Pancreatic Cancer UK

DEMAND FASTER TREATMENT

Pancreatic cancer won't wait

The case for faster treatment

The case for demanding faster treatment for pancreatic cancer

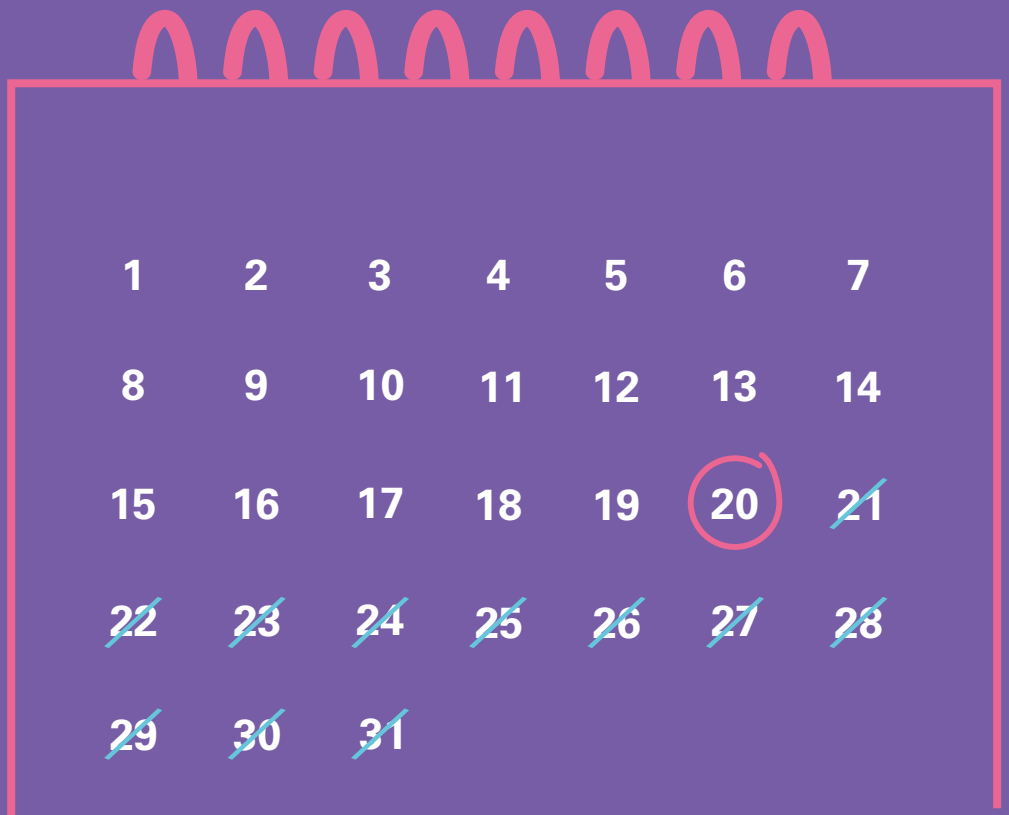
We are calling on the UK Governments to set an ambition to treat people with pancreatic cancer **within 20 days from diagnosis** by 2024.

For too long, survival of pancreatic cancer has not improved. It remains both the lowest surviving and quickest killing cancer. The need for a paradigm shift is now urgent.

Shockingly, 1 in 4 people diagnosed with pancreatic cancer do not survive the disease beyond a month and 3 in 4 do not survive beyond a year – many because they weren't treated quickly enough. With such a hard to treat disease, people with pancreatic cancer deserve to be given the best chance to survive longer by being treated as soon as possible after diagnosis. But many are given no chance at all, with only 3 in 10 people receiving active treatment.

Across the UK, too many people are waiting far too many days for treatment. This is why we are asking that pancreatic cancer is recognised as a "cancer emergency" by the governments and health services across the UK.

The appalling prognosis means that for people with pancreatic cancer, there is no time to waste. We demand faster treatment for people with pancreatic cancer, so that more more people can have treatment and survive longer.



We are calling on the UK governments to set an ambition to treat people with pancreatic cancer within

20 days

from diagnosis by 2024

Executive summary

Pancreatic cancer is the deadliest common cancer with a dismal prognosis that has hardly changed in the last 45 years. It is tough to diagnose, hard to treat and tough to survive.

Pancreatic cancer has the worst survival of all common cancers. 1 in 4 people facing a pancreatic cancer diagnosis will die within a month and 3 in 4 within one year. Survival estimates show that less than 7% of people affected [1] will survive for five years [2].

Treatments for pancreatic cancer are limited; surgery is the only potential curative treatment for the disease, however, less than 10% of people affected receive it [3,4]. Survival for those not receiving surgery is **10 times lower** than those who receive surgery [5].

When surgery is not an option, chemotherapy can increase life expectancy of people living with pancreatic cancer, however, only 2 in 10 people have it [6].

Increasing the number of people receiving treatment will give people diagnosed with pancreatic cancer a fairer chance to survive longer.

To make this a reality we need more people diagnosed with pancreatic cancer to have the option to receive active treatment such as surgery, chemotherapy and/or participate in clinical trials. **For example we estimate that if at least 15% of people diagnosed receive surgery, this will enable an extra 420 people per year to live beyond a year.**

More can be done to improve outcomes for pancreatic cancer in the UK and align them with the best in the world. For example, Belgium and USA have double the survival of the UK. Redesigning the patient pathway to make it faster without compromising on quality of care is key to aligning survival of pancreatic cancer with the best in the world.

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We are aware that for pancreatic cancer, the pathway from diagnosis to treatment is complex and it involves multiple clinical investigations and tests from different specialists and hospitals. These tests are critical for the specialist multi–disciplinary team (MDT) to determine the best treatment plan for each individual. We are concerned that the current pathway is too long for a disease, like pancreatic cancer, that kills so quickly.

