

*Case study*

# Introduction of Concentric digital patient consent tool for elective surgery

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## Summary

*Find out how we introduced a new digital patient consent tool for elective surgical procedures in Jersey General Hospital and the positive impact this has had on both patients and staff alike. In our story you can hear how we conducted our initial pilot of Concentric in cardiology and how it's now being rolled out across our hospital.*

## Case study overview

### Project aspirations

We set out to improve the process of patients providing consent for elective surgical procedures. We wanted to improve the consent experience for patients, while also improving safety and minimising risk associated with consent.

Additionally, we wanted to free up time amongst the team through an improved process, as well as save resources lost when procedures were cancelled at a late stage owing to lack/ withdrawal of patient consent.

### Prior to the project

The standard method of gaining patient consent relied on a manual process of providing information to patients about a procedure and obtaining their written consent to proceed.

Despite new guidelines from the Royal College of Surgeons, we found they were not being followed effectively. In some instances this led to patients withdrawing consent at the last moment owing to apprehension and lack of information. In rare cases this led to patient complaints and legal team involvement.

Fundamentally, we wanted to empower and engage patients to make informed decisions about their care.

### The catalyst for change

COVID-19 drove forward the need to push our processes to work remotely, but also to enable better use of resources owing to the pressures of the pandemic on scheduled care. However, prior to COVID, work was already underway in line with our digital strategy, which focuses on the 'right data, right person, right time'.

Following some research, we came across Concentric Health and engaged with them to discuss use of their solution for digital patient consent.

## Project kick-off

The opportunity arose to run a pilot through our multidisciplinary [HealthX](#) team, which sits within central Jersey Government.

As a board, it was agreed to run a six-week trial of Concentric via the [Allan Lab](#). The cardiology department was selected for the pilot as there was an existing working relationship in place and a receptiveness to innovative new ways of working.

Rollout of the tool was simple with no specific training requirements owing to the tool's simple user-interface.

## Project progression

Feedback from both staff and patients was resoundingly positive, even amongst those where we anticipated resistance e.g. older generations. The tool was introduced as an 'add-on' pilot, giving staff the reassurance of a fail-safe.

Initial plans were to stop use of Concentric at the end of the six-week pilot to allow assessment of its implementation. However, as its benefits were overwhelmingly evident, use of Concentric continued.

## Project achievements

Concentric is currently being rolled out across urology and endoscopy with hospital-wide rollout imminent. While there are some initial teething issues in scale-up associated with integration with existing systems, this is to be expected and we're confident they can be swiftly navigated.

Through the implementation of Concentric, patients now feel better informed, time in clinic is reduced and clinician time is freed up to focus on patient care rather than processes.

We unpacked how we implemented Concentric - an innovative digital consent application - in a case study on BOB. Patient consent remains a paper process across much of the UK, but with an increased appetite to accelerate digitisation across the NHS, we were invited to lead a BOB Talk to discuss how we rolled out and embedded the digital consent tool at Jersey General Hospital.

# Set-up and roll-out

## Declarations of interest

### Partnerships and collaborations

We worked together with Concentric Health to implement their digital patient consent tool into clinical practice.

### Project funding and support

Concentric Health provided their solution free-of-charge for the duration of the project. Additionally, they provided their services to support integration of the tool in practice. However, future rollout will involve procurement of the tool through our standard contracting procedures. Internal staff resource was funded by the Allan Lab.

## Background

### Project setting

Jersey General Hospital is the only hospital supporting the residents of the island with 4,500 staff and 200 beds serving 100,000 patients (equivalent to a District General Hospital in England).

This project was focused on patient consent for elective surgeries, of which there are around 1,000 per year covered by seven main theatres and three theatres in the day surgery unit.

## Preparation

### Understanding the issue

The Royal College of Surgeons' guidelines around patient consent provided an initial grounding, but their implementation in our organisation was challenging.

In order to understand the issues, we tracked the entire patient pathway from GP referral right through to the surgical procedure taking place. We spoke directly to three patients who had experienced issues with the current consent process, leading to cancellation and complaints.

