NATIONAL AUDIT OFFICE

DEPARTMENT OF HEALTH

The NHS Cancer Plan: A Progress Report

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL | HC 343 Session 2004-2005 | 11 March 2005

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Comptroller and Auditor General
National Audit Office

21 February 2005

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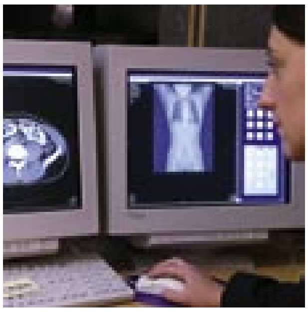

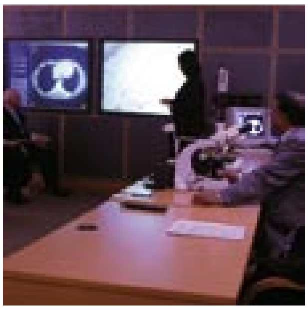

PART 2

APPENDICES

Photographs courtesy of Doncaster & Bassetlaw Hospitals NHS Foundation Trust. The Trust's Cancer Unit is committed to providing high quality services by involving patients, carers, and the public in their design and delivery.
Justine Desmond Photography www.justinedesmondphotography.co.uk

SUMMARY

1 This is the final report in a series of three National Audit Office studies on cancer services in England. The first[1] examined whether clinical aspects of cancer services are saving more lives across England and in comparison to other countries. The second study[2] examines how patients view services, based on the results of a major survey of cancer patients. This report focuses on the NHS Cancer Plan, reviewing its content, examining its implementation across the country, and reporting on progress to date against the targets and commitments in the Plan.

2 The NHS Cancer Plan was published in September 2000 and built on commitments set out in the NHS Plan, published two months earlier, which promised more staff and equipment for cancer along with a modernised NHS, with new ways of working to prevent and treat cancer. The NHS Cancer Plan is a ten-year programme of fundamental reform of cancer services in England. It formally established cancer networks across the country, bringing together the organisations and health professionals which plan and deliver treatment and care for cancer patients. The aims of the NHS Cancer Plan are:

- to save more lives;
- to ensure people with cancer get the right professional support and care as well as the best treatment;
- to tackle the inequalities in health that mean unskilled workers are twice as likely to die from cancer as professionals; and
- to build for the future through investment in the cancer workforce, through strong research and thorough preparation for the genetics revolution, so that the NHS never falls behind in cancer again.

3 The main participants in the implementation of the Plan are shown in **Figure 1**.

4 It will take time for the effects of the Plan to work through fully. To evaluate its impact to date we drew on a survey of all cancer networks, discussions with a wide range of health professionals within cancer networks across the country, a review of Department of Health papers and other material, and the advice of a panel of experts (Appendix 2) to provide a progress report on the NHS Cancer Plan some four years into its ten-year programme.

5 Overall, we found that:

- the Plan was generally well conceived and substantial progress has been made to date, with many targets in the Plan met or on course to be met. This should contribute to the downward trend in mortality rates observed for England, which are ahead of the Department's trajectory to achieve the target of a 20 per cent reduction in mortality from cancer in persons under 75 by 2010;
- while cancer networks – the vehicle for securing improvements in local cancer services – have made progress with some significant successes, they are not always as effective as they could be in terms of staffing, cancer services planning or in receiving the full support of other parts of the healthcare system. Networks were established before primary care trusts and other NHS organisational changes, and there is scope for working arrangements to evolve further.

We make a number of recommendations to consolidate progress to date and to reinforce networks and partnership working.

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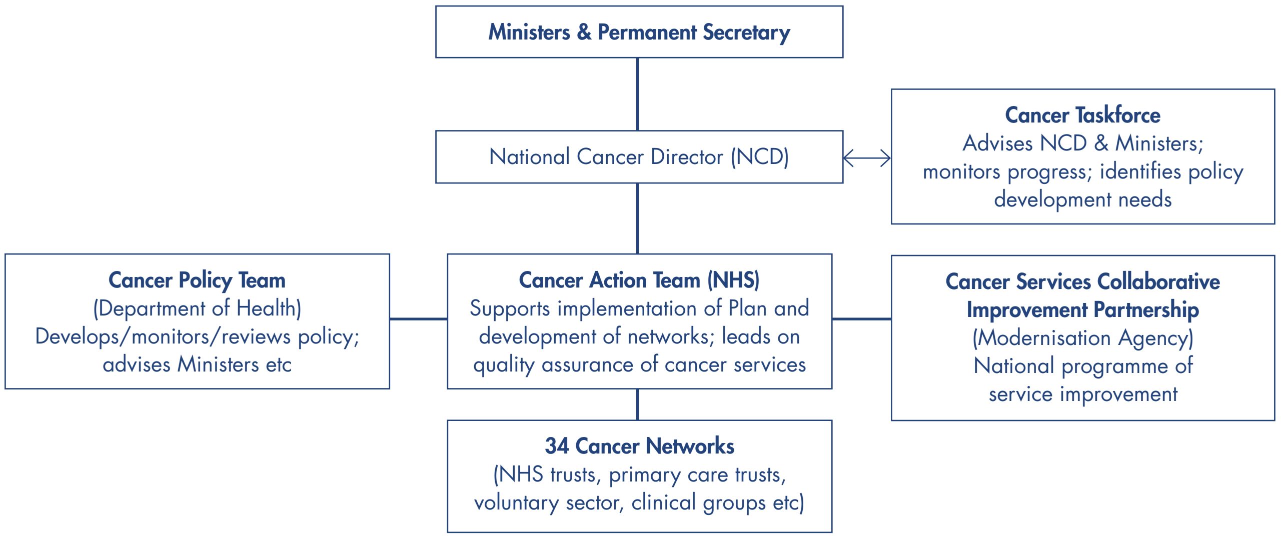
[1] 'Tackling cancer in England: saving more lives'. (HC 364, 2003-04). Published March 2004.

[2] 'Tackling Cancer: Improving the Patient Journey'. (HC 288, 2004-05). Published February 2005.

1 Key figures in the implementation of the NHS Cancer Plan



Source: Department of Health

The NHS Cancer Plan is broadly comprehensive but strategy will need to be kept up to date

6 We found that the NHS Cancer Plan is impressive in its coverage of the main elements of World Health Organisation guidelines[3] (especially as they were published after the NHS Cancer Plan) for designing strategies against cancer, effectively setting out a series of targets, commitments and milestones for improving cancer services. The Plan compares favourably with other national and state cancer plans published in recent years, and is regarded by cancer networks as a useful tool outlining strategic direction across the patient pathway.

7 However there are ways in which the strategy for tackling cancer in England could be improved to cover, for example, strategic issues such as estimates of the future cancer burden. Decisions now need to be taken on how to update and bring together all elements of the current cancer strategy in a unified way that ensures that it remains the central guiding approach for improving cancer services and outcomes.

The Plan has resulted in improvements to cancer services though there is still more to be done

8 The 34 cancer networks in England are responsible for implementing the NHS Cancer Plan. Almost all cancer network organisations we spoke to were positive about progress against the NHS Cancer Plan, partly because of the initiatives to identify and spread good practice put in place by the Department of Health and the Cancer Action Team, which supports implementation of the Plan within the NHS.

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[3] National Cancer Control Programmes: Policies and Managerial Guidelines. WHO, 2002.

9 The NHS Cancer Plan contains a very significant number of targets and commitments to be achieved during its ten-year lifetime. Progress to date in meeting them has been encouraging, including:

- Boosting the downward trend in smoking;
- Extending the breast screening programme;
- Speeding access to cancer diagnosis and treatment;
- Establishing specialist cancer teams;
- Reducing variation in access to cancer drugs;
- Boosting specialist palliative care services;
- Getting more cancer specialists in place, and faster than planned;
- Modernising and expanding cancer diagnostic and treatment facilities; and
- Increasing the pace of research.

10 Overall, though there has been some slippage in meeting some NHS Cancer Plan target dates, much has been achieved, and major improvements in cancer services secured. But some targets, such as achieving the waiting time targets for 2005, pose significant challenges if they are to be fully met.

11 In addition to the NHS Cancer Plan the Department has launched a number of related initiatives to improve cancer services, including a tobacco advertising ban, establishing an integrated cancer care programme to improve coordination of care, and strengthening the partnership between the NHS and the voluntary sector.

Cancer networks have helped drive forward improvements in cancer services, but there is more to do if they are all to become fully effective

12 Most cancer patients require care from many parts of the NHS at different points in their care journey. Primary, secondary and tertiary care, as well as the voluntary sector (such as hospices), need to work closely together to provide an integrated system of care. Cancer networks were set up to achieve integrated care as well as improved clinical outcomes, cost-effective services, improved patient experience and equity of service provision.

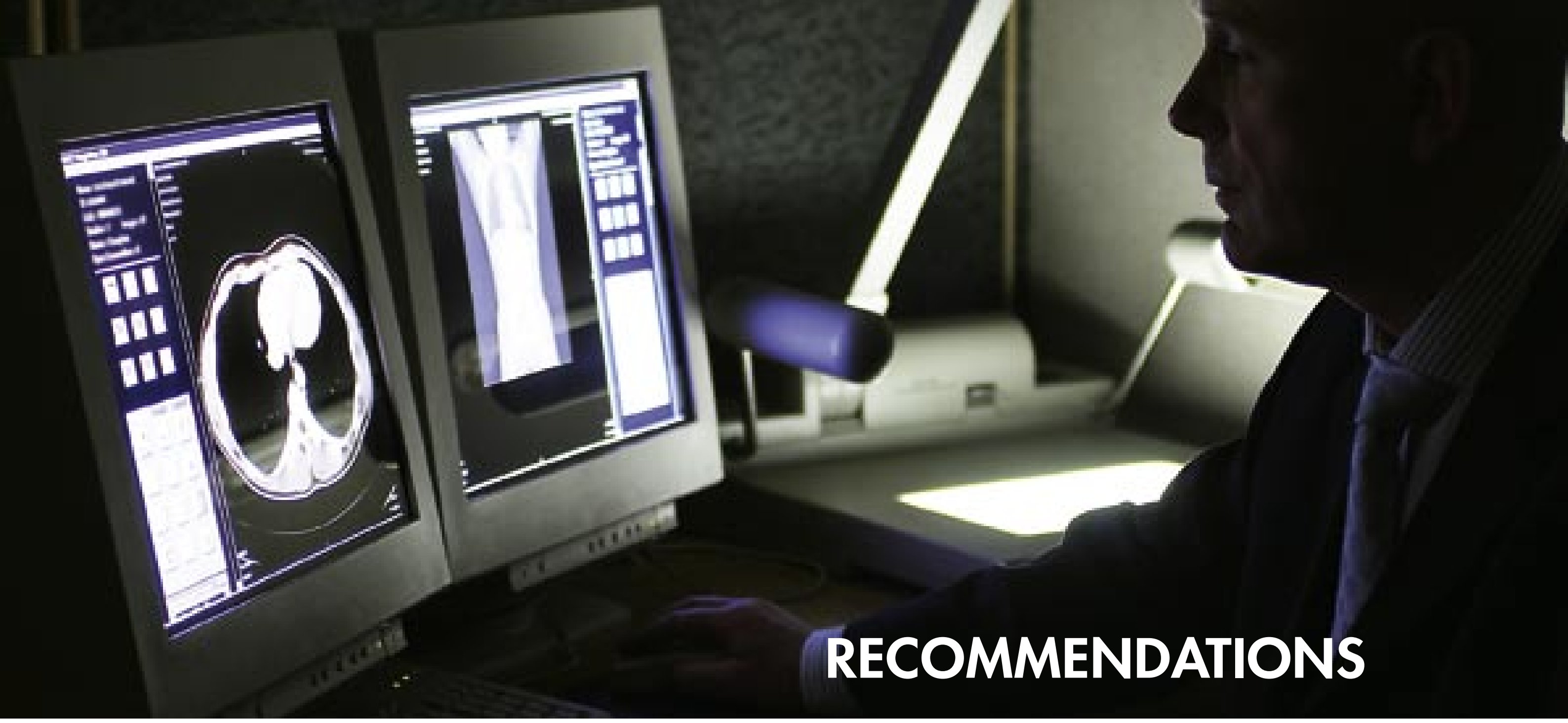
13 The NHS Cancer Plan established cancer networks as the vehicle for the delivery of cancer care. The first wave of cancer networks was established following the recommendations of the Calman Hine report, published in 1995. As a result of the NHS Cancer Plan full coverage in England was achieved, with a total of 34 networks established. The networks are responsible for developing and planning all aspects of cancer services. They are matrix organisations, combining expertise and input mainly from acute and primary care trusts, the voluntary sector, numerous generic and tumour-specific working groups, and a patient and user group, coordinated by a network management team and headed by a network board.

