



Welcome to the NHS Endoscopy Conference



06th May 2026
15 Hatfields Conference Centre, London,
SE1 8DJ

ENDOSCOPY 360 2026

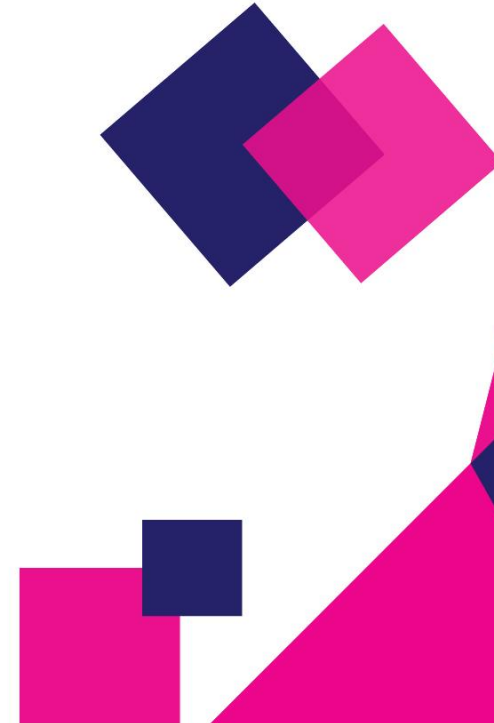
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SCAN ME



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Chair Opening Address



Mr Anil Vara

Bsc (Hons), Msc, MBA, CMgr, FCMI

Head of Elective Care

Doncaster and Bassetlaw Teaching NHS
Foundation Trust



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Keynote Presentation



Sas Banerjee

Cancer Clinical Lead | National Speciality Advisor –
Provider Support

NHS England | Barking Havering Redbridge
University Hospitals NHS Trust

Delivering the Endoscopy strategy

Sas Banerjee

National Specialty Advisor
– Diagnostics Programme



Declarations of interest





DHSC – uniting around a common cause:
To improve the health and care of the nation

The NHS 10-Year Plan: **Fit For The Future**

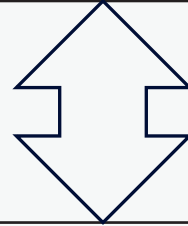
Three 'shifts' in care:

- From hospital to community
- From analogue to digital
- From sickness to prevention



DHSC:

To improve the health and care of the nation

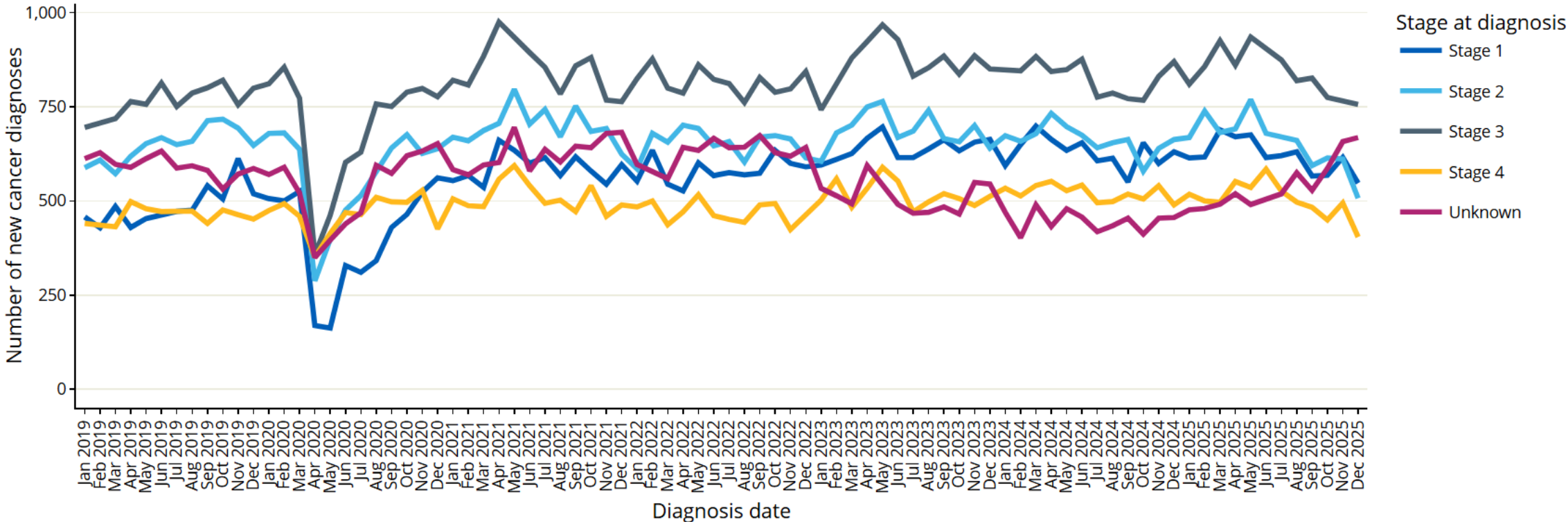


GI Endoscopy Programme – creating shared purpose:

To improve population outcomes, from digestive diseases, through quality endoscopy services for all who need them

Bowel Cancer Outcomes: The Case for Change

New cancer diagnoses, England, January 2019 to December 2025
 Cancer group: Bowel



Source: National Disease Registration Service, NHS England (CAS2603).

GI Endoscopy: Case for Change



Year on year increase in demand, especially for colonoscopy



Cancer conversion rates from suspected cancer / symptomatic pathways **are low**

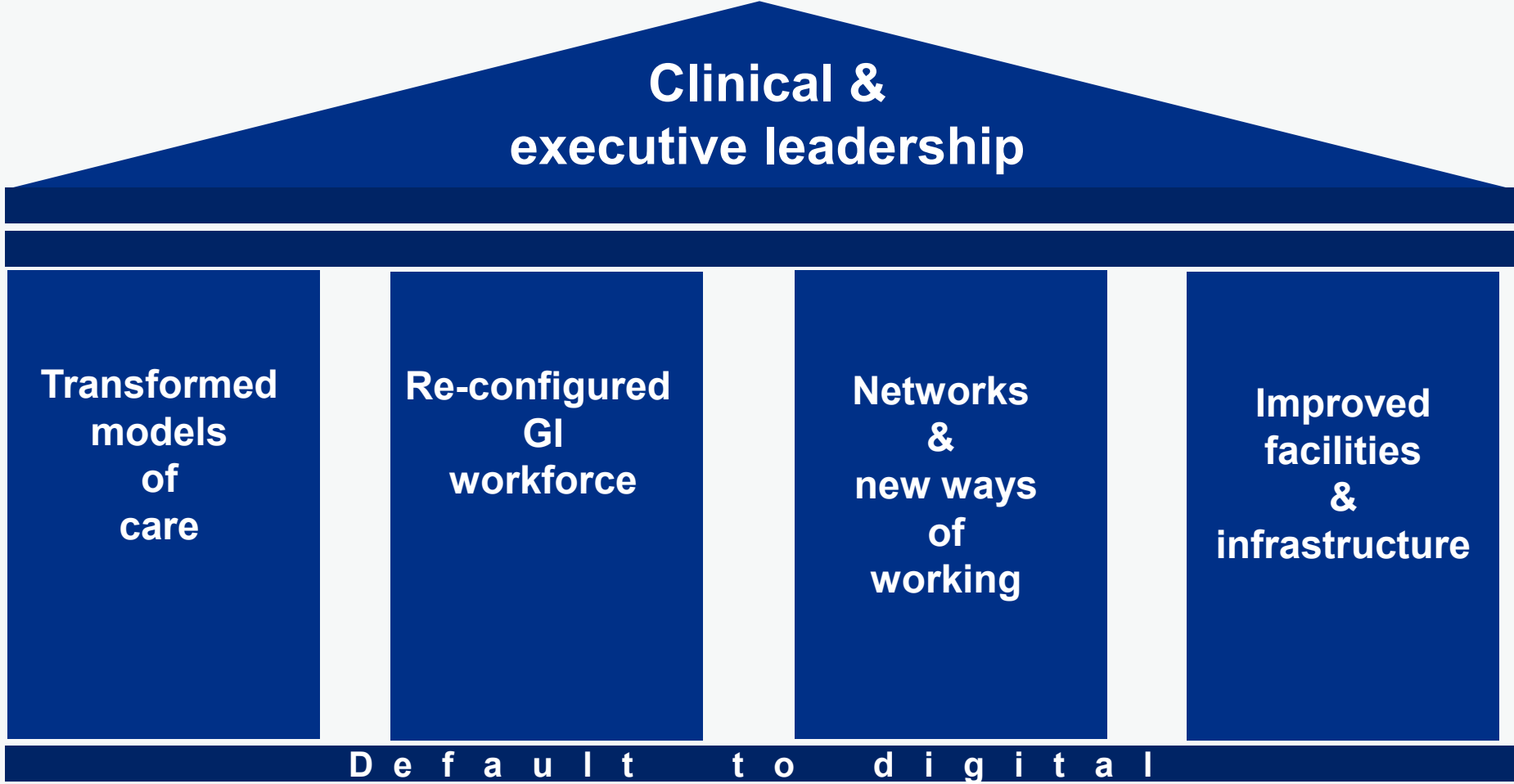


Low yield endoscopy is undesirable from patient and taxpayer perspective

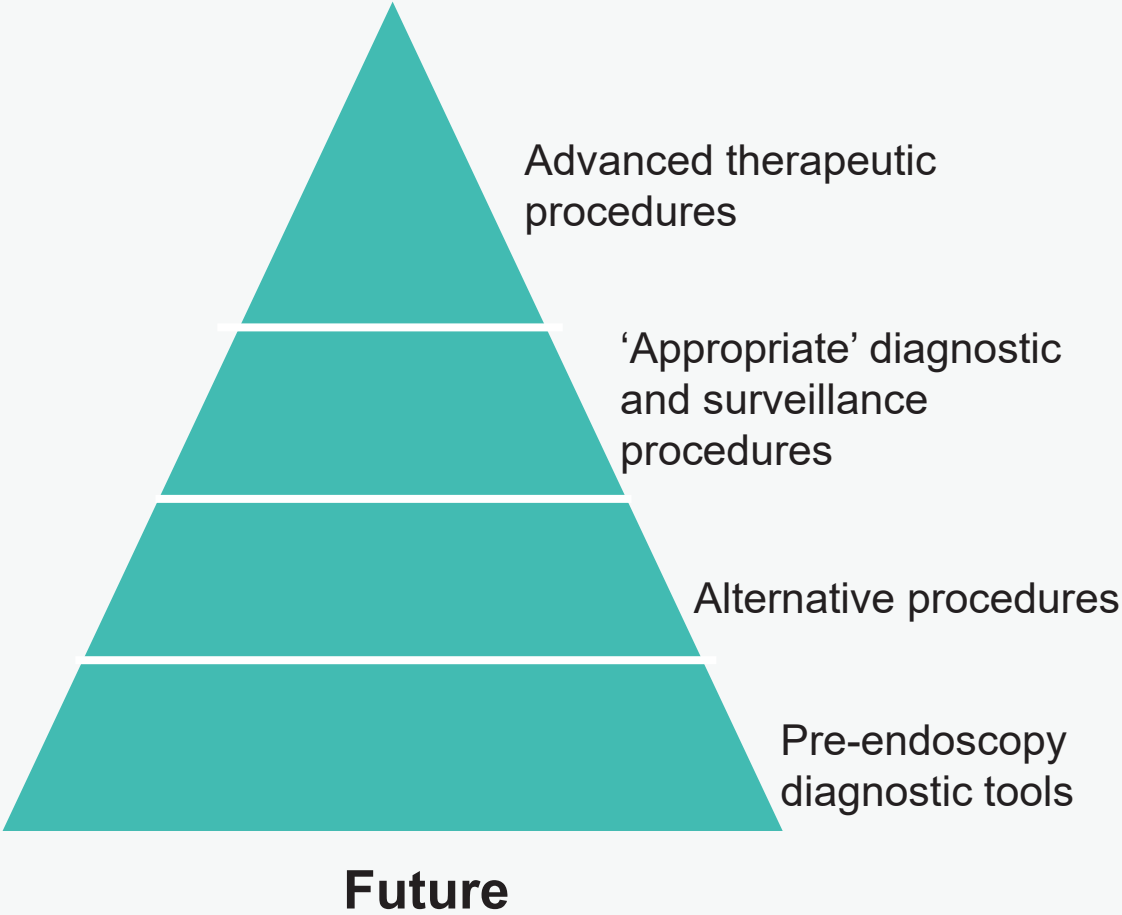
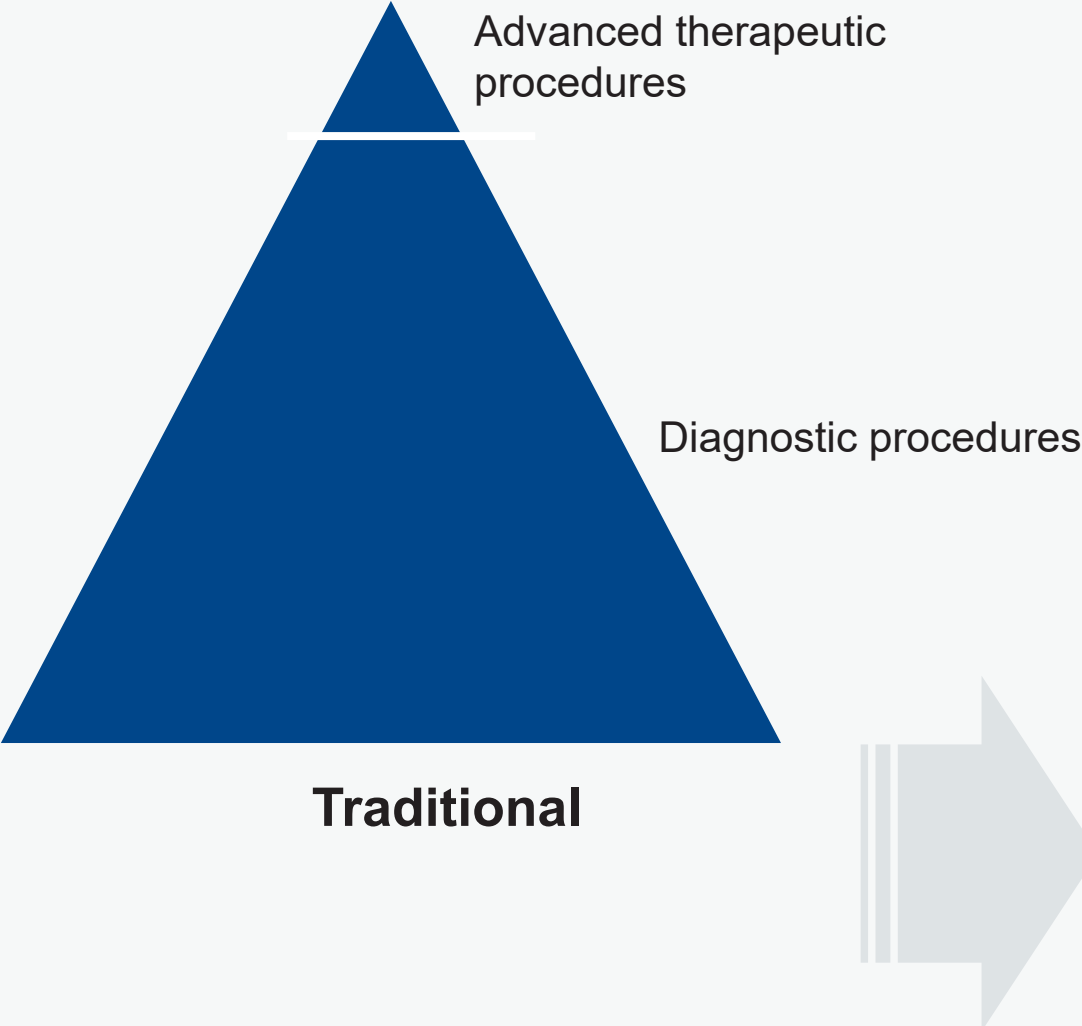


Current model of care is not sustainable, especially from a workforce perspective

GI Endoscopy Strategy



A Transformed Model of Care



Risk Stratification: ColoFIT



COLOFIT
Optimal Faecal Immunochemical Testing
in Suspected Colorectal Cancer

COLOFIT model

$$\left(e^{-0.6592014} \right) \left(+ 1.6685765 \frac{AGE^3}{100} - 13.9435406 \left(\frac{AGE}{100} \right)^3 \cdot \ln \left(\frac{AGE}{100} \right) \right. \\
 \left. - \frac{1.9965475}{\sqrt{\left(\frac{FIT}{100} \right)}} - \frac{0.2657153}{\sqrt{\left(\frac{FIT}{100} \right)}} \cdot \ln \left(\frac{FIT}{100} \right) \right. \\
 \left. + 0.9208493 \cdot \ln \left(\frac{PLATELETS}{100} \right) \right. \\
 \left. - \frac{3.9007829}{100} \cdot MCV \right. \\
 \left. + 0.4543275 \cdot male \right)$$



Risk Stratification: ColoFIT



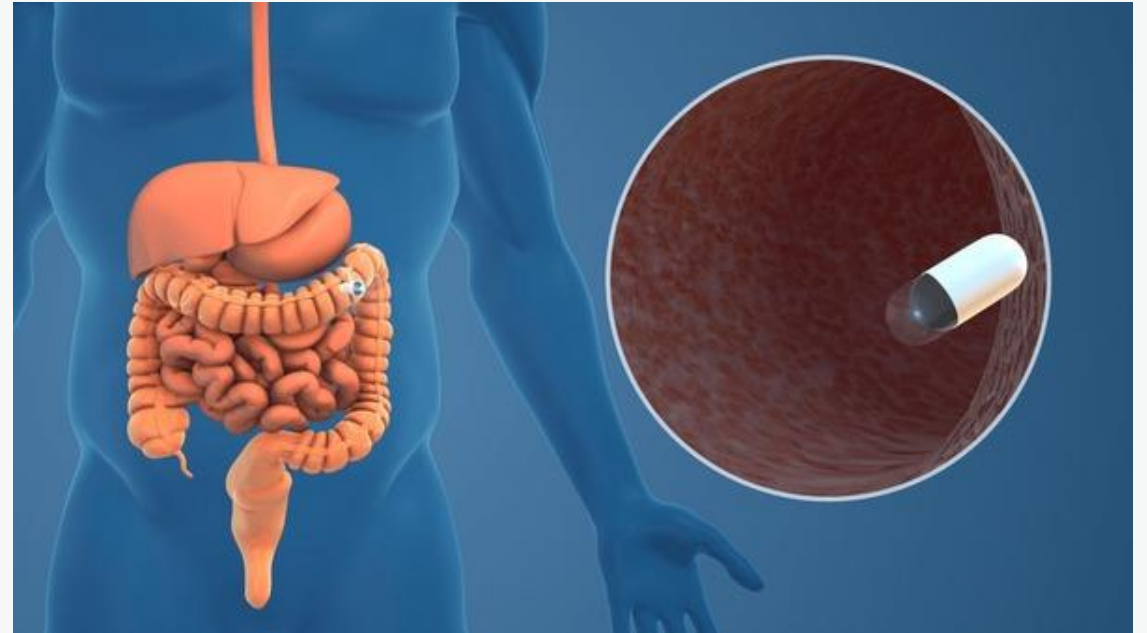
Ask of Cancer Alliances in 2026/27:

'Produce an initial plan and assessment of ICB and site readiness to transition to ColoFIT, including at least one trust identified to be a ColoFIT early adopter site; local validation and set up processes progressed in year so that site is ready to launch once national regulation is approved.'



Alternatives: Colon Capsule Endoscopy (CCE)

- Alternatives for people at low risk but not no risk
- Challenges in implementing CCE including the reading time
- AI Assisted Reading CCE project planned
- Further information on this opportunity in due course



Upper GI Alternatives: Capsule Sponge

- NICE National HealthTech Access Programme (NHAP)
- Capsule sponge:
 - Detection of Barrett's oesophagus and early-stage oesophageal cancer
 - Surveillance of Barrett's oesophagus
- Expected publication 24/2/27
- NHS will have 90-days to implement dependent on approval for either / both use cases





New Ways of Working

Integrated GI pathways and working across primary and secondary care enabling GI endoscopy referrals to be in accordance with NICE guidance and patient expectations to be managed in primary care.

- Small number of real world, time limited pilots
- Test new models of care potentially with national permissions
- Evaluation could inform policy in due course



Project aims:

- Improved **patient and population outcomes** i.e. improved cancer detection rates / early diagnosis
- Improved **patient experience** i.e. right pathway / test first time
- Increased **staff satisfaction** - enhanced primary / secondary care interface and joint decision making
- Increased **value for money** i.e. reduction of low yield procedures

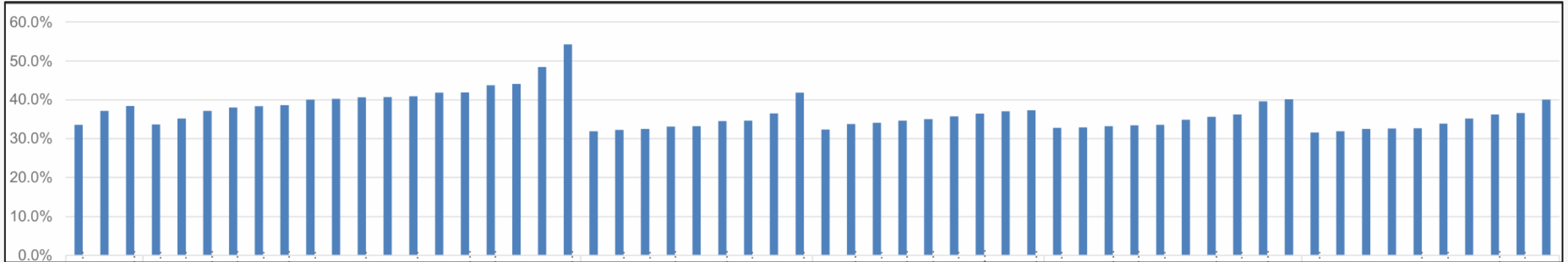
National Campaign: Right Test, Right Time



Gastrosopies in patients aged <55 years

Source: [NHS England - Model Hospital](#)

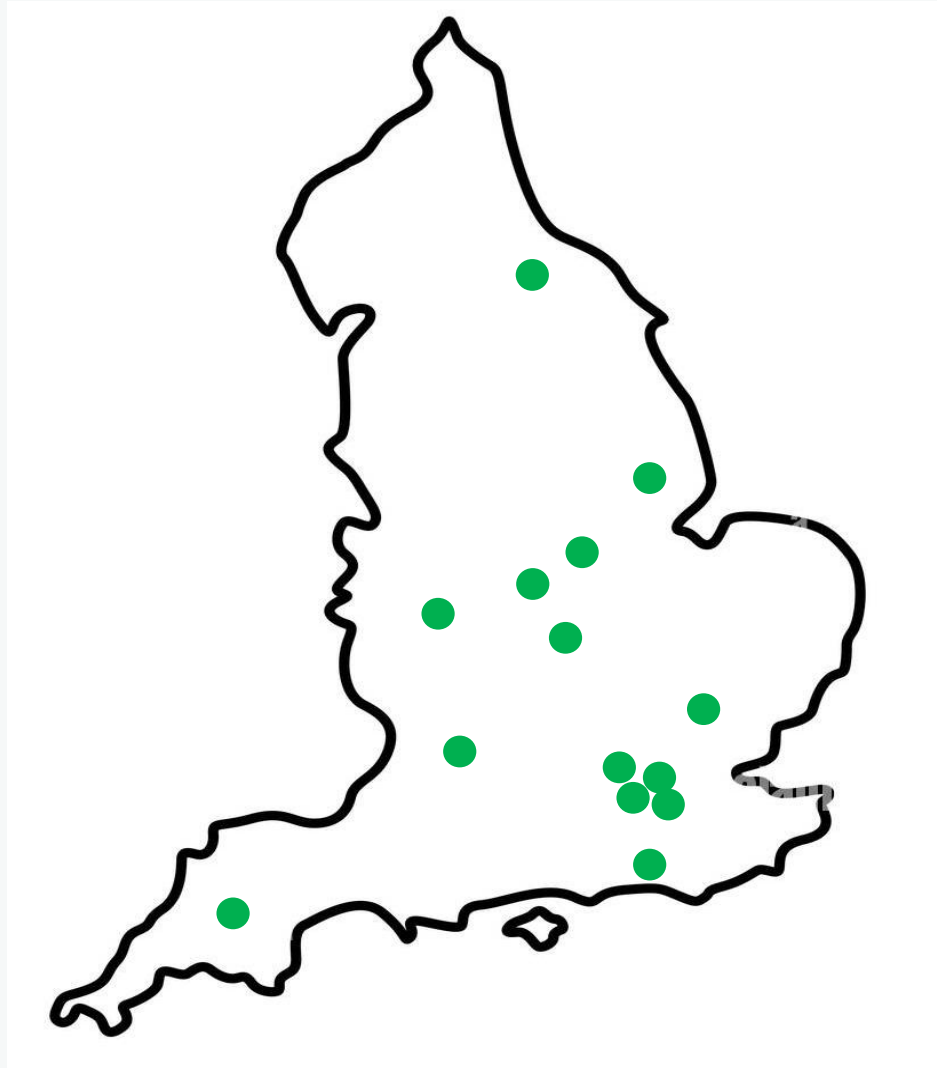
National average - 31.3% (Q3 2025/26)



Graph shows trusts where the percentage of gastroscopies in patients >55 is above the national average of 31.3% (Q3 2025/26)

- 58 trusts had higher than average % of gastroscopies in <55-years age group
- Trusts were in every region
- 1 trust had >50% compared to a national average of 31.3%

Shared Purpose: Improved Outcomes



- Bowel Cancer Screening Programme FIT@80
- Nearly a ¼ of eligible population soon to be covered by BCSP FIT@80
- Roll-out for all services by the end of 2027/28

January 2026	FIT@80 % Increase
Colonoscopies	39%
Diagnostic Test	38%
Resected polyps	39%
LNPCP	43%
High Risk Findings	37%
Cancers	19%

Thank You



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[company/nhsengland](https://www.linkedin.com/company/nhsengland)



[england.nhs.uk](https://www.england.nhs.uk)



Skill Clinic



Dr Umakant Dave
Consultant Gastroenterologist
Swansea Bay University
Health Board



Katy Tingey
Clinical Educator Endoscopy
Luton and Dunstable Hospital

Addressing Workforce Shortages and Enhancing Staff Capability

Sr. Katy Tingey

Clinical Educator Endoscopy
Luton and Dunstable Hospital

Dr Umakant Dave, MBE, MD, FRCP, FAcadMEd
Welsh Ass for Gastro & Endoscopy (WAGE) President,
Consultant Gastroenterologist, Swansea Bay UHB & Honorary Senior
Lecturer

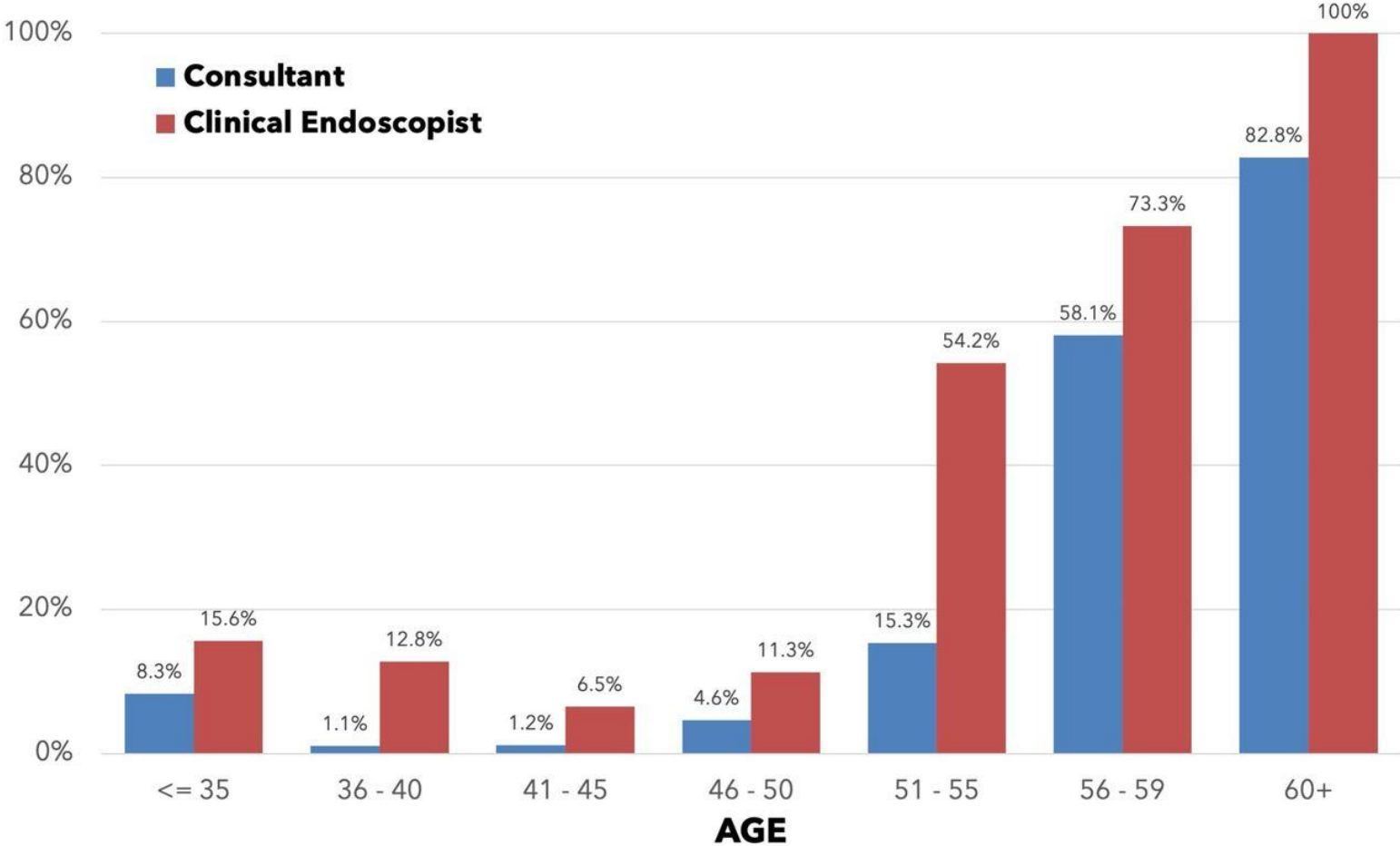
Baseline

- **Systems and organisations need to do more to support practitioners**
- Our presentation will cover system changes and personal skills

Our introductions and arrival

5-year intention to leave endoscopy by age group with comparisons between clinical endoscopists and consultants.

5-year Intention to Leave Endoscopy by Age and Role



Keith Siau et al. Frontline Gastroenterol
doi:10.1136/flgastro-2024-103039



Workforce shortages – Nursing staff

- Endoscopy staffing is individual to each trust.
- There is no specific models/tools or numbers in comparisons to ward nursing.
- Jag guidelines safe staffing guidance (March, 2026) states a ‘minimum uplift on 27% when setting establishments to support safe and efficient staffing levels to cover planned and unplanned absences’ >This is also inline with the RCN standards for nursing workforce.
- When staffing levels are below the need of the service, this not only impacts patient safety but can also be detrimental to staff wellbeing, leading to increased levels of stress and sickness.

- Workforce shortages also impacts upskilling of staff.
- Asking for help is not a weakness, informing leads, executives and also inphasing staffing shortages should not reflect badly on your service. These concerns should be taken seriously.
- Having a supportive senior management team who will keep pushing for funding.
- When the service is expanding staffing levels should be reviewed, training and skill mix should also be taken into account when setting up a new service or taking on new procedures.

Getting endoscopy known – recruiting those that are interested.

- University involvement/ student nurses
- Recruitment drives/ interview on the day
- Social media involvement

LGI: Diarrhoea in absence of positive FIT and age <50 years old	0.13%	0.21%
LGI: Constipation in absence of positive FIT and age <50 years old	0.09%	0.14%
LGI: Abdominal pain in absence of positive FIT and age < 50 years old	0.10%	0.16%
LGI: Weight loss in absence of positive FIT and age <50 years old	0.19%	0.30%

We need to reduce endoscopy workload- Positive Predictive Value (PPV) for GI cancer

Burnout in Gastroenterology/ Endoscopy

- Most gastroenterologists in the USA experienced moderate levels of burnout, while junior gastroenterologists had higher levels of stress than senior gastroenterologists (Keshwani et al 2011)
- Burnout in gastroenterology trainees within the East of England Deanery was 35% (Ong et al BMJ Open Gastroenterol. 2020)
- Statistically significant associations between work satisfaction and burnout among gastroenterologists and endoscopy staff was found in Germany.

Burnout Impact

- Patient safety
- Staff health and Wellbeing
- Maladaptation (Alcohol, drug, gambling...)
- Productivity and resource utilisation
- Patient satisfaction and Complaints
- Staff retention

Causes of burnout

- Excessive workload and dysfunctional workplace
- **Lack of control, sense of unfairness**
- Breakdown of community
- Discrimination, bullying and harassment (27% staff)
- Systems and culture: moral injury
- **Neuroticism** as a predictor of Burnout and extent of Exhaustion
- **Imposter Phenomenon**

Retaining staff – Team culture

- Support from doctors – Our recent staff survey 35% stated they did not feel supported by their endoscopist's.
- A senior team that leads from the front, including unit lead consultant.
- Flexible working.
- On going Training.
- Link roles and lead roles.
- Growth for progression – leadership.
- Team building/ social days.
- Celebrating successes.
- Vary workload – making sure work is engaging and not repetitive.
- Star of the month – voted by other team members.

Enhancing staff capabilities/skills

The importance of the clinical educator role in endoscopy – bridging the gap between theory and practical skills. Planning and organisation. Turning novices into competent staff. Our recent staff survey stated that 100% of staff had received vital training to complete their role.

Induction training plans – my 6 week immersive training plan for new starters

Immersive 6 week (level 1) training plan CDC endoscopy 2026					
1 st week	2nd week	3rd week	4th week	5th week	6th week
<u>1 st day</u>	<u>4 days</u>	<u>3 days</u>	<u>4 days</u>	<u>4 days</u>	<u>4 days</u>
Observe patient journey (AM)	Patient side (AM)	Recovery (AM)	Discharge (AM)	Consultant side OGD (AM)	Consultant side (AM)
DLS & ESR (PM)	Patient side (PM)	Recovery (PM)	Discharge (PM)	Consultant side Colon (PM)	skills needed for level 1 sign off (PM) - discussed with PDN
<u>2nd day</u>					
JETS E- LEARNING (AM)					
Admission (PM)					
<u>3rd day</u>					
Admission (AM)					
Admission (PM)					
<u>4th day</u>					
Admission (AM)					
Admission co-ordinator (PM)					
<u>Sign off:</u>	<u>Sign off:</u>	<u>Sign off:</u>	<u>Sign off:</u>	<u>Sign off:</u>	<u>Sign off:</u>
1. DLS/ESR/JETS 2. Admissions	1. patient side	1. Recovery 2. patient transfer	1. Discharge with PDN & band 6's	1. Some consultant side competencies	1. Consultant side competencies level 1
<u>Reviews/ one to ones:</u>					
one to one meeting with PDN and team leader - set objectives in skills book and probation paperwork				One to one meeting with PDN/team leaders - discuss areas needed for level 1 completion	one to one with team leader - 6 week competency review and additional objectives required (PDN present)

- Buddy roles.
- Regular feedback and skills review meetings. Including interests.
- Finding time (audit days/CGM/pre and post lists).
- CPD/study days – external.
- Cross site working.
- On day training/training trolleys/training reports/boards.

Steps we can take to improve wellbeing

- What active steps you/ your unit are taking to maintain wellbeing?

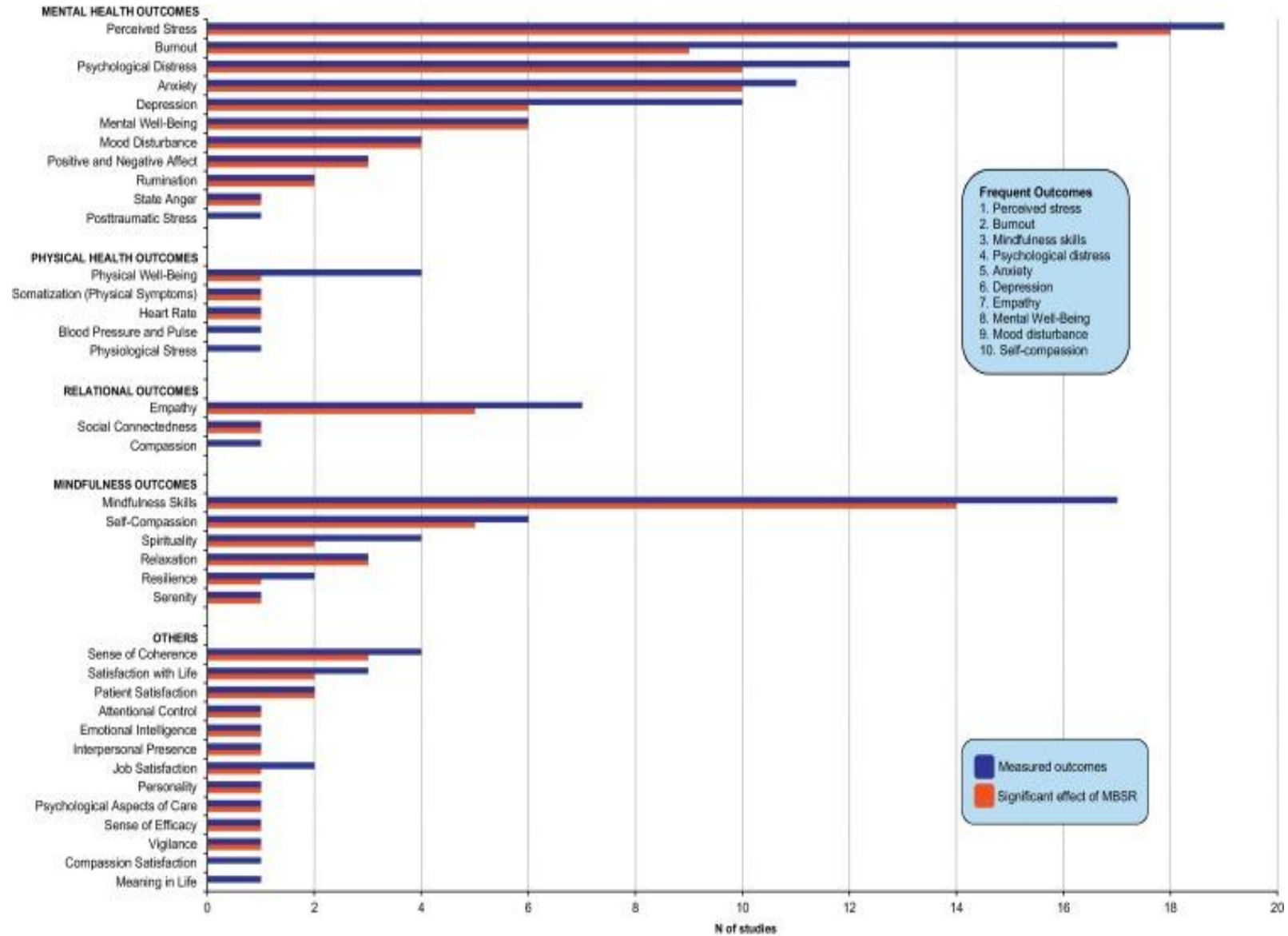
Prevent Musculoskeletal injury

- 89% of endoscopists report musculoskeletal injuries (MSI) compared to 37% of physicians in other specialties.
- Similarly, studies show that over 50% of endoscopy nurses suffer from MSI injuries related to their work.
- Training and adherence to preventive aspects reduces injury and improves wellbeing

Dispositional mindfulness

Trainable ability to pay attention to inner thoughts, emotions, and experiences in a non-reactive way

A systematic review. Complementary Therapies in Medicine 24 (2016) 19–28



RESEARCH

Open Access



Enhanced Stress-Resilience Training (ESRT) for graduate-entry medical students: a randomised-controlled, mixed-method investigation

Luke Sanders¹, Georgie Budd^{1,2}, Lebares Carter³, Umakant Dave^{2,4*} and Andrew H. Kemp^{1*}

Abstract

Background Medical students face demanding academic requirements, fierce competition, self-doubt and financial concerns contributing to high rates of depression, anxiety, stress, sleep problems and burnout, highlighting a need for effective interventions. We explored an intervention called Enhanced Stress-Resilience Training (ESRT), a modified form of mindfulness training adapted for clinicians, that was applied to medical students for the first time.

