HEALTH SCRUTINY PANEL

27 September 2016

FINAL REPORT – CANCER SCREENING AND REDUCING CANCER RELATED DEATHS

PURPOSE OF THE REPORT

1. To present the findings, conclusions and recommendations of the Health Scrutiny Panel following their investigation into the topic, Cancer Screening and Reducing Cancer Related Deaths.

AIM OF THE SCRUTINY INVESTIGATION

2. The panel received an overview on the health inequalities in Middlesbrough, as a result the panel focused in on 2 areas for further investigation, the first, Improving Levels of Breastfeeding in Middlesbrough for which a report has been produced and approved by the Executive and this topic – cancer screening and reducing cancer related deaths. The panel heard that the rates of death from cardio-vascular disease have been reducing; however Middlesbrough has not seen the same level of reduction in cancer deaths. Therefore the panel considered
    a. The current causes, trends and patterns relating to incidences of cancer in Middlesbrough.
    b. Why deaths from cancer are higher in Middlesbrough than the England average?
    c. How lifestyle factors affecting people in Middlesbrough can increase people's chances of developing cancer?
    d. How uptake in the levels of people attending screening can be improved?
    e. What is being done to raise awareness of the early signs and symptoms of cancer?

MEMBERSHIP OF THE PANEL

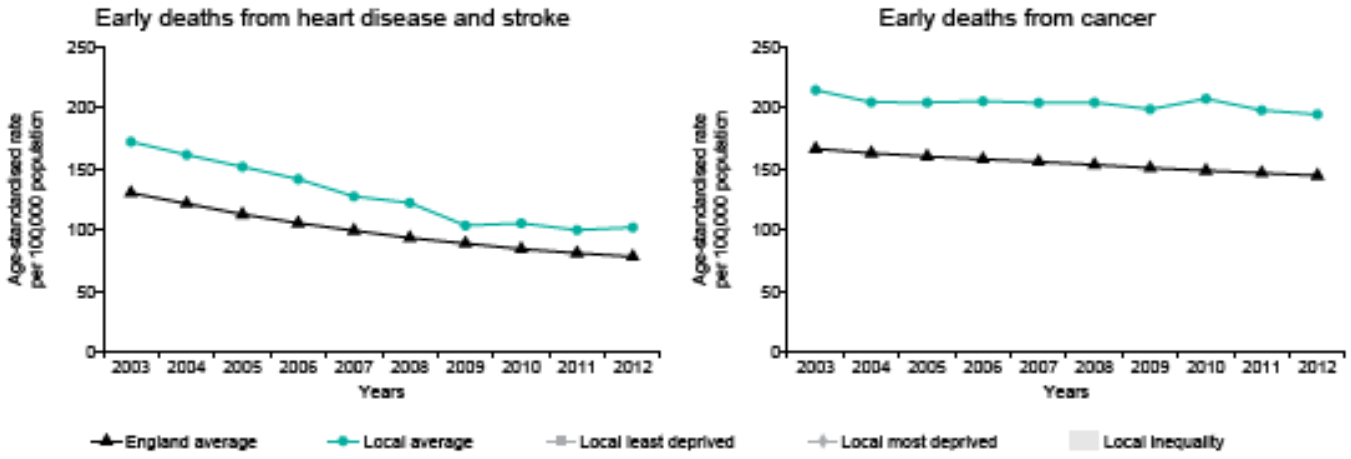
3. The membership of the Panel was as detailed below:
   2015/16
   Councillors E Dryden (Chair), Councillor Biswas, (Vice-Chair), Councillors, Cole, Dean, C Hobson, Hubbard, Lawton, McGee and Hellaoui.

   2016/17
   Councillors E Dryden, Biswas, Cole, Hellaoui, Hobson, Hubbard, McGee, G Purvis and Walters

THE PANEL'S FINDINGS

4. The panel had several meetings on this topic between 24 November and 25 July to discuss the topic.

5. Members were told that improvements had been made to the number of people in Middlesbrough dying from heart disease and stroke, however, as the following graph shows, as the gap between the rate in Middlesbrough and the national average has started to narrow, the same cannot be seen in the number of people dying early from cancer. That rate is still running parallel and the gap isn't getting any narrower. As a result of this information the panel wanted to take a closer look at what was, or needed to be done, to reduce this gap.



The National Picture

6.

- Every two minutes someone in England will be told they have cancer.
- Half of the people born since 1960 will be diagnosed with cancer in their lifetime.
- Cancer survival is at its highest ever.
- More than half of people receiving a cancer diagnosis will now live 10 years or more

Achieving World-Class Cancer Outcomes – A strategy for England 2015-2020 – Report of the Independent Cancer Taskforce

7. The document Achieving World-Class Cancer Outcomes – A strategy for England 2015-2020 by the Independent Cancer Taskforce provides a strategy for improving the outcomes that the NHS delivers for people affected by cancer. The taskforce

consulted widely and identified where opportunities existed for improvement and how resources could be used differently and in a more targeted way, including more integrated pathways of care and increased investment.

