Gloucestershire Hospitals
NHS Foundation Trust

General Surgery Reconfiguration Pilot

Health and Care Overview and Scrutiny Committee
20 February 2019

Agenda Item 4

Introduction

- The current model of emergency general surgery **does not meet national standards**
- Proposed changes will affect **5-6 patients** a day
- All 14 general surgeons agree that **'do nothing' is not an option**
- All 14 general surgeons agree that **Emergency General Surgery should be centralised at Gloucestershire Royal Hospital**
- This requires **changes in the way we provide planned care**
- There is **majority clinical support** for the proposed model for planned care, which is the **only** option which can be implemented in the short term.
- The pilot will be evaluated and, by its nature, is temporary; **any substantive and permanent change is subject to public consultation**.

We are striving for excellence and want to be proactive and design and implement this service change in a planned way. The alternative is to do nothing and risk having to make an emergency change as we did recently in relation to radiology services.

General Surgery comprises two abdominal specialities

Upper Gastro Intestinal (GI) includes:	Colorectal includes:
Oesophagus/stomach	Colon and rectum
Gallstones	Haemorrhoids
Weight loss surgery	Crohn's disease

Emergency work includes:

- Assessment and management of patients with abdominal symptoms
- Emergency operations - 70% of emergency patients do not require an operation
- Support to Emergency Department
- Support/opinion to patients under the care of other teams, including GPs.

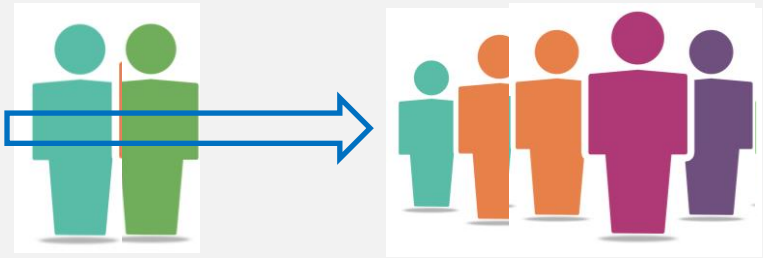
Elective work includes:

- Planned inpatient and day-case operating lists, including cancer surgery
- Outpatient clinics
- Endoscopy.

Centralising emergency general surgery will improve patient outcomes

Cheltenham General

Emergency General Surgery



Gloucestershire Royal

Emergency General Surgery

Current issues:

- Patients often wait to be reviewed by the surgical team
- Patients see the right specialist <50% of the time resulting in significantly sub-optimal care
- Patients are currently admitted unnecessarily

Pilot:

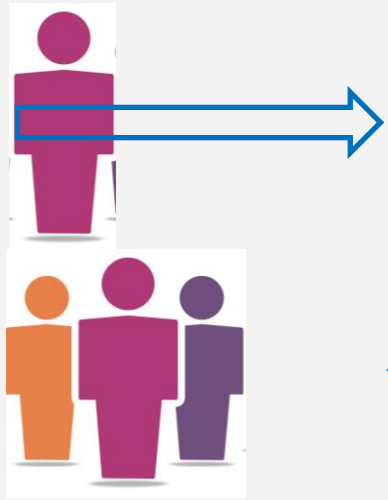
- All patients will see a sub-specialist surgeon
- Surgical 999 patients and patients referred by a GP will go to GRH
- CGH walk-in surgical patients will be seen in an Ambulatory Care Clinic at CGH and those who require specialist care, will be transferred directly to the GRH Surgical Assessment Unit
- If a patient is too ill to transfer, a GRH surgeon will go to CGH (24/7)
- Rapid initiation of treatment and investigations

Changes to elective care will reduce cancellations

Cheltenham General

Planned Complex General Surgery

Planned short-stay and daycase General Surgery



Gloucestershire Royal

Planned Complex General Surgery

Planned short-stay and daycase General Surgery

Current issues:

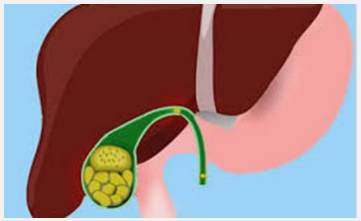
- Day case and short-stay patients may be cancelled
  - due to numbers of emergency admissions
  - due to priority of planned major operations

