Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Ymchwiliad i wasanaethau Endosgopi
HSCS(5) E06
Ymateb gan Tenovus Cancer Care

National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Endoscopy Services
Evidence from Tenovus Cancer Care

## Endoscopy Services, November 2018

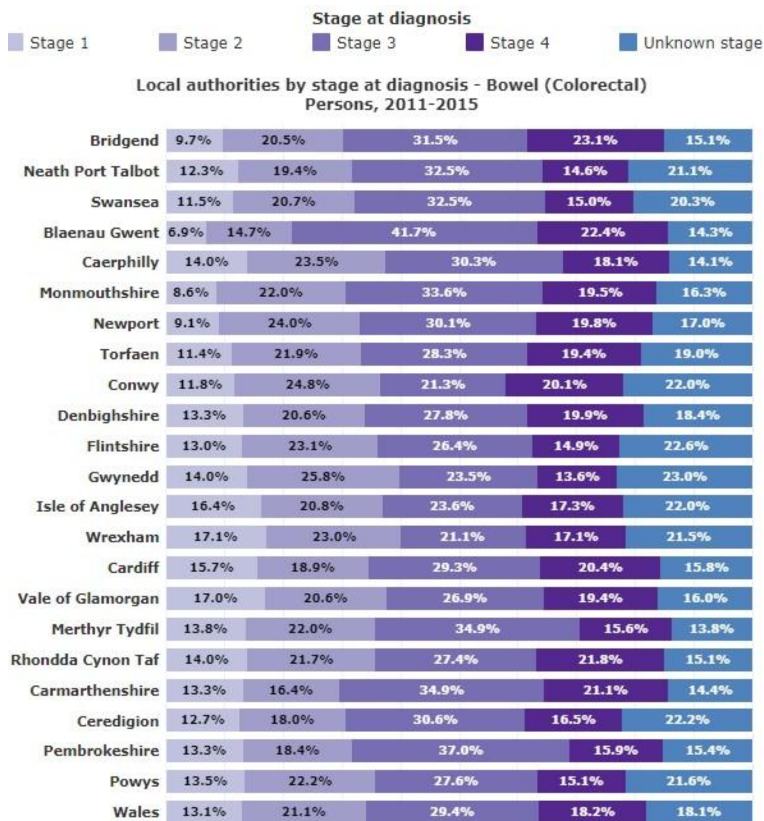
Tenovus Cancer Care is Wales' leading cancer charity. Our aims are simple. We want to help prevent, treat and find a cure for cancer.

We do this by offering support, advice and treatment to cancer patients and their loved ones. We also promote healthy lifestyles and fund cancer research to find new ways to prevent it, diagnose it, and treat it.

We welcome the opportunity to respond to this important consultation.

**Earlier diagnosis, specifically the introduction of the Faecal Immunochemical Test (FIT) into the bowel screening programme and the recently announced change to age range.**

Tenovus Cancer Care agrees that earlier diagnosis is absolutely essential in the fight against cancer. However diagnosis varies significantly throughout Wales, with Cardiff and Vale UHB having the highest (16.2%) and Aneurin Bevan UHB the lowest (10.6%) rates of Stage 1 colorectal cancer (CRC) at diagnosis, while Cwm Taf UHB experiences the highest incidence of Stage 4 CRC (20.6%) compared to just 15.1% in Powys THB. Broken down to Local Authorities, the differences are more pronounced (see below):




Population screening is one of the key tools in detecting bowel cancer earlier in Wales. Screening currently starts at the age of 60 years old for men and women and takes place every two years until the age of 74. Staging data is not available in Wales. However, in England, just over 37% of cancers diagnosed through screening are detected at the earliest stage, compared to just 6% of those diagnosed as an emergency (Bowel Cancer UK, 2018).

However screening uptake is historically low in Wales, with an average uptake of around 54% (Public Health Wales, 2017, p. 8). Therefore Tenovus Cancer Care, a member of both the FIT Project Board and the Communications group, fully supports the implementation of FIT testing, including to the intent to lower the age of commencement of screening to 50 years of age for both sexes. Both initiatives are widely expected to increase uptake rates and provide a more positive patient user-experience.

FIT is more accurate and cheaper than the current guaiac faecal occult blood test (gFOBT) for QualityAdjusted Life Years (QALYs) (Murphy, et al., 2017, p. 4) - with £25 per person saved at 180 μg Hb/g faeces threshold, rising to £62 per person at 20 μg Hb/g faeces threshold. That is, screening with FIT results in greater total QALYs and lower costs than gFOBT (Murphy, et al., 2017).

**Diagnostic service capacity and waiting times, including the extent to which capacity constraints are driving the recommendation to set the FIT threshold for its introduction to the bowel screening programme at a relatively insensitive level.**

Studies show that overall, “the total cost over 40 years is predicted to be lower for FIT at any threshold than for gFOBT, and this difference increases as the FIT threshold is decreased” (Murphy, et al., 2017, p. 7).

Tenovus Cancer Care accepts that there would be a risk of diagnosis capacity collapsing under the weight of demand were the FIT threshold reduced to the point at which risk is functionally eliminated. Tenovus Cancer Care believes that in the interest of public health and of the well-being of our clients this must ultimately be the long term aim of the NHS in Wales and urges the Welsh

Government to use this improved cost-efficiency to urgently move down the FIT threshold.

