Inspecting Informing Improving

Healthcare Commission

Taking a closer look

Endoscopy services in acute trusts

Acute hospital portfolio review

First published in March 2007

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The Healthcare Commission

The Healthcare Commission exists to promote improvements in the quality of healthcare and public health in England. We are committed to making a real difference to the provision of healthcare and to promoting continuous improvement for the benefit of patients and the public. The Healthcare Commission's full name is the Commission for Healthcare Audit and Inspection.

The Healthcare Commission was created under the Health and Social Care (Community Health and Standards) Act 2003. The organisation has a range of new functions and took over some responsibilities from other Commissions. It:

- replaces the Commission for Health Improvement (CHI), which ceased to exist on 31st March 2004
- takes over functions relating to independent healthcare previously carried out by the National Care Standards Commission, which also ceased to exist on 31st March 2004
- carries out the elements of the Audit Commission's work relating to the efficiency, effectiveness and economy of healthcare

We have a statutory duty to assess the performance of healthcare organisations in the NHS and award annual ratings of performance, to coordinate inspections and reviews of healthcare organisations carried out by others, and register organisations providing healthcare in the independent sector on an annual basis.

We have created an entirely new approach to assessing and reporting on the performance of healthcare organisations. Our annual health check examines a much broader range of factors than in the past, enabling us to report on what really matters to patients and the public.

Executive summary

This report presents the key national findings of an acute hospital portfolio* review of gastrointestinal endoscopy carried out in NHS acute hospitals in England. Endoscopy involves the use of a flexible device with a light attached (an endoscope) to check for the presence of polyps and other abnormalities in a body cavity such as the stomach or intestines. It was one of three components of an integrated review of the main diagnostic services in NHS trusts which the Healthcare Commission carried out in 2005, the others being imaging and pathology.

Of these three diagnostic services, endoscopy is the smallest, dealing with just over a million patients a year. Many endoscopy units have received less attention from management than imaging or pathology departments, and in many acute hospital trusts they lack a direct voice in decisions about planning services and investments. Yet endoscopy is as vital as the major diagnostic services to the successful treatment of serious diseases such as bowel cancer.

The greatest challenge facing all diagnostic services at the present time is to help trusts meet the Government's target of a maximum wait for patients, by the end of 2008, of 18 weeks from referral to treatment. The Department of Health set a milestone that by March 2007 no patient should wait for more than 13 weeks for a diagnostic test. Despite their best efforts, it has been a major challenge for some trusts to achieve this milestone for colonoscopies and gastroscopies. The difficulties have been exacerbated by rising numbers of referrals. The Department of Health's National Endoscopy Team has been active in improving the training of endoscopists and the tools for assessing the quality of endoscopy units with a view to increasing safety and giving patients a better experience.

The required improvements in waiting times and clinical quality must be delivered at a time when there are major uncertainties about the future shape of diagnostic services in acute trusts due to more choice for patients, practice-based commissioning and the potential growth of alternative facilities in the independent sector and in the community.

Our review sought to provide each trust with a clear picture of how its endoscopy units were performing and to provide a sound basis for future service level agreements and decisions about the reconfiguration of services.

Auditors have already agreed local findings and recommendations for action with each NHS trust. In March 2006 we distributed comparative data and presentation software to enable trusts to identify and prioritise areas for improvement. We also used the review's top-level performance indicators in our annual health check assessment of the provision of diagnostic services by each trust, which we published on August 25th 2006.

* A collection of reviews of key services, resources or issues of national concern and importance to patients, NHS trust managers and clinicians. From 2007 it will become part of a programme of service reviews. More information is available on our website: www.healthcarecommission.org.uk/acutehospitalportfolio

Key findings

Activity: there are marked regional differences in the number of endoscopies carried out. In relation to population, the number of colonoscopies and flexi-sigmoidoscopies (the use of an endoscope to examine the rectum and lower colon) carried out in the north east was more than double that in London. This variation is greater than could be explained by regional differences in the incidence of cancers. The mix of procedures also differs.

Waiting times: though long waits for endoscopic procedures have almost been eliminated in many trusts, unacceptable delays remain. The longest delays are concentrated in a few parts of the country. In December 2006, 50% of patients requiring a colonoscopy in the south east had been on a waiting list for more than 26 weeks, compared with less than 0.2% in the north east and Yorkshire. Unless there is a major increase in activity within the NHS or an expansion of the independent sector, these delays will endanger achievement of the Government's target of a maximum wait of 18 weeks from referral to treatment.

The patient's experience: most patients received good information before the procedure and on discharge. However some endoscopy units lacked facilities for private discussions, and at 44% of units formal consent was not secured until the patient was in the procedure room.

Assuring clinical quality: there were unacceptable variations in caecal intubation rates, (the proportion of colonoscopies that succeed in viewing the target areas of the bowel). Although this is a very important measure, 45% of trusts did not monitor their caecal completion rate. Of those that did, only 41% were achieving the 90% success target agreed for the National Bowel Cancer Screening Programme.

Some endoscopy units were five times more likely to find and report a polyp (abnormality) during a colonoscopy than others. Those that discovered more polyps took longer to carry out each colonoscopy.

Sedation was often given to older patients at levels in excess of the recommendations of the British Society of Gastroenterology, with no apparent increase in comfort for the patient.

Clinicians and professional bodies are making major efforts to raise the quality of endoscopy units to a common high level through training, development of clinical indicators, self-assessment systems and related knowledge management databases, and the introduction of an accreditation scheme.

Extended roles: greater use of nurse endoscopists (and other non-medical endoscopists) could reduce delays and increase the number of patients seen. While 85% of trusts employed nurse endoscopists, they were allocated just 13% of all programmed sessions.

Facilities: some endoscopy units had insufficient recovery places for the number of patients they saw. Recovery space was identified as a major 'bottleneck' by 37% of unit managers. The units with the most recovery places had four times as many for every endoscopy room as those with the least.

Equipment: older endoscopes are less versatile and less reliable than modern equipment. Twenty-eight per cent of the endoscopes in use were over eight years old. Some units had a far higher proportion of older equipment than others.

Efficient use of resources: one unit in eight cancelled over 20% of its scheduled sessions. This wastes the time of staff and other resources.

Use of information technology: 85% of units have a computer system for recording and quickly reporting results. However, 24% of these units reported that not all of their endoscopists made use of it.

Management: one endoscopy unit in seven had no designated consultant in overall clinical charge, and responsibilities for operational development of endoscopy within a trust were often spread among a number of managers.

Recommendations

Our review has highlighted areas that would benefit from adopting the following:

Trusts:

- appoint a single manager responsible for the planning and oversight of endoscopy, as well as a clinical lead for each unit and a nurse manager in charge of its day-to-day running
- ensure that endoscopy is adequately represented on the forums that decide on the allocation of resources to upgrade facilities and equipment
- set up an endoscopy user group
- persuade endoscopists in units with disparities in waiting times to 'pool' their individual lists
- improve procedures for re-assigning cancelled or under-used sessions to other endoscopists
- expand the role of nurse endoscopists (and other non-medical staff qualified to carry out endoscopy) whenever this could help to increase the number of patients treated and reduce waiting times
- ensure sufficient recovery facilities, including toilets, for the number of patients treated
- provide a computer system to record procedures and report results, and promote its use by all clinicians working in the unit. This computer system must be able to tabulate data that is required for clinical audit and for management of the unit

Clinicians:

By working locally and through national bodies:

- examine the reasons for regional and local variations in referral rates and review the referral guidelines as necessary
- agree a minimum set of clinical indicators that all units should monitor to a common standard
- continue to improve caecal intubation rates through training and clinical audit of failed procedures so as to achieve the 90% target by 2011
- do more to promulgate the adoption of recommended doses of sedatives and to determine whether it is sometimes appropriate to give higher doses, with a view to refining the guidelines
- ensure that patients consent formally to the endoscopy before they enter the procedure room or undress

Commissioning bodies:

- ensure that trusts have reviewed existing services and are satisfied that they are operating efficiently
- consider how best to expand provision, using the independent sector if necessary, in parts of the country where waiting times are still excessive
- agree how trusts will take forward the replacement of inadequate facilities and ageing equipment

Introduction

Endoscopic procedures involve the use of a flexible device with a light attached (an endoscope) to check for the presence of polyps and other abnormalities in a body cavity such as the stomach or intestines. These instruments, which come in a variety of types, can also be used to take samples of these polyps for analysis in a pathology laboratory. Most endoscopes transmit images to a computer screen.

This report is about gastrointestinal endoscopic procedures such as gastroscopy, flexi-sigmoidoscopy and colonoscopy and the units in acute hospitals where they are performed.

These procedures are carried out by: gastroenterologists who specialise in endoscopy but usually also see patients in outpatient clinics and on the wards; by colorectal surgeons or coloproctologists with an interest in endoscopy; by GP endoscopists; and, increasingly, by nurse endoscopists. They are supported by endoscopy nurses, one of whom is usually in charge of the day-to-day running of the unit, by technicians and by a small number of administrative and clerical staff. Endoscopists also perform endoscopic retrograde cholangio-pancreatography (ERCP) examinations of the pancreatic and bile ducts, although in two out of every three hospitals the procedure itself takes place in an imaging department rather than an endoscopy unit.

In many hospitals, doctors from other specialties also use endoscopy units for 'guest procedures' such as bronchoscopies and cystoscopies. Guest procedures account for an average of 12% of the total performed in the units reviewed here.

