



North West

The Cancer Plan for the North West of England to 2012



BETTER CARE • BETTER HEALTH • BETTER LIFE

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Foreword

Better Outcomes for Patients with Cancer in the North West of England

This plan has been produced jointly by and on behalf of the cancer networks and the NHS North West who have a shared vision and ambition to deliver world class cancer services to patients.

It was developed in parallel with the National Cancer Reform Strategy (CRS) and is in effect a local response identifying the actions that will be taken in the North West. The CRS was published in early December 2007 and it is a credit to those involved in cancer services in our region that this plan is being published so quickly in response to the National Strategy. There has been huge commitment and effort put into developing this and I hope that we will see the benefits to patients over the coming years so that it does what it intends, namely, achieves better outcomes for our patients.

Cancer incidence and mortality in the North West demands that we have a coordinated and effective implementation plan and I am grateful to all those who contributed to both its production but as importantly to all the organisations including PCTs, Trusts and clinicians who have signed up to delivering this over the next four years.

The added value of a plan for the North West has been to provide a framework for strategic collaboration across the cancer networks which cover the population of the North West. Commitment to cross working with neighbouring networks outside the boundary including North Wales has also been secured as they look to the North West for most services for the less common cancers.

This plan complements the *Our Life* programme in the North West; the Advancing Quality Programme and aims of *Our NHS Our Future* – the review of the NHS commissioned by the Department of Health under the leadership of Lord Darzi. It is our belief we can and should prevent cancer at the same time as striving to provide world class cancer services in the North West. The delivery of this plan will help bring about excellence in all parts for our population.

Mike Farrar, Chief Executive NHS North West
Kathy Doran – Chair, Merseyside and Cheshire Cancer Network
Gail Richards – Chair, Greater Manchester and Cheshire Cancer Network
Wendy Swift – Chair, Lancashire and South Cumbria Cancer Network
Sue Page, Cumbria PCT CEO

Background

Some sections of an earlier consultation paper 'Better Outcomes for Cancer Patients in the North West – October 2007' have been reproduced in this document as these provide the evidence base for the case for change. Some of the tables and charts have been updated as a result of the comments received and the availability of new intelligence available since the period of consultation in October and November 2007. Taking the broad headings from the Cancer Reform Strategy, the plan is structured along similar lines but focussed on what action will be taken at a North West level.

Pledges and actions

In addition to the pledges in the executive summary, there are a number of key actions described within the body of the plan. The expectation is that the pledges and actions within this plan will be translated through the strategic plans being prepared by all PCTs during the autumn. These have to be submitted to the SHA by the end of September 2008.

Contributions

The plan itself was widely circulated amongst cancer professionals and organisations involved in cancer services through cancer networks. It has therefore reached many potential contributors – probably in excess of 1,000 individuals. Of those who responded, their comments and contributions are reflected in this final version where appropriate.

Executive Summary

Why we need to have a North West plan in summary

Cancer in the North West presents a major challenge to health services and to the wider community. Although significant progress has been made in many areas in recent years to reduce the morbidity and mortality associated with cancer, the North West still has much to achieve. We know that the future demand for cancer services is likely to far outstrip current and planned services and therefore we need to make best use of resources to improve outcomes for patients; improve preventive programmes and work more closely with local communities to help prevent cancer together. The Cancer Reform Strategy published in December 2007 gives us the opportunity in the North West to address some of these issues collectively and individually.

There is little doubt that the number of new cases of cancer will rise sharply over the next 15 years.¹ Most of this increase is due to the ageing of the population, though the age-standardised rates for several cancers continue to rise. A recently published study predicted a 33% increase for England². Cancer is more common in the North West of England than in the rest of the country, except for the North East. Overall, after adjusting for age, cancer is 9% more common in men and 7% more common in women than the rest of England. Death rates are also higher by a similar proportion. Certain Local Authorities stand out as having particularly higher incidence rates of cancer (and even higher death rates), the most notable being (in order of severity) Liverpool, Knowsley, Salford, Manchester and Blackpool. The incidence rates for all cancers combined vary markedly by local authority within the region: from over 25% higher than the national average in Liverpool, to less than the England rate for some rural areas³.

Cancer accounts for 18% of the contribution to the life expectancy gap for males and 16% for females. Within this, (and the vast majority caused by smoking) the percentage attributable to lung cancer is 61% and 75% for males and females respectively.⁴

This plan has been developed collaboratively with cancer professionals across the North West and the pledges to patients are summarised below and overleaf.

To ensure delivery the NHS in the North West commits to:

Pledge 1: By 2012 the NHS in the North West will have implemented the actions identified in this plan.

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¹ Shack L et al. Cancer Incidence Projections in the North West , June 2007 NWCIS

² Moller et al. British Journal of Cancer (2007) 96 1484-1488

³ T Moran et al. Cancer mortality, incidence and survival in the North West, NWCIS 2007

⁴ DH Health Inequalities Unit 2006
May 2008

Prevention

We know that over 50% of cancers are preventable. The Chief Medical Officer at the Department of Health published the following Top Ten Tips for better health in December 2004. Though not cancer specific, most of them are relevant to helping prevent cancer.

1. Don't smoke and don't breathe others tobacco smoke
2. Eat at least 5 portions of fruit and vegetables each day and cut down on fat, salt and added sugar
3. Be physically active for at least 30 minutes, 5 days per week
4. Maintain, or aim for, a healthy weight (BMI 20-25)
5. If you drink alcohol, have no more than 2-3 units a day (women) or 3-4 units a day (men)⁵
6. Protect yourself from the sun. Cover up, even in the shade, never burn and use factor 15 plus sunscreen. Take extra care to protect children
7. Practise safer sex – use a condom
8. Make the decision to go for cancer screening when invited
9. On the roads, THINK safety
10. Manage stress levels- talking things through, relaxation and physical activity can help

To help prevent cancer:

Pledge 2: We will implement the Regional Tobacco Control plan.

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Pledge 3: We will use the 'Our Life' programme to push for a decrease in hazardous and harmful alcohol consumption.

Page 20

Pledge 4: Networks will support PCTs with the implementation of the Human Papilloma Virus (HPV) vaccination programme to commence September 2008 and we will ensure that by September 2010 all young women up to the age of 18 will have been offered HPV vaccination as part of the 'catch up' programme.

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Pledge 5: The North West will strive towards reducing obesity especially in children and young people.

Page 21

Pledge 6: The North West will campaign for greater regulation of sun beds to protect children and young people.

Page 22

⁵ But no more than 14 units per week for women and 21 per week for men.
May 2008

Screening

Screening programmes in the UK are world class and much envied and we can do better still. These are our pledges:

To speed up results following cervical screening:

Pledge 7: Having been the first SHA in the country to fully introduce Liquid Based Cytology (LBC) screening, we now want to go further with system redesign of cytology services and to ensure that all patients receive their results within 14 days by 2010. By March 2011, networks will have implemented changes arising out of the North West Review⁶ of cytology services.

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To reduce variation in screening rates:

Pledge 8: Unacceptable variations in screening uptake will be investigated and appropriate action will be taken to target the population never screened. PCT leads will examine the coverage and uptake rates for all screening programmes to improve and maintain uptake by their populations.

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To improve and extend breast screening services:

Pledge 9: We will review and enhance capacity within our breast services to ensure that we meet the new standards including the introduction of digital mammography. Those with a high familial risk of breast cancer will be kept under surveillance through the breast screening service. We will see greater integration with the symptomatic breast services. This will be fully implemented by December 2012.

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To improve and extend bowel screening services:

Pledge 10: As the bowel screening programme is made available to more people we will increase colonoscopy capacity to ensure that patients who require this following their positive FOB (blood in stool) test will wait no longer than 2 weeks. From 2010 people aged between 70-75 years will be invited for bowel screening.

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⁶ North West Guidance for Improvements in Cervical Cytology – Jan 2008

Treatment

Access to high quality treatment services is crucial to improving cancer rates. There are some geographical challenges that need to be overcome in ensuring equitable and effective treatment for all patients.

To improve waiting times for cancer treatments:

Pledge 11: We will ensure that all patients in the North West will meet extended standards for waiting times. For second or subsequent surgery and chemotherapy this will mean that patients will wait no longer than 31 days by December 08. All women referred by their GP with breast symptoms will be seen within two weeks by December 2009. All patients with a suspected cancer detected through screening programmes or as upgraded by their consultant will be treated within 62 days by December 2009.

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To improve access to radiotherapy:

Pledge 12: Networks will develop radiotherapy satellite facilities to meet the expectations within the CRS and NRAG report⁷ which will guarantee that patients have a maximum travel time of 45 mins (by car/ambulance) for the more common cancers and for those requiring palliative treatment. Those patients with rarer cancer or more complex treatment needs may need to travel beyond this time. Networks will identify sites by end of 2008 with a view to implementing the first of these by 2010/11. PCTs will commission any additional capacity that cannot be met from better utilisation of existing equipment. Where radiotherapy is a second or subsequent treatment, this will be ensured within 31 days by December 2010.

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To provide greater consistency across a range of treatments:

Pledge 13: A commitment is also given to review treatment protocols and clinical guidelines to ensure these are consistent with best practice and standardised across the North West. We will make treatment such as High Dose Rate Brachytherapy accessible across the North West. Patients will be supported wherever possible to have their radiotherapy treatment at a location convenient to them.

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To ensure equity of access to cancer drugs:

Pledge 14: Patients across the North West will continue to have access to cancer drugs positively appraised by NICE. For pre-NICE drugs and those unlikely to be considered in the short term by NICE, there will be a common approach adopted by commissioners to ensure equity across the North West. The opportunity to standardise treatment protocols will be explored and a commitment is given that all patients will be treated the same regardless of geographical location by 2012.

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⁷ National Radiotherapy Advisory Group report May 2007

Quality

We believe we can continue to improve quality of care in terms of both patient experience and outcomes.

To deliver local, consistent and safe chemotherapy:

Pledge 15: By 2012 Chemotherapy and other systemic therapies will be delivered as close to home as possible where this is safe to do so.

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To commission services only from accredited providers:

Pledge 16: Commissioners will only commission care from hospitals specifically designated to deliver care in accordance with NICE Improving Outcomes Guidance by 2012 at the latest.

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Pledge 17: Commitment has been given by all PCTs across the North West to accelerate the implementation of the plans where these have slipped behind national implementation milestones. In addition network organisations should ensure that peer review action plans are also actioned. A state of readiness report and IOG remedial action plan (if appropriate) will be required for each network by September 2008.

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To ensure access to the latest surgical techniques:

Pledge 18: Network organisations will ensure that all surgeons can access training in these techniques. Agreed new technologies such as laparoscopic procedures (e.g. for prostate, gynae and renal cancers) will be introduced once these become more the norm in practice and PCTs will then only commission from those providers who can offer these techniques.

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To respond to new guidance for rare cancers:

Pledge 19: We will balance the needs of travel distances with the need to concentrate some services in fewer locations for the rare cancers. Clinical guidelines will be standardised across the North West centres where there is more than one using best practice guidance and tools such as the Map of Medicine.⁸

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⁸ A national electronic tool for clinical pathways
May 2008

To be responsive to patients living with and beyond cancer:

Pledge 20: By listening to what patients tell us, we will constantly keep under review their views through a series of surveys and through Network Patient Partnership and other Patient and Public Involvement arrangements. We will ensure providers have robust systems in place to measure patient satisfaction and then act upon the findings. Providers will also ensure that professionals access the appropriate education and training e.g. in communication skills.

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Pledge 21: We want to ensure that all patients receive care as close to their home as is possible and that their stay as an inpatient is kept to a minimum. Where this cannot be avoided, we will enhance the quality of the patient experience, particularly for those with advanced disease. Continuity of care will be ensured through the transformation and development of nursing roles such as through implementation of the Integrated Cancer Care Programme (ICCP). This will also ensure that Clinical Nurse Specialists are used more effectively and appropriately.

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Pledge 22: Patients and Carers will have access to an appropriate level of psychological support throughout and beyond their cancer journey. Using the Improving Access to Psychological Therapies initiative patients will be referred to an appropriate service once they are diagnosed.

Page 37

Pledge 23: We will support patients in making choices around their end of life including increasing the number of people supported to die at home and to achieve their priorities for care.

Page 38

Pledge 24: We support the agreed key recommendations of the End of Life Care clinical pathway group.⁹

Page 38

To reduce cancer inequalities:

Pledge 25: By the end of 2008 all networks will have developed rigorous plans to reduce the health inequalities experienced by their population.

Page 39

Pledge 26: The inequalities in cancer mortality rates will then be rigorously monitored by the SHA.

Page 39

To commission and deliver world class cancer services:

Pledge 27: PCTs in the North West commit to the DH world class commissioning programme and the use of the cancer commissioning toolkit when available, through which standardised care across the North West can be monitored.

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Pledge 28: PCTs will ensure the ambitions and pledges in this plan are reflected in their strategic plans by September 2008.

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⁹ End of Life Care Our NHS Our Future clinical pathway group for the NHS North West March 2008. May 2008

The Cancer Plan for the North West

1. Why we need to have a North West plan

- 1.1** Cancer presents a major challenge to the health services and to the wider community in the North West. We want to encourage people with high risk factors to modify their behaviour to reduce those risks; we want people with symptoms or signs to seek medical help early; we want first contact professionals to have a high index of suspicion for cancer; we want diagnostic services to be able to respond promptly; we want cancer multidisciplinary teams to be organised to provide high quality care and advice; non-surgical oncology to be structured and sized to provide rapid access to the best available care in England, and finally we want specialist teams to be structured and organised to deliver expert care.
- 1.2** Although significant progress has been made in recent years to reduce the morbidity and mortality associated with cancer, the North West persists in having significant challenges. We know that the future demand for cancer services is likely to far outstrip current and planned services and therefore we need to make best use of our resources to improve outcomes for patients and we need to improve preventive programmes working more closely with local communities to help prevent cancer together. The Cancer Reform Strategy (CRS) published in December 2007 gives us an opportunity to address some of these issues collectively and individually.

