

# Health Inequalities National Support Team Diagnostic Workbook

Working in partnership with the DH Cancer Policy Team and the  
National Cancer Action Team

## **CANCER:**

**Systematic Delivery of Interventions  
to Reduce Cancer Mortality and Increase Cancer Survival  
at Population Level**

*Includes 10 Potential Key Actions for reducing mortality (Appendix 1)*

*Identifying strengths and effective practice and making tailored  
recommendations on how to address gaps in service delivery*



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<b>Description</b>	This workbook was developed by the Health Inequalities National Support Teams (HINST) with 70 local authorities covering populations in England. Local areas could use this approach when analysing whether a population level improvements could be achieved from a set of best-practice and established interventions. This is offered as useful resource for commissioners: use is NOT mandatory.
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<b>For Recipient's Use</b>	

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## Foreword

National Support Teams (NSTs) were established by the Department of Health from 2006 to support local areas – including Local Authorities, Primary Care Trusts (PCTs) and their partners – to tackle complex public health issues more effectively, using the best available evidence. By undertaking intensive, ‘diagnostic’ visits to local areas, spending time with key leaders (commissioners and providers) including clinicians and front-line staff, the ten NSTs provided intelligence, support and challenge to local areas to assist in their achieving better public health outcomes. The programme finished in March 2011.

The ten subject specific teams (Sexual Health, Tobacco Control, Health Inequalities, Teenage Pregnancy, Childhood Obesity, Alcohol Harm Reduction, Infant Mortality, Response to Sexual Violence, Vaccination and Immunisation and Children and Young People’s Emotional Wellbeing and Mental Health) were commissioned and established with a focus on improving health and reducing health inequalities.

The ten teams undertook more than 450 visits to local partnerships during the course of the programme and their findings and successes have been documented in Knowledge Management and Evaluation reports. Each team also produced reports setting out and consolidating the learning from their work. A further report that captures best practice identified by each team is planned to enable local areas to continue using the expertise and lessons learnt from the NST model.

The NST process involved a desk review of key documentation and data-based intelligence, and interviews with key informants, often in combination with a series of workshops or focus groups. Collation and analysis of findings was immediate, and the findings, including strengths and recommendations, were fed back straight away and on site to the key local players and leadership. Recommendations were accompanied by offers of support, either at the time of reporting, or as part of follow-up activity.

The Department is publishing a number of reports which distil the learning from the programme, and exemplify the methodology employed.

**Acknowledgements:** Thanks to the steering group who helped develop this workbook : Chris Bentley, Kathy Elliott, Dan Seddon, Mike McHugh, Jennifer Benjamin

## Executive Summary

This workbook is one of a series developed by the Health Inequalities National Support Team (HINST), in its work with the 70 local authorities covering populations in England with the highest levels of deprivation and poorest health. These workbooks are a summary of local views on good practice. The suggested approaches are not mandatory, and reflect learnings from a snapshot in time. Where there is clear established evidence to support interventions, this has been signposted in the footnote. This is offered as useful resource for commissioners: use is NOT mandatory.

The topic of this workbook – Systematic Delivery of Interventions to Reduce Cancer Mortality and Increase Cancer Survival at Population Level, was selected for its potential impact on health and wellbeing, and on mortality and life expectancy in the short, medium

or long term. On average, deaths from cancer account for about a fifth of the excess mortality in areas of greatest deprivation with the worst health, and in some of these they are the highest contributor to premature mortality.<sup>1</sup> There is now significant evidence about the nature and extent of inequalities that still persist in cancer, each of which is amenable to action.

In the case of cancer, there has been concerted action to reduce variation in the provision and experience of care (the right hand side of the 'Christmas Tree' diagnostic described below) through the national programmes and systematic peer review of improving outcomes guidance. There is now increasing emphasis on the left hand side of the diagnostic model, concerning variations in the stage at which people with symptoms come forward and are referred by their GP – in line with the advent of the National Awareness and Early Diagnosis Initiative<sup>2</sup> (NAEDI).

HINST has a collaborative working approach with the National Cancer Action Team (NCAT) on the NAEDI initiative. This workbook reflects effective practice that is emerging through NAEDI funding.

This workbook – which is recommended for use in a facilitated workshop – provides advice on achieving best outcomes at **population level**, and for identifying and recommending changes that could be introduced locally. Recommended workshop invitees are provided.

Central to the HINST approach is a diagnostic framework – *Commissioning for Best Population Level Outcomes* (see p11), which focuses on evidence-based interventions that produce the best possible outcomes at population level. Part of the framework addresses delivery of **service** outcomes in the most effective and cost effective manner. This is balanced by considerations of how the population uses services, and is supported to do so, to aim for **optimal population level** outcomes that are fairly distributed.

The framework points to the following areas of consideration:

#### **A CHALLENGE TO PROVIDERS**

1. Known intervention efficacy
2. Local service effectiveness
3. Cost effectiveness
4. Accessibility
5. Engaging the public

11. Adequate service volumes
12. Balanced service portfolio
13. Networks, leadership and coordination

#### **B POPULATION FOCUS**

6. Known population health needs
7. Expressed demand
8. Equitable resourcing
9. Responsive services
10. Supported self management

The workbook is made up of sets of detailed questions in the above categories. They provide local groups of commissioners and providers with **a systematic approach to deciding what needs to be done in relation to Cancer** to further improve population health and wellbeing, capitalising on evidence-based interventions. How these improvements will best be achieved in a given locality will be for local participants to decide. The workbook signposts good practice and guidance where this may be helpful. Appendix 1 outlines 10 potential key actions for successful interventions this area, which

<sup>1</sup> London Health Observatory website:

<http://www.lho.org.uk/NHII/Spearhead/LifeExpectancyChart.aspx?areaCode=00CC>

<sup>2</sup>National Awareness and Earlier Diagnosis Initiative <http://info.cancerresearchuk.org/spotcancerearly/naedi/>

have been identified by HINST to have the biggest impact on morbidity and mortality in the short term and thus impact on costs of hospital admissions and on health inequalities.

## Introduction

This is one of a series of diagnostic workbooks developed by the Health Inequalities National Support Team (HINST), while working with the 70 local authorities covering populations in England with the highest levels of deprivation and poorest health. HINST is one of the National Support Teams (NSTs) which were established by the Department of Health from 2006 to support local areas – including Local Authorities, Primary Care Trusts (PCTs) / PCT Clusters and their partners – to tackle complex public health issues more effectively, using the best available evidence. The programme finished work in March 2011, but the Department of Health is publishing its key outputs for local commissioners and providers to use if they so wish. Each workbook topic was selected for the importance of its potential impact on health and wellbeing, and also on mortality and life expectancy in the short, medium or long term.

At the core of each workbook is a diagnostic framework – Commissioning Services to Achieve Best Population Level Outcomes (see p7). The diagnostic focuses on factors that contribute to a process in which a group of evidence-based interventions produce the best possible outcomes at population level. Part of the structure addresses delivery of **service** outcomes in the most effective and cost effective manner. However this is balanced by considerations of how the population uses services, and is supported to do so, to aim for **optimal population level** outcomes that are fairly distributed.

The framework is made up of a set of detailed, topic-based questions. These provide local groups of commissioners and providers with **a systematic approach to deciding what needs to be done** to further improve population health and wellbeing, capitalising on evidence-based interventions. **How** these improvements will best be achieved in a given locality will be for local participants to decide. The workbooks signpost good practice and guidance where this may be helpful.

The resource represented by this workbook can make a significant contribution during a period of transition for the NHS, as responsibility for commissioning of health and health related services transfers to the NHS Commissioning Board, GP Commissioning Consortia and to help delivery pass to the Health and Wellbeing Boards. Changes are also in progress within local government, social care and the voluntary sector. Current policy in relation to public services highlights the centrality of engaging people – as individual service users and patients, and as whole communities, in their own health and wellbeing and that of the wider community.<sup>3</sup> The workbook will support the newly emerging organisations and networks as an aid to understanding commissioning processes to work towards population level outcomes. Key processes that should significantly influence local commissioning priorities as part of the development of Joint Strategic Needs Assessment and Health and Wellbeing Strategies, will be highlighted through the use of the workbooks. The skills and knowledge embedded within the realigned local Public Health teams will be critical in development and coordination of these key processes.

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<sup>3</sup> See for example NHS Constitution: <http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx> and Localism Bill: <http://services.parliament.uk/bills/2010-11/localism.html> And NHS and Social Care Bill: <http://services.parliament.uk/bills/2010-11/healthandsocialcare.html>

The workbook is designed and tested to help areas identify which factors are important in the systematic and equitable delivery of health improvement. They should, therefore, provide a good framework for early identification of local solutions driven by the new perspectives being brought to bear.

The NHS also faces a challenging financial environment during the transition. Through the Spending Review, the government protected the NHS, with cash funding growth of £10.6bn (over 10%) by 2014/15. Nevertheless, by historical standards this remains extremely challenging and the NHS has been developing proposals to meet the Quality, Innovation, Productivity and Prevention (QIPP) challenge of efficiency savings of up to £20bn by 2014/15 for re-investment. This means that considerations of the affordability, and evidence on the cost-effectiveness and cost-benefit of the interventions presented should be of central consideration. Where possible priority should be given to interventions which are likely to lead to cash-releasing savings that can be re-invested in other services, based on a sound evidence base. Some of the relevant evidence has been referenced through the workbook.

**Local facilitators and participants will be aware of changes that may be outside the scope of this workbook and of any detail in the workbook that may have been superseded. These should be taken into account. To facilitate this, a generic workbook has been produced that could be used to guide the diagnostic questions and discussion during the workshop, with this detailed workbook being used alongside the generic one for reference.**

### How to Use this Workbook – a guide for facilitators

The objective of the workbook, used in a workshop setting, is to gain a picture of the local strengths and gaps in services in relation to the objective of achieving best outcomes at **population level**, and to identify and recommend changes that could be introduced.

The workbook is best used in a **facilitated** workshop setting for a **minimum of 8 and a maximum of 25 participants. Allow 4 hours for the workshop.** The participants in the workshop should include key individuals who are involved in planning, commissioning and delivering services and interventions in relation to the workbook topic through a partnership approach. The make-up of the group will vary according to local situations but the suggested minimal attendee list for this workbook is set out below:

#### **Primary care trust Clusters / Clinical Commissioning Groups:**

- Cancer commissioning lead
- Primary care cancer lead / Lead GP
- PCT / PCT Cluster / Health & Wellbeing Board
- Cancer lead
- Population / Public health analyst
- Public health lead (if not the same person)

#### **Acute trust:**

- Acute trust cancer services manager
- Screening co-ordinator(s)
- Lead clinician / medical director when available

## **Other**

- Cancer Network representative (director, co-ordinator)
- Cancer registry representative / Population health analyst
- Healthy Communities Collaborative Lead (if applicable)
- Voluntary / Independent lead for related services

Where there is more than one organisation (for example, hospital trust) providing local services, it is advisable to invite senior representatives from each.

Provide a copy of this workbook to each participant at the workshop. It is suggested that the participants do not see the workbook in advance, but inform them that the workshop will be an opportunity to explore their knowledge of approaches to the issue with others who will bring differing perspectives. This will mitigate against any participants over-preparing, becoming defensive or being resistant to discussing, and finding solutions for , local issues

The facilitator should be familiar with the workbook questions and the model described below, which considers the population level perspective. It is suggested that facilitators introduce the participants to this model and approach. Following the introduction, it is useful to look at section 13 first as this gives an overview of the situation in the area for this topic and makes sure all participants have an opportunity to contribute at the beginning. Finish by working through each section 1-12 of the model.

Group discussions about all of the questions in each section allows strengths, best practice and gaps to be identified, and the group to begin to think about where improvements could be made. A separate publication available on the website includes a facilitator's recording book, which can be used during the workshop to record this discussion. This need not be copied for workshop participants.

Key actions and lead stakeholders to take these actions forward can be identified during the workshop. The greatest impact is likely to result if summaries of these key actions and of the recognised strengths and recommendations from the workshop are produced and circulated to attendees and key accountable stakeholders within the partnership, following the workshop.

These potential key actions to reduce mortality are summarised in Appendix 1. They will help to aim for services that are delivered in a way that is systematic, reducing variability and resulting in population level change. It is sensible to emphasise these questions during the workshop.

