REPORT OF: THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC):

Cancer Services in Oxfordshire

Report by: Dr Omid Nouri, Health Scrutiny Officer, Oxfordshire County Council

Report to:

- Matthew Tait (Chief Delivery Officer-Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board).
- Felicity Taylor Drewe (Chief Operating Officer, Oxford University Hospitals NHS Foundation Trust).
- Andy Peniket (Clinical Director for Oncology & Haematology, Oxford University Hospitals NHS Foundation Trust).

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report providing an update on the current state of cancer services in Oxfordshire during its public meeting on 06 March 2025.

2. The Committee would like to thank Matthew Tait (Chief Delivery Officer, Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board [BOB ICB]); Felicity Taylor Drewe (Chief Operating Officer, Oxford University Hospitals NHS Foundation Trust [OUH]); Andy Peniket (Clinical Director for Oncology & Haematology, Oxford University Hospitals NHS Foundation Trust); and Ansaf Azhar (Director of Public Health, Oxfordshire County Council); for attending the meeting on 06 March and for answering questions from the Committee in relation to cancer services in Oxfordshire.

3. The Committee had received reports of some of the challenges experienced by cancer patients with cancer services, particularly in the wake of and as a result of the covid-19 pandemic, and urges NHS partners to work closely toward improving these services through reducing wait times and addressing any backlogs. The Committee was also keen to gain insights into the different types of services provided for the various types of cancers, and the efficacies of these.

4. This item was scrutinised by HOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the initiatives taken by commissioners and providers to not only deliver but to also improve cancer services, particularly against a backdrop of general increases in demand for health services. When commissioning the report for this item, some of the insights that the Committee sought to receive were as follows:

   - Whether there were any backlogs in cancer appointments and treatments since the Covid-19 pandemic?

- If there were any variations in wait times for cancer diagnoses and treatments within different geographies in Oxfordshire?

- Details of any variations in wait times for diagnosis and treatment for different forms of cancer.

- How does Oxfordshire compare to other areas nationally with regard to cancer wait times?

- How effective was the referral process for cancer diagnosis and treatment, from the point of primary care onwards?

- Details of the availability of healthcare resources, including specialised personnel, diagnostic equipment, and treatment facilities (including how resource levels impact waiting periods).

- Details of any processes in place to monitor the effectiveness of diagnoses and treatments for cancer patients.

- How were side effects of cancer treatments monitored routinely and effectively?

- To what extent were cancer treatments personalised?

- Details of how healthcare professionals were being trained in any latest diagnostic techniques and protocols.

- How were cancer patients being communicated with clearly whilst on waiting lists and regarding their treatment journey?

- How was the mental health of cancer patients being supported?

- Details of any collaboration with other system partners to provide long-term care to cancer patients who needed it.

SUMMARY

5. During the 06 March 2025 meeting, the Chief Operating Officer at Oxford University Hospitals NHS Foundation Trust (OUH), discussed the Annual Cancer Survey feedback, noting that there were improvements in performance against other Trusts. The report included Cancer Outcomes and Services Dataset (COSD) data on treatment access and clinical outcomes, with an emphasis on personalised care.

6. The Committee inquired about the methods used by staff to provide patients with relevant information on available support and treatments. The Chief Operating Officer at OUH and Clinical Director for Oncology and Haematology explained that methods included distributing informational leaflets, offering

direct communication during appointments, and employing marketing strategies to promote NHS hearing tests and treatments.

7. The discussion included a strong emphasis on the imperative for patient follow-ups to ensure the effectiveness of treatments and to promptly address any issues. It was agreed that this comprehensive approach would help to enhance patient awareness and engagement with the services provided.

8. The Committee inquired about the support available for patients who do not speak English, citing a Healthwatch report that highlighted an instance where a non-English speaking patient was unaware of their diagnosis due to communication barriers. The OUH Chief Operating Officer acknowledged that providing support for non-English speaking patients was a significant concern. The Committee therefore reiterated the need to address the challenges and monitor the support mechanisms for such patients.

9. The increase in cancer referrals across Oxfordshire was also discussed, and the Committee sought to determine whether this rise was associated with specific towns, districts, PCNs, or GP practices, and if there were any demographic factors influencing this trend. The Chief Operating Officer and Clinical Director clarified that the rise in cancer referrals was not linked to specific locations or PCNs. Instead, it was observed as a general trend throughout the region.

