Cancer Cascade Workshop

Hotel Football – Old Trafford, Manchester

13\textsuperscript{th} October 2016

Dr Richard Roope
RCGP and Cancer Research UK Cancer Clinical Champion
Senior Clinical Advisor Cancer Research UK
Cancer Cascade Workshop

What’s new?
Cancer Cascade Workshop

What’s new?

- Colorectal paper
- 5-year Forward View for Primary Care
- E-cigarettes
- RCGP and CRUK Position Statement on Cancer
- New CRUK Stats/infographics
- Dashboard – My NHS
Colorectal cancer – when to refer?

• When did we refer?
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Colorectal cancer – when to refer?

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Colorectal cancer – when to refer?

- When did we refer?

Two thousand bowel cancer tumours a year are missing by GPs... before before spotted in casualty: Fifth of patients diagnosed in A&E had previously been turned away by a family doctor

- Patients were sent away by doctors despite having ‘red flag’ symptoms
- Finding out at a late stage greatly reduces a patient’s chances of survival
- 2,000 bowel cancer patients a year could have been diagnosed earlier
- Last year the health watchdog NICE issued GPs with a guide for spotting it

By SOPHIE BORLAND HEALTH EDITOR FOR THE DAILY MAIL

One in five bowel cancer patients diagnosed in an emergency had ‘red flag’ symptoms that should have been picked up earlier, a study in the British Journal of Cancer suggests.

And 16% of emergency bowel cancer patients had seen their GP three times or more with relevant symptoms.
Colorectal cancer – when to refer?

• When did we refer?

Epidemiology
Published online 18 August 2016

Do colorectal cancer patients diagnosed as an emergency differ from non-emergency patients in their consultation patterns and symptoms? A longitudinal data-linkage study in England

CONCLUSIONS: Emergency presenters have similar ‘background’ consultation history as non-emergency presenters. Their tumours seem associated with less typical symptoms, however opportunities for earlier diagnosis might be present in a fifth of them.
Colorectal cancer – when to refer?

• When did we refer? Variably
Colorectal cancer – when to refer?

• When did we refer? Variably across CCGs

http://www.ncin.org.uk/publications/routes_to_diagnosis (accessed 2.10.16)
Colorectal cancer – when to refer?

- When did we refer? Variably (across time)
Colorectal cancer – when to refer?

• When did we refer? Variably (across time) – improving!

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Colorectal cancer – when to refer?

- When did we refer? Variably (across time) – improving!
- 1 year survival

![Graph showing survival rates by gender and period of diagnosis](http://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/bowel-cancer/survival#heading-Two) Last accessed 28.9.16
Colorectal cancer – when to refer?

- When did we refer?  Variably (across time) – improving!

CRC cancer rates per 100,000

Incidence  Mortality

Colorectal cancer – when to refer?

- When did we refer? Variably – why is this important?

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Relative survival estimates by presentation route and survival time, Colorectal, 2006-2013

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Colorectal cancer – when to refer?

• What are the “key” symptoms?
Colorectal cancer – when to refer?

- What are the “key” symptoms for colon cancer?
- Rank order for symptoms reported or findings in 30 days prior to diagnosis:

<table>
<thead>
<tr>
<th>Option A</th>
<th>Option B</th>
<th>Option C</th>
<th>Option D</th>
</tr>
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<tbody>
<tr>
<td>1. Rectal bleeding</td>
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Discuss and choose which is correct ranking.
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<td>1. Rectal bleeding</td>
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<td>1. Abdominal pain 15.7%</td>
</tr>
<tr>
<td>2. Change in bowel habit</td>
<td>2. Anaemia</td>
<td>2. Anaemia 6.2%</td>
</tr>
<tr>
<td>3. Weight loss</td>
<td>3. Change in bowel habit</td>
<td>3. Rectal bleeding 4.4%</td>
</tr>
<tr>
<td>4. Abdominal pain</td>
<td>4. Abdominal pain</td>
<td>4. Change in bowel habit 2.5%</td>
</tr>
<tr>
<td>5. Anaemia</td>
<td>5. Weight loss</td>
<td>5. Weight loss 1.8%</td>
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http://www.nature.com/bjc/journal/v115/n7/pdf/bjc2016250a.pdf
Colorectal cancer – when to refer?

- What are the “key” symptoms for colon cancer?

