Agenda – Health and Social Care Committee

Meeting Venue:	For further information contact:
Committee Room 5 Ty Hywel and Video Conference via Zoom	**Helen Finlayson**
	Committee Clerk
Meeting date: 2 February 2023	0300 200 6565
Meeting time: 09.00	SeneddHealth@senedd.wales

Private pre-meeting (09.00 – 09.30)

1 Introductions, apologies, substitutions and declarations of interest

(09.30)

2 Endoscopy services: evidence session with cancer organisations

(09.30–10.30) (Pages 1 – 40)

Katie Till, Public Affairs Manager (Wales) Cancer Research UK

Gerard McMahon, Head of Policy & Influencing (Devolved Nations), Bowel Cancer UK

Research brief

Paper 1 – Evidence from Cancer Research UK

Paper 2 – Evidence from Bowel Cancer UK

Break (10.30–10.45)

3 Endoscopy services: evidence session with Public Health Wales

(10.45–11.45) (Pages 41 – 51)

Sharon Hillier, Director of the Screening Division, Public Health Wales

Steve Court, Head of Programme Bowel Screening Wales, Public Health Wales

Paper 3 – Evidence from Public Health Wales

Break (11.45-13.00)

4 Endoscopy services: evidence session with the National Endoscopy Programme and Wales Cancer Network

(13.00-14.00) (Pages 52 – 70)

Professor Sunil Dolwani, Clinical Lead for the National Endoscopy Programme

Professor Tom Crosby, Wales Cancer Network

Paper 4 – Evidence from the National Endoscopy Programme

Paper 5 – Evidence from Wales Cancer Network

5 Paper(s) to note

(14.00)

5.1 Letter to Digital Health and Care Wales regarding follow up information after the concurrent evidence session with the Public Accounts and Public Administration Committee on 26 October 2022

(Pages 71 – 75)

5.2 Letter from DHCW regarding follow up information after the concurrent evidence session with the Public Accounts and Public Administration Committee on 26 October 2022

(Pages 76 – 91)

5.3 Letter to Health Boards regarding Welsh Community Care Information System (WCCIS)

(Pages 92 – 93)

5.4 Letter from Aneurin Bevan University Health Board regarding the Welsh Community Care Information System (WCCIS)

(Pages 94 – 95)

5.5 Letter from Betsi Cadwaladr University Health Board regarding the Welsh Community Care Information System (WCCIS)

(Pages 96 – 97)

5.6 Letter from Cwm Taf Morgannwg University Health Board regarding the Welsh Community Care Information System (WCCIS)

(Pages 98 – 99)

5.7 Letter from Hywel Dda University Health Board regarding the Welsh Community Care Information System (WCCIS)

(Pages 100 – 103)

5.8 Letter from Swansea Bay University Health Board regarding the Welsh Community Care Information System (WCCIS)

(Pages 104 – 105)

5.9 Letter to the Deputy Minister for Mental Health and Wellbeing regarding the Food Supplement and Food for Specific Groups (Miscellaneous Amendments) Regulations 2023

(Pages 106 – 108)

5.10 Letter from the Deputy Minister for Mental Health and Wellbeing regarding the Food Supplement and Food for Specific Groups (Miscellaneous Amendments) Regulations 2023

(Pages 109 – 111)

5.11 Letter from the Local Government and Housing Committee regarding Corporate Joint Committees and the broader partnership landscape

(Page 112)

5.12 Letter from the Minister for Health and Social Services regarding dentistry

(Page 113)

6 Motion under Standing Order 17.42(ix) to resolve to exclude the public for the remainder of this meeting

(14.00)

7 Endoscopy services: consideration of evidence

(14.00–14.15)

Document is Restricted

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

Background

Endoscopy services play an essential role in investigating suspected bowel and upper gastrointestinal (GI) cancers and positive results from Faecal immunochemical testing (FIT). Bowel cancer is the fourth most common cancer in Wales and causes around 930 deaths per year[1]. However, if found early, it is also one of the most treatable cancers. When diagnosed at the earliest stage, more than 9 in 10 (94%) people with bowel cancer in Wales will survive their disease for five years or more, compared with around 1 in 10 (9%) people when the disease is diagnosed at the latest stage[2]. Endoscopy is also a vital diagnostic tool for upper GI cancers, including oesophageal and stomach cancers which affected over 2,600 people in Wales in 2017-19[1] and cause 698 deaths per year[3,] with the majority diagnosed of people diagnosed at stage IV (39.94% for oesophageal, 42.77% for stomach).[4]

The Endoscopy Action Plan was developed in response to the Health, Social Care and Sport Committee's recommendations following their 2018 inquiry into endoscopy services in Wales. The Endoscopy Action Plan set out a phased improvement plan to support Health Boards to develop sustainable endoscopy services covering 2019-2023. Much of the action of endoscopy improvement falls to the National Endoscopy Programme (NEP), which takes a nationally directed approach to endoscopy service improvement. The board is underpinned by four workstreams, demand and capacity, clinical pathways, workforce training and development, and facilities and infrastructure. The action plan set out a number of immediate, medium- and long-term goals to address some of the issues within endoscopy services in Wales. The plan set out where there was a need for improvement including better data to understand demand, capacity and productivity to feed into plans to address this, greater standardisation of referral pathways, and working toward accreditation of endoscopy sites.

Since 2019 the aims and areas for improvement in endoscopy in Wales remain much the same. Whilst concerted action has taken place and improvements have been made, driven by the NEP, the pandemic has had a detrimental impact and added pressures onto already stretched services. During the pandemic, endoscopy services were severely affected resulting in unavoidable delays for surveillance patients. COVID-19 is mainly spread via droplets and contact, with data supporting airborne spread during aerosol-generating procedures, including endoscopy[5]. In response to the pandemic, most gastroenterology societies, including the British Society of Gastroenterology (BSG) and Joint Advisory Group for Gastrointestinal Endoscopy (JAG), issued guidance advocating for the postponement on non-emergency cases, bowel cancer screening and surveillance[6] which have impacted on the cancer diagnostic pathway. The number of endoscopy procedures in Wales fell by 83.9% during the first three months of the pandemic (March-May 2020) compared to pre-pandemic levels.[7] The infection prevention and control measures put in place during the first phase of the pandemic were effective in reducing endoscopy-related transmission of COVID-19[8], however, they also dramatically reduced the number of procedures taking place, and therefore the number of patients receiving a diagnosis of cancer and other GI conditions. The pandemic also caused knock-on effects on the NEP, with staff being redeployed from frontline endoscopy services and the NEP to focus on the COVID-19 response.

In response to the COVID-19 pandemic and the disruption caused to services, in October 2021, the Minister for Health & Social Services approved the National Endoscopy Recovery Plan. The plan involves creating additional capacity regionally, to sit alongside local and national plans to improve endoscopy workforce availability and capacity. The National Endoscopy Recovery plan is a welcome step - increasing focus on capacity to ensure that patients can access endoscopy promptly and that the system is able to meet demand. Greater focus on increasing capacity as laid out in the recovery plan is encouraging, however, it is important to note that many of the issues existed before the pandemic, and concerted action is needed to continue to drive improvements in endoscopy in Wales.

Waiting times for endoscopy

The pandemic has exacerbated pre-existing challenges in endoscopy waiting times for urgent, routine, surveillance and screening appointments, and the latest waiting times data suggest the situation has seen little improvement. NHS cancer waiting times in September 2022 fell far short of meeting the vital treatment waiting time target of 75% of patients starting treatment within 62 days of being suspected of having cancer. For people with lower GI cancer in September 2022, only 35.1% of people with started their treatment within 62 days of being suspected of having cancer, compared to 37.4% in September 2021. For people with upper GI cancers, 57% of people started treatment within 62 days of being suspected of having cancer, compared to 58.9% in September 2021.[9] The NHS diagnostic waiting times for September 2022 show that over 16,000 people (64.6%) were waiting over 8 weeks for four key diagnostic endoscopy tests[i], far higher than pre-pandemic levels with only 2,888 people in this position in September 2019[10].

There is also significant regional variation between Health Boards in Wales. Cardiff & Vale Local Health Board performed the worst in both upper and lower GI cancer waiting times in the September 2022 cancer waiting times for Wales. Lower GI cancers were notably off-target waiting times across Wales, with Cardiff and Vale and Aneurin Bevan Local Health Boards particularly concerning at 19.0% and 25.0% of patients starting treatment within 62 days of first being suspected of cancer respectively[10]. In terms of NHS diagnostic waiting times for September 2022, Swansea Bay had the highest percentage of patients waiting 8 weeks or more for four key diagnostic endoscopy tests[1] (77%), whilst other Health Boards such as Cardiff and Vale (52.2%) and Betsi Cadwaladr (56.8%) performed significantly better.[11]

From the beginning of October 2022, bowel cancer screening was made available to more people in Wales, and is now open to 55 to 57 year olds, with plans for screening to eventually be made available to all over 50s. This means an additional 172,000 people aged 55 to 57 in Wales will receive FIT kits for home testing[11] by October 2023. The move to bring Wales in line with Scotland and the recommendations of the UK National Screening Committee (UK NSC) was a vital step which will make a significant difference to people with suspected cancer. This will also lead to a greater number of people being referred for endoscopies and adequate planning is required to ensure that there is sufficient capacity to meet the growing need.

Increasing capacity and the workforce to help clear the backlog and meet future demand in endoscopy is essential, however, there are also steps which could be taken on managing capacity and demand. Establishing a capacity and demand plan that includes endoscopy facilities, workforce,

[i] Four key diagnostic endoscopy tests are: colonoscopy, flexi-sigmoidoscopy, cystoscopy and gastroscopy

equipment and utilisation so that is clear what equipment is available, its current condition, and what staff are available to operate it, would allow for better short- and long-term planning.

Additionally, the NHS in Wales should look for innovative alternatives to endoscopy to enable better triage of patients and protect endoscopy services for those who need them, whilst allowing those who don't to receive a diagnosis more rapidly. Examples of alternatives which should be considered include the expansion of CT Colonography as an alternative to endoscopy for appropriate patients, further investigation on the potential of transnasal endoscopy (TNE), the use of Colon Capsule Endoscopy (CCE), and to expand the use of Cytosponge.

Recommendation

- **The Welsh Government and National Endoscopy Programme must ensure that the resources and investment are in place to support Health boards to actively plan and prepare for the increased levels of demand for endoscopy over the next couple of years due to the expansion in screening for bowel cancer**

Increasing capacity in endoscopy services

One of the main aims of the Endoscopy Action Plan is to enable improvement in endoscopy services to be driven at greater pace and with greater ownership by the NHS in Wales. So far, the recovery programme has seen four new endoscopy services go live in Wales, increasing the capacity for endoscopy in Wales and enabling more patients to receive this vital service more quickly.

However, more could be done to widen access and provide additional capacity to deliver diagnostic tests, such as the development of Community Diagnostic Centres (CDCs) which offer diagnostic testing including endoscopy provision outside of usual settings (though with consideration of acute services access in case of serious incident). Currently, there are no CDCs in Wales. This is in contrast to other UK nations, such as England where there has been the rollout of almost 100 such sites.

Wales is well ahead of the rest of the UK in the rollout of Rapid Diagnostic Clinics; however, these do not include endoscopy services suggesting there is scope to roll out a CDC-style initiative in Wales focused on boosting diagnostic capacity within the country including tests such as endoscopy. These services should be placed in areas of high need, including places with high levels of deprivation where they could make a marked difference in cancer diagnosis. Thinking strategically about the placement of sites could also help to reduce some of the current regional variation seen in endoscopy services in Wales.

Wales has also sort to address diagnostic capacity through the widening use of TNE. TNE can be performed non-sedated and be nurse-led as well as being performed in a community or mobile setting[12], these features can help lead to improvements in diagnostic capacity. The procedure has also been shown to be well-tolerated and preferred by patients compared to traditional endoscopy (oesophago-gastroduodenoscopy (OGD))[13,14]. However, the BSG has raised concerns with regards to image quality and diagnostic accuracy in TNE[15]. Since then, technological advances (such as Image enhanced endoscopy or virtual chromoendoscopy) have been found to potentially enhance gastric cancer detection[16,17]. Therefore, whilst TNE has the potential to improve diagnostic capacity and patient comfort, further evaluation considering diagnostic accuracy of TNE in Wales is needed.

Recommendations:

- **Health Boards, supported by the National Endoscopy Programme, must expand capacity for endoscopy, both making better use of existing sites as well as setting up new ones. Locations and service models for new sites should be considered strategically to take into account areas of high need**
- **The National Endoscopy Programme should ensure the use of TNE in Wales is accompanied by evaluation of its uptake by patients, diagnostic accuracy and impact on capacity**

JAG accreditation

Alongside increasing capacity for endoscopy, quality must also be maintained. Accreditation by JAG is a process that promotes quality improvement in endoscopy services by highlighting areas of best practice and areas of change. Services are assessed against four domains: clinical quality, patient experience, workforce and training[18]. Currently, there are only four JAG-accredited sites in Wales, out of a possible 25[19]. Whilst the NEP has rightly placed an emphasis on JAG accreditation, there is a risk that accreditation will not be achieved by all units across Wales. Whilst JAG accreditation is voluntary, it is an important way of ensuring that endoscopy services are continuing to meet quality standards. Maintaining quality of care for patients is vital, and therefore the importance of JAG accreditation should not be underestimated.

COVID-19 and pressures of capacity are having a knock-on effect on progress towards accreditation. Additional demand caused by the pandemic means that many teams feel unable to prioritise the work required for accreditation. Delays to accreditation can also be caused by a lack of support for the infrastructure improvements required to meet the accreditation standards. Ageing equipment and facilities, a lack of capacity to deliver the work required for accreditation due to a lack of staff, as well as a lack of focus by management to push for, and allow staff to prioritise, accreditation all pose barriers and cause delays.

Recommendations:

- **Welsh Government should support greater investment in infrastructure to prevent delays to JAG accreditation**
- **Health Boards should ensure that teams have the space, time and capacity to support the process of accreditation, and this should be built into local JAG action plans**

Bowel Cancer Screening

The UK NSC recommend biennial screening for people aged 50-74 years old, using the highest possible FIT threshold (down to 20µg/g). Wales has recently introduced bowel cancer screening, it is currently available biennially to people aged 55-74 years old, and a 150µg/g FIT sensitivity is used. The test sensitivity used in Wales at present is equivalent to that used in Northern Ireland, however, it is higher than in other nations of the UK, meaning that the test is less sensitive and therefore picking up fewer people for potential referral for further investigation. Scotland is ahead of all other UK nations, having biennial bowel cancer screening available to people aged 50-74, using an 80µg/g FIT sensitivity. England is inviting some people aged 56 and 58, and otherwise invite people aged 60-74, using a 120µg/g FIT sensitivity. Wales initially introduced FIT at a lower sensitivity (150µg/g) as this was felt to be feasible given the capacity of endoscopy at this time. Whilst it is unfortunate that endoscopy capacity is holding back Wales's ability to have a more sensitive test, which would pick up more potential early cancers, the realistic consideration of capacity as well as the ambition to increase the sensitivity of the test is welcome.

The 4-year bowel screening plan in Wales is a phased programme delivered by Public Health Wales which will see all people aged 50-74 years old invited for screening, with different ages invited in a phased approach (currently screening is only available for 55-74 year olds). By the end of 2024, the test sensitivity will also be increased to 80µg/g FIT. This approach is strongly encouraged and has the potential to improve overall bowel cancer outcomes, but the increase in activity must be taken into account in demand and capacity planning.

Consideration must also be given to who is benefiting from bowel cancer screening. The Wales Screening Division Inequalities Report 2020-21 suggests that, across all Health Boards, there is lower uptake in men, those living in more deprived communities, and across most Health Boards, in the youngest age group eligible for screening (60 to 64 years)[20]. It is important to address inequalities in screening and target lower uptake groups with support to help them make an informed decision about taking part in screening. Results from CRUK's awareness-raising campaign for bowel cancer screening show that public health campaign advertising and direct follow-up letters to first-timers and non-responders can increase uptake – with direct mail the most effective in addressing the barriers to uptake felt by first-timers and non-responders. The activity has also been shown to increase uptake in the most deprived groups compared to the least deprived groups for first-timers and previously screened, suggesting accurate, accessible and informative awareness-raising campaigns can help to address inequalities in screening.

Symptomatic FIT

There are two main ways FIT is used in the management of patients with lower GI symptoms: in primary care prior to an urgent referral or alongside an urgent referral, and as a triage test in secondary care to guide the management of patients who have been referred routinely or on an urgent referral pathway. The threshold for determining a positive result is lower than the national bowel cancer screening programme. For symptomatic patients, we recommend FIT is implemented in line with BSG guidance.

Symptomatic FIT is a useful tool for primary care aiding GPs' decision to refer, making it easier to manage a process for repeating FIT, ongoing tests and specialist advice, and referral of patients with a negative FIT result but ongoing clinical suspicion or unresolved symptoms/signs. In secondary care, FIT is a powerful triage test, allowing patients who are symptomatic but have a FIT <10 to be put on patient tracking lists to prevent them from getting lost in the system, and ensuring the specialist has responsibility for following up and acting on the FIT result. To ensure this pathway remains robust and effective there needs to be continued commitment from Health Boards for FIT symptomatic testing, with established business cases, adequate staff capacity and ongoing engagement with primary care.

Younger people

In those eligible for bowel cancer screening, the Wales Screening Division Inequities Report 2020-21 found that people in the youngest age group eligible for screening at the time (60 to 64 years) are less likely to participate in bowel cancer screening[21], and so, targeted awareness raising of screening in this group could be beneficial.

As bowel cancer is less common in younger people (aged under 50), screening for this age group is not recommended. However, it is important to note that bowel cancer rates are increasing in adults aged between 20 and 50[21], and bowel cancer cases increased on average by up to 7.3% each year in 30 to 39 year olds between 2005 and 2014[22]. The overall incidence in people under 50 years old remains very low in absolute terms, and so the benefits of bowel screening currently do not

outweigh the harms in these younger groups. The evidence on this will continue to be kept under review to inform UK NSC recommendations.

The timely recognition and referral of younger people with symptomatic bowel cancer is important. As per BSG guidance, FIT may be used to stratify adult patients aged younger than 50 years old with bowel symptoms suspicious of a diagnosis of colorectal cancer.

Lynch Syndrome

Lynch syndrome is a genetic condition with no known cure which predisposes people to a high risk of colorectal cancer. NICE guidance recommends that all people with colorectal cancer[23] and endometrial cancer[24] are tested for Lynch Syndrome. The BSG guidelines recommend that people with Lynch syndrome should have colonoscopic surveillance every 2 years aiming to reduce their lifetime risk of bowel cancer or detect bowel cancer as early as possible[25].

Currently, genetics teams are responsible for referring people with Lynch Syndrome to symptomatic bowel services for surveillance colonoscopy. From 1 April 2023, people with Lynch Syndrome in England will be included in the NHS Bowel Cancer Screening Programme for surveillance. We recommend that the NHS in Wales consider adopting this approach for people with Lynch Syndrome in Wales as well.

Recommendations:

- **Inequalities in screening must be addressed, Public Health Wales should consider launching an awareness-raising campaign for bowel cancer, specifically targeting lower uptake groups to help them make an informed decision about screening**
- **The NHS in Wales should consider developing a national screening and surveillance programme for people with Lynch Syndrome delivered through Bowel Screening Wales**

Diagnostics workforce

The NHS cancer workforce suffers from chronic shortages, with the most pressing shortages in diagnostic services. The 2021 national census of UK endoscopy services identified a total of 5973 endoscopists employed across services in the UK, with workforce shortages cited as an ongoing issue[26]. Significant growth in the NHS workforce, requiring significant investment, will be needed. Admirable efforts have already been undertaken to boost the recruitment of healthcare professionals, including endoscopists, such as targeted recruitment campaigns. However, increasing the healthcare workforce will take time and more immediate solutions are needed.

Medical education and training

The most important way to meet the growing need for endoscopy services is through long-term investment in medical education and training to increase the number of staff able to perform vital diagnostic tests such as endoscopy.

To support retention and ensure the right balance of skills across the system, Health Boards should also consider providing funding and opportunities to support the workforce to work differently and maximise capacity. For example, funding can be provided which enables staff to lead efforts to work more effectively, provide training for other parts of the workforce, or generally upskill.

The adoption of skill-mix approaches – where roles and responsibilities of a team are designed around the needs of the patient, rather than traditional organisational boundaries – in the diagnostic

workforce can help increase capacity. Health Boards should consider whether they are able to backfill the roles of upskilled staff and, if not, take steps to enable this, for example by recruiting more support workers. Health Education and Improvement Wales should ensure courses are designed with flexibility in mind, aiming to reduce geographical and financial barriers to participation.

