

The Kidney Cancer UK Annual Patient Survey:



A review of a decade of results.

Report from ten years of combined
Kidney Cancer UK annual patient surveys data



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Foreword

For 10 years Kidney Cancer UK has strived to learn more about the kidney cancer journey to enable the Charity to support patients, their families, and carers to the absolute best we can. We have run and developed the only UK-focused annual kidney cancer patient survey every year since 2013.

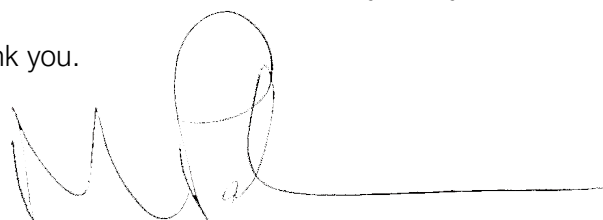
This ten-year analysis of all the surveys shows changes in the delivery of kidney cancer services, especially as they successfully adapted to the COVID-19 pandemic. The development of new treatments has been significant in surgery, radiotherapy and especially SACT. However, diagnosis has not advanced to the same extent. Almost half of people are being diagnosed at stage 3 or 4, with nearly the same percentage being diagnosed incidentally at A&E or through unrelated scans. Correcting this imbalance between diagnosis and treatment is an urgent priority. We still have rising mortality rates, which have increased by 73% since 1970, not because we do not have effective treatments, but because we cannot identify patients soon enough.

Kidney Cancer UK has changed the kidney cancer landscape, and we continue to do so. For example, we have secured the development of the first ever kidney cancer NICE guideline in England and Wales, which is rapidly advancing. We are also working closely with the National Kidney Cancer Audit, formed in 2023, which is now measuring the quality of kidney cancer services in England and Wales. We believe that the combination of these significant initiatives will have a major positive effect on services for kidney cancer patients in the future.

Of equal importance to diagnosis and treatment in a kidney cancer service are care and support of patients. This ten-year analysis shows that the NHS has struggled to meet these needs, despite the enormous efforts of NHS staff in specialist centres. However, listening to the voice of patients over the last decade through the results of our survey, has given Kidney Cancer UK unparalleled insight into the needs of patients and have guided our work throughout. We offer this to our colleagues in the NHS together with a commitment to collaborate with them to jointly support patients wherever possible.

So, if you are a patient reading this, thank you for your support in these surveys and know that your participation really does make a difference to the lives of all patients in the United Kingdom. If you are a healthcare professional, thank you for your hard work and know that the services, information and support Kidney Cancer UK, and Charities in general give can help lighten your workload. We are here to support you in your work, too.

Thank you.

A handwritten signature in black ink, appearing to read 'Malcolm Packer', with a long horizontal line extending to the right.

Malcolm Packer

Chief Executive Officer -Kidney Cancer UK

Table of Contents

Executive summary	5
Table of figures	6
Introduction	7
The Kidney Cancer UK Annual Patient Survey	7
Diagnosis	8
Key points	8
Waiting times	8
Patient identification.....	9
Later diagnosis	11
Treatment	12
Key points	12
Surgery	12
Systemic anti-cancer treatment (SACT)	13
Clinical trials	14
Patient support and information	14
Key points	14
Information at diagnosis	15
Information during treatment.....	16
Patient care and support.....	17
Counselling	17
Closing remarks	17
References	18

Executive summary

For the last decade, Kidney Cancer UK has carried out an annual survey of kidney cancer patients, focusing on their experience of services throughout the UK. This has allowed us to produce a report each year that is the focus of Kidney Cancer awareness Week each February. Having collected ten years of data, we have now looked back over the entire period to see how far services for kidney cancer patients have come.

Identifying patients remains a challenge with little improvement shown throughout the decade.

Symptoms are hard for GPs to interpret. There is no easy, cheap test for kidney cancer. Consequently, one in four patients who have kidney cancer are initially diagnosed with a different condition. This has been no improvement for the last four years.

Over the last nine years almost half of patients have been diagnosed incidentally whilst having a scan for an unrelated condition. This has shown no improvement.

Specialist diagnosis is carried out effectively. However, the results of the Kidney Cancer UK Annual Patient Survey consistently show that for last six years, around 45% of kidney cancer patients have reached stage 3 or 4 by the time they are diagnosed, making effective treatment difficult. This may be due to late referral for specialist diagnosis.

Treatment options, and their potential to treat kidney cancer effectively, have improved considerably over the last decade, but access has increased more slowly. This may be due to:

- variable- or under-utilisation in many areas, causing unwarranted variations
- limitations in diagnosis leading to a high proportion of patients who are not identified until they have reached stage 3 or 4.

Patient support and information have suffered as a result of the constant pressure on the NHS and on NHS staff, and have shown little improvement in the last decade.

The survey consistently shows that patient information is variable. Some aspects of treatment, e.g. SACT and its side-effects, are well-supported by information. However, information needs to be improved and made more accessible overall. The risk is that whilst most patients say their views are taken into consideration when considering treatment, they may not have all the information they need to make fully informed decisions.

Of particular concern is that the survey shows that one in four patients are still not given the name of a Clinical Nurse Specialist. This is despite some improvement up to 2017, after which the proportion has plateaued. Also, relatively few patients are offered psychological support when they need it, including counselling.

Overall, the Kidney Cancer Annual Patient Survey suggests:

- there have been substantial improvements in treatment potential, but this is not being fully realised due to difficulties in patient identification and slow uptake;
- ten years of survey responses show that in general the NHS is not providing adequate information and support to patients, and needs to improve sign-posting to other reputable sources, such as national patient organisations.

