

# Mike Richards:

## the man with the plan

→ Marc Beishon

“Congratulations, you are now in charge of sorting out England’s failing cancer services, what are your plans and can you start on Monday?” The job offer took Mike Richards by surprise but, mindful of the fickle nature of political support, he accepted the post, got straight down to work, and within six months he not only had a plan, but was ready to put it into action.

**T**here are two ways of looking at the job of a country’s cancer ‘czar’ – the person charged with masterminding a national cancer control plan. Many will see it as an impossible task, trying to keep everyone from politicians to doctors and patient groups in line with a programme that could never be comprehensive and chasing targets that are constantly out of reach, thanks to an ageing population, unhealthy lifestyles and lack of treatment progress, not to mention continual changes in healthcare bureaucracy. Others, however, will point to countries where a cancer plan and its leader have made clear progress despite these odds, and on the international stage arguably the most prominent example is England and its national cancer director, Mike Richards.

England stands out because, when it embarked on its cancer plan in 2000, it was the first large country in recent years to take this step. Denmark started its plan around the same time, but it was not until 2003, with the launch of the French cancer plan, that another large country followed suit. England also stands out as a country that was in desperate need of playing ‘catch up’ with comparable countries in the West (and this also applied to the

other countries in the UK, to which responsibility for health has now been devolved). The NHS Cancer Plan for England as drawn up in 2000 was, as Richards says, a long overdue necessity.

“No country has a perfect system, but ours was far behind many,” he says. “When I became national cancer director I visited Sweden and talked to people in charge of service delivery – they told me we were beginning to do the right things but they’d started 20 years earlier, with systems such as regional care networks and service guidelines. The UK had great fragmentation in its cancer workforce and too few people and facilities – we were not looking at cancer in the round, from prevention to screening, diagnosis, treatment and care. It was a system failure.”

The plan in 2000 set out to address these shortcomings. It has now been revised as a new reform strategy, targeting in more sophisticated ways areas that are proving most problematic, such as early diagnosis. After several years of spending a lot more on cancer – although still less per head than Germany or France – the emphasis is shifting to effectiveness, and Richards is now looking to establish England’s cancer care among the world’s best.

For his own part, Richards – who was a professor



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of palliative medicine in his last clinical post – does not preside over an expensive bricks-and-mortar institute to direct the strategy. He has kept his office at St Thomas' hospital, London, with a view over the River Thames to the Houses of Parliament, and has a small team to call on. Networks, and networking, he feels, are far more effective than central diktat.

A snapshot of just a few days in Richards' diary reveals just how varied his own networking is – and provides an insight into what a cancer czar does. “I had meetings and workshops on England's End of Life Care Programme [which Richards leads]; gave a briefing to England's health minister preparing for a European summit; made a presentation on the economics of care at the Berlin breast cancer conference; chaired a meeting with other national clinical directors; attended a meeting on funding hospices; met the chief executive of Cancer Research UK on initiatives for early diagnosis; attended a session on ‘e-learning’ for oncologists; and attended meetings on initiatives such as the UK's National Cancer Research Institute, radiotherapy standards, laparoscopic surgery and multidisciplinary teamworking.”

All this activity points to another key factor in running a national cancer programme – leadership. While a string of health ministers – and now one Prime Minister – have come and gone under Richards' tenure, he has been in post for all eight years of the initial plan, and has every intention of seeing through the latest reform strategy during the next five years. Finding a director for a national plan is no easy task for a government – there are very few senior clinicians in any country who possess the necessary managerial and diplomatic skills, and who are prepared to step away from successful jobs in front-line oncology. But an oncology background is surely a prerequisite for gaining the confidence of a diverse and complex healthcare workforce.

Richards thoroughly enjoyed his time as an oncologist and researcher and had never envisaged becoming a manager. “Fifteen years ago I wouldn't have believed anyone who told me I'd leave my clinical work to take on a role like this.

“I come from a medical family – my father was a GP, and both my sister and brother had gone into medicine – but I hadn't seriously considered it myself until I switched from a natural science degree at the end of my first year at university. I found it combined science with humanity and I've never regretted making the change,” he says.

Richards did the usual training in general medicine, and found his way into medical oncology. “It wasn't any one factor – but an influence was meeting Gordon Hamilton-Fairley when I was a student at St Bartholomew's [‘Barts’] in London. He was a very charismatic leader in this new field, but was tragically the victim of an IRA bomb. I also got involved with one of the first randomised controlled trials for chemotherapy, in small-cell lung cancer, while working in Nottingham.”

At Barts, a specialist centre for haemo-oncology, he gained exposure to lymphoma and leukaemia, and saw the potential of one of the first MRI machines in detecting lymphomas. “That's given me insight into how you evaluate diagnostic technologies, which is not an easy area,” he notes.

