25 BY 25

A TEN-YEAR STRATEGY TO IMPROVE LUNG CANCER SURVIVAL RATES

UNITED KINGDOM LUNG CANCER COALITION

OCTOBER 2016
MEMBERSHIP AND ACKNOWLEDGEMENTS

The UKLCC’s Clinical Advisory Group is a panel of senior clinicians, each representing particular specialities involved in the care of lung cancer patients, from the time of first suspicion of the diagnosis through to palliative care.

The members of the group are:

Dr Andrew Wilcock
Clinical Reader in Palliative Medicine and Medical Oncology, Nottingham University Hospitals NHS Trust

Ms Carol Stonham MBE
Prescribing Nurse Practitioner, Minchinhampton Surgery, Gloucestershire

Dr Clive Mulatero
Consultant in Medical Oncology, St. James’ Institute of Oncology, Leeds

Dr Dean Ferrall
Chair, Thoracic Medical Oncology, University of Leicester & Leicester University Hospitals NHS Trust

Dr Ian Williamson
Consultant Respiratory Physician, Assistant Medical Director for Cancer Services Aneurin Bevan University Health Board

Dr Jason Lester
Consultant Clinical Oncologist, Velindre Cancer Centre

Dr John Reynolds
Consultant Radiologist, Birmingham Heartlands Hospital

Professor Keith Kerr
Consultant Pathologist, Aberdeen Royal Infirmary

Ms Lavinia Magee
Nurse Consultant, Thoracic Oncology, Papworth Hospital NHS Foundation Trust

Professor Michael Lind
Professor of Medical Oncology, University of Hull

Dr Michael Snee
Consultant Clinical Oncologist, Leeds Teaching Hospitals NHS Trust

Professor Mick Peake (Chair)
Honorary Consultant and Senior Lecturer in Respiratory Medicine, University Hospitals of Leicester; Clinical Lead for Early Diagnosis, National Cancer Registration and Analysis Service, Public Health England

Mr Naidu Babu
Consultant Thoracic Surgeon, Birmingham Heartlands Hospital

Mr Richard Steyn
Consultant Thoracic Surgeon, Divisional Director - Surgery, Heart of England NHS Foundation Trust; Honorary Associate Professor, University of Warwick and Chair of the UKLCC

Dr Robert Rintoul
Consultant Chest Physician, Department of Thoracic Oncology, Papworth Hospital NHS Foundation Trust

Dr Steve Holmes
General Practitioner, The Park Medical Practice, Shepton Mallet, Somerset

Dr Wendy Anderson
Consultant Respiratory Physician, Antrim, Northern Ireland Lung Cancer Co-Lead

The CAG is also supported by leading patient and clinical group members, including:

– British Lung Foundation
– Macmillan Cancer Support
– Roy Castle Lung Cancer Foundation
– Tenovus Cancer Care
– British Thoracic Society
– National Lung Cancer Forum for Nurses
– The Primary Care Respiratory Society

The UKLCC is keen to work with all interested organisations and bodies to improve the quality and outcomes of lung cancer treatment and care.

For more information about our work and our partners, please visit our website or contact our secretariat.

www.uklcc.org.uk

CONTACT DETAILS

A TEN-YEAR STRATEGY TO IMPROVE LUNG CANCER SURVIVAL RATES
INTRODUCTION

For the last ten years, lung cancer has consistently been the UK’s biggest cancer killer\(^1\). In 2014 alone, it was the cause of almost 35,900 deaths\(^2\), which is more than breast\(^4\) and bowel cancers combined\(^5\). The UKLCC was set up in 2005 with the founding ambition to tackle poor lung cancer survival outcomes and, specifically, to double five-year survival by 2015.

In response to the growing need to address cancer as a whole, nations across the UK have undertaken efforts over recent years to help support improvements in long-term survival. Following this, estimates now suggest that the UKLCC’s founding ambition to double five-year survival has effectively been met in England\(^6\), with improvements also seen in Scotland\(^7\), Wales\(^8\) and Northern Ireland\(^9\).

However, whilst significant improvements have been made, there is still an urgent need for more to be done. Lung cancer is not prioritised as it should be compared with other common cancer types, quality of patient outcomes highly varies\(^10\) and whilst long-term survival across the UK has significantly improved, rates still fall behind in comparison with other developed countries\(^11\).

We know more needs to be done, and we know we need to aim higher to secure better outcomes for patients.

THE 25 BY 25 AMBITION

The UKLCC is calling for a drastic improvement in care for those with lung cancer across the UK in order to raise five-year survival rates to 25% by 2025.

To determine how to meet this ambition, the UKLCC sought to explore not just the existing evidence but also the opinions of those who face up to lung cancer every day, launching a number of surveys across the UK within the lung cancer community.

Based on this insight, this report contains a series of UK-wide principles to improve five-year survival rates and meet the 25 by 25 ambition. These principles, aimed across the patient pathway, are set out in three key phases up to 2025. Subsequent chapters of this report then set out tailored recommendations for each UK nation for immediate delivery, laying paths to success unique to each individual health service.

It is time for the community to redouble efforts to do the very best for people affected by lung cancer.

The NHS is facing massive financial pressures and resource strain, but there are also unprecedented opportunities offered by new national structures, local and regional autonomy and a drive for effective ‘whole person’ care.

A lung cancer diagnosis should not be a death sentence and we hope that those across UK Governments and health services can support the UKLCC’s 25 by 25 ambition and see its key recommendations implemented across the UK.
HOW TO MEET A NEW UK SURVIVAL AMBITION: SURVEYING THE LUNG CANCER CLINICAL AND PATIENT COMMUNITY

In order to achieve its five-year survival ambition, the UKLCC launched a series of UK-wide surveys to assess attitudes on long-term survival from across the lung cancer community.

This included a survey of 148 healthcare professionals (HCPs)* from across the composition of a multi-disciplinary team (MDT) – specialist nurses, pathologists, radiologists, oncologists, surgeons and respiratory physicians – trained in treating lung cancer. Alongside this, we surveyed 102 patients and carers from across the UK on their experiences of care and attitudes towards survival.

We also conducted a poll of over 1,000 GPs working in primary care at the forefront of detecting and referring suspected cases, and canvassed their views on what improvements need to be made to tackle poor survival.

Our aim was that, by listening to the views of the lung cancer community and utilising the latest evidence and data across the UK, we could begin to identify the necessary steps to combat the country’s biggest cancer killer – steps which will stand the test of time.

This chapter summarises the key results from the surveys undertaken. These have then been used in parallel with the most recent evidence to identify the overarching principles which need to be taken across the UK to improve survival both now and in the future.

