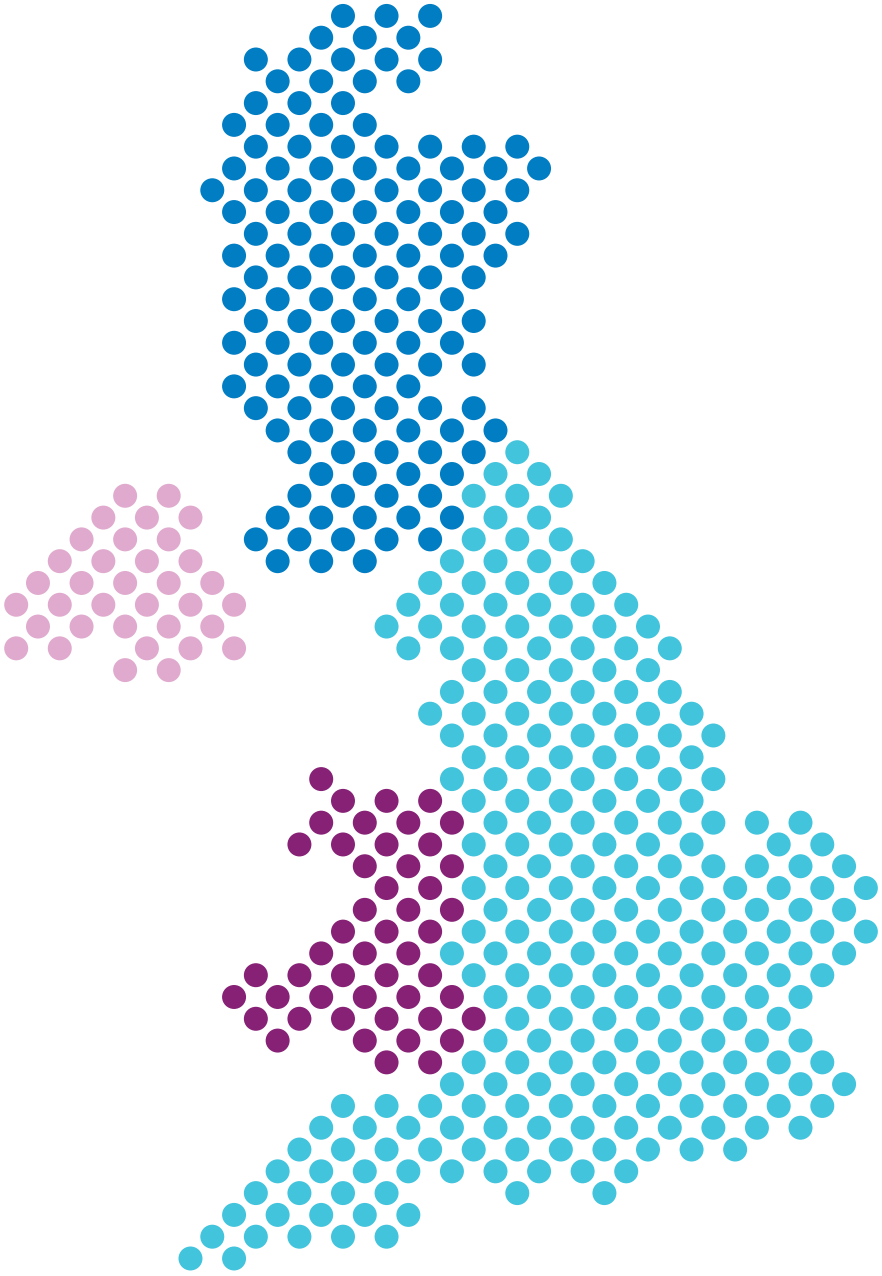
CANCER RESEARCH UK

Executive summary and recommendations

Improving cancer outcomes:
An analysis of the implementation of the UK's cancer strategies 2006-2010



Together we will beat cancer

Executive summary and recommendations

All four UK nations now have cancer plans which clearly set out aims, targets and solutions to improve cancer services. Each nation outlines different timelines for these improvements, and this report has critically appraised the implementation of cancer policy and identified gaps in the plans between the devolved nations which might have an impact on future patient outcomes. The plans in England and Scotland are more comprehensive than those in Wales and Northern Ireland.

