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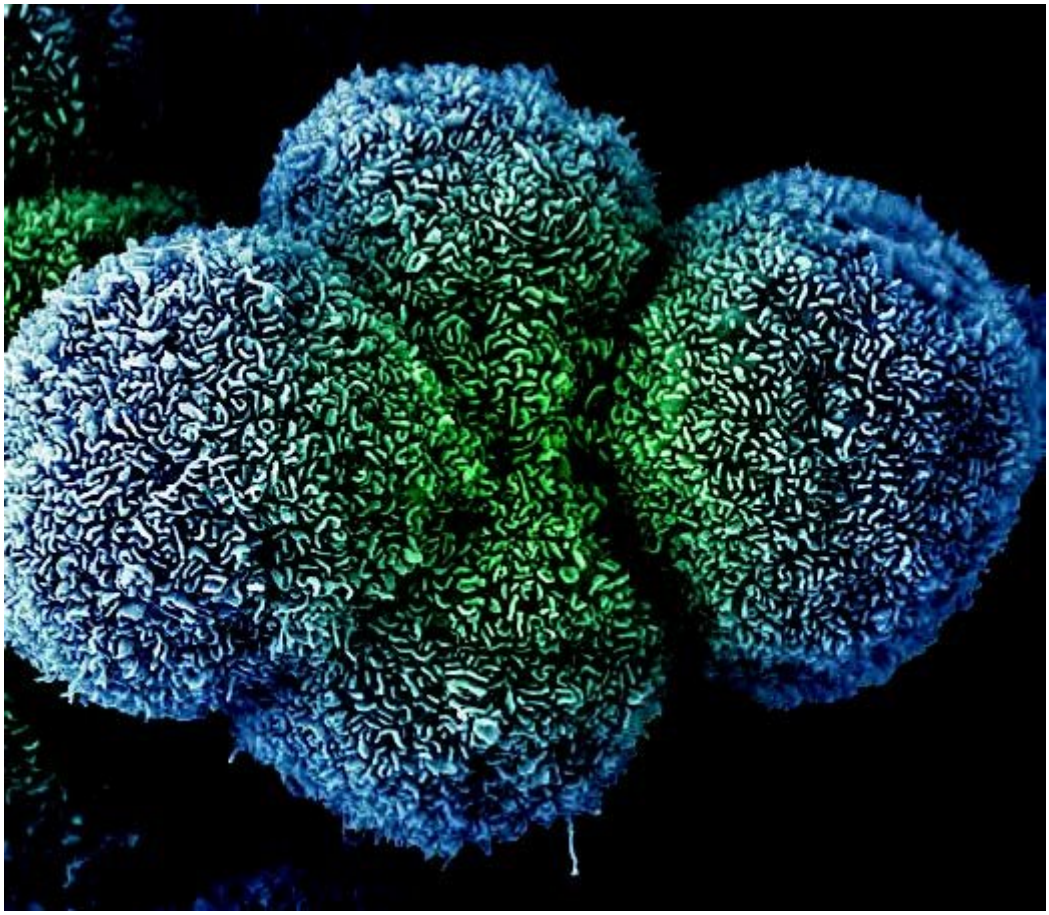

Cancer Deep Dive

A Thurrock Joint Strategic Needs Assessment (JSNA) Product

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1. Introduction

Every day in the UK there are more than 900 people diagnosed with cancer. It is estimated that one in two of us will develop cancer within our lifetime. However cancer is no-longer necessarily a death sentence. The most recent research suggests that for the first time in history, more people in the UK will survive cancer than die from it.

Improvements in lifestyle, early diagnosis and treatment have all had a positive impact on delivering this statistic, yet the UK still benchmarks poorly when compared to many other developed western countries when it comes to cancer survival rates. In Thurrock, cancer is still the most common reason for premature death in our population and as such is an absolutely key public health priority.

This report has been produced as part of the core Public Health offer to NHS Thurrock Clinical Commissioning Group. It was originally requested by the CCG in recognition of our poor local performance against the 62 day wait cancer standard – a national target which requires Clinical Commissioning Groups to ensure that no patient with cancer waits longer the 62 days from initial referral by their GP with symptoms that require investigation, through diagnosis, to receiving their first treatment for cancer. However I have expanded the scope of the initial request to include a section on local cancer epidemiology, and then to consider all elements of the cancer care pathway, from prevention, screening and referral though to diagnosis, treatment and survival.

As with so many Public Health issues, it is only by considering the totality of the picture and then taking coordinated action across agencies, in conjunction with the general public can we hope to have the greatest impact. As such, the report makes clear recommendations for a range of stakeholders to implement to improve the situation and reduce the number of people in our population who die from cancer in the future.

Ian Wake
Director of Public Health

Please note, where the phrases 'statistically significantly greater than or less than' are used in this report, they refer to statistical significance at 95% CI.

2. Executive Summary

The Epidemiology of Cancer in Thurrock

Cancer is the single biggest cause of premature mortality amongst our population. The most common new diagnoses for cancer in Thurrock are breast, urological, lung and lower GI and that order.

Thurrock has the highest rate of lung cancer new diagnoses in its ONS comparator population groups but the lowest rate of breast cancer. However there is little or no statistically significant difference between cancer incidences in different ONS comparator populations.

The most prevalent cancers in the Thurrock population (over a 20 year period) are breast, prostate, colorectal and lung, in that order. There are 2135 people in Thurrock, diagnosed with cancer in the last 20 years who are still alive.

The number of people living with cancer in Thurrock over the next 20 years is predicted to rise significantly. This is due to a combination of factors including an ageing population, earlier diagnosis and better treatment.

Mortality from cancer within the general population of Thurrock over the past five years is not statistically significantly different to England's or Essex.

Cancer Prevention: Smoking

Research suggests that at least one-third of all cancer cases are preventable. Prevention offers the most cost-effective long-term strategy for the control of cancer. Tobacco use is the single greatest avoidable risk factor for cancer mortality worldwide, causing an estimated 22% of cancer deaths per year. In 2004, 1.6 million of the 7.4 million cancer deaths were due to tobacco use.

It is estimated that between 21.1% to 22.8% of adults in Thurrock smoke, depending on the age range studied and the method of sampling. Thurrock has a smoking prevalence significantly greater than England's and many of its comparator populations

Smoking is strongly positively associated with deprivation in Thurrock, and is therefore a key driver of health inequalities.

Thurrock has rates of hospital admissions and mortality attributable to smoking that are significantly greater than England's and many of its comparator populations. There were an estimated 1356 additional hospital admissions amongst our population in 2014/15 as a result of the levels of smoking prevalence in our population, resulting in an additional £3.8M of cost to NHS Thurrock CCG and an additional deaths that can be attributable to smoking prevalence.

There has been no significant reduction in rates of smoking attributable hospital admissions over the past five years.

Despite 86.6% of smokers having a record of an offer of help to quit smoking by their GP practice, fewer than 6% made a quit attempt through an NHS stop smoking service in the preceding 24 months to March 2015. There is significant variation between different GP practice populations and this cannot be explained by differences in deprivation levels between practice populations.

The Health and Social Care system in Thurrock is failing to have any significant impact on smoking prevalence in our local population through smoking cessation work. It is estimated that less than 0.3% of smokers successfully quit long term in 2014/15 as a result of a commissioned stop smoking service. This is a product of both a failure of providers to identify and refer smokers into stop smoking services and a failure of stop smoking services to help sufficient people referred to them, to quit successfully long term.

Cancer Screening

Early identification of many types of cancer results in better treatment outcomes for patients. Cancer screening programmes aim to identify people likely to have cancer such that they can be referred for further diagnostic tests and if necessary for treatment. A positive screen in a cancer screening programme is not equivalent to a cancer diagnosis, but suggests that further investigation is necessary to ascertain whether or not the patient has cancer.

National cancer screening programmes are delivered by the NHS. They are coordinated by the national office of the NHS Cancer Screening Programmes, part of Public Health England. Commissioning and monitoring of local programmes is the responsibility of a local team of Public Health England based within the NHS England East office.

There are three cancer screening programmes:

- the NHS Cervical Screening Programme
- the NHS Breast Screening Programme
- the NHS Bowel Cancer Screening Programme

The mean 3.5 year screening cervical screening coverage of patients aged 25-49 across Thurrock is 71.7% which is above the minimum standard but below the target 80% rate However there is unacceptable variation in screening coverage between GP practice populations. Only 17 of our 32 GP practices (53.1%) achieve screening coverage at the minimum standard of 70% and only two (6.25%) achieve screening coverage at the target rate of 80%. Performance on screening coverage for women aged 50-64 is better than those aged 24-49. The mean screening coverage in this cohort across the CCG is 76.2% and variation between practice populations is lower than that in younger women. All but three practices (90.6%) achieve the minimum 70% coverage standard and a quarter of all practices achieve screening coverage above the 80% target.

Cervical screening coverage for women aged 25-49 is relatively strongly negatively associated with practice population deprivation and could therefore be said to be a driver for health inequalities. 11 practices (Jones and Byrne, Balfour, Deshpande, Roy and Partners, Masson and Masson, Kadim, Joseph and Ptnr, Thurrock Health Centre, Chadwell, Appledore MC and Mukhopadhyay) have screening coverage that is both below the 70% minimum standard and significantly below what would be expected for their level of practice population deprivation. This warrants further investigation. The absolute low level of cervical screening coverage within the Mukhopadhyay practice coupled with the significant distance below what would be predicted for the level of practice deprivation is particularly concerning.

The mean coverage rate for bowel cancer screening in Thurrock in the eligible population is 55%. This is below the national minimum standard of 60%. 26 of the 32 (81.26%) practice populations have screening coverage below the 60% target. There is considerable variation in uptake of bowel cancer screening

between GP practice populations, with the lowest coverage rate (Sai Medical Centre) being just over half the that in the population with the highest coverage rate (Hassengate Medical Centre). Given that GP practices have little involvement in this screening programme, the explanation for this is likely to a product of differences within the practice populations themselves. There is a strong negative association between bowel cancer screening coverage and deprivation. This is concerning as it is likely to be a driver of health inequalities related to cancer.

The mean screening coverage rate for breast screening of patients across Thurrock is 65.9% which is below the minimum standard of 70%. Like the other cancer screening programmes previously discussed there is considerable variation in coverage between different practice populations. Only 11 out of the 32 practice populations (34.3%) achieve the minimum 70% coverage standard and none are screened to the target 80% coverage. The practice population with the poorest breast cancer screening coverage rate (Acorns) achieves a rate that is only just over half that of the practice population with the highest coverage. (Cheung). There is a reasonably strong negative association between breast screening coverage and practice population deprivation. The Abella, St. Clements, Purfleet Care Centre, Thurrock Health Centre and Acorns Medical Centre have screening coverage rates significantly below what would be predicted given this association. This warrants further investigation.

Early Identification and Referral of People with Suspected Cancer

Timely and appropriate referral of patients with symptoms that could indicate that they have cancer is essential to improving cancer survival in our population. One of the explanations in much of the published literature on the UK's poor cancer survival rates compared to other countries is that patients are referred for cancer treatment to late. Conversely, over-referral of patients who do not have cancer risks clogging up NHS care pathways with the "worried well" and diverting capacity away from treating promptly patients who do have cancer.

The NHS has set a two week minimum waiting time for patients with suspected cancer to see a cancer specialist from GP referral. This forms part of the NHS Constitution.

Overall, 7.8% of patients referred into the two-week wait cancer pathway were subsequently found to have cancer. This is lower than England's rate (8.4%) but not statistically significantly different.

At GP practice level, three practices have a cancer diagnosis rate following referral into the two week pathway that is significantly greater than England's rate. In one practice over 30% of patients referred into the two week pathway were subsequently diagnosed with cancer. This suggests a significant under referral of patients and warrants further urgent investigation.

On a second metric to examine the appropriateness of referral of patients with suspected cancer into the two week wait pathway – the Indirectly Age Standardised Referral Ratio, there is also significant variation in between GP practices in Thurrock. Nine practices (28.1%) have referral ratios that suggest that they are under referring patients with suspected cancer and three practices (9.4%) have referral ratios that suggest they may be over-referring patients who do not have cancer. Three practices have scores on both metrics that suggest that they are failing to refer sufficient patients with suspected cancer into the two week wait pathway. This warrants further investigation.

Over half of all patients treated for cancer in Thurrock did not receive a referral through the two-week wait pathway. This is not significantly different to England's rate, but still suggests that too few patients are having their cancer detected early enough.

In terms of performance against the two-week waiting standard, Thurrock performs well with 95.6% of patients seeing a cancer specialist within two weeks of being referred into the pathway by their GP. This is second best performance in Thurrock's ONS comparator CCG group and statistically significantly better than the performance across England.

Cancer Diagnosis and Treatment

Prompt diagnosis and treatment is key both to the efficacy of treatment and to minimising the distress of people diagnosed with cancer.

There is significant variation between different GP populations in terms of rate of unplanned care admissions for cancer with 12 practices having rates significantly below the England mean and two practices significantly above and a 20 fold difference between the practice population with the highest and lowest rate. Cancer diagnosed and treated through an unplanned care hospital admission are likely to indicate late diagnosis and poorer patient outcomes. Cancer unplanned care admission rates as strongly positively associated with income deprivation levels in the practice population although the reasons for this are unclear. Explanations could include a greater level of under doctoring in deprived communities, a lower cancer screening coverage or a greater unwillingness of deprived populations to seek help early for cancer symptoms.

For patients who are referred into local cancer care pathways Thurrock CCG performs in line with England and its comparator group CCGs on the 31 day wait performance cancer standard suggesting that once cancer is diagnosed, the vast majority of patients (97%) receive treatment within 31 days. Conversely only 68.4% of patients with cancer receive treatment within 62 days from their initial GP referral. This is the lowest percentage of patients when compared to Thurrock's ONS comparator CCGs and is significantly worse than the England mean of 84%. Furthermore the situation has deteriorated over the last 15 months. Considering these two metrics together suggests that there are serious and unacceptable delays occurring in Thurrock in the initial diagnosis of cancer. Delays in cancer treatment due to delays in diagnostics is likely to impact adversely on mortality rates of Thurrock patients and is unacceptable. This warrants further urgent investigation.

Detailed category analysis on 62 day breach reports undertaken by the author between April 2014 and June 2015 suggests that 78% of all 62 day cancer wait breaches are potentially avoidable. The most common two reasons were either entirely or partly a function of the fragmentation of cancer pathways between multiple hospital sites across Essex. The most common reason was delays in access to diagnostics. This occurred either at one site or often because referral of patients between different sites was required in order to access to all diagnostic equipment in order to obtain an adequate diagnosis to begin treatment. This accounted for almost half of all breaches. Where specified, delays for MRI and CT scans and for TRUS featured commonly in breach reports categorised into this sub-category.

A theme running through many of the reports for breaches categorised as 'avoidable' was a lack of coordination of care of the patient. The care pathway operates as a series of linked individual processes with staff only taking responsibility for their part of the pathway or process. As soon as one part of the

pathway failed, the entire pathway failed and the delay occurred. Patients often appeared to be 'bounced' around different providers and different parts of the NHS system with no one individual taking responsibility for their journey through the pathway.

The Urological, lung, and upper gastrointestinal pathways give cause for significant concern with over 50% of patients entering these pathways failing to receive treatment for cancer within the 62 day standard because of reasons that were potentially avoidable. 47% of patients with lung cancer experienced a potentially avoidable delay in diagnostics in the first quarter of 2014/15.

Cancer Survival

Cancer one-year survival rates for both Thurrock and England have increased at largely the same yearly rate and by around 10% between 1996 and 2011, with Thurrock's one-year survival rate remaining slightly below that of England's.

Whilst improving, one-year survival rates for both breast and colorectal cancer in Thurrock are amongst the lowest amongst in our ONS comparator group of CCGs. One year lung cancer one-year survival rates are around median compared to our ONS CCG comparator group, although are not improving at the same rate as other CCGs.

Over the last 20 years, patients diagnosed with in Thurrock have generally survived for shorted periods of time than England and many of our comparator CCGs

3. Recommendations

Prevention: Smoking

1. Public Health should undertake a comprehensive review of current commissioning arrangements on tobacco control with a view to significantly improving the impact that future providers are having on smoking prevalence in Thurrock and achieving a minimum 1% prevalence reduction per annum. This should be monitored as part of the outcomes framework in the Joint Health and Wellbeing Strategy refresh.

2. Thurrock CCG should amend current commissioning arrangements with NELFT, SEPT and BTUH, and Thurrock Council with its front line providers to include an obligation them routinely to identify and refer patients who smoke into Public Health commissioned stop smoking services. Minimum agreed numbers of referrals should be incorporated into all contracts and routinely performance managed.

3. Thurrock Council should train its front line staff in 'Making Every Contact Count' and include identification and referral of smokers into commissioned stop smoking services.

4. Public Health should commission its stop smoking provider to provide further support and training to front line practice staff to improve the conversion ratio of patients offered support to quit who go on to make a quit attempt through a commissioned stop smoking service.

Cancer Screening

5. The Public Health England team based in NHS England East office should investigate and seek to reduce the level of variation in coverage between GP practice populations on all three cancer screening programmes. Specifically:

5a. For cervical screening the following practice populations warrant further investigation

- Jones and Byrne, Balfour, Deshpande, Roy and Partners, Masson and Masson, Kadim, Joseph and Ptnr, Thurrock Health Centre, Chadwell, Appledore MC and Mukhopadhyay

5b. For bowel screening, the following practice populations warrant further investigation

- Sai Medical Centre, Tilbury Health Centre, Okoi, Thurrock Health Centre, Darenth Lane, St. Clements, Dilip Sabnis, Purfleet Care Centre, Joseph and Partner, Acorns Medical Centre, Appledore and Medic House, Mukhopadhyay, Shehadah, Kadim Primecare, Aveley Medical Centre,

5c. For breast screening, the following practice populations warrant further investigation

- Acorns Medical Centre, Thurrock Health Centre, Purfleet Care Centre, Health Centre Darenth Lane, Okoi and Partner, Tilbury Health Centre, Sai Medical Centre, St. Clements Health Centre, Bellworthy, Abela and Partner, Aveley Medical Centre

6. GPs and practice staff with screening coverage below target should seek opportunities to promote and encourage cancer screening programmes to all patients

7. NHS Thurrock CCG in conjunction with Thurrock Council Public Health Team should develop and implement a communications campaign promoting the importance of cancer screening programmes, with particular targeting of areas with low screening coverage

Early Identification and Referral of People with Suspected Cancer

8. The CCG in conjunction with Thurrock Council should undertake a coordinated communications campaign aimed at increasing patient knowledge of potential cancer symptoms and encouraging them to consult their GP at the earliest possible opportunity. This campaign should be targeted at practice populations with referral ratios below 80% or where unplanned admission rates for cancer are high.

9. Practices that have been identified as having referral ratios into the TWW pathway below 80% and/or cancer TWW positivity rates that are significantly greater than the England mean should review their clinical practice with regard to cancer referrals to ensure that they are identifying and referring patients with symptoms that could be cancer, sufficiently early.

10. Practices with that have been identified has having referral ratios into the TWW pathway above 120% and/or TWW cancer positivity rates that are significantly less than the England mean should review their clinical practice with regard to cancer referrals to ensure that they are not over referring patients.

Cancer Diagnosis and Treatment

11. The current configuration of cancer pathways is fragmented across multiple hospital sites. NHS England should work with CCGs across Essex to rationalise cancer diagnosis and treatment into fewer specialist centres

12. No one professional is accountable for a patient's journey through the system. The CCG should commission a 'care coordination' approach to cancer care with a single named accountable professional being responsible for monitoring a patient's journey and ensuring each part of the system works in a coordinated and high quality care

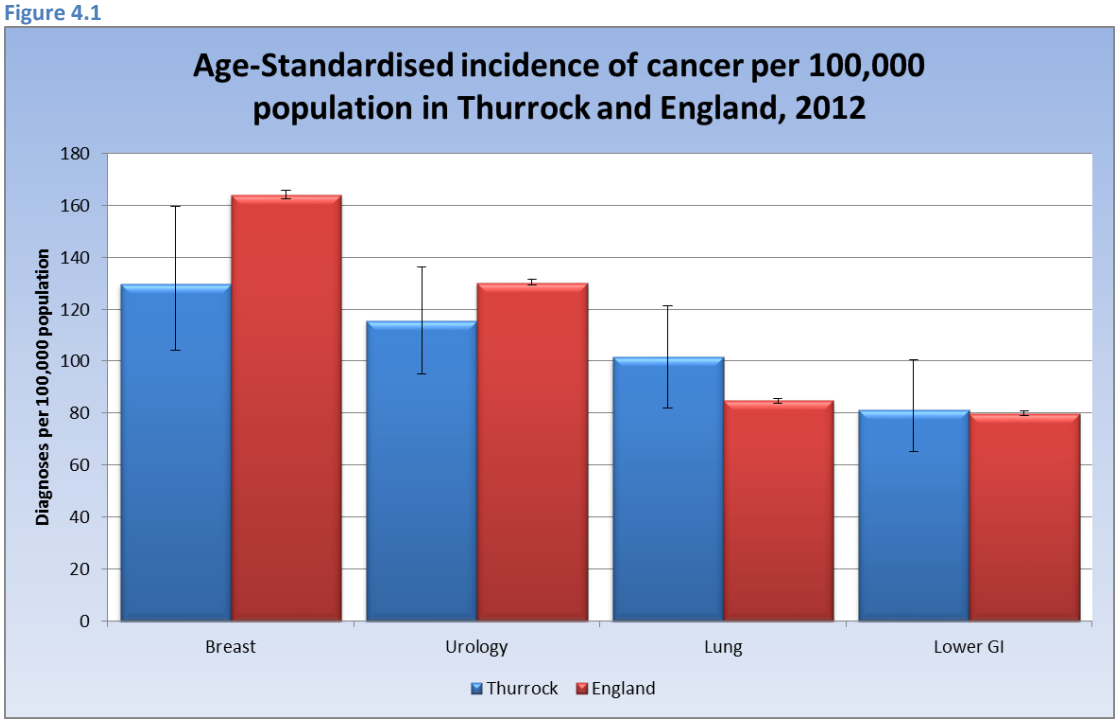
13. Delay in diagnostics in some tumour specific pathways is the primary reason for failure to meet the 62 day cancer waiting standard. The current level of delay for some types of cancer is unacceptable and may be unnecessarily compromising the efficacy of future treatment and causing distress to patients. The CCG, in association with the relevant providers should urgently review the following care pathways with a view to addressing delays in diagnostics: Urological, lung, upper and lower GI, haematological, head and neck, and gynaecological.

4. Cancer Epidemiology

4.1 Cancer Incidence

Cancer incidence is the rate of new cancer diagnoses within a given population and time period. It is a function largely of the health behaviour of the population and environment in which that population lives. Figure 4.1 shows the incidence of the four most common cancers in Thurrock and England in 2012 expressed as a rate per 100,000 population.

Figure 4.1



The most common new diagnosis of cancer in both Thurrock and England is breast, followed by urology (including prostate), lung and lower GI (bowel and colorectal).

Breast cancer incidence in Thurrock is statistically significantly lower in Thurrock than England (at 95% CI). Incidence for urological, lung and lower GI cancers is not statistically significantly different to England, although lung cancer incidence at 94% CI is significantly greater. This is likely to reflect the high prevalence of smoking in Thurrock compared to England.

Figures 4.2 to 4.6 show the incidence of the four most common types of cancer; breast, urological, lung and lower GI respectively for England, Thurrock and Thurrock CCG's Office for National Statistics (ONS) comparator CCGs. (These are CCGs serving populations with the most similar demographics to the population of Thurrock).

