Report to:	**SINGLE COMMISSIONING BOARD**
Date:	28 June 2017
Officer of Single Commissioning Board	Clare Watson, Director of Commissioning Angela Hardman, Director, Public Health
Subject:	**CANCER UPDATE**
Report Summary:	The purpose of this report is to inform the Board about a review of cancer data to help inform the development of locality specific actions to ensure we contribute to the ambitions set out within the plan for Greater Manchester.
Recommendations:	The Single Commissioning Board are asked to note the contents of the report

Financial Implications:

(Authorised by the statutory Section 151 Officer & Chief Finance Officer)

Budget Allocation (if Investment Decision)	No direct budget implications in paper
CCG or TMBC Budget Allocation	N/A
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	N/A
Decision Body – SCB, Executive Cabinet, CCG Governing Body	SCB
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	N/A
Additional Comments We note the data contained within this report. There are no immediate direct financial implications in the report, but over the longer term if we are able to improve outcomes for patients without significant additional investment, there would be clear alignment to the aspirations and goals of the Care Together programme.	

Legal Implications: **(Authorised by the Borough Solicitor)**	The purpose of this report is to ensure that the Board has sufficient data and performance information to ensure that it is allocating resources appropriately.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with Starting Well, Developing Well, Living Well, Working Well, Aging Well and Dying Well.
How do proposals align with Locality Plan?	The proposals are consistent with Healthy Lives (early intervention and prevention), Community development, Enabling self-care, Locality based services, Urgent Integrated Care Services and Planned care services strands of the Locality plan.

How do proposals align with the Commissioning Strategy?	The work contributes to the Commissioning Strategy by: • Empowering citizens and communities; • Commission for the 'whole person'; • Create a proactive and holistic population health system.
Recommendations / views of the Professional Reference Group:	In light of the information within this report the Board are asked to endorse the approach taken in ensuring better outcomes for our patients in terms of contributing to the level of ambition set for preventing avoidable deaths, reducing variation and improving experience.
Public and Patient Implications:	The implications for Public and Patients are to aim to develop a local plan that aims to prevent avoidable deaths, reduce variation and improve experience.
Quality Implications:	Tameside Metropolitan Borough Council is subject to the duty of Best Value under the Local Government Act 1999, which requires it to achieve continuous improvement in the delivery of its functions, having regard to a combination of economy, efficiency and effectiveness.
How do the proposals help to reduce health inequalities?	This report will help us to understand the impact we are making to reduce health inequalities to incorporate into the local plan.
What are the Equality and Diversity implications?	The proposal will not affect protected characteristics groups within the Equality Act.
What are the safeguarding implications?	Safeguarding will be central to the review /plan.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no information governance implications as part of the review. No privacy impact assessment has been conducted.
Risk Management:	No current risks identified
Access to Information :	The background papers relating to this report can be inspected by contacting Louise Roberts  Telephone: 07342056005  e-mail: Louise.roberts@nhs.net

1. BACKGROUND

1.1 NHS Tameside and Glossop Clinical Commissioning Group in partnership with Tameside and Glossop Integrated Care Foundation Trust are developing locality specific actions to ensure we contribute to the ambitions set out within the plan for the Greater Manchester Cancer Board and the cancer programme of the Greater Manchester Health and Social Care Partnership Strategic Partnership Board.

1.2 There are eight domains within the Greater Manchester plan**;** reflecting a combination of the five key areas for change set out in '**Achieving world-class cancer outcomes: Taking charge in Greater Manchester 2017-2021'** (each part of the system will be expected to contribute and will be held to account) and the six key work streams of the National Cancer Strategy.

1.3 A substantial part of the plan in 2016/17 and 2017/18 is part of the vanguard innovation programme and funded by NHS England's New Care Models Team; this may be funded by Transformation funding going forward. At a Greater Manchester and local level, work is ongoing to meet the level of ambition with the aim of preventing avoidable deaths, reducing variation and improving experience. Refer to **Appendix 1** for the level of contribution required from Provider Trusts and **Appendix 2** for Clinical Commissioning Groups).

