

Date: Wednesday 9 January 2002

Venue: Committee Room , National Assembly for Wales

Title: Commission for Health Improvement: Report on Cancer Services

Purpose

1. To provide the Committee with the Assembly's response to the Commission for Health Improvement's (CHI) and the Audit Commission's (AC) report "[NHS Cancer Care in England and Wales](#)", in order to consider its findings. Representatives from CHI and AC will provide a presentation on the report at this meeting.

Summary of Paper

2. The paper outlines the background and key findings of CHI's and the AC's report and provides information upon the Assembly's action in relation to this.

Background to Study

3. In 1999 the Government and the National Assembly asked CHI and AC to complete an independent study of the progress in implementing recommendations of the 1995 Calman-Hine Report on cancer services in England and Wales. The study began last year and focused on the range of services received by people with cancer (or those who suspect that they might have cancer) from their initial point of contact with the NHS. It was concerned with the diagnosis, treatment and broad supportive care of cancer in adults. The study was also keen to learn how the quality of services might be improved and resources used to best advantage.

4. The study focused on three main themes:

- The patient's experience of cancer and cancer services;
- Key events along the treatment pathway that affect survival, quality of life, access to services and efficiency;
- The management of cancer care in local health communities, paying special attention to the role

of Government and those responsible for commissioning services, and to the links between hospitals, GPs and community health services and between cancer units and cancer centres.

Study's Conclusions and Presentation

5. In general, the study concluded that the Calman-Hine Report was important in developing good practice and bringing cancer to the forefront of the health agenda, and that much has been done in the intervening years to develop cancer services. It found, however, that across England and Wales many of its key recommendations have not yet been fully implemented in all areas. The study's report highlights that formal policies and plans cannot alone ensure that services are provided in a truly patient centred way; a change in attitudes and behaviour of those working with patients is also required. Priorities highlighted include a need to identify gaps in planning for individual patients, to give more attention to those cancers where services are not well developed and to resolve issues arising from the creation of cancer networks at national and local level.

6. Committee Members should have already received a copy of the study's report and of a Welsh context executive summary prepared by CHI and the AC. Representatives from CHI and the AC will make a detailed presentation on these, which will highlight areas where Wales differs from England in policy, approach or the reality of service provision. This will be followed by an opportunity for discussion. As outlined below, my response to the report is targeted at its key findings.

Minister for Health and Social Services' Response to the Report and Summary

7. I welcome the report and summary and in general would concur with their overall findings of the progress to date in developing cancer services in Wales, but also of the need to do more. The report covers a large number of specific recommendations that will need attention and highlights some wider issues that affect all aspects of care for cancer patients. In the light of this, and in an effort to keep this paper to the point, it only addresses what I consider to be their key findings. That said, all of the report's recommendations will be considered in time.

8. The report acknowledges the work undertaken to implement the recommendations from Calman-Hine and confirms that it has led to a significant improvement in cancer services in Wales. To put this in context, this work started with the establishment of a Cancer Services Expert Group to work with health authorities in Wales to identify how future cancer services should be configured. This Group, under the chairmanship of Professor Ian Cameron, published its findings in 1996. The 'Cameron Report' set out the future strategic direction for cancer services and recommended that an all-Wales service should be integrated at cancer centre level, in association with local acute general hospitals; that cancer services are integrated with the aim of developing networks of cancer care across primary, secondary and tertiary sectors; that cancer care should be managed by specialists working in multi-disciplinary teams to evidence based standards in order to improve outcomes; and that standards for cancer care covering common treatment guidelines and protocols within Wales should be adopted. In 1997 the Cancer Services Co-ordinating Group (CSCG) was established in order to implement the key recommendations

of the Cameron Report.

9. The study endorses this approach and of using all-Wales developed minimum standards of care as a driver to this change. However, it does raise several wide-ranging issues and areas for further improvement, most significantly that the provision of services should be planned with a more patient centred approach. My response on these key findings is, therefore, below:-

Some patients felt diagnosis and treatment were hindered by the lack of key medical staff and specialist nurses

10. I fully recognise the need to increase manpower in these important areas and we are already increasing the number of consultants and grades leading to consultant. There are 88 additional consultant posts in Wales as a result of extra funds allocated last year and in addition, of the 630 Specialist Registrars in Wales, 13 are training to be radiotherapy consultants. The number of those in training in key cancer services areas is also being increased. The number of nurses in training has increased from just over 2,600 two years ago to over 3,200 now. By 2004 this will increase to more than 4,300. The number of medical students is likewise being increased from just under 1,000 last year to nearly 1,400 by 2004. All these measures will lead to a improvement in the provision of cancer services.

