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NHS ENGLAND – BOARD PAPER

Title: Cancer Programme Update
Lead Director: Cally Palmer, National Cancer Director
Purpose of Paper: Update the Board on progress on implementation of the cancer strategy
Patient and Public Involvement: <p>In 2015 the independent Cancer Taskforce report Achieving world-class cancer outcomes: a strategy for England 2015-2020 set out a vision for transforming cancer outcomes and experience for patients. The strategy built on substantial public engagement involving hundreds of written submissions and nearly 100 workshops and meetings involving around 600 participants including patients, charities and relevant professional groups.</p> <p>The Cancer programme is committed to patient and public engagement in our work at a national level and locally through our Cancer Alliances. We work closely with patient representatives, the voluntary community and social enterprise sector and with groups supported by NHS England's Experience, Participation and Equalities team.</p>
The Board is invited to: Review progress to date.

Cancer Programme Update

Purpose

1. This paper provides an update on progress on implementation of the cancer Taskforce strategy [Achieving World-Class Cancer Outcomes: A Strategy for the NHS 2015-2020](#) and the development of the cancer strategy in the long-term plan.

Background

2. The National Cancer Programme is now in the third year of implementing the Cancer Taskforce Strategy and has made significant progress towards increasing cancer survival and improving patient experience and quality of life by 2020.
3. In June 2018, the Prime Minister announced a funding settlement for the NHS of 3.4% real term growth a year - £20bn by 2023/24. NHS England has been asked to develop a ten-year plan – the five year funding settlement will be mapped to the first half of that plan.
4. The commitment to cancer as a priority for the Government and for the NHS strengthens our opportunity to consolidate and extend the excellent work underway.

Key achievements

5. Cancer survival has never been higher. The latest figures, for people diagnosed in 2015, show one year survival at 72.3% - a 0.7% increase from 2014.
6. We are shifting to earlier and faster diagnosis. Latest figures, for Q3 17/18, show diagnoses made following an emergency presentation at 18.5% - a 1% decrease in two years.
7. We are investing £200m through our Cancer Alliances in 17/18 and 18/19 to transform diagnostic services and care during and after treatment, including:
 - a. embedding the latest research on prostate diagnosis into clinical practice. The PROMIS trial showed twice as many cancers identified and up to one in four men avoiding an unnecessary biopsy;
 - b. rolling out straight to test (STT) pathways for colorectal cancer to speed up diagnosis. STT pilots have also shown outpatient appointments to reduce by half.
8. We have continued to implement the largest radiotherapy upgrade programme in 15 years. We invested £46m in 2017/18 on 26 new radiotherapy machines in 21 hospitals, and so far this year have funded a further 17 new machines. Together with roll-out of SABR and creation of radiotherapy networks, this year we will be offering the best standard of care anywhere in the world to patients wherever they live.
9. The new Quality of Life metric is being trialled in five Alliances and will help us better respond to the long-term impact of cancer on people's lives.

Further progress

National strategy, local delivery

10. **Nineteen Cancer Alliances** were established in 2016, bringing together senior clinical and managerial leaders from across a geographical area. Cancer Alliances are driving forward the Cancer Taskforce's ambitions, working across whole pathways and for all their patients to reduce variation and implement best practice.
11. Data and information from across the cancer pathway – including screening, diagnosis, treatment and patient experience – is being presented in a single dashboard to Cancer Alliances by our new **Cancer Alliance Data, Evidence and Analysis Service (CADEAS)**. This is the first time this data has been brought together in this way to enable evidence-based decision-making for service transformation.

Prevention

12. **Changing behaviour** in relation to diet, exercise, smoking and alcohol is crucial if we are to reduce the numbers of people who will develop cancer. Public Health England (PHE) leads the cancer prevention and public health work-stream of the national strategy working with partners across the system.
13. **Smoking rates** in England decreased from 25% in 2004, to 14.9% in 2017. However, there remain just over six million smokers in England and so smoking remains the single biggest avoidable risk factor for cancer.
14. **Be Clear on Cancer campaigns** aim to raise people's awareness of potential cancer signs or symptoms. A respiratory symptoms campaign ran for a second time from May to August 2017 to raise awareness that a persistent cough might indicate lung diseases and, the Breast Cancer in Women over 70 campaign ran for a third time February to March 2018 to raise awareness of age-related risk of developing breast cancer.