1.4 This report uses National, Greater Manchester and Local data to inform areas for improvement which can be incorporated into the locality-specific actions that are currently being developed within NHS Tameside and Glossop Clinical Commissioning Group.

1.5 The Greater Manchester Cancer Plan was received by Tameside Health and Wellbeing Board on the 09 March 2017. The Tameside and Glossop Cancer Board, which is led by T&G ICFT with membership from SCF, are currently developing a comprehensive implementation plan. The contributions of the SCF to the plan are outlined in the timeline at 5.1 below.

1.6 Reporting into Board currently includes the Better Care Measures:

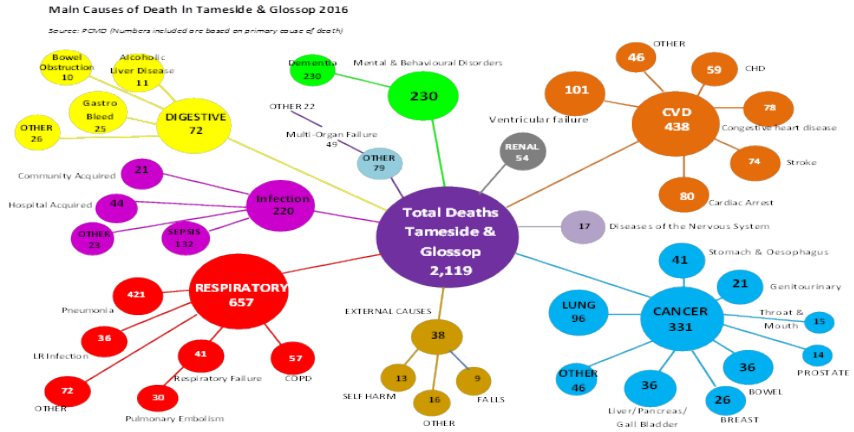
- One-year survival from all cancers;
- Proportion of people with Cancer diagnosed at an early stage;
- Cancer Patient experience;
- Cancer 2 week wait (2ww), Cancer 31 day wait and Cancer 62 day wait.

1.7 These need to be considered alongside measures that prevent incidence of cancer (e.g. reducing smoking prevalence, lifestyle and activity), cancer screening programmes and access to diagnostics along the pathway for patients.

1.8 Patients often have co-morbidities and we need to consider how we work across pathways in partnerships; for example Right Care data shows that of 187 patients admitted for Cancer, 54 patients were admitted for Gastro Intestinal conditions, 48 for Respiratory Conditions, 39 Genito Urinary, 43 Poisoning and adverse effects and 31 for circulation.

2. OVERVIEW

2.7 In 2016 Cancer was the main cause of death in 15.6% of the population in Tameside and Glossop Clinical Commissioning Group (331 out of 2,119 total deaths).



2.8 In 2012/14 1,756 children in England were newly diagnosed with Cancer (less than 1% of all cancers were in children) of these 257 died, 82% surviving five years and 91% one year. The commonest childhood cancer is leukaemia. Other than age and genetics, there is very little good evidence on risk factors that contribute to cancer in childhood. Statistics for childhood cancers are not routinely published for Greater Manchester, the North West or Tameside. Local data will be requested from the North West Local Cancer Intelligence Network and an analysis of data will be incorporated into the developing plan.

2.9 In Tameside and Glossop Clinical Commissioning Group all of the following were higher than the NHSE average:

- incidence of cancer;
- mortality rates;
- under 75 years of age mortality;
- number of deaths from cancers considered preventable;
- adult smoking rates.

2.10 The majority of the time we are achieving the operational waiting times standards (93% within 2ww, 96% within 31 days and 85% within 62 days).

