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Appendix 1


Calderdale
Clinical Commissioning Group


Greater Huddersfield
Clinical Commissioning Group

Action on Cancer

Strategic intentions on cancer 2015/6 to 2019/20

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Foreword

Cancer affects all of us. Over 250,000 people in England are diagnosed with cancer every year and around 130,000 die from the disease. Currently, about 1.8 million people are living with and beyond a cancer diagnosis. Even if we do not develop cancer ourselves, we all have family and friends who have had cancer. Surveys in England show that people fear cancer more than anything else.

Despite improvements in survival and mortality in recent decades, cancer outcomes in England remain poor when compared with the best outcomes in Europe. Although improvements have been made in the quality of cancer services, a significant gap remains in both survival and mortality rates.

Calderdale and Greater Huddersfield CCGs have seen a similar trend to the rest of England and are setting out in this document their plan to improve services and support to people with cancer and their families/carers.

This document is a response to the cancer strategy developed by 10CC¹ and sets out the following priority areas:

- Prevention
- Screening
- Awareness and Early Diagnosis
- Referral and Treatment
- Survivorship
- End of Life

We want to work together to support our populations to avoid cancer where possible, and to receive systematic high quality personalised care and support when they are affected by cancer.

Dr David Wild
Clinical Lead for Cancer
Calderdale CCG

Dr Bert Jindal
Clinical Lead for Cancer
Greater Huddersfield CCG

¹ The 10 Clinical Commissioning Groups in West Yorkshire

Introduction

'Action on Cancer' has been developed by Calderdale and Greater Huddersfield Clinical Commissioning Groups (CCGs). The CCGs lead the Calderdale and Greater Huddersfield Cancer Network, which includes commissioner and provider clinicians and managers, and representatives from the third sector.

The Network will be responsible for driving the work set out in this document, and progress will be reported back to the CCGs through their governance structures. The exception to this is the 10CC work, which will be managed and reported on by that body.

The actions to be undertaken are shown in bold.

Background

Calderdale and Greater Huddersfield

Calderdale and Greater Huddersfield have a population of more than 456,000 patients between them. Both areas include urban and rural areas. They share an acute trust (Calderdale and Huddersfield Foundation Trust), which also provides community health services to Calderdale. Community health services in Greater Huddersfield are provided by Locala Community Interest Company. There are 26 GP practices in Calderdale and 40 in Greater Huddersfield. Calderdale has its own local authority while Greater Huddersfield is part of Kirklees Metropolitan District Council.

Current position on cancer

The current position in relation to cancer in each CCG area is shown below.

Calderdale

- The number of people who have still stopped smoking four weeks after beginning is significantly lower than similar areas elsewhere
- There are low three year cancer screening rates
- Cancer mortality rates are higher than the England average. It is estimated that 39 lives could be saved across Calderdale if Calderdale reached the level of similar areas in the country
- Standardised Mortality Rates from cancer for those aged 65 and under, and those aged 75 and under are higher than the England average. There are higher mortality rates in Elland, Illingworth/Mixenden and Ovenden wards than the rest of Calderdale
- Lung cancer is the second highest cause of death, and higher than the England average
- The model of cancer care is largely hospital-based – there has been some investment into a different model of follow-up after breast cancer, but this is the exception rather than the rule
- There are variations in fast track referrals and pathways

Greater Huddersfield

- Prevention is crucial, including reducing smoking prevalence and harmful drinking rates, improving diet and increasing physical activity, along with raising awareness of symptoms and earlier diagnosis
- Cervical screening is of particular concern as the percentage of women attending for screening has declined over recent years, especially in the younger age group.

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- New cases of lung cancer remained significantly higher than the rates for England; the highest rates continued to be amongst men aged over 65 years. Whilst the rate in older men gradually declined, the rate in women aged over 65 years increased. This gradual convergence of lung cancer incidence rates for men and women reflects the regional and national trend, due to women taking up smoking later than men.
- Rates of new cases of breast cancer were highest in Denby Dale and Kirkburton, whilst rates of new cases of prostate cancer were significantly higher in the Valleys; both these cancers are more common in higher income groups.
- Cervical cancers continued to rise and remained above the national average, whilst uptake of cervical screening was declining in the younger age groups.
- Rates of new cases of bowel cancer were highest for men in Huddersfield north and for women in the Valleys.
- Cancer survival rates were also improving although lung cancer remained low
- Although rates of new cases for many cancers are rising survival rates for some cancers are improving due to screening, earlier diagnosis and improved treatments. Cancer patients can therefore experience similar challenges and opportunities as those with other long-term conditions.
- Cancer remains the most common cause of death in those aged under 75, although this is improving
- More men and women died from lung cancer than from any other type of cancer. In Kirklees² in 2008-2010, 1 in 4 (25%) of all cancer deaths were from lung cancer. The death rate for lung cancer in both men and women in Kirklees was also significantly higher than in England. As with new diagnoses, death rates reduced in men but increased in women.

