Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
National Assembly for Wales
Health, Social Care and Sport Committee

Ymchwiliad i wasanaethau Endosgopi

Inquiry into Endoscopy Services

Tachwedd 2018 / November 2018

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Introduction

Hywel Dda University Health Board have been considering the impact of projected demand and capacity implications of the First Line Faecal Immunochemical Testing (FIT) within the bowel screening programme in order to assess the impact from:

- Increased uptake of the test due to changes in the administration of the test
- Changes to the sensitivity of the test and what level an individual would be invited for a diagnostic procedure
- The lowering of the age to which an individual is sent a test

As part of this we have reviewed the current capacity across the Health Board, currently we are meeting the requirement to offer a procedure date within 2 weeks of undertaking the Screening Practitioner (SP) assessment appointment.

Next steps

We are now working to identify the Demand and Capacity required to deliver the service based on the increased uptake of 6.4% due to the implementation of FIT. It is expected that Hywel Dda's activity will increase by 115 patients during 19/20 and a further 236 during 20/21. During 19/20 we will be able to manage the increase by establishing an additional BSW weekly list at PPH, during this time we will be reviewing our workforce and capacity to deliver the increases required from 20/21 onwards.

To undertake this review a local project team is being developed who will work together to implement and manage any changes in practice, we hope to work with our Primary Care colleagues to support early diagnosis through FIT testing by general practitioners.

The group will include:

- Clinical champions
- Service manager for Endoscopy
- SNM for Endoscopy

- Specialist Screening Practitioner Lead
- Programme Manager for Bowel Screening Wales
- Management sponsor
- Laboratory manager and consultant clinical scientist
- GP cluster leads
- Gastroenterology team
- Information technology department lead
- Clinical audit facilitator
- Finance business partner

Future Plans

In addition to the above the Health Board is also pursuing a Business Case for the development of new endoscopy facilities for Prince Phillip Hospital (PPH), this will allow us to create additional capacity, for BSW increased uptake and the growing demand for diagnostic testing.

Further capacity considered would be the expansion of the bi-weekly list at Bronglais General Hospital (BGH) to a weekly list, Withybush General Hospital (WGH) also has the capacity to increase the number of lists delivered for BSW.

Currently we have 2 Nurse Endoscopists in training for the Health Board who are due to qualify in December 2018, these posts have been progressed as a contingency to managing the increased demand for routine endoscopy, to allow for Clinician capacity for the more complex Endoscopy, including BSW screening.

The IMTP being developed within Scheduled Care includes an aspiration to increase staffing numbers within the Endoscopy service to ensure all units are working at full capacity, this could include 3 session days and / or 6 day working.

The Health Board is fully engaged in the National Programme for Endoscopy and continues to work on a regional basis with ABMU, across both the BSW programme and diagnostic endoscopy.

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National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Endoscopy Services

Evidence from an individual

Introduction:

I am submitting this account as evidence to the Health, Social Care and Sport Committee as part of the consultation on endoscopy purposes.

Background:

I am a bowel cancer patient (Stage 3). I am currently in remission (2 years). Approximately 50% of patients diagnosed with bowel cancer at this stage do not survive a further 5 years.

This is a personal account relevant to the consultation and is by no means unique in nature – I have since come across many people whose diagnosis was delayed and whose prognosis was worsened as a result of failings of the current system.

Account:

In the summer of xxxx, aged xx, I noticed a change in bowel habit and a number of other unusual symptoms and went to my GP in xxxx. He examined me and took a blood sample but was unable to give a definitive diagnosis. Due to my age and other lifestyle factors, he thought it very unlikely that I had bowel cancer.

In xxxx, with my symptoms continuing, he referred me to a consultant enterologist.

I was seen by the consultant in xxxx. He thought I should have a colonoscopy and placed me on the waiting list.

My symptoms continued and in xxxx worsened. In early September, my GP was sufficiently concerned to send me to hospital as an emergency case. I was admitted and given an emergency colonoscopy which revealed a tumour which had grown to block my colon. I underwent surgery and spent 15 days in hospital. My surgeon told me I would not have survived a further 2 or 3 days without intervention.

Two weeks later, while recovering at home – in late September - I received an appointment letter from the endoscopy department of the xxxx, following the meeting with the consultant the previous xxx, inviting me to have a colonoscopy – 9 months after being referred by my GP; 6 months after seeing a consultant; a month after undergoing surgery to save my life.

Tests showed the cancer had spread to the lymph nodes in my groin. I spent several months off work recovering at home and from xxxx to xxxx underwent chemotherapy. I have a stoma which, because of the extent of the surgery, is permanent. I am at a higher risk of developing cancer in future.

Despite this, I consider myself fortunate – others in a similar position have undoubtedly died and will continue to do so.

Finance / resources:

From a resource perspective, my emergency care and subsequent chemotherapy cost the health service many thousands of pounds. My lifelong aftercare (stoma) continues to cost the health service several hundred pounds a month.

These are preventable costs. Bowel cancer, more prevalent in older people but a growing issue among younger people, is preventable and curable if caught early. More than 90% of those with Stage 1 bowel cancer survive more than 5 years. Even better: pre-cancerous polyps can be removed if they are detected by a colonoscopy.

Early detection is cost-effective. Additional resources need to be targeted at this, thus avoiding the often huge costs involved with treating cancer in its later stages – and the human (patient) advantages are obvious.

Conclusions:

I would urge the committee to consider recommending:

- Fully introducing the faecal immunochemical test (FIT) at a low threshold – certainly no higher than elsewhere in the UK.
- Ensuring the health service can cope with FIT testing at a lower age – 50
- Increased awareness for GPs about bowel cancer, particularly in relatively young patients, and the ability for GPs to short-circuit the diagnostic process.
- Significant investment in endoscopy services to be able to cope with the inevitable increase in the demand on diagnostic resources.

xxxx

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National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Endoscopy Services

Evidence from Cardiff and Vale University Health Board

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

Xxxx
(As a collated response on behalf of xxxx, xxxx and xxxx) from Cardiff and Vale University Health Board

Cynulliad Cenedlaethol Cymru Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon Ymchwiliad i wasanaethau Endosgopi HSCS(5) E04 Ymateb gan Cymdeithas Gastroenteroleg ac Endosgopi Cymru	National Assembly for Wales Health, Social Care and Sport Committee Inquiry into Endoscopy Services Evidence from Welsh Association for Gastroenterology and Endoscopy

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

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(President- Welsh Association for Gastroenterology and Endoscopy) on behalf of

xxxx (Secretary), xxxx (Treasurer) and xxxx (Ex-President) - WAGE

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1. About Bowel Cancer UK

Bowel Cancer UK is the UK's leading bowel cancer charity. We are determined to save lives, improve the quality of life and support all those affected by bowel cancer in the UK. We support and fund targeted research, provide expert information and support to patients and their families, educate the public and professionals about the disease and campaign for early diagnosis and access to best treatment and care.

Our pledge is bold and ambitious. Within ten years:

- We will transform survival rates from only one in very two people surviving bowel cancer over five years, to three out of four people surviving
- There will be better information and support for every patient throughout their journey
- Screening will be optimal leading to more cancers being detected early or prevented.

Our vision is where nobody dies of cancer

2. The facts

- Bowel Cancer is the fourth most common cancer in the UK and the second biggest cause of cancer deaths. 2,200 people in Wales will be diagnosed each year and over 900 will die.
- If detected early (stage 1) 98% of people will survive five years or more, if caught later (stage 4) only 8% of people will survive this long.
- Over half of bowel cancer cases are preventable
- Survival for people diagnosed in Wales is poorer than comparable countries (ICBP, CONCORD, Eurocare)
- Survival is disproportionately lower in more deprived communities.
- Screening is the best way to identify cancer early and can actually prevent bowel cancer in the first place as screening will identify high risk polyps and these can be removed before the cancer develops.
- The bowel screening programme in Wales has removed over 10,000 polyps over the last ten years.

- The bowel screening programme has identified 2,200 cancers since it was launched in Wales in 2008.
- We are pleased that Welsh Government has announced that Wales will be screening from the age of 50 by 2023.
- Only half of those offered the screening test take up the offer
- An optimal screening programme and a fully engaged public is the key to saving more lives from bowel cancer

3. The challenge

3.1 A new faecal immunochemical test (FIT) test will be introduced in Wales for those aged 60 - 74 from January 2018. This test is expected to see an increase in uptake of up to 10% and will impact on the capacity of Health Boards to carry out endoscopy tests.

3.2 On the 10 August 2018, the UK Screening Committee recommended that screening should be offered from aged 50 to 74 using the new and more accurate FIT screening at a sensitivity level of 20ug/g. FIT at this level has the potential to detect twice as many cancers and four times as many adenomas (polyps).

3.4 The Health Secretary stated (on twitter) that Wales would lower the screening age to 50 "ASAP". However, no commitment was made publically about increasing the sensitivity level from the proposed 150 ug/g

3.5 It is our understanding, that the Welsh Government expects Bowel Screening Wales to have reduced the screening age to 50 and also increased sensitivity to 80 ug/g by 2023 (this would bring us in line with Scotland as they have been delivering their programme at these levels since 2017)

3.6 The NHS in Wales is currently struggling to cope with the amount of people being referred for tests through the screening programme and symptomatic pathway and these latest announcements will add further pressure to an already overstretched system.

3.7 In 2013, representations were made to Welsh Government that there were challenges within the health service in relation to endoscopy and in particular colonoscopy capacity. At the time, a Task and Finish group was established to get to grips with these challenges and the group made specific recommendations for individual health boards to deliver. The recommendations from this group in 2014 were (broadly) as follows:

- Local Health Boards achieve Joint Advisory Group (JAG) accreditation on all units in Wales and that endoscopy waiting times are made a tier 1 priority
- That health boards make effective use of resources on an all Wales basis including bringing issues of capacity for resolution to the Endoscopy Group to resolve

- The Health Boards deliver evidence based services and phase out Barium Enema and that screening from 50 is recognised as gold standard
- Accountability, each Health Board to publish progress reports annually and publish training and quality plans

3.8 Apart from phasing out Barium Enema as a diagnostic tool, we are concerned that almost five years on from these set of recommendations, NONE of the others have been actioned robustly enough to bring about the whole system change needed to meet the demand for colonoscopy services. The Welsh Government and the NHS have been unable to identify a solution to mitigate the tsunami of demand which has been created as a result of an increasingly ageing population, increasing symptom awareness and most notably, the change in NICE guidance around referral for suspected cancer and the plans to introduce FIT from January 2019.

3.9 The Endoscopy National Survey (see below) published in 2017 found that bowel cancer services have introduced extended working hours over the weekend and many hospitals reported paying extra for bowel cancer diagnostic workload to be outsourced to external private providers to cope with demand.

3.10 Delivering a FIT test at a very sensitive level (10 ug/g) in the primary care setting as a stratification tool for those with vague symptoms (though not red flag symptoms as these would immediately be put on the Urgent Suspected cancer pathway) is currently being explored through pilots in parts of England and Scotland.

3.11 Some health board in Wales are wishing to roll out this new approach, however due to a lack of clear leadership within NHS structures to make Wales wide strategic decisions on the best way to approach introducing the FIT test for use with symptomatic patients, it is yet to be introduced. Some experts believe the test could reduce demand on endoscopy services by up to 40%; however other experts believe that it could potentially increase demand. Until these differences are resolved, and a framework to introduce a trialled approach, Wales will continue to fall further behind in our approach to identifying solutions that could potentially reduce demand on overstretched endoscopy services.

3.10 Whilst we recognised that the Welsh Government has been working through the Endoscopy Implementation Group to identify solutions to address theses challenges, we believe that the time for debate within committee and group structures must now move on to an implementation phase. Decisive and swift action is needed now more than ever, from Welsh Government, the Welsh NHS Executive and Health Boards to address these challenges.

3.11 Without focus and pace we will continue to fall behind other nations and Welsh patients will be disadvantaged and people will continue to die unnecessarily. In addition, without action NOW, we will cripple our workforce and disengage already beleaguered NHS colleagues. The system will simply crash.

4. The evidence

4.1 Cancer Research UK's 2015 report 'Scoping the Future' predicted that rising demand for endoscopy services will lead to nearly 1 million additional endoscopy procedures (more than 750,0000) a year will be undertaken by 2020 – more than a 50% increase on current activity in 2015. However, this does not even reflect the demands of introducing FIT to the Bowel Cancer Screening Programme at increasing levels of sensitivity and lowering the screening age to 50, following the UK National Screening Committee's recommendations. As such, this number is expected to increase.

4.2 Cancer Research in Wales' report on the diagnostic workforce also states that the NHS is already struggling to keep up with demand; the target of 95% of newly diagnosed cancer patients referred via the urgent route to begin treatment within 62 days of referral has not been met since 2008.

5. Endoscopy National Survey 2017

5.1 The 2017 UK survey for endoscopy surveyed 508 endoscopy centres across the UK and found that on average only 55% of units were meeting urgent cancer waiting targets and in Wales this number was even lower at 42%.

5.2 Shortages of endoscopists and nursing staff were cited as being the biggest barrier that prevents units meeting the demand. There is currently an 11% vacancy rate for endoscopy nurses in Wales.

5.3 Services have introduced extended working hours to cope with demand including over weekends and 16% of Wales units do not have an agreed capacity plan

5.4 Many reported paying for insourcing/outsourcing patients to external providers to improve waiting times.

5.5 16% of units in Wales had a "Did not attend" rate of more than 10%, compared to 5% in Scotland and 7% in England

6. Recommendations

6.1 We expect to see robust leadership from Welsh Government and senior NHS colleagues to drive a new and innovative approach to delivering endoscopy services in Wales

6.2 We expect to see the new Endoscopy Programme Board set out its timetabled work programme as soon as possible

6.3 We expect front line action and pace behind the capacity and demand modelling that is currently taking place in health boards as part of the Endoscopy Programme Boards work programme

6.4 We expect to see an NHS Executive led system wide solution being developed within six months to address the shortfalls in the identified capacity modelling

6.5 We expect to see investment from Welsh Government through ring fenced monies being allocated to support the implementation of this system wide solution

6.6 We expect to see a phased approach to ending expensive outsourcing to private providers as new solutions come into operation

6.7 We expect to see swift decision making about the best way to develop our use of FIT with symptomatic patients at a level of 10ug/g and a national framework developed to allow health boards to start using this test in their patient populations

6.8 We expect to see Health Education and Improvement Wales (HEIW) prioritise cancer diagnostics as part of their first tranche of work to enable future proofing of our endoscopic workforce

6.9 We expect to see robust and transparent performance monitoring put in place to surface ongoing issues so that they are identified and solved as quickly as possible.

6.10 We expect to see a public commitment from Welsh Government t hat this work is being carried out.

6.11 We would like to see the Health and Social Care Committee revisiting their recommendations in 18 months time to reflect on progress and to seek assurances that new models of work are being delivered so that we can optimise our Bowel Screening Programme by 2023 as per the Government's commitments.