A UK SNAPSHOT: TACKLING BARRIERS TO SURVIVAL

CURRENT VIEWS ON FIVE YEAR SURVIVAL: PATIENTS MORE OPTIMISTIC THAN DOCTORS?

50% of patients and carers now consider surviving lung cancer for more than five years to be achievable

65% of HCPs believe early-stage diagnosis to be the most important factor for improving five-year survival rates

43% of patients waited over one month for initiation of treatment after a diagnosis was confirmed by their clinician

Only 27% of patients saw their doctor because they recognised that they were experiencing signs and symptoms of lung cancer

50% of patients and carers now consider surviving lung cancer for more than five years to be achievable

65% of HCPs believe early-stage diagnosis to be the most important factor for improving five-year survival rates

43% of patients waited over one month for initiation of treatment after a diagnosis was confirmed by their clinician

There is an urgent need to meet the expectations of those affected by lung cancer. Of those polled, nearly half of patients and carers described surviving lung cancer for more than five years as “achievable”. Such optimism, when current five-year survival rates are estimated at only 16% at their highest in the UK, shows that patients have the determination and belief to fight lung cancer for longer. This also reflects the value of recent public awareness and patient group campaigns in demonstrating that lung cancer is survivable if caught early and treated effectively. However, in sharp contrast, the majority of HCPs described surviving for over five years as “difficult to achieve” and some as “completely unachievable”. These views may be formed partly by recent cuts to funding for key services related to lung cancer such as smoking cessation, increasing strains on diagnostic capacity and ill-resourced MDTs – demonstrating that more needs to be done to support services to meet ambitions for long-term survival.

PREVENTION: BEHAVIOURAL RISK FACTORS STILL NEED TO BE SIGNIFICANTLY ADDRESSED

HCPs believe that a reduction in smoking rates is the second most important factor, after early diagnosis, for improving five-year survival rates in lung cancer

GPS believe that improved access to smoking cessation services would have the second biggest impact, after public awareness campaigns, on improving lung cancer survival rates

50% of patients and carers now consider surviving lung cancer for more than five years to be achievable

On a scale of how achievable five-year survival is, 65% of HCPs considered five-year survival difficult to achieve and 15% completely unachievable

Tobacco use is the most important preventable cause of lung cancer in the UK. While we know there are a proportion of patients who have never smoked who have developed lung cancer, the majority of cases are preventable, with 86% of cases caused by smoking alone. However, whilst also reducing the number of cases, the risk of total mortality and rate of recurrence of lung cancer is also substantially lower in smokers who manage to quit smoking following diagnosis of early stage lung cancer or small cell lung cancer.

Whilst rates of smoking-related lung cancers reflect historical smoking trends, more needs to be done to support local services, such as those for smoking cessation, to reduce future incidence and to improve the survival of patients who are newly diagnosed.

*All mentions of HCPs refer to secondary and tertiary care clinicians so as to distinguish those polled in the HCP survey from the GP poll, which exclusively surveyed primary care clinicians.
**NATIONAL SCREENING: COULD SCREENING MAKE THE DIFFERENCE?**

We know from international examples that screening is an effective way to increase early identification. For example, a study in the US showed a 20% reduction in lung cancer specific mortality using low spiral CT screening tools. Positive steps are also being taken in the UK, with local initiatives such as UKLS17 and ECLS18, which assess screening techniques and the benefits of introducing screening across the country.

It is therefore encouraging that our findings show that clinicians agree with the growing evidence base that screening is an effective way to enable early diagnosis and have the desire to see such an initiative implemented as a means of improving survival. However, a decision is unlikely to be made until the UK national screening committee makes a recommendation based on the results of the NELSON trial.

There is a need now for these local initiatives to make further efforts to share their findings in a way that works towards a nationally funded programme, whilst the results of the NELSON trial are still pending.

**AWARENESS: LACK OF AWARENESS AMONGST PATIENTS OF THE SIGNS AND SYMPTOMS OF LUNG CANCER, AND WHEN TO SEE THEIR DOCTOR, IS STILL A CORE ISSUE**

Lack of awareness amongst patients of the signs and symptoms of lung cancer, and when to see their doctor, is still a core issue.

- **52% OF HCPs BELIEVE THAT A NATIONAL SCREENING PROGRAMME FOR LUNG CANCER SHOULD BE INTRODUCED**

**REFERRAL AND DIAGNOSIS: MORE NEEDS TO BE DONE TO IMPROVE PROMPT REFERRAL AND EARLY DIAGNOSIS TO ENSURE TREATMENT IS DELIVERED AS QUICKLY AS POSSIBLE**

- **65% OF HCPs BELIEVE EARLY-STAGE DIAGNOSIS TO BE THE MOST IMPORTANT FACTOR FOR IMPROVING FIVE-YEAR SURVIVAL RATES**
- **36% OF PATIENTS SURVEYED WAITED OVER ONE MONTH FOR A DEFINITIVE DIAGNOSIS AFTER AN INITIAL SUSPICION OF LUNG CANCER WAS MADE BY THEIR DOCTOR AND 17% WAITED OVER TWO MONTHS**
- **43% OF PATIENTS WAITED OVER ONE MONTH FOR INITIATION OF TREATMENT AFTER A DIAGNOSIS WAS CONFIRMED BY THEIR CLINICIAN**

Detecting cancer early and initiating treatment as quickly as possible following a diagnosis of lung cancer are imperative for improving survival rates. The NHS in England has set a waiting time standard of two weeks between urgent referral and hospital appointment to test for lung cancer and has also committed to the standard that treatment starts no more than 31 days after a treatment plan is agreed – with similar standards set across the UK. However, as the results of our survey show, lung cancer patients are still waiting a significant period of time before receiving a clear diagnosis and starting treatment. We also know from the latest statistics that across the UK, cancer waiting times vary and the targets which are set by nations are often missed.

