

# Cancer Reform Strategy

## Achieving local implementation – second annual report



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# Contents

Letter from Professor Mike Richards, National Cancer Director	3
<b>Chapter 1 – The challenge of cancer</b>	<b>7</b>
Introduction	7
Incidence	7
Mortality	7
Prevalence	7
Survival	8
<b>Chapter 2 – Preventing cancer</b>	<b>10</b>
Introduction	10
Tobacco and cancer	10
Obesity, diet and physical activity	10
Alcohol	11
Skin cancer prevention	12
Vaccination and cancer	12
Genetic predisposition	13
Occupational cancer prevention	13
<b>Chapter 3 – Diagnosing cancer earlier</b>	<b>14</b>
Introduction	14
Screening	14
Raising public awareness of cancer symptoms, encouraging people to seek help early and promoting early diagnosis in primary care	17
<b>Chapter 4 – Ensuring better treatment</b>	<b>30</b>
Introduction	30
Waiting time standards	30
Improving Outcomes Guidance	32
Participation in national clinical audits	34
Centralisation of complex surgery	35
Laparoscopic colorectal surgery	36
Radiotherapy	37
Drug treatments	38
Multidisciplinary team working	40
Other work on cancer treatments	41
<b>Chapter 5 – Living with and beyond cancer</b>	<b>47</b>
Introduction	47
Information and communication	47

National Cancer Survivorship Initiative	49
Supportive and palliative care	50
Measuring patients' experience	51
<b>Chapter 6 – Reducing inequalities</b>	<b>52</b>
Introduction	52
New analyses of cancer inequalities	52
Other groups	54
<b>Chapter 7 – Delivering care in the most appropriate setting</b>	<b>56</b>
Introduction	56
Transforming care for cancer inpatients	56
Enhanced Recovery Partnership Programme	58
What do the local data tell us?	59
Quality and productivity	61
<b>Chapter 8 – Using information to improve quality and choice</b>	<b>67</b>
Introduction	67
Measuring and improving clinical quality	67
Identifying cancer trends	68
Supporting other national initiatives	68
Encouraging informed national and local scrutiny of performance	69
Informing cancer research	69
Building the cancer intelligence infrastructure	69
<b>Chapter 9 – Stronger commissioning</b>	<b>70</b>
Introduction	70
Prioritisation of cancer by PCTs	70
Enabling stronger cancer commissioning	72
Commissioning "exemplars"	72
User involvement	73
Peer review	73
Ensuring that tariffs support service improvements	74
<b>Chapter 10 – Funding world class cancer care</b>	<b>75</b>
<b>Chapter 11 – Building for the future</b>	<b>76</b>
Introduction	76
Workforce planning and development	77
Cancer facilities	78
Research	78
Involving stakeholders	78
<b>Annex – Relevant documents published since the first Cancer Reform Strategy annual report</b>	<b>81</b>

## Letter from Professor Mike Richards, National Cancer Director

### Dear Secretary of State

The Cancer Reform Strategy (CRS) commits the National Cancer Director to deliver annual reports on progress to Ministers. This is the second such report.

The focus of this report has been informed by discussions with members of the CRS Advisory Board, to whom I am very grateful. They have recommended that, in addition to reporting on national initiatives, this year's report should also provide information on local progress, especially regarding standards which should by now have been met.

### National progress

Considerable progress has been made in national implementation over the past year. There has been a further fall in cancer mortality, with the latest data (the average for 2006–08) showing that, among people under 75, cancer mortality has fallen by 19.3% since 1995–97. We are well on track to achieve the target of a 20% reduction by 2010.

Recent analyses have shown that one- and five-year survival rates for breast, colon, rectum and prostate cancer have improved considerably since the publication of the *Cancer Plan*. For breast cancer, five-year survival rose from 80.6% in 2000 to a predicted level of 86.0% in women diagnosed in 2007. The equivalent figures for colon cancer in men are 47.6% rising to 53.4% and in women 47.6% rising to 52.7%.

Good progress has been made on the large majority of the components of the National Cancer Programme. For example:

- Over 78% of girls aged 12–13 years have received all three doses of the human papilloma virus vaccine, which will prevent the most common causes of cervical cancer. The catch-up programme targeted at young women aged 17–18 years is also progressing well, with around 63% having received their first dose of vaccine.
- Roll-out of bowel cancer screening to men and women aged 60–69 years is now almost complete across the country.
- On cervical screening, ten pilot sites have clearly demonstrated that a 14-day turnaround time can be achieved and that inadequate samples can be reduced at the same time. This is particularly encouraging given the surge in attendances for screening around the time of Jade Goody's death.
- The National Awareness and Early Diagnosis Initiative (NAEDI) is now becoming well established at both national and local (cancer network) levels. This has the potential to save thousands of lives per year.
- Compliance with the original waiting time standards has been maintained and good progress has been made with the extended waiting time standards, which are already "active". These were designed to ensure rapid access to treatment for a larger

number of cancer patients, including those diagnosed through screening and those with a recurrence of cancer.

- Good progress has been made on training surgeons and specialist cancer teams in innovative techniques, including sentinel lymph node biopsy for breast cancer and laparoscopic surgery for colorectal cancer. The number of patients benefiting from these procedures is now increasing rapidly.
- The National Chemotherapy Advisory Group published a report on the quality and safety of chemotherapy services in August 2009. Cancer networks, commissioners and service providers are now working hard to implement the recommendations with support from the National Cancer Action Team (NCAT).
- Good progress has been made on developing the National Cancer Survivorship Initiative. A vision document will be published shortly. The main focus in 2010 will be to engage service users, clinicians and commissioners in developing new models of aftercare for cancer patients.
- Almost 3,000 senior healthcare professionals have received communication skills training through the *Connected* courses over the past year. Good progress is also being made in partnership with Macmillan Cancer Support, Cancer Research UK and NHS Choices on the programme to provide high quality written information at each step in the care pathway.
- Reducing inequalities is central to the CRS. Joint work between the National Cancer Equality Initiative and the National Cancer Intelligence Network (NCIN) has led to a much better understanding of the problems faced by different inequality groups (for example, because of race, age or gender). A guide setting out practical action that needs to be taken at a local level will be published early in 2010.
- Many hospital admissions for cancer could be avoided or shortened with benefits for patients. Exciting work is now under way to “save a million bed days”. This includes promoting enhanced recovery for elective cancer surgery and a major initiative on emergency admissions being led by NHS Improvement.
- The NCIN has made excellent progress since its launch in 2008. The information provided by this partnership initiative is now becoming a major driver for improving both the quality and productivity of cancer services: NCIN has provided many of the analyses of local information in this report.
- Cancer research continues to thrive in this country. Accrual of patients into clinical trials is high in comparison with other countries. This is in large part due to the work of the National Cancer Research Network. The National Cancer Research Institute continues to facilitate new and better research across the spectrum from prevention to end of life care.

Alongside all of this progress, I feel duty bound to report some significant concerns:

- Progress at a local level on procurement of digital mammography equipment is slow. Unless corrected, this will hamper the extension of breast screening to a wider age range (47–73 years).
- From April 2009, all radiotherapy services should have been collecting and reporting a standardised dataset. In practice, only a minority of radiotherapy services are doing so on a regular basis. Remedial action is being taken on this.
- Progress towards the December 2009 target that all referrals of patients with breast symptoms should be seen within two weeks is also slow. I am working with strategic health authorities to tackle this.



- Recent studies have shown that cancer mortality in this country is falling much more slowly in older people (over 75 years) than in younger people. The fall in cancer mortality among older people in this country appears to be slower than in other developed countries. More detailed work to understand this is now under way, and this could be an important focus for attention at both national and local level.

## Local progress

Of course, much of the national progress outlined above has only been achieved because of the impressive progress made at a local level. This report sets out a detailed analysis of the progress made at a local level against key quality indicators for cancer, such as waiting time standards, mortality and survival. It is clear that there are variations in terms of progress on key areas, some of which are outlined above. Although no locality is experiencing difficulty on every measure, primary care trusts (PCTs) and service providers will want to reflect on their performance and consider the improvements that could be made.

## Comparisons with other countries

The CRS set the ambitious goal of making England's cancer services world class and I am pleased to be able to report continued progress towards this goal:

- On cancer screening, the centralisation of complex surgical procedures, the collection and analysis of cancer intelligence and in the field of research, NHS services are now comparable with the best in the world.
- On waiting times, very good progress has been made to achieve existing standards. Once the extended standards have been achieved, NHS performance should be comparable with international good practice.
- On radiotherapy and chemotherapy, good progress is now being made in improving the quality, safety and capacity of services. Provided this is continued, NHS services should be comparable with international good practice by 2012.

The area where significant challenges remain is in the stage of diagnosis of cancer in England. Patients in this country are diagnosed later and with more advanced disease than elsewhere in Europe. Addressing this problem could save thousands of lives. The intention to expand rapid access to diagnostics in primary care is an important step forward in this respect, as will be the implementation of the NAEDI.

## Priorities for 2010

This report also provides an opportunity to identify major priorities for the coming year. While further progress is needed across all aspects of the National Cancer Programme, I would draw specific attention to the following, which have the potential to save many lives, to improve quality of patient experience and to contribute to the challenge on productivity:

- As I have already highlighted, raising awareness and promoting early diagnosis are essential if we are to bring cancer survival rates up to the level of the best in Europe. One-year survival rates reflect late diagnosis and are poor across the country. All PCTs should be encouraged to take action on this.
- Improving access to diagnostic tests for GPs is essential to the drive for earlier diagnosis of cancer. The announcement made in September of a major programme to ensure that all patients can undergo tests within one week of request by a GP has been warmly welcomed. I am now chairing an advisory group to ensure delivery of this commitment.

- To achieve our aim of having world class cancer outcomes, we must benchmark ourselves against comparator countries. Work on comparisons of the use of drugs in different countries is now well advanced. This is being done in partnership with the pharmaceutical industry. The NCAT has also recently initiated a major programme to understand international variations in cancer survival rates.
- Given the financial downturn, it is imperative that we use NHS resources to best effect. Within cancer services we will continue to reduce unnecessary inpatient bed usage and to shift care to the community. This could, in my view, make a significant contribution to the “quality and productivity challenge”.

Good progress continues to be made in implementing the CRS, but further work is required. My focus over the coming year will be to support the NHS in ensuring that every area of the country is able to deliver on the core quality measures contained in this report, encouraging earlier diagnosis of cancer and delivering the quality and productivity improvements that will be imperative if we are to deliver world class cancer services in the context of the economic downturn.



**Prof Mike Richards CBE**

## Chapter 1 – The challenge of cancer

### Introduction

1.1 As with the first annual report, this progress report generally uses the same headings as were used in the Cancer Reform Strategy (CRS), in order to report systematically on progress over the past year. Again, the report begins with new figures on incidence, mortality, prevalence and survival. What is different this year, however, is that the report is in many areas providing information to demonstrate variations around the country.

### Incidence

1.2 As the population continues to age, so the incidence of cancer continues to rise. The latest cancer incidence figures for 2007 were published in November 2009 and they showed that:

- there were over 245,000 new cases of malignant cancer (excluding non-melanoma skin cancer) registered in England in 2007 – 123,000 new male cases and 122,000 new female cases – compared with around 242,000 in 2006 and 223,500 in 2000 (a 10% rise in seven years)
- the four most common cancers – breast, lung, colorectal and prostate – accounted for over half of all new cases
- breast cancer accounted for one in three newly diagnosed cases of cancer among women
- prostate cancer accounted for one in four newly diagnosed cases of cancer among men.

### Mortality

1.3 We are well on track to meet the overall target in under-75s, which is by 2010 to reduce mortality rates for England by at least 20% and the absolute gap in mortality rates between England and the spearhead group by at least 6%, from a 1995–97 baseline.

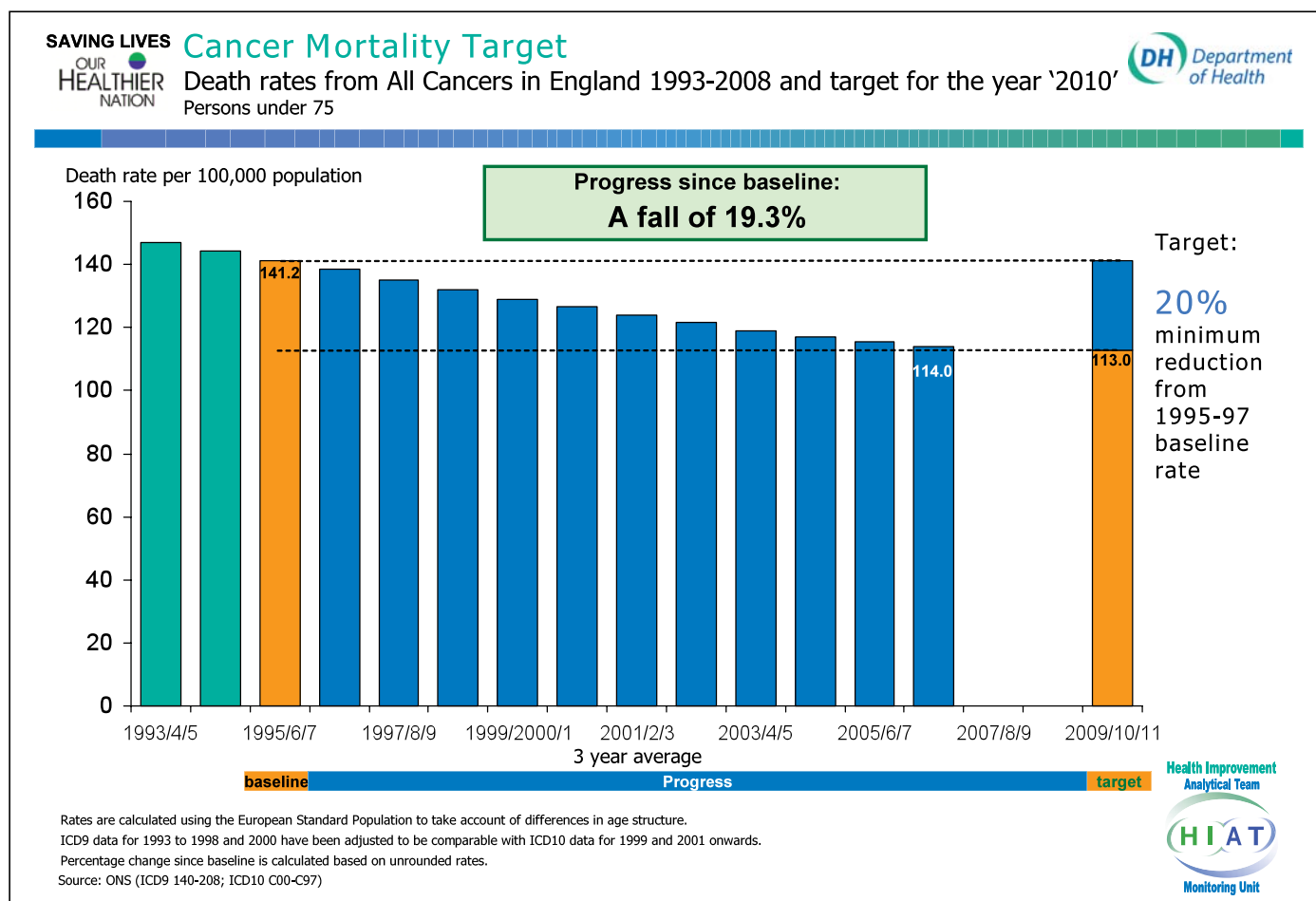
1.4 Figure 1 below shows that the three-year average mortality rates for cancer in people under 75 have fallen by 19.3% since the baseline.

1.5 Three-year average mortality rates for cancer (ages under 75) for England have fallen for each period since the baseline, from 141.2 deaths per 100,000 population in 1995–97 to 114.0 deaths per 100,000 population in 2006–08, and are now 19.3% below the baseline rate. If the trend of the last ten years were to continue, the target would be met.

1.6 Table 3 at the end of chapter 3 sets out the mortality figures by primary care trust (PCT) and also shows the Care Quality Commission (CQC) scores in relation to PCT delivery on mortality rate reductions. There is of course a range of reasons for different PCTs having different mortality rates.

### Prevalence

1.7 In June 2009, the National Cancer Intelligence Network (NCIN), in conjunction with Macmillan Cancer Support and Thames Cancer Registry, produced a report on one- and five-year cancer prevalence within cancer networks in England for the four major cancer sites (female

**Figure 1: Death rates from all cancers in England, 1993–2008, and target for 2010 (people under 75)**

breast, lung, colorectal and prostate) and for all cancers combined. In essence, the report:

- estimated that in 2008 there were at least 1.6 million cancer patients living with or beyond a diagnosis of cancer
- shows that the numbers of cancer survivors are increasing by 3% a year
- provides indicators of the burden of cancer within cancer networks and helps to facilitate healthcare service planning.

## Survival

1.8 Recent analyses (see Table 1) have shown that one- and five-year survival for breast, colon, rectum and prostate cancer has improved considerably since publication of the *Cancer Plan* in 2000.

1.9 One-year survival rates are generally accepted as a good proxy for early/late diagnosis. These measurements can be especially valuable if information on stage at diagnosis is not universally available.

1.10 The NCIN has developed benchmarks of good performance on one-year survival rates for the four commonest cancers, based on the EURO CARE-4 findings for patients diagnosed in 1995–99. “Average” is based on the average one-year survival rate for Europe in 1995–99. “Good practice” is based on the average achieved across a whole country by the best performing countries in EURO CARE-4.

1.11 As can be seen from Table 2, the range of one-year survival performances observed for cancer networks in England in 1999–2001 fell below the consensus benchmark on all four

major cancers (ie no single network achieved “good practice”). For colon and lung cancers, no single network achieved even the European

average. This shows the major scope for improvement. Performance at individual PCT level is shown in Table 3 at the end of chapter 3.

**Table 1: Age-standardised relative survival, England**

<b>Colon</b>	1 year	Men	69.5	69.9	73.0
		Women	67.6	67.9	70.4
	5 years	Men	47.6	48.9	53.4
		Women	47.6	49.2	52.7
<b>Rectum</b>	1 year	Men	76.4	77.1	79.3
		Women	75.6	75.8	77.7
	5 years	Men	49.6	51.9	54.3
		Women	51.2	53.6	56.0
<b>Breast (women)</b>	1 year		95.1	96.0	96.6
	5 years		80.6	83.7	86.0
<b>Prostate (men)</b>	1 year		92.5	94.4	95.8
	5 years		71.4	81.5	86.2

\*Survival estimates from model fitted to data for 1996–2000 or 2001–2003.

\*\*One-year survival from model for 2004–2006; five-year survival predicted with hybrid approach.

Explanatory note: Table 1 is derived from Rachet B, Maringe C, Nur U, Quaresma M, Shah A, Woods LM, Ellis L, Walters S, Forman D, Steward JA, Coleman MP (2009) ‘Population-based cancer survival trends in England and Wales up to 2007: an assessment of the NHS cancer plan for England’, *Lancet Oncology*, 10: 351–69. The classical cohort approach was used for calculating one- and five-year survival for patients diagnosed during 1996–2000, and one-year survival for those diagnosed during 2001–03 (since all patients were followed up for at least that long). The complete approach was used for five-year survival for patients diagnosed during 2001–03. Short-term prediction of survival for patients diagnosed during 2007 was made with the hybrid approach, combining the one-year survival probability for patients diagnosed during 2006 with the survival probabilities for the second and later years after diagnosis for patients who were alive and followed up for at least part of 2007. The survival estimates are not age standardised. More information is available in Rachet et al., 2009.

**Table 2: Consensus benchmarks for one-year survival rates for the four commonest cancers**

	<b>EUROCARE-4 average<sup>1</sup></b>	<b>EUROCARE-4 “good practice”<sup>2</sup></b>	<b>English cancer networks (range)<sup>3</sup></b>
Breast	93.8	97	90.0–95.8
Colon	74.2	79	63.0–72.2
Lung	36.0	37	21.5–29.7
Prostate	92.7	96	84.1–92.9

<sup>1</sup> EUROCARE-4: age-adjusted one-year relative survival rates, adults diagnosed 1995–99.

<sup>2</sup> “Good practice” is based on the highest one-year survival rates of countries with 100% cancer registration in EUROCARE-4, rounded down to the nearest whole number. For all four tumour types, Sweden was among the highest in Europe.

<sup>3</sup> The cancer network range is based on patients diagnosed in 1991–2001 (from the National Centre for Health Outcomes Development).

## Chapter 2 – Preventing cancer

### Introduction

2.1 While the population is generally aware of the risks associated with tobacco use and exposure to the sun in terms of causing cancer, knowledge around the links between obesity, diet, physical activity and alcohol consumption and cancer remains low. Whatever the level of knowledge, the challenges in terms of behaviour change remain significant across the board. Nevertheless, progress has been made and a range of work is under way to tackle the issues.

### Tobacco and cancer

2.2 As a result of the Government's focused action on tobacco, overall adult smoking prevalence has been reduced in England over the past decade, from 28% in 1998 to 21% in 2007. The current Government Public Service Agreement (PSA) is to reduce adult smoking rates to 21% or less by 2010. Through comprehensive action, an estimated 1,500 fewer deaths from cancers were caused by smoking in 2007 than in 2002.

2.3 NHS Stop Smoking Services are available across England and offer evidence-based and cost-effective support to all smokers. These services have helped over 500,000 people to become long-term quitters within the last ten years. This means that 70,000 premature deaths have been avoided through this service since its inception in 1999.

### Obesity, diet and physical activity

2.4 *Healthy Weight, Healthy Lives: A Cross-Government Strategy for England* (January 2008) and *One Year On* (April 2009) set out the Government's strategy to reduce obesity and help people to maintain a healthy weight. The strategy set out proposals to help people make healthier choices, create an environment that promotes healthy weight, ensure that effective services are available for those at risk, and strengthen the delivery system.

2.5 Data from the Health Survey for England 2007 provide the latest information on how common obesity is. This shows that in 2007 the proportion of obese and overweight adults (ie the "prevalence") had fallen slightly to 60.8%, from 61.6% in 2006; and obesity among 2–10-year-olds had increased very slightly to 15.5%.

2.6 As part of the strategy, DH has:

- launched Change4Life, a three-year, £75 million social marketing programme to help us all maintain a healthy weight
- given primary care trusts (PCTs) additional funding to commission more weight management services: we allocated £65.9 million in 2008/09 and £69 million in 2009/10 as part of PCT revenue allocations
- been working together with the Food Standards Agency to implement the Healthy Food Code of Practice: this contains eight



areas for the food industry to take action to demonstrate its commitment to promote healthy eating

- announced details of nine “Healthy Towns”, which will lead the way in changing their communities’ built environment to support people to become more active and to promote healthy eating.

2.7 For optimal protection against cancer, physical activity should be maintained throughout life. Moderate to vigorous intensity physical activity performed frequently appears to be required for a significant protective effect.

2.8 The Government is committed to getting 2 million more people active by 2012. Programmes include:

- Let’s Get Moving – this is a Physical Activity Care Pathway intervention for adults aged 16 to 74 who are not currently meeting the Chief Medical Officer’s recommendations for physical activity: it will be delivered by healthcare professionals within a general practice setting and can be used for both prevention and management of the long-term effects of cancer and cancer treatment
- the Dance Champions Group, aimed at appealing to young women and some ethnic groups who would not be taking part in other types of physical activity
- the Free Swimming Initiative, which enables local councils in England to offer free swimming to people aged 60 and over and 16 and under
- the Walking the Way to Health initiative to establish stronger links with primary care and other partners: this is a volunteer-run programme that introduces adults to regular and brisk walking and its health benefits within the natural environment.

2.9 As part of its work to promote good health among cancer survivors, the National Cancer Survivorship Initiative is promoting the beneficial role of physical activity and is looking at how this might be incorporated in patient information, supported self-management programmes and assessment and care planning.

## Alcohol

2.10 In May 2008, DH launched its Know Your Limits “Units” campaign, to help people understand how many units are in the alcohol they drink, and the link between alcohol consumption and their health, including cancer risks. Regular drinking, particularly above lower-risk daily levels (two to three units for women, or three to four units for men), increases the risk of a number of cancers, of the mouth and throat, the digestive system, the liver and breast. Building on the “Units” campaign, a social marketing programme, including direct mail, is targeting heavier drinkers. Support is available through the DrinkCheck website, the Drinkline telephone helpline and the NHS.

2.11 The Government has an agreement with the alcohol industry to include health and unit information on alcoholic drinks labels. The Government’s expectation has been that this should cover the majority of labels by the end of 2008. Interim monitoring of implementation has been disappointing, and the Government has just launched a public consultation seeking views on the next steps, and whether a renewed voluntary agreement or legislation is needed.

2.12 DH has developed a Vital Signs Indicator to measure change in the rate of hospital admissions for alcohol-related conditions – the first ever commitment to monitor how the NHS is tackling alcohol harm. This indicator is included in the Government PSA to reduce drug and alcohol harm and in the Communities and Local Government list of indicators for local authorities and their partners.

2.13 The indicator is expected to encourage earlier identification of people who drink too much and to encourage the provision of brief advice and support for them from GPs or hospitals. This has been shown to be an effective way of reducing the levels of “everyday” but excessive drinking that over time leads to alcohol-related cancers and other problems. The indicator is also likely to promote the efficient provision of accessible treatment for the heaviest drinkers who are at greatest risk of such harm in the short term.

## Skin cancer prevention

2.14 SunSmart, the national skin cancer prevention and sun protection campaign, continues to work to raise awareness and provide information and advice to the public and interested professionals. Recent campaign themes have particularly covered children and young people. They have also used online technology and interesting prize attractions to help promote messages and encourage behaviour change around UV exposure, including the risks posed by sunbed use. These include iPledge, Skindividual and a sunburn animation.

2.15 Cancer Research UK, through SunSmart, is also working with local cancer networks and local authorities to promote a unified approach to skin cancer awareness and sun protection.

2.16 In May 2009, the Health and Safety Executive (HSE) published revised guidance for users and operators of sunbed salons, which includes reference to the World Health Organization’s statement that sunbeds should not be used by those under 18 years of age and a recommendation that sunbed salons should have trained staff.

2.17 The Committee on Medical Aspects of Radiation in the Environment (COMARE) also published its report *The health effects and risks arising from exposure to ultraviolet*

*radiation from artificial tanning devices* in June 2009. DH is considering the COMARE report’s recommendations, which include prohibiting the use of sunbeds by under-18s.

2.18 Cancer Research UK has published findings from a review of sunbed use by minors in England. The research, commissioned by the National Cancer Action Team (NCAT) and DH, involved two large face-to-face surveys of sunbed use in over 9,000 children. A national prevalence study of 3,101 children showed that 6% of 11–17-year-olds had used a sunbed. More than a quarter said they used a sunbed at least once a month. In the second study, looking at six cities, sunbed use among children was highest in Liverpool (51%) and Sunderland (48%).

2.19 The National Institute for Health and Clinical Excellence is currently developing guidance on information, resources and environmental changes to prevent skin cancer, which it is expecting to publish in January 2011.

## Vaccination and cancer

2.20 The national immunisation programme against the human papilloma virus (HPV), known to cause cervical cancer, began in September 2008 and to date over two million doses of the vaccine have been administered in the UK. Confirmed national coverage data for the first year of the programme will be available by the end of 2009.