Fortuitously, our legal department was also looking for solutions to improve quality of care and prevent complaints around the consent process. In looking for a solution, together we discovered Concentric and explored its utility as a potential digital solution.

## Methodologies and models

As the project was a short six-week pilot aimed at addressing an issue we knew existed, our assessments were reserved for the end of the pilot. As we move forward with further rollout across other departments, we will introduce formal assessment methods.

## Planning

### Project catalyst: additional information

[The Jersey Care Model](#), introduced in 2020, calls for improvement around care in the community, which involves the rapid introduction of digital innovations to enable remote delivery of care; further accelerated by COVID-19.

Additionally, through our improvement work, we had identified instances of patients who were unhappy with their treatment. Some felt they had consented without fully understanding what was involved and others withdrew consent at the last minute through apprehension and lack of understanding.

We had already set out to change this through a new consent policy, but an implementation plan was needed to ensure adoption, particularly given the high turnover of visiting doctors.

### Project aims

Our prime aim was to deliver consent in line with the Royal College of Surgeons guidelines, thus ensuring the best possible patient experience and outcome.

Patient empowerment is a key focus of our organisation and so we wanted to move to a position where patients are able to make their own decisions about health together with their surgeon.

As a secondary aim, we wanted to free up staff capacity and resources removing room for human error associated with a manual process.

Ultimately, we aimed to ensure patients felt better informed in making decisions about their treatment without the need to come into hospital.

## Project administration

### Business case

As this was a pilot that did not require funding and we were confident in the solution we had identified, a business case was not required. We are now working on proposals to secure funding for future rollout.

### Baseline data collection

We didn't collect any formal data, but we already had a clear understanding of the issues with the previous processes through the patient journey, which was used as the justification to proceed with the pilot.

As Concentric is rolled out more widely across the hospital, we will collect additional data to conduct assessments of its impact.

### Project mapping methods

We mapped out the full implementation using Lucid charts. We deliberately kept the project team very small and defined, working with the cardiology team only. We developed an implementation plan for the pilot, which contained information about who were going to train, which methods we were going to use and how many consent episodes we were likely to cover in the pilot process.

We are now using this same implementation plan (with some refinements) for the rollouts across urology and other departments.

## Commencement

### Project sign-off

We worked together with HealthX to secure agreement to proceed with the pilot project. In the weekly meeting we went through the statistical analysis system (SAS) process, this involved checking non-functional requirements such as cyber security etc. We then worked through our implementation plan. This involved looping in finance, IT, information governance etc. so they were aware of what was going on and agreed to proceed.

## **Governance**

We sit within our HealthX board, a small group with a view of the entire estate, while also looping in people from the centralised systems (in our case, central Jersey Government) at an early stage, so they knew what the project was all about when signing off governance materials. This was really important to highlight the importance of the project to those in non-clinical roles to ensure it moved through quickly.

## **Key project resources**

We had the full time resource of one member of staff (Austin Gibbs) from the Allan Lab, which is focused on supporting the introduction of new innovations. We kept the team small, so there was limited input required from wider staff.

## **Implementation**

### **Challenges and stumbling blocks - Capability - knowledge, skills and abilities**

There were no restrictions or limitations to using the tool. The Concentric team was always on hand to provide support and help throughout the process, so we didn't encounter any issues

### **Challenges and stumbling blocks - Opportunity - external factors**

There were some sporadic issues around accessing the network and WiFi, which is a reflection of broader issues around our IT infrastructure rather than the tool itself. As we roll out Concentric more widely, we're identifying some teething issues around integration with our patient record systems. However, staff always felt reassured as the existing paper system was still available.

### **Challenges and stumbling blocks - Motivation - human factors**

There was general acceptance across the full team. One staff member was initially hesitant to use the technology, but they quickly came on board and have since become a key advocate for the tool's use.

As we roll out more widely, we are identifying some areas of scepticism, which is normal when it comes to IT for health, so staff need to be engaged early on. It's an organic process and for some people we are having to take a staggered approach e.g. allowing them to still print off the signed form while their confidence grows in the technology.