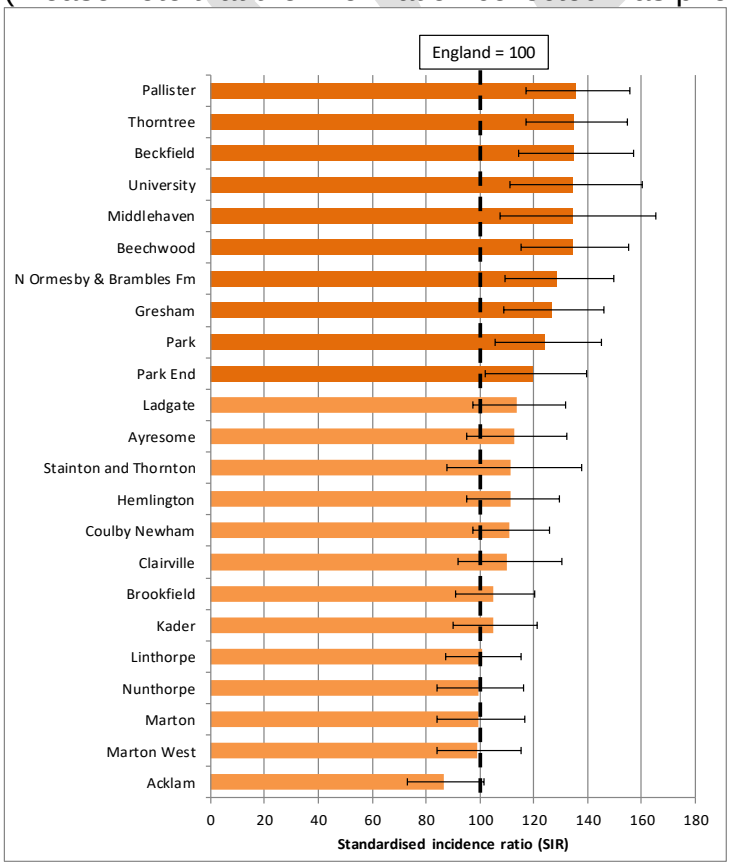
8. The report suggested a number of areas for improvement including
    a. Spearhead a radical upgrade in prevention and public health.
    b. Drive a national ambition to achieve earlier diagnosis.
    c. Establish patient experience as being on a par with clinical effectiveness and safety.
    d. Transform our approach to support people living with and beyond cancer.
    e. Make the necessary investments required to deliver a modern high quality service.
    f. Overall processes for commissioning accountability and provision.

Health Inequalities and Cancer

9. Health inequalities across England mean there is potentially avoidable variation in survival outcomes. There would be around 15,300 fewer cases and 19,200 fewer deaths per year across all cancers combined if social-economically deprived groups had the same incidence rates as the least deprived. More than half of the inequity in overall life expectancy between social classes is linked to higher smoking rates among poorer people.[1]

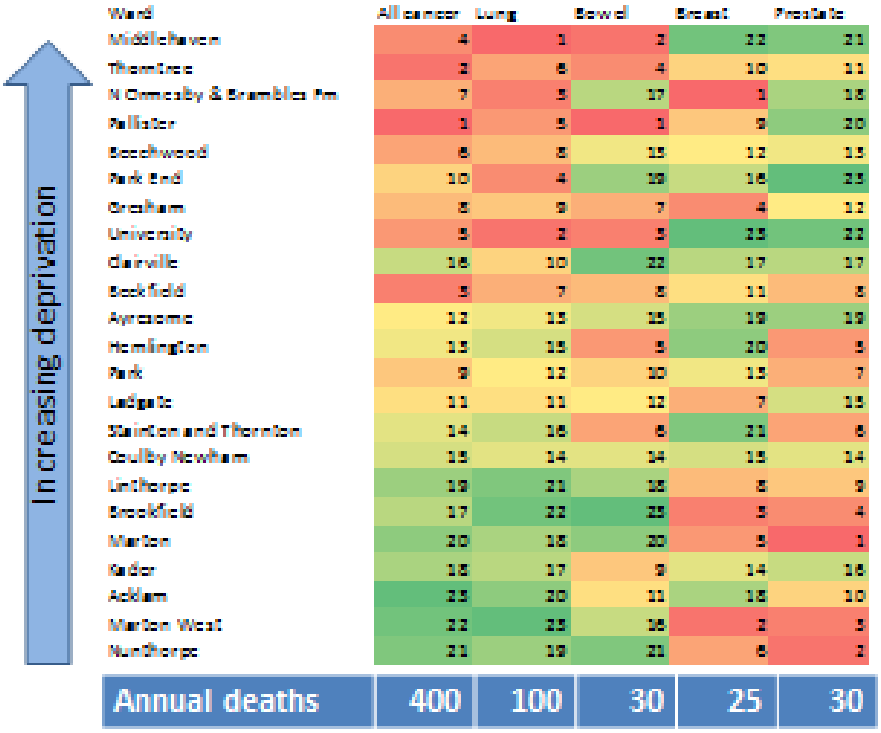
The Picture in Middlesbrough

10. There are ten wards in Middlesbrough with significantly more cancer cases than the England average. These wards are located in east and central Middlesbrough. (Please note that the information collected was prior to the ward boundary review)



[1] Achieving World-Class Cancer Outcomes – A Strategy for England 2015-2020, Report of the Independent Cancer Taskforce

Cancer incidence in Middlesbrough wards, rank of Standardised Incidence Ratio (SIR), 2007-11



All cancer, lung cancer and bowel cancer tend to be most common in deprived areas of Middlesbrough

Prostate cancer and (to a lesser extent) breast cancer tend to be most common in less deprived areas of Middlesbrough

11. The panel were told that all cancer, lung cancer and bowel cancer tend to be most common in deprived areas of Middlesbrough. Prostate cancer and (to a lesser extent) breast cancer tend to be most common in less deprived areas of Middlesbrough. It could be argued that people in more affluent areas are more likely to present to their GP and more likely to go for screening. (Although currently, there is no accurate method of screening for prostate cancer).

12. Cancer is responsible for about one third of deaths in Middlesbrough. With lung cancer causing the highest amount of deaths.

13. The panel were told that the number of deaths was at a pretty stable rate. There was an identical gap over time between Middlesbrough and the standardised rate. Whilst Middlesbrough is not managing to close the gap the good news is that the gap isn't widening.

14. There was a decreasing trend of cancer mortality in male lung cancer, and a small reduction in colorectal cancer, breast and cervical cancer, however there had been a rise in female lung cancer and prostate cancer. It was shown that despite the high numbers in Middlesbrough, when looking at 1 year relative survival rates women with

cervical cancer and men with prostate cancer had a survival rate which was better than the England average.