7. Further Information

For further information about our focus on the early diagnosis of bowel cancer, please see our report from February 2018: A Spotlight on Bowel Cancer in Wales,

For more information please contact xxxx, Head of Bowel Cancer UK in Wales, xxxx

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Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Ymchwiliad i wasanaethau Endosgopi
HSCS(5) E06
Ymateb gan Tenovus Cancer Care

National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Endoscopy Services

Evidence from Tenovus Cancer Care

Endoscopy Services, November 2018

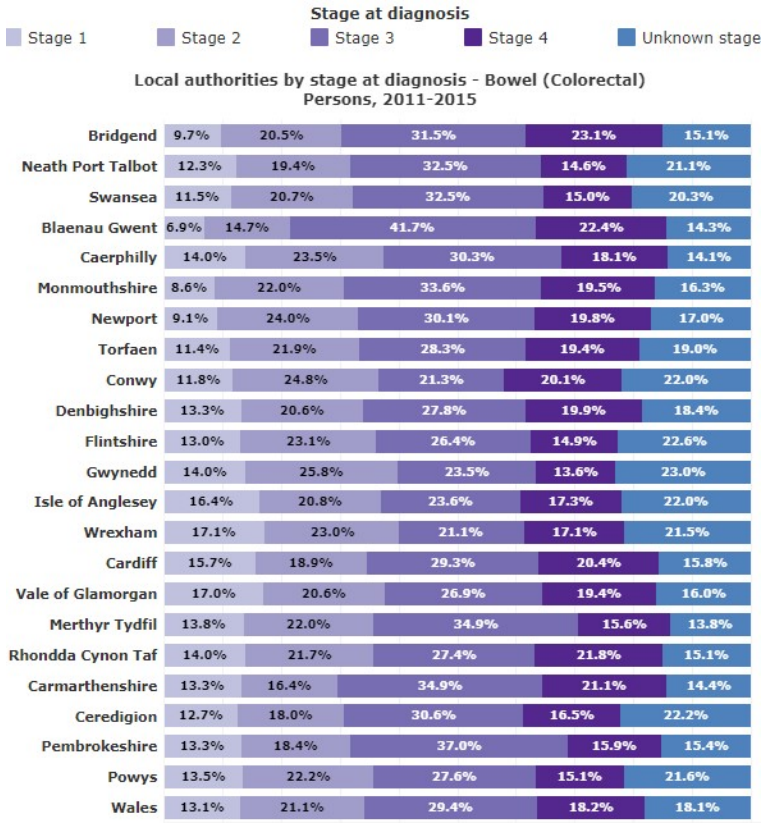
Tenovus Cancer Care is Wales' leading cancer charity. Our aims are simple. We want to help prevent, treat and find a cure for cancer.

We do this by offering support, advice and treatment to cancer patients and their loved ones. We also promote healthy lifestyles and fund cancer research to find new ways to prevent it, diagnose it, and treat it.

We welcome the opportunity to respond to this important consultation.

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

Tenovus Cancer Care agrees that earlier diagnosis is absolutely essential in the fight against cancer. However diagnosis varies significantly throughout Wales, with Cardiff and Vale UHB having the highest (16.2%) and Aneurin Bevan UHB the lowest (10.6%) rates of Stage 1 colorectal cancer (CRC) at diagnosis, while Cwm Taf UHB experiences the highest incidence of Stage 4 CRC (20.6%) compared to just 15.1% in Powys THB. Broken down to Local Authorities, the differences are more pronounced (see below):



Population screening is one of the key tools in detecting bowel cancer earlier in Wales. Screening currently starts at the age of 60 years old for men and women and takes place every two years until the age of 74. Staging data is not available in Wales. However, in England, just over 37% of cancers diagnosed through screening are detected at the earliest stage, compared to just 6% of those diagnosed as an emergency (Bowel Cancer UK, 2018).

However screening uptake is historically low in Wales, with an average uptake of around 54% (Public Health Wales, 2017, p. 8). Therefore Tenovus Cancer Care, a member of both the FIT Project Board and the Communications group, fully supports the implementation of FIT testing, including to the intent to lower the age of commencement of screening to 50 years of age for both sexes. Both initiatives are widely expected to increase uptake rates and provide a more positive patient user-experience.

FIT is more accurate and cheaper than the current guaiac faecal occult blood test (gFOBT) for QualityAdjusted Life Years (QALYs) (Murphy, et al., 2017, p. 4) - with £25 per person saved at 180 µg Hb/g faeces threshold, rising to £62 per person at 20 µg Hb/g faeces threshold. That is, screening with FIT results in greater total QALYs and lower costs than gFOBT (Murphy, et al., 2017).

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.

Studies show that overall, “the total cost over 40 years is predicted to be lower for FIT at any threshold than for gFOBT, and this difference increases as the FIT threshold is decreased” (Murphy, et al., 2017, p. 7).

Tenovus Cancer Care accepts that there would be a risk of diagnosis capacity collapsing under the weight of demand were the FIT threshold reduced to the point at which risk is functionally eliminated. Tenovus Cancer Care believes that in the interest of public health and of the well-being of our clients this must ultimately be the long term aim of the NHS in Wales and urges the Welsh

Government to use this improved cost-efficiency to urgently move down the FIT threshold.

The earlier bowel cancer is diagnosed the more likely you are to survive beyond 5 years. If you are diagnosed with bowel cancer at stage 1, you have a 95-100% chance of surviving 5 years.[1] If you're diagnosed at stage 4, your chances of survival at 5 years are only 5-10%. In Wales only 44% of people will have their bowel cancer diagnosed at stage 1 or stage 2. 48% will be diagnosed at Stage 3 or Stage 4.[2]

Tenovus Cancer Care views the FIT regime as a vital tool in increasing the diagnostic capacity for bowel cancer, thus improving patient outcomes. However this, combined with a reduction in the FIT sensitivity threshold, must be matched in ambition by an increase in diagnostic capacity in order to reduce the waiting time between screening and endoscopy.

On waiting times, we echo the view of Bowel Cancer UK who, in their recent report stated:

> Patients in Wales follow one of two routes to treatment depending on how their cancer is found – each of these routes has a separate waiting time. The urgent suspected cancer route has a target that 95% of all confirmed cases should start treatment within 62 days. For those on the non urgent pathway, once cancer is confirmed treatment should start within 31 days. This has led to concerns that there may be delays before diagnosis for those on the non urgent pathway.
>
> The current system is complex and very confusing for patients who will have been waiting for a diagnosis and then have a further wait to start treatment. These long waits between referral, diagnosis and treatment lead to increased levels of anxiety and uncertainty for patients. This is particularly true for patients with bowel cancer, who may not present with typical symptoms and will be recorded as having started their treatment within 31 days of diagnosis. In some cases, these patients will have been potentially waiting months before this to access the diagnostic tests needed to get their cancer diagnosis in the first place.
>
> - ***Spotlight on bowel cancer in Wales*, Bowel Cancer UK, 2018**

The gap created by diagnostic capacity shortfalls between screening and endoscopy creates unacceptably high levels of anxiety among patients, while delaying the start of potentially life-saving treatment. This is set to be exacerbated by the, otherwise incredibly welcome, introduction of FIT. However capacity issues extend beyond the initial diagnostic episode. There is evidence that patients, as a result of having had one or more polyps, are now having their follow-up surveillance endoscopies delayed. This will result in more interval cancers, and could cost lives which should be of concern to all.

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.

It is clear to all in the sector that there is a significant capacity issue at the heart of endoscopy services in Wales. There is also evidence of the significant capacity issue within endoscopy services being partly addressed by being contracted to private-sector third parties, and performed by clinically trained but nonspecialist practitioners. This is not only unsustainable in the long run, potentially at huge additional cost to the Welsh taxpayer, but also sub-optimal with non-specialists undertaking colonoscopies potentially with reduced diagnostic outcomes for patients.

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. New and innovative methods of increasing screening rates, reducing diagnosis waiting times and improving patient outcomes are welcome in whatever form they take. Through our *Closer to Home* programme our Mobile Support Units provide chemotherapy treatment to patients throughout the country in convenient, accessible locations that reduces their journey time, improves the patient experience and relieves capacity from an otherwise stretched NHS. We would welcome the opportunity to use this model to provide screening and diagnostic capacity, as we did with our Bowel Bus in 2015[1], particularly in harder-to-reach communities that we know are more exposed to poorer screening, and thus depressed survival rates (Public Health Wales, 2017, p. 8).

With the roll out of smarter digital patient records it should not be outside the scope of our ambition to be able to proactively identify those, particularly male, patients who have not taken up their routine FIT screening, as and when they attend ad hoc GP appointments.

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

The current level of update is unacceptably low. While it is accepted that men, in general, are a noted hard-toreach group, deprivation is a major driver of poor health outcomes and Tenovus Cancer Care believes that far more effort needs to be paid to focussing attention on more deprived communities. Particular focus should be paid to those identified as experiencing multiple deprivation, as defined in the Wales Index of Multiple

Deprivation (WIMD).[2] Confronting and reducing the undeniable stigma attached to bowel cancer and screening in general should be a key concern - for example

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[1] http://www.tenovuscancercare.org.uk/how-we-can-help-you/mobile-cancer-support/drop-in-bowel-clinic/

[2] https://gov.wales/statistics-and-research/welsh-index-multiple-deprivation/?lang=en

by targeting more community-focussed interventions, such as in rugby clubs and in targeting BAMER communities, including engagement with community and faith leaders.

References

Bowel Cancer UK, 2018. *Spotlight on bowel cancer in Wales*, s.l.: s.n.

Murphy, J., Halloran, S. & Gray, A., 2017. Cost-effectiveness of the faecal immunochemical test at a range of positivity thresholds compared with the guaiac faecal occult blood test in the NHS Bowel Cancer Screening Programme in England. *BMJ Open.*

Public Health Wales, 2017. *Bowel Screening Wales Annual Report 2016-17*, s.l.: s.n.

Cynulliad Cenedlaethol Cymru Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon Ymchwiliad i wasanaethau Endosgopi HSCS(5) E07 Ymateb gan Iechyd Cyhoeddus Cymru	National Assembly for Wales Health, Social Care and Sport Committee Inquiry into Endoscopy Services Evidence from Public Health Wales

On behalf of Bowel Screening Wales, Public Health Wales (xxxx, Head of Programme, Bowel Screening Wales)

This submission is in response to three of the terms of reference provided. The remaining two terms of reference relate to areas outside the remit of Bowel Screening Wales and have therefore not been included in this submission.

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

People diagnosed with bowel cancer as a result of participating in the screening programme have their tumours diagnosed at an earlier stage than those presenting through the symptomatic service. Around 37% of people with screen detected cancers are diagnosed with stage 1 disease and 8% at stage 4, compared with 18% at stage 1 in the symptomatic service and 22% at stage 4 (CRUK 2018). Around 9 out of 10 people with stage 1 bowel cancer will survive at least 5 years, compared to around 12% with stage 4 disease (CRUK 2018). In order to improve outcomes for bowel cancer patients it is therefore essential that the bowel screening programme is optimised to reduce the burden of bowel cancer disease in our population.

Currently Bowel Screening Wales offers screening to men and women aged 60 to 74 years and sends them a faecal occult blood test kit to complete every two years. If the test result is positive then they are offered a colonoscopy.

Bowel Screening Wales (BSW) has been asked by Welsh Government to introduce the first line faecal immunochemical test (FIT) as the screening test and this is planned to be introduce from January 2019. This is in line with UK National Screening Committee recommendations. The new test is more sensitive, specific and as it is easier to use than the current test an improvement in uptake is expected.

Welsh Government has also asked Bowel Screening Wales (BSW) to plan to optimise the screening programme by April 2023 by inviting people aged between of 50 and 74 years as recommended by the UK National Screening Committee.

This will challenge Health Boards by increasing demand on already pressurised diagnostic and treatment services. Health Boards have been asked to develop sustainable capacity to accommodate optimisation of the bowel screening

programme and this will require investment and resource that has not currently been identified.

As the FIT test is quantitative there is flexibility to adjust the cut off level in order to maximize cancer and adenoma detection. The initial cut off level (of 150ug/g) to be used in Wales is a pragmatic starting point which will marginally increase demand for diagnostic and treatment services, while delivering some improvement on the current test and allowing Health Boards time to develop additional capacity. A detailed optimisation plan has been developed and will be submitted to the Wales Screening Committee for approval. It incorporates age expansion and improvement in FIT threshold to maximise public health benefit with priority being given to age expansion.

The BSW FIT implementation project is on target to begin the phased implementation in January 2019 with national rollout planned from June 2019. Analysers have been procured and installed into the laboratory and staff training has begun. I.T. system development is ongoing and Public and Health Professional information is being developed. All work streams are on target to deliver on time despite a significant delay in procurement due to a legal challenge.

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.

Colonoscopy capacity has dictated the rate at which the bowel screening programme can be optimised. Bowel Screening Wales undertakes around 3,300 lower GI endoscopy procedures per year which accounts for 8- 10% of the total lower GI endoscopy demand. All Health Boards are currently funded for more screening activity than they deliver and yet they struggle to achieve the 28 day waiting time standard (from contact following positive screening test result). In July 2018 only 45% of participants were seen within timeliness standards. There are different issues in various units, but pressure on the symptomatic service is largely the issue as cancelled lists are often replaced with symptomatic cases.

Implementing and improving FIT and expanding the screening age range will be extremely challenging for Health Boards who are under pressure to reduce symptomatic service waiting times. Some progress is being made to reduce symptomatic waiting times across Wales, but this has been largely due to costly waiting list initiatives.

Individual Health Board teams are working very hard to address timeliness issues, but although some Health Boards have developed plans to improve sustainable capacity for endoscopy, others are yet to identify how this will be achieved. Of those that have developed plans a shortfall in capacity has been identified and significant improvement is needed to accommodate optimisation of the bowel screening programme.

Health Boards who have developed plans to increase sustainable capacity will need to undertake a variety of improvements including amending job plans for colonoscopists, recruiting more colonoscopists and nursing staff and some will need to develop additional endoscopy rooms. It is difficult to see how this will be possible within the current service model.

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

The standard for uptake of the Bowel Screening Programme has been set at 60% of invited participants who return a used test within six months of invitation. However, this has not been reached consistently since the start of the programme, although it has shown improvement in recent years. The latest published figures are for the period April 2016 to March 2017 and show an uptake of 53.4% across Wales. The next annual report is due to publish in January 2019 and is expected to demonstrate a small improvement in uptake, but not achieving the 60% target. Uptake is higher in women (54.7%) compared to men (52.0%). There is also a strong correlation with deprivation quintile with uptake in the most deprived areas being 43.6% compared to least deprived areas at 60.6%.

Improving uptake has been a continual focus for the programme and several initiatives have been evaluated and taken forward. These include development and dissemination of consistent key messages based on every contact counts methodology. Also pre-invitation letters were piloted and following evaluation, sent to men prior to their first invitation to improve uptake and reduce the gender inequality gap.

