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

On behalf of Cardiff and Vale University Health Board [redacted]

Dear Dr. Lloyd,

Thank you for asking us to provide written and oral evidence for the inquiry into Endoscopy services. This submission is a collated response focused on the 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 we understand has the potential to improve the uptake of screening (as a result of the new test requiring one instead of three consecutive samples) 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.

Cardiff and Vale UHB function at 2 separate though integrated levels of service for the bowel screening program. A) the same as every other health board for delivery of screening colonoscopy and associated functions (SSP assessment, surveillance and liaison with the colorectal cancer teams) and B) as the National Referral centre providing a service for management of complex polyps detected as a result of screening colonoscopy.

a) Currently Cardiff and Vale UHB have 3 bowel screening colonoscopists (the 3 authors of this document) and 2 Specialist screening practitioners (SSPs) along with an admin colleague as the core team delivering screening (along with colleagues in pathology and radiology). The retirement of another colleague who had stopped undertaking screening colonoscopy a few years prior to retirement added to pressures on us to absorb his screening service commitments without any immediate replacement. This situation has been ongoing for over 5 years with 2 of the 3 existing screening colonoscopists doing their best to deliver additional lists to cover the shortfall in delivery in addition to wider endoscopy service commitments. We appointed a consultant colleague earlier this year with the appropriate skillset to get trained and accredited for screening in order to assist with the delivery of existing demand from bowel screening as well as to plan for associated management of complex polyps (detailed below). However due to unanticipated reasons the colleague has had to phase in to work much more slowly than anticipated and therefore the timeline for their achieving screening accreditation is likely to be by the end of 2019 with other interim solutions having to be implemented in

the meantime. We also have a shortfall of an SSP and additional admin hours associated with the service which despite planning, consultation and agreement a year ago has still not been sent out to advertisement to recruit to a very stretched SSP workforce. The introduction of the FIT test at the current planned level will stretch these capacity constraints further.

b) The National Referral Centre (NRC) for management of complex polyps detected at screening colonoscopy at Cardiff and Vale UHB has been an enormous success in terms of reducing variation in care, avoiding harm from unnecessary surgery and providing an internationally benchmarked effective and cost effective care pathway to all participants in Bowel Screening Wales with complex polyps. The establishment of the Network MDT for complex polyps with colleagues across Wales and evidence based collaborative discussion and treatment planning with colleagues across all health boards has been cited as an exemplar service in many national and international forums. The introduction of the more sensitive FIT test will result in almost doubling the numbers of complex polyps detected through screening and requires expansion of the specialist capacity for this service. Currently the specialised nature of the skills required for this service has meant that there is a significant operator capacity constraint. The appointment of the additional colleague mentioned above was planned to assist and mitigate this to a significant extent. The additional SSP and admin hours mentioned above would only partly mitigate the significantly increased demand on the service.

The age extension of bowel screening down to age 50 as well as the planned introduction of lowered phased in FIT thresholds from an initial cut-off value of 150 down to a level of 80 by 2023 puts a significant pressure on our service. We currently deliver on average 2.5 standard screening lists per week and 1 NRC complex list per week (3.5 in total per week). If the projected modelling figures provided by BSW are translated into our requirement for list and operator capacity then by 2023 we will need to deliver approx. 5.5 standard screening lists/week and 2 NRC lists/week (more than double our current delivery within the next 5 years). In addition to this we will require a fourth SSP appointment (if the current third post is advertised in the near future) and further associated administrative support. We currently have a significant constraint with endoscopy room capacity and urgently require at least a further 2 rooms as soon as possible to deliver the planned requirement for both screening and the wider symptomatic endoscopy service in the next 5 years. We have also trained 2 Nurse endoscopists within our health board over the past 2 years and they are both recently accredited to be independent colonoscopists. We hope to train them further in additional skills and decision making in order for them to hopefully be in a position to become accredited screening colonoscopists in the next 2 years. This is however contingent on a number of factors including the nature, time and effort into training supported by the UHB and needs senior exec level support for it to be implemented successfully. This senior support is currently lacking.

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.

The wider diagnostic endoscopy service in Cardiff and Vale UHB similar to most other health boards in Wales has 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).

For approximately the last 7 months the UHB has contracted with external private providers to provide “insourcing” services in endoscopy within Cardiff and Vale on all weekends to deliver on average 50-60 endoscopy procedures on a Saturday and a similar number on Sundays. There was an initial “outsourcing” contract as well where patients were sent to private providers at sites outside of the health board with several consequent patient safety and quality incidents related to poor quality of procedures, lack of clarity on management and repeat procedures required. “Outsourcing” is therefore no longer undertaken within Cardiff and Vale UHB though “insourcing” continues. The current position is a waiting time of upto 16 days for patients categorised as USC (Urgent Suspected Cancer – 2 week wait target); upto 10 weeks for routine Diagnostic procedures; upto 12 weeks for capsule endoscopy and a Referral to treat (RTT) time of 32-36 weeks. However, there are 952 significantly overdue surveillance procedures (mainly colonoscopy) where patients considered as high risk and requiring ongoing surveillance endoscopic procedures that are more than 8 weeks overdue their planned surveillance. Despite this group being known to have a higher yield of cancer than most other groups and due to the focus on targets being mainly associated with new rather than follow up or surveillance this high risk group has been neglected and we have had several incidents of cancers arising in patients on this surveillance waiting list (potentially avoidable had they been scheduled for their procedure as planned and due to capacity constraints).

