

Written evidence submitted by The Royal College of Physicians (RCP) (ECS0037)

The RCP is grateful for the opportunity to respond to the above consultation. We have liaised with experts in Medical Oncology, Gastroenterology, Hepatology, Respiratory Medicine, and Haematological malignancies and would like to submit the following comments from our experts in Gastroenterology.

Government Commitment under evaluation	Was the commitment met overall? or (in the case of a commitment whose deadline has not yet been reached) Is the commitment on track to be met?	Was the commitment effectively funded (or resourced)?	Did the commitment achieve a positive impact for patients?	Was it an appropriate commitment ?
<p>1. Workforce</p> <p><i>The Cancer Workforce Plan committed to the expansion of capacity and skills by 2021</i></p> <p>Evidence could include</p> <p>Workforce planning</p> <p>Number of trained professionals in each role, change in percentage since the commitment was made, for example:</p> <ul style="list-style-type: none"> - WTE Medical Oncologists- WTE Clinical Oncologists- WTE Therapy Radiographers- WTE Chemotherapy 	<p>1. Does the commitment have a clear and fixed deadline for implementation ?</p> <p>2. Are there any mitigating factors or conflicting policy decisions that may have led to the commitment not being met or not being on track to be met? How significant are these? Was appropriate action taken to account for any mitigating factors?</p> <p>3. To what extent has the NHS's Covid-19 response affected</p>	<p>1. Were specific funding arrangements made to support the implementation of the commitment? If not, why? If so, what were these, when and where were they made?</p> <p>2. Do healthcare stakeholders view the funding as sufficient?</p> <p>3. Was any financial commitment a 'new' resource stream? If not, did reallocation of funds result in any</p>	<p>1. What was the impact on equity of outcome for different groups?</p> <p>2. Has (or will) there been (or be) a meaningful improvement in measurable outcomes, reasonably attributable to the commitment?</p> <p>3. Will (or have) service users benefit(ed) directly, indirectly or both?</p> <p>4. What category of service users have benefitted?</p>	<p>1. Was (or is) the commitment likely to achieve meaningful improvement for service users, healthcare staff and/or the healthcare system as a whole?</p> <p>2. Is the commitment wide enough in scope?</p> <p>3. Is the commitment specific enough?</p> <p>4. Has the commitment had any unintended consequence</p>

<p>Nurses- WTE Cancer Clinical Nurse Specialists (CNS)- Cancer specialists (Locums and Non- consultant grade)- Allied health professionals</p>	<p>progress on targets?</p> <p>4. How has this commitment been interpreted in practice at trust/patient level?</p> <p>5. Does data show achievement against the target (if applicable)?</p> <p>6. Has the commitment contributed to any measurable improvement in the wellbeing of the cancer services workforce?</p> <p>National Endoscopy Database data from 1.6 million endoscopies from 79% of UK endoscopy units: 4971 endoscopists comprised 1663 gastroenterologi sts (33% of endoscopists) who performed 43% of procedures; 1,610 consultant surgeons (32% of endoscopists) who performed 19% of procedures; 489 Specialist Trainees (10% of</p>	<p>unforeseen consequences / undesirable 'work arounds' at local level?</p>	<p>And why?</p> <p>5. Have (some) service users been hindered by the commitment and its implementatio n?</p>	<p>s?</p> <p>5. Was the level of ambition as expressed by the commitment reasonable?</p> <p>6. Has the commitment been met equally across England or are there regional variations?</p> <p>7. How has working to those commitment s affected other aspects of care?</p>
---	---	--	--	---

	<p>endoscopists) who performed 2% of procedures; 617 Other Doctors (12% of endoscopists) who performed 12% of procedures; and 592 Non-medical endoscopist (12% total endoscopists) who performed 23% of procedures. Half of these endoscopists did not meet recommended minimum numbers to maintain standards. This can lead to lower completion rates and higher complication rates. Job planning to enable increased endoscopy sessions for gastroenterologists will be beneficial. Ravindran et al. Frontline Gastroenterol 2022;13:12-19 showed Bowel Cancer Screening endoscopists undertaking BCSP endoscopy only average</p>			
--	---	--	--	--

	<p>1PA per week. 38% are considering giving up endoscopy in next 2-5 years. Consultants would increase screening PAs by 70% if able. An extra 155 colonoscopists needed to increase demand and planned retirement at current PAs. There is scope to alter the job plans of existing endoscopists to undertake more endoscopy if competing demands (including general medicine) on their time are mitigated. BSG workforce survey showed 45% of advertised consultant posts in 2019 were not appointed to. To secure the future workforce, it is essential that trainees continue to have access to endoscopy training – this is threatened by General Internal Medicine</p>			
--	--	--	--	--