<table>
<thead>
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<th>Symptom</th>
<th>30 days pre-(\Delta)</th>
<th>12 months - 30 days pre-(\Delta)</th>
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<tbody>
<tr>
<td>Abdominal pain</td>
<td>15.7%</td>
<td>25.1%</td>
</tr>
<tr>
<td>Anaemia</td>
<td>6.2%</td>
<td>19.2%</td>
</tr>
<tr>
<td>Rectal bleeding</td>
<td>4.4%</td>
<td>9.4%</td>
</tr>
<tr>
<td>Change in bowel habit</td>
<td>2.5%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Weight loss</td>
<td>1.8%</td>
<td>3.1%</td>
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Colorectal cancer – when to refer?

• What are the “key” symptoms?

[Graph showing frequency of symptoms in colon cancer]

http://www.nature.com/bjc/journal/v115/n7/pdf/bjc2016250a.pdf
Colorectal cancer – when to refer?

• What are the “key” symptoms?

![Graph showing frequency of symptoms 30 days pre-diagnosis in colon cancer. The key symptoms and their respective frequencies are:

1. Abdominal pain: Non-EP = 10.00%, EP = 35.00%
2. Anaemia: Non-EP = 5.00%, EP = 10.00%
3. Rectal bleeding: Non-EP = 5.00%, EP = 15.00%
4. Change in bowel habit: Non-EP = 2.00%, EP = 5.00%
5. Weight loss: Non-EP = 1.00%, EP = 2.00%]
Colorectal cancer – when to refer?

- What are the “key” symptoms?

![Frequency of symptoms in rectal cancer graph](http://www.nature.com/bjc/journal/v115/n7/pdf/bjc2016250a.pdf)
Colorectal cancer – when to refer?

• What are the “key” symptoms?

Frequency of symptoms 30 days pre-diagnosis in rectal cancer

1. Abdominal pain
2. Anaemia
3. Rectal bleeding
4. Change in bowel habit
5. Weight loss

Non-EP  EP

http://www.nature.com/bjc/journal/v115/n7/pdf/bjc2016250a.pdf
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5-year Forward View for Primary Care
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Investment in general practice - cash terms

£ BILLION

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5-year Forward View for Primary Care

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5-year Forward View for Primary Care

General Practice Forward View
Building General Practice Resilience
NHS GP Health service
The General Practice Development Programme
General Practice Forward View – implementation events
Support with GP indemnity costs

General Practice Resilience Programme

Royal College of General Practitioners
Cancer Research UK
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5-year Forward View for Primary Care

NHS GP Health service

As part of a broader package of support, the General Practice Forward View is committed to improve access to mental health support for general practitioners and trainee GPs who may be suffering from mental ill-health including stress, depression, addiction and burnout.

A new NHS GP Health service is therefore being developed, and following the appointment of The Hurley Clinic Partnership as the provider of this service, we expect it to launch in January 2017.

The service is an important part of our commitment to help retain a healthy and resilient workforce and in supporting GPs and GP trainees who wish to remain in or return to clinical practice after a period of ill health.
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5-year Forward View for Primary Care

NHS GP Health service

10 High impact actions to release time for care

1. Active signposting
2. New consultation types
3. Reduce DNAs
4. Develop the team
5. Productive workflows
6. Personal productivity
7. Partnership working
8. Social Prescribing
9. Support self care
10. Develop QI expertise
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5-year Forward View for Primary Care

• **Better Care Fund** - From April 2016 CCGs, Local Authorities and NHS England could pool budgets and jointly commission expanded services including:
  • Additional nurses in a GP setting to provide a co-ordination role in the management of long-term conditions.
  • GPs providing services in a nursing home setting.
  • Providing a ‘mental health specialist’ in a practice setting.
  • Hosting a social worker in a GP surgery.
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E-cigarettes
E-cigarettes
Toxicity:
• Smoking tobacco: >7000 chemicals\textsuperscript{1}
• Vaping: 42 chemicals\textsuperscript{2}

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E-cigarettes
Concerns:
1. Entry into smoking?
2. Safety?
3. Is it effective in cessation?
4. Is passive vaping of concern?
5. Should we wait for more research?
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E-cigarettes

Concerns:

1. Entry into smoking?
   • Use in children is rare – of those who do, most are ex-smokers
   • Youth smoking: 1996 13% → 2014 3%\(^1\)

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E-cigarettes

Concerns:
1. Entry into smoking?
2. Safety?
   - Long term safety profile not yet known – but much safer than cigarettes\(^1\)
   - PHE report 95% safer than cigarettes\(^2\)

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E-cigarettes
Concerns:
1. Entry into smoking?
2. Safety?
3. Is it effective in cessation?
   • Since 2013 ECs are England’s most successful quitting aid\(^1\)

