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Ymchwiliad i wasanaethau Endosgopi
Inquiry into Endoscopy Services
Ymateb gan Gymdeithas Gastroenteroleg ac Endosgopi Cymru
Response from Welsh Association for Gastroenterology and Endoscopy

Submission to the Health, Social care and Sport committee – Inquiry into Endoscopy services – 29th November 2018

On behalf of the Welsh Association for Gastroenterology and Endoscopy (WAGE)

Dear Dr. Lloyd,

Thank you for asking us to provide evidence for the inquiry into Endoscopy services. This submission is a collated response from the President, secretary, Treasurer and Ex-president of WAGE focused on four of the five terms of reference provided to us.

Earlier diagnosis, specifically the introduction of the Faecal Immunochemical Test (FIT) into the bowel screening programme and the recently announced change to age range

We welcome the introduction of the FIT test into the bowel screening programme as part of a strong evidence based change that has the potential to improve the uptake of screening as well as an improved detection rate for bowel cancer and advanced pre-cancerous polyps in the bowel. The planned threshold for introduction of the FIT test of 150 (micrograms/gram of stool – units same throughout) is set to balance the drive for improving our outcomes from bowel cancer (through earlier diagnosis and more people diagnosed) with the constraints of Endoscopy capacity.

As a multi-professional organisation, WAGE members include gastroenterologists, gastrointestinal surgeons, endoscopy nurses and nurse endoscopists many of whom are directly or indirectly involved with the bowel screening programme. We feel that there are several constraints to implementation of FIT within the screening programme that need resolution rapidly in order for it to be successful at achieving its aims of improving earlier diagnosis of and outcomes from bowel cancer.

There are currently 17 screening colonoscopists in Wales. Retirements and ill health have resulted in a slight reduction in these numbers from those at inception of the programme a decade ago and consequently greater strain on colleagues taking on the additional responsibilities resulting from these. The projected number of colonoscopies that will be required by the proposed plan for gradual reduction in the FIT threshold for screening from 150 to 80 by 2023 along with age expansion will require the workforce of colonoscopists and Specialist screening practitioners (SSPs) to increase procedure numbers dramatically to over four times the current numbers undertaken by most health boards. This urgently requires a strategy of intensive training for potential screening colonoscopists given the time it usually takes to achieve the standard required for screening accreditation. In the context of overall workforce pressures, we feel that this requires consideration of a) training more nurse and consultant colonoscopists; b) training intensively through a centrally supported “Endoscopy academy” programme rather than a fragmented approach left to individual health boards; c) integrating this training and upskilling initiative with the wider endoscopy service so as not to continue the perception of screening being perceived as a “separate” target to wider service activity; d) integrating planning initiatives with workforce constraints in pathology and radiology in view of the significantly more specimens of polyps and cancers that will be generated and staging radiology required.

Diagnostic service capacity and waiting times, including the extent to which capacity constraints are driving the recommendation to set the FIT threshold for its introduction to the bowel screening programme at a relatively insensitive level.

Endoscopy services in Wales have been facing a severe shortfall in capacity in relation to the existing demand, significant backlog of new and surveillance procedures and an approximate 8-10% annual increase in demand for endoscopy (primarily colonoscopy).

Many health boards have contracted external private providers to provide “insourcing” or “outsourcing” services in endoscopy where patients are either having procedures undertaken by private providers at weekends within the health board sites or sent to private providers at sites outside of the health board. There has been a short term reactive response to the challenges rather than a considered, strategic longer term sustainable one. As a consequence of this there are significant issues with endoscopy capacity in each health board with regard to infrastructure (state of endoscopy rooms, numbers of rooms per 100,000 population as compared to elsewhere in the UK); workforce (numbers of endoscopists particularly nurse endoscopists or colonoscopists currently or potentially available to undertake screening) and capacity planning (often with poor engagement between senior health board colleagues and the clinical workforce who deliver screening).