14 Cancer networks have, in a short time, helped to improve cancer services in England; though some have achieved more than others reflecting, in part, their current state of development. In terms of particular successes, cancer networks have, for example:

- planned for the introduction of new cancer drugs across the network;
- developed plans for funding specialist palliative care;
- drawn up action plans for the development of cancer services in line with guidance from the National Institute for Clinical Excellence; and
- facilitated development of multidisciplinary teams, which are an important element in delivering improved patient-centred treatment and better outcomes.

15 The extent to which networks have been fully established, and the degree therefore to which they are fully effective varies, however, and there is more to be done if all 34 networks are to function as effectively as possible. Important issues are:

- **Sufficient resources are not always available to enable networks to operate effectively.** We found that not all network management teams were fully staffed, with some networks having vacancies for essential posts. The staffing of additional desirable posts was also a challenge, with financial constraints given as the main explanation. Funding overall was seen as a problem by some networks.
- **Making the cross-boundary approach work has not been straightforward.** We found that some network boards did not have full representation from acute and primary care trusts in their area. Where present, representation was only at the expected Chief Executive level in around half of cases.
- **Not all cancer networks plan effectively.** Networks were required to prepare three-year service delivery plans by 2001, underpinned by workforce, and education and training strategies. Three of the ten networks we spoke to did not have a current service delivery plan, and although at a national level workforce development was seen as a priority in the NHS Cancer Plan, by late 2003 only a third of networks had produced a workforce strategy; and just over a third had developed an education and training strategy.
- **There is scope to improve the commissioning of cancer services in some networks.** Some primary care trust commissioners produce plans for cancer service provision in isolation, when they should be cooperating with other network constituent organisations. The extent to which network management teams input to the commissioning process also varies.
- **There are concerns regarding the duty of partnership expected from cancer network organisations in the context of an evolving NHS**. Generally, network management teams reported effective relationships between the networks and their constituent organisations, particularly in the case of acute trusts. However at the more strategic level some strategic health authorities were very proactive, whilst others made no reference to the cancer network in their summary local development plans. Some networks expressed concerns that, while NHS foundation trusts have the scope to benefit cancer patients, the freedoms that they have may limit effective partnership working and collective efficiency. Similar risks may arise with the emergence of independent sector treatment centres.



RECOMMENDATIONS

1 The NHS Cancer Plan is a good model from which other countries have taken inspiration. The National Cancer Director should continue to work with his equivalents overseas to share good practice in drawing up and implementing blueprints for the development of cancer services, taking account of good practice abroad that would be applicable in England.

2 With the approach of the mid-point in the ten-year life of the Plan, the National Cancer Director should - taking account of the changed and changing environment of the NHS, subsequent guidance published by the Department to take the Plan forward, and the views of stakeholders – consider what changes to the cancer strategy are needed, and how these should most appropriately be brought together and published in a unified and accessible form.

3 As part of its corporate accountability, the Department of Health should continue to publish progress against the key cancer outcomes in Figure 8 of this report as part of its existing reporting mechanisms.

4 Cancer networks should ensure that they are able to demonstrate to strategic health authorities that they have appropriate planning arrangements in place locally, including workforce and education and training strategies, and that these feed into the Local Delivery Plan process.

5 Strategic health authorities, working through primary care trusts, need to ensure that networks have the resources required for an effective and sustainable performance.

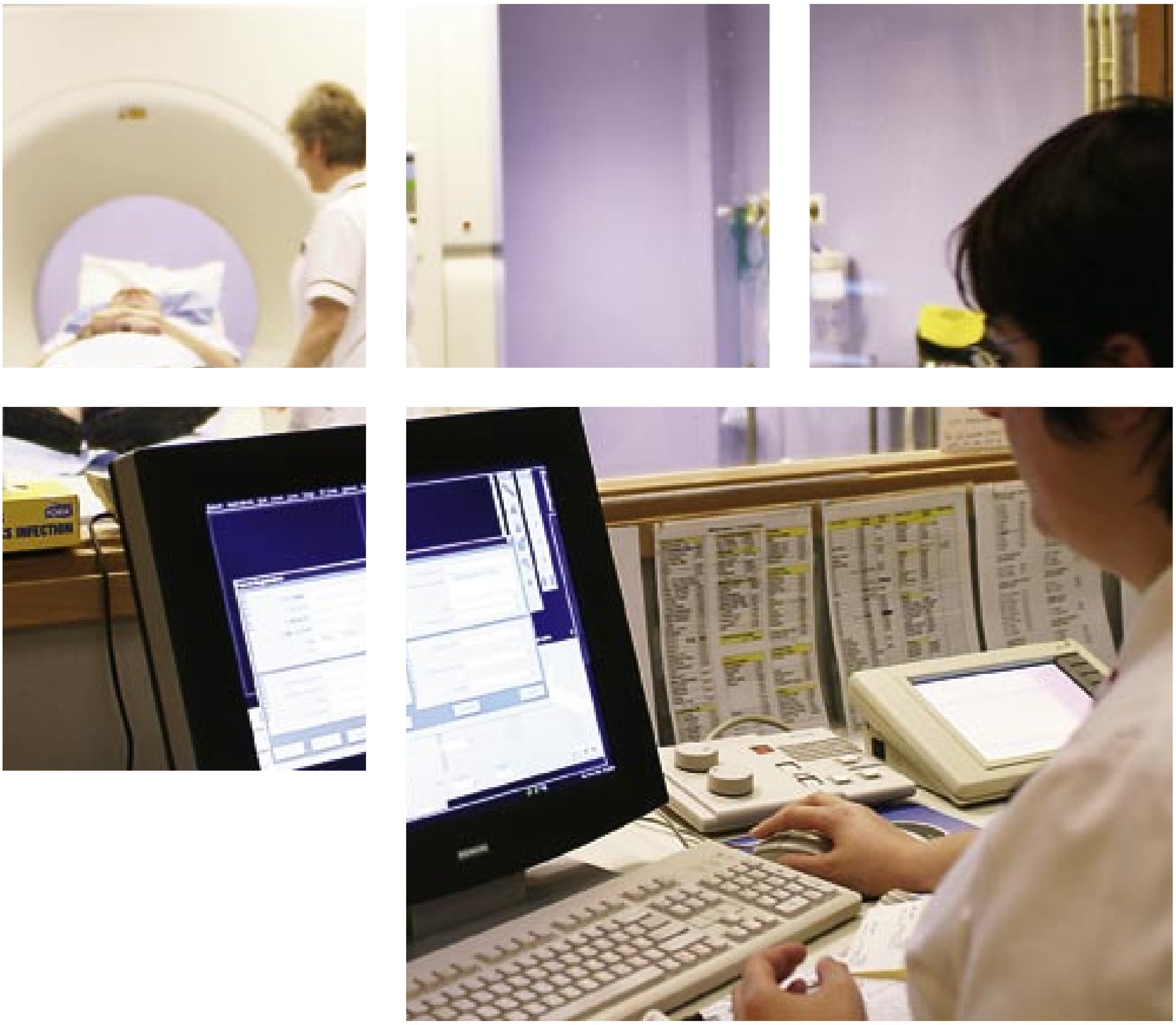
6 All networks should have agreed arrangements in place with local partners for monitoring progress against those targets for which they are responsible, and implement them. Where that is deemed not to be the case, the strategic health authority should take corrective action.

7 The network board should send annually updated information to its constituent bodies and its strategic health authority, to update them on progress against the NHS Cancer Plan. This information should be copied for information to the National Cancer Director so that he can have an overview of progress. Any performance management response needed would be for the strategic health authority to take forward.

8 To make cancer networks work better as cross-boundary organisations the Department of Health, in association with strategic health authorities, should strengthen the functioning of cancer networks by ensuring that roles and responsibilities of constituent organisations are clearly defined and adhered to. The outputs from this process should include clear common stated aims, to which all bodies should subscribe, with associated responsibilities and accountabilities.

PART ONE

There have been significant improvements in the management and provision of cancer services since the publication of the NHS Cancer Plan, but there is more to be done



The NHS Cancer Plan is a ten-year strategy to improve cancer services

1.1 In April 1995 a report (the Calman Hine report)[4] was published by the Expert Advisory Group on Cancer, which was established by the Chief Medical Officers of England and Wales to consider the direction in which cancer services should be developed. The report was prepared against a backdrop of increasing cancer incidence, variations in treatment outcomes, the major economic consequences of cancer, and the burden of cancer on the community. It outlined the strategic framework and the changes needed in the delivery of cancer services across the country to improve cancer outcomes and survival.

1.2 The Calman Hine report set out the general principles which should govern the provision of cancer care **(Figure 2)**, and proposed a new structure for cancer services based on a network of cancer expertise from primary care through to cancer centres. However, the report set no targets and gave no commitments to additional funding. It was left to local health organisations to determine how to implement this overall vision of cancer services.

2 Calman Hine general principles of cancer care provision

- All patients should have access to a uniformly high quality of care in the community or in hospital.
- Public and professional education to help early recognition of cancer symptoms, and the availability of national screening programmes are vital.
- Patients, families and carers should get clear information and assistance in a form they can understand about treatment options and outcomes available.
- The development of cancer services should be patient centred and should take account of patients', families', and carers' views and preferences.
- The primary care team is a central and continuing element in cancer care. Effective communication between sectors is imperative in achieving the best possible care.
- Psychosocial aspects of cancer should be considered at all stages.
- Cancer registration and monitoring of treatment and outcomes are essential.

Source: A Policy Framework for Commissioning Cancer Services (the Calman Hine report)

1.3 By 1999 there was general agreement that progress was not moving fast enough, and that further action needed to be taken to implement the Calman Hine recommendations and also address other issues such as prevention and screening. Following a cancer summit convened by the Prime Minister in May 1999, several initiatives were established including the appointment of a National Cancer Director (currently Professor Mike Richards) and the announcement of a single cancer target to reduce the death rate from cancer amongst people aged under 75 by at least 20 per cent by 2010 from a baseline of 1997. A decision to develop a comprehensive strategy to tackle cancer in England was taken by the Prime Minister and the Secretary of State for Health in February 2000. To assist with the development of what was to become the NHS Cancer Plan, a small advisory group was established and, whilst there was no formal consultation on drafts of the Plan, the National Cancer Director consulted widely on specific aspects with various groups of stakeholders.

1.4 The NHS Cancer Plan, building on a number of existing cancer initiatives, was published in September 2000. It was designed to be a comprehensive strategy to tackle cancer, covering prevention, screening, diagnosis, treatment and care for cancer, and the investment needed to deliver these services in terms of improved staffing, equipment, drugs, treatments and information systems. The Department of Health has responsibility for the NHS Cancer Plan. Supported by a commitment to increase funding to an extra £570 million a year for cancer services by 2003-04, the NHS Cancer Plan has four aims:

- to save more lives;
- to ensure people with cancer get the right professional support and care as well as the best treatment;
- to tackle the inequalities in health that mean unskilled workers are twice as likely to die from cancer as professionals; and
- to build for the future through investment in the cancer workforce, through strong research and through preparation for the genetics revolution, so that the NHS never falls behind in cancer care again.

