APPENDIX A

Title	**Update on Cancer Prevention work and NCL Cancer Network**
Audience	**NCL Directors of Public Health**
Date	**August 2012**
Author	**Rachel Wells** **NHS NCL/London Borough of Barnet**

1. Background

The landscape for cancer prevention and early diagnosis is changing in London. This paper sets out the current picture for cancer for the boroughs in NCL and identifies some of the challenges for the near future which should be taken into account when planning how cancer prevention, early diagnosis, treatment and public health will operate in any new structures.

2. Present and future structures

2.1 The NCL Cancer Network has merged with the NEL Cancer Network and jointly these are now known as the NCLNEL Cancer Commissioning Network, in which there is currently one day of public health support offered by NCL and a part time consultant attached to NEL. The structure mirrors that of the Commissioning Support Organisation and once staff consultation and re-organisation is complete the cancer network will transform to become a team with the new CSS known the Cancer Commissioning Team. It is not clear at present whether this will include any public health support within the team and neither of the current consultants will be available from Aug 2012. If public health does not exist in the team there may be an intention for public health support for come from within the boroughs, though there has been limited discussion on this to date as structures in general are still being clarified.

2.2 Alongside the development of the cancer commissioning team within the CSS is the establishment of the Integrated Cancer System. This has taken place only in London at present and brings together providers to integrate and co-ordinate the care that is provided to cancer patients, though the ICS that covers NCL/NEL is also keen to be involved in prevention and early diagnosis and is working hard to engage GPS and CCGs.

3. London Cancer, Integrated Cancer System

3.1 London Cancer is an Integrated Cancer System for North Central & North East London and West Essex. It brings together providers from across the health community, academia and the voluntary sector to drive step change improvements in outcomes and experience for the patients and populations.

3.2 In April 2011, responding to London's cancer challenge to improve survival and patients' experience of care, the Model of Care for Cancer (NHS London, 2010) noted that cancer services can only be substantially improved if care is provided through co-ordinated networks taking collective responsibility for whole pathways of care rather than individual NHS

organisations. Services would be built around the needs of cancer patients, rather than patients and their carers having to navigate the different approaches of individual NHS organisations. As such, it proposes a fundamental system shift with the creation of Integrated Cancer Systems (ICS) as provider collaborations to improve the delivery of cancer care.

3.3 The following provider organisations have co-created London Cancer:

•Barnet and Chase Farm Hospitals NHS Trust •Barts Health NHS Trust •Barking, Havering and Redbridge University Hospitals NHS Trust •Great Ormond Street Hospital for Children NHS Trust •Homerton University Hospital NHS Foundation Trust •Moorfields Eye Hospital NHS Foundation Trust •North Middlesex University Hospital NHS Trust •Princess Alexandra Hospital NHS Trust •Royal Free Hampstead NHS Trust •Royal National Orthopaedic Hospital NHS Trust •University College London Hospitals NHS Foundation Trust •Whittington Health.

3.4 London Cancer is the smaller of the two London ICS, the other one, known as London Cancer Alliance covers the rest of London. However UCLP is the key driver in London Cancer and the best contact details for information is:

Charlotte Williams, Director of Integrated Cancer, UCLPartners, 170 Tottenham Court Road, London W1T 7HA, T: +44 (0) 2031082346; M: +44 (0) 7703319213, E: charlotte.williams@uclpartners.com

4.0 Incidence, Mortality and One year Survival Current for Breast, Bowel and Cervical Cancers

The overall picture for cancer in NCL has improved since the last report from the National Cancer Action Team which identified several key issues with one year survival and mortality across the cluster. However we cannot be sure that these trends are likely to continue, and should continue to refresh the LAEDI baseline as a sense check for trends in mortality, incidence, one and five year survival and stage of diagnosis. This paper updates on mortality, incidence and one year survival.

4.1 Breast Cancer:

Incidence

Other than for Islington the incidence of breast cancer across NCL is lower than the England average for the rest of NCL boroughs, with Barnet and Enfield below the London average, See Appendix 1, figure 1.

Mortality

Mortality for all ages is lowest in Barnet and above the England and London average in the rest of the NCL boroughs see Appendix 1 figure 2.

One year survival

One year survival has been an area of concern recently though latest data suggests that differences in one year survival have evened out across NCL, see Appendix 1, figure 3.

