SCOPING THE FUTURE

An evaluation of endoscopy capacity across the NHS in England

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September 2015
Commissioned by Cancer Research UK

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Executive summary

Around half of us will be diagnosed with cancer in our lifetimes[i]. There are around 280,000 new cancer diagnoses in England every year[ii] and this is set to increase considerably as we live longer. Cancer survival is at its highest ever level, but the NHS in England is under considerable pressure. The '62-day wait' target - which states that 85% of cancer patients should receive treatment within 62 days of being urgently referred for suspected cancer by their GP – has now been breached for six consecutive quarters. This is indicative of pressures across the pathway – from seeing a specialist, to receiving a test, to getting results, and ultimately commencing treatment. New NICE guidelines on referral for suspected cancer are likely to exacerbate demand, as are changes to the bowel cancer screening programme. Action is now needed to ensure services are equipped to cope with rising demand.

Cancer Research UK commissioned this research to understand the pressures facing endoscopy services in England as a result of rising demand and to identify solutions for addressing these issues. Managing future demand and ensuring diagnostics can cope will be essential to improve cancer outcomes through early diagnosis. When cancer is diagnosed at an early stage, treatment options and chances of a full recovery are greater.

A number of challenges facing endoscopy services were identified through this research. These included:

- Rising demand for endoscopy services and a lack of capacity to respond to this increasing demand;
- More than 750,000 additional endoscopy procedures a year will be undertaken by 2020 – this is more than the population of Leeds and represents a 44 per cent increase on current activity;
- Workforce issues, including recruitment, retention, evening and weekend working and training and development;
- A need to improve productivity and efficiency, but a lack of 'headspace' to do so;
- Issues with data availability, quality and use.

Background

Endoscopy plays a vital role in the diagnosis of, and ongoing surveillance for gastrointestinal cancers, including bowel and oesophageal cancer. Endoscopy is also performed for the diagnosis, surveillance and treatment of a wide range of conditions and diseases that are not cancer-related. This study therefore considers the entire endoscopic service, and not just the ability of units to respond to increased demand for endoscopies related to cancer diagnoses or surveillance.

Demand for lower gastrointestinal endoscopies i.e. colonoscopy and flexible sigmoidoscopy has been reported as doubling between 2012 and 2017[iii]. In a financially constrained environment (the NHS is required to find £22bn in efficiency savings) increased demand will inevitably place pressure on endoscopy units.

A significant amount of work has been undertaken in the last 20 years to develop endoscopy services in order to improve quality, productivity and patient experience. However, in spite of these improvements, a more recent rapid review by the NHS Improvement Agency (2012) concluded that services were still encountering some key challenges in planning for increased demand and increasing capacity.

Research aims

Given the importance of endoscopy services within the cancer pathway it is critical that the organisation of this aspect of diagnosis, surveillance and treatment

delivers the capacity required. In light of this context and evidence, Cancer Research UK commissioned a research team from the Health Services Management Centre, University of Birmingham and the Midlands and Lancashire Commissioning Support Unit to undertake an evaluation of endoscopy capacity across the NHS in England to address the following key aims:

- Improve knowledge of current upper and lower gastrointestinal (G.I) endoscopy capacity in England;
- Ascertain by how much demand is likely to grow;
- Identify levels of resource (including staffing, equipment and facilities) necessary to meet growing demand;
- Estimate shortfalls in these resources, and;
- Understand what is causing this and how it can be addressed.

The findings of this report were shared with the Independent Cancer Taskforce, to inform the recently published cancer strategy, *Achieving World-Class Cancer Outcomes: a Strategy for England 2015-2020*. While this report shows a considerable gap between current capacity and demand for endoscopy services, if the Government and NHS bodies act to implement the recommendations of *Achieving World-Class Cancer Outcomes*, significant progress will be made towards delivering world class diagnostic services.

Recommendations

Meeting rising demand

Though many units described the steps they had already taken to respond to rising demand, the overriding impression from interviewees and survey respondents is of a service under increasing pressure. While units appear to have been managing waiting times to cope with increases in demand this has often meant putting on regular waiting list initiative sessions at weekends and in the evenings, or bringing in external staff through private companies to use their facilities during these times. These arrangements come with attendant additional costs which are ultimately unsustainable.

1. The Government should increase investment in diagnostic services, as set out in *Achieving World-Class Cancer Outcomes*, to ensure the NHS can meet rising demand and that our cancer outcomes become the best in the world. This should include a dedicated £125 million diagnostics fund over five years. For endoscopy specifically, investment will be needed to recruit and train new members of the workforce and replace ageing equipment.

2. NHS England and Public Health England should ensure learnings from the bowel screening programme are applied across the symptomatic pathway so there is not a two-tier system and patients receive a consistently high level of care regardless of their route into the health system.

Workforce

Staff shortages were commonly cited as the biggest barrier for units in managing demand. Though there were some issues mentioned in specific areas about a lack of physical space, many units have addressed this in recent years. However, using this additional capacity requires the appropriate workforce, including Consultant Gastroenterologists, Consultant GI Surgeons, Non-medical Endoscopists (including Nurse Endoscopists) and Senior Endoscopy Nurses.

