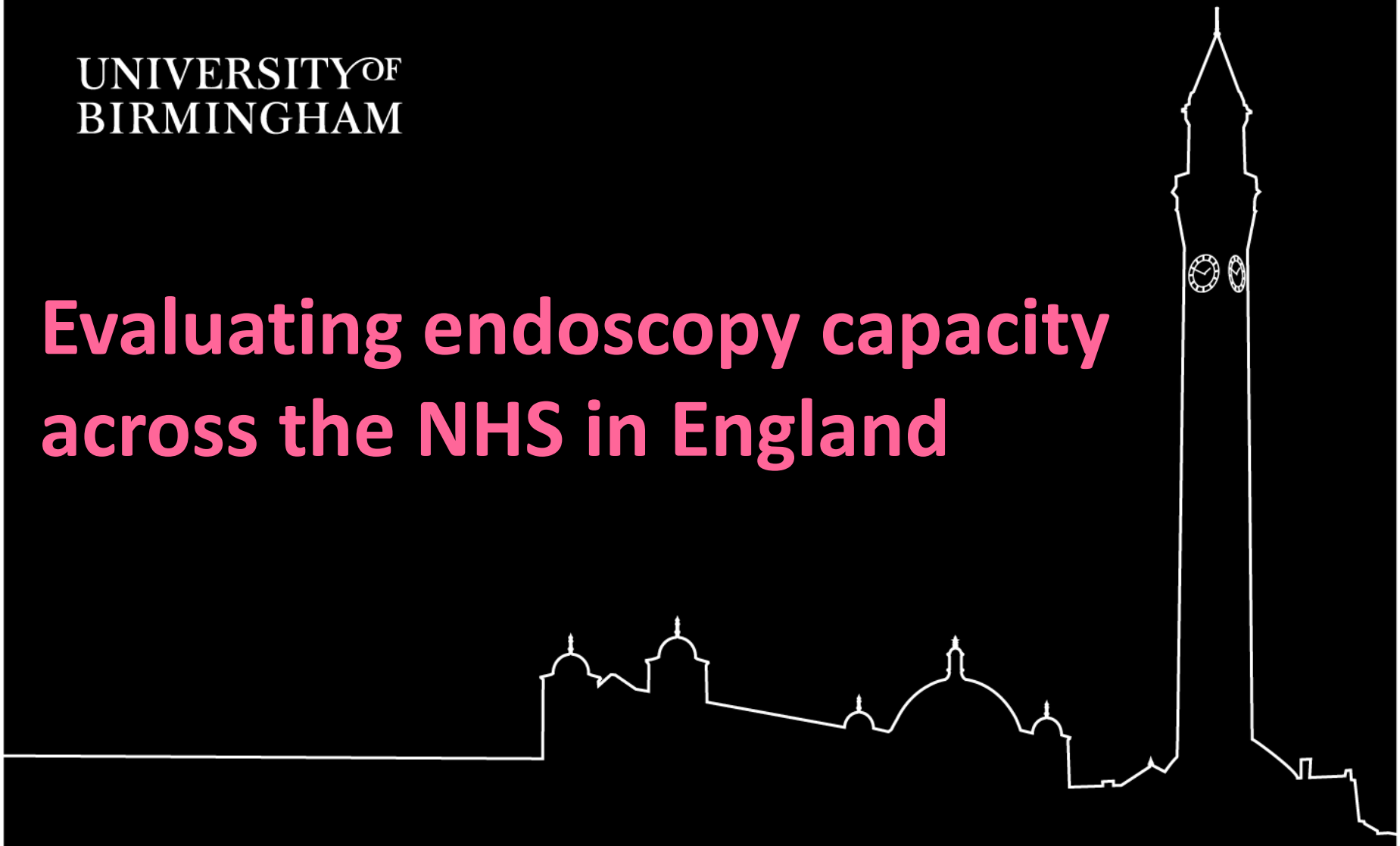
UNIVERSITY OF BIRMINGHAM

Evaluating endoscopy capacity across the NHS in England



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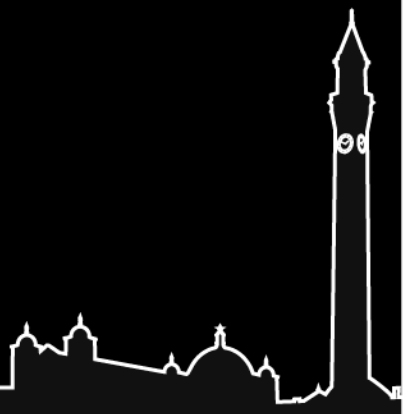
Methodology

