12_Systems59_64 10-10-2004 19:09 Pagina 59

Britain's Cancer Czar

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Five years ago, Britain's Prime Minister, Tony Blair, put out a call for someone who could get a grip on cancer services and pull up standards across the country. Oncologist Mike Richards agreed to take on the challenge. His progress is being closely followed in the rest of Europe.

The Minister left his desk with its picture postcard view of the Thames in central London and joined his team of civil servants on easy chairs around a table. An outer circle of advisers perched on straight-backed chairs. It was a stunning day but nobody was looking at the view.

John Reid, Secretary of State for Health in the Tony Blair Government, was being briefed about a harmless looking Parliamentary question from a Member of Parliament for Bolton. "How many additional scanners have been provided in the NHS in the last year, and how many of these are in the north-west?"

In the world of Westminster politics this was an opportunity for the Minister to highlight extra money spent on cancer services, and a potential trap, from behind which the Conservative opposition might launch an ambush.

John Reid, famous for his somewhat gruff Scottish public persona, was not happy with the draft answer, because it did not say where the scanners came from. He told his civil servants: "They do not just appear from nowhere. It was our decision to provide them."

The Minister was concerned about where opposition politicians may direct follow-up questions. He wanted facts to rebut attacks, not apple-pie answers about doing everything possible, he growled, with a humorous aside about the loneliness of a Minister at the dispatch box.

However, he listened closely as an adviser explained about the problems of success. Far more people in the UK are receiving treatment for cancer than ever before. And as family doctors refer more patients for hospital tests (another success), the waiting time before receiving a diagnosis has risen in some areas. So too has the wait for radiotherapy treatment.

This adviser was not a civil servant, but Professor Mike Richards, medical oncologist and specialist in palliative care, from across Westminster Bridge at St Thomas's Hospital. He is the man Tony Blair appointed to transform services at a time when the UK was propping up European league tables. His official title is National Cancer Director, but he is better known as Britain's 'cancer Czar'.

Richards has learned to live with this title, although its suggestions of dictatorial power sit awkwardly on a courteous man who likes to

12_Systems59_64 10-10-2004 19:09 Pagina 60

listen. "It is not a title I would use, but if it raises the profile of the work and helps to get the job done then I do not object. My post reflects the fact that cancer is being given priority.
"I have what authority I have because Ministers have given it to me. My job would be impossible if I did not have their support. Equally it is very important that I am seen as independent. I also work with clinicians in the broadest sense of the word – doctors, nurses, professional groups, charities, patient groups, chief executives… a whole range of stakeholders in the cancer world."
Whether the title helped or not, the UK is doing something right. Cancer death rates in England are falling faster than in most of Europe. However, this is progress from a very poor beginning. And with 225,000 cases of cancer each year in England alone and 120,000 people dying from the disease, cancer remains one of the biggest health challenges.

The road to Czardom

In 1993 Richards became director of clinical services at Guy's and St Thomas' Hospital. He helped to develop a cancer network covering a large area of south London, improving links and communications between the General Practitioner family doctors (GPs) and the hospital specialists. Such networks are now a key part of the NHS (National Health Service) Cancer Plan for England.
In 1995 he was appointed as Sainsbury Professor of Palliative Medicine at Guy's, Kings and St Thomas' Hospital School of Medicine, focusing on pain relief and quality of life for patients whose cancers were not going to be cured. He continued to treat patients as a medical oncologist.
While Richards was happy in his work, he was nagged by a growing sense of unease about the overall quality of cancer care in the country. He remembers a phone call from another hospital where a colleague wanted advice about how to treat a patient following surgery for breast cancer. How big was the tumour? "We don't record the size of the tumour." Had the cancer spread to the lymph nodes? "In this hospital surgeons do not remove the lymph glands," came the reply.
After more fruitless questions Richards realised that he could not give his colleague any useful advice, except to change the policies of his hospital. "As a clinician I was able to treat a couple of hundred patients a year and I believe I was able to treat them very well, and that did give me a lot of satisfaction. But what about thousands of other patients who were getting sub-standard treatment?"
This was a question he was soon asked by the Prime Minister, who came to power in 1997 with a commitment to improve the performance of the NHS. By the late 1990s, results of the Eurocare 2 study were being assimilated. The high-flyers were Sweden, The Netherlands, France and Switzerland. The poorest results were from Estonia, Poland, Slovakia and Slovenia. Survival in England was classified as low for lung, breast, stomach, bowel and prostate cancers.
In 1999 the London School of Hygiene and Tropical Medicine and the Office for National Statistics published a study of cancer survival trends in England and Wales.
- Survival in England and Wales was lower than in comparable countries in Europe,
- There had been little or no progress for several lethal cancers in adults in 25 years,
- Thousands of cancer deaths were avoidable, and
- Poor people got cancer more often, and once they had it they died from it faster.