There is some degree of variation between units as to where on the pay-scale Nurse Endoscopists sit which appears to be unwarranted in some cases. There were also concerns about staff experiencing stress and 'burn out' along with the potential for physical problems to develop, such as repetitive strain injury, as a result of

increasing the extent to which staff scope patients.

3. Strategic planning around workforce should happen at the national level, as stated in *Achieving World-Class Cancer Outcomes*. Health Education England is working with NHS England to deliver a training and development programme for Non-medical Endoscopists; this work should also include a robust assessment to determine the required number of trainees based on rising demand. Similar steps should be taken to ascertain the required level of new Consultant Gastroenterologists, Consultant GI Surgeons and Senior Endoscopy Nurses.

4. Commissioners should work with local services to ensure the protection of training lists so that staff are adequately trained.

5. Leadership teams should ensure the unwarranted variation between units in Nurse Endoscopists' pay is eliminated.

6. NHS England and the Department of Health should work to ensure all staff involved in the delivery of endoscopy services are prepared for the transition to 7-day working. This should involve the management of expectations from the recruitment stage, and the provision of appropriate compensation. In addition, local services should ensure job plans are appropriately balanced to encourage retention and avoid burn out.

Service Development and Improvement

The work of the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) and its accreditation process are internationally recognised as improving quality and productivity within endoscopy services as a whole, while strong clinical leadership was also highlighted as an important factor in ensuring the endoscopy service has a strong profile within its own organisation.

NHS IQ has recently produced the 'Productive Endoscopy' toolkit to support productivity and efficiency. This is now available to all units though its use is not yet widespread. However, many units felt that the 'low-hanging fruit' had already been addressed in their units and that any other improvement activities would require further resource. For example, a number of survey respondents commented that their Trusts were delaying replacing ageing equipment because of financial restraints.

The toolkit recommends the introduction of GP direct access to endoscopy where this does not already exist. The ACE (Accelerate, Co-ordinate, Evaluate) Programme is expected to produce evidence on best practice for innovative pathways, including GP direct access, which is mandated by both *Improving Outcomes: a Strategy for Cancer* and *Achieving World-Class Cancer Outcomes*. Respondents highlighted that the quality of GP referrals was variable and in places could be improved. Similarly, consultant-to-consultant referrals were also highlighted as a potential area for improvement.

7. NHS England should support services to achieve and maintain JAG accreditation. Services should also be encouraged and enabled through the commissioning process to make use of appropriate productivity tools.

8. Commissioners should consider innovative ways to meet rising demand, including alternative pathways and processes, such as supporting Straight to Test access to endoscopy through telephone triage/pre-assessment which would help to speed up diagnosis. In addition, increased collaboration between endoscopy units and strengthening links at the interface

between primary and secondary care could help to improve the quality and appropriateness of referrals.

Data Quality and Access

The datasets relating to endoscopy need improving so that it is possible to ascertain the reason why a patient has been referred for endoscopy (i.e. for surveillance, screening or symptomatic reasons). A National Endoscopy Database is in development, overseen by the JAG.

The data published on the activity and outcomes of the National Bowel Cancer Screening Programme is not as comprehensive as the data routinely published for other Cancer Screening Programmes (Breast and Cervical). Public Health England is working to produce data returns for publication, with the first return available in December 2015 (KC73) and a further return (KC72) by 2016. Data returns in their final form, will be developed by 2020. The process of assessing and processing information requests for researchers, which would not disclose patient identifiable information, could be streamlined.

9. The Health and Social Care Information Centre (HSCIC) should work with endoscopy providers to ensure that Hospital Episode Statistics (HES) contains a complete and accurate record of all NHS commissioned endoscopies, making changes to data specifications to identify whether a procedure is for surveillance, screening or symptomatic purposes.

10. Public Health England should work to ensure data on the activity and outcomes of the Bowel Cancer Screening Programme is routinely published in a format consistent with the breast and cervical screening programmes. Public Health England should also work to ensure there is timely access for researchers to appropriate data about the Bowel Cancer Screening Programme.

New Technologies

Given the scale of the anticipated increase in demand for endoscopy services, it is essential that any new technologies that are likely to increase demand in the future are properly planned for. One such example which is likely to increase demand on services is the introduction of the Faecal Immunochemical Test (FIT) to replace the Faecal Occult Blood Test (FOBT) as the primary test in the Bowel Cancer Screening Programme.

11. Public Health England (PHE), NHS England and the National Screening Committee (NSC) should undertake a strategic planning process to ascertain how best to manage the pressures which will inevitably be created in endoscopy services by the introduction of the Faecal Immunochemical Test (FIT) into the Bowel Cancer Screening Programme. Similarly, the ongoing rollout of Bowel Scope into the Screening Programme should take into account the pressures services are currently facing. Services should be supported to roll out these tests as swiftly as possible.

References

[i] Ahmad, A.S., Ormiston-Smith, N. and Sasieni, P.D. (2015)Trends in the lifetime risk of developing cancer in Great Britain: comparison of risk for those born from 1930 to 1960. *British Journal of Cancer*.

[ii] ONS, Cancer Registration Statistics, England, 2012. 2014, Office for National Statistics

[iii] NHS Improvement. (2012). *Rapid Review of Endoscopy Services*. NHS Improvement.

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