



Gastroenterology Specialty Group

Design Workshop Report
February 2019

Scottish Access Collaborative Approach

The aim of the Scottish Access Collaborative is to sustainably improve waiting times for patients waiting for non-emergency procedures.

The Cabinet Secretary for Health and Sport launched the Scottish Access Collaborative in November of 2017. This will be closely aligned with the Regional Planning, Realistic Medicine, Elective Centres Programme and extant Performance Management and Clinical Priorities, Delivery Activities and Programmes. In the complex landscape of healthcare planning and delivery the Access Collaborative will focus on developing collaborations which build on existing work streams and networks to sustainably balance demand and capacity.

The Collaborative is led by Professor Derek Bell, Chair of the Academy of Medical Royal Colleges, and Paul Hawkins, Chief Executive of NHS Fife and is made up of a range of professional bodies including the Scottish Academy of Medical Royal Colleges, patient representatives and service leaders. The Collaborative has developed six fundamental principles which will shape and prioritise the way services are provided in the future. These principles are described in this report in the context of the findings.

A key strand of the Collaborative's work is the delivery of the Specialty Group programme, in which a range of experts in clinical specialties undertake a cycle of design-led workshops with the support of the Digital Health and Care Institute.

The Digital Health and Care Institute (DHI) was commissioned to design workshops aimed at producing high level mapping of each clinical area and identifying clinically led and patient centred sustainable improvements. The findings from these workshops will form the basis of a speciality-led Access Collaborative programme delivering solutions to help scheduled care services to sustainably meet the challenges of the future.

The DHI was established as a collaboration between the University of Strathclyde and the Glasgow School of Art and is part of the Scottish Funding Council's Innovation Centre Programme. It is part funded by Scottish Government. DHI support innovation between academia, the public and third sectors and businesses in the area of health and care.

For more information on the workshops and instances of best practice please see the Collaborative's blog:

<http://bit.ly/accesscollaborative>

Contributors

Roles Involved

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- Scotland Lead - Coeliac UK
- Clinical Nurse Manager
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- Consultant Gastroenterologist
- Care Homes Dietitian
- Operational Management

Health Boards Involved

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- NHS Lanarkshire
- NHS Lothian
- NHS Highlands
- NHS Forth Valley
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Executive Summary

Members of the Gastroenterology Speciality Sub-Group came from more than 20 different specialists' areas and 9 different NHS Board areas, giving the Sub-Group both a broad geographic and functional reach. The first step for the workshops was to identify common Gastroenterology patient symptoms, noting their importance. Issues were mapped for each symptom and areas to focus on agreed. Further discussion around these focus areas led to suggestions for sustainable improvement. These ranged from better support for patient self-management, the suggestion of a more dynamic relationship between primary and secondary care to better use of community dietetics.

Work to further scope these improvements will be undertaken in the coming months allowing a prioritisation process to take place through the Scottish Access Collaborative (SAC). Future work will involve national support to ensure the Gastroenterology community along with primary care partners are supported to make the necessary changes to ensure efficient and effective patient pathways are achieved. It is envisaged that the work areas will be taken forward either through the Gastroenterology community itself or for broader issues which are not specialty specific, be achieved through the SAC Combined Action Group (CAG).

February 2019



- 1. Preparation
- 2. Map the Landscape
- 3. Ask the Right Questions
- 4. Sketch Solutions
- 5. Prioritise

Clinical Foreword

We are all aware of the pressures on gastroenterology services. Throughout Scotland, teams have developed many interesting innovations to help address these problems although service pressures can make it difficult to meet to develop these ideas. The Scottish Access Collaborative has brought together people from a wide range of disciplines in a series of workshops that identified key areas where service change may improve care. This report summarises the outcome of these meetings. Recurring themes have emerged including a desire to improve vetting, streamline patient pathways and allow patient self guided management. Clearly more work is needed to transfer these themes into clinical practice. Hopefully future work of the Collaborative will provide a platform to develop these ideas, disseminate good ideas around the country and lead to improvements to patient care. We would be delighted to hear from you if you wish to become involved in future.

