

19th July 2015

LETTER TO THE CHIEF EXECUTIVES OF THE SEVEN NHS ARMS-LENGTH BODIES

Dear Chief Executives,

This letter, and the accompanying report, set out a strategy for moving us closer to the world class cancer outcomes our patients deserve over the next five years. The report recommends a fundamental shift in how we think about cancer services, with a much greater emphasis on earlier diagnosis and living with and beyond cancer. The prize is great – 30,000 additional patients surviving cancer every year and a step-change in patient experience and quality of life, whilst also helping to close the funding gap that the NHS faces. Delivering the strategy will require committed leadership, smart choices around investing to save, and a firm intent to try new approaches and test new models of care. If, on the other hand, we continue as we are, the likelihood is that we will see a managed decline in outcomes, with England slipping further behind other countries.

In January, I agreed to chair an independent taskforce to produce a strategy for cancer services. We were asked to consider how to deliver better prevention, swifter diagnosis and improved treatment and care for all cancer patients and, in so doing, to deliver the vision of the Five Year Forward View (FYFV). The context for the taskforce was that, despite fifteen years of effort and progress, we still have outcomes that do not come close to meeting our aspirations as a society. Cancer Research UK's own report, in September 2014, concluded that whilst NHS staff had coped admirably with the pressures they face, cancer services are now at a tipping point, with little headspace for improvement. Despite pockets of activity that are global exemplars, we are some distance from having cancer services which in aggregate could be considered world-class.

What might world-class mean? A significant reduction in the pace of growth in preventable cancers, improvements in survival rates so that our patients have the same outlook as those in comparable countries, and a transformation in patient experience and quality of life.

Cancer is an appropriate exemplar to bring the FYFV to life. This is not just because one in two of us will get cancer in our lifetimes, or because it is responsible for more than a quarter of all deaths, or because cancer patients occupy around a fifth of hospital beds at any time. More than most disease areas, we have been accumulating a rich evidence base on what we do well, where we have poor performance, and where opportunities exist for improvement. Moreover, most of what we do to improve services for cancer patients should also benefit people with a range of other conditions.

Our approach to our task has been to assume that the current architecture of our health and social care services remains in place, but that there is both the intent and permission to test new models of care which 'blur' the boundaries of some of that architecture. We were clear that whilst we were likely to identify additional investment needs, we should produce a strategy that is deliverable. We note however that whilst we in England attempt to deliver outcomes that are world-class, we spend a considerably smaller proportion of our GDP (around 2% less) on health than countries such as France, Germany and The Netherlands.

Our report has been informed by hundreds of written submissions, nearly 100 workshops and meetings, involving around 600 participants, the proactive involvement of patients, and consultation with around 30 cancer charities and almost all relevant professional groups. We have reached broad consensus on the content of the strategy and the most important priorities within it. The rest of this letter highlights the six strategic priorities we have identified.

STRATEGIC PRIORITY 1: SPEARHEAD A RADICAL UPGRADE IN PREVENTION AND PUBLIC HEALTH

The NHS, working with local and national Government and the public, needs to take a much more proactive approach to public health, with a view to reducing the growth in the number of cases of cancer in the future. There are opportunities to address the range of lifestyle risk factors and also to boost efforts in prevention of secondary cancer. Notwithstanding the reductions we have seen, smoking remains responsible for more than 50,000 new cases of cancer every year, disproportionately affecting those from lower socio-economic backgrounds and people with mental health problems. We need to go further and faster on smoking. We should aim to reduce adult smoking prevalence to less than 13% by 2020. It is also time to get serious about tackling obesity. A failure to take dramatic action now to protect children means we are condemning many thousands of them to having serious health problems into adulthood, including increasing incidence of cancer. The NHS should work with Government to deliver and implement a new tobacco control strategy within the next 12 months, and a national action plan on obesity.

STRATEGIC PRIORITY 2: DRIVE A NATIONAL AMBITION TO ACHIEVE EARLIER DIAGNOSIS

Over the last 8 years, the National Awareness and Early Diagnosis Initiative has delivered a hugely improved understanding of the multi-faceted challenge of earlier diagnosis of cancer. Earlier diagnosis is pivotal, as it enables more patients to access potentially curative treatment options, such as surgery. We are now at a point where our knowledge needs to be translated into action.

Our primary care services are arguably world-leading in their 'gate-keeping' function, in applying resources to those patients presenting with the most acute needs, across all diseases. Whilst this has undoubtedly assisted in constraining overall health care costs, it is not an approach that optimises expedited diagnosis of cancer, resulting in poorer outcomes than countries of similar wealth. The impacts are felt further down the cancer pathway, with England allocating an increasing share of the cancer budget to treatments that are less cost-effective, towards the end of life.