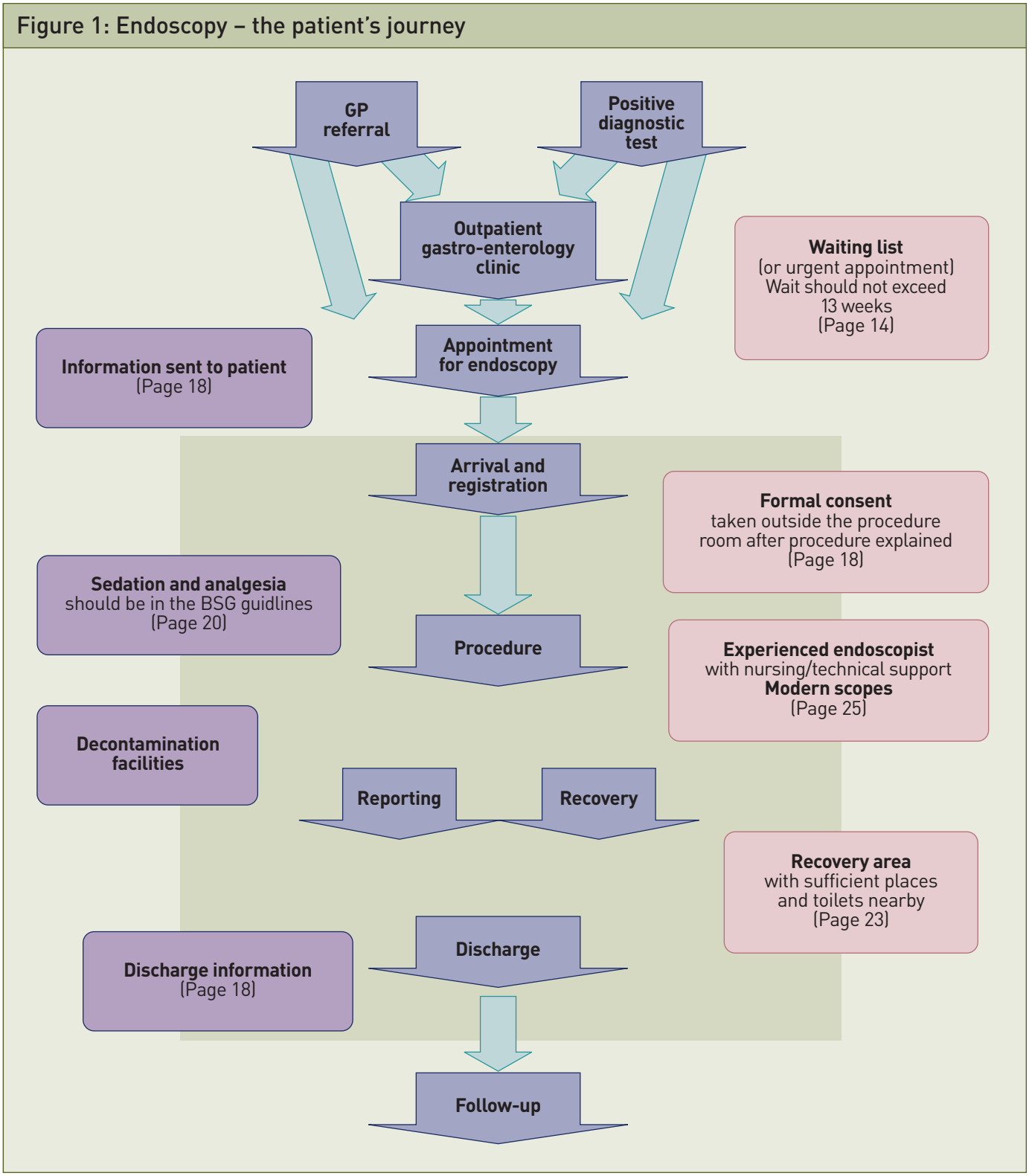
This review includes neither specialist gynaecological endoscopy units nor the types of endoscopic surgical procedure carried out in day surgery units, usually under general anaesthesia (referred to in the Healthcare Commission's *Acute hospital portfolio review: Day surgery* published in 2005). It does however include some gastrointestinal endoscopy suites that share reception and recovery facilities with day surgery units while retaining their own clinical staff.

This is one of three reports on diagnostic services to be published by the Healthcare Commission in 2007, the others being pathology and imaging services. In comparison with these, gastrointestinal endoscopy might at first sight seem to be a minuscule operation – just over a million endoscopy procedures are carried out each year, compared with 175 million pathology analyses. As a result, endoscopy services have received less attention from management. The responsibilities of management for endoscopy are diffuse in many trusts and units lack a direct voice in decisions about planning services and investments. Yet swift and accurate endoscopic diagnosis is as vital as the major diagnostic services to the successful treatment of serious diseases such as bowel cancer.

The key challenge facing all providers of diagnostic services at present is to meet the Government's target that by the end of 2008 patients should face a maximum wait of 18 weeks from referral to the start of their treatment. There are also more stringent 61-day targets for patients with suspected cancers. To achieve these targets, the Department of Health also set the primary care trusts (PCTs) who commission these services the milestone of ensuring that, by March 2007, no patient has to wait more than 13 weeks for a diagnostic test.

The PCTs currently rely heavily on acute hospitals for endoscopic examinations. Despite their best efforts some acute trusts

Figure 1: Endoscopy – the patient's journey



Source: Healthcare Commission

face a major task, exacerbated by rising referral rates, in achieving the 13-week milestone for colonoscopies and gastroscopies.

The introduction over the next two years of the new National Bowel Cancer Screening Programme is likely to result in a further increase in workload for about 100 endoscopy units that have been selected to be screening centres. This is because those patients whose initial home test results prove positive will be called for a colonoscopy.

In recent years increased importance has been accorded to improving the training of endoscopists in order to reduce clinical risk and make the experience more acceptable to patients. In 2005, the Department of Health's National Endoscopy Team introduced a tool to enable units to assess the quality of their own services, the Global Rating Scale (www.grs.nhs.uk). This is now used twice a year by all NHS endoscopy units in England. The results give a rounded picture of the units' comparative strengths and weaknesses and are linked to a knowledge management system that points to sources of advice on good practice.

The required improvements in waiting times and clinical quality must be delivered at a time when there are significant uncertainties about the future shape of diagnostic services in acute trusts. The introduction of payment by results, initiatives giving patients more choice, practice-based commissioning and policies that encourage the growth of diagnostic and treatment facilities in the independent sector have created uncertainty about the stability of funding in the future. In the medium term clinical and technological advances may tip the balance from endoscopy to non-invasive imaging techniques* for the detection of some types of bowel cancer.

These actual and potential changes make it imperative that each trust has a clear view of how its endoscopy units are performing at present so that there is a sound basis to inform service level agreements and decisions on the reconfiguration of services. This report seeks to draw the bigger picture made up of the results from the individual units.

About this report

Much of this report is based on data collected from all relevant endoscopy units in NHS acute hospitals in England** during the autumn of 2005. The review did not cover units in the independent sector or endoscopies performed by GPs or other practitioners outside an acute hospital.

Based on the data collected, we defined indicators and produced a framework of performance (see figure 2), databases and guidance. We used the most important indicators as a measure of performance to provide scores for diagnostic services in our annual health check for 2005/2006 (these scores were published on August 25th 2006).

* Virtual colonoscopy imaging techniques, such as computed tomography (CT) or magnetic resonance imaging (MRI) colography and double-contrast barium enema, are currently regarded as less reliable than endoscopy and too expensive for routine cancer screening, although they are used if a bowel obstruction prevents completion of a standard colonoscopy. However, if the technology continues to advance in a few years' time many patients may opt for these non-invasive procedures.

** Similar reviews took place in Wales and Northern Ireland but they are not included in this report.

Figure 2: Framework of performance for the review of endoscopy services

Theme	Issue	Example indicators
How does demand vary between units and across the country?	Are levels of demand in line with expectations?	GP/outpatient procedures per catchment population per year
	How fast is workload growing?	Annual % growth in workload by procedure type and source
Do those using services have a good experience?	How long are the waits for an endoscopy?	Current waits for gastroscopies, flexi-sigmoidoscopies, colonoscopies and ERCP – urgent/routine
		Hours/week that the unit is open
	Are results reported promptly?	Average turnaround for reporting routine examinations
	Are services focused on patients?	Patient experience score, consent, discharge information, privacy
Is the clinical quality of services good?	What proportion of procedures achieve their objective?	Caecal intubation rate for colonoscopies
	Is sedation given in line with professional recommendations?	Percentage of older patients sedated in line with BSG recommendations
	Are there suitable arrangements for out-of-hours endoscopy?	Location of emergency endoscopies out-of-hours and endoscopist cover
	What clinical indicators are monitored/audited?	Monitoring, feedback and change: clinical issues
Is there enough capacity to meet demand?	Are there adequate recovery facilities?	Recovery places per endoscopy room and toilets per 1,000 procedures
	How modern is the equipment?	Percentage scopes that are over eight years old and that are fibre optic
Are services efficient and well-managed?	Are the levels and mix of staff appropriate?	WTE staff in post, nursing grade-mix, % administrative staff
	Could nurse endoscopists have a greater role?	Endoscopy sessions per week by type of endoscopist
	Is there a stable workforce with low sickness and absence?	Sickness and absence, vacancy and turnover rates, bank and agency nurses
	How productive are staff?	Ratios of total and weighted procedures to staff
	How intensively are resources used?	Weighted activity per endoscopy room and per recovery bed/place
		Percentage planned sessions unused
	Is there a clear management structure?	Clinical leadership, day-to-day and strategic management responsibilities
	Is appropriate use made of automation, IT and management information?	Monitoring of management information: checklist
		Availability of information and digital technology score

Note: Issues included in the annual health check of diagnostics services are shown in bold boxes

This report draws on a wider set of indicators than the annual health check, including those used by reviewers appointed by the Audit Commission (working in partnership with the Healthcare Commission). The Audit Commission reviewers have now produced local reports based on standard templates for each trust and agreed conclusions and action plans with them. The trusts have had access to the review's databases and to 'Compare' presentation software (which enables them to compare their performance with that of others) since March 2006 and many will have already used them to promote improvements in services.

