

NCIN

national cancer
intelligence network



Using information to improve quality & choice

Lung TSSG Chairs' Workshop 2011

www.ncin.org.uk

Cancer Networks Lung TSSG Chairs' Workshop

Mick Peake

Glenfield Hospital, Leicester

National Clinical Lead, NHS Cancer Improvement

Clinical Lead, National Cancer Intelligence Network

Partners in the TSSG workshop

- National Cancer Intelligence Network
- National Cancer Action team
- National Cancer Peer Review team
- NHS Cancer Improvement
- National Lung Cancer Audit team
- (*DH Cancer Policy Team*)

AIMS

- An update session for Network Lung Cancer leads
- To illustrate how the NCIN is developing new ways of looking at data relating to lung cancer & mesothelioma
- An opportunity for the leads to 'network' and share ideas
- To identify a few of the more topical issues to be debated in depth
- To create an opportunity for feedback to the national team and help inform the direction of national policy

- Attendance certificates available on request
- Ideas about future meetings welcome:
 - Format
 - Frequency
 - Content
 - Range of attendees
 - Site
- Please email me or Nicky Coombes
 - mick.peake@uhl-tr.nhs.uk
 - nicky.coombes@ncin.org.uk
 - (available via NCIN website – www.ncin.org.uk)

Thoracic Oncology: A National Update

Mick Peake

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National Clinical Lead, NHS Cancer Improvement

Clinical Lead, National Cancer Intelligence Network

Some topical issues in lung cancer

- NICE guidance imminent
 - Access to EBUS/thoracocopy (waiting times)
- Pathology – NSCLC subtypes & EGFR status
- Variation in resection rates
 - MDT membership / attendance (peer review)
- Early diagnosis
 - NAEDI / international benchmarking / screening
- Support for CNS role
- Follow up (survivorship)
- Acute oncology

Overarching NHS context

- Financial constraints
- White Paper
- GP Commissioning
- NHS Commissioning Board
- Public Health England
- Improving Outcomes: A strategy for cancer
- (New NICE guidance)



Improving Outcomes: A Strategy for Cancer

January 2011

What is meant by an “outcome strategy”?

- Major focus on outcomes!
- Outcome strategies will cover topics (e.g. cancer) which require action from Public Health England, the NHS and/or social care (i.e. not simply the NHS)
- Cancer is the first topic to have an outcome strategy.

New evidence

The strategy takes account of a wide range of new evidence, including:

- Findings from the **International Cancer Benchmarking Partnership** – showing one year survival rates in the UK remain poor in comparison with other countries (Lancet Jan 2011)
- International variations in drug usage (July 2010)
- **Routes to diagnosis** – 23% of cancer patients present as emergencies (NCIN 2010)
- A review of cancer registration
- National overview of cancer **peer review** 2009/10
- Cancer **patient experience survey** (December 2010)
- New research on screening (bowel and flexible sigmoidoscopy)
- NAO report on cancer (November 2010)

Information and choice

- Information will be central to the drive for better outcomes
- Presumption of patient choice – informed by reliable information on services and on outcomes
- The new strategy recognises the progress that has been made on information through the **National Cancer Intelligence Network (NCIN)** and through the Information Prescriptions partnership, but recognises that further work is needed on:
 - **data collection** (e.g. **stage**; chemotherapy; date of recurrence)
 - making information available in appropriate formats for patients, clinicians and commissioners

Improving outcomes: Emphasis on one year survival

- **One year survival** will be a key indicator of progress on the strategy. This will require action from both public health and the NHS
- There is a time lag in collecting one year survival, so proxy measures will be introduced
 - **Proportion of cancers diagnosed at stages 1 and 2**
 - **Proportion of cancers diagnosed through emergency routes**
 - **GP usage of diagnostic tests**
- Providers will have a duty to include **staging data** in the information they supply to registries
- Publication of data by cancer registries will be speeded up

Improving outcomes: level of ambition

- “Our aspiration is that England should achieve cancer outcomes which are comparable with the best in the world”
- We believe that by 2014/15, **5000 additional lives can be saved each year**. It is now for the NHS, working with PHE to deliver this ambition.
- Note: The “additional 5000 lives” will require England to match the European average. Approximately 10,000 additional lives would be saved if England was to match survival achieved in Sweden (and Australia and Canada)

“Outcomes not process targets”

- A review of the cancer waiting times standards was undertaken in parallel with development of the new strategy.
- After extensive consultation it was concluded that these standards remain relevant to patient care and should be retained.
- The strategy confirms that the **waiting time standards should be retained.**

Improving outcomes: Prevention and early diagnosis

- Public Health England (PHE) will be responsible for a range of services relevant to cancer
 - Public health intelligence
 - Primary prevention interventions (e.g. tobacco)
 - HPV vaccination services
 - Cancer screening programmes, including QA
 - **Targeted campaigns to raise public awareness of symptoms and to encourage early presentation**
 - **Cancer registries**

Improving outcomes: promoting earlier presentation

- £10.75 m local and national “signs and symptoms” campaign
- **Local campaigns** involving over 100 PCTs are focusing on breast, bowel and lung cancer, where the numbers of ‘avoidable deaths’ are largest – **18 pure lung cancer projects, many more include it**
- DH is piloting a centrally led campaign in two regions (East of England and South West) in February/March 2011. This will focus on bowel cancer. If successful this will be rolled out across the country

Early diagnosis: The NHS role

- GPs will continue to have an important role in encouraging patients to present early and to communicate benefits of screening
- A **risk assessment tool** to support GPs is being developed
- GPs will be given better access to diagnostic tests (e.g. **chest x-ray**, ultrasound, lower GI endoscopy, brain MRI). This should reduce the need for referrals to secondary care. Guidelines will be developed, together with benchmarking data.

