

# ELIMINATING UNNECESSARY DELAY IN PATIENTS FINDING OUT IF THEY HAVE COLORECTAL CANCER OR NOT

Claire Gregory<sup>1</sup> Marion Lynch<sup>2</sup> Robert Howell<sup>3</sup> Geraldine Sweeney<sup>4</sup>

<sup>1</sup> Wessex QI Fellow; <sup>2</sup>Wessex QI Programme Director; <sup>3</sup>Colorectal MDT Clinical Lead, The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust; <sup>4</sup> Improvement Programme Manager, The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust

## Background

In June 2015 the National Institute for Health and Care Excellence (NICE) published new guidance for recognition and referral of suspected cancer (NG12). The guideline uses a concept of 'risk threshold' whereby if the risk of a patient's symptoms representing a cancer is above a certain level then action is warranted. Previously this level was 5%, but the new guidelines have reduced this to one of 3%. Focusing on patients with suspected bowel cancer, the most commonly associated symptoms are change in bowel habit and bleeding. These new guidelines now incorporate more non-specific symptoms such as weight loss or abdominal pain and have reduced the age at which a fast track referral should be made. As a consequence of these changes, more patients will be referred to the colorectal outpatient clinic, who will need to be seen, investigated and treatment started within 62 days. This is the government target for cancer waiting times, from GP referral to first definitive treatment.

## Aim

To reduce the average time for colonoscopy investigations from 30 days to below 28 days in the next six months, by the introduction of a colorectal telephone assessment clinic (TAC), triaging fast track colorectal patients straight to colonoscopy.

## Multi-Disciplinary Team

The project has involved the improvement team, surgical team, medical team, service line managers, endoscopy department, administration and outpatient booking team and the IT department.

