Colorectal
Straight To Test
Pathway for
2 week wait referrals

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Background

- **Traditional 2WW model**
  - Outpatient clinic within day 14
  - 20 minute appointment but usually only confirms the need for further investigations
  - Rigid sigmoidoscopy (no prep, limited value) and then further tests usually colonoscopy booked - by day 28 but often later
  - Creates ‘carve out’ of capacity resulting in routine patients waiting longer and if surgery needed, risk of breaching 18 week RTT targets.
  - This group is often where the patients with cancer are sitting
Traditional 2ww Patient Pathway

1. GP referral
2. Consultant triage (1 week)
3. OPD appointment (2 weeks)
4. Colonoscopy appointment (4-5 weeks)
5. OPD follow up if not cancer (3 months)
What did we want?

We wanted to:

• Diagnose **all** patients (with bowel cancer) in a more timely fashion
• Reduce waiting times
• Increase capacity by avoiding unnecessary OPA
• Ensure Endoscopy waits were managed and provide a filter for patient selection and safety
• Streamline patient journey
• Reduce number of visits for patients to hospital
• Manage a persistent surge in number of referrals
• Provide a flexible service that responds to peaks in demand
The STT Colorectal Telephone Assessment Pathway

- GP referral
- Nurse telephone assessment & triage: 1 – 4 days
- Colonoscopy appointment: 2 weeks
- Virtual Clinic / Results: 3 weeks
- 3 weeks
How does it work?

• Nurse assessment and triage
  • Given as a ‘choose and book’ appointment or via 2ww office
  • Clinical assessment plus first stage pre-assessment for Colonoscopy
  • Algorithm to follow / protocol driven
  • Able to direct book for a colonoscopy appointment
  • Bowel prep sent in post
  • Second stage telephone pre-assessment for high risk patients (anti-coag / diabetes etc.)
Colorectal
Telephone
Assessment /
Straight to Test
Pathway

- Patient sees GP
- GP refers pt to 2ww team at GSTT
- 2ww office call patient within 24 hours to book TAC
- Patient has Colorectal Telephone Assessment* within day 3 of referral
- Referred for one of the following by day 14
  - Flexi Sig*
  - Colonoscopy (+/- OGD)*
  - CT Colonography or CAP*
  - Discharged
  - Out-patient clinic*

* All appointment / investigation dates and times are chosen by patient at the time of the telephone assessment

- OPA if serious pathology found OR Discharged if normal / benign pathology with management advice – process managed by Consultant Nurse

Tests / Treatment / Discharge
Methodology

• 2WW patients are referred to a straight to test service, set up as a telephone clinic, via Cancer Office (or via Choose and Book).

• Patients’ first clinical contact is via a scheduled telephone assessment appointment with a consultant nurse or a member of her team.

• Triages the patients according to a protocol to be seen in most appropriate setting:
  o Straight to flexi sigmoidoscopy, +/- CT Enema same day if appropriate
  o Straight to CT Colonography or CT CAP
  o Straight to colonoscopy ( +/- OGD if IDA)
  o See in OPD, flexi sig facilities available at same appointment if required

• If, based on the clinical assessment, the patient requires endoscopy, patient is given the date there and then.

• Bowel prep sent out in post

• Endoscopy pre-assessment will be undertaken at the same time.
Benefits of CTAP

- Eliminate waits for non 2ww referrals – was up to 23 weeks
- Frequently pts phoned the following week and have test 2 weeks later
- Decreased wait times to investigation from 10 weeks to 3 weeks for all non 2ww referrals
- Flexible due to minimal set up so able to respond to peaks ie media campaigns for bowel cancer awareness
- Continuity for GP’s
- Quality, appropriate triage
- High quality counselling of patient
- Safe assessment of patient’s suitability for colonoscopy
- Positive feedback from GP’s & patients
- Frees up Surgeons to see more complex cases & operate
Dorset Results

- 4000 patients 2008 – 2012
- Non 2ww referrals initially
- 98% assessed within 3 weeks, 95% had colonoscopy within 3 weeks of telephone assessment
- 87% referrals diverted down ‘STT’ route
- High patient and GP satisfaction
- Time to assessment reduced - from 23 weeks (max), 13 (average) to 3 weeks
- Time to diagnosis 3 weeks for all patients (2 & 18ww referrals)
Outcomes – Phase 1 Pilot

- November 2013 – March 2015, a total of 403 patients were assessed through the TAC with 308 (76%) put forward for Endoscopy as their first diagnostic.

