NHS

Anglia Cancer Network

Agenda Item: **7**

From: **Dr Rory Harvey – Medical Director**

BOARD REPORT – Awareness and Early Diagnosis

Awareness and Early Diagnosis

1 Purpose

1.1 To report on information relevant to the Awareness and Early Diagnosis workstream:

- National Bowel Campaign update
- Be Clear On Cancer in Anglia (formerly outsmarting cancer)
- Supporting primary care (letter from Mike Richards Appendix I)

2 Background

2.1 The national policy document *Improving Outcomes: A strategy for cancer*[1] includes a chapter on improving awareness and early diagnosis. It is argued that awareness and early diagnosis is the main reason for the gap between the UK and other European survival outcomes and estimated that 11,000 lives a year could be saved if we matched the best survival rates. It sets a national target of achieving average survival rates by 2014/15 which would result in saving 5,000 lives a year. Anglia's survival rates are above the national average and Anglia Cancer Network's cancer strategy *Moving Forward on Cancer Services* sets out our aim to meet a more stretching target and match the best survival rates in Europe.

3 Key Points

National Bowel Campaign

3.1 As reported to the last board, the East of England and South West regions were chosen to pilot a national bowel cancer awareness campaign. The campaign ran from 3 February to 14 March 2011 and its objectives were to raise public awareness of the key signs and symptoms of bowel cancer and to prompt those with the relevant symptoms to see their GP. It consisted of a high profile advertising campaign featuring 'Be Clear on Cancer' branding.

3.2 The evaluation of the campaign is focusing on the following questions:

- Whether the public's awareness of relevant symptoms has changed (evaluated by DH using a pre and post campaign public awareness tracker survey).

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1 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123371

- Whether there is a change in numbers of people presenting to primary care (evaluated by the cancer network using GP read code analysis).
- Whether there is a change in referral activity (evaluated by analysis of Cancer Waiting times and cancer conversion rates).
- Longer term analysis will look at whether the campaign led to improved outcomes (evaluated using ECRIC's staging and survival data).

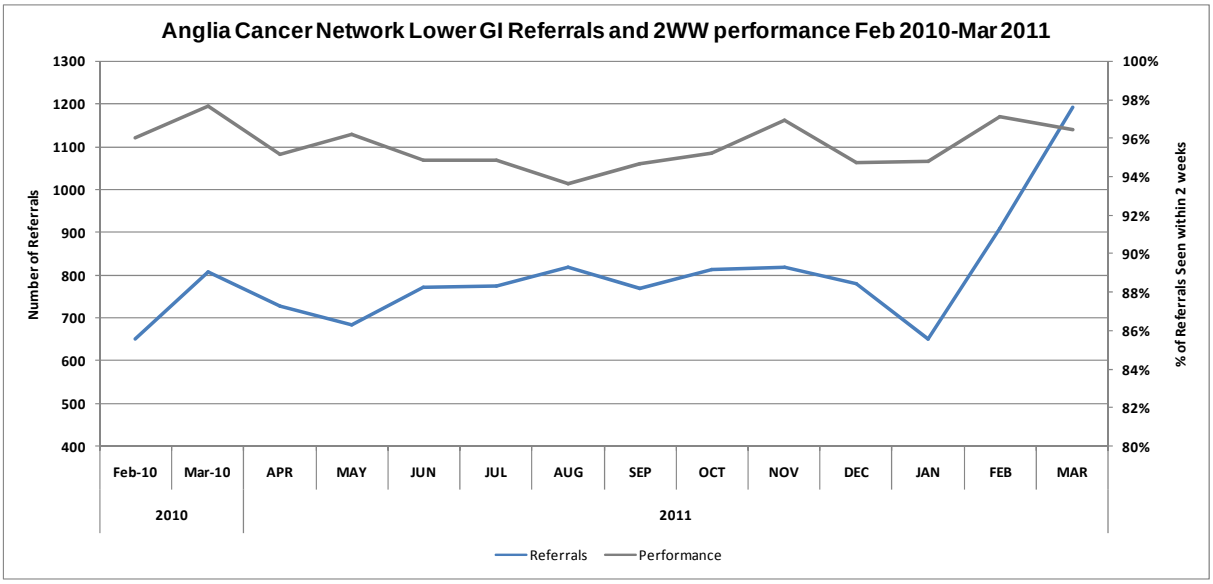
3.3 A meeting will be held 1 July and attended by those involved in the campaign to examine all the evidence emerging from the evaluation and identify lessons learnt. Following the meeting, the Department of Health will make a decision on whether to roll out the campaign nationwide. If it is rolled out nationally, the campaign will be repeated in our region in Oct/Nov 2011. There may also be potential to test the approach with other tumor sites.