This report also uses data from two other principal sources:

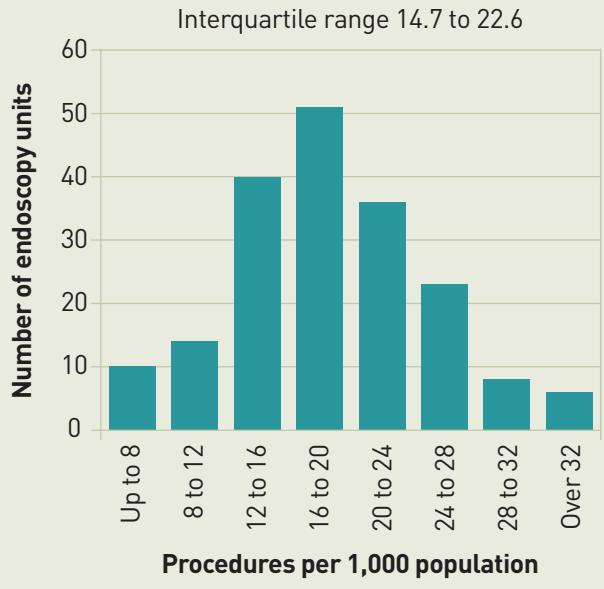
- the national monitoring data on the number of patients waiting for key diagnostic procedures and activity that has been collected by the Department of Health since January 2006
- results of mini-audits of colonoscopy completion and sedation carried out on patients aged 70 or over. These were developed by the Healthcare Commission with the British Society of Gastroenterology and carried out at 27 self-selected endoscopy units, mainly in the autumn of 2005

Meeting increasing demand

The average endoscopy unit that we reviewed performs about 2,500 gastroscopies, 1,100 colonoscopies, 900 flexi-sigmoidoscopies, 170 ERCPs and 350 guest procedures (bronchoscopies and cystoscopies) every year. However, the size of units and the mix of procedures that they carry out vary greatly, as do referral rates and the rate of growth in workload (the smallest unit reviewed performed only 400 procedures a year, the largest 19,000).

Some trusts carry out up to four times as many gastrointestinal endoscopies in relation to their catchment populations as those that are least active (see figure 3).

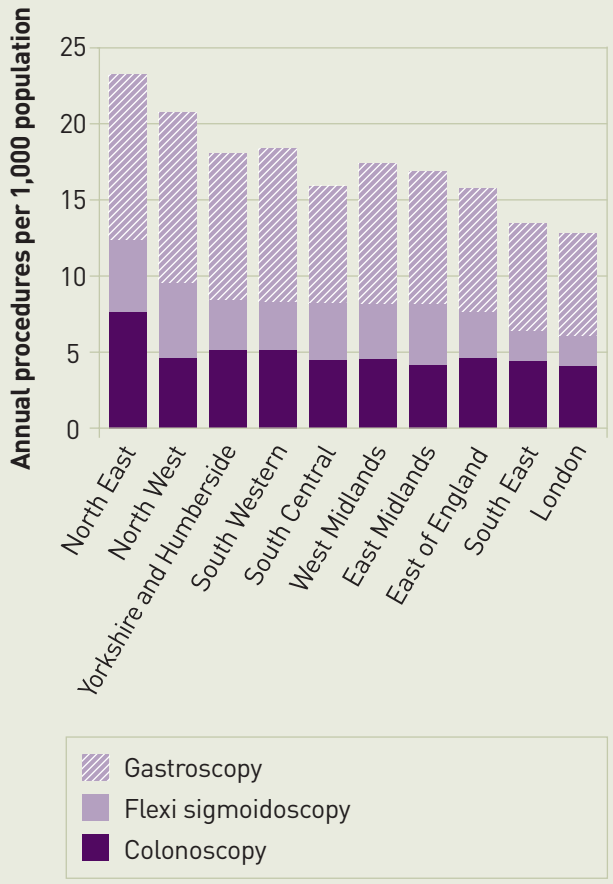
Figure 3: Gastro-intestinal endoscopies per 1,000 catchment population



Source: Healthcare Commission acute hospital portfolio returns, April to September 2005.

Much of this variation is regional (see figure 4). The rate of bowel examinations in the north east (colonoscopies and flexi-sigmoidoscopies either planned, unscheduled or from the waiting list during March to October 2006) was 12.3 per 1,000 population, which is twice the rate in London (6.0 per 1,000 population).

Figure 4: Regional variations in endoscopy



Source: Healthcare Commission from Department of Health's 18-week wait monitoring figures and 2004 mid-year estimates of SHA resident population based on the ONS 2001 census, March to October 2006 (excluding May for which no data is available) – annual equivalent.

To some extent, this may reflect differences in the incidence of disease. For example, the incidence of colorectal cancers in the former Northern and Yorkshire region was 22% higher for men (although slightly lower for women) than in the former South Thames region. This only partly explains the difference, however, and there is wide variation among units within the same region*. There are also marked regional variations in the ratio of colonoscopies to the simpler flexi-sigmoidoscopies. In the south east 69% of bowel examinations are full colonoscopies, compared with only 48% in the north west.

Comparing the number of procedures during the six months ending September 30th 2005 with those during the six months ending September 30th 2003, there was a national average year-on-year increase of: 13% in the number of flexi-sigmoidoscopies, 11% for colonoscopies, 7% for ERCPs and 2% for gastroscopies. The number of guest procedures was increasing too: cystoscopies by about 8.5% a year and bronchoscopies by 5.5%. There was also a shift of 3% a year towards endoscopic procedures involving therapeutic intervention in addition to diagnosis. At many endoscopy units the recent drives to eliminate backlogs of patients facing long waits has greatly increased these underlying rates of growth in activity.

Table 1: Weightings for endoscopic procedures

	BSG points	
	Diagnostic	Therapeutic
Gastroscopy	1	2
Flexi-sigmoidoscopy	1	2
Colonoscopy	2	3
ERCP	2	3
Breath tests	1	-
Scale extended for this review to cover bronchoscopies and other 'guest' procedures	1.5	

Note: One BSG point typically equates to a 20-minute procedure

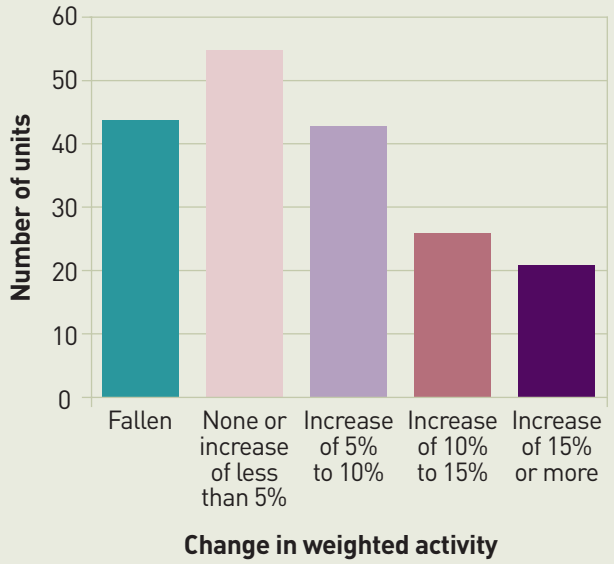
The workload of most units is therefore growing not only in terms of the numbers of procedures performed but also in complexity and the average time required for each procedure. Trusts need to consider both the shift in case mix and growth in the volume of cases when deciding what resources units need. One way of quantifying the change in case mix is to use the weightings for each type of procedure developed by the British Society of Gastroenterology (BSG), which are based on the average duration of each type of procedure (table 1). Multiplying numbers of procedures by their expected average durations and totalling the results suggests that the time required to carry them out was growing by an average of 7.3% a year. This growth rate may not accurately reflect the local picture,

* Rates for individual units need to be treated with caution as some units were unable to estimate catchment populations reliably. Where estimates of a trust's catchment population summed from those given by endoscopy units differ widely from those from other sources, rates for those units have been excluded from the figures presented here. Regional differences in private sector provision and in numbers of gastroenterology consultants have been suggested as other possible contributory factors.

however: 23% of units had a falling workload, while that of 11% of units was increasing at a rate that was more than twice the national average (figure 5).

More evidence is needed to show whether this growth in referrals and activity is reflected in improved detection of polyps or cancerous growths. Units should examine the reasons for high rates of growth in activity and consider whether they are justified. The review showed that referrals directly from GPs accounted for 22% of activity (table 2), and that this sector was growing faster than average, in contrast to below-average growth in numbers of endoscopies carried out on inpatients. There was a particularly wide variation in the rate of planned follow-ups: at one in 10 units more than 18% of procedures were follow-ups.

Figure 5: Annual change in workload of endoscopy units



Source: Healthcare Commission acute hospital portfolio data returns, September 2005 compared to September 2003 (difference halved).

Table 2: Source of referrals for endoscopy

Inpatient	18.0%
Outpatient	43.3%
GP	22.2%
Planned follow-ups	8.8%
Other	7.7%

Source: Healthcare Commission acute hospital portfolio data returns

Improving the patient's experience

Eliminating excessive waiting times

Since January 2006 the Department of Health has collected monthly data on the number of patients waiting for a gastroscopy, flexi-sigmoidoscopy or colonoscopy as part of its national monitoring of progress towards the Government's 18-week referral-to-treatment target. It has set a milestone that waits of over 13 weeks for diagnostic tests should be eliminated by the end of March 2007. However, this data shows that in December 2006, there were still some very long waits (NB: figures collected during the first few months may not have been entirely accurate). Sixteen per cent of patients waiting for a colonoscopy and 8% of those needing a gastroscopy had been on a waiting list for more than 26 weeks.

The national totals also show increasing activity and encouraging month-by-month reductions in waits. For example, 24% more colonoscopies were carried out on patients from the waiting list in November 2006 than in January of the same year (including only those trusts that returned activity data for both these months). This extra activity contributed to a reduction of 51% in the number of patients waiting for over 26 weeks for a colonoscopy and of 42% in those waiting for over 13 weeks.

The local picture is more varied. At the worst-performing trust 80% of patients on the waiting list for a colonoscopy in December 2006 had already waited over 26 weeks. At a few trusts the number waiting for more than 26 weeks actually increased between January and December 2006. Just four trusts together accounted for 65% of the patients waiting for more than 26 weeks and for 42% of those waiting for more than 13 weeks (see figure 6).