4.2 Cervical Cancer

Incidence

With the exception of Islington rates are lower than the England and London average across the cluster, see Appendix 1, figure 4

Mortality – Cervical Cancer

Mortality from cervical cancer is low, however when comparing rates across the cluster Islington and Enfield have higher rates than London and England, and the rest of the cluster. Camden, Haringey and Barnet have rates below those of both England and London, see appendix 1, figure 5

One year survival – Cervical Cancer

One year survival for cervical cancer is around the 83% for 2002-2006 rolling average for NCL, there is no significant difference between the London rate and the NCL rate for cervical survival.

4.3 Colorectal Cancer
Incidence

The incidence for colorectal cancer is above the national and London averages for Islington, and just about on the national average for Haringey. Camden, Barnet and Enfield sit on or just below the London average. However there are pockets in each borough where rates will be higher depending on particular populations, and factors which increase the potential for incidence to increase, these include gender, ethnicity and lifestyle factors**,** see Appendix 1, figure 6.

Mortality

Mortality for under 75s is above the England and London average in Haringey and Islington and sitting on average for Barnet and Enfield, whilst Camden sits just under these averages - see appendix 1, figure 7. Mortality is much higher in men than in women, reflecting the national and London picture.

One year survival

On year survival for colorectal cancer has been compared to Sweden and Norway, both countries offer a good comparison has they have similar levels of cancer registration as England. When comparing one year survival, Camden has the highest rate in the cluster, which is just above the England rate, with Islington and Barnet meeting the England average. Haringey and Enfield sit below the England average and NCL also sits below this. This

means that one year survival for colorectal cancer is poorer across NCL and below the best comparison in Europe, see appendix 1, figure 8.

5. What work is taking place on Cancer Awareness and Prevention?

5.1 The responsibility for cancer awareness and prevention transfers to local authorities in March 2013, though many NCL boroughs have been prioritising this work already. The Cancer Commissioning Network Team have also been the driver for much of the NAEDI (National Awareness and Early Diagnosis Initiative) work since funding for this has been awarded to Cancer Networks in the past, and not directly to boroughs or PCTs. It is not clear as yet how this might change but it may be significant if the competition to bid for NAEDI funds increases to a wider audience in future. It is likely that it would be expected that consortia would come together for this purpose but the configuration of these is unknown.

5.2 There are several initiaitives being conducted across the cluster led by the Cancer Commissioning Network Team, with contributions from local PCCLs and public health.

- GP Leadership Project – see Appendix 2
- NAEDI Cancer Networks Supporting Primary Care: Local Improvement Initiatives & GP Leadership (Wave 2) – see Appendix 3
- Achieving earlier presentation in lung cancer through targeted community awareness (Wave 3) – see Appendix 4

In addition to work being undertaken there are 2 expressions of interest awaiting news of funding:

- Expression of Interest – Promoting Earlier Diagnosis of Cancer 2012/13, funding for local activity on constellation of cancer symptoms North East London Cancer Network and North Central London Cancer Network, working with London Cancer
- Expression of Interest – Promoting Earlier Diagnosis of Cancer 2012/13, funding for local activity to run local stretch engagement activity for bowel cancer across the North East London Cancer Network (NELCN) and North Central London and West Essex Cancer Commissioning Network (NCL&WECCN), covering 13 PCT areas(coterminous with 13 Local Authority areas), representing a population of over 3million, and including; City and Hackney, Tower Hamlets, Newham, Waltham Forest, Redbridge, Barking and Dagenham, Havering, Enfield, Camden, Barnet, Haringey, Islington and West Essex.

The development of a new CSS covering both NCL and NEL means that any new NAEDI work will need additional public health support from boroughs in order to be successful and to build on local priorities. The relationships with the Cancer Commissioning Team and the CCGS are being well established

but the development of these with local authorities and public health vary at this time.

6. The role of the public health lead for the NCL/NEL Cancer Commissioning Network Team

This role has been primarily to support the development of public health relationships, and advise of the collection and interpretation of data. I have led on the information section of the Cancer Commissioning Strategy and interpreted the LAEDI baseline and the more recent LAEDI refresh for the purposes of providing public health information and data for NAEDI bids. I have advised on data interpretation and looked at detail at particular areas where queries have arisen.