10. The discussion also examined the role of coproduction in the development of cancer services and the Committee requested an update on stakeholder involvement in this process. Officers clarified that coproduction had played a significant role in the development of cancer services. Key stakeholders, which included patients, healthcare professionals, and community organisations, were actively engaged in the process.

11. The Committee inquired about the significance of outcome data in cancer treatment, the national comparison of OUH's outcomes, and the gap in treatments to achieve optimal results. The Chief Operating Officer and Clinical Director underscored the vital role of outcome data in cancer treatment, as it provided valuable insights into the effectiveness of therapies and highlighted areas needing enhancement. OUH's performance favourably compared to national outcomes, excelling in several key areas. Nonetheless, there remained a recognised treatment gap in achieving the best outcomes, attributed to factors such as resource limitations and the necessity for ongoing improvements in treatment protocols. Initiatives were underway to address these gaps and improve the overall quality of cancer care.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS:

12. This section highlights three key observations and points that the Committee has in relation to cancer services in Oxfordshire. These three key points of observation have been used to determine the recommendations being made by the Committee which are outlined below. The Trust may somewhat be implementing the substance of the recommendations being issued by the Committee (particularly around communication and advocacy for patients, and on encouraging cancer screening), although the Committee had not received as much information as to the extent to which this is the case. The Trust will be provided with an opportunity to respond to these recommendations with further evidence as to how they are potentially being implemented:

Outcomes across different types of cancer: Cancer remains one of the most formidable health challenges globally, affecting millions of people each year. As medical research and technology advance, the outcomes for various cancer types have shown significant variability. The report received by the Committee provided a summary of some of the key activities currently being undertaken within the cancer service of Oxford University Hospitals NHS Foundation Trust (OUH). However, the Committee had not received sufficient insight into the variations in outcomes for patients with different types of cancers in Oxfordshire.

Cancer is a complex and multifaceted disease that impacts individuals differently. Numerous factors can influence the variations in outcomes for cancer patients. These factors are not simply restricted to the clinical care provided by acute hospital Trusts. According to a study in the *Journal of Public Health*, there are wide ranging reasons for variations in the outcomes for different cancer types, from biological to socio-economic aspects, and understanding these factors is crucial for tailoring treatment plans and improving patient prognosis[1].

Wait times can be an important indicator of patient outcomes, notably in terms of how soon patients can be diagnosed as well as when treatments initiate. The Committee was pleased to hear that the Trust was meeting the NHS national Faster Diagnosis standard of *Communication of a cancer diagnosis or benign* to patients within 28 days of an Urgent Suspected Cancer referral. Nonetheless, given that the Trust is below the 31-day and 62-day treatment standards, work should urgently be undertaken to enhance performance against these standards. It is crucial that there is transparency and further information provided around:

1. The steps being taken to enhance performance in these treatment standards.

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[1] Do social factors affect where patients die: an analysis of 10 years of cancer deaths in England | Journal of Public Health | Oxford Academic

2. How patients with various types of cancer have/are being affected by these treatment standards not being met.

The Committee understands that the Trust had observed significant increases in referrals, with overall Urgent Suspected Cancer Referrals rising further. Some key causal factors would include a rising as well as an ageing population in the County. It could also be the case that, as highlighted by a 2015 study published in the *British Journal of Cancer*, increased public awareness of both cancer symptoms and of the importance of early detection results in increases in referrals.

Furthermore, the Committee had been informed that the Trust is witnessing elevated referrals for subsequent treatments. This includes further treatment for a primary diagnosis, treatment for a recurrence, and treatment for metastases or secondary conditions. This trend is partly attributed to the increasing success of initial cancer treatments in extending survival rates and the development and availability of new treatments. It is crucial that there is further transparency and information for both the Committee and the wider public around why the Trust is witnessing an increase in elevated referrals for subsequent treatments. This phenomenon raises critical questions about the underlying causes of this and the implications for patient care and the healthcare system more broadly. This could allow further collaborative system work to investigate the specific causes of such referrals as well as how to address these through invoking more prevention work. The Committee understands that the evolution of diagnostic technologies has significantly impacted the frequency of cancer referrals. According to a 2020 study published in the *Journal of Technology in Society,* modern imaging techniques allow for earlier and more accurate detection of cancerous lesions. Consequently, oncologists can identify secondary cancers or metastases sooner, prompting additional treatment referrals[2]. Therefore, these advancements not only improve the chances of detecting smaller, previously undetectable tumours but also enable more precise staging of the disease, guiding the need for further intervention. Additionally, with this in mind, there is a point about understanding which cancer types in Oxfordshire have been characterised by subsequent referrals as a result of enhancements in imaging technology specifically.