By now politicians had become alarmed. Was the UK really competing with Estonia at the bottom of European league tables?
Tony Blair called Richards to Downing Street and asked five questions. Was the situation as bad as the figures suggested? Why was it so bad? What would he do to change it? How long would it take? How much would it cost?

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12_Systems59_64 10-10-2004 19:09 Pagina 61

As National Cancer Director, Mike Richards, based at St Thomas's on the South Bank, provides a bridge between the world of cancer care and the world of politics across the river

The Plan seeks to bring care in every part of the country up to the standard of the best

Whatever Richards said must have sounded convincing. In October 1999 he was appointed as National Cancer Director.

Where do you start on a plan to deliver measurable improvements and set achievable targets for reducing cancer deaths?

Richards says: "We convened a workshop of experts to look at the big studies that compare England with European countries, and in particular the Eurocare study. It was vital to know how much reliance I could put on that data, and the answer resoundingly was that this was very largely fact, not artefact. That was very important."

"The first year of my task was taken up with what needed to be done across the board from prevention through to palliative care." In some areas Richards knew the shape of the reforms that he wanted. In others he relied on colleagues. "Did I know exactly what needed to be done on smoking? No, I am not an expert on that. Nor was I an expert about diet and fruit and vegetables and on screening etc., although I am more of an expert now than I was."

There was a need for a cultural shift – for the public to fear cancer less and to act more quickly, for GPs to speed up referrals and for hospitals to improve their response. There was also a need for resources if the NHS was going to deliver on its promises.

The Plan

The NHS Cancer Plan seeks to reduce three significant delays. The first is the delay between the time someone has symptoms and the time they

12_Systems59_64 10-10-2004 19:09 Pagina 62

seek medical advice. Some women delay a visit to their GP after finding a lump in their breast because they don't want to have their fears confirmed. Many people with advanced lung cancer simply have no idea, despite symptoms, that they are seriously ill, which is one reason why survival rates are so poor.

The second delay is in referring the right patients for the right tests at the right hospital. GPs see thousands of patients a year of whom only a few have cancer. Referral guidelines for GPs are currently being updated.

Third comes the delay in diagnosis and treatment once a patient is referred to hospital. The aim is that a patient should be seen at hospital within two weeks of an urgent referral, and that treatment should start no more than 31 days after diagnosis.

The Plan is about more than speeding up the process. It seeks to bring care in every part of the country up to the standard of the best. A system of 34 local cancer networks now covers the country, so that professionals in the community, local hospitals, cancer centres and hospices refer more accurately across organisational boundaries. Service improvement teams have been appointed to work with 1,600 specialist cancer teams in England to improve care through peer review.

Richards says: "That is one area where we will soon be able to say we are in the lead: 80% of patients are now seen by multidisciplinary teams, and that is higher than in America and in most other countries."

The National Institute for Clinical Excellence (NICE) has reviewed most of the major cancer areas and issued guidelines for diagnosis and care. Under the NHS, local Primary Care and Hospital Trusts have autonomy on how they commission services, and there is no guarantee that NICE guidelines will be implemented everywhere, especially when they recommend expensive treatments. However, Ministers have made it clear that they expect those commissioning health services to act promptly on advice from this authoritative source.