This is why we are calling for pancreatic cancer to be treated as a **"cancer emergency"** by the governments and NHS services across the UK.

We are demanding faster treatment for those with pancreatic cancer through rolling out national models of accelerated treatment pathways that will give people affected a better chance to survive longer.

In the NHS setting, this is possible as models for 'fast–track' treatment pathways in which people receive treatment **within 20 days** from diagnosis already exist. A model of fast–track surgery in Birmingham has demonstrated that an additional 20% of people can have surgery [7]. Another model in Clatterbridge Cancer Centre in Merseyside, for those with advanced cancer where surgery is not an option, has shown that if individuals are treated quicker 25% more can receive chemotherapy [8].

We know this is not an easy ambition to achieve, but we believe that this is possible. Rolling out 'fast–track' treatment models for pancreatic cancer like the ones in Birmingham and Merseyside nationwide is critical to treating people affected with the disease faster. Implementing approaches and learnings from other cancers that have seen enormous improvements in survival in the last half century will also help achieve the ambition of starting treatment within 20 days. For example, the establishment of one–stop clinics and appointment of patient navigators are the basis for the cancer optimal timed pathway pilots already happening for lung, colorectal (bowel) and prostate cancers.

We are calling on the UK Governments to set an ambition to treat people with pancreatic cancer **within 20 days from diagnosis** by 2024.

Policy calls

1

People with pancreatic cancer **to be treated within 20 days** from diagnosis by 2024.

2

A target of **15%** of people with pancreatic cancer having potentially curative **surgery** – to improve overall survival and to enable an extra 420 people per year to live beyond a year.

A 15% target for pancreatic cancer surgery already exists in Scotland.

3

Everyone has the chance to have treatment if they want it, and if they are fit enough to tolerate it.

Recommendations

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We need **optimal** pancreatic cancer treatment pathways.

1

Roll out of **fast–track surgery models** across the UK– to support implementation of the NICE Guidelines that recommend surgery rather than endoscopic stenting for eligible people for England and Wales and adopted in Northern Ireland.

2

Dedicated pancreatic cancer clinics for people who are not eligible for surgery – to accelerate access to treatment and increase the number of people who receive chemotherapy.

3

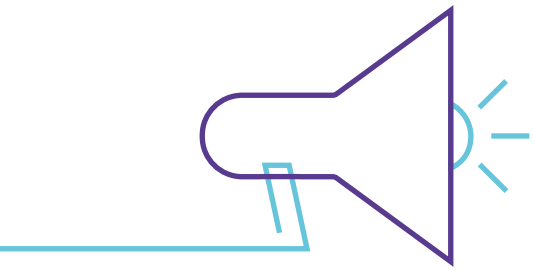
One–stop clinics for people with pancreatic cancer that accelerate treatment decisions for them post diagnosis by enabling them to have a range of tests in one place, on one day.

4

Pancreatic cancer pathway patient **navigators** – to better coordinate people's access to care and treatment, often across different health services and locations.

5

The deadliest common cancer



With 93% of people with pancreatic cancer dying within five years,

and **UK five–year survival significantly below that in other countries,** it is clear that more can be done to improve survival of pancreatic cancer in the UK to bring it in line with the best survival in Europe and worldwide.

Pancreatic cancer is the deadliest common cancer with the lowest one–year and five–year survival of all cancers.

Every year in the UK 10,000 people will face this devastating diagnosis. Estimates in England show that one–year survival is only 24%, compared to 70% for the 20 common cancers combined. Five–year survival drops further to 6.9%, lagging behind the 52.5% five–year survival for the 20 common cancers combined (Figure 1) [9].

Pancreatic cancer has been historically difficult to tackle worldwide; the CONCORD–3 study has proved that it has the lowest improvement in survival outcomes internationally. Despite poor outcomes globally, five–year survival of pancreatic cancer in the UK lags behind the rest of the world, with the UK ranking 29th out of 33 countries included in the study [10].

The UK falls behind other counterparts; it has a five–year survival of **6.9%** compared to an average of 8.8% across the other European countries (Figure 2). Belgium and Germany have a five–year survival of 12.4% and 10.7% respectively, and the USA has a five–year survival of 11.5%. Collectively, this shows that more can be done to bring the UK in line with best survival in the world [11].

