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Wales Cancer Network

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Senedd Cymru
Welsh Parliament
Health and Social Care Committee
Email * Ebost: SeneddHealth@senedd.wales

Dear Sir/Madam

INVITATION TO GIVE ORAL EVIDENCE TO THE COMMITTEE

Introduction

1. The Wales Cancer Network (WCN), as part of the NHS Wales Health Collaborative, is a partnership between Health Boards and Trusts, health professionals, the third sector, industry, academia and other stakeholders to develop and improve cancer services with the aim of improving cancer survival, and quality of life and experience of those living with the impact of cancer; ensuring the value, safety and sustainability of cancer services; reducing inappropriate variation in services; and encouraging and supporting innovation in service delivery. It supports Health Boards and Trusts to meet the requirements of the National Clinical Framework and associated Quality Statement for Cancer, and other national strategic plans and frameworks, and provides advice and guidance to Welsh Government on policy relating to cancer care in Wales. It is currently coordinating the writing of a refreshed Cancer Improvement Plan for Wales. The WCN will be moving into the National NHS Executive function once it is established.

2. A robust and well-functioning endoscopy service is an essential component of cancer services in Wales, and vital for the diagnosis of upper and lower gastrointestinal cancers. The WCN is therefore grateful for this opportunity to respond to the Health and Social Care Committee's (H&SCC) follow on to the 2019 inquiry into endoscopy services.

3. The previous inquiry focussed on endoscopy services for the gastrointestinal tract and both the National Endoscopy Programme (NEP) and **national endoscopy action plan**, are limited to those services. Whilst endoscopy is also essential for the pathways of other cancers (e.g. cystoscopy for bladder cancer) our evidence below relates to the services for upper and lower gastrointestinal cancers.

4. The WCN has a number of areas within its work programme that rely on or impact endoscopy services, including:

    - Bowel Cancer Initiative (BCI): focuses on improving outcomes for patients with bowel cancer. During the first year, the initiative concentrated on developing a colorectal data dashboard, improving ileostomy closure rates,

implementing FIT for symptomatic patients and Peer Reviewing colorectal cancer services. The next phase of the initiative will build on this to engage professionals and patients, and track improvements as a result of peer review actions.

- The Suspected Cancer Pathway (SCP) Programme supports Health Boards and Trusts to achieve compliance with the Welsh Government measure for cancer waiting times: 80% of patients to start their first definitive treatment within 62 days of the point of suspicion by 2026. Colorectal and oesophagogastric cancers are in the first wave of focus for improvement programmes. It has published National Optimum Pathways (NOP) for 21 cancer types, data and intelligence resources, and provides local project management for service improvement and innovation along those pathways.
- The NOP for Lower GI Cancer has been amended to include FIT as a primary care test undertaken prior to referral for suspected symptomatic bowel cancer. This has recently been approved at the Cancer Network Board in November 2022, and we shall work with the National Primary Care groups to implement.
- A rolling programme of Clinical Peer Review of cancer services. Colorectal cancer services were last reviewed in 2021, oesophagogastric in 2016.
- Rapid Diagnostic Clinic (RDC) Programme: co-ordinates the implementation of these novel clinics to quickly diagnose people with vague symptoms that may be due to cancer. Lower and Upper GI cancers are frequently diagnosed through this route.

5. These programmes work with the National Endoscopy Programme (NEP) and Bowel Screening Wales (BSW) to ensure that developments align without duplication. The WCN Clinical Director is a member of the NEP Board, and both the NEP and BSW are represented on the Cancer Network Board.

6. We will address each of the Committee's key areas of interest in turn.

The impact COVID-19 has had on delivery of endoscopy services and the implementation of the national endoscopy action plan, and the implications of this for patient outcomes and survival rates.