Earlier and faster diagnosis

15. **Earlier diagnosis** is the key to higher survival rates because patients can start their treatment earlier when more curative options are available to them to improve survival. More patients are being diagnosed at stage 1 and 2. In 2017 52.7% of all cancers were diagnosed at this stage – the highest on record.
16. A Faecal Immunochemical Test (FIT) Task and Finish Group has been established by the National Medical Director and National Cancer Director to oversee the delivery of the **introduction of FIT to the bowel screening programme**. Roll-out will commence in autumn 2018 with as many people as possible having access by spring 2019. FIT will be introduced at a sensitivity threshold of 120 ug/g, meaning an extra 1,500 cancers could be detected, and will be reviewed again after implementation to see if the sensitivity could be reduced further, taking us to the best in Europe. Regional teams are supporting screening centres to ensure that additional endoscopy and histopathology capacity is developed to meet this timetable.
17. **The Faster Diagnosis Standard** is a new performance standard that will ensure patients are told that they have a cancer diagnosis or an 'all clear' within 28 days of

being referred urgently by their GP for suspected cancer. This means swifter treatment for those diagnosed with cancer, and immediate reassurance for those who are not. The Standard has been developed following piloting in five areas across the country. Following a year of shadow monitoring from April 2019, the Standard will be published from April 2020.

18. **Timed pathways are being introduced** for three key cancer types – colorectal, prostate and lung cancer - that will reduce cancer waiting times, speed up diagnosis and limit the need for more invasive tests to those at greatest risk.
19. **Pilot programmes offering low dose CT scans are being launched** following the success of the lung health check study in Manchester, which resulted in a stage shift in the diagnosis of lung cancer. Prior to the study 18% of lung cancers were diagnosed at stage 1 and 48% stage 4. As a result of the study, 65% of lung cancers were diagnosed at stage 1 and 13% were stage 4.
20. **Ten multidisciplinary rapid diagnostic and assessment centres** across England have been set up to test new ways of working and to establish the evidence of what works to speed up cancer diagnosis. Through the ACE (Accelerate, Coordinate, Evaluate) Wave 2 programme, a partnership between NHS England, Cancer Research UK and Macmillan Cancer Support, the centres have begun to take patients with complex symptoms through to diagnosis.

Better treatment and care

21. We are implementing the largest **radiotherapy upgrade** programme in 15 years. We invested £46m in 2017/18 on 26 new radiotherapy machines in 21 hospitals and we are on track to deliver the commitment in the Five Year Forward View to deliver 50 LINACS to 34 trusts by October 2018.
22. We are investing £15 million over three years to evaluate the benefits of **stereotactic ablative radiotherapy (SABR)**. SABR is an innovative method of giving radiotherapy. It is only suitable for some people, usually those with smaller cancers, targeting the tumour precisely and reducing the damage to the surrounding tissues
23. **The 100,000 Genomes Project** has developed an exemplar cancer pathway to maximise the quality of material available for molecular diagnostics. This has included significantly reconfiguring the diagnostic cancer pathway from surgery through to pathological assessment – in particular the use of the ‘fresh-frozen’ approach to preserve tissue in operating theatres.
24. Since the launch of the new **Cancer Drugs Fund** in July 2016, 15,700 patients have been given access to the very latest and most promising new treatments.
25. We are preparing the NHS to begin delivering **Chimeric Antigen Receptor T Cell (CAR-T) Therapy** treatment from October 2018 to children and young people up to 25 years old with B cell acute lymphoblastic leukaemia (ALL) that is refractory, in relapse post-transplant or in second or later relapse. At the beginning of September, NICE approved the treatment for entry into the Cancer Drugs Fund following a successful commercial deal with the manufacturer Novartis. The Tisagenlecleucel form of CAR-T, also known as Kymriah, is the first in a wave of treatments in a new era of personalised medicine and part of the NHS’s long term plan to upgrade cancer services.

26. The process of producing such a treatment is complex and the first wave of potential providers are being inspected and accredited against the necessary regulatory, safety and quality standards with accreditation outcomes expected to be confirmed in the second half of October. The phased implementation required by the manufacturer and the NHS means that full capacity to treat eligible patients will take a number of months to achieve and a national structure will be put in place to assure equity of access and prioritisation of patients during this time. Provision is expected to begin in London, Manchester and Newcastle, subject to passing accreditation requirements the first treatments could begin in a matter of weeks. NICE continues to review CAR-T products for the third or subsequent line treatment of adults with Diffuse Large B Cell Lymphoma and similar lymphomas which are estimated to be c.200 patients per annum.

Workforce

27. Health Education England published the first ever **Cancer Workforce Plan** in December 2017 outlining the actions required to expand the cancer workforce so that the NHS can deliver a world-class service for patients.

