



Cancer Research UK's response to the Health, Social Care and Sport Committee inquiry into endoscopy services in Wales

Cancer Research UK (CRUK) welcomes the opportunity to respond to this consultation. Cancer survival in Wales lags behind international comparisonsⁱ: to achieve better survival outcomes for patients more patients must be diagnosed at an early stage. Achieving earlier diagnosis will involve conducting more diagnostic testing. Drivers for more testing include a growing and ageing population, efforts to achieve earlier diagnosis through symptom awareness campaigns, a lower referral threshold of risk for GPs to refer people with symptoms, and improvements to screening programmes.

Bowel cancer is the fourth most common cancer in Wales - around 900 people die every year from the diseaseⁱⁱ. Diagnosing bowel cancer at stage I means more than 9 in 10 people survive their diagnosis for five or more years. But diagnosed at stage IV, fewer than 1 in 10 people survive their bowel cancer for five or more years. The NHS Wales Bowel Cancer Screening Programme is one of the best ways to detect bowel cancer early, when it is easier to treat successfully. Yet, currently only around 1 in 10 bowel cancers are detected via this route. We want to see this increase so that fewer people die from bowel cancer.

Key points

- Diagnostic capacity in endoscopy services has been the main factor when determining the threshold for FIT and may impact national roll-out.
- Optimisation of the bowel cancer screening programme is solely dependent on having available capacity in endoscopy services.
- There are other interventions and innovations which can be adopted to improve earlier diagnosis of bowel cancer. FIT can assist in the triage of patients presenting with symptoms that suggest both a high or low risk of bowel cancer, which could reduce the number of patients referred onto colonoscopy.
- Diagnostic services are already struggling to deliver tests and the data on diagnostic staffing pressures is limited, which makes it difficult to make well-informed decisions about current and future workforce planning.
- We would like the Welsh Government to take a more strategic approach to workforce planning to address long-term shortages in the diagnostic workforce. The Welsh Government must conduct and publish a full review of the cancer workforce in Wales and make the necessary investment to pay for the training and employment of more staff based on clinical need and best practice.

Bowel Cancer Screening Programme

The UK National Screening Committee (UKNSC) made the recommendation in 2015 that the Faecal Immunochemical Test (FIT) should replace the guaiac faecal occult blood test (gFOBt) in the Bowel Cancer Screening Programme (BCSP) across the UK as FIT can be used as a more sensitive test. With the introduction of FIT there is significant potential for the BCSP to be more effective at diagnosing more cancers and detecting pre-cancerous adenomas. Previous pilots of FIT have shown a marked increase in uptake of around 7% and Scotland has seen a 10% increase since the introduction of FITⁱⁱⁱ especially in harder to engage groups such as men and people with low socio-economic status^{iv}.

It is evident the diagnostic capacity in endoscopy services has been the main factor when determining the threshold of FIT. While the threshold must be pragmatic and deliverable, it is disappointing that the most optimal screening programme is being determined by current endoscopy capacity. Our understanding is FIT is due to be introduced in January 2019 through phased roll-out at a threshold of 150 µg/g, with national roll-out commencing in June 2019. We are concerned that national roll-out may not be achieved in June due to the current lack of capacity in endoscopy services. We would like to see a more centralised approach taken by the Welsh Government to improve capacity in endoscopy services to manage the increased sensitivity of the bowel screening test as well as the potential increase in uptake with the introduction of FIT.

Public awareness campaigns can help improve uptake by raising awareness of screening programmes. Earlier this year CRUK ran a Be Clear on Cancer campaign in Wales which aimed to increase participation in the BCSP by raising awareness of the programme and reducing barriers to participation. Full evaluation is still ongoing, but Bowel Screening Wales has reported to CRUK an increase in returned kits during the campaign period. Once the results of the campaign are published we would recommend that these are considered when developing future campaigns. We would also like to see public awareness campaigns to be continually funded, and with the aim of 75% of all eligible participants choosing to take part in bowel cancer screening annually.

We welcome the recent commitment to lower the screening age to 50 years old as this will ensure that Wales's screening programme mirrors the NSC recommendation and depending on the threshold could detect more cancers earlier. This change to the programme is straight-forward logistically for Bowel Screening Wales and will therefore be solely dependent on having available capacity in endoscopy services.

We understand that the BCSP will screen from 50, every two years at a more sensitive threshold by early 2023. Achieving this will require 15,000 additional colonoscopies being required every year. While we welcome the plan to lower the age range and reduce the threshold by early 2023, the current proposal would only match the bowel screening programme as it was in Scotland in 2017. We would like the Welsh Government to be more ambitious in reducing the threshold - the UK NSC recommends a threshold of 20 µg/g which is considered the optimal threshold for public health benefit. To achieve this will require significant investment from the Welsh Government to train and employ more diagnostic staff to guarantee that services can cope with this increase in demand.

Workforce planning

Diagnostic services are already struggling to deliver tests; in August 2018, 181 people were waiting over 24 weeks for a diagnostic endoscopic test^v. This pressure is also highlighted by poor performance against the 62-day cancer waiting time target, which has been missed since June 2008, and the difficulties in introducing FIT in bowel screening, outlined above.

The data on diagnostic staffing pressures is limited, which makes it difficult to make well-informed decisions about current and future workforce planning. While we recognise streamlining pathways will go some way in supporting diagnostic capacity, these will not overcome the shortfall in key professional groups interpreting and delivering tests in Wales. For example, there are currently not enough trained staff to fill current posts, as shown by high levels of vacancies and outsourcing.