2. Why is there a new Cancer Reform Strategy?

- 2.1** The original NHS Cancer Plan published in 2000 focused on access to treatment and organisation of cancer services building on the earlier Calman-Hine report.¹⁰ Significant improvements have been achieved in terms of cancer waiting times, quality and service improvements over the last seven years. However the epidemiology of cancer in our population is such that cancer remains an important disease to address. Both nationally and locally we know that:
- ◇ The incidence of cancer is increasing, as people live longer
 - ◇ A large proportion of cancer is preventable
 - ◇ More people are alive having survived cancer
 - ◇ Scientific understanding of cancer is improving greatly
 - ◇ There are new opportunities for early diagnosis (genetics, screening, and diagnostic technologies)
 - ◇ There are many new treatments in the pipeline
 - ◇ There is considerable potential to introduce new service models to improve convenience and outcomes for patients
- 2.2** The Cancer Reform Strategy (CRS) sets out a programme of action across ten areas: six areas of action to improve cancer outcomes and four areas of action

¹⁰ Calman – Hine 1995 – A Policy Framework for Commissioning Cancer Services
May 2008

to ensure delivery. The following chapters describe the expectations nationally and some of the common actions that cancer networks in the North West pledge to undertake. Each network will localise these actions to ensure the delivery of this strategy across the North West.

- 2.3** There are three main cancer networks covering the North West population:- Greater Manchester and Cheshire Cancer Network (GMCCN), Lancashire and South Cumbria Cancer Network (LSCCN), Merseyside and Cheshire Cancer Network (MCCN). The North of England Cancer Network which covers the population in North Cumbria, are served largely by Trusts outside the North West. They have been involved in the development of this plan and are committed to its overall ambitions.

3. Purpose of the North West Plan

- 3.1** This plan demonstrates both the need and commitment to coordinated action across the North West to alter the epidemiology and natural history of cancer in the region. The cancer networks with the SHA have worked collaboratively to develop this response to the national strategy.
- 3.2** NHS North West is already committed to improving the health of the population through the **'Our Life'** programme which aims to empower people to take more responsibility for their own health recognising that many cancers are preventable and when found soon enough are treatable with good survival rates. The NHS North West is also contributing to the development of clinical pathways as part of the wider national review being undertaken by Lord Darzi known as **'Our NHS Our Future'** and developing a quality improvement programme called 'Advancing Quality'. The End of Life Care clinical pathway for the North West is being published in parallel with this Cancer Plan. One of the aims is to develop a framework which will reduce the number of deaths in hospital by 10% by 2012. Quality standards and associated measures are being developed by August 2008 against which organisations will be assessed. (see Appendix I for details)

4. Aims and Objectives of the North West Plan

4.1 The Key aims are to:

- a. Secure an affordable cancer plan for the North West which delivers the best quality
- b. Ensure the delivery of patient centred, equitable, cost effective services
- c. Reduce the inequalities of incidence, risk and the patients' experience of cancer
- d. Improve outcomes by reducing incidence and morbidity and increasing survival

- 4.2** This plan is intended to respond to the increasing needs of cancer patients and the underlying inequalities in incidence and access to high quality treatment by enhanced prevention and adaptation of current services with the following objectives in mind:

- a. Maximise the prevention of cancer
- b. Ensure earlier diagnosis of key cancers
- c. Ensure that the most cost effective treatments are available to all to the same standard
- d. Ensure that all services that define a cancer care pathway can *demonstrate* that they are responsive, safe, effective, accessible, offer value for money and high patient satisfaction.
- e. Support the development of information and intelligence which is accessible to users, providers and commissioners of the service
- f. Maximise opportunities of the health reform agenda in the delivery of all parts of the cancer pathway

Pledge 1: By 2012 the NHS in the North West will have implemented the actions identified in this plan.

5. The Challenge of Cancer in the North West

- 5.1** There is little doubt that the number of new cases of cancer will rise sharply over the next 15 years.¹¹ Most of this increase is due to the ageing of the population, though the age-standardised rates for several cancers continue to rise. A recently published study predicted a 33% increase for England¹². Cancer is more common in the North West of England than in the rest of the country, except for the North East. Overall, after adjusting for age, cancer is 9% more common in men and 7% more common in women than the rest of England. Death rates are also higher by a similar proportion. Certain Local Authorities stand out as having particularly higher incidence rates of cancer (and even higher death rates), the most notable being (in order of severity) Liverpool, Knowsley, Salford, Manchester and Blackpool.

- 5.2** The incidence rates for all cancers combined vary markedly by local authority within the region: from over 25% higher than the national average in Liverpool, to less than the England rate for some rural areas¹³. The absolute mortality targets to be achieved are

A reduction in cancer mortality of 20% in those under 65 years by 2010 with further 6% in spearhead PCTs¹⁴.

¹¹ Shack L et al. Cancer Incidence Projections in the North West , June 2007 NWCIS r

¹² Moller et al. British Journal of Cancer (2007) 96 1484-1488

¹³ T Moran et al. Cancer mortality, incidence and survival in the North West, NWCIS 2007

¹⁴ The group of PCTs who have the most deprived populations

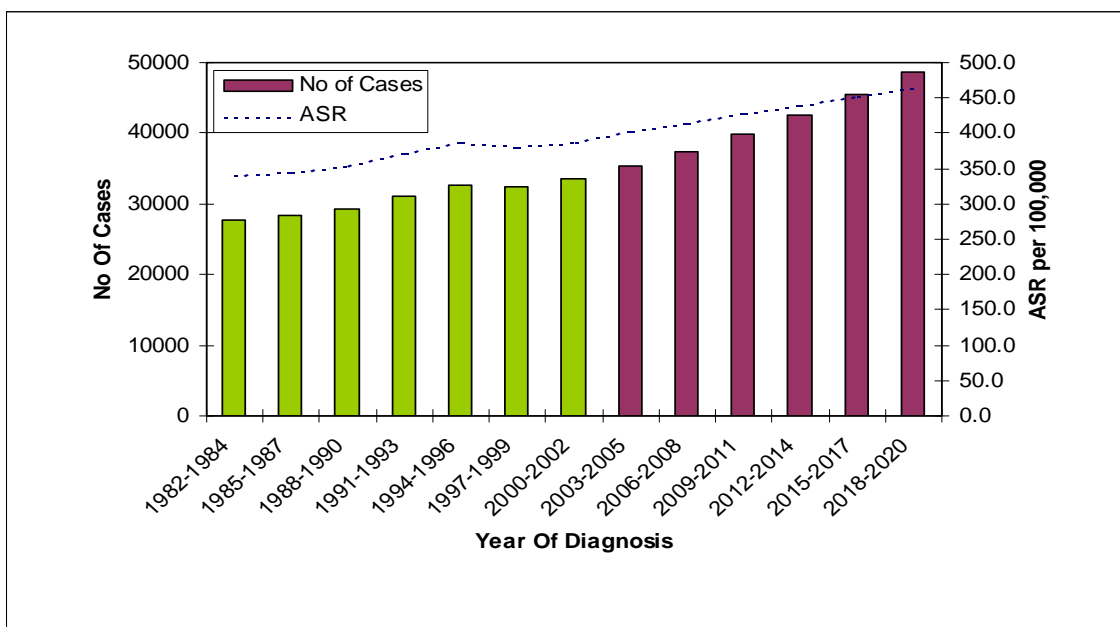
5.3 Cancer accounts for 18% of the contribution to the life expectancy gap for males and 16% for females. Within this, (and the vast majority caused by smoking) the percentage attributable to lung cancer is 61% and 75% for males and females respectively.¹⁵

6. Incidence

6.1 It is estimated that by 2020 almost 50,000 individuals in the North West will be diagnosed with cancer each year, an increase of more than 13,000 annually on the figures for 2003-2005¹⁶ (approximately 35,000). Recent analysis of trends in cancer incidence has shown that an increase in the number of cases of cancer of the order of 24% in men and 20% in women can be expected between 2007 and 2020. The largest increases in incidence are in cancer sites not normally associated with smoking, e.g. multiple myeloma, non-Hodgkin’s lymphoma, malignant melanoma.

6.2 Overall, after adjusting for age, cancer is 9% more common in men and 7% more common in women. Death rates are also higher by a similar proportion.

Figure 1: Actual and projected (from 2003) annual average number of new cases for all cancers combined (excluding non-melanoma skin) and age standardised (European) cancer incidence rates in the North West: 1982-2020.



Source : North West Cancer Intelligence Service 2007 (NWCIS)

¹⁵ DH Health Inequalities Unit 2006

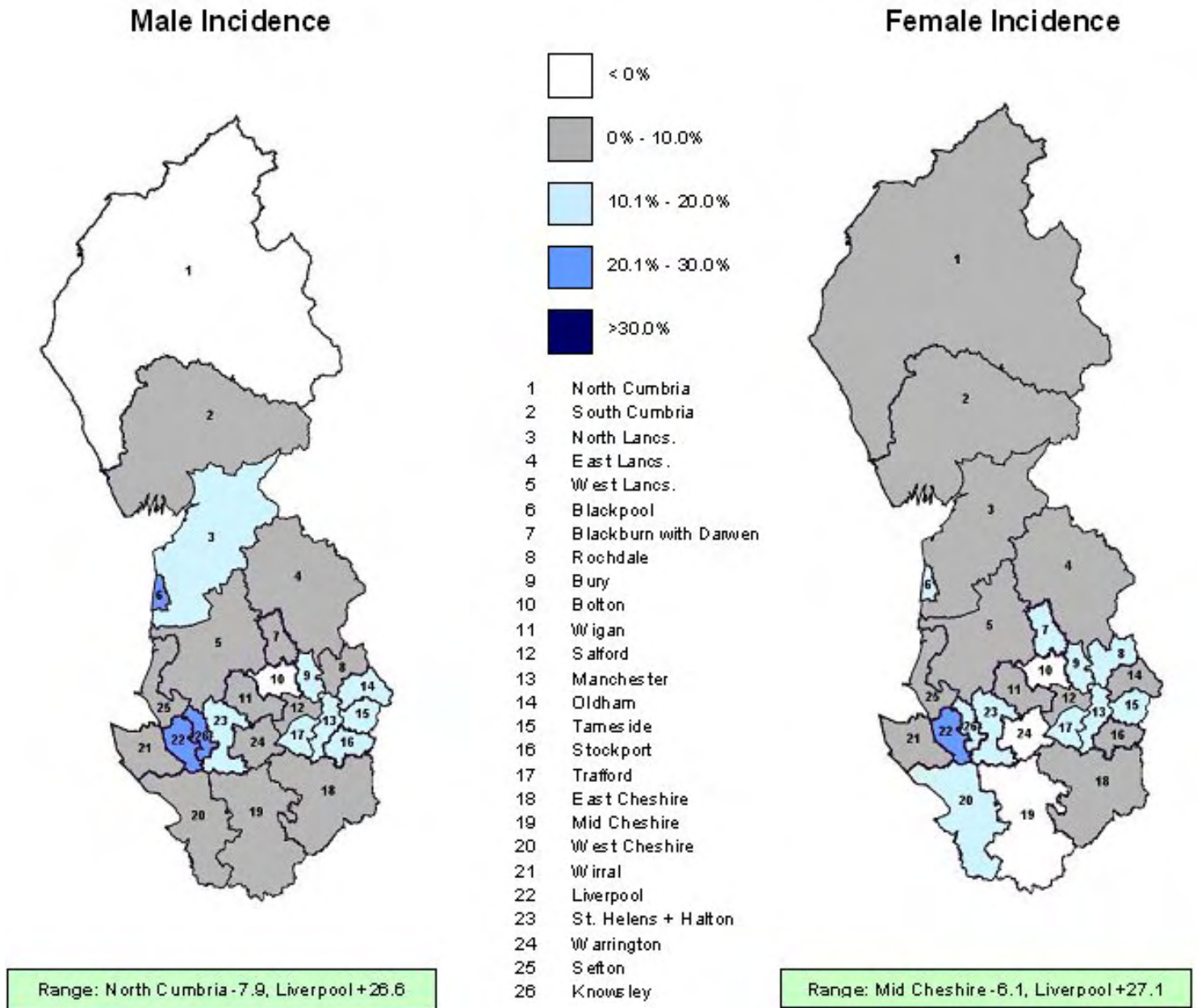
¹⁶ Shack L et al. Cancer Incidence Projections in the North West , June 2007 NWCIS May 2008

Table 1 Comparisons (as percentage differences) between the North West and England in age standardized (2001 England population) incidence rates. *Positive value = North West higher*

Site	INCIDENCE	
	MALES	FEMALES
	NW/England (%) 2001-03	NW/England (%) 2001-03
Stomach	24.6	25.3
Lung	20.8	33.2
Oesophagus	17.8	15.0
Colorectal	9.8	2.8
Cervix	-	18.3
Female Breast	-	1.3
Ovary	-	-2.3
* Bladder	18.8	23.0
Pancreas	-2.0	0.7
Melanoma	-7.7	3.4
Prostate	-1.1	-
Non Hodgkins Lymphoma	-2.9	-2.9
Head & Neck	11.9	8.4
* comparisons for Bladder unreliable		

Source NWCIS 2007

Figure 2: % Difference in age-standardised (England 2001 as standard population) cancer incidence rates (2001-2003) for each Local Authority compared to England



Source : NWCIS

7. Death rates

7.1 Almost 1300 more people die from cancer each year in the North West who would not have died if this region had the same death rates from cancer as England & Wales¹⁷. This report published after the initial consultation paper outlines the challenge cancer services face across the North West. Table 2 shows the number of annual excess cancer deaths for each PCT in the North West for the period 2001-2005, and the total number of cancer deaths for 2006.