The plans have achieved success in some areas. Overall, there is momentum among those working in cancer services and there is recognition that cancer services have improved significantly in recent years. The increase in resources has been welcomed. Standardisation in the delivery of treatment has taken place and there is increasing specialism in patient care.

However, the NHS must deliver efficiency savings and will need to improve quality, innovation, productivity and prevention to deliver the level of savings required to meet the increasing demands on the NHS and demographic pressures. This was an issue which was evident in many of the interviews undertaken as part of this research; how extra demand on services will be resourced was seriously questioned.

Some progress on cancer prevention has been made across the UK, most notably with the introduction of tobacco control measures, but it is also a challenging area, with corporate, political and social barriers to overcome. Other lifestyle factors that influence the risk of developing cancer, such as obesity, are perceived to be more difficult to influence. Many do not see it as within their remit to try. The plans have helped raise the profile of cancer prevention among the cancer workforce. However, there needs to be political will to take heed of the evidence in this area and to regulate where necessary. There must also be further work to reduce cancer inequalities.

The UK has world-class screening programmes of which we should be proud. There have been significant improvements to the screening programmes in recent years but concerns remain about national differences between the programmes in terms of the age at which some programmes are offered. We need to maintain our tradition of funding excellent research in this area and rapidly adopting new technologies and screening interventions where the evidence supports this.

Familiarity with the National Awareness and Early Diagnosis Initiative (NAEDI) in England is reasonably widespread. Some clinicians are involved in the Primary Care Audit as part of this and there is an expectation, especially in Cancer Networks, that this will yield very valuable data. Scotland, Wales and Northern Ireland need to prioritise the early diagnosis of cancer.

Improving cancer treatment has been a focus for a number of years and is seen as a strong component in the patient pathway. Chemotherapy has developed rapidly in recent years, offering new hope to many more patients. However, the increase in the use of chemotherapy has put a degree of stress on the services delivering it, and there is debate about the delivery of ambulatory chemotherapy and the use of mobile units. Radiotherapy capacity is even more of a concern; the building of new units is a major undertaking, and there remains a shortage of trained staff in many areas. There is a problem with access to new technologies, such as intensity modulated radiotherapy treatment (IMRT), in some parts of the country, which is a consequence of workforce planning issues. Surgery has become increasingly specialised, though new cancer surgeons are not receiving the same training time as their predecessors.

The commissioning of cancer services is a complex area and this research has not fully explored the associated complexities, but it is clear that for robust commissioning to be in place there is a need for better data, as well as more analytical capability to effectively make use of the data. The commissioning of new treatments and chemotherapy activity is a specialist activity; Cancer Networks should be better utilised to advise on the commissioning of new treatments and technologies. Commissioners need robust and detailed information on outcomes to assist them in commissioning services. The National Cancer Intelligence Network plays a crucial role in delivering this.

Living with and beyond cancer has sometimes been seen as a neglected area but it is now receiving more attention, not least because more people are surviving cancer. However, as a 'softer area' it could potentially be vulnerable to the challenging economic climate. In particular, there is considerable concern about follow-up appointments, which will very soon exceed system capacity.

Cancer Networks are operating with dedication and energy, but are not always seen to be as useful by the clinical workforce as they feel themselves to be. Notwithstanding this, if clinicians are heavily engaged, they tend to better understand the value they can add.

Overall the picture is one of dedicated, professional health service staff providing generally very good cancer services for the increasing number of cancer patients. The cancer pathway is complex, and over many care and treatment issues different perspectives about the appropriate way forward were voiced. The closer health professionals are to patients' experiences the more challenging it seems to be to work out a rigid 'what's best' strategy, and yet it would seem that certain targets and standardisation are of undoubted benefit to the population as a whole. To continue to improve cancer outcomes, and to make our outcomes among the best in the world in the coming years, we need to maintain comprehensive cancer plans that set national direction, incentivise action and dedicate resource to beating cancer.