Methods Graduate-entry medical students ($N = 118$) were randomised to ESRT or an active control condition as part of a registered trial (ISRCTN16324994). A 3 (Time: pre-, post-, and six-month follow-up) \times 2 (Group: ESRT, control) mixed design was used to assess changes in psychological flexibility, resilience, and stress reactivity. Due to attrition ($T3 n = 47$), additional sensitivity analyses, including intention-to-treat and subgroup analyses based on baseline resilience, were conducted. Qualitative data from exit evaluations ($n = 25$), interviews ($n = 12$), and focus groups ($n = 11$) underwent reflexive thematic analysis to explore student experience and contextualise quantitative findings.

Results ESRT users demonstrated increased psychological flexibility scores at post-intervention ($p = .001, d = 0.62$) and six-months follow-up ($p < 0.001, d = 0.96$), and these findings were confirmed in intention-to-treat analysis. Exploratory analyses revealed that those with low baseline resilience who underwent ESRT displayed increased resilience ($p < 0.001, d = 1.86$) and decreased stress reactivity ($p < 0.001, d = 1.58$) at the six-month follow-up. Qualitative findings highlighted high acceptability, perceived value, and a strong desire for curricular integration, while also revealing barriers to engagement, particularly time constraints.

Conclusions This study offers new evidence that ESRT may enhance psychological flexibility and resilience, and decrease stress reactivity, especially among more vulnerable students. Sustained effects and positive qualitative feedback suggest that curricular integration could improve feasibility and reach.

Welsh Nurses Pilot Study:

PM-344 Capstone Project Year: 2023, Swansea University

Liam J. Williams, Dr Alice Hoon, Dr Umakant Dave and Ms Heather Whitaker


- 6 endoscopy/ GP surgery nurses
- 3 minutes mindfulness meditation at the beginning of a shift
- Post-study WEMWBS scores increased, fairly significantly compared to the original mean scores of the pre-study versions (the most significant differences were seen in participants who had poorer wellbeing prior to starting the study)
- Helping them to be more present and aware in their work, enhancing their ability to deal with job-related stresses and to further ameliorate the nurse-patient relationship.
- 5 out of 6 will highly recommend it to colleagues


Are benefits long term?

- 288 medical & psychology students were given either a 15 hour mindfulness course (144 students) or normal curriculum (144 students).
- Six years later effects on wellbeing and better coping strategies persisted.
- [PLoS One](#). 2018 Apr 24;13(4)

Mindfulness in Gastroenterology Training and Practice: A Personal Perspective

This article was published in the following Dove Press journal:
Clinical and Experimental Gastroenterology

Umakant Dave ¹

Anjali Dave ²

Simon David Taylor-Robinson³

¹Department of Gastroenterology, Morriston Hospital, Swansea, Wales SA6 6NL, UK; ²Department of Psychology, Birmingham University, Birmingham B15 2TT, UK; ³Department of Surgery and Cancer, Imperial College London, St Mary's Hospital Campus, London W2 1NY, UK

Background: Work-related stress is becoming an increasingly recognised occupational hazard that can have detrimental effects on the health of both patient and doctor. The practice of gastroenterology not only includes the demands of clinics and in-patient work faced by other medical specialities but also the additional burden of complex, and often high-risk, endoscopic interventions. Mindfulness, a secular form of meditation, can relieve stress, even if only practiced for a few minutes a day.

Methods and Results: We present a personal perspective of the burnout experienced in stressful gastroenterology careers and the personal use of mindfulness in the daily routine to provide a source of calm when surrounded by many different pressures. We review some of the literature exploring the role of mindfulness in clinical practice with an emphasis on gastroenterology. While the practice of mindfulness is not designed to obviate immediacy and quick decisions in a rapidly changing clinical environment, it has been held widely useful to mitigate the stress involved in making those decisions.

Conclusion: Practicing mindfulness, meditation and mindful living offers many advantages to gastroenterologists' wellbeing as well improved patient care. We advocate its teaching to both gastroenterology trainees and consultants who are not familiar with the technique.

Keywords: mindfulness, gastroenterology, stress, meditation, wellbeing

8 steps to Wellbeing

- Diet and Nutrition
- Sleep
- Exercise
- Reappraisal of Stress
- Mindfulness
- Gratefulness
- Self-compassion and Self-care
- Being part of a supportive network

International Journal of General Medicine



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PERSPECTIVES

Maintaining Resilience in Today's Medical Environment: Personal Perspectives on Self-Care

Umakant Dave ¹, Simon D Taylor-Robinson ²

¹Department of Gastroenterology, Morriston Hospital, Swansea, Wales, SA6 6NL, UK; ²Department of Surgery and Cancer, Imperial College London, St Mary's Hospital Campus, London, W2 1NY, UK

Correspondence: Simon D Taylor-Robinson, Department of Surgery and Cancer, Imperial College London, St Mary's Hospital Campus, London, W2 1NY, UK, Tel +44 203 312 6254, Email str338333@gmail.com

ROI of wellbeing initiatives

- For every £1 spent on supporting the mental health and wellbeing of their workforce, employers get (on average) about £4.70 back in increased productivity.
- For doctors/ endoscopists:
 - Improved patient satisfaction
 - Better morale
 - Higher quality of care
 - Reduced medical errors
 - Improved recruitment and retention

Self-Compassion

Self-Kindness

Respond to personal suffering with warmth and understanding instead of harsh judgement.

Common Humanity

Recognize suffering and imperfection as universal human experiences, reducing isolation.

Mindfulness

Notice distressing thoughts and emotions without suppression or overwhelm to maintain balance.



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Ms Martina Trapani
Clinical Application Specialist
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PARTNERSHIPS IN ACTION: **LEVERAGING ERGONOMIC INNOVATION** **TO OPTIMISE ENDOSCOPY SERVICES**

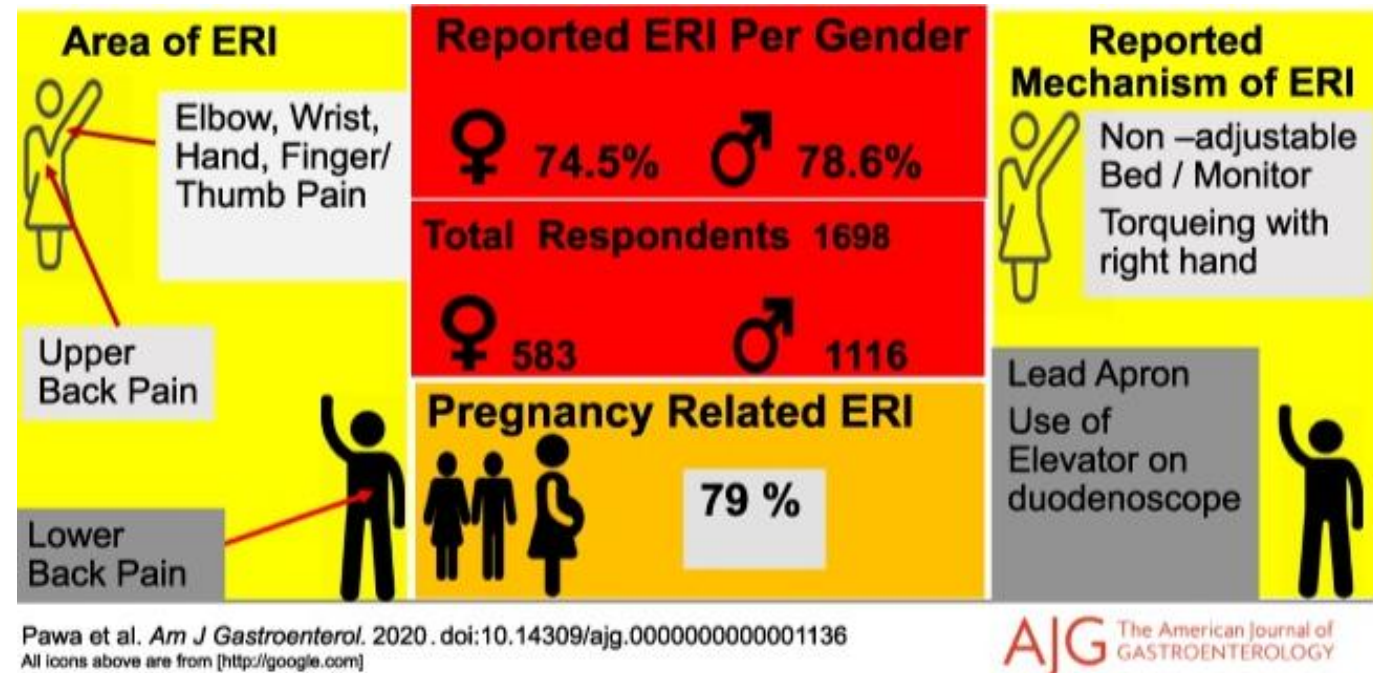
Martina Trapani

Clinical Application Specialist

06 May 2026

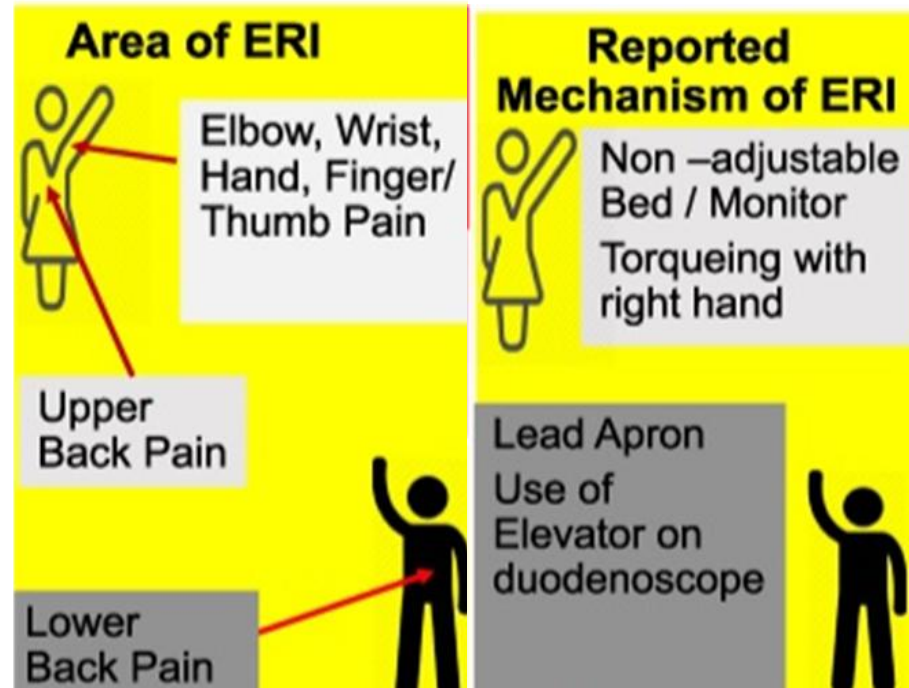
Why Endoscopy Related Injury (ERI) Matters in Endoscopy

- 75% of endoscopists report at least one ERI
- ERI affects clinicians across career stages and practice types
- Demonstrates ERI is a systemic occupational issue, not an individual failing



Where & How Injuries Occur

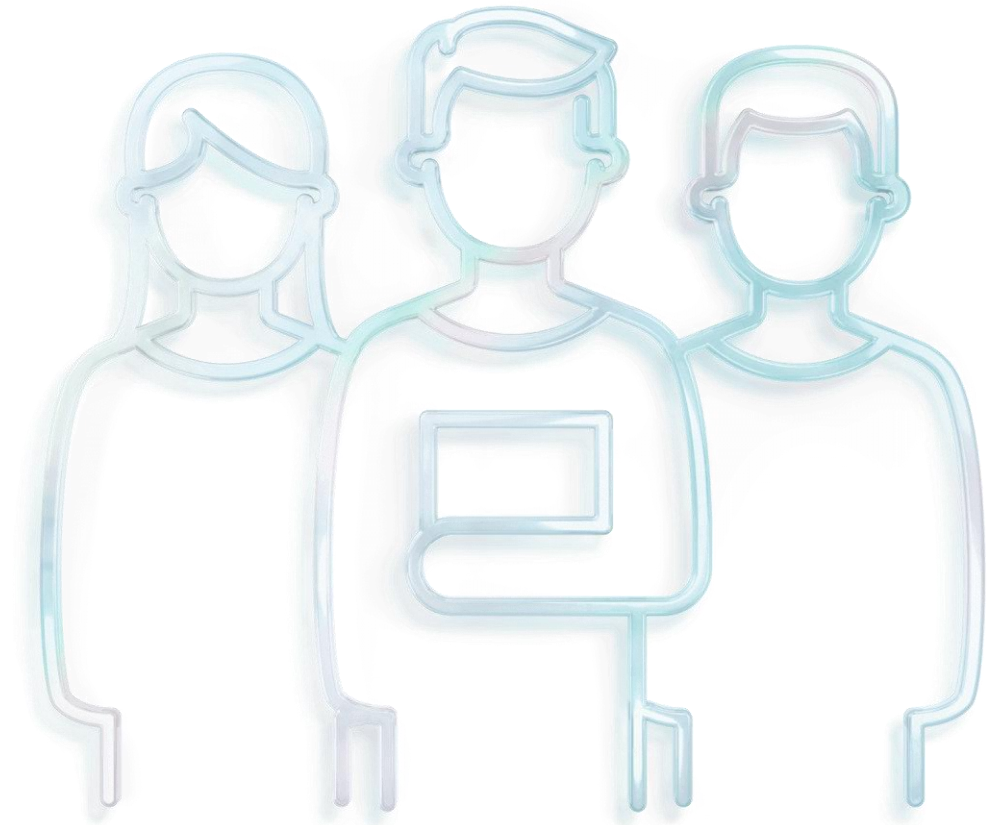
- Thumb 63%
- Neck – 59%
- Hand/Fingers – 56%
- Lower back – 53%
- Shoulder – 47%
- Wrist – 45%



The Training Gap

Prevention Is Underused

- 63% of endoscopists have never discussed ergonomic strategies
- Highlights lack of formal ergonomic education and preventive culture



How About Europe?



European Society of Gastrointestinal Endoscopy (ESGE)

16,430 followers

6mo



🔔 Concerned about your long-term health working in the endoscopy suite?

➔ 🔗 We invite GI endoscopy professionals to complete our important new survey on ergonomics here: <https://lnkd.in/d9KFX5hT>

Ergonomics is a major issue for practicing endoscopists. To tackle this issue, the Taskforce on Ergonomics from the ESGE Quality in Endoscopy Committee and the ESGE Diversity, Equity and Inclusion Working Group have prepared a survey to study knowledge, attitudes and practices of endoscopy-related health hazards – an important subject for men or women, young or senior, trainees or experts.

Your valuable participation and insights will help understanding working habits and conditions as well as informing future strategies to reduce endoscopy-related health hazards. The results of this survey will be published as an ESGE Position Statement on ergonomics in GI endoscopy in the journal Endoscopy. The survey is anonymous, not-for-profit and in-depth. Your responses will be used solely for research purposes. We encourage everyone who works in GI endoscopy to complete it

🙏 Thank you in advance for your time and effort!



How about us?



ERGONOMICS IN ENDOSCOPY: ALIGNING SKILLS AND WELLBEING

75% of endoscopists face endoscopy-related injuries*. Elevate your skills. Protect the longevity of your practice.

Join our masterclass to enhance your wellbeing. Learn from experts, combining their knowledge and skills to deliver a multidisciplinary approach to ergonomics in endoscopy.



Dr Raj Rameshshanker
Consultant
Gastroenterologist
Hillingdon Hospital, London



Jo Kelly
Owner of JoTopia Ltd
Physiotherapist



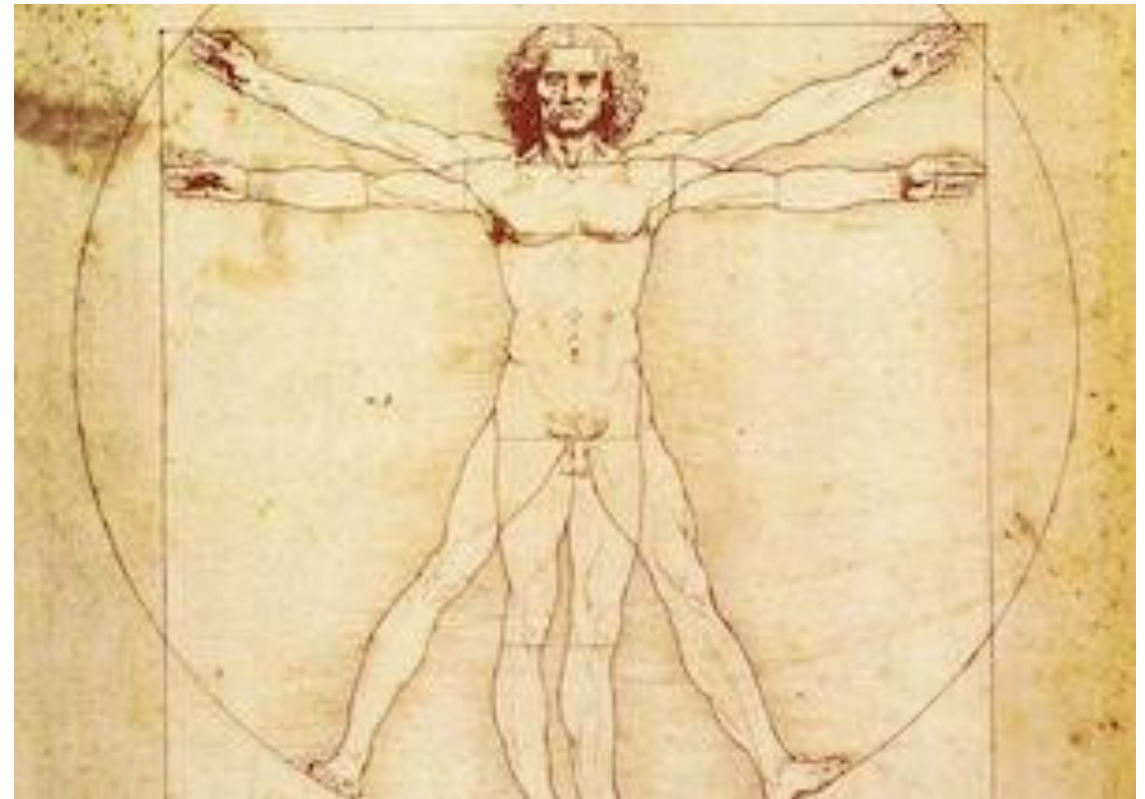
Martina Trapani
Clinical Application Specialist
PENTAX Medical UK

Date: Thursday, April 23rd, 2026
Venue: PENTAX Medical, Unit D1, Heron Drive, SL3 8PN



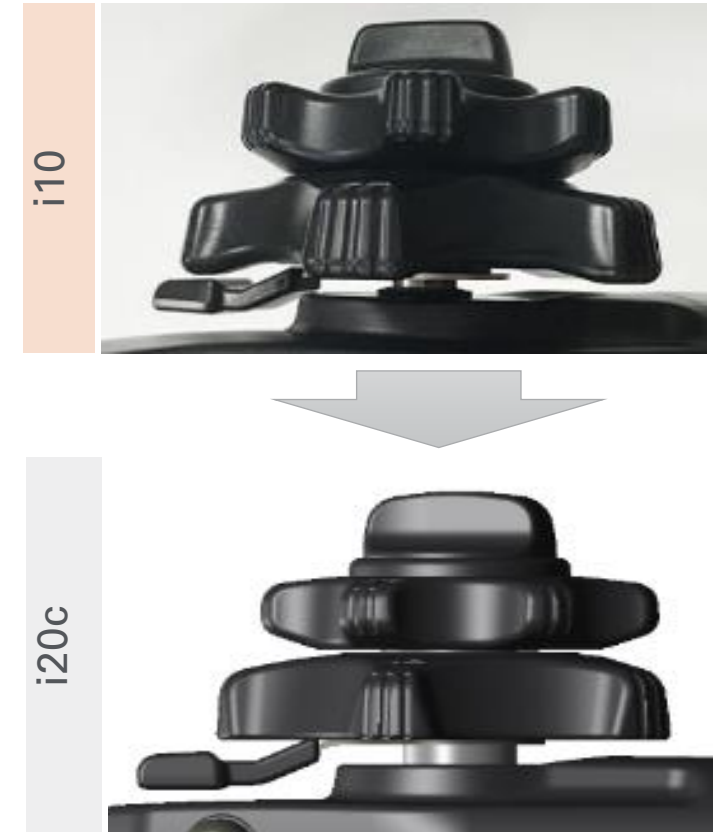
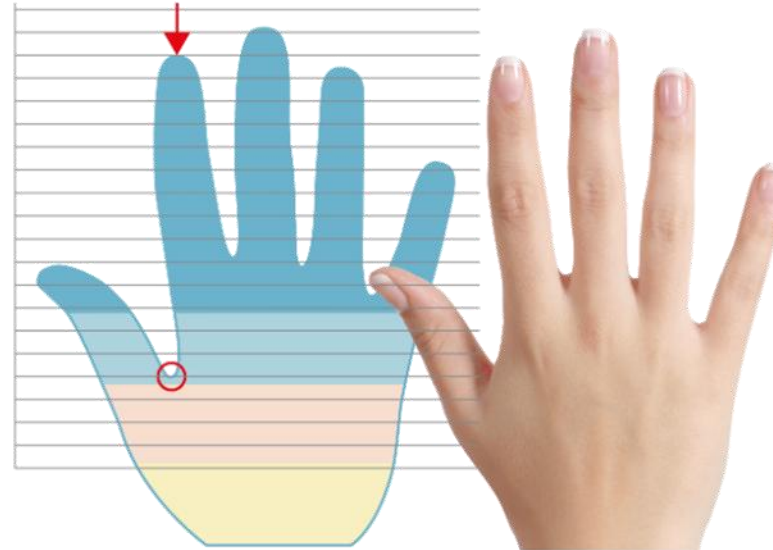
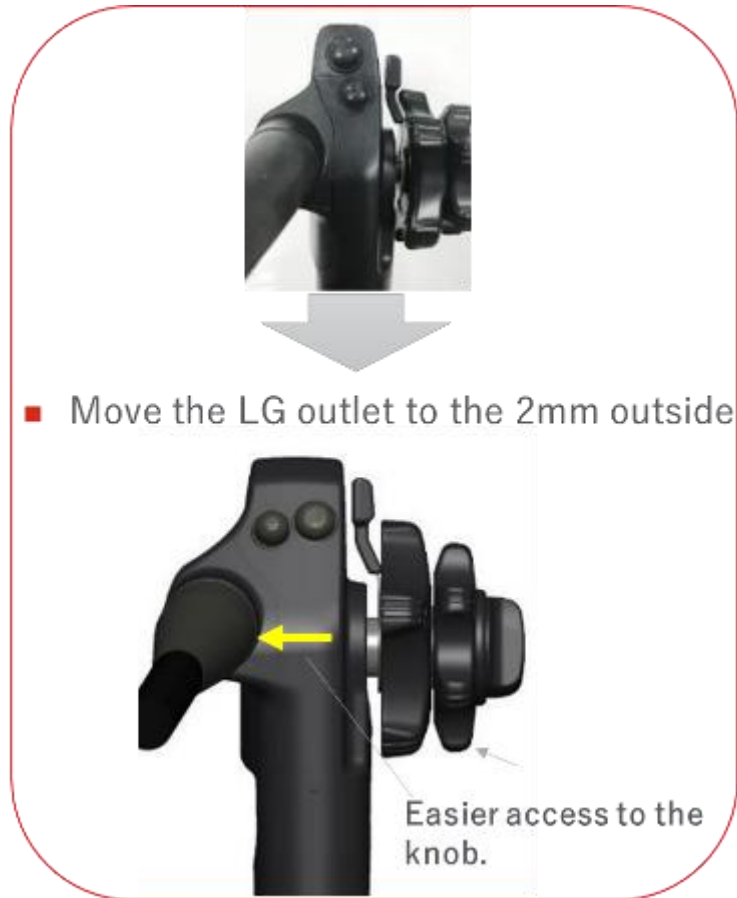
Leonardo Da Vinci: Legacy in Ergonomics

Leonardo da Vinci's meticulous study of human anatomy, proportion, and movement laid the foundation for modern ergonomics, demonstrating a deep concern for human interaction with tools, machines, and spaces.



The Vitruvian Man

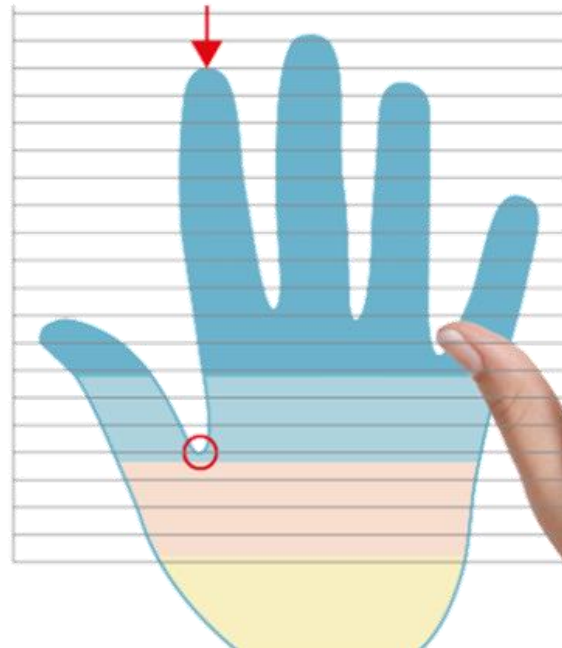
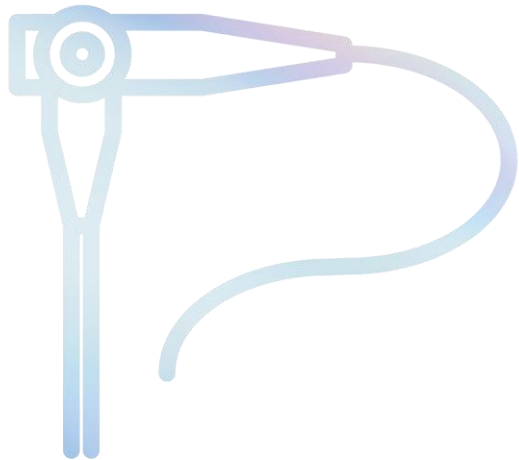
Where Modern Ergonomics Reflects Leonardo's Vision



Where Modern Ergonomics Reflects Leonardo's Vision

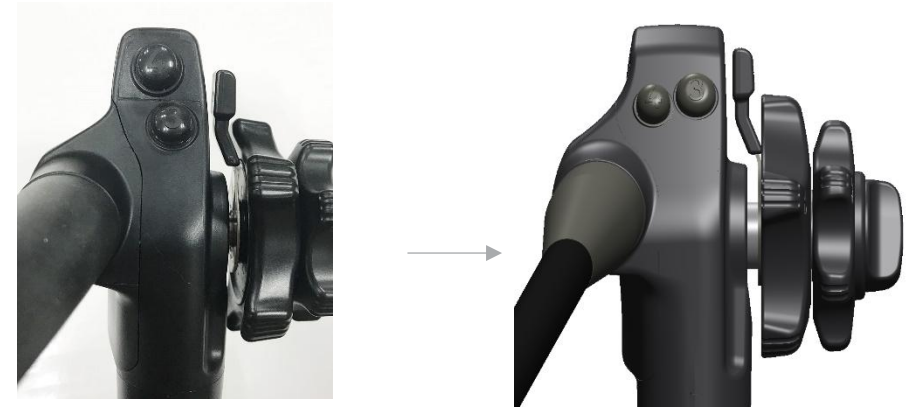
Ergonomics Isn't One-Size-Fits-All

Supporting Users at the Edges of the Anthropometric Range



Where Modern Ergonomics Reflects Leonardo's Vision

- Changed layout of remote button #3 and #4 from vertically to horizontally to minimise mis-pressing buttons and easier access
- Change press-direction of remote buttons for better finger access



Where Modern Ergonomics Reflects Leonardo's Vision

New designed air water and suction valve

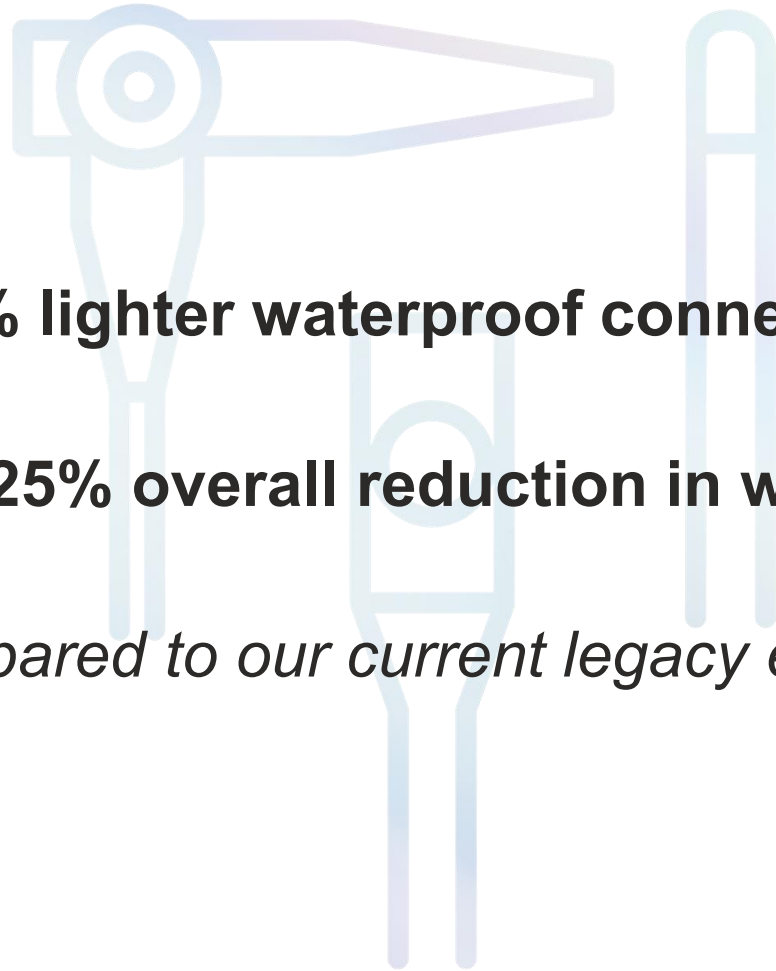
- Maintenance free
- More responsive
- Softer to press
- Graded suction



Where Modern Ergonomics Reflects Leonardo's Vision

- 40% lighter waterproof connector
- 20-25% overall reduction in weight

Compared to our current legacy endoscopes



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Where Modern Ergonomics Reflects Leonardo's Vision



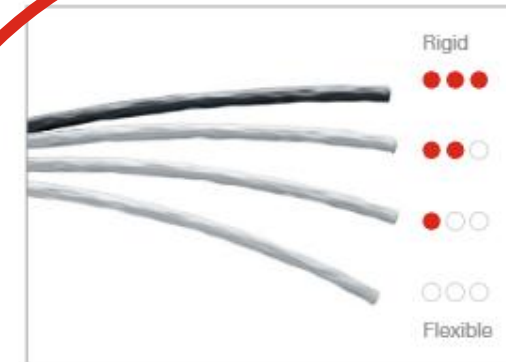
i-FLEX™

Graded endoscope flexibility to ease the maneuverability and help to reduce loopings



TrueTorque™

Delivers a higher tactile feel with the endoscopes, supporting a predictable movement



Adjustable stiffness

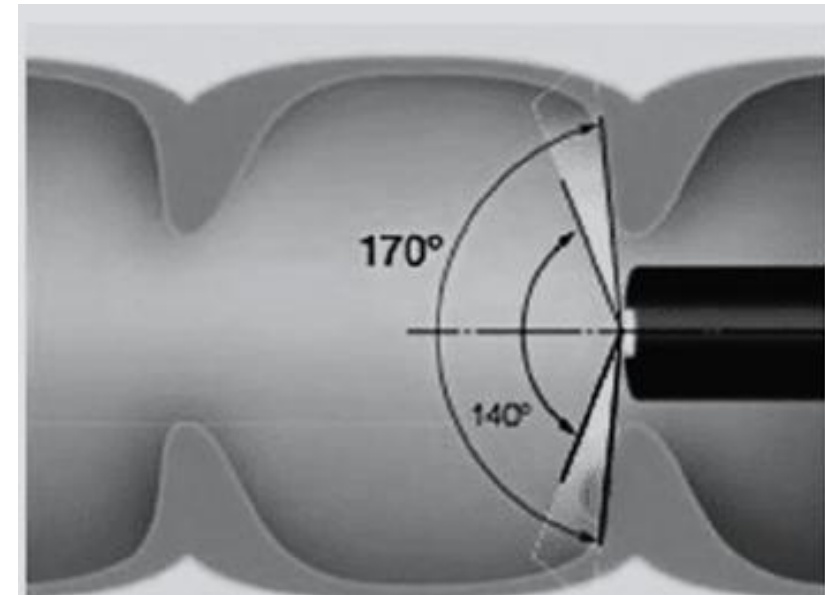
Rigidity of the insertion tube can be adjusted for individual patient's anatomy

Where Modern Ergonomics Reflects Leonardo's Vision

- Wider field of view



- Less wheel maneuvering



Where Modern Ergonomics Reflects Leonardo's Vision

PENTAX[®]
MEDICAL

Height-adjustable secondary monitor



Endoscopy is physically demanding. It requires clinicians to stand for prolonged periods in static postures while maneuvering complex equipment.

Dr. Raj Rameshshanker
Consultant Gastroenterologist Hillingdon Hospital
London, UK



Posture is fundamental to preventing injury and supporting a long, sustainable career.

Ms. Jo Kelly
Owner of JoTopia Ltd
Physiotherapist
London, UK



How did that go?



Overall, how satisfied are you with the event?

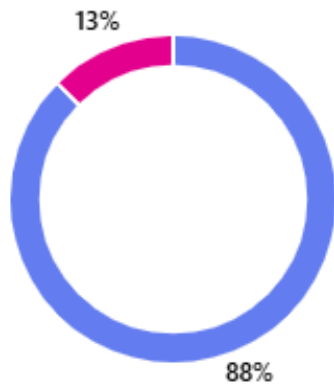
5.00

Average Rating



Were your expectations of the event met?

- Beyond my expectations 7
- Met as expected 1
- Below my expectations 0



Has today influenced how you think about your career longevity in endoscopy?



What ergonomic challenge did you recognise in your own practice today that you were not fully aware of before?

- Recognising my own posture and how it can be detrimental especially during extended periods of standing/scoping etc.
- It is not well taught, so I think this is an unmet need.
- My posture especially when using foot pump.



What is the single most important change you will make in your practice as a result of this masterclass?



- Being conscious of my posture. Remembering to pause, reassess my posture and realign.
- Regular teaching to my unit re ergonomics and I am going to introduce the exercises to my team.
- My posture especially when using foot pump.
- Awareness and self exercise to prevent and reduce ERI. Thank you PENTAX Medical for this course.
- Alternating foot pump use and changing my posture.





Anne Wong ✓ • 1st

Clinical Endoscopist & Independent Prescriber

1d • 🌐

...

Great to attend the first Ergonomics in Endoscopy at **PENTAX Medical** HQ last week.

An incredibly insightful and practical session. It really highlighted the importance of technique, posture, and equipment setup in reducing strain and preventing injury in our day-to-day practice. Lots of useful tips to take forward and apply immediately.

Looking forward to seeing continued focus on this area within endoscopy training and practice.

Hopefully **Martina Trapani** will be organising many more of these sessions for all to learn!



PENTAX Medical

2d • 🌐

What an insightful day at the "Ergonomics in Endoscopy: Aligning Skills and Wellbeing" Masterclass!

... more



PENTAX[®]
MEDICAL

... more



What's next?

ENDOSCOPY SAVES LIVES BUT WHO'S SAVING THE ENDOSCOPIST?



Join us at the ESGE Days Spotlight Stage to enhance your wellbeing. Discover how ergonomics, posture, and training can help prevent musculoskeletal (MSK) injuries and support better personal wellness in endoscopy.



Dr. Sandra Nagl
Universitätsklinikum
Augsburg
Augsburg, Germany

Dr. Keith Siau
Royal Cornwall
Hospitals NHS Trust
Truro, UK

Ms. Stacy Markwell
Markwell Physical Therapy,
LLC
Chapel Hill, USA



Date: Thursday, May 14th 2026
Time: 15:10-15:30 CEST
Location: Spotlight Stage, Exhibition Hall at the Allianz MiCo, Milan convention Centre



What's next?



22nd – 25th June 2026 | ACC Liverpool

Thank you!





Refreshments & Networking



Chair Morning Reflection



Mr Anil Vara

Bsc (Hons), Msc, MBA, CMgr, FCMI

Head of Elective Care

Doncaster and Bassetlaw Teaching NHS
Foundation Trust



Case Study





Case Study



James Geeson
HICSS Principal Analyst
HICSS - UHS Digital



Endoscopy Management System

Unlocking efficiency in Endoscopy Scheduling

6th May 2026

Endoscopy scheduling is far from simple

- Significant complexity built up over years
- Multiple procedure types
- Wide range of patient factors
- Clinician capability, experience, and working patterns matter
- Processes vary widely between Trusts
- Fragmented technology

No single “standard” way of doing endoscopy scheduling today.

Endoscopy doesn't fit generic booking models

Not outpatient, not theatre

Unique challenges

- Non-standard points
- Phone-based booking
- Skill-based staffing
- Parallel processes (e.g. pre-assessment, anti-coags, pacemaker check)

Leads to: Manual workarounds, duplicated effort, hidden inefficiency.

Stopping to challenge previous thinking

- Knowledge lives in people's heads
- Critical rules are undocumented and inconsistent
- Reporting often supports past performance, not operations
- Decisions remain reactive and intuition-led

The opportunity:

- Capacity often exists — it's just not organised or visible.



What We've Done Differently

Design for complexity, don't simplify it away

- Partnered with Gray – experts in complex clinical scheduling
- Purpose-built for NHS endoscopy
- Key capabilities:
 - Clinician capabilities captured centrally
 - Sessions inherit capability and constraints
 - Smart matching of referrals to the earliest appropriate slots
 - Patient flags
 - Order Comms integration

The screenshot displays a scheduling interface for Monday, 4 May 2026. It features a grid with time slots on the y-axis (8:30 to 15:30) and clinician columns on the x-axis. The clinicians shown are Kathryn Padilla, Salma Dotson, Rita Blaeze, and Tianna Woods. Each clinician's column lists their available sessions and the appointments scheduled within those sessions. Appointments are color-coded: pink for ERCP - Diagnostic Demo, green for Colonoscopy - Diagnostic, and light green for Therapeutic Gastro List. Some appointments include patient names and IDs, such as Brown, Samantha (535244) and Harper, Charles (015377). The interface also includes navigation controls for daily/weekly views and a 'Priority' mode toggle.

