Royal College of Physicians

Setting higher standards

JAG Global Ratings Scale Census (GRS) Report: England

April 2015

JAG

Joint Advisory Group on GI Endoscopy

Contents

1. Introduction

This report provides the Global Rating Scale (GRS) results for England. The results are drawn from the April 2015 GRS census returns.

The GRS is a web-based self-assessment quality improvement tool that underpins the JAG accreditation process for endoscopy services. The outputs of the GRS provide the JAG with a summary of progress against the standards. This progress is indicated by a score. The score is given in levels (A – D). A brief description of the GRS levels is given below.

Levels	Level Descriptor
Level D	A minimal achievement that shows inadequate levels of adherence to requirements
Level C	The service is only reactive to changes with only the most basic of adherence to requirements
Level B	The service is proactive to changes with a good adherence to requirements
Level A	The service is 'outward looking' with excellent adherence to requirements

The JAG requires all endoscopy services to submit the census annually each April. Completing the census is a key requirement for services planning to apply for accreditation. In April 2015, all endoscopy units who are signed up to JAG were asked to complete the GRS. The number of units who completed the census as of the 14 May 2015 is shown below.

Units completing the April 2015 GRS census				
Sector	**Units not submitting census**	**Units submitting census**	**Total units***	**Percentage completion**
Acute	6	212	218	97%
Community	23	26	49	53%
Independent Sector (IS)	13	105	118	89%
Total	42	343	385	89%

*The 'total units' refers to the number of services who are known to offer endoscopy by JAG.

To exhibit and examine the responses from these units, this report is broken down by sector (acute, community and IS). The data are then further segmented by domain. Each domain's findings are then presented as follows;

- A graph to show the percentage of units achieving As and Bs by item at the last five census points (services must achieve a level A or B for all items, except timeliness where they must reach level A, in order to apply for and maintain JAG accreditation).
- A table comparing the percentage of units achieving As and Bs in April 2014 and April 2015.
- To further examine the results, the responses at measure level for the 5 lowest performing measures are shown for each item.

Please note the results from the October census from 2012 onwards should be treated with caution as all accredited units were asked to submit an Annual Report Card and not the GRS census. In order to provide a useful assessment of GRS results, when directly comparing two census points this report compares the results from April 2015 census with those from April 2014.

2. Acute sector

a. Clinical quality

Graph 1. Acute – Clinical Quality. Percentage of units achieving A or B over the last five census points

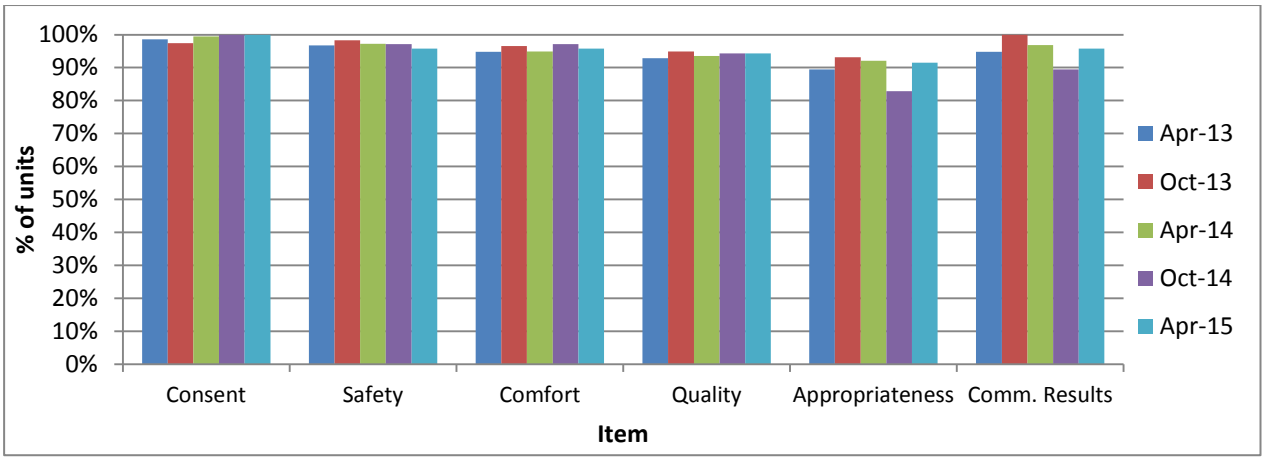

Table 1. Acute – Clinical Quality. Comparison of the percentage of units achieving A and B in April 2014 and April 2015