- Literature and evidence review
- Qualitative interviews
- Appreciative Enquiry event
- Questionnaire
- Analysis of JAG GRS data
- Describing current levels of Diagnostic Endoscopic activity
- Modelling Future levels of activity



Qualitative findings and evidence synthesis

- Workforce issues – recruitment, retention, job plans, cover arrangements, training, evening and weekend working, team work, independent sector
- Opportunities to improve productivity and efficiency – Productive Endoscopy, referral management, straight to test, pre-op assessment, reminder calls, surveillance
- Impact of awareness campaigns and screening programme – difficult to plan for activity spikes, impact on surveillance patients and non-urgent symptomatic
- Data – availability, quality and use
- Models of provision - independent sector, community provision
- Impact of technology and new tests - CT colonography, FOBT to FIT , increased use of complex therapeutic procedures
- Quality measures – to address variation in endoscopist outcomes
- Leadership, team work, flexibility, contribution of everyone recognised and valued

Modelling Potential Changes in Gastro-Intestinal Endoscopy Activity in England between 2013/14 and 2019/20

Objectives

To estimate levels of GI endoscopy activity required to meet demand in 2019/20.

To identify and quantify the key drivers of increased demand.

To differentiate the impact of increased demand by test type, mode (screening, symptomatic, surveillance) and condition.

Scope

NHS commissioned activity in England

Diagnostic and therapeutic GI endoscopy activity.

Including

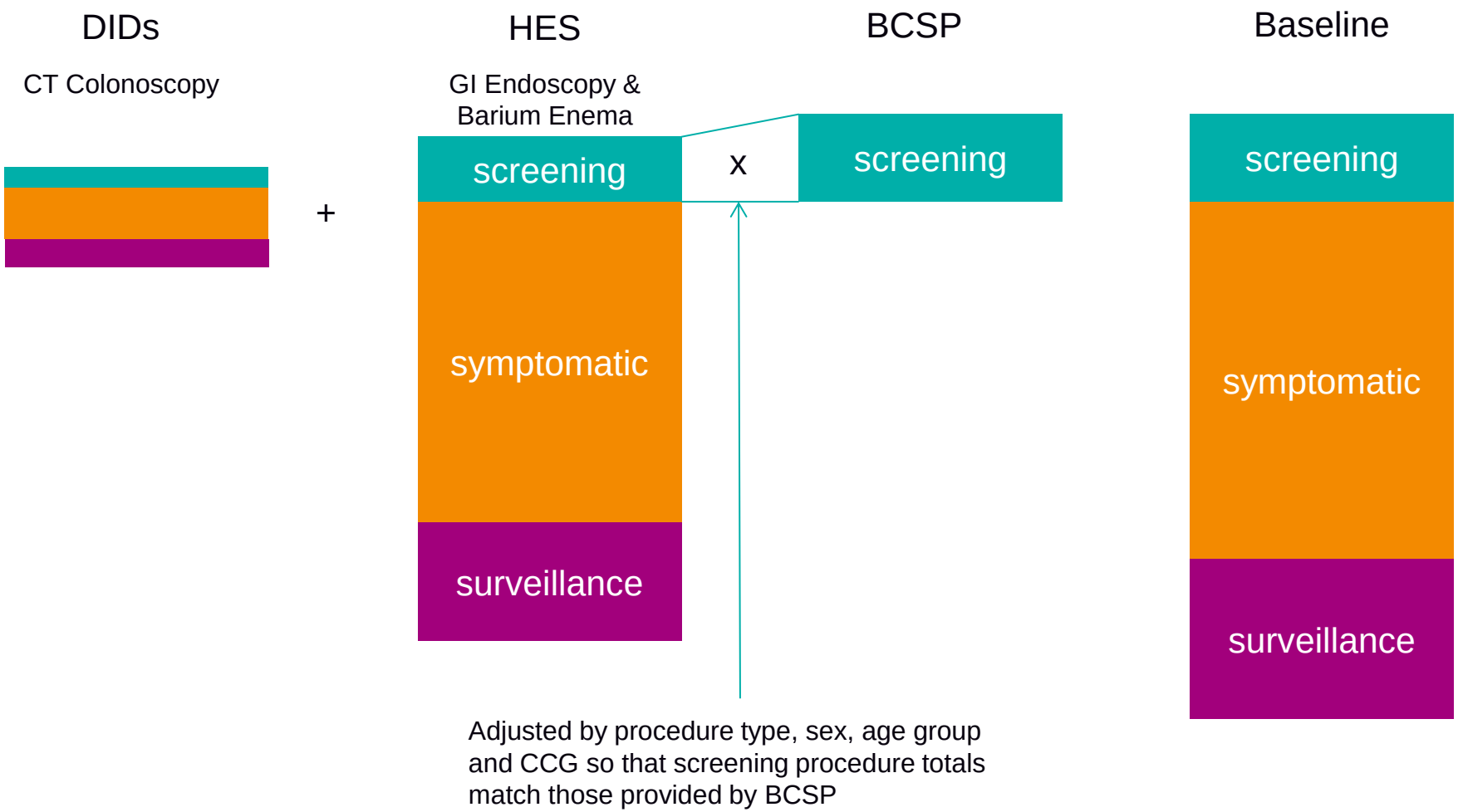
- CT colonoscopy and barium enema.
- Hepato-pancreatic biliary (HPB) activity
- independent sector activity commissioned by the NHS.