## Measuring progress

The team had full control over the project and their feedback throughout was that it was a widespread success, both from their own experience and patient feedback. At the end of the pilot, it was impossible to remove Concentric as per the original plan, as no one wanted to give it up.

## Risk & safety

### Risk assessments and considerations

We minimised integration with other systems to reduce information governance risk and errors. In addition, having a small project team with clear governance and running the project alongside existing processes enabled any risks to be mitigated.

### Capturing safety data

No additional safety measures were required as Concentric was implemented in addition to existing processes.

## People

### Project team

- Austin Gibbs - Director of the Allan Lab, CIO
- Angela Hall - Arrhythmia Nurse Specialist
- Kelly-Anne Kinsella - Arrhythmia Nurse Specialist
- Andy Mitchell, Cardiologist and CCIO
- X2 Consultant Cardiologists
- Dafydd Loughran, CEO, Concentric Health

## **Project stakeholders**

Initially the project just involved the small, core project team. However, as we roll out Concentric more widely, we're broadening out engagement to include change managers, IT, and other clinicians.

## **Key players**

Our Arrhythmia Nurse Specialists, Angela and Kelly-Anne, were fundamental in getting on board and implementing Concentric. They have been the wheels of the project.

## **Uniting the team**

### **Mobilising the team**

We held informal discussions before connecting with the cardiology multi-disciplinary team to conduct a demonstration of the technology, following which it was agreed to go forward.

### **Communicating with the team**

As a team, we have a standard daily 30-minute whiteboard catch-up, during which we were able to discuss any concerns. Microsoft Teams was key to team communication and also served as the central repository for document sharing. All meetings were hosted on Teams and recorded to allow staff to check back if needed. The use of Teams also meant full transparency and openness in terms of governance. The pilot was also discussed in our weekly HealthX board meeting.

We also communicated informally with Dafydd from Concentric via WhatsApp and email correspondence. As the project rolls out further, we will move into a formal once-a-week catch up with project lead.

### **Engaging staff**

Very little training was required as the user interface is extremely self-explanatory. Staff were engaged from the beginning and so were fully committed to implementing Concentric.

Moving forward as we roll out more widely, we will need to consider staff digital competency, so this is something we're currently measuring. We have conducted some staff webinars and created a Concentric repository via Microsoft Teams.

## Patient involvement

### Patient demographic

Concentric was used for any patients undergoing elective surgery. The pilot project was conducted in the cardiology department.

### Patient input

We engaged with three patients who'd previously experienced issues around the consent process. One of whom cancelled surgery on the day owing to their lack of understanding and anxiety about the procedure. Another patient had raised a formal complaint owing to issues around consent for obstetric treatment. This gave us a full understanding of the issues that needed to be resolved through the new digital tool.

### Communicating with patients

We spoke to patients directly to explain that we were using a new way of gaining consent, which would standardise and improve the process. In terms of accessibility, we anticipated issues around the elderly, but actually we found the opposite, they embraced the technology. For some people this also meant that the family were included more in the process.

The tool requires a patient to sign their consent using their finger, so for those without touch screen devices, we just had to ensure to obtain their signature when they came into the clinic, but this did not impinge on their ability to review the information in advance.

# Impact and key takeaways

## Outputs: Data

### Project timeframes

The pilot was completed on time. We put in soft deadlines and if they were not met, we held meetings so that we could allocate more resources and review the timelines we were working towards. As we now roll out Concentric more broadly, we're hitting a few hurdles - some of which are out of our control - so we have not yet achieved our goals for this wider implementation.

### Overall results

A reduction in in-person appointments was a key result, in addition to the time freed up to better spend with patients as they can access all background information in advance via the tool.

Patient feedback has also been fantastic and exceeded our expectations. There were no complaints or issues, and those who we felt may struggle were in fact more reassured than they would have been previously as the tool contains so much more information, including links and videos of procedures.