Table 2 Number of annual excess cancer deaths in the NW compared with England and Wales plus total number of cancer deaths

Primary Care Trust	All cancers Excess deaths			Lung Cancer			Deaths all Ca 2006 ¹⁸
	Male	Female	Total	Male	Female	Total	
Halton & St Helens	66	64	130	23	24	48	796
Knowsley	50	45	95	26	33	59	449
Liverpool	181	174	355	99	100	199	1330
Sefton	40	29	69	15	27	42	834
Warrington	6	-6	0	2	3	5	475
West Cheshire	2	9	11	-6	-1	-7	693
Wirral	33	49	82	18	24	41	1031
Sub Total MCCN	378	364	742	177	210	387	5608
Ashton Wigan Leigh	47	0	47	19	13	32	763
Bolton	15	8	24	10	9	19	661
Bury	17	8	26	9	10	18	484
Central & East Cheshire	-6	-44	-50	-10	-18	-28	1148
Manchester	119	72	190	64	46	110	1064
Oldham	29	23	53	14	13	27	546
Rochdale, Heywood and Middleton	20	20	39	16	16	32	495
Salford	70	61	132	35	40	75	638
Stockport	7	-10	-3	3	3	6	745
Tameside & Glossop	13	-13	-1	12	6	17	669
Trafford	-3	6	3	0	10	10	579
Sub Total GMCCN	328	131	460	172	148	318	7792
Blackburn with Darwen	11	20	31	13	10	23	298
Blackpool	24	41	65	11	15	26	469
Central Lancs	18	33	51	17	11	28	1166
Cumbria**	6	0	6	-5	5	0	1461
East Lancs	0	-3	-3	18	18	36	923
North Lancs	1	-19	-18	-8	-6	-14	1007
Sub Total LSCCN	60	72	132	46	53	99	5324
Grand total NW	766	567	1334	395	411	804	18724

*Numbers are rounded to the nearest whole number **Cumbria population crosses two networks

¹⁷ Excess cancer mortality and incidence by PCT in the North West, Dec 2007 NWCIS & NATCANSAT

¹⁸ Source NCHOD mortality all ages all cancers 2006

- 7.2** Death rates from cancer have been falling across the UK for many years. Until recently however the rate of decline was slower than in many other countries. During the last decade, and especially in the last five years, the decline in death rates has accelerated. The result of this is that there are many more people living with cancer; prevalence has doubled in 15 years. Furthermore, many people with cancer survive now long enough to develop late complications of the disease or treatment. The demand on services arising from this 'success' is rarely accounted for in service planning as the average life expectancy of adults has increased (as people are living longer), they then develop cancer in later life. The incidence of cancer is greater for those aged over 75.
- 7.3** The decline in death rates in the under 75s in the North West is similar to the national average but this masks a better trend in Merseyside and a worse trend in Greater Manchester and in Cumbria and Lancashire. The trend in more recent years has improved, in line with national experience. Mortality rates for all cancers combined have fallen considerably for most spearhead Primary Care Trusts (PCTs) in the North West and most will probably reach the target of a 20% reduction by 2010, at least for males. However, the decrease in rates for England as a whole has been greater than for the spearhead PCTs in the North West, which makes it unlikely that the target of a further 6% reduction in the difference in rates will be achieved.¹⁹
- 7.4** Though survival rates for the North West are similar to those for England, national rates are considerably lower than for many other countries. For example, in the recently published EURO CARE 4 papers²⁰, five-year survival rates for patients with colorectal cancer for Finland are 7.0% higher than for England in those diagnosed during 1995-1999 and 7.6% higher for those diagnosed in 2000-2002 (period analysis with incomplete follow-up)²¹. These reflect the rationale for having the original NHS Cancer Plan in 2000. Results from previous EURO CARE studies showed that most of the difference in survival between England and other countries occurred in the first year following diagnosis, suggesting that late presentation is a major cause of the poorer outcomes in this country. It is anticipated that the next EURO CARE papers will show the improvements that the current cancer plan has achieved.

8. Preventing cancer

- 8.1 Over half of all cancers could be prevented by changes to lifestyle.** The CRS has promised cross-government action to tackle the major risk factors for cancer. Improving awareness and encouraging people to adopt healthy lifestyles is therefore crucial to improving cancer rates. Various risk factors for cancer are more common in the North West. Most notably, smoking, alcohol misuse and sexually transmitted infections are more common than nationally.

¹⁹ Stakeholder Primary Care Trusts and progress towards decreasing cancer mortality, North West, 1995-2005. (NWCIS) April 2007

²⁰ The EURO CARE project (European cancer registries study on cancer patients' survival and care) is an international collaborative study on the survival of cancer patients in Europe

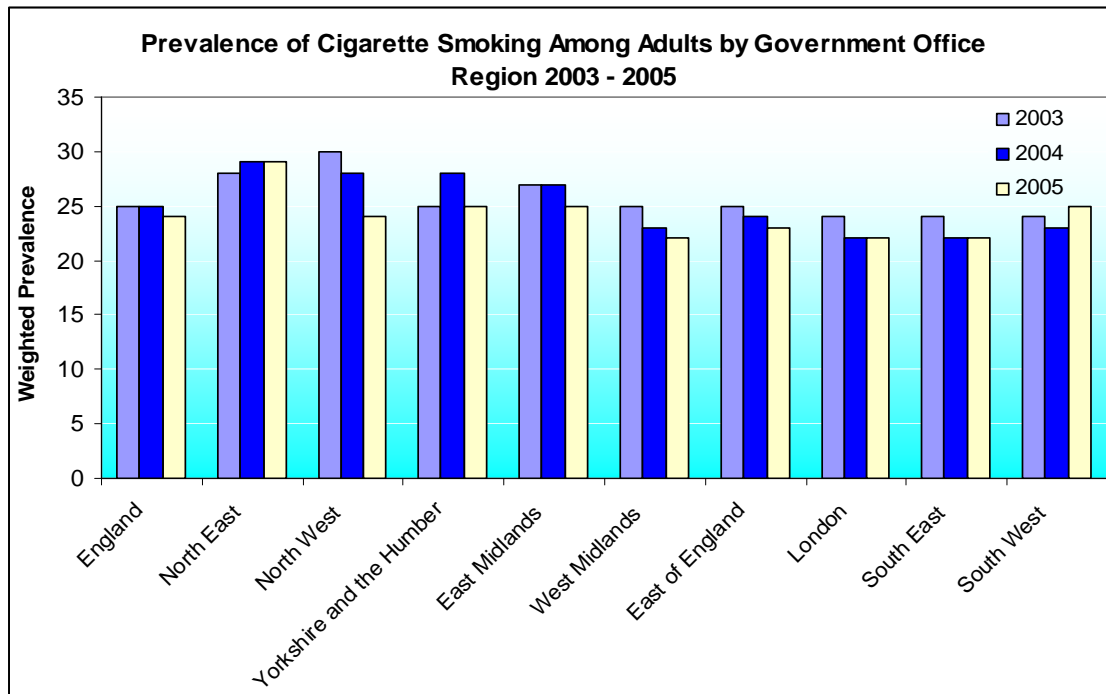
²¹ Berrino F et al: Lancet Oncology 2007 :8 : 773-796

Effective use of health protection services such as cancer screening is also poorer.

8.2 Smoking is the single largest preventable risk factor for cancer. As well as maintaining the high price of tobacco and taking action to reduce the availability of illicit tobacco, the government has committed to consult during Spring 2008 on proposals for the next steps in tobacco control and the further regulation of tobacco products, including the display of tobacco at the point of sale, access to tobacco from vending machines and packaging.

8.3 In 2005, within the North West smoking prevalence was comparable with England and other Government Office regions. The North West has experienced the greatest decrease in cigarette smoking overall compared to the rest of England. Previous to this, it had some of the highest prevalence rates throughout England. Work is underway on the Regional Tobacco Control Plan.

Figure 3 Smoking Prevalence 2003-2005



Source : ONS

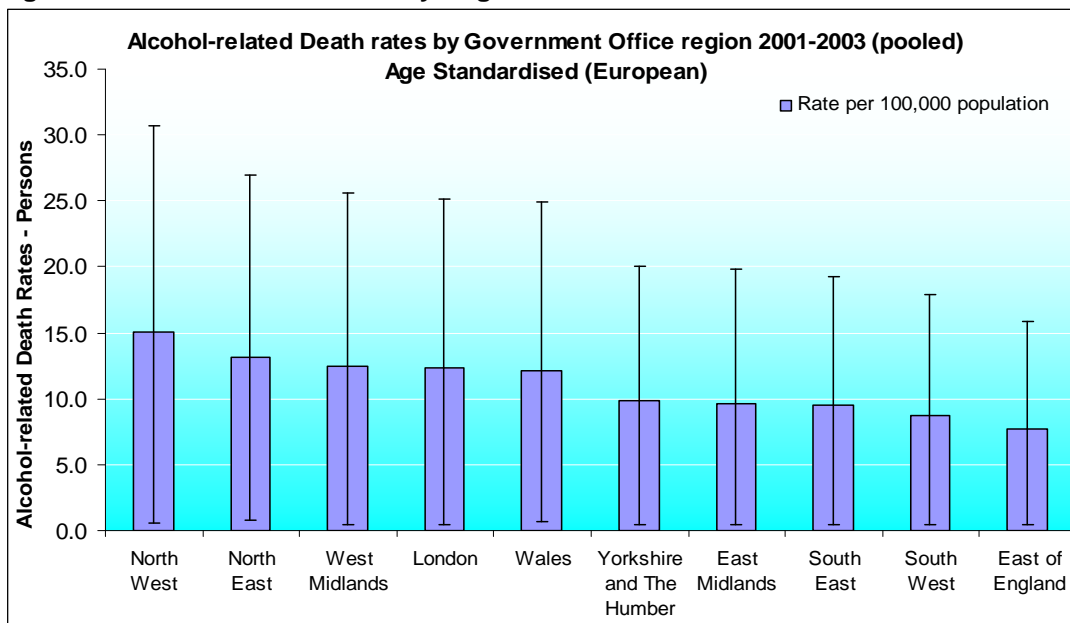
Pledge 2: We will implement the Regional Tobacco Control Plan.

8.4 The North West has the highest alcohol-related death rates when compared to the rest of England and Wales (see Figure 4). The North West has an alcohol-related death rate of 15.1 per 100,000 of the population while the lowest, East of England, has a rate of only 7.7 per 100,000 population. Excessive alcohol consumption is strongly linked to an increased risk of several cancers. To tackle this, a programme of activity is planned for next year and beyond, including a sustained national communications campaign to improve the public’s knowledge of units of alcohol and ensure everyone has the information they need to estimate how much they drink, targeted information and advice for people who

drink at harmful levels and consultation on the need for legislation regarding alcohol labelling. Effective intravenous drug misuse strategies and screening of high risk groups, e.g. prisoners, those with chronic Hepatitis C is needed in order to reduce disease progression and risk of sclerosis and Hepato Cellular Cancer. Disease progression is exacerbated by co-infection with other viruses e.g. HPV and HIV as well as alcohol consumption.

- 8.5** All PCTs in the North West are developing their local strategies on alcohol which will help reduce risk taking behaviour which in turn will impact on a number of tumour sites associated with heavy alcohol consumption such as head and neck, liver and oesophageal cancers. The 'Our Life' programme will focus on alcohol campaigns.

Figure 4 Alcohol related deaths by Region 2001-2003



Source: Information Centre 2007

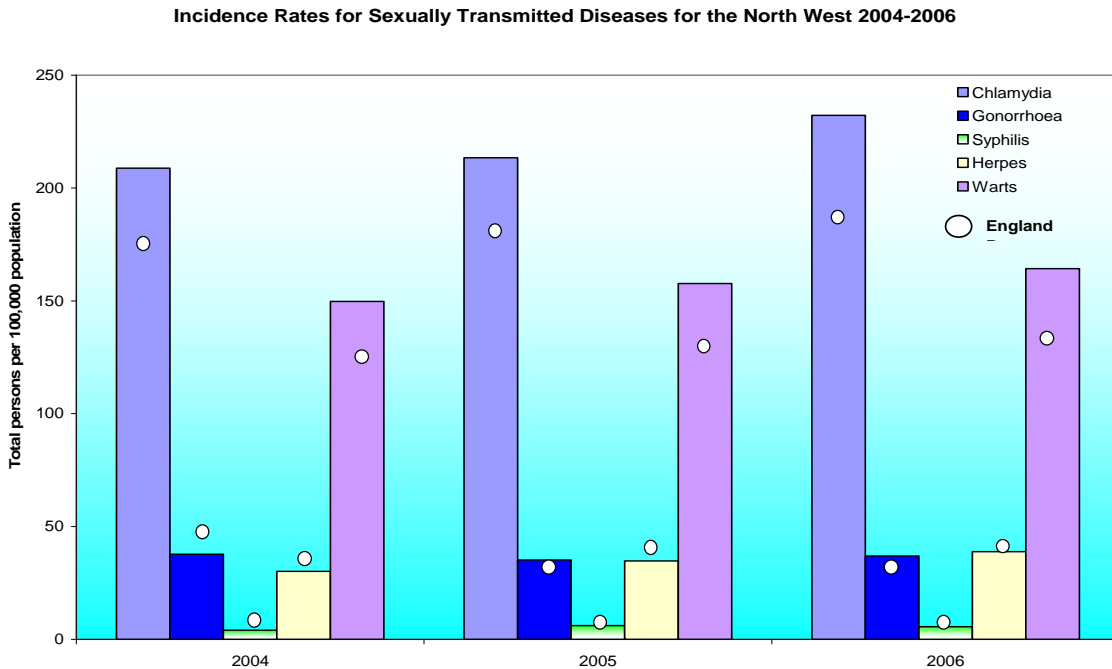
Pledge 3: We will use the 'Our Life' programme to push for a decrease in hazardous and harmful alcohol consumption.

- 8.6** Incidence rates for Chlamydia are rising in the North West. Syphilis rates have predominantly remained unchanged throughout the past 3 years. Herpes incidence has risen for the North West and for England each year; however the North West still remains slightly below England levels. Genital warts is the second highest sexually transmitted disease in the North West next to Chlamydia, and rates have risen each year above England rates. Whilst not directly linked to overall cancer incidence, such risk-taking sexual behaviour is linked to cervical cancer incidence.

- 8.7** The introduction of immunisation for the Human Papilloma Virus (HPV) for girls aged 12-13 years through the school vaccination and immunisation programme will contribute significantly to the reduction of incidence and mortality from cervical cancer and protect against the strains of the virus which cause about seven out of ten cases of cervical cancer. This is not an alternative to cervical

screening however, and PCTs will need to ensure coverage and uptake rates are maximised for both programmes.

Figure 5 Incidence rates for Sexually Transmitted Diseases



Source: Health Protection Agency

Pledge 4: Networks will support PCTs with the implementation of the Human Papilloma Virus (HPV) vaccination programme to commence September 2008 and we will ensure that by September 2010 all young women up to the age of 18 will have been offered HPV vaccination as part of the 'catch up' programme.