Inpatient stays and emergency admissions

- The large majority of cancer patients do not want to be admitted to hospital unless absolutely necessary and wish to be in hospital for as short a time as possible when this is necessary
- NAO report highlights scope to **reduce inpatient admissions and average length of stay**. Taken together this could save over £200 million p.a.
- DH Impact Assessment for the new strategy indicates that it should be possible to go further.

Inpatient Costs By Tumour Group

	In Patients	Day Cases	Total
Breast	£161,766,566	£29,547,803	£191,314,369
Colorectal	£237,498,834	£34,980,438	£272,479,272
Lung	£205,589,816	£17,333,829	£222,923,645
Upper GI	£187,176,356	£16,274,844	£203,451,200
Urology	£264,262,283	£34,909,932	£299,172,215
Haematology	£278,799,020	£103,878,769	£382,677,789
Gynaecology	£99,156,465	£13,701,543	£112,858,008
Neurology	£96,617,619	£3,710,744	£100,328,363
Head & Neck	£60,996,098	£2,432,666	£63,428,764
All Others	£316,267,883	£66,340,939	£382,608,822
TOTAL	£1,908,130,940	£323,111,507	£2,231,242,447

Excludes Regular Day Attenders (Total Costs £63m)

Shaping the Levels of Ambition

Lung & Urology Urgent & Emergency Care Workshop

10 March 2011; Holiday Inn London Bloomsbury



- To build the evidence base of best practice for emergency/urgent care – testing in lung and urology conditions.
- To align best practice with new initiatives – the new Urgent Care number 111
- To explore options to deliver emergency/urgent care in alternative settings

Register on line <http://bookwhen.com/u5h7g> Password: **emergency**

Or Email marie.tarplee@improvement.nhs.uk

Supporting quality services

- Multi-Disciplinary Team working emphasised
- Cancer Peer Review supported
 - aim is to reduce the burden on the NHS by around 40%
- Current national clinical audits will be maintained. We would expect new audits to be introduced over time

Improving outcomes: Commissioning

- Cancer commissioning is complex and will involve NHS Commissioning Board (specialised services), GP consortia and local health and well-being boards
- Stronger commissioning will be supported by the development of **NICE quality standards (lung starting soon!)**
- NCAT will work with networks and GP consortia (pathfinders) to develop commissioning support packs
- **Cancer networks will be funded during the transition.** Thereafter, it will be for the GP consortia and the NHS Commissioning Board to determine how support should best be provided

National support for implementation

- National Cancer Director post will remain important
- Implementation Advisory Group established
- NCAT, NHS Improvement and NCIN will support the implementation of the first phase of the strategy. Future arrangements remain to be determined.
- Annual reports on progress will be published

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NCIN Update

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NCIN - Update

- National Cancer Data Repository
- National Cancer Dataset
- NCIN Lung Site-Specific Clinical Reference Group – work programme with Thames Cancer Registry – data briefing on Mesothelioma
- Major Surgical Resection report
- ‘Routes to Diagnosis’
- Updating of Cancer Commissioning Toolkit
- NCIN Conference: 5th – 17th June 2011

National Cancer Data Repository (v2008)



Registry-HES linkage: 1985-2008 (England)

