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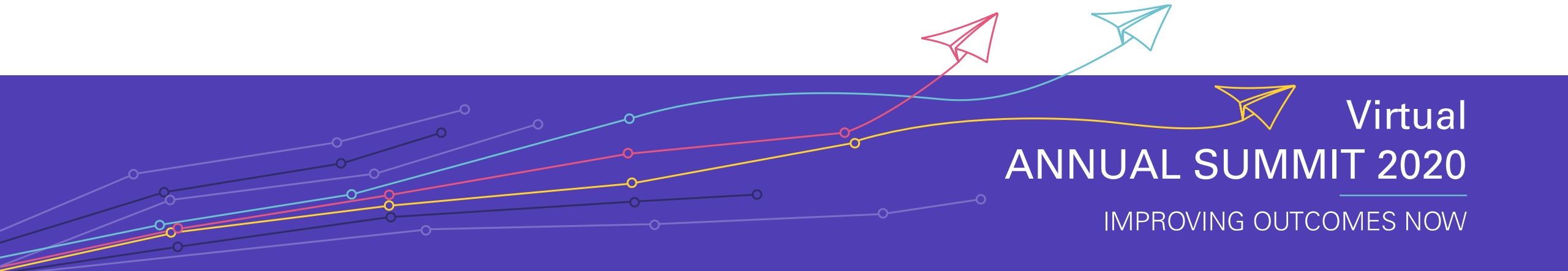
Variation in Access to Chemotherapy

09.05 – 09.15 | Thursday 17th September 2020 | Zoom Webinar

Anna Jewell, Director of Support, Research & Influencing



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Variation in survival

- Despite poor outcomes globally, the UK lags behind the rest of the world, ranking **29th out of 33 countries** for five-year survival.
- One-year survival for pancreatic cancer ranges from **21.3% to 29.1%** and five-year survival ranges from **4.8% to 10.6%** across Cancer Alliances in England
- There is variation in treatment and care for different groups: between young and old, between patients with operable and inoperable pancreatic cancer, and between specialist centres and secondary care.