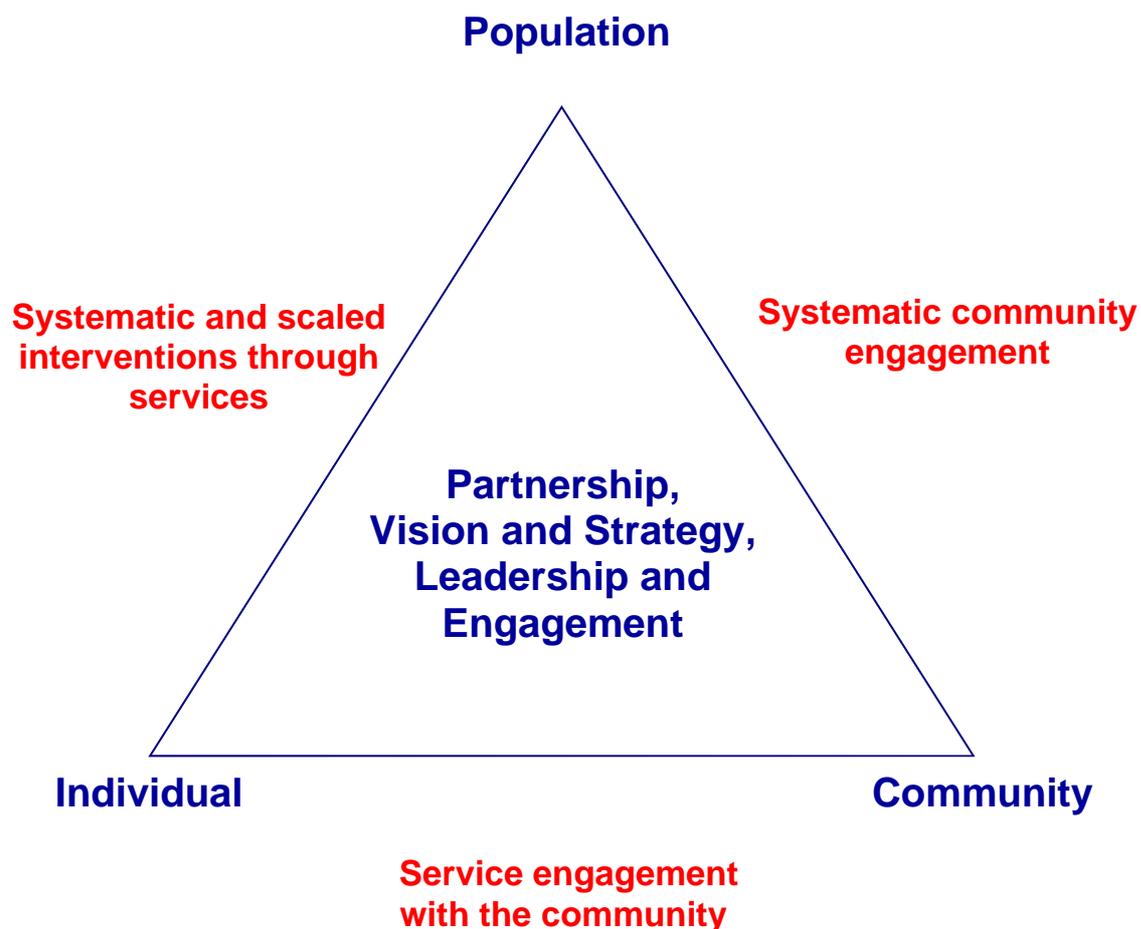
## Background to Population Level Interventions

Challenging public health outcomes, such as achieving significant percentage change within a given population by a given date, will require systematic programmes of action to implement interventions that are known to be effective, and reaching as many people as possible who could benefit.

Programme characteristics will include being:

- **Evidence based** – concentrating on interventions where research findings and professional consensus are strongest
- **Outcomes orientated** – with measurements locally relevant and locally owned
- **Systematically applied** – not depending on exceptional circumstances and exceptional champions
- **Scaled up appropriately** – ‘industrial scale’ processes require different thinking to small scale projects or pilots (‘bench experiments’)
- **Appropriately resourced** – refocusing on core budgets and services rather than short bursts of project funding
- **Persistent** – continuing for the long haul, capitalising on, but not dependant on fads, fashion and changing policy priorities

Interventions can be delivered through three different approaches to drive change at population level, illustrated by the following diagram:



### **Producing Percentage Change at Population Level**

C. Bentley 2007

#### **Population Approaches**

Direct population level interventions will include developing healthy public policy, legislation, regulation, taxation and public funding strategies. These elements should support making 'healthy choices easy choices' for individuals and communities.

The impacts of such population level interventions, however, will not automatically 'trickle down' to all, often in particular missing those who are socially excluded for various reasons. Strategies for targeted communication and education, service support and even enforcement will be required to achieve full impact.

#### **Individual Approaches through Services**

Some interventions taken up at individual level, such as support for environment and behaviour change, therapies, treatments and rehabilitation, can change individual risk significantly, in some cases by 30-40%. The challenge is to achieve so many of those individual successes that it adds up to percentage change at population level. This will be achieved only if services take into account issues of system and scale to enable this to happen, and work to address population level outcomes as well as those for individual service users.

Improvements in health and wellbeing will require some reorientation of health and other services to take a more holistic view of individual circumstances, with regard to any

personal characteristics/sub-population group status or socio-economic status and to focus on development of personal skills of staff and service users, so promoting healthy choices and actions.

### **Community Approaches**

Individuals will only choose to use and benefit from certain behaviours and actions if those behaviours fit with the cultural and belief system of their own community. Communities can be based on place (neighbourhood, school, workplace), culture (ethnicity, faith) and others (disability, sexual orientation). Community development is one way of facilitating communities' awareness of the factors and forces that affect their wellbeing, health and quality of life.

Community engagement is often patchy, favouring those communities that already have leadership, organisation and some resources. Instead, it needs to be systematic in bringing top-down and bottom-up priorities together into plans. This will strengthen community action to create more supportive environments and develop knowledge and skills of community members.

Service links into communities can be superficial, of poor quality, unsystematic, and based on low levels of understanding. Connectivity between services can be disorganised and confusing. Use of the voluntary, community and faith sector as a bridge between services and community based structures needs to be more systematic and based on need rather than supply. Commissioning is key to this.

## **Commissioning for Population Level Outcomes**

Substantial progress can be achieved in making an impact in the short, medium and long term in relation to inequalities in mortality and life expectancy through a focus on existing services. Because of this, extra attention is given here to extracting maximum benefit from delivery of interventions for which there is strong evidence of effectiveness. In addition there is a deliberate emphasis wherever possible, on improving access to services of a scale that will impact on bringing about a population level improvement in mortality and life expectancy within a two to three year period.

The detail is illustrated in the attached diagram on Page 12 with the title 'Commissioning for Best Population Level Outcomes', otherwise known as the 'Christmas Tree' diagnostic, with an accompanying description of its component principles. The framework balances two sets of factors that determine whether optimal outcome can be achieved at population level from a given set of personal health interventions.

**The right hand side of the diagram (1 to 5) - a challenge to providers:** links the factors that will influence health *service* outcomes, that is, how can we construct the most effective service.

However, optimal outcomes *at population level* will not be obtained without the following:

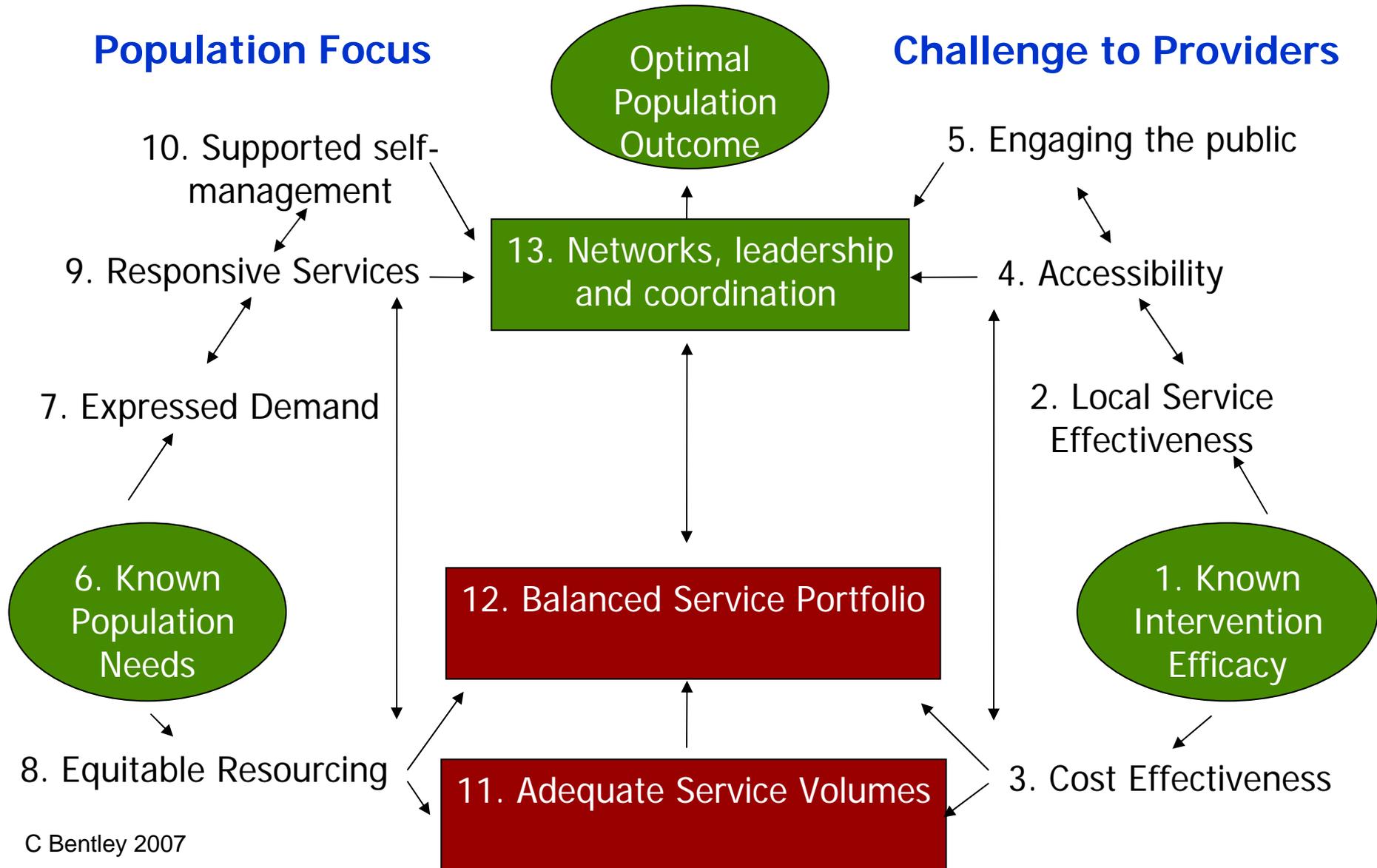
**The left hand side of the diagram (6 to 10) - a population focus:** identifies those factors that determine whether a community makes best use of the service provided – for example, whether the benefits of personalised improvements to services are having a systematic impact on reducing health inequalities at the population level.

**The balance between the two sides of the diagram - the commissioning challenge:**

Aiming for equality of outcome, not just equality of access to service provision and support, is a significant and crucial challenge for commissioners. The 'Christmas Tree' diagnostic, is a tool to help achieve this. The right side of the diagram enables commissioners to identify the best services available for their population. The left side allows commissioners to consider that what is commissioned and delivered best meets the needs of all people in the local population. Attention to both sides of the diagram will help work towards all services being effective **and** engaged with and used by all of the diverse communities in the area they serve.

The central elements of the diagram are concerned with working towards the most effective services/interventions which are identified being fully acceptable, accessible and effective in terms of take-up and compliance and there is adequate capacity to meet the need. Effective leadership and networks are needed to review all these elements to help continuous improvement and equality of morbidity and mortality outcomes.

# Commissioning for Best Population Level Outcomes



# Commissioning for Best Population Level Outcomes

## A CHALLENGE TO PROVIDERS

1. **Known Intervention Efficacy:** Looks at life saving interventions, for which there is strong evidence, are implemented equitably and made available to as many people who could benefit as possible.
2. **Local Service Effectiveness:** Aim for service providers maintaining high standards of local effectiveness through education and training, driven by systems of professional and organisational governance and audit
3. **Cost Effectiveness:** Aim for programme elements that are as affordable as possible at population level
4. **Accessibility:** Aim for services are designed with the minimum barriers to access, balancing a drive to bring services closer to the patient with the need for efficiency and effectiveness of that service.
5. **Engaging the Public:** Working with service users and communities to aim for needs and requirements being placed at the centre of service provision and for quality assurance systems in place that makes the services acceptable to service users
11. **Adequate Service Volumes:** Commissioning adequate service volumes to aim for acceptable access times.
12. **Balanced Service Portfolio:** Aim for balance of services within pathways to avoid bottlenecks and delays.
13. **Networks, Leadership and Co-ordination:** Designating leadership and co-ordination to aim for services that are commissioned and networked to meet population need and the population is supported to use services and interventions appropriately

## B POPULATION FOCUS

6. **Known Population Health Needs:** Aim for a realistic assessment of the size of the problem locally, and its distribution geographically and demographically and the level and type of service being based upon this assessment.
7. **Expressed Demand:** Aim for as many people as possible suffering from the problem or its precursors, to present to services in a timely and appropriate fashion, through informing, educating and supporting the population.
8. **Equitable Resourcing:** Aim for the distribution of finance and other resources to support equitable outcomes according to need.
9. **Responsive Services:** When people present to services, aim to make sure they are afforded equal access to timely beneficial interventions according to need.
10. **Supported Self Management:** Where appropriate, help service users to be empowered to make choices about their circumstances and service offer on the basis of good information, and to be supported to utilise the service offer to best effect

*Whilst the service design elements are an immediate concern to providers, all sections of the 'Christmas Tree' diagnostic are of direct relevance to commissioners*

## Equality

Equalities perspectives need to be built into all whole population approaches. The Equality Act 2010 set out the public sector equality duty:

- (1) *A public authority must, in the exercise of its functions, have due regard to the need to:*
  - (a) *eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;*
  - (b) *advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;*
  - (c) *foster good relations between persons who share a relevant protected characteristic and persons who do not share it.*

The Act identifies a number of “protected” population groups/characteristics where specific elements of the legislation apply. These groups/characteristics are:

- *age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.*

Although socioeconomic inequalities are not specifically included in the Equality Act, there are a range of duties in relation to tackling inequalities included at different levels in new health and social care legislation, and for all key structures and partners involved in the commissioning and delivery of this legislation.