Figure 6: Reduction of long waits for colonoscopy

Source: Healthcare Commission from Department of Health's monitoring figures on the 18-week wait

At the other extreme 120 of the trusts where colonoscopies were performed had no waits exceeding 26 weeks. The best 100 trusts together accounted for less than 5% of the 13-week waits. Proportionately, the number of long waits has been falling at a slower than average rate in the worst trusts. At the time of writing and assuming that any further expansion of capacity is at the current rate, it seems likely that by the end of March 2007 about 30 trusts could each still have more than 50 patients that had been waiting for more than 13 weeks for a colonoscopy. About one in five patients on a waiting list will have waited more than 13 weeks.

PCTs, not acute trusts, are responsible for ensuring that the 13-week milestone is achieved. The target will possibly be met by transferring more patients facing long waits to other trusts and, in the longer term, to the independent sector. However, there is limited potential to do this within the NHS due to the marked regional differences in waiting times. Long waits for colonoscopies are more common in the south of England than in the north. For example, in December 2006, 50% of patients on the waiting list in the south east had been waiting for more than 26 weeks, while in Yorkshire and the north east, less than 0.2% of patients had waited this long. This contrasts with activity rates (see figure 4), which were far higher in the north east than in the south east.

The picture is similar for gastroscopy. Between January and December 2006 the number of patients waiting for over 26 weeks for a gastroscopy almost halved. In December 2006, nine trusts alone accounted for 90% of the patients who had waited more than 26 weeks and for 58% of those who had waited more than 13 weeks (see figure 7).

Figure 7: Reduction of long waits for gastroscopy

Source: Healthcare Commission from Department of Health's monitoring figures on the 18-week wait

There was a similar regional imbalance in waiting times, with 32% of patients in the south east having waited more than 26 weeks in December 2006, compared with virtually none in the north east, Yorkshire and the east midlands.

The data on numbers of patients waiting for endoscopic procedures tells only part of the story about delays. In the review we collected data on how long patients referred at the end of September 2005 would typically have had to wait for an urgent or routine gastroscopy, flexi-sigmoidoscopy, colonoscopy or ERCP*. Although this data is now older than the Department of Health's figures on the number of people waiting, it brings out even more clearly the variation in waits in different parts of the country. For example, at 10 trusts the wait for a routine colonoscopy was less than a month, whereas at the other extreme 10 trusts had waits of over a year (comparison with the more recent monitoring data from the Department of Health suggests that this data on long waits was credible, but that six of the 10 worst-performing trusts in 2005 have now substantially reduced their waiting times for colonoscopy). There was a similar degree of variation in waits for other procedures (see figure 8).**

In general, units with long waits for gastrointestinal endoscopies allocated fewer sessions to guest users than those with shorter waits. There were exceptions,however. One unit with waits exceeding a year for a colonoscopy nevertheless devoted more than a quarter of its available sessions to non-gastrointestinal work; these appeared to be used less intensively than gastrointestinal sessions.

In some cases the patient's waiting time can be significantly different from the average for the trust in question. This can happen particularly if endoscopists retain their own separate waiting lists or if the management of lists is poor. For example, in 5% of trusts some patients who had a colonoscopy between April and September 2005 had waited more than a year longer than the trust's stated current waiting time. Such atypical waits are not entirely within a trust's control as procedures are sometimes deferred at the request of the patient.

Opening hours

These are defined as the time between the scheduled arrival of the first endoscopy patient of the day to the usual time of departure of the last patient following their recovery. Most of the units reviewed were open and staffed for endoscopy for between 28 and 60 hours a week. We could find no relationship between opening hours and the length of time that patients waited for a procedure. Many units with long waits would seem to have the potential to extend their opening hours if funding could be found.

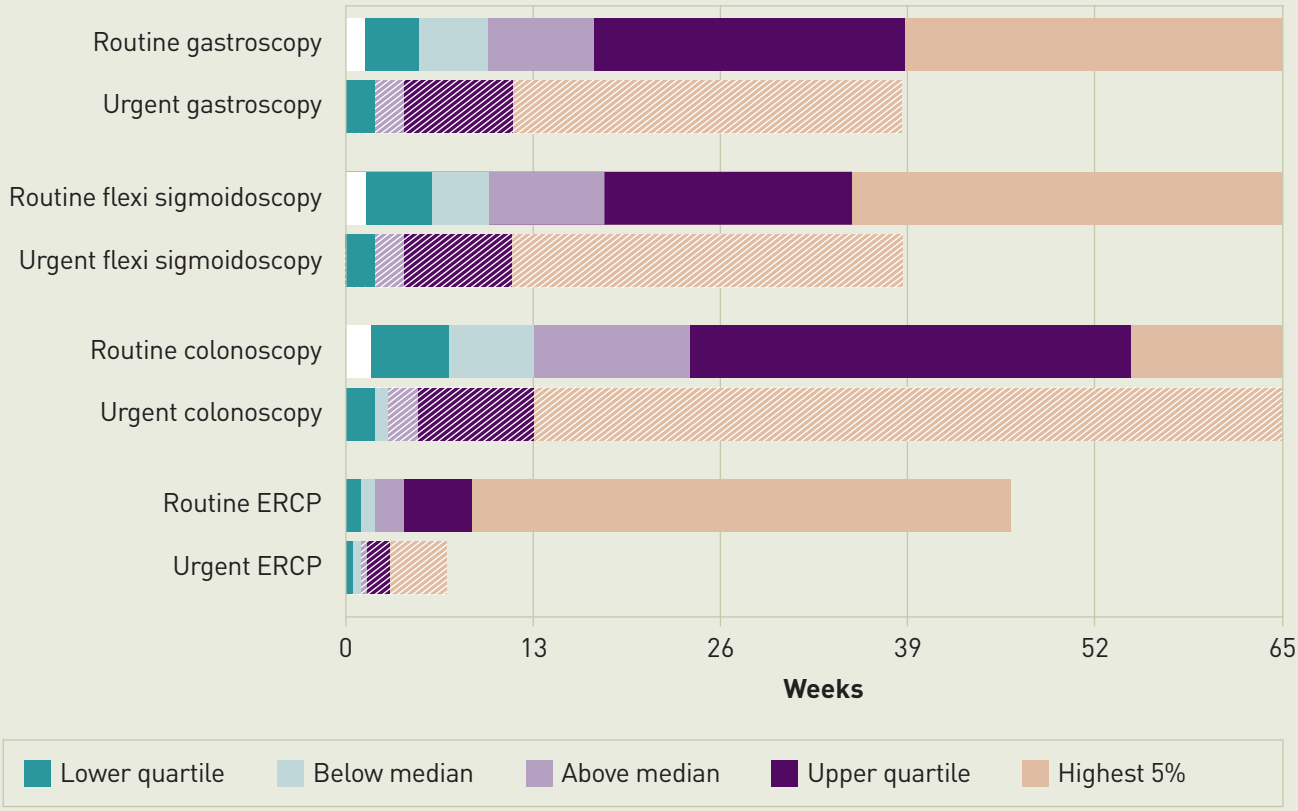
Delays in reporting

In the majority of trusts a report on the findings of the endoscopy was prepared immediately after the procedure was completed. Seventy-two per cent of the units reviewed had a clinical computer system that was always used to produce the reports and a further 13% said that the computer was used for some reporting. However, one in 10 units said that on average it took more than five days to produce a report, including the time for it to be typed. This length of delay is significant in

* Waiting time was defined as the number of days before two consecutive slots became available. Where there were several waiting lists for a procedure, units were asked to enter the waiting time for whichever list had the most referrals. Not all units were able to distinguish between urgent and routine patients, and some entered the same waiting time figures for both.

** It is to be hoped that the minority of units that admitted to waits of over six months for urgent procedures were using a definition of 'urgency' that differed from other units.

Figure 8: Waiting times for an endoscopy (September 2005)



Source: Healthcare Commission acute hospital portfolio data returns, September 2005

the context of the target for a maximum 18-week wait. Urgent positive results were of course communicated more speedily, but even if there is no particular need for haste, reporting delays can cause patients unnecessary worry and uncertainty and may delay the investigation of alternative causes of symptoms.

Other ways to improve the patient's experience

Though endoscopy is by its very nature likely to be an unpleasant experience for the patients, there is much that can be done to minimise worry and discomfort. Self-assessment by endoscopists against the Global Rating Scale has done much to raise awareness of factors that are likely to enhance the patient's experience. Our review asked about current practice in a number of areas.

Staggered arrival times

If patients are given staggered arrival times they are less likely to be kept waiting after arriving at the unit. Only two units did not do this. This contrasts very favourably with the level of performance reported by our 2004/2005 review of day surgery units, where only 35% of those units always gave staggered arrival times.

Quality of information

The level and content of written information given to endoscopy patients in advance of a procedure was better than those reported by day surgery units in 2004. Patients should be adequately informed about the procedure and what to expect on discharge before they are asked to give formal consent. Nearly all endoscopy units provided written information covering the specific procedure, what to expect on arrival at the unit and who to contact for further advice. However, only 9% gave written information about what to expect on discharge (it is important to do this so that the patient can make appropriate arrangements) and only half of the units included details of who to contact in the event of a complaint.

Timing of consent

We asked trusts at what stage the patient was asked to consent to a procedure. Best practice (found at 43% of the units responding) is for formal consent to be obtained when the patient arrives at the unit, before being asked to undress for the procedure. Even earlier than this, the procedure should have been fully explained to the patient, who should have had an opportunity to ask questions. However, 44% of the units that responded asked for consent only after the patient had undressed, by which time the patient was unlikely to ask further questions and had little real choice. Nine per cent of units secured consent before the patient arrived at the unit – depending on how and when it is done, this may not give the patient sufficient opportunity to ask questions or to change their mind about whether to have the endoscopy.

Discharge information

We asked respondents what discharge information was given to patients before they left the unit. Eighty-nine per cent of the units provided written information on what would happen next, and 95% provided information on possible post-procedure problems and how to deal with them. However, only 76% gave a phone number for out-of-hours advice.