**TREATMENT AND VARIATION: REGIONAL INEQUALITIES IN CARE AND UNDER-PRIORITYISATION OF MDTs MUST BECOME CENTRAL AREAS OF FOCUS FOR IMPROVEMENT**

- **52% OF HCPs BELIEVE THAT A LACK OF CAPACITY AND RESOURCE PRESENTS ONE OF THE GREATEST CHALLENGES TO THEIR MDT FOR IMPROVING LUNG CANCER SURVIVAL RATES**
- **84% OF HCPs BELIEVE REGIONAL INEQUALITIES IN HEALTH AND CARE SERVICES HAVE A MAJOR MODERATE IMPACT ON LUNG CANCER SURVIVAL RATES**
- **61% OF HCPs BELIEVE A STANDARDISED LUNG CANCER PATHWAY FOR THEIR NATION WOULD IMPROVE LUNG CANCER SURVIVAL RATES**

More needs to be done to ensure that there is quick and equitable access to diagnosis and treatment across the UK and to ensure that MDTs, which are a crucial part of delivering this, have sufficient capacity and resource in order to do so. A standardised lung cancer pathway within each UK nation was identified by HCPs as a way to improve survival rates and this may further assist in combating local variation rates. If HCPs believe they can do better for all patients by implementing new standards of care such as these, the benefits of doing so must be assessed and implemented by policymakers and health service leaders. Alongside this, such investments must be supported by increased investment in prevention and awareness, particularly in areas where incidence rates are at their highest, to reduce the risk of further perpetuating regional inequalities in care and outcomes.
## PRINCIPLES TO ACHIEVE BY 2025: IMPLEMENTING LASTING CHANGE

Using the insights from these surveys, the UKLCC has developed a comprehensive set of UK-wide principles which are phased for immediate, medium, and long term delivery towards 2025. These principles address key areas of improvement across the patient pathway, and are aimed to transform the way lung cancer services are delivered in order to drastically improve survival and meet the UKLCC’s 2025 survival ambition.

The following chapters of this report draw on the below principles marked for immediate delivery over 2016-18 and set tailored recommendations for England, Scotland, Wales and Northern Ireland that are necessary for achieving the UKLCC’s survival ambition.

### PHASE 1: 2016-2018

**Fundamental steps to meeting a new ambition**

<table>
<thead>
<tr>
<th>Principle</th>
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<tbody>
<tr>
<td><strong>1</strong></td>
<td>Governments across the UK to prioritise the improvement of lung cancer survival in any future plans or strategies relevant to the delivery of broader health, respiratory and/or cancer services.</td>
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<tr>
<td><strong>2</strong></td>
<td>UK governments to prioritise public health initiatives and prevention services, both locally and nationally with an aim to reduce and combat the number of lung cancer cases.</td>
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<td><strong>3</strong></td>
<td>Public health bodies across the UK to commit to the adoption of annual public awareness campaigns, funded nationally which are focused on raising awareness of the signs and symptoms of lung cancer.</td>
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<tr>
<td><strong>4</strong></td>
<td>UK governments should invest in local screening pilots, and continue to build an evidence base in anticipation of the NELSON trial results.</td>
</tr>
<tr>
<td><strong>5</strong></td>
<td>Health organisations and UK governments to commission national clinical audits or performance measures of referral services, which include the assessment of effectiveness of referral guidelines for suspected cancer, with target recommendations of how these can be improved.</td>
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### PHASE 2: 2019-2022

**Maximising improvements to continue to improve survival**

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<tr>
<td><strong>11</strong></td>
<td>UK-wide taskforce set up involving those across the lung cancer community and led by the UKLCC, to set out renewed nation-specific recommendations for improving five-year survival based on learning from existing European working groups (such as Cancer Benchmarking Partnership and the European Lung Foundation) and in line with European best practice and standards. UK governments to commit to taking these recommendations for achievement by 2025.</td>
</tr>
<tr>
<td><strong>12</strong></td>
<td>Ring fence budgets for smoking cessation services and improve public health initiatives/programmes and prevention services, which focus on reduction in smoking rates, aligning with current national guidance and initiatives.</td>
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<tr>
<td><strong>13</strong></td>
<td>Each nation to introduce a national screening programme for lung cancer for at risk groups, following the results of local initiatives and the NELSON trial.</td>
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### PHASE 3: 2023-2025

**Securing the 25 by 25 ambition**

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<td>Official standard set for 60% of those in at risk groups being screened as part of national screening programme for lung cancer.</td>
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<td><strong>18</strong></td>
<td>UK-wide working group to be established by UK public health bodies to work with the European Public Health Alliance. This group to examine and learn from best practice public health initiatives across Europe with the aim of lowering smoking rates in line with tobacco-free ambition of 5% by 2035.</td>
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### PRINCIPLES 2016-2018

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<td><strong>6</strong></td>
<td>Invest in existing bodies, including NHS England’s Lung Cancer Clinical Reference Group (CRO) and Public Health England’s Lung Cancer (Specific Clinical Reference Group (SISCRG)), and initiatives to improve and optimise referral, diagnostic and treatment pathways.</td>
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<tr>
<td><strong>7</strong></td>
<td>The National Cancer Institute to offer research funding towards projects aimed at developing cost-benefit assessments of diagnostic tools for lung cancer, with the objective of creating targeted recommendations to improve rapid diagnosis from point of initial suspicion.</td>
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<tr>
<td><strong>8</strong></td>
<td>National Institute for Health Research to work with UK nations to launch a pilot data programme to assess and address local variation for lung cancer treatment, with the aim of every part of the UK having sufficient resource and quality treatment to deliver above the European survival average by 2025.</td>
</tr>
<tr>
<td><strong>9</strong></td>
<td>ALL-MDTs should be responsible for designing their own diagnostic pathway following initial referral. They should also ensure that suspected cases are dealt with by a respiratory physician with a special interest in lung cancer and are assessed at a dedicated rapid access clinic.</td>
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<td><strong>10</strong></td>
<td>Upon diagnosis all MDTs should ensure patients have access to a lung cancer clinical nurse involved in all aspects of a patient’s care, and have a dedicated chest physician and a thoracic surgeon present as core members for all meetings.</td>
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<td><strong>11</strong></td>
<td>Annually review public awareness campaigns, focused on raising awareness of the signs and symptoms of lung cancer at a two month minimum, setting a minimum target to increase the number of those diagnosed at the earliest stage to 40%.</td>
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<td><strong>12</strong></td>
<td>Pilot the use of national lung cancer pathways in each devolved nation, aimed at improving survival outcomes and overall experiences of care.</td>
</tr>
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<td><strong>13</strong></td>
<td>Commit to ensuring that data collection, analysis and application matches the best in Europe as a means of improving lung cancer outcomes and experience of care.</td>
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<td>Define and deliver national lung cancer waiting times for all patients, as part of national screening programmes for at risk groups.</td>
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<td><strong>15</strong></td>
<td>Ensure that Lung Cancer Networks are established in each nation, led by national clinicians and led by the UKLCC, to set out nation-specific recommendations for improving five-year survival based on learning from existing European working groups (such as Cancer Benchmarking Partnership and the European Lung Foundation) and in line with European best practice and standards. UK governments to commit to taking these recommendations for achievement by 2025.</td>
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ENGLAND: MEETING THE 25 BY 25 SURVIVAL AMBITION

Lung cancer is the second most common cancer in England and is by far the biggest cancer killer overall, causing over 28,000 deaths in 2011 alone\(^4\).