Pilot:

- Three times the number of patients will have their operation at CGH
- Reduced risk of cancellation
- Enhanced ability to look after our own planned higher risk inpatients
- **Endoscopy** **No change**
- **Outpatient clinics** **No change**

Patient Scenario: Inflammation of Gallbladder

Mrs EL, 41 years old
3 young children
Works part-time



Colorectal consultant

Antibiotics

Improved and discharged

Referred to upper GI outpatient clinic

Emergency readmission

Seen in outpatient clinic

Operation

6 months

Upper GI consultant

Antibiotics

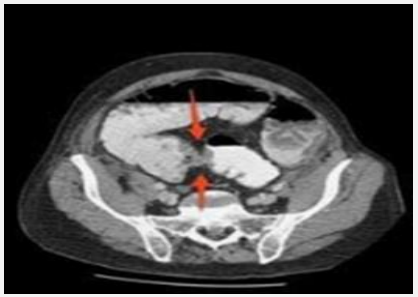
Operation during first admission

10 days

Patient Scenario: Cancer Causing Bowel Obstruction

Mr JS, 78 years old
Retired
Lives alone

Abdominal pain
Change of bowel habit
Vomiting



Upper GI consultant

Operation **with** colostomy

Recovers and discharged

Referral to colorectal surgeon

Second major operation

Recovers and discharged

9 months

Colorectal consultant

Operation **without** colostomy

Recovers and discharged

3 weeks

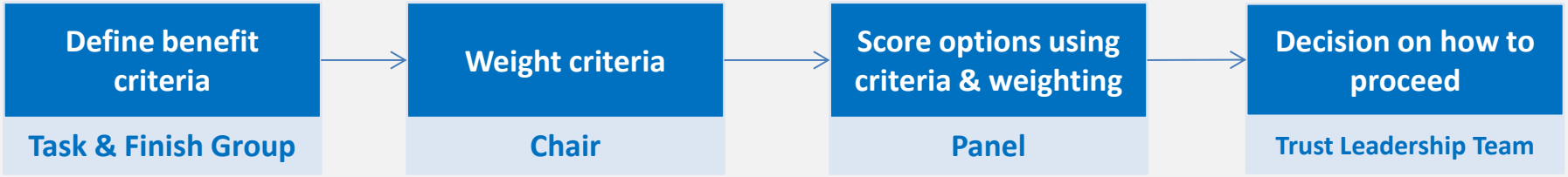
The pilot will deliver a number of benefits

Emergency Care	Planned Care

• Two surgical teams on duty providing 24/7 specialist colorectal and upper GI consultant cover
• 1 team available for emergency operations
• 1 team available to provide:
  • rapid access assessment, investigation and management via Surgical Assessment Unit
  • alternatives to admitted care via Ambulatory Care
  • ‘Hot’ advice to GPs
	• Reduced daycase and short-stay cancellations
	• Standardised care pathways
	• Better environment, improving patient experience
	• Major elective cases have immediate availability of the emergency team if required

A Task & Finish process was established to deliver a recommended option

- **Reconfiguration discussions started in 2011** – no clinical consensus
- Task and Finish process established **to deliver a recommendation**



- All options considered **were designed by clinical teams**
- All options included the **centralisation of emergency general surgery** at Gloucestershire Royal Hospital.
- The Task and Finish group included **representatives from specialties and services that have linkages to General Surgery e.g. urology / vascular**
- The panel was **chaired by Mr John Abercrombie**, national lead for the General Surgery Getting It Right First Time programme (GIRFT) and included other independent clinicians, a patient representative and a commissioning representative
- The model of care to be piloted was the **highest scoring option** and is the only option that could be implemented in the immediate term.