7. The beginning of the pandemic was a period of significant uncertainty in terms of the routes and risk of transmission. Endoscopy (both colon and upper gastro-intestinal) was identified as a high-risk Aerosol Generating Procedure (AGP) early in the pandemic. British Society of Gastroenterologists (BSG) guidance was rapidly produced in March 2020 advising that all non-emergency endoscopic procedures should be stopped to prevent the spread of the novel coronavirus and prioritise the use of Personal Protective Equipment (PPE). The Joint Advisory Group (JAG) reported at the end of April 2020 a 95% reduction in procedures across the UK identified via their National Endoscopy Database. Bowel Screening Wales (BSW) stopped population screening completely between March and July 2020.

8. Non-emergency procedures were gradually re-introduced following the peak phase. However, changes in protocols to accommodate additional decontamination, social distancing, PPE and other factors have decreased available capacity, and together with a backlog of demand this has exacerbated the pressure on a service that already had significant challenges, as evidenced in the 2019 inquiry.

9. In October 2020, the NEP amended the National Endoscopy Action Plan, recognising the impact that the pandemic had already had at that point. Further details will be available from the National Endoscopy Programme.

10. The Cancer Peer Review Programme reviewed colorectal Multi Disciplinary Teams (MDTs) in Wales in 2021, and identified that waiting times for endoscopy, particularly if referred via the Bowel Cancer Screening service, were of concern across Wales.

11. Cancer waiting times are now the worst they have ever been, with only ~ 50% of patients starting their first treatment within 62 days of point of suspicion in September 2022. No Health Board in Wales has met the target of 75% since July 2020. The data for upper gastrointestinal cancers is similar to the all-cancers average, however, for lower GI only 35.1% received their first definitive treatment within 62 days.

	Betsi Cadwaladr	Hywel Dda	Aneurin Bevan	Cardiff & Vale	Cwm Taf Morgannwg	Swansea Bay
Upper GI	69	47.1	57.1	33.3	57.7	57.9
Lower GI	40.4	35.5	25	19	41.9	43.5

Table 1 The percentage of patients starting their first definitive treatment in the month within 62 days of first being suspected of cancer (no suspensions) for Upper and Lower GI by Health Board, September 2022 Data source

12. For Health Boards to achieve the SCP measure, most people should be informed of their diagnosis approximately 31 days following the point of suspicion. Colorectal cancers have some of the longest delays in the interval between point of suspicion to the patient being informed they have a diagnosis of cancer, with a median of 50 days, an increase of 18 days since September 2021 (the all-cancer median is 34). This varies by Health Board between 26 and 69 days. Whilst this delay will not all be due to waits for endoscopy, a functioning, effective endoscopy service is critical to the timely diagnosis and treatment of colorectal cancer.

13. The latest published data for colonoscopy (for all reasons) reports that 58% carried out in September had waited more than 8 weeks, with 46% waiting more than 14 weeks. Waits appear to vary significantly by Health Board. The WCN is working with Health Boards and partners to understand the endoscopy waiting times experienced by patients on the Single Cancer Pathway.

14. A delayed cancer diagnosis results in worse outcomes for patients, in terms of available choices in treatments, inability to receive treatment with a potentially curative intent, quality of life following diagnosis, and survival. Quantifying this however is complex, particularly in the context of a pandemic exhibiting higher mortality rates for people in categories that are at increased risk for poorer cancer outcomes (e.g., increased age, lower socio-economic status, co-morbidities), and in a very dynamic situation that affected not only most healthcare systems but also the non-healthcare factors that influence outcomes for people with cancer.

15. Stage at diagnosis is often used as a proxy or early indicator of cancer survival: a shift in stage to a higher proportion of people diagnosed at a later stage could predict poorer survival and other outcomes.

16. A report of colorectal cancers in Cardiff diagnosed during 2020 evidenced a decrease in diagnostic colonoscopy and radiological imaging performed between March and June 2020 compared with previous years. More patients presented as emergencies with increased rates of large bowel obstruction, and more T4 cancers were diagnosed in 2020 (versus 2018-2019). Emergency diagnosis is associated with advanced cancer stage and poorer survival, even after controlling for stage.

