

<b>REPORT TO:</b>	<b>HEALTH AND WELLBEING BOARD (CROYDON)</b> <b>14 September 2016</b>
<b>AGENDA ITEM:</b>	<b>6</b>
<b>SUBJECT:</b>	<b>Improving the early detection and treatment of cancers in Croydon</b>
<b>BOARD SPONSOR:</b>	Paula Swann, Chief Officer – Croydon CCG

**BOARD PRIORITY/POLICY CONTEXT:**

**Croydon Joint health and wellbeing strategy, 2013-2018**

As part of its vision for longer healthier lives for everyone in Croydon, the Health and Wellbeing Board identifies as an ambition: increased healthy life expectancy and reduced differences in life expectancy between communities. The strategy identifies specific improvement areas relating to cancer that contribute to this ambition:

Improvement area 2: preventing illness and injury and helping people recover

- 2.1 Reduce smoking prevalence
- 2.2 Reduce overweight and obesity in adults
- 2.3 Reduce the harm caused by alcohol misuse

Improvement area 3: preventing premature death and long term health conditions

- 3.2 Early detection and treatment of cancers

Improvement area 5: providing integrated, safe, high quality services

- 5.4 Improve the clinical quality and safety of health services

Improvement area 6: improving people's experience of care

- 6.2 Improved patient and service user satisfaction with health and social care services

**Croydon CCG's Vision, Objectives and operating plan commitments**

Our vision is for longer healthier lives for all the people in Croydon. We will deliver this through an ambitious programme of innovation and by working together with the diverse communities of Croydon and with our partners. We will use resources wisely to transform healthcare to help people look after themselves, and when people do need care they will be able to access high quality services.

Our objectives are:

- 1.1 To commission high quality health care services that are accessible, provide good treatment and achieve good patient outcomes
- 2.1 To reduce the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital, for physical and mental health

3.1 To achieve sustainable financial balance by 2018/19 and NHS business rules of 1% surplus by 2020/21

4.1 To support local people and stakeholders to have a greater influence on services we commission and support individuals to manage their care

5.1 To have all Croydon GP practices actively involved in commissioning services and develop as a responsive and learning commissioning organisation

During 2016/17 we are working to:

- Ensure that all targets for cancer reporting are met, particularly with regards to the 62 day referral to treatment target, where there is poor performance across London and at a national level.
- We are achieving this through delivery of local action plans that are agreed with providers and which include the tracking of patient pathways to highlight issues that are causing delays.
- Adopt a collaborative approach across London on demand and capacity requirements for diagnostic services that are key in ensuring the delivery of the nationally set cancer targets. This involves establishing sufficient capacity within diagnostic services to ensure patients are seen and reported upon in a timely manner according to the agreed cancer pathways.
- Actively engage with clinicians in primary care to provide education and support in pathways for patients presenting with symptoms as per NICE guidance. This will improve on the percentage of patients who are detected and diagnosed at an earlier stage in their pathway and reduce levels of emergency activity.
- Implement the pan-London cancer pathways including direct access for GPs to diagnostics.

### **Achieving world-class cancer outcomes: A strategy for England 2015-2020**

The Cancer Strategy for England was published in July 2015 by an Independent Cancer Taskforce. It set out the following six strategic priorities:

1. Prevention and public health
2. Earlier diagnosis
3. Patient experience
4. Living with and beyond cancer
5. Investing in modern, high quality services
6. Overhauling processes for commissioning, accountability and provision

### **NHS England's Five year Cancer commissioning Strategy for London, 2014**

Clear themes emerged from engagement events held to develop the strategy. These themes were incorporated into it. They are:

- The importance of earlier detection
- The need to improve coverage and uptake of screening

- The need to support people living with and beyond cancer as a long term condition
- The importance of information and data as to the cost and performance of services
- The vital need for excellent communication

### **Five-year sustainability and transformation plan**

New planning guidance published in December 2015 by NHS England instructs CCGs and their partners to establish 'place-based planning'. This means that alongside a one-year operational plan, a five-year sustainability and transformation plan (STP) must be developed. The final South-West London (SWL) STP will be delivered in October 2016. One of the national challenges each plan must address is the question '*How will you deliver a transformation in cancer prevention, diagnosis, treatment and aftercare in line with the cancer taskforce report?*' In response to this challenge, the cancer priorities of the SWL STP will be:

1. Screening and Early Diagnosis
2. Cancer waits and diagnostics
3. Reducing variation
4. Living with and Beyond Cancer

As part of its commissioning intentions, Croydon CCG will develop pathways to reflect these priorities alongside the priorities already identified in our local cancer strategy. Additionally, Croydon has been identified as the lead CCG for the SWL STP on prevention.

### **Croydon CCG Cancer Strategy 2014-19**

In its Cancer Strategy 2014-19 Croydon CCG identifies its key challenges and areas for focus are:

- Prevention
- Improving early detection
- Reducing variation in care
- Improving breast screening rates for women and addressing an emerging issue of increased incidence of breast cancer<sup>1</sup>
- Addressing the increased incidence and emerging issue of increased deaths from prostate cancer
- Inequality in life expectancy between areas of deprivation
- Achievement of waiting time standards
- Improving patient experience

---

<sup>1</sup> Since the strategy was implemented the 1 year trend for incidence of breast cancer has shown some improvement

## **FINANCIAL IMPACT:**

Success in addressing preventable cancer mortality and morbidity necessitates adequate investment in prevention, awareness, screening and services. The costs of cancer, both in financial terms and in human terms, can be greatly reduced by early intervention. The earlier the intervention, the more impactful the investment will be. High quality prevention and awareness have the potential to deliver the greatest benefits.

## **1. RECOMMENDATIONS**

The Board is asked to support and ensure stronger partnership working between local commissioners of cancer provision, in particular:

- Croydon Clinical Commissioning Group
- Croydon Council and its Public Health function

Working alongside national partners:

- Primary Care Commissioning - NHS England
- Public Health England
- NHS England - Specialised Commissioning

This will improve cancer outcomes for the people of Croydon and address health inequalities issues by tackling cancer all along the pathway, from prevention, awareness and screening to early diagnosis and treatment.

## **2. EXECUTIVE SUMMARY**

- 2.1 Cancer causes one in four deaths in the UK and kills around 945 Croydon residents each year. Despite this toll, cancer care is improving significantly and currently around half of those diagnosed with the disease survive for 10 years or more. Incidence of cancer and cancer deaths are lower than England averages but Croydon does have challenges, in particular around breast and bowel screening.
- 2.2 There is evidence around serious health inequalities in cancer and work needs to take place locally to establish the scale and nature of health inequalities issues in the borough.
- 2.3 The financial and human costs of cancer are best addressed through 'upstream' interventions as many cases of cancer can be prevented through changes to lifestyles, such as quitting smoking or reducing excess weight. Smoking alone causes 28% of cancer deaths and this burden falls disproportionately on deprived communities.

- 2.4 Public health teams commission behaviour change service to deliver prevention and Croydon Council is implementing a new Livewell service to deliver this function during 2016-17. The council's NHS Healthchecks programme can support success in preventative interventions too. Other partners and stakeholders including Croydon CCG's Together for Health programme will need to join forces to be effective. The council is also able to use local regulation, such as licensing policy, to improve lifestyles.
- 2.5 Levels of awareness of cancer symptoms among the public are inconsistent and barriers exist to getting help when symptoms are discovered. Croydon can address this through promoting the national 'Be Clear on Cancer' campaigns as broadly as possible.
- 2.6 Similarly, there are issues around screening uptake, which the CCG is tackling through individual support for practices - in partnership with Cancer Research UK and Macmillan. This support includes improved cancer referral practice and 'safety-netting' to ensure patients do not fall through the cracks between services.
- 2.7 2015 NICE guidance has lowered the threshold of risk for symptoms suggestive of cancer, which triggers an urgent referral, to 3%. This will aid diagnosis of more cancers at an early stage - so called 'low risk but not no risk' cases. The CCG is also subject to a Quality Premium incentive scheme pushing for earlier stage diagnosis of cancer.
- 2.8 Despite improvements in cancer care, England performs poorly compared to some peer nations and so there is room for improvement in cancer survivorship. Survival is improved most profoundly through earlier diagnosis. A marker of late diagnosis (and hence a marker of survival) is the proportion of cancer cases that are discovered through emergency presentations at A&E. Croydon performs well against England in this respect, 17% against an England average of 20%.
- 2.9 Croydon CCG performs well against the range of cancer waiting time targets in the year to date, but the 62 day standard shows some underperformance and is a cause for concern. Plans to improve this performance issue are being implemented. It should be noted however, that Trusts report ever increasing pressures and there is a real risk that performance on waiting times may deteriorate.
- 2.10 For 2016-17 the CCG implemented a range of early diagnosis commissioning intentions within the acute care contract as local quality requirements.
- 2.11 In summary, the cancer pathway begins with sound, evidence-based behaviour change services, such as smoking cessation, weight management and physical

activity. Public awareness needs to be heightened through widely disseminated health promotion campaigns, such as *Be Clear on Cancer*.<sup>2</sup> Screening programs must be promoted and targeted to maximise uptake, for example, through the use of segmented social marketing approaches. Primary-care detection and referral must be optimised in line with best practice, and diagnostics must be accessible with prompt communication, both with primary care referrers and with patients.<sup>3</sup>

2.12 Only by a robust partnership approach can Croydon deliver the best possible cancer provision, increasing healthy life expectancy, reducing differences in life expectancy between communities and improving wellbeing and quality of life for all.

### 3. BACKGROUND

#### 3.1 What is cancer?

Cancer is a disease associated with the abnormal and uncontrolled division of cells in the body. This can be in the skin or tissues surrounding organs (carcinomas); in the connective or supportive tissues such as bone, cartilage, fat, muscle, or blood vessels (sarcomas); in the blood forming tissue such as bone marrow (leukaemias); in the cells of the immune system (lymphoma and myeloma); or in the central nervous system (cancers of the brain and spinal cord). Some cancers can spread into other tissues over time – what is known as metastasis. This involves cancer cells being shed from a tumour and travelling to new sites within the body where they may begin to multiply.