Recommendations:

- **Welsh Government must commit to long-term investment in growing the number of healthcare professionals able to perform endoscopy through recruitment, education and training**
- **Health Education and Improvement Wales, national and local health leaders should tackle the barriers to adopting skill-mix approaches**

Workforce plans

The limited data currently available on diagnostic staffing pressures makes it difficult to make informed decisions on current and future workforce planning. The Welsh Government need to take a more strategic approach to workforce planning to address long-term shortages in the diagnostic workforce. In endoscopy specifically, there is a need for a more robust method of collecting data, and better data sharing to effectively feed into an accurate and informed national workforce plan. A more comprehensive understanding of why people are leaving the endoscopy workforce is a prerequisite to an effective plan to reduce this. Both nationally and locally, comprehensive and standardised data on why people leave jobs in the endoscopy workforce should be collected, to feed into future policies that aim to minimise burnout and maximise retention.

Other measures can make a difference in ensuring the current NHS workforce is used most effectively in Wales. Recent studies in England have shown regional variation in both the distribution of the primary care workforce and turnover rates of GPs, with the most deprived areas having fewer GPs and higher turnover rates creating knock-on effects on services.[27, 28] The All-Wales National Nursing Bank has the potential to make a huge difference in the overall efficiency of the workforce, helping to plug gaps and reducing regional staffing disparities. This initiative should be rolled out as soon as possible, with endoscopy flagged as a priority area.

The BSG Workforce Report 2021 found significant regional variation within Wales for population per whole time equivalent (WTE) consultant gastroenterologist/hepatologist, with North Wales the second worst performing region in the UK at 71,004 people per WTE consultant[29]. Whilst the report does not specifically focus on the number of endoscopists per region in Wales, it does indicate a wider issue around geographical variation in the workforce for professions associated with bowel cancer which must be addressed. Better data collection and sharing should help illuminate the real regional variation, whilst workforce sharing arrangements, alongside targeted recruitment and training programmes could help to address some of this disparity.

Recommendations

- **The Welsh Government need to work closely with Health Education and Improvement Wales to take a more strategic approach to workforce planning, with robust data collection and better data sharing**
- **The NHS in Wales need to ensure innovative workforce-sharing arrangements, such as the All-Wales National Nursing Bank, go online as soon as possible, with endoscopy flagged as a priority**

Retention

Even before the pandemic, supporting the wellbeing of and maximising retention in the endoscopy workforce was recognised as vital. COVID-19 has further damaged the wellbeing of a workforce that was already struggling. A survey by Public Health Wales between June and August 2021, found that 71% of nurses, midwives and healthcare support workers in Wales said their mental health had worsened since the beginning of the pandemic, and almost 60% had considered leaving the profession since the pandemic, with the figure even higher for early-career nurses.[30]

A major driver of staff leaving the workforce is concern around work-life balance, demonstrating how a lack of capacity in itself can lead to burnout and harm retention. Allowing staff considering retirement the option of working part-time may aid retention. Healthcare providers should ensure that the option to work less-than-full-time is available to staff, particularly those approaching retirement, while future workforce planning should account for this growing preference when projecting the future supply of staff needed. More generally, healthcare providers should consider modifying the job plans of those nearing retirement – for example by making on-call duties opt-in rather than opt-out.

Recommendations

- **Health Boards should normalise and embed flexible working practices and ensure that the option to work less-than-full-time is available to staff**

Innovation in endoscopy

Innovative technologies have the potential to ease some of the burdens on the endoscopic workforce. Cytosponge, CCE and symptomatic FIT are examples of tools that have been shown to help triage patients based on their risk of having cancer. Whilst some progress has been made in trialling these innovations in Wales, there is still significantly more work to be done before they are utilised to their full potential.

CCE is currently being trialled in four of the seven Welsh Health Boards, in projects led by the NEP. These are key examples of the impact the NEP can have in bringing together clinical and research expertise to improve services and diagnostics for patients in Wales. It's encouraging to note that the project also aims to establish a national reporting pool of trained doctors and nurses who can review the images remotely. Focus should be maintained on these trials, as well as looking to expand access to CCE across Wales.

Cytosponge has seen less adoption, with one trial currently in progress in Wales, supported by the Moondance Cancer Initiative[31]. This is in sharp contrast to other nations within the UK, such as Scotland and England, where the technology is being trialled across multiple trusts. With no need for sedation or local anaesthetic, and requiring less equipment, infrastructure and staffing resource than a diagnostic UGI endoscopy, Cytosponge has the potential to bridge the gap between demand and service provision.

People can be reluctant to visit their doctor with digestive symptoms due to fear of endoscopy[32], however, delaying diagnosis can lead to worse outcomes. Cytosponge and CCE are less invasive and less stressful for patients, potentially making patients feel more comfortable coming forward for testing[33,34]. Given the potential benefits for both triaging patients to ease pressures on endoscopy services and for increasing timelier diagnosis, the NHS in Wales should embrace the potential of

innovative technologies, whilst also giving Health Boards the support to ensure effective implementation.

Recommendation:

- **The National Endoscopy Programme should encourage Health Boards to embrace innovative technologies such as CCE and Cytosponge, expanding trials throughout the country**

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[10] Four key diagnostic endoscopy tests include colonoscopy, flexi-sigmoidoscopy, cystoscopy and gastroscopy. Waitlists include all people referred for these tests, not just those ordered for suspicion of bowel cancer. Pre-pandemic levels is compared to same month in 2019. StatsWales. Diagnostic and Therapy Services Waiting Times by month. Accessed November 2022. Available from: https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Diagnostic-and-Therapy-Services/waitingtimes-by-month

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Endoscopy services: follow up inquiry

Bowel Cancer UK

Overview

We welcomed the Endoscopy Action Plan when published in 2019 and believe significant progress has been made in a number of areas. There are parts of the bowel cancer pathway that still require improvements, but we recognise the efforts of the National Endoscopy Programme Board (NEP) to work within the backdrop of COVID-19.

The speed and accuracy of diagnosing bowel cancer is of critical importance to patient outcomes. Bowel cancer is the second biggest cancer killer in Wales. However, it shouldn't be because it is treatable and curable especially if diagnosed early.[1] Nearly everyone survives bowel cancer if diagnosed at the earliest stage. However, this drops significantly as the disease develops.

Latest figures from StatsWales show bowel cancer patients continue to face delays getting diagnosed following an urgent suspicion of cancer referral. These diagnostic delays mean many patients fail to start vital treatment within the 62-day target (from referral with suspicion of cancer to the commencement of treatment).

The extent of the delays to accessing diagnostic tests, such as colonoscopy, varies across the nation with figures for September 2022 showing slightly higher than one third of lower gastrointestinal (GI) patients, including bowel cancer, were seen within this time. Only 35.1% of patients began treatment within 62 days in September's data[2]. This is a significant way short of where performance against the target (75%) should lie.

These waiting times figures show there is still a long way to go to deliver sustainable and robust endoscopy services across Wales.

COVID impact and increasing demand

The COVID pandemic led to a reduction in bowel cancer services in the NHS in Wales with a significant drop in referrals and investigations, as well as a considerable pause to the bowel screening programme.

Whilst these were understandable decisions taken to reduce transmission and prioritise patients requiring emergency treatment, as well as to ease the demand for Personal Protective Equipment (PPE), the disruption saw endoscopy procedures reduced substantially and this in turn has impacted upon delivery of all the objectives set out in the original Endoscopy Action Plan.

Endoscopy clinics were felt to provide a particular risk due to the increased chance of airborne transmission and many gastroenterologists were redeployed to support general medicine due to their dual accreditation as general physicians.

Lower GI referral data (available since December 2021) shows the total numbers being referred into the cancer diagnostic pathway and helps to show changes in demand.[3]

The data suggests that referrals for suspicion of lower GI cancers has increased in recent months (May 2022 to September 2022) with approximately 3,200 referrals each month. This is an almost 25% increase on the number of referrals seen during the previous five months. However, the data shows little change in the number of people being diagnosed with lower GI cancers each month.[2]

Bowel Screening Programme

Bowel Screening Wales faced a backlog of approximately 19 weeks following a pause of the screening programme in 2020. Since the resumption of the bowel cancer screening programme there has been a fantastic effort by staff to tackle the backlog. The 19-week backlog was recovered by September 2021.

This recovery was driven by a large increase in invitations to the programme and these successful efforts allowed Bowel Screening Wales to progress with planned optimisation of the programme. At the end of October 2021, the age criteria for eligibility were widened by including 58 and 59 year olds and more recently, in October 2022, the age criteria were widened further to include 55 to 57 year olds[4]. Previously invitations would be sent out to those aged 60-74 only.

Plans are in place to increase access further, dropping the age of eligibility to 50 years of age, while also increasing the sensitivity of the FIT test by dropping the positivity threshold to 80µg Hb/g faeces from the current level of 150µg/g. This programme of optimisation is scheduled to make its final changes in October 2024.

These changes would bring the bowel screening programme in Wales in line with the eligibility and sensitivity criteria seen in Scotland. England has plans for age reduction and while the FIT threshold is currently lower than seen in Wales (120 µg/g), there are no plans to bring this down to 80 µg/g at the current time. Northern Ireland published a cancer strategy in March 2022 which commits to reducing both age of eligibility and FIT thresholds to those sought by Bowel Screening Wales. There are no published optimisation plans for bowel screening in Northern Ireland at the current time.

The UK National Screening Committee (UKNSC) recommends further reductions in the sensitivity of the FIT test with a reduction to 20µg/g.[5] No nation of the UK has set out plans to reach this recommended level to date.

With the successful completion of optimisation of bowel screening in Wales in 2024, there is an opportunity for Wales to move to a UK-leading position by further optimising FIT thresholds to the 20 µg/g level advised by the UKNSC as being the most cost-effective FIT threshold.

At this level of sensitivity, the bowel screening programme would be more likely to identify patients at higher risk of developing bowel cancer in future and remove polyps to reduce this risk. This would alleviate financial pressure on the NHS however it would place further demand on screening colonoscopy lists, so investment in workforce would be essential.

The Welsh Government should support Bowel Screening Wales to explore the possibility of moving to this lower threshold when the current programme of optimisation ends. This would require a clear understanding of current and future demand based on demographic changes and the workforce required to meet future demand.

The bowel screening programme in Wales should also take steps in the coming years to prepare for a risk-stratified or personalised approach to bowel screening. Research is set to commence that will explore the impact of a number of demographic indicators (eg sex, ethnicity, deprivation, etc) on personal risk and how this may lead to a more flexible model of screening.

We welcome recent agreements to introduce GP endorsement letters, these have been shown to be effective at increasing uptake of bowel screening.

JAG accreditation

The Endoscopy Action Plan set out a recommendation that Health Boards would continue to work towards Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation.

JAG accreditation is a key component in delivering robust and sustainable screening colonoscopies and combined with lower FIT thresholds, can lead to a higher likelihood of detection of patients with bowel cancer and of those at higher risk of developing bowel cancer in future.

While work continues on this issue there have been delays and this objective is not likely to be met by the end of the original timeline. COVID has had a large impact on this workstream, but the NEP continues to seek ways to support Health Boards with the JAG accreditation process.

A number of sites across Wales have been identified as having the greatest likelihood of achieving accreditation in the next year, and they will be given focused support to achieve this goal.

qFIT – the symptomatic pathway

A key recommendation within the Endoscopy Action Plan was to set out a standardised referral pathway to endoscopy. The NEP published an agreed pathway in 2021.[6] qFIT can be used by primary or secondary care staff to help guide the management of patients with bowel cancer symptoms onto the correct referral pathway so they can be seen urgently.

While most Health Boards have adopted the new pathway in primary care, there is one Health Board yet to complete this process. We are aware that a rollout of the referral pathway by GP clusters in this area should be completed in the next few months. This is an important step in improving the bowel cancer diagnostic pathway.

qFIT is a test similar to the FIT used in bowel screening but with a lower sensitivity threshold (i.e. 10 µg/g). It is for people presenting with symptoms of bowel cancer and can be used, by GPs for example, to aid their decision to refer. This has the potential to reduce unnecessary colonoscopies and alleviate demand on colonoscopy services.

While the evidence is still being gathered across the UK, early indications are that the inclusion of qFIT in referral guidance could see a reduction in the number of people referred to secondary care services (-15.1%).[7]

Following the publication of a consensus on the use of qFIT, by the British Society of Gastroenterology and the Association of Coloproctology of Great Britain and Ireland in June 2022[8], there is now work underway to update NICE guidance. Embedding this consensus in formal NICE guidelines will solidify the role of qFIT in the referral pathway.

Innovation – Colon Capsule Endoscopy (CCE)

The pandemic has induced a culture of innovation and uptake that could bring significant benefits for bowel cancer patients in years to come. Faced with the widespread disruption of routine services, the NHS had to innovate either through the accelerated adoption of new technologies or changing clinical practice in terms of how patients are diagnosed, managed, and treated.

CCE has the potential to be particularly transformative through improving the diagnostic experience for patients and reducing the demand on traditional endoscopy services. The cameras are swallowed and then take pictures of the bowel as they pass through the colon. They can be used at home enabling patients to go about their normal day as well as reducing the demand on colonoscopy services so that those requiring urgent further tests can be prioritised.

A recent study has also shown the potential for Artificial Intelligence to support clinical decision-making and ensure that patients with advanced bowel cancer receive the right treatment.[9]

Training for the use of CCE has taken place across all Health Boards in Wales and a pilot has recently begun in four Health Boards. Bowel Cancer UK has been involved in the rollout of CCE in Scotland[10] and England, and we are prepared to support efforts in Wales too.

Building on innovations adopted throughout the pandemic will rely on ensuring that the infrastructure is in place to continually monitor their performance. If deemed effective, solutions should be scaled-up in a timely and appropriate manner to help increase capacity and improve patient experience of diagnostic and treatment services.

This monitoring should extend to assessing the impact of these innovations on reducing health inequalities. For example, the increased use of virtual clinics is widely viewed as one of the pandemic-induced innovations that should be embedded in the coming years. However, it will also be important to consider the impact of the reduction in face-to-face appointments for patients who rely on this service and aren't able to access the appropriate digital tools.

Lynch syndrome – testing and surveillance

In 2019, Wales became the first UK nation to commit to testing all newly diagnosed bowel cancer patients for Lynch syndrome. This condition can be passed from generation to generation and increase lifetime risk of bowel cancer by up to 80%.

The NEP has discussed conducting a Lynch audit to understand whether testing is being conducted as promised. Unfortunately, due to increasing pressures resulting from the pandemic, this audit has not taken place. We would like to see an audit of Lynch testing and surveillance to determine the current state of play, and to better understand what barriers may exist.

England, from April 2023, will incorporate Lynch surveillance within their bowel screening programme. This means that a more formalised programme of follow up with those at higher risk of developing bowel cancer will take place, with participants being screened every two years.

An additional benefit is that with screening colonoscopists being JAG accredited in English screening hubs, the quality of investigation will be higher for this at-risk group.

We believe Lynch syndrome surveillance in Wales should also be brought into the bowel screening programme, as JAG accreditation progresses, to improve surveillance among people with Lynch syndrome.

Workforce and equipment

The two biggest overarching barriers that have continually undermined attempts to improve bowel cancer outcomes, and that must be urgently addressed, are the chronic workforce and equipment shortages across bowel cancer diagnostics, and unwarranted regional variation and health inequalities.

Replacing old equipment and investing in additional kit, combined with further resources to deliver increased training places for endoscopists would create an environment where pressures on equipment and staff capacity are reduced. This would lead to improved outcomes for patients as they access speedier and more accurate diagnosis.

We recognise and welcome recent increases to workforce across the diagnostic pathway, in particular a recruitment drive in endoscopy, in Wales but the historic data in relation to cancer waiting times reinforce the need for greater action to address workforce capacity issues.

A comprehensive workforce strategy that aims to meet the demands of the future and not only those of today is needed urgently to ensure continued progress in endoscopy services and to underpin the aims of the anticipated Cancer Services Action Plan.

Long-standing issues with diagnostic workforce capacity have been exacerbated by the impact of the COVID pandemic. A workforce strategy that aims to prepare the NHS for the future must also aim to build in the additional capacity that is required to absorb shocks to the service, thus ensuring continuation of services as far as possible.

Reduced pressure on workforce and equipment capacity will also lead to the time and space for local services to innovate and transform, keeping to the forefront of technological advances to the benefit of their patients.

Reducing inequalities and variation

Bowel cancer services are subject to significant variation across the whole patient pathway from awareness of the signs and symptoms of bowel cancer, access to screening, and quality of care. This variation affects people from different population demographics and socioeconomic groups leading to inconsistent outcomes across the country and feeding into many existing narratives around healthcare inequalities. For example, people from deprived populations are almost half as likely to recognise a change in bowel habit as a potential symptom of bowel cancer.

Uptake of screening varies significantly according to several factors including socioeconomic status, ethnicity, gender, and age. Asian people are half as likely to take up screening compared to the rest of the population, with rates being particularly low amongst Muslims.[11] Uptake of screening is also lower amongst men, at 55% compared to 60% for women, whilst a large prospective study found that women with disabilities are

25% less likely to participate in bowel screening.[12] Bowel Screening Wales commissioned Learning Disability Wales to review accessibility within the bowel screening programme for people with learning disabilities and have accepted their recommendations. We welcome this move by Bowel Screening Wales as it is a clear indication of the focus on widening accessibility of the screening programme.

Patient information

Clear and accessible information for people concerned about bowel cancer symptoms or going through the bowel cancer diagnostic pathway is crucial.

Bowel Cancer UK provides a number of resources for patients and clinicians. The following are examples of the information available to people with concerns about bowel cancer or who are going through the diagnostic pathway:

https://www.bowelcanceruk.org.uk/about-bowel-cancer/our-publications/

https://www.bowelcanceruk.org.uk/about-bowel-cancer/symptoms/

https://www.bowelcanceruk.org.uk/about-bowel-cancer/diagnosis/

https://www.bowelcanceruk.org.uk/about-bowel-cancer/screening/

https://www.bowelcanceruk.org.uk/news-and-blogs/coronavirus-faqs/

Patient awareness of potential signs and symptoms of bowel cancer and timely presentation is a key driver of variation in outcomes. A recent survey, conducted by YouGov on behalf of Bowel Cancer UK, indicated that 45% of people in the UK are not aware of a single symptom of bowel cancer.[13]

Levels of awareness have a strong association with socioeconomic status as people from more deprived populations are less likely to recognise signs and symptoms of cancer than those in the least deprived.

Patient information aimed at increasing informed uptake across all demographics would improve the effectiveness of the screening programme, for example. To increase informed uptake, interventions must be targeted at groups where uptake is particularly

low such as ethnic minorities, people from low socioeconomic groups and disabled people whilst there is also a need to address the perceived stigma around bowel health.

Wider issues affecting uptake include concerns around the cleanliness of the test, misconceptions that the test is not applicable if people don't have any apparent symptoms, and fear and denial around the outcome. Measures that have been shown to be effective at increasing uptake are often based in primary care through the provision of a GP endorsement letter combined with face-to-face health promotion.

In the symptomatic pathway, work should be undertaken to ensure patients are clearly informed about the reason(s) for their referral and what to expect in the diagnostic pathway, including estimated timelines that reflect the Optimum Pathway.

Conclusion

The work of the NEP, Bowel Screening Wales and staff throughout the NHS, from GPs to SSPs, endoscopists to gastroenterologists, we have seen big strides within the bowel cancer diagnostic pathway.

There are still major concerns regarding the length of time people are waiting for their diagnosis of bowel cancer and this must be addressed through investment in recruitment, training, workforce planning and equipment.

Wales has set in place many foundations on which a sustainable endoscopy service can be built but it will require further focus and support from the Welsh Government to achieve such an outcome.

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Health and Social Care Senedd Committee
Inquiry into Endoscopy Services

Public Health Wales' Written Response

December 2022

1 Purpose

The purpose of this submission is to respond to the additional questions raised by the Health and Social Care Senedd Committee in relation to the inquiry into endoscopy services.

This submission focuses on the following key areas relating to the provision of the Bowel Screening Wales (BSW) programme and symptomatic faecal immunochemical testing (FIT) service including the:

- Impact of the COVID-19 pandemic on the BSW programme and the delivery of screening colonoscopy procedures
- Waiting times for screening colonoscopy and measures taken to manage this situation
- Progress against the plan to optimise the bowel screening programme in Wales and how the position compares to other UK-based bowel screening programmes
- Primary care access to symptomatic FIT and how this is being used to prioritise patients for endoscopy.