Current work that is underway to improve uptake includes:

a. Routinely sharing information with GPs about their patients who fail to respond to invitations for bowel screening. Bowel Screening Wales have worked with Cancer Research UK to develop a toolkit to increase knowledge of bowel screening among primary care staff in order to encourage them to implement interventions to improve uptake. Initiatives with GP Clusters and Health Boards to help capitalise on this opportunity are ongoing

b. The 'Be Clear on Cancer' campaign that was run with Cancer Research UK in February and March 2018 yielded a significant increase in returned test kits which was maintained for several months. The quantitative analysis of the effectiveness of the campaign is due to be completed in the next month and a meeting has been arranged with CRUK to discuss the findings and consider the implications in terms of future interventions

c. Discussion with public health colleagues in Cwm Taf Health Board with a view to piloting additional interventions in primary care which if successful could be rolled out nationally

d. Plans to review current letters and literature will also be undertaken with PHW behavioural insights team with a view to developing culturally and

literacy sensitive material in accessible formats for different groups of the population

e. Research into the barriers to participation particularly in the younger age range

Bowel Screening Wales is celebrating its 10 year anniversary and the programme is using this to further engage with the public and stakeholders. This has included programme representation at sport events including Cardiff 10K run and a 'walk with me event'. The Welsh Association of Gastroenterology and Endoscopy (WAGE) conference had a focus on the Bowel Screening Programme. Also during October Bowel Screening is going on a tour around Wales to raise awareness with focus on low uptake and seldom-heard groups. The emphasis is on capturing conversations with participants and the pubic to help us to understand awareness of the programme, barriers to participation and to develop insight as to how community led posts could support the work of BSW. In addition there has been media coverage across various channels including TV, local press and social media using participant stories to deliver a person-centred message around the importance of participating in screening. This has been undertaken with Macmillan, Cancer Research UK and Bowel Cancer UK.

Following on from this community engagement work the BSW team are collaborating with a small group of charity workers and Health Care Professionals to explore the possibility of developing joint work plans for community workers employed by Bowel Cancer UK to work within BSW. Informed by data gathered at the anniversary events, work plans could be developed to include locally led initiatives and support for primary care to encourage engagement with the programme.

References

Cancer Research UK 2018. Bowel Cancer Statistics. Cancerresearchuk.org

Cynulliad Cenedlaethol Cymru Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon Ymchwiliad i wasanaethau Endosgopi HSCS(5) E08 Ymateb gan Goleg Nyrsio Brenhinol Cymru	National Assembly for Wales Health, Social Care and Sport Committee Inquiry into Endoscopy Services Evidence from Royal College of Nursing Wales

The Royal College of Nursing Wales is grateful for the opportunity to respond to this consultation and would like to raise a number of points in relation to the inquiry:

Faecal Immunochemical Test (FIT)

I. The Royal College of Nursing welcomes the introduction of any form of screening that increases the simplicity and accuracy of testing, thereby increasing uptake. As is acknowledged by the Health Committee in the inquiry's background information, there are concerns about the capacity of existing services to cope with demand, and the RCN echoes these concerns. We are aware of shortages within the nursing and endoscopist workforce and this will undoubtedly impact the ability to deliver services in the face of increased demand.

II. The Royal College of Nursing also maintains the introduction of a new screening initiative should be accompanied by a public awareness campaign, with appropriate promotion and explanation of what is involved. A certain amount of stigma and sense of taboo still surrounds tests of these kinds, and the public needs to be assured of the effectiveness of the tests and for any myths or concerns to be dispelled via an appropriate marketing campaign, alongside ensuring that professionals with the right skills are involved in the delivery.

III. There needs to be significant investment and expansion of the current workforce and nurses can play a central role in this. For example, Advanced Nurse Practitioners (ANPs) and Clinical Nurse Specialists (CNSs) with competencies in the area of endoscopy are able to perform endoscopic procedures without the supervision of other health or medical professionals are can therefore be invaluable in expanding services. These competencies are set out in the All Wales Endoscopy Nurse Competency Framework. Opportunities for ANPs and CNSs for further education and development in the area of endoscopy should be made available to those wishing to pursue these skills.

IV. The Royal College of Nursing recommends that Health Education & Improvement Wales (HEIW) works with Health Boards and Higher Education Institutions to develop and implement a strategic plan to ensure that sufficient education opportunities are available for those wishing to undertake endoscopy training, ensuring that the funding is available for

these courses and also that the necessary backfill is available to enable staff to be released to undertake the courses. As more of these nursing roles emerge, it is vital that the funding is made available centrally. Health Boards should also ensure that plans around endoscopy services are reflected in their Integrated Medium Term Plans (IMTPs).

Uptake of the bowel screening programme

V. In areas of high deprivation where uptake of screening programmes is known to be poor, targeted action can help to improve uptake and improve outcomes. As acknowledged in the Welsh Government's Cancer Delivery Plan, this is important for helping to support a reduction in inequalities of health outcomes. The Royal College of Nursing recommends that the introduction of the FIT test must include targeted action of this kind in order to ensure the initiative helps to reduce health inequalities whilst also fitting in with the objectives of the Cancer Delivery Plan.

VI. Also important for improving the uptake of the bowel screening programme is ensuring that the appropriate staff with the right skills are deployed in the right areas to encourage uptake. Many patients will, in the first instance, be seen by a Practice Nurse, and it is essential therefore that the nursing workforce is engaged with and involved in any promotion activities related to screening. Ensuring that staff are engaged with on different initiatives, will help to ensure that patients and the general public have access to the right information, and is likely also to help to dispel some of the stigma around the screening tests and help patients to feel more confident in the process.

About the Royal College of Nursing

The RCN is the world's largest professional union of nurses, representing over 430,000 nurses, midwives, health visitors and nursing students, including over 25,000 members in Wales. The majority of RCN members work in the NHS with around a quarter working in the independent sector. The RCN works locally, nationally and internationally to promote standards of care and the interests of patients and nurses, and of nursing as a profession. The RCN is a UK-wide organisation, with its own National Boards for Wales, Scotland and Northern Ireland. The RCN is a major contributor to nursing practice, standards of care, and public policy as it affects health and nursing. The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies.

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National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Endoscopy Services

Evidence from Cancer Research UK

Cancer Research UK's response to the Health, Social Care and Sport Committee inquiry into endoscopy services in Wales

Cancer Research UK (CRUK) welcomes the opportunity to respond to this consultation. Cancer survival in Wales lags behind international comparisons[i]: to achieve better survival outcomes for patients more patients must be diagnosed at an early stage. Achieving earlier diagnosis will involve conducting more diagnostic testing. Drivers for more testing include a growing and ageing population, efforts to achieve earlier diagnosis through symptom awareness campaigns, a lower referral threshold of risk for GPs to refer people with symptoms, and improvements to screening programmes.

Bowel cancer is the fourth most common cancer in Wales - around 900 people die every year from the disease[ii]. Diagnosing bowel cancer at stage I means more than 9 in 10 people survive their diagnosis for five or more years. But diagnosed at stage IV, fewer than 1 in 10 people survive their bowel cancer for five or more years. The NHS Wales Bowel Cancer Screening Programme is one of the best ways to detect bowel cancer early, when it is easier to treat successfully. Yet, currently only around 1 in 10 bowel cancers are detected via this route. We want to see this increase so that fewer people die from bowel cancer.

Key points

- Diagnostic capacity in endoscopy services has been the main factor when determining the threshold for FIT and may impact national roll-out.
- Optimisation of the bowel cancer screening programme is solely dependent on having available capacity in endoscopy services.
- There are other interventions and innovations which can be adopted to improve earlier diagnosis of bowel cancer. FIT can assist in the triage of patients presenting with symptoms that suggest both a high or low risk of bowel cancer, which could reduce the number of patients referred onto colonoscopy.
- Diagnostic services are already struggling to deliver tests and the data on diagnostic staffing pressures is limited, which makes it difficult to make well-informed decisions about current and future workforce planning.

- We would like the Welsh Government to take a more strategic approach to workforce planning to address long-term shortages in the diagnostic workforce. The Welsh Government must conduct and publish a full review of the cancer workforce in Wales and make the necessary investment to pay for the training and employment of more staff based on clinical need and best practice.

Bowel Cancer Screening Programme

The UK National Screening Committee (UKNSC) made the recommendation in 2015 that the Faecal

Immunochemical Test (FIT) should replace the guaiac faecal occult blood test (gFOBt) in the Bowel Cancer Screening Programme (BCSP) across the UK as FIT can be used as a more sensitive test. With the introduction of FIT there is significant potential for the BCSP to be more effective at diagnosing more cancers and detecting pre-cancerous adenomas. Previous pilots of FIT have shown a marked increase in uptake of around 7% and Scotland has seen a 10% increase since the introduction of FIT[iii] especially in harder to engage groups such as men and people with low socio-economic status[iv].

It is evident the diagnostic capacity in endoscopy services has been the main factor when determining the threshold of FIT. While the threshold must be pragmatic and deliverable, it is disappointing that the most optimal screening programme is being determined by current endoscopy capacity. Our understanding is FIT is due to be introduced in January 2019 through phased roll-out at a threshold of 150 μg/g, with national roll-out commencing in June 2019. We are concerned that national roll-out may not be achieved in June due to the current lack of capacity in endoscopy services. We would like to see a more centralised approach taken by the Welsh Government to improve capacity in endoscopy services to manage the increased sensitivity of the bowel screening test as well as the potential increase in uptake with the introduction of FIT.

Public awareness campaigns can help improve uptake by raising awareness of screening programmes. Earlier this year CRUK ran a Be Clear on Cancer campaign in Wales which aimed to increase participation in the BCSP by raising awareness of the programme and reducing barriers to participation. Full evaluation is still ongoing, but Bowel Screening Wales has reported to CRUK an increase in returned kits during the campaign period. Once the results of the campaign are published we would recommend that these are considered when developing future campaigns. We would also like to see public awareness campaigns to be continually funded, and with the aim of 75% of all eligible participants choosing to take part in bowel cancer screening annually.

We welcome the recent commitment to lower the screening age to 50 years old as this will ensure that Wales's screening programme mirrors the NSC recommendation and depending on the threshold could detect more cancers earlier. This change to the programme is straight-forward logistically for Bowel

Screening Wales and will therefore be solely dependent on having available capacity in endoscopy services.

We understand that the BCSP will screen from 50, every two years at a more sensitive threshold by early 2023. Achieving this will require 15,000 additional colonoscopies being required every year. While we welcome the plan to lower the age range and reduce the threshold by early 2023, the current proposal would only match the bowel screening programme as it was in Scotland in 2017. We would like the Welsh Government to be more ambitious in reducing the threshold - the UK NSC recommends a threshold of 20 μg/g which is considered the optimal threshold for public health benefit. To achieve this will require significant investment from the Welsh Government to train and employ more diagnostic staff to guarantee that services can cope with this increase in demand.

Workforce planning

Diagnostic services are already struggling to deliver tests; in August 2018, 181 people were waiting over 24 weeks for a diagnostic endoscopic test[v]. This pressure is also highlighted by poor performance against the 62-day cancer waiting time target, which has been missed since June 2008, and the difficulties in introducing FIT in bowel screening, outlined above.

The data on diagnostic staffing pressures is limited, which makes it difficult to make well-informed decisions about current and future workforce planning. While we recognise streamlining pathways will go some way in supporting diagnostic capacity, these will not overcome the shortfall in key professional groups interpreting and delivering tests in Wales. For example, there are currently not enough trained staff to fill current posts, as shown by high levels of vacancies and outsourcing.

Workforce planning to date has been based on poor data, and providers stating what they can afford

rather than need to deliver clinical best practice. It is also difficult for the service to foresee innovation which may change workforce needs. The establishment of Health Education and Improvement Wales (HEIW) represents an opportunity for a more strategic approach to workforce planning in Wales but the new organisation must take a bold and strategic outlook on the diagnostic workforce.

To address immediate shortages in endoscopy, HEIW should look at ways to better use existing staff including developing a non-medical endoscopy accelerated training programme, making sure they are trained to perform colonoscopies. This should be alongside increasing training places for clinicians who perform endoscopies to ensure there is sufficient capacity in the longer term. The Government and Health Boards could test new ways to incentivise diagnostic staff to train and work where shortages are most acute as well as making contracts more flexible to minimise consultants retiring early.

We would like the Welsh Government to take a more strategic approach to workforce planning to address long-term shortages in the diagnostic workforce. The Welsh Government must conduct and publish a full review of the cancer workforce in Wales and make the necessary investment to pay for the training and employment of more staff based on clinical need and best practice.

Early diagnosis interventions and innovation

There are other interventions and innovations which can be adopted to improve earlier diagnosis of bowel cancer. We would recommend that Wales fully adopt the NICE recognition and referral guideline, NG12, for suspected cancer. The Cancer Delivery Plan 2016 identifies "the challenge for GPs to identify cancers that present with non-specific symptoms and a reluctance to refer onwards due to concerns about burdening stretched secondary care services"[vi]. NG12 guidelines address this challenge by encouraging GPs to refer at a lower threshold of risk: patients should now be referred for further tests where symptoms indicate a three per cent or higher risk of cancer[vii]. The Cancer Delivery Plan went on to highlight the importance for diagnostic services to be developed to cope with the expected increased demand.

It has also been found that people have expressed a clear preference for being referred to diagnostic tests at all risk levels, and individuals want to be tested at risk levels below those stipulated by UK guidelines.[viii] This suggests that patients may have a greater appetite for testing than currently guidelines stipulate.

Estimates of the impact of these guidelines on endoscopy activity were contained in a NICE costing report[ix] that was published alongside the draft guidelines. (Note that these figures were not updated when the final guidelines were published). This model suggested that the change in referral criteria and thresholds would result in an increase of between 5% and 15% of referrals for lower GI endoscopies. Furthermore, they assumed that 85% of lower GI referrals would result in an endoscopy. HEIW must ensure that there is sufficient capacity in the endoscopy workforce to support these increased rates of referral.

FIT can assist in the triage of patients presenting with symptoms that suggest both a high or low risk of bowel cancer, which could reduce the number of patients referred onto colonoscopy. But there are still unanswered questions of how the implementation of FIT in symptomatic patients will work in primary care. There needs to be careful consideration of the logistics, and communication to patients, especially considering the same test is used. Furthermore, some local health boards are considering ways to introduce FIT for symptomatic patients to relieve some capacity in their diagnostic services. However, to maximise effectiveness, and reduced variation and duplication, we would recommend that an all-Wales approach is explored as a priority.

The implementation of FIT in symptomatic patients requires careful consideration of the logistics and changes in ways of working as it will require a multidisciplinary approach, providing opportunities for professionals in the laboratory medicine to be involved. To date, reporting of results are normally done using µg Hb/g faeces

units and with knowledge of the limit of detection and limit of quantitation of the analytical system used. However, a small number of cases will be missed[x], and robust safety netting procedures are required to follow up FIT-negative patients. There should be clear guidance on safety netting approaches to limit the potential for variation in practice.

