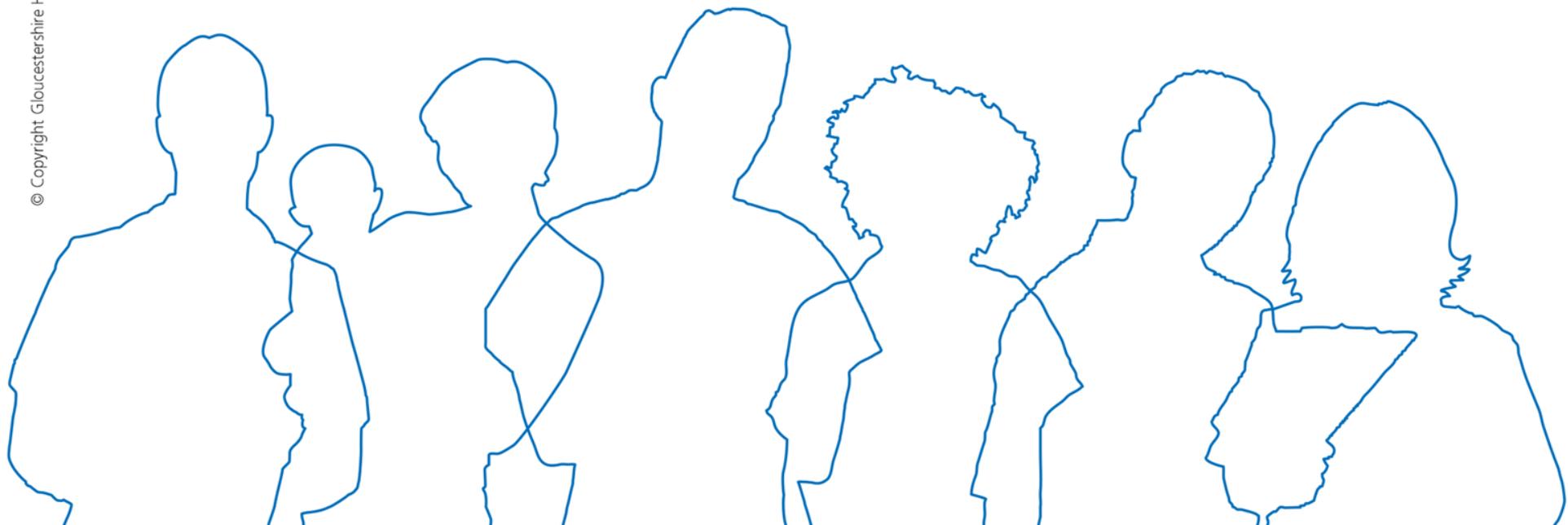


Gastroenterology Pilot

3-month HCOSC update, May 2019

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The case for change – a reminder

Gastroenterology service:

- Medical care (non-surgical) for patients with stomach, pancreas, bowel and liver problems.
- Endoscopy tests (diagnostic camera tests of either the upper or lower gut to diagnose a range of conditions including stomach and bowel cancer).
- Care for patients with illnesses like liver cirrhosis, coeliac disease, ulcerative colitis and Crohn's disease, Irritable Bowel Syndrome, stomach ulcers and indigestion.

Drivers for centralising the inpatient service at CGH:

- To ensure patients were cared for by the correct specialty team
- To address junior doctor concerns - high workload was compromising training experience risking removal of training status.
- To reduce patient waiting times for endoscopy and outpatients.
- To help address difference in bed occupancy: GRH 96%, CGH 88%.

The pilot:

- Inpatient Gastroenterology beds onto one ward at CGH (Snowhill ward).
- A 2-bed, 'high acuity' Gastroenterology bed-base at GRH for acutely unwell patients.