He then moved to Guy's hospital in London to become a breast cancer specialist, although he'd had little experience with the disease. “I've demonstrated throughout my career that I can take jobs for which I'm not qualified,” he says, adding more seriously that oncologists should be prepared to be adventurous in the way their careers evolve. Guy's was (and is, with its merger with St Thomas' hospital) one of the UK's leading teaching hospitals, and Richards was able to practise high-quality breast cancer care with some of the latest equipment and multidisciplinary working. But in the early 1990s he took a seminal phone call from an oncologist in a hospital outside London.

“This colleague was based in a city just 50 miles from London, and he asked my opinion about whether a 32-year-old woman with breast cancer should receive adjuvant chemotherapy. I asked three questions. Has the cancer spread to the axillary lymph nodes? Answer: ‘The surgeons here do not

“Oncologists should be prepared to be  
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remove lymph nodes.' Second – what grade is it? 'The pathologists here don't measure the grade.' Finally, I asked how large the tumour was – and was told it was not recorded in that case. I was horrified by this standard of care, and thought then I could either sit in my ivory tower and practise on relatively few patients or try to do things on a wider scale."

Working with colleagues in his regional cancer registry he found that this was not an isolated example, and there were wide variations in care. "That led me to work with the British Breast Group, which comprised researchers from a variety of backgrounds, where we wanted to produce guidance on breast cancer services. We were told it would be impossible to get consensus, but in six months we wrote a document on multidisciplinary teamworking in breast cancer, and that led to national guidance for all sorts of cancers. It was a very influential programme – these were not clinical treatment guidelines, but how services should be organised, as it became apparent that the problem in the UK was more about the system than anything else."

Along with underinvestment in the workforce and facilities, Richards says there was far too much fragmentation among the tiers of the health service – primary, secondary and tertiary – and also among disciplines within the acute sector. "People working in oncology were of high quality, but many were not looking sufficiently broadly at the care pathway."

Some other countries still suffer from very similar fragmentation and underinvestment in their cancer services, so an important question is how such a situation arises and is allowed to continue. Losing several cancer champions, such as Hamilton-Fairley, and in the early 1990s, the pioneering medical oncologist Timothy McElwain, certainly did not help, reckons Richards, but generally cancer did not have a high enough profile in the UK – in the media, among the public or in medicine. "And there was a fatalistic attitude, such that when I was a junior doctor an eminent gastroenterologist told me he couldn't understand why I wanted to be an oncologist. Equally, as a country, we were slow to believe we had fallen behind in care. We had a passionate belief in the NHS and it was hard to think our outcomes were worse than comparable countries."

It was the Eurocare comparative studies of European cancer registries that triggered a change in British thinking, says Richards. Eurocare-1, which



included patients diagnosed from 1980 to 1984, came out in 1989, and showed the UK well down the ranking for survival. The subsequent Eurocare-2 and 3 studies showed, he says, "that although outcomes were improving in the UK, the country was not closing the gap with others." While it is easy to dismiss some of the findings – there is for example incomplete cancer registration in Germany and regional bias in Italy – Richards says it became quite clear that data from Norway and Sweden, which have complete registration, were indicative of a higher quality cancer control system.

Eurocare-3 covered survival up to 1999, the year before the NHS Cancer Plan, but Eurocare-4, published last year, covered the early years of the plan and led to press reports that it is failing, as the UK figures were still not good. Richards notes, however, in an article on the Eurocare approach, that the time lag from diagnosis to analysis (from five to seven years) needs to be narrowed, and better information, such as on staging and symptom duration, needs to be added (see *Lancet Oncology*, online 21 August 2007). He is confident that England's cancer mortality and survival rates will show a closing of the gap with other nations.

Richards made another career switch that was to prove prescient, given his current leadership role in England's End of Life Care Programme, becoming professor of palliative medicine at Guy's and

**Celebrating success.** Earlier this year Richards marked 20 years of the NHS breast screening programme together with the Health Minister Alan Johnson (wielding the knife), Maureen Lubert from the charity Breakthrough Breast Cancer and Jeremy Hughes MP from the Parliamentary Group on Breast Cancer. The cancer reform strategy will extend the programme to women aged 47–73





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St Thomas'. "It made a big impact on me," he says. At the same time, he was working with the Department of Health on reducing waiting times and improving standards in the cancer service, but it came as a big surprise when he was selected as the national cancer director in 1999. "The Prime Minister, Tony Blair, had held a cancer summit earlier that year, where about 25 people including myself set out the problems. Later, I was asked to attend what I thought was an interview with the health minister – but she said, 'It is great that you are going to do the job. What

are your plans and can you start on Monday?'"