About us

Cancer Research UK is the world's largest independent cancer charity dedicated to saving lives through research. We support research into all aspects of cancer and this is achieved through the work of over 4,000 scientists, doctors and nurses. In 2017/18, we spent £423 million on research institutes, hospitals and universities across the UK with over £4m on research in Wales.

For more information please contact xxxx, Policy Advisor

[i] International Cancer Benchmarking Partnership, Survival benchmark 1995-2007. https://www.cancerresearchuk.org/health-professional/data-and-statistics/international-cancerbenchmarking-partnership-icbp/icbp-findings#ICBP_findings0

[ii] Bowel Cancer (C18-C20), Number of Deaths, Crude and European Age-Standardised (AS) Mortality Rates per 100,000 Population, UK, 2016 https://www.cancerresearchuk.org/health-professional/cancerstatistics/statistics-by-cancer-type/bowel-cancer/mortality#heading-Zero

[iii] UK National Screening Committee minutes June 2018 https://www.gov.uk/government/groups/uk-nationalscreening-committee-uk-nsc#meetings

[iv] Westwood, M et al (2017). Faecal immunochemical tests (FIT) can help to rule out colorectal cancer in patients presenting in primary care with lower abdominal symptoms: a systematic review conducted to inform new NICE DG30 diagnostic guidance. *BMC Medicine*, [online] 15(1). Available at: https://www.ncbi.nlm.nih.gov/pubmed/29061126

[v] Stats Wales, Diagnostic Endoscopy serviceshttps://statswales.gov.wales/Catalogue/Health-and-SocialCare/NHS-Hospital-Waiting-Times/Diagnostic-and-Therapy-Services/waitingtimes-by-month

[vi] NHS Wales, Cancer Delivery Plan for the NHS to 2020. https://gov.wales/docs/dhss/publications/161114cancerplanen.pdf

[vii] NICE NG 12 suspected cancer recognition and referral guidelines: http://www.nice.org.uk/guidance/NG12/

[viii] http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045%2813%2970588-6/abstract

[ix] http://www.nice.org.uk/guidance/NG12/documents/suspected-cancer-update-costing-report2

[x] Westwood, M. et al. Faecal immunochemical tests (FIT) can help to rule out colorectal cancer in patients presenting in primary care with lower abdominal symptoms: a systematic review conducted to inform new NICE DG30 diagnostic guidance (2017). BMC Medicine, [online] 15(1). Available at: https://www.ncbi.nlm.nih.gov/pubmed/29061126

Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Ymchwiliad i wasanaethau Endosgopi
HSCS(5) E10
Ymateb gan Goleg Brenhinol y Meddygon Cymru

National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Endoscopy Services

Evidence from Royal College of Physicians Wales

Gwasanaethau endosgopi yng Nghymru

Diolch i chi am y cyfle i ymateb i'ch ymgynghoriad ynglŷn â gwasanaethau endosgopi yng Nghymru. Ochr yn ochr â'r ymateb hwn, mae Coleg Brenhinol y Meddygon (CBM) yn cyflwyno'r ymatebion atodedig o'r Cydgrŵp Cynghori (CGC) ar Endosgopi GB, Cymdeithas Cymru dros Gastroenteroleg ac Endosgopi (CCGE) a Rhwydwaith Hyfforddi Endosgopi Cymru. Byddem yn falch o drefnu tystiolaeth ysgrifenedig neu lafar bellach o unrhyw un o'r sefydliadau hyn pe byddai hynny yn ddefnyddiol.

Pwyntiau allweddol

- Mae diagnosis cynnar o ganser y coluddyn yn cael effaith anferth ar oroesiad a thriniaeth ar gyfer cleifion unigol. Bydd hyn yn cael ei gyflawni yn unig drwy gynyddu'r amrediad oed sgrinio a defnyddio profion sensitif ar gyfer GCY, fel y prawf PIY.
- Rydym yn cefnogi ymdrechion i gynyddu'r nifer sy'n defnyddio rhaglen sgrinio'r coluddyn – ond mae'n rhaid i'r GIG feddu ar ddigon o adnoddau i reoli'r galw cynyddol.
- Mae buddsoddiad mewn gwasanaethau endosgopi wedi bod yn gyfyngedig yng Nghymru. Mae angen buddsoddiad gyda hyn, os ydym am gwrdd â thargedau rhestrau aros a rheoli'r galw.
- Dylai Llywodraeth Cymru ystyried cefnogi rhaglen hyfforddi ôl-TCH ar gyfer endosgopi, unwaith y daw'r newidiadau i gwricwlwm meddygaeth mewnol i rym.

Ein hymateb

- **Diagnosis cynharach, cyflwyno Prawf Imiwnocemegol yr Ysgarthion (PIY) yn benodol i mewn i raglen sgrinio'r coluddyn a'r newid a gyhoeddwyd yn ddiweddar i'r amrediad oed.**
  Mae diagnosis cynnar yn cael effaith anferth ar oroesiad a baich y driniaeth ar gyfer cleifion unigol.
  Bydd hyn yn cael ei gyflawni yn unig drwy gynyddu'r amrediad oed sy'n cael ei sgrinio a defnyddio profion sensitif ar gyfer GCY, fel y prawf PIY. Bydd gwelliannau goroesi yn cael eu gweld o fewn ychydig flynyddoedd.

- **Capasiti'r gwasanaeth diagnostig ac amseroedd aros, gan gynnwys y raddfa y mae cyfyngiadau gallu yn sbarduno'r argymhelliad i osod trothwy'r PIY ar gyfer ei gyflwyno i raglen sgrinio'r coluddyn ar lefel gymharol ansensitif.**
  Mae lefel y buddsoddiad mewn gwasanaethau endosgopi yng Nghymru wedi cael ei gyfyngu am nifer o flynyddoedd. Mae rhestrau aros ar gyfer mwyafrif yr unedau yng Nghymru ar gyfer gweithdrefnau diagnostig a gwyliadwriaeth yn uwch na'r lefel a argymhellir, a bydd angen buddsoddi yn y rhain er mwyn rheoli'r galw ar y trothwyon PIY isaf.

- **Mae atebion hirdymor a chynaliadwy i'r heriau sy'n bodoli o fewn y gwasanaethau endosgopi yng Nghymru, yn cynnwys sut mae data ynglŷn â phwysau ar staff diagnostig yn cael ei ddefnyddio i ddarparu gwybodaeth ar gyfer penderfyniadau ynglŷn â chynllunio gweithlu'r presennol a'r dyfodol.**
  Mae cynlluniau galw a chapasiti'r byrddau iechyd yn dangos diffyg ystafelloedd endosgopi, nyrsys endosgopi, endosgopyddion meddygol ac endosgopyddion sy'n nyrsys. Nid oes unrhyw gyfleuster na chyfadran endosgopi pwrpasol yng Nghymru. Byddai buddsoddiad mewn cyfleuster hyfforddi unigol ar gyfer endosgopyddion sy'n nyrsys ac endosgopyddion meddygol o fantais bendant. Yn ychwanegol, gyda hyfforddiant arbenigol yn cael ei leihau (o 5 i 4 blynedd) yn yr holl arbenigeddau meddygol, gan gynnwys gastroenteroleg, ni fydd pob hyfforddai sy'n cwblhau eu hyfforddiant yn y dyfodol yn gallu ymgymryd â cholonosgopi oherwydd nad yw'n gymhwysedd craidd. Mae anfanteision i hyn, ond mae hefyd yn codi'r posibilrwydd o drefnu ysgol gymhwyso yng Nghymru, gyda rhaglen hyfforddi bwrpasol am flwyddyn (o bosibl sy'n gysylltiedig â gweithio yng Nghymru). Gallai hyn ddefnyddio cyfadran o hyfforddwyr a fyddai hefyd yn darparu hyfforddiant ar gyfer endosgopyddion sy'n nyrsys.

- **Ystyriaeth o ymyriadau ac arloesedd diagnosis cynnar, fel cyflwyno'r profion PIY drwy feddygon teulu mewn cleifion symptomatig er mwyn lleihau atgyfeiriad ar gyfer profion diagnostig.**
  Gall PIY chwarae rhan mewn unigolion symptomatig gyda risg isel, er mai ychydig o'r unigolion hyn sy'n cael eu hatgyfeirio ar gyfer colonosgopi. Mae hefyd yn groes i'r syniad o dynnu swyddogaethau porthgadw er mwyn gwella diagnosis cynnar a gwell canlyniadau.

Ar gyfer cael mwy o wybodaeth

Gellir dod o hyd i fwy o wybodaeth ynglŷn â'n polisi a'n gwaith ymchwil yng Nghymru drwy fynd ar ein gwefan. Fel arall, cysylltwch os gwelwch yn dda â Lowri Jackson, pennaeth polisi ac ymgyrchoedd RCP dros Gymru, drwy ysgrifennu at xxxx gydag unrhyw gwestiynau.

Cynulliad Cenedlaethol Cymru
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Evidence from Royal College of Physicians Wales

RCP Cymru Wales response

Endoscopy services in Wales

Thank you for the opportunity to respond to your consultation on endoscopy services in Wales.

Alongside this response, the Royal College of Physicians (RCP) submits the attached responses from the

Joint Advisory Group (JAG) on GI Endoscopy, the Welsh Association for Gastroenterology and Endoscopy (WAGE) and the Welsh Endoscopy Training Network. We would be happy to organise further written or oral evidence from any of these organisations if that would be helpful.

Key points

- Early diagnosis of bowel cancer makes a huge impact on survival and treatment for individual patients. This will only be achieved by increasing the age range screened and using sensitive assays for FOB such as the FIT test.
- We support efforts to increase the uptake of bowel screening programme – but the NHS must be resourced to manage the increased demand.
- Investment in endoscopy services has been limited in Wales. This needs investment if we are going to meet waiting list targets and manage demand.
- The Welsh government should consider supporting a post-CCT training programme for endoscopy once changes to the internal medicine curriculum come into force.

Our response

Earlier diagnosis, specifically the introduction of the Faecal Immunochemical Test (FIT) into the bowel screening programme and the recently announced change to age range.
Early diagnosis makes a huge impact on survival and treatment burden for individual patients. This will only be achieved by increasing the age range

screened and using sensitive assays for FOB such as the FIT test. Survival improvements will be seen within a few years.

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 level of investment in endoscopy services in Wales has been constrained for many years.
Waiting lists for the majority of units in Wales for both diagnostic and surveillance procedures is above the recommended level, and these will need investment particularly if we are going to manage demand at the lower FIT thresholds.

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.
Health board demand and capacity plans show a lack of endoscopy rooms, endoscopy nurses, medical endoscopists and nurse endoscopists. There is no dedicated endoscopy training facility or faculty in Wales. Investment into a single training facility for nurse and medical endoscopists would be a distinct advantage. In addition with specialty training being reduced (from 5 to 4 years) in all medical specialties, including gastroenterology, not all future trainees will come out of training able to undertake colonoscopy as it is not a core competency. This has downsides, but it also raises the possibility of organising a post-CCT credentialing school in Wales with a one-year dedicated training programme (potentially with a tie-in to work in Wales). This could use a faculty of trainers that would also provide nurse endoscopist training.

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.
FIT may play a role in low risk symptomatic individuals, although few of these individuals are referred for colonoscopy. It also runs counter to the idea of removing gatekeeping functions to improve early diagnosis and better outcomes.

For more information

More information about our policy and research work in Wales can be found on our website. Alternatively, please contact xxxx, RCP head of policy and campaigns for Wales, at xxxx with any questions.

Endoscopy services in Wales © Royal College of Physicians 2018

19 October 2018

Dear colleague

JAG has been working Wales for a number of years, supporting endoscopy services to improve the quality of patient care. JAG accreditation provides a framework for services to benchmark their performance against best practice standards, implement improvement, and receive external and independent quality assurance that the best quality of care is delivered to their patients.

To become accredited, services must meet a range of standards which drive service efficiency and maximise capacity. Services must meet national waiting time targets, review current and future capacity against predicted demand and proactively manage waiting lists and booking and scheduling arrangements. Services must meet a number of requirements around workforce planning and development, ensuring services have the appropriate workforce to meet the current and future needs of the service. This is in addition to the other JAG standards which cover all aspects of a high quality service including patient experience, quality, safety, environment and training. Appendix one contains the GRS measures for productivity and planning, and workforce. The entire GRS is available on the JAG website www.thejag.org.uk

Currently 6 out of 20 services hold accreditation in Wales. The main barriers for Welsh services include meeting waiting time targets as well as the environment. The Welsh Assembly has voiced support for all services to gain JAG accreditation, and services must continue to have central mandate and support to receive the level of investment required. To support services in gaining accreditation, JAG has introduced an agreement where the standards on waiting times and environment do not need to be met in their entirety for the first year once accreditation has been granted to give the service time to address these challenges. JAG continues to support services including targeted training days and guidance as well as individual support for health boards to advise on how they can address the issues their boards face. JAG has met with the Welsh Government and attended the meeting of the Welsh Government Endoscopy Implementation Group (EIG) to provide support and guidance in this area. The accreditation status of all Welsh units is provided in appendix two.

JAG strongly believes that accreditation provides services with an effective and proven framework to make service improvement, unlocking capacity and improving the quality of care for endoscopy patients. JAG strongly believes that accreditation of all units in Wales will contribute towards delivering a step change in survival rates for bowel cancer in Wales.

Kind regards

Xxxx

JAG Chair

Appendix 1 – GRS productivity measures

11. Productivity and planning The purpose of this standard is to ensure that resources and capacity are used effectively to provide a safe, efficient service. This is supported by sound business planning principles within the service.			
11.1	Productivity metrics are agreed and documented in the service operational policy.	D	The service should consider including as a minimum the following performance and productivity dataset: – overall/individual utilisation of lists – start and finish times audit – room turnaround audit – did not attend (DNA) and cancellation rates.
11.2	There is a weekly review of waits, demand, capacity and scheduling with key service leads.	C	The service team needs to have access to accurate waits and capacity information to deliver and plan services effectively.
11.3	There is active backfilling of vacant lists, the frequency of unfilled lists is reviewed during the weekly meeting and there is sufficient flexibility in the job plans of endoscopists to enable backfilling of funded (ie staffed) capacity.	C	In the non-acute sector continuity of service provision is important, available lists may be offered to other consultants.