Having said that, there may be other more complex reasons behind the causes of subsequent referrals besides advancements in technology, including the specific nature of particular types of cancer per se, or even potentially particular population groups who may reside in certain areas around the County. Hence, it is pivotal that further demographic and geographic research is conducted to understand these patterns, and the Committee encourages research collaboration with Oxford's Universities to help determine this.

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[2] Deep learning technology for improving cancer care in society: New directions in cancer imaging driven by artificial intelligence - ScienceDirect

Furthermore, understanding variations in overall outcomes for cancer patients could help inform prevention work as well as any potential steps that could be taken as part of Oxfordshire's Health and Wellbeing Strategy. Whilst it may not be the responsibility of each and every system partner/actor to investigate the causes of cancer specifically, they certainly do all have a part to play in improving the overall health and wellbeing of cancer patients.

Moreover, cancer patients can often face significant emotional and psychological distress as a result of being diagnosed and the knowledge of how their lives have been transformed as a consequence. Such mental distress, according to one study in the *Journal of Cancer*, could be elicited by the knowledge of being diagnosed with cancer, as well as by the specific services available for such patients[3]. It is also the case that, as another study in the *Journal of the National Cancer Institute* identified, outcomes for various cancer types can be assessed through examining the psychological and mental health/state of cancer patients. Additionally, the study also found that patients who had worse physical cancer outcomes often had worse psychological symptoms and outcomes. The Committee therefore urges for psychological elements to also be taken into account when examining the outcomes for various types of cancers that patients in Oxfordshire are diagnosed with. Such assessments could help inform how to provide better support, physical and psychological, to residents living with cancer.

It is also crucial that the Committee and the wider public are made aware of how Oxfordshire compares with other geographies around the Country on the outcomes for different types of cancers. By outcomes, the Committee is pertaining to both:

- Health outcomes determined by the nature of the specific types of cancer as a disease.

- Health outcomes shaped by the efficacy of local cancer services in Oxfordshire.

Essentially, understanding these two things could help to determine where prevention work is best needed, as well as how services could be improved.

Recommendation 1: *For further detail to be shared on outcomes across different cancer types, and how that compares nationally and regionally.*

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[3] A prospective multicentre study in Sweden and Norway of mental distress and psychiatric morbidity in head and neck cancer patients | British Journal of Cancer

Clear communication and advocacy for cancer patients: Communication is a vital component in the delivery of effective healthcare, particularly for cancer patients who often face complex and sometimes emotionally difficult decisions. Language barriers can significantly impede the quality of care and support that non-English-speaking cancer patients receive. It is essential to establish clear communication mechanisms and robust advocacy mechanisms to ensure these patients receive equitable care and can navigate their treatment journey with confidence.

Prior to commissioning the report on cancer services in Oxfordshire, the Committee was keen to explore the support available for patients who do not speak English. This also stemmed from concerns elicited by a recent Healthwatch report that highlighted an instance where a non-English speaking patient was unaware of their diagnosis due to communication barriers. The Committee was pleased that the imperative for clear communication with patients was acknowledged by the Trust, and that the Trust was committed to work on expanding such support for patients. Non-English-speaking cancer patients often encounter several challenges that impact their care:

- *Language barriers:* According to a 2016 study in the *Journal of Internal Medicine*, it was found that cancer patients with language barriers often have difficulty in understanding medical terminologies. Such patients also struggle with communicating symptoms, concerns, and treatment preferences[4].

- *Lack of culturally appropriate resources*: The Committee received reports that non-English-speaking cancer patients can often experience limited access to educational materials in their native language. Such materials are crucial in helping patients to understand the nature of their disease and how to cope with it, as well as how to navigate and access support from available cancer services in Oxfordshire.