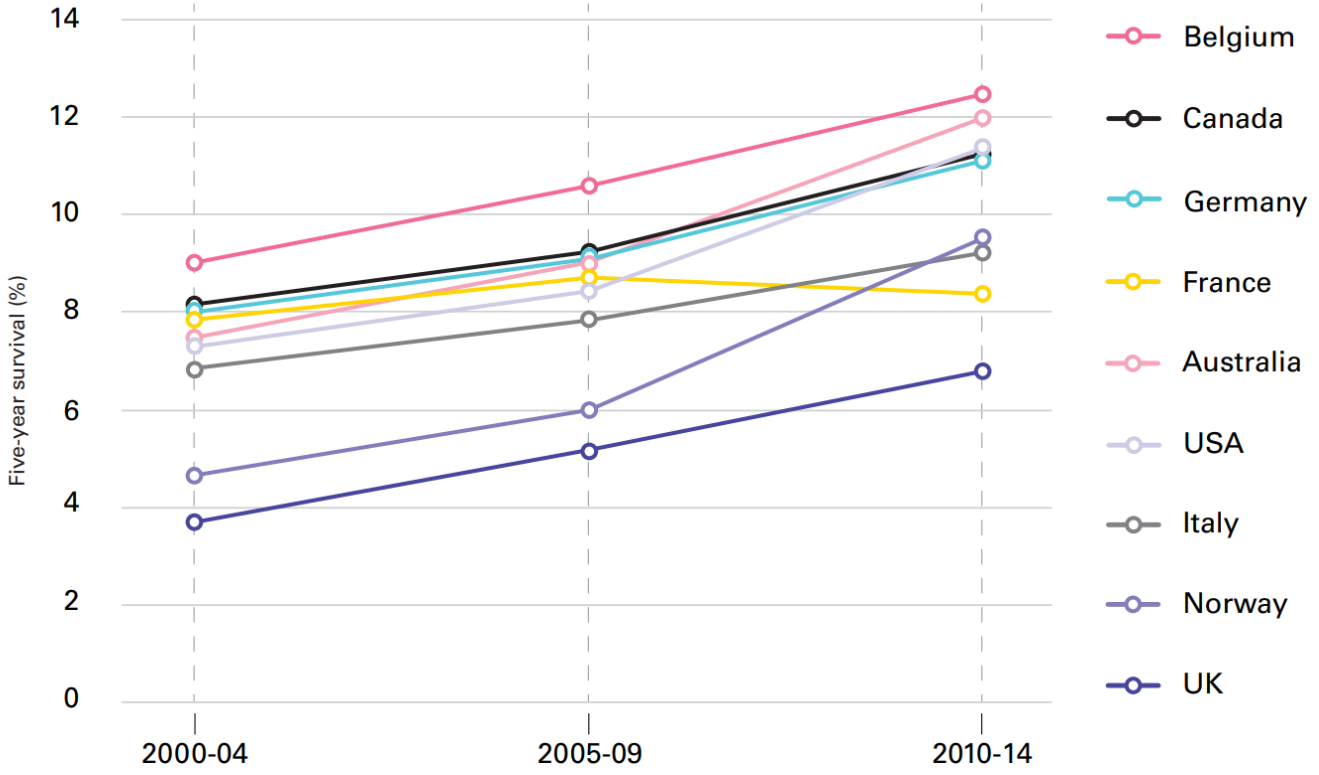

Figure 1: Five-year survival trend for pancreatic cancer between 2000-2004 and 2010-2014. Data adapted after CONCORD-3.

Variation in incidence and mortality

- There is variation in incidence and mortality across CCGs in England.
- There is expected normal random variation in incidence between CCGs with most falling within the control limits, although some CCGs fall outside.
- It is important to start to understand the factors underlying this unexpected variation in mortality and incidence.