17. Analysis of NHS Wales data by the DATA-CAN Cancer Collaboration Cymru (DATA-CAN CCC) research group, published in August 2022 reports a decrease in cases of colorectal cancer diagnosed in 2020 compared to 2019 (−23.7% in females and −12.1% in males) spread evenly across stages 1-4, however the substantial increase in colorectal cancers with stage unknown recorded in 2020, compared to 2019 (up 803.6% to approx. 12.5% of records) make comparison difficult and this does not preclude a stage shift nationally.

18. We have to date not seen any data identifying a migration in stage at diagnosis for patients with upper GI cancers in Wales.

19. Disentangling the impact of changes in any specific service within that whole landscape beyond a broad statement is outside the scope of the WCN. It is very probable however that the impact of the pandemic on endoscopy services will lead to poorer outcomes over the short to medium term for patients diagnosed with upper and lower GI cancers.

The priority given to endoscopy services in the Welsh Government's programme for transforming and modernising planned care, including who is responsible for delivering improvements through the reconfiguration of services and new models of care (including additional endoscopy theatres, diagnostic centres and regional units), and how endoscopy services will feature in the new cancer action plan (expected to be published autumn 2022).

20. Welsh Government's programme for transforming and modernising planned care, specifically references endoscopy in 3 places:

    - Formation of a diagnostics board which will "have delegated authority from the NHS Wales Leadership Board to provide direction on all diagnostics related matters including service models and allocation of available resources" and "use input from national programmes such as … Endoscopy [to] agree a holistic diagnostics approach for Wales."
    - An expectation that health boards "plan services regionally for those high volume, low complexity interventions such as … endoscopy …, where it is not possible to meet demand with minor and localised uplifts in capacity"
    - Reference to allocation of £170m of recurrent funding announced in October 2021 to support planned care recovery plans, and stating this investment would enable amongst other pressures, implementation of the recommendations of the National Endoscopy Programme.

21. The Minister for Health and Social Services approved the NEP recommendations in writing to Health Boards in October 2021, including

- Adoption of productivity and efficiency measures recommended by the National Endoscopy Programme that will enable the maximum output from existing capacity and the risk-based management of the patient population.
- Health Board initiated additional activity, delivered in the form of waiting list initiatives, insourcing, and outsourcing; including short term rental of staffed mobile units.
- Consideration of Health Board-initiated business cases for additional, permanent endoscopy theatres on the existing NHS estate.
- Procurement of managed service contracts to deliver any deficit in endoscopy theatre capacity, to be delivered in regional units.

22. The Cancer Improvement Plan for Wales (Cancer Action Plan) is due to be published in December 2022 and collates the agreed national and local actions towards achieving the ambitions of Welsh Government's Quality Statement for Cancer. We are confident that the plan adequately covers endoscopy, recognising that it has its own improvement plan, and we have worked with the NEP to align. Actions to improve access to, and efficiency of, endoscopy feature predominantly within the sections "Elective Care Recovery", "Faster Diagnosis" and "Compliance with the Single Cancer Pathway and National Optimal Pathways". In addition to specifics re endoscopy, the plan covers processes that will influence the effectiveness of timely endoscopy, such as Straight to Test and risk triage, and that ensures endoscopy fits into the flow of an effective, efficient pathway. Health Optimisation/prehabilitation is featured, emphasising that this should start at the point of suspicion, and contains actions to integrated models of prehabilitation being embedded as standard into cancer pathways to improve outcomes as per the "Waiting Well? The impact of the waiting times backlog on people in Wales" Senedd Health and Social Care Committee report.