- *Fear and anxiety*: Patients who cannot fluently understand or speak English can feel a sense of increased stress due to misunderstanding the nature and extent of their condition and the treatments that will ensue or that they could choose to proceed with. One study in the *Journal of Patient Experience* found that the anxiety that cancer patients face can be compounded by difficulties in being able to communicate in their first language, partly due to not being aware of the seriousness of their condition and the level of support they can expect to receive[5]. The Committee therefore urges for there to be translators available during appointments where patients cannot speak English to a reasonable level.

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[4] Navigating Language Barriers: A Systematic Review of Patient Navigators' Impact on Cancer Screening for Limited English Proficient Patients | Journal of General Internal Medicine

[5] Impact of Language Barriers on Quality of Care and Patient Safety for Official Language Minority Francophones in Canada - Danielle de Moissac, Sarah Bowen, 2019

- *Isolation*: One study published in the *Journal of Supportive Care in Cancer* discovered that cancer patients can already feel isolated with little expectations to any hope of receiving life-saving treatment. This could result in patients feeling disconnected from healthcare providers and support networks[6]. Reducing language barriers by providing verbal and written communications in a patient's own language could help reduce this sense of isolation.

The Committee had received reports of patients having to attend appointments in the absence of properly trained interpreters, or in some instances without the presence of an interpreter at all. The Committee had also not received sufficient evidence in the report it commissioned for this item around the extent of the support provided by trained interpreters. Therefore, employing trained medical interpreters can bridge the language gap and facilitate more accurate communication between patients and healthcare providers. Interpreters should ideally be available for all aspects of cancer care, including consultations, diagnostic procedures, treatment discussions, and follow-up appointments.

Furthermore, as patients navigate the complex and often overwhelming journey of diagnosis, treatment, and recovery from cancer, advocacy emerges as a crucial pillar of support. Advocacy for cancer patients serves not only to ensure their voices are heard but also that they receive optimal care, equitable access to support, and continuous support throughout their battle against the disease. According to a publication in the *Journal of Advanced Nursing*, patient advocacy is centred on empowering individuals diagnosed with cancer, ensuring their voices are heard, and their needs are met. This form of advocacy involves helping patients understand their diagnosis, treatment options, and potential side effects[7]. Advocates provide emotional support, assist with navigating the healthcare system, and connect patients with necessary resources. By championing the rights and needs of cancer patients, advocates foster a sense of empowerment and autonomy, enabling patients to make informed decisions about their care. In the case of cancer patients, the Committee had not received sufficient information or reassurance around the advocacy being provided for cancer patients by the Trust (particularly for patients who cannot speak English fluently). A useful case study is the steps taken by Guy's and St Thomas NHS Foundation Trust, who have developed a cancer centre which provides personalised care, including through sourcing potential advocates for patients by also connecting them with other people or organisations in their community for support as well as advocacy[8]. Therefore, the Committee urges that healthcare staff should undergo cultural competency training to better

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[6] From inside the bubble: migrants' perceptions of communication with the cancer team | Supportive Care in Cancer

[7] Self-advocacy and cancer: a concept analysis - Hagan - 2013 - Journal of Advanced Nursing - Wiley Online Library

[8] Cancer care and support - Overview | Guy's and St Thomas' NHS Foundation Trust

understand the diverse backgrounds of their patients and provide care that respects their cultural values and beliefs. This training can enhance provider-patient communication and help to foster a more inclusive healthcare environment in Oxfordshire.

As such, clear communication and effective advocacy are paramount in providing equitable care to non-English-speaking cancer patients. By implementing comprehensive communication strategies and robust advocacy mechanisms, healthcare providers can ensure that these patients receive the support and care they need. This approach not only improves patient outcomes but also fosters a more inclusive and compassionate healthcare system for Oxfordshire's residents.

