National endoscopy services: reflections on the impact of COVID-19

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The Joint Advisory Group (JAG) on gastrointestinal endoscopy carries out a biennial census of endoscopy services in the UK and these provide informative snapshots of aspects of activity such as capacity, staffing, safety, training and decontamination. The latest census by Ravindran *et al*, published in FG,[1] covers the 2020–2021 period and provides early insights into how the COVID-19 pandemic impacted provision of endoscopy. It is therefore welcome even though the full impact of the pandemic may not become apparent for several years yet. A cross-sectional survey design was used and services were contacted to help ensure near completeness of data returns. Seventy-nine per cent of JAG-registered services responded with good geographical coverage across England but, disappointingly, relatively less involvement in the devolved nations. Forty-five per cent of participating units were from the independent sector and there were approximately equal returns from JAG-accredited and non-accredited units, so the results are sufficiently representative of the state of play.

So, what are the key findings from the 2021 census? First, overall activity was around 80% of prepandemic levels by March 2021. Endoscopic activity was at an all-time high in 2019 and yet, even then, services were under pressure to meet targets.[2] It is commendable that units were able to recover to this level of activity within 1 year of the onset of a global pandemic and the upheaval that ensued. Bearing in mind that enhanced vetting and triage by senior clinicians and the rapid roll-out of new ways of working (eg, risk stratification tools, faecal immunochemical test (FIT) and Cytosponge), almost certainly removed significant numbers of low risk patients from waiting lists, overall demand management may in fact have been even closer to prepandemic levels. This appears to have allowed services to meet waiting times for urgent cancer referrals but the census emphasises yet again how units struggle to provide capacity for routine referrals and, critically, for surveillance patients—many of whom harbour a high risk of cancer and deserve to be prioritised.

The results also demonstrate the benefits of JAG accreditation—accredited units provided more lists per room per month, more procedures per room and were more likely to meet waiting times targets for urgent cancer referrals and have fewer patients waiting more than 6 weeks. They also reveal just how much service delivery relies on the need to insource, outsource, use waiting list initiatives and weekend working. All of this carries a large administrative burden, is tiring for already weary staff, is expensive and risks fragmenting services while impeding their ability to collect comprehensive data on quality metrics and key performance indicators. Such approaches are understandable in the short term, but were already being used prepandemic, and are surely unsustainable in the longer term, especially given the economic constraints looming.

The census additionally provides detail on other important areas and the toll COVID-19 exacted on these including training, services for upper GI bleeding, availability of equipment and facilities for decontamination but by far and away the most important findings that leap from the page relate to workforce. Many services had staff redeployed and struggled to repatriate them to their units. There were significant vacancy rates across all groups but, most concerningly, a 16% vacancy for band 5 endoscopy nurses. Without these key members of staff it is impossible to leverage greater levels of activity (from the census approximately 20% of lists were unused). Let's not forget that vacancy and sickness absence rates among staff in 2020–2021 have yet to factor in the effects of increasing fatigue and burn-out as the pandemic dragged on into this year. Nor do these figures tell us anything about projected retirals in the next few years but estimates of these do not augur well. The latest British Society of Gastroenterology (BSG) workforce report and a recent BMJ editorial on wider NHS workforce challenges make for sombre reading and there's no reason to believe endoscopy is any less affected.[3 4]

A striking workforce-related finding is the wide variability in the number of endoscopy sessions that consultants perform annually with some undertaking only one list per week, undoubtedly because of the many competing demands on their time. In contrast, clinical endoscopists make up a minority of the workforce yet provide a disproportionately large amount of our diagnostic activity. While training up more clinical endoscopists is an important strategy, we also need to find ways to free up consultant time to enable them to undertake more lists within their job plans, especially for bowel cancer screening[5]; and to provide more (and better) training for the next generation of endoscopists. This will be crucial as the impending gastroenterology training curriculum changes put pressure on time for endoscopy training.

There are limits to what a self-reported census can tell us about endoscopy services. While data returns were good, perhaps the 20% of units that did not respond (plus those not registered with JAG, the 'unknown unknowns') are less well-performing and we, therefore, cannot know how they are faring. Second, there was no patient involvement and so it cannot tell us about patient experience of endoscopy, an essential metric of a high-quality service. There are other data sources relevant to endoscopy, with which JAG censuses could triangulate, for example, Hospital Episode Statistics, the National Endoscopy Database, the Bowel Cancer Screening Programme and the Getting it Right First Time programme to provide a more comprehensive understanding of the performance of endoscopy services.

There is no magic bullet for solving the problems facing UK endoscopy. Demand will remain high and possibly rise further and services need to respond to this. Embedding and extending the use of enhanced vetting and triage, and wider adoption of the innovations and non-endoscopic diagnostic alternatives of recent years will be key: critical thinking about the appropriateness of endoscopy where the chances of important findings are small and alternative pathways exist or in frail, multimorbid patients is imperative. There are

also relatively simple incremental gains to be had—investments in additional rooms, equipment and decontamination facilities to boost productivity seem like easy wins. Tackling the workforce shortages will, however, be the greatest challenge in the coming years and perhaps future JAG censuses could drill down into the issues underlying these to inform solutions to recruit and retain staff. Gastrointestinal endoscopy is fascinating, continually evolving with its mix of elective and emergency work, diagnostic and increasingly advanced therapeutic roles and can be highly rewarding for all staff involved. We must relieve the burden on overworked staff and attract the best and brightest, train them to the highest standards and offer them sustainable long-term career development opportunities so that they can be rightfully proud of their work and their departments. A good first step is for endoscopy services to engage with JAG, seek accreditation and participate in valuable biennial surveys such as this.

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