

A Study of the Slot Wastage in a Sample Endoscopy Unit in United Kingdom: Analysis of the Causes

Tariq Mahmood^{1*} and Aqsa Aslam²

¹Department of Gastroenterology, National Health Service, Gastroenterology, 92 Long Lane, Ickenham, Middx, UB108SX, UK, Tel: +447956984625; E-mail: tm123@btinternet.com

²Department of Gastroenterology, National Health Service, Gastroenterology, 92 Long Lane, Ickenham, Middx, UB108SX, UK, Tel: +447956984625; E-mail: tm123@btinternet.com

*Corresponding author: Tariq Mahmood, Consultant Gastroenterologist, National Health Service, Gastroenterology, 92 Long Lane, Ickenham, Middx, UB108SX, UK, Tel: +447956984625; E-mail: tm123@btinternet.com

Rec date: Jul 8, 2015, Acc date: Oct 15, 2015, Pub date: Oct 21, 2015

Copyright: © 2015 Mahmood T, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Abstract

Background: Patients who do not attend (DNA) or cannot attend (CNA) outpatient endoscopy procedure appointments can be a source of resource wastage. This study was conducted to identify the causes of slot wastage in a sample endoscopy unit in United Kingdom. **Substrate:** This study was conducted in a sample endoscopy unit in United Kingdom. **Objective:** The objective of this study was to identify the causes of slot wastage in a sample endoscopy unit in United Kingdom. **Methodology:** A retrospective analysis of endoscopy appointments was conducted over a period of 12 months. **Results:** The study identified that the main causes of slot wastage were DNA and CNA. **Conclusion:** The study identified that the main causes of slot wastage were DNA and CNA. **Keywords:** Endoscopy, Slot wastage, DNA, CNA, United Kingdom.

surgeons, chest physicians or the urologists. Most bronchoscopies were done by chest physicians for suspected lung cancer. Likewise most colonoscopy done by surgeons was for suspected colorectal cancer. Urologists likewise were suspecting urinary bladder growths. Gastroenterologists on the other hand were doing endoscopy for a wide range of reasons including simpler and more benign conditions like dyspepsia (which is many times functional), gastro-esophageal reflux, acid peptic disease, inflammatory bowel disease and also gastro-intestinal cancers. This wider choice of reasons for endoscopy, including benign and functional diseases, could offer an explanation for higher DNA and CNA rates for Gastroenterologists. Furthermore, at present in the United Kingdom, there is a shortage of trained gastroenterologists who endoscope.

The DNA and CNA rates in clinical outpatients have been described in few studies but hardly any specifically relates to Endoscopy. National Health Service Highland Scotland have with appropriate actions been able to reduce their DNA rate from 8% down to 1% and the CNA rate from 5% down to 2%. Our study is unique in that it identifies the causes and recommends some solutions specific to endoscopy units.

Other solutions include; improving confirmation of endoscopy appointments through a follow up call by the receptionist, allowing patients to directly make appointments themselves for times that suit them, having enough trained gastroenterologists who can do endoscopy, back filling empty lists by appropriate holiday planning of the Endoscopists and ensuring minimal equipment or technical failure.

There are many Joint Advisory Group (JAG) accredited endoscopy units in the United Kingdom and our data pertains to one such busy unit in a district hospital. It would be useful to have data from other units as well, but one thing can easily be deduced based on our data, that the accumulative Endoscopy slot wastage in the UK would be very high.