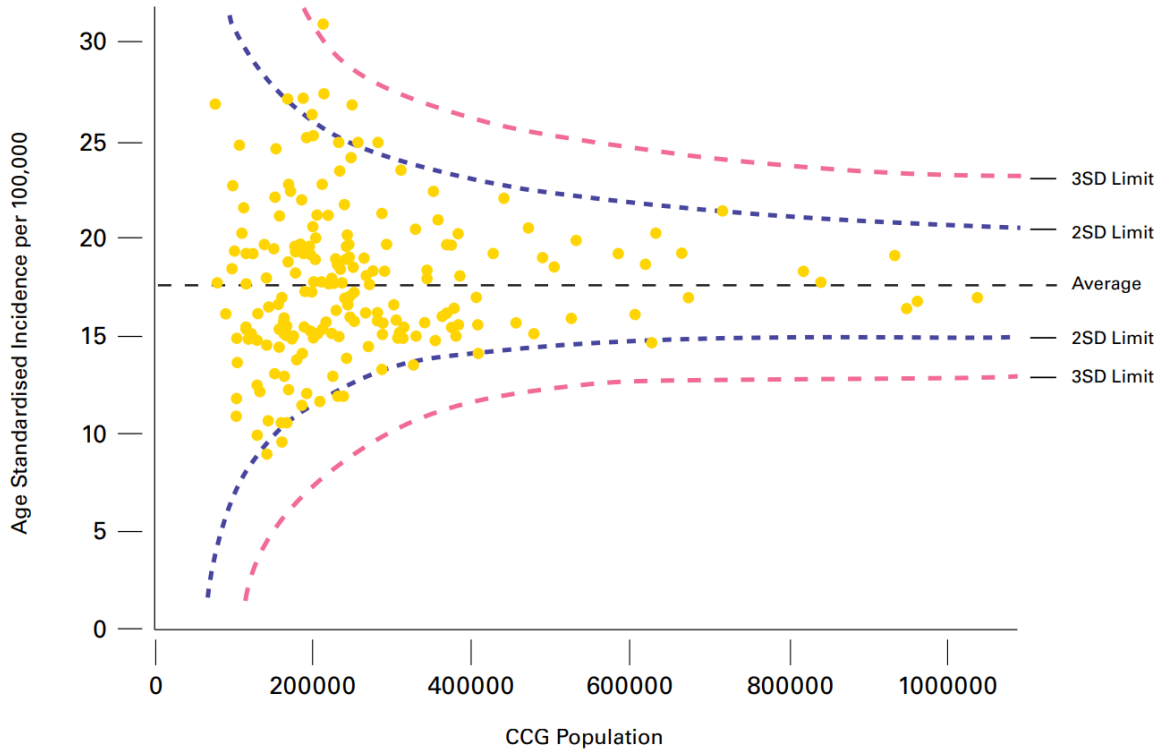

Figure 2: Funnel plot showing the variation in age standardised incidence per 100,000 across the Clinical Commissioning Groups in England (2017). CCGs that lie outside the inner dashed lines (2SD) have unexpected variation and may have real differences in incidence and not random variation. CCGs that lie outside the outer dashed lines (3SD) are more likely to have significant variation in incidence.