Figure 4.2

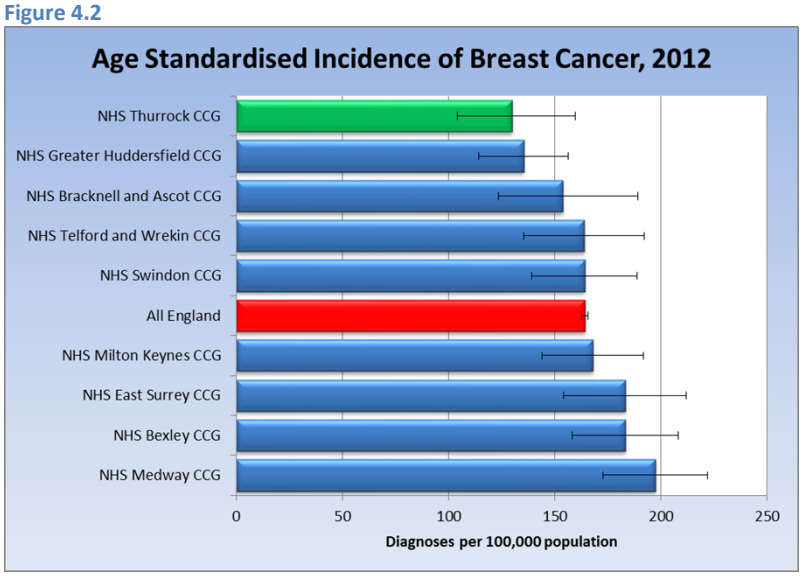


Figure 4.3

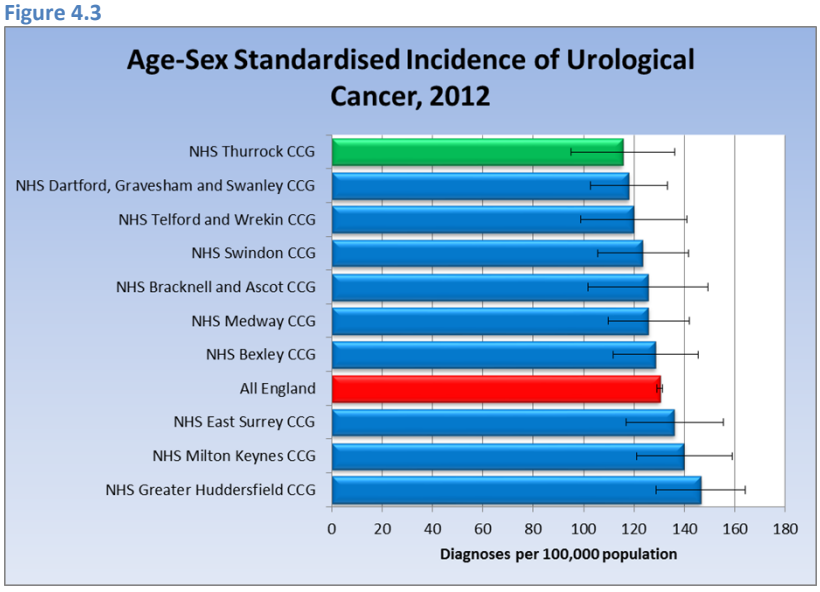


Figure 4.4

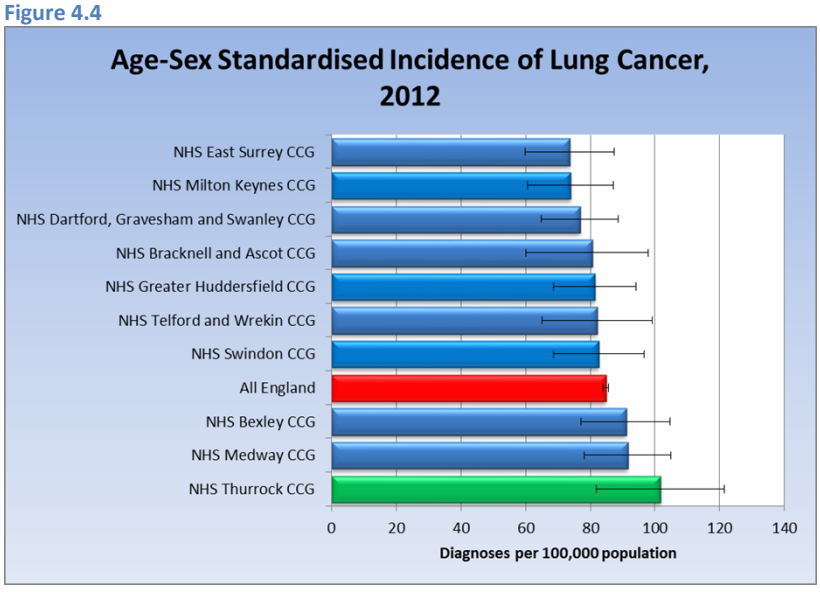
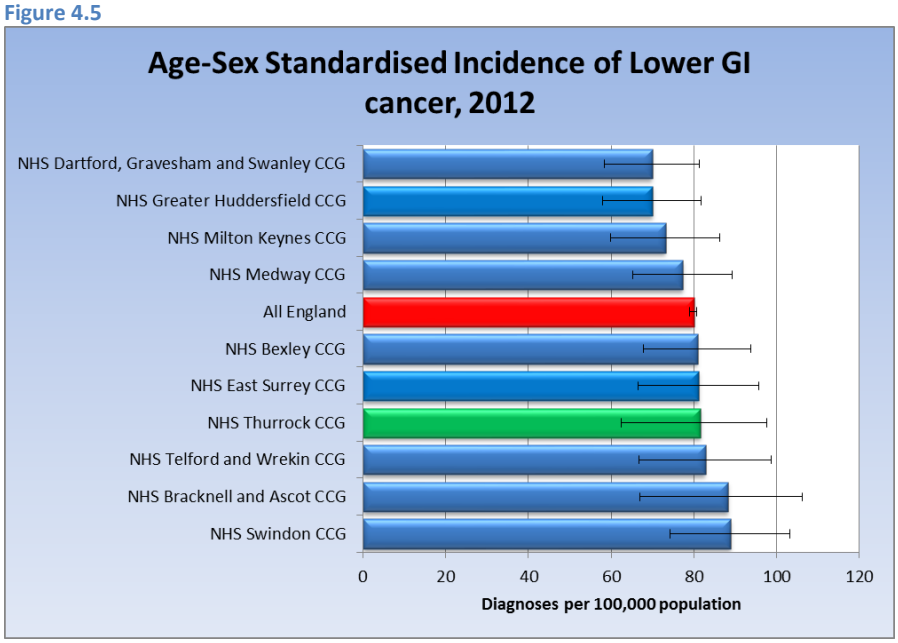


Figure 4.5

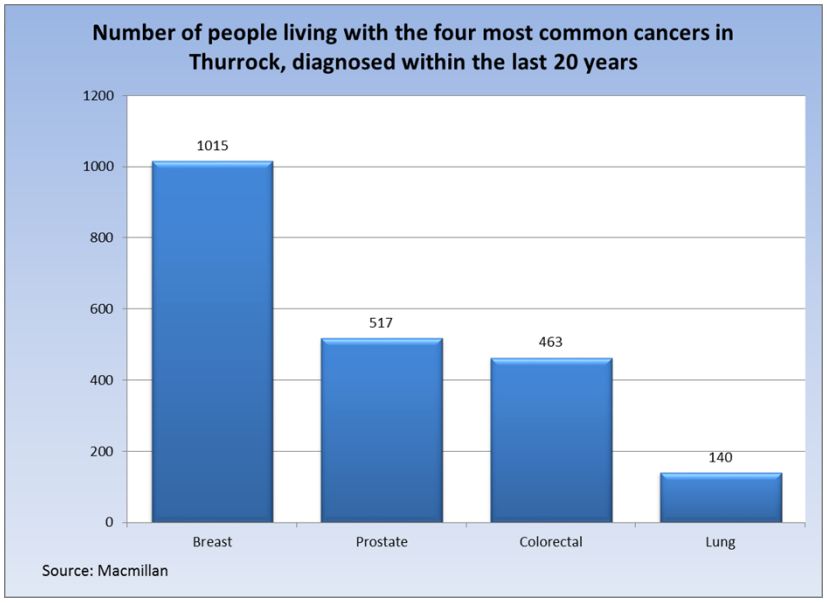


Thurrock has the lowest incidence of breast cancer compared to its ONS comparator populations, and a rate that is statistically significantly lower than England's and Medway's. It also has the lowest incidence of urological cancer, although this rate is not statistically significantly different to any of its comparator ONS populations or England's. Conversely, Thurrock's incidence of lung cancer is the highest in its ONS comparator group, although not statistically significantly different to any other population. Thurrock's incidence of lower GI cancer is also not statistically significantly different to any of its ONS comparator populations nor to England's.

4.2 Cancer Prevalence

Figure 4.6 shows the number of people in Thurrock that have been diagnosed with the four most common cancers in the last 20 years and are still alive. It can be used to asses cancer care needs of our population.

Figure 4.6



The most prevalent cancer is breast cancer, followed by prostate, colorectal and then lung. Prevalence will be a product of both cancer incidence (number of new cases per year) and survival.

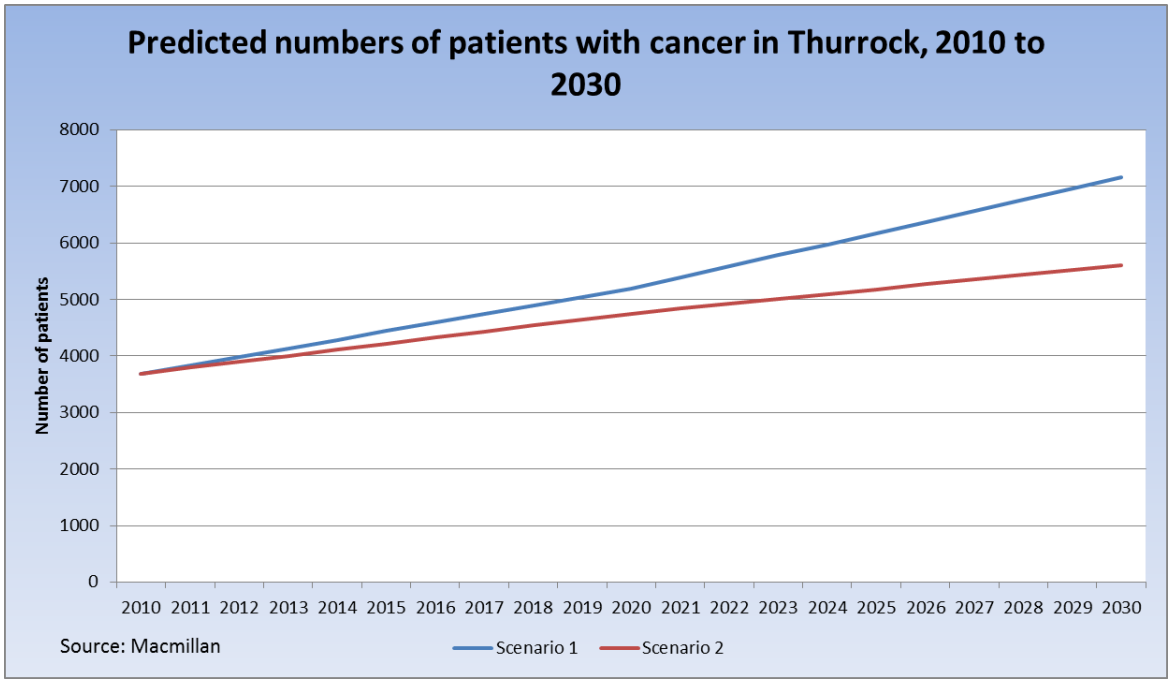
4.2.1 Future Predicted Prevalence

Cancer prevalence is predicted to increase into the future. This is a function of the growing and ageing population alongside the increasing number of people being diagnosed with and surviving cancer, together with changes in lifestyles (e.g. an increase in obesity but decrease in smoking) and a stronger focus on early diagnosis and treatment.

Figure 4.7 models two possible scenarios for future predicted numbers of patients with cancer in Thurrock from 2010 to 2030.

- Scenario 1: assumes people will continue to get and survive cancer at increasing rates in line with recent trends (except for prostate cancer), and the general population will continue to grow and age.
- Scenario 2: assumes people will continue to get cancer at the rate they do today, and that survival rates will remain as they are. The estimates are therefore driven by a growing and ageing population only.

Figure 4.7



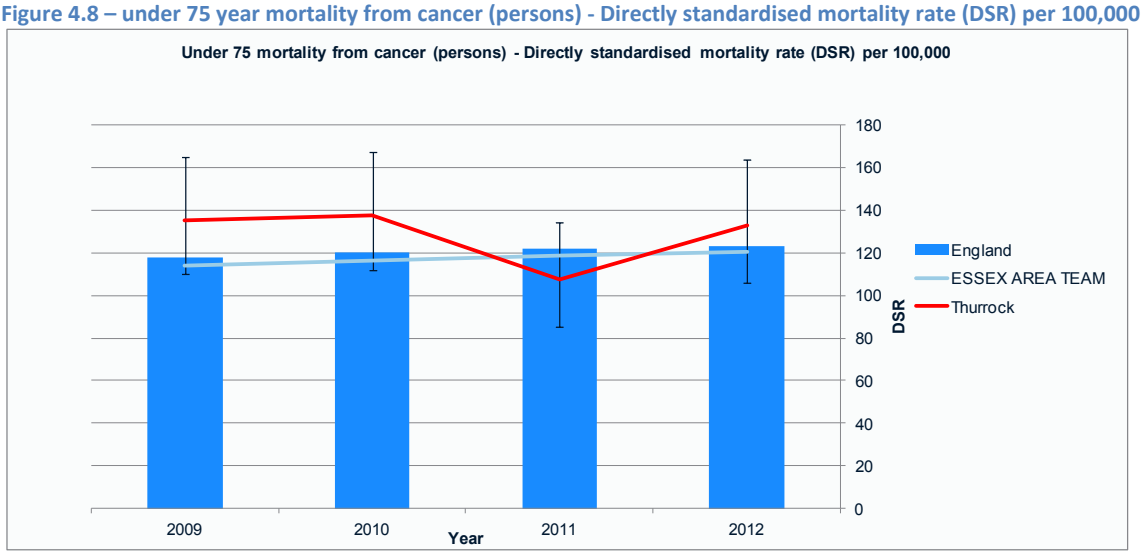
In scenario 1, numbers of patients living with cancer in Thurrock in time period from 2010 to 2030 is predicted to double, and in scenario 2, numbers of predicted to increase by 22%. Both scenarios have significant implications in terms of demands on local health and care systems.

4.3 Cancer mortality

4.3.1 All cancers

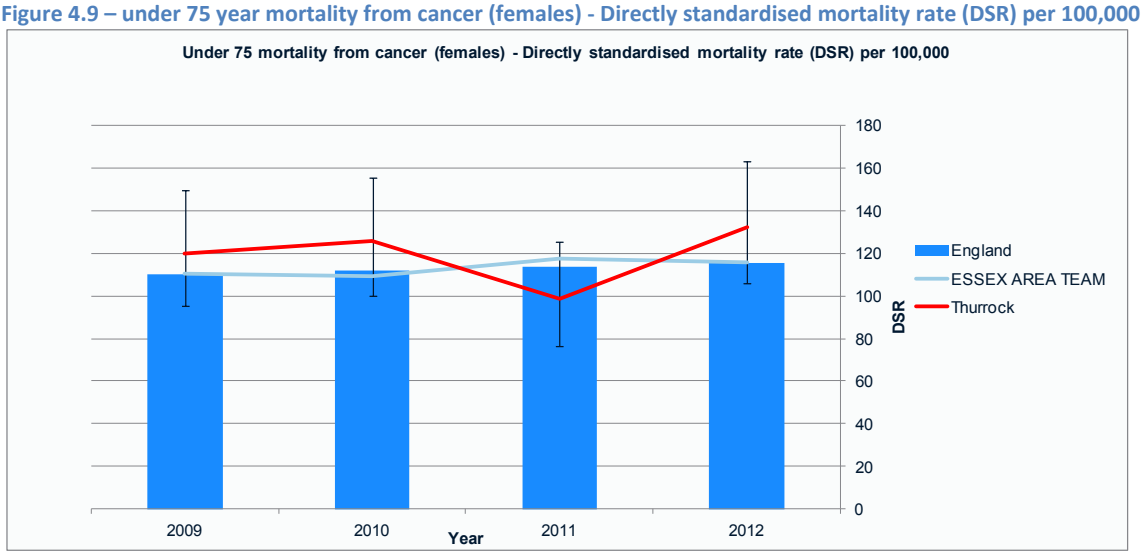
Figures 4.9-4.10 show the directly standardised mortality rates for under-75 year olds from cancer. These data highlight that deaths for women in Thurrock is slightly above the England and Essex rate. However the 95% confidence intervals for Thurrock indicate that this is likely to be due to random fluctuations over time and is not considered to be statistically significant

Figure 4.8 – under 75 year mortality from cancer (persons) - Directly standardised mortality rate (DSR) per 100,000



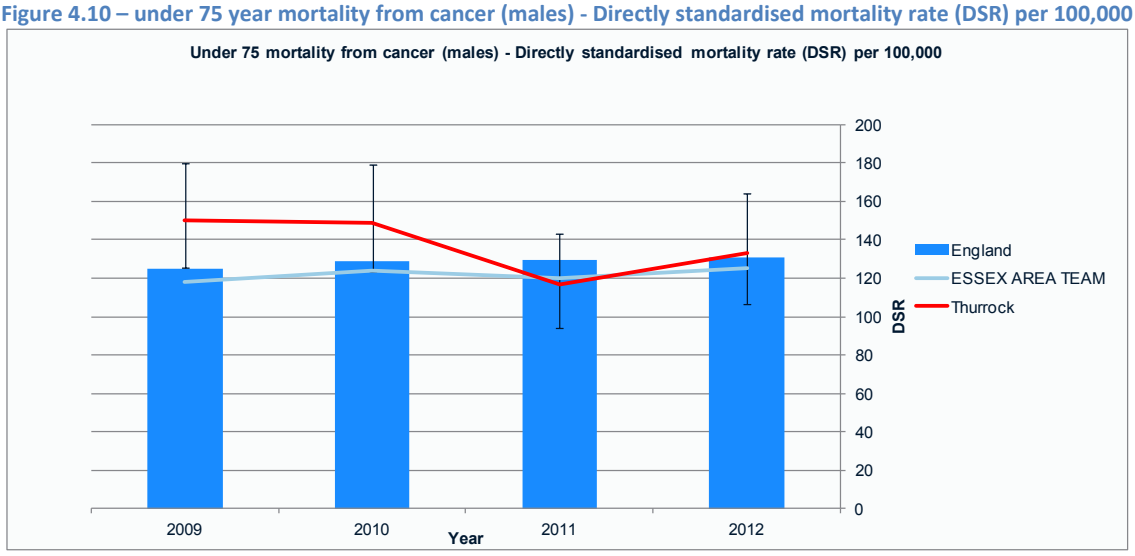
Taken from: Health and social care Information centre - https://indicators.ic.nhs.uk/webview/

Figure 4.9 – under 75 year mortality from cancer (females) - Directly standardised mortality rate (DSR) per 100,000



Taken from: Health and social care Information centre - https://indicators.ic.nhs.uk/webview/

Figure 4.10 – under 75 year mortality from cancer (males) - Directly standardised mortality rate (DSR) per 100,000



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4.3.2 Mortality from different types of cancer

Figure 4.11-14 shows under 75 mortality from different types of cancer and compares to England and East of England rates. There is no significant difference to England and east of England rates. DSRs for cervical cancer are considerably lower when compared to breast and prostate cancer rates for those aged under 75 years.

Figure 4.11 – under 75 year mortality from breast cancer (females) - Directly standardised mortality rate (DSR) per 100,000 (2010-12)

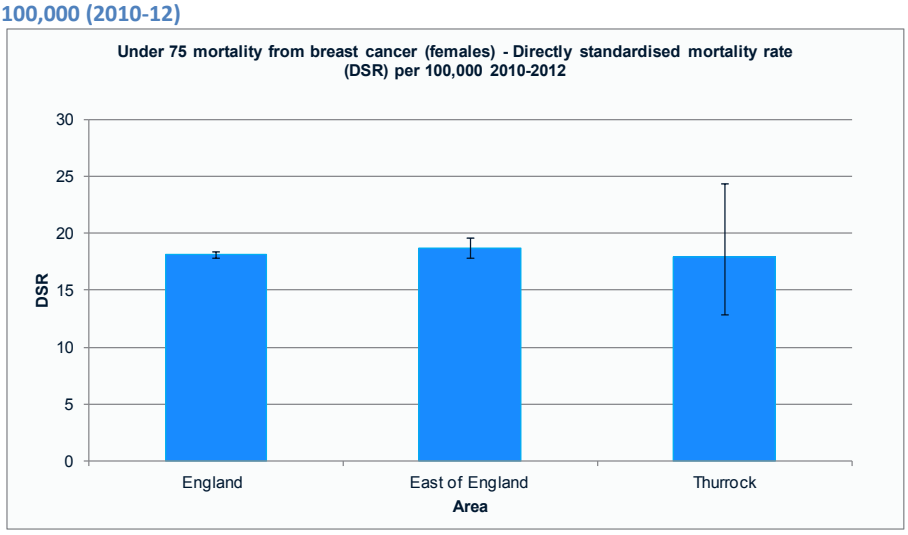

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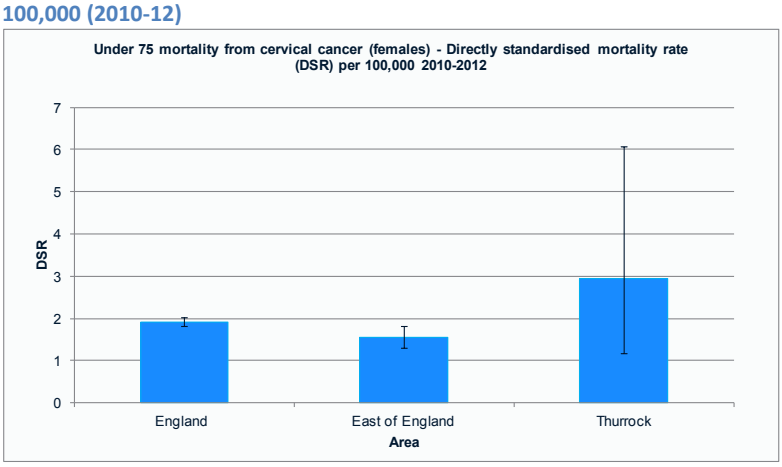
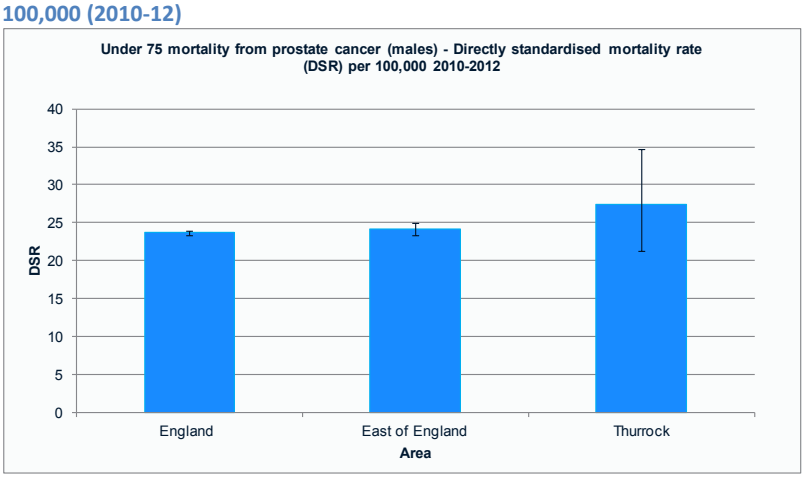
Figure 4.12 shows a higher mortality rate from cervical cancer in Thurrock when compared to England and East of England. However these data have wide confidence intervals (due to small numbers) so are not statistically significant. Similar findings for prostate (figure 6).

Figure 4.12 – under 75 year mortality from cervical cancer (females) - Directly standardised mortality rate (DSR) per 100,000 (2010-12)



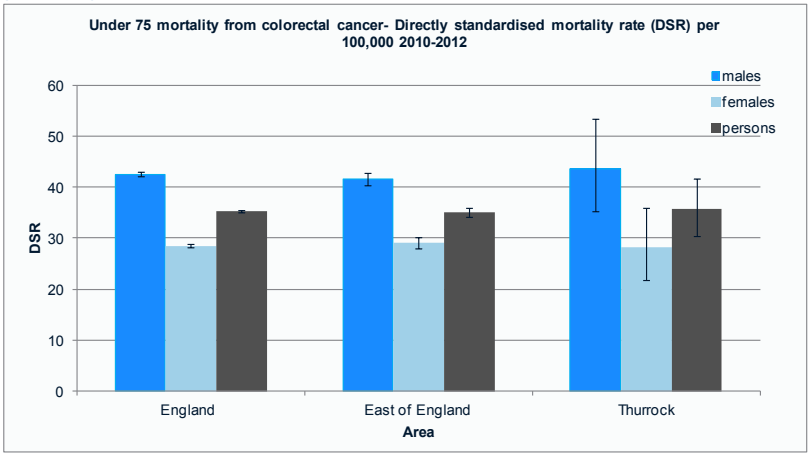
Taken from: Health and social care Information centre - https://indicators.ic.nhs.uk/webview/

Figure 4.13 – under 75 year mortality from prostate cancer (males) - Directly standardised mortality rate (DSR) per 100,000 (2010-12)



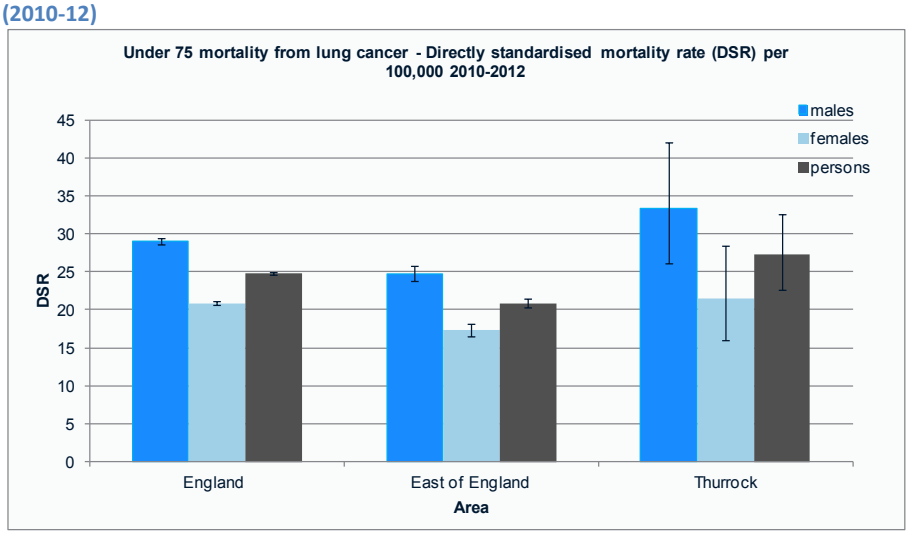
Taken from: Health and social care Information centre - https://indicators.ic.nhs.uk/webview/

Figure 4.14 – under 75 year mortality from colorectal cancer - Directly standardised mortality rate (DSR) per 100,000 (2010-12)



Taken from: Health and social care Information centre - https://indicators.ic.nhs.uk/webview/

Figure 4.15 – under 75 year mortality from lung cancer (females) - Directly standardised mortality rate (DSR) per 100,000 (2010-12)



Taken from: Health and social care Information centre - https://indicators.ic.nhs.uk/webview/

4.4 Summary of Cancer Epidemiology

The most common new diagnoses for cancer in Thurrock are breast, urological, lung and lower GI and that order.

Thurrock has the highest rate of lung cancer new diagnoses in its ONS comparator population groups but the lowest rate of breast cancer. However there is little or no statistically significant difference between cancer incidences in different ONS comparator populations.

The most prevalent cancers in the Thurrock population (over a 20 year period) are breast, prostate, colorectal and lung, in that order. There are 2135 people in Thurrock, diagnosed with cancer in the last 20 years who are still alive.

The number of people living with cancer in Thurrock over the next 20 years is predicted to rise significantly. This is due to a combination of factors including an ageing population, earlier diagnosis and better treatment.

Mortality from cancer within the general population of Thurrock over the past five years is not statistically significantly different to England's or Essex.

5. Cancer Prevention: Smoking

5.1 Introduction

Research suggests that at least one-third of all cancer cases are preventable. Prevention offers the most cost-effective long-term strategy for the control of cancer. There are five major modifiable factors that impact on cancer incidence:

- Tobacco consumption
- Diet, physical activity and obesity
- Alcohol consumption
- Infections
- Environmental factors such as air pollution

However, tobacco use is the single greatest avoidable risk factor for cancer mortality worldwide, causing an estimated 22% of cancer deaths per year. In 2004, 1.6 million of the 7.4 million cancer deaths were due to tobacco use.

Tobacco smoking causes many types of cancer, including cancers of the lung, oesophagus, larynx (voice box), mouth, throat, kidney, bladder, pancreas, stomach and cervix. About 70% of the lung cancer burden can be attributed to smoking alone. Second-hand smoke (SHS), also known as environmental tobacco smoke, has been proven to cause lung cancer in non-smoking adults. Smokeless tobacco (also called oral tobacco, chewing tobacco or snuff) causes oral, oesophageal and pancreatic cancer.

Ensuring that Thurrock CCG's commissioned provider patient facing staff and member GP practices support the reduction in smoking prevalence by proactively referring smokers to NHS quit services, is the single most important contribution the CCG could make to the cancer prevention agenda. As such, this section concentrates on the issue of smoking and smoking cessation in Thurrock.

5.2 Smoking Prevalence

Smoking prevalence is the proportion of smokers within our population within a given year. The actual estimated prevalence of smoking amongst Thurrock residents depending on the definition of what constitutes a smoker (i.e. how regularly an individual smokes a cigarette), the age of the population studied and the method of sampling.

Figure 5.1 shows the estimated prevalence of smoking in adults aged 18+ sampled through the Integrated Household Survey in 2014 for Thurrock and its CIPFA comparator populations. (These are local authority populations that have similar demographics to that of Thurrock's). Figure 5.2 shows the prevalence of smoking in 15 year olds in 2014/15 sampled through the WAY survey, for Thurrock and its CIPFA comparator local authority populations.

