

Editorial

Calman-Hine: two years on

Approximately one in three people in the UK will develop cancer and about one in four will die of the disease. The findings from the large EUROCARE study suggested that relative survival rates for several common cancers are lower in the UK than in most western European countries.¹ However, before the publication of the Calman-Hine report² there was little strategic planning of cancer services in the UK.

In the past few years several reports have drawn attention to the fragmentation of cancer care in the UK and to variations in the management and survival of patients with cancer.^{3,4} At the same time there is increasing evidence that provision of care by specialist teams leads to better survival rates, particularly in relation to breast cancer, ovarian cancer and some haematological malignancies.⁵ The deficiencies of current cancer services also relate to the patient-centredness of care. Concerns have been expressed about the communication skills of health professionals, the amount and quality of information given to patients and relatives, the level of psychosocial support provided and the lack of continuity of care.⁶

The three levels of care proposed in the Calman-Hine report (primary care, cancer units and cancer centres) are now widely known. The principles set out in the report as governing the provision of cancer services are perhaps less well known. The first of these is that all patients should have access to a uniformly high quality of care; the others stress the importance of:

- public and professional education to promote the early diagnosis of cancer;
- patients and carers being given clear information about treatment options;
- services being patient-centred;
- good communication;

- psychosocial aspects of cancer care;
- the central and continuing role of the primary care team;
- cancer registration and careful monitoring of outcomes.

In order to deliver high-quality care the report stresses the need for multiprofessional teams of experts and the value of 'networks' which cross boundaries between hospitals and the community. The need for palliative care to be integrated in a seamless way with all cancer treatment services is emphasized, as many patients present with incurable disease, needing expert symptom control and psychological, social and spiritual support from the time of diagnosis.

The Calman-Hine report sets out a new framework for cancer services. The challenges now are to secure the commitment of health care professionals to implement the necessary changes and the commitment of the National Health Service (NHS) to provide adequate resources.

What progress has been made in the past two years? The profile of cancer has certainly been raised within the NHS. Clinicians and managers at local, regional and national levels have devoted a great deal of time and effort to the process of implementation. Much of the early work focused on the designation of DGHs as cancer units, and indeed many hospitals view designation as a cancer unit as essential for their survival. Considerable progress towards specialization within DGHs has already been made to achieve designation. Over time this should result in better care and outcomes for patients.

Less progress has, as yet, been made in relation to the other two levels of care (primary care and cancer centres). One of the problems in relation to primary care is that an average general practitioner will only see about 10 new cases of cancer each

year. Maintaining the skills needed for early diagnosis and to provide high-quality care throughout the course of the disease can thus be very difficult. The need for purchasers to have contracts for specialist palliative care which are based on the health needs of the local population has been stressed by the NHS Executive (EL(96)85).

As far as cancer centres are concerned, few hospitals provide the full range of specialist services outlined in the Calman-Hine report. Co-operation between hospitals to form joint cancer centres is being actively encouraged by health authorities in several parts of the UK, in contrast with the competition that was inherent in the NHS reforms of the early 1990s. Clinicians and managers responsible for cancer centres are sharing information on facilities, workloads, manpower and financial resources. Significant inequalities in the provision of specialist cancer services have been revealed.⁷

In parallel with the work of local and regional groups, guidance related to specific cancer sites is being produced at a national level under the auspices of the Department of Health's Clinical Outcomes Group. A rigorous approach has been developed with the aim of producing objective, evidence-based guidance regarding the organization and delivery of high-quality care. The first stage in the process is the development of structured proposals related to the cancer site by a large group of relevant health care professionals, patients, purchasers and academics. These proposals, which cover all aspects of care for the particular cancer site, are submitted to extensive peer review and are evaluated through systematic reviews of the research literature. The final guidance takes account of the comments and reports from all of these sources. The breast cancer guidance was published in 1996.⁸ It is anticipated that guidance on colorectal cancer and lung cancer will be published in 1997 with other sites to follow thereafter.

As for the future, a great deal more needs to be done if the Calman-Hine framework is to be fully implemented; the momentum developed over the past two years must not be lost. The government's recent commitment of £10 million per annum to improve the quality of breast cancer services is very welcome. However, further funding will undoubtedly be required if all patients with cancer are to receive high-quality care. The need for additional trained personnel in a wide range of specialties is already apparent, including in surgery, radiology,

pathology, oncology, palliative care, liaison psychiatry, nursing and data management.

The formation of effective multiprofessional teams will require considerable commitment from all concerned. Teams must meet regularly to plan and review the management of individual patients. Patients' wishes for continuity of care must not be overlooked, and provision of joint or parallel clinics can facilitate the transition of patients between surgery and oncology and between oncology and palliative care. Processes need to be devised to ensure effective communication between primary care teams, site-specific teams and palliative care teams. The transfer of information between cancer units, cancer centres, hospices and cancer registries needs to be considered. Palliative care must be represented in discussions at local and national levels on the implementation of Calman-Hine to ensure that a truly seamless service is implemented.

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References

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