Bowel Screening Wales (BSW) aims to reduce the number of people dying from bowel cancer in Wales through early identification of cancer when treatment is more likely to be successful and through the removal of pre- cancerous growths. From October 2022, people aged from 55 to 74 years are invited to take part every two years. Eligible people are sent an invitation and a FIT test kit to their home address to complete and send to the screening laboratory for analysis to identify if there are small amounts of blood in the faecal sample, more specifically, the globin component of human haemoglobin.

Those who are identified as having blood in their faeces are offered further investigations in endoscopy (screening colonoscopy). Those who are referred for screening colonoscopy have a high pathology yield with over 70% having polyp detection and 10% bowel cancer detection. Evidence shows that 90% of people who have a bowel cancer diagnosed through screening are expected to be cured. Public Health Wales commissions colonoscopy and diagnostic services (radiology and pathology) from the seven health boards in Wales.

2 The impact COVID-19 has had on the delivery of endoscopy services and the implementation of the national endoscopy action plan, and the implications of this for patient outcomes and survival rates.

2.1 Pause of the Bowel Screening Programme

In March 2020, it was evident that the onward referral pathways for screen-positive participants who required further investigations in endoscopy were increasingly being impacted by the effects of the Coronavirus pandemic. This situation was under regular review at this time and on the 17 March 2020, following risk assessments and discussions with Welsh Government officials, Public Health Wales recommended a temporary pause of the adult screening programmes. The recommendation considered the Welsh Government's announcement of plans to suspend non-urgent outpatient appointments and non-urgent surgical admissions and procedures in order to redirect staff and resource to support the pandemic, and the UK Government guidance to stop non-essential social contact and travel. Welsh Government officials confirmed their acceptance of the recommendation and a proactive press release was issued on the 20 March 2020 which included a quote from the Minister for Health and Social Services.

This resulted in BSW pausing screening invitations from the 20 March 2020 and by the 30 March 2020, all screening colonoscopy procedures had ceased across Wales in response to recommendations issued by the British Society of Gastroenterology that stated that all but emergency endoscopy procedures should stop immediately. Computed Tomography (CT) Colonography procedures in radiology had also ceased at this time.

During this pause period, BSW introduced a temporary pathway to mitigate risks involving the use of CTs for the abdomen and pelvis for screen-positive participants who were identified with symptoms associated with bowel cancer, in order to highlight them for possible surgical intervention (this pathway operated from the 24 April to the 31 July 2020).

As COVID-19 cases started to reduce from May 2020, plans to reinstate COVID-19-safe screening pathways against agreed criteria were implemented, and the risk-based and phased implementation of the paused programmes started from June 2020 with Bowel Screening invitations restarting on the 1 July 2020.

As a consequence, the bowel screening programme in Wales was paused for 19 weeks from the end of March to July 2020, during which time approximately 110,000 screening participants were overdue their screening invitation

2.2 Restart and Recovery of the Bowel Screening Programme

On the 1 July 2020, BSW re-started the screening programme in a phased, risk-based manner. The first phase involved re-issuing screening kits to approximately 3,000 participants who had a screening test kit rejected for testing during the programme pause, with subsequent reinstatement of weekly screening invitations to the eligible population from the 7 August 2020. From November 2020, BSW

ensured that participants due their first screening kit were prioritised and not delayed their screening offer, given that these participants were deemed higher risk than those who had previously been screened by the Programme.

BSW put in place a plan to recover the screening programme following the pandemic pause, by increasing the quantity of weekly screening invitations to enable a reduction of the 110,000 individuals who were overdue a screening test kit. The additional volume of screening invitations varied between 20-30% in response to the impact of the ongoing pandemic on secondary care services and temporarily reverted back to baseline volumes of 6,000 weekly invitations during the second COVID-19 wave in January and February 2021. This process of over-inviting re-commenced in March and continued throughout 2021, with recovery of the bowel screening invitation backlog completed on the 24 September 2021.

The introduction of the screening FIT in 2019, increased uptake by 10% (55% with guaiac faecal occult blood test to 65% with FIT). Screening uptake immediately following the restart of the Programme in August and September 2020 was high at 69% and 68%, respectively and this increase has been maintained and is currently at 67% (October 2022).

The bowel screening programme has undertaken a range of initiatives aimed at reducing inequalities and increasing screening uptake. These include targeted interventions aimed at increasing screening uptake amongst individuals who did not return their screening test kit (non-responders) with the use of a GP endorsed reminder letter from the individual's GP practice and a follow-up telephone conversation to those who did not respond to the letter. In the latest intervention of this type conducted within Hywel Dda University Health Board in late 2021, these interventions increased bowel screening uptake by 13% in this targeted group of non-responders. BSW has also adjusted the wording of its Programme literature and website to make them more accessible to participants, has translated leaflets into multiple languages and is currently working closely with Learning Disability Wales to make adjustments to make bowel screening more accessible to participants with learning disabilities.

As detailed in the recent inequity report, the inequity gap which is the difference between uptake in the least deprived communities compared to the most deprived communities, was 14.5% for Bowel Screening in 2020/2021 which was an improvement of 2% compared with 2019/2020.

2.3 Impact on Screening Colonoscopy

Screening colposcopy services ceased to be offered across Wales from the 30 March 2020 and restarted in a staggered approach between June and August 2020. As a consequence, 32% less screening colonoscopies were performed in 2020 compared to 2019 (2077 in 2020 compared to 3056 total screening colonoscopies performed in 2019).

Whist BSW ceased referring participants for endoscopy during the Programme pause, a backlog of screening participants awaiting a colonoscopy had developed as

a consequence of endoscopy services ceasing to operate from March 2020. The plan to recover the screening programme by inviting additional people each week resulted in additional referrals to colonoscopy, with waiting times for screening colonoscopy as long as 28 weeks in some centres during 2020 and 2021.

BSW modelled colonoscopy demand based on the volume of additional participants being screened each week to recover the Programme. This showed that every 10% rise in the volume of weekly screening invites, increased the number of weekly screening colonoscopy referrals by six across the whole of Wales. Consequentially, the number of screening colonoscopies performed in 2021 (3809 procedures) increased by 25% compared to the pre-pandemic 2019 volume (3056 screening colonoscopies).

Public Health Wales commissions screening colonoscopy services from the seven health boards in Wales. Representatives from BSW met regularly (and continue to meet) with the health board endoscopy teams to share the screening colonoscopy demand data generated by Programme recovery and discuss options to increase screening colonoscopy capacity. The screening colonoscopy demand data was also shared with the National Endoscopy Programme's 'Demand and Capacity' subgroup. In addition, screening participants demonstrating 'red flag' symptoms were expedited for screening colonoscopy or referred to the GP if screening could not be expedited.

3 Issues relating to recovering and improving waiting time performance including: reducing waiting times for diagnostic tests and imaging to eight weeks by spring 2024 and support for people waiting for tests and follow up appointments; active waiting list size for all current inpatient and day-case patients waiting for endoscopic procedures (by modality); extent to which elective capacity is impacted by emergency activity and whether there is sufficient data to understand the impact of emergency cases; whether high risk patients requiring ongoing surveillance endoscopic procedures are included in current demand and capacity planning models; scope for upscaling lessons learned from previous waiting list initiatives such as insourcing, outsourcing or mobile units and what the current demand and capacity modelling tells us about when a sustainable position can realistically be achieved.

Waiting Times for Screening Colonoscopy and Measures taken to Help Manage this Situation

3.1 Components of the Bowel Screening Colonoscopy Waiting Time

The turnaround time for a participant sending in a screening test to the laboratory for testing consistently meets the seven days standard at 100%, and usually the result is sent within 48 hours of receipt. Those participants who have a screen negative result are returned to routine recall and invited again in two years if still within the eligible age range. Those participants who have a screen positive result

are asked to contact the programme to book a Specialist Screening Practitioner (SSP) appointment.

The total time a screen-positive participant has to wait for a screening colonoscopy is made up of two components, the time taken for a pre-colonoscopy assessment with a SSP and the subsequent time to receive the screening colonoscopy procedure. Combined, these component waits make up the total time a screen-positive participant is waiting for a screening colonoscopy. A screening colonoscopy can only take place once the pre-assessment to determine medical fitness to proceed has been performed, so any prolonged waits for pre-assessment will impact adversely on the colonoscopy waiting time.

3.2 Waiting Time for Pre-Colonoscopy Assessment with a SSP

All screen-positive participants receive an assessment with an SSP to explain the colonoscopy procedure, evaluate fitness for colonoscopy and to discuss any alterations to medication regimes prior to the screening colonoscopy. Once completed, those who are deemed fit are offered the next available screening colonoscopy appointment in their local hospital or referred for radiological examination (CTC) if deemed unfit. The majority of assessments are conducted over the telephone, with occasional need for a face-to-face assessment as determined by medical need or communication barriers.

Waiting times for SSP assessment have been prolonged on occasions since the restart of the Programme in July 2020 and ranged from 5-12 weeks in October 2021. This was caused by staff shortages in some units (COVID-19 and non-COVID-19 related absences), the increased volume of participants requiring assessment following Programme recovery and the loss of nursing staff to the local COVID-19 response in some units.

In response, BSW conducted an option appraisal to evaluate measures that could be implemented to reduce waiting times for pre-colonoscopy assessment, with the following initiatives implemented:

- BSW central nursing team assisted the SSPs in the pre-assessment, result and attendance at the colonoscopy procedures in response to acute staff shortages.
- BSW central administration staff assisted the hospital-based administration staff during staff shortages (where geographically feasible).
- Change in process to allow SSPs to conduct pre-assessments from home (subject to strict Information Governance requirements). This change enabled those SSPs who were self-isolating, but well enough to work, to continue to provide the pre-assessment service.
- A reduced pre-assessment pilot process was introduced that utilised enhanced participant information leaflets and a pre-assessment questionnaire. This resulted in a 25% reduction in the time taken to complete a telephone assessment and has been implemented across all 13 screening centres.

- Temporary funding to increase screening administration support in the local screening endoscopy units to ensure SSPs are relieved of administration tasks, thereby increasing the capacity of these screening nurses.
- Removal of management audits from the SSPs, with these now performed by the central BSW nursing team. This removes a further administration burden from the SSPs to enable them time to perform additional assessments and attend more screening colonoscopy procedures.
- Allow health boards to use insourced SSPs to attend screening colonoscopy lists (subject to satisfactory quality assurance checks), thereby enabling weekend screening lists whenever BSW SSPs were unavailable.
- Recruitment of additional SSPs and administration staff from April 2021 to support the planned optimisation of the Programme (with further funding being released from April 2023)

As a consequence, the waiting times for SSP assessment have since recovered in all 13 local screening assessment centres and are all now being conducted within the BSW 14-day standard (waiting time range for SSP assessment across the 13 local assessment centres was 5 to 12 days on the 11 November 2022).

3.3 Waiting Time for Screening Colonoscopy

Immediately following the pandemic pause in 2020 and through 2021, screen-positive participants were waiting as long as 28 weeks in some health boards for their first screening colonoscopy procedure. The total waiting time in April 2021 ranged from 4-28 weeks (average waits of 14 weeks) and between 7-28 weeks in October 2021 (average waits of 12 weeks). Currently, screening participants are waiting 8.5 weeks on average for their first screening colonoscopy (November 2022), with one health board currently an outlier with a waiting time of 20 weeks and BSW is actively working with them to address this.

3.4. Strategies to Increase Bowel Screening Colonoscopy Capacity

BSW managers continue to meet regularly with the endoscopy teams in every health board to discuss screening waiting times, share screening demand modelling data and investigate options to increase screening colonoscopy capacity. The following initiatives to increase screening capacity have been implemented at different times and in differing health boards since July 2020:

❖ Review of the BSG Colonoscopy Surveillance Guidelines

In 2019, the British Society of Gastroenterology (BSG), the Association of Coloproctology of Great Britain and Ireland (ACPGBI) and Public Health England (PHE) published consensus surveillance guidelines for the management of post polypectomy and colorectal cancers. In November 2019, the National Endoscopy Programme (NEP) published a document detailing the implementation of these guidelines. Between January and July 2020, BSW reviewed and applied the new surveillance pathway to 3,600 screening surveillance participants. This review

resulted in a number of participants moving either to a 3-year colonoscopy surveillance interval (from a one year colonoscopy surveillance) or removed entirely from surveillance, with a resultant increase in available capacity in endoscopy.

❖ Accreditation of Additional Screening Colonoscopists

Due to the nature of the small and subtle polyps found at screening colonoscopy, as well as the high pathology yield (i.e. 70% polyp detection and 10% cancer detection), BSW, in line with the English and Northern Irish screening programmes, requires that screening colonoscopy procedures can only be performed by Colonoscopists who have sufficient experience and skills to satisfy the accreditation standards set by the Joint Advisory Group on gastrointestinal Endoscopy (JAG).

In 2019, BSW had 18 accredited Screening Colonoscopists performing 21 screening colonoscopy procedures on a weekly basis. During 2020, an additional two individuals became accredited to perform screening colonoscopies, with another five accredited to date, the latest of which is the first Clinical Nurse Endoscopist to achieve screening accreditation in Wales (accredited on the 26 November 2022). Currently, BSW has 25 Screening Colonoscopists across the seven health boards, with another two individuals due for formal assessment in early 2023.

To assist this process, BSW works collaboratively with the JAG to administer the screener accreditation process, with certification of screeners issued by the JAG. In addition, BSW offers a range of support to all prospective candidates to maximise their chances of achieving accreditation, including review of key performance indicators prior to applying to become Screening Colonoscopists, local mentorship with assessors in their screening centre and bespoke, one-to-one, weekend mentorship sessions immediately prior to the formal assessment.

To encourage the future recruitment of Screening Colonoscopists, representatives from the bowel screening programme and colleagues from the NEP and the English screening programme presented at the recent Welsh Association of Gastroenterology and Endoscopy (WAGE) conference to explain the accreditation process, detail the support provided by BSW to candidates and raise awareness of the role of Clinical Nurse Endoscopists in screening.

❖ Alterations to Screening Colonoscopist Job Plans

In addition to the recruitment of additional Screening Colonoscopists, there is a need for some existing Screening Colonoscopists to adjust their job plans to allow them to undertake the screening colonoscopy procedures their health board is commissioned to provide. This approach is encouraged by BSW during the discussions with the health board endoscopy teams and this approach has proved to be successful at enabling additional local screening capacity, with clinician's backfilling the accredited Colonoscopists' more general medical roles. However, many health boards find this process difficult to implement due to a lack of clinicians to undertake the roles currently performed by the Screening Colonoscopists.

❖ Use of Insourced Screening Colonoscopists

In early 2021, the BSW Programme Board agreed to accept the use of insource Screening Colonoscopists within the bowel screening programme in Wales. All such individuals must be JAG accredited as Screening Colonoscopists and satisfy a range of strict key performance indicators before being sanctioned to perform BSW colonoscopy procedures (including a review of the screening data from their host national programme). To date, insourcing of screening colonoscopy has been undertaken in four of the seven health boards to assist with the reduction in screening backlogs and backfill lost lists caused by staff absences.

❖ Provision of Additional Screening Lists

All seven health boards have provided additional screening colonoscopy lists on an ad hoc basis to meet the increased demand, be these additional lists at weekends using waiting list initiatives or additional weekday lists. The provision of additional screening lists is dependent on the availability of nursing (SSPs and endoscopy nurses), Colonoscopists and endoscopy rooms, as well as competing demands of the symptomatic colonoscopy service.

4 The current position for optimising the bowel cancer screening programme (i.e. for increasing Faecal-Immunochemical Testing (FIT) sensitivity and age testing) and how this compares to other parts of the UK

4.1 UK National Screening Committee (UK NSC) Recommendation (August 2018)

In response to the UK NSC recommendation in August 2018, that all bowel screening programmes should optimise bowel screening by offering FIT-based screening to those aged between 50-74 years at as low a threshold as possible, BSW developed a multi-stage plan to optimise the bowel screening programme in Wales as outlined below.

4.2 Introduction of FIT as the Primary Screening Test

BSW commenced the rollout of FIT into the Welsh screening programme as planned in January 2019, with the initial roll out of 1:28 screening participants randomly issued with the FIT kit instead of the card-based guaiac faecal occult blood test. This new screening test was phased in during 2019, with all screening participants in Wales issued the FIT kit from September 2019. The FIT kit offered benefits of increased specificity, automated laboratory analysis and single, easier, sample collection, the latter of which helped improve participation rates for bowel screening by 10% compared to the previous test.

In order to meet the available colonoscopy capacity in 2019, the positive threshold (cut-off) for the screening FIT was set at 150 micrograms (µg) of haemoglobin/gram (g) of faeces. This continues to be the current positive screening FIT threshold in Wales.

4.3 Age Expansion and Changes to the Screening FIT Positivity Threshold

In collaboration with expert advisors, BSW initially developed a two-year plan to increase the eligible screening age from 60-74 to 55-74 from 2020, followed by a further expansion to 50-74 years from 2021. This process was due to commence in April 2020 but was not started due to the COVID-19 pandemic and subsequent screening programme pause.

During 2021, BSW reconvened its Optimisation Advisory Board to re-evaluate the Programme's plan for optimisation and it was agreed that due to the impact of the pandemic on available endoscopy service provision and waiting times, a more realistic approach would be adopted due to the impact of the pandemic on health services.

Instead of expanding the eligible screening age over two years, it was agreed this would be extended over a four-year period, with concurrent alteration to the screening FIT threshold during the latter two years as follows:

- From October 2021 – expand the eligible screening age to include those aged from 58-74 (FIT cut off of 150)
- From October 2022 – Further expand the age range to 55-year-olds (55-74), with the FIT cut off remaining at 150
- From October 2023 – Expand the eligible screening age to 51-74 and reduce the FIT threshold (increase kit sensitivity) from 150 to 120 µg/g
- From October 2024 – complete the age expansion process, by inviting all those aged from 50, whilst completing optimisation by reducing the screening FIT threshold to 80µg/g.

BSW has successfully completed the age expansion to the 58-year-olds on schedule between October 2021 and September 2022, and commenced the next phase of the revised optimisation plan on target, when those aged from 55 years started to receive their screening kits from the 5 October 2022 (rollout to all those aged between 55-57 years due to completed by September 2023).

This expansion to 55 years will add an additional 172,000 screening invitations per annum (estimated 492,000 invites per year), with future age expansion as planned, resulting in an estimated 537,000 individuals being issued with a bowel screening kit per annum from October 2024.

BSW has shared detailed demand modelling to all health boards and the NEP based on these invitation volumes. This suggest that the number of screening colonoscopy procedures will rise from 4,600 to 6,900 this year and plateau at over 12,000 procedures on completion of screening optimisation in September 2025.

The consequential anticipated increase in screen detected cancers rises from 330 when those aged from 58 were screened, to over 500 during the next two years and over 870 with completion of the planned screening age expansion and FIT sensitivity change. Prior to the optimisation of the bowel screening programme in 2019, approximately 10% of all newly diagnosed colorectal cancers in Wales were detected through screening. BSW modelling indicates that this screen detected proportion is expected to increase to almost 45% per year upon completion of the optimisation process in 2025.

4.4 Comparison with the other UK National Bowel Screening Programmes

As stated above, BSW plans to complete the process to meet the UKNSC recommendation for optimisation of the bowel screening programme in Wales by September 2025, when all individuals registered with a GP in Wales aged between 50 and 74 years will be invited for screening every two years using FIT at a positive threshold of 80µg/g.

The Scottish bowel screening programme is already offering screening to people aged 50 to 74 years for screening every two years using a FIT threshold of 80µg/g. Unlike the other UK-based bowel screening programmes, the Scottish programme is only responsible up to the delivery of the screening FIT results. All screening colonoscopy or CTC procedures are the responsibility of the local health boards and does not require the Colonoscopist to be accredited. This is a different model to other UK screening programme who commission diagnostic bowel screening services and only allow accredited screening Colonoscopists to perform screening procedures.

The English Bowel Cancer Screening Programme (BCSP) programme has commenced its optimisation process and has invited those age 56 years (the previous bowel scope eligible population) since 2021 and recently started inviting those aged from 58 years in 2022, using a FIT positive threshold of 120µg/g. The programme in England has a similar plan and timeframe to complete the optimisation of its programme to Wales.

Northern Ireland is using screening FIT at a positive cut off of 150µg/g, but has not commenced the age expansion and, as such, is currently inviting those aged between 60-74 for screening every two years.

5 Primary care access across different health boards to FIT for patients who do not meet the criteria for a suspected cancer pathway referral and how it is being used to help services prioritise patients and stratify referrals by risk (outpatient transformation)

Prior to the publication of the National Endoscopy Programme's National Framework document there was growing interest in the potential use of Symptomatic FIT to prioritise patients and stratify risk. The initial NICE guidance documents (NG12 and DG30) highlighted the potential of FIT to manage risk, and all-Wales guidance from the National Endoscopy Programme was considered key to implementing this on an effective and equitable all-Wales basis.

