

CANCER SERVICES: REVERSE, PAUSE OR PROGRESS?

**The NHS reforms and efficiency savings: an early assessment
of the impact on cancer services in England.**

An Executive Summary for Cancer Research UK by the Health
Services Management Centre, University of Birmingham.

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EXECUTIVE SUMMARY

INTRODUCTION

In July 2010, the Government unveiled plans to significantly reform the structure and organisation of the NHS in England. Changes were introduced to the NHS at every level in both service provision and commissioning. This came just over a year after the NHS had been set the unprecedented financial challenge of finding up to £20 billion in efficiency savings by 2014–15.

This report presents the findings of research commissioned by Cancer Research UK to assess the early impact of both the health reforms and NHS efficiency savings programme on cancer services in England. The research comprised two main activities:

- An analysis of trends in cancer waiting times, diagnostic waiting times and expenditure from April 2010 onwards
- Qualitative interviews with key stakeholders to explore views and experiences at both national level and in eight cancer network areas.

More than 50 in-depth interviews were carried out between April and August 2012 with a wide range of participants including policymakers, clinicians, cancer network staff, senior managers, primary care trust (PCT) and clinical commissioning group (CCG) commissioners, public health experts and patient representatives. Networks were selected to ensure a variety of socio-demographic, environmental and service-related characteristics. Geographical coverage was ensured by selecting two networks from each of the four Strategic Health Authority regional clusters.

The full scale and effect of the reforms will not be known for many years yet. The findings, which provide an early insight into the impact that they and efficiency

savings may be having on cancer services in England and the data gathered, tell a mixed story.

Performance of cancer services against national waiting time standards has – for many indicators – held or even slightly improved over the last two years, despite increasing numbers of patient referrals. The main exception to this is waiting times for endoscopic diagnostic tests, which started to increase in mid 2010 and have yet to return to previous levels.

But performance data do not reveal the full picture. Interviews with national and local stakeholders raise questions about the cost at which service performance is being held, as well as long-term sustainability of services.

Several themes dominated interviews, including concerns about local and national fragmentation, loss of cancer knowledge and expertise, the difficulty of developing and improving services in a climate of ongoing uncertainty and poor staff motivation and morale. While there was a widespread feeling that cancer may be more insulated from funding pressures than other areas, it appears that some services are soft targets for cuts, including administrative and clinical nurse specialist posts and rehabilitation and support services.

Several interviewees felt that these and various other factors have stalled improvements in cancer services, with estimates given of anywhere between 18 months to 3 years for recovery to occur. There is a pressing need for greater clarity about roles, responsibilities and accountabilities within the new system architecture. This is essential to overcoming the barriers to long-term and coordinated planning which cancer professionals and staff are currently contending with.

TRENDS IN CANCER SERVICE PERFORMANCE AND EXPENDITURE

Although the number of patients referred by their GP with suspected cancer has risen substantially in recent years, services have continued to perform well against the 2 week, 31 day and 62 day targets. Access to diagnostics shows a more varied picture, with significant increases in the number of patients waiting more than six weeks for a diagnostic test during 2010 and 2011. Waits have subsequently returned to previously seen levels for radiological imaging tests, but have yet to do so for endoscopic tests.

Over much of the 2000s, real-terms expenditure on cancer services grew year-on-year. But the most recent data show a reversal of this trend.

1. Diagnostic tests for cancer

As more patients are referred for suspected cancer, the number of diagnostic tests has also increased. The total number of tests performed increased by approximately 5% each year in 2010–11 and 2011–12. The two largest categories of diagnostic tests are radiological imaging investigations (MRI, CT and non-obstetric ultrasound), which represent 70–72% of all tests performed, and endoscopic tests (colonoscopy, flexisigmoidoscopy, cytoscopy and gastroscopy), which account for just under one in ten (9%) of all tests performed.