#### 3.2 Cancer mortality and morbidity

There are more than 200 different types of cancer and one in two people in the UK will get cancer in their lifetime.<sup>4</sup> Cancer causes 27% of global deaths<sup>5</sup> and in 2014 caused over 163,000 deaths (one in four of all deaths) in the UK alone.<sup>6</sup> The annual rate of cancer mortality in Croydon is 260 people per 100,000 population,<sup>7</sup> which means around 945 people die from cancer in the borough each year. However, advances in medicine mean that many people are cured and survival rates have improved with 50% of people diagnosed in England and Wales surviving their disease for ten years or more (2010-11).<sup>8</sup> Cancer survival is improving and has in fact doubled in the last 40 years in the UK.<sup>9</sup>

---

<sup>2</sup> <https://www.nhs.uk/be-clear-on-cancer#4Bq6gD5gWz9siiFO.97>

<sup>3</sup> [http://www.macmillan.org.uk/documents/aboutus/health\\_professionals/primarycare/improving-one-year-cancer-survival-2015.pdf](http://www.macmillan.org.uk/documents/aboutus/health_professionals/primarycare/improving-one-year-cancer-survival-2015.pdf)

<sup>4</sup> Trends in the lifetime risk of developing cancer in Great Britain: comparison of risk for those born from 1930 to 1960. *British Journal of Cancer* (2015) **112**, 943–947. doi:10.1038/bjc.2014.606 [www.bjcancer.com](http://www.bjcancer.com)

<sup>5</sup> Global status report on noncommunicable diseases. World Health Organization, 2010.

<sup>6</sup> Cancer Research UK <http://www.cancerresearchuk.org/health-professional/cancer-statistics> Aug 2016

<sup>7</sup> [https://www.cancerdata.nhs.uk/mortality/age\\_standardised\\_rates](https://www.cancerdata.nhs.uk/mortality/age_standardised_rates)

<sup>8</sup> Cancer Research UK <http://www.cancerresearchuk.org/health-professional/cancer-statistics/survival>

<sup>9</sup> Cancer Research UK <http://www.cancerresearchuk.org/health-professional/cancer-statistics/survival>

3.3 Cancer incidence and mortality is lower in Croydon than the England average (see tables 3 and 4).<sup>10</sup> The local Joint Strategic Needs Assessment (JSNA) highlights where the borough varies from both the London and England averages around other cancer indicators. Our local JSNA for 2015-16 tells us that in some areas Croydon is performing well (table 1). For example, deaths from oesophageal cancer and colorectal cancer are significantly better than England and in the best 25% of local authorities/CCG's. The one-year and three-year trends consistently show improvement. Croydon performs favourably with regard to early deaths from cancer and incidence of bladder cancer; again significantly better than England and in the best quartile among local authorities/CCG's. The trends for these indicators appear stable.

Indicator	Croydon	London	England	England Range	1 Year Trend	3 Year Trend	Time Period
177 Incidence of oesophageal cancer (rate per 100,000 population)	14.7	12.3	15.1		▶	—	2010 - 12
178 Deaths from oesophageal cancer (rate per 100,000 population)	9.0	10.5	13.3		▶	▶	2011 - 13
181 Incidence of colorectal cancer (rate per 100,000 population)	72.5	68.0	77.2		◀	▶	2010 - 12
182 Deaths from colorectal cancer (rate per 100,000 population)	24.5	26.6	28.8		▶	▶	2011 - 13
194 Incidence of bladder cancer (rate per 100,000 population)	16.0	18.2	19.3		◀	▶	2010 - 12
195 Deaths from bladder cancer (rate per 100,000 population)	7.3	8.2	9.0		▶	▶	2011 - 13

Table 1.

3.4 However Croydon is not without its challenges (table 2). The borough ranks low on financial expenditure on cancer and tumours. Another emerging issue for Croydon may be deaths from stomach cancer and, though current performance is not significantly worse than England, the one-year and three-year trends show deterioration. Breast screening rates for women aged 53-70 are also a cause for concern, with Croydon performing worse than both London and England. The worsening trend for this indicator is worrying. Likewise, the three-year trend for prostate cancer deaths warrants attention.

<sup>10</sup> <http://www.cancerresearchuk.org/cancer-info/cancerstats/local-cancer-statistics/?location-name-1=NHS%20Croydon%20CCG&location-1=07V>

Indicator	Croydon	London	England	England Range	1 Year Trend	3 Year Trend	Time Period
169 CCG spend per head on cancers and tumours	£40	£47	£50		no data	no data	2013/14
179 Incidence of stomach cancer (rate per 100,000 population)	11.2	11.9	12.4		—	—	2010 - 12
180 Deaths from stomach cancer (rate per 100,000 population)	9.1	8.0	8.1		◀	◀	2011 - 13
187 Breast screening rate (% of women aged 53-70)	66.7%	68.9%	75.9%		◀	◀	2014
188 Incidence of breast cancer (rate per 100,000 population)	156	155	164		▶	◀	2010 - 12
189 Deaths from breast cancer (rate per 100,000 population)	33.9	35.2	36.2		▶	◀	2011 - 13
192 Incidence of prostate cancer (rate per 100,000 population)	178	175	174		▶	▶	2010 - 12
193 Deaths from prostate cancer (rate per 100,000 population)	48.3	45.0	49.1		▶	◀	2011 - 13

Table 2.



Cancer incidence for all cancers combined



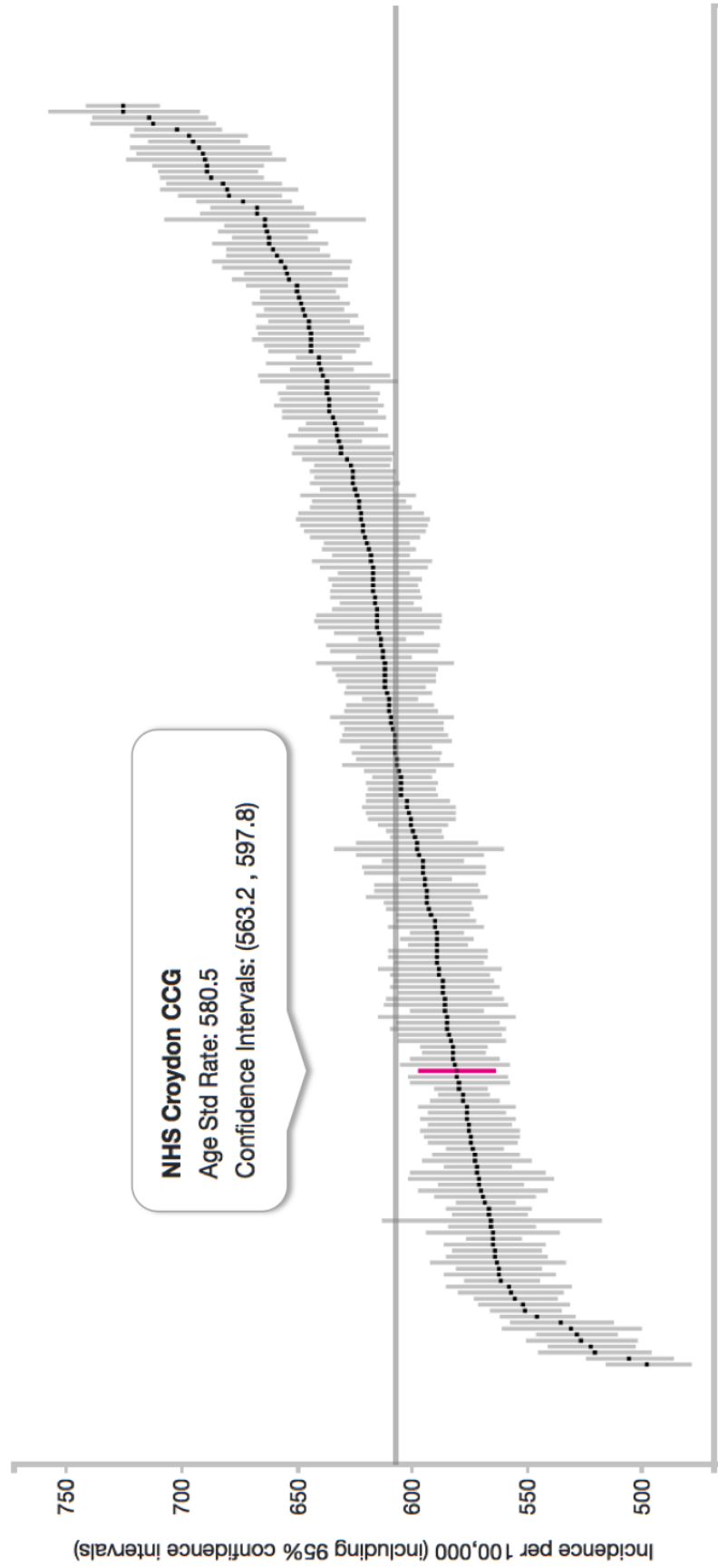
**580.5**

NHS Croydon CCG



**606.7**

National Average



Regions

Table 3.

