



House of Commons  
Committee of Public Accounts

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# The NHS Cancer Plan: a progress report

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**Twentieth Report of  
Session 2005–06**

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

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## The Committee of Public Accounts

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Diana R Johnson MP (*Labour, Hull North*)

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### Committee staff

The current staff of the Committee is Nick Wright (Clerk), Christine Randall (Committee Assistant), Emma Sawyer (Committee Assistant), Ronnie Jefferson (Secretary), and Luke Robinson (Media Officer).

### Contacts

All correspondence should be addressed to the Clerk, Committee of Public Accounts, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 5708; the Committee’s email address is [pubaccom@parliament.uk](mailto:pubaccom@parliament.uk).

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## Summary

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Cancer services are a major priority for the NHS. Although death rates from the disease have been falling, more than one in three people develop cancer at some point in their life. The 10 year NHS Cancer Plan published in 2000 built on existing cancer initiatives, to provide a comprehensive strategy to tackle cancer across the whole patient pathway. It established 34 cancer networks in England, to lead the improvement of cancer services in each locality.

Progress against the targets and commitments in the Plan has been encouraging, though with slippage in meeting some target dates, such as for raising public awareness of the signs and symptoms of cancer. Targets relating to waiting times, to be met by the end of 2005 will prove challenging, as will the target for 800,000 smokers to quit for at least 4 weeks between 2003–04 and 2005–06. Increased funding for cancer services is getting through to the front line and being spent directly to fund new drugs, staffing and new services, though some key staff positions remain vacant.

Cancer networks have introduced a new way of approaching the delivery of cancer services, involving several organisations, including the Strategic Health Authorities, acute and primary care trusts, the voluntary sector and local authorities, with significant successes in terms of better local cancer services, use of new drugs and funding for palliative care. But in some network localities, commissioning of cancer services is not sufficiently joined-up, and relationships between constituent organisations can be difficult. Some lack comprehensive plans to implement the Cancer Plan and monitoring of progress is inconsistent.

There are clear disparities between the affluent and poorer members of society in terms of cancer outcomes, with higher mortality rates in deprived areas and survival rates which consistently favour London and the south. There is also wide geographical variation in the use of NICE approved cancer drugs across the country, including those for breast cancer. With some networks being less effective than others there is a risk that less affluent parts of the country may lose out.

On the basis of a Report from the Comptroller and Auditor General<sup>1</sup> the Committee took evidence from the Department of Health (the Department) on three main issues: improving the provision of cancer services in England; making cancer networks work; and addressing inequalities.

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1 C&AG's Report, *The NHS Cancer Plan: a progress report* (HC 343, Session 2004–05)

## Conclusions and recommendations

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- 1. 30% of networks visited by the National Audit Office did not have comprehensive plans for providing cancer services in their locality,** though cancer networks have been in place for over three years. Under new performance management arrangements, Strategic Health Authorities (SHAs) will be responsible for ensuring networks operate effectively. SHAs should review the effectiveness of cancer networks in their locality and where necessary put cancer service plans in place without delay.
- 2. Monitoring of performance against Plan targets by cancer networks is inconsistent and, in five cases, does not take place.** All cancer networks should establish comprehensive arrangements to monitor progress against those targets for which they are responsible. For consistency and appropriate coverage of targets, including the challenging waiting time targets to be met by the end of 2005, the National Cancer Director should identify and establish the most suitable monitoring framework. Network boards should provide annual information on progress to key stakeholders, including the National Cancer Director. The networks should then conduct benchmarking to learn from each other's successes and challenges.
- 3. A third of cancer networks have at best an adequate relationship with the primary care trusts that provide their funding.** The creation of NHS foundation trusts adds a new factor, as their core freedoms bring new opportunities but also the risk of more limited partnership working and collective efficiency. Planning, financing and implementing cancer services need to be done collectively by cancer network organisations rather than in isolation. Where necessary they should adopt existing good practice in this respect, which the Department should identify and disseminate as a basis for joint working towards a shared goal of better cancer services for patients.
- 4. Cancer mortality rates tend to be highest in areas of greatest deprivation, particularly for lung cancer, with the highest mortality rates twice the lowest across Strategic Health Authorities.** These differences in part reflect lifestyles, notably the prevalence of smoking and the extent to which patients with symptoms get them addressed quickly, as well as the effectiveness of NHS cancer services. The Cancer Plan contains a number of targets aimed at reducing inequalities but meeting or exceeding them depends on cancer networks being fully effective, including having a greater focus on prevention. All networks should make clear in their delivery plans how cancer inequalities are to be addressed. The Department should bring the results of actions to address cancer inequalities together in a published progress report on this specific issue.
- 5. The Cancer Plan needs updating to take account of major NHS structural changes since it was published five years ago.** The current Plan should be reviewed and a revised version covering the period to 2010 should be published. It should include a more comprehensive set of targets for the second half of the planning period, and reflect the estimate of the future burden of cancer currently being developed by the Department.

6. **There is no straightforward but comprehensive account of progress being made against the Plan targets and commitments.** The Department should publish progress against key cancer outcomes annually, along the lines of Figure 8 of the Comptroller and Auditor General's report, to provide a clear and consistent basis for the public to see how much progress is being made over time.
7. **Patients are diagnosed with cancer at a later stage in the UK than in other European countries and this particularly affects people from deprived areas in England.** New guidance from NICE sets out best practice for referring patients with suspected cancer to specialist services on the basis of their symptoms. Supporting information to help the public understand the referral guidance should be adapted to provide easily understood key warning signs and symptoms of cancer. These key indicators could then be widely publicised, for example through readily available cards or leaflets, targeting those groups that tend to delay going to the doctor with symptoms of possible cancer.



# 1 Improving the provision of cancer services in England

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1. Despite a rise in cancer incidence of 31% between 1971 and 2000 in terms of new cases per 100,000 of the population, by 2002 the cancer mortality rate had fallen by 12% (18% for men and 7% for women). Death rates have fallen with the introduction of national screening programmes and new and better treatments.

2. But better prevention, detection, diagnosis, treatment and care for cancer remain important goals. More than one in three people in England will develop cancer at some point in their life; one in four will die from it; and there are over 220,000 new cases a year and 128,000 deaths. There are considerable variations in incidence and mortality between strategic health authorities, associated with differences in affluence<sup>2</sup>.

3. The NHS Cancer Plan, published in September 2000, is a ten-year programme of fundamental reform of cancer services in England, with stated aims to:

- save more lives;
- ensure people with cancer get the right professional support and care as well as the best treatment;
- tackle the inequalities in health that mean unskilled workers are twice as likely to die from cancer as professionals; and
- build for the future through investment in the cancer workforce, through strong research and through preparation for the genetics revolution, so that the NHS never falls behind in cancer again.<sup>3</sup>

4. The Cancer Plan is a comprehensive strategy to tackle cancer, covering the whole patient pathway from prevention (including lifestyle issues such as smoking and diet) and screening through to diagnosis, treatment and care; and the investment needed to deliver these services in terms of improved staffing, equipment, drugs, treatments and information systems. It formally established cancer networks across the country, responsible for implementing the Cancer Plan, and bringing together all the organisations and health professionals which plan and deliver treatment and care for cancer patients.<sup>4</sup>

5. The NHS Cancer Plan covers the main elements of World Health Organisation guidelines for cancer strategies, but there are ways in which the cancer strategy for England could be further improved. Individual components of the Cancer Plan are not explicitly costed, nor does the Plan itself provide a financial envelope within which strategic decisions can be made. There is no estimate of the future cancer burden, which makes it difficult to see how capacity to diagnose and treat patients can be estimated; and there is no consideration of efficiency issues through the identification of alternative spending plans.

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2 C&AG's Report, *Tackling cancer in England: saving more lives* (HC 364, Session 2003–04) paras 1–2, 13

3 *The NHS Cancer Plan*, September 2000

4 C&AG's Report, paras 2, 8, 14

The Department does now have plans to look at the future estimate of the cancer burden in England in more detail to inform the cancer strategy for the next five years.<sup>5</sup>

6. The NHS has undergone major structural and other changes since the publication of the Cancer Plan, including the creation of primary care trusts in 2001, the establishment of Strategic Health Authorities in 2002, and the creation of NHS Foundation Trusts in 2004. The Cancer Plan is in this respect starting to look somewhat dated. The Department has not yet taken a decision on whether to update parts of the cancer Plan or revise the whole Plan.<sup>6</sup>

7. The Cancer Plan contains many targets and commitments to be achieved between 2000 and 2010, covering better prevention, screening, treatment and care, cutting waiting times, and additional staff and facilities, **Figure 1**. At this halfway point in the Plan the NHS has met a number of important targets with, for example, 975 extra cancer consultants in post by June 2004, a 36% increase in cancer specialist training places by 2003 and over £400 million of new equipment such as scanners delivered.<sup>7</sup>

8. The C&AG's Report details progress to date.<sup>8</sup> Progress has been encouraging, though some targets for 2001 to 2004 were not fully met or will be met later than planned. For example, the target to develop a programme to promote public awareness of the symptoms of cancer, due by 2001, has not yet been fully met. Targets for improving routine screening for breast cancer by 2003 and age coverage by 2004 are expected to be met in 2005.<sup>9</sup>

9. Across the country significant progress has been made in improving cancer services and managing them more effectively, in particular, speeding access to cancer diagnosis and treatment. Over 99% of those referred urgently by a GP to see a cancer specialist are seen within the 2 week target. While unacceptable variation remains, there has been an increase in access to NICE approved cancer drugs across England, and this should in due course contribute to further cuts in mortality rates from cancer. The Cancer Plan has five more years to run, and the Department expects that all targets in the Plan will be met by 2010.<sup>10</sup>

10. For the public in general and above all, those who have or may have cancer, waiting times for diagnosis and treatment remain key issues. The Cancer Plan contains targets aimed at cutting waiting times including targets of one month maximum wait from diagnosis to treatment and two months maximum wait from urgent GP referral to treatment that are to be achieved by the end of 2005. These targets, and others such as those for the number of smokers quitting, pose significant challenges to the cancer networks and the NHS, and will require considerable effort if they are to be fully met.<sup>11</sup>

11. In terms of patients choosing where to be assessed or treated, the Department made it clear that they wanted patients with cancer to benefit from being able to make such

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5 C&AG's Report, paras 6–7; Q7

6 C&AG's Report, paras 2.14, 2.43; Qq 12, 72–74

7 C&AG's Report, para 1.13 and Figure 8

8 *ibid*, Figure 8

9 *ibid*, para 1.17 and Figure 8

10 *ibid*, para 1.13, Qq 103–104

11 C&AG's Report, paras 10, 1.18; Qq 8–11

decisions as much as other patients. The concept of choice may be meaningless, however, if meeting the two week referral target to see a cancer specialist is possible only at a limited number of hospitals. The Department has had extensive discussions with the NHS, and it had recognised that choice of hospital would not be appropriate for all services, and it included cancer services in this category. The Department considered rapid access to services as more important, though choice is important in cancer services and patients should be offered more choice about the treatment they receive, including choice of provider wherever possible.<sup>12</sup>

12. The NHS Cancer Plan announced increased funding for cancer, with an extra £280 million in 2001–02 rising to £570 million by 2003–04. Whilst funding for cancer is not ring-fenced, the results of a tracking exercise by the Department suggest that all of this extra money has been spent directly on cancer, including on new drugs, staffing and new services. All cancer networks have increased their expenditure on cancer quite considerably over the last three years, with the money allocated according to a revised formula to better distribute money to geographical areas according to need. The Cancer Plan also provided £50 million extra funding for specialist palliative care services, including hospices, provided through a central budget but with the local cancer network determining where the need is greatest at the local level.<sup>13</sup>