Item	Apr-14	Apr-15	% difference
Consent	100%	100%	0.5%
Safety	97%	96%	-1.4%
Comfort	95%	96%	0.9%
Quality	94%	94%	0.8%
Appropriateness	92%	92%	-0.6%
Comm. Results	97%	96%	-1.0%

Table 2. Acute – Clinical Quality. 5 lowest performing measures

No.	Measure	No	Yes
5.14	The vetting policy and the results of annual audits of vetting are presented to local commissioners each year	70%	30%
5.13	There is evidence that action plans for the vetting audit are successfully acted upon	36%	64%
5.15	Clinical pathways for at least three common GI symptoms, and processes to monitor them, are agreed with local commissioners	32%	68%
5.12	An audit of the vetting process (see 5.6) is undertaken once a year and action plans created if problems are identified	29%	71%
4.12	Systems are in place for monitoring level 'A' BSG auditable outcomes and quality standards	19%	81%

b. Quality of patient experience

Graph 2. Acute – Quality of patient experience. Percentage of units achieving A or B over the last five census points

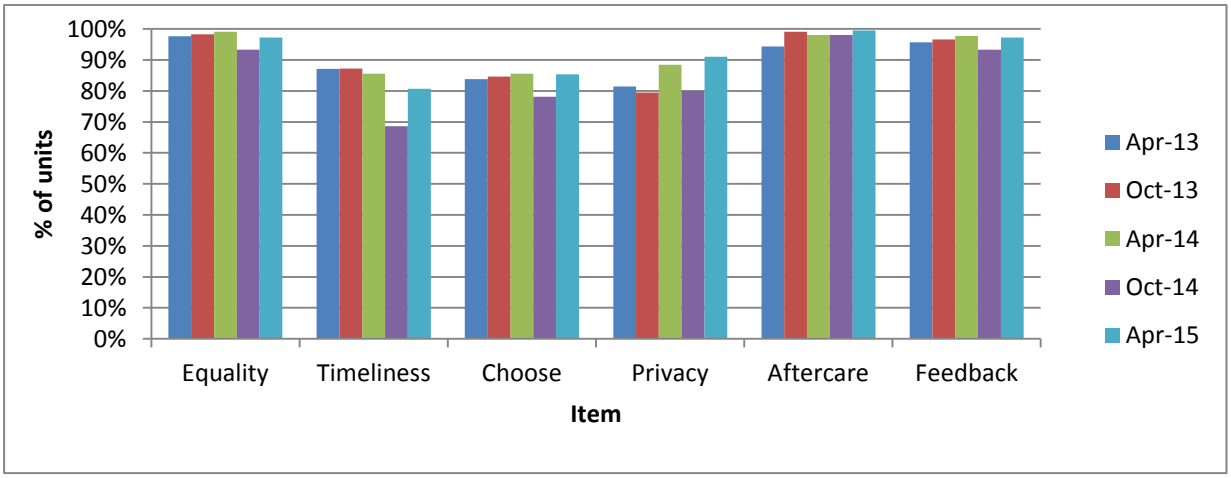

Table 3. Acute – Quality of patient experience. Comparison of the percentage of units achieving A and B in April 2014 and April 2015

Item	Apr-14	Apr-15	% difference
Equality	99%	97%	-1.9%
Timeliness*	86% (78% level A)	81% (60% level A)	-4.9% (-17.4%)
Choose	86%	85%	-0.2%
Privacy	88%	91%	2.6%
Aftercare	98%	100%	1.4%
Feedback	98%	97%	-0.5%

*Unlike all other items where a level A or B is required for accreditation, for timeliness a service must score a level A in order to be accredited. As a result for timeliness level A scores are given in brackets in the table 3.