Implementation Support

The aim of the Modern Outpatient Programme is to support the development of a Modern Outpatient service which, aligned with the principles of the SAC, will support effective and faster service change to ensure patients are able to access healthcare in a timely manner. This national Programme is well placed to action the outputs from the Gastroenterology workshops; supporting clinical teams to test innovative ways of working and how positive improvements proven to enable the provision of high quality care for patients, can be shared and implemented at scale across Scotland.

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Scottish Access Collaborative Principles

I.

Patients should not be asked to travel unless there is a clear clinical benefit, and that any changes should not increase the workload for primary, secondary or social care in an unplanned/unresourced way

II.

All referrals should either be vetted by a consultant/senior decision maker or processed via a system wide agreed pathway – value vetting

III.

Referral pathways (including self-management) should be clear and published for all to see

IV.

Each hospital and referral system should have a joint and clear understanding of demand and capacity

V.

Each local system should have a clear understanding of access to diagnostics as part of pathway management

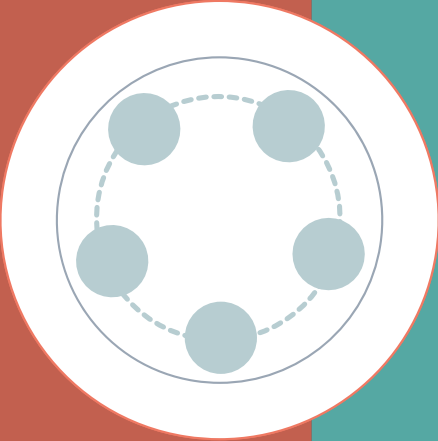
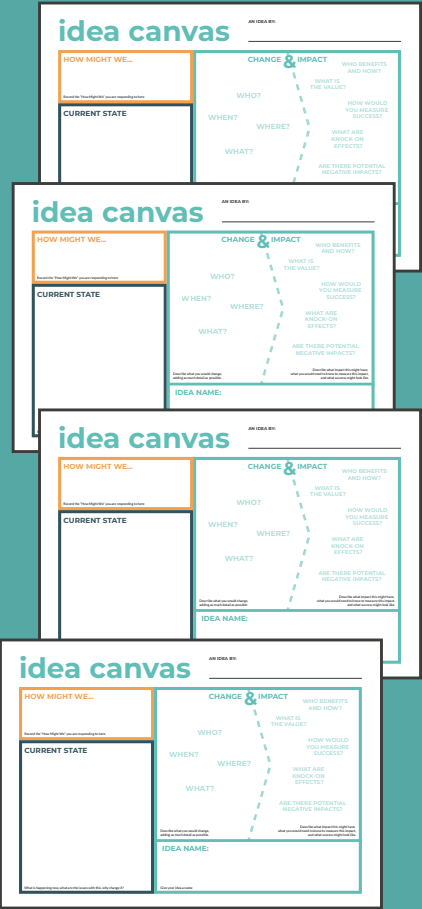
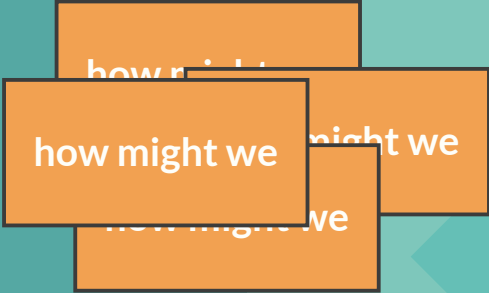
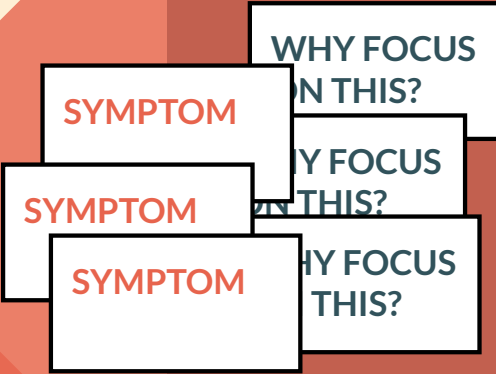
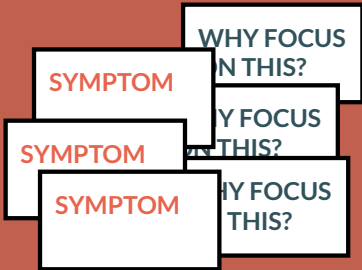
VI.

