Q-bital
Healthcare Solutions

THE IMPENDING BOWEL CANCER CRISIS

Ensuring bowel cancer doesn't become the forgotten 'C' in the long shadow of COVID-19.

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FOREWORD

Julien Wiggins, CEO Bowel Cancer Australia

Recognised for its contribution to the third sector in a meaningful and impactful way that produces measurable benefits, Bowel Cancer Australia has been creating positive change across the continuum of bowel cancer care for over 20 years.

We are committed to championing what matters most to people affected by bowel cancer and determined to have an everlasting impact where no Australian dies from bowel cancer and all those diagnosed receive the support they need.

Over the past two decades, bowel cancer incidence rates have decreased more than any other cancer, but these improvements are now at risk. Measures taken by governments to mitigate the spread of the virus and limit patient traffic have severely impacted cancer services across the country. Cancellation of elective surgery, followed by a phased reopening at reduced capacity, has impacted the entire bowel cancer care pathway, and the consequences have been particularly acute for colonoscopy services.

Early diagnosis is a key predictor of surviving bowel cancer and positive test results, and symptoms need to be investigated via timely colonoscopy. Studies have long established that delays in screening, diagnostic, and surveillance colonoscopies increase the risk for bowel cancer progression and mortality.

It is now more likely that patients will present with more advanced disease, require more complex treatments and experience poorer outcomes. Planning for post-COVID-19 colonoscopy catch-up and ongoing capacity is urgently required to ensure bowel cancer doesn't become the forgotten 'C' in the long shadow of COVID-19.

Peter Spryszynski, Country Manager, Q-bital Healthcare Solutions

There is a pressing need to provide cost-effective and accessible colonoscopy in Australia. This was true before the pandemic, and it remains so now.

COVID-19 has presented a unique series of challenges to the Australian healthcare system. Where previously people were encouraged to go to the doctor for regular checkups and screenings, the COVID-19 pandemic meant that many people without urgent symptoms stayed home instead.

It is clear that Australian health policy makers must take steps to avert an impending bowel cancer crises. Unlike routine doctors' appointments, screenings and colonoscopy procedures for bowel cancer cannot be postponed during a pandemic. There remains a backlog for screenings, colonoscopies and treatments in Australia, and evidence shows that delays in these procedures will result in patients presenting more advanced forms of cancer.

Q-bital Healthcare Solutions is addressing this issue, and ensuring Australia continues to be able to provide the vital diagnostic services Australia needs, now and in the future.

INTRODUCTION

Australia has one of the highest rates of bowel cancer in the world with 1 in 13 Australians developing the disease in their lifetime. Bowel cancer is Australia's third most commonly diagnosed cancer and the second leading cause of death. When detected early, the five-year survival rate for bowel cancer can be as high as 99 per cent. However, even prior to the pandemic, only 46 per cent of bowel cancer cases were being diagnosed in Australia at an early stage.[1]

COVID-19 has significantly disrupted cancer services and treatment pathways in Australia. Measures taken by governments to mitigate the spread of the virus have reduced patient traffic. Many patients have been avoiding medical appointments to access the diagnostic services they need in a timely manner.

As a consequence of the backlog of missed screenings and diagnoses, and the reduced capacity to deliver follow-up examinations, health experts in Australia are anticipating an impending deluge of more advanced cancer cases as normal cancer services gradually resume.[2]

Data gleaned from Q-bital Healthcare Solutions is already confirming this correlation in the UK, where one Oxford University study demonstrates that in April 2020 alone, there was a 63 per cent fall in the monthly number of 2-week referrals for suspected cancer, and a 92 per cent reduction in the number of colonoscopies.[3] A recent *Lancet* study showed that, in the UK, delays in diagnoses for bowel cancers since the onset of COVID-19 is estimated to result in a 15.3-16.6 per cent increase in deaths.[4]

It is important to note that it is not the scale of the pandemics in Australia and the UK which is the most pertinent comparison to make, but the scale of the respective responses, and what that means for cancer services and outcomes. In this regard, comparatively Australia endured one of the longest and most restrictive lockdowns anywhere in the world.