Table 4. Acute – Quality of patient experience. 5 lowest performing measures

No.	Measure	No	Yes
9.14	>75% of new referrals from outpatients are fully booked	43%	57%
11.12	All patients that require a follow-up appointment agree one prior to discharge	39%	61%
11.13	All patients are sent pathology results within 5 working days of the receipt of the pathology report if they have been told further information will be available and do not have an outpatient appointment	38%	62%
12.8	Patients participate in planning and evaluating services	35%	65%
8.14	Waits are <2 weeks for urgent procedures and <6 weeks for routines	34%	66%

c. Workforce domain

Graph 3. Acute – Workforce. Percentage of units achieving A or B over the last five census points

Table 5. Acute – Workforce. Comparison of the percentage of units achieving A and B in April 2014 and April 2015

Item	Apr-14	Apr-15	% difference
Skill mix	96%	94%	-2.4%
Orientation	92%	94%	2.6%
Assessment	99%	98%	-1.0%
Staff cared for	96%	95%	-1.0%
Staff listened to	97%	96%	-1.4%

Table 6. Acute – Workforce. 5 lowest performing measures

No.	Measure	% No	% Yes
16.14	The service lead evaluates annually the extent to which health and safety legislation, policies and procedures are implemented in the environment	16%	84%
17.17	There is documented evidence that action is taken in response to staff feedback within three months	15%	85%
16.15	Outcomes of service reviews are acted upon and fed into development plans for the service	14%	86%
17.15	Action plans developed in response to recommendations from exit interviews are implemented within six months	11%	89%
17.16	The staff actively promote and share knowledge of service developments with other services within the organisation and externally	11%	89%

d. Training domain

Graph 5. Acute – Training. Percentage of units achieving A or B over the last five census points

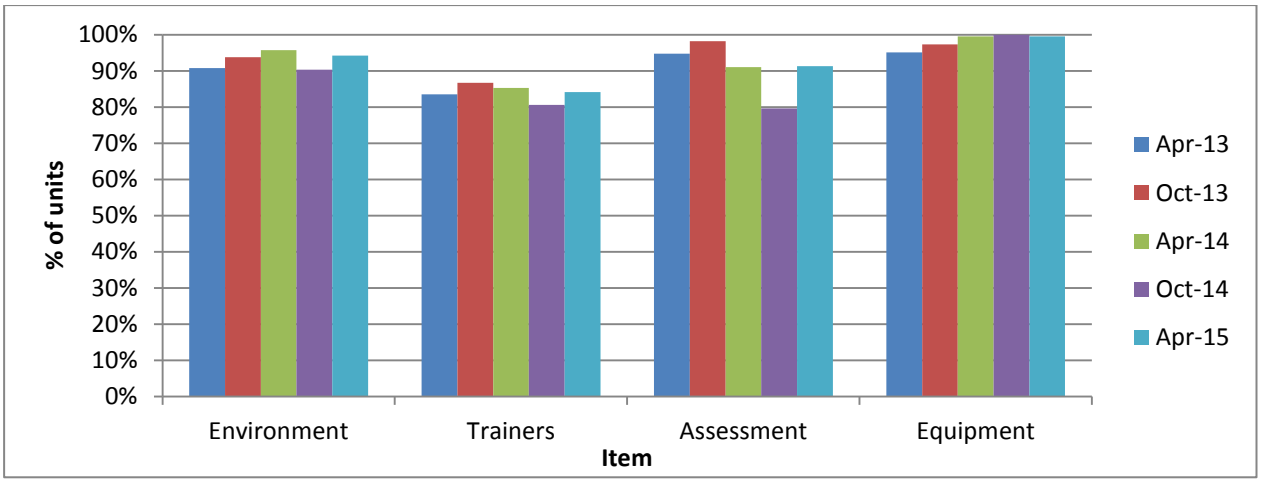

Table 7. Acute – Training. Comparison of the percentage of units achieving A and B in April 2014 and April 2015

Item	Apr-14	Apr-15	% difference
Environment	96%	94%	-1.5%
Trainers	85%	84%	-1.2%
Assessment	91%	91%	0.3%
Equipment	100%	100%	0.0%