Figure 5.1

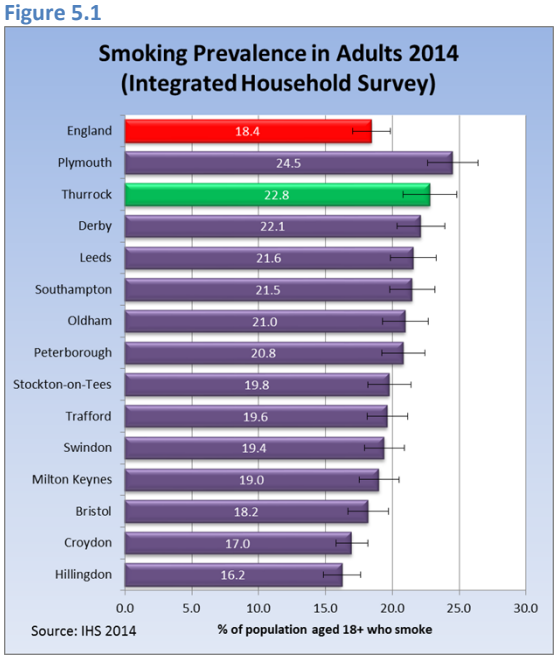
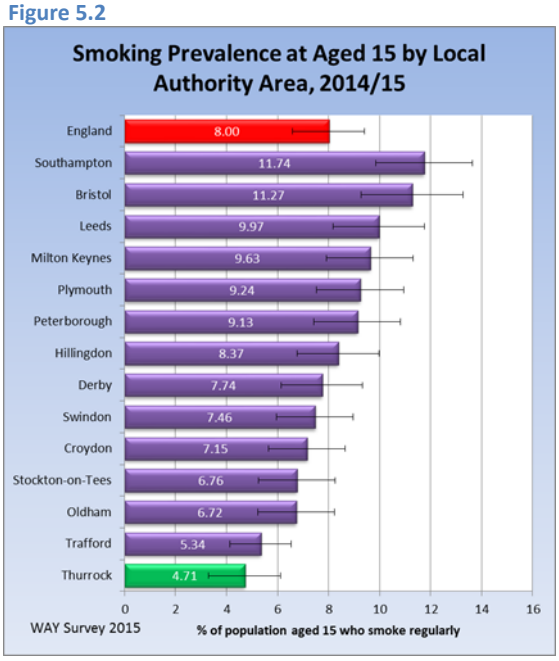


Figure 5.2



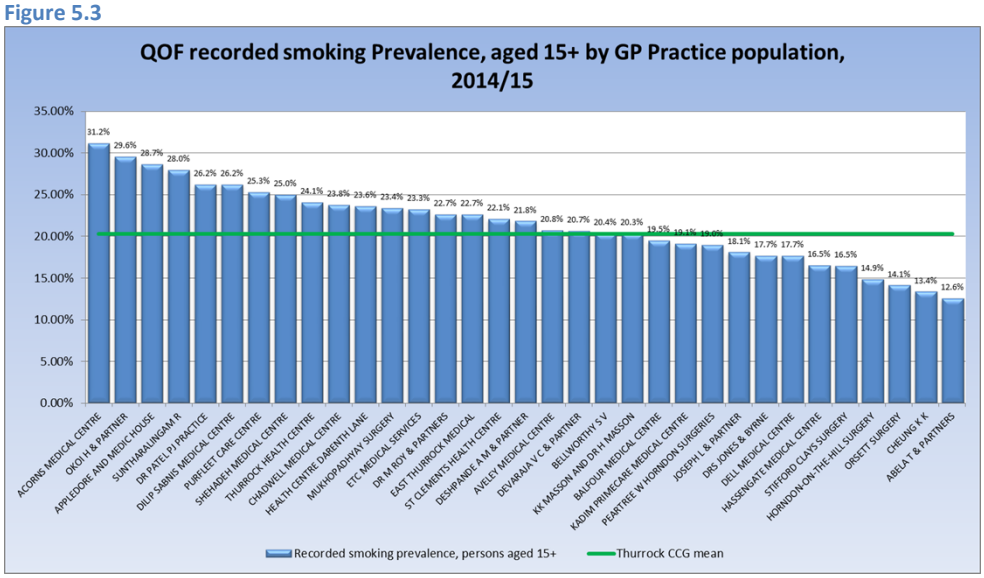
Thurrock's prevalence of smoking in adults aged 18+ is estimated to be 22.8% This is the second highest prevalence in compared to its CIPFA comparators, and statistically significantly greater than England's and seven of the 13 CIPFA comparators.

Conversely Thurrock's smoking prevalence amongst 15 year olds is estimated at 4.71%. This is the lowest compared to its CIPFA comparator populations and statistically significantly lower than England's and eight of its CIPFA comparators.

The incongruence between these two prevalence figures may suggest that Thurrock's population start smoking later than its comparators, or that once addicted, a smaller proportion are able to successfully quit.

Figure 5.3 shows the prevalence of smoking amongst CCG member practice populations and for Thurrock as a whole for those patients aged 15+.

Figure 5.3



The overall prevalence of smoking as reported through QOF (21.1%) is lower than that reported through the IHS. This may be due to differences in the age range of the population studied, and the fact that patients may be reluctant to admit to their GP or practice nurse that they are a smoker. There is considerable variation in prevalence between GP practice populations.

Figure 5.4 shows the QOF recorded prevalence in patients aged 15+ by quintile of practice population IMD deprivation score in 2014/15. Figure 5.5 shows the association between practice deprivation score and recorded smoking prevalence in patients aged 15+

Figure 5.4

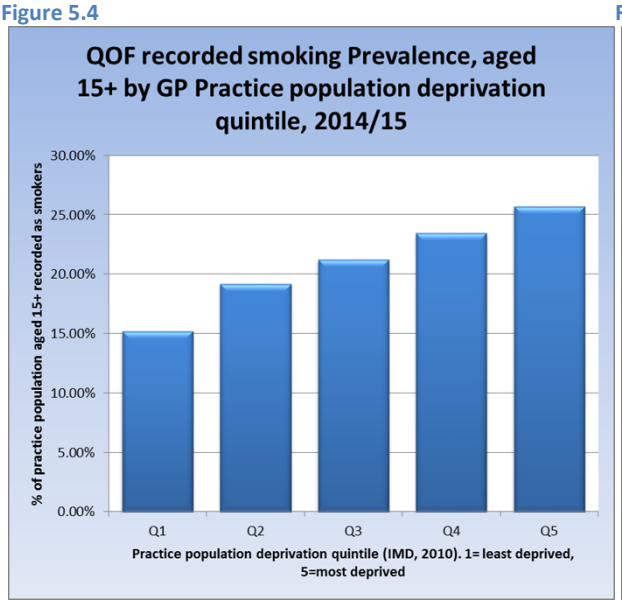
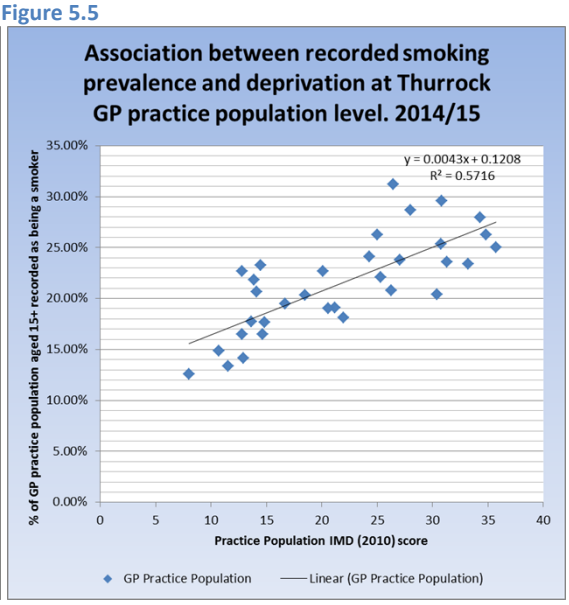


Figure 5.5

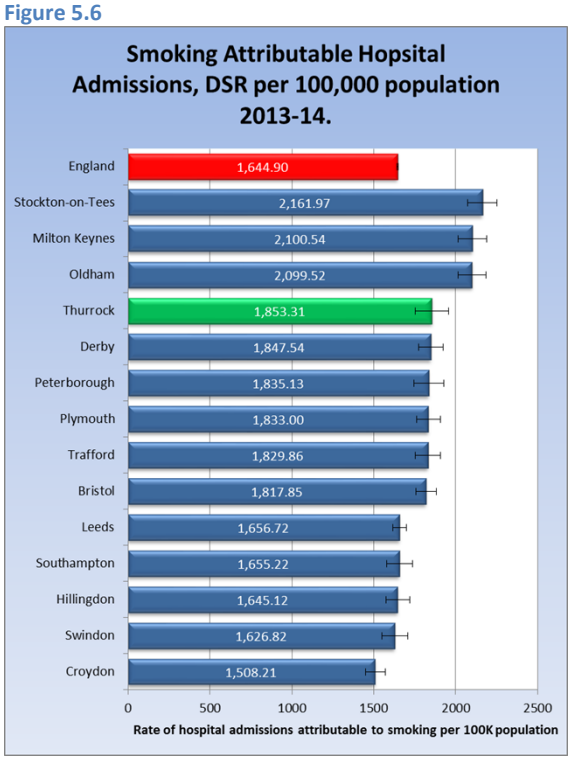


Figures 5.4 and 5.5 show a strong positive association between deprivation and smoking prevalence in Thurrock. This is in line with national published research suggesting that differences in smoking prevalence between affluent and deprived communities is a major driver of health inequalities.

5.3 Smoking Attributable Hospital Admissions

Figure 5.6 shows the directly standardised rate of smoking attributable hospital admissions per 100,000 population for England, Thurrock and Thurrock's ONS Comparators. Smoking attributable hospital admissions is an epidemiological concept that calculates the total number of excess admissions to hospital caused by the prevalence of smoking in a population.

Figure 5.6

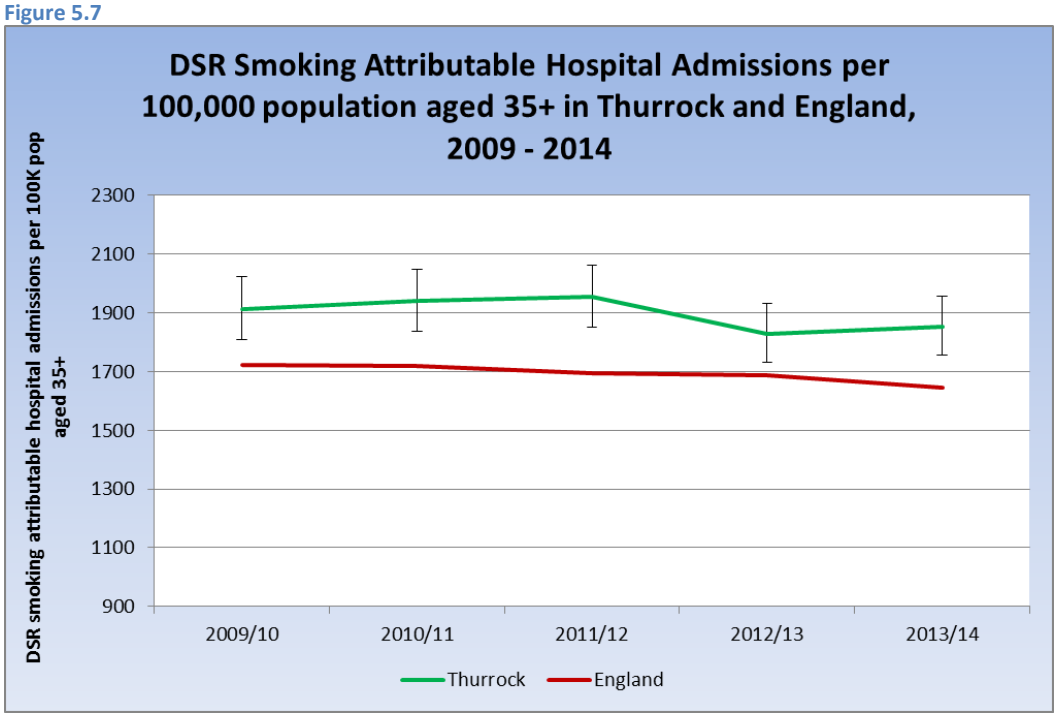


Thurrock has a directly standardised rate of smoking attributable hospital admissions that is significantly greater than England's and five of its comparator CCGs. This is likely to be a product of high overall smoking prevalence within the Thurrock population.

In Thurrock, in 2014/15 there were 1356 excess admissions as a result of smoking prevalence. At an average cost of £2800 per admission, this equates to almost £3.8M of excess spend in hospital admissions, charged to NHS Thurrock CCG that can be directly attributable to smoking.

Figure 5.7 shows the directly standards rate of hospital admissions per 100,000 population aged 35+ in Thurrock and England over time.

Figure 5.7

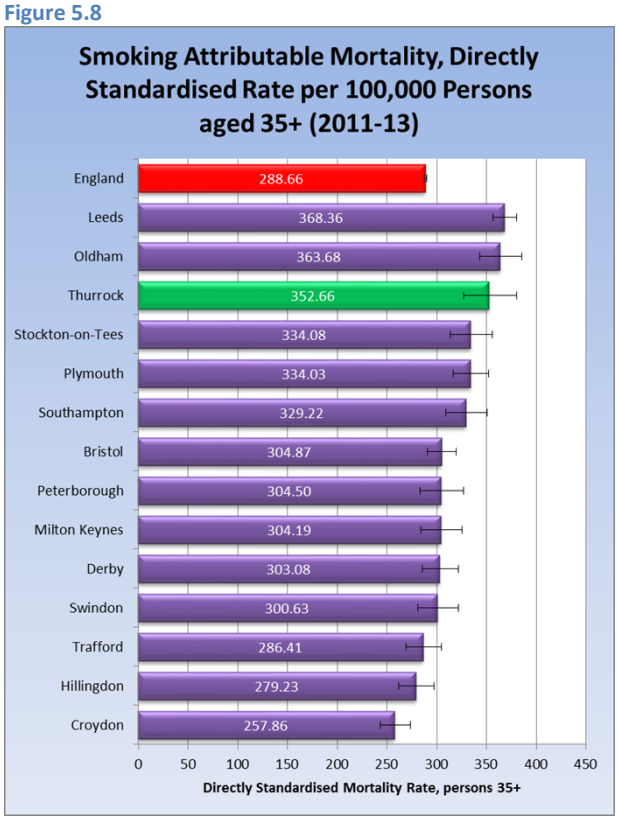


Thurrock has had a rate of smoking attributable hospital admissions that is significantly greater than England's for every year since 2009. There has been no significant decrease in the rate of smoking attributable hospital admissions in the population of Thurrock since 2009. This suggests a failure of the local health system to address successfully the issue of smoking in our local population over the last five years.

5.4 Smoking Attributable Mortality

Figure 5.8 shows the directly standardised rate of smoking attributable mortality per 100,000 populations for England, Thurrock and Thurrock's ONS comparator populations between 2011 and 2013 for those aged 35+. Smoking attributable mortality is an epidemiological concept that calculates the excess number of deaths within a population that can be attributable to smoking.

Figure 5.8



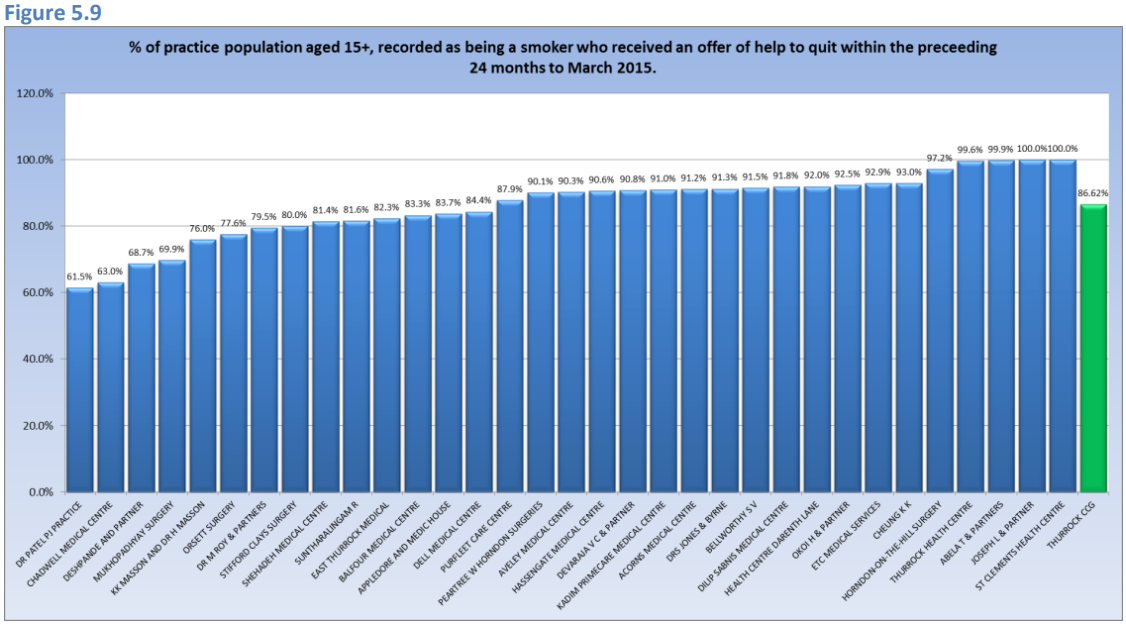
Thurrock has the third highest standardised rate of smoking attributable mortality compared to its ONS comparator populations, and a rate that is significantly greater than England's and eight of its ONS comparators. Between 2011 and 2013 there were 706 excess deaths in the Thurrock population that can be attributable to smoking prevalence within our population.

5.5 Smoking Cessation

The Quality Outcomes Framework (QOF) has targeted GP practices to offer support to patients recorded as smokers, to encourage them to quit for the last decade. Similarly Public Health has commissioned GP practices, pharmacists and NELFT to provide NHS stop smoking services to patients.

Figure 5.9 shows the percentage of recorded smokers at GP practice level who had a record of having received an offer of support to quit smoking in the preceding 24 months by their practice.

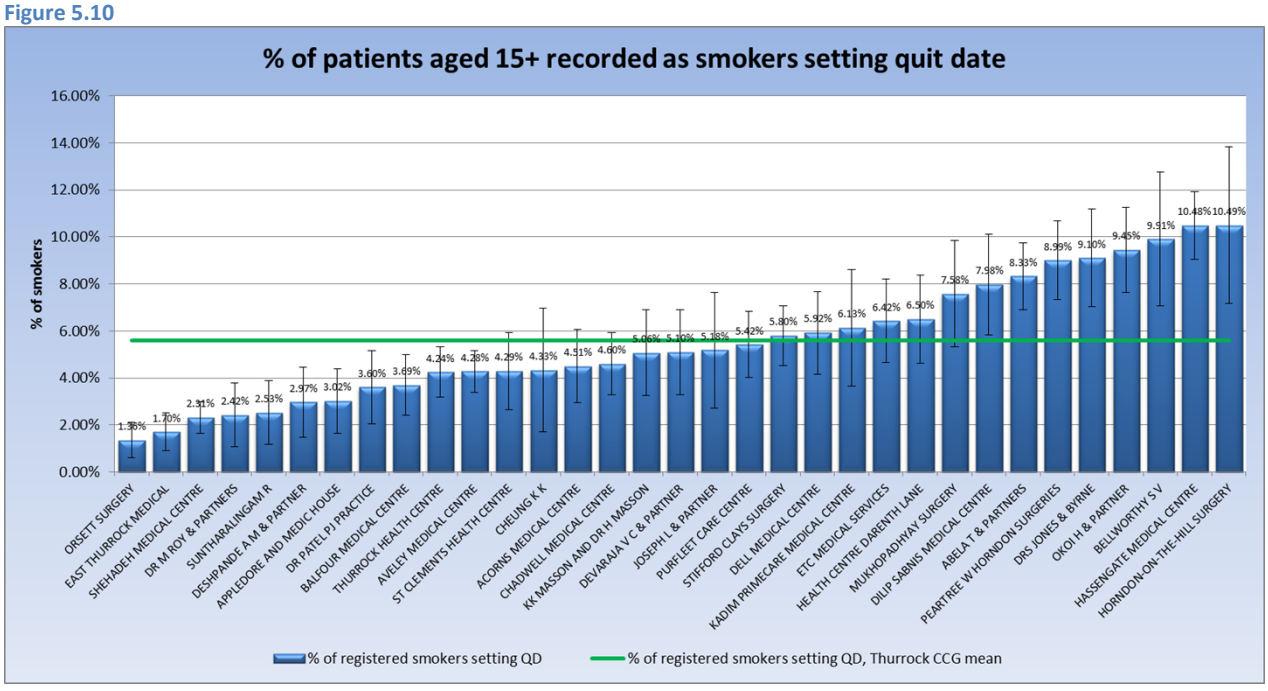
Figure 5.9



Overall, 86.2% of patients in Thurrock aged 15+ recorded as smokers received an offer of support to quit in the preceding 12 months to March 2015. However this varied considerably between different practices, from 61.2% to 100%

Figure 5.10 shows the percentage of patients aged 15+, recorded as smokers within each GP practice population who set a quit date using an NHS stop smoking service in 2014/15.

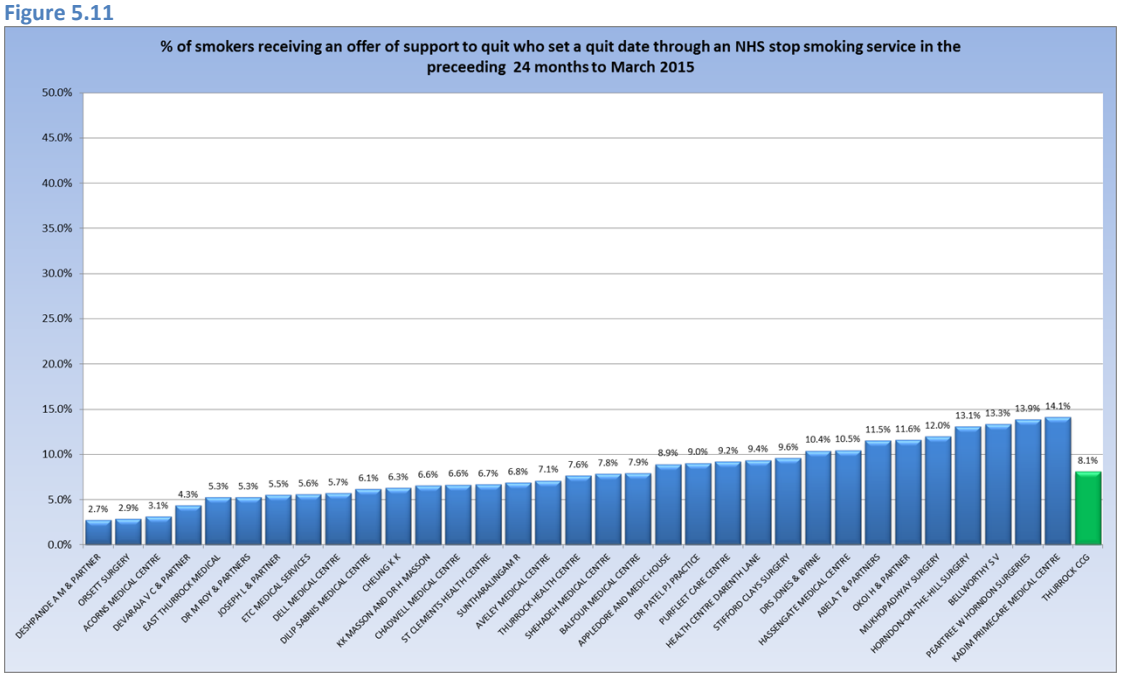
Figure 5.10



Research suggests that 75% of current smokers want to stop smoking. However only 5.8% of patients aged 15+ recorded as smokers set a quit date using an NHS stop smoking service in 2014/15. However there was considerable variation between GP practice populations and a more than seven fold difference between the practice population with the highest and lowest proportion of smokers setting a quit date through an NHS stop smoking provider.

Figure 5.11 shows the "conversion ratio" of smokers offered support to quit: smokers setting a quit date at GP practice population level.

Figure 5.11



Of smokers who were offered support to quit, 8.1% went on to make a quit attempt across all Thurrock GP practices. However there is again huge variation between different practice populations. Figure 5.12 examines the association between GP practice population deprivation score and the conversion ratio shown in figure 5.11

Figure 5.12

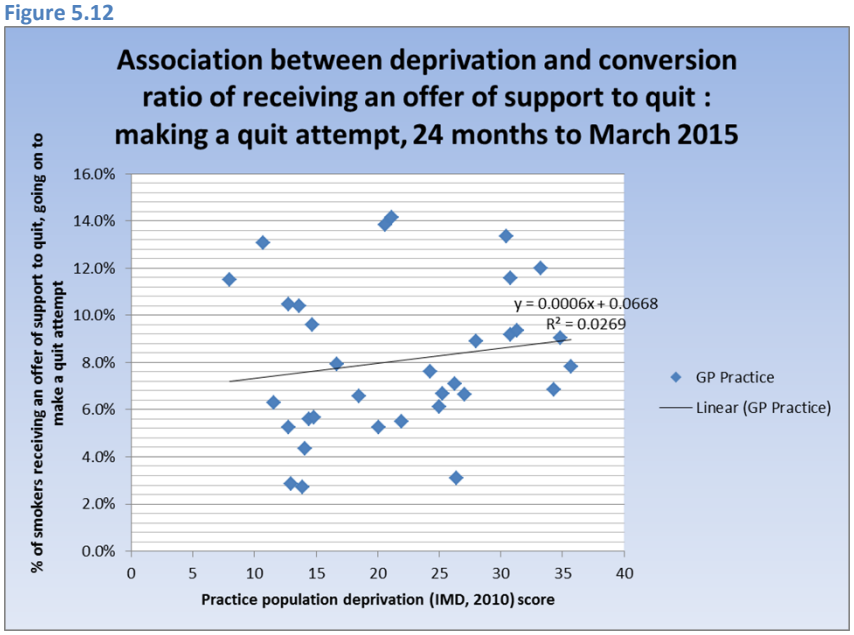


Figure 5.12 shows no significant association between practice population deprivation and conversion ratio from being offered support to quit to making a quit attempt. This may suggest a variation in the quality of the level 1 smoking cessation conversation between practice staff and patients at GP practice level and warrants further investigation.

Figure 5.13 shows the percentage of patients recorded as smokers who successfully quit smoking through an NHS stop smoking service in 2014/15. Figure Q shows the estimated percentage of patients aged 15+ recorded as smokers who will successfully quit permanently through an NHS stop smoking service.