A recent Cancer Australia study showed that between March and April 2020 alone, the number of colonoscopies utilised to diagnose bowel cancers fell by 55 per cent.[5] Referrals to oncology centres also plummeted, with a 40 per cent reduction reported in August as compared with previous years.[6]

It is easy to see why health experts are so concerned. It is now more likely that patients will continue to present with more advanced disease, requiring more complex treatments and resulting in poorer outcomes.

This report highlights the urgent need for Australian governments to invest in additional colonoscopy capacity. **By ensuring timely access to colonoscopy we can avert a potential bowel cancer crisis.**

BOWEL CANCER IN AUSTRALIA – A WORRYING TREND

WHAT IS BOWEL CANCER?

Bowel cancer, also known as colorectal cancer, can affect any part of the colon or rectum; it may also be referred to as colon cancer or rectal cancer, depending on where the cancer is located. The colon and rectum are parts of the large intestine.

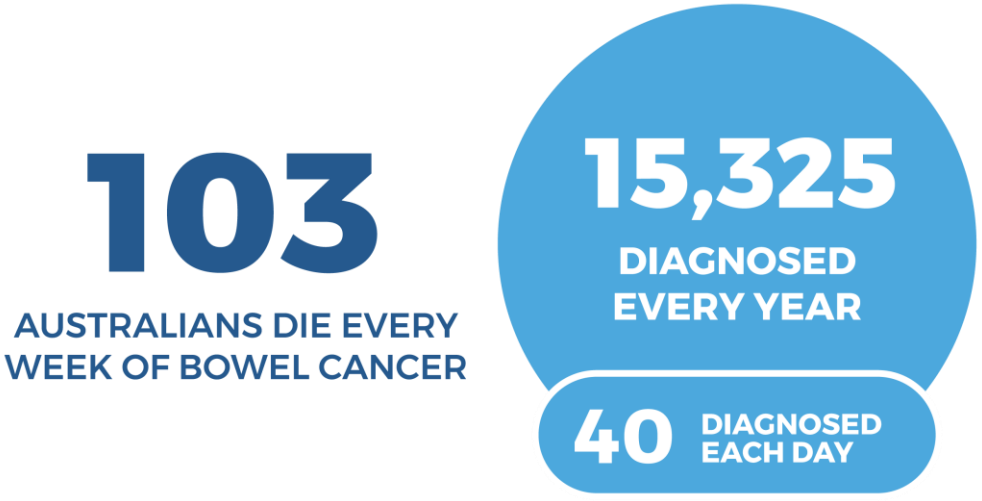
Most bowel cancers start as benign, non-threatening growths – called polyps – on the wall or lining of the bowel. Polyps typically grow in two shapes: flat or with a stalk. They can vary in size, ranging from a couple of millimeters to several centimeters. Polyps are fairly common. Around 30-40% of adults have polyps. They are more common in men and older adults. Polyps are usually harmless; however, adenomatous polyps can become cancerous (malignant) and if left undetected, can develop over time into a cancer.

Bowel cancer affects men and women of all ages. Around 30% people who develop bowel cancer have either a hereditary contribution, family history or a combination of both. The other 70% of people have no family history of the disease and no hereditary contribution.

The risk of developing bowel cancer rises sharply and progressively from age 50, but the number of Australians under age 50 diagnosed with bowel cancer has been increasing steadily; indeed 1 in 10 bowel cancers are now occurring in people under 50. That's why it's important to know the symptoms of bowel cancer and have them investigated if they persist for more than two weeks.[7]

BOWEL CANCER IN AUSTRALIA

Despite boasting a highly developed economy, first-class medical technology and research capability, and a health system that consistently ranks among the best in the world, Australia continues to have one of the highest rates of bowel cancer globally.



According to the most recent pre-COVID-19 figures, 103 Australians die every week of bowel cancer. Just over 40 Australians are diagnosed with the disease every day; some 15,325 each year. A shocking statistic of 1 in 13 Australians will develop the disease in their lifetime.[8]

This makes bowel cancer the third most commonly diagnosed cancer and the Australia's second deadliest cancer. More worrying still, of the top 10 cancers in Australia, bowel cancer is the only cancer to show an increase in mortality rate between 2008 and 2018 in the 45-49 cohort.[9] Even without the impact of COVID-19, this showed little sign of abating.