Table 8. Acute – Training. 5 lowest performing measures

No.	Measure	% No	% Yes
21.7	There is a seminar room within the unit, or close by, with video link to at least one procedure room	67%	33%
19.11	All trainers in the department have undergone a JAG approved TTT course	51%	49%
21.8	There is access to video photographic equipment during routine lists	33%	67%
19.10	At least one trainer participates as a trainer in a JAG approved training course each year	28%	72%
19.12	There is a process in place for ensuring the actions taken following review of trainer evaluations are acted upon and effective	27%	73%

3. Community sector

a. Clinical quality

Graph 10. Community – Clinical Quality. Percentage of units achieving A or B over the last five census points

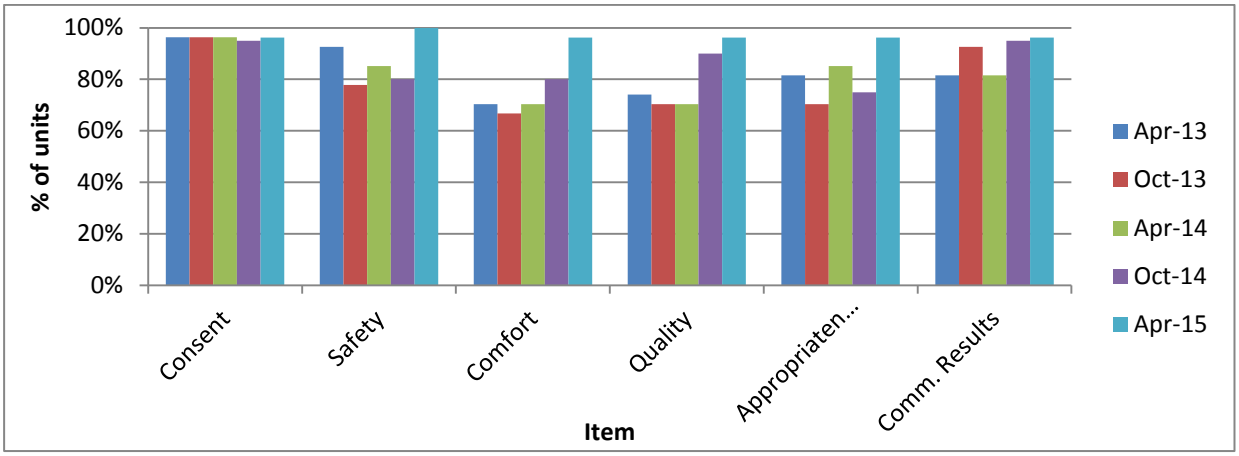

Table 15. Community – Clinical Quality. Comparison of the percentage of units achieving A and B in April 2014 and April 2015

Item	Apr-14	Apr-15	% difference
Consent	96%	96%	-0.1%
Safety	85%	100%	14.8%
Comfort	70%	96%	25.8%
Quality	70%	96%	25.8%
Appropriateness	85%	96%	11.0%
Comm. Results	82%	96%	14.7%

Table 16. Community – Clinical Quality. 5 lowest performing measures

No.	Measures	N/A	No	Yes
5.14	The vetting policy and the results of annual audits of vetting are presented to local commissioners each year	0%	69%	31%
5.13	There is evidence that action plans for the vetting audit are successfully acted upon	0%	50%	50%
5.12	An audit of the vetting process (see 5.6) is undertaken once a year and action plans created if problems are identified	0%	38%	62%
5.15	Clinical pathways for at least three common GI symptoms, and processes to monitor them, are agreed with local commissioners	0%	19%	81%
4.12	Systems are in place for monitoring level 'A' BSG auditable outcomes and quality standards	0%	12%	88%

b. Quality of patient experience

Graph 11. Community – Quality of patient experience. Percentage of units achieving A or B over the last five census points