Figure 5.13

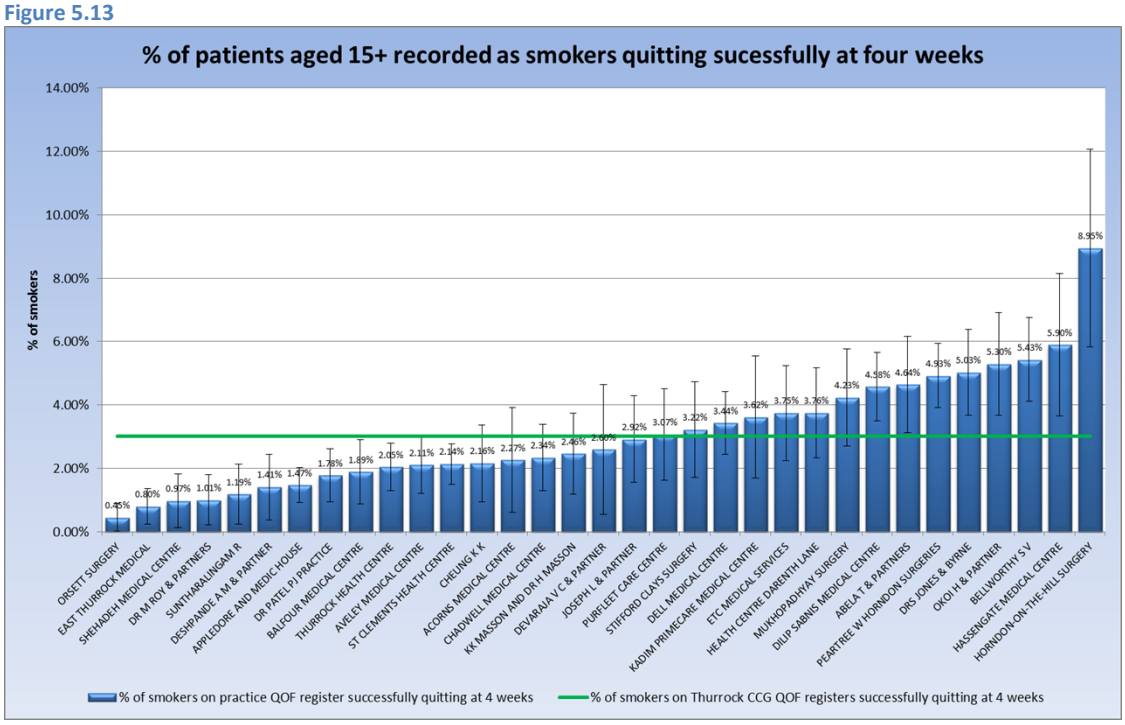
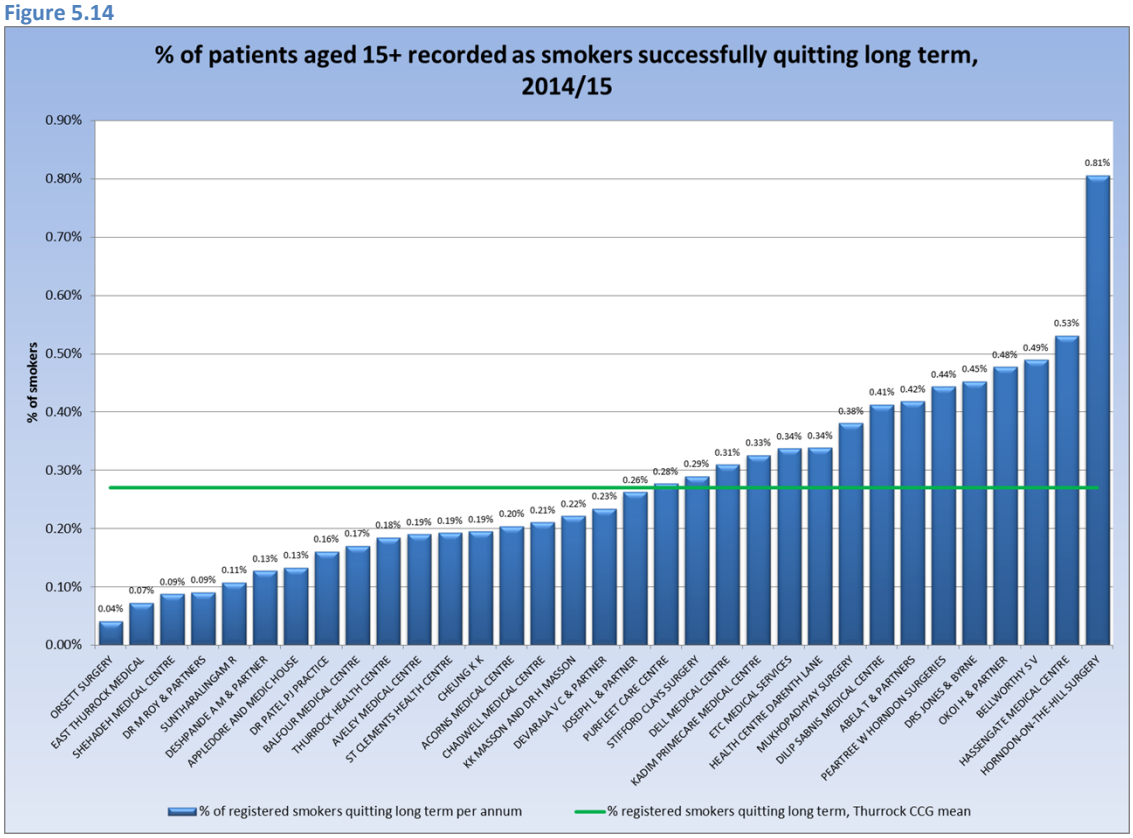


Figure 5.14



Both figures 5.13 and 5.14 show huge variation between different GP practice populations. In 2014/15, it is estimated that fewer the 0.3% of patients recorded as smokers will quit permanently as a result of

commissioned stop smoking services. This is a product of both a failure to refer sufficient smokers into NHS stop smoking services, and the impact of the services themselves on long term quit success. Modelling by the author suggests that only 74 smokers in Thurrock will successfully quit smoking permanently as a result of current commissioned stop smoking services. It can therefore be concluded that as a health and social care system, we are abjectly failing to have any significant impact on smoking prevalence in Thurrock as a result of the current commissioning arrangements. This warrants urgent further investigation and action.

5.6 Summary Prevention: Smoking

It is estimated that between 21.1% to 22.8% of adults in Thurrock smoke, depending on the age range studied and the method of sampling.

Thurrock has a smoking prevalence significantly greater than England's and many of its comparator populations

Smoking is strongly positively associated with deprivation in Thurrock, and is therefore a key driver of health inequalities.

Thurrock has rates of hospital admissions and mortality attributable to smoking that are significantly greater than England's and many of its comparator populations. There were an estimated 1356 additional hospital admissions amongst our population in 2014/15 as a result of the levels of smoking prevalence in our population, resulting in an additional £3.8M of cost to NHS Thurrock CCG and an additional deaths that can be attributable to smoking prevalence.

There has been no significant reduction in rates of smoking attributable hospital admissions over the past five years.

Despite 86.6% of smokers having a record of an offer of help to quit smoking by their GP practice, fewer than 6% made a quit attempt through an NHS stop smoking service in the preceding 24 months to March 2015. There is significant variation between different GP practice populations and this cannot be explained by differences in deprivation levels between practice populations.

The Health and Social Care system in Thurrock is failing to have any significant impact on smoking prevalence in our local population through smoking cessation work. It is estimated that fewer than 0.3% of smokers successfully quit long term in 2014/15 as a result of a commissioned stop smoking service. This is a product of both a failure to refer smokers into stop smoking services and the success of services to help people to successfully quit long term.

5.7. Recommendations: Prevention – Smoking

1. Public Health should undertake a comprehensive review of current commissioning arrangements on tobacco control with a view to significantly improving the impact that future providers are having on smoking prevalence in Thurrock and achieving a minimum 1% prevalence reduction per annum. This should be monitored as part of the outcomes framework in the Joint Health and Wellbeing Strategy refresh.

2. Thurrock CCG should amend current commissioning arrangements with NELFT, SEPT and BTUH, and Thurrock Council with its front line providers to include an obligation them routinely to identify and refer patients who smoke into Public Health commissioned stop smoking services. Minimum agreed numbers of referrals should be incorporated into all contracts and routinely performance managed.

3. Thurrock Council should train its front line staff in 'Making Every Contact Count' and include identification and referral of smokers into commissioned stop smoking services.

4. Public Health should commission its stop smoking provider to provide further support and training to front line practice staff to improve the conversion ratio of patients offered support to quit who go on to make a quit attempt through a commissioned stop smoking service.

6. Cancer screening

6.1 Introduction

Early identification of many types of cancer results in better treatment outcomes for patients. Cancer screening programmes aim to identify people likely to have cancer such that they can be referred for further diagnostic tests and if necessary for treatment. A positive screen in a cancer screening programme is not equivalent to a cancer diagnosis, but suggests that further investigation is necessary to ascertain whether or not the patient has cancer.

National cancer screening programmes are delivered by the NHS. They are coordinated by the national office of the NHS Cancer Screening Programmes, part of Public Health England. Commissioning and monitoring of local programmes is the responsibility of a local team of Public Health England based within the NHS England East office.

There are three cancer screening programmes:

- the NHS Cervical Screening Programme
- the NHS Breast Screening Programme
- the NHS Bowel Cancer Screening Programme.

Table 1 overleaf provides a breakdown of available datasets for cancer screening.

Table 1 – summary of National Cancer Screening Programme data available from NHS England

PROGRAMME	Name of indicator(s)	Definition	Standard	Target	How often	Data source	Level(s) of data available
Bowel cancer screening	Uptake	Proportion of eligible people adequately screened out of those invited for FOBt screening	≥60%		Quarterly & annually	Bowel screening hub	CCGs/ former PCT area / by provider
	Positivity rate	Proportion of people with a definitive FOBt outcome of 'abnormal' out of those who were adequately screened	2%		Quarterly & annually	Bowel screening hub	CCGs/ former PCT area / by provider
Breast cancer Screening	Coverage	Proportion of eligible women who have had a screening mammogram at least once in the previous three years	≥ 70%	≥ 80%	Annually	KC63	Former PCT area / by provider
	Round length	Proportion of eligible women whose first offered appointment is within the last 36 months of their previous screen	>90% within 36 months		Quarterly & annually	QA report / opensite	by provider
	Screen to normal	Proportion of women reported in period who received their results within 2 weeks	>90% within 2 weeks		Quarterly & annually	QA report / opensite	by provider
	Screen to assessment	Proportion of women actually assessed in reporting period within 3 weeks	>90% within 3 weeks		Quarterly & annually	QA report / opensite	by provider
Cervical cancer screening	Coverage	Percentage of women eligible women adequately screened in the last five years	≥ 70%	≥ 80%	Quarterly & annually	KC53	CCGs/ former PCT area / by provider
	14 day turnaround times (TAT)	Number of days from the date the sample was received by the laboratory to the date the report was issued by the laboratory	≥ 98% within 14 days		Quarterly & annually	QA report / opensite	Former PCT area / provider

6.2 Cervical screening

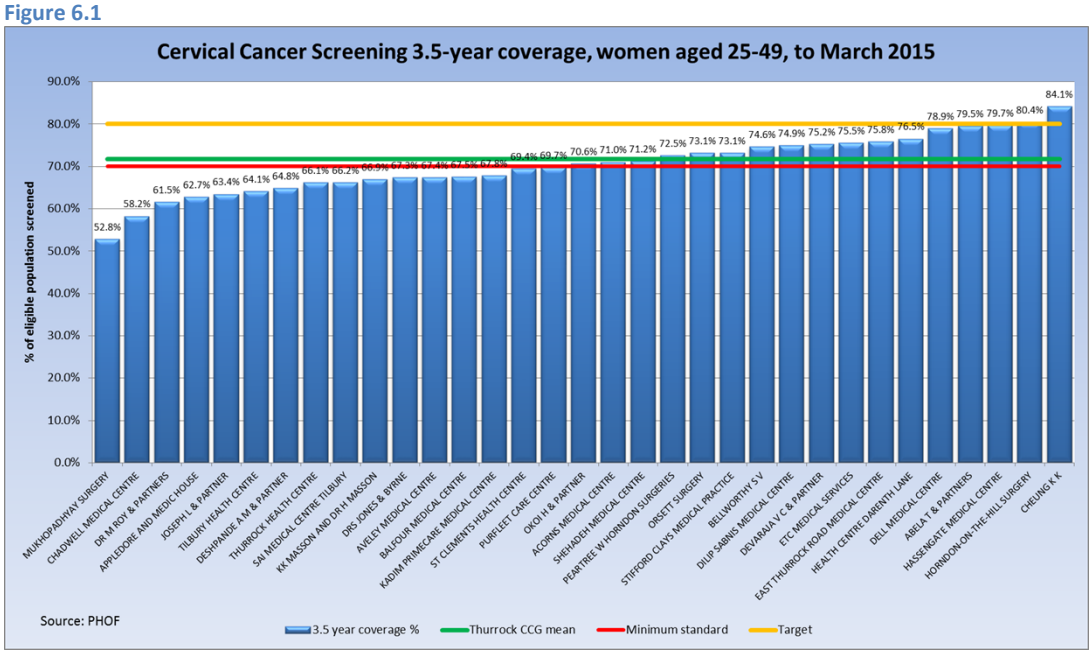
Cervical screening is provided by GP practices. The call-recall system for inviting eligible women for cervical cancer screening is coordinated Primary Care Support Services (PCSE) provided by Capita as Primary Care Support England. PCSE identifies the cohort of women eligible for screening and invites them to make an appointment to attend their GP practice. The cervical screening itself is provided within the patient's GP practice. The programme offers cervical cancer screening to women aged 25-49 every three years and to women aged 50-64 every five years.

6.2.1 Cervical cancer screening coverage in Thurrock

Cervical screening coverage is the percentage of eligible women 25 to 64 years screened adequately within the previous 3.5 or 5.5 years (according to age) on 31st of March.

Figure 6.1 shows the 3.5 year cervical cancer screening coverage for women aged 25-49 by GP practice population in Thurrock as of 31 March 2015, together with the mean rate for Thurrock CCG, the minimum standard and the target coverage rates.

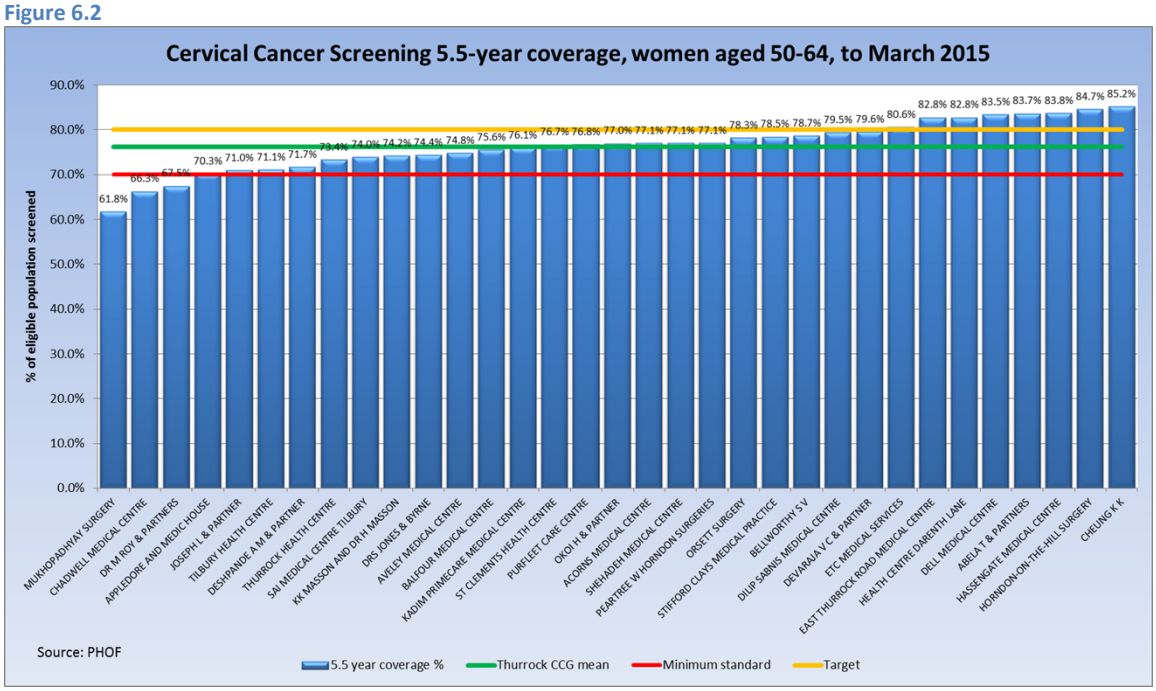
Figure 6.1



The mean screening coverage of patients in this cohort across Thurrock is 71.7% which is above the minimum standard but below the target 80% rate. However there is unacceptable variation in screening coverage between GP practice populations. Only 17 of our 32 GP practices (53.1%) achieve screening coverage at the minimum standard of 70% and only two (6.25%) achieve screening coverage at the target rate of 80%. Half of all practices fail to achieve cervical cancer screening coverage at the minimum 70% standard, potentially resulting in an increased risk of late diagnosis of cervical cancer in a significant proportion of the eligible screening cohort. This warrants further investigation.

Figure 6.2 shows the 5.5 year cervical cancer screening coverage for women aged 50-64 by GP practice population in Thurrock as of 31 March 2015, together with the mean rate for Thurrock CCG, the minimum standard and the target coverage rates.

Figure 6.2



Performance on screening coverage for women aged 50-64 is better than those aged 24-49. The mean screening coverage in this cohort across the CCG is 76.2% and variation between practice populations is lower than that in younger women. All but three practices (90.6%) achieve the minimum 70% coverage standard and a quarter of all practices achieve screening coverage above the 80% target.

6.2.2 Association between Cervical Cancer Screening Coverage and deprivation

Figures 6.3 and 6.4 show the association between Cervical Cancer Screening Coverage at GP practice population level and deprivation for women aged 25-49 and women aged 50-64 respectively together with confidence intervals (at 95% CI) around the 'line of best fit'.

Figure 6.3

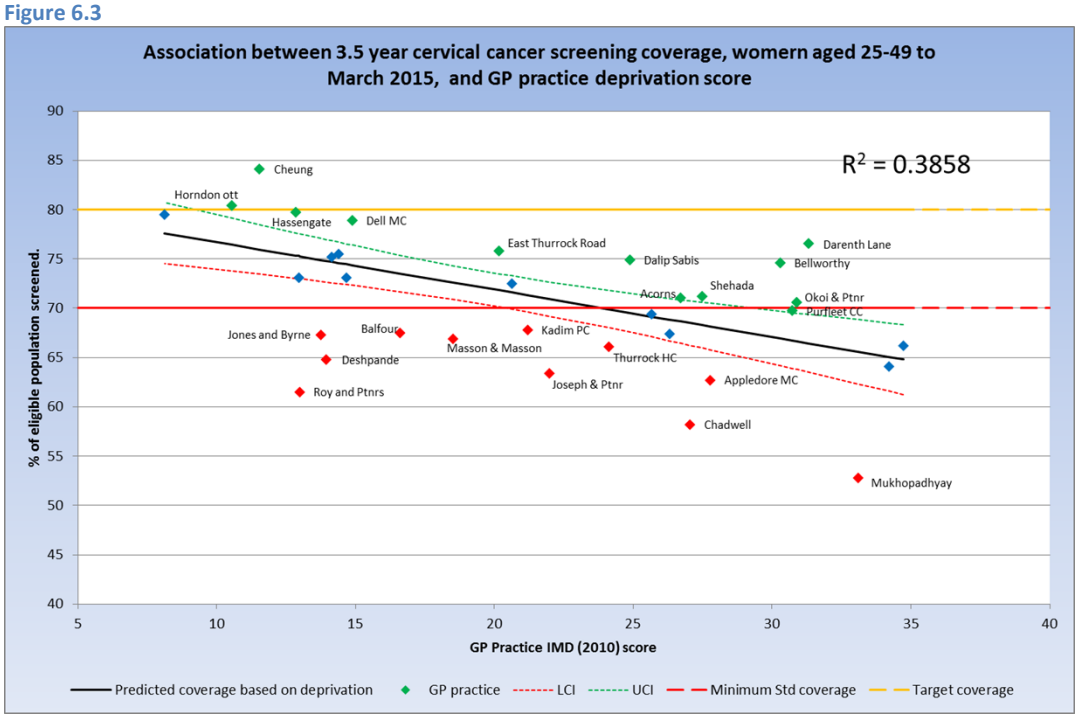
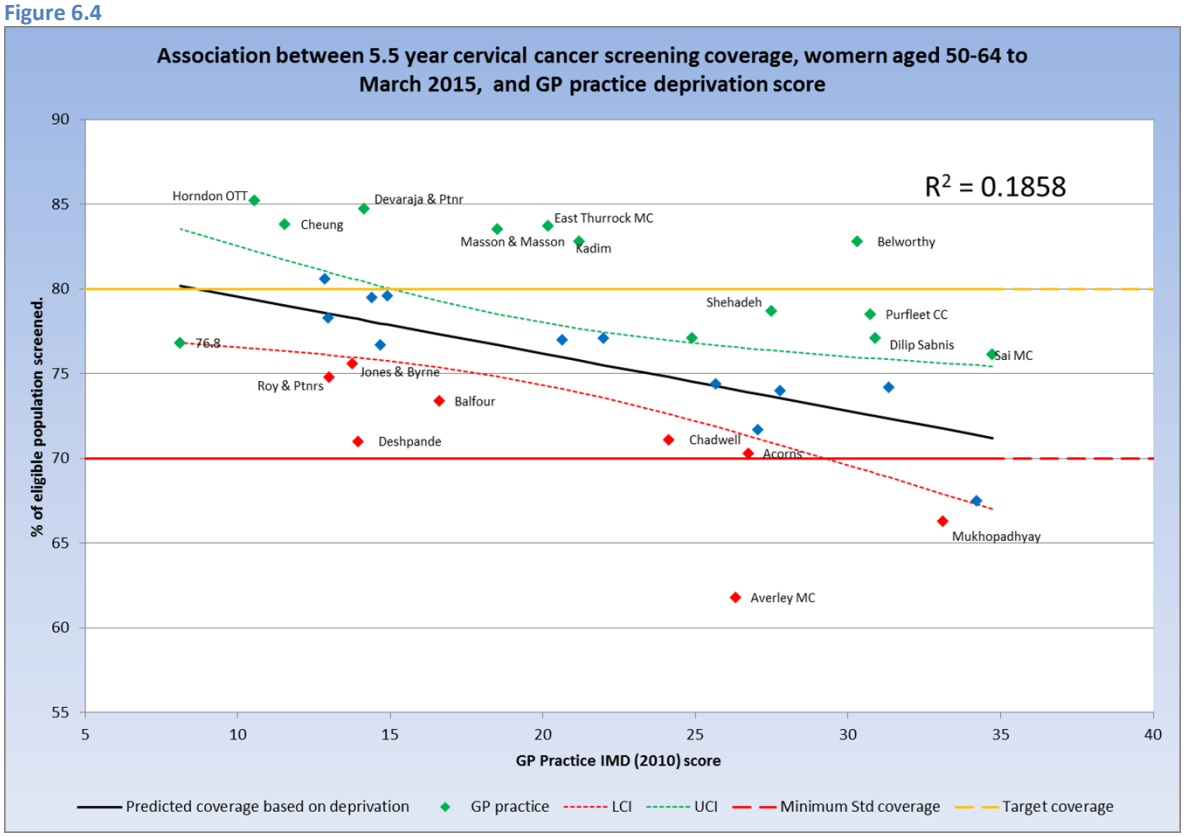


Figure 6.4



There is a reasonable association between practice population deprivation and cervical cancer screening coverage for the cohort of women aged 25-49 (figure 6.3) although this diminishes in women aged 50-64.

Practices marked with a green diamond (above the 95% CI of the line of best fit) have screening coverage that is statistically significantly greater than would be predicted for their level of population deprivation. Similarly practices marked with a red diamond (below the 95% CI of the line of best fit) have screening coverage that is significantly poorer than would be predicted for their level of population deprivation.

For the cohort of women aged 25-49, it is particularly worth noting that Dr. Belworthy and the Darenth Lane practice achieve screening coverage well above what would be expected for their levels of deprivation, despite serving very deprived populations. These 'positive deviants' are worth further investigation to ascertain whether they can share best clinical practice with other GP colleagues.

Similarly practice populations with red triangles, particularly those below the 70% minimum target line warrant further investigation. This is particularly urgent for Aveley Medical Centre and Mukhopadhyay.

6.3 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 year.[1]

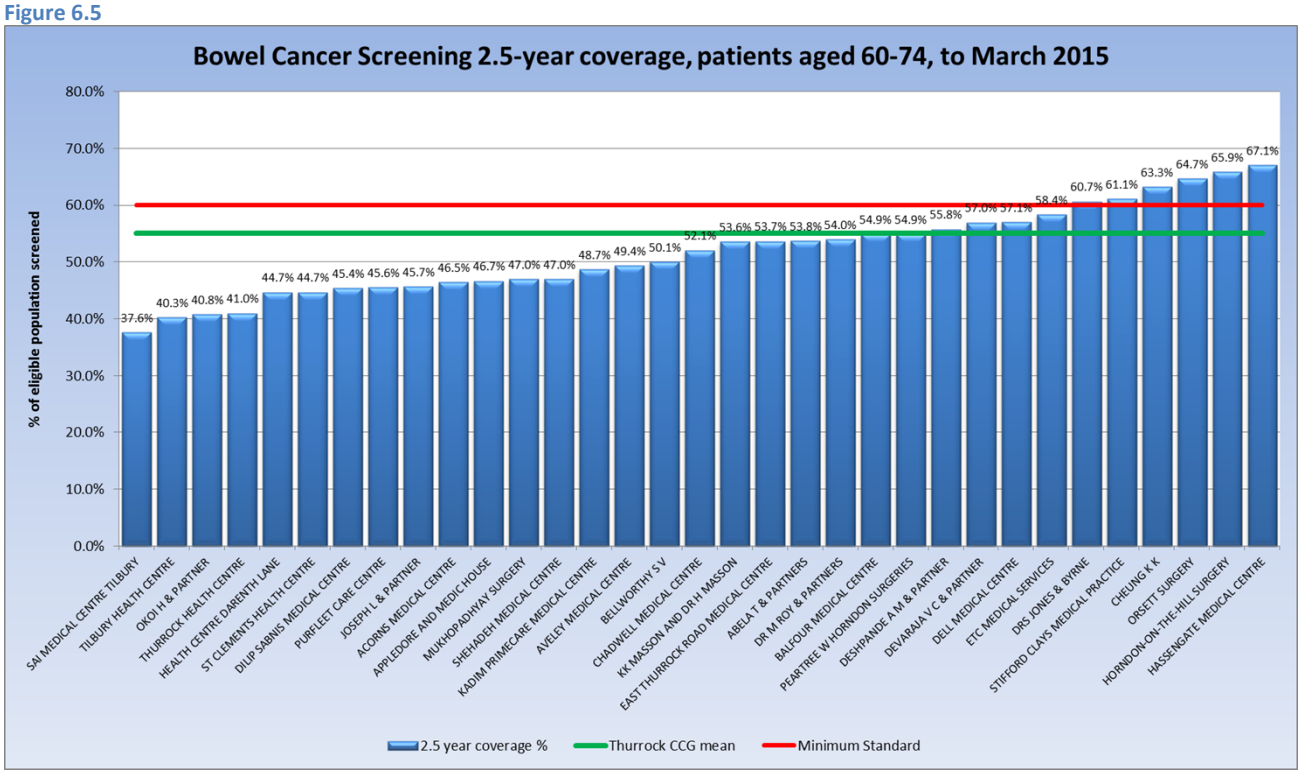
Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16 per cent[2] Men and women aged 60-74 are invited to participate in the bowel cancer screening programme every two years.

GP practices have very little to do with the Bowel Cancer Screening programme. Faecal occult blood testing (FOBt) kits are sent directly to patients from a centralised hub in Nottingham, who return them for screening. Those who screen positive are invited to attend the local Bowel Cancer Screening Programme Centre at Basildon Hospital for a colonoscopy.

6.3.1 Bowel Cancer Screening Coverage in Thurrock.

Figure 6.5 shows the 2.5 year bowel cancer screening coverage for patients aged 60-74 by GP practice population in Thurrock as of 31 March 2015, together with the mean rate for Thurrock CCG, the minimum standard and the target coverage rates.