Mortality for all cancers combined



260

NHS Croydon CCG



285.4

National Average

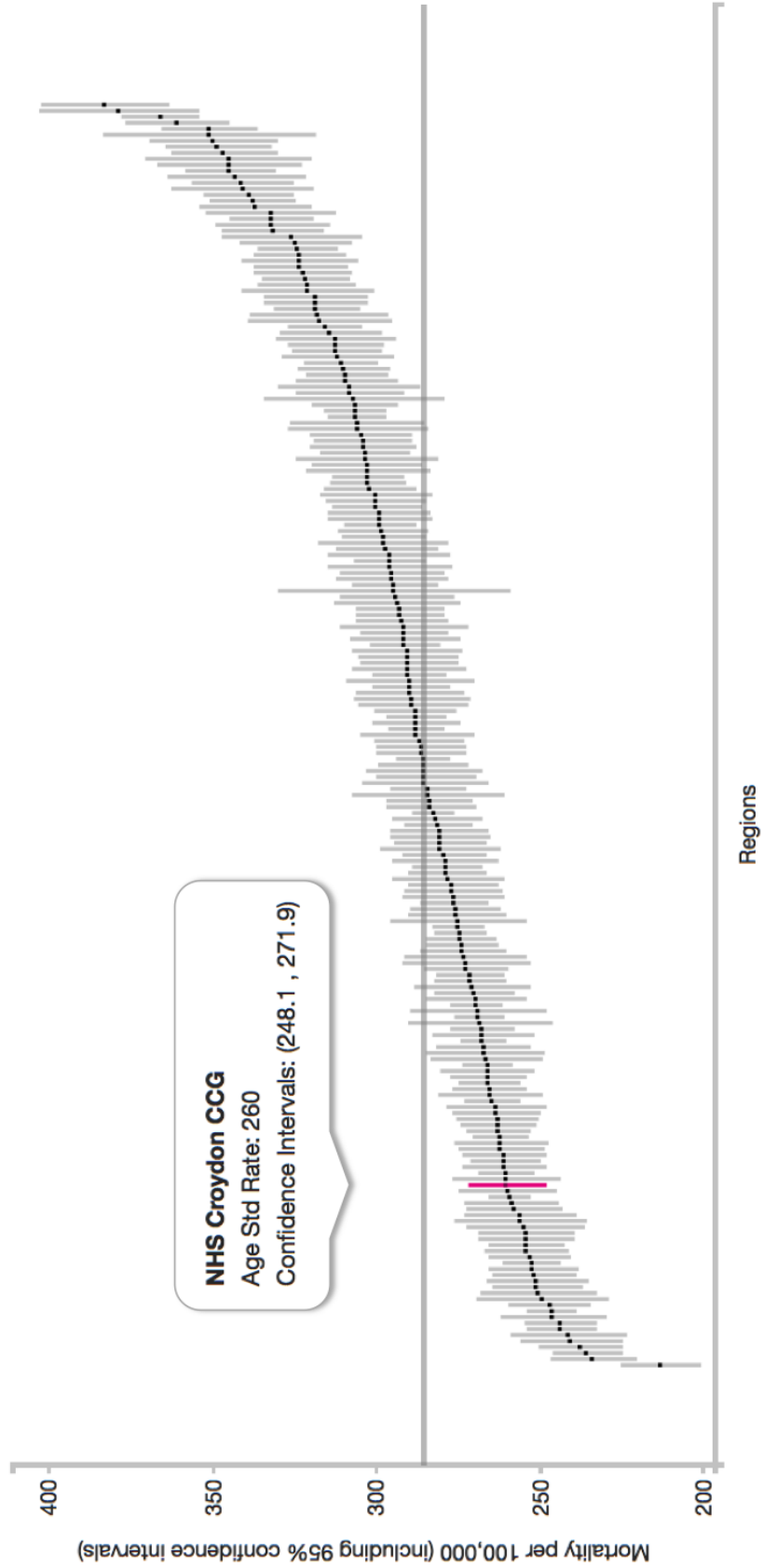


Table 4.

### 3.5 Health inequalities in cancer

Health inequalities issues relating to cancer exist, associated particularly with deprived communities and Black and Minority Ethnic (BME) groups. These inequalities issues manifest themselves in the following areas:<sup>11</sup>

- **Cancer incidence, mortality and survival** – for example, African Caribbean men have three times the risk of being diagnosed with prostate cancer than do White men in the UK<sup>12</sup>
- **Lifestyle factors that predispose people to cancer**, such as obesity and smoking – for example, while 19% of the general smoke tobacco,<sup>13</sup> 32% of people with depression smoke<sup>14</sup> and up to 60% of people with psychosis smoke.<sup>15</sup> These groups also smoke more intensively than the general population<sup>16</sup>
- **Perceptions of cancer risk**, with more privileged groups tending to be more informed about risk factors – for example, in one survey, twice as many people from the least deprived group reported being aware of the link between fruit and vegetable consumption and cancer compared with the most deprived group<sup>17</sup>
- **Cancer symptom recognition**, with some evidence suggesting that some groups may have reduced awareness – for example, older women may have poor levels of breast cancer symptom recognition, even though their risk of developing breast cancer is higher than younger women<sup>18</sup>
- **Awareness of and use of health services**, with so-called 'harder to reach' groups having unmet needs around information, support and services – for example, participation in breast, cervical, and colorectal screening programmes is generally lower in minority ethnic groups than in the population as a whole<sup>19</sup>
- **Experience of cancer treatment** – for example, there is some evidence that indicates older people receive poorer cancer treatment than younger people<sup>20</sup>

3.6 The Equality Act 2006 makes it unlawful to discriminate on the grounds of race, age, gender, sexual orientation and religion in the provision of goods, facilities and services. Effective steps to address health inequalities in cancer are described in *Improving Outcomes: A Strategy for Cancer, 2011*. These include greater targeting and tailoring of interventions all along the cancer pathway;

---

<sup>11</sup> Cancer and health inequalities: An introduction to current evidence. Cancer Research, 2006

<sup>12</sup> Yoav Ben-Shlomo et al. The risk of prostate cancer amongst Black men in the United Kingdom: The PROCESS cohort study. *European Urology* 2008; 53 99-105

<sup>13</sup> 2014 Opinions and Lifestyle Survey Office for National Statistics, Feb. 2016

<sup>14</sup> 2007 Adult Psychiatric Morbidity Survey

<sup>15</sup> Adult psychiatric morbidity in England, 2007. Results of a household survey. The Health and Social Care Information Centre. [http://www.esds.ac.uk/doc/6379/mrdoc/pdf/6379research\\_report.pdf](http://www.esds.ac.uk/doc/6379/mrdoc/pdf/6379research_report.pdf)

<sup>16</sup> The Royal College of Physicians. Smoking and mental health London, RCP, March 2013

<sup>17</sup> Reduce the Risk Survey (2004) Cancer Research UK

<sup>18</sup> Grunfield et al. (2002) *Women's knowledge and beliefs regarding breast cancer* *British Journal of Cancer* 86, 1373-1378

<sup>19</sup> Evidence to March 2010 on cancer inequalities in England [www.ncin.org.uk/equalities](http://www.ncin.org.uk/equalities)

<sup>20</sup> Turner. NJ, Haward RA, Mulley. GP, Selby PJ. Cancer in old age - is it inadequately investigated and treated? *BMJ*.1999.319:309-12.

applying a 'human rights' approach to delivering personalised cancer care; and embedding equality in cancer services so it is not seen merely as an 'add-on'.

Local areas can identify and address cancer related health inequalities by:

- Working with local authorities, public health teams and other partners to develop up-to-date intelligence, health inequalities mapping and health needs assessments. This will enable the provision of the most targeted solutions to meet the specific needs of different groups, thereby reducing health inequity.
- Providing targeted and tailored interventions at levels proportionate to identified need, in line with the principal of 'proportionate universalism', as advocated by the Marmot Review.<sup>21</sup>
- Undertaking detailed equalities impact assessments for all strategies, plans and provision.
- Understanding existing variations in disease prevalence, uptake of preventative interventions, and primary care and secondary care use that may reflect health inequality or differing needs. Develop plans to address these variations.
- Working with patients, the public and other stakeholders to develop outcomes-focused plans that meet identified needs in an equitable way. Strengthen this partnership approach to health and wellbeing with different communities.
- Focus investment 'upstream' to ensure health needs are met as early as possible for everyone.

## **4. PREVENTION**

### **4.1 Need for cancer prevention in Croydon**

Arguably, prevention of ill-health has never been higher on the agenda for health and social care in England. The NHS Five Year Forward View puts our present challenge in the starkest terms. It claims the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health.<sup>22</sup> Sadly, public health budgets are shrinking even as the need for strong public health measures becomes more pressing. This intensifies our present challenge.

4.2 The World Cancer Research Fund has estimated that 27-39% of the main types of cancers can be prevented by improving diet, physical activity and body composition.<sup>23</sup> Data from The World Health Organisation show that 40% of cancer cases could be prevented by lifestyle changes.<sup>24</sup> Healthier lifestyles,

---

<sup>21</sup> Fair Society, Healthy Lives. The Marmot Review, 2010

<sup>22</sup> <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

<sup>23</sup> Policy and action for cancer prevention. Food, nutrition, and physical activity: a global perspective. Washington, DC, World cancer research fund/american institute for cancer research, 2009.

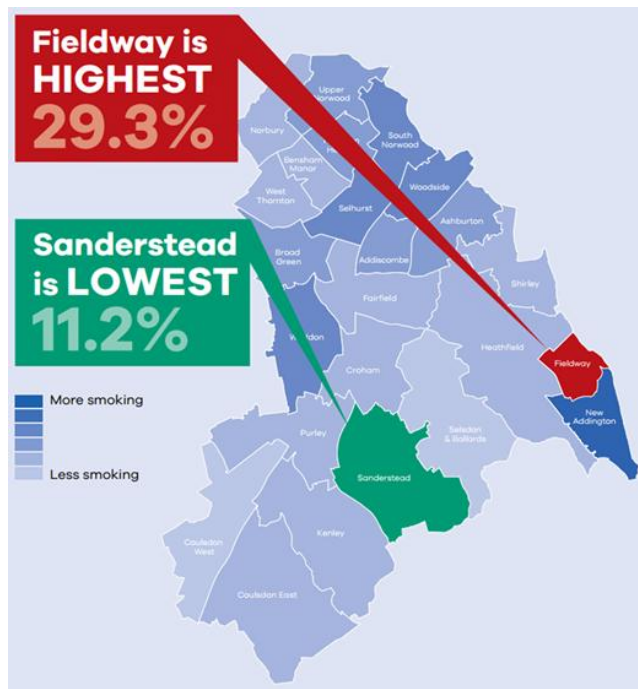
<sup>24</sup> [http://www.who.int/chp/chronic\\_disease\\_report/full\\_report.pdf](http://www.who.int/chp/chronic_disease_report/full_report.pdf)

promoted through effective ill-health prevention, will lead to reduced incidence of cancers (table 5).<sup>25</sup>

Lifestyle factor	Cancer cases prevented	% of new cancer cases
Be Smokefree	64,500	19%
Keep a healthy weight	18,100	5%
Eating fruit and veg	15,100	5%
Drink less alcohol	12,800	4%
Be SunSmart	11,500	3%
Less processed and red meat	8,800	3%
Eat a high fibre diet	5,100	2%
Be active	3,400	1%
Eat less salt	1,700	1%
Other factors	Cancer cases prevented	% of new cancer cases
Minimise risks at work, such as asbestos	12,100	4%
Minimise certain infections, such as HPV	10,600	3%
Minimise radiation, such as unnecessary x-rays	6,100	2%
Breastfeed of possible	2,700	1%
Minimise any time spent on HRT	1,700	1%

Table 5.