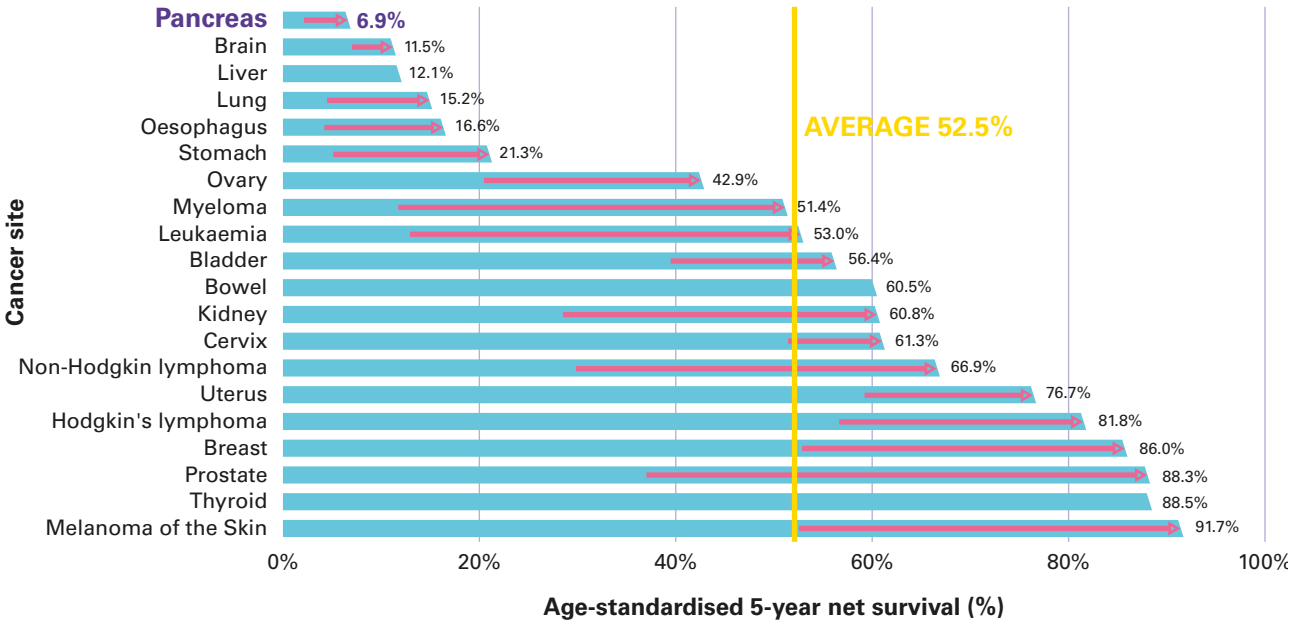


Figure 1: Five–year survival for the 20 most common cancers in England. Five–year survival in the period 2011–2015 (turquoise bars) and how it has changed (pink arrows) since 1971. 52.5% represents average five–year survival of 20 common cancers.

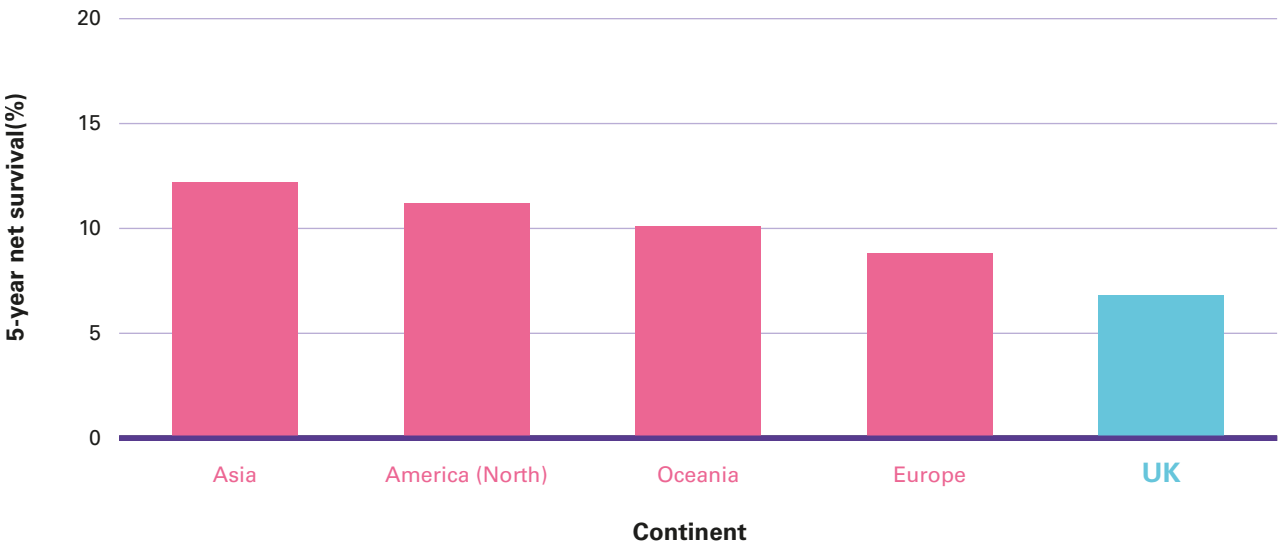


Figure 2: Five year survival of pancreatic cancer in the world based on the CONCORD-3 study

The quickest killing cancer

Every year 10,000 people will face a pancreatic cancer diagnosis – **2,500 will die within a month, often without any active treatment and without a fair chance to fight.**

Pancreatic cancer is hard to diagnose and once it becomes clinically detectable there is rapid progression to an advanced stage [12]. Therefore, for people facing a pancreatic cancer diagnosis, every day from diagnosis matters.

Pancreatic cancer is the **quickest killing cancer**. **1 in 4** people with pancreatic cancer **die within a month** of diagnosis, rapidly progressing to **3 in 4 dying within a year**. In contrast, 1 in 10 of patients across the other 20 common cancers will die within a month and 3 in 10 within a year [13].

1 in 4

people diagnosed with pancreatic cancer will die **within a month**

In contrast, only 1 in 10 people will die on average if diagnosed with one of the 20 common cancers

3 in 4

people diagnosed with pancreatic cancer will die **within a year**

In contrast, only 3 in 10 people will die on average if diagnosed with one of the 20 common cancers

Dying without a fair chance to fight

People facing pancreatic cancer have limited treatment options; here at Pancreatic Cancer UK, we too often hear through our Support Line, that people affected are not offered any life–extending treatment.

They are not always made aware of the treatments available, resulting in feeling that they never had a fair chance to fight the disease [14].

7 in 10 people with pancreatic cancer die without any active treatment in England, without the opportunity to receive surgery or chemotherapy [15]. This is devastating for families who do not have time to come to terms with a diagnosis, have little precious time left with their loved ones and never have a fair chance to say goodbye to what matters to them most.

Surgery is the only potentially curative treatment for pancreatic cancer, however, less than 10% of people affected undergo surgery in the UK. Surgery represents the best opportunity for a positive outcome for patients, with survival for those who do not receive potentially curative surgery **10 times lower** than those who receive surgery [16].