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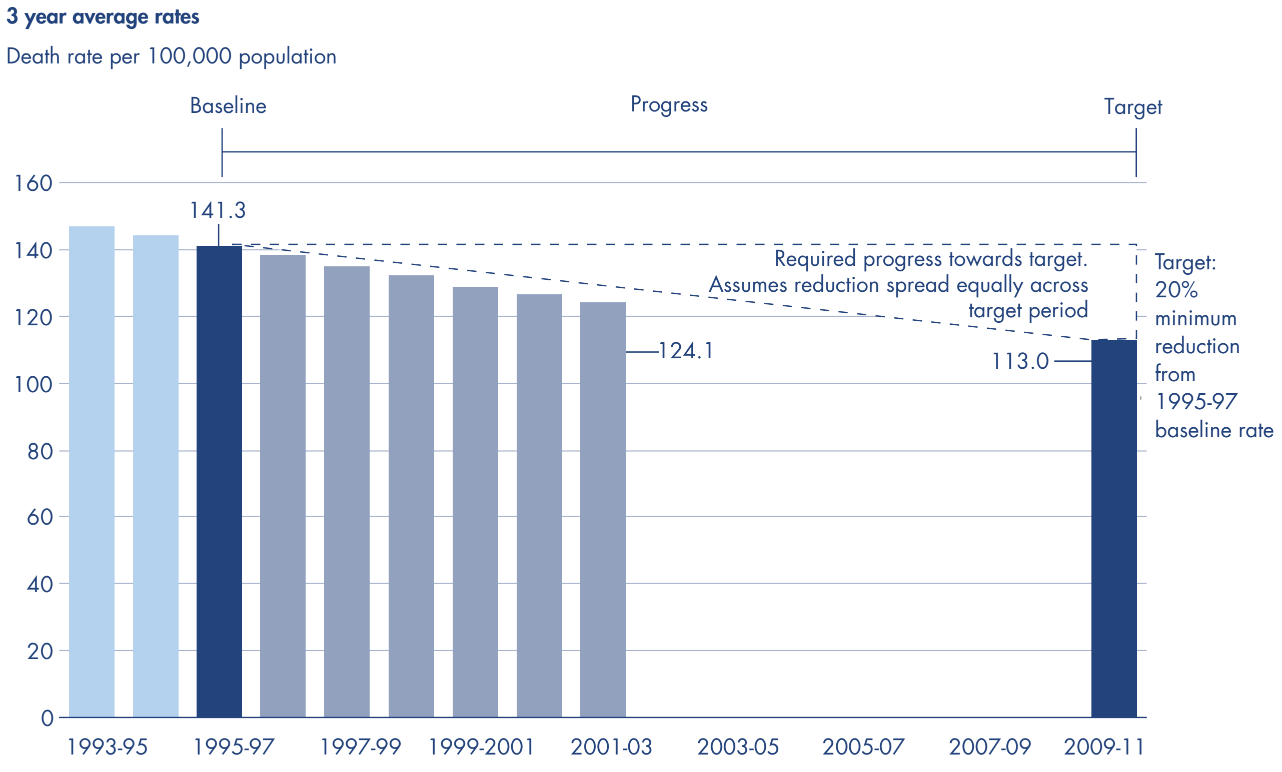
[4] "A Policy Framework for Commissioning Cancer Services" Department of Health/Welsh Office, 1995.

1.5 The NHS Cancer Plan is a ten-year programme to improve cancer services and outcomes, and contains a large number of targets, actions and milestones that are to be achieved up to 2010. Meanwhile cancer mortality in persons under 75 is falling, and is ahead of the Department's trajectory to achieve the 2010 cancer target **(Figure 3)**.

1.6 **Figure 4** outlines the content and key elements of the NHS Cancer Plan. Part 1 of this Report focuses on progress against the major targets; a full analysis of progress is at Appendix 1.

3 Performance against the cancer mortality target for persons under 75



Source: ONS (ICD9 140-209; ICD10 C00-C97)

NOTE

Rates are calculated using population estimates based on 2001 census, subsequent to amendments resulting from the Local Authority Population Study (LAPS). Rates are calculated using the European Standard Population to take account of differences in age structure. ICD9 data for 1993 to 1998 and 2000 have been adjusted to be comparable with ICD10 data for 1999 and 2001 onwards.

4 NHS Cancer Plan contents and key elements

Chapter 1: The challenge of cancer

Good progress in recent years

Relatively poor survival rates

Inequalities in cancer

A postcode lottery of care

Poor patient experience

Meeting the challenge of cancer

Chapter 2: Improving prevention

New national and local targets to reduce smoking in disadvantaged groups

New local alliances for action on smoking

Support in primary care to help people quit smoking

£2.5 million for research into smoking cessation

National five-a-day programme to increase fruit and vegetable consumption

National School Fruit Scheme

Raising public awareness

Chapter 3: Improving screening

Routine breast screening to be extended up to age of 70 and available on request to women over 70

Improved breast screening techniques to increase detection rates

New ways of working

Improved cervical screening techniques

Colorectal screening pilots

The NHS Prostate Cancer Programme

Better understanding of screening

Chapter 4: Improving cancer services in the community

A central role for primary care in new cancer networks

£3 million in partnership with Macmillan Cancer Relief for a lead cancer clinician in each PCT

£2 million for palliative care training for district nurses

New primary care clinical dataset for cancer patients

Chapter 5: Cutting waiting for diagnosis and treatment

Range of waiting time targets, including: maximum two month wait from urgent GP referral to treatment for all cancers by 2005

Roll out of Cancer Services Collaborative to streamline services in all networks

Cancer the first priority for roll out of booked appointments

By 2004 every patient diagnosed with cancer will benefit from pre-planned and pre-booked care

Chapter 6: Improving treatment

Extension of guidance programmes to all cancers

NICE appraisals of cancer to end postcode lottery of care

Establishment of specialist teams

Care of all cancer patients to be reviewed by specialist teams

Monitoring progress to achieve standards

National cancer datasets

Strengthening cancer registries

Chapter 7: Improving care

New supportive care strategy

NICE to develop guidance for supportive care

New training in communication skills

Improved information for patients

New Cancer Information Advisory Group

New internet resources for patients

£50 million extra for hospices and specialist palliative care services

New Opportunities Fund money for palliative care in deprived communities

Chapter 8: Investing in staff

Nearly 1000 extra cancer consultants

Increases in the number of specialist trainees

More cancer nurses, radiographers and other health professionals

More skills and new roles for cancer staff

Targeted training initiatives

Better planning for the future

Chapter 9: Investing in facilities

Substantial investment from New Opportunities Fund

Additional funding in NHS Plan for 50 MRI scanners, 200 CT Scanners and 45 linear accelerators

Modernisation of pathology services

First ever cancer facilities strategy

National audit of major cancer diagnostic facilities

New partnerships with the private sector

Chapter10: Investing in the future: research and genetics

New National Cancer Research Institute

Additional investment in research infrastructure

Additional investment in prostate cancer research

Partnership with Macmillan Cancer Relief on genetic counselling

Chapter 11: Implementing the NHS Cancer Plan

Additional £570 million by 2003-04 for cancer services

Implementation of cancer service improvements by cancer networks

Cancer networks develop strategic service delivery plans

Network workforce, education and training and facilities strategies to underpin service delivery plans

Cancer networks commissioning pilots to be established

Source: The NHS Cancer Plan

There has been good progress in improving cancer services during the early years of the Plan but there is more to be done

Cancer networks have been established across England to lead improvements in services

1.7 The Calman Hine Report of 1995 recommended the establishment of cancer networks throughout England, each network bringing together all cancer services in a locality. The main impetus for their establishment came, however, from the NHS Cancer Plan in 2000, which stated that cancer networks:

"would be the organisational model for cancer services to implement the Plan, bringing together health service commissioners and providers, the voluntary sector and local authorities to work together to improve cancer services."

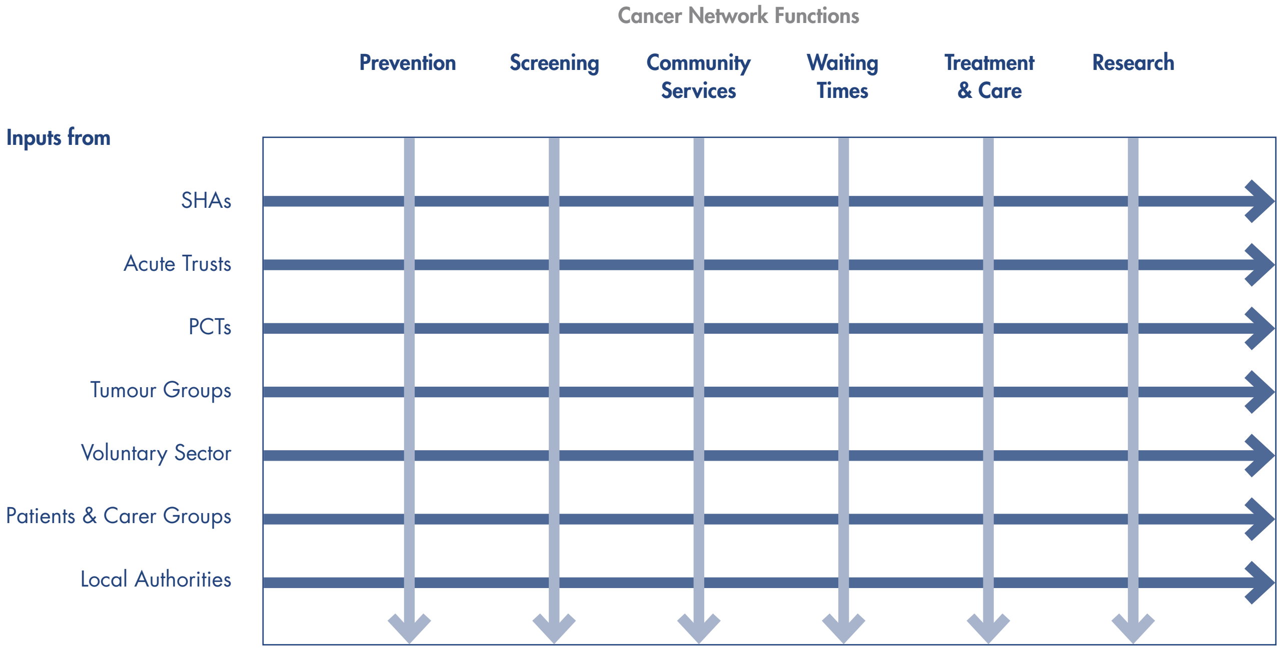
1.8 By early 2001 there were 34 established cancer networks covering the whole of England, each serving a population of between 700,000 and 3 million based around geographical health communities. Headed by a network board, and with a core management team, networks comprise acute trusts, primary care trusts (responsible for commissioning and, in some cases providing, cancer services), voluntary sector organisations, local authorities and a wide range of working groups responsible for developing guidelines and implementing good practice, and they include patient and carer involvement. Networks are accountable to strategic health authorities and are responsible for coordinating expert clinical advice, management and local strategy; working together to improve quality of care and address any inequalities in provision and access.

1.9 Networks are matrix organisations, **Figure 5**, involving all participants in the range of functions deriving from the NHS Cancer Plan for which the network has responsibility. The structure of a typical cancer network is shown in **Figure 6**, and an example of a particular cancer network in **Figure 7**.

Getting money through to front line cancer services

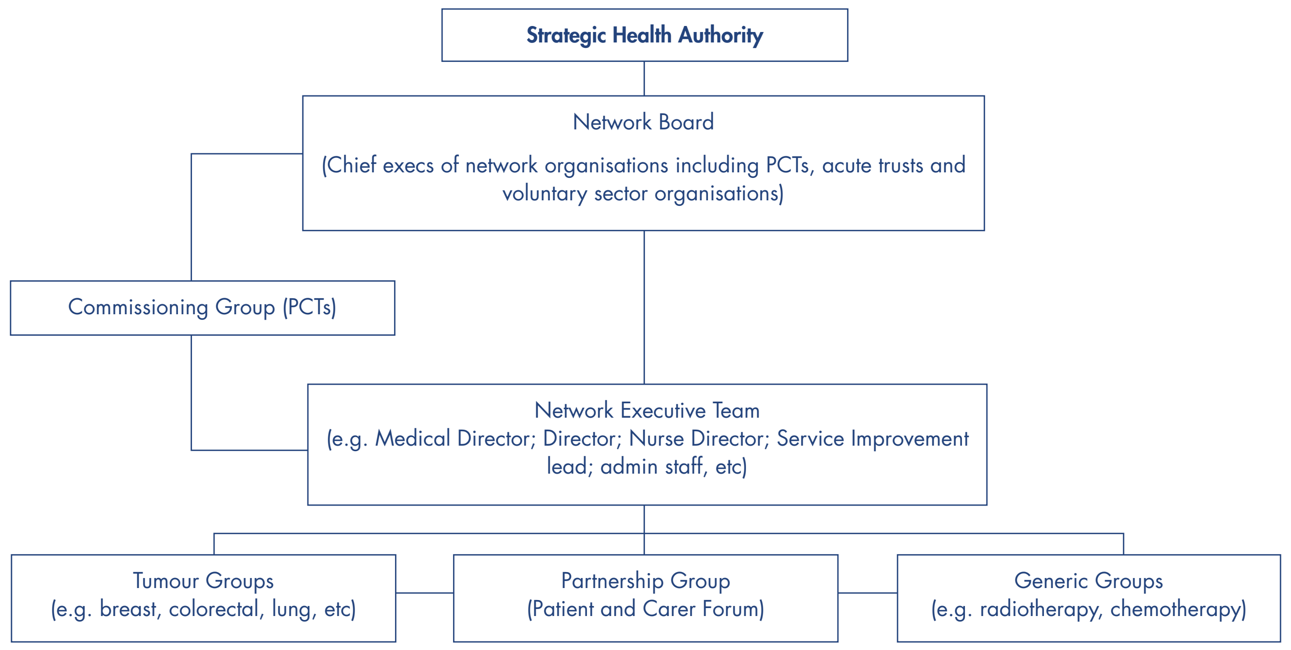
1.10 In the NHS Cancer Plan the Government promised an extra £280 million in 2001-02, rising to £407 million by 2002-03 and £570 million by 2003-04. An investment tracking exercise was undertaken by the Department in early 2003 which showed that investment in the first year had been below target (£199 million) followed by a period of catching up in 2002-03. A second investment tracking exercise is currently in progress. Preliminary results for the 34 cancer networks show that the £570 million target should be met.

