



HAEMATOLOGY

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Dear Sirs

Re: Response to A Healthier Future; A Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005 – 2025.

The radiotherapy and oncology committee was pleased to see this consultation document and recognises many positive features in it in improving the health and wellbeing of the nation. We would however, wish to make some specific comments with regard to some of the cancer related comment of the document:-

- 1 Smokefree public places and workplaces.
This committee endorses the overall aim of this document and in particular recommends the adoption of option three 'ban smoking in all enclosed public places and workplaces in Northern Ireland'. We are satisfied that this is one of the key recommendations of this document, the introduction of which will act up to free health resources in the longterm for investment elsewhere. Many members will have responded individually supporting this option and we recommend its adoption.
- 2 Key Population Health Outcomes.
The target to increase the five year cancer survival rates to the levels of the best European countries is noted. We applaud this objective and fully agree with its aim. It is necessary to realise that the best European countries five year cancer survival rates are not static but improving all the time. Thus it will be necessary to institute, at an early



stage, a programme to specifically target this outcome. Components of this programme, which can be identified at present are as follows:-

- 3 **Organisational changes in the practice of cancer medicine.**
The value of well-organised multidisciplinary meetings in the management of patients with cancer has now been well recognised. Unfortunately most MDMs are under-resourced and because of heavy workload commitments and the difficulties in finding agreed times in the working week for meeting most MDMs occur at 8 am in the morning. It will be necessary to find the resources to allow MDMs to be scheduled as part of the working day so that management of patients with cancer can be co-ordinated between modalities of pathology, surgery, radiotherapy and oncology, supportive care and any other approaches which may be necessary.
- 4 **Timeliness of surgery.**
Surgery remains one of the principal means of curing cancer. If we are to achieve survival rates equivalent to the best European countries it will be necessary to shorten the waiting time for surgery so that, for example, patients requiring surgery for cancer of the lung can be scheduled for rapid surgery reducing the number of patients who will be found to be inoperable. Patient education is also an important part of this process so that the patients seek help at an earlier stage of this disease. While the example of lung cancer has been used, this approach is relevant to many forms of cancer; early resection of liver metastases being another clearly identifiable growth area. Implicit in reaching this standard is an adequate provision of appropriately qualified surgeons with adequate numbers of theatre lists, theatre support services and anaesthetists.
- 5 **Adjuvant chemotherapy.**
The past few years have seen real advances in adjunct chemotherapy. In breast cancer Taxitene has been shown to increase disease-free survival by 8.7% and similar improved survival is seen with use of Oxiplatin on its own or in combination in colorectal cancer.
- 6 **Conventional chemotherapy with curative intent.**
Even more dramatic responses have been seen with the addition of Rituximab (MabThera) to conventional chemotherapy in diffuse large B cell lymphoma with improvements of disease-free survival after chemotherapy of between ten and twenty percent. As with advances in adjuvant chemotherapy these figures represent a real advance in cancer management and if we are to match best European practice then appropriate funds will be required to fund not only drug costs but also sufficient oncologists and oncology nurse specialists to support their administration.

- 7 Other chemotherapeutic advances.
Greater understanding of the cancer cell and cancer process has led to a new wave of drugs with entirely novel modes of action. The use of Thalidomide in myeloma has been a particularly remarkable example of more recent developments in the field. It has been shown that Bortezomib (Velcade) the first-class drug inhibiting the proteasome is highly effective in relapsed and refractory cases of myeloma, extending median survival by an additional 10 months, when used as a single agent. Interestingly like Thalidomide, Bortezomib may be even more effective when combined with conventional antimyeloma drugs as there appears to be significant synergy between the new biological agents and existing chemotherapy agents.

The implications of the above is clear; if we are to match best practice in comparator European countries then we will have to make available resources – both in terms of drugs and manpower – to optimise cancer survival.