Pilot metrics (as at February 2019)

#	Measure	Data source	Nov 18 to Feb 19
1	Improving patient experience	<i>FFT, bespoke ward survey</i>	A
2	Improving staff experience	<i>Monthly report from Medical Staffing</i>	G
3	Time for patient to see Gastroenterology specialist following inpatient e-referral	<i>Internal Audit - Gastro SpR</i>	G
4	Provision of additional Endoscopy capacity	<i>Internal Audit - Endoscopy Booking Team</i>	A
5	Reducing use of private sector	<i>Report from finance</i>	G
6	Achieving 6 week wait diagnostic standard	<i>6ww diagnostic report</i>	G
7	Reducing patient length of stay	<i>Data Warehouse</i>	A
8	Treating patients on the right medical ward (reducing outliers)	<i>Site snapshot</i>	G
9	Time to transfer patients to Snowhill ward at CGH (where required)	<i>Trakcare report</i>	G

1. Patient experience [1]

Scenario pre-pilot

Mrs J is a 67 year old lady who had been taking aspirin and clopidogrel following a coronary stent insertion.

She is admitted to GRH as an emergency with “coffee ground” vomiting.

She is seen initially by the Consultant Acute Physician on-call at 15:00 and referred to Gastroenterology.

She is admitted to ward 7a and reviewed the following morning by the Gastroenterology registrar who requests an upper GI endoscopy.

This is scheduled and performed on the next available inpatient endoscopy list, which is the following afternoon (48 hours after admission).

The scope shows mild gastritis and Mrs J is discharged the following morning. **She has been in hospital for 3 days.**

Scenario post -pilot

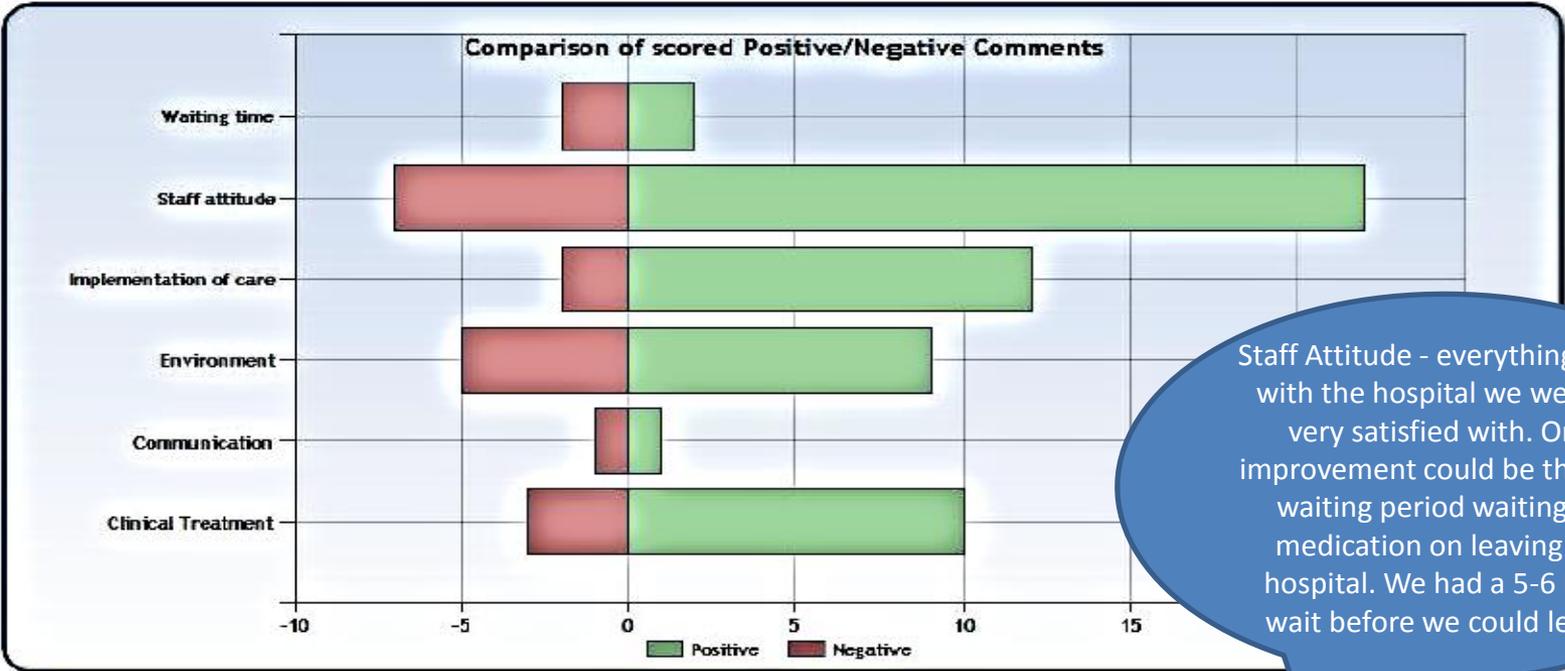
Mrs J is reviewed by a senior member of the Gastroenterology team shortly after she arrives.