	commitments, which will be exacerbated by Shape of Training. The			
<p>2. Diagnostics</p> <p><i>A faster diagnosis standard from 2020 to ensure most patients receive a definitive diagnosis or ruling out of cancer within 28 days of referral from GP or from screening</i></p> <p><i>By 2028 the proportion of cancers diagnosed at stages 1 and 2 will rise from around 50% now to 75% of cancer patients</i></p> <p>Evidence could include</p> <p>Statistics on the 28-day target and at what stage diagnosis are made</p> <p>Regional variation in diagnostic or therapeutic equipment</p>	<p>1. Does the commitment have a clear and fixed deadline for implementation ?</p> <p>2. Are there any mitigating factors or conflicting policy decisions that may have led to the commitment not being met or not being on track to be met? How significant are these? Was appropriate action taken to account for any mitigating factors?</p> <p>3. To what extent has the NHS's Covid-19 response affected progress on targets?</p> <p>4. Does data show achievement against the target (if applicable)?</p> <p>Our experts note that there are clear excess demands and</p>	<p>1. Does the commitment have a clear and fixed deadline for implementation?</p> <p>2. Are there any mitigating factors or conflicting policy decisions that may have led to the commitment not being met or not being on track to be met? How significant are these? Was appropriate action taken to account for any mitigating factors?</p> <p>3. To what extent has the NHS's Covid-19 response affected progress on targets?</p> <p>4. Does data show achievement against the target (if applicable)?</p>	<p>1. What was the impact on equity of outcome for different groups?</p> <p>2. Has (or will) there been (or be) a meaningful improvement in measurable outcomes, reasonably attributable to the commitment?</p> <p>3. Has the commitment been met/is it on track to be met equally across England or are there regional variations?</p>	<p>1. Was (or is) the commitment likely to achieve meaningful improvement for service users, healthcare staff and/or the healthcare system as a whole? If not, why not?</p> <p>2. Is the commitment specific enough?</p> <p>3. Has the commitment had any unintended consequences on other aspects of care?</p> <p>4. Is the target contained in the commitment an effective measure of policy success (if applicable)?</p> <p>5. Was the commitment addressing</p>

	<p>backlog in endoscopy (pre and post Covid) but the BSG were unable to provide data in the timeframe. This will however be available from NHS sources. Bowel Cancer Screening plans to age-extend from April 2022 but 12/64 centres are not yet back in standard for waits. 4/12 are very nearly there, and 8/12 hope to age extend early in 22/23. Much diagnostic endoscopy is performed to 'rule out' serious disease such as cancer, rather than to make a positive diagnosis: the diagnostic yield of cancer in patients referred for either upper endoscopy or colonoscopy with 'red flag' or 'alarm' symptoms under the 2-week wait pathway (NICE NG12) is only 3-5%. Also, the proportion of patients diagnosed with colorectal cancer</p>			<p>an identified need and relevant to the problem?</p>
--	---	--	--	---

	<p>is broadly similar whether they are referred urgently via 2-WW criteria or routinely (NICE DG30).</p> <p>Furthermore, when GI tract cancer is diagnosed in patients referred with symptoms, it is usually at least at a locally advanced stage with limited prospects of cure. This long-established system of referrals based on patients' symptoms will not increase the proportion of patients who have early-stage cancer at diagnosis: the presence of symptoms in a patient with GI cancer almost always implies the presence of locally advanced disease (or worse).</p> <p>There is thus a need to expedite the review of current NICE referral criteria for patients with upper or lower GI symptoms.</p>			
<p>3. Living well with and beyond cancer</p>				

<p><i>By 2021 where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support</i></p> <p>Evidence could include</p> <p>Patients' access to the right expertise and support at the right time.</p> <p>Quality of life outcomes for patients</p> <p>Support for long-term effects, including paediatric cancers</p> <p>Data detailing:- the proportion of patients who have received a personalised care plan</p>				
<p>4. Innovation and technology</p> <p><i>Safer and more precise treatments including advanced radiotherapy techniques and immunotherapies will continue to support</i></p>	<p>1. Does the commitment have a clear and fixed deadline for implementation ?</p> <p>2. Are there any mitigating factors or conflicting policy decisions</p>	<p>1. Was any financial commitment a 'new' resource stream? If not, did reallocation of funds result in any unforeseen consequences / undesirable 'work</p>	<p>1.What was the impact of outcome for different groups?</p> <p>2. Has (or will) there been</p> <p>or be) a meaningful improvement in measurable</p>	<p>1. Was (or is) the commitment likely to achieve meaningful improvement for service users, healthcare staff and/or the healthcare</p>