A particularly concerning fact is that young-onset bowel cancer is on the rise. A study led by American Cancer Society researchers finds that new cases of bowel cancer are occurring at an increasing rate among young and middle-aged adults in the US. Once age is taken into account, those born in 1990 have double the risk of colon cancer and quadruple the risk of rectal cancer compared to people born around 1950, when risk was lowest[10].

Every day in Australia four people under the age of 50 are diagnosed with bowel cancer, with 272 dying every year. This makes it the deadliest cancer for people aged 25 to 34. This tragic set of statistics is made worse by the fact that when detected early, five-year survival rates for bowel cancer can be as high as 99 per cent. Despite this, even prior to the pandemic only 46 per cent of bowel cancer cases were being diagnosed in early stages in Australia.[11]

COLONOSCOPY AND THE TREATMENT PATHWAY

Colonoscopy is a procedure to detect abnormalities in the large intestine (colon) and rectum. During the procedure, a long, flexible tube (colonoscope) with a small video camera at the tip is inserted into the rectum. The procedure allows a colonoscopist to view the inside of the entire colon and identify findings that may indicate the presence bowel cancer or detect and additionally remove pre-cancerous polyps, thus preventing them from ultimately becoming bowel cancer.

Colonoscopies are associated with up to a 75 per cent reduction in risk of death for bowel cancers, and a reduced risk of developing the disease.[12,13] Repeated colonoscopies have also been proven to save two to three times more lives than a single colonoscopy.[14]

Patients are referred for colonoscopy following a positive screening test result or to investigate symptoms. However, by October 2020, just 680,000 self-screening kits were returned as part National Bowel Cancer Screening Program, compared to almost 825,000 for the first half of 2019 alone. [15]

Delays in screening cascade through the entire treatment pathway.

Conversely, most recently, a $4m advertising campaign was undertaken by the Cancer Institute NSW to promote the National Bowel Cancer Screening Program. With increased screening to make up for the shortfall, there will be a greater need for increased colonoscopy capacity as more referrals are made.

This will significantly increase pressure on existing colonoscopy services, already trying to clear the backlog of 78,048 fewer procedures performed across Australia in 2020 and the wait-lists that existed prior to the COVID-19 pandemic.[16]

Colonoscopy capacity is a key concern as demand often exceeds supply, leading to long waiting times. In the UK, a *Lancet* study predicts that catch-up screening might temporarily increase colonoscopy demand to nearly twice that of normal levels.[17]

WHAT DO WE RECOMMEND?

In light of the dislocation that the COVID-19 pandemic has inflicted on Australia's healthcare system, additional support for our hospitals has never been more vital if we are to prevent an impending bowel cancer crisis.

It is this report's recommendation that Australian Governments increase colonoscopy capacity to ensure Australian patients have access to colonoscopy within 30 days, in accordance with colonoscopy categorisation guidelines.

COVID-19 AND THE IMPENDING BOWEL CANCER CRISIS

IMPACT ON SCREENING

COVID-19 has severely impacted cancer services across the board in Australia. Delays in treatments and services have cascaded through the entire cancer care pathway. By August 2020 referrals to oncology centres had plummeted, with a 40 per cent reduction reported compared with previous years.[18]

This is due to measures taken to mitigate the spread of the virus, reduce exposure to patients and staff, and reduce patient traffic. Many patients have themselves also been avoiding going to hospitals and doctors to access the routine health checks, testing and diagnostic services they need.

The consequences of these measures have been particularly acute for bowel cancer screening, diagnostic and treatment services.

