

## Comment on 'an Association of Cancer Physicians' strategy for improving services and outcomes for cancer patients'

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Sir,

We write to draw attention to the recently published strategy of the Association of Cancer Physicians (ACP; Baird *et al*, 2016). This ACP strategy reflects a significant evolution of medical oncology planning and practice in the United Kingdom. Previous strategies necessarily focused upon the development of medical oncology as a research-based discipline whose main contribution to cancer care was the development and delivery of systemic anti-cancer therapies (SACT). In the last three decades, the specialty has undergone rapid expansion in consultant numbers and in the roles performed by medical oncologists. This requires a reassessment of our priorities and our role in providing the best cancer care and outcomes for patients. Despite recent growth, the number of medical oncology consultants per head of the population in the UK is low by European standards (de Azambuja *et al*, 2014). There is an increasing recognition within the UK that, despite substantial progress, the job of improving cancer outcomes is far from complete (Allemani *et al*, 2015), significantly as a consequence of relatively late diagnosis compared with comparable countries (Forbes *et al*, 2013; Jensen *et al*, 2015). With the need to develop and deliver increasing SACT, which results from new scientific understanding of cancer and the epidemiological pressures of the ageing population, our discipline will continue to be one of the most rapidly growing of all medical specialties.

The strategy focuses on improving patient outcomes by a wide range of interventions and identifying the ways in which medical oncologists can contribute. It was 'co-produced' with cancer patients and is evidence-based with detailed supporting chapters written by ACP members and external advisors (Baird *et al*, 2016). Many of the recommendations of the Independent Cancer Taskforce in the UK (Independent Cancer Taskforce, 2015; ICTUK) are endorsed and integrated into our strategy. By working closely with other healthcare professionals, researchers, health service managers and, in particular, with patients, in implementing the recommendations of the Taskforce, we look forward to making a crucial and increasing contribution to improving cancer outcomes in the coming decades.

Having contributed substantially to the improvements in cancer outcomes over the past 25 years, we are greatly encouraged that over 50% of UK cancer patients now survive their disease for 10 years or more. We are at a time not only of unprecedented acceleration of knowledge with regards to all aspects of cancer, but also of rapid change in terms of patient management and new therapies. To deliver better outcomes for patients, we must overcome challenges over the next decade, such as increased demand for cancer services and financial constraint in the NHS. We are committed in working with our patients and colleagues to improve the outcomes for cancer patients so that 75% of the patients survive for 10 years or more, with improved patient experience and quality of life, within the next 20 years.

To contribute to this vision, over the next 3–5 years the ACP will work to achieve three broad goals:

- The delivery of excellent and safe medical oncology for all patients. We will continue to develop and strengthen multidisciplinary, specialised patient-centred care through provision of adequate numbers of highly trained medical oncologists; engaging closely with patients to understand their needs; and by application of high-quality research and innovation. By ensuring that training standards remain high and that the discipline grows appropriately, we can ensure safe and excellent cancer care for patients across the UK. Our European peers have more than one full-time equivalent (FTE) consultant for every 100 000 people (de Azambuja *et al*, 2014) and we will aim to match this in the UK by 2020 and then approach 1.5 FTE consultants per 100 000 people as soon as that is possible. This will require the right numbers of trainees to sustain the workforce over time.
- A substantial contribution to the overall development of NHS services, by developing cancer services to cope effectively with pressures currently impacting on other parts of the NHS. We particularly identify the demand for acute oncology and the care of older cancer patients as areas in which most medical oncologists will increasingly engage.
- A substantial contribution to the development of innovative approaches to cancer care, by close collaboration with primary care and other health professionals, developing better access to high-quality diagnosis, prevention and treatment. We will exploit modern health informatics, and better support the rapidly growing number of cancer survivors. We will develop and promote the rapid adoption of evidence-based innovations arising from biomedical sciences creating a more precise approach to oncology, providing patients with higher probabilities of treatment success and lower probabilities of toxicity.

