Achieving Excellence in Elective Care Pathways
Service Improvement in Endoscopy

Ed Seward    Elaine Kemp
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Service Improvement in Endoscopy

The case for change – why every unit needs service improvement

Productive Endoscopy

Worked examples

Discussion

Figure 3.3. International comparisons – crude colonoscopy rates per 1,000 in 2010/11
Department of Health (DoH) Direct Access to Diagnostic Tests for Cancer 2012

equal numbers of cancers diagnosed on two week wait and 18 week wait pathways suggests open access and ‘one stop shops’

DoH NHS Improvement Agency 2012

importance of organisational change, novel pathways
Map 15A: Rate of colonoscopy procedures and flexible sigmoidoscopy procedures per population by PCT
Indirectly standardised rate, adjusted for age, sex and deprivation 2011/12
Domain 1: Preventing people from dying prematurely
Increasing pressures

- Bowel scope
- Age extension
- In patient demands
- Increasing two week wait activity
- Redeployment of consultant staff
- Rising costs and capped budgets
So what can we do?

- Work more efficiently
- Spend more money
Work More Efficiently
  Productive Endoscopy

Spend More Money
  Build a business case
  Demonstrate savings
  Demonstrate patient benefit
PRODUCTIVE ENDOSCOPY

The Productive Endoscopy Unit

- Referral Management
- Pre-assessment and Patient Preparation
- Session Start Up and Patient Change-over
- Consumables and Equipment
- Handover, Recovery and Discharge

Patient Experience

- Team Working
- Scheduling
- Knowing How We Are Doing
- Well Organised Unit
- Operational Status at a Glance

Programme Leader's Guide

Executive Leader's Guide

Toolkit

Process

Enablers

Foundation
Adapted productive theatre models and rewrote. Created new modules.

National Improvement Lead’s working on site:
- test improvements
- develop appropriate case studies and examples for inclusion

Partnership with Joint Advisory Group on Gastrointestinal Endoscopy (JAG) & alignment to Global Rating Scale (GRS) (endorsement):
- JAG accreditation of endoscopy units & colonoscopists working in the Bowel Cancer Screening Programme (BCSP)

Learning workshop (October 2013):
- Showcase of achievements
- Training for sites

Six month timescale
Changed modules to reflect Endoscopy more appropriately

Executive leaders guide
- 10 minute précis incl. NHS Change Model, followed by full change management module

Programme leaders guide - extras added!
- NHS Change model
- A3 thinking (organisational tool) / Plan, Do, Study, Act (PDSA)
- Energy for change
- Benefits realisation

Handover, recovery & discharge (combined module)
- Identify requirement to standardise the process
- Eliminate duplication and delay
- The discharge process

Session start-up & changeover (combined module)
- Safe and efficient transfer between functions
Referral Management

- Understanding referral into & the process within the unit
- Reducing inappropriate referrals, delays & cancellation

Patient Experience

- Putting the patient at the centre of improvement activities
- Six C’s-Compassion in Practice, Care, Communication, Courage, Competence, Commitment, Compassion

Pre-assessment (& patient preparation)

- Correct patient evaluation, advice & support
- Creating efficient, no delay, ‘pull’ into rooms
Portsmouth

- 5S, a workplace organization method has resulted in £60,000 less stock held
- Redesigning workflow within reception
  - Search time reduced by 25 percent
  - seven days time saved of band two/three
  - 64km (37 miles) less walking per annum
- Two rooms redesigned as work-cells
  - Steps reduced from 22 to 11
  - Bottlenecks reduced from five to three
  - Hand-offs reduced from three to zero
  - 66 percent of patients discharged in less than one hour
- Standardised ways of working reduces time spent discussing results from 30 minutes to 15 minutes
Robust Measures

Across the four domains:
- quality/safety
- cost/ value for money
- timeliness/delivery
- morale (staff)/ patient experience
Measures representing Trust Values & NHS Outcomes Framework

mapped to six C’s
(Care, Compassion, Competence, Communication, Courage, Commitment)

individual module measures

module lead measures for use in Performance Development Review (PDR) process
# Productive Endoscopy Measures

<table>
<thead>
<tr>
<th>Definition:</th>
<th>Safety</th>
<th>Effectiveness</th>
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<tbody>
<tr>
<td></td>
<td>Reducing avoidable harm.</td>
<td>High quality clinical outcomes</td>
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<td>Levels of serious untoward incidents</td>
<td>These are dependant on the right time, right place, right first time.</td>
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<td>Levels of violence and aggression.</td>
<td>Compliance with National strategy</td>
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<td>Levels of clinical incidents.</td>
<td>National Framework Evidence based</td>
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<td>Levels of potentially preventable complications.</td>
<td>Royal Colleges/ Professors</td>
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<td>Hygiene and safeguarding standards</td>
<td>NICE guidance</td>
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<td>Care Quality Commission</td>
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<td>JAG accreditation</td>
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Measures

- Design

Fish Bone Analysis

Suppliers
- GP/Cons
- Ward... 