Recommendation 2: *For there to be clear communications with cancer patients who cannot speak in English (or who struggle to communicate in general), and for mechanisms to be in place to help with advocacy for such patients.*

System collaboration to encourage cancer screening: Cancer screening is a critical tool in the early detection and prevention of cancer, potentially saving countless lives. However, as indicated by a study in the *European Journal of Cancer*, many communities, particularly those with lower socioeconomic status, ethnic minorities, and rural populations, exhibit low take-up rates for these essential screenings[9]. The Committee has requested and is yet to receive evidence from the Trust or the ICB as to Oxfordshire-specific data on cancer screening uptakes. Addressing any disparities in uptake is of paramount importance, and one of the most effective strategies is through collaborative efforts between system partners in Oxfordshire. By uniting various stakeholders, including the County Council's Public Health team, the ICB, and the Trust, awareness campaigns can be created and implemented that resonate with communities with the lowest uptakes, ultimately improving screening rates and health outcomes for Oxfordshire's population.

Collaborative efforts between Oxfordshire's system partners would allow for a deeper understanding of the specific needs and barriers faced by communities with low take-up rates of cancer screening in the County. Community organisations and local leaders or elected representatives can often have intimate knowledge of cultural, linguistic, and socioeconomic factors that affect health behaviours of local communities in Oxfordshire. By working together, system partners can tailor messages and interventions to address these unique challenges, ensuring that campaigns are relevant and impactful.

Trust would be a critical component in health communication with Oxfordshire residents, particularly amongst marginalised or minority communities that may exhibit distrust in the healthcare system or in vaccines or screening. Collaborating with trusted community leaders and grassroots organisations can bridge this gap. When campaigns are

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[9] Uptake of the English Bowel (Colorectal) Cancer Screening Programme: an update 5 years after the full roll-out - ScienceDirect

endorsed and disseminated by familiar and respected figures within the community, they are more likely to be received positively and acted upon. One avenue would be to approach religious leaders and institutions within Oxfordshire, with the aim of not only building Trust but of harnessing this form/channel of communication that some communities might rely on.

Furthermore, launching effective awareness campaigns often requires significant resources, including funding, personnel, and materials. The Committee is yet to be informed of the degree to which resources are potentially being pooled between the Trust and the County Council as to supporting awareness campaigns for cancer screening. Collaboration allows for the pooling of these resources, making it possible to reach a broader audience and sustain efforts over a longer period. Healthcare providers can offer medical expertise and screening services, while community organizations can provide outreach and education. Local governments can support these initiatives through policy and funding. This approach was also utilised within Hampshire, where local NHS providers worked alongside the Council and Voluntary Sector community organisations to share resources to initiate a variety of cancer screening awareness initiatives[10].

In addition, a collaborative approach between the Trust and the County Council would enable the development of comprehensive and multifaceted strategies that address various aspects of cancer screening. This can include education on the importance of screening, logistical support such as transportation to screening sites, and follow-up care for those who need it. By integrating these components, campaigns can more effectively remove barriers and promote sustained engagement with cancer screening services.

As such, the importance of collaboration in launching awareness campaigns for cancer screening in communities with low take-up rates cannot be overstated. By leveraging the collective strengths of Oxford University Hospitals, the County Council, and community organizations, we can create tailored, effective, and sustainable interventions for the County. These collaborative efforts are essential to overcome barriers, build trust, and ultimately improve health outcomes for communities throughout Oxfordshire.

Recommendation 3: *For Oxford University Hospitals NHS Foundation Trust to collaborate with the Oxfordshire County Council's Public Health team on awareness campaigns with communities with low take-ups of cancer screening.*

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[10] Breaking down barriers to cancer screening - Action Hampshire

Legal Implications

13. Health Scrutiny powers set out in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide:
    - Power to scrutinise health bodies and authorities in the local area
    - Power to require members or officers of local health bodies to provide information and to attend health scrutiny meetings to answer questions
    - Duty of NHS to consult scrutiny on major service changes and provide feedback n consultations.

14. Under s. 22 (1) Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 'A local authority may make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised'.

15. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

16. The recommendations outlined in this report were agreed by the following members of the Committee:

    Councillor Jane Hanna OBE – in the Chair
    District Councillor Katharine Keats-Rohan (Deputy Chair)
    Councillor Jenny Hannaby
    Councillor Michael O'Connor
    District Councillor Paul Barrow
    District Councillor Elizabeth Poskitt
    District Councillor Susanna Pressel
    District Councillor Dorothy Walker
    Barbara Shaw

Annex 1 – Scrutiny Response Pro Forma

Contact Officer: Dr Omid Nouri
Health Scrutiny Officer
omid.nouri@oxfordshire.gov.uk
Tel: 07729081160

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