Drivers for improvement

There are four key drivers for improving cancer services:

Rising demand for healthcare: more people living longer, needing more care in the future: As a consequence of medical advances in cancer diagnosis and treatment, many patients live with and beyond cancer for long periods of time. We need to ensure that everything is done to allow them to live as healthy a life as possible, for as long as possible;

Needing to do more with less: the NHS is facing a projected funding gap of around £30bn between 2013/14 and 2020/21;

Patient experience and meeting rising expectations: there are variations in patients' experience of care. We need to make sure that patient feedback informs the co-design and delivery of safe, effective, easily accessible and patient-centred services;

Inequalities in cancer service access and outcomes: some groups in society have disproportionately poorer outcomes and people's health can vary according to where they live, how wealthy they are, and their ethnic background. The reduction of health inequalities within cancer services has been established in policy by the Department of Health as a key governmental goal at both a national and local level.

² Figures were not available specifically for the Greater Huddersfield population at this time – they were for Kirklees Primary Care Trust (from which Greater Huddersfield and North Kirklees Clinical Commissioning Groups have formed)

Identifying opportunities to improve

The CCGs have used the following information to help direct their areas of focus in this document.

National Cancer Patient Experience Survey

The National Cancer Patient Experience is undertaken every year. It covers all areas of care and support from referral to discharge to ongoing care and support, setting out specific statements under each area which respondents are invited to agree or disagree with in relation to their experience.

The results of the survey are published each autumn in a report with a series of tables showing percentage of achievement compared to the previous year, to the national average and to the lowest and highest performing Trusts in the country. The report also presents the results by site of cancer.

Each year the Cancer Locality Group will discuss the results of the survey and agree plans to address any areas of concern.

National Cancer Peer Review

The National Cancer Peer Review (NCPR) is a national quality assurance programme for NHS cancer services.

The programme involves both self-assessments by cancer service teams and external reviews of teams conducted by professional peers, against nationally agreed “quality measures”.

NCPR is managed by the National Cancer Action Team and is an integral part of the NHS Cancer Reform Strategy (2007) and the overall NHS Cancer Programme, led by the National Cancer Director.

The National Cancer Peer Review Programme aims to improve care for people with cancer and their families by:

- ensuring services are as safe as possible;
- improving the quality and effectiveness of care;
- improving the patient and carer experience;
- undertaking independent, fair reviews of services;
- providing development and learning for all involved;
- Promoting the dissemination of good practice.

The outcomes of National Cancer Peer Review Programme are:

- confirmation of the quality of cancer services;
- speedy identification of major shortcomings in the quality of cancer services where they occur so that rectification can take place;
- published reports that provide accessible public information about the quality of cancer services;
- timely information for local commissioning as well as for specialised commissioners in the designation of cancer services;
- validated information which is available to other stakeholders

CHFT will bring the outcomes of peer reviews to the Cancer Locality Group for discussion.

Commissioning for Value Insight Packs

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The Commissioning for Value Insight Packs produced by Yorkshire and Humber Public Health Observatory in October 2013 suggest that there are potential opportunities in cancer (set out in Table 1) to save lives, and reduce hospital visits by bringing care and support to the level of the highest amongst similar areas across the country.

Table 1. Potential improvement and saving opportunities

Area	Calderdale	Greater Huddersfield
Number of women undergoing breast cancer screening within the previous 36 months	An increase of 1,838	An increase of 610
Mortality from all cancers	40 fewer lives lost	
Mortality from lung cancer	24 fewer lives lost	10 fewer lives lost
Successful smoking quitters after 4 weeks	217 more	1,269 more
Elective and day case admissions	1,648 fewer	3,265 fewer
Non-elective admissions	250 fewer	137 fewer
Emergency bed days	1,335 fewer	
Elective and day case admissions savings	£311k	£1,073k
Non-elective admissions savings	£489k	£241k
Prescribing savings		£57k

What works?