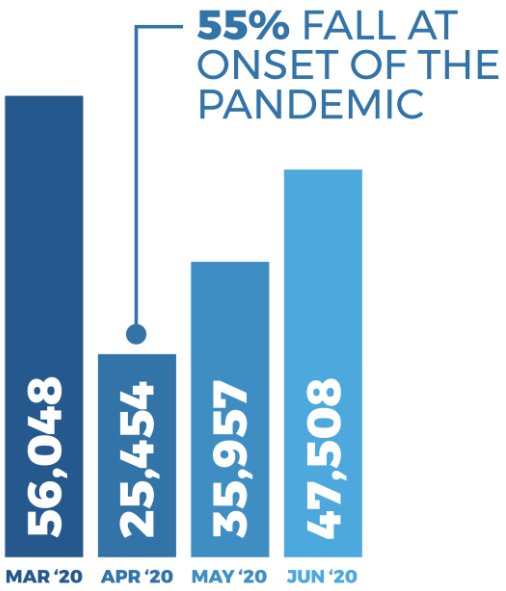
For example, bowel cancer screening is designed to detect very small amounts of blood in poo that is non-visible to the naked eye in people who do not have any obvious symptoms. In Australia, the National Bowel Cancer Screening Program (NBCSP) sends tax-payer funded faecal immunochemical tests (FIT) to eligible people between the ages of 50 and 74 years.

Between January and June 2020, 145,000 fewer bowel screening tests were completed compared to the previous year.[19] About 680,000 self-screening kits had been returned, compared to almost 825,000 for the first half of 2019.[20]

IMPACT ON COLONOSCOPY

Screening is one of the crucial pathways to colonoscopy. Prior to the pandemic, it was anticipated that 1.11 million colonoscopies would be performed each year in Australia by 2021, or 90,000 each month.

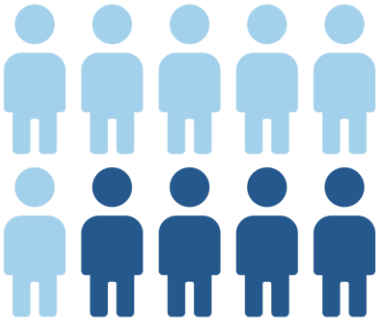
In reality, between March and April 2020 the number of colonoscopies and sigmoidoscopy procedures performed more than halved, falling by 55 per cent, from 56,048 to 25,454.[21] By May and June, the procedures were still 36% and 15% lower than in March, with 35,957 and 47,508 procedures performed, respectively.[22]



Comparing the total national number of services provided in January to September 2020 to the same period in 2019, there were 15% fewer colonoscopies and sigmoidoscopies, equating to 78,048 fewer procedures.[23]

Most recently the Cancer Institute NSW undertook a $4m advertising campaign to promote participation the National Bowel Cancer Screening Program. With increased screening there will be a greater need for increased colonoscopy capacity as more referrals are made. One Lancet study predicts that catch-up screening might temporarily increase colonoscopy demand to nearly twice that of normal levels.[24]

A colon polyp is a small collection of cells that forms on the lining of the colon. Some are harmless but others can develop into colon cancer. Almost all precancerous polyps found during colonoscopy can be completely removed during the procedure.



NEARLY A 60% DECLINE IN PATIENTS UNDERGOING POLYP REMOVAL PROCEDURES

However, as a result of COVID-19, between March and April 2020, procedures to remove polyps decreased a staggering 57%, from 25,509 to just 10,896.[25] Nationally, by May and June 2020 these figures had rebounded somewhat, but polyp removal procedures were still 34% and 11% lower in those months than in March, with 16,726 and 22,683 procedures completed respectively.[26]

In Victoria, however, by August 2020 the number of monthly services had decreased to 26% lower than in March, and by September the number of monthly services was 33% lower than in March.[27]

IMPACT ON SURVEILLANCE COLONOSCOPIES

According to one South Australian study, the majority of the much-reduced number of colonoscopies still performed during the pandemic were conducted as a result of symptoms or positive FIT results, e.g., urgent indications requiring investigation.[28]

Effective as of 26 March 2020, the Gastroenterological Society of Australia (GESA) suggested prioritising emergency and urgent colonoscopies like these, deferring elective colonoscopies and reviewing other indications on a case-by-case basis.

Non-urgent surveillance colonoscopies at regular interval timings are recommended to reduce the risk of developing bowel cancer for those individuals at an increased risk of bowel cancer, such as those with a personal or family history of the disease.

