REPORT FOR:	HEALTH AND WELLBEING BOARD
Date of Meeting:	6 November 2014
Subject:	Cancer Strategy Report
Responsible Officer:	Dr Heschil Lewin -GP Cancer Lead Harrow CCG Helena Sage- Nursing Commissioning Manager Harrow CCG
Public:	Yes
Wards affected:	All
Enclosures:	None

Section 1 – Summary and Recommendations

This report sets out to identify and clarify how Harrow CCG and the London Borough of Harrow can work in partnership to improve cancer outcomes in Harrow

Recommendations:
Acknowledge the joint objectives and support partnership working

Section 2 – Report

Harrow CCG Cancer lead -Program for working with Harrow GPs to improve Cancer outcomes

Working in partnership with London Borough of Harrow

Background:

A report was presented to the Health and Wellbeing Board on 3 October 2013 which outlined actions taken to conclude adult Partnership Boards and move to strategic groups, which focus on delivering local health and wellbeing priorities and joint commissioning intentions.

The seven key priory areas for action, as identified in Harrow's Health and Wellbeing Strategy 2013-2016, are:

• Long-term conditions

• **Cancer**

• Worklessness

• Poverty

• Mental health and wellbeing

• Supporting parents and the community to protect children and maximise their life chances

• Dementia

The current key top priorities are promoting the awareness of:

• Circulatory disease: mostly heart disease and stroke;

• **Cancer: with the highest being breast, lung, prostate and bowel Cancers**

• Respiratory disease: mostly chronic airways disease and pneumonia

•We also intend to raise awareness of diabetes, mental health and dementia through a series of workshops and/or joint events with service providers and commissioners. The overall objective is to ensure more people are aware of the underlying factors through prevention and effective cure where possible.

Cancer therefore is a major priority for Harrow CCG and LBH

Cancer was chosen as a priority because it has a significant impact on wellbeing and quality of life of people with cancer and their family and carers. Although many cancers are treatable and have a good and improving survival rate, cancer is the second highest cause of death in Harrow. Lung cancer and breast cancer are two specific cancers that drive the health inequalities gap. Effective prevention and early detection will have a long term impact on incidence of some cancers and deaths from other cancers.

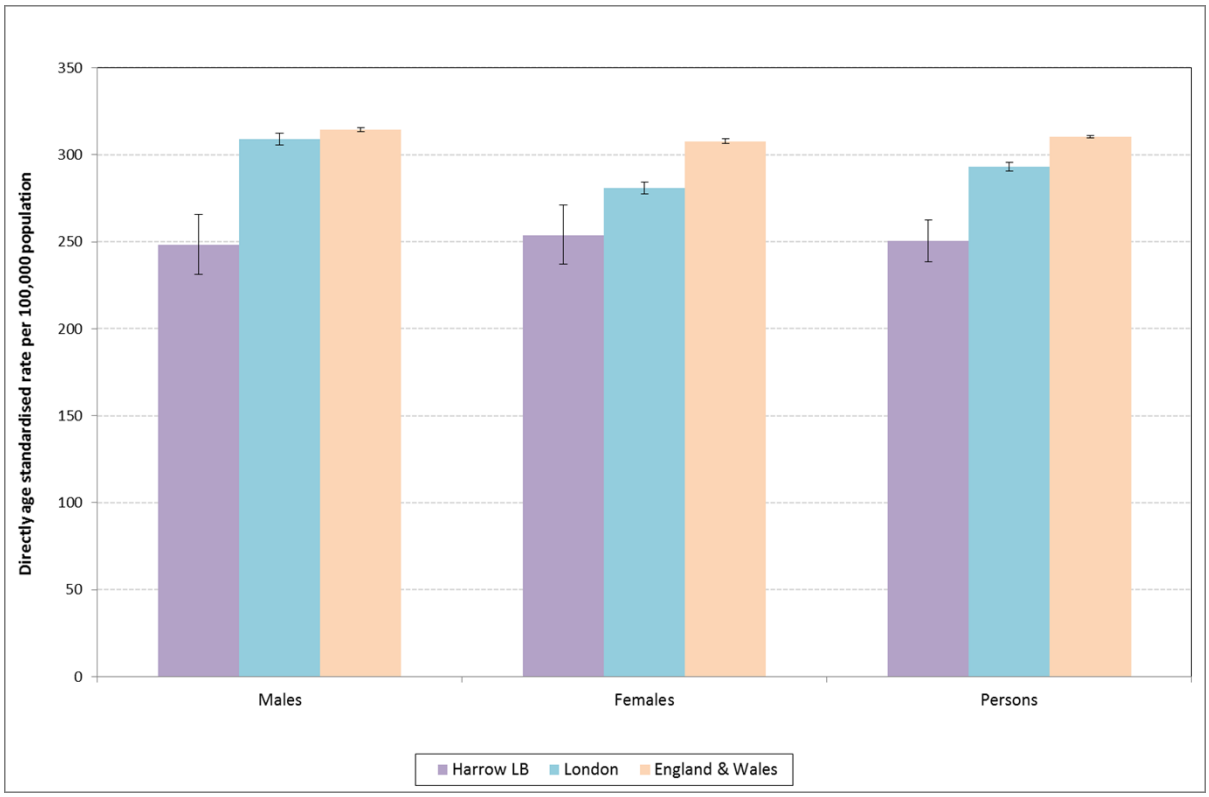
As with long term conditions, there is a significant role for ill health prevention and early detection and there are considerable employment issues for people with LTCs and impact of disease on local economy. Standard of living is affected impacting on the individual with the condition and their family.