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12 Qq 94–95; Ev 16

13 C&AG's Report, para 1.10; Qq 1, 3–4, 40–42, 96–97

Figure 1: NHS Cancer Plan contents and key elements<sup>14</sup>

<b>NHS Cancer Plan contents and key elements</b>	
<p><b>Chapter 1:</b> The challenge of cancer            Good progress in recent years            Relatively poor survival rates            Inequalities in cancer            A postcode lottery of care            Poor patient experience            Meeting the challenge of cancer</p> <p><b>Chapter 2:</b> Improving prevention            New national and local targets to reduce smoking in disadvantaged groups            New local alliances for action on smoking            Support in primary care to help people quit smoking            £2.5 million for research into smoking cessation            National five-a-day programme to increase fruit and vegetable consumption            National School Fruit Scheme            Raising public awareness</p> <p><b>Chapter 3:</b> Improving screening            Routine breast screening to be extended up to age of 70 and available on request to women over 70            Improved breast screening techniques to increase detection rates            New ways of working            Improved cervical screening techniques            Colorectal screening pilots            The NHS Prostate Cancer Programme            Better understanding of screening</p> <p><b>Chapter 4:</b> Improving cancer services in the community            A central role for primary care in new cancer networks            £3 million in partnership with Macmillan Cancer Relief for a lead cancer clinician in each PCT            £2 million for palliative care training for district nurses            New primary care clinical dataset for cancer patients</p> <p><b>Chapter 5:</b> Cutting waiting for diagnosis and treatment            Range of waiting time targets, including: maximum two months wait from urgent GP referral to treatment for all cancers by 2005            Roll out of Cancer Services Collaborative to streamline services in all networks            Cancer the first priority for roll out of booked appointments            By 2004 every patient diagnosed with cancer will benefit from pre-planned and pre-booked care</p> <p><b>Chapter 6:</b> Improving treatment            Extension of guidance programme to all cancers            NICE appraisal of cancer to end postcode lottery of care            Establishment of specialist teams</p>	<p>Care of all cancer patients to be reviewed by specialist teams            Monitoring progress to achieve standards            National cancer datasets            Strengthening cancer registries</p> <p><b>Chapter 7:</b> Improving care            New supportive care strategy            NICE to develop guidance for supportive care            New training in communication skills            Improved information for patients            New Cancer Information Advisory Group            New internet resources for patients            £50 million extra for hospices and specialist palliative care services            New Opportunities Fund money for palliative care in deprived communities</p> <p><b>Chapter 8:</b> Investing in staff            Nearly 1000 extra cancer consultants            Increase in the number of specialist trainees            More cancer nurses, radiographers and other health professionals            More skills and new roles for cancer staff            Targeted training initiatives            Better planning for the future</p> <p><b>Chapter 9:</b> Investing in facilities            Substantial investment from New Opportunities Fund            Additional funding in NHS Plan for 50 MRI scanners, 200 CT Scanners and 45 linear accelerators            Modernisation of pathology services            First ever cancer facilities strategy            National audit of major cancer diagnostic facilities            New partnerships with the private sector</p> <p><b>Chapter 10:</b> Investing in the future: research and genetics            New National Cancer Research Institute            Additional investment in research infrastructure            Additional investment in prostate cancer research            Partnership with Macmillan Cancer Relief on genetic counselling</p> <p><b>Chapter 11:</b> Implementing the NHS Cancer Plan            Additional £570 million by 2003–04 for cancer services            Implementation of cancer service improvements by cancer networks            Cancer networks develop strategic service delivery plans            Network workforce, education and training and facilities strategies to underpin service delivery plans            Cancer networks commissioning pilots to be established</p>

Source: *The NHS Cancer Plan*

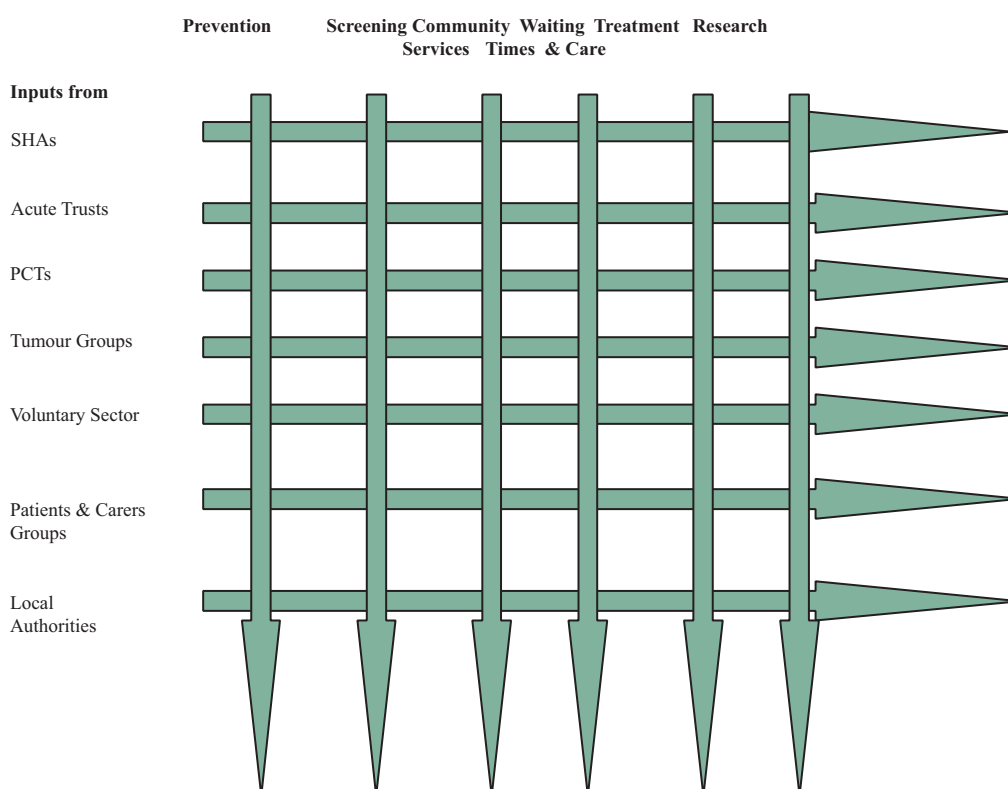
## 2 Making cancer networks work

13. In 1995, a report by the Chief Medical Officers of England and Wales to consider the direction in which cancer services should be developed recommended the establishment of cancer networks throughout England, bringing together all cancer services in a locality. The main impetus for cancer networks however came from the Cancer Plan, and by 2001 there were 34 networks comprising acute and primary care trusts, the voluntary sector, local authorities, a wide range of generic and tumour-specific working groups, and a patient and user group, coordinated by a network management team, **Figure 2**.

14. Accountable to Strategic Health Authorities, networks are responsible for coordinating expert clinical advice, management and local strategy, and working together to improve quality of care and address any inequalities in provision and access.<sup>15</sup>

**Figure 2: Cancer networks cross normal organisational boundaries<sup>16</sup>**

### Cancer network functions



15. There has however been delay in getting cancer networks fully up and running, due in part to NHS organisational changes. Three years after cancer networks were first established 30% of those visited by the National Audit Office had no comprehensive plans for the effective provision of cancer services in their locality. There were variations in the frequency with which progress against the Cancer Plan was monitored, and five of the 34

15 C&AG's Report, paras 1.7–1.8

16 *ibid*, Figure 5

cancer networks did not monitor their progress against the Cancer Plan at all. Networks cannot implement the NHS Cancer Plan effectively if they have no proper plans for doing so in the first place and if they do not monitor progress.<sup>17</sup>

16. To operate effectively cancer networks need to be appropriately staffed and resourced. The Department provided initial start-up costs, but beyond that networks obtain resources from their primary care trusts. Over the last few years there has been variation in how well networks have been supported by the local NHS, and some do not have the appropriate level of resources.<sup>18</sup>

17. Network management teams' core members comprise a lead clinician, lead nurse, lead manager and a service improvement lead. Other positions are at the discretion of individual networks. Some networks are carrying vacancies for key team members such as lead manager and lead nurse, and the staffing of other posts is clearly proving to be a challenge with, for example, a quarter of lead pharmacist positions unfilled (**Figure 3**).<sup>19</sup>

**Figure 3: Created positions within cancer networks are not all filled**

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

Source: C&AG's Report, Figure 13

18. Cancer networks have helped improve cancer services in England, including through planning for the introduction of new drugs across the network and developing plans for funding specialist palliative care. Some networks are not as effective as others, however, and the Department has announced that it is putting in place a formal performance management model under which strategic health authorities will be responsible for ensuring networks operate effectively, including assessing their level of resources.<sup>20</sup>

19. Primary care trusts, as budget holders, are responsible for commissioning cancer services. Funding is allocated to primary care trusts, which are responsible for looking after the health needs of their whole area, and they fund cancer services and their local facilities according to how they see the local needs within a national framework. There can be up to a dozen or so primary care trusts in an individual cancer network, and therefore joint commissioning, based on expert input from cancer network management teams, should be the norm. Primary care trusts were established shortly after cancer networks, and the relationships between them are continuing to develop. Many networks benefit from a

17 C&AG's Report, paras 2.32, 2.39; Q 78

18 C&AG's Report, para 2.29; Q 13

19 C&AG's Report, para 2.28

20 Q 13

network-wide approach to commissioning, but in others primary care trusts continue to commission in isolation, with the risk that cancer priorities identified by the network are not addressed, to the detriment of patient outcomes.<sup>21</sup>

20. Some primary care trusts find the commissioning process difficult, though in some parts of the country commissioning already works well. Some individual SHAs noted that the commissioning process was disjointed and unsatisfactory. The Department agrees that there is a learning process for primary care trusts, and that the networks need strengthening in this respect. Strategic Health Authorities will need to address this issue quickly, under the formal performance management model the Department is putting in place.<sup>22</sup>

21. Some organisations within networks do not co-operate as closely as they might with others (**Figure 4**). For example, a third of networks have at best adequate relationships with primary care trusts which provide their funding, and two-thirds of networks have poor or very poor relationships with local authorities. The Department expects that local authorities will become more important partners in cancer networks in coming years as cancer patients need more social care support, but recognises that they are not at present engaging fully with the network as a whole.<sup>23</sup>

22. The position is also complicated by the establishment of NHS Foundation Trusts and independent sector treatment centres. There are opportunities for them to bring benefits to NHS cancer services. On the other hand their freedom will put even more weight on the need for effective partnership working and collective decision making. The Department has stressed that there is no evidence that NHS Foundation Trusts are having a destabilising effect on cancer services, pointing to several NHS Foundation Trusts that have publicly affirmed their commitment to cancer networks. Foundation Trusts are part of cancer networks, and they have a duty to work with others. It is unclear however what the duty of co-operation between organisations in cancer networks means in practice, and concerns have been raised by primary care trusts and by cancer network management teams.<sup>24</sup>

**Figure 4: Assessment of relationships with constituent organisations**<sup>25</sup>

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

21 C&AG's Report, paras 2.34–2.35

22 *ibid*, para 2.37; Qq 75–76

23 C&AG's Report; Q 68

24 C&AG's Report, paras 15, 2.44; Qq 11, 84

25 C&AG's Report, Figure 12

### 3 Addressing inequalities of cancer incidence, treatment and the patient experience through the Cancer Plan

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23. Cancer mortality varies widely within England, with higher rates in areas with high levels of deprivation.<sup>26</sup> For each of the four major cancers – breast, lung, colorectal (bowel) and prostate – there are considerable variations between strategic health authorities. Mortality and survival rates consistently favour London and the South of England<sup>27</sup> as follows.

- There was a gap in the levels of survival rates during the 1990s of about 6% between the least and best off in society for breast, colorectal and prostate cancer. Research also suggests that while survival rates are increasing for all in society, they were increasing faster for the more affluent in society prior to the introduction of the Cancer Plan.
- Breast cancer mortality rates vary by 20% across SHAs in England, and survival rates are lowest in northern regions and highest in the South.
- The highest mortality rate for lung cancer across SHAs is twice that in the SHA with the lowest rate, reflecting the prevalence of smoking which is closely linked to deprivation. Survival rates for lung cancer are low everywhere but are worse in the former Northern & Yorkshire region than in the London region.
- For bowel cancer, some SHAs with the same number of cases per 100,000 of their population have noticeable differences in mortality, and more affluent areas have better survival rates.
- The proportion of those with prostate cancer alive five years after diagnosis is around ten percentage points lower in the former Trent and Northern & Yorkshire regions, than in London and the former South East regions.

