



House of Commons
Committee of Public Accounts

Tackling cancer in England: saving more lives

**Second Report of
Session 2004–05**

*Report, together with formal minutes,
oral and written evidence*

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The Committee of Public Accounts

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Ms Ruth Kelly MP (*Labour, Bolton West*)

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Summary

Introduction

More than a third of the population develops cancer at some point in their life. There are over 220,000 new cases each year in England, and 128,000 deaths. Cancer is easily the biggest killer in England, accounting for a quarter of all deaths. Those in deprived parts of England tend to die more frequently from cancer, and survive for a shorter time once diagnosed, than those in more affluent areas.

Since 1971 the rate of incidence (the number of new cancer cases per 100,000 population) in England has increased by nearly one third. Although patterns of incidence vary for individual cancers, incidence is likely to continue rising because of the ageing population. During the same period the cancer mortality rate (the number of deaths from cancer per 100,000 of the population) has fallen by one eighth in the last 30 years. Smoking related cancers remain particularly lethal however.

For some cancers, screening is improving early detection of people with the disease but without symptoms. Screening women over 50 for breast cancer is effective, with extension of the programme underway for women aged 65–70. After successful piloting, bowel cancer screening is due to be introduced in 2006. The Department will extend screening programmes only where it is clear they will save lives, because they increase pressure on diagnostic and treatment resources.

People with symptoms in some other countries have their cancer diagnosed at an earlier stage than is the case in England. This reflects a number of factors, including patient delay in coming forward, difficulties for GPs in recognising symptoms early enough and waits for diagnostic tests within the hospital. How much each of these factors contributes to overall delays is not known. The NHS in England is meeting its targets for urgent referral of those with suspected cancer but, once in the system, patients' waits for diagnostic services such as colonoscopies and scans are often too long.

The NHS has done much to improve the quality of cancer treatment through multidisciplinary team-working but the "postcode lottery" for chemotherapy treatment has yet to be tackled decisively though action is now in hand and waiting times for radiotherapy treatment are too long. The NHS is addressing these problems by greatly increasing capacity through increased staff and equipment. Service re-design is underway in some radiotherapy departments.

On the basis of a Report from the Comptroller and Auditor General,¹ we examined the Department of Health on: improving the prevention and early detection of cancer; improving the quality of cancer treatments; and reducing the variations in cancer survival and mortality rates between different parts of England.

1 C&AG's Report, *Tackling cancer in England: saving more lives*, March 2004 (HC 364, Session 2003–04)

Conclusions and recommendations

- 1. The Department should publicise some simple guidelines to help people recognise and act on appropriate symptoms for major cancers.** UK survival rates from cancer are still well below the best in the world. A key factor is the tendency of patients in England to be diagnosed at a later stage of the disease.
- 2. Research indicates that cancer is likely to be more advanced by the time it is diagnosed in poorer areas.** Cancer Networks should identify areas where cancer is diagnosed at a more advanced stage, with reference to measures of deprivation, so as to determine and tackle the underlying reasons for late presentation.
- 3. Action is needed to help GPs improve their ability to identify symptomatic patients.** Helpful measures would include better guidance; closer monitoring of GP referrals; and the development of GPs specialising in cancer as champions to spread good practice among the profession.
- 4. A significant number of patients referred non-urgently, and who eventually are diagnosed with cancer, wait much longer than they should to be treated.** The Department needs to develop a mechanism to record the time taken to assess and diagnose all patients who are routinely referred and then diagnosed with cancer. Delays in the patient pathway should be identified and reduced by redesign of services drawing on good practice such as that identified in the C&AG's Report.
- 5. Better information is needed on how far cancer has advanced at the point of diagnosis,** so that quality of treatment can be benchmarked properly for the first time. The Department should press ahead with its work to develop a database of waiting times for cancer diagnosis and treatment in order to set priorities for improvement and deal with blockages.
- 6. Patients and the public should have the information to help them press for improvements in cancer services in their locality.** Information about the level of cancer service provision, whether surgery is being carried out by specialists, and the performance of service providers should be disseminated locally.
- 7. A deadline should be set for ending the current wide variations in prescribing of anti-cancer drugs such as Herceptin.** The recommendations by the National Cancer Director regarding resources, clinical practices and enhancements in NICE guidance should be implemented speedily, with a clear timetable for monitoring their impact and reviews of progress.
- 8. Some areas benefit more than others from the current distribution of pathologists, diagnostic radiographers and scanner provision.** Lack of skilled staff is a major problem, not just in diagnostics but also in specialist surgery. The results of the exercises should then be used to work towards greater equity of provision over an explicit timescale.
- 9. Waiting times for radiotherapy treatment are too long and getting longer.** Besides continuing efforts to recruit more staff, there is a clear need for identification and

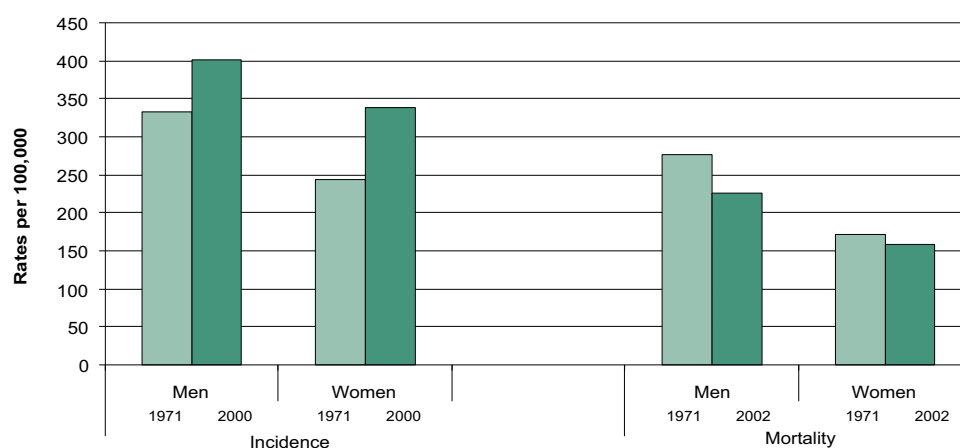
dissemination of good practice and re-design of services. The National Cancer Director should lead and co-ordinate this activity, following from his recent “stocktake” sessions with relevant stakeholders.

- 10. Primary Care Trusts in their role as commissioners of cancer services should promote the concentration of cancer surgery in the hospitals which carry out higher volumes of such operations, in line with best practice.** The National Cancer Director should report progress made in this respect.
- 11. The Department should commission research into the long term effectiveness of its Stop Smoking services.** Currently it is not clear why more than two thirds of people who initially quit using the service are likely to be smoking again within the year.

1 Improving the prevention and early detection of cancer

1. Rates of cancer incidence are increasing across the developed world. Between 1971 and 2000 total cancer incidence increased by 21% for men and 39% for women (Figure 1). The pattern varies among the major cancers. Incidence has increased sharply for breast and prostate cancer, much more slowly for bowel cancer and fallen sharply for lung cancer among men, but not women. There are a number of causes underlying this, in particular the ageing population, though the reasons for increases in some cancers are not fully understood. Nevertheless, it is estimated that up to two thirds of cancers are preventable.²

Figure 1: Changes in cancer incidence and mortality rates in the last 30 years



2. During the same period mortality fell by 18% for men and 7% for women (Figure 1). For men, the large fall is attributable to a sharp decline in cases of lung cancer. For women, falls in breast and bowel cancer mortality have been partially offset by increases in lung cancer mortality.

3. Despite the fall in lung cancer incidence, smoking remains the largest single factor influencing the overall level of cancer incidence and mortality.³ In measuring the success of its Stop Smoking programme, the Department considers that a person has successfully quit smoking if they abstain for four weeks. The long-term effectiveness of these measures is less clear, since it is estimated that only about 30% of people quitting will still not be smoking 12 months later. There is a seven-fold variation in the proportion of quitters between the Strategic Health Authorities with the largest and smallest numbers of quitters.⁴

4. English survival rates from cancer are still well below the best in Europe, especially for people in deprived areas of England. A key factor is the tendency of some patients, especially the old and those from deprived areas, to be diagnosed at a later stage of the

² Q 75

³ Qq 2, 68, 72

⁴ C&AG's Report, paras 2.8–2.9; Q 50

disease.⁵ There are several contributory factors to this later diagnosis. No one knows how much each factor contributes to delays:

- **Delay in patient awareness.** In the NHS Cancer Plan in 2000 the Department undertook to develop a comprehensive cancer public awareness programme, which is still awaited.⁶ Awareness of symptoms remains low among the population at large, despite the success of particular targeted campaigns.⁷
- **Delay in patient coming forward with symptoms.** The Department has commissioned several pieces of research to investigate the reasons why patients with symptoms delay consulting their GPs.⁸ This research, due to be published shortly, will form the basis for strategies to promote awareness.⁹
- **Delay in onward referral from GPs.** It is not known to what extent GPs' failure to identify cancer symptoms early contributes to poor outcomes. Half of GPs responding to the NAO survey were not finding existing guidance helpful. They frequently seemed to think guidance was not necessary,¹⁰ revealing a complacency evidenced by the large numbers of cancer sufferers not initially referred urgently by GPs. Patients referred urgently by GPs are now almost always seen by specialists within 2 weeks but those that are not (one third or more of patients subsequently diagnosed with cancer) can take several months to be seen by a specialist.¹¹
- **Delay in carrying out diagnostic tests.** Delays in carrying out vital diagnostic tests in radiology, endoscopy and pathology are common throughout England, but are difficult to quantify because this information is not collected in a standardised format on a day-to-day basis by the NHS.¹² The NHS is greatly expanding training facilities and increasing efforts to recruit staff in these areas, partly by restructuring services to widen access to these specialisms. However, in recent years vacancies for radiographers and pathologists have continued to rise.¹³

5 C&AG's Report, para 2.27

6 Qq 3–8

7 C&AG's Report, paras 2.30–2.32

8 Qq 67, 73–74

9 Q 82

10 C&AG's Report, para 2.35; Q 161

11 C&AG's Report, paras 2.41–2.42; Qq 160, 162, 164

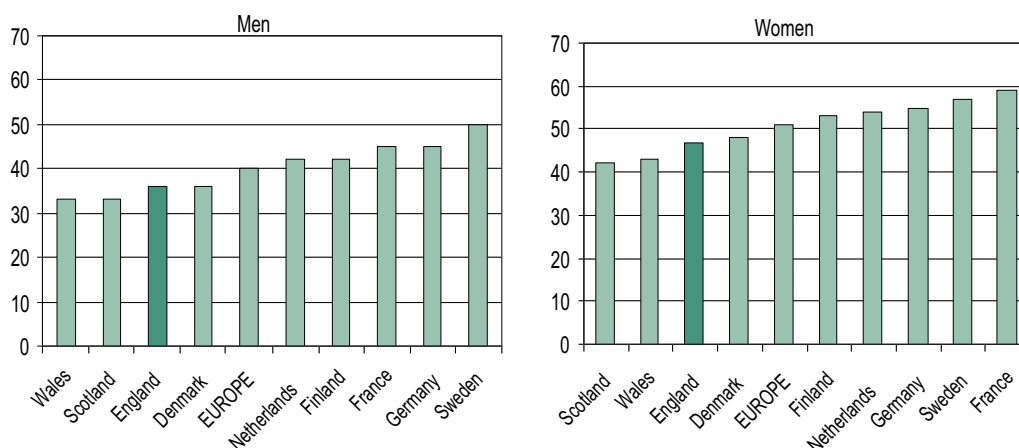
12 Qq 105–106

13 C&AG's Report, paras 2.45, 2.55

2 Saving more lives through improved treatment

5. During his evidence, the National Cancer Director expressed confidence that cancer mortality rates would fall by 20% for people under the age of 75 by 2010 and that over time our survival rates will reach the level of the rest of Europe.¹⁴ Although survival rates for men and women are improving they still lag behind countries in continental Western Europe with broadly similar population structures, health care systems and per capita wealth (**Figure 2**).¹⁵ If England's survival rates were comparable with the best in Europe, thousands more people across society, particularly those from deprived backgrounds, would survive for appreciable amounts of time after diagnosis.¹⁶

Figure 2: Five-year relative survival rates for men and women diagnosed between 1990 and 1994



Note: Data for France and Germany are based on outcomes in only a small proportion of those diagnosed with cancer

Source: *EUROCARE 3*

6. Achieving improvements requires a need for NHS diagnostic and treatment services to ensure that patients are treated more promptly and appropriately, besides enhanced detection of cancer and an improvement in low levels of awareness among sections of the public to facilitate earlier diagnosis, as discussed in part 1.¹⁷

7. To contribute to earlier detection of cancer, the bowel screening programme is likely to be introduced in 2006,¹⁸ while the breast screening programme is being extended to cover older women at risk and is being carried out using improved screening techniques. If these

14 Qq 158–159, 163

15 *Securing our future health: taking a long-term view*, Derek Wanless (HM Treasury, 2002)

16 Q 43

17 C&AG's Report, paras 17–18, 21–24, 26

18 Q 90

improvements are to be introduced successfully, more skilled staff need to be recruited to relieve increased pressures on other parts of the system and improve patient outcomes.¹⁹

8. Surgery remains the main curative treatment for a large majority of cancer patients. Research shows that the best results come when surgery is carried out by specialist surgeons. For the most prevalent cancers, such as breast cancer, specialisation in surgery is becoming the norm. However, the situation is not so satisfactory for prostate cancer. Although most prostatectomy operations are now carried out by surgeons who do at least 5 such operations per year, this is a long way off the NICE guidance target that all operations be carried out by teams who do 50 or more prostate operations a year.²⁰ Out of 133 Trusts where prostatectomies were carried out in 2002–03, only 12 Trusts carried out more than 50 operations.²¹ There are also insufficient specialist surgical resources to increase surgery for lung cancer to desirable levels.²²

9. Survey results from the Royal College of Radiologists show that radiotherapy waiting times in many parts of the country are too long to conform with clinical guidelines on the maximum acceptable delay before the start of treatment. This is putting the lives of many people at risk. The National Cancer Director is now carrying out a “stocktake” of the system and acknowledges the need to improve recruitment and retention of staff, but cannot provide a timetable for improvements in waiting times.²³

10. As long ago as 1996, we recommended that the NHS should direct clinical audit activity towards those areas of national importance where there was evidence of people receiving sub-optimal treatment.²⁴ Only now is the Department, in co-operation with clinician groups, developing a national clinical audit database for major cancers to determine why certain groups within the population, such as the elderly and the deprived, receive less radical treatment purely because of their poor physical condition or for other reasons.²⁵

19 Q 91; C&AG’s Report, para 2.22

20 Qq 16–24

21 Ev 19–20, 24 (Annex A (i))

22 Q 88

23 Qq 10, 84–87

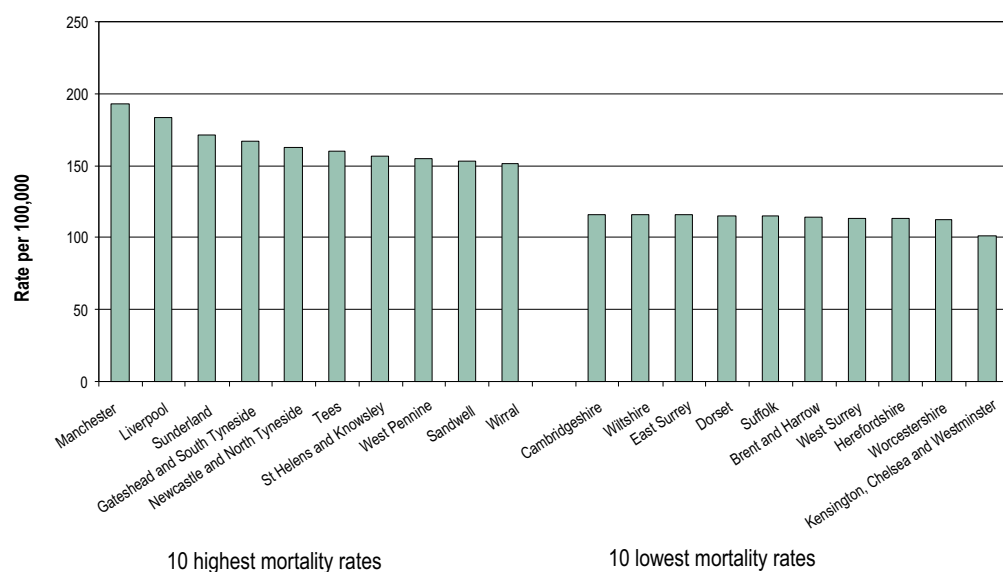
24 31st Report from the Committee of Public Accounts, *National Health Service Executive Clinical Audit in England* (HC 304, Session 1995–96).

25 Q 14

3 Reducing geographical inequalities

11. There are clear and unacceptable inequalities in outcome between different parts of the country. There is a “North–South” contrast in mortality rates (**Figure 3**),²⁶ suggestive of inequality between affluent and poorer areas, although the degree varies between individual cancers.

Figure 3: Cancer mortality rates 1998–2000: 10 highest and 10 lowest health authorities



12. In the late 1990s, research established that survival rates for 44 of the commonest 47 cancers were worse in deprived areas. Further research in 2003 established that, as survival rates improved generally during the 1990s, the five year survival gap between better and worse off has widened for both men and women, for the majority of cancers studied.²⁷

13. England (together with Wales and Scotland) has also traditionally suffered high cancer mortality rates compared with other European countries. Male cancer mortality rates now compare favourably with many countries in Europe and the United States, due to long-term falls in smoking rates in the UK. On the other hand, mortality rates for women remain among the highest internationally. Historically more women in the UK have smoked than in many other countries.

14. Variation in the stage at which the cancer is diagnosed is an important contributory factor in explaining some of these inequalities both within England and between England and other countries. Unfortunately, it is not known how widespread variations in ‘staging’ are, because of the difficulty cancer registries have in collecting comprehensive data.²⁸ In particular, people in less affluent areas seem more likely to be diagnosed at a more advanced stage, for the reasons explored in Part 1.

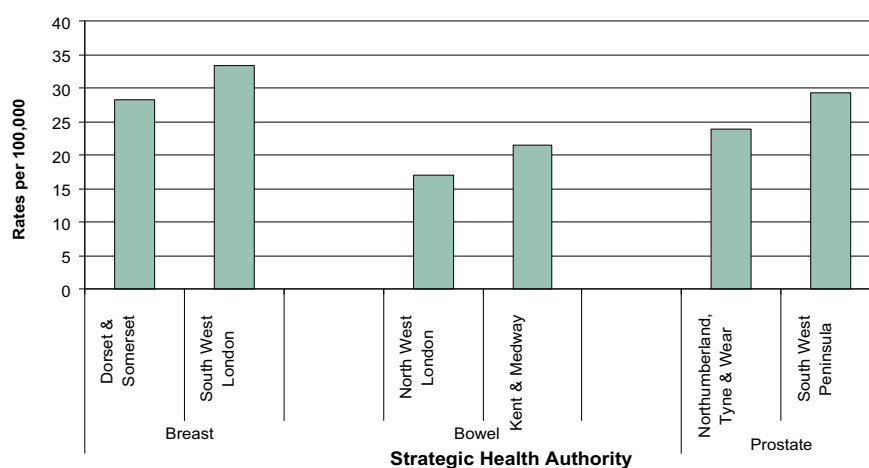
26 Qq 28–30, 45–47

27 Qq 32–42; C&AG’s Report, para 1.5

28 Q 131

15. **Figure 4** illustrates, however, that variable outcomes are not limited to deprived areas. Mortality rates for a number of cancers can also vary widely between areas which have a similar level of incidence.²⁹ It is not clear how variations in access to skilled clinicians and equipment might also contribute to variations. The Department acknowledged that recruitment of skilled staff is still not meeting demand nationally.³⁰ But the distribution of pathologists and oncologists, for example, does not indicate a bias towards more affluent areas.³¹ The provision of scanners has traditionally favoured London, although new procurement is reducing the variations between regions.

Figure 4: Differences in cancer mortality between areas with almost identical levels of incidence



16. The C&AG's Report highlighted wide variations in the availability of treatments such as Herceptin,³² which is suitable for the treatment of some women with advanced breast cancer and can roughly double their survival time.³³ The recent review of chemotherapy provision by the National Cancer Director,³⁴ just before our evidence session, revealed considerable variations around the country in the availability of a significant number of chemotherapy drugs approved by the National Institute for Clinical Excellence. In the review, local NHS Cancer Networks reported that uneven availability is not due to problems in getting funding for drug purchases,³⁵ but rather to:

- lack of specialist staff and unsuitable pharmacy accommodation; and
- variations in clinical practice in the prescribing of approved drugs, leading to local variations in the implementation of NICE guidance.

17. The Secretary of State has accepted the recommendations of the review. The main recommendations are that:

29 Qq 107–110

30 Q 9

31 C&AG's Report, paras 2.52–2.54, 2.59–2.61 and Figure 40

32 Qq 132–135, 151–157

33 *Full guidance on Trastuzumab for advanced breast cancer*, National Institute for Clinical Excellence, 2002

34 Qq 1, 11–13, 136

35 Qq 92–104, 137–138, 147–150

- NICE should include the resources required for implementation in its appraisals of new treatments;
- capacity planning models should be developed for chemotherapy at the local level; and
- implementing electronic prescribing of chemotherapy in hospitals should be brought forward from its previous delivery date of 2008–10.

Formal minutes

Tuesday 14 December 2004

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon
Mr Frank Field
Mr Brian Jenkins
Jim Sheridan

Mr Gerry Steinberg
Jon Trickett
Mr Alan Williams

The Committee deliberated.

Draft Report (Tackling cancer in England: saving more lives), proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 17 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

Resolved, That the Report be the Second Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That the provisions of Standing Order No. 134 (Select Committees (Reports)) be applied to the Report.

[Adjourned until Wednesday 15 December at 3.30pm]

Witnesses

Wednesday 16 June 2004

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Sir Nigel Crisp KCB, and Professor Mike Richards CBE, Department of Health

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Department of Health

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Cancer Research UK

Ev 40

Oral evidence

Taken before the Committee of Public Accounts

on Wednesday 16 June 2004

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon
Jon Cruddas
Mr Frank Field
Mr Brian Jenkins

Mr Gerry Steinberg
Jon Trickett
Mr Alan Williams

Mr Tim Burr, Deputy Comptroller and Auditor General and **Mr James Robertson**, National Audit Office, further examined.

Mr Rob Molan, Second Treasury Officer of Accounts, HM Treasury, further examined.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL:

Tackling cancer in England: saving more lives (HC 364)

Witnesses: **Sir Nigel Crisp KCB**, Permanent Secretary/NHS Chief Executive, and **Professor Mike Richards CBE**, National Cancer Director, Department of Health, examined.

Q1 Chairman: Welcome, Sir Nigel. “Tackling cancer in England” is the subject of our Report today and we are delighted to be joined once again by Sir Nigel Crisp, who of course is the Permanent Secretary and the Accounting Officer at the Department of Health. We are joined also by Professor Mike Richards, who is the National Cancer Director. Professor, you have just published a report in the last few days, have you not, which I think got some publicity, so Members may wish to ask you about that?