Table of figures

Figure 1 Proportion of patients waiting over 3 months for specialist diagnosis _____	8
Figure 2 Proportion of patients initially misdiagnosed by GP _____	9
Figure 3 Symptoms experienced by patients before being diagnosed with kidney cancer _____	10
Figure 4 Proportion of patients diagnosed incidentally _____	10
Figure 5 Proportion of patients diagnosed at stages 3 & 4 _____	11
Figure 6 Proportion of patients receiving surgery _____	12
Figure 7 Proportion of people receiving surgery who had it laparoscopically _____	12
Figure 8 Proportion of patients receiving robotic surgery _____	13
Figure 9 Proportion of patients receiving ablative therapy _____	13
Figure 10 Proportion of patients recommended SACT _____	13
Figure 11 Proportion of patients offered access to a clinical trial _____	14
Figure 12 Proportion of patients unhappy with the way they were told they had cancer _____	15
Figure 13 Proportion of patients who did not feel they had been given enough information at diagnosis ____	16
Figure 14 Proportion of patients who felt their views were not taken into consideration when deciding on treatment _____	16
Figure 15 Proportion of patients not given the name of their Clinical Nurse Specialist _____	17
Figure 16 Proportion of patients offered counselling _____	17

Introduction

Kidney Cancer UK's fundamental aim is to help patients, their families and their carers. To do this effectively means we must understand their needs and their experiences from beginning to end of their pathway. One of the most important ways in which we do this is Annual Patient Survey.

The 2023 survey was the tenth in the series, and this is a good point at which to look back over the last decade to see what has changed and what we can learn from this. 2023 was a momentous year for kidney cancer patients in England and Wales. It was the year in which the National Institute for Health and Care Excellence (NICE) began producing a clinical guideline on kidney cancer, following the Kidney Cancer UK Accord's successful campaign requesting NHS England commission them to do so. It was also the year in which work began on the Kidney Cancer National Audit. Both of these developments are major steps in the process of ensuring people with kidney cancer receive the earliest and most accurate diagnosis and the best possible treatment and care.

Such progress is of vital importance. With 13,322 new cases each year, kidney cancer is the seventh most common cancer in men and women in the UK.¹ Currently, around 4,700 people die each year from kidney cancer,² and this figure is growing. Kidney cancer is one of only seven cancers whose mortality rate is increasing.³ In the UK, mortality rates due to kidney cancer have gone up by 73% since the 1970s.²

The retrospective audit carried out by the Kidney Cancer UK Accord as part of the case supporting the need for a NICE guideline, looked at 18,640 tumours, identified in 18,421 distinct patients in 2017 and 2018 in England. Its results show significant unwarranted variations in the quality of services provided to people with kidney cancer in England.⁴

This paper looks at trends identified over the last ten years in the Annual Patient Survey that might suggest some of the reasons behind the audit's results.

The Kidney Cancer UK Annual Patient Survey

The first survey took place in 2014. The precise number of responses is not reported, but it was fewer than 100, as in the following year when there were 68 completed questionnaires. Engagement with the survey has greatly improved with the number completed rising by around 800% to over 500 in the two latest surveys with more than 600 responding in 2023..

The purpose of the survey is to capture the experiences of patients throughout the patient pathway. It measures the quality of services through the eyes of patients, and it looks at how well patients are informed and supported throughout their diagnosis, treatment and beyond.

The survey is designed to be completed by kidney cancer patients, or on their behalf by a member of their family or a carer, and focuses on diagnosis and treatment. It is also able to give a glimpse of what happens to patients pre-diagnosis.

Over the ten-year period, the questions have remained quite consistent. This was deliberate in order to provide longitudinal data on changes in service quality. There have been some changes to questions, particularly in the first two years, so caution should be exercised when drawing conclusions from trend data. Nevertheless, looking back across ten years of the survey results gives some strong indications that should be considered carefully.

The survey questionnaires are made available via the on-line platform QuestionPro and the majority are completed digitally. However, the questionnaire is also available in print, and a small proportion are received by Post.

The survey opens in mid-October and questionnaires can be completed via the Charity's social media channels. These include Kidney Cancer UK's open Facebook pages, and its three closed pages, as well as its website. In addition, the survey is promoted via Instagram and X . From launch through to closing the survey at the end of November, promotional posts are made three times per week through all of the channels above.

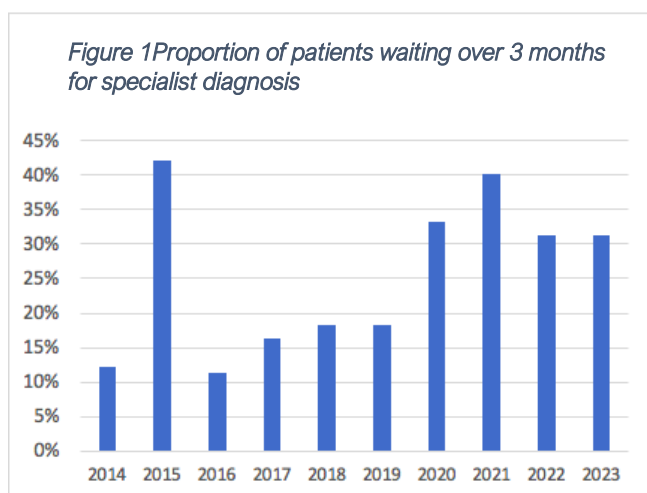
Results are published during Kidney Cancer Awareness Week in the following year, which is the first whole week in February.

Diagnosis

Key points

- Presently around one in three patients exceed the cancer diagnosis standards set by national devolved governments throughout the UK.
- For the last four years consistently 25% of patients diagnosed with kidney cancer had been misdiagnosed with a different condition prior to their cancer diagnosis.
- Almost half of all kidney cancer patients are diagnosed incidentally each year, and this has remained at broadly the same level for the past nine years.
- For the last six years the proportion of patients diagnosed at stages 3 & 4 has remained relatively steady at around 45%.
- There has been little or no improvement in diagnosing kidney cancer in the last six to eight years.
- Some of the issues with kidney cancer diagnosis are related to the identification of patients who may be at risk of kidney cancer and also prompt referral for specialist diagnosis.