2.21 Provisional data for England suggest that, by the end of August 2009, 78.4% of girls aged 12–13 years had received all three doses of vaccine and that 87.5% of the cohort had commenced the three-dose vaccination course. In parallel, a catch-up campaign has targeted girls up to the age of 18. Provisional data indicate that 62.8% of young women aged 17–18 years have received their first dose of HPV vaccine and that uptake is steadily improving. Work will continue to ensure that the uptake of



the vaccine by eligible girls is as high as possible. It is anticipated that this programme could save the lives of up to 400 women a year.

2.22 While HPV vaccination protects against over 70% of cancer-causing HPV types, it does not protect against all cervical cancers. Therefore, all women who have received the HPV vaccination will continue to be invited for cervical screening from the age of 25. Cervical screening continues to be an essential part of the strategy to fight cervical cancer.

### Genetic predisposition

2.23 As knowledge of the genetic causes of cancer develops further, so there will be increasing demand for the cancer workforce to be familiar with this area of medicine. Over 2,500 users have now completed the DH-funded *British Medical Journal* (BMJ) learning module “Cancer and genetics: an up-to-date guide”. This can be accessed at: [www.learning.bmj.com/cancergenetics](http://www.learning.bmj.com/cancergenetics)

### Occupational cancer prevention

2.24 Cancers are the largest cause of work-related deaths. The HSE estimates that there are around 8,000 deaths every year from occupational cancer due to past exposure to substances at work.

2.25 The HSE has held two stakeholder workshops to help set priorities and identify possible intervention activities to minimise the risk factors for cancer in the workplace. Priority areas include stainless steel welding, foundry work, construction work involving silica exposure, and asbestos.

2.26 HSE activity includes:

- developing a website providing information and advice on occupational cancers
- commissioning Imperial College London to

produce an updated and detailed estimate of the current burden of occupational cancer so as to inform the development and prioritisation of practical measures to reduce the burden in the future: interim results should be published in March 2010, with a final report by the end of the year

- undertaking a surface engineering partnership project to monitor and reduce exposure to carcinogens
- sponsoring research into whether semi-conductors increase the risk of cancer and undertaking a series of inspections at semi-conductor plants
- raising awareness that inhaling dust, vapours and fumes can increase the risk of cancer, initially targeting construction workers, stonemasons, welders, quarry workers and foundry workers
- funding ongoing research into the apparent association of shift work with cancer.

## Chapter 3 – Diagnosing cancer earlier

### Introduction

3.1 It is now generally agreed that later diagnosis has been a major factor in the poorer survival rates in England compared with other countries in Northern and Western Europe, and so much of the focus of our current work is on achieving earlier diagnosis. As explained in chapter 1, one-year survival data are used as a proxy for late diagnosis, as generally the later the diagnosis, the greater the likelihood of a person with cancer not surviving for a year. Table 2 in chapter 1 and Table 3 at the end of this chapter demonstrate the variations in one-year survival and, therefore, the scope to make improvements.

3.2 To achieve earlier diagnosis, we need to:

- ensure access to high quality screening programmes where there is evidence that these save lives (ie for breast, cervical and bowel cancers)
- promote awareness and early presentation, especially among those groups in society most likely to delay seeking advice
- facilitate earlier diagnosis in primary care, by eliminating delays and providing GPs with better access to diagnostic tests.

3.3 National coordination for earlier diagnosis of cancer in England is provided through the NHS Cancer Screening Programmes and by the National Awareness and Early Diagnosis Initiative (NAEDI), established in 2008, as part of the Cancer Reform Strategy (CRS).

### Screening

#### Breast cancer screening

3.4 In 2007/08, over 1.7 million women were screened for breast cancer in England, and over 14,000 cancers were detected. In February 2006, a report from the Advisory Committee on Breast Cancer Screening (*Screening for Breast Cancer in England: Past and Future*, NHS Breast Screening Programme Publication No. 61) estimated that the breast screening programme in England is saving 1,400 lives per year.

3.5 The extension of breast screening to women aged 47–49 and 71–73 by 2012 was a commitment in the CRS, reiterated as a Vital Sign in the NHS Operating Framework (VSA09). The CRS said that the necessary phasing in of the expansion should be carefully considered to ensure that the most useful epidemiological data can be gathered to inform future decisions about the programme. Following this, researchers at the University of Oxford produced a proposal to randomise the extension, with half randomised to invite women aged 47–49 and half to invite women aged 71–73. The half of each cohort not being invited would provide a control group to give directly comparable mortality data on the effectiveness of breast screening. This will provide further evidence of the magnitude of the benefit of additional screening rounds in younger and older women.

3.6 Ethical approval was granted to pilot the randomisation in April 2009, and the five pilot sites that had begun screening women aged 47–49 from January 2009 switched to the randomisation project.

3.7 The five pilot sites have been progressing well with no major problems. Plans for extending the age range of screening in other parts of the country are however disappointing. We expect all primary care trusts (PCTs) to be starting roll-out of the age extension during 2010/11 and we are working with strategic health authorities (SHAs) to highlight this to PCTs. PCTs should be aware that the submission of plans will be required as part of the planning round that follows publication of the NHS Operating Framework for 2010/11.

3.8 The CRS said that all local programmes should have at least one full-field digital mammography machine by 2010. Implementation of digital mammography has been slow, despite national framework agreements having been put in place through the NHS Supply Chain, with best prices negotiated nationally. Latest data suggest that a maximum of half of local programmes will have one digital set by 2010 and only six will be fully converted. The Advisory Committee on Breast Cancer Screening has recommended that no new analogue kit is purchased, and there are cost implications of running analogue and digital together, so full conversion is recommended.

3.9 In terms of the surveillance of women identified as being at high risk, three early implementer sites have been identified and the new IT software will be released to them to allow start of operations before the end of 2009.

3.10 Concerns have been raised about over-diagnosis of breast cancer. This has been fed into the ongoing review of the breast screening facts leaflet, the new version of which is expected to be published early in 2010.

3.11 Local progress on breast cancer screening coverage is shown in Table 3 at the end of this chapter. Across the country, the average coverage for breast screening among women aged 53–70 was around 73% in 2007/08. However, at PCT level, coverage ranged from

83.5% (Leicestershire County and Rutland PCT) to 42.3% (Barnet PCT). Just over a quarter (39 out of 152, or 26%) of PCTs achieved coverage levels above 80%, while 12 (8%) PCTs had coverage below 60% and a further 15 (10%) had coverage between 60% and 70%. The South West, East Midlands, South Central, East of England and West Midlands SHAs had the most PCTs in the upper quartile and least in the lower quartile. In contrast, 26 of the 31 PCTs in London were in the lower quartile, with no PCTs in the upper quartile.

### **Cervical screening**

3.12 The number of women screened increased by around 400,000 in 2008/09 from 3.2 to 3.6 million. This increase probably reflects the effect of raised awareness resulting from the publicity about Jade Goody's cervical cancer diagnosis and death. We estimate that this upsurge in screening could save hundreds of lives over the next 30 years.

3.13 Achieving a 14-day turnaround time for the results of cervical screening is a Vital Sign in the NHS Operating Framework (VSA15) – to be achieved by the end of 2010. NHS Improvement has been working with ten local programmes to streamline the whole pathway, from initial test to getting the results. The project has been a great success, with most sites achieving 14-day turnaround times for at least 99% of tests and with significant reductions in failed tests and in resource requirements. A call for bids to take part in the second wave of the NHS Improvement project was issued in July 2009, and nine further sites will be taking part. The achievement of the pilot sites is even more remarkable when taken against the unprecedented surge in the number of tests undertaken.

3.14 Around the time of Jade Goody's death, there was a call from the media, some charities and some Parliamentarians to lower the starting age of screening back to 20 from the current age of 25. As a result, Ministers asked the Advisory

Committee on Cervical Screening (ACCS) to review the evidence relating to screening women aged 20–24. The Committee met in May 2009, and agreed unanimously that there was insufficient evidence to lower the screening age, and that the harms of screening in women aged 20–24 outweighed the benefits. The evidence presented to the Committee was published in the *BMJ* in July 2009, and showed that cervical screening in women aged 20–24 has little or no impact on rates of invasive cervical cancer up to age 30.<sup>1</sup> However, the Committee was concerned that guidelines were needed for young women presenting to primary care with persistent gynaecological symptoms, and so the ACCS is developing those guidelines, which will be published shortly.

3.15 Other action is also under way to address cervical cancer in young women and lower rates of cervical screening in women aged 25–34, including clinical audits, the development of Key Messages on cervical cancer, and work with the Improvement Foundation. This is showing early signs of success and consideration is being given to rolling out the approach across England, providing this success is maintained.

3.16 Local progress on cervical screening coverage is shown in Table 3 at the end of this chapter. Across the country, the average coverage for cervical screening among women aged 25–64 years was around 77% in 2007/08. However, at PCT level coverage ranged from 85.8% (Nottinghamshire County Teaching PCT) to 65.8% (Hammersmith and Fulham PCT). 44% of PCTs (67 out of 152) achieved coverage levels of over 80%, while four (3%) had coverage levels below 70% and a further 23 (15%) had coverage levels between 70% and 75%. The Yorkshire and the Humber, East Midlands, North East, East of England and South West SHAs had the most PCTs in the upper quartile and the least

in the lower quartile. In contrast, 24 of the 31 London PCTs were in the lower quartile and only two in the upper quartile.

### **Bowel cancer screening**

3.17 Roll-out of the original programme, aimed at men and women aged 60–69 years, has progressed well to the target date of December 2009, with coverage of over 90% of PCTs. However, there are concerns about engagement in three areas, and DH is working with the relevant SHAs to highlight the issue.

3.18 As at 26 October 2009, over 4.5 million testing kits had been sent out and over 2.5 million returned. Nearly 60,000 men and women aged 70 and over had self-referred. 17,000 patients had had polyp removals and 4,000 cancers had been diagnosed.

3.19 The extension of bowel screening to men and women aged 70–75 from 2010 is a Vital Sign in the NHS Operating Framework (VSA10). Five sites have been piloting the extension to men and women aged 70–75 since September 2009. The pilots have progressed well with no major problems. Now all PCTs should commence roll-out of the age extension for bowel screening during 2010.

3.20 The CRS said that, by the end of 2010, a decision would be made on the roll-out of the programme to men and women in their 50s. Important data on the flexible sigmoidoscopy trial and the flexible sigmoidoscopy nurse-led demonstration are awaited to inform this decision.

### **Prostate cancer screening**

3.21 The Government remains committed to introducing a national screening programme for prostate cancer if and when screening and treatment techniques are sufficiently well developed. Research published in March 2009

<sup>1</sup> Sasieni P, Castanon A and Cuzick J (2009) Effectiveness of cervical screening with age: population based case-control study of prospectively recorded data. *BMJ*, 339:b2968.

showed that screening for prostate cancer could reduce the death rate from the disease by 20%. However, the study also showed that 1,410 men would need to be screened and 48 additional cases of prostate cancer would need to be treated to prevent one death from prostate cancer.<sup>2</sup> The UK National Screening Committee (NSC) is now reviewing the evidence, and has commissioned the School of Health and Related Research at the University of Sheffield to undertake modelling work based on the research data. The NSC is due to make its recommendation on prostate cancer screening in autumn 2010.

3.22 However, it is recognised that testing for prostate cancer may have some benefit for some individual men, based on their values and lifestyle. That is why the Prostate Cancer Risk Management Programme (PCRMP) was established in 2002 to ensure that men considering a prostate-specific antigen (PSA) test are given information concerning the benefits, limitations and risks associated with having a test.

3.23 A pack of materials, including a leaflet for men, was produced for primary care to help men make an informed choice about the PSA test. If a man still wants a PSA test after consultation and consideration of the leaflet, he can have one free on the NHS.

3.24 The PCRMP packs have been formally evaluated, and the results have appeared in peer-reviewed journals. Based on the findings of the evaluation and the new research published in March, the packs were revised and re-launched in July 2009. Packs were sent to all GPs in England with a covering letter from the Chief Medical Officer.

## Raising public awareness of cancer symptoms, encouraging people to seek help early and promoting early diagnosis in primary care

3.25 The NAEDI was launched in November 2008. This initiative is being jointly led by DH and Cancer Research UK.

### National implementation

3.26 At a national level, work has been progressing well in the following areas:

- assembling existing and new evidence linking awareness, late diagnosis and poor survival: a special supplement to the *British Journal of Cancer* will be published imminently
- measuring public awareness: a Cancer Awareness Measure has been developed and a population-based survey has been undertaken, as well as a separate survey of people from ethnic minority communities. These surveys have shown low general awareness of the signs and symptoms of cancer (see Box 1 below):

#### Box 1: Measuring public awareness

A baseline population-based survey using the Cancer Awareness Measure developed by University College London and Cancer Research UK was undertaken in September and October 2008 and included a general sample of 2,216 members of the public. A separate study focused on ethnic minority communities and recruited 1,500 respondents.

The results showed that, with the exception of “a lump or swelling”, less than 30% of the public surveyed were able to recall common cancer symptoms. Awareness of cancer symptoms was lower in men, younger people, those from a lower socioeconomic status (SES)

<sup>2</sup> Schröder FH, Hugosson J et al (2009) Screening and prostate-cancer mortality in a randomized European study. *N Engl J Med*, 360:1320–8.



group and ethnic minorities. On average, people were only able to recall two cancer signs or symptoms. Recognition of warning signs was considerably higher than recall for all groups surveyed. There was lower recall within ethnic minority groups, and significant variation between ethnic groups.

Few respondents anticipated that they would delay seeking help for a potentially serious symptom, although this did vary by symptom. For example, 71% of respondents said they would seek help for unexplained bleeding within one to three days, whereas nearly half said they would wait more than a month before seeking help for unexpected weight loss. The anticipated delay for different symptoms varied significantly across the ethnic groups surveyed, with Chinese respondents reporting that they were more likely to delay for several symptoms than other ethnic groups.

Reported barriers to seeking help included worry about what the doctor might find, not wanting to waste the doctor's time and difficulty making an appointment. Women and respondents from lower SES groups were more likely to report emotional barriers while respondents from higher SES groups were more likely to report practical barriers.

The full report is available at: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_108749](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108749)

- promoting awareness and earlier presentation by patients when they develop symptoms. Two national approaches to promote earlier presentation have recently been evaluated and produced evidence about the effectiveness of the interventions:

### **Box 2: One-to-one interventions to promote early presentation**

A ten-minute one-to-one intervention, to be delivered by a health professional to encourage women who may develop a breast symptom to seek early medical advice, has been developed by Professor Amanda Ramirez and funded by Cancer Research UK.

The trial involved 867 women aged 67 to 70 as they went for their final mammogram as part of the national breast cancer screening programme. The results showed a six-fold increase in the chance of women being breast aware and, one year after the talk, women were six times more likely to have the confidence to go straight to the doctor if they discovered a change that could be a sign of breast cancer.

### **Box 3: Healthy Communities Collaboratives**

The second approach to promoting early presentation is the establishment by the Improvement Foundation (with funding from DH) of a Healthy Communities Collaborative in 19 spearhead PCTs. Evaluation has shown that referrals using the two-week wait procedure have increased in wave one sites (ten PCTs) for bowel and lung cancers. The proportion of all new cases that are diagnosed following a two-week wait referral has also risen markedly for these cancers. The evidence suggests an increase in the proportion of cancer patients being diagnosed without spread of disease. However, this requires confirmation.

- establishing a national audit of cancer in primary care:

#### **Box 4: National audit of cancer diagnosis in primary care**

The Royal College of General Practitioners and the National Cancer Action Team have established a national audit of cancer in primary care. This is now being used in 18 cancer networks across the country and it is anticipated that this will yield 5,000 to 10,000 cases for further analysis and review to build a national picture of cancer diagnosis in primary care. This is also an important reflective and learning tool for primary care health professionals in clinical practice. The information will always remain confidential at practice and patient level. There will be ongoing user support and refinement of the audit tool in 2009/10 and 2010/11. The audit tool and guidance are available on the University of Durham website at: [www.dur.ac.uk/school.health/centres/erdu/cancer\\_audit/cancerdiagnosisaudittool/](http://www.dur.ac.uk/school.health/centres/erdu/cancer_audit/cancerdiagnosisaudittool/)

- running a significant event audit (SEA):

#### **Box 5: Significant event audits (SEA) of cancer diagnoses in primary care**

SEA is a team-based quality improvement technique routinely used in general practice. As part of a programme of work to develop the national audit of cancer diagnosis in primary care, SEA was used to gain insights into the diagnostic process for lung cancer and cancers affecting teenagers and young adults (TYA cancers).

Through the North of England cancer network, a sample of 202 practices were invited to participate. They were asked to identify their last registered patient diagnosed with lung cancer, and the last diagnosed with cancer as a teenager or young adult, even if that patient was now deceased. SEA reports were returned by 92 practices (46%) for 132 lung and 35 TYA cancers. Interpretation of these reports

demonstrated the complexity of the process of diagnosis in general practice. Most SEAs demonstrated appropriate recognition and referral; where that process took longer, there were often reasonable explanations. For lung cancer, these included chest X-rays reported as normal or with findings consistent with benign disease, and patient factors such as time to re-presentation. For TYA cancers, these were related to very unusual presentations in extremely rare cancers. Some examples of opportunities for earlier diagnosis were also found. There were learning points identified to do with presentation and diagnosis, safety-netting, system issues and the primary/secondary care interface, eg in relation to chest X-ray reports and the role of guidelines.

This is a novel approach to investigating circumstances surrounding diagnosis and referral for cancer symptoms in primary care. The work has produced valuable insights, resulting in useful recommendations for practice. The cancer network in the region is now responding to these findings by using rapid process improvement to redesign the way in which chest X-rays are reported and acted upon. This in turn will be evaluated to determine the extent to which evidence from the SEA analysis is able to influence practice and service configuration.

- developing Key Messages:

#### **Box 6: Key Messages**

This year, Key Messages for breast and ovarian cancer were launched. The development of cervical cancer Key Messages is one of the actions agreed following the review of cervical screening in women aged 20–24 in May 2009. These will be disseminated through a number of routes: NHS Choices, national cancer charities' websites, women's health magazines

and high-street pharmacies. A Cancer Awareness Measure tool has been developed for cervical cancer and this will be used to survey a sample population to measure the effectiveness of the cervical cancer Key Messages.

- promoting high quality research:

### **Box 7: Research into awareness and early diagnosis**

Work in each of the NAEDI work streams is identifying gaps in the evidence base and the need for further high quality research. This is likely to include research in:

- symptom awareness and beliefs in the general public
- interventions to promote behaviour change
- earlier diagnosis in primary care
- new diagnostic technologies for screening and symptomatic cases
- estimates of lifetime risk based on genetic factors.

This programme of research will be conducted under the auspices of the National Cancer Research Institute (NCRI).

DH's Policy Research Programme is commissioning policy research units in a number of high priority areas, including cancer awareness screening and early diagnosis. The unit will work closely with DH policy makers but will carry out independent research. Funding for the unit is expected to be £3 million to £5 million over five years. The successful bidder is likely to be announced in March 2010, with work starting in 2011.

The National Institute for Health Research (NIHR) has awarded a programme grant for applied research (£1.9 million over five years) to Dr Willie Hamilton at the University of Bristol entitled Diagnosis of Symptomatic Cancer (DISCOVERY). The programme aims to improve cancer diagnosis through six

interlinked projects. It will consider the issue from the patients' aspect (why they do or do not attend surgery with a symptom) and the GPs (what is the risk of cancer when a symptom is mentioned?), and will examine what is the optimum method of organising investigations for suspected cancer. It will also look at wider systemic questions such as what are current referral patterns; what level of risk needs rapid investigation; and how the system can be improved, from both an economic and a societal perspective.

Alongside this, a programme of international research will be developed as part of NAEDI to explore the different factors that are related to observed differences in survival rates. The NCAT and DH, working with a number of partner organisations, are seeking to establish an International Cancer Benchmarking Partnership to gain a better understanding of the reported differences in outcomes for cancer between England and other developed countries. The objective of the partnership is to identify the specific causes of performance differences across countries/jurisdictions (that have agreed to join the partnership) with comparable healthcare systems. It will draw on high quality cancer data and generate actionable insights to help all partners improve cancer survival outcomes in a way that is both credible to the clinicians and actionable for policy makers.

This is potentially a very large programme. Initial scoping work has therefore been undertaken, which has included identifying which cancers to focus upon, indicative components of the programme and ascertaining interest from a number of countries in joining the benchmarking partnership. The benchmarking is due to commence shortly with an initial "core benchmarking" module, looking at the root causes of differences in survival rates based on readily available data among participants.



- assessing the costs and benefits of earlier detection:

### **Box 8: Health economics of earlier diagnosis**

There is a need to understand the cost implications for the NHS of NAEDI. This autumn, an initial study was commissioned to establish the potential costs and benefits of earlier detection, focusing on breast, lung, colorectal, prostate and skin cancers. The initial results show that, for the four main cancers, there is likely to be an increased cost to the NHS, which is mainly attributed to an increase in the total cost of diagnostic tests and outpatient appointments. However, this is offset by the increase in the number of patients who are diagnosed early and improvements in both one-year and five-year survival rates in the target population, suggesting that there are important gains to be made in improving outcomes for cancer patients.

In the longer term, the aim is to produce a comprehensive economic case, based on evidence from relevant studies and pilots currently under way and on more detailed models of specific cancers.

### **Improving access to diagnostics**

3.27 The Government's announcement in September set out plans for GPs to refer patients for appropriate diagnostic tests, where the GP thinks that the risk of cancer does not justify a two-week urgent referral to see a specialist, but there are symptoms that require investigation. This supports the existing commitments in the CRS to improve access to diagnostics in primary care. The aim is to roll this out from 2011/12 over a five-year period. Initially, the focus will be on the diagnostics associated with lung, colorectal and ovarian cancer, with an expectation that people will know within two weeks whether they have cancer. This will be

followed in the subsequent three years by a move towards people with all conditions that could possibly be cancer knowing the results of tests, first, within two weeks and, by the end of the five-year period, within one week. This phased approach will enable the NHS to develop the extra workforce and equipment capacity that will be required to enable these tests to be carried out. Mike Richards, the National Cancer Director, will now work with the NHS, the professions and other key stakeholders to ensure that this commitment to patients is successfully delivered.

3.28 Open access to a number of diagnostic tests – including non-obstetric ultrasound, computer tomography, magnetic resonance imaging and endoscopy – appears to be variable across the country. Work is under way to ascertain the extent to which direct access to appropriate investigations is available to GPs and their perceptions of such services. Barriers to the provision of direct access services will be explored and overcome.

### **Local implementation**

3.29 Table 3 at the end of this chapter shows performance at PCT level on key indicators that relate to early/late diagnosis. Two columns relate to mortality at PCT level (which is a function of incidence, early/late diagnosis and treatment) and progress on mortality (as assessed by the Care Quality Commission (CQC)).

### **Box 9: What do PCT mortality data show us?**

No targets have been set for overall cancer mortality at PCT level, although PCTs are expected to contribute to progress on the national mortality target (a Tier 2 Vital Sign). The table sets out the cancer mortality rates by PCT, with those in the best quartile marked with \* and those in the worst quartile marked with !.

A marked north/south split is observed, with many more PCTs in the north in the worst quartile. The picture in London is mixed between PCTs. These results are likely to be strongly related to smoking prevalence.

The majority of PCTs have been rated by the CQC as having achieved their cancer mortality target reductions. Over half of the PCTs that have failed against the CQC standard are in London and the North West.

3.30 The other columns relate to:

- coverage of breast and cervical screening programmes, ie the proportion of eligible women who have been screened in the past five and three years (see commentary in chapter 2)
- one-year survival for the three commonest cancer killers (breast, colorectal and lung cancer):

#### **Box 10: What do one-year survival data tell us?**

##### ***Breast cancer – one-year survival***

One-year survival for breast cancer for all PCTs combined was 94.9%. At an individual PCT level this ranged from 89.3% (Tower Hamlets PCT) to 99% (Torbay Care Trust). 13 PCTs had survival rates above 97% (the consensus “good practice” benchmark based on international comparisons). In contrast, eleven PCTs had one-year survival rates below 92%. Eight of these were within London.

Both the North East SHA and the South West SHA have relatively high numbers of PCTs in the upper quartile and none in the lower quartile. In contrast, London, South East Coast and East of England SHAs have relatively high numbers of PCTs in the lower quartile and few, if any, in the upper quartile.

##### ***Colorectal cancer – one-year survival***

One-year survival for colorectal cancer for all PCTs combined was 70.7%. At an individual PCT level this ranged from 57.9% (Waltham Forest PCT) to 80% (Telford and Wrekin PCT). 19 PCTs had survival rates above 75%, though only one (Telford and Wrekin) achieved the international “good practice” level of 79%. Eleven PCTs had one-year survival rates below 65%, of which five were in London, two in the North West and one in Yorkshire and Humberside.

##### ***Lung cancer – one-year survival***

Average one-year survival for lung patients across all PCTs was 28.1%. Wide variation was observed between PCTs, ranging from 15.4% (Herefordshire PCT) to 43.7% (Kensington and Chelsea PCT). This was the only PCT to match the international “good practice” level of 37% or higher. A total of 21 PCTs had survival rates above 32%. Eleven of these were in London. Three PCTs (Blackpool PCT, Milton Keynes PCT and Hereford PCT) had survival rates below 20%. A further 22 had survival rates between 20 and 25%.

Two SHAs (London and South West) had a large number of PCTs in the upper quartile and only a few in the lower quartile. In contrast Yorkshire and Humber, East Midlands and South East Coast had several PCTs in the lower quartile and none in the upper quartile.

- information on the number of people referred through the two-week pathway and the proportion of cancers diagnosed through this route (see box below and Table 3 at the end of the chapter). It is important to note that there are no right or wrong figures, but PCTs with outlying figures may wish to look into this in more detail:

### Box 11: What do the data on urgent referrals for suspected cancer show us?

Across the country, around 800,000 urgent referrals are made by GPs each year. An analysis based on urgent referrals made in April to June 2009 shows that, on average, GPs make around 40 urgent referrals per quarter (or 160 per year) per 10,000 population. In other words, a practice serving a population of 10,000 people will make just over three urgent referrals each week.

There is wide variation in the uptake of the two-week wait referral route between PCTs. It is important to emphasise that there is no “right” or “wrong” level of urgent referrals, but PCTs may wish to examine use of this referral option at a general practice level, taking account of the national picture. In 38 (25%) PCTs, urgent referral levels were above 200 per 10,000 population pa, while in five (3%) PCTs referral levels were below 100 per (25%) PCTs, urgent referral levels were above 200 per 10,000 population per year, while in five (3%) PCTs referral levels were below 100 per 10,000 population per year. The full range varied from 70 per 10,000 (Newham PCT) to 248 per 10,000 (Liverpool PCT and Sefton PCT). Most (27 of 38) PCTs with high usage of the urgent referral route (ie above 200 per 10,000 population) were in four SHAs (North East, North West, West Midlands and South West). In contrast, three of the five PCTs with low usage were in London.