Professor Richards: I have, indeed.

Q2 Chairman: Sir Nigel, could I ask you, please, to look at paragraph 1.3, which you can find on page nine, where you will read that mortality rates for cancer in some parts of the country are almost twice as high as in others. Does this mean that the NHS is not doing enough for people in deprived areas?

Sir Nigel Crisp: There is a complex set of reasons for that, which are to do with both lifestyle and incidence of cancer in those areas but also supervision of services in those areas and we need to tackle both ends of that equation. You will be aware from elsewhere in this Report that we have been setting some of our targets, for example, for reduction of smoking, deliberately to focus more on deprived areas to try to affect the issues of incidence. We have been targeting resources such as staff and machinery in those areas as well in order to try to start to change that balance. Obviously, Professor Richards will be able to provide you with much more information about that.

Professor Richards: I think one of the major factors in both the incidence of cancer and the mortality from cancer relates to smoking and its impact on lung cancer, in particular, which is the commonest

killer from cancer. We know that smoking rates vary according to levels of social deprivation and that is one of the key factors in driving the mortality rates.

Q3 Chairman: Leading on from that, Sir Nigel, perhaps we can look at awareness campaigns, and if you look at page 32 and paragraphs 2.30 to 2.32 you will see that, in paragraph 2.31: “In 2000 the Department undertook to develop a cancer public awareness programme.” I do not think recently we have seen any public awareness programmes. What is going on?

Sir Nigel Crisp: We have done two things on this. Firstly, we have been carrying out research into what is the best way to do this so that we can get a proper picture on that and I believe that research is due to be reported on this year, but in the meantime we have not done nothing. We have backed with grants a number of voluntary organisations to hold campaigns on certain conditions, such as bowel cancer, and indeed those voluntary organisations have been extremely active in doing that in a whole range of areas. We expect to move on with more of a national campaign, about cancer, but also we are continuing to fund voluntary organisations on that basis.

Q4 Chairman: There is nothing new about this and, certainly listening to the last answer, one would have thought this was absolutely basic. Rather than just rely on voluntary organisations, even if you are helping them, one would have thought that a comprehensive national programme, say, on skin cancer, signs you should look at, prostate, smoking, something which you mentioned, is an elementary

 Department of Health

step, is it not? I am surprised we do not see it emanating from the NHS, with all the resources you have at your command?

Professor Richards: Of course, on smoking, we have had just exactly that sort of campaign, a major media campaign. We are working very closely with the charities, and the Department of Health has been funding both Cancer Research UK and British Heart Foundation to run those campaigns, which I am sure you will have seen. Certainly our research on the effectiveness of those campaigns is that they have very, very high levels of awareness in the population. Almost certainly they do have an impact on people who are beginning to think already about giving up smoking doing so and possibly then attending the Stop Smoking services which we have set in place since 2000.

Q5 Chairman: It says here: “a survey of men in 1999 found that only one-quarter of them considered that they knew ‘a lot’ or ‘a fair amount’ about prostate cancer;” so what public awareness campaigns have you had actually on prostate cancer, for instance?

Professor Richards: We have had a particular focus on prostate cancer since 2000.

Q6 Chairman: It has not achieved much apparently, has it, from what we read here?

Professor Richards: I think there are particular problems in raising awareness of prostate cancer, I will acknowledge that. What we have done is have a prostate cancer risk management programme, firstly making sure that GPs are aware of prostate cancer and what to do about it, how to advise patients on whether or not to have a PSA test and what are the pros and cons of that decision. We are working with GPs across the country on that and we wanted to make sure that was in place. Equally, we have been working with the prostate cancer charity, and with the Department of Health we have set up a Prostate Cancer Advisory Group, which I chair, and one of the key tasks of that Prostate Cancer Advisory Group is to advise on awareness programmes.

Q7 Chairman: This is all very well but I am not sure if we are any further forward: “a survey of women over 50 in 2003 found that two-thirds did not realise the risk of breast cancer increased with age.” It seems that when self-diagnosis is just so important in this area, whether it is skin or prostate or breast cancer, you are simply not getting your message through to the general public. I am wondering whether you are putting sufficient resources into this area?

Professor Richards: I think what we want to make sure we do is put resources where they are going to be effective. What we do not want to do is worry people unnecessarily, or indeed overburden general practitioners.

Q8 Chairman: Perhaps it is only a start then, is it, not worrying people unnecessarily?

Professor Richards: It is getting that balance right. One of the bits of research that Sir Nigel was referring to has looked at, first of all, what the

factors are which might cause patients to delay, but also looking at the world research on what interventions may be effective in reducing delays by patients. Sadly, there is very, very little evidence worldwide on what is actually effective in this area.

Q9 Chairman: Others can come in on that. Let us move on now. Sir Nigel, please can you look at page 36, paragraph 2.51. Obviously the demand for radiological services is increasing all the time. Are you recruiting enough skilled staff to meet your targets?

Sir Nigel Crisp: Not yet, is the straightforward answer. As you say, this is partly because we are seeing many more patients and partly because in a number of areas we have changed the treatments which are offered through radiotherapy so they take longer. This has become a really significant bottleneck in the Service now so this is a very serious issue for us. We have recruited a lot more diagnostic radiographers; there has been a big increase, of 1,300, in fact, in the last six years. We have more than doubled the number of people going into training. We have introduced radiology academics, in order to get more trainees through the system, and we have introduced what we call a tiered skills mix model, in other words, making sure that people with a lower level of skills can do more work than they have done in the past. All of this is only holding the problem level at the moment. We will see it start to improve over the next few years as some of the trainees come on line, but it is worth pointing out that this is a worldwide problem so this is not just about going for recruitment elsewhere.

Q10 Chairman: Then let us leave diagnosis and go on to treatment now and look at paragraphs 2.76 and 2.77 and talk about radiotherapy, shall we, Sir Nigel? If you look at 2.77, which you will find on page 42, you will see, three-quarters of the way down that paragraph, that in a survey conducted they indicate the situation has not improved since the previous such survey in 1998. I find that rather alarming, that radiotherapy services appear to be getting worse, not better. What have you got to say about that?

Sir Nigel Crisp: In a sense, it is repeating slightly what I have just said. Because we have got more patients, because we have changed our radiotherapies delivered, because we are identifying people earlier, we have got a much bigger throughput and the machinery has to run slower because we are operating a changed regime. We are doing a great deal both to increase recruitment of staff, which is the biggest bottleneck, and to put in more machines around the country, but it is a big problem.

Q11 Chairman: Thank you. Others can come in on that if they wish. Just carrying on now, can you please look at page 44, figure 39, “Variations in the percentage of eligible cancer patients receiving Herceptin in the 6 months before NICE approval

 Department of Health

(October 2001–March 2002) . . .” Looking at that figure, I found those variations rather alarming. Do they alarm you?

Sir Nigel Crisp: Indeed. This is again a subject which Professor Richards can talk about better than I can, but, I agree with you, this is a significant problem, it is a serious issue. This was why, having issued the NICE guidance, the Secretary of State asked Professor Richards to see if it was getting through and if it was making a difference in terms of reducing variation and increasing the take-up of the drugs.

Q12 Chairman: We have got the example of this drug here but I am told, Professor, that there are 15 or 20 drugs which are in this position, are there not?

Professor Richards: There are 16 drugs which have been appraised by NICE and 15 of those were approved by NICE. Also we looked at four standard drugs which are used in chemotherapy and have been used for the last 20 years. We looked at the whole period from July to December of 2003, at all of those drugs together, and the conclusion in my report was that the variation between cancer networks was unacceptably high. I should say also that since the appraisal by NICE the overall usage of those drugs has gone up quite considerably and there is evidence that over time the variations are narrowing, but not enough. What we looked into also was the factors underlying those variations and there were two principal factors which came through from that. It was not the funding of the drugs per se but, in some parts of the country, it was to do with the capacity, that is having enough nurses, enough pharmacists and indeed, sometimes, enough space in chemotherapy suites. It has to be remembered that the amount of chemotherapy being given in this country has gone up markedly over the last decade. That was one of the factors, the capacity, and the other factor is clinician variation. Because of those factors, I made a number of recommendations to the Secretary of State and I am very pleased to say that he accepted all of my recommendations on that. One is that we have asked the strategic health authorities responsible for individual networks to provide a commentary on the position in their locality. I will be developing a capacity model which then we will work with, with NICE, when they are doing future appraisals, and we will be able to apply it to past appraisals too, to look at the number of nurses and pharmacists we need to deliver these treatments. We will go on monitoring data in the same way as we did for this Report and, most importantly, it has been agreed that we will bring forward electronic prescribing of chemotherapy—which was scheduled to come on stream within the national programme for IT between 2008 and 2010—to 2006.

Q13 Chairman: So the long and the short of it is that when you come back to this Committee in three years' time, or whenever it is, we are not going to see a graph like this, where you have got availability, say, in Derby/Burton is 10%, going up to South West London 90%? All these variations are going to be a thing of the past when you come to see us at our next meeting, are they?

Professor Richards: I am confident that the variations will be reduced. I am not saying that they will be eliminated totally because there are individual clinical factors, and after all one needs to take account of patient preference as to whether they have these treatments.

Q14 Chairman: The last variation I want to deal with is, going straight over to figure 41, “Access to treatment for lung cancer patients diagnosed in 2000 varies with age,” you see a huge variation for patients receiving chemotherapy under 75 and over 75. Looking at this figure, it strikes me that there is no doubt that there is discrimination against older people?

Professor Richards: I think the difficulty with assessing whether there is ageism or not is that what we need to know is what was the extent of the disease in these patients, younger versus older. We need to know also the extent of their frailty or co-morbidity and we need to know about their preferences. Unfortunately, at the moment, we do not have information on those three very important factors. It is worth remembering, with lung cancer, that by the time they present to hospital the vast majority of patients have got disease which is at an inoperable stage. We do need that information. We are setting up a National Clinical Audit Programme for lung cancer specifically and that is being rolled out at the moment. That will collect the very information that we need in order to be able to tell whether or not there are unacceptable variations by age.

Chairman: Thank you.

Q15 Mr Field: Professor Richards, on behalf of my constituents who are treated at the Oncology Centre in Clatterbridge, can I thank you for the improvement your work has really made on a centre of excellence.

Professor Richards: Thank you.

Q16 Mr Field: Can I turn to Chapter 2 of the Report and ask you a couple of questions on that. If you or any of your family were diagnosed with cancer, heaven forbid that they should be, and the choice was that they went to a hospital where there were not many operations performed on people suffering from cancer and the treatment was that they should be operated on, would you accept that decision or would you move heaven and earth to get them into a hospital which operated on large numbers of people suffering from cancer?

Professor Richards: One of the things that we have been doing over the last few years is develop improving outcomes guidance on individual cancers: breast cancer, colorectal cancer, lung cancer, gynaecological cancers, etc. In each of those documents, which are under the auspices now of the National Institute for Clinical Excellence, we have looked at the relationship between the numbers of operations performed and outcome, and for some surgical procedures there is no doubt that there is a better outcome with higher throughput. For example, oesophagectomy would be one example and prostatectomy would be another. The guidance

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which has come out from NICE does say that we should concentrate those services in hospitals which have got larger volumes and we have asked the Health Service, each cancer network, to develop action plans to show how they will move towards that and those action plans are due in by the end of this month.

Q17 Mr Field: So the answer to my question?

Professor Richards: The answer to your question is, yes, I would prefer people to be treated where there is expertise and we are moving as fast as we possibly can to make sure that is the case for all people who need that surgery.

Q18 Mr Field: One of the things the Report, which does so much, does not do, it does not give me, anyway, the figure for how many of those operated on for cancer are operated on in the centres where very large numbers of operations are done and how many are scattered across other hospitals where very few are done. Do you have that figure at all?

Professor Richards: I do not have the figure off the top of my head. We have collected figures through hospital episode statistics on individual hospitals across the country for all of those procedures where there is evidence that volume is linked to outcome. I am sure this will be one of the topics which the National Audit Office will want to look at in their other Cancer Plan report.

Q19 Mr Field: Might we have a note on that?¹ The reason I ask the question is that, if you were going to be tougher and say “It wouldn’t be good enough for my family so it’s not actually good enough for anybody else,” at some stage soon, if the numbers operated on outside these great centres are relatively small, you might put a ban, might you not, on these operations scattered around, a few at a time, in different hospitals?

Professor Richards: That is exactly what we are working towards. For example, for prostatectomy, we have already said that, those people who are doing five or fewer a year, we are strongly recommending that should be moved and centralised. Also we have set up an appraisal process for cancer services and we will be going round to individual hospitals looking at what they are doing. That will be one of the things that we will be looking at specifically.

Q20 Mr Field: That was my second question, five or fewer for people suffering from prostate cancer; that is one operation less than every two months. Clearly you have to have some cut-off point to do with the analysis, but what sort of expertise do you think somebody builds up doing so few operations, even if they are doing five a year?

Professor Richards: What we have said is that we want to see prostatectomy being done in places which are doing 50 or more major procedures—that can be prostatectomy or removal of the bladder—in

a year, and that is what we are working towards. After all, we have to put in place the capacity in those hospitals to take on those patients.

Q21 Mr Field: Is it not likely that surgeons will build up that expertise if they are part of a team where their colleagues deal with those who it is suggested should not be operated on, rather than, what can still happen, somebody is diagnosed and really the team is largely the leader and they decide all forms of treatment, and not just those which lead to operations?

Professor Richards: I am not sure if I have fully understood that.

Q22 Mr Field: If you go to Guy’s they have a team and if you are going to be treated by an operation there is one of the consultants who specialises. If you are being treated in other ways, you will see one of the other specialists, according to how you have been diagnosed. Where Guy’s is today, should we not try to see other hospitals there very shortly?

Professor Richards: Absolutely. One of the key elements of each of these recommendations, from the improving outcomes guidance documents, focuses on the need for multi-disciplinary teams, whether that is in breast cancer or indeed in prostate cancer, and we are working hard to set up those teams. That has been one of the major changes over the last few years in this country and we estimate now that approximately 80% of cancer patients are being seen by specialist teams, and that is probably as high as anywhere in the world.

Q23 Mr Field: Do you have the power to forbid hospitals meddling in areas which would be concentrated better in centres of excellence?

Professor Richards: The approach we have taken is to issue guidance from NICE, to convert that into standards which then we appraise as we go round visiting, and we will be sharing the outputs of those appraisals with the Healthcare Commission, who are set up, as you know, to inspect hospitals.

Q24 Mr Field: Does not that come back to the Chairman’s point about people knowing? Should we not be publishing tables saying “Keep away from this hospital if you value your life”? I can do the figures for you now, you just have to fill in the details. It does not take much work. It requires will, does it not, and taking on some very powerful people?

Professor Richards: We are making those very changes now. That is precisely what NICE has recommended and what the action plans are all about, but it does take time to get the workforce into place, to get the capacity in the relevant hospitals and we are working as fast as we can to implement that.

Q25 Mr Field: I think we see where our report might go. Sir Nigel, your Secretary of State is usually very good at aiming his boot at the right part of someone’s anatomy, but recently he said “Why don’t all these middle-class yuppies get off the backs

¹ Ev 19–20

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of single mums under 21 who are smoking themselves to death?” Do you not think, for once, that he was missing the target, that our concern should be that we do seem to have a supply route of women who find themselves at 21 with three children, sometimes by different fathers, who are on sink estates, and then it is a hell of a job for them to rebuild their lives from that position? Should we not be concentrating more on not worrying about whether they smoke but trying to see fewer women ending up in that position?

Sir Nigel Crisp: I think the Secretary of State, and it was a Labour Party meeting, I understand,—

Q26 Mr Field: That makes it better then, really?

Sir Nigel Crisp: I do not know the exact circumstances. The point that I believe he was making within that was it is not just a matter of choice, it is a matter of circumstances, and circumstances will dictate your health, so I suspect that he would agree with the point that you were making. Certainly a lot of work we do in the Department is aimed at trying to tackle the determinants of health as well as the symptoms and I think that is your point, is it not?

Q27 Mr Field: It is.

Sir Nigel Crisp: The circumstances people find themselves in are fantastically important.

Q28 Jon Trickett: Paragraph 1.3 was referred to by the Chairman also, and in fact the same sentence stood out, it caught my eye as well, referring to the variation within district health authorities, from 101 deaths per 100,000 to 193, almost twice, presumably, more cancers. Can you tell me what the situation is, or was, in Wakefield, where we were between 101 and 193, because the table does not seem to be here?

Sir Nigel Crisp: I am sure we can, but not immediately.

Q29 Jon Trickett: Can you provide us with a list of the 95 district health authorities, just a table for the Committee, so that we can have a look?

Sir Nigel Crisp: I suspect we may have it, but certainly we can provide it for the Committee.²

Q30 Jon Trickett: If you could provide it for the members, because we have some indication, but not much, I think, in the rest of the Report of the variations which are going on, but this particular table I think will be extremely striking. Probably it is publicly available but I could not put my hand to it before the meeting. It would be helpful for us to have a look at that. The paragraph goes on to announce improvements across the board in survival rates. My own mother died recently from a brain tumour and I was struck by the immense professionalism of the NHS staff, and through you I would like to thank everybody working in cancer services. It is a truly humbling experience to go on to cancer wards and meet both the courage of patients and also the professionalism of the staff. Anything I say about

variations in treatment, and so on, I do not want to reflect in any way on the professionalism of the staff. I want to try to understand better the lack of uniformity in treatment over time between the districts, because the final sentence in the same paragraph says that progress was not uniform, so it is marking the fact that progress is being made. Larger improvements are being made in some districts than others, and variations in the level of improvement were not obviously linked to the levels of affluence and deprivation, it says. I struggle to understand that sentence, because the rest of the paper seems to say the exact opposite, and honestly I do not understand that. Can you tell me what the sentence means?

Professor Richards: Can I try to explain that. The levels of mortality do depend on levels of deprivation, and that is quite clear. If you look over the past few years at what the changes in mortality have been, that is what is not linked to deprivation and so there are very deprived areas that have made more rapid progress, there are some deprived areas that have made less rapid progress. Equally, for the more affluent areas, there are some that have made good progress and some that have made less good progress.

Q31 Jon Trickett: I thought that was what you would say. I want to go on to paragraph 1.5 then, if I may, which talks about the “survival gap”. I think that the survival gap is the gap between the number of people who survive cancer for a period of five years, as measured across the social classes. Am I right in that being a layman’s way of expressing it?

Professor Richards: Yes.

Q32 Jon Trickett: Looking at the number of people surviving five years, between rich and poor there is a gap, is there not, in survival?

Professor Richards: There is, indeed.

Q33 Jon Trickett: I think that the sentence we have just discussed, in paragraph 1.3, is saying that the change in the survival gap over time has not changed in relation to socioeconomic deprivation, and that was your answer. I think I am trying to demonstrate that is not the case, actually?

Professor Richards: Can I try to explain, that we have to look at three different parameters. One is incidence, the number of new cases, one is mortality, the death rate, and the third is survival rates, the proportion of patients surviving five years who have got cancer. The complexity of this is that you see differences for each of these things, so the survival rate, that is the number living for five years after a diagnosis of cancer, has been getting wider, in some instances, between rich and poor. When you look at survival and what influences that, there are two main things there. One is how advanced the disease was when the patient came to treatment, and the second obviously is the treatment they receive.

Q34 Jon Trickett: I do not want to go down that track, if you do not mind. I am trying to understand what is happening between social classes in Britain

² Ev 20–23

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in relation to cancer. What we discover, I think, in this paragraph and the bullet points beneath, is that, for example, in rectal and colon cancer actually the survival gap between the social classes has grown steeply, so fewer working class people than middle class are surviving for five years than they were at the beginning of the study. Is that not the case?

Professor Richards: I think it is important to say that across all sectors of the population survival rates are improving for colon and rectal cancers.

Q35 Jon Trickett: You have said all that already.

Professor Richards: I have not for survival, but the improvement in survival is faster in the more affluent groups, yes.

Q36 Jon Trickett: The whole tenor of these two paragraphs taken together, I think, is putting a fog over this issue and I want to try to bring it out. That is how I have read it, probably a dozen times, each paragraph, and noticed that?

Sir Nigel Crisp: May I have a go at this, as a fellow layman. I think the first paragraph, relating to mortality, and this one is relating to survival rates, mortality is the death rate, survival rates are those who survive five years, and the two may go in different directions.

Q37 Jon Trickett: I do not think that is exactly the case, but let me try to proceed a bit further. In paragraph 1.5, the first sentence terminates with a very, very small, barely legible, “iv” after “survival gap”. You have to run round the paper to find out what that refers to, and it refers to a learned paper produced in a medical journal, which, I have to confess, takes some reading for a layman. You have referred to the author of this paper. The author of the paper says the following, two sentences, and I will take them one at a time, if I may. “The deprivation gap in survival between rich and poor was wider for patients diagnosed in the late nineties than in the late 1980s. Increases in cancer survival in England and Wales during the 1990s are shown to be significantly associated with a widening deprivation gap in survival.” First of all, do you accept that, and, secondly, do you think that we have really captured the essence of that sentence in this Report?

Professor Richards: First of all, can I say, of course, this is not my report, this is the National Audit Office Report.

Q38 Jon Trickett: You have agreed every word of it?

Professor Richards: I have agreed every word of it.

Q39 Jon Trickett: I am running out of time rapidly and I want to try to get to the bottom of this?

Professor Richards: The gap in survival has widened. I fully accept what is in this Report. I fully accept what Professor Michel Coleman has written in his paper. The reasons for that, I am trying to explain, are partly—

Q40 Jon Trickett: I am not asking you the reasons, I am trying to establish the facts. Do you accept that, in fact, there has been a widening gap in survival rates, that, notwithstanding the fact that all sorts of classes are improving, actually the gap has widened?

Professor Richards: Yes, I do.

Q41 Jon Trickett: Do you accept that this is for 44 out of 47 cancers?

Professor Richards: Yes, I do.

Q42 Jon Trickett: The Report says something entirely different, does it not? It implies, in fact it says, in paragraph 1.5, “for 12 of the 16 cancers examined in men and nine of the 17 cancers examined in women.” It is talking about the survival gap actually not increasing. If you look at the detailed information behind it, it talks about 44 out of 47 adult cancers where the survival gap is widening. Do you accept that?

Professor Richards: I have not got his paper in front of me, but I would suspect that it is whether those differences were going to be statistically significant, that would be my guess about why there would be discrepancy.³

Q43 Jon Trickett: Do you accept the following, another sentence: “These inequalities in survival represented more than 250,000 deaths per year which could have been avoided if all cancer patients had had the same chance of surviving up to five years after diagnosis as patients in the most affluent group”?

Professor Richards: I have no reason to dispute that figure at all.⁴

Q44 Jon Trickett: Do you feel that the information which I have got—I will hand this information to the Chairman—is properly reflected in this paper?

Professor Richards: I think it is, because I think what the paper is saying here is that the survival gap is getting wider, and that I agree with.

Jon Trickett: I do not think really it does say that. In any event, my questioning and your answers, I think, are now in the verbatim record and hopefully will be reflected in our report.

