NHS
Gloucestershire Hospitals
NHS Foundation Trust

# General Surgery Reconfiguration Pilot

## Health and Care Overview and Scrutiny Committee
## 20 February 2019

# 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.

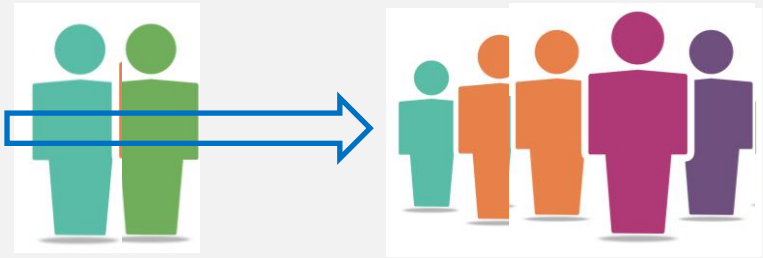
## Elective work includes:

- 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:

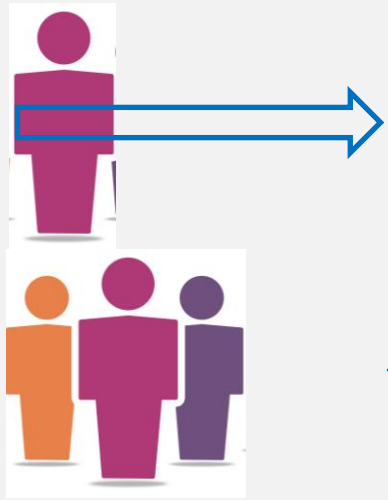
- All patients will see a sub-specialist surgeon
- Surgical 999 patients and patients referred by a GP will go to GRH
- CGH walk-in surgical patients will be seen in an Ambulatory Care Clinic at CGH and those who require specialist care, will be transferred directly to the GRH Surgical Assessment Unit
- 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:

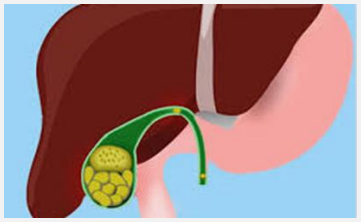
- Day case and short-stay patients may be cancelled
  - due to numbers of emergency admissions
  - due to priority of planned major operations

## 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

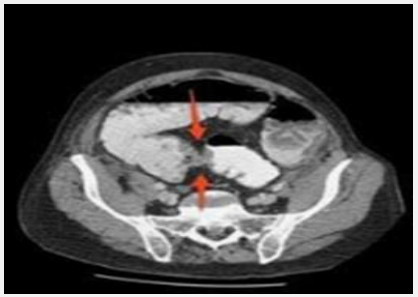
Operation during first admission

**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

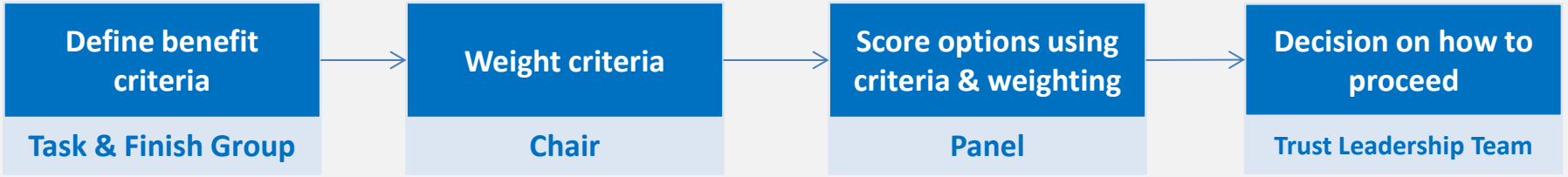
**3 weeks**

# 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<br>• 1 team available for emergency operations<br>• 1 team available to provide:<br>  • rapid access assessment, investigation and management via Surgical Assessment Unit<br>  • alternatives to admitted care via Ambulatory Care<br>  • ‘Hot’ advice to GPs | • Reduced daycase and short-stay cancellations<br>• Standardised care pathways<br>• Better environment, improving patient experience<br>• 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<br>• % patients cancelled for non-clinical reasons<br>• Number of patients admitted, following an emergency presentation<br>• Number of patients treated on the same day (ambulatory care)<br>• Proportion of gallbladder removals on first admission against the national benchmark<br>• % patients seen by correct sub-speciality | • % patients cancelled for non-clinical reasons<br>• Proportion of patients seen as day cases, against benchmark procedures<br>• Patient waiting time for planned surgery<br>• Number of surgical patients on non-surgical wards<br>• 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