Endoscopy capacity has been a significant issue in the UHB in terms of operators as well as endoscopy nurses, associated admin staff and currently room capacity. There are several streams of ongoing work that are seeking to maximise efficiency, productivity and list utilisation and the capacity constraints remain significant despite our best efforts at efficient and productive use of our resource. We have more nurse endoscopists than any other health board in Wales and 3 of these colleagues deliver Upper GI endoscopy, 2 deliver Flexible sigmoidoscopy and more recently Colonoscopy and 1 delivers capsule endoscopy reading. These nurse endoscopists however also have other clinical commitments as part of their job plan (e.g. Inflammatory bowel disease nurse, Dyspepsia nurse, Coeliac specialist nurse etc.).

There has been a focus on meeting RTT targets and concentrating on “breaches” as can be seen from the above but very little engagement from senior colleagues within the UHB on strategic planning and building a sustainable service instead of the short term “insourcing” and “outsourcing” approaches outlined above. The current projections for annual increase in demand 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 provision of at least 2 further endoscopy rooms and appointment of another consultant endoscopist by 2021 as well as ongoing and further training of nurse endoscopists to meet the capacity gap. This can only be

achieved through a nominated exec lead at board level being able to engage and drive this urgently to improve the current situation.

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 some 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. Within Cardiff and Vale UHB since we implemented an electronic referral system in Gastroenterology and Endoscopy about 2 years ago we do have some data on referral through different streams and outcomes. (Please see the separate response to the inquiry from the Welsh Association for Gastroenterology and Endoscopy – WAGE for details and context). Currently Dr. Dolwani and colleagues in the UHB are liaising with colleagues within Cwm Taf LHB and the Wales Cancer Network to outline what the baseline data collection and pathway measures needs to be in order to pilot the introduction of FIT in the symptomatic diagnostic pathway for earlier diagnosis of bowel cancer in the near future. 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. We hope that through engagement with the wider group involved in an all Wales initiative (led through WAGE and the Wales Cancer Network), Cardiff University, Health Technology Wales and local interest and initiative in health services research on this topic we are able to pilot a considered, systematic and evidence based roll out of FIT testing for symptomatic patients in 2019. The pilot from Cardiff and Vale and Cwm Taf will also enable other health boards in Wales to structure and implement their own services to integrate this into the symptomatic diagnostic pathway.

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.

Currently within Cardiff and Vale UHB there is a good understanding within the directorate of Gastroenterology, Hepatology and Endoscopy of the workforce and infrastructure requirements necessary to deliver the plans for roll out of FIT in the

bowel screening programme, the annual increase in demand on the wider symptomatic service, the current backlogs, surveillance waits and proposed roll out of FIT that may be informed by the planned pilot in primary care. This understanding is however not currently optimally understood or supported at a wider senior level in the Health Board outside of the directorate. Consequently, plans for improvement in endoscopy services have focused on meeting the immediate targets rather than building sustainability and resilience in the service. The last step change in Endoscopy within the UHB occurred in 2008-2009 when the then Director of Planning personally took charge of leading a project to improve Endoscopy infrastructure and staffing resulting in us nearly meeting the criteria for JAG accreditation in 2011 (unfortunately we were unable to do so solely because of the timelines domain and our waiting times despite meeting all other criteria). We urgently require a similar senior level engagement with UHB colleagues in Planning and Finance to have any hope of implementing the required changes in the timeframe necessary. Data on diagnostic staffing is currently not optimally integrated with service planning as outlined above.

Efforts being taken to increase uptake of the bowel screening programme.

Currently all service activity within Endoscopy in Cardiff and Vale UHB (and in all other health boards in Wales) is geared towards service delivery of screening assessments by SSPs and colonoscopy as outlined above. There is no provision for uptake improvement activity within the constraints of financial LTA and workforce issues. We would however be keen to address local engagement and improvement of screening uptake with initiatives underpinned with resource and support from Public Health Wales, Bowel Screening Wales and Cardiff University partners. The introduction of FIT into the screening service will also hopefully improve our uptake for screening within the UHB as it is currently among the lowest in Wales (though in line with other UK large city conurbations in comparison to other smaller towns and rural areas).

We hope that the above briefly outlines the current situation in Cardiff and Vale UHB with regard to the terms of reference of the committee inquiry into Endoscopy services. We are happy to provide further input and assistance to the committee as required and requested from us.

With best wishes

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(As a collated response on behalf of [redacted] from Cardiff and Vale University Health Board