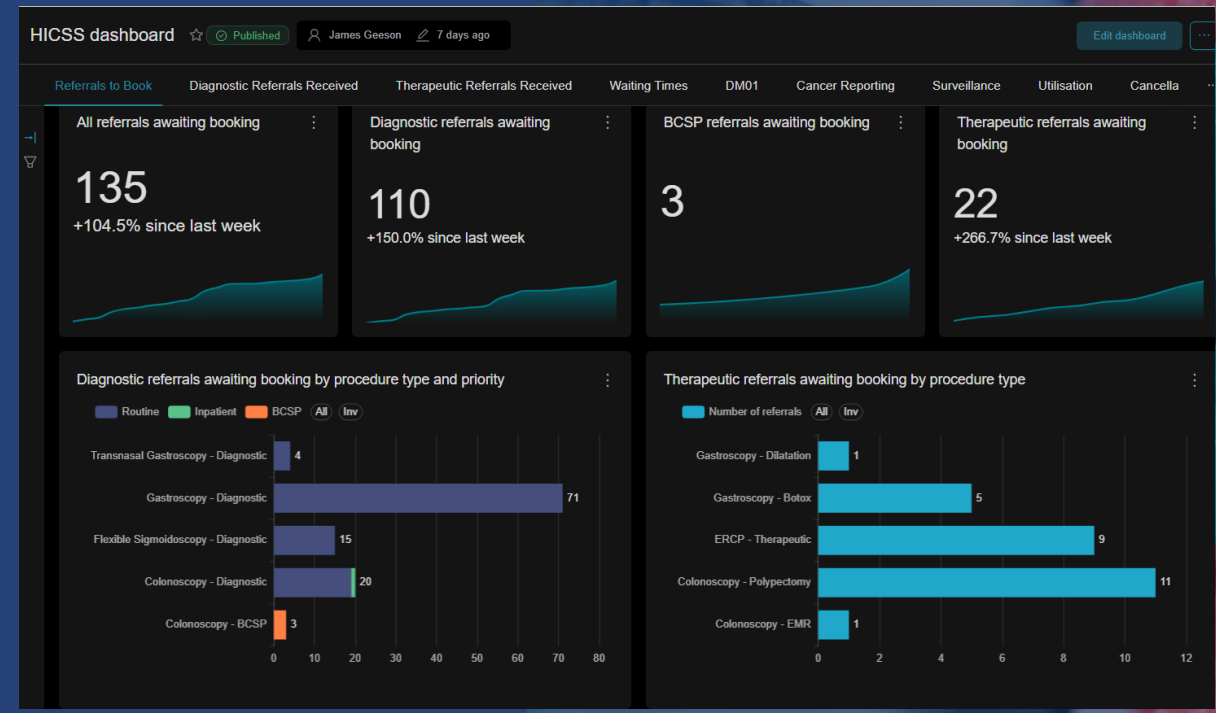
Time	Kathryn Padilla	Salma Dotson	Rita Blaeze	Tianna Woods
8:30	EMR 12/12	Mixed Theatre 12/12	ERCP 12/12	Gastro 8/12
9:00		Therapeutic Gastro List 9/12		
9:30				
10:00				
10:30				
11:00				
11:30				
12:00				
12:30				
13:00	EMR 12/12	Therapeutic Gastro List 9/12		Gastro 8/12
13:30	Smith, Alicia (751152)			Nichols, Shaun (316718)
14:00	Mercier, Claire (920536)			Shaffer, Douglas (151746)
14:30	Calhoun, Shelly (646255)			Mcgrath, John (099531)
15:00	Mccormick, Richard (881796)			Perez, Michael (688140)
15:30	Robinson, Kiara (925435)			Leqault, Mathilde-Aurélie (539660)



What We've Done Differently

Real-time operational insight

- Capacity and Upcoming Demand
- Utilisation
- DMO1
- Cancer Breach Tracking



Technology doesn't unlock efficiency on its own

Long-standing processes feel safe and familiar

True gains require changes in how departments work

Successful transformation needs:

- Time
- Clear explanation of why
- Trust in agreed rules and automation

The more we attempt to override automation, the longer the process takes.

From booking activity to service optimisation

- ✓ Automated surveillance scheduling
- ✓ Reduced reliance on phone calls
- ✓ Improved patient engagement
- ✓ Pre- Assessment

Direction of travel:

- Manual → Automated
- Reactive → Proactive
- Managing bookings → Improving the service

The capacity is often already there — the challenge is how we unlock it.



Book a demo today

call us on 023 8120 8888 or visit
www.hicssuhs.co.uk



Email: HICSS@uhs.nhs.uk
LinkedIn: HICSS UHS
X: @uhshicss





Case Study



FUJIFILM
Value from Innovation

UGI FDS pathway improvement project

CONNECT

Combined ONE stop trans Nasal Endoscopy and CT

Dr Jason Dunn

Consultant Gastroenterologist Guy's & St Thomas' Hospitals NHS FT
Associate Professor King's College London

Disclosures

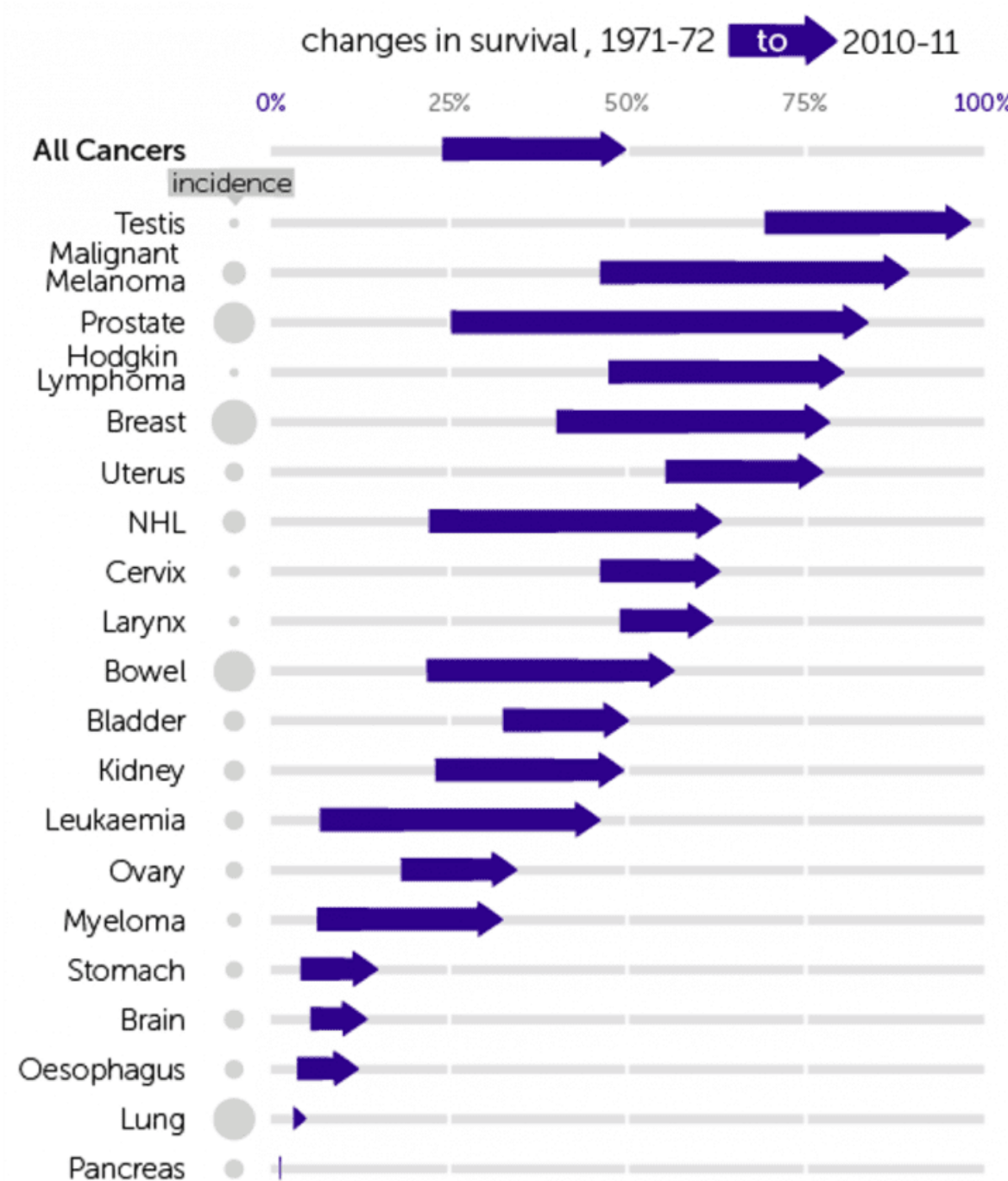
- Medtronic research grant
- Medtronic educational grant
- Dr Falk Pharma educational grant
- Fujifilm educational grant
- One Welbeck Health Partners shareholder

NHS long term plan for early cancer diagnosis

- NHS long term plan for improving cancer outcomes over next 10 years
 - Early cancer diagnosis
 - From 2028 extra 55,000 to survive 5 years or more following diagnosis
 - 3 out of 4 cancers diagnosed at stage one or two in 2028
- Faster diagnosis standard (FDS) – receive diagnosis or rule out cancer within 28 days of referral

UGI cancers – less survivable

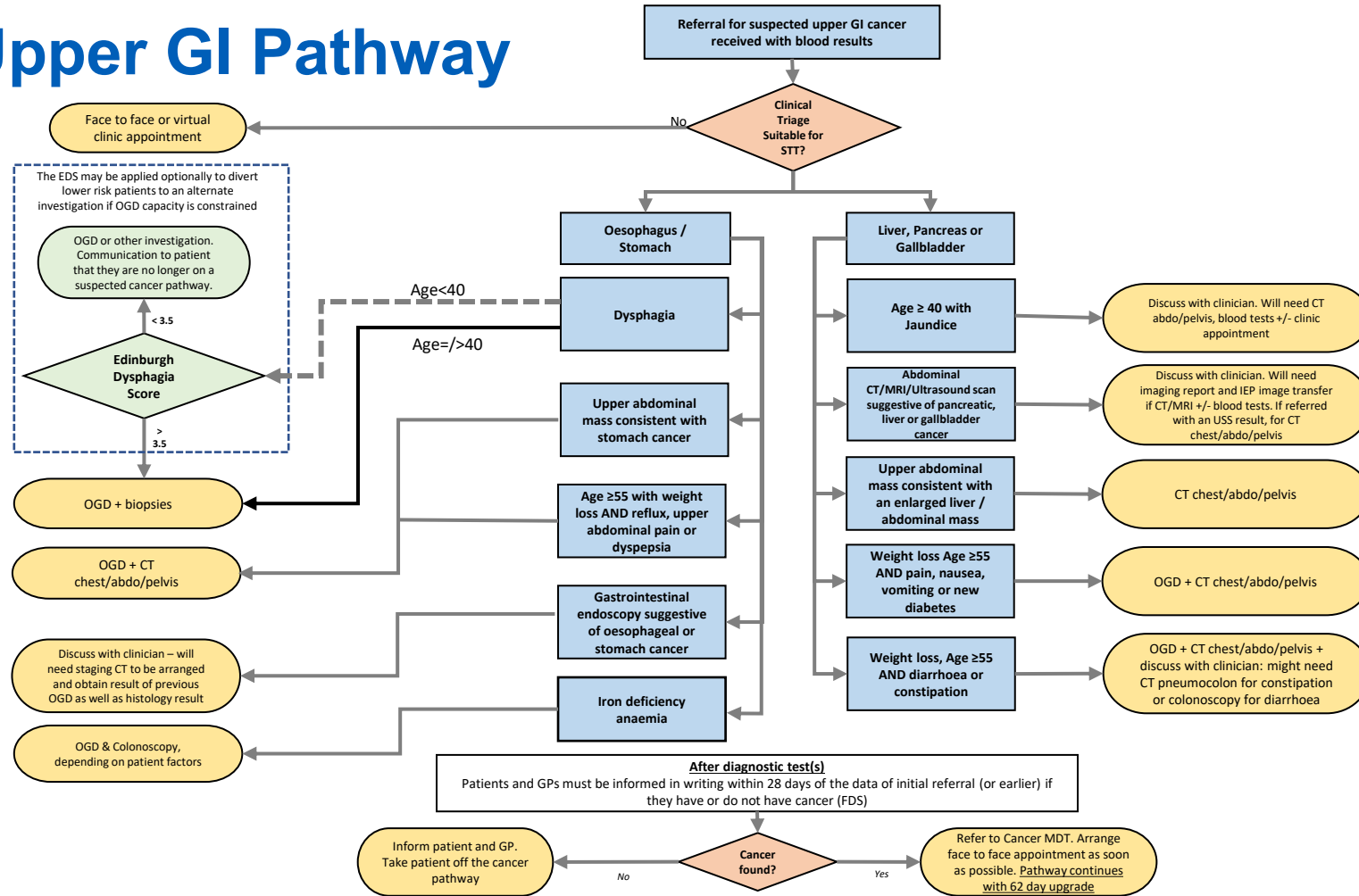
- 4/6 less survivable cancers are Upper GI
 - Pancreas, Liver, Oesophagus, Stomach
 - Lung, Brain
- 7-20% 5 year survival
- 90,000 people per annum
- They account for 40% of cancer related deaths
- Twice as likely to present as emergency (late) than other cancers
- Curable if treated early
 - Often with minimally invasive Endoscopic Therapy in case of OG cancers



The two pillars of UGI pathway



Upper GI Pathway

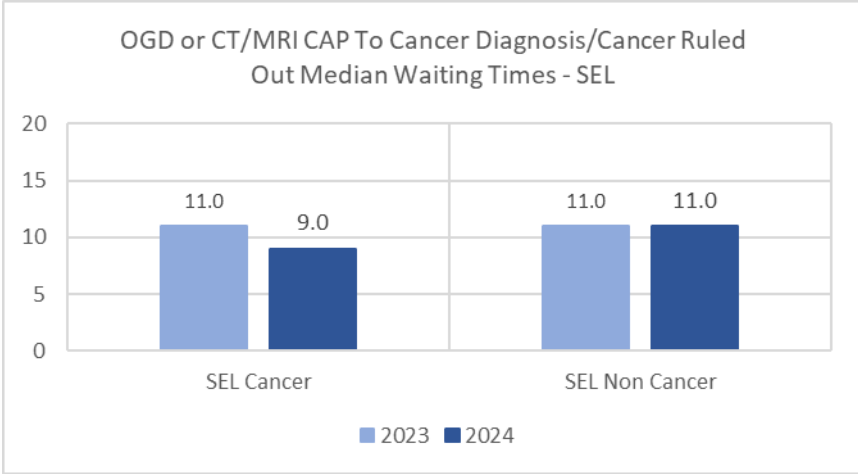
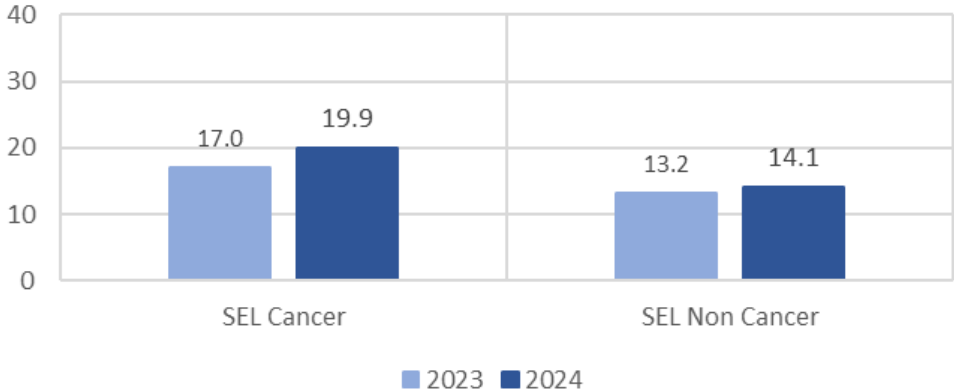


National best practice pathways targets

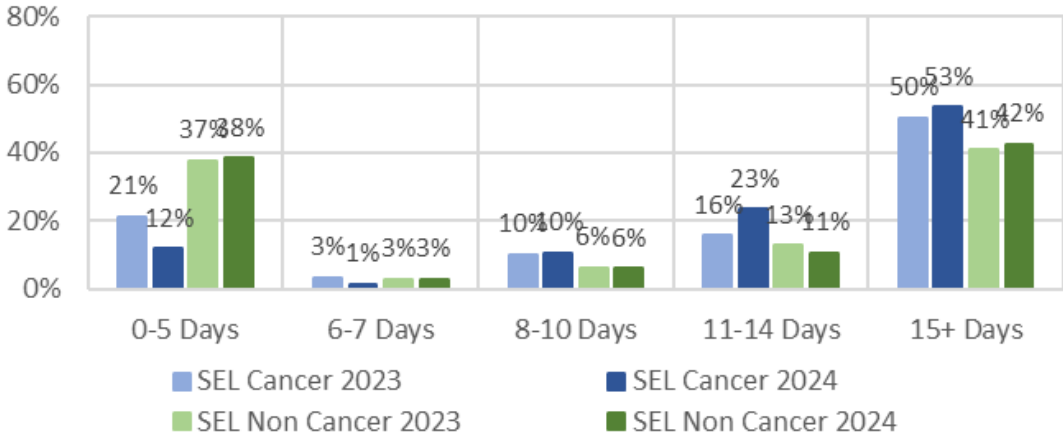
Pathway	Diagnostic	Turnaround time
Suspected colorectal cancer	Straight to test colonoscopy, CT colon and flexi-sigmoidoscopy	Within 14 days of referral received date
Confirmed colorectal cancer	Contrast CT chest, abdomen and pelvis	Within 7 days of request
Confirmed colorectal cancer	MRI +/- transrectal ultrasound (for rectal cancers)	Within 7 days of request
Suspected prostate cancer	Straight to test mpMRI and biopsy (with mpMRI before biopsy)	Within 9 days of referral received date
Suspected lung cancer	CT scan following a suspicious x-ray	Within 3 days of request
Confirmed lung cancer	PET-CT Detailed lung function and echocardiogram Spirometry CT or MRI of head	Within 7 days of request
Suspected oesophago-gastric cancers	Straight to test oesophago-gastro-duodenoscopy (OGD) +/- biopsy	Within 7 days of referral received date
Suspected oesophago-gastric cancers	CT scan for suspicious lesions	Within 1 day of OGD

Delays in the pathway

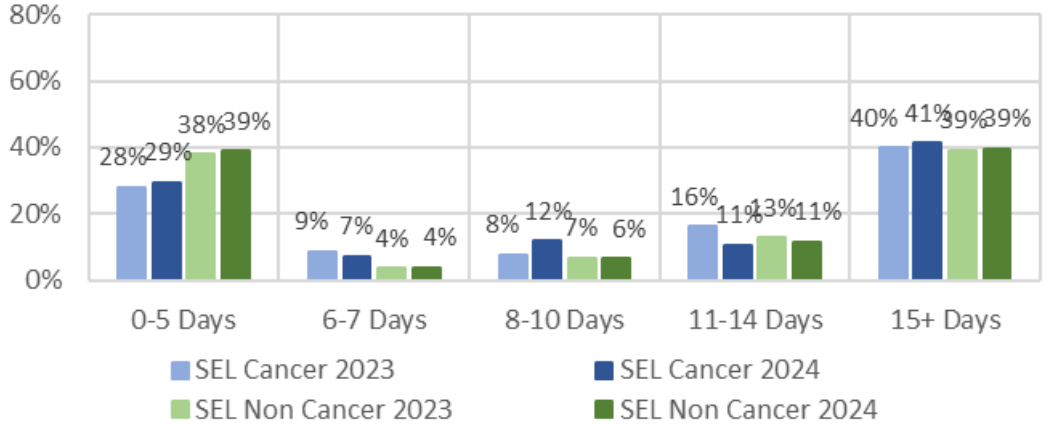
OGD To Cancer Diagnosis/Cancer Ruled Out Average Waiting Times - South East London



OGD to Cancer Diagnosis/Cancer Ruled Out By Wait Band South East London

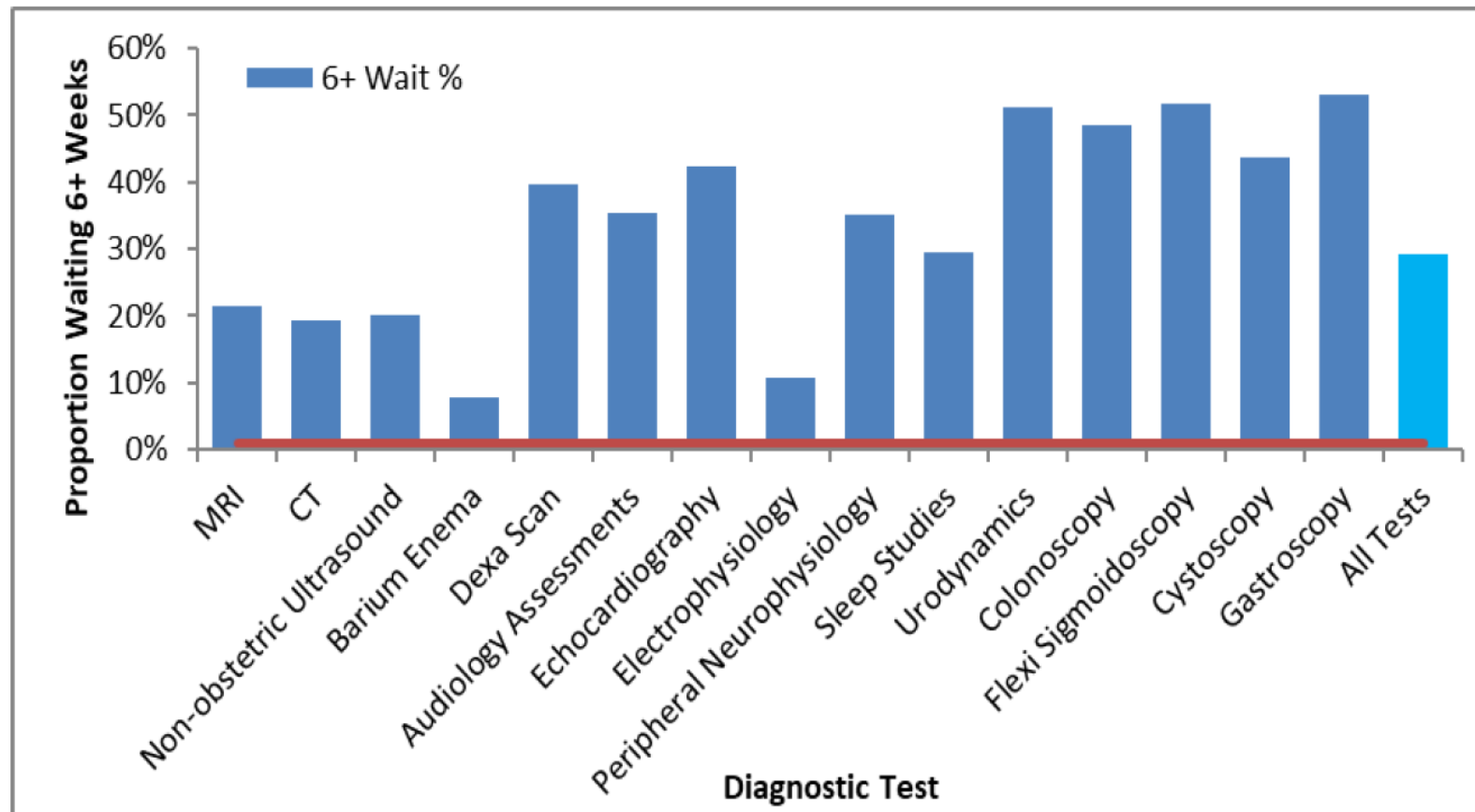


OGD or CT/MRI CAP to Cancer Diagnosis/Cancer Ruled Out By Wait Band - SEL



Gastrosocopy makes up largest proportion of backlog

Chart 6: Percentage of patients waiting 6+ weeks, by test – December 2020



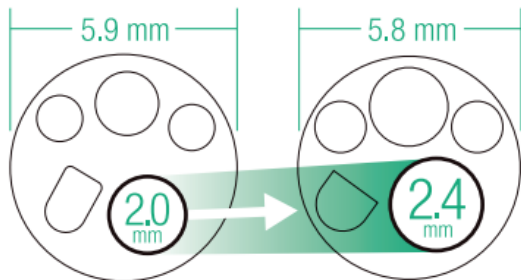
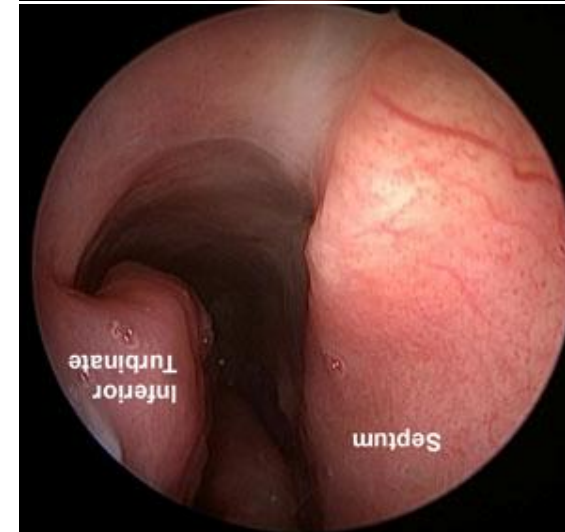
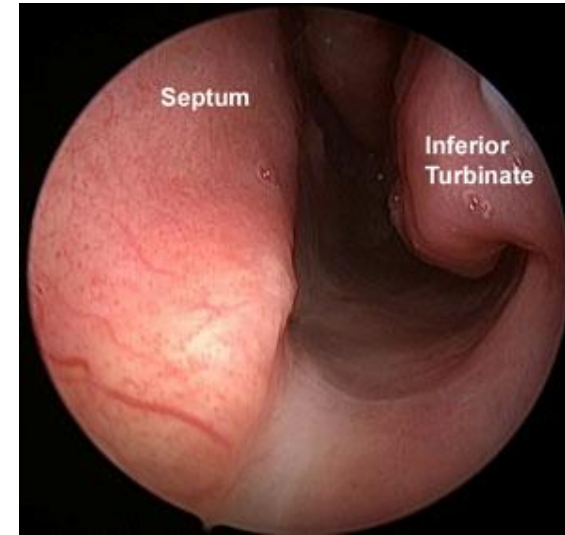
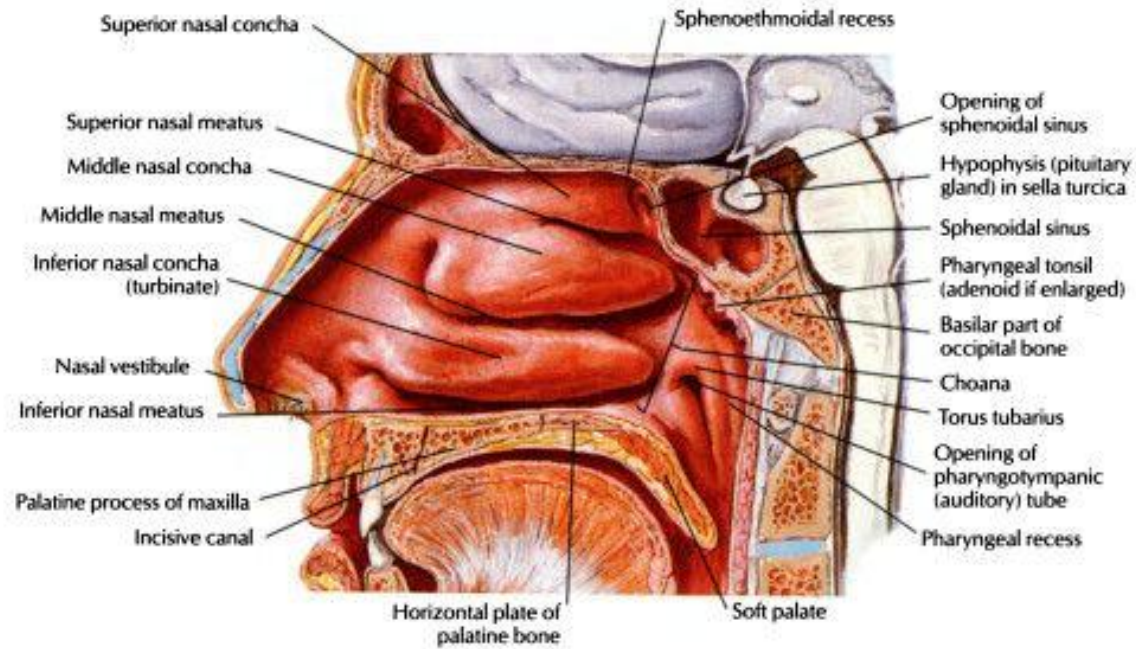
Comparison pre and post COVID

Table 2: Proportion of patients waiting 6+ weeks, by test – December 2019 and December 2020



	Dec-19	Dec-20	Difference (%age points)
MRI	3.4%	21.4%	18.1
CT	3.1%	19.2%	16.0
Non-obstetric Ultrasound	1.9%	20.0%	18.1
Barium Enema	1.4%	7.9%	6.5
Dexa Scan	1.1%	39.7%	38.7
Audiology Assessments	1.9%	35.3%	33.4
Echocardiography	6.6%	42.3%	35.7
Electrophysiology	2.3%	10.7%	8.4
Peripheral Neurophysiology	5.9%	35.1%	29.2
Sleep Studies	6.9%	29.5%	22.6
Urodynamics	16.3%	51.3%	35.0
Colonoscopy	13.1%	48.5%	35.5
Flexi Sigmoidoscopy	11.6%	51.6%	40.0
Cystoscopy	8.4%	43.8%	35.4
Gastrosocopy	10.8%	53.0%	42.1
All Tests	4.2%	29.2%	25.0

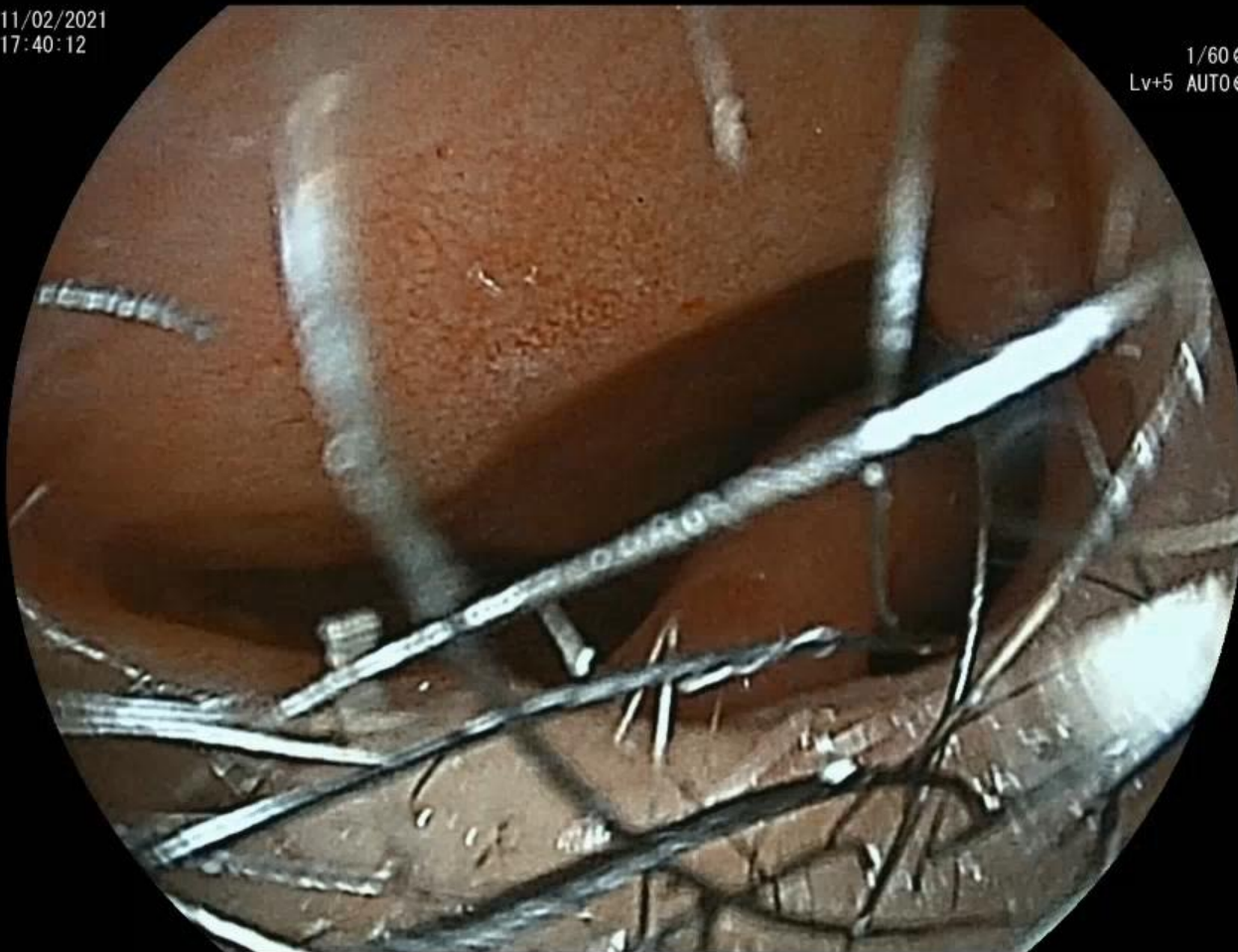
Note: Figures may differ due to rounding.

Trans-nasal Endoscopy (TNE)



11/02/2021
17:40:12


1/60 
Lv+5 AUTO 



HT NR




 *

2.4  5.8
5.9

S1: F/T
S2: EZOOM
S3: FICE
S4: LM

EG-740N

4G399K012

 BL-7000

St Thomas'

FUJIFILM

0

Specifications

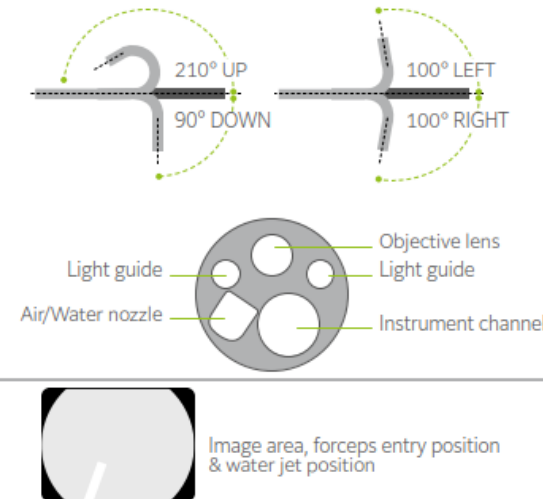
EG-840N ELUXEO® VIDEO GASTROSCOPE Ultra slim type



Viewing direction	0° (Forward)
Field of view	140°
Observation range	2 - 100mm
Bending capability	Up 210°/Down 90° Right 100°/Left 100°
Ø Distal end	5.8 mm
Ø Insertion tube	5.9mm
Minimum Ø of instrument channel	2.4 mm
Working length	1,100 mm
Total length	1,400 mm



ELUXEO 8000



Why TNE?

- Tolerability
- Safety
- Avoids sedation (patient safety, no escort / time off work, lower cost)
- No gagging!