15. Members were concerned with the 1-5 year relative survival estimates for breast cancer. The number of cases in Middlesbrough had followed the north of England average, however Middlesbrough's rates had started to level off. This could be because women were not attending regular screening or that there may be longer waiting times to access to appropriate/effective treatment. However the panel were told that waiting times in South Tees are very good and perhaps an intensive audit might be prudent.

The Key Challenges in Middlesbrough

16. The key challenges identified by the Tees Valley Shared Service are as follows
    a. Ensuring we create an environment and opportunities for people to live healthier lives by health protection and disease prevention (such as tobacco control and point of sale restrictions, both areas where the Council can have an impact).
    b. Improving awareness of risky behaviours for cancer.
    c. Promoting awareness of cancer screening and making it easier to be screening – ie providing more convenient opportunities to people in full-time work.
    d. Improving access for the early detection of cancer in GP practices.
    e. Supporting people living with cancer to improve their quality of life.
    f. Delivering specific measures to halt the increase in cancer in women.

What are we doing in Middlesbrough?

17. A Tees Cancer Plan has been developed which includes a number of key drivers: the increasing prevalence; the decreasing mortality; improving survival rates; and increasing spend. Priorities include: preventing cancer; detecting cancer quickly; delivering fast and effective treatment; meeting people's needs; and caring better at the end of life. Indicators to measure success included screening coverage, diagnosis at early stages, cancer waiting times, percentage of patients with a named key worker, and percentage of patients to die in their preferred place.

18. There is a South Tees GP Cancer Clinical Lead who engages with the hospital and GPs, ensures the CCGs are commissioning the right service and monitors waiting times etc. There is also a MacMillan GP lead for Middlesbrough who benchmarks and shares information between GP practices. In addition there is a Tees Macmillan awareness and early diagnosis facilitator.

19. Macmillan Integrated Cancer Care Project has introduced an open access screening chest x-ray service in Middlesbrough. A business case is being submitted to the CCG, which would see facilities in the One Life Centre and James Cook Hospital to ensure people with persistent chest infections were x-rayed, to try and capture the illness when people at stage 1 or 2.

20. Middlesbrough Tackling Cancer Together Group – This steering group had been in operation for over a year, with the aim of linking up the various work in this field. It was recognised that there was a lot of work going on in Middlesbrough across the whole cancer pathway, from diagnosis through to treatment. However wath was lacking was a co-ordinating body and it was felt that the steering group could bridge this gap.

21. The group met on a monthly basis with different agencies, with a wide representation from a range of partners. The group had an overview of all the Council's work in this area and other work that was going on across Middlesbrough. It also had oversight of the local cancer trends and date in order to identify potential ways of making improvements.

22. The group had a work plan and included work stream areas for the next 12-18 months and the three main work streams were as follows

    a. Geographical Targeting – There are significant challenges being faced in Middlesbrough. On the basis of statistics, the prevalence of cancer and associated mortality rates and the mix of residential and commercial areas, Central Ward was chosen as an area to focus on what action could be taken to improve prevention and screening.
    b. A Changing Perceptions Campaign – The group's vison was to create a 'Change in Perceptions' campaign. Rather than focus upon specific types of cancer it was intended that a general campaign that looked to tackle the barriers that people had eg. Not wanting to visit their GP, viewing cancer as a death sentence and also tapping in to age-related matters and trying to promote a positive lifestyle.
    c. Targeted Lung Cancer Awareness Raising Campaign – Within the risk awareness strategy the group had commenced the development of a targeted lung cancer awareness campaign. Prevalence in Middlesbrough was high and could be linked to smoking as the main risk factor. The campaign would be based on targeted insight from local people in order to determine how people's behaviour cold be changed.

Cancer Screening and Reducing Cancer Related Deaths

23. It is known that cancer screening rates are lower than England and are lowest in deprived areas. The panel investigated this area further.

Screening Rates

24. The panel were told that for breast screening, the One Life Centre offered the only facility in Middlesbrough. There was support from GPs for additional screening sites, however for reasons of confidentiality and secure connection requirements, mobile screening unites were required to be situated on NHS property or land. Members discussed how the establishment of a screening unit within East Middlesbrough would provide a base for those patients who lived away from the town centre and may improve take up of screening.

25. The Achieving World-Class Cancer Outcomes report noted that screening and vaccine uptake, and smoking cessation services – are admired across the world, but this is not reflected in our survival rates. We have amongst the lowest levels of cancer incidence of rich countries but amongst the highest levels of mortality. There is now strong evidence that late diagnosis and sub-optimal access to treatment – particularly for patients with more advanced disease that provide poor clinical outcomes.

26. The report says that over the last several years, the growth in demand for cancer services has not been met by an associated growth in capacity. There are significant workforce deficits, particularly in diagnostic services, oncology and in specialist nursing support.

Commissioning of Cancer Services

27. Nationally, the report by the Independent Cancer Taskforce stated that the commissioning of cancer services had become highly fragmented and, partly as a result, insufficiently accountable. Some CCGs have reported that they have neither the expertise nor the time to commission complex cancer services, many of which change as research drives progress. CCGs had little role in the commissioning of diagnostic services. Pathways are not optimised for patients nor for use of resources. There is also a lack of hard accountability when providers or commissioners fail to meet national targets as demonstrated by hospitals missing the 62 day wait standard over a year.

28. This is not found to be the case in the South Tees area where the NHS Constitutional Indicators April 2014-Jan 2015 show that the South Tees CCG met all of the Quality indicators, as did the South Tees Hospitals NHS Foundation Trust, including the 62 day maximum wait.