24. Other inequalities also exist. For example, whilst encouraging progress has been made in most aspects of patients' experience of cancer services, prostate cancer patients have a worse experience than those with other cancers, and patients' experience of services in London remains less positive than elsewhere in England for all types of cancer.<sup>28</sup>

25. The causes of these patterns are complex and involve life style habits such as smoking, the readiness of patients to seek advice quickly when symptoms appear, as well as the effectiveness of NHS cancer services in providing screening, diagnosis and treatment. Cancer death rates are falling both for more affluent people and for poorer people, and are

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26 C&AG's Report, *Tackling cancer in England: saving more lives* (HC 364, Session 2003–04), para 1.5. Further analysis published after the Committee's hearing is contained in *Office for National Statistics, Cancer atlas of the United Kingdom and Ireland 1991–2000*, July 2005

27 C&AG's Report, *Tackling cancer in England: saving more lives* (HC 364, Session 2003–04), Figures 13–20

28 C&AG's Reports, *Tackling cancer: improving the patient journey* (HC 288, Session 2004–05), paras 6, 13; *Tackling cancer in England: saving more lives* (HC 364, Session 2003–04), paras 12–13

falling roughly in parallel. There is however a higher death rate from cancer in poorer people mainly due to smoking, which causes about one third of all cancer deaths, and diet. The Department's aim is to accelerate the decline in mortality rates, particularly in the more deprived groups, by addressing issues such as smoking and late presentation by patients to their GPs with cancer symptoms.<sup>29</sup>

26. There are important challenges to be faced in ensuring that deprived areas of the country receive the cancer services that are necessary to address any inequalities. The Cancer Plan covers smoking cessation services, and 'Stop Smoking' services have been targeted particularly at deprived areas which have high smoking rates. Those areas now have the highest quit rates in the country. Patients generally in England tend to have more advanced cancer at the time of diagnosis than in other European countries and people from deprived groups in England are most likely to delay seeking medical advice. The Department has an innovative programme with the Health Communities Collaborative, and is taking a number of different approaches to inform people of cancer symptoms, including for skin and breast cancer.<sup>30</sup>

27. The National Institute of Clinical Excellence has recently issued best practice guidance for primary care teams to refer patients with suspected cancer to specialist services on the basis of their symptoms. The best practice material includes information to help people with suspected cancer, their family and carers to understand the full guidance and contains details of which symptoms indicate immediate, urgent and non-urgent referral.<sup>31</sup> In France, patient information about the signs and symptoms of cancer is widely provided on cards as part of a campaign to get patients to present earlier.<sup>32</sup>

28. There are also variations in the availability of cancer drugs, which are subject to an important commitment in the Cancer Plan. NICE appraises drugs for use within the NHS which should then be prescribed to patients whenever clinically appropriate. While improvements have been made, unacceptably wide variations in usage of NICE approved cancer drugs persist between different parts of the country. The use of the drug herceptin for metastatic breast cancer in the 6 month period 12 to 18 months following NICE approval in early 2002 ranged across cancer networks from 90% to under 10% of eligible women.<sup>33</sup>

29. In 2004 the Department looked at all 16 cancer drugs appraised by NICE and reported to the Secretary of State on variations across the country; largely caused through staffing and capacity issues. Recommendations to promote the rapid uptake of cancer treatments recommended by NICE were accepted and are now in the course of being implemented.

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29 C&AG's Report, *Tackling cancer in England: saving more lives* (HC 364, Session 2003–04), para 12; Q 14

30 Qq 14, 16–21

31 National Institute for Clinical Excellence, *Referral Guidelines for Suspected Cancer, and Information about NICE Clinical Guideline 27*, July 2005

32 NICE Evidence to the All-Party Parliamentary Group On Cancer, *Inquiry into national standards and local autonomy: the impact on cancer care in England*, 2004.

33 C&AG's Report, Figure 8; C&AG's Report, *Tackling cancer in England: saving more lives* (HC 364, Session 2003–04), paras 2.85–2.86, and Figure 39; Qq 53, 65

The Department believes that unacceptable variations should therefore be addressed whilst allowing some room for professional differences of approach.<sup>34</sup>

30. Under the Cancer Plan, networks have facilitated the development of multi-disciplinary teams, as required by the Department's Improving Outcomes Guidance for cancer. Multi-disciplinary team working brings together staff with the necessary knowledge, skills and experience to ensure high quality diagnosis, treatment and care. It also improves the co-ordination and continuity of care for patients. Multi-disciplinary team working is now well embedded in the NHS, though it is demanding of staff time.<sup>35</sup>

31. For the patient, support groups are an important source of information, advice and peer group support following their discharge from hospital. The National Audit Office found overall however that around 40% of cancer patients were not given information about relevant cancer support or self-help groups. While some 70% of breast cancer patients were given information about support groups, this was the case for only about a third of prostate cancer patients. This discrepancy in part reflects the fact that networks of support groups are better developed for some types of cancer than for others.<sup>36</sup>

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34 Department of Health Note, *Implementing NICE Guidance*

35 C&AG's Report, paras 14, 6.7–6.11

36 C&AG's Report, para 1.11; C&AG's Report, *Tackling cancer: improving the patient journey* (HC 288, Session 2004–05), Figures 50, 54; Qq 33–34, 90

# Formal minutes

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**Monday 19 December 2005**

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon  
Greg Clark  
Mr Ian Davidson  
Helen Goodman

Mr Sadiq Khan  
Sarah McCarthy-Fry  
Jon Trickett

Draft Report (The NHS Cancer Plan: a progress report), proposed by the Chairman, brought up and read.

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

Paragraphs 1 to 31 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

*Resolved*, That the Report be the Twentieth Report of the Committee to the House.

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

*Ordered*, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned until Wednesday 11 January at 3.30 pm

## Witnesses

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**Wednesday 23 March 2005**

*Page*

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

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Second Report	The regeneration of the Millennium Dome and associated land	HC 409 ( <i>Cm 6689</i> )
Third Report	Ministry of Defence: Major Projects Report 2004	HC 410 ( <i>Cm 6712</i> )
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Sixteenth Report	Home Office: Reducing vehicle crime	HC 696
Seventeenth Report	Achieving value for money in the delivery of public services	HC 742
First Special Report	The BBC's investment in Freeview: The response of the BBC Governors to the Committee's Third Report of Session 2004–05	HC 750
Eighteenth Report	Department for Education and Skills: Improving school attendance in England	HC 789
Nineteenth Report	Department of Health: Tackling cancer: improving the patient journey	HC 790
Twentieth Report	The NHS Cancer Plan: a progress report	HC 791

The reference number of the Treasury Minute to each Report is printed in brackets after the HC printing number



# Oral evidence

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## Taken before the Committee of Public Accounts

on Wednesday 23 March 2005

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Allan  
Mr Frank Field  
Jim Sheridan

Mr Gerry Steinberg  
Mr Alan Williams

**Mr Tim Burr**, Deputy Comptroller and Auditor General and **Dr James Robertson**, Director, Health Value For Money, National Audit Office, further examined.

**Ms Paula Diggle**, Second Treasury Officer of Accounts, HM Treasury, further examined.

### REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

#### THE NHS CANCER PLAN

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

**Q1 Chairman:** Good afternoon. Welcome to the Committee of Public Accounts. We are returning to the Cancer Plan. We had one session on cancer on Monday. It is the second session today and we are joined once again by Sir Nigel Crisp, who is the Chief Executive of the NHS and Permanent Secretary of the Department of Health, and Professor Mike Richards, who is the National Cancer Director. Thank you very much for coming back. You told me on Monday, Sir Nigel, that you had spent all the additional money that you had received for cancer services for 2003–04. Would you please reassure me what proportion of that money has ended up in the front line—doctors, nurses, equipment, drugs?

**Sir Nigel Crisp:** I think we are talking about two questions there. You were first of all, I think, referring to *The Sunday Times* and its assertions about where money was going. If you look at where the money is going we are spending a significant proportion of it on staff, which is the front line by definition within the NHS. That is what *The Sunday Times* article was implying, that spending it on staff was not the front line, which was an odd argument. In terms of the Cancer Plan, we are confident, as this document says (and I think the wording from the NAO is slightly cautious), that the early indications are that we have spent the amount of money that we said we would on cancer, and that is directly on cancer. That is not about overheads; that is in terms of being spent on the services.

**Q2 Chairman:** It would be quite helpful if we could have a note with a detailed breakdown of this, particularly your point about staff, or maybe you can answer this point now. People refer loosely to staff, to managers, nurses, doctors. It would be helpful if you could shed light on this particular debate.

**Sir Nigel Crisp:** Let me answer it on the whole NHS. We did indeed yesterday, I believe, publish the latest staff census which showed a big increase in doctors and nurses and staff in the caring role in the NHS last year. 86% of staff in the NHS had a direct role in hands-on care of patients. The number of managers is slightly under 3% now, which is a very small proportion compared to private health care, or indeed compared to other industries. Those figures are available and were put out yesterday.

**Q3 Chairman:** We are talking about the Cancer Plan now. Perhaps you can give us the figures that relate to both total numbers and increases.

**Professor Richards:** In terms of cancer, the commitment that we gave was that by 2003–04 we would be spending an extra £570 million per annum on cancer against the baseline in 2000–01. What we have done is to ask the 34 cancer networks to give us information on their new expenditure on cancer. They have broken that down into the new drugs for cancer, staffing and new services for cancer. What we can say at this point is that we are confident that we will have got to and exceeded the £570 million for cancer. We are asking the individual networks to validate the figures at the moment and that is why we are not in a position to give you a final result, but I hope that very soon we will be in a position to have those final results and there has always been a commitment that we will put that in the public domain.

**Q4 Chairman:** The £570 million you refer to is referred to in the Report at paragraph 1.10 on page 10, and you refer to the cancer networks. Please reassure me that they are receiving according to need and the money is being spent effectively.

**Professor Richards:** One of the things that we will be able to tell when we have validated the figures is how much is being spent in each of the 34 networks. I am

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not yet in a position to give you those figures but we know that all networks have increased their expenditure on cancer quite considerably over the last three years.

**Q5 Chairman:** It was not quite what I asked you. I asked you whether they had received according to need, and I also want to know whether they can spend the extra money you are giving them.

**Professor Richards:** They are spending the extra money that we are giving them on cancer and the other area that we have specifically invested in—

**Q6 Chairman:** Let us tidy it up a bit more. They can all use the extra resources effectively?

**Professor Richards:** That is what they are telling me, that they are using the extra resources.

**Q7 Chairman:** That is fine. There is a reference in paragraph 2.10 on page 22 to Scotland. Unlike in Scotland apparently in England we do not have any estimate of the future cancer burden in our Cancer Plan. Surely this is quite important, is it not?

**Professor Richards:** When we were preparing the Cancer Plan we took account of what we knew to be the trends for cancer in England in broad figures. If you take all cancers together the numbers are going up by 1.5% per annum. That is very largely because we have an ageing population and cancer is predominantly a disease of the second half of life. At that point we did not need more detailed estimates because frankly we knew we had a catching-up job to do. That meant that we needed to invest in staff, in machines, in getting these networks working, and so at that point to do detailed planning 10 years ahead was simply not necessary. I think we are getting to the point now where we need to look in more detail. We also did a lot of work at the time of the Cancer Plan looking at individual cancers to look at the projected death rates through to 2010 but, although that is not in the plan, it was part of our preparation for the plan.

**Q8 Chairman:** Let us get down to key point which is about targets. There is reference early on in the Report at page 3, paragraph 10, to these two key targets that the public really care about: one month maximum from diagnosis to treatment and two months maximum from urgent referral to treatment. There is again reference to this on page 15 of the Report, so this is an absolutely vital target that you have to meet.

**Professor Richards:** Yes.

**Q9 Chairman:** The NAO says that these pose significant challenges, which I am sure they do.

**Professor Richards:** Yes.

**Q10 Chairman:** I have to ask you and tie you down, Sir Nigel: yes or no, are these targets going to be met?

**Sir Nigel Crisp:** Yes.

**Q11 Chairman:** What more could we ask for? Thank you very much. If you now look at page 27, paragraph 2.44, there is reference there to

foundation trusts, and of course we have got foundation hospitals and we have got independent sector treatment centres. Are you certain that they are all going to co-operate fully in your cancer networks?

**Sir Nigel Crisp:** Let me approach this from two points. One is that I have no doubt that, as we develop our planning and contractual arrangements, we will require people providing cancer services to be part of cancer networks because we believe that is the way in which you provide quality, so they will not get paid for patients who are not being treated as part of cancer networks. The second point is that foundation trusts have a duty of partnership to work with others and a number of them have announced that they want to do this in any case, so I do not think this is going to be a problem. The only issue—and I have very recently talked to network managers about this—is the one that we have anyway, which is that with the number of organisations co-operating there are always going to be some negotiations and tensions within it, but I am confident that if foundation trusts are going to remain in the business of providing cancer services for NHS patients they will have to be part of networks.

**Q12 Chairman:** This plan lasts until 2010, quite a long time. The NHS will be very different by 2010. How are you going to update your plan?

**Sir Nigel Crisp:** We are almost halfway through this 10-year period, as you say. Again, there is a recommendation that we need to look at how we should update it. We have not yet taken a decision as to whether we want to merely issue some updating of some parts of it (I am assuming you are thinking about the period from now to 2010 rather than beyond) or whether we want to do a whole refresh of the plan. I am inclined to think that we will probably go for the first one of those and identify those areas that need updating and update them, but the decision has not been taken yet as to exactly how we will do it. It is midway through and we shall certainly review it.

**Q13 Chairman:** I have a last question on resources. Can I refer you please to page 25, paragraph 2.29? Four of the 10 cancer networks who were visited by the National Audit Office said that the level of resources that they had to do their job was poor. I would like to ask you whether you are reviewing if this applies to other networks and what you are doing about it.