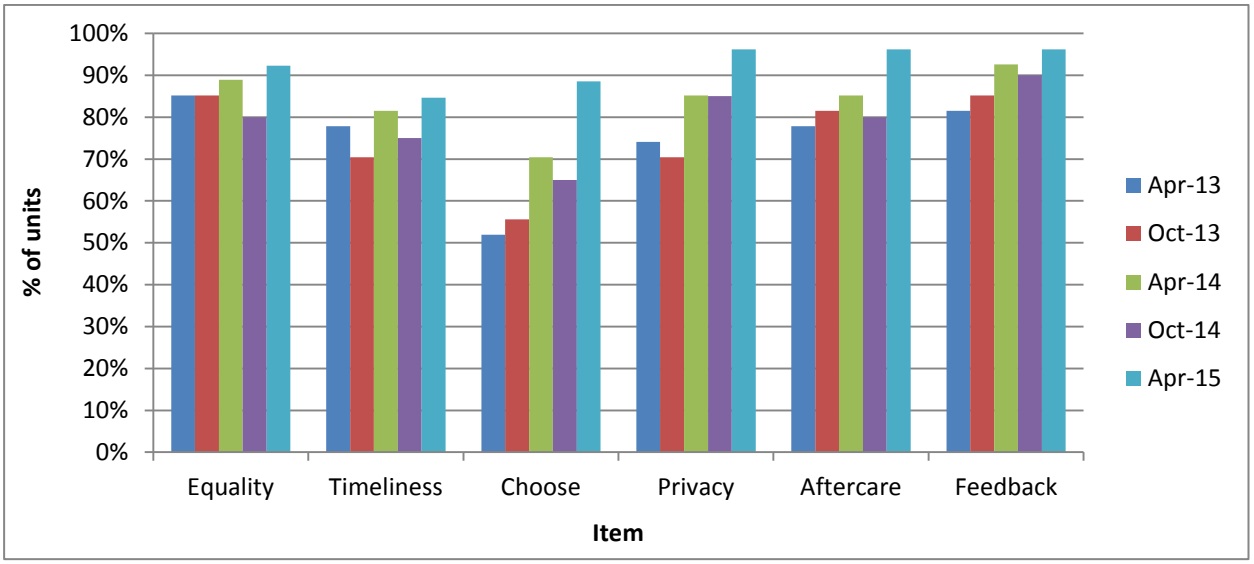

Table 17. Community – Quality of patient experience. Comparison of the percentage of units achieving A and B in April 2014 and April 2015

Item	Apr-14	Apr-15	% difference
Equality	89%	92%	3.4%
Timeliness*	82% (74% level A)	85% (77%)	3.1%
Choose	70%	89%	18.1%
Privacy	85%	96%	11.0%
Aftercare	85%	96%	11.0%
Feedback	93%	96%	3.6%

*Unlike all other items where a level A or B is required for accreditation, for timeliness a service must score a level A in order to be accredited. As a result for timeliness level A scores are given in brackets.

Table 18. Community – Quality of patient experience. 5 lowest performing measures

No.	Measures	No	Yes
7.9	Feedback is actively sought from minority groups on the services provided by the unit using questionnaires, telephone interview or focus group.	46%	54%
10.16	There is comprehensive separation between pre and post procedure patients, including in-patients	38%	62%
12.8	Patients participate in planning and evaluating services	35%	65%
7.1	Patient participation in planning and evaluating services is representative of the local population in terms of gender, ethnicity and disability	31%	69%
7.11	All booking procedures are assessed for equality of access.	23%	77%
7.9	Feedback is actively sought from minority groups on the services provided by the unit using questionnaires, telephone interview or focus group.	46%	54%

c. Workforce

Graph 13. Community – Workforce. Percentage of units achieving A or B over the last five census points

Table 19. Community – Workforce. Comparison of the percentage of units achieving A and B in April 2014 and April 2015

Item	Apr-14	Apr-15	% difference
Skill mix	74%	89%	14.40%
Orientation	89%	96%	7.30%
Assessment	85%	92%	7.10%
Staff cared for	89%	96%	7.30%
Staff listened to	85%	89%	3.30%