We will share and converge our goals and commitments with those of the ICTUK (Independent Cancer Taskforce, 2015) and with the other clinical and non-clinical bodies engaged in improving outcomes for cancer patients. We will work with the Royal College of Physicians ([www.rcplondon.ac.uk](http://www.rcplondon.ac.uk)) and our colleagues in Clinical Oncology (Royal College of Radiologists—RCR) converging our strategies and workforce plans ([www.rcr.ac.uk](http://www.rcr.ac.uk) (Clinical oncology—the future shape of the specialty. Royal College of Radiologists (2014); Clinical oncology workforce: the case for expansion. Royal College of Radiologists (2014))). We have shared our strategy with the RCR early on and have agreed joint working where appropriate. We will collaborate and consult with cancer charities, including those that focus on individual tumour types, and with Macmillan Cancer Support ([www.macmillan.org.uk](http://www.macmillan.org.uk)) and Cancer Research UK ([www.cancerresearchuk.org](http://www.cancerresearchuk.org)).

### CONFLICT OF INTEREST

The authors declare no conflict of interest.

### REFERENCES

- Allemani C, Weir HK, Carreira H, Harewood R, Spika D, Wang XS, Bannon F, Ahn JV, Johnson CJ, Bonaventure A, Marcos-Gragera R, Stiller C, Azevedo e Silva G, Chen WQ, Ogunbiyi OJ, Rachet B, Soeberg MJ, You H, Matsuda T, Bielska-Lasota M, Storm H, Tucker TC, Coleman MP. CONCORD Working Group (2015) Global surveillance of cancer survival 1995–2009: analysis of individual data for 25,676,887 patients from 279 population-based registries in 67 countries (CONCORD-2). *Lancet* **385**(9972): 977–1010.
- de Azambuja E, Amey L, Paesmans M, Zielinski CC, Piccart-Gebhart M, Preusser M (2014) The landscape of medical oncology in Europe by 2020. *Ann Oncol* **25**(2): 525–528.
- Baird R, Banks I, Cameron D, Chester J, Earl H, Flannagan M, Januszewski A, Kennedy R, Payne S, Samuel E, Taylor H, Agarwal R, Ahmed S, Archer C, Board R, Carser J, Copson E, Cunningham D, Coleman R, Dangoor A, Dark G, Eccles D, Gallagher C, Glaser A, Griffiths R, Hall G, Hall M, Harari D, Hawkins M, Hill M, Johnson P, Jones A, Kalsi T, Karapanagiotou E, Kemp Z, Mansi J, Marshall E, Mitchell A, Moe M, Michie C, Neal R, Newsom-Davis T, Norton A, Osborne R, Patel G, Radford J, Ring A, Shaw E, Skinner R, Stark D, Turnbull S, Velikova G, White J, Young A, Joffe J, Selby P (2016) An Association of Cancer Physicians' strategy for improving services and outcomes for cancer patients. *Ecancermedicalscience* **10**: 608.
- Forbes LJ, Simon AE, Warburton F, Boniface D, Brain KE, Dessaix A, Donnelly C, Haynes K, Hvidberg L, Lagerlund M, Lockwood G, Tishelman C, Vedsted P, Vigmostad MN, Ramirez AJ, Wardle J. International Cancer Benchmarking Partnership Module 2 Working Group (2013) Differences in cancer awareness

and beliefs between Australia, Canada, Denmark, Norway, Sweden and the UK (the International Cancer Benchmarking Partnership): do they contribute to differences in cancer survival? *Br J Cancer* **108**: 292–300.

Independent Cancer Taskforce (2015) 'Achieving World-Class Cancer Outcomes. A Strategy for England 2015–2020'. Independent Cancer Taskforce, 2015 Available at [www.cancerresearchuk.org/sites/default/files/achieving\\_world-class\\_cancer\\_outcomes\\_-\\_a\\_strategy\\_for\\_england\\_2015-2020.pdf](http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf) (accessed 26 May 2016).

Jensen H, Tørring ML, Olesen F, Overgaard J, Fenger-Grøn M, Vedsted P (2015) Diagnostic intervals before and after implementation of cancer patient

pathways – a GP survey and registry based comparison of three cohorts of cancer patients. *BMC Cancer* **15**: 308.

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