Q45 Mr Steinberg: Basically, exactly what Mr Trickett was saying baffled me as well. I read the Report and came to exactly the same view, though, I have to say, I understood it less well than he did, because I read the paragraph about half a dozen times and it just did not seem to make sense to me. What did make sense to me was that it made very

³ *Note by witness:* Professor Colman’s study referred to in the NAO Report (para 1.5) was to do with 16 cancers in men and 17 cancers in women. However, we believe that an earlier study conducted by the same author, covering an earlier time period, may well have looked at a wider range of cancers and this is, presumably, where he quotes the figure of 47 from.

⁴ *Note by witness:* “250,000 deaths per year” is not the figure that Professor Richards heard and he believe this cannot be correct as this figure exceeds the total number of cancer deaths (for example, all cancer deaths in England and Wales: 1997—135,647; 1998—136,289; 1999—134,135; 2000—132,686; 2001—135,839).

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depressing reading for a Member of Parliament who comes from the North East of England. I looked through the Report and, just quickly going through it, breast cancer, there is less incidence but there are just as high mortality rates in the North East. The survival after five years, you have a lot less chance of living than you have in the South East of England. If you have lung cancer, there is much more incidence and there are many more deaths. The same for bowel cancer. Colon cancer, you are more likely to die in the North East than you are in the South East. Prostate cancer, exactly the same. Going on to drugs. Eligible cancer patients prescribed Herceptin are amongst the lowest rates in the country. Death rates in the North East of England, in some cases, are twice those in the South of England. It appears to me, if Mr Trickett is correct in his assumption, which I think he is, that the more affluent areas of the South East of England certainly are looked after better than those in the North East of England, there is not much doubt about that at all. It seems to me that clearly we have a postcode service, in terms of cancer treatment. How would you respond to that?

Professor Richards: Firstly, if you take lung cancer, which is the commonest cause of death, the major factor there, by far the biggest factor, is the smoking prevalence. Smoking prevalence does vary across the country and is higher in the North East than in other parts of the country. In terms of other cancers, one of the key factors in whether people are going to survive is whether they present rapidly to their GP with their symptoms, and again there is some evidence that factor varies according to social class. Again, that is a major reason why we need to tackle that particular issue.

Q46 Mr Steinberg: Do more people die in deprived areas?

Professor Richards: More people do die in deprived areas, yes, certainly.

Q47 Mr Steinberg: Why?

Professor Richards: Because of smoking and also, almost certainly, because of later presentation to health services with their problems.

Q48 Mr Steinberg: Would you agree that more people survive in affluent areas?

Professor Richards: That is also true.

Q49 Mr Steinberg: Then the obvious question is, why are we not doing something about it?

Professor Richards: Certainly we are doing something about it.

Q50 Mr Steinberg: My constituents have a worse chance of living than people in the South East of England?

Professor Richards: I think it is worth just pointing out that these figures on survival relate to the 1990s, and that is before the Cancer Plan came in, in the year 2000. We are acting on all the various different things that you have mentioned. We have taken action specifically on smoking and initially we targeted Health Action Zones. In fact, if you also

look at the table which refers to Stop Smoking services, you will find that the North East comes out by far the best under Stop Smoking services, and I think that is an extremely welcome finding because in time that will reduce the rates of lung cancer, heart disease and other diseases. We are tackling it on smoking, we are tackling it across the country by making sure that we have got the services in place, the multi-disciplinary teams, which can make sure that care is provided to the highest quality wherever anybody is in the country.

Q51 Mr Steinberg: You mentioned that, in fact, lung cancer was the worst sort of example in the North East and I would agree with you totally. When my wife became pregnant, 30-odd years ago, in the very early seventies, she stopped smoking because there was a campaign at that particular time and I stopped smoking along with her, so we have not smoked for 30-odd years. It has been known for 30 years that smoking is very dangerous, has it not?

Professor Richards: For 40 years, in fact, yes.

Q52 Mr Steinberg: It has been widely accepted, is that right?

Professor Richards: Absolutely.

Q53 Mr Steinberg: Is it vital that people are encouraged to stop smoking, regardless of their background?

Professor Richards: I do not think it is right that we should impose things on people, but it is right that we should advise them of the dangers.

Q54 Mr Steinberg: You do not think it is right to impose things, so you do not think that, if something kills you, you should stop them doing it?

Professor Richards: I think there are elements of personal choice and I think it is very important to recognise—

Q55 Mr Steinberg: You think it is alright to smoke yourself to death then, do you?

Professor Richards: No. I am ex-smoker myself and I have given up smoking because I recognise the dangers, and I would want everybody in the country to be aware of those dangers. It is the single largest cause of both cancer death and premature death in this country.

Q56 Mr Steinberg: You would agree that it is sensible for Government to encourage people not to smoke, regardless of their social circumstances?

Professor Richards: I would, and over the last four years we have put in place the “ban on tobacco” advertising, the large media campaigns on television, the notices on cigarette packets, which are words of warning, and the Stop Smoking services.

Q57 Mr Steinberg: Was the Secretary of State given a copy of this Report, do you know? Has he read it?

Professor Richards: I cannot say whether he has read it. Certainly he is aware of it.

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Q58 Mr Steinberg: Could you suggest that he reads it, because really his statement was quite ignorant, was it not? Do not answer that. I am saying that his statement was quite ignorant. People have known for 30-odd years, have they not, that smoking, and passive smoking, is bad?

Professor Richards: The dangers of active smoking became apparent before the dangers of passive smoking, but I think it is widely accepted now.

Q59 Mr Steinberg: For how long would you reckon that passive smoking has been seen to be dangerous?

Professor Richards: Probably for at least a decade.

Q60 Mr Steinberg: When I asked a Parliamentary Question in March 1999, "To ask the Secretary of State for Health if he will take steps to impose a legal duty on restaurants to provide non-smoking areas," what would you expect the answer to have been?

Professor Richards: Obviously, Government has to take a whole range of different factors into account. I have made clear my views on smoking in public places.

Q61 Mr Steinberg: I will tell you what Ms Jowell said: "No." Then when I put the question, on 26 November, 2001, "To ask the Secretary of State for Health what proposals she has to ban smoking in the workplace and in public places," what was the response from Jacqui Smith? "We have no plans for legislation in these areas." Does that not show that Government just has not taken this problem seriously enough; and for Reid to say what he said is just encouraging people, who are likely to die anyway, to die a little bit quicker?

Professor Richards: I think the most important thing is that we have a major consultation, which is ongoing at the moment, about choosing health, where both smoking and obesity are major parts of that consultation. It is still in progress. I think it ends at the end of this month and there will be a White Paper in the autumn which will address issues to do with both smoking and obesity.

Q62 Mr Steinberg: Do not get me onto obesity. It is rather funny, I always seem to get letters just before we have a meeting of the Committee of Public Accounts, which usually come in very handy. This is a letter from a Reverend, and I am not going to say his name because he has not given me permission to do so. This is to Sir Nigel. He says: "In 1998 my GP referred me to an ENT consultant. He required a CT scan to assist diagnosis. I had that scan just seven days later. Earlier this year a similar referral within the same NHS Trust resulted in a three-month wait to see the consultant. Again a CT scan is required, but this time there is a three-month waiting list." I will miss a lot out. "However, it would be encouraging during this long wait to be able to hope that things might improve and that one day the high standards of former years could be restored." That goes totally against what we are told, and really what we read in this Report, that millions of pounds extra have been put in. Why do we get a situation like that?

Sir Nigel Crisp: If you get permission from the Reverend, I am very happy to look at the particular circumstances in the particular hospital. I will see what it says. I assume it is the same hospital. There will be some variation which goes the wrong way.

Q63 Mr Steinberg: Why is it going the wrong way? It is in the North East of England, again. Is it the same in the South East of England, Sir Nigel? Do they have to wait three months in the South East of England?

Sir Nigel Crisp: Some of our waits are far too long. We have made big improvements in waits, on average, but clearly, in that particular instance, he got his CT scan in seven days, which is where we should be aiming, is it not, for the future?

Q64 Mr Steinberg: Just give me an answer. You have not given me an answer as to why it is now three months when it was seven days?

Sir Nigel Crisp: I do not know the answer. Are they seeing more patients? Seriously, unless you let me have a look at the letter and find out what the answer is, I do not know.

Professor Richards: Obviously, I cannot answer on an individual circumstance, but what I can say is that the demand for CT scanning has gone up very considerably, as it has been found to be useful in a whole range of different conditions for which we were not using it a few years ago. Over the last few years, I think since April 2000, actually we have increased the number of CT scanners by 87%; that is bringing them up to 373 in the country by the end of this year. We have deliberately targeted those extra machines to make the provision more equal across the country.

Q65 Mr Steinberg: Less equal in the North East?

Professor Richards: No.

Q66 Mr Steinberg: It must be. If you have a scan in seven days and now it is three months, it has got worse?

Professor Richards: I cannot say what the circumstances are of that, but I do not believe, on average, they have got worse. I believe the demand has gone up. The capacity has increased and we are working extremely hard, through programmes like the Radiology Collaborative, which is part of the Modernisation Agency, to reduce waits in all aspects of diagnostics, particularly radiology. In those places which have been doing that we have reduced the waits very substantially.

Q67 Jon Cruddas: Sir Nigel, just going back to the initial questions asked by the Chairman as regards the research on patient behaviour, referred to on page 32, paragraph 2.31, even though the report is scheduled to come out later this year, has the research yielded any results yet?

Sir Nigel Crisp: Again, I am sorry, I think I am going to ask Professor Richards to try to answer that.

Professor Richards: The research programme which was commissioned following the publication of the Cancer Plan specifically because we knew that we

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did not know enough about the aspects of either patient delay or GP delay in terms of cancer, that is now coming to fruition. I have seen some of the early results from that. I think the facts which come through to me are, firstly, that the patient element of delay tends to be the major component, more so than the GP delay. In general, it is lack of awareness of the problem of cancer rather than fear, although sometimes fear can be paralysing and make people not go to seek help. There is an element of age, so that people who are older tend to delay longer before seeking medical advice. There is an element of social class in this as well, which may be related also to lack of awareness. All those parameters are coming through. Also we have asked the researchers to review the whole of the world evidence on what can be done to reduce delays and, as I was indicating a bit earlier, sadly, that research evidence is extremely thin in telling us in what ways to do things about it.

Q68 Jon Cruddas: One area you did not mention there was gender, in terms of some of the stuff that is coming out in this research, we have mentioned class and age, and so on. After reading this Report, I got a briefing, through the House of Commons here, from the Men's Health Forum. In their covering note, the first paragraph says: "Men are more likely than women to suffer from nine out of the 10 most common forms of cancer affecting both sexes, yet there remains an almost complete absence of strategic thinking about the relationship between gender and cancer. None of the various national targets relating to cancer makes any mention of the specific need to reduce the incidence of cancer in men." What would you say to that?

Professor Richards: Yes, cancers are often more common in men. Many of those cancers are smoking-related cancers, because it is not simply lung cancer but it is also bladder cancer, oesophageal cancer, laryngeal cancer, a whole range of cancers which are linked to smoking, and the tobacco epidemic in men has been worse than it has been in women. That is the single most important factor.

Q69 Jon Cruddas: So you accept that there is a gender demarcation in terms of the incidence of cancer?

Professor Richards: In terms of the incidence, there is no doubt at all.

Q70 Jon Cruddas: They say nine out of 10, with the exception of malignant melanoma?

Professor Richards: I would not dispute that. That is entirely correct.

Q71 Jon Cruddas: In terms of incidence, it is repeated in mortality rates as well, so it is not just the incidence?

Professor Richards: Sadly, that is because many of those smoking-related cancers are the cancers which have a high death rate.

Q72 Jon Cruddas: The second paragraph in this Men's Health Forum briefing states: "Consequently, there is virtually no planning at either national or local level that takes into account the clear need for policies, programmes or other dedicated forms of action targeted at men." I notice that your research did not mention gender. The sole factor that you have mentioned at the moment is the history of smoking?

Professor Richards: We have been talking in terms of incidence, which I have been relating to smoking. The research that we commissioned was looking particularly at factors which may be associated with people delaying longer before seeking healthcare advice. To the best of my knowledge, gender does not come through as a strong factor there, although it may be a factor. One of the factors which does seem to influence people is whether they have a partner or a close confidante to whom they communicate the fact that they have got a symptom, because the partner, whether that is a male partner or a female partner, probably then encourages people to go to see their GP. Certainly the evidence is there in a number of cancers, breast cancer being one, about people communicating with a partner.

Q73 Jon Cruddas: So men have higher incidence rates for all forms of cancer which affect both sexes, and, the mortality rates, this briefing says men are almost twice as likely in total to die from the cancers in the shared groups. We have isolated this issue of smoking but also there is a question of communication?

Professor Richards: There may be a question of delay in seeking help, yes.

Q74 Jon Cruddas: Even though the research does not jump out, in terms of the gender?

Professor Richards: It does not jump out, but I should say that research is not yet published and so it is not yet in a final form.

Q75 Jon Cruddas: Do you have an assumption within the Department about what proportion of cancers are preventable?

Professor Richards: Yes. Up to two-thirds of all cancers potentially are preventable because around one-third are related to smoking, which obviously is preventable, and probably up to a further third are related to a combination of obesity, a diet that is lacking in fruit and vegetables and lack of physical activity.

Q76 Jon Cruddas: I was looking here at the European Commission's Code against Cancer and it says that the evidence that cancer is preventable is compelling. Towards 80% or even 90% of cancers in western populations may be attributable to environmental causes, defining "environmental" in its broadest sense to include diet, social and cultural issues, and all of that. These differences in gender are not biologically determined, they are culturally, socially, economically or geographically defined?

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Professor Richards: In the main, yes.

Q77 Jon Cruddas: Accepting all of this, that it is environmentally determined, and accepting the statistics which this briefing supplies, would you accept the criticism, however, that there is not a strategic approach to men's health or patterns of consumption, over and above smoking, that is what I am saying?

Professor Richards: Can I say that, for example, for prostate cancer, obviously which only affects men, we have made that a specific target area. In fact, it was the first area that we made a target area. We published an NHS Prostate Cancer Programme back in 2000 which looked at research, it looked at better treatment and at early detection. The first of the advisory groups on a specific cancer that we set up related to prostate cancer. In terms of the Men's Health Forum specifically, the Department of Health has provided funding towards the Haynes Cancer Manual, which the Men's Health Forum has produced, which is a bit like an owner's manual for a car.

Q78 Jon Cruddas: It seems to me, and I am not a professional in this, looking at these statistics, it is pretty stark, in terms of the gender rates, and looking at the gender mortality breakdown, in terms of the top 10 cancers, the most common forms of cancer, it seems to say to me that the present range of cancer prevention policies and programmes is very much less successful with men than women. Everything else being equal, that would appear to be the case?

Professor Richards: I am not sure that I quite agree with you on that, because again it comes back to smoking. A lot of that is historical and there is a graph in this Report which shows smoking rates going back about 40 years, showing that the male smoking rates were very much higher in the sixties and seventies than they were for women. Now those two rates have converged, and over time, but probably it will take another 10 to 20 years, one would expect the cancer rates to come together because of that, because so many of those things are related to smoking.

Q79 Jon Cruddas: That is what you are assuming, is it?

Professor Richards: Because we know that these cancers are related to smoking, yes, and we know that giving up smoking helps.

Q80 Jon Cruddas: You see no case for health policy taking account of gender differences, over and above smoking, and if health improvement targets should be gender-specific?

Professor Richards: I think it is important to remember that, sadly, all of these cancers are very common in both men and women. We need to tackle both. For example, the second commonest killer, colorectal cancer, or bowel cancer, is a condition for which screening may help to reduce the death rates. We are committed to introducing a bowel cancer screening programme and we have got pilots and

projects up and running at the moment. The Secretary of State has already made a commitment to introduce a bowel cancer screening programme which will benefit both men and women equally.

Q81 Jon Cruddas: But yet no male-specific cancer targets?

Professor Richards: Because cancer is common in both men and women I am not sure what the specific advantage would be on that, other than for prostate cancer which obviously is a male-specific cancer.

Q82 Jon Cruddas: You have mentioned prostate cancer. There are no specific male outreach strategies for cancer, over and above prostate cancer?

Professor Richards: In terms of how we can get people to present earlier, we may well need to look at how best to get to different groups in society, whether that is men versus women or whether it is different ethnic groups, all sorts of different things. We need to look to see how best we can do that. Sadly, as I was saying before, the research evidence is thin and does not give us strong clues about how to do that. Therefore, I think we need to set up pilots, as recommended in this Report, in order that we can look into that and try to provide results.

Q83 Jon Cruddas: You did not mention gender when you talked about that?

Professor Richards: I said men and women, yes. We need to look at how to get to different groups in society, men and women, whites, ethnic minorities, all different groups we need to look at to see what will work in the individual groups.

Q84 Mr Jenkins: Sir Nigel, earlier on, the Chairman asked you about training for radiographers, etc., and you said we are doing better, we are training more radiographers, but we have been on this programme now for a number of years. When do you expect to get in place either a rearranged staffing programme or the fully qualified and trained members of staff, and will we not be in difficulty with staff leaving because of the poor pay and conditions they are operating under?

Sir Nigel Crisp: I cannot answer the first part of your question because I do not know yet. This is precisely why we are doing a stock-take of radiotherapy, actually to look at the fact that the waiting times have gone the wrong way and that we have got the pressure on the system, that absolutely we need to find out now when we are going to get them back down to the level that we think they need to be at. We should have an answer to that in the not too distant future. We are doing a stock-take precisely on that point. On the point of staff leaving, the evidence overall is that the staffing numbers are increasing, but I accept the point that we need to attack that issue by more training, by more recruitment and also by making sure that the conditions of work and pay retain people. It is all of those things.

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Q85 Mr Jenkins: Referring to the survey done in 1998, on page 42, chapter 2.77, it says: "the situation has not improved since the previous such survey in 1998, with only a minority of patients receiving treatment within recommended waiting times." There has been an enormous problem for quite a while and the problem has grown for quite a while, so now you have done a survey. When can we expect (a) the result of the survey and (b) a solution to the problem?

Sir Nigel Crisp: It is worth saying that there are a number of things which have happened which actually were unexpected. This is not just a problem growing, it is things like a recognition that you need to change the number of doses of treatment the patients get, and that means you are able to treat fewer patients in a treatment session because it takes longer to treat each patient. There is a series of things which were not expected and therefore which are making it harder to do this. Literally we are doing a stock-take now. I am not quite sure when we will get the results from it.

Professor Richards: I have convened a group to look specifically at the whole problem of radiotherapy waits, it is meeting next week, 21 June. This group includes people from the Royal College of Radiologists and the Royal College of Radiographers in order that we get the best advice on this. There is no doubt that we have increased the number of people in training. We started doing that three to four years ago, but training of a radiographer takes three years and it took us time to build up capacity in training schools. I am confident that over coming years the number of therapy radiographers, those are the people who actually operate the radiotherapy machines, will go up. It is already going up but not fast enough. As Sir Nigel has said, there has been a whole range of different factors increasing the demand for radiotherapy, better treatment by giving longer courses, identifying patients who, frankly, in the past, would have missed out on treatment. Now that we have multi-disciplinary teams, those patients are being identified and are being referred to radiotherapy, so there are more patients coming into the system and that is creating a bottleneck. We are determined to solve that as quickly as possible. As I said, we have already increased training, we have already increased the number of machines, we need to see if there is anything else that we can do to reduce those waits.

Q86 Mr Jenkins: Given all the different circumstances, given all the problems you have got being able to manage the situation, it is 2004 now, when do you expect to get to the situation where all patients will be treated within the recommended waiting times? That is all I ask. Give us a figure: 2007?

Professor Richards: I find it very difficult to give a precise figure. Obviously, I will ask the group that I am convening next week for their views on that. What I can say is that there will be significant increases in the number of radiographers coming into the system over the next two years and beyond.

Q87 Mr Jenkins: You would not predict a figure?

Professor Richards: I would not, because I do not know that I could be accurate in that prediction, but we are tracking it as fast as we can.

Q88 Mr Jenkins: If we could turn to page 41, chart 36, if I understand it right, it shows the percentage of people who are undergoing surgery by area, and the number in the South West is much greater than those in the North West. Why is it that the South West has a far greater number of people undergoing surgery than the North West, in that particular instance?

Professor Richards: Can I point out, first of all, that the figures really are quite low in all parts of the country, ranging from about 8% up to just over 16%. We have known that the percentage of people undergoing surgery for non small cell lung cancer has been low in this country. To a large extent, that relates to the fact that by the time people seek medical advice they have inoperable cancer, but once we have got them in the system we do need to get them through the system as quickly as possible and we do need to make sure that we have enough capacity in cardiothoracic surgery. That is an area again where we have been working with the cardiothoracic surgeons to improve the situation. Interestingly, that is an area where different factors happening in cardiac disease and thoracic disease may actually help us, as more people move towards having stenting procedures which are done by cardiologists rather than surgeons. Hopefully, that will give us greater capacity amongst the surgeons to do lung cancer surgery, but that can be done only if the patients present at a stage when they have got operable disease.

Q89 Mr Jenkins: That is the second part of the question. Unlike Mr Steinberg, I do not believe, no matter how well we preach at people, that we will alter people's habits in the foreseeable future, we may alter a percentage but not the total population. As a smoker, how does someone know when to go along to the doctor to have a check to ensure they have not got lung cancer?

Professor Richards: It is very difficult and there is no proven screening technique for lung cancer at this time. There are trials going on around the world to see whether it will be possible to screen for lung cancer using CT scanning, but at the moment that is not a proven technique. What we do know, from some of the research that I was mentioning earlier to Mr Cruddas, is that patients often have symptoms for quite a long time. Because they are smokers, many of these people will already have the early symptoms of chronic bronchitis, for example, and it is very difficult for them to differentiate between those symptoms and the symptoms of lung cancer. That is why all parts of the world have difficulty with lung cancer, and survival rates are universally low. Having said that, we need to improve our lung cancer survival rates to match the best in Europe, which we are trying to do.

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Q90 Mr Jenkins: I understand the difficulty of the problem. Of course, the difficulty we are facing is that health is a class issue, and a social class issue, and getting people to read the instructions, to read the information, to read about the change in their lifestyle is a very, very difficult job. I do not think anyone should walk away from the fact that this is a very difficult job to get this on board as really providing a health service when what we are doing is providing a sickness service, and the difference is that we are working harder at this. I am not sure what the answer is. If there were one, you would have it, believe me. You talk about bowel cancer screening and that you intend to start this programme of bowel cancer screening by 2006?

Professor Richards: Hopefully, yes.

Q91 Mr Jenkins: What are the implications for the staff and resources required to undertake this level of screening? Do you intend to make it a mass screening? Do you intend to target this at the people you think are affected most, is it the 50-plus, is it the 40-plus? How do you intend to approach this programme and get those people on board?