5 Cancer networks are complex organisations which cross normal organisational boundaries



Source: National Audit Office

6 Typical Cancer Network Structure



There has been good progress against most of the major targets in the NHS Cancer Plan

1.11 We visited a sample of cancer networks which was agreed with the Department of Health as being representative of networks across England. Cancer networks have, in a short time, helped to improve cancer services in England; though some have achieved more than others reflecting, in part, their current state of development. In terms of particular successes, cancer networks have, for example:

- planned for the introduction of new cancer drugs across the network;
- developed plans for funding specialist palliative care;
- developed action plans for the development of cancer services in line with guidance from the National Institute for Clinical Excellence; and
- facilitated development of multidisciplinary teams, which are an important element in delivering improved patient centred treatment and better outcomes.

7 An example of a cancer network

The 3 Counties cancer network is a relatively small cancer network covering a population of 1.02 million in Gloucestershire, Herefordshire and South Worcestershire. The network includes: thousands of nurses and allied health professionals, hundreds of GPs, hospital consultants and other doctors, scores of GP surgeries, 16 community hospitals, seven voluntary sector organisations providing hospice care, and many other charitable organisations working within its boundaries. The network covers five primary care trusts, two strategic health authorities, four district general hospitals, one oncology centre, two cancer intelligence units, three hospital trusts and two breast screening services.

Source: Department of Health, "The NHS Cancer Plan: Three year progress report - Maintaining the momentum", 2003

1.12 We used our visits to cancer networks (Appendix 2) to look in more detail at specific progress against the NHS Cancer Plan. In each of the cancer networks that we visited we asked the network management team, the SHA and a PCT to assess the progress of the cancer networks against the NHS Cancer Plan. Four (of eight) SHAs rated progress as good or very good, and four rated it as acceptable. Of eight PCTs, five rated progress as good, one as acceptable, one as acceptable/good and one as acceptable/poor. Of nine network management teams five rated progress as good or very good, and four as acceptable or acceptable/good.

1.13 The NHS Cancer Plan contains a very significant number of targets and commitments for achievement during the ten-year lifetime of the Plan. In 2001, 2003 and 2004 the Department of Health reported on progress in implementing the NHS Cancer Plan, taking stock and considering the challenges ahead. These reports showed that significant progress has been made in implementing the NHS Cancer Plan and improving cancer services in England, whilst recognising that there are challenges to be met and more to be done if all the Plan's targets and commitments are to be fully met. In addition to setting out progress, the 2004 report took account of changes since the NHS Cancer Plan was published, such as Shifting the Balance of Power and the NHS Improvement Plan, and demonstrated how cancer services fit in the "new" NHS.

1.14 **Figure 8 on pages 14 to 17** shows progress against the major targets of the NHS Cancer Plan. A detailed progress report is at Appendix 1.

Within overall progress there have been a number of major achievements

1.15 Key successes to date include:

- boosting the downward trend in smoking;
- extending the breast screening programme;
- speeding access to cancer diagnosis and treatment;
- establishing specialist cancer teams;
- reducing variation in access to cancer drugs;
- boosting specialist palliative care services;
- getting more cancer specialists in place and faster than planned;
- modernising and expanding cancer diagnostic and treatment facilities; and
- increasing the pace of research.

1.16 In addition to meeting many targets and commitments in the NHS Cancer Plan, the Department and others have taken a number of other initiatives to improve cancer services across the whole cancer care pathway. These include:

- **on prevention.** Introduction of a tobacco advertising ban in 2003 and restrictions on point-of-sale advertising (2004), the availability of nicotine replacement therapy and the stop-smoking aid Bupropion (Zyban) on prescription, and further measures on smoking prevalence in a Department of Health Public Health White Paper in November 2004. The White Paper also included a commitment to fund community food initiatives in more PCTs from 2006, following and building on lessons learned from the 5-A-Day evaluation;
- **on improving cancer services in the community.** Publication of good practice, commissioning relevant research projects, establishing a dedicated programme within the Cancer Services Collaborative Improvement Partnership, and establishing an integrated cancer care programme to improve coordination of care across the whole care pathway and between primary and secondary care;
- **on improving care.** Actions include strengthening the partnership between the NHS and the voluntary sector at a national level through the National Partnership Group for Palliative Care, the Coalition for Cancer Information which oversees the development, delivery and dissemination of patient information, and providing funding for an End of Life Care programme;
- **on investing in staff.** In addition to the NHS Cancer Plan commitments, the Cancer Care Group Workforce Team has commissioned Skills for Health (the sector skills council for health) to develop a range of competency frameworks to support the development of new and evolving roles within cancer care, including for chemotherapy services, supportive and palliative care, endoscopy services and cystoscopy, and for MDT coordinators. Additional national training programmes for colorectal and breast cancer teams, and for endoscopy;
- **on investing in research.** Actions include doubling the number of patients volunteering in cancer trials a year ahead of schedule; and new initiatives on prevention, and supportive and palliative care.

Some targets require more work to ensure they are met

1.17 Some targets for 2001 to 2004 in Figure 8 and Appendix 1 were not fully met or were met later than planned. In these former cases, there is on-going work to ensure that slippage is minimised. For example, on raising public awareness of cancer, the NHS Cancer Plan contained a target for the development of a programme to promote public awareness of the symptoms and signs of cancer and benefits of early diagnosis by 2001. Whilst this target was not met, the Department has provided funding to the voluntary sector to raise public awareness, and has undertaken research projects, the results of which are under consideration. It is currently planned that a pilot programme of raising public awareness of the symptoms of cancer will be set up in 2005, which will include an assessment of the impact of the programme on symptomatic patients and whether they are presenting earlier for diagnosis and treatment.

1.18 Other challenges remain. For example considerable effort will be required to meet the waiting times targets for all cancers by 2005; and further service expansion will be needed if the target for the number of smokers quitting is to be met.

Progress is being made in spreading good practice, facilitated by the Department of Health and the Modernisation Agency

1.19 A number of initiatives have been put in place to identify and implement good practice since the establishment of cancer networks. The Cancer Services Collaborative Improvement Partnership, founded in 1999 as part of the NHS Modernisation Agency, is a national initiative to improve experience and outcomes of care for patients with suspected or diagnosed cancer by optimising systems of care delivery. It provides specific funding for dedicated staff resources and project management support for clinical teams in cancer networks. All but one of the cancer networks in our survey told us that Cancer Service Collaborative Improvement Partnership projects had been useful in improving patient-centred care.

1.20 The Cancer Action Team (CAT) funded by the Department of Health has a key role to play in sharing information and spreading good practice. It runs the Network Development Programme (NDP), which hosts meetings of all 34 cancer networks and issues regular newsletters. Networks told us that the NDP was the main way in which they learned of, and shared, good practice. The programme is designed to support cancer networks in their development as well as the delivery of the NHS Cancer Plan.

1.21 All network management teams that we visited thought the CAT were very helpful and supportive, and were unanimous in their praise for the National Cancer Director and his team.

8 Progress against major targets in the NHS Cancer Plan

Improving Prevention

Smoking

Commitment	Progress
Reduce smoking among manual groups from 32% in 1998 to 26% by 2010.	Smoking among manual groups has reduced from 33% in 1998 to 31% in 2003. (Note – the method of calculation has changed for smoking prevalence in manual groups).[1]
Establish comprehensive smoking cessation services in PCTs by 2002.	Stop smoking services were established in all PCTs by 2001.
800,000 smokers successfully quitting[2] at 4-week stage between 2003-04 and 2005-06.	204,151 4-week quitters reported in 2003-04.
£2.5m for research into reduced smoking prevalence.	Funding for a range of projects, including evaluation of 'stop smoking' initiatives. £2.2m spend to date.

Diet & Nutrition

Commitment	Progress
5-A-Day programme to increase fruit & vegetable consumption. Roll-out 2002 onwards.	National awareness campaign on-going. 5-A-Day community initiatives targeting deprived areas (66 PCTs) being undertaken - to be evaluated late 2005.
National School Fruit Scheme - to make a free piece of fruit available to children aged 4-6 each school day.	Scheme extended to include vegetables. Nearly 2 million school children now participating – a 94.7% take up amongst eligible schools. Roll-out achieved in all English regions.

Public Awareness

Commitment	Progress
Public awareness smoking campaigns.	Large scale media campaigns funded by Department of Health. Evidence suggests increased awareness of key messages.
Development of programme to promote public awareness of cancer in 2001.	Funding provided for research into programme to raise public awareness. Five research projects commissioned in 2001. A pilot programme to raise public awareness of cancer symptoms will be set up in 2005.

Improving Screening

Breast Screening

Commitment	Progress
All women will have two views of the breast taken at every screening by 2003.	81 out of 85 breast screening units met target. All will achieve target by August 2005.
Routine breast screening to be extended up to age 70 by December 2004.	All 85 units are expected to extend screening by April 2005.

Cervical Screening

Commitment	Progress
Liquid based cytology pilots to be reviewed by NICE in 2002. If successful, introduced across the NHS.	Pilot studies completed. In 2003 NICE recommended national roll-out, and cervical screening modernisation programme announced.
Health authorities to achieve 80% cervical screening coverage by 2002.	Considered an unfair expectation for all PCTs, because of their smaller size. Target dropped.
By 2001 all PCTs to review cervical screening coverage in deprived and minority ethnic groups.	DH does not monitor this target because of 'Shifting the Balance of Power'. However it remains good practice and there is some good activity in some areas.

Bowel Screening

Commitment	Progress
Bowel screening introduced in 2003 if pilot studies support this.	Insufficient evidence by 2003 to take a decision. Roll-out will commence in April 2006.
Targeted training initiatives in endoscopy in 2001.	National training initiatives for endoscopy were established from 2001. 3 national and 7 regional training centres began training programmes in 2004.

NHS Prostate Cancer Programme

Commitment	Progress
Prostate cancer programme[3] to improve early detection, treatment, care and research.	Prostate Cancer Risk Management Programme launched in July 2001. Good progress made in all areas.

Improving Cancer Services in the Community

Commitment	Progress
£3m p.a. in partnership with Macmillan Cancer Relief for a lead cancer clinician in each PCT.	By April 2004, 279 out of 303 PCTs had lead cancer clinicians in post. But questions over continued funding.
£2m for training in palliative care for district and community nurses.	Training programmes for palliative care delivered in all 34 cancer networks. Funding extended to £2m p.a. for 3 years. 10,000 nurses participated to date.

Cutting Waits for Diagnosis and Treatment

Commitment	Progress
2 week wait for an outpatient appointment after urgent GP referral by Dec 2000.	Now 99.2% within 2 weeks. 93.5% of people with suspected cancer seen by a specialist within target by 2001.
Max 1 month from urgent GP referral to treatment for leukaemia, testicular and children's cancers by 2001.	Between 95% and 100% now achieved. (91.5% - 100% by 2002).
Max 1 month from diagnosis to treatment for breast cancer by 2001 and max 2 months from urgent GP referral to treatment by 2002.	97% of both targets for patients now achieved. 94.2% by 2002 for 1 month target, and 96.5% by 2003 for 2 month target.
Max 1 month wait from diagnosis to treatment for all cancers by end of 2005.	89.9% of patients diagnosed with cancer treated within 31 days. Target date 31 December 2005.
Max 2 month wait from urgent GP referral to treatment for all cancers by end of 2005.	78% of all urgently referred patients with cancer treated within 62 days. Target date 31 December 2005.
By 2004 all cancer patients will have pre-planned and pre-booked care.	Draft template issued to NHS in early 2004 to enable data collection to begin. Progress against target will be assessed in 2005.
Roll-out to cancer networks of Cancer Services Collaborative programme of service improvement by 2003-04.	Service Improvement Leads in every cancer network and service improvement underway.