The evidence base around cancer is described in detail in a number of publications, including the following:

- Improving Outcomes: A Strategy for Cancer - 2011 (and annual reports on it) (Department of Health and Public Health England)
- Cancer across the Domains - Cancer priorities for the new NHS 2013 (All Party Parliamentary Group on Cancer)
- Living With and Beyond Cancer: Taking Action to Improve Outcomes 2013 (National Cancer Survivorship Initiative)
- Innovation to Implementation: Stratified Pathways for Care 2013 (NHS Improvement)
- Healthy Lives, Healthy People: A Tobacco Control Plan for England 2011 (Department of Health)

More specific sources of evidence are set out in the areas of the pathway described in the sections below.

Prevention

There is evidence that there are a number of preventable or modifiable behaviours that may reduce an individual's risk of getting cancer. It is estimated that 43 percent of cancers are attributed to lifestyle and environmental factors³ meaning there is great potential to stop people from developing cancer in the first place, delivering better patient experience and savings for the NHS.

³ The Fraction of Cancer Attributable to Lifestyle and Environmental Factors in the UK in 2010, BJC; Volume 105, Issue S2 (Si-S81) Published 6 December 2011, Dr D Max Parkin; with Lucy Boyd, Professor Sarah C Darby, David Mesher, Professor Peter Sasieni and Dr Lesley C Walker

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The British Journal of Cancer review⁴ looked at the numbers of cancers attributable to fourteen lifestyle and environmental factors in the UK in 2010. These factors include tobacco, alcohol, diet, being overweight and/or obese, and levels of physical exercise. It is believed that more than 100,000 cancers – equivalent to one third of all those diagnosed in the UK each year – are caused by smoking, unhealthy diets, alcohol and excess weight.

Smoking is by far the most important risk factor for cancer, responsible for 19.4 percent of all new cancer cases in 2010 equating approximately to one in five cancers. Around 90 percent of lung cancers are due to lifestyle, with most of them associated with smoking⁵. The most significant action that could be taken in locally to prevent cancer is to help smokers to stop and to prevent young people from starting smoking in the first place.

Heavy alcohol consumption is a major risk factor for liver, oral and pancreatic cancers. In particular, the incidence of pancreatic cancer is increasing, and it is often diagnosed late with poor outcomes. There are significant health gains to be had through encouraging people to be drink aware and to drink responsibly.

There is also a need to focus on preventing/reducing obesity, particularly in women, and on encouraging certain other dietary changes – including increasing consumption of fruit and vegetables and fibre, and reducing high consumption of meat and salt. Being overweight or obese can increase the risk of endometrial and colorectal cancers.

There is also a need to encourage regular and adequate levels of physical activity. Physical inactivity is estimated to be the main cause for approximately 21 – 25% of breast and colon cancers, as well as other non-communicable diseases.⁶

Focusing on these four areas for cancer control would also substantially reduce the burden of other non-communicable diseases, particularly cardiovascular, diabetic, renal and hepatic disease.

All girls aged 12 to 13 are offered HPV (human papilloma virus) vaccination as part of the NHS childhood vaccination programme. The vaccine protects against cervical cancer. It's usually given to girls in year eight at schools in England.

Around 970 women died from cervical cancer in 2011 in the UK. It is estimated that about 400 lives could be saved every year in the UK as a result of vaccinating girls before they are infected with HPV.

The HPV vaccine is delivered largely through secondary schools, and consists of two injections into the upper arm spaced at least six, and not more than 24 months apart (girls who began vaccination before September 2014 receive three injections). Research has indicated that the HPV vaccine protects against cervical cancer for at least 20 years.

Local coverage of the HPV vaccination in 2013-14 was above the average for England and similar to the average for the West Yorkshire Area Team. The figures are shown in Table 2.

⁴ The Fraction of Cancer Attributable to Lifestyle and Environmental Factors in the UK in 2010, BJC; Volume 105, Issue S2 (Si-S81) Published 6 December 2011, Dr D Max Parkin; with Lucy Boyd, Professor Sarah C Darby, David Mesher, Professor Peter Sasieni and Dr Lesley C Walker

⁵ <http://www.cancerresearchuk.org/cancer-info/cancerstats/types/lung/riskfactors/lung-cancer-risk-factors>

⁶ World Health Organisation Fact Sheet No. 385: Physical Activity (Feb 2014)

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Table 2. Figures for local PCTs compared with Area Team and England

	Calderdale PCT	Kirklees PCT (see note 1)	West Yorkshire Area team	England
One injection	95.1%	93.3%	93.2%	91.1%
Two injections	94.1%	92.8%	92.4%	89.8%
Three injections ⁷	88.7%	92.1%	90.1%	86.7%

Note 1 – Covers population now split between Greater Huddersfield and North Kirklees CCGs

⁷ Girls who began vaccination before September 2014 receive three injections

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High exposure to ultraviolet (UV) light can cause malignant melanoma in people with all skin types but people with fair and/or freckly skins are at higher risk. UV exposure includes strong sunlight and sun beds. Protecting the skin from strong UV light through the use of appropriate sunscreens or sun avoidance reduces the chances of getting malignant melanoma.