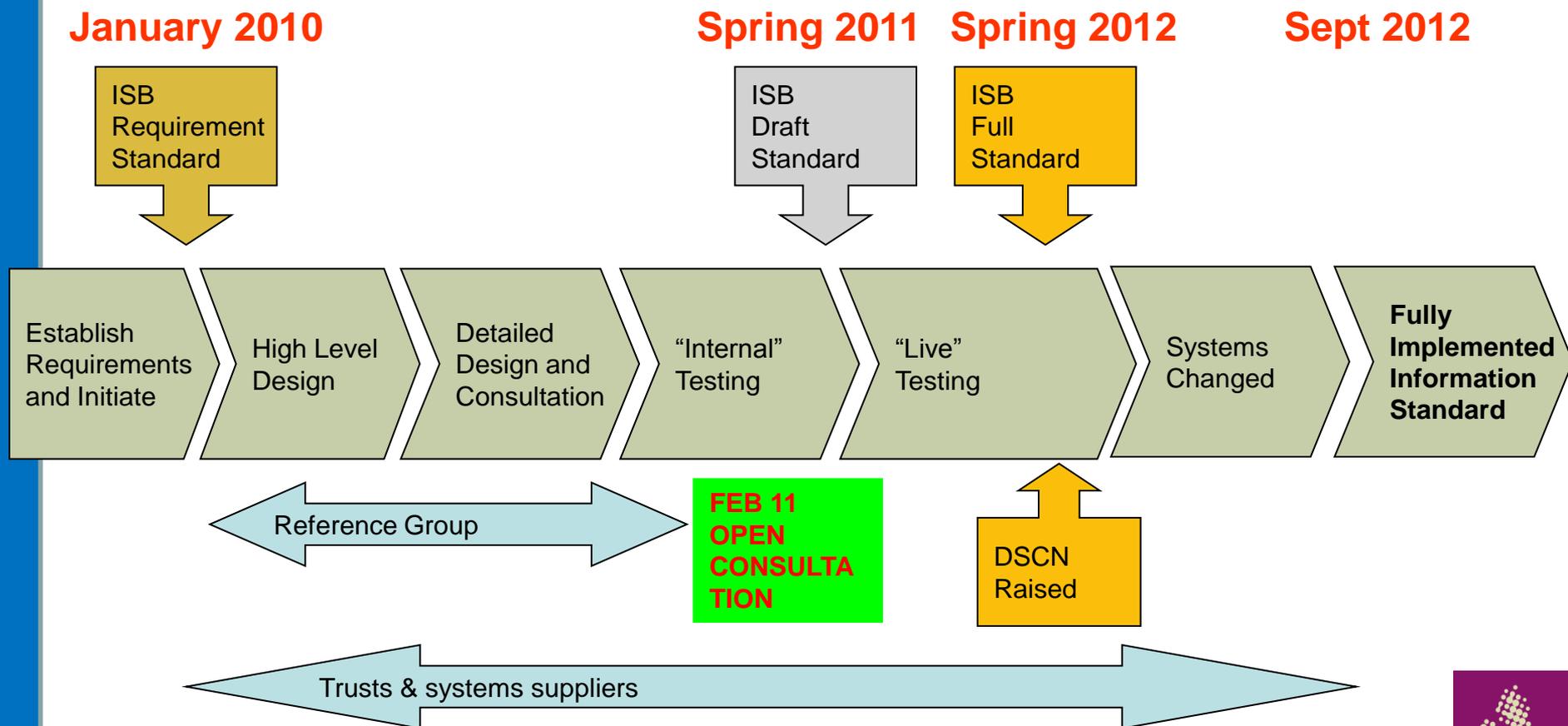
- 7.3 million tumour records from Registries
 - c. 30 fields of data
- 49 million hospital in patient episodes
 - c. 150 fields of data
- National Cancer Audit data
- Enables novel analytical approaches
 - ethnicity, co-morbidity, surgery, radiotherapy
 - non-cancer outcomes, hospital “footprints” (bed stay)
 - end of life resource use

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Cancer Outcomes and Services Dataset – Process overview (Trish Stokes)



Cancer Outcomes and Services Dataset – Progress last year



- Core dataset reviewed
 - Amendments, deletions and additions identified
- Site specific datasets agreed by Clinical Reference Groups
 - 11 items for lung
- Software Suppliers Day held in August
- First draft COSD dataset
- Definitional testing completed at Trusts
- Key staging RC Path items added
 - 9 path specific items
- Open consultation with all stakeholders – Feb to March 2011

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Definitional testing reports

COSD LUNG - CAPABILITY (Type of Match)

Date of Report 29/11/2010

Centre
for health and social care

Number of COSD Lung Data Items 11
Number of Sites Analysed 2

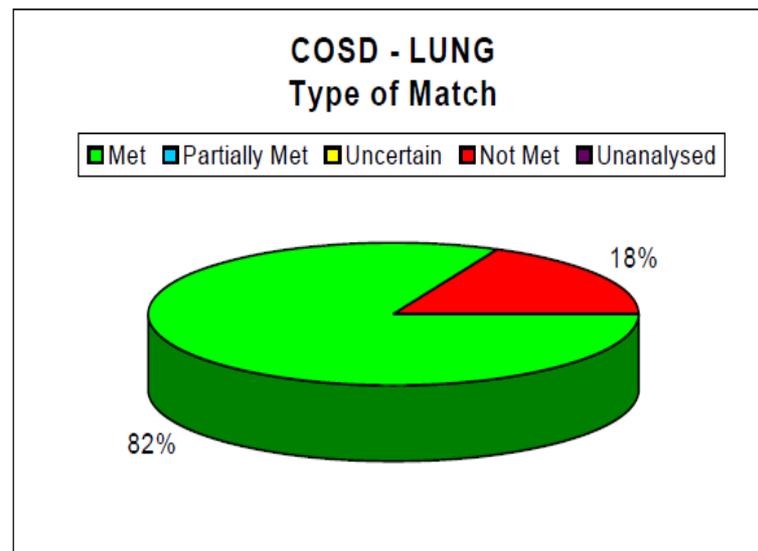
Systemic Capability*		%
System Capability	9	82%

* Including Met and Partially Met

Type of Match Category ¹	No. Data Items	%
Met	9	82%
Partially Met	0	0%
Uncertain	0	0%
Not Met	2	18%
Unanalysed	0	0%
TOTAL NO. DATA ITEMS	11	100%