Figure 6.5

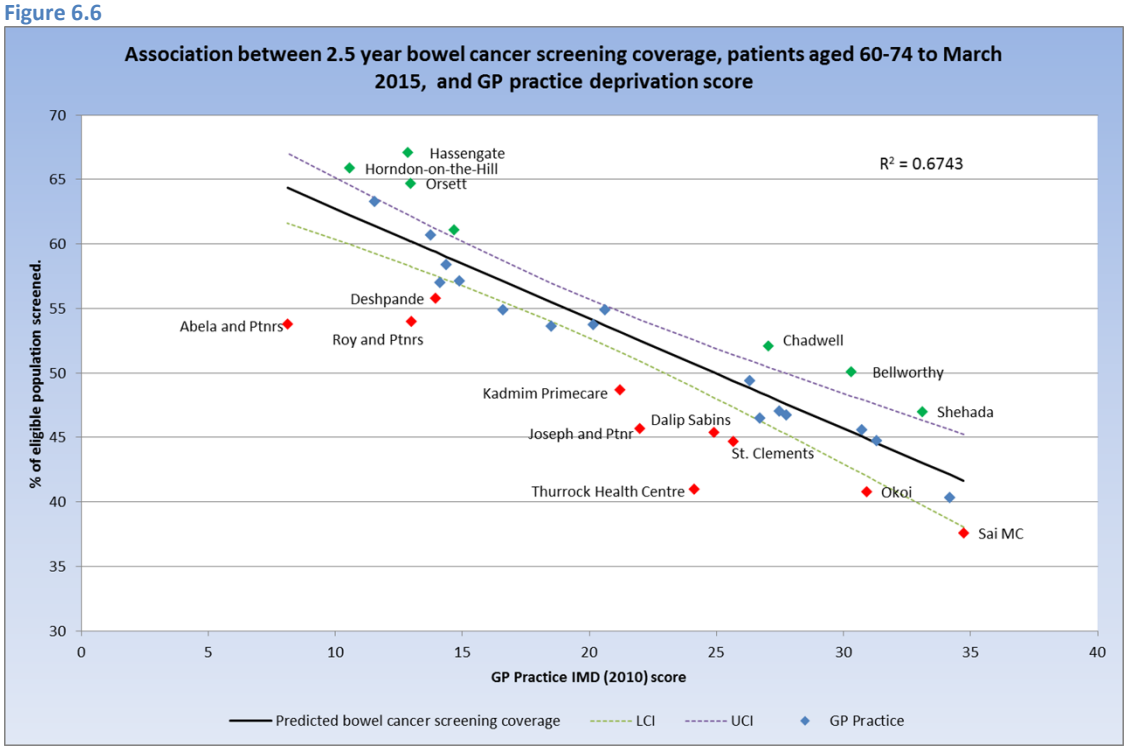


The mean coverage rate for bowel cancer screening in Thurrock in the eligible population is 55%. This is below the national minimum standard of 60%. 26 of the 32 (81.26%) practice populations have screening coverage below the 60% target. There is considerable variation in uptake of bowel cancer screening between GP practice populations, with the lowest coverage rate (Sai Medical Centre) being just over half the that in the population with the highest coverage rate (Hassengate Medical Centre). Given that GP practices have little involvement in this screening programme, the explanation for this is likely to a product of differences within the practice populations themselves.

Variation of this magnitude in uptake of the bowel cancer screening programme between different practice populations is concerning and warrants further investigation.

Figure 6.6 shows the association between bowel cancer screening coverage and GP practice population deprivation score.

Figure 6.6



There is a strong negative association between bowel cancer screening coverage and deprivation. This is concerning as it is likely to be a driver of health inequalities related to cancer. The black line (of best fit) predicts the level of screening coverage at a given deprivation level given the level of association between the two variables. Practices that lie above or below the two confidence intervals around this line can be said to have a screening uptake statistically significantly above (green diamonds) or below (red diamonds) what would be expected given the level of deprivation within their practice population.

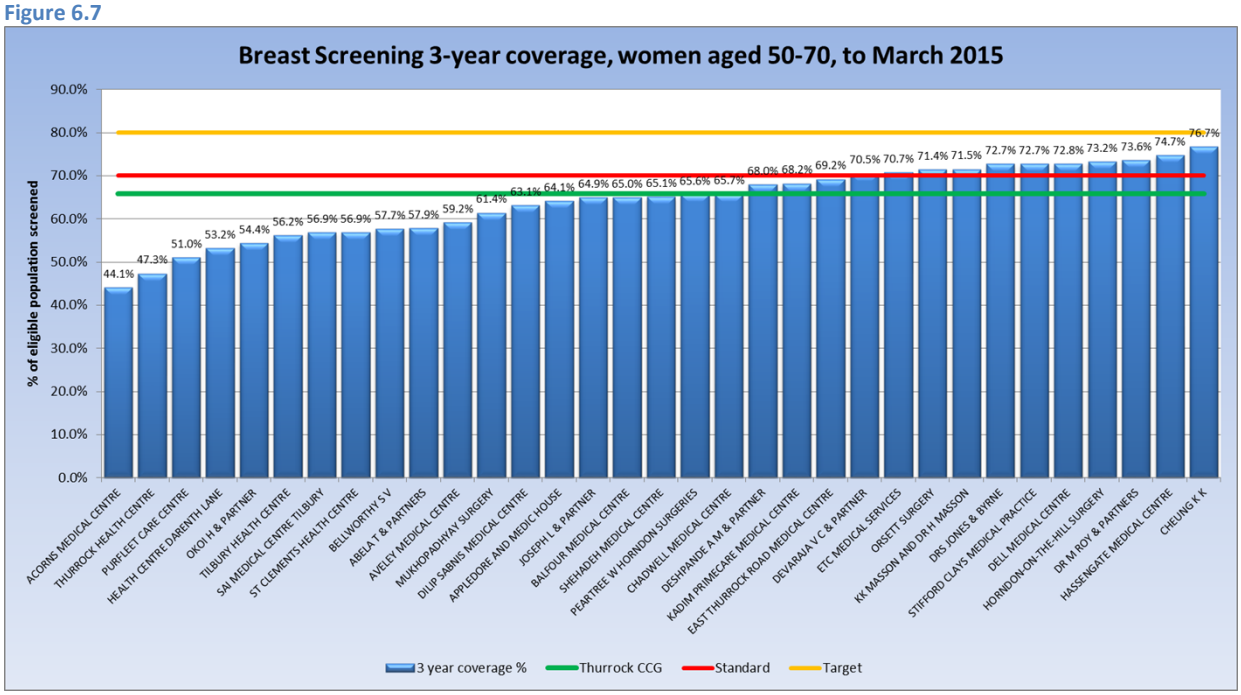
6.4 Breast Cancer Screening

The main objective of the NHSBSP is to reduce the mortality from breast cancer in women invited for screening. In the UK, women aged 50–70 years are invited for screening every three years. It is estimated that breast screening prevents up to 40% of breast cancer deaths in those women who attend for screening. This is because breast cancers can be detected and treated before symptoms are apparent.

The call-recall system for inviting eligible women for breast cancer screening is coordinated Primary Care Support Services (PCSE) provided by Capita as Primary Care Support England. PCSE identifies the cohort of women eligible for screening and sends their details of batches of women to the Southend Breast Screening Unit at Southend Hospital who is responsible for writing to them to invite them for screening. The screening (mammogram) itself is also provided by the same unit at Southend Hospital

Figure 6.7 shows the three year breast cancer screening coverage for patients aged 50-70 by GP practice population in Thurrock as of 31 March 2015, together with the mean rate for Thurrock CCG, the minimum standard and the target coverage rates.

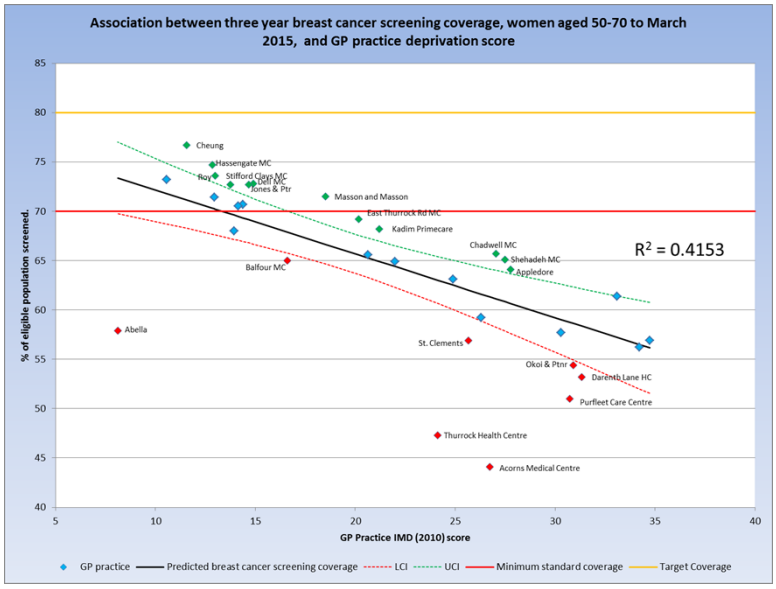
Figure 6.7



The mean screening coverage for this cohort of patients across Thurrock is 65.9% which is below the minimum standard of 70%. Like the other cancer screening programmes previously discussed there is considerable variation in coverage between different practice populations. Only 11 out of the 32 practice populations (34.3%) achieve the minimum 70% coverage standard and none are screened to the target 80% coverage. The practice population with the poorest breast cancer screening coverage rate (Acorns) achieves a rate that is only just over half that of the practice population with the highest coverage. (Cheung). As GP practices have little direct involvement in this programme, the variation between practice populations is likely to be a function of differences within the practice populations themselves. This variation warrants further investigation.

Figure 6.8 shows the association between breast cancer screening coverage and practice population deprivation.

Figure 6.8



There is a reasonably strong negative association between breast screening coverage and practice population deprivation. The black line (of best fit) predicts the level of screening coverage at a given deprivation level given the level of association between the two variables. Practices that lie above or below the two confidence intervals around this line can be said to have a screening uptake statistically significantly above (green diamonds) or below (red diamonds) what would be expected given the level of deprivation within their practice population.

Practices populations marked in red are of particular concern as their breast screening coverage is significantly lower than would be expected for their level of deprivation. This is particularly apparent for Abella, St. Clements, Purfleet Care Centre, Thurrock Health Centre and Acorns Medical Centre. This warrants further investigation.

6.5 Cancer Screening Summary

The mean 3.5 year screening cervical screening coverage of patients aged 25-49 across Thurrock is 71.7% which is above the minimum standard but below the target 80% rate However there is unacceptable variation in screening coverage between GP practice populations. Only 17 of our 32 GP practices (53.1%) achieve screening coverage at the minimum standard of 70% and only two (6.25%) achieve screening coverage at the target rate of 80%. Performance on screening coverage for women aged 50-64 is better than those aged 24-49. The mean screening coverage in this cohort across the CCG is 76.2% and variation between practice populations is lower than that in younger women. All but three practices (90.6%) achieve the minimum 70% coverage standard and a quarter of all practices achieve screening coverage above the 80% target.

Cervical screening coverage for women aged 25-49 is relatively strongly negatively associated with practice population deprivation and could therefore be said to be a driver for health inequalities. 11 practices (Jones and Byrne, Balfour, Deshpande, Roy and Partners, Masson and Masson, Kadim, Joseph and Ptnr, Thurrock Health Centre, Chadwell, Appledore MC and Mukhopadhyay) have screening coverage that is both below the 70% minimum standard and significantly below what would be expected for their level of practice population deprivation. This warrants further investigation. The absolute low level of cervical screening coverage within the Mukhopadhyay practice coupled with the significant distance below what would be predicted for the level of practice deprivation is particularly concerning.

The mean coverage rate for bowel cancer screening in Thurrock in the eligible population is 55%. This is below the national minimum standard of 60%. 26 of the 32 (81.26%) practice populations have screening coverage below the 60% target. There is considerable variation in uptake of bowel cancer screening between GP practice populations, with the lowest coverage rate (Sai Medical Centre) being just over half the that in the population with the highest coverage rate (Hassengate Medical Centre). Given that GP practices have little involvement in this screening programme, the explanation for this is likely to a product of differences within the practice populations themselves. There is a strong negative association between bowel cancer screening coverage and deprivation. This is concerning as it is likely to be a driver of health inequalities related to cancer.

6.6 Recommendations – Cancer Screening

1. The Public Health England team based in NHS England East office should investigate and seek to reduce the level of variation in coverage between GP practice populations on all three cancer screening programmes. Specifically:

1a. For cervical screening the following practice populations warrant further investigation

- Jones and Byrne, Balfour, Deshpande, Roy and Partners, Masson and Masson, Kadim, Joseph and Ptnr, Thurrock Health Centre, Chadwell, Appledore MC and Mukhopadhyay

1b. For bowel screening, the following practice populations warrant further investigation

- Sai Medical Centre, Tilbury Health Centre, Okoi, Thurrock Health Centre, Darenth Lane, St. Clements, Dilip Sabnis, Purfleet Care Centre, Joseph and Partner, Acorns Medical Centre, Appledore and Medic House, Mukhopadhyay, Shehadah, Kadim Primecare, Aveley Medical Centre,

1c. For breast screening, the following practice populations warrant further investigation

- Acorns Medical Centre, Thurrock Health Centre, Purfleet Care Centre, Health Centre Darenth Lane, Okoi and Partner, Tilbury Health Centre, Sai Medical Centre, St. Clements Health Centre, Bellworthy, Abela and Partner, Aveley Medical Centre

15. GPs and practice staff with screening coverage below target should seek opportunities to promote and encourage cancer screening programmes to all patients

16. NHS Thurrock CCG in conjunction with Thurrock Council Public Health Team should develop and implement a communications campaign promoting the importance of cancer screening programmes, with particular targeting of areas with low screening coverage

7. Early identification and referral of suspected cancer

7.1 Introduction

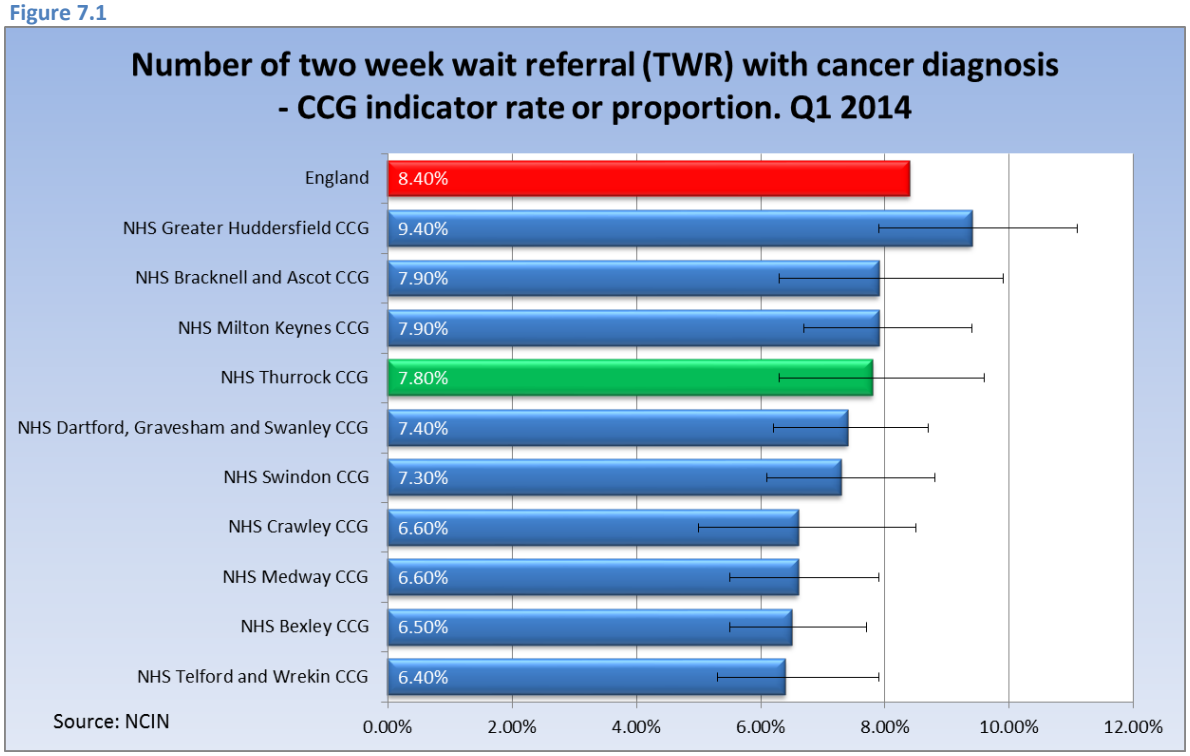
Timely and appropriate referral of patients with symptoms that could indicate that they have cancer is essential to improving cancer survival in our population. One of the explanations in much of the published literature on the UK's poor cancer survival rates compared to other countries is that patients are referred for cancer treatment to late. Conversely, over-referral of patients who do not have cancer risks clogging up NHS care pathways with the "worried well" and diverting capacity away from treating promptly patients who do have cancer.

The NHS has set a two week minimum waiting time for patients with suspected cancer to see a cancer specialist from GP referral. This forms part of the NHS Constitution.

7.2 Appropriateness of GP referral into the two-week wait pathway

Figure 7.1 shows the cancer positivity rate of two week wait referrals for Q1 2014

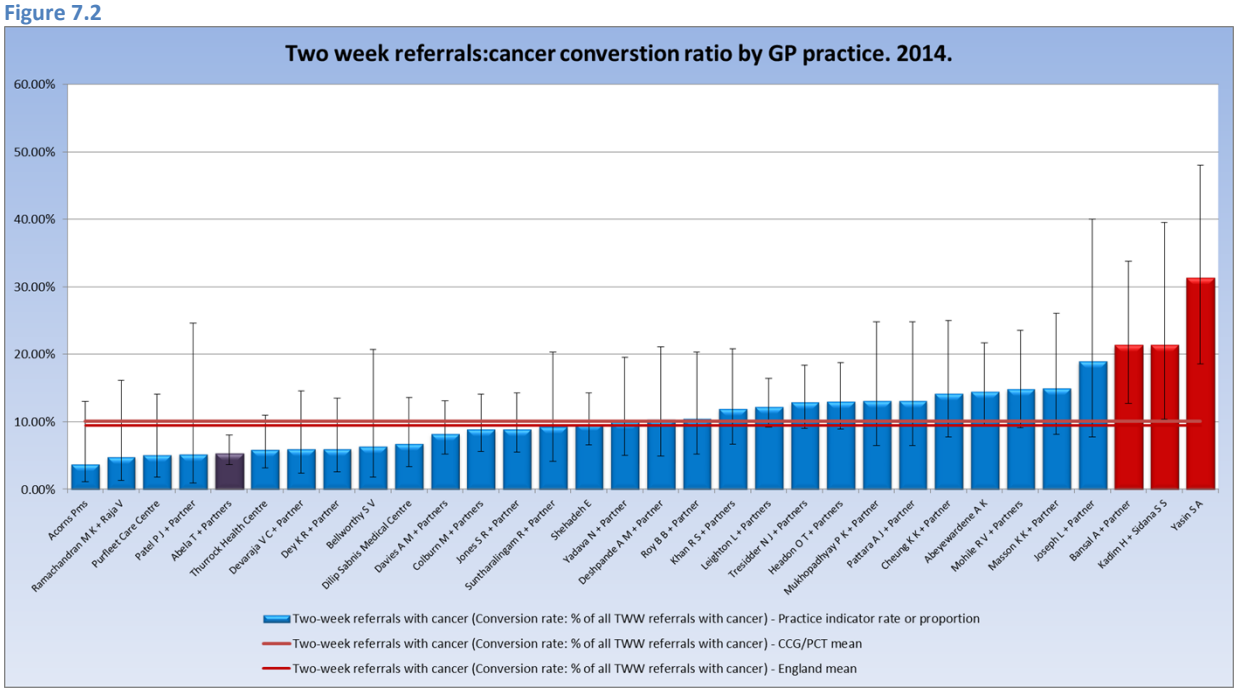
Figure 7.1



Thurrock's overall cancer positivity rate for two week wait referrals is 7.8%. This is not statistically significantly different to England's or any of its comparator CCGs (at 95% CI) and suggests that for the CCG as a whole, cancer referrals are appropriate.

Figure 7.2 shows the percentage of two-week wait referrals subsequently found to be patients with cancer by GP practice.

Figure 7.2



Again, there is significant variation between GP practices although some care needs to be taken in interpreting these results as the actual numbers of patients are small and so subject to statistical random variation.

However, one practice (Abela and Partners) has a cancer positivity rate from two week referrals that is statistically significantly lower than the national average. This may suggest an over-referral of patients into the pathway. Conversely, three practices (Bansal, Kadim and Yasin) have a cancer positivity rate that is statistically significantly greater than the national average and in the case of Yasin, over three times the national average. This may suggest a reluctance to refer patients that may have symptoms that could be cancer into the two-week wait cancer care pathway, a failure to identify potential cancer symptoms in patients or a reluctance of those practice populations with potential cancer symptoms to access primary care. This warrants further investigation.

Figure 7.3 shows the Indirectly Age Standardised two week wait referral ratio by GP practice in Thurrock in 2014. The ratio measures the actual versus the expected level of cancer referrals into the two-week wait care pathway for each practice population based on the demographic characteristics of that practice population. A GP practice that is making cancer referrals in line with what is expected for that practice population should have a referral ratio between 80 and 120%

Figure 7.3

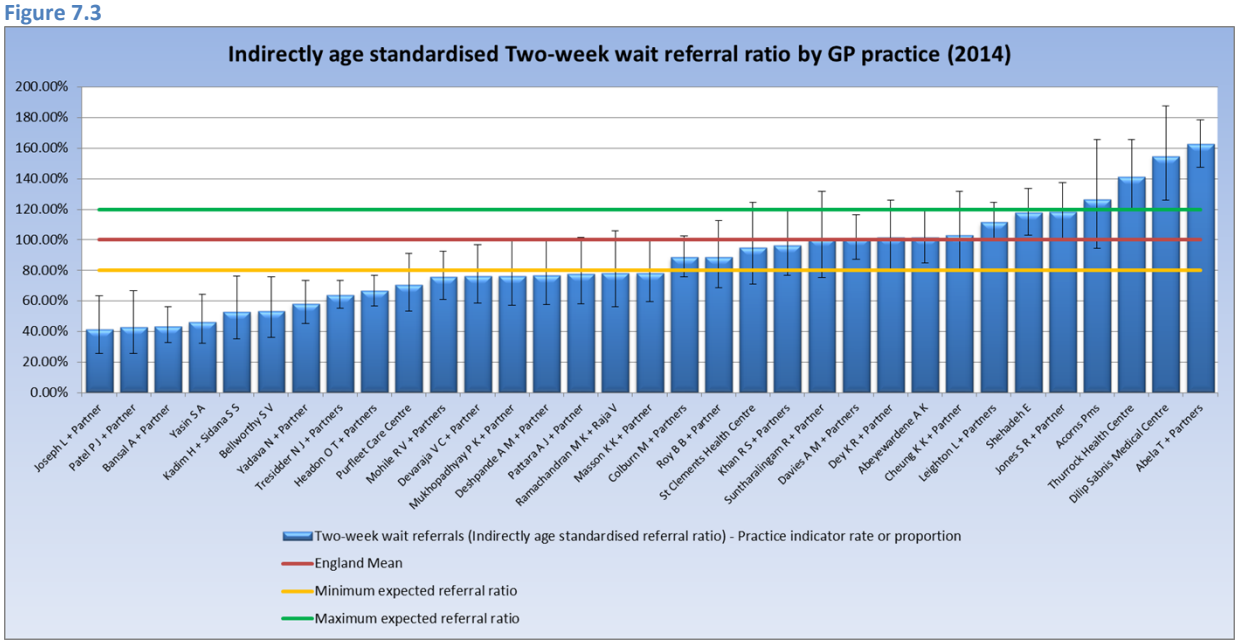


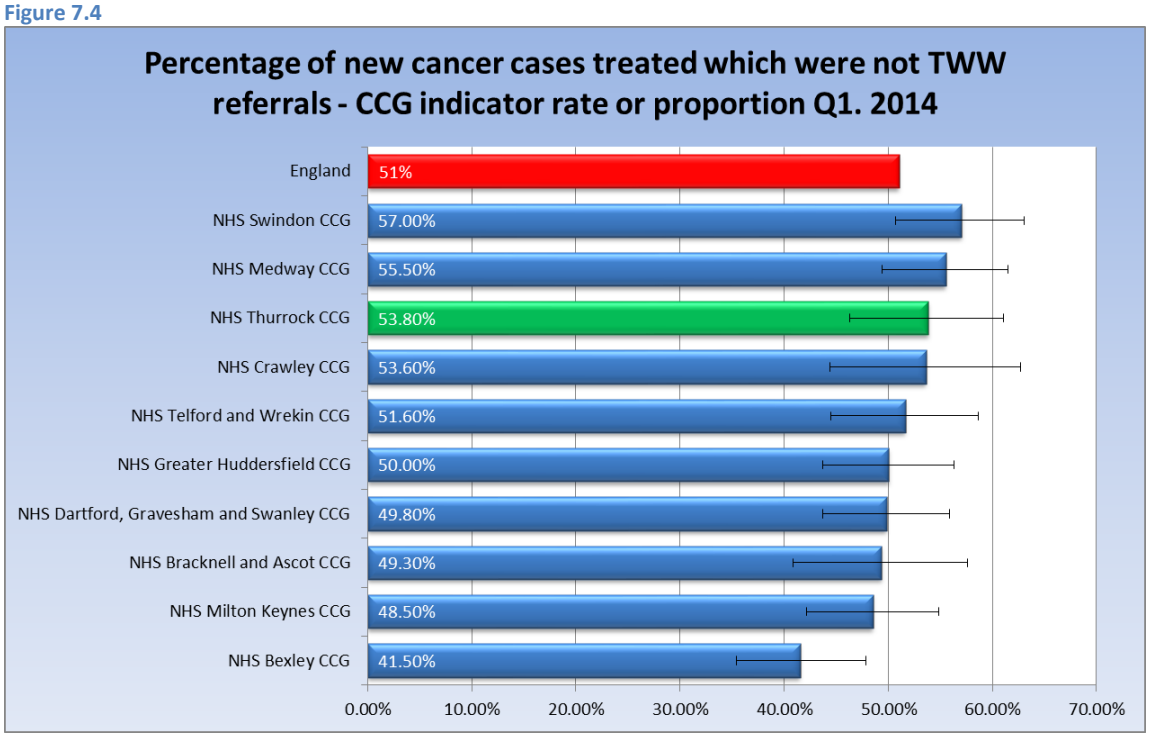
Figure 7.3 shows a significant variation in two-week wait referral ratios between different GP practices in Thurrock. Nine practices have indirectly standardised two-week wait referral ratios that are statistically significantly below 80% (at 95% CI). This suggests that these practices may be under-referring patients with cancer into the two week wait cancer care pathway. It is interesting and concerning to note that three practices, Bansal and Partner, Yasin and Kadim and Sidana, who have referral rates significantly below the minimum referral ratio, also have cancer TWWs positively rates significantly above England's (figure P). The reasons for this are unclear and could be a result of differences between practice population's willingness to recognise and seek help for cancer symptoms and/or differences in referral behaviour between clinicians working in different practices. However it warrants further urgent investigation.