Waiting times



The proportion of patients waiting more than three months (84 days) for specialist diagnosis almost doubled in 2020 from around 12-18% in the preceding years to 33%. It has remained close to this level since then.

The exact reasons for this jump are unclear, but may be linked to the impact of the COVID pandemic. The latest data suggest there has been little progress in reducing this proportion, which remains close to its level in 2020. N.B. The 2015 value is an unexplained anomaly.

Our survey measures the time from first feeling unwell and seeking medical advice to receiving a diagnosis. This does not correspond exactly to the Government standards set in any of the devolved nations, so direct comparison is not possible.

The closest Government target to this is in Wales where all patients with suspected cancer who are referred (urgent or otherwise) either by their GP or internally from another hospital department should have a confirmed diagnosis and start treatment within 62 days.

England, Scotland and Northern Ireland have time to treatment standards meaning:

patients should wait no longer than 62 days from the date their urgent referral for suspected cancer is received by the hospital to the start of treatment,

and

patients should wait no longer than 31 days from the consultation at which they and their doctor agree their treatment plan and the start of treatment.

Faster Diagnosis Standard

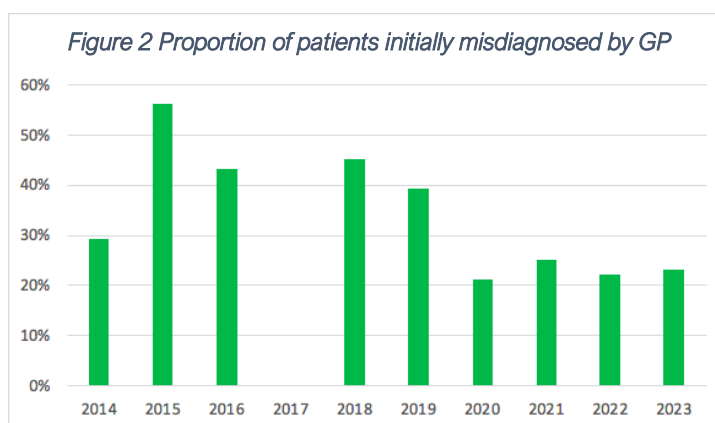
In England, the Faster Diagnosis Standard (FDS),⁵ which has superseded the two-week wait target,⁶ states that 75% of people should not wait more than 28 days from referral to finding out whether they have cancer or not. This is due to be increased to 80% in 2025-6.

Scotland, Wales and Northern Ireland do not have standards set for this parameter.

Patient identification

Patient identification is a major challenge. Patients present through a number of routes: just over 30% visit their GP due to feeling unwell and just over a further 10% go to their hospital's emergency department. Neither with symptoms relating to kidney cancer.⁷

Symptoms are often common to many other conditions and are not specific to kidney cancer. There is no simple test that can be used to confirm a diagnosis of kidney cancer. Consequently, many patients are initially diagnosed with other conditions. Our survey has shown that the proportion of patients who were initially misdiagnosed in this way has stood at around one in five for the last four years. Before that it appears to have been much higher.



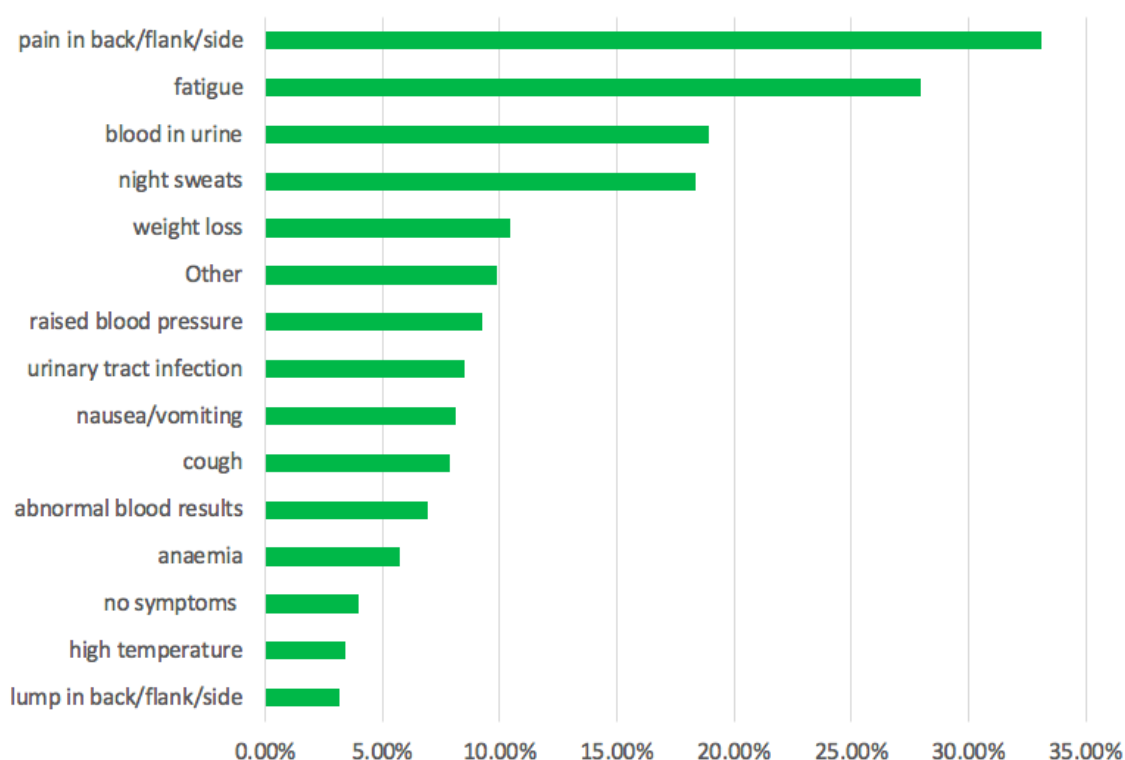
The main ways that patients are diagnosed require either an ultrasound scan (45% of cases in 2023) or a CT scan (40% of cases in 2023). These are services that are already under extreme capacity pressure, with relatively long waiting times in many cases. We do not know if these factors influence the way a GP or A&E doctor assesses the risk of kidney cancer versus other non-malignant conditions with similar symptoms. However, our survey results show that in 2022 and 23, only around 30% of cases were identified from further tests following a GP consultation. This is fewer patients than in 2016 when 38% were identified in this way, and the number has gradually fallen year-on-year ever since.