Table 20. Community – Workforce. 5 lowest performing measures

No.	Measures	No	Yes
17.16	The staff actively promote and share knowledge of service developments with other services within the organisation and externally	27%	73%
13.2	The teams workforce requirements are fed back into the Trust workforce planning strategy	23%	77%
14.14	Recommendations from staff feedback on training provision are acted upon within six months	19%	81%
14.15	There is an agreed annual education and training plan, supported by management, that reflects staff and service needs	19%	81%
17.17	There is documented evidence that action is taken in response to staff feedback within three months	19%	81%

4. Independent sector (IS)

a. Clinical quality

Graph 6. IS - Clinical Quality. Percentage of units achieving A or B over the last five census points

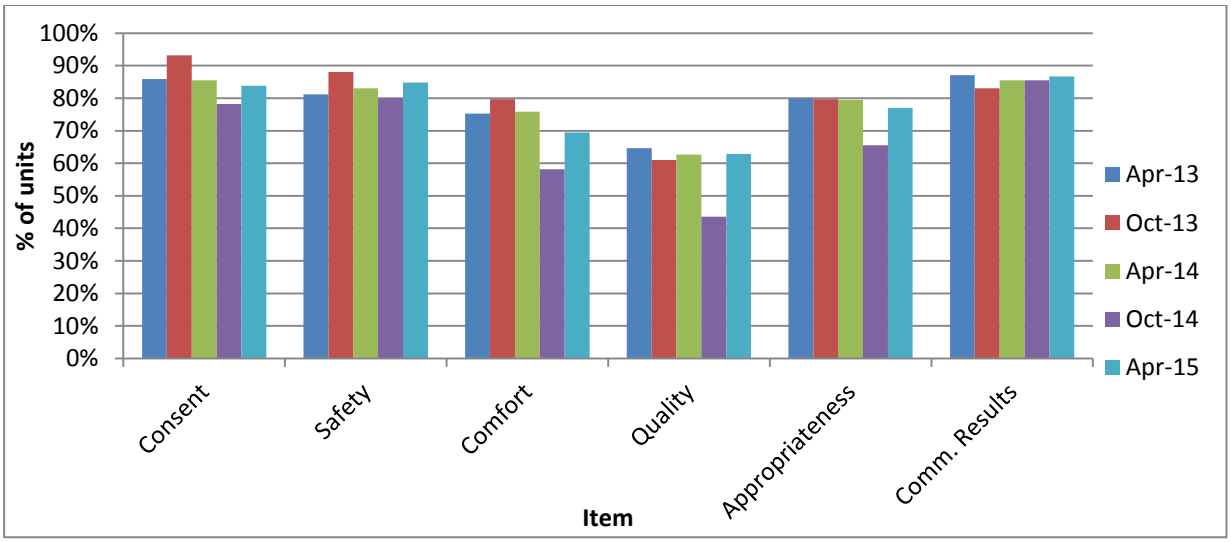

Table 9. IS – Clinical Quality. Comparison of the percentage of units achieving A and B in April 2014 and April 2015

Item	Apr-14	Apr-15	% difference
Consent	86%	84%	-2%
Safety	83%	85%	2%
Comfort	76%	70%	-6%
Quality	63%	63%	0%
Appropriateness	80%	77%	-2%
Comm. Results	86%	87%	1%

Table 10. IS – Clinical Quality. 5 lowest performing measures

No.	Measures	No	Yes
4.12	Systems are in place for monitoring level 'A' BSG auditable outcomes and quality standards	35%	65%
4.4	Individual endoscopists are given feedback on their immediate outcomes and standards at least 2x/year and audits of their late outcomes at least once/year	31%	69%
4.3	The outcomes and standards are reviewed on a regular basis (at least 2x/year)	30%	70%
4.8	Systems are in place for monitoring level 'B' BSG auditable outcomes and quality standards	30%	70%
4.7	There is an IT system in place to capture immediate auditable outcomes and quality standards	29%	71%

b. Quality of patient experience

Graph 7. IS – Quality of Patient experience. Percentage of units achieving A or B over the last five census points