I have also held the lead on inequalities for the network and undertaken the audit of inequalities in cancer work across the sector and convened a learning set to devise a forward plan for this. I co-chair the Primary Care and Prevention Board for the network which is the key driver for NAEDI and sit on the Cancer Commissioning Strategy Board and have held a role on several of the project teams.

The future of this role is uncertain and dependant on the Cancer Commissioning Team new structure.

7. Summary

- Progress on prevention and awareness work across the cluster has been led by the Cancer Network Commissioning Team with support from public health.
- The structure and relationship with this team is changing and arrangements for public health are uncertain.
- No announcement has yet been made about how funding for NAEDI funds will be accessed in future.
- The enlargement of the CSS to cover NCL and NEL means that relationships with local authorities, public health and CCGs need to be development to get the best from future funding and co-ordination over the larger area.
- The establishment of the ICS, London Cancer, is significant for commissioning but also prevention and awareness work.
- Mortality and one year survival concerns have improved though these maybe down the an additional period of data and a further refresh would be useful.

Appendix 1 Figure 1

Note that the contents of this appendix are not currently available

Appendix 2: GP Leadership Project

The project

In 2009/2010 all Cancer Networks received funding for the GP Leadership Project. The Project Initiation Document/ Service Level Agreement described the key outcomes – identification of practices of interest on the basis of the GP Practice Profiles; visits to an agreed number of practices to review the information and offer support, including funding for the Primary Care Audit; and implementation of an action plan. Funding was given for GP sessions (8 per borough) and the targeted use of the primary care audit. Since the start of the project, NCIN (National Cancer Intelligence Network) have updated the GP practice profiles and work continues in terms of promoting the use of the data to inform and improve practice.

Initial funding: Total budget £24k; £10k for the Practice visits, £14k for the RCGP audit.

1.0 Progress through life of project

How practice profiles have been distributed

- Commencing with receiving the Data Access Forms and distributing case by case
- Promoted the PPs at events and through the PCCLs
- The profiles were arranged in categories: 'more of a need' and 'maybe a need' individually with the PCCLs and from the 'first cut' list, 8-10 practices for each PCT were then selected for a potential visit following a second stage review, which involved clinical oversight and review by each PCCL.
- PCCLs contacted practices individually to offer the PP and a visit & RCGP audit.
- Received confirmation that PPs could be sent out to individual practices
- Compiled a GP database ensuring we had all correct GP email addresses
- Individually sent an email explaining the profiles, with profile and supporting documentation attached, an offer for PCCL to meet regarding the profile and a survey to gather thoughts
- Events used to 'promote' and distribute the profiles

Communications with GPs

- The Cancer Network have produced a number of communications in order to promote the use of practice profiles; through emails promoting the work, through inclusion in GP bulletins, personal emails as well as mentioning the project in communications relating to other projects.

- GP practice profiles (2009/10 QOF data) posted to all GP practices with the Bowel Cancer Awareness pack (posted July 2011) as well as the refreshed GP practice profiles (2010/11 QOF data) as part of the Lung Cancer Awareness pack (posted February 2012).

- GP practice profiles (2009/10 QOF data) posted to all GP practices as part of the two national campaigns, Bowel Cancer (posted January 2011) as well as the refreshed GP practice profiles (2010/11 QOF data) for the Lung Cancer campaign (posted April 2012).

- All GPs were emailed (using the dedicated primarycarecancer@nclondon.nhs.uk address) the refreshed GP practice profiles in May 2012.

The role of the Primary Care Cancer Lead

- Primary Care Cancer Leads have been promoting profiles at every opportunity within their patch; at meetings, through informal communications, through emailing personally to GPs in the area and through telephone conversations.

- The structure in the network is that of a devolved model where each PCCL conducted 8 or more visits for their PCT population; the lead GP has overall responsibility for the work and has regular input at the Primary Care & Prevention Board meetings and close liaison with the Senior Management and Quality Innovation team of the Cancer Commissioning Network.

Camden – Dr Lucia Grun (new in post) Islington - Dr Karen Sennett Barnet– Dr Clare Stephens	West Essex - Dr Christine Moss Enfield - Dr Mike Gocman Haringey– Dr Toni Hazel - Dr Kate Rees covering maternity leave (until March ’13)

Summary of achievements by PCCLs:

- Total visits to practices = 35
  Total RCGP audits completed = 10

- **How have the GP practice profiles informed strategy**

- The profile data is used to inform a number of projects in the Network as well as being discussed at Primary Care and Prevention Board and NAEDI programme board. The data will be used as a baseline for improvement work, for example, data around 2WW referral patterns can inform work around the

interface between primary and secondary care in the NAEDI and GP focussed programmes of work. In addition, the data will feed into our overall commissioning intelligence picture.