#### Conversion rates

The second column of figures relating to two-week wait referrals in Table 3 relates to the population of patients referred through the two-week wait route who were subsequently found to have cancer. This is sometimes referred to as the “conversion rate”. For the country as a whole the conversion rate is around 12%, but at PCT level this varied from 20% (Solihull Care Trust) to 7% (Camden PCT,

City and Hackney Teaching PCT, Greenwich Teaching PCT, Islington PCT, Waltham Forest PCT and North East Essex PCT). A total of seven PCTs had conversion rates of 17% or more, while 17 had conversion rates of 6% to 8%. Thirteen of the 17 with low conversion rates were in London.

While there is no right or wrong conversion rate, PCTs may wish to consider conversion rates alongside the number of referrals per 10,000 population. A low referral rate combined with a high conversion rate may indicate significant under-utilisation of the two-week wait referral route by GPs. A low referral rate and a low conversion rate may indicate both under-usage and poor selection of patients for urgent referral.

#### Proportion diagnosed through the urgent referral route

Across England as a whole, around 45% of cancers were diagnosed through the two-week wait referral route in Q1 2009/10. Other patients will have been diagnosed through screening, through emergency admissions or through routine referrals.

At PCT level, the proportion diagnosed through the two-week wait referral route ranged from 23% (Manchester PCT) to 76% (Greenwich Teaching PCT). A total of seven PCTs diagnosed 55% to 59% through this route. In contrast, six PCTs diagnosed less than 30% through this route (two in North West and four in London) and a further nine diagnosed only 30% to 34% through the two-week wait route.

Three SHAs (South West, South Central and West Midlands) had relatively high numbers of PCTs in the upper quartile and one or no PCTs in the lower quartile. In contrast, London and South East Coast SHAs had relatively high numbers of PCTs in the lower quartile.

3.31 In addition to the hard data set out above, there is also a lot of softer information about progress across the country on achieving earlier detection.

3.32 There is now a concerted effort across the NHS to bring a new focus to service delivery on awareness and early diagnosis. In a few areas of the country, this has built on existing programmes. For most, it has required cancer networks and PCTs to establish new areas of work. This year, DH invested over £6 million locally to help cancer networks and PCTs move forward on the commitments in the CRS on awareness and early diagnosis and put in place the basics for implementation: understanding the local needs; developing clinical leadership; agreeing plans with network and PCT boards; and commissioning new services.

3.33 The NCAT is working alongside the cancer networks and PCTs, providing tailored advice and support. Launch events have brought together health professionals, cancer charities and patient groups to shape local plans. A guidance note on conducting baseline assessments for awareness and early diagnosis was issued by the NCIN and the NCAT in May 2009.

3.34 All PCTs and networks have been encouraged to make use of this resource, and their proposals have included some or all of the following:

- adopting interventions such as social marketing to improve symptom awareness and to promote early presentation, particularly among high-risk populations – for example, a successful social marketing campaign was run by NHS Doncaster which increased significantly the early detection of lung cancer in a target group of men aged over 50 in six deprived wards
- addressing inappropriate variation in urgent two-week wait referrals between GP practices.
- undertaking a baseline assessment as the basis for local strategies
- using the Cancer Awareness Measure tool to assess population awareness of signs and symptoms of cancer
- using the National Audit of Cancer Diagnosis in Primary Care to gather data on the interval from symptom onset to diagnosis in primary care for most cancers

Table 3: Screening and early diagnosis

PCT name	Screening		Waits				Survival			Mortality	
	Cervical (25–64)	Breast (53–70)	Referrals/10,000 Popn thro 2WW	% 2WW with Cancer	% diag thro 2WW	62-day compliance	Breast – 1 Year Survival	Colorectal – 1 Year Survival	Lung – 1 Year Survival	PCT Local Mortality Targets (CQC)	Mortality Rate by PCT (per 100,000)
<b>NORTH EAST STRATEGIC HEALTH AUTHORITY</b>											
County Durham PCT	81.9% *	80.2% *	192	14%	44%	●	95.7%	65.4% !	29.1%	●	197 !
Darlington PCT	81.3% *	77.6%	155	16%	43%	●	97.9% *	73.7% *	34.5% *	●	186 !
Gateshead PCT	80.2%	78.5%	237	11%	42%	●	96.8% *	71.1%	29.0%	●	202 !
Hartlepool PCT	76.8%	77.6%	246	11%	47%	●	96.9% *	65.9% !	21.1% !	●	230 !
Middlesbrough PCT	75.0% !	72.2%	152	13%	41%	●	94.9%	73.4% *	27.1%	●	216 !
Newcastle PCT	77.8%	76.4%	190	9%	43%	●	96.5% *	72.2%	29.0%	●	205 !
Northumberland Care Trust	84.4% *	82.8% *	212	11%	37%	●	96.4% *	75.0% *	28.5%	●	177
North Tyneside PCT	81.8% *	78.2%	232	11%	49%	●	94.8%	70.2%	28.6%	●	199 !
Redcar and Cleveland PCT	80.1%	77.9%	164	17%	48%	●	97.2% *	69.6%	27.1%	●	190 !
South Tyneside PCT	79.1%	77.4%	242	10%	48%	●	96.9% *	71.1%	30.1%	●	214 !
North Tees PCT	79.5%	78.1%	224	9%	46%	●	96.3% *	75.0% *	27.8%	●	195 !
Sunderland Teaching PCT	80.7%	79.1%	181	14%	42%	●	95.9%	72.5%	32.5% *	●	201 !
<b>NORTH WEST STRATEGIC HEALTH AUTHORITY</b>											
Ashton, Leigh and Wigan PCT	80.3%	73.4%	122	11%	49%	●	95.4%	71.8%	29.9%	●	184
Blackburn with Darwen PCT	75.3% !	69.1% !	140	10%	36%	●	91.4% !	68.7%	24.5% !	●	192 !
Blackpool PCT	75.2% !	60.8% !	219	16%	48%	●	92.5% !	68.0% !	18.3% !	●	201 !
Bolton PCT	79.6%	77.9%	146	12%	46%	●	95.3%	67.9% !	28.8%	●	185
Bury PCT	81.0%	78.4%	158	14%	51%	●	93.5% !	70.0%	22.3% !	●	183
Central and Eastern Cheshire PCT	82.2% *	82.4% *	119	13%	40%	●	97.3% *	73.7% *	31.3% *	●	161
Central Lancashire PCT	78.8%	72.7%	185	13%	43%	●	94.9%	73.1%	26.0% !	●	175
Cumbria PCT	81.9% *	78.5%	225	11%	51%	●	95.3%	75.2% *	25.9% !	●	173
East Lancashire PCT	78.8%	73.6%	156	12%	43%	●	94.3%	72.9%	23.0% !	●	174
Halton and St Helens PCT	78.9%	76.1%	191	9%	42%	●	96.1%	70.9%	29.9%	●	202 !
Heywood, Middleton and Rochdale PCT	77.8%	71.0% !	131	14%	44%	●	95.9%	74.5% *	30.8% *	●	194 !
Knowsley PCT	75.7% !	69.1% !	238	8%	50%	●	95.0%	68.3%	32.6% *	●	223 !
Liverpool PCT	71.9% !	71.1%	248	9%	43%	●	93.1% !	70.4%	33.4% *	●	237 !
Manchester PCT	73.5% !	63.5% !	137	11%	23%	●	95.4%	63.1% !	28.7%	●	217 !
North Lancashire PCT	79.1%	76.2%	220	14%	49%	●	95.8%	72.7%	29.4%	●	173
Oldham PCT	79.0%	73.3%	101	18%	42%	●	95.7%	69.9%	23.2% !	●	191 !
Salford PCT	77.2%	71.6%	152	13%	43%	●	93.8% !	74.1% *	29.1%	●	218 !
Sefton PCT	74.6% !	74.3%	248	9%	43%	●	94.9%	72.2%	32.4% *	●	183
Stockport PCT	81.8% *	76.1%	198	13%	46%	●	97.6% *	73.9% *	28.5%	●	174
Tameside and Glossop PCT	79.6%	74.7%	145	14%	48%	●	96.5% *	61.5% !	22.7% !	●	197 !
Trafford PCT	80.7%	73.4%	131	14%	27%	●	94.9%	70.8%	27.6%	●	176
Warrington PCT	82.2% *	77.9%	157	12%	55%	●	97.6% *	67.9% !	26.1% !	●	177
Western Cheshire PCT	81.4% *	80.8% *	152	11%	52%	●	97.6% *	75.4% *	33.8% *	●	177
Wirral PCT	77.8%	78.7%	160	14%	53%	●	95.4%	71.6%	29.9%	●	193 !



Table 3: Screening and early diagnosis (continued)

PCT name	Screening		Waits				Survival			Mortality	
	Cervical (25–64)	Breast (53–70)	Referrals/10,000 Popn thro 2WW	% 2WW with Cancer	% diag thro 2WW	62-day compliance	Breast – 1 Year Survival	Colorectal – 1 Year Survival	Lung – 1 Year Survival	PCT Local Mortality Targets (CQC)	Mortality Rate by PCT (per 100,000)
<b>YORKSHIRE AND THE HUMBER STRATEGIC HEALTH AUTHORITY</b>											
Barnsley PCT	81.5% *	82.8% *	197	12%	38%	●	92.8% !	64.9% !	22.9% !	●	198 !
Bradford and Airedale PCT	76.6%	72.7%	185	11%	42%	●	95.7%	72.9%	28.8%	●	178
Calderdale PCT	81.8% *	70.3% !	135	18%	45%	●	96.1%	68.4%	27.5%	●	175
Doncaster PCT	81.6% *	75.7%	202	12%	36%	●	94.0% !	67.8% !	28.0%	●	195 !
East Riding of Yorkshire PCT	83.3% *	72.8%	153	17%	42%	●	96.9% *	73.3% *	29.8%	●	165
Hull PCT	79.3%	72.4%	121	15%	32%	●	96.4% *	66.5% !	27.1%	●	213 !
Kirklees PCT	80.9%	77.0%	122	16%	42%	●	96.7% *	73.6% *	25.8% !	●	176
Leeds PCT	77.2%	73.9%	166	12%	37%	●	95.4%	70.8%	28.5%	●	183
North East Lincolnshire Care Trust Plus	80.9%	56.6% !	–	–	–	●	–	–	–	●	182
North Lincolnshire PCT	81.1%	71.1%	187	11%	36%	●	97.5% *	66.9% !	26.0% !	●	174
North Yorkshire and York PCT	82.7% *	82.6% *	153	15%	40%	●	96.9% *	74.2% *	29.1%	●	159 *
Rotherham PCT	79.8%	82.2% *	178	11%	52%	●	93.9% !	70.4%	25.8% !	●	190 !
Sheffield PCT	79.8%	78.2%	174	13%	41%	●	94.3%	71.0%	28.3%	●	179
Wakefield District PCT	80.2%	76.9%	199	12%	41%	●	95.9%	70.9%	26.3%	●	189 !
<b>EAST MIDLANDS STRATEGIC HEALTH AUTHORITY</b>											
Bassetlaw PCT	84.5% *	80.4% *	153	14%	40%	●	94.8%	71.5%	22.7% !	●	192 !
Derby City PCT	81.0%	80.6% *	201	13%	44%	●	94.2%	62.6% !	26.0% !	●	166
Derbyshire County PCT	84.9% *	82.2% *	177	15%	43%	●	94.8%	68.2% !	24.3% !	●	172
Leicester City PCT	76.9%	74.8%	128	10%	44%	●	95.0%	70.9%	28.2%	●	172
Leicestershire County and Rutland PCT	83.9% *	83.5% *	159	12%	44%	●	95.2%	70.2%	29.6%	●	156 *
Lincolnshire Teaching PCT	81.6% *	73.5%	228	13%	49%	●	94.2%	70.1%	27.1%	●	166
Northamptonshire Teaching PCT	80.4%	81.4% *	169	15%	49%	●	95.4%	69.3%	24.5% !	●	174
Nottingham City PCT	79.6%	75.8%	189	15%	50%	●	93.4% !	62.7% !	27.5%	●	199 !
Nottinghamshire County Teaching PCT	85.8% *	82.7% *	223	15%	52%	●	95.2%	72.3%	27.4%	●	171
<b>WEST MIDLANDS STRATEGIC HEALTH AUTHORITY</b>											
Birmingham East and North PCT	74.4% !	72.4%	162	19%	47%	●	95.3%	71.4%	27.6%	●	181
Coventry Teaching PCT	77.1%	72.9%	235	8%	42%	●	94.6%	72.1%	23.8% !	●	178
Dudley PCT	79.8%	76.8%	233	10%	45%	●	95.6%	76.2% *	24.5% !	●	174
Heart of Birmingham Teaching PCT	76.3% !	66.0% !	93	10%	34%	●	94.3%	73.2%	26.0% !	●	180
Herefordshire PCT	80.7%	81.2% *	151	14%	45%	●	96.6% *	74.9% *	15.4% !	●	156 *
North Staffordshire PCT	82.3% *	78.9%	221	14%	54%	●	93.6% !	70.6%	26.2%	●	170
Sandwell PCT	77.5%	67.5% !	183	12%	32%	●	93.4% !	71.4%	30.4% *	●	191 !
Shropshire County PCT	82.4% *	82.9% *	169	15%	45%	●	96.1%	77.0% *	27.4%	●	161
Solihull Care Trust	77.7%	77.9%	202	20%	48%	●	96.4% *	72.9%	33.7% *	●	161
South Birmingham PCT	72.9% !	72.9%	218	8%	39%	●	96.8% *	75.8% *	34.6% *	●	179
South Staffordshire PCT	82.5% *	81.1% *	178	13%	51%	●	95.6%	74.9% *	28.3%	●	171
Stoke on Trent PCT	79.9%	76.7%	236	11%	58%	●	95.1%	66.1% !	27.1%	●	204 !
Telford and Wrekin PCT	79.6%	78.8%	145	11%	38%	●	95.8%	80.0% *	23.7% !	●	179
Walsall Teaching PCT	77.8%	72.9%	133	13%	30%	●	96.3% *	74.2% *	28.1%	●	182
Warwickshire PCT	80.4%	79.4%	208	12%	46%	●	95.0%	74.8% *	29.0%	●	166
Wolverhampton City PCT	77.5%	72.4%	168	10%	41%	●	95.4%	70.8%	30.6% *	●	186 !
Worcestershire PCT	79.1%	82.3% *	176	16%	61%	●	97.0% *	71.4%	28.4%	●	159 *

Table 3: Screening and early diagnosis (continued)

PCT name	Screening		Waits				Survival			Mortality	
	Cervical (25–64)	Breast (53–70)	Referrals/10,000 Popn thro 2WW	% 2WW with Cancer	% diag thro 2WW	62-day compliance	Breast – 1 Year Survival	Colorectal – 1 Year Survival	Lung – 1 Year Survival	PCT Local Mortality Targets (CQC)	Mortality Rate by PCT (per 100,000)
<b>EAST OF ENGLAND STRATEGIC HEALTH AUTHORITY</b>											
Bedfordshire PCT	82.0% *	79.7%	158	11%	46%	●	95.7%	70.6%	25.7% !	●	161
Cambridgeshire PCT	81.1%	79.8% *	222	11%	53%	●	96.3% *	73.9% *	30.4% *	●	157 *
East and North Hertfordshire PCT	81.4% *	76.5%	148	13%	43%	●	92.8% !	68.4%	20.3% !	●	158 *
Great Yarmouth and Waveney PCT	80.5%	79.7% *	203	14%	43%	●	94.9%	70.8%	28.5%	●	164
Luton PCT	77.0%	75.2%	93	9%	75%	●	93.2% !	64.9% !	24.5% !	●	170
Mid Essex PCT	79.8%	82.4% *	144	13%	61%	●	93.5% !	69.4%	26.7%	●	160 *
Norfolk PCT	80.8%	80.5% *	221	12%	50%	●	95.9%	72.8%	31.7% *	●	155 *
North East Essex PCT	81.4% *	81.4% *	198	7%	43%	●	96.0%	68.6%	26.1%	●	158 *
Peterborough PCT	77.1%	78.3%	171	12%	46%	●	95.6%	76.7% *	27.6%	●	168
South East Essex PCT	78.4%	73.5%	159	14%	41%	●	95.3%	72.1%	26.5%	●	169
South West Essex PCT	77.7%	72.4%	112	13%	38%	●	93.3% !	67.8% !	30.4% *	●	173
Suffolk PCT	80.9%	81.4% *	186	13%	46%	●	95.4%	72.1%	29.5%	●	158 *
West Essex PCT	80.4%	65.9% !	184	10%	45%	●	92.3% !	65.5% !	27.5%	●	163
West Hertfordshire PCT	79.8%	74.8%	168	10%	41%	●	90.6% !	65.7% !	22.8% !	●	161
<b>LONDON STRATEGIC HEALTH AUTHORITY</b>											
Barking and Dagenham PCT	75.7% !	70.0% !	166	8%	37%	●	90.2% !	65.6% !	26.9%	●	195 !
Barnet PCT	72.3% !	42.3% !	145	9%	36%	●	91.6% !	64.2% !	30.4% *	●	150 *
Bexley Care Trust	82.1% *	77.3%	174	8%	57%	●	96.9% *	66.8% !	29.3%	●	164
Brent Teaching PCT	70.3% !	44.1% !	143	12%	44%	●	95.4%	64.5% !	32.9% *	●	147 *
Bromley PCT	81.9% *	75.6%	139	10%	40%	●	95.9%	75.1% *	28.7%	●	158 *
Camden PCT	69.3% !	55.4% !	176	7%	48%	●	95.7%	71.2%	29.9%	●	173
City and Hackney Teaching PCT	72.7% !	54.4% !	150	7%	41%	●	92.2% !	77.5% *	32.6% *	●	171
Croydon PCT	75.9% !	69.8% !	116	11%	34%	●	96.2%	71.0%	31.8% *	●	160 *
Ealing PCT	73.1% !	68.0% !	111	8%	33%	●	91.9% !	67.5% !	32.2% *	●	154 *
Enfield PCT	76.9%	58.6% !	135	13%	51%	●	94.2%	62.6% !	28.5%	●	158 *
Greenwich Teaching PCT	74.4% !	66.0% !	206	7%	76%	●	92.4% !	68.2% !	30.0%	●	191 !
Hammersmith and Fulham PCT	65.8% !	59.9% !	71	13%	33%	●	91.4% !	72.6%	35.3% *	●	169
Haringey Teaching PCT	72.5% !	52.4% !	117	11%	48%	●	94.1%	65.3% !	28.6%	●	174
Harrow PCT	73.1% !	64.1% !	180	8%	47%	●	94.3%	71.2%	29.1%	●	145 *
Havering PCT	81.1%	78.8%	234	14%	60%	●	94.3%	66.4% !	27.7%	●	173
Hillingdon PCT	75.3% !	71.7%	113	9%	29%	●	89.5% !	66.2% !	27.4%	●	166
Hounslow PCT	73.1% !	66.3% !	104	8%	29%	●	91.7% !	69.9%	33.5% *	●	167
Islington PCT	72.7% !	59.1% !	157	7%	29%	●	95.0%	71.2%	34.8% *	●	196 !
Kensington and Chelsea PCT	67.2% !	55.3% !	124	10%	27%	●	96.4% *	76.6% *	43.7% *	●	113 *
Kingston PCT	76.1% !	71.4%	154	11%	37%	●	94.2%	68.5%	31.4% *	●	158 *
Lambeth PCT	71.2% !	59.6% !	187	8%	50%	●	92.1% !	70.5%	26.9%	●	187 !
Lewisham PCT	74.2% !	63.8% !	189	8%	55%	●	94.3%	65.6% !	32.9% *	●	191 !
Newham PCT	74.8% !	56.2% !	70	15%	44%	●	91.0% !	64.7% !	25.0% !	●	185
Redbridge PCT	77.6%	70.1% !	139	13%	60%	●	92.5% !	72.5%	27.1%	●	156 *
Richmond and Twickenham PCT	77.6%	70.5% !	136	8%	37%	●	95.6%	72.6%	35.2% *	●	163
Southwark PCT	71.9% !	61.5% !	145	11%	55%	●	93.2% !	67.9% !	25.4% !	●	174
Sutton and Merton PCT	76.0% !	70.5% !	153	14%	42%	●	94.6%	71.8%	32.4% *	●	160 *
Tower Hamlets PCT	70.8% !	53.4% !	109	13%	53%	●	89.3% !	67.1% !	29.1%	●	210 !
Waltham Forest PCT	78.4%	70.0% !	139	7%	69%	●	93.1% !	57.9% !	21.8% !	●	176
Wandsworth PCT	71.5% !	63.1% !	174	9%	40%	●	96.2%	70.9%	31.3% *	●	173
Westminster PCT	68.1% !	52.7% !	95	10%	34%	●	93.6% !	68.9%	33.4% *	●	141 *

Table 3: Screening and early diagnosis (continued)

PCT name	Screening		Waits				Survival			Mortality	
	Cervical (25–64)	Breast (53–70)	Referrals/10,000 Popn thro 2WW	% 2WW with Cancer	% diag thro 2WW	62-day compliance	Breast – 1 Year Survival	Colorectal – 1 Year Survival	Lung – 1 Year Survival	PCT Local Mortality Targets (CQC)	Mortality Rate by PCT (per 100,000)
<b>SOUTH EAST COAST STRATEGIC HEALTH AUTHORITY</b>											
Brighton and Hove City PCT	75.4% !	63.7% !	241	12%	46%	●	93.6% !	67.5% !	23.1% !	●	184
East Sussex Downs and Weald PCT	79.9%	72.1%	187	16%	50%	●	92.6% !	71.5%	28.9%	●	155 *
Eastern and Coastal Kent PCT	80.8%	78.7%	239	12%	58%	●	93.5% !	65.1% !	23.7% !	●	173
Hastings and Rother PCT	80.6%	78.8%	191	17%	51%	●	90.3% !	57.8% !	23.2% !	●	169
Medway PCT	82.0% *	80.7% *	106	11%	51%	●	94.6%	70.9%	23.2% !	●	187 !
Surrey PCT	80.6%	76.9%	169	12%	43%	●	95.2%	71.1%	29.9%	●	150 *
West Kent PCT	83.2% *	78.9%	170	12%	47%	●	94.4%	67.9% !	29.0%	●	160 *
West Sussex PCT	81.0%	76.6%	193	13%	44%	●	93.5% !	70.1%	26.9%	●	159 *
<b>SOUTH CENTRAL STRATEGIC HEALTH AUTHORITY</b>											
Berkshire East PCT	77.6%	80.2% *	145	9%	41%	●	96.8% *	73.1%	26.6%	●	157 *
Berkshire West PCT	80.2%	80.7% *	160	13%	59%	●	95.1%	71.4%	25.3% !	●	161
Buckinghamshire PCT	81.5% *	82.9% *	150	13%	41%	●	97.0% *	72.4%	30.5% *	●	151 *
Hampshire PCT	81.2% *	78.0%	158	15%	45%	●	96.5% *	75.0% *	31.3% *	●	155 *
Isle of Wight Healthcare PCT	80.2%	81.0% *	196	13%	41%	●	95.4%	73.9% *	23.7% !	●	158 *
Milton Keynes PCT	79.1%	79.0%	177	13%	48%	●	95.9%	68.6%	17.5% !	●	176
Oxfordshire PCT	77.1%	81.2% *	165	14%	50%	●	97.0% *	75.4% *	27.2%	●	158 *
Portsmouth City Teaching PCT	74.6% !	72.1%	196	16%	50%	●	93.4% !	69.2%	29.0%	●	181
Southampton City PCT	74.8% !	71.0% !	180	13%	49%	●	95.7%	74.0% *	30.8% *	●	179
<b>SOUTH WEST STRATEGIC HEALTH AUTHORITY</b>											
Bath and North East Somerset PCT	79.5%	76.8%	112	16%	34%	●	97.0% *	69.4%	33.6% *	●	156 *
Bournemouth and Poole PCT	82.8% *	77.2%	161	15%	43%	●	96.4% *	76.5% *	32.9% *	●	156 *
Bristol PCT	74.7% !	73.7%	221	10%	44%	●	96.3% *	72.0%	28.0%	●	181
Cornwall and Isles of Scilly PCT	80.5%	79.9% *	225	15%	54%	●	96.6% *	74.2% *	30.6% *	●	162
Devon PCT	82.3% *	80.0% *	205	13%	43%	●	96.3% *	72.0%	29.6%	●	159 *
Dorset PCT	84.1% *	80.5% *	183	13%	39%	●	94.7%	75.8% *	25.1% !	●	151 *
Gloucestershire PCT	82.1% *	80.1% *	187	14%	44%	●	96.2%	75.8% *	28.3%	●	153 *
North Somerset PCT	81.2% *	80.2% *	217	12%	48%	●	95.7%	72.5%	31.1% *	●	151 *
Plymouth Teaching PCT	79.8%	81.3% *	240	13%	54%	●	94.3%	76.6% *	26.5%	●	184
Somerset PCT	82.0% *	82.1% *	233	12%	50%	●	94.2%	71.7%	27.4%	●	153 *
South Gloucestershire PCT	82.7% *	80.5% *	206	10%	45%	●	95.7%	75.1% *	28.2%	●	156 *
Swindon PCT	76.8%	79.1%	194	9%	44%	●	94.7%	73.6% *	30.4% *	●	170
Torbay Care Trust	80.4%	77.9%	209	13%	38%	●	99.0% *	74.9% *	29.9%	●	159 *
Wiltshire PCT	80.7%	80.3% *	155	13%	37%	●	97.2% *	72.6%	27.5%	●	152 *



**Cervical screening**

This shows screening coverage for cervical national screening programmes, for the PCT.

The figure shown is from the most recent published data from the NHS Information Centre (2008/09).

Those in the highest quartile are shown with a \* alongside the percentage.

Those in the lowest quartile are shown with a !.

Screening coverage rates demonstrate the proportion of the population eligible to be screened who actually are screened.

**Breast screening**

This shows screening coverage for breast national screening programmes, for the PCT.

Data are for 2007/08, the most up to date published by the NHS Information Centre, sourced from the Cancer Commissioning Toolkit.

Those in the highest quartile are shown with a \* alongside the percentage.

Those in the lowest quartile are shown with a !.

Screening coverage rates demonstrate the proportion of the population eligible to be screened who actually are screened.

**Referrals per 10,000 population through two-week wait**

This shows the number of cases (per 10,000 population) referred as an urgent GP referral for suspected cancer (two-week wait) within a PCT. Data are from Q1 2009/10.

**Percentage two-week wait with cancer**

This shows the percentage of two-week wait referrals who were then diagnosed with cancer. Data are extracted from the latest available from the Cancer Commissioning Toolkit and are for Q3 2008/09.

**Percentage diagnosed through two-week wait**

This shows the percentage of all cancer patients who were referred urgently for suspected cancer (two-week wait) by their GP. Data are extracted from the latest available from the Cancer Commissioning Toolkit and are for Q3 2008/09.

**62-day compliance**

This shows compliance with the 62-day treatment standard between urgent referral and first treatment, extracted from the Cancer Commissioning Toolkit using the latest available processed data, from Q3 2008/09. The chart shows a simple green or red indicator to indicate compliance. A black indicator shows that no processed data were available.

Waiting times statistics sourced from the Cancer Commissioning Toolkit are extracted from the NHS management datasets held on the Cancer Waiting Times Database.