3.4 The evaluation of a public awareness campaign using primary care GP systems is relatively innovative. The network has worked with Mount Vernon and Avon and Somerset cancer network's to develop a robust methodology. Developments of the methodology required liaising with primary care to develop understanding of relevant read codes, GP practice systems and how patients present and are coded.

3.5 A common methodology was used by all three networks to maximize opportunity to look for trends within the data. The read code evaluation was restricted to practices with EMIS systems and 21 practices participated within Anglia. Data extracts included age, gender, visit date and relevant read codes related to the campaign such as rectal bleeding, loose stools as well as control codes over a 16 month period Jan 2010-April 2011.

3.6 The final report of the analysis is not yet available, but early analysis suggests that there was significant increase in recording of the three read codes directly relevant to the campaign rectal bleed (37%), change in bowel habit (92%) and loose stools (278%). Moreover, the network has shown that it is possible to further understand patterns in how patients present via analysis of primary care systems.

3.7 The network has helped in the co-ordination and collection of other metrics to evaluate the campaign. The graph and table below clearly show that there was also a significant increase in the numbers of patients that GPs sent for urgent referral during the campaign. ECRIC will be supplying information on the conversion rates, i.e. how many turned out to have cancer, and whether there has been any alteration in the stage at diagnosis of the disease.



Increase in lower GI two week wait referrals

Trust Name	Feb-Mar 2010	Feb-Mar 2011	% inc
Bedford Hospital NHS Trust	92	157	71%
Cambridge University Hospitals NHS FT	199	250	26%
Hinchingbrooke Health Care NHS Trust	80	147	84%
Ipswich Hospital NHS Trust	171	247	44%
James Paget University Hospitals NHS FT	144	203	41%
Norfolk and Norwich University Hospitals NHS FT	334	535	60%
Peterborough and Stamford Hospitals NHS FT	179	188	5%
The Queen Elizabeth Hospital King's Lynn	144	210	46%
West Suffolk Hospitals NHS Trust	115	162	41%
Anglia Cancer Network	1,458	2,099	44%

3.8 The graph above shows that there was no significant decrease in two week wait performance during the campaign period. However, trusts have indicated that the increased activity led to delays in screening activity, pathology services and diagnostic clinics.

3.9 The increases in activity are clearly higher than the 10% increase that the Department of Health estimated would result from the campaign. No extra resources were provided centrally to handle the increase in activity. Concerns about this impact will be raised centrally at the meeting 1 July. If the campaign is to be rolled out and repeated in Oct/Nov, the network will work with Department of Health and trusts to identify how to best mange the resultant increase in demand.

3.10 The campaign appears to have been successful in affecting a behavior change getting the public to present to their GPs with symptoms. Further analysis will be able to demonstrate whether this resulted in more cancers diagnosed early and therefore lives saved.

Be Clear on Cancer in Anglia Campaign

3.11 The network is working with its six PCTs has commissioned a Be Clear on Cancer in Anglia campaign. This aims to help raise awareness of the symptoms of breast, bowel and lung cancer and to encourage people to see their GP if they have concerns. The campaign targets the over 50s as they are at most risk of developing these cancers. It takes a matrix approach with a media and PR push accompanied by the launch and signature roadshows which will try to get relevant messages to the broad audience and more localised targeted interventions at local events identifying and working with community champions to take the message direct to the target audience.