Professor Richards: For bowel cancer, all the evidence points to screening people over the age of 50, and usually people between 50 and 70. That is what all the trials have been done on and that is where we know it is fatal. Bowel cancer under the age of 50 does occur but it is uncommon under the age of 50. Although we want to roll out the screening programme as quickly as possible, what we are doing now is increasing the number of people who can do endoscopy, that is colonoscopy and flexible sigmoidoscopy, as quickly as possible. We have invested £9 million over the next three years in a national endoscopy training programme. We have already trained a considerable number of people, and over the next two years we will be training even more, in order that we can improve both our symptomatic services for people with bowel symptoms but also so that we can bring in the screening programme.

Q92 Mr Jenkins: Can I ask you to look at pages 44 and 45, diagrams 39 and 40, because it does cause me some concern with regard to the spread. I was looking at diagram 39, at the North West Midlands, Pan Birmingham and Derby/Burton. Living in that part of the world, I realise that you can be in one GP's surgery and you can get directed into three areas. In one area you get 5% receiving Herceptin, and if I go across a few miles I get 50% receiving the drug. It is this postcode lottery system, where people feel, I think justifiably, in a National Health Service, they should receive uniform treatment. The next chart does not do any more for me to understand the degree of specialists who are involved and where they are. When will we start to tackle this as a national problem, rather than looking after the more vocal, more articulate and more educated parts of our population?

Professor Richards: We have started tackling it already. I think the first step was in setting up the National Institute for Clinical Excellence to say

which drugs do work and which should be available to patients. Since we set up NICE we have seen the overall usage of drugs increasing across the country, but, as I mentioned earlier, in my report of two days ago I have pointed out that there is an unacceptable variation in the use of drugs, not just for this one, which is Herceptin, but also across a range of different drugs. What we found was that some networks have a very mixed picture, so they may be high on one drug and low on another and in the middle for the rest. There are some networks which generally are higher and some networks which generally are lower. That was the whole reason why I put in place some recommendations to the Secretary of State, and I am very pleased to say that all of those recommendations are being acted upon.

Chairman: Thank you. Just for the sake of the record, Mr Jenkins referred to paragraph 2.77. I do not think he mentioned that the final results of the Royal College of Radiologists' snapshot survey of radiotherapy waiting times is now available. They confirm that waiting times have lengthened in most places for all categories of patients since 1998 and few patients are being treated with good practice guidelines.

Q93 Mr Bacon: Sir Nigel, if I could start with this Herceptin question on page 44, you did say, did you not, that it is not a funding issue, or was it Professor Richards who said that?

Sir Nigel Crisp: Let us be clear, it is not a funding of the drug issue.

Q94 Mr Bacon: It is to do with how many nurses and chemotherapy suites there are?

Sir Nigel Crisp: It is that; have you actually got the whole system in place, because you need to make the drug and you need to—

Q95 Mr Bacon: The system consists of nurses who are specialists in this area, is that right?

Professor Richards: Yes. We undertook a survey of all 34 cancer networks to ask them what they saw as the problems, and they told us that it was not a problem with the funding. That came from the clinicians themselves.

Q96 Mr Bacon: What I am asking is what are the bits of the system?

Professor Richards: It is particularly the nurses who administer chemotherapy and the pharmacists.

Q97 Mr Bacon: These are nurses who are trained especially in that area?

Professor Richards: Yes, especially trained nurses.

Q98 Mr Bacon: How long does it take to train a nurse in that area?

Professor Richards: Three years.

Q99 Mr Bacon: Do you think you could give us another version of this chart, which is a table? These are strategic health authorities, are they, on page 44?

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Professor Richards: In figure 39 they are actually the 34 cancer networks and there are 28 strategic health authorities.

Q100 Mr Bacon: Can you say, for each cancer network, how much money is spent in them in total, and then, this is my request, the chart, in other words, this chart here with extra information? First, the stuff which you have got there, the percentage of eligible women receiving it, it would be quite helpful, I think, to have it as a numerical percentage rather than a bar chart. Then also the number of nurses, the number of pharmacists and the number of chemotherapy suites. Can you do that?

Professor Richards: At the moment, we do not have that information.

Q101 Mr Bacon: You do not know? How do you know that is the reason it varies if you do not even know how many there are?

Professor Richards: We asked the networks themselves what they saw as the problems, and again we have set up a chemotherapy advisory group.

Q102 Mr Bacon: Can you send us what you have got, as much information as you have got?

Professor Richards: Yes, indeed.⁵ A lot of this information is in the report which I published two days ago and I will be happy to provide you with a copy of that report.

Q103 Mr Bacon: Really I would like this figure 39 but expanded for inclusion in our report and appendix?

Professor Richards: We have, effectively, similar figures to that for all 16 drugs which have been to NICE, in a slightly different format, and we can send that to you.

Q104 Mr Bacon: It is Herceptin I am interested in particularly, simply because of this huge variation. Especially when on the left-hand side there is South West London, everyone knows that is a rich part of the country, they are up at 90%, and you are down at 5% at the other end. Then we hear it is nothing to do with funding. It just sounds odd. Is it just that there are loads of nurses down in South West London?

Professor Richards: I think there are different factors in individual networks.

Q105 Mr Bacon: This is why I need as much information as possible on the number of pharmacists, the number of nurses, etc. If you could send that to us it would be great. Could I ask you to turn to page 36, the radiology point, this is just a point of clarification again. Sir Nigel, you used the word “bottlenecks” and the Report here says, in paragraph 2.52: “many radiology departments provided rapid access for patients with suspected cancer: 74% of departments for suspected breast cancer, 46% for suspected lung cancer” and so on. Really the question to which I would like to know

the answer is, why is it not all radiology departments, and you were saying it is simply that we do not have enough trained staff, or what? 74% sounds quite high but what about the other 26%, and 46% does not sound that high at all?

Sir Nigel Crisp: I think there will be different reasons for each of these. If I remember rightly, the Audit Commission survey may give you some of the answers to that question as to why there are different reasons for those different numbers which are referred to there. I am sorry. I do not know if Professor Richards may be able to say something useful on that.

Professor Richards: I think all that information comes from the Audit Commission’s own report, to the best of my knowledge.

Q106 Mr Bacon: Your recommendation is that where people are suspected of having cancer they should be prioritised, but it does not always happen, does it?

Professor Richards: It is done on the basis of clinical need and my experience as a cancer clinician is that when one needs to get a patient scanned urgently usually one can, because radiology departments work very closely with cancer teams to make sure that happens.

Q107 Mr Bacon: If I could ask about the graph on page 21, this says that the incidence rates vary considerably across the country, and indeed—this is the point I wanted to get to—that mortality rates can vary by as much as 20% between strategic health authorities with almost identical levels of incidence. I found this a very difficult graph to read but can you give me an example, Sir Nigel, of two SHAs which have identical levels of incidence where the mortality varies by 20%?

Professor Richards: Can I take this one. If you look towards the left-hand end and there is a blip up.

Q108 Mr Bacon: From Northumberland, Tyne & Wear, or roughly around there anyway?

Professor Richards: I am not sure whether it is Northumberland, Tyne & Wear, but round about there.

Q109 Mr Bacon: Where it is 25 and then shortly afterwards it is 30?

Professor Richards: As against, let us say, Thames Valley, at the other end of the graph, at the right-hand end. Then if you look higher at the incidence rates which were on the higher level you will find that there is a major difference in incidence.

Q110 Mr Bacon: That is not what I am talking about. The whole point is, my question is about ones which have an identical level. If you read the thing at the top, please, it says: “Mortality rates can vary by as much as 20% between SHAs with almost identical levels of incidence.” If you go to your example of, I think it is, West Yorkshire, and it is very difficult to read, on the left-hand side where there is that sort of kink upwards, the bottom part of that kink, if you go up to the higher chart you get incidence, if you go

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up to the top part of that kink and go up to the chart you get another incidence level, it is almost identical. Is that what it is talking about?

Professor Richards: It is talking about that kink, yes. I am sorry.

Q111 Mr Bacon: Is it possible that we can have this chart reproduced in a way that is more easy to read, and in particular where you can see which hospital or which SHA or cancer network, or whatever it is, is being talked about?

Professor Richards: Certainly it would be possible to reproduce this graph, one of them as bars and the other as a line. I think that would be possible to do.

Q112 Mr Bacon: I think if we could just see which specifically, rather than having to work it out by drawing a line and hoping, it would be very helpful? If you could turn to pages 54 and 55, there is a chart of mortality rates and it shows England and Wales in comparison with a number of other countries, including the United States, France and Germany. It does not include Japan, which I would have thought would be interesting, but it does include those other, very big countries. If you turn over the page to 56/57, which is talking about survival rates, once again you have got England, actually not England and Wales any more just England, but suddenly Germany, the United States and France, with the exception of the top left, where there is a France one, French data is included here as it is collected more widely, all those big ones have disappeared, so you are not comparing like with like really, are you?

Professor Richards: Can I explain this. The mortality figures which are shown on page 55 come from global data called GLOBOCAN and that covers virtually all countries in the world, or certainly all developed countries in the world, that provide data on this.

Q113 Mr Bacon: I can see that they come from different sources. What I really want to know is, why do we not have survival rate information on these major countries?

Professor Richards: Because the one source that is reliable on survival rates is the series of EURO CARE studies which are shown here and those are related to European countries.

Q114 Mr Bacon: We have got Slovakia and Slovenia and Estonia, are you telling me that you cannot find reliable survival rate information for the United States, Germany and France for all these different cancers?

Professor Richards: In terms of being directly comparable data that have been looked at by the researchers and deemed by them to be valid comparisons, at the moment that is for Europe only.

Q115 Mr Bacon: You have just done this before for mortality. I will tell you why I ask this, it is because I have heard many times anecdotally that our survival rates for a range of leading cancers are lower—survival rates, mark you—than in the United States, in Germany and in other European countries. If you

look at the brief, which unfortunately you do not have the benefit of but I do, which the National Audit Office has supplied to us to go with this Report, it says, and I quote: “For countries in Europe where reliable comparisons are possible, England’s survival rates consistently fall below those of the best and are typically higher only than Scotland and Eastern Europe. The US consistently out-performs Europe on cancer survival—people there appear to be diagnosed when their cancer is at an earlier stage of development.” I would like to see some information on survival rates of the top five largest economies in the world and you do not seem to be able to provide it?

Professor Richards: Can I just say, the reason why Germany does not feature in the survival figures is that the cancer registration in Germany is reported for about only 1% of their population. That is why, in combination with the National Audit Office, we were not sure that their data was a reliable comparison. What we have put here is where we know the comparisons are reliable. Yes, I will accept that the reported survival rates in the United States are better than ours and we can show that, but it is not from a direct comparison as this is done.

Q116 Mr Bacon: You have been Cancer Director for five years. Are you saying that nothing has been done in the last five years to sort this out? Surely it is much more interesting for us to compare ourselves with Germany, France and the United States than it is with Slovakia?

Professor Richards: Frankly, our cancer registration is better than that of the United States. The United States has a programme called the SEER programme which covers about 14%.

Q117 Chairman: That was not the question you were asked. It was a specific question and Mr Bacon’s time is now up. He asked you a specific question. Will you please give a specific answer? He wants to know why you have been in this job for five years and we still cannot get a proper comparison between the United States, France and Germany, and that seems a fair question which now you have got to answer?

Professor Richards: The simple answer is that I am not responsible for cancer registration in Germany or the United States.

Q118 Mr Bacon: You mentioned the SEER programme, and I know I am intruding on the Chairman’s generosity. In paragraph 1.22, on page 24, it says, and I quote: “Five-year relative survival rates for all cancers in the United States were 56% for persons diagnosed in 1987 and 63% for persons diagnosed in 1992. Recent research on breast cancer has shown that the higher survival rates . . . compared with Europe . . . are linked to diagnosis of the disease at a less advanced stage in the United States.” Are you saying that is not correct?

Professor Richards: No. What I am saying is, those are reported results in the United States. I have just come back from the United States where I have been talking to experts over there and their reported rates

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are higher, but in this Report we wanted to make sure we had data that was directly comparable and so we went for those countries within Europe for which we knew we had directly comparable figures.

Q119 Mr Bacon: Like Slovakia?

Professor Richards: Yes.

Q120 Mr Bacon: Sir Nigel, you were bursting to say something, in all fairness?

Sir Nigel Crisp: I was going to make the point that I do not think you can hold Professor Richards accountable for how they account for cancer registration in the United States, and if they do not do it on the same basis as we do it is difficult to make a direct comparison.

Chairman: Could I ask the NAO, as it seems to me this is absolutely basic, is there no way we can get proper comparisons?

Q121 Jon Trickett: Chairman, I do not want to intrude but I am certain that the Derek Wanless report has something called “potential years of life lost” (PYLL) and I am certain that they compare Australia, New Zealand, America, ourselves and the advanced Western European countries on cancer. I am quite certain that the information is there, if they have not got it today?

Professor Richards: Can I say, yes, it is, because that is based on death rates and death rates are comparable. What you are asking here is on survival rates where we do not have the direct comparison, because survival rates require incidence data as well as the death data.

Q122 Chairman: Anyway that might have been interesting to have in our report. Perhaps NAO could comment on it?

Mr Burr: We are dependent upon the data which exist for these countries and, as we are saying, for survival it is patchy, but certainly we can have a look at what is available.

Mr Bacon: This is fundamental, is it not?

Q123 Chairman: James, do you want to comment?

Mr Robertson: As Professor Richards has said, we have attempted to draw together comparisons of data which are comparable. The difficulty with data for other countries is that it is collected from very small percentages of the population, often parts of the population which are more affluent, and therefore, as the Committee was saying earlier on, you could get a very distorted picture of what the relative survival rates are, and that is why we have used all the reliable data. I do not think there is any more data that we can draw on but we have used the data that is comparable in order not to be misleading.

Q124 Chairman: What about the point Mr Trickett was putting to you?

Mr Robertson: I am sorry, could you repeat that?

Q125 Jon Trickett: In the Wanless Reports, of which there are several now, Wanless uses something very interesting called PYLL, which stands for “potential years of life lost”, and he demonstrates that, on average, we die eight years younger than they do in the United States, Australia and elsewhere, a whole basket of countries. Wanless has done this most sophisticated analysis on which the NHS funding for the next 20 years is being determined, and for us to say that data is meaningless is quite surprising, to be honest?

Mr Robertson: Those data relate to mortality figures, and because mortality is better recorded than survival and there are debates about how you define survival, and so on, it is possible to draw on those figures. Indeed, figure 23 in the Report has got the comparison with other EU countries on cancer mortality, so those you can use.

Chairman: I think that has been a useful discussion.

Q126 Mr Williams: I was going to ask a point about statistics anyhow. To NAO, were you surprised at gaps in availability of statistics within the country? Ignore the international comparisons for a moment because that is outside NHS control. Were you surprised at the lack of any figures or the up-to-date nature of the information or the quality of the statistics which you found when you were trying to prepare this Report?

Mr Robertson: When I first came to looking at this, I was surprised about the age of figures for survival, but at that point I did not understand that, if you are looking at a five-year survival rate, you have to wait five years in order to get that figure.

Q127 Mr Williams: They are then five years out of date?

Mr Robertson: On that definition, they must be.

Q128 Mr Williams: They are using the figures they got five years ago?

Mr Robertson: Yes, and they must always be out of date.

Q129 Mr Williams: That is 10 years. The table which shows survival takes diagnosis in '94 as the latest figure. Therefore, you are five years in '99, therefore we have got another five years, so it is still five years out of date?

Mr Robertson: Certainly we would have liked more recent data. That is a reflection of the way that cancer registries deal with their data.

Q130 Mr Williams: Go on, Professor, we are dodging about here?

Professor Richards: Can I comment on that. The international comparisons do end with patients diagnosed in 1994. We would like to have more up-to-date comparisons there. Of course, for this country, we do have data, as in this Report, up to at least 1999, from Professor Coleman's study. We are now planning a further EURO CARE study, the cancer registries of Europe getting together, and I

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hope that will bring us a whole lot more up to date. I am encouraging them to look even more up to date than just keeping five years behind, because there are modern statistical methods that will allow us to get the survival rate data more up to date.

Q131 Mr Williams: Are there any gaps in the type of information that is available? If you were able to wave a wand now and say, "I wish this information were available," is there anything that comes to mind?

Professor Richards: In terms of the data on incidence survival/mortality, I think we are doing well. What we need to do better on is getting the information on the stage of disease which patients have and on any other illnesses they have and on the treatment they have. That is why we have put in place this National Clinical Audit Programme which will do just that, and that will allow us then to answer a whole lot of the questions you have been asking us today about the appropriateness of treatment, for example, in different age groups.

Q132 Mr Williams: It was virtually 10 years ago that this Committee—I doubt if anyone else who is here at the moment was on it at the time—actually commended clinical audit as a very important tool, and yet here we are all that time on and we are still bemoaning the fact that it is not available. I do not criticise you for that, I can understand why you wish you had it. However, we will leave that. Can I satisfy a piece of ignorance here. Table 39, the percentage of eligible women receiving Herceptin, how important a treatment is that?

Professor Richards: It is an important treatment. It is a treatment given for breast cancer, for people with advanced breast cancer. It is suitable for only a minority of people with advanced breast cancer. It is a drug which attaches to a particular receptor on the cancer cell which is present in about a quarter of cases of breast cancer, but people who are given that drug, on average, will survive approximately six months longer than those who are not given it.

Q133 Mr Williams: It gives a further six months of life?

Professor Richards: That is an approximate figure, and so it is an important drug and we welcome the fact that NICE approved it and we want to see it available for everybody who can take it.

Q134 Mr Williams: I welcome that intention. I know it is not within your gift to deliver. Looking at table 39, what strikes one, obviously quite out of any proportion to the rest of the table, looking across the country, are the first two figures, South West London and Dorset, and they were already leading the country before the NICE approval. Since then, in the case of South West London, the availability has increased four-fold to virtually 90% of eligible women, and in the case of Dorset by eight-fold, again 90%. Those are staggering increases. That is a multiplication of figures which are already ahead of the rest of the country. Why is it that when we go to the other end of the table, the depressing end of the

table, Arden, Derby/Burton and West London, you get down to 1-30th of the best?⁶ A woman there has one chance in 30 of getting the extra six months that people can expect if they live in South West London and Dorset. Who is responsible? Why on earth cannot anything be done to get greater equality of availability?

Professor Richards: As I have said before, my own report says that these variations are unacceptable. We have talked already about what some of those reasons are, particularly the capacity in terms of having enough nurses and pharmacists.

Q135 Mr Williams: With respect, when you look at the lower end of this table, and when I say the lower end I am talking halfway up it, there is still virtually a three-fold magnitude of difference. There cannot be that difference between staff?

Professor Richards: No, I am not saying it is all down to staff. I think also it is down to variation between clinicians, and I have said it very clearly in my report to the Secretary of State. One of the ways in which we can tackle that is by collecting this sort of information, and even more detailed information than this, and feeding it back to individual practitioners.

Q136 Mr Williams: You want to feed it to the public, not to the practitioners, feed it to the public and let the public find out the extent of deprivation there is. We want to make this as public as we can? I am not blaming you. I get angry at the situation, not at you.

Professor Richards: What I am saying is, we have got all the information for all the drugs approved by NICE. Here we have just one drug. We have now put information on all 16 cancer drugs appraised by NICE into the public domain, named by cancer network, and we put that into the public domain two days ago.

Q137 Mr Williams: Would this come within the area that you said is not a matter of money, that money is not the determining factor?

Professor Richards: The clear view that we got from the cancer networks themselves was that funding for the drugs themselves was not the issue. There may be funding issues related to the staff, the pharmacists and the nurses, but funding for the drugs was not the issue and that came through very clearly in the survey that we undertook for my report.

Q138 Mr Williams: In that case, I regard this as so important, because the figures are so widely different, I would like as full a document as you can put in for us as a supplementary note in relation to this particular diagram?

⁶ *Note by witness:* The reference to West London is erroneous. We believe that Mr Williams was using the old version of the NAO's figure 39 and not the corrected version as West London comes just after halfway and not in the last three.

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Professor Richards: As I said, now that we have published my report, I will be happy to give you copies of the full report as a supplementary to this.⁷

Q139 Mr Williams: That will be very helpful. Thank you very much. One thing, to help us in our judgment when we are dealing with our own local hospitals and health authorities, you said that nearly always a scan can be organised urgently when it is needed. From a layman's point of view, which is most of us, how critical is time, what is "urgent" in terms of getting someone to a scan?

Professor Richards: I think you have to think of this in two different ways. First of all, the anxiety that a patient faces when they have got either a definite diagnosis of cancer—

Q140 Mr Williams: What would you regard as the clinical urgency time span?

Professor Richards: I consider that the anxiety of the patient is part of the clinical situation, but, in addition to that, in terms of whether a disease is going to progress, it is very difficult to put an exact timescale on that. In setting our targets for cancer, in saying we want people from urgent referral to get through to treatment, and we have set the target of that being two months, I think you can see that for each step in the process, getting to the hospital, getting through diagnosis, getting to treatment, we want that to be a matter of weeks only.

Q141 Mr Williams: Thank you. One final question, because my time is up. Do you smoke?

Professor Richards: No. I have said already that I used to.

Q142 Mr Williams: Do you, Sir Nigel?

Sir Nigel Crisp: No. I used to smoke. We are reformed at this end of the room.

Q143 Mr Williams: Do you find that, if possible, you avoid smoke-filled rooms?

Sir Nigel Crisp: By and large I would, but not always.

Professor Richards: I tend to avoid smoke-filled rooms.

Mr Williams: We will draw these comments to the attention of some of our colleagues. Thank you very much.

Q144 Mr Jenkins: Sir Nigel, do not go away feeling that we are critical of this Report, in fact I think it is quite a good Report in many areas, it shows we are moving forward across a wide front. If we look at figure 23, where it shows, particularly on the north side, the progress we have made, I have worked out that we have dropped a good way down the league table and the only country that has bettered us is Finland, we are almost on a par with Finland, so I think we have done some good work there. We were looking at the chart earlier on and I want to ask a question on figure 19, on page 21, it was quite

interesting I thought. If you look at one end of the chart, am I reading this right, South Yorkshire with regard to prostate cancer mortality has got 45 as a rate per 100,000, and the other one, Thames Valley, has got 85, on the incidence scale? Why is South Yorkshire, which has never struck me as a particularly healthy part of the world, so low?⁸ Is it a blip, is it an accident in the collection of data, or really is it that they are eating something or doing something up there which I need to know about quick?

Professor Richards: When we were preparing this Report with the NAO, clearly all of us asked that same question. I do not think I have an absolute answer to it, but with prostate cancer in particular the reported incidence of the disease depends critically on how much PSA testing is done in the locality. What I would want to know, and I do not have an answer to, is whether the PSA testing rate in that part of the country is significantly lower than it is in other parts. I simply do not know that.

Q145 Mr Jenkins: Would that cause you concern and would you flag up now the need to do some more testing in that area to show us the real figure we are looking at?

Professor Richards: Certainly we would wish to explore that further. In fact, I believe that during the course of the preparation of the Report we went back to the relevant cancer registry and asked them specifically to check that figure. They checked it and said to the best of their knowledge that was accurate but I am not sure that they were able to tell us the specific reason for it, except the possibility that it relates to low PSA testing rates. I agree that it looks very strange.

Q146 Mr Jenkins: It could be a hidden condition?

Professor Richards: It could be, yes.