Variation in stage

- Variation exists in the stage profile across CCGs, with the proportion of pancreatic cancer cases diagnosed at an early stage ranging from 2.4% to 46.7% across CCGs

- 21% of pancreatic cancer cases across England in 2017 had no reported stage and this can be as high as 63% across CCGs.

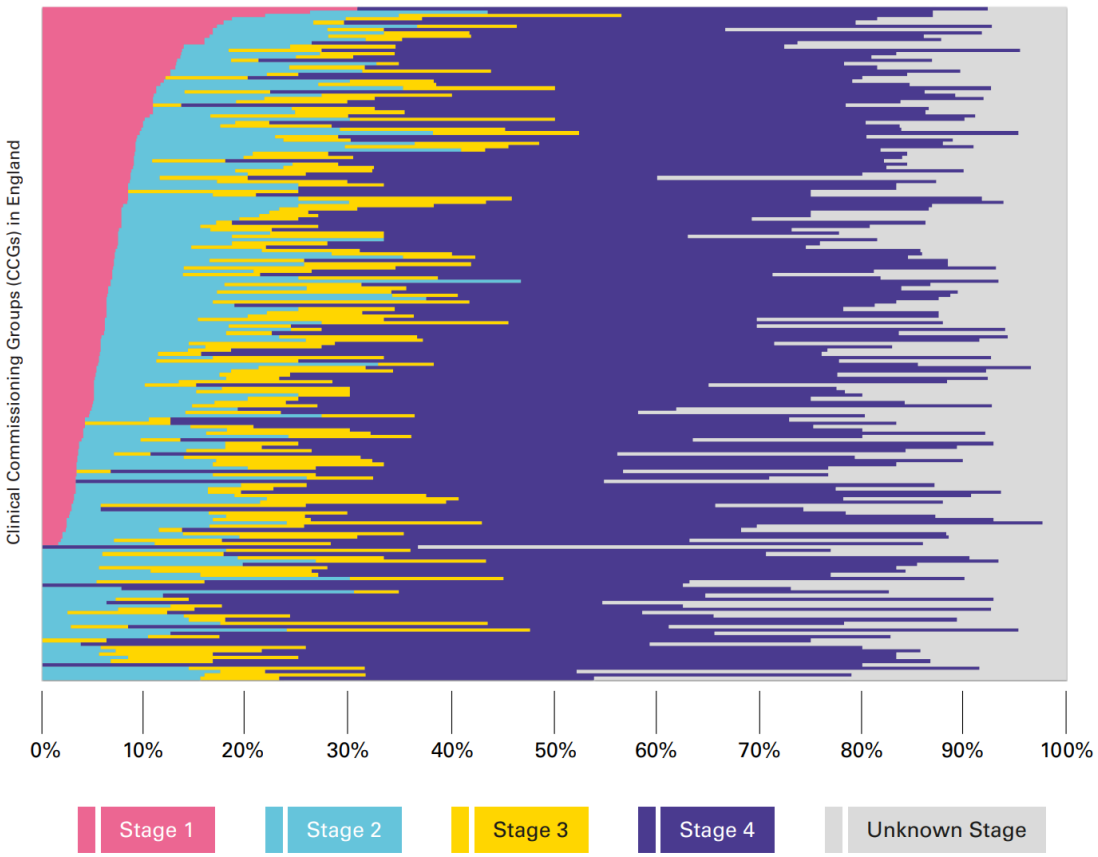

Figure 5: Graph representing the stage profile for pancreatic cancer across all CCGs (2017)[20]