They request an Upper GI endoscopy which is carried out the following morning in the new daily protected inpatient endoscopy slots.

This confirms mild gastritis and, as the scope is carried out in the morning she can be discharged later the same day.

Mrs J was only in hospital for 1 day.

1. Patient experience [2] (Pre Move)



Staff Attitude - everything to do with the hospital we were all very satisfied with. Only improvement could be the long waiting period waiting for medication on leaving the hospital. We had a 5-6 hour wait before we could leave.

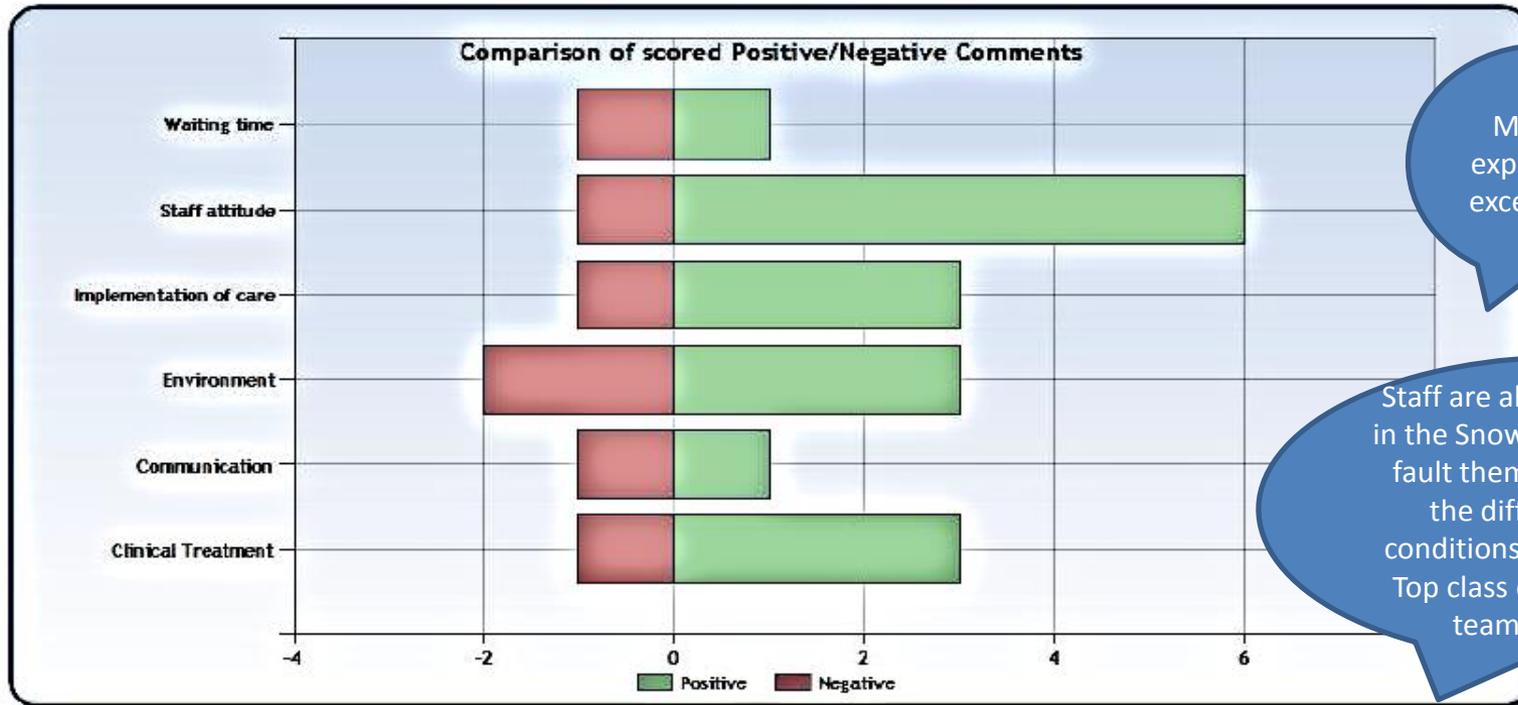
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20%
Response Rate

Positive: 79.84%
Negative: 6.98%

Ratings

1. Patient experience [2] (Post Move)



Medical expertise is exceptional

Staff are absolutely fantastic in the Snowhill ward. Cannot fault them especially given the difficult and busy conditions they work under. Top class care from a great team. Thank you!