SYSTEM(S) MAPPED

Somerset Cancer Register
In-house Dedicated Lung Cancer DB



¹ Definitions of Type of Match Categories

Routes to Diagnosis

*Lucy Ellis-Brookes &
Jon Shelton*

All Persons									Total	Number of patients
	Death Certificate Only	Emergency presentation	GP referral	Inpatient elective	Other outpatient	Screen detected	Two Week Wait	Unknown		
Acute leukaemia	0%	57%	17%	4%	14%		3%	4%	100%	2,551
Bladder	0%	18%	28%	2%	15%		32%	4%	100%	7,665
Brain & CNS	0%	58%	17%	4%	14%		1%	6%	100%	4,147
Breast	0%	4%	12%	0%	9%	21%	42%	12%	100%	34,232
Cervix	0%	12%	25%	2%	16%	14%	16%	13%	100%	2,085
Chronic leukaemia	1%	30%	30%	2%	12%		10%	16%	100%	2,869
Colorectal	1%	25%	24%	4%	15%		26%	6%	100%	27,903
Kidney	1%	24%	29%	1%	18%		20%	6%	100%	5,172
Larynx	0%	12%	32%	1%	21%		31%	3%	100%	1,583
Lung	1%	38%	20%	1%	13%		22%	5%	100%	29,420
Melanoma	0%	3%	29%	1%	11%		41%	16%	100%	8,117
Multiple myeloma	0%	38%	27%	1%	15%		13%	6%	100%	3,145
Non-Hodgkin's lymph	0%	28%	30%	2%	17%		16%	7%	100%	7,777
Oesophagus	1%	21%	21%	10%	17%		25%	4%	100%	6,001
Oral	0%	6%	28%	1%	30%		26%	9%	100%	3,062
Other	1%	36%	25%	2%	15%		14%	7%	100%	27,730
Ovary	1%	29%	22%	1%	15%		26%	6%	100%	5,012
Pancreas	1%	47%	18%	2%	12%		13%	6%	100%	5,989
Prostate	0%	9%	38%	3%	16%		20%	14%	100%	28,362
Stomach	1%	32%	21%	7%	16%		17%	5%	100%	5,841
Testis		10%	14%	2%	16%		48%	10%	100%	1,569
Uterus	0%	8%	31%	1%	16%		35%	8%	100%	5,733

- **Emergency Presentations – 23% overall**
 - Major variations between cancer types
 - Melanoma 3%, Breast 4%
 - Colorectal 25%, Lung 38%, Brain 58%
 - Most common in the youngest (0-24) and oldest (75+)
 - Major variations between PCTs

Findings

- **One year survival rates (%):**

	<u>All routes</u>	<u>Emergency</u>
• Breast	97	53
• Colorectal	73	48
• Lung	26	9
• Ovary	69	42
• Bladder	72	35
• Kidney	66	33
• Stomach	38	22

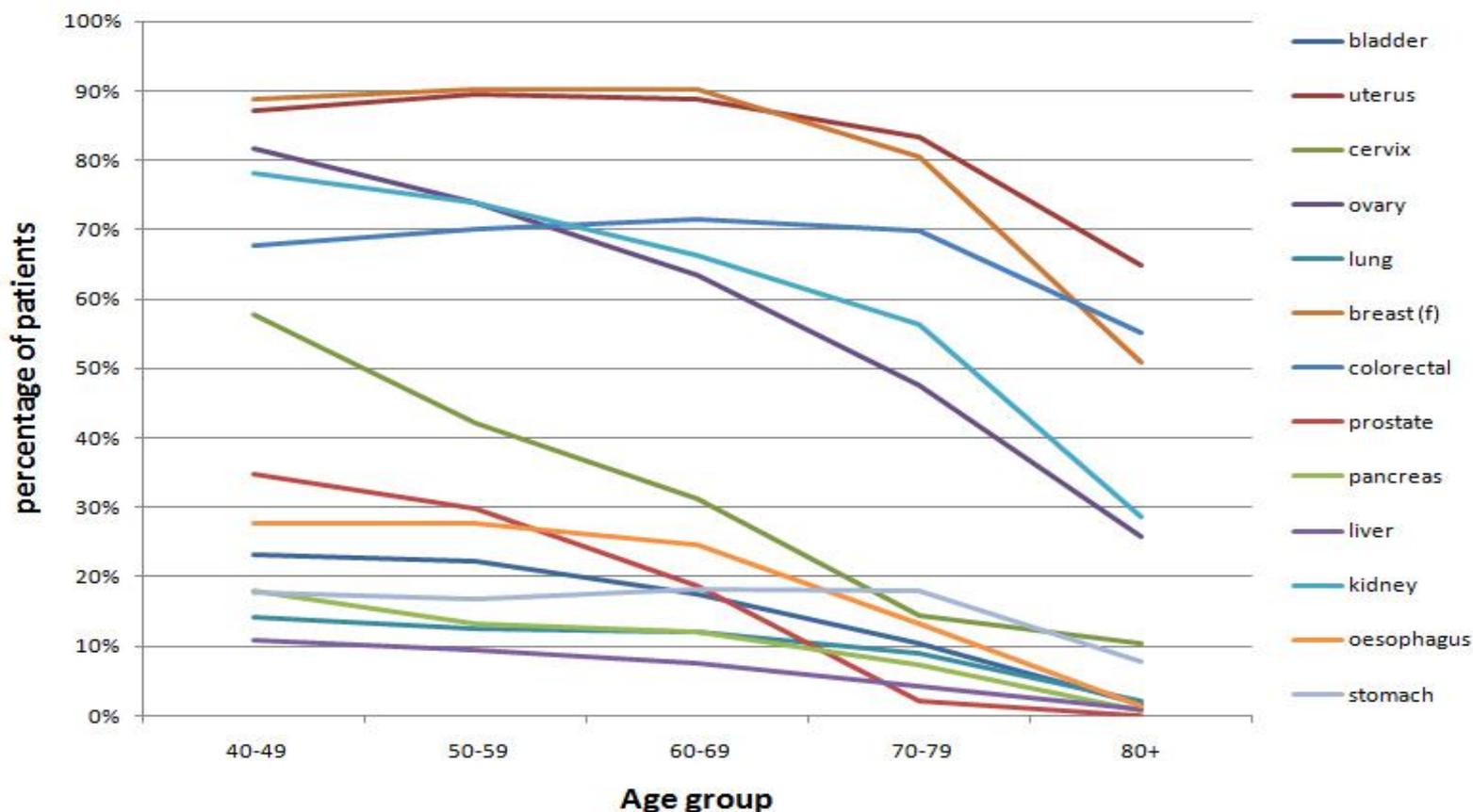
Major surgical resections
England, 2004-2006