Conversely three practices have referral ratios statistically significantly above 120%. These practices may be over-referring patients into the pathway. In the case of Abela and Partners, the high referral ratio is also congruent with a cancer positivity rate that is significantly below England's for patients referred into the two week wait pathway, providing stronger evidence that this practice may be over-referring patients.

7.3 Late detection of patients with cancer

Figure 7.4 shows the percentage of cancer treatments that were not two week referrals. A high percentage of cancer being treated outside the two-week wait referral pathway could suggest poor early detection.

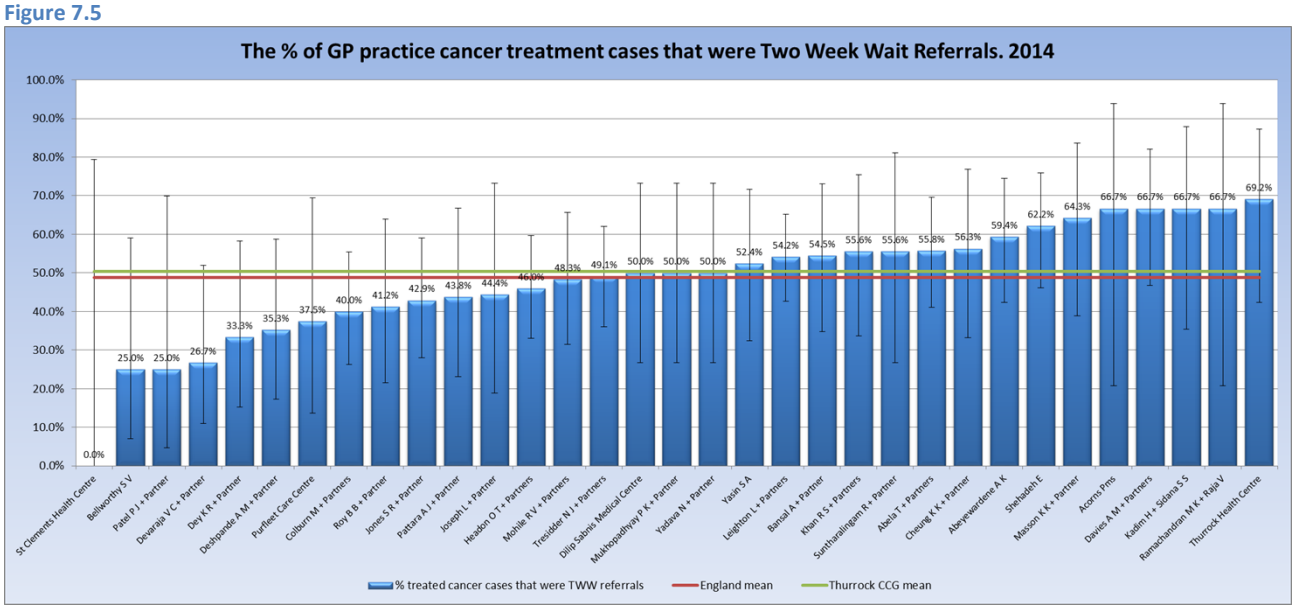
Figure 7.4



53.8% of patients with cancer in Thurrock were treated without coming through the two-week-wait referral pathway. This rate is not statistically significantly different to England's or any of Thurrock's comparator CCGs, although still identifies scope for improvement.

Figure 7.5 shows the percentage of patients treated for cancer in each GP practice population that were not two week referrals. Patients treated for cancer not referred through the two-week wait pathway are likely to be emergency presentations at A&E and are therefore less likely to have had their cancer detected at an early stage.

Figure 7.5

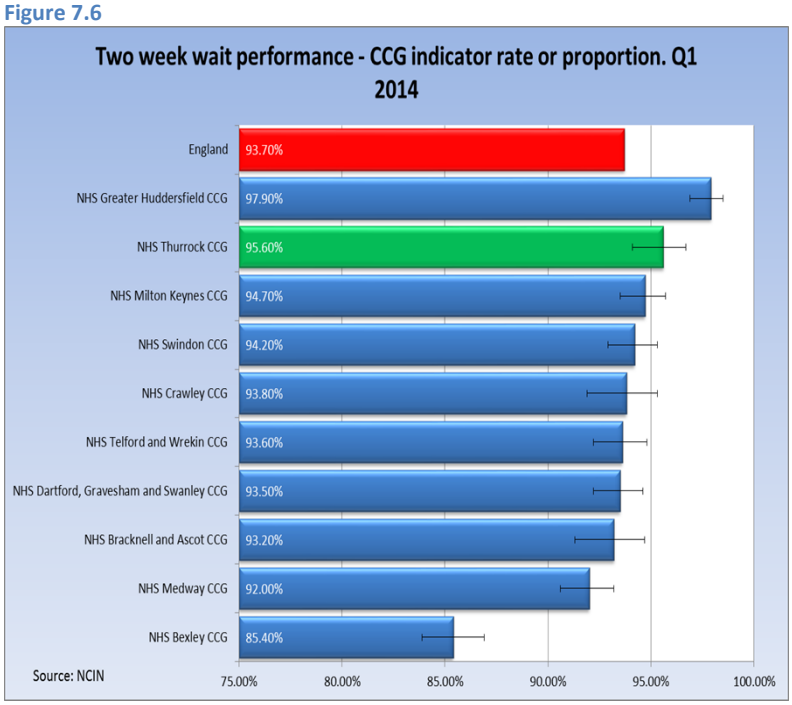


Whilst there is variation between different practice populations, the small numbers of patients involved from each practice results in no practice having a percentage that is statistically different to the England or Thurrock mean.

7.4 Performance against the two week wait referral cancer standard

Figure 7.6 shows performance on the two week wait standard for Thurrock CCG and its ONS comparator CCGs for Q1 2014.

Figure 7.6



Thurrock CCG performs well on the two week wait standard, with 95.6% of patients seeing a cancer specialist within two weeks of referral by a GP. This rate is statistically significantly better than that of England's and is the second best in the ONS comparator group of CCGs.

Figure 7.7

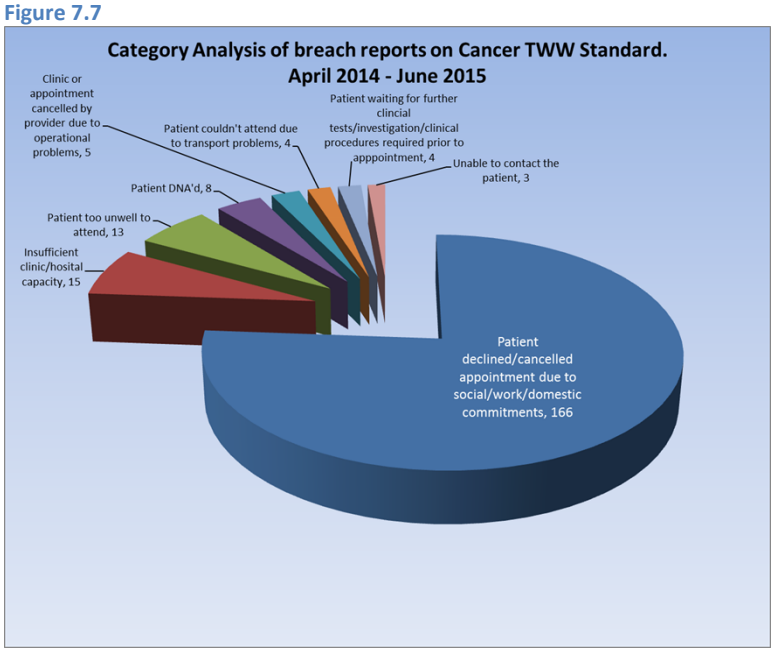


Figure 7.7 shows an analysis of reasons for two week wait breaches. By far the most common reason was that the patient declined the appointment offered due to other social/work/holiday commitments.

7.5 Summary: Early identification and referral of suspected cancer

Overall, 7.8% of patients referred into the two-week wait cancer pathway were subsequently found to have cancer. This is lower than England's rate (8.4%) but not statistically significantly different.

At GP practice level, three practices have a cancer diagnosis rate following referral into the two week pathway that is significantly greater than England's rate. In one practice over 30% of patients referred into the two week pathway were subsequently diagnosed with cancer. This suggests a significant under referral of patients and warrants further urgent investigation.

On a second metric to examine the appropriateness of referral of patients with suspected cancer into the two week wait pathway – the Indirectly Age Standardised Referral Ratio, there is also significant variation in between GP practices in Thurrock. Nine practices (28.1%) have referral ratios that suggest that they are under referring patients with suspected cancer and three practices (9.4%) have referral ratios that suggest they may be over-referring patients who do not have cancer. Three practices have scores on both metrics that suggest that they are failing to refer sufficient patients with suspected cancer into the two week wait pathway. This warrants further investigation.

Over half of all patients treated for cancer in Thurrock did not receive a referral through the two-week wait pathway. This is not significantly different to England's rate, but still suggests that too few patients are having their cancer detected early enough.

In terms of performance against the two-week waiting standard, Thurrock performs well with 95.6% of patients seeing a cancer specialist within two weeks of being referred into the pathway by their GP. This is second best performance in Thurrock's ONS comparator CCG group and statistically significantly better than the performance across England.

7.6 Recommendations: Early identification and referral of suspected cancer

1. The CCG in conjunction with Thurrock Council should undertake a coordinated communications campaign aimed at increasing patient knowledge of potential cancer symptoms and encouraging them to consult their GP at the earliest possible opportunity. This campaign should be targeted at practice populations with referral ratios below 80% or where unplanned admission rates for cancer are high.

2. Practices that have been identified as having referral ratios into the TWW pathway below 80% and/or cancer TWW positivity rates that are significantly greater than the England mean should review their clinical practice with regard to cancer referrals to ensure that they are identifying and referring patients with symptoms that could be cancer, sufficiently early.

3. Practices with that have been identified has having referral ratios into the TWW pathway above 120% and/or TWW cancer positivity rates that are significantly less than the England mean should review their clinical practice with regard to cancer referrals to ensure that they are not over referring patients.

8. Cancer Diagnosis and Treatment

8.1 Routes to Cancer Diagnosis

Figures 8.1 to 8.3 show the 'routes to diagnosis' for the three most common cancers; lung, colorectal and bowel in Thurrock and its comparator CCG populations between 2006 and 2010. As discussed in section 7, population outcomes for cancer will improve if a greater number of patients are diagnosed via screening or a managed presentation (TWW referral) as opposed to an emergency presentation, as cancer is more likely to be detected at an earlier stage.

Figure 8.1

	Directly age-standardised rate per 100, 000 population by route							Percentage by Route				
	Lung	Screen detected	Managed	Emergency presentation	Other		Number of cases	Screen detected	Managed	Emergency presentation	Other	
2006-2010	England		27.5	16.6	1.6		163,176		58%	38%	4%	
	Confidence interval		*27.4 27.7*	*16.5 16.8*	*1.5 1.6*				*58% 58%*	*38% 39%*	*4% 4%*	
	NHS Bexley CCG		30.1	16.5	1.8		759		59%	36%	4%	
	Confidence interval		*27.3 32.9*	*14.6 18.5*	*1.2 2.5*				*56% 63%*	*33% 40%*	*3% 6%*	
	NHS Bracknell And Ascot CCG		23.2	14.9	1.4		291		57%	39%	3%	
	Confidence interval		*19.6 26.7*	*12.1 17.6*	*0.5 2.3*				*52% 63%*	*34% 45%*	*2% 6%*	
	NHS Crawley CCG		20.0	18.6	1.9		247		48%	47%	4%	
	Confidence interval		*16.4 23.6*	*15.2 22.0*	*0.8 3.0*				*42% 54%*	*41% 54%*	*3% 8%*	
	NHS Dartford, Gravesham And Swanley CCG		27.8	14.7	2.2		742		60%	34%	6%	
	Confidence interval		*25.2 30.4*	*12.9 16.5*	*1.6 2.9*				*57% 64%*	*31% 38%*	*4% 7%*	
	NHS Greater Huddersfield CCG		25.9	18.5	1.4		715		55%	42%	4%	
	Confidence interval		*23.4 28.5*	*16.4 20.6*	*0.9 2.0*				*51% 58%*	*38% 45%*	*3% 5%*	
	NHS Medway CCG		27.2	18.4	2.2		744		55%	40%	5%	
	Confidence interval		*24.6 29.9*	*16.3 20.5*	*1.5 2.9*				*52% 59%*	*37% 44%*	*4% 7%*	
	NHS Milton Keynes CCG		26.5	17.9	1.9		567		56%	40%	4%	
	Confidence interval		*23.6 29.4*	*15.5 20.2*	*1.1 2.6*				*52% 60%*	*36% 44%*	*3% 6%*	
	NHS Swindon CCG		26.6	17.3	2.2		564		56%	39%	5%	
	Confidence interval		*23.7 29.5*	*15.0 19.5*	*1.3 3.0*				*52% 60%*	*35% 43%*	*3% 7%*	
	NHS Telford And Wrekin CCG		30.8	15.7	1.9		485		62%	34%	4%	
	Confidence interval		*27.3 34.2*	*13.3 18.2*	*1.1 2.8*				*58% 67%*	*30% 38%*	*3% 6%*	
	NHS Thurrock CCG		30.5	19.1	1.3		444		58%	39%	3%	
	Confidence interval		*26.8 34.2*	*16.2 21.9*	*0.6 2.1*				*54% 63%*	*35% 44%*	*2% 5%*	

For lung cancer, Thurrock has a rate of diagnosis per 100K population and percentages of cancers detected by each route that is largely the same as both England and its comparator group CCGs.

Figure 8.2

	Directly age-standardised rate per 100, 000 population by route Bordered cells indicate 3 SD outliers on respective funnel plots									Percentage by Route							
	Colorectal	Screen detected		Managed		Emergency presentation		Other		Number of cases	Screen detected		Managed		Emergency presentation		Other	
2006-2010	England	2.5		29.3		10.2		1.9		156,057	5%		66%		25%		4%	
	Confidence interval	*2.5*	*2.6*	*29.1*	*29.4*	*10.1*	*10.3*	*1.9*	*1.9*		*5%*	*5%*	*66%*	*66%*	*25%*	*25%*	*4%*	*4%*
	NHS Bexley CCG	1.7		27.7		9.3		2.3		640	3%		66%		26%		5%	
	Confidence interval	*1.0*	*2.5*	*25.1*	*30.4*	*7.9*	*10.7*	*1.5*	*3.0*		*2%*	*5%*	*62%*	*70%*	*22%*	*29%*	*4%*	*7%*
	NHS Bracknell And Ascot CCG	2.6		23.7		9.3		3.5		293	6%		60%		26%		9%	
	Confidence interval	*1.4*	*3.9*	*20.2*	*27.2*	*7.2*	*11.3*	*2.2*	*4.9*		*4%*	*9%*	*54%*	*65%*	*21%*	*31%*	*6%*	*12%*
	NHS Crawley CCG	1.2		24.7		9.1		2.3		223	2%		66%		26%		6%	
	Confidence interval	*0.1*	*2.2*	*20.7*	*28.6*	*6.8*	*11.5*	*1.0*	*3.5*		*1%*	*5%*	*60%*	*72%*	*20%*	*32%*	*3%*	*10%*
	NHS Dartford, Gravesham And Swanley CCG	1.2		27.6		8.8		2.1		648	2%		69%		23%		5%	
	Confidence interval	*0.6*	*1.7*	*25.1*	*30.2*	*7.4*	*10.3*	*1.3*	*2.8*		*2%*	*4%*	*66%*	*73%*	*20%*	*27%*	*3%*	*7%*
	NHS Greater Huddersfield CCG	2.1		27.7		9.5		1.8		624	4%		67%		25%		4%	
	Confidence interval	*1.3*	*2.9*	*25.0*	*30.3*	*8.0*	*11.0*	*1.1*	*2.5*		*3%*	*6%*	*63%*	*70%*	*22%*	*28%*	*3%*	*6%*
	NHS Medway CCG	1.8		27.9		10.3		2.0		649	4%		67%		25%		4%	
	Confidence interval	*1.1*	*2.5*	*25.3*	*30.6*	*8.7*	*11.8*	*1.2*	*2.7*		*3%*	*5%*	*63%*	*70%*	*22%*	*29%*	*3%*	*6%*
	NHS Milton Keynes CCG	1.0		30.2		10.8		3.2		558	2%		66%		25%		7%	
	Confidence interval	*0.4*	*1.7*	*27.2*	*33.3*	*9.0*	*12.6*	*2.2*	*4.2*		*1%*	*4%*	*62%*	*70%*	*21%*	*29%*	*5%*	*10%*
	NHS Swindon CCG	0.0		29.4		11.5		2.1		540			68%		27%		5%	
	Confidence interval			*26.4*	*32.4*	*9.6*	*13.3*	*1.3*	*3.0*				*64%*	*72%*	*24%*	*31%*	*3%*	*7%*
	NHS Telford And Wrekin CCG	1.2		33.1		11.1		1.5		469	2%		70%		25%		3%	
	Confidence interval	*0.5*	*1.9*	*29.5*	*36.6*	*9.0*	*13.1*	*0.7*	*2.2*		*1%*	*4%*	*66%*	*74%*	*21%*	*29%*	*2%*	*5%*
	NHS Thurrock CCG	3.3		28.1		11.4		1.8		380	7%		64%		26%		4%	
	Confidence interval	*2.0*	*4.7*	*24.6*	*31.7*	*9.1*	*13.6*	*0.9*	*2.7*		*5%*	*10%*	*59%*	*69%*	*22%*	*30%*	*2%*	*6%*

For colorectal cancer, Thurrock as a rate per 100,000 population and percentage of cancer detected by screening that is significantly greater than England's and many of its comparator CCGs and a rate and percentage of cancer detected by emergency presentation that is not significantly different to England's or other CCGs. This suggests that our bowel cancer screening programme may be more effective than in other areas and is good news in terms of population health outcomes for cancer.

Figure 8.3

	Directly age-standardised rate per 100, 000 population by route Bordered cells indicate 3 SD outliers on respective funnel plots									Percentage by Route							
	Female Breast Cancer	Screen detected		Managed		Emergency presentation		Other		Number of cases	Screen detected		Managed		Emergency presentation		Other	
2006-2010	England	38.4		71.2		3.9		6.0		191,120	28%		62%		5%		5%	
	Confidence interval	*38.1*	*38.7*	*70.8*	*71.6*	*3.8*	*4.0*	*5.9*	*6.1*		*28%*	*29%*	*62%*	*62%*	*5%*	*5%*	*5%*	*5%*
	NHS Bexley CCG	36.4		65.3		3.3		8.8		805	28%		61%		4%		7%	
	Confidence interval	*31.6*	*41.1*	*59.6*	*71.1*	*2.2*	*4.4*	*6.5*	*11.1*		*25%*	*31%*	*58%*	*64%*	*3%*	*6%*	*6%*	*9%*
	NHS Bracknell And Ascot CCG	36.6		71.2		4.4		14.0		457	25%		60%		5%		11%	
	Confidence interval	*29.9*	*43.3*	*62.7*	*79.6*	*2.5*	*6.2*	*10.1*	*17.9*		*21%*	*29%*	*55%*	*64%*	*3%*	*7%*	*8%*	*14%*
	NHS Dartford, Gravesham And Swanley CCG	43.2		69.4		3.4		8.9		922	31%		59%		4%		7%	
	Confidence interval	*38.1*	*48.2*	*63.5*	*75.2*	*2.3*	*4.6*	*6.7*	*11.1*		*28%*	*34%*	*56%*	*62%*	*3%*	*5%*	*5%*	*8%*
	NHS East Surrey CCG	42.1		60.8		3.4		13.3		635	31%		55%		4%		11%	
	Confidence interval	*36.1*	*48.0*	*54.4*	*67.1*	*2.0*	*4.7*	*10.1*	*16.5*		*27%*	*34%*	*51%*	*59%*	*3%*	*6%*	*8%*	*13%*
	NHS Greater Huddersfield CCG	34.7		69.9		3.6		5.3		799	27%		64%		4%		4%	
	Confidence interval	*30.1*	*39.4*	*63.9*	*75.9*	*2.3*	*4.8*	*3.6*	*7.1*		*24%*	*30%*	*61%*	*68%*	*3%*	*6%*	*3%*	*6%*
	NHS Medway CCG	43.2		66.0		2.9		5.8		862	33%		58%		4%		5%	
	Confidence interval	*38.2*	*48.2*	*60.2*	*71.8*	*1.9*	*3.9*	*4.1*	*7.6*		*30%*	*37%*	*55%*	*61%*	*3%*	*5%*	*4%*	*7%*
	NHS Milton Keynes CCG	34.4		71.5		4.1		8.8		748	26%		62%		4%		7%	
	Confidence interval	*29.6*	*39.2*	*65.0*	*78.0*	*2.7*	*5.6*	*6.5*	*11.1*		*23%*	*30%*	*59%*	*66%*	*3%*	*6%*	*6%*	*9%*
	NHS Swindon CCG	45.0		73.1		4.8		4.0		732	31%		61%		5%		3%	
	Confidence interval	*39.1*	*50.9*	*66.3*	*79.8*	*3.2*	*6.3*	*2.4*	*5.7*		*27%*	*34%*	*58%*	*65%*	*4%*	*7%*	*2%*	*5%*
	NHS Telford And Wrekin CCG	35.3		79.6		2.4		4.7		577	27%		67%		2%		4%	
	Confidence interval	*29.7*	*40.8*	*71.7*	*87.6*	*1.1*	*3.6*	*2.8*	*6.7*		*23%*	*31%*	*63%*	*70%*	*2%*	*4%*	*3%*	*6%*
	NHS Thurrock CCG	39.5		70.4		3.2		5.3		495	29%		62%		4%		4%	
	Confidence interval	*33.1*	*45.9*	*62.6*	*78.3*	*1.7*	*4.6*	*3.1*	*7.6*		*26%*	*34%*	*58%*	*67%*	*2%*	*6%*	*3%*	*7%*

For breast cancer, both standardised rate per 100K population and percentage of cancers detected via each route is statistically no different to England's or other CCGs.

It is however worth remembering that England benchmarks poorly when compared to other European countries on early detection of cancer and so figures A to C still identify significant scope for improvement

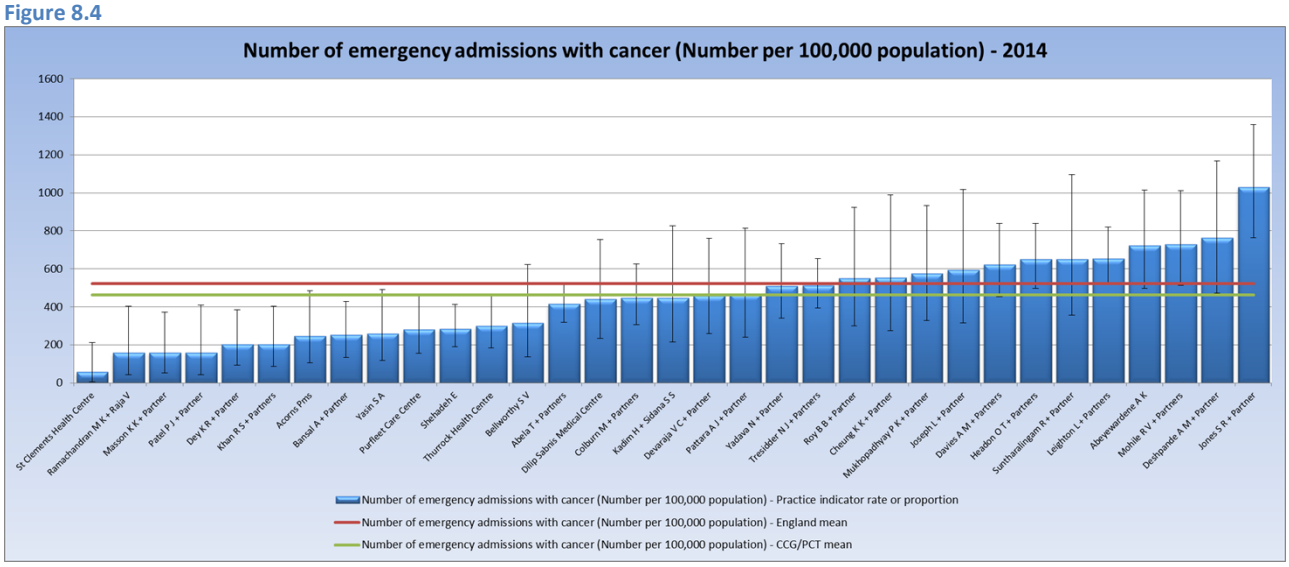
8.2 Diagnosis of Cancer following an Unplanned Care Admission

Figure 8.4 shows the rate of unplanned care admissions per 100,000 population for cancer in 2014 for each practice population. A high rate of unplanned care admissions for cancer suggests a poorer level of early detection of cancer within that practice population. There are many explanations for this including:

- Differences in the over-all prevalence of cancer in different practice populations
- Differences in the types of cancer that different practice populations are most at risk of
- Difference between practice populations in their access of cancer screening programmes
- Differences in the willingness of different practice populations to access primary care when they first notice symptoms
- Differences in referral behaviour of primary care clinicians when patients do present with symptoms.

As such interpretation of figure 8.4 needs to be made with some caution.

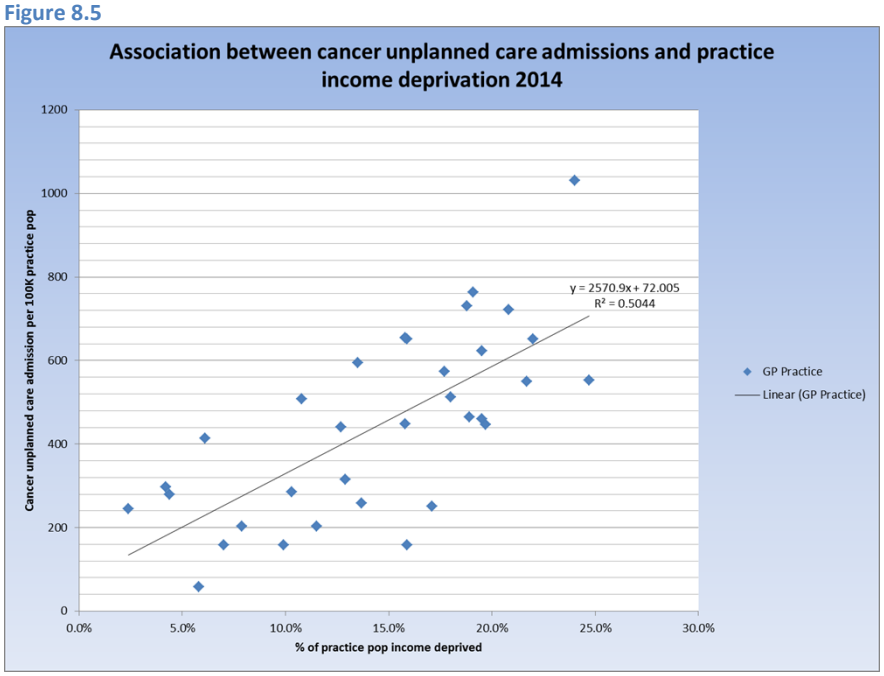
Figure 8.4



There is however significant variation between the rate of unplanned care admissions for cancer between different practice populations in Thurrock. The practice with the highest rate of unplanned care admissions (Jones and Partner) has a rate that is 20 fold that of the practice with the lowest rate of unplanned care admissions. (St. Clements). Ten practice populations have unplanned care admission rates that are statistically significantly lower than England's and two have rates that are statistically significantly greater. This may warrant further investigation.