7 in 10

people with pancreatic cancer **do not receive any active treatment**

1 in 10

people with pancreatic cancer receive potentially curative **surgery**

2 in 10

people with pancreatic cancer receive **chemotherapy only**

Opportunity missed

Treatment must come shortly after diagnosis – every day matters in the short window while opportunities for treatment are still high. **Action needs to be taken now.**

Diagnosis at an early stage, when the tumour has not spread, provides an opportunity for individuals affected to have potentially curative surgery. However, over half of those diagnosed at stage 1 and stage 2 will miss this opportunity, and not receive any surgery.

For those diagnosed with advanced cancer and for whom surgery is not an option, chemotherapy can offer a chance to survive longer. However, over half of people diagnosed at stage 3 and stage 4 do not receive any active treatment at all [17]. These extra months or years offered by chemotherapy are valuable to people affected by the disease and their families.

The current picture is unacceptable. Too many with pancreatic cancer do not receive any form of active treatment, even when they are diagnosed at an early stage. We need to engender a sense of urgency when someone has pancreatic cancer. The rapid worsening of the disease means that people need to receive optimal and timely treatment so that the window of opportunity to be treated is not missed.

We need more people diagnosed with pancreatic cancer to have the option to receive life–saving and life–extending treatment, including surgery and chemotherapy. This is how we will start to drive improvements in survival across the UK.

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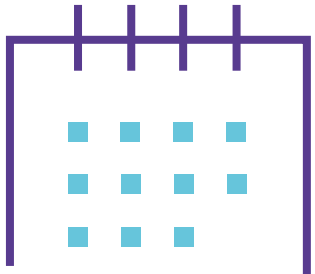
"When you are diagnosed with pancreatic cancer you are treated like a dead person walking. I felt like I was written off and I had to fight to get treatment. This isn't fair and it wouldn't happen with any other cancer. This has to change."

– Erika, pancreatic cancer patient

Tackling the quickest killing cancer: The 20–day treatment window



For people diagnosed with pancreatic cancer

every day matters

For potentially curative and life–extending treatment such as surgery and chemotherapy, there is an optimal time window of 20 days from diagnosis when people with pancreatic cancer will have the option to be treated and the chance to live longer.

Surgery

Surgery to remove pancreatic cancer offers the only realistic opportunity for potential cure and long–term survival. When people are diagnosed at a stage where surgery is possible, it is important that they receive surgery early.

At clinical diagnosis the disease is getting worse quickly from early stage to an advanced stage [18,19]. The longer people with a pancreatic cancer diagnosis wait from their initial diagnostic imaging test (CT scan) to have surgery, the higher the risk the cancer will grow and spread, preventing them from being eligible to have surgery anymore [20,21,22,23]. Pancreatic cancer can spread to other organs in the waiting time between diagnostic CT scan to surgery, with the number of unanticipated metastasis increasing with a longer wait between imaging and surgery [24].

A study in the UK demonstrated that people with pancreatic cancer who waited up to 20 days from initial review of the CT scan to receive treatment had a greater chance of receiving surgery. Whereas 25% of cases who waited between 41 and 60 days were not able to receive surgery anymore (Figure 3) [25,26].