21%
Response Rate

Positive: 93.10%
Negative: 3.45%

Ratings

2. Staff experience [1]

“I spent all of my time doing tasks of **high educational value**. New clinical skills developed, ward work was challenging with **lots of learning opportunities**. Additional learning opportunities were regularly offered also.

Feedback on my clinical performance was of a high quality and regular.

The Clinical experience I had was appropriate all of the time. **Safe supervisions of learning new procedures**. Registrars prompt with bleep advice when not on the wards and **Consultants were also contactable for advice and support**.

The **process for raising Patient Safety concerns was clear and effective in most cases**, in addressing all issues raised. Senior sisters and consultants approachable and dealt with concerns effectively.

Upmost attempts made to ensure I was supervised at all times although occasionally this wasn't possible, but didn't feel dangerous as there was **always support in the building, if not directly on the ward**”

Deanery Placement Feedback – Foundation Doctor Year 1

2. Staff experience [2]

“As a speciality trainee the pilot, specifically the inpatient bed base move to Cheltenham has been very positive. Our focus is allowed to be more on Gastroenterology patients, **having optimal time to review them with greater Consultant support** and supervision, especially in Gloucester. It allows **more time for learning**, on the wards, in endoscopy and with access to a wider number of clinics across both sites” **Junior Doctor**

“From a medical ward team point of view, **staffing seems much better and safer**. It can be difficult to move Gastroenterology patients into beds and medically fit patients or general medical patients out at times. But **we are enjoying the higher dependency of patients** and the Gastroenterology specific problems. As a junior doctor rotation therefore, it will continue to **grow in reputation and attract more people** to the post.” **SpR**

Gastroenterology

“We have a much higher Dependency level now, as usually have 2 or 3 really sick patients, often needing DCC input, and lots of central lines and I.V’s. **Staff are enjoying the challenge of these patients and are feeling well supported by Medical Team**. 2 weeks at a time for Consultants working well. **Ward Manager Snowhill**

AMU Team “**Reliable gastro input at consultant level every day 7/7**, usually first thing (8am), seeing referrals, giving advice and following up on sick gastro patients from previous days. It’s also **easier to transfer specialist gastro patients to Snowhill** than it was to the Tower” **Specialty Director Unscheduled Care**

Pilot metrics: #3 to 6

3. Time for patient to see specialist following inpatient e-referral:

Pilot target :100% within 24 hours

- Before pilot - 24 to 48 hours
- After pilot - 6 to 12 hours

4. Providing additional Endoscopy sessions:

Pilot target: additional 7 lists per week

- 5.6 additional endoscopy lists per week (equates to 237 per year)