8.8 The evidence linking obesity to cancer has become much stronger since the publication of the NHS Cancer Plan in 2000. The government has recently published a cross government strategy to tackle obesity. Local obesity strategies are now being developed by all PCTs as part of this year's strategic planning round. The Operating Framework²² issued recently highlights the need for strategic joint needs assessments to be undertaken across Local Authority and PCT boundaries resulting in commitments in Local Area Agreements (LAAs). The regional framework for healthy weight was published in February 08.

Pledge 5: The North West will strive towards reducing obesity especially in children and young people.

8.9 Skin cancer incidence is rising rapidly, almost certainly reflecting patterns of behaviour over recent decades. The government will expand the Sunsmart campaign, which is aimed at promoting behaviour change to prevent skin cancer and raising awareness of the early signs of the disease. The Department of Health is reviewing options for regulation of the industry and as a first step will

²² DH Guidance for the NHS in England 2008/09
May 2008

gather more information about the number and distribution of sun beds and the scale of sun bed use by minors. The inclusion of this commitment was instigated by the work undertaken in Merseyside and Cheshire Cancer Network within schools in Liverpool.

Pledge 6: The North West will campaign for greater regulation of sun beds to protect children and young people.

8.10 In summary all networks need to focus their efforts in developing prevention strategies which seek to change risk-taking behaviour using social marketing and community engagement models. Learning from each other's experience, a range of targeted interventions will be piloted.

9. Diagnosing cancer earlier

9.1 In general, the earlier a cancer can be diagnosed the greater the chance of a cure. Late diagnosis is the major factor contributing to poor cancer survival rates. Optimal treatment including surgery, radiotherapy, chemotherapy and access to research trials are clearly important and are discussed in later sections. In developing local strategies emphasis will need to be put on detecting cancers early including through screening programmes. As well as this we need to raise public awareness of the need to present early enough to their GP who can then refer on for prompt investigation.

9.2 In addition we need first contact professionals to have a high index of suspicion for cancer. GPs in particular will need improved access to diagnostic facilities such as imaging. Rapid access to diagnostics will be key to the success of detecting cancers early. Access to primary care in terms of extended opening hours would also facilitate the chances of early detection.

9.3 Any strategy to encourage patients to present earlier or to improve treatment outcomes is dependent upon staging data to measure its success. The lack of complete staging data in the North West has prevented the publication of analyses such as case-mix adjusted outcomes and geographical variations in stage at presentation. For this reason, no outcomes data has been included in this paper but we believe the publication of such analyses in the future would help to improve prevention and quality. Below we describe a set of actions which will be taken to address this and which we think will support the capture of such data as well as improve the effectiveness of Multi-Disciplinary Team working (MDT), which in turn will benefit all patients.

9.4 In the North West we want to be the first area in the country to address in a comprehensive manner the quality of staging data. It is important for a number of reasons. We aim to understand the extent of the stage or spread for cancers diagnosed in 2006 so that we can measure how our outcomes compare with other parts of the country. The retrospective collection will give us a benchmark against which the quality and quantity of prospective data can be measured. Risk adjusted data on survival can then be produced for these cancers to inform commissioners and clinical teams alike.

- 9.5** Funding is being made available by NHS North West to achieve this, including investment in information systems which support MDTs and feed other systems such as National Audits and Cancer Waiting Times databases as a by-product. Trusts will need to ensure that effective and sufficient MDT Co-ordinators are available to support the collection of this data, including the Cancer Registry dataset which is now mandatory for Trusts through the Operating Framework and National Contract. Networks will facilitate a programme of improvement in the effectiveness of MDTs, which are now the cornerstone of cancer treatment services, to ensure they are as efficient and effective as possible.

Action 1: By Dec 2009 we will have completed the collection of retrospective staging data for cancers diagnosed in 2006. During 2008/09 all data will be collected prospectively through MDTs to capture these in real time, and be used as a basis for treatment decisions

- 9.6** We also need to understand more about the nature and extent of the delays in cancer diagnosis so that we can change the behaviour of patients and/or professionals. A national audit in primary care of newly diagnosed cancers is being conducted and will be used to make decisions about how best to provide more support to primary care professionals to ensure the early diagnosis of cancer. The Prime Minister recently announced that screening for a range of conditions including stroke and coronary heart disease would be introduced in primary care. Some preventive measures for other diseases will be of benefit to cancer. We will also seek to understand why some patients who present with the same symptoms on several occasions are not referred as promptly as they might be. Several PCTs are early adopters of the Map of Medicine and this should enable us to standardise referrals against particular symptoms. Thereafter, the treatment offered will be the optimal based on evidence based best practice.

Action 2: Whilst we await the national work we will work with the Healthy Communities Collaborative being piloted in areas across the North West in deprived communities such as in Manchester, Liverpool, Halton, East Lancashire and Blackpool to understand issues of late presentation. We will aim to target GP populations that have not presented at their GP surgery for the last 5 years. Using the tried and tested model known as Plan, Do, Study, Act (PDSA) those involved with the pilots will scope this PDSA working with community teams.

Action 3: Working with NHS professionals in primary care and using the Map of Medicine Pathways that are being developed for cancer (beginning with bowel symptoms) we will ensure that this tool is readily available and used throughout the North West.

- 9.7** Whilst a new National Awareness and Early Diagnosis Initiative will coordinate a programme of activity to support local interventions to raise public awareness of

the signs and symptoms of early cancer and encourage people to seek help sooner, we hope our local strategies will pre-empt some of the steps. We look forward to using the national tool being developed for measuring awareness levels and supporting high quality evaluations of pilot projects.

- 9.8** Pathology and imaging services are critically important in diagnosing which patients have cancer (and which do not), what is the nature of their cancer and the extent of disease. Improvements in technology e.g. MRI and PET-CT should provide greater accuracy in staging cancers and need to be readily available with trained staff to use the equipment and interpret the findings. The latter is now becoming available across the North West through investment by PCTs which are being delivered through cancer centres and in some cases in partnership with the private sector.
- 9.9** The ability of pathology services to provide a more precise description of the type of cancer is improving year on year giving patients a prognosis (i.e. how the cancer will behave) and in determining optimum treatment. We have already seen how such an approach to providing HER-2 testing has benefited patients with breast cancer and in the use of Glivec for those with haematological cancers. Similar approaches to treatment that is targeted against specific molecules in cells of other cancers are already being assessed in clinical trials and are likely to become part of routine practice in the next few years.
- 9.10** The move towards providing more prognostic information for patients by using gene expression profiling means that it is essential that new molecular techniques are given full support in the North West. This will allow their development and translation into routine diagnostic processes.

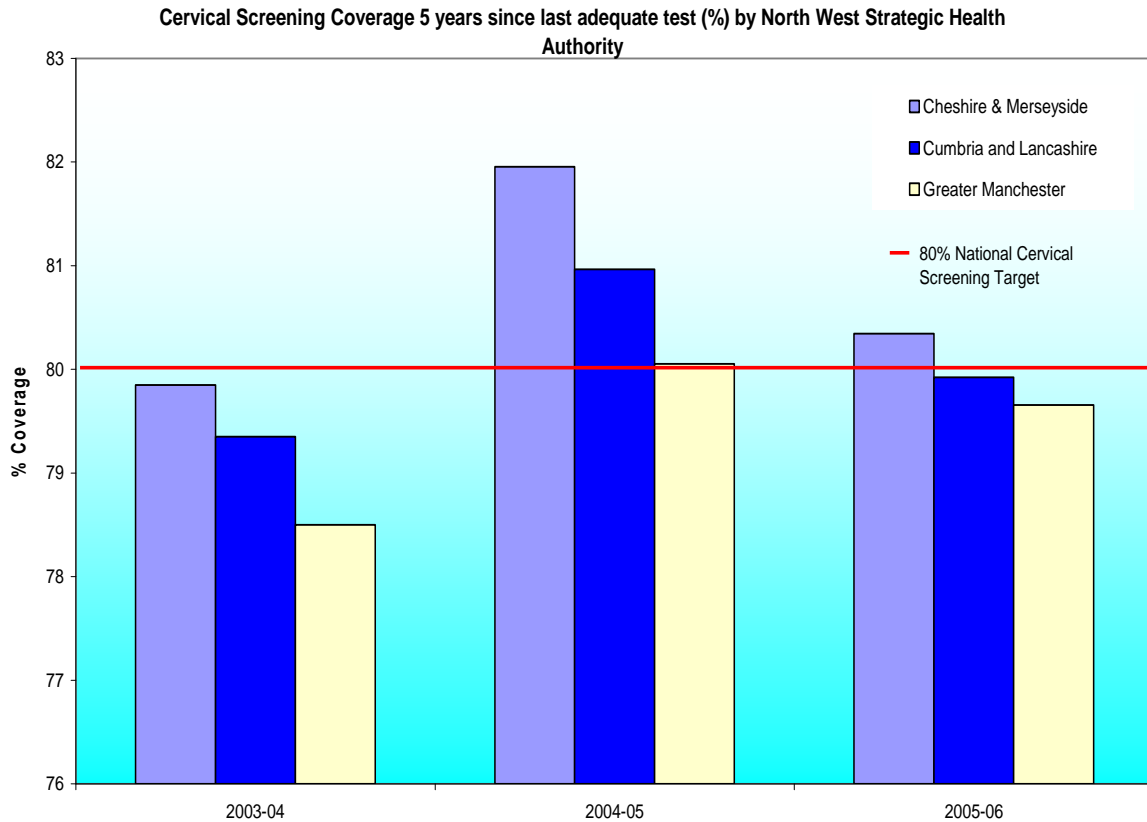
Action 4: We will commission work through networks to consider the impact on pathology services so that pathology laboratories are prepared (equipped and trained) to meet this demand. The impact of gene profiling will be assessed as part of this.

- 9.11** The establishment of a formal network of “Family History Cancer Clinics” (FHCCs) could provide patients with first-line advice on the probability of inheriting certain cancers. There are several models of practice in place across the North West for Breast, Ovarian and Bowel cancers, but a cohesive strategy is required to ensure consistent application across existing services and expansion to other cancer sites. The outcome of FHCCs such as resource implications for increased mammography services, prophylactic surgery, etc., is an area that will benefit from an integrated approach, as will education of secondary and primary care professionals. The North West participates in national discussions on issues such as complex bio-markers and assisted reproduction for couples at risk of life-threatening inherited conditions, and will follow central guidance when available.
- 9.12** Screening is vital to diagnosing some cancers early. To improve and expand cancer screening, the government has committed through the CRS to:

- Build on progress on cervical cancer screening, by reducing the variation of coverage between PCTs, informing women of the result of their cervical screening test within two weeks of it being taken, using new technologies as and when the research evidence supports this and tackling the falling participation of women aged 25 to 35;
- Extend breast screening to nine screening rounds between 47 and 73 years, with a guarantee that women will have their first screening before the age of 50, facilitated by the roll out of digital mammography;
- Expand the NHS Bowel Cancer Screening Programme from 2010 to invite men and women aged 70 to 75 to take part. By the end of 2010, decisions will be taken about possible roll out to people in their 50s; and
- Commission research on the feasibility of a UK trial of CT screening for lung cancer, working with the National Cancer Research Institute.

9.13 There is variation in the coverage and uptake rates of the two national screening programmes across the North West. Cervical screening coverage has been falling with Cheshire and Merseyside having the largest decrease of 0.08% in 2005-06. The national target remains at 80% for cervical screening and the graphs below indicate that all parts of the North West are failing to achieve the target. The CRS also advises that cervical screening results should be available to patients within 14 days - this will benefit 4 million women nationally every year. At present, over half of patients wait 6 weeks or more for their results.

Figure 6 – Screening coverage in the North West



Source : The North West Cervical Quality Assurance Programme

Pledge 7: Having been the first SHA in the country to fully introduce Liquid Based Cytology (LBC) screening, we now want to go further with system redesign of cytology services and to ensure that all patients receive their results within 14 days by 2010. By March 2011, networks will have implemented changes arising out of the North West Review²³ of cytology services.

Pledge 8: Unacceptable variations in screening uptake will be investigated and appropriate action will be taken to target the population never screened. PCT leads will examine the coverage and uptake rates for all screening programmes to improve and maintain uptake by their populations.

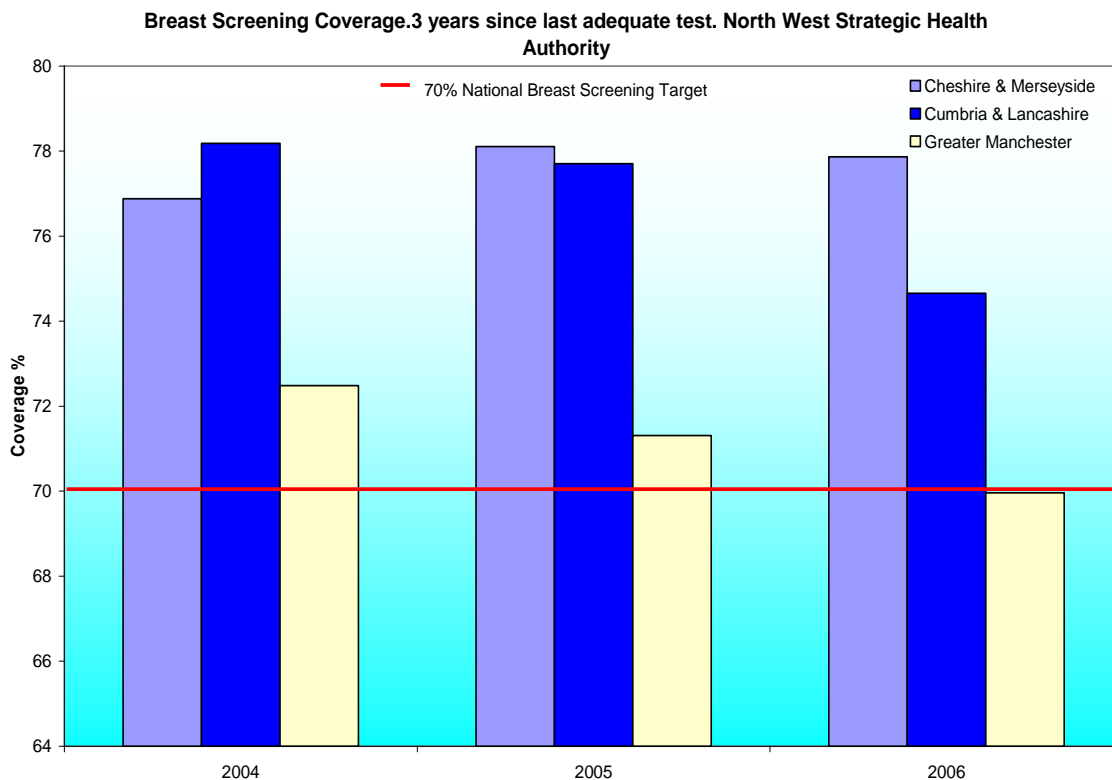
²³ North West Guidance for Improvements in Cervical Cytology – Jan 2008

- 9.14** The CRS commits us to extending the age range to women from 47 – 73 years which will mean an extra 60,000 women a year in the North West will need to be screened – an increase of 28.5%.