Major Surgical Resections

Jon Shelton

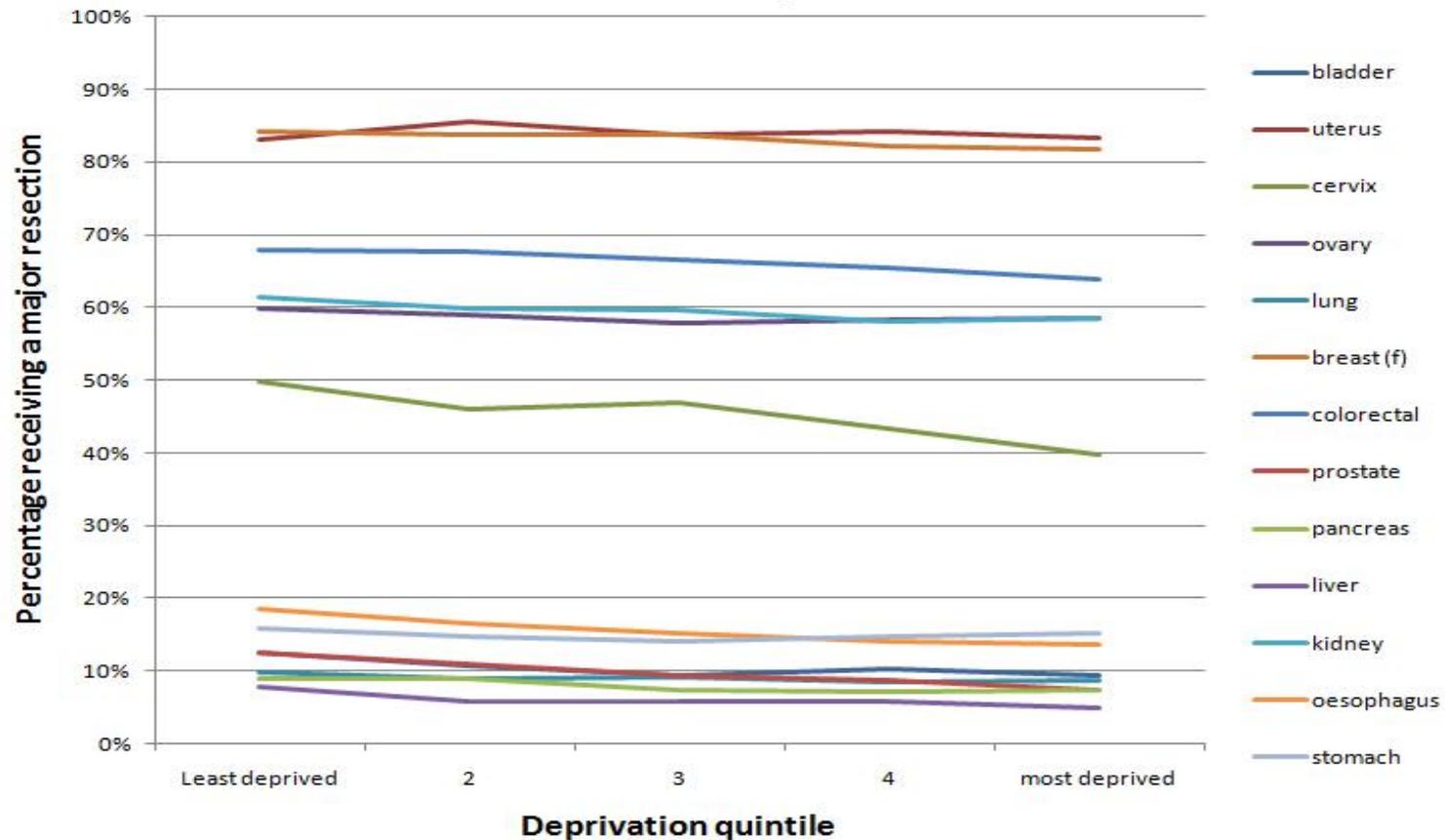
Major resection rates by age

Percentage of patients with a record of a major resection, by age and cancer site, patients diagnosed 2004-2006, followed up to 2007