With one of the lowest survival outcomes of any cancer type, the UKLCC has welcomed efforts to date to improve long-term survival. In the five-year cancer strategy published by the Independent Cancer Taskforce, it was noted that survival for lung cancer remains low, with 9,900 lung cancer avoidable deaths each year due to health inequalities\(^25\). The strategy sets out a number of recommendations in the report, four specific to lung cancer, focusing on screening, awareness campaigns, access to molecular diagnostics and national clinical audits for critical cancer services.

Encouragingly since the strategy’s publication in 2015, several efforts have been made to deliver against its recommendations and improve long-term survival for lung cancer:

- Public Health England introduced a chest symptoms awareness campaign in 2016, which included lung cancer and ran for four months (July - October)\(^26\)
- Whilst the UK National Screening Committee are yet to make a decision on lung cancer until the results from the NeLSoN trial are published, local screening initiatives, such as the United Kingdom Lung cancer Screening (UKLS) trial, have been commissioned by the Department of Health’s technology Assessment Programme, showing positive results in 2016 to support the case for a national programme\(^17\)
- Over 93% of patients are discussed at an MDT level, a key way to ensure patients receive the highest quality treatment and have a good experience of care\(^18\)

As a result of such improvements in care, long-term survival for lung cancer in England has significantly improved with recent estimates even now suggesting that five-year survival may have increased to 16%, and would appear to be directly correlated with the increase in surgical resection rates\(^9\).

As a result of such improvements in care, long-term survival for lung cancer in England has significantly improved with recent estimates even now suggesting that five-year survival may have increased to 16%, and would appear to be directly correlated with the increase in surgical resection rates\(^9\).

However, despite this, we know that overall outcomes are still poor in comparison to other cancer types, and the UKLCC is concerned that such positive momentum to tackle this may be under threat.

For example, in only a year, active treatment for lung cancer has fallen from 60.2% to 57.6% and there is still a high level of variation against the national average (15.4%) for NSCLC surgery\(^10\). Further, whilst reform to the original Cancer Drugs Fund (CDF) model was welcomed, there is uncertainty regarding the effectiveness of the new model proposed and the subsequent impact this will have on patient’s access to critical treatment. In addition, the £23 million Radiotherapy Innovation Fund launched in 2013 demonstrated how targeted service upgrades could be undertaken in a short space of time.

As well as this, smoking cessation services, which are essential to prevent cases from occurring in the first place, and to ensure those diagnosed who smoke have the best chance of survival, are under serious threat, with 40% of local authorities in England thought to be cutting their budgets to such services\(^12\).

Below is a series of immediate recommendations for England to improve five-year survival in line with the UKLCC’s 25 by 25 ambition. These recommendations are actions to maintain momentum around prevention and awareness, and explore additional steps which can be taken to ensure that patients present as early as possible. As well as this, they include utilising existing bodies and initiatives to optimise the diagnosis, referral and treatment pathway, as well as steps to tackle the still unacceptable levels of variation that occur in England, and throughout the UK.

- 24,000 people a year in England receive a lung cancer diagnosis at a late stage\(^3\)
- Access to a lung cancer nurse specialist varied from 33.7% to 100% across England in 2014\(^9\)
- Active treatment for lung cancer has fallen from 60.2% to 57.6%\(^10\)
- Five-year survival estimated to have increased to 16%\(^6\)
- The percentage of lung cancer patients receiving anticancer treatment varied by hospital trust from 32% to 83% in 2014\(^10\)
- Lung cancer is the biggest cancer killer in England\(^24\)
- One year survival (2013)\(^9\), 35%
- Five year survival (2013 predicted)\(^6\), 16%
PHASE 1
FUNDAMENTAL STEPS TO MEETING A NEW AMBITION: 2016-2018

1. A national cancer implementation group was set up in 2016 to oversee the delivery of the five-year cancer strategy published in 2015. Further to this, they have recently published an implementation plan which tracks progress against the plan to date.

2. The Cancer Implementation Group should work with NHS England to ensure that the specific recommendations for lung cancer from the report of the independent Cancer Taskforce are delivered as a priority within the group’s programme — and also ensure that lung cancer is appropriately prioritised in dealing against the wider recommendations.

3. With almost 24,000 people a year in England receiving a lung cancer diagnosis at a late stage, it is essential to focus on efforts which support early presentation. Public Health England ran a new awareness campaign in 2016 following the success of previous campaigns on the signs and symptoms of lung cancer, which saw an increase in the number of urgent referrals for suspected lung cancer of 30% during that period compared with the previous year. However, this campaign has so far been focused on respiratory conditions as a whole rather than on lung cancer specifically.

4. Following the results of the most recent national awareness campaign, Public Health England should commit to introducing dedicated public awareness campaigns for lung cancer annually and set a new target to double the percentage of people diagnosed at stage I of the disease in the next five years.

5. The Department of Health uses the NICE urgent referral guidelines as a key resource to refer patients as quickly as possible. However, currently it is difficult to measure whether the guidelines are fully adopted locally and their current effectiveness for lung cancer, and more broadly how referral pathways can best be improved. Alongside this, there are, however, existing innovation programmes such as Accelerate, Coordinate, Evaluate (ACE) which are exploring innovative approaches to achieving rapid diagnosis, including referral pathways.

6. The Department of Health should commission an annual national audit, based on the findings from the ACE programme’s assessment of NHS England’s referral routes, to assess cancer referral in England for the most common cancer types including lung.

7. The Lung Cancer CRG publishes a multitude of resources which can aid efforts to optimise pathways, however is not formally integrated into NHS England’s body of work. In particular, the group recently published the lung cancer service specification or “whole cancer pathway” for England. Having an established pathway was supported in the results of our HCP survey, with 60% believing that a standardised pathway would improve survival rates. The work of the CRG will become increasingly important now that there is no dedicated clinical reference group for thoracic surgery.

8. NHS England should consider how to integrate the Lung Cancer CRG within existing frameworks and support the implementation of the CRG whole lung cancer pathway.

9. Tackling variation was identified as one of the key priorities within the report by the Independent Cancer Taskforce. Given the importance of timely, appropriate treatment as early on in the lung cancer pathway, it is essential that efforts are taken to tackle this barrier. As our survey shows, 84% of secondary/tertiary HCPs believe regional inequalities in health and care have an impact on lung cancer survival rates. For example, in England the percentage of lung cancer patients receiving anticancer treatment varied by hospital trust from 31.6% to 83.2% in 2014.

10. The Department of Health should work with the National Institute for Health Research and the National Lung Cancer Audit to launch a pilot data programme to assess and address local variation for lung cancer treatment.