Overarching recommendations

1 Cancer Plans are important and useful. They set direction and make the best use of resources to reduce cancer incidence and mortality. To continue to improve cancer outcomes, and to make our outcomes among the best in the world in the coming years, we need to maintain comprehensive cancer plans that incentivise action and dedicate resource to beating cancer.

2 A more comprehensive plan should be developed to ensure consistent delivery, implementation and integration across Wales.

3 Northern Ireland should finalise and publish its Service Framework as a priority.

4 Scotland should review progress against Better Cancer Care, address the gaps identified, such as promoting awareness and early diagnosis of cancer, and begin preliminary consideration of an updated plan.

Chapter specific recommendations

Prevention

1 In order to reduce the incidence of smoking related cancers and see cancer mortality fall, we should continue to promote comprehensive tobacco control measures. This should include:

- **a)** A strong commitment to the World Health Organisation's Framework Convention on Tobacco Control.
- **b)** The development and ongoing monitoring of a tobacco control programme by each nation in the UK.

2 We welcome the legislation in England, Scotland and Wales to regulate the use of sunbeds. Supportive regulations should be developed and implemented in England and Wales to ensure maximum effectiveness of the measures. In addition, there should be further work to communicate with the public about the dangers of sunbeds and the link between their use and skin cancer. The Northern Ireland Assembly should pass and implement the Sunbeds Bill.

3 The roll-out of the HPV vaccination programme has been a notable success to date. We support the continuation of a school-based vaccination programme, reaching girls before they are likely to be at risk of infection.

4 Any future strategies to prevent obesity and promote physical activity should be multi-faceted. They should include initiatives to increase physical activity, improve dietary quality, reduce energy intake and develop clear, consistent and evidence-based messages on healthy eating.

5 Any future strategies to tackle alcohol should include:

a) Measures to increase the cost of alcohol
b) Further restrictions on the marketing of alcohol
c) Investment in information campaigns to raise awareness of the long-term health risks associated with cancer and other diseases.

Awareness and early diagnosis

6 The National Awareness and Early Diagnosis Initiative (NAEDI) needs to maintain momentum and deliver change in England. Best practice in promoting awareness and early diagnosis needs to be replicated in each of the other UK nations. Though we know of some relevant work underway in other nations, the priority given to encouraging early diagnosis should be increased.

7 GP access to the appropriate diagnostic tests should be improved. To make progress in this area, we need to better understand current access levels. Appropriate follow-up is also critical.

8 Anecdotal evidence suggests that clinical leadership at a local level is a helpful driver for progress in promoting early diagnosis; some Cancer Networks have appointed short-term clinical leads. We think there could be value in formalising these arrangements.

9 Information to help health professionals is vital. First, referral guidelines for different cancers should be regularly updated. Second, work to develop decision-support tools to help referral in primary care has not progressed as quickly as hoped. We would welcome further work in this area. This may help to address a lack of continuity in primary care, for example, patients not always seeing the same GP.

10 Research should be undertaken across the UK to understand more about the pathways of non-urgent referrals, for example, for those patients admitted as emergencies. This research should explore whether or not patients had experienced symptoms and/or previously presented to a health professional.

11 Coordinated work should be undertaken to engage health professionals, particularly pharmacists, to promote early diagnosis. This should be especially targeted to lower socio economic groups as we know that people living in deprived areas are less likely to survive common cancers than those living in more affluent areas[3].

12 We must continue to build the evidence base and incentivise the better measurement of important indicators to assess the progress we are making. For example, the mandatory collection and reporting of staging data would be a useful driver to encourage the earlier diagnosis of cancer.

Screening

13 Northern Ireland's bowel screening programme was delayed due to financial constraints. This is being addressed and the programme is beginning to roll out. This must be completed as a matter of urgency.

