

Cancer Research UK response to the APPGC inquiry into the England Cancer Strategy **June 2016**

Cancer Research UK (CR-UK) welcomes the opportunity to respond to this inquiry into the England Cancer Strategy. This response does not take into account the wider views of the National Cancer Advisory Group, which our Chief Executive chairs, as these will be represented in an oral evidence session.

We welcomed the publication in July 2015 of *Achieving World-Class Cancer Outcomes: a strategy for England 2015 – 2020*. We were represented on the Independent Cancer Taskforce, submitted written evidence, and attended many of the workshops¹. We strongly supported the need for a new cancer strategy, as despite improvements, cancer outcomes in England still lag behind other comparable countries and there is unacceptable variation throughout the country. We believe that national cancer strategies focus and drive improvements in cancer services. They set direction and make the best use of resources over a specific time period.

The appointment of a National Cancer Director in October 2015, and the subsequent establishment of a National Cancer Transformation Board and Independent National Cancer Advisory Group in early 2016, are welcome developments. Combined with the appointment of the new National Clinical Director for Cancer they represent strong national leadership and oversight of the cancer programme. It also represents a collaborative approach to the cancer programme, working across Arms Length Bodies and Government, something that was lacking prior to the publication of the cancer strategy.

The publication of an implementation plan² by the National Cancer Transformation Board, in May 2016, has established a blueprint of priorities and activities. The foundations for implementing the recommendations in the strategy are now all in place. Work on some early priorities is already well underway. However, we now need to see outcomes and experience for patients start to improve in line with the ambitions set out in the strategy. The necessary investment has to reach services. The rhetoric around public health needs to translate into action. And the leadership and structures being set up at a national level need to be replicated within Alliances across England to ensure everyone has the best possible cancer care.

What progress has been made in implementing the Cancer Strategy? Is progress happening at a pace which will enable successful delivery of the Strategy against the timescales set out in the Taskforce's report?

We have focused our response in those areas where CR-UK has the most interest, grouped into the same strategic priorities as the National Cancer Transformation Board have set out.

Overhaul processes for commissioning, accountability and provision

Since the publication of the strategy there has been a strong focus on establishing a cancer programme within NHS England, and indeed across the other Arms Length Bodies³ and government,

¹ Our Chief Executive, Sir Harpal Kumar, chaired the Cancer Taskforce in an independent capacity.

² *Achieving World-Class Cancer Outcomes: Taking the strategy forward*, May 2016

³ The Arms Length Bodies responsible, together with government, for delivery of the strategy are: NHS England, Public Health England, Health Education England, Care Quality Commission, NICE, NHS Improvement

with the associated governance required. We welcomed the appointment of Cally Palmer as National Cancer Director to lead the implementation of the strategy and provide crucial accountability.

The Five Year Forward View governance structure seeks to bring together all the key NHS organisations, and the Cancer Transformation Board replicates this structure. The publication by the Transformation Board of the NHS cancer delivery plan, *Taking the strategy forward* (released 12th May), is also a positive development. It provides clear actions for relevant organisations and prioritises activities for the first year of delivery.

We welcome the establishment of the independent national advisory group⁴, chaired by our Chief Executive, Sir Harpal Kumar. Membership of the advisory group is made up of a range of organisations, including charities, professional bodies and patients. This group will have a key role in providing advice and assessing progress.

To achieve success, we need to be able to measure progress. Therefore it is positive that the cancer dashboard has been developed to highlight key measures in cancer care – this is being rolled out now. It is also good news that metrics are in development for cancer surgery and quality of life.

Radical upgrade in prevention and public health

Prevention is crucial to reduce incidence, a key theme in both the Five Year Forward View and the cancer strategy. Although we welcome the commitment to publish the tobacco control plan, national childhood obesity strategy and the alcohol evidence review in 2016 – we need to see more detail and ambition. We welcomed the announcement of the soft drinks industry levy: but would like to see more ambitious commitments to reduce the impact of preventable risk factors, including removing junk food advertising from TV before the 9pm watershed and sustainable funding for Stop Smoking Services and mass media campaigns to drive people to these services.

National ambition to achieve earlier diagnosis

There was an early commitment to early diagnosis following the publication of the strategy – in September 2015 the Government announced that they would invest up to £300m more by 2020 to improve diagnostic capacity. The implementation plan has now outlined some ways in which this funding will be spent, although a more detailed approach should be made clear – especially how this will link to the recommendations relating to workforce.

