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Dear Russell,

Thank you for your letter of 8 July on behalf of the Health and Social Care Committee regarding progress against the Committee's 2019 recommendations for endoscopy services in Wales.

You have requested updates on several specific points. I have set out my response according to your numbered questions but have re-ordered the subsidiary points for ease of explanation.

1. Please provide an update on progress in implementing the national endoscopy action plan, including:

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

b. Whether changes in the programme so far have increased referrals for endoscopic procedures.

d. Efforts to address health inequalities, particularly to increase uptake among men in deprived areas.

I hope the Committee does not mind me referring to our previous responses and the National Endoscopy Action Plan, which explains that optimisation of the Bowel Screening Programme is not part of the Action Plan or the work of the National Endoscopy Programme Board.

The Bowel Screening Programme involves sending a person with no known symptoms of bowel cancer, a Faecal Immunochemical Test kit ("FIT") to their home address, for self-sampling and return. Public Health Wales sends these testing kits to the eligible population and then measures the amount of blood found in the returned sample. This is the primary screening test. Those people with a positive result are then referred to health boards for colonoscopy. Optimisation of the bowel screening programme only refers to the introduction of FIT as the initial screening test to replace the Faecal Occult Blood ("FOB") test; changes to the age range of those invited to participate in the programme; and changes to the sensitivity of the FIT test that is sent to people in those age ranges.

Optimisation of the bowel screening programme is overseen by the Bowel Screening Optimisation Advisory Board. Public Health Wales introduced the more accurate and more user-friendly FIT test in September 2019. The timescales for the optimisation plan then had to be revised as the pandemic led to a temporary suspension of screening and a backlog of

screening activity to recover. As a result, age optimisation of the programme did not commence until October 2021, when the starting age was reduced from 60 to 58. Age optimisation is due to continue in a phased manner: reducing to age 55 from October 2022; age 52 from October 2023; and finally age 50 from October 2024. In parallel, the test sensitivity will be increased in a phased manner: from 150µg/g to 120µg/g in October 2023 and then to 80µg/g in October 2024. This will complete the optimisation and bring the screening programme into line with recommendations from the UK National Screening Committee. The position and progress of other countries throughout the UK in complying with the UK National Screening Committee recommendations are not for me to comment upon as I can only set out what the NHS in Wales has planned to achieve, taking into account our own circumstances.

The current progress with optimisation has contributed to an increase in participation in the programme. The participation rate has increased from around 56% prior to optimisation beginning, to around 66% over the past year. The programme is therefore now meeting the 60% uptake standard. As well as more people participating, the new test is identifying more positive cases for colonoscopy. In combination, this has increased the number of index, repeat and surveillance colonoscopies required. The number is expected to increase from a total of 3,462 procedures between October 2020 and September 2021 (the last whole year prior to beginning the age optimisation process), to around 4,600 between October 2021 and September 2022 (the first phase of age optimisation) and then up to an estimated 6,900 procedures between October 2022 and September 2023 (the second phase of age optimisation).

In terms of increasing the rate of uptake amongst men in deprived areas, across the national screening programmes in Wales, the aim is that everyone eligible for screening has equitable access and opportunity to take up their screening offer, using reliable information to make a personal informed choice. Although bowel screening uptake is better than it has ever been, it has been shown that there is a social gradient in uptake of screening where people living in the most deprived communities in Wales are less likely to take up their offer of screening. Also, although the gap is small, men are less likely to take part than women. The importance of ensuring that people take up their first offer of screening has been demonstrated, as uptake amongst people who have previously not responded is very low. Public Health Wales has developed an Equity Strategy, with actions across five key areas: Communication, Community and Engagement, Collaboration, Service Delivery and Data and Monitoring. Specific actions include review of their public information to ensure that it is accessible to people with different communication needs and levels of health literacy, building sustainable community networks and partnerships, and exploring how they can better use their data to support actions and measure impact.

The bowel screening programme has recently done some work with Learning Disability Wales, and is about to embark on some work with certain GP clusters looking at innovative ways of connecting with first timers and non-responders in specific communities.

1. Please provide an update on progress in implementing the national endoscopy action plan, including:

c. An update on plans for introducing FIT in primary care.