It is widely accepted that the main reason why one year survival rates (regarded as a proxy indicator of early diagnosis) compare poorly with those in Europe is because of later stage at diagnosis. In 2012, London Clinical Commissioning Groups (CCGs) identified early detection as a priority area to transform cancer services and that an important way to achieve this is to raise GP awareness of quality and timeliness of referral routes, symptoms of cancer and access to diagnostics.

Every year more than 30,000 Londoners will be diagnosed with Cancer.

Cause of death	**Death rate per 100,000 populations in Harrow**
Cancer -	83.3
Cardiovascular disease	51.4
Respiratory disease	18.2

Incidence of all cancers, under 75s, by gender, 2009-11 - Harrow LB



Routes to diagnosis

Patients arrive at the point of diagnosis through different parts of the healthcare system. The table below shows the national routes to diagnosis taken by patients

diagnosed with lung, prostate and female breast cancer in 2006-10, and the corresponding one-year survival for patients diagnosed by each route

Most patients are diagnosed through the two week wait and this route has the highest one-year survival rate, whereas diagnosis via emergency presentation has the lowest survival rate. This suggests that the proportion of patients diagnosed through an emergency route should be decreased if survival rates are to improve..

Lung	All routes		Two Week Wait		GP referral		Other Outpatient		Inpatient Elective		Emergency presentation		Unknown	
Route	-		24%		21%		10%		2%		38%		3%	
Confidence interval	-		*24%*	*24%*	*21%*	*22%*	*10%*	*11%*	*2%*	*2%*	*38%*	*39%*	*3%*	*3%*
1-year survival	29%		42%		38%		42%		32%		11%		23%	
Confidence interval	*28%*	*29%*	*41%*	*42%*	*38%*	*39%*	*41%*	*43%*	*30%*	*33%*	*11%*	*12%*	*22%*	*25%*