3.12 The following activity has occurred and is planned:

- 19 May launch event (attended by Andrew Lansley)
- Two day signature roadshow events have been held in each PCT (feedback from these has been positive and thousands of symptom cards have been distributed to the target age group).
- Media relations programme – feeding news stories throughout the campaign (to date 17 print articles, 10 online and 8 broadcasts have covered the campaign)
- GP engagement – we have informed GPs of the campaign and have provided them with a reminder of the relevant referral pathways.
- Washroom posters using Department of Health 'Be Clear on Cancer' materials have been placed in locations with high over 50s footfall across the network.
- Performances of 'The Ballard of Bob and Sue' (a song written to help raise awareness of the relevant symptoms) have been given at the events and released on the network's YouTube channel[2].
- Attendance at a number of local events over the summer (see below)
- Sending stakeholder presentations and toolkits to community champions

Date	Day	Place	Type of event
19-May	Thursday	Cambridge Research Institute, Li KaShing Centre, Cambridge	Launch event
27-May	Friday	The Grafton Shopping Centre, Cambridge	Roadshow
28-May	Saturday	The Grafton Shopping Centre, Cambridge	Roadshow
29-May	Sunday	Ipswich Town Hall	Roadshow
30-May	Monday	Ipswich Town Hall	Roadshow
02-Jun	Thursday	Chapelfield Shopping Centre, Norwich	Roadshow
03-Jun	Friday	Chapelfield Shopping Centre, Norwich	Roadshow
04-Jun	Saturday	Market Place, Great Yarmouth	Roadshow
05-Jun	Sunday	High Street, Lowestoft	Roadshow
08-Jun	Wednesday	Cathedral Square, Peterborough	Roadshow
09-Jun	Thursday	Cathedral Square, Peterborough	Roadshow
10-Jun	Friday	Church Square, Bedford	Roadshow
11-Jun	Saturday	Church Square, Bedford	Roadshow
Local events the campaign will be present at (some additional dates are still to be added):			
04-Jun	Saturday	Cambridgeshire garden show (Godmanchester)	
04-Jun	Saturday	Bedford kite festival (Bedford)	
05-Jun	Sunday	Pensthorpe gardening festival (Norfolk)	
12-Jun	Sunday	Festival on the green (Orton Longueville)	
12-Jun	Sunday	Race for Life (Peterborough)	
18-Jun	Saturday	Beccles farmers market (Beccles)	
23-Jun	Thursday	Lavenham coffee morning (Lavenham)	
25-Jun	Saturday	Ely farmers market (Ely)	

[2] http://www.youtube.com/user/AngliaCancerNetwork

Date	Day	Place	Type of event
25-Jun	Saturday	Arts and crafts fair (Woburn Sands)	
02-Jul	Saturday	Rose fair (Wisbech)	
02-Jul	Saturday	Sacrewell craft fair (Thornaugh)	
03-Jul	Sunday	Race for Life (Cambridge)	
07-Jul	Saturday	Vintage rail weekend (Stibbington)	
09-Jul	Sunday	Kimbolton country fayre (Kimbolton)	
10-Jul	Wednesday	Farmers market (Bedford)	
13-Jul	Sunday	Julie's gigantic car boot (Great Yarmouth)	
17-Jul	Sunday	Long Melford street fair (Long Melford)	
17-Jul	Sunday	Relay for Life (Great Yarmouth)	
24-Jul	Friday	Westleton wild flower festival (Westleton)	
29-Jul	Saturday	Relay for Life (Horringer)	
30-Jul	Saturday	Farmers market (Hoveton)	
06-Aug	Saturday	Cople music festival (Cople)	
06-Aug	Sunday	Skylark car boot sale (Cambridge)	
07-Aug	Friday	Lowestoft seafront air festival (Lowestoft)	
12-Aug	Saturday	Aldeburgh carnival (Aldeburgh)	
13-Aug	Sunday	Bedfordshire summer fete (Moggerhanger)	
14-Aug	Sunday	Peterborough car boot sale (Peterborough)	
14-Aug	Sunday	Air and vintage vehicle show (Little Gransden)	

3.13 One of the key aims of the campaign will be to develop a LAEDI stakeholder resource that can be used to help implement future campaigns in a sustainable way. All of the materials created as part of the campaign have been designed with reuse in mind. In addition community champions and spokespeople have been identified who are well placed to get messages across to our target audience. The launch event and road show events have already helped identify a wide range of people who have expressed willingness to work with the network to help with the campaign these include charity representatives, faith group leaders and WI groups.

3.14 The network has recently appointed SMR to carry out an evaluation of the campaign. A report due end October 2011 will report conclusions on whether the campaign was successful in achieving its aims. It will also contain recommendations on the aspects of the campaign which were most cost effective and suggest how future campaigns may be improved.