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1. Smoking Toolkit Study [www.smokinginengland.info](http://www.smokinginengland.info)
E-cigarettes
Concerns:
1. Entry into smoking?
2. Safety?
3. Is it effective in cessation?
4. Is passive vaping of concern?
   • No identified hazards to bystanders

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E-cigarettes
Concerns:
1. Entry into smoking?
2. Safety?
3. Is it effective in cessation?
4. Is passive vaping of concern?
5. Should we wait for more research?
   • No – the benefits are so larger, there are lives to be saved...
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E-cigarettes
Position statement due in next 2 weeks

Recommendations

In line with recommendations from PHE\textsuperscript{10}, it is recommended that:

1. All Primary Care Clinicians (PCCs) provide accurate advice on the relative risks of smoking and e-cigarette use, and providing effective referral routes into stop smoking services.
2. PCCs engage actively with smokers who want to quit with the help of e-cigarettes.
3. Where a patient is wanting to quit smoking and has not succeeded with other options, PCCs should recommend and support the use of ECs.
4. PCCs recognise ECs offer a wide reach, low-cost intervention to reduce smoking in more deprived groups in society and those with poor mental health, both having elevated rates of smoking.
5. All PCCs encourage smokers who want to use e-cigarettes as an aid to quit smoking to seek the support of local stop smoking services.
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Cigarette smoking prevalence

http://www.smokinginengland.info/latest-statistics/ Accessed 6.10.16
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% of smokers trying to stop

Percent of smokers trying to stop

Year: 2009-3 to 2016-3

- E-cigs
- NRT OTC
- NRT Rx
- Champix
- Beh'l supp

www.smokinginengland.info/latest-statistics
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Cigarette smoking prevalence

% smoking/% of use of e cigs for cessation

- % smoking
- % using e cigs to stop
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RCGP and CRUK Position Statement on Cancer
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RCGP and CRUK Position Statement on Cancer

1. We call for UK governments to ensure that the importance and role of appropriately resourced primary care is emphasised within national cancer control agendas.
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RCGP and CRUK Position Statement on Cancer

2. The RCGP will work with partners, including Cancer Research UK, through the clinical priority and spotlight programmes to ensure access by members to **accredited education and practical information about cancer prevention, screening, diagnosis, follow-up care and end-of-life care.**
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RCGP and CRUK Position Statement on Cancer

3. We call for a coordinated multiagency approach to the national delivery of evidence-based cancer prevention, lifestyle and intervention programmes focused on behaviour change (including smoking cessation, reduction in obesity, promotion of physical activity and alcohol reduction interventions).
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RCGP and CRUK Position Statement on Cancer

4. We call for the ongoing collection and review of evidence about current and new screening technologies including cost-benefits.
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RCGP and CRUK Position Statement on Cancer

5. The RCGP will develop appropriate responses to national calls for roll-out of new screening technologies where there is clear evidence of improved outcomes and cost benefits, including consideration by the National Screening Committee of the potential for over-diagnosis.
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RCGP and CRUK Position Statement on Cancer

6. We call for further funding and research in the development of innovative and timely diagnostic pathway models. The RCGP will work to ensure the results of these projects are communicated to members.
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RCGP and CRUK Position Statement on Cancer

7. We call for resourcing and support for direct access by general practitioners to key diagnostic tests for cancer as a mechanism to streamline referrals for investigation of signs and symptoms.
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RCGP and CRUK Position Statement on Cancer

8. The RCGP will continue to actively support the Patient Online programme through the RCGP Clinical Innovation and Research Centre.
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RCGP and CRUK Position Statement on Cancer

9. We call for primary care and community nursing to be appropriately resourced to meet the needs of people following diagnosis and treatment for cancer. Separate to this is a need to support appropriate and best practice palliative and end-of-life care.
10. We call for appropriate investment in primary care workforce and infrastructure to support the increasing demand placed on primary care services by their expanding role in cancer control.
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RCGP and CRUK Position Statement on Cancer

11. The RCGP through its Clinical Innovation and Research Centre will work to **promote quality improvement activities** as a core part of primary care which could help to drive improved outcomes for people with suspected or diagnosed cancer.
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RCGP and CRUK Position Statement on Cancer

12. The RCGP will maintain an involvement in and awareness of the primary care research agenda relevant to cancer control.
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What’s new?
  • New CRUK Stats/infographics
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New CRUK Stats/infographics

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New CRUK Stats/infographics

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New CRUK Stats/infographics

UNHEALTHY DIETS COULD CAUSE 7 TYPES OF CANCER:
- Mouth & Upper throat
- Larynx
- Oesophagus
- Lung
- Stomach
- Bowel

BEING PHYSICALLY INACTIVE COULD CAUSE 3 TYPES OF CANCER:
- Breast after menopause
- Bowel
- Womb

ALCOHOL CAN CAUSE 7 TYPES OF CANCER:
- Mouth and upper throat
- Larynx
- Oesophagus
- Breast in women
- Liver
- Bowel

Drinking less alcohol could prevent 12,800 cancer cases per year in the UK.