The majority of cases are identified other routes. In 2023, 60% of cases were diagnosed either when the patient was undergoing a scan for an unrelated condition, or following a visit to A&E because of feeling unwell. In 2016, this figure was 62%: there has been no significant improvement since.

Guideline NG12 from the National Institute for Health and Care Excellence (NICE) cover recognition and referral for suspected cancer mentions only blood in the urine as a symptom suggesting kidney cancer. However, our survey results have consistently shown that people exhibit other common symptoms before a diagnosis of kidney cancer. The results from our latest survey show that 33% of patients experience pain in the flank or side, 28% fatigue and 19% blood in the urine.

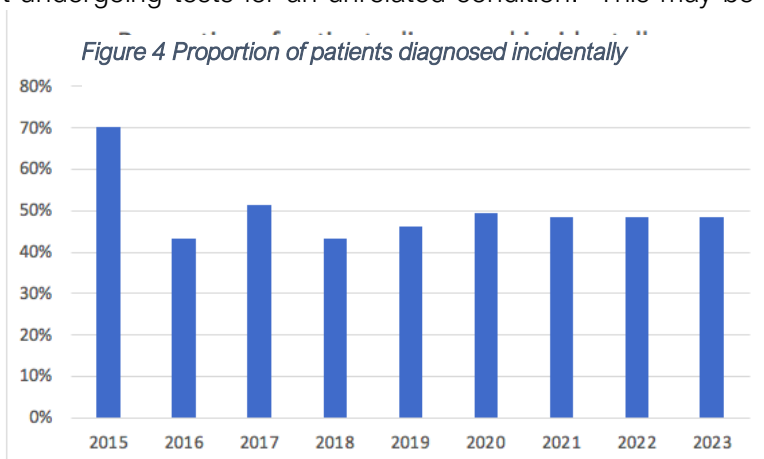
This might suggest that recognising patterns of symptoms – especially where one or more of the above are present – could be more successful than focusing only on the presence of blood in the urine. However, things are unlikely to change unless the brief kidney cancer section in guideline NG12 is reviewed and updated.

Figure 3 Symptoms experienced by patients before being diagnosed with kidney cancer



According to our surveys over the last nine years, almost half of all kidney cancer patients have been diagnosed incidentally whilst undergoing tests for an unrelated condition. This may be a consequence of difficulties in patient identification as discussed previously, and the absence of a simple, standard test for kidney cancer.

For patients, a diagnosis of kidney - or any other – cancer in these circumstances is even more traumatic. The shock of receiving such a diagnosis when cancer is not even suspected, is greater.



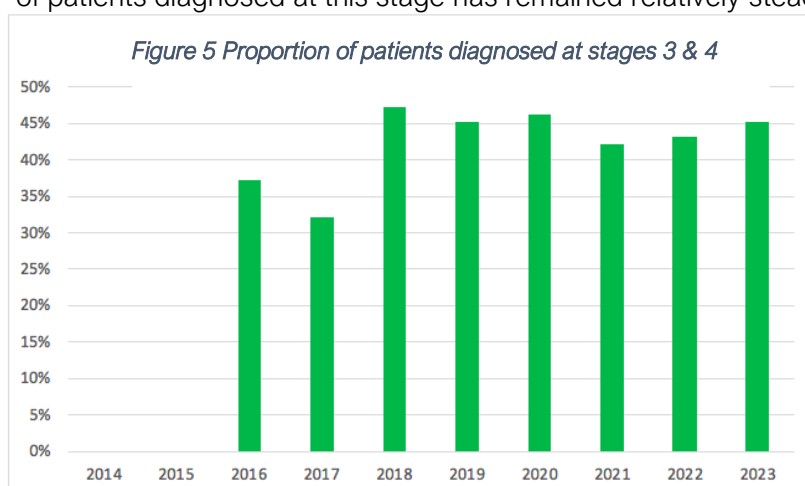
In the absence of a diagnostic test for kidney cancer, the pressure remains on health care professionals, particularly GPs and A&E doctors, to recognise patterns of symptoms, possibly combined with risk factors identified from the patient's history.

Later diagnosis

A further consequence of the difficulties in identifying patients at risk and referring them for specialist diagnosis – at least in part - is later diagnosis. Treatment outcomes tend to be better if kidney cancer is diagnosed at earlier stages. In addition, treatment of earlier stage kidney cancer is generally less radical. For example, there is a greater probability that patients can be successfully treated with nephron-sparing surgery (a partial nephrectomy), with conversely fewer needing to have their whole kidney removed.

In its early stages, kidney cancer may be asymptomatic. When patients do present, incorrect initial diagnosis leading to inappropriate treatment can cause further delays leading to later diagnosis (i.e. stages 3 or 4). It is highly likely that many early diagnoses made at stages 1 or 2 are incidental findings.

The survey started to measure stage 3 & 4 diagnosis in 2016. For the last six years the proportion of patients diagnosed at this stage has remained relatively steady at around 45%.