3.15 Further details about the campaign, including a link to the Ballad of Bob and Sue can be found on the network's website[3].

Supporting Primary Care and Plans for earlier diagnosis

3.16 A key part of the awareness and early diagnosis work stream is to support General Practitioners to manage patients effectively in order to improve their detection and diagnosis of cancer.

3.17 NCAT has identified four key deliverables to help achieve this:

- To implement **local improvement initiatives**, delivered in general practices, to drive earlier diagnosis in primary care
- To share learning, innovation, best practice and evidence
- To support **GP Leadership**, including clinical engagement in the national communication campaign.

3 http://www.angliacancernetwork.nhs.uk/page.php?page_id=1106&current_id=937&parent_id=472&level=3

- To support national Primary Care Development Projects – the first project will be the development of the Cancer Diagnosis in Primary Care Audit with RCGP.

3.18 The network has been invited to bid for £105k for the improvement initiative and £25k for GP leadership (see Appendix I) and submitted a bid in early June. Mike Richards has also written to the network to restate the importance of improving primary care access to diagnostics to the achievement of the saving 5,000 lives target and further work commissioning diagnostics presented to the last meeting of the board (see Appendix II).

3.19 Working with PCTs Anglia has responded to the invitation and submitted a bid to support primary care within the network. We have suggested building on successful work implementing tools such as the Willie Hamilton diagnostic decision making tool and the Lancashire and Cumbria frontline staff cancer awareness toolkit. The network is also exploring other prompting systems for GPs to keep them informed of LAEDI campaigns, new pathways and diagnostics.

3.20 The network has made good progress ensuring GPs have access to practice cancer profiles and identifying 'practices with a difference' that may warrant further investigation. The bid proposes that this work is furthered and we work with consortia to develop better understanding of reasons behind the variation in the GP profiles. The network will facilitate the uptake of the cancer primary care audit which GPs have found beneficial to help identify areas for improvement in their management of early diagnosis.

3.21 The network has proposed that the GP leadership part of the bid would be used to develop appropriate leadership in each consortia to take forward the LAEDI agenda. This capacity will be taken forward through funding GP sessions in each PCT area to support us on working with primary care – particularly the early diagnosis and practice profile agendas.

3.22 The network is also bidding to MacMillan to build primary care capacity. The MacMillan bid has a wider remit than this bid (as it relates to wider community care and the survivorship agendas) but the network will work to ensure that, should the two bids be successful, the two work streams complement each other and that benefits from each are maximised.

3.23 We have learnt that we were successful in achieving £25k funding. The £105k is now subject to a more detailed proposal addressing questions raised in response to the initial bid.

4 Future Action

4.1 The network awareness and early diagnosis steering group will work with key stakeholders to make sure this work is fully discussed and future actions developed. Specifically at the next meeting in July it will be responding to questions raised by NCAT in relation to the supporting primary care bid.

4.2 There will be reduced central funding for awareness and early diagnosis campaigns in the future. Evidence is growing that they provide a cost effective method to improve cancer outcomes. The network will be working to improve this evidence base as it evaluates the bowel campaign and Be Clear on Cancer in Anglia campaign.

4.3 The network will continue to work with GPs and trusts to identify and plan for the increase in demand for diagnostic tests including developing an indicator to monitor progress in line with the Improving Outcomes strategy.

4.4 The board will receive an update on the evaluation of the national bowel campaign and progress with the Be Clear on Cancer in Anglia campaign. An evaluation report is due end October 2011.

5 Recommendations

5.1 The board note that Department of Health is due to make a decision on whether to repeat the Bowel Cancer awareness campaign in July. If it rolls it out trusts will need to prepare for an uplift in demand in Oct/Nov 2011.

5.2 The board notes that the network has bid for £130k to support primary care in the LAEDI agenda.

5.3 The board note progress on these campaigns and consider how future awareness and early diagnosis campaigns might be funded if they're shown to be effective.

Author: James Perry, Project Manager/Information Analyst

Appendix I

Dear Network Director,

Network Directors were sent a letter from Mike Richards – *Improving Outcomes – A strategy for cancer: saving 5000 lives* – on 21st April, 2011 (attached), which indicated that there would be funding available, via Cancer Networks, for primary care.

NAEDI – Cancer Networks Supporting Primary Care, is the project, through which NCAT will be making this funding available.

