GIRFT national report for gastroenterology recommends more weekend services and early specialist triage to help manage demand and improve productivity

A range of measures to help the NHS recover gastroenterology services and mitigate against surges of COVID-19 are outlined in the Getting It Right First Time (GIRFT) national report for gastroenterology.

Hospital gastroenterology teams care for millions of patients every year – gastrointestinal (GI) complaints account for one in ten GP consultations and digestive diseases are a factor in one in eight deaths.

The national report offers practical solutions for managing the demand for services and optimising the capacity of units in England, with a particular focus on meeting challenges created by the COVID-19 pandemic, such as the backlog of patients waiting for endoscopic procedures and gastroenterology clinic appointments.

Written by Dr Beverly Oates, GIRFT's clinical lead for gastroenterology and a consultant physician and gastroenterologist at Wirral University Teaching Hospital (WUTH) NHS Foundation Trust, the report's recommendations aim to ensure the right patients are prioritised and then cared for quickly, efficiently and safely.

Aligning with Professor Sir Mike Richards' recent review of diagnostic services *Diagnostics: Recovery and Renewal* – commissioned by NHS England and NHS Improvement – measures in the report include:

More six- and seven-day services and extended hours, to boost capacity and improve patient flow: Gastroenterology has expanded at a greater rate than any other acute major medical specialty over the past 30 years, due in part to increased demand for diagnostic and therapeutic endoscopy. Before the pandemic 71% of trusts had six- or seven-day endoscopy lists and 54% of trusts were doing weekend gastroenterology ward rounds, but more weekend and evening services are needed to meet demand, with additional recruitment to ensure staff do not burn out. Extra sessions will mean that patients can be seen more quickly and return home with minimal hospital exposure to COVID-19.

Better triage to help streamline referrals: Early specialist triage will ensure the most urgent patients are seen first and identify those who no longer need to attend hospital, which will reduce waiting times for those that do. The report also recommends closer working with primary care colleagues to improve awareness of services which allow patients to better self-manage their condition.

More proactive care programmes for patients with chronic conditions: Liver disease is the biggest cause of death in those aged between 35 and 49 and the third leading cause of premature death. Proactive programmes, giving patients access to services such as community

alcohol care teams or weight loss clinics, will help patients better manage their own condition, minimising the need to be seen in hospital and reducing emergency admissions for cirrhosis.

Similarly, more proactive management for patients with inflammatory bowel disease (IBD) will help enable earlier diagnosis and management of flare-ups, reduce emergency admissions and the need for surgery.

The report is based on visits to all 129 NHS trusts in England providing gastroenterology services and features more than 20 examples of best practice seen by the team during their 18-month review. The recommendations also present the opportunity for potential cost efficiencies of between £35m and £62m a year.

Report recommendations

Optimising capacity

1 Revisit working practices and service organisation to maximise workforce capacity.

2 Review contractual arrangements for gastroenterology staff to create efficiencies and address long waiting times for outpatient services.

3 Optimise outpatient and day case services, maximising the effective use of clinical time.

Managing patient demand

4 Consider triaging solutions to direct referrals appropriately and improve outpatient waiting times.

5 Work with primary care colleagues to improve awareness of and access to alternative services, support self-management and shared decision making with patients, and manage expectations and understanding of referral pathways and the value of interventions.

Endoscopy

6 Review and expand endoscopy capacity by revisiting working models, waiting lists and departmental resources.

7 Improve testing for and treatment of H. pylori.

8 Review usage of gastroscopy, particularly in younger patients (under 55s).

9 Improve pre-assessment and referral vetting for colonoscopies and increase access to CT Virtual Colonoscopy and CT where appropriate.

10 Analyse emergency and Post-Colonoscopy Colorectal Cancer (PCCRC) occurrences of cancer, keep a register of surveillance for high-risk patients, and remedy any identified issues to improve access to prompt diagnosis.

Liver, pancreas and biliary system (hepatobiliary)

11 Review liver disease programmes, particularly focusing on early identification, proactive management and reduced occurrence of, and emergency admissions for, cirrhosis.

12 Improve screening and treatment for varices.

13 Work with primary care to give direct open access to best practice fibrosis assessment.

14 Ensure awareness and consistent use of cirrhosis care bundles and discharge checklists.

15 Ensure Endoscopic Retrograde Cholangio-Pancreatography (ERCP) is performed safely and only when necessary, as day cases where clinically appropriate, in sufficient volumes, and ideally with input from an ERCP multidisciplinary team (MDT).

16 Ensure there is an effective programme in place for tracking and replacement of removable biliary stents.

Luminal gastroenterology

17 Ensure there is sufficient proactive management for Inflammatory Bowel Disease (IBD) patients, to reduce emergency admissions and the need for surgery.

Nutrition support

18 Review nutrition support infrastructure and establish nutrition support teams and steering groups as outlined in *NICE clinical guideline CG32 on nutrition support for adults*.

19 Monitor complication rates across nutrition support services, and implement measures to reduce rates.

Medicines optimisation

20 Work with pharmacy colleagues to carry out further investigation into any medicines recorded as unmapped or no-moiety medicines.

Improving future gastroenterology services

21 (Re)introduce and use initiatives and systems to share knowledge, resources and best practice to improve gastroenterology and endoscopy services.

Procurement

22 Enable improved procurement of devices and consumables through cost and pricing transparency, aggregation and consolidation, and by sharing best practice.

23 Use drinking water instead of bottled sterile water for manual flushing (via single use syringes) of scopes during endoscopy procedures, provided receptacle/water and syringes are routinely changed between patients.

Reducing the impact of litigation

24 Reduce litigation costs by application of the GIRFT programme’s five-point plan.