PREVENTION

AWARENESS

PRESENTATION

REFERRAL

DIAGNOSIS

TREATMENT
SCOTLAND: MEETING THE 25 BY 25 AMBITION

In 2014 alone, there were 4,117 deaths caused by lung cancer, representing over a quarter of all cancer related deaths7 and resulting in the poorest survival outcomes of any other cancer type in Scotland.

The UKLCC has welcomed steps in Scotland to tackle inequalities, improve prevention, and ultimately improve outcomes for those diagnosed with cancer. Most recently Scotland published a new plan for cancer services, Beating Cancer: Ambition and Action42, which positively had a strong focus on improving early stage diagnosis and preventing cases from arising in the first place. However, despite being the biggest cancer killer in Scotland, there were no dedicated actions in the plan for lung cancer. Quality Performance Indicators (QPIs) were also published in 2012 to support commitments against specific tumour groups, first seen in Better Cancer Care: An Action Plan43, and these are updated annually. Further to this, there are 13 dedicated QPIs for lung cancer, including indicators related to MDT meetings, pathological diagnosis and surgical resection in non-small cell lung cancer.

The Scottish Government has introduced a number of measures on prevention in line with a national ambition to ensure patients present as early as possible in order to have the best chance of survival:

— The Scottish Government has placed a large amount of resource on supporting a reduction in smoking rates, most recently evidenced in the publication of Creating a tobacco-free generation in 201344
— The Detect Lung Cancer Early programme was launched in 2013, aiming to improve awareness of symptoms and therefore encourage early diagnosis. The latest statistics also show that the percentage of lung cancer patients diagnosed at the earliest stage has increased by 24.7% since its launch46
— NHS Scotland has supported a screening study, ECLOS, which is trialling a new blood test called Early CD1-Lung, to test whether small lung cancers can be detected before they cause any issues amongst those who are at risk48

With regards to treatment itself:
— The percentage of all patients seen by a lung cancer clinical nurse has increased by 80.9% in 201346 to 84.2% in 201410
— The percentage of NSCLC patients receiving surgery has also increased from 15.7% in 201346 to 21.7% in 201447 and NSCLC patients at stage I or II having surgery has increased from 45.9% to 63.1%10 during the same period

It is clear that positive steps have been taken over the last few years to improve outcomes for patients. However, we know that momentum needs to be maintained in order to deliver substantive improvements against current survival statistics and consistently deliver a high standard of care. For example, the number of patients discussed at MDT level has slightly decreased from 97.4% in 201346 to 93.6% in 201410 and long-term survival still falls behind the best performing countries in Europe.

In order to make the next steps to improve five-year survival for lung cancer and meet the UKLCC’s 25 by 25 ambition, a number of recommendations for Scotland have been set out below based on the UKLCC’s survey findings and the most recent data and evidence.

Overall, these focus on ensuring that lung cancer is appropriately prioritised in the future and that the Scottish government and relevant organisations continue to undertake efforts to ensure those with lung cancer are treated in a way that ensures their chances of surviving for as long as possible.

LUNG CANCER HAS THE POOREST SURVIVAL OUTCOMES OF ANY OTHER CANCER TYPE IN SCOTLAND7

LUNG CANCER REPRESENTS OVER 25% OF ALL CANCER RELATED DEATHS7

PATIENTS DISCUSSED AT MDT LEVEL DECREASED FROM 97.4% IN 201346 TO 93.6% IN 201410

THE PERCENTAGE OF ALL PATIENTS SEEN BY A LUNG CANCER CLINICAL NURSE HAS INCREASED BY 80.9% IN 2013 TO 84.2% IN 201410

4,117 DEATHS CAUSED BY LUNG CANCER IN 20147

FIVE YEAR SURVIVAL (2007-2011)7

ONE YEAR SURVIVAL (2007-2011)7
PHASE 1
FUNDAMENTAL STEPS TO MEETING A NEW AMBITION: 2016-2018

RECOMMENDATIONS:

1. The Scottish Government published the latest cancer strategy, Beating Cancer: Ambition and Action, in 2016. However, whilst the UKLCC welcomed the actions and recommendations, we were disappointed that there were no dedicated actions for lung cancer.

2. The Scottish Cancer Taskforce should publish annual reports to assess progress made in delivering the ambitions set out in Beating Cancer: Ambition and Action and set targeted recommendations accordingly.

3. Despite marginally meeting its ambition to increase diagnosis for lung cancer patients at the earliest stage (stage I) by 25% by 2015 when first launched, it is still very positive that Detect Lung Cancer Early increased this number to 24.7%.

4. The Scottish Government should continue to invest in the Detect Lung Cancer Early programme and set a new early-stage diagnosis ambition for the next five years.

5. The Scottish Government use the Scottish urgent referral guidelines to facilitate appropriate referral between primary and secondary care for patients with suspected cancer. However, as with the NICE guidelines, it is difficult to measure whether the guidelines are fully adopted locally and their effectiveness in improving lung cancer care specifically.

6. Existing innovation programmes such as ACE aim to explore innovative approaches to achieving rapid diagnosis, including new referral pathways.

7. The Scottish Government should commission an annual national audit, or work with other UK bodies as part of the National Lung Cancer Audit in order to assess cancer referral in Scotland for the most common cancer types including lung, and provide targeted recommendations on how the pathway can be improved and whether the Scottish urgent referral guidelines need to be updated as a result.

8. Variation in outcomes exists in Scotland as does throughout the UK, with mortality rates varying by up to 20% across the three different regions in Scotland in 2014.

The Scottish Government should work with the National Institute for Health Research to launch a pilot UK data programme to assess and address local variation for lung cancer treatment.

PREVENTION

1. The Scottish Government should continue to promote smoking cessation services, following the publication of Creating a tobacco-free generation and most recently Beating Cancer: Ambition and Action, both to prevent future cases, and to improve survival for those who smoke and have recently been diagnosed with lung cancer.

2. Scotland has made great progress in investing in local programmes to demonstrate the value of lung cancer screening and current initiatives consider the cost-effectiveness of current screening methods versus the possible alternatives. NHS Scotland should establish local screening initiatives, utilising the £5 million announced in Beating Cancer: Ambition and Action for addressing health inequalities.

AWARENESS

3. Variation in outcomes exists in Scotland as does throughout the UK, with mortality rates varying by up to 20% across the three different regions in Scotland in 2014.

4. Despite marginally meeting its ambition to increase diagnosis for lung cancer patients at the earliest stage (stage I) by 25% by 2015 when first launched, it is still very positive that Detect Lung Cancer Early increased this number to 24.7%.

PRESENTATION

5. The Scottish Government use the Scottish urgent referral guidelines to facilitate appropriate referral between primary and secondary care for patients with suspected cancer. However, as with the NICE guidelines, it is difficult to measure whether the guidelines are fully adopted locally and their effectiveness in improving lung cancer care specifically.