11. While the provision of specialist nurses varies throughout Wales at present, the Assembly plan for the NHS in Wales, Improving Health in Wales, gives an assurance that more specialist nurses will be available for cancer patients. I remain firmly committed to that. Apart from increasing the number of nurses in training, we are also fully committed to increasing the number of qualified nurses returning to work. Last year, at least 145 returnees completed the Return to Practice course and the expectation is that numbers should be exceeded this year.

Some patients experience late, non urgent or inappropriate referrals

12. With any referral system we must be sure that the categorisation used to classify any fast tracking of urgent cases is appropriate to that patient group. In Wales, following advice from clinicians, we decided that the cancer specialist should be the clinician who categorises referrals as urgent or non-urgent based on the information provided by the GP. Recently published data on breast cancer referrals from the British Association of Surgical Oncologists supports this policy.

13. I would be concerned if patients with symptoms suggesting cancer, which was subsequently confirmed, were referred as non-urgent and as a result experienced delays. For example, the latest survey data for February 2001, collated by the CSCG working directly with our breast cancer teams, shows an improvement from the previous survey with the average wait for non-urgent referrals at 19.6 working days. This survey showed that only 13 of 634 non-urgent referrals were subsequently found to have breast cancer. That said, there will always be some patients who are found to have cancer and who present with non-urgent symptoms. CSCG has already asked NHS Trusts in Wales to collect similar waiting times data for other cancers and this will be available in the next few months.

14. As to inappropriate referrals I am aware that in England, the Department of Health has issued guidance on referral procedures for GPs. This guidance has, I believe, caused concern amongst health professionals there and CSCG is working with GPs and cancer specialists in Wales to refine the guidance for use here. We will help to improve the timeliness of the initial diagnosis and will speed up the process, reducing uncertainty for the patient.

Communication between consultants, GPs and their patients over diagnosis, treatment and discharge was not always what it should be

15. In my plan for the NHS in Wales mentioned above, I pointed to the need for joint working with good hospital, primary and community care services, putting people at their centre. The patient and their family or carers should feel that they have choices about the services provided for them, where these are available. The role of the GP both in the rapid referral of patients with suspected cancer and the care of patients following treatment should not be underestimated. The data from the CSCG's minimum standards monitoring for 1999-2000 show that over 75% of breast, colorectal and urology multidisciplinary teams (MDTs) provide written information to GPs informing them of MDT contact names and telephone numbers. This information is essential for patients to be referred to the appropriate specialist member of the MDT. Once a diagnosis has been reached the minimum standards require that the GP should be informed within 24 hours in order to provide information on their patient's disease and treatment. The recent CSCG breast and colorectal waiting time surveys have shown that this occurs in over 90% of cases.

16. As with all discharges from hospital, there should be a clear care plan established after a multidisciplinary assessment and with careful explanation to the patient and where appropriate their carers. There has been a great deal of improvement in discharge planning in Wales but it can still be patchy and we will build targets into our monitoring procedures to improve this.

Some patients diagnosis was delayed due to the lack of imaging equipment

17. I recognise the need to ensure that we have the best possible facilities to enable patients to be quickly and correctly assessed and I have already started to put in place essential improvements to the equipment available in the NHS in Wales. The new cancer treatment centre in North Wales, and the re-provision of cancer treatment equipment in Swansea, are both very necessary investments, targeted at developing high quality care to improve treatment and survival figures. I also agreed to a central procurement of life saving diagnostic equipment earlier this year and I know that at least one of the CT scanners involved will be used specifically for cancer diagnosis and treatment. In addition to this, the all-Wales Health Capital Renewal Programme has given Trusts the opportunity to bid for major pieces of equipment, which can be used in the treatment and detection of cancer. An all-Wales tendering exercise has just been completed which, with the all-Wales Capital Renewal Programme, has resulted in the purchase of 2 new MRI scanners and 6 new CT scanners to replace ageing equipment.