Cancer services now attract an extra £570 million (830 million euros) a year from central funding, which allows real progress in commissioning equipment and recruiting staff. Richards emphasises that change on this scale involves a long-term commitment by Government and at every level in the NHS.

"The NHS is one of the largest organisations in the world. It has 1.3 million people working for it. Whether it is bigger or smaller than the Chinese Red Army or the Indian railways I am not sure, but they always get compared. It is a constant challenge to make sure that communications get through.

"We have a relatively small full-time workforce of 10,000 to 15,000 oncologists, palliative care specialists and specialist nurses who deal with virtually nothing but cancer. There are a whole lot more for whom cancer is an important part of their working life: the chest physician who specialises in lung cancer, the colorectal surgeon who specialises in colorectal cancer. Then there are hundreds of thousands for whom cancer is a small part of their working life, including 30,000 GPs and 30,000 High Street chemists who may dispense hormone tablets to women with breast cancer.

"My post is about making sure the Plan does happen in all these areas. It is partly about winning hearts and minds, about communicating to those out in the NHS what the Minister thinks and about communicating back to Ministers what the NHS is thinking."

Richards seizes every opportunity to talk and listen to staff. He was due to open a new cancer unit in Ipswich. "There will be a lot of jollifications, but the value of my going is I will hear from people on the ground. Apart from cutting a ribbon it gives me the opportunity to hear from

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12_Systems59_64 10-10-2004 19:09 Pagina 63

consultants, senior managers and from radiographers and nurses. It is important that I keep myself grounded."

Amongst his most challenging experiences was addressing 450 teenagers who had survived cancer. They used keypad voting to prioritise their questions and each had a drum to indicate what they thought of the answers. A loud drum burst indicated approval; a single drum beat, boredom. "I can assure you they did not give me an easy time. They could give me instant feedback on what they thought of my answers."

Four years after the plan was published, his verdict is positive. "I have no doubt that we are making progress, whether on smoking prevalence, improving our screening programmes, cancer services in the community, improving services in hospitals or supportive palliative care services. If you look at the number of scanners and radiotherapy machines, all of these are going in the right direction faster than we have ever gone before. However, there is a huge amount more to be done before we have got the cancer services that the population deserves."

He acknowledges that targets can be a blunt instrument, but believes that these targets reflect clinical priorities.

"If the targets describe something important both from the patients' point of view and from the doctors' point of view, then having a target can be useful in focusing the efforts of everybody down the scale – from Ministers, Czars and chief executives to people in individual departments. We know that cancer waiting times have a very high importance to the public. If we are aiming to be a high-quality service, then these things matter.

"People have known about the targets for four years and have not questioned them, but they may start questioning them now that they are being forced to implement them. But everybody

BLUEPRINT FOR BETTER SERVICES

THE PLAN

The NHS Cancer Plan, published in September 2000, pledged to reduce cancer death rates in people under the age of 75 by one fifth over a 14-year period. The Plan also aims to reduce inequalities and promises a greater investment in recruiting and training staff and in equipment. It covers everything from primary prevention to detection and screening, diagnosis, treatment and palliative care.

TASKFORCE

A national Cancer Taskforce was established to drive the Plan and advisory groups have been established for individual cancers. They include GPs, hospital specialists, nurse specialists, managers, voluntary groups and patient representatives.

LIVING WITH CANCER

In a bid to improve care for people living with cancer, a National Partnership Group for Palliative Care and a Coalition for Cancer Information were set up. The National Cancer Research Institute was set up in 2001 to aid collaboration and identify gaps in research.

SCREENING

Four years into the Plan, the national breast screening service has been extended to include women aged 65–70. The cervical screening programme, which has reduced mortality in women under the age of 75 from 8 to 2 deaths per 100,000, is introducing liquid-based cytology to improve the quality of smear slides. A national screening programme of adults over the age of 50 will be introduced to detect early signs of bowel cancer. An appraisal is under way to decide between the faecal occult blood test and flexible sigmoidoscopy. A national screening programme will not be introduced for prostate cancer, but PSA tests are being more widely advertised and offered.