8 Progress against major targets in the NHS Cancer Plan *(continued)*

Improving Treatment

Commitment	Progress
National Institute for Clinical Excellence (NICE) to commission Improving Outcomes guidance on all cancers by 2003 for health authorities (now PCTs) and trusts to implement.	4 new reports and 2 updates since 2000. Programme to be completed in 2005-06. During 2004 cancer networks developed action plans for implementing guidance setting firm milestones for delivery.
NICE appraisals of cancer drugs to end the postcode lottery.	16 drugs appraised and 11 appraisals in progress. National Cancer Director in 2004 reported increasing drug use, but unacceptable variations between networks remain. New measures being introduced to address this.
Care of cancer patients to be reviewed by a specialist multi-disciplinary team.	More than 95% of trusts report providing care within teams for lung, breast, upper gastro-intestinal and bowel cancers.
National Cancer Standards published in 2000. Peer Review visits to begin in 2001.	Standards published in 2000; revised and extended in 2004. All cancer networks reviewed in 2001. Second review began in November 2004 to assess progress.
National cancer datasets developed by 2002.	Largely complete. Datasets for some rarer cancers will not be completed until 2005.
The government will set out plans to strengthen cancer registries in 2000.	Action plan for cancer registries published in 2001. Cancer registration improved and links to cancer networks established.

Improving Care

Commitment	Progress
Health authorities to agree palliative care investment with networks in 2001.	Cancer network investment strategies for palliative care in place for 3 year period 2003-2006.
£50 million for hospices and specialist palliative care services by 2004.	£50m has been allocated to cancer networks.
Supportive care strategy to be developed, including standards for supportive and palliative care in 2001.	Draft strategy published as cancer standards in 2002. Due to be completed in 2005.
NICE to develop guidance on supportive care in 2001.	Guidance published March 2004.
New training in communication skills.	Advanced communication skills training programmes developed. Pilots successful; roll-out started.
Cancer Information Advisory Group will identify gaps and develop guidance on patient information in 2001.	Remit changed to focus on dissemination and delivery. Accreditation processes for information providers being developed, and cancer information leaflets are now available centrally for local use.
Cancer networks to take account of views of patients/carers in planning services in 2001.	Partnership Groups established in 30 out of 34 networks by 2004.

Investing in Staff

Commitment	Progress
By 2006 there will be nearly 1000 extra cancer specialists.	Met ahead of schedule. 975 extra consultants in post by June 2004.
Increase specialist trainee places by 2008.	No specific target in plan, but 36% increase in training places between 1999 and 2003.
Scheme to increase SHOs in histopathology.	£1.3m invested to fund 3 training centres. An Intensive Training and Assessment Centre for histopathologists from overseas was set up in 2003-04. In 2004-05, 3 new training centres have been set up and 6 additional centres will come on stream in 2005-06.
Training places for radiographers to be increased; attrition rates reduced.	Training places have more than doubled. Average attrition rates reduced significantly between 2001 and 2002 in diagnostics and radiotherapy.
New skills and new roles for cancer staff.	New roles introduced for diagnostic and other staff. New skill mix models are being implemented for breast and cervical screening and radiotherapy.

Investing in Facilities

Commitment	Progress
New MRI scanners, linear accelerators and other cancer equipment to be delivered.	Over £400m invested in new facilities so far. All plans achieved by end of 2004. By end of 2004 the NHS had received 68 MRI scanners, 177 CT scanners, 83 Linear accelerators and over 700 items of breast screening equipment since April 2000.
Additional funding to support modernisation of 23 pathology services.	£28m invested to support upgrades and reconfigurations in 39 pathology sites.
National Cancer Facilities Strategy based on an audit by cancer networks by 2001.	Audits undertaken. Single facilities strategy document not produced. New facilities strategy in development incorporating, for example, radiotherapy stocktake and PET-CT framework.

Investing in the Future: Research and Genetics

Commitment	Progress
National Cancer Research Institute, including National Cancer Research Network, to be fully established in 2003.	NCRI established 2001, and NCRN fully established in October 2002.
Form partnership with Macmillan Cancer Relief on genetic counselling in 2001 to develop new services.	Pilot work underway.

Implementing the NHS Plan

Commitment	Progress
Additional £570m for cancer services by 2003-04.	Preliminary results of current tracking exercise show target met.
Networks to develop service delivery plans, underpinned by workforce, education and training and facilities strategies in 2001.	Strategic plans produced, but variable quality. By late 2003 a third of networks had a workforce and/or education and training strategy. Improving Outcomes guidance action plans and other initiatives are seeking to address this.

NOTES

1 General Household Survey data is now weighted. This roughly increases prevalence by one percentage point.

2 New commitment in Priorities & Planning Framework 2003-06

3 Published September 2000 in advance of NHS Cancer Plan

PART TWO

The NHS Cancer Plan is well founded and there is an opportunity now to extend and update the strategy to reinforce partnership working and network structures

The Plan is well constructed, well regarded and provides a good foundation for further refinements

The NHS Cancer Plan is broadly comprehensive

2.1 In 2002 (after publication of the NHS Cancer Plan) the World Health Organisation (WHO) published guidelines setting out good practice for the content and implementation of national cancer control programmes. In the WHO's view, such programmes should evaluate ways to control cancer and implement those that are the most cost-effective and beneficial for the largest part of the population. A national cancer control programme should promote the development of treatment guidelines, emphasise prevention and early detection, and provide support to patients with advanced disease. The WHO guidelines, **Figure 9 overleaf**, are intended to provide the information needed for the development of feasible, equitable, sustainable and effective national cancer control programmes, setting out ways to approach cancer control, and how to plan, implement, monitor and evaluate a cancer control programme.

2.2 We commissioned an independent consultant – Anthony J Harrison, Senior Fellow, King's Fund – to compare the NHS Cancer Plan against the WHO guidelines, looking in particular at whether the Plan is comprehensive, covering all the areas identified by the WHO; and whether the NHS Cancer Plan is consistent with the guidelines in terms of devising, implementing and monitoring a national cancer control programme.

2.3 He concluded that the NHS Cancer Plan broadly covers all of the main elements which the WHO considers appropriate to an effective cancer control programme, from prevention through to terminal care. We consider that the coverage of the Plan is impressive; and it sets out, for each of the areas where action is proposed, indicators of what should be achieved by specific dates. The Plan also provides the basis for the improvement of cancer services through new equipment, extra and more specialised staff, better access to drugs and a redesigned care pathway, focussed in particular on delays in access.

The NHS Cancer Plan has been a model for cancer plans in other countries

2.4 A number of overseas national or state cancer plans have been published in recent years, some of which have been modelled on the NHS Cancer Plan. Inevitably, because they start from different baselines, it is not straightforward to compare the NHS Cancer Plan with those of other countries. Nonetheless, in key aspects such as coverage and comprehensiveness, use of evidence and the setting of explicit goals for the implementation process, the NHS Cancer Plan compares favourably with other national or state plans.[5]

Cancer planning in Scotland and Wales follows broadly similar lines to England

2.5 In recent years, major steps have been taken in both Scotland and Wales to improve the provision of cancer services. Scotland has its own national Cancer Plan, published in 2001, and has three cancer networks which receive ring-fenced funding **(Figure 10 on page 21)**.

2.6 In Wales **(Figure 11 on page 21)** three cancer networks were established in 2002. A Welsh Strategic Service Development Plan was published at the end of 2002 by the Cancer Services Co-ordinating group (CSCG). This Plan was further developed by Cancer Networks in their Service Development Plans.

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[5] *"Cancer control policies in eleven OECD countries"*, JA Bennett et al, University of Ottawa, 1999. This covers Australia, Belgium, France, Germany, Ireland, Italy, Japan, New Zealand, Sweden, US and UK. Anthony J Harrison also considered the following in greater depth: France: *"Cancer: Une mobilisation nationale tous ensemble"*; New Zealand: *"Towards a cancer control strategy for New Zealand"*; American States: *"New Jersey Comprehensive Cancer Control Plan"*.

9 Priority actions for National Cancer Control Programmes

Component	Guidelines for all countries	Additional guidelines for countries with a high level of resources
National cancer control programme	1 Develop a national cancer control programme to ensure effective, efficient and equitable use of existing resources. 2 Establish a core surveillance mechanism to monitor and evaluate outcomes as well as processes. 3 Develop education and continuous training for health care workers.	a Full, nationwide implementation of evidence-based strategies guaranteeing effectiveness, efficiency and accessibility. b Implement a comprehensive surveillance system, tracking all components and results. c Provide support for less affluent countries.
Prevention	1 Implement integrated health promotion and prevention strategies. 2 Control tobacco use, and address alcohol use, unhealthy diet, physical activity and sexual and reproductive factors. 3 Promote policy to minimize occupational related cancers and known environmental carcinogens. 4 Promote avoidance of unnecessary exposure to sunlight in high risk populations.	a Strengthen comprehensive evidence-based health promotion and prevention programmes and ensure nationwide implementation in collaboration with other sectors. b Establish routine monitoring of ultraviolet radiation levels if the risk of skin cancer is high.
Early diagnosis	1 Promote early diagnosis through awareness of symptoms of prevalent cancers. 2 Ensure proper diagnostic and treatment services are available for the detected cases. 3 Provide education and continuous training to target population and healthcare workers.	a Use comprehensive nationwide promotion strategies for early diagnosis of all highly prevalent detectable tumours.
Screening	1 Implement screening for cancers of the breast and cervix where incidence justifies such action and the necessary resources are available.	a Effective and efficient national screening for cervical cancer (cytology) for women over 30 and breast cancer screening (mammography) of women over 50.
Curative therapy	1 Ensure accessibility of effective diagnostic and treatment services. 2 Promote national minimum essential standards for disease staging and treatment. 3 Establish management guidelines for treatment services, essential drugs list, and continuous training. 4 Avoid performing curative therapy when cancer is incurable and offer palliative care instead.	a Reinforce the network of comprehensive cancer treatment centres that are active for clinical training and research, and give special support to the ones acting as national and international reference centres.
Pain relief and palliative care	1 Implement comprehensive palliative care that provides pain relief, other symptom control, and psychosocial and spiritual support. 2 Promote national minimum standards for management of pain and palliative care. 3 Ensure availability and accessibility of opioids, especially oral morphine. 4 Provide education and training for carers and public.	a Ensure that national pain relief and palliative care guidelines are adopted by all levels of care; and nationwide there is high coverage of patients through a wide variety of options, including home-based care.

Source: WHO: "National Cancer Control Programmes: Policies and managerial guidelines." 2002

10 Cancer planning in Scotland

In May 2001 scenarios published by the Scottish Executive Health Department set out forecast cancer incidence and mortality, providing a forward look to enable the NHS in Scotland to plan future cancer services. These scenarios are currently being updated.

In July 2001 the Cancer Plan – *'Cancer in Scotland: action for change'* – was published, expected to run for at least 10 years, and covering prevention, screening, access, improving treatment and care, palliative care, resources and research and development.

The Plan established three regional cancer network areas, in the north, west and south east of Scotland. Each was given flexibility as regards structure, and additional ring-fenced investment totalling £25 million a year until at least 2005-6 was provided for all three networks to use to improve access, availability and quality of cancer services. The regional networks' structures, including governance and accountability issues and how they work with the NHS Scotland, the voluntary sector and patients, is currently being restructured to keep pace with organisational developments, and remain at the forefront of cancer services planning and delivery.

Each cancer network is required to produce an annual plan and 6-monthly feedback reports based on a Scottish Executive Health Department template. The Health Department produces an annual report on progress, and has recently published a three-year review of progress against all actions set out in the Cancer Plan. This report concluded that there have been significant improvements to date, though more remains to be done. The Health Department is likely to review progress again in 2 years time.

Source: Scottish Executive Health Department

Cancer networks have very positive views of the NHS Cancer Plan

2.7 Cancer leads or managers from each cancer network management team, primary care trust and strategic health authority we spoke to (Appendix 2), were very positive about the NHS Cancer Plan. They described it as a useful tool which outlined strategic direction across the patient pathway. Other positive comments included that it was evidence based, provided real targets and milestones, and had succeeded in driving improvements in cancer services for patients. Limited criticisms raised were mainly on the Plan being focussed on secondary care at some expense of primary care and prevention. The Department told us that the focus at the time of publication of the NHS Cancer Plan was addressing secondary care and that further research had been needed to establish what was needed in primary care. This has been addressed and the Department is now putting greater focus on primary care. A White Paper on Public Health which includes prevention of cancer has recently been published.

11 Cancer planning in Wales

After Calman Hine, the Cameron Report (1996) reviewed cancer services in Wales, concluding that multi-disciplinary team working was essential, with service development based on implementation of standards for cancer services. The CSCG was established to implement the recommendations of the Cameron Report. The CSCG advises the Welsh Assembly Government on the development of cancer policy.