Working closely with the National Endoscopy Programme and interested health boards across Wales, the Public Health Wales Screening Division Laboratory indicated its ability to support the Framework. The FIT test and analysers were already in use within the laboratory to provide testing on behalf of Bowel Screening Wales. Beginning in mid-2020, and as part of Public Health Wales's commitment to provide mutual assistance across NHS Wales during the height of the pandemic, the offer was made to all health boards to offer symptomatic FIT testing on their behalf to mitigate harm due to impact of pandemic on health care systems to risk assess symptomatic patients to prioritise the capacity of colonoscopy.

The symptomatic FIT test can identify possible signs of bowel disease by detecting small amounts of blood in faeces, more specifically the globin component of human haemoglobin. The laboratory utilises the recommended threshold of 10µg/g of faeces above which investigations should be triggered. The result is returned to the requesting clinician to enable the risk stratification of patients and effective management of referrals to colonoscopy, with the potential to reduce the 'Numbers needed to scope' (NNS) in order to detect one CRC.

The laboratory currently provides Symptomatic FIT testing to primary care services across five of the seven health boards in Wales (Aneurin Bevan, Betsi Cadwaladr, Cardiff and Vale, Powys and Swansea Bay). This provides coverage to approximately 75% of the population. Uptake has risen over this time as population coverage has increased, and the laboratory is now testing around 5000 samples per month. The service is based on electronic referrals made by the requesting clinician, which are received by the laboratory each day. A test kit is then sent to the patient via Royal Mail, the patient takes the sample, and returns it to the lab in the post. This model is demand-led and is scalable to meet the needs of primary care. It is intended to be readily accessible to clinicians without the need for them to manage test kit stock, and for the patient it provides an easy-access service. The commissioning health boards are responsible for the follow up of the patient result, and the subsequent risk stratification. The laboratory provides safety netting data to local service coordinators to facilitate this.

Health and Social Care Committee Endoscopy services: follow up inquiry

Written Evidence Submission:
Hayley Heard – Programme Lead, National Endoscopy Programme
December 2022

Background

1. The National Endoscopy Action Plan (which can be found on the Welsh Government website at https://gov.wales/sites/default/files/publications/2019-10/national-endoscopy-programme-action-plan-2019-2023.pdf) was published in October 2019. The action plan clearly sets out the original, pre pandemic NEP work plan for 2019-2023.

2. The action plan's immediate phase actions were completed on time and a diagnostic workshop was held on 6th March 2020, presenting its findings and recommendations for delivery of the overall aims.

The impact COVID-19 has had on delivery of endoscopy services and the implementation of the national endoscopy action plan, and the implications of this for patient outcomes and survival rates.

3. In March 2020 Welsh Government announced the suspension of all non-urgent outpatient appointments, surgical admissions, and diagnostic procedures, due to high risk of transmission of the Covid-19 virus and the prioritisation of Personal Protective Equipment (PPE). This significantly impacted all endoscopy services across Wales, and the UK.

4. The British Society of Gastroenterology (BSG) swiftly issued further advice recommending all non-emergency endoscopy procedures should be stopped.

5. The Bowel Screening Programme also suspended its service, until July 2020.

6. Between March and June 2020 staff within the endoscopy teams and the NEP were recruited to support the emergency and critical care management of Covid-19 patients.

7. The National Demand and Capacity (D&C) modelling tool developed by the NEP as part of the action plan, showed in April 2020 there was only 6% of the total endoscopy activity delivered compared to Feb 2020 (fall of 94%).

8. In light of the significant challenges faced within endoscopy services across Wales, understanding that delivery of the original action plan would be affected by the pandemic; the NEP rapidly developed a recovery plan that was signed off by the NEP Board and presented to the Welsh Government in April 2020.

9. The NEP and BSG produced recovery guidance in May 2020 setting out 3 phases to recovery. It also sourced and produced a plethora of information and guidance to support recovery such as air flow guidance in endoscopy units.

10. In October 2020 the NEP submitted a refreshed Action Plan (which can be found on the Welsh Government website at https://gov.wales/sites/default/files/publications/2020-12/national-endoscopy-programme-revised-action-plan-october-2020_0.pdf) which set out the original actions planned for the immediate, stabilisation and sustainability phases of the programme; achievements to date and revised deadlines for delivery of remaining actions; along with the additional actions necessary to support Health Boards recover from the pandemic.

11. The NEP Board agreed the extension of the programme to December 2023 in order to continue progression of the action plan.

The priority given to endoscopy services in the Welsh Government's programme for transforming and modernising planned care, including who is responsible for delivering improvements through the reconfiguration of services and new models of care (including additional endoscopy theatres, diagnostic centres and regional units), and how endoscopy services will feature in the new cancer action plan (expected to be published autumn 2022).

12. The Covid-19 pandemic exacerbated many pre-existing challenges within endoscopy services across Wales, and Health Boards are under increased pressure to manage the backlog of patients awaiting an endoscopy procedure, as well as build a sustainable endoscopy service for the future.

13. In October 2021 the Welsh Government Minister for Health and Social Care approved the NEP recovery plan and the deputy CEO for NHS Wales and Deputy Chief Medical Officer for Wales wrote to Health Board CEO's setting out the overall approach to include:

    I. Maximising outputs from existing units
    II. Continuing health board short term additional activity i.e., insourcing, waiting list initiatives
    III. Considering business cases for permanent local increases in capacity
    IV. Procurement of managed service contracts to develop regional units

14. The NEP published action plan & additional components of the recovery plan have been developed into an integrated work plan.

15. In October 2021 Regional Operational Groups supported by the NEP were established to develop plans to deliver the NEP recovery plan, in line with the Welsh Government Minister for Health and Social Care's approach.

16. The NEP established within their core team a regional lead who links in with HBs on a regular basis to provide support, information sharing and continuity.

Issues relating to recovering and improving waiting time performance, including: reducing waiting times for diagnostic tests and imaging to eight weeks by spring 2024 and support for people waiting for tests and follow up appointments; the active waiting list size for all current inpatient and day-case patients waiting for endoscopic procedures (by modality); the extent to which elective capacity is impacted by emergency activity, and whether there is sufficient data to understand the impact of emergency cases; whether high risk patients requiring ongoing surveillance endoscopic procedures are included in current demand and capacity planning models; the scope for upscaling lessons learned from previous waiting list initiatives such as insourcing, outsourcing or mobile units; and what the current demand and capacity modelling tells us about when a sustainable position can realistically be achieved.

17. The recovery of the pre-pandemic endoscopy waiting list position was already challenged for NHS Wales, with work carried out prior to 2020 identifying a shortfall in capacity to deliver against demand levels (based on no improvement in productivity) of between 18 and 25 lists per week throughout Wales.

18. April 2020 saw a drop-in overall endoscopy activity of 94% in comparison to February of the same year due to the effect of COVID-19 and the resulting closure and redistribution of key health care services having a dramatic effect on endoscopy capacity. Whilst this dramatic change in activity would result in an increase in the total size of the waiting list, this was somewhat mitigated by a corresponding fall in the number of endoscopy requests, with a fall of 78% observed in the same month when compared to February 2020.

19. Both the numbers of activity and of requests received would continue to recover toward pre-COVID levels as the year progressed. Activity would climb from 6% of pre-COVID levels in April 2020 to 50% by December 2020, and request levels would rise from 22% of pre-COVID levels in April 2020 to 65% by December 2020.

20. Whilst both figures would continue to rise, the disparity between requests (adding patients to the waiting list) and activity (removing patients from the list) would mean that the waiting list would continue to grow in size. From a total of 10,305 waiting in February 2020[1] to 18830 waiting in December 2020.

[1] *(Waiting list numbers presented here are for colonoscopy, gastroscopy, or flexi sigmoidoscopy only, excluding screening and surveillance)*

Data sources – National Endoscopy Programme for activity and request numbers, Diagnostic and Therapies Dataset for Waiting List numbers.

21. Notably as the time spent on the waiting list continued to grow the number of patients waiting for more than 8 weeks would rise even faster – with 1,566 waiting for more than 8 weeks in February 2020 rising to 12,277 by December 2020. This pattern would continue through to December 2021, with slowly recovering activity, up to 70% of pre-COVID levels by that time, and requests which were up to 82%. The waiting list would rise further to a total of 23,711 with 15,911 waiting for more than 8 weeks.

22. At the time of writing, this growth in the waiting list has largely been halted, with 22,604 total waiting at the end of September 2022 and 14,522 of these waiting for more than 8 weeks.

23. The total number of patients waiting for endoscopy has risen by more than 100% between February 2020 and September 2022. (10305 in Feb 2020 to 22604 in Sep 2020). The proportion of patients waiting for 8 weeks or more has risen from 15% of total waits in Feb 2020 to 64% in September 2022 (from 1566 in Feb 2020 to 14522 in Sep 2022), a rise of over 800%. The proportion of patients waiting for 14 weeks or more has risen from 9% of total waits in Feb 2020 to 52% in September 2022 (from 906 in Feb 2020 to 11708 in Sep 2022), a rise of over 1100%. The proportion of patients waiting for 24 weeks or more has risen from 3% of total waits in Feb 2020 to 37% in September 2022 (from 327 in Feb 2020 to 8438 in Sep 2022), a rise of over 2400%.

24. Surveillance endoscopic procedures are included within current demand and capacity planning models.

25. The NEP developed guidance, published in early 2021, to support HBs in their risk stratification of all surveillance patients, in light of waiting time challenges post-pandemic. This followed on from the 2019 guidance on the implementation of surveillance guidelines for post-polypectomy and post-colorectal cancer resection to ensure the appropriateness of patients on surveillance waiting lists across Wales.

26. In order to support HBs with waiting list management the NEP in partnership with the Bevan Commission has established a national pilot of Colon Capsule Endoscopy and will support the dissemination of evaluation findings of pilots of Trans-nasal Endoscopy (TNE) and Cytosponge.

27. Many of the regional solutions provided and the data submitted now indicates an improving position regarding planned increased capacity over the next 12 months. This capacity, however, appears to be predicated against higher risk / non-sustainable solutions such as insourcing solutions, outsourcing solutions, temporary funding, Waiting List Initiatives (funded by Welsh Government) and short-term additionality reliance on staff “good will”. In the shorter term the current demand and capacity modelling tells us that HBs/Regions can largely absorb the current demand levels and overall, can consume the additional waiting cohort with this additional planned capacity. However, the modelling shows clearly that this will be only the case for the next 12 months. The model predicts increasing demand levels over the years ahead,

and this coupled with the inability to confirm additional funding into 23/24 and 24/25 and later - would result in a rapid regrowth in waiting lists in those later years. The model also assumes that these capacity solutions can be operational soon. This model assumption obviously does not take into consideration the 'real-world' operational risks around delivery of this capacity and should therefore be considered higher risk.

What barriers there are to achieving accreditation from the Joint Advisory Group on GI Endoscopy, including whether health boards are investing sufficient resource in developing the facilities and infrastructure for endoscopy services, decontamination services, and the progress that has been made in expanding the endoscopy workforce.

Joint Advisory Group on GI Endoscopy (JAG) Accreditation

28. Each Endoscopy Services' state of readiness and potential to participate in a JAG assessment was examined in late 2019 by the NEP, via a series of service visits and engagement with service teams. Following this exercise, formal pre-JAG visits were undertaken by external JAG assessors, to gain an up to date understanding of the state of readiness of endoscopy services to participate in a JAG assessment, and the barriers affecting local progress towards accreditation. Following these visits, a series of pre-assessment reports were developed, clearly defining the actions and trajectories for achievement of JAG accreditation and an accurate description of limiting factors for each endoscopy unit across Wales.

29. In 2021, the NEP identified eight units recognised as being in a strong position to focus and apply for an assessment for JAG accreditation within 6-12 months.

30. Currently only one of the aforementioned units believe they are in a position to apply for assessment for JAG accreditation by March 2023; with service and managerial capacity pressures cited as one of the main reasons not to pursue accreditation. As such, no tangible progress made towards one of the Programme's key aims of achieving JAG accreditation of endoscopy units.

31. The NEP recognises the additional pressures faced by endoscopy services as a consequence of the COVID-19 pandemic, and the impact this is having on the capability of operational teams to prepare for and be in a position to apply for and achieve JAG accreditation.

32. To support endoscopy services in their plans to achieve JAG accreditation, the National Endoscopy Programme has established a number of support mechanisms, through providing additional capacity and expertise. These include:
    - The development of a SharePoint site to share JAG materials to aid services in pulling together evidence to demonstrate their compliance against the JAG standards.
    - Monthly drop-in sessions (chaired by a Lead JAG Assessor) to offer guidance and support to services on the JAG standards.
    - Training sessions to educate endoscopy teams on the steps required to prepare for accreditation.

- Targeted meetings to raise awareness with Endoscopy Executive Leads.
- Annual decontamination audits to review the quality and safety of decontamination facilities across Wales.
- Quarterly meetings with the central JAG team, including the JAG Chairman, JAG Accreditation Managers and Lead JAG Assessors.

33. In recognition of the impacts of the pandemic, JAG are currently excluding their mandatory minimum waits from the accreditation process (recognising that units will be many months away from meeting this). This pragmatic and flexible approach presents endoscopy units in Wales with an opportunity to achieve accreditation, despite a historic inability to meet ministerial waiting time targets. It is the view of the programme that this revised approach from JAG presents Wales with the best chance of getting the majority of units JAG accredited.

34. Whilst some progress has been made to increase compliance against the JAG standards across a number of units in Wales, no service has gained JAG accreditation since this initial assessment in 2020. The list below summaries the outstanding challenges facing each endoscopy service, hindering progress made towards achieving JAG accreditation. These include:
    - Increased pressure on the leadership teams within services – with no additional support for clinical (Medical and Nursing) and managerial leads to deliver and complete the work required for accreditation, despite recommendations for services to invest in quality manager roles.
    - A lack of understanding of endoscopy services at senior management level.
    - Poor facilities & infrastructure which require major capital investment – this includes decontamination facilities.
    - Loss of particular focus on key JAG standards e.g., quality, safety (audits) and training.
    - No coordinated approach to achieving accreditation within Health Boards.
    - Poor knowledge of capacity planning for endoscopy service delivery, including workforce requirements.
    - Inadequate systems to support productivity measurements, reports, and improvements.
    - Short term solutions to address capacity issues and waiting list backlogs.
    - Health Boards not being directed to submit applications for accreditation and accreditation seeming to be optional

<u>Expanding the Endoscopy Workforce</u>

35. In May 2022, the NEP held a National Workforce Planning workshop, to engage a select number of the endoscopy community, to agree on a vision for the endoscopy workforce of Wales and begin to develop a plan for implementation. Following this workshop and given the challenges experienced by many services in the access and availability of endoscopy workforce data, a series of workforce planning visits were undertaken with all HBs to support them with their development of local endoscopy workforce plans.

36. In order to appropriately engage the endoscopy workforce across Wales, the NEP has developed a Workforce Stakeholder Engagement Taskforce supported by a dedicated Endoscopy Community Teams channel.

37. Through consultation with Clinical Endoscopists and key stakeholders within the endoscopy clinical community and wider, the NEP has developed a series of Clinical Endoscopist national role profiles. These have been developed in conjunction with Trade Union colleagues, job matched by the All-Wales Job Evaluation Unit and recommended as best practice guidance to all HBs within Wales.

38. The NEP has worked closely with an external design agency and the endoscopy community in Wales to develop a bilingual National Attraction Campaign for use by all Health Boards to support endoscopy recruitment.

39. The NEP has worked with Health Boards to introduce new and advanced roles within their structures to ensure an improved career pathway – these include Clinical Endoscopists, Clinical Nurse Educators to focus ion training and development (nursing) roles, JAG Nursing Leads and Co-Ordinator roles to support JAG accreditation of units. These have helped to define career pathways for professions and improved traditionally 'flat' nursing and administration structures to support with the recruitment and retention of the endoscopy workforce in Wales.

40. The NEP has developed a Band 4 Assistant Practitioner qualification in Endoscopy, with a task & finish group established for assessment and resource development to aid training implementation.

41. The NEP has recruited to three Clinical Endoscopist cohorts, with delivery of training through HEIW and Swansea University and the first cohort of Physician's Associates training in colonoscopy has commenced.

42. An All-Wales Education and Training Management Group (ETMG), chaired by the Health Education Improvement Wales (HEIW) Postgraduate Dean has been established with four clinical leads appointed to oversee all-Wales endoscopy education and training approaches – the group, via engagement with the endoscopy workforce has identified ten training pathways as key areas of focus.

    - A Training Academy proposal paper has been formally submitted to Health Education Improvement Wales (HEIW) Executive
    - All-Wales prescribing guidelines have been agreed and formalised for distribution.
    - The first all-Wales undergraduate nursing endoscopy training session has been delivered
    - Bowel Cancer Upskilling & Potential Screener pilot workshop has been completed.
    - All Wales training data and estimates of training capacity requirements has been collated from various information sources to provide us with an overview of the training picture.
    -

The current position for optimising the bowel cancer screening programme (i.e., for increasing Faecal-Immunochemical Testing (FIT) sensitivity and age testing) and how this compares to other parts of the UK. The experiences of younger people and those most at risk of developing bowel cancer (i.e., those living with Lynch syndrome) and efforts to diagnose more patients at an early stage.

43. Please refer to the Bowel Cancer Screening programme for response to the above questions

Primary care access across different health boards to FIT for patients who do not meet the criteria for a suspected cancer pathway referral and how it is being used to help services prioritise patients and stratify referrals by risk (outpatient transformation).

44. The NEP has focused on assessing options to support Health Boards (HBs) to increase their diagnostic capacity within the LGI pathway, especially while having to address the increasing backlogs of patients waiting for procedures. These efforts have been targeted at implementing those interventions likely to have the greatest impact and scale, progressing systematically in descending order of likely impact, and capacity creation within the service. With this strategy we have thus far supported implementation of:

- the surveillance validation of colonoscopy according to updated BSG guidelines which resulted in 50-70% of surveillance capacity being freed up in those HBs where validation has been implemented to a significant extent
- embedding of the Faecal Immunochemical test (FIT) for routine referral streams (NICE DG30) in HBs across Wales and implemented a pilot for USC referrals in Cardiff and Vale UHB.
- The piloting of Colon Capsule Endoscopy

45. In March 2021, ahead of the planned action plan timeframe the NEP produced an evidence-based and externally peer reviewed FIT National Framework ahead of time in order to guide and support Health Boards during the Pandemic and provide a common approach to the implementation in primary and secondary care.

46. The NEP shared best practice and learning at a national symptomatic FIT learning event in April 2022.

47. Six HBs have now fully implemented use of symptomatic FIT in primary care within the low risk (DG30) population while the last HB will have a pathway in place by March 2023.

48. HBs to date report challenges with administrative and informatics support in FIT implementation that is proving to be a barrier to improved, more rapid implementation, and to the tracking of referrals and implementation of safety netting processes.

Rhwydwaith Canser Cymru
Wales Cancer Network

Llawr 1af / 1st Floor
Tŷ Afon / River House
Llys Ynys Bridge / Ynys Bridge Court
Gwaelod-y-Garth / Gwaelod-y-Garth
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16 December 2022

Senedd Cymru
Welsh Parliament
Health and Social Care Committee
Email * Ebost: SeneddHealth@senedd.wales

Dear Sir/Madam

INVITATION TO GIVE ORAL EVIDENCE TO THE COMMITTEE

Introduction

1. The Wales Cancer Network (WCN), as part of the NHS Wales Health Collaborative, is a partnership between Health Boards and Trusts, health professionals, the third sector, industry, academia 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 value, 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 National Clinical Framework and associated Quality Statement for Cancer, and other national strategic plans and frameworks, and provides advice and guidance to Welsh Government on policy relating to cancer care in Wales. It is currently coordinating the writing of a refreshed Cancer Improvement Plan for Wales. The WCN will be moving into the National NHS Executive function once it is established.

2. A robust and well-functioning endoscopy service is an essential component of cancer services in Wales, and vital for the diagnosis of upper and lower gastrointestinal cancers. The WCN is therefore grateful for this opportunity to respond to the Health and Social Care Committee's (H&SCC) follow on to the 2019 inquiry into endoscopy services.

3. The previous inquiry focussed on endoscopy services for the gastrointestinal tract and both the National Endoscopy Programme (NEP) and **national endoscopy action plan**, are limited to those services. Whilst endoscopy is also essential for the pathways of other cancers (e.g. cystoscopy for bladder cancer) our evidence below relates to the services for upper and lower gastrointestinal cancers.