Discharge summaries

Clinicians are divided over whether the unit should give the patient a discharge summary before departure. Just over half of the units did so routinely, and a further 10% sometimes did. While letting patients know the outcome of the procedure in writing reduces worry and uncertainty, it is not always appropriate. If there is bad news, for example, it might be better conveyed by the referring clinician as part of a discussion of plans for continuing treatment. There should therefore be clear trust-wide policies on whether, and in what circumstances, the endoscopist should inform patient about outcomes. However, fewer than one in five trusts had a documented policy.

Private consultation rooms

It is important that each unit has somewhere where a clinician can speak to the patient in private if, for example, there is bad news to impart. Sixty per cent of units had a room dedicated to this purpose, while a further 28% had a room that could be vacated if needed.

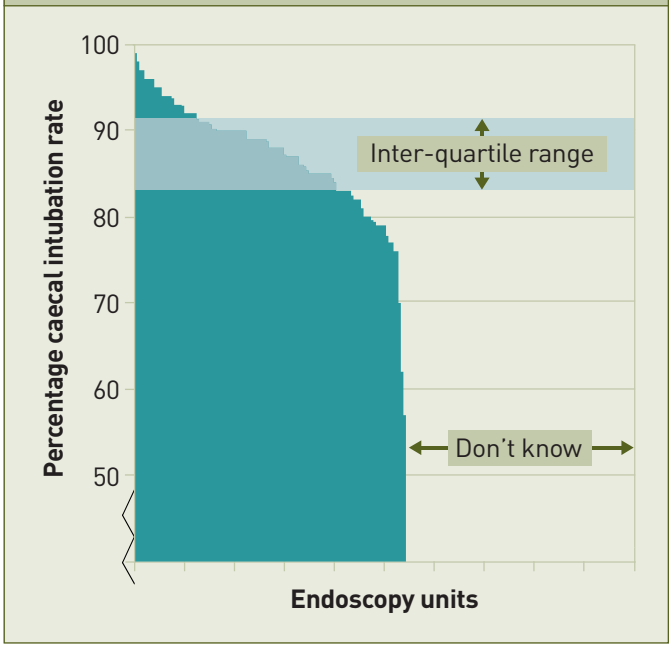
Assuring clinical quality

Caecal intubation rates

Major initiatives are underway to improve the training and accreditation of endoscopists. It is estimated that currently at least 32,000 colonoscopies a year do not succeed in reaching and diagnosing the problem area of the bowel. Unsuccessful procedures cause unnecessary discomfort and inconvenience for the patient and delay appropriate care. One measure of success is the caecal intubation rate – the percentage of patients having a colonoscopy in whom the endoscope reaches the caecum or beyond. Forty-five per cent of trusts could not supply data on caecal intubation rates, and of the remainder only 41% were achieving the 90% success target* agreed for endoscopy units participating in the National Bowel Cancer Screening Programme (see figure 9). It has now been agreed that, as a condition of accreditation, caecal intubation rates will be monitored using a standard definition.

A number of units volunteered to take part in mini-audits of colonoscopies carried out on patients aged 70 or over (see page 10). These audits helped to confirm the extent of variation in caecal intubation rates when they were calculated using a standard definition. Unsurprisingly, completion rates for these older patients were somewhat lower than those reported in the main review with an interquartile range between 81% and 89%.

Figure 9: Caecal intubation (completion) rates



Source: Healthcare commission acute hospital portfolio data returns, September 2005

Polyp detection rates

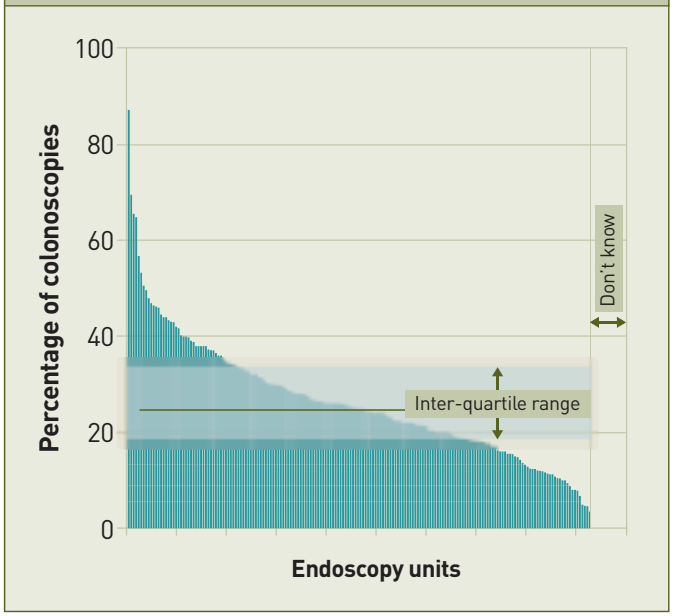
Even if a colonoscopy is completed successfully, the endoscopist may occasionally miss signs that should have been reported. Apart from peer review, there is no certain way of measuring this. We asked what proportion of colonoscopies resulted in the detection of a polyp or cancerous growth. Although only 46% of units said they monitored or audited this routinely, all but 16 managed to provide data on detection rates for the review. In these circumstances it is likely that some of the figures provided are of questionable accuracy. There was also some ambiguity about whether or not all types of polyp – small polyps with no malignant

* Caecal intubation rate, measured on an intention-to-treat basis, with no adjustment for any circumstances preventing completion that the endoscopist may consider to be outside his/her control. Units that are not participating in the National Bowel Cancer Screening Programme have been set a lower target of an unadjusted completion rate of 85% for 2006/07, rising by 1% each year to 90% by 2011/2012.

potential, for instance – should be included. Nevertheless, the extent of variation (figure 10) is such as to demand further investigation. Even ignoring the 10% of units reporting the most extreme values, the percentage of patients in whom polyps or cancer were reported ranged from 10% to 47%. This could reflect differences in referral criteria or the characteristics of patients, as well as in reporting practices or detection rates. We could find no statistical relationship between detection rates and numbers of endoscopies performed per 1,000 people.

Polyp detection rates appear to be higher at units where the average time taken for each colonoscopy was longer than the average of 27 minutes for all units. However, it is unclear whether more polyps were detected because more care was taken during withdrawal of the endoscope or whether the procedure took longer because of the extra time needed to investigate polyps, navigate the endoscope around them and remove samples for pathology.

Figure 10: Percentage of colonoscopies demonstrating polyps or cancer



Source: Healthcare commission acute hospital portfolio data returns, September 2005

Sedation

Patients undergoing an endoscopy are usually given a sedative plus a painkiller (analgesic), and sometimes also a muscle relaxant. The British Society of Gastroenterology (BSG) has issued recommendations on doses. High doses extend the time taken to recover and could be harmful, especially to older patients. In extreme cases a further drug (a 'reversal agent') may have to be administered to bring the patient round.

The mini-audits revealed that doses were within the BSG guidelines for sedative and analgesic drugs in only 28% of the audited colonoscopies, while in 50% the doses for sedation and/or analgesia exceeded the guidelines; the remaining 22% were unrecorded. This suggests that the BSG guidelines should either be promulgated more strongly or reviewed.

The endoscopy unit at Leeds Teaching Hospitals NHS Trust has devised scales against which nurses can assess the degree of drowsiness in colonoscopy patients and, with the help of the patients, how much discomfort they feel. The mini-audits demonstrated significant differences in the comfort of patients among trusts. They also suggested that, on average, comfort was not improved by higher doses of sedation and analgesia, although these higher doses may have been administered because the patient was already experiencing discomfort due to their medical condition.

Other clinical indicators

Other indicators that some units monitor regularly include:

- rates of endoscopic perforation – damage to tissue from the endoscope (monitored by 50% of units)
- re-bleeding after endotherapy (monitored by 28% of units)
- unplanned overnight admissions (monitored by 35% of units)

Unplanned admissions to hospital may occur following an endoscopy because of clinical complications, the discovery of conditions requiring emergency treatment, unexpectedly protracted recovery from sedation, or occasionally for non-clinical reasons. With a few exceptions, the incidence of such unplanned admissions was low. We did not collect data on the reasons why they had occurred and further information would be required to draw any conclusions from benchmarked data.

The profession has now agreed a list of clinical indicators that should be monitored or audited routinely to support Global Rating Scale assessments and is developing standard definitions for how the indicators should be measured.

The results of monitoring should be fed back to referring clinicians. Three out of four hospitals had an endoscopy user group that would be a suitable forum for the discussion of findings. About half of the groups met at least once every two months.