**One-year survival**

This shows the number of cancer patients alive one year after diagnosis of cancer, by PCT. This is an important proxy indicator of a late diagnosis of cancer.

Please note: within these data, breast cancer includes DCIS (ductal carcinoma in situ) and lung cancer includes mesothelioma.

The following ICD groupings have been used for the survival figures:

- Breast: C50+D05
- Colorectal: C17–21+C26
- Lung: C33–C34

The chart shows the actual figure, sourced from the Cancer Commissioning Toolkit, using the latest PCT survival data for 2006 from the National Cancer Information Service (NCIS).

Those in the highest quartile are shown with a \* alongside the percentage.

Those in the lowest quartile are shown with a !.

**PCT local mortality target**

The definitions used by the CQC to determine the scores for this indicator are:

Achieved = performance consistent with plan (GREEN)

Underachieved = performance poorer than plan (AMBER)

Failed = performance poorer than plan by a clear margin (two standard deviations) (RED).

**Mortality by PCT**

Numbers of deaths with cancer as the underlying cause of death for 1996–2007 have been extracted from the NCIS database by ICD-10 three-digit cancer site, single year and quinary age group for PCTs.

The data are the February 2009 mortality data provided by Thames Cancer Registry to NCIS on behalf of the United Kingdom Association of Cancer Registries (UKACR) and the Office for National Statistics (ONS).

These data use the actual number of patients in the PCT who have died from cancer within the time period. It is not adjusted for differences in the profile of a population, eg an older population that would be expected to have more cancers, or for the size of the underlying geographic area, eg some PCTs are larger than others.

Those in the lowest quartile are shown with a \* alongside the figure.

Those in the highest quartile are shown with a !.

## Chapter 4 – Ensuring better treatment

### Introduction

4.1 To achieve the best possible outcomes, cancer patients should:

- have access to high quality services, as defined by the National Institute for Health and Clinical Excellence (NICE) Improving Outcomes Guidance (IOG)
- receive the optimal treatment for their condition.

4.2 Recommendations on optimal treatment should be made by properly constituted multidisciplinary teams (MDTs) in line with good practice guidelines. These treatments may include surgery, radiotherapy, chemotherapy (including targeted therapies), hormonal therapies or a combination of modalities.

4.3 Patients will also want to know that the quality of care is being properly monitored. National clinical audits provide one important way of doing this.

4.4 In this chapter we report on:

- progress on waiting times standards
- implementation of IOGs
- participation in national clinical audits and some of the headline findings from these audits
- centralisation of complex surgery for urological and upper gastrointestinal cancers

- uptake of laparoscopic colorectal surgical techniques
- progress on capacity and quality of radiotherapy services
- progress on drug treatments
- MDT developments.

### Waiting times standards

#### Current cancer waiting times standards

4.5 Chapter 3 reported on those elements of the waiting times standards which are particularly relevant for earlier diagnosis. This chapter looks at those standards more relevant to treatment once diagnosis has been made.

4.6 The Cancer Reform Strategy (CRS) built on the success of the Cancer Plan (2000) and introduced an extension to the existing waiting times standards covering cancer services. The key aim of this development was to ensure that more patients benefited from the success of the existing cancer waiting times standards by extending the commitments to cover more patient pathways.

4.7 The first wave of this extension, introduced from 31 December 2008, set out the following commitments:

- a maximum wait of 31 days for a second or subsequent treatment, where the treatment is surgery

- a maximum wait of 31 days for a second or subsequent treatment, where the treatment is an anti-cancer drug regimen
- a maximum wait of 62 days for first treatment for those patients urgently referred from an NHS cancer screening service
- a maximum wait of 62 days for first treatment for those patients who are upgraded onto a fast-track pathway with a suspicion of cancer by the consultant responsible for their care.

4.8 It was recognised that the implementation of these extended waiting times commitments would have a significant effect on the number of patients who might benefit, and that consequently a much larger volume of data would have to be collected on individual patients and their episodes of care to manage this. It was decided to take the opportunity afforded by this development to align the way in which these patients are monitored and managed with the existing 18 weeks processes and definitions. Under this process, cancer treatment providers no longer have to collect information about delays arising from patients' unfitness for treatment or from their taking time to think about and discuss their various treatment options. This updated process therefore:

- makes the calculation of waiting times more meaningful for patients by aligning it more fully with their actual experience
- reduces the burden on the NHS of collecting data, particularly of data that are not used for clinical purposes
- streamlines the data collection process for treatment providers
- better supports patient choice and clinical autonomy (not every patient wants to be treated within the standard time, and not every patient can be)

- helps the NHS deliver a service that better meets patients' expectations.

4.9 This new management and monitoring methodology has been implemented within the NHS since 1 January 2009. Periodic performance statistics are assessed against an "operational standard" as a means of reviewing the progress the NHS is making towards implementing the commitments within the CRS and sustaining the achievements prior to its publication.

4.10 An operational standard is the level of sustained performance against a given commitment that the NHS can reasonably be expected to deliver. For the cancer waiting times commitments, the operational standards take into consideration that for any given period there will be a number of patients who are not available for treatment. This may be because they elect to delay their treatment (patient choice), or are unfit for their treatment, or it would be clinically inappropriate to treat them within the standard time.

4.11 The most recent statistics available (Quarter 2 2009/10) show that performance continues to be sustained for these commitments. The headline results for the existing cancer waiting times commitments introduced by the Cancer Plan and those implemented following the publication of the CRS, for the period July to September 2009, are shown in Table 4.

4.12 Performance by individual PCTs against the 62-day standard is set out in Table 3 at the end of chapter 3 (but the data in that table are for an earlier period than in the national table, Table 4).

4.13 DH has recently published a consultation document about possible new rights under the NHS Constitution, including turning the two-week wait into a right.

**Table 4: Quarter 2 2009/10 waiting times performance**

Two-week wait from referral for suspected cancer to being seen by a specialist	93%	94.4%
31-day wait from diagnosis to first treatment for all cancers	96%	98.0%
62-day wait from referral for suspected cancer to first treatment for all cancers	85%	85.7%
31-day wait for subsequent treatment where the treatment is surgery	94%	95.7%
31-day wait for subsequent treatment where the treatment is an anti-cancer drug regimen	98%	99.5%
62-day wait from a referral from an NHS screening service to first treatment for all cancers	90%	93.7%
62-day wait from a consultant's decision to upgrade a patient's priority to first treatment for all cancers	None set	93.8%

**Future standards**

4.14 In addition to the standards introduced from December 2008, the CRS included two Vital Signs for cancer waiting times, which were to be phased in over a longer time period to enable the NHS to develop the required levels of service provision. These were:

- a maximum wait of two weeks for referral of general breast symptoms, where cancer is not initially suspected, to the date of the first appointment: this will be implemented from 31 December 2009
- a maximum wait of 31 days for all subsequent treatments for new cases of primary and recurring cancer. The Vital Sign is already operational for surgery, chemotherapy and other treatments and will be implemented for radiotherapy from 31 December 2010.

4.15 Concerted effort is still needed to ensure that these two Vital Signs are achieved – the first of which is relevant to achieving earlier diagnosis of cancers. PCTs are still in the process of commissioning these services and NHS providers are in the process of developing them

in order to meet the required service standard. There is already a considerable programme of work under way to support the NHS in delivering the new standards, in particular through the National Cancer Action Team (NCAT).

**Improving Outcomes Guidance**

4.16 In general, reconfiguration of services for gynaecological, upper gastrointestinal, urological, haematological and head and neck cancer services in line with NICE IOGs has now been achieved, with 123 out of 140 services being shown as “green” in Table 5.

4.17 Head and neck cancer reconfiguration lags slightly behind that for the other four cancer areas. This largely reflects the later publication date of the guidance and the later date set for implementation.

4.18 Significant problems persist in relation to implementation of the recommendations related to specialist haematological malignancy diagnostic services (shown as PATH services in Table 5). These are now being tackled with support from the NCAT.

Table 5: Improving Outcomes Guidance

Cancer network	PSA03b1 Gynaecology	PSA03b2 Upper gastrointestinal	PSA03b3 Urology	PSA03b4 Haematology	PSA03b4 Haematology – Pathology	PSA03b6 Head and neck
Anglia	●	●	●	●	●	●
Essex	●	●	●	●	●	●
Mount Vernon	●	●	●	●	●	●
North London	●	●	●	●	●	●
South East London	●	●	●	●	●	●
South West London	●	●	●	●	●	●
West London	●	●	●	●	●	●
North East London	●	●	●	●	●	●
North of England	●	●	●	●	●	●
Humber and Yorkshire Coast	●	●	●	●	●	●
Yorkshire	●	●	●	●	●	●
North Trent	●	●	●	●	●	●
Greater Manchester and Cheshire	●	●	●	●	●	●
Lancashire and South Cumbria	●	●	●	●	●	●
Merseyside and Cheshire	●	●	●	●	●	●
Central South Coast	●	●	●	●	●	●
Thames Valley	●	●	●	●	●	●
Kent	●	●	●	●	●	●
SWSH	●	●	●	●	●	●
Sussex	●	●	●	●	●	●
Avon, Somerset and Wiltshire	●	●	●	●	●	●
Dorset	●	●	●	●	●	●
Peninsula	●	●	●	●	●	●
Three Counties	●	●	●	●	●	●
East Midlands	●	●	●	●	●	●
Arden	●	●	●	●	●	●
Greater Midlands	●	●	●	●	●	●
Pan Birmingham	●	●	●	●	●	●

Source: Cancer networks report on progress to the NCAT, November 2009. Green = fully implemented; red = not fully implemented; amber = delays due to capital build projects.

4.19 At an individual cancer network level, excluding haematological malignancy diagnostic services, one cancer network – Greater Midlands – still has to complete implementation for four cancer areas; two networks still have to complete implementation for three cancer areas – Peninsula and Greater Manchester and Cheshire; and one network in two cancer areas – Avon, Somerset and Wiltshire.

## Participation in national clinical audits

4.20 There are currently five nationally designated clinical audits relating to different cancers. These are:

- the National Lung Cancer Audit (LUCADA)
- the National Colorectal Cancer Audit (NBOCAP)
- the National Head and Neck Cancer Audit (DAHNO)
- the Oesophagogastric Cancer Audit
- the Mastectomy and Breast Reconstruction Audit.

4.21 The intention is that all acute NHS trusts that provide any type of service for relevant groups of cancer patients should participate in these audits, collecting and reporting a complete dataset on each of their patients. This will allow valid comparisons to be made between trusts, taking account of case-mix variations (eg stage of disease, age and co-morbidity). These comparisons should in turn help to drive up quality.

4.22 As can be seen from Table 9 at the end of this chapter, most NHS trusts are participating in most of the audits that are relevant to them. High levels of participation are generally observed in the North East and South West Strategic Health Authorities (SHAs), demonstrating that this is achievable. In contrast,

only a small minority of trusts in London, East of England, South East Coast and South Central SHAs are reporting fully.

### Box 12: Participation in national clinical audits

Table 9 shows participation in the national clinical audits related to the three commonest cancers by NHS trusts. Participation levels are shown for a total of 156 acute NHS trusts, 147 of which provide general services and nine specialist services only. The specialist trusts would only be expected to participate in audits relevant to their patient population.

In total 34 (23%) of the 147 NHS trusts providing general services supplied data on all or the large majority (>75% of expected numbers) of new cases for all three cancer types. A further 54 (37%) provided data on all or the large majority of (>75% of expected numbers) for two of the three cancer types. However, 59 (40%) of acute trusts reported less fully than this.

Overall participation levels appeared rather better than average in the North East and South West SHAs and rather poorer than average in the South Central and South East Coast SHAs. However, there is room for improvement in participation across the country.

4.23 Despite the lack of full coverage, the audits are now beginning to yield valuable information highlighting areas requiring further action or investigation. For example:

- the National Lung Cancer Audit shows that only around 10% of patients with non-small-cell lung cancer are undergoing surgical resection. Studies in other countries suggest that a figure of around 20% should be achievable. This does, of course, depend on patients presenting and being referred when they have operable disease and are fit for



surgery. Within England, resection rates vary between cancer networks from 4% to 20%.

- the National Colorectal Cancer Audit shows that around 60% of patients with this disease undergo a major resection. Again, resection rates appear to vary widely (from around 20% to around 80%). Poor reporting of surgery may account for some of the low rates. This is being investigated urgently as part of this year's audit.

## Centralisation of complex surgery

### Major urological procedures

4.24 A total of 5,483 prostatectomies and cystectomies were undertaken in 2008/09. The IOG for urological cancers recommended that all radical prostatectomies (for prostate cancer) and cystectomies (for bladder cancer) should be undertaken in centres carrying out at least 50 such procedures in total each year.

4.25 Hospital Episode Statistics (HES) show that prostatectomies and/or cystectomies were undertaken in a total of 128 trusts in 2008/09. Table 6 shows the proportion of procedures that took place in trusts performing different numbers of procedures per year.

4.26 As can be seen, 85% of all prostatectomies were carried out in 52 centres undertaking at least 50 radical prostatectomies per year, and a further 7% in hospitals dealing with at least 40

prostatectomies. These latter hospitals may well be undertaking an appropriate workload when combined with cystectomies.

4.27 However, 4% of all prostatectomies were carried out in hospitals undertaking fewer than ten procedures per year and a further 5% (rather than 4%, as suggested by the table, because of rounding) in hospitals undertaking between 10 and 39 procedures. As prostatectomy is almost always an elective procedure, this practice must be questioned.

### Major oesophagogastric procedures for cancer

4.28 A total of 3,668 major oesophagogastric procedures were undertaken in 2008/09. The IOG for upper gastrointestinal cancer recommended that these procedures should be concentrated in centres dealing with a catchment population of at least 1 million to achieve the best possible outcomes. If this guidance had been fully implemented, one would therefore expect that services would be delivered from a maximum of 50 centres.

4.29 In practice, HES shows that these procedures are spread across 126 NHS trusts. There has undoubtedly been a major shift towards consolidation in large centres, but this is not as complete as it should be, as shown in Table 7.

**Table 6: Major urological procedures, 2008/09**

No. of major urological procedures	No. of trusts	Total major urological procedures	Percentage of national total
1–9	58	231	4%
10–19	5	76	1%
20–29	2	44	1%
30–39	3	102	2%
40–49	8	358	7%
50+	52	4,672	85%

**Table 7: Major oesophagogastric procedures, 2008/09**

No. of procedures	No. of trusts	Total procedures	Percentage of national total
1–9	61	224	6%
10–19	9	117	3%
20–29	13	313	8.5%
30–39	9	312	8.5%
40–49	6	358	10%
50+	28	2,344	64%
<b>Total</b>	<b>126</b>	<b>3,668</b>	<b>100%</b>

Source: Hospital Episode Statistics, 2008/09

4.30 Around three-quarters of all major oesophagogastric procedures were undertaken in 34 trusts carrying out at least 40 procedures per year, with a further 17% in 22 trusts dealing with between 20 and 39 cases per year. Commissioners may wish to pay particular attention to the 70 NHS trusts undertaking fewer than 20 procedures per year and accounting for 9% of the overall workload.

4.31 Table 9, at the end of this chapter, sets out the number of procedures carried out in each provider trust in relation to the above procedures. It should be noted that, at individual provider level, there may well be particular reasons for low numbers of procedures, for example reconfiguration of services during the period, and so low numbers should be a reason for asking questions rather than a matter for concern.

### Laparoscopic colorectal surgery

4.32 A national training programme (LAPCO) was established during 2008 to accelerate the adoption of laparoscopic surgery among experienced consultant surgeons with the aim of training sufficient surgeons in this technique to allow access to this treatment for all colorectal cancer patients across the country for whom it is clinically appropriate. There are ten training centres around the country, based in 16 trusts.

A new training centre in the North West has recently been agreed and will be able to take on trainees from January 2010.

4.33 Over the past 12 months, the number of trainees has increased from 30 to 87, and a further 23 consultants are in the process of being registered as trainees. A baseline survey across England in June 2009 identified an additional 100 expressions of interest in joining the national training programme which are currently being followed up. This could take the numbers in training to over 200.

4.34 National data (taken from HES) show that the proportion of laparoscopic colorectal resections has increased from 5% in 2005/06 and 12% in 2007/08 to 18% in 2008/09. A review of colorectal teams across the country using the HES data shows that 95 teams have at least one laparoscopic lead and a developing team, but there are still 69 teams in the process of establishing laparoscopic activity or with low levels of activity and with no laparoscopic lead.

4.35 In light of this, it has been decided that the waiver for the NICE guidance on colorectal laparoscopic surgery should be extended by a further 12 months to allow those MDTs with little or no expertise to support a trainee through the national training programme and start to establish a suitable practice.



## Radiotherapy

4.36 The CRS recognised the need for further expansion of radiotherapy capacity and for the need to make new technological developments (intensity modulated radiotherapy (IMRT) and image-guided radiotherapy (IGRT)) available across the NHS. This builds on the recommendations of the National Radiotherapy Advisory Group (NRAG) in 2006.

4.37 Around 85% of all radiotherapy is given as a “subsequent” rather than a “first” treatment for cancer. The 31-day standard for subsequent radiotherapy has to be achieved by December 2010. This is challenging, but achievable, and will benefit large numbers of patients.

4.38 Action is being taken at both national and local levels to support the development of radiotherapy services.

4.39 In relation to IMRT, the aspiration is to ensure that this technology is available in at least one centre per network by 2012, although the development of this service will be a matter for local decision making.

4.40 National actions include:

- tools and training to support the implementation of IMRT
- a national purchasing framework for linear accelerator machines (linacs)
- development of a capacity-planning tool (RPORT)
- provision of Virtual Environment Radiotherapy Training (VERT) across 40 clinical sites
- promoting workforce development (eg a national dosimetrist training pilot)
- development of a framework for costing external beam radiotherapy to support implementation of HRG4.

4.41 Local actions include provider organisations:

- collecting and submitting data for shadow monitoring of the 31-day standard
- completing the development of plans to achieve the NRAG-recommended standard of 40,000 fractions per million population by 2010
- reviewing plans for the longer-term expansion of radiotherapy, and, where appropriate, the establishment of satellite services
- collecting the radiotherapy dataset: radiotherapy providers are expected to be submitting complete data by the end of 2009.

## Proton beam therapy

4.42 Following the commitment in the CRS to consider options for the development of proton beam therapy (PBT) services, a framework for the development of PBT services in England was produced with the help of an expert advisory group. The National Specialised Commissioning Team (NSCT) has been asked to begin planning to commission services for 1,500 patients, including 250 paediatric patients, in England from three to five years' time.

4.43 DH is working with the NSCT to identify an NHS trust or trusts that could host these services and develop a full business case. The Government has not yet decided the funding available to the NHS beyond 2010/11, and a decision on whether to proceed with the business case will depend on future available funding.

4.44 In identifying the potential providers, the Government will be looking for those that can meet the requirements for a quality service for patients and will favour those presenting the most innovative proposals, providing the best value for money.

## Drug treatments

### Cancer drug appraisal by NICE

4.45 The CRS made a commitment that all new cancer drugs and significant licence extensions would be referred by default to NICE's technology appraisal work programme – provided that there was a sufficient patient population and evidence base for NICE to undertake an appraisal. DH and NICE developed revised topic selection arrangements for cancer drugs to deliver this commitment and these took effect from early 2008. As of October 2009, 26 cancer appraisal topics have been referred to NICE under these new arrangements.

4.46 Changes have also been introduced in 2009 to streamline the process for selecting technology appraisal topics for referral to NICE and to ensure that potential topics for referral to NICE are identified as early as possible in their development. Taken together, these changes will

enable NICE by 2010 to be able to issue draft or final guidance for new cancer drugs within six months, on average, of a drug being licensed.

4.47 NICE has provided supplementary advice to its appraisal committees when appraising treatments that may be life-extending for patients with short life expectancy and that are licensed for indications affecting small numbers of patients with incurable illnesses. The objective of this advice is to ensure that appraisal committees fully consider all the benefits that are appropriate to take into account when appraising treatments at the end of life. The flexibilities have already been applied in a number of appraisals and have helped to secure access for NHS patients to treatments such as sunitinib for renal cell carcinoma and lenalidomide for multiple myeloma.

4.48 A list of the cancer drugs approved by NICE over the last year is shown in Table 8 below.

**Table 8: Cancer drugs approved by NICE since January 2008**

Drug and indication	Approved
Pemetrexed disodium for the treatment of mesothelioma	Jan 2008
Erythropoietin (alpha and beta) and darbepoetin for the treatment of anaemia (cancer treatment induced)	May 2008
Cetuximab for the treatment of head and neck cancer	Jun 2008
Erlotinib for the treatment of non-small-cell lung cancer	Nov 2008
Sunitinib for the treatment of renal cell carcinoma	Mar 2009
Lenalidomide for the treatment of multiple myeloma	Jun 2009
Rituximab for the treatment of chronic lymphocytic leukaemia	Jul 2009
Cetuximab for the first-line treatment of colorectal cancer	Aug 2009
Sunitinib for the treatment of gastrointestinal stromal tumours	Sep 2009
Pemetrexed for the first-line treatment of non-small-cell lung cancer	Sep 2009
Topotecan for the treatment of recurrent cervical cancer	Oct 2009

### **Improving access to medicines for NHS patients**

4.49 In June 2008, the Secretary of State for Health invited Professor Mike Richards to lead a review to examine current policy relating to patients who choose to pay privately for drugs that are not funded on the NHS. Professor Richards' report, *Improving access to medicines for NHS patients*, was published in November 2008. The 14 recommendations made in his report were accepted by the Secretary of State and, following consultation, final guidance on their implementation was issued to the NHS in March 2009. Good progress has been made in meeting all the recommendations in the report.

4.50 Over the past year, the Government has also consulted on and published the NHS Constitution, which, for the first time, sets out patients' explicit rights relating to access to treatments on the NHS. The NHS Constitution enshrines patients' right to drugs and treatments recommended by NICE where they are clinically appropriate. It also makes explicit patients' right to expect local decisions on the funding of other drugs and treatments to be made rationally following a proper consideration of the evidence and with an explanation of any decision not to fund a treatment. The Government has issued Directions to NHS organisations to underpin this second right, and the DH-funded National Prescribing Centre has developed and issued principles and more detailed good practice guidance to PCTs that set out the procedures and processes they should have in place to support decision making.

4.51 In addition, the 2009 Pharmaceutical Price Regulation Scheme, which was agreed with the pharmaceutical industry, promotes more flexible approaches to the pricing of new drugs and sets the framework for patient access schemes (PASs). PASs can help improve the cost-effectiveness of a medicine and therefore allow

NICE to recommend treatments that it would not otherwise have found to be cost-effective. PASs have helped to secure the availability of a number of new drugs for NHS patients while delivering value for money for the NHS.

### **Quality and safety of chemotherapy services**

4.52 A report from the National Confidential Enquiry into Patient Outcomes and Death, published in November 2008, highlighted concerns about the quality and safety of chemotherapy services. In response to this, the National Chemotherapy Advisory Group (NCAG) published guidance in August 2009. The guidance recognises both the increasing and changing use of chemotherapy. It provides best practice for chemotherapy services by setting out a new framework for commissioning, delivering and monitoring those services and introduces the concept of "acute oncology".

4.53 One of the key recommendations in the NCAG guidance is that all hospitals with emergency departments should establish an acute oncology service. The guidance also makes recommendations on issues around chemotherapy such as decision to treat, patient consent, prescribing and dispensing, and information for patients and carers.

4.54 DH will continue to work with the NHS to determine how the guidance can be taken forward. The NCAT will provide central support as necessary and is currently establishing an oversight group to support progress. Work is already under way to develop a commissioning framework and outline service specification for chemotherapy and this will be available shortly.

4.55 The National Peer Review Team is revising the existing chemotherapy measures to take account of the recommendations in the guidance and is developing new measures for acute oncology services. This will enable networks and service providers to self-assess

their services against these measures and a further round of peer review will be undertaken to ensure that quality has improved.

### Supporting better local planning for chemotherapy

4.56 We reported last year on developments with C-PORT, a chemotherapy planning tool, which should help trusts ensure that they plan for the safe introduction of new drugs in a thorough and cost-effective way. Extensive development in the last year has resulted in the release of version 4 of C-PORT. An additional finance module is also now available and is currently being tested.

4.57 Around half of all chemotherapy services (80) are engaged with the project. A further 40 are expected by summer 2010.

4.58 C-PORT has facilitated the collection, analysis and interpretation of data from multiple sources in a way that has not previously been possible and has led to greater interdepartmental understanding of planning for new drugs. The capacity planning element has helped with the day to day delivery of chemotherapy services and has the potential to provide efficiency improvements, benefiting both patients and staff.

4.59 Further developments of C-PORT are planned. These include linking C-PORT with electronic prescribing systems and with the Cancer Commissioning Toolkit. A full package of training and support materials for version 4 will also be available.

### Chemotherapy at home

4.60 Building Britain's Future ([www.hmg.gov.uk/buildingbritiansfuture.aspx](http://www.hmg.gov.uk/buildingbritiansfuture.aspx)) said that it was important to develop more services for patients at home, where appropriate. As part of this work, DH is looking at the scope to expand the provision of chemotherapy services at home.

### Chemotherapy workforce

4.61 Work continues to support the development of the chemotherapy workforce and includes:

- updating and widening the scope of the existing chemotherapy competence framework to include primary care as well as acute oncology: this will underpin localised workforce planning and the provision of training as well as supporting new and extended roles and should be completed in 2010
- Skills for Health is developing "skills passports" as part of Modernising Nursing Careers, and links have been made to review their use for chemotherapy nurses – this will support the work being undertaken to review the scope and transferability of current localised training programmes
- e-Oncology is a web based learning resource designed to complement medical and clinical training in oncology: it is being developed as a collaboration between the Royal College of Physicians, the Royal College of Radiologists and DH's e-Learning for Healthcare.

### Multidisciplinary team working

4.62 The CRS made clear that MDT working would remain the core model for cancer service delivery in the future. The focus to date has been on getting the MDTs in place (around 1,500 in England). We now need to focus on **how** these MDTs are working.

4.63 The NCAT is overseeing a project to:

- identify the characteristics of an effective MDT
- put in place a mechanism for MDTs to assess themselves against these characteristics

- develop a programme to support MDTs to achieve and maintain these characteristics.

4.64 Over 2,000 MDT members responded to a questionnaire in February and March 2009 seeking views on MDT working to inform this project, and six workshops were held in May to seek further views. A summary of the findings from the survey can be found at: [www.ncin.org.uk/mdt](http://www.ncin.org.uk/mdt)

4.65 Key messages include the following:

- MDTs need support from their trusts
- MDT members need protected time for preparation, travel and attendance at meetings
- good leadership is a prerequisite for a good MDT
- dedicated MDT meeting rooms should be the gold standard, with robust and reliable technology
- tools to support the assessment of MDT effectiveness are needed
- a varied development & support package is needed for MDTs with different tools, some aimed at the team and others aimed at individuals.

4.66 The next steps will be to:

- issue the characteristics of an effective MDT based on the survey findings
- develop a toolkit based on the characteristics, which includes examples of local practice and national products such as checklists, proformas, specifications and templates for local adaptation
- issue a DVD on MDT working to highlight

the impact of poor working practices, poor working environments, poor technology and unhelpful behaviours

- pilot approaches to self-assessment, feedback and support with a small number of MDTs to inform any future national programme.