An Advisory Group will be established to provide advice and feedback on the project.

National evaluation will be commissioned, building on the current evaluation of the GP Leadership Project, being done by the University of Durham (Professor Greg Rubin).

A key part of NAEDI is supporting General Practitioners to optimise the cancer diagnostic pathway of their patients. In 2011/12 central funding (NCAT/ DH) will be made available through Cancer Networks to achieve four key deliverables. These are:

1. To implement **local improvement initiatives**, delivered in general practices ,to drive earlier diagnosis in primary care
2. To share learning, innovation, best practice and evidence
3. To support **GP Leadership**, including clinical engagement in the national communication campaign.
4. To support national Primary Care Development Projects – the first project will be the development of the Cancer Diagnosis in Primary Care Audit with the RCGP.

Cancer Networks are asked to submit proposals for part 1 and 3 on the attached NCAT Project Initiation Document / Service Level Agreement. The total funding that will be available to Cancer Networks will be £3m for local improvement initiatives and £700k for GP Leadership. Funding will be on a shared allocation basis, and will not exceed **£105k per Network for the Improvement Initiative and £25k per Network for GP Leadership**. We will consider adjusting according to size of the network and the plan.

The criteria for approval of the funding will be -

Local Improvement Initiatives for General Practice
Proposals will need to include -

- A detailed description of the General Practice /primary care project, including robust costings.
- The evidence or insight on which the project is based.
- A description of the intended impact or outcomes of the activity. The proposal will need to confirm their participation in the national evaluation as well as doing local monitoring of outcomes.
- It will be important to quantify and demonstrate an increase in the reach of NAEDI to GPs and GP Practices. This will build on the information that Networks have provided previously on the number of practices and GPs participating in the Cancer Diagnosis in Primary Care Audit; the Risk Assessment Tool evaluation; engagement in the Regional

Bowel Campaign Pilot; and other local initiatives. In addition, the new funding will be aiming to have an impact on the key outcome metrics (for NAEDI as a whole - increased 2ww referrals and decreased emergency presentations. Further information on the metrics and evaluation plans will be provided.

Projects/ initiatives will need to describe how they aim to achieve (and measure)

- An increase in the number of GPs that are more aware of the importance of early diagnosis and their role in improving survival outcomes.

Also that there are improvements in

- Relevant professional practice, for example an increase in reflective practice by GPs in relation to early diagnosis of cancer, for example, in some areas GPs are using reflection on the Cancer Diagnosis in Primary Care Audit in their professional portfolios for appraisal and revalidation.

- Practice systems – organisational arrangements within the practice that might facilitate early diagnosis or reduced delays, clearly identifying the changes, for example implementation of safety netting applied to early diagnosis of cancer.

- Interface between primary and secondary care – informal and formal mechanisms, for example joint work to implement changes in the patient pathway; joint education programmes; or informal consultation on referrals.

- Preparation for more patients consulting with early signs and symptoms of cancer. All projects need to include support/ engagement with clinicians in primary and secondary care on national, regional and local campaigns.

- The usage (an increase) of access to diagnostics.

And finally

- How the project aims to achieve improved cancer outcomes – 1 year survival, saved lives and treatment at an earlier stage.

- A plan for sustainability to ensure commissioning of effective elements of the work beyond the life of the nationally funded project.

GP Leadership

The list of activities that can comprise the GP session(s) and specific work for Public Health Consultants include:

- Practice visits to review the GP Practice Profiles and offer support, including the targeted use of the primary care audit. The intention is to achieve a further increase this year in the proportion of GPs using their practice profiles and the proportion of practices that have been identified for further support and development. We will agree a target for the number of practices visited and audits completed for each Network, referring to the stock take on progress in 10/11 currently being completed by Networks.

- Clinical (GP) leadership for the local improvement initiatives (see above) – ensuring the involvement of emerging PCT Clusters and GP Consortia. GP Leads will provide information about existing work, as well as possible metrics and approaches to monitoring and evaluating change.

- Clinical engagement in the roll out, pending evaluation, of the national communication campaign (further information to follow). Cancer Networks in the regional pilot were provided funding for Public Health / GP sessions to deliver the local clinical engagement in the national campaign. Evaluation is in progress.

- Ensuring commissioners have access to existing expertise on awareness and early diagnosis and build on current work.