The Health and Social Care Bill 2010 proposes new legal duties on health inequalities for the Secretary of State and the NHS. Subject to Parliamentary approval:

- The Secretary of State for Health must have regard to the need to reduce health inequalities relating to the NHS and Public Health.
- The NHS Commissioning Board and GP consortia must have regard to reducing inequalities in access to, and outcomes of, healthcare.

In order to carry out these duties effectively an emphasis on socioeconomic disadvantage will be essential as it is recognised as a major driver in relation to inequalities of access to, and outcomes of, health and wellbeing services.<sup>4</sup>

### *Useful Materials*<sup>5</sup>

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<sup>4</sup> The Marmot Review (2010) *Fair Society, Healthy Lives - Strategic Review of Health Inequalities in England post 2010*  
<http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf>

<sup>5</sup> Department of Health (2008) *Making the difference – The Pacesetters beginner’s guide to service improvement for equality and diversity in the NHS*  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_086039](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086039)

## Why this topic has been chosen

Improving cancer outcomes is a government priority and the new cancer strategy, 'Improving outcomes: A Strategy for Cancer'<sup>6</sup> sets out how this will need to be achieved.

On average, deaths from cancer account for about a fifth of the excess mortality in areas of greatest deprivation with the worst health, and in some of these they are the highest contributor to premature mortality.<sup>7</sup>

Significant progress has been made on cancer over recent years. Cancer mortality has fallen, survival rates are improving for many cancers and patients' experience of their care has improved, but there is further to go to match outcomes in other countries. The Government has made a commitment to concentrate on improving cancer outcomes.<sup>8</sup>

There is now significant evidence about the nature and extent of inequalities that still persist in cancer, including:

- Incidence and mortality are generally higher in more disadvantaged groups, and when incidence is higher in more affluent groups (e.g. breast cancer) mortality is still higher amongst less affluent women
- There are lower levels of awareness of signs and symptoms in more disadvantaged communities, amongst Black and Minority Ethnic (BME) groups and men
- Lifestyle factors almost certainly account for most of the variation in incidence between the most and least deprived
- Poorer experience of care is reported by BME groups, non-heterosexuals, patients living with other long term conditions and Londoners
- Part of the variance in mortality rates is due to delayed diagnosis amongst disadvantaged groups, older people and certain BME groups
- Improvements in mortality have been slower in older people than in younger people<sup>9</sup>

Each of these is amenable to action. The points of the 'Christmas Tree' diagnostic will lead work groups to consider each of these in context.

In the case of cancer, there has been concerted action to reduce variation in the provision and experience of care through the national programmes and systematic peer review of improving outcomes guidance. This is the area covered by the right hand side of the Christmas Tree model. There is now increasing emphasis on the left hand side of the diagnostic model, concerning variations in the stage at which people

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<sup>6</sup>

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_123371](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123371)

<sup>7</sup> London Health Observatory website:

<http://www.lho.org.uk/NHII/Spearhead/LifeExpectancyChart.aspx?areaCode=00CC>

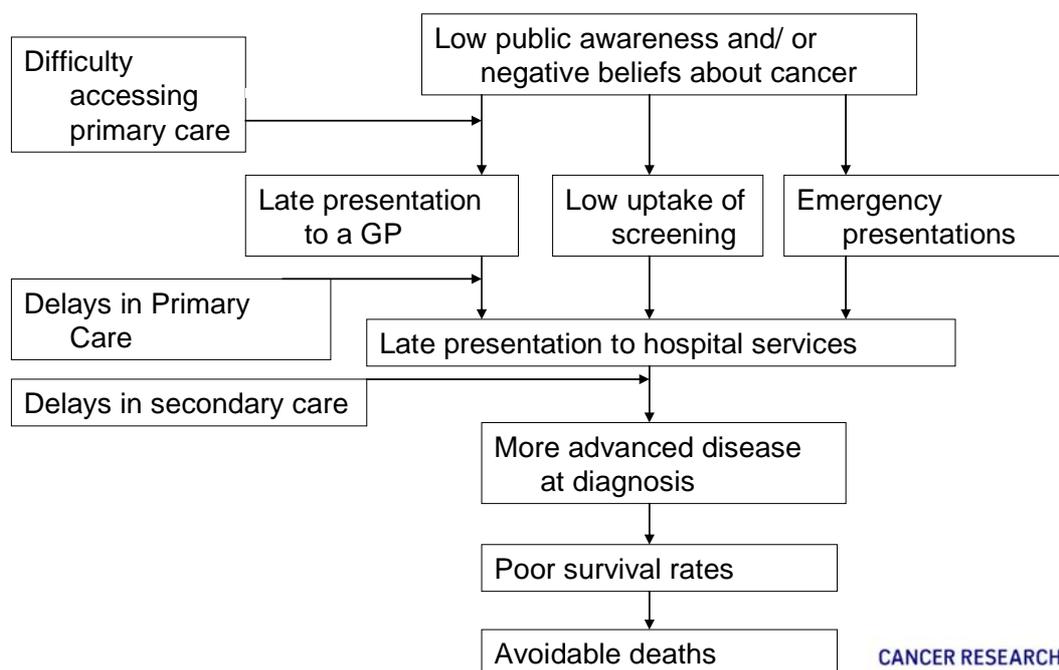
<sup>8</sup> Richards Prof. Sir Mike, Department of Health (7 July 2010) *Review of the Cancer Reform Strategy* Gateway reference 14527, p1

<sup>9</sup> National Cancer Equality Initiative, Department of Health (2010) *Reducing cancer inequality: evidence, progress and making it happen* Gateway reference 13852, pp 4-5

with symptoms come forward and are referred by their GP – in line with the advent of the National Awareness and Early Diagnosis Initiative<sup>10</sup> (NAEDI). HINST has a collaborative working approach with the National Cancer Action Team (NCAT) on the NAEDI initiative. This workbook reflects effective practice that is emerging through NAEDI funding.

The NAEDI ‘hypothesis’ pathway<sup>11</sup> shifts the focus onto the ‘demand’ side of the model:

## National Awareness and Early Diagnosis Initiative (NAEDI) – ‘the hypothesis’



This workbook is one of the outputs from the collaborative working arrangement between HINST and the National Cancer Action Team (NCAT), summarised in the report – ‘How to reduce health inequalities due to cancer in areas of worst health and greatest deprivation’ – published by NCAT. The summary chart from that report appears at the end of the workbook.

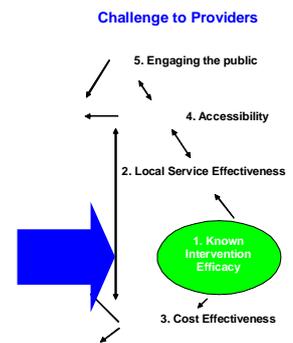
The workbook can be used to examine these areas in depth, providing partners with a fuller picture of why outcomes are worse in more disadvantaged areas, and where priority action is needed to reverse trends.

<sup>10</sup>National Awareness and Earlier Diagnosis Initiative  
<http://info.cancerresearchuk.org/spotcancerearly/naedi/>

<sup>11</sup> MA Richards and S Hiom, in summary of the special edition of the British Journal of Cancer:  
[http://info.cancerresearchuk.org/prod\\_consump/groups/cr\\_common/@nre/@hea/documents/generalcontent/cr\\_044142.pdf](http://info.cancerresearchuk.org/prod_consump/groups/cr_common/@nre/@hea/documents/generalcontent/cr_044142.pdf)

# **The Workbook**

**Systematic Delivery of Interventions  
to Reduce Cancer Mortality and Increase Cancer  
Survival  
at Population Level**



## 1. Known Intervention Efficacy

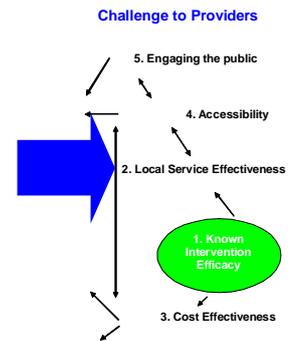
*Looks at life saving interventions, for which there is strong evidence, are implemented equitably and made available to as many people who could benefit as possible.*

*This is not addressed through this workbook. Interventions for which there is strong evidence are detailed in the NICE Improving Outcomes Guidance (IOG)<sup>12</sup> on a cancer site-specific basis. The main cancers that will impact on life expectancy and tackle health inequalities in the short term are lung, breast and colorectal. Cervical cancer shows good potential for action if screening and vaccination programmes are implemented systematically.*

*These are the critical aspects of effective services that the rest of the structure examined in this workbook seeks to bring to the local population*

*However, application of the 'Christmas Tree' diagnostic to provision of services for all cancers would have an impact through the 'aggregation of marginal increments'.*

<sup>12</sup> <http://guidance.nice.org.uk/CSG/Published>



## 2. Local service effectiveness

*Aim for service providers maintaining high standards of local effectiveness through education and training, driven by systems of professional and organisational governance and audit*

1. What are the survival rates<sup>13</sup> for major cancers by Cancer Network and PCT / PCT Cluster / GP Commissioning area: and how do they benchmark against others, nationally and within the Network measured by:

- 1 year survival
- 5 year survival

In particular, is the PCT's / PCT Cluster's / GP Commissioning population in the highest or lowest quartile for 1 year cancer survival for:

- breast
- colorectal
- lung?

2. How many lives would be saved if the rates were the same as the consensus good practice rates?<sup>14</sup>
3. What is the proportion of patients with cancer presenting as emergencies against those being referred through the two week wait route?<sup>15</sup>
4. What is the rate of participation by the different service providers in the National Clinical Audit Support Programme against expected (colorectal, lung, breast, oesophogastric, urology)?<sup>16</sup>

<sup>13</sup> Information available from *Cancer Registry Commissioning Toolkit*, [http://www.ncin.org.uk/cancer\\_information\\_tools/cct.aspx](http://www.ncin.org.uk/cancer_information_tools/cct.aspx) and CRS 2<sup>nd</sup> Annual Report Table 3 (pp 25 – 28) - see Appendix 2 below

<sup>14</sup> Department of Health (2009) *Cancer Reform Strategy Achieving Local Implementation Second Annual Report* (pp25-28)

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_109338](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109338)

<sup>15</sup> Highlighted in Department of Health (12<sup>th</sup> January 2011), *Improving Outcomes: A Strategy for Cancer*, Gateway Reference 15108

This information is available in the Cancer Toolkit. The log on page for this toolkit is

<https://www.cancertoolkit.co.uk/PublicPages/Login.aspx?ReturnUrl=%2fPages%2fPracticeProfiles.aspx>

but those wanting to see it will need to have an account, and their application needs to be approved by their local Cancer Network

<sup>16</sup> Department of Health (2009) *Cancer Reform Strategy Achieving Local Implementation Second Annual Report*. Table 9 (pps 42-45)

5. Does the commissioner / local network have rates of surgical intervention for the local provider(s) and how do they benchmark with comparative trusts and recognised good practice?
6. Are all current Cancer Network Improving Outcomes Guidance (IOG) plans signed off and approved by the National Cancer Action Team? Have implementation milestones been met within the agreed timetable?
7. Have there been any major concerns raised during cancer screening programme quality assurance visits for each of the screening programmes? Are these being addressed satisfactorily?
8. Are the breast screening 36 month round length, and the three weeks screen – to - assessment times standards being met?
9. Have the proposals set out in the *NCAG Report Chemotherapy Services in England: Ensuring Quality & Safety* been implemented – particularly in relation to patients with unplanned admissions to hospital (acute Oncology services)?<sup>17</sup>
10. How successful has the introduction of the national HPV vaccination programme been?
11. What is the experience of cancer patients at the local Trust, as recorded through the National Cancer Patient Experience Survey?<sup>18</sup>
12. What arrangements are in place to provide personalised assessment and care plans following cancer treatment which include lifestyle advice and interventions to reduce recurrence and minimise late effects of treatment <sup>19</sup>

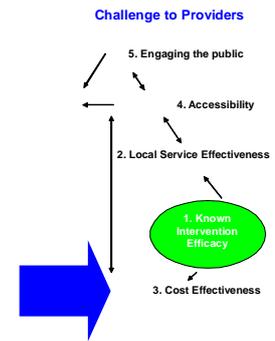
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(see Appendix 2 below)

<sup>17</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH\\_104500](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_104500)

<sup>18</sup> available via <http://www.quality-health.co.uk/cancer-reports>

<sup>19</sup> Department of Health (2011) *Improving Outcomes: A strategy for Cancer*  
<http://www.dh.gov.uk/en/Healthcare/Cancer/index.htm>



### 3. Cost effectiveness

*Aim for programme elements that are as affordable as possible at population level*

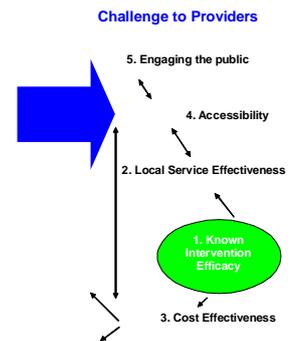
1. Has the 2 week wait urgent referral standard been implemented and is there assurance that it can be sustained in the longer term?<sup>20</sup>
2. Is finance assured for current IOG plans with regard to:
  - capital
  - revenue
3. Has programme budget analysis been undertaken to assess the comparative cost / benefit of local services?
4. What actions have commissioners taken, supported by Cancer Networks, to respond to the early information on costs and benefits to investment in awareness and early diagnosis, as described in the CRS Second Annual Report (p2)?<sup>21</sup>
5. How has the national information on cost benefit of cancer screening been utilised to evaluate local services?<sup>22</sup>