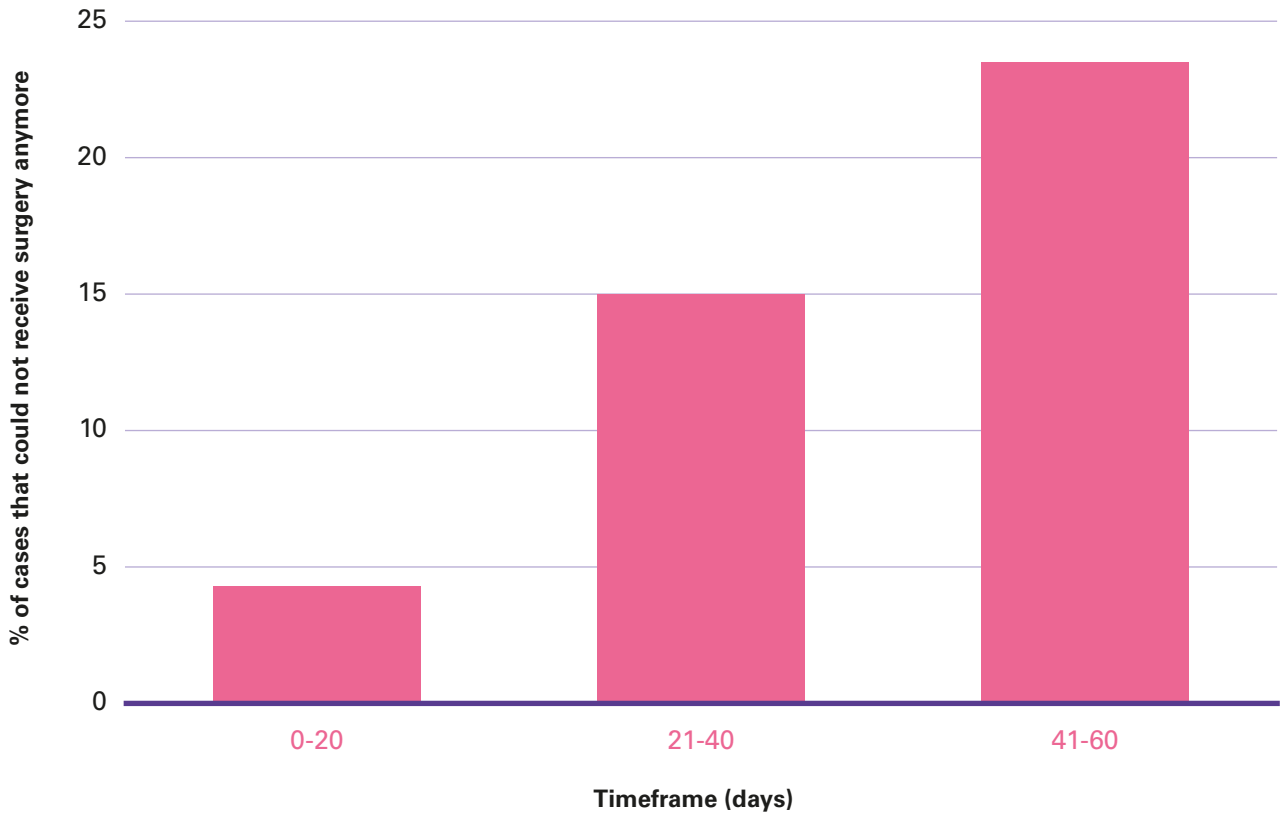


Figure 3: Higher waiting time associated with not being able to receive surgery anymore. Data demonstrates how waiting time affects potential to receive curative surgery.

A target of 15% of people diagnosed with pancreatic cancer to have potentially curative surgery should be set by the UK Governments.

15%

target for pancreatic cancer surgery **already exists in Scotland**

Earlier treatment is essential to increase survival

Increasing the number of people having surgery is essential to increase overall pancreatic cancer survival because survival for people affected who do not receive surgery is **10 times lower** than those who receive surgery; 2.3% vs 22.3% five–year survival, respectively [27].

Around 20% of those diagnosed with pancreatic cancer in the UK are diagnosed at stage 1 and stage 2, and have the best chance of being able to have surgery. However, currently less than 10% of individuals with pancreatic cancer will have surgery [29] and this is **a major limiting factor for improving pancreatic cancer survival in the UK**.

We estimate that **at least 15% of people diagnosed with pancreatic cancer could receive surgery** [30,31]. This means that **an extra 420 people per year will live beyond a year.**

Increasing surgery rates to 15% in the UK can be achieved within the current NHS capacity and structure and this is a target set in Scotland for the specialist Hepato–Pancreatic Biliary (HPB) centres[32]. Also, there are exemplifying areas that are close to this target across the UK. The Cancer Alliance of Humber, Coast and Vale in England has the highest surgery rate for pancreatic cancer, with 13.5% of people diagnosed with pancreatic cancer undergoing surgery[33]. At the same time, this Cancer Alliance has the lowest pancreatic cancer mortality rates[34]. The HPB centre South East Scotland Cancer Network (SCAN) has a 11.3% surgery rate that brings this cancer network closer to the 15% target in Scotland[35].

European countries have also proved that this is possible. For example, Belgium has the highest proportion of people having potentially curative surgery in Europe (21.7%) and it also has almost double the five–year survival of the UK (12.4%) [36].

Chemotherapy

Early access to treatment is also critical for chemotherapy. A significant proportion of those who do not receive any active treatment could potentially have life–extending chemotherapy when surgery is not an option.

A study in the UK has convincingly demonstrated the benefit of chemotherapy in prolonging life–expectancy in those with advanced pancreatic cancer. Overall one–year survival was 22% for patients who received chemotherapy – it was zero for those who did not receive chemotherapy [37].

The same study showed that quick action is essential to ensure that everyone affected has chemotherapy. **Two–thirds (67%) of those with pancreatic cancer who waited less than 18 days to be seen by a specialist MDT received chemotherapy.** Just 10 days later (waiting 28 days), this had dropped significantly to 43%.

"With pancreatic cancer we have no time. It is highly likely my dad would have had a better response to chemotherapy if this had been put in place earlier when he was assessed as fit enough for Folfirinox."

– Lynda whose father died from pancreatic cancer

We are calling on the UK Governments to set an ambition to treat people with pancreatic cancer **within 20 days from diagnosis** by 2024.

Accelerating the treatment pathway to achieve treatment within 20 days

"There is good evidence to suggest that patients with mild jaundice who can have surgery are better served going directly to surgery without interventions to alleviate jaundice. In the UK this does not occur often. Endoscopic stenting is usually carried out prior to surgery; this is sometimes done because facilities for fast–track surgery are not available."

– Zahir Soonawalla, Consultant Surgeon Lead of Hepato–Biliary Pancreatic Centre in Oxford

Teams in the UK have already pioneered and proved how treatment for those affected with pancreatic cancer can be speeded up and how this can happen within 20 days; for both surgery and chemotherapy. These approaches must be rolled out across the UK, giving people longer to live, improving the patient pathway – and saving money.

Getting people into surgery faster

Many individuals affected with pancreatic cancer develop jaundice. This is typically treated via preoperative biliary drainage (a stent insertion before surgery), however this can often cause major delays to people receiving surgery or even preclude them from surgery due to clinical complications associated with the procedure.

NICE Guidelines for management of pancreatic cancer in adults address this with a recommendation [38]:

Offer resectional surgery rather than preoperative biliary drainage to people who:

- have resectable pancreatic cancer and obstructive jaundice and
- are well enough for the procedure and
- are not enrolled in a clinical trial that requires preoperative biliary drainage.

Implementing this guideline is currently a challenge in the UK due to lack of resources and capacity issues.

A successful model to address this is the 'Fast–track surgery' pathway developed in University Hospitals Birmingham (UHB) NHS Trust. This pathway speeds up treatment from 62 days to 16 days, reduces complications and delays associated with endoscopic stenting to treat jaundice and increases the number of people undergoing successful surgery. Moreover, it saves the NHS £3,200 per individual associated with the insertion of stenting [39].