Prevention offers the most cost effective long term strategy for the control of cancer.

The CCGs will work with partners in their Local Authority to commission high quality prevention services (for example alcohol services, weight reduction) that meet the needs of their local populations and to use public education/awareness campaigns to improve their uptake.

The CCGs will work with their 10CC partners on smoking prevention in relation to the following areas:

- **To develop a single voice of commissioners within Health & Wellbeing Boards**
- **To incentivise improved outcomes (CQUINs and Quality Premiums)**
- **To undertake GP regional benchmarking**

Screening

National screening programmes

Under the new NHS reforms, NHS cancer screening programmes are now commissioned by NHS England from local organisations.

There are three national programmes, set out below:

Bowel cancer screening

About one in 20 people in the UK will develop bowel cancer during their lifetime. It is the third most common cancer in the UK, and the second leading cause of cancer deaths, with over 16,000 people dying from it each year⁸. Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16%⁹.

Breast cancer

Breast cancer is the most common type of cancer in the UK. About 12,000 women in the UK die of breast cancer every year. Survival from the disease has been improving over time, and now 3 out of 4 women diagnosed with breast cancer have a life expectancy of more than 10 years. The risk of getting breast cancer goes up as women get older. About 4 out of 5 breast cancers are found in women over 50 years old. Most women with breast cancer **do not** have a family history of the disease.

Cervical cancer screening

Cervical cancer can often be prevented. The signs that it may develop can be spotted early on so it can be stopped before it even gets started. Around 750 women die of cervical cancer in England each year. However many of those who develop it have not been screened regularly. Not going for cervical screening is one of the biggest risk factors for developing cervical cancer.

⁸ Cancer Research UK **Cancer stats** 2005

⁹ Cochrane Database of Systematic Reviews **Screening for colorectal cancer using the faecal occult blood test: an update** 2006

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Table 3 sets out breast and cervical screening data for Calderdale and Kirklees compared with the highest and lowest Local Authorities in the region.

Table 3. Breast and cervical cancer screening rates

	Calderdale MBC	Kirklees MDC ¹⁰	Highest LA in the Region	Lowest LA in the Region
Breast cancer screening – % uptake (July 2014)	66.1%	70.1%	82.6%	51.3%
Cervical cancer screening % uptake (July 2014)	77.2%	75.1%	78.9%	69.6%

Source: *Local Cancer Screening Performance Report (Feb 2014)*

Table 4 sets out bowel cancer screening data for Calderdale and Greater Huddersfield CCGs compared with the highest and lowest CCGs in West Yorkshire.

Table 4. Bowel cancer screening rates

	Calderdale CCG	Greater Huddersfield CCG	Highest CCG in West Yorkshire	Lowest CCG in West Yorkshire
Bowel cancer screening – uptake (July 2014)	55.9%	60.1%	61.7%	32.1%

Source: *Local Cancer Screening PHOF Indicator Report (Feb 2015)*

It can be seen from these figures that across all screening programmes there is scope for the CCGs to increase their rates.

New cancer screening programmes such as Bowel scope for 55 year olds are being rolled out across the country offering new opportunities to prevent and diagnose cancers earlier. Breast screening now provides screening for women at high risk of breast cancer due to their family history. Other developments will be introduced in line with national policy.

Other potential programmes are being explored at a national level, for example CT screening for populations at high risk of lung cancer. There is evidence that screening persons aged 55 to 74 years who have cigarette smoking histories of 30 or more pack-years and who, if they are former smokers, have quit within the last 15 years reduces lung cancer mortality by 20 percent and all-cause mortality by 6.7 percent¹¹.

To maximise the impact of existing and new programmes, it is vital coverage and uptake is optimised so that more people are diagnosed at an early stage or prevented from developing cancer through the identification of pre-cancerous conditions.

The CCGs will work with their 10CC partners to undertake targeted interventions to improve the effectiveness of screening programmes, to increase screening rates in areas of low uptake and to reduce inequalities.

¹⁰ This information is collected by Local Authority. Kirklees MDC covers Greater Huddersfield and North Kirklees CCGs

¹¹ National Cancer Institute, Randomised Control Trial
(<http://www.cancer.gov/cancertopics/pdq/screening/lung/HealthProfessional/page1/AllPages>)

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Genetic testing for familial cancer

Genetics specialists estimate that about 2 or 3 in every 100 cancers diagnosed (2 – 3%) are linked to an inherited gene fault.