Inputs
- Forms
- Ref
- Process
- Outputs
- Customer

- Diary
- DRMS
- ALS
- 28 weeks
- Records
- End user

- Vetting
- Booking
- Pre-assessment
- Consent
- Admission
- Procedure
- Report
- Discharge
- Results

- Appt date
- Patient prep
- Pre-admission
- Report
- Scoping
- Notes

- Patients
- GP/Cons
- Nurses
- Doctors
- Admin staff
- Radiology
- Lab staff
- Birth staff
- Secretaries
- Admissions
- Coding

NHS

Improving Quality

Fish Bone Analysis

People
- Equipment
- Method

Optimum

Productive Unit
What is important to you?
"Friendliness, someone who is able to put you at ease and explain everything."

What did we do well?
"I had the most friendly, helpful and approachable nurse for my appointment. She couldn’t have possibly done anything more for me and is the best person I have met in the whole of the NHS."
"I now couldn’t work in a unit that didn’t display metrics to show how it was performing.” Clinical Lead, Barts Health

“We’re trying to create the Bible for the Endoscopy Unit” Jim Buenaventura, Endoscopy Unit Manager, Whipps Cross University Hospital

“This was a very different approach to what we’d had before. Previous experiences of Lean left us feeling very 'done to' but this was very inclusive” Nicky Taggart, Endoscopy Manager, RLBH NHS Trust

“Always end the huddle on a high!” Jim Buenaventura, Endoscopy Unit Manager, Whipps Cross University Hospital

“Out team now understands the importance of communication & are utilising the brief and debrief to good effect, as well as time-out sessions to plan changes” Lead Nurse, Liverpool

“All you need are a few flip charts and some creative minds.” Ed Seward – Consultant gastroenterologist, Whipps Cross Hospital, Barts Health

“It’s important that the team make the connection that each piece of paper in this unit is a patient!” Koralie Bird, Sister, Portsmouth Endoscopy Unit

“As a result of our 5S activities, we now hold £60k less stock compared to last year” Barbara Crean, Unit Matron, Portsmouth Hospitals
Purpose of this guide

The Productive Endoscopy Unit

As endoscopy staff, you may face daily frustrations; wasting your time searching for equipment and supplies that are not where they should be, cluttered and untidy store rooms that make it difficult to find anything, and a shortage of storage space within your department. All these factors can make carrying out even the simplest of tasks far more difficult than it should be.

Imagine an endoscopy department where the environment supports you to do your job rather than hinders you, where things are easy to find and there is room to store everything you need where you need it.

The Well Organised Unit module will empower you and your endoscopy team to achieve this goal and sustain the improvements made.
Clinician Engagement

Data, data, data

It must be defensible and of high quality
ENDOSCOPY UNIT WEEKLY ACTIVITY UPDATE
START FROM JANUARY 2012 TO DATE

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<tr>
<td>22/04/12</td>
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</table>

TOTAL: 1971

Clinician Engagement

- Demand vs. capacity
- Start times
- Points on lists
- Room utilisation
- Patient feedback – both negative and positive
Caring and compassionate, with patients, each other and our partners

Actively listening, understanding and responding to patients, staff and our partners

Relentlessly improving and innovating for patient safety

Achieving ambitious results by working together

Valuing every member of staff and their contribution to the care of our patients
Colonoscopy Process Map

June 2013

Improving Quality

Referral made → Request sent → Request vetted → Appointment scheduled → Appointment Letter produced → Appointment letter sent 2nd class → Patient telephones

Up to 10 days → 1 Day → 1 Day → 10 Days

Appointment Pre assessment agreed → Pre assessment performed → Pre assessment appointment sent → Pre assessment planned → Patient is telephoned → Appointment Re-scheduled → Request returned to scheduling

3 Weeks → 10 Days → 1 Day

Patient arrives → Patient changed → Directed to male or female waiting room → Procedure performed → Investigation reported → Patient to 1st stage recovery → 4 copies of printed report follows the patient