Pledge 9: We will review and enhance capacity within our breast services to ensure that we meet the new standards including the introduction of digital mammography. Those with a high familial risk of breast cancer will be kept under surveillance through the breast screening service. We will see greater integration with the symptomatic breast services. This will be fully implemented by December 2012.

- 9.15** Breast cancer screening coverage has been slowly decreasing for all areas within the North West with the exception of Cheshire and Merseyside in 2005. All areas experienced a decrease in 2006 with Cumbria and Lancashire having the largest decrease of 6.4% and Greater Manchester having the smallest decrease of 4.7%. The national target is 70% and whilst this is being met overall it masks a variation between PCTs and communities with high levels of deprivation.

Figure 7 Breast Screening coverage in the North West



Source : The North West Breast Screening Quality Assurance Programme

- 9.16** Bowel screening has already been rolled out across all PCTs in Cheshire and Merseyside and Bolton. The rest of the North West will be rolled out in the next phase. From the data available from the first phase it would appear that we are achieving the uptake rate of 60% experienced in the national pilots. However, there is a higher positivity rate following FOB (blood in the stool) testing than in

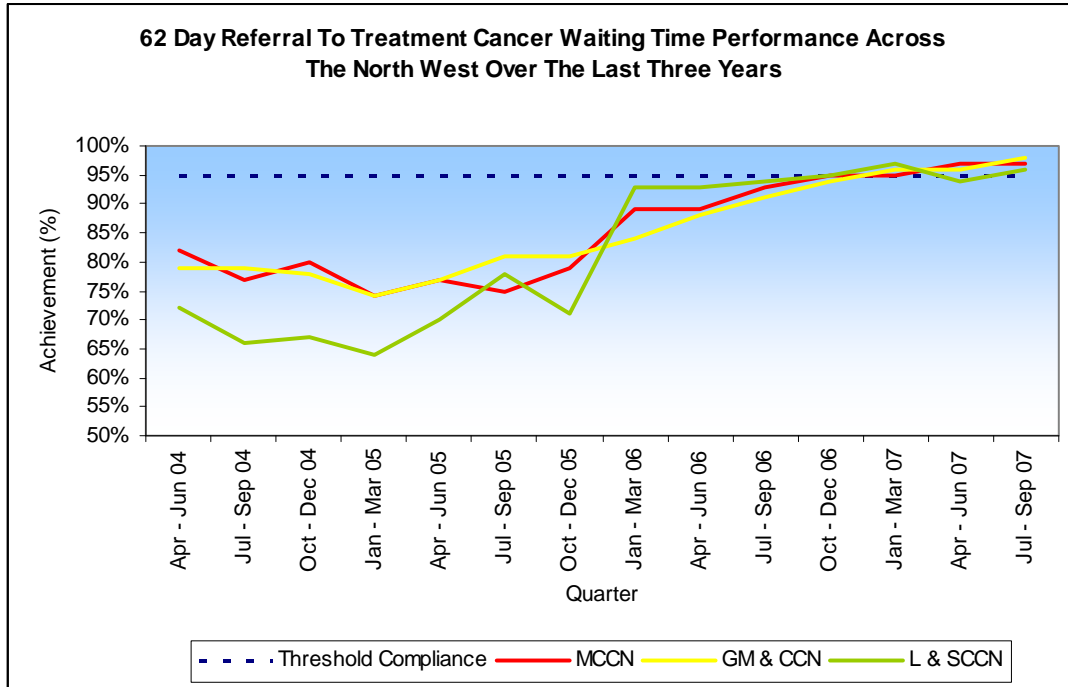
many parts of the country. The national rate is around 2% but the rate in Cheshire and Merseyside is nearer 3% i.e. 50% higher. If this is replicated elsewhere in the North West there will need to be a step change in colonoscopy capacity.

Pledge 10: As the bowel screening programme is made available to more people we will increase colonoscopy capacity to ensure that patients who require this following their positive FOB (blood in stool) test will wait no longer than 2 weeks. From 2010 people aged between 70-75 years will be invited for bowel screening.

10. Ensuring better treatment

- 10.1** Access to treatment services needs to be timely, safe and effective if those diagnosed with cancer are to survive longer or be cured. The 2 week target has been achieved for some time across all cancers and the challenge for the future will be in delivering this for all breast related referrals
- 10.2** For the 31 day cancer target from decision to treat to treatment being carried out, the national achievement threshold is 98%. The performance around this indicator varied considerably between the Networks, with each showing considerable improvement over the three years. Each of the Networks began to achieve the 97% threshold at the end of 2005 and have remained above the threshold ever since with performance at either 99% or 100%.
- 10.3** The 62 day referral to treatment cancer waiting time target has proved to be the most demanding threshold to achieve. However, as can be seen from Figure 7, there has been a significant improvement in the cases treated within 62 days across the whole of the North West. Over the past 3 years, performance has improved by 15-25% across the Cancer Networks.

Figure 8: 62 day Cancer Waiting time targets



Source : Open Exeter Cancer Waiting Times database

10.4 Whilst excellent progress has been made on reducing waiting times locally and nationally, the CRS will now extend the range of patients who benefit from the current standards:

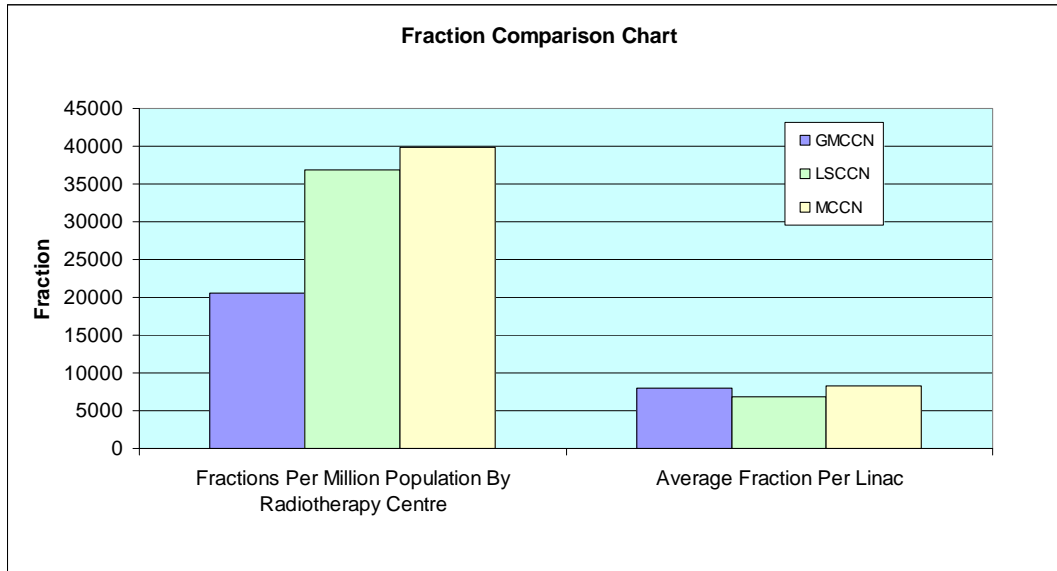
- The 31 day standard will be extended to cover **all** not just first cancer treatments;
- In addition to patients referred urgently by their GP, all patients with suspected cancer detected through national screening programmes will in future enter the 62 day pathway;
- Hospital specialists will have the right to ensure that patients who were not referred urgently by their GP, but who have symptoms or signs indicating a high suspicion of cancer, are managed on the 62 day pathway; and
- All patients referred to a specialist with breast symptoms, even if cancer is not suspected, should be seen within two weeks of referral.

Pledge 11: We will ensure that all patients in the North West will meet extended standards for waiting times. For second or subsequent surgery and chemotherapy this will mean that patients will wait no longer than 31 days by December 08. All women referred by their GP with breast symptoms will be seen within two weeks by December 2009. All patients with a suspected cancer detected through screening programmes or as upgraded by their consultant will be treated within 62 days by 2009.

11. Radiotherapy

- 11.1** To achieve a world class radiotherapy service, local investment will be needed both in equipment and workforce. The national strategy aims to ensure that the recommendations for improving capacity in radiotherapy services that were set out in the National Radiotherapy Advisory Group's (NRAG) report are achieved and that providers have sufficient capacity to meet the 31 day waiting time standard for all radiotherapy, not just first treatment.
- 11.2** In all parts of the North West this will require an expansion in the number of linear accelerators (linacs) – currently estimated to be 40 from the current 26. Specific discussions and option appraisals are underway in all networks to achieve better geographical access for patients.
- 11.3** Waiting and access times for radiotherapy treatments are also variable across the North West and the reasons for this also need addressing. Using the data available from the Cancer Waiting Times database and National Cancer Services Analysis Team on travel/drive times to current and potential radiotherapy centres, PCTs will commission additional capacity across the North West footprint. Access to radiotherapy across the North West relies on patients travelling often in excess of 1.5 hours to reach the currently designated centres at The Christie, Clatterbridge and Royal Preston sites.
- 11.4** Historical under-treatment, for example in radiotherapy, will need to be addressed by systematic investment in networked and more accessible facilities. Figure 8 shows the comparative data on provision of linacs, fraction rates per million population/machine for each centre. These data need to be examined in relation to cancer incidence to ensure that patients are not under treated by radiotherapy.

Figure 9 Fraction Comparison between networks 2007 survey



Source: NATCANSAT Survey of Radiotherapy Centres 2007

- 11.5** In all networks discussions are advancing to achieve better time to treatment and travel times. Mapping exercises have been carried out in all three networks to identify the optimal location of satellite radiotherapy centres. Existing providers are being encouraged to develop satellite services in locations more accessible to patients. Commissioners will need to commission additional capacity (assuming optimal productivity is first achieved) to meet the recommendations of the NRAG report.

Pledge 12: Networks will develop radiotherapy satellite facilities to meet the expectations within the CRS and NRAG report which will guarantee that patients have a maximum travel time of 45 mins (by car/ambulance) for the more common cancers and for those requiring palliative treatment. Those patients with rarer cancer or more complex treatment needs may need to travel beyond this time. Networks will identify sites by end of 2008 with a view to implementing the first of these by 2010/11. PCTs will commission any additional capacity that cannot be met from better utilisation of existing equipment. Where radiotherapy is a second or subsequent treatment, this will be ensured within 31 days by December 2010.

Pledge 13: A commitment is also given to review treatment protocols and clinical guidelines to ensure these are consistent with best practice and standardised across the North West. We will make treatment such as High Dose Rate Brachytherapy accessible across the North West. Patients will be supported wherever possible to have their radiotherapy treatment at a location convenient to them.

12. Anti-cancer drugs and systemic therapies

- 12.1** Drug treatments for cancer have developed substantially over the past 20 years and are set to develop further. It is important that NICE guidance on new technologies is available as soon as possible. In future the default position for all new cancer drugs and significant new licensed indications will be that they will be referred to NICE, where there is a sufficient patient population and evidence base on which to carry out an appraisal. NICE will undertake as rapid an appraisal as is possible ideally in parallel with licensing.
- 12.2** The current expenditure on NICE approved anti-cancer drugs varies across the three networks and the proportion of cancer drug expenditure compared with overall expenditure on cancer. The analysis of NICE drug expenditure in Figure 9 is taken from drug sales provided by Trusts through an independent company. Although indicative of the amount spent on NICE approved cancer drugs, it is not fully reflective of the volume of drugs available to cancer patients. We have a high number of patients in drug trials and these drugs are provided free by the drug companies whilst the patient remains in a trial. Whilst each network has differing cancer incidence this does not explain this level of variation. Differing drug preferences between oncologists is also a possibility although the most likely explanation is historical patterns of spend by commissioners.