Re–design of the pathway by the team in Birmingham involved working with hospitals to speed up referrals and also review of the CT scan for individuals who may be suitable for fast–track surgery within one day from referral. Then, the case is discussed in the specialist MDT meeting within seven days from the CT scan review and the individual is seen and prepared for surgery in the next eight days. In total, from referral to surgery, the pathway is 16 days (Figure 4).

A provisional treatment plan such as appointments, further tests and arrangements for operation theatre capacity happen within the first half of the pathway (first seven days).

Moreover, by avoiding pre–surgery complications, individuals will recover better and faster from surgery in order to be able to tolerate subsequent treatments such as adjuvant chemotherapy that is linked with improved survival [41]. Currently, national data shows that only 50% of those who receive surgery undergo adjuvant chemotherapy [42].

"Stenting can be the thing that causes most delays in the patient pathway. This is due to recovery time needed, poor maximisation of patients condition. Jaundiced patients do not necessarily need stenting but can be fast tracked for surgery providing they are referred promptly from secondary care to the specialist HPB centre. The difficulty is primarily logistic as specialist centres must have the capacity to absorb this workload without delay."

– Kito Fusai, Consultant Surgeon in Hepato–Biliary Pancreatic Centre in Royal Free London

"We have shown that it is possible to create a much faster path to surgery for pancreatic cancer patients within the NHS. This pathway avoids unnecessary, unpleasant and potentially dangerous interventions which therefore improves patient care, experience and outcome. There is a reduced cost of treatment to the NHS which could be redirected to further improving the pathway – these changes are desperately needed but are difficult to achieve hence the need to redirect any cost saving into ensuring the sustainable delivery of this fantastic service. It is possible that early surgery will improve survival. Certainly some 20% more patients are undergoing potentially curative surgery within this pathway than before. We are sharing the results of our pilot far and wide, in the hope that more trusts will roll it out."

– Mr. Keith Roberts, Consultant Hepatobiliary and Pancreatic Surgeon, University Hospitals Birmingham

The pilot fast–track surgery pathway for pancreatic cancer resulted in:

Individuals affected received surgery in 16 days as opposed to 62 days.

A cost–saving benefit of £3,200 per patient.

An increase of the number of those having surgery by more than a fifth [40].

20%

more people with jaundice **received surgery with this model**

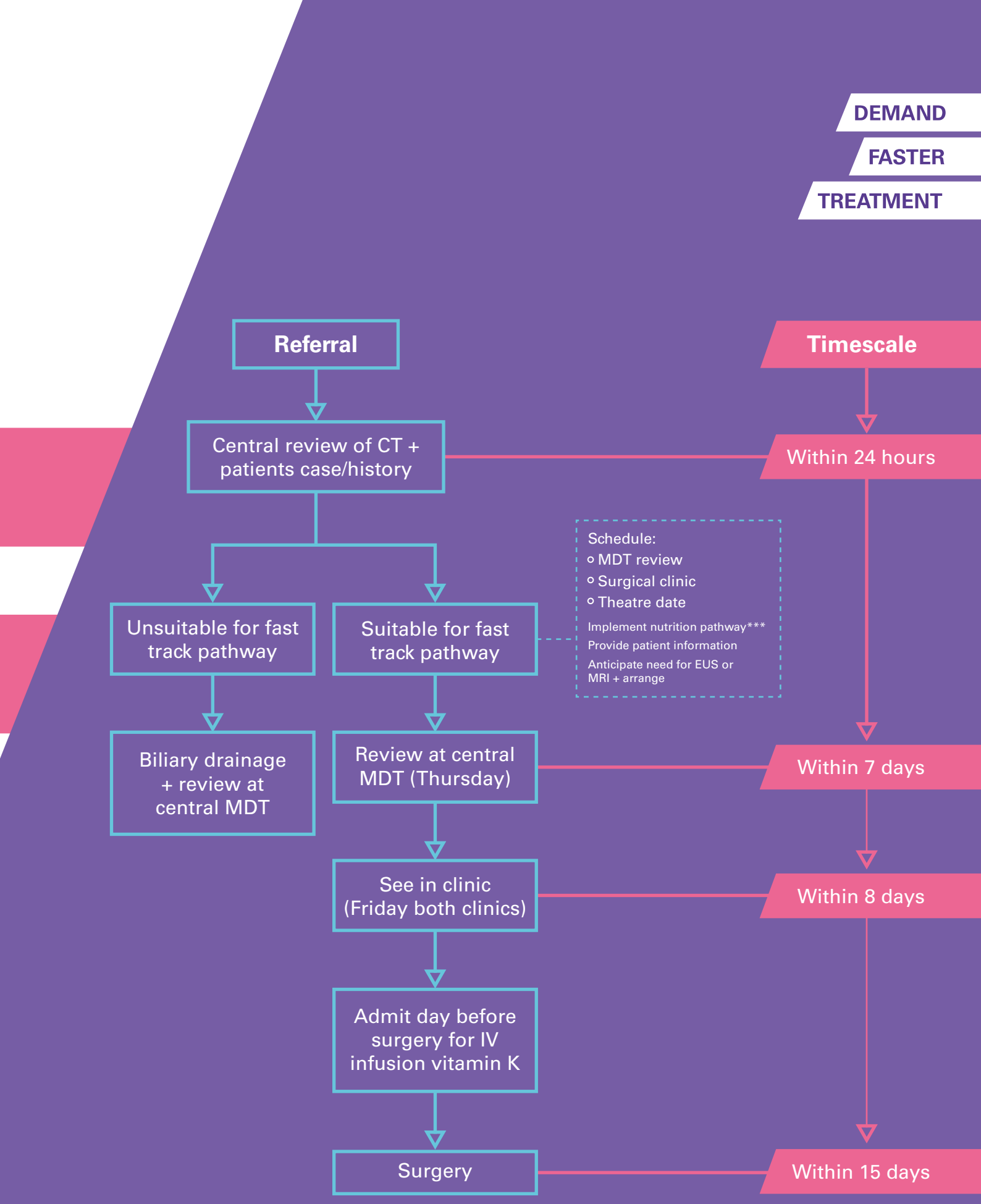


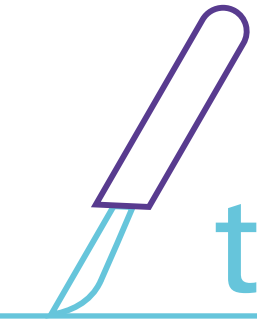
Figure 4: Schematic summary showing the timescale of fast–track pathway. Implemented fast–track pathway to achieve surgery **within 16 days** from presentation of jaundice to surgery, if pancreatic cancer is diagnosed at early stage.