The factors discussed previously are likely to have contributed to these figures. The relative stability in the proportion of cases diagnosed at these stages may also be partly due to the fact that there have been no major improvements in the technology used to diagnose kidney cancer.

The quality of CT and ultrasound scans have improved, but not to the point where it would encourage earlier referral. The main discouraging factors are likely to include the cost of scans and issues with capacity in diagnostic imaging. The latter may increase waiting times for scans and also for scan results, given the shortage of consultant radiologists to interpret them.

Diagnosing kidney cancer therefore remains a challenge. The Galleri test – a blood test that may be capable of detecting up to fifty different types of cancer – is presently being trialled in the NHS. It remains to be seen whether it could be the breakthrough kidney cancer has been waiting for. That will depend on not only its effectiveness in kidney cancer, but also its cost to the NHS.

Work is also advancing in using positron emission tomography (PET) imaging agents to identify kidney tumours.

Treatment

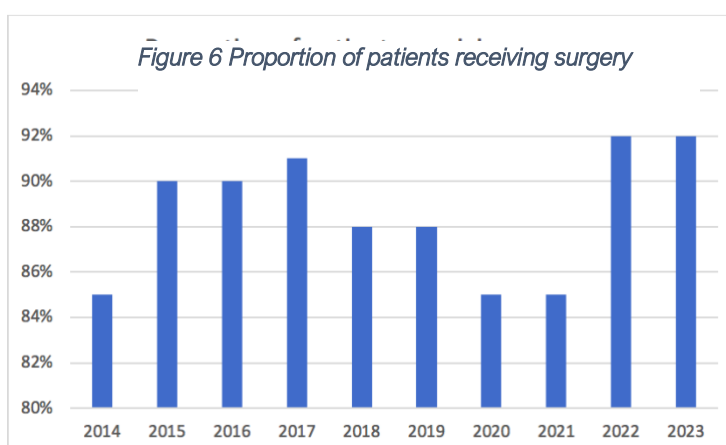
Key points

- *Surgery remains the dominant treatment for kidney cancer, but more needs to be done to improve patient access to techniques that are less invasive.*
- *The number of Systemic Anti-Cancer Therapy (SACT) agents has improved hugely over the last ten years with the number of treatment options rapidly increasing. Consequently the survey shows a steady increase in access. However, may still be under-utilised in some areas.⁴*
- *Clinical trial access has generally fallen since 2017 and is now at a very low level (6%). This should be urgently addressed.*

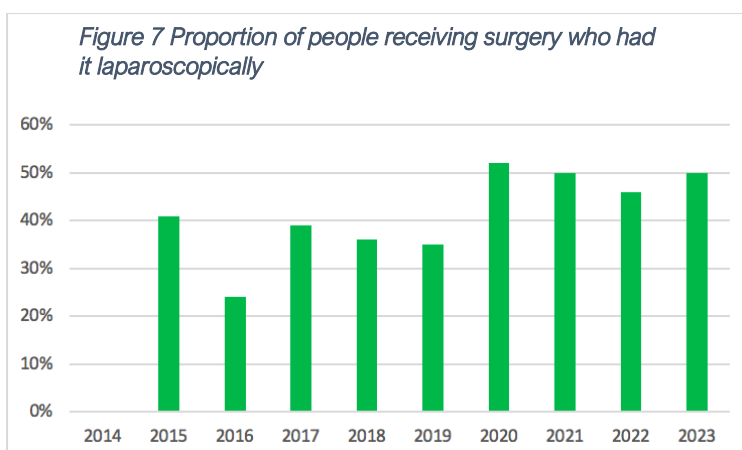
Surgery

Surgery has been the dominant treatment for kidney cancer throughout the last decade, with between 85% and 92% of patients receiving it. The dip of approximately 10% in 2020 and 2021 coincides with the COVID pandemic, but there are no hard data in our surveys that link the two.

The proportion of who had laparoscopic surgery has remained at around half of those receiving surgery since 2020.

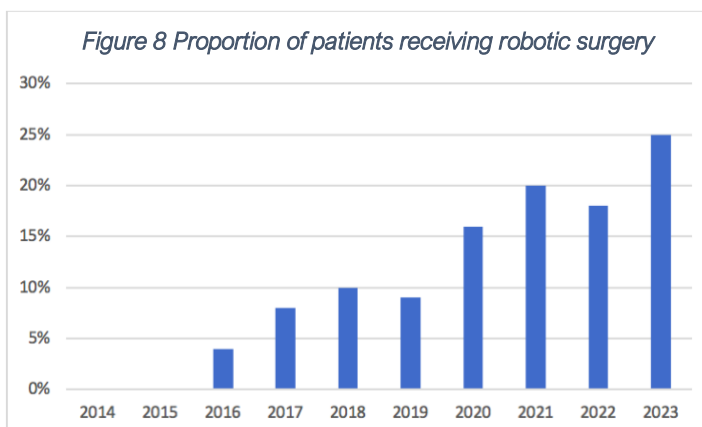


Over the preceding five years, since 2015, the proportion having laparoscopic surgery grew steadily. However, the first laparoscopic nephrectomy in the UK (and Europe) was performed in 1991,⁸ meaning that it took over approximately thirty years for this technique to be used in half of patients needing surgery. Of course, the optimal usage of laparoscopic surgery will never be 100%. Nevertheless, this illustrates the relatively slow pace at which routine use of this technique increased.