Figure 9 Drugs spend as a proportion of total cancer spend by network

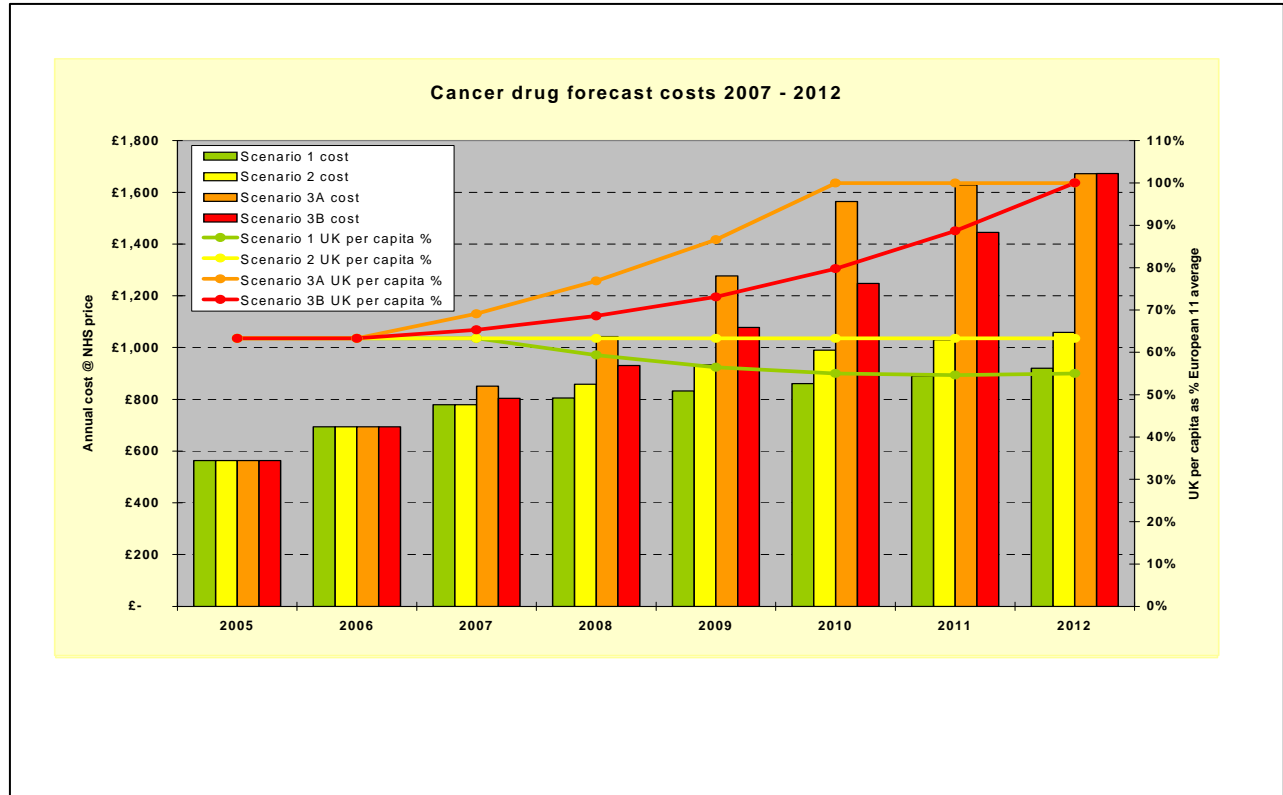
Greater Manchester & Cheshire
– Rank 7th of 34 networks
– 10.3 % of total cancer spend is spent on anti-cancer drugs
Lancashire & South Cumbria
– Rank 28th of 34 networks
– 4.8 % of total cancer spend is spent on anti-cancer drugs
Merseyside & Cheshire
– Rank 23rd of 34 networks
– 6.6 % of total cancer spend is spent on anti-cancer drugs

Source : Analysis of cancer spend by networks by Roche Pharmaceuticals 2007

Pledge 14: Patients across the North West will continue to have access to cancer drugs positively appraised by NICE. For pre-NICE drugs and those unlikely to be considered in the short term by NICE, there will be a common approach adopted by commissioners to ensure equity across the North West. The opportunity to standardise treatment protocols will be explored and a commitment is given that all patients will be treated the same regardless of geographical location by 2012.

- 12.3** The challenge of introducing and funding new anti-cancer drugs should not be underestimated. Horizon-scanning as shown in Figure 10 would suggest a significant investment in cancer drugs will be required and gives a range of scenarios, although these are reproduced for illustrative purposes only.

Figure 10 Cancer Drug Forecast costs 2007-2012



Source : Roche Pharmaceuticals presented at BOPA Annual Conference 2007²⁴

12.4 Current clinical audits do not collect sufficient information to understand why variations in the usage of drugs occur. Better data collection on chemotherapy activity will also aid PCTs in their planning. PCTs, working with their cancer networks, will want to undertake a review of cancer chemotherapy and develop a strategic framework for chemotherapy services, setting out clear service specifications, taking account of forthcoming advice from the National Chemotherapy Advisory Group's report which is expected in June 2008. The report is likely to recommend delivery as near to home as possible and consider other settings such as home or primary care for the delivery of some regimens e.g. some oral and intra-venous chemotherapy is already delivered in patients' homes in some parts of the country.

12.5 Local access to chemotherapy is partly in place across the North West and remains an ambition in others. The major cancer centres in Manchester and Preston have the greatest challenge. Patients tell us they want to receive such care in their local hospitals and preferably in an outpatient setting where the

²⁴ Notes to chart

1. Assumes that UK cancer drug expenditure increase by the general annual inflation rate (assumed to be 3.4%) from 2008 to 2012
2. Assumes that UK cancer drug expenditure increases each year at the same rate as the Wood Mackenzie global forecast (c. 8.5% CAGR)
- 3A. Assumes that UK cancer drug expenditure is increased to match the average W. European rate by 2010, and is maintained thereafter
- 3B. Assumes that UK cancer drug expenditure is increased to match the average W. European rate by 2012.

regimen permits. Lengthy, complex chemotherapy infusions may require an in-patient stay. The preferred model for patients should be offered equitably across the North West. The NCAG report will require consideration of the future delivery models. The resources released from this shift from the in-patient setting can be used to support these new models of care and the cost of new drugs.

Pledge 15: By 2012 Chemotherapy and other systemic therapies will be delivered as close to home as possible where this is safe to do so.

Action 5: By October 2009 all chemotherapy service providers will collect and return an agreed dataset on all patients receiving chemotherapy so that standardisation of use across the North West can be better monitored

12.6 As EURO CARE 4 highlights, we are lagging behind on outcomes. It will not be enough for England to achieve earlier identification and treatment of cancer patients to catch-up with Europe; we also need to improve patient access to new innovative cancer drugs. The cost of these oral agents may be higher, however this can be offset in other ways. Providing safe governance and patient concordance with these regimens can be assured, there will be a gradual shift towards fewer inpatients stays and more ambulatory care offered in the community. The process of approval of drugs which are proving effective through clinical trials will be accelerated and increasingly the introduction of new drugs will be uniform across the North West.

Action 6: Networks will examine the reasons for the variation in spend on chemotherapy and seek to reduce variation over time. All networks will examine the NCAG²⁵ report and ensure its recommendations are embedded in their local strategies. Variations in prescribing practice between clinicians will be examined for appropriateness.

13. Surgery

- 13.1** Surgical treatments for the common cancers such as breast and bowel cancer is delivered in most hospitals, (where there is a critical mass) and therefore close to patients' homes. For the less common cancers there will be fewer centres undertaking more complex care in accordance with NICE Improving Outcomes Guidance (IOG).
- 13.2** The importance of implementing national guidance cannot be overstated as these demonstrate that services are both properly organised i.e. through MDTs, and working safely to protocols and pathways which are clinically effective in terms of outcomes. There is evidence from previous reviews, cancer peer review and the National Cancer Action Team that the implementation of national policies on the organisation of specialist services in the North West has not kept pace with national requirements. Overall, quantitative assessment of service organisation is lower in the North West than the rest of England except Greater London. The reconfiguration of specialist surgical oncology has been slower and remains incomplete. Whilst all plans are currently approved by the Cancer Action Team, some milestones have been missed and others have been marked as high risk, and in some cases not accepted as the direction of travel by provider organisations.

Pledge 16: Commissioners will only commission care from hospitals specifically designated to deliver care in accordance with NICE Improving Outcomes Guidance by 2012 at the latest.

- 13.3** Peer Review is an external quality assurance programme to test the quality of local services against quality measures defined through the national Cancer Action Team interpreting NICE²⁶ Improving Outcomes Guidance (IOG). The Peer Review process for cancer services has proved a significant driver for service improvement. Whilst this process may move towards more self-assessment in the future, it is expected that a continual process will lead to organisations becoming self improving. Most organisations providing cancer services in the North West have been reviewed with good to high compliance in most trusts.

Pledge 17: Commitment has been given by all PCTs across the North West to accelerate the implementation of the plans where these have slipped behind national implementation milestones. In addition network organisations should ensure that peer review action plans are also actioned. A state of readiness report and IOG remedial action plan (if appropriate) will be required for each network by September 2008.

- 13.4** Surgery remains a critically important treatment for cancer and will continue to improve. Where possible, patients should be offered the latest surgical techniques such as laparoscopic and robotic surgery.

²⁶ National Institute for Health and Clinical Excellence
May 2008

Pledge 18: Network organisations will ensure that all surgeons can access training in these techniques. Agreed new technologies such as laparoscopic procedures (e.g. for prostate, gynae and renal cancers) will be introduced once these become more the norm in practice and PCTs will then only commission from those providers who can offer these techniques.

- 13.5** The challenge around some cancers such as Sarcoma, Brain and Children and Young People will require close working between the three cancer networks and the North West Specialised Commissioning Group. In line with IOG, these services require a degree of centralisation and specialisation and it may be that fewer centres than at present will be accredited to provide these services. As a result these services may not be as local to patients as they are currently or as patients might wish. However, patients have told us that they are willing to travel greater distances, if required, to access the services offered by such centres of excellence and provided they can be assured of this quality.

Pledge 19: We will balance the needs of travel distances with the need to concentrate some services in fewer locations for the rare cancers. Clinical guidelines will be standardised across the North West centres where there is more than one using best practice guidance and tools such as the Map of Medicine.

14. Living with and beyond cancer

- 14.1** As a result of improved technologies and treatments more patients than ever are now living with and surviving cancer and as a result, greater the demand for supportive care will be. Although patients' experience of their care has improved in recent years, we want to do more to support and empower patients throughout their cancer journey. One of the aims of the CRS is to improve information for patients through a range of products and pathway initiatives. Tumour specific national information pathways will be launched in 2008, making nationally agreed information available to frontline cancer health professionals to offer to patients at key points in their cancer journey. These information pathways will facilitate the roll out of information prescriptions. These will provide patients with high quality information, tailored to their individual needs. It is also intended to expand the provision of communications skills training for healthcare professionals. NHS Cancer Patient Experience Survey Programme will also be established and surveys conducted annually.
- 14.2** The CRS promotes continuity of care for patients and wants particular consideration to be given to the role of Clinical Nurse Specialists (CNSs) who play a critical role in cancer care. Patients repeatedly report how much they value the role in terms of assessing familial risk, continuity of care, support during treatment and psychological support. There is considerable variation in the numbers between networks and their access to training.

Pledge 20: By listening to what patients tell us, we will constantly keep under review their views through a series of surveys and through Network Patient Partnership and other Patient and Public Involvement arrangements. We will ensure providers have robust systems in place to measure patient satisfaction and then act upon the findings. Providers will also ensure that professionals access the appropriate education and training e.g. in communication skills.

- 14.3** Other nursing models also now exist through the introduction of programmes such as the Integrated Cancer Care Programme (ICCP). The benefits include the co-ordination of their care with less frequent visits to hospital and fewer admissions. Care Co-ordinators can work as 'navigators' to assist patients as they are receiving active treatment and beyond treatment. ICCP nurses, in the model piloted within our region, are District Nurses with extended skills beyond cancer who can offer holistic assessments to patients who may have other co-morbidities such as heart disease or chest disease. They work closely with Clinical Nurse Specialists (CNS) who have the tumour specific expertise and research locally and nationally report that patients' experience of such programmes is positive. Alternatives to follow-up in hospital, such as in primary care, should now be explored.

Pledge 21: We want to ensure that all patients receive care as close to their home as is possible and that their stay as an inpatient is kept to a minimum. Where this cannot be avoided, we will enhance the quality of the patient experience, particularly for those with advanced disease. Continuity of care will be ensured through the transformation and development of nursing roles such as through implementation of the Integrated Cancer Care Programme (ICCP). This will also ensure that Clinical Nurse Specialists are used more effectively and appropriately.

- 14.4** Cancer patients and their families and carers may need psychological support throughout their journey. The range of support available will vary according to need from counselling through to specialist interventions reflecting the 4 tier model of care recommended in the NICE Supportive and Palliative Care IOG. The Improving Access to Psychological Therapies initiative will provide a single point of access and assessment for patients and generally enhance capacity.

Pledge 22: Patients and Carers will have access to an appropriate level of psychological support throughout and beyond their cancer journey. Using the Improving Access to Psychological Therapies initiative patients will be referred to an appropriate service once they are diagnosed.

- 14.5** For those patients with a terminal prognosis, they and their carers will want to be assured that their wishes and preferences around death are respected. The national End of Life Care Strategy is due to be published in the summer and will likely suggest that they are actively involved in choices about how and where their care is managed during the last days of life. This could be across a range of settings from hospitals, hospices to home (including care homes). The North West response on End Of Life Care arising from the Darzi review will consider End of Life across a range of disease areas not just cancer. Some of the tools

developed within the cancer arena such as the Liverpool Care Pathway and the Preferred Priorities for Care were developed in the North West. The End of Life Care clinical pathway for the North West is being published in parallel with this Cancer Plan. One of its key aims is to develop a framework which will reduce the number of inappropriate deaths in hospital. Quality standards and associated measures are also being developed by August 2008 against which organisations will be assessed.

Pledge 23: We will support patients in making choices around their end of life including increasing the number of people supported to die at home and to achieve their priorities for care.

Pledge 24: We support the agreed key recommendations of the End of Life Care clinical pathway group²⁷.

14.6 The CRS signalled that patients should have better access to information on the financial support that may be available to them. Information on financial benefits will be made available in the forthcoming national information pathways. Travel and loss of earnings are amongst the prime concerns of patients and the Department of Health is working to support people experiencing financial hardship. Employers need to have greater awareness of cancer in respect of the Disability Discrimination Act.

14.7 A new National Cancer Survivorship Initiative, in partnership with cancer charities, clinicians and patients, will consider a range of approaches to improving the services and support available for cancer survivors.

Action 7: Networks will await the national information promised and review access to Benefits Advisors and seek to rationalise this to ensure equity. We will await this national initiative to inform our local approach.

15. Reducing cancer inequalities

15.1 There are major inequalities in cancer incidence, access to services and outcomes, according to deprivation, race, age, gender, disability, religion and sexual orientation across the North West and nationally. The CRS has placed a high priority on ensuring that action is taken to reduce these inequalities. Inequalities impact on incidence, survival, mortality, patient experience and quality of life. These are linked to exposure to infections, genetic risk, awareness and attitude to lifestyle, uptake on screening services, access to diagnostics and treatment and provision of information. The improvements in access to services described elsewhere in the various chapters are all aimed at helping to reduce inequalities. Socio-economic deprivation is closely linked to high cancer mortality rates where death rates can be on average 15% higher. The table in section 7 shows the strong correlation between deprivation and cancer rates across the North West.

²⁷ End of Life Care Our NHS Our Future clinical pathway group for the NHS North West March 2008.
May 2008

- 15.2** An Equality Impact Assessment (EqIA) has been undertaken and will be published on the NHS Northwest website (www.northwest.nhs.uk). The six key areas of an EqIA require plans to consider the impact on the following groups:

Age
Disability
Gender
Race
Religion or belief
Sexual orientation and gender identity

An assessment of inequalities caused through socio-economic deprivation is not a legal requirement. However, it has been found to play a significant part in differing cancer outcomes. The strategies we require PCTs and networks to develop must seek to develop actions targeted at these groups building on examples already undertaken in MCCN for example regarding access for patients with Learning Disabilities.