4.3 Smoking is the biggest single cause of preventable cancers. Smoking causes more than one quarter (28%) of all cancer deaths in the UK.<sup>26</sup> More than eight out of ten lung cancers are caused by smoking.<sup>27</sup> According to the 2015 Annual Public Health Report for Croydon, locally one in five adults still smokes tobacco (58,000 people) and two thirds of these people started smoking before the age of 18, which is the legal age for purchasing tobacco products.



<sup>25</sup> Parkin DM, Boyd L, Walker LC. The fraction of cancer attributable to lifestyle and environmental factors in the UK in 2010. Summary and conclusions (link is external). Br J Cancer 2011;105 (S2):S77-S81.

<sup>26</sup> Parkin, DM. Tobacco-attributable cancer burden in the UK in 2010. Br J Cancer 2011; 105: S6-S13

<sup>27</sup> Cancer Research UK <http://www.cancerresearchuk.org/health-professional/cancer-statistics/incidence>

- 4.4 Smoking is the most significant cause of health inequalities.<sup>28</sup> Those who work in routine and manual occupations (low paid work) are twice as likely to smoke as the general population,<sup>29</sup> so smoking rates are higher in deprived areas. In Fieldway, one of Croydon's most deprived wards, 29% of adults smoke, whereas in Sanderstead, which is one of the most affluent, only 11% of adults smoke.<sup>30</sup> People with mental health problems also bear a disproportionate burden of smoking harms and smoking is the single largest contributor to the 10-20 year reduced life expectancy gap for this group.<sup>31</sup>
- 4.5 Alcohol use and obesity also contribute to ill-health including cancer. One in six adults in Croydon drinks at risky levels and two in three adults are overweight or obese (181,000 people)<sup>32</sup> predisposing them to a range of cancers. The links between economic deprivation, mental health problems and excessive use of alcohol are well established.<sup>33</sup> Raised Body Mass Index (BMI) increases the risk of cancers of the breast, colon/rectum, endometrium, kidney, oesophagus and pancreas.<sup>34</sup> <sup>35</sup> Conversely, moderate physical activity for 150 minutes each week is estimated to reduce the risk of breast and colon cancer by 21–25%.<sup>36</sup>
- 4.6 In line with national trends, Croydon's population is getting older and excess weight in the population is increasing.<sup>37</sup> This means that, without action, incidence of lifestyle-related cancers is likely to increase correspondingly.
- 4.7 Other factors associated with cancer can be addressed through communications campaigns around sun protection and interventions such as improving vaccination rates for HPV.
- 4.8 Action on prevention in Croydon**  
Public Health Teams based within local authorities lead on local preventative health, tying into regional and national campaigns as appropriate e.g. British Heart Foundation's National No Smoking day;<sup>38</sup> Alcohol Concern's Dry January,<sup>39</sup> and Public Health England's (PHE) Change 4 Life.<sup>40</sup>

<sup>28</sup> Fair Society, Healthy Lives. The Marmot Review, 2010

<sup>29</sup> 2014 Opinions and Lifestyle Survey Office for National Statistics, Feb. 2016

<sup>30</sup>

<https://www.croydon.gov.uk/sites/default/files/articles/downloads/Annual%20Public%20Health%20Report%20for%202015.pdf>

<sup>31</sup> Primary care guidance on smoking and mental disorders. Primary Care Mental Health Forum, 2014. <http://www.rcpsych.ac.uk/pdf/PrimaryCareGuidanceonSmokingandMentalDisorders2014update.pdf>

<sup>32</sup>

<https://www.croydon.gov.uk/sites/default/files/articles/downloads/Annual%20Public%20Health%20Report%20for%202015.pdf>

<sup>33</sup> Clustering of unhealthy behaviours over time: Implications for policy and practice. King's Fund, 2012.

<sup>34</sup> Policy and action for cancer prevention. Food, nutrition, and physical activity: a global perspective. Washington, DC, World cancer research fund/american institute for cancer research, 2009.

<sup>35</sup> The world health report 2002: Reducing risks, promoting healthy life. Geneva, World Health Organization, 2002.

<sup>36</sup> Global health risks: mortality and burden of disease attributable to selected major risks. Geneva, World Health Organization, 2009.

<sup>37</sup> <http://www.croydonobservatory.org/profiles/profile?profileid=47>

<sup>38</sup> <https://www.bhf.org.uk/health-at-work/blog/no-smoking-day>

<sup>39</sup> <http://www.dryjanuary.org.uk/>

4.9 Public Health Teams also commission or provide behaviour change services and support to enable local residents to make healthy changes to their lifestyles. These services are evidence-based and provide good return on investment.<sup>41</sup> For example, it has been suggested that preventing a 1% increase in the number of people who are overweight or obese could save the NHS and Local Authorities around £97 million per annum.<sup>42</sup> A locally commissioned report in 2010, found that for every £1 invested in smoking cessation services, Croydon gained a return on investment of £5.36.<sup>43</sup>

4.10 Though local Public Health Teams have the key role, other council departments should support ill-health prevention, as should other public sector organisations, voluntary sector organisations and even local employers through workplace health initiatives, such as the Workplace Wellbeing charter,<sup>44</sup> which is supported by NHS England (NHSE) and PHE. Such workplace health initiatives could be supported by local public health teams and the NHS to raise the profile among employers. This represents a communications opportunity.

#### 4.11 **The launch of Livewell**

Croydon Council's new Livewell programme will integrate the existing separate behaviour change services including smoking cessation, weight management and physical activity. The aim of Livewell is to help improve the health and wellbeing of the borough's residents by supporting healthy behaviour change.

4.12 One arm of the programme, known as 'Just Be', will promote behaviour change via an online platform providing information and practical advice on local health improvement services and assets. 'Just Be' will be complemented by the service currently known as MiChange, which is a 12-week, face-to-face motivational interviewing plan. MiChange has already delivered some success with past users. A broad marketing programme will be essential to achieving further success.

4.13 Livewell is due to roll out in quarters 3-4 of 2016-17. The implementation of the Livewell programme necessitates greater and continuing engagement with partners and stakeholders, in particular local healthcare services and local clinicians. The digital solution that comprises the main component of the council's behaviour change offer is heavily dependent on strong and consistent referral and signposting from local health, social care and voluntary sector professionals. Without this robust partnership, an online solution provided by a local authority is likely to experience difficulties in reaching potential users due

---

<sup>40</sup> <http://www.nhs.uk/change4life/Pages/change-for-life.aspx>

<sup>41</sup> <https://www.nice.org.uk/about/what-we-do/into-practice/return-on-investment-tools>

<sup>42</sup> <https://www.nice.org.uk/news/press-and-media/nice-produces-interactive-tools-to-help-local-authorities-improve-peoples-health-and-save-money>

<sup>43</sup> Croydon Smoking Costs. The Mackinnon Partnership, 2010.

<sup>44</sup> <http://www.wellbeingcharter.org.uk/index.php>

to being crowded out by gamut of high-quality, online alternatives already offering healthy lifestyle advice and support.

#### 4.14 NHS Healthchecks Programme

Local authorities are also responsible for offering the National NHS Healthchecks Programme to their residents, which provides an opportunity to offer face-to-face, individualised health and wellbeing advice. The NHS Healthchecks programme aims to help people lower their risk of developing common but often preventable diseases. Croydon has struggled to achieve national targets for NHS Healthchecks in recent years. The JSNA key dataset for 2015-16 shows that there is work to do around offers of Healthchecks to residents, as well as delivery of Healthcheck interventions. A partnership approach is a useful way of increasing uptake, as will targeting the Healthchecks offer to local communities of higher risk.

Domain	Indicator	Croydon	London	England	England Range
NHS health checks	274 Offered an NHS health check (cumulative % of eligible people aged 40-74)	11.9%	44.6%	37.9%	
	275 Received an NHS health check (cumulative % of eligible people aged 40-74)	6.9%	21.5%	18.6%	

Table 6.

#### 4.15 Local policy and regulation

The Local Authority also has powers to implement local policies that improve preventive health. For example, by legislating against shisha bars, the proliferation of unhealthy takeaways and restricting the availability of alcohol through licensing or mandatory pricing arrangements.

#### 4.16 NHS prevention initiatives

The NHS increasingly plays a role in preventative health too. In particular this priority is promoted through Making Every Contact Count (MECC),<sup>45</sup> a partnership between PHE, NHSE and Health Education England as well as other organisations. MECC is an approach to behaviour change that uses the millions of day-to-day interactions that occur within the NHS, and other health and social care organisations, to support people in making positive changes to their physical and mental health and wellbeing.

4.17 A MECC interaction takes a matter of minutes and is not intended to add to the busy workloads of health, care and the wider workforce staff, rather it is structured to fit into and complement existing professional clinical, care and social engagement approaches. Evidence suggests that the broad adoption of the MECC approach by people and organisations across health and social care could potentially have a significant impact on the health of our population.<sup>46 47</sup>

<sup>45</sup> <https://www.gov.uk/government/publications/making-every-contact-count-mecc-practical-resources>

<sup>46</sup> Making Every Contact Count (MECC): Consensus statement, Produced by Public Health England, NHS



4.18 Croydon CVA is a delivery partner for MECC, and receives grant funding from the CCG to deliver Asset Based Community Development and MECC in some of Croydon most deprived wards.

4.19 In addition, primary care are addressing cancer risk factors – for example, a majority of GP networks have chosen obesity as a priority for their Practice Development and Delivery Schemes (PDDS).

#### 4.20 **Together for Health**

Croydon CCG is promoting and embedding prevention in its commissioning approaches through its Together for Health (TFH) programme. TFH seeks to improve patient outcomes and experience as well as creating conditions for a more financially sustainable local healthcare system. It achieves this through actively promoting, encouraging and embedding Prevention, Self-Care, Self-Management and Shared Decision Making (PSSSD) within the healthcare workforce and the wider population to increase independence, personal responsibility and personal ownership and around health and wellbeing. This will allow people to become informed and active participants in their health - in line with the strategic vision laid out in the NHS Five Year Forward View.