23. The National Diagnostics Board, as per the programme for transforming and modernising planned care**,** is overseeing the development of community diagnostic hubs/centres (also termed Regional Diagnostic Centres/Hubs), and undertakes to establish two centres this year, however, with the most advanced plans looking to implement in Q3/4 of 2023/24, it is unlikely this will be fulfilled in the current financial year. It is unclear whether endoscopy services will be included or co-located within this development, taken forward separately by the NEP, or driven individually by Health Boards. There are advantages for cancer diagnostics if they are co-located with other diagnostics regionally.

24. There has been some variation over time between a WG directive approach and a HB delivered approach and there is now a need for a clear national strategy albeit locally and regionally delivered.

Issues relating to recovering and improving waiting time performance, including: reducing waiting times for diagnostic tests and imaging to eight weeks by spring 2024 and support for people waiting for tests and follow up appointments; the active waiting list size for all current inpatient and day-case patients waiting for endoscopic procedures (by modality); the extent to which elective capacity is impacted by emergency activity, and whether there is sufficient data to understand the impact of emergency cases; whether high risk patients requiring ongoing surveillance endoscopic procedures are included in current demand and capacity planning models; the scope for upscaling lessons learned from previous waiting list initiatives such as insourcing, outsourcing or mobile units; and what the

current demand and capacity modelling tells us about when a sustainable position can realistically be achieved.

25. Endoscopy waits are a component of the SCP measure for Upper and Lower GI cancers. The National Optimum Pathways identify that for the SCP measure to be met for patients with Upper and Lower GI, endoscopies should be carried out within 7 days of the point of suspicion for colorectal cancers, and 5 days for oesophageal and gastric cancers. Some patients are also diagnosed incidentally via endoscopy, whilst not on the SCP, and therefore the timeliness of routine Referral to Treatment waits for endoscopy is also of interest.

26. Prior to the pandemic the International Cancer Benchmarking Partnership (ICBP) reported that Wales had significantly longer intervals at multiple points in the pathway for colorectal cancers compared to similar high-income countries. So much so, that Wales was used as the reference against which other jurisdictions were compared. The wait for diagnostics was particularly poor.

27. Health Board data[1] reports that demand for cancer diagnostics has been consistently higher than pre-covid levels over the last year and is increasing. Lower Gastrointestinal demand has been disproportionately high compared to other tumour sites, with an average increase across Wales of 44%. The size of this increase is not consistent across Wales, with Swansea Bay UHB experiencing more than double the usual demand.

University Health Board	Betsi Cadwaladr	Hywel Dda	Aneurin Bevan	Cardiff & Vale	Cwm Taf Morgannwg	Swansea Bay
Increase in demand for lower GI cancer over 2019 levels	40%	80%	75%	30%	30%	150%

Table 2 increasing demand for Lower GI cancer diagnostics: comparison of August 2022 data to 2019 average (number of people starting the lower GI SCP) rounded to nearest 5%.

28. Broadly cancer waiting times are increasing, largely driven by delays in the diagnostic stage, and SCP/Health Board performance data suggests significant variance across Health Boards in the diagnostics component of the pathway.

29. There are indications that the number of people recorded as actively waiting for an endoscopy on the SCP for colorectal cancer peaked in August 2022 and has been steadily reducing since, but is high compared to historic levels. Anecdotally, it appears there are variations in the waits experienced by patients living across Wales.

30. The number of endoscopies carried out for potential cancer diagnoses has increased to approximately 150% of pre-pandemic levels, indicating that endoscopies for cancer are being prioritised and activity delivered is higher than ever.

[1] Data available via the National Endoscopy Programme and Health Board Single Cancer Pathway Dashboard.

31. Health Board data highlights variation in straight to test for endoscopy across Wales, and there are opportunities to align the use of this route nationally, reducing the need for a consultant out-patients appointment before endoscopy within the SCP. This was recently prioritised by the Minister for Health and Social Services at the Cancer Summit.