- 15.3** Although a comparatively small chapter in this plan, the theme of minimising inequalities experienced by such groups of patients is woven throughout other chapters particularly screening, prevention, radiotherapy, chemotherapy and treatment. The focus on such groups and how this is translated into action will come through the strategic plans being developed by the autumn. Such plans will need to address both equity of access for these groups and consider the outcomes experienced by them.

Pledge 25: By the end of 2008 all networks will have developed rigorous action plans to reduce the health inequalities experienced by their population.

Pledge 26: The inequalities in cancer mortality rates will then be rigorously monitored by the SHA.

- 15.4** The government will begin a National Cancer Equality Initiative, bringing together key stakeholders from the professions, voluntary sector, academia and equality groups to develop research proposals on cancer inequalities, test interventions and advise on the development of wider policy. The National Cancer Equality Initiative will focus initially on optimising data collection to enhance our understanding of the inequalities that exist, promoting research to fill gaps in the evidence and spreading good practice.

16. Delivering care in the appropriate setting

- 16.1** New models of care can bring considerable advantages to patients. The reform strategy sets out a range of ways in which service models for cancer could be improved, based on two key principles: first, that care should be delivered locally wherever possible to maximise patient convenience; and second, that services should be centralised where necessary to improve outcomes. In all cases, care must be delivered by providers which conform to national standards such as the Improving Outcomes Guidance and which are fully integrated with other

services within the cancer network, though some patients will need to be supported if they choose to access IOG accredited services outside their 'home' network.

- 16.2** GPs and primary care professionals must have quick and easy access to relevant diagnostic tests, both to exclude cancer in patients with a low chance of having cancer and to diagnose cancer quickly in patients with a high chance of having cancer. We will work closely with commissioners to ensure that access to diagnostic services is maximised as this links closely to the 18 week target.
- 16.3** Regarding inpatient care for cancer, there are significant opportunities to shift some services from inpatient to ambulatory care. Evidence from successful pilots and international experience confirms that this shift improves the patients' experience and their outcomes whilst increasing the efficiency of services. The NHS Improvement Partnership and the Cancer Action Team are developing a programme of work on inpatient management to support local implementation of these new service models.
- 16.4** Over the past eight years inpatient admissions for cancer have risen by 25% from around 625,000 to 785,000 per annum nationally. Most of this increase relates to emergency inpatient episodes, which have increased by 47%, while elective inpatient episodes have increased by 8.6%. A large proportion of emergency admissions for cancer are managed by physicians in general medicine or geriatricians. Over the same time period elective day case episodes have risen by 50%. Around 60% of all cancer bed days relate to non-elective admissions.
- 16.5** Focussing on redesigning current delivery models of care will be a key priority for each network as the evidence at a national level would suggest that significant resources are tied up in both elective and non elective episodes of care and bed utilisation of patients with a diagnosis of cancer. Nationally this equates to 5 million beds days per annum with approximately 14,500 patients with a cancer diagnosis occupying beds in any one day. The re-design of some nursing roles such as through the ICCP should avert some unnecessary admissions. Tools already developed by the Institution for Innovation and Improvement such as The 'Opportunities Locator' which uses existing NHS data such as admission rates and OPD attendances to calculate the ratio of new to follow up appointments will help PCTs release resources and capacity.

Action 8: Networks will work with their providers to reduce the number of bed days occupied by 2012 and to bring follow up ratios in line with the national average where these are exceeded. Networks will support testing models and settings learning from projects already underway in the North West.

17. Using information to improve quality and choice as an enabler for delivery

Collecting and using improved information on different aspects of cancer services and outcomes is central to delivering this strategy. Better information will enhance quality, inform commissioning and promote choice. The CRS

recommends the collection of defined datasets of clinical outcomes information as part of the national model contract. To co-ordinate this work, a National Cancer Intelligence Network (NCIN) will be established, building, maintaining and quality assuring a new national repository of cancer data. The partner organisations within the National Cancer Research Institute (NCRI) will help fund research on the data collated by the NCIN, facilitating a more informed analysis of cancer services than has ever been possible before. The action described in section 9 will put the North West at the forefront of this work.

18. Stronger commissioning

18.1 Strong commissioning will be particularly important in driving service quality and ensuring value for money. Cancer networks will support PCTs in their commissioning role. They will provide the mechanism through which PCTs can carry out their partnership responsibilities effectively and they will act as agents for commissioners, maintaining the dialogue with clinical teams and users, agreeing clinical guidelines and pathways and driving forward innovative, high quality care.

18.2 A guide for cancer commissioners is currently in development, which will set out the appropriate level for the commissioning of different cancer services. Alongside this is the development of an electronic commissioning toolkit to provide commissioners with comparative data on incidence, survival and mortality from cancer and on information available from national sources such as hospital episode statistics.

Pledge 27: PCTs in the North West commit to the DH world class commissioning programme and the use of the cancer commissioning toolkit when available, through which standardised care across the North West can be monitored.

18.3 Cancer networks are the delivery mechanism for improvements to cancer care. Both the SHA and PCTs have concluded together that the networks, as currently configured, will be a key driving force for implementing this local plan in the North West.

18.4 The following assumptions have been made:

- a. Implementation of existing Improving Outcomes Guidance (IOG) is a given starting point for the plan with the agreed configuration being fixed points.
- b. PCTs will commission services in order to both meet the demand now and in the future whilst investing in prevention and early detection strategies concurrently to reduce the pace of increase in incidence and the prevalence burden for the longer term future.
- c. PCTs will recognise the burden of cancer in their Joint Strategic Needs Assessment (JSNA) for their population.

- 18.5** Given the scale of the problem, PCTs will ensure through the JSNA process that they have firm commissioning intentions for cancer services particularly as cancer tariffs and therefore Payment by Results is less developed within cancer. PCT will need to ensure the strategic fit of cancer plans within their overall strategic plans being developed by autumn 2008. Where patient flows cross network areas, service will be agreed with neighbouring areas. The Rare Cancers subgroup of the Specialised Commissioning Group will develop a decision making framework.
- 18.6** There are numerous references throughout the CRS to stronger commissioning which point PCTs in the direction of cancer networks to support them in this role. Networks across the North West have or are being reviewed in order to support cancer commissioning whilst maintaining strong clinical engagement with providers.

Action 9: Network teams will develop stronger links with leads for cancer in Professional Executive Committees and locality practice based commissioning arrangements in PCTs

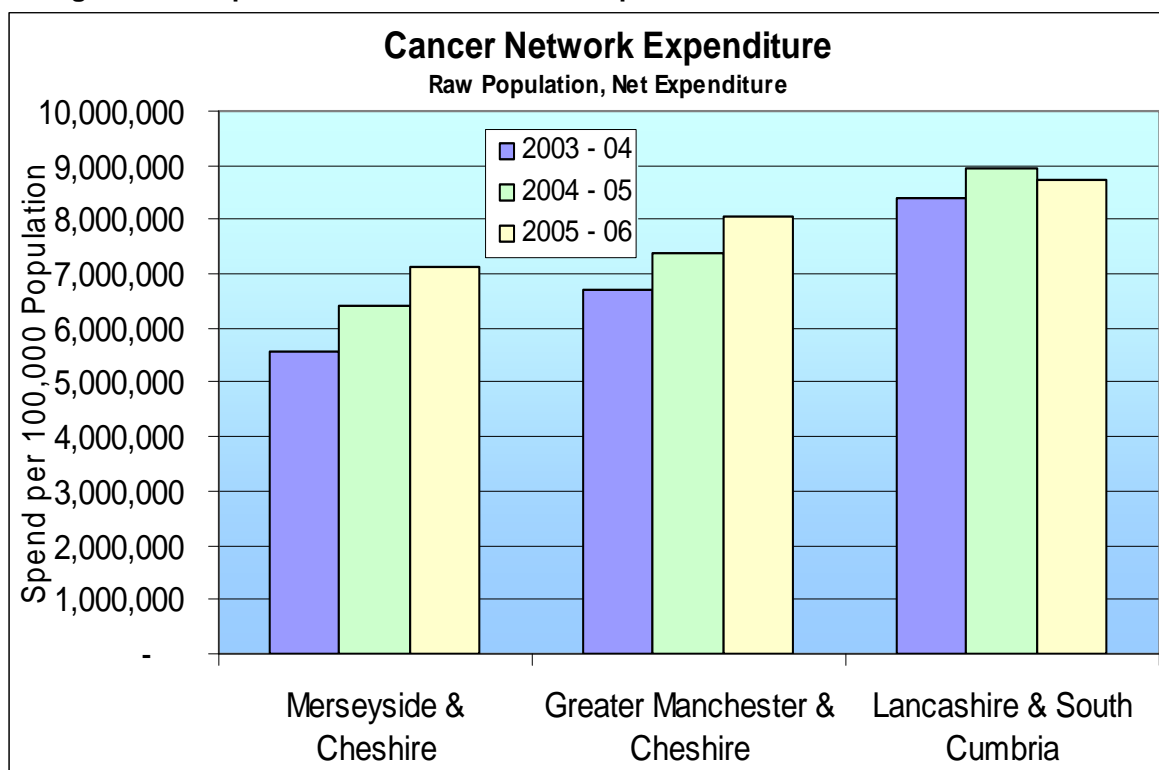
19. Funding Cancer Care in the North West

- 19.1** There is a variation in the level of investment across the North West and whilst growth has been more rapid in some parts of the North West, the financial implications of this plan need to address the level of growth in incidence and prevalence now predicted. Even if the cost of individual cancer episodes remained constant, more funding overall will be required to keep pace with the epidemiological and demographic changes. This does not necessarily mean all of the investments will need 'new' money. The CRS has pointed to where economies might be found and all networks and PCTs are committed to identifying these with a view to 'recycling' these efficiency savings. Through re-design, significant reductions in length of stay could be achieved.
- 19.2** The significant increase in demand for cancer treatment, through increased incidence and prolonged survival, requires a coherent commissioning plan for the right services to be delivered to the right people by the right teams in the right place. Analyses by the Department of Health²⁸ reveals a degree of variation in spend between the networks within the North West. These data are available at PCT level enabling comparisons with incidence of cancer and investment to be made which will inform future investment strategies.
- 19.3** Whilst the trend is upwards over the three years the data have been collected, the first year is thought to be unreliable for trends analysis due to the inaccuracies of coding between the programme budget headings. The last two years are thought to be much more reliable. However, the increased spend is not necessarily keeping pace with incidence and prevalence of cancer. PCTs will also need to consider this with spending on other programme headings.

²⁸ www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/index.htm
May 2008

19.4 The amount spent in the North West on cancer and tumours was £590,673,000 in 2005/06 compared with £497,965,000 in 2004/05 - an 18% increase. This was the fourth highest amount compared with other categories in 2005-6 compared with 2004-5 when cancer was only the seventh highest spend (see Figure 11).

Figure 11 Comparisons between networks expenditure



Source : DH Programme Budgeting

19.5 A 37% growth in cancer incidence will not necessarily translate into 37% increase in costs because of expectations that improvements in productivity, including more care outside hospital, will counterbalance cost of drugs etc. However, there will be a need to invest concurrently in the prevention of cancer whilst at the same time treating those predicted – double running for a period of five years would not be an unreasonable planning scenario as lifestyle changes will take some time to impact on the future burden. The Cancer Reform Strategy suggests growth in the order of 1.5% per annum in incidence should result in a similar increase in expenditure.

19.6 Funding will be made available to the NHS to invest in the latest cancer equipment and this is likely to be for the improvements to radiotherapy capacity and extension to screening programmes – for digital mammography in particular though the figure for the North West is not yet known.

19.7 Although the level of funding for cancer services in the North West has increased in recent years at a faster pace than some, given the levels of incidence and excess deaths we may need to accelerate this further over the next five years.

Action 10: The financial implications, as identified in the Impact Assessment of the CRS²⁹ will need to be modelled with PCT Directors of Commissioning and Finance in all PCTs. Networks will assist commissioners to model the financial impact of the growth in cancer incidence whilst ensuring that the savings from reducing unnecessary admissions and shorter lengths of stay are made available for re-investment in new technologies and treatments. Using the information available from Department of Health Programme Budgeting, PCTs will commit to invest in cancer services appropriately and according to need.

20. The NHS Operating Framework and National Contract

20.1 The Operating Framework both requires and enables PCTs to address cancer as extracted below. This presents an enormous opportunity for commissioners of cancer services to require the improvements in cancer as outlined in the CRS. In respect of cancer, PCTs will need to take particular action in 2008/09 to ensure progress:

2.41 *The Cancer Reform Strategy sets out the next steps that need to be taken by commissioners and providers of cancer services. Attention needs to be given to prevention, earlier diagnosis to ensure better treatment, improving patients' experience of care, and providing care in appropriate settings. To support this, we need to go further on our existing commitments in a number of areas, such as screening, access and NICE guidance.*

2.42 *PCTs will also need to ensure that providers of cancer services collect datasets as set out in national contracts.*

2.65 *PCTs will also want to begin preparing for action on those issues that will need addressing to secure future improvements in services and to ensure that they are in the best possible position to respond to future challenges.*

Specifically this includes:

• **end of life care:** *we expect PCTs to build on their baseline reviews of end of life care services, which were undertaken to support the forthcoming End of Life Care Strategy that is due to be published in tandem with the NHS Next Stage Review in summer 2008. A key element of the strategy will be to improve people's access to high-quality services, close to their homes. Central to the delivery of this change will be the development of rapid-response services and coordination centres;*

20.2 Using the levers available to them, PCTs can include clauses within contracts that commit providers to a range of specific actions to improve cancer services and as a minimum to engage with their cancer networks. An example would be as follows:

Using the new model contract, PCTs will require Trusts to ensure their clinicians are supported to engage effectively with their cancer networks on service planning and improvement.

