# HEALTH, SOCIAL CARE AND SPORT COMMITTEE: INQUIRY INTO ENDOSCOPY SERVICES

**This paper responds to the points on which the Committee is seeking views**

The Welsh Government is aware of the pressures facing endoscopy services in Wales. The number of diagnostic endoscopy procedures required is increasing due to population changes, a lower threshold for suspected cancer investigation and the need to expand the bowel screening programme. The British Society of Gastroenterology expects further annual increases in endoscopy referrals of 5-10% over the next three years. Use of endoscopy is an important investigative procedure used for urgent patient care and also as part of planned care appointments. Diagnostic endoscopy is subject to the national eight week diagnostic target. Health boards have been working hard to improve and the number of people waiting over eight weeks for diagnostic endoscopy has reduced from 4,210 in March 2012 to 1,633 in August 2018 – a reduction of 2,577 (61%). The total number of people on the waiting list for the five specified endoscopic diagnostic procedures has reduced from 12,809 in March 2012 to 10,366 in August 2018 – a reduction of 2,443 (19%) despite increased demand.

The Welsh Government also expects health board endoscopy units to achieve accreditation by the Joint Advisory Group of the British Society of Gastroenterology. A national implementation group was established in 2014 to support health boards to work towards this. Six units are now accredited and others are close to achieving accreditation. However, the pressures on waiting times, the enhanced criteria introduced in 2016, and in some units the environmental constraints, have prevented further progress. The Welsh Government is mindful that pressures at the endoscopy stage of the cancer pathway are one of the most significant factors in potential breaches of the cancer waiting time targets. It is thought that these in-system delays may play a part in relative international cancer outcomes. In addition, it is not possible to fully optimise the bowel screening programme without ensuring sufficient endoscopy capacity is available to investigate positive histopathology results in a timely manner.

The NHS in Wales is not alone in this challenge; similar pressures are felt across the UK. Demand is increasing faster than additional capacity can be created and it is sometimes a challenge to attract an already limited pool of clinicians to existing posts that become vacant. It has become clear that diagnostic endoscopy demand has become out of balance with core capacity. In seeking to balance their focus across the breadth of their services, most health boards have been unable to redress this balance and develop more sustainable endoscopy services. It is clear longer-term planning and sustainable models of service delivery are needed. A Healthier Wales announced a greater leadership role for the Welsh Government in NHS service transformation and as a result a nationally directed approach has been agreed for diagnostic endoscopy.

The NHS Executive Board has considered how to address this issue, drawing on the expert advice of the Endoscopy Implementation Group (EIG) and Public Health Wales (PHW). The Deputy Chief Executive of NHS Wales and the Deputy Chief Medical Officer are jointly chairing the new nationally directed approach. In order to

support this national endoscopy programme, the NHS Collaborative has been directed to establish programme support arrangements. This will be supported with a workshop in December of health boards and stakeholders, in order to create an agreed baseline position for service planning and to support incremental increases in capacity for the years ahead. In parallel, the Welsh Government has instructed the NHS to optimise the bowel screening programme by April 2023. PHW is making recommendations on a phased optimisation of the programme to the Wales Screening Committee (WSC) in November and to the NHS Wales Executive Board in December.

**SPECIFIC ISSUES**

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

2. **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 bowel screening programme began in 2008 by inviting men and women aged 60 to 69 years to send a stool sample for guaiac faecal occult blood (gFOBt) testing every two years. In November 2012, the programme was expanded to include people aged 60 to 74. The rationale is that the majority of bowel cancers affect those over the age of 60. Further expansion of the programme to include people 50 to 59 has been considered by the WSC on a number of occasions and the Endoscopy Implementation Group. The Welsh Government's approach has been to focus on achieving the target uptake of 60% among the higher risk population before expanding the age range further. However, uptake has consistently remained below 60% and in 2016-17 was 53.4%.

In November 2015, the UK National Screening Committee (UKNSC) recommended introducing the Faecal Immunochemical Test (FIT) into the programme. This new test is more accurate and easier to use. One of the particular benefits of the test is the ability to adjust the sensitivity in line with the available colonoscopy capacity. The UKNSC did not specify a recommended sensitivity level for FIT but recommended as colonoscopy capacity grew or screening uptake increased that programmes should adjust the sensitivity level to increase the number of cancers detected.

In anticipation of the UKNSC recommendation on FIT, the WSC commissioned an outline business case from PHW. This was endorsed by the WSC on 27 January 2016 subject to a robust and detailed implementation plan being developed, including further analysis on the sensitivity of the test to be adopted. The EIG concurred with the need for the screening service to prioritise the introduction of FIT in Wales. PHW held a stakeholder event with health boards on the 17 June 2016 to consider the implications and stakeholders supported the introduction of FIT at the most sensitive level possible. The introduction of FIT at a sensitivity of 150ug/g was recommended as a practical starting point based on existing NHS capacity. On 2

November 2016 the Cabinet Secretary for Health, Well-being and Sport and the Minister for Social Services and Public Health agreed to:

- introduce FIT to the bowel screening programme in Wales, with services working towards roll-out beginning in 2018/19; and
- a test sensitivity level of 150(ug/g) for planning purposes, noting the associated resource implications for NHS Wales.