Figure 8.5 shows the association between GP practice population unplanned care admission rates for cancer and practice population income deprivation.

Figure 8.5



There is a strong positive association between the percentage of the practice population classed as 'income deprived' and unplanned care admission rates for cancer. Just over half of the variation in unplanned care admission rates between practices can be explained by income deprivation levels within the practice population. This may suggest that differences in behaviour and underlying cancer prevalence between practice populations are a key driver of differences in unplanned care admission rates.

8.3 Cancer Waiting Times for Diagnosis and Treatment

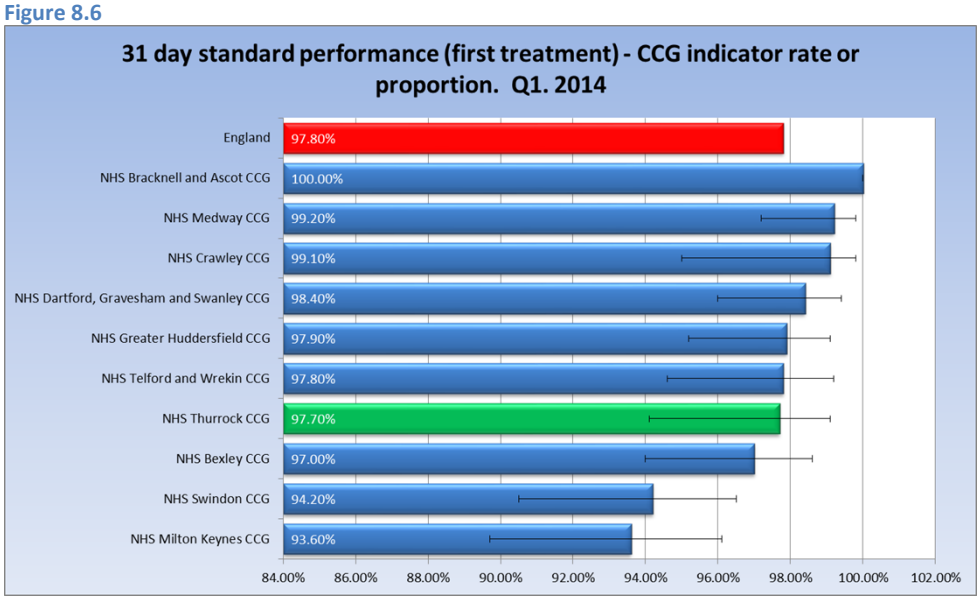
There are a number of maximum waiting time standards cancer treatment that CCGs are mandated to deliver and held accountable for through the NHS Operating and Performance Frameworks These include:

- a maximum one month (31-day) wait from the date a decision to treat (DTT) is made to the first definitive treatment for all cancers;
- a maximum 31-day wait for subsequent treatment where the treatment is surgery;
- a maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy;
- a maximum 31-day wait for subsequent treatment where the treatment is an anti-cancer drug regimen;
- a maximum two month (62-day) wait from urgent referral for suspected cancer to the first definitive treatment for all cancers;
- a maximum 62-day wait from referral from an NHS cancer screening service to the first definitive treatment for cancer;
- a maximum 62-day wait for the first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers);
- a maximum two-week wait to see a specialist for all patients referred with suspected cancer symptoms
- a maximum two-week wait to see a specialist for all patients referred for investigation of breast symptoms, even if cancer is not initially suspected.

8.3.1 Performance against 31 day cancer treatment waiting times

Figure 8.6 shows performance against the 31 day cancer waiting standard for first treatment for Thurrock CCG, England and Thurrock's ONS comparator CCGs. This is the time that a patient waits to receive first treatment after diagnosis and a decision to treat (DTT) has been made.

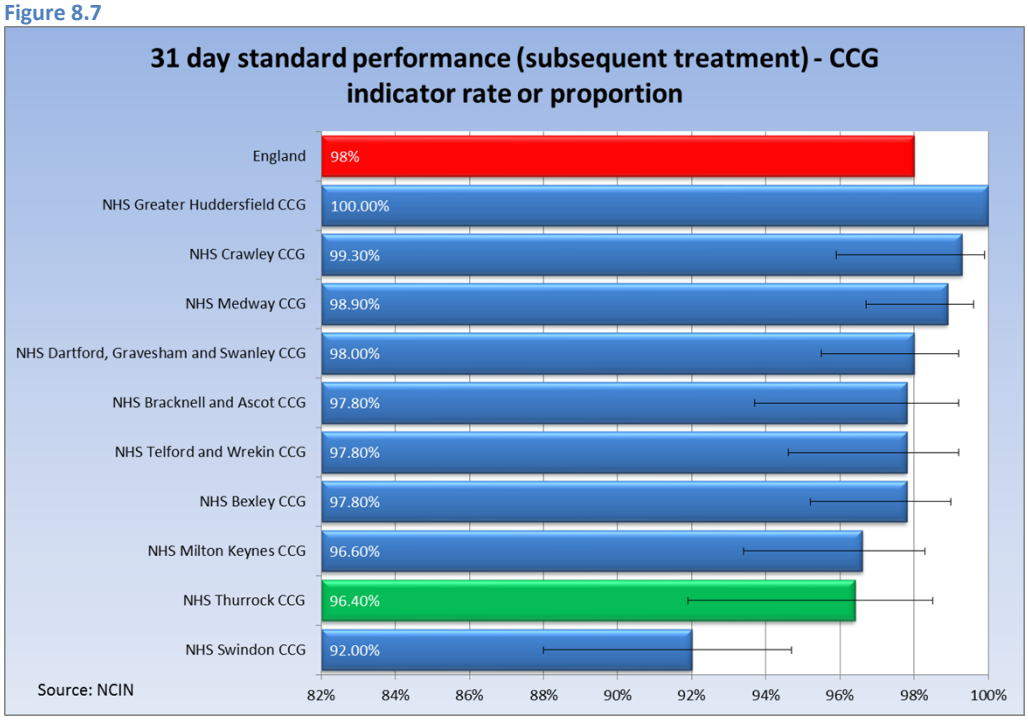
Figure 8.6



97.7% of cancer patients in Thurrock waited 31 days or fewer between initial GP referral and decision to treat their cancer for first treatment in Q1 2014. This is not statistically significantly different to England's performance or performance in an of Thurrock's ONS comparator CCGs.

Figure 8.7 shows performance against the 31 day cancer standard for subsequent cancer treatments for Thurrock CCG, its comparator CCGs and England in Q1. 2014.

Figure 8.7

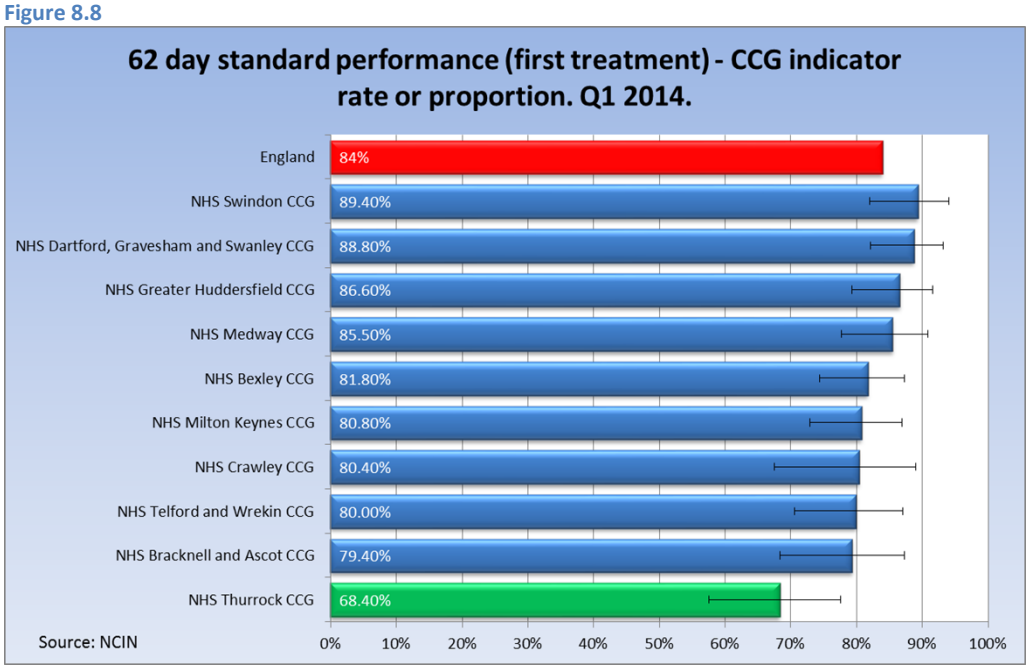


Thurrock's performance is not statistically significantly different to either England's or its ONS comparator CCGs at 95% CI. However it has the second poorest performance compared to its ONS comparator group CCGs.

8.3.2 62 Day Cancer Waiting time standard

Figure 8.8 shows performance against the 62 day cancer waiting time standard for Thurrock CCG, its comparator CCGs and England in Q1 2014.

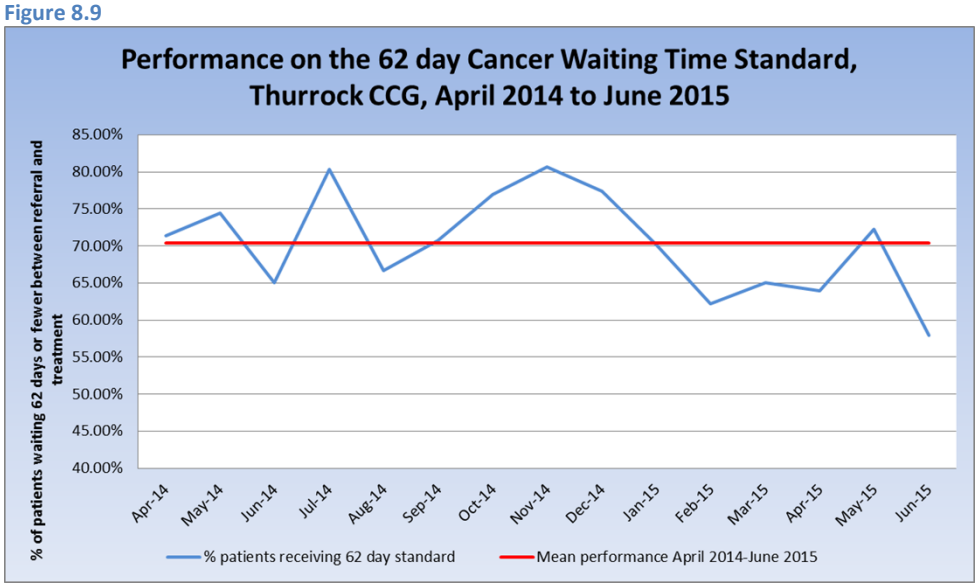
Figure 8.8



Only 68.4% of Thurrock cancer patients received their first treatment for cancer within 62 days of initial referral by their GP. This is statistically significantly worse than the rate for England and the poorest performance within the CCG's ONS comparator group. Given that performance on the two week wait target and 31 day wait target from decision to treat to the patient receiving first treatment, figure P suggests that something is going wrong in the system between the patient seeing a cancer specialist and the point of diagnosis and decision to treat. Delays in cancer treatment due to delays in diagnostics is likely to impact adversely on mortality rates of Thurrock patients and is unacceptable. This warrants further urgent investigation.

Figure 8.9 shows performance on a month by month basis from April 2014 to June 2015 on the 62 cancer waiting time standard for Thurrock CCG patients.

Figure 8.9



Performance has declined from November 2014. In June 2015, fewer than 60% of Thurrock patients with cancer received treatment within 62 days of referral by their GP.

8.3.3 Category Analysis on recorded reasons for 62 Day Breaches

Figure 8.10 shows category analyses undertaken on the 62 day cancer standard breach reports. Reports were categorised two categories (potentially avoidable, and unavoidable), and seven sub-categories

1. Potentially avoidable – Pathway referral delays/ pathway inefficiency
2. Potentially avoidable – Delays in diagnostics, or required referral across multiple sites to access all necessary diagnostics
3. Potentially avoidable – lack of clinic/hospital/bed capacity
4. Unavoidable – clinically complex case with unclear initial diagnosis
5. Unavoidable – patient initiated social or emotional related delays
6. Unavoidable – patient too ill for operation or treatment or receiving other medical treatment/operation
7. Unavoidable – patient DNA.

Figure 8.10

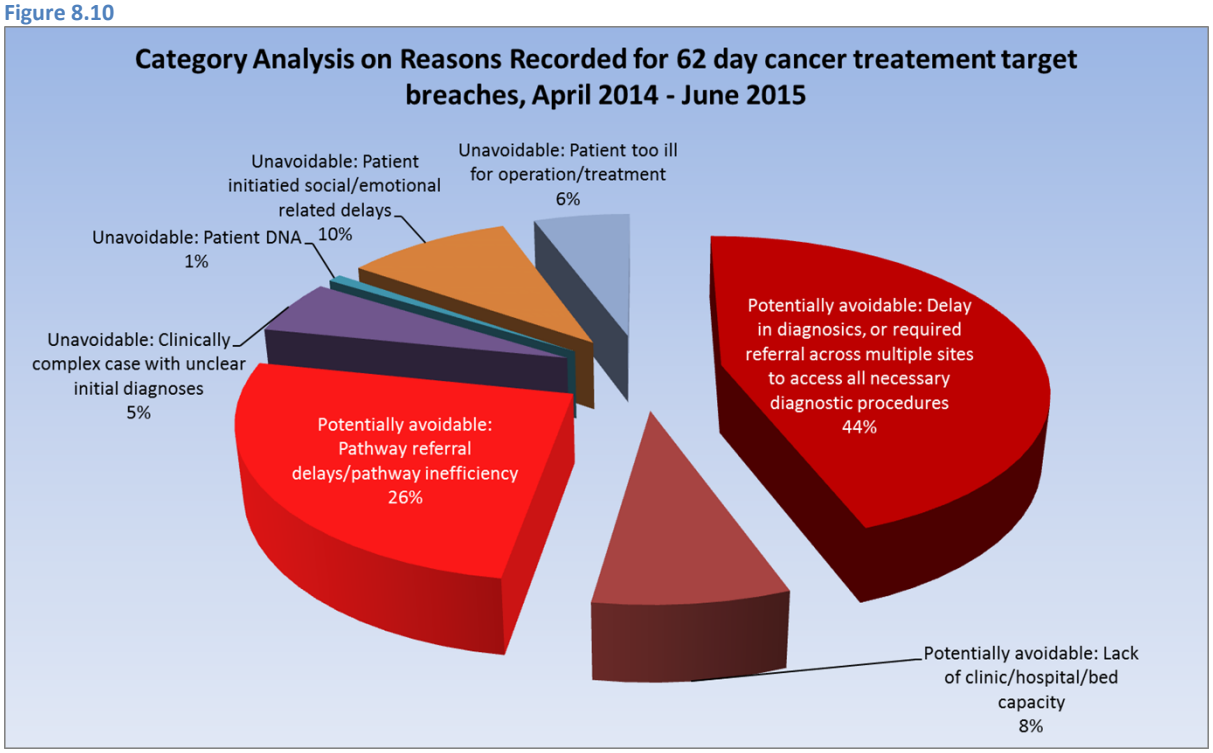


Figure 8.10 makes uncomfortable reading. 78% of all 62 day cancer treatment standard targets were breached for reasons that were potentially avoidable. Of all of the seven sub-categories, three most common were both classed as potentially avoidable.

The most common two reasons were either entirely or partly a function of the fragmentation of cancer pathways between multiple hospital sites across Essex. The most common reason was delays in access to diagnostics. This occurred either at one site or often because referral of patients between different sites was required in order to access to all diagnostic equipment in order to obtain an adequate diagnosis to begin treatment. This accounted for almost half of all breaches. Where specified, delays for MRI and CT scans and for TRUS featured commonly in breach reports categorised into this sub-category. What is striking from reading the individual breach reports is the number that stated that the breach was 'unavoidable because of the need to refer across multiple hospital sites'. However if adequate cancer diagnostics were provided in one specialist centre on one site, these breaches would not be unavoidable. In addition, a further 26% of breaches were explained simply by a lack of efficiency across the pathway. Again a common theme running through these breach reports was that referrals between different parts of a fragmented cancer pathway had not been made in a timely way. Too often, breach reports cited examples of referrals for treatment not being received until near the end of the 62 day wait.

What is striking from this analysis is that NHS Thurrock CCG is being held to account for a 62 day cancer wait target that at largely not within its gift to deliver given the current fragmentation of cancer care pathways across multiple hospital sites many of which are out of area. Rationalisation of diagnostics and treatment is required on in larger specialist cancer centres would seem to be the logical way to address the current fragmentation. This requires systems leadership from NHS England.

Lack of clinic/hospital or bed capacity was the third (although much rarer) reason given for avoidable breaches. Examples include lack of beds, cancellation of procedures due to staff absence and long waits for oncology clinics.

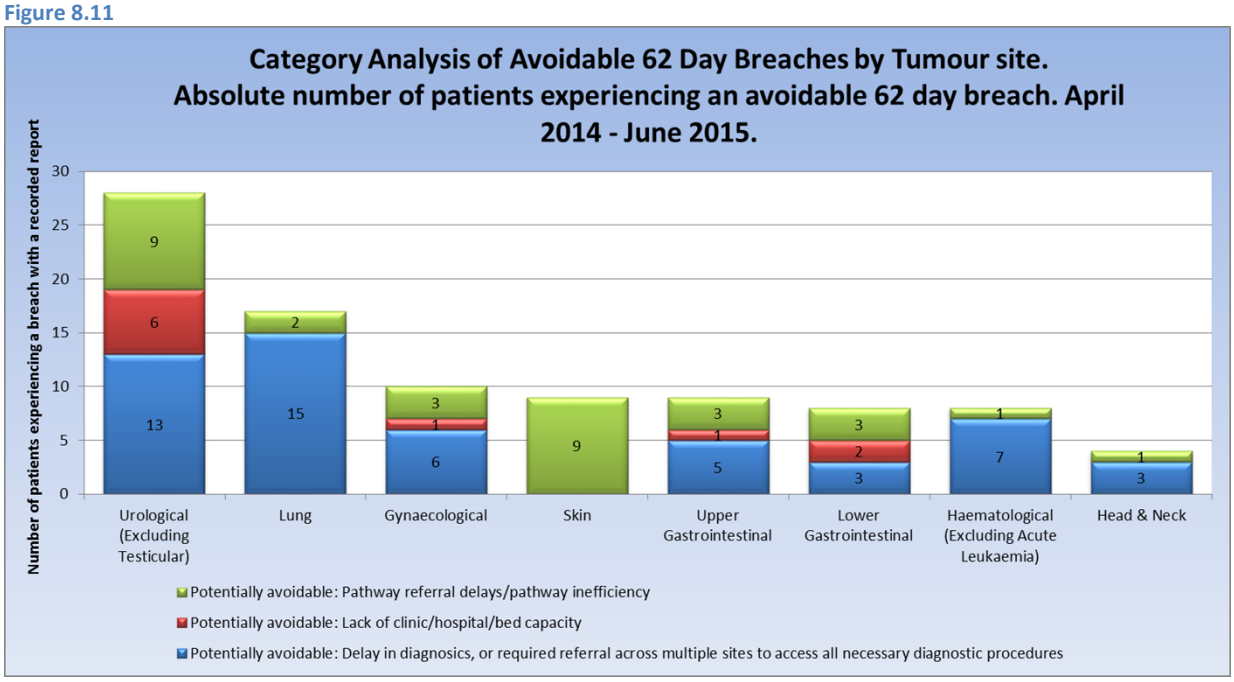
A theme running through many of the reports for breaches categorised as 'avoidable' was a lack of coordination of care of the patient. The care pathway operates as a series of linked individual processes with staff only taking responsibility for their part of the pathway or process. As soon as one part of the pathway failed, the entire pathway failed and the delay occurred. Patients often appeared to be 'bounced' around different providers and different parts of the NHS system with no one individual taking responsibility for their journey through the pathway. A care coordination approach to cancer with a single named accountable clinician taking responsibility for a patient's journey through the cancer pathway is required.

8.3.4 Category Analyses of Avoidable 62 Breaches by Tumour Pathway

To explore the above further, the three sub-categories of the 'Potentially avoidable Breach' category were analysed by tumour site.

Figure 8.11 shows the number of patients experiencing a 62 day breach classed as potentially avoidable by tumour site and sub-category.

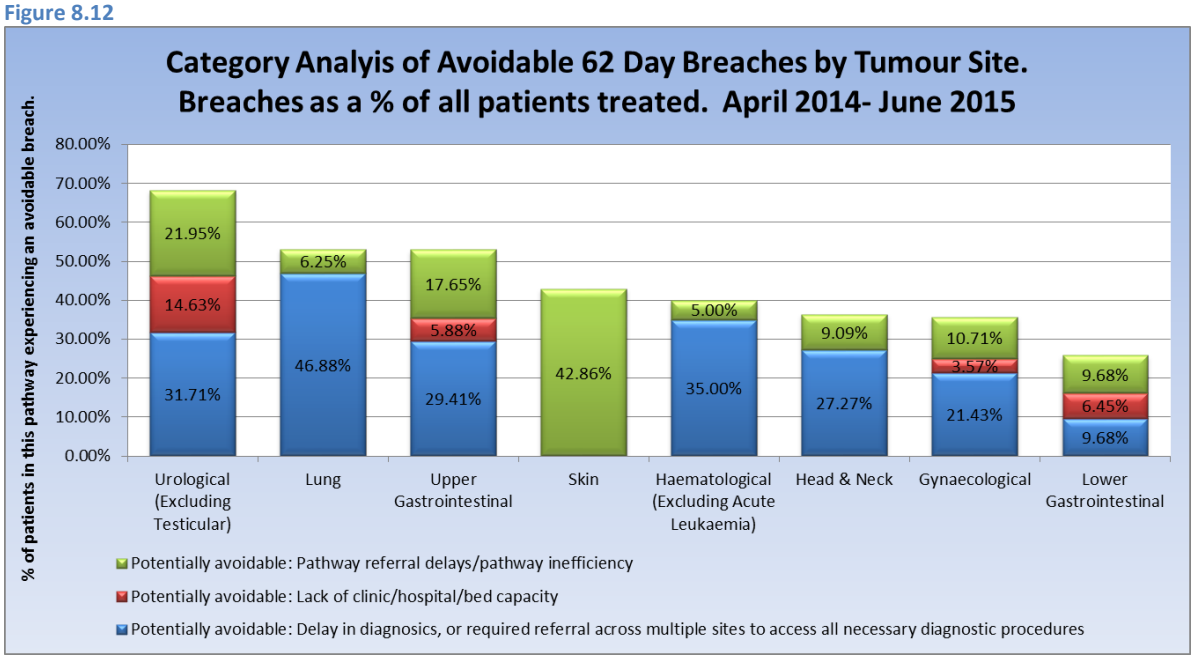
Figure 8.11



The tumour pathways with the greatest number of potentially avoidable 62 day standard breaches were Urological, lung, skin gynaecological, gastrointestinal, haematological and head and neck. Concentrating efforts on reducing avoidable breaches on these pathways in the order shown in figure Y will have the greatest impact on the CCG's 62 day cancer target.

Figure 8.12 shows the percentage of patients by tumour pathway experiencing an avoidable 62 day breach.

Figure 8.12



Patients are treated for Urological cancers, lung, upper gastrointestinal, skin, and haematological cancer are at greatest individual risk of experiencing a 62 day breach, with over 40% of patients in these four pathways failing to complete treatment within 62 days due to potentially avoidable reasons on the part of the NHS. Figure Z therefore gives an assessment of the *quality* of individual pathways against the 62 day standard. Over half of all patients in the urological, lung and upper GI care pathways failed to receive cancer care that met the 62 day standard because of reasons that were potentially avoidable. Delays in diagnostics or requirement to refer across multiple sites in order to access sufficient diagnostics was by far the most common reason, although the category 'pathway referral delays/inefficiency' may well also relate to reasons of diagnostics access which were not made clear on the breach report. This level of delay is unacceptable in terms of clinical quality for the population of Thurrock and warrants further investigation and action.

It is worth noting that the Urological pathway features as the poorest performing both in terms of absolute numbers of patients waiting more than 62 days, and the risk to an individual cancer patient of waiting more than 62 days for treatment. This pathway warrants immediate further investigation.

Considering figures 8.11 and 8.12 together, delays in diagnostics in the head and neck, lung, haematological, gynaecological and upper GI warrant immediate further investigation, as do referral protocols and pathway efficiency in the upper GI, lung and skin cancer pathways.

8.3.5 Patient Flows within and between Provider Trusts

The provider to whom the patient is first seen by is not necessarily the same one providing diagnosis or treatment for cancer. All of Thurrock patients with cancer between April 2014 and June 2015 were first seen by either Basildon and Thurrock University Hospital Trust or Southend University Hospital Trust. First treatment was then either provided by these two Trusts or a referral made for the patient receive first treatment at a different trust. In total, there were 14 different combinations of 'first seen' and 'first treatment' NHS provider trusts. The numbers of Thurrock patients in each combination together with the

numbers who had to wait over 62 days and hence the performance of the combination against the 62 day cancer standard is explored in table 2

Table 2

First Seen' Provider	First Treatment Provider	Number of patients	Total over target	Performance against 62 day cancer standard
SUHT	SUHT	22	0	100.00%
SUHT	Mid Essex Hospital Services Trust	4	0	100.00%
BTUH	University College London	2	0	100.00%
BTUH	BTUH	548	102	81.39%
BTUH	Guys and St.Thomas'	4	2	50.00%
BTUH	SUHT	181	97	46.41%
BTUH	Mid Essex Hospital Services Trust	32	22	31.25%
BTUH	BHRT	6	6	0.00%
BTUH	Cambridge University Hospitals Trust	6	6	0.00%
BTUH	Royal Marsden	4	4	0.00%
BTUH	Kings College Hospital	2	2	0.00%
BTUH	Royal Brompton and Harefield	2	2	0.00%
BTUH	North West London	2	2	0.00%
BTUH	Barts Health	2	2	0.00%

All patients who were first seen by Southend University Hospital Trust (SUHT) were treated within the 62 day cancer standard, although the absolute numbers of patients was small.

For patients seen at BTUH, 81.39% were treated within the 62 day cancer standard if their first treatment was also provided by BTUH. Where the system appeared to fail is where patients first seen at BTUH were treated by another provider. Less than half of patients first seen at BTUH and first treated at SUHT were treated within the 62 day cancer standard. This figure deteriorated to 31.25% for patients first treated at Mid Essex and to 0% for all other providers.

This level of performance is clearly unacceptable and warrants immediate further investigation.

Figures 8.13,8.14 and 8.15 explore performance against the 62 day cancer standard of the three combinations of 'first seen' and 'first treatment' with the greatest number of patients; BTUH-BTUH, BTUH-SUHT and BTUH Mid-Essex for different tumour groups. Pathways relating to tumour groups towards the left hand side of the graph should be investigated first. Head and neck, gynaecological, gastrointestinal, skin, lung and urological are of particular concern.