²⁹ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_081004
May 2008

21. Building for the future

- 21.1** Securing the workforce for the present and future demands will be critical to the delivery of this plan. The commissioning of training places is a responsibility of the SHA but networks will need to identify the future needs. The key challenges to ensuring that there is the right number of people with the right skills, in the right place, at the right time to meet the needs of people with cancer and requiring palliative care throughout the North West are significant. Networks will support the development of a North West Workforce Strategy that enables commissioners and providers to implement the CRS and guidance such as the National Radiotherapy Advisory Group (NRAG) report.
- 21.2** The rate-limiting step to increasing treatment capacity will be the number and type of staff needed to treat patients and support departments. An integrated approach needs to recognise that the cancer and palliative care workforce sits within the wider health and social care workforce and often cannot be identified separately.
- 21.3** Education and training of the workforce is also a critical component of the workforce strategy so that cancer professionals are equipped with the necessary skills, including leadership. Networks will need to consider putting programmes in place to address this.

Action 11: Networks will work with the NHS North West to develop a NW Workforce Strategy by December 2008 to identify the shortages in both clinical and medical oncology and other cancer professionals. The SHA Workforce Directorate will use this to commission sufficient training places to build the workforce for the future. PCTs and providers will commit to developing their teams in accordance with this strategy. An Education and Training plan for each network will also be required to deliver skills training, including leadership.

22. Research and Development

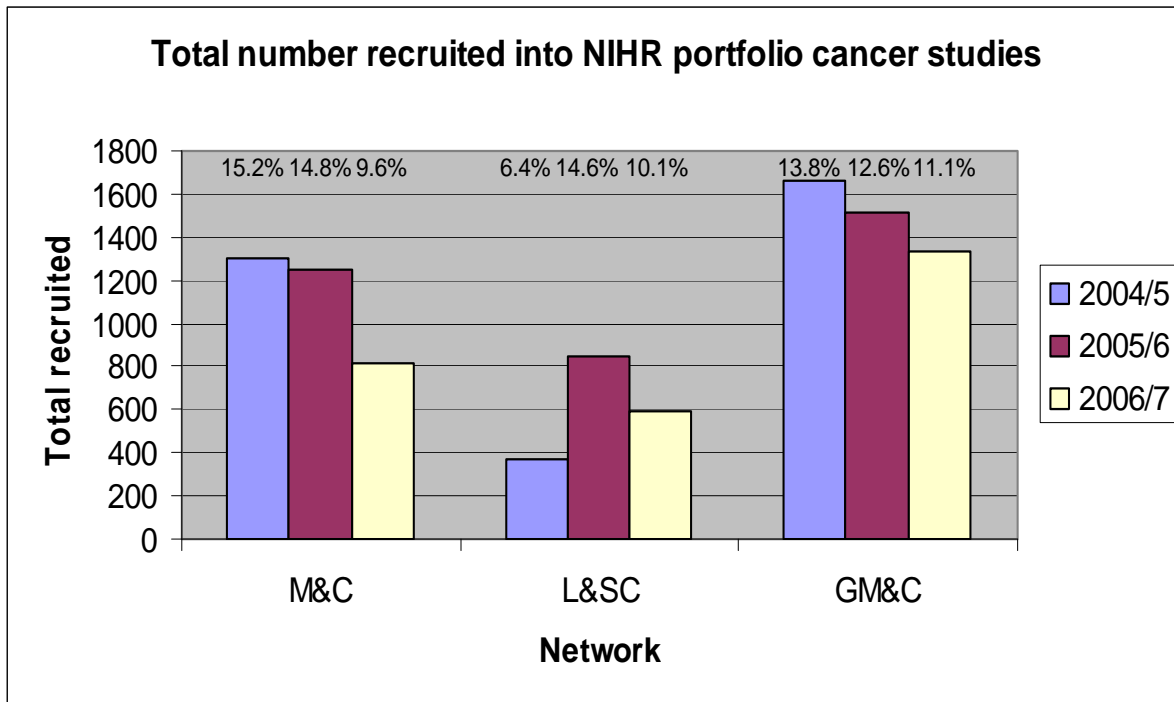
- 22.1** The contribution of research to improvements in cancer care cannot be overstated. In addition to the overarching benefits of improving knowledge and developing better treatments, there is reliable evidence that the clinical outcomes for patients participating in clinical trials are better than those for non-trial patients. It is therefore as important that patients have equal access to clinical trials as it is that they have equal access to treatment. There do, however, need to be coherent strategies around research if opportunities are to be maximised. Closer working with universities, NHS partners, charitable funders, industry and the Regional Development Agency is likely to produce the best results to attract funding and individuals with world class credentials and ambition. If we are to aspire to world class research, the NHS needs to support this through consideration of the optimal service models. This plan is not prescriptive about which service models will support this ambition as this will be for networks and PCTs to determine. The characteristics of world class cancer services can be defined as follows:-

- ◇ They integrate cancer services, research and education
- ◇ They have strong cancer registries which are the basis of much research and evaluation
- ◇ They have excellent operational performance and management
- ◇ They provide a comprehensive and equitable service to a local population
- ◇ They take a lead role whilst valuing their partners
- ◇ Academic leadership is secured.

22.2 The cancer centre model across the North West has evolved over time and we would wish all our cancer centres to aspire to the highest research ambitions which include cancer care across the spectrum from prevention and early detection to specialist treatments. Utilising NHS staff as health promoters should figure highly amongst all cancer service providers. Partnerships with Cancer Research UK such as already in Manchester Cancer Research Centre (at the Christie) are hopefully soon to be replicated in Liverpool. The branding of such centres and the goals of Cancer Research UK are fully supported (see Appendix II).

22.3 The Cancer Research Networks in the North West need to maintain and improve accrual of patients into trials in line with the National Cancer Research Institute's targets and ambition. The performance of the three Cancer Research Networks also varies across the North West though we believe cancer patients should have equitable access to the latest trials. The number of patients involved in clinical trials in 2006/7 was 2740 which meets the 10% target of the annual cancer incidence across the North West (see Figure 12). The national target for accrual into randomised controlled trials (RCTs) is 7.5%. It is recognised that this is a challenging target that requires a collective effort nationally. All research networks have been asked to formulate plans to increase recruitment into RCTs in future years. The 2006/7 performance is below target for all three networks.

Figure 12



22.4 In line with the yet to be published revised NCRI Strategic Plan (which will likely focus on early detection, diagnosis and prevention), the partners within the North West will work more closely together to ensure we deliver high quality research capability which builds on the key regional economic priorities for biohealth. This will include universities, charities and the pharmaceutical industry. Opportunities for funding research e.g. through the North West Development Agency and other funders are being actively explored. It is hoped that those differences between institutions (NHS or academic) can give way to collaboration to achieve the greater gain for our population.

Action 12: Networks are committed to working with the research community to develop a strong research capability. Research networks will work with cancer networks to ensure that patients have equal access to clinical trials throughout the North West.

23. Performance management arrangements.

The delivery of any plan to improve cancer services is only as good as the performance framework in place to monitor progress. The Strategic Health Authority will develop this framework.

Pledge 28: PCTs will ensure the ambitions and pledges in this plan are reflected in their strategic plans by September 2008.

24. Conclusion

This plan has broad support for its aims, objectives and pledges amongst cancer professionals and organisations involved in cancer service provision or commissioning. The plan will be available on the *NHS North West* and the network websites below. All PCTs in the North West will also publish this on their websites alongside their strategic plans on which they will be consulting. There are 24 PCTs in the North West and their websites can be accessed via the NHS North West Website or the respective network websites below.

NHS North West - www.northwest.nhs.uk

Greater Manchester and Cheshire Cancer Network – www.gmccn.nhs.uk

Lancashire and South Cumbria Cancer Network – www.cancerlancashire.org.uk

Merseyside and Cheshire Cancer Network – www.mccn.nhs.uk

Appendices

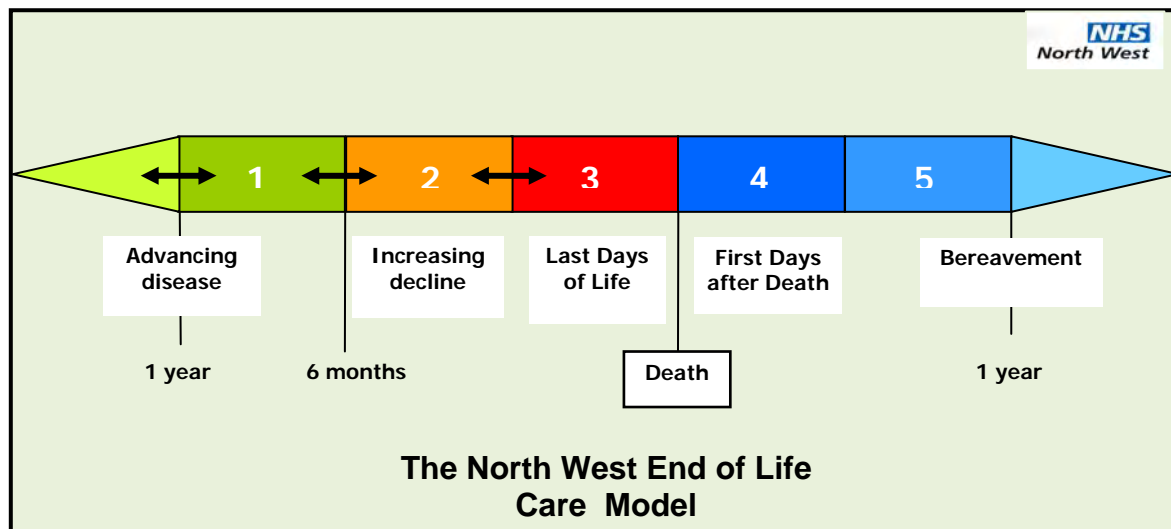
Appendix I

Key recommendations proposed by the NW End of Life Clinical Pathway Group

1. A robust integrated commissioning framework based on the North West end of life care model should be developed across health, social care, voluntary, charitable and independent sectors, with identified strategic leadership within each Primary Care Trust (PCT). This framework should enable a 10% reduction in hospital deaths by 2012.
2. Quality standards with associated measures should be developed to support self-assessment based on the North West EOLC strategy by August 2008.
3. A public campaign should be established to raise awareness about end of life care resulting in a more open conversation within society which also engages people's views about death and dying.
4. The NHS North West should continue to build on the current success of implementation of the National End of Life Care tools. Gold Standards Framework, Liverpool Care Pathway and Preferred Priorities for Care (GSF; LCP; PPC).
5. Advance care planning (ACP) should be undertaken in all sectors of care preferably electronically based. A person's preferences and choices should be identified, fully shared with all relevant staff and accessible 24 hours a day, 7 days a week.
6. Fully integrated and co-ordinated services should be available across organisations with 24 hour and 7 day access to specialist palliative care services. This should be underpinned by a single point of access for the person and their carers including documented evidence of the use of supportive care registers.
7. There should be in place evidence of comprehensive holistic assessment that clearly meets the person's individual needs. The assessment should be based on the North West EOLC model and standards.
8. Support should be provided for carers of all ages during the person's life and during the bereavement phase.
9. Workforce development with mandatory training and education in end of life care with a particular emphasis on effective and sensitive communication should be provided for all relevant staff, (clinical/non clinical) on a continuing basis. This is fundamental to ensuring quality in end of life care and must be a key feature in local delivery plans.
10. A strategy should be developed by the Strategic Health Authority (SHA), PCTs and the local authority to support a culture of change in end of life care, incorporating research, innovation and service improvement.
11. A financial investment programme should be identified to support the delivery of the health and social care, commissioning strategy.

The North West End of Life Care Model

The model of delivery advocated by the clinical pathway group uses a whole systems approach for all adults with a life limiting disease regardless of age and setting, moving from recognition of need for end of life care, to care after death. In order to apply the model, staff across organisations are required to understand the needs and experiences of people and their carers. The pathway model identifies five key phases:-



The model comprises five phases as described below with some examples of practice highlighted

1. **Advancing disease** – timeframe 1 year or more. Example of practice required - the person is placed on a supportive care register in General Practitioner (GP) practice/care home. The person is discussed at monthly multidisciplinary practice/care home meetings.
2. **Increasing decline** – timeframe 6 months [approximate]. Example of practice required - DS1500 eligibility review of benefits, Preferred Priorities for Care (PPC) noted, Advance Care Plan (ACP) in place and trigger for continuing healthcare funding assessment.
3. **Last days of life** – timeframe last few days. Examples of practice required - primary care team/care home inform community and out of hours services about the person who should be seen by a doctor. End of life drugs prescribed and obtained, and Liverpool Care Pathway (LCP) implemented
4. **First days after death** – timeframe first few days. Examples of practice required include prompt verification and certification of death, relatives being given information on what to do after a death (including D49 leaflet), how to register the death and how to contact funeral directors
5. **Bereavement** – timeframe 1 year or more. Examples of practice required include access to appropriate support and bereavement services if required

Appendix II

The Goals of CR-UK

The National Cancer Reform Strategy commends the goals of the CR-UK and NHS in the North West wholly subscribe to these which are reproduced below.

Cancer Research UK has developed ten goals to measure our success in beating cancer over the coming years. We will work with our partners to achieve the following by 2020:

1. People will know how to reduce their risk of cancer - Three-quarters of the UK public will be aware of the main lifestyle choices they can make to reduce their risk of getting cancer.
2. The number of smokers will fall dramatically - Four million fewer adults will be smokers, preventing thousands of new cases of cancer every year.
3. People under 75 will be less likely to get cancer - The chances of a person developing cancer up to the age of 75 will fall from more than one in four to one in five.
4. Cancer will be diagnosed earlier - Two-thirds of all cancer cases will be diagnosed at a stage when the cancer can be successfully treated.
5. We will understand how cancer starts and develops - We will have a detailed understanding of the causes and changes in the body in two-thirds of all cases of cancer.
6. There will be better treatments with fewer side effects - Treatments that accurately target the cancer and have few serious side effects will be available for at least half of all patients.
7. More people will survive cancer - Survival rates for all common cancers will increase, with more than two-thirds of newly-diagnosed patients living for at least five years.
8. We will especially tackle cancer in low income communities - The differences in the risk of dying from cancer between the most affluent and the least affluent will be reduced by half.
9. People with cancer will get the information they need - At least nine out of ten patients will be able to access the information they need at the time of diagnosis and during treatment.
10. We will continue to fight cancer beyond 2020 - Sufficient scientists, doctors, nurses and infrastructure will be in place to ensure continued rapid progress in the fight against cancer beyond 2020.