Twilight TNE Service at GSTT to meet 18w target - 2019

Pilot phase - Oct 2019 – March 2020

1 list per week, 6-8 patients per list

2 endoscopists

98 patients – 97% completion rate

Roll out phase - Sep – Dec 2020

3 lists per week, 6 patients per list

9 endoscopists (4 consultants, 2 Nurse Endoscopists, 3 Fellows)

127 patients - 90% completion rate

Inclusion criteria	Exclusion criteria
1. Any patient ASA grade II or less who requires standard diagnostic gastroscopy (including two week wait patients)	1. ASA grade III and IV
2. Barrett's oesophagus short segment (<3cm)	2. *Unable to stop aspirin/clopidogrel
3. Eosinophilic oesophagitis (EOe) assessment and biopsies	3. *Current use of DOAC
4. Gastric intestinal metaplasia surveillance	4. #Check ulcer healing
5. Post-HALO radiofrequency ablation surveillance (>2 years from procedure)	5. Barrett's surveillance >3cm
	6. Any intervention required/expected
	7. H pylori culture
	8. Duodenal biopsies for coeliac assessment (Type 1/2 refractory)
	9. Nasal surgery / fractures / septal deviation / recurrent epistaxis (unless cleared by ENT)
	10. 12-months following endoscopic eradication therapy for Barrett's (either RFA or EMR)

Rolling out TNE pan London

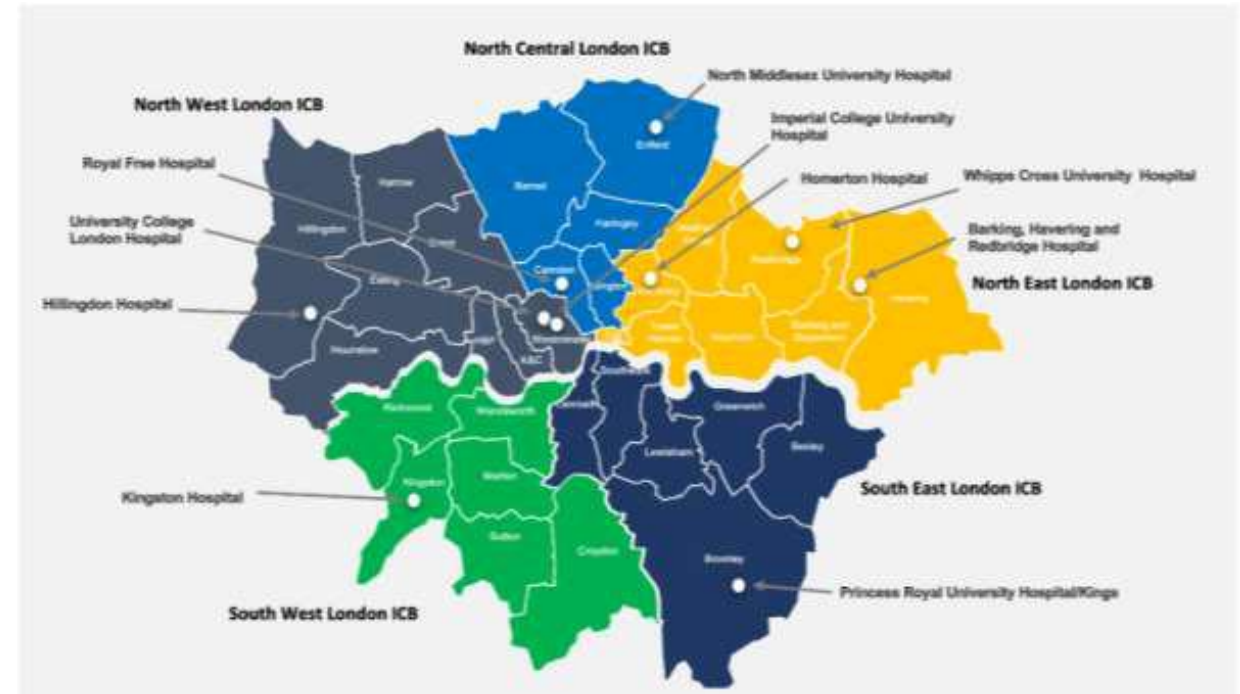
Classification: Official



Transforming London's Trans-nasal

Endoscopy Services

An NHS England London Pilot Evaluation

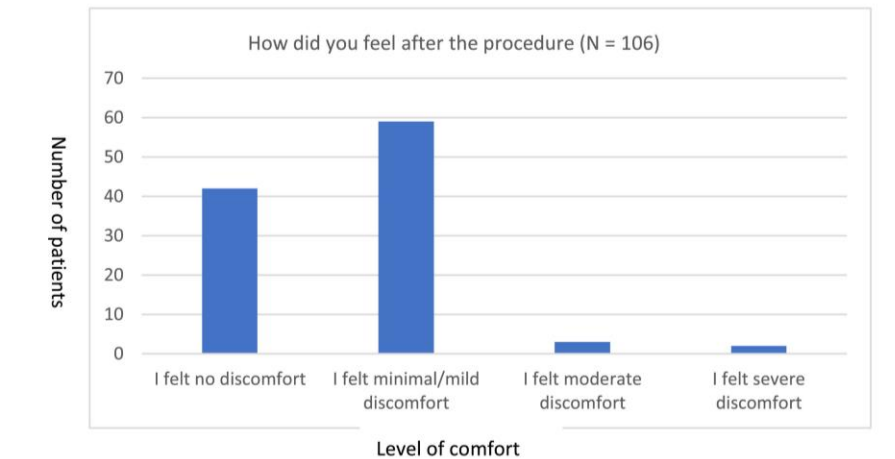
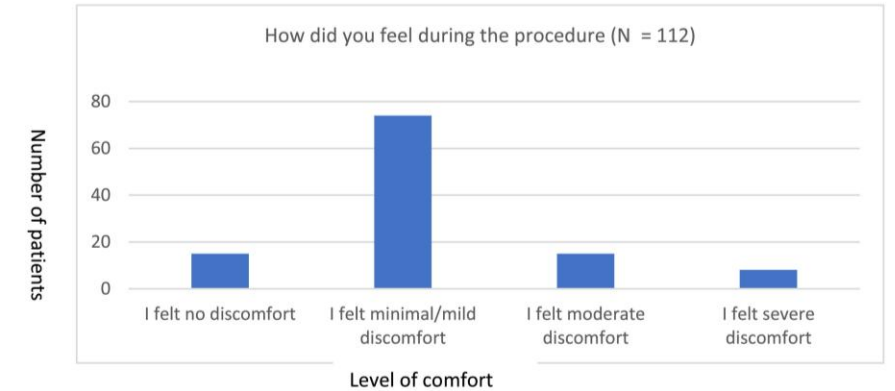
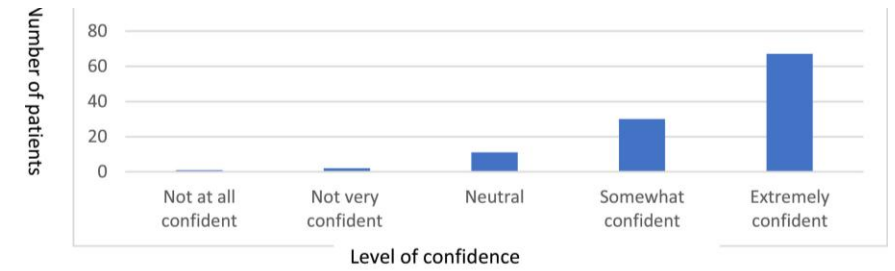


10 sites in pilot evaluation

£2.48 million capital funding and a further £150,000 revenue funding

Patient uptake and tolerability

- 26,755 upper GI referrals during the 6-month pilot period
 - 9.1% TNE (2,429 patients)
- 112 patient survey from 6 sites
- Of 46 patients who had both procedures, 78% preferred TNE



Comparing different models

- In endoscopy setting (as our pilot)
 - Less problems with decon as on site
 - So less scopes required
 - No issues with air exchanges
 - Same throughout endoscopy unit
 - Admin similar in terms of booking
 - Reporting tools, image capture
- Outside of endoscopy
 - Clinic in hospital outpatients
 - Community Diagnostic Centre (CDC)
 - Mobile Unit



How Outpatient TNE service would support meeting national targets

- Address the UGI diagnostic endoscopy backlog
- Meet the 28-day FDS UGI pathway target
 - By improving access to the 2 diagnostic pillars
- Create space in endoscopy units which would indirectly support the meeting of other 2ww pathway targets (eg colorectal cancer)
 - More space for colonoscopy and therapeutic procedures in endoscopy
- Reduce the surveillance back log

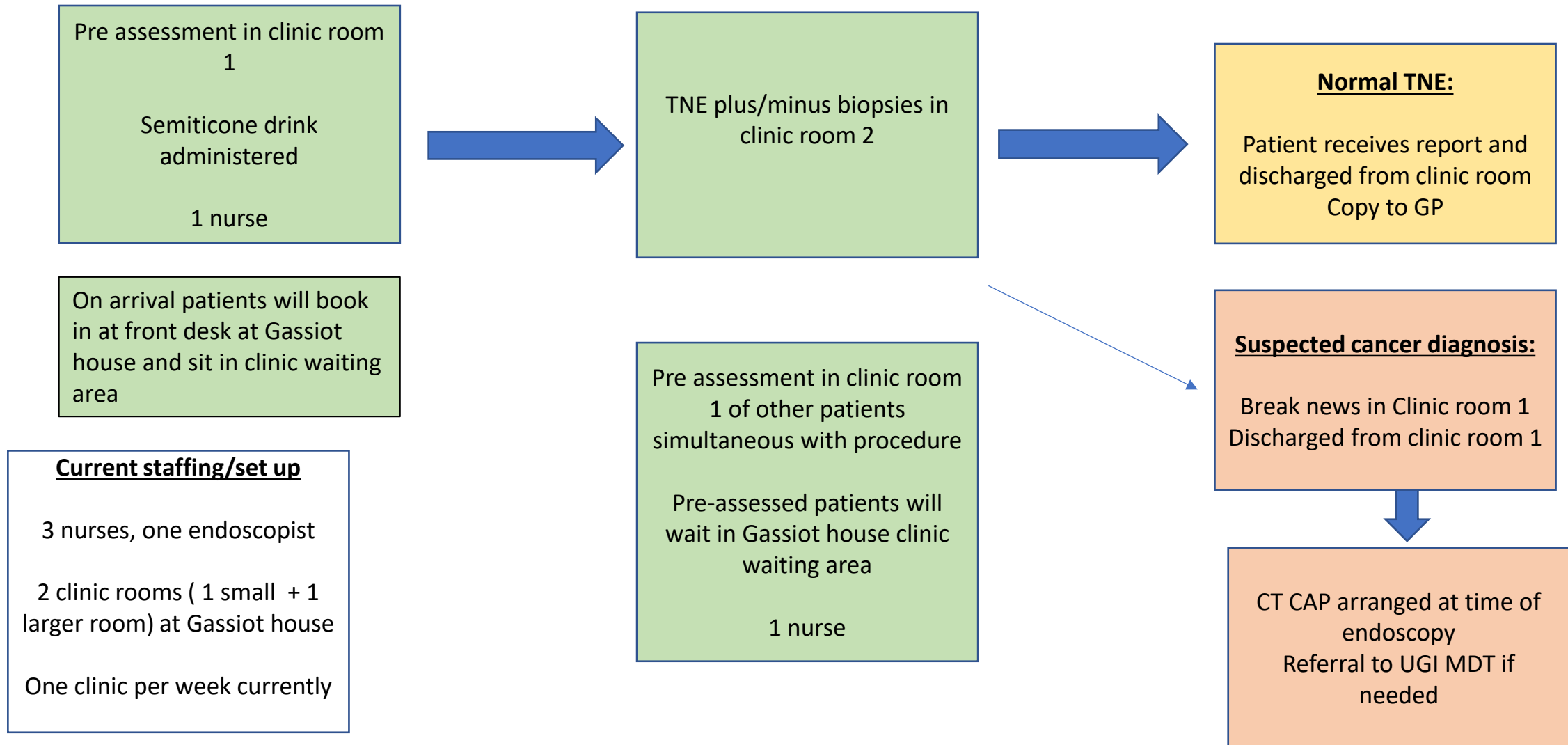
CONNECT Pilot : Combined **ONE** stop Nasal Endoscopy and **CT** pilot

Mohamed Hussein
Jason Dunn

CONNECT - Combined ONE stop Nasal Endoscopy and CT pilot

- Awarded £87,500 grant from SELCA
- Started St Thomas' Hospital March 1st 2023
- Outpatient setting
 - 8 patients per list
- Equipment – Fujifilm scopes (x8) and stack
- Staffing
 - 2ww TAC nurse
 - Band 6 nurse
 - HCA
 - Admin

TNE clinic set up at STH Gassiot house outpatients



Equipment

- Essentials
 - 1 endoscopist, 1 nurse (+HCA desirable)
 - 5 scopes and a dedicated stack
 - Pre prep 50mls per patient
 - 20mls NAC, 15 drops of infacol, 500mls water
 - Phenylephrine 0.5%/Lidocaine 5%
 - Paediatric biopsy forceps
- Desirables
 - Quiet pump!
 - Entonox



Initial results

- 151 procedures scheduled (March 2023 – April 2024)
 - 107 2ww patients scheduled and had procedure
 - 22 non-2ww patients scheduled and had procedure
 - 10 DNA's
 - 8 rebooked due to BP issues and poor tolerance requiring sedation
- One list per week (Wednesday am) – 40 lists

Equivalent of 19 lists out of endoscopy (based on 8 points per list)

Sub-analysis of 2ww patients that had procedures at Gassiot house

- N = 107 patients
- Procedure metrics
 - 92% completion rate to D2
 - 75% nasal intubation rate
- Referral times:
 - 93% of procedures scheduled within 14 days of GP referral
 - 61% of procedures scheduled within 7 days of GP referral

Subanalysis of 2ww patients only that had procedures at Gassiot house

- 47% of procedures had a biopsy taken
- CT imaging:
 - 22% required CT scan
 - 50% CT scans same day
 - 67% of scans within 24 hours of procedure
 - Any CT delay due to lack of available renal function bloods on referral form

Case examples with a cancer diagnosis

- Two oesophageal cancer diagnosis
 - Patient 1 – 70 M
 - CT scan same day as TNE and patient referred straight to the MDT
 - Diagnosis on endoscopy within 5 days of the GP referral
 - Patient 2 – 47 M
 - CT next day after TNE
 - UGI MDT discussion 9 days after GP referral
- One diagnosis of pancreatic cancer – 51 M
 - CT scan same day as TNE
 - MDT discussion 9 days after initial GP referral

CONNECT pilot

- Feasible
- Can work in outpatients
- Creates capacity:
 - Cancer resections
 - 2ww colonoscopies
 - Capacity for 2ww UGI endoscopies in outpatients

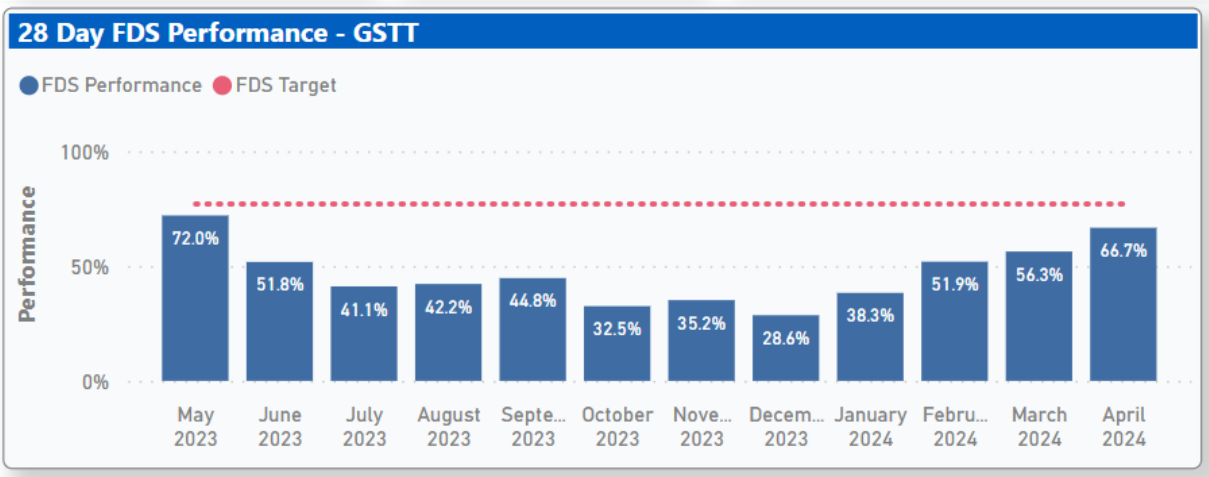
FDS

March 2023 – Sept 9th 2023 – FDS rate = 73%

Sept 2023 – April 2024 – FDS rate = 54%

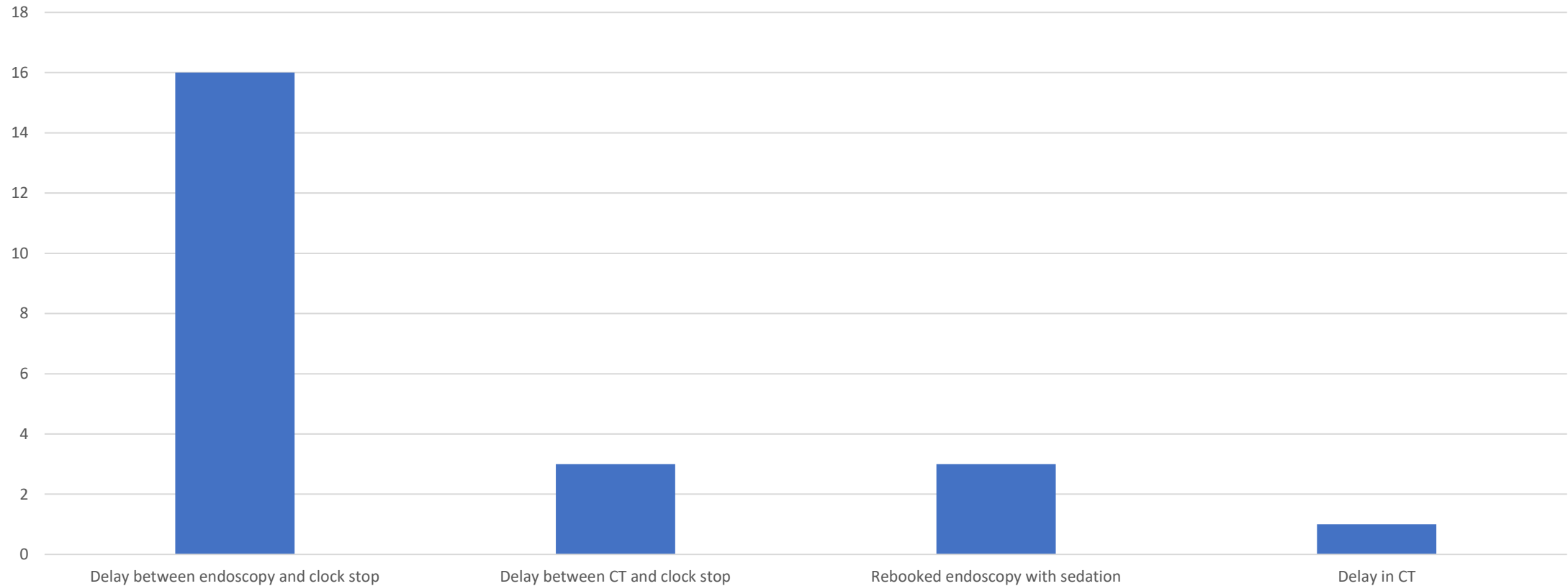
Overall FDS performance
in same period = 44%

FDS – 65%



Factor for FDS delay (Sept'23 – April'24)

Primary cause of FDS delay



Reasons for Clock stop delay

- Histology
 - 91% had routine biopsies for dysphagia (rule out EoE)
 - ALL NORMAL
- Increased average number of days post endoscopy to clock stop to 30 days
- On peer review, if stopped at appropriate time point

FDS if clock stopped earlier = 83% in this cohort



Increase of 29%

Changes initiated – re audit

- Added in removal or retain on pathway statement on report
- Routine biopsies (i.e no visible lesion) followed up outside of pathway and do not delay pathway exit
- FDS increased to 86%

Areas to help improve FDS

- Patients to come off pathway on the day of endoscopy
 - Should not wait for routine biopsy result to stop clock
 - Make use of epic
 - Most patients clock can be stopped on day of procedure
- Formalise 2 slots with with radiology per list
- Renal function results provided by GP at point of referral (part of GP education)
- GP education and education of admin staff
 - Minimise patient anxiety on day and therefore less DNA rates/better understanding before day of procedure

Conclusions

- TNE is a safe and viable alternative to conventional OGD that can be performed in outpatient setting
- The London TNE pilot has led to increase work force trained in TNE but adoption not widespread
- Novel one stop pathway demonstrates rapid diagnostics, with improvement in FDS over standard pathway

WELCOME, FUTURE



Join the
'Welcome, Future'
Initiative



Questions?



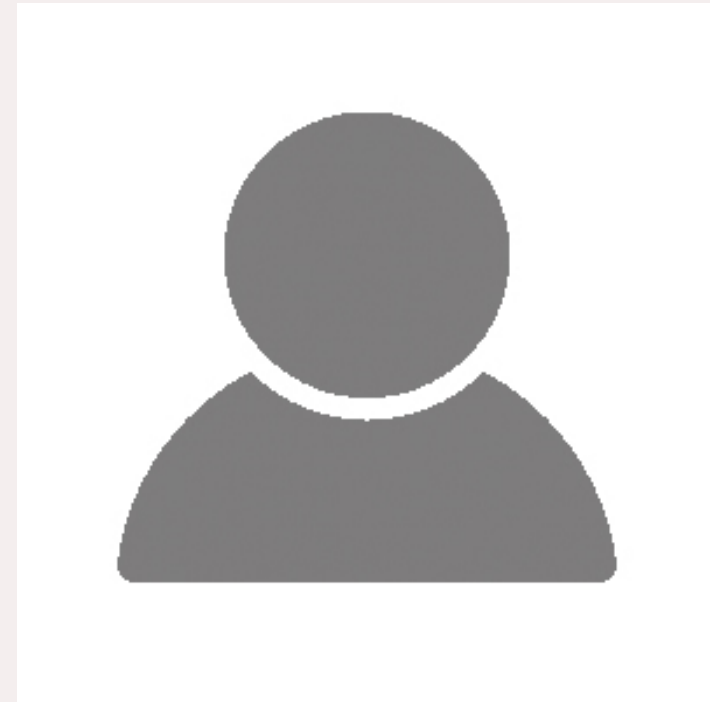
Slido

Please scan the QR Code on the screen. This will take you through to Slido, where you can interact with us.





Keynote Presentation



Dr Roland Valori
Consultant Gastroenterologist
Gloucestershire Hospitals NHS FT

Benchmarking the efficiency of endoscopy services

Roland Valori

Gloucestershire Hospitals Trust

May 2026

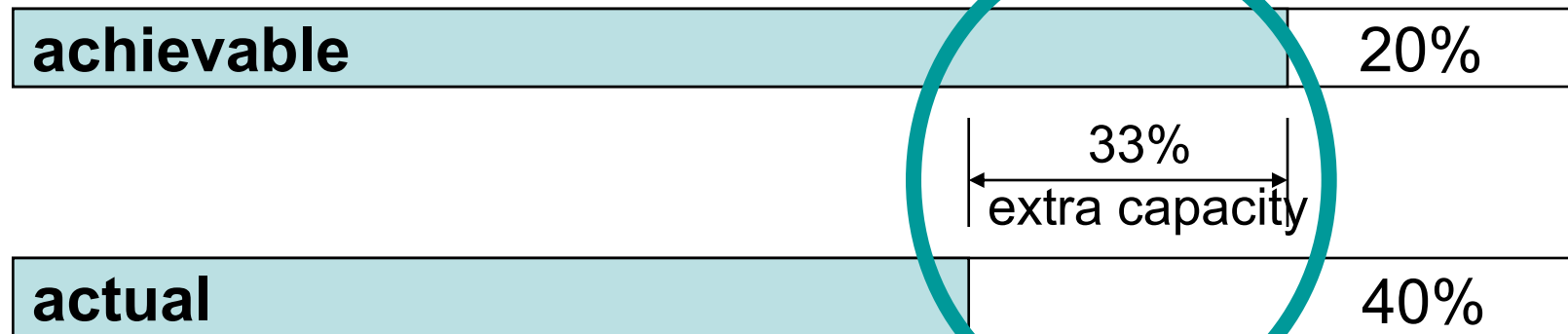
Improving utilisation of funded capacity

Basic premise: there is enough *funded capacity* in most endoscopy services to eliminate waits and dispense with expensive options to reduce waits such as WLIs, insourcing and outsourcing

Without compromising patient experience, effectiveness or safety

List utilisation

Blue: the patient is in the room
White: room empty



This slide is >20 years old!

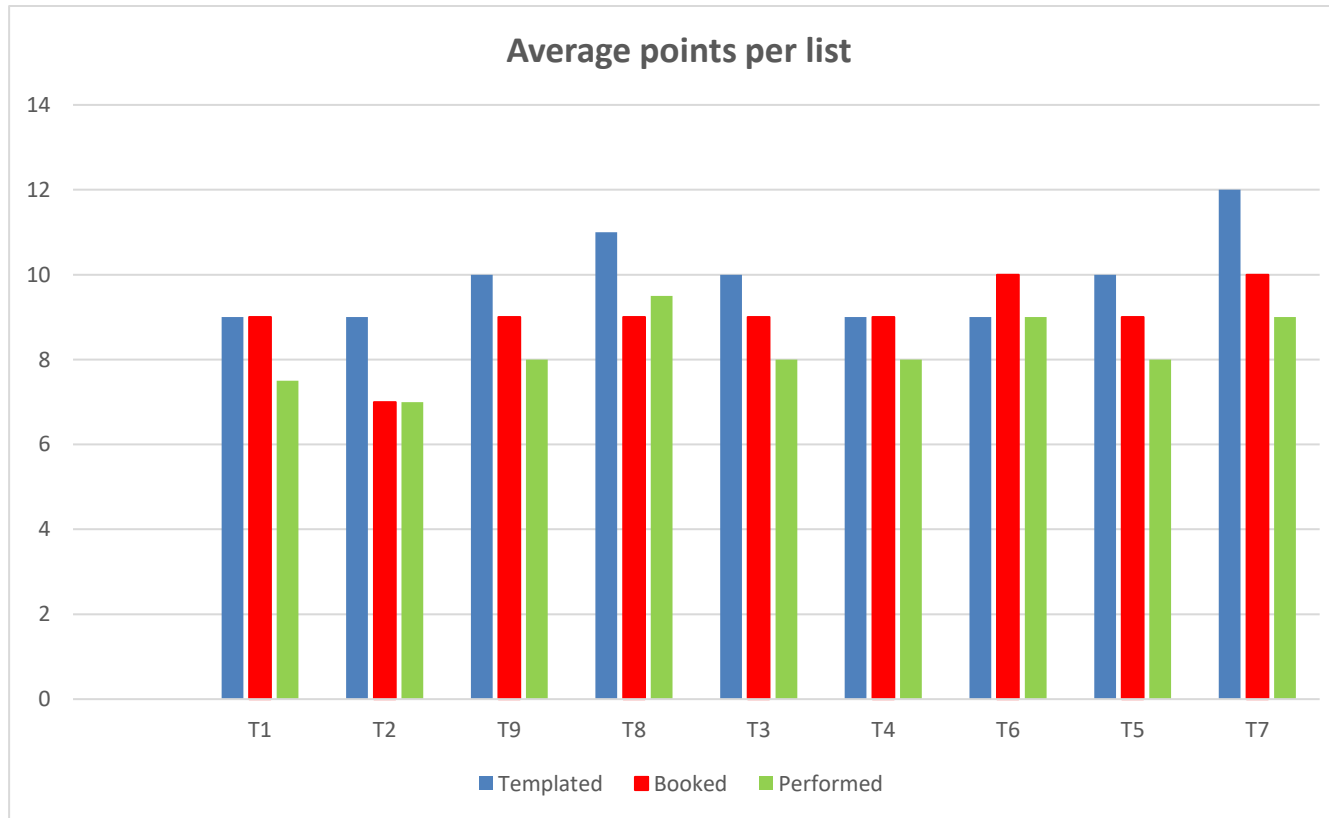
How many points should there be on a list?

- A point is a form of currency; a substitute for time.
- Ideally a point should reflect the total time from one patient to the next
 - This facilitates scheduling and capacity planning
- There is no agreement on how long a point should be
- The points on a list should reflect the time the list is operational

Points on a list should = **list time** in minutes, divided by the **time per point** in minutes

At 20 minutes **per point**, a **list time** of 240 minutes should achieve 12 points

Average points per list C&M 2018



- Points delivered per staffed sessions fall well below the average templated list across the network
- **The network average performed is 8 points per list:**
 - Achieving 10 points on all lists consistently would give 25% more capacity across the network
 - Individual trust productivity reports suggest bigger capacity gains
 - **Overall, 58,000 more points are achievable or 20,000 colonoscopies per annum**

Caution: There needs to be an agreed network wide method of allocation points.

Don't delay improving efficiency

- Top five tips
 - Fill empty lists
 - Fully book each list
 - Reduce avoidable late cancellations
 - Start lists on time
 - Reduce turnaround time

What is a benchmark and why do we need it?

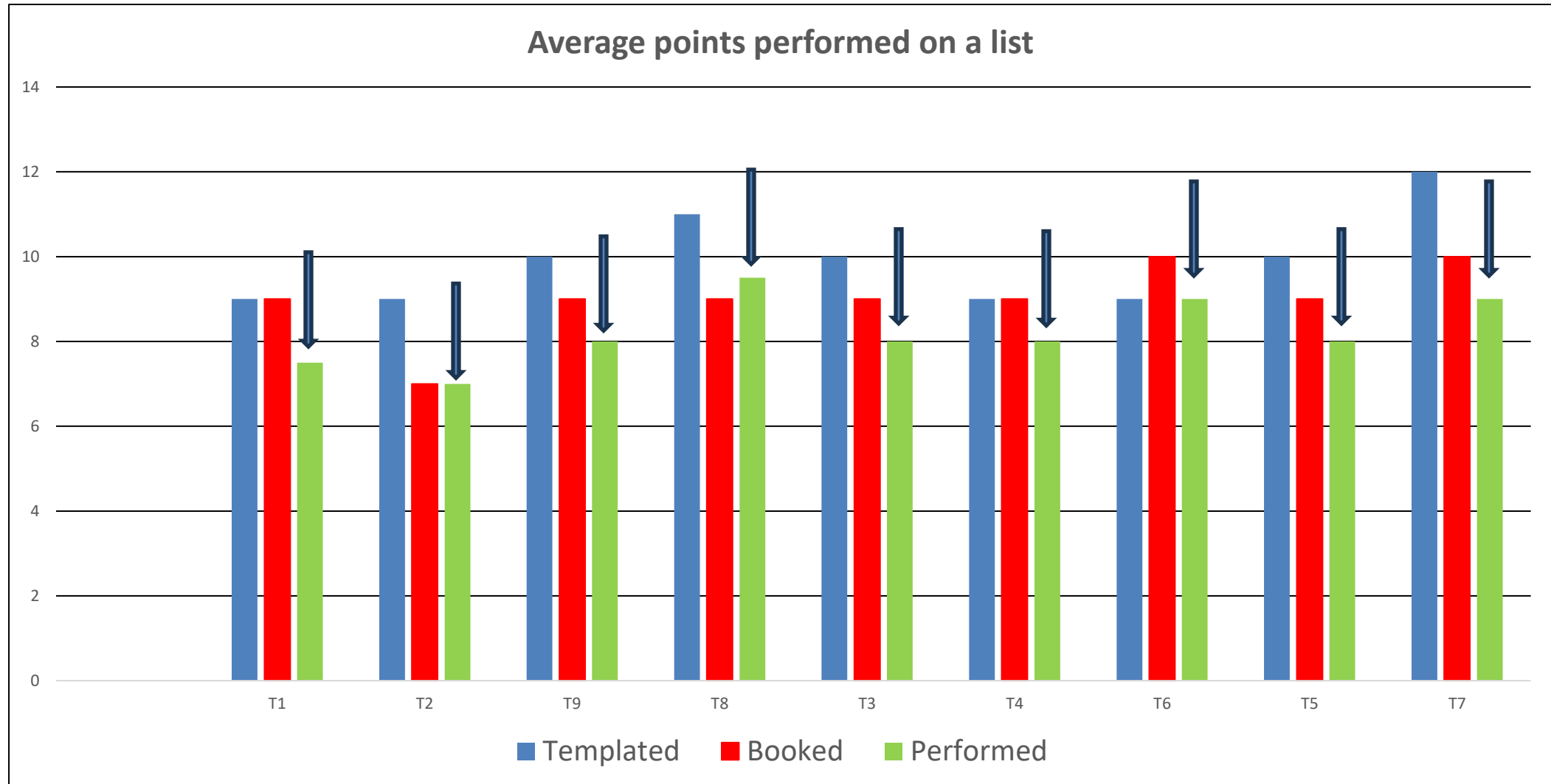
- A benchmark is a measure or indicator which is used to compare performance
- A benchmark drives improvement:
 - it shows what is possible
 - it reveals poor performance
 - it incentivizes a search for remedial inefficiencies
 - it provides justification for investment (when it is justified!)

Defining a benchmark

- A benchmark must be defined
- The components of the definition must be captured consistently
- Caecal Intubation Rate is a benchmark. It is defined by a:
 - **Denominator:** all colonoscopies, including those where the prep was incomplete or there was an obstruction preventing complete colonoscopy
 - **Numerator:** all colonoscopies that reach the caecum. “Reach the caecum” is defined by visualisation of the caecal landmarks: ICV, AO and triradiate fold

We call this the “unadjusted caecal intubation rate”

The ultimate benchmark of list utilisation



Average points performed on a list

- Minutes/point must be the same
- Points/procedure should be consistent
- Lists should the same length
 - or adjust the benchmark for list length

This benchmark captures list utilisation but not resource utilisation

South West region endoscopic procedure points allocation – included in future benchmarking

List Type	Procedure	Points for procedure	Points for training	Total time (mins, inclusive room turnaround and training)	Notes
Dedicated service	Colonoscopy	2		40	
	Colonoscopy FIT \geq 120	3		60	
	Basic therapeutic colonoscopy	3		60	Includes known planned polypectomy APC, stent insertion, dilatation
	Advanced resection	Variable		60-120	Endoscopist to decide points allocation – e.g. EMR, ESD, known multiple small polyps
	Rescope colonoscopy	3		60	Previous incomplete or previous poor prep – at least 3 points
	Flexi sig	1		20	
	Therapeutic flexi sig	1.5		30	Banding of haemorrhoids, EAUS, APC
	OGD and colonoscopy	3		60	
	OGD	1		20	To include varices check (no banding)
	Therapeutic OGD	1.5		30	Includes Dilatation (all types), varices with intent to band
	Surveillance OGD	1.5		30	Barrett's surveillance (if <5cm),
	Surveillance OGD	2		40	Barratt's surveillance >5cm
	Rescope OGD	2		40	Defined list of reasons for rescope requires further definition e.g. previously failed
Transnasal	1		20		
BCSP	BCSP colonoscopy	3		60	Complexity may require increase points
Dedicated training	Planned polypectomy	3	1	80	For lists not assigned as dedicated training need ability to label as trainee endoscopist present (ad hoc) and/or trainee endoscopy nurse present (as part of identifying who's in the room). Need to agree how to account for how close someone is to certification and for newly qualified independent endoscopists
	Service colonoscopy	2	1	60	
	Flexi sig	1	0.5	30	
	OGD	1	0.5	30	

South West region endoscopic procedure points allocation – not included in proposed benchmarking

List Type	Procedure	Points for procedure	Points for training	Points for context	Total time (mins, inclusive room turnaround and training)	Notes
GA	BCSP colonoscopy or planned polypectomy	3		2	100	Principle to add two points for GA
	Service colonoscopy	2		2	80	
	Flexi sig	1		2	60	
	OGD	1		2	60	
	OGD and colonoscopy	3		2	100	
Propofol	BCSP colonoscopy or planned polypectomy	3		1	80	Principle to add one point for propofol
	Service colonoscopy	2		1	60	
	Flexi sig	1		1	40	
	OGD	1		1	40	
	OGD and colonoscopy	3		1	80	
Inpatient	Service colonoscopy	2		1	60	Complexity may require increase points
	Flexi sig	1		0.5	30	
	OGD +/- low risk GI bleed	1		0.5	30	
	OGD high risk GI bleed	1		1	40	
	ERCP	3			60	

Benchmarking should be viewed in the context of allocation of points – last 365 days colonoscopy data for Gloucestershire

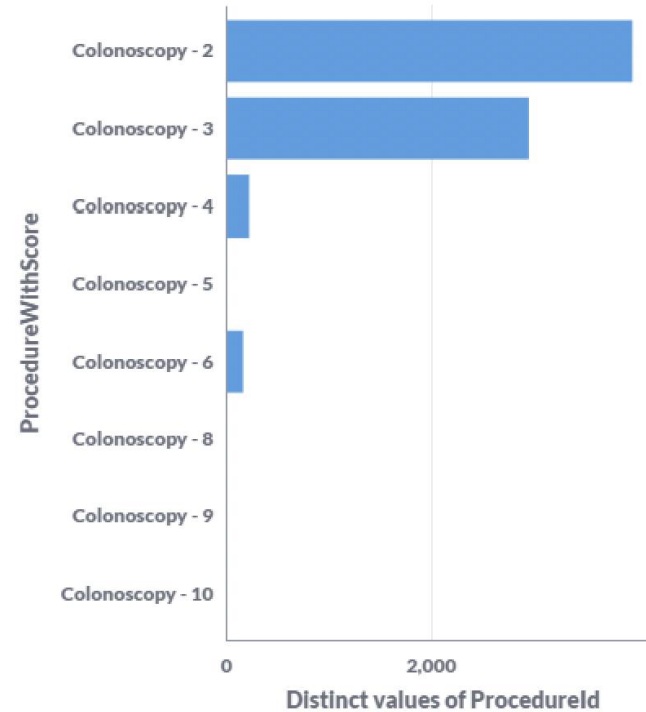
Reporting » Procedure Analysis

Appointment Type ▾

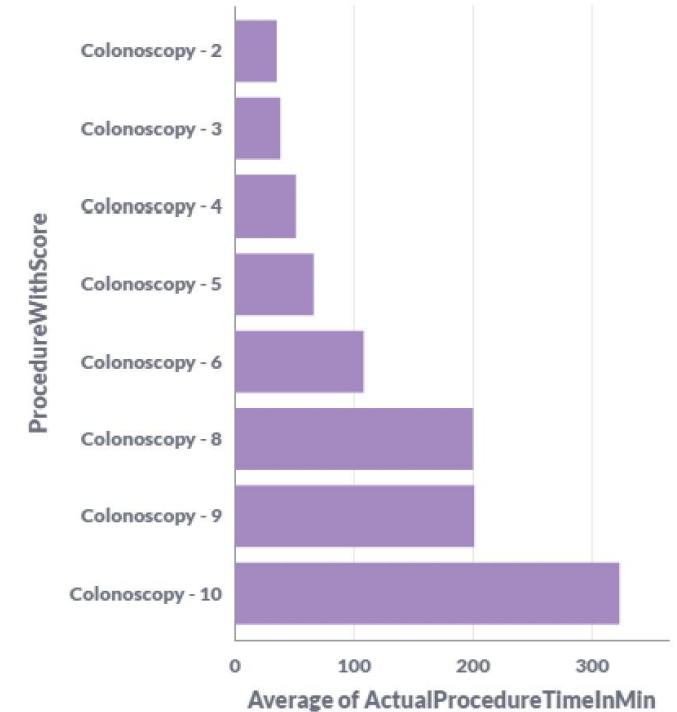
Procedures - Count and Average Time

ire/Points ^	Number Performed	Average Time Minutes
copy - 2	3,966	35
copy - 3	2,954	38
copy - 4	220	51
copy - 5	2	66
copy - 6	161	108
copy - 8	2	200
copy - 9	1	201
copy - 10	1	323

Procedures Performed



Average Procedure Time Taken



What activity should be benchmarked?

- Most (>80%) endoscopy work is predictable and suitable for benchmarking
- To have a reliable benchmark the unpredictable work needs to be excluded:
 - inpatient lists
 - Lists in theatre or radiology
 - ERCP/EUS lists
 - Ad hoc bleed lists

Don't delay improving efficiency

- Top five tips
 - Fill empty lists

Scheduling Overview

Month:

Site:

Endoscopist:

Other Endoscopists?

