

## Achieving world-class cancer outcomes: a strategy for England 2015-2020: Summary

The Independent Cancer Taskforce was established in January 2015 by NHS England on behalf of the Care Quality Commission, Health Education England, Monitor, National Institute for Health and Care Excellence, Public Health England and the Trust Development Authority to develop a five-year strategy for cancer services with the aim of improving survival rates and saving thousands of lives.

***“Achieving world-class cancer outcomes: a strategy for England 2015-2020”*** was published in July 2015. The full report is available here: <http://www.cancerresearchuk.org/about-us/cancer-taskforce>

### Background

- Incidence increasing 2% per annum - additional 20-30K new cases each year by 2020
- Breast, lung, prostate and colorectal account for half of all diagnoses
- Ageing population, increase in lifestyle risk factors (40% of cases)
- Prevalence of cancer is projected to increase to 3.4 million people by 2030
- Mortality rates decreasing and survival time improving

#### BUT

- Despite a lower incidence of cancer to countries of similar wealth, England compares poorly for overall survival, particularly for colon and lung cancers
- Late diagnosis and sub optimal access to treatment, particularly for advanced disease, are key drivers for poor survival outcomes
- Cancers are diagnosed at a more advanced stage overall and emergency presentations account for a fifth of diagnoses
- Survival within stage groups also compares poorly to similar countries, particularly for advanced breast and ovarian cancers
- Curative treatment rates are lower and there is variation in access to radical treatment
- Outcomes are worse for older age groups, with a 20% absolute difference in 1 year survival between 55-64 and 75+ year olds, higher rates of emergency presentations and lower likelihood of receiving the most effective and appropriate treatment
- The majority of cancer patients are over the age of 65, and it is estimated that 70% of cancer patients have at least one other LTC and a quarter have at least three other LTCs
- Inequalities exist with higher incidence rates in socio-economically deprived groups, primarily linked to smoking prevalence
- Patient frustration with fragmentation of care, lack of information on diagnosis and treatment, and longer term post treatment support
- Patient satisfaction with treatment is lower in older and younger patients, BME groups, LGBT groups, those with less common cancers and those presenting as an emergency
- At the end of life, only a third of people die in their place of choice
- There are significant deficits in workforce capacity, cancer pathways lack co-ordination and commissioning is disjointed

## Six Strategic Priorities:

Prevention, Earlier Diagnosis, Patient Experience, Recovery, Investment (Workforce, Equipment, Treatments and Research), Commissioning Redesign

## Key Outcomes Focus on Prevention, Earlier Diagnosis, Recovery and Variability:

### Incidence:

- A reduction in age standardised incidence and in deprived groups by 2020
- A reduction in adult smoking rates to 13% overall and 21% in routine and manual groups by 2020

### Survival

- Increases in 5 and 10 year survival, with 57% surviving at least 10 years by 2020, increasing to 75% by 2034
- Increases in 1 year survival, to 75% for all cancers combined by 2020, with a reduction in variation between CCGs
- A reduction in the survival deficit for older people

### Patient Experience and Quality of Life

- Continuous improvement in patient experience survival with a reduction in variation between CCGs and cancer types
- Continuous improvement in long term quality of life (based on a new indicator)
- A majority of patients having been assessed as having a 'good' death

## Proposed National CCG and Provider Metrics Dashboard (with cancer type and equality breakdowns)

### Vital Statistics

1. Under-75 mortality
2. Over-75 mortality
3. One year survival

### Early Diagnosis

1. Proportion of patients referred for diagnostic testing by a GP receiving a definitive result within 2 and 4 weeks (50% and 95% respectively) (NB New Metric to replace 2WW)
2. Proportion of cancers diagnosed through emergency presentation
3. Proportion of cancers diagnosed at Stage 1 or 2 (62% by 2020 with overall increase in % staged)
4. Screening uptake (with 75% uptake for FIT test in the bowel screening programme by 2020)

### Cancer Services

1. Proportion of patients meeting referral to treatment cancer waiting times targets (96% for 31 days and 85% for 62 days)
2. Proportion of patients with patient-agreed written after-treatment plan (95% by 2020)

### Patient Experience

1. Overall Care Rating Analysis (positive ratings across all Cancer Patient Experience Survey measures)
2. Quality of Life (to be developed e.g. PROMs)
3. Proportion of people who die who had a personalised end of life care plan