Earlier diagnosis will only be achieved by being less restrictive in our approach to investigative testing. As such, whilst it will not be cost-saving, it should be highly cost-effective, with estimates of cost per QALY at around £7000 to £8000. As soon as possible, we should require GPs to refer patients for investigative tests if they present with symptoms that represent a 3% level of suspicion or above, i.e. in line with the new NICE guidelines. 3% is higher than the level adopted in many other countries. It is also higher than the public's expectation – closer to 1% – and whilst I want us to be ambitious in this area I feel it is a suitable aspiration for the next five years. Delivering this will require us to unlock access to diagnostic services, where we currently are under-invested in both people and equipment. Most activity would continue to be funded through normal commissioning processes. However, in addition we propose that a national fund – akin to the highly successful Prime Minister's Radiotherapy Innovation Fund – is created and used flexibly to enable local health economies to unlock local solutions. Not all of the new capacity needs to be provided in the secondary sector – much could be delivered through the new models of care set out in the FYFV.

Speed in diagnosis is of the essence, which is why we are also proposing a new metric – definitive cancer diagnosis or cancer exclusion within 4 weeks. We recommend that you set an aspiration that this should be achieved for 95% of patients by 2020. This will be highly challenging, but it is possible; other countries would hope to achieve this today. Speed can also be enhanced by

giving GPs direct access to a range of tests, and trusting them to make use of them appropriately. We have estimated that direct access alone could save hundreds of thousands of outpatient appointments, and more than £100m per annum.

STRATEGIC PRIORITY 3: ESTABLISH PATIENT EXPERIENCE AS BEING ON A PAR WITH CLINICAL EFFECTIVENESS AND SAFETY

Perhaps the most disappointing aspect of the Taskforce's work has been the countless stories we have heard from patients and their carers of poor communication and suboptimal coordination of care. The Francis report highlighted gross inadequacies; we too have heard some appalling examples. It is time to make a step-change and to establish patient experience as being on a par with clinical outcomes.

First, patients should be properly informed and empowered to be equal partners in their care. We should revolutionise the way we communicate with and the information we provide to cancer patients using digital technologies. From the point of a cancer diagnosis onwards, we recommend giving all consenting patients online access to test results and other communications involving secondary or tertiary care providers by 2020. This could yield substantial efficiencies also, although we have not attempted to quantify these. Secondly, we should systematise patients having access to a Clinical Nurse Specialist or other key worker to help co-ordinate their care. Thirdly, we have identified the need for a set of meaningful metrics to encourage providers to focus on patient experience, including the annual Cancer Patient Experience Survey. We expect these to be embedded across the NHS accountability framework to drive further improvement.

STRATEGIC PRIORITY 4: TRANSFORM OUR APPROACH TO SUPPORT PEOPLE LIVING WITH AND BEYOND CANCER

Many cancer patients suffer long-term consequences from their cancer or their treatment and are at higher risk of recurrence. Many will suffer psychological or financial hardship. Most will have another long-term condition they are trying to manage in addition to their cancer. These consequences adversely affect long-term quality of life, and can also result in acute episodes of health care need, much of which is avoidable or can be mitigated.

I have been struck by how many areas of the country are testing initiatives to support better this growing cohort and delivering some truly exciting results, which we need to start taking forward at a national level. The highest priority should be to accelerate the roll-out of stratified follow up pathways and the commissioning of holistic packages of support. The aim should be that by 2020 every person with cancer will have access to relevant elements of the Recovery Package and that stratified follow-up pathways should be in place for the common cancers. We also need to develop a national quality of life metric – ideally by 2017 – to ensure that we monitor and learn lessons to support people better in living well after treatment has ended. We should also ensure that end of life care planning and choices are made available to all who have a terminal diagnosis, without delay.

STRATEGIC PRIORITY 5: MAKE THE NECESSARY INVESTMENTS TO DELIVER A MODERN HIGH-QUALITY SERVICE

Late diagnosis is not the only driver of our poorer survival rates. Over the last five years, we have come to understand that we also do not provide optimal access to treatment. This is in part caused by workforce and equipment deficits. Whether we compare numbers of oncologists or CT machines per head of population, our provision in England lags considerably behind other countries.

We need to upgrade our radiotherapy machines, around half of which are reaching the end of their useful life. Doing so will not only deliver safer care, it will also enable more widespread use

of modern radiotherapy techniques which spare normal tissue and the associated adverse consequences. Furthermore, because we can use modern machines more efficiently, replacing old machines will preclude the need to invest in additional machines or suffer even worse access. This will require significant capital investment. However I see a real opportunity through a centralised procurement process to get a much better deal for the NHS, in line with the recommendations in the Carter review.

Secondly, we need to address acute workforce deficits, particularly in oncology, radiology, radiography and endoscopy, as well as in specialist nursing provision. There is also a very strong case to undertake a strategic review to determine future workforce and skills mix needs in cancer.