REFERRALS

Today, more than 98% of patients who are referred urgently are seen by a specialist within two weeks, while almost 97% of women with breast cancer receive treatment within a month of diagnosis.

PALLIATIVE CARE

The Plan also includes improvements for people living with cancer, with a review of care guidelines by the UK National Institute of Clinical Excellence and £50 million for specialist palliative care.

The NHS Cancer Plan is at: *www.publications.doh.gov.uk/cancer*
The three-year progress report, *Maintaining the Momentum*, is at: *www.dh.gov.uk/assetRoot/04/06/64/40/04066440.pdf*
The plan covers England alone, as Scotland and Wales run their own health services while Northern Ireland has its health service run directly from Westminster. Wales has a target to reduce cancer deaths by 20% by 2012. Scotland has its own strategy *Cancer in Scotland: Action for Change*, published in July 2001.

12_Systems59_64 10-10-2004 19:09 Pagina 64

has been saying these are sensible targets and they are reasonable."

It will be some years before European studies show the full impact of the Plan. But the latest figures show a rapid fall in cancer deaths in England and Wales, especially in lung cancer in men and breast cancer deaths in women. A three-year progress report of the Cancer Plan, published in October 2003, showed that the overall cancer death rate had fallen by 10.3%, ahead of schedule for the 20% target by 2010.

Richards acknowledges that much of this is due to a reduction in smoking. "This began before I ever came on the scene. The test for what we are doing is can we now accelerate?"

The UK has not yet shown the boldness of the Republic of Ireland in banning smoking in workplaces – including pubs. Moreover, Tony Blair's Government had its anti-smoking credentials dented soon after coming to power when it exempted Formula 1 Racing from a tobacco advertising ban, shortly after the Labour Party had taken receipt of a £1 million donation from the man who controls the sport.

The Plan does, however, include initiatives on smoking, diet and exercise directed particularly at areas of deprivation. The Public Health Minister, Melanie Johnson, chairs an inequalities group within the Department of Health focused on speeding up improvements in 73 Primary Care Trusts (PCTs) in deprived areas, and has set a target of reducing inequalities by 6%. But because PCTs in more affluent areas are also improving, it is proving difficult to close the gap.

PLAYING CATCH-UP

Richards visited many countries to see what the UK can learn and concluded that those with most success, such as Sweden and Finland, simply started doing the right things sooner. "I firmly believe that the targets are achievable, but we are trying to do in 14 years what they did in 19. The question is: Can we go faster?

"We were amongst the first to have a Plan. A lot of other countries are looking at how we have gone about that and whether that would be useful for them. There is recognition that to get the maximum benefit, it is the comprehensive nature of looking at everything from prevention through diagnosis, treatment and care that matters."

When progress was reviewed in October 2003 there was a very positive reaction from professionals and from patient organisations. Peter Cardy, Chief Executive of Macmillan Cancer Relief, said the plan was making a real difference to the patient experience. "There are some great initiatives such as user involvement, cancer leads [team leaders] in every primary care organisation and cancer networks that are really shaping future cancer services. We must ensure funding to continue these initiatives gets to the frontline."

A few days after his briefing, the Secretary of State told the Member of Parliament for Bolton South East that 29 CT and 16 MRI scanners were delivered to the NHS through centrally funded programmes in 2003–2004, of which six went to the north-west. The number of clinical radiologists had increased by 26% and diagnostic radiographers by 13%. There was no ambush, but his colleague Melanie Johnson was asked why waiting times for radiotherapy for breast cancer patients had risen in one area.

She responded: "To a degree we are victims of our own success: as a lot more women are identified, a lot more women need treatment." She also said that she had asked the national cancer director to look into the issue.

Another task for Professor Mike Richards and his team. The English patient seems to be responding to treatment but there is still much recovery to be made. It looks as though the NHS will have to keep taking the medicine.

Because more affluent areas are also improving, it is proving difficult to close the gap