<p><i>improvements in survival rates.</i></p> <p>Evidence could include</p> <p>Progress on upgrading radiotherapy machines/equipment across England</p> <p>Information on whether an improvement in access to care and specialist treatment to improve patient care as a result of commitment.</p>	<p>that may have led to the commitment not being met or not being on track to be met?</p> <p>How significant are these? Was appropriate action taken to account for any mitigating factors?</p> <p>3. To what extent has the NHS's Covid-19 response affected progress on targets?</p> <p>4. Has this commitment been interpreted differently in practice at trust/patient level?</p> <p>5. Does data show achievement against the target (if applicable)?</p> <p>BSG, working with NHSE/I, have led on innovations to improve and streamline pathways to urgent (2WW) diagnosis of GI cancers, reducing the need for endoscopy, particularly</p>	<p>around's' at local level?</p> <p>2. Were specific funding arrangements made to support the implementation of the commitment? If not, why? If so, what were these, when and where were they made?</p> <p>3. Who was involved in determining the funding arrangements? Who was ultimately responsible for this decision?</p> <p>4. What factors were considered when funding arrangements were being determined?</p> <p>5. Do healthcare stakeholders view the funding as sufficient?</p> <p>6. When funding was from local budget allocation which relevant organisation(s)</p>	<p>outcomes, reasonably attributable to the commitment?</p> <p>3. Will (or have) service users benefit(ted) directly, indirectly or both?</p> <p>4. What category of service users have benefitted? And why?</p> <p>5. Have (some) service users been hindered by the commitment and its implementation?</p>	<p>system as a whole?</p> <p>2. Is the commitment wide enough in scope? Is it specific enough?</p> <p>3. Has the commitment been met equally across England or are there regional variations?</p> <p>4. Is the target contained in the commitment an effective measure of policy success (if applicable)?</p> <p>5. How has working to those commitments affected other aspects of care? Has it had any unintended consequences?</p> <p>6. Did the system have the relevant tools/resources to support the change?</p>
--	---	---	--	--

	<p>during the height of the pandemic. These include FIT triage for patients referred for colonoscopy, and Edinburgh Dysphagia Score for patients referred for upper GI endoscopy. Newer innovation such as Cytosponge for detection of Barretts are being evaluated on a wider scale. Colon Capsule Endoscopy has been introduced but needs a well-designed RCT vs colonoscopy to understand its comparative value.</p>	<p>) responsible for the patients' care made commissioning decisions (local budget allocation)?</p>		
--	---	--	--	--

We have also enclosed some key data from the census over the last 5 years.

1. AACs for England

AACs England only								
Year	Gastroenterology		Hepatology		Medical oncology		Respiratory med	
	Successful	Unsuccessful	Successful	Unsuccessful	Successful	Unsuccessful	Successful	Unsuccessful
2008	55	11	6	3	23	3	45	16
2009	70	13	3	1	27	4	59	9
2010	67	8	3	1	23	12	65	8
2011	54	26	2	–	27	9	49	9
2012	61	22	10	2	30	16	68	9
2013	77	46	5	3	29	22	70	37
2014	70	64	8	3	33	27	100	53
2015	73	80	6	4	40	27	73	59
2016	70	71	12	2	32	24	71	54

2017	59	80	5	2	32	19	58	63
2018	51	47	7	–	17	14	59	37
2019	47	38	5	–	17	17	51	35
2020	40	39	–	3	19	9	69	36
2021 (part)	27	12	–	–	11	8	21	20
Total	821	557	72	24	360	211	858	445
AACs England only As %								
Year	Gastroenterology		Hepatology		Medical oncology		Respiratory med	
	Successful	Unsuccessful	Successful	Unsuccessful	Successful	Unsuccessful	Successful	Unsuccessful
2008	83%	17%	67%	33%	88%	12%	74%	26%
2009	84%	16%	75%	25%	87%	13%	87%	13%
2010	89%	11%	75%	25%	66%	34%	89%	11%
2011	68%	33%	100%	–	75%	25%	84%	16%
2012	73%	27%	83%	17%	65%	35%	88%	12%
2013	63%	37%	63%	38%	57%	43%	65%	35%
2014	52%	48%	73%	27%	55%	45%	65%	35%
2015	48%	52%	60%	40%	60%	40%	55%	45%
2016	50%	50%	86%	14%	57%	43%	57%	43%
2017	42%	58%	71%	29%	63%	37%	48%	52%
2018	52%	48%	100%	–	55%	45%	61%	39%
2019	55%	45%	100%	–	50%	50%	59%	41%
2020	51%	49%	–	100%	68%	32%	66%	34%
2021 (part)	69%	31%	–	–	58%	42%	51%	49%
Total	60%	40%	75%	25%	63%	37%	66%	34%

2. FTE consultant vs headcount. HST headcount

Estimated FTE consultants England only					
Year	Gastroenterology	Hepatology	Medical oncology	Respiratory medicine	Haematology
2016	1,054	123	436	1,084	836
2017	1,099	125	447	1,078	808
2018	1,148	114	448	1,157	826
2019	1,183	113	435	1,186	821
2020	1,252	143	483	1,234	825

Consultant headcount England only					
Year	Gastroenterology	Hepatology	Medical oncology	Respiratory medicine	Haematology
2016	1,130	128	478	1,132	891
2017	1,158	132	473	1,154	892
2018	1,214	141	495	1,225	894
2019	1,248	140	499	1,256	884
2020	1,336	149	517	1,325	902

HST headcount England only				
Year	Gastroenterology and hepatology	Medical oncology	Respiratory medicine	Haematology
2015	563	221	586	420
2016	578	234	607	443
2017	603	254	634	460
2018	594	250	651	490
2019	623	256	678	507
2020	625	258	672	540

Feb 2022