## Key Recommendations and Actions to Deliver Outcomes

### REDUCING GROWTH IN INCIDENCE:

#### 1) Focus on prevention through lifestyle risk factors:

- New Tobacco Control Strategy
- National Action Plan on Obesity
- Increasing awareness of alcohol as a risk factor and development of a strategy based on PHE rapid review
- Intensive lifestyle change programmes for high risk groups
- Ensure all cancer patients receive lifestyle interventions to reduce recurrence
- Increasing early awareness through prevention in schools
- Making Every Contact Count

#### 2) Increase uptake of cancer screening and chemo-prevention programmes

- Extension of HPCV vaccine to males if cost-effective
- Ensure appropriate prescribing, uptake and adherence of chemo-preventive drugs

### IMPROVING SURVIVAL:

#### 3) Screening

- Improving uptake in inequality groups
- Roll out of FIT testing in bowel cancer screening and primary HPV testing in cervical cancer screening

#### 4) Early Diagnosis

- Continued investment in “Be Clear on Cancer” campaigns with a minimum of 2 per year
- Implement the new threshold guidelines from NICE for GP cancer referrals
- Direct access for GPs to key investigative tests
- Replace the 2WW metric with GP Referral to Diagnosis within 4 weeks by end of 2015
- GPs should be required to undertake a Significant Event Analysis for patients diagnosed through emergency presentation
- Increasing diagnostic capacity, particularly in radiography, radiology and endoscopy, through workforce measures and establishment of a national diagnostic capacity implementation fund
- Implementation of new models for diagnostics pathways such as the Accelerate, Coordinate and Evaluate (ACE) programme or multi-disciplinary diagnostic centres (MDTs)
- Pilot self-referral for patients with red flag symptoms or limited GP access
- Pilot GP practice based Cancer Nurse Specialists

#### 5) Treatment:

##### • Surgery

- Reduce variation in curative surgery rates and outcomes, with a potential reconfiguration into centralised centres for upper GI, brain, rectal, urological, lung and gynaecological cancers
- Define key quality metrics for each cancer surgery sub-speciality by mid-2016
- Monitor the number of cancer patients with cancelled elective surgery

##### • Radiotherapy

- Reduce variation in Intensity Modulated Radiotherapy (IMRT) provision and commissioning of Stereotactic Radiosurgery (SRS) and Stereotactic Radiotherapy (SRT)
- Regional delivery of programme to upgrade and replace linear accelerators (LINACs)

- **Chemotherapy**

- Define a sustainable solution for access to new cancer drugs to replace the Cancer Drugs Fund by April 2016
- Sanctions for any provider not fully complying with electronic prescribing by March 2016
- Regular and consistent submission of the Systemic Anti-Cancer Therapy Dataset (SACT) by providers to become part of CQC assessment

## **6) Molecular Diagnostics:**

- All patients under the age of 50 receiving a bowel cancer diagnosis are offered a genetic test for Lynch Syndrome
- All women with non-mucinous epithelial ovarian cancer are offered testing for BRCA1/BRCA2 at the point of diagnosis
- All women under the age of 50 diagnosed with breast cancer are offered testing for BRCA1/BRCA2 at the point of diagnosis
- Nationally commissioned molecular diagnostic service starting with melanoma, lung, colorectal, breast and all paediatric cancers in 2016.
- Use of molecular diagnostic tests by providers to be added to the COSD data set

## **7) Treatment Service Delivery:**

- MDTs to review a monthly audit report of patients who have died within 30 days of active treatment
- National or regional MDTs for rarer cancers where treatment options are low volume and/or high risk
- Decreasing the workforce deficit in clinical oncology, medical oncology and clinical nurse specialists

## **8) Target Groups:**

- Pilot a care pathway for 75+ years incorporating frailty and geriatric needs assessments
- Increasing recruitment to clinical trials for teenage and young adults (15+ years)
- NICE to develop updated guidelines for adjuvant treatment for breast cancer
- Explore the needs of people with serious mental illnesses or learning difficulties

## **9) Palliative Care and Allied Health Professional Services**

- Pilot assessment of holistic needs for cancer patients at the point of diagnosis, evaluating the benefit of earlier palliative care and/or intervention from AHPs

## **10) Research**

- Publish clear guidance by the end of 2015 that commissioners must meet excess treatment costs for clinical trials on the NIHR portfolio
- Excess Treatment Costs (ETCs) for radiotherapy trials should be distributed through a national fund held by NHS England to ensure high quality clinical trials are developed and delivered
- Develop a process to channel practice-changing clinical trial results through to NICE and CRGs for incorporation into new clinical guidelines and develop an early warning system for ground-breaking trials that are due to report