Better Care

Description	Indicator	F	Level	Better is...	Threshold	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	Exceptions
Cancer 2Week Wait	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	M	T&GCCG	H	93%	95.3%	97.1%	94.1%	94.3%	94.6%	95.4%	94.5%	97.5%	96.3%	94.4%	91.6%	95.2%	91.9%	
	Maximum two week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	M	T&GCCG	H	93%	93.3%	98.0%	91.8%	94.0%	94.7%	97.3%	100.0%	100.0%	96.8%	100.0%	91.4%	98.3%	91.6%	
Cancer 31 Day Wait	Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers	M	T&GCCG	H	96%	100.0%	98.9%	100.0%	100.0%	96.8%	98.9%	96.0%	98.2%	100.0%	98.9%	100.0%	97.7%	100.0%	
	Maximum 31 day wait for subsequent treatment where that treatment is surgery	M	T&GCCG	H	94%	100.0%	100.0%	100.0%	100.0%	100.0%	94.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Maximum 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	M	T&GCCG	H	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	Breach due to deferred treatment in Jan-16.
	Maximum 31 day wait for subsequent treatment where the treatment is a course of radiotherapy	M	T&GCCG	H	94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.8%	100.0%	100.0%	100.0%	100.0%	
Cancer 62 Day Wait	Maximum two month (62 day) wait from urgent GP referral to first definitive treatment for cancer	M	T&GCCG	H	85%	89.7%	88.6%	91.3%	89.6%	91.1%	78.6%	91.7%	90.6%	88.0%	89.1%	87.7%	82.6%	91.4%	There were 10 breaches out of a total of 70 seen in Sept 16.
	Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers	M	T&GCCG	H	90%	100.0%	100.0%	88.0%	100.0%	100.0%	100.0%	100.0%	92.9%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Maximum 62 day wait for first treatment following a consultant's decision to upgrade the priority of the patients (all cancer)	M	T&GCCG	H	85%	81.1%	85.7%	94.4%	92.6%	100.0%	56.8%	71.7%	94.6%	73.8%	75.0%	87.5%	85.2%	91.7%	For Jan 17 20 patients treated with 4 being treated over the target. For Dec 16 14 patients treated with 3 being treated over the target. For Sept 16 there were 13 patients treated with 6 being treated over the target

2.11 We have a higher than average number of 2ww referrals than the NHS average for suspected cancers per 100,000 of the population.

2.12 The conversion rate into diagnosed cancer is lower than the NHSE average but 2015/16 data shows that we are starting to reduce the gap.

2.13 While survival rates from cancer are increasing we have a relatively high number of cancers detected late, with 20% of all cancers identified through emergency presentation (slightly higher than NHSE average), and consequently reduced survival rates, compared to the England average and other CCGs across Greater Manchester.

2.14 Therefore it is important to focus on prevention and early diagnosis of cancer and offer support to reduce any variation across Tameside and Glossop CCG, for example screening uptake within Tameside is lower than High Peak for Breast and we are outliers across Greater Manchester for cancer screening for people with Learning disabilities.

3. HOW DO WE COMPARE?

3.1 NHS England Clinical Commissioning Group Improvement and Assessment Framework:

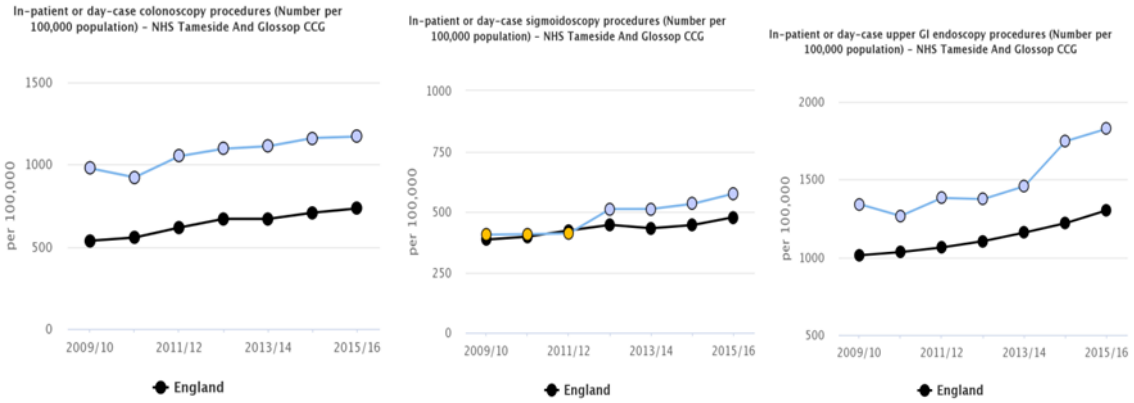
- One year survival from cancer is improving year on year but is lower that the NHSE average (70.2%) at 67.6% in 2013. When comparing to 10 similar CCGS two were lower than T&G CCG.
- Fewer cancers (45.2%) are detected at an early stage compared NHSE Average 50.7% in 2014. When comparing to 10 similar CCGS one was lower.
- Better than the NHSE average (82.2%) for GP referral to first definitive treatment within 62 days in Q1 16/17. When comparing to 10 similar CCGS all were lower.
- Cancer patient experience is slightly lower than the National average in 2015.