Excluding children (aged < 18 years)

And considers the impact of a limited and agreed set of change factors.

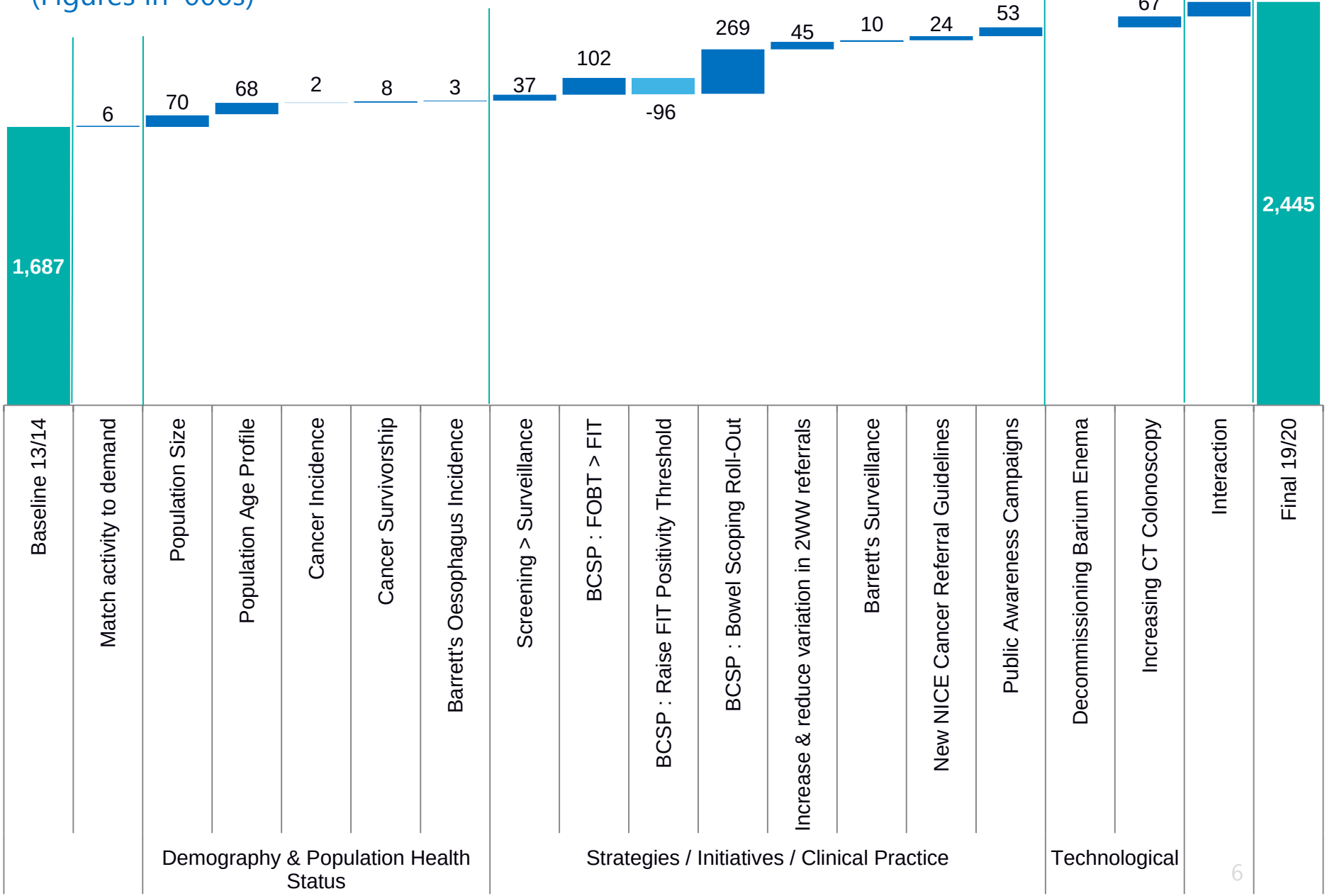
Assumes no capacity constraints.