- A summary of the profiles is as below:

- **Responses from GPs**

- A survey was used to gather responses: https://www.surveymonkey.com/s/GP_PracticeProfiles - the results are in the document below.

- Overall, GPs and GP practices have found the information to be useful, there is definitely an appetite for this kind of information and when presented to GPs in a appropriate format (A3)/forum (GP event) then the profiles are welcomed.

- **2.0 Next steps:**

- **PCCLs**

    - Continue with GP leadership work in each borough.

Network

- Continue to progress GP leadership work through the NAEDI programme.

- Explore interdependencies with additional programmes of work; GP education (series of education sessions being planned) and GP engagement work (Cancer Research UK) as well as London Cancer and the Primary and Community Care Engagement Project

- Explore opportunities with CCGs and use of practice profiles; produce a usable dashboard for example.

- End of life profiles: http://www.endoflifecareforadults.nhs.uk/news/all/new-end-of-life-care-primary-care-trust-profiles are now available and can be used to inform future strategy.

Appendix 3: NAEDI Cancer Networks Supporting Primary Care: Local Improvement Initiatives & GP Leadership (Wave 2)

Introduction

Following the development of a successful bid during July 2011, the NCL &WECCN were awarded National Funding in September 2011 as part of the NAEDI programme Cancer Networks Supporting Primary Care.

There are 2 parts, or work streams within the programme;

- Part one; strengthening GP leadership within the network
- Part two; the development of local initiatives to promote earlier diagnosis for Lung and Oesophageal cancers.

The programme will run from September 2011 to March 2012 (final evaluation due). Reports due in September (completed) and March 2012.

Outcomes

To increase the reach of NAEDI to our local GPs and their practices
To ensure appropriate treatment at an earlier stage
To improve 1 & 5 year Survival
To increase % of diagnosis via 2WW
To reduce % of diagnoses via emergency presentation
To reduce the proportion of late stage presentation
To increase the proportion of early stage diagnosis
To increase uptake of thoracic surgery (lung)
To increase access and timeliness feedback to straight to test (chest x ray for suspected lung cancer)
To improve referral interface between primary and secondary care
To promote engagement / communication between primary and secondary care
To increase the number of GP's that are aware of the importance of early diagnosis
To develop practice and learning through reflective practice
To share learning, innovation, best practice and evidence
To improve GP confidence and ability to recognise signs and symptoms of cancer

(NB The national team are advising regarding collection of pre and post project evaluation metrics)

Progress to date

- NAEDI Programme board meeting continues to meet monthly
- Weekly project team meetings continue
- TCR / ECRIC / data analysis /segmentation completed
- Detailed project plan developed
- Project running to plan, please contact Emma if you would like a copy.

4. **Progress since last reporting period**

GP Leadership

The team met with Brondesbury GP practice to discuss the practice profiles and cancer more generally; this proved to be a useful meeting and additional meetings could be set up.

Next steps: Strategic GP meeting to take place under the GP leadership programme of work rather than Wave 2. West Essex event to be scheduled for the summer period.

Lung Cancer

Next steps: As part of the the GP education work conduct sessions for GPs focusing on lung cancer.

OG Cancer

Next steps: sign off the new 2WW form and urgent endoscopy form and implement across the network. This is being led by London Cancer.

Overall next steps:

- Evaluation interviews run by Durham University are taking place in July.
- Developing the NAEDI presence with the NCL web manager on the NCL website.
- All 2WW forms to be uploaded on the Cancer Network website and the changes communicated through the relevant GP IT leads by *London Cancer.*
- Final 'wrap up' event is planned for September – agenda to be agreed with Primary Care and Prevention Board.

- Pan London specification around chest x-rays being produced; once this has been produced a local decision can be made as to future improvement in this area.

- Tumour site evaluation to take place (ie. Lung Cancer) in order to establish impact of the programmes of work in totality.