32. Work is underway to improve efficiency of and access to endoscopy for cancer, e.g.: local audit and process mapping by the SCP team in SBUHB has demonstrated variation in triage and safety netting of low-quality referrals, and highlighted improvement opportunities, which have been shared nationally via the WCN Operational Managers Group. We have had exposure to data suggesting a productivity gap with sub-optimal endoscopy list utilisation. We would recommend that this becomes an area of focus for the NHS Executive once established.

33. Accelerated staging post-endoscopy is being rolled out across UHBs using a co-production approach between endoscopy and radiology services within units.

34. A project is underway looking at the triage / vetting component of patient pathways following referrals from GP (including endoscopy).

35. The Cancer Implementation plan, contains a number of locally specific actions identified by Health Boards to address issues with endoscopy within the SCP, these include:

- Maximising the potential of 1 stop scope to CT pathway for colorectal cancers.
- Maximising additional capacity through mobile endoscopy unit.
- Reviewing all first outpatient referrals weekly to establish which can be converted straight to FIT and Endoscopy.
- Trialling RDC approach for some tumour sites.
- Research and implement new diagnostic techniques including Cytosponge and Transnasal Endoscopy.

36. We are not aware of any prehabilitation or specific support packages for patients' pre-endoscopy for suspected cancer. The WCN has partnered with the Bevan Commission to support innovative improvement projects at the beginning of the SCP. One of these projects, being developed by 2 Health Boards in collaboration, is assessing digital prehab resources, aiming to report at the beginning of the next financial year.

37. There are various opportunities to implement innovations which could decrease demand on endoscopy for cancer or mitigate the risk for patients experiencing longer waits for endoscopy. Examples are summarised in the table below.

Innovation	Description	Potential benefits
Colon Capsule endoscopy (CCE)	A minimally invasive procedure, where a patient swallows a pill containing two tiny cameras to examine the large bowel (colon).	Can help to reduce the need for optical colonoscopy. The British Society of Gastroenterology (BSG) reports that evidence to date, indicates that procedure-related distress (discomfort and embarrassment) is less with CCE than colonoscopy and has a similar

		diagnostic sensitivity to colonoscopy in clinical trials.
Transnasal endoscopy (TNE)	An upper gastrointestinal (GI) endoscopy method performed via the nose instead of the traditional method through the mouth, using a thinner endoscope.	Better patient outcomes - as the procedure is less invasive it is therefore more comfortable. Improved efficiency - TNE can take less time and fewer resources, thus enabling more patients to be seen overall and can therefore contribute to reducing the growing backlog facing endoscopy services.
Cytosponge™	The Cytosponge™ cell collection device can be described simplistically as a "sponge on a string": a minimally invasive, non-endoscopic system that has been developed to allow the sampling of cells lining the oesophagus.	Can reduce the burden on secondary care endoscopy services for example by being used to risk stratify those patients on endoscopy waiting lists.

Table 3 description of potentially beneficial innovations/technologies

38. Colon Capsule is currently being taken forward via a partnership between the Bevan Commission and the NEP.

39. WCN is exploring working with partners including the Life Sciences Hub Wales and Welsh Association of Gastroenterology and Endoscopy (WAGE) to support Health Boards to roll out TNE across Wales, following successful implementation in C&VUHB. Cytosponge is being piloted in BCUHB, with interest in other regions including Powys. WCN is helping to support Health Boards in the assessment of outstanding clinical queries re its routine use, and in discussions regarding Wales participating in a trial of Cytosponge use in primary care.

What barriers there are to achieving accreditation from the Joint Advisory Group on GI Endoscopy, including whether Health Boards are investing sufficient resource in developing the facilities and infrastructure for endoscopy services, decontamination services, and the progress that has been made in expanding the endoscopy workforce.