We are calling on the UK Governments to allocate funding for and to roll out the model of fast–track surgery – **to support implementation of the NICE Guidelines** that recommend surgery rather than endoscopic stenting for eligible people for England and Wales and adopted in Northern Ireland.

Nationwide benefits

We believe that the fast–track surgery pathway can be rolled out across the 29 specialist HPB centres across the UK [43], allowing more people diagnosed with early stage pancreatic cancer in all nations to have the chance for potentially curative surgery.

Our forecast analysis shows that rolling out the fast–track pathway across the UK will increase the number of people able to have surgery. Over 1000 people with pancreatic cancer presenting with jaundice will be able to have fast–track surgery annually, representing 11.7% of overall people affected with the disease in the UK [44,45].



Implementation of fast–track surgery can bring the proportion of people with pancreatic cancer receiving potentially curative surgery closer to

the 15% target

Getting people into chemotherapy faster

The development of specialised care for advanced pancreatic cancer can provide better access to treatments and supportive care leading to improved survival.

The centralisation of pancreatic cancer care with the introduction of HPB specialist centres has been a key development for the improvement of surgical outcomes for people affected with pancreatic cancer diagnosed at an early stage. However, the vast majority of people are diagnosed with advanced disease, where surgery is not an option. Decisions about the treatment plan are made by the specialist MDT team, when surgery is not an option, but then treatment such as chemotherapy is often given at a local hospital by a specialist oncologist who is not necessarily a pancreatic cancer expert. The model in Clatterbridge Cancer Centre (CCC) in Merseyside and the team at the University of Liverpool demonstrated that pancreatic cancer dedicated clinics for people with inoperable pancreatic cancer have better disease outcomes than clinics where oncologists are not pancreatic cancer specialists [46,47].

In this model, individuals with advanced disease receive care and treatment in one of the two dedicated clinics from pancreatic cancer specialist oncologists in the area.

Those seen in these clinics initiate treatment within **18 days** on average after initial review rather than 28 days in non–pancreatic cancer oncology clinics. The dedicated clinics can achieve **25% more individuals having chemotherapy**, with a median **survival of five months** as opposed to three months.

5 months

median survival rather than **three months**

Summary of outcomes of the case study in Clatterbridge Cancer Centre

	Non–pancreatic cancer oncology clinic	Pancreatic cancer oncology clinic
Time to start treatment after clinical review	28 days	**18 days**
Individuals having chemotherapy	43%	**67%**
Median survival	3 months	**5 months**

Speeding up chemotherapy is associated with a range of improved outcomes

In pancreatic cancer oncology clinics where people can be reviewed and receive treatment quicker, there is also evidence that they are more likely to receive multiple lines of chemotherapy treatment. Sequential lines of chemotherapy can give a better chance of survival and it is a promising area for poor prognosis and hard to treat cancers. A recent study in the NHS Royal Marsden Hospital showed profound improvement in survival of individuals with advanced oesophageal cancer with increasing numbers of lines of chemotherapy. For those who received more than 3 lines of treatment, median survival increased to 33 months as opposed to 8.3 months for those with one line of treatment [48]. This concurs with the NICE guidelines on pancreatic cancer recommending second–line chemotherapy when patients can tolerate it [49].

The success of the one–stop clinics to accelerate healthcare pathways

The two models of fast–track treatment pathways for surgery and chemotherapy for pancreatic cancer discussed above explicitly show that treatment within 20 days after diagnosis of pancreatic cancer is possible. This is why we set a 20 day treatment window as an ambition for people affected with pancreatic cancer from diagnosis. We believe this is possible. If we work together with the government, NHS and healthcare professionals across the country more can be done to successfully implement and roll out fast-track treatment across the UK.

Pancreatic cancer is a disease with complex symptoms such as pain and malnutrition. It is diagnosed late and treatment decisions are not simple. We very often hear through our Support Line and from pancreatic cancer healthcare professionals that it can take a long time for clinical tests to be carried out and require co–ordination among multiple different services, which can slow down treatment decisions. But pancreatic cancer can't wait. Every day matters for pancreatic cancer, the pathway to treatment must become quicker and give more people the chance of being treated before options close off.

Implementing approaches and learnings from other cancers that have seen enormous improvements in the last half century, such as prostate cancer, will be a big step forward towards making the models of treatment described above successful and achieving treatment within 20 days from diagnosis.

Optimal timed pathway pilots to provide faster diagnosis and provisional treatment plans have been rolled out by NHS and Cancer Alliances for prostate, colorectal and lung cancer in England. A key element of these pathways is the set–up of one–stop clinics where clinical investigations and tests can take place all at once [50].

Streamlined one–stop clinics are vital for speeding up healthcare pathways and allowing specialist MDTs to make quicker and better decisions [51]. One–stop clinics minimise the number of appointments required during diagnostic investigations and treatment decision making. NHS cancer waiting time data for 2016/2017, showed that one–stop clinics can reduce time from referral to treatment by **13 days** [52]. One–stop clinics are even more important for Upper Gastro–Intestinal (UGI) cancers, reducing the referral to treatment pathway length by **23 days** [53].