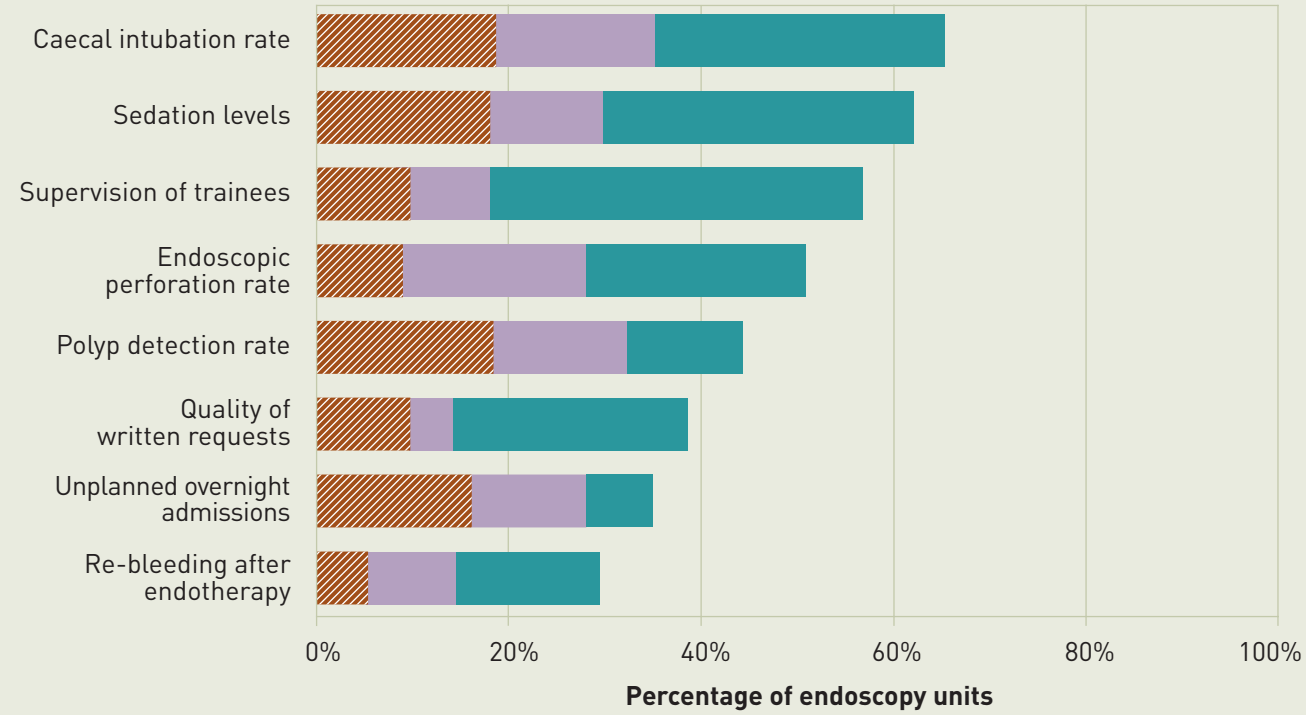
We also asked respondents whether any changes in practice had resulted from the feedback of monitoring information (see figure 11).

Emergency endoscopies

Hospitals must make suitable arrangements for carrying out emergency endoscopies in an appropriate location and with experienced staff to cover times when the endoscopy unit is shut. Solutions varied according to local circumstances. At 35% of hospitals the endoscopy unit was usually opened up under these circumstances; another 15% sometimes did this. Fifty-eight per cent normally used an operating theatre, with another 32% sometimes doing so. Twenty-nine per cent sometimes used a room adjacent to a high-dependency or intensive care unit. However, 22% of hospitals said that some emergency endoscopies were performed in other locations, such as a procedure room in a short-stay unit. This is widely considered to be less safe.

Best practice for providing cover from an endoscopist for emergency endoscopies outside normal hospital hours is to establish a rota of endoscopists (54% of hospitals had done this). Failing that, arrangements should be agreed formally (10% had done this). These arrangements should not be limited to part of the day or week, as they were at 18% of hospitals. Cover should if possible be shared among a reasonable number of endoscopists – 54% of those endoscopists who were on an emergency rota were on-call one day in seven or less. These on-call duties should be included in job plans (as they were for 61% of those on a rota) rather than additional to endoscopists' normal commitments. Though these endoscopists need to be supported by nurses experienced in endoscopy, this happens at only 51% of hospitals. Other hospitals may rely on theatre nurses with no specific training in endoscopy to support out-of-hours endoscopy.

Figure 11: Monitoring of clinical issues



Source: Healthcare Commission acute hospital portfolio data returns, September 2005

Facilities and staff

We asked unit managers about hold-ups or 'bottlenecks' in their units and the main reasons for them (see table 3). Insufficient space in the recovery area was identified as a major problem by 37% of managers. The next greatest constraints on activity were lack of equipment and insufficient staff in procedure rooms. Only 6% of respondents said there were no bottlenecks. However, it was not clear from the responses how serious the bottlenecks were considered to be.

Facilities in endoscopy units

Endoscopy units need an appropriate balance of space for reception and preparation, procedures and recovery. If there are too few recovery places it is likely that procedure rooms and staff will not be used to their full capacity. It will also be more difficult to maintain a satisfactory quality of care for patients. Endoscopy units must also have a dedicated decontamination room (present in 98% of units) and adequate toilet facilities for patients within easy reach.

Recovery places

Twenty-one per cent of endoscopy units shared recovery areas with day surgery units. Some staff may also work across the two units (10% of endoscopy units). Rarely, procedure rooms were also shared (6%), though this is not regarded as good practice.

Most endoscopy units have recovery areas with a mixture of trolleys or beds and reclining chairs. The number and mix of places should depend on how many procedures of each type are carried out. A colonoscopy requires a longer period of recovery than a gastroscopy, for example, and a chair is therefore less suitable for recovery from this procedure.

We found that whereas some endoscopy units had 12 or more recovery places available for each procedure room, others had three or fewer. If there are too few recovery places, the scope for increased activity will be very limited.

It is more important for quality of care to look at the number of recovery places that are available in relation to the number of procedures carried out in the unit each year (see figure 12). This varied from less than one

Table 3: Bottlenecks and constraints in endoscopy units – managers' perceptions

	Admission	Procedure room	Recovery area	Discharge	Total
Lack of space	18%	14%	37%	10%	55%
Lack of equipment	7%	22%	12%	5%	30%
Lack of staff	16%	20%	14%	7%	38%
Unspecified	2%	6%	2%	1%	10%
Total	29%	41%	42%	13%	94%

Source: Healthcare Commission survey of endoscopy unit managers, September 2005

Note: Shaded boxes indicate the combinations of bottlenecks and constraints that were of the most concern

Figure 12: Recovery places

Source: Healthcare Commission acute hospital portfolio data returns, September 2005

Note: The chart also shows the statistical regression lines of best fit for both the total numbers of recovery places and for beds/trolleys

place for every 1,000 procedures to more than five. Those endoscopy units whose managers said that inadequate recovery space was a bottleneck had on average 32% fewer recovery spaces in relation to their activity than others (although this difference was not statistically significant). On average, units have a minimum of six recovery places plus an additional three for every 2,000 patients each year. Two-thirds of these places would normally be beds or trolleys. On this basis a unit with 10,000 patients each year could expect to have 14 trolleys/beds plus seven chairs.

Utilisation of endoscopy rooms

On average 2,340 procedures each year were carried out in each endoscopy room. Although there is wide variation among units in the level of weighted activity* in each room – from 1,490 to 3,665, excluding extreme values – this is less than for most other facilities. A value that is markedly lower than average suggests that these facilities are poorly utilised, so that spare sessions could perhaps be offered to guest users. A high value suggests that insufficient availability of procedure rooms may be a constraint on increasing the unit's activity.

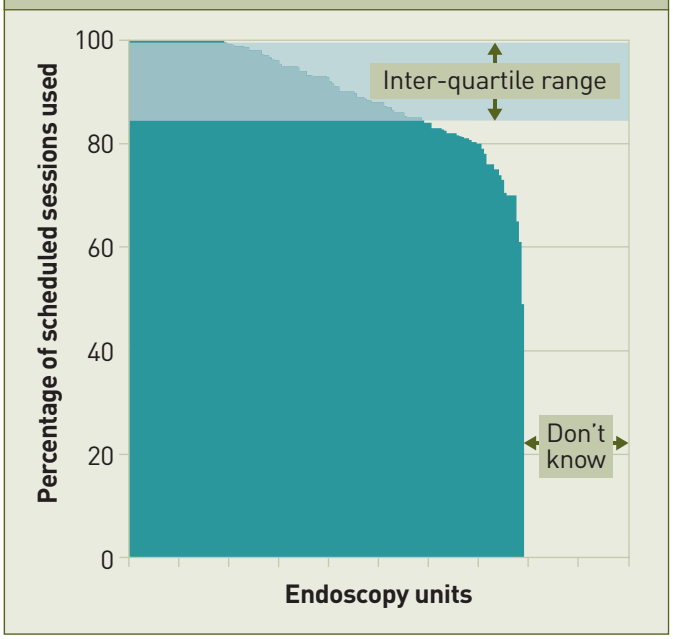
Though unused sessions represent a significant waste of the staff's time and other

* Activity was standardised by weighting it by BSG points, which reflect the average time needed for each type of procedure, and then dividing by the national average number of points per procedure.

resources, one in five units was unable to provide information on this measure. In one in eight units, over 20% of the scheduled sessions were cancelled (see figure 13). This could have been because no endoscopist was available (due perhaps to sickness, leave or conflicting commitments), or because the required equipment was unavailable, the room was out of commission, or there were not enough patients to justify holding the session.

Patients undergoing colonoscopies or flexi-sigmoidoscopies are likely to need to use a toilet before or after the procedure. There must therefore be adequate toilet facilities within or adjacent to the endoscopy units. We found units carrying out an average of 15 such procedures a day that had only three toilet cubicles within easy reach, less than half of the number that would be most usual for a unit of this size.

Figure 13: Utilisation of scheduled endoscopy sessions



Source: Healthcare Commission acute hospital portfolio data returns, September 2005

Equipment

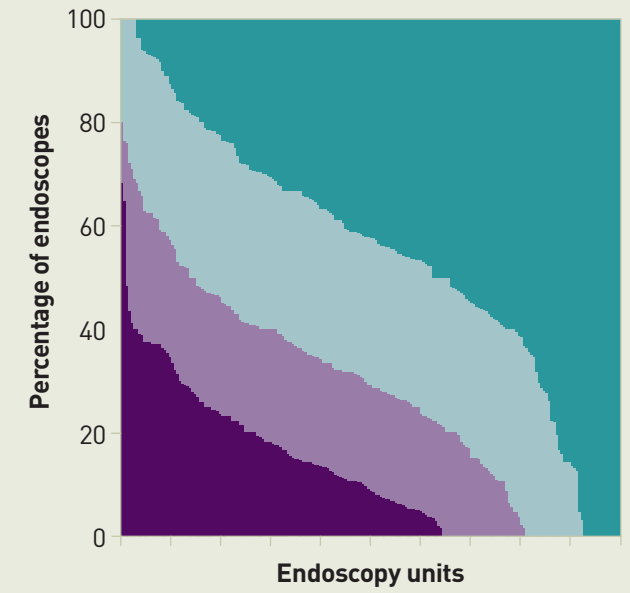
We looked at both the number of endoscopes available in each unit in relation to its activity and the age of the endoscopes to see whether unit managers were justified in saying that a shortage of equipment was a main cause of bottlenecks in some hospitals. Those units that identified the availability of equipment as a constraint did on average make more intensive use of endoscopes than others. Units with a perceived bottleneck due to a shortage of serviceable equipment also had a higher percentage of older endoscopes.