5. Reducing use of private sector:

Pilot target: to reduce spend

- No longer sending patients to private sector

6. Achieving 6 week wait diagnostic standard:

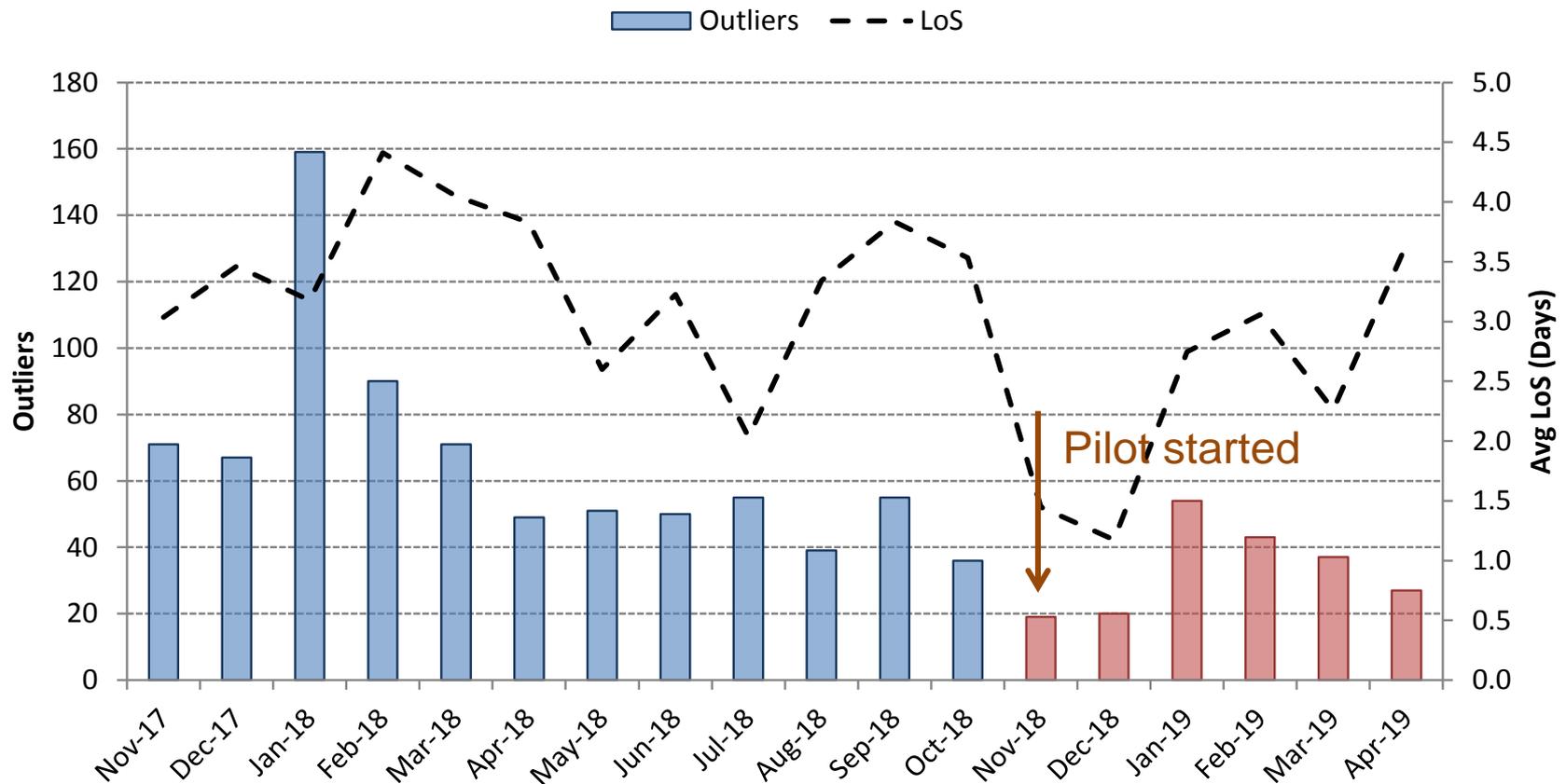
Pilot target additional 7 lists per week

- 100% compliance against the 6 week wait diagnostic target

7. Reducing patient length of stay

8. Treating patients on the right ward (outliers)

Trust Gastroenterology Outliers and Avg LoS (Nov-17 to Apr-19)



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9. Time to transfer patients to Snowhill ward at CGH (where required)

Our planning assumption assumed **2 to 3 patients per day** would need to be transferred from Gloucester Royal to Cheltenham General.

Between November 2018 and February 2019 **only 21 patients** have required transfer, an average of **less than 1 patient per day**.

This is because:

- More patients are being discharged home direct from Acute Medical Unit at GRH
- Patients referred by GP are being directed straight to Cheltenham General.

Providing Advice & Guidance to GPs

Month	Summary of Requests			Response within 2 days		Response within 5 days	
	Received	Advice Given	%	Total	%	Total	%
Nov 18	113	94	83%	108	96%	113	100%
Dec 18	89	64	72%	74	83%	89	100%
Jan 19	95	72	76%	89	94%	95	100%
Feb 19	99	76	77%	95	96%	99	100%

Gloucestershire is the **3rd highest nationally** for use of Advice and Guidance.