Over the last two years, the proportion of patients waiting more than six weeks for a diagnostic test has fluctuated substantially. There was a marked decline in waiting times for imaging tests between December 2010 and mid 2011, but waits have subsequently recovered to more normal levels. A similar pattern can be observed for endoscopic tests, with waiting times steadily increasing from summer 2010 and peaking in May 2011. While there has been some improvement in endoscopic waiting times more recently, they have not yet returned to previously seen levels. The data on patients waiting more than 13 weeks mirrors the movements in the six week wait data.

2. Cancer waiting times

The number of patients referred to specialist services with suspected cancer has grown in recent years. In 2011–12 there were 1.1 million urgent patient referrals, some 10.3% higher than the previous year. Despite this increase in demand, the speed at which patients accessed services was sustained and, in some cases, improved over the same period. In April–June 2010,

the two week wait target was achieved for 95.5% of all patients referred; by March 2012 it had reached 96.3%. In both 2010–11 and 2011–12, treatment was initiated within 31 days of a positive cancer diagnosis for 98.4% of patients.

3. Expenditure on cancer services

In recent years there has been significant investment in cancer services in England. Real-terms expenditure on cancer rose by 2.9% in the 2008–09 financial year and by 11.2% in 2009–10. However, data for 2010–11 show a 2.6% real-terms decrease in cancer spend due to a combination of low nominal growth in total expenditure, a small reduction in the proportion of the NHS budget allocated to cancer and high inflation. In the same financial year, the money spent on cancer services per head of the population declined in real terms by 3.4%.

VIEWS AND EXPERIENCES OF THE HEALTH REFORMS AND EFFICIENCY SAVINGS

The most dominant theme from cancer services staff interviewed was that the reforms were starting to cause fragmentation of cancer services. Concerns were also raised about CCGs accessing cancer knowledge and expertise to commission services and the implications this might have for further progress in integrating pathways of care and improving the patient experience. Transferring public health to local authorities was expected to create risks and opportunities. A stronger national focus on awareness and early diagnosis was widely acknowledged, but many interviewees argued that recent campaigns had put additional pressure on already stretched services.

1. Scale of change

The current changes to the NHS are of a different order and scale than previously seen. The sheer scale of the reforms with changes being implemented and felt at the local, regional and national level across commissioning, provision and public health has created a situation where there were ‘no islands of serenity’. The challenge of implementing far-reaching changes had been compounded by the absence of a clear policy narrative and an ongoing lack of clarity about major aspects of the reform programme.

Uncertainty about roles, relationships and accountabilities in the new system architecture, and the future commissioning arrangements for cancer services, were common sources of concern.

2. Financial austerity

Alongside the issue of the scale of the reforms was their introduction at a time of financial austerity. The NHS has periodically implemented government reforms or made financial savings, but it has never before been asked to achieve these at the same time. Finding £20 billion savings through productivity improvements would require large-scale service redesign, not just the identification of 'quick wins'. There was a widespread sense that the capacity and skills to undertake this kind of work was being jeopardised by the disruption which the reforms had created locally.

3. Fragmentation

One of the main outcomes of the health reforms will be a substantial increase in the number of organisations involved in planning, commissioning and delivering cancer services. Particular concerns were expressed that, in place of 152 PCTs, there will be public health teams based in local authorities, approximately 220 local commissioning bodies (CCGs) and an as yet unspecified number of commissioning support organisations. The issue of whether and how CCGs will collaborate across boundaries to ensure a consistent and integrated approach to cancer care was also raised.

Interviewees were starting to observe fragmentation in both the commissioning and provision of cancer services, as well as in national policy and oversight bodies. Many interviewees felt that the development of a nationally coordinated approach to cancer, under the high profile leadership of Sir Mike Richards, had played a pivotal role in driving improvements in cancer services over recent years.

4. Local leadership

This linked to a broader concern about who would be providing local system leadership and coordination given the abolition of PCTs and strategic health authorities (SHAs) and reduction in the number and capacity of cancer networks. While views about cancer networks varied, many applauded the expertise and support they had provided to plan and improve local services and facilitate joint working. Interviewees felt that networks with fewer staff covering larger geographical areas would struggle to retain the local knowledge and engagement that was vital to their success.