11.4	The service offers an administrative and nursing (if appropriate) pre-check for all patients before the date of the procedure to identify issues and to avoid late cancellations.	C	An administrative pre-check or telephone pre-assessment is performed by booking/administrative staff to ensure that the service has the most up-to-date information about the patient's condition. Nurses may further support this. In some cases this check is led by nurses and this is down to local policy.
11.5	Booking efficiency is monitored (through DNA and cancellation monitoring) at least monthly and is fed back to endoscopy staff.	C	
11.6	Room utilisation data (such as start and finish times and room turnaround times) is collected, collated, reviewed and acted upon. There is an agreed room utilisation performance target.	B	The service should consider including as a minimum the following performance and productivity dataset: – overall/individual utilisation of lists – start and finish times audit – room turnaround audit – DNA and cancellation rates.
11.7	There is an annual planning and productivity report for the service with an action plan.	B	The PPAT (which is accessed via the GRS tab of www.jagaccreditation.org) is designed to support improved productivity of an endoscopy service. It is intended to assist an endoscopy service in self-assessment and action planning. It is particularly important for units who have known waiting time problems to complete the PPAT and commit to an action plan.

			The PPAT is split into five domains, each of which contains a number of productivity-related objectives: 1. **Demand and capacity (7 objectives)** 2. **Waiting List Management (6 objectives)** 3. **Booking and Choice (6 objectives)** 4. **Performance and Productivity (6 objectives)** 5. **Workforce (5 objectives)** The PPAT reviews an endoscopy unit's progress towards achieving these objectives. It is recommended that each unit carries out a monthly review of progress towards each objective.
11.8	Demand, capacity and utilisation data are used to inform short- and long-term business planning to ensure sufficient capacity, and the service has an agreed business plan if shortfalls are identified.	B	Refer to the PPAT. See guidance to measure 11.7.
11.9	There is, on an annual basis, a measurement of the demand for endoscopy to support service planning.	A	Refer to the PPAT. See guidance to measure 11.7.

15. Workforce delivery This item ensures that the service has the appropriate workforce and that recruitment processes meet the needs of the service.		
There are policies and systems in place to ensure that there are sufficient competent staff within the service with an appropriate mix of skills to enable delivery of the service.	D	This should include a process describing staffing allocation for each list, including risk management of substantive and non-substantive staff. There should be a policy and escalation process for patient activity if staffing and skillmix do not meet the established agreed levels.
The service rosters staff according to service activity and the competency level required to support it. Allocation of the workforce must be based on the expected duration of the service activity.	D	Modelling of the day and activity is undertaken as part of productivity and safety. Allocation of the workforce must support the expected duration of all service activity eg inpatient activity, safety checks, handover etc.
A workforce skillmix review is completed on at least an annual basis for all functions of the service and an impact assessment of the gaps is made and objectives are agreed on how these will be addressed in the immediate year.	C	This includes the management, medical, nursing and administrative team members.
There are polices and systems in place to meet the induction requirements of the endoscopy team, including any additional service	C	This includes all visiting and non-substantive staff to a service such as agency staff, staff from other areas, insourcing teams, and should be based round national and professional guidance eg

specific education and training.		Royal College of Nursing (RCN) First Steps http://rcnhca.org.uk/. This should include national guidance per country e.g. https://hee.nhs.uk/our-work/developing-ourworkforce/nursing/shape-caring-review.
There is a training needs analysis for all new staff that supports the needs of the service.	C	A training needs analysis tool is used to identify transferable and required skills for all staff.
There is a training needs analysis for substantive staff, which is agreed by the appropriate senior manager responsible for each workforce group.	C	This should be undertaken when there is a change or adoption of practice, when team members leave, during succession planning or at least yearly.
The impact of recruitment processes for new or replacement senior or essential core staff do not adversely affect the running of the service.	C	There should be processes and escalations to provide continuity of service without safety or quality being compromised.
There are monitored processes to ensure the recruitment of suitable staff in a timely manner.	C	It is expected that the recruitment of new staff does not negatively impact upon the service.
As a result of the workforce skill mix review an action plan is created and acted upon in a timely fashion.	B	It is expected that the workforce skill mix review is actioned so that it does not negatively impact upon the service.

There is a training programme that meets the needs of new staff that is implemented in a timely and efficient way to minimise disruption to the service.	B	The training programme should meet nationally agreed profiles and should be implemented in a structured, modular way to build on learning and skills progression.
The service-specific induction programme for all new staff is modified on the basis of feedback.	B	
Workforce development plans are in place in anticipation of future demands in the volume and type of future demand, for the next 2–5 years.	B	A needs analysis and development plan should be developed around service provision for the medical, nursing and administrative workforce.
There is a process for the recruitment and induction of senior staff, which allows a handover period prior to replacement.	A	There should be processes and escalations to provide continuity of service without safety or quality being compromised.

Appendix 2 – current welsh service accreditation status

Health board	Hospital	Accreditation status
Abertawe Bro Morgannwg University Health Board	Morriston Hospital	Not Assessed
Abertawe Bro Morgannwg University Health Board	Neath Port Talbot Hospital	Not Assessed
Abertawe Bro Morgannwg University Health Board	Princess of Wales Hospital	Assessed: Criteria met
Abertawe Bro Morgannwg University Health Board	Singleton Hospital	Not Assessed
Aneurin Bevan University Health Board	Nevill Hall Hospital	Not Assessed
Aneurin Bevan University Health Board	Royal Gwent Hospital	Not Assessed
Aneurin Bevan University Health Board	Ystrad Fawar Hospital	Not Assessed
Betsi Cadwaladr University Health Board	Glan Clwyd Hospital	Not Assessed
Betsi Cadwaladr University Health Board	Wrexham Maelor Hospital	Not Assessed

Betsi Cadwaladr University Health Board	Ysbyty Gwynedd, Bangor	Not Assessed
Cardiff and Vale University Health Board	University Hospital Llandough	Assessed: Accreditation not awarded
Cardiff and Vale University Health Board	University Hospital of Wales	Not Assessed
Cwm Taf Health Board	Prince Charles Hospital	Not Assessed
Cwm Taf Health Board	Royal Glamorgan Hospital	Not Assessed
Hywel Dda University Health Board	Bronglais General Hospital	Assessed: Criteria met
Hywel Dda University Health Board	Glangwili General Hospital	Assessed: Criteria met
Hywel Dda University Health Board	Prince Philip Hospital	Assessed: criteria met - level 1
Hywel Dda University Health Board	Withybush Hospital	Assessed: Criteria met
Powys Teaching Health Board	Brecon War Memorial Hospital	Assessed: criteria met - level 1
Powys Teaching Health Board	Llandrindod Wells County War Memorial Hospital	Not Assessed

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

xxxx

(President- Welsh Association for Gastroenterology and Endoscopy) on behalf of

xxxx (Secretary), xxxx (Treasurer) and xxxx (Ex-President) - WAGE

The focus of this consultation are the actions needed to deliver a step change in the survival rates for bowel cancer in Wales.

Population screening (asymptomatic population)

- The Bowel Screening Wales (BSW) programme was initiated in 2008 and has demonstrated effectiveness in detecting bowel cancer at an earlier stage in the screened population (60-74 year-olds).
- Uptake within the screening programme based on Guiaic faecal occult blood testing has been limited in some geographical areas and socioeconomic groups. The conversion rates from a positive screening test to patients undergoing colonoscopy have been high.
- The introduction of Faecal Immunochemical Test (FIT) into the BSW programme is anticipated to increase uptake by 7-10% - with increased sensitivity of the test this will also increase the number of patients requiring colonoscopy.
- The selection of the FIT threshold for the BSW programme is entirely pragmatic based on available colonoscopy capacity. There is no doubt that a lower threshold consistent with those seen in other European screening programmes would be preferable and supported by the GI community if the colonoscopic capacity was available.
- There is widespread support in the GI community in Wales for the age range for screening to be widened to include 50-60 year-old patients (as in the screening programme in Scotland).
- This would further increase the demand for BSW colonoscopy capacity.
- Within CTUHB, which also provides BSW screening lists for the Bridgend area, BSW colonoscopy comprises between 12-15% of all annual colonoscopy procedures.
- Within the BSW programme capacity is reserved for ongoing surveillance of patients at intermediate or high risk of polyp recurrence.

Symptomatic population

- The majority of colonoscopic activity within Health Boards deals with patients presenting with lower GI symptoms and the surveillance of ‘high risk groups’ (e.g. patients with a previous polyps or colorectal cancer; patients with inflammatory bowel disease [IBD]) □ Demand for colonoscopy services has risen year on year by 15% in CTUHB.
- Prioritisation of referral for limited colonoscopy (or flexible sigmoidoscopy) resource is based on patient age and symptom patterns (NICE CG12) which explicitly sets a colorectal cancer detection rate threshold at 3% - this detection rate is supported by local audit.

- Unfortunately, the detection of colorectal cancers presenting via symptomatic pathways continues to be later stage disease (with a predominance of T3N1 staging) associated with poorer disease outcomes.
- CTUHB, along with other Health Board, realises the potential of faecal immunochemical testing in the symptomatic population, where the quantitative nature of the test with the ability to control sensitivity and specificity parameters, to improve the yield of clinically important findings from colonoscopy (compared with sensitivity and specificity of clinical symptoms alone).
- Several large cohort trials using FIT (with or without associated faecal calprotectin tests) have provided data using a cut of range between 7-10ug Hb/g stool in symptomatic patients.
- There is interest in several Health Boards to implement the use of FIT testing in symptomatic patients. The main concerns over immediate implementation are whether this would produce a short term increase in demand for colonoscopy (at a time when no Health Board has yet developed increased capacity to meet this demand) and developing a robust
- pathway minimising the risk of patients with false negative stool tests and missed cancer diagnosis (any damage to the wider reputation of FIT testing in the community may have knock-on effects for uptake in the BSW programme).
- Further investigation of the potential benefits of the use of FIT in the symptomatic patient population in Wales should be supported but where possible investigator groups should align data collection so that transferable conclusions for Health Boards across Wales can be drawn from the data across the 'FIT pathway' (from GP consultation, completion of FIT, processing & communication of results, secondary care mechanisms for review and delivery of colonoscopy, integration into MDT cancer pathways and management of FIT negative patients).

Diagnostic service capacity for lower GI endoscopy

- The effect of combined rising baseline demand (based on current NICE guidance), planned implementation of FIT within the BSW programme and increased age range can be modelled to predict future demand on local services.
- Within CTUHB predicted demand for colonoscopy services is being considered within planning for the second phase of the Diagnostic Hub model to support wider goals to improve early diagnosis and clinical outcomes for colorectal cancer.
- The Diagnostic Hub project group has acknowledged that capacity issues will require an initial 'interim' uplift of an additional theatre at the Royal

Glamorgan Hospital site pending a definitive sustainable plan which will require a new build to expand the number of endoscopy theatres across the Health Board – a business case for submission to Welsh Assembly Government is being prepared.

Workforce development

- Historically workforce development in Endoscopy has been ad hoc and driven by local needs
- Commitment of capital expenditure to achieve expansion in endoscopy capacity needs to be matched by funding to increase the workforce.
- It has been recognised that all Wales census data of the current Endoscopy Workforce and estimated needs within capacity expansion programmes in the next few years would be helpful
- The needs of individual Health Boards may vary depending on their existing workforce, but practice standards and competencies for the endoscopy workforce should be standardised across Wales.
- In 2006 Welsh Assembly Government provided some funding to set up an infrastructure for delivering skills training for Endoscopists and Endoscopy Nurses – the Welsh Endoscopy Training Network (WETN). Funding ceased in March 2009 and since that time no further central funding has been received to support training endoscopists. The hardware purchased in 2006 is now either out of date or no longer functioning. WETN has continued to provide a functioning JAG approved Regional Training Centre based on goodwill of participating faculty with income based solely on course fees. Some funding was made available via NLIAH to support level 7 modules for nurse endoscopists and endoscopy nurses at Swansea and Bangor University – but this funding stream has also ceased. An updated training model for Wales, capable of supporting required growth in the Endoscopy Workforce (endoscopists and endoscopy nurses) to achieve agreed national competencies and performance standards is required.
- Within CTUHB the Diagnostic Hub project group have acknowledged the importance of workforce development and are supporting the following work streams;
    - Local workforce planning to support an expanded endoscopy service with improved development and career opportunities for the workforce, including increased use of nurse-led pre-assessment given a rise in 'direct-to-test' cohort of patients
    - Combined work with WED to survey the Welsh Endoscopy workforce
    - Local increase in Colonoscopists trained to meet BSW performance standards

- Local identification of a ‘flexible’ endoscopy workforce including staff grade and nurse endoscopist posts able to provide a backfill capacity across CTUHB
- Commitment to support a National Endoscopy Training capacity as part of the Diagnostic Hub project with close links to the Imaging Academy in Pencoed - currently all Endoscopy Training Courses in Wales are provided by the Welsh Endoscopy Training Network with clinical training at the Royal Glamorgan and Princess of Wales Hospitals, with simulation training at the Welsh Institute of Minimal Access Therapy (WIMAT) in Cardiff.
- Delivery of competency-based training pathways for endoscopy nurses, based on the All Wales Endoscopy Nurse Competency Framework (AWENcf)

xxxx Endoscopy Lead CTUHB, Clinical Lead of the Welsh Endoscopy Training Network

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National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Endoscopy Services

Evidence from Welsh NHS Confederation

Introduction

1. The Welsh NHS Confederation welcomes the opportunity to respond to the Health, Social Care and Sport Committee's inquiry into endoscopy services in Wales. The Welsh NHS Confederation represents the seven Local Health Boards, the three NHS Trusts in Wales and Health Education and Improvement Wales (HEIW). We support our members to improve health and wellbeing by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work.

Overview

2. Over a number of years, NHS Wales has been working to bring endoscopy demand and capacity into balance to enable delivery of the eight-week diagnostic target and endoscopy unit accreditation. Clinical Directors and management leads have been collaborating through the national Endoscopy Implementation Group (EIG) and significant progress has been achieved. Eight-week breaches have declined and additional units have achieved accreditation.

3. In this financial year, NHS leaders have agreed to establish a national programme for endoscopy services, led by a reformed EIG, to provide an additional and sustained focus on the service in the next period and to develop a plan which will reduce the screening threshold and age range to optimal levels by 2023. Immediate priorities for the programme include: completing demand and capacity modelling; developing a standardised pathway to drive maximum efficiency and productivity; and ensuring workforce plans and Integrated Medium Term Plans (IMTPs) for 2019 and beyond take account of uplift in capacity that will be required.

4. This paper will address the five areas of focus identified in the Terms of Reference of the inquiry.

Inquiry areas of focus:

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;

5. Our members welcome the introduction of the FIT test from January 2019 into the bowel screening programme as part of a strong evidence-based change that has the potential to improve the uptake of screening. This is due in large part to the new test that requires just one (instead of three) samples, as well as an improved detection rate for bowel cancer and advanced pre-cancerous polyps in the bowel.

6. Health Boards and Bowel Screening Wales are working together to review their capacity to deliver the FIT and have assessed the anticipated impact of increased uptake of the test as a result of three key changes:

   a. Changes in the administration of the test;

   b. Changes to the sensitivity of the test and the level at which an individual would be invited for a diagnostic procedure; and

   c. The lowering of the age of those to whom a test will be sent.