- In the same period, 947 other 2WW patients were seen via the traditional outpatient pathway.

- 30% of 2WW patients were seen via TAC in the pilot period.

- Pilot – One Consultant Nurse - 2 x TACs per week
TAC to Endoscopy - 315 (89%) of patients were offered and booked their endoscopy procedure within 14 days of their telephone assessment. (April 14-March 15)
Pilot outcomes

- The TAC pilot demonstrated that the overall waiting time to Endoscopy was reduced using the new methodology to 14 days or less for most patients.
- For non–TAC patients the average wait was 26 days and for TAC the average was 12 days.
- However Pilot was one Consultant Nurse and minimal infrastructure to support the service with only 30% of 2ww referrals going through this route.
- As of Nov 1\textsuperscript{st} 2015 - further resources were put in place and we now put 94% of all 2ww referrals via TAC.
STT post pilot

- Full engagement of the 2ww cancer team to drive and manage the STT service, reduce cancellation and DNAs and optimise pathway
- Full time endoscopy scheduling support assigned to the TACs and pathway management
- Appointment of 3 new full time GI nurse endoscopists who also carry out TACS and help manage the STT pathway
- Progressed from 2 TACs per week to 7 TACs, 5 days a week
- 8 - 10 slots per TAC
- Endoscopy Nurses sending out bowel prep and pre-assessing high risk patients
- Improved data analysis support
- Increased use of CT colonography & streamlined pathway
- Since Nov 2015 over 2000 patients assessed via STT / TAC
- 76% referred for an endoscopic procedure
CT Colonography

- Development of GSTT CT colonography service
- Useful investigation especially for elderly pts who those who decline colonoscopy
- Extra colonic pathology identified
- Development of pathway continues to streamline pathway around delivery of the preparation (faecal tagging) and meet the needs of patients unsuitable for colonoscopy
What are the downfalls to STT?

• Pathway pressures
• Needs micro managing in order to avoid breach dates
• Relies on co-operation and compliance of patients & GPs to achieve targets
• Needs high quality referral information
• Scepticism amongst traditionalist!
Commissioners & GP’s engagement crucial

• Appropriate tariff to be agreed
• GPs knowledge & support of pathway vital
• Pts need to be informed and expectations managed:
  – To be available on their phone with immediate effect
  – To expect to be booked in for a scheduled telephone assessment within the next 2 days.
  – A test as first appointment (rather than a clinic appointment) within 14 days of seeing GP.
  – This won’t always be a colonoscopy
What next?

• NHSE currently working with main stakeholders to agree an ‘Optimal Colorectal Pathway’ for the roll out of STT
• Stakeholders include BSG, ACP, Bowel Cancer Charities, CRUK
• NHSE currently consulting on BPT for STT
• Parallel work to compliment STT includes FIT and VCE
Health Education England
Non Medical Endoscopist
National Accelerated Training Programme
Background

- Well documented shortage of Gastrointestinal endoscopists to meet increasing demands (symptomatic and screening)
Background

- National approach required to address shortfall
- NHS England – National Endoscopy Workforce Committee
- Non-medical agenda – recruitment and retention of Non-Medical Endoscopists (NME)
- Health Education England (HEE) Mandate
HEE’s role

- Work with key partners to ensure the NHS has available the right number of trained staff to deliver current and future demand for diagnostic test.

