Inside Out: Gastroenterology & Hepatology Workshop

Saturday 25 October 2025
Clinical Skills Development Service | RBWH

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Metro North services & referrals

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GP Referral Management in Metro North

Mark Appleyard

Director, RBWH

GE lead MN

Chair, Qld GE Network

	Jan	Feb	Mar	Apr	May	June	July	August	September	October	November	December	YTD Total
2022	1644	2263	2303	1829	2093	2199	2062	2195	2366	2280	2468	2132	25834
2023	2266	2485	2731	1964	2563	2456	2482	2558	2226	2443	2510	1832	28516
2024	2379	2859	2779	2695	2803	2478	2821	2714	2604	3042	3008	2298	32480
2025	2581	2969	2701	2579	3027	2960	3020	2871	3064	1681			27462

Interested in GP feedback why 15% increase/year

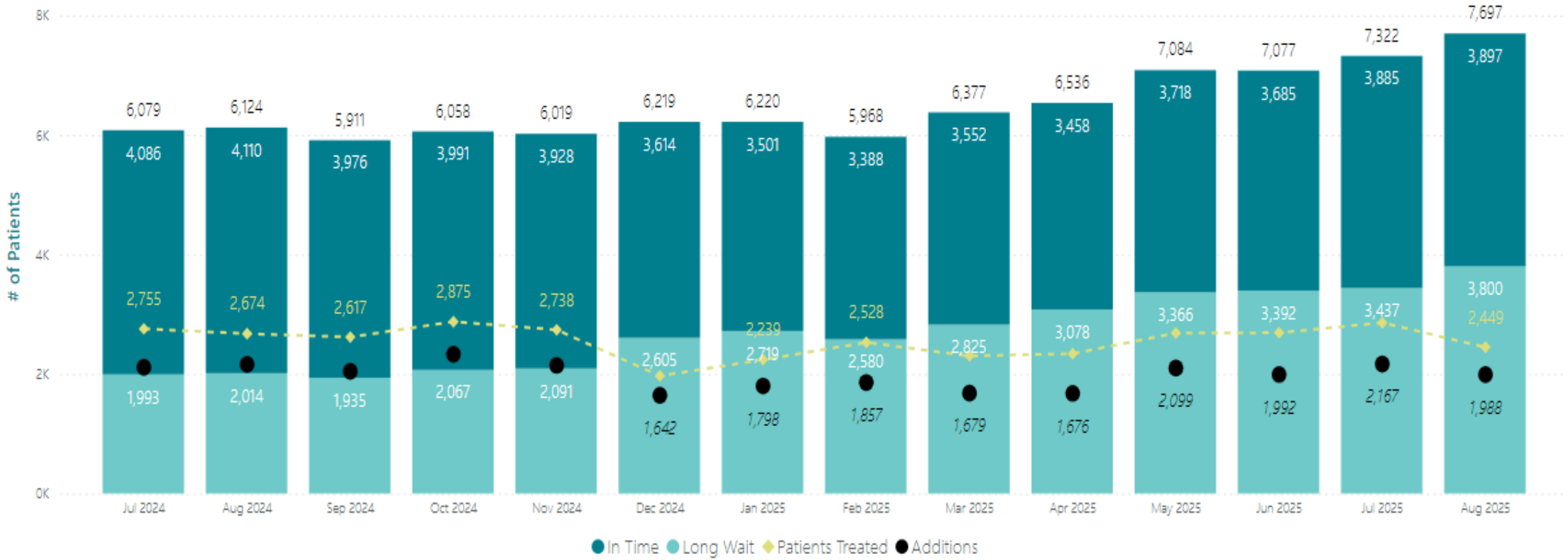
Referral flow to GE Hub via Smart referrals

- GE Hub staffed by senior nursing/Admin
  - Aim to get referral right place first time
  - Treat close to home
  - Load share
- ~50% referrals are triaged by nursing to colonoscopy consent/fast track endoscopy
  - Majority of STARS suitable patients flowed to STARS
    - ASA 1, 2, stable 3
- ~50% flow to facilities for medical triage
  - 95% Cab OP referrals to STARS

STARS

- Designed for volume endoscopy (diagnostic/OP/surveillance)
- Large General OP service
  - RBWH
  - Supporting Red/Cab
- Can’t currently refer directly to STARS
- GE Hub directs STARS suitable