6. Existing innovation programmes such as ACE aim to explore innovative approaches to achieving rapid diagnosis, including new referral pathways.

REFERRAL

6. The national standard from decision to treat until first treatment for all cancers is 31 days. However, the UKLCC’s survey found that from the lung cancer patients surveyed, 43% waited over one month to initiate treatment after a diagnosis was confirmed. More needs to be done to optimise treatment as well as referral and diagnostic pathways in order to achieve the best outcomes possible for patients. As well as QPIs, there are other existing programmes such as ACE which consider referral and overall lung cancer diagnostic pathways that can be utilised in Scotland.

DIAGNOSIS

7. Variation in outcomes exists in Scotland as does throughout the UK, with mortality rates varying by up to 20% across the three different regions in Scotland in 2014.

8. Whilst positive that the percentage of patients discussed at MDT level has increased from 86.1% to 97% from 2008 to 2013, this has now decreased to 93.6% in the last year alone. As an essential part of high quality care for all patients, the relevant organisations need to work with Trusts to ensure that MDTs are utilised to the greatest degree possible.

TREATMENT

8. Whilst positive that the percentage of patients discussed at MDT level has increased from 86.1% to 97% from 2008 to 2013, this has now decreased to 93.6% in the last year alone. As an essential part of high quality care for all patients, the relevant organisations need to work with Trusts to ensure that MDTs are utilised to the greatest degree possible.

Healthcare Improvement Scotland should work with Trusts to ensure at a minimum that 95% of patients are discussed at MDT level in line with the standard outlined in the lung cancer quality performance indicator. The Scottish Cancer Taskforce in their review of the QPI for lung cancer should include the recommendations for MDTs outlined in Principle 9 of this report to optimise survival at the point of treatment.
WEALES: MEETING THE 25 BY 25 SURVIVAL AMBITION

Over recent years, significant steps have been taken in Wales to improve outcomes for those diagnosed with lung cancer. With the worst survival outcomes in comparison to any other cancer type, accounting for almost 22% of all cancer deaths in 2013, the Welsh Government has identified lung cancer as one of five national cancer priority areas and in 2014 made the first necessary steps to improve survival outcomes for Wales’ biggest cancer killer.

Most significantly, lung cancer was a core focus of the ‘Together for Health: Cancer Delivery Plan’, and has featured in the last two annual action plans which support its implementation. In the 2014 annual report, it was noted that there was a need to focus on improving outcomes for patients by exploring awareness campaigns and improving access to curative treatments, research and stratified medicine initiatives.

In the 2015 annual report, lung cancer similarly remained one of the five national priorities for the cancer implementation group, with the report focusing on increasing access to key workers and introducing a second patient experience survey.

The UKLCC has welcomed efforts to deliver against these ambitions to improve long-term survival. These have included focusing on early diagnosis and making positive steps to ensure that patients’ quality of care and treatment is optimised and equitable across Wales:

— NHS Wales launched a new public awareness campaign, ‘Be Clear on Cancer’, to help raise awareness of the signs and symptoms of lung cancer running from July — August 2016. Previous campaigns had only focused on the risk factors of lung cancer, such as Stop Smoking Wales.

— The Lung Cancer initiative was launched in South Wales with the aim to increase survival for lung cancer patients, with later ambitions to introduce the initiative across the whole of Wales in 2017.

— Welsh Government and Macmillan Cancer Support launched the second cancer patient experience survey in July 2016 to gain insight into people’s experiences of cancer care, what is working and what areas need to improve, and to better understand the clinical and non-clinical needs of people with cancer in Wales.

— Since 2014, 99.6% of patients have been discussed at MDT level, which is a key way to ensure that patients have the best possible experience and care.

— Treatment levels have also increased with the number of people with NSCLC stage IIIB/IV and PS 0-1 receiving chemotherapy increasing from 56.4% between 2011 and 2013 to 61.1% in 2014.

— A number of regional cancer diagnostic work programmes have been undertaken across Wales, such as the Cwm Taf Early Stage Cancer Diagnosis Model.

— The ‘One Wales’ interim commissioning process was introduced to facilitate equitable access to treatments deemed effective for cohorts of patients which do not have a positive technology appraisal from the National Institute for Health and Care Excellence.

— The Lung Cancer initiative was launched in South Wales with the aim to increase survival for lung cancer patients, with later ambitions to introduce the initiative across the whole of Wales in 2017.

— Welsh Government and Macmillan Cancer Support launched the second cancer patient experience survey in July 2016 to gain insight into people’s experiences of cancer care, what is working and what areas need to improve, and to better understand the clinical and non-clinical needs of people with cancer in Wales.
**PHASE 1**
**FUNDAMENTAL STEPS TO MEETING A NEW AMBITION: 2016-2018**

**RECOMMENDATIONS:**

1. Lung cancer has been a named priority in the last two annual reports of the Together for Health: Cancer Delivery Plan. The current plan runs until 2016, and as such will be refreshed by the Welsh Government’s Cancer Implementation Group. Similarly, local health board cancer delivery plans, which were developed as part of the recommendations in Together for Health, also run up until 2016, and will be due to be re-assessed and updated.

   In order to build on the momentum already made, it is essential that lung cancer remains a priority in the new iteration of the national and local cancer delivery plans. The Welsh Government and local health boards should also commit to publish annual reports and action plans against the new plan(s) which tracks progress of delivery.

2. NHS Wales positively ran a national Be Clear on Cancer campaign from July - August 201615, and such efforts need to be continued.

   Following the results of the Be Clear on Cancer campaign, NHS Wales and Public Health Wales should commit to refreshing this campaign annually at a national level. Local health boards should also outline specific measures to promote this campaign locally or introduce separate initiatives to raise awareness of the signs and symptoms of lung cancer.

3. Wales currently has national screening programmes for breast, bowel and cervical cancers16. However, despite causing more deaths than breast and bowel combined17, there is no screening initiative available for lung cancer. The Welsh Government will consider the introduction of such a programme following advice from the UK National Screening Committee and the Welsh Screening Committee, both of which are awaiting for evidence from the NELSON trial. The Welsh Government stated that it will consider new evidence as soon as it becomes available18. In the meantime, the results from existing local screening trials should be evaluated and new local programmes in the immediate term should be introduced.

   Health and Care Research Wales should fund a local screening initiative to build the evidence base for lung cancer screening programmes, utilising evidence from the results of existing local lung cancer screening studies in the UK, such as UKLS and ECLS, when making future recommendations for lung cancer.