This was the first salaried post of its type in government – not an advisory position but a full-time programme leader. "I then had a meeting with Tony Blair and put forward the idea of a national plan. He asked, 'Is cancer in this country as bad as made out, why is it so, what can you do about it, how long will it take and what will it cost?' The plan came out of that meeting – and it was clear to me that when you have political support you should act fast, and we published it six months later."

Richards worked mainly with a small, informal group of advisers from across the cancer spectrum, as it was clear what the main priorities should be, especially on the treatment side. But he emphasises that a cancer control plan should be a very broad programme, from prevention to screening, treatment and indeed end of life care, informed by existing evidence and new research as needed. "But there won't always be controlled trials that show you how services should be – I cannot envisage doing an RCT on multidisciplinary team working, for example, as it is unthinkable we'd randomise patients to be managed by professionals who don't work closely together. Sometimes you have to work with commonsense and consensus."

Indeed, he says the single biggest change so far has been in creating multidisciplinary teams (more than 1,500 are in place), aligned with reconfiguring services so that complex procedures are carried out in larger centres where there is evidence that this improves outcomes. "We've moved a lot further here than some countries have been able to – such as for oesophageal cancer, where you should be dealing with populations of a million or more, and pancreatic cancers, for 2 million and over. And now the vast majority of men who undergo a prostatectomy are treated at centres with at least 40 procedures. Each year progress is in the right direction." He adds that units that do not measure up have been closed. For example the number of hospitals carrying out major oesophageal/gastric procedures has halved from 160 to about 80. But he is not an advocate of migrating too far in the direction of a few comprehensive cancer centres – England now has regional networks and he is keen to see as much appropriate care as possible located close to home, with involvement from primary care and district hospitals, and increasing use of tools such as videoconferencing.

The earlier service documents for cancer types

that Richards helped to draw up have now evolved into guidance produced by England's National Institute for Health and Clinical Excellence (NICE). "Each report says what the shape of services should be and who is needed in a multidisciplinary team for the relevant cancer type. We also have a system of peer review in place to assess whether services meet the recommended stance." For the most common cancers and also for supporting services such as radiotherapy and pathology, Richards says more than 2,000 reviews by outside colleagues have been conducted so far – these are mainly appraisals of procedures but may include sitting in on team meetings.

A report on the peer review findings is in preparation, and should also be of interest to international colleagues. "We have identified much good practice, but there are still places where the workforce is not sufficient to hold, say, weekly multidisciplinary meetings. They may be missing certain specialists such as pathologists and, in some cases, nurse specialists, who we think are a very important part of the team.

"Administrative support is also a challenge. We have spent ten years building up these teams – now we need to make sure they work effectively."

Prevention has made headway – smoking rates among adults have now dropped to 22%, and should fall further following the recent smoking ban in public places in England. Richards reports "major success" in screening, with women aged 50–70 now screened for breast cancer with two-view mammography, and colorectal cancer screening being rolled out to people in their 60s. Limiting factors, such as the availability of high-quality endoscopy services, are being mitigated by expanding the range of practitioners who can carry them out – including nurse specialists – and insisting that units must improve quality and cut waiting times to be part of the national screening programme.

Probably the parts of the 2000 plan that have been – and continue to be – most controversial, certainly in the public eye, concern waiting times and drug availability. Richards regularly appears in newspaper items on subjects including the wide variability of

access to new drugs such as Herceptin, often presented using highly emotive stories about young cancer sufferers. "We have acknowledged that the interval between a drug being licensed by the European Medicines Agency and approval by NICE is too long," he says, adding that there are moves to speed up appraisal and to monitor the variation of provision around the country. It is not a uniquely British problem though. "Variations in the use of drugs and surgical procedures feature in most countries," he notes.

Waiting times from referral by a primary care doctor (GP) to being seen by a specialist are now much shorter – there is a two-week target set by government. But there can still be lengthy delays in accessing treatment such as radiotherapy. Late presentation by patients and late onward referral by GPs have remained tough nuts to crack, and are major planks of the reform strategy. However, a cancer czar can easily find himself at the centre of a dispute which is not of his making. A recent front page newspaper story suggested that Richards had issued a 'warning' to GPs about 'botched diagnoses'. "I was scurrilously misrepresented," says Richards. "I did say it is hard for GPs who see only about eight new cancer cases a year to distinguish these from the hundreds of people they see with similar symptoms. I had not issued a 'warning', nor had I mentioned 'botched diagnoses'. In England we ask GPs to be gatekeepers and we need to equip them with decision-making aids and better access to diagnostic tests like ultrasound. What we don't need are more guidelines – GPs are already flooded with these."

An important point he stresses is that, while many of the issues facing England are common to other countries, what needs to be done has to fit with the existing healthcare system. While he can see some changes, which might include increasing recourse to private medical facilities, the NHS and its primary/acute system is not likely to change radically.