40. The 2019 H&SCC Inquiry into Endoscopy Services recommended that all endoscopy units in Wales aim to achieve Joint Advisory Group (JAG) on GI Endoscopy accreditation in the future, ensuring that endoscopy services are being delivered in line with best clinical practice. This was incorporated in the **national endoscopy action plan** as a phased approach to support those units that were ready to apply by end of March 2023. Further details will be available from the National Endoscopy Programme.

41. To date, only three (3) NHS endoscopy units, of 20 in Wales registered with JAG, have achieved accreditation: Glangwili General Hospital, Withybush Hospital and Brecon War Memorial Hospital. This compares unfavourably with 111 of 221 in

England. On latest published data, none of the NHS units in Scotland and Northern Ireland have completed an accreditation assessment.

42. It is considered that the extended waiting times for endoscopy currently experienced by patients in Wales is a major barrier to achieving accreditation in many units across and therefore overcoming the issues highlighted above with respect to achieving waiting times are also applicable in this context.

The current position for optimising the bowel cancer screening programme (i.e. for increasing Faecal-Immunochemical Testing (FIT) sensitivity and age testing) and how this compares to other parts of the UK.

43. The National Screening Committee recommends that screening for bowel cancer should be offered every 2 years to men and women between the ages of 50 and 74 in the UK using the faecal-immunochemical test (FIT). Currently Wales offers screening to people aged between 55 and 74.

44. The current threshold for a "positive" FIT screening result in Wales is 150µg/g. This is the same as Northern Ireland, however in Scotland, the threshold of FIT is 80µg/g, and in England, 120 µg/g.

45. Wales is halfway through an expansion programme that in the next 2 years will see the following implemented:

    - Year 3 - age expansion (invite 52- to 54-year-olds) and FIT positivity threshold reduction from 150ug/g to 120ug/g.
    - Year 4 - age expansion (invite 50- & 51-year-olds) and FIT positivity threshold reduction from 120ug/g to 80ug/g.

46. Peer review of colorectal cancer services throughout Wales in 2021 highlighted that Bowel Screening Wales (BSW) waits were of particular concern. Significant variation between Health Boards was reported for the average waits to endoscopy following a positive screening FIT, from 7 weeks (C&VUHB) to 27 weeks (BCUHB). In all Health Boards this was categorised as a Peer Review "Concern" requiring action: all the average waits reported would be outside the timeframe required to achieve the SCP measure of 62 days to treatment from point of suspicion.

47. Action plans were received from Health Boards in response to this concern and Health Boards are responsible through their Quality and Safety arrangements for tracking and delivery of Peer Review actions.

48. Bowel Screening Wales reports that currently waiting times for screening endoscopies are around 10-12 weeks across Wales, an improvement, but still outside the timeframe necessary for the SCP measure

49. The national colorectal peer review summary emphasised that Health Boards should consider these cases as SCP cancer waiting times from the point of suspicion, at positive bowel screening FIT test, as defined in the colorectal cancer NOP and the Bowel Cancer Initiative advocates the alignment of processes and timescales for symptomatic and screening at point of suspicion entering Single Cancer Pathway following a positive FIT result.

50. A significant proportion of the endoscopy practitioners were accredited by BSW for screening endoscopies at the initiation of the bowel screening programme and are of a similar age. Workforce planning will need to take this into account before this cohort nears normal retirement age.

The experiences of younger people and those most at risk of developing bowel cancer (i.e. those living with Lynch syndrome) and efforts to diagnose more patients at an early stage.

51. The WCN partners worked with Macmillan to undertake the periodic Wales Macmillan Cancer Patient Experience Survey (WMCPES). The most recent of these was carried out recently and is due for publication in the new year. Whilst this survey does not ask a question specifically about endoscopy, a number of respondents referred to their experience with endoscopy in their commentary. This is currently under embargo until publication, but we should be able to share themes at the oral evidence session.

52. We are aware that Moondance have commissioned work to understand the experiences of people in Wales who have been diagnosed with Bowel Cancer, and will be taking this into account in the future work-plans for colorectal cancer once this has been published.