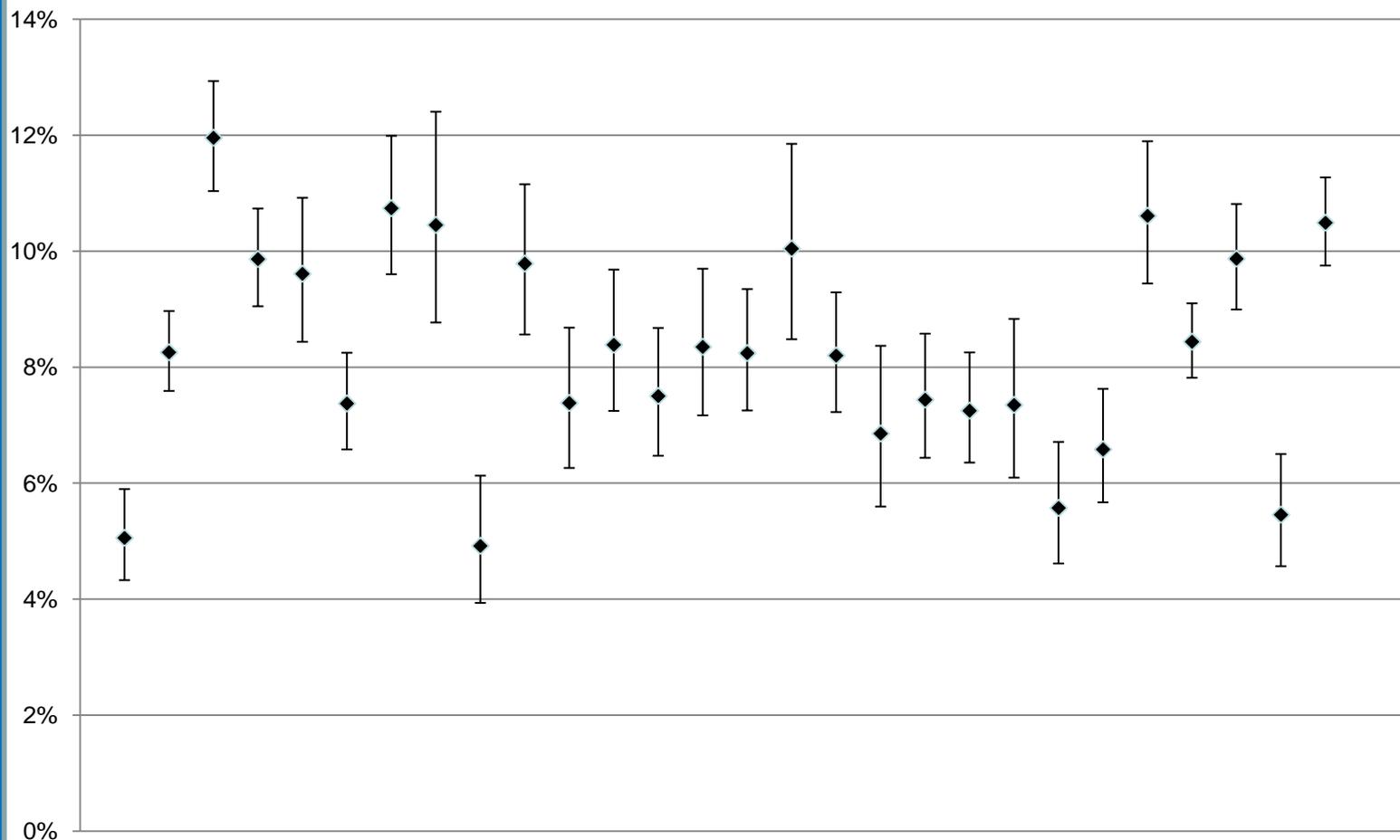


Rate by deprivation quintile

Percentage of patients with a record of a major resection, by cancer site and deprivation quintile, patients diagnosed 2004-2006, followed up to 2007



Cancer Networks – Lung



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The
Health
Foundation
Inspiring
Improvement

Improving Lung Cancer Outcomes Project

The Health Foundation is an independent charity working to continuously improve the quality of healthcare in the UK

- 2 year project
- NLCA metrics to drive local improvements
- New patient experience questionnaire
- Reciprocal peer review
- Facilitated quality improvement
- Disseminate the learning
- Bring all MDTs up to standard of the best





NCRI

National
Cancer
Research
Institute

**A REVIEW OF RESEARCH
IN MESOTHELIOMA AND
OTHER
ASBESTOS-RELATED
DISEASES
NOVEMBER 2010**



**British Lung
Foundation**



**A REVIEW OF RESEARCH
IN MESOTHELIOMA AND
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NOVEMBER 2010



- £3m over 3 years from 4 members of the Association of British Insurers
- Administered by the BLF
- First call for bids now open (via BLF website)

