VANGUARD ENDOSCOPY QUALITY COLLABORATIVE

Ed Seward
Dec 2016
OVERVIEW

What is a Vanguard

Why endoscopy efficiency is important

What we’d like to achieve

How you can help
National Cancer Vanguard

Part of the New Care Models Programme (from NHS Five Year Forward review)

Designed to try out novel ways of working to inform the rest of the NHS

In collaboration with two other cancer centres (Royal Marsden and The Christie)
Waiting lists across the sector have grown by 82% (Colonoscopy) from December 2013 to December 2015.
Most CCGs in NCEL/WE are below national median in terms of endoscopy access.
Faecal Immunochemical Test (FIT) & Positivity
Thresholds adopted by National Bowel Cancer Screening Programmes
(1st October 2016)

Predicted FIT positivity - % of participants referred for colonoscopy

Threshold used in the FIT pilot in England

Faecal Immunochemical Test (FIT) threshold (ug haemoglobin /g faeces)
PICTURE OF CURRENT ROLLOUT OF BSS

Scopes

- NHS England Trajectory
- Actual (attended)
## 11. Productivity and planning
The purpose of this standard is to ensure that resources and capacity are used effectively to provide a safe, efficient service. This is supported by sound business planning principles within the service.

<p>| 11.1 | Productivity metrics are agreed and documented in the service operational policy. | D | The service should consider including as a minimum the following performance and productivity data: overall/individual utilisation of lists, start and finish times audit, room turnaround audit, did not attend (DNA) and cancellation rates. |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.2</td>
<td>There is a weekly review of waits, demand, capacity and scheduling with key service leads.</td>
</tr>
<tr>
<td>11.3</td>
<td>There is active backfilling of vacant lists, the frequency of unfilled lists is reviewed during the weekly meeting and there is sufficient flexibility in the job plans of endoscopists to enable backfilling of funded (ie staffed) capacity.</td>
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<tr>
<td>11.4</td>
<td>The service offers an administrative and nursing (if appropriate) pre-check for all patients before the date of the procedure to identify issues and to avoid late cancellations.</td>
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<tr>
<td>11.5</td>
<td>Booking efficiency is monitored (through DNA and cancellation monitoring) at least monthly and is fed back to endoscopy staff.</td>
</tr>
<tr>
<td>11.6</td>
<td>Room utilisation data (such as start and finish times and room turnaround times) is collected, collated, reviewed and acted upon. There is an agreed room utilisation performance target.</td>
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<tr>
<td>11.7</td>
<td>There is an annual planning and productivity report for the service with an action plan.</td>
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<tr>
<td>11.8</td>
<td>Demand, capacity and utilisation data are used to inform short-and long-term business planning to ensure sufficient capacity, and the service has an agreed business plan if shortfalls are identified.</td>
</tr>
<tr>
<td>11.9</td>
<td>There is, on an annual basis, a measurement of the demand for endoscopy to support service planning.</td>
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TCST BASE LINING EXERCISE

Understanding capacity, demand and activity

Modelled 2015 baseline, provided a 2020 projection, and a projection plus ‘optimisation’

JAG return
WHAT DO WE MEAN BY ‘OPTIMISATION’

DNA/same day cancellation

List utilisation

Room utilisation

Start/stop audits

Bowel prep/surveillance/ STT
WHAT DO WE MEAN BY ‘OPTIMISATION’

But mostly – it’s up to you!

What does good look like?

What do you do well? What do you do less well?
Endoscopy Information - October

This month's utilisation

DNA Rate 3% - 53 points
(Last month 3%)

Late Cancellations
2% - 36 points
(Last month 3%)

Start and End Times

Referral Triage – outstanding

Patient comments

How likely are you to recommend our clinic to friends/family?

In October 56% morning sessions started late, totalling 2040 mins lost – equivalent to 136 points!

*based template points against actual points; excluding BCS, bronchoscopy and cystoscopy
Endoscopy Information - November

**Monthly Utilisation**
- Chart showing utilization data for rooms 1 to 7 and total.

**DNA Rate**
- 3% DNA - 55 points (Last month 3%)

**Late Cancellations**
- 4% - 72 points (Last month 2%)

**Patient comments**
- Well done on first class 5 star treatment.
- The staff were incredible, professional, empathetic, kind and very knowledgeable and reassuring.

**Friends & family test:**
- 96.4% would recommend

**CO2/Air COMFORT SCORE – Results of Nurses’ Audit**
- Graph showing comfort score results.

**Start and Finish Times (%)**
- Chart showing percentages of sessions ending late.

**Diagnostics waiting time compliance**
- Routine patients seen within 6 weeks: 84.8%
- Urgent patients seen within 2 weeks: 85%

In November 23% of sessions ended more than 20 minutes early. Thank you to Phoebe for the Comfort Score information.
WHAT TO DO WITH THE DATA

Do not allow it to be a one off

It must inform ongoing practice
OTHER IDEAS

**Process mapping** – optimise patient pathway

Split dosing of bowel prep – to reduce repeat procedure rate

Home enemas – to reduce pressure on recovery beds

Unsedated/entonox recovery pathways

In patient liaison nurse – to improve prep and smooth patient flow
TEAM HUDDLE
## QUALITY COLLABORATIVE DASHBOARD