7. In addition, bowel screening is currently offered to men and women aged 60 to 74 using a Guaiac Faecal Occult Blood test and colonoscopy, if necessary. Extending screening for men and women aged 50 to 74 by the year 2023 is expected to result in increased demand for diagnosis and treatment services. Currently for patients categorised as Urgent Suspected Cancer (USC), Health Boards are either meeting, or close to meeting, the requirement to offer a procedure date within two weeks of the screening assessment appointment. The challenge will be maintaining that level of performance in the face of additional demand.

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

8. As mentioned, endoscopy services across Wales face extremely testing workforce challenges, which are exacerbated by an average increase in demand for services of 8- 10% per annum. As a result, our members have had to work under extreme workforce and resource pressures to deliver the level of service that is required.

9. It is for these reasons that the planned threshold for introduction of the FIT test of 150 (micrograms/gram of stool – units same throughout) has been set, so that NHS Wales can balance the drive for improving outcomes from bowel cancer through earlier and increased diagnosis with the constraints of current endoscopy

capacity. Due to these very real capacity constraints, it is necessary to have a phased approach and there is a commitment from NHS leaders, working with Welsh Government, to reducing the screening threshold and age range to optimal levels by 2023.

10. The next step is to identify the resources that will be required to meet the anticipated future demand and local project teams are being developed in some areas to implement and manage changes in practice. These teams will comprise local GP cluster leads, a specialist screening practitioner lead and a service manager for endoscopy. Health Boards are also starting to work with primary care colleagues to support the early intervention agenda, for example through possible FIT testing by general practitioners.

11. In recent months, Health Boards have sought to manage the increased levels of demand for treatment by utilising sites outside of their operational boundaries. This practice has since come to an end and some Health Boards have developed plans to improve sustainable capacity. While challenges persist, there are a several streams of work ongoing that are seeking to maximise efficiency, productivity and list utilisation. Health Boards are also reporting increased numbers of nurse endoscopists which have been progressed as a contingency to managing the increased demand for routine endoscopy. Having nurse endoscopists in post to deal with routine endoscopy procedures means that senior clinicians have more time to undertake the more complex procedures.

12. We would emphasise however that despite these measures, the fact that nurse endoscopists also deliver a range of other clinical commitments as part of their job plan means that Health Boards continue to experience significant challenges to delivering the level of service that is required. Our members feel that amending these job plans, as well as an increase in the recruitment of colonoscopists and nurse endoscopists, is urgently required to meet current levels of demand. Our members also emphasise the need for an IT system that integrates the bowel screening software with units of endoscopy activity so that the data can be captured and compared across platforms.

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;

13. Generally, Health Boards have a good understanding within the Gastroenterology, Hepatology and Endoscopy Directorates about the workforce and infrastructure requirements that are necessary to deliver the plans for roll out of FIT under the Bowel Screening Programme. There is also a generally good understanding of the annual increase in demand on the wider symptomatic service, current backlogs, surveillance waits and proposed roll out of FIT that may be informed by planned pilots in primary care.

14. In addition to future workforce planning within endoscopy and establishing the number of required professionals, Health Boards also need greater capacity in

terms of increasing physical space and equipment to cope with the anticipated additional demand. Where necessary, this needs to underpin workforce plans with significant input from strategy and estate teams.

15. Recent plans for improvement in endoscopy services have focused on meeting immediate targets rather than building sustainability and resilience into the system. Our members will continue to work with the Welsh Government to ensure that the infrastructure needs of the service are built into IMTPs and national investment plans.

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;

16. 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, particularly for "low risk" patients (e.g. NICE Diagnostic Guidance 30). Despite this, the evidence base for the effectiveness of FIT testing as part of a primary care/secondary care diagnostic pathway in symptomatic patients is not as robust as it could be.

17. It is for this reason that Health Boards have been working collaboratively to outline what the baseline data collection and pathway measures need to be to pilot a study of this type. It is hoped that research of this kind will strengthen the evidence base for such an intervention so that it can be used in bowel cancer screening procedures in future. The Wales Cancer Network has been a key partner in this work. Health Boards have also engaged in detailed discussions with NHS organisations in Scotland (where a pilot has already taken place) to learn from their experiences, and with organisations in NHS England such as the FIT pioneers' group.

18. It is hoped that through continued engagement with the groups involved in the all-Wales initiative, such as Health Technology Wales and the Welsh Association for Gastroenterology and Endoscopy (WAGE), at least one Welsh Health Board will be well- placed to pilot a systematic and evidence-based roll out of FIT testing for symptomatic patients in 2019. The hope is that having the pilot in place in one Health Board will enable other Health Boards to structure and implement their own services to integrate this into the symptomatic diagnostic pathway.

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

19. Our members recognise the importance of increasing uptake of the bowel screening programme and a number of approaches are currently in development to address this challenge. Examples of such interventions include the dissemination of consistent key messages, pre-invitation letters and primary care pilots with non-responder data. Further examples of ongoing work in this area include analysis of Cancer Research UK's "Be Clear on Cancer" campaign; the

development of further pilots in primary care; collaborative projects with charity organisations to develop community engagement workers; and a review of letters and leaflets using behavioural insight techniques that aim to develop culturally and literacy sensitive material.

Conclusion

20. Our members welcome the introduction of the FIT test into the bowel screening programme and are taking a strategic approach to demand and capacity planning to prepare for its introduction. Health Boards are working closely with Bowel Screening Wales, are committed to the National Programme for Endoscopy services and are working closely with colleagues and partners across Wales and in other UK countries to drive improvements and achieve the efficiency savings that are required.

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Ymateb gan BMA Cymru

National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Endoscopy Services

Evidence from BMA Wales

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the inquiry by the National Assembly for Wales Health, Social Care and Sport on Endoscopy Services.

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

RESPONSE

BMA Cymru Wales welcomes the opportunity to respond to the consultation and wholeheartedly supports the need for a step change in survival rates for bowel cancer in Wales, given that they are currently amongst the poorest in Europe. This situation is unacceptable, and we commend the committee for focusing on this important topic.

When discussing endoscopy services and tacking colorectal cancer diagnosis, it is important to differentiate between the different groups of patients that will be or will need to access such services.

Cyfarwyddwr Cenedlaethol (Cymru)/National director (Wales):

xxxx

Firstly, those with clear cut symptoms of Urgent Suspected Cancer (USC) will require a colonoscopy within a very short time span. GP members across Wales have highlighted significant delays and long waiting times for these urgent endoscopies. This has required some Health Boards having to bring in teams from England in order to clear their backlog, no doubt at great cost. This has been attributed to the increase in screening without a consequent increase in the number of endoscopists being recruited and/or trained in these parts of Wales.

Secondly, the patients displaying less clear symptoms which do not merit an USC referral are particularly poorly served. Patients in this group may have cancer, or other conditions such as IBS or colitis. The variation in waiting times between an ‘USC’ referral to colonoscopy and ‘urgent’ referral can be measured in months meaning that some cancers are undiagnosed for some time. This group would be very well served by non- invasive testing, such as a fecal immunochemical test

(FIT) referral directly by the GP (often not permissible in some areas), which would help to enable speedier diagnosis.

Other non-endoscopy alternatives are CT colonograms and MRIs of small bowels, could be considered.

Finally, there is the asymptomatic group considered ‘at risk’ of bowel cancer, and thus covered by the bowel screening programme. Evidence suggests that non-invasive tests such as FIT are the best option for screening.

We consider the higher threshold of 150ug/g for the FIT screening test in Wales to be unacceptable, particularly when other nations have lower sensitivity thresholds (80ug/g in Scotland and 120ug/g in England). This could be viewed as a ‘rationing’ step which has a detriment on early cancer detection for this asymptomatic group. Given the increased sensitivity of this test (which we acknowledge could create more false positives), detailed workforce planning is necessary to create capacity for follow up endoscopies in an appropriate time span, as this service is currently lacking in many parts of Wales.

We would also ask that patients with non-cancerous conditions such as colitis are considered within any review of endoscopy services. These patients can suffer from debilitating symptoms but are often not prioritised within the system.

We welcome your consideration of the above issues and would be happy to provide further comment if you deem necessary.

Yours sincerely

Xxxx
Chair, BMA Welsh Council

Cynulliad Cenedlaethol Cymru Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon Ymchwiliad i wasanaethau Endosgopi HSCS(5) E13 Ymateb gan unigolyn	National Assembly for Wales Health, Social Care and Sport Committee Inquiry into Endoscopy Services Evidence from an individual

The points I would like to make are as follows:

1 The bowel screening service is a totally non invasive/non risk procedure

2 Vaughan Gething makes the statement-- "Bowel screening aims to identify cancer at an early stage when treatment is likely to be more successful and to identify and remove polyps that might otherwise go on to develop into cancer. The natural history of bowel cancer is such that it takes, on average, 10 years for a polyp to develop into cancer. If, following the recommended period of bowel screening, no polyps are detected in the bowel by the age of 74, the risk of premature death from bowel cancer is accordingly lower. "

This strikes me as a highly ageist remark.

The impression received is, that by the time we get to 84, it doesn't matter if we die from bowel cancer.

3. When we have the last faeces test at 73 or 74, we do not know for certain that we do not have any polyps.

The test is only for faecal blood, and there could be polyps present that are not yet bleeding, which would make themselves evident at the next screening.

If we do not have another test after 74, and visible faecal blood appears in the stool later, it may then be untreatable.

4. Vaughan Gething also states---"Eligibility criteria for population bowel screening in Wales are based on the latest available evidence. Current guidance from the UK National Screening Committee (UK NSC) recommends that routine screening should be provided to both men and women up to 74 years of age.

This is true, but in England, if you wish to have a test after the age of 75, you may ask for one.

5.I realise that some people do not take up the test, (I don't know the percentage), and this is a waste of NHS money.

However, if someone over the age of 74 goes to the trouble of requesting a test, it is very unlikely they are going to waste it.

6. I would like this request for a test to be available to people in Wales, as well as to those in England.

Otherwise welsh people are put at a great disadvantage.

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Evidence from Powys Teaching Health Board

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.

PTHB response:

Currently we offer bowel screening colonoscopy to residents of Powys within our endoscopy suites in South Powys. We have recently successfully appointed a part time (3 days / week) Bowel Screening Wales (BSW) Specialist Practitioner who screens the participants for fitness for procedure and then guide them through the process.

We run bowel screening Wales colonoscopy lists twice a month which are run on a Saturday, and performed by a BSW colonoscopist who visits from another Health Board, as we do not have our own BSW colonoscopist. We have recently subsumed the BSW patients from the English/ Welsh border who previously visited Hereford Hospital for their tests.

It is our understanding that the introduction of FIT testing and the lowering of the age range will increase the demand for BSW services nationally, including in Powys, and estimates state we may have to double, or even triple the number of patients we see in the next 3-5 years. We have limited flexibility to respond to any moderate or large increase in demand. In order to ensure patients are seen within target for BSW with a year on year increase in demand we would need to look at an increase in the number of BSW colonoscopists, of BSW specialist practitioners, and of endoscopy assistants

We do have the physical room capacity, especially when the facility at Llandrindod Wells is complete.

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.

PTHB response:

We understand that the Welsh threshold at which FIT will be set is less sensitive than that employed by some other home nations, i.e. there may be the possibility of an increased number of false negatives. We are also aware that the level will be changed to become more sensitive as service capacity improves to cope with the number of participants within the system.

We are mindful that we wish to provide the best and most sensitive service to our local population whilst being able to pragmatically continue to provide a balanced capacity and demand within the endoscopy service.

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.

PTHB response:

We are aware that there is a UK wide shortage of Gastroenterologists, and that it has been reported that there are up to 30% vacancies in some areas. We are also aware that the training time for colonoscopists can be many years and is arduous. We understand that in order to provide the good quality standard of endoscopy services required, based upon the JAG accreditation criteria, that leadership, administrative and nursing and workforce support are also crucial to the long term success of the service.

Here in Powys we have been planning for this, and are opening a new endoscopy unit in Mid Wales in the next month. This will provide care closer to home for our rural populations and increase our capacity from one to two rooms, with a potential of 20 sessions / week. We have employed an additional Nurse Endoscopist to perform upper GI endoscopy in this Mid Wales facility, from next month also.

Our patients are all vetted from referral, and we carry out only low complexity procedures for those with less complex needs. This carefully designated population is ideal for specialist nurse services and nurse endoscopist input.

Our service is a multi-professional one, led by a Consultant Surgeon and includes a Gastroenterologist. As the service indicates we will expand our provision of endoscopists to meet demand and look at multi-professional options for this.

Our assisting staff work jointly across endoscopy and day surgery and we are careful to balance capacity in both areas and skill mix.

However, we do recognise that our service is fragile, as we do not have a large team to cross cover etc., and many of our endoscopist team have their substantive role in adjoining organisations, and so we need to be able to flex accordingly.

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.

PTHB response:

In Powys we can see both advantages and disadvantages in facilitating GP access to FIT.

For patients, access to symptomatic FIT testing could mean faster access to endoscopic procedures, as straight to colonoscopy testing may be advantageous and could enable the removal of an outpatient clinic prior to endoscopy. Patients may get investigated & diagnosed more quickly.

However, in order for this to be facilitated the endoscopy departments need to be able to cope with the significant increase in referrals. We currently estimate that we could cope with a 10% to 15% rise gradually per year; if demand exceeded this, without significant investment in equipment, clinical staff of all levels, administration staff and infrastructure such as IT support, we would struggle to maintain the JAG accreditation quality of service we currently deliver and timeliness of patients access to procedures.

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

PTHB response:

The efforts to increase the uptake of bowel screening by participants is very much welcomed. We have noticed that at times of increased publicity of BSW programmes we appear to be busier with an increased number of participants in the service. Our rural community very much appreciate the opportunity to have the screening tests close to home in a local facility. It could be difficult for patients to travel longer distances because of the bowel preparation needed in advance, and the potential distances to travel.

In South Powys we are a JAG accredited endoscopy unit. We closely audit and monitor our service to anticipate stresses on the service and plan for future developments, via ongoing capacity and demand analysis work.

For further information, please contact:

xxxx (Powys Teaching Health Board), xxxx, xxxx.

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National Assembly for Wales
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Evidence from Wales Cancer Network

Introduction

1. The Wales Cancer Network is a collaboration between health boards and trusts, health professionals, the third sector and other stakeholders to develop and improve cancer services with the aim of improving cancer survival, and quality of life and experience of those living with the impact of cancer; ensuring the safety and sustainability of cancer services; reducing inappropriate variation in services; and encouraging and supporting innovation in service delivery. It supports health boards and trusts to meet the requirements of the Welsh Government's Cancer Delivery Plan, and other national strategic plans and frameworks for cancer, and provides advice and guidance to Welsh Government on policy relating to cancer care in Wales

2. A robust and well-functioning endoscopy service is an essential component of cancer services in Wales, and the Wales Cancer Network is therefore grateful for this opportunity to respond to the Health, Social Care and Sport Committee's inquiry into endoscopy services in Wales.