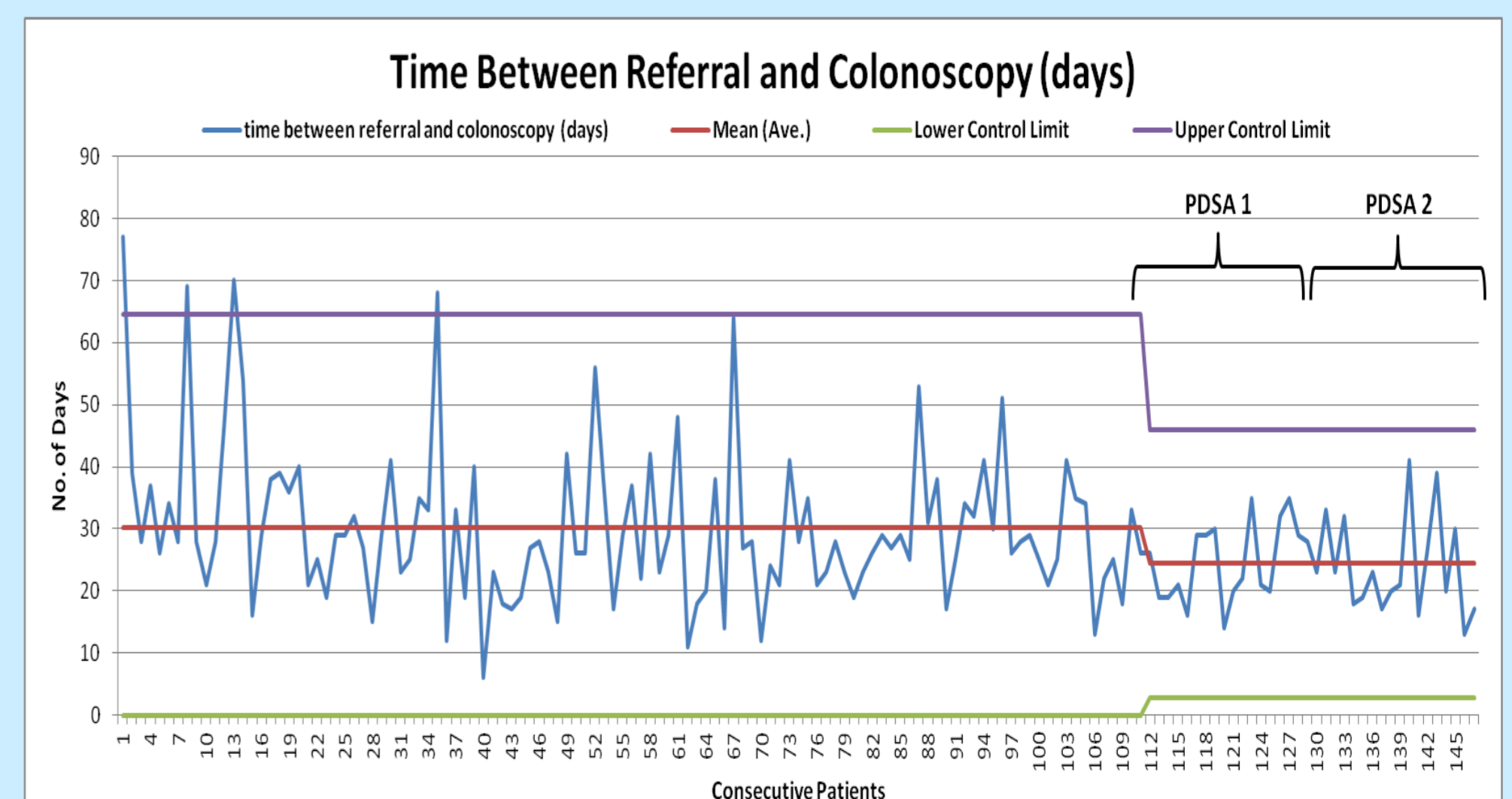
## Design/ Strategy

- A Plan-Do-Study-Act (PDSA) methodology was used.
- Baseline data was collected for the time in days between GP referral and colonoscopy, for colorectal patients referred as fast track patients and seen in the outpatient clinic
- The intervention required a telephone assessment clinic (TAC) to be set up for patients to be referred to, instead of being assessed in the traditional outpatient clinic.
- PDSA cycle1: 4 clinics in Nov/Dec 2015, each TAC was carried out by a senior surgical registrar. This cycle was to assess whether a TAC was possible and a viable intervention.
- PDSA cycle2: 4 clinics in Feb/Mar2016, this time each TAC was carried out by a senior endoscopy nurse, observed by a surgeon. This cycle was to determine what resources would be needed for the TAC to be successfully and safely conducted by a nurse.
- Patient numbers assessed via the TAC were measured, along with the time from GP referral to TAC and time from GP referral to colonoscopy.
- Each patient assessed in the TAC were sent a patient satisfaction survey, to gather patient feedback on the intervention.

## Results

- 44 patients were referred to TACs in PDSA cycles 1 & 2
- Baseline data showed an average of 30 days between GP referral and colonoscopy.
- PDSA1 & 2 cycles showed an average of 24 days between GP referral and colonoscopy, see SPC chart below.

## SPC Chart



## Outcomes

- Patient Survey results showed positive response to TAC:
  - 86% happy to receive future TAC appointments should they be necessary, 5% would prefer face to face clinic
  - 'Much better to have assessment by phone.' ..... 'no travel time—no sitting around waiting'
  - 'Very satisfied with the telephone assessment service', 'Anything that saves a journey to hospital is a bonus. It takes me 3 buses each way'
- A reduction of 6 days in a 62 day patient pathway is a promising outcome
- Charity money has been allocated to fund a nurse-led TAC position for 6 months to continue the proof of concept

## Lessons Learnt

- Slower progress than was first anticipated - multiple departments involved in design and implementation
- Needed a system in place for TAC patients to be urgently referred back to outpatient clinic if necessary
- Close liaison with endoscopy booking team was vital to ensure available slots to book into from TAC
- Needed to develop a database for TAC patients for easy follow-up.