Improved and published metrics including how we record and measure virtual/ telehealth/ tech-enabled care

Contents

Design Approach	10
Symptom Profiles	12
Focus Areas	16
Challenges and Suggestions	26
Other Ideas	37
Next Steps	38

Design Approach



MEETING

The DHI team interviews one consultant to look at common symptom areas and current key issues.

From this interview the DHI team maps out the insights for consideration by the group in the workshop.

WORKSHOP

We prioritise which symptom to take forward and why. We map where key issues lie within each symptom pathway, and compare regional variation.

From these discussions, the DHI team pulls together a set of maps which show current issues and distills these into a set of challenges.

WORKSHOP

We prioritise the challenges as a group. People form working groups around challenges and start ideating and developing ways to address the challenge.

Symptom Profiles

The set of design-led workshops started with the participants agreeing on a small number of Gastroenterology symptoms they felt were of top priority to deliver maximum impact through service improvements. These symptoms were then mapped describing the current Gastroenterology services from initial consultation to eventual discharge. What follows are the five symptom profiles which were identified. Each profile is described along with reasons for why it should form an area to focus on.



This word cloud reflects the relative frequency of the most commonly used words in a group of Gastroenterology referrals from Fife. The data was collected from more than five thousand referrals and was taken from the 98 character field in SCI Gateway. While the word cloud was used for reference only it does support the broad choices of symptoms made in the workshops.

Reflux

Reflux, also known as indigestion or acid reflux is a common problem. It is a condition where contents of the stomach come back up into the oesophagus. This symptom was chosen because it has a high volume of referrals and the current guidelines may result in referrals that have no diagnosis after diagnostic testing, typically an endoscopy. A proportion of patients with this symptom may make unnecessary journeys to hospital and have a fairly invasive test with no subsequent diagnosis.

Unintentional Weight Loss (non-specific)

This symptom refers to patients who show signs of significant weight loss without a significant change to their diet or lifestyle. It is a small to medium volume of presentations, however it poses a very difficult decision in primary care with various pathway options. It is not always a Gastroenterology issue but knowing what is the best referral can be problematic.

Change of Bowel Habit

Change of bowel habit represents a large volume of presentations and crucially a lot of presentations are deemed to be inappropriate for Gastroenterology consultation. Change of bowel movement includes diarrhoea, constipation or a change in frequency of bowel movement. This is a challenging area both because it covers a number of different symptoms and because there may be little that can be done in secondary care that could not be managed by the patient, community, or primary care.

Chronic Abdominal Pain

Chronic abdominal pain encompasses any long-term pain or discomfort in the abdominal area with or without a change in bowel habit. There are many different possible causes for these symptoms and they result in a significant volume of these cases referred to secondary care. There is a wide variety in both the threshold for referral and for the amount of information the referrals contain. Furthermore, a significant proportion of patients are subsequently re-referred after testing proved inconclusive. This symptom pathway can be variable depending on the region.

Incidental Abnormal Liver Function (from GP test)

Abnormal liver function refers to abnormal liver enzyme test results which can be a marker for other conditions but often it is something that can be managed by the patient through lifestyle and diet changes. The Liver Function Test (LFT) may have been carried out as part of a group of tests. Abnormal results from LFTs for patients who are not experiencing any related Gastroenterology symptoms are reasonably common in primary care and are generally not referred to secondary care. This group was identified because proposed guidelines will mean that more patients will be referred into secondary care. Investigation of liver function related issues can result in long periods of diagnostic tests with limited or no added value to the patient.