Establishing Activity in the Baseline Year - 2013/14



Modelled Changes in GI Endoscopy Activity 2013/14 to 2019/20

(Figures in '000s)



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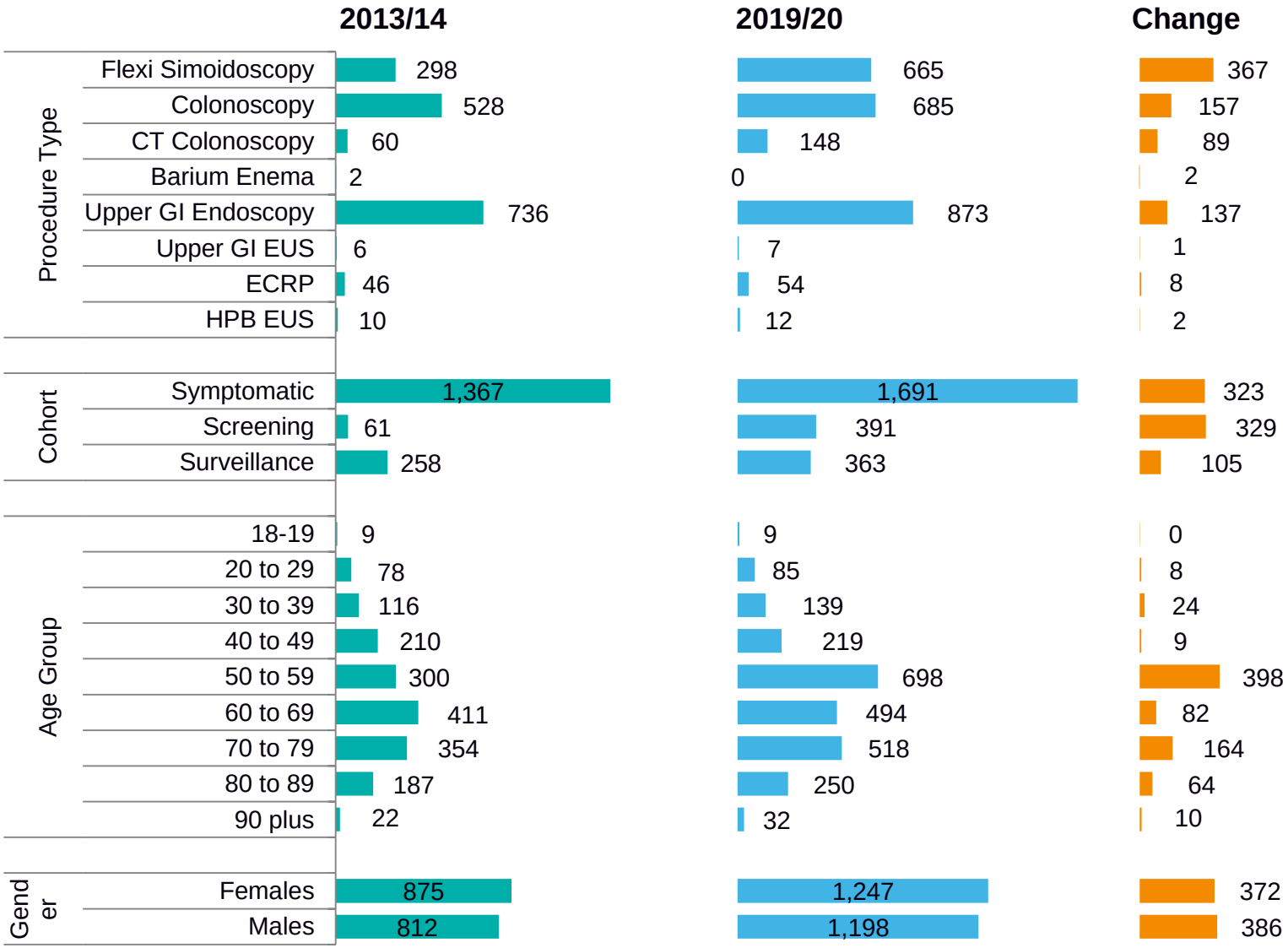
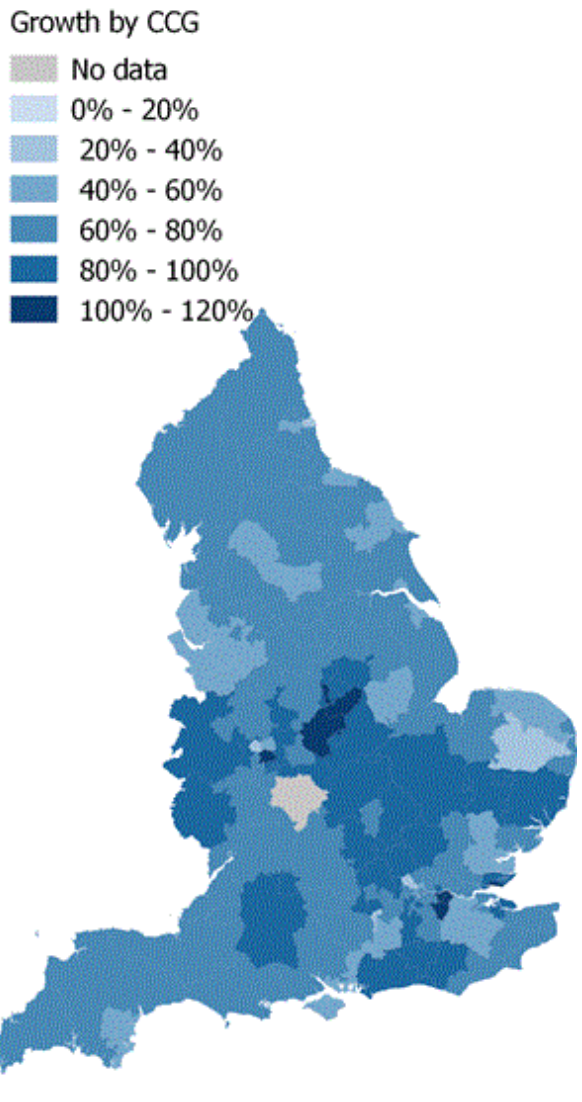
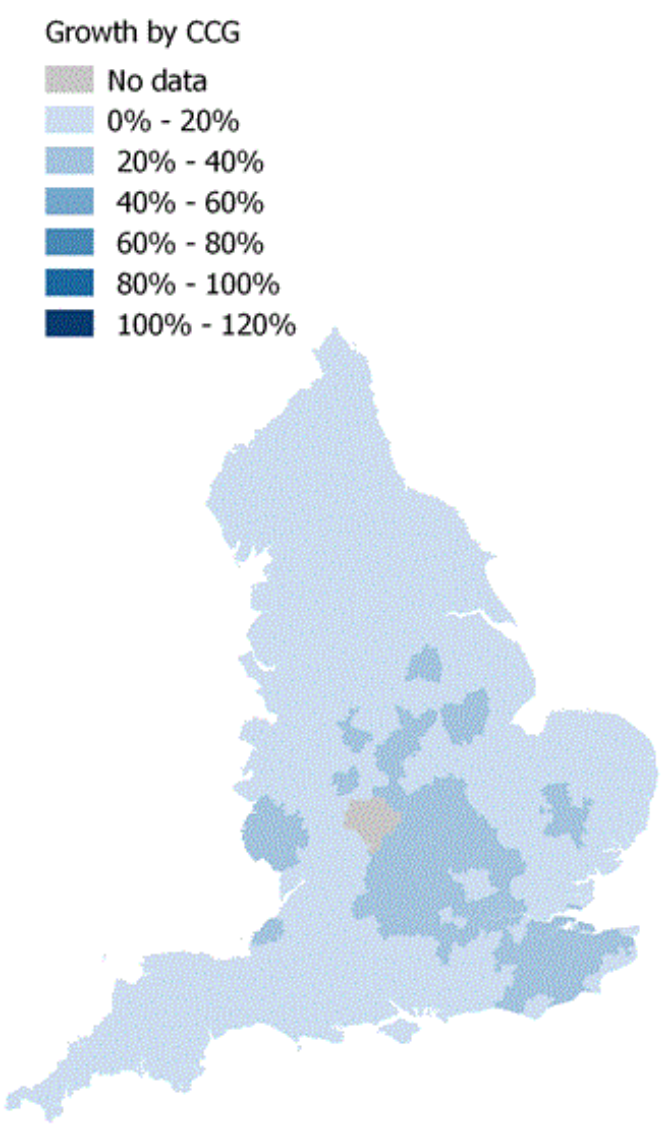


