



Prifysgol Cymru
Y Drindod Dewi Sant
University of Wales
Trinity Saint David

Changemakers: Creativity and Value Creation

Professions (BMHP5014)

EndoReturn: Improving Post-Laparoscopy Endometriosis Care Through a Clear Return Route

Component 2: Written Assignment (Poster and Pitch)

Student name: Yuliia Silman

Student number: 2431446

Lecturer's name: Laila Surani



EndoReturn

A supported return route after laparoscopic endometriosis care
Proposed local NHS service improvement

1. Introduction

Existing services and records

EndoReturn is a proposed local service innovation that brings together NCEPOD's recommended discharge information, direct re-entry and patient-initiated follow-up within one co-produced, choice-based pathway. It would be piloted where local audit shows that these elements are not yet delivered consistently, with documented communication to the GP (NCEPOD, 2024).

2. Problem Statement

WHY A ROUTE IS NEEDED

After laparoscopic diagnosis or treatment, some patients continue to experience symptoms but may not have a clear route back into specialist care.



52.1%

(124 of 238)

patients had persistent or recurrent symptoms after laparoscopy



25.8%

experienced delay in further investigation or treatment.



38.7%

had to restart the process through GP re-referral.



9.7%

could contact a gynaecology team or endometriosis clinical nurse specialist directly.

A clearer local return route should be tested where this gap is identified (NCEPOD, 2024).

HOW ENDORETURN WORKS

A clear, choice-based route after laparoscopic diagnosis or treatment.



Step 1

DISCHARGE

Laparoscopic diagnosis or treatment completed.



Step 2

PERSONALISED PLAN

Written information on symptoms, medication, when to seek urgent help and who to contact.



Step 3

SHARED CHOICE

Planned review or patient-initiated follow-up (PIFU), selected according to clinical need and patient preference.



Step 4

CONTACT AND TRIAGE

Telephone or optional digital contact. A nurse or clinician reviews the request.



Step 5

APPROPRIATE NEXT STEP

Advice, review appointment or onward referral. The GP receives an update.

3. Target Audience and Impact

Adult patients discharged from one local NHS gynaecology or endometriosis service after laparoscopic diagnosis or treatment, especially those with persistent or recurrent symptoms or uncertainty about next steps. **EndoReturn** aims to make access to follow-up support more equitable. Patients receive understandable information, an accessible contact route and a response based on clinical need, rather than relying only on their ability to navigate re-referral. This can support earlier triage and review of persistent symptoms, reducing avoidable delays in further care (NCEPOD, 2024). Telephone contact and accessible information formats ensure that access does not depend on smartphone use (NHS England, 2025a).

4. Implementation

EndoReturn will be delivered in one local NHS gynaecology or endometriosis service. A gynaecologist, endometriosis nurse, administrator, GP representative and people with lived experience will co-produce the discharge plan, contact process and staff guidance.

5. Timeline



Month 1

Co-design, local audit and staff briefing.



Months 2–4

12-week pilot with eligible patients.



Month 5

Review results and decide whether to refine, stop or extend the route

6. Regulations

Clinical decisions follow NICE guideline NG73 (NICE, 2024). Relevant information is shared securely with the GP under the Data Protection Act 2018. **EndoReturn** must also meet CQC Regulation 9 on person-centred care (CQC, 2025).

7. Technology Integration

The existing electronic patient record records the **EndoReturn** plan, contact preference and triage outcome. This helps the service and GP work from the same up-to-date information, reducing repeated explanations and avoidable delays.

8. Dissemination

The 12-week pilot will use quantitative measures and short patient and staff feedback to assess plan completion, time from contact to triage, re-entry contacts, patient confidence and staff workload (Sherlaw-Johnson et al, 2024). Findings will be shared through a short report to the Trust quality board, local ICB, a GP update, staff briefings for the endometriosis service and feedback sessions with people with lived experience.