Mr Jenkins: Yes, that was what I suspected.

Q147 Mr Bacon: Professor Richards, going on to this point about Herceptin and the lack of various parts of the system, like pharmacists, chemotherapy suites, nurses, and so on, you said that the training for a nurse was three years. I want to clarify this, because everyone knows that it takes three years to train a nurse. Are you saying that once you have got a trained nurse it is a further three years to have an oncology nurse?

Professor Richards: No.

Q148 Mr Bacon: Was that not what you were saying? I was talking about Sir Nigel's point about the lack of nurses. My assumption was, and I need to get this clear, if you have got a nurse and you turn him, or her, into an oncology nurse, how long extra does that take?

Professor Richards: Usually one would be taking somebody who is already an experienced nurse and at usually at least an E or F grade, so they would have spent three years training to become a nurse, usually at least another couple of years of experience

⁷ Not printed—*Variations in usage of cancer drugs approved by NICE—Report of the Review undertaken by the National Cancer Director*, NICE, May 2004.

⁸ Ev 23

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as a registered nurse, and then to become an oncology nurse on top of that takes between nine months and a year to get those skills to be able to deliver chemotherapy.

Q149 Mr Bacon: It should not take that long. I still do not understand. I find it incredible that the variation in this chart for Herceptin can be explained simply by the lack of things like nurses. I have got two other questions and I do not have a lot of time. Are nurses prohibited from telling patients about Herceptin?

Professor Richards: No.

Q150 Mr Bacon: There is a lady at the back of the room who campaigns on Herceptin and she said she was at a conference three weeks ago where a nurse spoke and said that she was prohibited from telling patients about Herceptin. How can you explain that?

Professor Richards: I certainly cannot explain that because I do not believe that is good practice. I think that all patients should have the advantage of at least having Herceptin discussed with them.

Q151 Mr Bacon: The survival rates, you mentioned that it increases the length of life for women with this particular kind of breast cancer by six months; what is that, an average?

Professor Richards: Of course it is an average, yes.

Q152 Mr Bacon: From where did you get that number?

Professor Richards: There has been a large, randomised control trial of patients with advanced breast cancer, comparing patients getting standard chemotherapy with Herceptin versus standard chemotherapy on its own.

Q153 Mr Bacon: What is the range? You say six months is the average; what is the range?

Professor Richards: The range is from no extra benefit up to several years. Certainly I know of individual patients who have lived for several years when I would not have expected them to.

Q154 Mr Bacon: So has the lady at the back of the room, she is one of them, she has lived for three years and she says there are cases of four years around. Is this six months a reliable figure?

Professor Richards: It is a reliable figure as the average, yes, it is absolutely reliable, but I accept that there is a range on this and I know of patients who have lived, let us say, five years or more when I would not have expected them to do so without it.

Q155 Mr Bacon: How much is a course of Herceptin per month?

Professor Richards: Off the top of my head, I cannot give you an answer to that, but a total course of Herceptin certainly would run into thousands of pounds.

Q156 Mr Bacon: Per month?

Professor Richards: I would have to come back to you on the exact costing.

Q157 Mr Bacon: If you could send us a note on that, please?

Professor Richards: Yes, certainly.⁹

Q158 Chairman: I think we are nearly at the end of our hearing now, Professor, but just to give you a chance to say—and we have very much enjoyed having you here this afternoon, with your obvious dedication to your job and your knowledge—what further improvements in the incidence of mortality and survival do you expect in this country in the next five years?

Professor Richards: May I say, I have enjoyed being here too. I think there will be very considerable improvements over the next few years in cancer in general. I think there will be further improvements in both mortality and survival rates. In some cases incidence is set to continue to rise because of the ageing of the population, but despite that incidence rising I am confident that we will see both falls in mortality and improvements in survival, and I would attribute that to several different things. I think we will see the prevalence of smoking going down, which will reduce the death rate from smoking-related cancers, particularly lung cancer. We will see the introduction of bowel cancer screening, which will reduce the mortality from bowel cancer. We will see further progress on waits, both for urgently-referred and for routinely-referred patients. We will see all patients being seen by specialist teams and therefore getting the best treatments. We will see the variations decrease in relation to the drugs approved by NICE, and we will see patient experience improved in terms of provision of information and communication and palliative care. I think we will see improvements across the board. I am confident that we will achieve the 20% reduction in the death rate for people under the age of 75 by 2010, as set out in our targets. I am confident also that over time we will catch up with Europe in terms of our survival rates.

Q159 Chairman: In this Committee, everything you say is noted down and may be used against you, so I hope that is right?

Professor Richards: I am confident in those statements.

Q160 Mr Steinberg: Professor, what is the percentage of mistakes made by doctors in terms of referring people as non-priority who turn out to be priority?

Professor Richards: It is very difficult to put a figure on that. I think one has to remember how difficult it is for a GP who sees probably only seven or eight new patients with cancer in a year but will see hundreds of patients who have symptoms which just possibly could be cancer. That is why we issued guidelines on referral, and those guidelines are being

⁹ Ev 24

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revised by NICE at the moment, and it is why we are working with GPs to improve decision support so that they can make the best decisions with patients about who needs to be referred urgently to hospital.

Mr Steinberg: I have always had the feeling, since I came onto this Committee, that doctors are very arrogant.

Chairman: Unlike Members of Parliament.

Q161 Mr Steinberg: Unlike Members of Parliament. I think I read in a Report somewhere that, the information, the guidelines which had been given out, 50% said it was useless anyway. That is the attitude I would expect from a lot of doctors, that they always know better. Should there be a sort of national guideline, standardisation?

Professor Richards: First and foremost, I would like to defend my clinical colleagues against that charge.

Q162 Mr Steinberg: I can give you lots of examples after the meeting.

Professor Richards: I am not saying there are no examples of it at all. I think that the culture amongst doctors has changed enormously during my working time, where we have moved very substantially from a period of paternalism to one of a great deal more of working in partnership with patients to do what is best for patients and what they want. We may not have gone as far as we need to on that, but certainly over the 25 years that I have been a doctor I have seen very, very substantial changes in that regard. I am not saying we have not got further to go, and certainly we are keen to work with doctors to help them to know when to refer patients urgently.

Q163 Chairman: You have closed your book, Sir Nigel. It is always a dangerous thing to do, because I have got one last one for you, following that marvellous speech from your colleague. When you come back in five years' time, do you expect to be able to tell us that our survival rates are comparable to the best in Europe?

Sir Nigel Crisp: I expect us to have closed the gap. Also it depends on where their survival rates are going. What is clear at the moment is that our survival rates are improving faster and we are starting to catch up. It is clear also, and maybe this gives me the opportunity to say just one thing to pick up on this, that the other thing I think we will see is patients with much more information. This is one of the underlying issues which I think has been around this Committee and also is part of the answer to Mr Steinberg. We do need people to understand the treatments which are available and the success rates, and I think that will be a force which probably you will be reporting on in five years' time, whether I am here or not.

Q164 Mr Steinberg: Can I defend what I said. I had a constituency case where a lady was referred to a consultant not as urgent, and she contacted me and I told her to go back to the doctor. When he wrote the letter he had forgotten to put "urgent" on it, so she went down the list and was not seen as an urgent case because he forgot to say it was a priority. Is that good enough?

Sir Nigel Crisp: No.

Professor Richards: No.

Chairman: Thank you very much, Sir Nigel and Professor Richards. It has been a very good hearing. I think colleagues have dug up some very interesting information. Thank you very much.

 Supplementary memorandum submitted by the Department of Health

Questions 18–19 (Mr Field): How many of those operated on for cancer are operated on in the centres where very large numbers of operations are done and how many are scattered across other hospitals?

For certain complex procedures carried out on cancer patients, there is evidence that the number of procedures undertaken by a trust is linked to outcome for cancer patients receiving that procedure. There is evidence that those hospitals where large numbers of complex procedures take place will have better outcomes for patients.

Please see **Annex A** which contains six spreadsheets.

Annexes A(i) and A(iv) show summary tables for two areas where there is evidence that volume of procedures undertaken is linked to outcome for patients: firstly, urology (prostatectomies & cystectomies), and secondly, upper gastrointestinal (all major oesophagogastric procedures).

Annexes A(ii) and A(iii) relate to A(i) and Annexes A(v) and A(vi) relate to A(iv) as follows:

- Annex A(i): This shows the frequency of number of major urology procedures per annum, per NHS trust.
- Annex A(ii): This shows the number of major urology procedures carried out by NHS trust in 2002–03.
- Annex A(iii): This shows the number of major urology procedures carried out by NHS trust, grouped by Strategic Health Authority, in 2002–03.
- Annex A(iv): This shows the frequency of number of major upper gastrointestinal procedures per annum, per NHS trust.
- Annex A(v): This shows the number of major upper gastrointestinal procedures carried out by NHS trust in 2002–03.

- Annex A(vi): This shows the number of major upper gastrointestinal procedures carried out by NHS trust, grouped by Strategic Health Authority, in 2002–03.

Question 29 (Jon Trickett): Can you provide a list of the 95 district health authorities with mortality rates?

The table below shows the cancer mortality rate for the 95 district health authorities from 1998–2001.

(DSR = Directly Standardised Rate per 100,000 (the higher the number, the higher the mortality)).

OBS = Number Observed—actual number of cancer deaths).

Cancer mortality by District Health Authority

DIRECTLY STANDARDISED RATES, 1998 TO 2001 ANNUALLY,
AGES LESS THAN 75 YEARS

		1998	1999	2000	2001
ENGLAND	DSR	136.17	131.81	129.01	126.42
	OBS	68745	66821	65711	64728
Bradford HA	DSR	155.20	140.84	138.74	134.12
	OBS	697	639	619	601
County Durham and Darlington HA	DSR	154.56	151.43	146.71	144.49
	OBS	1021	1002	977	956
East Riding and Hull HA	DSR	150.29	139.12	133.30	132.19
	OBS	929	855	827	825
Gateshead and South Tyneside HA	DSR	175.19	162.35	167.77	170.10
	OBS	707	650	665	664
Leeds HA	DSR	141.97	148.75	125.77	136.25
	OBS	1014	1066	894	963
Newcastle and North Tyneside HA	DSR	172.89	158.24	164.34	160.54
	OBS	846	760	789	774
North Cumbria HA	DSR	140.72	139.96	145.08	134.97
	OBS	510	510	538	510
Northumberland HA	DSR	151.61	138.91	125.16	134.94
	OBS	544	503	454	492
Sunderland HA	DSR	190.52	164.81	171.70	161.41
	OBS	580	501	525	494
Tees HA	DSR	165.63	160.44	159.01	153.15
	OBS	959	926	917	888
Wakefield HA	DSR	143.29	157.89	137.10	145.04
	OBS	477	520	456	484
North Yorkshire HA	DSR	118.08	119.97	120.06	109.54
	OBS	985	1017	1021	944
Calderdale and Kirklees HA	DSR	136.61	133.78	120.36	126.83
	OBS	785	776	697	738
Barnsley HA	DSR	177.41	140.21	146.74	141.29
	OBS	420	340	353	339
North Derbyshire HA	DSR	133.61	127.78	137.55	127.78
	OBS	558	541	578	544
Southern Derbyshire HA	DSR	129.07	125.28	128.27	124.21
	OBS	758	733	749	728
Doncaster HA	DSR	146.85	151.34	140.64	131.56
	OBS	468	473	447	414
Leicestershire HA	DSR	122.14	119.42	117.35	101.98
	OBS	1120	1107	1087	959
Lincolnshire HA	DSR	127.62	126.03	121.10	123.10
	OBS	965	951	937	974
North Nottinghamshire HA	DSR	144.40	135.56	129.90	132.30
	OBS	622	582	564	577
Nottingham HA	DSR	140.37	143.65	138.86	141.73
	OBS	890	910	877	882
Rotherham HA	DSR	147.55	137.26	135.59	135.39
	OBS	387	364	361	360
Sheffield HA	DSR	143.02	140.58	140.61	131.62
	OBS	760	738	743	695

		1998	1999	2000	2001
South Humber HA	DSR	152.09	140.36	142.11	136.66
	OBS	512	476	490	470
Birmingham HA	DSR	146.02	138.86	135.83	130.91
	OBS	1362	1268	1244	1184
Coventry HA	DSR	137.96	138.06	137.00	131.78
	OBS	412	410	399	379
Dudley HA	DSR	144.83	132.06	141.72	118.28
	OBS	497	454	490	405
Herefordshire HA	DSR	112.911	10.97	108.71	104.00
	OBS	226	225	226	217
Sandwell HA	DSR	160.15	146.40	152.00	154.84
	OBS	482	437	458	461
Shropshire HA	DSR	138.27	130.16	128.83	117.22
	OBS	639	611	615	569
Solihull HA	DSR	129.23	118.22	137.06	126.51
	OBS	291	269	305	288
North Staffordshire HA	DSR	148.51	145.52	143.42	134.91
	OBS	752	728	723	688
South Staffordshire HA	DSR	142.22	134.47	122.87	129.91
	OBS	884	847	789	834
Walsall HA	DSR	153.12	141.71	139.45	128.29
	OBS	429	400	395	359
Warwickshire HA	DSR	124.53	122.26	121.76	110.79
	OBS	672	670	674	621
Wolverhampton HA	DSR	148.20	150.04	136.38	129.50
	OBS	380	380	346	330
Worcestershire HA	DSR	118.05	107.73	118.42	117.22
	OBS	691	637	702	713
South Lancashire HA	DSR	118.97	137.06	140.62	131.63
	OBS	392	456	473	448
Liverpool HA	DSR	177.16	185.03	187.29	173.36
	OBS	797	833	838	775
Manchester HA	DSR	199.89	206.73	197.71	189.55
	OBS	692	691	661	621
Morecambe Bay HA	DSR	132.21	132.48	123.67	126.49
	OBS	453	463	433	452
St Helens and Knowsley HA	DSR	159.65	161.06	149.30	160.26
	OBS	563	572	528	567
Salford and Trafford HA	DSR	152.30	156.31	142.86	153.63
	OBS	689	700	641	681
Sefton HA	DSR	146.69	167.06	137.25	135.87
	OBS	490	557	458	459
Stockport HA	DSR	133.47	125.04	130.10	124.52
	OBS	417	396	408	387
West Pennine HA	DSR	158.24	147.85	159.20	148.34
	OBS	732	680	728	685
Bury and Rochdale HA	DSR	142.65	148.52	130.39	137.68
	OBS	548	572	508	535
North Cheshire HA	DSR	158.16	149.01	141.02	144.14
	OBS	491	461	440	454
South Cheshire HA	DSR	131.25	132.01	125.83	123.11
	OBS	981	983	950	936
East Lancashire HA	DSR	152.05	139.42	133.59	141.91
	OBS	777	710	681	731
North West Lancashire HA	DSR	143.22	147.19	137.89	142.20
	OBS	754	774	740	758
Wigan and Bolton HA	DSR	147.51	159.20	148.06	133.90
	OBS	853	916	850	780
Wirral HA	DSR	155.59	151.78	155.44	147.19
	OBS	555	537	548	528

		1998	1999	2000	2001
Bedfordshire HA	DSR	124.48	120.68	123.01	125.34
	OBS	649	641	657	682
North Essex HA	DSR	121.98	123.50	123.69	118.53
	OBS	1179	1209	1219	1185
South Essex HA	DSR	132.24	125.18	125.33	118.78
	OBS	971	938	942	891
Suffolk HA	DSR	121.45	110.80	113.91	111.70
	OBS	885	820	847	847
Cambridgeshire HA	DSR	126.46	112.82	114.38	116.63
	OBS	866	779	800	825
Norfolk HA	DSR	123.26	116.46	118.41	109.08
	OBS	1158	1116	1143	1072
Hertfordshire HA	DSR	127.06	120.71	117.29	117.99
	OBS	1304	1243	1228	1232
Hillingdon HA	DSR	149.311	29.08	131.53	125.16
	OBS	335	291	299	283
Kensington & Chelsea and Westminster HA	DSR	124.83	113.00	111.01	106.38
	OBS	367	335	330	317
Redbridge and Waltham Forest HA	DSR	130.98	131.88	126.00	137.46
	OBS	521	518	493	543
Croydon HA	DSR	134.07	121.40	124.23	122.29
	OBS	404	360	373	363
Kingston and Richmond HA	DSR	129.08	127.88	115.21	116.83
	OBS	371	360	326	329
Lambeth, Southwark and Lewisham HA	DSR	154.90	144.40	143.15	145.54
	OBS	870	809	801	797
Merton, Sutton and Wandsworth HA	DSR	147.27	133.35	126.88	126.39
	OBS	767	692	656	645
Barking and Havering HA	DSR	144.55	145.83	137.42	131.12
	OBS	590	592	556	528
Brent and Harrow HA	DSR	124.85	107.51	108.73	118.54
	OBS	515	444	457	503
Camden and Islington HA	DSR	153.49	158.81	140.67	144.59
	OBS	447	451	397	407
Ealing, Hammersmith and Hounslow HA	DSR	133.41	132.60	110.96	119.54
	OBS	732	725	609	648
East London and the City HA	DSR	164.26	149.53	136.79	152.20
	OBS	736	677	604	676
Barnet, Enfield and Haringey HA	DSR	125.03	118.27	126.90	113.88
	OBS	869	822	887	805
Bexley, Bromley and Greenwich HA	DSR	138.14	129.35	127.32	127.99
	OBS	995	935	916	922
Berkshire HA	DSR	124.94	115.14	115.46	114.05
	OBS	898	834	844	841
Buckinghamshire HA	DSR	125.33	120.85	117.37	118.60
	OBS	798	783	769	790
East Kent HA	DSR	138.17	125.30	135.07	127.51
	OBS	920	827	900	853
West Kent HA	DSR	127.58	130.75	131.66	130.42
	OBS	1263	1311	1333	1331
East Surrey HA	DSR	126.38	116.68	106.50	116.91
	OBS	564	521	484	529
West Surrey HA	DSR	113.51	117.44	112.74	110.68
	OBS	743	777	743	737
East Sussex, Brighton and Hove HA	DSR	125.09	124.66	120.89	120.84
	OBS	1033	1046	1008	1015
West Sussex HA	DSR	120.97	122.79	120.26	111.57
	OBS	1027	1056	1034	971
Northamptonshire HA	DSR	135.12	132.96	126.61	114.84
	OBS	807	810	780	717
Oxfordshire HA	DSR	131.74	122.68	119.40	117.53
	OBS	758	708	705	695

		1998	1999	2000	2001
North and Mid Hampshire HA	DSR	122.60	112.16	119.14	112.04
	OBS	646	604	645	612
Southampton and South West Hampshire HA	DSR	128.59	122.28	125.34	112.19
	OBS	735	705	723	651
Isle of Wight, Portsmouth and South East Hampshire HA	DSR	133.85	124.34	118.08	125.99
	OBS	972	897	877	942
Somerset HA	DSR	121.23	112.29	114.66	105.65
	OBS	685	647	657	632
South and West Devon HA	DSR	132.75	129.91	124.58	118.40
	OBS	888	883	847	804
Wiltshire HA	DSR	118.08	119.09	110.89	114.64
	OBS	724	741	701	721
Avon HA	DSR	122.94	118.69	122.06	116.48
	OBS	1231	1201	1229	1177
Cornwall and Isles of Scilly HA	DSR	122.52	118.08	118.20	109.81
	OBS	736	719	733	695
Dorset HA	DSR	117.65	112.20	110.10	112.36
	OBS	981	945	942	960
North and East Devon HA	DSR	119.29	116.83	116.01	119.85
	OBS	688	679	688	719
Gloucestershire HA	DSR	114.59	129.45	115.57	114.40
	OBS	702	793	712	716

Questions 100–102 (Mr Bacon): With regard to Figure 39, can you say how much money is spent in total on Herceptin; the percentage of eligible women receiving it; and, the number of nurses, the number of pharmacists and the number of chemotherapy suites?

The money spent in each cancer network on Herceptin is not an accurate reflection of usage. For example, some trusts may be able to negotiate sizeable discounts for certain drugs. It is more meaningful to compare networks in terms of volume of Herceptin sold. Data showing volume sold per network are, therefore, shown in **Annex B**. The data are expressed as volume in mg sales of Herceptin, for Quarter 1 2000–01—Quarter 2 2003–04 and has been provided by Roche.

The Department does not identify nor calculate the percentage of eligible women receiving Herceptin. However, at **Annex C** we attach estimates provided by Roche, which are calculated using their own algorithm. The Department can not validate these data but have included them here, as they translate to Figure 39 in the National Audit Office's Report.

Although information on the overall figures of nurses is available centrally, the cancer nurse specialist is not a regulated role. Around 2002 the Cancer Workforce Care Group Team commissioned the collection of data on the number of these nurses. However, due to a lack of uniformity of roles across the country, (trusts interpret the role "cancer nurse specialist" differently) the collection was unsuccessful.

The number of hospital pharmacists is known, but the numbers of oncology pharmacists is not available centrally.

The number of chemotherapy suites is not available centrally.

Question 144 (Mr Jenkins): Why is South Yorkshire, which has never struck me as a particularly healthy part of the world, so low (Figure 19)?—an explanatory note

The National Audit Office made enquiries about the validity of the South Yorkshire data on prostate cancer incidence during the preparation of the report and was given assurance that the data were accurate. Subsequent to the publication of the report, Trent Cancer Registry, which covers the South Yorkshire Strategic Health Authority (and Trent SHA, and Leicester, Northants and Rutland SHA) reported that for most, if not all, of the period covered by the data there would have been some patients diagnosed with prostate cancer as out-patients. These cases would not have been picked up by the registry as their principal source of information was from the in-patients systems, and at the time they were not receiving data from pathology laboratories. Pathology data started becoming available only in 1999, with full data in 2000. In addition, there were staff problems in the coding department in one of the major hospitals in South Yorkshire in 1998, which could also explain why its rate was noticeably low.

Questions 155–157 (Mr Bacon): How much is a course of Herceptin per month?

Some patients receive Herceptin for a few weeks and others have it for years, therefore, overall costs vary considerably. However, an example for demonstrative purposes only, follows:

- For a typical patient, Herceptin monotherapy would cost approximately £5,900 for a 12 week course of treatment:
 - £5,300 for Herceptin, £21 for the HER2 test and £580 for a set of four cardiac tests.
- For a typical patient, combination treatment (Herceptin and Paclitaxel) would cost approximately £23,400–£24,200 for a 37 week course of treatment:
 - £15,900 for Herceptin, £6,900–£7,700 for Paclitaxel, £21 for a HER2 test and £580 for a set of cardiac tests.

It should be noted that these costs do not include some other costs associated with Herceptin treatment, largely revolving around the administration costs (weekly drip lasting 30–45 minutes, nursing time to administer, doctor time for regular monitoring etc). These costings are not available centrally.