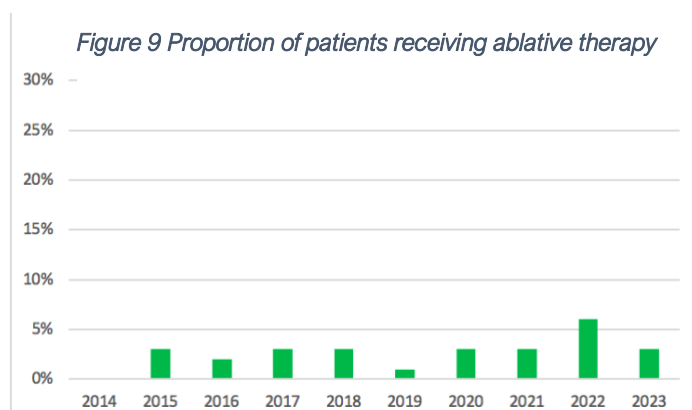
Robotic surgery is another minimally invasive technique the use of which took a long time to develop. The first robot-assisted laparoscopic partial nephrectomy was introduced in 2004. It was first recommended by NHS England in 2016 for early kidney cancers unsuitable for conventional laparoscopic surgery.⁹

In the same year, robotic surgery first registered in our survey results when 4% of patients surveyed received it. This gradually rose to around 20% over the following five years. In our latest survey results, usage has increased to 25%.



Excluding the 12 years between its first introduction and its first commissioning on the NHS, this appears to be a more rapid increase in usage compared with conventional laparoscopic surgery.

The use of ablation therapy for localised kidney lesions has been slow in contrast. It first registered in our annual survey in 2015 when 3% of patients said they had received it. However, it has remained around the same level for a decade, showing no growth. The exception to this is 2022



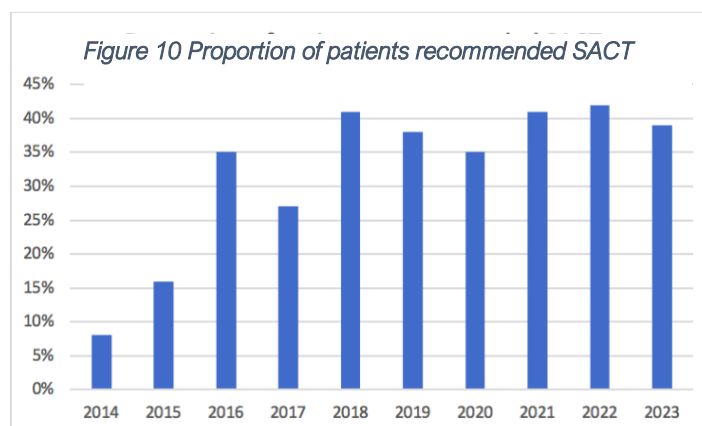
when 6% of surveyed patients said they had undergone ablation therapy, but given the low base level, this cannot be considered as a sign of growth.

This low level of uptake is supported by results from the Kidney Cancer UK Quality Performance Audit of kidney cancer services in England⁴, which showed that just 3% of T1a and T1b kidney tumours were treated with ablation therapy.

We anticipate that the clinical guideline under development by National Institute for Health and Care Excellence (NICE) will recommend wider use of ablation therapy, where appropriate, leading to better access for patients.

Systemic anti-cancer treatment (SACT)

The number of SACT agents has risen dramatically over the last ten years. It is now standard treatment for metastatic disease and very recently some agents have started to be used as adjuvant therapy following surgery. This is reflected in the survey results where, in 2014, just 8% of patients said they had been offered SACT. The growth in SACT usage over the next four years was rapid, reaching 42% of patients in our survey in 2018 (an increase of over 500%). Since then usage seems to have plateaued. However the report of



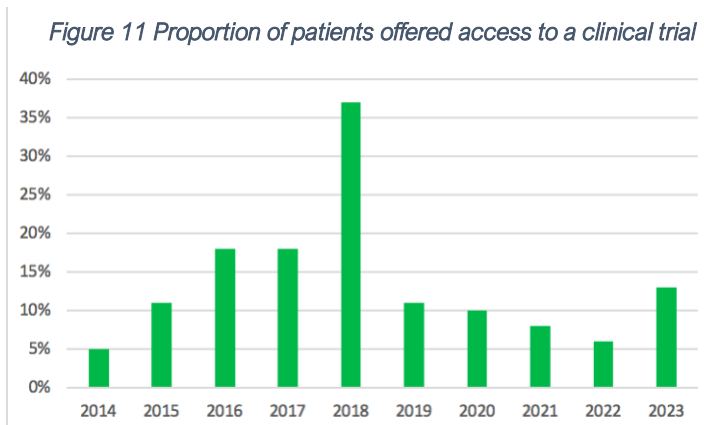
the Kidney Cancer UK Quality Performance Audit of kidney cancer services in England, published in 2022,⁴ commented that there were indications that SACT was being under-utilised in some areas. This was based on 18,640 tumours in patients between 58-77 years (median 68).

Clinical trials

Apart from their crucial role in the development of new diagnostic agents and treatments, clinical trials are an important way in which patients can access these developments.

Our survey has indicated that access to clinical trials has generally declined. The results of our first surveys in 2014 and 2015 show that 4% and 11% of patients surveyed had taken part in a clinical trial. These are relatively low numbers compared with 2016 and 2017, but this might be influenced

by the sample sizes of the surveys in these years. Nevertheless, the trend after 2017 is generally downwards. Recruitment into individual trials can result in large annual variations and this might explain the results in 2018 and possibly 2023.



It is also worth noting that the Kidney Cancer UK Quality Performance Audit of kidney cancer services in England⁴ showed that almost 25% of NHS trusts did not recruit any clinical trial participants.

Patient support and information

Key points

- *Information and support between diagnosis and treatment needs to be improved. Many patients complain of a lack of information and are unhappy with the way they are told their diagnosis.*
- *During treatment, some aspects of information and support are good. Relatively few people complain their views are not considered in decisions about their treatment, but although the proportion has reduced, one in four patients are still not given the name of a Clinical Nurse Specialist.*
- *Only a low proportion of patients (roughly (30%-40%) are offered counselling*

Patient information and support is vitally important to treatment outcomes and also to the wellbeing of patients at all stages of diagnosis and treatment. This is reflected in their inclusion in the scope of the NICE clinical guideline and quality standard that are under development at the time of writing.