The current projections for annual increase in demand from screening and consequent requirements for room, operator and nurse capacity will need to be met in order to fulfil this in a timely and sustainable manner. This includes –

i) provision of further endoscopy room capacity within each health board (currently each HB has 6 rooms between all endoscopy units for its population which is inadequate when benchmarked against units in England and Scotland as well as internationally) and
ii) appointment of additional endoscopists by 2021 as well as immediate consideration of job planning issues and commitment to endoscopy
iii) ongoing and further training of nurse endoscopists to meet the capacity gap and enable the phased roll out of a reducing threshold for FIT and age expansion by 2023.
iv) Provision of adequate support from pathology and radiology

Consideration of other early diagnosis interventions and innovation, such as the introduction of FIT testing by general practitioners in symptomatic patients to reduce referral for diagnostic tests.

The introduction of FIT testing as part of a primary care-secondary care diagnostic pathway in symptomatic patients has evidence to support its use and NICE DG30 guidelines recently support its use in “low risk patients”. The introduction of this test is however predicated on there being i) significant endoscopy capacity to perform a diagnostic colonoscopy in those testing positive; ii) there being accurate and real-time data to measure and evaluate its impact on direct to test colonoscopy, clinic referrals, GP referral patterns and cost effectiveness of introducing this. Currently none of these requirements are met in most health boards in Wales.

WAGE along with the Wales Cancer network have engaged with Health Technology Wales (to review and update existing evidence) and with 3 health boards on this issue where plans for implementation of FIT in primary care for symptomatic patients are being considered (Cardiff and Vale, Cwm Taf and Aneurin Bevan HB). Cardiff and Vale and Cwm Taf HB are considering a joint systematic pilot with evaluation of data to inform the development of a national framework for Wales in the context of endoscopy capacity. Aneurin Bevan HB has plans to roll out this test though it is unclear if this is through a systematic data driven and evaluated plan. We plan to engage all HBs in a WAGE and Wales Cancer network led national framework for implementation informed by the pilot. This will inform us on how the service in both primary and secondary care may need to change and adapt to the change in referral patterns likely to result from the introduction of FIT into the symptomatic service and integrate with other all Wales initiatives such as the “Single Cancer Pathway”.

There have been detailed discussions with colleagues in Scotland (NHS Tayside) where the FIT pilot has been implemented as well as through external peer review involvement in the pilots in various areas in the English NHS and liaison with the FIT pioneers group in England. This has led to a clear understanding that unless we work in parallel to improve our colonoscopy capacity and data collection, collation and evaluation the introduction of FIT into the symptomatic service may actually be counterproductive to the endoscopy service as well as lead to increase in patient anxiety rather than being of benefit.

The long term and sustainable solutions to the challenges that exist within endoscopy services in Wales, including how data on diagnostic staffing pressures is being used to inform decisions about current and future workforce planning.

The significant constraints within endoscopy services in Wales are currently still being looked at in a fragmented manner with different approaches and varying levels of engagement between stakeholders within each health board. We feel that given the common themes involving infrastructure, workforce, planning and capacity and the population demographic this may benefit from a centralised approach with delivery and operational elements closely monitored for each health board.

Given the annual increase in demand for symptomatic endoscopy (8-10% approx.), the increase in demand from introduction and phased reduction in threshold and age expansion of FIT in the screening programme and lack of implementation of previous evidence based NICE guidelines relating to endoscopy within Wales (e.g. RFA for dysplasia in Barrett's oesophagus) a common supportive framework with collaboration between health boards to maximise the use of resources would be more effective and cost effective than the current strategy.

We feel that the solutions may need to involve – a) Establishment of an "Endoscopy academy" analogous to the "Radiology academy" recently agreed and implemented by Welsh Government. This would enable intensive and rapid training of the workforce to address workforce capacity constraints in a sustainable manner as well as attract colleagues to work within Wales.; b) Ensuring that each health board has a nominated senior exec lead responsible for the team and for planning and implementation of solutions as described above; c) Applying an all Wales centrally supported approach to planning and implementation of wider endoscopy services with WAGE as an integral part of the new approach (liaising with the Wales Cancer Network, Health Education and Innovation Wales, Public Health Wales and the NHS collaborative).

We hope that the committee finds this a helpful contribution to its inquiry into Endoscopy services in Wales with regard to the terms of reference. We are happy to provide further input and assistance to the committee as required and requested from us.

With best wishes

Dr. Sunil Dolwani
(President- Welsh Association for Gastroenterology and Endoscopy) on behalf of

Dr. D Durai (Secretary), Miss J Hilton (Treasurer) and Prof J Torkington (Ex-President) - WAGE