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Alignment with NHS reforms

‘Improving outcomes: A strategy for cancer’ sets out how the future direction for cancer will be aligned with:

- Equity and Excellence: Liberating the NHS
- Healthy Lives; Healthy people
- The new emphasis on:
 - Patient information and choice
 - Outcomes not process targets
 - Stronger commissioning
 - New arrangements for public health and local democratic legitimacy

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Improving outcomes: Quality of life and patient experience

- The new strategy builds on existing initiatives including:
 - The Advanced Communication Skills Training Programme (Connected)
 - The information prescriptions partnership
 - The National Cancer Survivorship Initiative
 - The Cancer Patient Experience Survey
 - New modelling on the costs/benefits of one-to-one support
- Results of the cancer patient experience survey can be used to incentivise improvements – An aggregate score will be derived for each Trust
- Patient Related Outcome Measure (PROMs) will be piloted for cancer survivors
- New tariffs will be developed to incentivise better ‘aftercare’ for cancer patients

Improving outcomes: better treatment

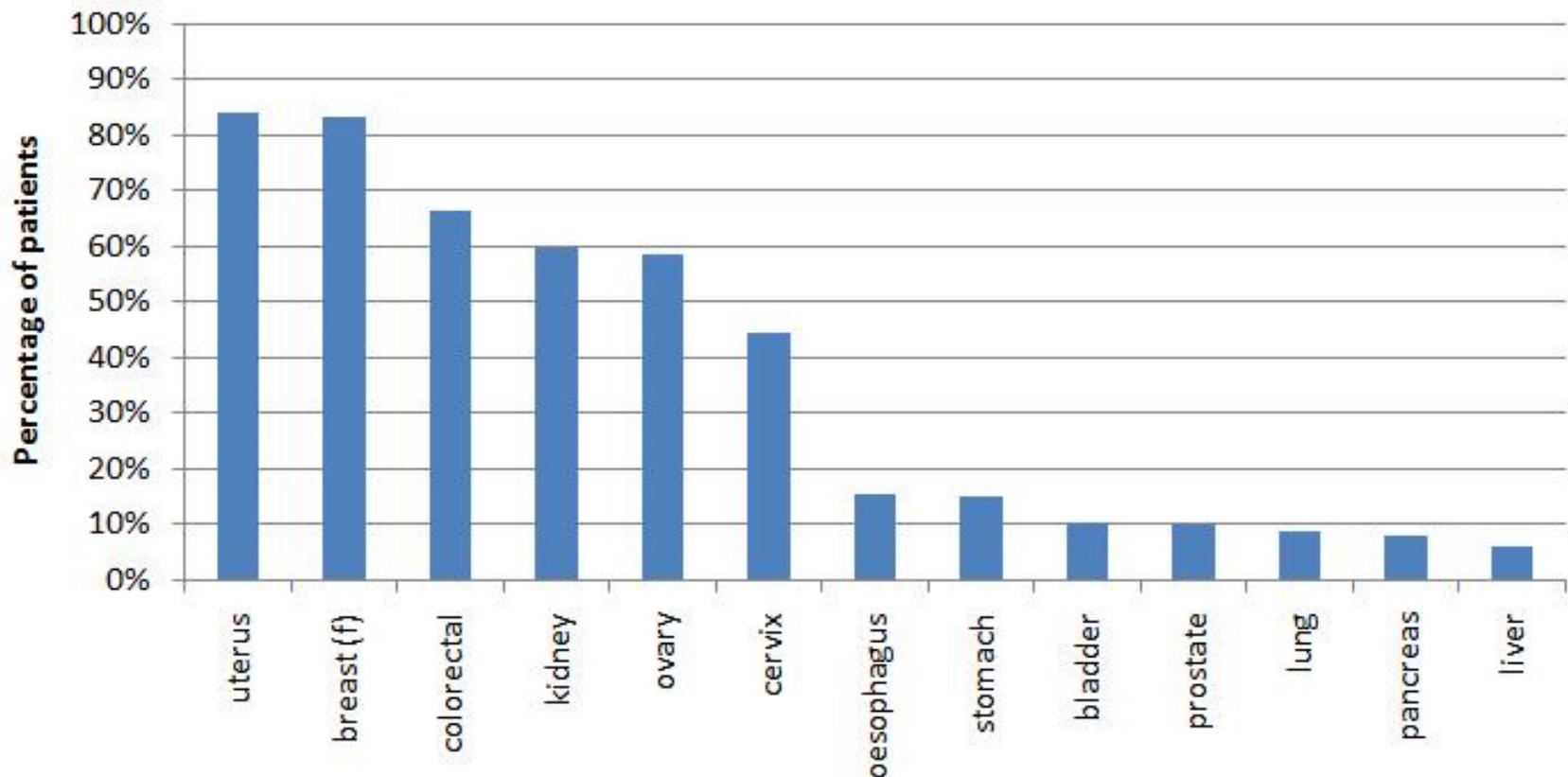
- Implementation of NCAG report on quality and safety of chemotherapy remains a priority – including acute oncology services. Note: This should reduce unnecessary emergency admissions
- Improve collection and publication of chemotherapy data – by April 2012
- Cancer Drugs Fund: £200m p.a. from April 2011. Details will be formulated following consultation and learning from experience with the interim fund
- Targeted/stratified medicine: Further work is needed to determine how best to undertake molecular testing