14 Recent research[4] has shown that flexible sigmoidoscopy (or 'flexi-scope') can prevent a third of bowel cancers and reduce deaths from bowel cancer by up to half. As well as the potential to save lives, incorporating the flexi-scope test into a national bowel cancer screening programme would result in long-term cost savings due to the reduced costs of bowel cancer diagnosis, treatment and follow-up years later[5]. We strongly recommend the introduction of the flexi-scope test into a national screening programme for bowel cancer.

3 Ellie L, Rachet B, Shah A, Walters S, Coleman M (2009) Trends in cancer survival in Spearhead Primary Care Trusts in England, 1998-2004. *HealthStat* Q 41: 7-12

4 Atkin et al (2010) *Once-only flexible sigmoidoscopy screening in prevention of colorectal cancer: a multicentre randomised controlled trial* Lancet; 375: 1624-33

5 Tappenden et al (2007) Option appraisal of population-based colorectal cancer screening programmes in England *Gut* 56: 677-684.

15 Take-up rates for bowel cancer screening are low, which may be due to the fact that it is a relatively new programme. This may also be because the test requires a more active role by the participant than the breast or cervical screening tests and because people may find the test unpleasant. Uptake is lower among men, more deprived groups and among certain minority ethnic groups, such as people from the Indian sub-continent. Steps should be taken to address inequalities in uptake and ensure that as many people as possible are taking up the offer of bowel cancer screening. This includes developing messages that are tailored to the UK's diverse communities.

Surgery

16 Laparoscopic surgery has improved the quality of cancer surgery, is less invasive than other forms of traditional surgery and should lead to lower morbidity and speedier recovery rates for patients, as well as cost savings for the NHS. Further progress should be made in rolling out new surgical techniques such as laparoscopic surgery across the UK.

17 Our research highlighted that there has been political intervention regarding the choice of location for surgery for Welsh patients. This would be of great concern if it means surgery is not being carried out in places that can deliver the best outcomes. Cancer patients in Wales should have access to good quality surgical treatment regardless of location.

18 The reduction in training time for new surgical oncologists is worrying. The EU Working Time Directive is stopping junior surgeons from receiving the requisite experience. Trainee surgeons should have dedicated time to receive the appropriate level of surgical training to overcome the constraints of the Working Time Directive.

Chemotherapy

19 Where drugs have been referred to NICE for appraisal, they should be appraised quickly and as close to licensing as possible.

20 The expertise of Cancer Network staff must be better used to improve the commissioning of chemotherapy treatments in the NHS.

21 UK spending on new cancer therapies still lags behind the rest of Western Europe. Major cancer medicines are still being prescribed in the UK at under two-thirds of the European average, five years after licensing. Healthcare providers should encourage doctors to use these new drugs when treating cancer patients.

22 There must be a continued commitment from local providers that all patients across the UK should have access to the appropriate treatments for their condition, regardless of where they live. Local providers should be reminded of their requirement to provide approved treatments.

Radiotherapy

23 All UK governments should introduce datasets for the reporting of fractionation, waiting times, access, and patient outcomes. The routine collection of benchmarked radiotherapy data should be obligatory for radiotherapy services across the UK.

24 All UK governments should produce a rolling ten-year plan, setting out a vision and strategy for future radiotherapy services, which should be revised every few years. These plans will include detail about how quickly patients are being seen and whether services are reaching all patients who should be receiving radiotherapy as part of their treatment.

25 Radiotherapy techniques which have become established practice in other countries for a number of years such as intensity modulated radiotherapy (IMRT) and proton therapy should be introduced and implemented in the NHS as quickly as possible to ensure that all patients who may benefit can get access to these new technologies.

26 The UK governments must ensure that the UK is equipped with sufficient numbers of linear accelerators (LINACs) and that these machines are able to deliver the most up-to-date techniques. This needs careful planning to address future need, as cancer incidence rises and more patients are being offered radiotherapy.