The strength of family history depends on who in the family has had cancer and how old they were at diagnosis. The more relatives who have had the same or related cancers, and the younger they were at diagnosis, the stronger the family history, and the more likely it is that cancers are being caused by an inherited faulty gene.

This is an increasingly important area that is growing all the time. Detecting genetic flaws in new cancer sufferers and screening the relatives is an area where there is no consistent approach to following up at risks cases. A recent Freedom of Information request from a national bowel cancer body has highlighted an example where the approach to detection and follow-up screening for a genetic condition is inconsistent across the country. There are other examples and we need to commission a consistent approach to this area.

The CCGs will develop a consistent approach to genetic testing for cancer

Awareness and early diagnosis

For many cancers, the earlier a cancer is diagnosed and treated, the greater the prospect of survival and improved quality of life. Achieving earlier diagnosis has great potential for improving outcomes and survival for cancer patients in Calderdale and Greater Huddersfield. The implications for increasing earlier detection include increasing the volumes of patients referred for diagnostics.

Cancer diagnoses in A&E

A number of cancer diagnoses will occur in A&E where the potential for a successful outcome is much lower. A percentage of these will enter A&E as a result of direct referral from the GP to enable fastest access for a late stage patient into secondary care.

Information shows a variation in the percentage of diagnoses in A&E across GP practices.

The CCGs will reduce ~~increase~~ the number of cancers diagnosed in A&E

Improving awareness

Fear at what the doctor might find, worry about wasting the GP's time, lack of knowledge about specific cancer signs and symptoms and inability to make a GP appointment at a suitable time can all contribute to a public delay in getting medical help. These issues need to be addressed in campaigns to improve awareness and early diagnosis.

The Be Clear on Cancer campaigns are nationally funded by Public Health England and occur three times per year. They are tested on the public before launch in order to ensure positive patient experience. These campaigns are therefore ready to implement and the recent lung cancer campaign saw 700 [equivalent to 10% more people than in the same months during the previous year] extra people diagnosed with lung cancer. Many of these additional diagnoses were at an early stage and resulted in 300 more patients getting surgery, offering the best chance of prolonged survival.¹²

The CCGs will work with their 10CC partners and local authorities, including Public Health to design and implement local public self-awareness campaigns around the early warning signs of cancer, building on the national campaigns

¹² Cancer Research UK; *Be Clear on Cancer* evaluation

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The third sector and community organisations provide a powerful channel to communities who do not generally engage with public services.

The CCGs will work with partners, including local authorities, to use or develop mechanisms within the local community to get messages out into the community about cancer.

Primary care

The cancer agenda requires changes in practice systems and behaviour if the goals of earlier diagnosis and effective support are to be met. There is currently no systematic approach to cancer education and training for primary care as a whole.

The overall agendas of earlier stage diagnosis, effective support during the cancer journey and shared/self-management within a survivorship phase will need a structured approach by primary care. Many of the principles of recall, review, partnership working and self-management are already used in managing other long-term conditions e.g. diabetes. Education and training will support practitioners and practices to develop sustainable changes in practice systems.

Some patients attending their GP with suspicious symptoms are not referred as early as they should be. Interventions tackling GP delay will improve the patient experience since patients will be referred more promptly, access diagnostics quickly and, where referred onto a diagnosis pathway, should reach that diagnosis more quickly. In the same way, patient outcomes should improve as this will lead to diagnosis made at an earlier stage of the cancer.

Supporting GPs to be able to spot signs and symptoms of cancer and to then refer within an appropriate, timely manner is essential to reducing delays in treatment pathways. There are a number of tools that can be used to support GPs to refer appropriately and promptly. Local GP leadership is vital to making sure these tools are received and embedded.

The CCGs will support GP practices in increasing the use of diagnostic tools in primary care

Education and training

Many healthcare providers and other groups of staff will routinely come into contact with the public and those at higher risk of cancer providing an ideal opportunity to both educate the public about cancer signs and symptoms and/ or sign post those at risk to the GP or other suitable service. Education and training will help these conversations to be as effective as possible.

The CCGs will work with their 10CC partners in conjunction with Health Education Yorkshire and Humber to undertake/commission awareness and education of healthcare professionals (primary/secondary care) and the third sector to enable them to respond appropriately to presenting and/or undiagnosed patients.