3.2 Public Health NHSE Dashboard and trends :

- Higher Incidence rate of cancers per 100,000 in 2014 at 647.82 compared to NHSE 608.3.
- 20.7% of Cancers are diagnosed through an emergency presentation (higher than average and a good proxy measure).
- Achieve the operational performance standards (2ww, 31 days and 62 days standard) and better than the NHSE average; however our average 2ww for breast, lower GI and lung is higher than the NHSE average.
- Worse than the NHSE Average (608.3) for Cancer Incidence and Mortality at 647.82 per 100,000, < 75 mortality, from cancers considered preventable and adult smoking rates (21.7% 2015).

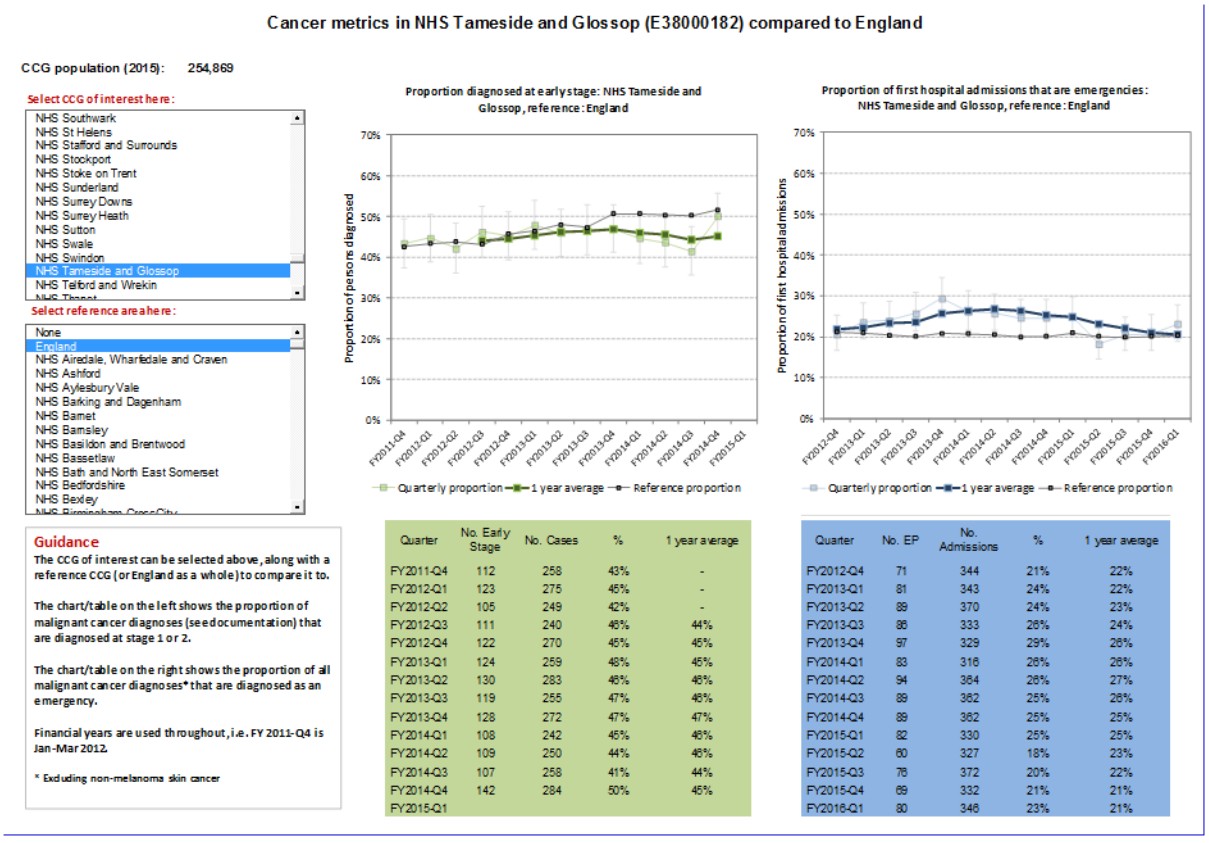
	Breast	**Bowel**	**Lung**
Incidence rate per 100,000 – 2014 (CCG)	NHSE 173.38 Tameside 148.52	NHSE 70.43 Tameside 78.43	NHSE 78.34 Tameside 121.8
Incidence rate per 100,000 – <75 Mortality, 2014 (CCG)	NHSE 21.21 Tameside 25.35	NHSE 11.9 Tameside 13.03	NHSE 33.26 Tameside 46.82
Screening uptake 2015 (LA) %	NHSE 75.4 Tameside 68.4 High Peak 77.4	NHSE 57.1 Tameside 52 High Peak 60.02	X