<sup>20</sup> Department of health (2011) *The likely impact of earlier diagnosis of cancer on costs and benefits to the NHS*, [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_123576.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123576.pdf)

<sup>21</sup> Department of Health (2009) *Cancer Reform Strategy Achieving Local Implementation Second Annual Report*. (p2)

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_109338](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109338)

<sup>22</sup> Department of Health, *The Likely Impact of Earlier Diagnosis of Cancer on Costs and Benefits to the NHS*, (12th December 2010), Gateway reference 015375



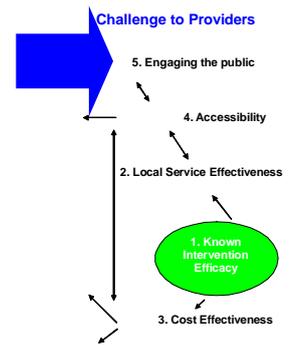
## 4. Accessibility

*Aim for services are designed with the minimum barriers to access, balancing a drive to bring services closer to the patient with the need for efficiency and effectiveness of that service.*

1. Have IOG plans involved significant re-configuration of patient pathways locally? Have these been commissioned with consideration of a health inequalities impact assessment?
2. Are patient pathways designed with patient access in mind, for both primary care and specialist cancer care - particularly for cancer sites involving cancer unit to cancer centre referral? i.e.:
  - lung
  - upper gastrointestinal (GI)
  - lower GI
  - prostate/urological
  - gynaecological

(Awareness and early diagnosis requires commissioners and providers to revisit patient pathways to check that primary care and outreach is adequately covered.)
3. Has consideration been given to whether there is sufficient open access to diagnostic services in primary care to improve GP access to diagnostics – particularly in the four key tests?
4. What arrangements have been made to make each of the screening services more accessible to people in hard to reach communities in terms of:
  - geography
  - timing of clinics
  - translation/sign language services
  - acceptability to users?
5. What arrangements have been made to shift systemic therapy provision from Cancer Centre to Cancer Units and the community – particularly chemotherapy? (providing patient choice)<sup>23</sup>

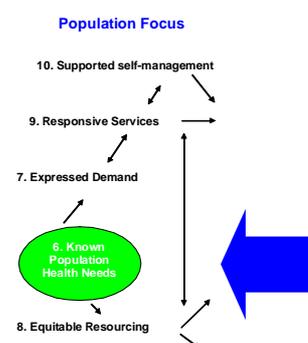
<sup>23</sup> Department of Health (2009) Chemotherapy Services in England: Ensuring quality and safety  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_104500](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_104500)



## 5. Engaging the public

*Working with service users and communities to aim for needs and requirements being placed at the centre of service provision and for quality assurance systems in place that makes the services acceptable to service users*

1. Were significant recommendations made during the Peer Review affecting involvement of users in the Cancer Network? How are they being actioned?
2. Have patients been involved in the development of IOG plans? In particular, what was their involvement where significant changes in patient pathways and service configuration were proposed?
3. Have patients and the public been involved in the development of local awareness and early diagnosis strategy and services? To what extent are the views of seldom seen and seldom heard groups evident and their proposals reflected in the outcome?
4. Have patient surveys been run by any of the cancer screening services? What did they show, and what changes have been made as a result?
5. What steps have been taken to address the falling rates of participation in cervical screening amongst women aged 25 to 35?
6. The Cancer Awareness Measure (CAM) is testing the extent of public awareness of cancer and engagement in cancer issues. Is the CAM information available locally? Has this information been taken into account in the local planning and action? If it is not available locally has the PCT / PCT Cluster, through the Cancer Network, learned from other areas of the country and/or the national survey results? How will it be used to identify communities who are not engaged when services are being planned?
7. How are these new public-facing initiatives working with changes in primary care, such as safety netting and new risk assessment tool for diagnosis and referral?
8. How are partner organisations collaborating in engaging with the public / employees to raise awareness of risks and symptoms?
9. How are Local Strategic Partnerships being supported to include awareness and early diagnosis in their work programmes, for example, to achieve local outcomes identified as priorities – in the (emerging) Health & Wellbeing Strategy?



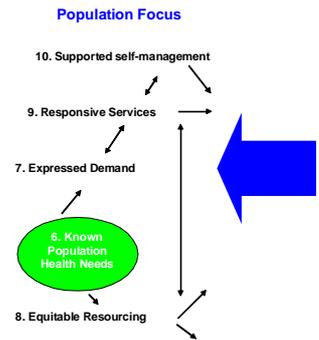
## 6. Known population health needs

*Aim for a realistic assessment of the size of the problem locally, and its distribution geographically and demographically and the level and type of service being based upon this assessment.*

1. Has the *Health Inequalities Toolkit*<sup>24</sup> been utilised to quantify how cancer as a whole contributes to health inequalities gaps, and whether the pattern of cancers is atypical? Is the new information from National Cancer Intelligence Network (NCIN) and the National Cancer Equalities Initiative being used locally?
2. Has local analysis established the contribution towards excess deaths of:
  - higher than average incidence
  - poorer than average survival at 1 and 5 years?
3. Has local analysis included analysis of local cancer prevalence and established trends for individual cancers? What does this show?
4. Has there been any analysis of mortality at sub-district level? Are there intra-district inequalities and if so what specific action is being taken to address them?
5. Has analysis influenced the choice and development of indicators in local partnership plans?
6. What are the local plans for the using local and national data on incidence, survival and mortality drawn from sources such as the *Cancer Commissioning Toolkit*?<sup>25</sup> Has the PCT / PCT Cluster, with support of the Cancer Network, done the Baseline Assessment for cancer awareness and early diagnosis? Is the NCAT/ NCIN guidance being used? Have the commissioners / Cancer Network learned from the case study and national exemplars?
7. How are the baseline assessments influencing the local strategy and commissioning plans for awareness and early diagnosis?

<sup>24</sup> *Health Inequalities Intervention Toolkit*, developed by the Association of Public Health Observatories and Department of Health to assist evidence-based local service planning and commissioning, including Joint Strategic Needs Assessments.  
[http://www.lho.org.uk/LHO\\_TOPICS/ANALYTIC\\_TOOLS/HEALTHINEQUALITIESINTERVENTIONTOOLKIT.AS](http://www.lho.org.uk/LHO_TOPICS/ANALYTIC_TOOLS/HEALTHINEQUALITIESINTERVENTIONTOOLKIT.AS)  
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<sup>25</sup> Cancer Commissioning Toolkit, [http://www.ncin.org.uk/cancer\\_information\\_tools/cct.aspx](http://www.ncin.org.uk/cancer_information_tools/cct.aspx)



## 7. Expressed demand

*Aim for as many people as possible suffering from the problem or its precursors, to present to services in a timely and appropriate fashion, through informing, educating and supporting the population.*

- **Clinical presentation**

**Is there any evidence that patients are not presenting or presenting late with clinical symptoms of Cancer?**

1. Is comparative analysis available of the proportion of 'Death Only Certificates'?
2. What proportion of registrations comes with staging data, by tumour type? How does this benchmark with other areas? Are there initiatives in place to improve staging information (e.g. required information to justify tariff payment)? Are opportunities taken, through the Cancer Network, to learn from areas that have specific projects to improve staging data? Are PCTs / PCT Clusters & GP Commissioning Consortia aiming for Trusts to submit complete data?
3. Does staging or other data suggest that patients are presenting late, and whether there are specific problems associated with:
  - tumour site
  - geography
  - ethnicity / religion
  - age (particularly the over '75s)
  - sex
  - disability / mental health
  - social marketing group?
4. Have social marketing or other techniques been used to promote earlier presentation by increasing recognition of symptoms and tackling fear or embarrassment – within each of these groupings?<sup>26</sup>

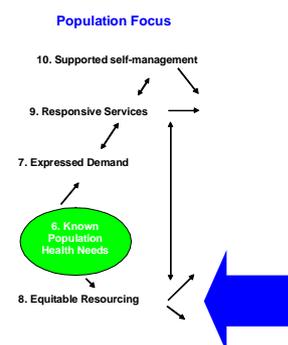
<sup>26</sup> There are increasing numbers of case studies of the successful use of social marketing to encourage early presentation of cancers. One well recognised example is the Doncaster work – more information and contact details can be found at:  
<http://info.cancerresearchuk.org/spotcancerearly/naedi/local-activity/getting-results/interventions-services-and-service-change-public/social-marketing-doncaster/>

- **Auditing delays in primary care**
5. What steps have been taken to review critical cases to identify where there were avoidable delays (such as missed diagnosis) in primary care or where the two week referral route was not utilised? How is that information being used to work with GPs to help them improve their practice?
- **Screening**
6. Is there evidence that sections of the population are not attending screening services?
  7. Has analysis identified specific problems of low attendance by:
    - screening programme
    - geography
    - ethnicity
    - age (particularly the over '75s)
    - sex
    - disability / mental health
    - social marketing group
    - general practice?
  8. Is there an assessment of acceptance rates of invitations to breast and bowel screening by:
    - geography / general practice
    - ethnicity
    - equity grouping?
  9. Is there an assessment of failure to take up invitation to cervical screening by;-
    - general practice
    - postcode
    - equity grouping?
  10. Is the service taking part in the breast screening age extension randomisation project? What is the uptake in the different age ranges? How has the project been promoted?
  11. What initiatives have been used to target non-attenders? Have these involved population segmentation approaches?
    - **Cancer awareness**
  12. Has the Cancer Network, with commissioners, undertaken a baseline assessment for cancer awareness and early diagnosis in order to understand local needs and priorities, and if so what did it show?
  13. Do commissioners have timely and high quality information from Public Health Observatories, Cancer Registries, primary care and others to support awareness and early diagnosis? (These relationships should be forged through the production of the baseline assessments but will need to be supported and sustained) Have there been any community based interventions, programmes, services or campaigns to support the

drive for earlier presentation, diagnosis and treatment of common cancers?<sup>27</sup>

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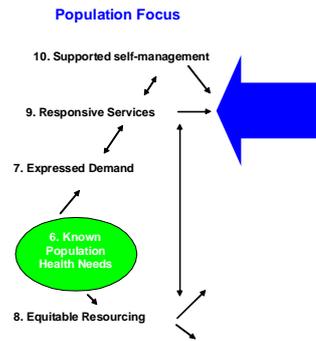
<sup>27</sup> Are the programmes making use of information produced centrally (e.g. Key Messages on signs and symptoms of cancer on NHS Choices)? Are they building on the evidence in the BJC supplement, the CRS 2<sup>nd</sup> Annual Report and the NAEDI Hub case studies? NCAT is producing a short review of how social marketing could be applied to awareness and early diagnosis, along with case studies of a range of interventions.



## 8. Equitable resourcing

*Aim for the distribution of finance and other resources to support equitable outcomes according to need.*

1. Has a move to needs based funding been reflected in budgeting programmes designed to achieve equitable outcomes amongst more disadvantaged communities? Does this include awareness and early diagnosis?
2. It is likely that late presentation of cancer from more disadvantaged areas is resulting in disproportionately high cost of 'salvage' treatments and palliative care. To what extent has this been reflected in targeted plans to increase awareness and early diagnosis to reduce the number of people who come into this category?
3. Are there examples of where the disproportionately high costs of achieving equitable outcomes amongst hard to reach groups are covered by programme funding? Does this include awareness and early diagnosis?



## 9. Responsive services

*When people present to services, aim to make sure they are afforded equal access to timely beneficial interventions according to need.*

- **Clinical presentation**

1. Have there been any audits of adherence to cancer referral guidelines? How systematically were cancer referral guidelines introduced in primary care? Is there a record of who has received training? In addition to the NICE guidelines, are PCTs / PCT Clusters looking at other ways to support GPs to diagnose cancer earlier?<sup>28</sup>
2. In relation to primary care which of the following audits have been carried out, and what do they show and what action has resulted from each:
  - RCGP / NCAT Primary Care audit<sup>29</sup>
  - Cancer referral guidelines
  - Audit of adherence to NICE lung cancer guidance<sup>30</sup> on chest X-ray for designated symptoms persistent for more than 3 weeks?
3. Is the number of urgent referrals per 100,000 > 200 or < 100 for the PCT / PCT Cluster? (See Appendix 1, below)
4. Is the conversion rate > or < the average 12% for the PCT / PCT Cluster (and has the information been analysed for individual practices)?
5. Has the conversion rate been identified as an outlier and are there training programmes to address this?
6. Has primary care training addressed the adverse correlation between age and education and practitioner-mediated delay?<sup>31</sup>
7. What were the results of the local review of use of NICE cancer drugs?<sup>32</sup> Is there an

<sup>28</sup> National Institute for Clinical Excellence and Health (June 2005) *Referral for suspected cancer*  
<http://www.nice.org.uk/CG027>

<sup>29</sup> Cancer Research UK. *Clinical Leadership - Engaging public health and general practice*  
<http://info.cancerresearchuk.org/utilities/atozindex/013964>

<sup>30</sup> BMJ Learning Tool (2010) *Suspected lung cancer: when you should refer - in association with NICE*  
<http://learning.bmj.com/learning/search-result.html?moduleid=5003314&searchTerm=>

<sup>31</sup> Macleod, U et al (Nov. 2010) "Risk factors for delayed presentation and referral of symptomatic cancer: evidence for common cancers" *British Journal of Cancer* pp92-101

<sup>32</sup> Department of Health (14 June 2004) *Variations in usage of cancer drugs approved by NICE*  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4083901](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4083901)

effective action plan in response?