30 Mins → 30 Mins → 5 Mins → 20-30 Mins

Value added → Business non VA → Non VA

Patient home → Patient to 2nd stage recovery/discharge → Patient monitored → Scope sterilised & dried → Scope washed

20-30 Mins → 40-45 Mins → 10-15 Mins

Current State
Clinician Engagement

Staff event – clear diaries
cancel lists
ensure global representation
executive sponsor
senior clinician

RELEVANCE Global Rating Scale (GRS), ‘hard’ outcomes

visual stream map
invite suggestions
Colonoscopy Future State

- Referral made
- Appointment agreed
- Direct Booking
- Pre-assessment performed
- Information sent/given
- Appointment agreed
- Patient arrives
- Patient changed
- Directed to male/female waiting area
- Procedure performed
- Investigation reported
- Report printed
- Patient to 1st stage recovery
- Scope washed
- Scope dried
- Patient monitored
- Patient 2nd stage recovery
- Patient home

Removing 10 process steps and 25% rework at booking – potentially saving 2 days work and at least 3 weeks patient waiting time.
Clinician Engagement

Introduce the huddle
Straight to test
Unsedated gastroscopy pathway – straight to discharge lounge
Unsedated colonoscopy pathway
Photo montage of pathway through the unit
Home enemas for flexible sigmoidoscopy
Cannulation extended to band twos and threes
World Health Organisation checklist
Store cupboard, stock control, room homogeneity

Nurse consent
Reclining chairs for colonoscopy
Rationalise bowel prep use
Training nurse endoscopists

Three session days
Clinician Engagement

**BUT**

Not everything will work, and there’s not time for everything

Be prepared for some stick, actually, a lot of stick

Choose your battles

Rely on your colleagues

Data, data, data
Clinician Engagement

If all else fails:

Engaged workforce, high morale

Safer for patients

Better communication

You’ll know what needs doing
the bmj awards

Straight to test – worked example
Straight to test
What used to happen

GP referral
Consultant triage
Out-Patient Department (OPD) appointment
8 weeks
Colonoscopy appointment
6 weeks
OPD follow up
3 months

What used to happen
Straight to test

What now happens

- GP referral
- Nurse telephone assessment
- Colonoscopy appointment
- OPD review

3 days
2-3 weeks
Straight to test

How does it work?

GP makes Choose & Book appointment for any patient with colorectal symptoms

Telephone assessment by trained nurse for 20 minutes

Proforma and decision algorithm

Options are

- colonoscopy
- flexible sigmoidoscopy
- CT pneumocolon
- clinic
Straight to test

Lower gastrointestinal (GI) Testing

Patient assessed by a doctor or specialist nurse

Decision made as to future management

Post procedure

Data entered into database, outcomes tracked

Histology results to GP and patient

Patient satisfaction sought with survey monkey

Weekly and ad hoc debrief
Straight to test

Data 1

123 patients in first six months, 58 percent female

Mean age 60 (range 28-90)

76 percent on two week wait pathway

Two percent sigmoidoscopy, no patients required prior clinic assessment

Did not attend (DNA) rate three percent (unit average seven percent)
Straight to test

Data 2

Mean wait on two week wait pathway 13 days (range 5-14) 
i.e. saving of 54 percent

Mean wait on 18 week wait pathway 16 days (range 5-38) 
i.e. saving of 87 percent

Most common diagnoses 
diverticular disease 41 percent 
polyps 19 percent 
Irritable Bowel Disease 8 percent 
cancer six percent
Straight to test

Data 3

26 percent patients required clinic follow up

Estimated saving of over 12 clinic lists, saving of £22,596

Patient satisfaction very high
‘brilliant and efficient’
‘extremely pleased with the treatment I received’
‘whole team made me feel relaxed and confident’

Nobody has indicated they would prefer face to face consultation
Straight to test

Tried and Tested

Similar (but different) models exist elsewhere e.g.
- St Marks
- Dorset
- St Thomas’
- Northumberland
- Whittington
- Homerton
- Leeds

Uniquely different

All colorectal patients – gastro and surgical, two week wait and 18 week wait
Actively shared with other hospitals
- e.g.. UCLH Royal London
- Sussex Somerset South Wales
Straight to test

Please try it

More information:

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phillip.andrews@bartshealth.nhs.uk
lindsay.steward@bartshealth.nhs.uk
Learning Points

Every endoscopy unit needs service improvement

Productive Endoscopy offers a framework for delivery

Process starts and finishes with data

Data must be robust, transparent, and defendable

Benefits are enormous
Endoscopy webpage
http://www.nhsiq.nhs.uk/7923.aspx