Over the last decade, our survey has indicated that balancing these patient needs with clinical services has always been difficult for the NHS, not least because of budgetary pressures. This is an area in which patient charities can support both patients and the NHS by augmenting the services available. Kidney Cancer UK's nurses can support CNSs in units and patients with general enquiries. (N.B. we do not provide advice on specific, individual cases).

Information and support are needed at all stages of diagnosis and treatment, as well as after treatment has been carried out. The Kidney Cancer UK Annual Patient Survey results from the last ten years have thrown a light on the needs of patients, the parts of the pathway in which information and support are good, and those where it needs improvement. These have been remarkably consistent in most cases.

Of course the needs of patients are as individual as they are, and the provision of information and support must take this into consideration. For example, some patients will want to have lots of information to understand their condition and will feel more in control when they do, but others will want to focus on living their life as normally as possible and will not want anything other than the very basic information.

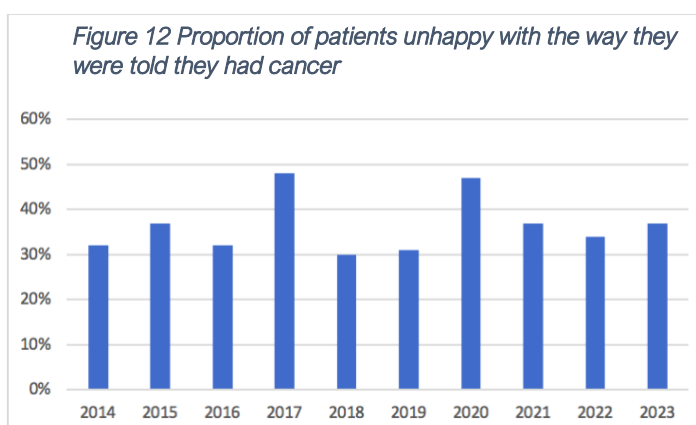
There has never been a better opportunity than now to get the provision of information right for patients, given the capabilities of modern technology. Yet, our survey results suggest this is not being achieved and there is no clear trend showing improvement on this.

Information at diagnosis

The patient survey has always asked if people were happy with the way in which they were told they had cancer. In considering these results, it is also worth remembering that around half of these patients will have been incidentally diagnosed with kidney cancer.

The proportion of patients unhappy with the way they were told they had cancer has remained generally around one in three patients throughout the ten years. In 2020 it rose to 47%, which may have been due to COVID.

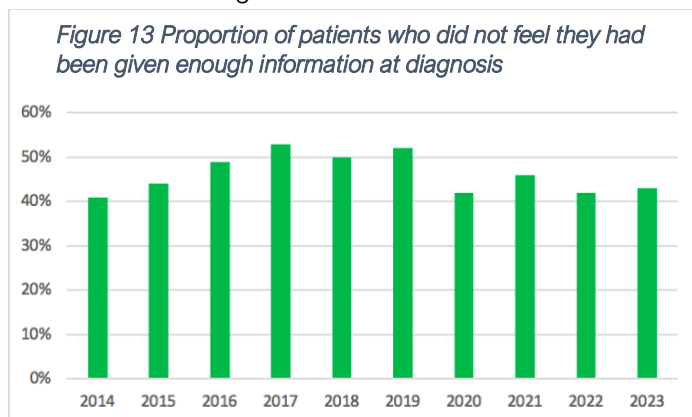
Some people thought the news could have been communicated in a more sensitive way (23% in 2023) or that it felt rushed (7% in 2023).



Communicating news such as a diagnosis of cancer is never easy, but current conditions in the NHS throughout all devolved nations make it more difficult. However, one in three patients who are not satisfied is a proportion that must be reduced and the results of successive Annual Patient Surveys have shown that this is not being achieved.

It is also worth drawing attention to the 9% of patients who said they did not remember or were too shocked to remember. Information that is given to people who are clearly shocked is unlikely to be remembered. These patients need to be able to access it at a later stage, if they wish to. Whilst reassurance from a health care professional can be very helpful, some people will forget it and will need reassurance later on.

Over the last ten years the proportion of patients who did not feel they were given enough information at diagnosis has remained between 40 – 50%. This high proportion needs to be



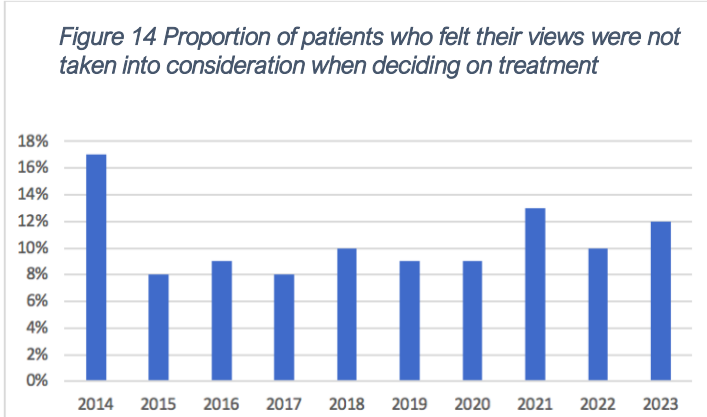
reduced. 'At diagnosis' does not necessarily mean at the consultations in which patients are given the diagnosis. The provision of information that can be read at a later stage and access to information sources that can be accessed after the diagnosis has been given are crucial and these must be provided. The survey results suggest such resources are not always available (in our 2023 survey 43% of patients said they were not given any information to

take away and read later. This may be true in the NHS to a greater or lesser extent, but resources do exist in the Third Sector, which begs the question: are patients being signposted to them?