3. Whilst we are aware that there have been some recent improvements in services across Wales, with the number of patients waiting greater than 8 weeks decreasing, it is essential for cancer services that waiting times for endoscopy are as short as possible to support earlier diagnosis and ensure that patients can start their treatment as quickly as possible. Any delays are likely to have a direct impact on outcomes for patients, including survival.

4. Recent international benchmarking studies such as the International Cancer Benchmarking Programme (ICBP) have shown that Wales has the worst survival for cancers of the gastro-intestinal tract when compared to other jurisdictions across three continents. Wales has worked with the ICBP to understand the causes of this poor survival, which include late stage at diagnosis; a reduced threshold to investigate symptoms; access to diagnostic tests; and excessively long times for Welsh patients in going through diagnostic pathways. For gastro-intestinal cancer, access to endoscopy, as well as radiological imaging, are the key components of the diagnostic pathway.

5. We will address each of the Committee's key areas of interest in turn.

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

6. We welcome the introduction of the FIT test for screening, especially as it is proven to increase uptake in bowel screening. A pilot study in Scotland showed an increase in uptake of 4.8 percentage points. We also welcome the extension in the age range. It is, however, clear that these changes will lead to an increased demand for endoscopy and, as a result, the extension in the age range will not be fully implemented until 2023. We are aware that health boards are working with Bowel Screening Wales to review their capacity in the light of the anticipated increase in uptake of the test. It is essential that endoscopy capacity is increased to enable these changes to be introduced sooner and to meet the growing demands, otherwise waiting times are likely to increase.

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

7. From a survey conducted by the Wales Cancer Network, primary care access to endoscopy services is variable across Wales and is not timely. According to the survey, most units are unable to carry out investigations quickly enough to ensure that patients are treated within the existing Urgent Suspected Cancer waiting times target that requires patients to have started treatment within 62 days of referral.

8. Overall, the demand for cancer diagnostic services has risen by approximately 8-10% per year for the past few years. This is probably as a result of increased suspected cancer referrals as a result of NICE Guidance (NG12) for Suspected Cancer: recognition and referral, which provides guidance for primary care on recognising those patients who have symptoms that could be caused by cancer and on referring them for investigation. This was published in 2015. In addition, it is clear that demand for services will continue to increase each year because of the ageing population.

9. There are concerns that the lack of timely access to endoscopy from primary care can lead to ‘gate keeping’, with GPs either consciously or unconsciously changing the threshold at which they decide to refer patients for investigations for symptoms which may be caused by cancer. When they do refer, there is evidence that patients in Wales spend longer in the healthcare system, present with later stage disease and have poorer 1 and 5-year survival than similarly developed countries and jurisdictions.

10. The Faecal Immunochemical (FIT) Test in Wales is being introduced at a planned sensitivity threshold of 150µg/g (micrograms/gram of stool), whilst the level in England is planned to be 120µg/g and in Scotland it is 80µg/g. The lower the sensitivity threshold, the more cancers can be detected, but also the more patients are referred for colonoscopy. The higher level chosen in Wales is not in line with that recommended by evidence-based guidelines, but has been chosen because of the constraints in current endoscopy capacity. This will lead to a lower number of cancers being screen detected at an earlier stage with a detrimental effect on patient outcomes, including survival. It is also likely to inhibit more cost effective treatment. There is a commitment to lower this threshold to optimal levels and the Network will support NHS Wales in working to achieve this as soon as is practicably possible.

11. The clinical community in Wales welcomes the intent to reduce the age and sensitivity threshold. The Wales Cancer Network is leading the implementation of the *single cancer pathway* on behalf of the Cancer Implementation Group. This programme has recognised the need to improve information systems, develop capability to better model the required endoscopy capacity to meet demand and the development of optimal pathways and service models. These will be essential components of the solution to meet the demand created by the introduction of evidence based screening thresholds. The Cancer Network believes that, with an appropriate system-wide approach to service improvement, these changes to the screening programme could be brought in ahead of the current proposed timeline of 2023.

12. Within the current screening programme, some health boards are finding it challenging to see screen detected suspected cancers within target timescales. The Cancer Peer Review programme has found that, in some health boards, for those patients that require on-going surveillance (e.g. where polyps have been detected) there is insufficient capacity to provide surveillance colonoscopy within the recommended standards, which can mean that some patients develop cancer whilst waiting for their surveillance colonoscopy (interval cancers). A national system-wide approach to improving access to endoscopy services, delivered through the national directed programme for endoscopy (para 22) and the Cancer Implementation Group's Bowel Cancer Initiative (para 23) will undoubtedly help to address this.

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

13. The increasing demand has not yet been addressed by a sustainable increase in endoscopy capacity (activity, infrastructure or workforce). Most health boards have a shortage of gastroenterologists, and there is also a lack of availability of non-medical endoscopists; in Wales, there is also a disparity of pay

grade for nurse endoscopists compared to England. It is anticipated that this will be addressed as part of the national directed programme for endoscopy.

14. Short-term improvements in waiting times for endoscopy have often been achieved by the use of insourcing and outsourcing, utilising external providers.

15. In developing a sustainable service, there needs to be an on-going commitment to increasing the number of gastroenterologists and other medical endoscopists but also to developing nurse and other non-medical-endoscopists. We believe that this would benefit significantly from a national approach in support of work at both national and local levels. The recent development of the Imaging Academy could provide a model for Wales in increasing the endoscopy workforce.

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

16. There is emerging evidence (NICE Diagnostic Guidance 30) for the use of FIT testing in symptomatic patients to supplement the current 'alarm' or 'red flag' signs/symptoms that underpin the NICE referral guidance for urgent suspected cancers (NICE NG 12). This could significantly reduce the demand for endoscopy services by identifying those people who present with symptoms that could be related to colorectal cancer, but who are actually at a 'low-risk' of having cancer. Services in Wales should participate in pilots and/or research within a common framework of evaluation. We are working closely with health boards and other partners including the Welsh Association for Gastroenterology and Endoscopy (WAGE) and Health Technology Wales to develop a pilot for the use of FIT Testing in symptomatic patients.

17. This pilot would provide additional evidence for its effectiveness as a tool in primary and secondary care as well as 'real-life' experience in setting up and implementing such a service, which could then be shared across Health Boards.

Efforts being taken to increase uptake of the bowel screening programme

18. In 2016/17, the uptake for bowel screening fell by 1% to 53%. Uptake is significantly lower in the most deprived areas of Wales when compared to the least deprived areas (43.6% and 60.6% respectively). It is hoped that the new FIT test will lead to an increase in uptake but it is clear that more work is needed to increase the uptake, especially in 'hard to reach' groups such as BME communities and in particular deprived communities. The Scottish Detect Cancer Early programme is targeting social marketing campaigns to C2DE individuals who are less likely to participate in screening.

19. There are a number of initiatives underway led by Bowel Screening Wales looking at improving the way the screening programme operates, and by third sector partners including Cancer Research UK's primary care facilitator programme in Wales which provides support and advice to primary care in increasing screening uptake in their practice

Conclusion

20. We believe that Wales will need to plan for a sustainable increase in endoscopy capacity of the order of 10-20% to meet the forecast increases in demand.

21. There also needs to be a national coordinated programme of service improvement such as standardised pathways, training a new workforce, IT developments, capacity and demand modelling, research and evaluation, as well as the development of regional/local service delivery models. Work on developing and implementing these plans need to move at significant pace if the introduction of screening at an appropriate age and at a lower threshold are to be achieved, and improvements to patient outcomes delivered. This requires both a coordinated national approach as well as regional and local initiatives. This would undoubtedly improve patient experience and survival. The Cancer Network will work with NHS Wales and other stakeholders to take this work forward as part of the planned Bowel Cancer Initiative (see para 23) and as part of the national directed programme for endoscopy (see para 22).

22. The NHS Wales Health Collaborative, of which the Wales Cancer Network is a part, is providing support to the national directed programme for endoscopy recently announced by the Welsh Government. This work programme is being led by a reformed Endoscopy Implementation Group, co-chaired by the Deputy Chief Medical Officer and the Deputy NHS Chief Executive. A multi-disciplinary workshop involving all health boards, Welsh Government and the third sector will be held on 12 December 2018 to launch this work.

23. In addition, the NHS Wales Cancer Implementation Group has recently agreed to establish a Bowel Cancer Initiative (BCI) Programme to provide national strategic direction and co-ordinate a number of different initiatives across NHS Wales to improve the services and outcomes for people diagnosed with, suspected of having, or at risk of bowel cancer in Wales, some of which have been detailed above. This work is supported by Bowel Cancer UK and other third sector partners. The BCI Programme will work closely with the Endoscopy Implementation Group.

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National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Endoscopy Services

Evidence from Health Education and Improvement Wales

BUILDING THE ENDOSCOPY WORKFORCE – THE NEED FOR A NATIONAL ENDOSCOPY TRAINING STRATEGY

Report Authors

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Executive Summary

Gastrointestinal (GI) endoscopy is an important tool in early diagnosis of cancer, allows tissue diagnosis and therapeutic intervention. Demand for endoscopy services has risen across the all parts of the United Kingdom, in response to referral guidance [NICE Clinical Guidance 12], public awareness campaigns and the introduction of population-based bowel cancer screening programmes. To achieve goals of further reduction in mortality from all GI cancers, the capacity of endoscopy services across all Health Boards in Wales needs to increase.

Strategic planning for the expansion of endoscopy services requires accurate demand and capacity data, agreed productivity metrics, detailed information on the endoscopy workforce and an analysis of the training infrastructure required to build and sustain a high-quality endoscopy service.

Nationally the Joint Advisory Group in Gastrointestinal Endoscopy (the JAG) provide accreditation standards for endoscopy units and certification requirements for individual endoscopists. The advent of the National Endoscopy Database (NED) will provide real-time data on the quality of performance of units and individual endoscopists across all regions of the UK. Competency-based training, supported by dedicated and skilful trainers, will be required to develop a workforce operating across all endoscopic specialities capable of meeting these performance standards.

This report summarises what endoscopy training resource is available in Wales, how training needs of an expanded endoscopy workforce may develop, identifies the elements of a National Endoscopy Training programme, key strategic goals

and funding requirements. Without a properly developed national endoscopy training strategy and updated training scaffold, endoscopy workforce expansion required to meet capacity issues is unlikely to be deliverable in the required timeframe.

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Predicting the shape of the future endoscopy service in Wales

1. Demand for endoscopy services across the UK has increased in response to referral guidance [NICE Clinical Guidance 12] (1), public awareness campaigns and the introduction of population-based bowel cancer screening programmes.

2. The introduction of Faecal Immunochemical Testing (FIT) to the Bowel Screening Wales (BSW) programme and the extension of the age range being offered screening, in addition to a baseline increase in demand due to demographic population change is predicted to increase demand for endoscopy by 20% by 2020 (2).

3. Health Education England, in response to similar service pressures on Endoscopy services in England, commissioned the Centre for Workforce Intelligence to produce a report 'Securing the future workforce supply - Gastrointestinal endoscopy workforce review' published in March 2017 (3).

4. Five Endoscopy Units in Wales – in Brecon, Haverfordwest, Carmarthen, Aberystwyth, Llanelli and Bridgend - achieved JAG accreditation. Other Units across Wales have not met requirements due to waiting times, which are linked to capacity issues. Some Units will require redesign if this is to be achieved.

5. Increasing the capacity of endoscopy units across Wales, either by increasing the number of sessions worked across a 24-hour period, including weekend lists or by increasing the number of endoscopy theatres will require an increase in the complement of endoscopy nurses and administrative staff support and changes either to the pattern of list provision by existing endoscopists, or an increase in the number of endoscopists.

6. Strategic planning needs to ensure a competent, well-trained endoscopy workforce that provides high-quality and timely patient-centred care, with effective outcomes to support the requirements of the Cancer Delivery Plan for Wales (4).

Overview of the endoscopy workforce

7. In 2017, the JAG included in the Global Rating Score questions relating to workforce and pressures on the service. Their report 'Endoscopy in 2017: a national survey of practice in the UK' (5) details the summary data for the number of GI endoscopic procedures (table 1) and contributions from different endoscopists to the service (table 2).

Table 1 Number of procedures undertaken during 2016 in endoscopy services (rounded to nearest 1000 procedures, blank squares have <1000 procedures performed)

Procedures	England NHS acute (n=215)	England NHS non- acute (n=34)	Northern Ireland (n=11)	Scotland (n=43)	Wales (n=19)	England independent sector (n=162)	Total (n=484)
OGD (Oesophagogastroduodenoscopy diagnostic and therapeutic)	937 000	35 000	23 000	104 000	37 000	99 000	1 235 000
Colonoscopy (including BCSP)	670 000	23 000	18 000	83 000	27 000	90 000	911 000
Flexiblesigmoidoscopy (including BCSP)	416 000	17 000	6000	30 000	16 000	34 000	519 000
Any type enteroscopy	5000						5000
ERCP (Endoscopic Retrograde Cholangiopancreatography)	53 000	1000	1000	7000	2000	1000	65 000
Endoscopic ultrasound	27 000		1000	2000			30 000
Capsule endoscopy	12 000			1000		1000	14 000
Bronchoscopy	46 000	1000	2000	4000	2000	1000	56 000
Cystoscopy	105 000	12 000	2000	15 000	4000	23 000	161 000
Hysteroscopy	3000	1000				5000	9000
Colposcopy	1000					1000	2000

These data show the number done in the endoscopy unit and not the whole organisation (so excludes radiology, theatres and so on).
BCSP, Bowel Cancer Screening Programm; NHS, National Health Service.

Table 2 Numbers of endoscopists of different backgrounds employed in different sectors and the average mean number of lists performed per week (in brackets)

	England NHS acute (n=215)	England NHS non- acute (n=34)	Northern Ireland (n=11)	Scotland (n=43)	Wales (n=19)	England independent sector (n=162)
Consultant gastroenterologist	1507 (2.1)	81 (1.1)	44 (1.5)	171 (2.1)	71 (1.5)	838 (0.9)
Consultant colorectal surgeon	989 (1.0)	48 (1.0)	25 (1.1)	133 (1.3)	56 (1.0)	661 (0.8)
Consultant upper gastrointestinal/ hepatobiliary surgeon	475 (0.9)	21 (0.9)	7 (0.9)	56 (1.0)	25 (0.9)	259 (0.6)
Other consultants, for example, radiology	186 (1.3)	2 (1.0)	7 (1.7)	22 (1.1)	13 (1.5)	136 (0.6)
Nurse endoscopist	620 (2.5)	30 (1.9)	16 (2.3)	76 (2.7)	25 (1.6)	25 (1.20)
Other non-medical endoscopist	36 (1.6)	–	–	5 (3.0)	4 (0.25)	–
GP	51 (1.2)	30 (0.9)	29 (1.5)	22 (1.3)	1 (1.2)	10 (1.5)
Non-consultant grade medical endoscopist	235 (1.7)	7 (1.3)	9 (1.2)	23 (2.0)	8 (1.0)	8 (2.4)
Total	4099	219	137	508	203	1937

GP, general practitioner; NHS, National Health Service.