<table>
<thead>
<tr>
<th>Measure</th>
<th>Outcome</th>
<th>RAG</th>
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</thead>
<tbody>
<tr>
<td>STT</td>
<td>Pathway in place</td>
<td>Red</td>
</tr>
<tr>
<td>Demand/capacity awareness</td>
<td>IMAS support tool or similar</td>
<td>Green</td>
</tr>
<tr>
<td>List utilisation</td>
<td>Backfilling &gt;90%</td>
<td>Red</td>
</tr>
<tr>
<td>DNA/cancellation rates</td>
<td>&lt;4%</td>
<td>Green</td>
</tr>
<tr>
<td>Room utilisation</td>
<td>Points on list optimised</td>
<td>Yellow</td>
</tr>
<tr>
<td>Start/stop audits</td>
<td>Lists start and finish on time &gt;90%</td>
<td>Green</td>
</tr>
<tr>
<td>Surveillance request validation</td>
<td>100% of surveillance requests</td>
<td>Green</td>
</tr>
<tr>
<td>Bowel prep adequate</td>
<td>&gt;90% of procedures</td>
<td>Red</td>
</tr>
</tbody>
</table>
Section 1 will give an overview of outcome data for context and comparisons

- Aim to show high level comparison of real world outcomes (for patients, and potentially for staff and Trusts)

- This sets context for why endoscopy efficiency and best practice matter, that is:
  - Performance varies across the area
  - All Trusts face serious issues for capacity and demand

- Other potential metrics include:
  - Overall cost of unit/ cost per activity
  - Clinical outcomes
  - Patient satisfaction (FFT?)
  - Staff satisfaction/ staff vacancy rate

Legend:
- The Whittington
- University College London
- Royal Free London
- North Middlessex University
- Homerton University
- Barts Health
- Barking, Havering & Redbridge
- The Prince's Alexandra
**Section 2 will break down non-productive time to show the efficiency of the endoscopy unit’s physical resources**

### Overall efficiency of Endoscopy Unit

<table>
<thead>
<tr>
<th></th>
<th>100%</th>
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<tbody>
<tr>
<td>Total resource</td>
<td></td>
</tr>
<tr>
<td>Resource not used all week [e.g. room not operational]</td>
<td></td>
</tr>
<tr>
<td>Resource not used during week [e.g. weekends/evenings not scheduled]</td>
<td></td>
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<tr>
<td>Low List utilisation [e.g. 7 points per list instead of 12]</td>
<td></td>
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<tr>
<td>Slots not booked on lists [e.g. unfilled hospital cancellation]</td>
<td></td>
</tr>
<tr>
<td>DNAs (defined as on day PLUS cancellations too late to rebook)</td>
<td></td>
</tr>
<tr>
<td>Scopes not completed [e.g. due to late start]</td>
<td></td>
</tr>
<tr>
<td>Re-work [e.g. bowel prep not correct]</td>
<td></td>
</tr>
<tr>
<td><strong>Productive Time (overall efficiency)</strong></td>
<td><strong>42%</strong></td>
</tr>
</tbody>
</table>

- **5%**
- **12%**
- **8%**
- **8%**
- **4%**
- **4%**
- **4%**
- **4%**
- **4%**
- **4%**

This could be highlighted with key root cause information (more detail in section 3)

- The aim is to break down efficiency of the unit to highlight areas of waste
- The common unit throughout is physical capacity multiplied by time. This allows different wastes to be stacked up to 100% and directly compared
  - For example tracking “hospital cancellation rate” would be valuable but is not directly comparable with DNAs as these cancellations are usually refilled
  - Instead we would look at unbooked slots (which may be the result of cancellations or for other reasons). The cancellation rate would appear in section 3
Section 3 would then provide supporting information and root causes behind each of the categories of waste

- Each of the (currently 7) wastes identified in section 2 will then have their own appendix of supporting information and root causes for either positive/negative performance
- Best practice would be taken from the JAG

<table>
<thead>
<tr>
<th>What are the known issues which contribute to waste in this area?</th>
<th>What systems do you have in place to address these issues?</th>
<th>How operational are these systems (e.g. are staff compliant?)</th>
<th>What have been the results?</th>
</tr>
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<tbody>
<tr>
<td>Short notice cancellations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinician leave planning and rotas</td>
<td></td>
<td></td>
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<tr>
<td>Supporting quotes and comments</td>
<td></td>
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</tbody>
</table>

Example: Supporting information for list slots not booked

<table>
<thead>
<tr>
<th>Hospital cancellation rate</th>
<th>UNIVERSITY COLLEGE LONDON</th>
<th>BARKING, HAVERING AND REDBRIDGE</th>
<th>THE PRINCESS ALEXANDRA</th>
<th>THE WHITTINGTON</th>
<th>BARTS HEALTH</th>
<th>ROYAL FREE LONDON</th>
<th>HOMERTON UNIVERSITY</th>
<th>NORTH MIDDLESEX UNIVERSITY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.2%</td>
<td>5.4%</td>
<td>6.0%</td>
<td>10.0%</td>
<td>13.6%</td>
<td>13.7%</td>
<td>16.8%</td>
<td>17.4%</td>
</tr>
</tbody>
</table>
OBJECTIVE OUTCOMES

Measured at 6 and 12 months (and thereafter?)

Improvement in dashboard RAG status

Improvement in throughput: activity/capacity = efficiency ratio

Possible clinical outcomes such as unit ADR to follow
OTHER OUTPUTS FROM VANGUARD

**GUT**

*Faecal haemoglobin and faecal calprotectin as indicators of bowel disease in patients presenting to primary care with bowel symptoms*

Craig Mowat, Jayne Digby, Judith A Strachan, Robyn Wilson, Francis A Carey, Callum G Fraser and Robert J C Steele

*Gut* published online August 20, 2015

Colon capsule
CONCLUSIONS

Service improvement is a necessity

Service improvement can allow every department to run more efficiently, be more patient focused, be more team centred and be more fun

Vanguard wide quality collaborative should provide support
THANK YOU

edward.seward@uclh.nhs.uk