

Lung cancer

The UK Lung Cancer Coalition is a partnership of charities, clinicians, senior NHS professionals and health-care companies with a commitment to double lung cancer survival. It is the nation's only multi-interest group in lung cancer. In this one-to-one interview, Alison Bloomer talks to Dr Mike Peake, Chair of the Coalition, about lung-cancer care in the UK.

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Lung cancer is the most common cause of death from cancer in the Western world—more women die of lung cancer than of breast cancer in most areas. Although the incidence in men is steadily falling, in the UK, one person dies from lung cancer approximately every 15 minutes. According to the recently published results of the first national review of lung-cancer services,¹ the NHS is still failing lung cancer patients.

Despite making headway on prevention of lung cancer, disease awareness and screening, key areas such as diagnosis, treatment rates, and access to specialists are still inadequate. In this one-to-one interview, Dr Mike Peake talks about current lung-cancer care in the UK.

Dr Peake is involved in the development of national policies for lung cancer in various roles. He was a member of the writing committee for the National Clinical Outcomes Group Guidelines on Lung Cancer, he chaired the Department of Health's Urgent Referral Guidelines Group for Lung Cancer, and is Programme Director of the Lung Cancer Project at the Clinical Effectiveness and Evaluation Unit of the Royal College of Physicians. He also chairs the Intercollegiate Lung Cancer Group, and is a member of the Department of Health's Lung Cancer Advisory Group.

How did you become an expert in lung cancer?

I am a respiratory physician by background and a lot of respiratory physicians do not have formal training in lung cancer. I developed an interest in lung cancer because these patients always seemed to be getting the worst possible deal. Even more unsettling was that these patients did not expect much and were happy with the crumbs of treatment that they received. We used to have to beg for CT scans.

We have seen improved organisation of services in the past decade, following the Calman Hine report² in 1995, the NHS National Cancer Plan³ in 2000, and the work of the Cancer Services Collaborative Programme. These initiatives have led to the near-universal adoption of multidisciplinary team working, rapid referral and diagnosis clinics, methods to ensure the vast majority of lung-cancer patients are seen by a specialist, and increasing active treatment rates.

Why was the UK Lung Cancer Coalition created?

It was created in 2003 after a group of us became anxious that the Cancer Services Collaborative Programme was not going to be funded after 2004. Industry was interested in sponsoring the

group since better care meant more referrals and access to treatment. The Government has continued to fund the Cancer Services Collaborative Programme so the Coalition is primarily a campaigning organisation. Charity members include British Lung Foundation, Cancer Black Care, Cancer Research UK, Macmillan Cancer Support, Marie Curie Cancer Care, Roy Castle Lung Cancer Foundation, and Tenovus.

What do you do to raise awareness of lung cancer?

In 2007, the Coalition developed a 12-point plan.⁴ It calls for action, that would make a real difference for lung-cancer patients. Raising standards of care across the NHS to those in the best centres would, we believe, save many thousands of lives. We are keen to work with the NHS and Government, patients and carers, industry, and the voluntary sector to make sure this change happens.

Our challenge is to double 1-year lung-cancer survival by 2015 and 5-year survival by 2020. It was quite difficult to know what to target. We chose survival since rates can vary widely across the UK. If we bring the worst areas up to the average then we can improve 5-year survival—and save an estimated 13,000 lives.

	Progress rating	2010 call for action—what the Government needs to do for lung cancer
Prevention	Good	<ul style="list-style-type: none"> Commit to funding and implementing comprehensive national tobacco strategies with clear goals. Challenge medium-term and long-term targets, including a review of smoking cessation services to assess fitness for purpose and meeting users' needs.
Screening	Good	<ul style="list-style-type: none"> Monitor and support the National Institute for Health Research's feasibility study, to enable making a swift decision on the viability of a lung-cancer screening programme.
Awareness	Good	<ul style="list-style-type: none"> Raise awareness of the signs and symptoms among the general public and health-care professionals. Improve knowledge of treatment options to address the fatalism and stigma associated with this disease.
Primary care	Limited	<ul style="list-style-type: none"> Incentives should be included in the Quality and Outcomes Framework to encourage general practitioners to refer at-risk patients for a chest X-ray, particularly those with newly diagnosed or developing COPD symptoms.
Information and support	Limited	<ul style="list-style-type: none"> Ensure that patients are offered high-quality information at key points in their cancer journey, tailored to individual's needs and supported by face-to-face contact with a health-care professional. All patients should have access to a specialist lung-cancer nurse, and receive regular holistic needs assessments and updated care plans at key points in their cancer journey, including at diagnosis, end of treatment, and end of life.
Diagnosis and staging	Poor	<ul style="list-style-type: none"> Investment in radiology services for accurate diagnosis and staging. Every Trust should achieve proven diagnosis rates of at least 75%.
Treatment	Poor	<ul style="list-style-type: none"> Every Trust should examine levels of active treatment and strive to bring them closer to the 70% achieved in some parts of the country. Clinical guidance should be updated to reflect new therapeutic and technological options. Tools should be developed to support in commissioning effective lung-cancer services.
End-of-life care	Limited	<ul style="list-style-type: none"> Implement 24/7 coordinated community nursing care across the country, as quickly and efficiently as possible, in line with the End of Life Care Strategy in England.
Managing care	Poor	<ul style="list-style-type: none"> Every patient's case should be considered by a fully representative multidisciplinary team of specialists with a prime interest in lung cancer.
Workforce capacity	Poor	<ul style="list-style-type: none"> Shortages in the workforce must be addressed, and every Trust and Cancer Network should review workforce capacity as a matter of urgency, to ensure parity with services for patients with breast cancer.
Research	Limited	<ul style="list-style-type: none"> Provide and invest in a supportive environment for research to include funding into early detection and diagnosis, basic research, treatment and clinical trials. All patients should be offered the opportunity to participate in trials if eligible.
Data collection	Good	<ul style="list-style-type: none"> Compliance with national comparative audits should be a core part of Quality Accounts and every Trust should be striving to complete and submit datasets for all patients.