- Support for the implementation of the Risk Assessment Tool (the evaluation of the pilot will be available in November 2011).

- working alongside national primary care organisations, including charities for example CRUK; Macmillan GPs to support the local dissemination and application of guidelines for GPs on promoting access to diagnostics; and the RCGP to endorse and help promote cancer awareness and early diagnosis tools, information and guidance for General Practice.

- Support for education and training of GPs related to cancer and the contribution of awareness and early diagnosis to improving outcomes. This will also include updates and induction for GPs using the Cancer Diagnosis in Primary Care Audit.

Networks do not necessarily have to implement work in all of these areas. The funding for the GP (and for specific work Public Health Consultants) sessions will be negotiated on an individual network basis, taking into account the 2010/11 stock take.

The competed Outline Project Initiation Document / Service Level Agreement is to be sent to Kathy Elliott (contact details below) at NCAT by 6th June, 2011. In addition to the outline proposal, a more detailed project plan (attached) will be required by 15th July. We hope that this will give time for the very important involvement of local stakeholders and GPs.

The outline proposals, plus the 10/11 stock take on the GP Leadership Project (now being completed by Networks) will be reviewed by DH and NCAT for a decision about funding. Outline proposals will also go to the Steering Group for review and recommendations on how the plans could be improved. We aim to give feedback to Cancer Networks about the funding and hold the first Steering Group Meeting by the end of June.

The Department of Health will be leading a NAEDI national engagement strategy. This supporting primary care programme is important in achieving the local element of this engagement to achieve earlier diagnosis. This requires the public health, primary care, secondary care and commissioners responding in a way that can ensure patients with potential early signs or symptoms of cancer are managed more effectively. This means setting out the case for early diagnosis, expecting GP to respond differently to patients presenting earlier and ensuring secondary care understands that there will be a change in the way GP access specialist support for the investigation and diagnosis of suspected cancers (e.g. increased use of the 2 ww referrals and more direct requests for diagnostic tests).

Kind regards,

Kathy Elliott
National Lead for Prevention,
Early Diagnosis & Inequalities

21st April 2011
To: Cancer Network Directors

Dear Colleague,

IMPROVING OUTCOMES – A STRATEGY FOR CANCER: SAVING 5,000 LIVES

I thought it would be useful to update you on our current plans for tackling late diagnosis.

In *Improving Outcomes - a Strategy for Cancer*, the Government made a commitment to bring England's cancer survival rates up to the European average, by 2014/15. As you will know, the Strategy says that, on the basis of analysis of past European survival rates, matching the European average equates to saving roughly 5,000 additional lives per year.

We need to turn this into an appropriate level of ambition for the cancer survival rate indicators which are part of Domain 1 in the NHS Outcomes Framework, and we are currently working on this. (We may well need also to work out an appropriate level of ambition for a cancer mortality indicator in the Public Health Outcomes Framework, but next steps on this have yet to be decided.)

More significantly, we need to work out how to focus our efforts to deliver the commitment to improved survival rates. As we made clear in the Strategy, although screening and treatment are important to deliver the improved survival rates, our main focus needs to be on earlier diagnosis of symptomatic cancer. During the last financial year, DH, NCAT and the NHS, working with the voluntary sector, ran the bowel cancer symptom awareness pilot campaigns and supported a range of local campaigns to achieve earlier diagnosis of breast, lung and bowel cancer - and of course there has been a range of other work to tackle late diagnosis of these and other cancers. We also undertook a range of work to support primary care in referring on appropriate patients, e.g. through Cancer Network GP leads working with GPs on practice profiles. But we know that there is a long way to go before we have tackled the problem of late diagnosis.