30 July 2004

Annex A(i)

MAJOR UROLOGY PROCEDURES: HES DATA EXTRACTS 3 AND 5

PROSTATECTOMIES AND CYSTECTOMIES (TOTAL AND PARTIAL): ENGLAND (1995–2003)

<i>Number of procedures [Range (eg 15–19 procedures)]</i>		<i>Frequency of number of procedures per annum per Trust Number of Trusts</i>							
		<i>Min</i>	<i>Max</i>	<i>1995–96</i>	<i>1996–97</i>	<i>1997–98</i>	<i>1998–99</i>	<i>1999–00</i>	<i>2000–01</i>
0	4	20	19	15	20	14	18	17	22
5	9	24	22	21	16	22	21	17	9
10	14	32	29	28	24	16	25	18	15
15	19	25	29	26	19	20	13	15	16
20	24	22	14	14	16	16	12	15	10
25	29	19	12	17	17	11	13	13	7
30	34	3	13	5	9	11	10	6	13
35	39	5	10	12	8	14	12	6	11
40	44	8	4	2	16	9	10	5	9
45	49	3	4	4	5	5	3	10	8
50	54	1	3	6	2	3	5	7	8
55	59	1	0	4	2	4	7	6	6
60	64	3	2	0	4	2	1	4	2
65	69	0	2	0	1	1	4	6	1
70	74	0	0	1	1	2	1	1	6
75	79	0	0	1	0	1	1	3	4
80	84	0	0	0	0	1	1	0	3
85	89	0	0	0	0	0	1	1	2
90	94	0	0	0	0	0	0	2	2
95	99	0	0	0	0	0	0	1	1
100	104	0	0	0	0	0	1	1	1
105	109	0	0	0	0	0	0	0	0
110	114	0	0	0	0	0	0	0	1
115	119	0	0	0	0	0	0	0	0
120	124	0	0	0	0	0	0	0	0
125	129	0	0	0	0	0	0	0	0
130	134	0	0	0	0	0	0	0	0
135	139	0	0	0	0	0	0	0	0
140	144	0	0	0	0	0	0	0	0
145	149	0	0	0	0	0	0	0	0
150	154	0	0	0	0	0	0	0	0
Trusts		166	163	156	160	152	159	154	156
> 50 procedures pa		5	7	12	10	14	22	32	36

Annex A(ii)

NUMBER OF MAJOR UROLOGY PROCEDURES CARRIED OUT BY NHS TRUST:
HES DATA EXTRACT 5

CYSTECTOMIES (TOTAL & PARTIAL) AND PROSTATECTOMIES BY TRUST (2002–03)

<i>Number of procedures</i>	<i>Main procedure</i>			Grand total
	<i>Trust</i>	<i>Partial excision</i>	<i>Total excision</i>	
North Bristol NHS Trust	1	31	70	102
The Newcastle Upon Tyne Hospitals NHS Trust	7	51	38	96
Hammersmith Hospitals NHS Trust	4	20	68	92
South Tees Hospitals NHS Trust	5	16	69	90
Oxford Radcliffe Hospital NHS Trust	3	24	61	88
Birmingham Heartlands & Solihull NHS Trust	3	16	68	87
Royal Bournemouth & Christchurch Hospitals		26	57	83
United Lincolnshire Hospitals NHS Trust	4	31	46	81
Ashford & St Peter's Hospitals NHS Trust	1	17	62	80
University Hospital Birmingham NHS Trust	7	15	57	79
West Hertfordshire Hospitals NHS Trust	5	17	56	78
North Staffordshire Hospital NHS Trust	3	26	47	76
Norfolk & Norwich University Hospital NHS Trust	6	20	50	76
Portsmouth Hospitals NHS Trust	3	29	40	72
Maidstone & Tunbridge Wells NHS Trust		19	53	72
Sheffield Teaching Hospitals NHS Trust	13	24	34	71
Mid Yorkshire Hospitals NHS Trust	7	32	31	70
Leeds Teaching Hospitals NHS Trust	11	22	37	70
Lancashire Teaching Hospitals NHS Trust	2	14	54	70
Medway NHS Trust	1	17	49	67
East Sussex Hospitals NHS Trust	3	25	36	64
Southampton University Hospitals NHS Trust	4	32	27	63
Stockport NHS Trust	2	17	40	59
Shrewsbury and Telford Hospitals NHS Trust		19	40	59
Southern Derbyshire Acute Hospitals NHS Trust	1	20	36	57
Mayday Healthcare NHS Trust	4	13	40	57
Heatherwood & Wexham Park Hospitals NHS Trust	1	19	35	55
Gloucestershire Hospitals NHS Trust	2	21	32	55
Guy's & St Thomas' NHS Trust	1	18	35	54
East Kent Hospitals NHS Trust	4	12	37	53
East & North Hertfordshire NHS Trust	2	11	40	53
Nottingham City Hospital NHS Trust		26	26	52
The Mid Cheshire Hospitals NHS Trust		15	36	51
St George's Healthcare NHS Trust	3	13	34	50
Epsom & St Helier NHS Trust	2	17	31	50
East Lancashire Hospitals NHS Trust	2	14	34	50
Barking, Havering & Redbridge Hospitals NHS Trust	4	5	40	49
Pennine Acute Hospitals NHS Trust	6	15	27	48
Buckinghamshire Hospitals NHS TRUST	2	14	31	47
Sandwell & West Birmingham Hospitals NHS Trust	2	13	31	46
Salisbury Health Care NHS Trust	6	10	30	46
Royal Free Hampstead NHS Trust	3	3	40	46
West Dorset General Hospitals NHS Trust	1	6	38	45
Addenbrooke's NHS Trust	3	26	16	45
University Hospitals Coventry & Warwickshire	2	6	36	44
Royal United Hospital Bath NHS Trust	4	9	31	44
Brighton & Sussex University Hospitals NHS Trust	13	15	15	43
University College London Hospitals NHS Trust	1	15	26	42
University Hospitals of Leicester NHS Trust	5	26	10	41
York Health Services NHS Trust	1	12	27	40
Christie Hospital NHS Trust		22	18	40
Plymouth Hospitals NHS Trust	5	13	22	40
Kings Lynn & Wisbech Hospitals NHS Trust	4	13	23	40
United Bristol Healthcare NHS Trust	4	12	23	39
Worthing & Southlands Hospitals NHS Trust	3	16	19	38
Doncaster & Bassetlaw Hospitals NHS Trust	4	16	18	38
King's College Hospital NHS Trust	2	3	33	38

<i>Trust</i>	<i>Main procedure</i>		<i>Open excision</i>	Grand total
	<i>Partial excision</i>	<i>Total excision</i>		
Hull & East Yorkshire Hospitals NHS Trust	5	15	17	37
St Mary's NHS Trust	2	10	24	36
Chelsea & Westminster Healthcare NHS Trust	1	9	26	36
Basildon & Thurrock General Hospitals NHS Trust	2	8	26	36
City Hospitals Sunderland NHS Trust	2	18	15	35
Frimley Park Hospital NHS Trust	5	8	22	35
Countess of Chester Hospital NHS Trust	5	6	24	35
Ipswich Hospital NHS Trust	4	11	19	34
Bolton Hospitals NHS Trust	2	14	17	33
Mid Essex Hospital Services NHS Trust	5	13	15	33
James Paget Healthcare NHS Trust	1	15	16	32
Barnet & Chase Farm Hospitals NHS Trust	2	12	18	32
Royal Berkshire & Battle Hospitals NHS Trust	4	11	16	31
North Hampshire Hospitals NHS Trust	2	6	23	31
Whipps Cross University Hospital NHS Trust	3	6	21	30
The Royal West Sussex NHS Trust	3	5	22	30
The Royal Marsden Hospital NHS Trust	5	14	11	30
Bradford Hospitals NHS Trust		6	24	30
Airedale NHS Trust		7	23	30
Northampton General Hospital NHS Trust	2	12	16	30
Winchester & Eastleigh Healthcare NHS Trust		9	20	29
Royal Devon & Exeter Healthcare NHS Trust	4	9	16	29
Dartford & Gravesham NHS Trust	3	15	10	28
West Suffolk Hospitals NHS Trust	1	14	12	27
Chesterfield & North Derbyshire Royal Hospital		14	13	27
The Princess Alexandra Hospital NHS Trust	1	6	18	25
Royal Liverpool & Broadgreen Hospitals		6	19	25
Rotherham General Hospitals NHS Trust	2	7	15	24
The Royal Wolverhampton Hospitals NHS Trust	1	4	18	23
Northern Lincolnshire & Goole Hospitals NHS Trust	4	3	16	23
George Eliot Hospital NHS Trust	1	8	14	23
Morecambe Bay Hospitals NHS Trust	1	13	9	23
Calderdale & Huddersfield NHS Trust	5	6	11	22
Worcestershire Acute Hospitals NHS Trust	1	9	10	20
The Hillingdon Hospital NHS Trust		3	17	20
Luton & Dunstable Hospital NHS Trust	1	8	11	20
Essex Rivers Healthcare NHS Trust	4	6	10	20
Weston Area Health NHS Trust	1		18	19
Peterborough Hospitals NHS Trust	2	11	6	19
South Manchester University Hospitals NHS Trust		1	18	19
Wirral Hospital NHS Trust	6	6	6	18
Northern Devon Healthcare NHS Trust	2	5	11	18
Bromley Hospitals NHS Trust	2	12	4	18
North West London Hospitals NHS Trust	2	5	10	17
South Devon Health Care NHS Trust	5	8	4	17
Blackpool, Fylde & Wyre Hospitals NHS Trust		7	10	17
Wrightington, Wigan & Leigh NHS Trust		7	9	16
Whittington Hospital NHS Trust	3	7	6	16
Good Hope Hospital NHS Trust		5	11	16
Surrey & Sussex Healthcare NHS Trust	1	6	9	16
Southport & Ormskirk Hospital NHS Trust		4	12	16
Walsall Hospitals NHS Trust	3	9	3	15
County Durham & Darlington Acute Hospitals	2	12	1	15
North Middlesex University Hospital NHS Trust		2	11	13
Taunton & Somerset NHS Trust	3	8	2	13
Dudley Group of Hospitals NHS Trust	4	9		13
South Warwickshire General Hospitals NHS Trust	3	6	4	13
Queen Elizabeth Hospital NHS Trust	3	5	4	12
North Tees & Hartlepool NHS Trust	2	8	2	12
Southend Hospital NHS Trust	1	5	6	12
St Helens & Knowsley Hospitals NHS Trust	3	8	1	12
Central Manchester & Manchester Children's Hospitals	6	4	1	11
Salford Royal Hospitals NHS Trust	2	7	2	11

<i>Trust</i>	<i>Main procedure</i>		<i>Open excision</i>	Grand total
	<i>Partial excision</i>	<i>Total excision</i>		
North Cheshire Hospitals NHS Trust	3	8		11
Northumbria Health Care NHS Trust	10	1		11
Bedford Hospitals NHS Trust	3	3	4	10
Barts & The London NHS Trust	4	1	5	10
Royal Cornwall Hospitals NHS Trust	2	6	2	10
Kettering General Hospital NHS Trust	1	5	3	9
Kingston Hospital NHS Trust		6	3	9
Swindon & Marlborough NHS Trust	1	8		9
Harrogate Health Care NHS Trust	2	6		8
Sherwood Forest Hospitals NHS Trust	1	5	1	7
South Tyneside Health Care NHS Trust	1	5		6
Aintree Hospitals NHS Trust	2	4		6
Royal Surrey County Hospital NHS Trust	2	2	1	5
East Somerset NHS Trust	2		3	5
Tameside & Glossop Acute Services NHS Trust	3	1		4
Hereford Hospitals NHS Trust		4		4
East Cheshire NHS Trust	1	3		4
Burton Hospitals NHS Trust		3		3
West Middlesex University NHS Trust	2		1	3
The Royal National Orthopaedic Hospital NHS Trust	1	1	1	3
Milton Keynes General Hospital NHS Trust	3			3
Queen's Medical Centre, Nottingham Univ Hospital	3			3
Hinchingbrooke Health Care NHS Trust		2		2
Gateshead Health NHS Trust	2			2
Queen Mary's Sidcup NHS Trust	2			2
Mid Staffordshire General Hospitals NHS Trust	2			2
The Lewisham Hospital NHS Trust	1	1		2
North Cumbria Acute Hospitals NHS Trust		1	1	2
Barnsley District General Hospital NHS Trust		1	1	2
Scarborough & North East Yorkshire Health Care	1		1	2
Trafford Healthcare NHS Trust	1			1
Ealing Hospital NHS Trust			1	1
Royal Liverpool Childrens NHS Trust	1			1
Birmingham Children's Hospital NHS Trust		1		1
Liverpool Womens Hospital NHS Trust	1			1
Isle of Wight Healthcare NHS Trust	1			1
Grand total	391	1,620	2,993	5,004

Annex A(iii)

Number of major Urology procedures carried out by NHS trust by SHA						
HES Data Extract 5						
Cystectomies (Total & Partial) & Prostatectomies by SHA & Trust (2002-2003)						
SHA of Trust	Trust	Main Procedure				Grand Total
		Partial	Excis	Total	Excis	
Avon, Gloucestershire & Wiltshire HA	North Bristol NHS Trust	1	31	70	102	
	Gloucestershire Hospitals NHS Trust	2	21	32	55	
	Salisbury Health Care NHS Trust	6	10	30	46	
	Royal United Hospital Bath NHS Trust	4	9	31	44	
	United Bristol Healthcare NHS Trust	4	12	23	39	
	Weston Area Health NHS Trust	1		18	19	
	Swindon & Marlborough NHS Trust	1	8		9	
Avon, Gloucestershire & Wiltshire HA Total		19	91	204	314	
Bedfordshire & Hertfordshire HA	West Hertfordshire Hospitals NHS Trust	5	17	56	78	
	East & North Hertfordshire NHS Trust	2	11	40	53	
	Luton & Dunstable Hospital NHS Trust	1	8	11	20	
	Bedford Hospitals NHS Trust	3	3	4	10	
Bedfordshire & Hertfordshire HA Total		11	39	111	161	
Birmingham & The Black Country HA	Birmingham Heartlands & Solihull NHS Trust	3	16	68	87	
	University Hospital Birmingham NHS Trust	7	15	57	79	
	Sandwell & West Birmingham Hospitals NHS Trust	2	13	31	46	
	The Royal Wolverhampton Hospitals NHS Trust	1	4	18	23	
	Good Hope Hospital NHS Trust	1	5	11	16	
	Walsall Hospitals NHS Trust	3	9	3	15	
	Dudley Group Of Hospitals NHS Trust	4	9		13	
Birmingham Children's Hospital NHS Trust		1		1		
Birmingham & The Black Country HA Total		20	72	188	280	
Cheshire & Merseyside HA	The Mid Cheshire Hospitals NHS Trust	5	15	36	51	
	Countryside Of Chester Hospital NHS Trust		6	24	35	
	Royal Liverpool & Broadgreen Hospitals	6	6	19	25	
	Wirral Hospital NHS Trust	6	6	6	18	
	Southport & Ormskirk Hospital NHS Trust	3	4	12	16	
	St Helens & Knowsley Hospitals NHS Trust	3	8	1	12	
	North Cheshire Hospitals NHS Trust	3	8		11	
	Aintree Hospitals NHS Trust	2	4		6	
	East Cheshire NHS Trust	1	3		4	
	Liverpool Womens Hospital NHS Trust	1			1	
Royal Liverpool Childrens NHS Trust	1			1		
Cheshire & Merseyside HA Total		22	60	98	180	
County Durham & Tees Valley HA	South Tees Hospitals NHS Trust	5	16	69	90	
	County Durham & Darlington Acute Hospitals	2	12	1	15	
	North Tees & Hartlepool NHS Trust	2	8	2	12	
County Durham & Tees Valley HA Total		9	36	72	117	
Cumbria & Lancashire HA	Lancashire Teaching Hospitals NHS Trust	2	14	54	70	
	East Lancashire Hospitals NHS Trust	2	14	34	50	
	Morecambe Bay Hospitals NHS Trust	1	13	9	23	
	Blackpool, Fylde & Wyre Hospitals NHS Trust	1	7	10	17	
	North Cumbria Acute Hospitals NHS Trust		1		1	
Cumbria & Lancashire HA Total		5	49	108	162	
Dorset & Somerset HA	Royal Bournemouth & Christchurch Hospitals		26	57	83	
	West Dorset General Hospitals NHS Trust	1	6	38	45	
	Taunton & Somerset NHS Trust	3	8	2	13	
	East Somerset NHS Trust	2		3	5	
Dorset & Somerset HA Total		6	40	100	146	
Essex HA	Basildon & Thurrock General Hospitals NHS Trust	2	8	26	36	
	Mid Essex Hospital Services NHS Trust	5	13	15	33	
	The Princess Alexandra Hospital NHS Trust	1	6	18	25	
	Essex Rivers Healthcare NHS Trust	4	6	10	20	
	Southend Hospital NHS Trust	1	5	6	12	
Essex HA Total		13	38	75	126	
Greater Manchester HA	Stockport NHS Trust	2	17	40	59	
	Pennine Acute Hospitals NHS Trust	6	15	27	48	
	Christie Hospital NHS Trust		22	18	40	
	Bolton Hospitals NHS Trust	2	14	17	33	
	South Manchester University Hospitals NHS Trust		1	18	19	
	Wrightington, Wigan & Leigh NHS Trust	2	7	9	16	
	Salford Royal Hospitals NHS Trust	2	7	2	11	
	Central Manchester & Manchester Children's Hospitals	6	4	1	11	
	Tameside & Glossop Acute Services NHS Trust	3	1		4	
	Trafford Healthcare NHS Trust		1		1	
Greater Manchester HA Total		22	88	132	242	
Hampshire & Isle Of Wight HA	Portsmouth Hospitals NHS Trust	3	29	40	72	
	Southampton University Hospitals NHS Trust	4	32	27	63	
	North Hampshire Hospitals NHS Trust	2	6	23	31	
	Winchester & Eastleigh Healthcare NHS Trust		9	20	29	
	Isle Of Wight Healthcare NHS Trust	1			1	
Hampshire & Isle Of Wight HA Total		10	76	110	196	
Kent & Medway HA	Mainstone & Tunbridge Wells NHS Trust		19	53	72	
	Medway NHS Trust	1	17	49	67	
	East Kent Hospitals NHS Trust	4	12	37	53	
	Dartford & Gravesham NHS Trust	3	15	10	28	
Kent & Medway HA Total		8	63	149	220	
Leicestershire, Northamptonshire & Rutland HA	University Hospitals Of Leicester NHS Trust	5	26	10	41	
	Northampton General Hospital NHS Trust	2	12	16	30	
	Kettering General Hospital NHS Trust	1	5	3	9	
Leicestershire, Northamptonshire & Rutland HA Total		8	43	29	80	
Norfolk, Suffolk & Cambridgeshire HA	Norfolk & Norwich University Hospital NHS Trust	6	20	50	76	
	Addenbrooke's NHS Trust	3	26	16	45	
	Kings Lynn & Wisbech Hospitals NHS Trust	4	13	23	40	
	Ipswich Hospital NHS Trust	4	11	19	34	
	James Paget Healthcare NHS Trust	1	15	16	32	
	West Suffolk Hospitals NHS Trust	1	14	12	27	
	Peterborough Hospitals NHS Trust	2	11	6	19	
	Hinchingbrooke Health Care NHS Trust		2		2	
Norfolk, Suffolk & Cambridgeshire HA Total		21	112	142	275	
North & East Yorkshire and Northern Lincolnshire HA	York Health Services NHS Trust	1	12	27	40	
	Hull & East Yorkshire Hospitals NHS Trust	5	15	17	37	
	Northern Lincolnshire & Goole Hospitals NHS Trust	4	3	16	23	
	Harrrogate Health Care NHS Trust	2	6		8	
	Scarborough & North East Yorkshire Health Care	1		1	2	
North & East Yorkshire and Northern Lincolnshire HA Total		13	36	61	110	
North Central London HA	Royal Free Hampstead NHS Trust	3	3	40	46	
	University College London Hospitals NHS Trust	1	15	26	42	
	Barnet & Chase Farm Hospitals NHS Trust	2	12	18	32	
	Whittington Hospital NHS Trust	3	7	6	16	
	North Middlesex University Hospital NHS Trust	2	2	11	13	
	The Royal National Orthopaedic Hospital NHS Trust	1	1		2	
North Central London HA Total		10	40	102	153	
North East London HA	Barking, Havering & Redbridge Hospitals NHS Trust	4	5	40	49	
	Whipps Cross University Hospital NHS Trust	3	6	21	30	
	Barts & The London NHS Trust	4	1	5	10	
North East London HA Total		11	12	66	89	

Annex A(iii)—continued

North West London HA	Hammersmith Hospitals NHS Trust	4	20	68	92
	St Mary's NHS Trust	2	10	24	36
	Chelsea & Westminster Healthcare NHS Trust	1	9	26	36
	The Hillingdon Hospital NHS Trust		3	17	20
	North West London Hospitals NHS Trust	2	5	10	17
	West Middlesex University NHS Trust	2		1	3
	Ealing Hospital NHS Trust			1	4
North West London HA Total		11	47	147	205
Northumberland, Tyne & Wear HA	The Newcastle Upon Tyne Hospitals NHS Trust	7	51	38	96
	City Hospitals Sunderland NHS Trust	2	18	15	35
	Northumbria Health Care NHS Trust	10	1		11
	South Tyneside Health Care NHS Trust	1	5		6
	Gateshead Health NHS Trust	2			2
Northumberland, Tyne & Wear HA Total		22	75	53	150
Shropshire & Staffordshire HA	North Staffordshire Hospital NHS Trust	3	26	47	76
	Shrewsbury and Telford Hospitals NHS Trust		19	40	59
	Burton Hospitals NHS Trust		3		3
	Mid Staffordshire General Hospitals NHS Trust	2			2
Shropshire & Staffordshire HA Total		5	48	87	140
South East London HA	Guy's & St Thomas' NHS Trust	1	18	35	54
	King's College Hospital NHS Trust	2	3	33	38
	Bromley Hospitals NHS Trust	2	12	4	18
	Queen Elizabeth Hospital NHS Trust	3	5	4	12
	The Lewisham Hospital NHS Trust	1	1		2
	Queen Mary's Sidcup NHS Trust	2			2
South East London HA Total		11	39	76	126
South West London HA	Mayday Healthcare NHS Trust	4	13	40	57
	St George's Healthcare NHS Trust	3	13	34	50
	Epsom & St Helier NHS Trust	2	17	31	50
	The Royal Marsden Hospital NHS Trust	5	14	11	30
	Kingston Hospital NHS Trust		6	3	9
South West London HA Total		14	63	119	196
South West Peninsula HA	Plymouth Hospitals NHS Trust	5	13	22	40
	Royal Devon & Exeter Healthcare NHS Trust	4	9	16	29
	Northern Devon Healthcare NHS Trust	2	5	11	18
	South Devon Health Care NHS Trust	5	8	4	17
	Royal Cornwall Hospitals NHS Trust	2	6	2	10
South West Peninsula HA Total		18	41	55	114
South Yorkshire HA	Sheffield Teaching Hospitals NHS Trust	13	24	34	71
	Doncaster & Bassetlaw Hospitals NHS Trust	4	16	18	38
	Rotherham General Hospitals NHS Trust	2	7	15	24
	Barnsley District General Hospital NHS Trust		1	1	2
South Yorkshire HA Total		19	48	68	135
Surrey & Sussex HA	Ashford & St Peter's Hospitals NHS Trust	1	17	62	80
	East Sussex Hospitals NHS Trust	3	25	36	64
	Brighton & Sussex University Hospitals NHS Trust	13	15	15	43
	Worthing & Southlands Hospitals NHS Trust	3	16	19	38
	Frimley Park Hospital NHS Trust	5	8	22	35
	The Royal West Sussex NHS Trust	3	5	22	30
	Surrey & Sussex Healthcare NHS Trust	1	6	9	16
	Royal Surrey County Hospital NHS Trust	2	2	1	5
Surrey & Sussex HA Total		31	94	186	311
Thames Valley HA	Oxford Radcliffe Hospital NHS Trust	3	24	61	88
	Heatherwood & Wexham Park Hospitals NHS Trust	1	19	35	55
	Buckinghamshire Hospitals NHS TRUST	2	14	31	47
	Royal Berkshire & Battle Hospitals NHS Trust	4	11	16	31
	Milton Keynes General Hospital NHS Trust	3			3
Thames Valley HA Total		13	68	143	224
Trent HA	United Lincolnshire Hospitals NHS Trust	4	31	46	81
	Southern Derbyshire Acute Hospitals NHS Trust	1	20	36	57
	Nottingham City Hospital NHS Trust		26	26	52
	Chesterfield & North Derbyshire Royal Hospital		14	13	27
	Sherwood Forest Hospitals NHS Trust	1	5	1	7
	Queen's Medical Centre, Nottingham Univ Hospital	3			3
Trent HA Total		9	96	122	227
West Midlands South Strategic HA	University Hospitals Coventry & Warwickshire	2	6	36	44
	George Eliot Hospital NHS Trust	1	8	14	23
	Worcestershire Acute Hospitals NHS Trust	1	9	10	20
	South Warwickshire General Hospitals NHS Trust	3	6	4	13
	Hereford Hospitals NHS Trust		4		4
West Midlands South Strategic HA Total		7	33	64	104
West Yorkshire HA	Mid Yorkshire Hospitals NHS Trust	7	32	31	70
	Leeds Teaching Hospitals NHS Trust	11	22	37	70
	Airedale NHS Trust		7	23	30
	Bradford Hospitals NHS Trust		6	24	30
	Calderdale & Huddersfield NHS Trust	5	6	11	22
West Yorkshire HA Total		23	73	126	222
Grand Total		391	1,620	2,993	5,004