53. Detecting and diagnosing cancer at an earlier stage is a priority for the Welsh Government and the NHS in Wales as reflected in the Quality Statement for Cancer requirement that “more cases of cancer are detected at earlier, more treatable stages through more timely access to diagnostic investigations”.

54. The Cancer Improvement Plan for Wales, which will be published in December 2022 section on earlier diagnosis, outlines national and local actions to support this quality statement. Improving the uptake of screening, streamlining pathways, tackling inequity for underserved groups, implementation of innovations in primary and secondary care all have their role to play.

55. For Gastro-intestinal cancers, improving the uptake of Bowel screening, along with the expansion of the programme, is critical to earlier diagnosis, as is decreasing the waits for screening endoscopy.

56. Innovations such as the Rapid Diagnostic Clinics, FIT in primary care, primary care cancer education programmes (e.g. Gateway C), trans-nasal endoscopy, colon capsule and cytosponge are being implemented or piloted in Wales.

57. The Suspected cancer pathway: guidelines (WHC/2022/18) emphasises that patients should be informed when they are referred via the SCP that cancer is a possible, albeit very low probability, diagnosis. A patient leaflet has been developed with Cancer Research UK that is currently being evaluated and should be available nationally in the near future to support primary care with this.

58. Additionally, we would encourage initiatives that ensure patients are informed of the outcomes of referral vetting (up or down-grading) by secondary care, to help with safety netting.

Primary care access across different Health Boards to FIT for patients who do not meet the criteria for a suspected cancer pathway referral and how it is being used

to help services prioritise patients and stratify referrals by risk (outpatient transformation).

59. With partners, the BCI was able to drive through the adoption of FIT during the pandemic to help prioritise symptomatic patients, which is helping to mitigate risk.

60. The Association of Coloproctology of Great Britain and Ireland (ACPGBI) and British Society of Gastroenterology (BSG)[2] have provided joint national guidelines that support embedding FIT in primary care to help inform the need and priority of referral for people with suspected lower GI cancer.

61. SCP project managers are helping to support roll out in Health Boards where it is not uniformly accessible across primary care (e.g. HDUHB). Hywel Dda is the final Health Board in Wales to implement, and are planning to do so by January 2023.

62. The SCP team have also undertaken a review of data within some Health Boards to support improvement opportunities. SCP and BCI/colorectal Cancer Site Groups (CSG) have collaboratively developed national FIT guidance based upon ACPGBI/BSG guidelines including point of suspicion and a FIT micro-pathway as part of an updated Colorectal NOP. This has included engagement with broad range of stakeholders including the GPC. SCP team is working with the Delivery Unit (DU) to evaluate FIT demand and opportunities to further refine existing pathways and variance across UHB's. A number of bids for funding have been developed to support the primary care aspects of this work.

63. NHS England is expanding direct access to diagnostic scans across all GP practices, helping cut waiting times and speeding up a cancer diagnosis or all-clear for patients. Wales could move towards this to compliment the recent roll-out of RDCs and implementation of the SCP.

We hope that a renew of the Cancer Network engagement / influence in the work around endoscopy is useful to the inquiry.

If you require any further information, please do not hesitate to contact the above mentioned.

Yours sincerely

Claire Birchall
Network Manager
Wales Cancer Network

Copy to: Wales Cancer Network Board

[2] Faecal immunochemical testing (FIT) in patients with signs or symptoms of suspected colorectal cancer (CRC): a joint guideline from the Association of Coloproctology of Great Britain and Ireland (ACPGBI) and the British Society of Gastroenterology (BSG) - The British Society of Gastroenterology available at: https://www.bsg.org.uk/clinical-resource/faecal-immunochemical-testing-fit-in-patients-with-signs-or-symptoms-of-suspected-colorectal-cancer-crc-a-joint-guideline-from-the-acpgbi-and-the-bsg/