29. Every single person in South Tees referred for cancer care received that care within the nationally set waiting times. [2]

Work by the Clinical Commissioning Group

30. Members were interested to learn more about the Tackling Cancer Together partnership. Members heard how the aim of the multi-agency partnership was to join up the vast range of work happening in Middlesbrough across the cancer pathway. The group meets monthly and is represented by the following agencies:

- Local authority (including Public Health and Social Care)
- South Tees Clinical Commissioning Group
- Tees Valley Public Health Shared Service
- NHS England
- South Tees Hospitals Foundation Trust
- Cancer Research UK
- Macmillan Integrated Care Project/Macmillan Cancer Support
- Middlesbrough Voluntary and Development Agency
- Middlesbrough Environment City
- Healthwatch

31. The panel heard that the Be Clear on Cancer Campaign, which was a national campaign to highlight early symptoms of a number of cancers which included: bowel, lung, breast, ovarian, skin, and oesophago-gastric. It was reported that whilst the campaign had been successful nationally it had no real impact in Middlesbrough. The panel discussed how the council could bring attention to campaigns such as this and Members discussed the use of the Council's Love Middlesbrough magazine as a potential additional vehicle for these issues.

32. The panel were informed about the workstreams undertaken by the panel and the key workstreams included:

Geographical Targeting – in central ward that included focussing on a small area to see what facilities and services are available to people, gauging local knowledge around signs and symptoms, risk factors and lifestyle. Links were made with businesses to promote cancer awareness amongst employees.

[2] South Tees CCG Annual Report and Accounts 2014/15

Targeted lung cancer awareness raising campaign – linking smoking as the make factor and based on targeted insight from local people.
Changing Perceptions Campaign – addressing barriers and fears associated with cancer and based on risk factors linked to a range of cancers and long term conditions.

Tackling Cancer Together (TCT) and Screening

33. In Middlesbrough, the panel heard that rates of cervical screening and bowel cancer screening are low. The TCT partnership has been promoting the website http://www.screeningsaveslives.co.uk/ as part of series of campaigns to raise public awareness.

34. The cervical screening campaign was developed in response to the low uptake of regular routine cervical screening amongst women in Middlesbrough. A local pilot was developed by the Council's public health team, working in partnership with NHS England. It was launched in June 2015 and consisted of a range of activities including GP engagement, publicity campaigns, adverts, social media targeting, development of 'No Fear' practices, information packs and community development work and events. (The campaign is currently being evaluated and the results are due imminently).

35. The campaign reach was town-wide, it was developed using targeted insight with women who are statistically the typical non-attenders including: women from BME communities, women aged 25-35, and women from deprived wards. Early results show that there was overall increase in uptake rates with 17 out of 26 GP practices reporting an increase. All the 'No Fear' practices engaged by the campaign have seen an increase in uptake.

36. As a result of the campaign a number of initiatives have been implemented including, actively chasing up non-attenders which is what happened in the 'No Fear' practices and the establishment of a dedicated staff cervical screening clinic at James Cook hospital to provide a convenient facility for women staff who work shifts or full time and who otherwise would not have been able to attend appointments at their GP practice.

Women with Learning Disabilities

37. As part of the development work for the cervical screening campaign, an event was held for women with learning disabilities to discuss cervical screening and get a better understanding of their issues and concerns. Recommendations were made to ensure a number of reasonable adjustments would be made to services including: easy read invitations, improved appointment systems, improved access for people with mobility problems, learning disability training for health staff that carry out cancer screening services and, education and awareness raising for people with learning disabilities and family carers.

Bowel Screening

38. Cancer Research UK launched an awareness campaign to increase uptake of bowel screening. South Tees had been chosen as a target area as uptake was low. The campaign will be delivered in 4 bursts from 24 August to 16 April. The Tees Valley Public Health Shared Services is co-ordinating a local approach to supporting the campaign, overseen by the TCT group.

Community training

39. The panel were informed about how training a small number of people could have a wider impact amongst the community. Therefore a range of community training opportunities are available to build community capacity in terms of the ability to pass on key messages and promote a positive behaviour change. MVDA has a fund available and so far 14 community groups have been given a small grant to take part in training. For example a number of community organisations have held a range of engagement events to promote awareness training in the communities they work with. As a result of the 14 groups providing training and resources that over 800 people were contacted or spoken to about cancer as a result.

40. The public health team commission a local training provider to offer cancer awareness training (accredited to level 2 and 3) to local residents which covers early warning signs, how cancers can be prevented and information about screening programmes.

South Tees CCG

41. The CCG's five year Clear and Credible plan was the strategic commissioning plan that informed all the work that the CCG carried out. It was recognised that cancer was one of the biggest health challenges that the CCG faced as a commissioning group. Therefore the Tees Cancer Strategy had been developed along with a document entitled 'Achieving World-Class Cancer Outcomes'. Members were keen to understand how the CCG were addressing the cancer challenge. With regards to reducing health inequalities, the CCG had established a health Inequalities Steering Group in order to provide strategic direction to CCG clinical workstreams. Representatives included Executive GPs, Directors of Public Health and non-clinical support. Very positive work had been undertaken and a Lung Cancer Task and Finish group has been established.

42. Given the prevalence of lung cancer within the South Tees there was a push to increase early detection rates, through a targeted campaign to encourage residents from deprived communities in the TS1 and TS3 postcodes to present earlier if they showed lung cancer symptoms. The CCG had agreed in principle to contribute funding to the project which provided open access chest x-rays, whereby people could attend for an x-ray without having visited their GP first.

43. GP training was also considered to be of particular importance. GPs would be typically presented with about 3 to 10 cases of cancer per year. In order to refresh their skills, half day education sessions had been held, which focussed on the early diagnosis of lung cancer. In addition a good relationship had been established with the CCG and Macmillan Cancer Support and there had been five Macmillan supported education sessions on topics such as early referral for Lung, Gastrointestinal, Gynaecological and Urological cancers. It was acknowledged that the challenge would now be to ensure that as many GPs as possible undertook the training to increase the knowledge as widely as possible.