Conclusion

EndoReturn turns discharge into a safer point of connection, not the end of support.

Pitch

Introduction

Endometriosis is a chronic condition, and symptoms may persist after laparoscopy, even when the procedure is used for diagnosis or treatment. The NCEPOD national review identified that some patients faced delays when trying to access further care and did not have a direct way to contact a specialist team (NCEPOD, 2024). EndoReturn is a proposed local NHS service improvement for adult patients discharged from one gynaecology or endometriosis service. It is not designed as a new app, treatment, or routine follow-up for every patient. Instead, it gives patients a clear discharge plan, an accessible contact route back into the service, and review by a nurse or clinician. Based on clinical need, patients can then agree either a planned review or patient-initiated follow-up (PIFU). The purpose is to make post-discharge support more accessible, safer and more equitable.

Background

Endometriosis care does not necessarily end when surgery is completed. Although laparoscopy can confirm the diagnosis and may remove or treat endometriosis, pain and other symptoms may persist or return over time. After discharge, a patient may still need advice, medication review or another specialist appointment. NCEPOD highlights a broader issue: endometriosis is often managed as separate episodes of care, rather than as an ongoing long-term condition. This can make discharge unclear for both patients and the services involved in their support (NCEPOD, 2024).

The evidence shows why this is important. In the NCEPOD review, 124 out of 238 patients (52.1%) reported persistent or recurrent symptoms after laparoscopy. Among these patients, 32 (25.8%) experienced a delay in further investigation or treatment. Forty-eight patients (38.7%) had to restart the process through a new GP referral, while only 12 (9.7%) were able to contact a gynaecology team or endometriosis clinical nurse specialist directly. These findings do not suggest that all NHS services provide limited follow-up. Many hospitals reported using PIFU. However, local systems are not consistent, and patients may not always know how to return to the right service when they need further support (NCEPOD, 2024).

EndoReturn responds to this practical gap. It is not routine follow-up for every patient. It provides a clear discharge plan and a safe contact route back into the service if symptoms or concerns return.

Innovation Description

EndoReturn is a practical approach to improving the clarity of discharge after laparoscopy. Before discharge, eligible patients would receive an EndoReturn plan. This would summarise the diagnosis or treatment provided, list current medication, explain which symptoms require urgent help, and outline how to contact the service if symptoms return. The plan would be recorded in the existing electronic patient record and shared with the GP.

The patient and clinician would then agree whether a planned review or patient-initiated follow-up (PIFU) is more appropriate. PIFU allows patients to request follow-up when they require further support. It can be beneficial, but it is not appropriate for all patients. NHS England explains that PIFU requires clinical oversight, clear patient information, safety-netting and local tracking. It can also be combined with planned review (NHS England, 2025b). For this reason, EndoReturn provides a choice rather than one standard route.

EndoReturn does not assume that every patient requires a routine appointment. However, it also does not expect patients to manage a PIFU pathway without support. The service provides a clear plan and a direct route for contact. When a patient contacts the service, a nurse or clinician reviews the request and decides whether advice, an appointment or onward referral is needed. The improvement is that existing staff and systems are used to make the route back to care clearer, more accessible and safer.

Impact on Health and Social Care

EndoReturn would not remove all symptoms or replace clinical treatment. Its purpose is to reduce uncertainty for patients when symptoms or concerns return after discharge. Before leaving the service, patients would understand which symptoms require urgent help, what support is available and how to contact the appropriate service. This may reduce the need for patients to restart the process through a GP referral when specialist advice is still required.

The route would also offer patients a choice in how they contact the service. Telephone support would be available for patients who do not wish to use digital systems, alongside a digital option for those who prefer it. Information would be provided in a clear and accessible format that patients can understand and use. This reflects the NHS Accessible Information Standard, which requires services to identify, record and meet people's communication needs (NHS England, 2025a).

