Lean service redesign in GI: with productive outpatients

Project sponsor - Richard Cohen
Project Lead - Esther Rainbow - Assistant General Manager, GI Services
Clinical Lead - Mr Jonathan McCullough - GI Consultant
Why Productive Outpatients?

Identification of appropriate speciality as Colorectal due to:
- Waiting times
- RTT
- Patient experience

Preparation and Start Up:
Dedicated focus on Colorectal, with involvement of whole team and all clinics
Strong admin engagement with 2 Colorectal Pathway Co-ordinators,
Pathway Manager, Service Manager & AGM
Some cross divisional links with GI Medicine, important for later initiatives
Three Distinct Projects:

1) Diagnostic Review Spreadsheet

2) Straight to scope

3) Intestinal Failure Pathway Redesign
First steps

Meeting with clinical staff to ensure multi-disciplinary ownership

Key points:
Understanding the perspectives - clinical & management/performance
Patient Waits
Volume of patient in clinics

Involving full MDT
Nurses
Reception staff
HCA
QEP Team
Redesign Event
1) Pathway Redesign – Diagnostic Spreadsheet

Old pathway –
every patient sent for tests would come back to clinic

New pathway –
results are reviewed and only appropriate patients brought back

• Reduction in N:Fup
• Better patient experience
• 50% of patients discharged without having to come back to clinic
• Major reduction in waiting times for patients – reduced by 25%
• From 12 weeks to 8 for new patients
Impact on waiting times
Pathway Changes – Straight to Scope
Colorectal Pathway Process Map

1. Patient referred by GP
   - Referral through C&B or Dr
2. Sent to Pathway Coordinators
3. Referral Graded
4. Sent to Contact Centre
5. Current wait times
   - 24 hours
   - 5 - 7 days
   - Current wait times 11 - 13 weeks
6. In 24 Hours
   - Current DC wait approx 1 month
   - Current IP wait approx 3/4 months
7. Total Wait
   - IP 24 - 30 WEEKS
   - DC 16.5 - 19 WEEKS
8. Follow Up Required
9. Patient sent for tests
10. Patient attends appointment
11. Patient Discharged (Treated/Self Discharge/No treatment) (CLOCK STOP)
12. Patient added to Waiting List
13. Patient added to Waiting List
14. Patient contacted and availability confirmed.
15. Date for surgery & pre assessment given
16. Patient attends pre assessment
17. Patient attends for surgery. Treated (CLOCK STOP)
18. Patient DNA's - discharge (CLOCK STOP)
19. Patient DNA's TCI (Discharge - CLOCK STOP)
20. Patient attends for post surgery follow up (NO CLOCK)
21. Patient DNA's - discharge (CLOCK STOP)
22. Patient Unfit - discharged by pre assessment back to GP (CLOCK STOP)
23. Patient discharged (CLOCK STOP)
24. Further treatment required (NEW CLOCK)
25. Patient Discharged

Continues below...
Within 2 weeks

Within 6 weeks

In 24 Hours

Straight to Scope Initiative

A clinical triage assessment made by nurse in the telephone assessment clinic

Patient presents with lower GI symptoms to GP who refers on 2ww. GP refers patient via Choose and Book to 2ww Outpatient Telephone clinic

Patient sent for Clinical Review (Outpatients)

Patient sent for colonoscopy

Patient sent for Flexi Sig

Patient Discharged (Treatment given at endoscopy / Treatment suitable for GP / No Treatment Required)

Patient referred on to Gastro/Medical Team

In 24 Hours

Patient DNA's TCI (Discharge - CLO CK STOP)

Patient attends for surgery. Treated (CLOCK STOP)

Patient attends for post surgery follow up (NO CLOCK)

Patient Discharged

Further treatment required (NEW CLOCK)

Polyps removed at endoscopy. Haemorrhoids given advice regarding treatment (for those not requiring surgery). These patients never hit outpatient setting

Triage is supported by Colorectal Consultant and follows strict written guidelines - those unsuitable for telephone continue to clinic. However, estimated reduction in approx 15-20 outpatient appts.

Patients over 40 with the same referred for colonoscopy

Those under 40 for anal symptoms such as bleeding, itching etc considered for flexi sig.

Patient contacted and availability confirmed. Date for surgery & pre assessment given

Digestive Assessments

Patient attended clinic

Patient contacted and booked for 2ww telephone clinic

Patient contacts Pathway Coordinators to overbook if necessary

Patient Discharged

Further treatment required (NEW CLOCK)

Patient Unfit - discharged by pre assessment back to GP (CLOCK STOP)

Patient DNA's - discharge (CLOCK STOP)

Ward Clerk books follow up appointment or contacts Pathway Coordinators to overbook if necessary

Patient Added to Waiting List

Patient added to waiting list

EPR completed by Clinician. Added to EPR by the Admission Coordinators

Patient contacted by Admission Coordinators by telephone to confirm availability. Appropriate pauses added to EPR if unavailable following Access Policy Guidelines

Patient contacted and availability confirmed. Date for surgery & pre assessment given