44. The strategy also covered how people with learning disabilities were assisted and encouraged to attend screening and events had been health by Middlesbrough Public Health for ladies with a learning disability where breast screening was discussed.

45. Investment was also being made in welfare advice, which saw public health personnel attending James Cook University Hospital and GP surgeries to advise

patients with a cancer diagnosis on finance matters to alleviate potential money worries.

46. The CCG had supported the Trinity Holistic Centre through the Community Innovation Fund, with £40,000 for a range of projects to improve the wellbeing of people who had a cancer diagnosis or long term condition and their families. This included programmes around improving self-esteem, healthy eating, mindfulness and outdoor activities.

47. In order to five up the quality of the services being commissioned the CCG had established a Cancer Performance task and Finish Group to examine how to improve the 62 day referral to treatment performance, as set by the Government. At the South Tees Hospitals NHS Foundation Trust, the current performance level sat at 79.5% against a national target of 85% and a national average of 82%. The CCG explained that this target was fair and made sense in terms of improving patient outcome.

Screening

48. There are 3 national screening programmes in England. They are commissioned by NHS England and they are as follows

Type	Target Population	Frequency
Breast Screening	Women aged 50-70	Every 3 Years
Cervical Screening	Women aged 25-49 Women aged 50-64	Every 3 years Every 5 years
Bowel Cancer Screening	People aged 60-74 Self-referral after 74	Every 2 years

49. Breast cancer accounts for 4 out of 5 cancers in women under the age of 50. There are around 12,000 deaths from breast cancer each year. It is the most common cancer in the UK. 1 life is saved for every 200 women screened. In order to be called for screening women need to be registered with a GP practice.

50. The panel learnt that breast screening programmes work exceptionally well and that breast cancer was one of the more easily detectable cancers, and women do present to their GP if they discover a lump. In Middlesbrough 71.1% of women attend screening, higher than the England average of 70.7% but not as many as the North East average of 77.9%. Members questions what work was taking place in order to improve Middlesbrough's rates, but it was noted that there were fewer activities taking place in respect of breast screening than in other areas such as cervical or bowel.

51. The panel discussed what more could be done to bring awareness to breast screening. Women are invited for screening every three years. Letters are sent out to women by their GP practice. There are no awareness campaigns as such. Councillors were keen to ensure that there was more targeted promotional work undertaken, especially to coincide with the location of mobile screening vans in different areas. Councillors agreed that that they could circulate this information to

their residents and use social media sites to raise awareness. It was noted that the public health team have the resources and skills to talk to the right people and give the right message and that the Councillors could utilise this expertise and link with public health to help publicise screening events.

52. It was thought that the Council, as a large employer of women, could encourage female employees to attend screening, and making sure that women were allowed time off work to attend screening appointments.

53. Public Health England would like to see a system which, if when a person attends a GP practice for another issue, it would 'flag-up' that they had not attended a designated screening appointment.

54. The Chair outlined how the South Tees Health Scrutiny Joint Committee were currently involved the South Tees CCGs review of Urgent Care, which involves the realigning of opening hours in GP practices and the provision of GP hubs to provide extended hours care. The Chair of the Health scrutiny panel agreed to ensure that the Committee asked if the hours that screening was to be made available had been factored in to the extended opening hours it was planning to implement.

Cervical Cancer

55. In Middlesbrough 70.6% of women are screened for cervical cancer compared with 75.7% in the North East and 73.5% nationally. The target age group for screening is 25-64. Cervical cancer is the eleventh most common cancer in the UK and the most common cancer in women under the age of 35. The screening programme had been in place for many years and had done very well in preventing cancers by screening for cell changes that may have turned cancerous if left untreated.

56. The panel questioned why younger women from the age of 20 were not screened, and it was explained that research showed that cervical cancer is very rare in women younger than 25 and that changes in the cervix are quite common in younger women. So, screening them leads to unnecessary treatment and worry. Scientists have worked out that screening younger women leads to more harms than benefits.

Screening Process

57. Invitations for screening are sent out to women who are asked to make an appointment at their GP surgery. Members were reminded of the Middlesbrough Project carried out by Public Health, NHS England and other partners.

58. The panel were informed of a new contract for sexual health services which would be provided by Virgin Healthcare, which offered opportunistic cervical screening for women attending the service for other reasons. It was expected that a specific number of women would be screened and for the first time targets had been put in place.

59. Other local initiatives to improve screening take up were

    a. Female employees at James Cook University Hospital and the South Tees NHS Foundation Trust had been contacted to ask if their cervical screenings were up to date. 20% of the work force weren't so women were encouraged and supported to have the screenings competed during work time and at their place of work. The activity was still ongoing, however to date 50 women

had been screened, 6% of which had moved on to further treatment. This demonstrates that if appointments can be fitted in around women's working commitments that benefits can be seen in terms of people receiving further treatment who may otherwise have found out symptoms too late.

b. Work had also been undertaken around gynaecology outpatient; women attending outpatients would be offered an immediate appointment on site.
c. Additional training with health visitors had been undertaken in order to encourage women with families and young children to attend.

60. Members questioned whether a patient presenting to their GP for a different matter would have their records checked to determine if their screening were up to date. In response, it was felt that use of a flagging system on medical records would ensure that this occurred and GP practices with low update had begun to do this. Members were advised that every GP practice in Middlesbrough carried out cervical screening. Reference was made to women's working hours and how extended opening hours may help women fit appointments around their work commitments.

61. The panel then discussed the work currently being undertaken by the South Tees CCG on their restructuring of the urgent care services. Members agreed to refer a recommendation to that review which would be to ask the CCG to ensure that screening services are offered in some of the hubs which provided extended hours services.

62. The representatives from NHS England were keen to see the continuation of the support to the Public Health Team on their efforts to improve screening take up. They also would like to see that female employees both directly employed by the Council and contractors, be offered the opportunity to attend screenings during work hours. They also wished to see that women with learning difficulties were accessing services.