4. The WCN has a number of areas within its work programme that rely on or impact endoscopy services, including:

    - Bowel Cancer Initiative (BCI): focuses on improving outcomes for patients with bowel cancer. During the first year, the initiative concentrated on developing a colorectal data dashboard, improving ileostomy closure rates,

implementing FIT for symptomatic patients and Peer Reviewing colorectal cancer services. The next phase of the initiative will build on this to engage professionals and patients, and track improvements as a result of peer review actions.

- The Suspected Cancer Pathway (SCP) Programme supports Health Boards and Trusts to achieve compliance with the Welsh Government measure for cancer waiting times: 80% of patients to start their first definitive treatment within 62 days of the point of suspicion by 2026. Colorectal and oesophagogastric cancers are in the first wave of focus for improvement programmes. It has published National Optimum Pathways (NOP) for 21 cancer types, data and intelligence resources, and provides local project management for service improvement and innovation along those pathways.
- The NOP for Lower GI Cancer has been amended to include FIT as a primary care test undertaken prior to referral for suspected symptomatic bowel cancer. This has recently been approved at the Cancer Network Board in November 2022, and we shall work with the National Primary Care groups to implement.
- A rolling programme of Clinical Peer Review of cancer services. Colorectal cancer services were last reviewed in 2021, oesophagogastric in 2016.
- Rapid Diagnostic Clinic (RDC) Programme: co-ordinates the implementation of these novel clinics to quickly diagnose people with vague symptoms that may be due to cancer. Lower and Upper GI cancers are frequently diagnosed through this route.

5. These programmes work with the National Endoscopy Programme (NEP) and Bowel Screening Wales (BSW) to ensure that developments align without duplication. The WCN Clinical Director is a member of the NEP Board, and both the NEP and BSW are represented on the Cancer Network Board.

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

The impact COVID-19 has had on delivery of endoscopy services and the implementation of the national endoscopy action plan, and the implications of this for patient outcomes and survival rates.

7. The beginning of the pandemic was a period of significant uncertainty in terms of the routes and risk of transmission. Endoscopy (both colon and upper gastro-intestinal) was identified as a high-risk Aerosol Generating Procedure (AGP) early in the pandemic. British Society of Gastroenterologists (BSG) guidance was rapidly produced in March 2020 advising that all non-emergency endoscopic procedures should be stopped to prevent the spread of the novel coronavirus and prioritise the use of Personal Protective Equipment (PPE). The Joint Advisory Group (JAG) reported at the end of April 2020 a 95% reduction in procedures across the UK identified via their National Endoscopy Database. Bowel Screening Wales (BSW) stopped population screening completely between March and July 2020.

8. Non-emergency procedures were gradually re-introduced following the peak phase. However, changes in protocols to accommodate additional decontamination, social distancing, PPE and other factors have decreased available capacity, and together with a backlog of demand this has exacerbated the pressure on a service that already had significant challenges, as evidenced in the 2019 inquiry.

9. In October 2020, the NEP amended the National Endoscopy Action Plan, recognising the impact that the pandemic had already had at that point. Further details will be available from the National Endoscopy Programme.

10. The Cancer Peer Review Programme reviewed colorectal Multi Disciplinary Teams (MDTs) in Wales in 2021, and identified that waiting times for endoscopy, particularly if referred via the Bowel Cancer Screening service, were of concern across Wales.

11. Cancer waiting times are now the worst they have ever been, with only ~ 50% of patients starting their first treatment within 62 days of point of suspicion in September 2022. No Health Board in Wales has met the target of 75% since July 2020. The data for upper gastrointestinal cancers is similar to the all-cancers average, however, for lower GI only 35.1% received their first definitive treatment within 62 days.

	Betsi Cadwaladr	Hywel Dda	Aneurin Bevan	Cardiff & Vale	Cwm Taf Morgannwg	Swansea Bay
Upper GI	69	47.1	57.1	33.3	57.7	57.9
Lower GI	40.4	35.5	25	19	41.9	43.5

Table 1 The percentage of patients starting their first definitive treatment in the month within 62 days of first being suspected of cancer (no suspensions) for Upper and Lower GI by Health Board, September 2022 Data source

12. For Health Boards to achieve the SCP measure, most people should be informed of their diagnosis approximately 31 days following the point of suspicion. Colorectal cancers have some of the longest delays in the interval between point of suspicion to the patient being informed they have a diagnosis of cancer, with a median of 50 days, an increase of 18 days since September 2021 (the all-cancer median is 34). This varies by Health Board between 26 and 69 days. Whilst this delay will not all be due to waits for endoscopy, a functioning, effective endoscopy service is critical to the timely diagnosis and treatment of colorectal cancer.

13. The latest published data for colonoscopy (for all reasons) reports that 58% carried out in September had waited more than 8 weeks, with 46% waiting more than 14 weeks. Waits appear to vary significantly by Health Board. The WCN is working with Health Boards and partners to understand the endoscopy waiting times experienced by patients on the Single Cancer Pathway.

14. A delayed cancer diagnosis results in worse outcomes for patients, in terms of available choices in treatments, inability to receive treatment with a potentially curative intent, quality of life following diagnosis, and survival. Quantifying this however is complex, particularly in the context of a pandemic exhibiting higher mortality rates for people in categories that are at increased risk for poorer cancer outcomes (e.g., increased age, lower socio-economic status, co-morbidities), and in a very dynamic situation that affected not only most healthcare systems but also the non-healthcare factors that influence outcomes for people with cancer.

15. Stage at diagnosis is often used as a proxy or early indicator of cancer survival: a shift in stage to a higher proportion of people diagnosed at a later stage could predict poorer survival and other outcomes.

16. A report of colorectal cancers in Cardiff diagnosed during 2020 evidenced a decrease in diagnostic colonoscopy and radiological imaging performed between March and June 2020 compared with previous years. More patients presented as emergencies with increased rates of large bowel obstruction, and more T4 cancers were diagnosed in 2020 (versus 2018-2019). Emergency diagnosis is associated with advanced cancer stage and poorer survival, even after controlling for stage.

17. Analysis of NHS Wales data by the DATA-CAN Cancer Collaboration Cymru (DATA-CAN CCC) research group, published in August 2022 reports a decrease in cases of colorectal cancer diagnosed in 2020 compared to 2019 (−23.7% in females and −12.1% in males) spread evenly across stages 1-4, however the substantial increase in colorectal cancers with stage unknown recorded in 2020, compared to 2019 (up 803.6% to approx. 12.5% of records) make comparison difficult and this does not preclude a stage shift nationally.

18. We have to date not seen any data identifying a migration in stage at diagnosis for patients with upper GI cancers in Wales.

19. Disentangling the impact of changes in any specific service within that whole landscape beyond a broad statement is outside the scope of the WCN. It is very probable however that the impact of the pandemic on endoscopy services will lead to poorer outcomes over the short to medium term for patients diagnosed with upper and lower GI cancers.

The priority given to endoscopy services in the Welsh Government's programme for transforming and modernising planned care, including who is responsible for delivering improvements through the reconfiguration of services and new models of care (including additional endoscopy theatres, diagnostic centres and regional units), and how endoscopy services will feature in the new cancer action plan (expected to be published autumn 2022).

20. Welsh Government's programme for transforming and modernising planned care, specifically references endoscopy in 3 places:

    - Formation of a diagnostics board which will "have delegated authority from the NHS Wales Leadership Board to provide direction on all diagnostics related matters including service models and allocation of available resources" and "use input from national programmes such as … Endoscopy [to] agree a holistic diagnostics approach for Wales."
    - An expectation that health boards "plan services regionally for those high volume, low complexity interventions such as … endoscopy …, where it is not possible to meet demand with minor and localised uplifts in capacity"
    - Reference to allocation of £170m of recurrent funding announced in October 2021 to support planned care recovery plans, and stating this investment would enable amongst other pressures, implementation of the recommendations of the National Endoscopy Programme.

21. The Minister for Health and Social Services approved the NEP recommendations in writing to Health Boards in October 2021, including

- Adoption of productivity and efficiency measures recommended by the National Endoscopy Programme that will enable the maximum output from existing capacity and the risk-based management of the patient population.
- Health Board initiated additional activity, delivered in the form of waiting list initiatives, insourcing, and outsourcing; including short term rental of staffed mobile units.
- Consideration of Health Board-initiated business cases for additional, permanent endoscopy theatres on the existing NHS estate.
- Procurement of managed service contracts to deliver any deficit in endoscopy theatre capacity, to be delivered in regional units.

22. The Cancer Improvement Plan for Wales (Cancer Action Plan) is due to be published in December 2022 and collates the agreed national and local actions towards achieving the ambitions of Welsh Government's Quality Statement for Cancer. We are confident that the plan adequately covers endoscopy, recognising that it has its own improvement plan, and we have worked with the NEP to align. Actions to improve access to, and efficiency of, endoscopy feature predominantly within the sections "Elective Care Recovery", "Faster Diagnosis" and "Compliance with the Single Cancer Pathway and National Optimal Pathways". In addition to specifics re endoscopy, the plan covers processes that will influence the effectiveness of timely endoscopy, such as Straight to Test and risk triage, and that ensures endoscopy fits into the flow of an effective, efficient pathway. Health Optimisation/prehabilitation is featured, emphasising that this should start at the point of suspicion, and contains actions to integrated models of prehabilitation being embedded as standard into cancer pathways to improve outcomes as per the "Waiting Well? The impact of the waiting times backlog on people in Wales" Senedd Health and Social Care Committee report.

23. The National Diagnostics Board, as per the programme for transforming and modernising planned care**,** is overseeing the development of community diagnostic hubs/centres (also termed Regional Diagnostic Centres/Hubs), and undertakes to establish two centres this year, however, with the most advanced plans looking to implement in Q3/4 of 2023/24, it is unlikely this will be fulfilled in the current financial year. It is unclear whether endoscopy services will be included or co-located within this development, taken forward separately by the NEP, or driven individually by Health Boards. There are advantages for cancer diagnostics if they are co-located with other diagnostics regionally.

24. There has been some variation over time between a WG directive approach and a HB delivered approach and there is now a need for a clear national strategy albeit locally and regionally delivered.

Issues relating to recovering and improving waiting time performance, including: reducing waiting times for diagnostic tests and imaging to eight weeks by spring 2024 and support for people waiting for tests and follow up appointments; the active waiting list size for all current inpatient and day-case patients waiting for endoscopic procedures (by modality); the extent to which elective capacity is impacted by emergency activity, and whether there is sufficient data to understand the impact of emergency cases; whether high risk patients requiring ongoing surveillance endoscopic procedures are included in current demand and capacity planning models; the scope for upscaling lessons learned from previous waiting list initiatives such as insourcing, outsourcing or mobile units; and what the

current demand and capacity modelling tells us about when a sustainable position can realistically be achieved.

25. Endoscopy waits are a component of the SCP measure for Upper and Lower GI cancers. The National Optimum Pathways identify that for the SCP measure to be met for patients with Upper and Lower GI, endoscopies should be carried out within 7 days of the point of suspicion for colorectal cancers, and 5 days for oesophageal and gastric cancers. Some patients are also diagnosed incidentally via endoscopy, whilst not on the SCP, and therefore the timeliness of routine Referral to Treatment waits for endoscopy is also of interest.

26. Prior to the pandemic the International Cancer Benchmarking Partnership (ICBP) reported that Wales had significantly longer intervals at multiple points in the pathway for colorectal cancers compared to similar high-income countries. So much so, that Wales was used as the reference against which other jurisdictions were compared. The wait for diagnostics was particularly poor.

27. Health Board data[1] reports that demand for cancer diagnostics has been consistently higher than pre-covid levels over the last year and is increasing. Lower Gastrointestinal demand has been disproportionately high compared to other tumour sites, with an average increase across Wales of 44%. The size of this increase is not consistent across Wales, with Swansea Bay UHB experiencing more than double the usual demand.

University Health Board	Betsi Cadwaladr	Hywel Dda	Aneurin Bevan	Cardiff & Vale	Cwm Taf Morgannwg	Swansea Bay
Increase in demand for lower GI cancer over 2019 levels	40%	80%	75%	30%	30%	150%

Table 2 increasing demand for Lower GI cancer diagnostics: comparison of August 2022 data to 2019 average (number of people starting the lower GI SCP) rounded to nearest 5%.

28. Broadly cancer waiting times are increasing, largely driven by delays in the diagnostic stage, and SCP/Health Board performance data suggests significant variance across Health Boards in the diagnostics component of the pathway.

29. There are indications that the number of people recorded as actively waiting for an endoscopy on the SCP for colorectal cancer peaked in August 2022 and has been steadily reducing since, but is high compared to historic levels. Anecdotally, it appears there are variations in the waits experienced by patients living across Wales.

30. The number of endoscopies carried out for potential cancer diagnoses has increased to approximately 150% of pre-pandemic levels, indicating that endoscopies for cancer are being prioritised and activity delivered is higher than ever.

[1] Data available via the National Endoscopy Programme and Health Board Single Cancer Pathway Dashboard.

31. Health Board data highlights variation in straight to test for endoscopy across Wales, and there are opportunities to align the use of this route nationally, reducing the need for a consultant out-patients appointment before endoscopy within the SCP. This was recently prioritised by the Minister for Health and Social Services at the Cancer Summit.

32. Work is underway to improve efficiency of and access to endoscopy for cancer, e.g.: local audit and process mapping by the SCP team in SBUHB has demonstrated variation in triage and safety netting of low-quality referrals, and highlighted improvement opportunities, which have been shared nationally via the WCN Operational Managers Group. We have had exposure to data suggesting a productivity gap with sub-optimal endoscopy list utilisation. We would recommend that this becomes an area of focus for the NHS Executive once established.

33. Accelerated staging post-endoscopy is being rolled out across UHBs using a co-production approach between endoscopy and radiology services within units.

34. A project is underway looking at the triage / vetting component of patient pathways following referrals from GP (including endoscopy).

35. The Cancer Implementation plan, contains a number of locally specific actions identified by Health Boards to address issues with endoscopy within the SCP, these include:

- Maximising the potential of 1 stop scope to CT pathway for colorectal cancers.
- Maximising additional capacity through mobile endoscopy unit.
- Reviewing all first outpatient referrals weekly to establish which can be converted straight to FIT and Endoscopy.
- Trialling RDC approach for some tumour sites.
- Research and implement new diagnostic techniques including Cytosponge and Transnasal Endoscopy.

36. We are not aware of any prehabilitation or specific support packages for patients' pre-endoscopy for suspected cancer. The WCN has partnered with the Bevan Commission to support innovative improvement projects at the beginning of the SCP. One of these projects, being developed by 2 Health Boards in collaboration, is assessing digital prehab resources, aiming to report at the beginning of the next financial year.

37. There are various opportunities to implement innovations which could decrease demand on endoscopy for cancer or mitigate the risk for patients experiencing longer waits for endoscopy. Examples are summarised in the table below.

Innovation	Description	Potential benefits
Colon Capsule endoscopy (CCE)	A minimally invasive procedure, where a patient swallows a pill containing two tiny cameras to examine the large bowel (colon).	Can help to reduce the need for optical colonoscopy. The British Society of Gastroenterology (BSG) reports that evidence to date, indicates that procedure-related distress (discomfort and embarrassment) is less with CCE than colonoscopy and has a similar

		diagnostic sensitivity to colonoscopy in clinical trials.
Transnasal endoscopy (TNE)	An upper gastrointestinal (GI) endoscopy method performed via the nose instead of the traditional method through the mouth, using a thinner endoscope.	Better patient outcomes - as the procedure is less invasive it is therefore more comfortable. Improved efficiency - TNE can take less time and fewer resources, thus enabling more patients to be seen overall and can therefore contribute to reducing the growing backlog facing endoscopy services.
Cytosponge™	The Cytosponge™ cell collection device can be described simplistically as a "sponge on a string": a minimally invasive, non-endoscopic system that has been developed to allow the sampling of cells lining the oesophagus.	Can reduce the burden on secondary care endoscopy services for example by being used to risk stratify those patients on endoscopy waiting lists.

Table 3 description of potentially beneficial innovations/technologies

38. Colon Capsule is currently being taken forward via a partnership between the Bevan Commission and the NEP.

39. WCN is exploring working with partners including the Life Sciences Hub Wales and Welsh Association of Gastroenterology and Endoscopy (WAGE) to support Health Boards to roll out TNE across Wales, following successful implementation in C&VUHB. Cytosponge is being piloted in BCUHB, with interest in other regions including Powys. WCN is helping to support Health Boards in the assessment of outstanding clinical queries re its routine use, and in discussions regarding Wales participating in a trial of Cytosponge use in primary care.

What barriers there are to achieving accreditation from the Joint Advisory Group on GI Endoscopy, including whether Health Boards are investing sufficient resource in developing the facilities and infrastructure for endoscopy services, decontamination services, and the progress that has been made in expanding the endoscopy workforce.

40. The 2019 H&SCC Inquiry into Endoscopy Services recommended that all endoscopy units in Wales aim to achieve Joint Advisory Group (JAG) on GI Endoscopy accreditation in the future, ensuring that endoscopy services are being delivered in line with best clinical practice. This was incorporated in the **national endoscopy action plan** as a phased approach to support those units that were ready to apply by end of March 2023. Further details will be available from the National Endoscopy Programme.

41. To date, only three (3) NHS endoscopy units, of 20 in Wales registered with JAG, have achieved accreditation: Glangwili General Hospital, Withybush Hospital and Brecon War Memorial Hospital. This compares unfavourably with 111 of 221 in

England. On latest published data, none of the NHS units in Scotland and Northern Ireland have completed an accreditation assessment.

42. It is considered that the extended waiting times for endoscopy currently experienced by patients in Wales is a major barrier to achieving accreditation in many units across and therefore overcoming the issues highlighted above with respect to achieving waiting times are also applicable in this context.

The current position for optimising the bowel cancer screening programme (i.e. for increasing Faecal-Immunochemical Testing (FIT) sensitivity and age testing) and how this compares to other parts of the UK.

43. The National Screening Committee recommends that screening for bowel cancer should be offered every 2 years to men and women between the ages of 50 and 74 in the UK using the faecal-immunochemical test (FIT). Currently Wales offers screening to people aged between 55 and 74.

44. The current threshold for a "positive" FIT screening result in Wales is 150µg/g. This is the same as Northern Ireland, however in Scotland, the threshold of FIT is 80µg/g, and in England, 120 µg/g.

45. Wales is halfway through an expansion programme that in the next 2 years will see the following implemented:

    - Year 3 - age expansion (invite 52- to 54-year-olds) and FIT positivity threshold reduction from 150ug/g to 120ug/g.
    - Year 4 - age expansion (invite 50- & 51-year-olds) and FIT positivity threshold reduction from 120ug/g to 80ug/g.

46. Peer review of colorectal cancer services throughout Wales in 2021 highlighted that Bowel Screening Wales (BSW) waits were of particular concern. Significant variation between Health Boards was reported for the average waits to endoscopy following a positive screening FIT, from 7 weeks (C&VUHB) to 27 weeks (BCUHB). In all Health Boards this was categorised as a Peer Review "Concern" requiring action: all the average waits reported would be outside the timeframe required to achieve the SCP measure of 62 days to treatment from point of suspicion.

47. Action plans were received from Health Boards in response to this concern and Health Boards are responsible through their Quality and Safety arrangements for tracking and delivery of Peer Review actions.

48. Bowel Screening Wales reports that currently waiting times for screening endoscopies are around 10-12 weeks across Wales, an improvement, but still outside the timeframe necessary for the SCP measure

49. The national colorectal peer review summary emphasised that Health Boards should consider these cases as SCP cancer waiting times from the point of suspicion, at positive bowel screening FIT test, as defined in the colorectal cancer NOP and the Bowel Cancer Initiative advocates the alignment of processes and timescales for symptomatic and screening at point of suspicion entering Single Cancer Pathway following a positive FIT result.

50. A significant proportion of the endoscopy practitioners were accredited by BSW for screening endoscopies at the initiation of the bowel screening programme and are of a similar age. Workforce planning will need to take this into account before this cohort nears normal retirement age.

The experiences of younger people and those most at risk of developing bowel cancer (i.e. those living with Lynch syndrome) and efforts to diagnose more patients at an early stage.

51. The WCN partners worked with Macmillan to undertake the periodic Wales Macmillan Cancer Patient Experience Survey (WMCPES). The most recent of these was carried out recently and is due for publication in the new year. Whilst this survey does not ask a question specifically about endoscopy, a number of respondents referred to their experience with endoscopy in their commentary. This is currently under embargo until publication, but we should be able to share themes at the oral evidence session.