- **Primary Care Delay**

8. Has there been analysis using the approach of the Significant Event Audit <sup>33</sup> on lung and young people's cancers to identify delays due to missed diagnosis or instances where the two week referral route has not been used?
9. The new RCGP/ NCAT – Primary Care Audit is providing new information about the delays or intervals from first presentation in primary care to referral to secondary care. Is this audit information available locally?
10. Has the Practice Profile information<sup>34</sup> been used to identify outliers in the numbers of patients being diagnosed after emergency attendance rather than through GP referral?
11. Has this information been taken into account in the local planning and action? How is it being used to work with GPs to help them improve their practice?

- **Screening**

12. Has there been a satisfactory review of failsafe procedures within local cancer screening programmes?
13. In bowel screening what proportion of patients with a positive Faecal Occult Blood Test does not attend for colonoscopy and steps are taken to follow them up?
14. In cervical screening, is there direct referral from laboratory to colposcopy clinic for women with abnormal cytology results?

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(and 2006)

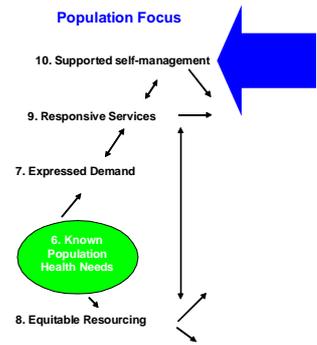
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<sup>33</sup> For this and an overview of the Local Awareness and Early Diagnosis see the excellent report - NCAT (2010) *Local Awareness and Early Diagnosis Initiatives 2009/2010 - Programme Summary Report*

<sup>34</sup> The log on page for this toolkit is

<https://www.cancertoolkit.co.uk/PublicPages/Login.aspx?ReturnUrl=%2fPages%2fPracticeProfiles.aspx>

but those wanting to see the data will need to have an account, and their application needs to be approved by their local Cancer Network



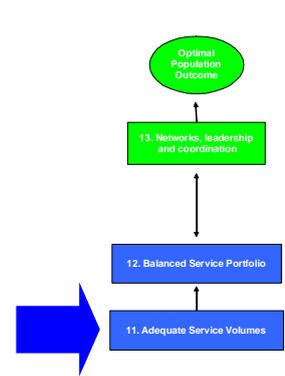
## 10. Supported self-management

Where appropriate, help service users to be empowered to make choices about their circumstances and service offer on the basis of good information, and to be supported to utilise the service offer to best effect.

1. Are Cancer Specialist/Liaison Nurses appointed to support major common cancer sites. Do they provide open access and if so what form does it take? Is local access to Specialist Nurses changed by Cancer Plans that affect the patient pathway?
2. Are interpreter services available covering major language groups across the full length of the patient pathway? How does this work?
3. What is happening to improve patient information services, in line with the Cancer Reform Strategy and Improving Outcomes: A strategy for Cancer? <sup>35</sup>
4. Is good psychological support available to support patients and their relatives through their 'cancer journey', and is it being taken up in proportion to need?
5. Is access to advice on financial benefits being taken up, similarly?
6. Does the PCT / PCT Cluster, with support from the Cancer Network, have updates on the survivorship programme?
7. Has there been local research into the way that minority populations approach cancer - including coping strategies? Is learning developing from the NCEI initiatives and research in developing local services?
8. Are information prescriptions being used to help guide people to relevant and reliable sources of information to allow them to feel more in control, better able to manage their condition and maintain their independence?
9. In order to achieve the aim of *no decision about me without me* what evidence is there that commissioners are making clear choices which patients can make at the point of urgent referral by a GP, whilst recognising that pooled referrals are critical to helping speedy access to a first appointment with a specialist?

<sup>35</sup> Department of Health (12<sup>th</sup> January 2011), *Improving Outcomes: A Strategy for Cancer*, Gateway Reference 15108  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_123371](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123371)

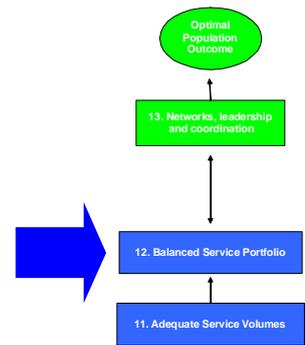
10. How do follow up services support people top self manage where appropriate with information and contacts in case there are signs of recurrence?



## 11. Adequate service volumes

*Commissioning adequate service volumes to aim for acceptable access times*

1. What 'bottlenecks' have been identified along the local pathways of care for each of the major cancers?
2. Is radiotherapy capacity sufficient to meet the 31 day waiting times operational standards? Is access being tracked through RPort and is it improving?



## 12. Balanced service portfolio

*Aim for balance of services within pathways to avoid bottlenecks and delays.*

- **Commissioners and providers**

1. Are the right systems in place across the health economy to work towards a 31 and 62 day operational standards for cancer waits being sustained in the long term?
2. Are systems in place across the whole health economy to work towards the radiotherapy waiting time operational standard (as set out in the Operating Framework 2011/12) being sustainable in the long term and also meets the NRAG recommendations?
3. Is there a mechanism to help providers and commissioners to prepare to accommodate potential increases in the number of patient presentations and referrals as a result of future campaign work to raise public awareness of cancer signs and symptoms and encourage earlier presentation?
4. Are there any plans to provide a one-stop clinic for all breast referrals?
5. Has the PCT/PCT Cluster, working with their partners in the Cancer Network, commissioned a review of cancer chemotherapy as part of a strategic framework for chemotherapy services?
6. Are data completeness returns for number of patients treated, consistently within 10% of the benchmark figure:
  - for the PCT / PCT Cluster
  - for main providers?
7. Are causes of breach being analysed on an ongoing basis, and are plans being instigated to correct persistent causes?
8. Are there any significant outstanding delays in access to diagnostic, or treatment facilities (e.g. PET scanning, radiotherapy)?
9. What arrangements are in place to take part in the breast screening extension randomisation project to women aged 47-49 and 71-73?
10. Where applicable, have there been delays in scheduled visits of mobile breast screening units? Are these being addressed?

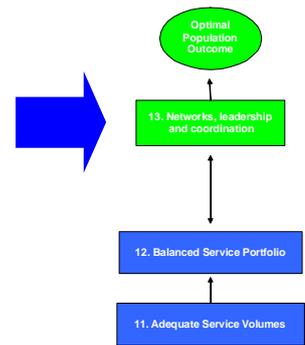
11. Do cancer screen reporting times consistently meet quality criteria? Specifically: is the operational standard of 98% being met for women receiving the results of their cervical screening test within 14 days of the sample being taken?

For breast screening are all women receiving their results within two weeks and do they go from screening to assessment within three weeks?

12. Have PCT s / PCT Clusters, with Cancer Networks, put in place 'the basics' for awareness and early diagnosis, that is:

- baseline assessment of data
- clinical leadership – public health and general practice
- strategy and local targets
- commissioning service change and new interventions

13. Key interventions and services will be to raise public awareness and reduce barriers to going to general practice; and to support primary health care professionals to diagnose patients early, including access to diagnostic services. Has this resulted in commissioning intentions and committed resources in the PCT's / PCT Cluster's Operating Plan?



### 13. Networks, leadership and coordination

*Designating leadership and co-ordination to aim for services that are commissioned and networked to meet population need and the population is supported to use services and interventions appropriately.*

- **Commissioners**

1. Is there evidence that the Commissioning Strategy contains a plan for cancer services that:
  - is comprehensive
  - is needs based
  - is geared to population rather than service outcomes
  - actually addresses differential need / health inequalities
  - will deliver the vision contained in the Cancer Reform Strategy and the local Network Cancer Action Plan, including awareness and early diagnosis.

2. Are there any substantial outstanding contractual or reconfiguration debates that may threaten plans and milestones?

- **Local Network**

3. Is there a local Cancer Management Group/Local Network in place to coordinate activity across the commissioning area?
4. What is the level of leadership of the local network? Does this include public health and general practice clinical leadership?
5. Are there a GP and public health clinical lead with dedicated time?
6. Is there a dedicated manager / coordinator with dedicated time?
7. Is there a recent local network strategy / action plan? For awareness and early diagnosis?

- **Supra-district (Cancer Network)**

8. Within the Network, who are the main partners and what is their level of representation and attendance?

9. What are the findings of the most recent peer review? What are the actions to come out of it?
10. How does it reconcile the needs of commissioners, clinicians, general managers and patients/carers?
11. What are the governance arrangements between the Network and the trusts?
12. What is happening within the Network in response to the *Cancer Reform Strategy Second Annual Report* in relation to health inequalities and improving awareness and early diagnosis?
13. Specifically, what arrangements has the Network developed for:
  - baseline audit(s)
  - a sustainable strategy
  - ambition and targets
  - clinical leadership
  - primary care representation
  - dissemination of the learning from LAEDI initiatives?
  - **General**
14. How are the needs of joint commissioning and joint provision with partners in the local authority accommodated in these arrangements?
15. What evidence is there that the principles in *Reducing Inequalities in Commissioning Cancer Services: Principles and Practical Guidance for Good Equality Working* – published by the National Cancer Equality Initiative June 2009<sup>36</sup> - have been used to review the commissioning and provision of current service provision?
  - evidence based approach
  - targeted and specific work
  - community engagement
  - service improvement and innovation
  - interventions are tested and refined
  - effectiveness is measured
  - champions and partnerships
  - evaluation
  - sustainability
  - shared learning

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<sup>36</sup> [http://www.cancerinfo.nhs.uk/images/stories/ncei\\_docs\\_/final\\_principles\\_\\_guidance\\_doc.pdf](http://www.cancerinfo.nhs.uk/images/stories/ncei_docs_/final_principles__guidance_doc.pdf)

## Optimal Population Outcome

*Are services being commissioned with the aim of reducing population level mortality from cancer?*

1. Is reducing excess mortality from cancer:
  - one of the prioritised local Outcomes?
  - one of the prioritised local Vital Signs outcomes?
  - one of the indicators selected for the Local Area Agreement?
  - other locally chosen performance or strategic outcome?
2. How are these reported to:
  - The PCT Boards?
  - The local Partnership?
  - The Local Authority?
  - Cancer Network?
  - SHA?
3. Are planned outcomes supported by a clear delivery plan with quantified milestones and actions assigned to named organisations or individuals?
4. Is the PCT / PCT Clustering the highest or lowest quartiles for its mortality rate from cancer overall compared to other PCTs/ PCT Clusters across the country (recognising that rates quoted in CRS2 are not standardised)?

## **Appendix 1: Health Inequalities National Support Team - Tackling Inequalities in Cancer Mortality Rates - Ten Potential Key Actions to reduce mortality & Step by Step Chart**

This checklist assumes that IOG plans for all major cancers are signed off and being implemented, that national cancer waiting times standards are being met sustainably, and that, following the last Peer Review visit, an action plan has been signed off and is being implemented. The recommended actions below will be modified and supported by the national programme as the Cancer Reform Strategy is implemented.

- 1. *Has the pattern of cancer mortality in your health community been reviewed? Can you identify any cancer types for which survival rates, as opposed to higher incidence, benchmark poorly against the national levels? Might this be due to:***

- Consistently late diagnosis?
- Low intervention rates?
- Poor treatment outcomes?

(Work in this area will be supported by introduction of the National Clinical Audit Support Programme.)

- 2. The cancers for which there is usually the greatest opportunity to save lives from earlier diagnosis are:**
  - breast (around 2000 avoidable deaths per annum nationally)
  - colorectal (1700)
  - lung (1300)

The most important measure is to get relevant patients to potentially curative surgery.

***Do networks and commissioners know their intervention rates, and are they aiming for the top end of the ranges seen in the National Cancer Audit programmes?***

- lung 4% - 20%
- colorectal 20% - 80%
- breast – up to 20% may not be undergoing surgery

- 3. *Are all multidisciplinary teams, particularly those for survival outlier sites, carrying out ongoing audit of the overall outcomes of their care? Are audit cycles are being completed to drive up standards? Do commissioners aspire to achievement of above national average survival rates by cancer stage at presentation?***
- 4. *Are Trusts in the local cancer network reporting cancer stage at diagnosis promptly and consistently to the cancer registry? If not, are commissioners working with cancer registries to aim that they do so through the commissioning process? Are they also considering, for example, making payment conditional on complete provision of staging data?***

5. ***Is staging data, in conjunction with intelligence from local practitioners, being used to identify where late presentation could be a substantial contributor to poorer survival by:***

- cancer site
- geography of residence
- cultural community?

6. ***Is primary care being engaged in a strategy to achieve earlier diagnosis, and is this being driven through involvement in the national RCGP/ NCAT Primary Care Audit? How are GPs and primary care teams being supported to achieve early diagnosis, including further education/support to achieve earlier diagnosis being identified? How is the work of the Network and PCT / PCT Cluster GP leads being established and sustained?***

In particular, is a campaign, including an audit of referrals, being carried out to drive up adherence to NICE lung cancer guidance on chest X-ray for designated symptoms persistent for more than 3 weeks, to promote earlier detection of lung cancer?

7. ***Are there targeted programmes aspiring to improve earlier presentation of the signs and symptoms of common cancers***

- Work with target communities, using social marketing principles, to change health seeking behaviours towards earlier presentation
- Look to derive learning from successful 'community level' programmes (e.g. Healthy Communities Collaborative Cancer Programme)?
- Responding to new evidence (such as in the BJC supplement and the NAEDI case studies).

8. ***Has failure to take up invitation to uptake on screening for breast, cervical, and bowel cancers been assessed by:***

- Geography / practice
- ethnic / religious group
- age
- gender
- disability (e.g. learning disabled) / mental health?