## **EXPERIENCES OF CARE, TREATMENT AND SUPPORT:**

### **11) Patient Experience:**

- Increase BME representation in CPES, link CPES to other datasets to understand experience across the pathway and extend to beyond acute care, and develop a methodology to collect data on patient experience for under 16s

- Incentivise improvement in patient experience by developing a set of metrics by 2017 to be rolled out nationally and embedded in mechanisms of accountability e.g. CQC assessment of hospitals
- Develop on-line decision and communication aids for patients and carers to use with their clinicians
- All new and, where appropriate, existing staff should have mandatory communication skills training including empathetic listening skills, shared decision-making, empowering patients to self-manage, and how to deliver difficult news.

**12) Digital Communication:**

- From confirmation of a diagnosis, all consenting patients should have the ability to access all test results and other communications involving secondary/tertiary care providers online by 2020, extending to include all GP records thereafter
- Commissioning the development of a smartphone app with charities or commercial partners which patients can use to collate all their diagnosis and treatment related information and correspondence in one place
- All hospital providers to provide a directory of local services (electronic and on paper) and facilitate local cancer support groups (e.g. by providing free space), to provide peer and signposting support to cancer patients

**13) Clinical Nurse Specialists:**

- Ensure all patients can access a CNS, through increasing workforce and evaluating the role of Support Workers with charity providers

**QUALITY OF LIFE AFTER TREATMENT AND AT THE END OF LIFE****14) QoL With and Beyond Cancer:**

- Develop a national metric on long term quality of life after treatment by 2017
- PROMs should be rolled out across breast, colorectal and prostate cancer by 2020
- Accelerate the commissioning of services for patients living with and beyond cancer, with a view to ensuring that every person with cancer has access to the elements of the Recovery Package by 2020
- Develop a NICE guideline, by mid-2016, for a minimum service specification on the Recovery Package to be commissioned locally with a suite of metrics
- Piloting, commissioning of integrated depression care that includes screening and treatment systems, such as “Depression Care for People with Cancer” (DCPC)

**15) Stratified Follow Up:**

- All providers incentivised to start implementing stratified follow-up pathways of care for patients treated for breast cancer
- Pilot stratified follow-up pathways of including prostate, colorectal and some rarer cancer types, with an aim to roll out nationally for at least two other cancer types by 2020

**16) Rehabilitation**

- A national review of the cancer rehabilitation workforce and promote the role of AHPs in multi-disciplinary teams prior to palliative care stage
- Evaluate community oncology nurse services and community pharmacy services for management of consequences of treatment and treatment adherence
- Ensuring that return to work is fully integrated into assessment and care planning and commissioning of vocational rehabilitation services.

**17) End of Life**

- Ensure that CCGs commission appropriate integrated services for palliative and end of life care, in line with the NICE Quality Standard (2011)
- Consider the role of the 'Gold Standards Framework' for commissioning of primary care
- CQC to incorporate end-of-life care into its assessment metrics for hospitals and other providers of cancer services

**IMPROVING EFFICIENCY AND EFFECTIVENESS OF DELIVERY**

There is strong evidence for increased centralisation of complex services, such as some surgery, radiotherapy and chemotherapy. There is equally a patient "pull" and a need to integrate with other locally-provided services that drives for decentralisation of others such as access to diagnostics, rehabilitation, end of life care, and some types of "safe" chemotherapy

**18) Commissioning:**

- All treatment services for rare cancers (fewer than 500 cases per annum across England, including all paediatric, teenage and young adult services) should be commissioned nationally
- Other cancer treatment services (cancer surgery where national volumes are less than 2,500 per year, all remaining radiotherapy, and all remaining chemotherapy) should be commissioned by a lead commissioner across populations of 4-5 million or more
- Cancer surgery where national volumes are between 2500 and 7500 per year should be commissioned by a lead CCG commissioner for populations of 1-2 million or more
- Breast and colorectal cancer surgery should be commissioned at CCG level
- Diagnostic services to confirm or exclude cancer should be commissioned at CCG level, including a range of blood tests, chest x-ray, ultrasound, CT, MRI, endoscopy and biopsy
- Primary care services should be commissioned by NHS England Regional Teams or through CCGs via delegated responsibility where appropriate
- Services to support living with and beyond cancer, including end of life care, should be commissioned by CCGs with support from HWBs
- Pilot the commissioning of the entire cancer pathway in at least one area, to include investigation, diagnosis and treatment, living with and beyond cancer, and end of life care. The pilot should test a fully devolved budget for that population, to be delivered over multiple years. Commissioning of services should be based on a pre-specified set of clinical and patient experience outcomes.