52. We are aware that Moondance have commissioned work to understand the experiences of people in Wales who have been diagnosed with Bowel Cancer, and will be taking this into account in the future work-plans for colorectal cancer once this has been published.

53. Detecting and diagnosing cancer at an earlier stage is a priority for the Welsh Government and the NHS in Wales as reflected in the Quality Statement for Cancer requirement that “more cases of cancer are detected at earlier, more treatable stages through more timely access to diagnostic investigations”.

54. The Cancer Improvement Plan for Wales, which will be published in December 2022 section on earlier diagnosis, outlines national and local actions to support this quality statement. Improving the uptake of screening, streamlining pathways, tackling inequity for underserved groups, implementation of innovations in primary and secondary care all have their role to play.

55. For Gastro-intestinal cancers, improving the uptake of Bowel screening, along with the expansion of the programme, is critical to earlier diagnosis, as is decreasing the waits for screening endoscopy.

56. Innovations such as the Rapid Diagnostic Clinics, FIT in primary care, primary care cancer education programmes (e.g. Gateway C), trans-nasal endoscopy, colon capsule and cytosponge are being implemented or piloted in Wales.

57. The Suspected cancer pathway: guidelines (WHC/2022/18) emphasises that patients should be informed when they are referred via the SCP that cancer is a possible, albeit very low probability, diagnosis. A patient leaflet has been developed with Cancer Research UK that is currently being evaluated and should be available nationally in the near future to support primary care with this.

58. Additionally, we would encourage initiatives that ensure patients are informed of the outcomes of referral vetting (up or down-grading) by secondary care, to help with safety netting.

Primary care access across different Health Boards to FIT for patients who do not meet the criteria for a suspected cancer pathway referral and how it is being used

to help services prioritise patients and stratify referrals by risk (outpatient transformation).

59. With partners, the BCI was able to drive through the adoption of FIT during the pandemic to help prioritise symptomatic patients, which is helping to mitigate risk.

60. The Association of Coloproctology of Great Britain and Ireland (ACPGBI) and British Society of Gastroenterology (BSG)[2] have provided joint national guidelines that support embedding FIT in primary care to help inform the need and priority of referral for people with suspected lower GI cancer.

61. SCP project managers are helping to support roll out in Health Boards where it is not uniformly accessible across primary care (e.g. HDUHB). Hywel Dda is the final Health Board in Wales to implement, and are planning to do so by January 2023.

62. The SCP team have also undertaken a review of data within some Health Boards to support improvement opportunities. SCP and BCI/colorectal Cancer Site Groups (CSG) have collaboratively developed national FIT guidance based upon ACPGBI/BSG guidelines including point of suspicion and a FIT micro-pathway as part of an updated Colorectal NOP. This has included engagement with broad range of stakeholders including the GPC. SCP team is working with the Delivery Unit (DU) to evaluate FIT demand and opportunities to further refine existing pathways and variance across UHB's. A number of bids for funding have been developed to support the primary care aspects of this work.

63. NHS England is expanding direct access to diagnostic scans across all GP practices, helping cut waiting times and speeding up a cancer diagnosis or all-clear for patients. Wales could move towards this to compliment the recent roll-out of RDCs and implementation of the SCP.

We hope that a renew of the Cancer Network engagement / influence in the work around endoscopy is useful to the inquiry.

If you require any further information, please do not hesitate to contact the above mentioned.

Yours sincerely

Claire Birchall
Network Manager
Wales Cancer Network

Copy to: Wales Cancer Network Board

[2] Faecal immunochemical testing (FIT) in patients with signs or symptoms of suspected colorectal cancer (CRC): a joint guideline from the Association of Coloproctology of Great Britain and Ireland (ACPGBI) and the British Society of Gastroenterology (BSG) - The British Society of Gastroenterology available at: https://www.bsg.org.uk/clinical-resource/faecal-immunochemical-testing-fit-in-patients-with-signs-or-symptoms-of-suspected-colorectal-cancer-crc-a-joint-guideline-from-the-acpgbi-and-the-bsg/

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Health and Social Care Committee

Y Pwyllgor Cyfrifon Cyhoeddus a Gweinyddiaeth Gyhoeddus
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Simon Jones
Chair, Digital Health and Care Wales
Helen Thomas
Chief Executive, Digital Health and Care Wales

5 December 2022

Dear Simon and Helen

Follow up questions after general scrutiny session on 26 October 2022

Thank you for attending our meeting on Wednesday 26 October and responding to our questions.

Following the evidence session, Members agreed to write to you with follow-up questions on the issues outlined in the annex to this letter.

As we will be returning to these issues next term, we would welcome a response by 13 January 2023.

Yours sincerely

Russell George MS
Chair, Health and Social Care Committee

Mark Isherwood MS
Chair, Public Accounts and Public Administration Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Annex: follow up questions after general scrutiny session on 26 October 2022

Following the general scrutiny session with Digital Health and Care Wales (DHCW) on 26 October 2022, we would welcome further information on the matters listed below. We would be grateful to receive your response by Friday 13 January 2023.

Transition to the cloud

1. In the session, Helen Thomas, DHCW Chief Executive, reported that DHCW had moved 25 per cent of their estate into the cloud. You undertook to write to the Committees with figures on the consequent reduction in the number and percentage of servers being used in the past five years.

Progress on recommendations of Fifth Senedd Public Accounts Committee (PAC) reports

2. You undertook to provide further detail on work relating to the Welsh Community Care Information System (WCCIS). In particular, the Committees would welcome information on the following:

    a. An overview of the current take-up of WCCIS across health boards and local authorities.

    b. The reasons for any health boards or local authorities not signing up to WCCIS, but choosing to use different systems.

    c. Whether those different systems are interoperable with WCCIS.

    d. Organisations currently using the system have moved to it at different times, meaning their deployment orders will also expire at different times. Has DHCW a profile of the timescales for these contractual milestones.

    e. Whether there is a process and a timescale for decisions on a future contracting strategy, including whether to retain the commitment to a single system solution or to allow for a future pattern of different interoperable systems.

    f. An additional £12 million has been committed to WCCIS over the next three years. How will this be allocated and spent (by project and health board area)? What the timescale is for project completion and the objectives in terms of benefits realisation from the system.

    g. Any other outstanding key risks around the WCCIS programme and how DHCW is addressing those risks.

Prioritisation and manageability of the DHCW work programme including workforce issues

3. In the session, you discussed the challenges DHCW were experiencing with vacancies. You reported that you had a plan in place to address these issues and undertook to share that plan with the Committees.

4. The overall number of staff within DHCW (headcount and WTE), the number working on cybersecurity, assurances on whether the right expertise is in place, and how DHCW works with other NHS Wales bodies to address cybersecurity issues.

5. In your oral evidence you indicated that there weren't many women within your organisation and agreed to send to the Committees some data around performance on workforce diversity.

Service transformation

You indicated in the session that:

> "digital technology is moving from a capital intensive to a revenue-based funding model, particularly as you move from a data centre into the cloud. And that will mean, from an operational perspective, that our funding requirements will change and migrate".

However, you also acknowledged that transformation and future interoperability of systems will require investment in ensuring up to date hardware and systems in health boards and primary care.

6. What is the DHCW view on the future capital funding requirements for digital transformation in healthcare within Wales.

7. How is DHCW ensuring that the software you develop is usable by others within NHS Wales.

Social care

8. DHCW's focus to date has been very largely on healthcare. What plans there are for any expansion of work into social care.

Data security and patient access

9. Since Welsh Government published Informed Health and Care - a Digital Health and Social Care Strategy for Wales in 2015 there has been a strategic aim to make patients medical records and data available. Other countries have provided direct electronic patient access to their records. What plans are there in Wales for progressing work on this.

10. In the session the Committees asked whether there were any machine decision making processes taking place in relation to patient data. You undertook to provide details of what was in place currently The Committees were interested in particular on:

    a. The use of algorithms, categorisation, and predictive analytics;

    b. If so, the datasets that are being used in them and how categories are decided;

    c. Details of the data controllers, the data processors and any audits undertaken in those areas;

    d. Whether any data sets are currently open-source or planned to be made open-source.

11. What assessment has DHCW made of any changes to General Data Protection Regulations (GDPR) and how could this impact on data collection, protection and sharing of NHS Wales data.

12. In the evidence session you highlighted the need for improved cross-border data and systems interoperability between NHS services in Wales and England and indicated there was work underway on this issue. We would be grateful if you could keep the Committees updated on progress in this area of work.

Cancer information systems

13. In the session, you indicated that Phase 1 of the replacement system for CaNSIC would be going live in November. You also indicated that Phases 2 and 3 were complex, would require detailed planning, and could take up to two years to put in place. We would be grateful if you could provide further information on:

    a. The original timescales for the replacement of CaNISC, and any reasons for slippage against those.

    b. The current timetable for decommissioning CANISC and replacing it with alternative system/s.

    c. Whether you are on track to achieve the current timetable, and whether the decommissioning of activity due for November that was mentioned in the evidence session has taken place.

Key performance indicators (KPIs) and benchmarking

14. In the evidence session you indicated that you were using your KPIs to benchmark your performance against other organisations. Could you provide further information on the

benchmarking referred to, indicating how your performance compares to elsewhere in the UK and more widely.

Prison healthcare data

15. The Fifth Senedd's Health, Social Care and Sport Committee's inquiry into health and social care provision in the adult prison estate in Wales heard evidence around the limitations of the IT infrastructure used in prison healthcare. The Minister for Health and Social Services has said Welsh Government are assessing the resourcing needed to improve access to the medical records of prisoners, although this has implications in terms of IT infrastructure and investment priorities. Have DHCW been involved in any work or discussions around this issue?

GIG CYMRU NHS WALES
Iechyd a Gofal Digidol Cymru
Digital Health and Care Wales

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Russell George MS Chair,
Health and Social Care Committee

Mark Isherwood MS Chair,
Public Accounts and Public Administration Committee

13 January, 2023

Dear Russell and Mark,

Thank you for your letter dated 5 December 2022. We are pleased to respond to the follow up questions after the scrutiny session on 26 October 2022.

Our responses to the follow up questions are outlined below.

Yours sincerely

Helen Thomas, CEO DHCW

Simon Jones, Chair DHCW

GIG CYMRU NHS WALES
Iechyd a Gofal Digidol Cymru
Digital Health and Care Wales

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DHCW Follow-Up Responses

Transition to the cloud

Q1. In the session, Helen Thomas, DHCW Chief Executive, reported that DHCW had moved 25 per cent of its estate into the cloud. You undertook to write to the Committees with figures on the consequent reduction in the number and percentage of servers being used in the past five years.

DHCW operate in a highly dynamic environment, with new servers being commissioned regularly to deal with new services and growth, and old servers being decommissioned or replaced. DHCW utilise a highly virtualised server estate, where numerous virtual servers run on a smaller number of physical servers. In 2021 DHCW moved 25% of the servers that host national digital services into Microsoft's Cloud as part of our Cloud first approach. This allowed DHCW to remove 9 physical servers from the data centre.

Other services previously hosted on-premises have now moved to cloud, these include Email services (MS Exchange to MS 365 Exchange on-line), Team collaboration services (MS Skype to MS Teams), File Storage (OneDrive and SharePoint on-line replacing file servers and on-premises SharePoint) and many others. This has reduced a further 40 on-premises servers being a mix of Physical and Virtual. We have also deployed a number of new services directly into the cloud, which include the Covid Vaccine Rebooking System, the NHS Wales App, the Covid Contact Tracing solution, and servers supporting connectivity to the Welsh Community Care Information System (WCCIS).

Progress on recommendations of Fifth Senedd Public Accounts Committee (PAC) report

Q2. You undertook to provide further detail on work relating to the Welsh Community Care Information System (WCCIS). In particular, the Committees would welcome information on the following:

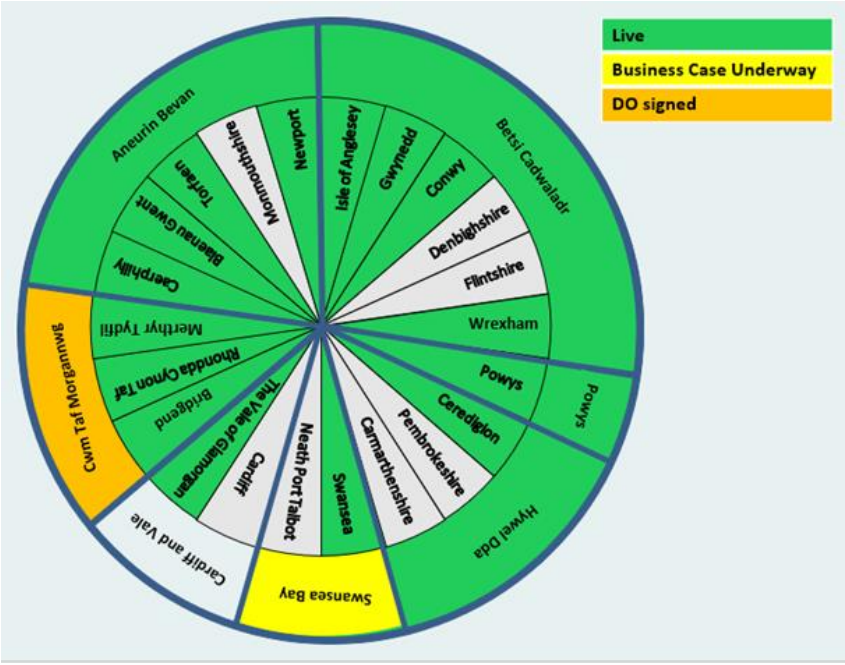
a) An overview of the current take-up of WCCIS across health boards and local authorities.

The WCCIS digital platform, known as CareDirector, is live in 19 out of 29 organisations. In the remaining organisations the position is as follows:

- Cwm Taf Morgannwg UHB has signed a deployment order to use WCCIS and Swansea Bay UHB is preparing a business case for using WCCIS
- Cardiff & Vale UHB have stated that they will not implement CareDirector, as the product does not meet their requirements, but they will work with the national team to review interoperability options as part of the wider WCCIS Programme

- Monmouthshire Local Authority – uses their own in-house system but will consider a move to WCCIS (CareDirector v6)
- Denbighshire and Flintshire Local Authorities are currently running a joint procurement for which WCCIS - CareDirector v6 is being considered
- Pembroke and Carmarthen Local Authorities are upgrading their current systems, and have had limited engagement with the WCCIS Programme
- Neath Port Talbot Local Authority will be procuring a replacement system - likely to be Spring 2023
- Cardiff Council – are committed to their current system

The diagram below shows the Health Boards and Local Authorities who are already using CareDirector or have committed to do so through a Deployment Order (DO) or are working on a business case.



b) The reasons for any health boards or local authorities not signing up to WCCIS and choosing other systems.

Organisations make their own decisions on whether to adopt the WCCI digital platform, based on local plans, requirements, service models and governance. Encouraging take up requires collaboration at a national, regional, and local level, with organisations working within different accountability frameworks. In addition:

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- Evolving new models of care are affecting system requirements
- Change in ownership of the CareDirector software
- Instability in the technical system between October – November 2021, fully resolved in February 2022
- Trust and confidence of users reduced by past issues
- Impact of COVID on technical resources and staffing
- On-going assessment needed of future technical choices, work on this is currently underway following the Strategic Review into WCCIS.

c) Whether those different systems are interoperable with WCCIS?

The WCCIS programme is leading national data standards work for community health to support interoperability and to drive the adoption of common digital processes. The programme is developing integrations with other national datasets and will define a standard for interoperability as part of the Strategic Review work. This will form a requirement for any future technology choices. Organisations not using WCCIS provisioned systems will be encouraged to adopt these interoperability standards.

d) Organisations currently using the system have moved to it at different times, meaning their deployment orders will also expire at different times. Has DHCW a profile of the timescales for these contractual milestones?

The profile of the timescales for the deployment order contractual timeframes is as follows:

	Initial contract end	Max contract term end
Bridgend	01/01/2024	01/01/2028
Ceredigion	01/01/2024	01/01/2028
Powys	01/10/2024	01/10/2028
Powys Health Board	01/10/2024	01/10/2028
Blaenau Gwent	01/10/2024	01/10/2028
Merthyr Tydfil	01/12/2024	01/12/2028
Gwynedd	01/01/2025	01/01/2029
Anglesey	01/02/2025	01/02/2029
Torfaen	01/04/2025	01/04/2029
Vale of Glamorgan	01/05/2025	01/05/2029
Caerphilly	01/08/2025	01/08/2029
Rhondda Cynon Taf	01/12/2025	01/12/2029
Newport	01/05/2026	01/05/2030
Hywel Dda Health Board	01/05/2027	01/05/2031
Wrexham	01/06/2027	01/06/2031
Conwy	Milestone not met yet*	Not known*
Swansea	01/09/2029	01/09/2033
Aneurin Bevan Health Board	Milestone not met yet*	Not known*
Betsi Cadwaladr Health Board	01/03/2030	01/03/2034
Cwm Taf Health Board	Milestone not met yet*	Not known*

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Contracts may be extended for up to a maximum of 4 years, provided the extensions are enacted before the end date of the Master Service Agreement, which is 31 March 2027.

e) Whether there is a process and a timescale for decisions on a future contracting strategy, including whether to retain the commitment to a single system solution or to allow for a future pattern of different interoperable systems.

The WCCIS Strategic Review which is currently under way will define the future contract and technology strategy. This work is supported by consultancy firms Channel 3 Consulting and In-Form Solutions. The output is due by the end of March 2023 and will include an assessment of future options regarding different interoperable systems and a plan to deliver them.

f) An additional £12 million has been committed to WCCIS over the next three years. How will this be allocated and spent (by project and health board area)? What the timescale is for project completion and the objectives in terms of benefits realisation from the system.

£12m of funding has been committed to the programme for the 3-year period April 2022 to March 2025. This will cover a forecast national programme cost of £8.25 million, and regional funded activity of £3.74 million. The allocation of this investment is as follows:

Table: Forecast spend for WCCIS programme

	Note	FY 2022/23	FY 2023/24	FY 2024/25	Total funding
National Programme Staff	Staff costs including training, travel and subsistence	£1,783,389	£2,462,925	£2,462,925	£6,709,240
National Programme -Non-pay	Additional project and operational costs	£298,637	£400,000	£400,000	£1,098,637
National Programme - Strategic Review	Phase 2 project	£273,660			£273,660
National Programme - hosting	Additional hosting requirements	£173,666			£173,666
Regional Funding - West Glamorgan	Includes implementation support for SBUHB (FY23/24 and FY24/25)	£262,638	£254,932	£360,341	£877,911
Regional Funding - Cwm Taf Morgannwg	Includes funding for Data Cleanse Team delivering national work	£312,606	£46,653		£359,259
Regional Funding - Powys		£75,160			£75,160
Regional Funding - Gwent	Includes implementation support for ABUHB	£210,000			£210,000
Regional Funding - West Wales		£265,000			£265,000
Regional Funding - North Wales	Includes implementation support for BCUHB	£320,000			£320,000
Regional Funding - Cardiff & Vale		£190,000			£190,000
Regional funding to be allocated			£275,000	£630,000	£905,000
Regional integration pilot	Pilot looking at interoperability between WCCIS and other regional systems		£250,000		£250,000
District nursing - service design	Funding for regional support for this project		£288,753		£288,753
	Total	£4,164,756	£3,978,263	£3,853,266	**£11,996,286**

Committed spend

Proposed spend

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Timeline of Programme

Implementation of the WCCIS digital platform CareDirector will continue in those health boards and local authorities that wish to adopt it. This is forecast to conclude in 2027, which would bring the WCCIS programme to its original projected timespan of 12 years.

Benefits Realisation from the System

A benefits roadmap was included as part of the original WCCIS business case. The benefits are realised by supporting implementation of the WCCIS digital platform across Wales. Once the strategic review work packages are complete, benefits will be reassessed and refreshed as part of any future business case. Benefits identified for WCCIS include: quicker hospital discharge, fewer missed appointments and wasted visits, accurate records, safer care, time and cost savings, clinical safety through data sharing, decrease of record duplication, improved service delivery, integrated / shared assessments, reduction in unnecessary hospital admissions, improved patient experience.

WCCIS was identified as an invaluable tool for the Covid-19 response. Where used, frontline health and care staff were able to quickly identify and target support for vulnerable individuals, such as those 'shielding'. Staff were also protected through remote working, and valuable Covid data / insights gained.

g) Any other outstanding key risks around the WCCIS programme and how DHCW is addressing those risks.