Cancer is a stated top priority for the Welsh Assembly Government and work is in hand to develop a national policy for tackling this disease. Targets for cancer services are published in the annual Welsh Assembly Government's Services & Financial Framework planning guidance. There are 12 acute trusts in Wales, with (since April 2003) 22 local health boards who commission health services. Health Commission Wales commissions specialised cancer services at a national level. The Assembly Government's Health and Social Care Department's three regional offices performance manage the NHS against the SaFF targets. To assist efforts to improve cancer services additional funding in support of cancer services has been made available at various times since 1999 by the Welsh Assembly Government.

From 1997 minimum standards were set for specific cancer types and revised versions of these standards are to be published in 2005. Three cancer networks, funded by the Welsh Assembly Government, were set up in 2002. These networks are seen by the Assembly Government as the driving force in implementing the standards and improving the quality of care for patients with cancer.

In December 2002 a Welsh Strategic Service Development Plan (SSDP) looked at the requirements for cancer services over 5 years (10 for radiotherapy). The three cancer networks have now further developed the all Wales SSDP with their own detailed network five-year SSDP. Implementing the new 2005 Cancer Standards through the SDPs and meeting the SaFF targets will lead to improved patient outcomes.

Source: Welsh Assembly Government, Cancer Services Co-ordinating Group, Wales

2.8 Cancer network management teams also felt that the NHS Cancer Plan had been a welcome and useful document, though there was some concern that the focus on waiting times had made it difficult to sell the Plan to clinicians. Some cancer network management teams felt that a review of the NHS Cancer Plan would be timely, building on the excellent work that had already been achieved, and focusing on the future of cancer services in England, though these comments were made prior to the 2004 progress report on the NHS Cancer Plan by the Department of Health.

There is scope to extend and update the strategy to tackle cancer in England

2.9 Since the NHS Cancer Plan was published in 2000 things have moved on within the NHS. There are new organisational structures within the NHS and new developments within cancer. In the light of these and planned and future changes there is scope to extend and update the cancer strategy, and ensure that it is available and published in a useful and unified way:

i) Estimates of the future cancer burden

2.10 The WHO guidelines state that "as an initial step, a national cancer control programme requires an analysis of the cancer burden and risk factors….as well as a capacity assessment". Though some aspects are covered in other guidance, such as that produced by NICE, the Plan contains no estimates of the numbers expected to be diagnosed with cancer over the medium to long term (as has been done in Scotland), nor of changes in the relevant risk factors. Such estimates have three key functions:

- at a tactical level they are needed as the basis for estimating the scale of the capacity required to treat the estimated numbers requiring treatment, and of the care facilities for those for whom treatment is not successful;
- at a strategic level they are a key element in determining the appropriate balance between prevention and treatment; and
- they provide the baseline for determining what the impact of the NHS Cancer Plan is expected to be, and therefore its expected effectiveness.

ii) Efficiency of NHS cancer services

2.11 The WHO guidelines comment that "an efficient programme is one that achieves the best possible results using the available resources". Although this is complex, and has not been done comprehensively in any country, this requires the identification of alternative spending plans – different mixes of policies and resources and different spending levels - and measures of what they will achieve. At the strategic level, for example, this involves estimating the impact of preventive measures on the numbers developing cancer and of different treatment regimes on survival chances, the costs of achieving these reductions and the alternative uses of the resources involved. It would also include, given the objectives of the NHS Cancer Plan, estimating the most cost-effective ways of reducing disparities in access and incidence and improving patient experience.

iii) Costing the objectives of the Plan

2.12 Although the Plan makes specific commitments on additional funding for cancer (£570 million over three years), the costs of individual components of the Plan are not all made explicit. While early reports on specific cancers published by the Department were supported by specific funding for restructuring cancer services to improve outcomes[6], the Plan itself does not provide a financial envelope within which strategic decisions could be made. However the Department told us that, in line with devolving responsibilities to the front line, NHS organisations have maximum flexibility to use allocated resources to meet local circumstances and priorities within the context of national frameworks.

iv) Updating the cancer strategy

2.13 There are no plans in place to formally revise or update the NHS Cancer Plan itself, though the Department (including organisations such as the National Institute for Clinical Excellence) has published, and will continue to publish, guidance to take the Plan forward. This includes the Department's four-year review in October 2004 which aims to show how cancer fits into the evolving NHS, and a rolling publication and revision programme of clinical guidelines (by NICE).

2.14 The NHS has undergone structural and other major changes since the publication of the NHS Cancer Plan, including the creation of strategic health authorities in 2002. Current and future changes include the creation of NHS foundation trusts and independent sector treatment centres. These changes mean that cancer networks are increasingly operating in a new environment. However, the Department currently has no plans to bring together and publish in a unified form a revised and updated cancer strategy, which could also include clarification of the role of network management teams, and broad descriptions of key players' roles within the wider cancer network.

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[6] Improving Outcomes Guidance on breast cancer (1996), colorectal cancer (1997), and lung cancer (1998). Later IOG reports set out costings for implementation but had no ear-marked funding. IOG implementation was considered as part of the spending review, and appropriate funding included in NHS allocations but not separately identified.

Cooperation between constituent organisations is key to the effectiveness of cancer networks and the NHS Cancer Plan, but in many cases needs further development

2.15 Most cancer patients require care from many parts of the NHS – primary, secondary and tertiary care as well as the voluntary sector. As noted by the All Party Parliamentary Group on Cancer[7], cancer networks have shown that they are capable of delivering change, by working across the traditional primary – secondary care divide and across different professional disciplines.

2.16 Cancer networks are a partnership of constituent organisations, at the centre of which is the network management team. They were set up to ensure integrated care across geographical localities. They were new to the NHS, but since their creation there have been various structural changes to the NHS, including new organisations and new roles for strategic health authorities and primary care trusts. These changes require strong and committed partnership working among the networks' constituent organisations, and appropriate resourcing of, and effective planning and monitoring by, network management teams.

2.17 Our survey asked network management teams to assess the effectiveness of relationships between the network and its constituent organisations. The results are shown in **Figure 12**. With the exception of local authorities, relationships were generally regarded as at least adequate.

2.18 From our discussions with cancer network management teams and others, it is apparent that relationships with PCTs were particularly challenging, though good relationships had been built up in many cases. This is partly explained by the fact that most PCTs were in general set up after cancer networks had formed, PCTs thus finding their own feet at a time when cancer networks had only just begun to establish themselves. Department of Health guidance[8] issued in 2002 recommended that cancer networks should develop formal agreements between constituent organisations about their authority and how they work together, but there has been little progress made in implementing this recommendation.

Involvement of acute and primary care trusts in cancer networks can be a very positive factor but does not always happen

2.19 Network management teams told us that senior managers in most acute trusts were actively or very actively involved in the cancer network. There was less participation from PCTs, with half of all network management teams reporting that some or all the PCTs had little or no senior management involvement with the network.

2.20 There was a strong correlation between networks with effective relationships and those in which constituent organisations were actively involved. For example, networks reported that where involvement is high, relationships helped to push forward the NHS Cancer Plan, with effective joint working at a strategic and clinical level. However, where networks reported low involvement, they commented that a lack of enthusiasm by trusts and rivalries between trusts had hindered progress, particularly in planning and adopting network wide approaches to service reconfiguration and in addressing specific problems such as a shortage of radiologists.

12 Network management teams' assessment of the effectiveness of relationships with constituent organisations

Constituent Organisation	Very Good	Good	Adequate	Poor	Very Poor
Acute Trusts	11 (32%)	20 (59%)	3 (9%)	0	0
PCTs	8 (24%)	15 (44%)	8 (24%)	3 (9%)	0
SHAs	11 (32%)	9 (26%)	12 (35%)	2 (6%)	0
Voluntary Sector	7 (21%)	19 (56%)	7 (21%)	1 (3%)	0
Local Authorities	0	0	10 (34%)	10 (34%)	9 (31%)

Source: NAO survey

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[7] "Meeting national targets, setting local priorities: the future of cancer services in England". All-Party Parliamentary Group on Cancer, 2004.

[8] 'Shifting the Balance of Power: Next Steps', Department of Health, 2002.

Some strategic health authorities are proactive and support cancer networks, but not all

2.21 In January 2003, the Chief Executives of SHAs and the National Cancer Director agreed that further work was needed to clarify the accountabilities of cancer networks, their role in clinical governance, and help define what makes a cancer network. They acknowledged also that there needs to be clarity within and across SHAs about how networks are integrated into whole systems. The National Cancer Director and SHA Chief Executives are currently reviewing the functioning of cancer networks in the light of changes within the NHS.

2.22 SHAs are responsible for ensuring cancer networks are in place and operating effectively, and for supporting their development. Whilst most SHAs that we visited acknowledged that providing support to facilitate the development of cancer networks was a key role, it was clear that some adopt a much more hands-on approach than others. At one end of the spectrum some SHAs took very much a strategic overview; at the other they were very proactive, for example publishing a detailed strategic framework for cancer services development in their locality. Summary local development plans produced by SHAs in 2003 varied in the extent to which they addressed cancer issues, with some making no reference to cancer network involvement. The NAO believes good practice by SHAs in supporting cancer networks includes establishing accountability agreements with networks to ensure a common understanding of strategic direction and goals.

Good initial progress has been made in securing patient involvement, and networks now need to build on this and develop partnership groups into fully representative, effective network participants

2.23 As noted by the National Institute for Clinical Excellence in their guidance on supportive and palliative care, patient involvement in decisions about health care can bring about changes in the provision of services. The NHS Cancer Plan confirmed that NHS decision makers at all levels should take account of the views and preferences of patients, and included a commitment for 2001 that cancer networks should take account of the views of patients/carers in planning services. Consequently a 3-year Cancer Partnership Project, jointly funded by the Department and Macmillan Cancer Relief aimed to establish partnership groups (patients, carers and professionals) on each cancer network.

2.24 An independent evaluation in May 2004 by Professor Alison Richardson from the Florence Nightingale School of Nursing and Midwifery, and John Sitzia and Phil Cotterell from the Patient and Public Involvement Research Unit at Worthing and Southlands Hospitals NHS Trust, concluded that 30 of the 34 cancer networks had established a partnership group and that the range and depth of activities accomplished by them was impressive, both in terms of projects completed and their visibility in the cancer network. Cancer networks confirmed, in our survey, that the majority (16 out of 27 networks who responded) of partnership groups had been effective or very effective. However, the May 2004 evaluation found that over half of groups expressed concerns over future funding, and that around half of the groups had no representation from black and ethnic minority ethnic communities.

Network boards can have problems settling their purpose and getting representation from participant bodies

2.25 Cancer networks are headed by a network board. Key responsibilities of the board include strategic planning, clinical governance development, strategic monitoring, and ensuring support strategies are in place for workforce and facilities planning. Discussions with the Cancer Action Team indicated that by 2004 a considerable number of cancer network boards were still struggling with issues such as clarity of purpose, authority and consistent senior membership

2.26 The NHS Cancer Plan notes that close involvement of Chief Executives of provider trusts and PCTs in network boards is essential. However, our survey of cancer networks found that complete representation of acute trusts applied in three quarters of the networks which provided information (18 out of 23 respondents). For the other five networks, between half and three quarters of trusts were represented on the network board. Our survey showed that about half of the acute trust representatives were at Chief Executive level. For PCTs, 11 of the 23 network boards had full representation; and a quarter of the PCTs represented were represented at below their board level.

Networks face challenges in their staffing and resources

Not all network management teams are fully staffed

2.27 Each network should have an effective management team, and network-wide working groups to plan services and map patient pathways. As a minimum, the network team should include a lead clinician, lead nurse, lead manager and a service improvement lead. Increasingly cancer networks also have leads for pharmacy, information, audit, palliative care, user involvement and public health. We regard this as good practice.

2.28 Our survey returns revealed that these complements were not always complete. At the time of our survey all networks had a lead clinician in place, but five networks had no lead nurse. One network had no lead manager and one had no service improvement lead. With other positions in the network management team, whilst it is left to the networks themselves to decide upon whether or not such posts are required, the staffing of these positions, once created, is also a challenge **(Figure 13)**. Networks told us that financial constraints were the main reason why vacancies were not filled.

Cancer network funding and resourcing remains a challenge

2.29 From 2001, cancer network management teams have received central funding from the Department of Health of £40,000 a year for initial set-up/support costs, irrespective of the size of the network or the community served. Any other resources were expected to be obtained from the network's PCTs responsible for commissioning cancer services. Six of the ten network management teams that we spoke to told us that they thought the level of resources they had was acceptable (four) or good (two). Four teams told us the level of resources was poor. One network management team told us that the network was being kept afloat by keeping staffing vacancies open, one was seeking funding from the voluntary sector for a lead pharmacist post which the PCTs would not finance, and others were required to pay for accommodation without this being adequately funded.