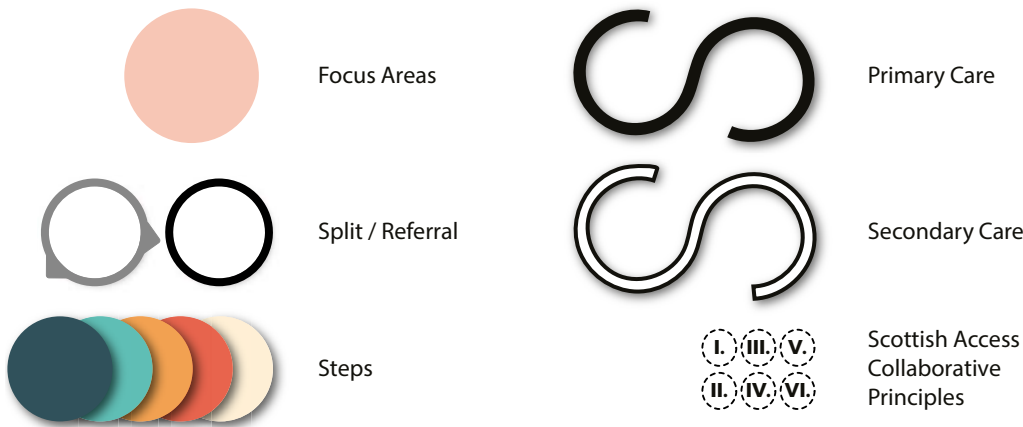
Focus Areas

After the symptoms were identified and discussed within the group, it was agreed that the number should be reduced from five to four and incidental abnormal liver function was removed. The group then began to look at the current patient journeys, highlighting areas to focus on. The second step involved developing a series of maps describing the current high level pathway. While mapping these services for each of the four different symptoms described above the group highlighted regional differences and explored and shared best practice. After identifying and locating key areas on this map, the group collaboratively prioritised what to focus on.

These focus areas were then investigated further to gather the factors which influenced the stated issue.

Following what emerged from the workshop, the DHI team translated the group’s discussions and maps into four summary maps illustrating and locating focus areas. These maps are categorised by symptom. However, many of the areas they show clearly stood out as important and challenging areas for more than one symptom, region or service. They are therefore key areas for improvement and could deliver significant impact for patients and staff.

Map key



Chronic Abdominal Pain



For chronic abdominal pain, many patients would be better served with a dietetic service than hospital visits to see a consultant. Currently they can end up in a ‘revolving door’ situation where they have a number of inconclusive tests, putting demands on them and the service. The question is how to support and properly resource primary and community services to identify and support those patients who do not require a hospital visit.

Focus Areas

It is a challenge for the GP to record an adequate patient history in the time allowed for a standard appointment and this may be reflected in the subsequent referral.

There is a lack of available standard quality health information and advice for the GP to give to the patient.

Figures for the number of patients who return to the GP after negative results and the efficacy of further testing could inform current practice.

Minimal information is not always included in the referral.

Reflux

For reflux the greatest opportunity for improvement is in the diagnostics. The majority of cases are referred for an endoscopy which finds nothing definitive. The endoscopy does not confirm reflux and patients may end up back on the medication they were on before. The patient may end up in a loop of treatment, test, and then treatment.

Focus Areas

Testing for reflux can be inconclusive and patients could be directed to self-management options and be supported in the community in the first instance.

Can patients be encouraged to continue with dietetics treatment? A relatively high drop out rate was identified.

A referral from the GP greatly benefits from a full patient history however there is limited time to gather this during the standard appointment.

Can follow-up appointments take place in community services where additional lifestyle support could be given?



Change in Bowel Habits

This symptom relies on a good patient profile for efficient, appropriate, and timely treatment. GPs may find that they do not have enough time to take history in the time they have been allocated for patient consultation. There are a number of questions

in this area such as: Can the definition of change of bowel habits be refined to separate out constipation from diarrhoea? Can the history taking describing the change discussed between patient and clinical staff be improved? Could there be an

engagement with patients before their GP appointment to help frame the GP questions and history taking? What additional role could dietitians play in patient engagement and vetting?

Focus Areas

There is a lack of public health awareness of what constitutes normal bowel habit. There is a subsequent lack of information on initial self-management options.

Lack of time in primary care to ensure a comprehensive history is included in referrals.

There is a lack of available trusted information on coeliac and IBS for the GP.

Current cancer guidelines include change in bowel habit, however this is a broad term and can lead to unnecessary referrals.