While it is largely unknown precisely how the COVID-19 pandemic and responses to it affected timeliness and patient participation rates of surveillance colonoscopies, over a three-month audited period in South Australia, data shows there was a 51%. decrease in the number of completed surveillance colonoscopy procedures. [29]

Coupled with already limited colonoscopy capacity, as well as patient reluctance to attend hospital, many surveillance colonoscopies have been delayed. As a result, surveillance procedures were disproportionately affected by reduced service delivery.

This may have led to increased progression of cancer in people at increased risk of bowel cancer.

It is also important to note that within Australia, surveillance colonoscopies comprise the majority of nonurgent colonoscopies. Compared to 2019, the South Australian study identified a huge 63% reduction in the number of completed nonurgent surveillance colonoscopies.[30]

IMPACT ON SURGERY

Surgery for bowel cancer was also impacted. A range of surgical procedures are utilised for treatment of bowel cancer carefully determined according to multiple factors and particularly to the nature of each case of bowel cancer.

The number of operations for bowel cancer fell from 1,056 to 883 from March to May 2020. A fall of over 16 per cent. Some recovery of service numbers was observed in June with 938 services, but this was still 11 per cent lower than for March.[31]

DELAYS AND BOWEL CANCER MORTALITY

In the long shadow of COVID-19, cancer must not be the forgotten 'C' as it is likely that Australian patients will increasingly present with more progressed diseases, require more complex treatments and experience poorer outcomes.[32]

Planning for post-COVID-19 colonoscopy capacity is urgently required to avoid cancer progression.

Studies have long established that delays in screening, diagnostic, and surveillance colonoscopies increase the risk for bowel cancer progression and mortality.

Delayed screening leads to delayed diagnosis. Delayed diagnosis leads to delayed treatment. Delayed treatment leads to poorer outcomes.

Put simply, delays can lead to unnecessary deaths. In fact, just a four-week delay of cancer treatment is associated with increased mortality.[33]

DELAYS AND INCREASED DEATHS – A UK CASE STUDY

The Australian Institute of Health and Welfare (AIHW) is Australia's leading health statistics agency. However, because it relies on the State and Territory cancer registries to submit data, there is a two-to-three-year lag. As such it is difficult to draw a complete up-to-date picture of the situation in Australia, and the impact on bowel cancer incidence and mortality.

Abundant data from the UK exists demonstrating the impact of lockdown measures on bowel cancer services. The most pertinent comparison to make between the UK and Australia is not the scale of the pandemic itself, but the scale and nature of the respective policy responses to it and the consequences this has had for cancer services and treatment.

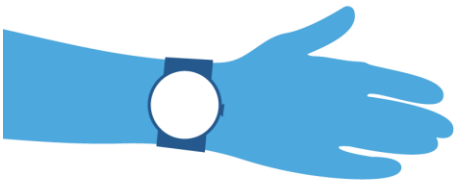
A similar picture emerges from the UK as experienced in Australia.

Dramatic reductions were detected in the demand for, and supply of, cancer services which have not fully recovered with lockdown easing:

- Between April and July 2020, the number of patients starting treatment for cancer fell 26 per cent compared with the same period in the previous year.[34]
- As of August 2020, two-week-wait referrals for all cancers fell 43 per cent.[35]
- The number of endoscopies fell 76 per cent.[36]
- NHS figures published in January 2021 show that in May 2020 the number of colonoscopies performed had fallen to 7,332, from 48,804 in January 2020. By November the number of colonoscopies performed had still not recovered.[37]
- Between March and September 2020, the waiting list for colonoscopies in England rose 68 per cent from 44,561 to 75,300.[38] By March 2021 (the latest month which data is available for) this figure still stood at 63,637.
- Compared with March 2020, the test type with the largest increase in the proportion of patients waiting six weeks or more in March 2021, was endoscopy, with an increase of 26.0 per cent.[39]
- Patients waiting more than six weeks for a colonoscopy procedure increased from 6,838 to 43,274 between January and June 2020.[40]
- By November 33,252 people had still been waiting more than six weeks.[41] By March 2021 (the latest month which data is available for) this figure still stood at 28,731

- Patients waiting more than thirteen weeks for a colonoscopy procedure increased from 1,897 to 29,582 between January and July 2020. [42]