**Sir Nigel Crisp:** This is an issue and we know it is an issue. What you can see around the country is some variation. We provided some start-up costs for networks and said broadly how we wanted them to work. We provided some support and some co-ordination. Networks work best when they are fully embedded in the local NHS because there are very few hospitals, for example, that do not provide some kind of cancer service and therefore the network needs to reach everywhere. What has clearly happened over the last few years is some variation in how they have been supported by the local NHS.

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What we are going to do? This is entirely coincidental timing but I put out a paper last week about how we are going to manage networks more generally in the NHS and we will be expecting SHAs to be responsible for ensuring that networks operate effectively. We are putting them into a formal performance management model and part of that will require assessment of whether they have got the resources there, but I accept that at the moment some of them do not.

**Q14 Mr Field:** We published a Report earlier called *Saving More Lives* and that showed that the poorer you are the worse the outcome. How long do you think it will be, if you think it is a realistic objective, before we will be able to report that poor people have the same outcome if they are affected by cancer as richer people?

**Sir Nigel Crisp:** I think we discussed this to some extent at one of the earlier PAC meetings but can I ask Professor Richards to pick it up?

**Professor Richards:** What we know is that cancer death rates are falling both for more affluent people and for poor people, and they are falling roughly speaking in parallel. What we are trying to do is accelerate the decline, particularly in the more deprived groups. The issue there first of all is smoking. We have got some good news on that, which is that the Stop Smoking services have been targeted particularly at those areas which have high smoking rates, which are the more deprived areas, mostly in the north of the country, and they have the highest quit rates of the country. Places like Hartlepool, Easington, Liverpool are among the star performers on that. Equally, what we need to do is try to get patients, when they do develop symptoms, to come forward quickly and we know that that is an issue again in more deprived groups. They are more likely to delay seeking medical advice and we have an innovative programme that we are working up with the Healthy Communities collaborative to try to get those messages through to people in the community about what the symptoms are of cancer and what they need to do about it when they get them.

**Q15 Mr Field:** When Sir Nigel was asked by the Chairman whether the targets about the length of time from diagnosis to treatment beginning would be met, the Chief Executive very confidently said yes. To what extent, if those targets are met, would that begin to reduce the difference between rich and poor, and to what extent are they the other issues which you have already touched upon?

**Professor Richards:** To be quite honest, I think the differences between rich and poor are not in those waiting times. With regard to those waiting times, from the time that people get into the system to being referred onwards, I am not aware of any evidence that there is a difference between rich and poor there. It is the wait before they go to see a GP which tends to be longer for more deprived people, as indeed are the smoking rates higher. The two are separate. They are both important. We need to tackle the wait after people have been referred, and I agree with Sir Nigel

that we have to do that by the end of this year and get that cracked, but we also need to look at the earlier period.

**Q16 Mr Field:** You seemed to be suggesting earlier that it may be that poorer people are less aware of what the symptoms might be. I have to say that I have not gone around Birkenhead trying to Hoover up information but I have never seen a piece of information anywhere in a doctor's surgery or in a public building which would tell me what the symptoms are, so what is the campaign?

**Professor Richards:** There are a number of different approaches being taken. You may have read in the paper today about the information on skin cancer and the Sun Smart campaign that is being run by Cancer Research UK but funded by the Department of Health. That is £400,000 funding over three years and this is the beginning of the second year of that programme. That is one example.

**Q17 Mr Field:** The data shows that poorer people are less inclined to get skin cancer, are they not?

**Professor Richards:** They are less inclined to but—

**Q18 Mr Field:** So it is a campaign which is not aimed at them.

**Professor Richards:** No, but they may be more likely to delay seeking medical advice and that is extremely important in skin cancer in terms of what the outcome is likely to be. The evidence in breast cancer, for example, again is that it tends to be the elderly and the relatively poorer people who are more likely to delay before they seek medical advice. One of the things that we did shortly after the Cancer Plan was published was to commission research in this area, and one of the reasons we have not been able to take it forward faster is that we needed to wait for that research to find out what people did and did not know so that we could plan our campaigns most effectively. That research has now come in. We held a workshop on it just over a month ago and we are now planning the campaign in order that we can target the right people in the community, who are the poorest people and the elderly.

**Q19 Mr Field:** When you refer to an example of the differences on breast cancer does the approach differ from younger women in my constituency compared with pensioners on screening?

**Professor Richards:** Yes. The situation with breast cancer is that there is a lot of misinformation about at what age people are most likely to get breast cancer. Partly that is because if you look at the media or listen to any soap opera, they tend to give breast cancer to people aged 30 or 35 which, although it can happen, is very unusual, whereas breast cancer is much commoner in women over 50 and in fact is commoner over the age of 70. That is a message that we need to get through to the public and we now know that it is something that the public do not fully understand and that will be part of our campaign.

**Q20 Mr Field:** So will part of the campaign to be automatic screening for older women over 70?

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**Professor Richards:** One of the things that we have done is extend the breast screening programme, which used to end for routine invitations at 64, up to 70; that has been done over the past four years. That is a massive increase in the screening workload; it is about a 40% increase, and we have had to get more staff, such as trained radiographers to report on mammograms. That is a very innovative programme, and that is already having a major impact. Over the last two years the number of cancers detected through the breast screening programme has gone up by almost a quarter and we can be confident that that will translate through into better survival rates because these are small cancers that are being picked up.

**Q21 Mr Field:** But you suggested a moment ago that the chance of getting breast cancer was greater over 70 but your programme stops at 70.

**Professor Richards:** The evidence supporting breast screening over 70 is very thin indeed. We took the decision to extend it up to 70 but I think we do now need to review that and look again to see whether we should go on beyond 70. Equally, it is a question of what messages we give to people when they have come to their final screen about the fact that they still need to be aware of their own breasts and still need to be aware of symptoms and, on top of that, that they are eligible to come back for screening at their own request at three-yearly intervals should they wish to. That has always been the case but not many people take that up.

**Q22 Mr Field:** You denoted to me three main categories as the causes of cancer. One was about income and background, one was the effectiveness of treatment and one was about awareness. The income one was related to whether people smoke or not, what they do with their lives. I just wondered whether you would be able to provide the Committee with a note, if we were looking at survival chances, about to what extent you could in a loose way blame the person for how they treat themselves, which was one of the factors you located, compared to how important the other two factors were that you located for us.<sup>1</sup>

**Professor Richards:** To a certain extent this was covered in the first NAO Report. It matters critically whether we are looking at the death rate or the survival rate, and they are separate. If you look at the death rates from cancer, which are obviously affected by how many people get the disease as well as how well they do once they have got the disease, there is no doubt at all that there is a higher death rate from cancer in poorer people. The single largest contributing factor for that is smoking. Secondly, it is almost certainly diet, so these are the two factors in terms of their lifestyle and whether they are likely to get cancer. There is also the fact that once they have got cancer they have less good survival rates. That is almost certainly largely due to the fact that

they may present to doctors later when their disease is more advanced and that obviously is a problem in terms of being able to cure and treat it.

**Mr Field:** Both you and Sir Nigel kept saying, "This came up in our last report". We are discussing today a progress report on the Cancer Plan and my constituents' lives do not easily fit into the reports that we necessarily do.

**Q23 Chairman:** A fair point.

**Professor Richards:** I agree with that.

**Q24 Jim Sheridan:** I apologise in advance if some of my questions are repetitive in the sense that I missed the previous session. Following on from what Mr Field has already said about poor and deprived areas, has there been any assessment carried out of what the impact would be on cancer related deaths of a smoking ban in this country?

**Professor Richards:** The first thing to say about smoking is that it causes about one third of all cancer deaths. We know there are a number of different things that you can do to reduce smoking in the population and we have a very comprehensive tobacco control strategy that includes things like raising taxation, media campaigns, labelling of cigarette packets, the Stop Smoking services, banning advertising, on top of which banning smoking in public places is another important factor. They are all factors. Interestingly, I was recently shown a European study that had looked at tobacco control strategies in 28 European countries. This was an independent study looking at which ones had the most effective strategies. The UK came second out of 28 countries with only Iceland ahead. In general terms therefore I think we can be said to have an effective tobacco control strategy. I have made it perfectly clear in the past and I will make it clear again that I would support a complete ban on smoking in public places because I think that would protect the public and encourage smokers to give up.

**Q25 Jim Sheridan:** A complete ban in all public areas?

**Professor Richards:** All enclosed public places. That is my own advice and the Chief Medical Officer has made it clear that that is his advice as well, but clearly politicians have to take political decisions.

**Q26 Jim Sheridan:** Again focusing on some of the more deprived areas, smoking is just one aspect of cancer. There is another major aspect of cancer and that is industry related-diseases. Here I am talking about asbestos-related diseases of which millions of people have died and yet most of the people who have died depended on charity organisations giving them information and advice as opposed to the government or established bodies. Why is that?

**Professor Richards:** Asbestos-related diseases are important. In terms of cancer, the cancer that asbestos causes is called mesothelioma and that currently causes about 1,800 deaths a year in the UK. That number is still going up and will peak at about 2,100 in a few years time according to the latest estimates. That is because that is related to

<sup>1</sup> Ev 16

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asbestos exposure 30 years or more ago and it is a cancer that takes a very long time to develop. We are working hard through our 34 cancer networks to make sure that services available for people when they do get mesothelioma are as good as they possibly can be. It is a very difficult cancer to treat. It is a cancer that has a lot of problems in terms of pain, breathlessness and fatigue. It is a very nasty cancer.

**Q27 Jim Sheridan:** In a lot of industries, the shipbuilding industry, for instance, I have seen people die of this horrible disease, not only the people who worked in the industry, but their families as well were very distressed. What I find really frustrating from my point of view is that people who are diagnosed as having asbestosis-related diseases are now depending on a charity to advise them and give them information about benefits, about how to claim compensation. Why is there not a government department which deals with that, or is there a government department that deals with that?

**Professor Richards:** We work very hard with the charities, with the British Lung Foundation and a whole range of other charities. There was a summit on mesothelioma just a couple of weeks ago at which I was the invited speaker from the Department of Health, and we all agreed that we needed to work more closely together on this. We are doing so. We have an advisory group at the Department of Health, which I chair, which brings together the charities interested in both lung cancer and mesothelioma with people from the NHS as well in order that we can make sure that for the cancer-related diseases and asbestos we do as well as we possibly can.

**Q28 Jim Sheridan:** Where was the summit you have just referred to held and how were people expected to get there? What was the cost of the conference? Usually those will just be for professionals or consultants to have a blether amongst themselves.

**Professor Richards:** It was held in central London.

**Q29 Jim Sheridan:** As usual. How many shipyard workers or engineering workers work in central London?

**Professor Richards:** Not very many, but there were representatives there from trades unions, there was really quite a large number of widows of people who had had mesothelioma.

**Q30 Jim Sheridan:** How many charities were there?

**Professor Richards:** I cannot remember the number of charities but there were several charities and one of the things that they were doing was agreeing amongst themselves that they should work more closely together on this and also that they wanted to work with me and the Department of Health on this.

**Q31 Jim Sheridan:** How many representatives of those who have suffered from asbestosis were at the summit?

**Professor Richards:** I cannot give you a number. There were quite a number of people who had been directly affected, mostly, it has to be said, as widows, because, as you know, people who have got the disease are often very ill and the length of time that they survive is often quite short, so it is not surprising there were not very many of them at the meeting.

**Q32 Jim Sheridan:** So was the question of benefits discussed at this summit and how best to impart that information?

**Professor Richards:** It certainly was.

**Q33 Jim Sheridan:** How are you going to do it?

**Professor Richards:** This is where we need to work very closely with the cancer teams across the country, the teams that look after lung cancer and mesothelioma. They need to be the first port of call, of saying, "These are the people you need to go and deal with". They need to be able to signpost people to benefit services through Citizens' Advice Bureaux and through other services as well. For example, in my own hospital, St Thomas's, we have an arrangement where people from the Citizen's Advice Bureau come and do sessions in the hospital so that patients who have got conditions like that can get excellent advice straight away.

**Q34 Jim Sheridan:** You will be aware therefore of the Macmillan Better Deal campaign. Is that a campaign that you wholeheartedly support?

**Professor Richards:** We mentioned this on Monday and it is a campaign that I strongly support. Again, on Monday we acknowledged that in the past I do not think the Health Service has done well enough in terms of signposting people to the services they need in order to make sure they get their financial benefits.

**Q35 Jim Sheridan:** I have to say that I still remain unconvinced because even in this day and age people who have suffered injuries as a result of industrial diseases, as a result of carrying out their everyday work, are still now dependent on charities to advise them. I still find that somewhat frustrating. Why is money given to the Primary Care Trusts as opposed to giving it directly to the cancer networks?