4 WAYS ALCOHOL CAUSES CANCER:
- Damages cells
- Increases damage from tobacco
- Affects hormones linked to breast cancer
- Breaks down into cancer-causing chemicals

Larger circles indicate cancers with more cases linked to alcohol in the UK.

Let’s beat cancer sooner

https://pbs.twimg.com/media/B2uE_6vCQAAB_pK.png last accessed 8.10.16
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New CRUK Stats/infographics

What difference does breast screening make?

Screening catches more cancers earlier

Cancer is unpredictable, so it's not possible to know how a woman's cancer would have grown had it not been caught and treated.

Some would grow quickly

Some would grow slowly

Some of these would go on to spread

Some of these would never cause harm

If these spread to vital organs, they may cause death.

If we look at 1,000 women over 20 years

If they were not screened, 58 would be diagnosed with breast cancer

21 die from breast cancer

57 are treated and survive their disease

17 live healthy lives not affected by their cancer

With screening, 76 are diagnosed with breast cancer

16 die from breast cancer

59 are treated and survive their disease

Lives saved by screening

This many women would have died if breast screening had not caught their cancer early

1,300 lives saved a year in the UK

For every one life saved, three women are overdiagnosed

Overdiagnosed due to screening

This many women are treated for breast cancers that are real, but would not have caused them any harm

4,000 women treated a year when there would have been no harm

So, breast screening saves lives, but causes some women to be treated who didn't need to be.

On balance, Cancer Research UK recommend that women go for breast screening when invited.

bit.ly/screening-review

http://www.cancerresearchuk.org/prod_consump/groups/cr_common/@cah/@gen/documents/image/cr_123923.png last accessed 8.10.16
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New CRUK Stats/infographics

What difference does breast screening make?

Screening catches more cancers earlier

Cancer is unpredictable, so it’s not possible to know how a woman’s cancer would have grown had it not been caught and treated.

Some would grow slowly
Some would grow quickly
If these spread to vital organs, they may cause death

If we look at 1,000 women over 45

If they were not screened, 58 would be diagnosed with breast cancer
21 die from breast cancer
57 are treated and survive their diagnosis

With screening, 75 are diagnosed with breast cancer
16 die from breast cancer
59 are treated and survive their diagnosis

Lives saved by screening
This many women would have died if breast screening had not caught their cancer early

1,300 lives saved a year in the UK
For every one life saved, three women are overscreened

So, breast screening saves lives, but causes harm for a few women to be treated who didn’t need to be.

On balance, Cancer Research UK recommend women go for breast screening when invited.

PSA screening in men without any symptoms

The evidence so far...

WITHOUT SCREENING

69 will get a prostate cancer diagnosis

OF 1,000 men aged 45-59 will be screened at least once

WITH SCREENING

88 will get a prostate cancer diagnosis

After at least 10 years, of the men diagnosed...

7 will die of prostate cancer

61 will be treated and survive their cancer

20 will be diagnosed with cancers that would not have caused any harm.

0 lives will be saved due to screening

DUE TO SCREENING, around 20 men will be diagnosed with cancers that would not have caused any harm and no lives would be saved.

Reference: Screening for Prostate Cancer (Review), The Cochrane Library 2015

WE WILL BEAT CANCER SOONER.

Cancer Research UK

http://publications.cancerresearchuk.org/downloads/Product/prostate_screening_info.pdf last accessed 8.10.16
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CCG Cancer Dashboard
Cancer Cascade Workshop

CCG Cancer Dashboard
My NHS
Cancer Cascade Workshop

CCG Cancer Dashboard

My NHS
Data for better services

https://www.nhs.uk/service-search/scorecard/results/1173 last accessed 8.10.16
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CCG Cancer Dashboard
My NHS

Metrics:
1. Cancer diagnosed at early stage
2. Urgent referral with 1\textsuperscript{st} treatment within 62 days
3. 1 year survival
4. Cancer patient experience
5. Overall assessment
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What’s new?

• NHSE Cancer Strategy Implementation Plan
• 5-year Forward View for Primary Care
• E-cigarettes
• RCGP and CRUK Position Statement on Cancer
• New CRUK Stats/infographics
• Update from Ca-PRI
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What’s new?
• LOTS...!!!
THANK YOU