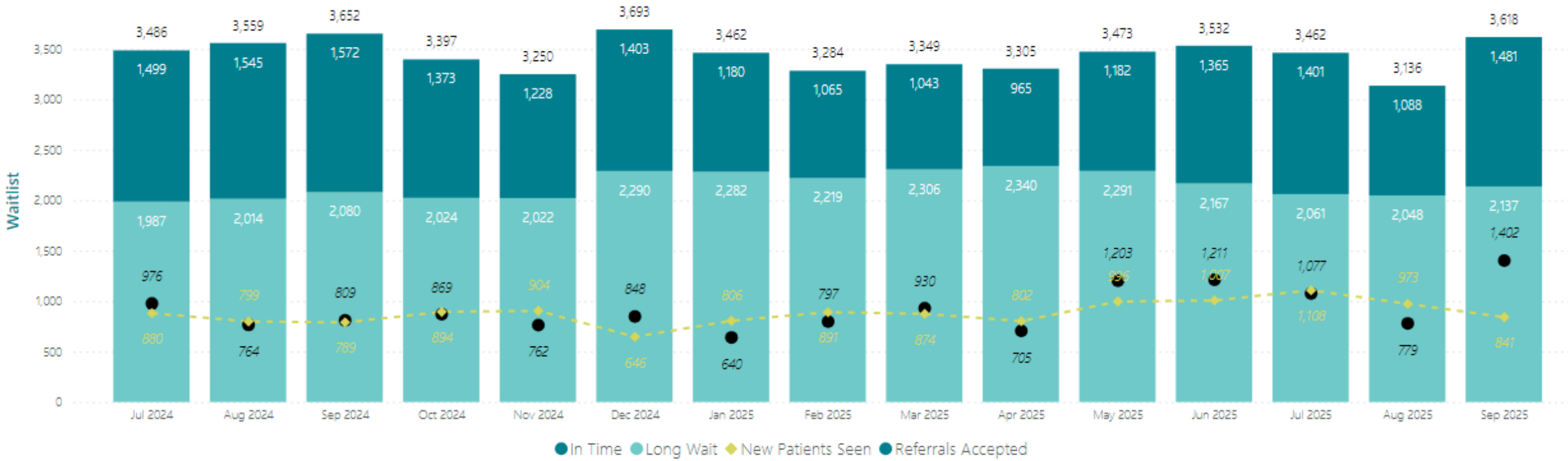
MNH - Procedural Waitlist by Wait Status, Treated and Additions - as at Aug 2025 (EOM)



MNH - Median Wait Time (Days on Waitlist) by Category - as at Aug 2025 (EOM)

Category Code	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025
4	29	29	29	29	31	43	47	31	36	38	40	43	43	47
5	64	67	64	66	61	70	80	86	76	84	82	88	80	82
6	150	147	162	154	149	156	168	173	181	192	192	189	171	180
Total	**55**	**58**	**56**	**57**	**52**	**62**	**71**	**75**	**63**	**70**	**69**	**77**	**70**	**74**

MNH In Time vs Long Wait Activity (305 - GASTRO, 360 - Hepatology, 500 - Colon Consent)



MNH - Median Wait Time (Days) by CCC and Category - as at Sep-25 (EOM)

GASTRO CCC Description	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025
305 - Gastroenterology	101	104	102	102	104	105	113	116	133	146	123	113	119	123	112
1	44	46	48	49	53	54	59	48	54	49	52	35	31	38	30
2	106	109	111	115	115	117	122	122	139	155	131	124	129	138	127
3	247	265	214	218	236	258	262	271	289	315	292	287	220	231	230
360 - Hepatology	90	86	84	94	103	106	123	123	128	133	114	127	109	103	90
1	28	33	26	31	34	41	43	34	35	36	39	32	23	32	42
2	105	95	96	112	122	119	141	134	139	147	129	139	126	122	113
3	181	68	97	119	48	79	102	138	169	201	297	152	357	101	100
Total	**99**	**98**	**98**	**99**	**104**	**105**	**114**	**117**	**132**	**142**	**121**	**119**	**115**	**116**	**107**

Current Challenges

- Caboolture
  - Insufficient workforce
  - 95% GP referrals to STARS
  - Majority of urgent/emergency IP GE/Hepatology to RBWH
- TPCH
  - Currently with largest OP/Endoscopy waiting lists

How to manage increasing demand?

- Work in CPC/Health pathways
  - Committed to ongoing improvement/statewide standardisation
  - Improve referral quality
- Expand services where possible
  - In reality we have hit an infrastructure limit
- Expand the use of current infrastructure
  - Extended days/sat lists
- Alternative Models of care

Alternative Models of Care (>50%)

- Fast track endoscopy
  - Clearly needs an OGD
  - Appt offered direct to endoscopy with information and copy of consent form
  - Acceptance allows booking directly to OGD
- Colonoscopy consent clinic
  - Clearly needs colonoscopy
  - Appropriate to bypass medical clinic
  - Senior nurse RV (confirm indication/doc relevant hx/medications/manage medications/explain risks and bowel prep education/document/sign proforma

Dietitian First Gastroenterology Clinic

- Evidenced based Model of Care
- Dietitian works independently as first contact to provide care to low risk patients referred to Gastroenterology
- Escalation pathways back to Gastroenterology

Outcomes

- Reduced wait-times and compliance with clinically recommended review times
- High levels of patient satisfaction
- Reduced symptom severity
- Improved QoL
- Low re-referral rates
- Lower health service usage

Model of Care - Dietitian First Gastroenterology Clinic

Eligibility criteria

Inclusion criteria:

- 18-49 yo
- Referred for
  - Abdominal pain
  - Altered bowel habits
  - Constipation
  - Diarrhoea
  - Dyspepsia/heartburn/reflux
  - Non-CPC descriptions e.g. bloating, nausea
  - ID in menstruating women

Exclusion criteria:

- ≥50 yo
- Unexplained weight loss of ≥5% in previous 6 months
- Unexplained fevers
- Abnormal pathology or imaging
- ID in males or non-menstruating women or unexplained ID in menstruating women
- Abdominal mass on clinical examination or imaging
- Patient history of GI cancer, IBD, Barrett's
- GI bleeding
- Nocturnal diarrhoea
- Difficulty or pain on swallowing
- Persistent vomiting or abdominal pain

Virtual Dietitian First Gastro Clinic at STARS

Methods

Digital systems were utilised to manage referrals, documentation, virtual care and health outcomes, intervention and information sharing.

STARS Dietitians work as the first contact practitioner for suitable category 2 and 3 patients referred to gastroenterology

Co-design workshops with consumers and staff were facilitated to inform service improvements

Results

12% of care provided via Phone

86% of care provided via Telehealth (Videoconference)

Referrals 128 from partnerships across Queensland Health

$740 saved per patient DFGC vs Usual Care

Consumers accessing the service who identified as Aboriginal and/or Torres Strait Islanders was 7.29%.

89% patients rated their care VERY GOOD or GOOD

11% rated their care as Average

0% rated their care as Poor or Very Poor

Model of Care – Dietitian Led Coeliac Clinic

Eligibility criteria

Inclusion criteria:

- New diagnosis of coeliac disease (post diagnostic scope)

OR

- Previous diagnosis of coeliac disease with ongoing positive coeliac serology or histology

Exclusion criteria:

- Gastrointestinal conditions other than coeliac disease that require Gastroenterologist consultation including Barrett's Oesophagus, Eosinophilic Esophagitis, Inflammatory Bowel Disease.
- Refractory coeliac disease (persistent or recurrent malabsorptive symptoms and signs with villous atrophy despite adherence to gluten free diet for at least 12 months)
- Category 1 GE features: abnormal imaging, abdominal mass on examination, GI bleeding, difficulty swallowing, persistent vomiting, persistent abdominal pain, patient or family history of GI cancer or Barrett's Oesophagus.

GPwSI Gastroenterology

CCAC (Complex Colonoscopy Assessment Clinic)

Dr Noela Kwan – RBWH and STARS

Commenced September 2022

Dr Amy Wang – Redcliffe

Commenced July 2024

2023/24 Audit

- 145 patients – age, indication, ASA grade (1-5)
- 57% ≥75 years
- 48% surveillance/screening colonoscopy
- 52% symptomatic (includes FOBT+) referrals

Surveillance colonoscopies ≥75 years (N=48)

- 71% (N=34) did not proceed to colonoscopy after consultation
- 29% (N=14) proceeded to colonoscopy with no adverse outcomes
- 71% (N=10) had histopathology collected with no cancers detected
- Charlson Comorbidity index

https://www.mdcalc.com/calc/3917/charlson-comorbidity-index-cci

The elderly and stopping rules

Practice point

Careful assessment and shared decision-making should be utilised when considering surveillance colonoscopy in the elderly, most of whom will have no significant findings and will not benefit.

Practice point

Surveillance colonoscopy in those ≥75 years should be considered based on age, co-morbidity and the preferences of the patient. The reproducible and validated Charlson score is useful to assess life expectancy and could be implemented to assist decision-making (see Tables 17 and 18 below).

Practice point

In obtaining consent for colonoscopy for an elderly patient, complication rates should reflect the individual risk based on age and comorbidity rather than 'standard' figures.

Table 17. Surveillance recommendations for individuals age ≥75 years

Age (years)	Charlson score	
	≤4	>4
75–80	Surveillance colonoscopy to be considered	Surveillance colonoscopy not recommended
>80	Surveillance colonoscopy not recommended	

Table 18 . Charlson score for colonoscopy benefit

Age (years)	Medical conditions	
75–79 years (3 points)	**May have one of these conditions only (1 point each):** - Mild liver disease - Diabetes without end-organ damage - Cerebrovascular disease - Ulcer disease - Connective tissue disease - Chronic pulmonary disease - Dementia - Peripheral vascular disease - Congestive heart failure - Myocardial infarction	**May not have any of these medical conditions (≥1 point each):** - Moderate/severe liver disease - Diabetes with end-organ damage - Hemiplegia - Moderate or severe renal disease - AIDS - Metastatic or non-metastatic solid organ or haematopoietic malignancy
80 years (4 points)	May not have any of the above medical conditions	

Summary

- Under pressure from the demand
- Please use CPC/Health pathways to manage patients where appropriate in the community
- Aware that referred patients will not always see a gastroenterologist
  - Carefully implemented/evidence based/evaluated alternative models of care