	CGH							
	Theatre 1		Theatre 2		Theatre 3		Theatre 4	
	AM	PM	AM	PM	AM	PM	AM	PM
Tue 09-Apr-2024								
Wed 10-Apr-2024				1	0.5			
Thu 11-Apr-2024	-1	-4		1	2			
Fri 12-Apr-2024						-0.5	-1	
Sat 13-Apr-2024								
Sun 14-Apr-2024				9				
Mon 15-Apr-2024	1	1	7	3		8	-2	1
Tue 16-Apr-2024	4	3	-1	2	3	5	6	3
Wed 17-Apr-2024					2		6	
Thu 18-Apr-2024			2	1		-2	-2	
Fri 19-Apr-2024				9	-1	5	-1	
Sat 20-Apr-2024								
Sun 21-Apr-2024								

Numbers indicate available slots
Brown are my slots, and none have free slots

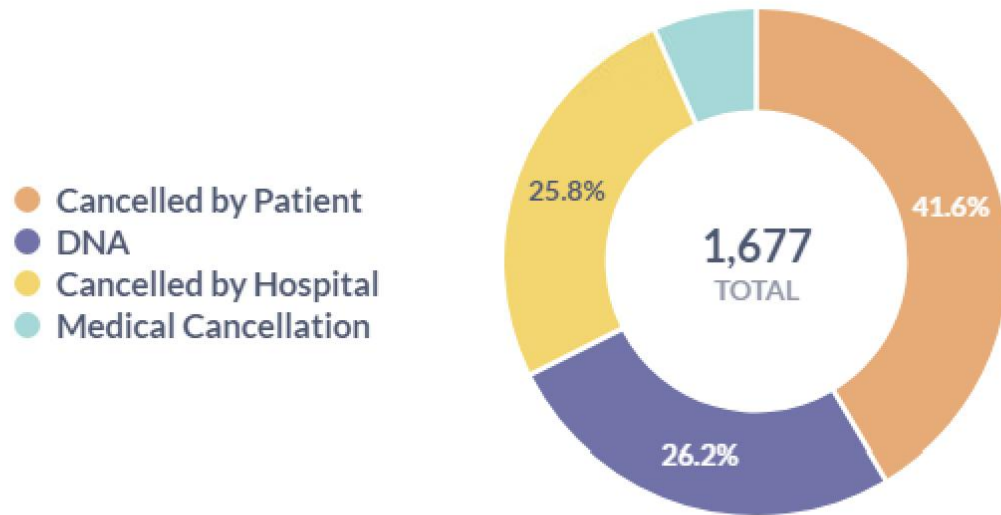
Don't delay improving efficiency

- Top five tips
 - Fill empty lists
 - Fully book each list
 - Reduce late cancellations

Reporting » Appointment Cancellations

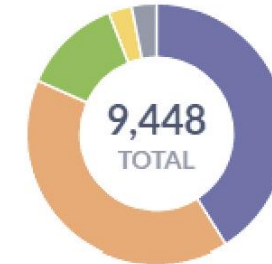
Previous 180 days – cancellations within 72 hours of appointment

Summary of Appointment Cancellations

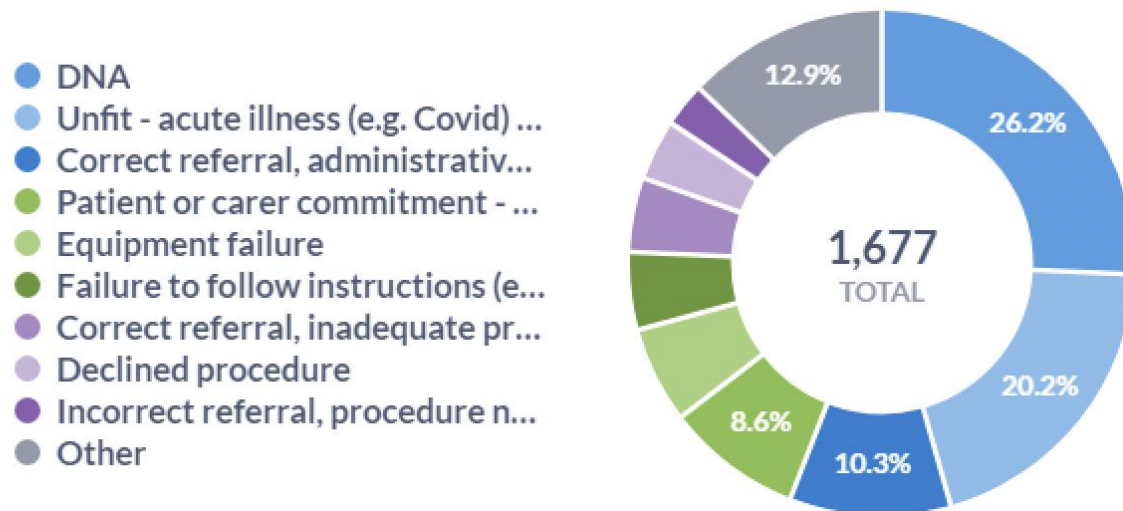


Total Procedures Performed by Type

- Colon 41.38%
- OGD 40.88%
- FlexiSig 12.19%
- Bronch 2.69%
- Other 2.86%



Appointment Cancellations by Reason



Appointment Cancellations by Reason Table

Reason ^

DNA	439
Unfit - acute illness (e.g. Covid) or acute exacerbation of chronic illness	338
Correct referral, administrative booking error	173
Patient or carer commitment - unexpected	145
Equipment failure	101
Failure to follow instructions (e.g. prep or fasting)	81
Correct referral, inadequate pre-assessment	77
Declined procedure	62

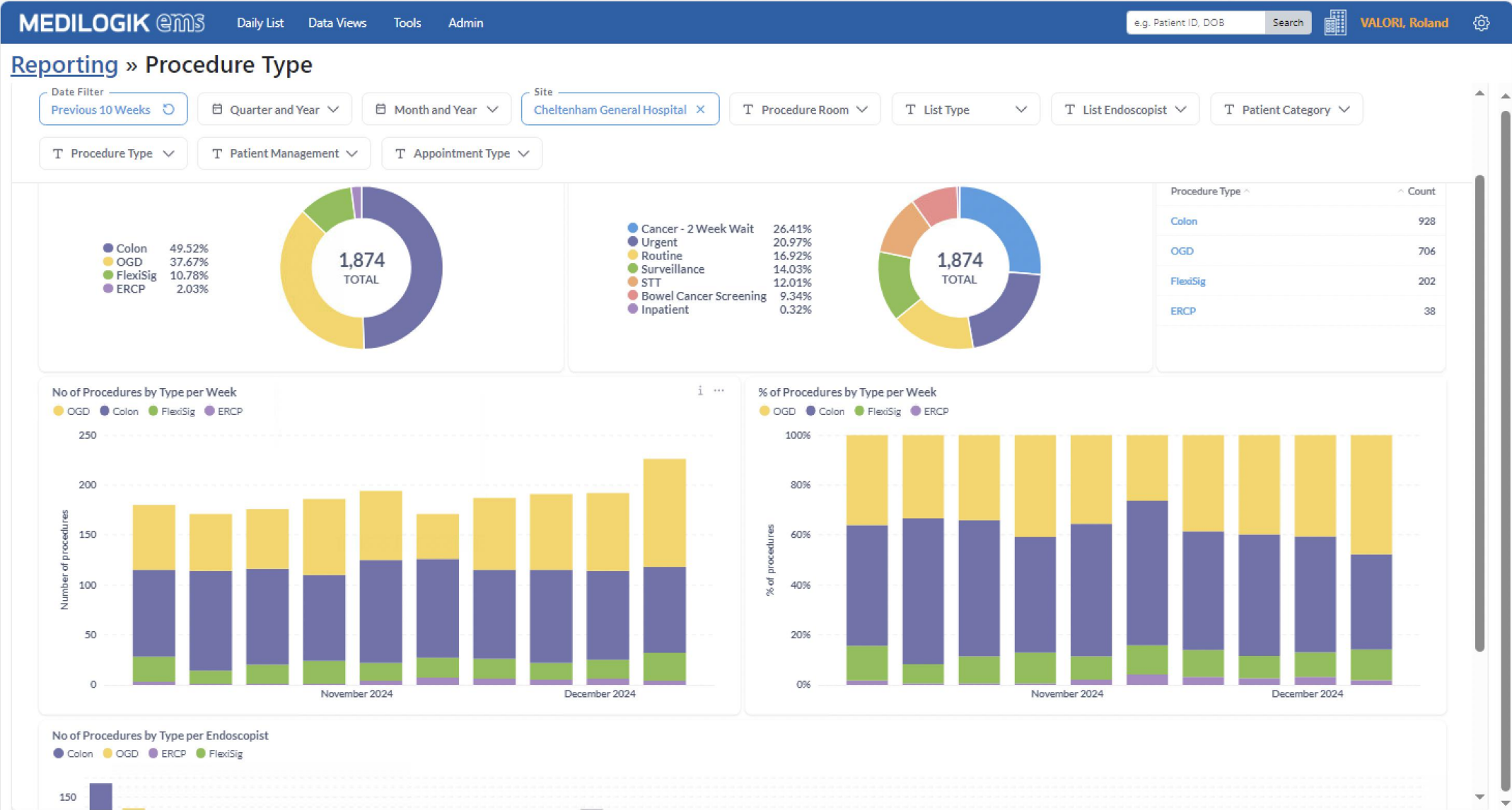
Don't delay improving efficiency

- Top five tips
 - Fill empty lists
 - Fully book each list
 - Reduce late cancellations
 - Start lists on time
 - Reduce turnaround time

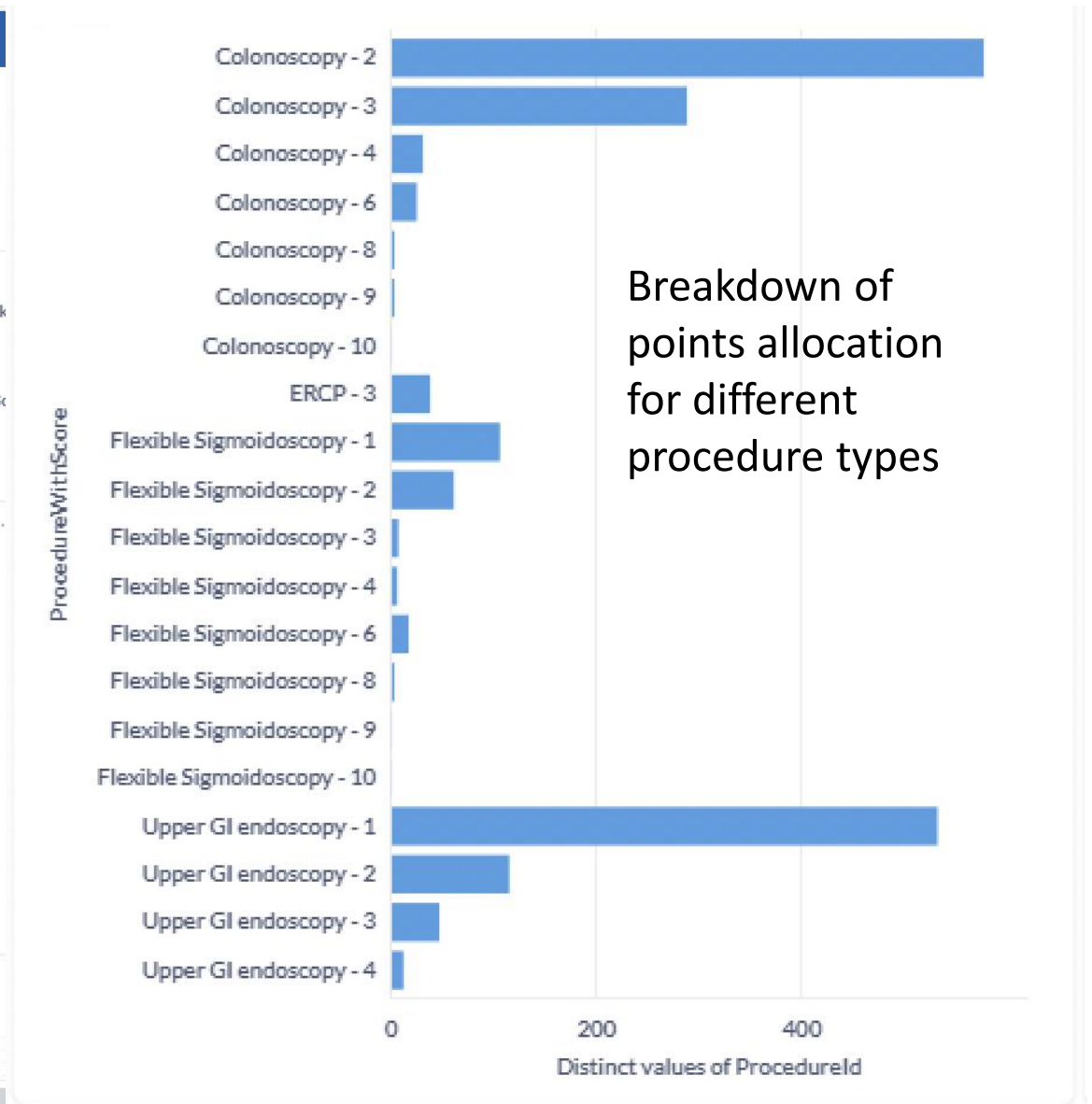
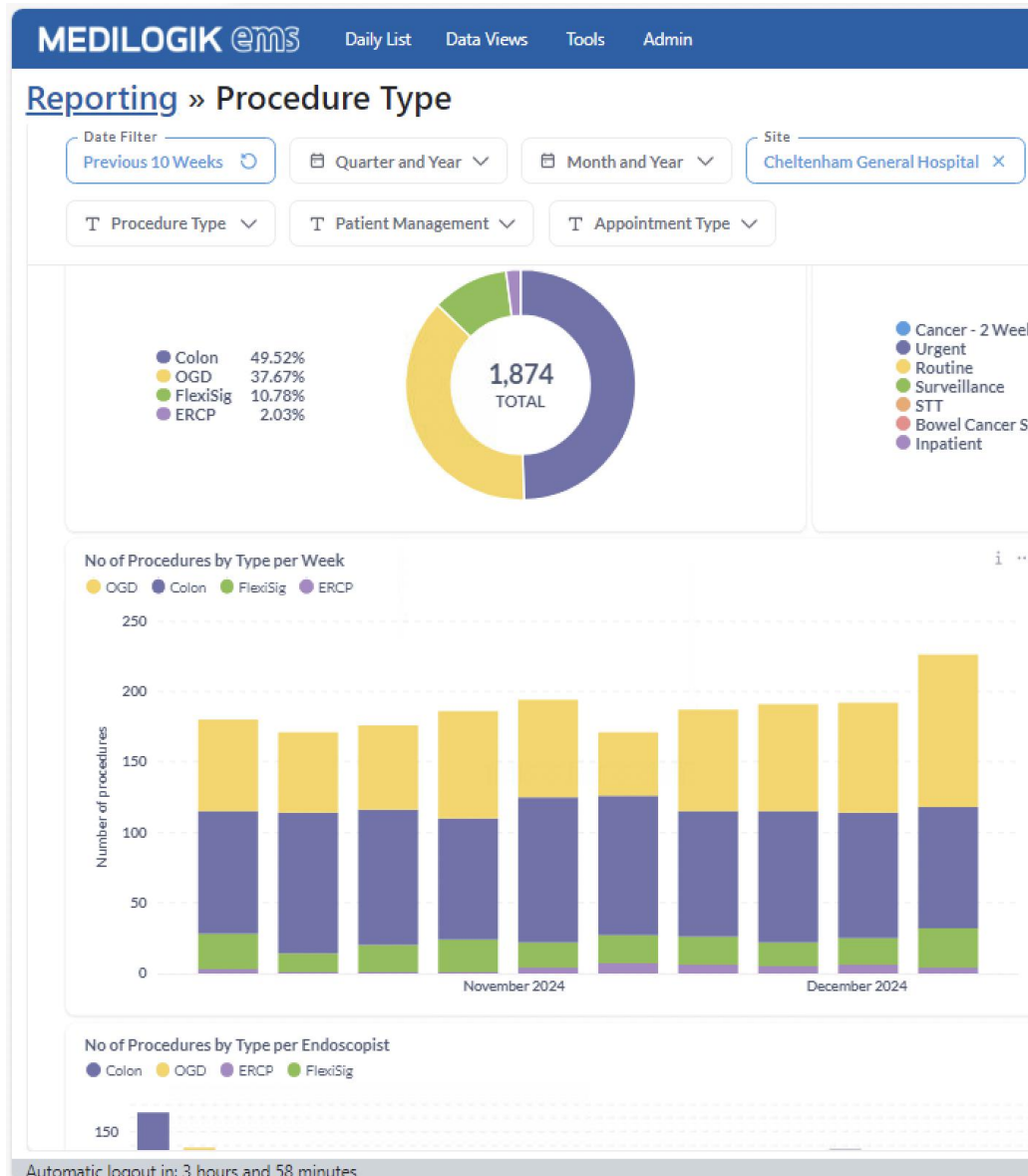
What follows is an illustration of how to derive benchmarking data - EMS was the source of the information and gathering it took <2 hours

CGH = Cheltenham General Hospital, a four-room endoscopy unit that does a lot of immersion training and complex lower bowel endoscopy.
No weekend work was done during this 10-week period

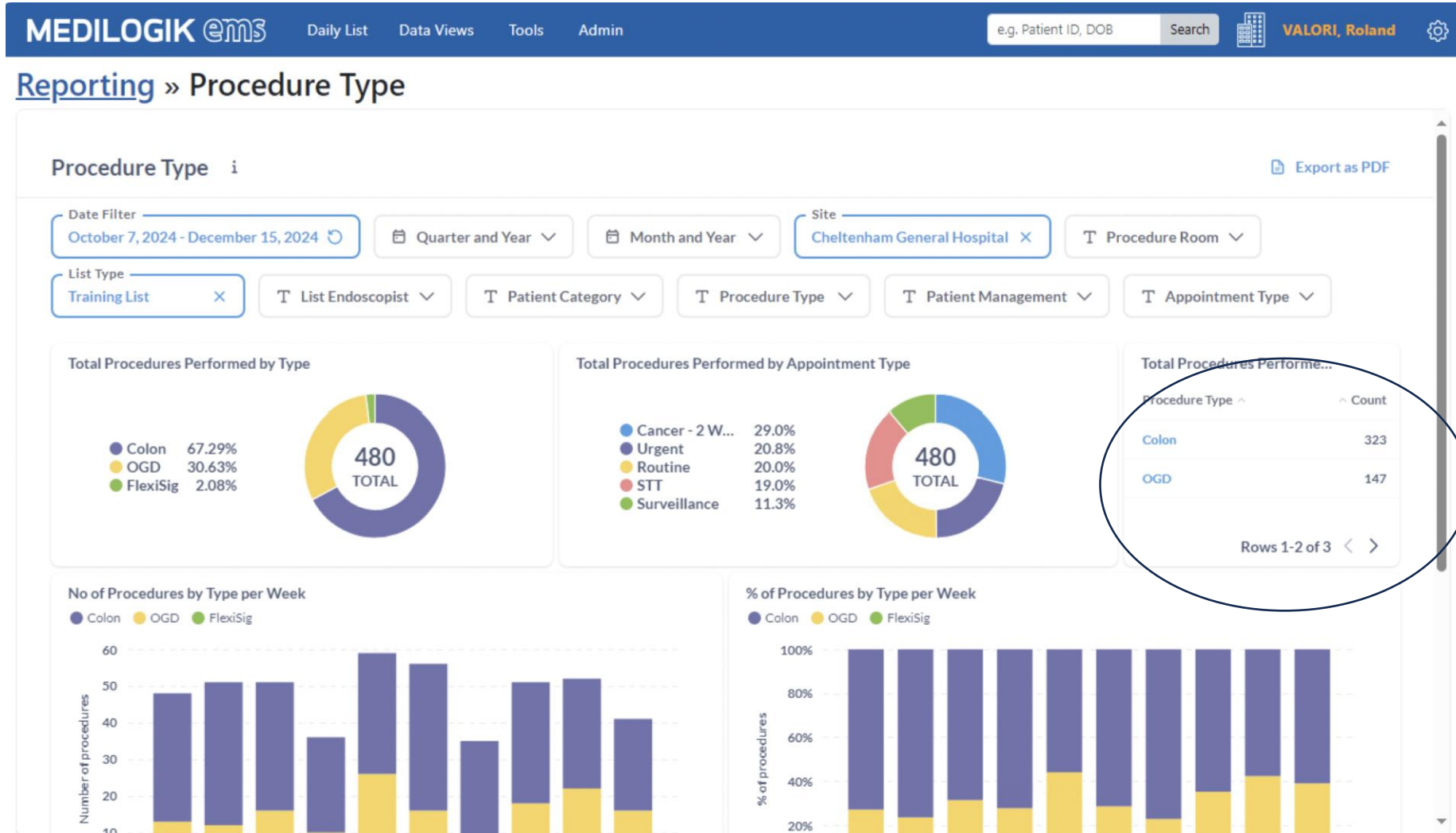
Procedures performed in last 10 weeks – CGH (6/10/24-15/12/24)



Procedures performed in last 10 weeks - CGH



Training procedures performed in last 10 weeks - CGH



480 of 1874 procedures done were done for training

Training is allocated
 0.5 point for OGD
 1.0 point for colon

Additional training points

Colon = 323
 OGD = 147/2
 FS = 10/2

Total training points = 401.5

Breakdown of points allocation for different procedure types

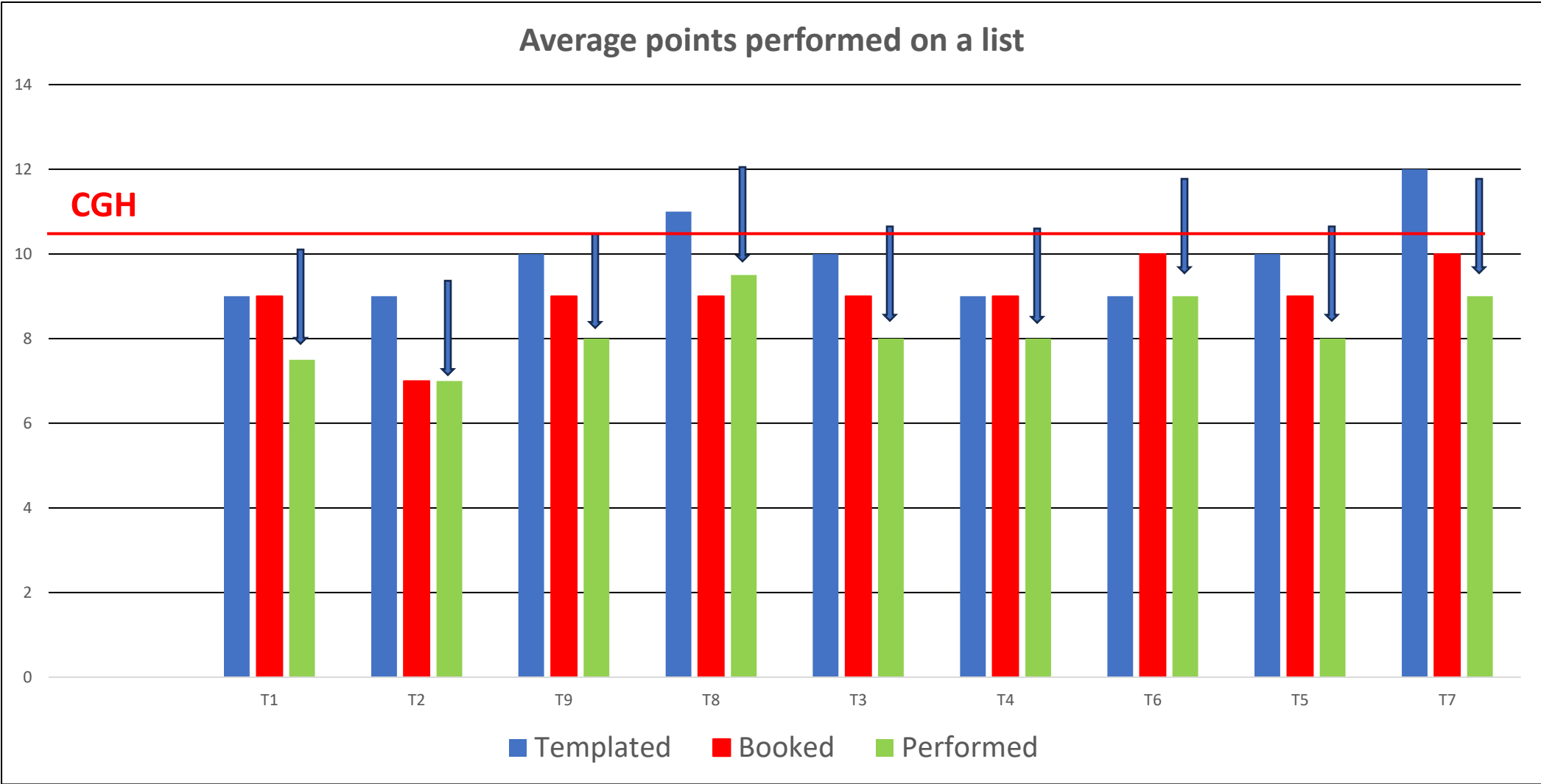
Number performed in one four room endoscopy unit in 10 weeks = 1874
There 388 scheduled lists in the 10 weeks

Procedure/Points ^	Number Performed	Average Time Minutes
Colonoscopy - 2	577	38
Colonoscopy - 3	288	36
Colonoscopy - 4	31	63
Colonoscopy - 6	25	124
Colonoscopy - 8	3	151
Colonoscopy - 9	3	188
Colonoscopy - 10	1	110
ERCP - 3	38	31
Flexible Sigmoidoscopy - 1	106	12
Flexible Sigmoidoscopy - 2	61	16
Flexible Sigmoidoscopy - 3	7	25
Flexible Sigmoidoscopy - 4	6	51
Flexible Sigmoidoscopy - 6	17	106
Flexible Sigmoidoscopy - 8	3	122
Flexible Sigmoidoscopy - 9	1	242
Flexible Sigmoidoscopy - 10	1	298
Upper GI endoscopy - 1	532	9
Upper GI endoscopy - 2	115	12
Upper GI endoscopy - 3	47	32
Upper GI endoscopy - 4	12	43

Points	Number	Totals
1	638	638
2	753	1506
3	342	1026
Training	480	401
4	49	196
6	42	252
8	6	48
9	4	36
10	2	20
Total		4123

During these ten weeks there were 394 scheduled lists of a possible 406 = 97%. The average number of points achieved per list was $4123/394 = 10.5$ points/list

The ultimate benchmark of list utilisation



A common refrain.....

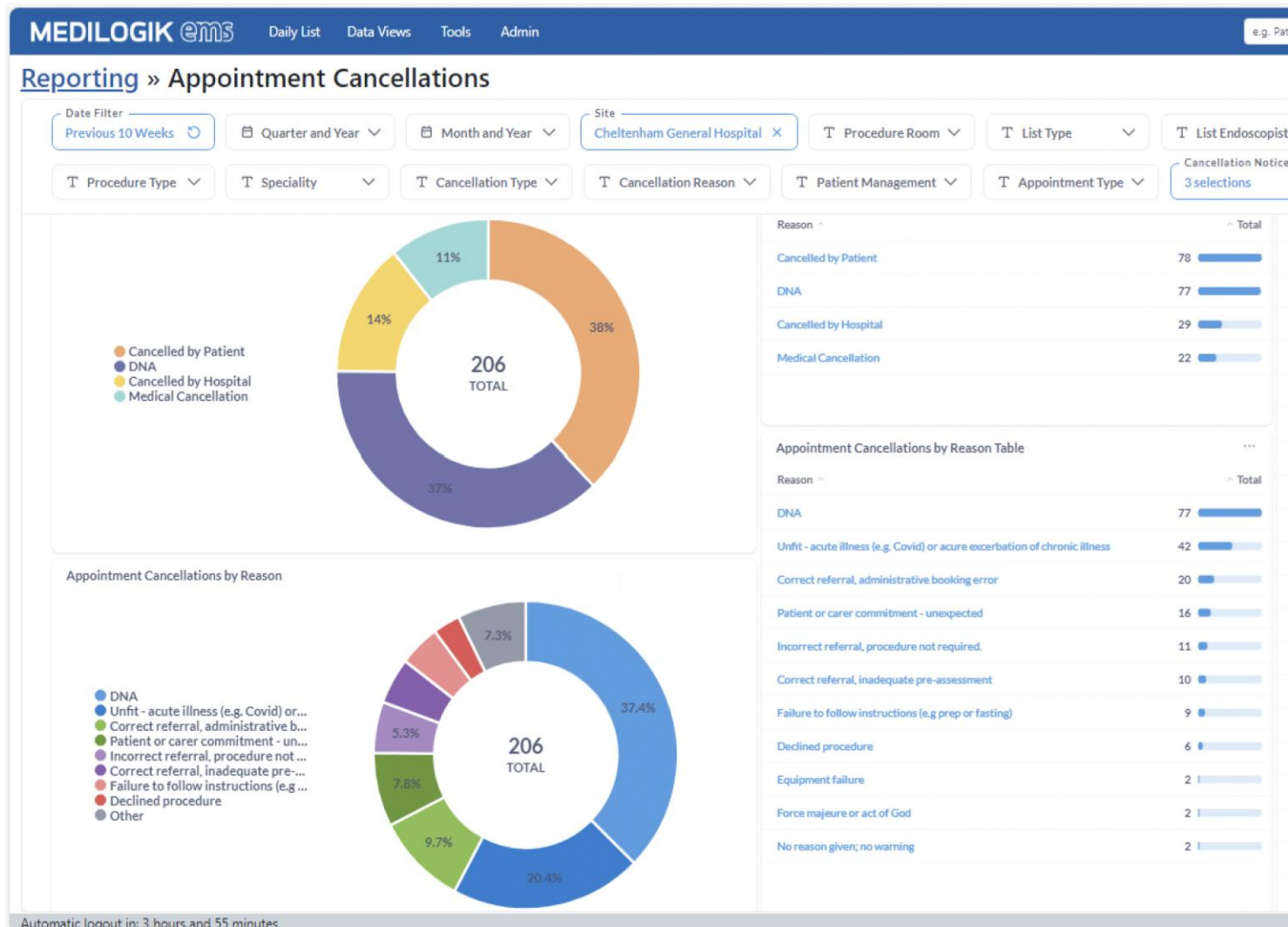
“We need to reduce the points on a list because:

- There are checklists to complete before and after the procedure
- Procedures take longer so we don't miss pathology
- We find more pathology and spend more time dealing with it
- There is more pathology to process afterwards
- Report writing is more complex and time-consuming
- At the same time, we are expected to deliver a great patient experience”

Yes, all these changes are happening

No..... the solution is not to reduce the points on a list; the solution is to ensure points allocation of procedures reflect the time the procedures take

All cancellations within 48 hours in last 10 weeks - CGH



Benefits of benchmarking endoscopy utilisation

- *Reliable benchmarking data – achieved points/list*
 - Shows what is possible
 - Poor performance is evident
- *Reveals where the problems are*
 - And where it is best to start
- *Makes the benefit of investment transparent and measurable*
 - Investment is easier to justify and monitor
- *Builds executive confidence in the team*
 - Executive more likely to trust the endoscopy team and give them more autonomy.



Slido

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Keynote Presentation



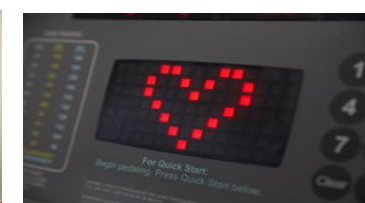
Dr Sarah Jowett

Consultant Gastroenterologist and Clinical
Lead for Endoscopy
Bradford Teaching Hospitals NHS Trust

The Journey to a £25 Million State-of-the-Art Endoscopy Unit

From NHSE Funding to a World-Class Facility

Dr Sarah Jowett, Consultant Gastroenterologist &
Clinical Lead for Endoscopy, Bradford Teaching
Hospitals



The Problem

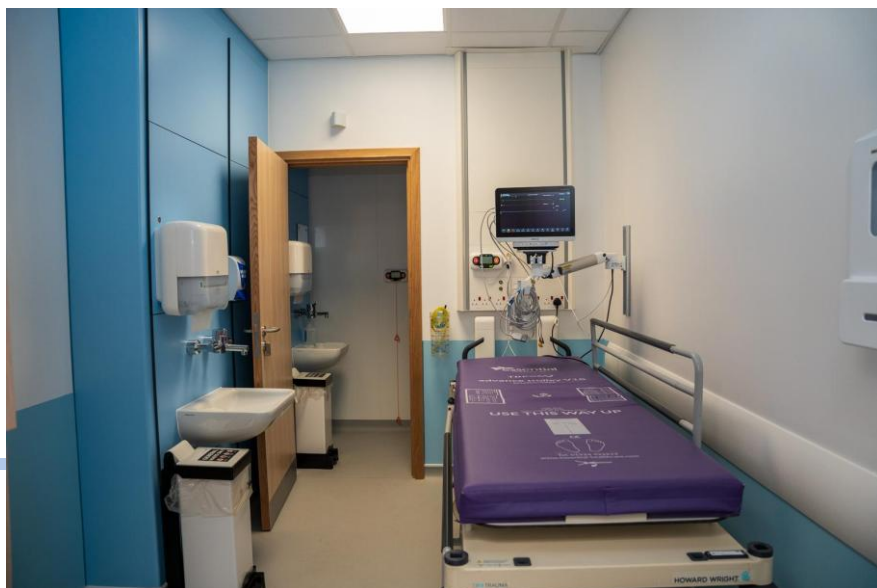
- Outdated endoscopy unit on 2 floors, shoe-horned into previous office space
- Inadequate capacity despite 6 rooms plus outsourcing and insourcing because of increasing demand and COVID backlog
- Impossible to meet post COVID ventilation standards... JAG accreditation
- Local population with high index of deprivation and ethnicity

The Vision & Funding Catalyst

- **Goal:** To create a large NHS endoscopy unit that provided in-patient and outpatient services on a single site, reduced waiting lists and improved patient outcomes.
- **Funding Source:** A £25 million investment, from NHS England.

The Outcome

- **Bespoke** unit with **8 spacious rooms**
- ERCP and GA within the department
- A purpose built environment with **individual patient pods** for admission and recovery
- **Separate access** for outpatients (from the street) and inpatients (link corridor to main hospital)
- **Pandemic proof**: we will be able to separate hot and cold areas if needed
- Academy standard **training facilities**

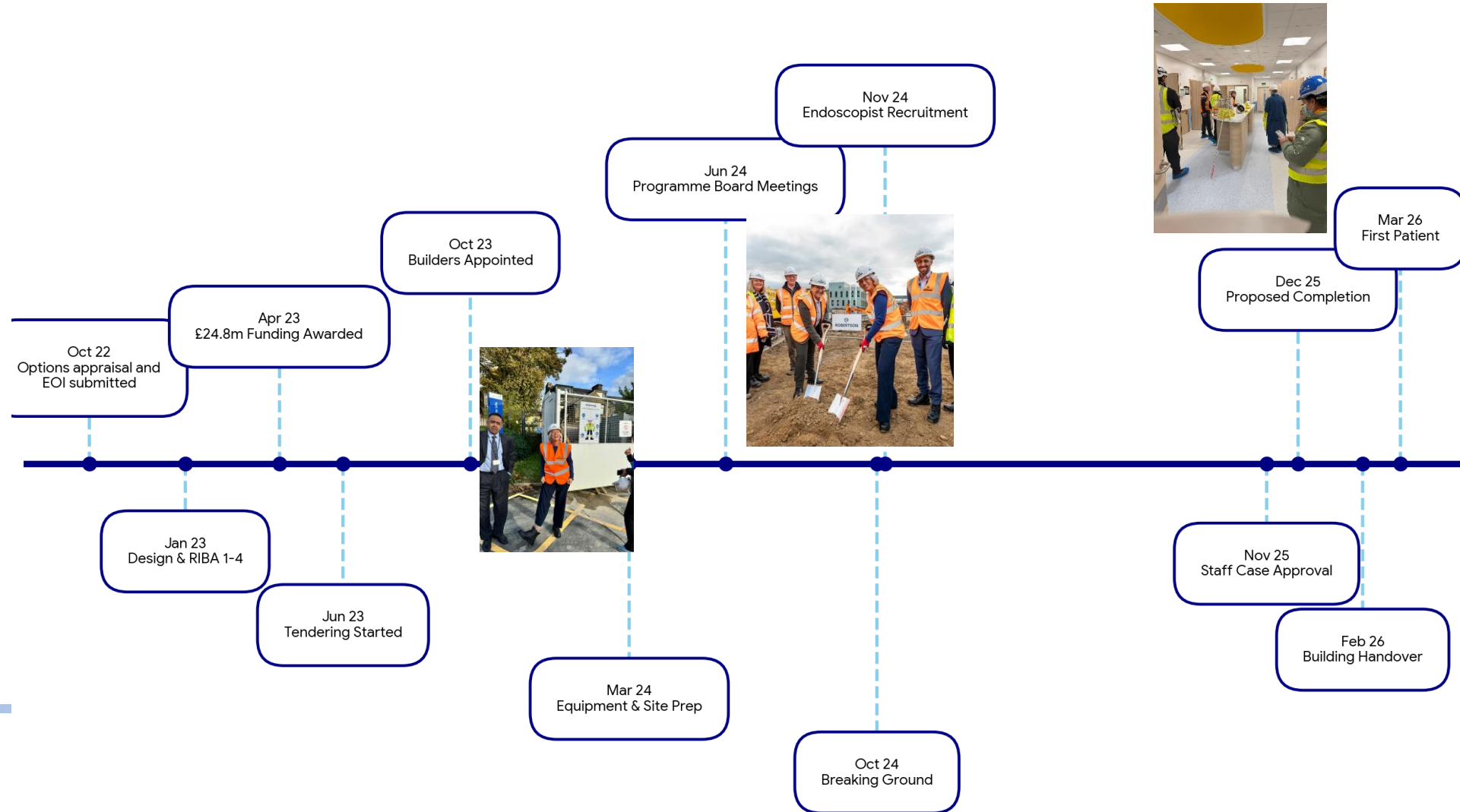


- [Our Patients - Endoscopy – YouTube](#)
- <https://youtu.be/IDTNOSHGasw>

Key lessons

- Takes longer than you'd think
- The right people are key
 - Architects
 - Builders
 - Project manager
 - Project Board with execs
- Be clear about the brief
- Attention to detail is key and takes time
- Monopolise on the impetus of a new unit to introduce other change

Timeline ~3.5 years



Time taken

- 6 months to develop design with architects to allow tendering process, then ongoing development
- 4 months to appoint builders and “value engineer” the design, including switching floors
- 20 month build (proposed 18months)
- Staff Recruitment
 - clinical endoscopists were recruited and trained in time
 - business case for other staff took longer, still in training

Key People and Processes

- **Benchmarking:** Visits to existing units to identify best practices in patient flow, clinical efficiency and design.
- **Contracting:** Appointment of [The Manser Practice](#) as architects and [Robertson Construction](#) as the main delivery partner.
- **Strategy:** Incorporation energy efficiency and sustainability in design, including high levels of insulation, PV panels, LED lights, air source heat pumps and heat recycling.

Collaborative Design Process

- **Design Philosophy:** Moving from segregated waiting and recovery areas to individual en-suite “pods” for better privacy.
- **Staff Involvement:** Multiple workshops with stakeholders to agree proposal and ensure best floor plan, including mapping rooms out
 - clinical (medical, nursing, theatre and radiology)
 - patient rep
 - estates and facilities teams
- **Wider Patient & Public Engagement:** Consultation with the local planning authority and stakeholders, eg ENT theatre staff

Attention to Detail & Aesthetics

- **Bradford Heritage:** An interior colour palette inspired by local artist David Hockney.
- **Room Data Sheets:** Dull but critical to allow appropriate planning (including finances) especially when items are being re-used
- **Equipment Planning:** Funding limitations required equipment to be ordered nearly 2 years ahead of opening, complicated by move to pendants

Service Development Opportunities

1. Developed Business Intelligence tool to give us oversight of demand and waiting lists
2. Recruited and trained a more flexible clinical endoscopist workforce
3. Improved patient communication
4. Develop PAC process and standardise staff processes
5. Improve list utilisation/ reduce DNAs
6. Patient involvement/ representation

Patient Communication

- Simplified letters, emphasizing instructions
- Text reminders (manual process so only FT)
- Patient booklets too large to send electronically, alternative quick guide developed
- Website redeveloped (with transformation team) with functionality to display in multiple languages and with accessible videos

[Endoscopy – Bradford Teaching Hospitals NHS Foundation Trust](https://www.bradfordhospitals.nhs.uk/endoscopy/)
<https://www.bradfordhospitals.nhs.uk/endoscopy/>

PAC

- DrDoctor pre-clinic electronic questionnaire
 - reduced time per patient
 - improved capacity
 - reduced DNAs on the day
- SOPs for PAC nurses...diabetes, anticoag, steroids etc – centralised on intranet
- Standardised “Extended bowel prep”
- PAC improved introduction of home enemas
- Streamlined written patient information prior to colonoscopy

Improve list utilisation and reduce DNAs



Weekly team meeting for nursing and admin to reduce booking errors

Feedback on booking errors identified on
the list

Written standardised booking processes

Procedure competency list- right person
doing the test

Points allocation



PAC clinic

Identified non-attenders

Prevented issues on the day eg
anticoagulation/ ICD

The results

- Capacity utilisation increased dramatically from 50% to 93% throughout 2025
- 2WW performance improved from 81% to 91%
- Surveillance backlog was reduced from around 500 overdue patients to 9 as of the 13/02/2026
- DNA rate decreased from 15% to 8.6% (4.93% DNA and 3.73% cancellations on the day)
- Patient experience has improved (patient questionnaires and the friends and family test).
- Visible impact on staff well-being and strengthening of team culture

Our Difficulties! ...and solutions

- **Optimal site selection** in Victorian hospital grounds- options appraisal
- **Live Environment Challenges:** Managing construction without disrupting existing services- builder cooperation.
- **Transition from old to new site** whilst maintaining services-soft landing
- **Staff Training** in a new way of working and with new equipment in a short time frame
- **Building Security** – tweaks post handover

What I would do differently?