28. Seven key areas are identified in the plan, where professions most under pressure were identified for national action:

- Histopathology and health care scientists
- Gastroenterology
- Clinical radiology
- Diagnostic radiography
- Medical and clinical oncology
- Therapeutic radiography
- Nursing (Cancer Clinical Nurse Specialists)

29. Steps to **increase professional numbers** over the next one to three years include:

- a. In addition to the 200 clinical endoscopists already committed, HEE will invest in 200 more endoscopists to support earlier diagnosis by 2021. To date, 128 trainees have completed, or are in training on, HEE's clinical endoscopist training programme. Two further cohorts go ahead in 2018 and training grants have been offered to support training and supervision to encourage uptake to these cohorts.
- b. HEE will invest in 300 reporting radiographers by 2021 to support an increase in the capacity for earlier diagnosis as part of a national programme to assure quality and consistency. There has been significant interest in training in radiographer reporting, with the first courses to commence in September 2018.
- c. HEE is supporting the development of new apprenticeship routes into the clinical cancer workforce and is facilitating the development of apprenticeship standards at Level 4 in mammography (associate mammographer), Level 6 in diagnostic radiography, sonography and in therapeutic radiography, and Level 7 in advanced clinical practice (nursing & AHPs).

Operational Performance

30. The Cancer Programme aims to diagnose cancer earlier in order to increase survival rates. This focus leads to an increase in referrals, which in turn puts pressure on diagnostic and treatment services. The effect of this can be seen in operational performance.

31. In March this year, following concerted effort by local teams and Cancer Alliances to clear backlogs and improve cancer pathways against a backdrop of increasing demand, performance against the 62 day referral-to-treatment standard for cancer was at 84.7% (national standard is 85%).
32. 2018/19 has seen steep increases in referrals across all tumour types (13.6% growth between April-July 2018 and the corresponding period last year), most starkly in urology (26%). Performance against the 62 day standard subsequently fell to 78.2% in July 2018. It should be noted, however, that there has been a 10.6% growth in the numbers of people treated within 62 days when comparing April-July 2018 with the same period from last year. In July 2018, 14,361 people received their first treatment within 62 days, compared to 12,534 in July 2018. This is an increase of 1,827 and the highest monthly figure ever recorded.
33. We are taking focused action to support the NHS to meet the operational standard:
- a. Close operational oversight:
 - i. Better basic grip on Patient Tracking Lists by Cancer Alliances and regional leads to speed up pathways, identify capacity constraints and escalate problems to Chief Executive level
 - ii. New joint oversight structures at national/regional level
 - b. Targeted improvement support:
 - i. Ensuring Cancer Alliances are actively implementing the ten high impact actions
 - ii. Targeting use of Intensive Support Team capability
 - c. Prioritise system transformation which supports operational delivery:
 - i. Speeding up the introduction of optimal best practice pathways
 - ii. Working with an expert prostate clinical group to modernise cancer waits guidance
34. In response to this recent rise in referrals, we are making more funding available to support delivery of immediate actions to improve performance, with priority given to actions that will improve performance on the urology pathway. The funding will be directed locally by joint 'SWAT teams' from regions and Cancer Alliances parachuted into the worst-performing areas and trusts. These teams will diagnose and address the key issues and barriers affecting performance.
35. Ensuring transformation activity stays on track while performance is improved is key to delivering sustainable services in the medium to long-term. This will be supported by the Programme, taking into account the spike in urology referrals in agreeing Alliances' Q3 and Q4 transformation funding allocations. At the same time, to support improvements against the 62 day urology pathway in particular, we will require all Alliances to further prioritise and accelerate implementation of the best practice timed pathway for prostate cancer across all of its providers, and work with their regional teams to ensure that any shorter-term interventions that will support delivery of the 62 day pathway for urology are immediately implemented.

Reducing health inequalities

36. The Programme is committed to reducing health inequalities, including, but not limited to, those people defined as having protected characteristics under the Equality Act 2010.

37. The Programme has embedded the requirement to consider health inequalities in its business planning thereby ensuring teams plan their projects through a health inequalities lens, in particular in relation to ethnicity and socioeconomic deprivation.
38. Current and proposed projects that will help to reduce health inequalities include:
- a) piloting the low dose CT scanning in CCGs with lowest lung cancer survival rates;
 - b) Implementing rapid diagnosis pathways for lung, prostate and colorectal cancers, which are the three most common cancers and are most likely to occur in the most deprived (lung) and BME communities (prostate), with colorectal cancer often diagnosed later in Black patients.
39. Working with the Empowering People and Communities Taskforce, we are expanding our engagement with patients and public affected by cancer, building on the solid patient and public engagement work underway in the programme, both nationally and locally through Cancer Alliances.

Next steps

40. The continued commitment to cancer as a priority for the Government and for the NHS strengthens our purpose to consolidate and extend the excellent work underway to deliver the Taskforce Report, which set ambitious goals for the NHS. We are continuing to work together with national and regional colleagues and Cancer Alliances to ensure that we can deliver against the core constitutional standards for cancer. Our third annual report of progress in delivering the cancer strategy will be published this autumn.
41. We have engaged with over 50 organisations to date in the development of the cancer section of the Long Term Plan for the NHS which will be published later this year. The Plan enables us to push even further on the transformation of services and outcomes for people with cancer.

Recommendations

42. The Board is invited to review progress to date.

Author: Joanna Cottam, Deputy Director, Cancer Programme