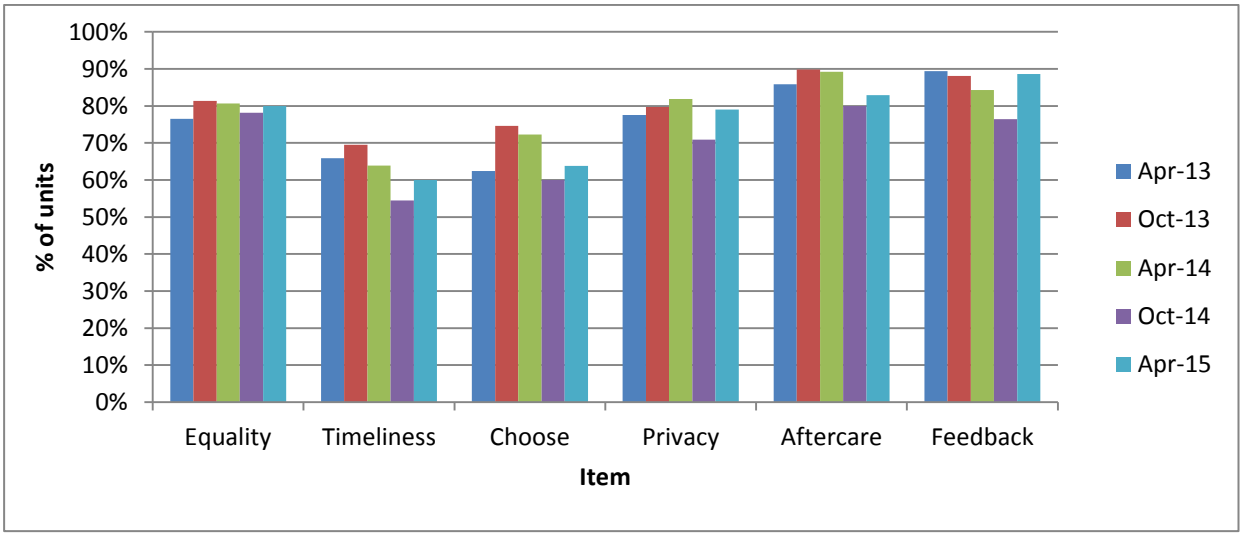

Table 11. IS – Quality of patient experience. Comparison of the percentage of units achieving A and B in April 2014 and April 2015

Item	Apr-14	Apr-15	% difference
Equality	81%	80%	-0.7%
Timeliness*	64% (64% level A)	60% (60% level A)	-3.9%
Choose	72%	64%	-8.5%
Privacy	82%	79%	-2.9%
Aftercare	89%	83%	-6.3%
Feedback	84%	89%	4.3%

*Unlike all other items where a level A or B is required for accreditation, for timeliness a service must score a level A in order to be accredited. As a result for timeliness level A scores are given in brackets.

Table 12. IS – Quality of patient experience. 5 lowest performing measures

No.	Measures	No	Yes
8.10	There is some pooling of endoscopy lists	30%	70%
12.8	Patients participate in planning and evaluating services	27%	73%
7.10	Patient participation in planning and evaluating services is representative of the local population in terms of gender, ethnicity and disability	26%	74%
8.13	There is regular administrative validation of waiting lists	26%	74%
9.12	Results of patient feedback on booking processes are reviewed through the endoscopy users group	26%	74%

c. Workforce

Graph 9. IS – Workforce. Percentage of units achieving A or B over the last five census points

Table 13. IS – Workforce. Comparison of the percentage of units achieving A and B in April 2014 and April 2015

Item	Apr-14	Apr-15	% difference
Skill mix	75%	78%	3.4%
Orientation	82%	77%	-4.8%
Assessment	78%	82%	3.6%
Staff cared for	87%	90%	2.8%
Staff listened to	82%	81%	-0.9%

Table 14. IS – Workforce. 5 lowest performing measures

No.	Measures	No	Yes
17.17	There is documented evidence that action is taken in response to staff feedback within three months	15%	85%
13.13	There is an information pack about the service for potential applicants	13%	87%
14.9	Patient feedback is used in training to develop awareness of the patient experience	12%	88%
17.15	Action plans developed in response to recommendations from exit interviews are implemented within six months	11%	89%
17.8	There is documented evidence that staff ideas on improving the service are acted upon	10%	90%