5. Planning blight

The experiences shared indicate that, in the transition to the new system, a decision-making vacuum has emerged which is causing planning blight. A strong theme in many of the interviews was that a 'gap in the middle' was opening up with the move towards a larger number of more localised commissioning bodies and a smaller number of more distant regional bodies.

Long-term strategic planning is proving a major challenge, and several examples were given where uncertainty about who has the authority to make decisions and sign off budgets had negatively impacted on service development. Interviewees believed further improvements in cancer services would be stalled for anywhere between 18 months and 3 years.

6. Expertise to commission cancer services

Interviewees were broadly positive about having greater clinical and primary care involvement in commissioning, and potential benefits include better engagement across primary and secondary care and a strengthened focus on aspects of the cancer pathway that are most relevant to primary care.

However, interviewees expressed doubts about whether GPs possess a sufficiently detailed understanding and knowledge of cancer to commission services effectively at a local population level. Concerns were expressed that CCGs and GPs did not fully understand pathways of cancer care because they predominantly saw cancer as a 'secondary care issue' or a 'referral issue'. There was therefore a risk that GPs may focus attention on redesigning specific parts of the patient pathway (e.g. referrals, follow-ups) in isolation, rather than looking at cancer services across the patient pathway, particularly given the pressure on them to make cost savings. In some areas, specific services were being targeted in a way that was variously described as 'dibbling and dabbling', 'tinkering' and having 'pet projects'.

Concern was also expressed by a number of interviewees about how to source the necessary knowledge and expertise to commission cancer services, especially at a time when many experienced colleagues had left the NHS, cancer networks were being substantially reduced in size and public health was moving into local authorities.

7. Impact of the reforms on the cancer workforce

Many interviewees felt that cancer had been relatively protected from financial cutbacks in comparison to other clinical areas. They agreed there was scope for cancer care to be provided more efficiently, and this has been a key driver of local pathway redesign.

The push to achieve efficiency savings appears to be affecting cancer services in several ways, not all of which were welcomed. In addition to post freezes and redundancies reducing capacity and increasing workload pressures, certain services – including clinical nurse specialists and rehabilitative and support services – are soft targets for spending cuts. This raises questions about the impact that efficiency savings may be having on the cancer patient experience as well as on outcomes.

8. Public health

Interviewees welcomed the focus on cancer prevention and early diagnosis and the vital role public health teams contribute to this agenda. Concerns were raised about the pressure the electoral cycle may place on local governments to demonstrate short-term outcomes and may discourage strategies where health improvements would only be realised in the medium to long term.

Concern was also expressed about a possible loss of focus on the medical aspects of public health practice which are central to cancer prevention. Local authorities would take a broader view of public health than Primary Care Trusts (PCTs) had done, integrating areas such as housing, employment, transport and regeneration.

9. Research and clinical trials

Some interviewees stated that because of the lack of appropriate numbers of staff clinics, the time spent with each patient was limited. Cancer services teams were having great difficulty doing the extra things which make a good service which are important, such as setting up clinical trials.

CONCLUSION

The findings in this report present a mixed picture. The performance of cancer services against national waiting time standards has – for many indicators – held or even slightly improved over the last two years, despite increasing numbers of patient referrals. However, policymakers, professionals and patients share a number of concerns about how the reforms and efficiency savings are affecting cancer services and patient care. The insights from interviews raise questions about the cost at which service performance is being held, as well as the long-term sustainability of this situation.

There is a very real possibility of fragmentation in cancer services at both a local and national level. There is a need to ensure that the right structures, levers and incentives are in place to enable and encourage joint working. Equally, the issue of who will provide the local system leadership and coordination on which integrated models of cancer care depend must be addressed. These should be urgent priorities for NHS leaders and policymakers as implementation of the reforms progresses.

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