## Other work on cancer treatments

4.67 There is a range of other work under way in this area, including:

- DH is working with experts in the field to prepare a report on photodynamic therapy
- the Breast Cancer Working Group has prepared best practice guidelines for use across primary and secondary care for the diagnosis of breast cancer following presenting with symptoms at a GP practice. To be published in the new year, the guidelines aid improving patient experience and ensuring all patients are properly diagnosed.

Table 9: Audit participation and procedures by trust

Trust name	Audits			Procedures	
	Colorectal audit (NBOCAP)	Lung audit (LUCADA)	Mastectomy/reconstruction audit	Oesophagogastric procedures (per year)	Radical urological procedures (per year)
<b>NORTH EAST STRATEGIC HEALTH AUTHORITY</b>					
City Hospitals Sunderland NHS Foundation Trust	●	●	◐	5	113
County Durham and Darlington NHS Foundation Trust	●	●	●	3	1
Gateshead Health NHS Foundation Trust	●	●	◐	3	3
The North Tees and Hartlepool NHS Foundation Trust	●	●	●	2	8
The Northumbria Healthcare NHS Foundation Trust	●	●	◐	21	1
The South Tees Hospitals NHS Foundation Trust	●	◐	●	80	120
The South Tyneside NHS Foundation Trust	●	●	●	1	0
The Newcastle upon Tyne Hospitals NHS Foundation Trust	●	◐	●	163	159
<b>NORTH WEST STRATEGIC HEALTH AUTHORITY</b>					
Aintree University Hospitals NHS Foundation Trust	●	◐	●	53	3
Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust	●	◐	●	27	7
Liverpool Heart and Chest Hospital NHS Trust		◐		101	0
Central Manchester University Hospitals NHS Foundation Trust	◐	●		21	37
Clatterbridge Centre for Oncology NHS Foundation Trust	◐	◐		0	0
Countess of Chester Hospital NHS Foundation Trust	●	●	●	7	1
East Cheshire NHS Trust	◐	●	●	3	2
East Lancashire Hospitals NHS Trust	◐	◐	◐	37	35
Liverpool Women's NHS Foundation Trust			●	0	1
Mid Cheshire Hospitals NHS Foundation Trust	◐	◐	●	4	4
North Cumbria University Hospitals NHS Trust	●	●	●	28	1
Pennine Acute Hospitals NHS Trust	◐	◐	◐	71	49
Royal Bolton Hospital NHS Foundation Trust	●	●	●	3	5
Royal Liverpool and Broadgreen University Hospitals NHS Trust	◐	◐	●	10	89
Salford Royal NHS Foundation Trust	◐	◐	●	39	58
Southport and Ormskirk Hospital NHS Trust	◐	◐	◐	6	6
St Helens and Knowsley Hospitals NHS Trust	●	◐	◐	0	9
Stockport NHS Foundation Trust	◐	◐	●	18	92
Tameside Hospital NHS Foundation Trust	●	●	◐	25	0
The Christie NHS Foundation Trust	●	◐	●	1	53
Trafford Healthcare NHS Trust	◐	◐		0	0
University Hospital of South Manchester NHS Foundation Trust	●	◐	◐	31	90
University Hospitals of Morecambe Bay NHS Trust	●	●	◐	26	4
Warrington and Halton Hospitals NHS Foundation Trust	●	●		8	0
Wirral University Teaching Hospital NHS Foundation Trust	●	●	◐	5	45
Lancashire Teaching Hospitals NHS Foundation Trust	●	◐	◐	20	93
Wrightington, Wigan and Leigh NHS Foundation Trust	◐	◐	◐	2	3
<b>YORKSHIRE AND THE HUMBER STRATEGIC HEALTH AUTHORITY</b>					
Airedale NHS Trust	●	●	●	2	2
Barnsley Hospital NHS Foundation Trust	●	◐	●	2	3
Bradford Teaching Hospitals NHS Foundation Trust	●	●	◐	57	109
Calderdale and Huddersfield NHS Foundation Trust	◐	◐	◐	6	5
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	◐	●	◐	52	7
Harrogate and District NHS Foundation Trust	●	●	◐	0	3



Table 9: Audit participation and procedures by trust (continued)

Trust name	Audits			Procedures	
	Colorectal audit (NBOCAP)	Lung audit (LUCADA)	Mastectomy/reconstruction audit	Oesophagogastric procedures (per year)	Radical urological procedures (per year)
Hull and East Yorkshire Hospitals NHS Trust	●	●	●	104	95
Leeds Teaching Hospitals NHS Trust	●	●	●	130	133
Mid Yorkshire Hospitals NHS Trust	●	●	●	5	69
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	●	●	●	29	23
Scarborough and North East Yorkshire Healthcare NHS Trust	●	●	●	5	0
Sheffield Teaching Hospitals NHS Foundation Trust	●	●	●	82	150
The Rotherham NHS Foundation Trust	●	●	●	2	3
York Hospitals NHS Foundation Trust	●	●	●	25	17
<b>EAST MIDLANDS STRATEGIC HEALTH AUTHORITY</b>					
Chesterfield Royal Hospital NHS Foundation Trust	●	●	●	0	2
Derby Hospitals NHS Foundation Trust	●	●	●	46	70
Kettering General Hospital NHS Foundation Trust	●	●	●	4	4
Northampton General Hospital NHS Trust	●	●	●	35	68
Nottingham University Hospitals NHS Trust	●	●	●	122	80
Sherwood Forest Hospitals NHS Foundation Trust	●	●	●	1	2
United Lincolnshire Hospitals NHS Trust	●	●	●	13	91
University Hospitals of Leicester NHS Trust	●	●	●	40	57
<b>WEST MIDLANDS STRATEGIC HEALTH AUTHORITY</b>					
Birmingham Children's Hospital NHS Foundation Trust				4	0
Birmingham Women's NHS Foundation Trust				0	2
Burton Hospitals NHS Foundation Trust	●	●	●	2	0
George Eliot Hospital NHS Trust	●	●	●	3	2
Heart of England NHS Foundation Trust	●	●	●	62	210
Hereford Hospitals NHS Trust	●	●	●	7	0
Mid Staffordshire NHS Foundation Trust	●	●	●	1	3
Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust				0	0
Sandwell and West Birmingham Hospitals NHS Trust	●	●	●	9	8
Shrewsbury and Telford Hospital NHS Trust	●	●	●	14	48
South Warwickshire General Hospitals NHS Trust	●	●	●	0	1
Dudley Group of Hospitals NHS Foundation Trust	●	●	●	79	0
Royal Wolverhampton Hospitals NHS Trust	●	●	●	12	67
University Hospital Birmingham NHS Foundation Trust	●	●	●	78	151
University Hospital of North Staffordshire NHS Trust	●	●	●	100	48
University Hospitals Coventry and Warwickshire NHS Trust	●	●	●	84	105
Walsall Hospitals NHS Trust	●	●	●	5	1
Worcestershire Acute Hospitals NHS Trust	●	●	●	3	94
<b>EAST OF ENGLAND STRATEGIC HEALTH AUTHORITY</b>					
Basildon and Thurrock University Hospitals NHS Foundation Trust	●	●	●	10	18
Bedford Hospital NHS Trust	●	●	●	2	2
Cambridge University Hospitals NHS Foundation Trust	●	●	●	104	232
Colchester Hospital University NHS Foundation Trust	●	●	●	5	55
East and North Hertfordshire NHS Trust	●	●	●	11	30
Ipswich Hospital NHS Trust	●	●	●	17	3
Papworth Hospital NHS Foundation Trust		●		0	0
James Paget University Hospitals NHS Foundation Trust	●	●	●	4	6
Luton and Dunstable Hospital NHS Foundation Trust	●	●	●	24	17
Mid Essex Hospital Services NHS Trust	●	●	●	30	4

Table 9: Audit participation and procedures by trust (continued)

Trust name	Audits			Procedures	
	Colorectal audit (NBOCAP)	Lung audit (LUCADA)	Mastectomy/reconstruction audit	Oesophagogastric procedures (per year)	Radical urological procedures (per year)
Norfolk and Norwich University Hospitals NHS Foundation Trust	●	●	●	78	122
Peterborough and Stamford Hospitals NHS Foundation Trust	●	●	●	4	2
Southend University Hospital NHS Foundation Trust	●	●	●	4	41
The Princess Alexandra Hospital NHS Trust	●	●	●	2	8
Queen Elizabeth Hospital King's Lynn NHS Trust	●	●	●	6	2
West Hertfordshire Hospitals NHS Trust	●	●	●	22	60
West Suffolk Hospitals NHS Trust	●	●	●	1	6
<b>LONDON STRATEGIC HEALTH AUTHORITY</b>					
Barking, Havering and Redbridge University Hospitals NHS Trust	●	●	●	37	68
Royal National Orthopaedic Hospital NHS Trust	●	●	●	0	2
Barnet and Chase Farm Hospitals NHS Trust	●	●	●	3	80
Barts and the London NHS Trust	●	●	●	71	4
Chelsea and Westminster Hospital NHS Foundation Trust	●	●	●	37	5
Ealing Hospital NHS Trust	●	●	●	1	3
Epsom and St Helier University Hospitals NHS Trust	●	●	●	4	4
Guy's and St Thomas' NHS Foundation Trust	●	●	●	95	161
Homerton University Hospital NHS Foundation Trust	●	●	●	34	0
King's College Hospital NHS Foundation Trust	●	●	●	22	41
Kingston Hospital NHS Trust	●	●	●	0	1
Mayday Healthcare NHS Trust	●	●	●	0	4
Newham University Hospital NHS Trust	●	●	●	0	2
North Middlesex University Hospital NHS Trust	●	●	●	4	11
North West London Hospitals NHS Trust	●	●	●	4	30
Royal Free Hampstead NHS Trust	●	●	●	7	9
St George's Healthcare NHS Trust	●	●	●	32	59
The Hillingdon Hospital NHS Trust	●	●	●	1	0
The Lewisham Hospital NHS Trust	●	●	●	0	0
The Royal Marsden NHS Foundation Trust	●	●	●	83	173
The Whittington Hospital NHS Trust	●	●	●	8	4
Royal Brompton and Harefield NHS Foundation Trust	●	●	●	2	0
University College London Hospitals NHS Foundation Trust	●	●	●	100	72
West Middlesex University Hospital NHS Trust	●	●	●	0	5
Whipps Cross University Hospital NHS Trust	●	●	●	2	73
Imperial College Healthcare NHS Trust	●	●	●	120	188
South London Healthcare NHS Trust	●	●	●	11	10
<b>SOUTH EAST COAST STRATEGIC HEALTH AUTHORITY</b>					
Ashford and St Peter's Hospitals NHS Trust	●	●	●	4	50
Brighton and Sussex University Hospitals NHS Trust	●	●	●	52	60
Dartford and Gravesham NHS Trust	●	●	●	3	21
East Kent Hospitals University NHS Foundation Trust	●	●	●	9	83
East Sussex Hospitals NHS Trust	●	●	●	2	61
Frimley Park Hospital NHS Foundation Trust	●	●	●	7	4
Surrey and Sussex Healthcare NHS Trust	●	●	●	0	19
Maidstone and Tunbridge Wells NHS Trust	●	●	●	60	44
Medway NHS Foundation Trust	●	●	●	2	61
Royal Surrey County Hospital NHS Trust	●	●	●	57	54
Western Sussex Hospitals NHS Trust	●	●	●	18	18

Table 9: Audit participation and procedures by trust *(continued)*

Trust name	Audits			Procedures	
	Colorectal audit (NBOCAP)	Lung audit (LUCADA)	Mastectomy/reconstruction audit	Oesophagogastric procedures (per year)	Radical urological procedures (per year)
<b>SOUTH CENTRAL STRATEGIC HEALTH AUTHORITY</b>					
Nuffield Orthopaedic Centre NHS Trust		◐		0	0
Basingstoke and North Hampshire NHS Foundation Trust	●	●	◐	12	4
Buckinghamshire Hospitals NHS Trust	◐	◐	◐	3	78
Heatherwood and Wexham Park Hospitals NHS Foundation Trust	●	◐	●	3	73
Milton Keynes Hospital NHS Foundation Trust	◐	●	◐	1	4
Oxford Radcliffe Hospitals NHS Trust	◐	●	◐	117	54
Portsmouth Hospitals NHS Trust	●	◐	●	42	78
Royal Berkshire NHS Foundation Trust	◐	●	◐	23	87
Southampton University Hospitals NHS Trust	●	◐	◐	72	63
Winchester and Eastleigh Healthcare NHS Trust	●	●	●	1	9
<b>SOUTH WEST STRATEGIC HEALTH AUTHORITY</b>					
Gloucestershire Hospitals NHS Foundation Trust	◐	●	◐	48	75
Great Western Hospitals NHS Foundation Trust	●	●	●	1	1
North Bristol NHS Trust	●	◐	●	7	225
Plymouth Hospitals NHS Trust	●	●	●	50	75
Poole Hospital NHS Foundation Trust	●	●	◐	1	2
Dorset County Hospital NHS Foundation Trust	●	●	●	1	14
Royal Cornwall Hospitals NHS Trust	●	●	●	20	6
Royal Devon and Exeter NHS Foundation Trust	●	●	◐	47	80
Royal United Hospital Bath NHS Trust	◐	●	●	9	50
Salisbury NHS Foundation Trust	●	●	●	0	13
South Devon Healthcare NHS Foundation Trust	◐	●	●	1	7
Taunton and Somerset NHS Foundation Trust	●	●	●	5	42
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	●	●	●	49	56
University Hospitals Bristol NHS Foundation Trust	●	◐	●	88	3
Weston Area Health NHS Trust	●	●	●	0	1
Yeovil District Hospital NHS Foundation Trust	◐	●	●	1	2
<b>Key:</b> Less than 25% of expected cases ◐ Between 25% and 75% of expected cases ◑ Over 75% of expected cases ●					

**National Audit participation: NCASP**

This shows the participation of provider trusts in the national clinical audits for 2007/08 as provided by the National Clinical Audit Support Programme (NCASP) project team to the Healthcare Commission. These are categorised as:

*Colorectal Audit:* NBOCAP ratings as published for Case Ascertainment 2007/08, extracted from the latest NHS Information Centre (NHSIC) publication for the National Bowel Cancer Audit. Trusts flagged as not eligible to submit data by the NHSIC publication, or where there is no information available, are shown with a blank indicator.

An ascertainment over 75% of expected incidence is shown with a black circle. Trusts with less than 25% of expected incidence are shown marked quarter circle. Trusts between 25% and 75% are shown with a half circle. This key is also highlighted at the end of the table.

*Lung Cancer:* This shows the participation of provider trusts in the national Lung Cancer clinical audit for 2007/08 as detailed in the most recent NHSIC Annual Report. Trusts flagged as not eligible to submit data by the NHSIC publication, or where there is no information available, are shown with a blank indicator.

An ascertainment over 75% of expected incidence is shown with a black circle. Trusts with less than 25% of expected incidence are shown marked quarter circle. Trusts between 25% and 75% are shown with a half circle. This key is also highlighted at the end of the table.

*Mastectomy and Breast Reconstruction Audit:* This shows the participation of provider trusts in the national Breast Reconstruction clinical audit for 2007/08 as detailed in the most recent NHSIC Annual Report. Trusts flagged as not eligible to submit data by the NHSIC publication, or where there is no information available, are shown with a blank indicator.

An ascertainment over 75% of expected incidence is shown with a black circle. Trusts with less than 25% of expected incidence are shown marked quarter circle. Trusts between 25% and 75% are shown with a half circle. This key is also highlighted at the end of the table.

*Procedures:* Urology procedures include prostatectomy and cystectomy combined.

Oesophagogastric procedures include oesophagectomies, gastrectomies and oesphagogastrectomies.

Sourced from HES 2008/09; provided by the National Cancer Services Analysis Team.

## Chapter 5 – Living with and beyond cancer

### Introduction

5.1 There are now over 1.6 million people in England living with and beyond cancer, and it is recognised that there needs to be a focus not just on their primary treatment, but also on their wider needs. This chapter reports on progress in this area.

### Information and communication

#### Face-to-face communication

5.2 *Connected*, the advanced communication skills training programme, has focused on both building capacity and extending the remit of the courses provided over the past year. This has involved the training of extra facilitators and adapting the courses to meet the needs of clinicians working with children and young people and in end of life care.

5.3 There are now 302 facilitators engaged by *Connected*, and every cancer network has a number of facilitators available to deliver the course. Since the official launch of *Connected* in July 2008, 44 facilitators have made the successful transition through the assessment process from trainee to approved status. An additional 32 will be assessed by January 2010. 2,971 senior healthcare professionals have been trained since July 2008.

5.4 Further development of the *Connected* website ([www.connected.nhs.uk](http://www.connected.nhs.uk)) is taking place to allow analysis of the data gathered from all participants. This will enable us to identify how many doctors, nurses and allied health

professionals are trained in each network from their constituent trusts, the specific clinical background of the participants and other such useful data. Access to these data will support the cancer networks to target those clinicians who have not yet accessed the course.

5.5 The inclusion of attendance at a *Connected* communications skills training programme as a peer review measure has driven demand for the course and the balance of participants has shifted, with far more doctors attending since January 2009. Demand for the course now exceeds the current budget capacity, and networks are having to manage increasing waiting lists for the course. The challenge from 2010 will be to embed the programme in strategic health authority (SHA) workforce development funding, rather than continued reliance on central funding.

5.6 A review of the course was started in July 2009, one year from its launch. While all aspects of the course have proved to be valid and are positively received, some adjustment to the content and process of delivery is under way and will be rolled out in December 2009. In addition further trigger tapes have been developed to support the course.

5.7 The work with healthcare professionals dealing with children and young people has progressed well: 14 facilitators are in training and three of these are now fully approved. Working with NHS West Midlands, a number of

specific trigger tapes have been developed to support programme delivery that is relevant to children and young people.

5.8 Close collaboration with the National End of Life Care Team has resulted in twelve pilot programmes being run throughout the country. Various partners are engaged in these pilots, including local authorities, higher education institutions, hospices, SHAs, trusts and cancer networks. The pilots will look at all levels of communication skills and provide information to inform capacity building for the development of the current and future workforce.

5.9 In addition, a number of locations have secured additional funds from their SHAs and are running *Connected* programmes for clinicians other than those from cancer. This has focused primarily on those working within end of life care although other specific clinical areas are also expressing interest in the programme. The course is readily transferable to all clinical areas because it focuses on communication skills rather than the communication of specific information.

5.10 Feedback from the course remains generally extremely positive.

### **Information products, pathways and prescriptions**

5.11 Ensuring that patients receive written information which meets their needs at all phases of the care pathway is a high priority within the CRS. Work in this area is being taken forward in close partnership with Macmillan Cancer Support and Cancer Research UK.

5.12 Key elements in this programme are the development of:

- high quality information materials for all cancer types, cancer treatments, etc, and on wider issues such as work and finance: much of this work is led by Macmillan Cancer Support

- electronic platforms to make information available wherever it is needed (for example in cancer centres, cancer units, GP surgeries or in patients' homes)
- information prescriptions, whereby clinicians can "prescribe" information products in consultation with individual patients, and which can then be "dispensed" (for example in a patient information centre).

5.13 The first phase of the information prescription pilots concluded in June 2008. A second phase commenced in February 2009.

5.14 A total of 38 trusts took part across 65 settings, eleven of which were dedicated patient information centres. The aims of these pilots were to:

- test the revised system functionality
- test the use of information prescription templates
- test different modes of dispensing and prescribing
- understand the experience and needs of clinical nurse specialist prescribing/dispensing
- understand the needs of consultants as prescribers
- understand the role/support requirements of information centres.

5.15 An independent evaluation of these pilots will be available early in 2010. An implementation framework will then be developed.

5.16 During 2009 a further eight information pathways have been developed and consulted on. These cover stomach, head and neck, bladder, oesophageal, pancreatic and kidney cancers as well as melanoma.



5.17 In relation to the electronic platform to make information available, a new partnership has been established between DH, NHS Choices, Macmillan Cancer Support and Cancer Research UK. The new tool will be available for healthcare professionals from spring 2010.

## National Cancer Survivorship Initiative

5.18 The overarching goal of the National Cancer Survivorship Initiative (NCSI) is to ensure that the physical, psychological, social, spiritual, financial and information needs of cancer survivors are met. As set out in the first annual report on the CRS, the NCSI is being jointly led by DH and Macmillan Cancer Support, working with a wide range of clinicians and service users.

5.19 During 2009 good progress has been made on developing the vision for good survivorship care from the point of diagnosis onwards. A document setting out this vision will be published shortly. The vision document will describe five key shifts that the NCSI has identified as necessary to achieve the vision for improved care and support for cancer survivors. These are:

- a cultural shift in care and support for people affected by cancer to a greater focus on recovery, health and well-being after treatment
- a shift towards assessment and personalised care planning
- a shift towards support for self-management
- a shift towards personalised information, support and preparation for possible consequences of treatment and further disease
- a shift towards measuring experience and outcomes for cancer survivors.

5.20 The testing phase of the initiative is now under way and will continue into 2010. The main focus in 2010 will be to engage service users, clinicians and commissioners in developing new models of aftercare for cancer patients.

5.21 Seven survivorship work streams have been tasked to assist the development of new models of care, which meet survivors' needs and are deliverable given constraints on the cancer workforce and NHS, social care and other budgets. Three of the seven work streams deal specifically with steps in the survivorship pathway – assessment and care planning, consequences of treatments and active and advanced disease. Three work streams cover the whole survivorship pathway – work and finance, self management and research. The work stream on survivors of childhood and young people's cancer also covers the whole survivorship pathway, but focuses on the needs of children and young people living with and beyond cancer. Each work stream has also been asked to consider issues relating to patient information, commissioning and workforce.

5.22 The work streams are now supported by 38 test communities which are testing models of survivorship care and support. NHS Improvement is working with these communities. There are currently 28 test communities looking at care and support for adults and ten sites testing models of care for children and young people.

5.23 In September 2009 over 230 clinicians, managers, researchers, patients and carers from the NCSI work streams, test communities and from cancer networks attended a conference to review the progress of the NCSI. Attendees shared findings and developed the emerging principles for new models of care for those living with and beyond cancer.

5.24 Further information about the NCSI is available on the NCSI website at: [www.ncsi.org.uk](http://www.ncsi.org.uk)

## Supportive and palliative care

5.25 The CRS confirmed that the Government remains committed to the full implementation of the NICE guidance on supportive and palliative care. The intention had been for this guidance to be fully implemented across the country by December 2007. However, this guidance was particularly complex and wide ranging, and the initial timetable for implementation overlapped with the development of other national strategy areas such as end of life care and the DH Common Assessment Framework, which needed to be taken into account as networks took forward implementation of the SPC guidance.

5.26 In recognition of these factors, DH agreed that the deadline for implementation of the SPC IOG would be extended to December 2009. However, to keep in line with existing monitoring systems, reporting of partial compliance by December 2008 was required for some priority areas, with full compliance/implementation by December 2009.

5.27 Monitoring of the guidance through cancer networks shows good progress made on the recommendations on advanced communication skills training, patient information, specialist palliative care services and patient experience. A progress report will be published early in 2010. Early indications show that networks are making good progress on ensuring that all patients have access to key workers across the pathway and assessment tools implemented for end of life care. Further work will be needed at the network level to support the implementation of rehabilitation services and psychology services.

5.28 Peer review measures for psychology services have been drafted and are currently out for national consultation. These are consistent with key recommendations in the CRS, with the

focus on skilling up Level 2 practitioners through the provision of training courses at the local level and ensuring clear referral pathways to Levels 3 and 4. An example of a psychological support the service is set out in the following box.

### Box 13: Psychological support for cancer patients

In 2006 Salisbury District Hospital, funded by Wessex Cancer Trust, commenced a three-year programme to implement and evaluate a four-tier model of psychological support for people with cancer and their families. To adhere to the model at Levels 3 and 4, a dedicated psychological support team was created for patients and families. This team consists of a clinical psychologist, an assistant psychologist, a counsellor and a social worker, in order to provide a service at both Levels 3 and 4. Since reaching full staffing levels (January 2007), the team has received over 300 referrals from across the hospital, including oncology, haematology, palliative care, surgery, ITU, genetics, ENT, and chemotherapy outpatients.

In order to satisfy Level 2 of the model, a teaching programme was developed, based on an extensive literature review, to train staff in how to detect psychological distress and intervene with appropriate techniques. The programme is delivered across two cancer networks.

Evaluations of the service from both staff and patient perspectives show that:

- patients are increasingly satisfied with the support they receive from their medical and nursing team
- those patients who do get referred to the Level 3 and 4 services are satisfied with the support they receive from the specialist service

- the quality of referrals increased as staff became better at identifying those patients who required support at Levels 3 and 4
- the teaching programme means that Level 2 staff are providing improved psychological support to patients and families
- the development of a dedicated team at Levels 3 and 4 means that those people who require assessment and intervention at these levels can access it quickly and easily.

5.29 Since 2007 the NCAT has been working proactively with partner organisations (DH, the national Workforce Review Team, rehabilitation specialist interest groups, Royal Colleges, commissioners and cancer network lead allied health professional forum members) and practitioners to raise the profile and improve the provision of rehabilitation services for cancer and palliative care patients in line with national guidance.

5.30 A best practice approach to supporting and improving the commissioning of cancer rehabilitation services has been developed for networks to engage with commissioners. Included within this is an outline commissioning specification and key performance metrics. Over time, these will be included within the national commissioning guidance and the national commissioning toolkit.

5.31 A national review of rehabilitation service provision was undertaken in 2008 and is currently being repeated. A toolkit has been developed inclusive of guidance documents and spreadsheet templates for local use.

5.32 A website has been developed and further information on national work can be found at: [www.cancer.nhs.uk/rehabilitation](http://www.cancer.nhs.uk/rehabilitation)

## Measuring patients' experience

5.33 The CRS set out a commitment to measure the experience of cancer patients through large-scale surveys. These will build on previous surveys undertaken in 2000 and 2004. The new survey will enable us to monitor progress on improving patient experience, and will serve as a baseline for the work on survivorship.

5.34 Progress on the procurement for the new survey has been unavoidably delayed during 2009, but the various difficulties have now been overcome and an Invitation to Tender will be issued in December 2009, in an advertisement placed in the *Official Journal of the European Union*.

## Chapter 6 – Reducing inequalities

### Introduction

6.1 Reducing inequalities in cancer services and outcomes is one of the major goals of the Cancer Reform Strategy (CRS). A National Cancer Equality Initiative (NCEI) has been established, with an advisory board co-chaired by Joanne Rule (a member of the CRS Advisory Board) and Mike Richards, the National Cancer Director.

6.2 During 2009 the major focus of the NCEI has been to understand the different factors contributing to inequalities by race, age, gender, disability, religion or spiritual belief, sexual orientation and deprivation. From this understanding, plans to tackle inequalities are being developed.

6.3 A practical guide to reducing cancer inequalities will be published by the NCEI early in 2010. It was originally intended for publication in 2009 but has been deliberately deferred until the output from the All Party Parliamentary Group on Cancer inquiry into cancer inequalities is available.