#### 4.21 **Outcomes Based Commissioning through The Croydon Accountable Provider Alliance**

Outcomes Based Commissioning (OBC) is an innovative approach that promotes the integration of health and social care services in order to transform the way services are provided for older people in Croydon. The Croydon Accountable Provider Alliance (APA) will deliver OBC. The APA partners comprise Age UK, Croydon Council Adult Social Care, Croydon GP Collaborative, Croydon Health Services NHS Trust and South London & Maudsley NHS Foundation Trust. The APA's goal is to develop high-quality, person-centred, evidence-based, co-ordinated models of care for the over 65s in Croydon by engaging with stakeholders and the public. Due to a capitated budget arrangement, OBC will need to focus on prevention and early intervention as a fundamental principle of delivery. OBC is due to roll out in October 2016.

#### 4.22 **The alignment of Local prevention programmes**

A workshop took place in July 2016 for the teams delivering Together for Health, Outcomes Based Commissioning and Public Health's Livewell programme. The purpose of this workshop was to discuss aligning these three local programmes, which all share ambitions around 'upstream' health and wellbeing in Croydon, and to establish what the benefits, risks and practical considerations would be for such a proposal. As they have common goals, it

has been proposed that the three programme teams should increase cooperation, collaboration and programme alignment through greater partnership working. A general consensus emerged from the workshop that further work should be undertaken to dovetail the programmes.

## **5. AWARENESS**

5.1 Early diagnosis is vital in the fight to beat cancer. It has been estimated that if cancer survival rates in Great Britain matched the European average, then 6,000–7,000 deaths could be avoided each year. And if they matched the best, around 11,500 deaths could be avoided.<sup>48</sup> A key part of early diagnosis is public awareness of signs or symptoms of possible cancer. Awareness is worryingly low.

### **5.2 Delays in detection**

There are three main barriers to early detection of cancer: public delay, GP delay and system delay. Tackling GP delay is addressed through addressing variation e.g. in rates of urgent referral, or in the provision of direct access diagnostics. System delay is addressed primarily through the waiting time standards framework. Patient delay relates to lack of knowledge, lack of awareness, attitudes to risk and even patient anxieties.

### **5.3 Patient delay**

In a 2010 survey conducted by Cancer Research UK, more than three quarters of people asked to list possible warning signs and symptoms of cancer failed to mention pain, coughing or problems with bowels or bladder.

5.4 Even when people recognised signs they thought might be serious the survey found that nearly 40% said they might delay getting symptoms checked out because they would be worried about what the doctor might find and more than 25% might delay because they would be worried about wasting the doctor's time.<sup>49</sup>

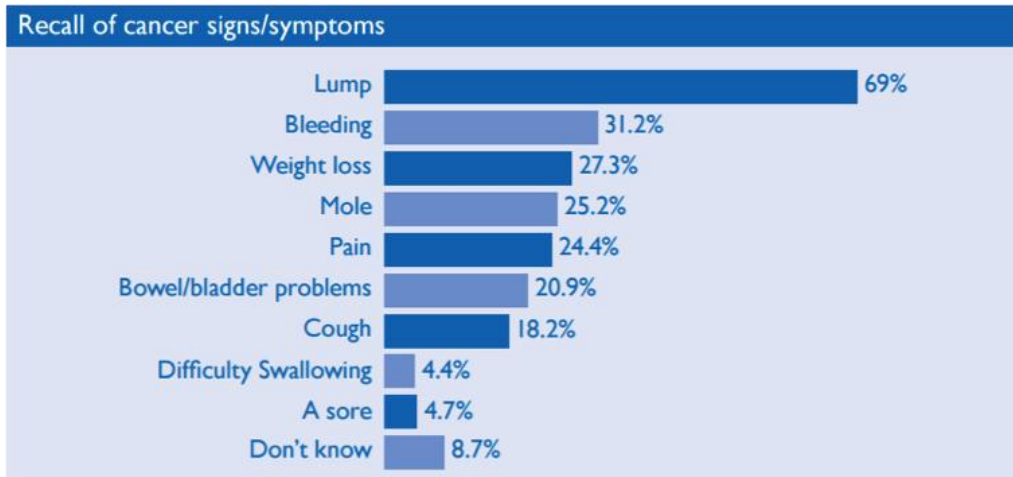
---

48

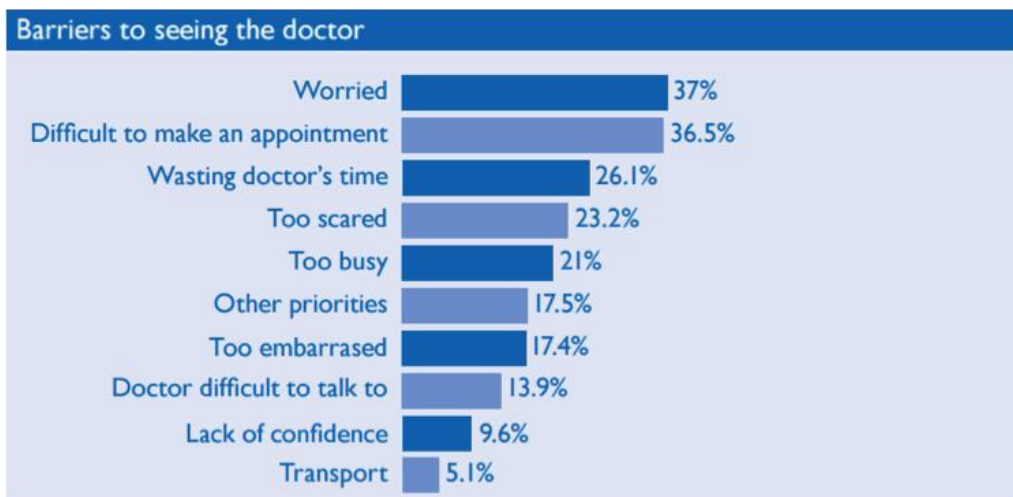
[http://www.cancerresearchuk.org/prod\\_consump/groups/cr\\_common/@abt/@gen/documents/generalcontent/cr\\_085096.pdf](http://www.cancerresearchuk.org/prod_consump/groups/cr_common/@abt/@gen/documents/generalcontent/cr_085096.pdf)

49

[http://www.cancerresearchuk.org/prod\\_consump/groups/cr\\_common/@abt/@gen/documents/generalcontent/cr\\_085096.pdf](http://www.cancerresearchuk.org/prod_consump/groups/cr_common/@abt/@gen/documents/generalcontent/cr_085096.pdf)



(Tables courtesy Cancer Research UK)



## 5.5 Be Clear on Cancer

Be Clear on Cancer is a series of national campaigns aiming to improve early diagnosis of cancer by raising public awareness of signs and/or symptoms of cancer, and to encourage people to see their GP without delay. The programme is led by PHE, working in partnership with the Department of Health, NHSE and Cancer Research UK. Each campaign is tested locally and then regionally, and then rolled out nationally if it proves to be effective.

The advertisement features a green background. In the top left, a white stamp-like box contains the text 'BE CLEAR ON CANCER'. In the top right, there is a search bar with the text 'Find your local GP' and the NHS logo. Below this is a text input field labeled 'Enter your postcode' and a 'Find' button. On the left, a photograph of Dr Ian Watson, a male doctor with glasses and a white coat, is shown. He is holding a white sign that says 'Tell your doctor'. To the right of the photo, the text reads: 'Been coughing for 3 weeks or getting out of breath easily? Tell your doctor.' Below this text are two buttons: 'Persistent coughing' and 'Out of breath'. At the bottom right, the name 'Dr Ian Watson' is written.

5.6 Local partners should work together more closely to reinforce the impact of national campaigns through local channels. This would include information in local GP practices, secondary care, pharmacies, council services, through the voluntary sector and local awareness events led by public health. Efforts might be focused in areas where communities are particularly susceptible to certain cancers, or in pathways where a bottleneck of high-risk people might be found e.g. stop smoking services.

## 6. SCREENING

Cancer screening is an important way to detect cancer early. In the UK there are national screening programmes for breast, cervical and bowel cancer.

6.1 **Breast screening** is offered to women aged 50-70 in England. Women over 70 can still be screened, but will need to make their own appointment as they will not get an invitation. In England, this age range is gradually being extended to 47-73. **Cervical screening** is offered to women aged 25-64 in England. **Bowel screening** is offered to men and women aged 60-74 in England and a new test called Bowel Scope is starting to be offered to people at age 55.

6.2 In Croydon, six GP Networks exist – each comprising a number of local GP practices. Practices and their networks are profiled annually for a range of indicators around demography, disease prevalence, activity and quality of care - including cancer screening uptake. The networks are:

1. Mayday (MDY)
2. Thornton Heath (THN)
3. East Croydon (ECR)
4. Woodside/Shirley (WSS)
5. Purley (PRY)
6. New Addington/Selsdon (NAS)

6.3 The data in the network profiles highlights the areas where each network is significantly different from the Croydon average or where performance is well below target. As can be seen in table 7 below, there is variation around cancer prevalence as well as around cancer screening. Of especial concern are the low rates of bowel screening for 60-69 year olds within three GP networks. In the current year, practices have been given the opportunity to choose bowel screening as a practice priority within their mandatory Practice Development and Delivery Schemes (PDDS). This may help incentivise improved performance for this screening programme. Though it is not reflected at network level, Croydon poor performance around breast cancer screening has already been highlighted above.

5.6.1 Prevalence and incidence										
Indicator	MDY	TNH	WSS	NAS	PRY	ECR	Cro	Lon	Eng	Target
Cancer diagnosed (since 1st April 2003) (all ages)	1.36%	1.56%	1.84%	2.06%	2.41%	1.42%	1.75%	1.54%	2.26%	
New cancer cases (incidence per 1,000)	2.84	3.57	3.66	4.45	4.61	3.32	3.70	3.38	5.08	

5.6.2 Cancer screening										
The targets shown are the national targets for coverage.										
Indicator	MDY	TNH	WSS	NAS	PRY	ECR	Cro	Lon	Eng	Target
Cervical screening coverage (last 5 yrs) (ages 25-64)	68.3%	74.1%	73.9%	75.0%	76.4%	68.1%	72.2%	68.4%	73.5%	80
Cervical screening coverage (excl. exceptions) (CS002)	79.5%	82.4%	82.2%	84.1%	85.8%	78.5%	81.8%	79.7%	81.8%	80
Breast screening coverage (last 3 years) (age 50-70)	57.9%	58.2%	66.3%	65.1%	69.0%	58.6%	62.9%	64.2%	72.2%	80
Bowel screening coverage (last 2.5 years) (age 60-69)	42.3%	43.4%	52.0%	53.8%	58.2%	44.2%	49.8%	48.8%	57.9%	

Table 7.