5. Risks and Issues

Ref	Risk	Mitigating Factor
1	**Increased Referral Demand** - planned interventions could increase the number of inappropriate referrals, which has the potential to compromise the delivery of acute sector services.	Mitigated by measuring data from Providers monthly, having a central point of contact in case of difficulty, communicating with Providers & Tumour Board Chairs to ensure that they are aware of the interventions and their likely impact and have developed capacity plans based on planned scenarios, i.e., x% increase in appropriate referrals and x% decrease in inappropriate referrals.
2	**Timing** - risk that as the Programme is very tightly packed that not all aspects of it will be completed on-time.	Mitigated by robust performance management. As soon as funding is confirmed the programme governance structure will be established and performance management will begin on a weekly basis. All non-compliance will be escalated to project management group in the first instance and Programme Board should the issue fail to be resolved.
3	**Changing NHS Landscape -** risk that stakeholders are distracted by the structural reforms taking place currently and fail to deliver Programme objectives, in addition there is a risk that during this time key staff will leave.	Mitigated by being clear what the Programme objectives are and the strategy that we are deploying to deliver the end results. Positive communication of the benefits to all stakeholders of improved 1 year survival. Programme Manager will need to ensure that all members of the programme team know what is expected of them and develop succession plans should they leave during the Programme.
4	**Sustainability -** risk that as the NHS landscape evolves the impact of this intervention will lessen.	Mitigated by ensuring that within each work stream sustainability is a key deliverable and that attention is paid to ensuring that structural changes are made to enable improvement work to continue, i.e., addressing gaps in processes to routinely collect staging data within MDTs.

6.0 Costing

Delivery of the project is currently within agreed budget.

7.0 Conclusion

The project is currently in the wrap up and evaluation stage, with completion of outputs by April and evaluation completed by July 2012. In order to sustain the work, some outputs will continue to run over the summer, 2012.

Appendix 4: Achieving earlier presentation in lung cancer through targeted community awareness (Wave 3) – see Appendix 3

1. **Introduction**

Following the development of a successful bid during August 2011, the NCL&WECCN, were awarded funding from the promoting earlier diagnosis of cancer investment programme 2011/12. The Project will run from September 2011 – May 2012.

The aim of the project is to work with and through a range of existing community networks including traditionally hard to reach communities, to reach those population groups where lung cancer incidence, smoking rates and / or late presentation are known to be a particular issue across the Network.

The project is based on a review of the available evidence into community outreach, faith groups, lay health workers, peer educators, peer support and other forms of community engagement in health promotion/improvement, as well as learning from what has been shown to work both locally and in other NAEDI funded projects, to develop a community-focused project to promote earlier presentation for individuals with signs and symptoms of lung cancer.

The project aims to raise awareness of lung cancer and deliver the positive message that cases are treatable if diagnosed at the early stages. By drawing upon the knowledge and energy of local communities, the project will seek to ensure messages are tailored and delivered in a way that reaches those most at risk.

2.0 Outcomes

- *To improve 1 & 5 year relative survival from lung cancer*
- *To increase % conversion rates of diagnosis via 2WW*
- *To reduce % of diagnoses via emergency presentation*
- *To reduce the proportion of late stage presentation*
- *To increase the proportion of early stage diagnosis*
- *To raise awareness of early signs and symptoms of lung cancer*

(NB awaiting DH input re exact metrics to be collected)

8. **Progress in this period**

- Phase 1 project work complete
- Phase 1 evaluation complete
- The 4 Community Organisations: Haringey Life Savers, Tottenham Hotspur Foundation, Arab Advice Bureau and Bangladeshi Association have commenced phase 2 work (June-August 2012) in the community delivering health events and the Lung cancer messages.

- Contracts and project plans have been developed, agreed and signed off by the project teams.

- Event evaluation and Lung CAMs are being submitted by the organisations and are being analysed by the Islington Public Health team.

- The project manager has been meeting with each organisation to ensure the project is on track and any issues are picked up as well as attending community events.

2. **Next Steps**

- Community organisations to deliver Phase 2 three month campaign and awareness raising and submit evaluation for the period before the end of August.

- Central evaluation carried out by the community organisations of interventions will be collated by 27th September.

- Additional feedback/presentation session for the community teams to be held in August '12 for teams to present progress so far and learn from each other.

- Final event to be held at 24th of September to feedback to stakeholders.

4.0 Risks and Issues

5.0 Costing

Delivery of the project is currently within agreed budget.

3. **Conclusion**

Project in delivery phase; interventions to be delivered by community partners June-August with final conclusion of phase 1 of the project by the end of September.