6.4 The NCEI launched *Reducing Inequalities in Commissioning Cancer Services: Principles and Practical Guidance for Good Equality Working* in October 2009. The document can be used as both a tool and guidance for primary care trusts (PCTs), strategic health authorities, cancer networks, and voluntary sector organisations who are commissioning or running services that aim to reduce cancer inequalities. For primary care or acute services, it can be used as

a checklist for equalities proposals or tenders, allowing potential services to include the suggested criteria for success. Case studies with links to further information are used throughout the document to highlight good practice that already exists. The document can be viewed at: [www.cancerinfo.nhs.uk/index.php?option=com\\_content&view=article&id=73&Itemid=121](http://www.cancerinfo.nhs.uk/index.php?option=com_content&view=article&id=73&Itemid=121)

### New analyses of cancer inequalities

6.5 New analyses have been undertaken for the NCEI by the NCIN during 2009. These relate to ethnicity and cancer, gender and cancer and older age and cancer. The findings formed a major part of the evidence submitted by the NCEI to the All Party Parliamentary Group on Cancer's inquiry into cancer inequalities.

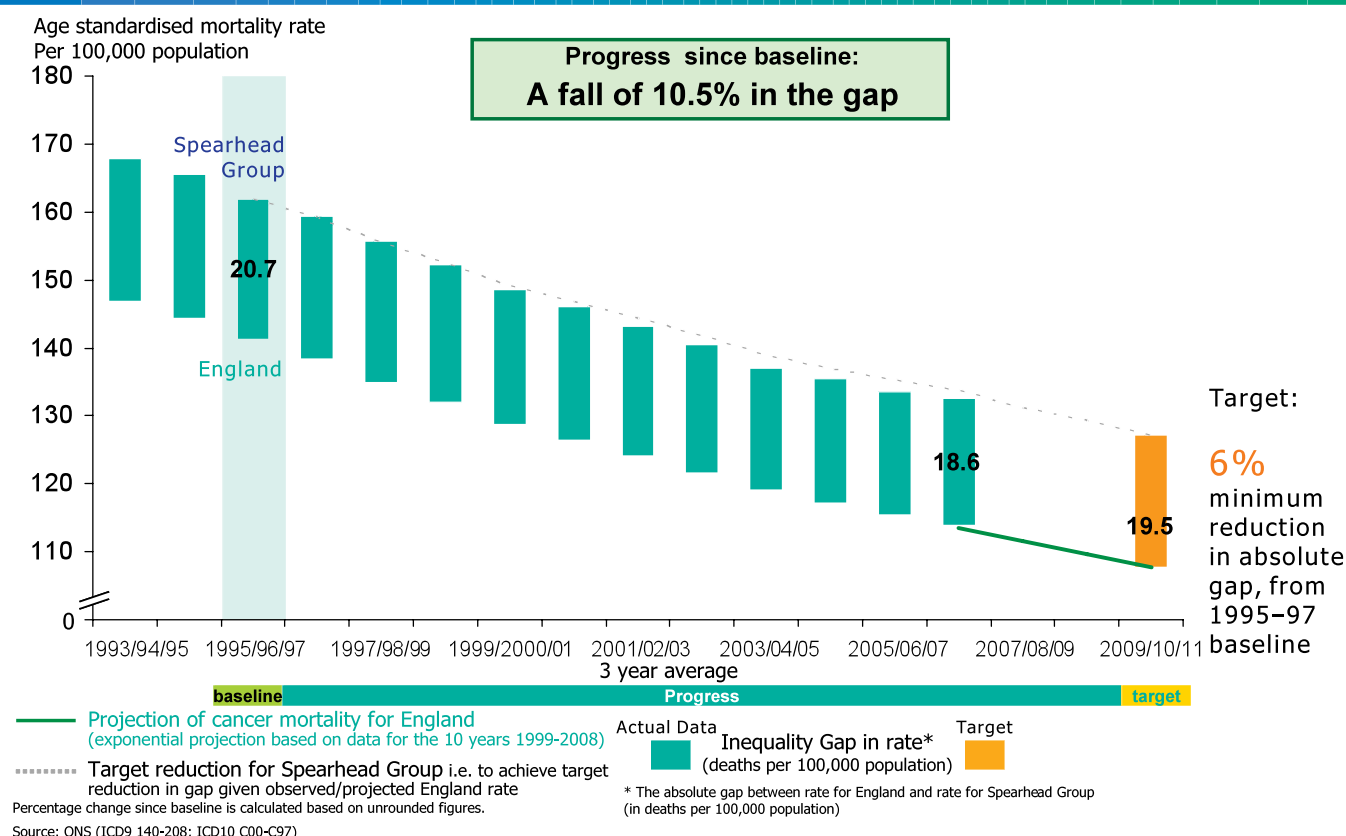
### Social deprivation and cancer

6.6 In addition to the Government's PSA target to reduce overall cancer mortality in people under 75 by 20% compared with the baseline years (1995/96/97), a second goal is to reduce the gap in mortality between more and less affluent groups in society. The target is measured in terms of the gap between mortality in spearhead PCTs and that in England as a whole.

6.7 Figure 2 below shows the trends in cancer mortality in the spearhead group and in England. Mortality is falling in both groups, the gap having narrowed slightly over the whole time period (from 20.7 to 18.6 deaths per 100,000 population). However, it should be noted that the gap widened a little between 2005–07 and 2006–08 (from 18.0 to 18.6 deaths/million).

**Figure 2: Cancer mortality in people under age 75 – inequality gap**

### Cancer mortality in people under age 75 – inequality gap England 1993–2008 and the target 2010



This highlights the need for further action in deprived areas.

### Age and cancer

6.8 The goal of the CRS is to achieve world class outcomes for all patients with cancer, irrespective of age. It is therefore important to monitor trends in mortality at all ages, not just those covered by the PSA target (ie under 75 years).

6.9 Between 1995–97 and 2005–07 the following changes have been observed:

- all-age cancer mortality fell by 14% (from 203.7 to 175.5 per 100,000 population)
- cancer mortality in people under 75 years fell by 18% (from 141.2 to 115.5 per 100,000)
- cancer mortality in people over 75 years fell by 5% (from 1,703.4 to 1,617.1 per 100,000).

6.10 The decrease in cancer mortality in older people has clearly been much less marked than for younger people. This is a matter of concern and is now being investigated further on a cancer by cancer basis. In addition, international trends in cancer mortality by age group have been assessed by the North West Cancer Intelligence Service on behalf of the NCIN. Further details will be presented in the forthcoming NCEI publication, together with specific recommendations to tackle this.

### Ethnicity and cancer

6.11 The NCIN published a major report on ethnicity and cancer in England earlier this year. This landmark publication showed that:

- overall, the incidence of cancer in the minority ethnic population is lower than that in the White British population: much of the difference in incidence is likely to be attributable to differences in lifestyle and

behaviours (such as tobacco consumption, diet, obesity and alcohol).

- certain minority ethnic groups have higher incidence of specific cancers; for example prostate cancer in Black African and Black African Caribbean men.

6.12 Survival rates for people with cancer may also be affected by ethnicity. This may reflect later presentation among minority ethnic groups. There is increasing evidence that this is a factor in the relatively poor survival of Black African/Black African Caribbean women with breast cancer.

### Men and cancer

6.13 An analysis undertaken by the NCIN has shown that, in cancers which affect both men and women, incidence is higher in men in almost all cases. Mortality is higher in men for all these cancers. (See Table 10 below.)

### Other groups

6.14 The NHS does not routinely collect data on disability, religion or sexual orientation, so it is not possible at present to undertake the types of analyses which are now available for ethnicity, age, gender and social deprivation (assessed by postcode). However, this does not mean that inequalities experienced by these groups are any less important. The forthcoming NCEI publication will cover this in greater detail.

**Table 10: Incidence and mortality: excess in men**

	Excess in men	
	Incidence %	Mortality %
All cancers except non-melanomatous skin cancer (x NMSC)	16	38
All cancers except NMSC and lung cancer	10	31
All cancers except NMSC, breast and sex-specific cancers	62	69
All cancers except NMSC, breast, lung and sex-specific cancers	61	71
Oesophagus	148	168
Stomach	148	132
Colorectal	54	56
Liver	121	99
Pancreas	27	27
Lung	64	65
Melanoma	-8	46
Kidney and other urological	99	107
Bladder	230	194
Brain and central nervous system	53	52
Non-Hodgkin's Lymphoma	39	57
Myeloma	52	39
Leukaemia	72	79



6.15 The case has also been made that people with less common cancers are subject to inequalities compared with those with more common cancers, for example in terms of availability of drugs or specialist services. While the forthcoming NCEI publication will not focus specifically on services for the less common cancers, it is agreed that tackling the biggest cancer killers should not be at the expense of people with the less common cancers.

6.16 Approximately one fifth (9.7 million) of the population of England live in areas which are designated as rural by the Commission for Rural Communities. The Commission has undertaken some preliminary research looking at access to cancer services for rural patients and their experiences, as well as the views of providers. The findings of this research will be discussed at a workshop to be held in London in February 2010, where key service and stakeholder representatives will be present.

## Chapter 7 – Delivering care in the most appropriate setting

### Introduction

7.1 Delivering high quality cancer care requires a balance between ensuring appropriate levels of specialism and delivering treatment and care in a location which is convenient for patients.

7.2 Chapter 4 sets out the good progress that has been made in ensuring that all patients requiring complex procedures are cared for by specialist teams, although further work on this issue is required in some areas. However, more can still be done to ensure that patients are cared for closer to their home, unless specialist attention is absolutely necessary.

7.3 The large majority of cancer patients do not want to be admitted to hospital unless it is absolutely necessary and, when it is, wish to be in hospital for as short a time as possible.

7.4 Studies undertaken during the development of the Cancer Reform Strategy (CRS) indicated that:

- expenditure on inpatient care and surgery accounts for almost one half of total cancer expenditure
- other countries (for example the USA) put more emphasis on ambulatory care, thereby reducing the need for inpatient admissions.

7.5 To tackle this, a major programme has been established to transform inpatient cancer care.

### Transforming care for cancer inpatients

7.6 The Transforming Inpatient Care programme has several elements:

- elective surgery, including introducing 23-hour admissions for breast cancer surgery and the Enhanced Recovery Partnership Programme (which is focusing on colorectal, urological and gynaecological cancer patients as well as non-cancer patients)
- emergency admissions, focusing on the development and spread of “acute oncology” models, to benefit all cancer patients, not just patients receiving chemotherapy
- elective admissions for non-surgical oncology, focusing on avoiding unnecessary admissions for the delivery of chemotherapy and other procedures (for example the insertion of long lines).

7.7 The Transforming Inpatient Care programme has set out four “winning principles”. The aim now is to achieve systematic spread and adoption across England.

#### Box 14: Winning principle 1

Unscheduled (emergency) patients should be assessed prior to the decision to admit. Emergency admission should be the exception, not the norm.

**Winning principle 2**

All patients should be on defined inpatient pathways based on their tumour type and reasons for admission.

**Winning principle 3**

Clinical decisions should be made on a daily basis to promote proactive case management.

**Winning principle 4**

Patient and carers need to know about their condition and symptoms to encourage self-management and to know who to contact when needed.

[www.improvement.nhs.uk](http://www.improvement.nhs.uk)

**Box 15: Improving inpatient care through winning principle 2: Pan-Birmingham cancer network****Move to a 23-hour stay model and wound drains as the exception for breast cancer surgery (excluding reconstruction) across a cancer network**

Sandwell and West Birmingham Hospitals NHS Trust and University Hospitals Birmingham NHS Foundation Trust became involved in testing a model of care that improved the breast cancer care pathway for patients. The testing identified that a 23-hour model was deemed the appropriate length of stay for 80% of patients.

The model has now spread across the Pan-Birmingham cancer network, and the quality improvements have identified potential efficiency benefits as outlined in the table below.

*Potential cost savings in breast cancer treatment across Pan-Birmingham cancer network using baseline data*

Site	Total number of episodes	Average length of stay (days)	Cost at £200 per day	Day case cost at £250 per day	Potential saving
Sandwell and West Birmingham	473	5.32	£503,272	£118,250	£385,022
University Hospital Birmingham	394	4.04	£318,352	£98,500	£219,852
Birmingham Heartlands and Solihull	270	5.19	£280,260	£67,500	£212,760
Good Hope	156	5.03	£156,936	£39,000	£117,936
Walsall	231	3.95	£182,490	£57,750	£124,740
Network total	1,524	4.70	£1,441,310	£381,000	£1,060,310

Source: *Transforming Care for Cancer Inpatients: Spreading the Winning Principles and Good Practice*. [www.improvement.nhs.uk](http://www.improvement.nhs.uk)

7.8 These “winning principles” were launched in July 2009, and 121 hospital sites have registered an interest in spreading the winning principles. There are currently 51 active locally driven initiatives under way.

7.9 The development of acute oncology services was one of the recommendations highlighted in the National Chemotherapy Advisory Group’s report. All hospitals with emergency departments are encouraged to develop acute oncology services, bringing together expertise from emergency medicine, general medicine and oncological specialities.

#### **Box 16: Improving inpatient care through Winning Principles 1 and 3: The Whittington Hospital NHS Trust**

##### **Acute oncology**

The acute oncology model of care delivery aims to reduce length of stay for emergency admissions and avert unnecessary acute admissions. The Whittington Hospital NHS Trust made use of the experience gained by an oncologist who had worked at another hospital to implement the service.

An acute oncologist is now available to see new inpatient referrals every day, and there is a rapid access clinic for new patients presenting acutely with suspected malignancy. It has resulted in shorter lengths of stay for emergency admissions with new cancers, reduced admissions for acute patients with suspected cancer and the ordering of fewer unnecessary tests.

Source: *Transforming Care for Cancer Inpatients: Spreading the Winning Principles and Good Practice*. [www.improvement.nhs.uk](http://www.improvement.nhs.uk)

7.10 Supporting cancer networks to develop these services will form a major piece of work during 2010. There will be an increased focus on the emergency pathway, and six to ten pilot sites working with NHS Improvement and the NCAT will be identified to test new models of emergency care.

7.11 A tool will be available during 2010 for trusts to use to compare their length of stay against an ambulatory model of care. This was part of the original work in the CRS and demonstrated significant opportunities to reduce length of stay.

#### **Enhanced Recovery Partnership Programme**

7.12 Linked to the Transforming Inpatient Care programme is the Enhanced Recovery Partnership Programme. This programme has been established to improve the quality and clinical outcomes of patients and reduce the length of elective care pathways across the NHS by sharing the good practice principles of enhanced recovery models of care.

7.13 Enhanced recovery – sometimes referred to as rapid, fast-track or accelerated recovery – was pioneered and evaluated in Denmark.<sup>1</sup> It is an evidence-based approach to elective surgery that ensures that patients are in the optimal condition for treatment, have innovative care during their operation and experience optimal post-operative rehabilitation, all of which are shown to reduce post-operative complications.

7.14 So far, enhanced recovery has been successfully implemented in a number of centres in England, mainly in colorectal and musculoskeletal pathways, but also in such specialties as gynaecology and urology.

<sup>1</sup> [www.institute.nhs.uk/quality\\_and\\_service\\_improvement\\_tools/quality\\_and\\_service\\_improvement\\_tools/enhanced\\_recovery\\_programme.html](http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/enhanced_recovery_programme.html)

7.15 DH, NHS Improvement, the NCAT and the NHS Institute for Innovation and Improvement are working collaboratively to establish the Enhanced Recovery Partnership Programme and to maximise the skills and resources to support the spread and adoption of this model of care. The focus of the programme is on building the evidence base, collecting examples of good practice and testing the most appropriate method to support spread and adoption.

7.16 Work to date has focused on agreeing the generic principles and identifying the best methods and approaches to support adoption and spread of enhanced recovery. This was achieved through two NHS events held in the summer. An online enhanced recovery library has also been set up to help facilitate the sharing of information and experience from across the country. This can be found at: [www.18weeks.nhs.uk](http://www.18weeks.nhs.uk)

7.17 The benefits are significant for both patients and the NHS in terms of improved patient experience and clinical outcomes, as well as significant reductions in length of stay.

**Box 17: Improving inpatient care through winning principle 2: Department of Urology, Royal Devon and Exeter NHS Foundation Trust**

**Applying the principles of enhanced recovery to radical cystectomy**

The principles of enhanced recovery have been applied to patients requiring radical cystectomy, reducing the mean total length of stay from 17 days two years ago to 12 days at present. The length of stay is still falling.

Key areas of improvement have been the re-alignment of patients and carers' expectations regarding length of stay, changing post-operative nursing care so that early mobilisation and early feeding is targeted and introducing measures to reduce blood loss.

The team believes that the length of stay can be reduced further with changes in stent placement and pre-operative stoma education, and has set a target for a median post-operative stay of eight days as they continue to enhance patients' preparation for and recovery from surgery.

A working group has been formed within the trust to implement enhanced recovery principles across urological, colorectal and gynaecological surgery, which would equate to affecting approximately 500 patients per annum.

7.18 Following on from establishing the generic principles and benefits of enhanced recovery, 14 innovation sites are currently testing and evaluating the model of care and how this can be spread and adopted in their organisation. The sites are across all SHAs covering colorectal, musculoskeletal, gynaecological and urological specialties. Subject to evaluation of the innovation sites, the next stage will focus on developing an implementation strategy to support spread and adoption across the rest of the NHS in England.

**What do the local data tell us?**

7.19 Table 11 at the end of this chapter sets out a range of information relating to inpatient care at an individual PCT level. Five of the data items relate to elective admissions and three to emergency admissions linked to cancer. All the figures are based on hospital episode statistics for 2008/09. While there is no "right" number of bed days, it is clear from the work described above that patient care and outcomes can often

be improved by reducing average bed days and emergency admissions.

### **Box 18: Elective bed days – cancer**

The first column in Table 11 shows the total number of elective bed days (for any cancer) per new cancer case registered for that PCT. Across England the average was 7.2 elective bed days per new case. The range was from 4.9 (Bromley PCT) to 11.5 (North Staffordshire PCT).

There were no obvious geographical patterns in terms of elective bed utilisation across all cancer types combined, except that South East Coast SHA had six PCTs with low bed occupancy and none with high bed occupancy.

### **Box 19: Average length of stay – cancer surgery**

#### **Average length of stay – breast surgery**

Across England the average length of stay (ALOS) for breast surgery was 2.8 days. This ranged from 0.9 (Southampton City PCT) to 6.6 days (Hastings and Rother PCT).

There were marked geographical variations in ALOS for breast surgery. Out of 17 PCTs in West Midlands SHA 15 were in the “best” quartile (short ALOS), as were six PCTs in South West SHA. In contrast, London SHA and North West SHA had high numbers of PCTs with longer ALOS.

#### **Average length of stay – colorectal cancer surgery**

Across England, the ALOS for colorectal cancer surgery was 10.0 days. This ranged from 4.1 days (Lincolnshire Teaching PCT) to 20.8 days (Leicester City PCT). No obvious geographical

### **Average length of stay – gynaecological cancer surgery**

Across England, the ALOS for elective gynaecological cancer surgery was 4.5 days (range 2.3–7.7 days). Once again, no obvious geographical pattern was observed, though East Midlands SHA had several PCTs with shorter ALOS.

### **Average length of stay – urological cancer surgery**

Across England, the ALOS for elective urological cancer surgery was 2.4 days. This ranged from 0.9 to 4.6 days. PCTs in three SHAs (East Midlands, South Central and South West) more frequently had short ALOS, whereas those in the North East and London more frequently had longer ALOS.

### **Box 20: Emergency admissions – cancer**

Across England there were on average 1.8 emergency admissions related to cancer per new cancer case in 2008/09. At PCT level this ranged from 1.0 (Bolton PCT) to 2.6 (Coventry PCT).

In two SHA areas (South East Coast and South West) there were PCTs with low emergency admission rates and only one or no PCTs with high emergency admission rates. In contrast, both NHS North East and NHS London had an excess of PCTs with high emergency admission rates.

### **Emergency bed days**

Emergency cancer admissions accounted for 11.3 bed days per new cancer on average across England in 2008/09. This ranged from 7.1 days (Wiltshire PCT) to 17.7 days (Ealing PCT).

In three SHA areas (South East Coast, South Central and South West) there were relatively large numbers of PCTs with low emergency bed usage and no PCTs with high usage.



**Average length of stay – emergency admissions**

The ALOS for emergency cancer-related admissions was 6.5 days across England, ranging from 4.1 days (Torbay PCT) to 9.0 days (Stockport PCT). The most notable geographical feature was that 16 PCTs in London had ALOS in the upper (longer) quartile.

**Quality and productivity**

7.20 Modelling work based on the outcomes of the work that the NHS has been undertaking around the winning principles is under way to establish the potential savings from reductions in inpatient stays and emergency admissions. Evidence from the pilot projects suggests that inpatient bed days could be reduced by at least 20%. If this level of reduction were achievable across the NHS, there would be a potential efficiency gain of about £190 million, representing approximately 8.1% of the cancer inpatient budget (£2.332 billion in 2007/08. Source: HES analysis in the Cancer Commissioning Toolkit).

Table 11: Inpatients

PCT name	Elective inpatient stays					Emergency inpatient stays		
	Bed days per registration	Average length of stay – breast	Average length of stay – colorectal	Average length of stay – gynaecology	Average length of stay – Urology	Admissions per registration	Bed days per registration	Average length of stay – total
<b>NORTH EAST STRATEGIC HEALTH AUTHORITY</b>								
County Durham PCT	7.0	2.2	9.1	5.4	2.6	1.8	10.0	5.6 *
Darlington PCT	5.8 *	1.1 *	7.1 *	4.0	2.8	1.9	11.2	5.9 *
Gateshead PCT	7.9 !	2.1	8.8	7.6 !	2.6	1.9	14.1 !	7.3 !
Hartlepool PCT	6.1 *	1.8 *	11.4	3.3 *	3.8 !	1.9	9.8	5.2 *
Middlesbrough PCT	5.3 *	3.3	9.4	3.7 *	3.6 !	2.0 !	10.4	5.2 *
Newcastle PCT	6.7	3.7 !	9.3	6.8 !	1.4 *	1.7	14.3 !	8.5 !
Northumberland Care Trust	7.4	3.4 !	8.6	7.0 !	2.8	1.9	12.2	6.4
North Tyneside PCT	6.8	3.0	9.0	5.2	2.5	2.2 !	12.9 !	6.0
Redcar and Cleveland PCT	6.3	4.6 !	9.2	2.4 *	3.8 !	1.9 !	10.7	5.5 *
South Tyneside PCT	8.2 !	2.9	6.2 *	6.9 !	2.3	1.8	13.1 !	7.4 !
North Tees Teaching PCT	5.5 *	1.7 *	6.4 *	3.9	3.2 !	2.0 !	11.8	5.9 *
Sunderland Teaching PCT	8.2 !	2.2	11.6	2.7 *	3.5 !	2.4 !	14.4 !	6.1
<b>NORTH WEST STRATEGIC HEALTH AUTHORITY</b>								
Ashton, Leigh and Wigan PCT	6.7	3.6 !	9.2	5.8 !	2.2	1.9	10.6	5.5 *
Blackburn with Darwen PCT	5.6 *	3.3	10.4	3.8	0.9 *	1.7	9.9	5.9 *
Blackpool PCT	5.4 *	2.1	3.3 *	4.0	1.2 *	1.9	11.5	6.1
Bolton PCT	6.5	4.2 !	9.7	4.3	4.2 !	1.0 *	8.4 *	8.1 !
Bury PCT	8.8 !	5.3 !	14.1 !	5.1	3.4 !	1.5 *	8.9 *	6.1
Central and Eastern Cheshire PCT	7.6	2.5	11.0	5.9 !	2.3	1.8	10.9	6.1
Central Lancashire PCT	7.6	3.5 !	11.1	5.2	2.3	1.6	12.6	7.7 !
Cumbria Teaching PCT	8.2 !	2.9	8.3 *	6.4 !	2.4	1.5 *	10.2	6.8
East Lancashire Teaching PCT	6.5	3.1	10.5	4.8	1.6 *	1.7	9.4 *	5.6 *
Halton and St Helens PCT	6.6	2.2	9.3	3.3 *	2.4	1.8	10.7	5.8 *
Heywood, Middleton and Rochdale PCT	8.1 !	4.6 !	12.1 !	5.9 !	2.3	1.6	10.8	6.7
Knowsley PCT	5.7 *	2.5	6.2 *	3.9	3.4 !	2.2 !	12.0	5.5 *
Liverpool PCT	7.5	3.4 !	10.6	4.1	2.4	2.0 !	12.4	6.3
Manchester PCT	7.8	4.2 !	13.3 !	6.9 !	3.0 !	1.9	14.5 !	7.7 !
North Lancashire Teaching PCT	5.5 *	2.9	6.9 *	4.8	1.6 *	1.7	10.9	6.3
Oldham PCT	8.4 !	4.2 !	12.6 !	5.9 !	3.7 !	1.7	12.4	7.4 !
Salford PCT	6.4	3.4 !	10.0	5.5 !	4.3 !	1.7	10.8	6.3
Sefton PCT	7.6	3.2	8.7	4.1	1.6 *	2.0 !	13.2 !	6.6
Stockport PCT	7.8	3.2	6.0 *	6.6 !	2.1	1.5 *	13.1 !	9.0 !
Tameside and Glossop PCT	7.8	2.8	10.2	3.0 *	2.6	1.8	11.1	6.2
Trafford PCT	6.9	3.4	12.0 !	7.2 !	2.4	1.5 *	10.0	6.8
Warrington PCT	6.9	2.9	9.2	3.7	3.4 !	2.0 !	11.3	5.6 *

PCT name	Elective inpatient stays					Emergency inpatient stays		
	Bed days per registration	Average length of stay – breast	Average length of stay – colorectal	Average length of stay – gynaecology	Average length of stay – Urology	Admissions per registration	Bed days per registration	Average length of stay – total
Western Cheshire PCT	6.7	2.7	8.6	3.6 *	1.9	1.7	9.5 *	5.7 *
Wirral PCT	8.4 !	3.4	10.0	3.6 *	3.5 !	2.3 !	15.6 !	6.7
<b>YORKSHIRE AND THE HUMBER STRATEGIC HEALTH AUTHORITY</b>								
Barnsley PCT	8.3 !	3.4	13.4 !	4.8	1.6 *	2.0 !	9.9	5.0 *
Bradford and Airedale Teaching PCT	7.0	2.5	10.9	2.4 *	1.7	1.5 *	9.7 *	6.4
Calderdale PCT	6.3 *	2.3	10.3	5.6 !	1.3 *	1.6	13.2 !	8.1 !
Doncaster PCT	7.7	2.6	12.0 !	4.9	3.5 !	1.8	10.8	6.0
East Riding of Yorkshire PCT	7.4	2.8	11.4	4.2	1.8	1.7	12.0	7.1
Hull Teaching PCT	6.5	2.7	13.6 !	2.5 *	1.8	2.1 !	15.3 !	7.2 !
Kirklees PCT	7.1	2.7	9.3	7.4 !	2.0	1.5 *	10.4	6.8
Leeds PCT	6.4	3.4	12.2 !	5.5 !	1.8	1.6	11.3	7.2 !
North East Lincolnshire Care Trust Plus	9.5 !	3.8 !	8.5	3.3 *	2.6	1.4 *	11.3	7.9 !
North Lincolnshire PCT	8.6 !	3.7 !	5.9 *	4.3	2.6	1.8	9.1 *	5.1 *
North Yorkshire and York PCT	6.7	2.1	10.2	4.7	2.0	1.4 *	8.4 *	6.0
Rotherham PCT	8.5 !	1.8 *	8.4 *	2.0 *	2.2	2.2 !	14.3 !	6.6
Sheffield PCT	9.5 !	3.2	11.7 !	5.5 !	4.2 !	2.0 !	14.1 !	7.1
Wakefield District PCT	6.7	3.3	11.5	5.5	3.4 !	1.4 *	9.5 *	6.6
<b>EAST MIDLANDS STRATEGIC HEALTH AUTHORITY</b>								
Bassetlaw PCT	8.9 !	3.0	9.6	4.5	2.4	1.6	10.0	6.2
Derby City PCT	6.3 *	1.9 *	9.2	2.7 *	1.9	2.1 !	13.2 !	6.3
Derbyshire County PCT	7.4	2.1	8.2 *	4.1	1.4 *	1.5 *	9.6 *	6.3
Leicester City PCT	5.5 *	3.9 !	20.8 !	5.0	2.1	1.7	11.6	6.9
Leicestershire County and Rutland PCT	8.1 !	3.2	13.9 !	4.2	2.4	1.7	10.7	6.2
Lincolnshire Teaching PCT	6.8	2.6	4.1 *	3.0 *	1.1 *	1.8	11.6	6.3
Northamptonshire Teaching PCT	7.7	1.7 *	14.4 !	2.7 *	2.7	1.5 *	10.3	6.9
Nottingham City PCT	6.4	3.3	9.1	3.6 *	1.3 *	1.8	12.1	6.6
Nottinghamshire County Teaching PCT	6.9	3.4 !	7.9 *	2.4 *	1.3 *	1.6	9.5 *	5.8 *
<b>WEST MIDLANDS STRATEGIC HEALTH AUTHORITY</b>								
Birmingham East and North PCT	6.5	1.3 *	12.4 !	6.5 !	1.9	1.7	11.5	6.8
Coventry Teaching PCT	7.3	1.5 *	8.1 *	4.6	3.4 !	2.6 !	17.4 !	6.8
Dudley PCT	6.1 *	2.0 *	11.3	5.3	4.6 !	1.8	12.1	6.9
Heart of Birmingham Teaching PCT	7.6	1.3 *	15.1 !	5.0	1.8	1.9	13.5 !	7.2 !
Herefordshire PCT	8.9 !	1.0 *	13.9 !	4.2	1.7 *	1.4 *	7.2 *	5.4 *
North Staffordshire PCT	11.5 !	1.6 *	9.8	4.1	2.4	1.4 *	10.0	7.0
Sandwell PCT	9.6 !	1.8 *	14.8 !	6.3 !	2.2	1.8	12.2	6.9
Shropshire County PCT	7.7	1.7 *	9.0	3.2 *	1.7 *	1.6	8.0 *	5.1 *
Solihull Care Trust	6.2 *	1.1 *	12.9 !	4.9	1.6 *	1.5 *	10.1	6.7
South Birmingham PCT	8.3 !	1.9 *	15.3 !	5.6 !	2.7	1.8	13.2 !	7.5 !