- Negotiate more time
- Pay attention to doors!
 - Automatic opening or not -to avoid damage from trolleys etc

What do I wish was different?

- Bigger PAC room

Key Lessons Learned from a Bespoke Build

- Involve as many people as possible to define what you need/want.
- Visit other units for design and operational issues
- Be clear with your architect about what you require
- Be willing to compromise and a problem solver
- Negotiate time to deliver clinical leadership
- Pay attention to detail
- Forge relationships- architects/ project manager/ head gaffer!
- Use the excitement and momentum to harness change in other areas



Sarah.Jowett@bthft.nhs.uk



Lunch & Networking



Chair Afternoon Address



Mr Anil Vara

Bsc (Hons), Msc, MBA, CMgr, FCMI

Head of Elective Care

Doncaster and Bassetlaw Teaching NHS
Foundation Trust



Keynote Presentation



Zuzana Topham
Project Manager
King's College Hospital NHS
Foundation Trust



King's College Hospital
NHS Foundation Trust

Evolution of Excellence

*Delivering Enhanced Patient Care through our New 6-
Room Endoscopy & Diagnostic Centre Princess Royal
University Hospital*

Zuzana Topham MBA, CMgr FCMI

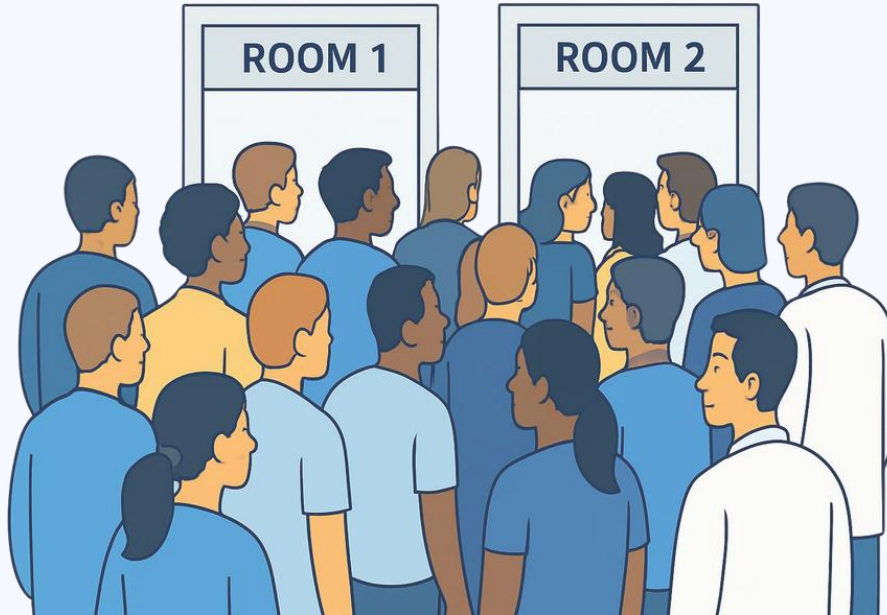
Project Manager

The Starting Point

A Legacy of Risk

Our journey began in a unit for a different era. We were operating within an infrastructure that had become a **barrier to safe, dignified care.**

- Outdated facility
- Demand vs Capacity
- Compromised Privacy & Dignity
- Breaking bad news
- Single sex pathway compromised
- Not JAG accredited
- Offsite decontamination



The 2019 Harm Review

Demand vs Capacity
Unseen Patients
Clinical Consequences

“The outcome was devastating. Patients slipped through the net and came to harm because our capacity prevented early cancer detection.”



Bromley's Silver Tsunami



60,100+

Residents aged 65+

Bromley has the largest elderly population of all London boroughs.



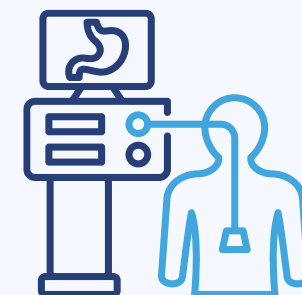


SEL Demand & Capacity

D&C Model: 6.5% growth

Proposal: 27 JAG accredited rooms

- **Collaborative Development:** SEL APC created a unified Endoscopy Business Case
- **Strategic Alignment:** SEL priorities – health inequalities, complex cancer pathway challenges
- **Cross-System Support:** Promotes mutual aid
- **Capacity expansion:** 27 JAG accredited rooms in the sector
- **Policy Support:** Sir Richard's Report (2020)
- **NHS Long Term Plan:** Achieving 75% of detecting cancer at stage I or II
- **PRUH:** 6 JAG accredited rooms with onsite decontamination unit



Securing the £23m vision

THE MULTI-YEAR STRATEGIC CAMPAIGN

Site	Trust	Number of rooms	Net increase of rooms	Timeline	Capital required from this bid	Co-funding commitment	Total cost
PRUH	KCH	6	4	1.5 years in development, becoming operational in Q3 24/25	£10.6 million	£8.3 million	£18.9 million
QEH	LGT	1	1	9 months in development, becoming operational in Q3 23/24 for theatres and in Spring 2024 for Endoscopy	£0.9 million	£0.1 million	£1 million
Guy's	GSTT	2	1	2 years in development, becoming operational in Q4 24/25	£3.5 million	£2.9 million	£6.4 million
TOTAL	All	8	6	All schemes operational and all capital spent by March 2025	£15 million	£11.3 million	£26.3 million



NHSE FUNDING £10.6M



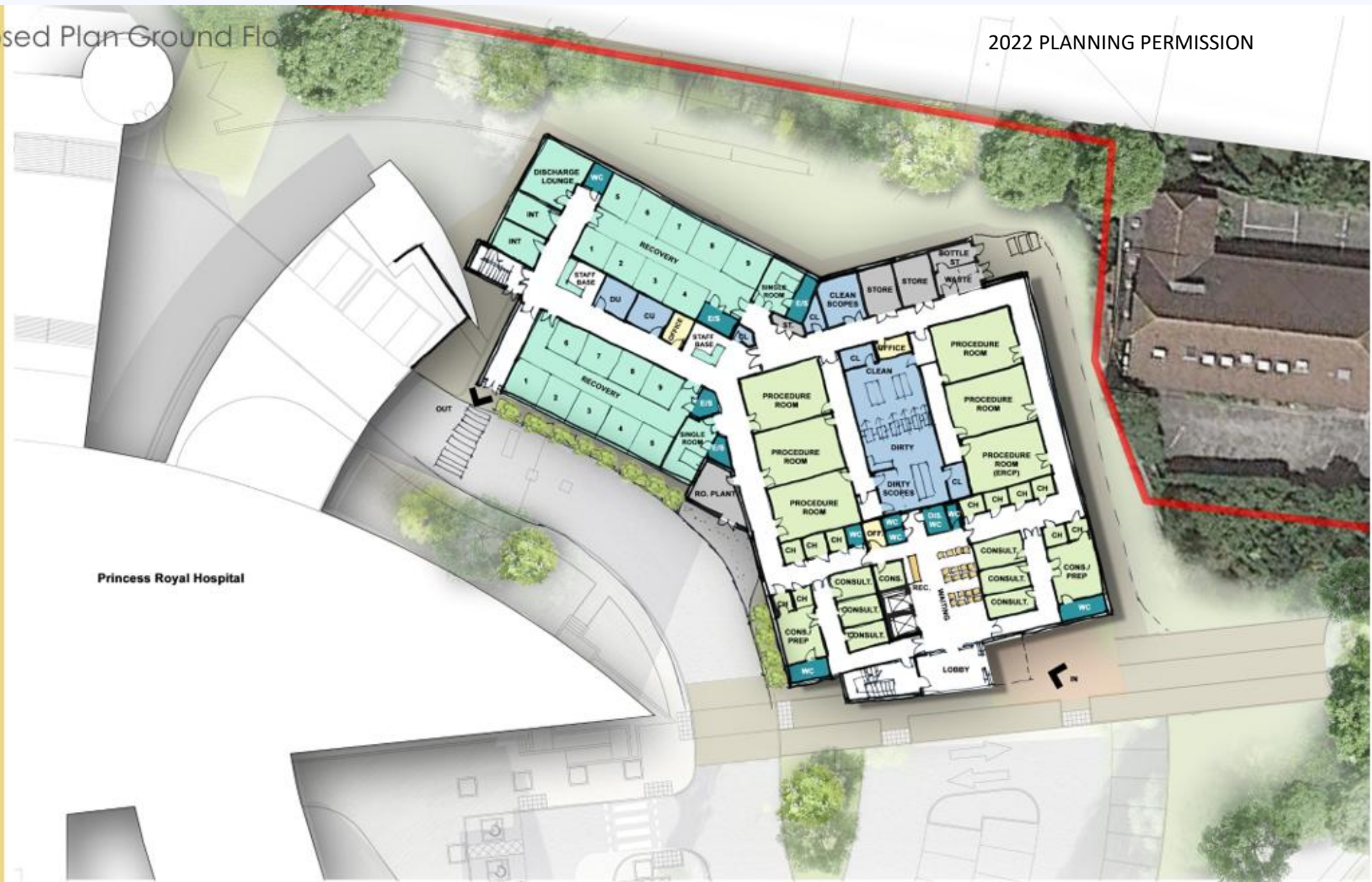
TRUST COMMITMENT



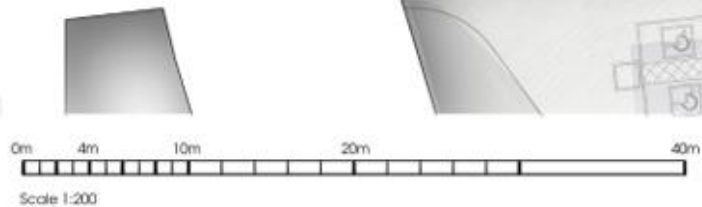
THE APPROVAL MARATHON

Proposed Plan Ground Floor

2022 PLANNING PERMISSION



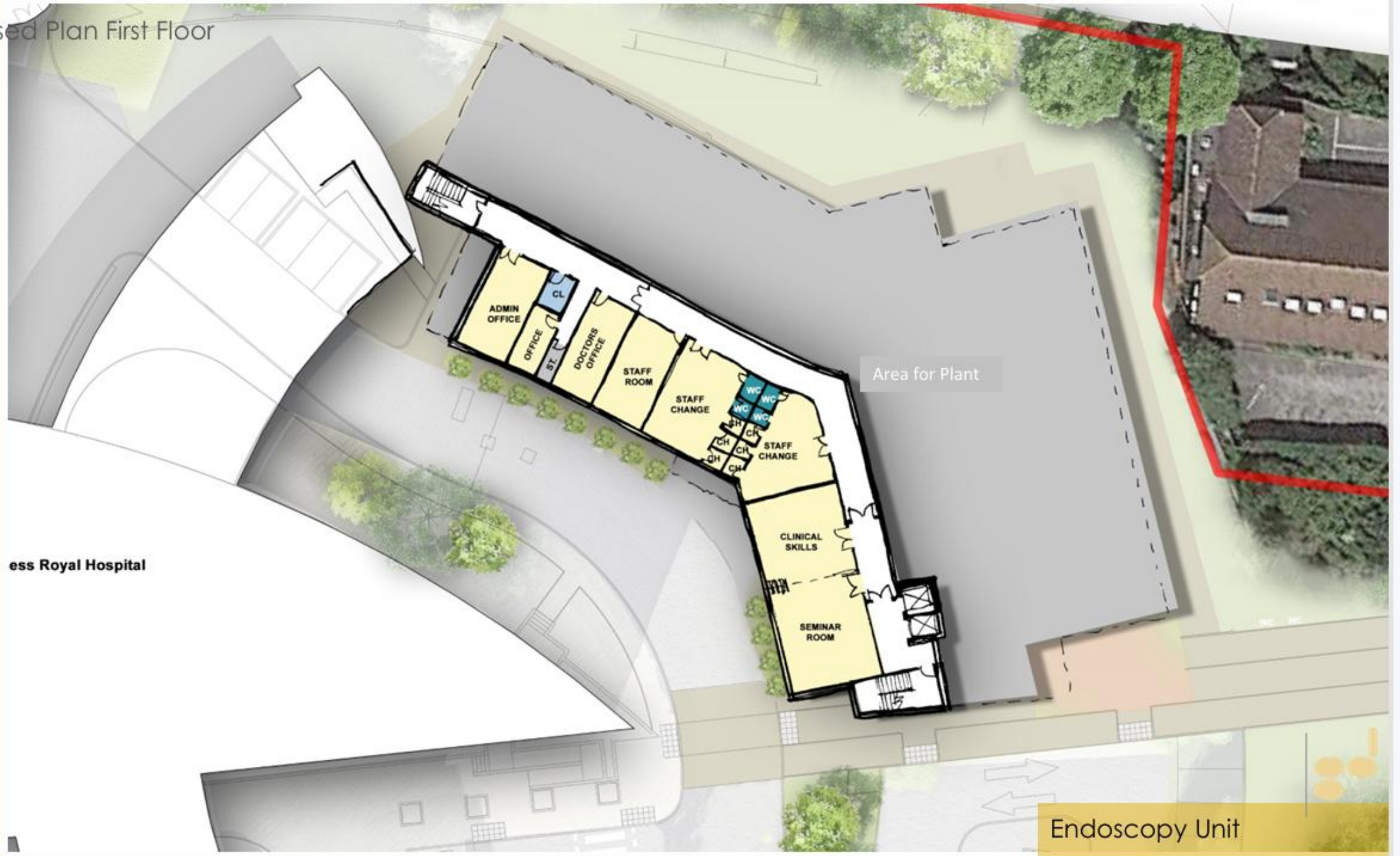
Princess Royal Hospital



- Procedural Patient Areas
 - Recovery Patient Areas
 - WCs / Ensuitee
 - Clinical Support
 - Storage
 - Staff Support
- Site Boundary

Endoscopy Unit

Proposed Plan First Floor



ess Royal Hospital

Area for Plant

Endoscopy Unit

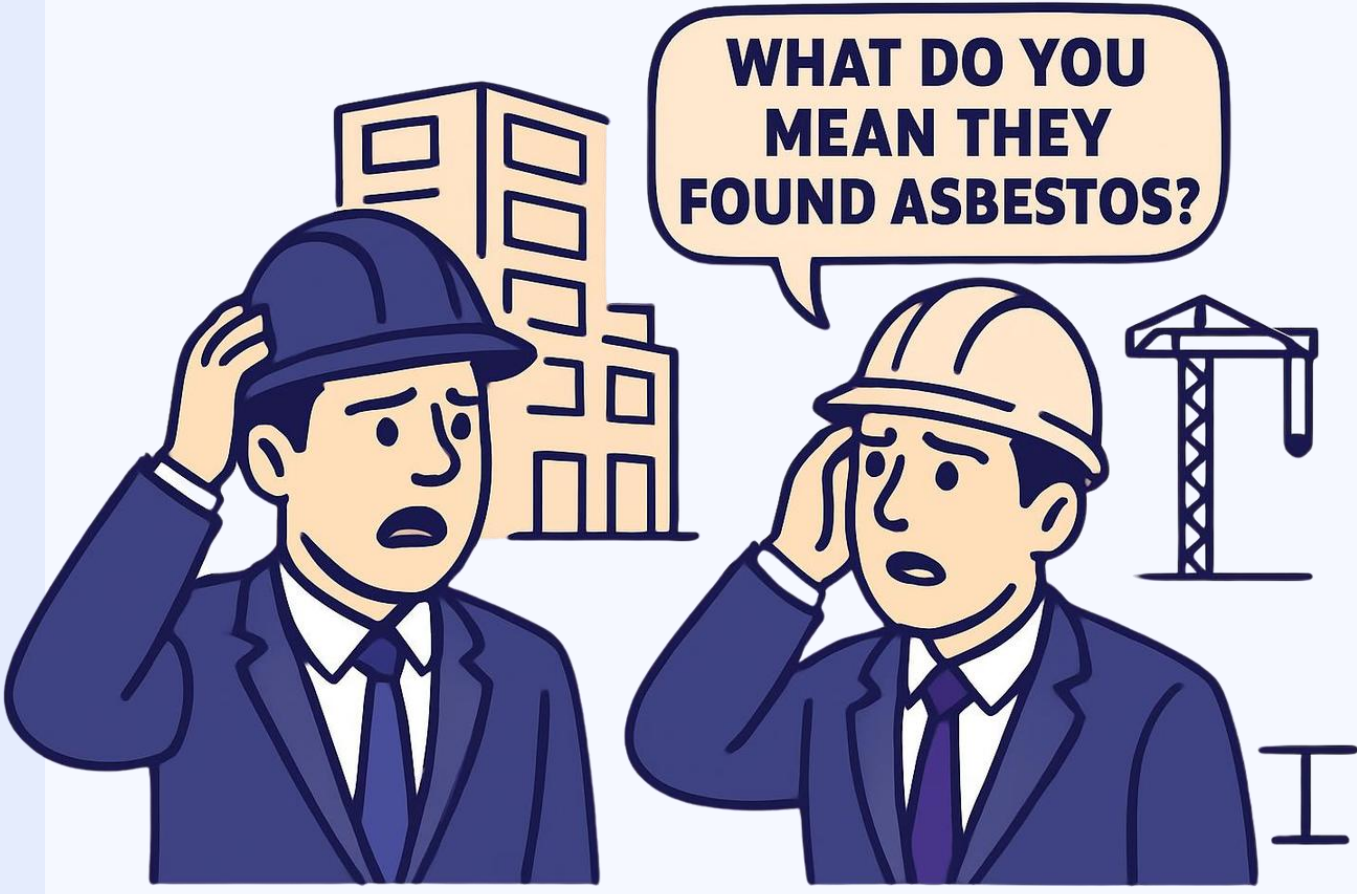
Shall we begin?



Murphy's Law of NHS Construction



King's College Hospital
NHS Foundation Trust



August
2023

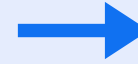




Reception



Interview/Consult Room



Changing Room

Endoscopy and Diagnostic Centre One-way System



Stage 2 Recovery



Stage 1 Recovery



Procedure Room





King's College Hospital
NHS Foundation Trust

Thank you



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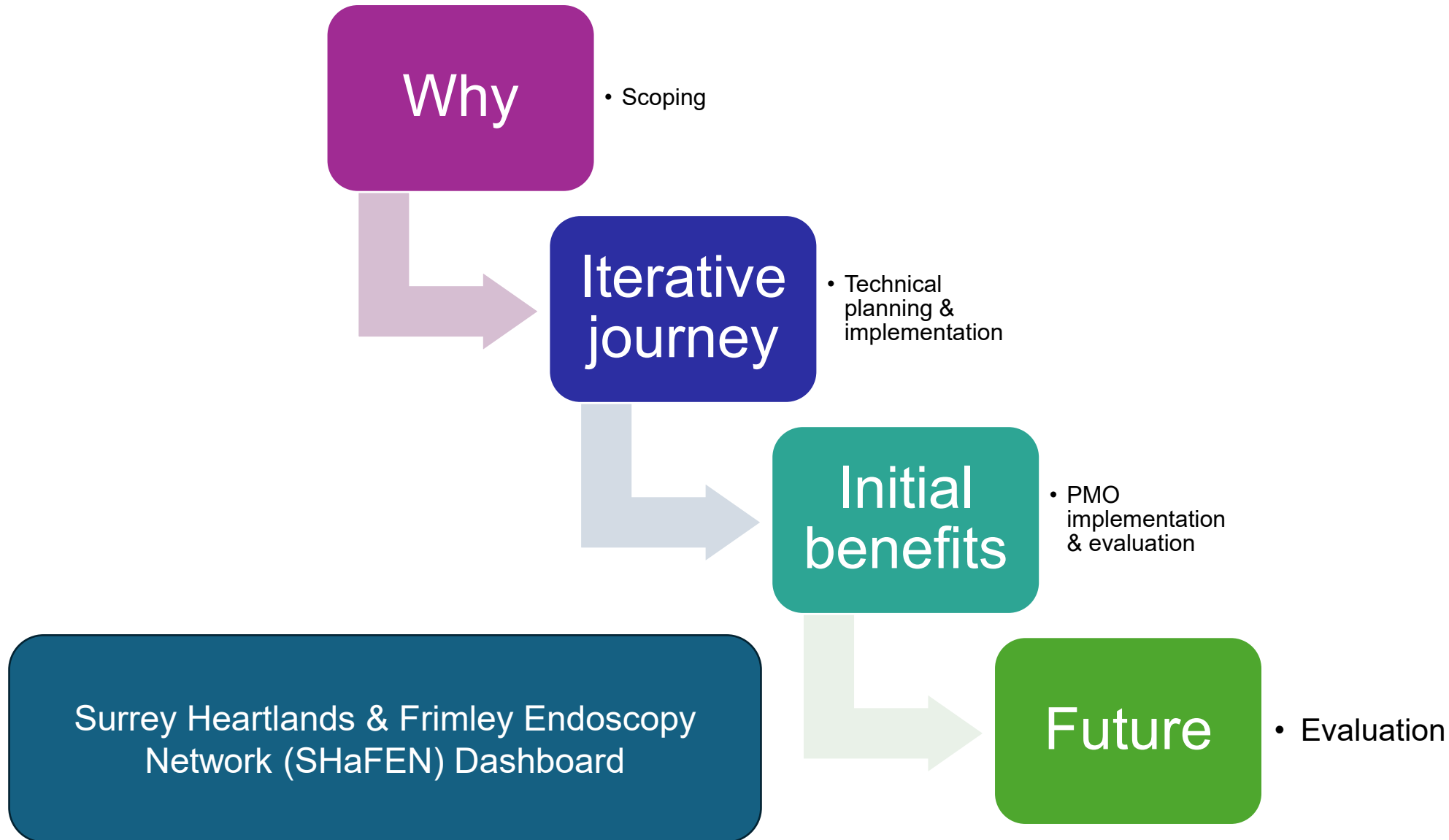




NHS Deep Dive



James Pyke
General Manager
Surrey Heartlands and Frimley
Endoscopy Network

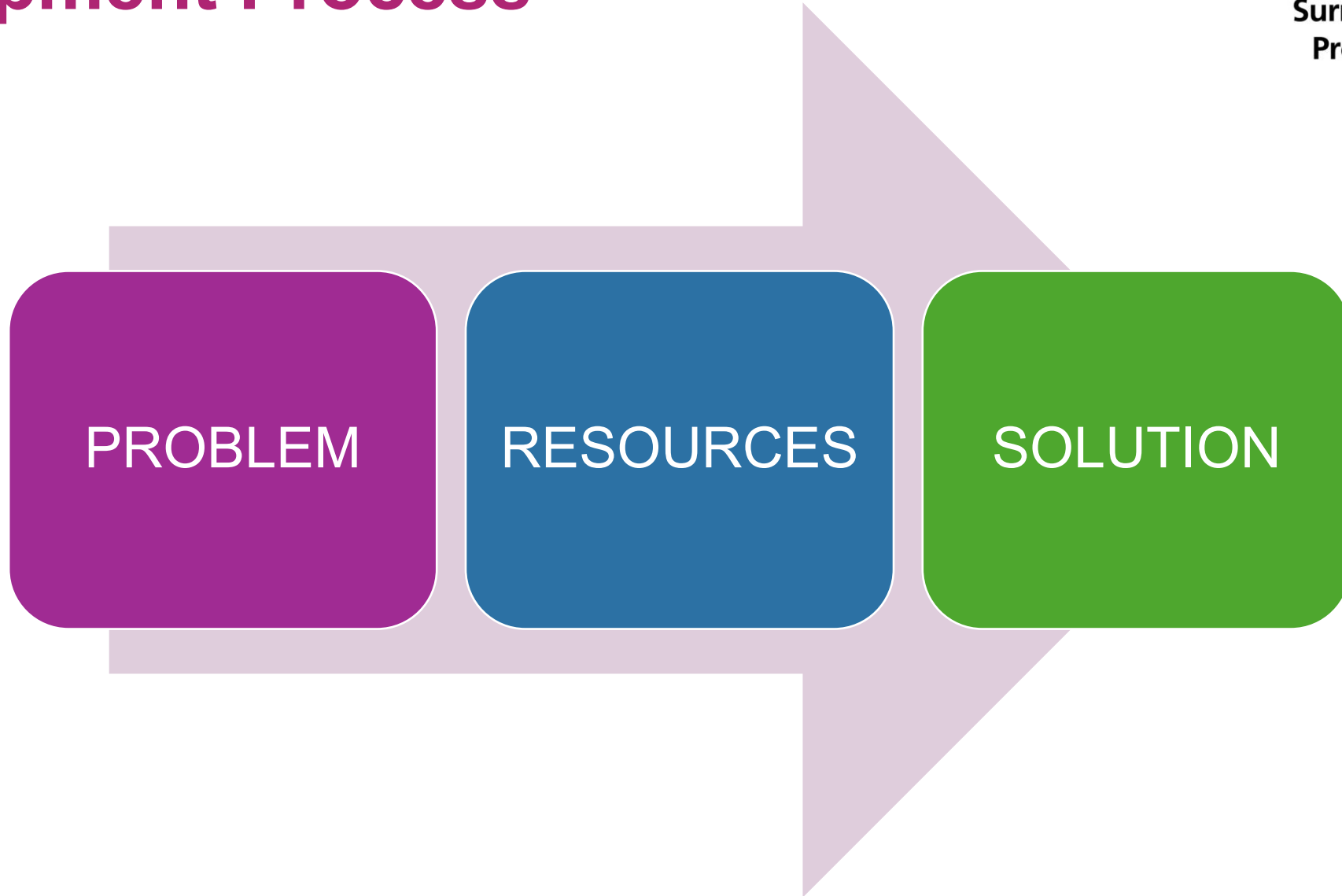


Endoscopy Programme

Scope and Objectives

- To transform the endoscopy provision across Surrey Heartlands (SH) to provide sufficient diagnostic capacity for its population, including screening and surveillance.
- Ensuring modern facilities meeting JAG requirements with a network approach and integrated training through the endoscopy academy.
- To reduce variation in practice, which should lead to reduced incidence of unnecessary endoscopy. Consider creation of single point of access.
- To increase the use of alternative diagnostics and ensure standardised offering of these across SHICS.

Development Process



Problem

- Cannot develop a “future state” without a “current state”
- NHSE model outdated, snapshot focussed and aggregates data
- Fledgling network

Resource

- Network Manager, Clinical Lead, Executive SRO (Strategist)
- BI Lead
- Trusts – clinical (nursing, medical, surgical), operational, A&C

Solution

- Co-designed dashboard
- Monthly update
- Trust and Network view

Purpose



Surrey Heartlands Trust
Provider Collaborative

“To develop a live, co-designed dashboard accessible to all Trusts, enabling consistent, like-for-like comparison between and supporting the identification and reduction of unwarranted variation through the Network.”

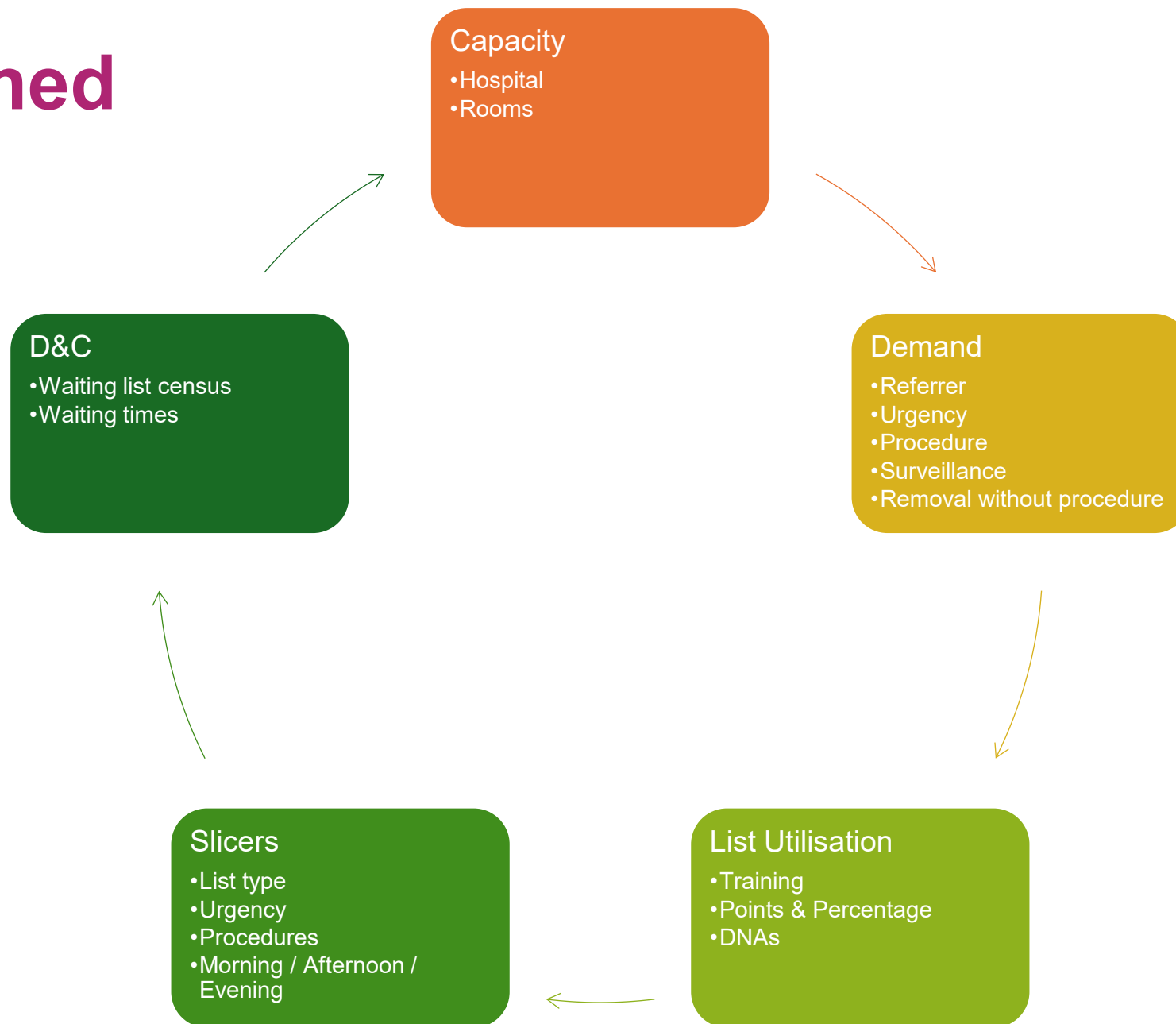
Technical Elements



Surrey Heartlands Trust
Provider Collaborative

- **Data Protection Impact Assessment**
 - Good governance
 - Less detail
- **Cost**
- **Working with EPR**
 - Cerner & EPIC
- **Working with MS Excel & Teams**
- **Manual Requirement**

Co-designed



Current Dashboard



Surrey Heartlands Trust Provider Collaborative



Ashford and St. Peter's Hospitals
NHS Foundation Trust



Royal Surrey
NHS Foundation Trust



Surrey and Borders Partnership
NHS Foundation Trust

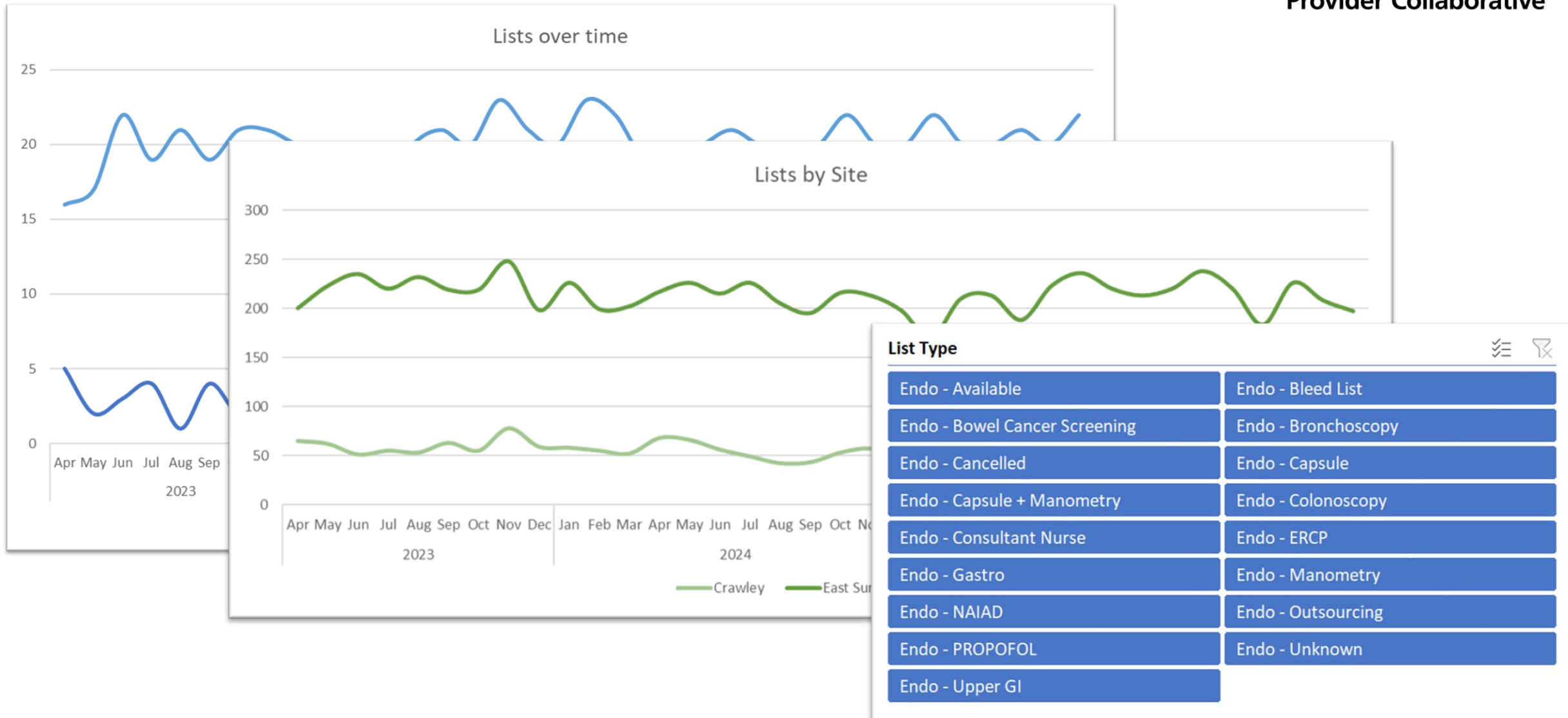


Surrey and Sussex Healthcare
NHS Trust

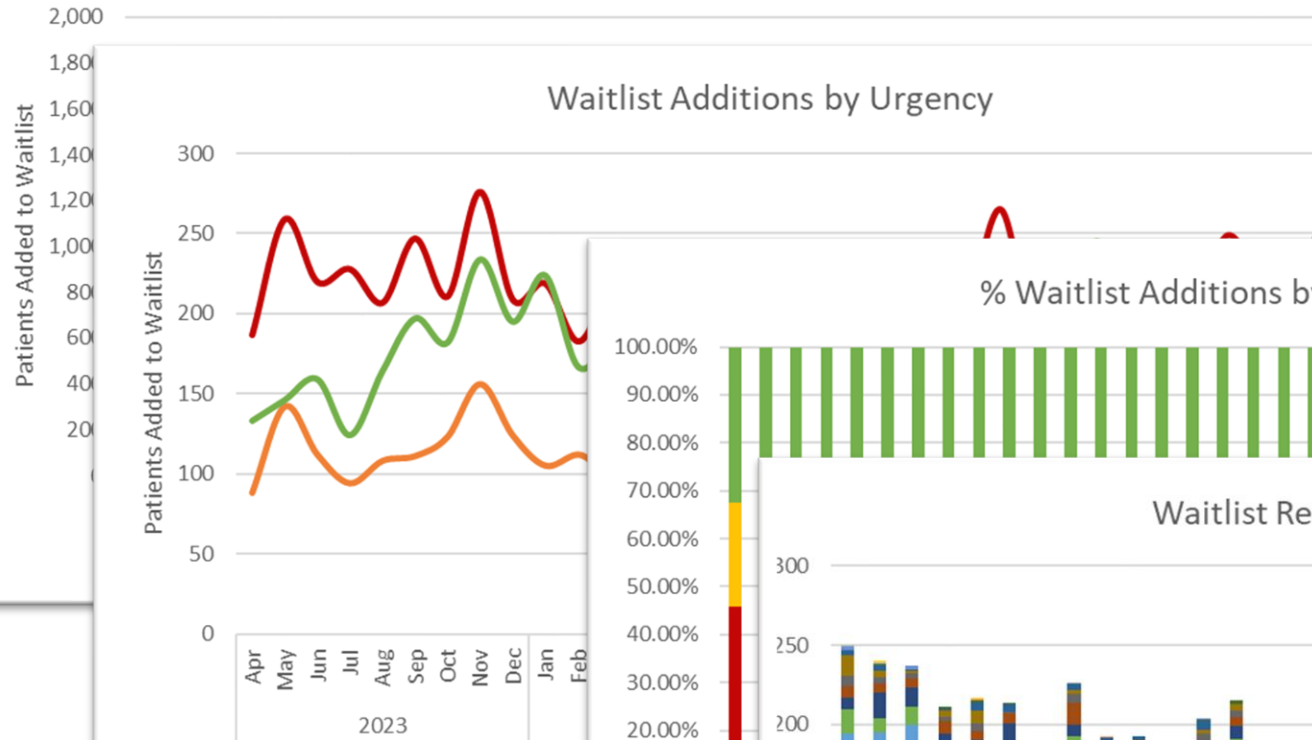
Dashboard Views (Trust)



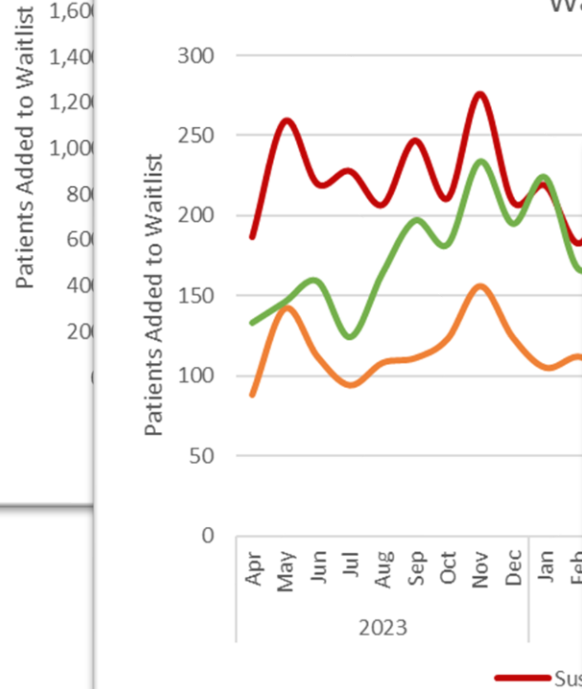
Surrey Heartlands Trust
Provider Collaborative