**Sir Nigel Crisp:** Because that is how we distribute money in the NHS. We give it to the local body that has responsibility, which is what Primary Care Trusts do, for looking after the health needs of their whole area. Therefore they get the money and therefore they need to make decisions which, as you very rightly said just now, will depend on the health needs of the local population, and they take that overview which will include cancer but will also include services other than health.

**Q36 Jim Sheridan:** Surely the cancer networks are best placed to decide where that money should be spent?

**Sir Nigel Crisp:** Cancer networks only look at cancer whereas PCTs look at the health of the local population which goes much wider than that and that is the process that we use to try and get local

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decision-making related to local needs. As part of that they obviously fund cancer networks but, more importantly, in funding cancer networks they fund cancer services and their local facilities according to how they see the local needs within a national framework of which Professor Richards is the director.

**Professor Richards:** It is also very important to say that Primary Care Trusts are part of the networks, that the networks are partnerships between the organisations which hold the purse strings, the primary care trusts, and those that are providing the services, the acute trusts, the foundation trusts, etc, and so the Primary Care Trusts are part of those networks. The body that brings them together is the network and so through the network they do their planning for cancer and then the Primary Care Trusts determine what funding is then needed to make sure that they achieve the national standards.

**Q37 Jim Sheridan:** Again, from my own experience one of the imponderables of life is the work that local hospices do and if the National Health Service are to pick up the bill or the tab for carrying out the work that hospices do. They are mainly staffed by volunteers and charities. A personal frustration of mine is the National Insurance that hospices have to pay. I have been campaigning for that to be removed. Would you support any campaign for that or is that a legitimate argument, for hospices to be excluded from these payments?

**Professor Richards:** What we have said is that we recognise that the voluntary sector, the hospices, are shouldering too much of the financial burden of hospices. That is in the Cancer Plan and that is why the Government made a commitment in the Cancer Plan to provide £50 million extra for specialist palliative care services, including the hospices, and that has been done through a central budget but with the local cancer networks determining where the need was greatest at the local level. They submitted their plans for how they wanted to spend the money and a committee, including the voluntary sector, then adjudicated on those plans. The money has been given out and I can assure you that the money has got through to the front line.

**Q38 Jim Sheridan:** I am not denying for a minute that the money has got through. What I am saying is that people go out collecting in cans and having jumble sales, whatever it may be, and that money just goes back to the Chancellor of the Exchequer.

**Professor Richards:** In terms of what those arrangements are, that is beyond the Department of Health. That is more a matter for the Treasury. Having said that, I support more money going to hospices. They do an extremely valuable task and the Department of Health has put more money into that, which of course has come from the Treasury, if you like, so it comes from the taxpayer.

**Q39 Mr Steinberg:** I have got to say, Sir Nigel, that this Report was a huge disappointment to me. It is probably my last Committee of Public Accounts and I was fully hoping that I could really put you under

pressure for the last meeting as something to remember me by, but I have to say that this is probably the best Report that I have read in the last five or six years that I have been a Member of this Committee, so I am not going to be able to do that. The more I read the Report the more I looked to see what I could have a go at and there was very little. This Committee is never very political but I have to say I was rather proud when I read this Report of the achievements that we have made over the last seven or eight years. I think anybody who denies the fact that this is being well and truly handled now is very churlish. Everybody on this Committee knows that where criticism is due I am quite happy to give that criticism, so it is good job we are not talking about the CSA or helicopters or something like that this afternoon when I could have gone out on a really good note. The Report is a first-class Report. Can I just follow on from what Jim said? He questioned you on the allocation of resources to the PCTs and the cancer networks. I was not certain whether that money went via the PCTs or straight to the networks. Clearly it goes straight to the PCTs and not to the networks. Is this money on top of money that the PCTs would have got anyway for dealing with cancer, or anything else for that matter?

**Sir Nigel Crisp:** Can I make two responses to that? First, I very much appreciate your comments about this Report. It is very significant that we have had Professor Richards dealing with this for the last few years and this is due to an enormous amount of work by a number of people, including several behind me, from around the NHS. A great deal of effort has gone into this, as indeed you know. On the PCTs, this is the money that goes out to PCTs. As again I am sure you know, we want to make sure that we have got as much as we can of the money that is voted to the NHS going to the local community so they make the decisions.

**Q40 Mr Steinberg:** Is this money ring-fenced for cancer?

**Sir Nigel Crisp:** No. A very small amount is ring-fenced.

**Q41 Mr Steinberg:** That is disappointing.

**Sir Nigel Crisp:** We are working on the outcomes, not on the inputs. We measure them on things, as the Chairman asked me, such as waiting times.

**Q42 Mr Steinberg:** In the Report there are the usual remarks that they do not get enough resources and you always expect to get remarks like that from the National Health Service. Could it be argued, if that is the case, that some PCTs, if it is not ring-fenced, are not passing it down the line and it could be spent on something else?

**Sir Nigel Crisp:** Over the period of this plan we changed policy slightly. We started off at the beginning of the NHS plan allocating direct sums and ring-fencing them so we did ring-fence some additional money for cancer. In the next spending round we decided it was better to give as much

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money as possible to the local community so that they made the decisions but we nevertheless have indicative amounts of money—

**Q43 Mr Steinberg:** Would you name and list those PCTs who are receiving the extra money for cancer networks and are not using that money where it was intended to be spent?

**Sir Nigel Crisp:** As Professor Richards said a moment ago, he is going to be producing a report on how the extra money has been spent, because it is £570 million on top—

**Q44 Mr Steinberg:** That is not quite what I am asking though, is it?

**Sir Nigel Crisp:**— and that will undoubtedly identify the areas.

**Q45 Mr Steinberg:** When will that be published?

**Sir Nigel Crisp:** Not at PCT level. It will identify it at cancer network level, which covers a number of PCTs.

**Q46 Mr Steinberg:** But if the cancer networks are not getting the money from the PCTs how can you then blame the cancer networks?

**Sir Nigel Crisp:** I am not sure we are blaming anyone on this particular thing.

**Q47 Mr Steinberg:** What I want to know is which PCTs are not handing down the money that they are supposed to hand down? Could we have a list of those PCTs?

**Sir Nigel Crisp:** I do not think we break down PCT expenditure by cancer. We break it down at the larger level, ie, at the cancer network level.

**Q48 Mr Steinberg:** In terms of spending the money, and again Jim touched on this, you could get a load of money and you could spend it, as you think, very wisely but at the end of the day you might not be doing that because, for example, you could have X amount of new scanners and not have the staff to use those scanners. Have you got any evidence to show that they know how they are spending the money and if they are spending it wisely?

**Sir Nigel Crisp:** Part of Professor Richards' role as the National Cancer Director is supervising the activity that is going on across the entire country. The plan is trying to knit together all the features you need to get a really good cancer service. He does have a supervisory role and an oversight of all of that, but perhaps he could give you the level of detail he will be able to produce.

**Professor Richards:** We are collecting that information at the level of the cancer networks and the networks largely map onto Strategic Health Authorities, not exactly but largely. What we also do is collect information on the number of scanners that are in each Strategic Health Authority so that we can convert that into the number of scanners per million population, the number of radiotherapy machines per million population. We also look at the workforce and so we are in a position to say which parts of the country have relatively more or

relatively less, and over the last few years our plan has very deliberately been to even things up. Where we have seen, for example, that there are not as many CT scanners from the money that was allocated to CT scanners in the Cancer Plan, we have targeted those deliberately at the areas that had the least.

**Mr Steinberg:** I do not want to sound like the Prime Minister at Prime Minister's Question Time and in the thrust of politics one never knows whether the statistics are correct. My view has always been to look at the NAO and see what statistics they have given and they are usually correct. If you look at page 17, figure 8,975 extra consultants in post by 2004, a 36% increase in training places, £1.3 million invested in three training centres, £400 million invested in new facilities, 668 MRI scanners. You can go on and on. This has got to be an excellent record.

**Jim Sheridan:** Vote Labour.

**Chairman:** That is enough of that.

**Q49 Mr Steinberg:** This Report makes excellent reading. Coming on to the points Mr Field made, I come from the north east of England where we have probably got similar records in terms of deprivation to Merseyside. What I was disappointed about in this Report was that there was no indication at all of any priority being given to our areas in specific terms. They were mentioned as disadvantaged areas but there seems to be no priority plan. I am not asking that we should get more resources but there should certainly be a plan set down. What disappointed me as much as that was that in the NAO Report itself—and it is not often I criticise the NAO—when I looked at Appendix 2, for example, and where they have gone to do their research, it was Birmingham, Manchester, Humber, London, Peninsula (wherever that is), Surrey, Sussex and West Hampshire, South West London and West Anglia. There is not a mention of the north east of England. I would have thought that would be one of the prime areas you would have gone to.

**Dr Robertson:** The way we selected these cancer networks to visit was in consultation with the Department.

**Q50 Mr Steinberg:** So they did not want you to go there?

**Dr Robertson:** No: we were taking a view as to those which were regarded as being particularly effective, those that you might regard as in the middle and those that might be viewed as less effective. Our primary requirement was to get a range of networks in terms of their performance and that is what we did.

**Q51 Mr Steinberg:** It is a shame that you did not go to the north east. When you are talking about cancer, everybody knows from that last Report that we did a few months ago that it clearly said disadvantaged areas were the ones that had the worst cancer records and then we come to this Report and there is no real plan to specify and prioritise the areas that are the worst sufferers. That I find disappointing.

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**Professor Richards:** With regard to the two networks that cover the north east, one is the Northern Cancer Network, which is based on Newcastle but covers a large swathe of the north of the country, and the other is the one for County Durham and Tees Valley, the Cancer Care Alliance there. They are both very effective networks and they are particularly putting effort into things like smoking cessation because they recognise that that is such a problem in the north east.

**Q52 Mr Steinberg:** What about the report that came out from somebody at Newcastle University which said that you were failing miserably on your targets to stop people smoking and you could not achieve your targets?

**Professor Richards:** If I can be bold, I think it was an entirely mischievous report and it absolutely failed to recognise what is going on in tobacco control in this country. It was saying we will not achieve targets by smoking cessation alone. We have never said we would. We have always said that was one part of a six-strand tobacco policy, and I mentioned the other parts earlier, and also as I said earlier, we are rated second out of 28 countries for our tobacco control strategy, so I think we are doing a lot. They are effective but they are only one part of the solution. There is work being done on taxation and on media campaigns. I am sure you are all aware of the media campaigns. You will have seen the advertisements that show a cigarette with fat in the middle of it looking like a coronary artery. You will have seen the ones about second-hand smoking of children blowing out smoke sitting at the bottom of stairs. Those have been seen by vast numbers of the public and they have been very effective campaigns.

**Q53 Mr Steinberg:** If you look at page 16, figure 8, it says under “Improving treatment”, “NICE appraisals of cancer drugs to end the postcode lottery”. Can you give us a list of the postcode lottery? I would be very interested to know which PCTs distribute the drugs and allow their practices to do so and those who do not.

**Professor Richards:** Again, what we can give you is information at the cancer network level, because in June of last year I wrote a report for the Secretary of State, on the variations in use of drugs. We looked at all 16 drugs that had been appraised by NICE. We reported on the variations. I made recommendations on what should be done to reduce the variations and I am pleased to say that Ministers accepted my recommendations and those are now in action. We can send you a copy of that report. It is probably in the House of Commons library anyway but we will send you another copy.<sup>2</sup>

<sup>2</sup> MACDONALD, S., et al., Department of Health Research Programme: Cancer Symptom Profiles and Referral Strategies for Primary Care, 2004. *Factors influencing patient and primary care delay in the diagnosis of cancer: a database of existing research and its implications for future practice.*

**Q54 Mr Allan:** Sir Nigel, as politicians, when we talk about the Health Service we like to talk about managers and bureaucrats being bad and doctors and nurses being good, but when I look at the NHS accounting department it seems to be a success. Would it be fair to say that this is an example of managers and bureaucrats carrying out a tremendous job of work in terms of improving the effectiveness of doctors and nurses?

**Sir Nigel Crisp:** I hope that is what we try and do anyway. This is a very clinically focused Report, as it should be. You will be aware that there are now something like nine equivalents to the Cancer Plan, national service frameworks, whether for coronary heart disease or for mental health or whatever, and in all of those cases what you will find is very good close working between a senior clinician, who is taking the lead, which is very important for dealing with the credibility in respect of his or her peers, and a good infrastructure of people who are bringing in all the different expertises you need, some of which, frankly, are about managing money. This is a Health Service that spends £2,000 a second. It is remarkably important that we manage that money very well. This is the forerunner of all those other plans and I think people have done exceptionally well.