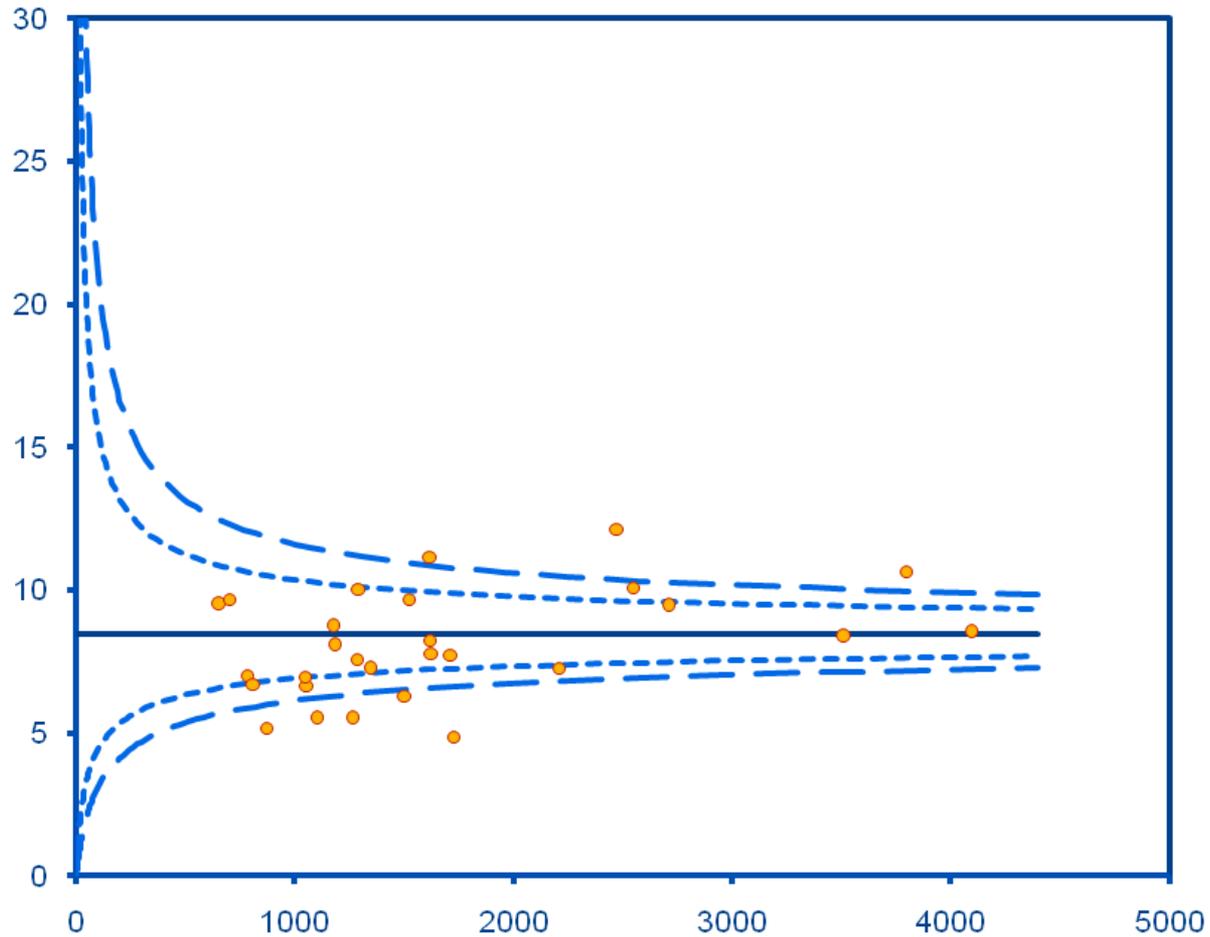
Funding the new strategy

- An economic impact assessment was published alongside the new cancer strategy
- The Government has committed a total of over £750m over the Spending Review period to achieve the outcomes set out in this strategy
- The main areas requiring increased expenditure will be:
 - Increased access to diagnostics for GPs
 - Flexible sigmoidoscopy screening
 - Public awareness campaigns
 - Radiotherapy (including proton beam therapy)
 - Increased use of surgery as more patients present with operable disease
- Much if not all of this increased expenditure can be balanced against potential savings on inpatient care
- The £750 m does not include the £200m for the Cancer Drugs Fund

Major resections: Headline rates

Percentage of patients with a record of a major resection, by cancer site, diagnosed 2004-2006, followed up to 2007





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The
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The Health Foundation is an independent charity working to continuously improve the quality of healthcare in the UK

Progress

- 92 of 156 trusts agreed to participate
- 30 trusts randomised to intervention group
- 24 visits completed
- 437 patient experience questionnaires returned
- Quality improvement work underway
- Baseline results presented BTOG poster