On average each endoscope is used 228 times a year, though some units make much more intensive use of equipment than others. Since some of the variation may be due to case mix, we have adjusted for this. Excluding the 5% of units that said their endoscopes were used most intensively, and the 5% that made least use of them, the number of procedures for each endoscope ranged from 124 to 433 each year.

Older equipment is less versatile and likely to be less reliable than modern equipment. We found that 28% of the endoscopes in use were more than eight years old. However, at 15% of the units more than half of the endoscopes were of this age (see figure 14). This has implications for efficiency, for successful completion of procedures and for the unnecessary prolongation of examinations, adding to discomfort for patients.

The continued use of fibre-optic endoscopes, which derive the image from a collimated fibre-optic bundle, was of particular concern. Such endoscopes yield poorer definition than modern endoscopes (which derive the image from a video camera chip via a large number of charge-coupled devices) and do not enable images to be recorded. It is likely that this distinction was not well understood by all

Figure 14: Age of endoscopes



Source: Healthcare Commission acute hospital portfolio data returns, September 2005

respondents. Yet even if the returns from those units that reported all of their equipment to be fibre-optic are excluded from the calculation, some 13% of the endoscopes that were in use would appear to have been fibre-optic.

It has been suggested that some of this old equipment was being retained for use in case a front-line endoscope were to fail. However, there is no evidence of this as units with old equipment use it just as intensively as better-equipped units. Retaining equipment as a back-up is not a good idea if reliability is an issue. Alternatively, it could be that old equipment is used only for very simple procedures. High percentages of outdated equipment raise questions about the adequacy of the budget for replacing equipment at certain trusts.

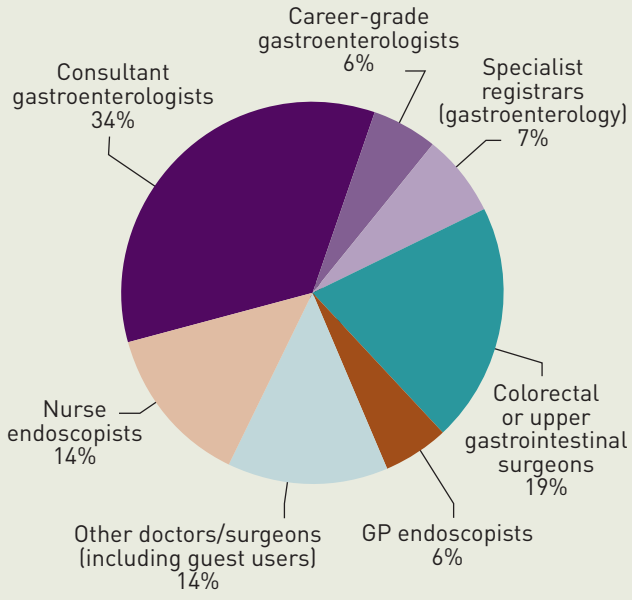
The workforce

Endoscopists

Gastrointestinal endoscopies should normally be performed by a consultant or experienced physician or surgeon with specialist skill in this field, or by a trained and accredited nurse endoscopist. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report for 2004 comments: "Consultants should not expect members of their team to perform procedures beyond their competence and trainees must be encouraged to seek help when cases are more difficult than they were expecting". NCEPOD found that "in 94% of cases the grade of the endoscopist was appropriate for the type and complexity of the procedure."

We collected data on the types of clinician that had been allocated sessions in endoscopy units (see figure 15). When sessions are carried out

Figure 15: The allocation of sessions in endoscopy units



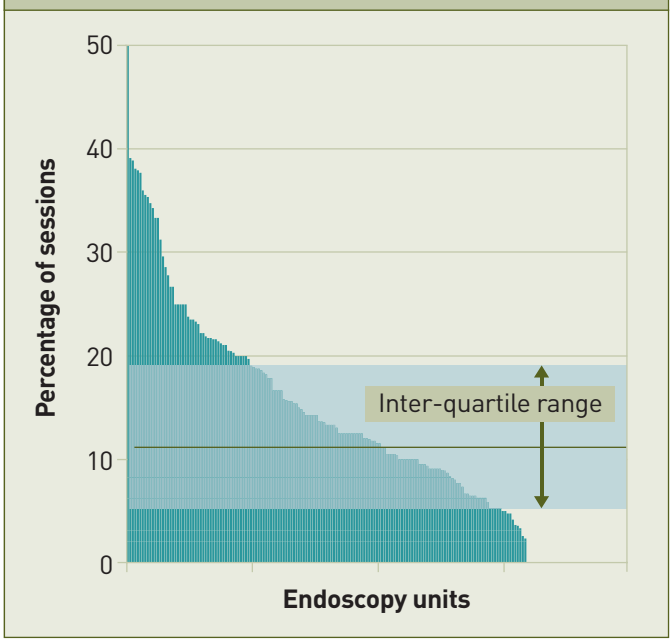
Source: Healthcare Commission acute hospital portfolio data returns, September 2005

by specialist registrars it is important that expert support is available from a consultant as needed. Independent practitioners using the unit, such as the GP endoscopists (to whom 6% of sessions were allocated) need to be included in audit activities.

Nurse endoscopists

Eighty-five per cent of the units employed or had sessions allocated to nurse endoscopists*, and about 40% employed more than one. However, many trusts, particularly those with long waiting times for gastroscopy, could make greater use of their skills. Nurse endoscopists were allocated just 13% of all programmed endoscopy sessions. At one unit in 10 they performed more than a quarter of the sessions (see figure 16).

Figure 16: Percentage of endoscopy sessions allocated to nurse endoscopists



Source: Healthcare Commission acute hospital portfolio data returns, September 2005

Nursing and support staff

Relative to their activity, and even after account is taken of variations in case mix (figure 17), some units had as much as five times as many staff as the least highly staffed units. We have only been able to estimate ratios of staff to activity because the staff of some units rotated to and from duties on gastroenterology wards, outpatient clinics or elsewhere in the hospital**.

Neither the highest nor the lowest ratio is necessarily the best. High levels of activity in relation to numbers of staff may raise questions about whether adequate care is being given to patients. Low ratios may indicate questionable efficiency. The data we collected on waiting times, numbers of staff and activity show that units with long waiting times had relatively high numbers of staff in proportion to their throughput of patients.

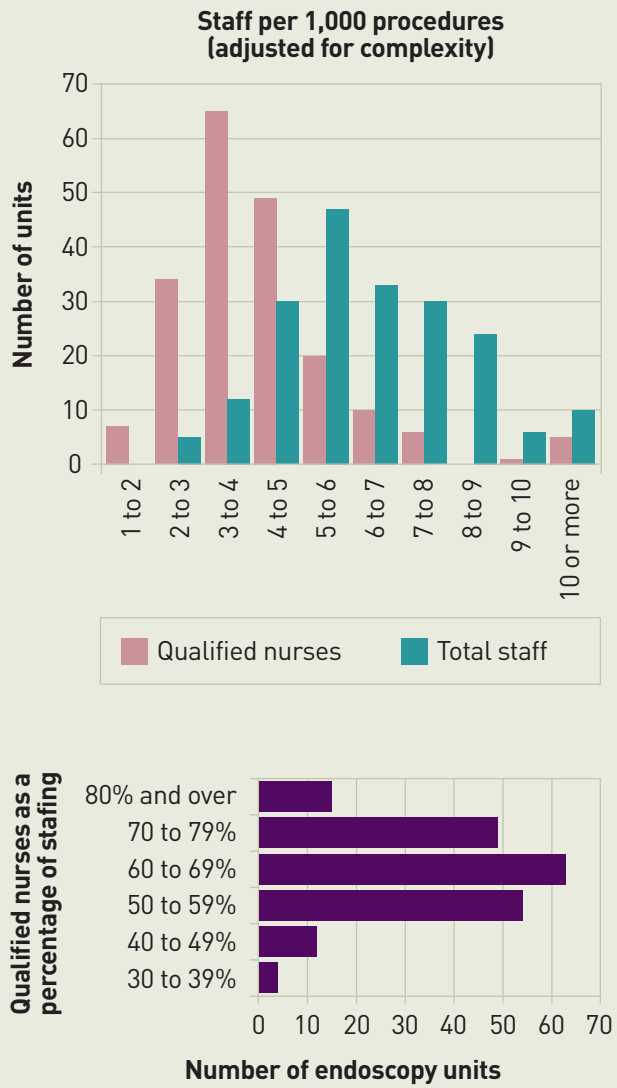
The variation in ratios of qualified nurses to activity was even greater than that for total staff and activity. There was also great variation in the mix of grades of staff. One unit in 10 has over a third of nursing staff (including care assistants) at F grade (or band 6) and above. At the other extreme, one in 10 has fewer than 11% of nurses at these senior grades.

Percentages of administrative and clerical (A&C) staff compared to the total non-medical staff available to the unit also vary significantly around an average of 15%. If there are too few A&C staff, patients may receive a poorer service, nurses' time may be used inefficiently and there will be less capacity to produce the monitoring information that is needed to develop the unit.

* We did not ask specifically about non-medical endoscopists other than nurses. However, a few may be included in this figure.

** We asked for the average number of additional hours each week worked in the endoscopy unit by staff based elsewhere in the hospital.

Figure 17: Staffing of endoscopy units in relation to activity



Source: Healthcare Commission acute hospital portfolio data returns, September 2005

Stability of the workforce

Factors such as the turnover of non-medical staff, sickness and absence, vacancy rates and the use of temporary staff were of particular relevance to the local reports prepared for each trust by the Audit Commission reviewers.

