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Cancer Services: Matching Supply with Demand

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Redesigning cancer services in the acute setting is the only way to cope with growing demand. A transformation of cancer services in the UK needs to be brought about as a matter of urgency if there is to be any hope of matching current, not to mention future, demand with supply. Incidence of cancer is rising by two to three percent per annum and in some tumour sites the figure is higher. By 2030, there could be four million people living with and beyond cancer across the country (Macmillan Cancer Support 2013). How will the National Health Service (NHS) cope?

There is no shortage of evidence pointing to the need for a change in the delivery of services to meet this growing need. While rates of survival from some cancers, such as breast and prostate, are improving, there is little sign of progress for others, such as lung and pancreas, where symptoms tend to be picked up later.

This picture is confirmed by recent research by the London School of Hygiene and Tropical Medicine, which found that cancer survival rates in England alone are a decade behind other countries with similar healthcare systems (Walters et al. 2015). The study showed that, overall, the proportion of patients living for five years after diagnosis was 5 per cent to 12 per cent lower in England than it was in Australia, Canada, Norway and Sweden, when the same time periods were compared.

With these figures in mind, the report published in July by the Independent Cancer Task force — Achieving world class cancer outcomes: a strategy for England (2015), was timely. The task force's six strategic priorities are all important, but the first two — to spearhead a radical upgrade in prevention and public health, and to drive a national ambition to achieve earlier diagnosis — may prove to be the most challenging.

In recent years there has been no let up in attempts to drive home public health messages in key areas such as smoking, drinking and diet, as well as to raise awareness through the "Be clear on Cancer" campaigns, such as "blood in pee" and "been coughing for three weeks? Tell your doctor'". However, the jury is still out on how effective these have been. Feedback to date suggests that the campaigns have led to more visits from the worried and increased referrals, but not necessarily better detection rates.

Despite some success in reducing smoking prevalence, other key lifestyle changes are not evident:

obesity is an increasing problem, men are still poorer at visiting the general practitioner (GP) and seek diagnosis later than women, and there are important cultural issues which need to be addressed. How key damaging behaviour is modified remains a major challenge from the provider perspective. What is clear, however, is that everyone, including the acute sector, has a role to play in this by making every patient contact count.

Capacity Shortages

How earlier diagnosis is achieved when there is a manpower and skills shortage is another major conundrum. The aim of offering two weeks for an outpatient appointment and four weeks for diagnosis, as detailed in the Cancer Task force recommendations, is laudable and would have a positive impact on cancer outcomes, but the acute sector can only stretch its financial and staff assets so far. The answer, not least because funding is so tight, has to be to rethink delivery of services; this is not about adding something on but of doing things in a different way. There is a need to seek capacity, where it is needed and close to where patients live, through buddying and partnering other organisations and creating a new flexibility in the system

Working in partnerships and networking will improve resilience by creating a way to fill in the gaps that occur, for example when a consultant in rare cancers is on leave. At present, as the survival of some service providers comes under threat, territorial issues and competition can get in the way of creating effective partnerships. While this may be understandable, these barriers need to be overcome in the interest of matching supply with demand.

The private sector may be in a position to provide some extra capacity, but its involvement can carry the risk of creating undesirable delays and fragmentation of service delivery unless its providers are committed to delivering the whole cancer pathway. The holy grail for cancer services is to create a slick pathway, which offers the quickest possible diagnosis and treatment. This requires total confidence in areas such as testing arrangements, whoever provides them, to avoid hold-ups caused by the need for re-testing.

Limited Skills Pool

Another potential problem that needs to be recognised is the risk that the NHS and the private sector will end up fishing from the same skills pool, which is at present too small. The NHS spend on cancer is estimated to be 6.7 billion pounds and there is a commitment to double this, with the major investment being made in staff. This is a recognition that it is not lack of equipment, but a shortage of staff with the diagnostic skills to use the equipment, which is creating a problem. We are experiencing a serious lack of radiologists nationally. Without more staff, the ideal of using existing equipment 24 hours a day to improve efficiency and outcomes remains a pipe dream.

Meanwhile, talk of out-of-hours working and weekend working — the seven-day NHS — has to take into account the cost to staff, which currently would be enormous. This level of service provision is simply not sustainable without increasing staff numbers — the unacceptable alternative is to wear staff out. There is already plenty of evidence elsewhere in the NHS to suggest that this is already a problem, with workload of GPs, for example, driving an exodus from the service. It should also be remembered that, currently, in terms of routine diagnosis, the NHS works on a five-day basis.

In the longer term, training more health professionals in the field will help meet the demand for cancer services, but there is still a need to look at opportunities for different professionals doing different jobs, such as clinical nurse specialists carrying out endoscopies and cystoscopies, or Advanced Pharmacy Practitioners following up patients instead of doctors, or generalists learning specialist cancer skills. Engaging clinicians in new ways of working will be an important job for managers.

New Approach Needed

The development of new drugs and advancements in techniques will play a part in easing the strain on cancer services. One example is hypo-fractionation in radiotherapy which, although it increases the length of each patient’s visit, reduces the number of visits, so freeing capacity to treat more people. In the past, patients with breast cancer, for example, may have needed 25 treatments, but hypo-fractionation has reduced this to 15.

Robotic surgery may also bring huge benefits by reducing the length of stay in hospital, and in many cases reducing demand for radiotherapy follow-up treatment after surgery. A national tariff to support this growing treatment should be in place by next year. Meanwhile, commissioning and financial arrangements will clearly need to support the use of new technology if its potential is to be fully realised.

Pushing forward community-based chemotherapy, when it is safe to do it in this setting, is another transformation that needs to take place, whilst cancer admissions triage teams staffed by nurses,

trained to provide reassurance to patients about normal reactions to treatment and other worries, is a way of keeping patients out of hospital. These and other innovations which support patients are going to be needed to reduce the demand on limited hospital facilities.
Cancer is currently the biggest cause of death from illness or disease in every age group, with 160,000 people still dying from the disease each year (Cancer Research UK). As people continue to live longer, the problem of increasing incidence is not going to go away. Services must undergo a major transformation to cope with demand and to ensure an improvement in outcomes.

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