- In November 2020, 21,868 people had still been waiting more than thirteen weeks. By March 2021 (the latest month which data is available for) this figure still stood at 18,958.[43]

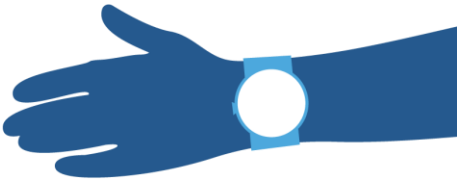


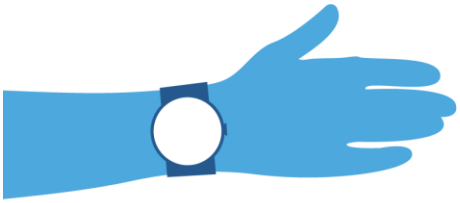
63,637

PEOPLE WERE WAITING FOR A COLONOSCOPY
(UP FROM 44,561 IN MARCH 2020)

28,731

HAD BEEN WAITING MORE THAN
SIX WEEKS FOR A COLONOSCOPY
(UP FROM 6,838 IN JANUARY 2020)





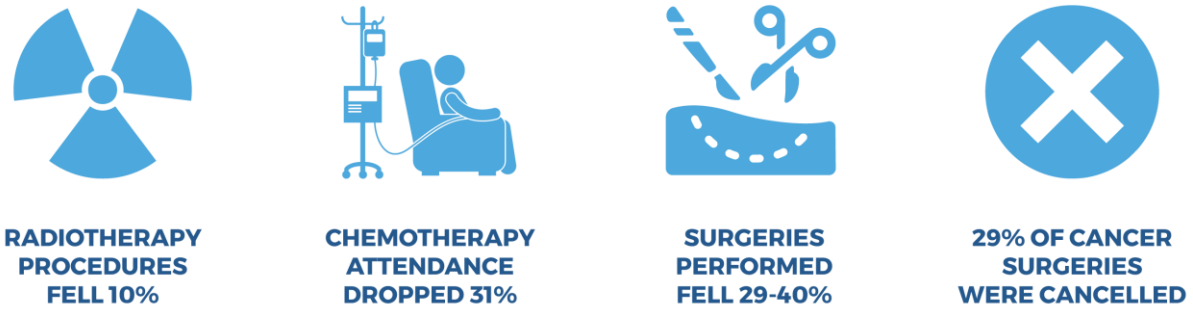
18,958

HAD BEEN WAITING MORE THAN
THIRTEEN WEEKS FOR A COLONOSCOPY
(UP FROM 1,897 IN JANUARY 2020)

For those already diagnosed with cancer, treatments were also affected. Figures for April, May and June 2020:

- Radiotherapy procedures fell by 10 per cent.[44]
- Chemotherapy attendances dropped 31 per cent.[45]
- The number of surgeries performed fell between 29 and 40 per cent.[46]
- In May 2020, 29% of cancer surgeries were cancelled, later rising to an estimated 40%.[47]

A February 2021 *British Medical Journal* study predicts that disruptions like these may result in significant excess mortality among cancer patients. The research estimated that declines in urgent referrals for cancer and chemotherapy attendances during the initial UK lockdown period (March-May) would result in between 7,165 and 17,910 excess cancer deaths in a 1-year total.[48]



It is important to note that with a duration of 112 days, Victoria endured the longest continuous lockdown anywhere in the world and measures taken in health settings across Australia broadly resembled those taken in the UK.

One *Lancet* study published in August 2020 assessed the impact delays in the two-week-wait cancer referral pathway during the COVID-19 pandemic on cancer survival in the UK for the 20 common tumour types, of which bowel is the fifth most common.