**19) Cancer Alliances:**

- Establish Cancer Alliances at sub-regional level to oversee key metrics, address variation and ensure effective integration and optimisation of treatment and care pathways and accountability in cancer
- To include local patients and carers, nurses and Allied Health Professionals, have the authority to request CCGs to undertake root cause analysis of deficits in services, e.g. high percentage diagnosed through emergency presentations. Cancer Alliances should be accountable to the National Cancer Team

**20) National Quality Standards:**

- NICE guidelines should be updated every 2-3 years for most types of cancer
- Clinical Reference Groups to develop clinical guidelines into more detailed service specifications where necessary by the end of 2016

**21) National Quality Assessment:**

- Extend the scope of CQC inspections taking a condition-based approach that cuts across core services and populations for complex pathways, using cancer as the exemplar to embed formal accountability
- Primary care: advice on smoking, obesity, alcohol consumption; Use of recognised algorithms to assess risk in patients with symptoms that could potentially be due to cancer; Referral rates for diagnostic tests; Safety netting processes; Significant event analyses; Fast tracking of patients with possible recurrence of cancer; Use of end of life care registers and electronic palliative care coordinating systems
- Secondary/Tertiary Care: Access to and quality and accuracy of diagnostic services and timelines of reporting; Activity levels and outcomes for cancer surgery, chemotherapy and radiotherapy; MDT working and compliance with NICE guidance; Patient experience through the Cancer Patient Experience Survey (CPES); Acute oncology service provision; Access to CNSs; End of life care provision; Provision of data to national clinical audits and to the cancer outcomes services dataset (COSD), diagnostic imaging dataset (DID), and systemic anticancer therapy dataset (SACT)
- Commission a rolling programme of national clinical audits for critical cancer services, e.g. annually for lung cancer, and oversee an annual audit of cancer diagnosis

**22) Workforce:**

The growth in cancer need, earlier diagnosis, improved survival and changes to practice e.g. seven-day working are adding to workforce pressures.

- Develop a vision for the future shape and skills mix of the workforce required to deliver a modern, holistic patient-centred cancer service to report by the end of 2016
- **Radiologists:** a minimum of 80 trained radiologists per million population over the next 7 years by increasing training positions by 60 per year over the next five years
- **Endoscopy:** colonoscopy rates per head of population in England are among the lowest of all developed countries and deficits are inhibiting the optimal roll-out of bowel screening and preventing increased investigative testing for suspected cancer
- **Sonography:** Make sonography a separate registration to radiography to enable quicker training
- **Oncology:** increasing the number of clinical oncology, medical oncology, medical physics, therapy radiography and CNS training positions with immediate effect
- Develop a programme for international promotion of specialist recruitment opportunities in key areas where shortfalls currently exist and where future demand is expected to grow
- Pilot all secondary/tertiary cancer treatment services provided through a 'lead provider' managing the entire treatment budget

**23) Intelligence:**

- Urgently address current information governance problems around access to data for organisations which are compliant with appropriate standards of data security and confidentiality
- Ensure that a policy and legal framework is in place that facilitates the ongoing flow of data from and between HSCIC, MHRA, NIHR, and PHE
- Innovative linkage of datasets across providers including RTDS, CPRD, SACT, and DID
- Mandate the collection of data on recurrent and secondary cancer occurrences for all cancers and make this available for analysis and research
- Develop better health economic evaluation of new service models and interventions

**24) Implementation:**

- Establish a National Cancer Team (NCT) for oversight and delivery
- The NCT should also oversee the development, resourcing and support of cancer CRGs, commission reviews of specific cancer services from CQC where appropriate, and commission the rolling programme of national audits

**25) National Accountability:**

- NHS England should sponsor a National Cancer Advisory Board, independently chaired, to oversee and advise on implementation of the national strategy. This body should prepare an annual report for the CEOs of the seven ALBs and the Secretary of State for Health
- The National Cancer Team should have the responsibility of directly informing the CEO of NHS England of CCGs or providers which are consistently failing to deliver against national metrics