Workforce planning to date has been based on poor data, and providers stating what they can afford rather than need to deliver clinical best practice. It is also difficult for the service to foresee innovation which may change workforce needs. The establishment of Health Education and

Improvement Wales (HEIW) represents an opportunity for a more strategic approach to workforce planning in Wales but the new organisation must take a bold and strategic outlook on the diagnostic workforce.

To address immediate shortages in endoscopy, HEIW should look at ways to better use existing staff including developing a non-medical endoscopy accelerated training programme, making sure they are trained to perform colonoscopies. This should be alongside increasing training places for clinicians who perform endoscopies to ensure there is sufficient capacity in the longer term. The Government and Health Boards could test new ways to incentivise diagnostic staff to train and work where shortages are most acute as well as making contracts more flexible to minimise consultants retiring early.

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Early diagnosis interventions and innovation

There are other interventions and innovations which can be adopted to improve earlier diagnosis of bowel cancer. We would recommend that Wales fully adopt the NICE recognition and referral guideline, NG12, for suspected cancer. The Cancer Delivery Plan 2016 identifies “the challenge for GPs to identify cancers that present with non-specific symptoms and a reluctance to refer onwards due to concerns about burdening stretched secondary care services”^{vi}. NG12 guidelines address this challenge by encouraging GPs to refer at a lower threshold of risk: patients should now be referred for further tests where symptoms indicate a three per cent or higher risk of cancer^{vii}. The Cancer Delivery Plan went on to highlight the importance for diagnostic services to be developed to cope with the expected increased demand.

It has also been found that people have expressed a clear preference for being referred to diagnostic tests at all risk levels, and individuals want to be tested at risk levels below those stipulated by UK guidelines.^{viii} This suggests that patients may have a greater appetite for testing than currently guidelines stipulate.

Estimates of the impact of these guidelines on endoscopy activity were contained in a NICE costing report^{ix} that was published alongside the draft guidelines. (Note that these figures were not updated when the final guidelines were published). This model suggested that the change in referral criteria and thresholds would result in an increase of between 5% and 15% of referrals for lower GI endoscopies. Furthermore, they assumed that 85% of lower GI referrals would result in an endoscopy. HEIW must ensure that there is sufficient capacity in the endoscopy workforce to support these increased rates of referral.

FIT can assist in the triage of patients presenting with symptoms that suggest both a high or low risk of bowel cancer, which could reduce the number of patients referred onto colonoscopy. But there are still unanswered questions of how the implementation of FIT in symptomatic patients will work in primary care. There needs to be careful consideration of the logistics, and communication to patients, especially considering the same test is used. Furthermore, some local health boards are considering ways to introduce FIT for symptomatic patients to relieve some capacity in their

diagnostic services. However, to maximise effectiveness, and reduced variation and duplication, we would recommend that an all-Wales approach is explored as a priority.

The implementation of FIT in symptomatic patients requires careful consideration of the logistics and changes in ways of working as it will require a multidisciplinary approach, providing opportunities for professionals in the laboratory medicine to be involved. To date, reporting of results are normally done using µg Hb/g faeces units and with knowledge of the limit of detection and limit of quantitation of the analytical system used. However, a small number of cases will be missed^x, and robust safety netting procedures are required to follow up FIT-negative patients. There should be clear guidance on safety netting approaches to limit the potential for variation in practice.

About us

Cancer Research UK is the world's largest independent cancer charity dedicated to saving lives through research. We support research into all aspects of cancer and this is achieved through the work of over 4,000 scientists, doctors and nurses. In 2017/18, we spent £423 million on research institutes, hospitals and universities across the UK with over £4m on research in Wales.

For more information please contact [REDACTED]

ⁱ International Cancer Benchmarking Partnership, Survival benchmark 1995-2007.

https://www.cancerresearchuk.org/health-professional/data-and-statistics/international-cancer-benchmarking-partnership-icbp/icbp-findings#ICBP_findings0

ⁱⁱ Bowel Cancer (C18-C20), Number of Deaths, Crude and European Age-Standardised (AS) Mortality Rates per 100,000 Population, UK, 2016 <https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/bowel-cancer/mortality#heading-Zero>

ⁱⁱⁱ UK National Screening Committee minutes June 2018 <https://www.gov.uk/government/groups/uk-national-screening-committee-uk-nsc#meetings>

^{iv} Westwood, M et al (2017). Faecal immunochemical tests (FIT) can help to rule out colorectal cancer in patients presenting in primary care with lower abdominal symptoms: a systematic review conducted to inform new NICE DG30 diagnostic guidance. *BMC Medicine*, [online] 15(1). Available at: <https://www.ncbi.nlm.nih.gov/pubmed/29061126>

^v Stats Wales, Diagnostic Endoscopy services <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Diagnostic-and-Therapy-Services/waitingtimes-by-month>

^{vi} NHS Wales, Cancer Delivery Plan for the NHS to 2020. <https://gov.wales/docs/dhss/publications/161114cancerplanen.pdf>

^{vii} NICE NG 12 suspected cancer recognition and referral guidelines: <http://www.nice.org.uk/guidance/NG12/>

^{viii} <http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045%2813%2970588-6/abstract>

^{ix} <http://www.nice.org.uk/guidance/NG12/documents/suspected-cancer-update-costing-report2>

^x Westwood, M. et al. Faecal immunochemical tests (FIT) can help to rule out colorectal cancer in patients presenting in primary care with lower abdominal symptoms: a systematic review conducted to inform new NICE DG30 diagnostic guidance (2017). *BMC Medicine*, [online] 15(1). Available at: <https://www.ncbi.nlm.nih.gov/pubmed/29061126>