Patient DNA's TCI (Discharge - CLOCK STOP)

Patient attends pre assessment

Patient Untt - discharged by pre assessment back to GP (CLOCK STOP)

Patient DNA's TCI (Discharge - CLOCK STOP)

Patient DNA's - discharge (CLOCK STOP)

EPR completed by Clinician. Added to EPR by the Admission Coordinators

Patient DNA's TCI (Discharge - CLOCK STOP)

Patient attends pre assessment

Patient DNA's TCI (Discharge - CLOCK STOP)

Patient attends for surgery. Treated (CLOCK STOP)

Patient attends for post surgery follow up (NO CLOCK)

Patient Discharged

Further treatment required (NEW CLOCK)
Straight to Scope Pathway Improvements:

Current waits for OPD focussed model –
• Up to 10 weeks for OPD
• Up to 6 weeks for diagnostics
• Up to 8 weeks for f/up

Waits with S2S model -
• 2 weeks from referral to triage
• Up to 6 weeks for diagnostics
• Clinical decision for 50% of patients made on day of scope or within 5 days (diagnostic spreadsheet)
OPD Pathway Reduction post straight to scope
Straight to Scope - Where are we?

Strong engagement across MDT

- DCD Richard Cohen leading
- Rachel Evans (SpR) undertaking local audit
- Jacquie Peck (CNS) advising regarding London Cancer initiative
- Jason Willis (GM) leading on management of project

Audit objective

To audit a controlled group of patients to review appropriate patients for Straight to Scope Initiative, and to track whether expected reduction in wait times has been achieved. In addition, to ensure change to Straight to Scope is patient centred by reviewing patient feedback via a survey.
Start Up

Suitable patients reviewed by Richard Cohen from referrals

Patients booked in to specialist Straight to Scope clinic run by Rachel Evans for review

Wait time audit as well as clinical appropriateness

Patients asked to complete survey to gain feedback of the initiative

Audit undertaken by Rachel Evans regarding suitability post OPA
Audit Data (so far):

97% of patients were suitable for S2S

97% patients had clear enough referrals that a decision could have been made at the time of referral/grading, that patient was suitable for S2S

Average wait for first appointment was 3.8 weeks.

Current wait for New appt in Colorectal clinics, at present, is 8 weeks –reduction of 4 weeks wait
Patient views - survey monkey results:

Would you have preferred a telephone consultation if this option was available to you?
- Yes: 82.14%
- No: 17.86%

We are aiming to start a straight to test service. Is this something you would like to see?
- Yes: 96.43%
- No: 3.57%
Next Steps – S2S

• Clear pro-forma for telephone assessment
• Nurse led service with Consultant support
• Recruitment of Nurse Specialist
• Review of Endoscopy capacity and impact of S2S
• Discharge from colonoscopy
• GP engagement
• Choose and Book clinic booking
• Expansion for other services
1. Short term inaccessible or non-functioning gut
   - self-limiting/treatable IF (e.g., post-op ileus)
   - temporary PN

2. Complex metabolic/nutritional disturbance
   - Surgical misadventure (e.g., sepsis & EC fistulae)
   - uncertain prognosis / potential surgical resolution
   - multidisciplinary care

3. Chronic gut failure
   - need HPN (e.g., enterectomy for mesenteric infarction)
Multidisciplinary Team Approach

PATIENT

- GASTROENTEROLOGY
- RADIOLOGY
- SURGEONS
- NUTRITIONISTS
- THEATRE STAFF
- INTENSIVE CARE
- SPECIALIST NURSING
No Matter How Skilled….
At some stage we all end up in the sh.......!

The next decisions are critical...
Dear Mr Engledow

RE: Mr [REDACTED] D.O.B: 16/1/69, MRN 26391582

Would you be so kind as to review this gentleman, with the view of possible transfer to UCLH Abdominal Catastrophe unit. I believe Mr Frances has discussed him with you already.
Intestinal Failure Pathway Redesign

• Complex patients requiring inpatient assessment

• Previous inpatient assessment had an average LOS of 58 days, costing £28,000 per pre assessment per patient

• Reliance on junior staff to organise assessment – unplanned

• Lack of formalised communication within MDT
Changes so far for IF Pathway:

• Implementation of weekly MDT

• New model agreed

• Planned admissions with aim for 3 day assessment period led by peri-operative team - £1,400 cost for pre-assessment per patient

• Planned discharge with better links with discharge team/coordinators
University College London Hospitals
NHS Foundation Trust

Peri-Operative Team
Nutrition/Gastro Team
Radiology/Imaging
Colorectal Surgical Team
Colorectal Admin Team
Bed Manager/Discharge Co-Ordinator
Pain Management Consultant

IF MDT
Next Steps:

Successful 3 day assessment period

Better links with referring hospitals to support transfer and discharge

Increased IP capacity (extended days)

Formalised admin support

Formalised peri-operative support
Next Steps:

Large projects including straight to scope & IF redesign

Further capacity and demand review – move away from waiting list initiatives

Share good practice with other GI Teams

More POP!