Cancer Plan - Challenges

- Cancer burden
- Variation – 23% difference in incidence between least and most deprived areas
- Higher rates of late stage and emergency presentation of disease
- NICE guidance – 10% conversion down to 3%
- Numbers living with cancer
- Time frame
- Resources
Cancer Plan - overall

- What makes it different
- Prevention
- Detecting Cancer Earlier
- MDTs
- Oncology centres
- Peer Review
- Metastatic disease
- Information
- Performance
Primary care

- Prevention
- Screening
- Detecting cancer early
- Communication and data
- Post treatment care
- Governance
- Change
Prevention and Screening

- Everyones business
- Making every Contact Count
- Screening take up

- Bowel
- Cervical screening

- Clusters
Lung cancer awareness campaign
11 July – 11 August 2016
Bowel Screening

Home FOB test kit every two years for adults aged 60-74 in England & Wales

Adapted technologies may be offered in future

Bowel screening uptake by deprivation quintile and gender, 2010-11
Detecting Cancer Earlier

Milestones in early diagnosis
- the Aarhus statement
  Total interval

- Patient interval
- Doctor interval
- System interval

- Primary care interval
- Secondary care interval

- Diagnostic interval
- Treatment interval

First symptom
First presentation / clinical appearance
First investigation / primary care responsible for the patient
First referral to secondary care/transfer of responsibility
First specialist visit
Diagnosis
Treatment start

The diagnostic process

>15% of adults have alarm symptoms every year

"The ocean of symptoms"

In 6% of consultations, the GP suspects serious disease incl. cancer (1-2 per day)

50% referred, primarily to imaging
50% ‘wait and see’

5% have cancer (1 per month)

Cancer

And ALL the other symptoms

Attend the doctor

Referred to secondary care

Frede Olesen
International comparisons - crude colonoscopy rates per 1,000 in 2010/11

- Wales
- England Worst (West Midlands)
- England Average
- England Best (N East)
- Scotland
- Poland
- Australia
- Canada (Nova Scotia)
The Danish 3-Legged Model

- **Alarm symptom** *(the obvious)*
  - Urgent referral for specific cancer
  - 50

- **Serious, non-specific symptoms** *(the difficult)*
  - Urgent referral to Diagnostic centre
  - 20

- **Vague symptoms** *(the common)*
  - Quick and direct access to investigations
  - 30
Structure of the Danish three-legged strategy

General practice responsible

Urgent referral for specific alarm symptoms

Hospital responsible

Fast-track pathway

Urgent referral for non-specific, serious symptoms

Filter-function

Diagnostic centre

General practice

patients with signs and symptoms

Yes-No-investigations
Silkeborg Diagnostic Centre

It’s not just about cancer – it’s about diagnosis

Diagnostic Center, Silkeborg Regional Hospital
University Research Clinic for Innovative Patient Pathways
Increase in 1-year relative survival

Increase in 1-year relative survival for MEN
All cancers except skin and prostate

Sverige

Norge

Finland

Danmark

2004-2008 til 2009-2012

Our Learning

Gatekeeper system and downgrading

- Vested et al suggest from their research that there is a correlation between relative one-year survival and the existence of a gatekeeper system.
- *Encourage referrals and low conversion rate*

Clinical Responsibility and onward referral

- Role of Co-ordinator is key for patient pathway management and for point of contact for patient
Use Radiologist to their full potential

- In Aarhus, Radiologists are encouraged to act as diagnosticians and refer onwards to the next pathway step as per their clinical judgement

The Welsh infrastructure requires investment

- Diagnostic workforce and equipment
Communication and information

- In and out – post treatment summaries
- Patient Holistic Needs Assessment and Care plans
- Acute oncology
- Metastatic patients

- Cancer Information Framework
- CANISC replacement

Post Treatment Care
Governance and change

- Peer Review – primary care engagement
- SEA analysis
- HB structures and strategic interface
- Framework for Cancer
- CR-UK