The study demonstrates that delays in presentation over a three-month lockdown period (with an average presentational delay of two months per patient) would result in 181 additional deaths for a 25 per cent backlog of referrals, 361 additional deaths for a 50 per cent backlog of referrals and 542 additional deaths for a 75 per cent backlog in referrals.[49]

The study also analysed the compound effects of delaying additional diagnostic capacity. It found that a delay in additional diagnostic capacity spread over three-eight months after lockdown would result in 401 additional lives lost under the 25 per cent backlog scenario, 811 additional lives lost under the 50 per cent backlog scenario and 1231 additional lives lost under the 75 per cent backlog scenario.[50]

A separate *Lancet* study demonstrated that delays in diagnoses for bowel cancers as a result of COVID-19 was likely to result in a 15.3-16.6 per cent increase in deaths from the disease in the UK.[51]

It is clear that bowel cancer screening, diagnoses and treatment have also been delayed in Australia because of the COVID-19 pandemic. Australia was already underperforming with colonoscopy delays prior to the pandemic, which has further compounded the problem. It is also clear that delays and backlogs in these services result in poorer patient outcomes, stage migration and additional deaths.

The question now is how does Australia address the additional diagnostic capacity needed to mitigate an impending bowel cancer crisis?

SUSTAINABLE SOLUTIONS TO DEAL WITH THE BACKLOG: MOBILE COLONSOCOPY FACILITIES

PRINCE CHARLES HOSPITAL CASE STUDY

Most recently, Q-bital Healthcare Solutions installed a two-room colonoscopy facility at Prince Charles Hospital in Brisbane, Queensland.

Comprising a mobile operating theatre, a mobile ward and a modular decontamination unit, the facility will provide an additional 24-27 colonoscopy procedures each day, or 6,600 each year.

The mobile and modular operating room facilities offer a significant increase in capacity for the duration of high patient demand periods. The operating room solution has provided Prince Charles Hospital with a reliable, safe answer to capacity pressures.

All operating room facilities offer High-Efficiency Particulate Absorbing-filtered (HEPA) environmental air that conforms to Grade C EU Good Manufacturing Practices and all applicable Australian Standards for optimal clinical care delivery.

The mobile and modular endoscopy suites are designed to accommodate a complete patient pathway, including on-board decontamination facilities for flexible endoscope reprocessing. With HEPA-filtered environmental air and integral medical gas, vacuum and scavenging systems, as well as decontamination equipment and storage for endoscopes, it provides a safe and comfortable environment for both patients and staff.

The introduction of this facility is supporting the hospital to maintain targets, improve patient flows and address backlogs, and cements Q-bital's growing presence in Australia. It builds on twenty years of experience as a trusted partner to the NHS and private

healthcare providers in the UK, and previous infrastructure projects in Victoria and Queensland. This considerable experience enables Q-bital to offer versatile, tailored and measurable solutions to help meet individual hospitals' unique challenges.

TESTIMONIALS

JO LOUGHEED, DIRECTOR OF INFRASTRUCTURE PLANNING AND CAPITAL PROJECTS AT METRO NORTH HOSPITAL AND HEALTH SERVICE

Creating additional capacity for endoscopy procedures at Prince Charles Hospital in Brisbane - in as short a time as possible - was the challenge faced by Jo Lougheed, Director of Infrastructure Planning and Capital Projects at Metro North Hospital and Health Service.

With the right solution it was a challenge which could be met. Q-bital Healthcare Solutions have helped Jo and her team create a dual-procedure theatre facility, including a fully-equipped modular decontamination suite and a mobile eight-bed recovery ward.

This would usually take years to build. However, using a combination of modular and mobile solutions, the facility was created from scratch, with no compromise on quality and bespoke to the hospital’s needs, in just months:

Jo said: “My colleague had come across Q-bital and learned about what they do; creating mobile and modular solutions to help hospitals add capacity in a shorter time-frame than building new infrastructure. She felt they could help us meet our endoscopy challenge.

We needed additional endoscopy capacity, and we wanted it quickly. When I began working on the project, the hospital had already ordered a dual-procedure endoscopy theatre, bespoke-built modular decontamination suite and a modified mobile ward from Q-bital to help us meet our capacity challenges.

Q-bital made these solutions work for the hospital and the environment it sits within. We knew we needed to integrate these separate solutions into one facility as well as with the

existing endoscopy service within the hospital and to do so as seamlessly as possible.

Because this was the first project of this kind we'd undertaken, we didn't know exactly what we needed – but even when we asked for things at the 11th hour, like a second scope washer and processor – Q-bital made it happen.