Information during treatment

Involving patients in decisions about their treatment and paying attention to their personal needs is universally recognised as important. Our survey results show that consistently since 2014, NHS staff have been good at doing this.

The proportion of patients who said their views were not taken into consideration when deciding treatment has remained low, fluctuating around 10%.



In 2023, two in three (66%) of patients said they were happy with the information and support they received before and after surgery.

Almost 90% of patients receiving SACT said they were happy with the information they were given about side-effects.

This seems to suggest that the provision of information and support is better in relation to treatment than to diagnosis. However, the third of patients remaining unhappy with information and support before and after surgery means there is still work to be done to ensure that when patients are involved in decisions about their treatment, they have all the information they need to make informed choices.

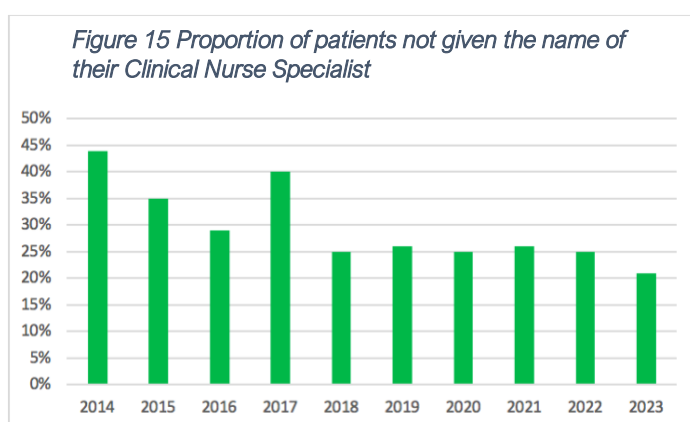
Patient care and support

One of the most important sources of information and support is the clinical nurse specialist (CNS). The NHS England service specification for specialised kidney, bladder and prostate cancer services (Adults)¹⁰ states:

“Patients must have access to a ‘key worker’ - this is normally the Clinical Nurse Specialist (CNS) with an expertise in Urological Cancers. Patients must meet their key worker as early as possible within their pathway of care”

And

*“Every patient and family / carer must receive information about their condition in an appropriate format. Verbal and written information must be provided in a way that is clearly understood by patients and free from jargon. The information must cover:
.... Contact details of the patient’s allocated named nurse...”*

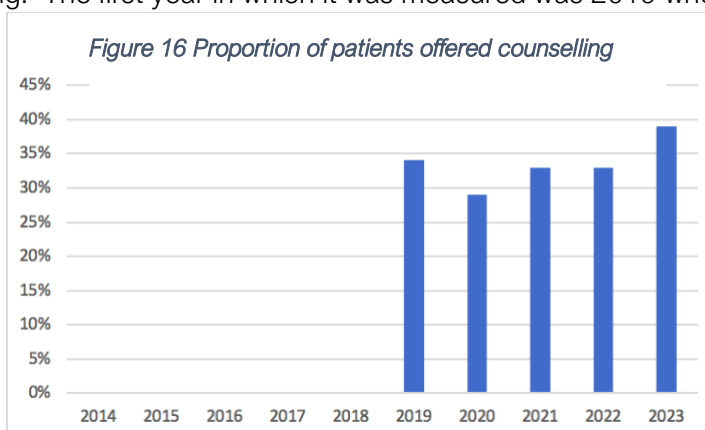


In spite of this, the number of patients who say they were not given the name of a CNS was around 40% until 2017 after which it fell to around 25% where it has consistently remained since. So after ten years, nearly 1 in 4 patients are still not given the name of a CNS.

Counselling

Since Kidney Cancer UK launched its free counselling service, the Annual Patient Survey has measured overall access to counselling. The first year in which it was measured was 2019 when 34% of patients said they had been offered counselling. The results in the four subsequent years suggest a small upward trend, but the proportion of patients offered counselling remains low.

We know that not all people want or benefit from counselling. In our survey, of those who did receive counselling 55% said they felt it was a benefit. The provision of NHS counselling must be improved so that all kidney cancer patients can be offered it throughout their diagnostic and treatment pathway.



Closing remarks

A decade of surveying patients has shown some improvements in services, notably in the capabilities of treatment (surgical and SACT). Patients have access to more treatment options

than ever before. However, not all treatment options are universally available, meaning that some patients who might benefit are unable to access the treatment, leading to health inequalities. Also some treatment techniques that are available on the NHS have been relatively slow in uptake.

Despite the strides forward in treatment, diagnostic capabilities have remained largely unchanged. The imaging capabilities of CT and ultrasound scanners have increased, and this has brought some improvement, but diagnosing kidney cancer remains almost as difficult as it was ten years ago. The early identification of high risk patients has also remained as difficult as ever. This represents an urgent research need to develop better diagnostic tests/scans that will allow patients access to the significant armoury of treatments at an earlier stage, when their cancer is more likely to respond to treatment.

Information and patient support are variable. There is a need for improvement at diagnosis and during the period up to the first treatment. More use of modern technology is needed to make information available to all patients available at all times, so they can choose when they want to access it.

Patient support is seriously hampered by variable access to a named CNS. The need to rectify this so that every patient has a named CNS from initial diagnosis throughout is urgent.

Access to counselling is generally poor, but variable. This, along with support for the entire mental health and wellbeing of patients' needs improvement.

Information and support do not always have to come from the NHS. Patient charities have useful resources in both, but NHS health care professionals need encouragement to signpost patients towards them. Better collaboration between NHS units and patient charities would result in more integrated services and more streamlined support for patients.

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Kidney Cancer UK 10 Year Patient Survey Report

All data from published Kidney Cancer UK Patient Surveys' from 2013 through to 2023

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