The agreed introductory threshold will result in an increased demand for colonoscopy as the participation rate is expected to increase and the test is slightly more sensitive. Modelling provided at the time suggests that implementation at this threshold will result in an additional 350 screening colonoscopies per year across Wales. This will be challenging given the existing pressure on services but is expected to improve the number of cancers detected by 90, which is a 43% increase. Learning from international experience has demonstrated the importance of a phased approach to test modelled assumptions and avoid destabilising services.

In August 2018, the UKNSC reviewed the optimisation of bowel screening and recommended that FIT is offered to people aged 50 to 74 at as low a threshold as possible, although this will need to be kept under review. PHW is currently modelling a phased approach to optimising the programme, which will include an increase in the sensitivity of FIT and expansion of the age range by April 2023.

**3. 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 workforce capacity available to provide diagnostic endoscopy is a complicated issue because gastroenterology consultants provide a range of different services for health boards, including participation in the general medical rota and 24/7 GI bleeding cover, therapeutic and diagnostic endoscopy, as well as outpatients and multi-disciplinary team meetings. Often procedures are undertaken by other specialists e.g. surgeons, making overall management of the service more complex. There are also a range of endoscopic procedures, each with different time allocations; as well as issues filling available vacancies due to a UK-wide shortage of available trained clinicians. Increasingly, the role of non-medical endoscopists is an important aspect of service provision but the scope of practice is more limited and requires ongoing mentoring and support from consultants. Workforce solutions that unlock capacity for diagnostic endoscopy are likely to be local solutions, depending on the interaction of these different factors. There is also potential for additional capacity to be held at regional level to better cope with fluctuations in demand locally.

Health boards are responsible for planning their workforce and Health Education and Improvement Wales will increasingly support local providers with workforce intelligence and workforce planning. The numbers of full time equivalent gastroenterology consultants has increased from 66.6 in 2009 to 96.7 in 2017. As a result of the nationally directed approach, the Assistant Directors of Workforce are represented in the preparations for the national workshop in December and

workforce intelligence is one of the key work streams underway. It will be important to balance and develop the non-medical roles, as an area of support and practice. The Welsh Government has also considered the reports produced by Cancer Research UK (CRUK) and Bowel Cancer Research UK early this year and held a meeting with the charities to discuss the diagnostic workforce issues relating to cancer.

**4. 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.**

We are aware of studies which suggest that FIT can be used to triage urgent suspected cancer referrals related to suspected lower GI cancers. A number of health boards are considering piloting this approach. It is important the potential for FIT as a triage test is carefully tested, particularly around the safety-netting of referrals that do not proceed to endoscopy. There are also important considerations in terms of the increased histopathology demand and commonality of the standard of testing, as well as the need for close working with primary care. The Welsh Government will monitor health board progress with piloting these approaches and assist with the adoption of learning and common approaches across Wales. Health Technology Wales has also received a topic request from the Wales Association of Gastroenterology and Endoscopy to review the evidence for the use of FIT in the symptomatic population in line with guidance from the National Institute for Health and Care Excellence (NICE) to guide referral for suspected colorectal cancer in people without rectal bleeding who have unexplained symptoms but do not meet the criteria for a suspected cancer pathway referral.

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

The standard for uptake for the bowel screening programme has been set at a UK level of 60% of invited participants returning a used test within six months of invitation. The standard has not been reached since the programme began in 2008. Uptake of bowel screening is below standard across the UK and this is largely attributed to the nature of the test. The latest figures for the period April 2016 to March 2017 are an uptake of 53.4% at an all-Wales level for all of the invited participants. Uptake is higher in females (54.7%) compared to males (52.0%). There is also a strong correlation with deprivation - with uptake in the most deprived areas being 43.6% compared to least deprived areas at 60.6%.

It must also be acknowledged that screening is voluntary and many people actively choose not to participate. Population screening is not without risks and participants need to be fully informed in order to make an informed choice as to whether it is right for them. PHW has focused on improving uptake and promoting informed choice. Since 2015, pre-invitation letters have been sent to targeted participants to improve uptake and reduce inequalities in the programme. Since March 2018 information on non-responders has been shared with GPs. BSW has also worked with CRUK to develop a toolkit to increase knowledge of bowel screening among primary care staff. BSW ran the ‘Be Clear on Cancer’ campaign in conjunction with CRUK earlier this year which showed a sustained increase in completed test kits returned. The implementation of FIT is expected to increase uptake as has been the experience

from pilots in England and the roll out in Scotland. The new test is easier to use with only one sample needed rather than three samples over a 10-day period.