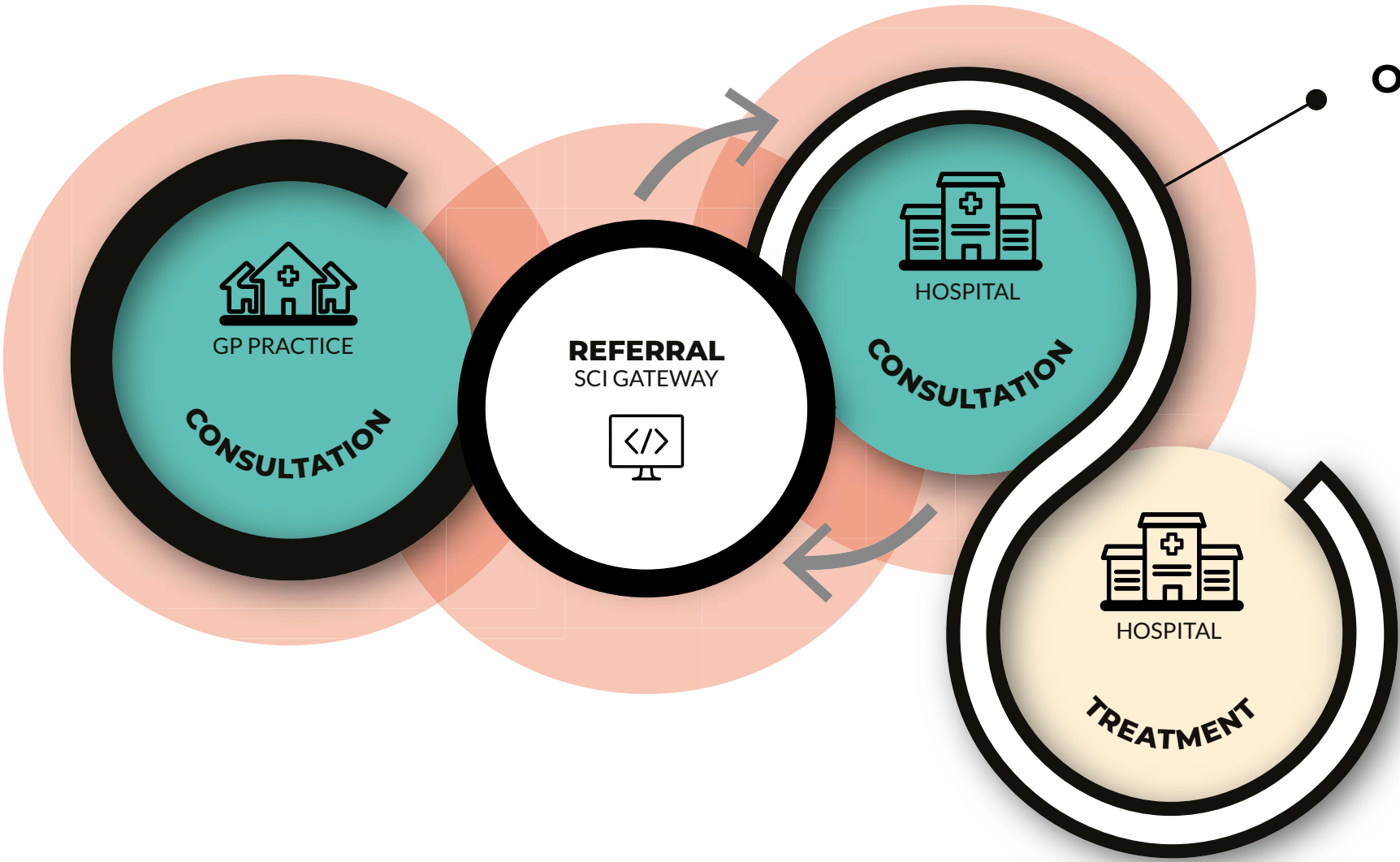
Is there a need for patients to be referred to secondary care for FIT and TTG?

There is no clear pathway to dietetics and pelvic floor physiotherapy, both of which are under resourced.

Routine follow ups within secondary care can often be unnecessary.