Improvements are possible in the ways in which cancer networks plan, commission cancer services and monitor performance

Not all cancer networks are planning effectively

2.30 The NHS Cancer Plan requires cancer network constituent organisations to work together to develop strategic service delivery plans to develop all aspects of cancer services – prevention, screening, diagnosis, treatment, supportive care and specialist palliative care. The target set was for each network to draw up a three-year service delivery plan in line with the NHS Cancer Plan and other cancer guidance by 2001. By the same date, all cancer networks were expected to draw up workforce, and education & training strategies to underpin the cancer network service delivery plan.

2.31 In December 2001 NHS regional offices (as they then were) provided the National Cancer Director with an appraisal of service delivery plans that were to be produced by their cancer networks by 31 October 2001. Inevitably, with networks and PCTs in the early stages of development, the appraisal showed that not all networks had produced fully comprehensive service delivery plans. Regional offices had varied opinions on the quality of the service delivery plans. Typical comments stated that some plans were comprehensive and well-focussed, well-structured with a sound appreciation of problems within the health community, whilst other plans lacked strategic grasp, contained a great many omissions and outstanding questions, and varied in content and structure.

13 Created positions within cancer networks are not all filled

	Created	Staffed	Not Staffed	% Created and Not Staffed
Lead Pharmacist	16	12	4	25%
IT/Data Manager	25	21	4	16%
User Liaison Lead	32	29	3	9%
Public Health Lead	19	15	4	21%
Palliative Care Lead	25	23	2	8%

Source: NAO Survey

2.32 Of the ten cancer networks that we spoke to in 2004, six had a three-year service delivery plan drawn up in 2001 or 2002 and which was still a live planning document. Of these three had been or were currently the subject of review. A seventh cancer network had drawn up an interim service delivery plan in 2001 and produced a revised document in 2004. Three of the ten cancer networks told us they had no current planning document to plan for and monitor the implementation of the NHS Cancer Plan.

2.33 Although at a national level workforce development was seen as a priority in the NHS Cancer Plan, only 12 of the 34 cancer networks had developed a workforce strategy by 2003, and only 13 of the 34 had developed an education and training strategy. A network of workforce development cancer leads is now in place to assist cancer networks with workforce planning and related education and training. In addition, Improving Outcomes guidance action plans are now starting to address workforce issues.

Most commissioning of cancer services is joined up but there are nevertheless problems

2.34 PCTs, as budget holders, are responsible for commissioning cancer services. They are expected to use cancer network plans and advice to contract for cancer services across the network.

2.35 Generally, the cancer networks that we visited had adopted (or were planning to adopt) a network-wide approach to commissioning cancer services, with the designation of a lead commissioning PCT, allowing all PCTs within a network to agree on funding a common cancer strategy across the network. In practice, however, there are variations and the Cancer Action Team noted that some PCTs were producing their commissioning plans in isolation from other PCTs in the network, and continuing to contract cancer services in the traditional way with their local acute trust. The All Party Parliamentary Group on Cancer noted that in some parts of the country joint commissioning is not sufficiently in place and they recommended that the PCTs should be required to collaborate in commissioning cancer services. The inherent risk in individual commissioning by PCTs is that the priorities identified by the network are not addressed, to the detriment of patient outcomes.

14 Example of collective commissioning

The North Derbyshire, South Yorkshire and Bassetlaw PCT Consortium (NORCOM) provides an example of collective commissioning. NORCOM is a formal joint sub-committee of the 13 PCTs in the cancer network, that allows the PCTs to make collective decisions on the planning, procurement and review of cancer services in their area.

Benefits of NORCOM are that it has enabled the PCTs to prioritise the development of cancer services across the network, including addressing variations in prescribing practices within the community, ensuring NICE guidance is implemented, and planning tertiary services in the area effectively. NORCOM has also facilitated the making of difficult decisions on a collective basis, for example on the reconfiguration of cancer services.

2.36 The extent to which cancer network management teams provide input to the local delivery planning process varies. Some network management teams (six of the ten we spoke to) are closely involved in providing information to enable PCTs to prepare local development plans, resulting in well-defined plans based on a firm assessment of current service provision. But some have limited input into the process (three of the ten) and in one case virtually no input.

2.37 Many individuals we spoke to in PCTs told us that they were finding the planning process for commissioning cancer services difficult. In particular, the variable quality, completeness, and consistency of local data led to difficulties at the planning stage. This was attributed partly to a lack of resources and structure devoted to data collection and analysis locally. SHAs are responsible for amalgamating PCT local plans. Individual comments from SHAs that we spoke to included that the quality of PCT planning documents varied considerably, that the local planning process was an ongoing learning process, and that the process was disjointed and unsatisfactory.

Key performance targets are generally monitored at all levels within the cancer network but monitoring of other targets and commitments is variable

2.38 Cancer networks have an important role in monitoring progress against the Plan. We found variation in the extent to which this was being done, and confusion as to whose responsibility within the network it was to do this.

2.39 Cancer network management teams monitored progress against the Plan through reports to their network Board, but there was inconsistency in how frequently this was done. We found that that four networks out of 34 monitored progress at least monthly, around half monitored quarterly, seven monitored less frequently than once a quarter, and five did not monitor progress at all.

2.40 Most network management teams we visited monitored key targets on a regular basis (other than that on smoking cessation, which is largely left to PCTs), and there is regular reporting to the network board on other issues, usually annually or on an ad hoc basis. For some issues, such as patient communication and communication skills of health professionals, networks generally had no formal process for monitoring or reviewing progress. These are now starting to be addressed.

2.41 Most SHAs that we visited monitored key targets in the NHS Cancer Plan on a monthly basis, though two regarded it as the responsibility of the network management team to do so. All of the PCTs that we visited – as part of their remit to hold provider trusts to account for the delivery of the services they commissioned - were monitoring key targets on a regular basis.

Policy and structural changes in the NHS pose challenges for the implementation of the Plan, particularly in terms of cooperation between constituent network organisations

2.42 Since the NHS Cancer Plan was published in September 2000 the NHS has seen a number of structural changes, including the abolition of health authorities and the establishment of SHAs. There are further policy and structural changes that are already known about and which will take place over the next few years. Some of these will provide a significant challenge to cancer networks (and the wider NHS) and the way in which they operate. For example, giving patients more choice about where they receive treatment and care, and the establishment of NHS foundation trusts, are likely to provide challenges for at least some cancer networks.

2.43 In April 2002 the Secretary of State for Health announced the establishment of NHS foundation trusts. Twenty NHS foundation trusts were approved by 1 July 2004. Whilst they are bound by a duty of partnership under the Health and Social Care Act 2003 to cooperate with other NHS bodies, it is unclear what this means in practice. On the positive side the core freedoms of NHS foundation trusts will give them greater flexibility and speed in developing services, and this could well be of benefit to patients.

2.44 However, PCTs and cancer network management teams that we interviewed expressed concerns as to the extent to which NHS foundation trusts will continue to cooperate with the rest of the cancer network, and the extent to which they remain accountable to other network members. A workshop of key stakeholders, convened by the Cancer Action Team in January 2004, identified NHS foundation trusts as one of the high risk areas in terms of implementing the NHS Cancer Plan, as they may limit effective partnership working and collective decision making, and the effective implementation of NICE Improving Outcomes Guidance. On the other hand the Department has stressed that there is no evidence that NHS foundation trusts are having a destabilising effect on cancer services. They also pointed to several NHS foundation trusts that have publicly affirmed their commitment to cancer networks.

2.45 Similar concerns may apply to other developments such as the introduction of independent sector treatment centres, although the Department has confirmed that there is a clear national understanding that independent sector treatment centres should be active participants in cancer networks if they undertake cancer care.

APPENDIX 1

Progress against the targets and commitments in the NHS Cancer Plan

Improving Prevention

Commitment	**Progress**
Smoking	
Reduce smoking among manual groups from 32% in 1998 to 26% by 2010.	Smoking among manual groups has reduced from 33% in 1998 to 31% in 2003 (Note - the method of calculation has changed for smoking prevalence in manual groups).[1]
Establish comprehensive smoking cessation services in PCTs by 2002.	Stop smoking services were established in all PCTs by 2001.
Set local targets to reduce smoking in the 20 health authorities with highest rates.	£50k allocated to the 20 most deprived HAs for projects (with agreed local targets) to help smokers from manual groups to quit.
800,000 smokers successfully quitting[2] at 4-week stage between 2003-04 and 2005-06.	204,151 quitters reported in 2003-04.
Establish local alliances for action on smoking.	42 alliances established across England.
£2.5m for research into reduced smoking prevalence.	Funding for a range of projects, including evaluation of 'stop smoking' initiatives. £2.2m spend to date.
Pilots in prisons and hospitals to reduce smoking prevalence in 2001.	Pilot projects in prisons and hospitals by 2001. Also in the army, factories and working men's clubs. Good practice guides for each setting produced.
Diet and Nutrition	
5-A-Day programme to increase fruit and vegetable consumption. Roll-out 2002.	National awareness campaign on-going. 5-A-Day community initiatives targeting deprived areas (66 PCTs) being undertaken - to be evaluated in late 2005. 'Choosing health' commitment to fund community food initiatives in more PCTs from 2006 following and building on lessons learned from the 5-A-Day evaluation.
Raising awareness of the 5-A-Day message.	Awareness increased from 52% in 2002 to 59% in 2003. Consumption of fresh fruit rose by 5.8% between 2001-02 and 2002-03. Over 450 organisations have been licensed to use the 5-A-Day logo. 'Choosing Health' commitment to extend the criteria for using the 5-A-Day logo to processed foods and foods targeted at children (mid 2005).
National School Fruit Scheme - to make a free piece of fruit available to children aged 4 - 6 each school day.	Scheme extended to include vegetables. Nearly 2 million school children are now participating in the scheme - a 94.7% take up amongst eligible schools. National roll-out completed November 2004. 'Choosing Health' commitment to consider extending schemes to all LEA maintained nurseries.

Improving Prevention continued...

Commitment	**Progress**
Public awareness	
Public awareness smoking campaigns.	Large scale media campaigns funded by Department of Health. Evidence suggests increased awareness of key messages and campaigns now the single biggest reason for quit attempts.
Development of programme to promote public awareness of cancer in 2001.	Funding provided for research into programmes to raise public awareness. Five research projects commissioned in 2001. A pilot programme to raise public awareness of cancer symptoms will be set up in 2005.
Assessment of research evidence related to approaches to raise awareness.	Application of research findings under consideration.
Levels of public awareness and understanding will be assessed.	The pilot programme to raise public awareness of cancer symptoms will include assessment of the programme's impact.

Improving Screening

Commitment	**Progress**
Breast Screening	
All women will have two views of the breast taken at every screening by 2003.	81 out of 85 breast screening units met target. All will achieve target by August 2005.
Routine breast screening to be extended up to age of 70 by Dec 2004.	All 85 units are expected to extend screening by April 2005.
Introduce new 4-tier working for breast screening.	Major on-going progress. Posts established in all four tiers, with 53 Asst. Practitioners and 158 Advanced Practitioners in post at March 2003.
Cervical Screening	
Liquid based cytology pilots to be reviewed by NICE in 2002. If successful, introduced across the NHS.	Pilot studies completed. In 2003 NICE recommended national roll-out, and cervical screening modernisation programme announced.
A 4- tier skill mix model for cervical screening staff is under development.	30 Advanced Practitioners currently in post. Problems identified are being addressed.
Health authorities to achieve 80% cervical screening coverage by 2002.	Considered an unrealistic expectation for all PCTs, because of their smaller size. Target dropped.
By 2001 all PCTs to review cervical screening coverage in deprived and minority ethnic groups.	DH does not monitor this target because of Shifting the Balance of Power. However, it remains good practice and there is some good activity in some areas.

Improving Screening continued...

Commitment	**Progress**
Bowel Cancer Screening	
Bowel screening introduced in 2003 if pilot study supports this.	Insufficient evidence by 2003 to take a decision. Roll-out will commence in 2006.
Research is continuing to evaluate approaches to colorectal screening.	Pilots will commence in 2005, with further expansion in 2006. Major trial will report in 2007.
Targeted training initiatives in endoscopy in 2001.	National training initiatives for endoscopy were established from 2001. 3 national and 7 regional training centres began training programmes in 2004.
NHS Prostate Cancer Programme	
Prostate cancer programme[3] to improve early detection, treatment, care and research. Risk management programme to be launched in 2001.	Prostate Cancer Risk Management programme launched in July 2001. Good progress in all areas.
£4.2 million on prostate cancer research.	Funding provided.
Evidence to support a screening programme will be kept under review.	On-going review.
Understanding Screening	
New national information sources to be developed.	New information leaflets introduced in Oct 2001, translated into 18 languages, and sent out with all screening invitations.
Good practice guidance and materials for women with learning disabilities.	Guidance, leaflets and picture books developed with women with learning disabilities have been published.