Annex A(iv)

MAJOR UPPER GASTROINTESTINAL PROCEDURES: HES DATA EXTRACTS 3 AND 5

OESOPHAGECTOMIES; OESOPHAGO-GASTRECTOMIES AND GASTRECTOMIES:
ENGLAND (1995–2003)

<i>Number of procedures [Range (eg 15–19 procedures)]</i>		<i>Frequency of number of procedures per annum per Trust Number of Trusts</i>							
		<i>1995–96</i>	<i>1996–97</i>	<i>1997–98</i>	<i>1998–99</i>	<i>1999–00</i>	<i>2000–01</i>	<i>2001–02</i>	<i>2002–03</i>
<i>Min</i>	<i>Max</i>								
0	4	5	9	9	9	9	11	11	16
5	9	6	11	8	11	8	23	15	20
10	14	18	13	16	15	24	23	32	24
15	19	30	26	28	21	19	20	24	22
20	24	19	21	19	24	25	20	15	17
25	29	14	18	18	18	21	14	14	8
30	34	20	15	15	14	9	13	12	14
35	39	6	12	8	7	9	5	6	9
40	44	10	5	7	11	8	10	7	5
45	49	8	6	7	7	5	5	3	7
50	54	4	5	4	6	4	3	4	3
55	59	5	6	4	6	5	3	7	2
60	64	2	4	3	2	4	4	0	3
65	69	2	1	5	1	2	0	1	1
70	74	1	3	0	3	1	1	0	1
75	79	5	0	0	1	2	1	0	3
80	84	1	2	0	0	1	0	4	0
85	89	2	1	1	1	2	2	0	3
90	94	1	3	4	0	1	3	0	0
95	99	0	1	1	1	0	0	2	0
100	104	3	1	2	1	0	0	1	1
105	109	1	0	0	0	1	0	0	0
110	114	0	1	1	0	0	0	0	1
115	119	0	0	0	1	0	0	0	0
120	124	1	0	0	2	0	2	1	0
125	129	0	0	0	0	0	0	0	0
130	134	0	1	0	0	1	0	1	0
135	139	0	0	1	0	0	0	0	0
140	144	0	0	0	0	0	0	0	0
145	149	0	0	0	0	0	0	0	0
150	154	0	0	0	0	0	0	0	0
Trusts		164	165	161	162	161	163	160	160
> 50 procedures pa		28	29	26	25	24	19	21	18

Annex A(v)

MAJOR UPPER GASTROINTESTINAL PROCEDURES CARRIED OUT IN NHS TRUSTS:
HES DATA EXTRACT 5OESOPHAGECTOMIES; OESOPHAGO-GASTRECTOMIES & GASTRECTOMIES BY TRUST
(2002–03)

<i>Trust</i>	<i>Number of procedures</i>		<i>Main procedure</i>			Grand total
	<i>Partial excision of oesophagus</i>	<i>Total excision of oesophagus</i>	<i>Excision of oesophagus and stomach</i>	<i>Partial excision of stomach</i>	<i>Total excision of stomach</i>	
The Newcastle Upon Tyne Hospitals NHS Trust	51		3	36	22	112
Nottingham City Hospital NHS Trust	30	2	42	23	5	102
Leeds Teaching Hospitals NHS Trust	2	3	27	35	22	89
Sheffield Teaching Hospitals NHS Trust	4	1	38	25	20	88
University Hospitals of Leicester NHS Trust	9	9	22	27	19	86
Norfolk & Norwich University Hospital NHS Trust	7	16	30	20	5	78
Birmingham Heartlands & Solihull NHS Trust	27	4	17	23	7	78
Oxford Radcliffe Hospital NHS Trust	12	17	26	16	5	76
Guy's & St Thomas' NHS Trust	35	7	13	12	3	70
Hull & East Yorkshire Hospitals NHS Trust	8	1	29	13	14	65
Pennine Acute Hospitals NHS Trust			17	30	16	63
Plymouth Hospitals NHS Trust		1	42	13	6	62
United Bristol Healthcare NHS Trust	3	20	12	15	10	60
University Hospitals Coventry & Warwickshire	29		2	19	5	55
South Tees Hospitals NHS Trust	10	1	14	19	11	55
Lancashire Teaching Hospitals NHS Trust			30	11	13	54
Sandwell & West Birmingham Hospitals NHS Trust	19	2		22	9	52
Aintree Hospitals NHS Trust	7		10	23	10	50
Mid Yorkshire Hospitals NHS Trust	3		9	20	17	49
The Cardiothoracic Centre—Liverpool NHS Trust			47	1		48
Southampton University Hospitals NHS Trust	1	2	22	17	5	47
Shrewsbury and Telford Hospitals NHS Trust	13	2	16	6	10	47
North Staffordshire Hospital NHS Trust			26	15	5	46
United Lincolnshire Hospitals NHS Trust		3	17	18	7	45
South Manchester University Hospitals NHS Trust		1	24	11	9	45
Barking, Havering & Redbridge Hospitals NHS Trust	1		9	23	8	41
University Hospital Birmingham NHS Trust	6	2	10	16	7	41
Bradford Hospitals NHS Trust	8	4	9	11	8	40
Royal Brompton & Harefield NHS Trust			37	1	2	40
East Kent Hospitals NHS Trust	1	4	16	16	3	40
Royal Devon & Exeter Healthcare NHS Trust	10		15	13	1	39
Royal Bournemouth & Christchurch Hospitals			31	5	3	39
Northern Lincolnshire & Goole Hospitals NHS Trust		1	14	20	4	39
Doncaster & Bassetlaw Hospitals NHS Trust	2		15	14	7	38

<i>Trust</i>	<i>Number of procedures</i>		<i>Main procedure</i>			Grand total
	<i>Partial excision of oesophagus</i>	<i>Total excision of oesophagus</i>	<i>Excision of oesophagus and stomach</i>	<i>Partial excision of stomach</i>	<i>Total excision of stomach</i>	
Portsmouth Hospitals NHS Trust	1		16	15	6	38
Gloucestershire Hospitals NHS Trust	1	2	10	16	9	38
The Royal Wolverhampton Hospitals NHS Trust	1		15	18	3	37
East Lancashire Hospitals NHS Trust	11		3	14	7	35
North Cumbria Acute Hospitals NHS Trust	7	5	3	13	7	35
Wirral Hospital NHS Trust	6		6	16	6	34
Bolton Hospitals NHS Trust			11	18	5	34
The Royal Marsden Hospital NHS Trust	1	7	15	2	9	34
Southern Derbyshire Acute Hospitals NHS Trust	7	1	15	10	1	34
Essex Rivers Healthcare NHS Trust	15	1	5	6	6	33
Royal Cornwall Hospitals NHS Trust	1		12	10	10	33
Peterborough Hospitals NHS Trust		2	15	9	7	33
Addenbrooke's NHS Trust	4		9	10	9	32
Royal Liverpool & Broadgreen Hospitals			9	14	9	32
East & North Hertfordshire NHS Trust		4	11	11	6	32
City Hospitals Sunderland NHS Trust			10	14	8	32
West Hertfordshire Hospitals NHS Trust		2	9	12	8	31
York Health Services NHS Trust	1		10	13	6	30
Blackpool, Fylde & Wyre Hospitals NHS Trust	3	1	18	6	2	30
Worcestershire Acute Hospitals NHS Trust	2		16	4	7	29
Brighton & Sussex University Hospitals NHS Trust		1	12	9	7	29
St Helens & Knowsley Hospitals NHS Trust			16	8	4	28
Tameside & Glossop Acute Services NHS Trust	1	2	10	12	2	27
Scarborough & North East Yorkshire Health Care	6	1	9	7	4	27
Maidstone & Tunbridge Wells NHS Trust	1	2	6	14	4	27
Morecambe Bay Hospitals NHS Trust	7	1	10	6	2	26
Dudley Group of Hospitals NHS Trust	1		8	12	4	25
Wrightington, Wigan & Leigh NHS Trust	1	1	8	7	7	24
The Royal West Sussex NHS Trust			6	17	1	24
Salford Royal Hospitals NHS Trust	2		12	7	3	24
Frimley Park Hospital NHS Trust	3		6	10	5	24
Ipswich Hospital NHS Trust	1		6	14	2	23
Walsall Hospitals NHS Trust			1	16	6	23
Southend Hospital NHS Trust			7	12	4	23
County Durham & Darlington Acute Hospitals			6	12	5	23
Royal United Hospital Bath NHS Trust	8			10	5	23
Hammersmith Hospitals NHS Trust	1		6	13	3	23
The Mid Cheshire Hospitals NHS Trust	3	1	3	10	5	22
King's College Hospital NHS Trust			6	14	2	22
St George's Healthcare NHS Trust	2		4	12	4	22
Queen Mary's Sidcup NHS Trust	6	1	5	5	5	22
North Tees & Hartlepool NHS Trust	1			19	2	22

<i>Trust</i>	<i>Number of procedures</i>					Grand total
	<i>Partial excision of oesophagus</i>	<i>Total excision of oesophagus</i>	<i>Main procedure</i>		<i>Total excision of stomach</i>	
			<i>Excision of oesophagus and stomach</i>	<i>Partial excision of stomach</i>		
Calderdale & Huddersfield NHS Trust			3	12	5	20
North Bristol NHS Trust	3		4	9	4	20
Mid Staffordshire General Hospitals NHS Trust	5		2	7	5	19
Whipps Cross University Hospital NHS Trust			5	11	3	19
Luton & Dunstable Hospital NHS Trust			11	5	3	19
Epsom & St Helier NHS Trust	6			9	4	19
Basildon & Thurrock General Hospitals NHS Trust			3	13	3	19
Northumbria Health Care NHS Trust			2	13	4	19
Royal Free Hampstead NHS Trust	2	3	7	7		19
Royal Berkshire & Battle Hospitals NHS Trust	2	1	8	7	1	19
Northampton General Hospital NHS Trust			9	8	1	18
Homerton University Hospital NHS Trust	3			10	5	18
Worthing & Southlands Hospitals NHS Trust			4	10	3	17
Countess of Chester Hospital NHS Trust	1		7	3	6	17
Southport & Ormskirk Hospital NHS Trust			8	4	5	17
Buckinghamshire Hospitals NHS TRUST				13	4	17
Bromley Hospitals NHS Trust	9		1	5	1	16
Ashford & St Peter's Hospitals NHS Trust	1		6	7	2	16
Good Hope Hospital NHS Trust			1	8	6	15
Rotherham General Hospitals NHS Trust				15		15
North Middlesex University Hospital NHS Trust			5	8	2	15
East Sussex Hospitals NHS Trust				14	1	15
Kettering General Hospital NHS Trust			7	4	4	15
Barts & The London NHS Trust	1		2	6	6	15
North West London Hospitals NHS Trust			1	9	4	14
James Paget Healthcare NHS Trust				11	3	14
The Lewisham Hospital NHS Trust		2	3	9		14
St Mary's NHS Trust	2		3	8	1	14
North Cheshire Hospitals NHS Trust	1		2	10	1	14
East Cheshire NHS Trust	1	1	3	7	1	13
Whittington Hospital NHS Trust	1		6	4	2	13
Central Manchester & Manchester Children's Hospitals	3	2	2	5	1	13
Stockport NHS Trust			3	5	5	13
Queen Elizabeth Hospital NHS Trust			2	8	3	13
Royal Surrey County Hospital NHS Trust			6	6	1	13
Barnet & Chase Farm Hospitals NHS Trust		1	2	8	2	13
Barnsley District General Hospital NHS Trust				10	2	12
Mid Essex Hospital Services NHS Trust			6	5	1	12
Chesterfield & North Derbyshire Royal Hospital				9	3	12
Burton Hospitals NHS Trust			4	8		12
Taunton & Somerset NHS Trust				9	3	12

<i>Trust</i>	<i>Number of procedures</i>		<i>Main procedure</i>			Grand total
	<i>Partial excision of oesophagus</i>	<i>Total excision of oesophagus</i>	<i>Excision of oesophagus and stomach</i>	<i>Partial excision of stomach</i>	<i>Total excision of stomach</i>	
South Warwickshire General Hospitals NHS Trust	1		7	1	3	12
North Hampshire Hospitals NHS Trust				9	2	11
Bedford Hospitals NHS Trust	3	2	1	5		11
Poole Hospitals NHS Trust			2	8		10
Papworth Hospital NHS Trust	1		9			10
Heatherwood & Wexham Park Hospitals NHS Trust				9	1	10
Queen's Medical Centre, Nottingham University Hospital		2		8		10
Hereford Hospitals NHS Trust			4	4	1	9
West Suffolk Hospitals NHS Trust			3	6		9
West Dorset General Hospitals NHS Trust			1	6	2	9
Airedale NHS Trust			1	5	3	9
The Princess Alexandra Hospital NHS Trust	1		1	6	1	9
Salisbury Health Care NHS Trust				8	1	9
Medway NHS Trust				8		8
Gateshead Health NHS Trust			1	6	1	8
Sherwood Forest Hospitals NHS Trust				7	1	8
Kingston Hospital NHS Trust			1	4	3	8
Surrey & Sussex Healthcare NHS Trust				7	1	8
Mayday Healthcare NHS Trust			3	5		8
Isle of Wight Healthcare NHS Trust	2		1	4		7
Winchester & Eastleigh Healthcare NHS Trust				5	2	7
South Tyneside Health Care NHS Trust		1		5		6
George Eliot Hospital NHS Trust			1	4	1	6
Harrogate Health Care NHS Trust				5	1	6
Northern Devon Healthcare NHS Trust				4	2	6
The Hillingdon Hospital NHS Trust				5		5
Dartford & Gravesham NHS Trust				5		5
Hinchingbrooke Health Care NHS Trust			3	1		4
Great Ormond Street Hospital for Children		2	2			4
Kings Lynn & Wisbech Hospitals NHS Trust				3	1	4
South Devon Health Care NHS Trust	1			2	1	4
Chelsea & Westminster Healthcare NHS Trust				3	1	4
Swindon & Marlborough NHS Trust				3		3
East Somerset NHS Trust				2	1	3
University College London Hospitals NHS Trust				1	2	3
Ealing Hospital NHS Trust				1	1	2
Milton Keynes General Hospital NHS Trust				2		2
Newham Healthcare NHS Trust				1		1
Royal Orthopaedic Hospital NHS Trust				1		1
Royal Liverpool Childrens NHS Trust			1			1
Sheffield Children's NHS Trust				1		1
West Middlesex University NHS Trust				1		1
Weston Area Health NHS Trust				1		1
Grand total	453	155	1,236	1,577	659	4,080

Annex A(vi)

Number of major Upper gastrointestinal procedures carried out in NHS trusts by SHA: HES Data Extract 5							
Oesophagectomies; Oesophago-Gastrectomies & Gastrectomies (2002-2003)							
SHA of Trust	Trust	Main Procedure					Grand Total
		Partial Excision of Oesophagus	Total Excision of Oesophagus	Excision of Oesophagus and Stomach	Partial Excision of Stomach	Total Excision of Stomach	
Avon, Gloucestershire & Wiltshire HA	United Bristol Healthcare NHS Trust	3	20	12	15	10	60
	Gloucestershire Hospitals NHS Trust	1	2	10	16	9	38
	Royal United Hospital Bath NHS Trust	8			10	5	23
	North Bristol NHS Trust	3		4	9	4	20
	Salisbury Health Care NHS Trust				8	1	9
	Swindon & Marlborough NHS Trust				3		3
	Weston Area Health NHS Trust				1		1
Avon, Gloucestershire & Wiltshire HA Total		15	22	26	62	29	154
Bedfordshire & Hertfordshire HA	East & North Hertfordshire NHS Trust		4	11	11	6	32
	West Hertfordshire Hospitals NHS Trust		2	9	12	8	31
	Luton & Dunstable Hospital NHS Trust			11	5	3	19
	Bedford Hospitals NHS Trust	3	2	1	5		11
Bedfordshire & Hertfordshire HA Total		3	8	32	33	17	93
Birmingham & The Black Country HA	Birmingham Heartlands & Solihull NHS Trust	27	4	17	23	7	78
	Sandwell & West Birmingham Hospitals NHS Trust	19	2		22	9	52
	University Hospital Birmingham NHS Trust	6	2	10	16	7	41
	The Royal Wolverhampton Hospitals NHS Trust	1		15	18	3	37
	Dudley Group Of Hospitals NHS Trust	1		8	12	4	25
	Walsall Hospitals NHS Trust			1	16	6	23
	Good Hope Hospital NHS Trust			1	8	6	15
	Royal Orthopaedic Hospital NHS Trust				1		1
Birmingham & The Black Country HA Total		54	8	52	116	42	272
Cheshire & Merseyside HA	Aintree Hospitals NHS Trust	7		10	23	10	50
	The Cardiothoracic Centre - Liverpool NHS Trust			47	1		48
	Wirral Hospital NHS Trust	6		6	16	6	34
	Royal Liverpool & Broadgreen Hospitals			9	14	9	32
	St Helens & Knowsley Hospitals NHS Trust			16	8	4	28
	The Mid Cheshire Hospitals NHS Trust	3	1	3	10	5	22
	Countess Of Chester Hospital NHS Trust	1		7	3	6	17
	Southport & Ormskirk Hospital NHS Trust			8	4	5	17
	North Cheshire Hospitals NHS Trust	1		2	10	1	14
	East Cheshire NHS Trust	1	1	3	7	1	13
	Royal Liverpool Childrens NHS Trust			1			1
Cheshire & Merseyside HA Total		19	2	112	96	47	276
County Durham & Tees Valley HA	South Tees Hospitals NHS Trust	10	1	14	19	11	55
	County Durham & Darlington Acute Hospitals			6	12	5	23
	North Tees & Hartlepool NHS Trust	1			19	2	22
County Durham & Tees Valley HA Total		11	1	20	50	18	100
Cumbria & Lancashire HA	Lancashire Teaching Hospitals NHS Trust			30	11	13	54
	East Lancashire Hospitals NHS Trust	11		3	14	7	35
	North Cumbria Acute Hospitals NHS Trust	7	5	3	13	7	35
	Blackpool, Fylde & Wyre Hospitals NHS Trust	3	1	18	6	2	30
	Morecambe Bay Hospitals NHS Trust	7	1	10	6	2	26
Cumbria & Lancashire HA Total		28	7	64	50	31	180
Dorset & Somerset HA	Royal Bournemouth & Christchurch Hospitals			31	5	3	39
	Taunton & Somerset NHS Trust				9	3	12
	Poole Hospitals NHS Trust			2	8		10
	West Dorset General Hospitals NHS Trust			1	6	2	9
	East Somerset NHS Trust				2	1	3
Dorset & Somerset HA Total			34	30	9	73	
Essex HA	Essex Rivers Healthcare NHS Trust	15	1	5	6	6	33
	Southend Hospital NHS Trust			7	12	4	23
	Basilston & Thurrock General Hospitals NHS Trust			3	13	3	19
	Mid Essex Hospital Services NHS Trust			6	5	1	12
	The Princess Alexandra Hospital NHS Trust	1		1	6	1	9
Essex HA Total		16	1	22	42	15	96
Greater Manchester HA	Pennine Acute Hospitals NHS Trust			17	30	16	63
	South Manchester University Hospitals NHS Trust		1	24	11	9	45
	Bolton Hospitals NHS Trust			11	18	5	34
	Tameside & Glossop Acute Services NHS Trust	1	2	10	12	2	27
	Wrightington, Wigan & Leigh NHS Trust	1	1	8	7	7	24
	Salford Royal Hospitals NHS Trust	2		12	7	3	24
	Central Manchester & Manchester Children's Hospitals	3	2	2	5	1	13
	Stockport NHS Trust			3	5	5	13
Greater Manchester HA Total		7	6	87	95	48	243
Hampshire & Isle Of Wight HA	Southampton University Hospitals NHS Trust	1	2	22	17	5	47
	Portsmouth Hospitals NHS Trust	1		16	15	6	38
	North Hampshire Hospitals NHS Trust				9	2	11
	Isle Of Wight Healthcare NHS Trust	2		1	4		7
	Winchester & Eastleigh Healthcare NHS Trust				5	2	7
Hampshire & Isle Of Wight HA Total		4	2	39	50	15	110
Kent & Medway HA	East Kent Hospitals NHS Trust	1	4	16	16	3	40
	Maidstone & Tunbridge Wells NHS Trust	1	2	6	14	4	27
	Medway NHS Trust				8		8
	Dartford & Gravesham NHS Trust				5		5
Kent & Medway HA Total		2	6	22	43	7	80
Leicestershire, Northamptonshire & Rutland HA	University Hospitals Of Leicester NHS Trust	9	9	22	27	19	86
	Northampton General Hospital NHS Trust			9	8	1	18
	Kettering General Hospital NHS Trust			7	4	4	15
Leicestershire, Northamptonshire & Rutland HA Total		9	9	38	39	24	119
Norfolk, Suffolk & Cambridgeshire HA	Norfolk & Norwich University Hospital NHS Trust	7	16	30	20	5	78
	Peterborough Hospitals NHS Trust		2	15	9	7	33
	Addenbrooke's NHS Trust	4		9	10	9	32
	Ipwich Hospital NHS Trust	1		6	14	2	23
	James Paget Healthcare NHS Trust			9	11	3	14
	Papworth Hospital NHS Trust	1		9			10
	West Suffolk Hospitals NHS Trust			3	6		9
	Hinchingbrooke Health Care NHS Trust			3	1		4
Kings Lynn & Wisbech Hospitals NHS Trust				3	1	4	
Norfolk, Suffolk & Cambridgeshire HA Total		13	18	75	74	27	207

