9 June 2016	ITEM: 7
Health and Wellbeing Overview and Scrutiny Committee	
Cancer Deep Dive (Health Needs Assessment) in Thurrock	

Wards and communities affected: All	**Key Decision:** Non-key

Report of: Funmi Worrell, Public Health Registrar
Accountable Head of Service: Ian Wake, Director of Public Health
Accountable Director: Ian Wake, Director of Public Health
This report is Public

Executive Summary

A Joint Strategic Needs Assessment/Cancer Deep Dive report was produced as part of the core Public Health offer to NHS Thurrock Clinical Commissioning Group (CCG).

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 CCGs to ensure that no patient with cancer waits longer than 62 days from initial referral by their GP with symptoms that require investigation, through diagnosis, to receiving their first treatment for cancer.

However, the scope was broadened to consider all elements of the cancer care pathway, from prevention, screening and referral through to diagnosis, treatment and survival.

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. 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.

A number of areas where discovered where joint working between the CCG, council and other partners could lead to improved outcomes for the population.

1.   Recommendation(s)

1.1   That the Health Overview and Scrutiny Committee note the contents of this report.

1.2   HOSC should support the work done by public health, CCG colleagues and other partners to improve cancer services and outcomes in Thurrock.

2.   Introduction and Background

2.1.   Cancer is the single biggest cause of premature mortality amongst our population.

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

2.3   Research suggests that at least one-third of all cancer cases are preventable.

2.4   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.

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

2.6   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.

2.7   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.

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

3.   Issues, Options and Analysis of Options

3.1   **Overview of issues – Cancer is the single biggest cause of premature mortality in Thurrock.**

3.2   **Cancer Prevention: Smoking**

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.

3.3   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.

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

3.5   Thurrock has rates of hospital admissions and mortality attributable to smoking that are significantly greater than England's and many of its comparator populations.

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

- 86.6% of smokers have 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.
- There is significant variation between different GP practice populations and this cannot be explained by differences in deprivation levels between practice populations.

3.7   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.

3.8   **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.

3.9   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.

3.10   **There are three cancer screening programmes:**

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

3.11   **Cervical Screening**

- 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.
- 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 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.

3.12   **Bowel cancer screening**

- 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 being just over half of that in the population with the highest coverage rate.
- 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.

3.13 **Breast cancer screening**

- The mean screening coverage rate for breast screening of patients across Thurrock is 65.9% which is below the minimum standard of 70%.
- 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%.

3.14 **Early Identification and Referral of People with Suspected Cancer:**

- Timely and appropriate referral of patients with symptoms is essential to improving cancer survival in our population.
- One of the explanations in 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.
- 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.
- 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.

3.15 **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 are 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.
- Delays in cancer treatment due to delays in diagnostics is likely to impact adversely on mortality rates of Thurrock patients and is unacceptable.
- 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:
- Over 50% of patients entering these pathways fail 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.
- 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

4. **Reasons for Recommendation**

4.1   HOSC is asked to note the contents of this report.

4.2   HOSC is asked to support the work that public health, CCG and other partners are doing in order to improve outcomes for those affected by cancer in Thurrock.

5. **Consultation (including Overview and Scrutiny, if applicable)**

5.1   This report has been presented to Thurrock CCG colleagues, who supported the recommendations made.

6. **Impact on corporate policies, priorities, performance and community impact**

6.1   This report should be used by the Council and partners to influence new ways of working and supporting policies and actions that aim to improve outcomes by those affected by cancer.

7. **Implications**

7.1 **Financial**

Implications verified by: **Jo Freeman**

Management Accountant, Social Care & Commissioning

There are no financial implications following the recommendations of this report.

7.2 **Legal**

Implications verified by: **David Lawson**

Monitoring Officer and Deputy Head of Legal

There are no direct legal implications at this stage.

7.3 **Diversity and Equality**

Implications verified by: **Natalie Warren**

Community Development and Equalities Manager

There are no direct diversity implications arising from this report.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder

Implementing the recommendations of the report will help to improve the health of the population by diagnosing cancers earlier and treating them more quickly in order to improve cancer survival rates.

8. **Background papers used in preparing the report** (including their location on the Council's website or identification whether any are exempt or protected by copyright):

None.

9. **Appendices to the report**

Appendix 1 - Cancer Deep Dive

Report Author

Funmi Worrell

Public Health Registrar