Figure 8.13

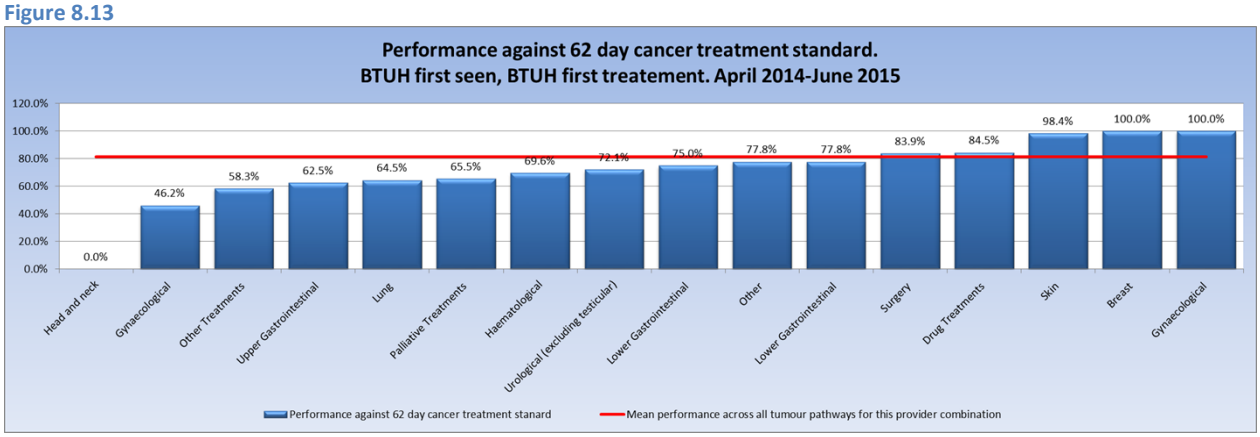


Figure 8.14

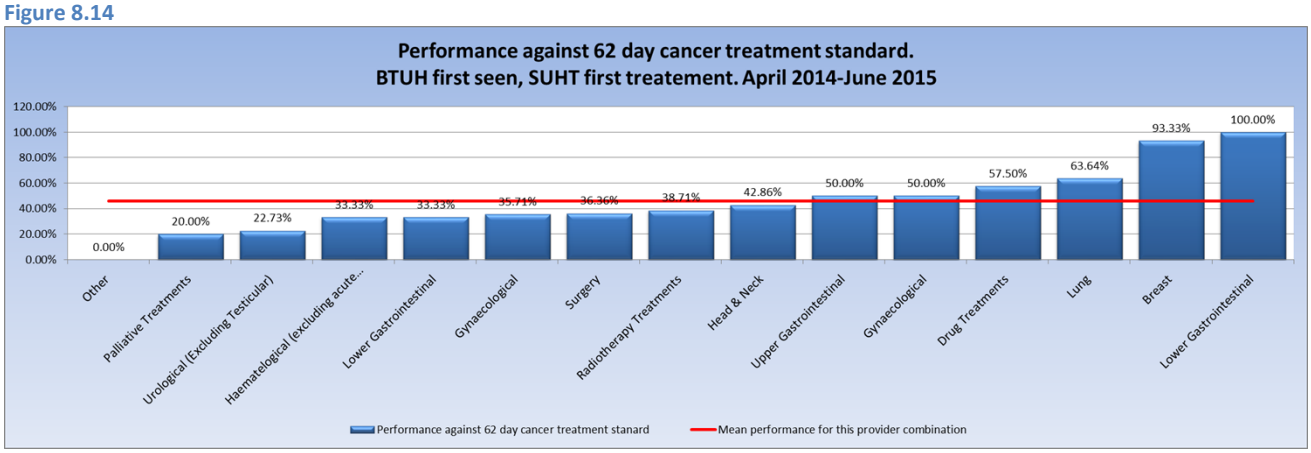
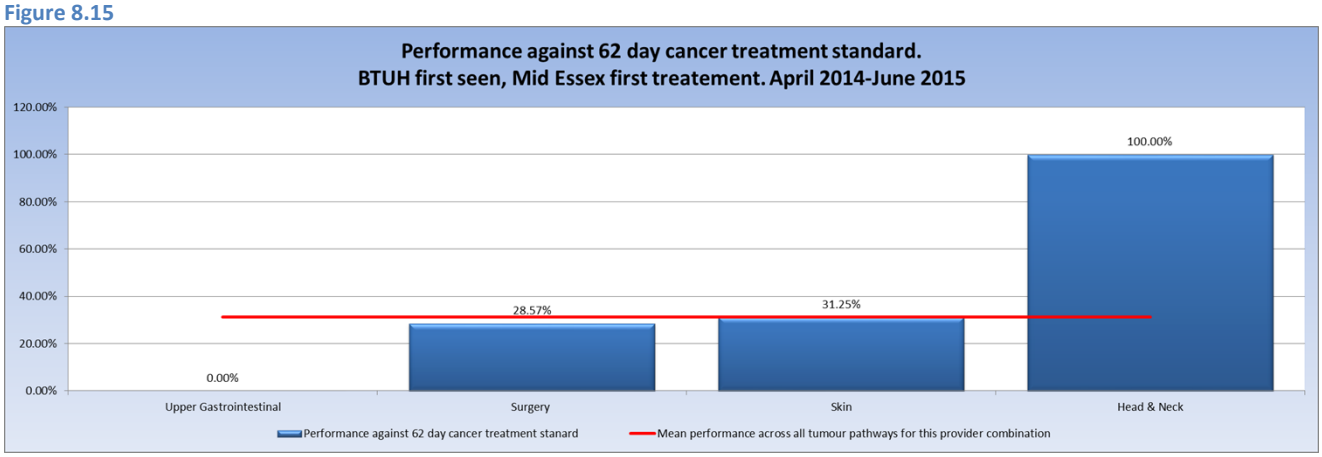


Figure 8.15



8.4 Summary: Cancer Diagnosis and Treatment

There is significant variation between different GP populations in terms of rate of unplanned care admissions for cancer with 12 practices having rates significantly below the England mean and two practices significantly above and a 20 fold difference between the practice population with the highest and lowest rate. Cancer unplanned care admission rates as strongly positively associated with income deprivation levels in the practice population although the reasons for this are unclear. Explanations could include a greater level of under doctoring in deprived communities, a lower cancer screening coverage or a greater unwillingness of deprived populations to seek help early for cancer symptoms.

The CCG performs in line with England and its comparator group CCGs on the 31 day wait performance cancer standard suggesting that once cancer is diagnosed, the vast majority of patients (97%) receive treatment within 31 days. Conversely only 68.4% of patients with cancer receive treatment within 62 days from their initial GP referral. This is the lowest percentage of patients when compared to Thurrock's comparator CCGs and significantly worse than the England mean of 84%. Furthermore the situation has deteriorated over the last 15 months. Considering these two metrics together suggests that there are serious and unacceptable delays occurring in the initial diagnosis of cancer. Delays in cancer treatment due to delays in diagnostics is likely to impact adversely on mortality rates of Thurrock patients and is unacceptable. This warrants further urgent investigation.

Detailed category analysis on 62 day breach reports undertaken by the author between April 2014 and June 2015 suggests that 78% of all 62 day cancer wait breaches are potentially avoidable. The most common two reasons were either entirely or partly a function of the fragmentation of cancer pathways between multiple hospital sites across Essex. The most common reason was delays in access to diagnostics. This occurred either at one site or often because referral of patients between different sites was required in order to access to all diagnostic equipment in order to obtain an adequate diagnosis to begin treatment. This accounted for almost half of all breaches. Where specified, delays for MRI and CT scans and for TRUS featured commonly in breach reports categorised into this sub-category.

A theme running through many of the reports for breaches categorised as 'avoidable' was a lack of coordination of care of the patient. The care pathway operates as a series of linked individual processes with staff only taking responsibility for their part of the pathway or process. As soon as one part of the pathway failed, the entire pathway failed and the delay occurred. Patients often appeared to be 'bounced' around different providers and different parts of the NHS system with no one individual taking responsibility for their journey through the pathway.

The Urological, lung, and upper gastrointestinal pathways give cause for significant concern with over 50% of patients entering these pathways failing to receive treatment for cancer within the 62 day standard because of reasons that were potentially avoidable. 47% of patients with lung cancer experienced a delay in diagnostics in the first quarter of 2014/15.

8.6 Recommendations: Cancer Diagnosis and Treatment

1) The current configuration of cancer pathways is fragmented across multiple hospital sites. NHS England should work with CCGs across Essex to rationalise cancer diagnosis and treatment into fewer specialist centres

2) No one professional is accountable for a patient's journey through the system. The CCG should commission a 'care coordination' approach to cancer care with a single named accountable professional being responsible for monitoring a patient's journey and ensuring each part of the system works in a coordinated and high quality care

3) Delays in diagnostics in some tumour specific pathways is the primary reason for failure to meet the 62 day cancer waiting standard. The current level of delay for some types of cancer is unacceptable and may be unnecessarily compromising the efficacy of future treatment and causing distress to patients. The CCG, in association with the relevant providers should urgently review the following care pathways with a view to

addressing delays in diagnostics: Urological, lung, upper and lower GI, haematological, head and neck, and gynaecological.

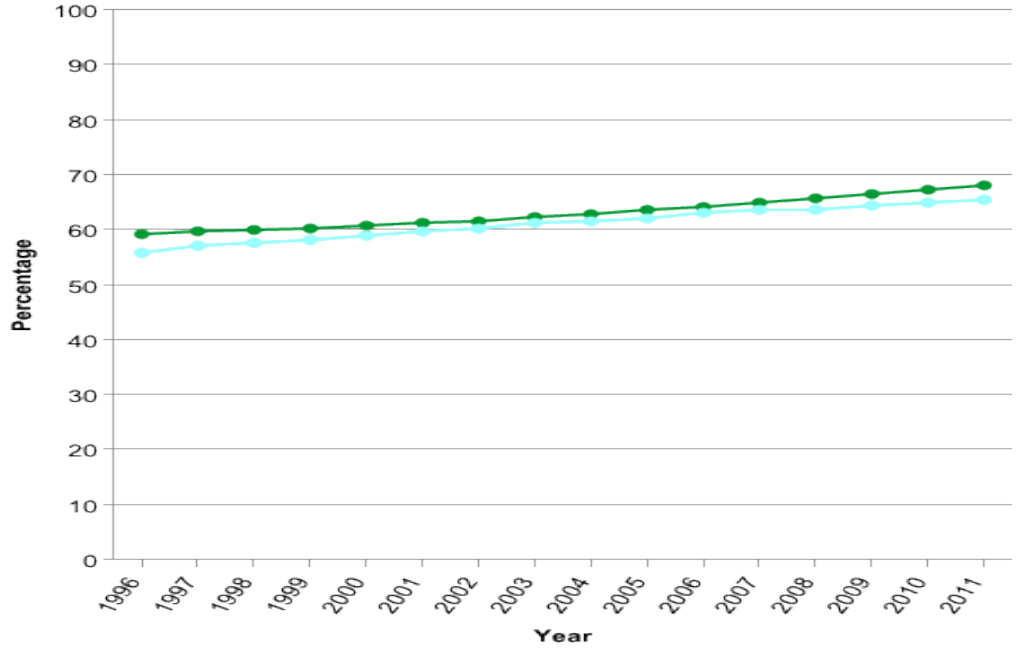
9. CANCER SURVIVAL

9.1 One year cancer survival rates

Figure A shows the one-year net survival index for all cancers for Thurrock and England over time. This is the percentage of patients with cancer, still alive one year after diagnosis.

Figure 9.1

One-year net cancer survival index, all cancers



Cancer one-year survival rates for both Thurrock and England have increased at largely the same yearly rate and by around 10% between 1996 and 2011, with Thurrock's one-year survival rate remaining slightly below that of England's.

Figures 9.2-9.4 show one year survival rate for the three most common cancers in Thurrock and in Thurrock CCG's ONS comparator group of CCGs over time. These are CCGs serving populations with demographics most similar to our own.

Figure 9.2

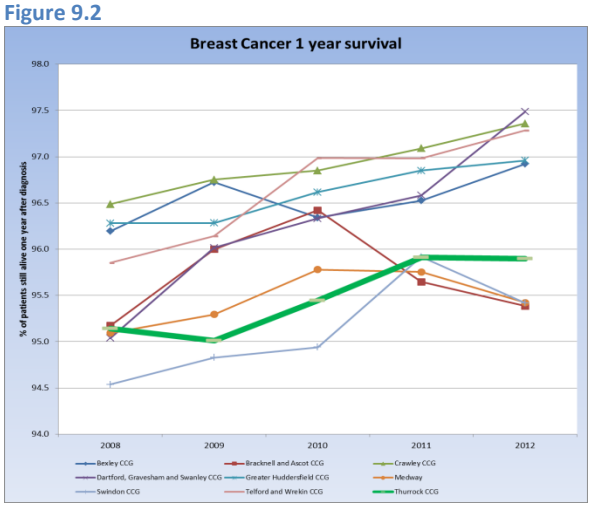


Figure 9.3

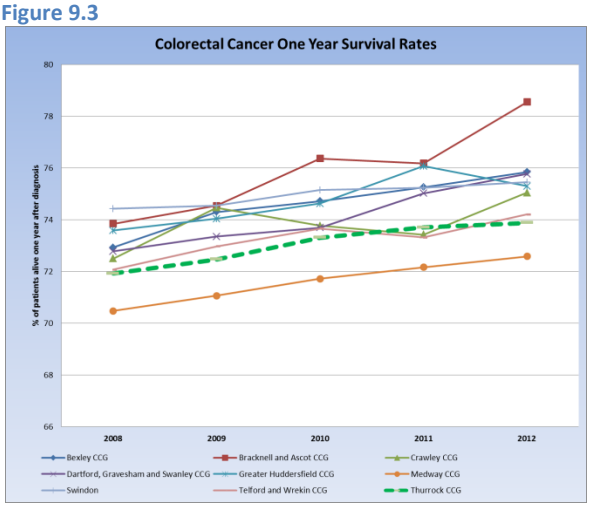
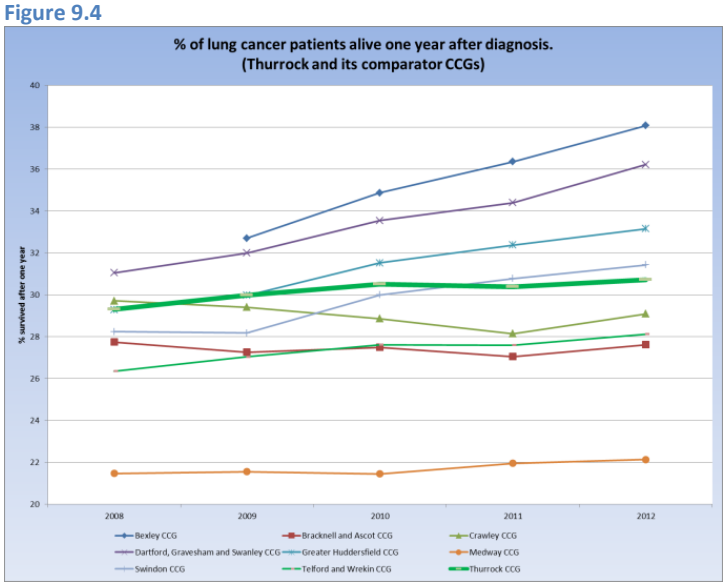


Figure 9.4



Whilst improving, one-year survival rates for both breast and colorectal cancer in Thurrock are amongst the lowest amongst in our ONS comparator group of CCGs. One year lung cancer one-year survival rates are around median compared to our ONS CCG comparator group, although are not improving at the same rate as other CCGs.

Our performance in terms of cancer survival rates are highly likely to be a product of all of the issues examined in the previous sections of this report.

9.2 Cancer five year survival rates

Figures 9.5, 9.6 and 9.7 show five year cancer survival rates for breast, lung and lower GI cancer respectively for Thurrock (SW Essex PCT) and England.

Figure 9.5

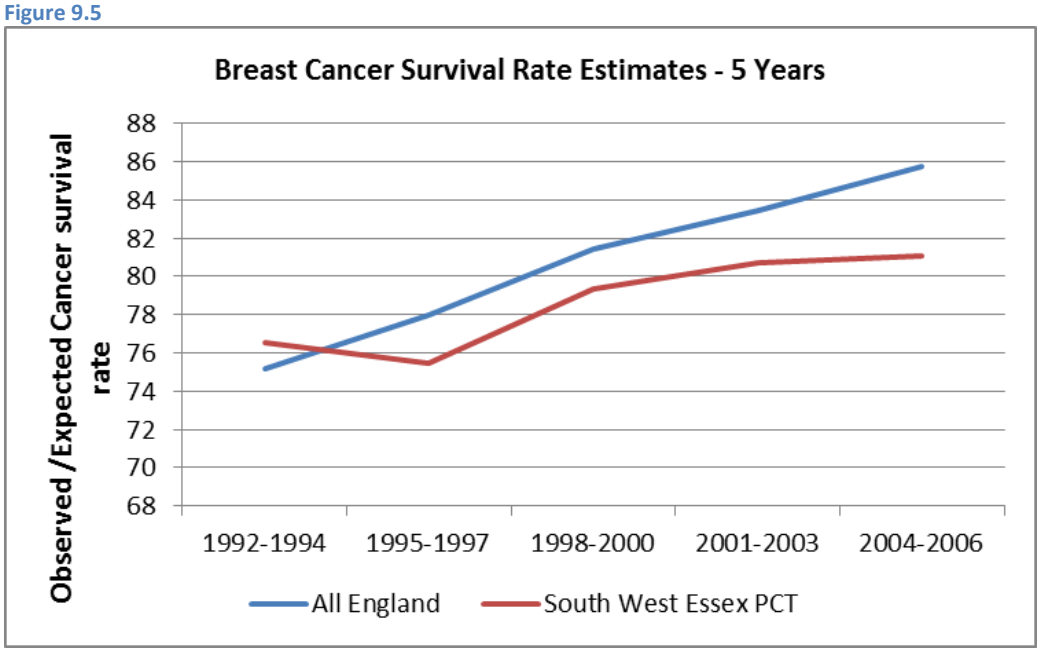


Figure 9.6

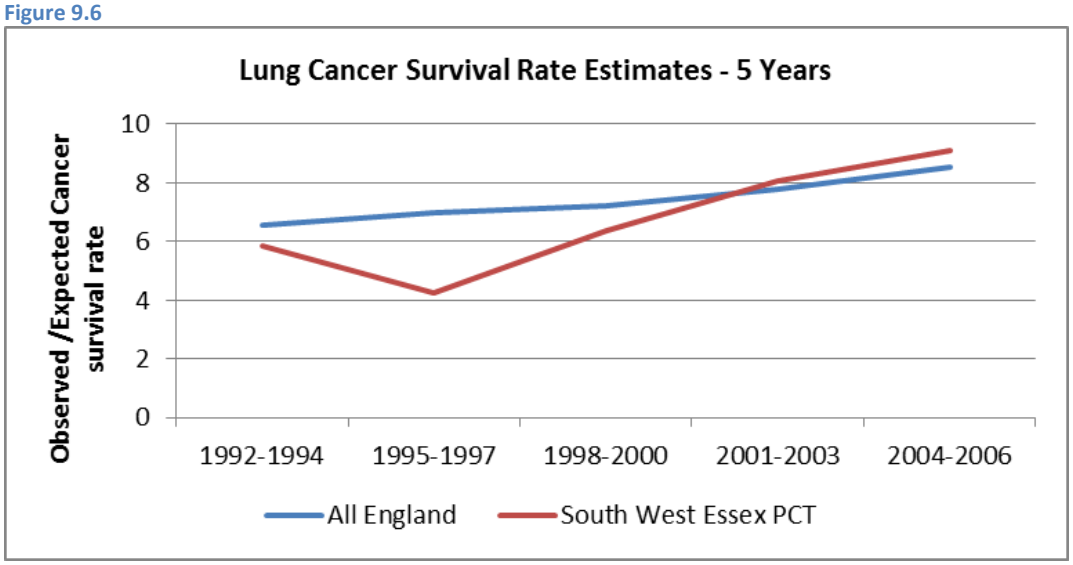
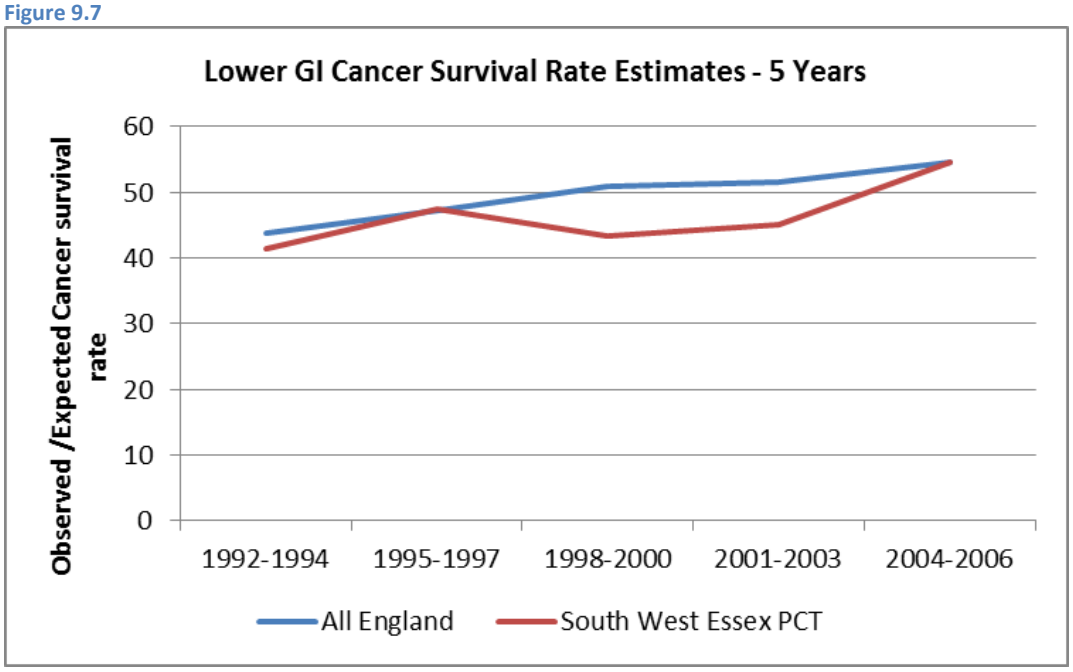


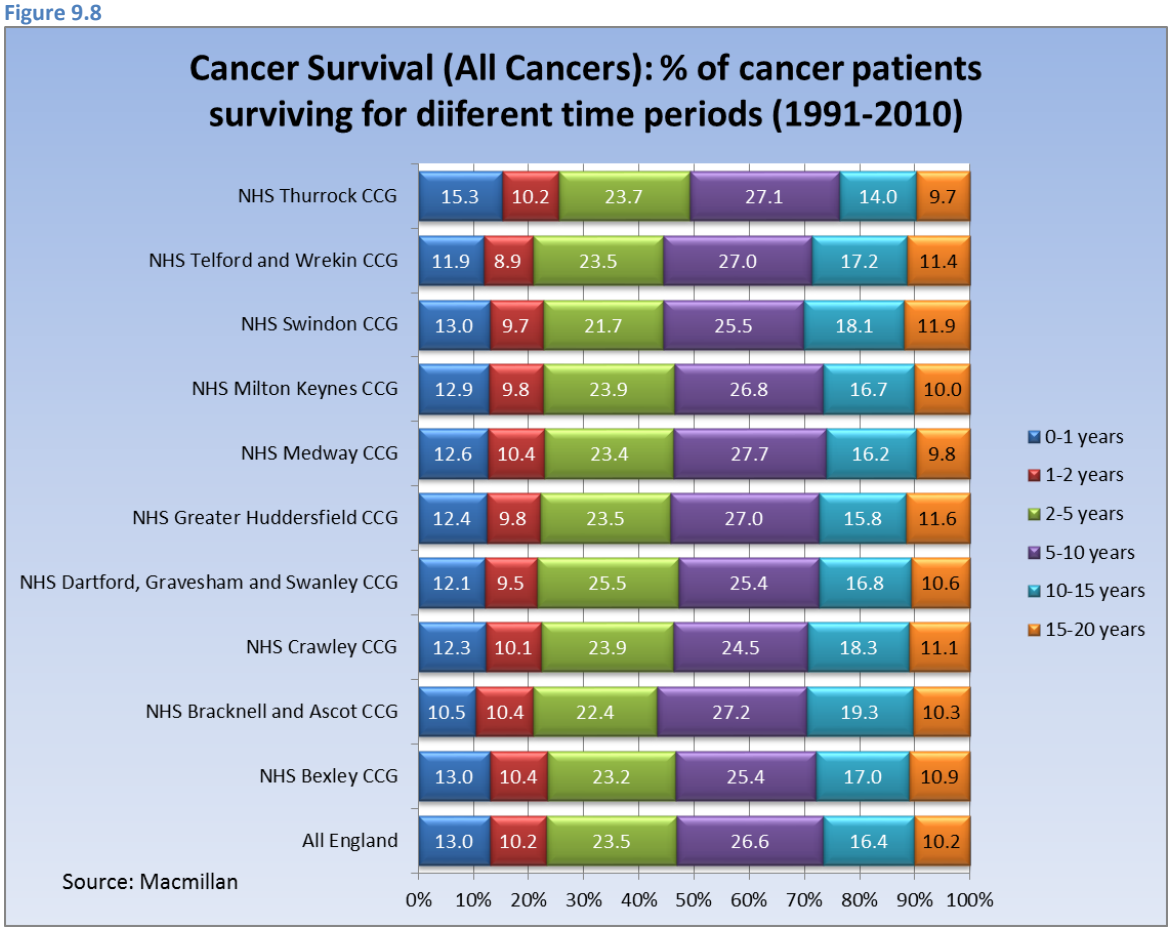
Figure 9.7



Figures 9.5-9.7 show five year lower GI and lung cancer to be largely in line with England's, with survival rates for breast cancer survival being below England's. However it should be noted that these data are almost ten years out of date now.

Figure 9.8 shows the length of time that patients survive cancer (for all cancers) in Thurrock, England and our ONS comparator CCG populations from 1991 to 2010.

Figure 9.8



Over the last 20 years, patients diagnosed with in Thurrock have generally survived for shorted periods of time than England and many of our comparator CCGs. 15.3% of patients diagnosed with cancer in Thurrock have survived no more than one year, compared with 13% in England. Conversely, after 15-20 years only 9.7% of patients with cancer in Thurrock have survived, compared to 10.2% for England and 11.9% for NHS Swindon. However, this will impart reflect historical factors that may have improved.

9.3 Cancer Survival Summary

Cancer one-year survival rates for both Thurrock and England have increased at largely the same yearly rate and by around 10% between 1996 and 2011, with Thurrock's one-year survival rate remaining slightly below that of England's.

Whilst improving, one-year survival rates for both breast and colorectal cancer in Thurrock are amongst the lowest amongst in our ONS comparator group of CCGs. One year lung cancer one-year survival rates are around median compared to our ONS CCG comparator group, although are not improving at the same rate as other CCGs.

Over the last 20 years, patients diagnosed with in Thurrock have generally survived for shorted periods of time than England and many of our comparator CCGs