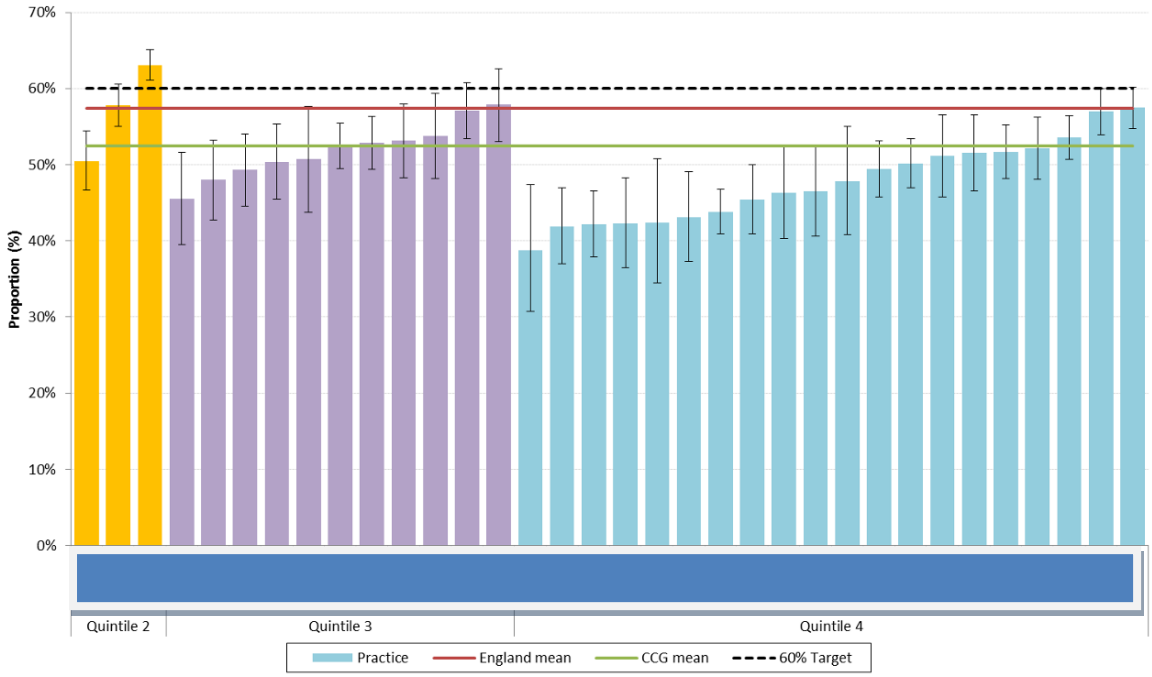
Prostate	All routes		Two Week Wait		GP referral		Other Outpatient		Inpatient Elective		Emergency presentation		Unknown	
Route	-		29%		42%		12%		3%		9%		5%	
Confidence interval	-		*29%*	*29%*	*42%*	*42%*	*11%*	*12%*	*3%*	*3%*	*9%*	*10%*	*5%*	*5%*
1-year survival	95%		98%		99%		96%		98%		56%		97%	
Confidence interval	*95%*	*96%*	*98%*	*98%*	*99%*	*99%*	*95%*	*96%*	*97%*	*99%*	*56%*	*57%*	*97%*	*98%*

Screening

Another route to diagnosis is screening, available for breast, bowel and cervical cancers

In England in 2007, 21% of all breast cancers were screen detected and 14% of cancers of the cervix. Screening uptake is usually lower in quintile 5. Cervical screening uptake is also low. Research suggests that for cervical screening, ethnicity is the most important predictor for participation. Delivering cervical screening in a culturally appropriate manner is particularly important in Harrow

Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, 2009/10-2011/12) - NHS Harrow CCG practices



In Harrow there still needs to be an increase in uptake of screening among certain groups plus there also needs to be an increase in certain groups of symptom awareness. There are groups which present late to GPs and these have a poor prognosis.

Aim:

The aim is to improve the early detection of cancer and referral management of cancer cases, both factors known to influence survival rates. This work also has relevance for the CCG's efforts towards meeting the NHS Outcome Framework Domain 1 target to, and to reduce deaths in the people aged under 75. We also aim to reduce the proportion diagnosed through the emergency referral route, which will usually have a more advanced cancer, poorer survival chances and higher care costs for the CCG.

How?

1) Review the referral patterns of individual practices

2) Institute regular educational programs

3) Audit of emergency presentations with cancer as Significant Events and to report on the key findings.

4) Improve access to GPs and develop the use of alternative pathways like pharmacies and the direct referral for i.e chest x-ray to the Pin/Alexandra HC.

5) Develop strategies in conjunction with the Public Health department and cancer charities, community leaders which include symptom awareness and access to screening.

The aim is to develop an integrated model of cancer awareness among the general public and GPs and to improve the quality of the referrals which will improve the prognosis and survival of our patients.

How will we measure success?

1) Improved rates of cancer diagnosis

2) Decrease in late diagnosis and reduction in one year mortality

3) Reduction in diagnosis in emergency settings

4) Increase in uptake of screening in certain groups

To achieve these outcomes working in closer partnership with public health and voluntary groups is essential .Partnership working will improve uptake in screening ,especially in marginalised groups and hard to reach patients. Public Health messages will help all cancer outcomes as they emphasise healthy lifestyles which will improve outcomes in cancer and all other disease areas.

Section 4 - Contact Details and Background Papers

Contact:

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Background Papers:

http://www.ncin.org.uk/cancer_information_tools/profiles/gp_profiles