Diagnostics

Direct access to diagnostics was a commitment made in the national strategy, 'Improving outcomes: A strategy for cancer'¹³, for:

- Non obstetric ultrasound
- Chest X-ray
- Flexible sigmoidoscopy
- Brain Magnetic Resonance Imaging.

The CCGs will work with their 10CC partners to undertake a system-wide review of access to diagnostics and existing diagnostic procedures and to implement the review's recommendations.

It may be also be that other diagnostics are suitable for direct access from Primary Care, including CT scan for vague abdominal symptoms, and this document proposes exploring with the clinical community whether direct access for CT scan is or could be appropriate. Molecular biomarkers are increasingly being researched meaning in future there may be an increase in the use of blood-based diagnostics which can be carried out in primary care settings.

Insufficient capacity in secondary care to meet rising referral demand can also play a role in delaying the time it takes to get a diagnosis.

The CCGs will ensure diagnostic routes are clear and performing effectively with the necessary capacity and capability to deliver effective care.

The CCGs will work with CHFT to deliver one stop shops for particular areas, including Post-Menopausal Bleeding, prostate and colorectal

In 2013, the Royal College of Radiologists (RCR) and the Royal College of General Practitioners (RCGP) published 'Quality imaging services for Primary Care: a good practice guide'¹⁴ which sets out recommended turnaround times for reports to reduce delays in reaching a diagnosis.

The CCGs will require all providers to adopt the recommendations set out in the RCR and RCGP report.

Staging describes the severity of a person's cancer based on the size and/or extent (reach) of the original (primary) tumour and whether or not cancer has spread in the body. Staging is important for several reasons:

- Staging helps the doctor plan the appropriate treatment.
- Cancer stage can be used in estimating a person's prognosis.
- Knowing the stage of cancer is important in identifying clinical trials that may be a suitable treatment option for a patient.
- Staging helps health care providers and researchers exchange information about patients; it also gives them a common terminology for evaluating the results of clinical trials and comparing the results of different trials.

The CCGs will work with CHFT to ensure that staging is undertaken at diagnosis for all patients

¹³ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213785/dh_123394.pdf

¹⁴ <http://www.rcgp.org.uk/revalidation-and-cpd/~media/Files/CfC/RCGP-Quality-imaging-services-for-Primary-Care.ashx>

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With the advancement of stratified medicines in treating cancers, comes the need for more specialist diagnostics that identify biomarkers. Increasingly it is likely such molecular testing will become the norm for diagnosis, treatment and stratification of cancer patients. Molecular tests are currently predominantly ordered via oncologists. There is further work to do to rationalise services so that expertise is concentrated to ensure new tests are introduced in a timely and equitable way.

Referral and treatment

Referral

The two week wait standard from GP urgent referral to first outpatient appointment for suspected cancer was introduced in 2000, as part of the NHS Cancer Plan¹⁵. Latest figures (Quarter 4, 2013/14) show that performance against this standard was 99% in Calderdale and 98.8%.

In the last four months, 22.7% were seen within seven days and 21% were seen on Day 14. This has been identified as an issue that needs to be addressed as breaches can occur if a clinician is not available on Day 14 (for example through sickness).

The CCGs will support CHFT to increase the percentage of patients seen within seven days of GP referral

The CCGs will work with CHFT and tertiary providers to ensure that all treatment time targets are met and where possible exceeded

The CCGs and CHFT will work together to develop one stop shop pathways for appropriate conditions.

The CCGs will work with their 10CC partners with health professionals to embed consistency in access and use of diagnostics, assessments and referral processes

Treatment

There are a range of treatments that are used to treat or cure cancer – the main ones being radiotherapy, chemotherapy, surgery, hormone therapies, biological therapies, bisphosphonates and bone marrow/stem cell transplants.

A number of new drugs and treatments have been introduced in recent years, and service providers need to ensure they are taking these into account when making decisions about treatments.

The CCGs will ensure that service providers take into account the evidence base for new drugs and treatments when making clinical decisions

Other areas of drug innovation include the growing numbers of subcutaneous formulations for medicines previously administered intravenously. Subcutaneous administration reduces the length of stay a patient needs to spend in hospital thereby improving patient experience and reducing costs. NHS England commissioners are currently modelling the impact of introducing subcutaneous formulations to understand both the cost impact and to develop a consistent approach for their introduction.

¹⁵ Department of Health **NHS Cancer Plan** (2000)

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The CCGs will work with CHFT and tertiary providers to ensure that all treatment time targets are met and where possible exceeded

The CCGs will commission services from providers taking into account the emerging evidence base.