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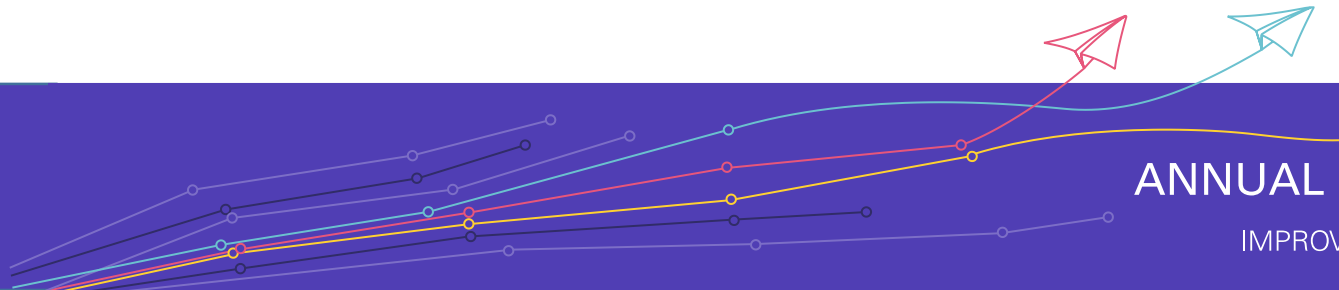

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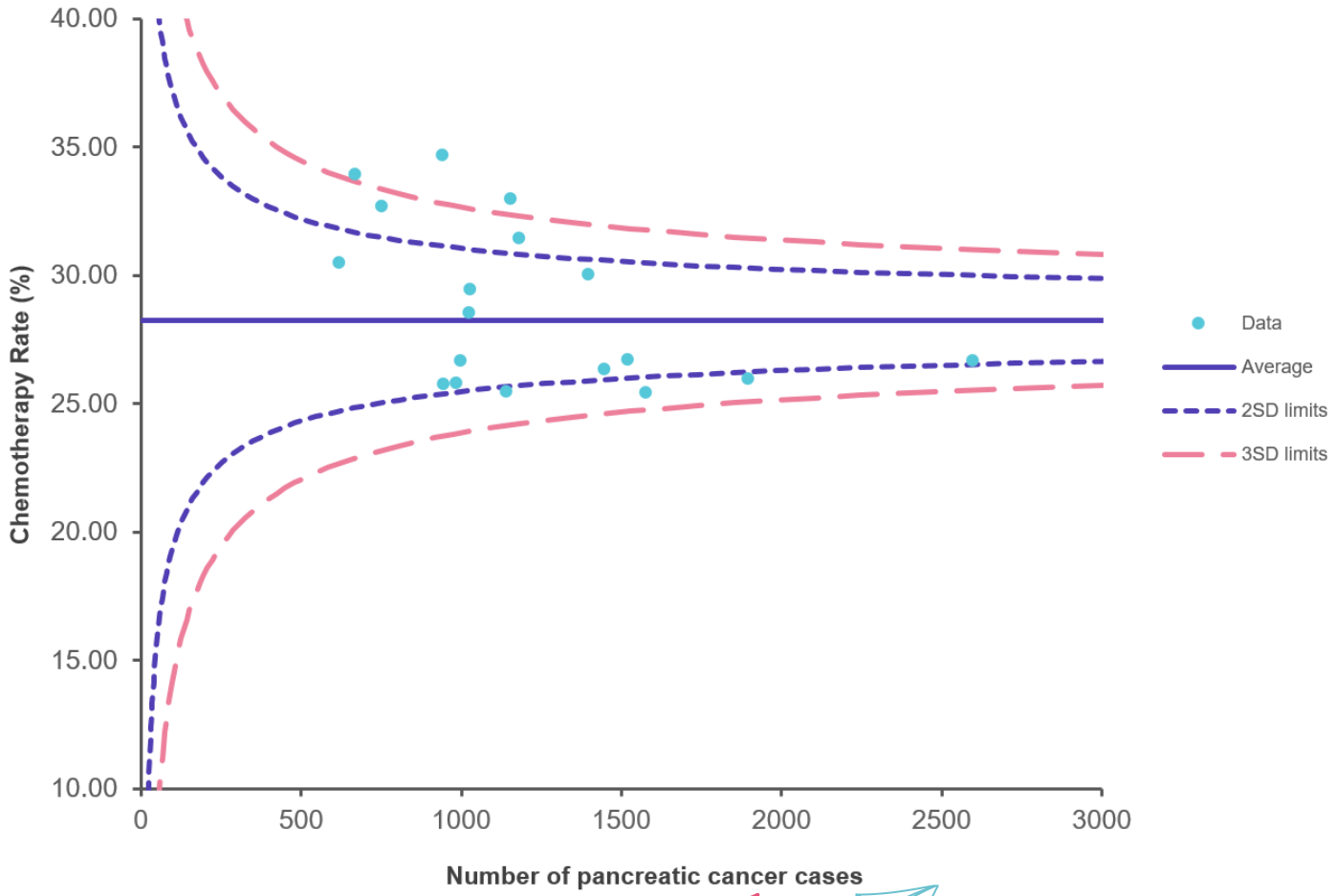
Variation in access to chemotherapy