Staff turnover:* the median turnover rate was 8% but one in 10 units exceeded 24%. Although a reasonable turnover of staff may ensure that the unit keeps up to date with practice in other hospitals, high turnover can have a detrimental effect on efficiency.

Sickness and absence: the median rate of sickness and absence for non-medical staff was 5.2%. This is similar to the rate observed in the 2004 review of day surgery units. Rates in excess of 15% were reported by 5% of units. These figures include any long term sickness and maternity leave. Short term sickness (normally defined as absences of 28 days or less) averaged 1.9%.

Vacancy rates: the median rate of funded vacancies was 5.4% but exceeded 20% in one in eight units. Units with high vacancy rates will rely more on bank and agency or borrowed staff and overtime if they are to maintain a high level of patient throughput.

Temporary staff: some units rely heavily on bank and agency nurses who, in five London hospitals, constitute more than one in three of the available qualified nursing staff. High use of bank and agency staff increases costs, and their lack of familiarity with the layout and procedures of the unit may be detrimental to the care of patients.

* Staff turnover during the year was calculated as the number of staff who left during the year divided by the number (not whole-time equivalents) in post at the end of the period. This calculation assumes that there had not been major changes to the service during the year and that numbers of staff in post at the end of the year were not atypical of the total period.

Management of endoscopy units

In addition to a senior nurse (or equivalent) in charge of day-to-day running of the unit and a manager who takes responsibility for its operational management, including procurement, there should also be someone in overall clinical charge. One in seven endoscopy units has no designated consultant in overall clinical charge.

A range of management issues, determined by local relevance, should be monitored or audited periodically and action taken where necessary. The Healthcare Commission will work with the National Endoscopy Team to develop further guidance in this area. Examples in figure 18 include:

- appropriateness of requests, including urgency of requests and levels of demand by individual clinicians
- did not attend (DNA) rates - a high percentage of DNAs makes it harder to run a unit efficiently. Though DNAs for all medical procedures tend to be higher in urban areas with high population mobility, units with rates higher than those of neighbouring hospitals should consider whether there is anything to be learned from them about how to select patients for referral, give them information about their procedure and remind them of appointments
- unused sessions - units should also monitor periodically whether all sessions are fully utilised or whether some regularly start late and finish early, either because the endoscopist has conflicting commitments or because the number of patients scheduled for each session is insufficient
- lost and late reports
- satisfaction of patients

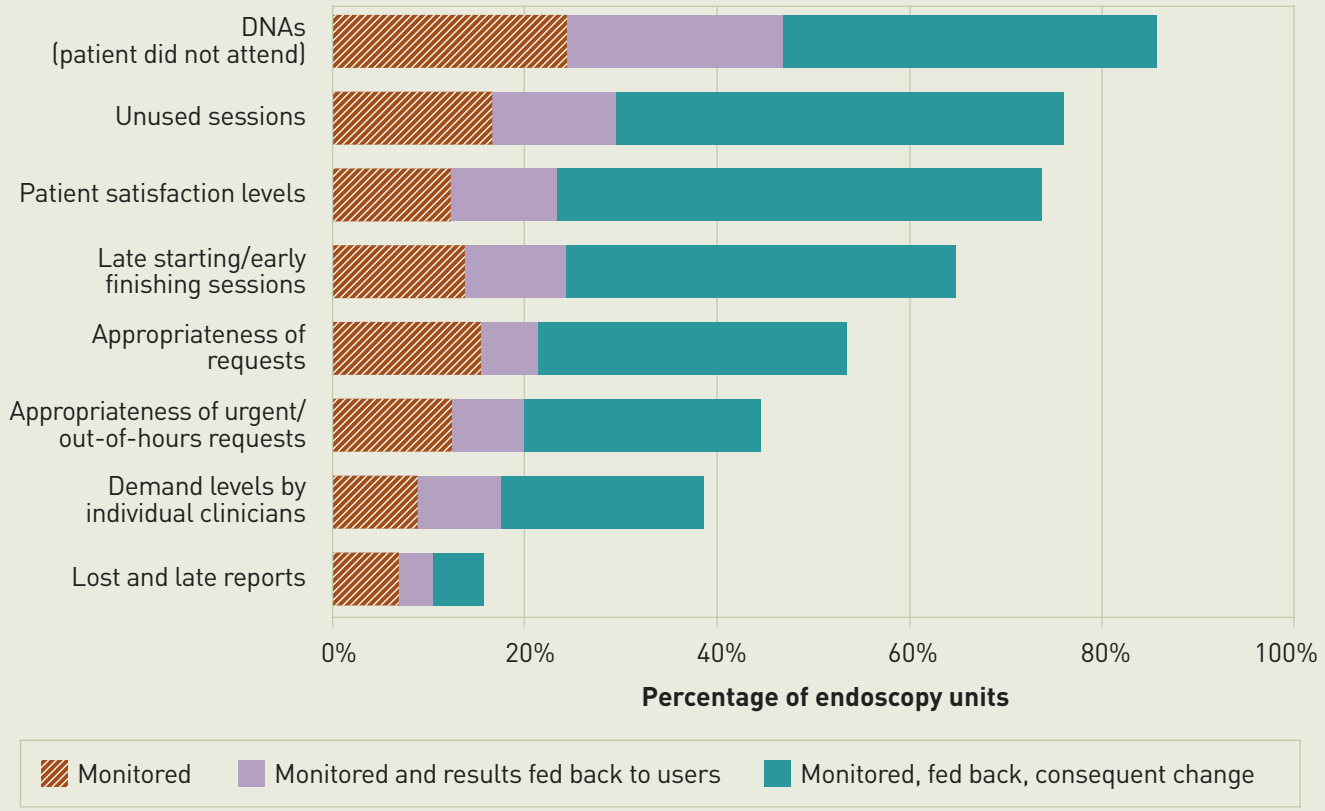
Digital technology and clinical information

Eighty-five per cent of units had a computer system for recording and reporting results. However, 24% of those units said it was not used for all procedures, presumably because some endoscopists were unfamiliar with it. One in five units, including some that also had a computer system, used a voice dictation system for some or all reporting. The majority of the computer systems were able to produce some audit tabulations, although some lack of flexibility was reported. However, over a half of the systems were not fully linked to the hospital's main information systems, making it difficult to integrate automatically the results of procedures. One in three systems was not able to use a patient's NHS number as a common identifier.

Thirty-five per cent of units made reports available to some requesters electronically. However, this was usually confined to on-site users. Only 10% of units said that electronic reports were routinely available to requesters outside the hospital. Forty-two per cent of units routinely faxed reports to referring GPs and another 41% did so when circumstances dictated. It was less common for requesters to be able to view images as well as reports, though 20% of units provided on-site access to a digital image archive.

There is perhaps less benefit in electronic requesting of endoscopies than in the case of other diagnostic procedures. Seventeen per cent of units received some electronic requests, but these were usually either from clinics or from GPs, depending on the most common referral routes into the unit. A minority (6%) had referral protocols built into the requesting system. Thirty-eight per cent of units provided some online access to referral guidelines.

Figure 18: Monitoring of management issues in endoscopy units



Source: Healthcare Commission acute hospital portfolio data returns, September 2005

Reviewing demand and processes

The report *Modernising Endoscopy services – a practical guide to redesign*, published by the NHS Modernisation Agency (Department of Health) in 2003, recommended that all trusts should carry out capacity and demand modelling and process mapping in order to reduce waiting times and improve the patient's experience. Capacity and demand modelling had been completed in 58% of units and a further 10% had done this for some types of procedure. The 10% of units that had not yet started tended to be those with shorter waiting times. Forty-nine per cent of the units said that they had carried out process mapping – the second key step in *Modernising Endoscopy* – and a further 30% had done this for some procedures.

Conclusions and recommendations – the way forward

This report has shown that despite continuing increases in workload, long waits for endoscopic procedures have almost been eliminated in many trusts. It recognises that most endoscopy units do all they can to make inherently unpleasant procedures acceptable to patients. There are major initiatives underway to improve training, introduce accreditation for endoscopists and units, and spread best practice through self-assessment and linked systems for knowledge management.

However, there are still some areas that can be improved upon:

1. Clinicians, locally and through national bodies, should examine critically the clinical justification for the marked regional differences in the number of endoscopies carried out in relation to population and in the mix of procedures so as to harmonise referral guidelines.
2. Waiting times for colonoscopies and gastroscopies are still unacceptably long, though the worst delays are concentrated in specific areas of the country. Endoscopists in units with long waits or disparities in waiting times should be persuaded to merge their individual lists.
3. The endoscopy service in each trust should consider whether there is a case for expanding the number and range of procedures undertaken by nurse endoscopists (or other non-medical endoscopists) to increase throughput and reduce waiting times.
4. Some units need to improve procedures for re-assigning cancelled or under-used sessions to other endoscopists.
5. Trusts and commissioning bodies should ensure that existing services are operating efficiently. However, some areas may require major local expansion of NHS activity or increases in provision by the independent sector if delays are not to endanger achievement of the Government's 18-week referral-to-treatment target.
6. Clinicians should agree a minimum set of clinical indicators and standard definitions for them. All units should monitor these indicators regularly.
7. Units should continue to work towards achieving a 90% unadjusted caecal intubation rate by 2011 (85% in 2006/2007, rising by 1% a year) through training and clinical audit of failed colonoscopies.
8. The clinical justification for administering sedation in excess of levels recommended by the British Society of Gastroenterology should be audited periodically and guidelines refined as necessary.
9. Clinicians at all units should secure formal consent from patients before they enter the procedure room or undress.
10. All units should have a computer system for recording and reporting results. They should promote its use by all clinicians carrying out procedures in the unit.
11. A single manager should be responsible for the planning and oversight of endoscopy services in each trust.
12. Trusts should ensure that endoscopy units are represented adequately on resource allocation forums. This would enable them to put forward a stronger case for increasing the number of recovery and toilet facilities, to improve the privacy of patients, to replace old equipment, and to update clinical information technology.

This information is available in other formats and languages on request. Please telephone 0845 601 3012.

ENGLISH

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