PCT name	Elective inpatient stays					Emergency inpatient stays		
	Bed days per registration	Average length of stay – breast	Average length of stay – colorectal	Average length of stay – gynaecology	Average length of stay – Urology	Admissions per registration	Bed days per registration	Average length of stay – total
South Staffordshire PCT	7.7	2.0	10.4	3.8	2.7	1.6	9.8	6.0
Stoke on Trent PCT	8.2 !	1.9 *	7.5 *	2.3 *	2.2	1.6	11.0	7.0
Telford and Wrekin PCT	6.3 *	1.7 *	9.4	3.5 *	2.5	2.0 !	10.2	5.2 *
Walsall Teaching PCT	6.9	2.2	12.4 !	3.8	2.4	1.8	12.5	6.8
Warwickshire PCT	7.4	1.8 *	10.8	2.4 *	2.0	1.8	12.1	6.8
Wolverhampton City PCT	6.9	1.5 *	9.4	5.3	2.1	2.4 !	13.0 !	5.3 *
Worcestershire PCT	8.4 !	1.9 *	11.4	4.8	2.0	1.4 *	8.9 *	6.3
<b>EAST OF ENGLAND STRATEGIC HEALTH AUTHORITY</b>								
Bedfordshire PCT	6.3 *	2.7	11.1	5.1	2.3	1.6	9.6 *	6.1
Cambridgeshire PCT	7.2	3.0	8.5	4.4	1.3 *	1.7	10.5	6.1
East and North Hertfordshire PCT	6.8	3.0	9.1	6.4 !	2.9 !	1.1 *	8.6 *	7.7 !
Great Yarmouth and Waveney PCT	6.1 *	2.2	9.1	3.7 *	1.4 *	1.6	8.3 *	5.3 *
Luton PCT	6.9	1.3 *	13.2 !	5.1	1.7 *	1.9 !	10.8	5.6 *
Mid Essex PCT	6.1 *	2.7	6.6 *	3.8	2.2	1.7	10.4	6.0
Norfolk PCT	6.9	1.7 *	5.0 *	3.5 *	1.5 *	1.9	9.8	5.0 *
North East Essex PCT	5.8 *	3.4	9.0	4.4	4.0 !	1.9 !	11.2	5.7 *
Peterborough PCT	6.5	3.9 !	13.0 !	3.4 *	1.4 *	2.4 !	11.5	4.8 *
South East Essex PCT	6.2 *	3.0	12.6 !	5.7 !	2.1	1.7	11.3	6.5
South West Essex PCT	6.6	3.7 !	6.6 *	4.0	2.9 !	2.0 !	12.4	6.3
Suffolk PCT	5.9 *	1.7 *	5.9 *	3.0 *	2.2	1.8	9.5 *	5.1 *
West Essex PCT	8.0 !	4.6 !	10.6	6.4 !	1.7	1.8	14.3 !	7.8 !
West Hertfordshire PCT	8.4 !	2.5	8.8	5.0	3.0 !	1.7	10.6	6.3
<b>LONDON STRATEGIC HEALTH AUTHORITY</b>								
Barking and Dagenham PCT	6.4	3.2	8.9	3.2 *	2.9 !	2.4 !	16.4 !	6.8
Barnet PCT	7.9	3.7 !	10.8	4.6	3.0 !	2.2 !	12.5	5.8 *
Bexley Care Trust	6.1 *	3.9 !	11.5	4.9	2.0	1.7	12.0	6.9
Brent Teaching PCT	9.4 !	1.6 *	15.8 !	5.0	2.1	2.0 !	15.0 !	7.5 !
Bromley PCT	4.9 *	2.1	12.8 !	3.1 *	1.7	1.2 *	7.7 *	6.3
Camden PCT	7.2	4.3 !	10.0	6.0 !	4.1 !	1.8	13.2 !	7.4 !
City and Hackney Teaching PCT	11.3 !	4.0 !	11.3	6.9 !	4.5 !	1.9	13.5 !	7.2 !
Croydon PCT	6.9	2.2	11.5	2.8 *	2.8	1.6	12.3	7.6 !
Ealing PCT	9.0 !	3.7 !	8.8	6.3 !	3.1 !	2.2 !	17.7 !	8.1 !
Enfield PCT	6.9	3.9 !	7.6 *	3.8	2.3	2.0 !	14.1 !	7.1
Greenwich Teaching PCT	6.7	3.2	12.6 !	3.8	1.5 *	1.8	12.0	6.8
Hammersmith and Fulham PCT	8.5 !	3.7 !	8.6	5.2	3.3 !	2.1 !	15.1 !	7.2 !
Haringey Teaching PCT	7.5	3.3	10.7	4.4	2.6	2.5 !	16.3 !	6.5
Harrow PCT	8.0 !	1.2 *	8.3 *	6.6 !	2.2	1.7	12.6	7.2 !
Havering PCT	6.8	3.9 !	8.3 *	4.6	3.0 !	2.4 !	15.2 !	6.2
Hillingdon PCT	7.9	3.4	11.7 !	5.8 !	4.3 !	1.7	12.8 !	7.7 !

	Elective inpatient stays					Emergency inpatient stays		
Hounslow PCT	9.0 !	3.1	9.8	4.8	3.1 !	2.1 !	13.3 !	6.3
Islington PCT	9.2 !	3.4 !	13.4 !	2.4 *	4.2 !	2.3 !	16.2 !	7.1 !
Kensington and Chelsea PCT	9.9 !	3.2	10.8	3.4 *	2.3	1.8	13.2 !	7.4 !
Kingston PCT	6.7	2.5	8.2 *	5.9 !	3.0 !	1.7	10.7	6.3
Lambeth PCT	5.4 *	2.8	9.7	4.6	1.6 *	1.4 *	11.5	8.0 !
Lewisham PCT	7.9	2.6	11.8 !	3.5 *	2.3	1.5 *	12.7 !	8.4 !
Newham PCT	7.2	4.5 !	11.9 !	5.2	2.1	2.3 !	14.8 !	6.4
Redbridge PCT	7.1	4.0 !	7.4 *	4.0	2.5	2.1 !	13.9 !	6.8
Richmond and Twickenham PCT	6.4	2.2	9.4	4.5	2.7	1.6	9.5 *	6.1
Southwark PCT	5.2 *	3.1	7.7 *	4.6	2.6	1.3 *	9.1 *	7.3 !
Sutton and Merton PCT	7.1	2.8	11.9 !	4.6	1.7	1.9	12.6	6.6
Tower Hamlets PCT	6.4	5.3 !	11.5	7.7 !	3.5 !	1.7	15.0 !	8.7 !
Waltham Forest PCT	8.4 !	3.7 !	5.4 *	3.9	1.9	2.3 !	14.0 !	6.1
Wandsworth PCT	6.3 *	3.7 !	11.7 !	5.8 !	2.2	1.5 *	12.5	8.4 !
Westminster PCT	9.2 !	4.2 !	11.7 !	5.6 !	2.0	1.8	13.1 !	7.2 !
SOUTH EAST COAST STRATEGIC HEALTH AUTHORITY								
Brighton and Hove City PCT	5.1 *	2.5	8.6	5.9 !	1.5 *	1.6	9.8	6.1
East Sussex Downs and Weald PCT	6.8	3.5 !	12.3 !	4.9	2.8	1.3 *	8.5 *	6.7
Eastern and Coastal Kent PCT	5.0 *	1.6 *	10.7	4.2	2.6	1.5 *	8.9 *	5.9 *
Hastings and Rother PCT	7.3	6.6 !	10.2	3.7	2.6	1.7	12.1	7.1 !
Medway PCT	5.9 *	2.1	7.6 *	3.9	2.3	1.4 *	9.1 *	6.4
Surrey PCT	5.7 *	2.2	10.5	6.3 !	1.9	1.5 *	9.9	6.8
West Kent PCT	6.0 *	1.8 *	6.9 *	3.5 *	3.4 !	1.4 *	10.7	7.5 !
West Sussex PCT	6.1 *	2.5	11.3	4.6	1.4 *	1.5 *	9.5 *	6.3
SOUTH CENTRAL STRATEGIC HEALTH AUTHORITY								
Berkshire East PCT	5.4 *	2.1	5.8 *	4.4	1.6 *	1.8	10.6	5.9 *
Berkshire West PCT	8.9 !	2.4	8.1 *	5.5 !	1.7 *	1.3 *	9.3 *	7.2 !
Buckinghamshire PCT	6.1 *	1.8 *	6.2 *	4.0	2.2	1.4 *	9.0 *	6.4
Hampshire PCT	6.5	1.9 *	9.3	4.1	1.8	1.6	9.6 *	5.9 *
Isle of Wight NHS PCT	8.6 !	1.3 *	12.4 !	5.5 !	2.2	1.3 *	8.8 *	6.9
Milton Keynes PCT	7.8	4.1 !	10.4	3.3 *	2.3	1.9	9.3 *	4.9 *
Oxfordshire PCT	6.7	3.1	9.2	5.7 !	1.3 *	1.6	11.2	7.1 !
Portsmouth City Teaching PCT	6.4	2.5	7.5 *	3.9	1.7	2.0 !	11.2	5.7 *
Southampton City PCT	8.2 !	0.9 *	11.8 !	3.5 *	1.0 *	2.1 !	12.2	5.7 *
SOUTH WEST STRATEGIC HEALTH AUTHORITY								
Bath and North East Somerset PCT	8.6 !	3.2	11.8 !	2.9 *	3.0 !	1.6	11.0	6.8
Bournemouth and Poole Teaching PCT	6.1 *	1.9 *	7.1 *	6.2 !	1.3 *	1.7	11.3	6.6
Bristol PCT	5.3 *	1.6 *	8.4 *	3.3 *	3.2 !	1.5 *	10.1	6.5

PCT name	Elective inpatient stays					Emergency inpatient stays		
	Bed days per registration	Average length of stay – breast	Average length of stay – colorectal	Average length of stay – gynaecology	Average length of stay – Urology	Admissions per registration	Bed days per registration	Average length of stay – total
Cornwall and Isles of Scilly PCT	8.9 !	3.1	8.1 *	3.8	1.4 *	1.7	7.5 *	4.5*
Devon PCT	7.5	2.5	10.3	4.0	2.0	1.3 *	6.8 *	5.1 *
Dorset PCT	7.2	2.0 *	7.2 *	4.1	1.6 *	1.5	9.4 *	6.1
Gloucestershire PCT	7.8	2.4	6.3 *	3.8	1.7 *	1.8	11.3	6.3
North Somerset PCT	6.0 *	2.1	7.5 *	2.3 *	1.9	1.4 *	9.0 *	6.6
Plymouth Teaching PCT	7.2	1.6 *	9.5	5.3	1.5 *	1.3 *	9.7 *	7.2!
Somerset PCT	7.1	2.1	8.7	4.7	1.6 *	1.5 *	8.2 *	5.6*
South Gloucestershire PCT	5.3 *	1.3 *	11.3	3.5 *	1.9	1.2 *	9.5 *	7.9!
Swindon PCT	6.6	2.6	9.1	4.2	2.7	2.0 !	9.9	5.1*
Torbay Care Trust	6.8	3.3	10.4	3.9	1.6 *	1.9	7.6 *	4.1*
Wiltshire PCT	5.6 *	2.0 *	11.8 !	4.1	2.4	1.2 *	7.1 *	6.0

### Elective bed days per registration

Data are sourced from the National Cancer Services Analysis Team and are from HES for 2008/09. The number of bed days is adjusted for PCT crude incidence – a higher incidence would expect a higher number of bed days.

PCTs in the quartile that has the lowest number of bed days per registration are shown with \* alongside the figure.

PCTs in the quartile with the highest number of beds per registration are shown with !.

### Elective – average lengths of stay

Shown for elective admissions for four main tumour sites, using HES data for 2008/09 supplied by the National Cancer Services Analysis Team.

PCTs in the quartile with the lowest average length of stay are shown with \* alongside the figure.

PCTs in the quartile with the highest average length of stay are shown with !.

### Emergency admissions per registration

Data are sourced from the National Cancer Services Analysis Team and are from HES for 2008/09. The number of emergency admissions is adjusted for PCT crude incidence – a higher incidence would expect a higher number of admissions.

PCTs in the quartile with the lowest number of emergency admissions per registration are shown with \* alongside the figure.

PCTs in the quartile with the highest number of emergency admissions per registration are shown with !.

### Emergency bed days per registration

Data are sourced from the National Cancer Services Analysis Team and are from HES for 2008/09. The number of bed days is adjusted for PCT crude incidence – a higher incidence would expect a higher number of bed days.

PCTs in the quartile with the lowest number of emergency bed days per registration are shown with \* alongside the figure.

PCTs in the quartile with the highest number of emergency bed days per registration are shown with !.

### Emergency admissions – average length of stay

Shown for elective admissions for four main tumour sites, using HES data for 2008/09 supplied by the National Cancer Services Analysis Team.

PCTs in the quartile with the lowest average length of stay are shown with \* alongside the figure.

PCTs in the quartile with the highest average length of stay are shown with !.



## Chapter 8 – Using information to improve quality and choice

### Introduction

8.1 The Cancer Reform Strategy (CRS) identified the important role that high quality intelligence on cancer services can play in:

- measuring and improving clinical quality
- identifying cancer trends and using this insight to inform decisions on service delivery
- supporting other national initiatives
- encouraging informed national and local scrutiny of performance
- informing cancer research.

8.2 As a result, the National Cancer Intelligence Network (NCIN) was created, with the intention of establishing the world's leading cancer intelligence service. This chapter reports on some of the NCIN's work over the past year.

### Measuring and improving clinical quality

8.3 Measuring variations in outcomes can make an important contribution to improving clinical quality. Accurate measurement requires high quality, consistent data and the NCIN has been leading work in cancer to ensure that this is collected, analysed, published and applied in order to deliver real quality improvements.

8.4 Effective data collection requires the clear and consistent definition of what needs to be collected. As part of a project to review

the dataset for cancer, each of the NCIN Site Specific Clinical Reference Groups (SSCRGs) has identified those additional site specific items that they consider are required to support outcomes analyses and that should be captured for all their patients as part of routine care. The project has been divided into "pathology" and "non-pathology" items, as follows:

- The pathology element is being led by a small project team representing the NCIN, the Royal College of Pathologists (RCPATH) and the UK Association of Cancer Registries (UKACR), and is managed by Cancer Research UK. All of the RCPATH datasets have been mapped against the cancer registration dataset, and SSCRGS pathologists are currently reviewing this work with a view to proposing those items which should be supplied to the local cancer registries. Other parallel work streams are defining the format for transferring pathology data to local registries, and are collaborating with national diagnostic initiatives within NHS Connecting for Health (CfH).
- The non-pathology element, handled directly by the SSCRGS, is progressing well. Site specific datasets will be shared for consultation before the end of 2009 with the relevant clinical communities via a series of workshops. A draft chemotherapy dataset will also be released for consultation soon.

8.5 The process to secure NHS Data Standards approval will commence in January 2010 and it

is anticipated that, providing that final approval is granted in September 2011, data capture will start from April 2012.

8.6 As reported in chapter 4, radiotherapy data were mandated for capture and onward submission as part of the outpatient commissioning dataset from April 2009. Work is ongoing to ensure completeness and quality.

8.7 While cancer outcomes can be adjusted to take into account various factors such as age, it is not yet possible routinely to adjust for co-morbid conditions which may affect patients. Work is under way to identify a way forward that is appropriate and relevant for future outcomes analyses and patient care.

## Identifying cancer trends

8.8 Over the past year, the NCIN has published a series of analyses of cancer trends:

- *Cancer Incidence and Survival By Major Ethnic Group, England, 2002–2006* (with Cancer Research UK)
- *Colorectal Cancer Survival by Stage: NCIN Data Briefing*
- *The Excess Burden of Cancer in Men in the UK* (with Men's Health Forum)
- *One Year and Five Year Cancer Prevalence by Cancer Network, England, 2004*
- *Cancer Incidence by Deprivation, England, 1995–2004*
- *Cancer Incidence and Mortality by Cancer Network, UK, 2005*
- *One Year Cancer Survival Trends* (including *One Year Cancer Survival, by Cancer Network, England, 2000–2004*), *England, 1985–2004*

- *All Breast Cancer Report* (undertaken by West Midlands Cancer Intelligence Unit).

These are available at [www.ncin.org.uk](http://www.ncin.org.uk)

8.9 In addition, the SSCRGs are all establishing work plans which will include analyses of trends in different cancers. Several sets of baseline materials are already being produced. Some examples are:

- national head and neck cancer baseline
- cervical cancer atlas
- lung cancer resection rates analyses.

8.10 The NCIN has also begun producing regular data briefings covering different topics, which will be guided by the work of the SSCRGs and produced by the relevant lead cancer registry. The purpose of the data briefings is to stimulate discussion on how cancer outcomes could be improved and to encourage NHS action to address the issues identified.

8.11 The first data briefing presented colorectal survival results according to stage of disease at diagnosis, comprehensively demonstrating the critical importance of early diagnosis to outcomes. Briefings for skin, lung, breast and head and neck cancer will follow before the end of 2009.

## Supporting other national initiatives

8.12 The NCIN has played a critical role in informing the work of other national programmes, including the National Awareness and Early Diagnosis Initiative, the National Cancer Survivorship Initiative, the National Cancer Equality Initiative and the Transforming Inpatient Care programme.

## Encouraging informed national and local scrutiny of performance

8.13 The CRS made clear that scrutiny of performance at a national and a local level could play an important role in enabling patients to make choices, informing strong commissioning decisions and assisting providers in improving the quality of their services.

8.14 This progress report contains a detailed analysis of the progress made in improving cancer services and outcomes at both a national and a local level. It is only possible to publish this information because of the work undertaken to bring together and analyse different sources of cancer data.

## Informing cancer research

8.15 Cancer intelligence can also be a valuable asset to researchers. Early work between the NCIN and the National Cancer Research Network (NCRN) has demonstrated the feasibility of using routine clinical care data to supplement that collected in clinical trials, by identifying cohorts of patients who could be eligible for trials, completing data items missing from the trial and providing information about participants who are lost to follow up. In the long term this resource should improve the completeness of trial datasets and reduce the burden of following up.

8.16 The 2009/10 NCIN work programme outlines three areas in which the NCIN expects to contribute to research. It commits to identifying pilot studies in each area and to holding workshops to further areas for research. The three areas are:

- supplementing existing cohort datasets
- hypothesis-led research questions
- methodological research.

8.17 To enable this programme to address primary care issues, a linkage between registry

data and the General Practice Research Database (GPRD) has been established.

8.18 To date, two hypothesis-led studies using GPRD data have been agreed and the principal investigators have been asked to keep the coordinating team informed of their experiences of using these data and of any lessons that may be of use to other research groups.

8.19 The NCIN is also supporting the Research Capability Programme's pilot Health Research Support Service both as a data provider (through the cancer registries) and as a study owner (for a joint study with the NHS Cancer Screening Programmes).

## Building the cancer intelligence infrastructure

8.20. The collection, analysis and publication of information on the quality of cancer services and the outcomes delivered is only possible because of the cancer intelligence infrastructure that exists in England. Further action has been taken to strengthen the infrastructure, including the following:

- identifying the training requirements of all staff groups involved in supporting MDTs and managing cancer information
- the National Cancer Data Repository has been expanded to include data from registries and hospital activity up to and including new diagnoses made in 2007: the extended registry data also include available staging and treatment data
- prospective rather than retrospective data linkage is being discussed with the NHS Information Centre: this should enable analyses which go beyond just cancer
- a review of cancer registry data systems is under way to examine the feasibility of moving all registries onto one processing system.

## Chapter 9 – Stronger commissioning

### Introduction

9.1 The Cancer Reform Strategy (CRS) reflected the transition from central command towards local empowerment and control in the delivery of health services. It made clear that the stronger commissioning of cancer services would be particularly important if world class cancer care is to be delivered.

9.2 This chapter sets out the progress that has been made in strengthening commissioning in the second year since the publication of the CRS. It reviews:

- the extent to which primary care trusts (PCTs) have prioritised issues relating to cancer as part of local commissioning policies
- the information, support and guidance that have been published to enable stronger cancer commissioning
- the development of cancer commissioning “exemplars”, providing practical examples of how cancer commissioners can improve the quality and productivity of services
- the work undertaken to support improved user involvement in the commissioning of cancer services
- the way in which the new approach to peer review is providing more timely and relevant information to support commissioning decisions
- the activity to improve the costing and payment mechanisms for radiotherapy, chemotherapy and multidisciplinary teams (MDTs).

### Prioritisation of cancer by PCTs

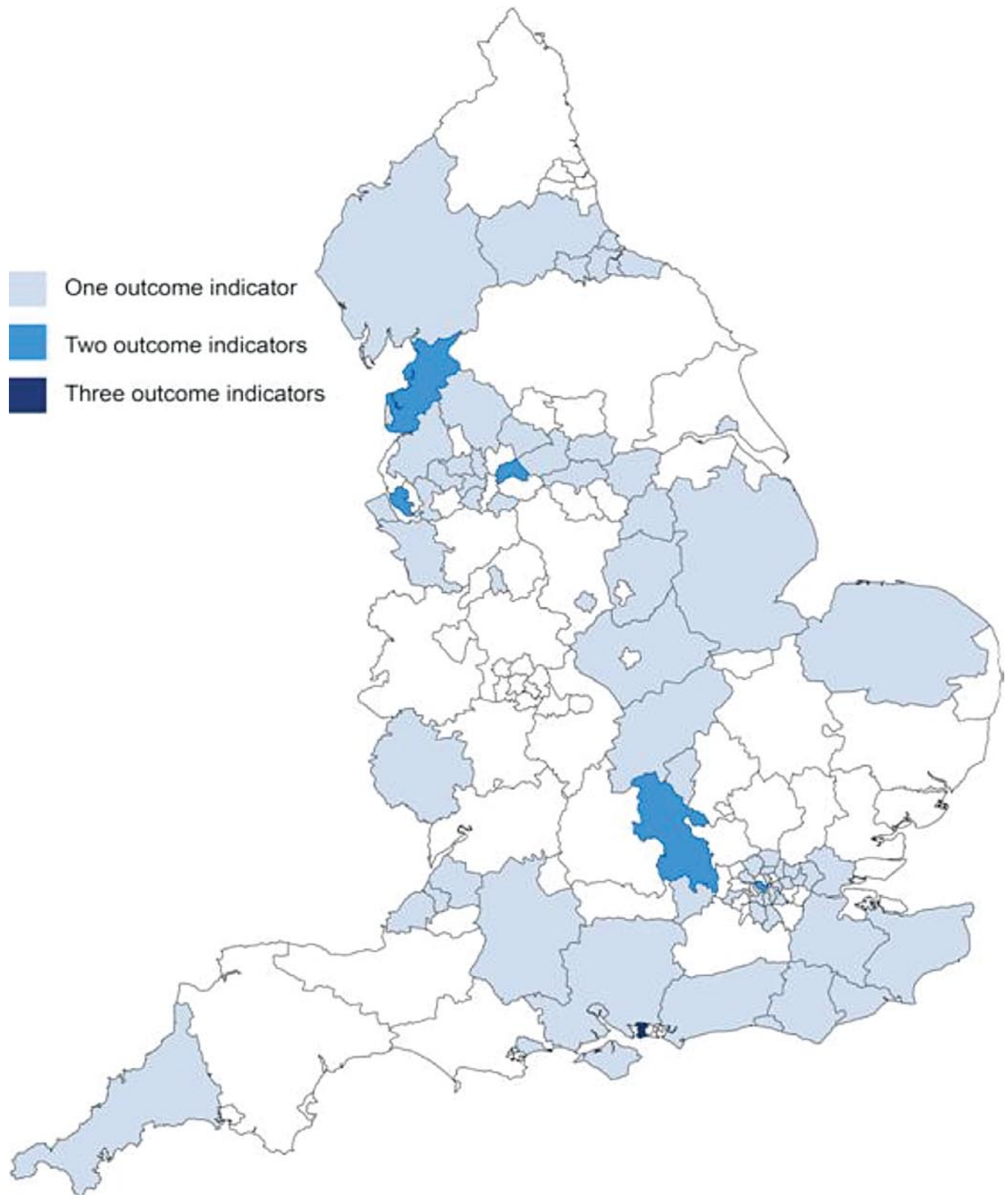
9.3 The World Class Commissioning assurance process requires that PCTs select eight outcome measures that are reflected in their strategic priorities and that have been agreed with partners, including the public and patients, community organisations and clinicians. PCTs can select indicators from a national list of outcome measures or can define their own local measures. Progress towards achieving these objectives is then monitored through the assurance process.