Improving Cancer Services in the Community

Commitment	**Progress**
£3m p.a. in partnership with Macmillan Cancer Relief for a lead cancer clinician in each PCT.	By April 2004, 279 out of 303 PCTs had lead cancer clinicians in post. But questions over continued funding.
Development of primary care cancer datasets in 2003.	Dataset developed and piloted in 2004.
£2m for training in palliative care for district and community nurses.	Training programmes for palliative care delivered in all 34 cancer networks. Funding increased to £2m p.a. for three years. 10,000 nurses participated to date.
A central role for primary care in cancer networks.	All 34 cancer networks have PCT representation. Most network boards are chaired by a PCT Chief Exec.
DH will develop good practice guidelines in out of hours palliative care.	Superceded by NICE guidance on supportive and palliative care. Tools are being implemented in each cancer network to support out of hours care.

Cutting Waits for Diagnosis and Treatment

Commitment	**Progress**
2 week wait for an outpatient appointment after urgent GP referral by Dec 2000.	Now 99.2% of people with suspected cancer seen by a specialist within two weeks. 93.5% of people with suspected cancer seen by a specialist within target by 2001.
Max 1 month from urgent GP referral to treatment for leukaemia, testicular and children's cancers by 2001.	Between 95% and 100% now achieved. (91.5% - 100% by 2002).
Max 1 month from diagnosis to treatment for breast cancer by 2001, and max 2 months from urgent GP referral to treatment by 2002.	97% of both targets for patients achieved. 94.2% by 2002 for 1 month target, and 96.5% by 2003 for 2 month target.
Max 1 month wait from diagnosis to treatment for all cancers by end of 2005.	89.9% of patients diagnosed with cancer treated within 31 days by June 2004. Target date 31 December 2005.
Max 2 month wait from urgent GP referral to treatment for all cancers by end of 2005.	78% of all urgently referred patients with cancer treated within 62 days by June 2004. Target date 31 December 2005.
By 2004 all cancer patients will have pre-planned and pre-booked care.	Draft template issued to NHS in early 2004 to enable data collection to begin. Progress against target will be assessed by 2005.
Roll-out to cancer networks of Cancer Services Collaborative programme of service improvement by 2003-04.	Service Improvement Leads in every cancer network, and service improvement underway.

Improving Treatment

Commitment	**Progress**
NICE to commission Improving Outcomes guidance on all cancers by 2003 for health authorities (now PCTs) to implement.	4 new reports and 2 updates since 2000. Programme to be completed during 2005-06. During 2004 cancer networks developed action plans for implementing guidance setting firm milestones for delivery.
NICE appraisals of cancer drugs to end the postcode lottery.	16 cancer drugs appraised and 11 appraisals in progress. National Cancer Director in 2004 reported increasing drug use, but unacceptable variations between networks remain. New measures being introduced to address this.
Care of cancer patients to be reviewed by a specialist multi-disciplinary team.	More than 95% of trusts report providing care within teams for lung, breast upper GI and bowel cancers.
National Cancer Standards published in Autumn 2000. Peer review visits to begin in 2001.	Standards published in 2000; revised and extended in 2004. All cancer networks reviewed in 2001. Second review began in November 2004 to assess progress.
National cancer datasets developed by 2002.	Largely complete. Datasets for some rarer cancers will not be completed until 2005.
Local health communities to provide sufficient support such that complete and accurate cancer data can be collected.	Some progress made on certain cancers (lung, head and neck, colorectal), but complete data not yet available.
The government will set out plans to strengthen cancer registries in 2000.	Action Plan for cancer registries published in 2001. Cancer registration improved and links to cancer networks established.

Improving Care

Commitment	Progress
Health authorities to agree palliative care investment with networks in 2001.	Cancer network investment strategies for palliative care in place for 3 year period 2003-2006.
£50 million for hospices and specialist palliative care services by 2004.	£50m was allocated in 2003-4, with £38.5m being spent to date.
Supportive care strategy to be developed, including standards for supportive and palliative care in 2001.	Draft strategy published as cancer standards in 2002. Due to be completed in 2005.
NICE to develop guidance on supportive care in 2001.	Guidance published March 2004. Cancer networks are developing action plans for implementation of NICE guidance.
New training in communication skills.	Advanced communication skills training programmes developed. Pilots successful; roll-out started.
Cancer Information Advisory Group will identify gaps and develop guidance on patient information in 2001.	Remit changed to focus on dissemination and delivery. Accreditation processes for information providers being developed, and cancer information leaflets are now available centrally for local use.
Trusts and networks to make high quality, culturally sensitive information available to cancer patients.	Included as a recommendation in the NICE guidance on supportive and palliative care. Patchy progress to date. Networks have completed action plans to implement the NICE guidance.
DH to commission development of audit tools to measure patient care experience.	NICE guidance on supportive and palliative care recommends that networks should ensure audits of patients' experience are undertaken. NHS R&D has commissioned an audit tool focusing initially on prostate cancer.
New internet resources for patients.	DH provided £440k for development of prostate and breast cancer internet sites.
Cancer library to be launched in October 2000.	Now due to be launched 2005.
Cancer networks to take account of views of patients/ carers in planning services by 2001.	Partnership Groups established in 30 out of 34 networks by 2004.
New Opportunities Funding for palliative care in deprived communities.	Community Palliative Care programme is funding 55 projects between 2003 and 2007. The Living with Cancer Programme, 2001-2005, funds projects for disadvantaged groups, including black and minority ethnic groups.
DH to agree with the voluntary sector the core elements of specialist palliative care to be available to patients	Included in NICE supportive and palliative care guidance. Aimed at ensuring services are planned, commissioned, organised and provided to the highest possible quality across the NHS and voluntary sectors.

Investing in Staff

Commitment	**Progress**
By 2006 there will be nearly 1000 extra cancer specialists.	Met ahead of schedule. 975 extra consultants in post by June 2004.
National Cancer Director to set long term targets for numbers of cancer specialists by 2001.	National Cancer Director works closely with the Workforce Review Team to project future workforce requirements for cancer, though no specific long term targets have been set.
Increase specialist trainee places by 2008.	No specific target in Plan but 36% increase in training places between 1999 and 2003.
Scheme to increase SHOs in histopathology.	£1.3m invested to fund 3 training centres. An Intensive Training and Assessment Centre for histopathologists from overseas was set up in 2003-04. In 2004-05 3 new training centres have been set up and 6 additional centres will come on stream in 2005-06.
More cancer nurses.	The number of cancer nurses has increased, but figures are not held centrally.
Training places for radiographers to be increased; attrition rates reduced.	Training places have been more than doubled. Average attrition rates reduced significantly between 2001 and 2002 in diagnostics and radiotherapy.
New skills and new roles for cancer staff.	New roles introduced for diagnostic and other staff. New skill mix models are being implemented for breast and cervical screening and radiotherapy.
All cancer service providers to have a written training strategy for cancer clinicians.	No cohesive training strategies have been drawn up at network level. Partly addressed through improving outcomes guidance action plans.

Investing in Facilities

Commitment	**Progress**
New MRI scanners, linear accelerators and other cancer equipment to be delivered.	Over £400m invested in new facilities so far. By the end of 2004 the NHS had received 68 MRI scanners, 177 CT scanners, 83 linear accelerators and over 700 items of breast screening equipment since April 2000. All plans achieved by the end of 2004.
Additional funding to support modernisation of 23 pathology services.	£28m invested to support upgrades and reconfigurations in 39 pathology sites.
National Cancer Facilities Strategy based on an audit by cancer networks by 2001.	Audits undertaken. Single facilities strategy document not produced. New facilities strategy in development incorporating, for example, radiotherapy stocktake and PET-CT framework.
DH will explore the scope for private partnerships in relation to pathology and imaging.	On imaging, strategic health authorities have identified potential gaps in capacity. Part of the strategy for imaging is to meet these gaps through more partnerships with the private sector. On Pathology DH is considering the potential for independent sector involvement, in line with the NHS Improvement Plan approach to diagnostic services.

Investing in the Future: Research and Genetics

Commitment	**Progress**
National Cancer Research Institute, including National Cancer Research Network, to be established in 2003.	NCRI established 2001, and NCRN fully established in October 2002.
Research into cancer genetics.	This is part of the ongoing NCRI Strategic Analysis. The National Cancer Tissues Resource being established under NCRI is expected to provide a world-class resource for genetic research.
Form partnership with Macmillan Cancer Relief on genetic counselling in 2001 to develop new services.	Pilot work underway.
DH will commission evidence based reviews relating to cancer.	The Department continues to commission evidence reviews to support the work of NICE.

Implementing the NHS Plan

Commitment	**Progress**
Additional £570m for cancer services by 2003-04.	Preliminary results of current tracking exercise show target met.
Cancer networks will be the organisational model to implement the NHS Cancer Plan.	34 cancer networks were established by 2001, covering the whole of England. Development programmes for network boards and network teams have been commissioned from the Clinical Governance Support Team and the NHS Leadership Centre.
Networks to develop service delivery plans, underpinned by workforce, education and training and facilities strategies in 2001.	Strategic plans produced but of variable quality. By late 2003 a third of networks had a workforce and/or education & training strategy. Improving Outcomes guidance and other initiatives are seeking to address this.
Cancer Network Commissioning Pilots to be established.	8 pilots were established during 2001. The move to PCT-led commissioning in 2002 affected the impact of these pilots, though good practice was shared through the Network Development Programme.
Cancer Taskforce to be established.	Cancer Taskforce established in 2000 chaired by the National Cancer Director and involving patient representatives, clinicians and managers.

NOTES

1 General Household Survey data is now weighted. This roughly increases prevalence by one percentage point.

2 New commitment in Priorities & Planning Framework 2003-06

3 Published September 2000 in advance of NHS Cancer Plan

APPENDIX 2

Methodology

1 We used a variety of methods to obtain evidence to produce a progress report on the NHS Cancer Plan. These are summarised below.

Survey of cancer networks

2 We surveyed the 34 cancer networks in late 2003 on behalf of all three cancer studies to establish their views on the NHS Cancer Plan, their role in implementing the Plan, and progress in meeting the targets, milestones and commitments within it. We received responses from all 34 networks.

Interviews with NHS organisations

3 We undertook a series of interviews with constituent organisations of a sample of cancer networks, agreed with the Department of Health as being representative of cancer networks across England. In each network we spoke to representatives from at least one primary care trust and strategic health authority, and from the network management team. In some localities we spoke to more than one network, at their request. The agreed sample of networks that we visited was:

- Pan Birmingham
- Greater Manchester and Cheshire
- Humber and Yorkshire Coast
- North London
- Peninsula
- Surrey, Sussex and West Hampshire
- South West London
- West Anglia

Literature reviews and existing research

4 We reviewed and analysed existing literature and research from a variety of sources, including academic journals, official Department of Health and other publications.

Reference Panel

5 We formed a joint reference panel for all three cancer studies to provide feedback on our proposed approach and initial findings. The members are:

- Mary Barnes, Avon, Somerset and Wiltshire Cancer Services;
- Mitzi Blennerhassett, former cancer patient and participant in a number of patient advocacy and support groups;
- Derryn Borley, CancerBACUP;
- Dr Peter Clark, Clatterbridge Centre for Oncology and Association of Medical Oncologists;
- Stephen Dunmore, Big Lottery Fund;
- Dr John Ellershaw, Marie Curie Hospice Liverpool and Royal Liverpool University Hospitals;
- Professor David Forman, Northern & Yorkshire Cancer registry and Information Service ;
- Martin Ledwick, CancerBACUP;
- Dr Fergus Macbeth, Velindre NHS Trust, Cardiff and the National Collaborating Centre for Cancer;
- Dame Gill Oliver, Macmillan Cancer Relief;
- Professor Mike Richards, National Cancer Director;
- Professor Alison Richardson, Florence Nightingale School of Nursing and Midwifery;
- Mr Zen Rayter, Association of Breast Surgery at BASO;
- Peter Tebbit, National Council for Palliative Care;
- Jill Turner, Cancer Services Collaborative 'Improvement Partnership';
- Dr John Wiles, Harris Hospiscare, Orpington, Kent; and
- Julie Wood, South Leicestershire PCT.

We are grateful to all members of the reference panel for their help and advice.