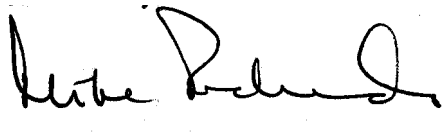
Subject to a successful evaluation of the pilots, the plan is to roll out nationally - later this year - the bowel symptom awareness campaign. But, on the basis of the calculations that produced the 5,000 figure, even if we were to match the best in Europe, we could save only 1,700 additional lives in bowel cancer. And we would have to match the best in terms of breast, bowel and lung cancer survival rates in order to achieve the 5,000 figure, and that is a big ask by 2014/15. So, we need to improve survival rates in other cancers too. We are currently considering which additional tumour sites to focus on or whether we should trial a generic, rather than a site-specific campaign to encourage earlier diagnosis of cancer. If we were to select additional tumour sites it might be logical to focus on oesophagogastric cancer next as this accounts for the next highest number of potential lives to be saved after breast, colorectal and lung.
DH has provisionally allocated £8.5 million to run awareness campaigns this year, and so there is scope to make a real difference in terms of raising awareness and achieving earlier presentation. We hope to come back to you shortly with firm plans about the type of campaigns that will be run, but it may well be that, in addition to national campaigns, we invite bids for some further local projects, which will aim to tackle particular problems, e.g. breast symptom awareness among women over 70. Whatever the nature of the campaigns, we will need your help, working with the NHS generally, to maximise their benefit.

We are conscious that there is an issue around the interface between national and existing local campaigns. For example, if we run the Be Clear on Cancer bowel campaign nationally, and local projects have been running with different messaging on bowel cancer symptom awareness, we could confuse the public. We will also need your help to tackle any such interface issues.

In addition to funding social marketing campaigns, we have it in mind to fund, via Cancer Networks, further support for primary care. The plan would be to set out the criteria for such funding (which would include supporting primary care to prepare for a national campaign, building on the learning from the Networks which provided this support for the regional pilots) and we would invite Networks, working with local commissioners and providers as appropriate, to submit plans in this area. It could well be that we will make available roughly £100K per Network, so it would be good if you could start thinking about the sort of work you would like to undertake to support primary care (this funding would be in addition to continuing the current funding of GP leads). As soon as we have firmed up plans here, we will come back to you.

It is going to be a major challenge to achieve 5,000 additional lives saved per year by 2014/15. In terms of a back of the envelope calculation, we are talking about nearly 200 lives per annum per Network – and the NHS, working with PHE, will be held to account for delivering this. We will need Networks to prioritise this area of work if we are to achieve earlier diagnosis and improved survival rates.

Yours sincerely



Mike Richards
National Cancer Director

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Appendix II

Dear Colleague,

GP ACCESS TO CANCER DIAGNOSTICS

Further to my letter of 21st April about "Saving 5,000 lives per year", I thought that it might be helpful to provide further information around our plans for improving GP access to diagnostic tests. Questions were raised at the March NDP about those plans, and I recognise that we have not so far disseminated much information. In addition to providing you with information, this letter also seeks your help with rollout of our plans.

I will start with some background. You will recall that the last Government made a commitment to deliver results from key cancer diagnostics within one week. The idea was that, if a patient did not meet the criteria for a 2WW referral, but the GP felt that further investigation of their symptoms was advisable (even if the GP had no suspicion of cancer at that stage), then it was important to be able to have the issue investigated rapidly so that, where cancer was found, it would be possible to begin treatment quickly.

Following the commitment, we set up the Cancer Diagnostics Advisory Board (CDAB) to help us with developing and implementing the policy. We sought the Board's advice on which diagnostic tests GPs needed direct access to, in order to speed up diagnosis of cancer. The CDAB advised that there were four diagnostic tests that GPs should have direct (and speedy) access to. These are:

- chest x-ray: to support the diagnosis of lung cancer
- non-obstetric ultrasound: to support the diagnosis of abdominal and pelvic cancers and especially ovarian cancer
- flexible-sigmoidoscopy/colonoscopy: to support the diagnosis of bowel cancer;
- Magnetic Resonance Imaging (MRI) brain: to support the diagnosis of brain tumours.

There were some cancers where the 2WW pathway was considered always to be appropriate and some tests which it was considered GPs did not need to have direct access to. (E.g. breast problems)

While the Coalition Government has moved on from the commitment to results in one week, there is just as strong a commitment to tackling late diagnosis and, therefore, to improving GP access to diagnostic tests.

Nearly all GPs have access to chest x-rays, but their usage of them is variable, and we want to encourage all GPs routinely to refer symptoms which do not meet the criteria for a 2WW for suspected lung cancer but do cause concern. A growing number of GPs (now about half, we believe) have access to non-obstetric ultrasound, but again use of this access for symptoms of ovarian cancer is variable. Very few GPs have direct access to flexible-sigmoidoscopy or colonoscopy or to MRI brain scans, although there are examples around the country of schemes that have been successfully set up to provide this.