The introduction of FIT in primary care does not relate to the bowel screening programme. This is within the purview of the National Endoscopy Action Plan and its Programme Board. It relates to testing of people who present to their GP with symptoms suggestive of colorectal disease. Within this use, there are two distinct applications of FIT. The first is implementation of the DG30 guideline from the National Institute for Health and Care Excellence (NICE). DG30 is about guiding referral for suspected colorectal cancer in people without rectal bleeding, who have unexplained symptoms, but do not meet the criteria for a

suspected cancer pathway referral. It is an additional tool to help GPs deal with patients that do not meet the criteria for suspected cancer referral. Primary care access to FIT to implement DG30 has now been achieved in six out of seven health boards. The seventh health board is due to implement by April 2023.

The second application of FIT in symptomatic care is its potential to triage referrals for suspected colorectal cancer. NICE guideline NG12 describes the criteria to make a referral for patients with suspected colorectal cancer. The referral will be triaged by gastrointestinal services and in most cases the patient will undergo a colonoscopy. Around 2,600 people a month are referred on this pathway from primary care but only around 5% will be treated for colorectal cancer. Emerging evidence suggests that undertaking a FIT test can help to stratify these referrals by risk; helping services prioritise those with a positive FIT and potentially avoid colonoscopy among those that are low risk. All health boards in Wales can now provide FIT as triage in the colorectal cancer pathway.

1. Please provide an update on progress in implementing the national endoscopy action plan, including:

e. The extent to which workforce issues are being addressed:

i. including details of the health boards that have JAG accreditation, and ii. the reasons why some endoscopy units in Wales still haven't achieved it.

In terms of the workforce able to undertake gastroscopy, colonoscopy and screening colonoscopy, this remains a significant challenge and plans have been disrupted by the pandemic. A plan for the development of a national endoscopy training programme has been formulated, which includes recognition of ten areas for training (for all staffing groups) within endoscopy and work is underway to start developing the training packages within these. An Education and Training Management Group (ETMG) has now been established to support these developments. The ETMG will focus on the training and development of the current and future workforce. The NEP Workforce Team is working with health boards to complete their local workforce plans for endoscopy to inform regional and national planning. A marketing campaign is in development with health boards to raise the profile of endoscopy and support recruitment.

National role profiles have been produced for clinical endoscopists in order to standardise terms, conditions and pay. Retention analysis of the endoscopy workforce is underway, seven clinical endoscopists have completed training, and a further three training posts have been filled to start in September this year.

Accreditation of endoscopy units by the Joint Advisory Group on GI Endoscopy involves a holistic assessment of a unit's quality, performance, and environment. It is not specifically about its workforce complement, although it has workforce components. It applies to individual endoscopy units within hospitals rather than the health board. At the present time, five units are accredited and 16 units (two of which are separate paediatric units in the same hospitals as adult services) are not accredited. This information is published at: JAG (thejag.org.uk)

JAG accreditation is highly demanding to achieve and sustain. Health boards have significant challenges to overcome, including recovering waiting time performance, estate constraints and decontamination standards. A vital aspect of accreditation is the compilation of the relevant evidence, which is substantial and requires a significant amount of scarce staff time to collate. The National Endoscopy Action Plan has made this a key focus of its work, including a specific work stream and subgroup. The Plan's intention was to achieve accreditation of half of all units by the midway point of the plan (31 March 2021). The

national programme has provided significant support to health boards, including commissioning pre-accreditation visits by JAG; providing accreditation workshops, expert advice and evidence templates; targeted support at those closest to achieving accreditation.

Eight additional units have been assessed as close enough to apply for accreditation. Four of these require focused effort from local teams to undertake the accreditation process. The other four also require capital investment to change infrastructure. Unfortunately, the pandemic has significantly exacerbated the demand challenge facing endoscopy units. There have been very significant increases in the number of patients waiting for procedures and at risk of disease progression. The Welsh Government has worked throughout the pandemic with health boards to focus on reducing risk to patients by reducing these waiting lists and improving timeliness of procedures. As a result, the improvements in infrastructure and the provision of evidence that are required to achieve accreditation among these eight units have been reduced in priority. This will result in delay and potentially fewer than expected units achieving accreditation during the stabilisation phase of the action plan. We will have a better picture of progress on accreditation by early 2023, following the first round of accreditation visits that are scheduled.

1. Please provide an update on progress in implementing the national endoscopy action plan, including:

f. An update on endoscopy service facilities and infrastructure.