Bowel Screening

63. In the South Tees area 57.9% of people were screened for bowel cancer, more than in the North (57.2%) and the national figure of 56.9%. The national target was set at 60%. So there was room for some improvement in all areas.

64. Members heard that the testing age was based on the prevalence of bowel cancer in the population. Bowel cancer is the third most common cancer in the UK – 4 out of 5 people are diagnosed after the age of 60. Screening came by way of a home testing kit for those people registered with the GP practice. People who were eligible were sent an invitation to take part in the programme and had to indicate if they wanted to participate, they would then be sent a kit.

65. The panel learnt that it was a very effective programme, which was expected to reduce cancer deaths by 16%. Uptake rates were increasing over time and this could be attributed to familiarity with the programme and discussions between friends and family.

66. Members questioned why people didn't automatically just receive the kit, rather than having to respond to an invitation. Members thought that if people were sent the pack directly that this would save on administration costs and potentially increase uptake. Members thought that it might be prudent to ask the CCG to undertake a pilot exercise whereby kits could be sent to a group of people to establish if this method improved uptake. Members asked if kits could be available in GP surgeries

however it was explained that packs were barcoded with individuals' information to enable it to be traceable to individuals, therefore the packs could not be readily available in GP practices.

67. The panel were told about the work being undertaken by the Public Health team in targeting specific populations where participation in the programme was low. Both men and women were invited to the programme equally, there tended to be a 2-4% difference in participation rates, with more women attending than men.

68. The panel were interested in what activities were taking place in terms of improving coverage of the bowel screening programme. Cancer Research UK have been carrying out campaigns across the country. Specific targeting had taken place in Middlesbrough because update figures were low. Media campaigns have taken place last summer and repeated in January/February 2016 and it was hoped that participation figures would increase as a result. In addition a letter from the person's GP would be included in the screening kit to try and boost participation.

69. Screening practitioners in the colonoscopy service were required to promote the programme by visiting various venues and holding presentations. The panel through that there could be opportunities for the Council to support this, for example. Promoting the screening programme to its own workforce and for Councillors to support the promotional work in their wards. It would be useful to the NHS if the Council could assist the colonoscopy practitioners to located potential places for undertaking presentations.

70. Members suggested several media platforms that the Council could utilise to assist in the promotion of the screening programme, which included the Love Middlesbrough Magazine and the Council's Twitter feed. Community Hubs and leisure centres could be utilised by having a public health presence and Members agreed there was a need for this.

Lessons learnt from Denmark

71. Denmark's health service is similar to the NHS. They started to look in depth at the problem of cancer survival rates in 2000. They reorganised the way patients were diagnosed by GPs and specialists, bringing in a new approach, especially to deal with those cancer cases which were not initially obvious. When looking at the issue it was recognised that waiting times patients faced before getting a diagnosis were too long. Not so much in the most serious cases as they could be fast-tracked to specialist in hospital. It was the cases where patients either had vague or difficult to diagnose symptoms or the small number of cancers found in patients who said they were ill but mostly needed a quick test or scan to rule something more serious out.

72. They looked at 30,000 cancer cases and more that 25% of all cancer case were from that group where it wasn't thought that something was wrong but then showed as being something more serious.

73. The model of care in Denmark introduced three routes

1	Fast Track – for patients with 'alarm' symptoms and treatment routes with strict time targets.
2	Diagnosis centres set up at existing hospitals and clinics – where patients with symptoms that GPs cannot diagnose are given a range of scans and tests to quickly find out the cause – whether cancer or something else. This

	helps doctors who suspect something is wrong but not necessarily cancer. This stops the 'ping pong' between GPs and specialists.
3	'Yes-No' centres – which offer a simple test or scan so they can be seen quickly and problems identified. Most cases are solved within hours but some (1%) had a serious disease detected, for those patients they would have otherwise had to wait four to six months and they can now access their treatment quicker.

74. The result – the changes have not led to a 'flooding of the system' by more GP referrals but a better organisation of how patients are diagnosed within existing resources. Importantly it has also led to better survival rates.

Joint Tees Clinical Commissioning Groups Cancer Strategy – 2016-2021

75. At their meeting on 25 May the South Tees Clinical Commissioning Group approved the Joint Tees Clinical Commissioning Groups Cancer Strategy 2016-2021. The strategy's executive summary highlighted what the panel had heard, that cancer services had improved considerably over the last decade and there had been a reduction in cancer mortality. However not everyone was benefiting from improvements in cancer services and strategies to reduce health inequalities had not worked to reduce variations in cancer outcomes between the least and most deprived areas. The strategy recognised the need to improve efforts to prevent cancer and further develop services that are effective, appropriate and accessible to all residents.

76. The strategy sets out a five year vision for improving cancer outcomes in Teesside, to develop and promote services that reduce the risk of developing cancer and if they do that they have an excellent chance of surviving, wherever they live. This will be supported by prevention, diagnostic, treatment and support services that are comparable with the best in England.

77. The Tees Cancer Locality Group will oversee the implementation of the local strategy. It is a multi-agency group which ensures that there are effective programmes to reduce the risk of people in Teesside developing cancer and those affected receive the best care possible.

78. Members had received details of the excellent work that was being undertaken by the Macmillan Integration of Cancer Care Programme and were keen to receive more information about the work they were undertaking on cancer care pathways. The panel met with representatives at James Cook Hospital and went on a tour of the Chemotherapy Day Unit and the Endeavour Unit to see the facilities that were available and to speak to some of the clinical staff.

Macmillan Integration of Cancer Care Programme

79. The programme was developed to review the existing services and pathways, consult with all stakeholders to define standardised pathways for patients with cancer from diagnosis, support, care closer to home and working across traditional boundaries in order to transform services.