- Only 28.3% of people with pancreatic cancer have any form of chemotherapy (either neo-adjuvant, adjuvant or palliative) in England

- Across Cancer Alliances, the proportion of people receiving chemotherapy ranges from 25% to 35%



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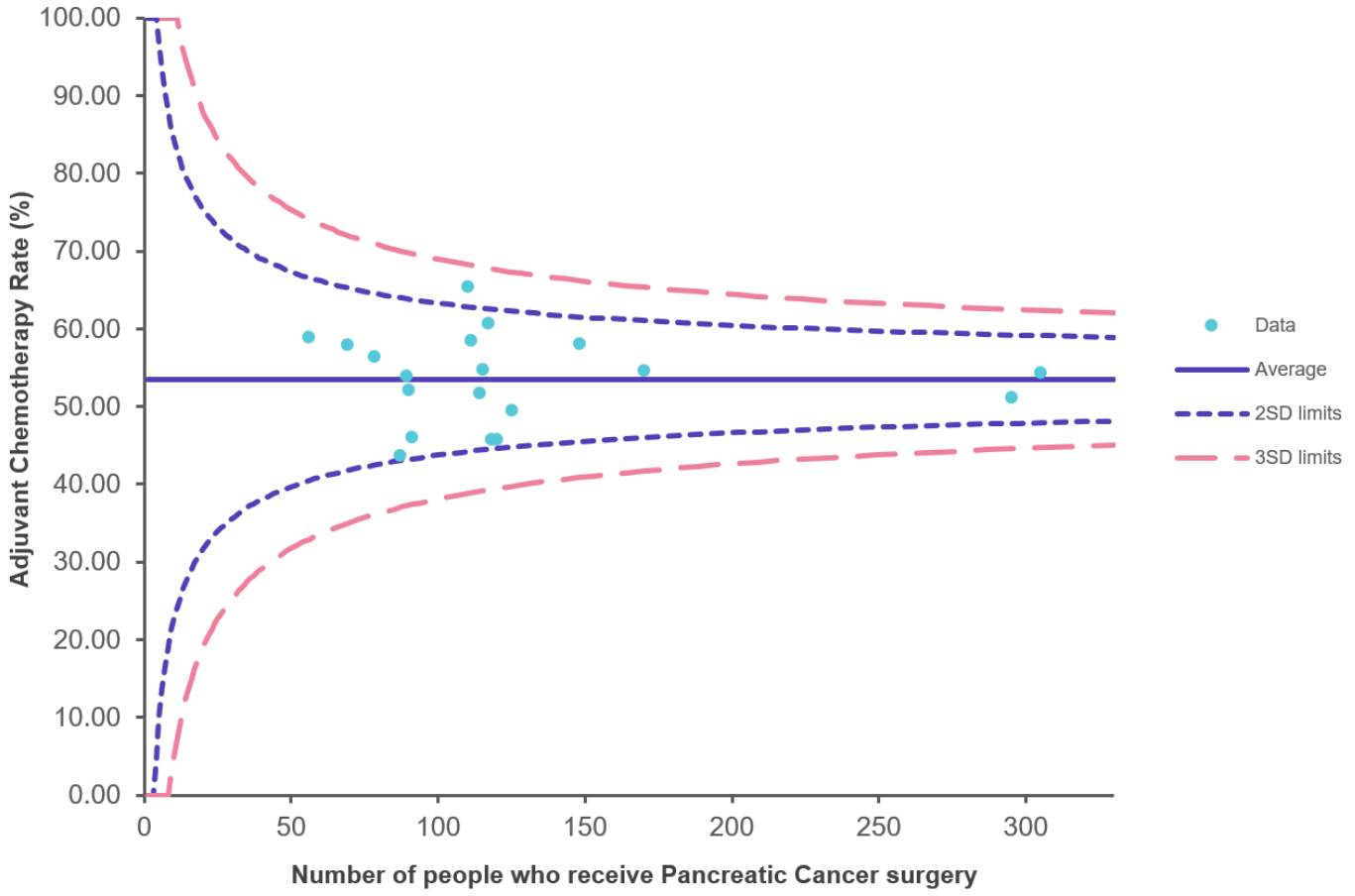
Variation in access to adjuvant chemotherapy