Percentage growth of lower GI endoscopies between years 13/14 and 19/20



Percentage growth of upper GI and HPB endoscopies between years 13/14 and 19/20



Key Findings – Model Results

The model suggests 44% growth in GI endoscopy between 2013/14 and 2019/20, a growth rate of 6.5% per annum.

This compares to reported growth rates for GI endoscopy activity from DM01 between 2006/7 and 2013/14 of circa 2.8%.

Approximately one quarter of this growth (c. 1.5% per annum) is as a result of changes in demography and population health status; factors that might be regarded as outside the immediate control of the health system.

The remaining 75% of the modelled growth is a function of NHS strategies or technology changes. Of these factors, changes to bowel screening are the most significant.

The model suggests greater growth in lower GI procedures, with flexi-sigmoidoscopy, colonoscopy and CT colonoscopy expected to grow by 122%, 29% and 146% by 2019/20.

The opportunity to reduce levels and variation in DNA rates offers some opportunity to increase endoscopy unit capacity and productivity. If all England NHS acute trusts achieved a reduction to the median rate in the region with the lowest DNA rates, then this would create 3% additional capacity.

Solutions must lie in;

- management of demand
- improvements in productivity
- increases in capacity

Recommendations - Executive Summary

- Investment - workforce and equipment
- Strategic planning for workforce training and development
- Job planning to encourage retention and avoid burn out
- Support to achieve and maintain JAG accreditation and make use of tools such as the 'Productive Endoscopy' toolkit and the JAG Productivity and Planning Assessment Tool (PPAT)
- More active engagement with commissioners to explore alternative pathways and processes
- Collaboration between units, and primary and secondary care, to support appropriate referrals
- Enhancements to Hospital Episode Statistics (HES) to contain complete and accurate record of the nature of all NHS commissioned endoscopies
- Routine publication of data on activity and outcomes of Bowel Cancer Screening Programme
- Strategic planning process to ascertain how best to manage the pressures future developments will inevitably create in endoscopy services i.e. FIT

Further points to note

- Government's subsequent response included additional investment and training of an additional 200 non-medical endoscopists
- Introduction of 28 day standard for cancer diagnosis - our study demonstrates that under existing and future predicted pressures the system needs investment irrespective of the speed of diagnosis
- What is extent of delays in current diagnostic pathway and what is their impact?
- Case for improving cancer outcomes by investing in a significant expansion in diagnostics has yet to be made i.e. will the provision of more diagnostics decrease late diagnosis enough to make a significant difference to outcomes?
- How far can we go with improvements in the 'missed' cancer rate for colonoscopies?
- A careful evaluation of costs and benefits of changes to cancer care across the pathway will be needed if essential improvements in outcomes are to be achieved whilst maximising cost-effectiveness at a time of NHS austerity.