**Q55 Mr Allan:** What you have done, because patients' outcomes are so much better now, is that you have taken a service which was under-managed or poorly managed before and are managing it more effectively. Is that fair to say?

**Sir Nigel Crisp:** What happened before this Plan was in place was that everyone did their own thing and some of what they did was fantastic and some of it was not and it was not joined up. One of the things that we all understand about the Health Service is that almost no institution provides health services by itself. It is primary care and the secondary hospital and the tertiary hospital and that is even more true in cancer.

**Q56 Mr Allan:** You have moved, or rather we politically have decided to move all the pieces around the Health Service board to suit the plans. I just want to go into it a little bit to understand these relationships. For example, the PCTs have had them before. Can I be clear, and I will take my own area of Sheffield? At Weston Park Hospital the Cancer Network, which is kind of a creep from the acute sector, which seems to predominantly live there, has made sure that there are clinicians there so that when somebody in Sheffield presents they get the treatment in the timescales that you are now setting out.

**Sir Nigel Crisp:** Can I give a layman's view of this and ask someone who is more directly involved to answer? What we have tried to do in the network is to say that people with cancer use services in a whole lot of different institutions, almost more than any other group of patients. We need to get that group of people together so that we understand that they are using the same data, that they are communicating with each other, that they have got protocols to help patients move between them, that

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they have audit happening and so on, and that there is some coherent cancer planning going on for the area. That is why we have created networks. That is a very simple lay perspective.

**Q57 Mr Allan:** I am specifically speaking about the diagnosis and treatment bit, which is the bit which for most people is the crunch point. They have gone to a GP, there is a suspicion, they want to get into an acute unit to get diagnosis and treatment very quickly, and the plan seems to be doing that more effectively. I am just wondering whether the PCT is at all relevant in a sense, that if that person goes to their GP they are going to refer them. There is no difference between one PCT and another as to whether or not they are going to pay for it, is there?

**Professor Richards:** If I can take the network in your area, the North Trent Network, and in fact it is mentioned specifically on page 26, figure 14, as an example of effective collective commissioning, that network is not just for Sheffield; it is also for places like Doncaster and it is very important that for patients who come in through Doncaster as their local hospital get seen there, a lot of their diagnosis will be done there, some of their treatment will be given in Doncaster, and then for radiotherapy, for example, and complex chemotherapy they will need to come on to Weston Park in Sheffield. It is extremely important that Doncaster and Sheffield work closely together and that the PCTs that cover those two areas also work together so that they can make sure that the resources are in place both for the local treatment that they need in Doncaster and for the treatment they need to have in Sheffield.

**Q58 Mr Allan:** Does it matter to the patient which PCT they are in? Is it ever going to matter if they are in the same cluster? Everyone is prioritising on the grounds of clinical need. Does it matter to the patients?

**Professor Richards:** It should be invisible to the patient.

**Q59 Mr Allan:** Is it in reality?

**Professor Richards:** I think it is in reality, yes. What matters is that the PCTs work effectively together so that they can plan, let us say, effective radiotherapy services in Sheffield for the whole of that population, which is about 1.8 million that that network serves and, as you can see, it is an example of where a network is getting it right.

**Q60 Mr Allan:** Is it ever the case that somebody could go to a GP and the GP say, "I want to refer them", and the PCT say, "We are not prepared to pay for it"? Does that sort of thing happen because that is the kind of thing people are going to be worried about structurally?

**Professor Richards:** Not to my knowledge. I think that patients that need to be referred get referred.

**Q61 Mr Allan:** In terms of the drug treatment, again, is there a variation there? You said that there are variations and in Sheffield we have got four PCTs, but is it ever the case that out of two patients with

exactly the same symptoms and the same clinical needs in two different PCT areas one could get the drug and the other not on the basis of a PCT decision?

**Professor Richards:** Emphatically in that network that would not be the case because that is the effective joint commissioning that they have agreed to. They have binding rules. I think there are 13 PCTs in that network and they collectively agree on what will be done so that you can be absolutely sure in that network that everybody will get the same across the board. That is the arrangement that Sir Nigel mentioned earlier that is now going to be put in place across the whole of the NHS.

**Q62 Mr Allan:** From the patient's point of view that is what you mean by a good network: it is one where they are given consistent treatment?

**Professor Richards:** Yes, absolutely.

**Q63 Mr Allan:** But they could be in another area and this might not be the case?

**Professor Richards:** Consistent treatment and treatment that is in line with national guidance which comes from the National Institute of Clinical Excellence.

**Q64 Mr Allan:** But there are other parts of the country—and this is what your Report brought out—where NICE have said that the drug should be available, somebody has gone to their GP, and in Sheffield where it is working well they would be getting the drug, but their GP is told by the PCT that they will not pay for it.

**Professor Richards:** To be quite honest, my Report actually showed that this was not a funding issue. None of the networks told us that this was a funding issue from the PCTs. There was a variety of other issues, often to do with staffing and making sure that we have the capacity in the system in terms of pharmacists and chemotherapy nurses, and also it is a question of making sure that doctors are giving the very best treatments.

**Q65 Mr Allan:** I have to say, Sir Nigel, as an observation that the whole PCT logic seems crazy when you do not want a postcode lottery because you are talking about PCTs allocating according to their local priorities but you have a national plan that says, "We have a national priority for cancer and you have all got to do it". You are saying, "Do not have any variation", and there are lots of local bodies who are supposed to do it—

**Sir Nigel Crisp:** I understand the point you are making exactly, but what we are trying to get to is what is unacceptable variation and what is appropriate variation or reasonable variation. We have set up the National Institute for Clinical Excellence precisely to say that these are the things that should happen in a national health service. That is where we do pick up the unacceptable variation, and there is some of it, and some of it may be for reasons that, as Professor Richards said, that some doctors do not necessarily agree with the recommendation. There is some room for

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professional differences in some of this as well which we have to understand but there are points when we also have to be really quite rigid because we are clear the evidence is telling us the answer.

**Q66 Mr Allan:** Another management job. You are clear from the patient's point of view where you have got National Cancer Plan targets and NICE group drugs that wherever you are in the country they should meet the targets and the drugs should be available? That is the instruction that is going out?

**Sir Nigel Crisp:** Those are the specifics that we are saying are not negotiable.

**Q67 Mr Allan:** And they can vary upwards? They can treat people more quickly?

**Sir Nigel Crisp:** That is perfectly true.

**Q68 Mr Allan:** But not downwards. The bit that seems to be missing, when we look at table 12 on page 23, and I know we are always going to pick out the slightly weaker bits, is the local authority co-operation, where we read that two-thirds of local authorities are described as having poor or very poor co-operation with their Cancer Networks, and 34% are adequate, none good or very good. Is that because it is not a priority for them or they cannot be bothered? Do you have a view on why that is not happening?

**Professor Richards:** I think this is the stage of evolution which networks have got to at the moment. The Primary Care Trusts and the acute trusts are the absolutely critical partners in that with the strategic health authorities taking the overview. The voluntary sector, the hospices, are also smaller in terms of the amount of money they are contributing but they are very important as well.

**Q69 Mr Allan:** They get a good write-up here.

**Professor Richards:** Oh yes, very definitely, and so they should. Over the next few years we will see local authorities become more important partners in this, particularly as people with cancer live longer, more of them are elderly, they will have other illnesses to contend with, they will need more social care support, and then it will be even more important to have the local authorities involved. They are after all very closely involved with the individual PCTs and where that is working best is often where the PCTs and the local authorities are coterminous. There is at that level engagement but they are not at the moment engaging at the level of the whole network. To what extent they need to do that if they are really engaging well locally I think we can debate as time goes on.

**Q70 Mr Allan:** But at the moment very good progress has been made.

**Professor Richards:** Yes.

**Q71 Mr Allan:** And they are still thinking, "This is for the NHS. This is nothing to do with us, guv"?

**Professor Richards:** Largely I think that is true.

**Q72 Mr Williams:** Like Mr Steinberg, I welcome the extra resources and the obvious commitment that comes out in this Report. The thing that worries me is how far, despite the commitment and despite the resources, is delivery being impeded by reorganisation overload?

**Sir Nigel Crisp:** During the course of the Cancer Plan, which has been in existence for five years, I think we have had one reorganisation that is relevant, which was the creation of PCTs, and that did change the circumstances but that is now three years old.

**Q73 Mr Williams:** You see, this is at deviance from what the NAO have told us in the background briefing where they say that with the abolition of the health authorities, the creation of new strategic health authorities, the PCTs and foundation trusts, the plan is looking increasingly dated. This is very different from the impression you were giving in the answer earlier.

**Sir Nigel Crisp:** I am not sure of the reference.

**Q74 Mr Williams:** No; this is in the briefing we have received.

**Sir Nigel Crisp:** I see. We created PCTs in 2001. The plan came out in 2000. The old health authorities disappeared at the beginning of 2002 and the new ones came in and that did make a change.

**Q75 Mr Williams:** Look at paragraph 2.37 which explains it: "Many individuals we spoke to in PCTs told us that they were finding the planning process for commissioning cancer services difficult". That was the PCTs. The SHAs are responsible for amalgamating the PCT plans and they say that the quality of PCT planning documents varied considerably and that the local planning process was an ongoing learning process, so you are making it up as you go along.

**Sir Nigel Crisp:** No. Let us be clear. When this was created there were a hundred health authorities and no PCTs but something called PCGs, so it was a different world. There were still a lot of organisations there which cancer networks needed to work with. We have created 28 Strategic Health Authorities which almost map onto the cancer networks but not quite, and then we have created PCTs. That did happen three years ago. You are quite right: with any new system the first year of planning will not be as good as the second year or the third year. This was part of my answer to the Chairman right at the start, that we think the networks have done a very good job but we do think they need some strengthening.

**Q76 Mr Williams:** But we are three years on now. The SHAs said, and it is spelt out in the Report, that the process was disjointed and unsatisfactory, paragraph 2.37.

**Sir Nigel Crisp:** But that is why we are changing it. It is not really reorganisation. It is a change in process here.

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**Q77 Mr Williams:** Did the process not in part have to be amended because of the reorganisation?

**Sir Nigel Crisp:** It did but it had only been going for a year if you look at those dates, so I am not sure that reorganisation is an issue here. I think the issue is the bigger issue, which is that you have a number of organisations working together and how do you make independent but linked organisations work together effectively, how do you get joint decision-making and so on? What we have done is, having made good progress, we are now making the strategic health authorities directly responsible for ensuring that networks operate effectively by monitoring and managing them.

**Q78 Mr Williams:** We did not start from scratch. It was not as if there was nothing in existence before, no process, no system, and yet we are told in paragraph 2.32 that 30% of network management teams that were visited had no current plan for cancer services in their locality. That is abysmal because surely, as I say, they are not starting from scratch.

**Professor Richards:** The early cancer networks started in the mid to late 1990s and that showed us what could be achieved by networks and that is why we adopted the network model in the Cancer Plan. That gave us the grounds for knowing that that would work. I think there was some degree of hiatus when you have got to change from health authorities to PCTs. They had a lot to do to get their own house in order, if you like and there was a degree of hiatus. I believe that one of the things that the networks have been doing is educating the PCTs about cancer. When I ran the South East London Cancer Network in the 1990s, which was one of the early ones, I saw part of my job as educating the health authorities (as they then were) about cancer. I used to go round giving what I called my O-level cancer lecture.

**Q79 Mr Williams:** It worries me, you see, that you had to do it at O-level.

**Professor Richards:** It is important to do it and the networks that have been successful have brought their PCTs on board, have brought them up to speed and have got them seeing how important this is for delivering what is important to the individual PCT. If you look at the individual PCT they have a lot of people with cancer and a lot of people dying from cancer and it is, as I have said before, a national priority but also a local priority.

**Q80 Mr Williams:** But what is coming over at PCT level and at network management team level is that the co-ordination is not working. You say it is nothing to do with organisation. Look at paragraph 2.44, the NHS foundation trusts. There it says, "A workshop of key stakeholders, convened by the Cancer Action Team in January 2004, identified NHS foundation trusts as one of the high risk areas in terms of implementing the NHS Cancer Plan". If you look at the previous paragraph it says that 20 foundation hospitals were set up and they are bound by a duty to co-operate with other NHS bodies, but—and you signed up to this—"it is unclear what

this means in practice". That is just a year-old change and at the time of this Report it was still not clear what that means.

**Sir Nigel Crisp:** Let me say I would not have written that, and I had not spotted it and I should not have signed up to that sentence, that it is unclear what it means in practice.

**Q81 Mr Williams:** But, you know, Sir Nigel, that really is not good enough.

**Sir Nigel Crisp:** No, it is not good enough but I do not sign up to the fact that we do not know what partnership means.