80. There were 14 cancer pathways in the Trust and as it was impossible, with the resources available, to look at all 14 the review concentrated on 3, lung, lymphoma and brain and CNS (Central Nervous System). Lung cancer because the prognosis was poor and staffing had been concentrated in that pathway, lymphoma because it

affected a greater age range of people and Bran and CNS because it was a rare cancer with a very poor prognosis.

81. The panel heard details about how the methodology for the programme was developed, including assessing pathways and how they impacted on patients. Separate process maps were developed and although each map was different in its own right, they were similar. They were complex models but highlighted the same issues that were barriers to patients from getting the diagnosis through to treatment. Six main areas of concern were identified – referral, communication, learning and development, diagnostic waits, information technology and staffing issues.

82. The panel learnt that one of the most pressing issues was that of diagnostic testing and capacity. The panel knew from what they had heard in relation to screening that there had been big drives in screening and the Government were pushing for more people to be screened, and rightly so. However the difficulties recruiting qualified radiologists are well documented. The key for the Trust was to make the best use of testing and move away from sequential testing. For example, if it was clear that a patient had a tumour, rather than wait for each test result it might be better to carry out all the tests at the same time, although this might cost more it was often quicker.

83. When assessing how to improve outcomes for cancer, consideration had been given to how screening was carried out, how patients could be seen earlier and how GPs could better diagnose. When promotional campaigns had been carried out, for example for lung cancer, it did not necessarily lead to more diagnoses. In partnership with the Public Health Shared Service an Open Access Chest X-ray initiative had been funded by the South Tees CCG. It had been developed specifically for patients who would not traditionally attend GP practice and placed in two accessible locations in Middlesbrough (TS1 and TS3) with the aim of increasing the number of people screened for lung cancer and catching them earlier. In many cases people would be presenting at Accident and Emergency with other symptoms such as breathlessness and by then it may be too late for a more positive outcome.

84. Members spoke the Lead Cancer Nurse who explained that she supported the Cancer Care Co-ordinators and the Clinical Nurse Specialists to ensure that there was equity across all pathways. The roles supported the national 31 and 62 day targets and they ‘pushed and pulled’ the patients through the pathways more quickly. The co-ordinators supported the Multi-Disciplinary Teams (MDT) and worked closely with consultants, radiology, oncology and secretaries to assist patients. The co-ordinators were available to answer questions and queries and allay patients’ concerts. They also helped patients through chemotherapy sessions, provided support mechanisms and befriending services.

85. Discussing her role of Cancer Care Co-ordinators in more detail, she explained that her role had previously been in the remint of the Clinical Specialist Nurses but they were now required to do more high level conversations and interventions so the co-ordinators had taken over the lower level 1 and 2 interventions. The new co-ordinator role was currently for a fixed term and would be evaluated quantatively and qualitively and the views of patients and staff would be sought. If the role evaluated well, the Trust and the commissioners would be asked to commission them permanently. Similar roles had been piloted in North Yorkshire and had evaluated well.

86. On a day to day basis the role involved attending the 2 week clinic to meet patients who were attending to receive the results of their x-rays. The co-ordinator would ensure a spirometry (breathing) test was carried out. The co-ordinator would attend the clinic appointment with the patient as a form of support and to ensure that the patient understood what was being said, what tests would need to be undertaken and the times and dates of their appointments.

87. The co-ordinator would assess how much time could be saved for a patient moving through the pathway. For example, a patient was due to be referred back to a clinic but no appointment was made. The co-ordinator chased this up and made the appointment. It was clarified that this would have happened but the care co-ordinators carry out negotiations in the hospital to 'pull' patients through the pathway.

88. Information was shared with the MDT which the co-ordinators had access to, with the aim of improving the communication across the pathway. It was not always necessary for the specialist nurse to speak with a patient to reiterate information that had been given. However it was recognised that patients tended to forget what was said to them after they had heard a cancer diagnosis. The co-ordinator could then provide any support as the information was documented on the system. Anything that couldn't be answered would be marked and followed up by the specialist nurse.

89. The panel also heard about the role of the Clinical Nurse Specialist in lung care. It was a busy pathway. There were currently two, 2 week rule clinics, which were supposed to have 8 patients per clinic. However clinics were often overbooked and there could be up to 12 patients per clinic. Staffing levels had not increased and nurses were seeing up to 24 patients a week. Whilst only have of this number would go through the entire pathway, there were approximately 440 patients per year with a cancer diagnosis.

90. The clinical nurse specialist would meet every patient at the 2 week rule clinic and then again when they received their results. The patient would then receive a key worker card with contact details for advice and support from the nurse specialist throughout their treatment and even when it was completed.

91. The Macmillan Programme Manager gave details on the Macmillan Integration of Cancer Care Programme (MacICC). The Programme was developed to review existing services and pathways, consult with all stakeholders to define standardised integrated pathways for patients with cancer from diagnosis to death, support care closer to home and work across traditional boundaries to transform services. This meant providing the right care, in the right place, at the right time, with the right professional.

92. There were fourteen cancer pathways in the Trust and the review concentrated on lung, lymphoma and brain and CNS (Central Nervous System). Lung cancer was chosen because the prognosis was poor and staffing was very concentrated in that particular pathway. Lymphoma affected a greater age range of people. Younger people were affected by lymphoma usually from the age of 30 and there was a greater possibility of survivorships. This gave the project team the ability to look at people who lived with and beyond cancer and all of the issues associated with having had cancer treatment and coming through it. Brain and CNS were chosen that because it was a much rarer cancer than the other two with a very poor prognosis. Whilst there was not a very big patient cohort, it created a greater

dependency on other services because it led to very debilitating illness. A tumour in the brain or spine affected the way people thought and moved.

93. The review also considered cross cutting issues of palliative care, workforce and community. This included how the workforce and community could be used to better effect and what services were available. Patients had a life outside of the hospital with family and friends and it was important to assess what support was available when a patient was not in active treatment.