27 More work needs to be done to ensure that measures to improve workforce capacity, such as the four-tier skills model for radiotherapy, are fully implemented.

Information

28 Tailored information for patients from hard to reach groups should be developed and appropriately targeted.

29 All patients should have access to high-quality information at all relevant points along the patient pathway to ensure that they can make fully informed choices about their care.

30 Healthcare professionals also need to be provided with accurate and up-to-date information about the choices available to their patients, and how best to communicate with patients to ensure the choices they make are fully informed.

31 Information on additional support from healthcare providers should be discussed before patients are discharged from hospital treatment.

32 Healthcare professionals should, as part of their ongoing career development, receive training in communication skills, with a focus upon harder to reach communities.

33 It is important to carry out patient experience surveys across all nations and at Cancer Network level to accurately assess patients' views of their treatment and care. The National Cancer Patients Experience survey in England and similar surveys in Scotland, Wales and Northern Ireland should be carried out on a bi-annual basis.

34 The collection and analysis of cancer information and data is an integral part of delivering world-class cancer services. The UK governments must develop methods to collate good quality cost and quality metrics to ensure cancer services and treatments are properly commissioned and planned.

Survivorship

35 Survivorship is an important and emerging policy area, which should be fully embedded in the patient care pathway.

36 Wales and Northern Ireland should develop a survivorship initiative.

Palliative care

37 Palliative care strategies should be fully implemented for maximum effectiveness.

38 Further work about how the intent of palliative care treatment is communicated to patients should be undertaken.

39 Support for patients who wish to self-manage their cancer and die at home can be good for patients and will reduce the burden on the NHS, and require fewer bed days in hospital. Work in this area should be accelerated.

Cancer networks

40 Cancer Networks are helpful vehicles for planning and implementing cancer services on behalf of their populations. They also have a key role in commissioning cancer services. The incentives for Networks should be focussed around improved outcomes for cancer patients rather than equality of services, which might lead to services being reduced to the lowest common denominator.

41 Cancer Networks should play an important role in assisting GPs by acting as advisers in the commissioning of cancer services and treatment in England. Advice provided should include: needs assessment and demand profiling, prioritisation within the cancer agenda, service design and improvement, quality assurance and peer review, pathway and provider performance, patient experience and value for money.

Multi-disciplinary teams (MDTs)

42 The Department of Health should review the operation of MDTs and put in place a programme to ensure that cancer patients have equal access to high quality care and co-ordination provided by MDTs.

Commissioning

43 Cancer services should be commissioned by NHS staff who have expertise and skills including risk analysis, health economics, procurement and data management.

National standards

44 National standards are one way of driving improvements to cancer services and removing variation in access to those services. They are useful for benchmarking services and monitoring changes to see whether they lead to improvements. Further national standards are needed in some areas of the cancer patient pathway, such as the provision of radiotherapy and surgery, and in dealing with less common cancers.

Incentives

45 The government should review the points along the patient pathway where Primary Care can be more involved in cancer care, and propose a range of new measures for inclusion in the Quality and Outcomes Framework and other relevant incentive schemes to encourage this.

46 The Quality and Outcomes Framework should include an incentive for GPs to collect staging data for all newly diagnosed cancer patients, to find out where improvements in earlier diagnosis could be made.

47 We should continue to drive improvements in cancer services via the use of relevant incentives – both financial and quality-enhancing.

Leadership

48 National leadership to help drive improvements in cancer services is seen as important by the workforce. The National Clinical Director for Cancer in England and Chief Medical Officers in Scotland have played key roles in cancer service planning; these roles should be maintained and replicated where appropriate.

Funding

49 Sustained investment in cancer services is critical to achieving excellent cancer outcomes. The UK governments should commit to a continuing programme of long-term investment in cancer services. Governments should continually review the efficiency, effectiveness and value for money of services, and make comparisons of different pathways of care with our European and other international comparators.

Cancer Research UK
61 Lincoln's Inn Fields
London
WC2A 3PX
Telephone: 020 7242 0200

www.cancerresearchuk.org