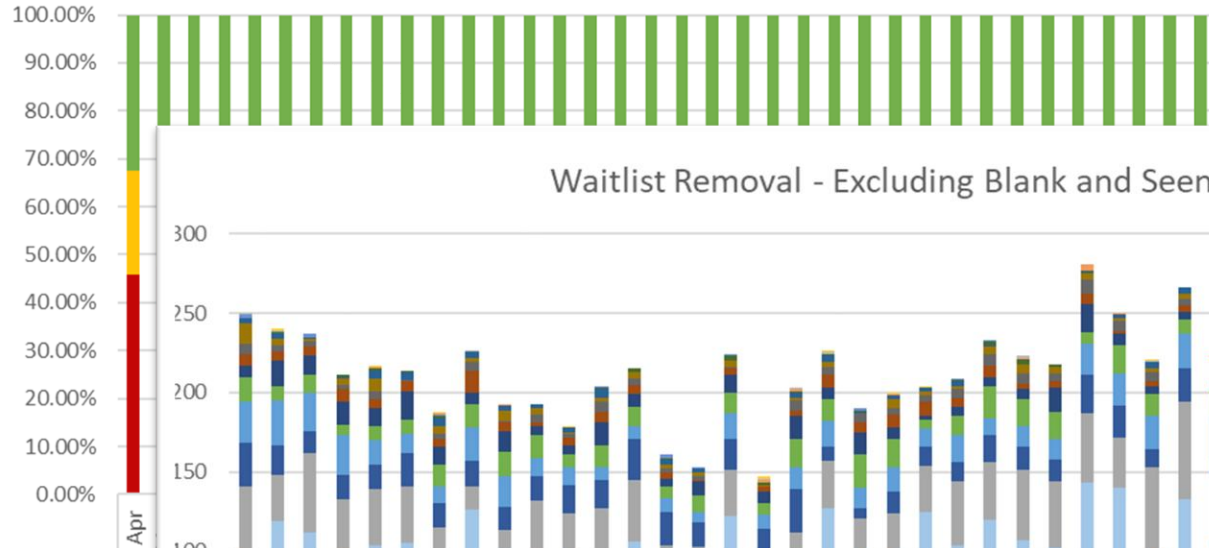
Total Waitlist Additions by Month



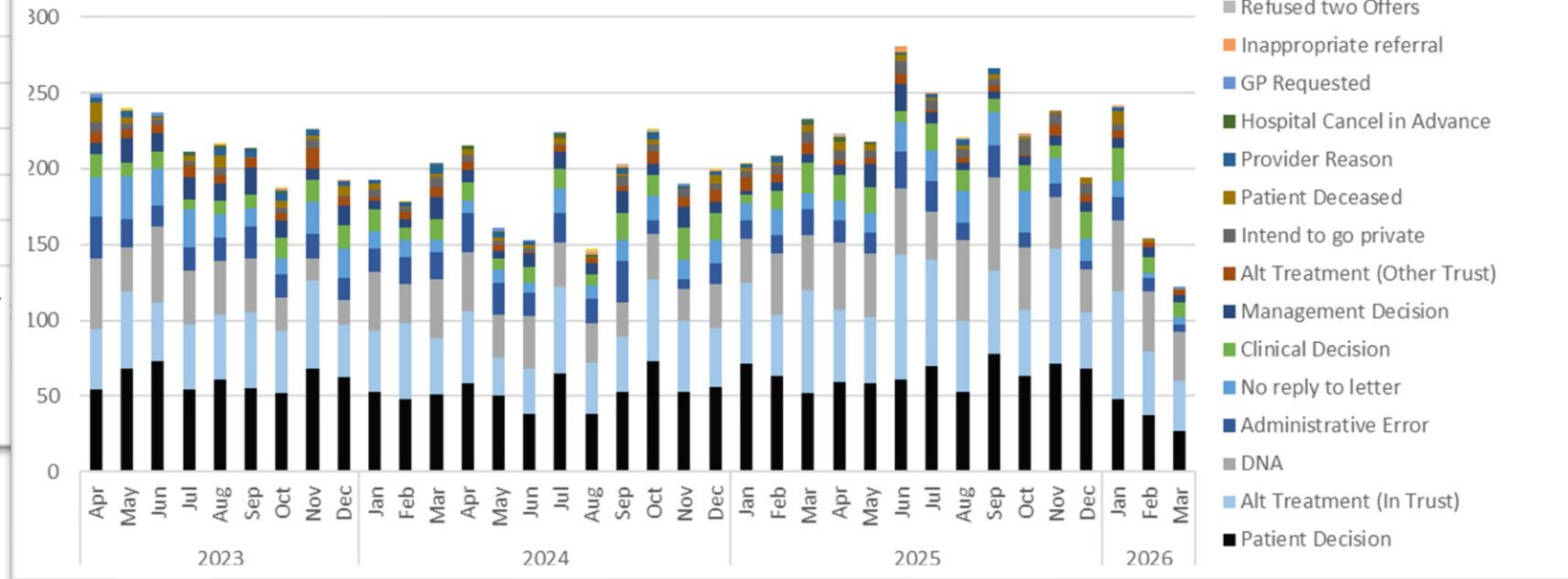
Waitlist Additions by Urgency



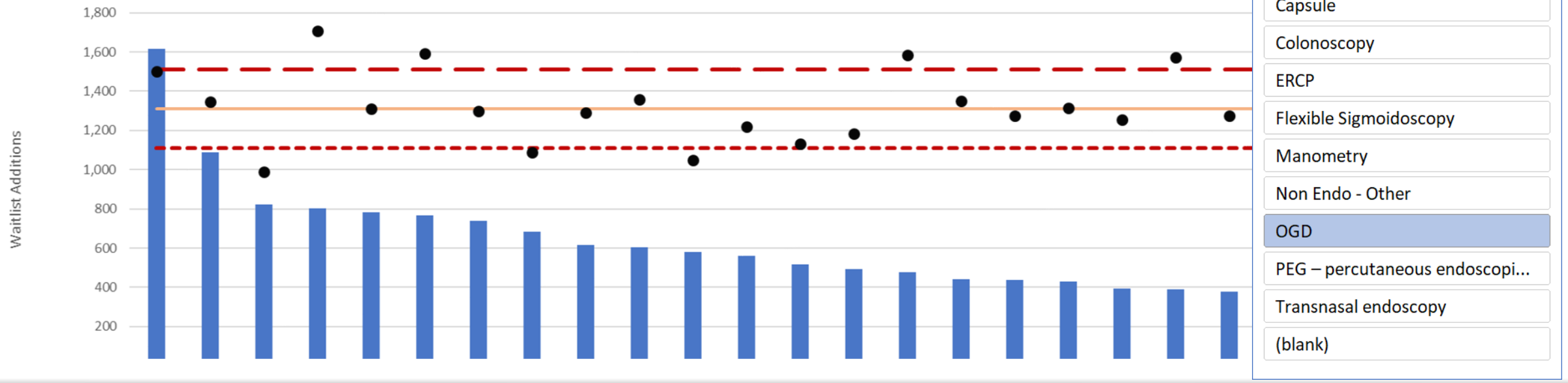
% Waitlist Additions by Urgency



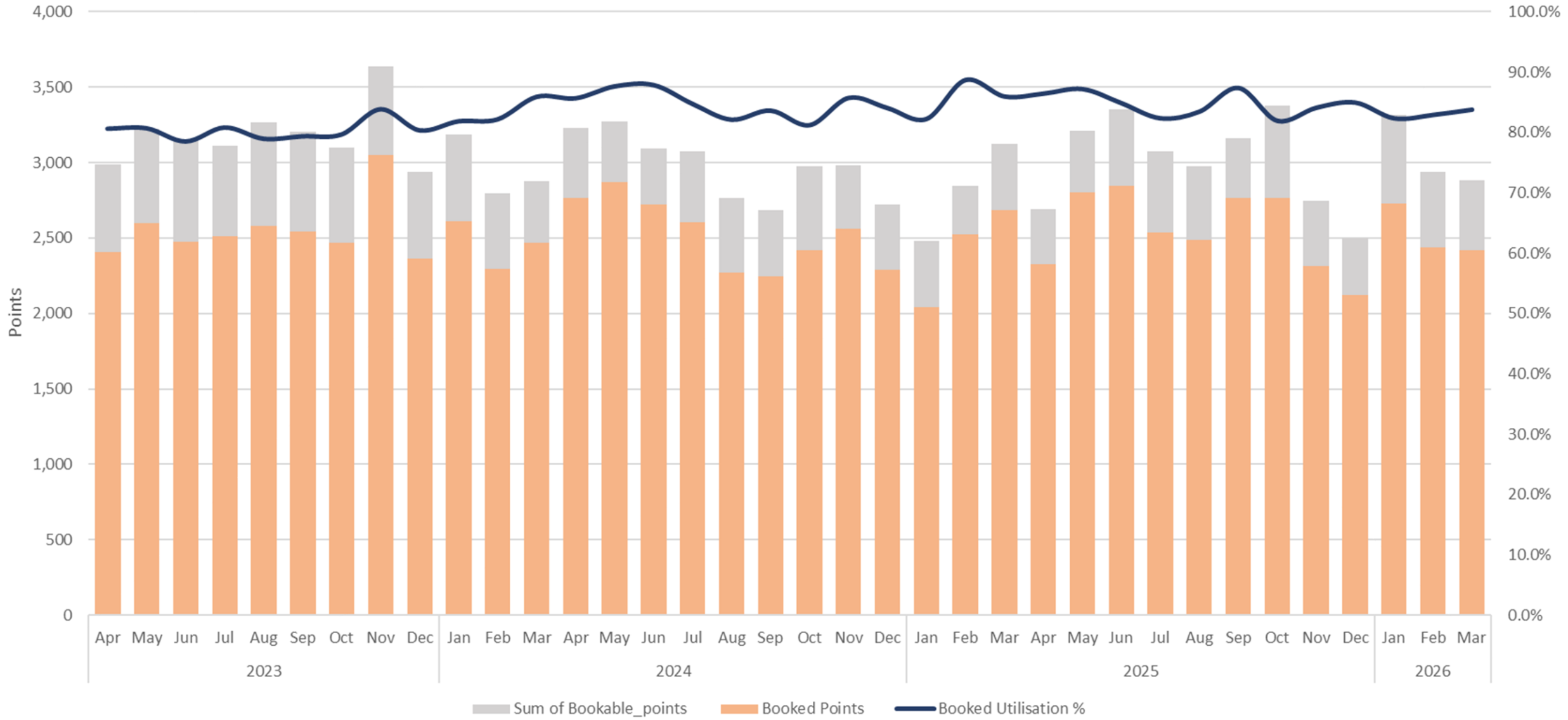
Waitlist Removal - Excluding Blank and Seen



Top 20 GP Surgeries by waitlist additions and avg ratio per 1,000 registered population

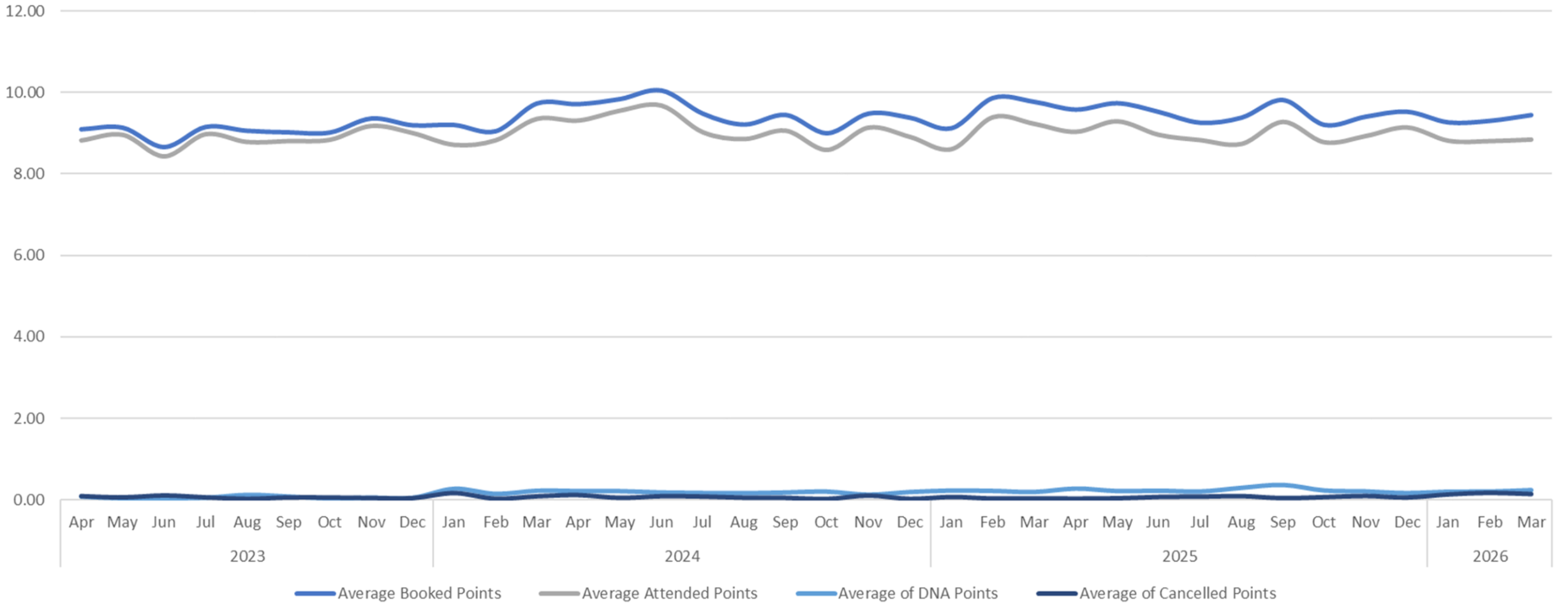


Lists Booking Utilisation

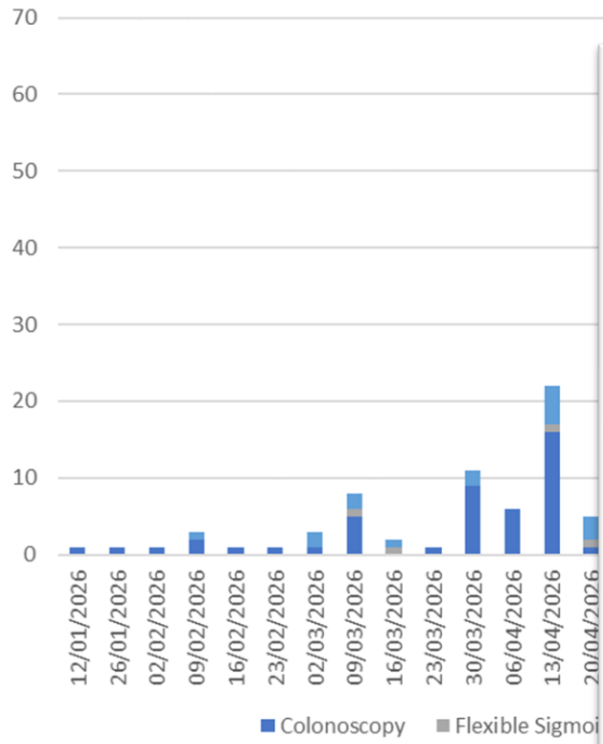


List	Sat				Sun				Weekday	
	2023	2024	2025	2026	2023	2024	2025	2026	2023	2024
Endo - NAIAD										105%
Endo - Gastro	98%	116%	118%	115%	102%	119%	114%	109%	88%	88%
Endo - PROPOFOL			99%	96%			99%	83%		92%
Endo - Bowel Cancer Screening	105%	97%	102%	95%		94%			89%	90%
Endo - Upper GI	91%	89%	97%	89%	93%	92%	93%	88%	84%	83%
Endo - Colonoscopy	91%	92%	88%	83%	86%	94%	86%	93%	83%	83%
Endo - ERCP									76%	81%
Endo - Capsule	50%	50%	50%	50%					80%	71%
Endo - Consultant Nurse										88%
Endo - Bronchoscopy									53%	63%
Endo - Unknown	17%	18%	17%			27%				91%
Endo - Capsule + Manometry									53%	61%
Endo - Manometry			25%	25%					45%	53%
Endo - Bleed List	99%	94%	96%	83%	38%	113%			46%	49%
Endo - Outsourcing									33%	10%
Endo - Available									22%	17%
Endo - Cancelled										8%
Grand Total	93%	97%	102%	94%	93%	105%	103%	99%	77%	81%

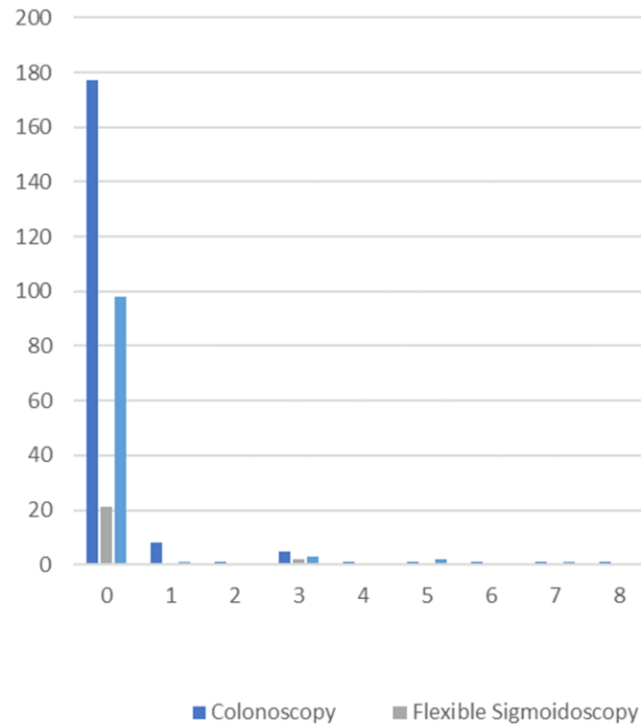
Avg Points per List



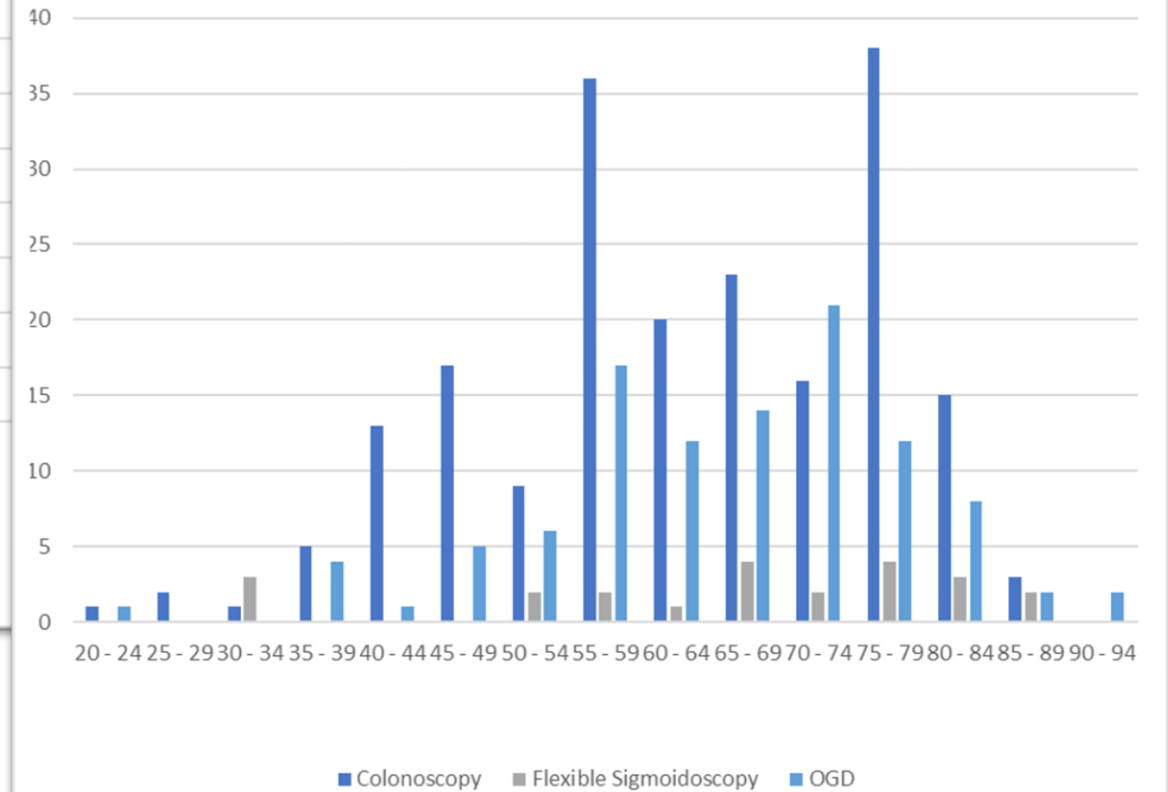
Surveillance Patients currently unbooked or due within 90 days



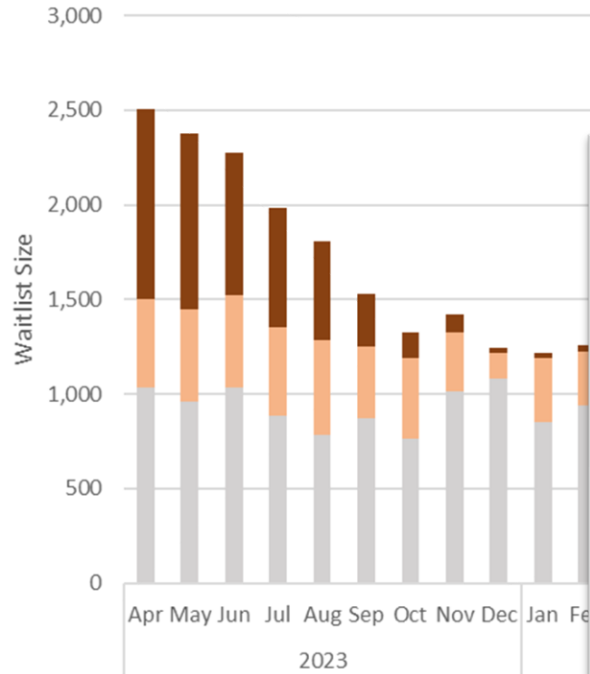
Surveillance Patients - Weeks Overdue



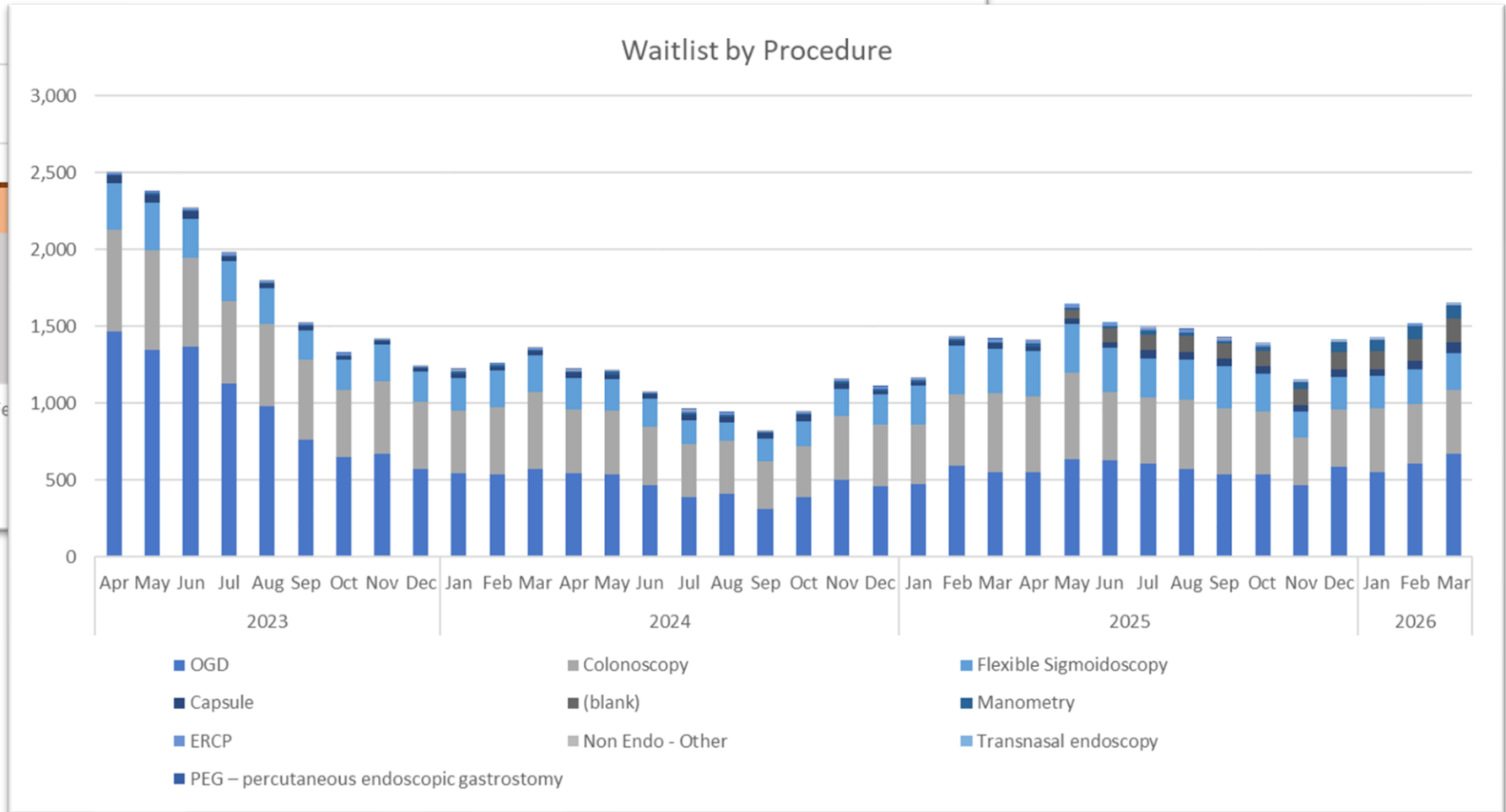
Surveillance Patients by Age Group



Waitlist Census

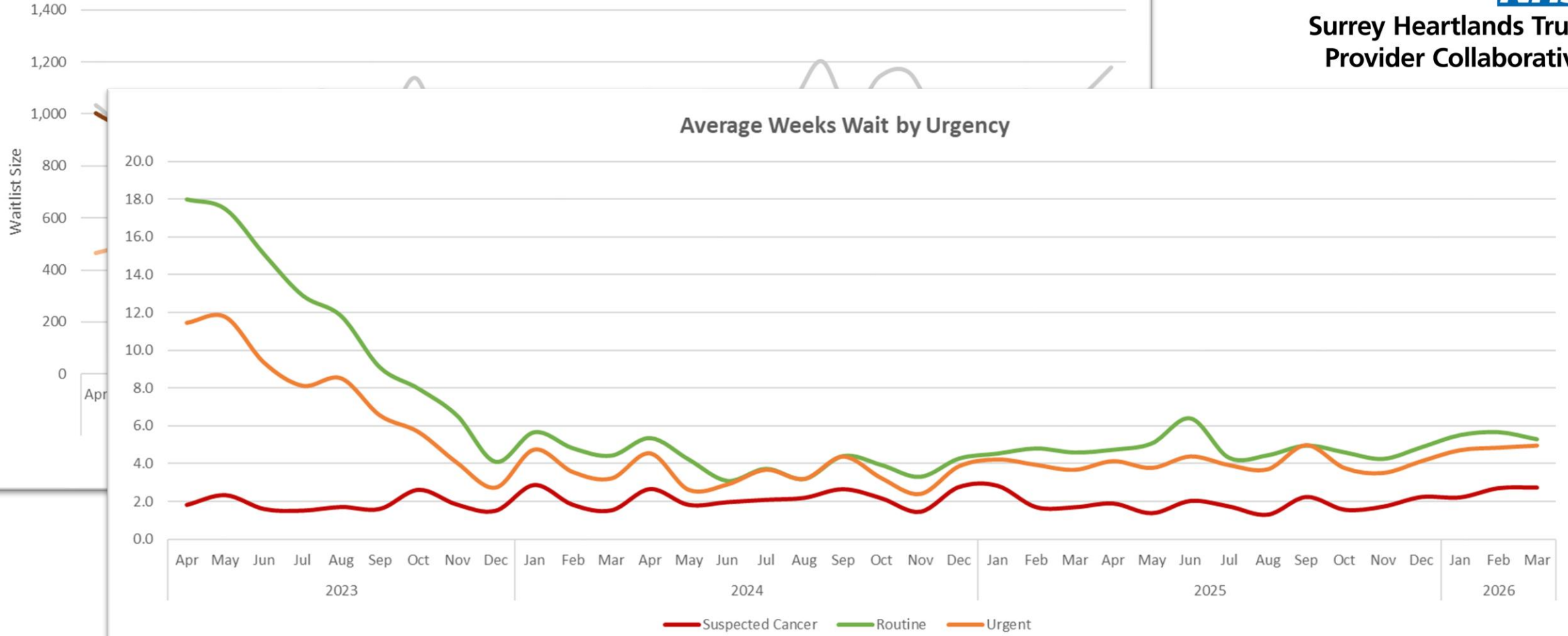


Waitlist by Procedure



Waitlist Trend

Average Weeks Wait by Urgency



Procedure Description

Capsule	Colonoscopy	ERCP	Flexible Sigmoidoscopy
Manometry	Non Endo - Other	OGD	PEG – percutaneous endoscopic...
Transnasal endoscopy	(blank)		

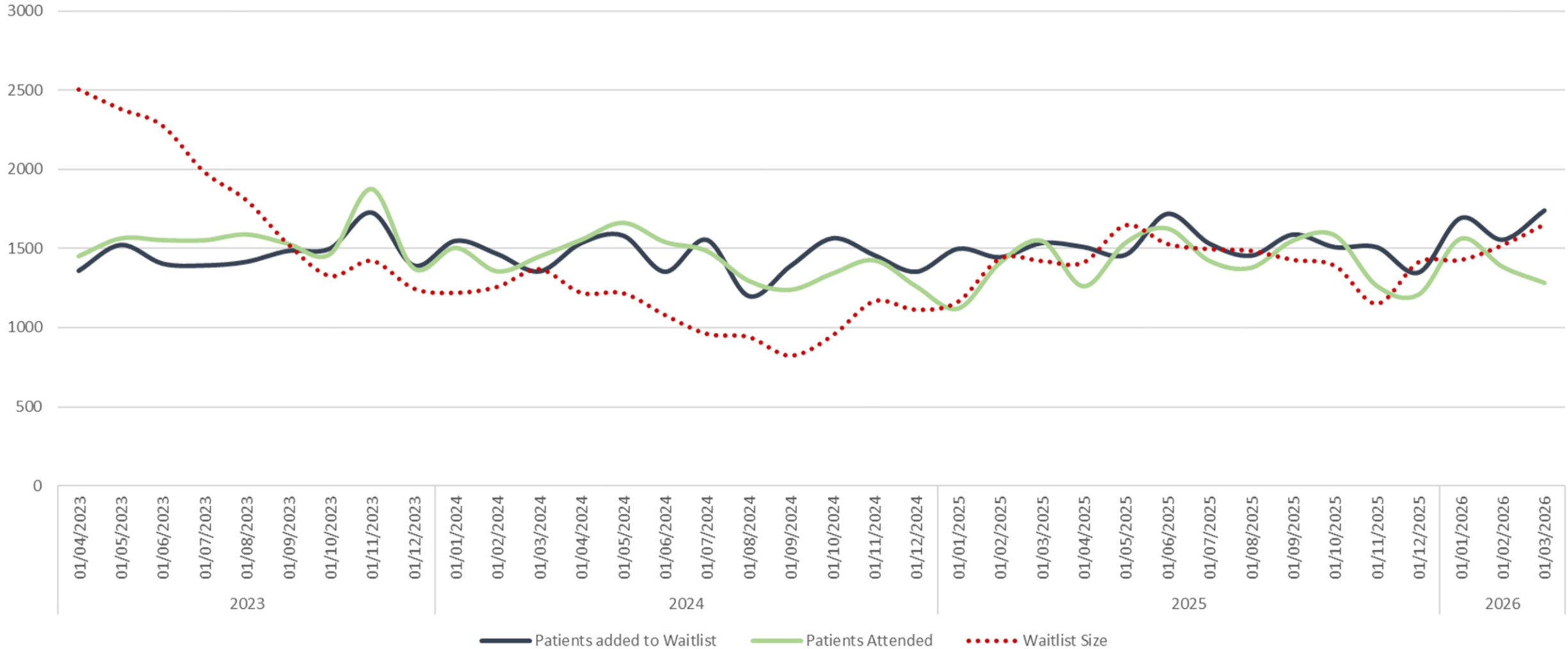
Referral Urgency

Routine
Suspected Cancer
Urgent

Year

2024
2025
2026

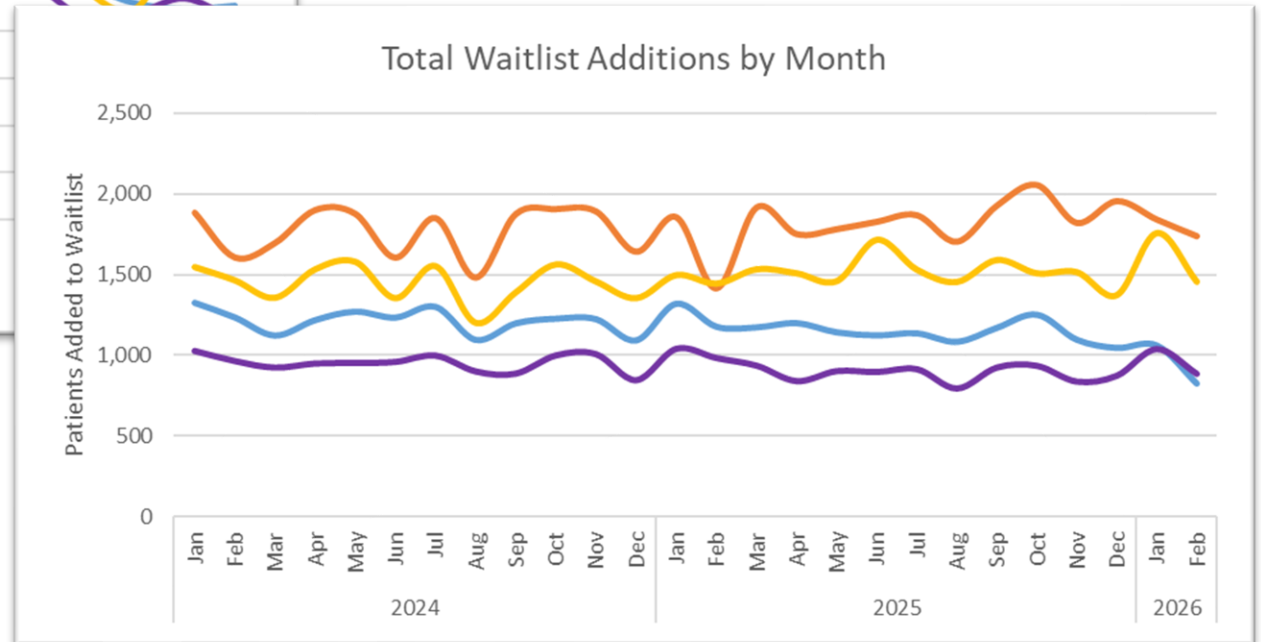
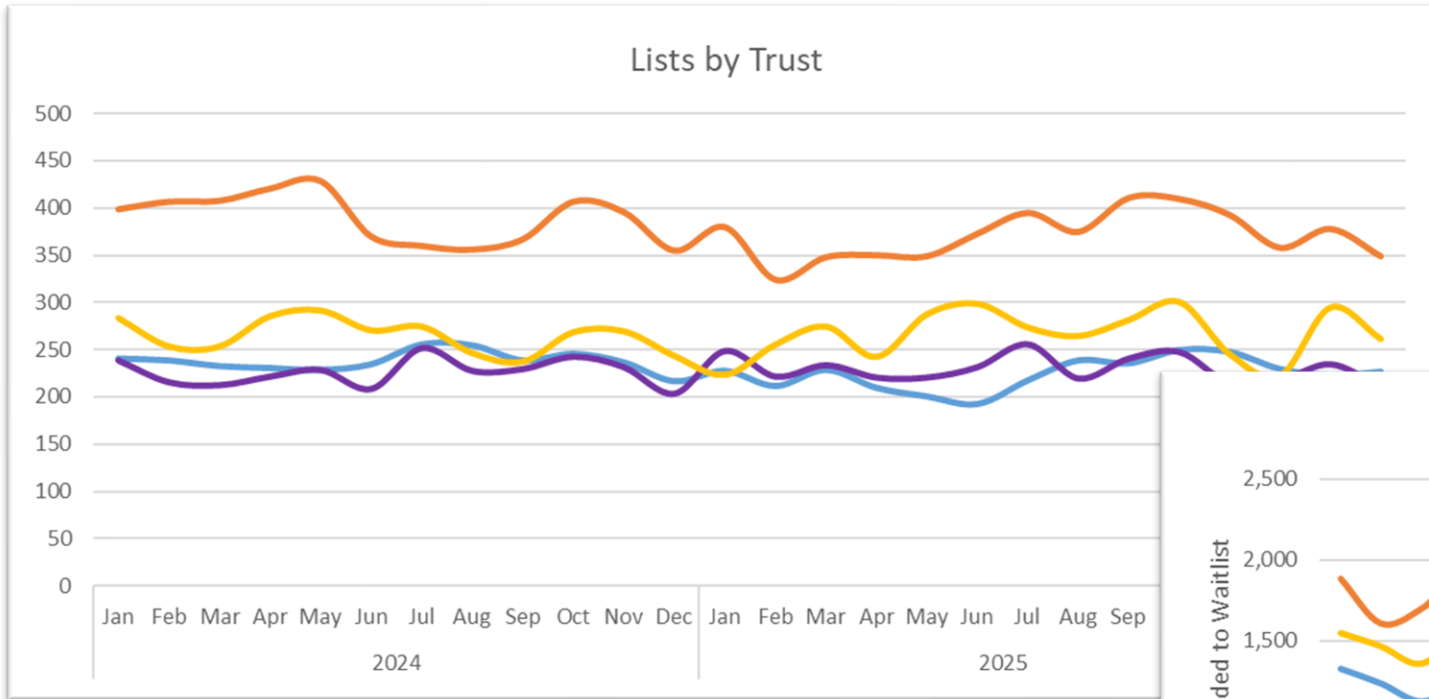
Waitlist Additions, Activity performed and Total Waitlist



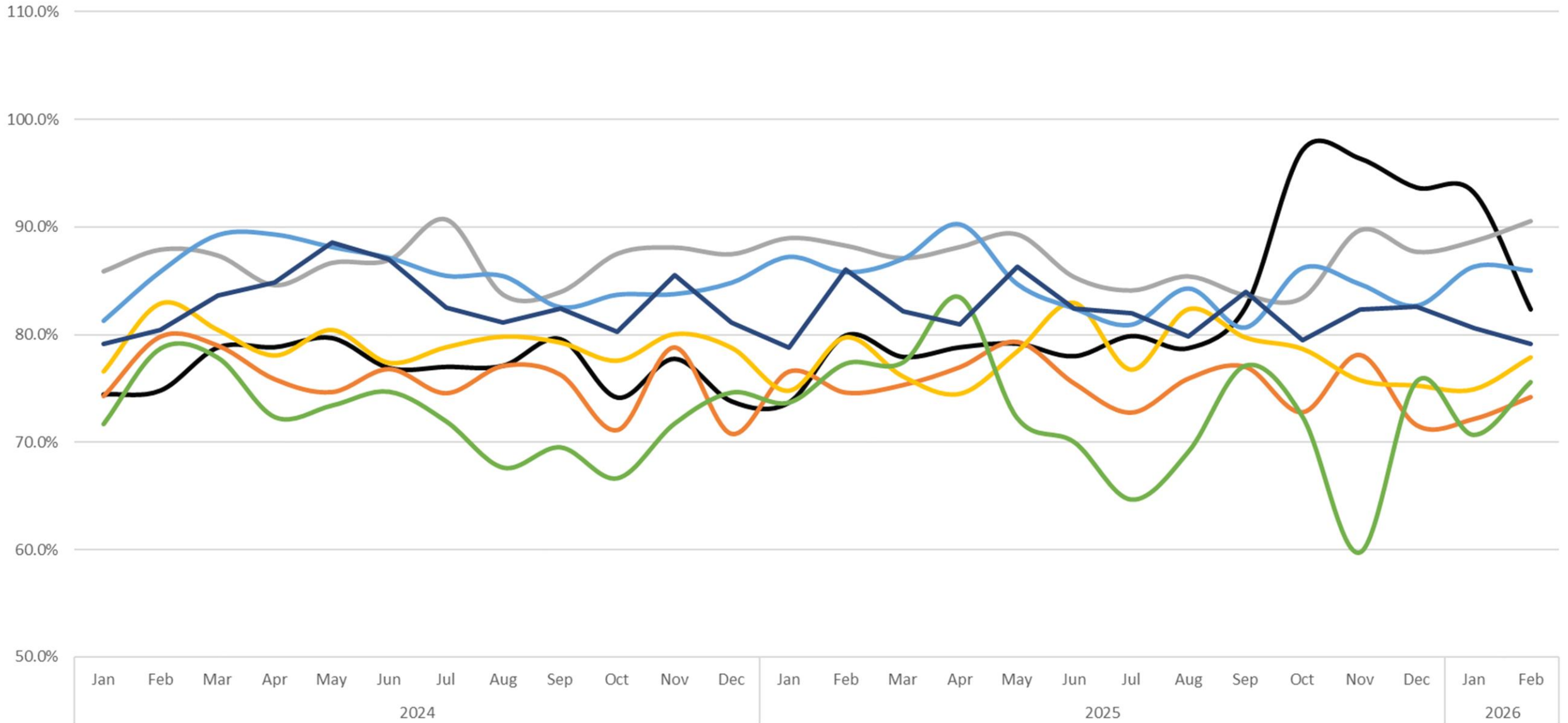
Dashboard Views (SHaFEN)