Unintentional Weight Loss



ONE OR MORE OF:
DIETETICS
GASTROENTEROLOGY
SURGERY
GENERAL MEDICINE
MENTAL HEALTH
OTHER SPECIALTIES

Finally, for unintentional weight loss, patients falling into a diagnostic loop between specialties without any resolution presents an opportunity for improvement. The causes of this symptom are many and patients may be passed between different specialisms before they are given a diagnosis and treatment. One of the key questions identified by the group, was how to reach diagnosis and treatment as early as possible.

Focus Areas

- There is a need to gather a full patient history for this symptom which is a challenge for the GP given the time allowed for consultation.
- Guidelines for GPs could be improved to include clearly defined referral options.
- Patients can end up going round the system in a loop.

Challenges and Suggestions

A number of the opportunities for improvement were put forward to address focus areas by the participants in the third workshop which were then further developed. Some improvements apply to more than one symptom and if successful could have significant potential for sustainably improving the balance between demand and capacity. The following summary describes these suggestions and also includes a set of other ideas which emerged during the discussion but did not relate directly to the symptom areas.

It should be noted that some opportunities for improvement will have a greater impact when implemented together with another option. For example, improvements in vetting coupled with agreed referral guidelines could have a significant effect on the volume of referrals into secondary care.

Each challenge area was addressed by a multi-disciplinary team from the workshop, with any suggestions presented back to the whole group for validation and wider input. These suggestions will now be put forward as priority areas of focus for Gastroenterology and candidates for further development and scaling through existing national programmes of work, or as specific pieces of work within the Scottish Access Collaborative.

The following outlines the four key challenge areas and the suggestions made by the group.



Patient Self-Management

The first challenge was how to encourage more patient self-management, supported by community services for a range of conditions such as reflux, weight loss, and change in bowel habit.

Currently there is variation in services nationally, a varied patient experience, a lack of knowledge and awareness of local community supports such as community pharmacy and a need for accessible self-management information for patients. Because of these issues there is currently a higher than necessary referral rate into secondary care for patients who have symptoms such as reflux and change in bowel habit.

The group also recognised that there is a lack of standardised measures across the service, that more IT could be used to support patients to self-manage and that there needs to be better public health messaging. The workshop attendees considered how A.H.P.s (Allied Health Professionals) can be used better in community service provision and why some diagnostics and treatments are not directly accessed from primary care.

Suggestions

To address these challenges and opportunities the group had the following suggestions:



Better use of IT:

to support patients with information and advice and to help primary care services stay in touch with patients who are managing their own condition.

Public Awareness Campaign:

raising awareness that some of these symptoms can be dealt with at the “first line” before going to secondary care.

Multi-disciplinary Working:

a focus on multi-disciplinary teams including GPs, consultants, dietitians and other health professionals working together to share information and support holistic care for patients.

Refer to Therapist: there could be a national agreement to shift from the current protocol of refer to clinic first to one where the first referral from a GP could be to another service if appropriate.

Care Navigation:

there could be the addition of individuals in GP practices who can point patients to care in community options.

Dynamic Primary Secondary Relationship

The second challenge was to create a more dynamic relationship between primary and secondary care allowing mutual feedback especially during vetting.

Changing the current situation will need the development and delivery of easy access to advice and guidelines from a variety of means including mobile apps. These could usefully include stratification of risk that identifies patients that are at high risk and prioritises them.

Suggestions

To address these challenges and opportunities the group had the following suggestions:



Enhanced Vetting:

for example, opportunities to book a short phone call or virtual consultation to speak with a GP about a patient referral or to speak with a patient to let them know options other than bringing them into a clinic.

Single on-call

Gastroenterology Consultant:

the availability of a single on call consultant covering all of Scotland for a limited number of virtual sessions a month.

Quality of Correspondence:

if a GP referral is rejected by secondary care the response back to the GP would benefit from having more and possibly standardised information to advise and inform the GP of the current practice.

Dedicated Vetting Time:

the key to improving and enhancing the scope of the communication between primary and secondary care is to allocate sufficient time for this.

Reflux Pathways

The next challenge relates to the current pathways for reflux where there is variation in the patient experience once they enter the health care system. Some patients who have been self-managing may be encouraged to continue self-managing their symptom while other patients may be referred for endoscopy and others may be managed by the GP. Some endoscopies currently being carried out do not add value to the understanding of the patient’s condition. The challenge is how to improve the patient experience while reducing the number of unnecessary scopes and appointments.

