Royal College of Physicians | JAG Joint Advisory Group on GI Endoscopy

JAG accreditation scheme
JAG briefing 18/06: increasing demand and waiting times

Audience: All endoscopy services
Date issued: November 2018
Review date: November 2019
Standards relevant: NA

About this document
In August 2017, JAG wrote to all NHS trust chief executives, NHS medical directors and endoscopy service leads in the UK to inform them of a temporary tolerance related to some JAG accreditation standards in support of increasing demand and waiting time pressures on services. This briefing provides an update to that letter and is supported by the British Society of Gastroenterology.

Introduction
The guidance contained in the letter has been reviewed and it has been agreed that the tolerances described will continue for a further 12 months until November 2019. This guidance will be reviewed again after this period and is likely to cease or alter as it is not intended that this becomes permanent practice.

Appendix one contains the original letter, the contents of which are continuing. In addition to this guidance, the following provides further guidance/clarification.

Guidance

Waiting times tolerance
The tolerance on waiting times is continuing. However, JAG would like to provide further clarification that the tolerance does not include urgent two-week wait cancer pathway, which must remain within targets.

Referral pathways
In reviewing referral pathways to ensure efficiency, organisations should also consider and review:

- Upper and lower GI pathways to ensure that they are clinically agreed and timely
- Whether CTC provision is optimised where available and appropriate
- Vetting processes are agreed with STP and CCG (England only). Sharing responsibility for refusing inappropriate referrals
- Plan for changes in demand including BCSP. Ensure that the organisation has a clear capacity business development plan that has the support of the relevant CCG (in England only).

Other initiatives
Other initiatives will impact on demand and capacity to a variable degree in the coming months and years including FIT testing in bowel cancer screening, the introduction of FIT into symptomatic work and the introduction of ACE (Accelerate, Coordinate, Evaluate) type pathways. The British Society of Gastroenterology is working with other professional partners to update the BSG polyp and cancer surveillance guidelines with the anticipation that these will be available in early 2019. All services should consider how these developments will affect their local capacity planning.

Further information
For more information please see www.thejag.org.uk/support.

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Appendix one – letter sent to NHS services in August 2017

Dear Colleague

Increasing demand and waiting times for endoscopy patients

JAG is aware that there is an increasingly significant and persistent challenge with waiting times in endoscopy. This has arisen primarily from an increase in demand and has caused:

1. Challenges in endoscopy services' ability to achieve and maintain accreditation
2. Patients to wait beyond acceptable limits for endoscopy
3. Increased pressure on the delivery of screening programmes.

JAG recognises the unprecedented strain on endoscopy services and wants to offer the right support and guidance to ensure patients continue to receive their endoscopy in a timely fashion. JAG has shown an increasing degree of flexibility and reasonable tolerance with services struggling to achieve standards on access and booking. Additionally, given the challenges described, JAG has agreed the following solutions to address these issues:

1. **Surveillance practice:** JAG is aware that with improving quality, more surveillance procedures are requested (as recommended in national guidelines). However, evidence indicates patients colonoscoped by high quality colonoscopists are less likely to subsequently have cancer, or die from cancer[i] and therefore are less likely to need surveillance. Preliminary analysis of data from the English screening programme (where the quality of colonoscopy is very good) supports this study as it shows the chance of cancer in surveillance patients is likely to be less than the background risk.

   Service leads are reminded that BSG guidance already recommends that those in the lowest risk category for polyp follow up (1-2 adenomas which are both <1cm) may be recommended to either have follow up in five years or be discharged. Services should have a process for informing patients and referrers of any change in surveillance interval.

   As the risk to some patients from increased surveillance waits is low, the JAG has developed the following guidance which supports management of surveillance cases:

   For any indication, (e.g. polyp follow up; IBD surveillance; Barretts surveillance) and based on the first (or most recent) procedure being complete with high quality views:

   i. Surveillance procedure due 1 year: tolerance of 6 weeks allowed (no change in guidance)
   ii. Surveillance procedure due 1-3 years: tolerance of 3 months allowed
   iii. Surveillance procedure due >3 years: tolerance of 6 months allowed.

   These tolerances have the potential to arguably make the biggest impact on waiting times and has been agreed by key stakeholders[ii] until new evidence based guidelines are published. Plans for the review of these guidelines are currently in place.

2. **Waiting time tolerances:** JAG will allow up to 2% tolerance of waiting list breaches on national targets for routine waits (98% compliance). This is in recognition that achieving the national target is only one indicator of a quality service out of many, and that there now needs to be flexibility where a service otherwise shows achievement of the other JAG standards. For the avoidance of doubt, the national targets for waiting times have not changed.

   Where these tolerances are used by services (for both waiting times and surveillance practice), JAG will require sight of a clear plan to recover waiting times and address capacity issues as part of the assessment process. This guidance on tolerances will be reviewed on at least an annual basis.

3. **List validation**: evidence shows that between 20-30% of endoscopy demand is composed of surveillance procedures and that up to 30% of patients undergo surveillance procedures at incorrect intervals or where it is not indicated at all[iii]. Many services are already addressing this issue by regularly and prospectively validating lists and through other innovative initiatives. JAG encourages you to explore with your teams if any further efficiency can be made to reduce unnecessary demand and better use existing capacity. Teams should be adequately resourced to carry out robust validation.

4. **Referral criteria:** the criteria for an urgent '2 week non-cancer' referral for endoscopy should be reviewed and clearly defined by services. Many referrals made under this criteria may not require an appointment within 2 weeks and so there is the potential to increase capacity. Furthermore, many trusts no longer use this category and so trusts still using it may want to consider its value and appropriateness.

5. **Post Colonoscopy Colorectal Cancers (PCCRC):** all PCCRC should be investigated thoroughly and actions taken to prevent recurrence where possible. The requirement to perform Root Cause Analysis (RCA) on all PCCRC can change practice based on the findings of the RCA and is an effective way to use resources.

6. **Operating practices:** there is a range of known best practices for managing waiting times which have improved productivity and efficiency in services. JAG encourages you to explore with your teams how these practices can be adopted by your service[iv].

It is ultimately for hospitals locally to determine the appropriate arrangements for each individual patient, but this must consider achieving the best clinical outcomes for patients. This includes complying where appropriate with NICE quality standards and evidence based guidelines and following a risk stratification approach as outlined above.

We ask you to work with your endoscopy clinical lead and senior management team to ensure all options for improved management of waiting times and validation of surveillance cases are being implemented. Sustaining a low wait service is a key factor in achieving and maintaining JAG accreditation and in providing high-quality and responsive care to patients.

JAG continues to provide support to our colleagues in endoscopy and we are happy to advise individual services on the above. Please contact us through the usual channels or through askjag@rcplondon.ac.uk.

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[i] Corley, D., et al. (2014). Adenoma Detection Rate and Risk of Colorectal Cancer and Death. New England Journal of Medicine, 370(14), pp.1298-1306.
[ii] This includes the professional groups represented on JAG, and the British Society of Gastroenterology (BSG).
[iii] Hassan, C., et al. (2013). Post-polypectomy colonoscopy surveillance: European Society of Gastrointestinal Endoscopy (ESGE) Guideline. Endoscopy, 45(10), pp.842-864.
[iv] See www.thejag.org.uk