The Q-bital team worked really carefully and methodically with us to make sure everything was as we wanted and needed it to be. We looked carefully at how we could tweak the environment to meet our model of care and make sure our clinicians were happy with their working environment.

It's easy to think that units like this can just be plonked into place, everything switched on and off you go. It's a bit more complicated than that! But Q-bital really made the process painless and everyone is really happy with the result. It's light and bright and the quality of the clinical environment is very high. The Q-bital team took our ideas and made them deliverable."

ANN VANDELEUR, PROJECT NURSE MANAGER, PRINCE CHARLES HOSPITAL IN BRISBANE

Delivering additional capacity at speed, while still meeting national quality and assurance standards – and ensuring patient and clinical safety – were the priorities for Project Nurse Manager Ann Vandeleur when creating the new endoscopy facility at Prince Charles Hospital in Brisbane. Working alongside Q-bital Healthcare Solutions, all of those priorities were met and exceeded.

Ann said: "We have a huge demand for endoscopy services and not much capacity to deliver that, along with a shortage of space to create new capacity.

"This area is densely populated. We've got an older population and it's a demographic that is getting larger. Many people relocate to this area from the South and we are seeing an increasing demand for services as a result.

"That is also coupled with the increased screening for bowel cancer as part of the National Bowel Cancer Screening program. This has been rolling out since 2006 but in January 2020 it became fully operational. It sees everyone between the ages of 50 and 74 screened.

"We had tried to add our additional capacity through using the private healthcare sector but just couldn't get the numbers we needed through because people weren't hitting the criteria. It was too restrictive and it just didn't help us meet our demand.

"For us, speed was the really important element. We needed to increase capacity and to increase it quickly. We had been trying to find a solution for three years, but the solutions we considered or tried were just too slow.

"The Q-bital solution works well because it could be co-located with our current building. It was really important to have it placed where it is for patient, and clinical, safety. It also allows us to be really efficient and effective having staff and equipment right next door to each other. It means we can, for example, use the same admission process.

"It's also important that it meets all of the latest standards for decontamination of reusable instruments, which is does. While the unit is of course smaller, it is amazing what has been achieved in the space. It has been carefully designed to achieve everything we want and need it to, and at the standards we need.

"It will make a real impact on the numbers of people who have endoscopy procedures. We will be working on high volume colonoscopy and have opted to have two procedure

rooms. On a monthly basis, we are looking at performing 400 procedures a month. That's working across the two rooms, five days a week, seeing around 24 or 25 patients per day. It will make a real difference.

"Creating the solution was a real team effort alongside Q-bital. It was really fast moving, which was exactly what we needed – and nothing was too much trouble. Everything happened very quickly and having the building and the equipment so quickly was of real benefit to us.

"People couldn't believe what was being created, and so quickly. If you built from scratch it could take three or four years. Not only has it been delivered in a fraction of that time, it's been delivered to the quality and standard we and our patients need and expect, safely."

ABOUT US

Q-BITAL HEALTHCARE SOLUTIONS

Q-bital Healthcare Solutions is a clinical health solutions provider, operating a range of mobile and modular clinical facilities that can facilitate over 74 per cent of all clinical procedures performed in a major acute hospital.

To date, more than 300,000 medical procedures have been undertaken in the Q-bital mobile facilities globally. Facilities include day surgery units, laminar flow operating theatres, outpatient clinics, decontamination and sterilization facilities, visiting hospitals to remote regions and – crucially – colonoscopy suites.

Most recently, a two-room Q-bital colonoscopy facility was installed at Prince Charles Hospital, Brisbane, Queensland.

This deployment cements Q-bital's growing presence in Australia. It builds on twenty years of experience as a trusted partner to the NHS and private healthcare providers in the UK, and previous infrastructure projects in Victoria and Queensland. This considerable experience enables Q-bital to offer versatile, tailored and measurable solutions to help meet individual hospitals' unique challenges. Q-bital's world-class portable facilities are able to support hospitals maintain targets, improve patient flow and address backlogs anywhere in Australia, including regional and remote communities.

For more information about Q-bital, scan this QR code:

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