9. ***Have strategies been established for improvement based on segmentation of target population, 'insight' assessment of barriers to access, marketing to raise public awareness?***

Is commissioning responsive to screening services with a corresponding menu of customer access strategies? For bowel cancer, are there strategies to enhance take up by people from disadvantaged communities as the programme rolls out, rather than retrospectively? For cervical cancer have causes of any fall off in uptake been investigated?

10. ***Has there been a stock-take of systems of delivery?***

## Appendix 2: CRS Second Annual Report – Table 3 Screening & Early Diagnosis

(pp 25-28)

Screening and Early Diagnosis

PCT Name	Screening		Waits				Survival			Mortality
	Cervical (25-64)	Breast (53-70)	Referrals/10,000 Popn thro 2WW	% 2WW with Cancer	% diag thro 2WW	62 day compliance	Breast - 1 Year Survival	Colorectal - 1 Year Survival	Lung - 1 Year Survival	PCT Local Mortality Targets (CQC) Mortality Rate by PCT (per 100,000)
<b>NORTH EAST STRATEGIC HEALTH AUTHORITY</b>										
COUNTY DURHAM PCT	81.9% *	80.2% *	192	14%	44%		95.7%	65.4% !	29.1%	197 !
DARLINGTON PCT	81.3% *	77.6%	155	16%	43%		97.9% *	73.7% *	34.5% *	186 !
GATESHEAD PCT	80.2%	78.5%	237	11%	42%		96.8% *	71.1%	29.0%	202 !
HARTLEPOOL PCT	76.8%	77.6%	246	11%	47%		96.9% *	65.9% !	21.1% !	230 !
MIDDLESBROUGH PCT	75.0% !	72.2%	152	13%	41%		94.9%	73.4% *	27.1%	216 !
NEWCASTLE PCT	77.8%	76.4%	190	9%	43%		96.5% *	72.2%	29.0%	205 !
NORTHUMBERLAND CARE TRUST	84.4% *	82.8% *	212	11%	37%		96.4% *	75.0% *	28.5%	177
NORTH TYNESIDE PCT	81.8% *	78.2%	232	11%	49%		94.8%	70.2%	28.6%	199 !
REDCAR AND CLEVELAND PCT	80.1%	77.9%	164	17%	48%		97.2% *	69.6%	27.1%	190 !
SOUTH TYNESIDE PCT	79.1%	77.4%	242	10%	48%		96.9% *	71.1%	30.1%	214 !
NORTH TEES PCT	79.5%	78.1%	224	9%	46%		96.3% *	75.0% *	27.8%	195 !
SUNDERLAND TEACHING PCT	80.7%	79.1%	181	14%	42%		95.9%	72.5%	32.5% *	201 !
<b>NORTH WEST STRATEGIC HEALTH AUTHORITY</b>										
ASHTON, LEIGH AND WIGAN PCT	80.3%	73.4%	122	11%	49%		95.4%	71.8%	29.9%	184
BLACKBURN WITH DARWEN PCT	75.3% !	69.1% !	140	10%	36%		91.4% !	68.7%	24.5% !	192 !
BLACKPOOL PCT	75.2% !	60.8% !	219	16%	48%		92.5% !	68.0% !	18.3% !	201 !
BOLTON PCT	79.6%	77.9%	146	12%	46%		95.3%	67.9% !	28.8%	185
BURY PCT	81.0%	78.4%	158	14%	51%		93.5% !	70.0%	22.3% !	183
CENTRAL AND EASTERN CHESHIRE PCT	82.2% *	82.4% *	119	13%	40%		97.3% *	73.7% *	31.3% *	161
CENTRAL LANCASHIRE PCT	78.8%	72.7%	185	13%	43%		94.9%	73.1%	26.0% !	175
CUMBRIA PCT	81.9% *	78.5%	225	11%	51%		95.3%	75.2% *	25.9% !	173
EAST LANCASHIRE PCT	78.8%	73.6%	156	12%	43%		94.3%	72.9%	23.0% !	174
HALTON AND ST. HELENS PCT	78.9%	76.1%	191	9%	42%		96.1%	70.9%	29.9%	202 !
HEYWOOD, MIDDLETON AND ROCHDALE PCT	77.8%	71.0% !	131	14%	44%		95.9%	74.5% *	30.8% *	194 !
KNOWSLEY PCT	75.7% !	69.1% !	238	8%	50%		95.0%	68.3%	32.6% *	223 !
LIVERPOOL PCT	71.9% !	71.1%	248	9%	43%		93.1% !	70.4%	33.4% *	237 !
MANCHESTER PCT	73.5% !	63.5% !	137	11%	23%		95.4%	63.1% !	28.7%	217 !
NORTH LANCASHIRE PCT	79.1%	76.2%	220	14%	49%		95.8%	72.7%	29.4%	173
OLDHAM PCT	79.0%	73.3%	101	18%	42%		95.7%	69.9%	23.2% !	191 !
SALFORD PCT	77.2%	71.6%	152	13%	43%		93.8% !	74.1% *	29.1%	218 !
SEFTON PCT	74.6% !	74.3%	248	9%	43%		94.9%	72.2%	32.4% *	183
STOCKPORT PCT	81.8% *	76.1%	198	13%	46%		97.6% *	73.9% *	28.5%	174
TAMESIDE AND GLOSSOP PCT	79.6%	74.7%	145	14%	48%		96.5% *	61.5% !	22.7% !	197 !
TRAFFORD PCT	80.7%	73.4%	131	14%	27%		94.9%	70.8%	27.6%	176
WARRINGTON PCT	82.2% *	77.9%	157	12%	55%		97.6% *	67.9% !	26.1% !	177
WESTERN CHESHIRE PCT	81.4% *	80.8% *	152	11%	52%		97.6% *	75.4% *	33.8% *	177
WIRRAL PCT	77.8%	78.7%	160	14%	53%		95.4%	71.6%	29.9%	193 !

PCT Name	Screening		Waits			Survival			Mortality	
	Cervical (25-64)	Breast (53-70)	Referrals/10,000 Popn thro 2WW	% 2WW with Cancer	% diag thro 2WW	62 day compliance	Breast - 1 Year Survival	Colorectal - 1 Year Survival	Lung - 1 Year Survival	PCT Local Mortality Targets (CQC) Mortality Rate by PCT (per 100,000)
<b>YORKSHIRE AND THE HUMBER STRATEGIC HEALTH AUTHORITY</b>										
BARNSELY PCT	81.5% *	82.8% *	197	12%	38%		92.8% !	64.9% !	22.9% !	198 !
BRADFORD AND AIRES DALE PCT	76.6%	72.7%	185	11%	42%		95.7%	72.9%	28.8%	178
CALDERDALE PCT	81.8% *	70.3% !	135	18%	45%		96.1%	68.4%	27.5%	175
DONCASTER PCT	81.6% *	75.7%	202	12%	36%		94.0% !	67.8% !	28.0%	195 !
EAST RIDING OF YORKSHIRE PCT	83.3% *	72.8%	153	17%	42%		96.9% *	73.3% *	29.8%	165
HULL PCT	79.3%	72.4%	121	15%	32%		96.4% *	66.5% !	27.1%	213 !
KIRKLEES PCT	80.9%	77.0%	122	16%	42%		96.7% *	73.6% *	25.8% !	176
LEEDS PCT	77.2%	73.9%	166	12%	37%		95.4%	70.8%	28.5%	183
NORTH EAST LINCOLNSHIRE CARE TRUST PI	80.9%	56.6% !	-	-	-		-	-	-	182
NORTH LINCOLNSHIRE PCT	81.1%	71.1%	187	11%	36%		97.5% *	66.9% !	26.0% !	174
NORTH YORKSHIRE AND YORK PCT	82.7% *	82.6% *	153	15%	40%		96.9% *	74.2% *	29.1%	159 *
ROTHERHAM PCT	79.8%	82.2% *	178	11%	52%		93.9% !	70.4%	25.8% !	190 !
SHEFFIELD PCT	79.8%	78.2%	174	13%	41%		94.3%	71.0%	28.3%	179
WAKEFIELD DISTRICT PCT	80.2%	76.9%	199	12%	41%		95.9%	70.9%	26.3%	189 !
<b>EAST MIDLANDS STRATEGIC HEALTH AUTHORITY</b>										
BASSETLAW PCT	84.5% *	80.4% *	153	14%	40%		94.8%	71.5%	22.7% !	192 !
DERBY CITY PCT	81.0%	80.6% *	201	13%	44%		94.2%	62.6% !	26.0% !	166
DERBYSHIRE COUNTY PCT	84.9% *	82.2% *	177	15%	43%		94.8%	68.2% !	24.3% !	172
LEICESTER CITY PCT	76.9%	74.8%	128	10%	44%		95.0%	70.9%	28.2%	172
LEICESTERSHIRE COUNTY AND RUTLAND PCT	83.9% *	83.5% *	159	12%	44%		95.2%	70.2%	29.6%	156 *
LINCOLNSHIRE TEACHING PCT	81.6% *	73.5%	228	13%	49%		94.2%	70.1%	27.1%	166
NORTHAMPTONSHIRE TEACHING PCT	80.4%	81.4% *	169	15%	49%		95.4%	69.3%	24.5% !	174
NOTTINGHAM CITY PCT	79.6%	75.8%	189	15%	50%		93.4% !	62.7% !	27.5%	199 !
NOTTINGHAMSHIRE COUNTY TEACHING PCT	85.8% *	82.7% *	223	15%	52%		95.2%	72.3%	27.4%	171
<b>WEST MIDLANDS STRATEGIC HEALTH AUTHORITY</b>										
BIRMINGHAM EAST AND NORTH PCT	74.4% !	72.4%	162	19%	47%		95.3%	71.4%	27.6%	181
COVENTRY TEACHING PCT	77.1%	72.9%	235	8%	42%		94.6%	72.1%	23.8% !	178
DUDLEY PCT	79.8%	76.8%	233	10%	45%		95.6%	76.2% *	24.5% !	174
HEART OF BIRMINGHAM TEACHING PCT	76.3% !	66.0% !	93	10%	34%		94.3%	73.2%	26.0% !	180
HEREFORDSHIRE PCT	80.7%	81.2% *	151	14%	45%		96.6% *	74.9% *	15.4% !	156 *
NORTH STAFFORDSHIRE PCT	82.3% *	78.9%	221	14%	54%		93.6% !	70.6%	26.2%	170
SANDWELL PCT	77.5%	67.5% !	183	12%	32%		93.4% !	71.4%	30.4% *	191 !
SHROPSHIRE COUNTY PCT	82.4% *	82.9% *	169	15%	45%		96.1%	77.0% *	27.4%	161
SOLIHULL CARE TRUST	77.7%	77.9%	202	20%	48%		96.4% *	72.9%	33.7% *	161
SOUTH BIRMINGHAM PCT	72.9% !	72.9%	218	8%	39%		96.8% *	75.8% *	34.6% *	179
SOUTH STAFFORDSHIRE PCT	82.5% *	81.1% *	178	13%	51%		95.6%	74.9% *	28.3%	171
STOKE ON TRENT PCT	79.9%	76.7%	236	11%	58%		95.1%	66.1% !	27.1%	204 !
TELFORD AND WREKIN PCT	79.6%	78.8%	145	11%	38%		95.8%	80.0% *	23.7% !	179
WALSALL TEACHING PCT	77.8%	72.9%	133	13%	30%		96.3% *	74.2% *	28.1%	182
WARWICKSHIRE PCT	80.4%	79.4%	208	12%	46%		95.0%	74.8% *	29.0%	166
WOLVERHAMPTON CITY PCT	77.5%	72.4%	168	10%	41%		95.4%	70.8%	30.6% *	186 !
WORCESTERSHIRE PCT	79.1%	82.3% *	176	16%	61%		97.0% *	71.4%	28.4%	159 *