8. Across the seven Health Boards in Wales there are 19 endoscopy units providing regular NHS Endoscopy services.

9. Management structures for Endoscopy differ widely and staff contributing to the service are drawn from different directorates e.g. Medicine, Surgery, Radiology.

10. Guidance has been published from the British Society of Gastroenterology to provide a UK consensus on non-medical staffing required to deliver safe, quality-assured care for adult patients undergoing gastrointestinal endoscopy (6).

11. The certification requirements for endoscopist and nursing staff performing different type of endoscopic procedures are shown in Table 3.

Table 3. Type of procedure performed as part of endoscopy service and staff requirements

Procedure type	Endoscopist requirements	Nurse requirements
Diagnostic UGI endoscopy	JAG Certification in UGI endoscopy (n=200, JAG course, e-portfolio, S-DOPS*)	Core AWENcf competencies
Diagnostic flexible sigmoidoscopy (FS)	JAG Certification in FS (n=200, JAG course, e-portfolio, S-DOPS*)	Core AWENcf competencies
Diagnostic Colonoscopy	JAG Certification in Colonoscopy (n=300**, JAG course, e-portfolio, S-DOPS*)	Core AWENcf competencies
GI haemostasis	New JAG Certification standards (n=30, JAG course, e-portfolio, sign-off)	Advanced AWENcf competencies
ERCP	JAG Certification standards (n=300, JAG course, e-portfolio, sign off, mentor)	Advanced AWENcf competencies
Advanced mucosal resection	BSG guidelines, JAG recommendations	Advanced AWENcf competencies

12. To assist a deeper understanding of how individual Endoscopy Units can increase their capacity and productivity a more detailed and up to date survey of key information is required. This needs to detail for all Units which endoscopists contribute what sessions and whether additional sessions can be performed by a given endoscopist if capacity is to be expanded. This will allow a better understanding of the gaps in both the number of additional endoscopy sessions required to meet demand, and the nursing complement to support these lists, so assisting workforce planning and training requirements.

Workforce expansion

13. Consultant grade gastroenterologists or GI surgeons provide the largest contribution to endoscopy capacity. Endoscopy sessions within their job plans will vary from 0.5 to 5 endoscopy sessions per week and the type of endoscopic procedure they perform.

14. SAS doctors (specialty doctors, associate specialists, staff grades), research fellows and non-medical endoscopists (nurses, operating department practitioners, radiographers) provide an important contribution to diagnostic endoscopy capacity. Increased flexibility in their job plans makes this element of the workforce important in backfilling endoscopy lists at short notice ensuring no loss of capacity.

15. Health Boards need to urgently explore what additional sessional time can be engineered from its local workforce and what new staff, of various type and grade, may be required to support demand for all types of endoscopic procedure.

16. The time taken to train new endoscopists and endoscopy nurses must be factored into workforce plans. Historically endoscopy trainees spend their first 1-2 years learning upper GI endoscopy and between years 2-5 achieve competency in colonoscopy. Endoscopy nurses will need up to three months for induction and achievement of core competencies prior to independently assisting during endoscopy sessions.

17. The Welsh Endoscopy Training Network developed the SPRINT programme (Structured Programme for Induction and Training) to accelerate progress in upper GI endoscopy training and demonstrated significant reduction in time to JAG Certification – with most trainees being certified within nine months (7).

18. The SPRINT template for training was used as the basis for Health Education England's Non-Medical Endoscopist (NME) accelerated training programme which provided additional support and training resource and achieved certification for upper GI endoscopy and flexible sigmoidoscopy for the majority of NMEs in seven months (8).

19. Additional ongoing support and mentorship was essential for the non-medical endoscopists for aspects of practice such as lesion recognition and assessment skills and clinical decision-making.

20. Accelerated (SPRINT) training for colonoscopy was explored in a cohort of Welsh Speciality Trainees and delivered central elements successfully but was limited by the availability of colonoscopy training lists in base hospitals. This effect of high service pressure causing constraints on training list provision across Health Boards in Wales must be acknowledged when planning the training of new endoscopists.

Competency of the endoscopy workforce

21. The British Society of Gastroenterologists have set performance standards for upper GI endoscopy (9), colonoscopy (10), endoscopic retrograde cholangiopancreatography (ERCP) (11) and management of large polyps (12).

22. The National Colonoscopy Audit covering 20,085 colonoscopies and 2681 colonoscopists collected from 302 units showed that key performance indicators for colonoscopy in Wales were slightly inferior to those for other home nations (13).

23. Screening colonoscopists who have undertaken additional training and completed a certification process to participate in the Bowel Screening Wales programme have an annual review of their performance and operate within a performance standards framework. Data from this source demonstrates maintenance of high performance with caecal intubation rates of greater than 95%.

24. Local audit data (unpublished) suggests that a 'significant minority' of colonoscopists working within the non-screening colonoscopy workforce are not performing the minimum recommended number of colonoscopies per year and are not meeting BSG performance standards. An estimated 4% of colonoscopy capacity was lost by having to repeat incomplete colonoscopy tests by endoscopists not meeting BSG performance standards.

25. Regional list sharing was explored successfully in the Laparoscopic Colorectal Training Programme allowing Welsh Specialist Trainees to access lists available in neighbouring Health Boards – a similar scheme applied to Endoscopy training may increase effective training list capacity if trainees can be released from their base hospitals.

26. The National Endoscopy Database is now live and endoscopy units across Wales are required to upload data from their electronic reporting systems. This will provide a mechanism for benchmarking endoscopy performance standards against other regions of the UK.

27. The British Society of Gastroenterology Endoscopy Quality Improvement Programme (EQIP) is designed to promote ongoing improvement of endoscopists and endoscopy services. An EQIP meeting of ERCP practitioners across Wales has agreed a framework for improvement of services and wider sharing of key performance outcome data.

Existing resources to train different levels of staff

28. In 2006 the Welsh Endoscopy Training Network (WETN) was founded to provide access to hands-on endoscopy training courses and establish a JAG-approved Regional Training Centre. The administrative hub was based at the Welsh Institute for Minimal Access Therapy (WIMAT) with clinical centres in South East, West and North Wales.

29. WETN has trained more than 1000 endoscopists since its inception and WIMAT has gained an international reputation as a centre of excellence for simulation and endoscopy animal tissue model production and validation (14,

30. Over the past decade training leads have led the development of a range of JAG courses targeting various stages of endoscopy skills development (table 4). The WETN led the UK-wide validation process of the JAG polypectomy course in conjunction with training lead from other Regional Training Centres and is actively engaged in a similar process for the standardisation of the JAG Haemostasis course. This process ensures high quality teaching materials, standardisation of course design and quality assurance framework for course delivery.

Table 4. Type of courses developed to support endoscopy training at various performance levels

Pre-certification courses	Core therapy courses	Upskilling and Sub-speciality courses
Simulation courses (pre-ST experience)	JAG GI haemostasis course	ERCP Foundation course
Upper GI SPRINT programme	JAG Core Upper GI therapy course	Lesion recognition and assessment course*
JAG Basic Upper GI endoscopy course	JAG Polypectomy course	STEP-UP colonoscopy course**
JAG Basic Flexible Sigmoidoscopy course		Hi-FIVE - Human factors and team training
JAG Basic Lower GI endoscopy course		Training the Endoscopy Trainer

31. *Course materials in development – Upper GI and Lower GI versions aimed at senior trainees and independent practitioners. **Longitudinal training programme proposed for upskilling independent colonoscopists.

32. In association with the Welsh Endoscopy Nurse Training (WENT) committee a complete set of training courses to support the development of competencies mapped to the All Wales Endoscopy Nurse competency framework (AWENcf) [Table 5].

Table 5. Type of courses developed to support endoscopy nurse development (mapped to AWENcf)

ENDO 1	ENDO 2	ENDO 3
SECTION 1 & 2 AWENcf Competencies 1.1-1.5 and 2.1-2.9	Section 3 AWENcf Competencies 3.1-3.10	Section 4 & 5 Competencies 4.1-4.5 and 5.1-5.2

33. National Leadership And Innovation Agency For Healthcare (NLIAH) supported Level 7 training Endoscopy and endoscopy nurse practice modules developed in association with Swansea and Bangor Universities. This allowed nurses with an interest in developing skills as a nurse endoscopist or leadership roles within Endoscopy Units to gain additional training at 'Masters' level. Alternative models for in-house delivery of Level 7 training are being explored to

maximise learning within the workplace, paralleling work completed in other specialities.

The need for a National Endoscopy Training strategy

34. Welsh Assembly Government has acknowledged the accreditation standards for endoscopy services provided by the JAG. Training goals should include JAG certification of endoscopists.

35. A well-trained workforce will deliver higher quality, safer outcomes, and be more likely to deliver increased productivity and diagnostic yields. An example is in the higher yield of detected adenomas during colonoscopy – where every 1% increase in adenoma detection rate (ADR) is linked to improved survival rates from colorectal cancer (16).

36. An investment in training infrastructure for endoscopy is badly needed – no central funding has been given since March 2009. Equipment purchased in 2006 is now outmoded and in some of the original clinical training centres the training environment does not meet JAG quality assurance standards. Course fees contribute partially to covering an administrator salary, but the current programme runs on the goodwill of contributing faculty - this is not sustainable.

37. Detailed workforce data is required to understand the numbers required in different workforce groups, workforce gaps, and the numbers needing training at each level of the service. Tailored training may be required at different levels (table 6).

Table 6. National Endoscopy Training strategy – components required to support the endoscopy workforce

Entry Level	Independent Practitioners	Advanced Practice
Training cohorts of new endoscopists	Updates and endoscopic CPD	Training colonoscopists for BSW assessment
Accelerated training pathways	Upskilling performance	Advanced endoscopy fellowships
JAG courses	Supporting hands-on trainers	Mentorship programmes

A National Endoscopy Training strategy should address;

a. Funding settlement for state-of-the-art training equipment

b. Funding settlement for lead faculty members

c. A service-level agreement (once agreement is reached on the site of an upgraded clinical training centre) with Health Board 'ownership' of training facilities, release of sessional time for faculty leads in job plans and maintenance and replacement programme of training equipment.

d. Programming of all prioritised training needs to match requirements of multi-disciplinary workforce development and mandated JAG course provision.

e. An agreed programme evaluation strategy.

38. Several options for training infrastructure support in the setting of a need to expand the endoscopy workforce – the advantages and disadvantages to each of these options are shown (Table 7);

Table 7. Options for training infrastructure support for an expanding endoscopy workforce

Training support level	Advantages	Disadvantages
No change or investment	No cost.	Existing training infrastructure will cease to be able to provide effective training. Threat to maintaining JAG Regional Training Centre in Wales. Inequality in training provision across HBs. Slow progression of trainees through system. No balancing of training need across different levels of endoscopic practice in the workforce.
Target NME cohort training	Costs for commissioning understood. HEE course already proven (for OGD and FS only).	NME trainees will require integration with local systems with ongoing mentorship. Short-term intervention - single cohort addition to service. No resource enters the Welsh training network and disadvantages of 'no change' still apply.
Support for accelerated training in Wales of specified cohorts	Investment to support specific courses to give NME and selected medical trainees rapid training. Some balance to ensure equal selection across HBs is possible.	Short term support for central course elements, no investment in infrastructure. Progress will be slowed by lack of access to training lists in base hospitals. Other 'no change' disadvantages still apply.
Support given for new equipment to replace failed equipment in original clinical centres	Provides a spread of geographical resources to support running courses and central training pathway elements.	Costly to replace equipment in three or four centres – level of resource use is not optimal. Does not provide for faculty sessional time.
Support given for new equipment to replace failed equipment in original clinical centres	Provides a spread of geographical resources to support running courses and central training pathway elements. Maintains an existing WETN structure. Will support a JAG Regional Training Centre (RTC).	Costly to replace equipment in three or four centres – level of resource use is not optimal. Does not provide for faculty sessional time. No plan to address increased training list capacity. No provision for WIMAT support staff costs.
Support for an upgraded National Endoscopy Training Centre	Centres flexible training resource to meet training needs at all levels. Meets JAG RTC criteria. Provides 'best value' in terms of state-of-the-art resource being widely used. Provides the basis for ongoing training of cohorts of trainees in Wales. Incorporate training into an SLA agreement with HB ownership. Create specific training list capacity for national endoscopy training. Links to post graduate centres across Wales and to Imaging Academy.	Cost of training equipment for single upgraded Unit and lead faculty training time. Cost of WIMAT support staff.

39. Key stakeholders within the endoscopy training community propose the following elements as providing a cost-effective, state-of-the-art, integrated National Endoscopy Training infrastructure in Wales to support high quality training over the next decade;

a. JAG-approved Regional Training Centre status

b. Use the expertise of WIMAT as an administrative hub, source of technical expertise and to support an endoscopy simulation laboratory.

c. A single, well-resourced clinical training centre located on the M4 corridor, aligned to a single Health Board with a service-level agreement to provide agreed training capacity as a National Endoscopy Training centre.

d. A programme clinical lead, nursing lead and deputy leads.

e. Formally identified Health Board Endoscopy training leads – responsible for co-ordination of 'on-the-ground' training list delivery and organisation of elements of accelerated and other longitudinal training pathways. These appointees would also be expected to play an active role as faculty member on courses.

f. Facilities to enable transmission of training courses from the National Endoscopy Training centre into Postgraduate Training Centres across Wales to allow wider access to high quality training opportunities.

g. Develop an online training library to facilitate 24/7 access to learning resources.

h. Facilitate multi-professional training e.g. links to the Imaging Academy and opportunities for shared training e.g. MDT-style cross-speciality training.

40. A major factor identified by staff within NHS Wales as a barrier to further progression in endoscopy is the cost of mandatory endoscopy training. The central funding for such courses as part of strategic approach to recruitment and retention of Welsh healthcare professionals should be considered and would be likely to reduce training programme administrative costs.

41. The benefits of a state-of-the-art National Training Centre and National Endoscopy Training strategy would be considerable; producing a well-trained workforce, attracting the best endoscopists and nursing staff to Wales; improving staff retention; promoting patient safety; supporting quality improvement projects; strengthening multi-disciplinary networks across Wales; and providing a focus for research and innovative development in endoscopy.

42. The risks of not delivering a National Endoscopy Training strategy that predicts the increased demand on endoscopy services include;

a. Failure to identify staff requiring training in a timely fashion.

b. Inequalities in training provision and quality of training across Health Boards.

c. Slow progression of trainees through the training system.

d. Missed opportunities to improve clinical networks and the quality agenda.

e. Failure to attract and retain staff within the endoscopy service.

f. Endoscopy Service capacity limited by a lack of endoscopists.
g. No future-proofing of the endoscopy service.
h. Inefficient use of currently developed training resources.

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