- Alignment to Local Authority level shows variation across tumour sites.
- Clinical Headline Data is also available by provider for Breast, Colorectal and Cervix.
- Higher than the NHS and GM average for In patient day case colonoscopy, upper GI endoscopy and sigmoidoscopy.



Key: Light blue – Higher then NHSE and GM and Dark Blue – Lower than NHSE and GM

3.3 Cancer Outcomes: Stage at Diagnosis and Emergency Presentations



Quarter	No. Early Stage	No. Cases	%	1 year average
FY2011-Q4	112	258	43%	-
FY2012-Q1	123	275	45%	-
FY2012-Q2	105	249	42%	-
FY2012-Q3	111	240	46%	44%
FY2012-Q4	122	270	45%	45%
FY2013-Q1	124	259	48%	45%
FY2013-Q2	130	283	46%	46%
FY2013-Q3	119	255	47%	46%
FY2013-Q4	128	272	47%	47%
FY2014-Q1	108	242	45%	46%
FY2014-Q2	109	250	44%	46%
FY2014-Q3	107	258	41%	44%
FY2014-Q4	142	284	50%	45%
FY2015-Q1				

Quarter	No. EP	No. Admissions	%	1 year average
FY2012-Q4	71	344	21%	22%
FY2013-Q1	81	343	24%	22%
FY2013-Q2	89	370	24%	23%
FY2013-Q3	86	333	26%	24%
FY2013-Q4	97	329	29%	26%
FY2014-Q1	83	316	26%	26%
FY2014-Q2	94	364	26%	27%
FY2014-Q3	89	362	25%	26%
FY2014-Q4	89	362	25%	25%
FY2015-Q1	82	330	25%	25%
FY2015-Q2	60	327	18%	23%
FY2015-Q3	76	372	20%	22%
FY2015-Q4	69	332	21%	21%
FY2016-Q1	80	346	23%	21%

3.4 Health and care of people with learning disabilities:

- Data shows the number of eligible adults with Learning disabilities screened for cancer is poor in Tameside and Glossop CCG compared to those with no Learning Disability and we are outliers across Greater Manchester. Cervical 25%, Breast 33% and Bowel 48%.

3.5 NHS Right Care data highlights the following areas for improvement as we were worse than our average 10 CCG equivalents in the following

- Breast cancer screening, emergency presentation of breast cancer and <75 Mortality from breast cancer.
- Bowel cancer screening, < 75 mortality from colorectal cancers and cases of C.diff.

- Number of successful 16+ quitters, Non elective spend on lung cancer, detection of lung cancer at an early stage, lung detected at an early stage and <75 mortality from lung cancer.
- Spend on Primary Care Prescribing.
- Lower GI - 6 week waits for colonoscopy and rate of emergency colonoscopies.
- Upper GI - 6 week waits for Gastroscopy and number of alcohol related hospital admissions.
- Liver Disease Pathway – Alcohol specific hospital admissions, non-elective spend on liver disease, alcoholic liver disease - emergency admissions, Liver cancer incidence and <75 mortality from liver disease.
- The Right Care Focus data pack published in May 2016 suggested the additional improvements areas: Cervical screening, LOS, Detecting bowel cancers at an early stage, diagnostic and surgical procedures and Information provided following discharge.
- The Cancer focus pack was updated in April 2017 to include further possible improvement areas: spend on non-elective admissions, total spend on Cancer, detecting breast cancer at an early stage, rate of bed days and average number of days spent in hospital as a result of an emergency admission for patients in their last year of life.