PCT Name	Screening		Waits			Survival			Mortality		
	Cervical (25-64)	Breast (53-70)	Referrals/10,000 Popn thro 2WW	% 2WW with Cancer	% diag thro 2WW	62 day compliance	Breast - 1 Year Survival	Colorectal - 1 Year Survival	Lung - 1 Year Survival	PCT Local Mortality Targets (CQC)	Mortality Rate by PCT (per 100,000)
<b>EAST OF ENGLAND STRATEGIC HEALTH AUTHORITY</b>											
BEDFORDSHIRE PCT	82.0% *	79.7%	158	11%	46%		95.7%	70.6%	25.7% !		161
CAMBRIDGESHIRE PCT	81.1%	79.8% *	222	11%	53%		96.3% *	73.9% *	30.4% *		157 *
EAST AND NORTH HERTFORDSHIRE PCT	81.4% *	76.5%	148	13%	43%		92.8% !	68.4%	20.3% !		158 *
GREAT YARMOUTH AND WAVENEY PCT	80.5%	79.7% *	203	14%	43%		94.9%	70.8%	28.5%		164
LUTON PCT	77.0%	75.2%	93	9%	75%		93.2% !	64.9% !	24.5% !		170
MID ESSEX PCT	79.8%	82.4% *	144	13%	61%		93.5% !	69.4%	26.7%		160 *
NORFOLK PCT	80.8%	80.5% *	221	12%	50%		95.9%	72.8%	31.7% *		155 *
NORTH EAST ESSEX PCT	81.4% *	81.4% *	198	7%	43%		96.0%	68.6%	26.1%		158 *
PETERBOROUGH PCT	77.1%	78.3%	171	12%	46%		95.6%	76.7% *	27.6%		168
SOUTH EAST ESSEX PCT	78.4%	73.5%	159	14%	41%		95.3%	72.1%	26.5%		169
SOUTH WEST ESSEX PCT	77.7%	72.4%	112	13%	38%		93.3% !	67.8% !	30.4% *		173
SUFFOLK PCT	80.9%	81.4% *	186	13%	46%		95.4%	72.1%	29.5%		158 *
WEST ESSEX PCT	80.4%	65.9% !	184	10%	45%		92.3% !	65.5% !	27.5%		163
WEST HERTFORDSHIRE PCT	79.8%	74.8%	168	10%	41%		90.6% !	65.7% !	22.8% !		161
<b>LONDON STRATEGIC HEALTH AUTHORITY</b>											
BARKING AND DAGENHAM PCT	75.7% !	70.0% !	166	8%	37%		90.2% !	65.6% !	26.9%		195 !
BARNET PCT	72.3% !	42.3% !	145	9%	36%		91.6% !	64.2% !	30.4% *		150 *
BEXLEY CARE TRUST	82.1% *	77.3%	174	8%	57%		96.9% *	66.8% !	29.3%		164
BRENT TEACHING PCT	70.3% !	44.1% !	143	12%	44%		95.4%	64.5% !	32.9% *		147 *
BROMLEY PCT	81.9% *	75.6%	139	10%	40%		95.9%	75.1% *	28.7%		158 *
CAMDEN PCT	69.3% !	55.4% !	176	7%	48%		95.7%	71.2%	29.9%		173
CITY AND HACKNEY TEACHING PCT	72.7% !	54.4% !	150	7%	41%		92.2% !	77.5% *	32.6% *		171
CROYDON PCT	75.9% !	69.8% !	116	11%	34%		96.2%	71.0%	31.8% *		160 *
EALING PCT	73.1% !	68.0% !	111	8%	33%		91.9% !	67.5% !	32.2% *		154 *
ENFIELD PCT	76.9%	58.6% !	135	13%	51%		94.2%	62.6% !	28.5%		158 *
GREENWICH TEACHING PCT	74.4% !	66.0% !	206	7%	76%		92.4% !	68.2% !	30.0%		191 !
HAMMERSMITH AND FULHAM PCT	65.8% !	59.9% !	71	13%	33%		91.4% !	72.6%	35.3% *		169
HARINGEY TEACHING PCT	72.5% !	52.4% !	117	11%	48%		94.1%	65.3% !	28.6%		174
HARROW PCT	73.1% !	64.1% !	180	8%	47%		94.3%	71.2%	29.1%		145 *
HAVERING PCT	81.1%	78.8%	234	14%	60%		94.3%	66.4% !	27.7%		173
HILLINGDON PCT	75.3% !	71.7%	113	9%	29%		89.5% !	66.2% !	27.4%		166
HOUNSLOW PCT	73.1% !	66.3% !	104	8%	29%		91.7% !	69.9%	33.5% *		167
ISLINGTON PCT	72.7% !	59.1% !	157	7%	29%		95.0%	71.2%	34.8% *		196 !
KENSINGTON AND CHELSEA PCT	67.2% !	55.3% !	124	10%	27%		96.4% *	76.6% *	43.7% *		113 *
KINGSTON PCT	76.1% !	71.4%	154	11%	37%		94.2%	68.5%	31.4% *		158 *
LAMBETH PCT	71.2% !	59.6% !	187	8%	50%		92.1% !	70.5%	26.9%		187 !
LEWISHAM PCT	74.2% !	63.8% !	189	8%	55%		94.3%	65.6% !	32.9% *		191 !
NEWHAM PCT	74.8% !	56.2% !	70	15%	44%		91.0% !	64.7% !	25.0% !		185
REDBRIDGE PCT	77.6%	70.1% !	139	13%	60%		92.5% !	72.5%	27.1%		156 *
RICHMOND AND TWICKENHAM PCT	77.6%	70.5% !	136	8%	37%		95.6%	72.6%	35.2% *		163
SOUTHWARK PCT	71.9% !	61.5% !	145	11%	55%		93.2% !	67.9% !	25.4% !		174
SUTTON AND MERTON PCT	76.0% !	70.5% !	153	14%	42%		94.6%	71.8%	32.4% *		160 *
TOWER HAMLETS PCT	70.8% !	53.4% !	109	13%	53%		89.3% !	67.1% !	29.1%		210 !
WALTHAM FOREST PCT	78.4%	70.0% !	139	7%	69%		93.1% !	57.9% !	21.8% !		176
WANDSWORTH PCT	71.5% !	63.1% !	174	9%	40%		96.2%	70.9%	31.3% *		173
WESTMINSTER PCT	68.1% !	52.7% !	95	10%	34%		93.6% !	68.9%	33.4% *		141 *

PCT Name	Screening		Waits			Survival			Mortality	
	Cervical (25-64)	Breast (53-70)	Referrals/10,000 Popn thro 2WW	% 2WW with Cancer	% diag thro 2WW	62 day compliance	Breast - 1 Year Survival	Colorectal - 1 Year Survival	Lung - 1 Year Survival	PCT Local Mortality Targets (CQC) Mortality Rate by PCT (per 100,000)
<b>SOUTH EAST COAST STRATEGIC HEALTH AUTHORITY</b>										
BRIGHTON AND HOVE CITY PCT	75.4% !	63.7% !	241	12%	46%		93.6% !	67.5% !	23.1% !	184
EAST SUSSEX DOWNS AND WEALD PCT	79.9%	72.1%	187	16%	50%		92.6% !	71.5%	28.9%	155 *
EASTERN AND COASTAL KENT PCT	80.8%	78.7%	239	12%	58%		93.5% !	65.1% !	23.7% !	173
HASTINGS AND ROTHER PCT	80.6%	78.8%	191	17%	51%		90.3% !	57.8% !	23.2% !	169
MEDWAY PCT	82.0% *	80.7% *	106	11%	51%		94.6%	70.9%	23.2% !	187 !
SURREY PCT	80.6%	76.9%	169	12%	43%		95.2%	71.1%	29.9%	150 *
WEST KENT PCT	83.2% *	78.9%	170	12%	47%		94.4%	67.9% !	29.0%	160 *
WEST SUSSEX PCT	81.0%	76.6%	193	13%	44%		93.5% !	70.1%	26.9%	159 *
<b>SOUTH CENTRAL STRATEGIC HEALTH AUTHORITY</b>										
BERKSHIRE EAST PCT	77.6%	80.2% *	145	9%	41%		96.8% *	73.1%	26.6%	157 *
BERKSHIRE WEST PCT	80.2%	80.7% *	160	13%	59%		95.1%	71.4%	25.3% !	161
BUCKINGHAMSHIRE PCT	81.5% *	82.9% *	150	13%	41%		97.0% *	72.4%	30.5% *	151 *
HAMPSHIRE PCT	81.2% *	78.0%	158	15%	45%		96.5% *	75.0% *	31.3% *	155 *
ISLE OF WIGHT HEALTHCARE PCT	80.2%	81.0% *	196	13%	41%		95.4%	73.9% *	23.7% !	158 *
MILTON KEYNES PCT	79.1%	79.0%	177	13%	48%		95.9%	68.6%	17.5% !	176
OXFORDSHIRE PCT	77.1%	81.2% *	165	14%	50%		97.0% *	75.4% *	27.2%	158 *
PORTSMOUTH CITY TEACHING PCT	74.6% !	72.1%	196	16%	50%		93.4% !	69.2%	29.0%	181
SOUTHAMPTON CITY PCT	74.8% !	71.0% !	180	13%	49%		95.7%	74.0% *	30.8% *	179
<b>SOUTH WEST STRATEGIC HEALTH AUTHORITY</b>										
BATH AND NORTH EAST SOMERSET PCT	79.5%	76.8%	112	16%	34%		97.0% *	69.4%	33.6% *	156 *
BOURNEMOUTH AND POOLE PCT	82.8% *	77.2%	161	15%	43%		96.4% *	76.5% *	32.9% *	156 *
BRISTOL PCT	74.7% !	73.7%	221	10%	44%		96.3% *	72.0%	28.0%	181
CORNWALL AND ISLES OF SCILLY PCT	80.5%	79.9% *	225	15%	54%		96.6% *	74.2% *	30.6% *	162
DEVON PCT	82.3% *	80.0% *	205	13%	43%		96.3% *	72.0%	29.6%	159 *
DORSET PCT	84.1% *	80.5% *	183	13%	39%		94.7%	75.8% *	25.1% !	151 *
GLOUCESTERSHIRE PCT	82.1% *	80.1% *	187	14%	44%		96.2%	75.8% *	28.3%	153 *
NORTH SOMERSET PCT	81.2% *	80.2% *	217	12%	48%		95.7%	72.5%	31.1% *	151 *
PLYMOUTH TEACHING PCT	79.8%	81.3% *	240	13%	54%		94.3%	76.6% *	26.5%	184
SOMERSET PCT	82.0% *	82.1% *	233	12%	50%		94.2%	71.7%	27.4%	153 *
SOUTH GLOUCESTERSHIRE PCT	82.7% *	80.5% *	206	10%	45%		95.7%	75.1% *	28.2%	156 *
SWINDON PCT	76.8%	79.1%	194	9%	44%		94.7%	73.6% *	30.4% *	170
TORBAY CARE TRUST	80.4%	77.9%	209	13%	38%		99.0% *	74.9% *	29.9%	159 *
WILTSHIRE PCT	80.7%	80.3% *	155	13%	37%		97.2% *	72.6%	27.5%	152 *

Table 9: Audit participation and procedures by trust

Trust name	Audits			Procedures	
	Colorectal audit (NBOCAP)	Lung audit (LUCADA)	Mastectomy/reconstruction audit	Oesophagogastric procedures (per year)	Radical urological procedures (per year)
<b>NORTH EAST STRATEGIC HEALTH AUTHORITY</b>					
City Hospitals Sunderland NHS Foundation Trust	●	●	◐	5	113
County Durham and Darlington NHS Foundation Trust	●	●	●	3	1
Gateshead Health NHS Foundation Trust	●	●	◐	3	3
The North Tees and Hartlepool NHS Foundation Trust	●	●	●	2	8
The Northumbria Healthcare NHS Foundation Trust	●	●	◐	21	1
The South Tees Hospitals NHS Foundation Trust	●	◐	●	80	120
The South Tyneside NHS Foundation Trust	●	●	●	1	0
The Newcastle upon Tyne Hospitals NHS Foundation Trust	●	◐	●	163	159
<b>NORTH WEST STRATEGIC HEALTH AUTHORITY</b>					
Aintree University Hospitals NHS Foundation Trust	●	◐	●	53	3
Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust	●	◐	●	27	7
Liverpool Heart and Chest Hospital NHS Trust		◐		101	0
Central Manchester University Hospitals NHS Foundation Trust	◐	●		21	37
Clatterbridge Centre for Oncology NHS Foundation Trust	◐	◐		0	0
Countess of Chester Hospital NHS Foundation Trust	●	●	●	7	1
East Cheshire NHS Trust	◐	●	●	3	2
East Lancashire Hospitals NHS Trust	◐	◐	◐	37	35
Liverpool Women's NHS Foundation Trust			●	0	1
Mid Cheshire Hospitals NHS Foundation Trust	◐	◐	●	4	4
North Cumbria University Hospitals NHS Trust	●	●	●	28	1
Pennine Acute Hospitals NHS Trust	◐	◐	◐	71	49
Royal Bolton Hospital NHS Foundation Trust	●	●	●	3	5
Royal Liverpool and Broadgreen University Hospitals NHS Trust	◐	◐	●	10	89
Salford Royal NHS Foundation Trust	◐	●	●	39	58
Southport and Ormskirk Hospital NHS Trust	◐	◐	◐	6	6
St Helens and Knowsley Hospitals NHS Trust	●	◐	◐	0	9
Stockport NHS Foundation Trust	◐	◐	●	18	92
Tameside Hospital NHS Foundation Trust	●	●	◐	25	0
The Christie NHS Foundation Trust	●	◐	●	1	53
Trafford Healthcare NHS Trust	◐	◐		0	0
University Hospital of South Manchester NHS Foundation Trust	●	◐	◐	31	90
University Hospitals of Morecambe Bay NHS Trust	●	●	◐	26	4
Warrington and Halton Hospitals NHS Foundation Trust	●	●		8	0
Wirral University Teaching Hospital NHS Foundation Trust	●	●	◐	5	45
Lancashire Teaching Hospitals NHS Foundation Trust	●	◐	◐	20	93
Wrightington, Wigan and Leigh NHS Foundation Trust	◐	◐	◐	2	3
<b>YORKSHIRE AND THE HUMBER STRATEGIC HEALTH AUTHORITY</b>					
Airedale NHS Trust	●	●	●	2	2
Barnsley Hospital NHS Foundation Trust	●	◐	●	2	3
Bradford Teaching Hospitals NHS Foundation Trust	●	●	◐	57	109
Calderdale and Huddersfield NHS Foundation Trust	◐	◐	◐	6	5
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	◐	●	◐	52	7
Harrogate and District NHS Foundation Trust	●	●	◐	0	3

Table 9: Audit participation and procedures by trust (continued)