Table: Reviewing the Lung Cancer Plan: are we emerging from the shadow of lung cancer?

The UK Lung Cancer Coalition launched its 12-point Lung Cancer Plan⁴ in 2007—the first of its kind in the UK. The Plan set ambitious and challenging targets to help to double lung-cancer survival and eradicate the huge national inequalities that exist in lung-cancer care. Two years on from the launch of the Plan, the Coalition asked its clinical advisers, all of whom work in front-line cancer services, to assess the progress made to date and to help map out the priorities for the future. In each area the progress made was rated as either good, limited, or poor.

Why do survival rates vary so widely across the UK?

The National Lung Cancer Audit⁵ for 2007, which was published in April 2009, highlighted that only half of lung-cancer patients receive any kind of active treatment, and only 10% of patients have surgery—which is still the best hope of cure. Additionally, not all patients have access to a specialist nurse—a vital source of information and support for patients and their families.

Our review of the Lung Cancer Plan¹ found that in some parts of the UK, fewer than 10% of patients receive any form of treatment to halt the spread of their disease—chemotherapy, radiotherapy or surgery. We are calling for a 70% active treatment rate across the board, which would mean a massive reduction in the number of lung cancer deaths. Up to 3000 lives could potentially be saved each year as a result (table).

Why is the number of patients who undergo surgery so low?

Surgical rates vary greatly. You can be six times more likely to have an operation in some parts of the country than in others. There are only 44 full-time equivalent specialist thoracic surgeons spread thinly over 240 multidisciplinary cancer teams across the country and many teams lack core members so we do not have not enough surgeons.

A number of cardiac surgeons do some thoracic work and they are very competent, but they are not specialists and do not understand the complexities and technical aspects of lung-cancer surgery. A whole group of patients cannot access the surgeons. We do not need large numbers of surgeons but we do need better access to them, and some form of referral system.

Where do most lung cancer patients present?

A lot of patients will present to their general practitioner. One problem is that general practitioners have a low threshold for getting an X-ray. They need to know the risk group that the patient in front of them falls into. The bulk of lung-cancer patients are ex-smokers, it is more common in chronic obstructive pulmonary disease, and patients are mostly older than 50 years.

Persistent symptoms, such as cough or a previous cough that gets worse, should be looked for. A group of patients will also end up on elderly-care wards. A lot of these patients will not receive a biopsy to confirm diagnosis and a large percentage do not receive access to treatment. Often geriatricians cannot do much for these patients, but sometimes a specialist can help. That is why patients should always be referred to a lung-cancer specialist after diagnosis.

What does the future hold for lung cancer patients?

Lung cancer is on the agenda at last, but it still does not have the government and public presence that breast cancer has. That needs to be addressed. The amount of cash available to spend on research is small compared with the scale of the problem. The jigsaw is coming together: a fall in the incidence of smoking has helped; there is growing public and primary care awareness; and there are new drugs in development that are very interesting.

Advances in treatment include combination chemo-radiotherapy, the establishment of the place of chemotherapy in non-small cell lung cancer, adjuvant chemotherapy, improved surgical techniques, CHART radiotherapy, and the whole new field of the biological agents such as inhibitors of

epidermal growth factor receptor or vascular endothelial growth factor. Lung cancer has different patterns—each patient is different so the same treatment cannot apply to everyone. Lung cancer is not what it was when a lot of general practitioners and geriatricians were training—proper staging and specialist assessment is essential.

Other factors that are making a difference include the establishment of a National (England and Wales) audit programme for lung cancer, which will begin to publish comparative data for activity and performance on outcomes that can only help to drive up standards. We do have a lot to be optimistic about but we still have a long way to go.

References

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