"It is important that, in the future, a biopsy taken for diagnostic purposes is also suitable for specialist molecular profiling. Initially, this may only be possible in specialist centres, but the aim should be for this to be available as part of 'standard care'. This will ensure a more timely assessment of all the relevant clinical information in order to make the right treatment decision."

– Juan Valle, Professor and Honorary Consultant in Medical Oncology, the Christie NHS Foundation Trust

One–stop clinics for pancreatic cancer for all clinical investigations and provisional treatment plans can be delivered within one day are **essential to speed up treatment pathway and accelerate treatment decisions.**

"At the Royal Free, in the last two years we have developed and implemented the one-stop clinic where patients can undergo investigations, attend a consultation with the consultant and have their preoperative assessment on the same day. This pathway has proven to be a very successful model which has reduced significantly the waiting time for surgery with obvious patient benefit and satisfaction."

– Kito Fusai, Consultant Surgeon in Hepato–Biliary Pancreatic Centre in Royal Free London.

A model example of an one–stop clinic for pancreatic cancer is at John Hopkins Hospital, USA where there is a diagnostic and consultation service for patients with newly diagnosed pancreatic cancer, in a **'one–site one–visit'** [54]. This one–stop clinic is well positioned to provide the correct diagnosis, determine if surgery is possible, the sequence of therapy and consideration for a clinical trial.

At the John Hopkins pancreatic cancer one–site clinic, 23.6% patients who attended had a change in their recommended management. Notably, some individuals who were previously considered not eligible for surgery, after clinical assessment from the dedicated pancreatic cancer clinic, proved that these patients could receive surgery.

In 13% of cases there was identification of previously unsuspected metastatic disease which had therapeutic implications, leading to aborting previous plans for surgery. There was also increased access to clinical trials with 51 of the 203 patients offered participation in the clinical trials and 10 actively enrolled.

One–stop clinics have been an integral part in the RAPID pathway pilot for prostate cancer to accelerate diagnosis with an ambition to reduce referral–to–treatment time to 20 days [55]. The Royal Marsden and the Trusts in the West Midlands have funding from the National Cancer Transformation Programme available to implement the pathway pilot [56]. Learning from these pilots and replicating such examples of best practice is key to driving innovation in cancers with a devastating prognosis, such as pancreatic cancer.

Pancreatic cancer patient navigators to accelerate treatment

Another feature of the optimal timed cancer pathways is development of the workforce to support better communications between different NHS services, better co–ordination of each step of the pathway and provide better administrative support. We want to see patient navigators who will accelerate the pancreatic cancer pathway. For example the appointment of a Clinical Nurse Specialist (CNS) who will have a leading role in coordinating all steps of the pathway and also support and prepare the individuals for treatment are essential to tackle delays and capacity issues.

The appointment of a CNS to fulfil this role is possible through re–investment of the costs saved by unnecessary pre–operative treatments such as endoscopic stenting to treat jaundice in the model of fast–track surgery. Our cost–saving analysis estimates that by facilitating the pathway with appointment of an extra CNS as patient navigator in each of the 29 specialist HPB centres in the UK, the NHS will save at least **£2.3 million** annually [57]. These savings can be invested in the establishment of one–stop clinics for pancreatic cancer and also to set up optimal timed pathway pilots.

"The most frustrating part of the process is waiting for the results of your blood tests. The system is not always a smooth one. Much chasing from the nurses brings no result. The minutes and hours tick past. The treatment can't be started, or even prepared without a green light from the blood test results."

– Tom, pancreatic cancer patient

We want to see pilots of optimal timed pathways for pancreatic cancer with the ambition of treating people with pancreatic cancer **within 20 days from diagnosis**, by 2024.

We ask for the appointment of **patient navigators** to enable successful implementation of accelerated treatment pathways.

Cost Benefit: Based on the savings seen in Birmingham we estimate that

£2.3 million

can be saved if the pathway is rolled out across the UK

Key recommendations

We are calling on the UK governments to set an ambition to treat people with pancreatic cancer **within 20 days from diagnosis** by 2024.

We demand faster treatment for pancreatic cancer. It is the quickest killing cancer and it can't wait. Healthcare pathways that accelerate treatment are a game–changer and will increase the number of people facing a pancreatic cancer diagnosis to receive treatment and have the chance to live longer.

Our Policy Calls:

1. People with pancreatic cancer **to be treated within 20 days** from diagnosis by 2024.
2. A target of **15%** of people with pancreatic cancer having potentially curative **surgery** – to improve overall survival and to enable an extra 420 people per year to live beyond a year.

   A 15% target for pancreatic cancer surgery already exists in Scotland.
3. Everyone has the chance to have treatment if they want it, and if they are fit enough to tolerate it.

The evidence outlined in this report shows that this is possible if the below recommendations are implemented:

1. We need optimal pancreatic cancer treatment pathways.
2. Roll out of fast–track surgery models across the UK – to support implementation of the NICE Guidelines that recommend surgery rather than endoscopic stenting for eligible people for England and Wales and adopted in Northern Ireland.
3. Dedicated pancreatic cancer clinics for people who are not eligible for surgery – to accelerate access to treatment and increase the number of people who receive chemotherapy.
4. One–stop clinics for people with pancreatic cancer that accelerate treatment decisions for them post diagnosis by enabling them to have a range of tests in one place, on one day.
5. Pancreatic cancer pathway patient navigators – to better coordinate people's access to care and treatment, often across different services and locations.

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Pancreatic Cancer UK

Join us by demanding faster treatment for pancreatic cancer

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