The Operating Framework for the NHS in England 2011/12 asked commissioners and providers to consider these four tests and ensure continuity of commissioning and provision is secured in the move to commissioning by the NHSCB and GP consortia. This was followed up, shortly afterwards, with *Improving Outcomes – a Strategy for Cancer*, which said that "GPs need easy access to the right diagnostic tests to help them to diagnose or exclude cancer earlier. We are committing additional funding over the next four years to enable GPs to have better access to selected diagnostic tests, along with funding for the additional costs of tests and treatment in secondary care."

The Impact Assessment for *Improving Outcomes – a Strategy for Cancer* set out the Government's commitment to additional funding (£450 million over the four years of the SR) to enable GPs to have direct access to the above tests in cases where the 2WW urgent referral pathway was not appropriate but a patient's symptoms nonetheless required investigation. Funding is also being provided to cover the costs of additional tests and treatment in secondary care incurred by the earlier detection of a greater number of cancers. The costs have been calculated on the basis of the additional tests per year that were considered appropriate in order to give GPs the sort of access that they would need to the tests listed above.

Improving Outcomes – a Strategy for Cancer recognises that commissioners may choose approaches other than increasing GP access to cancer diagnostics as one of the methods of achieving earlier diagnosis, and so we need to use a range of levers in order to deliver this policy (apart from holding commissioners to account for delivering the improved survival rates).

One aspect of our approach is through providing data about usage of these different diagnostic tests, so that GPs will be able to benchmark their usage alongside other GPs, and alongside usage of the 2WW referral pathway. Data on GP usage of diagnostic tests are not currently routinely available at national level, but we are working to set up a new data collection, from April 2012. The plan then is to include the data returns in the consortia and GP profiles in the future – so that low users of diagnostic tests are encouraged to increase their usage.

Perhaps not surprisingly, the media coverage of increased GP access to diagnostics was met in some quarters by a concern that the acute sector would be overwhelmed with referrals. To ensure that only appropriate patients are referred, a group of clinicians from both primary and secondary care has been convened to draw up (on the basis of existing criteria) guidance for GPs on the best use of direct access to each of the four priority areas for diagnostics. This guidance will be disseminated to GPs in the autumn, following consultation with relevant stakeholders in the cancer field. (Although it would be unusual to refer for a NOU for symptoms of other abdomino-pelvic cancers, this may be appropriate in some circumstances, and so the group will also be producing guidance covering appropriate symptoms other than for ovarian cancer.)

Other work that we have underway includes the following:

- NHS Improvement is mapping the direct access pathways for each of the four priority areas for diagnostics, drawing on examples of existing good practice. They will produce a report with recommendations on what a good pathway looks like which will also be disseminated in the autumn. They will also be looking for volunteers to pilot some of the pathways.
- The Department of Health is working to ensure that tariffs will incentivise quick access to diagnostics and that there are no inappropriate disincentives to providing direct access.

We are conscious, however, that we need to do more if we are to deliver improved GP access to diagnostic tests and, thereby, to achieve earlier diagnosis. We (NCAT, NCIN and cancer networks) need to engage commissioners, GPs and secondary care providers in this. To take this forward we have the following work in hand:

- development of key messages for commissioners
- development of consortium and GP practice profiles
- development of a primary care engagement strategy
- Inclusion of relevant material related to diagnostics in the commissioning support pack that the Cancer Outcomes Strategy commits us to producing.

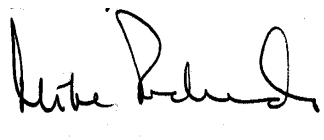
This will need to be a joint endeavour between the "centre" and cancer networks. I would be grateful if you could ensure that your local commissioners and providers are aware of the importance of improving access to diagnostics in order to meet the challenge of "saving 5000 lives p.a."

As we discussed at our recent meeting at the Ambassador's Hotel increasing endoscopy capacity is likely to be one of the highest priorities.

In the two Regions that have acted as pilots for a national bowel cancer awareness campaign we have seen a marked increase in 2ww colorectal referrals and in demand for endoscopy. Although we do not yet have a decision on the national campaign, if it does go ahead it is likely to be in October/November 2011 – so planning of additional capacity will need to start soon.

If there are any ways in which you think that DH and/or NCAT could best help you in this task do please let us know?

Best wishes



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