4. Both the Welsh Government and the Department of Health promote the use of the NICE urgent referral guidelines19 as a key resource for patients with suspected cases of cancer. However, currently it is difficult to measure whether the guidelines are fully adopted locally and their current effectiveness for lung cancer specifically. Alongside this, there a number of diagnostic pathways across Wales assessing new innovative ways to optimise early diagnosis and referral in response to new evidence from Denmark20.

   The Welsh Government should assess findings from new cancer diagnostic models being implemented in Wales, such as in Cym Taf, in order to update existing referral guidelines.

5. Wales have National Cancer Standards, including standards for lung cancer, which were originally introduced in 2005 as a means to demonstrate best practice in care and treatment21.

   The Welsh Government should carry out a public consultation on the current National Cancer Standards for Wales, and commit to updating them based on the recommendations provided.

6. The UKLCC’s survey identified that access to investigative tests and referral are still the greatest delays to rapid diagnosis, with 36% of patients surveyed waiting over one month for a definitive diagnosis after initial suspicion of cancer and 17% waiting over two months. Attempts to rectify delays in diagnosis are underway in Wales through The Outcomes Focused Partner Project which has a specific aim to improve the lung cancer diagnostic pathways22.

   The Welsh Government should commit to delivering a review of cancer diagnostic services in Wales, as stipulated in the Together for Health annual report for 2015, with a focus on lung cancer diagnosis.

7. The Together for Health annual report for 201523 announced the establishment of a cancer innovation pathway programme, with the first flagship programme dedicated to lung cancer. The programme aims to learn from existing and new improvement projects in order to reduce the inequality of care and outcomes.

   The Welsh Government should commit to delivering against the recommendation to introduce a flagship innovation pathway for lung cancer, and publish a timeline of when the results of the pathway will be published.

8. In Wales, as across the UK, there is still a significant amount of regional variation in access to treatment, which we know impacts overall outcomes. For example, the proportion of NSCLC patients who had surgery across Wales in 2014 varied by over two fold (8.7-19.6%)24.

   The Welsh Government should work with the National Institute for Health Research and National Lung Cancer Audit to launch a pilot data programme aimed at assessing and addressing local variation for lung cancer treatment.

9. Wales has made substantial steps to ensure that almost all patients are discussed at MDT level (99.6%), however access to specialist nurses still varies from 39.1% to 99% across the country25.

   The Welsh Government should work to ensure there is necessary support at a local level for MDTs, ensuring that their structures are in line with those recommended in Principle 9 of this report. Further to this, it should ensure that all patients have access to a lung cancer clinical nurse involved in all aspects of their care, as recommended in Principle 10.
NORTHERN IRELAND: MEETING THE 25 BY 25 AMBITION

Lung cancer causes more than one in five of all cancer-related deaths, is the biggest cancer killer in Northern Ireland and presents an average of 1,165 cases a year.

In 2011, there was a renewed focus on cancer services in the publication of the Service Framework for Cancer Prevention, Treatment and Care. This set out specific standards of care for different cancer types, including lung, focusing on smoking prevention, appropriate use of CT Scans in suspected cases and radiotherapy. Prevention was also a core focus in Transforming Your Care, a review of health and social care services published in 2011, which highlighted that around 340,000 people aged 65 and over smoke, and proposed measures to introduce further controls on tobacco usage. Similarly, in Making Life Better, a 10-year public health strategy published in 2014, preventing smoking was a key focus in improving health and wellbeing.

One of the first main assessments of current care was in Monitoring care of lung cancer patients in Northern Ireland, published in 2009, which compared the lung cancer care received by patients during 1996 and 2001. The report found positive improvements including patients presenting earlier, use of more complex imaging and increased equality of service access and increased referral rates. However, a significant proportion of patients were still being diagnosed at a late stage, and subsequently survival rates were still poor. As such, the report recommended efforts to promote earlier diagnosis, through better recording of disease stage and increased surgical, radiotherapy or chemotherapy treatment.

Over the last few years the UKLCC has welcomed initial efforts to tackle these identified challenges:

- In 2015, the Public Health Agency (PHA) launched the ‘Be Cancer Aware’ campaign, created to raise awareness of the signs and symptoms of cancer, with a phase for lung cancer specifically.
- The publication of the cancer patient experience survey was also welcomed, as it acts as a key way to help improve services and patients’ overall experience of care.

Whilst there have been some positive steps identified, gaps in care and services were highlighted in the most recent peer review of lung cancer services, which tracked adherence against Commissioning for Quality and Innovation (CQUIN) measures. Northern Ireland performed well against measures for MDT review and adherence to clinical guidelines and treatment pathways. However, the percentage of lung cancer patients having access to a key worker has decreased from 60% to 40% from 2014 to 2015.

Furthermore, and despite efforts to improve diagnosis at an earlier stage, 50.9% of cases from 2010-2014 involved the latest stage of the disease (stage IV), which results in a far poorer chance of survival than when a diagnosis is made at an earlier stage.

Overall it is difficult to definitively track progress in all areas of care as there has not been a comprehensive assessment of services since 2007, and Northern Ireland has been unable to submit data for the National Lung Cancer Audit. Positively, however, a new audit is underway and is due for publication in 2016.

Below are the recommendations for Northern Ireland, aimed at combating poor survival in lung cancer, alongside the UK principles, to meet the 25 by 25 ambition. Northern Ireland has identified tackling prevention and encouraging early diagnosis as key priorities. As such, the recommendations below are aimed at building on these initial first steps and setting new ambitions for the future. They are also aimed at creating a renewed focus on giving patients the best chance of survival from the point of seeing their doctor — optimising referral, diagnostic and treatment pathways.

ACCESS TO LUNG CANCER KEY WORKERS HAS DROPPED 20%.

2,400 AVOIDABLE DEATHS EACH YEAR DUE TO SMOKING.

45% OF LUNG CANCER CASES ARE DISCOVERED WHEN PATIENTS VISIT ACCIDENT AND EMERGENCY.

BIGGEST CANCER KILLER IN NORTHERN IRELAND.

50.9% OF CASES DIAGNOSED AT LATE-STAGE.
improving quit smoking services.

As part of the department of health’s annual reporting, preventing it from arising in the first place.

those who already have it, reducing smoking is key to due to lung cancer. Whilst it is essential to ensure treating each year due to smoking, a large proportion of which are in 201166, there has been no formal assessment published.

The Department of Health should commit to publishing an assessment of the progress made against the recommendations set out in Service Framework Care Prevention, Treatment and Care and Transforming Your Care and in line with results from the ongoing audit due for 2016 publication. The Department should then utilise these findings to produce a new framework which is published for public consultation, and sets out specific standards on how to tackle poor survival in lung cancer.

The UKLCC welcomed the introduction of the lung cancer Be Cancer Aware campaign in 2015. With 45% of lung cancer cases found when a patient attends accident and emergency, where only 13% are deemed fit for surgery, such efforts are crucial in raising awareness of the signs and symptoms of lung cancer and encouraging patients to see their doctor.