Endoscopy units across Wales require significant investment in infrastructure to meet demand and comply with accreditation standards; and a particular area of focus is decontamination. The National Programme is working closely with shared services to ensure annual audits of decontamination services are taking place and concerns are escalated. However, making improvements to facilities is complicated by the scarcity of available capital funding, the layout of existing hospitals and the contractual arrangements in place for specific hospitals such as Prince Philip and Nevill Hall. Nonetheless, the Welsh Government has approved both NHS business cases for capital investment it has received during the life of the action plan.

These capital business cases will refurbish and increase theatre capacity from four to six at the University Hospital of Llandough in Cardiff; as well as from two to four at the Royal Gwent Hospital in Newport. Further capital business cases are expected in the coming years to refurbish units in line with standards and to expand theatre capacity. Further consideration is being given to the potential for additional units as part of wider recovery plans and the potential for new diagnostic centres.

A notable development has been the integration of endoscopy reports from a first health board into the all-Wales Welsh Clinical Portal. This will be rolled out across Wales and means that any clinician, anywhere in Wales, will be able to access endoscopy reporting to support the management of a patient, no matter where they are being treated in Wales. In addition, six of the seven health boards are now uploading data to the National Endoscopy Database, which will permit better benchmarking of care quality across Wales. The final health board is in the process of procuring an endoscopy reporting system that is compliant with the database.

2. Please outline the impact COVID-19 has had on delivery of the national endoscopy action plan and any implications this has had for patient outcomes.

Health boards remain responsible for the delivery of endoscopy services. The national

action plan and programme board has been put in place to support health boards to improve capacity, standards, and performance. The pandemic's most significant impact on the programme has been to reduce the capacity of health boards to respond to the support available from the national programme. For instance, the national programme has introduced support to undertake the accreditation process, but health boards have rightly focused their capacity on dealing with the increased backlog of procedures caused by the pandemic. The NHS has focused on this because it is the most important way to reduce risk among those waiting and is the course of action I have asked them to take as part of recovery planning. I remain committed to achieving unit accreditation, but I must recognise the change in circumstances. The pandemic led to a short pause in non-emergency endoscopy activity in response to guidance from professional bodies. Upper GI endoscopy is an aerosol generating procedures and it is correct that additional precautions were instituted. The waiting list grew significantly even when services recommenced due to staff absence and reduced productivity caused by enhanced infection prevention controls. The overall impact has been that waiting lists have increased significantly and all efforts are being directed at bringing this down.

The principal impact on patients is that they are having to wait longer than previously, and some are waiting longer than targets require because there are so many more patients being referred and capacity has been restricted. This is likely to lead to greater degrees of distress and worry among those waiting. However, whilst it is possible, or even likely, that there will be an impact on colorectal cancer outcomes, it is too soon to determine what that impact might be. It takes several years to measure, record and report mortality rates and survival at one or five years. The impact of the pandemic on the overall programme is likely to result in approximately a two-year delay in achieving the programme's main aims, for instance, in creating sufficient core capacity to meet need and in accrediting units. It is also important to recognise that recovery in endoscopy services, and the risk in those patient pathways, must now be managed alongside higher than normal levels of risk and delay in almost all other planned care services. This is a completely different context than that in which the National Endoscopy Action Plan was initially introduced.

3. To what extent are endoscopy services being prioritised in the planned care recovery plan? What are the timescales and targets for improvement (including plans to tackle the waiting times backlog for diagnostics, as well as high risk patients requiring ongoing surveillance endoscopic procedures (demand and capacity planning).

On page 37 of the Programme for Transforming and Modernising Planned Care, it describes how the recurrent allocation of an additional £170 million made available to support planned care recovery includes implementation of the recommendations of the National Endoscopy Programme. I approved these recommendations and my officials set these out in writing to health boards in October 2021. They include:

- 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.

The Programme for Transforming and Modernising Planned Care sets out our ambitions for planned care recovery, including diagnostics and commits to:

- Increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024

The overall impact on the waiting lists will be monitored through regular accountability meetings with health boards. This measure will be reported at: statswales

I remain committed to achieving the original aims of the National Endoscopy Action Plan and I am confident these remain the correct aspirations to ensure that people in Wales get access to timely and high-quality endoscopic diagnostic procedures. They will also be important in retaining and attracting the clinical workforce. The pandemic has made progress significantly challenging and clearly resulted in delay.

Nonetheless, as we emerge from the pandemic, we will return to making progress in this clinical service and look for important opportunities to accelerate this work alongside our wider approach to diagnostic care.

I hope this information is helpful to the Committee.

Yours sincerely

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