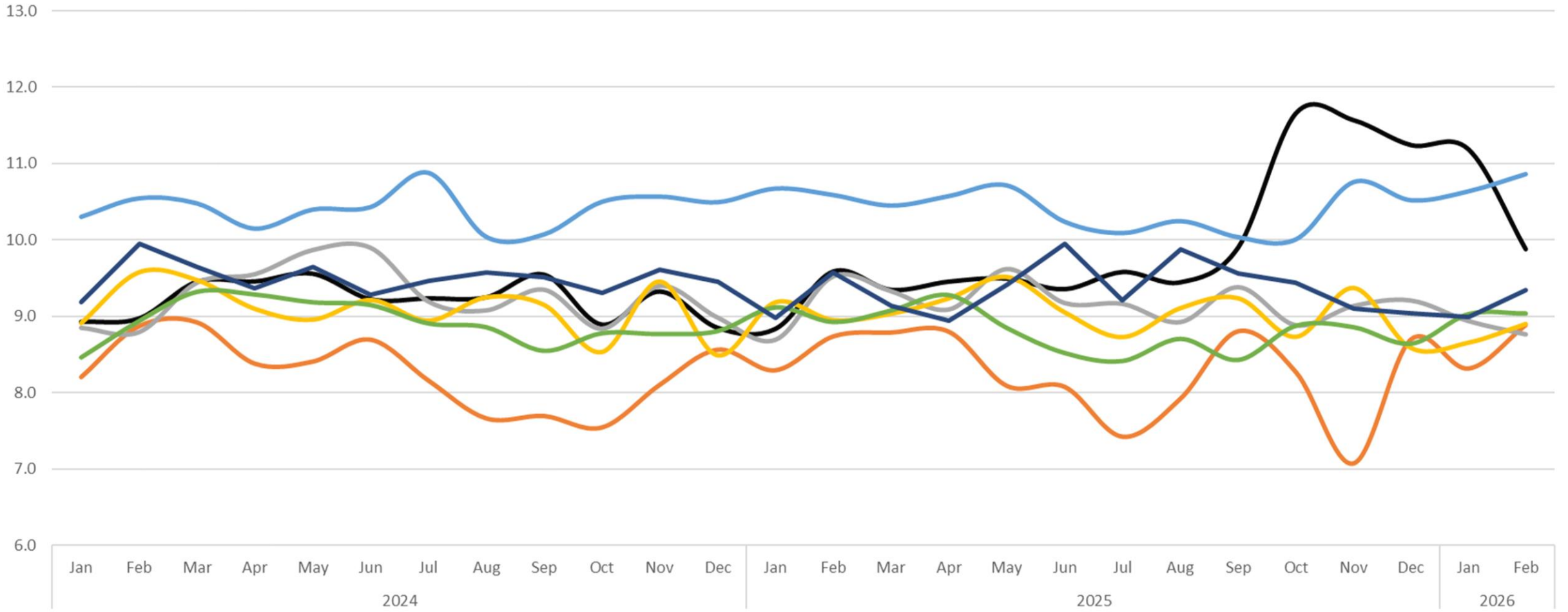
Surrey Heartlands Trust
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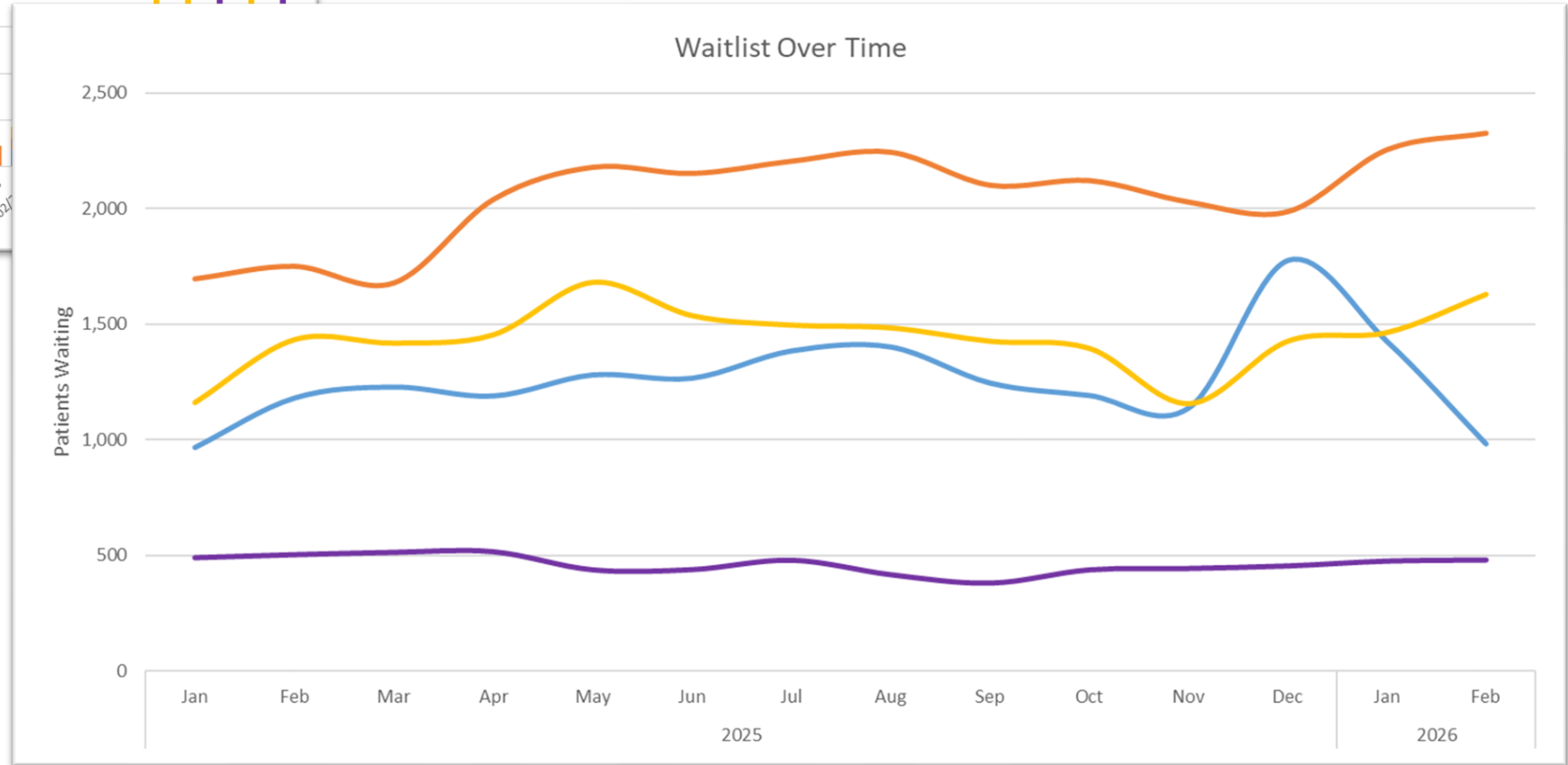
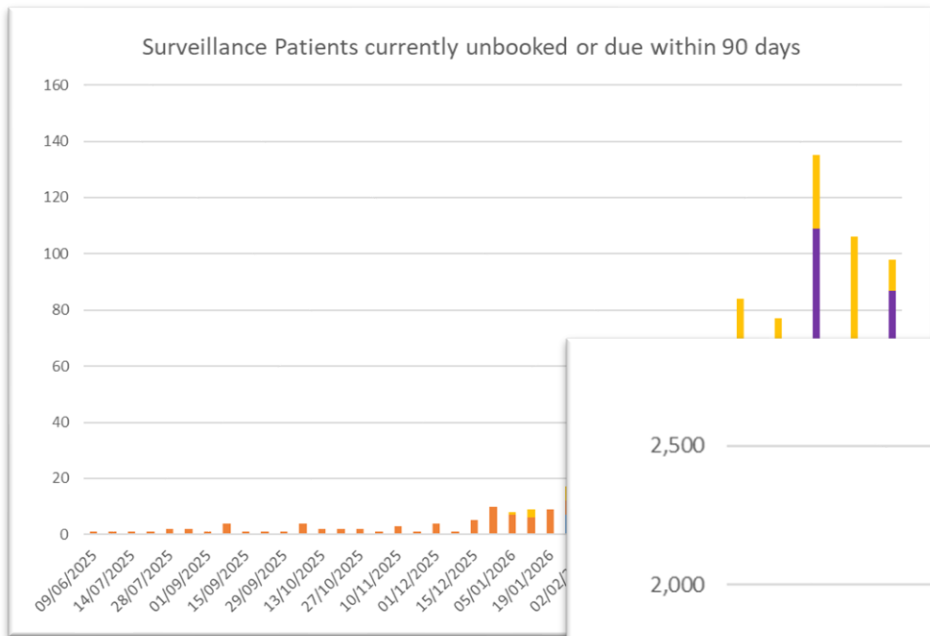


Attended vs Bookable Points Utilisation %

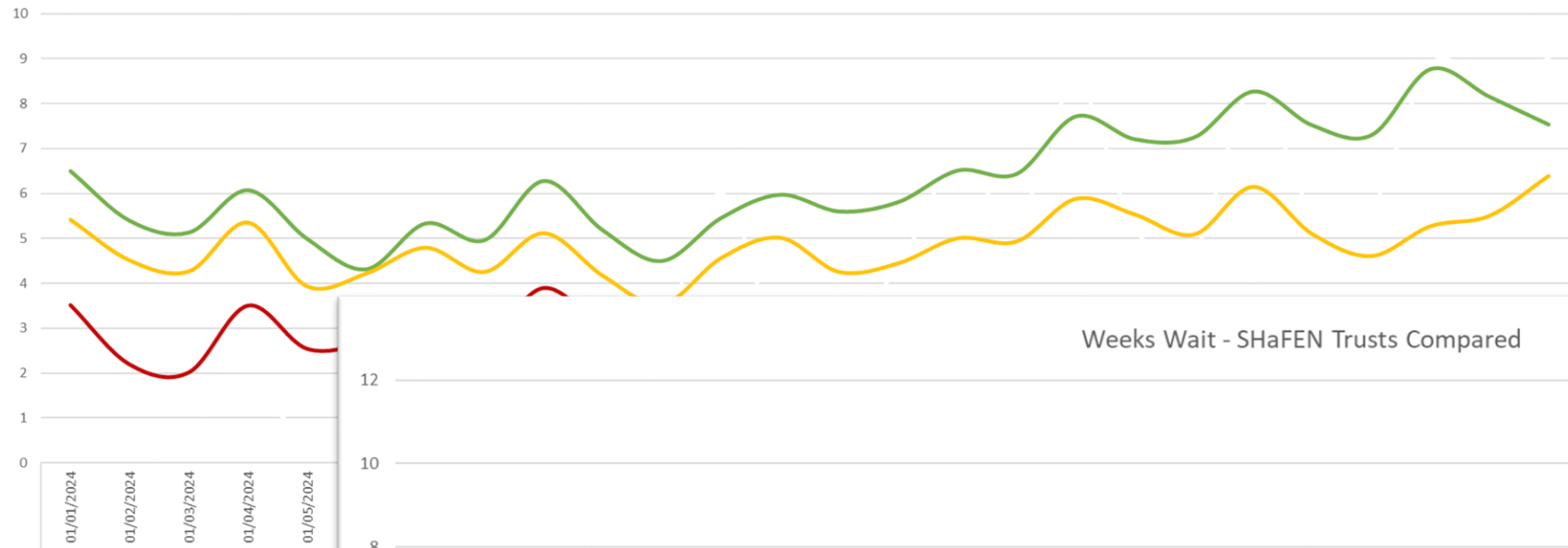


Average Attended Points per List

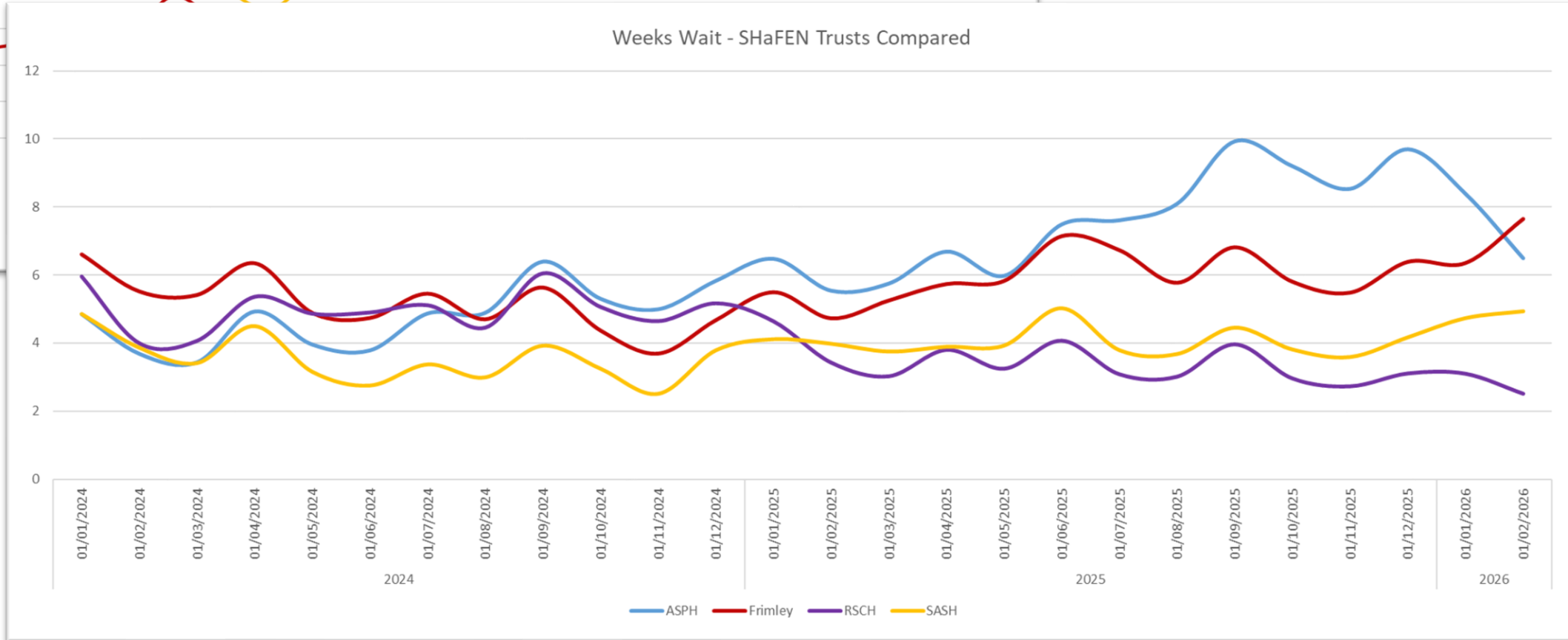




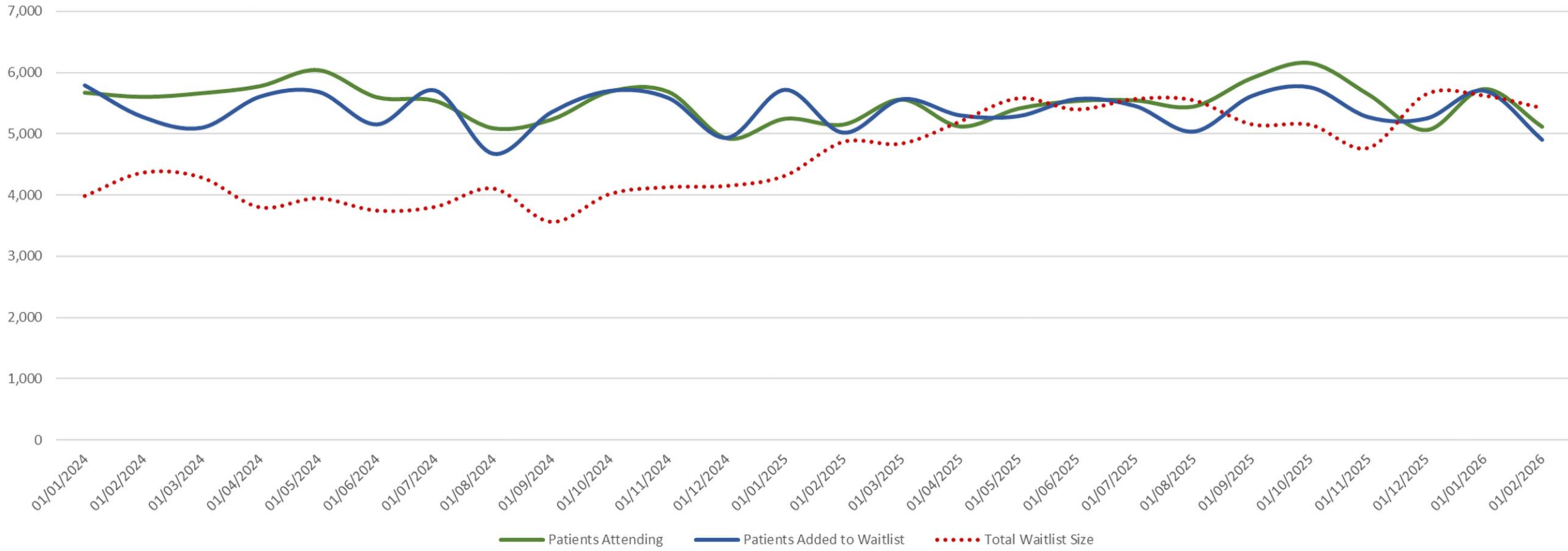
Average Week Wait by Urgency



Weeks Wait - SHaFEN Trusts Compared



Waitlist Additions, Activity performed and Total Waitlist



Trusts

- Availability of multiple data sources in one dashboard
- Has been utilised to deliver efficiency improvements resulting in financial benefit
 - Reduced Sunday working = £267k saved in 12 months
- Has been used for internal data reporting

Network

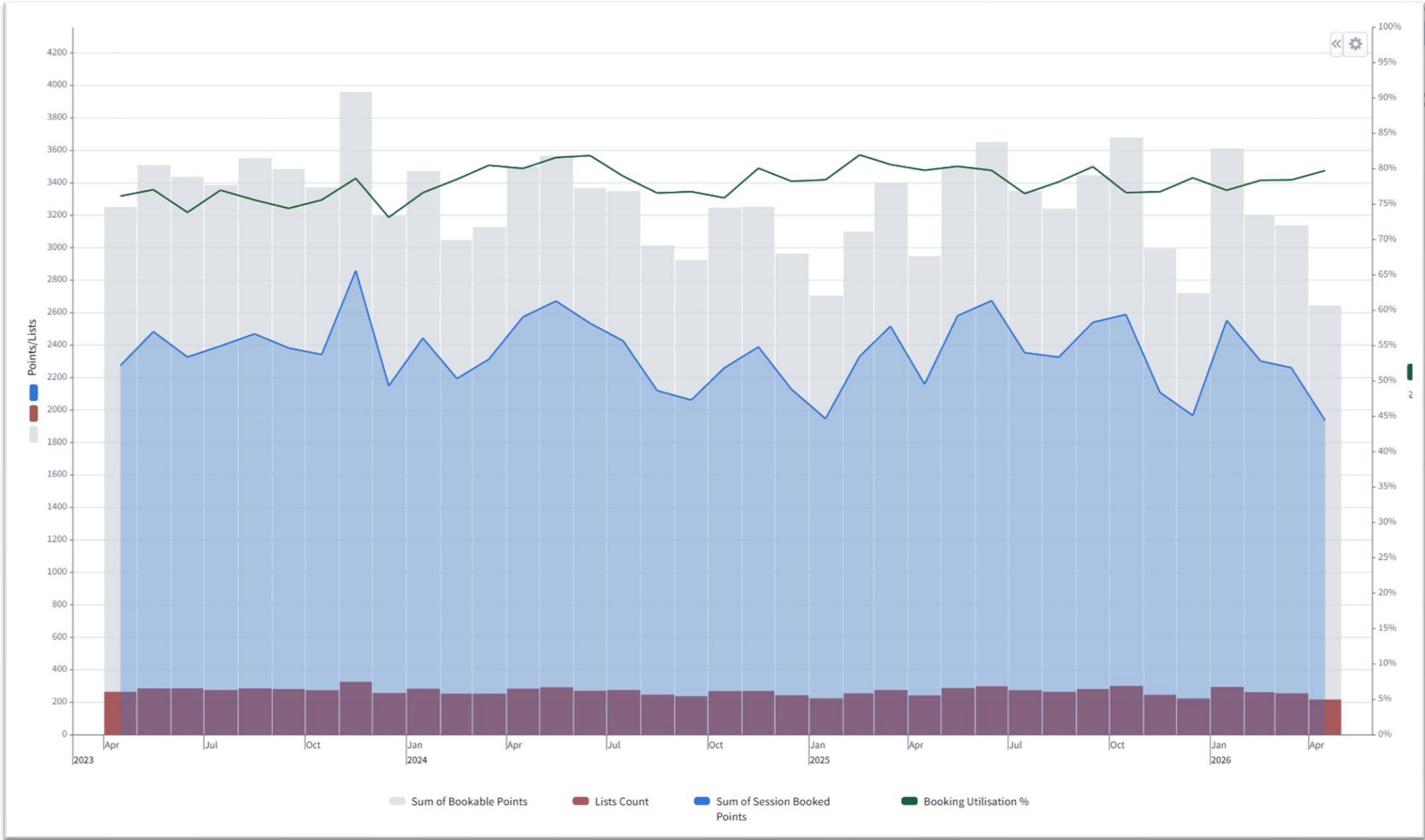
- Assurance of sufficient capacity to deliver FIT@80 earlier than planned

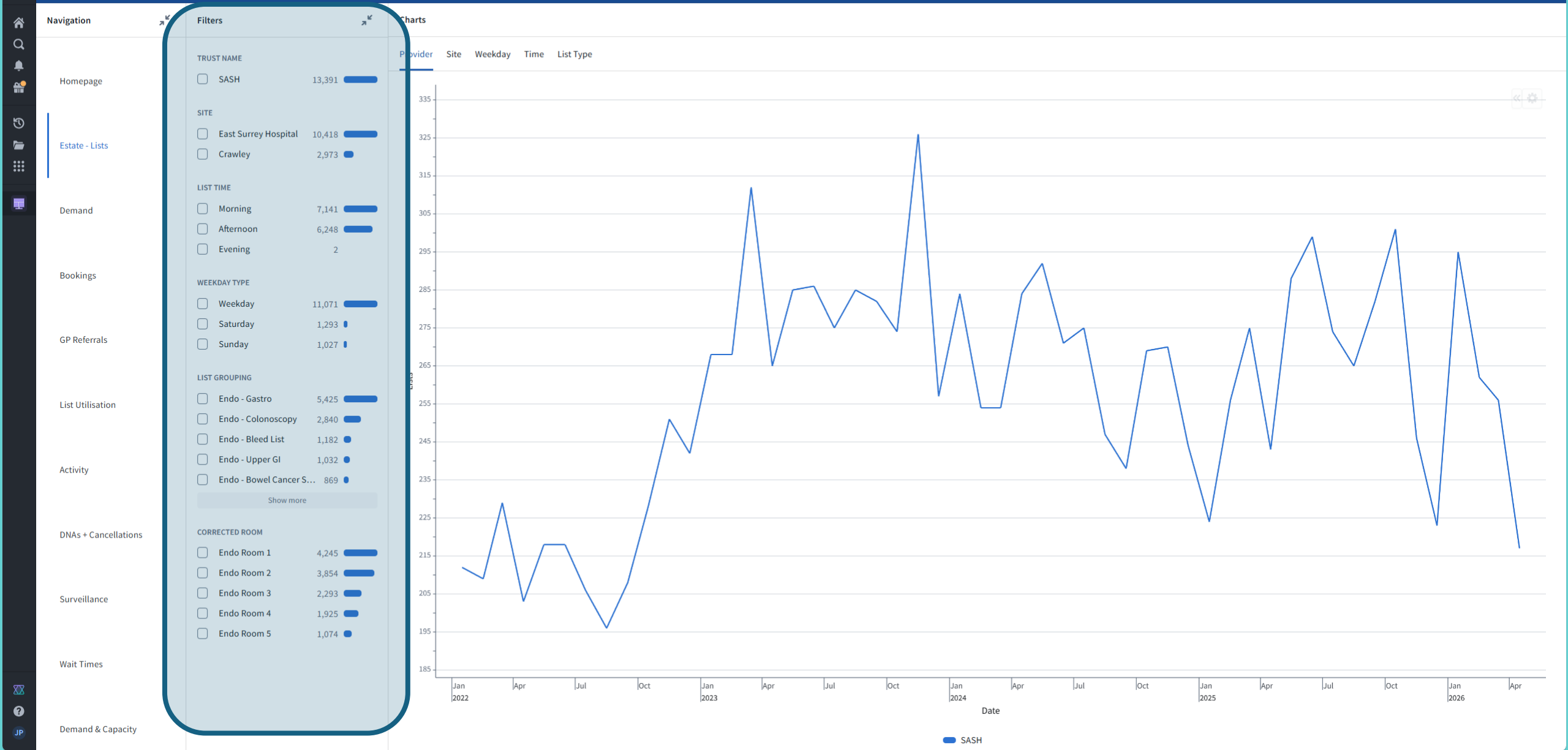
Future



Surrey Heartlands Trust
Provider Collaborative

- **Maintaining ownership**
 - Constant evolution
 - Monitoring of programme impact
- **Embedding as BAU Activity**
 - Not as replacement, but as support
 - Monthly data pack for wider stakeholder engagement
- **Federated Data Platform**





Filters

TRUST NAME

- SASH 13,391

SITE

- East Surrey Hospital 10,418
- Crawley 2,973

LIST TIME

- Morning 7,141
- Afternoon 6,248
- Evening 2

WEEKDAY TYPE

- Weekday 11,071
- Saturday 1,293
- Sunday 1,027

LIST GROUPING

- Endo - Gastro 5,425
- Endo - Colonoscopy 2,840
- Endo - Bleed List 1,182
- Endo - Upper GI 1,032
- Endo - Bowel Cancer S... 869

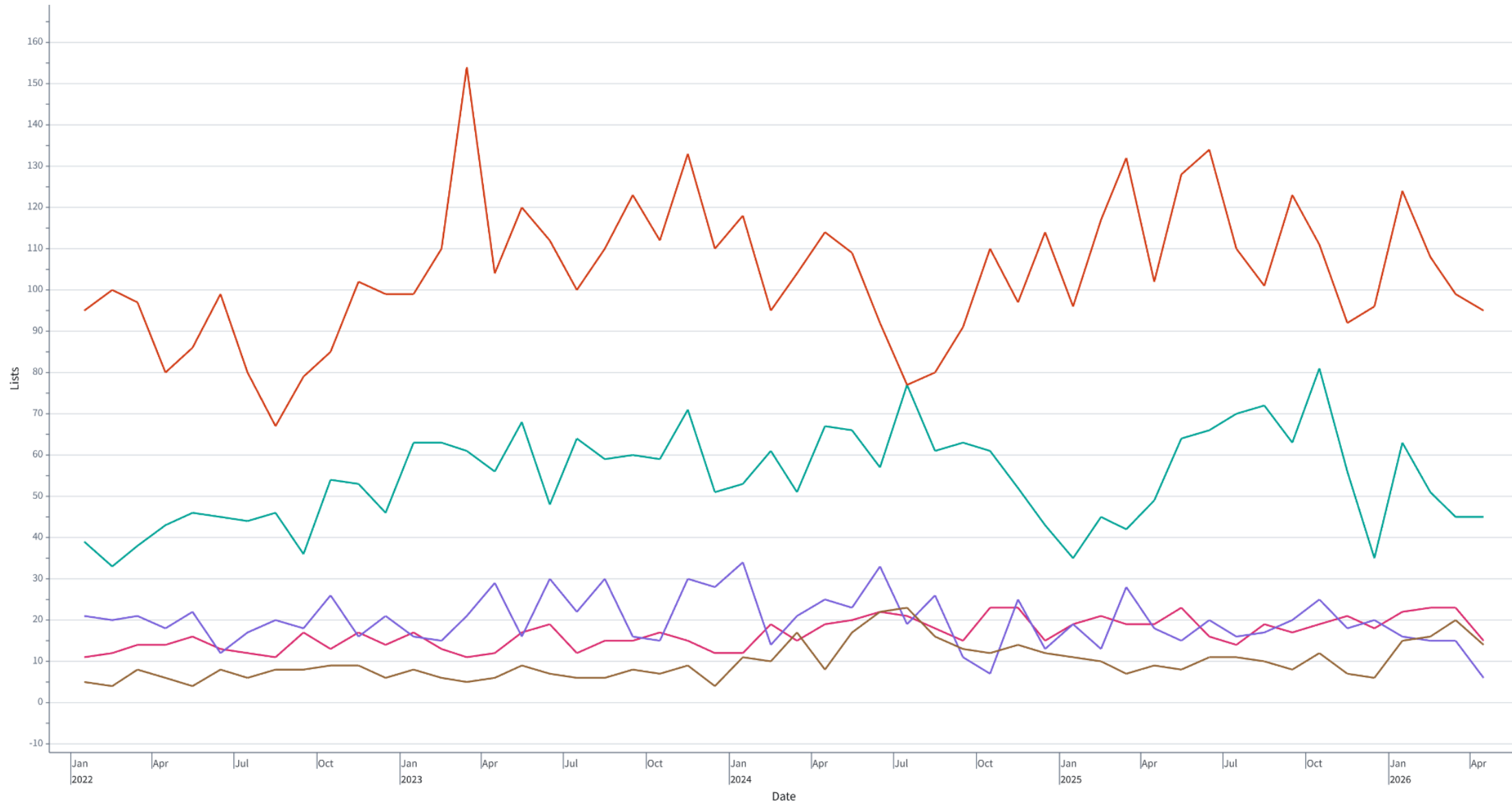
Show more

CORRECTED ROOM

- Endo Room 1 4,245
- Endo Room 2 3,854
- Endo Room 3 2,293
- Endo Room 4 1,925
- Endo Room 5 1,074

Charts

Provider Site Weekday Time List Type



- Endo - Bleed List
- Endo - Bowel Cancer Screening
- Endo - Bronchoscopy
- Endo - Capsule
- Endo - Colonoscopy
- Endo - ERCP
- Endo - Gastro
- Endo - Upper GI
- No Value
- Other

WAITING LIST START TIME

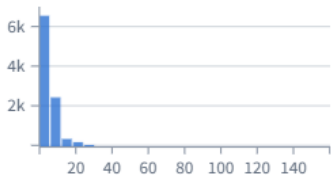


Start date: End date:

PROCEDURE DESCRIPTION

OGD 9,750

WEEKS WAITING



Min value: Max value:

URGENCY

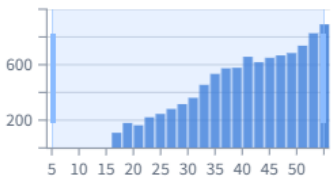
Routine 4,503

Urgent 2,673

Suspected Cancer 2,571

Rapid Access 3

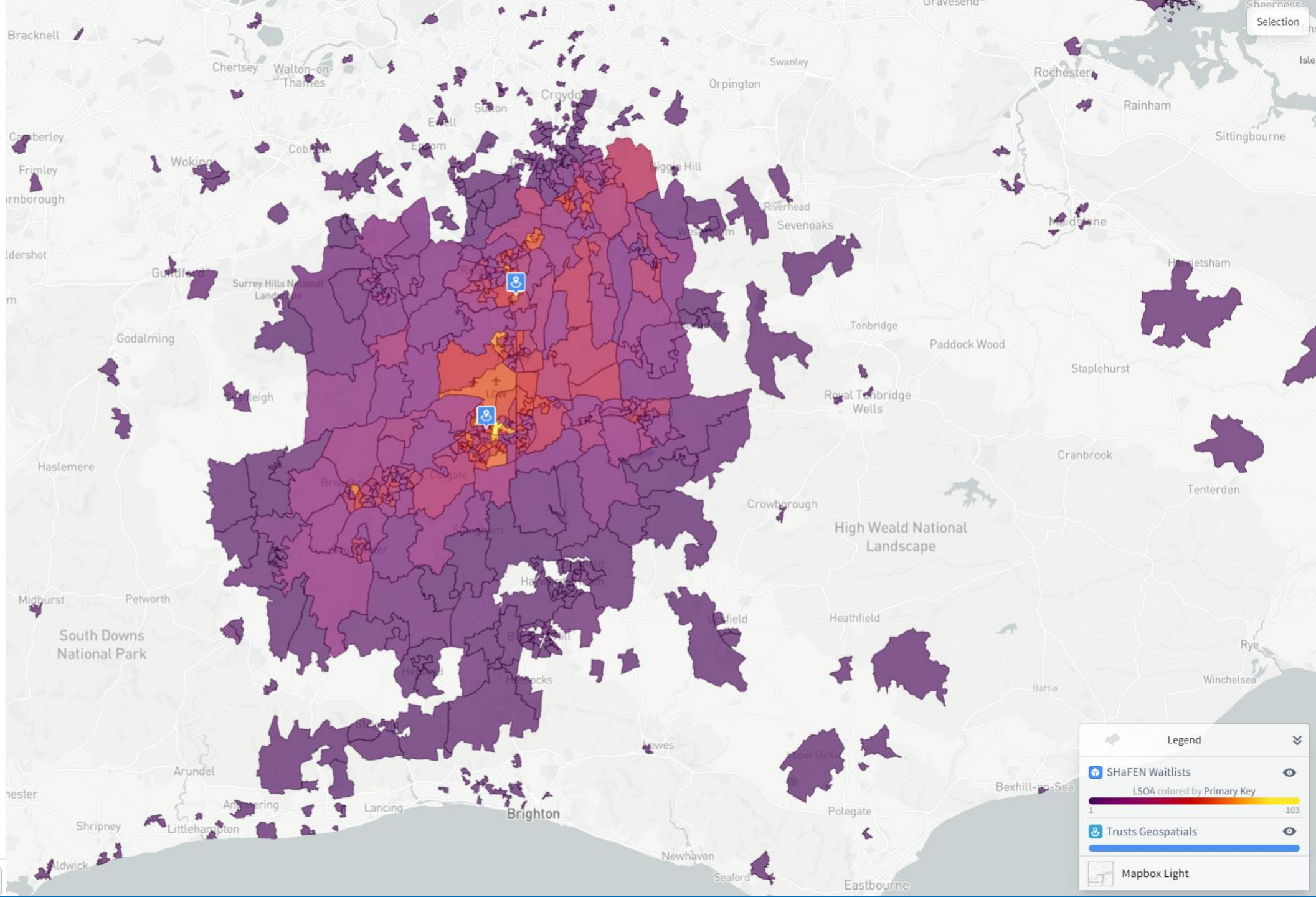
AGE



Min value: 55

SEX

Add filter



Legend

- SHaFEN Waitlists
- LSOA colored by Primary Key
- Trusts Geospatials
- Mapbox Light

Filters

TRUST NAME
 SASH 2,588

WAITING LIST START TIME
 Jan Jul Jan Jul Jan Jul Jan
 2023 2024 2025 2026
 Start date End date

PROCEDURE DESCRIPTION
 OGD 2,588

WEEKS WAITING

 Min value Max value

URGENCY
 Suspected Cancer 2,588

AGE

 Min value 55

SEX
 Female 1,518
 Male 1,068
 Unspecified 2

Add filter

Patients with duplicate procedures in 3 years

Clicking on a number will take you to the patient details

GENERAL M...	Practice Name	OGD Patients	Total Patients
H8		2	2
H8		1	1
H8		1	1
H8		1	1
H8		1	1
H8		1	1
Total		7	7

Small number suppression

Active Waitlist Only? All Patients

Summary



Surrey Heartlands Trust
Provider Collaborative

- **Co-designed, built and owned by SHaFEN**
- **Delivered strategic benefit – FIT@80**
- **Delivered financial benefit- reduced Sunday working (£267k/year)**

- **BAU tool**



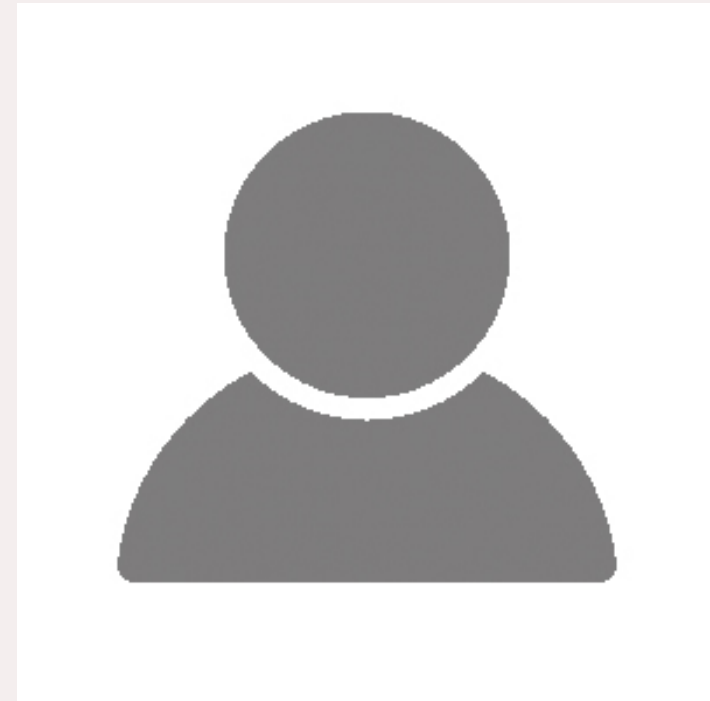
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Keynote Presentation



Paresh Sankhe
Senior Clinical Fellow, Urology
Southmead Hospital, North Bristol Trust



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Skill Clinic



Sara Brogden

Lead Clinical Endoscopist / GI Nurse Specialist
University College London



Dr Roland Valori

Consultant Gastroenterologist
Gloucestershire Hospitals NHS FT



David Turnbull

Consultant Anaesthetics and Critical Care
Sheffield Teaching Hospitals Trust