The Public Health Agency should commit to annual public awareness campaigns on the signs and symptoms of lung cancer and set a target for doubling the number of patients diagnosed at the earliest stage possible (stage I) in the next five years.

The Northern Ireland Cancer Network provide guidance on the red flag criteria in urgent referral guidance for suspected cancer cases, including lung. This is based on the NICE referral guidelines from 2005, which were subsequently updated in 2015.70

The Northern Ireland Cancer Network should work with the National Cancer Registry to conduct a national audit to assess cancer referral services in Northern Ireland, providing targeted recommendations on how the pathway can be improved and whether the current guidance needs to updated based on the most up-to-date iteration of the NICE urgent referral guidance.

The collection of data by the Northern Ireland Cancer Registry is fundamental for improving regional variation in care and treatment for those with lung cancer across Northern Ireland.

Local health bodies should work in co-ordination with the Department of Health and Northern Ireland Cancer Registry to develop local targets aimed at raising overall quality of care and reducing regional variation.

Since the publication of the Service Framework Care Prevention, Treatment and Care and Transforming Your Care in 201111, there has been no formal assessment published of progress against meeting the recommendations set out, despite a review having already been undertaken. Similarly, no progress report for Monitoring care of lung cancer patients in Northern Ireland has been published.12

The Department of Health should commit to publishing an assessment of the progress made against the recommendations set out in Service Framework Care Prevention, Treatment and Care and Transforming Your Care and in line with results from the ongoing audit due for 2016 publication. The Department should then utilise these findings to produce a new framework which is published for public consultation, and sets out specific standards on how to tackle poor survival in lung cancer.

Estimates suggest that there are 2,400 avoidable deaths23 each year due to smoking, a large proportion of which are due to lung cancer. Whilst it is essential to ensure treating those who already have it, reducing smoking is key to preventing it from arising in the first place.

As part of the Department of Health’s annual reporting of smoking quit rates each year, they should include a comprehensive assessment of the current barriers to improving quit smoking services.

Although there are currently screening programmes for breast, bowel and cervical cancer, there are no such plans for the introduction of a lung programme or studies to assess the effectiveness of introducing one in the future. Given early diagnosis was identified as a key way to improve survival in the UKLCC survey and over half of HCPS interviewed felt it could significantly improve survival, screening is an initiative which should be given consideration in future decisions on national screening programmes.

The Public Health Agency should work with the HSC Research and Development division of the department to fund a local pilot for lung cancer screening in Northern Ireland. This pilot should consider current evidence on local programmes for lung cancer screening across the UK, including from the Southern Health and Social Care Trust and local trials such as UKLS and ELCS. Following results from the trial, the Public Health Agency should then reassess the effectiveness of introducing a national programme following the decision from the UK National Screening Committee.

We know that once a patient presents, it is vital to ensure that they are diagnosed and commence the optimal treatment for them as soon as possible. However, we know from the UKLCC survey that this pathway is not always optimised. Further, the 2015 patient experience showed that whilst it was positive that 65% of lung cancer patients didn’t have to see their GP more than twice before being referred to hospital, this is the third lowest percentage of all cancer types assessed, and almost a third worse than breast cancer (94%)51.

The Northern Ireland Department of Health should work with the Northern Ireland Cancer Network to set up a working group to develop a standardised lung cancer pathway aimed at optimising diagnostic, referral and treatment pathways.

Transforming Your Care49 noted the importance of an effective MDT, with access to lung cancer clinical nurses also identified by patients in the UKLCC survey as one of the most important factors in ensuring they have a positive experience of care. Currently 66% of lung cancer patients are assigned to a clinical nurse specialist52, compared to 94% in breast cancer. In a census of clinical nurse specialists from 2014, the number of CNS posts for lung cancer have stayed the same since 201176. As such, more needs to be done to ensure that lung cancer MDTs are delivering the same quality and experience of care in comparison to the other most common cancer types.

The Department of Health in Northern Ireland should work with local trusts to ensure their MDT structures and processes are in line with current standards, immediately prioritising the elements highlighted in Principle 9 of this report. The Department should ensure that all patients have access to a lung cancer clinical nurse involved in all aspects of their care, as recommended in Principle 10.
CONCLUSION

We can clearly see from this report that across the UK significant steps have already been made to improve long-term survival for lung cancer patients, all contributing to the progress against meeting the UKLCC’s founding 10 years ago to double five-year survival rates. However, the lung cancer community has a mandate, founded in the needs of patients, to be more ambitious to pursue the very best chance of patient survival, bridging the gap between other cancers, and to meet The 25 by 25 ambition.

The UKLCC survey which aimed to identify what the key factors were in meeting this ambition. There was clear consensus from both primary and secondary care professionals that the most significant factor in improving survival was improving early diagnosis rates and optimising referral and treatment pathways. However, the surveys also identified that there is still a significant gap in patient knowledge of the signs and symptoms, with only 25% of patients going to see their doctor because they recognised their symptoms as those of lung cancer and 51% of GPs identifying that patients not knowing when to see their doctor was the biggest barrier to early diagnosis. As well as these 25% of patients are identified they still face significant waiting times to be referred and receive treatment, with 43% of patients waiting over one month for confirmation of diagnosis was confirmed.

Positively it is encouraging that UK governments have clearly identified this as an area in need of improvement, with all nations having invested in public awareness campaigns on the signs and symptoms of lung cancer, either as part of wider respiratory campaign or as a dedicated campaign itself. Parallel with this there is a number of initiatives to optimise care pathways and improve survival, such as the ACE programme in England and Wales which looks to optimise and speed up diagnostics to ensure that people are diagnosed as soon as possible.

It is imperative that actions are taken to maintain this positive momentum, and address the other key areas of improvement identified within this report, including building local evidence to support a lung cancer screening programme in anticipation of the NELSDN trial results and tackling regional inequalities in treatment and care and under prioritisation of MDts across the UK – in which we know from existing evidence, still occurs.

This report is aimed not only to identify the immediate steps which need to be taken now, but to set a vision for the future for lung cancer survival up until 2025.

As an organisation whose members are health care workers working directly within lung cancer services, as well as wider patient and industry groups, we are all too aware of the competing pressures currently facing health organisations across the UK.

However, it would be wrong to respond to these pressures simply by curtailing our ambition. By setting a long-term vision for lung cancer survival, underpinned by tailored initiatives for each nation, this report provides a transformative and attainable plan for lung cancer outcomes so that, year on year, patients diagnosed with lung cancer are living longer.

REFERENCES

25 Royal College. Service Specification for