The CCGs will review secondary and tertiary pathways of care to ensure these are optimised and integrated with community services, using process mapping and lean methodology

The CCGs will ensure that the quality of care and treatment in secondary and tertiary care is best in class and delivering service outcomes.

The CCGs will support CHFT to implement the recommendations of peer reviews.

Clinical research

Evidence shows that patients who participate in clinical trials have improved outcomes. Locally, patients are encouraged to take part in trials where appropriate.

Time to treatment

The Coalition Government's document 'Improving Outcomes: A Strategy for Cancer' confirmed that cancer waiting times remain an important issue for cancer patients and the NHS should continue to ensure that cancer services are delivered to patients in a timely manner. The standards that providers are expected to meet as well as the two week wait referred to on page 14 are set out in Table 5, along with the latest performance on each.

Table 5. Performance against cancer waiting times standards Q2 2014/15

	Calderdale	Greater Huddersfield
14 days – urgent referral to day seen	97.3%	97.0%
Two weeks from symptomatic breast referral (even if cancer is not suspected) to first outpatient attendance	98.3%	95.9%
31 days from decision to treat to first definitive treatment for cancer;	97.8%	97.5%
31 days from decision to treat or earliest clinically appropriate date (ECAD) to subsequent treatment (surgery, drug or radiotherapy) for all cancer patients including those with a recurrent;	98.1% (Surgery) 100% (Drugs) 100% (Radiotherapy)	100% (Surgery) 100% (Drugs) 98.8% (Radiotherapy)
62 days from urgent GP referral for suspected cancer to first definitive treatment for cancer (31 days for suspected children's cancers, testicular cancer, and acute leukaemia);	90.2%	88.0%
62 days from referral from NHS Cancer Screening Programmes (breast, cervical and bowel) to treatment for cancer;	90.9%	97.8%
62 days from a consultant's decision to upgrade the urgency of a patient (e.g. following a non- urgent referral) to first treatment for cancer.	100%	75.0%

Source: Yorkshire and the Humber performance report – November 2014

The CCGs will ensure there are no avoidable performance breaches due to pathway/transfer of care delays – breaches should only occur on clinical grounds.

Cancer Nurse Specialists

Evidence shows that patients are more likely to have a positive experience of care if they are supported by a cancer nurse specialist (CNS) in place, accessible, and available¹⁶.

The CCGs will maximise the value of Cancer Nurse Specialists working out in the community to support integrated health and social care models.

Survivorship

With improvements in early detection and rapid advances in treatment, we should expect even larger numbers of people living with and beyond cancer, and greater numbers of local people acting as carers for people with cancer.

Supporting people recovering from a cancer episode, or living with recurrent episodes of cancer, is nowadays comparable to other long term conditions albeit with cancer-specific interventions still required. Additionally certain cancer treatments can increase the risk of long term conditions such as heart disease, osteoporosis or a second cancer, and can add to other acute and chronic conditions. There will also be a need to support the increasing numbers of carers looking after family members and loved ones so that they are equipped both physically and psychologically to provide care. There are also specific gaps in services, on issues such as access to advice on finances¹⁵.

The CCGs wish to move to a survivorship culture. The Department of Health, in partnership with Macmillan Cancer Support, published the National Cancer Survivorship Initiative (NCSI)¹⁷ in March 2013. This sets out a clear framework for supporting the increasing numbers of people living with and after cancer.

The key elements of the framework are as follows:

- **The Recovery Package** – this consists of a holistic needs assessment, a care plan, treatment summary and a health and wellbeing event. These interventions can play an important role in establishing a baseline from which a patient's recovery can be planned and supported: they also support patients to take control of their own recovery and to promote positive lifestyle change. It includes advice and support on longer-term planning, including considering options on work, finances and education, as appropriate.
- **Stratified pathways for the follow-up of cancer patients** - The NCSI¹⁸ recommends that, following initial treatment, all patients should be assessed for their risk of developing further disease or consequences of treatment, i.e. be risk-stratified. This risk stratification will identify those who can safely self-manage without the need to attend hospital-based follow up appointments. Supporting patients to self-manage their own health and wellbeing can meet unmet needs, reduce demand on services and so reduce costs through removing a number of follow up outpatient appointments. To do this, patients will need to be stratified according to their clinical and individual needs.
- **The management of consequences of treatment** - Side effects from cancer treatments are common and usually resolve themselves within a few months of treatment. However some side effects continue and can affect the quality of both

¹⁶ Department of Health **Improving Outcomes – A Strategy for Cancer** 2011

¹⁷ <https://www.gov.uk/government/publications/living-with-and-beyond-cancer-taking-action-to-improve-outcomes>