For the service, EndoReturn creates a clear process: the patient contacts the team, a nurse or clinician reviews the request, and the patient receives advice, an appointment or referral if needed. This may help staff direct appointments to those who need them most, but it is not realistic to promise lower workload or shorter waiting times before the pilot is tested. Research in UK gynaecology found that patients and clinicians were positive about PIFU, but they also stated that it requires clear information, safety arrangements and careful selection of patients (Chainrai et al., 2024).

Overall, EndoReturn supports the common good by giving patients a fairer and more understandable route back to care.

Public and Stakeholder Involvement

EndoReturn should be co-produced with service users, rather than designed by professionals alone. People with lived experience of endometriosis should be involved from the beginning. During the first month, they would review the draft discharge plan and contact route. They could identify which parts are easy to understand, which parts are unclear, and what barriers might prevent someone from using the pathway. Their feedback could be collected through a discussion, telephone call or written response.

A gynaecologist would confirm the clinical criteria. The endometriosis nurse would assess and triage patient requests. An administrator would manage contacts and keep records updated. A GP representative would review whether the information shared with primary care is practical and useful. This is important because patients need consistent information from both the hospital team and their GP.

During the 12-week pilot, feedback would be gathered from patients and staff about how the route worked in practice. This feedback would guide any changes before a decision is made about continuing EndoReturn.

Implementation, Feasibility and Evaluation

EndoReturn would be piloted in one local NHS gynaecology or endometriosis service. During the first month, the team would examine the current discharge process after laparoscopy. They would agree which patients are eligible, who will review new requests, what information patients should receive, and what response time is expected. The plan would be stored in the existing electronic patient record, so a separate app would not be required. The service would then test the route with eligible patients over 12 weeks.

The proposal is feasible because it builds on existing staff roles and systems. However, it still requires protected time and clear accountability. A nurse or clinician would need to review requests and decide what type of support is appropriate. Administrative staff would need to record contacts correctly and share information with the right people. Patients would also need clear advice about when to seek urgent help. PIFU will not be appropriate for every patient: some will require a planned review, while others may not feel confident managing follow-up independently. NHS England states that PIFU requires local clinical selection, clear information, safety-netting and reliable tracking (NHS England, 2025b).

The pilot would assess both data and user experience. It would record how many patients receive an EndoReturn plan, how quickly requests are reviewed, and what action is taken afterwards. Brief feedback from patients and staff would show whether the route is understandable, usable and manageable for the service. The quality board could then decide whether to refine, stop or extend EndoReturn. The pilot would not prove long-term outcomes, but it would show whether the route is safe and workable in the local service.

Policies, Professional Links and Information Sharing

EndoReturn would operate within the current NHS endometriosis service. Any further treatment or onward referral would follow NICE guideline NG73 (NICE, 2024). It also supports the Renewed Women's Health Strategy for England (DHSC, 2026).

The choice between PIFU and planned review would be made jointly by patients and clinicians. NICE advises that patients should be involved in decisions and receive information in a format they can understand (NICE, 2021). PIFU should not replace planned follow-ups for all patients (NHS England, 2025b).

Requests would be reviewed by the gynaecology team. The GP would receive the discharge plan and any later update, helping both services work from the same information.

The plan, contact preference and triage outcome would be recorded in the electronic patient record and shared with the GP in line with the Data Protection Act 2018. Regulation 9 requires care to reflect individual needs and preferences (CQC, 2025). Pilot findings would be shared with the Trust, local ICB, GPs and the people involved in co-producing the route.

Conclusion

EndoReturn is not proposed as a new national programme, but as a local service improvement. Its aim is to make care after laparoscopy easier to understand, so patients know how to seek support if symptoms return. The pilot will not be able to prove reduced delays or lower workload, but it can show whether the route is safe and practical in the local service. Evidence on PIFU shows that implementation and outcomes differ between services (Sherlaw-Johnson et al., 2024). If the pilot is positive, the route can be refined before wider use.

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