94. The methodology for developing the programme to assess what was happening in the pathways and how this impacted on patients included: process mapping to record the pathway from pre-diagnosis to the end of life, triangulation of data to ensure that everyone was saying the same, a thematic analysis to identify the main areas of concern and patient stories to support issues identified.

95. Separate process maps were developed for the three areas reviewed and even though each disease was different in its own right, the maps were quite similar. The three pathways all had complex models but highlighted the same issues that were barriers to patients from getting the diagnosis through to treatment. Six main areas of concern were identified which were: Referral, Communication, Learning and Development, Diagnostic waits, Information Technology and Staffing issues.

96. Whilst some issues were cultural, ie things that had always been done in a certain way, many of them were about limited resources and needing to do things differently. For some patients, whilst they had a diagnosis and had had treatment, there were still gaps in the care provided.

97. One of the biggest issues identified was diagnostic testing and capacity issues. For example, whilst the Government was pushing for more people to be screened for cancer, there were difficulties recruiting qualified radiologists. The key thing was trying to make best use of testing and move away from sequential testing. If it was clear that a patient had a tumour for example, rather than wait for each test result, it might be better to carry out all the tests at the same time. Although this might cost more, it was often quicker.

98. Following all the research, the stated aim of the MacICC was to integrate cancer care by promoting patient choice and streamlining working practice across the South Tees and Hambleton, Richmondshire and Whitby health economy. A proposed Programme Structure was developed to promote system-wide improvement from referral, through diagnosis, treatment and living with and beyond cancer. The challenges to each step of the workstream had been clearly identified.

99. In order to improve outcomes for cancer, consideration had to be given to how screening was carried out, how patients were seen earlier and how GPs could better diagnose. Many patients presented at Accident and Emergency with other symptoms, for example, breathlessness. One of the big issues when promotional campaigns were carried out for lung cancer was that it did not necessarily lead to more diagnoses. In partnership with Public Health Shared Services the Open Access Chest X-Ray initiative had been funded by the Clinical Commissioning Group (CCG). This initiative had been specifically developed for patients who did not traditionally attend GP practices to assist in earlier diagnosis of lung cancer. The initiative was based in two accessible locations in Middlesbrough and targeted at communities in TS1 and TS3 to enable self-referral for a chest x-ray.

100. Other innovations included the pilot of the new posts of the Cancer Care Co-ordinators and Community Sister/Charge Nurse roles in partnership with Macmillan Cancer Support. One of the key things identified by staff working in the community was that whilst there was excellent acute care provision in hospital, there was no-one based in the community to provide patient support when leaving the acute treatment. Other professionals had been able to participate in the Induction Programme for the Community Sister/Charge Nurses and the Care Co-ordinators to increase their knowledge. The Community Sister/Charge Nurse roles, like the Care Co-ordinator roles, had fixed term funding. If the posts evaluated successfully it was hoped they would be commissioned on a permanent basis.

CONCLUSIONS

101. Based on evidence given throughout the investigation the Panel concluded:
TO BE DISCUSSED AT THE PANEL'S NEXT MEETING

DRAFT RECOMMENDATIONS

102. That the Health Scrutiny Panel recommends to the Executive:

a) That Love Middlesbrough Magazine features an article – Be Clear on Cancer
b) That the Council's Public Health Team consider having a regular public health presence located in Community Hubs in order to promote prevention initiatives and screening services.
c) That the South Tees Health Scrutiny Joint Committee included a recommendation, as part of their response to the Urgent Care Review, to ask that screening services are included in the South Tees CCG's proposals for the new extended hours at GP Hubs.
d) A flagging system be designed in GP systems for all three screening programmes to remind people that their screening may be due or overdue.
e) Additional resources be sourced to assist in undertaking further work to target GP practices with low screening uptake
f) That the issue of improving Breast Screening rates across the Tees Valley be submitted to as a potential work topic for the Tees Valley Health Scrutiny Joint Committee
g) That people be given a list of screening drop-in sessions when they attend their NHS Health Check.

ACKNOWLEDGEMENTS

103. The Panel is grateful to all those who have presented evidence during the course of our investigation. We would like to place on record our appreciation, in particular of the willingness and co-operation we have received from the below named:

- Kate Birkenhead – Public Health Commissioning Manager, NHS England
- Fergus Neilson – Screening and Immunisations Manager, Cumbria and the North East, NHS England
- Carol Taylor, Macmillan Programme Manager, Macmillan Cancer Support/South Tees Hospitals NHS Foundation Trust
- Mark Reilly, Assistant Director, Public Health Intelligence, Tees Valley Public Health Shared Service

- Leon Green, Public Health Specialist, Tees Valley Public Health Shared Service
- Dr Janet Walker, Chair, South Tees Clinical Commissioning Group
- Becky James, Health Improvement Specialist, Early Intervention and Prevention, Public Health, Middlesbrough Council
- Dr Victoria Ononeze, Public Health Specialist, Tees Valley Public Health Shared Service
- J Bailey, Partnerships and Innovations Manager, South Tees CCG
- Alex Sinclair, South Tees CCG
- Dr J Walker, Chair, South Tees CCG
- Dr Angela Wood, Macmillan Programme Sponsor, Haematologist and Chief of Speciality Medicine, South Tees Hospitals NHS Foundation Trust
- K Dover, Service Improvement Lead, South Tees Hospitals NHS Foundation Trust
- J Hughes, Clinical Nurse Specialist, South Tees Hospitals NHS Foundation Trust
- T Jasper, Cancer Care Co-ordinator, South Tees Hospitals NHS Foundation Trust
- N Hand, Lead Cancer Nurse, South Tees Hospitals NHS Foundation Trust.

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BACKGROUND PAPERS

The following background papers were consulted or referred to in the preparation of this report:
(a) The minutes of the Health Scrutiny Panel.