#### 6.4 Support to address variation in screening

Practices are also receiving individual support visits to address variation against a number of cancer indicators. The CCGs own Variation Team provides the core support, across the whole range of care, helping practices eliminate variation, in line with best practice in local primary care.

6.5 In addition, Croydon has on-site practice support provided by our Macmillan GP, Dr Jaimin Patel, and our Cancer Research UK Health Professional Engagement Facilitator, Ekta Patel. Both work closely with individual practices to deliver a recognisable improvement across cancer care. Their work includes:

- Providing support and clinical advice to inform CCG strategies for cancer and end of life care
- Influencing GP peers to drive up standards of cancer care and ensure continuous improvement
- Facilitating and enabling education of primary health care teams
- Supporting practice nurses to take on a greater role for cancer, building on their skills used to support people with other long-term conditions
- Pathway and service redesign, including support to achieve quality and productivity targets

- Enhancing communication between primary, secondary and tertiary care

This support also involves assistance around other areas of cancer care, such as addressing variation in cancer urgent referrals (2 week waits); conversion rates for urgent referrals (positive diagnoses); ‘safety netting’ to ensure patients are not lost during referral; Significant Event Audits (SEA) to analyse cases where care doesn’t go as planned and addressing health inequalities variation for BME groups, the elderly and the deprived.

Find a list of the practices visited in the past 12 months by our Macmillan GP and CRUK Engagement Facilitator below (table 8).

Practices visited in 12 months to date	Date:	Cancer Research UK	Macmillan
Portland medical centre	01/10/2015	x	x
Greenside Medical Practice	16/10/2015	x	
Mitchley Avenue Surgery	12/11/2015	x	
Downland Surgery	18/11/2015	x	
Old Coulsdon Medical Practice	25/11/2015	x	
Leander Road Primary Care Centre	30/11/2015	x	x
The Moorings Medical Practice	08/12/2015	x	
Parkside Practice	09/12/2015	x	x
The Coulsdon Medical Practice	09/12/2015	x	
Mersham Medical Centre	10/12/2015	x	
Selsdon Park	14/12/2015	x	
Woodcote Group	23/12/2015	x	
Keston	07/01/2016	x	
Brigstock Medical Practice	22/01/2016	x	x
Bramley Medical Practice	25/01/2016		x
Auckland	10/02/2016	x	
Violet Lane	12/02/2016	x	x
Norbury Medical Practice	07/03/2016	x	x
Thornton Heath	19/04/2016	x	x
Hartland Way Surgery	22/07/2016	x	x
Stovell House Surgery	01/08/2016	x	x

Table 8.

6.6 Croydon CCG has also used a Local Incentive Scheme (LIS) to deliver screening for prostate cancer in men – Prostate Specific Antigen (PSA). A range of additional practice visits took place in support of this LIS.

## 7. DIAGNOSIS

### 7.1 Cancer survivorship

Cancer survival is a key measure of the effectiveness of health-care systems. Persistent regional and international differences in survival represent many

avoidable deaths. Internationally, England is not among the best for cancer survivorship. During 1995–2007, survival for four cancers (breast, colorectal, lung and ovarian) improved in a number of comparable countries including England. However, survival was persistently higher in Australia, Canada, and Sweden, intermediate in Norway, and lower in Denmark, England, Northern Ireland, and Wales, particularly in the first year after diagnosis (table 9) and for patients aged 65 years and older.<sup>50</sup>

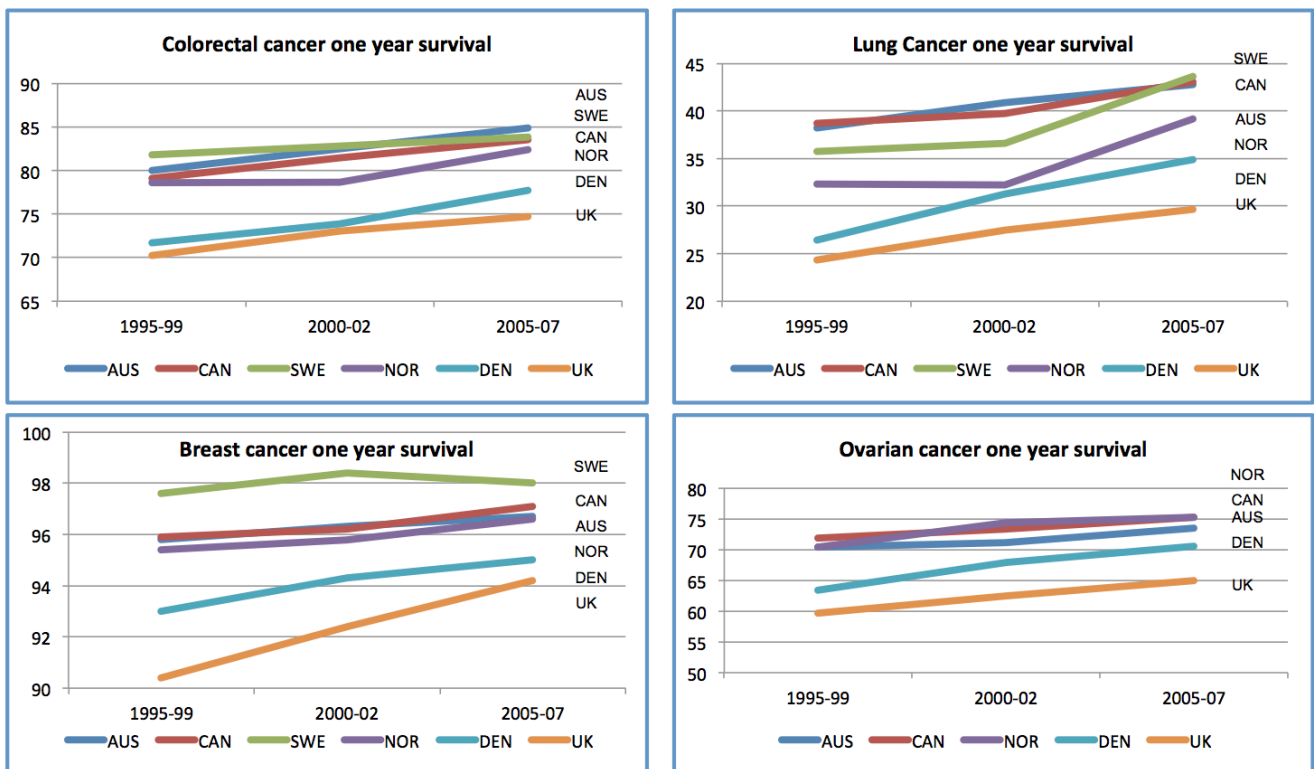


Table 9.

7.2 Evidence suggests that this variation in cancer survival is attributable to late diagnosis. In one study,<sup>51</sup> excess mortality in England was found to particularly pronounced in the first month and in the first year after diagnosis, and generally more marked in the oldest age groups. Survival was more comparable to better performing countries after the first year (see table 10). This suggests that cases are being diagnosed at later stages when cancer is less amenable to treatment.

<sup>50</sup> Cancer survival in Australia, Canada, Denmark, Norway, Sweden, and the UK, 1995–2007 (the International Cancer Benchmarking Partnership): an analysis of population-based cancer registry data. Coleman et al. 2010

<sup>51</sup> International Journal of Cancer. Volume 127, Issue 11, pages 2630-2638, 16 FEB 2010 DOI: 10.1002/ijc.25264 <http://onlinelibrary.wiley.com/doi/10.1002/ijc.25264/full#fig4>

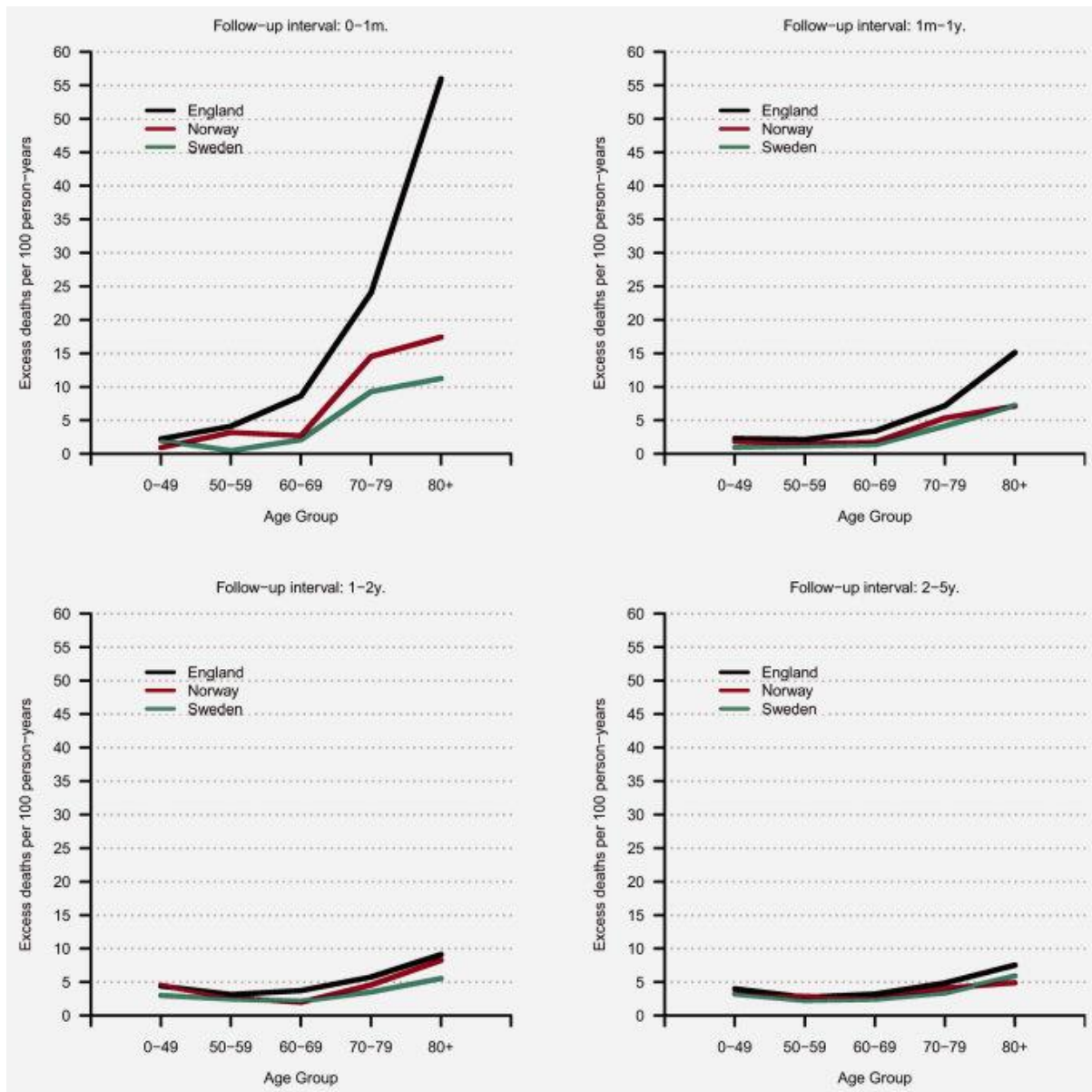


Table 10.

