Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gwasanaethau endosgopi

This response was submitted to the Health and Social Care Committee consultation on Endoscopy Services

EN 13

Ymateb gan: | Response from: Unigolyn | An Individual

Endoscopy services: follow up enquiry

Thank you for inviting views on the delivery of endoscopy services in Wales.

I am writing this based upon observation and in a personal capacity as a consultant gastroenterologist/endoscopist. I confirm that I am aged over 18 years old. **I do not wish for my name to be published alongside this information.**

The comments made below relate to sections 2, 3 and 4 of the outlined terms of reference (priority to endoscopy services; issues relating to recovering and improving waiting time performance; barriers to achieving JAG accreditation). Key areas of comment have been highlighted in bold.

The National Endoscopy Programme (NEP) should be complemented on progress in different areas such as the delivery of a structured training programme for clinical endoscopists.

There would be ***significant value in the NEP publishing an annual report to record changes implemented and associated outcome data*** (e.g. impact on demand / capacity). This would align to the National Clinical Framework and the Duty of Quality (The Health and Social Care Act 2020), as well as updating and maintaining engagement of those involved in delivering endoscopy services across Wales.

Several national bodies have published improvement opportunities for endoscopy services (NHS Improvement Hub: The Productive Endoscopy Unit (JAG endorsed); Getting It Right First Time (GIRFT): Gastroenterology). ***There is currently significant variation in endoscopy pathways both within and across health boards. There would be benefit in adoption of a similar approach, using evidenced-based improvement methodology to look at core endoscopy pathways with the spread of learning and innovation nationally.*** This would support health boards in planning and delivering endoscopy services based upon prudent and value based healthcare principals. Areas likely to yield the most significant impact include:

1. **Productivity/Utilisation**
   Excellent progress has been made in providing a national picture of endoscopy unit demand, activity and unit capacity. ***Inclusion of endoscopy unit productivity and utilisation data would highlight opportunities to increase capacity on a recurrent basis and to help clear the COVID related backlog.***

   Data including DNA (Did Not Attend) and CNA (Could Not Attend) rates and session finish times would identify variation across hospitals and potential national learning opportunities.

   Utilisation data would also identify any national themes and opportunities. As an example, in my base hospital endoscopy sessions have been vacant at least 25% of the time over the last 4 - 6 months in the main unit, with activity maintained through insourcing.

2. **Pathway variation**

   There is currently significant variation in endoscopy pathways from the point of referral both within and across health boards (e.g. straight to test suspected cancer colonoscopy rates have been shown to vary anywhere between around ***22 – 85%*** across organisations).

   Process mapping and knowledge of existing endoscopy service processes across Wales would identify potential opportunities to reduce endoscopy demand and opportunities to optimize pathways and increase throughput, with shared learning of best practice nationally. It would allow understanding as to what level of pathway variation & inefficiencies could be contributing to increased demand and reduced capacity, leading to risk of patient harm resulting from backlogs.

   Getting It Right First Time (GIRFT): Gastroenterology and NHS Improvement Hub: The Productive Endoscopy Unit (JAG endorsed) outline multiple examples of opportunities to improve efficiency and manage help demand (e.g. 'We recommend that trusts consider increasing their capacity for CT virtual colonoscopy, a non-invasive alternative to colonoscopy, which may be more suitable for some patients, depending on their health status. We found wide variation in how many CT virtual colonoscopy procedures trusts were carrying out, compared to colonoscopy.' 'Some trusts were performing over 12% of colonoscopies on patients aged 80 or over, while for others this figure was only 3%. Trusts need to review how well or frail a patient is, and whether they are an inpatient or an outpatient, before deciding whether a colonoscopy is appropriate, and when it should be performed if it is appropriate.')

3. **Workforce**

   As in other areas of the NHS, one of the principal constraints to endoscopy delivery appears to relate to workforce. ***Publication of national workforce data, gaps and plan across workforce groups (including administrative staff, endoscopy nurses and endoscopists) would provide insight into current constraints and potential solutions.***

   Inclusion of data related to staff retention rates (alongside staff satisfaction surveys – JAG requirement) would allow assessment of the impact upon endoscopy capacity. Snapshot workforce data would fail to represent existing challenges associated with a continuous cycle of retraining new staff, which results in reduced capacity.

References

https://www.england.nhs.uk/improvement-hub/publication/the-productive-endoscopy-unit/

https://gettingitrightfirsttime.co.uk/wp-content/uploads/2021/10/Gastroenterology-Oct21v.pdf