Work to develop the ‘Four-weeks-to-diagnosis’ standard is positive: progress has been continuing and we understand from the implementation plan that a ‘test and learn’ approach is going to take place in five health economies in 2016/17.

The cancer strategy stipulated two specific screening changes which were dependent on recommendations from the UK National Screening Committee: that the Faecal Immunochemical Test (FIT) should replace the Faecal Occult Blood Test in the bowel screening programme and that testing for Human Papilloma Virus (HPV) is used as the primary test for cervical screening. The NSC recommended these changes in January 2016, and since then Public Health England has been planning how they would implement. The Government committed to implement FIT in June 2016,

⁴ <http://www.cancerresearchuk.org/about-us/cancer-strategy-in-england>

but has yet to commit to HPV. We would like to see clear support from the Government to allow these changes to be delivered as they can detect more cancers, and precancerous changes.

It is also a concern that the recommendation to mandate that GPs have direct access to key investigative tests for suspected cancer has not progressed sufficiently. Diagnostic capacity is a key barrier to delivering this and is also problematic for the delivery of other initiatives to drive the earlier diagnosis of cancer, as well as service standards such as cancer waiting times.

Modern high-quality services

There are many recommendations in this area that are fundamental to the treatment that cancer patients receive, and the development of modern high-quality care. Whilst there have been developments in many areas, there are two key themes that need to be addressed urgently: workforce and radiotherapy provision.

Radiotherapy plays a major role in curing cancer, but the service needs more support. The cancer strategy highlighted that many linear accelerators (LINACs), are nearing the end of their ten year lifespan. Funding to replace and upgrade LINACs, as well as a sustainable plan for their future is required urgently. Recommendation 29 had a deadline of 'Autumn 2015' which has been missed, and little clarity is available about progress.

The cancer workforce underpins a patient's journey: without sufficient or appropriately skilled health professionals, all other efforts are undermined and we will not achieve these ambitions. As workforce training is a long term endeavour – in many cases a consultant's training will take over a decade - workforce shortages must be addressed as a matter of urgency: both those faced currently, and likely to arise in the future. We welcome the commitment in the cancer strategy implementation plan for a cancer workforce review led by Health Education England: they have now set out a timeline for this activity which suggests they are aiming for rapid progression of the review. We want to ensure this does not just address 'business as usual' approached but considers new ways of working (including approaches to skills mix, new models of care, digital and technological changes), and is informed by stakeholder engagement.

We feel that more action is need to supporting the environment for research within the NHS. Ensuring that there are incentives to maintain the UK's world leading position in cancer studies and applied health research is crucial for the future, and it is also important to ensure that more people take part in clinical trials. Although a commitment has been made, NHS England has yet to publish its 2016/17 research plan, leaving the NHS without an up-to-date strategy for research. It is, however, positive that NHS England has published guidance setting out commissioners' duty to meet the Excess Treatment Costs for clinical trials. We hope this will reduce delays setting up cancer trials - but it will be important for NHS England to monitor the impact of this guidance to ensure it goes far enough. It should be noted that there has been no progress towards establishing a national fund for radiotherapy ETCs. ETCs for radiotherapy trials are so prohibitively expensive that they are limiting innovation in this area and must therefore be given national oversight.

We welcome the commitment from NHS England and the Department of Health to providing 20,000 more molecular diagnostic tests by 2020. The planned re-procurement of the genetic lab service, which was meant to be implemented by April 2016 and deliver molecular diagnostic tests in a more coordinated way, has not yet been published. So whilst there has been some notable progress in this area, there still remains more to be done.

As emphasised in the cancer strategy, access to data has been problematic, in many cases causing delays of up to a year. We have seen improvement in access to data over the past year. However, we are concerned that in the light of a 30% cut to NHS Digital's (previously the Health and Social Care Information Centre) budget by 2020, this progress may reverse. We are hopeful that upcoming work by Dame Fiona Caldicott and the Cabinet Office will provide clarity on the legal and regulatory framework underpinning data release. Cancer Research UK and Macmillan Cancer Support are conducting a review of informed choice for cancer registration⁵, which we hope will provide a steer for responding to the Caldicott review when published.

What needs to be in place to ensure successful delivery of the Cancer Strategy? Are these structures and systems being established effectively and/or at the necessary pace - particularly when it comes to rarer cancers?