What is the risk	How is DHCW managing this
If the Strategic Review outcome does not align to existing live organisations' expectations	Significant engagement has taken place across the WCCIS partner community as part of the Strategic Review activity, with the production of a charter stating common ground and an agreed way forward underway. The programme will seek the agreement on the charter in Q4
If the Strategic Review outcome does not produce a clear direction quickly	Significant engagement has taken place across the WCCIS partner community as part of the Strategic Review activity, with the production of a charter stating common ground and an agreed way forward underway. The programme will seek the agreement on the charter in Q4
If organisations do not adopt national information data standards and national approaches	DHCW and WCCIS are creating a capability to support the creation of digital standards for data and processing for Social Care emulating the work already underway in the Health Care

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Prioritisation and manageability of the DHCW work programme including workforce issues

Q3. In the session, you discussed the challenges DHCW were experiencing with vacancies. You reported that you had a plan in place to address these issues and undertook to share that plan with the Committees.

Our plan to address these issues is set out in our new People and OD strategy published in 2022.

DHCW has made good progress in recruiting staff despite there being a very competitive market for digital and technical skills across the UK, and our limited ability as an NHS employer to compete on salary and wider benefits packages. DHCW has increased its head count from 675 in 2019 to 969 in March 2021 and our staff retention and turnover is around a third of the industry average. DHCW has also won several awards and accreditations:

- Winners of the Best Place to Work in IT at the BCS UK Industry Awards - November 2022
- Finalist for the Best Employer for Health and Well-Being - October 2022
- BS 76000 Valuing People accredited
- BS 76005 Valuing People through Diversity and Inclusion accredited

Q4. The overall number of staff within DHCW (headcount and WTE), the number working on cybersecurity, assurances on whether the right expertise is in place, and how DHCW works with other NHS Wales bodies to address cybersecurity issues.

In December 2022, DHCW had 1075 employees, which is a whole time equivalent of 1040. DHCW has 25 people working on cybersecurity.

DHCW works closely with other NHS Wales bodies through two cyber security delivery functions.

1. Since April 2021, DHCW delivers the NHS Wales Cyber Resilience Unit (CRU) on behalf of Welsh Government, which is the delegated competent authority for Wales under the National Information Security regulations. The CRU provides national guidance, an assessment framework, and assurance reporting. It works closely with NHS Wales organisations designated under the NIS regulations, including DHCW itself. The CRU has a team of 5 cyber security experts.

2. DHCW has its own cyber security team of 20, which provides operational delivery support for DHCW itself and to national programmes. This team advises on cyber issues and threats and acts as the liaison between NHS Wales, other UK Home Countries, the wider cyber security industry, including the UK's National Cyber Security Centre. The team also leads on the coordination of NHS Wales wide responses to any Cyber Security attacks or

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increased threats. There are several national groups or boards that meet regularly to discuss Cyber Security related matters. These include the Operational Security Services Management Board (OSSMB), the Infrastructure Management Board (IMB) and the Microsoft 365 Service Management Board. DHCW organise and facilitate these meetings and have the appropriate technical representation on all of them. DHCW cyber management staff also provide briefings to Health Board and Trusts and peer-groups such as the All Wales Directors of Finance, Directors of Digital and the Independent Members Digital Peer group.

Within DHCW resources there are a range of skills and expertise. DHCW have contractual arrangements with specialist third party providers where additional technical support is required. DHCW has independently accredited ISO27001 certification (Information Security Management System). This requires full re-accreditation every 3 years with surveillance audits every 6-12 months. The last full accreditation was in June 2022.

Q5. In your oral evidence you indicated that there weren't many women within your organisation and agreed to send to the Committees some data around performance on workforce diversity.

DHCW employs a much higher proportion of women than the average across the digital and technology industry. The DHCW workforce is more diverse than the average for the population of Wales. Although the organisation would like to see these numbers increase.

According to UK government-funded growth network Tech Nation, there are around 3 million people employed in the tech industry of which 26% are women (as at January 2022). At DHCW the workforce employed is:

- Gender – Male 59%, Female 41%
- Disability – 5.9% recorded disability, 17% not declared
- Black, Asian Minority Ethnic Community – 7.8% (the population figure across Wales is 4.9% - ONS Nov 2021)

<u>Service transformation</u>

You indicated in the session that: “digital technology is moving from a capital intensive to a revenue-based funding model, particularly as you move from a data centre into the cloud. And that will mean, from an operational perspective, that our funding requirements will change and migrate”. However, you also acknowledged that transformation and future interoperability of systems will require investment in ensuring up to date hardware and systems in health boards and primary care.

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Q6. What is the DHCW view on the future capital funding requirements for digital transformation in healthcare within Wales?

DHCW's view is informed by its close working with other NHS Wales organisations and engagement with the wider digital health and care sector in the UK and internationally. Our view is that the capital funding requirement for digital transformation may reduce, but the revenue funding requirement will significantly increase, by more than any capital reduction.

This is driven by two industry trends. Firstly, a shift from capital to revenue funding, driven by a transition from on-premises hardware and licence-based software to cloud infrastructure and software which has a subscription or consumption based charging model. Secondly an overall increase in funding requirements driven by increasing use of data and digital, and by general inflation and specific cost increases from digital suppliers.

DHCW is not able to quantify the capital or revenue funding requirements for digital transformation at this time. DHCW is working with the All Wales Directors of Digital Peer Group to assess the digital maturity of each organisation in NHS Wales using international benchmarks, and to clarify the definition of digital spend. This consistent and objective approach across Wales will help to prioritise digital investment and forecast future funding requirements.

Q7. How is DHCW ensuring that the software you develop is usable by others within NHS Wales?

DHCW works closely with users to understand their requirements and to design and deliver software which meets user needs. Through a Stakeholder Engagement Strategy and Plan DHCW also works closely with delivery organisations and other key partners like the Centre for Digital Public Services. DHCW undertakes extensive clinical engagement, employs clinical leads, and co-designs systems with users. The NHS Wales App is currently in a 'managed private beta' phase through which there is structured testing and feedback with up to 1000 users.

Our approach to user design also includes:

- Engaging with the Welsh Clinical Informatics Council which acts as a user request / assurance / change control forum for clinical software. This forum is chaired by the DHCW Medical Director
- Clinical user assessment and patient safety assessments form part of DHCW's formal assurance process, which is overseen by the Welsh Informatics Assurance Group
- The DHCW Business Change team works with users to provide support, particularly in areas of digital transformation and adoption. The Business Change team offers a mix of

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support delivering technical advice on changes to the system, training, eLearning and quick reference guides, videos and demonstrations, in addition to collecting user feedback informing product enhancements

- Regular meetings are held between the DHCW executive team and the executive teams of partner NHS bodies throughout the year to review and agree organisational priorities and alignment at a strategic level
- Major digital services are overseen by Service Management Boards, Change Advisory Boards, and Clinical Advisory Boards, which provide guidance and feedback on user requirements and experience
- Our Service Desk handles around 250,000 calls a year, which includes feedback from users, as well as technical support ensuring that callers are able to use our digital services

Social Care

Q8. DHCW's focus to date has been very largely on healthcare. What plans there are for any expansion of work into social care?

The DHCW Transition/Establishment Programme Board agreed that DHCW's role with regards to social care would be to support the delivery of joined up digital services for health and social care, without impacting the current mechanisms for governance and accountability for directly delivering care.

Following DHCW's establishment a Memorandum of Understanding (MOU) with Social Care Wales was developed to set out how DHCW and Social Care Wales will jointly deliver many of the strategic digital health and care priorities, the MOU was agreed and signed by both parties.

In November 2022 DHCW's Leadership Team expanded to include a new role of the Director of Primary, Community and Mental Health Digital Services. This role will forge closer links with Social Care colleagues in Local Government and the 3rd Sector, with the aim of understanding how best DHCW can help support the social care challenges, now and in the future.

Engagement with users in health and social care is at the heart of the development and delivery of the WCCIS programme.

Data security and patient access

Q9. Since Welsh Government published Informed Health and Care - a Digital Health and Social Care Strategy for Wales in 2015 there has been a strategic aim to make patients medical records and data available. Other countries have provided direct electronic patient access to their records. What plans are there in Wales for progressing work on this?

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Through the Digital Services for Patients and Public Programme DHCW is delivering the NHS Wales App, which will give people access to health and care services through their electronic devices. The NHS Wales App will provide a safe and coordinated way for people in Wales to access records held about their health and care and to help them access appropriate services when needed.

This programme will start with patient access to their summary care record, as coded and held in the primary care system. This will be supplemented with appointments and signposting to disease specific online resources to help self-management of specific disease conditions such as diabetes and help promote improvement behaviours such as stopping smoking and weight management.

The NHS Wales App is currently in a managed private beta phase involving around 1,000 people. It is anticipated to transition to a public beta phase in Spring 2023, followed by a full live release later this year.

Q10. In the session the Committees asked whether there were any machine decision making processes taking place in relation to patient data. You undertook to provide details of what was in place currently.

The Committees were interested in particular on:

A. **The use of algorithms, categorisation, and predictive analytics;**
B. **If so, the datasets that are being used in them and how categories are decided;**
C. **Details of the data controllers, the data processors and any audits undertaken in those areas;**
D. **Whether any data sets are currently open-source or planned to be made open-source.**

Early projects have involved working in partnership with academia and NHS partners in the use of machine learning in areas such as Did Not Attend prediction and Natural Language Processing, with encouraging early results.

Through the National Data Resource Programme, DHCW has recently confirmed arrangements for using the Google Cloud Platform to host key services including national data stores, data services, and a data analytics platform. Subject to robust and transparent, ethical and governance processes, this will provide opportunities to increase the use of algorithms, categorisation, and predictive analytics. Leads from DHCW have met with Sarah Murphy MS following her questions at the scrutiny session and we will be happy to provide further updates to the Committees as our activity in this area develops.

DHCW are supporting a new All Wales AI Working Group, established to improve co-ordination of Machine Learning and AI across NHS Wales.

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DHCW has robust Information Governance and Data Privacy processes. Any new information processing is subject to a Data Protection Impact Assessment (DPIA), and this will include AI and other approaches. DHCW works closely with the Information Commissioners Office and will follows the Information Commissioners Office guidance and seek specific advice to ensure any AI system is compliant with data protection law and provides safeguards for individuals rights and freedoms.

Whilst we publish information that relates to NHS activity, we do not currently have any data sets that are open source. We are developing options to publish further data in a safe and secure way, working with open data principles.

Q11. What assessment has DHCW made of any changes to General Data Protection Regulations (GDPR) and how could this impact on data collection, protection and sharing of NHS Wales data. In the evidence session you highlighted the need for improved cross-border data and systems interoperability between NHS services in Wales and England and indicated there was work underway on this issue. We would be grateful if you could keep the Committees updated on progress in this area of work.

The Data Protection and Digital Information Bill (first reading 18 July 2022) followed publication of the UK Government's response to Data: a New Direction Consultation.

Once the Bill reaches its final stage it will become the Data Protection and Digital Information Act 2022, which will enact changes in current UK legalisation. The proposed Bill looks to amend rather than radically overhaul current legislation – the UK GDPR and Data Protection Act 2018. Key areas include:

- Reform of the Information Commissioners Office structures, duties and enforcement powers
- Frameworks for Digital Verification Services
- Updates to Provisions on Information Standards for health and adult social care (England Only)
- Provisions relating to smart data schemes and the sharing of customer data
- Provisions to facilitate the flow of data for law enforcement and national security
- Reforms in Birth and Death registrations enabling a move to an electronic system
- Research provisions
- Cross Border flows of Information (Ref - Cross UK and Euro Borders)

Data safety and audit

DHCW places high importance on patient confidentiality and data security for all national systems, this is managed through:

- A user ID for every member of staff

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- An electronic master patient index to keep patient data such as name, address, date of birth and sex, current and accurate
- Specialised user monitoring software known as the National Intelligent Integrated Audit Solution which proactively monitors users access to patients' electronic records, potential data breaches, and highlights unusual or suspicious activity for further investigation. This software protects privacy and helps NHS Wales organisations build trust with citizens, enabling the sharing of patient data where legitimate use cases exist.
- Patients may opt out of a summary of information held by their GP being used within other Health Care bodes

Q12. In the evidence session you highlighted the need for improved cross-border data and systems interoperability between NHS services in Wales and England and indicated there was work underway on this issue. We would be grateful if you could keep the Committees updated on progress in this area of work.

Work is underway with four NHS England Integrated Care Systems which border Wales to improve cross-border data sharing, cross-border care pathways, and interoperability between systems. The initial focus of this work is on the Powys area, due to its health system configuration, through which Powys Teaching Health Board commissions services from adjacent health providers in England, as well as other NHS Wales organisations.

We will be happy to keep the Committees updated on this work as it progresses.

Cancer information systems

Q13. In the session, you indicated that Phase 1 of the replacement system for CaNSIC would be going live in November. You also indicated that Phases 2 and 3 were complex, would require detailed planning, and could take up to two years to put in place.

We would be grateful if you could provide further information on:

A. **The original timescales for the replacement of CANISC, and any reasons for slippage against those.**
B. **The current timetable for decommissioning CANISC and replacing it with alternative system/s.**
C. **Whether you are on track to achieve the current timetable, and whether the decommissioning of activity due for November that was mentioned in the evidence session has taken place.**

The Cancer Informatics programme was established in November 2019. The first major milestone, Phase 1, went live on 14 November 2022 at Velindre Cancer Centre, reducing the reliance on CANISC for information access and availability of the cancer care record.

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Phase 1 was delivered within the three-year timeline, maximising investment already made in existing national applications/services (Welsh Clinical Portal - WCP and the Welsh Patient Administration System - WPAS).

In addition, the focus of Phase 1 has been on standardising data across Wales and improving workflows for cancer pathways across health board boundaries. This followed earlier work undertaken to ensure the summary cancer record was available to clinicians across Wales. The next phase of development will focus on functionality in WCP to support palliative care and colposcopy services.

From Quarter 1 2023/24, cancer services across Wales will start to transition to use the newly developed software to capture cancer data; the transition will progress sequentially (services for one tumour site at a time) starting with cancer data that is required for national audits. This will reduce CANISC usage through 2023 to the point where it can be switched to "read only" during 2024.

Key performance indicators (KPIs) and benchmarking

Q14. In the evidence session you indicated that you were using your KPIs to benchmark your performance against other organisations. Could you provide further information on the benchmarking referred to, indicating how your performance compares to elsewhere in the UK and more widely.

DHCW reports detailed KPIs to the DHCW Board at its public meetings which are available to view from the DHCW website via the Integrated Organisational Performance Report. KPIs cover all areas of DHCW delivery performance through our Integrated Organisational Performance Report. Several KPIs reported on can be benchmarked against other NHS organisations.

We are exploring areas in which we could introduce benchmark reporting. For example, we have identified a KPI on Service Availability which has been benchmarked against NHS Digital, and will now be presented at the DHCW Board meetings from January 2023 onwards.

As mentioned above, DHCW is working with health boards and trusts in Wales to undertake digital maturity assessments, using internationally recognised assessment frameworks which can be benchmarked between organisations in Wales, the UK and internationally. DHCW is funding this national approach across NHS Wales, using the HIMSS Electronic Medical Record Adoption Model (EMRAM) digital maturity assessment (for technical functionality) and the KLAS User Research survey (for user experience). Together these assessments are expected to provide a robust benchmark across Wales which will be a foundation for prioritised investment and planning.

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Prison healthcare data

Q15. The Fifth Senedd's Health, Social Care and Sport Committee's inquiry into health and social care provision in the adult prison estate in Wales heard evidence around the limitations of the IT infrastructure used in prison healthcare. The Minister for Health and Social Services has said Welsh Government are assessing the resourcing needed to improve access to the medical records of prisoners, although this has implications in terms of IT infrastructure and investment priorities. Have DHCW been involved in any work or discussions around this area?

DHCW provides a full suite of modern IT infrastructure services to HM Prisons in Wales in the same way as delivered to GP Practices in Wales, such as Broadband Connectivity (PSBA), Managed Desktop PCs and Printers, Microsoft Office 365 (NHS email/Teams), Training and Service Desk support.

DHCW also provides Welsh Prisons with access to a shared (England and Wales) Prison Clinical System to support offender healthcare and immediate access to offender's health record when offenders move between Prisons across England and Wales.

In addition to the Prison Clinical System, DHCW also provides Prisons with access to our national applications such as the Welsh Clinical Communications Gateway (WCCG) for e-referrals and the Welsh Clinical Portal (WCP) providing access to the patient's full medical record, including the record held by the patient's registered GP. Currently, two Prison (HMP Berwyn and HPM Cardiff) have access to these services with plans to roll out to remaining Prisons this year.

DHCW is not aware of any discussions or received requests for additional IT services beyond what is currently provided or available to Prisons.

Y Pwyllgor Iechyd a Gofal Cymdeithasol
–
Health and Social Care Committee

Y Pwyllgor Cyfrifon Cyhoeddus a Gweinyddiaeth Gyhoeddus
–
Public Accounts and Public Administration Committee

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Chief Executives of health boards

5 December 2022

Dear colleague

Welsh Community Care Information System (WCCIS)

On Wednesday 26 October the Health and Social Care and Public Accounts and Public Administration Committees held a concurrent session to scrutinise Digital Health and Care Wales.

Following the evidence session, Members agreed to write to you with to seek information on the issues outlined in the annex to this letter.

As we will be returning to these issues next term, we would welcome a response by 13 January 2023.

Yours sincerely

Russell George MS
Chair, Health and Social Care Committee

Mark Isherwood MS
Chair, Public Accounts and Public Administration Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Annex: questions for health boards following scrutiny of Digital Health and Care Wales on 26 October 2022

Following the Committee's general scrutiny session with Digital Health and Care Wales on 26 October 2022, we would welcome information on the matters listed below. We would be grateful to receive your response by 13 January 2023.

1. Whether your health board has agreed to adopt the Welsh Community Care Information System (WCCIS)

2. If so, an overview of the current position in implementing WCCIS within the health board

3. If your health board has chosen to use a different system instead of WCCIS:

    a. The reasons for deciding to do so;

    b. Whether that system is interoperable with WCCIS;

    c. Any potential risks that have been identified, and how they are being managed.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Our Ref: NP/MO Date: 9th January 2023

Email SeneddHealth@senedd.wales

Mr Russell George MS
Chair, Health and Social Care Committee
Mr Mark Isherwood MS
Chair, Public Accounts and Public Administration Committee
Welsh Parliament
Cardiff Bay
Cardiff
CF99 1SN

Dear Members of the Welsh Parliament

Welsh Community Care Information System (WCCIS)

Further to your letter of 5th December 2022, I am pleased to confirm that Aneurin Bevan University Health Board has committed to implementing WCCIS.

The Health Board's business case was approved in 2018 with an original go LIVE date of July 2019. Following a delay notice from the supplier in February 2019 to inform us that there were delays to the integration development, the go LIVE date was rescheduled. The Health Board's programme is split into five phases affecting over 4000 members of staff. The implementation plan was therefore phased over a 3-year period recognising the significant business change activities required.

The Health Board went LIVE with Mental Health & Learning Disabilities Services (MH&LD) in August 2022, following significant delays due to system readiness and performance issues. Due to the end of life of the current MH&LD system in use within Aneurin Bevan University Health Board, the decision was taken to go LIVE on WCCIS without integration and interoperability with other national systems, and without the mobile app being available. This has presented a significant loss of benefits to the service, the Health Board and to the Gwent Region.

Cont/d

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Unfortunately, the integration and mobile app are still not available for use and the Health Board is awaiting national programme and supplier delivery plans.

The focus for the Health Board is currently on supporting the MH&LD services and transitioning to a business-as-usual state. We are currently in a position where we are unable to carry out statutory reporting to Welsh Government from WCCIS and await essential system fixes and changes to enable reporting to recommence.

The Health Board is working with the national programme team to determine a prioritisation process for fixes and a national release schedule. We also await the national programme plan and progress on the strategic review recommendations to enable planning to commence for future phases and further roll out.

Aneurin Bevan University Health Board remains engaged as a Gwent Region and seek ways to collaborate and align system and contract requirements.

I hope the above update is helpful but should you have any queries please do not hesitate to contact me.

Yours sincerely

Nicola Prygodzicz
Prif Weithredwr / Chief Executive

Response from Betsi Cadwaladr University Health Board

Whether your health board has agreed to adopt the Welsh Community Care Information System (WCCIS) If so, an overview of the current position in implementing WCCIS within the health board

In the Betsi Cadwaladr University Health Board (BCUHB) context, we will answer the first two questions together.

WCCIS is the commercial off the shelf product (COTS), which is Care Director v5 from the company, Advance. v5 is obsolete and Advance sells Care Director v6 to the market primarily as a Mental Health or Social Care System.

BCUHB has persevered with the WCCIS programme for several years, making slow progress due to many and varied issues. BCUHB has finally got to the stage where a pilot is running with a small number of users in order to test the efficacy of the system and inform decisions on its future adoption.