Waiting times to treatment can vary

18. The CSCG have carried out audits that focus on the initial waiting times to first consultation. Fortunately, the numbers of diagnosed cancers are much lower than the number of referrals. The audit done of breast cancer teams referred to previously showed that of 57 patients admitted for surgery, 86% were admitted for surgery within the standard of 15 working days from the time the patient was given the diagnosis. This is the all-Wales figure and I am heartened that 11 out of 14 teams in Wales actually achieved 100% compliance. The move to specialist teams and Cancer Networks are major changes for the NHS and should impact on helping to reduce waiting in all other cancers. Unfortunately, data verified by the cancer teams for other cancers is not readily available and this is currently being addressed.

Some patients are still operated on by non-specialist surgeons

19. I concur with the need for the cancer teams in Wales to ensure specialisation to improve outcomes for patients. This may involve merging teams and/or reconfiguration of services provided, as appropriate. Clear evidence is needed to underpin such moves. We need to consider an implementation that is appropriate for Wales whilst ensuring best clinical outcomes. The CSCG, who are overseeing the development of Cancer Networks, have already emphasised the importance to Networks of achieving and maintaining specialisation.

Multidisciplinary teams are not in place for all cancers and progress needs to be made on their arrangements

20. It is acknowledged that multidisciplinary teams (MDTs), working with cancer specialists, are the most effective way to deliver overall care and treatment to patients. This was a key recommendation of the Cameron Report and is echoed in the all-Wales Minimum Standards for Cancer Services the CSCG have developed. The MDT meeting enables all those directly involved in the care of the patient to discuss and agree the appropriate treatment plan and provides a focus for the collection of clinical information. The most recently published Minimum Standards Monitoring Report for 1999-2000 indicates that MDTs for all the main cancer types of breast, colorectal, lung, urology and haematology, have almost all the appropriate specialists in place. All breast, colorectal and urology cancer MDTs are now meeting regularly, usually on a weekly basis. Development of MDTs for the less common cancers is continuing.

Some Trusts have no agreed policies for the management of many cancers

21. Last year the CSCG revised the Minimum Standards for Cancer Care and re-issued these to the service in Wales. These standards have provided the drive towards ensuring access to high quality specialist cancer care in Wales and provide a consistent overall policy for the management of the 9 major cancers and for specialist palliative care. The standards were developed and produced by the all-Wales Cancer Site Steering Groups and will become subject to regular review, incorporating new guidance as appropriate.

22. Clinical guidelines are produced by Royal Colleges or other specialist groups. The minimum standards state that each MDT should work within documented evidence-based local clinical policies, based on national guidelines and be able to audit against them to ensure that the appropriate care is being given. The CSCG's 1999-2000 monitoring report indicates that over 50% of teams now have locally agreed policies.

Small proportion of cancer patients are involved in clinical trials

23. Increased access to clinical trials is an important aspect of providing a quality service. The Assembly is committed to providing access to trials and this is mirrored in both the minimum standards for cancer care and in the Assembly's plan for the NHS in Wales. The Wales Cancer Trials Network was established in 1998 and its administrative costs are jointly funded by the Assembly and the Cancer Research Campaign (CRC); consequently the proportion of patients in Wales entering clinical trials is not small. This year the Network has begun on a programme of expansion, which will enable it to offer more patients the opportunity to participate in trials. Around 1,500 patients per annum (10% of all cancer patients in Wales) will as a result be offered places on trials. The Assembly and CRC have agreed funding of just over £1,300,000 for this and the next two financial years to facilitate this expansion.

Variation in the availability of palliative care services

24. There are many examples of good palliative care across Wales but there are also problems as identified by the report. Multi-agency working is key and we must ensure that the statutory sector works well with the voluntary sector which has an equally important role to play. In conjunction with the Wales Association of Palliative Care, we are developing a Strategy for Palliative Care, which should be ready for consultation in February next year. Very constructive meetings have been held and much useful preparatory work undertaken already. We recognise the complexity of provision which can be given at home, in the community, in hospital and in hospices and all these aspects will be reflected fully in the Strategy

Lead clinicians with centres and units are required, with authority over other clinicians

25. Every Trust in Wales has a dedicated lead clinician for cancer services. Each clinician should have at least one session per week dedicated time to this post. To help strengthen and develop this role, sessional funding for each Trust cancer lead was introduced from April last year for an initial 2-year period. At the time of the study, Cancer Networks in Wales were not formally established. We have moved on from here and now have Network Chairs, Lead Clinicians and Managers appointed. The establishment of these Cancer Networks will help strengthen this lead clinician role further.