**Q82 Mr Williams:** Sorry; I have got to emphasise this, Chairman. As far as this Committee is concerned one of the ways we work efficiently is that we are not arguing about the contents of your Report. It has been agreed in advance and you are signing up to it. The fact that you missed it is in fact a neglect on your part but it is what you signed up and you are now telling us it is wrong.

**Sir Nigel Crisp:** Can I tell you what I also signed up to? First can I accept the fact that in looking at that on reflection I would have disagreed with those words, but if you look at paragraph 2.44, which you quoted, you may have noticed at the bottom of it it says, "On the other hand the Department has stressed that there is no evidence that NHS foundation trusts are having a destabilising effect on cancer services", and indeed they pointed to several that had reasserted their commitment.

**Q83 Mr Williams:** It says "several" of the 20, not 20 out of 20.

**Sir Nigel Crisp:** Again, with respect, my first answer to your Chairman said very clearly that we will only be commissioning services for cancer patients from people who are part of networks. That is what we are saying. It is not in this report but that is the position we are taking.

**Q84 Mr Williams:** That is fine but we are back on the other points. If 30% of the networks have not got current plans for cancer services in their locality it is not going to work very well, is it?

**Sir Nigel Crisp:** But all the PCTs are commissioning primary care and cancer services, are they not? People are getting cancer services. What we are saying is that people will only get cancer services on the NHS if the services they are being offered are part of a cancer network. It is that simple. I have no doubt at all that people were concerned about foundation trusts, as they were, for all kinds of other reasons, about foundation trusts. The foundation trusts are part of cancer networks.

**Q85 Mr Williams:** Can I switch away from your direct response to me and maybe you do not want to comment on that, to the activities of cancer charities? There are so many of them, a plethora of them, and the public does not know which are high quality, which are poor quality, which are jobs for the boys and which are doing something worthwhile.

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Is there any system of co-ordination of the role of these charities? Is there any examination of possible waste through duplication?

**Professor Richards:** There are a large number of different charities related to cancer. There are three which are very large. There is Cancer Research UK, which clearly focuses exclusively on research, Macmillan Cancer Relief and Marie Curie Cancer Care. Those are by far the largest ones but there are a myriad other smaller ones. Over the past four years, as part of the Cancer Plan, we have been developing very effective partnerships in a number of different ways, trying to work with charities that have similar interests. For example, those charities that are engaged in research are invited to be members of the National Cancer Research Institute. This is a partnership body between the Department of Health, the Medical Research Council, Cancer Research UK and a range of other smaller research charities—the Leukaemia Research Fund, Breakthrough Breast Cancer and so on.

**Q86 Mr Williams:** Did they all accept?

**Professor Richards:** Oh yes, and they have been very active members of that. Equally, on palliative care, clearly that is the hospices' area of interest along with Macmillan and Marie Curie, and we have set up a national partnership group on palliative care, which I chair, which brings those charities together. We have done it with individual cancers so that for lung cancer, for bowel cancer, for prostate cancer we have advisory groups and we get the relevant charities, Beating Bowel Cancer and Colon Cancer Concern, for example, to be members of the Bowel Cancer Advisory Group. In that way we are working with a large number of charities but in a way that meets what they want to do and where our common interests lie.

**Q87 Mr Williams:** Being frank about it, every advanced country in the world is carrying out massive research into cancer, as they are into arthritis too but with limited success. This is a genuine request for information. How far is the charitable contribution to actual positive research significant and how far might it be better if perhaps they concentrated to some extent (as some of them do) on the educative side, a point which several of my colleagues have mentioned, making people aware of what the symptoms and hazards are?

**Professor Richards:** I think the contribution of an organisation like Cancer Research UK to worldwide research is indisputable.

**Q88 Mr Williams:** That is one.

**Professor Richards:** That is by far the largest one. Equally, I could look at others like Breakthrough Breast Cancer, which is much smaller but doing a very good job in research, have excellent laboratories but work very closely with us, and the Leukaemia Research Fund as well. I personally think they have a major contribution. I ought to declare an interest here. I was funded by the

predecessor body of Cancer Research UK for 14 years in my clinical research that I conducted into cancer before taking up my current post. I think they have played a major part and what is happening now is that they are doing it much more effectively in partnership with government, the Medical Research Council and the Department of Health through the National Cancer Research Institute, and in the last three years the number of patients going into clinical trials for cancer have more than doubled. I do not know of any other country that has got as rapid an increase and I can tell you that when I talk to colleagues in the United States about that they are very impressed and quite envious.

**Mr Williams:** That is a reassuring answer. It was a genuine search for information. Thank you very much.

**Mr Field:** Professor Richards, Mr Williams at one point emphasised the effect that reorganisation can have on delivering the plan, and there is a rumour that if the Government is re-elected it will reorganise PCTs; there will be fewer of them. When the Strategic Health Authority was established covering the area which I represent, an early move on its part was to suggest that the oncology centre at Clatterbridge would be merged with the one across the river and a huge amount of the time of the centre went in fighting that proposal. Because we are interested in influencing what the policy might be, do you think it will be more difficult to achieve these targets if the Government goes in for another round or reorganising than not?

**Q89 Chairman:** If you want to plead the fifth amendment on that, that is a rather unfair question.

**Professor Richards:** It is not for me to speculate on what will happen. What I would say is that the document that came out from the Department of Health last week called *Creating a Patient-led NHS* was very important in reaffirming the need for networks. Actually, I think that is true whatever organisation we have—Primary Care Trusts, including health authorities—because networks match the natural flow of patients from primary care to secondary care to tertiary care. I believe that networks are fundamental to this and will continue.

**Mr Field:** I just wanted it on the record for when we come to our Report. That is very, very helpful. Sir Nigel, we had a submission from Macmillan Cancer Relief and one of their points was that the Government should do more to tell patients about the benefits to which they may be entitled. I know this is another Department. All of us would salute the work that the Macmillan nurses do but I just think they are wide of the target on this issue, that really the person who is probably best placed to tell patients about their benefits would be Macmillan nurses. Should they not take on the task? Even if they are not completing the forms they would be the ones to say “You are probably eligible for DLA. You are probably eligible for Attendance Allowance”, even if somebody else then helps them fill in the forms.

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**Q90 Chairman:** Again, I do not really think—

**Sir Nigel Crisp:** We did discuss this on Monday, so it is in the record there, but not specifically about Macmillan nurses. What we are saying is we do think frontline staff, including Macmillan nurses, the people who are actually dealing with the patients, need to know enough at least to signpost people and we do not think they do enough of that at the moment.

**Q91 Mr Field:** Can I try and get this last question in order then. Gerry mentioned the incredible increase in staff and equipment. I was in a hospital—not in my constituency—looking at the scanning equipment which ceases to work at five o'clock. Do you have any printouts at all on how many hours a day the new equipment that we are all so proud of is used?

**Professor Richards:** We do not have central information on that. What we do know is that the new generation of CT scanners take the scans a great deal faster so the number of people being scanned per day on one machine is a lot higher than it was in the past and the picture quality is better as well. We are making a further major investment in diagnostic equipment and in staff. I think I mentioned at one of the other meetings that in terms of the radiographers, who are the staff who actually operate the scanners, we have doubled the number of radiographers in training. That will enable us to work longer hours. A lot of the thing that is holding this up at the moment is not having enough staff. We cannot expect them all to work 12 hour shifts every day, so what we need is more staff. We set that in motion as part of the Cancer Plan, so those extra staff have been going through training—it takes three years—and from this summer we should start seeing substantial increases in numbers. That will take two or three years to build up but we have put the foundations in place with the extra training.

**Q92 Mr Field:** But it is Sunday trading hours at the moment, is it not, with use of equipment?

**Sir Nigel Crisp:** Not always but too much.

**Q93 Mr Williams:** In view of what was pointed out earlier on the difficulties of the PCTs in commissioning cancer services, how hard is the addition of the element of choice going to make it for them to commission? It must be a complicating factor for them, or it may be the other way. What is your recommendation on that?

**Professor Richards:** Going back to commissioning generally, the first thing to say is that some parts of the country—we talked about Sheffield a little earlier—have clearly cracked this, so it can be dealt with. What we are now doing is making sure that problem is dealt with across the country.

**Q94 Mr Williams:** Can you let us have a note on that so we can put it in our report?<sup>3</sup>

**Professor Richards:** Certainly we can let you have a note and we can also point you to the pages in the new document from the Department of Health that specifically mention what we are doing on networks, I think that could be helpful. In terms of choice, clearly we want patients with cancer to benefit from being able to make choices the same as other patients. I think there is also a case where if you want to make sure that patients are seen and dealt with very fast within the two week rule that we have, it may not always be possible to offer people a choice of five hospitals where they can be seen within two weeks, so for the time being we have said the priority is to make sure that people are seen at a hospital that has got a properly appointed team but within the two weeks. For the time being, the choice of five hospitals does not apply to those who are being referred earlier.

**Q95 Chairman:** It is a bit of a meaningless choice, is it not: you can be seen at five hospitals but if you want to be seen within two weeks you have to go to hospital A?

**Sir Nigel Crisp:** May I make a variation on that. That does not mean to say there is not choice in the wider sense. There is a great deal of discussion about choice of treatment, for example, and a whole range of other things like that which are very important to patients. We do recognise that in cancer services, perhaps more than in most other services, it is important to be part of a whole joined-up system.

**Chairman:** It looks like choice may be somewhat more limited than we might have hoped.

**Q96 Jim Sheridan:** Picking up one of the points that Mr Steinberg made about PCTs in areas where there is a high level of cancer being diagnosed, as I understood it I think you said that many resources that go in cannot be ring-fenced to deal with cancer treatment. Am I right so far?

**Professor Richards:** What we have said is that we have set standards for the outcomes that we are looking for from cancer networks and, indeed, from individual PCTs.

**Q97 Jim Sheridan:** Any additional resources cannot be ring-fenced to deal solely with cancer treatment?

**Sir Nigel Crisp:** I do not think it is “cannot be ring-fenced”, we do not ring-fence as a matter of policy.

**Q98 Jim Sheridan:** I am trying to see if we can get a handle on these PCT areas where there are high levels of cancer-related diseases. I am trying to get a handle on just how much has been spent in these areas compared to others and the additional demands on PCT areas where there is a high level of cancer treatment. What also concerns me is if other government departments which are charged with the responsibility of advising people of benefits, *et cetera*, do not allocate additional resources to explain to people what their benefits are when they have cancer, that kind of thing, how will they know about it?

<sup>3</sup> Ev 16

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 Department of Health
 

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**Sir Nigel Crisp:** There are two things. Firstly, how do we decide how much money each area gets anyway. We have a formula for allocation to PCTs, and we have recently revised the way the money goes into that system, which tries to pick up need in areas which will not only pick up the need for cancer services but for other services as well. The latest figures were announced about a month ago and there was considerably more investment in what we call spearhead PCTs, those areas that we saw as having the greatest need. That is available to you if you want to see that. What is also true is that different areas have higher incidences of different cancers, which is the other point that is worth noting, so we will see more breast cancer in the South, for example.

**Q99 Jim Sheridan:** How do the general public know how much resources are going in there over and above the general medical bill for PCTs? How much more financial resources or otherwise are going into the PCT areas where there is a high level of cancer? How do we know that is happening?

**Sir Nigel Crisp:** I am not entirely sure that there are PCTs that you would necessarily say were a high level of all cancers, I think it is just one of the features of—

**Q100 Jim Sheridan:** I think we have already identified the North in relation to high levels of smoking and industrial-related diseases.

**Professor Richards:** There are high levels of lung cancer in the North, for example, related to smoking, and bladder cancer as well. There are higher levels of breast cancer in the South of the

country which is more a disease of affluence. Overall, in terms of cancer deaths there is an excess in the North and that is largely because lung cancer, sadly, is largely an incurable disease whereas breast cancer now, fortunately, is largely a curable disease.

**Q101 Jim Sheridan:** How do we know that the money is going in there?

**Professor Richards:** We know what extra money has been going in over the last years because we have been round to the cancer networks and they have supplied us with information on what they are spending.

**Sir Nigel Crisp:** PCT plans are available, if that is part of your question.

**Chairman:** I have got one last question. You gave a very good answer to my question about waiting time targets, the best answer I have heard in five years of this Committee.

**Mr Field:** That was because he said yes.

**Sir Nigel Crisp:** I am not asking for it to be excised from the record.

**Q102 Chairman:** No, I know that. There are other targets in this plan that have to be met by 2010, so will you now reply yes that all targets in this plan will be met by 2010?

**Sir Nigel Crisp:** Can I just consult because I am not sure I know absolutely every target. Our expectation is that they are all going to be met and, indeed, before 2010.