Thirdly, we should not delay any longer in establishing a modern molecular diagnostics service. We should be doing this already. Not only is its absence meaning patients are missing out on treatment options, but we are also using drug treatments inefficiently and in some cases inappropriately. Further delay risks accentuating the UK as a slow adopter of innovation with the consequent implications for inward R&D investment.

Finally, we need to establish a more sustainable model for access to novel cancer drugs. Our drugs usage has increased over the last five years – a welcome development – but we are still somewhat behind other countries. The Cancer Drugs Fund has helped to unlock access to new treatments for a large number of patients. However, its implementation could be adjusted to enable more innovative treatments to be provided in a more sustainable way. The new system should be co-designed by NHS England, patients and NICE, in a way that does not allow the budget to grow any further, since other areas of investment will deliver greater benefits.

STRATEGIC PRIORITY 6: OVERHAUL PROCESSES FOR COMMISSIONING, ACCOUNTABILITY AND PROVISION

Tackling variation represents the final top priority for progress over the next five years. Whilst our best Centres provide care comparable with anywhere in the world, quality is far from uniform. We need to determine how to configure services to deliver the best for all patients, no matter where in the country they live. This needs to start with appropriate commissioning to defined national standards. While some services can be commissioned at CCG level, particularly where these services are also relevant for other disease areas, much of cancer care needs to be commissioned across larger populations than would be typical for a CCG.

Secondly, we need to establish sub-regional alliances or networks that provide a forum to bring providers and commissioners together with patients, so that they can co-design services to optimise pathways, ensure effective integration and address variation. This, in turn, will be facilitated by providers and commissioners working to standard dashboards of key metrics, which highlight variation both within a health economy and compared to the national average. Finally, given that our current payment by results systems encourage fragmentation and struggle to keep pace with progress, we strongly advocate piloting new models of care and commissioning. This should include, in at least one area, the entire cancer pathway will full devolved budget over multiple years, based on achievement of a pre-specified set of outcomes. To maximise the chances of success, this should be across a population of 1-2 million or more.

The FYFV established an exciting and progressive vision for a modern health service. It highlighted the need to address three gaps. I believe that the work of the Taskforce has shown how, in cancer, all three can be addressed:

- our recommendations around prevention and public health will address the ‘Health and Wellbeing’ gap;
 - our recommendations around earlier diagnosis, patient experience, living with and beyond cancer, workforce and equipment, will address the ‘Care and Quality’ gap;
 - our recommendations around commissioning and accountability, coupled with the other recommendations, will address the ‘Efficiency’ gap. We estimate that once implemented,
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the system should release substantially in excess of £400m per annum towards the “Funding” gap.

The strategic priorities set out above offer the potential to transform outcomes over the next five years. In the absence of implementation, the NHS will be unable to meet demand, resources will be spent inefficiently, costs will escalate, and patients will not receive the standard of care that they rightly deserve. However, change of this scale will require strong leadership. There will be many challenges along the way. Traditional barriers and vested interests will need to be tackled. We have tried to steer a course that will create the right conditions and environment for the future, whilst continuing to serve the needs of patients today.

I believe that four enablers will be critical to delivering this strategy. First there needs to be properly resourced leadership, with change management skills, which can work effectively across the ALBs and support the sub-regional alliances we propose. Secondly, transparent data and intelligence will be pivotal. Over the last two years, despite significant improvements in data collection by PHE, such as the addition of staging information, there has been a loss of confidence in our ability to deliver the data that we need to drive improvement or facilitate research. This needs to be addressed as a matter of urgency. Thirdly research. There are many questions to which we do not know the answers, such as how we can improve outcomes for older people, or what we can do about the long-term effects for adults treated for cancer. We must continue to lead the world in cancer clinical research, enabling us both to evaluate new technology that other countries do not, such as newer radiotherapy techniques, but also to offset NHS costs, for example in free drugs provided in trial settings. Finally, we need to give the cancer community and patients the confidence that this strategy will be implemented as a priority. The fragmentation that now exists in commissioning and provision can sometimes lead to blame at times of stress, such as the NHS faces now and for the foreseeable future. Whilst the ALBs will themselves hold each other to account, we have also recommended an independent advisory group to provide an annual objective assessment of progress at a national level, together with patient representatives on the sub-regional alliances, to provide accountability at a local level.

I would like to thank the members of the Taskforce and associated secretariat who have worked hard over the last six months to deliver this report, as well as the hundreds of patients and professionals who gave us their time and expertise.

Achieving world-class cancer outcomes is a multi-faceted challenge. No one initiative will fix all the problems or address all the opportunities. I hope that our report offers you the path forward and that its recommendations will be implemented with commitment and speed.

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