3.6 Tameside and Glossop Integrated Care Foundation Trust presents a cancer performance report to the Cancer Board. The report provides assurances that standards are being met, includes exception reporting of any breaches, highlights any area of concerns and how they will mitigate these. Information is available by tumour site and directorate pathways. The December 2016 / January 2017 Board report showed 38 breaches year to date on the 62 day pathway, 24 were due to complex cases with co morbidities; 5 patient dis engagement, 4 Internal diagnostics, 2 multiple MDTs and treatment delays. The Trust will continue to review capacity and demand.

4. CONSIDERATIONS

4.1 The development of locality-specific actions, currently being developed within NHS Tameside and Glossop Clinical Commissioning Group will support achievement of all the measures identified in within 'Achieving world-class cancer outcomes: Taking charge in Greater Manchester 2017-2021' and the six key work streams of the National Cancer Strategy. The following areas need to be considered as part of an ongoing improvement process and incorporated into the plan:

- What else can we do to detect Cancer earlier and raise Public awareness through National and Local Campaigns?
- How do we reduce emergency presentations (impact on non-elective admissions)?
- Role of Primary Care e.g. Use of E Referrals and EMIS templates.
- Improve access e.g. STT Colonoscopy, New Lung pathway, Bowel prep issued within Primary care etc.
- Ensure access to services are equitable.
- Planning, demand and Capacity.
    - Impact of Locum staff e.g. new rules IR35.
    - How do we reduce the number of DNAs?
    - Learning from breach analysis.
    - Support within the Community.
    - Data shows LOS in hospital is greater than comparative CCGS.
    - Care planning, data shows we only prepare 32.5% of after care plans
    - How do we improve Patient experience?

5. TIMELINE

5.1 The following Timeline details the development of the locality specific action plan.

DATE	PROGRESS OR ACTIONS REQUIRED
Early 2017	Greater Manchester (GM) Plan ratified on 24 February 2017.
March 2017	Introduction to GM plan to Health and Wellbeing Board on the 09 March 2017.
March 2017	Outcomes from local Cancer Board discussions on 29 March 2017: • Ongoing development of locality specific actions • Audit of Local working position and develop actions required to meet the Locality Specific actions • Identified membership of GM Cancer Plan local working group to further progress the plan.
March 2017	On 07 March 2017 established a GM Cancer Plan local working group that will meet on a monthly basis.
April 2017	Review of Cancer data to highlight areas for consideration for inclusion within the plan.
May 2017	GM Cancer Plan local working group: • agreed Terms of Reference and governance process agreed by Cancer Board on 19 May 2017 • assigned a Care Together Project Manager who started to develop a project plan • progressed the development of the Locality specific plan • Established Task and Finish Groups for each of the work streams identified within the plan to oversee the implementation of Locality Specific actions. • The work streams are: o Prevention and Earlier & Better Diagnosis (lead - Gideon Smith) o Living With and Beyond Cancer (lead - Carol Diver) o Improved & Standardised Care (lead – Susi Penney o Patient Experience & User Involvement (lead - David Banks) o Commissioning & Accountability (lead - Alison Lewin) o Research & Education – (lead Tameside and Glossop Cancer Board) • **Appendix 3** provides an update on the current local position and next steps required to deliver the contributions required in the Locality specific plan.
June 2017	Present update at Chairs Brief on 13 June 2017 and 28 June 2017
July 2017	Present update at Single Commissioning Board on 11 July 2017
July 2017 to March 2021	GM Cancer Plan local working group Board will be kept informed of progress with any areas of concern escalated as appropriate.

6. RECOMMENDATIONS

5.1 As set out at the front of the report.