### Data collection

Concentric has an in-built dashboard which helps collect data directly. We are also planning to do a full health economic analysis time and motion study at the one-year-mark to benchmark against our early findings. This will measure direct economic benefits, but there are also a wealth of indirect, intangible benefits that are equally as important to consider.

## Outputs: People

### Patient impact

The tool was used with an average of five patients per week - over a hundred episodes in total to date. We've had episodes of patients choosing lifestyle alternatives to operative management as a result of the informed consent process.

## Staff impact

There has been a positive impact across all staff. Five staff members currently actively use the tool, which means that seven pre-op nurses no longer need to consent patients in the pre-op waiting room. Additionally, anaesthetists and theatre staff have fewer patient cancellations and also no longer have to interpret written forms with hard-to-read handwriting.

## Communications

### Internal communication

Word of mouth has been the main way by which we have communicated this project. We've held formal webinars, conferences and presentations which are also uploaded on YouTube, and we share links about it on Twitter. More informally, we also discuss it with colleagues in coffee room and corridor chats.

### External communication

Our priority focus at the moment is communicating with patients. Patients need to engage with digital structures like this just as much as staff. This project is growing organically as we expand across departments.

## Outcomes

### Key enhancements to patient care

As a result of this project, we've observed that patients are now more reassured about the consent process with a range of materials that they can access ahead of their surgery. It is also now more of a shared journey between patients and surgeons.

There are also benefits to staff in that there have been reduced cancellations due to patient consent issues, and the time with patients is now better spent.

### Savings and efficiencies

Although we don't have formal data yet, there are undoubtedly efficiencies. Out-patient face-to-face contact time has been reduced which is a valuable resource saved pre-operatively. Many patients can now complete the consent process at home meaning they no longer have to come into hospital unnecessarily.

## **Staff engagement and morale**

There has been a positive impact on staff who can now make the best use of the time spent in face-to-face meetings with patients.

Consent being taken before the booking of surgeries also now means that patients only get to theatre if they're happy to go ahead, thus reducing cancellations.

Previously, some procedures would be delayed as a doctor was required to attend the consent meeting with the patient, even if they themselves were not completing a procedure. Introducing digital consent in such cases has reduced these delays.

## **Sustaining**

### **Considerations as project ends**

We're in the process of requesting a procurement exemption which can be lengthy, but given we know costs and that the tool works, we will propose an exemption to overcome the need to go to the open market. However, ahead of committing to Concentric we will need to get tenders from three providers.

### **Embedding process**

We have created a Concentric repository via Microsoft Teams which contains webinars and information which will help support the implementation of this tool elsewhere in our organisation.

We also plan to have policy that had previously been written for the pilot to be formally signed-off ahead of the tool being rolled out across the organisation.

Our long-term vision is for this tool to be the only method of consent, including across primary care. This early engagement will ensure that nothing is booked until it is confirmed that patients are fit for surgery, engaged and consented.

### **Lessons learned**

The key take home is that if you run a small pilot with engaged individuals, you learn so much that you can then jump through the hoops that were previously barriers.

## Final thoughts & acknowledgements

### Considerations for future project implementation

Supplier engagement was key, with the support and resources from Concentric meaning that no initial funding was required.

Having the support of the multidisciplinary team e.g. Governance structures also played an important part in the success of this pilot, as did the use of the Allan Lab as a vehicle to run the project.

### Author's key takeaways

The importance of engagement with the supplier, the support of the wider team and the Allan Lab in our case was a key takeaway on reflection of this pilot.

In addition, running the pilot alongside clinicians, with the original process in place as an alternative to reduce any risks, helped us inform central government procurement on how we can successfully roll the project out across the hospital.

Lowlights were trying to navigate bureaucratic processes, which often felt like a tick-box exercise, but we've found a way to satisfy these requirements.

### Why the author is proud of this project

We're proud of the way we were able to implement this project and run the project so smoothly without any hiccups, receiving brilliant feedback from our patients.

### Author's words of wisdom

If the solution is right, you won't have a problem and everything will fall into place.