- Run a pilot training programme to train 40 Non-medical endoscopists by end of 2016

- Fulfil the Secretary of States commitment to train 200 additional non medical endoscopists by 2018.
Non-Medical Endoscopists (NMEs) Competence Assessment Portfolio

Trainee name:

Registration number:
Transferable Role Template
Career Framework Level 7

Non-Medical Endoscopist (NME)

Published : 03-09-2015

Developers

Non-Medical Endoscopist Competence Assessment Portfolio

- Based on National Occupational Standards for Endoscopy
- Competencies are set at Level 7 (M)
- 26 underpinning principles:
  - 8 common / core
  - 18 specific to endoscopy
- Transferable Roles template to support the portfolio
8 common / core underpinning principles

• Communication - general
• Personal & People Development
• Health, Safety & Security
• Service Improvement
• Quality
• Equality & Diversity
• Education, learning and research
• Management and administration
18 endoscopy specific principles

• Communication
• Providing information about endoscopic procedures
• Informed consent
• Individualised care
• Procedure Scheduling
• Equipment safety
• Pre-procedure preparation
• Correct procedural positions
• Practitioner roles and responsibilities
• Sedation & Analgesia

• Patient Safety
• Procedural performance
• Diagnostic Findings
• Specimen collection
• Polyp management
• Haemostasis management
• Endoscopic procedure reporting
• Interpretation of clinical investigations
Pilot Selection

• Robust selection process
• Application form to HEE – strict selection criteria based on individual’s suitability
• 3 way interview process after short listing to assess:
  – Individual trainee suitability & motivation
  – Practical, listening & recall skills assessment
  – Organisation / Trust’s ability to provide & support the training
Pilot Summary

• 6 month accelerated training programme
• 6 attended study days (Induction day, 4 taught days & assessment day)
• Support throughout from Pilot faculty
• On-line forum for discussions / programme literature / networking etc.
• Multi-modal assessment consisting of:
  – 200 clinical procedures with JAG certification (assigned a Clinical Supervisor)
  – 30 credit Level 6 or 7 Academic assignment
  – OSCE & presentation
  – Completion of SLATE eLearning module levels 1 - 6
  – Completion of HEE NME competency portfolio
  – JAG Basic skills course
  – Senior nurse / advanced practitioner in-house review
## HEE NME Pilot Training Programme Summary

<table>
<thead>
<tr>
<th>Learning mode</th>
<th>Month 1</th>
<th>Month 2</th>
<th>Month 3</th>
<th>Comments</th>
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<tr>
<td><strong>Formal endorsed theoretical training</strong></td>
<td>National Taught Induction day</td>
<td>Taught day</td>
<td>Taught day</td>
<td>Taught days hosted by JAG Federation of training centres</td>
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<tr>
<td><strong>Clinical in house</strong></td>
<td>Completion minimum 15 cases</td>
<td>Completion minimum 50 cases</td>
<td>Completion minimum 80 cases</td>
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<td><strong>SLATE on line resource</strong></td>
<td>Level 1+2</td>
<td>Level 3</td>
<td>Slate test Level 4</td>
<td>Feedback at completion of each level .</td>
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<tr>
<td><strong>Amended JAG Basic skills course</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Trainees attend one course only</td>
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<tr>
<td><strong>Summary of personalised learning and development aims and objectives and action plan</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Interim review at 3/12</td>
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<tr>
<td><strong>Senior nurse review</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Interim review at 3/12</td>
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<table>
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<th>Month 5</th>
<th>Month 6</th>
<th>Comments</th>
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<tr>
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<td>Taught day</td>
<td>Taught day</td>
<td>Taught day</td>
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<tr>
<td><strong>Clinical in house</strong></td>
<td>Completion minimum 120 cases</td>
<td>Completion minimum 160 cases</td>
<td>Completion 200 cases</td>
<td>200 flexible sigmoidoscopies* and summative JAG accreditation or 200 OGDs and summative JAG accreditation</td>
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<tr>
<td><strong>SLATE on line resource</strong></td>
<td>Level 5</td>
<td>Level 6+7</td>
<td>Level 8</td>
<td>Feedback at completion of each level</td>
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<tr>
<td><strong>Amended JAG Basic skills course</strong></td>
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<tr>
<td><strong>Summary of personalised learning and development aims and objectives and action plan</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Summative review at month 6</td>
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<tr>
<td><strong>Senior nurse review</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Summative review at month 6</td>
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Pilot Summary