The pilot is due to complete by March 2023, at which point there will be a report initially to the BCUHB WCCIS Project Board recommending a way forward. That Board will then make recommendations to the Health Board as to the way forward.

The original expectation of the product was to be able to use it in Community and mental Health Services and have some information sharing with Local Authorities. This requirement is undermined due to the level of dissatisfaction with Care Director v5 as a Social Services System in Local Authorities. Denbighshire, Flintshire and Wrexham have decided that they will not adopt WCCIS and others who have it are considering their current position. Therefore, for BCUHB that spans the geography of the whole of North Wales, the integration with Social Care will be limited and service design and delivery would be inconsistent, adding more complexity and cost overall.

The scope of the pilot is primarily Community Services functionality. It is expected that the functionality of Care Director V5 will not be sufficient to meet the basic requirements for Community Services. However, it is

understood through inquiries, that Care Director V6, may address many of the deficiencies identified.

This will be a consideration in the evaluation report post pilot in March 2023. BCUHB understands from DHCW that an upgrade from v5 to v6, and the use of v6 would come at no additional costs.

NB. With there being no digital capabilities in Mental Health, the risks with current systems in Therapies being unsupported and there being no money, BCUHB is also considering the use of WCCIS for Mental Health and Therapies functionality. Although this will be regarded as a Hobson's choice.

If your health board has chosen to use a different system instead of WCCIS:

a. The reasons for deciding to do so;

The Health Board has not chosen to use a different system at this stage and due to the financial constraints, are likely not to do so.

b. Whether that system is interoperable with WCCIS;

Not applicable to BCUHB

c. Any potential risks that have been identified, and how they are being managed.

There are significant risks across the Health Board with the willingness of services to adopt WCCIS. Examples would be the poor functionality compared to existing systems in use (i.e., Therapies Service who currently use an obsolete system called Therapy Manager) and the lack of a mobile version.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

PM/TLT
12 January 2023

Private and Confidential
Ms Madelaine Phillips
Policy and Public Affairs Officer
Welsh NHS Confederation

Dear Madelaine

Health Committee Letter on Welsh Community Care Information System

Thank you for your email of the 6 December 2022 asking for information on the letter from the Health and Social Care Committee. Please see below comments from CTMUHB :

1. **Whether your health board has agreed to adopt the Welsh Community Care Information System (WCCIS)**

   As a Health Board we have worked in collaboration with our adjacent Health Boards to understand their roll out plans for WCCIS.

   Given our challenging position with the availability of information for Mental Health Services, we have proposed to focus our roll out of WCCIS for Mental Health in the first instance.

   This decision has also been made in collaboration with the Local Authorities within the Cwm Taf Morgannwg region.

   While there have been concerns raised regarding the suitability of WCCIS, we are committed to ensuring the long term join up of services between Health & Social Care throughout the Cwm Taf Morgannwg region.

Cyfeiriad Dychwelyd/Return Address:
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Cwm Taf Morgannwg University Health Board, Headquarters, Navigation Park, Abercynon, CF45 4SN

Cadeirydd/Chair: Emrys Elias Prif Weithredwr/Chief Executive: Paul Mears

2. **If so, an overview of the current position in implementing WCCIS within the health board**

   The rollout of WCCIS within Mental Health is subject to final approval of a Business Case by our Health Board. Funding will need to be made available to support the implementation, technology requirements and long term sustainable operating support model.

   It is anticipated that this will be submitted to our March 2023 Board and an implementation plan commencing in Quarter 1 of 2023/2024.

3. **If your health board has chosen to use a different system instead of WCCIS:**

   N/A.

Yours sincerely

Paul Mears
Prif Weithredwr/Chief Executive

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Swyddfeydd Corfforaethol, Adeilad Ystwyth
Hafan Derwen, Parc Dewi Sant, Heol Ffynnon Job
Caerfyrddin, Sir Gaerfyrddin, SA31 3BB

Corporate Offices, Ystwyth Building
Hafan Derwen, St Davids Park, Job's Well Road,
Carmarthen, Carmarthenshire, SA31 3BB

Ein cyf/Our ref: CEO9402 G

Dyddiad/Date: 13 January 2023

Russell George MS,
Chair, Health and Social Care Committee

Mark Isherwood MS,
Chair, Public Accounts and Public Administration Committee

Email: SeneddHealth@senedd.wales

Dear Russell and Mark,

Re: Welsh Community Care Information System (WCCIS)

Thank you for your letter of 5 December 2022 and for the opportunity to provide evidence to the Health and Social Care Committee on the adoption of the Welsh Community Care Information System (WCCIS) within our Health Board.

Please find attached our response to the questions raised by the Committee. Should the Committee have any further queries, I would be happy to provide additional information.

Yours sincerely

Steve Moore
Chief Executive

Enc. Hwyel Dda University Health Board WCCIS position statement

Health and Social Care Committee 26/10/2022 – Welsh Community Care Information System (WCCIS)

1. **Whether your health board has agreed to adopt the Welsh Community Care Information System (WCCIS)**

The vision for integrated, person centred health and social care services is critical for the integration of services which and is fundamental to the digital direction of the Health Board.

We recognise that WCCIS/CareDirector system can support this integrated working across Health and Social Care. However, while the vision is right, the system itself has a number of fundamental issues which have affected the expected functionality and system performance. This has impacted on adoption, meaning that the vision is still a long way from being realised, as highlighted by the Auditor General's report in July 2022.

In August 2017, our Board received an outline business case for the implementation of WCCIS within Hywel Dda in pilot form. This pilot implementation would run for 12 months from signing the deployment order or until such time that an evaluation of the product could be undertaken. The initial deployment order was for community nursing and integrated teams only as proposed by CareWorks (the systems supplier, now changed to Advanced), however we had the ability to define what we considered to be an integrated team. Mental Health and Therapies were excluded unless part of an included integrated team, and a separate deployment order would be required for implementation to any other area.

Our deployment order was formally signed in November 2019 with the first users onboard in December 2019. The deployment order was limited to a maximum of 400 users. Currently the Health Board has 389 active users, most of whom are community staff within Ceredigion.

The Committee should note that it was always the intention of the WCCIS Project to begin with the implementation within the Community Nursing sector as they do not have any digital collection systems and would benefit the most from implementation. Mental Health teams have a robust clinical reporting system, as do Therapies for the secondary care elements.

2. **If so, an overview of the current position in implementing WCCIS within the health board**

As stated above WCCIS is currently used by about 389 staff consisting of District Nurses, Porth Gofal integrated team (the integrated community team between the Health Board and Ceredigion County Council) and Children's Disabled Health Team in the Ceredigion area, Flying Start teams in both Carmarthenshire and Pembrokeshire and generic Health Visitor and Looked after Children teams.

The Health Board fully supported the adoption of WCCIS, however there have been a number of negative experiences raised by front line staff around the use of WCCIS within Hywel Dda. As a result of the issues the Digital Director wrote to the Programme Director for WCCIS outlining the following specific user issues. Please note that this is not a full list of the user issues but are the key themes.

- Community Nursing, Health Visitors and Community Therapies services remain supportive of WCCIS and a desire for other teams to begin using the WCCIS system now that performance of the system appears to have been stabilised. However, we are reluctant to bring new users on to WCCIS and to increase license numbers until the Mobile App and Integration is available. The Mobile App and Integration are approximately 26 months behind the original delivery date. We have recently tested a beta version of the mobile application, but it is not truly a native mobile application, but a secure website which requires a secure connection to a mobile network or wi-fi to be operational. Connectivity challenges within our rural communities makes this response more challenging for us operationally.

- The lack of mobile integration, and contemporaneous note taking within the system means that the current version is not fit for purpose. Community nurses have to make written notes at the time of the patient encounter and then type these notes into WCCIS later. This leads to duplicated effort, which is wasteful and frustrating for our staff. While the scanning into WCCIS of hand-written, paper-based documentation is possible, linking the scanned image to the patient record is time consuming and limits the ability to extract useful data for reporting and analytics from the system.

- District nurses need to be able to refer to existing information about a patient and without mobile or offline access to relevant patient information or documents the district nurses need to take paper notes with them. The paper file for a patient needs to be as complete as possible which means that the paper files need to include any documentation that is created on WCCIS which leads to printing from WCCIS to go into the paper file.

- Access is also needed to non WCCIS documents which are created electronically and form part of the “single patient record”. Documents such as Outpatient Clinic letters and Discharge Advice Letters cannot be accessed via WCCIS as the integration work has not been completed.

The Health Board acknowledges that the digital transformation programme within the Community setting is very complex, however the issues that have been experienced by our front line users with WCCIS have hampered the continued improvement. The system will need to be user designed to allow ease of use and provide the reporting and the interoperability required for the strategic direction of the Health Board The current Master Services contract states that the contract will run for a period of 7

years, with options to extend annually for a further period up to March 2030. As the deployment order was agreed in 2019, the Health Board will be out of contract in 2026. To that end the Health Board is actively exploring a replacement solution for district / community nursing which will allow the flexibility outlined in the feedback from users, based on the timescales for adoption, a new system will have to be commissioned within 2024/2025.

3. **If your health board has chosen to use a different system instead of WCCIS:**
    a. **The reasons for deciding to do so;**

N/A

    b. **Whether that system is interoperable with WCCIS;**

N/A

    c. **Any potential risks that have been identified, and how they are being managed**

N/A

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Cadeirydd / Chair: **Emma Woollett**
Prif Weithredwr/Chief Executive: **Mark Hackett**

gofalu am ein gilydd, cydweithio, gwella bob amser
caring for each other, working together, always improving

Rydym yn croesawu gohebiaeth yn y Gymraeg neu'r Saesneg. Atebir gohebiaeth Gymraeg yn y Gymraeg, ac ni fydd hyn yn arwain at oedi.
We welcome correspondence in Welsh or English. Welsh language correspondence will be replied to in Welsh, and this will not lead to a delay.

Date: 13th January 2023

Swansea Bay University Health Board
Headquarters
One Talbot Gateway, Seaway Parade,
Port Talbot
SA12 7BR

Russell George MS Chair, Health and Social Care Committee
Mark Isherwood MS Chair, Public Accounts and Public Administration Committee

Sent via email to: SeneddHealth@senedd.wales

Dear colleague,

Welsh Community Care Information System (WCCIS)

Further to your letter of 5th December 2022, I am pleased to provide the information you have requested, as detailed in my response below.

Whether your Health Board has agreed to adopt the Welsh Community Care Information System (WCCIS)

The Health Board is committed to adopting WCCIS and has invested considerably in readiness activities, which includes the development of a comprehensive benefits realisation plan and significant regional planning with local authority colleagues over a number of years. The Health Board's has previously approved an outline business case (OBC) for the implementation of WCCIS within Swansea Bay University Health Board (SBUHB). A full business case (FBC) has been in development and is due to be presented to Management Board for approval in Q4 2022/23.

If so, an overview of the current position in implementing WCCIS within the Health Board

SBUHB already has 450 users of WCCIS under the Swansea Council deployment of WCCIS and continue to work closely with Swansea Council and the region on WCCIS adoption and benefits realisation.

As outlined above SBUHB are in the process of completing the development of an FBC for consideration for internal approval. The development of the FBC, following the approval of the OBC, has been delayed due to a number of external factors beyond the HBs control including COVID, the WCCIS strategic review, gaps in "health" system functionality, system performance and commercial arrangements.

SBUHB have invested significant resources into WCCIS since its national procurement and have supported the national program and regional implementation/development, as well as completing readiness work locally and investing in the preparation of business cases. The local OBC and FBC outline the significant investment required to implement the solution to SBUHB's 3500 users and the further investment needed to pay for the solution and local support going forward. Therefore, significant focus is being placed on identifying and measuring the potential benefits from WCCIS that can be realised to cover the ongoing costs.

Funding the implementation costs (in excess of £3m over 4 years) is particularly challenging in the current environment. However, we have a worked up local investment plan and have also established potential support from WG and the National Program Team. To this end, a proposal to access WG Digital Priority Investment Funding (DPIF) to part fund the implementation has been submitted in January 2023. The approval of this is crucial to enabling SBUHB to progress with the implementation of WCCIS.

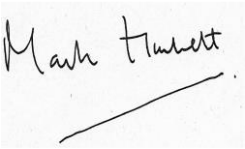
Subject to approval of the FBC and funding model, SBUHB are targeting the signing of a deployment order for WCCIS in Q2 2023/24. This is based on the assumption of adopting the current platform and the assurances that any move to a different/new version platform would be cost neutral to SBUHB. It also assumes the necessary integrations with the National Technical Architecture will be in place prior to the SBUHB first phase go live date.

Not applicable:

If your health board has chosen to use a different system instead of WCCIS:

a. The reasons for deciding to do so;
b. Whether that system is interoperable with WCCIS;
c. Any potential risks that have been identified, and how they are being managed.

Yours sincerely



MARK HACKETT
CHIEF EXECUTIVE

Y Pwyllgor Iechyd a Gofal Cymdeithasol

—

Health and Social Care Committee

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Lynne Neagle MS
Deputy Minister for Mental Health and Wellbeing
Welsh Government

16 January 2023

Dear Lynne

Food Supplement and Food for Specific Groups (Miscellaneous Amendments) Regulations 2022

Thank you for your letter of 20 December 2022 regarding the above Regulations. We considered your response, and your recent exchange of correspondence with the Legislation, Justice and Constitution Committee, at our meeting on 11 January 2023. Following our discussion, we would welcome clarification of the following issues (including, where appropriate) where the relevant information can be found in the Explanatory Memorandum to be laid alongside the Regulations.

Timing of the Regulations

Your letter of 21 November indicated that the Regulations would be laid before the UK Parliament on 14 December 2022, and that they would come into effect on 18 January 2023. Your subsequent letter of 20 December 2022 states that the Regulations will be laid "in December". We noted at our meeting on 11 January 2023 that the Regulations do not yet appear to have been laid.

1. Could you confirm when the Regulations are expected to be laid and enter into force?

2. Could you outline why the Regulations have been delayed, and whether the delay will give rise to any consequences?

Divergence with Northern Ireland

You indicate in your letter of 20 December 2022 that no formal assessment has been undertaken of divergence between GB and Northern Ireland regarding barriers to trade or public health.

3. Could you clarify whether standards will be different in GB and Northern Ireland as a result of the amendments to be made by the Regulations?

Bilingual legislation

In your answer in your letter of 20 December to question 3 from our letter of 1 December 2022, you explain that you considered different options for taking forward the proposed amending regulations, including the option for Welsh Government to bring forward its own Statutory Instrument. However, you did not indicate whether the availability of legislation in Welsh and in English, and the implications for the accessibility of law in Wales, was a factor in your consideration.

4. What consideration was given to the impact of the UK Government making regulations on the accessibility of the law and the availability of bilingual legislation?

Consultation with stakeholders

In your response to the LJC Committee's letter, you explain that the UK Government undertook a three week consultation with specific stakeholders on the proposed changes.

5. Could you provide details of which stakeholders were consulted, and how any responses are reflected in the Regulations?

Amendments to be made by the Regulations

Thank you for the information you have provided on the rationale for the amendments to be made by the Regulations. We welcome the indication that the Welsh Government will be bringing forward its own Regulations regarding baby food.

We note that one amendment will update the definition of pesticide residue from the terminology used in Regulation (EC) No 1107/2009 to a narrower definition taken from an earlier regulation (Regulation (EC) No 396/2005).

6. Could you provide further information about the rationale for reverting to a narrower definition, and what the implications of such a change might be?

We would be grateful for a response by 24 January 2023.

Yours sincerely

Russell George MS
Chair, Health and Social Care Committee

cc Jayne Bryant MS, Chair, Children, Young People and Education Committee
Huw Irranca-Davies MS, Chair, Legislation, Justice and Constitution Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Lynne Neagle AS/MS
Y Dirprwy Weinidog Iechyd Meddwl a Llesiant
Deputy Minister for Mental Health and Wellbeing

Llywodraeth Cymru
Welsh Government

Russell George MS,
Chair, Health and Social Care Committee
Welsh Parliament
Cardiff Bay
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24 January 2023

Dear Russell,

Food Supplement and Food for Specific Groups (Miscellaneous Amendments) Regulations 2023

Thank you for your follow up letter dated 16 January 2023 regarding the above amending regulations. If I take each of your points in order.

1. **Could you confirm when the Regulations are expected to be laid and enter into force?**

The legislation was laid on Friday 13 January. The link is attached The Food Supplements and Food for Specific Groups (Miscellaneous Amendments) Regulations 2023 (legislation.gov.uk).

2. **Could you outline why the Regulations have been delayed, and whether the delay will give rise to any consequences?**

DHSC officials advised on 12 December that the Regulations would not be laid 14th December 2022 due to them not being unable to get the necessary Ministerial clearance in time.

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Gohebiaeth.Lynne.Neagle@llyw.cymru
Correspondence.Lynne.Neagle@gov.wales

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3. **Could you clarify whether standards will be different in GB and Northern Ireland as a result of the amendments to be made by the Regulations**

The standards will be the same across GB and Northern Ireland. The GBSI makes minor amendments and forms part of a single GB legislative framework. This is consistent with the approach taken in respect of previous legislative amendments in this area. The EU has made legislation to make the same amendments which are already applicable in corresponding nutrition regulations across the EU.

4. **What consideration was given to the impact of the UK Government making regulations on the accessibility of the law and the availability of bilingual legislation**

They met the following criteria specified by the Counsel General for when such legislation may be made in the UK Parliament on behalf of Welsh Ministers.

a. where the interconnected nature of the relevant Welsh and English administrative systems mean that it is most effective and appropriate for provision for both to be taken forward at the same time in the same legislative instrument; and

b. where the devolved provisions in question are minor or technical and non-contentious.

The regulations are considered to be technical in nature for this purpose and as such I considered there to be limited impact.

5. **Could you provide details of which stakeholders were consulted, and how any responses are reflected in the Regulations?**

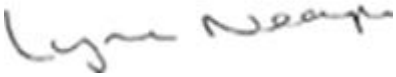
The consultation invited comments from the food and nutrition industry, representative groups, the public and other interested parties across the UK on the proposed approach. The consultation document was also placed on the Knowledge Hub, a closed forum for Local Authorities, to discuss views on enforcement issues.

There was overall support for the technical amendments to food supplements and the respondents welcomed the changes which were proposed. There was a request for a longer transition period for the change in unit of measurement used for labelling copper in food supplements and this was agreed and reflected in the SI.

6. **Could you provide further information about the rationale for reverting to a narrower definition, and what the implications of such a change might be**?

This change will provide a more precise definition of residues taken from Regulation (EC) No 396/2005 (on maximum residue levels of pesticides in or on food and feed of plant and animal origin) and give more clarity and consistency with the definition which is used in the legislation for general food.

Yours sincerely,



Lynne Neagle AS/MS
Y Dirprwy Weinidog Iechyd Meddwl a Llesiant
Deputy Minister for Mental Health and Wellbeing

Y Pwyllgor Llywodraeth Leol a Thai

Local Government and Housing Committee

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Russell George MS
Chair
Health and Social Care Committee

19 January 2023

Dear Russell

Corporate Joint Committees and the broader partnership landscape

At our meeting on 14 December 2022, the Local Government and Housing Committee agreed to undertake work during the autumn term on Corporate Joint Committees ("CJCs") and their role within the broader partnership landscape in Wales. As part of this work the Committee is keen to explore how CJCs interact with, and impact, other examples of partnership working in Wales, including Public Services Boards and Regional Partnership Boards ("RPBs"). As RPBs is an area of mutual interest, we discussed the possibility of holding a joint session with your Committee to look at whether the current system provides for the effective delivery of services.

I would be grateful if you could consider this opportunity for joint working as part of any forward work planning discussions you may be having with your Committee. In the meantime, I have asked my clerk to ensure that your clerk is kept informed as our planning for the inquiry develops.

Yours sincerely

John

John Griffiths MS

Chair

Croesewir gohebiaeth yn Gymraeg neu Saesneg.

We welcome correspondence in Welsh or English.

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Russell George
Chair Health and Social Care Committee
National Assembly for Wales

Russell.George@senedd.wales

19 January 2023

Dear Russell,

During the evidence session for the dentistry inquiry, I agreed to provide the committee with the Health Board Chairs' objective in relation to improving access to NHS dental services. The wording is as follows:

> *"Demonstrate how the Board has sought assurance regarding improving access to dentistry for the health board's population"*

To evidence delivery of this objective each health board will need to provide data available to them from activity levels demonstrating the impact of dental contract reform measures including an increase in access to NHS dentists.

I hope the committee finds this information useful.

Yours sincerely,

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
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