The Task and Finish group included representatives from a range of specialties and services

Core Members:

- **Simon Lanceley:** Director of Strategy
- **Simon Dwerryhouse:** Service Line Director
- **Vinay Takwale:** Chief of Service
- **Tim Cook:** Colorectal Consultant
- **Neil Borley:** Colorectal Consultant
- **Simon Higgs:** Upper GI Consultant
- **Mark Peacock:** Colorectal Consultant
- **Mike Scott:** Colorectal Consultant
- **Damian Glancy:** Colorectal Consultant
- **Mark Vipond:** Upper GI Consultant
- **Felicity Taylor-Drewe:** Deputy Chief Operating Officer
- **Bernie Turner:** Project Manager
- **Jules Roberts:** Matron

Co-opted membership:

- **Clare Fowler:** Urology, Breast & Vascular Service Line Director
- **Jonathan Eaton:** Urology Clinical Lead
- **Rob Gornall:** Gynae-Oncology Consultant
- **Mark James:** Gynaecology Consultant
- **Jonothan Earnshaw:** Vascular Clinical Lead
- **Steve Twigg:** Anaesthetics & Critical Care Service Line Director
- **Amer Rehman:** Radiology Service Line Director
- **Charlie Candish:** Oncology Service Line Director
- **Candice Tyers:** Theatres Manager
- **Kim Benstead** – Medical Education
- **Mark Pietroni** – Unscheduled Care Service Line Director

Addressing the letter signed by 57 colleagues

The letter is broadly one of support for the centres of excellence vision:

"We support the principles of the new clinical model and centres of excellence vision as presented to the SW Clinical Senate and the decision to endorse work to develop such a full emergency – elective split"

The letter also confirms support for the centralisation of emergency general surgery at Gloucestershire Royal Hospital;

"We believe the long term future of emergency and in-patient acute care is best delivered by an emergency care centre based at Gloucestershire Royal Hospital",

and the proposed long-term strategy to centralise planned (elective) day case and short stay surgical services at Cheltenham General Hospital:

"We believe the long term future of commissioned elective services is best secured by dedicated elective centres where possible in co-located, protected specialist units delivering optimum care centred around the elective care pathway."

Where there is a difference of opinion (4/14) is the preferred location of complex planned (elective) general surgery. This difference of opinion is long-standing, discussions have been ongoing since 2011.

We are finalising the pilot evaluation criteria, but will include…

Emergency	Planned
• % of patients operated on the day surgery was originally planned • % patients cancelled for non-clinical reasons • Number of patients admitted, following an emergency presentation • Number of patients treated on the same day (ambulatory care) • Proportion of gallbladder removals on first admission against the national benchmark • % patients seen by correct sub-speciality	• % patients cancelled for non-clinical reasons • Proportion of patients seen as day cases, against benchmark procedures • Patient waiting time for planned surgery • Number of surgical patients on non-surgical wards • Patient experience

Next steps & timescales

2018/19		2019/20				2020/2021			
Q3 (Oct - Dec)	Q4 (Jan - Mar)	Q1 (Apr – Jun)	Q2 (Jul – Sep)	Q3 (Oct – Dec)	Q4 (Jan – Mar)	Q1 (Apr – Jun)	Q2 (Jul – Sep)	Q3 (Oct – Dec)	Q4 (Jan – Mar)

Implementation Planning

- **February 2019 – Implementation approach approved by GHFT**
- **February 2019 – Update HCOSC on pilot proposal**
- **March 2019 – John Abercrombie returning to GHFT**

System Mobilisation

- **May 2019 – Project 'Go / No-go' Gateway**
- **Sep 2019 – Pilot 'Go Live'**

12 Month Pilot / KPI Monitoring & Evaluation

- **12 month review of Pilot to agree preferred next step**

3-monlthly update to HCOSC

Stakeholder Communication & Engagement

Trauma & Orthopaedic Pilot - update

Trauma & Orthopaedic pilot went live in October 2017:

- Emergency (Trauma) activity is centralised at GRH
- Planned activity is centralised at CGH

#	Measure	Average pre reconfiguration	Average post reconfiguration	+/-
1	Number of planned patients treated per month	594	650	**+56**
2	Length of stay - planned hip surgery	5.4 days	4.2 days	**-1.2 days**
3	Cancellations per week due to emergency work	40	7.5	**-32.5 patients**
4	Wait for trauma surgery - from injury	16 days	6 days	**- 10 days**
5	Wait for trauma surgery - from referral	4 days	3 days	**-1 day**
6	% patients reviewed daily by a senior decision maker	unknown	100%	

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Questions

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