• 2 phases
• 1st Cohort:
  – Guys & St.Thomas’ Hospital with Kings College London
  – 14 trainees (12 nurses, 1 ODP, 1 surgical practitioner) started Jan 2016
• 2nd Cohort:
  – Liverpool John Moores University
  – 26 trainees (all nurses) started April 2016
Pilot programme - first cohort

- 14 trainees started 21st January 2016: 1 withdrew after 2 months
- 6 training in OGD, 7 in flexible sigmoidoscopy
- 12 trainees have now completed all elements: 2 trainees awaiting formal sign off due to re-submitted academic assignment
- 9 of the 13 trainees completed 200 or more procedures within 6 months
- 3 further trainees completed 200 or more procedures within 7-8 months
- All OGD trainees completed 200 procedures earlier than those doing flexi sig

Overall timescale

- 5 trainees completed all programme elements in 6-6.5 months
- 7 trainees completed all elements 7 - 8 months
Cohort 1

Completion of procedures - by trainee, procedure type and month

- Trainee 1. OGD JAG certified (16.7)
- Trainee 2. OGD JAG certified (12.7)
- Trainee 3. OGD JAG certified (16.7)
- Trainee 4. OGD JAG certified (20.8)
- Trainee 5. OGD JAG certified (4.7)
- Trainee 6. OGD
- Trainee 7. Lower GI
- Trainee 8. Lower GI
- Trainee 9. Lower GI
- Trainee 10. Lower GI JAG certified (8.8)
- Trainee 11. Lower GI
- Trainee 12. Lower GI JAG certified (23.8)
- Trainee 13. Lower GI

Minimum number
Pilot programme - second cohort to date

- 26 trainees started 19th April 2016; 1 withdrew after 3 months, 1 after 5 months; 1 has deferred to a future cohort
- 9 training in OGD, 14 in flexible sigmoidoscopy
- 21 have completed all programme elements
- 5 were granted short extensions
- 13 of the 23 trainees completed 200 or more procedures within 6 months
- All OGD trainees except 1 completed 200 procedures earlier than those doing flexi sig
Completion of Procedures - 2nd Cohort trainees

Trainee 1. OGD JAG Certified (20.9)
Trainee 2. OGD
Trainee 3. OGD
Trainee 4. OGD
Trainee 5. OGD
Trainee 6. OGD JAG Certified (27.9)
Trainee 7. OGD JAG Certified (17.9)
Trainee 8. OGD
Trainee 9. OGD
Trainee 10. Lower GI
Trainee 11. Lower GI
Trainee 12. Lower GI
Trainee 13. Lower GI
Trainee 14. Lower GI
Trainee 15. Lower GI
Trainee 16. Lower GI
Trainee 17. Lower GI
Trainee 18. Lower GI
Trainee 19. Lower GI
Trainee 20. Lower GI
Trainee 21. Lower GI
Trainee 22. Lower GI
Trainee 23. Lower GI
Trainee 24. Lower GI

Minimum number
Evaluation so far

• 3 trainees withdrew from the programme.
  – 1 due to organisational pressure, Trust unable to commit to training the NME on an accelerated programme as original hoped.
  – 2 trainees withdrew due to personal reasons, unrelated to the programme

• First mandatory use of the HEE NME Competency Portfolio – ongoing work to evaluate its practical application and wider launch within the Endoscopy community

• Full Programme Evaluation by Office of Public Management (OPM)
Evaluation so far cont...

• JAG’s engagement – await publication of final evaluation by OPM
• Initial reviews are looking at:
  • Programme design
  • Length of accelerated training,
  • Methods of assessment, etc
• Phase 3 to commence January 2017 in Liverpool
• Shortlisting currently taken place, interviews next week
• HEE to then facilitate roll out to any qualified provider to train 200 NMEs by 2018
• Pressure on units and impact on other trainees huge consideration vs having more NMEs with high quality training then in post
Many thanks

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