Royal College of Physicians | Coleg Brenhinol y Meddygon (Cymru)

Endoscopy services in Wales

RCP Cymru Wales response

About us

The Royal College of Physicians (RCP) aims to improve patient care and reduce illness, in the UK and across the globe. We are patient centred and clinically led. Our 35,000 members worldwide, including 1,300 in Wales, work in hospitals and the community across 30 different medical specialties, diagnosing and treating millions of patients with a huge range of medical conditions.

Amdanom ni

Mae Coleg Brenhinol y Meddygon yn amcanu at wella gofal cleifion a lleihau salwch, yn y DU ac yn fyd-eang. Rydym yn sefydliad sy'n canolbwyntio ar y claf ac sy'n cael ei arwain yn glinigol. Mae ein 35,000 o aelodau o gwmpas y byd, gan gynnwys 1,300 yng Nghymru, yn gweithio mewn ysbytai a chymunedau mewn 30 o wahanol feysydd meddygol arbenigol, gan ddiagnosio a thrin miliynau o gleifion sydd ag amrywiaeth enfawr o gyflyrau meddygol.

For more information, please contact:

RCP head of policy and campaigns for Wales

Royal College of Physicians Cymru Wales
Baltic House
Mount Stuart Square
Cardiff CF10 5FH
+44 (0) 074 5812 9164
www.rcplondon.ac.uk/wales

Health, Social Care and Sport Committee
National Assembly for Wales
Pierhead Street
Cardiff CF99 1NA
SeneddHealth@Assembly.Wales

5 November 2018

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.

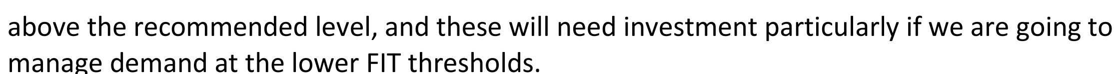
Key points

- 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.

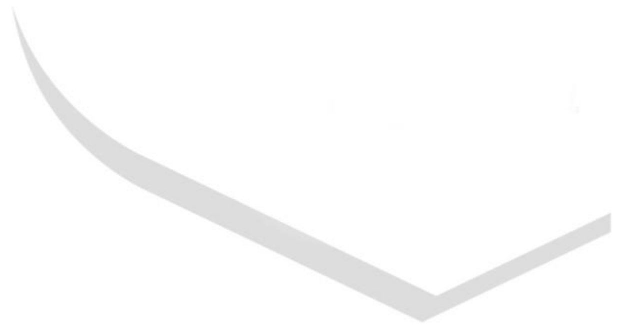
- **Consideration of other early diagnosis interventions and innovation, such as the introduction of FIT testing by general practitioners in symptomatic patients to reduce referral for diagnostic tests.**
  FIT may play a role in low risk symptomatic individuals, although few of these individuals are 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 RCP head of policy and campaigns for Wales with any questions.

Royal College of Physicians

JAG
Joint Advisory Group on GI Endoscopy



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

Siwan Thomas-Gibson
JAG Chair

11 St Andrews Place, Regent's Park, London NW1 4LE
Tel: +44 (0)20 3075 1620, www.rcplondon.ac.uk/accreditation
Registered charity no 210508

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-our-workforce/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

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

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

Dear Dr. Lloyd,

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

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

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

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

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

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

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

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

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

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

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

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

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

There have been detailed discussions with colleagues in Scotland (NHS Tayside) where the FIT pilot has been implemented as well as through external peer review involvement in the

pilots in various areas in the English NHS and liaison with the FIT pioneers group in England. This has led to a clear understanding that unless we work in parallel to improve our colonoscopy capacity and data collection, collation and evaluation the introduction of FIT into the symptomatic service may actually be counterproductive to the endoscopy service as well as lead to increase in patient anxiety rather than being of benefit.

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

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

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

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

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

With best wishes

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

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

Senedd health committee consultation on endoscopy services in Wales.

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)

DR NEIL HAWKES Endoscopy Lead CTUHB, Clinical Lead of the Welsh Endoscopy Training Network