The earlier bowel cancer is diagnosed the more likely you are to survive beyond 5 years. If you are diagnosed with bowel cancer at stage 1, you have a 95-100% chance of surviving 5 years.[1] If you're diagnosed at stage 4, your chances of survival at 5 years are only 5-10%. In Wales only 44% of people will have their bowel cancer diagnosed at stage 1 or stage 2. 48% will be diagnosed at Stage 3 or Stage 4.[2]

Tenovus Cancer Care views the FIT regime as a vital tool in increasing the diagnostic capacity for bowel cancer, thus improving patient outcomes. However this, combined with a reduction in the FIT sensitivity threshold, must be matched in ambition by an increase in diagnostic capacity in order to reduce the waiting time between screening and endoscopy.

On waiting times, we echo the view of Bowel Cancer UK who, in their recent report stated:

> Patients in Wales follow one of two routes to treatment depending on how their cancer is found – each of these routes has a separate waiting time. The urgent suspected cancer route has a target that 95% of all confirmed cases should start treatment within 62 days. For those on the non urgent pathway, once cancer is confirmed treatment should start within 31 days. This has led to concerns that there may be delays before diagnosis for those on the non urgent pathway.
>
> The current system is complex and very confusing for patients who will have been waiting for a diagnosis and then have a further wait to start treatment. These long waits between referral, diagnosis and treatment lead to increased levels of anxiety and uncertainty for patients. This is particularly true for patients with bowel cancer, who may not present with typical symptoms and will be recorded as having started their treatment within 31 days of diagnosis. In some cases, these patients will have been potentially waiting months before this to access the diagnostic tests needed to get their cancer diagnosis in the first place.

- ***Spotlight on bowel cancer in Wales*, Bowel Cancer UK, 2018**

The gap created by diagnostic capacity shortfalls between screening and endoscopy creates unacceptably high levels of anxiety among patients, while delaying the start of potentially life-saving treatment. This is set to be exacerbated by the, otherwise incredibly welcome, introduction of FIT. However capacity issues extend beyond the initial diagnostic episode. There is evidence that patients, as a result of having had one or more polyps, are now having their follow-up surveillance endoscopies delayed. This will result in more interval cancers, and could cost lives which should be of concern to all.

**The long term and sustainable solutions to the challenges that exist within endoscopy services in Wales, including how data on diagnostic staffing pressures is being used to inform decisions about current and future workforce planning.**

It is clear to all in the sector that there is a significant capacity issue at the heart of endoscopy services in Wales. There is also evidence of the significant capacity issue within endoscopy services being partly addressed by being contracted to private-sector third parties, and performed by clinically trained but nonspecialist practitioners. This is not only unsustainable in the long run, potentially at huge additional cost to the Welsh taxpayer, but also sub-optimal with non-specialists undertaking colonoscopies potentially with reduced diagnostic outcomes for patients.

**Consideration of other early diagnosis interventions and innovation, such as the introduction of FIT testing by general practitioners in symptomatic patients to reduce referral for diagnostic tests.** New and innovative methods of increasing screening rates, reducing diagnosis waiting times and improving patient outcomes are welcome in whatever form they take. Through our *Closer to Home* programme our Mobile Support Units provide chemotherapy treatment to patients throughout the country in convenient, accessible locations that reduces their journey time, improves the patient experience and relieves capacity from an otherwise stretched NHS. We would welcome the opportunity to use this model to provide screening and diagnostic capacity, as we did with our Bowel Bus in 2015[1], particularly in harder-to-reach communities that we know are more exposed to poorer screening, and thus depressed survival rates (Public Health Wales, 2017, p. 8).

With the roll out of smarter digital patient records it should not be outside the scope of our ambition to be able to proactively identify those, particularly male, patients who have not taken up their routine FIT screening, as and when they attend ad hoc GP appointments.

**Efforts being taken to increase uptake of the bowel screening programme.**

The current level of update is unacceptably low. While it is accepted that men, in general, are a noted hard-toreach group, deprivation is a major driver of poor health outcomes and Tenovus Cancer Care believes that far more effort needs to be paid to focussing attention on more deprived communities. Particular focus should be paid to those identified as experiencing multiple deprivation, as defined in the Wales Index of Multiple

Deprivation (WIMD).[2] Confronting and reducing the undeniable stigma attached to bowel cancer and screening in general should be a key concern - for example

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[1] http://www.tenovuscancercare.org.uk/how-we-can-help-you/mobile-cancer-support/drop-in-bowel-clinic/

[2] https://gov.wales/statistics-and-research/welsh-index-multiple-deprivation/?lang=en

by targeting more community-focussed interventions, such as in rugby clubs and in targeting BAMER communities, including engagement with community and faith leaders.

## References

Bowel Cancer UK, 2018. *Spotlight on bowel cancer in Wales*, s.l.: s.n.

Murphy, J., Halloran, S. & Gray, A., 2017. Cost-effectiveness of the faecal immunochemical test at a range of positivity thresholds compared with the guaiac faecal occult blood test in the NHS Bowel Cancer Screening Programme in England. *BMJ Open.*

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