7.3 In London alone, more than a quarter of diagnoses are made in accident and emergency – which is very late. Croydon CCG’s rate of diagnosis of cancer through emergency admission is 17.4% of cases, which is lower than the England average of 20.1% (see table 11). CCGs are now measured on one-year cancer survival as part of the *NHS England Assurance Framework* and improving cancer survival is one of the three key ambitions outline in *Achieving World-Class Cancer Outcomes*.<sup>52</sup>

<sup>52</sup> <https://www.england.nhs.uk/wp-content/uploads/2016/05/cancer-strategy.pdf>



## Emergency Presentations

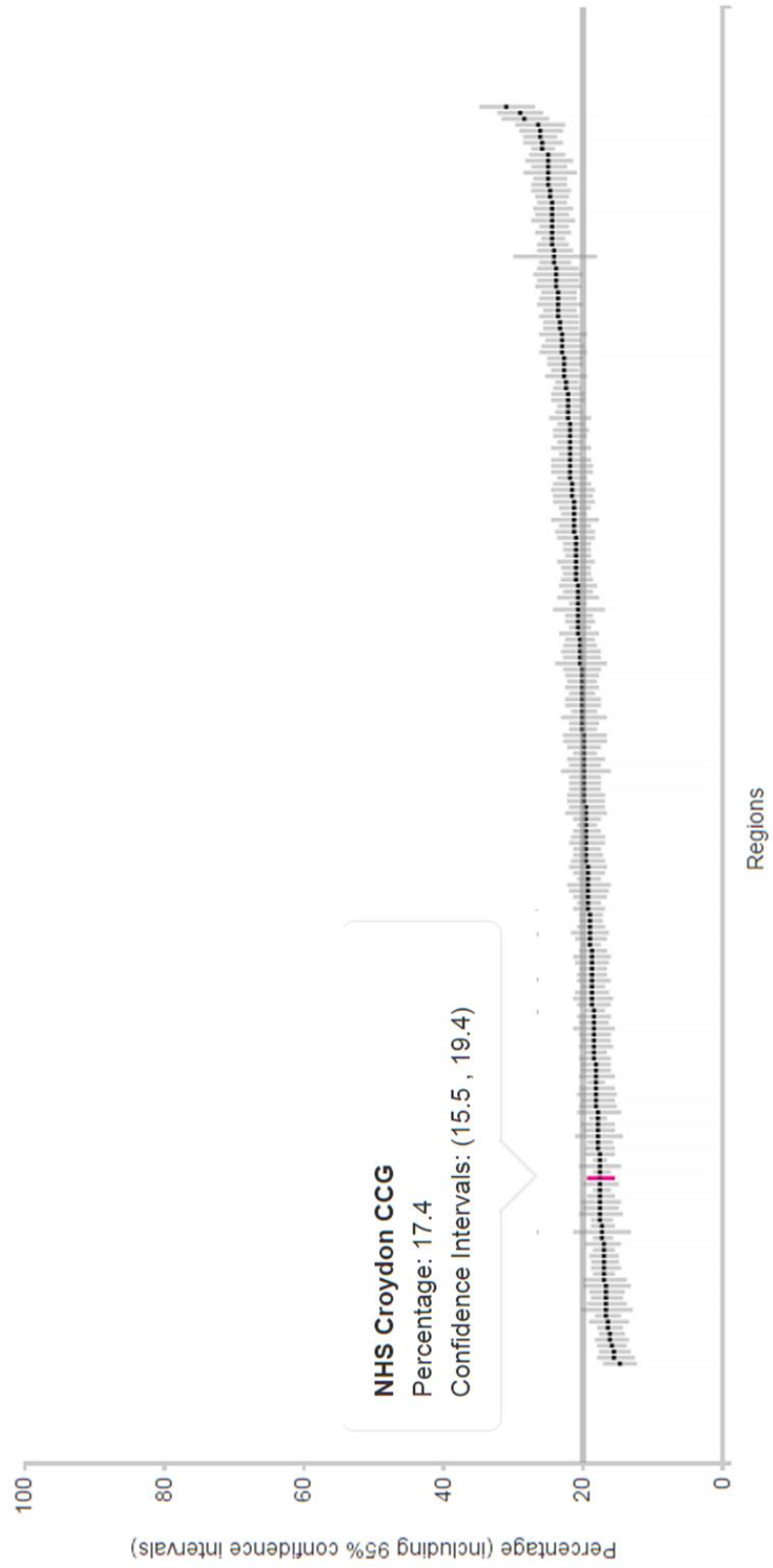


Table 11.

#### 7.4 What is cancer staging?

Staging is a way of describing the size of a cancer and how far it has grown. Ideally cancer is diagnosed at the earliest stage possible when it is more treatable. When a cancer is first diagnosed, tests are carried out to establish how big the cancer is and whether it has spread into surrounding tissues. Checks will also be made to see whether it has spread to other parts of the body. Cancer staging systems may sometimes include grading of the cancer, which describes how similar a cancer cell is to a normal cell.

- 7.5 Staging is important because it helps determine appropriate treatment and it is strongly associated with survival: 1 year survival goes from 98% at stage 1 down to 46% for stage 4. The dominant staging model for commissioners uses four stages. A description of what the stages mean for most types of cancer is as follows:

**Stage 1** usually means that a cancer is relatively small and contained within the organ where it started

**Stage 2** usually means the cancer has not started to spread into surrounding tissue but the tumour is larger than in stage 1. Sometimes stage 2 means that cancer cells have spread into lymph nodes close to the tumour. This depends on the particular type of cancer

**Stage 3** usually means the cancer is larger. It may have started to spread into surrounding tissues and there are cancer cells in the lymph nodes in the area

**Stage 4** means the cancer has spread from where it started to another body organ. This is also called secondary or metastatic cancer

#### 7.6 Reducing late stage diagnosis

Cancer survival rates in England have never been higher, but clearly we still lag behind the highest performing countries in the world. We know that the earlier cancer is diagnosed, the more likely it is to be successfully treated, and survival rates can be dramatically improved. Much of the early work that emphasised the importance of early diagnosis comes from the National Awareness and Early Diagnosis Initiative (NAEDI), a partnership between public and third sector organisations which was formed in 2008.<sup>53</sup> More recently, the independent cancer taskforce, in their report *Achieving World-Class Cancer Outcomes*, published in July 2015, set an ambition for the NHS that 62% of all cancers with known stage at diagnosis would be diagnosed at stages 1 and 2 by 2020. Achieving this target will require every CCG to focus on and make significant improvement in early stage diagnoses.

- 7.7 Supporting clinicians to spot cancers earlier and allowing greater GP access to diagnostic and specialist advice were outlined in the NHS Five Year Forward View as key means of improving our diagnostic success. In addition, The

---

<sup>53</sup> [http://www.cancerresearchuk.org/sites/default/files/health\\_professional\\_naedi\\_briefing\\_sheet.pdf](http://www.cancerresearchuk.org/sites/default/files/health_professional_naedi_briefing_sheet.pdf)

National Institute of Clinical Excellence (NICE) published new guidance on appropriate referral for suspected cancer in 2015, which lowered the threshold of risk for symptoms suggestive of cancer to trigger an urgent referral for suspected cancer to 3%, with the aim of diagnosing more cancers at an early stage.<sup>54</sup> So called 'low risk but not no risk' cases.

#### 7.8 **Quality premium: Cancer Diagnosed at Early Stage**

The NHSE Quality Premium is a financial incentive intended to reward CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

7.9 An indicator describing the proportion of cancers diagnosed at an early stage is clearly a useful measure for assessing improvement in early diagnosis and, ultimately, cancer survival. Thresholds have been set by NHSE based on levels of improvement previously seen amongst high-performing CCGs and thus felt to be achievable for the majority of CCGs.<sup>55</sup>

7.10 One limitation around the Quality Premium scheme in the current year (its first year) is a latency problem around staging data. Currently the most recent staging data is from the year 2013-14. In order to determine performance against the Quality Premium, access to accurate in-year data is necessary. The South West London Transforming Cancer Services Team (TCST) is working to address this problem by reducing the existing two-year lag in staging data. A solution is anticipated in quarter three of 2016-17.

#### 7.11 **Cancer waiting times in Croydon**

The NHS has set maximum waiting time standards for access to healthcare. In England, those for cancer care fall under two headings: Individual patient right (as per the NHS Constitution) and waiting time standards to which the Department of Health holds both individual providers and commissioners to account.

Patients with suspected cancer have the right to:

- Access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible
- Be seen by a cancer specialist within a maximum of two weeks from urgent GP referral for suspected cancer

Government pledges on waiting times include:

- A maximum two-week wait (2WW) to see a specialist for all patients referred with suspected cancer

---

<sup>54</sup> <https://www.nice.org.uk/guidance/conditions-and-diseases/cancer>

<sup>55</sup> Quality Premium: 2015/16 Guidance for CCGs. NHSE, 2015

- A maximum 2WW to see a specialist for all patients referred for investigation of breast symptoms, even if cancer is not initially suspected
- A maximum one-month (31-day) wait from the date a decision to treat (DTT) is made to the first definitive treatment for all cancers
- A maximum 31-day wait for subsequent treatment where the treatment is surgery
- A maximum 31-day wait for subsequent treatment where the treatment is an anti- cancer drug regimen
- A maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy
- A maximum two-month (62-day) wait from urgent referral for suspected cancer to the first definitive treatment for all cancers
- A maximum 62-day wait from referral from an NHS cancer screening service to the first definitive treatment for cancer
- A maximum 62-day wait from a consultant's decision to upgrade a patient's priority to the first definitive treatment for all cancers

#### **7.12 Croydon CCG performance on cancer waiting times**

As can be seen from table 12, to May 2016 Croydon is experiencing some success in meeting its waiting time targets, outperforming its SWL peers in many cases. The exception to this is the 62 day standard target, where some underperformance has been recorded. Plans to address and improve this performance issue are being implemented. It should be noted however, that Trusts report ever increasing pressures and there is a real risk that performance on waiting times may be in jeopardy going forward.