¹⁸ A partnership between NHS England and Macmillan Cancer support

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physical and psychosocial health. Whilst much of the Recovery Package for cancer patients aligns with services already commissioned for patients with other long term conditions, it is imperative that specific support for conditions relating to side effects of treatment are commissioned:

- Physical activity
- Lymphedema
- Pelvic radiation disease
- Treatment related sexual problems

- **The Cancer Care Review (CCR)** – this plays an important part in the living with and beyond cancer agenda and, as such, needs to be developed and improved. The Quality and Outcomes Framework (QOF) requires all patients diagnosed with cancer to receive a CCR by their GP within six months of the GP practice being notified that the person has a cancer diagnosis. The QOF lacked clarity surrounding what the CCR should consist of and what is helpful and necessary to include. As a result the patient experience is variable. The NCSI has worked with Macmillan Cancer Support in the development of a CCR template to improve the quality and delivery of the CCR¹⁹.

The CCGs will work with their 10CC partners in undertaking pathway redesign including risk stratified follow up, designing follow up treatment pathways to address the holistic recovery of the patient, and developing and implementing remote patient monitoring (surveillance)

The CCGs will encourage and support GP practices and providers to implement the elements of the Survivorship Initiative as described above.

End of life care

Although around 70% of people would prefer to die at home, only 42 percent do nationally and the proportion in Calderdale and Greater Huddersfield is even lower, being 21.3% and 21.6% respectively. This is in line with the England average but the highest CCG across the country is at 27.2%.

The average length of hospital stay for people with a terminal illness is 14 days in Calderdale and 12 days in Greater Huddersfield, compared to the England average of 12.9 days²⁰. The majority of patients die in hospital and yet this is not their first choice of location for place of death.

Five priorities for the care of people who are dying were recommended in a recent publication from the Leadership Alliance for the Care of Dying People²¹:

1. The possibility that a person may die within the coming days and hours is recognised and communicated clearly, decisions about care are made in accordance with the person's needs and wishes, and these are reviewed and revised regularly.
2. Sensitive communication takes place between staff and the person who is dying and those important to them.
3. The dying person, and those identified as important to them, are involved in decisions about treatment and care.
4. The people important to the dying person are listened to and their needs are respected.

¹⁹ <http://www.ncsi.org.uk/wp-content/uploads/EMIS-guide-info.pdf>

²⁰ Data: Hospital Episode Statistics (HES) from Public Health England (NEoLCIN). End of life care profiles summary statistics 2010 to 2012.

²¹ Leadership Alliance for the Care of Dying People (LACDP) **One Chance To Get It Right** (2014)

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5. Care is tailored to the individual and delivered with compassion – with an individual care plan in place

The CCGs will ensure their end of life pathways and models are commissioned in accordance with the above priorities, and are integrated across health, social care and hospice provision to maximise choice outside hospital

Patient and carer experience

The key tool for collecting patient/carers experience information on cancer services is the annual National Cancer Patient Experience Programme National Survey, described on page 6.

The CCGs will use the above survey to track the progress of cancer service providers, and to identify areas for further engagement with patients and carers.

The CCGs will test models with patient experience and quality of life indicators.

Tracking progress

Data and Information underpin every part of delivering this document. Cancer is fortunate to have seen an improvement in data available on services over the past 10 years, meaning there is now a wide range of data sources to assess the quality and outcome of services provided to patients. Much of this data is collected by providers in nationally agreed datasets and extracts of this data are used by CCGs and NHSE to support commissioning responsibilities.

The CCGs will work to ensure all services are underpinned by robust outcome-based service specifications which prioritise high quality care in line with the current evidence base from relevant bodies such as NICE, Royal Colleges, etc.

The CCGs have identified a series of indicators to be used to track progress in the improvement of prevention, treatment and care. These are as follows:

- Under 75 mortality from cancer
- One year survival from all cancers
- One year survival from breast, lung and colorectal cancer
- Cancer: diagnosis via emergency routes
- Cancer: record of stage at diagnosis
- Cancer: early detection
- Lung cancer: record of stage at diagnosis
- Breast cancer: mortality

The CCGs will develop a dashboard with the above information and other agreed areas which will be used to monitor progress in performance in cancer outcomes and patient/carers experience.

Summary

Cancer is a key priority for the NHS in Calderdale and Greater Huddersfield, and the CCGs and partners are committed to working together to improve outcomes for local people through prevention, screening, early diagnosis, access to better treatment, improving survivorship and improving end of life care. The priorities set out in this document will ensure that everything possible is done to tackle all types of cancer on all levels.

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