We have identified the following key elements that need to be in place to ensure successful delivery:

1. **Leadership and commitment from across the Arms Length Bodies and Government:** the appointment of a National Cancer Director, and a new National Clinical Director for Cancer in NHS England represents enhanced leadership. Similarly, 'cancer leads' in other organisations together with continued senior level commitment should support a sustained focus on deliver of the strategy. Public Health England has established a cancer board, providing a more aligned focus across the organisation on all cancer-relevant activities.
2. **National programme of work and governance structures:** Many of the central structures which have been established will be integral to effective implementation. The implementation plan is a useful resource as it sets out some key milestones as well as the governance structure. We are pleased that relevant oversight groups - relating to the strategic priorities - have been formed, as well as the commitment of resource. Representation on these oversight groups appears to be well considered.
3. **Regional structures and leadership:** Translation and delivery of policy changes into practice will rely on alliances. Alliances will be crucial to translate initiatives in the cancer strategy to local delivery. However, they are still in the process of being established. We think there will be challenges given that some alliances are forming now – in piecemeal fashion – so their geographical 'footprint', remit and terms of reference may vary, even before they are officially rolled out from September 2016. It is also unclear if enough has been done to align the work of these alliances with other plans which are in train, including the 44 footprints of the sustainability and transformation plans (STPs). This should now be an area of focus for the national cancer team.

What are the key challenges in implementing the Cancer Strategy, and how well are these being addressed?

There are several competing pressures on the delivery of new ways of working. This includes financial constraints, increasing demand and significant workforce shortfalls. All of these were outlined in detail in the cancer strategy.

It is often difficult to deliver consistent change through the NHS. Alliances and their alignment with other structures (such as STPs) are likely to be a useful tool in addressing the problems associated with 'dissemination' as they will allow local intelligence and specificity to shape changes. However – these local structures must not lose the crucial element of central oversight and a drive to reduce unwarranted variation.

⁵ <http://www.cancerresearchuk.org/health-professional/review-of-informed-choice-for-cancer-registration>

What should the priorities be for the Cancer Transformation Board and the National Cancer Advisory Group in the next 12 months with regards to delivering the Cancer Strategy?

We appreciate that 96 recommendations cannot be actioned simultaneously. Broadly we support the 'early priorities' chosen for cancer strategy implementation, especially those which underpin other work or are piloting a new initiative: therefore early diagnosis, workforce, data and regional structures should all be prioritised.

Has sufficient funding been allocated and made available for delivery of the Strategy?

In the context of a financially constrained NHS, it is positive that some funding commitments have already been made. However – sustainability is crucial and in many cases, clear investment is only guaranteed in the 2016/17 financial year. For example, the National Diagnostics Capacity Fund is 'subject to future budgets'.

Not all desired funding commitments have been made – including significantly, an assessment of the additional costs of workforce, as well as the required funding for more radiotherapy equipment.

In addition, significant public health cuts have been made despite the cancer strategy (and the Five Year Forward View) highlighting the importance of prevention. The decision to make significant cuts to local authority public health allocations is both short-sighted and representative of false-economy in the long-term: investments in the prevention of disease has the potential not only to save lives, but to result in significant cost savings. If we don't start to make a dent in the burden that cancer incidence places on our health system then investment in other areas of the pathway will be negligible in their impact.

What mechanisms are in place to involve patients in the delivery of the Strategy, and how effective have these been during the first year?

We are pleased that the National Cancer Advisory Group, and the Oversight Groups as they are now being established, have representation from people who have personally experienced cancer. There are likely to be more opportunities as local-level structures (like alliances) are established. It is important that patient involvement is conducted meaningfully to make a real difference to how the cancer strategy is delivered and we would like to ensure that patients are central when establishing alliances.

In addition to patients being involved, engagement and input should also be sought from other interested groups, including clinicians and other health professionals, and researchers. For example: there has been little mention of the involvement of clinical reference groups who would be able to provide useful insight.

About us

Cancer Research UK is the world's largest independent cancer charity dedicated to saving lives through research. It supports research into all aspects of cancer and this is achieved through the work of over 4,000 scientists, doctors and nurses. In 2015/16, we spent £404 million on research in institutes, hospitals and universities across the UK. We receive no funding from the Government for our research and are dependent on fundraising with the public. Cancer Research UK aims to accelerate progress so that three in four people survive their cancer for 10 years or more within the next 20 years.