**Q103 Chairman:** Just say yes.

**Professor Richards:** Yes.

**Chairman:** Thank you. That is the end of the meeting, thank you very much gentlemen.

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 Memorandum submitted by Avon, Somerset and Wiltshire NHS Cancer Services

## ASWCS' RESPONSE TO THE NAO REPORT: THE NHS CANCER PLAN

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

1.1 Sufficient resources are not always available to enable networks to operate effectively.

In a survey carried out recently across the 34 networks with 28 responses it was found that the funding is inconsistent bearing no relation to network size or complexity, with very different staffing structures in place to achieve the targets of the Cancer Plan. Arguably it should be a fairer process for resourcing each of the networks' across England. Most of the networks survive because of charitable funding; earlier networks have reached the end of the three years charitable funding and are faced with negotiating further income from the Pre-owned Assets Tax's (POT). The Primary Care Trust (PCT) and Strategic Health Authority (SHA) support is very variable across the country and many of the network managers are finding it hard to keep going, relying on staff vacancies and subsequent slippage to manage their incomes. Multi Disciplinary Teams (MDT) also need to be fully resourced to work adequately and key staff such as specialist nurses are often inappropriately administrating. There is also evidence in some networks when the core team leaves and time is taken to replace them no progress is made on targets.

POT income to networks across England ranges from an average per POT of £11,000 per annum to £111,000, 21 of the 28 networks have an income shortfall in 2005.

*Question: Whilst SHA's support networks, basis for funding networks is inconsistent. There may be a link to those receiving less funding support being less effective. Should there be a consistent approach?*

#### 1.2 Making the cross-boundary approach work has not been straightforward.

Across England network Boards are non statutory and made up of membership across many organisations (26 in ASWCS). The membership of the Boards changed significantly following "Shifting the Balance of Power" and it is very hard to get Chief Executives engaged from the Strategic Health Authorities the PCT's and Trusts. Where they are engaged the networks' report much clearer decision-making and support.

Decision-making across a network is made more difficult because of the difficulty of the cross boundary approach, as each of the statutory organisations feel they want to keep the freedom to deploy resources in the way they see fit. The network being an overarching non-statutory organisation challenges that position by arguing for a population approach.

*Question: We found that most networks still have service changes to be made to meet the requirements of the NICE Improving Outcomes Guidance. Do networks in their present format have the ability to bring about these most difficult of service changes?*

#### 1.3 Not all Cancer Networks plan Effectively.

Many of the networks surveyed by the NAO did not have service delivery plans and other key strategies in place. Some networks do not have the capacity, or resources and skills, to plan effectively, though this is a priority. Most of the networks would have moved forward since the NAO survey and have these structures in place or are working to do so. The ongoing peer review process will ensure that the networks are compliant and will require that the appropriate planning be in place.

*Question: Given the inconsistent staffing structures in networks, how could they improve their planning to adequately address the strategic direction of their varied constituent organisations?*

#### 1.4 There is scope to improve the commissioning of cancer services in some networks.

The support of PCT's varies from network to network, with the development of the commissioning groups as outlined in the Cancer Measures improving the situation, but the evolving NHS creates more challenges to the overarching role of Cancer networks and the influence, which they can bring to bear.

*Question: Given the autonomy of PCT's to make their own financial decisions, should the SHA's underpin Networks' specific knowledge of a disease group and require PCT's to consult prior to submission and sign off, of Local Delivery Plans?*

#### 1.5 There are concerns regarding the duty of partnership expected from cancer network organisations in the context of the evolving NHS.

The networks operate by facilitating changes and improvements throughout their constituent organisations. The cancer network has a specific role in planning and implementing elements of the Cancer Plan, which because they affect wider populations are beyond the control, expertise and resources of individual Trusts, POT's or local health communities. An example of this is in managing the service based NICE Improving Outcomes Guidance. For many cancers patient numbers across the network are small and a critical mass of cases need to be managed in centres to meet quality measures, clinical governance demands and outcome targets. The resulting reconfiguration of services goes beyond the scope and discretion of an individual PCT or Trust to decide the best outcomes across a whole network population (ASWCS 2.2 million).

Central policy is being pursued through networks: Funding allocations are passed, in some cases through SHA's for distribution and monitoring by networks. Responsibility for implementing national guidance on cancer care (NICE) and for devising Action Plans, many of which have major implications for the configuration of hospital services, is also with the networks.

The advent of Foundation Trusts is also contrary to population planning and management.

*Question: How can a network balance the goals of the Department of Health with the considerable constraints in the local health communities, especially around lack of funding to deliver the targets?*

Mary Barnes  
Director of ASWCS

21 March 2005

### Supplementary memorandum submitted by the Department of Health

*Question 22 (Mr Field):*

Earlier diagnosis improves the likelihood of survival. An international workshop of cancer epidemiologists and other experts examined evidence during the preparation of the NHS Cancer Plan on

differences in cancer survival rates—this was reported in the National Audit Office (NAO) Report “Tackling Cancer in England: Saving More Lives” published in March 2004. The workshop concluded that patients in England tend to have more advanced cancer at the time of diagnosis than in some other countries, at least for breast and bowel cancer.

A study commissioned by the Department of Health from Una Macleod *et al* on “*Factors influencing patient and primary care delay in the diagnosis of cancer: a database of existing research and its implications for future practice*” looked at studies which had considered patient delay and practitioner delay separately, rather than comparing the relative delay. However, the study did identify that the patient phase of delay was generally greater than the practitioner phase, and that patient delay varied for different cancers. (A hardcopy of this study has been sent separately to the Committee.)

It should be noted that the term “delay” may not be appropriate to use in relation to patients in primary care as it includes both a conscious decision by a patient not to consult about symptoms but possibly also a lack of awareness of symptoms. In addition, we are aware that some patient groups dislike the term “delay” because it is judgmental.

*Question 93 (Mr Williams):*

We are committed to giving patients more choice and control over their healthcare and services and we are already increasing choice of hospital for patients needing planned hospital care. Since last August, patients who will wait more than six months for their elective care are being offered the choice of faster treatment at an alternative provider, meaning that those waiting longest are benefiting first from choice.

By the end of this year, patients needing a referral for surgery will be offered a choice of four to five providers at the time they are referred for treatment by their GP. Most patients referred for elective care will be offered this choice from December. However, following extensive discussions with the NHS, we have recognised that choice of hospital would not be appropriate for all services. We included cancer services within this category. We are committed to ensuring that patients with suspected cancer are seen within two weeks of referral and ensuring this rapid access to services was considered more important. However, choice is important in cancer services. Patients should be offered more choice about the treatment they receive, including choice of provider wherever possible.

Giving patients the opportunity to choose their provider is one of the first areas in which we are extending choice. We are continuing to work to ensure that patients have an informed choice of treatment options and treatment providers, choice about their ongoing care and choice at the end of life. There is more work to be done in developing our thinking on how choice should be available within primary care and emergency and specialist networks.

We are currently developing the detailed policy for the extension of choice of hospital to give patients needing planned hospital care the right to choose any healthcare provider which meets the Healthcare Commission’s standards and which can provide the care within the price that the NHS will pay by 2008. As part of this, we will consider how best to ensure these choices are available to cancer patients.

*Creating a Patient-led NHS: Delivering the NHS Improvement Plan*

The above report (available at [www.dh.gov.uk/publications](http://www.dh.gov.uk/publications)), published in March 2005, addressed specialist networks (of which cancer networks are an example):

- **Chapter 2** sets out what services will look like and confirmed that the NHS will offer “integrated networks for . . . specialist care to ensure that everyone throughout the country has access to safe high quality care.”—see paragraphs 2.22–2.28 in particular.
- **Chapter 3** sets out how the NHS will develop the way it secures services for its patients including that it will: “Strengthen existing networks for . . . specialist services, with PCTs and Strategic Health Authorities (SHAs) having explicit responsibility to review and develop them” and confirms that “There is more work to do to develop thinking on how choice should be available within . . . specialist networks, how far providers should offer choices in treatment and ongoing care and how choice at the end of life will work.”
- **Chapter 5** talks about making the changes and notes that: “a strong network of care providers is required who can respond quickly to what patients want, who can introduce new clinical practices at pace and who can flex their services to fit new pathways of care.”

COLLECTIVE COMMISSIONING

During the Committee hearing, Sheffield was given as an example of an area that had established successful collective commissioning—NORCOM, the North Derbyshire, South Yorkshire & Bassetlaw

Commissioning Consortium. The Committee requested a note on NORCOM, which follows below:

North Derbyshire, South Yorkshire & Bassetlaw Commissioning Consortium (NORCOM)

<i>Constituents PCTS</i>	<i>Weighted Population</i>
<i>Barnsley</i>	258,256
Doncaster Central	108,712
Doncaster East	92,263
Doncaster West	119,496
<i>Doncaster Total</i>	320,471
<i>Rotherham</i>	255,278
North Sheffield	142,837
South East Sheffield	174,626
Sheffield South West	106,987
Sheffield West	119,144
<i>Sheffield Total</i>	543,594
<i>South Yorkshire Strategic Health Authority Total</i>	1,377,599

Updated November 2003



#### WHAT IS NORCOM?

The North Derbyshire, South Yorkshire and Bassetlaw Commissioning Consortium (NORCOM) came into effect from 1 April 2002 and covers the 13 PCTs operating in this geographical area.

NORCOM is a joint sub-committee of the 13 PCT Boards and all the Boards have signed up to a formal Establishment Agreement which defines the membership, the lines of accountability and the working arrangements.

The focus of the NORCOM process is a monthly meeting of the PCT Chief Executives and the Acute Trust Chief Executives to receive reports, recommendations etc and make collective decisions.

The minutes of the NORCOM meetings go to the public session of all the PCT Board meetings.

#### THE NORCOM TEAM

There is a central specialist team of 16 staff, hosted by Barnsley PCT to support the NORCOM activities. There are also two lead nurses and eight lead clinicians relating to the clinical networks. The current central budget is £1.93 million.

The member PCTs fund the work of the NORCOM team through a capitation-based levy, reviewed on an annual basis.

#### WHAT DOES NORCOM DO?

The Consortium is responsible for two main areas of work:

- commissioning specialised services,
- supporting the development and maintenance of clinical networks.

More recently the NORCOM team has also been approached to take on specific project work relating to “Booking and Choice”.

#### SPECIALISED SERVICES

The main focus of the specialised services work is the planning and review of services and agreeing a common commissioning framework. The central team co-ordinates a limited pooled budget for selected high cost procedures, to reduce financial risk. All the other service budgets continue to be held by the individual PCTs.

There are seven commissioning groups covering the following services:

- Renal;
- Cardiac;
- Specialist Cancer;
- Neurosciences;
- Specialist Childrens;
- Genetics; and
- Dental Services.

There are NORCOM representatives on the various groups involved in the commissioning of high and medium secure services.

There is a formal collaborative working arrangement with TrentCOM and the LNR Specialist Commissioning Group, who are similar specialist commissioning consortia covering Leicester, Northampton, Rutland, Nottinghamshire and Derbyshire. This joint work will focus on co-ordinating the commissioning of specialist services for populations greater than 3–6 million.

There are also regular meetings with the West Yorkshire and North & East Yorkshire and North Lincolnshire Consortia to co-ordinate commissioning priorities.

There is regular attendance at the DoH/Specialist Commissioning Group representatives meetings.

There are NORCOM officers participating in national work eg Burns, Pulmonary Hypertension.

As the host commissioner, NORCOM recently led on behalf of all commissioners, nationally, the assessment of the Sheffield stereotactic radiosurgery service.

#### CLINICAL NETWORKS

There are seven clinical networks in existence:

- Cardiac;
- Cancer;
- Critical Care;
- Neonatology;
- OMFS/ENT;
- Pathology; and
- Vascular.

All the clinical networks have network co-ordinator support from the NORCOM specialist team, together with a lead clinician.

The existing networks are at various stages of development.

The Cardiac and Cancer networks are both in a stage involving some re-organisation and modernisation of their working arrangements.

The Pathology network is taking forward a number collaborative projects, including joint purchasing and workforce planning.

The Critical Care network is currently focusing on clinical service improvement and consolidation of service changes implemented.

The OMFS/ENT, Neonatology and Vascular networks were formed last year and are still in a development phase.

The potential added value of other clinical networks is being investigated.

**OTHER/MISCELLANEOUS**

NORCOM is co-ordinating the North Trent Priorities process for the development of common commissioning policies across the patch.

The NORCOM specialist team is also participating fully in the LDP process, and the implementation of the Financial Flow Reforms.

The team negotiates and performance manages service level agreements with specialist hospitals elsewhere in the country. This work is shared with TrentCom.

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