9.4 A recent analysis suggests that many PCTs are focusing on issues that are highly relevant to cancer as part of the World Class Commissioning assurance process, as follows:

- reducing smoking prevalence and alcohol-related harm, both significant risk factors for cancer, were the two most commonly selected indicators by PCTs
- nearly half of all PCTs selected at least one outcome indicator directly relating to cancer
- nearly half of all PCTs opted to measure the percentage of deaths that occur at home.

9.5 In total, 71 PCTs selected one outcome indicator on cancer, with five PCTs selecting two cancer outcome indicators and one PCT selecting three cancer outcome indicators. London (20 PCTs) and the North West (16 PCTs) were the regions in which most PCTs opted to focus on cancer outcomes (see the map in Figure 3):

**Figure 3: PCTs which selected one or more cancer outcome indicators as part of the World Class Commissioning process**



Source: Health Mandate (2009), *National priorities, local action? An analysis of Primary Care Trusts' World Class Commissioning policies*



## Enabling stronger cancer commissioning

9.6 A variety of different forms of support have been provided to PCTs and cancer networks to support stronger commissioning. In September 2009 over 80 participants from PCTs, cancer networks and providers came together at an accelerated learning event to discuss how to better commission cancer services. Key outcomes from the event included clarifying how cancer networks should support PCTs in commissioning cancer services. Further work will now be undertaken to consider how cancer services commissioning could be improved within the context of the health outcomes and governance parts of the World Class Commissioning programme.

9.7 The *Cancer Commissioning Guidance* was published in final form in January 2009. This sets out the key issues that commissioners will wish to consider when assessing health needs, reviewing services, developing contract service specifications and monitoring performance. The guidance will be continually updated, with the next version incorporating the conclusions of the accelerated learning event and greater context on how cancer fits into the World Class Commissioning programme, as well as a section on services for people with a family history of cancer.

9.8 In June 2009 a guide to practice-based commissioners in developing good cancer services was published. The document profiles effective models of care for cancer. Practice-based commissioners may wish to commission similar services in their local area.

9.9 In order to make effective commissioning decisions, it is vital that PCTs and cancer networks have access to high quality, contextualised data. The Cancer Commissioning Toolkit (CCT) brings together a variety of sources of data in an accessible format, enabling the

benchmarking of services. Uptake and ongoing usage of the toolkit has been impressive, with over 1,500 registered users. There are approximately 700 users accessing CCT on a monthly basis, with over 9,000 log-ins.

9.10 An updated version of the CCT was launched in September 2009. This version delivers data updates for programme budgeting, smoking cessation, screening, the Cancer Information Service and cancer waiting times. It also includes chart and functionality enhancements. Further updates will be released every three months, reflecting developments in data and feedback from users.

## Commissioning “exemplars”

9.11 A key element of the commissioning support programme has been the development of specific cancer commissioning “exemplars”, which are intended to demonstrate the kind of improvements in quality and productivity that can be delivered through effective commissioning.

9.12 During 2009/10 the National Cancer Action Team (NCAT) has commissioned 21 commissioning exemplars across 16 networks. These are intended to have a particular focus on the following competencies:

- engage with public and patients
- manage knowledge and assess needs
- stimulate the market
- promote improvement and innovation
- secure procurement skills.

9.13 The projects address a range of areas of cancer services, including integrated chemotherapy services, satellite radiotherapy services, cancer pathways and supportive therapy services.



9.14 The projects are due to report by the end of July 2010. Every project will be evaluated, with the learning spread across all cancer networks in order to aid rapid uptake. The exemplar areas will also use the projects as evidence during the next year of the World Class Commissioning assurance process.

## User involvement

9.15 Patient and public involvement (PPI) is fundamental to the process of commissioning cancer services. Cancer networks with an infrastructure that supports service user involvement will be better placed to provide support to PCTs in commissioning high quality cancer services that meet the needs of users and local populations.

9.16 Building on a multi-stakeholder workshop held in May 2009 and the current policy framework for patient and public involvement, the NCAT has published guidelines on the involvement of service users in commissioning. Recommendations are organised under the ten guiding principles and functions set out in the box below.

### Box 21: Principles for user involvement

**1. Commitment** – cancer network, service provider, PCT and strategic health authority (SHA) leaders need visibly to champion and embed PPI throughout their organisations

**2. Respect** – PPI is built on partnership, mutual respect, honesty and openness (for example about cost constraint)

**3. Access** – PPI starts early and occurs at each stage of the commissioning cycle: it covers a range of activities, from information giving to collecting patient experience data, from social marketing to direct participation in decision making meetings

**4. Diversity** – PPI reflects the demographics of the local community

**5. Value** – make it easy for people to be involved with you and make it a good experience for the patients, carers and public who are involved

**6. Feedback** – feedback starts early and occurs at each stage, because user involvement should always be a two way process

**7. Outcomes** – demonstrable outcomes of user involvement in commissioning are established and achieved

**8. Contracts** – requirements for PPI are built into providers' contracts and quality standards

**9. Resources** – PPI initiatives are resourced properly – through facilitation, expenses, support and training

**10. Infrastructure** – cancer networks provide the infrastructure, including a designated lead, to support continuing patient involvement in the commissioning of cancer services.

9.17 The next steps in support of cancer networks will be to offer a development programme to strengthen patient and public involvement. Macmillan Cancer Support is funding an evaluation of the experiences of early adopters.

## Peer review

9.18 The new approach to peer review set out in the CRS's first annual progress report was launched on 1 April 2009. The intention of this new approach to peer review is to introduce a greater focus on regular self-assessments and a targeted external peer review visit programme.

9.19 Between April and September 2009, all breast and lung MDTs and Network Site Specific Groups (SSGs), together with those gynaecological, upper gastrointestinal and urology MDTs and SSGs which were not subject to an external peer review visit during 2009/10, have completed a self-assessment which has been validated by their host organisation. External verification of a sample of these validated self-assessments is now being undertaken. The external visit programme for 2010/11, which will be finalised by 31 December 2009, will be informed by the external verification exercise.

9.20 It is also intended that the peer review process should have an increasing focus on clinical issues, with a move towards reviewing clinical outcomes. A new clinical outcomes group has therefore been established to ensure that the intelligence gathered on cancer services, from activities such as peer review as well as from the NCIN, meets the needs of commissioners and helps address the quality and productivity challenge.

## Ensuring that tariffs support service improvements

9.21 There are technical challenges in accurately costing and developing tariffs for some complex areas of cancer service, including radiotherapy, chemotherapy and MDTs.

9.22 The NCAT has been working in partnership with DH's Payment by Results team to develop a costing framework to support the implementation of HRG4 for external beam radiotherapy. This has involved approximately 20 radiotherapy centres. It is anticipated that this work will lead to greater consistency in applying costs, as well as a better understanding of how variations in the capital costs of radiotherapy bunkers might affect tariffs.

9.23 A project has also been launched to develop an improved understanding in the variations in the cost base for chemotherapy, with the intention of improving reference cost guidance and validating HRG4 as the basis of a national chemotherapy tariff. This project is drawing on the data generated from the new C-PORT financial module.

9.24 MDTs play a vital role in delivering high quality cancer care, and it is important that they are properly resourced and fairly reimbursed. It is important that host organisations report costs as part of their reference costs returns. Although quality and uptake have improved over the last few years, the numbers of reference cost returns in this area are still low (only about 40 trusts).

9.25 Work is also under way to ensure that the tariff provides fair payment for highly complex cancer procedures. The NHS Information Centre is working to develop a new HRG for head and neck reconstructive surgery, based on case-mix data. While this is being developed, it is likely that this procedure will be a tariff exclusion under HRG4 in 2010/11.

## Chapter 10 – Funding world class cancer care

10.1 In total, an estimated £4.96 billion was spent on cancer services in 2007/08, amounting to 5.3% of all NHS spending or £98 for every person in England.

10.2 Spending on cancer services has increased by an estimated 32% over the last four financial years. Cancer is the third-largest disease programme in the NHS, behind mental health and circulatory diseases.

10.3 There are, however, significant variations in the levels of expenditure on cancer services, which cannot be explained by differences in need or outcome alone. Primary care trusts (PCTs) and cancer networks will wish to benchmark their expenditure on cancer services with comparable health economies. Comparisons in expenditure can be made by using either programme budgeting data (available at: [www.dh.gov.uk/en/Managingyourorganisation/financeandplanning/Programmebudgeting/DH\\_075743](http://www.dh.gov.uk/en/Managingyourorganisation/financeandplanning/Programmebudgeting/DH_075743)) or the Cancer Commissioning Toolkit.

10.4 The Cancer Reform Strategy set out the Government's commitment to delivering additional funding for cancer services in order to meet the costs of rising incidence and technological change. However, it also made clear that there is significant scope to make more effective use of existing resources, while also benefiting patient care. This is particularly important given that the rate of increase in NHS expenditure can be expected to slow significantly in the coming years in light of public finances.

10.5 This report sets out a number of initiatives which, although their primary purpose is to improve the quality of patient care, also have the potential to deliver significant savings. These include the following:

- improving the quality of inpatient care could save one million bed days, releasing 20% of the inpatient bed capacity currently occupied by cancer patients
- supporting clinicians in improving their communication skills could enhance patients' experience, reduce staff stress, make consultations more efficient, improve concordance with treatment and reduce compensation claims arising from poor communication
- streamlining cervical screening can improve patients' experience, increase opportunities for early detection and enhance staff productivity
- improving the quality and safety of chemotherapy services can reduce emergency admissions and improve health outcomes.

10.6 The evidence clearly shows that quality improvements in cancer services can realise cost savings. The challenge for the NHS is now to realise the potential of these savings, so freeing up resources to reinvest in areas of cancer services, which can deliver improvements in quality and outcomes. A significant focus for the National Cancer Programme will be to support the NHS in achieving this.

## Chapter 11 – Building for the future

### Introduction

11.1 Cancer services have changed dramatically over the past decade and look set to continue to do so. As well as increased incidence, survival and prevalence of cancer, it is likely that treatment will continue to evolve, with many interventions taking place closer to patients' homes but others requiring high levels of specialisation.

11.2 It is important that NHS cancer services continue to plan for these changes and that they are supported in doing so by clear national leadership, support and oversight and by ensuring that good practice is spread, economies of scale are realised and that the cancer community works together to capitalise on the opportunities which will undoubtedly arise to improve cancer outcomes still further.

This chapter sets out the progress made in:

- workforce planning and development
- improving cancer facilities
- stimulating cancer research
- involving stakeholders.

### Workforce planning and development

11.3 The cancer workforce has expanded considerably since 2000 and looks set to continue to do so in coming years. Overall, it is projected that there will be a 23% increase in consultants

in specialties with a major role in cancer care between 2008 and 2012, as set out in Table 12.

11.4 Despite these increases there are still workforce pressures, because expansion has not kept pace with increases in activity in some areas. It will also be important to consider how other disciplines can be given appropriate training to assist in the care of cancer patients, as set out in the National Chemotherapy Advisory Group report.

11.5 There are significant workforce requirements associated with the need to expand radiotherapy capacity that is outlined in chapter 4. The September 2008 NHS annual census shows good progress in increasing the number of therapeutic radiographers, with an overall increase of 45.8% since 1999 and 4.1% (73 full-time equivalent) since September 2007. Feedback from the DH Workforce Directorate meetings with strategic health authorities (SHAs) early in 2009 showed that, from nine SHAs, a growth of 93.8 FTE (6.85%) between 1 April 2009 and 31 March 2010 is planned.

11.6 Nonetheless, radiotherapy service capacity will need to increase further to ensure that waiting times standards are met by the end of 2010 and that the service can meet the anticipated increased demand by 2016.

11.7 In the field of nursing, a group has been established to assess in detail the contribution nurses make to the quality of cancer care.

Strong links have been made with the Chief Nursing Officer's "Modernising Nursing Careers" initiative, and cancer is one of the pilots for taking forward the mapping of the new Nursing Career Framework. This work should help to attract new nurses into the profession – especially those with an interest in cancer services – and enable them to see a development pathway for the future.

11.8 The nursing group will:

- formalise the successful cancer nurse specialist census previously undertaken in 2007 and 2008 by the Network Nurse Directors group; this has already informed a number of local commissioning processes
- develop a set of metrics for care quality in key settings where nurses make a significant contribution to cancer patient outcomes
- produce a short publication aimed at commissioners, employers and patients demonstrating the contribution of the cancer nurse specialist and what key interventions they are best placed to undertake and why
- assess the contribution made by nurses across the care pathway and consider if and how the role of the cancer nurse specialist needs to evolve and change to reflect the shift of care away from secondary care.

**Table 12: Cancer workforce supply projections (headcount)**

	2000	2008	% increase, 2000–08	Projected 2012	Projected % increase in 2008–12
<b>Consultants in specialties with a major role in cancer care</b>	<b>9,681</b>	<b>13,670</b>	<b>41%</b>	<b>16,778</b>	<b>23%</b>
General surgery	1,331	1,797	35%	2,260	26%
Urology	382	560	47%	667	19%
Anaesthetics	3,322	4,991	50%	6,644	33%
Respiratory medicine	439	565	29%	754	33%
Gastroenterology	481	612	27%	832	36%
Clinical radiology	1,585	2,059	30%	2,146	4%
Histopathology	865	1,129	31%	1,191	5%
Clinical oncology	307	533	74%	604	13%
Medical oncology	133	235	77%	308	31%
Palliative medicine	111	229	106%	295	29%
Haematology	527	684	30%	783	14%
Cardiothoracic surgery	198	276	39%	294	7%
All radiographers	12,489	15,636	25%	16,564	6%
Diagnostic radiographers	11,036	13,423	22%	14,248	6%
Therapeutic radiographers	1,453	2,213	52%	2,316	5%

Note: 2012 figures are sourced from the NHS Workforce Review Team and are modelled using a number of variable assumptions that may change significantly due to general economic factors and the outcome of future Spending Review decisions.

## Cancer facilities

11.9 The quality of environment in which a cancer patient is treated can have a significant impact on their experience of care: and so the CRS announced that a “kitemark” would be developed for good-quality cancer facilities. To meet this commitment, the Macmillan Cancer Support Quality Environment Mark will be launched in January 2010.

11.10 The criteria that will be included in the Quality Environment Mark have been identified through a comprehensive literature review and a consultation process involving over 300 people affected by cancer. Twelve beacon sites have been identified in England to undergo early assessment.

## Research

11.11 DH is a key member of the NCRI, and is a major financial contributor to NCRI initiatives. In the past year research initiatives have been planned on survivorship, end of life care and early diagnosis. Research initiatives on radiotherapy, positron emission tomography (PET), prostate cancer, tissue banking and cancer informatics have also progressed well.

11.12 The NIHR Clinical Research Network Coordinating Centre had a very successful international review, and DH has confirmed funding for a further five-year period. The research network itself continues to provide NHS support (about £18 million per year) to enable cancer patients to enter later-phase clinical trials and other well-designed research studies. Currently about 12% of patients enter research studies, which is the highest percentage in the world. Table 13 shows the participation in trials by cancer networks.

11.13 The 15 NIHR/Cancer Research UK Experimental Cancer Medicine Centres (ECMCs) across England continue to run over 300 early-phase trials of new interventions. Many of

these trials involve the first use of a cancer drug in humans.

11.14 The Royal Marsden Hospital/Institute of Cancer Research partnership has “NIHR Specialist Biomedical Research Centre” status in cancer (£46 million of NIHR funding over five years). All five NIHR Comprehensive Biomedical Research Centres (BRCs) have cancer as a major research theme. NIHR BRCs are NHS/university partnerships that drive progress on innovation and translational research in biomedicine.

11.15 Research projects funded under the third phase of the National Prevention Research Initiative were announced in September 2009. Sixteen projects were funded to a total of approximately £10 million, most of which have a direct relevance to cancer (for example, smoking cessation/prevention, weight loss, physical activity).

## Involving stakeholders

11.16 The National Cancer Programme continues to work closely with a wide variety of stakeholders from across the cancer community, including patients, clinicians, researchers, charities and the pharmaceutical industry. In order to ensure that stakeholders are informed and engaged with ongoing work streams to implement the CRS, the *National Cancer Programme Bulletin* has been launched. Stakeholders wishing to receive the bulletin should visit: [www.dh.gov.uk/en/Publicationsandstatistics/Bulletins/NationalCancerProgrammebulletin/index.htm](http://www.dh.gov.uk/en/Publicationsandstatistics/Bulletins/NationalCancerProgrammebulletin/index.htm)

11.17 A number of advisory groups, involving a wide range of expert stakeholders, continue to support the implementation of the CRS. These include:

- Bowel Cancer Advisory Group
- Bowel Screening Advisory Committee



- Breast Cancer Advisory Group
- Advisory Committee on Breast Cancer Screening
- Prostate Cancer Advisory Group
- Lung Cancer and Mesothelioma Advisory Group
- National Chemotherapy Implementation Group
- National Radiotherapy Implementation Group
- Proton Beam Therapy Delivery Board
- Children’s and Young Persons Improving Outcomes Guidance Advisory Group
- National Cancer Survivorship Initiative Steering Group
- National Cancer Equality Initiative Advisory Group
- NHS Cancer Patient Experience Advisory Group
- National Awareness and Early Diagnosis Initiative Advisory Group
- Going Further on Cancer Waits Advisory Group
- National Cancer Intelligence Network Steering Group.

11.18 In addition, the Cancer Reform Advisory Board will continue to meet and provide advice on next steps as we move into the third year of CRS implementation.

Table 13: Participation in research trials, by cancer network

Network	"NCRN" cancer incidence	2001-2	2001-2	2002-3	2002-3	2003-4	2003-4	2004-5	2004-5	2005-6	2005-6	2006-7	2006-7	2007-8	2007-8	2008-9	2008-9	2009-10 (6 months to date)	2009-10*	2009-10*
Arden NCRN	4600	237	5.2%	300	6.5%	352	7.7%	297	6.5%	194	4.2%	148	3.2%	217	4.7%	355	7.7%	189	378	8.2%
Avon, Somerset and Wiltshire NCRN	7636	396	5.2%	564	7.4%	623	8.2%	530	6.9%	479	6.3%	488	6.4%	542	7.1%	632	8.3%	321	642	8.4%
Central South Coast NCRN	10580	532	5.0%	368	3.5%	444	4.2%	468	4.4%	333	3.1%	445	4.2%	578	5.5%	518	4.9%	248	496	4.7%
Derby/Burton NCRN	3680	196	5.3%	106	2.9%	130	3.5%	146	4.0%	105	2.9%	116	3.2%	210	5.7%	170	4.6%	65	130	3.5%
Dorset NCRN	3220	69	2.1%	134	4.2%	220	6.8%	166	5.2%	126	3.9%	143	4.4%	177	5.5%	198	6.1%	147	294	9.1%
Greater Manchester and Cheshire NCRN	13800	499	3.6%	444	3.2%	640	4.6%	797	5.8%	554	4.0%	604	4.4%	774	5.6%	1124	8.1%	693	1386	10.0%
Greater Midlands NCRN	10120	590	5.8%	621	6.1%	623	6.2%	511	5.0%	412	4.1%	449	4.4%	546	5.4%	601	5.9%	354	708	7.0%
Humber and Yorkshire Coast NCRN	4600	190	4.1%	412	9.0%	522	11.3%	480	10.4%	315	6.8%	248	5.4%	228	5.0%	225	4.9%	145	290	6.3%
Kent and Medway NCRN	7360	157	2.1%	146	2.0%	177	2.4%	236	3.2%	252	3.4%	391	5.3%	420	5.7%	342	4.6%	151	302	4.1%
Lancashire and South Cumbria NCRN	6670	79	1.2%	64	1.0%	50	0.7%	198	3.0%	132	2.0%	220	3.3%	287	4.3%	325	4.9%	170	340	5.1%
Leics, Northants and Rutland NCRN	6440	286	4.4%	237	3.7%	255	4.0%	270	4.2%	170	2.6%	169	2.6%	165	2.6%	224	3.5%	102	204	3.2%
Merseyside and Cheshire NCRN	9844	475	4.8%	485	4.9%	595	6.0%	606	6.2%	378	3.8%	476	4.8%	599	6.1%	655	6.7%	325	650	6.6%
Mid Anglia NCRN	4140	230	5.6%	169	4.1%	189	4.6%	191	4.6%	177	4.3%	265	6.4%	254	6.1%	252	6.1%	122	244	5.9%
Mid Trent NCRN	7820	288	3.7%	217	2.8%	266	3.4%	378	4.8%	332	4.2%	405	5.2%	321	4.1%	358	4.6%	231	462	5.9%
Mount Vernon NCRN	7475	180	2.4%	230	3.1%	345	4.6%	304	4.1%	264	3.5%	175	2.3%	261	3.5%	423	5.7%	193	386	5.2%
Norfolk and Waveney NCRN	3220	68	2.1%	33	1.0%	111	3.4%	139	4.3%	88	2.7%	120	3.7%	130	4.0%	173	5.4%	95	190	5.9%
North East London NCRN	6900	197	2.9%	198	2.9%	261	3.8%	227	3.3%	212	3.1%	231	3.3%	203	2.9%	239	3.5%	164	328	4.8%
North London NCRN	7475	219	2.9%	166	2.2%	307	4.1%	395	5.3%	383	5.1%	370	4.9%	651	8.7%	540	7.2%	251	502	6.7%
North of England – North NCRN	9200	290	3.2%	368	4.0%	495	5.4%	429	4.7%	220	2.4%	360	3.9%	417	4.5%	383	4.2%	203	406	4.4%
North of England – South NCRN	4600	155	3.4%	109	2.4%	140	3.0%	176	3.8%	124	2.7%	79	1.7%	132	2.9%	110	2.4%	80	160	3.5%
North Trent NCRN	8280	358	4.3%	433	5.2%	519	6.3%	495	6.0%	375	4.5%	464	5.6%	466	5.6%	479	5.8%	191	382	4.6%
Pan Birmingham NCRN	8280	566	6.8%	548	6.6%	553	6.7%	454	5.5%	352	4.3%	336	4.1%	420	5.1%	452	5.5%	265	530	6.4%
Peninsula NCRN	6900	328	4.8%	566	8.2%	512	7.4%	466	6.8%	525	7.6%	568	8.2%	428	6.2%	407	5.9%	251	502	7.3%
South East London NCRN	6900	115	1.7%	93	1.3%	162	2.3%	179	2.6%	155	2.2%	194	2.8%	340	4.9%	300	4.3%	201	402	5.8%
South Essex NCRN	3220	160	5.0%	162	5.0%	165	5.1%	173	5.4%	149	4.6%	135	4.2%	114	3.5%	116	3.6%	59	118	3.7%
South West London NCRN	8740	906	10.4%	486	5.6%	501	5.7%	518	5.9%	514	5.9%	543	6.2%	584	6.7%	633	7.2%	487	974	11.1%
Surrey, West Sussex and Hampshire NCRN	5060	308	6.1%	275	5.4%	224	4.4%	172	3.4%	138	2.7%	220	4.3%	245	4.8%	232	4.6%	132	264	5.2%
Sussex NCRN	4600	210	4.6%	192	4.2%	279	6.1%	247	5.4%	190	4.1%	164	3.6%	226	4.9%	258	5.6%	81	162	3.5%
Thames Valley NCRN	11500	226	2.0%	215	1.9%	376	3.3%	339	2.9%	270	2.3%	360	3.1%	445	3.9%	418	3.6%	245	490	4.3%
Three Counties NCRN	5060	349	6.9%	296	5.8%	255	5.0%	222	4.4%	218	4.3%	205	4.1%	210	4.2%	247	4.9%	169	338	6.7%
West Anglia NCRN	6325	380	6.0%	625	9.9%	638	10.1%	712	11.3%	713	11.3%	826	13.1%	597	9.4%	538	8.5%	354	708	11.2%
West London NCRN	8740	144	1.6%	171	2.0%	248	2.8%	297	3.4%	240	2.7%	399	4.6%	315	3.6%	318	3.6%	163	326	3.7%
Yorkshire NCRN	11500	603	5.2%	722	6.3%	709	6.2%	968	8.4%	721	6.3%	668	5.8%	589	5.1%	676	5.9%	414	828	7.2%

\*Note that 2009/10 is calculated from the first six months of the year. Source: NCRN

## Annex – Relevant documents published since the first Cancer Reform Strategy annual report

The National Cancer Programme includes a number of different organisations including DH, the National Cancer Action Team, NHS Improvement, NHS Cancer Screening Programmes, the National Cancer Intelligence Network and the National Cancer Services Analysis Team.

Some key documents that readers of this publication may find of interest are listed below. Please note this list is not exhaustive.

### Department of Health publications

Available from [www.dh.gov.uk](http://www.dh.gov.uk)

*Cancer Commissioning Guidance*, DH, January 2009

*Public awareness of cancer in Britain*, DH and UCL, November 2009

*Children's Cancer Measures*, DH, November 2009

*National Cancer Programme Bulletin*, DH, November 2009

*Manual for Cancer Services 2008*, DH, October 2009

*Complementary measures consultation on the draft psychological support measures*, DH, October 2009

*National Cancer Survivorship Initiative newsletter*, DH and Macmillan Cancer Support

*Manual for Cancer Services: Draft Radiotherapy Measures*, DH, August 2009

*Chemotherapy Services in England: Ensuring quality and safety*, DH, August 2009

*Revised Prostate Cancer Risk Management Programme resource pack*, DH, July 2009

*Guide to practice-based commissioners in developing good cancer care services*, DH, June 2009

### National Cancer Intelligence Network

Available from [www.ncin.org.uk](http://www.ncin.org.uk)

November 2009: Report and presentations from the NCIN Co-morbidity Data Collection Workshop

October 2009: National Oesophago-Gastric Cancer Audit: second annual report

October 2009: MDT Development Survey

July 2009: NCRI's free online cancer research portal, ONIX

June 2009: NCIN June Newsletter

June 2009: Colorectal Cancer Survival

June 2009: Access to samples and data for research

June 2009: Men's Health and Cancer

### NHS Improvement

Available from [www.improvement.nhs.uk](http://www.improvement.nhs.uk)

*Cytology improvement guide – achieving a 14 day turnaround time in Cytology*, November 2009

*Transforming Care for Cancer Inpatients – Spreading the Winning Principles and Good Practice*, July 2009

*Ensuring Better Treatment: Going Further on Cancer Waits – An improvement guide for supporting sustainable delivery*, February 2009

## National Cancer Action Team

Available from [www.cancerinfo.nhs.uk](http://www.cancerinfo.nhs.uk)

*Principles and Practical Guidance in Good Equality Working*, October 2009

*National Cancer Equality Initiative 'We Can' Newsletter*, June 2009

*Cancer Information Prescription Briefing*, April 2009





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