Trust name	Audits			Procedures	
	Colorectal audit (NBOCAP)	Lung audit (LUCADA)	Mastectomy/reconstruction audit	Oesophago-gastric procedures (per year)	Radical urological procedures (per year)
Hull and East Yorkshire Hospitals NHS Trust	●	●	●	104	95
Leeds Teaching Hospitals NHS Trust	●	●	●	130	133
Mid Yorkshire Hospitals NHS Trust	●	●	●	5	69
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	●	●	●	29	23
Scarborough and North East Yorkshire Healthcare NHS Trust	●	●	●	5	0
Sheffield Teaching Hospitals NHS Foundation Trust	●	●	●	82	150
The Rotherham NHS Foundation Trust	●	●	●	2	3
York Hospitals NHS Foundation Trust	●	●	●	25	17
<b>EAST MIDLANDS STRATEGIC HEALTH AUTHORITY</b>					
Chesterfield Royal Hospital NHS Foundation Trust	●	●	●	0	2
Derby Hospitals NHS Foundation Trust	●	●	●	46	70
Kettering General Hospital NHS Foundation Trust	●	●	●	4	4
Northampton General Hospital NHS Trust	●	●	●	35	68
Nottingham University Hospitals NHS Trust	●	●	●	122	80
Sherwood Forest Hospitals NHS Foundation Trust	●	●	●	1	2
United Lincolnshire Hospitals NHS Trust	●	●	●	13	91
University Hospitals of Leicester NHS Trust	●	●	●	40	57
<b>WEST MIDLANDS STRATEGIC HEALTH AUTHORITY</b>					
Birmingham Children's Hospital NHS Foundation Trust	●	●	●	4	0
Birmingham Women's NHS Foundation Trust	●	●	●	0	2
Burton Hospitals NHS Foundation Trust	●	●	●	2	0
George Eliot Hospital NHS Trust	●	●	●	3	2
Heart of England NHS Foundation Trust	●	●	●	62	210
Hereford Hospitals NHS Trust	●	●	●	7	0
Mid Staffordshire NHS Foundation Trust	●	●	●	1	3
Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust	●	●	●	0	0
Sandwell and West Birmingham Hospitals NHS Trust	●	●	●	9	8
Shrewsbury and Telford Hospital NHS Trust	●	●	●	14	48
South Warwickshire General Hospitals NHS Trust	●	●	●	0	1
Dudley Group of Hospitals NHS Foundation Trust	●	●	●	79	0
Royal Wolverhampton Hospitals NHS Trust	●	●	●	12	67
University Hospital Birmingham NHS Foundation Trust	●	●	●	78	151
University Hospital of North Staffordshire NHS Trust	●	●	●	100	48
University Hospitals Coventry and Warwickshire NHS Trust	●	●	●	84	105
Walsall Hospitals NHS Trust	●	●	●	5	1
Worcestershire Acute Hospitals NHS Trust	●	●	●	3	94
<b>EAST OF ENGLAND STRATEGIC HEALTH AUTHORITY</b>					
Basildon and Thurrock University Hospitals NHS Foundation Trust	●	●	●	10	18
Bedford Hospital NHS Trust	●	●	●	2	2
Cambridge University Hospitals NHS Foundation Trust	●	●	●	104	232
Colchester Hospital University NHS Foundation Trust	●	●	●	5	55
East and North Hertfordshire NHS Trust	●	●	●	11	30
Ipswich Hospital NHS Trust	●	●	●	17	3
Papworth Hospital NHS Foundation Trust	●	●	●	0	0
James Paget University Hospitals NHS Foundation Trust	●	●	●	4	6
Luton and Dunstable Hospital NHS Foundation Trust	●	●	●	24	17
Mid Essex Hospital Services NHS Trust	●	●	●	30	4

Table 9: Audit participation and procedures by trust (continued)

Trust name	Audits			Procedures	
	Colorectal audit (NBOCAP)	Lung audit (LUCADA)	Mastectomy/reconstruction audit	Oesophagogastric procedures (per year)	Radical urological procedures (per year)
Norfolk and Norwich University Hospitals NHS Foundation Trust	●	●	●	78	122
Peterborough and Stamford Hospitals NHS Foundation Trust	●	●	●	4	2
Southend University Hospital NHS Foundation Trust	●	●	●	4	41
The Princess Alexandra Hospital NHS Trust	●	●	●	2	8
Queen Elizabeth Hospital King's Lynn NHS Trust	●	●	●	6	2
West Hertfordshire Hospitals NHS Trust	●	●	●	22	60
West Suffolk Hospitals NHS Trust	●	●	●	1	6
<b>LONDON STRATEGIC HEALTH AUTHORITY</b>					
Barking, Havering and Redbridge University Hospitals NHS Trust	●	●	●	37	68
Royal National Orthopaedic Hospital NHS Trust	●	●	●	0	2
Barnet and Chase Farm Hospitals NHS Trust	●	●	●	3	80
Barts and the London NHS Trust	●	●	●	71	4
Chelsea and Westminster Hospital NHS Foundation Trust	●	●	●	37	5
Ealing Hospital NHS Trust	●	●	●	1	3
Epsom and St Helier University Hospitals NHS Trust	●	●	●	4	4
Guy's and St Thomas' NHS Foundation Trust	●	●	●	95	161
Homerton University Hospital NHS Foundation Trust	●	●	●	34	0
King's College Hospital NHS Foundation Trust	●	●	●	22	41
Kingston Hospital NHS Trust	●	●	●	0	1
Mayday Healthcare NHS Trust	●	●	●	0	4
Newham University Hospital NHS Trust	●	●	●	0	2
North Middlesex University Hospital NHS Trust	●	●	●	4	11
North West London Hospitals NHS Trust	●	●	●	4	30
Royal Free Hampstead NHS Trust	●	●	●	7	9
St George's Healthcare NHS Trust	●	●	●	32	59
The Hillingdon Hospital NHS Trust	●	●	●	1	0
The Lewisham Hospital NHS Trust	●	●	●	0	0
The Royal Marsden NHS Foundation Trust	●	●	●	83	173
The Whittington Hospital NHS Trust	●	●	●	8	4
Royal Brompton and Harefield NHS Foundation Trust	●	●	●	2	0
University College London Hospitals NHS Foundation Trust	●	●	●	100	72
West Middlesex University Hospital NHS Trust	●	●	●	0	5
Whipps Cross University Hospital NHS Trust	●	●	●	2	73
Imperial College Healthcare NHS Trust	●	●	●	120	188
South London Healthcare NHS Trust	●	●	●	11	10
<b>SOUTH EAST COAST STRATEGIC HEALTH AUTHORITY</b>					
Ashford and St Peter's Hospitals NHS Trust	●	●	●	4	50
Brighton and Sussex University Hospitals NHS Trust	●	●	●	52	60
Dartford and Gravesham NHS Trust	●	●	●	3	21
East Kent Hospitals University NHS Foundation Trust	●	●	●	9	83
East Sussex Hospitals NHS Trust	●	●	●	2	61
Frimley Park Hospital NHS Foundation Trust	●	●	●	7	4
Surrey and Sussex Healthcare NHS Trust	●	●	●	0	19
Maidstone and Tunbridge Wells NHS Trust	●	●	●	60	44
Medway NHS Foundation Trust	●	●	●	2	61
Royal Surrey County Hospital NHS Trust	●	●	●	57	54
Western Sussex Hospitals NHS Trust	●	●	●	18	18

Table 9: Audit participation and procedures by trust (continued)

Trust name	Audits			Procedures	
	Colorectal audit (NBOCAP)	Lung audit (LUCADA)	Mastectomy/reconstruction audit	Oesophagogastric procedures (per year)	Radical urological procedures (per year)
<b>SOUTH CENTRAL STRATEGIC HEALTH AUTHORITY</b>					
Nuffield Orthopaedic Centre NHS Trust		◐		0	0
Basingstoke and North Hampshire NHS Foundation Trust	●	◐	◐	12	4
Buckinghamshire Hospitals NHS Trust	◐	◐	◐	3	78
Heatherwood and Wexham Park Hospitals NHS Foundation Trust	●	◐	●	3	73
Milton Keynes Hospital NHS Foundation Trust	◐	●	◐	1	4
Oxford Radcliffe Hospitals NHS Trust	◐	●	◐	117	54
Portsmouth Hospitals NHS Trust	●	◐	●	42	78
Royal Berkshire NHS Foundation Trust	◐	●	◐	23	87
Southampton University Hospitals NHS Trust	●	◐	◐	72	63
Winchester and Eastleigh Healthcare NHS Trust	●	●	●	1	9
<b>SOUTH WEST STRATEGIC HEALTH AUTHORITY</b>					
Gloucestershire Hospitals NHS Foundation Trust	◐	●	◐	48	75
Great Western Hospitals NHS Foundation Trust	●	●	●	1	1
North Bristol NHS Trust	●	◐	●	7	225
Plymouth Hospitals NHS Trust	●	●	●	50	75
Poole Hospital NHS Foundation Trust	●	●	◐	1	2
Dorset County Hospital NHS Foundation Trust	●	●	●	1	14
Royal Cornwall Hospitals NHS Trust	●	●	●	20	6
Royal Devon and Exeter NHS Foundation Trust	●	●	◐	47	80
Royal United Hospital Bath NHS Trust	◐	●	●	9	50
Salisbury NHS Foundation Trust	●	●	●	0	13
South Devon Healthcare NHS Foundation Trust	◐	●	●	1	7
Taunton and Somerset NHS Foundation Trust	●	●	●	5	42
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	●	●	●	49	56
University Hospitals Bristol NHS Foundation Trust	●	◐	●	88	3
Weston Area Health NHS Trust	●	●	●	0	1
Yeovil District Hospital NHS Foundation Trust	◐	●	●	1	2

**Key:**

Less than 25% of expected cases ◐

Between 25% and 75% of expected cases ◑

Over 75% of expected cases ●

**National Audit participation: NCASP**

This shows the participation of provider trusts in the national clinical audits for 2007/08 as provided by the National Clinical Audit Support Programme (NCASP) project team to the Healthcare Commission. These are categorised as:

*Colorectal Audit:* NBOCAP ratings as published for Case Ascertainment 2007/08, extracted from the latest NHS Information Centre (NHSIC) publication for the National Bowel Cancer Audit. Trusts flagged as not eligible to submit data by the NHSIC publication, or where there is no information available, are shown with a blank indicator.

An ascertainment over 75% of expected incidence is shown with a black circle. Trusts with less than 25% of expected incidence are shown marked quarter circle. Trusts between 25% and 75% are shown with a half circle. This key is also highlighted at the end of the table.

### Annex 3: Acronyms and abbreviations

<b>BJC</b>	British Journal of Cancer
<b>BME</b>	Black and minority ethnic
<b>CAM</b>	Cancer Awareness Measure
<b>HINST</b>	Health Inequalities National Support Team
<b>HPV</b>	Human papilloma virus
<b>IOG</b>	Improving Outcomes Guidance
<b>LAEDI</b>	Local Awareness and Early Diagnosis Initiative
<b>NAEDI</b>	National Awareness and Early Diagnosis Initiative
<b>NCAAG</b>	National Chemotherapy Advisory Group
<b>NCAT</b>	National Cancer Action Team
<b>NCIN</b>	National Cancer Intelligence Network

Summary of the process described in the HINST – NCAT report (see page 14 above)



## Health Inequalities National Support Team

# How to Reduce Excess Mortality from Cancer in the areas of highest deprivation and worst health

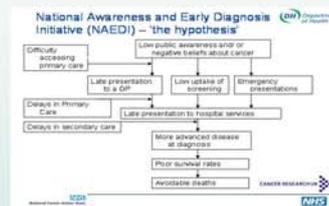
### Step 1 : Define the problem

1 How do one year survival rates compare with neighbours / similar areas ?



### Step 2 : Understand the Reason for it:

2.i Where the delay is happening ?



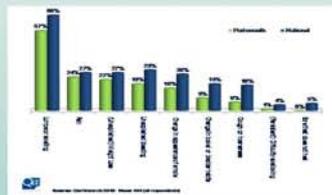
1.i What is the impact on health inequalities ?

Health Inequalities Intervention Tool for All Areas : London Health Observatory website



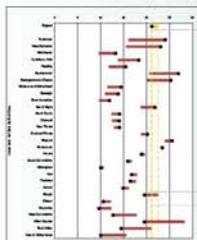
2.ii Why are people are not coming forward earlier ?

(Central & South Coast Cancer Network CAM results)



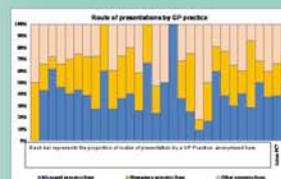
1.ii How is it changing ?

Raindrop chart spreadsheet, SWPHO



2.ii What is happening with GP referrals ?

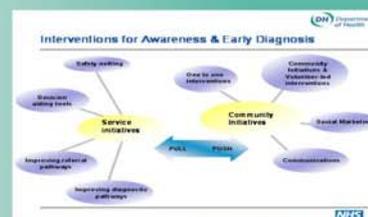
(Greater Manchester & Cheshire Cancer Network Review of referrals by Cancer type)



### Step 3: Evaluate, Act & Monitor

Together with service users, clinicians and the Cancer Network:

1. Construct a 'Plausible Hypothesis for Change' that identifies the problem and its causes, using epidemiological data and trend analysis, and specify the (quantified) outcome that partners will commit to
2. Research effective practice then appraise options (and include a cost benefit analysis in the option appraisal)
3. For population interventions - awareness raising among the public - segment the target audience and define the behaviours that need to be addressed - through social marketing techniques and community engagement
4. For service interventions - develop support mechanisms and feedback loops between clinicians to continually improve practice
5. Model the impact on capacity and either invite to tender or recruit and retrain staff
6. Monitor, feedback and modify the intervention in response
7. Evaluate
8. Start again



NAEDI 2010

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