"The NHS has changed over the past eight years. In the year 2000 plans were all about expansion – now it's about driving change through better information and commissioning, and yes, we can now look

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Critical coverage. Richards has had to learn to deal with the British press, where stories on the NHS tend to be driven by a political agenda

increasing the move towards carrying out more complex procedures in major centres, while doing more ambulatory care closer to home. “We need to free up resources: we spend a lot more on inpatient services for cancer than they do in the US,” says Richards. Collecting and applying better information is also a major plank of the strategy. “We already have comprehensive cancer registration and extensive information on patients attending NHS hospitals in England, but we are not making the best use of this.” A national cancer intelligence network is now being established to provide comparative data on cancer activity and outcomes. “My aim is to have the best cancer information system of any large-population country by 2012.”

Until recently, Richards was also the chair of the National Cancer Research Institute (NCRI), the virtual coordination body for research centres and funding bodies in the UK. The cancer plan has triggered much more research, says Richards – and certainly the various networking initiatives now running are among the more visible success stories on the international stage. Among the achievements are the National Cancer Research Network, designed to boost clinical trial rates in NHS hospitals (the enrolment rate has now reached 12%). A recent initiative has been to establish 19 experimental cancer medicine centres to fast-track phase I/II trials.

The NCRI, adds Richards, also maintains the same database structure of ongoing research as the US and Canada. “I would very much like to make this a Europe-wide initiative, so we can better identify gaps in research.” Analysis of the database showed low levels of funding on research into prevention and into supportive and palliative care. As a result, new initiatives have been established in both areas.

Richards’ involvement with England’s End of Life Care Programme goes beyond cancer to all illnesses – as he says, the majority of the 500,000 deaths in England each year are from a chronic condition. But, as with cancer care a decade ago, end of life experience can vary greatly in quality, and

to the independent sector if we want.” The cancer reform strategy includes actions to diagnose cancer earlier through extensions to screening and helping primary care, and it also has a new equality initiative to tackle disparities among populations that have worse incidence, access to services and outcomes. “We need to push relentlessly on the smoking agenda – should cigarette displays now be banned in shops, for example – and develop community awareness. We have a number of pilot programmes running in deprived areas that are trying to inform older people about the major cancers – it is partly the media’s fault that many think that cancer is a disease of younger people and not primarily of people in their 60s, 70s and 80s. The media always tend to focus on younger cancer patients.”

Other elements of the new strategy include

“It is partly the media’s fault that many think that cancer is a disease of younger people”



## Richards would like to see much more awareness, and even anger, about poor end of life care

Richards would like to see much more awareness – and even anger – about poor care to help drive up quality for a topic that tends not to be talked about. “Doctors need to be trained to initiate discussion with people about their preferences regarding end of life care – much of the problem starts at the beginning of the end of life pathway.”

For palliative care, he notes the huge range of professionals who are involved in helping people towards the end of their lives – but relatively few who are specifically trained in the discipline. “We need to skill up the wider professional community and improve coordination, for example, so that people do not end up in hospital unnecessarily.” Survivorship care, as more and more people live with after-effects of treatment, also now needs greater attention, he adds.

Richards recognises that there will be continuing controversies, adding to the string of problems that have already landed on his desk, such as shortcomings in radiotherapy and drug availability. On the latter, the NHS is now in the bizarre but understandable situation of not allowing patients to pay for their own drugs and have them administered by the NHS, as this would promote inequalities. Such ‘co-payments’ are commonplace in many European countries.

One of Richards’ biggest critics – and simultaneously one of his friends – is probably the best known British oncologist, Karol Sikora, who is agitating for much more and faster reform, such as a network of dedicated privately-run clinics, to drive efficiency, and wider drug availability. “There are ten cancer drugs you can get in Calais that you can’t get in Canterbury,” he comments. But Sikora recognises the tightrope that Richards walks, despite labelling him a ‘political servant’. As Richards says: “I can’t keep everyone happy – the way I work is to keep what’s right for the patient clearly in mind in the way I respond, and that does make me unpopular with some groups.” No doubt sometimes the politicians feel he is the patients’ – or the oncologists’ – servant.



LUIGI INNAMORATI

There is little disagreement – apart from the odd map-reading dispute – with Sikora when they are out hill walking, Richards’ great passion outside work. “My aim is to climb all the Munros in Scotland – these are mountains over 3,000 feet (914 metres) – there are 284, and I have done 232 so far.”

It’s an apt analogy with England’s cancer control plan – opinions vary but no one can now deny that a concerted ascent of the cancer mountain has been made. “My ambition now is for England to be among the best in Europe and the world in cancer, and recognised as such, and also to be a leader in end of life care. But of course it is still a big challenge.”

**Walking a tightrope.** Richards spoke of the need to maximise the value cancer patients get from a limited health budget at a panel debating the case for rationing expensive drugs that was organised to mark the 25th anniversary of the European School of Oncology last year