Annex A(vi)—continued

North & East Yorkshire and Northern Lincolnshire HA	Hull & East Yorkshire Hospitals NHS Trust	8	1	29	13	14	65
	Northern Lincolnshire & Goole Hospitals NHS Trust		1	14	20	4	39
	York Health Services NHS Trust	1		10	13	6	30
	Scarborough & North East Yorkshire Health Care	6	1	9	7	4	27
	Harrogate Health Care NHS Trust				5	1	6
North & East Yorkshire and Northern Lincolnshire HA Total		15	3	62	58	29	167
North Central London HA	Royal Free Hampstead NHS Trust	2	3	7	7		19
	North Middlesex University Hospital NHS Trust			5	8	2	15
	Whittington Hospital NHS Trust	1		6	4	2	13
	Barnet & Chase Farm Hospitals NHS Trust		1	2	8	2	13
	Great Ormond Street Hospital For Children		2	2			4
	University College London Hospitals NHS Trust				1	2	3
North Central London HA Total		3	6	22	28	8	67
North East London HA	Barking, Havering & Redbridge Hospitals NHS Trust	1		9	23	8	41
	Whipps Cross University Hospital NHS Trust			5	11	3	19
	Homerton University Hospital NHS Trust	3			10	5	18
	Barts & The London NHS Trust	1		2	6	6	15
	Newham Healthcare NHS Trust				1		1
North East London HA Total		5		16	51	22	94
North West London HA	Royal Brompton & Harefield NHS Trust			37	1	2	40
	Hammersmith Hospitals NHS Trust	1		6	13	3	23
	North West London Hospitals NHS Trust			1	9	4	14
	St Mary's NHS Trust	2		3	8	1	14
	The Hillingdon Hospital NHS Trust				5		5
	Chelsea & Westminster Healthcare NHS Trust				3	1	4
	Ealing Hospital NHS Trust				1	1	2
	West Middlesex University NHS Trust				1		1
North West London HA Total		3		47	41	12	103
Northumberland, Tyne & Wear HA	The Newcastle Upon Tyne Hospitals NHS Trust	51		3	36	22	112
	City Hospitals Sunderland NHS Trust			10	14	8	32
	Northumbria Health Care NHS Trust			2	13	4	19
	Gateshead Health NHS Trust			1	6	1	8
	South Tyneside Health Care NHS Trust		1		5		6
Northumberland, Tyne & Wear HA Total		51	1	16	74	35	177
Shropshire & Staffordshire HA	Shrewsbury and Telford Hospitals NHS Trust	13	2	16	6	10	47
	North Staffordshire Hospital NHS Trust			26	15	5	46
	Mid Staffordshire General Hospitals NHS Trust	5		2	7	5	19
	Burton Hospitals NHS Trust			4	8		12
Shropshire & Staffordshire HA Total		18	2	48	36	20	124
South East London HA	Guy's & St Thomas' NHS Trust	35	7	13	12	3	70
	King's College Hospital NHS Trust			6	14	2	22
	Queen Mary's Sidcup NHS Trust	6	1	5	5	5	22
	Bromley Hospitals NHS Trust	9		1	5	1	16
	The Lewisham Hospital NHS Trust		2	3	9		14
	Queen Elizabeth Hospital NHS Trust			2	8	3	13
South East London HA Total		50	10	30	53	14	157
South West London HA	The Royal Marsden Hospital NHS Trust	1	7	15	2	9	34
	St George's Healthcare NHS Trust	2		4	12	4	22
	Epsom & St Helier NHS Trust	6			9	4	19
	Kingston Hospital NHS Trust			1	4	3	8
	Mayday Healthcare NHS Trust			3	5		8
South West London HA Total		9	7	23	32	20	91
South West Peninsula HA	Plymouth Hospitals NHS Trust		1	42	13	6	62
	Royal Devon & Exeter Healthcare NHS Trust	10		15	13	1	39
	Royal Cornwall Hospitals NHS Trust	1		12	10	10	33
	Northern Devon Healthcare NHS Trust				4	2	6
	South Devon Health Care NHS Trust	1		2	1		4
South West Peninsula HA Total		12	1	69	42	20	144
South Yorkshire HA	Sheffield Teaching Hospitals NHS Trust	4	1	38	25	20	88
	Doncaster & Bassetlaw Hospitals NHS Trust	2		15	14	7	38
	Rotherham General Hospitals NHS Trust				15		15
	Barnsley District General Hospital NHS Trust				10	2	12
	Sheffield Children's NHS Trust				1		1
South Yorkshire HA Total		6	1	53	65	29	154
Surrey & Sussex HA	Brighton & Sussex University Hospitals NHS Trust		1	12	9	7	29
	The Royal West Sussex NHS Trust			6	17	1	24
	Frimley Park Hospital NHS Trust	3		6	10	5	24
	Worthing & Southlands Hospitals NHS Trust			4	10	3	17
	Ashford & St Peter's Hospitals NHS Trust	1		6	7	2	16
	East Sussex Hospitals NHS Trust				14	1	15
	Royal Surrey County Hospital NHS Trust			6	6	1	13
	Surrey & Sussex Healthcare NHS Trust				7	1	8
Surrey & Sussex HA Total		4	1	40	80	21	146
Thames Valley HA	Oxford Radcliffe Hospital NHS Trust	12	17	26	16	5	76
	Royal Berkshire & Battle Hospitals NHS Trust	2	1	8	7	1	19
	Buckinghamshire Hospitals NHS TRUST				13	4	17
	Heatherwood & Wexham Park Hospitals NHS Trust				9	1	10
	Milton Keynes General Hospital NHS Trust				2		2
Thames Valley HA Total		14	18	34	47	11	124
Trent HA	Nottingham City Hospital NHS Trust	30	2	42	23	5	102
	United Lincolnshire Hospitals NHS Trust		3	17	18	7	45
	Southern Derbyshire Acute Hospitals NHS Trust	7	1	15	10	1	34
	Chesterfield & North Derbyshire Royal Hospital				9	3	12
	Queen's Medical Centre, Nottingham Univ Hospital		2		8		10
	Sherwood Forest Hospitals NHS Trust				7	1	8
Trent HA Total		37	8	74	75	17	211
West Midlands South Strategic HA	University Hospitals Coventry & Warwickshire	29		2	19	5	55
	Worcestershire Acute Hospitals NHS Trust	2		16	4	7	29
	South Warwickshire General Hospitals NHS Trust	1		7	1	3	12
	Hereford Hospitals NHS Trust			4	4	1	9
	George Eliot Hospital NHS Trust			1	4	1	6
West Midlands South Strategic HA Total		32		30	32	17	111
West Yorkshire HA	Leeds Teaching Hospitals NHS Trust	2	3	27	35	22	89
	Mid Yorkshire Hospitals NHS Trust	3		9	20	17	49
	Bradford Hospitals NHS Trust	8	4	9	11	8	40
	Calderdale & Huddersfield NHS Trust			3	12	5	20
	Airedale NHS Trust			1	5	3	9
West Yorkshire HA Total		13	7	49	83	55	207
Grand Total		453	155	1,236	1,577	659	4,080

Annex B

VOLUME IN MG SALES OF HERCEPTIN IN CANCER NETWORKS FOR QUARTER 1 2000–01 TO QUARTER 2 2003–04

	<i>CancerNetwork</i>	<i>Q101</i>	<i>Q201</i>	<i>Q301</i>	<i>Q401</i>	<i>Q102</i>	<i>Q202</i>	<i>Q302</i>	<i>Q402</i>	<i>Q103</i>	<i>Q203</i>	<i>Q303</i>	<i>Q403</i>	<i>Q104</i>	<i>Q204</i>
England	3Counties	5,250	3,450	4,500	3,750	5,100	6,900	10,200	24,600	19,950	8,400	4,500	12,450	27,750	25,950
England	Arden	0	0	0	0	0	0	5,100	4,200	2,700	6,900	4,050	4,950	4,800	5,100
England	AvonSomWilt	9,150	7,050	8,100	11,550	3,900	36,150	63,750	60,900	58,200	57,150	68,550	51,000	92,550	94,650
England	BlackCountry	750	3,000	3,000	1,950	600	1,050	2,850	4,500	15,150	16,500	13,800	10,650	16,350	16,500
England	CentSouth	4,800	9,750	6,600	15,300	14,100	20,700	24,000	31,050	26,250	52,200	42,750	54,300	66,300	76,350
England	DerbyBurton	0	0	0	0	0	0	0	1,200	2,400	1,800	2,400	3,900	9,300	10,350
England	Dorset	0	2,100	6,750	4,050	6,150	8,550	8,100	15,300	28,350	29,850	46,200	42,000	56,850	61,500
England	GrManchester	7,200	5,400	11,700	21,600	40,500	46,500	51,000	64,200	75,000	95,250	89,250	82,800	117,000	115,500
England	Humber	600	450	5,700	8,250	12,000	11,100	17,100	18,600	27,000	30,600	23,250	32,550	22,200	26,850
England	Kent	450	2,550	4,500	6,900	12,300	13,950	14,850	7,950	36,750	26,100	33,000	68,550	21,600	54,450
England	LancsSCumb	0	0	0	1,800	900	8,700	13,650	24,300	23,400	29,400	41,850	54,450	59,400	64,500
England	Leicestershire	0	1,650	2,550	900	10,350	4,650	8,400	12,600	25,650	23,700	21,750	32,700	34,050	24,000
England	MerseyChesh	0	5,550	17,100	6,750	24,000	24,000	34,500	58,500	52,500	48,000	28,500	34,200	45,000	52,500
England	MidAnglia	3,000	4,950	3,000	2,250	3,450	8,100	10,200	9,150	12,600	16,350	22,650	37,050	59,250	51,300
England	MidTrent	1,350	1,350	1,500	1,950	4,800	7,050	12,450	16,350	15,150	16,350	18,000	13,950	11,550	17,850
England	MtVernon	0	0	0	0	0	3,450	9,300	15,600	22,200	33,450	36,150	34,350	47,400	38,700
England	NELondon	300	4,800	11,850	15,900	8,100	14,850	15,300	5,850	18,450	18,750	26,850	19,650	28,650	36,000
England	NLondon	2,250	5,100	5,250	7,800	9,900	23,400	17,700	26,550	35,550	24,150	35,400	36,000	38,250	61,950
England	NorfolkWav	450	2,700	1,200	2,700	7,950	3,450	15,900	23,550	19,800	22,950	24,000	26,850	21,750	32,400
England	Northern	0	0	150	2,100	2,700	3,150	6,450	19,200	29,100	29,250	34,500	48,150	29,400	61,200
England	NTrent	0	0	0	600	2,400	6,750	13,500	27,900	28,500	27,000	24,000	30,000	34,500	25,500
England	NWMidlands	2,400	5,250	5,250	3,000	3,900	12,450	10,800	15,600	28,050	35,850	48,750	38,550	54,450	44,850
England	PanBirmingham	1,800	5,400	12,900	12,000	9,900	13,800	15,900	20,850	20,250	17,400	24,300	30,300	44,100	41,400
England	Peninsular	9,000	6,300	6,300	8,400	6,000	12,600	23,250	45,900	36,600	32,250	55,650	45,000	55,950	68,550
England	SELondon	9,750	9,150	12,450	11,400	19,950	37,650	48,000	34,200	53,400	49,650	51,750	35,550	69,000	66,750
England	SEssex	450	2,100	1,200	1,500	5,700	5,700	10,500	15,000	18,000	10,500	3,000	3,750	4,050	2,550
England	SurrWSusxHamp	0	600	3,750	12,300	18,750	25,500	35,100	37,500	41,100	46,500	42,000	34,500	42,000	45,000
England	Sussex	0	0	750	1,800	3,300	5,850	13,050	14,550	20,550	20,100	25,950	33,150	30,150	36,450
England	SWLondon	4,800	5,550	12,300	18,900	25,200	33,000	22,500	48,000	44,100	75,900	88,350	102,900	129,150	126,450
England	TeesDurNYorks	5,550	4,050	3,450	6,900	4,950	3,600	9,600	6,450	9,150	14,550	12,600	26,400	39,300	37,350
England	ThamesValley	21,000	31,500	16,800	10,950	24,450	33,600	26,700	31,950	52,350	55,050	59,250	52,650	58,650	48,150
England	WAnglia	0	900	1,650	3,600	4,950	11,100	20,100	25,650	36,750	42,000	37,350	37,650	45,600	36,150
England	WLondon	3,900	10,050	12,000	7,950	4,800	18,000	33,900	26,400	29,700	32,700	30,750	32,550	42,600	24,000
England	Yorkshire	7,350	8,100	12,000	16,950	21,750	42,000	51,150	61,650	58,800	59,100	70,350	62,850	100,050	118,200

Source: Roche

Annex C

**ESTIMATE OF ELIGIBLE PATIENTS (AS CALCULATED BY ROCHE) RECEIVING
HERCEPTIN PRE AND POST NICE GUIDANCE BY CANCER NETWORK***

The Department of Health does not identify nor calculate the percentage of eligible women receiving Herceptin. The table below shows data provided by Roche (to the NAO), which are calculated using their own algorithm. The Department can not validate these data but have included them here, as they translate to Figure 39 in the NAO's Report.

The Committee should note that the table below is provided by the NAO and cannot be amended.

The figure for West London cancer network is incorrect. The penetration (percentage of eligible cancer patients receiving Herceptin 12–18 months after NICE approval) for West London was 38%, not 4%. This makes the median 39% and improves the West London ranking to 18th from 34th.

The NAO Report included an insert with a revised Figure 39, in which West London was correctly ranked.

Herceptin	Population	Breast cancer patients	Metastatic population	HER2 +ve	Patients eligible for treatment	0-6 Months Pre-NICE			0-6 Months Post-NICE			6-12 Months Post-NICE			12-18 Months Post-NICE		
						actual patients on treatment	Penetration	Penetration	actual patients on treatment	Penetration	Penetration	actual patients on treatment	Penetration	Penetration	actual patients on treatment	Penetration	Penetration
South West London	1,335,450	948	303	61	49	12	24%	15	31%	25	51%	44	90%	61%			
Dorset	618,961	439	141	28	23	3	12%	4	20%	12	52%	20	90%	61%			
Surrey, West Sussex & Hampshire	1,182,568	840	269	54	43	8	19%	16	38%	21	49%	24	55%	61%			
South East London	1,388,110	986	315	63	50	7	14%	22	45%	23	46%	27	54%	61% Top Quartile			
North West Midlands	1,210,667	860	275	55	44	2	4%	6	14%	12	26%	22	51%	61% Quartile			
Norfolk & Waveney	679,669	483	154	31	25	3	12%	5	21%	12	47%	13	51%	61%			
Avon, Somerset & Wiltshire	1,878,097	1,333	427	85	68	4	6%	27	39%	32	47%	34	49%	61%			
Thames Valley	1,667,860	1,184	379	76	61	7	12%	16	27%	23	37%	30	49%	61%			
Greater Manchester & Cheshire	2,932,017	2,082	666	133	107	17	16%	26	24%	35	33%	49	46%	41%			
North London	982,022	697	223	45	36	5	13%	11	31%	17	46%	16	45%	41%			
Peninsular (Devon & Cornwall)	1,476,249	1,048	335	67	54	4	7%	10	18%	22	41%	23	44%	41% Second Quartile			
Humber & Yorkshire Coast	990,598	703	225	45	36	5	14%	8	21%	12	34%	14	40%	41%			
Sussex	833,968	592	189	38	30	1	4%	5	15%	9	28%	12	39%	41%			
Yorkshire	2,495,045	1,771	567	113	91	10	11%	25	28%	32	35%	35	38%	41%			
Central South Coast	1,818,407	1,291	413	83	66	8	12%	12	18%	15	23%	25	38%	41%			
Lancashire & South Cumbria	1,404,343	997	319	64	51	1	1%	6	12%	13	25%	19	37%	41%			
West Anglia	1,599,881	1,136	363	73	58	2	4%	8	14%	17	29%	21	36%	36% Median			
Mid Anglia	904,779	642	206	41	33	2	5%	5	15%	6	18%	10	32%	26%			
Merseyside & Cheshire	2,027,048	1,439	461	92	74	8	11%	16	21%	30	40%	20	28%	26%			
Mount Vernon	1,985,447	1,410	451	90	72	0	0%	3	5%	10	14%	19	26%	26%			
Kent	1,722,467	1,223	391	78	63	5	8%	8	12%	12	19%	16	25%	26% Third Quartile			
Leicestershire	1,334,904	948	303	61	49	3	6%	3	7%	10	21%	12	25%	26%			
Northern	1,983,464	1,408	451	90	72	1	2%	3	4%	13	18%	17	24%	26%			
North East London	1,466,489	1,041	333	67	53	6	12%	8	15%	6	12%	12	23%	26%			
North Trent	1,661,137	1,179	377	75	60	1	1%	5	9%	15	25%	14	23%	26%			
Teesside, S Durham & N Yorkshire	983,392	698	223	45	36	3	9%	4	10%	4	11%	7	20%	12%			
Black Country	1,296,236	920	295	59	47	1	1%	1	2%	5	11%	8	17%	12%			
Mid Trent	1,479,361	1,050	336	67	54	2	3%	5	10%	8	16%	9	17%	12%			
South Essex	618,722	439	141	28	22	2	9%	4	19%	9	39%	4	16%	12% Bottom Quartile			
Pan Birmingham	2,244,096	1,593	510	102	82	6	7%	8	10%	11	13%	11	14%	12%			
Three Counties	1,067,845	758	243	49	39	2	6%	4	10%	10	26%	3	8%	12%			
Arden	1,153,063	819	262	52	42	0	0%	2	5%	4	9%	3	8%	12%			
Derby/Burton	589,462	419	134	27	21	0	0%	0	0%	1	4%	1	5%	12%			
West London	1,291,165	917	293	59	47	1	1%	0	1%	3	7%	2	4%	12%			

Letter to the Committee from Cancer Research UK

I am writing further to the Committee of Public Accounts evidence session on the NAO Report “*Tackling Cancer in England: saving more lives*”, which took place at the end of the summer session.

Cancer Research UK welcomes the NAO’s Report, and the work the Government has done so far to prioritise cancer. However much energy and financial expenditure is needed to make a real and lasting impact on both cancer prevention and cancer treatment. This is especially relevant with the anticipated future increase in cancer incidence resulting from an ageing population as well as lifestyle factors, including smoking, obesity, diet and reproductive patterns. Inequalities in access to treatment between rich and poor need to be addressed, in tandem with efforts to help reduce cancer incidence in deprived groups. Tackling cancer in the UK is a formidable task for the Government, requiring inter-departmental collaboration and considerable determination and resources.

Cancer Research UK applauds the work of the Committee of Public Accounts in scrutinising the state of cancer services in the UK, specifically in examining socioeconomic inequalities in cancer survival.

We followed with interest the Committee’s discussion on public awareness campaigns, and mortality and survival statistics. Cancer Research UK jointly funded Professor Michel Coleman’s study “Trends and socioeconomic inequalities in cancer survival in England and Wales up to 2001”, which provided the figures on survival and mortality that appear in the above NAO Report. We would like to offer the Committee further information on the following areas raised at the evidence session:

- Cancer Research UK’s SunSmart skin cancer prevention campaign.
- Cancer mortality and survival statistics.
- Clarification on statistics used in the NAO Report.

CANCER RESEARCH UK SUNSMART CAMPAIGN

During the evidence session the Chairman asked about the existence of a comprehensive national programme on skin cancer. In November 2002 Cancer Research UK was commissioned by the UK Government to run a national skin cancer prevention initiative, called SunSmart, which was launched in March 2003. After an initial pilot year Cancer Research UK was funded to run the SunSmart campaign until 2007, with funding over three years totalling £525,000. The aim of the campaign is to increase awareness of the preventable nature of skin cancer and effective methods of sun protection, with the eventual long-term aim of reducing the incidence of, and mortality from, skin cancer in the UK. Campaign strategies include public communication, support to professionals, and research and policy development.

The campaign raises awareness of the actions people can take to protect their skin from the sun through the SunSmart Code, and highlights the importance of seeking early advice from health professionals in the event of skin changes and the appearance of lesions. The campaign also works to increase shade provision and ensure safe school environments. These messages can be seen in a wide variety of locations in our range of posters, leaflets, website, press and PR activities, and through corporate partnerships. Materials have been sent in various forms to every nursery, primary and secondary school, health promotion unit, dermatologist, primary care and Sure-Start coordinator in the UK. The SunSmart campaign has distributed over 40,000 posters to UK GP Surgeries to assist health professionals in the identification of suspicious skin lesions, as well as distributing 175,000 general posters and over two million postcard sized message cards.

Market research conducted pre and post campaign, in February and September 2003, showed significant increases in overall knowledge of skin cancer prevention measures, and considerable increases in unprompted knowledge around specific sun awareness behaviours.

CANCER MORTALITY AND SURVIVAL STATISTICS

In the evidence session on this Report, the Committee questioned the links between mortality and survival figures and deprivation. The NAO Report makes clear that there are no obvious links between the changes in cancer *mortality* rates and levels of affluence. However the figures on cancer *survival* rates in the report, taken from Professor Michel Coleman’s study, “Trends and socioeconomic inequalities in cancer survival in England and Wales up to 2001” show that there is a link between improvement in cancer survival rates and affluence.

CLARIFICATION ON STATISTICS USED IN NAO REPORT

Members of the Committee questioned the figures taken from Professor Coleman’s paper and used in the NAO Report. Specifically members asked why the NAO Report used figures attributed to Professor Coleman’s paper stating that the survival gap had widened for 12 of the 16 cancers examined in men, and nine of the 17 cancers examined in women, when the Professor Coleman’s paper appeared to state that “five year survival was significantly lower than for those [in the most affluent areas] for 44 out of 47 cancers”.

The explanation for this anomaly is that the research conducted by Professor Coleman used for the NAO Report did not find that “five year survival was significantly lower than for those in the most affluent areas for 44 out of 47 cancers”. This statistic is quoted at the beginning of Professor Coleman’s paper, but is taken from a previous piece of research conducted in 1999—‘Cancer survival trends in England and Wales 1971–95: Deprivation and NHS Region’. This research examined a greater number of cancers, and used figures from the period 1981–90, hence the difference in statistics.

I hope this information is useful.

Yours sincerely

Catherine Muge
Public Affairs
Cancer Research UK

16 September 2004