The role of cancer networks in commissioning services, and their responsibilities, need to be clarified

26. The 3 Cancer Networks to co-ordinate services in Wales have only recently been established, with the key appointments being made in October. With this in mind, we are still working through the issues

of commissioning and accountability, and flexibility will be needed as new organisational structures develop in the NHS in Wales. The study's comments are welcomed as this will provide a means for the Assembly and the CSCG to ensure Networks in Wales run in an efficient and effective manner, taking account of the concern expressed over their operation in England.

Patients need to be consulted at Network level in planning cancer services and in monitoring those currently provided / Patient centred approach to the provision of services

27. I agree with the observations made about the need for a more patient centred approach. This is an integral part of the improvements the NHS Plan envisaged and which are now being taken forward in the Plan's implementation. For example, the all-Wales Cancer Genetics Service is already a prime example of a patient centred service. Referrals are made from GPs of individuals with worries about a family history of cancer and the service provided to address these concerns has, as a major theme, consideration of users view.

28. The Assembly also intends that patients should be fully involved in the new Cancer Networks in Wales. In future the Networks, involving both providers, commissioners and with patient input, will have the information required to plan services and have already been tasked with drawing up a development plan for the next 3-5 years so that service developments can be planned effectively; this will involve patient representation from an early stage.

High rate of mastectomies in Wales

29. The CSCG and the all-Wales Breast Cancer Steering Group are fully aware of this. This was highlighted in the recent report "The Management of Breast Cancer in Wales", which was commissioned by the CSCG and describes the patterns of management of patients diagnosed and treated with breast cancer in 1997. The data from this show that for patients undergoing primary surgical treatment, 60% had a mastectomy and 40% had breast conservation (wide local excision). There are several possible explanations for this (but none definitive):-

- patient choice;
- variation in practice between surgeons;
- geographical location, as cases resident in rural areas may have to travel long distances to radiotherapy centres.

30. During this year the all-Wales Breast Cancer Steering Group have been working on all-Wales Treatment Guidelines for Breast Cancer. This document has been widely consulted upon across Wales and is now in the final stages of development. However the CSCG have delayed its publication because of the imminent release of the NICE guidelines for the treatment of breast cancer, due out early next year (which has also gone out for consultation across Wales). Thus any recommendations made in the NICE treatment guidelines will be considered for incorporation into the all-Wales Treatment Guidelines for Breast Cancer. These documents will provide further stimulus within breast cancer teams across

Wales to re-assess and review their future practice and protocols.

Conclusion

31. The forgoing outlines the Assembly's previous and current work in tackling the development of cancer services in Wales. From this it will be seen that while there are many areas of the CHI and AC report that we now need to consider, a substantial amount of our efforts in this area are already addressing a large number of the study's findings.

32. The new Cancer Networks being established by the Assembly and the CSCG, I see as a key development to drive through future improvements in services. They will be tasked with looking objectively but critically at the organisation of services in their geographical areas, facilitating changes where necessary, at the priorities for development of services in their areas, informing commissioners as appropriate, and at the achievement of Minimum Standards of Cancer Care in their areas.

33. Cancer Networks are the answer to the challenge of planning and delivering high quality cancer services in Wales and I expect Chief Executives of Health Authorities and Trusts to now work through their respective Cancer Networks in the development of cancer services locally. I will be taking a keen interest over how Chief Executives and the Networks rise to this challenge in the coming months.

Action for the Committee

34. The Committee is asked to note the study's report, CHI's and the AC's presentation upon this and the Assembly's response, in order to consider its findings. I will be accompanied at Committee by Fiona Peel, Chair of the CSCG, and Professor Malcolm Mason, Chair of the CSCG's Minimum Standards Group, who will be able to ensure the Committee receives comprehensive answers on issues raised.

Jane Hutt
Minister for Health & Social Services

Contact

Ms Cathy White
Head Of Branch, Acute Services Development
Health and Well-being Planning and Strategy Team
NHS Directorate, National Assembly for Wales
Cathays Park, Cardiff, CF10 3NQ
Tel: Cardiff (029) 20826108 Fax: Cardiff (029) 20825126
E-mail: Cathy.White@wales.gsi.gov.uk