Suggestions

To address these challenges and opportunities the group had the following suggestions:



Improved National Guidelines:
a new nationally agreed pathway for reflux which is made easily available to GPs can reduce the number of patients needing secondary services and relieve the pressure on endoscopy services.

Quality Patient Information:
delivered in the GP consultation and again at the point of an appropriate referral.

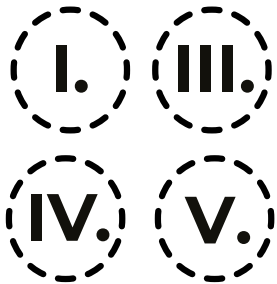
Patient Led Opt In:
patients are given the option to self-refer into secondary care rather than having a planned review. This would be for long-term patients self-managing their condition.

Support Better Use of Community Dietetics

The final challenge was to improve use of community dietetics. Currently patients with functional conditions like IBS are referred to Gastroenterology clinics after a GP has done all that can be done in the primary care setting including tests and treatments. The challenge is how to bring dietetics into the pathway sooner when that is appropriate.

Suggestions

To address these challenges and opportunities the group had the following suggestions:



First Line Dietetics:
patients are directed to first line advice and treatment rather than refer to secondary care. This does not necessarily have to come from a dietitian.

Group Dietetics:
patients who have been given advice but have continuing symptoms are referred for group dietetic care for their condition. This will also usually involve a period following a specific diet.

Direct Referral from Dietetics to Secondary Care:
where appropriate a dietitian will directly refer appropriate patients to Gastroenterology with a detailed account of what has been tried already and the patient history.

Patient Led Opt in Referral:
similar to the suggestion for the reflux pathway, the suggestion for community dietetics pathway is that patients are given an opt in to secondary care referral enabling the patient to play an active role in their care.

Dietetic Referrals for the over 45s:
this is currently offered for under 45s. Expand this to the over 45s who have a negative colonoscopy to reduce the number of patients coming back for unnecessary repeat appointments and scopes.

Other Ideas

Patients with symptoms such as unintentional weight loss could be encouraged to prepare for their GP appointment by bringing their background history with them. This information could even be submitted to the GP prior to the appointment.

The need for longer GP appointments during which patient history can be gathered was highlighted a number of times.

Better information could be made available for GPs on Coeliac Disease and Irritable Bowel Syndrome (IBS).

A public awareness campaign could be produced to explain what normal bowel habit is and give improved information on the changes to look out for.

Metrics could be gathered for the number of patients with abdominal pain who return to GP after negative tests and the efficacy of those tests. These metrics could include the proportion of patients with chronic abdominal pain who benefit from referral to secondary care.

Next Steps

The Gastroenterology Speciality group workshops generated broad agreement on the areas most likely to make a difference to patients presenting with Gastroenterology symptoms. In conjunction with the pathways and tools already developed in the Modern Outpatient Programme GI Collaborative (Coeliac Disease, IBS, IBS and iLFT), the recommendations detailed in this report will now be taken forward with national support via the Gastroenterology community itself, or where the issue is not specialty specific, through the SAC Combined Action Group (CAG). The CAG’s purpose is to address cross-cutting areas of challenge.

This further work will begin immediately, bringing together primary and secondary care to achieve efficient and effective pathways for patients.

PATIENT SELF-MANAGEMENT

Better use of IT

Public Awareness Campaign

Multi-disciplinary Working

Refer to Therapist

Care Navigation

**DYNAMIC PRIMARY
SECONDARY RELATIONSHIP**

Improved National Guidelines

Quality Patient Information

Patient Led Opt In

REFLUX PATHWAYS

Enhanced Vetting

Single on-call
Gastroenterology Consultant

Quality of Correspondence

Dedicated Vetting Time

**SUPPORT BETTER USE OF
COMMUNITY DIETETICS**

First Line Dietetics

Group Dietetics

Direct Referral from Dietetics
to Secondary Care

Patient Led Opt in Referral

Dietetic Referrals for
the over 45s



Scottish Government
Riaghaltas na h-Alba
gov.scot

DHI is a collaboration between:

**THE GLASGOW
SCHOOL OF ARE**