- Adjuvant chemotherapy after surgery has been shown to have significant survival benefit compared to surgery alone.
- Only around 50% of patients who have surgery undergo adjuvant chemotherapy in England.
- Anecdotally we know that some centres have much higher adjuvant chemotherapy delivery and Scotland has 83% adjuvant chemotherapy delivery



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"I have been offered poor information and advice, refused first line adjuvant chemotherapy - despite petitioning the oncologist to change his mind based on the NICE guidelines and research-based practice, resulting in me even involving PALS (Patient Advice and Liaison Service) and my local MP to fight for treatment for me. I have subsequently had to transfer my care which has delayed the start of my adjuvant therapy drastically and caused an insurmountable amount of anxiety, anguish and upset for myself and my whole family."

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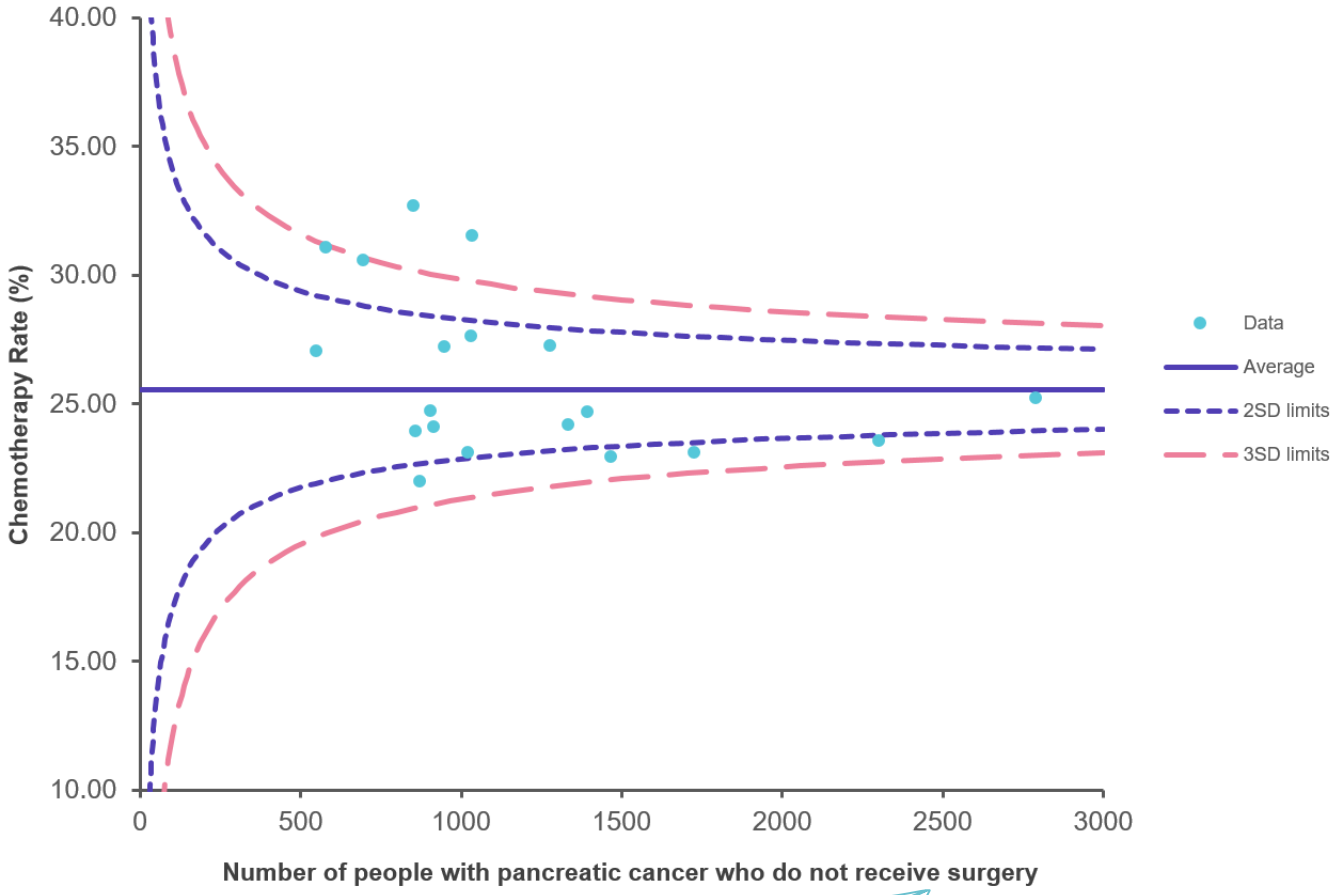
Variation in access to palliative chemotherapy

- Palliative chemotherapy for patients with advanced and metastatic pancreatic cancer has been shown to improve survival.

- Only 25% of people with metastatic pancreatic cancer (stage 4) receive chemotherapy in England.



Inoperable vs. Operable

- Overall, variations are larger in the non-resected patients compared to the resected patients. There is more variation in access to chemotherapy for non-resected patients and there is more variation in one-year survival in the non-resected population compared to the resected population

- A key difference in the management of resected and non-resected patients is that surgery is centralised to specialist centres, while chemotherapy and palliative care is often delivered in wider local care and often by non-HPB specialists.

Limitations

- Although there is observed variation in access to chemotherapy, this could reflect regional demographic characteristics of the local population, including differences in stage at diagnosis, age, performance status, inconsistencies in the data recording or differences in clinical approach and practice.

- The reporting period is before the publication of the pancreatic cancer NICE guidelines in 2018. As a result, this data will not capture any subsequent standardisation in treatment and care.

Next steps…

- Analysing and publishing more and better data will start to improve data quality, highlight inconsistencies between data and clinical experience, allow more accurate comparisons between centres and drive up standards across the country.

- As part of the **Virtual Annual Summit 2020** today, we will be exploring innovative practice that aims to improve access to chemotherapy. Through working with the clinical community to share and highlight best practice we can start to reduce unjustified variation in practice and outcomes and build consensus on optimal treatment and care.
  - **Overcoming the Barriers to Pancreatic Cancer Trials**
  - **The Bridging Clinic: Treating Medical Complications so Patients are More Likely to Receive Chemotherapy**
  - **Centralised Care for Pancreatic Cancer**

Unanswered questions...

- What are the principal drivers of this regional variation in access to chemotherapy?
- To what extent are demographic differences or variations in clinical practice responsible for differences?
- How can we reduce variation in practice and outcomes?
- Where can we identify and share best practice to reduce inequity in care, treatment and outcomes?
- What does variation in access to neo-adjuvant chemotherapy look like?
- Does the data fit the clinical experience?