- 8 Technology
Under paragraphs 2.9, 2.10, 2.11 and 2.12 technological developments are highlighted which may well impact on the treatment of malignant disease as much or more than almost any other condition. What is certain is that to remain abreast of current technology once again investment will be required so that new technologies may be availed of in a timely manner and within an appropriate science base to quality assure our use of these exciting biotechnology opportunities. Though these new techniques may well assist in conserving resources it is likely that one or more predictive markers will be developed indicating the specific drug which may be of benefit in particular tumours allowing rational therapy to be designed and preventing the use of what might be found to be ineffective therapy after a prolonged and inexpensive trial providing little benefit but significant side-effects for the patients. Furthermore the use of molecularly targeted drugs may turn many previously fatal malignant conditions into chronic illnesses which may well be capable of being managed by molecular regulators for significant periods of time.
- 9 Screening
Screening has been shown to improve the outcomes for both breast and bowel cancer; no screening of prostate cancer has yet to be shown to have any beneficial effect. However, as trials of screening mature it is clear that screening may well need to be applied to a wider group of women for breast screening and to a much greater number of patients suspected of having bowel cancer. We do not at present have the manpower or facilities to undertake the necessary colonoscopies which a full and proper screening programme would indicate as

necessary. Significant thought needs to be given to the training of non-medical personnel to undertake routine colonoscopy and, in the laboratory, radiology and other facilities needed to undertake screening or deal with the results of screening. Other areas in which it is anticipated that screening may prove to be of value will include the use of high resolution CT in select patients suspected of being at risk for lung cancer.

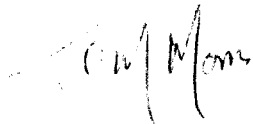
- 10 Improving quality, 3.18.
While we agree it is good to be honest and clear about what can and cannot be provided within the resources available this paragraph may be at odds with some of the previous statements in which aspirations to match best outcomes in cancer care in other European countries is clearly identified as a target. It would be clearly necessary to change our way of working so that services can be organised to bring the best of care to patients in a timely fashion, however if we do not have access to new technologies and therapeutic agents in a timely fashion then the task of achieving these clearly desirable objectives may well be beyond even the most well intentioned and hard working clinicians and health care professionals no matter how well organised.
- 11 New roles and competencies, 6.13, 6.26.
We note and welcome the proposal to develop Nurse Practitioners and commend those already in post providing care to specific groups of cancer patients. We believe this role is very suitable for development but are concerned at the slow pace in implementing these valuable posts which have a benefit for all concerned including patients, relatives, nurse practitioner and consultant.
- 12 Under 6.17, 6.18 the committee is concerned that the recruitment of staff from overseas is seen as a longterm goal. We believe that government policy should be to make our community self-sufficient in the provision of healthcare delivery; in particular the recruitment of doctors and skilled nurses from developing countries is not an appropriate drain on their resources.
- 13 The committee welcomes section 8 making it happen which is essential to the success of the document. We are disappointed that a section on the harnessing of new technologies has not been included in this part of the document although it is frequently alluded to in earlier sections. While much good work can be done in terms of cancer prevention the fact remains that with an aging population cancer rates will become more common. If overall health is improved then older patients will be eligible to receive intensive anti-cancer medication. Furthermore, the design of new anti-cancer medications mean they are frequently less toxic than existing agents. We believe that the

harnessing of technology and technological advance in the treatment of existing (and new) diseases is an objective that should not be overlooked if we are truly to achieve a healthier future comparable to our European neighbours.

- 14 (XI) Cross border co-operation.
We were disappointed that a number of excellent initiatives in 32 county cross border co-operation have not been highlighted. In particular Irish Clinical Oncology Research Group, which is now spearheading a number of important new initiatives, and the movement of patients across the border in both directions for the provision of highly specialised services which are only provided in one site.

There is much in this document to offer encouragement for a healthier future. We hope that the above comments will make clear the significant efforts and commitment of resources which will be necessary in order that medical and other health professional time is used to best effect in the care of cancer patients and that screening services, together with the diagnostic and imaging services are provided with the staff and means to create the most cost effective interventional services in both surgery, radiotherapy, chemotherapy and other specialisms to meet the aspirations of this document and the general public.

Yours sincerely



Dr T C M Morris
Chairman of Radiology and Oncology Subcommittee

EH 552