Cancer waits in Croydon - NHS Croydon CCG									
	Target	Performance YTD	Performance Month	Breaches	Latest Data	Previous Months			12M Trend
						Apr-16	Mar-16	Feb-16	
Cancer - 2 weeks	93%	96.4%	96.6%	39	May-16	96.2%	97.0%	97.4%	▲
Breast symptoms 2 week wait	93%	92.7%	94.9%	6	May-16	90.4%	99.0%	100.0%	▲
Cancer - 31 days	96%	97.5%	98.0%	2	May-16	97.1%	100.0%	98.4%	▲
31 day first definitive treatment	94%	96.9%	100.0%	0	May-16	93.8%	100.0%	100.0%	▲
31 day subsequent treatment drug	98%	100.0%	100.0%	0	May-16	100.0%	100.0%	100.0%	▲
31 day subsequent treatment radiotherapy	94%	97.8%	97.7%	1	May-16	97.9%	100.0%	100.0%	▲
Cancer - 62 days	85%	81.9%	77.0%	14	May-16	87.3%	85.1%	89.0%	▲
62 day standard	90%	90.9%	100.0%	0	May-16	87.5%	100.0%	90.9%	▲
62 day screening	90%	100.0%	100.0%	0	May-16	100.0%	87.5%	100.0%	▲
62 day upgrade									
<b>Quarterly Activity</b>									
Cancer - 2 weeks	93%	95.3%	96.6%	104	Mar-16			96.7%	▲
Breast symptoms 2 week wait (Quarterly)	93%	95.3%	99.6%	1	Mar-16			96.9%	▲
Cancer - 31 days	96%	98.0%	96.7%	12	Mar-16			98.0%	▲
31 day first definitive treatment (Quarterly)	94%	96.1%	96.1%	2	Mar-16			93.3%	▲
31 day subsequent treatment drug (Quarterly)	98%	99.8%	100.0%	0	Mar-16			100.0%	▲
31 day subsequent treatment radiotherapy (Quarterly)	94%	98.0%	98.6%	2	Mar-16			97.5%	▲
Cancer - 62 days	85%	82.4%	84.1%	32	Mar-16			88.7%	▲
62 day standard (Quarterly)	90%	92.4%	95.8%	1	Mar-16			95.5%	▲
62 day screening (Quarterly)	90%	87.1%	95.5%	1	Mar-16			80.0%	▲
62 day upgrade (Quarterly)									

Table 12.

### 7.13 Croydon CCG commissioning intentions 2016-17

In its commissioning intentions for the current year, the CCG committed to the following measures supporting earlier detection and treatment of cancers:

1. All GPs to have direct access to colonoscopy for low risk, not no risk of cancer via a diagnostic service
2. All GPs to have direct access to diagnostic services - flexible sigmoidoscopy for low risk, not no risk of cancer
3. All GPs to have direct access to diagnostic services - non-obstetric ultrasound for low risk, not no risk of cancer
- 3a. In order to promote the earlier diagnosis of ovarian cancer, services will be commissioned to support Ultrasound (US) and CA125 concurrently (CA 125 is a blood test to check for the cancer antigen which in itself is not a definite indicator for ovarian cancer which is why an ultra should also be undertaken)
4. All GPs to have direct access to same day chest x-ray for high risk of cancer and access for low risk, not no risk of cancer
- 4a. In order to support the reduction of the risk of delayed diagnosis, all commissioned services will be required to formally report A&E, Urgent Care Centres and inpatient chest x-rays

These standards have now been enshrined within the acute care contract as local quality requirements which will add extra impetus to their achievement.

## 8. CONCLUSION

### 8.1 The importance of partnership working

Good cancer care encompasses comprehensive prevention and awareness raising; targeted screening; early and accurate diagnosis through prompt and appropriate referral; high-quality, evidence-based treatment and aftercare; holistic support, including psychological support for patients and their families all along the pathway, including for those who are 'Living with and Beyond' (LWAB) cancer; effective palliative care; and care planning to meet individuals needs and desires at the end of life (EOL).

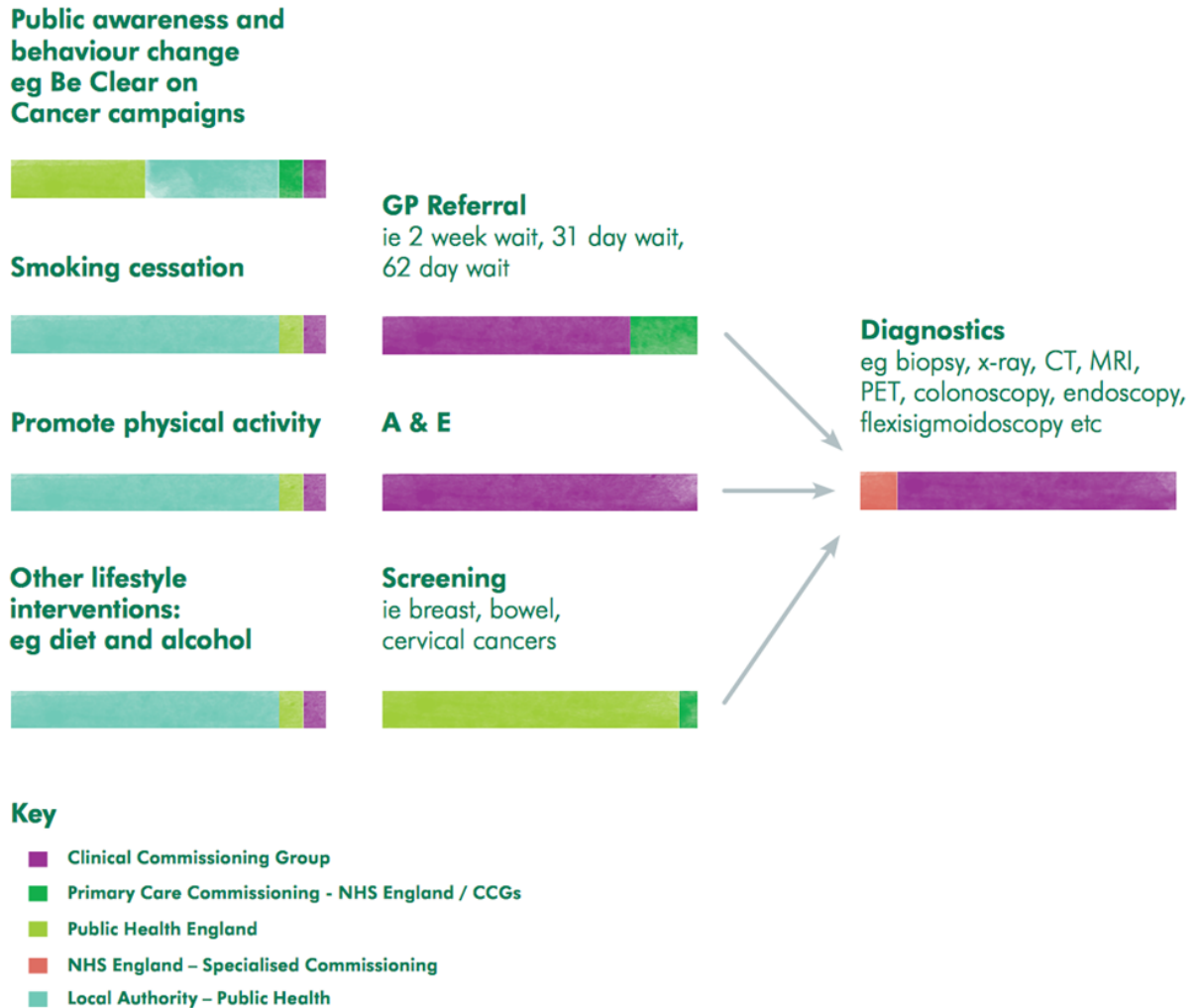
8.2 Responsibility for commissioning these varied elements of cancer provision is shared across multiple commissioners. Therefore all these commissioners must collaborate closely to deliver improved cancer outcomes and experience (figure 1).

8.3 If we are to improve cancer prevention, as well as **increasing early detection and treatment of cancers in Croydon**, a number of commissioning partners will need to come together. These partners are:

- Croydon CCG
- Primary Care Commissioning - NHS England
- Public Health England

- NHS England - Specialised Commissioning
- Croydon Council - Public Health

Shared commissioning responsibilities from prevention to diagnostics



This diagram is an estimate and is not an exact representation of responsibilities; it will vary according to the particular intervention and any local arrangements. It illustrates that responsibility for and commissioning of activities that impact on one-year cancer survival is shared across organisations, so close collaboration is essential. The Health and Wellbeing Board should play a key role to bring the health and care system together to improve the health and wellbeing of their local population and reduce health inequalities.

Figure 1.

8.4 Only through working together can local partners give patients and the public in Croydon the best possible cancer provision, increasing healthy life expectancy, reducing differences in life expectancy between communities and improving wellbeing and quality of life for all.

**9. CONSULTATION**  
NOT APPLICABLE

**10. SERVICE INTEGRATION**  
NOT APPLICABLE

**11. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS**  
NOT APPLICABLE

**12. LEGAL CONSIDERATIONS**  
NOT APPLICABLE

**13. EQUALITIES IMPACT**  
NOT APPLICABLE

---

**CONTACT OFFICER:** Jimmy Burke, Senior Commissioning Programme Lead  
Croydon Clinical Commissioning Group

E-mail: Jimmy [Burke@croydonccg.nhs.uk](mailto:Burke@croydonccg.nhs.uk)

Tel: 0208 544 2268